A rough guide to eye health financing in the Philippines

Author: Dr Lachlan McDonald, Senior Economist

The Philippines has one of the longest histories of social health insurance in Southeast Asia. On the face of it, the system, popularly known as ‘PhilHealth’, has the features required for universal eye health. Most of the population (87 per cent in 2014) is covered by the scheme. This includes all formal sector workers who make mandatory income-based payroll deductions. General tax revenues and proceeds from a consumption tax on cigarettes and alcohol (known as the 'Sin Tax') provide the finance to cover almost all of the poor, known as “indigent”, who are automatically enrolled. In 2014, the population aged over 60 were also extended sponsored coverage.

Large coverage gaps still remain. In 2014 around 14 million adults and their dependents were estimated to be without coverage, of which most are informal workers (and most likely near-poor). Unlike formal workers and the indigent, informal workers contribute voluntarily to the scheme (Table 1).

### Table 1: PhilHealth cohorts and respective financial contributions

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Enrolment</th>
<th>Classification and contribution rate</th>
<th>Per cent of Beneficiaries</th>
<th>Contributions</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigent / Sponsored</td>
<td>Non-contributory &amp; automatic</td>
<td>Flat ₱2,400 ($50) annual fee 100 per cent sponsored by government</td>
<td>58</td>
<td>45</td>
<td>32</td>
</tr>
<tr>
<td>Senior*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal / OFW**</td>
<td>Contributory &amp; mandatory</td>
<td>Payroll deduction of 2.5 per cent of monthly income for domestic formally employed (split 50% employee; 50% employer) - Min annual fee of ₱2,400 for monthly income of ₱8,999 ($190) and below and for OFW - Max premium of ₱10,500 for monthly income of ₱35,000 ($750)</td>
<td>31</td>
<td>49</td>
<td>36</td>
</tr>
<tr>
<td>Informal</td>
<td>Contributory &amp; voluntary</td>
<td>Annual fee of ₱2,400 for individuals with monthly income of ₱25,000 and below ($530) Annual fee of ₱3,600 for individuals with monthly income above ₱25,000</td>
<td>9</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>Lifetime</td>
<td>Non-contributory &amp; automatic</td>
<td>Individuals who have paid at least 120 monthly contributions and are: - 60 years and above; - uniformed personnel 56 years and above; - underground miner-retirees 55 years and above</td>
<td>2</td>
<td>0</td>
<td>7</td>
</tr>
</tbody>
</table>

* Senior Citizen category is not the same with the Lifetime Members (LMP) category since LMP members need not pay any additional premium contribution to avail of the benefits since they have already complied with the 120 monthly contributions prerequisite prior to their retirement while the Senior Citizen category have premium contributions which are being paid from the proceeds of the Sin Tax Law

**Overas Filipino Worker


All surgical treatments and inpatient services are included in the PhilHealth benefit package and are purchased using a fixed case-based payment. In eye health, payments of ₱16,000 (approximately US $350) are provided for cataract removal. This payment is the same, regardless of the surgical technique, inpatient or outpatient, level of facility, or private/public sector. It is a relatively high rate of 1

1 This report is based on a week-long exploratory visit to the Philippines, occurring 1st – 4th September 2015. This WHO-sponsored review of the government eye care system in the Philippines had as its objectives to review the current national eye care systems in the Philippines and to provide recommendations to improve service delivery outputs and quality of outcomes. It focuses on cataract surgery; the main cause of avoidable blindness in the Philippines and a conventional proxy indicator for general eye care service delivery used by WHO. This is a summary of a more comprehensive report submitted to WHO.
reimbursement compared with other Asian countries such as China and Viet Nam. Indigent patients are prohibited, by *PhilHealth Advisory No. 09-01-2011*, from “balance billing” – being charged an additional co-payment on top of the official PhilHealth reimbursements – in accredited public facilities for services covered under the insurance package. In contrast, non-indigent patients can be charged co-payments in public facilities, and no pricing restrictions are in place in private facilities.

