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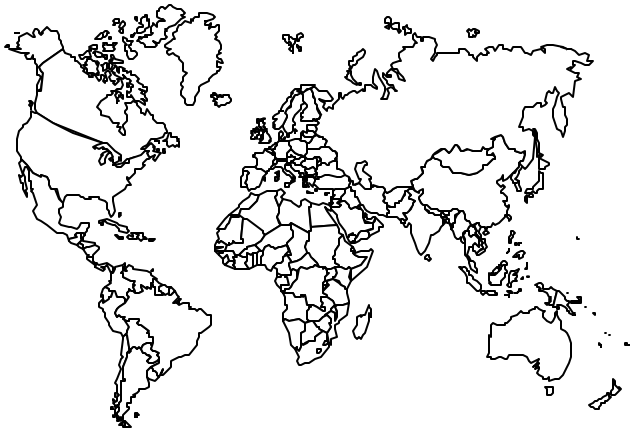

PHILAMCARE LOW-COST HEALTH PLAN (PHILIPPINES)

FINAL EVALUATION REPORT MAY 1994–DECEMBER 1996

By

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The PROFIT (Promoting Financial Investments and Transfers) Project seeks to mobilize the resources of the commercial sector to expand and improve the delivery of family planning services in selected developing countries. The PROFIT Project is a consortium of five firms, led by the international management consulting firm of Deloitte Touche Tohmatsu and including the Boston University Center for International Health, Multinational Strategies, Inc., Development Associates, Inc., and Family Health International.

This report is part of a series of PROFIT Evaluation Reports, which address various topics related to private sector family planning. The studies grow out of PROFIT subprojects within the following three strategic areas: innovative investments, private health care providers, and employer-provided services.

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We will use your comments and suggestions to improve our reporting and dissemination of the lessons and experiences of the PROFIT Project's work to involve the commercial sector in developing country family planning services.

CONTENTS

LIST OF TABLES

ACRONYMS

CPR	contraceptive prevalence rate (percent of women aged 15 to 49 years who use use modern methods of contraception)
DMPA	Depo-Provera® (injectable)
DRTI	DRTI Consultancy, Inc. (Philippines)
FP	family planning
GSIS	Government Service Insurance System
HMO	health maintenance organization
IUDs	intrauterine devices
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health (formerly the Johns Hopkins Program for International Education in Gynecology and Obstetrics)
JSI	John Snow, Inc.
MCCH	Metro Cebu Community Hospital
MCM	Medical Center Manila
MJH	Mary Johnston Hospital
PROFIT	Promoting Financial Investments and Transfers Project
SHH	Sacred Heart Hospital
SSS	Social Security System
USAID	U.S. Agency for International Development
USAID/G/PHN/POP	U.S. Agency for International Development's Office of Population

EXECUTIVE SUMMARY

In May 1994, the Promoting Financial Investments and Transfers (PROFIT) Project, funded by the U.S. Agency for International Development's Office of Population (USAID/G/PHN/POP), collaborated with PhilamCare, a local health maintenance organization (HMO), to establish a health insurance plan in the Philippines. The unique feature of the plan was that it targeted lower-income families, with a particular emphasis on those in the informal sector of the population, who were not currently covered by social security benefits. In addition, the plan included family planning benefits, which existing health insurance plans in the Philippines did not. The subproject was designed and implemented in order to:

- increase access to health care services among underserved segments of the population, particularly low-income individuals and those in the informal sector of the economy who were not covered by Medicare (the social security system)
- provide the plan at a cost lower than that of existing plans through the use of a managed care system, capitated payments, and a single service delivery site (a contracting hospital)
- include family planning benefits as part of the health care plan.

PROFIT assisted PhilamCare in designing the health insurance plan and provided funds to underwrite the risks associated with launching the plan. PhilamCare took responsibility for managing the day-to-day operations. In addition, PROFIT offered technical assistance to the contracting hospitals in managed care principles and in providing family planning services. The agreement with Philamcare was to launch the plan on a pilot basis. These pilots were launched in the two Philippine cities of Manila and Cebu. This report describes the subproject's activities from its inception in May 1994 until its termination in December 1996.

During the first year of the subproject, PhilamCare focused on establishing accounting, sales, and collection systems for the plan. Contracting hospitals were recruited, and managed care training was provided. The subproject ran into difficulty during the first year in several areas, including identifying a contracting hospital in Manila that was willing to participate in the plan, retaining a sales staff, and marketing to a new client base, the informal sector. In addition, an unexpectedly high number of enrollees allowed their coverage to lapse. As a result of these difficulties, sales only reached 1,403 members, far below projections.

