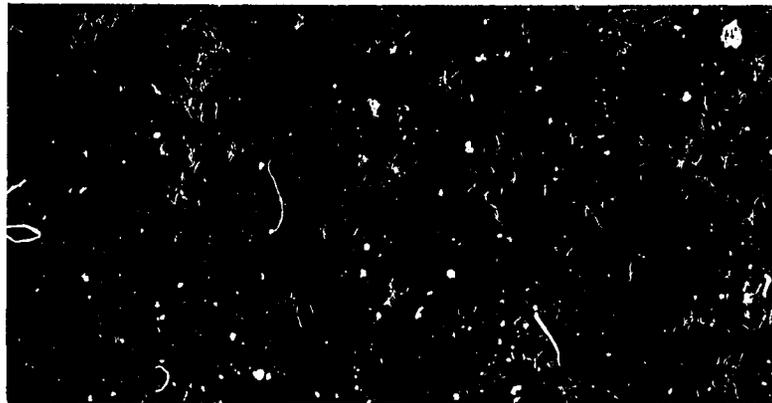


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IMPLEMENTATION OF HEALTH CARE
FINANCING SCHEMES COMPONENT OF
PRIMARY HEALTH CARE IN THE
PHILIPPINES

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INTRODUCTION

This memorandum reports findings from my assignment with USAID/Manila during the 2 weeks beginning August 22, 1983.

General Comments

The format of the financing schemes component of this project is highly appropriate to achieve the goals and objectives of the project. A key element is that the project seeks to be responsive to initiatives by the parties to the health financing schemes, rather than making what would be, especially in the domain of health sector financing events, the error of seeking to play a very directive role at the outset.

Pursuant to this, the project is willing to entertain a wide variety of financing schemes as potential candidates for support, without preselecting the parties to be involved in project implementation. As the project paper points out (pp. 70-71), this means that it is not possible to involve particular parties in design prior to project initiation. To my knowledge, this approach breaks new ground insofar as AID health sector projects are concerned. It is very important that this new ground has been broken, if AID is to play a useful role in assisting the evolution of health sector financing events, not only in the Philippines but in LDCs (less developed countries) generally. In this section, I suggest a few modifications of the apparent content and specific focus of parts of the financing schemes component, which the mission may wish to consider.

As I understand it, the financing schemes component now explicitly contemplates assistance to the parties for initial planning and design of schemes and assistance with their startup costs. It would be wise to include an additional element in the assistance package--namely, assistance in underwriting certain kinds of financial risks that must be assumed by the parties to financing schemes, especially social financing schemes of the kind AID is most apt to want to encourage. The general point is that financing schemes frequently entail contractual commitments regarding beneficiary contribution (premium) rates and benefits to be afforded to the beneficiaries. The terms of these contracts are drawn on the basis of the best information available at the time of contracting; e.g. information regarding prospective beneficiary utilization rates, the unit cost of benefits, and the like. Assumptions about such values made at any point in time may, of course, be proven wrong by subsequent experience.

As the schemes function year in and year out, experience will guide the changes in the terms of contracts necessary to maintain the viability of the schemes. In any short run, however, deficits may be encountered. Even if a scheme is contracting on the basis of correct assumptions insofar as its long-run viability is concerned, short-run fluctuations in health (morbidity) events may entail short-run deficits. Some mechanism is required to underwrite such risks if financing schemes are to be launched. For example, establishing a reserve fund for this purpose, the universal practice of firms writing health insurance, may be appropriate. Over the long run, the health financing schemes assisted under the project will want to establish the necessary reserves. At the outset, however, the parties might be encouraged to embark upon these untested financing waters if the project could find some way to assist with underwriting such risks.*

A principle purpose of the project is to increase access to primary health care, which is expected to result in increased utilization of such care and consequent reductions in fertility and infant/child mortality. The discussion in the project paper almost seems to assume that the financing schemes to be assisted by the project must mainly and directly entail the delivery of primary health care. If this is the assumption, it should be reexamined. Access to primary health care may be increased by schemes to finance the demand for secondary and tertiary care. In fact, such schemes may well be the most promising way to increase access to the most crucial preventive and promotive components of primary care. A few words of explanation are in order.

*Although it is not my intention to engage these issues in detail here, an additional point may be of interest in this context. Consider the classic, prepaid group practice (now called HMO, Health Maintenance Organization), of the Kaiser-Permanente format. To contract for the provision of services to consumers, the provider system that is to supply the services must be in place and functioning. Hence, current-account costs must be incurred at the outset. However, until a sufficient number of consumers has been brought on board, there will not be enough current account revenue to defray all of these costs. This explains why fledging HMOs of this type almost always run current account deficits during their first several years while they are building up their markets. This also explains why the 1972 HMO Act in the United States, which sought to encourage the growth and proliferation of HMO-type delivery systems, included in its assistance package help with defraying the operating deficits to be expected in the first few (three, in this case) years.

In the Philippines as elsewhere, the public primary health care system properly is expected to carry the bulk of the public health (preventive/promotive load. I say "properly" because public health services tend to be in the technical sense public goods, such that public finance is peculiarly appropriate for production and delivery of them. Conversely, curative services tend to be private goods, for the production and delivery of which private finance may be regarded as more appropriate. The MOH (Ministry of Health) is charged to provide both primary care (including the crucial preventive/promotive components) and secondary and tertiary curative care. In the Philippines, as elsewhere, the latter two gobble up the lion's share of the scarce general tax revenue funding available to the MOH. Demands for curative secondary and tertiary services compromise the capacity of the MOH to fund the primary health care system such that it chronically is underfunded.

