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THE PHILIPPINES COUNCIL FOR HEALTH RESEARCH AND DEVELOPMENT "SEMINAR-WORKSHOP ON HEALTH CARE" FINANCING SCHEMES

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TRIP REPORT

The Philippines Council for Health Research and Development
"Seminar-Workshop on Health Care Financing Schemes"

Introduction

During the past year, public and private sector groups have been requesting USAID/Manila and PCHRD for assistance in the development of alternative financing schemes. Subsequently, PRITECH was asked to recruit a team of prepaid financing experts to help conduct a workshop and provide technical information on prepayment to these groups. For this purpose, PRITECH, with the assistance of the Group Health Association of America (GHAA), arranged to bring a team to the Philippines during the period May 19 - May 30. The team was composed of:

Timothy Brady, General Manager, Family Health Plan, a 30,000 member HMO in Guam;

Jeremiah Norris, PRITECH's Chairperson for Private Sector initiatives;

Robert Rosenberg, M.D., Executive Director, Group Health Association, Inc., a 150,000 member cooperative in Washington, D.C. and

Michael Wood, Membership Director, PRIME Health, a 60,000 member HMO in Kansas City.

The Philippine Council for Health Research and Development (PCHRD) was the host for the workshop.

Field Activities

In preparation for the Workshop, the PRITECH team visited with various groups to learn first-hand their problems in implementing prepayment schemes. The initial period of the consultation was spent discussing the local

environment with USAID officials and other representing such organizations as: the Medicare Commission; private cooperatives; the Asian Development Bank; PCHRD officials; the WHO Regional Office; and investor owned groups, i.e., Health Maintenance, Inc., a 20,000 member HMO in Manila. In addition, two full-day field trips were scheduled into provincial areas to see Medicare and Ministry of Health facilities. Following consultations with PCHRD, preparations for the two and one-half day Workshop were made and the course itself was conducted on May 28, 29, and 30 at the Development Academy of the Philippines conference center in Tagaytay City.

Workshop Activities

The Seminar-Workshop addressed issues pertinent to health care financing schemes, particularly their development, implementation and application as they relate to the objectives of the AID-financed Philippine Primary Health Care Financing Project. The purpose of this project is to increase access to and utilization of sustainable primary health care services managed and financed by the government and the communities. The Seminar-Workshop objectives were to:

- Develop vital information on health care financing through exchange and sharing of experiences and ideas.
- Discuss local issues concerning rules and regulations, sociological, and other variables pertinent to health care financing.
- Begin the preparation of concept papers on health care financing schemes which can be further developed into proposals for possible funding under the AID-financed project.

Participants in the Workshop-Seminar activities (approximately 50) came from both the public and private sectors. The Ministry of Health, National Economic Development Authority, and the Asian Development Bank sent observers. Topics in the Plenary Sessions were:

- Prepayment Schemes--organizational options; principles of prepayment; types of benefit packages; and marketing strategies
- The Philippine Medicare Experience since 1972
- Summary reports from case presentations of proposals submitted to PCHRD for funding

Integrated with Plenary Sessions were small work-groups which reviewed in-country case presentations on the following options: Community Models; Government/Hospital Models; Enterprise-based Models; and Health Maintenance Organization (HMO) Models.

Participants were all trying to implement some kind of health financing scheme in their communities. Thus, the expected outputs of the Seminar-Workshop were targeted in three distinct areas:

1. To assist with the development of an information/data base on health care financing projects in the Philippines.
2. To initiate potential solutions to health care financng problems, and to build a knowledge base of anticipated constraints of such prepayment schemes.
3. And, to develop concept papers on health care financing projects so experiences/problems could be mutually shared.

