



# Technical Brief **No. 2 October 1994**

The paper, **Medicare Program II Pilot Project Experience: Issues and Concerns** was prepared in response to the need for an evaluation framework which will gauge the success of Medicare Program II (P-II). This paper served as a background document for the Medicare Program II Evaluation Workshop

service providers, availment procedures and requirements, utilization patterns, and financial viability considerations. In sum, Prof. Alonso's paper is a review of P-II experience. The action plans that address the programmatic issues and concerns he raised were discussed by participants of the workshop, and have been included as part of this **Technical Brief**.

## **MEDICARE PROGRAM II PILOT PROJECT EXPERIENCE: ISSUES & CONCERNS**

*By Ruperto Alonso<sup>1</sup>*

conducted by the Philippine Medical Care Commission on July 4 - 6, 1993 at Hotel del Rio, Iloilo. Three of the longest-running P-II pilot projects were singled out by the study, namely, Bauan, Batangas; Unisan, Quezon; and Nueva Valencia, Guimaras. Their varied experiences yielded wellsprings of discussion of management and other related issues affecting municipal P-II programs. In presenting his evaluation framework, Prof. Alonso centered on the aspects of coverage, premium and benefit schedules,

Over the past decade, indicators of the health status of the Philippine population showed a mixed trend. From the late 70s to the mid-80s, infant mortality rate improvements were minimal, despite some gains in 1986. Infectious and communicable diseases remained the leading causes of mortality. Malnutrition indicators were high and fertility declined slowly.

This uncertain performance was accompanied by a sharp decline in real terms of both per capita public and private health expenditures over the 80s. Whereas the Philippine population increased by 20% between 1982 and 1990, total health expenditures declined by 43% over the period. The 80s also witnessed a growing share of the public sector in health expenditures, so that by the end of the decade, the public sector accounted for more than half of total health expenditures.

### **BACKGROUND: PHILIPPINE HEALTH SCENARIO**

Table 1 presents estimates of the 1988 breakdown of health expenditures and their

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Written in July 1993 as a background paper for  
PMCC's P-II Evaluation Workshop, Iloilo City.



**"TECHNICAL BRIEF"**

reports on the findings of research studies and their interpretations of implications for health policy. They also highlight information regarding important aspects of health policy based on conferences, research, policy speeches, demonstration and pilot project results, consultations, and public discussions.

**"TECHNICAL BRIEF"** draws attention to recent factual findings that have significant policy implications. It is meant to disseminate factual information and expressions of opinion bearing on policy and policy related issues to provide important information and to encourage the exchange of ideas, interpretation of facts and expressions of opinion among those interested in development and formulation of health policy in the Philippines.

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financing. Out of the total of P13.64 billion (in current prices), 50.4% was spent by government, 42.7% by direct family outlays, 1.7% by private insurance, and 5.2% by compulsory insurance. In the financing of public health costs, taxes accounted for 43% while the local governments' share was only 4.6%. Even more appalling was the measly 2.1% contribution of operating income (down from 6.8% in 1981).

Such inadequacies in health care spending were partly addressed by the Philippine government through the Medicare Program I (P-I) of the Philippine Medical Care Commission (PMCC), which provides compulsory coverage to members of the Social Security System (SSS) and the Government Service Insurance System (GSIS). In 1983, Medicare Program II or P-II evolved in an attempt to cover non-members of the SSS and the GSIS and extend the benefits of P-I to them to the extent affordable premium could buy. It has been in existence for more than a decade now and, to this time, remains in a pilot stage, as its development and coverage have been hampered by certain organizational, financial, and administrative constraints.

These problems notwithstanding, and considering that the Filipino families' out-of-pocket outlays for health accounted for a whopping 42.7 percent of the country's total expenditures for health in 1990 alone, clearly, an expanded health insurance program by way of P-II will benefit larger segments of the population and will help reduce families' reliance on disposable income to defray the costs of health. It will also shift the share of private investments in health from outright expenditure to insurance, wherein the concept of cross-subsidy thrives.