One remedy would be to recruit more private financing for primary care services. Increased private financing of curative primary services is feasible in many situations and should be encouraged. However, in most situations, significant private financing for important public health, preventive/promotive services is not feasible. Generally speaking, attempting to rely upon private financing for resource allocation to public health services will result in inappropriately low rates of resource allocation. Another remedy would be to recruit more local (community) public financing for primary care, public health services. While this approach is conceptually more acceptable, (i.e., it represents public financing of public goods), the practical problem is that the constrained fiscal capacity of local governments results in inappropriately low rates of funding.

Another remedy would be for the MOH to allocate more funding for primary health care, especially public health activities. For several reasons, this remedy requires a diversion of the scarce general tax revenues available to the MOH from curative services, mainly secondary and tertiary services, to primary care, public health services.* This is probably the most promis-

*Funding might, of course, be diverted from primary curative services to public health, preventive/promotive services. However, given prevailing low rates of funding for primary curative services, not much relief for the public health budget can be expected from this strategy. For significant diversion from curative to public health services, we must look to where the big curative claims on the MOH budget are--namely, secondary and tertiary services.

ing of the available remedies. The key element is a large-scale increase in private social financing of the demand for secondary and tertiary services delivered in both the private and public sectors. This is to relieve the MOH system of a major part of its responsibility for funding secondary and tertiary curative services from the tax revenues available to it (i.e., substitute private social financing for public social financing of the demand for these services). The promotion of such alternative financing of secondary and tertiary services should be regarded as an integral and principle element of the GOP's primary health care strategy. It will facilitate better access to primary health care by facilitating a necessary condition--namely, more adequate funding for primary health care. There may be no better alternative way to achieve this result.

The foregoing points have been very briefly mentioned without much discussion. The purpose is to convey the point that schemes for financing the demand for secondary and tertiary services should not be regarded as inappropriate pursuant to the purposes of the project (as might possibly be inferred from the discussion in the project paper). Quite to the contrary, such schemes should be regarded as at least as appropriate as schemes that may directly entail financing the demand for primary care services. It is important for the project to recognize the interdependencies among the activities that comprise the health-services sector as a whole. Important GOP policy objectives in the health domain, e.g., the implementation of Program II of Medicare, are apt to be served by schemes for financing the demand for secondary and tertiary services. The project can entertain the prospect of assistance to such schemes as fully pursuant to project purposes.

According to the project paper (p. 10), the detailed criteria for selecting schemes will be developed during the early months of implementation. In developing these criteria, account should be taken of the points made above regarding the wider implications of schemes to finance the demand for secondary and tertiary services. This might suggest some rephrasing of certain of the general criteria for selecting schemes set out in the project paper (p. 9)-- or, at least, some agreements on construction of the language. For example, item A says: "Schemes must principally support primary health-care services supplemented when possible by secondary level services..." The points made above might suggest some such rephrasing as: "Schemes must show promise of increased support for primary health care services, either because they support such services directly or because of their implications for otherwise increased support for such services." Also, for example, item E provides that schemes will be evaluated on the impact they have on utilization of services aimed at reducing high fertility and infant mortality. This language could be construed to accommodate the points presented here. An important part of the impact of, say, scheme A might be on the utilization of these services delivered somewhere in the health services sector other than by scheme A itself, i.e., we would not look just to scheme A to

evaluate this dimension of its impact. The general point is that, in the design and implementation of financing initiatives to modify the performance of the health services sector, it is important to adopt a systems perspective. If we focus just upon the direct and proximate results of each of a myriad of health services activities, neglecting relationships among the components of a health sector financing and delivery system, we are very apt to miss potentially important, indirect impacts of the various activities.

II. EXEMPLARY FINANCING SCHEMES

EXEMPLARY FINANCING SCHEMES

Introduction

The logic that informs this project is that it be responsive to initiatives by the parties to financing schemes themselves, thereby greatly increasing the probable viability of any schemes assisted by the project. However, as recognized in Annex C of the project paper, it will be helpful for project implementation and not inconsistent with this logic for the project administrators to give some prior attention to the kinds of schemes that might evolve as likely candidates for assistance under the project. Pursuant to this, some exemplary schemes are discussed in this section. This is necessarily done in rather general terms, e.g., without attempting to specify premium or contribution rates, the detailed content of benefit packages, and the like. Much of the information required for the detailed and specific design of schemes for each of various cohorts of beneficiaries must be obtained by investigation of their circumstances. As a first step toward the actual implementation of schemes, the project is designed to assist the parties in making the investigation to obtain such information.

Type I Schemes: Cooperatives on the Demand Side, Hospitals on the Supply Side, Demand Financed on a Prepaid Capitation Basis

In terms of the discussion in the project paper, Type I schemes may be regarded as combining elements of three of the four sample financing schemes set out in Annex C. Under Type I, hospitals would market inpatient and outpatient services to groups of consumers (the members of cooperatives) on a prepaid, capitation basis. By cooperatives, is meant any of various organizations, e.g. SNs, AMCs, Irrigation Associations, Credit Unions, Cooperative Banks, and the like. Marketing on a capitation basis means that the hospital would contract with the representatives of cooperatives to provide a stipulated bundle of services to the co-op members for a payment by the cooperative to the hospital of a monthly fee (premium) per member-beneficiary. Such a scheme might include some consumer cost sharing by beneficiaries, i.e., typically modest out-of-pocket payments (deductibles, copayments) set at some fraction of the cost of services, usually with an eye to discouraging unnecessary utilization. In the main, however, demand would be financed by prepayment.

