

POLICY BRIEF on Health Insurance



HOMENET PHILIPPINES Magna Carta for the Informal Sector Alliance

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TOWARDS HEALTH INSURANCE FOR ALL FILIPINOS? ¹

In the Philippines, people often kid each other, “Bawal magkasakit!” (“You are not allowed to get sick!”) The high cost of medical care, especially of patients needing hospitalization, is truly a burden that can send the uninsured to debt or penury. A survey done among one thousand homebased and other informal workers some years ago show that among the risks that vulnerable people face everyday, illness was the most dreaded ². The promise of universal health insurance by 2010 as mandated by law is therefore much awaited but the question still remains just months before the deadline: To what extent has the promise been met?



Introduction

PhilHealth, established in 1995, is mandated to provide health insurance coverage to all Filipinos within 15 years from the year of establishment. It provides subsidy for room and board, drugs and medicines, laboratory fees, operating room and professional fees for in-patient members. It also covers day surgeries, dialysis and cancer treatment procedures for out-patients. In addition, it has the newborn care, maternity care, tuberculosis, and SARS special benefit packages. These services and packages can be obtained from accredited medical facilities.

To have the concerns of its clientele tackled more directly in its decision-making, the PhilHealth Board has members representing workers, the self-employed, and the National Anti-

Poverty Commission (NAPC).

In order to spread its membership reach more rapidly, PhilHealth now has the KaSAPI (Kalusugang Sigurado at Abot-Kaya sa PhilHealth Insurance) program in partnership with large organizations such as microfinance institutions (MFIs), cooperatives, NGOs, and rural banks having more than 1000 members and strong operational, management, and financial capacities.

One of PhilHealth's guiding principles is that its program must have maximum community participation and must recognize the roles and strengths of the “public and private sectors in health care, including people's organizations and community-based health organizations.”

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¹ Prepared by Rosalinda Pineda Ofreneo with comments and inputs from the members of Homenet Philippines, and the Magna Carta for the Informal Sector Alliance (MAGCAISA).

² See Homenet Southeast Asia, *Social Protection for Homebased Workers in Thailand and the Philippines*. Quezon City: 2006, 90. Published under the auspices of the Ford Foundation, 2006.

POLICY BRIEF on Health Insurance

Given this context, it is only fair to ask the following key questions:

1. Has the PhilHealth membership become more representative and inclusive to bolster its goal of universality by 2010?
2. Has the PhilHealth Program reached the most vulnerable sections of the population, particularly the indigent, the working poor (most of whom belong to the informal economy), migrants, women and children? Do these vulnerable groups benefit the most or do the rich, or even the health care providers, get the lion's share?
3. How effective have the PhilHealth outreach programs been?
4. How responsive has the PhilHealth Board been to the articulated needs and suggestions of its most vulnerable clientele?
5. To what extent has PhilHealth been cognizant and supportive of people's and community-based health organizations providing services conceived and initiated from the ground?

Some answers to these questions are provided by the following findings and observations resulting from a review of the relevant documents as well as proceedings of various conferences, workshops, dialogues, consultations and interviews with PhilHealth representatives and other stakeholders ³.

MEMBERSHIP PER SECTOR AS OF DECEMBER 2007 ⁴

SECTOR	MEMBERS (in millions)	BENEFICIARIES
Government –Employed	1.78	7.42
Private-Employed	7.00	24.86
Sponsored Program – Active	2.72	13.64
Individually Paying Program (IPP)	2.94	11.07
Non-Paying (registered)	0.34	0.57
OWP (registered)	1.59	6.91
TOTAL	16.37	64.47

As of December 2007, there were 16.37 million members and an estimated 64.47 million beneficiaries (the members' next of kin). However, majority of the members (8.78 million or 53 percent) belong to the formal sector, of which 7 million are privately employed and 1.78 million are public employees.

³ Among these are the Conference on Extending Social Health Insurance to Informal Economy Workers, 18-20 October, 2006, Mandarin Oriental Hotel Manila, sponsored by PhilHealth, GTZ, ILO, World Health Organization and the World Bank; ILO Association of the Philippines (LAPI) Colloquium on Workers' Protection in the Informal Economy through Occupational Safety and Health (OSH), Social Health Insurance Coverage (SHIC) and Self-Help Schemes in Social Protection (SHSSP), 3 July 2006; MAGCAISA dialogue with PhilHealth representative Lolita Tuliao and SSS Commissioner for Labor Jose Matula on 23 July 2008 at Adarna Restaurant, Quezon City; Multi-Stakeholder Forum on Social Protection for Women in Informal Economy, 14-15 August 2008 Bayview Park Hotel, sponsored by the National Commission on the Role of Filipino Women with the support of CIDA; NGO-PO Consultations on the Alternative Report on the implementation of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) conducted by PHILRIGHTS for the NCR-Luzon (4 September 2008), Visayas (28 August), and Davao (10 September), the results of which were submitted to and uploaded by the United Nations Committee on Economic, Social and Cultural Rights (UNCESCR) to its website; interview with Calixtra Patacsil, OHPS health promoter, conducted by Josephine Parilla, Naguilian, La Union, 28 October 2008.

