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HEALTH FINANCE DEVELOPMENT PROJECT

HFDP Monograph No. 7
April 1993

Department of Health
Republic of the Philippines

Prepared by Management Sciences for Health

Andersen Consulting

CARRA, Inc.

Harvard Institute for International Development (HIID)

Funded by
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RESULTS OF RECENT RESEARCH CONCERNING MEDICARE IN THE PHILIPPINES

by
Emelina S. Almario
Maria Luisa Beringuela
Eduardo Gonzales
James R. Jeffers

List of Abbreviations

APHO	Assistant Provincial Health Officer
ARHO	Assistant Regional Health Officer
CGE	Computable General Equilibrium
COTG	Central Health Tariff Organization
DOH	Department of Health
DRG	Diagnostic Related Group
GNP	Gross National Product
GSIS	Government Service Insurance System
HIC	Health Insurance Company
HIF	Health Insurance Fund
HMO	Health Maintenance Organization
LGU	Local Government Unit
MOA	Memorandum of Agreement
NCR	National Capital Region
NEDA	National Economic and Development Authority
NGO	Non-Government Organization
NHI	National Health Insurance
NHS	National Health Service
PIDS	Philippine Institute of Development Studies
PMCC	Philippine Medical Care Commission
PPO	Preferred Provider Organization
ROI	Return on Investment
RUV	Relative Unit Value
SSS	Social Security System
UP	University of the Philippines
USAID	United States Agency for International Development
WHO	World Health Organization

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A

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Results of Recent Research Concerning Medicare in the Philippines

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EXECUTIVE SUMMARY

INTRODUCTION

Health financing has become a major health policy concern of many countries. Efforts are being made to lay the foundation for a more comprehensive coverage (more people and more benefits) and a more sensible approach to the financing of health services (such as more consistent quality of financially accessible services and controlled rise in service costs).

In recent decades many developed as well as developing countries in Europe, the Americas, and the Asia-Pacific have taken important steps toward the establishment of national health insurance (NHI). Some of the countries aspire ultimately to set up an NHI program for the entire population, ranging from a package of all needed health services, from cradle to grave, paid for by the state to health financing programs for those segments of the population that are in greatest need of health services, such as the elderly, the poor, and women and children.

All the programs are intended to make health services more financially accessible to everyone or selected segments of the population. In the Philippines, the Medicare program can be viewed as the nucleus of an NHI program. If expanded, it could become an NHI program offering universal entitlement to health services to all Filipinos, as envisioned by the first Medicare law passed in 1969.

Government or parastatal agencies can provide insurance or health services. Alternatively, service delivery and financing can fall to private health providers and insurance companies, with the government as sponsor. The right approach for a country depends largely on certain political preferences, such as whether government and government-controlled agencies or the private sector should take a dominant role.

Sharply divergent views within a nation too often beget political gridlock over the approach to development in any area including health delivery or financing. An unfortunate consequence could be slow progress in improving or expanding the delivery or financing of health services. The scope and organization of the health insurance program could also undergo drastic reversal with a change in the party in power.

Fortunately, such does not seem to be the case in the Philippines where Medicare is concerned. There appears to be widespread agreement that present programs should be expanded as quickly as economic and administrative constraints allow. Yet there are important differences of opinion about which aspects of the Medicare experience should be dealt with and in what order, and how best to develop the Medicare system further. The appropriate strategy must be agreed upon.

PURPOSES OF THIS PAPER

This paper briefly reviews the health financing experience of other countries, presents the results of recent research on Medicare, and discusses the ramifications of the research, as background information for the Medicare Strategic Planning Workshop on February 18 to 20, 1993. The paper does not attempt to prescribe policies; it is up to the Philippine Medical Care Commission (PMCC) to do so. The paper does recognize, however, that with properly designed and implemented policies, Medicare can become the nucleus of an NHI program.

It is hoped that this paper yields useful information about the related experience of other countries, shows how Medicare has affected the financing and delivery of health services in the Philippines, and clarifies what these observations mean for the development of Medicare as a health care financing institution. The information and materials are presented as objectively as possible. The writers of this paper have no biases or prejudice as to the ideal character of Medicare, the best health financing mechanisms, or the manner in which Medicare should evolve. The paper hews to these three main themes:

- More than mobilizing funds, health financing involves setting in motion factors that strongly influence the structure of the health service delivery system—the numbers and types of providers, the types of services they make available and where, and the terms of availability.
- Some matters may require more study and research, including pilot and demonstration field trials, before being made into policy or law.
- No health financing system is perfect. Each system must reflect the cultural, historical, socioeconomic, political, and institutional realities of its country.

ORGANIZATION OF THIS PAPER

This paper has six main parts. The first part, following this executive summary, is a brief introduction to the paper. The second sets out policies and issues that are important and relevant to the assessment of the health financing experiments in other countries, and summarizes the experience of those countries.

The third part presents the results of research sponsored by the Department of Health (DOH) and the Philippine Institute of Development Studies (PIDS) and other, related research on the role of Medicare in the financing of health service delivery in

recent decades. The fourth part discusses the results of a study of the Medicare organization, management, and finances.

The fifth part reviews the PMCC tie-up and the Program II pilot studies. The sixth and final part brings together the major recurring themes of the paper and points out their likely ramifications, particularly for the further expansion of Program II.

HIGHLIGHTS OF THE FINDINGS

Following is a recap of the major findings discussed at greater length elsewhere in this paper.

EXPERIENCE OF OTHER COUNTRIES

- Health insurance programs come in different forms involving different degrees of involvement by the government and the private sector in the financing and delivery of health services.
- Countries with full NHI programs are relatively wealthier, but wealth alone does not explain their success in implementing comprehensive national programs. Just as important, or even more so, are political will, sense of priority, commitment, and implementation mechanisms.
- Countries with NHI programs developed these over long periods (often hundreds of years). In the course of development, political and economic factors thwarted progress for a time. Then, as conditions improved, the programs once again made headway. This sequence of rapid inception, followed by periods of slow or no progress, followed by brisk development is true of all growth, biological as well as institutional.
- NHI programs, whether comprehensive or more modest in scope, are rooted in a unique history, politics, traditions, and institutions. Often it is dangerous to draw conclusions from the experience of other countries. Things that work well in those countries may not work well in the Philippines. On the other hand, things that do not appear to work well in other countries may work very well in the Philippines, if modified properly.

What to borrow, if at all, from the experience of other countries and what modifications should be made, depend on the peculiarities and experience of the Medicare system. These are the subject of the next three parts of this paper.

THE PHILIPPINE MEDICARE EXPERIENCE: AN OVERVIEW OF PROGRAM I

This part gives an overview of Medicare Program I from its start, particularly the years between 1980 and 1991. The data and information presented deal with revenue mobilization, allocation of benefit payments among broad categories of medical services, the financial burden on contributors (classified by income quartile), cross-subsidy, membership coverage, and the role of private insurance companies in the financing of medical services.

The following findings are especially noteworthy:

Revenue Mobilization

- In the '80s, benefit payments grew moderately in nominal terms, but in real terms the average growth rate was actually -1.7%. The '90s look more auspicious given the PMCC's higher support levels. Medicare expenditures on health services grew at an average of 42.72% in nominal terms between 1989 and 1991, for an annual increase of 23.26% in real terms.
- The rise in Medicare benefit payments meant an increase of three percentage points in the share of Medicare in total health care financing from 1988 to 1991, from 5.65% to 8.5%. (These are based on estimated total health expenditures for 1988 and 1991.)

Allocation Among Categories of Health Services

- The bulk of Medicare benefit payments went to drugs and medicines (31%) and payments for the services of physicians and surgeons (21%).
- These were followed by room and board (17%) and diagnostic tests (16%), with the rest going to anesthesiologists' fees and to operating room and other charges.

Financial Burden

- The Medicare tax is expectedly regressive. Lower-income groups with average monthly incomes below the ceiling contribute about 2.5% of total income. Above the ceiling, the tax is fixed so that the tax rate falls as income increases.
- On the whole, Social Security System (SSS) members contribute a smaller percentage of their income to Medicare than Government Service Insurance System (GSIS) members, possibly because of irregular remittance of contributions by private employers. An SSS member may file for Medicare benefits if he has paid at least three months' contributions during the year immediately preceding.
- There is no indication that the tax is passed on to consumers. The prices of almost all goods from the production sectors decreased after the tax.
- Instead, the market wage of unskilled workers decreased as a result of the Medicare tax.
- Although most unskilled workers belong to the agricultural and informal service sectors, which have no access to Medicare benefits, they bear part of the financial burden of the tax in the form of lower wages.

Contributions vs. Benefit Payments

- For both SSS and GSIS, the second poorest group appears to be subsidizing higher-income groups. Already, this group pays the maximum monthly contribution of ₱62.50.
- The two highest-income groups under

GSIS fail to provide subsidy, since they also account for a higher average value of claims. "Expensive" diseases are highly prevalent in these groups. Besides, wealthier government employees generally opt for tertiary-level private facilities. These findings may have to be revised in the light of recent wage equalization measures.

- According to the available data, the pattern of cross-subsidy between age groups is similar for both systems. Morbidity rates increase with age. The younger members are therefore expected to subsidize the older members, especially in the absence of a positive correlation between incomes and age, as is true of GSIS. This is also true of SSS, although the difference in income between age groups is very small.

- The youngest group is a source of subsidy. But for both systems, the 26-45 age group receives subsidy while the 45-65 group contributes more than its share of benefits.

- For GSIS, the explanation lies in the lower average income of the 26-45 group which, for both systems, files frequent claims for dependents. Most couples get married and have children in this age group, and morbidity rates are quite high among very young children.

Regional Distribution

- The National Capital Region (NCR) and Region 8 contribute more than what they get in benefits. NCR resources are properly redistributed to the other regions, but perhaps more benefits should go to Region 8, a poor region.

- Cross-subsidy between regions is determined by utilization rates. A study should be made to explain the huge disparity in utilization rates between regions.

Coverage

- In 1991, Medicare covered 28 million Filipinos, or 44.7% of the population. From its modest beginnings, Medicare coverage peaked at 51% in 1984-86, then dropped dramatically to 42.2% in 1987 with the purging of inactive members from the SSS files. Estimates of Medicare coverage could be higher than actual because of the high dependency ratio used. In 1983, the 3:1 ratio was increased even more, to 4:1, despite a report from the Population Institute of the University of the Philippines that dependency rates have been going down through the years (Gonzales 1992).

- Two other facts support the contention that Medicare coverage is overestimated. In 1990, only 22.5% of all the employed and 40% of the salaried employed were members of either SSS or GSIS. Indeed, Gonzales observed that the membership base has been shrinking. He concluded that "Medicare is increasingly unable to provide a wider safety net to a growing work force" (Gonzales 1992).

- Program I is geared towards the industrial sector and a minority in the service sector. Recent data, however, show that agriculture is still the biggest sector and that the industrial sector remains small. In the '80s and '90s, increases in the labor force have been absorbed by the services sector, which is the only sector that has been growing consistently during the period.

- The data do not reflect the large numbers of unemployed and underemployed in the country. Employers are not inclined to provide social security to unskilled workers and contractuals since every job has possibly 10 other workers, currently unemployed, just waiting in line to get it.

The Role of Other Financing Institutions

- Private health insurers consider health insurance an unprofitable product line, but not because the market is cornered by Medicare. Slow growth in this industry is attributed to such factors as low incomes, soaring health care costs, and inappropriate regulation (Gamboa 1991).

- Health maintenance organizations (HMOs), on the other hand, seem to have found their niche in the market by offering coverage beyond the Medicare level. Many HMOs are therefore sanguine about growth prospects.

MEDICARE AS AN INSTITUTION: SUMMARY OF MAJOR PROGRAM I ISSUES

Organization

- The overall management of Medicare nominally rests with the PMCC; the GSIS and SSS act as financial intermediaries. The PMCC is recognized as the focal point of the Medicare program.

- The delegation of the financial management of the Health Insurance Fund (HIF) to SSS and GSIS has left the PMCC without much muscle to directly manage it. Yet RA 6111 is emphatic that "the deposit, investment, administration, and disbursement of the funds conform with the policies established by the Commission."

- Planning by the PMCC has been limited to providing inputs to the Medium-Term Development Plan of the National Economic and Development Authority (NEDA). It does no research and development, even if this is one area in which it could very well play a central role.

- A host of administrative shortcomings undermine PMCC capacity. The administrative staff outnumber the technical staff three to one. Consistently underspending its budget by an average of 47.4%, the PMCC has seen its policy-making and administrative capacity sapped by budgetary attrition and low expenditure on program development. Only two PMCC units, the providers service, which has 10 medical doctors, and the hearing and investigation service, which has 10 law graduates, seem to have the appropriate mix and concentration of required skills.

- Several factors hinder decision making. Major decisions are made by four executive committees: hearing and

investigation, appealed claims, accreditation, and rules and regulations. The service departments—hearing and investigation, providers service, programs development—only support the committees. Department managers have some control over resources but lack the authority to do more than recommend, and must rely heavily on the committees for final decisions. As if by design, each department has a matching committee (programs development service, for instance, is paired with the rules and regulations committee).

- Decision making seems to be turning more complex and costly, and there are frequent complaints of another bureaucratic layer, a new source of directives, and new reports to be prepared. Counterpart arrangements in this case only divert decision making and further erode operating efficiency.

Financial Performance

- The composition of Medicare income over the years has shifted progressively in favor of investment income, with the change occurring much more rapidly for SSS.

- In the early '80s, SSS' total income was roughly double that of GSIS; by 1985, it had tripled, and SSS has pulled away since then. The growth of investment income explains why. In 1980, investment income made up a little less than 10% of Medicare's total income (more than 90% being accounted for by premium collection and other income, such as penalties for delayed remittances). By 1990, 44.6% of Medicare's earnings came from investment interest payments alone. SSS has disproportionately contributed to this shift: thrice in ten years (in 1985, 1986, and 1990), investments provided more than half of its total income.

- Before 1988, GSIS barely earned from its investments. GSIS experienced net underwriting losses in 1985, 1988, and 1991. In 1990, its interest earnings went up modestly to 24.7% of total income. There were suggestions that GSIS may be paying a high price for unsound investments (locked in unproductive assets) made prior to 1986.

- GSIS' unpaid premiums rose from zero in 1980 to an all-time high of ₱160 million in 1991, causing a sharp drop in collection efficiency. This steep descent reflects the difficulties that GSIS underwent in compelling a quick turnover of its collection income from the Department of Budget and Management (which holds the bulk of government payroll deductions), leading to a severe cash squeeze.

- Medicare's high investment performance—the system now relies less on premiums since interest income makes up almost half of total income—means any further slackening of collection efficiency may be offset by high investment income.

- Medicare's finances are generally well-managed, no doubt because SSS, with its impressive financial performance, dominates the system. SSS has done better than average in most of the financial indicators examined.

Increasing Benefit Expenses: Tradeoffs Between Financial Viability and Fund Utilization

- GSIS' benefit expense has grown faster than SSS', but has a larger claim on its collection income.

- Between the two agencies, GSIS has given benefits to a higher proportion of its Medicare eligibles—roughly 10% to SSS' 5%. Many more public-sector workers apparently depend on Medicare, presumably because Medicare is the only medical insurance available to them.

- GSIS benefit expenditures have a relatively larger claim on collection income, compared to SSS'. GSIS' benefit expense claimed 115% of collection revenues in 1991, the first time in 12 years that GSIS or SSS claims payments exceeded premium payments.

- In 1991, recipients were paid an average of ₱1,263.93 in benefits. SSS paid higher average values per claim. Between 1980 and 1986, SSS paid out an average of ₱293.24 per recipient, while GSIS disbursed an average of ₱281.16 for a difference of ₱12.08. Between 1987 and 1991, the corresponding figures were ₱814.18 for SSS and ₱638.50 for GSIS. The difference was now ₱175.68.

- GSIS has paid higher benefits per capita, by as much as two-thirds more than what SSS pays, on the average, because of the bigger proportion of beneficiaries in its coverage base. The upward trend in benefits paid per capita is also evident.

- Regardless of the real reasons for the contrast between GSIS and SSS in their administrative expense patterns, it is safe to say at this point that GSIS—with lower administrative costs per peso of benefit expense—has been "giving back" much more of its Medicare resources to eligibles, compared to SSS.

- It costs SSS members almost five times as much to underwrite their own medical care. The low benefit expenses of SSS stem from a number of other forces, such as low utilization rates in the private sector and the possible exclusion of high-risk people from SSS' insurance plans.

Administrative Costs

- In 1990, it cost six times as much to process claims in SSS than in GSIS; in 1989, the cost was almost three times as much. The declining trend for GSIS means that its transaction costs are relatively less than those of SSS, and each GSIS Medicare beneficiary gets back a bit more than his counterpart in the SSS, at least through lower administrative costs per capita.

- In 1981, SSS administrative expenses were estimated at ₱7 million; by 1991, they had reached ₱86.635 million, a twelvefold increase over a period of 10 years.

- By contrast, GSIS' operating costs are declining. In 1980, GSIS' operating costs were placed at ₱15.116 million. By 1991, however, the amount had gone down to ₱11.182 million.

- PMCC's declining expenditures parallel declining appropriations from the national government, and suggest inefficient use of financial resources. PMCC has a more limited financial base because it relies on government appropriations, which are often subject to political pressures. PMCC's appropriations have continued to decline since 1988, at one time dropping by as much as 60%.
- This situation should be mitigated somewhat by the fact that the central government has often imposed mandatory cutbacks in agency expenditures to reduce the fiscal deficit. Still, the PMCC record would make it difficult for the Commission to justify higher annual appropriations.

Claims Processing

- The GSIS Medicare claims processing system is functionally adequate, but it is plagued by the uncertain quality of processing and a persistent backlog.
- The SSS processing system is well-equipped with controls that detect fraud at an early stage. SSS Medicare claims processing is by and large similar to the GSIS system and follows the same routine, except that major responsibilities are vested in several independent departments.
- Unlike GSIS, where all processing takes place at the central headquarters in Manila, SSS has completely decentralized claims processing to its 10 regional offices.

Access to Medical Services

- A synoptic view of the regional distribution of providers accredited by PMCC shows that, surprisingly, it is not the NCR but Region 3 (Central Luzon), Region 4 (Southern Tagalog), and Region 11 (Southern Mindanao) which have the most number of accredited providers.
- Closer scrutiny requires evaluating the distribution of bed capacity among those insured by Medicare. The findings hold no surprises. Metro Manila, as expected, leads the other regions in the tally, with 8.6 beds per thousand.
- Thus, while the introduction of Medicare has caused the outlying regions as a whole to make rapid gains in the provision of medical services, these regions have yet to experience any substantial gain in per capita availability of facilities and medical manpower relative to Metro Manila residents. The failure of Medicare to balance the growth of facilities and physicians per capita suggests that the accreditation program may be less than successful in areas removed from Manila.
- The Medicare program has no adequate public information campaign to help consumers deal effectively with providers and reimbursement agencies. Because social insurance schemes often suffer from a dearth of information, a public awareness program is always helpful.

Accreditation and Monitoring

- The PMCC depends substantially on the capacity of the assistant provincial health officer and the assistant regional health officer to evaluate hospitals. They recommend accreditation.
- PMCC accreditation procedures clearly lack transparency. Appropriate standards for the number of medical personnel, number of beds, facilities, location, manpower- and facilities-to-population ratios, and other relevant indicators as reflected in the application forms, are not determined precisely. Too much discretion is left to those who recommend and approve licensing, contrary to a rule of thumb that procedures must be unequivocal.
- Severe administrative and budgetary limitations keep the PMCC from monitoring more than 15% of Medicare providers.
- PMCC has not fully exercised its power to monitor all accredited hospitals in the country because of a tight budget and lack of coordination within the Medicare system. The providers service department is grossly understaffed.
- Monitoring of data collection is weak, unreliable, and in some cases nonexistent. The monitoring forms that reach the providers service department are often incompletely filled out; some statistics in the forms do not tally. The forms have no practical value for forecasting or trend extrapolation. Poor compliance in the submission of forms is compounded by an inadequate supply of qualified statisticians, actuaries, and other technical personnel. Efforts to reform the system have met with little success.
- There is evidence the weakness of the monitoring system has paved the way for massive "rent-seeking" and fraud. The hearing and investigation service has resolved an average of 64 cases of fraud yearly from 1979 to 1991, and there is suspicion that the full extent of the irregularities is still to be uncovered.

SUMMARY OF PROGRAM I FINDINGS

The foregoing summary dwells on some rather negative aspects of the Medicare Program I, suggesting some needed improvements. These can be classified into two major categories: benefit improvements and administrative improvements which, in turn, can further be classified into distinct subcategories as follows.