Capitation generally is regarded as an advantageous arrangement for remunerating the providers of health services. This is mainly because unlike remuneration on a conventional fee-for-

service basis, capitation does not provide an incentive for overdoctoring leading to unnecessarily high utilization rates.*

Hospitals participating in Type I schemes would operate like HMOs for their clients who were beneficiaries. To my knowledge, no hospitals or other health services delivery systems in the Philippines now market services on a prepaid, capitation basis. This may be owing in part to traditional provider preferences for fee-for-service remuneration. It may also be owing in part to lack of familiarity with this mode of marketing. In any event, an issue for Type I schemes is whether hospitals would be willing to market in this way. These waters will have to be tested.** If organized consumers on the demand side of the market prefer capitation, the fact that they represent a significant market might give them some bargaining power. GOP interest in implementing Program II of Medicare might also play a role here. (I will comment upon the relationships between Type I schemes and Medicare Program II subsequently in this section.)

Under Type I schemes, services are marketed to groups of beneficiaries, as versus individual beneficiaries. Individual-beneficiary health insurance schemes have a useful role to play in any country's overall health services financing system. However, for any given benefit package, individual-enrollment schemes always entail much higher premium or contribution costs to the beneficiaries than do group enrollment schemes, owing to the factor of adverse risk selection under the individual schemes. As commonly recognized, to really achieve the risk-spreading benefits of health insurance schemes and to otherwise increase efficiency, these schemes should be operated on a group-

*Capitation is, of course, the hallmark of HMOs, e.g., the Kaiser-Permanente Health Plans, where the periodic capitation payments are called dues and the beneficiaries are known as members. The relatively economic performance (e.g., low utilization rates) of such plans is widely ascribed to the capitation mode of remuneration. It has also been contended that capitation schemes encourage provider interest in prevention/promotion, since the delivery of such services may forestall demand for more expensive curative services. In the U.S. health services system, there is not much evidence to support this contention. Nevertheless, this should still be regarded as a potential benefit of capitation schemes operating here (at least until there is evidence to the contrary).

**There might, of course, be variants on Type I schemes, such as hospitals marketing to groups of consumers on a fee-for-service basis. Thus, unwillingness of hospitals to act like HMOs would not necessitate abandoning the general Type I format.

enrollment basis. Under Type I schemes, it is contemplated that, where cooperatives contract with hospitals for the provision of services, they would insure that some large proportion (say 80 percent) of their members would be beneficiaries under the scheme. In addition to risk spreading, there are other advantages in financing schemes that entail organized groups of consumers on the demand side of the market.

From the provider's point of view, this arrangement simplifies administration and management of the scheme and reduces transaction costs. Thus, the hospital contracts with and is reimbursed by one organization, the cooperative rather than having to contract with each of a large number of individuals. It would be up to the cooperative to collect the contributions of its member beneficiaries and remit them to the provider.*

There are also benefits in organization on the demand side of the market from the beneficiaries' point of view. As members of a cooperative, the beneficiaries will be able to participate, through the regular governance procedures of the organization, in design of the scheme to be contracted. Moreover, the cooperative as an organization should be in a position to monitor the performance of the scheme and look after the welfare of its member beneficiaries in this context. For example, members can take complaints about the performance of the provider hospital to the officers of the cooperative, who can represent them in processing grievances with the provider hospital. This is an important protection not enjoyed by those who must operate as individuals in the medical market place and who, short of malpractice actions, do not have access to grievance procedures.

This protection may be particularly important under Type I schemes, where the beneficiaries are contracted for some period of time to obtain services from given providers. They are less free, in the short run, to respond to dissatisfaction with the services by simply switching providers, than are consumers reimbursing whatever providers they select on a fee-for-service basis**. Also, it should be recognized that, although the in-

*This might be done in any of various ways. The cooperative members might make periodic direct contributions to the cooperative health insurance fund. Or, the members might decide that the premium payments be made out of the surplus of the cooperative. In the interests of distributional equity, contributions to the cooperative health fund might be income related, such that members with lower incomes pay less than members with higher incomes.

**Of course, even for these consumers, a lack of options on the supply side of the market (in medically underserved areas) may preclude resort to this kind of remedy for dissatisfaction.

centives implied by capitation do not encourage overdoctoring (a benefit), they may encourage underdoctoring (a drawback), such that organization-based grievance procedures are to be recommended.

A final point should be made with respect to organization on the demand side of the market. If Type I schemes are to be launched, there must be parties (individuals, organizations) who are interested in promoting them. Where is this initiative to come from? In some instances, it might come from hospitals on the supply side of the market who have an interest in marketing their services in this way. In other instances, however, it might come from organizations on the demand side of the market who are interested in making services available to their members.

Facilitating this kind of promotional initiative may result in the launching of schemes that might never have been launched, were this enterprise to depend solely upon initiative from the supply side of the market.

