Philippine Institute for Development Studies

Medicare I: Administrative Issues

Eduardo Gonzalez

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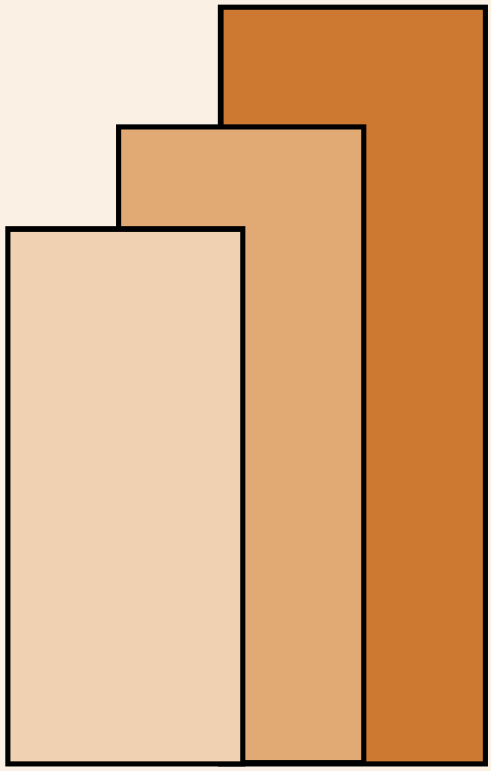

June 1995

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EVALUATION OF MEDICARE I: ADMINISTRATIVE ISSUES

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Makati, Metro Manila

FINAL REPORT

I PROJECT TITLE:

EVALUATION OF MEDICARE I: ADMINISTRATIVE ISSUES

II NAME AND ADDRESS OF PRINCIPAL INVESTIGATOR

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III TIMEFRAME

A DATE PROJECT STARTED: March 1, 1992
B DATE OF COMPLETION: June 30, 1993

IV SUMMARY DESCRIPTION OF PROJECT

A. Brief Description

This project is one of the baseline studies required to complete the DOH-PIDS Health Care Financing Project. Along with the economic evaluation of Medicare I, this project will feed into designing new policy and program options for the Medicare program. The project will help generate information needed in developing alternative strategies in "coverage" pricing, in the context of organizational reform that hopefully will result in a more efficient use of resources.

B. Objectives

This study has a number of specific objectives:

1 To discuss problems encountered in achieving full enrollment of the Medicare I uncovered population.

2 To assess the capacity of the Philippine Medical Care Commission to guarantee that affordable and effective services are being provided to the Medicare beneficiaries.

3 To evaluate the efficiency of the two financial intermediaries, the Government Service Insurance System and the Social Security System, in conducting standard operations including collection of contributions, processing of claims and disbursements, as well as in the management of the Medicare fund and the monitoring of providers, with specific reference to fraud and abuses.

4 To evaluate the efficiency of, and measure the administrative costs

associated with, the current PMCC-GSIS-SSS setup. The operational efficiency of a parallel institution, the Employment Compensation Commission, will also be appraised.

5 To evaluate the effectiveness of the present accreditation scheme of PMCC, including sanctions for violating Medicare implementing rules and regulations.

6 To establish general guidelines to evaluate alternative structures for the PMCC-GSIS-SSS system (plus components of ECC), specifically focusing on the possible integration of all policy-determining, management and administrative functions under a single Medicare setup.

C. **Approaches and methodology**

The study relied mainly on institutional sources of data. These are the PMCC, SSS, GSIS, and ECC. Secondary data include historical records of Medicare which contributed to the understanding of administrative issues facing the program. Information gaps were filled by other data sources, including the outcomes of diagnostic sessions with key informants in the PMCC, ECC, SSS, and GSIS.

