Health Policy Notes

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"Improving PhilHealth Benefits and Provider Relations: Leaping Forward in 2009 and Beyond"

Mandate

It is the declared policy of the State to "adopt an integrated and comprehensive approach to health development which shall endeavour to make essential goods, health and other social services available to all people at affordable cost" (Article XIII, Constitution of the Republic of the Philippines). This is the same principle by which the National Health Insurance Program under Republic Act 7875 (as amended) was established with the Philippine Health Insurance Corporation (PhilHealth) as implementer.

PhilHealth's mandate is to continually evolve a progressive benefit package pursuant to the principles of Social Health Insurance particularly on increasing the financial protection of members in times of illness. The product of PhilHealth is an investment for good health thru a combination of provision of benefit packages and the manner by which the accredited health care providers deliver these benefits to intended beneficiaries. Such product must respond to the health needs of the entire client base as well as the wide range of financial and resource capability of the stakeholders such as the employers, LGUs, Legislators, premium donors and National Government Agencies (NGAs).

In a bigger context, NHIP benefits should be able to influence benefit delivery at the local and national level by using benefit spending to leverage effective quality care, influence the desired national health outcomes and significantly make a difference in the lives of all Filipinos, especially the marginalized through the development of pro-poor benefit packages.

Evolution of NHIP Benefits

Benefit payment mechanism provided by PhilHealth is mostly based on a fee-for-service scheme whereby health care providers are paid for every unit of service rendered. Since the turn-over of operations from SSS, and GSIS in 1995, the NHIP benefit package has progressively expanded to meet the needs of its varied members within the context of equity, social solidarity and sustainability. We note for example, the following milestones:

- 1996: 50% increases in benefit packages for SSS, 25% for GSIS, 50% for OWWA was effected in December 22, 1996.
- 1999: Implemented a 50% increase in benefit ceilings both for private and government sector and 73% increase for the indigent members. In December of the same year, PhilHealth started to implement a unified benefit package for all PhilHealth members.
- 2000: Out-Patient Benefit Package (OPB) paid through capitation was initially provided to indigent members in Laguna and Pasay and later on to the rest of the country.
- 2002: Increase in ceilings of certain benefit items by as much as 34% for drugs and medicines and 45% for X-ray and laboratory.
- 2003: Increase in benefits for Room and Board across hospital category. Launched TB DOTS, Maternity, SARS and Dialysis packages.
- 2004: Launched the Quality Improvement Development Studies (QIDs).
- 2005: Assumed the OWWA Medicare functions and has maintained the benefit package enjoyed by our Filipino overseas workers;
- 2006: Implemented the New Born Care Package (NCP); PhilHealth also started coverage for preoperative tests performed in planned (elective) surgery;
- 2007: Carried out the revised benefit schedule with the following new characteristics: (1) revised case-typing system listed as Case-types A, B, C and D; (2) Unified Benefit Schedule for all PhilHealth member categories including Overseas Worker Members and (3) General Rule of fixed case-typing to facilitate transparency and responsiveness.
- 2008: Started the following packages: Outpatient Malaria Package and Voluntary Surgical Contraception Procedures.
- 2009: PhilHealth implemented the expanded coverage of PhilHealth Normal Spontaneous Delivery and Maternity Care Package, tiered payment of professional fees (higher professional fees for specialists), coverage of P100 drugs for take home medication of sponsored members and dependents, Revised Case Type Classification, Cataract Package, and, Revised Value Scale.

The new PhilHealth inpatient benefit schedule, that replaces the 2002 benefit table, was implemented on April 5, 2009. The new benefit is basically similar to the old system wherein benefits are defined by a table of expenditure caps; and the benefit ceiling depends on the severity of patients' condition (Case type A, B, C or D) and the type of facility where the service is provided (Primary or Level 1, Secondary or Level 2, and, Tertiary or Level 3 & 4 hospital).

For example, the maximum benefit for drugs in a case type A admitted in primary hospital is set at 2,700 pesos while the ceiling for a case type D in a tertiary hospital is 40,000 pesos *(see Table 1)*.