I have sketched above some general features of Type I schemes. These schemes might operate with either private or public hospitals on the supply side. Operating features and implications for national health policy and the evolution of the overall health sector financing system will differ in the two cases. We turn to a brief consideration of these matters.

Type I Schemes and Private Hospitals

The main implication of Type I schemes operating in the private hospital sector is the prospect of diversion of MOH resources from the funding of secondary and tertiary care to the funding of primary care. The extent to which it is in principle or politically necessary for the GOP to allocate funds for the delivery of publicly sponsored secondary or tertiary services depends, upon what alternatives are available to consumers. In the Philippines, where on the order of half of the hospital beds are private, the private sector affords a major alternative. Indeed, present and longer run health services policy of the GOP appears to be to encourage the private sector generally to carry a major share of the health services load. In addition to simply encouraging the utilization of private sector services, Type I schemes operating in the private sector have another important significance.

As matters stand, consumers of private hospital services, who are not covered under Medicare Program I for the most part, finance their demand for these services by out-of-pocket payments, i.e., devoid of the advantages and protections afforded by health insurance. The implementation and proliferation of Type I schemes would mean that many of these consumers would be covered by hospital services insurance. Such a development should make it more ac-

ceptable than it otherwise would be for the MOH to reduce its own commitment to the funding of secondary and tertiary services. For, under these circumstances, reductions in public social financing of the demand for these services would be compensated by increases in private social financing rather than resulting in yet greater dependence of consumers on out-of-pocket financing.

Type I Schemes, MOH Hospitals and the Implications for Medicare Program II

Type I/MOH hospitals schemes could operate as free-standing arrangements quite independent of Medicare although as matters stand, there would be disadvantages in this approach.

Unlike MOH hospital systems in many LDCs, the MOH hospitals in the Philippines are not supposed to deliver services free of charge to all comers. They operate a rather complicated multi-tier fee structure based upon the apparent capacity of the patients to pay for services delivered.* Larger (provincial) hospitals classify patients in five categories:

- Full-pay (non-Medicare) patients in private rooms,
- Partial-pay (non-Medicare) patients in semiprivate rooms,
- Medicare patients, expected to pay the difference between Medicare benefits and hospital charges; they get discounted rates, e.g. for ancillary services,
- Charity (non-Medicare) patients who are judged to pay at least something,
- Charity (non-Medicare) patients who get totally free-of-charge services.

Incoming patients are screened by hospital social workers, who attempt to assign them to one of the foregoing categories. Small hospitals such as San Jose District apparently administer

*Most of the following information was obtained during visits to the Dr. Paulino J. Garcia Memorial Research and Medical Center, a 300-bed hospital located in Cabanatuan City (Manuel L. Yambao, Chief) and San Jose (Neuva Ecija) District Hospital, a 50-bed facility which is about to move to a new site and increase capacity to 150-beds in accord with its recent designation as a provincial hospital. Our respondents indicated that their arrangements could be regarded as typical for the MOH hospital system as a whole.

the means tests in a less formal, structured way, e.g., the hospital employs no social workers and patients are screened on the basis of general appearance. As would be anticipated, a major problem with this scheme is great difficulty in actually collecting the fees. For example, Garcia Memorial estimates that 50 to 70 percent of the pay ward patients never pay for services received. San Jose District patients judged able to pay who do not are referred to the District Department of Social Work following their discharge. If judged at that point unable to pay, their debts are written off. If judged able to pay, they are asked to sign promissory notes. What the collection procedures are beyond that point we were not informed. In any event, this hospital also appears to experience very low collection rates.

For Garcia Memorial, of 15,726 discharges in 1982, about 75 percent were classified charity, about 15 percent Medicare, and about 10 percent pay ward. The distribution of patients for San Jose District was about the same.*

For the MOH hospitals attempting to administer income-related charges for services, participation in Type I schemes would have a number of advantages. The prepayment entailed by Type I schemes provides an answer for the collection problems MOH hospitals experience under present arrangements. In the Philippines as in other LDCs, it may well be that the only feasible way to administer income-related charges for MOH services is through some kind of insurance scheme, such as Type I. Under Type I schemes, basing charges on income does not depend on a sliding-fee system based upon a means test administered upon

*MOH cost recovery (90 percent owing to hospital fees) currently runs at about 8 percent of the MOH budget, which itself in recent years has claimed about 3.5 percent of government current-account expenditures. Thus, hospital fees make only a miniscule contribution to public revenues--about 0.25 percent of total government current expenditure. Where revenue from MOH fees reverts to the general treasury, the appropriateness of the fee system should be evaluated as a part of general government fiscal arrangements. Given the miniscule contribution to public revenues, the question should be asked whether these fees represent a relatively inefficient (e.g., high ratio of collection costs per unit revenue) tax that might better be raised by alternative means.

If revenues from such fees reverted to the MOH or to the facilities marketing the services, the fees would be evaluated from the point of view of their implications for performance of the MOH and the facilities comprising the system, e.g., incentives for more efficient performance by the facilities and for the distribution of general tax funding as between hospital and field services. Some comments on this appear in the text below.

admission of the patient. Rather, under any given Type I scheme, all beneficiaries are entitled to the same benefits and, if admitted as patients, confront the same charges. These schemes may be income related, however, by varying the contribution rates to the insurance program, such that individuals with low incomes make smaller contributions than individuals with high incomes. Medicare Program I achieves this effect in that individual contributions are set at 2.5 percent of wages and salaries.