BENEFIT IMPROVEMENTS

- Population coverage
- Enrolment of firms and their employees in Program I
- Contribution and benefit structures
- Incentives implicit in the Medicare benefit structure
- Support levels

ADMINISTRATIVE IMPROVEMENTS

- Medicare claims processing
- Levels of reserves
- Fraud and abuse by providers and consumers
- Effective use of the private sector and appropriate distribution of risks and costs between the public and private sectors

Recent initiatives of the PMCC board have already dealt with many of these matters. Among them are improvements in claims processing, studies on ways of ensuring greater compliance by firms and individuals, the possibility of consolidating program administration, revision of the relative unit values scales on which provider reimbursements are based, and a large demonstration project involving expansion of out-patient benefits under fee-for-service and capitation provider payment schemes. What remains to be discussed are recent innovations, experiments involving tie-ups with HMOs, and pilot projects to test approaches to covering people not employed in the formal sector, such as agricultural workers and fishermen.

SUMMARY OF HMO TIE-UP AND PROGRAM II FINDINGS

HMO TIE-UP EXPERIENCE

- The tie-up could not provide a higher level of financial coverage for the health care expenses of its members. The amount paid out by the regular Medicare program to its members was higher on the average than the amount paid out by the tie-up. In addition, the actual costs of treatment of tie-up members, especially the affiliated providers, were higher.
- Members indicated greater satisfaction with the benefits and provider services under the tie-up than with the regular Medicare program. But the rules and procedures of the regular Medicare program were preferred over those of the tie-up.
- Affiliated providers, too, showed satisfaction with the tie-up. They felt the tie-up should continue, despite operating problems, for these reasons:
  - Greater financial coverage for members, and
  - Ability of HMOs to control unnecessary treatment costs, through gatekeeping and case management.
- Both SSS and GSIS benefitted from the tie-up. The share of tie-up members' contributions which they retained partly made up for the costs incurred. This share was initially pegged at 3% of premium contributions but was later increased to 34%.
- Problems of coordination with SSS and GSIS caused certain inefficiencies in the operations of HealthKard and Pamana. Delays in the remittance of premium contributions led to cash deficits in some periods during which the HMOs' other programs had to subsidize tie-up operations. Delays in membership verification and in the transmittal of misrouted claims delayed payment of benefits which, in turn, strained relationships between the HMOs and the providers and members.
- PMCC should continue with this type of experiment, especially in view of the rising demand for health care, its spiraling costs, and the limitations of the government when it comes to health care delivery and financing. PMCC can use the lessons learned from this initial effort in future experiments.

PROGRAM II INITIATIVES

Medicare Program II has been in a rather extended pilot and field-testing phase. A review of several of these Program II projects turned up the following findings.

- In 1983, the Medicare Program was expanded to include compulsory coverage for the self-employed. Still, large segments of the Philippine population, specifically the poorer occupational groups and the unemployed, could not afford Program I premiums without any health insurance coverage. PMCC responded by launching pilot projects to serve these segments. It was conscious of its mandate to gradually provide complete medical services by adopting and implementing a comprehensive and well-coordinated medical care plan.
- The pilot projects conformed to Section 31 of its legal mandate, which states that "as soon as feasible, medical care benefits under Program II will be provided either through a social insurance medical care service similar to that of Program I or through the public medical care service under rules and regulations to be promulgated by the Commission."
- Ongoing projects are very small and usually involve fewer than 3,000 members. The Program 2 pilot projects of PMCC have grown slowly through the years, not for lack of interest by potential participants but primarily because of the limited resources that PMCC can devote to them, given its present network, and because of the limited capacity of the target beneficiaries to pay. But, according to a recent Development Academy of the Philippines study, the projects hold promise for decentralizing the Medicare system and making it more broad-based.
- Already the projects are drawing questions from participants. The answers could mean stronger, better-designed projects in the future.
- The questions involve sustainability, financial management, choice of benefit package, access to more providers, use of managed care principles, role of local health officials, and subsidy of indigents, among others. Although these questions remain unanswered, bills submitted recently to the House of Representatives and the Senate are calling for nationwide implementation of Program II.
- Experience gained on the PMCC pilot projects should be gathered and studied to provide PMCC with the information needed to shape a legislative agenda.

TOWARD THE LAUNCHING OF MEDICARE II

The systematic and large-scale launching of Medicare Program II is of considerable importance. As outlined later on in this paper, Program II initiatives revolve around individual communities. Accelerating Program II is therefore particularly challenging in view of the large number of existing communities which must be involved.

The following are some matters that may be crucial to determining the appropriate strategy for the expansion of Medicare Program II:

- Determining the **appropriate benefit entitlement** (who receives what),
- Determining the **appropriate revenue bases and methods of payment** (who pays and how much),
- Deciding the **role of the private and public sectors in financing and delivery** (who delivers what goods and services and who pays what share),
- Deciding **the manner of cost containment and quality maintenance** (how cost increases can be controlled and the quality of services kept at an acceptable level), and
- Determining **appropriate intersectoral relationships** (who should coordinate health care delivery across government and private-sector lines).

In summary, this paper sets forth a number of facts and matters of importance to both Programs I and II of Medicare. It is hoped that this information is of value to PMCC and other agencies that are charting the course of Medicare in the Philippines in the 21st century.

INTRODUCTION

This paper briefly reviews the health financing experience of other countries, presents the results of recent research on Medicare, and discusses the ramifications of the research, as background information for the Medicare Strategic Planning Workshop on February 18 to 20, 1993. The paper does not attempt to prescribe policies; it is up to the Philippine Medical Care Commission (PMCC) to do so. It is hoped that this paper yields useful information about the related experience of other countries, shows how Medicare has affected the financing and delivery of health services in the Philippines, and clarifies what these observations mean for the development of Medicare as a health care financing institution.

The information and materials are presented as objectively as possible. The writers of this paper have no biases or prejudice as to the ideal character of Medicare, the best health financing mechanisms, or the manner in which Medicare should evolve. The paper hews to these three main themes:

- Health financing is more than mobilizing resources or funds. In every country, how health financing is organized clearly and noticeably affects the way in which health services are delivered and then used by consumers. Administrative arrangements and payment mechanisms implicitly offer varying incentives to providers to make the services available, and to consumers to use the services.

- To understand fully the impact of administrative and financing arrangements on health service delivery and utilization, and ultimately on the attainment of health policy goals, more research on what is happening and why may be required before policies are drawn up.

- No health financing system is perfect. Things that work well in other countries may not work well in the Philippines. On the other hand, things that do not appear to work well in other countries may work very well in the Philippines, if modified properly. Each system must reflect the cultural, historical, socioeconomic, political, and institutional realities of its country. Changes in any of these may require corresponding modifications in health financing arrangements.

This paper has six main parts. The first part, following this executive summary, is a brief introduction to the paper. The second sets out policies and issues that are important and relevant to the assessment of the health financing experiments in other countries, and summarizes the experience of those countries.

The third part presents the results of research sponsored by the DOH and PIDS and other, related research on the role of Medicare in the financing of health service delivery in recent decades. The fourth part discusses the results of a study of the Medicare organization, management, and finances.

The fifth part reviews the PMCC tie-up and the Program II pilot studies. The sixth and final part brings together the major recurring themes of the paper and points out their likely ramifications, particularly for the further expansion of Program II.

EXPERIENCE OF OTHER COUNTRIES

POLICY INITIATIVES IN OTHER COUNTRIES

Policy initiatives are generally designed to improve the equity and efficiency of health service delivery and consumption. As stated elsewhere, increasing health service outlays, at least up to a point, is a rational individual and national response to the fact that health services maintain the stock of human capital, which is the most important capital they will ever have.

But aside from improving the equity and efficiency of health service delivery and providing more services, adequate attention must be given to the quality of the services and to cost containment. Innovations made in this regard by other countries, mainly those within the Asia-Pacific region, are presented below. It is immediately obvious that almost all countries are trying to change the way in which they are mobilizing resources for health care financing.

The information is organized under the following headings:

- Benefit entitlement (who receives what),
- Revenue bases and methods of payment (who pays and how much),
- Role of the private and public sectors in financing and delivery (who delivers what goods and services and who pays what share),
- Cost containment and quality maintenance (how cost increases are controlled and the quality of services kept at an acceptable level), and
- Intersectoral relationships (who should coordinate health care delivery across government and private-sector lines).

EXPERIENCE OF SELECTED COUNTRIES

UNITED KINGDOM

Benefit Entitlement

The health service delivery system in the U.K. is almost completely nationalized. In principle, all persons are entitled to all the health services they will ever need. But in practice, health services are not uniformly accessible throughout the nation. Urban areas, particularly the Thames district, have more resources per capita than remote areas. Moreover, hospital waiting lists have bloated over time. In January 1988, for instance, more than 800,000 operations still had to be performed.

Revenue Bases and Methods of Payment and Collection

Nearly 90% of health service delivery is financed from government sources. Private health insurance covers roughly 10% of the population. The U.K. has no NHI scheme, although considerable thought is being given to developing one. The public system is financed almost entirely through the consolidated revenue fund. Thus the public system is financed through the collection of various taxes, particularly the income tax. User fees on drugs, optical devices, and special service items provide less than 8% of the total revenues of the National Health Service (NHS). Private-sector charges and fees are paid either out-of-pocket or from private health insurance.

Medical costs are reported to be about 5.5% of GNP, but privately funded cost studies have shown that this estimate is too low. It includes only NHS costs and excludes estimates of service delivery costs in the private medical sector, health care costs borne by local governments, and costs of health services provided by the Department of Defense. With all these costs added, health care costs in Great Britain are more accurately estimated at between 7% and 8% of GNP.

Role of Private and Public Sectors in Financing and Delivery

The U.K. system is a mixed system of providers in the case of consultant specialists. If employed full time by the NHS, they receive salaries, may earn up to 10% of their base salary in private practice, and are eligible for bonuses, which for senior specialists is said to equal or even exceed their base salary. Only 48% of all specialists in the NHS are so employed.

Alternatively, specialists may contract with the NHS. Under this arrangement, the specialist gives up one-eleventh of his base salary and must provide an agreed number of sessions per week, after which he is allowed unlimited private practice. In December 1987, 52% of all consultants employed by the NHS were on contract. In addition, from time to time, the NHS has temporarily contracted both beds and services directly with private hospitals and doctors who serve exclusively in the private medical sector.

Cost Containment and Quality Maintenance

Even in the public system, there is little utilization review and no organized approach to quality assurance. Some district health authorities have initiated utilization review programs in health service delivery units under their control. The U.K. now plans to carry out utilization review more broadly in the NHS and to privatize significantly the financing of health services, particularly in leading hospitals.

Regulation and Control

Traditionally a nationalized health service, the NHS has been heavily regulated and controlled. But over the years there has been a steady trend towards devolution and decentralization from central to lower administrative levels. Area and district health authorities have been granted considerable autonomy. An extensive public debate is going on around the issue of apparent underfunding of health service delivery. Britain has introduced more rational cost allocation formulas into the NHS system and has appointed general managers at the district health authority level to make the system more efficient and hold down costs. Recently, the government has come up with far-reaching proposals for significantly privatizing the NHS.

Intersectoral Relationships

As in most health systems, intersectoral coordination seems to be lacking. The permanent secretaries of the various ministries meet as needed, but there appears to be no formal arrangement for coordination and planning.

SINGAPORE

Benefit Entitlement

Singapore's system is unique and does not lend itself easily to the categories chosen for comparison. All services, including tertiary care, are available; the only constraint is ability to pay. Payment is simplified with the Medisave program, which was adopted in 1983.

Contrary to widespread reports, the program is not an NHI program. Wage and salary earners and the self-employed contribute part of their earnings to the Medisave program, but their contributions are held in individual accounts. An account can be drawn from to finance health care benefits only for the member and his immediate family. There is therefore no broad pooling of risk among Medisave members and the program is best characterized as a mandatory pre-savings program which finances health service consumption in behalf of individual contributors and their immediate families.

Revenue Bases and Methods of Payment and Collection

The revenue base for the Medisave program is wages and salaries, and taxable income tax in the case of the self-employed. Contributions are collected from wage and salary earners through their employers, and from the self-employed through the income tax authorities. Collection rates are said to be 98% to 100%. Recently, the Medisave tax rate on the income of wage and salary workers was set at 8%. In addition, there is a 14% pension contribution collected by the Employee Provident Fund, which also administers Medisave.

Role of Private and Public Sectors in Financing and Delivery

Singapore's health service delivery system is dominantly a public system, about 60% public and 40% private, but is obviously in a state of major transition. Recently, the government let a contract to privatize the General Hospital of Singapore, which has just been partially completed. The financing base of both public and private medical systems has largely been privatized through the Medisave program.

Cost Containment and Quality Maintenance

Very little cost containment is built into the system. In fact, an adverse incentive exists in the public sector. Doctors are allowed to collect a service or procedure fee for treating public patients, thus encouraging "overdoctoring."

Regulation and Control

The Singapore public and private systems are well controlled. Hospitals and clinics are strictly licensed and certified.

Intersectoral Relationships

Intersectoral coordination is quickly accomplished. The government is very cohesive and the country is small, so communication is easy and effective.

UNITED STATES OF AMERICA

Benefit Entitlement

The country's strong commitment to free enterprise in the health area is well known. Most health services are delivered and financed through the private sector. The Constitution vests states with the right to administer health and welfare programs. It was only in the mid-'60s that the federal government found a constitutional means to establish major national health financing programs. These are called Medicare and Medicaid. The discussion will center on these two programs, although they cover only about 30% of the population.

Originally established to finance the delivery of health services to those 65 years old and over, Medicare now also includes the totally disabled and finances such special services as renal dialysis, regardless of age of beneficiary. The Medicaid program is jointly sponsored by the federal and state governments. The states receive matching federal funds for health services to the "poor," or medically indigent, as defined by each state. States can provide more than the minimum benefits, which are uniform for all states, but they must absorb part of the additional costs.

Since Medicaid is limited to the medically indigent and is financed mainly from general revenue funds at federal and state levels, it does not pool risk independently of government. It is more of a welfare than an NHI program, redistributing income in the form of health benefits to the poorer members of society. Neither benefits nor coverage are uniform among the states.

Revenue Bases and Methods of Payment and Collection

As stated above, Medicaid covers only the medically indigent and is financed mainly from general revenue funds at federal and state levels. Medicare is financed from

the income-based contributions of wage earners and the self-employed. The assessment makes up around two percentage points of the roughly 8% social security tax levied on the first $51,000 of taxable income. The amount subject to assessment was revised upward in recent budget negotiations, but the final level still has to be determined.

The remaining assessment is set aside in trust funds to pay for old age and survivor benefits (pension and disability benefits). The health portion of social security taxes is also placed in separate trust funds from which health disbursements are made. These contributions, plus copayments and deductibles, are set high enough to yield revenues that can cover disbursements. Since the funds collected by the Medicare program are held in special trust fund accounts, there is risk pooling.

While the program has gone through financial difficulties, the federal government has never had to pay for Medicare benefits out of the general revenue fund. Medicare may therefore be regarded as a limited nationally sponsored health insurance scheme which, however, applies only to the aged (at least 65 years of age) and the permanently disabled.

Role of Private and Public Sectors in Financing and Delivery

Health services are delivered mostly by private providers who operate almost entirely for profit, or at least for surpluses over all costs. The vast majority of doctors lack concern for national health policy goals or issues. About 85% of the U.S.A.'s more than 6,000 acute general hospitals are community hospitals and are thus not profit-seeking. But it is well known that these institutions often manage to collect sizable revenues in excess of costs, and that doctors control or direct at least 70% of their health resource expenditure.

Health financing is done mainly by private health insurance companies which, while not expressly operating for profit, have also managed to amass substantial revenues in excess of costs. The profit motive caused medical prices and costs in the U.S.A. to soar before the introduction of Medicare in 1965 and Medicaid in 1966. This pattern was firmly set long before the federal government got into the massive funding of the routine costs of health service delivery.

Cost Containment and Quality Maintenance

Since the mid-'70s, the federal government has taken significant steps to establish quality assurance and utilization review programs in connection with Medicare and Medicaid. Until recently, however, any influence those programs could have had in containing health costs has been offset by uncommonly generous benefit packages, Congressionally mandated expansion of the program to include more people than originally intended, dramatic increases in the development and use—often unwarranted and wasteful—of new medical technologies, and rapid growth in the age structure of the population. Since the states had direct authority over matters of health, their cooperation was needed to make federal cost containment programs work. But given the vested interests of the states and the fact that they themselves had to rely for technical direction and administration on private providers with vested interests that ran counter to the programs' goals, the programs failed to contain medical costs and prices. Greater progress was made in improving the quality of services delivered simply because, unlike cost containment, quality appealed strongly to doctors' professionalism.

Regulation and Control

States hold the right to regulate and control health service delivery. But the federal government has increasingly encroached on this right by encouraging more responsible and efficient medical practice by providers, through conditions placed on direct financial reimbursements to them. Health care expenditures in the U.S. have hovered around 10% to 11% of GNP during the last several years and are predicted to go even higher. But with Diagnostic Related Group (DRG) reimbursement of hospital in-patient services and the rapid growth of HMOs, preferred provider organizations (PPOs), and other managed-care forms of health service delivery, the rate of inflation of hospital in-patient costs has begun to decline, from an annual rate of increase of 12% in 1984, when DRGs were first introduced, to 6% in 1988, after DRGs were phased in. On the other hand, the cost of out-patient services has gone up rapidly since that time. To contain costs, there are plans to apply the DRG approach to the reimbursement of out-patient services.

Intersectoral Relationships

Virtually no intersectoral coordination exists in the U.S. because there are almost no federal health services. As stated earlier, the states have Constitutional authority over health matters and the federal government is confined to funding research, special programs like Medicare, and programs administered jointly by the federal and state governments like Medicaid. The largest federal health service delivery systems are those of the Department of Defense and the Veterans Administration. These systems are administered separately from that of the Department of Health and Human Services. All attempts at comprehensive health policy formulation and coordination have been resisted by both politicians and professionals, as well as by state governments and federal administrative agencies like the Department of Defense and the Veterans Administration.

AUSTRALIA

Benefit Entitlement

Medibank antedated Australia's present NHI program, but it existed for only a few months before its principal sponsor, the Labor Party, fell from power. Medibank itself did not fail. Moreover, largely because of its basic acceptability to most of the people, it managed to survive the whittling of the Conservative government and was later refined and developed into the present NHI program, Medicare.

Medicare began in February 1984 as a

universal NHI program designed to provide access to health care services to several million people with little or no financial means. To help finance the added costs, a marginal tax of 1.25% was added to the existing income tax schedule, which was already sharply progressive. Medicare is a program of universal entitlement and covers all citizens of Australia, residents with visas allowing stays of over six months, and residents or visitors from countries with which Australia has reciprocal agreements, including New Zealand, Britain, Malta, and Italy.

Revenue Bases and Methods of Payment and Collection

The provision of medical services is a Constitutional right of the states and not of the federal government or Commonwealth, which merely provides policy guidance and financing. The federal government reimburses the state-run public hospitals and the private hospitals and extends to them direct grants from general revenue funds under other programs. Disbursements of funds from the federal level to states are always negotiated. For example, reimbursement rates for Medicare patients are specified in agreements with the state health authorities. Thus, for all practical purposes, under Medicare the federal government is a purchaser of medical services from state-level providers, with the exception of two municipal hospitals run by the federal government in the federal territory of Canberra.

Role of Private and Public Sectors in Financing and Delivery

All monies spent at the federal level in connection with Medicare are allocated from the general revenue fund. The Medicare levy of 1.25% is therefore a marginal increment to the income tax but is in no way dedicated to the provision of Medicare benefits. Medicare expenditures and costs have no actuarial basis. Following negotiations with providers, funds are transferred from the federal general revenue fund. There is thus no way that one can say that the program is insolvent, ever has been, or ever will be. In the absence of a strict division between the federal government as a financier and state governments as providers, the program would be a national health service like the NHS in the U.K.

In Australia's mixed system of health service delivery, doctors receiving salaries from public systems can admit and attend to private patients who choose to be treated as private patients. Public hospital beds outnumber private beds, which make up about 40% of all beds. Patients who choose to be Medicare patients can be admitted to public hospitals and receive for free all accommodation and ancillary medical services, drugs, etc., but have no choice of doctor. Patients can elect to be treated as private patients in either public or private hospitals. In private hospitals patients must pay out of their own pockets or from insurance for accommodation, drugs, and ancillary services.

In either case, Medicare pays only 75% of the basic cost of medical services, which is a uniform tariff for all hospitals, public or private. Private and public patients, regardless of type of institution, are required to pay the balance of 25%.

Private insurance companies cannot insure the costs of out-patient services for more than the 25% balance. Basic medical service fees charged by doctors beyond what is stated in the published tariff must be paid by the patients themselves and not from private health insurance.

