The high cost of health care can produce severe financial shock on poor households that can ill afford it. Faced with catastrophic health care spending, poor households are forced to reduce their expenses on basic items such as food, transportation, and education; use their savings, if there are any; or borrow in order to cope with the medical bills of one or more of their members. Prolonged—and at times—fatal illness of the household head could mean deeper poverty for the rest of the household.

In light of this situation, the critical role of health insurance is being recognized. Health insurance programs “ease the burden of medical expenses during times of illness and medical emergencies”¹ and prevent “impoverishment through protection against catastrophic health expenditure” (Kabawata, Xu, and Carrin 2002).² Preliminary analysis by Kabawata and others of income and expenditure survey data for 60 countries shows that lower income groups have a greater proportion of households with catastrophic levels of health care spending than do higher income groups.

To address this problem, governments have typically used either one or a combination

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Many developing countries have decided to implement social health insurance programs. The aim is to provide universal coverage for the population at affordable prices. In the Philippines, the National Health Insurance Act of 1995 tasks the Philippine Health Corporation (PhilHealth) to attain universal coverage for the population using the SHI approach.

of the following: (a) tax-financed health insurance programs that are accessible to all of their population, or (b) social health insurance (SHI) which, in principle, involves compulsory membership of the population. For the first approach, wage earners, salaried workers, the self-employed, firms, and government pay contributions into a social health insurance fund. Government may subsidize the contributions of those who are unable to pay. Under the second approach, the SHI may either own a provider network, use accredited public and private health care providers, or use a combination of both. ³

Many developing countries have decided to implement social health insurance programs. The aim is to provide universal coverage for the population at affordable prices. Some examples of social health insurance programs are community-based health insurance schemes in East Africa (Musau 1999) and health financing schemes in Chile, Korea, and India (GTZ 2005). In the Philippines, the National Health Insurance Act of 1995 (Republic Act 77875) tasks the Philippine Health Corporation (PhilHealth) to attain universal coverage for the population using the SHI approach. Formal sector workers, employees, and the self-employed in the business sector contribute to a social health insurance fund managed by the PhilHealth. However, the informal sector, a very large segment of the population, remains outside the social health insurance cover. To reach this sector, PhilHealth uses a strategy called “Kalusugang Sigurado at Abot Kaya sa PhilHealth Insurance (KASAPI)” program.

This Policy Notes comments on the design features of KASAPI to identify areas for improvement by policymakers, PhilHealth, and its partner organizations.

Why use KASAPI?
Ten years after the establishment of PhilHealth, a study by Jowett (2004) observed that the formal sector still accounted for two-thirds of those in the health insurance scheme of the public sector. Less than one in five health insurance scheme members came from the informal sector. Only one among two working people has an official contract of employment, the basis for being classified as part of the formal sector. The other half of the labor force work on a noncontractual basis in the informal sector or in self-employment such as street ven-

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dors, petty traders, or motorcycle taxi drivers. One-third of the population are classified as poor. A serious illness can mean financial ruin for a whole family. Currently, patients are still expected to pay over 40 percent of the costs of their drugs and medical treatment themselves.\(^5\)

The KASAPI program “aims to help a range of organizations like microfinance institutions (MFIs) and cooperatives to provide social health insurance to their members through an affordable group payment scheme under the National Health Insurance Program (NHIP).”\(^6\) PhilHealth is the biggest health provider network with more than 1,500 facilities and more than 19,000 accredited health care professionals nationwide. For the informal sector, a PhilHealth membership means that a member and his dependents can enjoy health coverage “anytime and anywhere in the country” (ibid.).

Under KASAPI, the MFIs and cooperatives act as marketing and collection agents for PhilHealth insurance to reach the informal sector. This partnership can lead to the inclusion of a huge number of those currently outside the NHIP, thereby significantly contributing to universal coverage.