In the second year, the day-to-day operations of the plan improved. A manager was hired whose time was dedicated exclusively to the plan, and agreements were signed with new participating hospitals. Nonetheless, the plan continued to face difficulties in meeting sales targets. In its last year, May 1996 – December 1996, a decision was made by the Philamcare Board that, because PROFIT could not continue to underwrite the plan, the plan would be discontinued unless it could reach a break-even enrollment of approximately 4,000 members by the end of the year.

By December 1996, the plan had only just over 2,000 enrollees, and it was therefore discontinued. Nonetheless, Philamcare is considering ways to re-launch a plan targeted to lower-income families.

This subproject confirmed that there is demand for health insurance among low-income individuals in the informal sector. To succeed, future projects of this kind will need to control recruitment costs, target client groups rather than individuals, and reduce drop-outs. Moreover, motivating consumers to use the family planning benefits under a health plan requires educating them about the importance of family planning. It also requires understanding the reasons why some consumers use government facilities in order to uncover potential motivations for them to shift to designated private providers. These and other lessons are described in this report.

INTRODUCTION

I.

The Promoting Financial Investment and Transfers (PROFIT) Project is funded by the U.S. Agency for International Development's Office of Population (USAID/G/PHN/POP). PROFIT was designed to mobilize resources of the for-profit commercial sector for family planning objectives. In the Philippines, PROFIT established, together with PhilamCare, a local health maintenance organization (HMO), a health insurance plan that included family planning benefits targeted to the informal sector of the population. The subproject was launched in May 1994. This report describes the subproject over the full time period that the project was implemented (May 1994–December 1996).

A. Brief Description of the Plan

PhilamCare, together with PROFIT, agreed to launch a new, low-cost health care plan, called "HealthSaver," to provide services for those with no formal employment. These individuals, who generally have low incomes, had not previously been targeted by commercial insurance companies. This population also was not generally enrolled in the government-sponsored Medicare system because payments into that system are typically made through employers.

In 1994 when PROFIT and PhilamCare began working together, PhilamCare was the leading HMO in the Philippines. It served over 100,000 health care plan enrollees, mostly group enrollees, through three health care plans offered at various price levels. Prior to the launch of the PROFIT sponsored low-cost health plan, all PhilamCare plans were targeted to "formal sector" workers and their employers. At the time, Philamcare's traditional plans provided outpatient benefits at PhilamCare's own clinics, employing a staff model HMO, with PhilamCare physicians and nurses serving as gatekeepers. For inpatient services, PhilamCare contracted on a fee-for-service basis with a large network of hospitals and specialty doctors throughout the country. The low-cost health plan on the other hand, was designed as a managed care plan, with a capitation fee paid to set hospitals to provide all in and out-patient care. The purpose being to keep the cost of services down and the price of the plan low, so that the lower income individual/families, could afford to purchase the plan.

The plan was launched on a pilot basis in Manila and Cebu in May 1994, with a monthly premium of 80 pesos ($2.86) per covered individual. In comparison, the most affordable of the three plans previously sold by PhilamCare was the Pearl Plan, which had a premium of P170 (or roughly $6) per month. The cost of the LCHP was lowered by:

- limiting "sophisticated" diagnostic testing and tertiary care
- placing an annual cap on benefits (p15,000 per year, or approximately $536 in 1994)
- limiting the provision of benefits to a single contracting hospital.

On the other hand, HealthSaver offered family planning benefits, which the existing plans did not, and provided care for newborns at age 16 days versus at age 6 months under existing plans. The pilot plan was launched in two cities: Manila and Cebu. The goals of the plan were to:

- increase access to health care services by underserved segments of the population, particularly low-income individuals and those in the informal sector of the economy who were not covered by Medicare (the social security system)
- provide health coverage at a price lower than that of existing plans through the use of a managed care system, capitated payments, and a single service delivery site (a contracting hospital)
- include family planning benefits.

B. PROFIT's Role and Participation

PROFIT provided:

- technical assistance to PhilamCare to design the plan
- funds to underwrite the risks associated with launching the plan
- funding to provide technical assistance to the contracting hospitals in implementing managed care principles
- family planning assistance (training and basic equipment) to the contracting hospitals.

PROFIT's funding included $150,000 for underwriting the risk of launching the plans and $29,000 for technical assistance.