Table 1. Maximum Benefit for Drugs

Benefit Items	Primary Hospital	Secondary Hospital	Tertiary Hospital
Case Type A (Simple)	2,700 pesos	3,360 pesos	4,200 pesos
Case Type B (Moderate)	9,000 pesos	11,200 pesos	14,200 pesos
Case Type C (Severe)	9,000 pesos	22,400 pesos	28,000 pesos
Case Type D (Extreme)	9,000 pesos	22,400 pesos	40,000 pesos

There has been a substantial increase in benefits payments through the years from 6.8 Billion in 2000 to 18.2 Billion in 2008. Drugs and medicines comprise about 31% of the total amount paid while 21% went to payment of professional fees. (See Figure 1 and 2)

Figure 1: Benefit Payment by Item Distribution

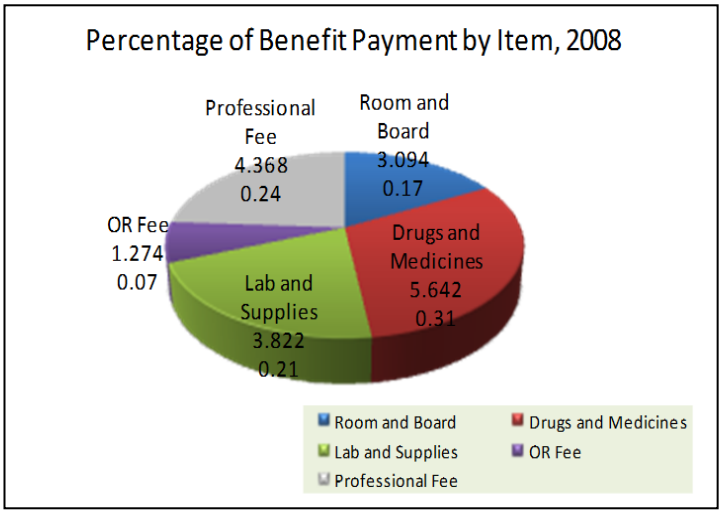
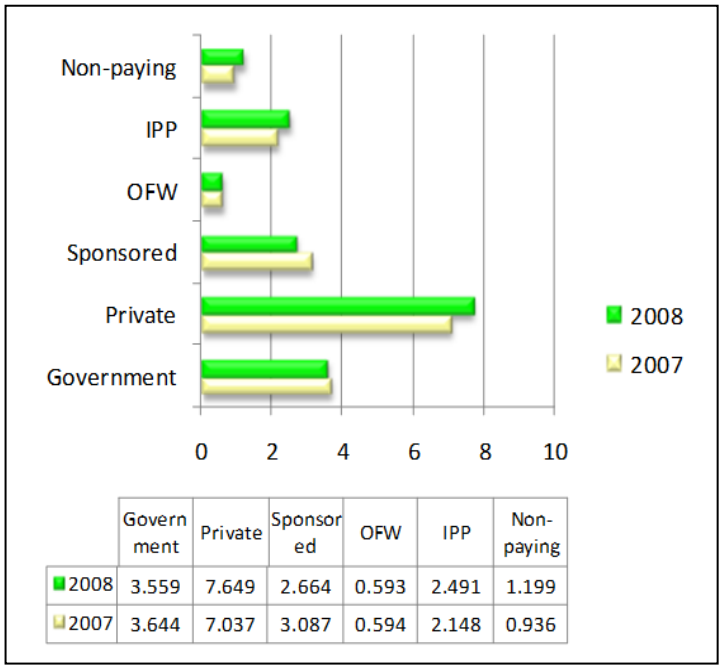


Figure 2: Benefits Payment by Sector



	Government	Private	Sponsored	OFW	IPP	Non-paying
2008	3.559	7.649	2.664	0.593	2.491	1.199
2007	3.644	7.037	3.087	0.594	2.148	0.936

THE CHALLENGES

A. Benefit Delivery

Despite the accelerated enhancements and development of NHIP benefits including systems (database) integration to facilitate reimbursement, a lot of hard work needs to be done to address the gaps in the way the NHIP benefits are managed, availed and delivered. PhilHealth has identified the following issues where policy interventions are desired:

- Low member awareness on PhilHealth benefits
- Low support value for catastrophic cases; high out-of-pocket expenditures
- Non-availability of drugs and medicines in government hospitals
- Obstacles to claims processing (erroneous ICD-10 codes, documentary deficiencies, signature verification)
- Long turn-around time for claims processing
- Provider uncertainty to receive full reimbursement of benefits leading to under deduction of benefits due to members
- Fraudulent claims and supplier-induced demand
- Adverse selection (e.g., self-employed/Individually Paying members on pregnancy-related benefits), and;
- Predominantly in-patient benefit coverage

B. Financial Protection

It is expected that the aggregate effect of the new benefit schedule will increase PhilHealth payment by 35%. Under the new inpatient benefit package, allowances for drugs and medicines grew more than double as in the case of diseases classified as moderate conditions (Case Type B) in Level 1 hospitals where an increase of about 260% is demonstrated – from 2,500 pesos to 9,500 pesos per single period of confinement.