**An analytical framework**

The design features or activities of KASAPI are as follows: (a) generation of sufficient resources for sustainable health care financing; (b) optimal resource utilization by modifying incentives and adopting appropriate use of these resources; and (c) assurance of financial accessibility to health services. The final goal of KASAPI is the overall health of the informal sector that will be achieved through the outputs of the three activities (Figure 1).\(^7\)

The first design feature has two parts: (a) population base or coverage, and (b) method of payment or collection. The main challenges include (a) having a comprehensive enrollment of the target population, (b) finding the most effective means to enroll the target population (the informal sector), (c) monitoring demand preferences and actual access to health services, and (d) expanding health insurance membership of the informal sector. A broad and heterogeneous coverage addresses the problem of adverse selection. There is a need to develop a suitable method of payment or collection for those in the informal sector who have irregular income or cash flows and lack access to banking facilities.

The second design feature has three components: (a) benefit package, (b) provider payment mechanism, and (c) administrative

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\(^7\) The approach takes off from Diagram 1: Social health insurance – financing targets and final health system goals (Carrin and James). Guy Carrin and Chris James (2004), Reaching universal coverage via social health insurance: Key design features in the transition period, Discussion Paper No. 2-2004, World Health Organization, Geneva.
efficiency. The KASAPI guidelines state that “three months after enrollment and payment of premium contributions, the members and their dependents become entitled to inpatient and certain outpatient benefits under the program.” The annual premium contribution is PhP1,200. The package of benefits include hospital room and board, hospital and doctor’s services, maternity care, complicated deliveries, eye surgeries, organ transplant benefits, SARS treatment benefit, TB directly-observed treatment short course, outpatient benefit package, and dialysis in freestanding dialysis facilities.

And the third design feature has three basic parts: (a) level of consolidation of beneficiaries, (b) composition of risk pools, and (c) affordable tariffs or premiums. Risk pooling is crucial because individual persons no longer bear the risk on an individual basis.

**Issues and areas of improvement**

**Competition imposed by the Indigent (Sponsored) Program**

A principal constraint to the implementation of KASAPI is the competition provided by the government’s sponsored program, that is, the Indigent Program, also a component strategy of the NHIP. The tax-financed Indigent Program and the individually paying, member-financed KASAPI exist side by side and are both implemented and managed by PhilHealth. The problem is the lack of an effective firewall to prevent migration from the member-financed KASAPI to the subsidized Indigent Program. Under the sponsored program, a beneficiary enjoys a subsidy to the premium contribution. The local government unit (LGU) and the national government pay for the premium contribution of targeted local constituents (Box 1).

In principle, there are cogent arguments for providing premium subsidies to those too destitute to afford health insurance. Catastrophic health expenditures, for one, will drive the indigents deeper into the poverty pit. But precisely because of these premium subsidies, beneficiaries (who are not indigents) are motivated to migrate from the KASAPI to the sponsored

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**Figure 1. KASAPI – activities and final goal**

![Diagram showing performance of KASAPI on three activities: Coverage and resource generation, Optimal resource use, Financial accessibility of health services for all, and final goal: HEALTH.](image-url)
programs. The leakage bloats the budget for premium subsidy and the free riding creates a big fiscal burden for the sponsored program. KASAPI is also adversely affected because of the reduction in coverage and in the associated revenue generation. The leakage therefore puts at risk the viability and sustainability of both the KASAPI and sponsored programs and creates a large fiscal burden on both the national government and LGUs. It promotes dependence on subsidized financing for an otherwise legitimate individual expenditure of a KASAPI beneficiary.

There is of course scope for improving the targeting of members from the informal sector. Effective targeting will identify real indigents who are qualified for the sponsored program, prevent leakage from the individually paying program such as KASAPI, and conserve scarce government resources. To attain this, PhilHealth can work with LGUs and MFIs/cooperatives in using such tools as the Community-Based Monitoring System (CBMS), now a primary tool used by LGUs in poverty mapping, planning, program implementation, and monitoring. CBMS stores and displays household and individual level information and uses basic indicators to determine the welfare status of local population. On the other hand, MFIs and cooperatives have also developed their respective targeting methodologies for microfinance services to poor communities.