Several analytical tools were employed:

Methods analysis: this basically ascertains and describes the claims procedures which are currently being employed by GSIS and SSS. Initially, a process flow chart--a graphic presentation of the sequence of operations occurring during a process--was made. It included information considered desirable for analysis such as time required. The operations and inspections performed by the Medicare units were described, as were the "motion" o documents, and the delays and bottlenecks experienced. Following the proces chart approach, work simplification analysis was undertaken, incorporatin the following: why/what to/where to/when to combine, what sequence to change what responsibilities to alter, and what procedures to improve. It involve capacity evaluation, the determination of appropriate number c organizational units, the time element, and distribution (time/work sharing

Regression analysis: the approach was to use a regression model which the role of provider elements as determinants of the efficiency c claims processing and the length of hospital confinement was emphasize Regression analysis was used in a very limited statistical sense to facilitat sensitivity analysis and to determine quantitative relationships amor various variables relevant to the administration of the program. Suc quantification was not uncovered in systems-type studies.

Secondary data analysis and diagnostic interviews with key informan in PMCC, ECC, SSS and GSIS.

D. **Major conclusions**

1 Medicare has been unable to expand coverage in pace with the grow of salaried employees. It has mainly ignored workers in the informal sect

the self-employed and agricultural workers.

2 Tertiary level hospitals are concentrated in Metro Manila but at the very least, Medicare members have access to primary hospitals especially in the poorest regions. However, Metro Manila Medicare members still have the advantage since bed and manpower to population ratios are highest in this area and consequently, more specialized care is available here unlike in other regions. Thus, it is doubtful whether the PMCC's accreditation program is effective in encouraging uniform access to care among the members.

3 GSIS claims processing is associated with backlogs and low disapproval rate (or an inability to detect fraudulent claims). "Routinization" has taken place and no clear-cut guidelines are being followed. Definitely this system leaves a lot to be desired.

4 SSS claims processing, on the other hand, is still new but has a very elaborate system whose main advantage is the detection of incomplete, irregular or fraudulent claims. There are no backlogs since they process very few claims daily. In the future, the disapproval rate of SSS should be looked into because too high disapproval rates imply that fewer members will benefit from Medicare.

5 Investment income as against collection income is increasing through the years, more so for SSS than GSIS. This decreased dependence on collection income allows the Medicare program to expand risk coverage for the benefit of the members.

6 Application of financial indicators on the Medicare Fund of the two systems shows that SSS consistently outperforms GSIS, which is occasioned by the latter's unsound investments made prior to 1986. The uneven financial performance of the two systems and economies of scale raises the question of the possible advantages of merging the two systems.

7 A great proportion of Medicare expenses goes to benefit payments which is greater for GSIS than for SSS, the former serving more beneficiaries than the latter. Although the number of members who availed of Medicare benefits has not greatly increased through the years, average payment per claim has increased sharply in recent years--but only in nominal terms. It actually declined in real terms.

8 Operating expenses for SSS has been increasing recently, though still below the mandated 12 percent of income. This is a puzzle since scale economies and the low number of claims processed (compared with GSIS) imply that SSS should have lower operating expenses. This increase in operating expenses was caused by increase in benefits to employees which is not bad by itself. However, the cost of insurance through SSS is much higher than that of GSIS, and SSS members are paying for this through lower benefits.

9 The PMCC's accreditation program was supposed to ensure that Medicare members have access to quality and affordable health services. Naturally, the accreditation requirements follow DOH licensing requirements, and are a needless duplication. What is required though is a complete manual

of operations since the present system leaves much to discretion.

10 Due to lack of resources and personnel and lack of coordination among PMCC, SSS and GSIS, providers have not been closely monitored. Information necessary for monitoring has not been built up through the years since monitoring forms were not filled out by hospitals. PMCC could do its part by streamlining these forms. The end result is depletion of the HIF due to abuse.

11 Monitoring should focus on deterrence, not on detection due to the high cost of litigation. Sanctions against erring providers are very light. Very few hospitals have had their licenses permanently revoked since PMCC feels that closing down a hospital would severely limit access to medical care in some areas.

12 PMCC is the policy-making body of the Medicare program but due to the control of the SSS and GSIS in financial decisions, it has very little power over the overall direction of the program and over the policies of the two systems. One major weakness of the program is that none of the three agencies are involved in research and development.