However, there are problems. Currently, revenues from charges to Non-Medicare, pay ward patients revert to the general treasury, not the MOH or the hospitals. Moreover, budget allocations to the MOH hospitals are based upon the number of authorized beds, not the volume of services delivered. These circumstances create a considerable disincentive for MOH hospitals to invest the resources (staff time, effort, startup costs) necessary to market these pay ward services in the context of Type I scheme or any other schemes.* Nevertheless, there may still be some incentive for MOH hospitals to participate in Type I schemes for these patients. That is, in spite of the apparent disincentives to market their services, they do attempt to market them. To this extent, the prepayment feature of Type I would be attractive as a strategy to help with otherwise intractable collection problems.

There is also the problem of the impact Type I schemes can have on rationalizing the overall health services financing system. That is, as long as revenue reverts to the general treasury, then simply financing the demand for these services through Type I schemes will not divert general tax funds from hospital services to primary health services. That is, the hospitals would still be completely dependent as before on general tax funding. On the other hand, if the hospitals could retain revenue from charges, they would have two sources of funding--one private (the charges) and one public (general tax funding). Under these circumstances, a diversion of public funding from hospital services to primary care services could be compensated by increases in private funding to the hospitals, which participation in Type I schemes would encourage. These considerations

*Proposals have been put forward to permit the MOH hospitals to retain the revenue from such fees, and a good case can be made in favor of this approach. If there were a prospect of a change in the regulations to permit this, MOH hospitals might begin now to participate in Type I schemes for the pay ward patients, with an eye to benefits to be realized subsequently with the change in regulations.

of public policy argue strongly in favor of a change in the regulations to permit retention of revenue from charges by the hospitals.*

The situation with respect to the Medicare Program I patients is very different from that of the pay ward patients discussed above. Professional fees paid on behalf of (and by), Medicare patients are retained by the hospital and distributed among the hospital staff in accordance with a standard formula. Also, Medicare benefit payments for room and board and other services are retained by the hospital and can be used to enhance the capacity of the hospital to deliver quality services. This does provide an incentive to market services to Medicare beneficiaries. Medicare Program I, financed by payroll taxes, covers employees in both the private and the public sector, comprising only about 45 percent of the work force. Medicare Program II, which is supposed to cover the self-employed (and others) has been on the books since the inception of the Medicare program, but so far, and in spite of declared government intentions on this score, it has not been implemented in other than a couple of experimental contexts. Participation by MOH hospitals and private hospitals in Type I schemes would, if these schemes were part of the Medicare Program II on a significant scale. This would be attractive to both private and MOH hospitals. It also should be attractive to the GOP, in light of its professed intentions over many years to implement Program II. Moreover, a significant expansion of Medicare coverage in both the private and public sectors would facilitate a reduction in the MOH commitment to hospital-services funding such that more funds might be diverted to primary care.

At present, implementation of Medicare Program II is confined to a couple of small experiments, under which services are delivered by Medicare Community Hospitals (MCH).** A good bit may

*Hospital budgeting procedures, based upon a combination of private and public funding, can be designed such that hospital management is at risk for success and for failure. That is, hospitals would have something to gain from careful attention to cost containment and effective marketing and something to lose from poor management. Indeed, in addition to the advantages cited in the text, one of the most attractive features of having the hospitals retain revenues from charges is that it opens the way for genuine incentives for efficient management and administration into the MOH hospital system.

**One of these is the Bauan MCH (unusually large for such hospitals with 45 beds), which we visited. The other is the Dumarao (Capiz) MCH reported in Ma. Concepcion P. Alfiler, "Local Resource Utilization Schemes for Selected Community Based Primary Health Care Projects in the Philippines," Nov. 5, 1982.

be learned from these trials and they should be regarded as well worthwhile. However, insofar as wide-scale implementation of Program II is concerned, these particular experimental settings must be regarded as very special cases, rather than as exemplary of a format to be generalized. There are presently some 88 MCHs (formerly call CCHCs) with an average of 15 beds and collectively comprising only a little more than 1 percent of the hospital beds in the Philippines. Thus, the MCH system does not have the capacity to provide services to more than a very small number of Medicare II patients. If Medicare II is to cover a significant number of beneficiaries, services under the program will have to be provided by the private hospitals and the MOH hospitals, just as they are to the Medicare I patients. A major problem with the MCH experiments is that they are based on individual rather than group enrollment of beneficiaries. Also, since MCHs are the providers, it is natural to provide a Medicare contribution to the experimental Program II beneficiaries in the form of Medicare-financed hospital facilities and staff. However, if Medicare Program II is to cover a significant number of beneficiaries, the services will be largely delivered by private and MOH hospitals. Consequently, for wide-scale implementation of Program II, the nonbeneficiary contributions have to be arranged in some other way for those practice settings.