While benefits have remarkably increased, one major concern is the tendency of some institutional and professional health care providers to likewise increase hospital charges which deprive the members of or reduce the financial protection intended for the members. A study by Gertler and Solon about social insurance in the Philippines published in 2002 showed that in private hospitals the average total hospitalization cost is 40 percent higher for PhilHealth members as compared to non-members, but the patients' share of payments are almost equal for the same quantity of services. Their study suggests that unregulated private providers increase their prices to actually gain from PhilHealth reimbursement without necessarily resulting to increased financial protection of members. (Gertler and Solon 2002)

Reimbursement of PhilHealth is mainly through the fee-for-service scheme – a provider charges separately for each service rendered. Payment increases if more services (e.g., over prescription of drugs) are given or a more expensive service is substituted for a less expensive one (e.g., caesarean section over normal delivery). Under this scheme, there is a financial incentive for providers to increase income by increasing the volume and intensity of care.

The policy of reimbursing expenses up to a ceiling limits financial risk for the Corporation. But this first-peso coverage policy combined with unregulated providers' fees resulted to substantial patients' out-of-pocket payment for catastrophic medical conditions. Members end up paying the charges above the benefit package thereby reducing the significance of the National Health Insurance Program.

Table 2. 2004 Survey on Support Value of PhilHealth Benefits, 2005

	All Charges	Hospital	Professional Fee
Public	87.92	87.11	94.61
Private	53.43	58.11	48.7
All hospitals	62.04	65.36	60.8

Under RA 9502 or the Universally Accessible Cheaper and Quality Medicines Act of 2008, PhilHealth is tasked to limit reimbursement of drugs based on a fixed reference price. This provision was appended to reduce, if not to eliminate, out-of-pocket expenses of members of the National Health Insurance Program. Reimbursement shall only be made for drugs and medicines within the allowable mark-up price.

During the pilot testing of the drug price reference index in 2005 using 849 claims, a decrease of up to 7% in benefits for drugs was demonstrated if PhilHealth limits reimbursement of individual drugs (See Table 3). Reference pricing for drugs is based on Section 48 of the revised IRR - "Reimbursement Limits for Drugs and Medicines - The Board shall provide for a process to determine the price index of drugs and medicines included in the PNDF and reimbursable by the Corporation. Based on the indices, the Board may from time to time set the allowable percentage mark-up in the prices of drugs and medicines charged by health care providers on members. Reimbursement shall only be made for drugs and medicines within the allowable mark-up price."

Table 3. Summary of the Change in total Amount of Benefit for Drugs and Medicines Computed With and Without DPRI; 2005

PhilHealth Regional Office	Total Benefit for Drugs Without DPRI (Mean)	Total Benefit for Drugs With DPRI (Mean)	Change in Amount of Total Benefit for Drugs (Mean)	Percent Change in Amount
II	Php 359,874 (Php 1,207)	Php 335,074 (Php 1,124)	Php 24,798 (Php 83)	**6.89%**
VIII	Php 555,416 (Php 993)	Php 541,132 (Php 1,798)	Php 40,647 (135)	**7.32%**
IX	Php 249,136 (Php 993)	Php 232,359 (Php 925)	Php 17,218 (Php 69)	**6.91%**
Total	Php 1,164,427 (Php 1,367)	Php 1,108,566 (Php	Php 82,664 (Php 97)	**7.10%**

This could be taken as a possible 7% savings for PhilHealth but a concomitant 7% increase in out-of-pocket expenses by members since PhilHealth limits only the amount reimbursed and there is no limit on the actual price of the drug preparation or a limit on members' out-of-pocket payment.

Another problem is the unregulated professional fees of doctors. Although PhilHealth limits payment of professional fees, physicians can freely charge patients the amount in excess of the PhilHealth ceiling for professional fee. Therefore, members pay for any increased volume or an inflated professional fee.

C. Benefit Overlap

Section 1 of the revised Implementing Rules and Regulations of RA 7875 as amended by RA 9241 states that "Public Health Services – The Government shall be responsible for providing public health services for all groups such as women, children, indigenous people, displaced communities and communities in environmentally endangered areas, while the NHIP shall focus on the provision of personal health services. Preventive and promotive health services are essential for reducing the need and spending for personal health services".

In 2003, PhilHealth implemented a benefit for outpatient tuberculosis for Directly Observed Treatment Shortcourse (DOTS). The package is worth 4,000 per case to cover drugs, sputum microscopy, supplies and professional fees. In 2008, total PhilHealth reimbursement for TB-DOTS Package amounted to 17.5 million pesos – 12.5 million paid for claims for intensive phase and 5 million for maintenance phase.