The PhilHealth system is growing rapidly. In 2014, the total benefits paid were ₱78.1 billion ($1.67 billion), which was a 41 per cent increase from the previous year. Total premiums collected in 2014 were ₱81.4 billion ($1.74 billion), which was a rise of 43 per cent from the year before. Almost all of this growth was attributable to the more-than doubling in the contributions paid on behalf of the indigent. There has been a strong push since 2010 from the Government to expand the coverage rates of the insurance system among the poor, using the revenues of the Sin Tax to sponsor premiums of selected cohorts. In response, the aggregate coverage rate of the system rose from 74 per cent in 2010 to 87 per cent in 2014.

Total PhilHealth spending on cataract surgery in 2014 was ₱2.1 billion in 2014. This represented 2.6 per cent of total PhilHelath benefit payments. It was the third-largest expenditure item in the PhilHealth system.

Despite its many strengths, it is clear that the PhilHealth system is presently failing many Filipinos. This is evidenced by the high and rising out-of-pocket costs, which accounted for 54 per cent of total health expenditure in 2014. Most of this is attributable to spending on medicines, though balance billing is also common. This is particularly the case in for-profit private hospitals, which dominate as health care providers in the Philippines. Further, the poor are still being excluded as a group from eye care. PhilHealth records show that in 2012, of the estimated 92,000 indigent patients blind from cataract, only 6,341 indigent people used the PhilHealth system.

Four main factors underpin why patients face difficulties accessing cataract surgeries:

1. **Cataract surgery is not equitably accessible and available because of a mal-distribution of service providers.** This, combined with the high costs of consumables, drives up patient costs. Facilities and skills tend to be concentrated in urban areas. This leaves people from outer rural areas and those on remote islands with limited service options, forcing them to incur travel costs to access care. The high cost of consumables used in cataract surgery, relative to international benchmarks, also drives up the direct costs of cataract surgery, which are often passed onto patients via balance billing.

   Interviews in a public hospital in Manila, indicated that the total cost of consumables in a cataract removal is around ₱4,500 ($95), with most of the cost reflecting the lens. This is high relative to international benchmarks – though not as high as in Viet Nam (Table 2). Costs are considerably more expensive than available in India, where low priced manufacturers of ophthalmic products are located.

<table>
<thead>
<tr>
<th>Source</th>
<th>Prices for IOLs range from $40-$150.</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>Prices for IOLs range from $40-$150.</td>
</tr>
<tr>
<td>Canada</td>
<td>$72 for all consumables; including $22 for an IOL.</td>
</tr>
<tr>
<td>China</td>
<td>Surgery costs around US$275. Of this, $150 – $200 is the price of the IOL plus surgical consumables.</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>The price of cataract surgery averages $250, of which around $85-150 is the IOL.</td>
</tr>
<tr>
<td>India (wholesale and direct pricing)</td>
<td>Prices of IOLs: $4-5 for PMMA (hard) IOL and $15-$25 for foldable (soft) IOL. Prices of consumables: $11-15 for all consumables, including IOL for M-SICs; and $35-40 for all consumables, including IOL for phaco technique.</td>
</tr>
<tr>
<td>Philippines</td>
<td>The price of consumables in cataract surgery averages $95 – most of this is the IOL.</td>
</tr>
</tbody>
</table>

Sources: Authors’ discussions with health providers; all prices are in US dollars.
2. **The for-profit private sector is dominant; however unregulated private sector activity does not necessarily translate into affordable high-quality services being available for the poor.** At every level of care in the Philippines there are more private hospital facilities than public hospitals. Approximately 70 per cent of the overall heath workforce is employed in the private sector. This is the same for eye health, in which 90 per cent of services are provided by private providers. The reasons given for the dominance of the private sector include their superior recruitment and retention of skilled labour, more streamlined patient admission practices, and patients’ perceptions that private doctors provide a superior quality service.