⁴ Latest published data from the Public Affairs Department of the Philippine Health Insurance Corporation claim a 66-million membership base, representing 73 percent of the population. More than half of this membership consists of government and private sector employees, while the sponsored members consisting of "the less privileged families" account for about three million. Individually paying members total 2.4 million (lower than the 2.94 million earlier reported). About 1.6 million members are overseas Filipino workers and almost half a million are registered under the Lifetime Member Program.



PhilHealth booth attracts applicants

The individually paying members, to which informal workers are categorized, comprised only 2.94 million or a little less than 18 percent of the total PhilHealth membership. The sponsored program (which used to be called the indigent program) covered 2.72 members or 16.6 percent of total. But the number of sponsored members fluctuates from year to year because it is dependent on whether politicians – especially those wishing to influence the outcome of elections, local government units, or private corporations, agree to defray membership cost just for a year.

There are less women members among the formally employed and the sponsored (indigent program) but more under the individually paying program. Overall, there are more benefit claims filed by female beneficiaries (56 percent) than male beneficiaries (44 percent). This may be due to the childbirth/maternity care that only women can claim.

Overseas Filipino workers (OFWs) have 1.59 million members in PhilHealth. In 2005, PhilHealth assumed the administration of the Medicare Program of the Overseas Workers Welfare Administration (OWWA). The Medicare funds of the OFWs were thus transferred to PhilHealth.

Migrant workers' groups during the Sept. 4 2008 NCR consultation conducted by PHIL-RIGHTS voiced out their concern about how these funds have been actually used for the benefit of their contributors. Again, the need for transparency and information dissemination regarding these matters was underscored. Migrant workers' groups are also advocating for the portability of their benefits.

Small farmers and fisherfolk may find it difficult to access PhilHealth services, since PhilHealth representatives themselves admit that rural areas remain underserved, and accredited PhilHealth facilities have not sufficiently spread out to the countryside.

This reflects a major problem in the Philippine health care system: the over-concentration of facilities and personnel in urban areas, particularly Metro Manila

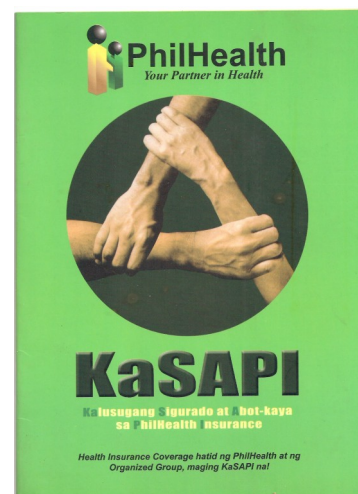
As mentioned earlier, the PhilHealth Board has members representing workers, the self-employed, and the National Anti-Poverty Commission (NAPC). Pressure from within the Board as well as from forces outside pushing for faster inclusion of marginalized sectors has helped accelerate efforts to develop partnerships with organized groups.

The KaSAPI program is supposed to be a triple-win for the three actors in the program: a.) informal economy workers receive protection when they fall ill, payment for them is more flexible (saving them time and effort), they have lower premium and more benefits; b.) PhilHealth benefits from increased, sustained coverage, and improved financial stability of the program for informal sector workers; and c.) the partner institution is able to fulfill its social mission, gain additional membership, and reduce risk.

But PhilHealth's KaSAPI program still has a very limited reach and has very stringent requirements, preventing many interested groups from joining it.

Likewise, many individually paying members (including informal economy workers) are unable to sustain their contributions, endangering both their access to benefits as well as the overall sustainability of PhilHealth. This highlights the "major gap" in terms of widespread and sustained coverage identified in many social health insurance programs – the working poor who are "neither poor enough to qualify as indigents nor well-off enough to pay regular PhilHealth premium contributions."⁵ The problem is further magnified by PhilHealth policies which require fairly consistent contributions in order to access benefits when the need arises.⁶

Moreover, since the focus of PhilHealth packages is on hospital care, it is claimed that it tends to benefit health care providers more. This has been inviting unscrupulous Health Maintenance Organizations (HMOs) to make fraudulent claims which have built



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⁵ Eduardo Gonzalez, Political Will is the Key to Social Protection, Social Watch Report, 2007, p. 4.