13 Pilot projects, targeting some groups not currently covered by Medicare I, has already been undertaken. Some innovations were introduced like payment of Medicare contributions only and decentralization of collection and disbursement. There are indications that viable and easily administrable ways could be found in order to cover groups not reached by Medicare I.

14 The Employee's Compensation Program covers about half of the total employed force in the country, compared to Medicare's 22 percent. SIF collections have been about 55 of HIF collections on average. On average, ECP benefits expense is about 30 percent of Medicare benefit payments. Coupling ECC benefits with Medicare benefits means taking a hard look at ECC services that ideally could be part of the Medicare program. ECC's medical and rehabilitative services are the logical candidates for inclusion in Medicare. That would streamline the whole medical insurance setup and lessen transaction costs.

15 Consolidation could streamline claims processing, and avoid costly backlogs. It could also allow the PMCC to reclaim many policy initiatives and reverse prevailing trends. The new structure will conceivably remove dualities in benefit payments and administrative expense, reduce adverse selection by distributing risk more evenly, and maintain a better symmetry between the benefit structure and the pattern of premium collections. There would be a sustained attack on fraud, with the unified institution being able to orchestrate otherwise separate efforts on monitoring providers and imposing appropriate sanctions. A consolidated fund and a single Medicare institution should also be able to widen coverage to include uncovered segments of the population. It would also make possible the integration of three separate licensing and accreditation processes, perhaps one of the most wasteful practices in the health sector. In the final analysis, the syndicated PMCC-ECC setup, as proponents argue, might serve as the nucleus of a truly comprehensive national health plan.

16 In making choices, the concern is whether the alternative could guarantee that the quality of service is upgraded, and the quantity improved. Equally important is the extent of population coverage. Each new context (practicality of objectives, political feasibility, ease of implementation, sustainability, flexibility over time, etc.) might call for different handling and must be appraised in its own right.

V. TECHNICAL REPORT (Attached)

VI. PROBLEMS ENCOUNTERED AND RECOMMENDATIONS

The project encountered a number of problems in conducting research on Medicare. In some instances, progress in doing analysis was slow because evidence on some topics was scarce, or was not easily accessed. Information on Medicare utilization patterns across regions, for example, was practically non-existent. So were data on the demographic characteristics of Medicare eligibles, and on distribution of Medicare membership by industry. Sometimes, sets of data that needed to be linked with each other are instead found in separate, fragmented computer files. This was the case with claims data and income data, which were difficult to match because of file compatibility problems. Information resources such as financial statements were quite handy, however, and provided the project staff with valuable details. Still, they could not be complemented by actuarial estimates of Medicare costs and benefits, which for reasons of "confidentiality" were made out of reach of the project.

Yet steps are being taken to make the needed information easily available. The Philippine Data Project, a foreign-assisted undertaking currently underway, hopes to regularly gather under a single data base most of the Medicare (and health insurance) data from PMCC, GSIS and SSS. That should be quite helpful to the current and future projects on Medicare. Information not available from the three agencies (and from ECC as well) will remain a big problem, however. In such a case, there is probably no substitute to conducting surveys, even if considerably costly to researchers.

Diagnostic interviews partly solved many of the project's information gap problems. Generally, the officials and the technical staff of the four agencies were rich sources of data which otherwise would be missed in official agency reports. Indeed there were officials who pressed strongly for greater attention to many of the topics included in the project. But they also drew the line on what they judged to be "sensitive" information, denying the project access to details that were central to the analyses in the study. A major reason for the reluctance to disclose vital information was that they were not exactly clear on the purposes of the project, and felt they were the *objects* of the inquiry, rather than partners in the research process who stand to benefit from the findings. They were also apprehensive that the facts they reveal or the opinions they express could be self-incriminating should the findings turn out to be adverse to their agencies. In the future, it might help if the research effort is accompanied by a consultation process that would secure the agencies' cooperation and even "sponsorship" of the

project. For example, a workshop among the various agency officials and staff could be conducted prior to the start of the project, for "unfreezing" purposes and to create a research-friendly atmosphere.