C. Summary of Pre-Implementation Baseline Information

The idea of a low-cost health care plan was first introduced as part of a feasibility study conducted in 1991 by Arthur Andersen (Philippines) for John Snow, Inc. (JSI) under the USAID–funded Enterprise Program.[1] The product model was PhilamCare's Pearl Plan, which featured both inpatient and outpatient services for a proposed target market of 280 vendors and their 1,050 dependents. Although the plan's financial feasibility was not considered to be encouraging, the market was deemed "too attractive to abandon." Moreover, the study suggested that an HMO could enter the market through a test marketing activity. The project was re-initiated by PROFIT in collaboration with PhilamCare. As a first step, PROFIT hired a consultant to develop enrollment projections, outline a service delivery package, recommend contracting hospitals, and devise a system to keep costs low.[2]

PROFIT considered the following factors in developing the low-cost health care plan:

- Philamcare's institutional capacity and commitment to testing a new health insurance model
- the low level of hospital utilization in the Philippines
- out-of pocket expenditures on health care, which comprised 54 percent of all private health care expenditures
- Medicare coverage, which included 45 percent of the population (mostly workers in the formal sector) and financed less than 9 percent of total health care expenditures
- the prevalence of private health insurance, which financed less than 2 percent of total health care spending
- contraceptive prevalence rates, which were relatively low, with about 25 percent of married women in union using modern methods[3]
- current sources for family planning services, which consisted overwhelmingly of public sector outlets (providing 71 percent of all services)
- USAID/Manila's interest in supporting new health financing initiatives.

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[1] *Feasibility of Moving Health Manpower and Family Planning Services to Underserved Areas through Private Sector Initiatives* (Arlington, VA: John Snow, Inc., 1991).

[2] Hopkins Holmberg, *Preliminary Feasibility of PhilamCare's Proposed Low Cost Health Plan* (Arlington, VA: PROFIT Project, September 1993).

[3] Philippines National Demographic Survey (Manila: National Statistics Office; and Columbia MD: Macro International Inc., 1993).

D. Evolution of the Subproject

Contracting Hospitals

A key feature of the HealthSaver plan was the role of the contracting hospitals. PhilamCare relied on the capacity of a single facility in each city to provide all the benefits guaranteed by the plan. Moreover, enrollees were required to chose one facility to provide all their care. This version of the capitation scheme involved implicit and interdependent prerequisites:

- PhilamCare needed a reputable hospital in order to successfully market and sell the plan.
- PhilamCare needed to guarantee a high enough volume or level of sales to make it attractive for the hospital to accept the capitation payments.
- The hospital needed to understand and be able to implement a managed care system within the cost structure permitted under the capitation payments.

PhilamCare launched HealthSaver in two locations, the metropolitan areas of Manila and Cebu, and proposed using the following contracting hospitals:

- Sacred Heart Hospital (SHH) in Cebu
- Metro Cebu Community Hospital (MCCH)
- Medical Center Manila (MCM)

Both Metro Cebu Community Hospital and Medical Center Manila were considered to have good reputations and had been contracted by PhilamCare on a fee-for-service basis to provide services for PhilamCare's other plans. PhilamCare's existing relationship with these hospitals was expected to help them better manage the operations of HealthSaver. Sacred Heart Hospital was introduced to PhilamCare by PROFIT. SHH was a teaching hospital and did not have as strong a reputation for patient service as the other two proposed hospitals. PhilamCare agreed to add SHH as a contracting hospital in Cebu because of its strong family planning orientation. PhilamCare also was interested in seeing which of the two Cebu hospitals would be more appealing to the target market.

Manila

PhilamCare was unable to reach a formal agreement with MCM in Manila during the entire first year of the HealthSaver pilot plan. MCM was hesitant to contract with the plan because of concerns that the capitation payments would be insufficient to cover its costs at the initially low enrollment levels. PhilamCare could not sell the plan in Manila without a contracting hospital, and MCM refused to provide the services until PhilamCare could guarantee a minimum enrollment level.

To help persuade MCM to enter a formal agreement, PhilamCare hired an independent actuary to conduct an assessment of the financial implications of HealthSaver for MCM. The consultant reported that even with conservative scenarios, the capitation fee of P45 ($1.60) per month per enrollee was sufficient to cover the costs of providing the HealthSaver benefits. Nevertheless, the consultant acknowledged that there were legitimate risks for the hospital. MCM remained unwilling to participate in the plan on a capitation basis.

Despite its inability to contract a hospital in Manila, PhilamCare was able to sell over 400 plans in Manila during the first year. PhilamCare offered a service delivery scheme that used PhilamCare's existing delivery structure — providing outpatient benefits at its own clinics and contracting with hospitals as needed, on a fee-for service basis, for inpatient services. This arrangement served as a short-term solution, but it did not serve PhilamCare's goal of moving to a capitated HMO model that shifted financial responsibility for patients to a designated provider. Moreover, it made provision of family planning services difficult, because the PhilamCare board, which was comprised of conservative Catholics, refused to allow family planning services to be provided on PhilamCare's premises.