These restrictions on what private health insurance can pay for have been established to contain costs. They keep the medical profession from using private health insurance to raise medical fees. But private health insurance can be used to pay the costs of room and board, ancillary services, prosthetic devices, drugs, etc., in hospitals, if patients elect to be admitted as private patients. About 50% of the population is covered by private health insurance.

A separate pharmaceutical scheme was started in the '50s, before both Medibank and Medicare. This scheme provides financial assistance to various categories of low-income persons, including the unemployed, pensioners, the disabled, and those on welfare, to help cover the costs of drugs. In 1989, the scheme required a copayment of A$11 per item from nondisadvantaged general users, but after spending A$275 in any given year a family received all drugs for free.

Cost Containment and Quality Maintenance

Cost containment and quality assurance are just being introduced in Australia. The Health Insurance Commission, which processes about 130 million claims each year, estimates claims processing costs at only 6% of the total volume of funds disbursed and reports a turnaround time of about one week. Claims are often settled in cash over the counter. Clearly, no utilization review or even effective checking for fraud can be done in such a short time and for so little money.

With the assistance of U.S. experts, a pilot project is being carried out with university medical centers to determine how utilization review can best be developed and carried out in Australia. Certificate-of-need legislation has been on the books for years and has been vigorously enforced. The Commonwealth ordered the introduction in 1990 of DRG hospital reimbursement.

Regulation and Control

While the states have authority over the direct delivery of services, most state health departments have devolved their authority in recent years to autonomous local boards, which administer hospitals and primary health service delivery according to general guidelines set by the state health departments. The general manager of the state health department in each state can veto the appointment of the chairman of the local board and in some states has the power of direct appointment.

Intersectoral Relationships

There is little formal intersectoral coordination between departments within a state and between states. There is even less coordination or communication between counterpart organizations at the state and Commonwealth levels. Each state has a

health minister. State health ministers meet only once a year. However, a great deal of informal communication occurs between staff members of health departments.

REPUBLIC OF SOUTH KOREA

Benefit Entitlement

Korea's NHI program consists of three major programs which were launched one after the other and in phased fashion beginning in 1977. When the Medical Service Insurance Program (Class 1) was launched in 1977, it covered only workers of private companies employing at least 500, as well as their dependents, for a total coverage of only 8.6% of the population in that year. This program was gradually liberalized over a period of years until, around 12 years later, it included workers of companies employing at least five, plus their dependents.

A companion program (Class 2), launched in 1979, covered only private teachers and civil servants but was also gradually expanded over the next few years. Together, the two programs covered roughly 50% of the population in 1984. In 1988, insurance (Class 3) was extended to the rural areas, and by 1989 about 75% to 80% of the total population was receiving benefits. Korea planned to reach 100% coverage of the population by the end of 1989-90, which meant covering as well the self-employed in urban areas.

The benefits under the programs include in-patient hospitalization and out-patient medical treatment, drugs, and ancillary services. The benefits are, however, limited and many exclusions apply. People can borrow to pay for excluded services, at repayment terms which are worked out individually.

Workers get more benefits than their dependents, and benefit and contribution rates differ among the three programs and among the more than 300 separate societies that administer the programs at the city, village, and township levels. This arrangement provides maximum contact with the people, and is believed to result in a higher collection rate than would be the case if the program were completely centralized.

Earlier attempts to operate the programs at the regional level were unsatisfactory and were thus abandoned in favor of the local society approach. The major problem facing the programs is that of attaining uniform benefit and contribution rates for all programs and societies. Expanding the programs to cover the entire population requires administering over 300 societies.

Revenue Bases and Methods of Payment and Collection

Premium rates are set as a percentage of income and range from 3% to 8% of taxable income, depending on the program and the administering society. The levy is shared equally by workers and employers in the case of wage and salary earners. Rural farmers and other self-employed are assessed roughly 7% of notional income, which is estimated with the use of defined formulas. All contributions are held in special accounts with commercial banks throughout the country. Administrative costs initially averaged about 13% of total collections and have declined only modestly. User fees have constantly been increased to curb excess utilization.

Role of Private and Public Sectors in Financing and Delivery

About 90% of medical services are supplied by private providers. The level of services in rural areas is distinctly lower than in urban areas, but this difference has diminished considerably over time, particularly with the passage in the late '70s of legislation requiring doctors to serve out their compulsory military obligation in rural health centers. Private doctors and hospitals are paid according to a fee and charge tariff drawn up by the Ministry of Health and Social Affairs after consulting with professional organizations. Providers are supposed to accept such fees and charges as payment in full. Breadwinners pay 20% to 25% copayments for hospital admissions; their dependents pay higher copayment rates when hospitalized. Copayments for out-patient services also average close to 25% for workers and dependents.

Cost Containment and Quality Maintenance

Both cost containment and quality of services delivered under the programs have met with considerable problems. Doctors have been accused of effectively raising fees by billing falsely for procedures not rendered or for rendering unnecessary services which yielded more profit than medically indicated services. In other cases, patients have accused doctors and hospitals of giving them lower-grade accommodations and medical treatment than those received by patients who paid their own way or had private health insurance coverage.

The programs have upgraded their hardware and software capabilities and strengthened their claims and utilization review programs. A provider may have to wait for about one month to be paid, but fraud and overutilization of services have also noticeably decreased, and quality of care is believed to have improved.

Regulation and Control

The Korean programs are reasonably well administered and controlled. Without certificate-of-need legislation, rural infrastructure has progressed swiftly, keeping pace with the rapid development of the country over the last two decades. Decentralization and local autonomy have contributed to more responsible and effective planning and coordination of health resources.

Intersectoral Relationships

In 1976, Korea established a National Health Council with the deputy prime minister as chairman and the minister of health and social affairs, ministers of related ministries, and representatives of private professional societies and organizations as members. The council seldom met for various reasons and has been dissolved.

Health matters still lack formal and

systematic coordination. As in most countries, matters requiring cooperation are worked out through informal consultations as needed. This arrangement is not always satisfactory.

THE NETHERLANDS

Benefit Entitlement

The Dutch system of health care financing and insurance is one of the most complicated but also one of the most comprehensive in the world. Socially mandated insurance covers an estimated 62% of the Dutch population, with the rest (about 36%) being covered by strictly private health insurance. Over the centuries, as in many other countries in northern Europe, a system of sickness funds evolved from the efforts of individual doctors, concerned employers, guilds, religious sects, and private voluntary agencies, resulting in hundreds of small funds financing the provision of curative services on a cross-subsidy contribution basis. This tradition has persisted, although the funds were substantially consolidated during World War II, largely on account of the German occupation.

Around 115 private insurance firms now serve as financing agencies for all the curative health services in the nation. A special supplementary act, the Extraordinary Medical Services Act, provides for virtually unlimited stay in hospitals and long-term care facilities, when medically indicated.

Revenue Bases and Methods of Payment and Collection

Income is the revenue base and the income tax authorities are principally responsible for determining the level of income. Collections are made annually from the self-employed, of which there are few in the Netherlands. Low- to medium-income workers who qualify for sickness fund coverage pay premiums assessed on their wages and salaries by their employers, who pass on the premiums to the sickness fund carriers.

Role of Private and Public Sectors in Financing and Delivery

Sickness fund health insurance is compulsory for low- to medium-income workers. In December 1988, there were 45 private insurance companies which were designated sickness fund carriers. Their rather even regional distribution provides each with a monopoly market share of the sickness fund business. In return for the explicit monopoly, these firms may not offer any other kind of insurance.

Premiums are paid by the federal government for the unemployed, the disabled, or those with extremely low income. Workers, wage and salary earners, and the self-employed pay the sickness fund carriers roughly 8% of their income up to a maximum level of income of 52,000 guilder a year, for coverage for themselves and their families.

A person whose earnings exceed that figure (which is adjusted periodically) is no longer eligible for sickness fund coverage and is forced to either forego health insurance or seek coverage from a strictly private insurance company. The latter must offer him the same coverage as the sickness fund policy he held earlier, at an only slightly higher price. In practice, however, people generally choose a different product which is more suited to their own needs and their families', for example, a policy with a lower premium but with a higher deductible.

Around 92% of all the medical services in the Netherlands are rendered by private providers.

Cost Containment and Quality Maintenance

Much effort is being made to contain medical care costs. Certificate-of-need legislation has been on the books in some form for years and is strictly enforced, even to the extent of regulating the facilities that a hospital can provide. Hospital construction plans have to be approved by local and national health authorities. While doctors can recommend hospitalization, the hospital admission office determines whether or not to admit a patient. True emergency cases are admitted without delay, but emergency cases are investigated individually and doctors who refer nonemergency cases for immediate admission merit severe sanctions.

Global budgeting allocates funds prospectively to hospitals, taking into account projected admissions, out-patient visits, special services, and staffing configurations. However, the average length of stay for ordinary acute hospital admissions is 11 days, which is high by international standards. Hospital authorities concede that this duration can be cut substantially.

Regulation and Control

Lacking a comprehensive NHI program, the country looks forward to one but has been held back by a recent concern with rising medical costs. Health costs shot up dramatically to nearly 9% of GNP in 1983, triggering the passage of greatly strengthened certificate-of-need and other major health legislation governing the private and comparatively small public medical sector.

The whole health service delivery system is highly regulated. Aside from the new certificate-of-need legislation, there are laws regulating the prices of medical equipment, drugs, and prosthetic devices, professional fees and charges, and health insurance premiums. These laws are administered by the minister of health and welfare with the advice of the Central Health Tariff Organization (COTG), a professional advisory body of economists.

Even the maximum number of professional procedures that a specialist can perform in a year is regulated. This, coupled with regulation of professional fees, implies that professional incomes are regulated as well. It is not uncommon for a specialist to go on leave for the remainder of the year after performing the number of procedures allowed.

The country is becoming increasingly

interested in managed-care approaches to health service delivery and in a comprehensive NHI program which would encourage greater competition among private health insurance firms—and presumably bring down medical fees.

Intersectoral Relationships

The Dutch system is a consensus system. There are many professional bodies and advisory committees formally appointed by the minister of health and welfare which meet regularly. These agencies are adequately funded and include chambers of representatives from all the professional and government agencies concerned. The National Council of Public Health reports directly to the minister. Matters requiring coordination between or among ministries are raised during Cabinet meetings.

MALAYSIA

Benefit Entitlement

Malaysia's health service delivery system is primarily a public system. But while more than 80% of all hospital beds are public, more than half of the doctors are in the rapidly growing private sector. The Ministry of Health is by far the dominant provider of services, providing much more than 50% of the medical services received by the population. In principle, all citizens are entitled to all the services available throughout the system at rather nominal user fees. The public is believed to prefer private medical services, when available, mainly in the larger urban areas, because of better facilities, better appearance, and quicker service.

Revenue Bases and Methods of Payment and Collection

Since most medical services are provided by the public national health service, most medical expenditures (roughly 75%) are financed through the general revenue fund. Apart from the 10% of the population who have some form of private health insurance, private patients pay out of their own pockets or with employers' contributions.

The government is studying a proposal to establish an NHI program where there is more equal sharing of medical costs by the government and consumers. Consumers would contribute a percentage of their income based on ability to pay. Those who can afford to pay would be charged a modest user fee at the point of service to curb excess utilization.

Role of Private and Public Sectors in Financing and Delivery

Malaysia has been experimenting with component privatization of hospital support services in several district hospitals. In Sarawak state, one hospital has successfully contracted out all services except for medical services. The possible corporatization of the planned Thoracic Care Center at the General Hospital in Kuala Lumpur is under study. Two other district hospitals were offered for lease to the private medical sector (after preliminary discussions the offers were withdrawn).

Because the public system is generally acknowledged to be extremely efficient, some wonder about the wisdom of going too far in privatizing a system that already runs very well. Emphasis is being placed on finding ways to increase the private sector's role in the financing of health service delivery beyond the payment of ordinary taxes.

Cost Containment and Quality Maintenance

Malaysia spends slightly over 3% of its GNP on health. This figure has not changed appreciably in the last five years, partly on account of the dominance of the public health service delivery system. The system is run by civil servants whose salaries have been held down by economic austerity measures. Moreover, the majority of the physicians who left the public system in recent years were fairly senior ones who have since been replaced by new medical graduates.

The possible deterioration of the quality of care in the public sector is a matter of concern. But in the private sector, quality has clearly increased. Several years ago, Malaysia introduced a very credible program of quality assurance in the public system at national, state, district, and individual health facility levels. Costs have been contained largely by limiting budget allocations to the public sector. This situation cannot be expected to continue long into the future. A variety of proposals for cost containment are therefore being studied with a view to the possible introduction of an NHI program.

Regulation and Control

The public system enjoys a great deal of discipline without undue regulation, although this is disputed by many who would like less control over what they do. The private medical system is only loosely regulated. For example, general practitioners often perform surgical procedures for which they have had little training. On the other hand, specialists also often do the work of GPs. Hospitals in the private sector are licensed on the basis of very limited data and information, and are seldom visited by members of the licensing authority. Private-sector doctors move their practice to another place without informing the licensing authority, and have been known to operate two or more clinics in different locations, with the assistance of less well-trained medical personnel who often work with minimal supervision.

Intersectoral Relationships

The importance of intersectoral relationships is recognized in Malaysia, where many government ministries other than the Ministry of Health are direct providers of services, as is the case in most countries. A study on the feasibility of establishing a National Health Council to coordinate health service delivery is being carried out with the assistance of the World Health Organization (WHO). For the first time, the government is contemplating the involvement of the private medical sector in the development of the next five-year development plan.

CONCLUDING REMARKS

The comparisons made among the financing schemes of the countries reviewed in this section of this paper are summarized in the annex. Truly all countries are unique and their health financing systems reflect their history, culture, traditions, and the needs of modern society.

The Philippines is unique in many ways. Often it is dangerous to draw conclusions from the experience of other countries. Things that work well in those countries may not work well in the Philippines. On the other hand, things that do not appear to work well in other countries may work very well in the Philippines, if modified properly.

From the foregoing brief review, it would appear that the Philippines is under-investing in health services and may be in danger of failing to provide sufficient health services to maintain its work force at the required level of efficiency and skill. Hence, the effort to place curative health care services on a more solid financial basis is both timely and wise. The WHO target of spending 5% of GNP on health is not unreasonable, yet the Philippines now spends less than 2% or 3%.

Nations that underwent rapid and unwarranted increases in medical care prices and costs gave inadequate consideration to keeping tight control over health benefit entitlement, growth in medical technology, and unnecessary duplication of medical facilities and equipment. Likewise, in adopting or expanding health financing programs to cover more segments of the population, they failed to establish utilization review and other cost containment measures at an early stage.

This review of the experience of other countries gives an idea of the difficulties that are inherent in establishing a health financing program in different settings. Some of the mistakes made can be avoided by other countries, including the Philippines.

The remaining sections of this paper present information gained from the research of several individuals and cover virtually all aspects of the experience of Medicare in the Philippines over the last two decades.

THE PHILIPPINE MEDICARE EXPERIENCE: AN OVERVIEW

INTRODUCTION

This part gives an overview of Medicare Program I from its start, particularly the years between 1980 and 1991. The data and information presented deal with revenue mobilization, allocation of benefit payments among broad categories of medical services, the financial burden on contributors (classified by income quartile), cross-subsidy, membership coverage, and the role of private insurance companies in the financing of medical services. The major findings are highlighted at the end of the report.

REVENUE MOBILIZATION

The Philippine health care sector has traditionally been financed mainly through taxes and family spending. In recent years, however, other financing mechanisms, especially prepayment and insurance schemes, have steadily increased their share in health expenditures. Among the insurance schemes, compulsory insurance, or Medicare, is the most established, considering it has been in operation since 1972.

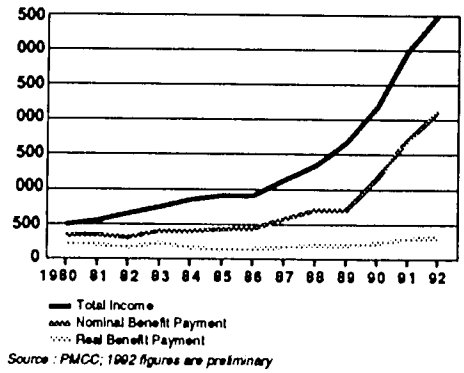
Figure 1 charts the growth of the total income and benefit payments of Medicare. Benefit payments represent actual expenditures on health services. The graph shows that, in the '80s, benefit payments grew moderately in nominal terms, but in real terms the average growth rate was actually only -1.7%.

The '90s look more auspicious. Medicare expenditures on health services grew at an average of 42.72% in nominal terms between 1989 and 1991, for an annual increase of 23.26% in real terms. Concerned over the declining support value of Medicare, PMCC raised benefit ceilings substantially starting 1989.

Total income is the sum of collection, investment, and other income. Its growth pattern is similar to that of benefit payments. The gap between total income and benefit payments indicates that Medicare can potentially spend more on benefits. SSS outperforms GSIS on all financial tests but has been criticized for its apparent overemphasis on accumulating reserves, at the cost of benefit payments to its members.

According to Table 1, the public sector (financed mainly through taxes) and family spending make up the bulk of health care expenditures. Insurance schemes have

Fig.1 **Total Income and Benefits Payments**



Source : PMCC; 1992 figures are preliminary

plenty of room for growth. In fact, the tremendous increase in Medicare benefit payments discussed above meant an increase of three percentage points in the share of Medicare in total health care expenditures from 1988 to 1991.

ALLOCATION AMONG CATEGORIES OF HEALTH SERVICES

The pattern of Medicare expenditures on various hospitalization items is the same for GSIS and SSS, as shown in Table 2. As expected, drugs and medicines and payments for the services of physicians and

Table 1. **Estimated Health Care Expenditures: 1985, 1988, and 1991 (In Current Prices)**

	1985		1988		1991	
Source	Bill (Pesos)	% of Total	Bill (Pesos)	% of Total	Bill (Pesos)	% of Total
Public	3.78	38.4	6.87	50.4	7.42	36.3
Private	6.05	61.6	6.77	49.6	12.67	63.7
Family	5.36	54.5	5.82	42.7	10.94	53.6
Private Ins.	.15	1.5	.24	1.7	.33	1.6
Compulsory Ins.	.55	5.6	.71	5.2	1.73	8.5
TOTAL	9.83	100.0	13.65	100%	20.09	100.0
Present GNP		1.64		1.66		1.63

Sources: Solon et al. 1992 for 1985 and 1988, Herrin 1992 for 1991 (preliminary figures for 1991)

Table 2. **Total Expenditures by Item of Hospitalization**

	GSIS (Aug '91 - Jul '92)		SSS (Mar - Aug '92)		
	PESOS	%	PESOS	%	RANK
Room and Board	83,067,049	18.42	36,125,782	17.88	3
Diagnostic Tests	56,846,946	12.60	32,963,557	16.31	4
Drugs and Medicines	146,744,442	32.54	63,204,485	31.28	1
Physician's/Surgeon's Fees	112,812,544	25.01	40,983,454	20.28	2
Anesthesiologist's Fees	22,033,700	4.89	9,493,589	4.70	6
Operating Room Fees/Others	29,525,158	6.55	19,300,135	9.55	5
TOTAL	451,029,839		202,071,002		

Source: GSIS and SSS claims files

surgeons take up the largest portion of total expenditures. Room and board and diagnostic tests require the next largest outlays, while anesthesiologists' fees, operating room fees, and other charges account for less than 10% of the total.

FINANCIAL BURDEN

GSIS AND SSS

Assuming that the employee bears the full financial burden of the Medicare contribution, the percentage share of contributions in employee income in 1982 and 1991-92 are estimated for different income groups in Table 3 using GSIS data. The 1982 data are based on a sample of 5,000 members, while the 1991-92 data are population statistics.

The Medicare tax is expectedly regressive. Lower-income groups with average monthly incomes below the ceiling contribute about 2.5% of total income. Above the ceiling, the tax is fixed so that the tax rate falls as income increases.

Data from SSS show a different picture. The values presented in Table 4 are based on a sample of 872 members. On the whole, SSS members contribute a smaller percentage of their income to Medicare than GSIS members, possibly because of irregular remittance of contributions by private employers. The Medicare contributions of income group 2 (Table 4) have a smaller percentage share in salaries than the contributions of the other two income groups because the members (or their employers) are less conscientious in paying the contributions. At present, an SSS member may file for Medicare benefits if he has paid at least three months' contributions during the year immediately preceding.