Despite the wide coverage of Medicare Program I in nominal terms (23.2 million members and dependents or 38.4% of the population in 1980), the contribution of compulsory insurance to total health care financing was only 5.2% in 1990. The total membership of 5.06 million in 1990 composed only 22.5% of the employed labor force.

**MEDICARE I-II  
 IN PERSPECTIVE**

A breakdown of the 1990 Medicare coverage by region (Table 2) shows that the industrial regions (Metro-Manila, Central Luzon, and

**P-II ISSUES & CONCERNS 3**

**Table 1**  
**Uses and Sources of Funds**  
**(₱ Billion at Current Prices)**

	Amount	Percent
<b>Uses of Funds</b>		
Public	6.87	50.4
Private	6.77	49.6
Family	5.82	42.7
Private Insurance	0.24	1.7
Compulsory Ins.	0.71	5.2
<b>TOTAL</b>	<b>13.64</b>	<b>100.0</b>
<b>Sources of Funds</b>		
Public	6.67	50.4
Taxes	5.87	43.0
Operating Income	0.29	2.1
Foreign Assistance	0.09	0.7
LGUs	0.62	4.6
Private	6.77	49.6
Family	5.82	42.7
Private Insurance	0.24	1.7
Compulsory Ins.	0.72	62.2
<b>TOTAL</b>	<b>13.64</b>	<b>100.0</b>

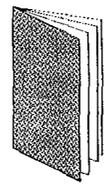
Source: Solon et al 1993

increased.

It is within this context that an expansion of Medicare P-II becomes more urgent. The share of private resources in health care financing will have to rise, and health insurance, if properly designed and implemented, offers a potentially efficient and effective way of tapping these resources.

While Program II has been in existence since late 1983, it remains limited in scope, and earlier assessments have centered more on the concept rather than on the pilot projects' experience.

**EARLY STUDIES OF PROGRAM II**



Solari (1988) cites that the issues which

Southern Luzon) has the highest rate of coverage and lowest in the regions of Bicol (10.9%), Western Mindanao (15.1), Ilocos (19.4%) and Cagayan Valley (19.7%). These statistics show ample scope for an expanded national health insurance program that would cover those who remain outside the Medicare system.

On the health care providers' side, DOH's emphasis on preventive care may mean less public funds for its hospital system, as the overall budgetary position of the national government remains bleak in the near and medium terms. This implies that public hospitals may have to increase efforts at cost recovery through user charges. The devolution of these hospitals to the LGUs may also strain the coffers of many provinces and municipalities unless hospital revenues are

**Table 2**  
**Medicare Coverage by Region**

Region	Coverage	Population	%Share	%Coverage
NCR,III,IV	13,914	22,394	60.1	62.1
I	783	4,036	3.4	19.4
II	531	2,700	2.3	19.7
V	426	3,910	1.8	10.9
VI	1,808	5,393	7.8	33.5
VII	1,069	4,593	4.6	23.3
VIII	1,086	3,055	4.7	23.3
IX	476	3,159	2.1	15.1
X	869	3,510	3.8	24.8
XI	1,427	4,457	6.2	32.0
XII	772	3,171	3.3	24.4
<b>TOTAL</b>	<b>23,160</b>	<b>60,378</b>	<b>100.0</b>	<b>38.4</b>

Note: NCR, Regions IV and V have identical SSS/GSIS coverage reporting.  
 Source: PMCC as cited by Beringuela, 1993

impede P-II development are paucity of information on target population; complex administrative arrangements; and dependence on the improvement in the credibility of P-I.

Ron (1989) suggests that a better benefit package be designed first before it is expanded.

Jeffers (1990) cites administrative problems and mentions as important issues the determination of members' capacity to pay, the efficiency of premium contributions, and the design of the reimbursement scheme.

Gonzales (1992) recognizes the decentralized structure of P-II as having the potential for more efficient operation and more effective health service delivery.

Almario (1993) points out that for P-II to succeed, the program must be appropriate in scope, standards, and structure.