Private practice allows ophthalmologists to target wealthier patients, to whom they can charge higher prices. Cataract surgery tends to involve, higher-cost techniques, such as phaco, as well as more expensive foldable IOLs. Phaco cataract surgeries can cost up to ₱35,000 – 45,000 ($750 – $950) in the private facilities – well above the ₱16,000 PhilHealth reimbursement – leaving patients with a considerable out-of-pocket balance bill.

Some private providers are shifting their attention toward treating indigent patients using relatively low-cost manual small incision cataract surgery (M-SICS) techniques and capitalising on high volumes and the relatively lucrative PhilHealth reimbursement to make a profit. While on the face of it this expands service access to the poor, it has not always been in the interests of patients. Revelations of misdiagnosed need and fraudulent claims for cataract surgery of indigent people has shown the importance of upholding rigorous eligibility guidelines and quality standards.

3. **Public services are in short supply and the public sector generally underperforms.** Public services are an important element in providing equitable access for people at the lower end of the socioeconomic spectrum. The no-balance billing policy means that once indigent patients enter the public health system they are entitled to access all the services they need, including diagnostics and after-surgery care and treatment of any hospital acquired infections, etc. with no out-of-pocket cost. This permits more comprehensive patient-centric care, compared with the fee-for-service model of the private sector. Low-cost M-SICs techniques are more prominently used in public facilities – often because hospitals lacked the required equipment to undertake phaco procedures.

Public services, however, are in precious short supply; comprising around 10 per cent of services. This means that indigent people in less-densely populated and remote areas where government services are not available face additional costs – being forced to pay out-of-pocket costs to local providers, or paying for transport to a government facility.

Further, public facilities that do exist also appear to be operating below capacity. This reflects a combination of problems including: the inability to retain skilled staff; insufficient support staff; operating inefficiencies; and generally weak incentives to improve performance. Low professional remuneration is key: PhilHealth mandates mandates that the ₱16,000 case payment for cataract is to be allocated 60 per cent between the facility and 40 per cent for professionals. In public facilities the professional fee tends to be shared among all professionals (surgeons and support staff). This pooling of fees reduces the competitiveness of remuneration for doctors in the public sector vis-à-vis the private sector, where the full amount of the fee usually accrues to the surgeon. Consequently most government-employed ophthalmologists only work part time and supplement their income with private consulting.

Public facilities clearly need to be more competitive in attracting and retaining skilled staff and increasing patient volumes. A public eye hospital in Tarlac has devised a way that these can work hand in glove (see Box 1). It could serve as a model for public facilities more broadly.
Box 1: A successful innovation to improve the performance of a public eye hospital – using high volumes and cost control to retain skilled labour

Attempts have been made at the Tarlac Provincial Hospital to recruit and retain private ophthalmologists by providing them with the full value of the professional fee. An effective partnership between the hospital and the local government was established, where private eye professionals brought in their service, technical know-how and expertise and the public health system provides support staff, infrastructure and equipment.

Supported with funds from The Fred Hollows Foundation, the aim of the partnership is to provide quality patient-centred care consistently (i.e. not like infrequent environment of a surgical mission) and continuously (in a facility that is always open). Demand is generated through regular outreach and awareness-raising exercises in rural areas of the province. The model has been successful in widening the availability of services to the point where the facility performed 75 per cent of all cataract surgeries in the province in 2014 (consultations increased 24-fold between 2011 and 2014 to 1,450 surgeries). This goes against the nation-wide trend that public hospitals perform a relatively small share of services.

Limited financial autonomy of the eye hospital permits the hospital to provide competitive remuneration for skilled staff. Private ophthalmologists do not charge consultation fees nor receive salaries; they instead obtain the full value of the mandated professional fees for surgeries from the PhilHealth system.

Key to the model is high patient volumes, which provide sufficient remuneration for the hospital to retain its skilled labour.