Table 3. **Financial Burden of Medicare Contributions, GSIS, Philippines, 1982 and 1991-92**

	Quartiles			
	I	II	III	IV
1982				
Ave. Annual Salary (Pesos)	3,754	6,136	8,314	17,202
Annual Contrib. as % of Annual Salary	**2.5**	**2.6**	**2.2**	**.01**
1991				
Total Annual Income (Million Pesos)	8,617.3	8,217.2	2,887.8	3,458.5
Ave. Annual Income (Pesos)	10,745	33,996	58,160	110,883
Total Annual Cont. (Million Pesos)	217.7	92.0	18.6	11.5
Contrib. as % of Income	**2.53**	**1.12**	**0.65**	**0.33**

Sources: Griffin et al. 1985 for 1982 and Beringuela 1993 for 1991

Table 4. **Financial Burden of Medicare Contributions, SSS, National Capital Region, 1992**

	Income Groups		
	I	II	III
Total Income (Mar - Aug '92) (Pesos)	763,613	9,086,414	9,433,870
Total Contributions (Pesos)	5,742	52,668	68,248
Total Contributions as % of Total Salary	0.75	0.58	0.72

Source: Beringuela 1993

EFFECTS OF MEDICARE CONTRIBUTIONS

Although the tax is imposed on employers and employees, economic theory shows that other economic sectors may also bear part of the financial burden of the payroll tax (the generic term for the Medicare tax).

Two sectors in particular can be affected. First are the consumers, through an increase in the prices of goods. To keep their profits at pretax levels, employers raise the prices of goods to offset the increase in labor costs. Secondly, labor in general can absorb the tax through lower wages.

The DOH-PIDS project used one of the latest and largest Computable General Equilibrium (CGE) models for the Philippines in analyzing the distribution of the burden of the Medicare tax. The effects of the tax on households are summarized in Table 5. The tax is consistently regressive through all households. Since the prices of almost all goods from the production sectors decreased after the tax, the tax is apparently not passed on to consumers. However, the market wage of unskilled workers went down, indicating that such workers bear part of the financial burden of the tax although most of them belong to the agricultural and informal service sectors, which have no access to Medicare benefits.

CONTRIBUTIONS VS. BENEFIT PAYMENTS

Table 6 indicates the cross-subsidies occurring among GSIS members and among SSS members in different income, age, and gender groups. In both systems, the lowest-income groups have a higher share in benefits than in contributions. They contribute less because they have low incomes and so are recipients of subsidy.

For both systems, the second poorest group is the primary source of subsidy. This group already pays the maximum monthly contribution of ₱62.50. The two highest-income groups under GSIS fail to provide subsidy, since they also account for a higher average value of claims. "Expensive" diseases are highly prevalent in these groups. Besides, the wealthier government employees generally opt for tertiary-level private facilities.

Since the highest monthly salary credit (the only indicator of income available from SSS files) is ₱5,000, only three income groups could be set up for SSS. The highest-income groups receive subsidy because most claims come from this group. Efforts should be made to explain the very low number of claims from the two lower-income groups. The results for both systems indicate the importance of having a progressive contribution structure to ensure that the subsidy comes from the higher-income groups.

The pattern of cross-subsidy between age groups is similar for both systems. Morbidity rates increase with age. The younger members are therefore expected to subsidize the older members, especially in the absence of a positive correlation between incomes and age, as is true of GSIS. This is also true of SSS, although the difference in income between age groups is very small.

Naturally, retirees benefit from the system since they no longer pay contributions. GSIS retirees account for less than 10% of total Medicare expenditures; SSS retirees, for only 1.2% of all claims from March to August 1992.

The youngest group, not surprisingly, is a source of subsidy. But for both systems, the 26-45 group receives subsidy, while the 45-65 group contributes more than its share in benefits. For GSIS, the explanation lies in the lower average income of the 26-45 group which, for both systems, files frequent claims for dependents. Most couples get married and have children in this age group, and morbidity rates are quite high among very young children.

Table 5. **Financial Burden of the Medicare Tax, Philippines, 1989**

	Income in Billion Pesos		
	Before Tax	After Tax	% Change
Household 1	53.31	53.23	-.166
Household 2	85.41	85.27	-.157
Household 3	119.02	118.85	-.148
Household 4	174.30	174.07	-.133
Household 5	337.25	336.82	-.129

Source: Beringuela 1993

Table 6. **Share in Contributions and Benefits by Income, Age, and Sex Groups**

	GSIS: % Share in Contributions	GSIS: % Share in Benefits	SSS: % Share in Contributions	SSS: % Share in Benefits
Income Groups				
< 2,000/mo.	64.05%	72.48%	4.53%	8.50%
2,000-4,000/mo.	27.07%	19.74%	41.58%	32.20%
4,000-6,000/mo.	5.49%	4.58%	53.88%	59.76%
6,000 above	3.40%	3.20%	N.A.	N.A.
Ages				
< 26	2.43%	0.83%	12.23%	7.68%
26-45	63.35%	64.64%	66.45%	75.00%
46-65	34.20%	25.73%	21.31%	15.91%
above 65	0.00%	8.78%	0.00%	1.41%
Sex				
Male	49.49%	51.48%	65.59%	49.70%
Female	50.81%	48.52%	34.41%	50.30%

Source: Beringuela 1993

This table may be indicative, rather than conclusive, of what is happening. For GSIS, data was based on files of individual members which may not all be updated (e.g., incomes may not reflect adjustments made on account of the Salary Standardization Law).

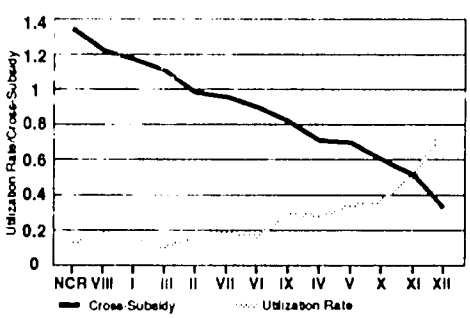
The two systems show dissimilar cross-subsidy patterns only between gender groups. Females generally have higher morbidity rates and are expected to have lower incomes than males; they therefore contribute less to Medicare. In the GSIS group, females apparently have a slightly higher average income than the males but contribute almost the same amount as the males to the Medicare fund. The higher morbidity among females is apparently offset by the higher frequency of dependent claims from the males so that the females end up subsidizing the males, although only for a very small amount.

In the SSS sample, males also have a higher frequency of dependent claims, but females share more in benefits than in contributions because of their lower incomes and the higher number of claims they file in their own behalf.

REGIONAL DISTRIBUTION

As shown in Figure 2, the NCR and Region 8 contribute relatively more than what they get in benefits. NCR resources are properly redistributed to the other regions, but perhaps more benefits should go to Region 8, a poor region. Figure 2 shows that cross-subsidy between regions is determined by utilization rates. A study should be made to explain the huge disparity in utilization rates between regions.

Fig.2 **Cross-Subsidy Across Regions**



Source : Bernguela 1993

COVERAGE

In 1991, Medicare covered 28 million Filipinos, or 44.7% of the population. From its modest beginnings, Medicare coverage peaked at 51% in 1984-86, then dropped dramatically to 42.2% in 1987 with the purging of inactive members from the SSS files. Estimates of Medicare coverage could be higher than actual because of the high dependency ratio used. In 1983, the 3:1 ratio was increased even more, to 4:1, despite a report from the UP Population Institute that dependency rates have been going down through the years (Gonzales 1992).

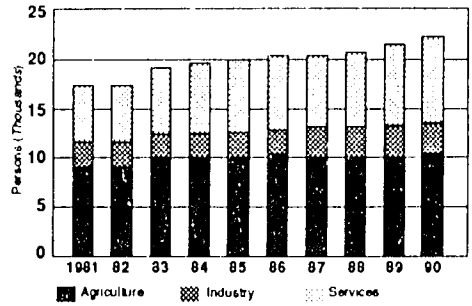
Two other facts support the contention that Medicare coverage is overestimated. In 1990, only 22.5% of all the employed and 40% of the salaried employed were members of either SSS or GSIS. Indeed, Gonzales observed that the membership base has been shrinking. He concluded that "Medicare is increasingly unable to provide a wider safety net to a growing work force" (Gonzales 1992).

For GSIS, collecting contributions from members is not difficult; for SSS, it is a real challenge. The rate of compliance among employers is very low. Most pay the premiums irregularly or do not pay at all, especially for their casual or contractual employees, who are supposed to be covered. Many people believe that enrolment of the self-employed is voluntary. In fact, it is mandatory, but SSS has very limited power of enforcement.

SSS is unable to cover the Program 1 target population on account of Philippine economic stagnation. Economic development entails structural change: the industrial sector grows at the expense of the agricultural sector. Program 1 is geared towards the industrial sector and a minority in the service sector.

Figure 3 clearly shows that the industrial sector remains small, agriculture is still the biggest sector, and in the '80s and '90s increases in the labor force have been absorbed by the services sector, which is the only sector that has been growing consistently during the period. The data do not reflect the large numbers of unemployed and underemployed in the country. Employers are not inclined to provide social security to unskilled workers and contractuals since every job has possibly 10 other workers, currently unemployed, just waiting in line to get it.

Fig.3 **Employed Persons by Sector**



Source : Philippine Statistical Yearbook 1991

THE ROLE OF OTHER FINANCING INSTITUTIONS

Private institutions—the HMOs and indemnity health insurance companies—cover a very select group within the Medicare population. These companies are either indifferent to the program or are benefitted by it. Private indemnity insurers are among the indifferent. They consider health insurance an unprofitable product line, but not because the market is cornered by Medicare. Slow growth in this industry is attributed to such factors as low incomes, soaring health care costs, and inappropriate regulation (Gamboa 1991).

HMOs, on the other hand, seem to have found their niche in the market by offering coverage beyond the Medicare level. Many HMOs are therefore sanguine about growth prospects. Moreover, the Medicare tie-up project was obviously to their advantage so much so that participating HMOs wanted the program to continue and others were still applying to participate in it when the project was stopped.

Generally, private institutions can benefit from Medicare if it demonstrates the benefits of being insured. And if people in general are aware of insurance principles and mechanics, then private companies can spend less on informing their clients. Gamboa reports that many HMOs still complain of the ignorance of the public when it comes to insurance (Gamboa 1991). Finally, Medicare may indirectly affect the regulation of the health insurance industry. HMOs actually look upon the DOH as a

possible regulating agency for the industry on account of its experience in financing (through PMCC) as well as in the delivery of health services. The alternatives, the Insurance Commission and the Securities and Exchange Commission, have expertise only in financing. Furthermore, experience with relative unit values (RUVs) in the current program renders the DOH capable of setting the standard for all institutions to follow (Gamboa 1991).

CONCLUDING REMARKS

Clearly, Medicare has come a long way from its start in 1972. Membership has grown and about 45% of the population are now eligible for Program I benefits. While Medicare finances only about 8.5% of the total health bill, it clearly has had a marked effect in distributing private-sector health resources to encourage the growth of small hospitals outside Metro Manila (Griffin *et al.* 1985).

The bulk of Medicare benefit payments go to drugs and medicines (about 31%) and payments for the services of physicians and surgeons (about 21%), followed by room and board (17%) and diagnostic tests (16%). The rest cover anesthesiologists' fees and operating room and other charges.

As most would expect, Medicare taxes are regressive. Lower-income groups contribute more of their incomes than higher-income earners. This structure will obviously persist for as long as the wage or income ceiling on Medicare contributions remains below the highest incomes earned.

It is worthy of note that SSS has accumulated more reserves than GSIS and that an SSS member who has paid at least three months' contributions during the year immediately preceding the time of filing is entitled to benefits.

Analysis reveals that Medicare contributions do not appear to be shifted forward and incorporated into higher prices for consumer goods and services. Rather the evidence is that Medicare taxes are shifted backward in the form of lower wages and salaries. Surprisingly, the analysis also reveals that Medicare contributions cause a decline in the wages of unskilled workers generally, including agriculture and other informal-sector workers who have no access to Medicare benefits. More research in this area is needed.

Finally, the analysis shows that higher-income recipients of Medicare benefits fare better than those in low income quartiles. The second lowest income quartile appears to be the primary source of this subsidy which arises in large part from the fact that higher-income beneficiaries are treated for relatively more expensive illnesses and use relatively more expensive sites of treatment (such as tertiary hospitals) compared to lower-income beneficiaries.

The analysis thus far has not dealt with the organizational aspects, problems, and difficulties involved in administering a program like Medicare. These matters are dealt with in the next part of this paper.

MEDICARE AS AN INSTITUTION: SUMMARY OF MAJOR ISSUES

INTRODUCTION

The expansion of Medicare has created pressures on the operating viability of the system. This section of the paper looks at the Medicare organization, financial performance, increasing benefit expenses, claims processing procedures and experience, factors influencing apparent access to services, and accreditation and monitoring procedures.

ORGANIZATION

The overall management of Medicare nominally rests with the PMCC; GSIS and SSS act as financial intermediaries. The PMCC is recognized as the focal point of the Medicare program. Under RA 6111, the Medicare Act, the PMCC is mandated to carry out three vital functions: "formulate policies, administer, and implement the Philippine Medical Care Plan, consistent with the National Health Plan." Through a governing board chaired by the secretary of health, the PMCC designs and administers contribution and benefit plans, sets premiums, establishes methods of paying medical care providers, and guarantees quality standards. GSIS and SSS collect premiums, process claims, make payments, and underwrite coverage through a Health Insurance Fund (HIF). The issue of the degree of autonomy in decision making with respect to Medicare financial resources makes the division of responsibilities among PMCC, GSIS, and SSS uneven.

The delegation of the financial management of the HIF to SSS and GSIS has left the PMCC without much muscle to manage it directly. SSS and GSIS have undue leverage over general Medicare policy since they supervise the direction and economic consequences of Medicare fund management. Yet RA 6111 is emphatic that "the deposit, investment, administration, and disbursement of the funds conform with the policies established by the Commission."

In the early stages of the Medicare program, ineffectual PMCC leadership may have allowed the imbalance to occur by letting too much financial power drift into SSS and GSIS. This spinoff of authority—and the subordination of Medicare to the two systems' own program priorities—has resulted in a poorly defined and inconsistent program of benefits and a confusing portrayal of policy to the public and the PMCC personnel.

Planning by the PMCC has been limited to providing inputs to the Medium-Term Development Plan of the NEDA. Planning is to administration as epidemiology is to disease prevention. PMCC's lack of clout within the Medicare system has unfortunate implications. Unable to beef up its technical competence, it escapes the pressures of long-range planning. It is more involved in solving immediate problems. It does no research and development, even if this is one area in which it could very well play a central role since neither GSIS nor SSS has shown much interest in this area.

The PMCC has been basically a regulatory agency. To achieve its ends, it licenses providers, carries out inspections, and makes rules. From the very start, PMCC has had court powers and has held hearings and investigations, in the process toughening its regulatory muscle. An appeals process, and most importantly accreditation, are fundamental regulatory functions. It is precisely from its watchdog function—setting standards and regulations to protect the public from unethical practitioners—that PMCC derives its capability and competence.

A host of administrative shortcomings undermine PMCC capacity. The PMCC organization lacks focus. Consistently underspending its budget by an average of 47.4%, the PMCC has seen its policy-making and administrative capacity sapped by budgetary attrition and low expenditure on program development.

On a more basic level, the Commission cannot build up an independent management information system or actuarial expertise. As an agency that develops health insurance policy, it should have a health care economist/analyst in its staff. Only two PMCC units, the providers service, which has 10 medical doctors, and the hearing and investigation service, which has 10 law graduates, seem to have the appropriate mix and concentration of required skills.

The administrative staff outnumber the technical staff three to one. That ratio is inordinately high, by any standard. Most of PMCC's administrative positions are protected civil service positions, secured at the expense of a certain amount of inflexibility in agency staffing. In the field, where administrative controls are weaker, and as a result of long-standing difficulties in attracting staff away from Manila, the quality of staff is inevitably poor. Low salaries compound the situation; salary standardization, which allows less differentiation, only tends to underreward the most productive and overreward the least productive.

Since its start, the PMCC has not had a particularly strong operational leadership, and the gap between authority (the right to make decisions) and power (the ability to execute them) has increasingly widened.

At the top, the PMCC has a governing board and an executive director. Until the assumption of the Aquino administration in

1986, the PMCC had a full-time board chairman, who could, theoretically, take the lead in policy making and management. Now the board is headed by the secretary of health and consists of several other Cabinet members and the heads of SSS, GSIS, the Philippine Medical Association, and the Philippine Hospitals Association, making the entire board a part-time concern of its members. Yet the board performs a myriad functions, including operational ones: regulating, providing feedback from top government health officials, acting as final hearing panel for complaints, developing and analyzing Medicare-related legislation, and promulgating Medicare regulations.

What is needed is a strong full-time chief operating officer who can manage the operations of the PMCC with least supervision. The executive director ought to be responsible for carrying out PMCC's mission, which is expressed in statutory language and involves three key functions: policy execution, operational initiative, and management of the commission's resources. In practice, the board has rarely allowed authority to devolve casually to the director. The board determines the areas in which the director must act and the boundaries limiting that action. As a result, no director has been able to establish a strong office.

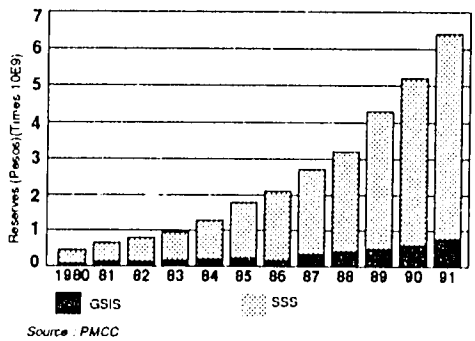
Major decisions are made by four executive committees: hearing and investigation, appealed claims, accreditation, and rules and regulations. The service departments—hearing and investigation, providers service, programs development—only support the committees. Department managers have some control over resources but lack the authority to do more than recommend, and must rely heavily on the committees for final decisions. As if by design, each department has a matching committee (programs development service, for instance, is paired with the rules and regulations committee).

Decision making seems to be turning more complex and costly, and there are frequent complaints of another bureaucratic layer, a new source of directives, and new reports to be prepared. Counterpart arrangements in this case only divert decision making and further erode operating efficiency.

FINANCIAL PERFORMANCE

Figure 4 shows that Medicare reserves have grown steadily, with SSS accounting for a large part. The HIF, Medicare's reserves, has risen steadily, from ₱491 million in 1980 to ₱3 billion in 1991, a respectable record by insurance industry standards. That represents an average yearly increase of 18.4%. Anywhere from two-thirds to three-fourths of the fund is accounted for by SSS. That is partly explained by the larger membership base of SSS, which brings into the system a correspondingly bigger chunk of collection income.

Fig.4 **Reserve Fund, 1980-91**

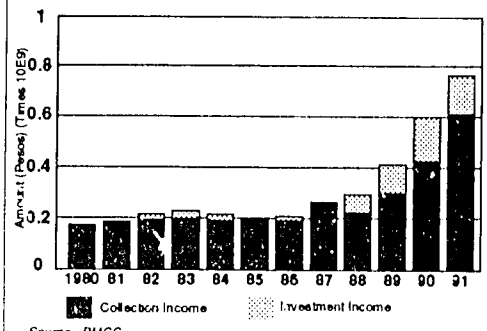


Source : PMCC

The composition of Medicare income over the years has shifted progressively in favor of investment income. In 1980, investment income made up a little less than 10% of Medicare's total income (more than 90% being accounted for by premium collection and other income, such as penalties for delayed remittances). By 1990, 44.6% of Medicare's earnings came from investment interest payments alone.

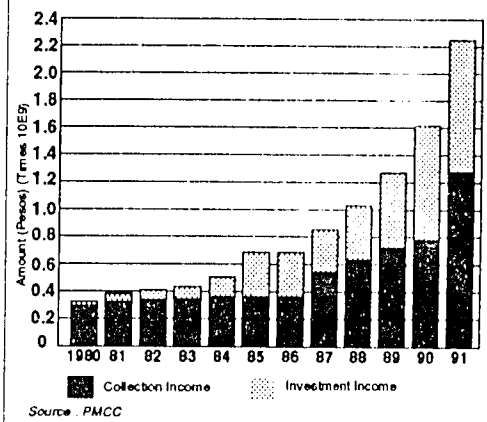
SSS has disproportionately contributed to this shift. In the early '80s, SSS' total income was roughly double that of GSIS; by 1985, it had tripled, and SSS has pulled away since then (Figures 5 and 6). The growth of investment income explains why. Thrice in ten years (in 1985, 1986, and 1990), investments provided more than half of its total income. This suggests that sound fund management decisions were made, at least during those years.

Fig.5 **Collection, Investment, and Other Income GSIS, 1990-91**



Source : PMCC

Fig.6 **Collection, Investment, and Other Income SSS, 1990-91**



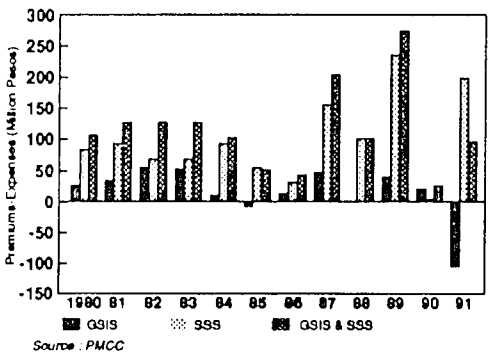
Source : PMCC

The phenomenal growth of investment income suggests an increasing ability by Medicare to cope with inflationary medical care costs by lessening pressures on collection income, which, although expected to rise in nominal terms because of incremental increases in premium payments, may actually decline in real terms. As Medicare becomes less dependent on premium income, its risk-sharing capability can also be expanded.