During the second year, PhilamCare entered into an agreement with Mary Johnston Hospital (MJH), a private hospital located in the Tondo section of Manila. From PROFIT's standpoint, MJH was an ideal provider for three reasons:

- MJH was a widely recognized provider of family planning services in Manila located adjacent to and affiliated with the Fertility Care Center, a USAID–supported family planning training and service site.
- Tondo is a lower-income area, with a population made up mostly of informal sector workers.
- Tondo is a residential area and therefore could service families, whereas MCM was located in an area predominated by office buildings and therefore encouraged enrollees to choose individual rather than family coverage.

Cebu

The plan was launched in Cebu using two hospitals that had agreed to the capitation payment, Sacred Heart Hospital (SHH) and Metro Cebu Community Hospital (MCCH). However, because SHH

did not have as strong a reputation as MCCH, PhilamCare had a more difficult time marketing the hospital as a choice for the plan. Before the end of the first year, PhilamCare had discontinued its agreement with SHH due to low enrollment levels.

The plan's sales levels in Cebu were nearly double those in Manila, which PhilamCare attributed primarily to the reputation of MCCH. However, MCCH had difficulties implementing the plan, primarily because of disagreements among its medical and administrative staffs over instituting a managed care system. In particular, MCCH's medical staff was unwilling to yield to the terms and conditions necessary to implement a managed care scheme, i.e., limiting services to accommodate cost constraints. By the end of the first year, MCCH completely refused to continue to provide the services for HealthSaver on a capitation basis. In July 1995, PhilamCare therefore negotiated with another hospital, St. Vincent, to be the contracting hospital in Cebu. St. Vincent General Hospital had a good reputation in the community and had recently been accredited by the Department of Health as a "tertiary hospital." Moreover, St. Vincent specialized in reproductive health care and had a well-known Reproductive Health Center, which had been built with the support of the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO, formerly the Johns Hopkins Program for International Education in Gynecology and Obstetrics).

Sales Performance/Enrollment

PhilamCare set ambitious enrollment targets for the first year of the HealthSaver pilot: 4,500 new members at each site, for a total of 9,000 new members during the first year. This translated into an average of roughly 375 new enrollees per month in each city. In comparison, PhilamCare had a total enrollment of 100,000 members from its existing plans, of which all but 2,500 were part of group accounts.

PhilamCare submitted enrollment statistics and data to PROFIT on a monthly basis. At the end of the first year (June 1995), HealthSaver had 1,403 enrollees (534 in Manila and 869 in Cebu). This translated into an average enrollment of roughly 215 new members per month. Early increases in enrollment were later offset by the fact that large numbers of enrollees allowed their coverage to lapse. By the fifth month (November 1994), PhilamCare started to experience a level of drop-outs that often exceeded the number of new enrollees. The result was that total membership increased at a very slow rate — roughly 5 percent a month. By the end of the first year (June 1995), PhilamCare had achieved only 16 percent of its original enrollment target.

During the second year, enrollment remained stagnant at approximately 1,500 enrollees, while PhilamCare negotiated with new contracting hospitals. Soon after agreements were reached with both new hospitals (MJH and St. Vincent) during the last quarter of 1995, enrollment levels increased. By the end of the second year (June 1996), enrollment had reached 1,986 (905 in Manila and 1,081 in Cebu). The

effort to attract new enrollees was helped significantly by the recruitment of a full-time project manager for the plan in February 1996. Nonetheless, drop-outs continue to offset the gains from the new enrollment efforts.

Sales continued to grow slowly in year three, reaching a peak in October 1996 at 2,153. Since the plan could not reach a break-even level of enrollment, which was estimated at approximately 4,000 members, before PROFIT's funds to underwrite the program were depleted, the Philamcare board of directors made the decision to halt the program, serving existing members but discontinuing efforts to recruit new members. PROFIT's formal relationship with Philamcare was terminated in December 1996 (except for evaluation purposes).

ACHIEVEMENT OF SUBPROJECT GOALS

II.

A. Summary of Goals and Data Collection Methods

The evaluation objectives for the HealthSaver plan reflected the subproject's health finance, primary health care, and family planning service delivery objectives.

Input Goals

The input goals of the subproject were to provide:

- managed care training to the contracting hospitals
- family planning technical assistance to the contracting hospitals.

Short-Term Goals

The short-term goals of the subproject were to:

- launch the HealthSaver plan in both Manila and Cebu City
- provide the informal sector and/or low-income segments of the population with access to affordable health services
- contract on a capitation basis with hospitals to provide the services covered by the plan
- test the financial viability of the capitation agreement.