PhilHealth should first examine the policy framework for the indigent (sponsored, tax-financed) program and the KASAPI (member-financed program). It is possible to have both tax-based health financing and individually paying program in health insurance models but great care has to be exercised to avoid distortion in the strategy to attain universal coverage and to prevent the weakening of the NHIP resulting from the migration of paying beneficiaries to the subsidized sponsored program.

**Monitoring and evaluation**

There is a need for an efficient monitoring and evaluation (M&E) system to track the performance of both the MFIs/cooperatives.

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8 The Social Health Insurance in Batanes named Kapanidungan sa Kalusugan (KsK) had discussions about a partnership with PhilHealth but the partnership did not materialize because of the implementation of the sponsored program in the area. CARD MBA reported that the sponsored program poached members from the KASAPI-CARD MBA partnership.
and accredited health care providers. Monitoring will yield a valuable stream of data, e.g., level of utilization, pattern of illness, money cost per unit of care for different health services, quality of care perceptions, demand patterns and preferences, among others, that PhilHealth can use to gauge the performance of health care providers in order to improve service delivery. For example, an efficient M&E system will be able to cross match statistics of claims report of health care providers with MFI reports on use of health care benefits by their members. Making such information available to the public will create an incentive for good performance by both the health care providers and the agents such as MFIs/cooperatives that are used by the PhilHealth to enroll individuals from the informal sector into the NHIP.

There is a need for a standardized data collection system, a computer-based bookkeeping and control system to deal with the voluminous data and information generated by thousands of MFI/cooperative clients or members. With manual processing, there is a great risk of data inconsistencies and errors and inefficient service delivery. Already, MFI partners are wary of the inefficiencies in the KASAPI Members Information System (KMIS) installed in their computers and meant to help them encode members’ data, record premium payments, and prepare remittance reports.9

Monitoring mechanisms should be in place to ensure that the benefit package is fully received by all the insured who are entitled to it. This could be accomplished by an appeals mechanism that enables patients to give feedback or information on the quality of health care that they have received. The appeals mechanism will create an incentive for health care providers to provide the best and correct treatment possible, especially because of the asymmetric information present in an agency relationship between the patient (‘the principal’) and the health care provider (‘the agent’) who is better informed and makes decision on behalf of the patient. The agency relationship can expose a provider not providing interventions included in a benefit package to a patient even when they are necessary (Carrin and James 2004). There may also be cases of overprovision of health interventions which will unduly burden the KASAPI program as observed by Kwon (2005). Health care providers can increase their income by increasing the price, volume, and intensity of health care.10

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9 The problem with KASAPI’s database is that it is difficult to cross match the data file of organized groups (OG) with that of the PhilHealth. One reason is that OG members may be members of both the individually paying program (IPP) and indigent (sponsored) programs. Sorting and filtering membership data file entail a high transaction costs if the MIS is inefficient. There is a need to ensure that all members of OGs are enrolled and that there is no duplication of membership. A big NGO partner in KASAPI observes that their database and that of PhilHealth are not synchronized and there is no electronic link with PhilHealth for easy monitoring and updating of membership.

should thus be developed to take care of these concerns as well to enable PhilHealth to evaluate whether or not claims made by health care providers are justifiable.\textsuperscript{11}

Monitoring and review of claims will reduce the possibility of fraud by health service providers. Unannounced visits by PhilHealth staff to health service providers may be used to compare documentation and claims to detect inconsistencies and fraud. In addition, Asanza (2006) notes that the PhilHealth KASAPI program has developed a monitoring framework and log-frame with performance indicators and targets.\textsuperscript{12} However, this has yet to be fully implemented.