GSIS' relatively unimpressive investment income performance is a matter of serious concern, however. Before 1988, GSIS barely earned from its investments. In 1990, its interest earnings went up modestly to 24.7% of total income. There were suggestions that GSIS may be paying a high price for unsound investments (locked in unproductive assets) made before 1986. Yet its low earnings from investments may be due as much to GSIS' high level of benefit expenditures, exerting tremendous strain on its collection income and leaving little for investment and reserve capacity building.

At no point between 1980 and 1990 has the entire system endured an underwriting shortfall (Figure 7). As a whole, the yearly Medicare contributions have been enough to cover all expenses, including benefit expenditures and administrative expenses. Net underwriting gain is measured as the difference between premium payments and total expenditures—the amount that can be invested. The net underwriting gain exceeded ₱200 million in 1987 and 1980. It did fall to ₱40 million in 1986 and to a precarious level of ₱28 million in 1990. But a close look at the financial records of both GSIS and SSS reveals that the positive gains came mostly from SSS. The net gain has become a significant source of investable funds for SSS, permitting the SSS to further deepen its investment income base.

Fig.7 **Net Underwriting Gain, 1980-91**

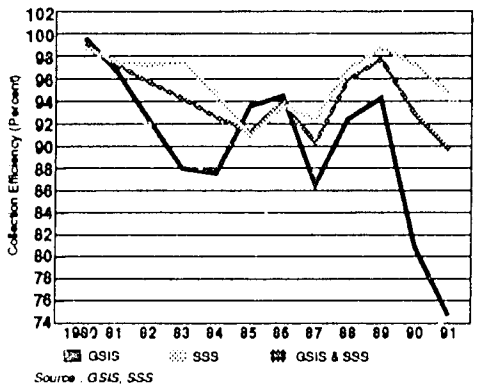


Source : PMCC

GSIS, on the other hand, experienced net underwriting losses in 1985, 1988, and 1991. Claims and operating expenses exceeded premium income in those years. The shortfall in 1991, amounting to ₱104 million, was largely made up for by income on investments. Altogether, these underline the structural weakness of GSIS: lower net underwriting yield decreases the availability of investable funds, which in turn tends to drain the already weak investment income buffer.

Figure 8 indicates that total collection efficiency, which is a measure of how well the system is able to redeem premium and investment interest payments, has been generally on the decline for Medicare as a whole, and for GSIS, in particular. From a high of 99% in 1980, GSIS' total collection

Fig.8 **Total Collection Efficiency, 1980-91**



Source : GSIS, SSS

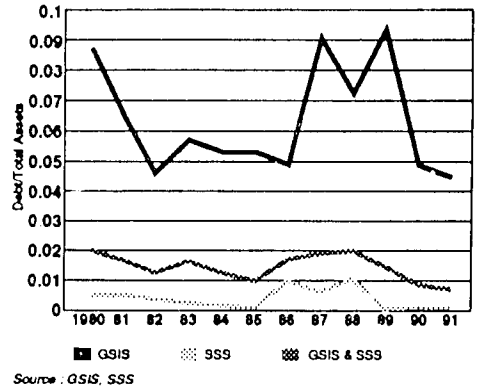
efficiency went down to 87% in 1984, improved slightly in 1985-86, and then dropped to 75% in 1991. GSIS' unpaid premiums rose from zero in 1980 to an all-time high of ₱160 million in 1991, causing a sharp decline in collection efficiency. This steep descent reflects the difficulties that GSIS underwent in compelling a quick turnover of its collection income from the Department of Budget and Management (which holds the bulk of government payroll deductions), leading to a severe cash squeeze.

SSS has a better collection record—its total efficiency has not gone down below 94%. Yet even this mild dip in its collection efficiency translates into millions of pesos that have not changed hands, and may be the result of weaknesses in collection procedures. SSS has to deploy plenty of resources to track down hundreds of late-paying employers, thus considerably raising transaction costs.

The continuous inflow of incomes has led to the strong build-up of assets and reserves, providing a big cushion for the Medicare program as a whole. Medicare's ability to meet long-term obligations from its total assets and earning power, as measured by leverage ratios, is much more secure and less susceptible to destabilizing factors.

The predictability of premium income (due to the regularity of payroll deductions) and sound investment decisions largely kept debt-to-total-assets ratio (total liabilities/total assets) exceedingly low (less than 0.1) between 1980 and 1991 (Figure 9). Of the

Fig.9 **Debt-to-Total-Assets Ratio, 1980-91**



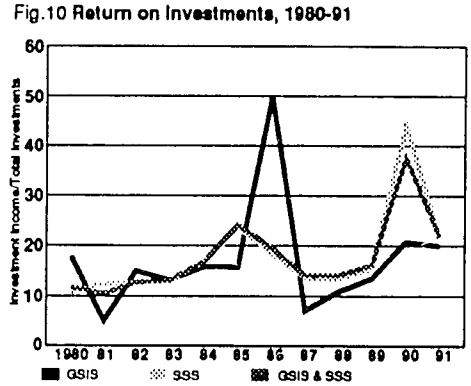
Source : GSIS, SSS

two systems, SSS is the more conservative one, having kept total liabilities to a minimum while constantly stockpiling assets. GSIS has relatively higher liabilities, although they are still quite low by insurance industry standards. Medicare's profitability, or degree of success in earning a return on investment, provides further proof of the system's long-term robustness.

Overall, the system's ROI has alternated between respectable lows (10%) and exceptional highs (38%). Individually, GSIS and SSS have been raking in good investment returns (Figure 10). In 1986, not exactly a good year for the Philippine economy, GSIS managed to post a windfall ROI of 50%. SSS' turn came in 1990, a year marked by natural catastrophes, when it posted a record high ROI of 44%. During the crisis years of 1983 and 1984, GSIS was able to earn an ROI of 16%, and SSS, 13%-17%.

In the main, Medicare's high investment performance—the system now

Fig.10 **Return on Investments, 1980-91**



Source : GSIS, SSS

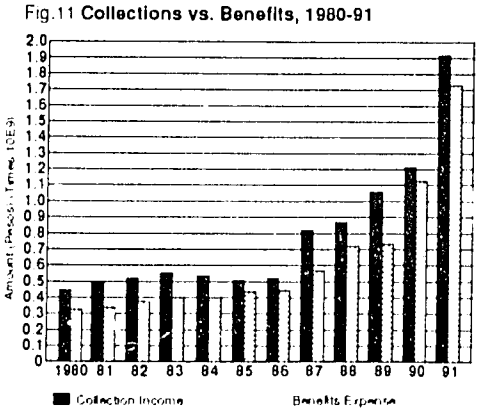
relies less on premiums since interest income makes up almost half of total income—means any further slackening of collection efficiency may be offset by high investment incomes. This is especially true of SSS, whose investment income is almost half of its total income base.

But for GSIS, whose financial foundation continues to be hobbled by a relatively small investment income base, it may not be quite as true. Even with high investment returns, a tiny investment income buffer has limited usefulness. GSIS still has to get by with the help of premium income. It remains highly vulnerable to a sudden surge of benefit expense.

On the average, it will take about 3.4 years before Medicare funds dry up, given current levels of expenditure. The relationship between collections and benefit payments for the years 1980 to 1991 is illustrated in Figure 11.

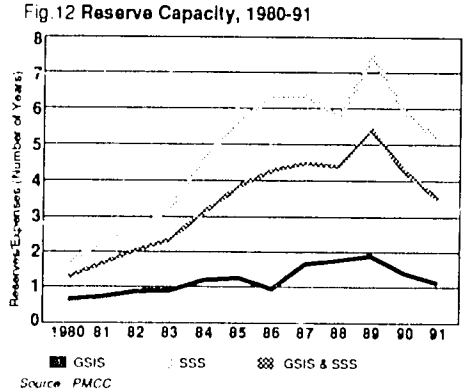
Just how long will Medicare survive if its reserves were used to defray current expenses? Reserve capacity, or reserve levels as a percentage of total expenses, reflects the number of years current reserves can sufficiently cover Medicare disbursements. For the entire system, as cumulative reserves shot up fifteenfold from ₱439 million to ₱6.55 billion, the reserve capacity also went up from 1.3 years to as high as 5.5 years in 1989 (Figure 12). SSS has been spectacular in maintaining an inordinately high reserve capacity. As its reserves piled up incessantly—by 1991 it had accumulated ₱5.7 billion!—SSS' ability to sustain current operations averaged 4.8

Fig.11 **Collections vs. Benefits, 1980-91**



Source PMCC

Fig.12 **Reserve Capacity, 1980-91**



Source PMCC

years in the last decade, and reached an all-time high of 7.6 years in 1989. By comparison, the insurance industry standard is set at two years' reserve capacity. GSIS' reserves grew tenfold, from ₱84 million in 1980 to ₱825 million in 1991. High expenditure levels, however, have kept it from attaining satisfactory capacity increases. In 1980-91, GSIS' reserve capacity averaged only 1.2 years, a precariously low level of sustainability.

Overall, Medicare's financial management is in a good condition, no doubt because SSS, with its impressive financial performance, dominates the system. SSS has performed better than average in most of the financial indicators examined. On the other hand, GSIS seems to perform less favorably. The disparity in the financial management record of the two systems raises disturbing questions about economies of size. Increasing efficiency is associated with a reasonably large operation, and GSIS may have a difficult time reaching that level, given that its market—government employees—is a small market and one that may get even smaller.

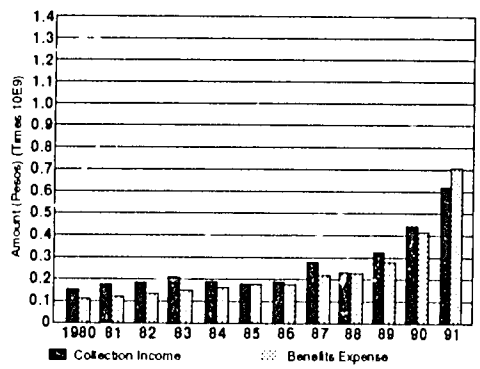
INCREASING BENEFIT EXPENSES: TRADE-OFFS BETWEEN FINANCIAL VIABILITY AND FUND UTILIZATION

GSIS' benefit expense has grown faster than SSS' (19.7% to 17.4%, a 2.3 percentage point difference) but has a larger claim on its collection income. Benefit claims are the single largest expense of Medicare. Benefit payments reached ₱1.1 billion in 1990 and ₱1.7 billion in 1991, only 8%-10% short of collection income for those years. As a proportion of collection income, benefit expense amounted to 68%-92%, again indicating that without healthy reserves, the HIF would be vulnerable to depletion.

GSIS benefit expenditures have a relatively larger claim on collection income, compared to SSS' (Figures 13 and 14). GSIS' benefit expense claimed 115% of collection revenues in 1991, the first time in 12 years that GSIS or SSS claims payments exceeded premium payments.

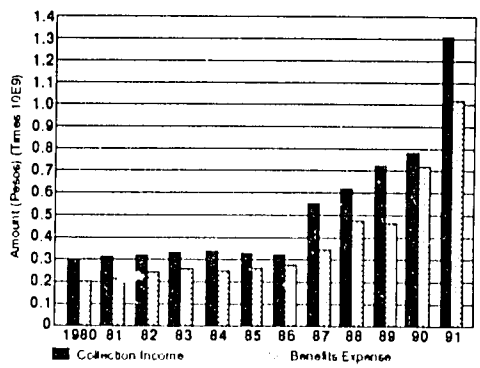
During the same period, the number of people receiving Medicare benefits rose only slightly, from 1.2 million in 1980 to 1.37 million in 1991—increasing by only 1.4% each year. The number of recipients topped 1.4 million only in 1983-85 and again in 1988. Although conceivably more people were brought into the program

Fig.13 **Collections vs. Benefits, GSIS, 1980-91**



Source PMCC

Fig.14 **Collections vs. Benefits, SSS, 1980-91**



Source PMCC

(even if quite a number were purged from the Medicare rolls in 1986-87), not many more of those eligible for benefits actually received medical care services.

While the coverage base increased, the proportion of beneficiaries hardly changed. Only about 5.7% received benefits in 1991. In earlier years, the proportion was a little higher--6% to 7%--but did not reach even 10%. But between the two agencies, GSIS has given benefits to a higher proportion of its Medicare eligibles—roughly 10% to SSS' 5%.

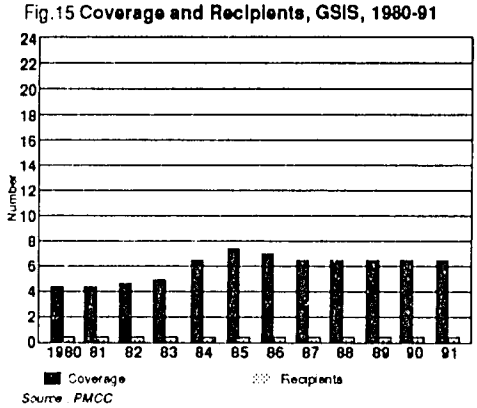
Many more public-sector workers apparently depend on Medicare, presumably because Medicare is the only medical insurance available to them (Figures 15 and 16). In the private sector, many firms offer their workers comparable social security benefits apart from Medicare, thus lowering usage of Medicare.

SSS paid higher average values per claim. Between 1980 and 1986, SSS paid out an average of ₱293.24 per recipient, while GSIS disbursed an average of ₱281.16, for a difference of ₱12.08. Between 1987 and 1991, the corresponding figures were ₱814.18 for SSS and ₱638.50 for GSIS. The difference was now ₱175.68. The gap between the two agencies hardly existed before 1986, but widened after that year. The dual benefit structure that has effectively been created is not sanctioned by Medicare officials, who have always favored across-the-board benefit changes (Figure 17).

The average payment to each Medicare recipient rose between 1980 and 1991. The benefits paid per recipient amounted to ₱262.70 in 1980, increased gradually in 1981-86, and then rose steeply in the succeeding years. In 1991, recipients were paid an average of ₱1,263.93 in benefits.

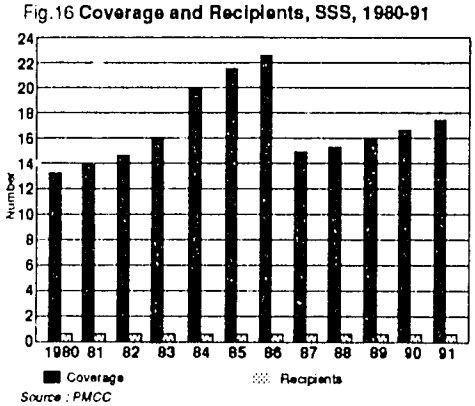
GSIS has paid higher benefits per capita—by as much as two-thirds more than what SSS pays, on the average—because of the bigger proportion of beneficiaries in its coverage base (Figure 18).

Fig.15 **Coverage and Recipients, GSIS, 1980-91**



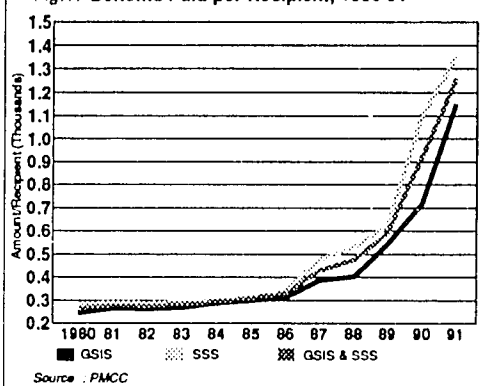
Source : PMCC

Fig.16 **Coverage and Recipients, SSS, 1980-91**



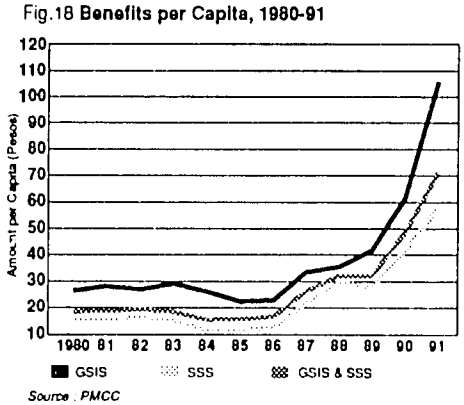
Source : PMCC

Fig.17 **Benefits Paid per Recipient, 1980-91**



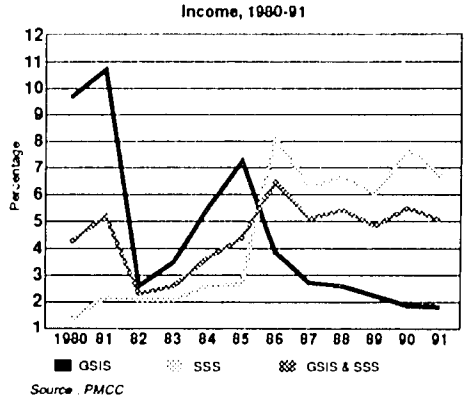
Source : PMCC

Fig.18 **Benefits per Capita, 1980-91**



Source : PMCC

Fig.19 **Operating Expense as % of Collection Income, 1980-91**



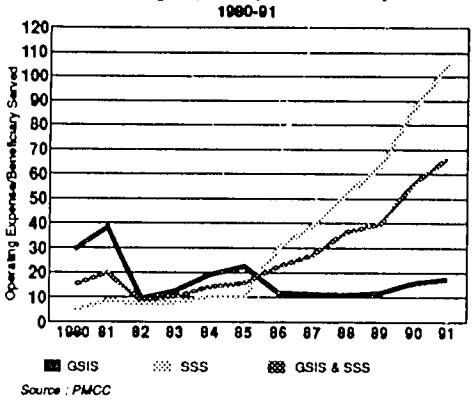
Source : PMCC

Although this rise in benefits per recipient and per capita is an apparent gain to Medicare members and dependents, during much of the period that Medicare has been in operation, benefits per person have remained stagnant in real terms. For the most part, it has had great difficulty in staying ahead of inflationary medical prices, so that the value of benefits does not appear to be high. (Note that since Medicare covers a population with presumably average health problems, the average claim size may not be really substantial, in the first place.) Generally, the program has experienced more rapid increases in claims expenses than in the number of eligibles reached.

Operating expense as a percentage of collection income averaged 4.62% between 1980 and 1991. This suggests that even if investment income were excluded from the calculation, the figure would still be well below the 12% ceiling prescribed by the Medicare law (Figure 19). It has generally stayed above the 5% level since 1986, in part because the system is experiencing an observable upward trend in operating expense by SSS, the more dominant of the two Medicare fund managers.

Between 1980 and 1986, SSS' operational expenditures were below the ₱10 million mark, or equivalently, it was spending for overhead and administration an average of only 2.2% of collection income. In 1986, the amount went up to ₱27.3 million; by 1991, SSS had incurred ₱86.6 million in operating costs, or about 88% of the cost of running the entire system. As a percentage of collection income, SSS'

Fig.20 **Operating Expense per Beneficiary Paid 1980-91**



Source : PMCC

operating expenditures averaged a high 8.34% between 1987 and 1991.

This was somewhat offset by a downward trend in GSIS' operating expenses. As a percentage of collection income, administrative costs incurred by GSIS went as high as 10.7% in 1981 but since 1986 has settled to an average of 2.3%. GSIS hit the ₱19 million mark in 1981—its highest so far—but after 1985, its operating expense settled to the ₱7-P8 million level.

Since the number of claims has declined slightly, the rise in costs per beneficiary, for both GSIS and SSS, presumably reflects inflationary trends in the economy. For GSIS, operating costs per eligible served have settled to an average of ₱13.18 beginning in 1986, after highs of ₱29.64 and ₱37.92 and a low of ₱8.99. That means much of the upward pattern in operating expenses, at least after 1986, is being contributed by SSS. For SSS, operating expenses per beneficiary increased from ₱4.78 in 1980 to a high ₱105.65 in 1991. The latter figure alone is more than six times the amount spent by GSIS (Figure 20).

This is puzzling, to say the least, since unit costs for SSS should have gone down on account of economies of size. As it is, it is GSIS which, despite struggling to achieve scale economies, has been successful in containing unit operating costs. For the system as a whole, the rate of growth of operating expenses in 1980-91 averaged 19.7% yearly. The breakdown by agency depicts contrasting situations: the average annual growth rate of operating costs for SSS was 40.2%; for GSIS it was 5.2%. One way of balancing the picture is to determine whether the growth rate of benefit payments per recipient exceeds the growth rate of costs per beneficiary.