⁶ For example, failure to make payments during the last quarter before needed hospitalization disqualifies the member concerned from enjoying inpatient benefits, except when it is clear that contributions for at least nine months during the last year were made, in which case the member can be given a grace period to make full payments.

POLICY BRIEF on Health Insurance

up to a staggering sum of P4 billion since 1995, involving “unnecessary operations, overpriced medicine, and even ghost patients.”⁷ At least two sources (Eduardo Gonzalez of Social Watch and former Health Secretary Alberto Romualdez Jr.) say that in PhilHealth, the poor subsidize the rich or the “relatively well-off employees who have a higher incidence of catastrophic illnesses requiring more expensive treatments.”⁸

Furthermore, the sponsorship program of PhilHealth can

unintentionally undermine community-based health insurance initiatives, such as the well publicized ORT Health Plus Scheme (OHPS) in La Union, also highly promoted by the ILO in recent years. The OHPS collapsed when many of its members became beneficiaries under the Philhealth sponsorship program and no longer felt the need to continue their contributions to the OHPS. When the sponsorship ended a year after, the sponsored members were left with no health insurance and even if they wanted to resume their obligations to and benefits from OHPS, the latter could no longer maintain its services.¹⁰

Ways Forward

Several meetings involving various institutions and organizations came up with the following recommendations addressing the issues earlier explained:

1. PhilHealth should move swiftly towards universal coverage with state subsidy and sponsorship programs from various stakeholders for those who cannot afford to pay the full premiums.
2. Government subsidies for sponsorship programs should be better targeted and expanded to fully or partially cover the working poor and the ultra poor against illness and other contingencies.
3. PhilHealth’s presence should also be extended further to rural areas which are still underserved both in terms of membership and access to accredited hospitals.⁹
4. All micro finance institutions (MFIs) should be required to integrate micro-insurance into their lending operations.¹¹
5. In the meantime, the KaSAPI and other PhilHealth programs for indigents and the working poor should be expanded and improved in order to develop effective partnerships with organized groups, especially those composed and led by women, senior citizens, persons with disabilities, ethnic communities and other marginalized sectors, to better serve increasing numbers of those in need.

Organized groups with at least 500 members (not 1000 as presently required) should be allowed to be collecting agents benefiting from certain incentives.

6. Women worker leaders suggest that reproductive health as well as occupational safety and health concerns should be integrated into the orientation programs and benefit packages of PhilHealth.

For example, it is recommended that family planning services, commodities and supplies based in hospitals should be fully covered by PhilHealth benefits, especially in the case of patients who cannot afford to pay.¹²

Workplace-related injuries and illnesses, which afflict not only formal workers but also the more numerous workers in the informal economy, should also be covered.

To emphasize the preventive aspect further, it is also recommended that annual physical medical check-ups and other outpatient services be covered by PhilHealth.

7. Mutual benefit associations, community-based health insurance and indigenous schemes such as the *damayan* should be supported through appropriate recognition, technical assistance, and other incentives by national and local bodies so that they can be of better service to their membership who cannot access or who need to supplement benefits provided by PhilHealth.

⁷ Gonzalez, Social Watch Report, 2007, p. 3.

⁸ Romualdez showed a chart of 10 hospitals leading in PhilHealth reimbursements, of which only one was public. This suggests that private patients (who are better off) use PhilHealth more. This is according to Michael Tan, in his column “Health for All,” Philippine Daily Inquirer, 12 September 2008, featuring the University of the Philippines Centennial Lecture of Romualdez.

⁹ For an extended discussion on OHPS, see Homenet Southeast Asia, 2006, pp. 45-46.

¹⁰ Interview with Calixtra Patacsil, OHPS promoter, Naguilian, La Union, 28 October 2008, conducted by Josephine Parilla.

¹¹ It was also suggested during the NCR consultation conducted by PhilRights on 4 September 2008 that these MFIs should be more tightly monitored by government for policies that actually worsen rather than alleviate poverty.

¹² Results of the workshop on national policies and programs, Multi-Stakeholder Forum on Social Protection for Women in the Informal Economy, 15 August 2008, Bayview Park Hotel, sponsored by the National Commission on the Role of Filipino Women.