\textit{Treating MFIs and cooperatives as real development partners}

PhilHealth’s effort to partner with MFIs and cooperatives to reach the informal sector appears to be a sound strategy. Because of their strong links with the informal sector, these organizations have developed an effective distribution and collection network for their financial products and services. In this light, it would be best for PhilHealth to have a good understanding of MFIs and cooperatives. This will lead to a respect for MFIs, cooperatives, and organized groups who want to be treated as real development partners, not mere marketing and collection agents for the KASAPI.\textsuperscript{13}

At the same time, the success of the KASAPI strategy will depend on the financial soundness and solid performance of these organizations in providing their members with access to finance services. The World Bank (2006) points out that “although there is intuitive appeal for insurance to be linked to MFIs, in practice, many MFIs are struggling to achieve and maintain financial sustainability, and adding another product or service could overwhelm them.”\textsuperscript{14} PhilHealth should therefore monitor their performance and establish links with associations such as the Microfinance Council of the Philippines and regulatory bodies such as the Cooperative Development Authority and the Bangko Sentral ng Pilipinas that monitor cooperatives and microfinance banks, respectively.

\textit{Awareness, information, and education campaign}

The Memorandum of Agreement of the MFIs and cooperatives with PhilHealth stipulates the conduct of information and education (IEC) campaigns on the policies, rules, and regulations related to the benefits under the NHIP; on procedures for availing the NHIP’s

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\textsuperscript{11} See Carrin and James (2004).
\textsuperscript{12} Anna Asanza (2006). Support to the implementation of PhilHealth Board Resolution 719, Final Report, July 19.
\textsuperscript{13} One big MFI partner of PhilHealth complains that there is “a one-way partnership with PhilHealth… There were some problems resulting from the lack of understanding about operations of an MFI and attitudes of PhilHealth personnel toward informal sector workers.”
\textsuperscript{14} Social Protection Unit and the Financial Services Department (2006). Risks, poverty, and insurance: innovations for the informal economy. Workshop Proceedings, World Bank, September. In this same paper, the World Bank says that “insurance could actually strengthen the financial sustainability of MFIs.”
benefit package; and on members’ rights and obligations under the NHIP. An effective IEC campaign will contribute to a better understanding of health insurance and will be an important tool for building trust in the industry.

IEC campaigns will make potential members—people who have to scrimp on meager resources and do not easily accept the idea of health insurance—understand the benefits of membership and how it works to their advantage. The campaigns may also help erase some people’s bad memories of failed local insurance companies.

**Risk pooling**

Membership in partner MFIs/cooperatives is voluntary. Because of this, it is difficult to reach the whole of the target population of KASAPI. Moreover, voluntary membership in social health insurance schemes gives rise to adverse selection “where bad (high) risks chase good (low) risks out of the insurance market” (Carrins and James 2004). The risk pool will thus be composed mainly of higher risk beneficiaries where new members may only begin to enroll when they fall ill. In this case, the premium contributions of the high-risk individuals may not be sufficiently adjusted to fit this high-risk profile. Thus, inefficient risk pooling arising from voluntary membership in KASAPI will give rise to such an adverse selection situation. Typical strategies to deal with this would be to modify the benefit package or adjust upward the premiums to take care of the concentration of risk. These strategies, however, fail to completely eliminate the adverse selection problem.

MFIs/cooperatives have somewhat mitigated this problem by providing incentives for enrollment, e.g., advancing the premium contributions or giving out “health loans” that are amortized over a period of time. They also admit as members individuals who come from a broad range of socioeconomic classes in the informal sector. On the other hand, KASAPI provides a much lower group premium rate when membership enrollment reaches a certain size. This may encourage MFIs to enroll more of their members.

To be sure, compulsory membership is preferred to ensure universal coverage and to address the problem of adverse selection. Compulsory membership in KASAPI is possible, as indicated by the interviews conducted by this author. Cooperatives can require compulsory membership by way of a resolution passed by the general assembly. In exchange, cooperatives can pay for the enrollment of their members in the KASAPI as a free benefit. The payment may come from the optional fund required by law of all cooperatives where 10 percent of net surplus is set aside every year comprising of two parts: (a) community development, and (b) social services. The health insurance package may be given as part of social services if the general assembly so approves it.
NGO–MFIs and rural banks, unfortunately, do not have a similar mechanism to encourage compulsory membership. However, experience shows that the trust of members with their MFIs, whether these are NGOs, cooperatives, or rural banks, can inform a drive for compulsory membership. Successful MFIs and members have a long-standing relationship built on mutuality, trust, and confidence. The more successful MFIs include life insurance and/or credit life insurance as a mandatory component of their loan products. There is thus scope for the inclusion of health insurance as a mandatory component of the services received from those MFIs.