As a whole, the rate of change in benefit expense per recipient was 16.5% during the same period. For SSS, benefit payments grew at the rate of 17.3%; for GSIS the rate was 16.2%, which was not far behind. Thus, it is costing SSS much more to maintain a healthy 17% growth rate in benefits. For GSIS, the administrative cost per peso of benefits is low. Public-sector employees are able to claim back a bigger portion of what they put in GSIS than private-sector workers are able to get back from SSS. Of course, it is often alleged that the apparent laxity in GSIS' processing of claims hikes the amount of benefit "leakages" to excessive levels.

Regardless of the real reason for the contrast between GSIS and SSS in their administrative expense patterns, it is safe to say at this point that GSIS—with lower administrative costs per peso of benefit expense—has been "giving back" much more of its Medicare resources to eligibles, compared to SSS.

This is further illustrated by the cost of insurance, which is the difference between premium payments and benefit expenditures (the amount that goes to investment, administrative expenses, and overhead). That cost (which is borne by Medicare enrollees), measured as a percentage of premiums (loading rate), is lower for GSIS members than for SSS members (Figure 21). On the average, the cost of insurance for public-sector employees was 14.4% of premiums during the period 1980-91; for private-sector workers, it averaged 25.4% of premiums. Thus it costs SSS members 11 percentage points more to underwrite their own medical care.

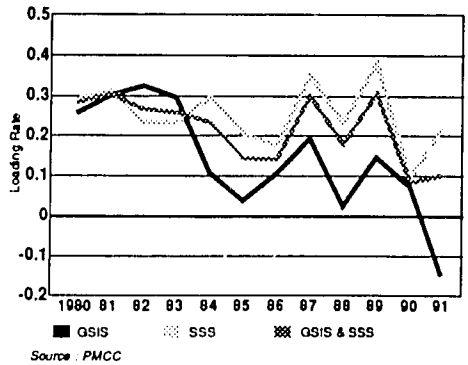
A number of other forces give rise to the low benefit expenses of SSS, such as low utilization rates in the private sector and the possible exclusion of high-risk people from SSS' insurance plans. Still, elimination of this dual pricing of insurance would be a logical course.

ADMINISTRATIVE COSTS

The system has kept operating expenses below the 12% cap. Operational expenses for the whole Medicare program have varied from year to year, but have been below 12% of the total contributions and investment earnings that the Medicare law permits SSS and GSIS to disburse yearly (Figure 22). From 1980 to 1990, SSS' ratio of operating expenses to total income averaged 2.9%. Before that, it had ranged between 1% and 4%. For GSIS, the ratio of operating expenses to revenues for the same period was 4.2%. It reached a high 10.4% in 1981 but has generally been on the decline since then.

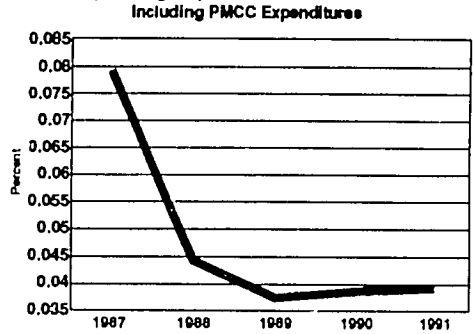
In the years 1987-91, GSIS posted a much lower proportion of operating costs: 1.9%. In 1991, the percentage of operating expenses to Medicare revenues was only 1.48%. Including the annual expenditures of PMCC in the total administrative costs

Fig.21 **Cost of Insurance, 1980-91**



Source : PMCC

Fig.22 **Operating Expense as % of Total Incomes Including PMCC Expenditures**



Source : PMCC

would add only two percentage points, so that the total costs would still be below the 12% ceiling. GSIS' transaction costs per claim are relatively less than those of SSS.

Comparatively, the cost of processing each claim with SSS was ₱92.62 in 1990 and ₱61.84 in 1989; with GSIS, it cost ₱13.54 to process each claim in 1990 and ₱22.21 in 1989. Thus, it cost six times as much to process claims in SSS than in GSIS in 1990, and almost three times as much in 1989. The declining trend for GSIS means that its transaction costs are relatively less than those of SSS, and each GSIS Medicare beneficiary gets back a bit more than his counterpart in the SSS, at least through lower administrative costs per capita. The operating expenses of SSS are on the rise while those of GSIS are on the decline; in both cases, a large part of the expenses go to salaries and wages.

In 1981, SSS administrative expenses were estimated at ₱7 million; by 1991 they had reached ₱86.635 million, a twelvefold increase over a period of 10 years. Since 1986, SSS operating expenses for Medicare have been increasing at an average rate of 26.73%. During the same period, the HIF increased by only 25%. Between 1988 and 1991, personal services averaged 67.5% of SSS Medicare expenditures. The inverse, of course, of the high share of personal services in SSS' administrative expenses is the relatively low share of expenses for strict enforcement of Medicare regulations. Expense items for deterring fraud and abuse, such as traveling expenses, trial allowance, and communication expenses, compete for "other expenditures" which in the same period (1988 to 1991) averaged 32.5% of total operating expenses.

By contrast, GSIS' operating costs are declining. In 1980, they were placed at ₱15.116 million; by 1991, however, the amount was down to ₱11.182. Like SSS, salaries and wages constitute almost the entire allocation for GSIS Medicare. The proportion of so-called "noncontrollable" items of expenditure rose by as much as 95% at one time.

It is worth bearing in mind that differing accounting systems may have led to an overstatement of SSS' operating expenses and an understatement of those of GSIS. SSS does full accounting or costing in the sense that it includes support costs like rent, equipment rental, light, and water and uses the benefit payment ratio in charging the Medicare program for these costs. GSIS excludes such overhead expenses from its expense statements. GSIS charges actual direct expenses on the basis of Medicare-related activities, which also explains the low level of its operating expense. SSS, however, appears to be charging some expense items rather heavily. But these differences in accounting methods are not expected to alter the overall expenditures picture significantly.

The relative net gain accruing from high fixed costs which constitute salaries, allowances, and fringe benefits is in question because both systems have not progressed well in improving the Medicare program. Although both financial institutions have faithfully observed the 12% cap, the relative incidence of benefits has not risen much; the scope of and access to the program has hardly broadened. Cursory evidence would show that much of the incremental advances in Medicare could have been accomplished even without employee incentives. That would also suggest that worker productivity has not improved much. The other side of the coin is that spending by both systems on program research and development has been nil.

The PMCC's declining expenditures parallel declining appropriations from the national government, and suggest inefficient use of financial resources. PMCC has a more limited financial base because it relies on government appropriations, which are often subject to political pressures. PMCC's appropriations have continued to decline since 1988, at one time falling by as much as 60%. Among the reasons cited for the decline were the Salary Standardization Law and attrition in the civil service, which accelerated during the Aquino administration. By 1990, casuals, who made up the greater part of PMCC's extension service, were dropped from the rolls, and this appeared to hobble the Commission's capacity for field monitoring and supervision.

A major reason, however, for the budgetary attrition is that PMCC has been consistently spending below its budget. If PMCC were a parastatal body, such savings would have been used to build a healthy reserve fund. But as a regular government agency, PMCC is required by law to return all unused funds to the national treasury. In a situation where distribution of government funds has often been dictated by the level of past agency expenditures, the decline was inevitable. In the end, the variance may have been the result of poor planning and weak administrative structure—an inability to maintain current levels and scale of operation, a persistent failure to accurately forecast needs and requirements, and inefficient use of available financial resources.

This situation should be mitigated somewhat by the fact that the central government has often imposed mandatory cutbacks in agency expenditures to reduce the fiscal deficit. Still, the PMCC record would make it difficult for the commission to justify higher annual appropriations.

Although salaries and wages ordinarily get the biggest chunk of budgetary resources, the PMCC's slice for personal services is quite hefty. This pattern has characterized the PMCC's budget in recent years, and is closely linked to the resource management policies of the commission. In the face of a dwindling budget, and given the fact that no further reductions can be made in civil service - protected positions, the outcome has been an unduly large concentration of resources on manpower, especially administrative personnel. That would explain the growing lack of flexibility in the PMCC's policy and planning, since it is clogged with manpower whose impact on the PMCC's output has been relatively slight.

The decline in budgetary resources also has unduly disruptive effects on the PMCC's level and scale of operations. Each decrease in every budgetary cycle seems to have had an immediate and unacceptable impact on the quality of medical care, since surveillance activities had to be curtailed, and field capacity had to be stretched too thinly. It was also, in the final analysis, responsible for uncertainties and shortfalls in the development of new policies and programs aimed at expanding Medicare.

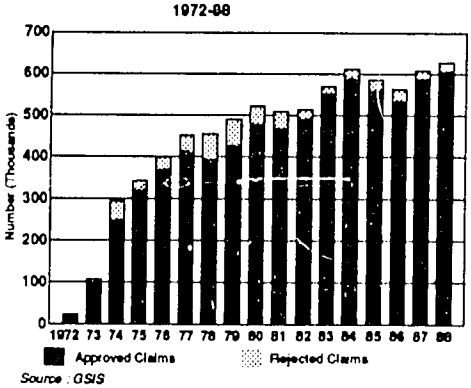
CLAIMS PROCESSING

The GSIS Medicare claims processing system is functionally adequate, but it is plagued by the uncertain quality of processing and a persistent backlog. A hallmark of GSIS Medicare processing is the clear-cut separation of responsibilities and control among various entities. Since claims are paid on a reimbursement basis, the claims flow process reflects this payment mode. Processing involves six divisions of the Medicare department of GSIS, the central unit which processes medical claims from health providers and beneficiaries.

Statistics on claims processing capacity are reasonably accurate, and can be the basis for assessing the efficiency of the system. As one would expect, the number of claims processed has steadily risen over time (Figure 23). The claims control and data entry division can preprocess an average of 2,500 claims daily. On the other hand, the medical evaluation staff can process an average of 300 claims per day. It takes 10 days to complete the processing of each of the 2,000 incoming claims daily. This translates into a backlog of 50,600 claims a month (assuming there are 22 working days per month).

GSIS accomplishments in 1990 and 1991 reveal that its backlog seems to have substantially declined. In 1990, some 47,458 claims failed to pass GSIS processing. In 1991, the stock of unprocessed claims was reduced significantly to 28,567. Yet the average monthly balance of unprocessed claims in 1991 was 50,615, which is very close to the 50,600 backlog computed above.

Fig.23 **Number of Processed Claims, GSIS 1972-88**



Source : GSIS

A total of 50,600 unprocessed claims per month when translated into days would mean a nine-day backlog (assuming 6.5 productive working hours a day). For the medical evaluation staff to ease the backlog, eight more doctors are needed. In turn, that would create a chain effect; for instance, 16 additional processors would automatically have to be added to the claims processing division to complete all claims.

Understaffing is apparent from the growing stockpile of half-processed claims. However, GSIS has obviously not found a good formula—such as the ratio of processing personnel to the number of claims—linking its staff capacity to the volume of transactions the department handles. Capacity lags behind demand and redeployment of workers is limited by pressures to maintain the present separation of functions within the department. There is evidence that few claims are being disapproved by the GSIS.

Since 1980, there has been a declining trend in the number of disapprovals (Figure 23). It averaged only 4% of total processed claims between 1982 and 1988. Deviations from the process are rare, and an obvious routinization has set in. More often than not, claims are just allowed to "go through the motions."

It is unclear whether this lack of rigor actually encourages fraud; what is clear, however, is that the system leaves much to be desired. There are no definite standards to go by, since there is no complete manual of operations; office orders frequently substitute for a more comprehensive manual which contains all the claims processing details. A number of exogenous factors, including location and type of provider, distance and amount of customary charges, determine GSIS claims processing efficiency.

Claims processing really measures waiting time. There is an opportunity cost associated with long processing periods. Since Medicare insurance works on a reimbursement basis, the cost to the provider may be significant in terms of foregone earnings. On the basis of provider-level data from GSIS computer files, and using a linear regression model in which the role of institutional (provider) elements as determinants of the efficiency of claims processing is emphasized, the results show that processing time (average number of days a claim is processed) is:

- inversely related to distance (remoteness is a deterrence to filing claims, because of the high opportunity costs of the extended processing period; with fewer claims filed, the procedural routine speeds up);
- lower for claims filed by urban-based hospitals (urban location is a proxy for availability of high-quality care, knowledge, adaptability to modern medical concepts, and education);
- greater for public hospitals (which often receive subventions from the government and may perceive that they can always be financially bailed out by government in a crisis; this is clearly a disincentive to pursuing prompt reimbursements); and
- shorter as the average Medicare charges increase (other things being equal, high Medicare-reimbursable expenses induce quick action).

SSS Medicare claims processing is by and large similar to the GSIS system and follows the same routine, except that major responsibilities are vested in several independent departments. SSS' Medicare department provides coordination and oversight. The SSS system is also different in that it is decentralized. Unlike GSIS, where all processing takes place in its central headquarters in Manila, SSS has completely devolved claims processing to its 10 regional offices.

The processing system of SSS in each regional office is a very detailed system. It itemizes all processing activities as well as identifies and pinpoints who is responsible for each particular activity. It is exhaustive: all activities are described to the minutest detail, and so are the tasks that need to be done if there are deviations from the process.

The system is well-equipped with controls that can detect most incomplete, irregular, as well as fraudulent claims. The screening process allows for immediate

rejection at the outset once an irregularity is detected. SSS Medicare department officers claim, not without reason, that the only flaw which the system is ill-equipped to identify is the case of dual memberships, that is, when a husband is insured by GSIS and the wife is insured by SSS, or vice versa. To establish controls in this regard would require linking the SSS and GSIS data base systems through a network.

Surprisingly, the system is new and is in the "break-in" stage. That also suggests that the system's information base is just beginning to be built up. So far, no "heavy traffic" in claims processing has developed, and the backlog is quite low.

SSS has set a new standard of 10 days' processing time for all claims that come in on a particular day. There is plausibility to this since the number of claims which come in daily ranges only from 600 to 700. If this were true, the more important thing to consider is the rate of rejection. If the rate of rejection is too high, which is the widely held perception, processing efficiency is being falsely exchanged for a fewer number of beneficiaries.

On the other hand, a spinoff benefit of an efficient processing scheme is early detection of claims which are irregular, incomplete, or fraudulent. If the system can identify erring providers, and check whether they have provided quality service or complied with PMCC accreditation requirements and rules and regulations, it would be a handy companion to the monitoring system.

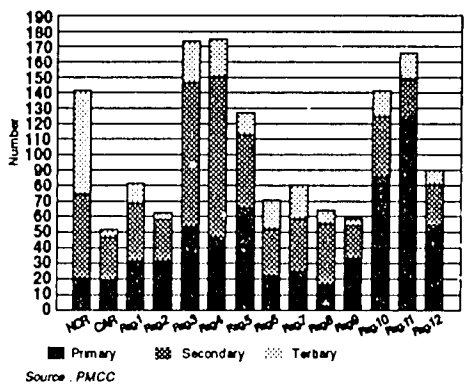
ACCESS TO MEDICAL SERVICES

HOSPITALS AND BEDS

Broadly, the presence of a fairly large number of nontertiary facilities in outlying regions suggests that efforts to widen the catchment area for Medicare services have not been wanting, as a result of which Medicare eligibles have access to at least primary types of medical care. The goal of Medicare accreditation is to equalize access by making sure enough facilities and physicians are present in each region.

A synoptic view of the regional distribution of providers accredited by PMCC shows that, surprisingly, in terms of absolute numbers, it is not Metro Manila (NCR) but Central Luzon (Region 3), Southern Tagalog (Region 4), and Southern Mindanao (Region 11) which have the most number of accredited providers (Figure 24). The count in these regions ranges from 164 to 173 hospitals and clinics, compared to Metro Manila's 142. Northern Mindanao (Region 10) has almost an equal tally of providers (141) as Metro Manila.

Fig.24 **Distribution of Providers, by Region**



Source : PMCC

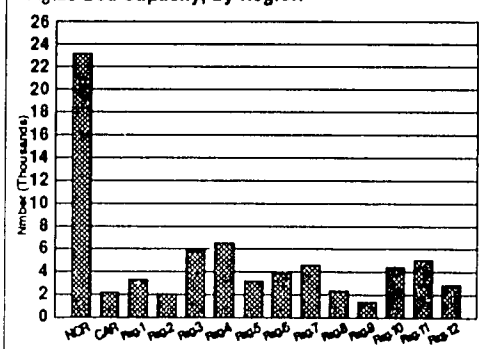
Without looking at other indices, the large quantity of medical facilities in several regions away from Metro Manila may already indicate a better geographic spread of these facilities. A good number of primary and secondary providers are also located in other regions, all of them relatively poor. The Cordillera Administrative Region and Western Mindanao have the lowest overall number of facilities. Within these needy regions, only a scattering of tertiary facilities can be found.

The existing geographic spread of facilities does not imply that the regional concentration of medical services has moved away from Metro Manila. The distribution of bed capacity, a more appropriate indicator of access at the regional level, shows why. The number of beds here refers to those specifically reserved for Medicare patients. As expected, Metro Manila is far too dominant in terms of Medicare bed capacity (Figure 25). Its total bed count, 23,100, is almost four times as many as the number of beds found in Southern Tagalog, which ranks second (6,547 beds) and is an adjoining region. Central Luzon and Southern Mindanao, despite being at the top in terms of number of providers, have less than 6,000 beds each. Again, Cordillera and Western Mindanao have the lowest tally, with only 3,663 beds between them.

Closer scrutiny requires evaluating the distribution of bed capacity among those insured by Medicare (Figure 26). The findings hold hardly any surprises. Metro Manila, as expected, leads the other regions in the tally, with 8.6 beds per thousand. Central Visayas (Region 8) and Western Mindanao, two areas with low bed capacities, have likewise low bed-to-population ratios—1.9:1000 and 1.4:1000, respectively.

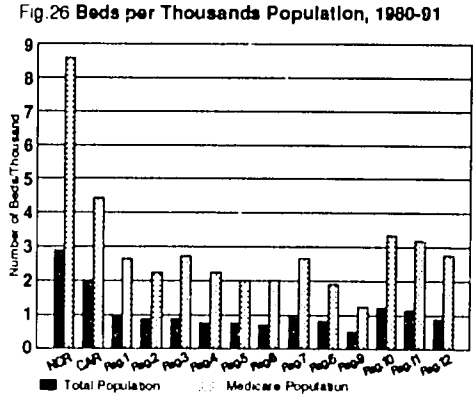
The surprise is provided by Cordillera, which has a high bed count per thousand,

Fig.25 **Bed Capacity, by Region**



Source PMCC

Fig.26 **Beds per Thousands Population, 1980-91**



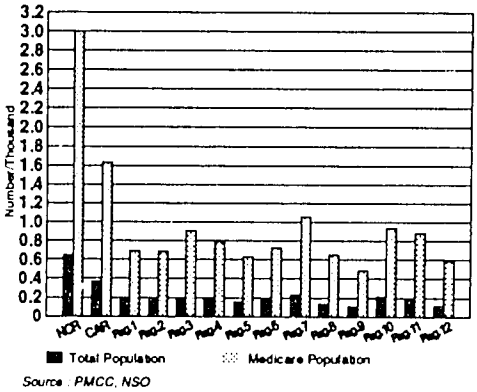
Source PMCC, NSO

4.4, despite having a low bed capacity. The reason is that this region also has the lowest estimated Medicare population (500,000). As for the rest, the number of beds per thousand averages 2.4.

DOCTORS AND DENTISTS

The regional pattern of allocation of physicians (including dentists) accredited by Medicare looks very much like the skewed regional distribution of health facilities (Figure 27). This is no accident, since these accredited doctors work within the accredited hospitals and clinics.

Fig.27 **Physician - Population Ratios, 1980-91**
Total and Medicare Population



Source : PMCC, NSO

More than a third of these physicians are found in Metro Manila, which supplies three doctors for every 1,000 Medicare eligibles. Again, the Cordillera Administrative Region fares better than the other regions since it can provide 1.6 doctors per thousand, although most of them are presumably practicing in Baguio City, where most of the region's tertiary facilities are found. Except for Eastern Visayas (Region 7), with a 1:1000 doctor-to-Medicare-population ratio, all the others have fewer than one doctor serving each thousand Medicare members and dependents.

Thus, while the introduction of Medicare has caused the outlying regions as a whole to make rapid gains in the provision of medical services, these regions have yet to experience any substantial gain in per capita availability of facilities and medical manpower relative to Metro Manila residents. The failure of Medicare to balance the growth of facilities and physicians per capita suggests that the accreditation program may be less than successful in areas removed from Manila.

INFORMATION, EDUCATION, AND COMMUNICATION

The Medicare program has no adequate public information campaign to help consumers deal effectively with providers and reimbursement agencies. Because social insurance schemes often suffer from a dearth of information, a public awareness program is always helpful.