Summary of Observations

It would appear that the Philippines, unlike so many other nations in the world, a) is turning out adequate numbers of medical and paramedical personnel to provide care for its population; b) has hospitals in greater proportion to the population than many other developing nations; and c) has an apparently solvent government-sponsored insurance (Medicare Commission) program to finance a portion of the care required by wage-based employees. Despite this generally positive position, medical care is poorly distributed within the country and is becoming more expensive (on a fee-for-service basis) than even the middle class can afford. Without commenting on issues beyond the purview of PRITECH's consultation visit, it would seem that the Philippines could benefit from the substantial body of expertise in prepayment that has developed in the United States within the private sector as a result of a public policy mandate (the Congressional HMO Act of 1973).

The same innovative spirit that caused the initial rise of HMOs in the United States exists in the Philippines. There are, for example, dedicated civil servants devising alternative entrepreneurial schemes to provide additional funds to support the health care system. There are also cooperative leaders responding to the needs of their members by developing a medical clinic which features prepayment (through reallocation of profits and cash reserves) for capital costs, and fee-for-service payment for recurrent costs. The private entrepreneur is also getting into the field (Health Maintenance, Inc.), responding to an opportunity to make a profit while providing a valuable service to the public.

The Philippine Government, in recognition of the power of the private sector, has stated that the public will need to rely in greater and greater measure on the private sector for the provision and financing of medical care. Yet, just at the time the government needs support and creativity from private resources, there appear to be problems and delays. For whatever reason, the government's efforts seem to have been more stifling of creativity than encouraging. PCHRD, although slow to react, seems to find the HMO experience relevant and should certainly benefit from USAID encouragement. The Workshop demonstrated that there is no lack of innovative ideas from the health community; PCHRD needs to view these ideas as intellectual capital which it can match with the fiscal resources USAID has made available. More importantly, PCHRD should recognize that USAID has already underwritten many of the risks through this project and that those making an application for funds are, fundamentally, risk-takers, too.

The HMO-type concepts definitely seem viable in the Philippines. Although the fine points (covered services, for example) may vary significantly from those in the United States, the broad concepts can be readily applied. Two organizations are already familiar with the United States experience in this regard: Health Maintenance, Inc. and InterCare. These two organizations typify what has made the HMO movement a success in the United States. They are market driven. That is, they respond (must respond) to the demands of the market.

However, there remain some questions as to what exactly the market is

demanding in the Philippines. The Medicare Commission's Phase II program, for example, which invites voluntary contributions for the purchase of supplementary insurance coverage from the nonwage-based population, attracts only transitory enrollment. The result is that there is no continuity of membership and an extreme risk of adverse selection if pure insurance principles are applied. The low enrollment figures may be due to an erosion of public confidence in the Medicare program itself. The Vice Chairman reported to the PRITECH team that Medicare reserves were at ₱1.2 billion, or a factor of 4 beyond legal requirements. Moreover, when Medicare was instituted in 1972, it covered 70 percent of a member's bill; today it covers only 30 percent--even though premiums were increased in 1979.

Thus, the market may not be asking for better coverage. On the list of one's personal needs, health care insurance coverage may place far below other priorities such as food, clothing, and shelter.* On the other hand, the consultants and many local informants seem to agree that better service on a prepaid basis might be a feature that the market would be willing to pay for on a consistent basis. If this is what the market demands, then it is certainly worth pursuing, for whatever the demand, the ultimate benefits of prepaid medical services (efficient utilization of resources, economies of

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*This statement should be viewed apart from the willingness to pay concept at the household expenditure level. That is, prepayment for a service which may or may not be consumed is a philosophical mind-set requiring social conditioning. Fee-for-service health expenditure on a when-needed, as-needed basis is a high priority in the Philippines.

scale, quality care, etc.) will still accrue to the country.

There appears to be a significant potential for the growth of alternative financing schemes for health care programs in the Philippines. The basic principles of organized and comprehensive delivery of services on a prepaid basis that have been developed in the United States are applicable in the Philippines despite (and even perhaps even because of) the large percentage of the population who remain incapable of purchasing private fee-for-service medical care. The four development proposals presented to the PCHRD at the Seminar-Workshop reflect the varied possibilities that remain open, even under adverse economic circumstances. Given some continued support and counsel, a number of small private sector programs can be established that would considerably increase access to primary health care services.