These studies offer a convenient framework for the conduct of an evaluation of P-II experience. This paper adopts this framework, centering on coverage, premium and benefit schedules, service providers, availment procedures, utilization patterns, and financial viability.

**M**embership coverage is a critical factor in the sustainability of any health insurance program. A wide membership base ensures proper spread of fixed costs and helps minimize adverse selection and moral hazard problems.

**PROJECT  
EXPERIENCE:  
COVERAGE**

In Bauan, active membership moved

erratically, with a high of 629 when the program started in 1983 to a low of 13 members in 1989. Active participation rose again to 568 members in 1992 but as of March 1993 the number was once more down to 121 members. PMCC attributes the fluctuation to the withdrawal and re-entry of barangay-sponsored members wherein the barangay paid for membership premiums out of budget. As of March 1992, only 12 of the 33 barangays were supporting premium payments.

Bauan's fluctuating membership is also attributed to problems with the provider, the Bauan Medicare Community Hospital (now Bauan Community Hospital). Upon its devolution to the local government, renewed interest from the local officials caused membership to grow once more.

In Unisan, where the program was established in 1984, similar fluctuations of membership were observed. Low levels prevailed from 1985 to 1989, rising again in 1990 and reaching a peak of 940 members in 1991. By March 1993, active membership was once more down to 669 participants.

In Nueva Valencia, when the program was revived in 1990, 341 active members were registered, rising to 411 in 1991, but declining again to 356 in 1992 and 329 as of February 1993. A large number of barangays, 22 in all, were involved in the program, in contrast to others wherein membership is concentrated in barangays closest to the provider.

The basic question is why, for the more mature pilot projects, continuing membership cannot be sustained. For all three municipalities, drop-outs have outnumbered new members. PMCC's Evaluation Report on Nueva Valencia cites two causes of recruitment problems: 1) lack of information campaign to sustain the interest of

members in the project, and 2) absence of a coordinator and/or collector at the barangay level.

Membership campaigns, when launched earnestly, can produce significant increases in the number of enrollees. Trips by members to the Municipal Treasurer's office to pay premiums can pose a heavy financial burden on those living in remote barangays.

It is clear from these experiences that more people should be assigned as collection agents. In other pilot projects, the P-II office is allowed to issue official receipts, facilitating membership payments. Another suggestion is to tie-up premium collection with the payment of electricity/water bills to save on administrative costs.

It also appears that the community's perception of the credibility of the provider is a major factor affecting enrollment behaviour. If the management of the participating hospital is perceived to be inefficient, arrogant or unmindful of patients' needs, no amount of information campaign would enjoin people to participate.

**A**nother important issue is the presence of "substitutes" for services which P-II offers. If hospital care is available for free anyway, there is no incentive for people to join the program. It has been mentioned, however, that the devolution of public hospitals to LGUs can prod new hospital administrators into achieving cost-recovery targets higher than the historical 9% revenue-to-cost ratio.

**PREMIUM &  
BENEFIT  
SCHEDULES**



On one hand, many potential beneficiaries could not afford the annual premium payment yet, on the other, members are willing to pay a higher premium for an increased benefit package. What this suggests is that the potential program participants are not homogenous in their capacity and willingness to pay, and a menu of premium and benefit options may have to be offered for the program to remain attractive.

The premium-to-benefit relationship should take into account not only actuarial considerations but also the historical trend in utilization patterns and rates. Much lower utilization rates are observed for P-II than for P-I, which may be due to a variety of factors such as difficulty of access to designated providers, longer processing time, and the common resort to traditional forms of health care in rural areas. If such low utilization rates are expected to be maintained, then perhaps benefit limits can be extended.

Most pilot projects rely on public hospitals as partner-providers, with the exception of Clinica Tolentino in Quezon.