Information is a necessary ingredient in reducing the uncertainty in the Medicare system: the PMCC can function as a perfect information agent for Medicare enrollees. This role extends more broadly to the diffusion and incorporation of information into the patterns of behavior of both providers and patients. A well-informed membership can deter abuses and collusive behavior and prevent roundabout procedures that lead to a misallocation of time and money resources.

The PMCC's public information division is supposed to take care of information planning and dissemination. Severely understaffed, it has been reduced to doing perfunctory jobs, such as over-the-counter information dissemination. It would be more appropriate for it to render more aggressive frontline services, aside from conducting a systematic public information campaign.

The information dissemination should provide Medicare users with sufficient knowledge about the program. As long as the marginal social benefit of efforts needed to raise public consciousness of the program to a higher level exceeds the marginal social cost, the information campaign is justified.

ACCREDITATION AND MONITORING

The PMCC provider accreditation system is based on DOH licensing standards and is dependent on regional and local DOH arrangements. All hospitals and clinics—the channels through which medical services are distributed to the population—are required to register with the DOH and comply with its implementing rules and regulations on providers. For Medicare purposes, a separate accreditation process is required, and PMCC is the sole body authorized to license government and private hospitals and medical and dental practitioners. Licensing is not the only responsibility of PMCC; accreditation involves applying sanctions as well to providers caught violating PMCC rules.

The PMCC depends substantially on the capacity of the assistant provincial health officer (APHO) as well as the assistant regional health officer (ARHO) to evaluate hospitals. They recommend accreditation. At first glance, this decentralized nature of accreditation seems to be a sound set-up, since a local health official would be in the best position to determine how well-equipped a provider is to deliver medical care.

Since this system is tied up with the DOH, devolution will in fact affect the set-up. At present, PMCC needs to deal only with central DOH authorities to ensure the continued participation of the APHO and the ARHO in the process. As decentralization makes significant strides, PMCC will have to face the prospect of coordinating with hundreds of local executives to retain the existing arrangement.

Medicare accreditation is based on DOH licensing standards. Secondary and tertiary hospitals need only show their license to operate to be accredited. In theory, simplifying rules are meant to facilitate, rather than hinder, accreditation. It also makes no sense to impose requirements that diverge considerably from those that DOH imposes on providers.

Yet PMCC accreditation procedures clearly lack transparency. Appropriate standards for the number of medical personnel, number of beds, facilities, location, manpower- and facilities-to-population ratios, and other relevant

indicators as reflected in the application forms are not determined precisely. Too much discretion is left to those who recommend and approve licensing, contrary to a rule of thumb that procedures must be unequivocal. Neither is the accreditation scheme explicit with respect to time standards, responsibility centers, and the itemized and detailed identification of hospital activities and tasks. A comprehensive manual of accreditation, in the context of a more professionalized process, is clearly necessary.

Severe administrative and budgetary limitations keep the PMCC from monitoring more than 15% of Medicare providers. PMCC's surveillance system, implemented by its providers service department, has two key objectives:

- to make sure there are actual hospital staff on duty and to validate their existence (licensure and license renewals depend on field reports); and
- to establish statistical trends of each hospital's occupancy record as an aid to the early detection of fraud and the prevention of the filing of fraudulent claims.

The Commission has full access rights over the medical records of Medicare patients. PMCC agents are likewise authorized to inspect the physical plant and equipment of each hospital and, if considered necessary, examine Medicare patients during confinement to determine whether laboratory procedures were actually performed and whether appropriate medication or treatment was actually administered.

PMCC monitors the providers every other day, and at random. Likewise, spot inspections are undertaken every now and then. PMCC's monitoring strategy thus partakes of both routine and nonroutine activity. The implementors of the system are the administrative assistants and clerks, numbering 172 to date, who are dispersed thinly all over the country.

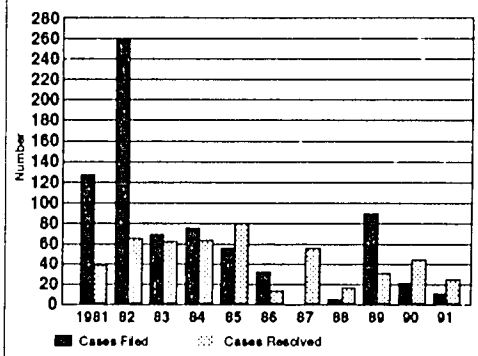
The PMCC's monitoring performance has been mixed. On the basis of the First Quarter Monitoring Program in 1991, the PMCC has monitored 88.82% of the targeted number of primary clinics, 79.17% of secondary hospitals, and only 25% of the targeted tertiary hospitals. This indicates that the PMCC can put under surveillance only 15% of the total number of providers all over the country, estimated at 1,543. Sampling is not necessarily an inadequate monitoring procedure, especially since the PMCC has only a limited capacity in the field, but there is no indication that PMCC is following a proven statistical sampling technique.

PMCC has not fully exercised its power to monitor all accredited hospitals in the country because of a tight budget and lack of coordination within the Medicare system. The providers service department is grossly understaffed. Only 10 medical doctors and 172 field personnel (administrative assistants and clerks) are doing the monitoring function. On the average, each field worker has to observe nine providers; in turn, each PMCC doctor has to be accountable to at least 150 providers. The PMCC does not appear to coordinate sufficiently with the GSIS and SSS, both of which also have surveillance powers over the hospitals. A coordinated attack on the problem would have resolved some of the capacity constraints being experienced by PMCC, and perhaps would have achieved economies of scale in monitoring.

Monitoring of data collection is weak, unreliable, and in some cases nonexistent. The monitoring forms that reach the providers service department are often incompletely filled out; some statistics in the forms do not tally. The forms appear to have no practical value for forecasting, or trend extrapolation. Poor compliance in the submission of forms is compounded by an inadequate supply of qualified statisticians, actuaries, and other technical personnel. Efforts to reform the system have met with little success. Attempts to provide a solid evaluation of providers' performance have been frustrating at all levels.

There is evidence that the weakness of the monitoring system has paved the way for massive "rent-seeking" and fraud. The hearing and investigation service has resolved an average of 64 cases of fraud yearly from 1979 to 1991, and there is suspicion that the full extent of the irregularities is still to be uncovered (Figure 28). Of more than 724 cases filed within 1981-91 (no data for 1987 were available), 472 were resolved, for a yearly efficiency rate of 65%. Many of the cases involved confinement violations and false claims. Surprisingly, the sanctions given were disproportionately light, compared to the gravity of the violation. The more common resolutions made, particularly before 1986, were warnings and one to three month suspensions.

Fig.28 **Number of Cases Filed and Resolved**



Source: GSIS

The more important aspect of monitoring, however, is not fraud detection but deterrence. Prevention seems to be a more useful way of indicating the costs and benefits of monitoring. PMCC estimates that if vigorous monitoring were undertaken, total savings in 1991 would amount to ₱120 million (at the conservative rate of ₱480 per claim). If the GSIS benefit expense rate of ₱878 per claim were used, savings would run to over ₱221 million, more than enough to dispose of the total deficit of GSIS amounting to ₱202.6 million.

Despite the existence of fraud, a word of caution may be necessary. Patients may prefer to be hospitalized even when out-patient care would be cheaper. Providers have been alleged to have taken advantage of assured revenues from Medicare insurance. There are no incentives for both patients and hospitals to police the Medicare market or to insist that services be efficiently provided and worth the resources devoted to them. If Medicare

insurance has conceivably lessened the cost of medical care to working families, they are provided them with an incentive to purchase more medical care than they would have without Medicare. It is to the families' advantage to behave in this way since the premium is scarcely affected by the choices they make.

Regression results indirectly show that hospital confinement time is influenced by factors susceptible to patient and provider abuse. The period of confinement for Medicare recipients is a crucial factor in PMCC's monitoring efforts. There is a widely held perception that some Medicare beneficiaries connive with the provider to extend the period of confinement to cover expenses beyond Medicare benefits. Using GSIS data, regression analysis was used to investigate some institutional and areal factors influencing the length of hospital stay, and thus to determine which constituent elements are susceptible to patient and provider abuse. The empirical results show that the length of hospital stay is:

- directly associated with bed capacity (more hospital beds encourage longer confinement periods) in a context where the majority of the patients are not surgical/intensive care cases);
- shorter with an increase in the number of surgical cases (hospital time and space are dominated by cases requiring only simple curative services, leaving less space for more serious cases);
- longer in government hospitals (bureaucratization in public hospitals leads to slower patient discharge procedures); and
- longer as Medicare charges increase (providers may be influencing the behavior of patients to cover expenses not compensable under Medicare).

Overall, there is evidence that Medicare facilities are inappropriately used.

CONCLUDING REMARKS

During the roughly two decades since the start of compulsory risk coverage, Medicare has experienced dramatic change in three dimensions. First, coverage has expanded phenomenally. Second, the range of Medicare benefits has also widened, even if the benefit structure itself has remained unchanged. Third, Medicare has created a large market that generated positive externalities in the form of more providers entering the program to supply in-patient medical services.

The administration of Medicare has generally not kept pace with its expansion, and current arrangements appear to be over-stretching the capacity of the system. What is problematic in the long run is the administrative cost of running an expansionary risk-sharing program, monitoring service, collecting premiums, staying liquid, and attracting new health service consumers that include those in the informal sector.

These issues are currently being tackled by the PMCC board with the approval of several initiatives approved at the last meeting in February. These initiatives, however, are almost exclusively confined to ways of increasing coverage, enforcing compliance, improving administration, rationalizing the bases for reimbursing providers (RUV scale revision) under Program I of Medicare, and expanding out-patient benefits in consonance with the in-patient benefits offered under Program I.

The next section of the paper addresses issues concerning two very important related topics and recent innovations -the HMO tie-up and Program II pilot projects.

INNOVATIONS IN THE MEDICARE PROGRAM

INTRODUCTION

A main objective of Medicare, according to the Philippine Medical Care Act, is to provide complete medical care to Filipinos progressively, within the nation's economic means and capability. Section 25 of the act directs the PMCC to monitor the program and undertake continuing research to improve it.

This section presents two such undertakings—the PMCC-HMO Tie-Up Project, which attempted to provide higher benefits to Medicare members without increasing premium contributions, and Medicare Program II pilot projects, which are aimed at providing health benefits to those who are not covered by Program I.

PROGRAM I: IMPROVED BENEFITS THROUGH THE PMCC-HMO TIE-UP PROJECT

BACKGROUND

The Philippine Medicare Program is an indemnity fee-for-service program. Therefore, despite increasing its benefits, Medicare has never been able to reach its targeted support value of 70% of hospitalization costs. Every time Medicare has tried to raise its support value, providers hiked their rates. In 1987, Medicare covered only 48% of the hospitalization expenses for SSS members and only 28% for GSIS members. That same year, PMCC launched an experimental project to provide increased Medicare benefits at the existing contribution levels.

OBJECTIVE AND DESCRIPTION

Alternative health care mechanisms were used by the tie-up to expand Medicare benefits without increasing premium contributions. Private health companies directly provided higher coverage to participating members for health care expenses or health care services. SSS and GSIS, on the other hand, collected premium contributions and remitted the contributions of participating members to their HMOs.

Health insurance companies (HICs) and health maintenance organizations (HMOs) were invited to take part in the experiment. To participate, they had to accept all Medicare members who wanted to enrol in the project; no one could be rejected. They had to offer a benefit package higher than that offered by the regular Medicare program. Lastly, they could not increase premium contributions.

In June 1988, HealthKard International signed a memorandum of agreement (MOA) with the PMCC and became the first HMO to join the experimental project. In May 1989, Pamana Inc. signed a similar MOA. The project became known as the PMCC-HMO Tie-Up Project.

In the first phase of the tie-up, from September 1988 to February 1991, participation was limited to Medicare members living or working in Metro Manila or working in branch offices of companies based in Metro Manila. Their benefits came in the form of higher hospitalization ceilings and out-patient services.

In January 1991, after evaluating the project, the PMCC decided to extend the tie-up until the end of the year. During this second phase, benefits were increased by an average of 60%. Premium contributions remitted to the HMOs were also increased, in step with the increases in Medicare contributions and benefits mandated by Executive Orders 365 and 441. But, to allow the project to clear the administrative backlog and resolve problems, marketing and enrolment came to a halt. An information campaign was waged to increase awareness of the tie-up among members and providers. By this time, the tie-up had more than 100,000 members.

A coordinating committee, in which the two HMOs, SSS, GSIS, and the PMCC were represented, oversaw the implementation and management of the tie-up. The committee met monthly to evaluate the tie-up and settle issues.

EVALUATION

In January 1992, the PMCC contracted Andersen Consulting for a second, more extensive evaluation of the tie-up to help the PMCC board decide whether or not to continue with the project.

Primary and secondary data were used to assess how the tie-up was viewed by its major stakeholders. Primary data were taken from a survey of randomly selected tie-up members and benefit claimants, and interviews with members, providers, and key personnel of the HMOs, SSS, GSIS, and PMCC. Secondary data were gathered from the members' application forms, the HMOs' claims data bases, and financial reports of the HMOs, SSS, and GSIS.

A summary of the results of the evaluation follows.

- **Nonrestrictive marketing and recruitment of members.** Tie-up members were not much different from the NCR labor force in age, sex, and civil status composition. The average income of the members was close to the minimum

Table 7. **Awareness Survey of Tie-Up Members**

Benefits	Percentage Aware		Percentage Not Aware
	Before/Upon Joining	Some Time After Joining	
Higher hospitalization limits	38	32	29
Out-patient benefits	33	28	39
Benefits are not additional benefits over regular Medicare benefits	25	25	49
Benefits may be availed of only from HMO-affiliated providers	36	29	35
Members who receive medical attention from nonaffiliated providers are entitled to regular Medicare benefits only	29	23	49
Letter of authorization from HMO is required before availment of hospital benefits	19	23	58
SSS/GSIS continues to collect Medicare contributions for remittance to HMOs	35	22	43
Claims are paid directly by HMOs, not SSS/GSIS	21	17	62
Cost of services utilized will be paid only up to limit/coverage specified	33	27	40
Legal dependents are covered under the tie-up	35	27	38
Membership in the tie-up is voluntary	43	20	37

Source: Survey data

wage level, indicating that the HMOs were not favoring the higher-income group. But there seemed to be more members from the manufacturing and service sectors and from larger firms, perhaps because of the HMOs' marketing strategy and not necessarily because of restrictive recruitment. The HMOs' agents generally found it easier to recruit members in larger companies, which were more inclined to offer health benefits to their employees.

- **Uninformed members.** A survey of 185 tie-up members disclosed that the members had a general idea of their benefits but were poorly informed about how to use them (Table 7). Consequently, many did not avail themselves of the benefits due them when seeking medical treatment. Also, because the members were unfamiliar with requirements like the letter of authorization and with the use of affiliated providers, the HMOs were not very successful in implementing managed-care practices such as gatekeeping and case management.

- The lack of adequate information was likewise evident in the number of claims filed with SSS and GSIS instead of the HMOs, delaying reimbursements to members and increasing the administrative tasks and costs of SSS and GSIS, which had to reroute the claims.

- **Limited access to service providers.** Tie-up members had a limited choice of hospitals for their in-patient needs, as apparent from an evaluation of the affiliated provider network of the two HMOs. In the NCR, only 31 hospitals were affiliated with the HMOs. Member-to-bed ratio, however, was quite respectable, although physicians were few in relation to the number of members to be served. The small number of accredited clinics also restricted members' access to out-patient care (Table 8).

- **Low financial coverage.** On the average, the regular Medicare program paid out a higher amount to its members than the tie-up. Higher actual costs of treatment, especially in affiliated providers, put the tie-up members at a further disadvantage.

- **HMO operating problems.** Poor coordination with SSS and GSIS drained the operating efficiency of HealthKard

Table 8. **Evaluation of Affiliated Provider Network of HMOs in Tie-Up**

	Member-to-Bed Ratio	Member-to-Physician Ratio	No. of Clinics (NCR)
Regular Medicare	95:1		
Total Tie-Up	21:1	311:1	21
HealthKard	17:1	176:1	12
Pamana	18:1	419:1	9

Source: List of Affiliated Providers

and Pamana. Cash-strapped as a result of the delayed remittance of premium contributions, the HMOs had to dip into their other programs to subsidize tie-up operations. Slow membership verification and transmittal of misrouted claims caused corresponding delays in payment of benefits, straining the relationship of the HMOs with providers and members.

But these operating problems did not keep the tie-up from being very profitable for HealthKard and Pamana. Operating margins, from a cash as well as an accrual standpoint, exceeded those of the two HMOs' regular programs as well as the operating margins of other HMOs.

This high profitability can be traced to low use of funds (for every peso of premium contribution, Pamana paid out only ₱0.36 in benefits and HealthKard ₱0.25) and low program utilization (availment of both in-patient and out-patient benefits was considerably lower than under the regular Medicare program).

- **Generally satisfied members and providers.** A survey of 149 members nevertheless showed satisfaction with the hospitalization benefits and even higher satisfaction with out-patient benefits. They generally preferred the benefits and provider services under the tie-up to those available under the regular Medicare program, but they found the Medicare rules and procedures easier to comply with.

  Affiliated providers, too, said they were satisfied with the tie-up, despite the operating problems. They wanted the tie-up to continue because of the higher financial coverage available to members and the HMOs' tighter control of unnecessary treatment costs through gatekeeping and case management.

- **Higher operating costs and lost income for SSS and GSIS.** Having to verify membership in the tie-up and to segregate tie-up claims from regular Medicare claims caused SSS' and GSIS' operating costs to spiral. To cope with the added administrative requirements, SSS and GSIS had to allocate or hire personnel, purchase additional supplies and materials, and acquire or allocate computer equipment and other fixed assets. These meant an estimated ₱612,000 in additional operating costs for GSIS and ₱1.36 million for SSS, from 1989 to March 1992. The tie-up processes also disrupted and delayed their normal operations.

  Moreover, because the contributions of tie-up members had to be remitted to the HMOs, the surplus of these contributions over benefit payments could not be invested. SSS would have earned around ₱1 million in interest and investment income between January 1989 and December 1991. GSIS, on the other hand, given its funds utilization history, would not have had any surplus funds for investment.

  Still, both SSS and GSIS benefitted from the tie-up. The costs they incurred were partly made up for by the share of tie-up members' contributions which they retained. This share was pegged initially at 3% of premium contributions but was later increased to 34%.

  Savings were also generated by shifting the potential costs of the members' benefit claims to their respective HMOs. SSS transferred around ₱22.6 million of potential claims expenses to the HMOs; GSIS, an estimated ₱12.9 million.

LESSONS LEARNED

After three and one-half years of existence, the PMCC-HMO Tie-Up Project was discontinued by the PMCC board in July 1992. While the project was still considered sound in principle, its structure was deemed seriously impaired by the administrative shortcomings of SSS, GSIS, and the participating HMOs. Furthermore, it could not consistently provide its members with better financial coverage than the regular Medicare program.

The PMCC should, however continue with this type of experiment. Rising demand for health care, which is becoming more costly, plus the growing inability of the government to deliver or finance health care services, makes imperative the search for similar experiments. In the future, PMCC can be guided by the lessons learned from this initial effort.

ALIGNMENT OF PUBLIC- AND PRIVATE-SECTOR OBJECTIVES

The PMCC and the systems saw the tie-up as raising Medicare benefits without appreciably adding to costs. The two participating HMOs, on the other hand, regarded viability as their objective. The expectations, commitment, and subsequent actions of the HMOs and the systems could have been conditioned by this divergence of aims. No well-defined, measurable, and acceptable evaluation criteria guided the project. Future projects should recognize and reconcile the objectives of all participants.

PROJECT PLANNING AND ADMINISTRATION

The evaluation of the tie-up uncovered planning and administrative flaws which better-defined project terms could have corrected. These terms can include, among others:

- Penalties for noncompliance with the rules by participating HMOs;
- Provision for renegotiation of rates to reflect any risk selection biases;
- Sharing of HMO profits beyond a predetermined level;
- Stop-loss reinsurance to protect HMOs in case of medical expenses above a certain limit;
- Formal grievance procedure; and
- Clearer marketing guidelines for participating HMOs.

PROJECT ADMINISTRATION

PMCC was responsible for administering the tie-up, yet it did not have authority over the HMOs, SSS, and GSIS. For example, although the systems had agreed to verify membership and remit premiums more quickly, HMO receivables remained high. The PMCC had limited power to compel the two HMOs to carry out a more sustained and thorough information campaign. For future projects, the role and authority of the PMCC should be strengthened. Only then can there be greater commitment among the project participants to deal satisfactorily with administrative, legal, and procedural constraints.