Long-Term Goals

The long-term goals of the subproject were to:

- increase the availability of family planning services in the private sector
- shift users of family planning services from the public sector to the private sector
- sustain operations of the plan beyond the end of the subproject.

Three data collection efforts were undertaken to address the evaluation objectives:

- A baseline survey was conducted with a sample group of 269 plan members to obtain demographic characteristics, contraceptive practices, health status, and health-seeking behavior. The data was collected for the period July–December 1995 for Cebu, and for July 1995–November 1996 for Manila.
- A cost and utilization survey was conducted using the contracting hospital records to determine the costs of services provided to HealthSaver members and to track changes in patterns of care received by enrollees. Costs were compared with capitation payments to determine the profit or loss for the hospital. The report covered those enrolled in the plan for at least one year as of February/March 1996.
- Between January 1995 and July 1996, data was collected using HealthSaver sales and collection agents to understand consumers' interest in and satisfaction with the plan.

These data were augmented by the monthly enrollment and financial reports submitted by PhilamCare.

B. Inputs

Table II-1 shows the input goals, indicators, data sources, and results.

Table II-1
Inputs

Goal	Measurable Indicator (Target)	Source of Information	Status
To provide managed care training for contracting hospitals	Managed care training is provided to all hospitals that contract with PhilamCare for the plan.	PhilamCare correspondence	Managed care training was conducted at all contracting hospitals.
To provide family planning technical assistance to contracting hospitals	Family planning technical assistance is provided to contracting hospitals that need assistance.	PROFIT situation analysis	Assistance was provided to MJH (Manila).

PhilamCare staff members conducted managed care training at all contracting hospitals. The training course covered the features of a managed care system and reviewed procedures and techniques to help ensure the quality of services and control utilization. Training was provided to primary care physicians in the outpatient clinics and to nurses, hospital administrators, and emergency room personnel in the hospital. The course was conducted over two days.

In February and March 1996, a family planning needs assessment was conducted at the two participating hospitals, Mary Johnston in Manila and St. Vincent in Cebu. The assessment used a simplified situational analysis and found that St. Vincent met all criteria of an appropriate service delivery site. However, Mary Johnston, which had closed the Fertility Care Center due to a dispute within the management, lacked supplies, equipment, trained staff, and information, education, and communications (IEC) materials. Assistance was provided to Mary Johnston to address all these areas of need.

C. Short-Term Outcomes

Table II-2 shows the short-term goals, indicators, data sources, and results.

Table II-2
Short-Term Outcomes

Goal	Measurable Indicator (Target)	Source of Information	Outcomes
To launch the HealthSaver plan in Manila and Cebu	C Number of HealthSaver sales force hired and trained (36) C Number of separate departments established at PhilamCare (1)	PhilamCare correspondence	A separate department was established at PhilamCare for Healthsaver; a separate sales force was hired (17).
To provide informal sector or lower-income segments of the population with access to affordable health services through the plan	C Enrollment targets: 4,500 in year 1; 6,000 in year 2; and 6,000 in year 3 C Drop-out rate targets: <50 percent in year 1; 25 percent in year 2; and 20 percent in year 3 C Number of enrollees from lower-income population segments and/or the informal sector	C PhilamCare monthly enrollment reports C PhilamCare enrollment forms and baseline survey forms from DRTI Consultancy Inc. (Philippines)	C Enrollment reached 1,403 at end of the year 1, and 1,986 at end of year 2. C Drop-out rates were higher than projected in both years. C A majority of enrollees were from the target market.
To contract with hospitals to provide benefits of the plan	Number of hospitals contracted utilizing full capitation model (1 in Cebu and 1 in Manila)	Signed legal agreements with hospitals	Legal agreements were signed with MJH in Manila and with SHH, MCCH, and St. Vincent in Cebu.
To test the financial viability of capitation agreement with contracting hospitals	Costs at the hospitals to be maintained (e.g., within capitation fee and with at least a 7 percent profit margin)	C DRTI hospital utilization survey forms C PhilamCare hospital cost data	In all cases, profits exceeded the 7 percent target margin.

Staffing

PhilamCare had difficulty recruiting sales agents for HealthSaver, in part because the agents were not given the same employment contract as permanent PhilamCare staff members. Moreover, commissions were based on sales, and HealthSaver was sold on an individual basis and at a lower premium than existing plans, which decreased the agents' total compensation. In addition, sales agents were difficult to retain. This was particularly true in Manila, where sales were low.

The training and choice of sales agents was considered to be very important to the success of the HealthSaver product. Since the target market was a lower socioeconomic group, it was important to educate potential consumers about the advantages of setting aside money to cover a potential future illness. The sales manager recruited in year two felt that the sales agents involved in this program should have been better prepared to serve as change agents, in the mode of community organizers.