**SERVICE  
PROVIDERS**



Thus, it would be good to look into the current supply of private providers over an area that may extend beyond the boundaries of the project municipality (in terms of hospital bed capacity and types of services offered). The LGU may then concentrate its membership drive on barangays likely to use its own facility, and enter into an M-O-A with the neighboring municipality for the servicing of its residents in barangays which have easier access to the facilities of those municipalities. Or if the health insurance scheme

**P-II Issues & Concerns C**

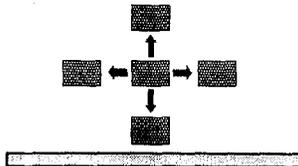
**TABLE 3: BASIC INFORMATION, OLDER P-II PROJECTS**

	Bauan			Unisan			Nueva Valencia		
	1993	1992	Cum*	1993	1992	Cum	1993	1992	Cum
Renewals, members	17	146	1,312	87	549	1,406	38	251	482
Renewals, dependents	40	398	2,843	237	483	3,484	152	961	1,802
New members	17	423	1,609	49	206	1,834	6	119	768
New dependents	44	1,192	5,574	114	534	4,592	16	372	2,501
Active members	121	568		669	640		329	356	
Active dependents	224	1,557		1,558	1,497		1,145	1,237	
Cumulative members			1,609			1,834			766
Cumulative dependents			5,574			4,592			2,501
Dropouts, members	481	254	2,234	107	1,055	2,571	71	426	919
Dropouts, dependents	1,397	756	5,722	290	2,819	6,518	269	1,550	3,167
Members served	5	56	245	27	170	436	3	42	115
Dependents served	17	130	467	58	403	1,008	6	116	256
Collections	3,060	51,695	219,280	7,380	45,060	183,020	3,270	1,920	123,754
Interest	0	8,570	45,634	0	4,016	12,685	960	8,839	20,225
Disbursements	12,271	50,535	140,369	21,459	65,548	164,095	9,502	28,789	70,681
Operating expenses	0	0	0	0	0	0	0	201	699
Claims paid	36	137	638	NA	413	1,034	42	129	325
Annual savings	(9,211)	9,730		(14,079)	(16,472)		(5,272)	(6,869)	
Cumulative reserves	124,525	133,735		31,610	45,689		72,599	77,871	
Average Medicare cost	330	373	246	160	162	136	195	227	201
Average actual cost	1.115	790	450	314	318	239	230	300	216
Support value	29.6%	47.2%	54.7%	50.9%	51.0%	57.1%	84.9%	75.6%	92.9%
Value per claim	341	3	220	NA	159	159	226	223	217
Dependents per member	2.02	2.74		2.33	2.34				
Collection per member	90	91	75	54	70	56	74	62	99
Disburse/collection	401.0%	97.8%	64.0%	290.8%	145.5%	89.7%	290.6%	131.3%	57.1%
Percent served	6.03%	8.75%		3.82%	26.81%		0.61%	9.92%	

\* Cumulative figures

is operating smoothly, the LGU may include in its coverage residents of other municipalities who have easier access to its facility.

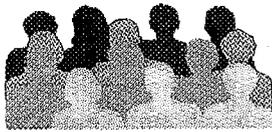
**AVAILMENT PROCEDURES**



P-II pilot projects are characterized by long claims procedures. PMCC consistently reports a higher volume of members and

dependents claims filed or served rather than claims actually paid (assuming that a claim is filed for each person served). In Nueva Valencia, 129 claims were paid while 46 others were under process as of yearend 1992. Reports do not reflect the number of average calendar days that transpire between claims filing and check release. One previous cause of delay in Unisan was the decision to withhold payments temporarily because of the status of Medicare Health Fund reserves. A selective admission policy was adopted by the provider in order to safeguard the fund from depletion.

**UTILIZATION PATTERNS**



The Nueva Valencia and Unisan Evaluation Reports both noted the satisfactory ratings which members gave their community

hospitals, despite complaints of dissatisfaction with the level of benefits received from the program. Low utilization rates may be due to

- Difficulty of access to designated providers;
- Lack of information on service availment procedures;
- Complicated service availment and claims payment procedures;
- Availability of free medical services in rural areas.