Conversely, Type I schemes, under which group enrollment of self-employed beneficiaries is accomplished by cooperatives contracting with all types of hospitals (private, MOH, and MCH) for the provision of services on a prepaid, capitation basis, afford a realistic prospect of wide-scale implementation of Medicare Program II.*

If early Type I schemes were to be regarded as Medicare Program II experiments (and, more generally, if Type I schemes were to become a regular part of Medicare Program II), additional thought should be given to the nature and logic of the non-beneficiary contribution to Medicare insurance for self-employed beneficiaries. Under Medicare Program I, contributions to the insurance fund are made by the employees and the employers on a 50-50 basis (in the case of the public sector, the government itself is the employer). Since Medicare Program II is to enroll the self-employed and also the unemployed, there will be no employer of these prospective beneficiaries. Consequently,

*It was my impression from a discussion of these matters with Dr. Jesus V. Tamesis, vice chairman of the Medicare Commission, that he was in general agreement with this proposition. Similarly, it was my impression from a discussion of these matters with Insurance Commissioner Gregoria Arnaldo, who also sits as a member of the Medicare Commission, that she was in general agreement.

there appears to be a problem of where the employers' contribution is to come from for Medicare II beneficiaries. Current thinking and planning suggests that this contribution come from the employers who participate in Medicare I. The SSS component of Medicare I currently generates a surplus (as it has in years past), which would facilitate contributions from this component. The GSIS component of Medicare I, however, does not generate a surplus and, in this case, the contributions to Medicare II would have to come directly from the government--a prospect which has been resisted.*

From various points of view, there might be a good bit to be said in favor of achieving this kind of apparent symmetry between the Medicare I and Medicare II 50-50 contributions format. However, it would be possibly helpful to reexamine the logic of the current approach to contributions for Medicare II. A potentially important question that does not seem to be explicitly addressed is the incidence of the employers' contributions under Medicare I. In economic analysis of taxation, it is recognized that the real burden of any tax does not necessarily come to rest at the point where the tax is imposed--e.g., taxes imposed on business enterprises (employers) may be shifted backward to employees or shifted forward to consumers, such that the enterprise itself bears only a fraction of the burden. There is no prima facie reason to suppose that the employers' contribution to Medicare I (a 2.5 percent payroll tax) provides an exception to this. Thus, the question arises: To what extent do the employee beneficiaries under Medicare I receive wages and salaries (and other fringe benefits) less than they otherwise would in consequence of their employers' labor-cost-increasing contributions mandated under Medicare I. That is, to what extent has the real incidence of the tax been shifted to the employees? To the extent that employee beneficiaries of Medicare I bear the incidence of their employers' contributions, then these beneficiaries are assuming a greater than 50 percent share of the costs of their own program. Thus, the nominal 50-50 contribution format may be illusory and logically it would not need to be followed under Medicare II. Under these circumstances, Medicare I contributions to Medicare II imply support of the latter program by the beneficiaries of the former.

*It should be recognized that, if the SSS component contribution to Medicare II comes from surplus, it cannot, even nominally, be regarded as solely a contribution by employers; i.e., the surplus has, presumably, resulted from contributions of both employers and employees.

Along with the foregoing considerations, it should also be recognized that, even if the incidence of the employers' contributions under Medicare I is shifted to the employee's beneficiaries, this approach to Medicare II financing might still serve distributional-equity objectives. That is, generally speaking, the wage-employed beneficiaries will be better off than the self-employed beneficiaries in that some subsidy of the latter by the former might be regarded as appropriate. But if the main objective in the design of the Medicare II financing scheme is to achieve distributional-equity objectives, then there might be something to be said for explicitly basing the design on that criterion, e.g., if Medicare II beneficiaries were enrolled as groups, making larger contributions for poor beneficiaries and smaller contributions for more affluent beneficiaries. Such an approach would certainly be in accord with the logic that informs the operation of the MOH hospital system, under which the hospitals are supposed to administer an income-related system of charges for services provided.

Another policy issue for implementation of Medicare II is whether it should be a mandated program like Medicare I or a voluntary program. The prospect that a mandatory Medicare II program could be successfully administered would appear to be remote, the voluntary route is probably the only feasible one. By implementing a voluntary program in which consumers are offered the opportunity to finance their demand for health care in an advantageous way and thus escape the disadvantage of having to rely solely upon out-of-pocket financing, the government would be, and should be recognized as being, responsive to an important social responsibility in the health services sector. In any event, the Type I schemes contemplated here are voluntary schemes and would continue to be so as components of Medicare II.

Type II Schemes: Cooperatives on the Demand Side, Nonhospital Primary Care Providers on the Supply Side, Demand Financed in Various Ways

The hospitals participating in Type I schemes will deliver some primary care through their OPDs and otherwise. However, I have lumped together under the rubric Type II schemes those that feature nonhospital providers of primary care on the supply side. Obviously this is a rather heterogeneous collection of schemes. It is not my intention to attempt to canvass them all. Rather, I will draw attention to certain issues that are common to such schemes. Although Type I and Type II schemes are treated in separate parts of this memorandum, it will be apparent to the reader that some of the points made regarding Type I schemes apply to Type II and vice versa.

In taking the initiative to promote Type II schemes, some cooperatives might seek to contract with physicians for the provision of services to their members on a prepaid, capitation basis. Some cooperatives may be too small by themselves to comprise a market for such prepaid schemes. For small cooperatives, access to prepaid schemes may depend upon their joining together to make a larger market. Where natural federations of cooperatives already exist (e.g., the SN members of AMCs or of cooperative rural banks), this may be an attractive approach. However, where federations or coalitions of cooperatives must be contrived specifically for health-financing purposes, the situation will be less favorable. That is, to the extent possible and in the interests of longer term viability, the schemes should be based on preexisting coalitions. Alternatively, even small cooperatives may have access to prepaid schemes if they contract with providers who are also contracting with other client groups such that, from the provider's point of view, the market is large enough to permit sound determination of capitation rates.* This latter situation is most likely to pertain where there is initiative from the supply side of the market, i.e., where individual physicians or groups of physicians actively market their services to various groups. Presumably, the project will assist such parties.