Another problem was that poor training and high turnover left many sales agents unfamiliar with the benefits of the plan. As a result, few sales agents discussed the family planning benefits.

Enrollment Targets

Sales did not reach target levels in either of the first two years. The primary reasons were the inability to finalize agreements with contracting hospitals, the difficulty of recruiting sales staff, and the difficulty of marketing to individuals and small groups, particularly in the informal sector.

According to the Task 3 report conducted by DRTI,[4] consumers in Manila cited the following reasons for not purchasing the plan:

- They wanted to have another health provider (31 percent)
- They were already covered by another health insurance (26 percent)
- The benefits were insufficient (21 percent).

In Manila, financial considerations played a relatively small role (17 percent) in people's decisions. The fact that many potential customers in Manila wanted another health provider is consistent with the fact that most lived outside of the hospital catchment area. In other words, these people may prefer a provider that is closer to their homes than to their workplaces, which was where MCM was located.

In Cebu, financial difficulty was the main reason cited for not purchasing the plan (32 percent). This was followed by coverage under another insurance plan (29 percent), and a preference for another provider (10 percent).

In Manila, 84 percent of potential customers were approached in their workplaces; the figure in Cebu was only 54 percent. This was because the catchment area surrounding MCM housed primarily office buildings, which might also account for the high proportion of white collar workers that registered

[4] *Task 3 (Consumer Survey) Final Report Manila and Cebu,* Darwin Yu Team Leader (Philippines: DRTI Consultancy, Inc., October 1996). This survey was conducted using survey forms for sales agents and collection agents and is based on 574 Call reports for Manila and 298 for Cebu and 568 collectors' surveys for Manila and 1,000 for Cebu. The report looks specifically at reasons for non-purchase and reasons for lapsation.

for HealthSaver in Manila. The Manila sales agent targeted primarily workers whose families resided in a different neighborhood, which probably made it more difficult to sell coverage for dependents. The neighborhood surrounding the Cebu hospital was largely residential, which made it much easier to recruit sales agents and to sell the plans. In addition, since Cebu is a much smaller city, the provider hospitals were much more accessible to members who lived or worked outside the neighborhood. The Manila agents were forced to conduct a lot more "cold calls" than their Cebu counterparts (82 percent versus 36 percent). Cebu sales agents were better able to approach people they knew such as friends and relatives, which made the task of selling easier and made it easier to retain sales agents.

A Profile of Enrollees

Despite these difficulties, the sales agents did seem to be attracting target enrollees, according to baseline data collected and analyzed for both Manila and Cebu.[5] Specifically:

- The mean monthly income of the head of enrolled households was 10,824 pesos ($386) for Manila and 3,676 pesos ($131) for Cebu. The differences in income might be explained by the relatively higher cost of living in Manila. On the other hand, 45 percent of those interviewed in Manila said that they would characterize their physical environment as a slum location, whereas this as the case for only 26 percent of households in Cebu.
- Although they have low incomes, HealthSaver enrollees are relatively well educated, with 63 percent having completed college in Manila and 43 percent in Cebu.
- A relatively high proportion of enrollees in Manila worked in professional jobs (15 percent) or clerical jobs (28 percent). (The remainder were unskilled or semi-skilled workers.) These proportions were much lower for Cebu, where 7 percent had professional jobs, and 3 percent had clerical jobs.
- HealthSaver subscribers bought the product even though some members of their households had access to government-sponsored health insurance coverage for inpatient care. Forty-nine percent of HealthSaver households in Manila and 42 percent in Cebu were members of the Social Security System (SSS), which provides health coverage for employees of private companies. An additional 6 percent in Manila and 8 percent in Cebu were covered under the Government Service Insurance System (GSIS), which provides coverage to government employees and their dependents.

[5]This data was collected and compiled by DRTI Consultancy, Inc., (Philippines), Darwin Yu, team leader. Additional analysis was provided by Frank Feeley, Director of Operations, Boston University Center for International Health.

A relatively high percentage of HealthSaver enrollees in Cebu used family planning; the opposite was true in Manila. Of the married enrollees aged 18 to 49, 24 percent in Manila and 44 percent in Cebu indicated that they currently practiced family planning. This compares to the national average for urban areas of 43 percent, according to the National Demographic Survey 1993.

Prior to joining the plan, enrollees sought medical attention for their general health needs from private doctors or hospitals. Only a very small percentage of respondents used the public sector. For medical emergencies, most respondents in both areas reported using money from their savings.