PhilHealth does not prescribe how funds will be utilized but the intent of its benefit payments is to use these to further improve the health services being offered by the DOTS facilities. In order to sustain operations of DOTS facilities, LGUs and private providers are requested to follow the recommended allocation of PhilHealth payments as per Department Circular 104, series of 2004.

Table 4. PPMD recommended allocation of PhilHealth Payments for DOTS

ACTIVITIES	ALLOCATION	RECIPIENT
Referral of TB symptomatics diagnosed as active TB case	P100.00	DOTS Referring Physicians; Barangay Health Worker
Clinical Consultations w/ DOTS Referring Physician	P350/month x 3 months = P1,050.00	DOTS Referring Physician
QA for Sputum Microscopy	P200.00	Provincial or City Health Office QA program
TB Diagnostic Committee	P700.00	TB Diagnostic Committee
Pool for Contingency (drugs)	P1,250.00	RHU/HC/PPMD Unit
Recording and reporting sessions	P200.00	RHU/HC/PPMD Unit
Production of NTP-PPMD forms	P200.00	RHU/HC/PPMD Unit
Advocacy activities	P300.00	RHU/HC/PPMD Unit
	4,000 pesos	

A package for outpatient treatment of malaria, worth Php 600 per case, was also implemented in 2008 to cover management of uncomplicated malaria. The amount also covers drugs, sputum microscopy, supplies and professional fees.

These packages were developed to reduce the need for a more expensive inpatient care for complicated cases of tuberculosis and malaria. This, however, led to an overlap with the public health services functions of DOH.

The major financing source of TB control is the national government through the National Tuberculosis Program (NTP) of the Department of Health. In 2008, TB expenditures summed to P680 million wherein the major allocation was on drug which amount to P439 million. For 2009 TB allocation is P1.3 billion with P730 million allocated for drugs.

NTP BUDGET AND EXPENDITURES	2007	2008	2009
Drugs	128,549,500	439,358,000	730,634,800
Laboratory Supplies	6,717,050	42,067,000	55,109,250
Capacity building	34,437,400	-	124,450,000
Logistics Management	-	14,700,000	78,500,000
Monitoring/Evaluation	-	4,350,000	23,000,000
Advocacy	294,150	14,050,000	30,800,000
Policy Support	-	4,250,000	11,300,000
Research and Development	-	4,200,000	6,000,000
Equipment support	-		81,500,000
Partnerships/Collaboration	-	300,000	1,500,000
General admin/office support	-	4,192,000	59,655,950
TOTAL	235,536,500	680,007,000	1,300,000,000

Source: DOH-NTP records

*2007 figures reflect expenditures while 2008 and 2009 figures represent budget allocation in 2008 and 2009 General Appropriations Act

Section 4 of RA 7875 defines public health services as "services that strengthen preventive and promotive health care through improving conditions in partnership with the community at large." These include control of communicable and non-communicable diseases, health promotion, public information and education, water and sanitation, environmental protection and health-related data collection, surveillance, and outcome monitoring.

CURRENT EFFORTS

A. Survey on Support Value

In order to determine the extent of the financial protection accorded to members, a survey on the support value provided by PhilHealth benefits is conducted. While there is an existing methodology and procedure in place, this is currently being assessed and reviewed for better and more reliable results. A pilot survey was recently conducted to test the revised tool and the result shall be presented to the ExeCom for approval of the methodology and continuation of the survey for nationwide evaluation.

B. Benefit Review

The current benefits are also undergoing review from policy development, implementation and delivery of services. Results of this evaluation will hopefully input towards improving our benefits packages, implementation guidelines with established monitoring and evaluation mechanism.

C. Contracting

The stakeholders particularly health care providers are PhilHealth partners in the delivery of health services and consequently in the availment of benefits for members. Strengthening this partnership is vital for the success of this program. While accreditation is a privilege and provides conditions for compliance of health care providers, these are mostly to the advantage of the members and the Corporation.

Notwithstanding the accreditation of health care providers, a contracting mechanism shall be established in order to ensure provider participation and voluntary commitment in delivering quality, affordable and accessible services.

D. Payment Mechanism

The current payment mechanism which is primarily fee-for–service as described above are beset by problems administratively for both PhilHealth and the providers and is exposed to abuses. A shift to other payment mechanism such as case-payments will help address these problems. Studies are currently being conducted towards gradual shift to fee-for-service and together with contracting, will hopefully be able to provide adequate financial protection for PHIC members.

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