HMO-type schemes are not, of course, the only possibilities. Thus, cooperatives might seek to contract for the provision of services on a negotiated fee-for-service basis (fees lower than regularly charged). In such a negotiation, a cooperative's bargaining power would derive from the fact that it represented a substantial market for the provider physicians. There is evidence from other countries that bargaining power of this kind can get results. For example, in Jamaica, Blue Cross, which represents a substantial number of beneficiaries, negotiates fees for Blue Cross beneficiaries that are considerably lower than the fees charged by the participating physicians to their non-Blue Cross clientele.

However, under Type II schemes, the demand for care is financed. An important potential benefit from such schemes is that they might help to redress the urban-rural imbalance in the distribution of physicians' services. Overall, the physician supply in the Philippines is adequate, and if the present high rates of

*This is anticipated to be the situation for the hospitals participating in Type I schemes.

supply of the physicians continues (the medical schools graduate some 1,300 physicians per year), even with substantial losses to emigration, the supply situation should improve sharply over the coming years. In the Philippines as elsewhere, however, physicians tend to concentrate in the urban centers. Type II schemes operating in rural areas could offer substantial guaranteed markets to physicians willing to locate there, and the prospect of such markets might make location in rural areas much more attractive to physicians than it now is. These considerations imply that the promoters of Type II schemes from the demand side should not regard themselves as solely dependent upon the preexisting physician supply situation in their market area. They might seek to contract with physicians now located in urban areas who could in this way be induced to locate in rural areas.*

The promoters of capitation Type II schemes should be aware at the outset of a common problem. Where physician providers are serving both the prepaid beneficiaries of the cooperative and their regular fee-for-service patients, there may be a tendency for them to neglect the former in favor of the latter, e.g., longer waiting times for the prepaid beneficiaries.** This phenomenon may lead to dissatisfaction with the scheme on the part of the cooperative beneficiaries and hence to the breakdown of the scheme. Efforts should be made in drawing the terms of the contracts with providers to build in some protections against this phenomenon.

One approach to this problem, where the schemes are large enough to warrant a formal approach, is to build systematic grievance procedures into the contracts for services. HMO contracts in the U.S. commonly provide such procedures. Even where the providers' full-time practice is serving the HMO clients, the fact that the consumers confront zero or significantly discounted prices at the service delivery point may encourage over utilization from the providers' point of view. That is, with price rationing of services among the would-be consumers suspended,

*The MARIA program (Medical Aid to Rural Isolated Areas), operated some years ago under the aegis of the Philippine Medical Association, was successful in somewhat this same way in attracting physicians to rural service according to Dr. Tamesis who was the architect of the program. The MARIA experience should be examined in regard to its implications for current developments.

**Insurance Commissioner Arnaldo cited this phenomenon as an important reason for the breakdown of a number of experiments with prepayment in the Philippines.

there has to be rationing from the supply side of the market. The promoters of schemes will want to think about approaches to handling potential over utilization problems that may disrupt relationships between consumers and providers. The general point is that operating health financing schemes may entail problems that are not sufficiently appreciated by the promoters at the outset. The technical assistance to be provided to the promoters of schemes by the project will be especially valuable in helping the parties to anticipate such problems.

Type II schemes have a potentially important role to play in making drugs and medications available to their beneficiaries on terms substantially better than they can get as individuals in the medical marketplace. In many LDCs, drugs are a major component of medical care expenditure--on the order of 50 percent of the total. The Philippines appears to be no exception to this general rule. Moreover, in the Philippines as elsewhere in LDCs, private expenditure for drugs is overwhelmingly greater than public expenditure. In 1982, private expenditure for drugs at wholesale prices came to about P4 billion, contrasted with public expenditure in that year of about P500 million. In the aggregate, private and public expenditure for drugs was about two and a half times the entire MOH budget. Drugs carry a substantial markup at retail, such that the share of private spending for drugs in the total is larger than suggested by the wholesale comparison.

Faced with this situation, cooperatives might wish to consider whether to operate pharmacies or more modest kinds of drug outlets for their members, financed by contribution to a fund established for this purpose. Schemes of this kind would be similar to other consumer co-ops, albeit technically a bit more complicated. The general idea would be to purchase drugs at wholesale prices (perhaps generic rather than brand-name drugs) and sell them to the members with small markups. Such schemes would employ a pharmacist, the markup should be sufficient to defray this salary and other operating expenses.* Supply loqis-

*In various LDCs, the local pharmacist is known as "doc" and is, in effect, a primary care provider of medical services in addition to supplying drugs. Thus, communities may be provided with more than just a drug outlet when they acquire a good pharmacy.

tics would depend upon regular commercial channels. More modest schemes might also be contemplated, e.g., analogous to the boticas sa barangays, which have been promoted in various locations. The possibilities for socially financed drug supply schemes depend upon the characteristics of the overall drug acquisition and distribution system, including the laws governing this sector. For example, questions such as whether there is foreign exchange rationing for acquisition of drugs or the fine chemicals from which they are compounded, or whether a cooperative pharmacy could itself tender for drugs from overseas suppliers or whether it is necessary to go through a central importing agency, must be answered. A study of the drug acquisition and distribution system in the Philippines might be included among the research projects to be supported by the project. The findings from such a study would help in the design of drug schemes.*