In Manila, enrolles relied equally on the private and the public sectors for family planning advise; those in Cebu relied more heavily on the public sector (see ***Table II-3).***

Table II-3
Source of Family Planning Supplies for HealthSaver Enrollees
(number and percent of enrollees using a given source)

Type of Health Professional	Cebu		Manila	
	number	percent	number	percent
Public Health Center and/or hospital	33	66	23	43
Private doctors and/or hospital	15	30	25	47
NGO clinic	1	2	1	2
Other/No Response	0	0	4	18
Total	49	100	53	100

Among members in Cebu, natural family planning was the most popular method, followed by tubal ligation and oral contraceptives. In Manila, pills were the most popular method, followed by natural family planning and tubal ligation. (See ***Table II-4.)***

Table II-4
Family Planning Methods Used by HealthSaver Enrollees
(number and percent of married women aged 18–49 years who use family planning)

	Cebu		Manila	
	number	percent	number	percent
Natural/Rhythm	23	39	9	18
Tubal Ligation	14	24	9	18
Pills	10	17	16	33
Intrauterine device	8	14	2	4
Other/No Response	4	6	13	27
Total	59	100	49	100

Dropouts

Dropout rates were considerably higher than anticipated. The average monthly gross "lapsation" rate (calculated as the number of lapsed enrollments divided by the previous month's enrollment) was 13.8 percent in year one and 17.6 percent in year two. The average monthly net lapsation rate (calculated as the number of lapsed enrollments minus the number of re-enrollments divided by the previous month's enrollment) was 10.8 percent in year one and 7.0 percent in year two.

Almost half of the Cebu enrollees who dropped out did so within the first two months. The probability of dropping out decreased dramatically after the first two months. If efforts had been made to maintain the enrollees beyond the first two months, the probability of their dropping out might have been decreased dramatically.

For dropouts in Manila, the most common reason by far was that the "member changed (his or her) mind about wanting HealthSaver" (42.4 percent). Financial considerations played only a limited role in enrollees' decisions to drop out in Manila (12.9 percent) but played a primary role in Cebu, where 52.5 percent of dropouts reported having "no more money to pay premium."

Another factor behind the high dropout rates was that members seemed to disappear without reporting having moved or providing a new address — 17.3 percent of dropouts in Manila and 11.7 percent in Cebu. The sales manager also attributed the high dropout rate to the sales incentive structure, which concentrated rewards on obtaining new business rather than maintaining enrollment.

Contracting Hospitals

Recruiting participating hospitals was one of the most difficult tasks, because hospital managers feared they would lose money under the arrangement, which paid them 45 pesos each month per enrollee to provide all the services covered under the HealthSaver plan. PhilamCare initially succeeded in contracting with two hospitals in Cebu, but later relied on a single hospital. It took until October 1995 before a capitation agreement was signed with a hospital in Manila. The main reason for the delay was concern on the part of the hospital that the capitation payment would be insufficient to cover the costs of delivering the covered services. That is why an important element of this subproject was to determine whether or not the plan was indeed financially viable to the contracting hospitals at the capitated payment level.

In fact, the plan was highly profitable for the participating hospitals. In Manila, Mary Johnson Hospital had a surplus from the Philamcare arrangement of between 34 and 72 percent of costs (depending on whether full or variable costs are utilized). In Cebu, Sacred Heart Hospital had a surplus of between 28 and 68 percent, and Saint Vincent's surplus was between 69 and 85 percent.

This data show that the hospitals were able to operate under a capitation arrangement and still remain financially viable. This should make recruiting hospitals for future such plans in the Philippines easier. The numbers also show that there is a lot more room for the hospitals to promote and provide preventive care to their members, including family planning benefits, without incurring a financial risk.

D. Long-Term Outcomes

Table II-5 outlines the subproject's long-term goals, indicators, data sources, and outcomes.

Table II-5
Long-Term Outcomes

Goal	Measurable Indicators	Source of Information	Outcomes
To increase availability of family planning services in the private sector	C Number of modern methods available at the contracting hospitals C Number of enrollees that obtain family planning services	C Situational analysis C DRTI utilization survey	C Both hospitals provide a full range of contraceptive methods. C Overall utilization of the family planning benefits were minimal.
To shift clients from the public to the private sector	Number of family planning clients new to private sector	DRTI baseline and utilization survey	Not available
To sustain operations of HealthSaver beyond the end of the PROFIT Project	Number of years Philam-Care continues to operate project beyond end of PROFIT assistance	Interview with the CEO of PhilamCare at the end of the subproject	The plan was terminated in December 1996, but PhilamCare's CEO indicated an intention to re-launch it.