Further, everyone in the department – even the janitor – has basic training as a mid-level ophthalmic personnel. This provides surgeons with a large complement of support staff, which helps maintain higher rates of productivity.

The sheer volume of patients changed the competitive landscape for eye health in the province – with one private provider in Tarlac City reportedly reducing their price to the no-balance billing rate (₱16,000) in order to compete for patients.

The hospital remains constrained, however, by the fact that its financial autonomy is still limited. The facility fee and its margins are still pooled at the hospital level and the eye department continues to be dependent on the hospital for finance to purchase equipment and other capital expenses. At present a generous governor allows the eye center to budget for what it needs. It is therefore sustainable to the extent that there is political support, however it raises questions about whether it can be replicated, or its longevity if political will changes.

4. Limited verification of clinical need for cataract surgery or measurement of quality cataract surgery outcomes. As revealed in the fraudulent claims for cataracts the mechanisms in place to ensure quality appear to be inadequate.

A broad regulatory response to the unnecessary treatments was the imposition of an explicit daily and monthly cap on the number of surgeries that can be claimed for reimbursement. The cap is designed to prevent a repeat of the high numbers of spurious claims. Specifically, Paragraph VII of PhilHealth Circular 018-2015 indicates that:

“only up to a maximum of fifty requests for pre-surgery authorisation per PhilHealth-accredited eye surgeon per month, not exceeding ten scheduled surgeries per day... the limit shall apply to all healthcare providers except for those performed by residents
in training in accredited government and private [Health Care Institutions] with a Philippine Board of Ophthalmology (PBO) accredited residency training program.”

This means that all hospitals, both public and private, that do not have residency-training programs are, in effect, expected to ration their services. It locks in a ceiling of 600 surgeries per surgeon per year – a considerably lower level of activity than surgeons are capable of performing. It also means that non-training public hospitals, such as Tarlac, lose their competitive advantage for retaining skilled labour, as they can no longer offer high volumes (see Box 1). Most importantly, limits on surgery volume run directly counter to attempts to clear the backlogs of untreated cases of cataract blindness among the poor.

**Conclusion**

The high cost of cataract in the PhilHealth system and revelations of fraudulent activity have drawn considerable attention to how eye health is financed in the Philippines and the sustainability of the system in its current form. Cataract surgical volumes need to increase dramatically to meet the goals as set out in *Universal Eye Health: A Global Action Plan 2014-2019*. The corresponding implication is that the total amount of PhilHealth spending on cataract surgery must rise to accommodate any increase in surgical volumes. Yet cataract removal was already the third highest procedure PhilHealth paid for in 2014. The growing elderly population, along with the recent inclusion of the elderly in automatic lifetime sponsored coverage is only likely to intensify these pressures on the health financing system.

The key for PhilHealth is to find ways to extract as much value for money as possible from expenditure on eye health – including targeting of the neediest. There is a clear risk that, without some reform, a re-evaluation of how eye health is financed in the Philippines may be imminent. Caps imposed on surgical volumes in the private and public sectors (in response to the recent issue of unnecessary cataract surgery being performed) is an ominous portent of how sweeping regulatory changes to improve the effectiveness of government spending may actually run counter to public health goals of reaching those in need of cataract surgery.

Organisational and institutional reform of public health facilities could help unlock the considerable underutilized capacity in the public eye care system and increase the availability of quality affordable eye care treatments. Reducing the overall cost of cataract surgery, while maintaining quality, will aid in rationalizing and extending limited health care insurance funds. Providing eye departments within public hospitals with the autonomy to control decisions on purchasing, investment and staffing should assist in increasing both the efficiency and equity in the public eye health system.

The private sector can, and should, play a complementary role in increasing accessibility of affordable quality services. As has been demonstrated in a number of other countries, private facilities can sustainably provide low-cost services to the poor while remaining profitable, and without sacrificing quality, by combining high volumes, low costs and strong value-driven governance. A similar model could be developed in the Philippines, using the PhilHealth reimbursement as a revenue source.