Summary of Findings

USAID's efforts to promote primary health care services and access to health care through alternative financing systems is a logical and potentially effective methodology. Up to date, the main channel for undertaking these efforts has been the PCHRD, which has had difficulty dispensing funds for innovative development proposals from the community. It may be advisable to introduce some competitive forces, both to lesson the exclusive role of PCHRD and to increase the probability that "something" positive can happen when risks are spread.

The PRITECH team has four main findings which stem from its discussions

with community groups in the field, and participants at the Seminar-Workshop:

1. There is a large supply of physician/paramedical personnel available in the Philippines, matched with increasing amounts of disposable income for health services. It is in the government's interest to seek more efficient means of service delivery through organizational models which both finance and deliver health care to a defined population on a prepaid basis.

2. There is a tendency on the part of applicants for PCHRD funds to justify their requests by proposing economic activities (beach resorts, minimarts, etc.) secondary to the main activity (health services). Since applicants are requesting funds for these secondary activities, PCHRD has to ensure that grantees do not displace other competitors, who must rely on market financing, through favorable access to grant financing. This places an unnecessary monitoring burden on the PCHRD, and it spreads management expertise within the community too thinly to cover both health services and an additional economic activity. The downside risks for PCHRD are great if it undertakes this kind of financing.

3. There is, at this time, no coordinated planning by the public and private sectors for the development of alternative health care delivery systems.

4. There is a potential for cooperatives to play a larger role in alternative delivery schemes. The San Dionisio Credit Cooperative is an example: over a twenty-three year period, it was successful with one activity .... the provision of credit to its members, it used extant management expertise to move into health care.

Recommendations

USAID should continue to support innovative approaches towards private sector health care financing schemes. The development of a variety of community based programs tailored to the specific local needs and funded at a level the community can support will ultimately lead to an improvement in access to health care for both urban and rural populations. At the same time, this should allow government funds to be utilized for preventive and public health measures rather than for curative medicine.

Although USAID should continue with the PCHRD project, other institutional support should also be cultivated as insurance factors. The Asian Institute for Management (AIM) is one such institution. AIM could be most useful in improving the implementation of this kind of activity. Initially, this assistance would be in the development of incentive programs for local groups implementing prepaid health programs, and to develop case studies of groups (Health Maintenance, Inc., the San Dionisio Credit Cooperative, etc.) now delivering prepaid health care to a defined population. Local groups need to know that there is a body of indigenous expertise and knowledge available from their own communities. An institution with the reputation and credibility of AIM could be an effective promotor of prepayment among corporate entities in the Philippines, as well as with local agencies, i.e., the National Irrigation Authority, etc.

As mentioned elsewhere, the experience of the United States in prepayment appears relevant to the problems of the Philippines. Thus, it is in the interest of both governments to encourage demonstrations in the prepayment of medical care.

Specifically, the PRITECH team has six main recommendations for USAID's consideration:

1. Continue to work closely with PCHRD to encourage higher levels of activity. The current "analysis paralysis" at PCHRD risks scuttling any innovative spirit which currently exists in the health community. Dependency could be lessened through an expansion of the institutional base to a group with management and organizational

expertise, i.e., AIM. In the process, USAID may well assist AIM to be both a national and regional resource for prepayment development.

2. Fund several simultaneous experiments in prepayment to demonstrate the viability or non-viability of different sponsoring organizations, such as cooperatives. The major point of this recommendation is that the experiment should be limited in scope in favor of speed in implementation. The results may be most significant when minds are free to imagine possibilities without such constraints as nationwide applicability, replicability, or other confining considerations.