Both contracting hospitals (Mary Johnston and Saint Vincent) offered a full range of family planning services, including natural family planning, condoms, pills, intrauterine devices (IUDs), tubal ligation, and injectables (i.e., DMPA). Services and products were available free to enrollees. Nonetheless, utilization of those benefits was minimal. There are several possible reasons. First, more emphasis was placed on implementing the overall plan than on promoting utilization of the family planning benefits. Second, because the family planning benefits were not specifically promoted, members might have been unaware that the benefit was covered under the plan. Finally, members may have been more comfortable using their traditional sources of supply.

Although the subproject was terminated in December 1996, the CEO of Philamcare indicated that he believes it is critical for private insurance to move "down market." He therefore hopes to re-launch the plan independently using the lessons from this initiative. There is also some indication that other insurance companies have come to the same conclusion and are attempting to launch health insurance products to serve lower-income families.

CONCLUSIONS AND LESSONS LEARNED

III.

A. Conclusions

Sales and Dropouts

- A critical factor behind some of the problems the plan encountered is the perception among members that the contracting hospitals had only a limited ability to deliver the level and quality of services guaranteed by the plan. Specifically, the reputations of some of the contracting hospitals affected initial enrollment levels, an effect that was underestimated by both PROFIT and PhilamCare.
- Limiting members to a single provider hospital seems to have reduced the appeal of HealthSaver, even if it enabled the plan to maintain a relatively low price.
- More attention should have been paid to retaining members rather than continuing to attract new ones. The commission structure of the sales agents should have been re-examined to determine how to prevent members from lapsing. One possible explanation for the high dropout rates might be that enrollees did not perceive that they were getting a return for their premiums and that their limited money could be better spent elsewhere. One suggestion was for a nurse to call on enrollees within two months of their enrollment to better explain the benefits and to conduct some basic tests (e.g., blood pressure screening) so that enrollees would feel they were getting something for their investments.

Marketing

- The difficulty of selling health insurance to low-income individuals and those in the informal sector was underestimated by both PROFIT and PhilamCare. PhilamCare could have focused its efforts on identifying groups of potential customers in the informal sector, rather than on targeting individual households (for example, through neighborhood associations, local NGOs, taxi drivers' associations , and the like).

Contracting Hospitals

- PhilamCare's capitation model for HealthSaver represented a new approach for paying for and managing health care. This approach is not widely used by HMOs in the Philippines and was perceived by the hospitals to involve considerable financial risk. Therefore, greater time and effort could have been expended by PhilamCare to educate the hospitals about the assumptions, benefits, and risks of managed care and about how to implement managed care systems within the contracting hospitals' existing structures.
- The choice of Medical Center Manila as the initial hospital for Manila skewed the initial enrollment in favor of people who had professional or clerical occupations and who purchased individual rather than family coverage. The shift to Mary Johnson Hospital, which is in a lower-income residential area, appears to be a more appropriate choice for the target market.

Staffing and Management

- PhilamCare had difficulty recruiting and retaining a sales force dedicated to selling the HealthSaver plan to lower-income or informal sector workers partly because the compensation, which was based on sales, was too low, and because agents were given little training in how to reach this new target market. Staffing problems resulted in lower-than-anticipated enrollment figures, particularly for Manila.
- Since the HealthSaver product was targeted to a lower socioeconomic group, it was important to educate potential consumers about the advantages of setting aside money for a potential future illness. Sales agents needed better preparation to act as change agents.
- Despite the difficulties encountered during implementation, PhilamCare remained committed to the plan, in large part because senior management was committed to the subproject's goals.

Family Planning

- Coverage of family planning benefits alone may not motivate consumers to utilize those benefits. Moreover, where patterns of seeking care area well established, the enrollees may continue to go to their traditional providers for family planning, even while using the contracting hospitals for their other health care needs.

B. Lessons Learned

- Introduction of new health care financing mechanisms requires a great deal of research, planning, training, and technical support.
- Provider hospitals need to be where the target market is located — in this case, in lower-income residential areas.
- Particular attention needs to be paid to recruiting sales agents who can also educate potential enrollees about the benefits of setting aside funds for future health needs.
- There is a market for health insurance among low-income individuals. However, the high costs of recruitment and the high dropout rates require innovative approaches to sales and retention (e.g., group payments, a specialized sales force).
- The success of managed care health insurance programs is highly dependent on the reputation and quality of the providers.
- Introducing new health care systems requires local leaders who are visionary, dynamic, and entrepreneurial.
- Motivating consumers to use the family benefits covered by such a plan requires educating them about the availability of the benefit and the importance of family planning. It is also important to understand the motivations of those who use government facilities for their family planning needs if an effort is to be made to shift them to designated private providers.