Institutional Differences on the Demand Side

Throughout the foregoing discussion, we have used the term "cooperatives" to designate the organizations on the demand side of the market, having indicated that this term includes various kinds of organizations, e.g., SNs, AMCs, Irrigation associations, or cooperative banks. In fact, there are considerable differences in the way potential farmer-beneficiaries are organized, depending upon the crop they produce. The organizations (SNs, etc.) that are representative of cooperatives are largely organizations of rice farmers. Different organization modes obtain for the other major farmer groups, namely, coconut and sugar farmers.

In the sugar industry, a major distinction is made between workers who work in the sugar mills (the 41 sugar centrals) and those who work the plantations.** The sugar mill workers are organized by various labor unions, are in an employer-employee relationship and are covered by the SSS component of Medicare I. The 450,000 plantation workers include resident workers (about half the total), itinerant workers, and migratory workers. The resident workers are also eligible for coverage under the SSS

*It is my understanding that research addressed specifically to the performance of the boticas sa barangays is now planned. It might be advisable to expand the scope of this research as suggested in the text. A descriptive piece on the operation of the drug sector as a whole could be easily pulled together from readily available sources.

**Information on the sugar farmers was obtained during a discussion with Raphael Espiritu, head of the Bureau of Rural Workers, Ministry of Labor and Employment. I might add that Mr. Espiritu is very interested in any assistance that the project might give in helping to arrange better access to health care for sugar workers.

component of Medicare I. The itinerant and migratory sugar workers, who are among the poorest members of the farm labor force in the Philippines, are not eligible for coverage under Medicare I. They are, however, potential beneficiaries of Medicare II, if that scheme is ever implemented on a general scale.

The plantation sugar workers are not represented by labor unions nor are they likely to be in the foreseeable future.* Nor are these workers members of cooperatives of their own devising. Thus, the question arises: What organization is to serve as the cooperative for sugar workers seeking to participate in Type I or Type II schemes? The Bureau of Rural Workers, aware of the lack of organization of the sugar workers and of the disadvantages entailed by this, has had a program in operation for some years to promote the establishment of rural workers association not only in sugar but also elsewhere--some 400 such associations in total have been established. These associations, which are intended to promote the social and economic well being of (among others) the itinerant and migratory sugar workers, are a promising prospect for the cooperative role on the demand side of the market in Type I and Type II schemes. The plight of the sugar workers, their extreme poverty, and lack of access to medical services of any kind makes them a worthy target group for assistance under the project. A unique feature in the sugar industry, of potential interest to schemes to improve access to health care, is the sugar social amelioration fund. This fund is largely used to finance bonuses for sugar workers. However, under the provisions of the fund, 30 percent can be used for social amelioration projects to benefit the workers--a use that comes about as a response to proponents of such projects. The original notion under the sugar fund was that labor unions would be the proponents of social amelioration projects. My understanding is, however, that rural workers associations might also have access to such funding.

The organization of coconut farmers is largely under the aegis of COCOFED, which has a national board of directors, 56 provincial chapters, and more than 970 municipal chapters.**

*It appears that, although the unions are interested, they have been unable to overcome the formidable obstacles encountered in attempts to organize these workers.

**Information on the coconut farmers obtained during a discussion with Col. Ernesto Del Rosairo, Head of the Administration Department of COCOFED. Mr. Del Rosairo appears to be very interested in any assistance that the project might give in helping to arrange better access to health care for coconut farmers.

Since there are on the order of 1 million coconut farmers, the average size of the municipal chapters would be about 1,000 members (assuming that all coconut farmers belong to their municipal chapters). Thus, many of the municipal chapters of COCOFED must be substantial organizations and, according to Mr. Del Rosairo, these chapters are functioning organizations. The municipal chapters of COCOFED might be a promising prospect for the cooperative role on the demand side of the market in Type I and Type II schemes.*

Private Health Insurance

In developing health care financing schemes, it is necessary to take into account the context provided by the health financing system as a whole. One component of this system is private health insurance. More information is needed about this sector. Insurance Commissioner Arnaldo indicated that quite a lot of health insurance is written in the Philippines, and she promised to have her statisticians prepare a figure on this, distinguishing between accident/income replacement (disability) type schemes and regular health insurance. In response to inquiry, Commissioner Arnaldo said that she could not say whether schemes on the order of Type I and Type II would be subject to regulation under the laws that regulate the insurance industry without seeing specific examples. In any event, in seeking to promote health care financing schemes, the parties to these schemes and the project administrators will want to inform themselves about the legal status of any schemes that are seriously proposed in specific enough form to permit such judgment.

*The coconut industry also had a social amelioration fund as a component of COCOFUND. However, under the law establishing COCOFUND, contributions to the fund were to continue for no more than 10 years. This time is up and the contributions have ceased, leaving COCOFUND at ₱154 million. It appears that the coconut farmers are now in the process of deciding what disposition is to be made of COCOFUND; e.g., whether it should be a revolving loan fund. It is not clear what social amelioration function or potential COCOFUND now has.