Average Medicare cost, however, is much higher for Bauan (P330 per claim for the first quarter of 1993, P246 per claim cumulatively) than for Unisan (P157 per claim for the first quarter 1993 and P137 per claim cumulatively). The Nueva Valencia figures fall in between. The average actual cost per claim is also much higher for Bauan than for the other two, leading to its support value of only 29.6% for the first quarter of 1993. Over time, the trend has been a decline in support values, reflecting pressures on the cost of medical care.

The potential importance of P-II to the local community may be gleaned from the number of admissions to the Unisan Medicare Community Hospital in 1992. Out of 1,743 patients admitted, 26.3 were P-II members, compared to 25.2% for P-I members. The data shows that P-II can contribute significantly to cost recovery efforts of the public hospital system.

**FINANCIAL VIABILITY**



Achieving financial viability is crucial to sustainability. One main issue is accounting for the cost of program inputs other than

claims payment. The Nueva Valencia Evaluation Report presents estimates of the PMCC cost of about P190,000 in support of the project over the year 1990 to 1992. This cost is far bigger than the sum of annual collections over the same three-year period, which amounted to only P67,470 (P140,000 including the beginning balance and interest income), and the total claims disbursement of P61,000. Not included in this administrative cost is the cost to the LGU (in terms of membership campaigns, collection trips, etc.)

The magnitude clearly shows that the membership volume of Nueva Valencia is much lower than what is ideal for the project to be self-sustaining. The PMCC cost, however, has been declining over the years, from P74,000 in 1990 to P52,500 in 1992, suggesting that part of it is set-up cost. For Unisan, the amount mentioned in the report is much lower (at P24,460 in 1992). If salary rates apply uniformly in Unisan and Nueva Valencia, total collections for the year would fall short of administrative expense.

**EVALUATION FRAMEWORK AND ACTION PLANS**

The components of a framework typically suited to P-II project monitoring and evaluation are:

**P-II Issues & Concerns 8**

Inputs -> Outputs -> Effects -> Impact

Each of these components has its own pertinent input indicator and program cost in terms of expense category and financing source. Some of these indicators per component are:

1. Input Indicators:

1.1 Availment Procedures

- Average length of claims processing
- Claims paid/claims filed by member and by value

1.2 Program Costs

- By expense category
- By source of financing

2. Output and Effect Indicators:

2.1 Coverage

- Number of active members
- Coverage ratio (active members vs. potential)
- Dropout rates
- Utilization rates

2.2 Premium and Benefits

- Premium collections
- Collection efficiency ratio
- Benefit disbursements citing average costs and support values

2.3 Provider Service Capacity

- Medical personnel per 1,000 population
- Hospital beds per 1,000 population

2.4 Provider Service Delivery

- Average length of stay
- Net death rates
- Percentage of availers satisfied
- Percentage of members satisfied

2.5 Financial Viability

- Administrative cost vs. income
- Administrative cost vs. benefits paid

- Reserve fund level and growth
- Investment income vs. reserve fund
- Reserve fund, member & dependent
- Net underwriting gain
- Reserve capacity

3. Impact Indicators (health outcomes)

- Morbidity rates
- Mortality rates
- Nutrition indicators
- Fertility rates
- Support value

As has been mentioned, this paper served as a background material in the Iloilo workshop of PMCC. The following were the suggestions given by the workshop participants to address some of the issues identified by Prof. Alonso:

1. Conduct of Information, education and communication (IEC) campaigns
2. Training of P-II officers and staff
3. Enhanced package of benefits
4. Simplification of claims processes
5. Involvement of local officials and NGOs
6. Tapping of alternative funding sources,
7. Establishment of harmonious relationships with private health care providers
8. Improve collection efficiency
9. Institutionalization of P-II through community organizing
10. Explore partnerships with *Botika sa Barangay/Bayan*
11. Creation of a Program Advisory Council

**CONCLUSION**

The P-II experiences in Bauan, Unisan and Nueva Valencia provided rich operational and policy insights which may prove invaluable inputs in the future implementation of the National Health Insurance (NHI) program that is envisioned to cover all Filipinos.