Improving accessibility and affordability of health care

Member-beneficiaries want a health insurance program that is both affordable and accessible in terms of easy payment of premium contributions, filing of claims, settlement of claims, and other related administrative procedures. The affordability of the health insurance package likewise depends on the mode of payment, e.g., flexible payment methods that are adjusted to the cash flow of informal sector workers and microenterprises. With the assistance of MFIs/cooperatives, PhilHealth should devise a system of premium collection and remittance that is flexible, adjusted to the irregular cash flow of members and requires minimal documentation.¹⁵

Recognition and acceptance of these realities in the informal sector will be important first steps for PhilHealth to adjust its internal rules and procedures accordingly. Some MFI partners indicate their willingness to advance the premium contributions of their members and treat the advance as a soft loan that is amortized over a short period of time. This is an example of a flexibility that is used to address the objectives of affordability and accessibility. At the same time, MFIs earn interest income from these advances.

The long-term patronage of the KASAPI program also depends on the quality and range of health care services provided to members. There is a need for a continuing effort to monitor, review, and accredit only high quality health care service providers.

Accessibility of health care relies on the physical location of health facilities and professionals. The high cost of local travel and distance reduce the attractiveness of KASAPI. This should thus merit the immediate attention of PhilHealth.

Finally, there should be continuous product development and marketing of a suitable and affordable health insurance package for the informal sector. Well-designed health insurance products encourage membership in the KASAPI. PhilHealth and its partners

¹⁵ This is not an insurmountable challenge. The recognition by the Bangko Sentral ng Pilipinas of the peculiarities of microfinance led it to develop circulars that are conducive to the growth of the microfinance industry, without necessarily creating undue risks for the financial system.
should combine efforts to establish demand preferences, profiles of potential clientele, health risks that may be specific to certain areas or regions, among others, to inform product development. PhilHealth should conduct willingness-to-pay surveys to establish demand preferences and affordability levels by the target (informal) sector.

**Combining preventive and curative health plans to address moral hazard**

Finally, moral hazard problem affects health insurance plans. Members or policyholders should stay as healthy as possible to minimize the number and value of claims. One way to reduce the number and value of claims is to emphasize preventive care among members. Timely health interventions should be undertaken prior to the onset of fatal or life-threatening illness of a member or prior to admission to a hospital/clinic for curative purposes.

PhilHealth’s intervention happens at the curative level when the member is admitted as a patient in a hospital. This therefore becomes a relatively costly program. It will therefore be useful for PhilHealth to consider a health insurance package that provides both preventive and curative health care benefits. A proactive health risk management approach composed of consultation with accredited physicians and other health care workers as well as access to laboratory tests before the onset of illness will increase the attractiveness of PhilHealth’s social health insurance program. It will also help reduce the financial burden of the program as members receive timely health interventions prior to actual sickness.

Another way to reduce moral hazard is to use positive incentives. The traditional approach uses negative incentives such as excluding certain situations or behaviors from coverage like alcoholism, drug abuse, among others. A positive incentive is to give a rebate, reward, or prize to members who did not make any claim during the year. Brown and Churchill (2000) report that the Start Up Fund in South Africa provides policyholders with incentives, e.g., substantial bonus for not engaging in behavior that leads to moral hazard. Capitation payments, that is, paying the health service provider a fixed fee for the size of the population served instead of paying for the number of services offered, will, on the other hand, reduce overprovision of treatment and related services.

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10 Brown and Churchill (2000) note that health insurers exclude from coverage self-destructive behavior such as alcoholism, drug abuse, and injuries resulting from participation in riots.