PROGRAM II: WIDER COVERAGE THROUGH PARTNERSHIPS WITH LGUs AND SERVICE PROVIDERS

BACKGROUND

In 1983, the Medicare program was expanded to provide compulsory coverage to the self-employed. Still, large segments of the population, particularly the poorer occupational groups and the unemployed, could not afford the Program I premiums without any health insurance coverage. Pilot projects for these segments were launched by the PMCC, in the knowledge that it was expected to gradually provide total medical service by adopting and implementing a comprehensive and coordinated medical care plan.

OBJECTIVE AND DESCRIPTION

PMCC's Program II pilot projects are supposed to expand Medicare coverage to include the low-income self-employed and nonmembers of Program I. Program I members may also participate provided they claim Program II benefits only after they have availed of Program I benefits. Benefit packages and contributions vary among the pilot sites and are based on the economic capability of the target market. All contributions and accruals are kept in the Medicare Community Health Fund, from which all benefit payments and allowable operating expenses are drawn.

The pilot project is built on a three-way partnership. The local government unit facilitates the recruitment of members, administers the collection and disbursement of funds, disseminates information, and supports the operations of the Program II office. The DOH provides out-patient and in-patient services through Medicare community hospitals and private service providers contracted by the PMCC. The PMCC, for its part, sets policies, rules, and regulations in coordination with the local government unit and the service providers, monitors and evaluates the status of the project and compliance by all parties with the rules and regulations, and provides technical support in keeping the projects financially viable and in disseminating information.

The Program II pilot projects are managed by the PMCC's program development service. Its planning, research, and development division takes charge of promotion and implementation, while the evaluation and statistics division is responsible for monitoring and evaluation. Program II also has a basic package of benefits, an implementation process for bringing it into a community and setting it up, a prototype memorandum of agreement between PMCC and the local government unit, a manual of operations, and an information manual.

PILOT SITES AND EXPERIENCE

The PMCC launched a Program II pilot project in Bauan, Batangas, in 1983; in Nueva Valencia, Guimaras, in 1985; and in Majayjay, Laguna, in 1992. Among the provinces, Quezon has the most pilot projects: Unisan, started in 1983, and Agdangan and Padre Burgos, started in 1992. Six other municipalities in Quezon have expressed their interest to participate in the program. To date, the pilot projects cover fewer than 5,000 active members and beneficiaries, have paid out claims with an average value paid per claim ranging from ₱115.13 to ₱375.85, and provide an average support value ranging from 46% to 86%.

Statistics from the PMCC, presented in Table 9 on the next page, give an idea of the scope of its Program II activities.

Bauan, Batangas, the site of the first pilot project, had an active coverage of 971 (255 members and 716 dependents) at the end of 1991. Funds utilization is relatively low at 38% of total collections, but among the pilot projects, the Bauan project provided the highest average value paid per claim as well as the highest support value.

The first pilot project in Quezon was set up in 1984 in Unisan. In that municipality, health services are provided by the Unisan Medicare Community Hospital and Clinica Tolentino, a private provider. Income problems among the members depressed coverage from a high of 6,399 to 2,508 (627 members and 1,881 dependents) in 1992. Funds utilization has been quite high. Of the total collection of about ₱183,000, around 78% has been spent for benefit payments and operating expenses. In 1992, total disbursements exceeded premium collections; average support value for the year went up to 51% from a project average of 46%. The Unisan project was expanded in 1992 to include its neighboring municipalities: Agdangan (196 members and dependents), Padre Burgos (278 members and dependents), and, most recently, Sampaloc.

A pilot project was launched in Nueva Valencia, Guimaras, in 1985. By 1991, active coverage had dropped to 1,865 (411 members and 1,454 dependents). Funds utilization was 59% of total collections. The project paid an average of ₱175 per claim and had an average support value of 80%.

No statistics are available as yet for the pilot project launched in Majayjay, Laguna.

Table 9. **Medicare II Activities**

	QUEZON			BATANGAS	GUIMARAS ISLAND
	UNISAN	AGDANGAN	PADRE BURGOS	BAUAN	NUEVA VALENCIA
	1992	1992	1992	1991	1991
TOTAL COLLECTION (Pesos)	183,195	2,940	16,680	205,908	55,976
Premium Collection	170,510	2,940	16,680	168,845	45,550
Interest Income	12,685			37,064	10,426
TOTAL DISBURSEMENT (Pesos)	143,456			77,516	532,986
Benefit Payment					32,201
Operating Expenses					785
CUMULATIVE COVERAGE	6,399	196		5,159	2,754
Member	1,796	49		1,123	641
Dependent	4,603	147		4,036	2,113
ACTIVE COVERAGE	2,508	196	278	971	1,865
Member	627	49		255	411
Dependent	1,881	147		716	1,454
BENEFICIARIES SERVED	1,344	2	2	494	204
Member	405	2	2	184	67
Dependent	939			310	137
NO. OF CLAIMS PAID	1,246				
AVE. VALUE PAID/CLAIM (Pesos)	115.13			375.85	175.30
SUPPORT VALUE (%)	46			86	80
YEAR BEGUN	1984	1992	1992	1983	1985

Source: PMCC

FROM PILOT TO PROVINCIAL

The slow growth of the Program II pilot projects of PMCC is not due to lack of interest on the part of potential participants but primarily to the limited resources that PMCC can devote to them and to the limited capacity to pay of target beneficiaries. Even so, a recent study made by the Development Academy of the Philippines urged the PMCC to take the lead in projects of this type if it wants to decentralize the Medicare system and make it more broad-based. Already, questions are being raised by prospective participants; the answers should lead to stronger, better-designed projects.

The questions involve sustainability, financial management, choice of benefit package, access to more providers, use of managed care principles, role of local health officials, and subsidy of indigents, among others. These questions remain unanswered, but recent bills submitted to the House of Representatives and the Senate are calling for nationwide implementation of Program II.

The experience of the existing pilot projects of the PMCC must be culled to determine the areas that the PMCC should study further so it can develop more informed legislative proposals. A preliminary list of these areas follows. They may seem daunting on a national, or even a provincial, scale, yet even the meager PMCC initiatives have already begun providing partial answers.

- **Appropriate scale.** For its existing Program II projects, the PMCC is trying to decide how many members and how much in premium contributions will ensure fund stability and sustainability. The entry point for projects was always the municipality; now, the province is regarded as the more suitable unit. Working with a province guarantees stronger political will among both provincial and municipality officials; offers a wider provider network, from both public and private sectors; and, more importantly, generates a larger, more actuarially sound fund with which to run the project, pay for benefits, and deal with equity issues through cross-subsidy.

  To determine the right scale, the PMCC will also have to determine more precisely how much it costs to set up and run a Program II project. The cost of the pilot projects has not yet been established since many inputs from both national (DOH and PMCC) and local governments have not been costed. These costs should be tracked and captured more accurately so that economies of scale can be assessed and more viable decisions can be reached.

- **Appropriate scope.** Each existing Program II pilot project offers only one benefit package designed with the help of local government unit officials, representative beneficiaries, and provider partners. The package is usually very basic, relies on public providers, and pays mostly for drugs and medicine. Program II can attract beneficiary markets and achieve wider coverage only if it offers alternative benefit packages to suit differences in capacity and willingness to pay, provider preference, and health-seeking behavior. Program II packages can easily break out of the Program I mold by offering innovations such as out-patient benefits, managed care, and capitation payment schemes.

- **Appropriate standards.** Program II planners should bear in mind how the system of provider incentives and disincentives of Program I is shaping the health care delivery system of the

country. In the same manner, Program II can use financing to encourage cost containment, correct use of health care facilities, proper treatment procedures, and rational health-seeking behavior.

- **Appropriate structure.** To increase and grow, Program II projects must have the necessary support structures and systems. While Program I rests on the organization of SSS and GSIS, the organization for Program II has to be worked out with the host local government unit and the provider network. The duties and expectations of Program II participants, including the PMCC, must be managed to preserve members' rights and benefits. The authority of the PMCC to administer Program II projects must be reevaluated and strengthened. As of now, the PMCC cannot enforce policies and regulations or penalize non-compliance. It also needs supporting manpower and management systems, at its central and field offices and in the local government unit and the providers.

SUMMARY OF MEDICARE CONCERNS

INTRODUCTION

Several recurring issues in the preceding sections of this paper appear to warrant further consideration. They are discussed briefly in this section of the paper.

PROGRAM I ISSUES FOR FURTHER STUDY

These Medicare Program I issues may warrant further consideration:

POPULATION COVERAGE

Current coverage is scanty and uneven. Not all the unemployed and only a few self-employed are covered. Besides, those living in the rural areas, even if covered under Program I or Program II, do not have access to the same quality and quantity of medical services as those living in major towns and cities (Beringuela 1993, Gonzales 1992). Accessibility also varies within major cities.

ENROLMENT OF FIRMS AND EMPLOYEES IN PROGRAM I

Although larger employers are probably enrolled, it appears that Program I has not fulfilled its mandate of enrolling all the firms and employees in the formal wage and salary sector, which is important for risk pooling. Available funds, along with additional subsidy assistance from the government, must be consolidated to provide for cross-subsidy for the low-income self-employed and the unemployed.

FRAUD AND ABUSE BY PROVIDERS AND CONSUMERS

The PMCC may not be unaware of instances of fraud and abuse, but it lacks the technical manpower and the authority to enforce its rules (Gonzales 1992).

MEDICARE CLAIMS PROCESSING

There have been complaints that it sometimes takes as long as six months for the SSS and the GSIS to process claims. While these assertions need to be validated, the number of complaints suggests that the claims turnaround time can and should be shortened.

ABILITY TO PAY

The Philippines has an annual per capita GNP of about US$800. The distribution of income is, however, lopsided in favor of those living in urban areas. In the urban areas, too, there is a great disparity in the distribution of income, which is aggravated by the large numbers of unemployed and marginally employed people (street hawkers, vendors, etc.). Recent studies show that between 40% and 50% of the population live below the official poverty line, depending on the current definition, so even modest premiums may be onerous.

CONTRIBUTION AND BENEFIT STRUCTURES

When Medicare beneficiaries are grouped according to income, the resulting rate structure shows the poorer groups subsidizing the wealthier ones. This seems to be particularly true in the case of the second lower income quartile (Beringuela 1993).

For national insurance programs to have the best chance of remaining solvent while still offering a reasonable package of benefits even at a comparatively low level of development, cross-subsidy is essential. The Medicare contribution structure is "regressive" (Beringuela 1993). "Cutting off" contributions at arbitrary levels, such as ₱2,500 (or even ₱3,000), deprives the Medicare program of funds that it could use to pay for benefits for the poor and the unemployed. It may therefore be necessary to examine the present salary contribution base, as well as projected increases, to find ways of maximizing opportunities for cross-subsidy.

SUPPORT LEVELS

The benefit structure was originally targeted to cover 70% of the cost of eligible services but now covers only about 50%, despite being revised upward several times.

There is reason to be cautious about reimbursing on the basis of reported fees and charges (or prices), since providers are prone to adjust their fees and charges upward after every increase in the composite support ceiling. Also, the experience of other countries like the U.S.A. offers substantial evidence to warrant misgivings about the ability of Medicare to achieve any support value target, in the absence of other measures.

LEVELS OF RESERVES

The system does not seem to have a uniform policy or strategy of reserve targeting and accumulation. The GSIS and the SSS differ significantly in their forward reserve levels and investment strategies

(Gonzales 1992), conceivably affecting their contribution collection efforts and claims processing policies and procedures. Low contributions coupled with lack of vigor in ensuring the validity of claims before they are paid eventually result in high benefit payments relative to collections and, consequently, a low rate of reserve accumulation.

IMPLICIT INCENTIVES INCORPORATED INTO THE MEDICARE BENEFIT STRUCTURE

It is generally recognized that health financing schemes must include incentives and disincentives which, over time, will improve the health service delivery system. The fact that Program I is limited to covering in-patient services in the short and the long term may encourage the overutilization of hospitals and the underutilization of out-patient clients and services, which are less expensive health service delivery sites when it comes to the treatment of ordinary illnesses (Gamboa 1991, Griffin *et al.* 1985, Jeffers 1990). Expanded out-patient services, if done on a fee-for-service basis, will mean more claims processing. The forthcoming experiment with fee-for-service, along with capitation provider payment, will shed light on this matter.

EFFECTIVE USE OF THE PRIVATE SECTOR AND PROPER DIVISION OF RISKS AND COSTS BETWEEN THE PUBLIC AND PRIVATE SECTORS

The tie-up experiment between the PMCC and HMOs had results that were deemed unsatisfactory, but many people still look to HMOs to strengthen health delivery and financing and make them more equitable. An additional concern is how to tap the resources of the private sector, including insurance companies, cooperatives, NGOs, and local communities.

RECENT PMCC POLICY INITIATIVES

Recent initiatives of the PMCC board have already dealt with many of the matters listed above. The initiatives include improvements in claims processing, studies on ways of ensuring greater compliance by firms and individuals, the possibility of consolidated program administration, revisions of the relative unit values scales on which provider reimbursements are based, and a large demonstration project involving expansion of out-patient benefits under fee-for-service and capitation provider payment schemes.

These are bold and important steps toward expanding Medicare as a major financing institution, as well as improving its capacity to fulfill its legal mandate. One matter still to be dealt with is the launching of Program II more systematically and on a larger scale than at present. As outlined in the previous section of this paper, Program II initiatives revolve around individual communities, whose large number constitutes a particular challenge to the program.

In conclusion, this paper goes over some major points that may be pertinent to developing a strategy for the expansion of Medicare Program II.

POINTS TO CONSIDER IN EXPANDING PROGRAM II

The factors that are crucial in defining a suitable strategy for the expansion of Program II are those set out at the start of this paper and used in reviewing the health financing experience of several countries. These essential criteria can be applied to the development of health financing program strategies in general, and are therefore helpful in categorizing matters that must be considered when expanding Program II.

The factors are as follows:

- Benefit entitlement (who receives what),
- Revenue bases and methods of payment (who pays and how much),
- Role of the private and public sectors in financing and delivery (who delivers what goods and services and who pays what share),
- Cost containment and quality maintenance (how cost increases are controlled and the quality of services kept at an acceptable level), and
- Intersectoral relationships (who should coordinate health care delivery across government and private-sector lines).

BENEFIT ENTITLEMENT

This category is concerned with the level of benefits to be offered. The benefits can range from the entire set of in-patient services now offered under Medicare Program I, to very minimal benefits such as payment for drugs and medicines, or something in between. Something in between could be payment for first-line primary health care services (including preventive and promotive health measures) and a package of well-defined out-patient services (acute curative medical interventions by barangay health workers, hospital out-patient departments, or private clinics). Obviously the decision as to the level of benefits that can be offered depends in part on cost, viability of Medicare program funds, and administrative feasibility.

REVENUE BASIS

The issue here is how to collect revenues from persons in the informal sector, particularly fishermen and farmers, and how much of the total cost of services beneficiaries should bear, considering the possibility of subsidizing the costs that they cannot afford. The subsidies could be paid by the government at the point of delivery or the subsidies could be paid from a central, regional, provincial, or community Medicare fund.

It may be worth considering beneficiary contributions in kind (produce or livestock)

as an alternative to cash contributions. Contributions in kind involve administrative problems of distribution and monetization. Agricultural cooperatives, fishermen's groups, and other associations are some organizations that may be able to handle these matters satisfactorily.

DELIVERY AND FINANCING BY PRIVATE AND PUBLIC SECTORS

The functions of public- and private-sector providers and financing agencies have already been touched on. Perhaps the most important issue in this regard is who provides the package of services which constitute the program benefits—public- or private-sector providers or both—and on what terms.

COST CONTAINMENT AND QUALITY MAINTENANCE

It may be well to consider the effects of devolution on the development of Program II, as well as any changes that may affect quality maintenance and cost containment under Program I. Quality and cost are very closely related. Efforts to contain costs may lower the quality of services provided.

Before devolution, the PMCC could rely on provincial health offices to assist in accrediting program participants and investigating claims of abuse. Since then, the PMCC has had to deal individually with hundreds of provincial and municipal governments which are responsible for hospitals (Gonzales 1992). In the case of community-based service delivery which comes with devolution, the matter of how the PMCC and the DOH can maintain quality, monitor costs, and screen out fraud and abuse is of considerable importance.

INTERSECTORAL RELATIONSHIPS

It is also important to decide how Program II will be structurally organized and administered. Should the PMCC guidelines and models be followed, or should there be separate guidelines? Should such guidelines be issued to regions, provinces, etc.? Should funds be administered centrally, regionally, provincially, or at the community level? Who or which agency should coordinate matters, and at what level of government should coordination occur?

CONCLUDING REMARKS

The discussions in the preceding sections indicate that the Medicare program has undoubtedly played a very significant role in the financing of health services in the country. The challenge now faced by Medicare is how to improve Program I and implement Program II on a much broader scale.

In measuring up to this test, Medicare is faced with many difficult issues and concerns that this paper has sought to help identify. Addressing those issues may require basic research, analysis, and pilot-testing. It is recognized that it is not always possible to have all the answers to all the questions. But because of the far-reaching influence of Medicare in health resource allocation and consumption, and on the behavior of beneficiaries and providers, there is a compelling need to have some basic awareness of the implications of policy decisions made by Medicare.

The government can ill afford to raise the expectations of the people regarding health benefits; once given, health benefits are politically difficult to take back. The current dilemma of the United States in reforming its Medicare and Medicaid programs vividly illustrates this point.

The Philippines can review and learn from, instead of blindly emulating, the health financing experience of other countries. As has been emphasized throughout this paper, the Philippines has to develop its own health financing scheme based on its peculiar historical, cultural, sociopolitical, and economic situation.

The recent moves of the PMCC and the DOH to confront and study systematically the difficult Medicare issues are very encouraging. The strategic planning workshop is a testimony to the determination to develop a truly responsive and sustainable Medicare program. And the links being forged with Congress and other private-sector stakeholders in tackling Medicare issues augur well for a common vision of the role of Medicare in the health care financing system of the country.

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ANNEX

HEALTH POLICY INITIATIVES IN SELECTED COUNTRIES

	Benefit Entitlement	Revenue Base	Public vs. Private	Cost Containment	Intersectoral Coordination
United Kingdom	Universal in NHS, with long waiting lists, over 800,000 in 1989	About 92% of NHS is government-funded	90% public and 10% private provision	Few formal mechanisms other than physician capitation and cash limiting, with plans to privatize significant parts of NHS	Few formal mechanisms other than meetings, as necessary
Singapore	Universal through Medisave, at public and certified private facilities	Tax on wage and salaries, self-employed income	Dominantly public system in terms of in-patient care, although Singapore GH is being corporatized	Second opinion on surgery and good referral system	Good coordination
U.S.A.	30% coverage, uneven, through Medicare and Medicaid government programs, bulk of people covered by NHI	Medicare funded through tax on wages and salaries and self-employed income, while Medicare is funded by general revenues of federal and state governments. Co-payments are significant.	Dominantly a private-sector provider system, hospitals supposedly nonprofit, doctors dominantly attempt to maximize income	DRGs, certificate of need, HMOs, customary fees, second opinions on surgery	Poor coordination and little cooperation for common good because financing and provision are left to unregulated market forces
Australia	Universal coverage through Medicare, drugs covered under separate program	Medicare funded through dominant contribution of Commonwealth and state government tax revenues. NHI carried but provides limited coverage.	Dominantly public sector but public hospitals can admit private patients	Medical services tariff set by government, which often is protested by doctors and other health professionals resulting in frequent strikes	Few formal attempts at coordination among states and between Commonwealth and state governments
Rep. of S. Korea	Universal coverage achieved with NHI programs launched 1976-79	Percentage assessments of wages and salaries shared by employers and employees, and on earnings of self-employed. User fees are 20/30% for hospital admissions.	Dominantly private providers, especially in cities. Doctors drafted into military service and required to serve in rural areas	Utilization review mechanisms just being computerized, government sets fee and charge tariff in consultation with medical society	Tremendous problems, since little coordination among government agencies and NHI is administered by about 300 different regional societies
Netherlands	Sickness fund for low- to moderate-income earners who upon receiving higher incomes must enrol in highly regulated NHI	Percentage assessments on incomes of sickness fund beneficiaries	About 92% of medical services are supplied by private providers, and 97% of financing done by private insurers	Very heavy regulation of fees, construction, acquisition of equipment, number of procedures, and hospital admissions	Good coordination through a wide variety of chambers and advisory councils
Malaysia	Currently public health services delivery system offering universal entitlement, but considering universal NHI program and corporatizing elements of public system maintaining universal coverage	Currently about 75% funded from public revenues	Public sector supplies around 85% of services, yet over 50% of doctors are in private medical sector. Doctors must choose between public and private medical practice.	Cost containment in public sector good through cash-limiting budgetary procedures. Almost no cost containment measures in private medical sector.	Little coordination and control in government sector beyond influence of MOH. Little or no coordination between public and private medical sectors, but private sector may be invited to participate in development of next five-year plan