3. Provide a central technical resource to these experimental operations. In addition to library resources, technical assistance should be made available to PCHRD, AIM, or other independent bodies.*

4. Initiate a program of travel awards for prominent decision makers to visit successful operating models in prepayment in other countries. Some possible candidates: Dr. Jesus Tamesis; Dr. Tony De Jesus; Dr. Tony Perlas; Dr. Alberto Romualdez; Dr. Pacita Zara; Dr. Sergio Gasmen; Dr. Alfredo R.A. Bengzon; Dr. Gabino Mendoza (President of AIM); and MOH officials.

5. Develop technical workshops to assist proponents in preparing alternative delivery schemes, and provide technical expertise to PCHRD on proposal review. One method which might serve to introduce this concept is to have AIM conduct the workshop, thus demonstrating the process for proponents and PCHRD.

6. Assist the Medicare Commission in restructuring its incentive program and benefit package to address physician/hospital inefficient utilization practices and the country's epidemiologic transition.

In addition to these main recommendations, PRITECH would like to take the opportunity to mention a series of secondary recommendations to USAID:

1. Establish periodic educational programs and seminars, through PCHRD, AIM, etc. to provide information on the components of successful

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*This recommendation does not include long-term resident advisors. The kind of technical-assistance envisioned is short-term and quite varied on a case by case situation: management information; data processing; development of actuarial tables; insurance underwriting; risk management; epidemiologic considerations for the design of local health benefit packages; incentive planning, membership information and education programs; family planning through prepayment; the integration of primary health care with curative services; etc.

health care delivery systems in the Philippines, as well as in developing and industrial countries.

2. Develop formal relationships with professional management organizations to assist in the development and monitoring of alternative health schemes.

3. Request authority to fund viable schemes directly.

4. Develop an operating model in the Philippines as soon as possible. Too many resources are being applied to theoretical discussions and not enough resources are being applied to the establishment of operating models. InterCare and the San Dionisio Credit Cooperative represent possibilities.

5. Identify specific reasons why PCHRD and the MOH are slow to move on the development of alternative schemes. Develop short-term and long-term strategies to overcome these difficulties.

6. Develop and distribute informational materials to organizations interested in developing alternative schemes. The goals and objectives of the project have to be better marketed to interested parties.

7. Assist appropriate agencies, SEC and the Insurance Commission, in developing rules and regulations for regulating schemes outside the MOH control. A body of information on generic legal and regulatory issues could be made available from institutions such as the Group Health Association of America.

8. Discuss funding and technical assistance agreements with the Asian Development Bank, or alternative funding organizations. The participation of the ADB should be invited in an effort to introduce the prepaid medical concept to a broader audience.

9. Request cooperation from the Medicare Commission to use its reserves for internally funding alternative delivery schemes. Bring together a coalition of businss, labor, professional medical societies, and government to make the case for this funding.

Conclusion

It is particularly relevant to note the U.S. experience with regard to the relationship of the HMO Act of 1973 to the fledgling HMO movement in the Philippines. That is, the system of grants and loans that were available under the Act, in combination with the sponsorship by the government of

private technical resources, encouraged a great variety of experimentation in the free market that resulted in some extremely innovative, efficient, and successful health care delivery systems. Subsequently, not only was the U.S. government able to reduce substantially its grant and loan funding once the private sector took over financing, but it has also been able to begin the transfer of Medicare and Medicaid members to HMO coverage. Although these members previously received their health coverage in the private sector, it was under costly provisions in fee-for-service practices. Since the government financed the services delivered by the private sector, it has little control over utilization. Now, HMOs both finance and deliver services, and if utilization is inappropriate, the HMO pays rather than the government.

In the Philippines context, USAID has made grant funds available through the PCHRD. This is quite analogous to the Department of Health and Human Services making funds available to the U.S. private sector, thereby underwriting the risks. The PRITECH team believes USAID and PCHRD are on the right track. Undoubtedly, there will be mistakes and failures, and there will be a learning period, much as there was in the U.S. experience. USAID should continue on its present course, with modifications as noted; it is the best option available in the Philippines today.