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A Complete Regression Results, GSIS Claims Processing Efficiency

B Complete Regression Results, Length of Confinement

List of Acronyms

APHO	-	Assistant Provincial Health Officer
ARHD	-	Assistant Regional Health Director
COA	-	Commission on Audit
DBM	-	Department of Budget and Management
DILG	-	Department of Interior and Local Government
DOF	-	Department of Finance
DOH	-	Department of Health
DOLE	-	Department of Labor and Employment
DTI	-	Department of Trade and Industry
ECC	-	Employees' Compensation Commission
ECP	-	Employees' Compensation Program
ECSIF or SIF	-	Employees' Compensation State Insurance Fund
EDP	-	Electronic Data Processing
GFI	-	Government Financing Institution
GOCC	-	Government Owned and Controlled Corporation
GSIS	-	Government Service Insurance System
HIF	-	Health Insurance Fund
HMO	-	Health Maintenance Organization
MOOE	-	Maintenance and Other Operating Expenses
NCR	-	National Capital Region
NSO	-	National Statistics Office
PHA	-	Philippine Hospital Association
PHC	-	Philippine Heart Center
PIDS	-	Philippine Institute for Development Studies
PMA	-	Philippine Medical Association
PMCC	-	Philippine Medical Care Commission
ROE	-	Return on Equity
ROI	-	Return on Investment
SGV	-	Sycip Gorres and Velayo
SSS	-	Social Security System

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Any factual errors or misstatements in this paper are the sole responsibility of the authors.

EVALUATION OF MEDICARE I: ADMINISTRATIVE ISSUES

*Eduardo T. Gonzalez, Corazon Urquico, and Edwin Canonizado**

I. INTRODUCTION

During the roughly two decades since the inception of compulsory risk coverage, Medicare has experienced dramatic change in three dimensions. First, coverage has expanded phenomenally. By 1991, close to 40 percent of the population can avail of the benefits of Medicare, compared with fewer than 15 percent in 1972, when the program was first introduced. Second, the range of Medicare benefits 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.

All these have created pressures on the operational viability of the system. 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 often exact a high price, reflected in growing administrative inefficiencies. This study has attempted to identify such pressure points, and determine whether the performance efficiency of Medicare has successfully withstood them in an effort to keep pace with current Medicare requirements. The study also tried to find out whether new practical arrangements have to be instituted so as not to overstretch the capacity of the system.

It is said that the only economic cost of a self-sustaining, viable risk-coverage program is the administrative cost (World Bank, 1987). This being the case, the importance of studying the administrative aspects of Medicare cannot be overemphasized. In this regard, the study examined the following administrative processes: enrollment; accreditation and monitoring; processing and payment of claims; and HIF management (including collection efficiency, utilization pattern and investment practices). Also included were the medical, rehabilitative and ambulatory aspects of the existing workers' compensation program.

A. *Specific Objectives*

This study has a number of specific objectives:

1 To discuss problems encountered in achieving full enrollment of the Medicare I uncovered population.

2 To assess the capacity of the Philippine Medical Care Commission to guarantee that affordable and effective services are being provided to the Medicare beneficiaries.

3 To evaluate the efficiency of the two financial intermediaries, the

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Government Service Insurance System and the Social Security System, in conducting standard operations including collection of contributions, processing of claims and disbursements, as well as in the management of the Medicare fund and the monitoring of providers, with specific reference to fraud and abuses.

4 To evaluate the efficiency of, and measure the administrative costs associated with, the current PMCC-GSIS-SSS setup. The operational efficiency of a parallel institution, the Employment Compensation Commission, will also be appraised.

5 To evaluate the effectiveness of the present accreditation scheme of PMCC, including sanctions for violating Medicare implementing rules and regulations.

6 To establish general guidelines to evaluate alternative structures for the PMCC-GSIS-SSS system (plus components of ECC), specifically focusing on the possible integration of all policy-determining, management and administrative functions under a single Medicare setup.

The research focused only on the present system of the Medicare program. The urgent need was to identify the flaws and inefficiencies of the *current* setup, as opposed to identifying *possible* administrative inadequacies that could result from a shift to an alternative system. The research must be viewed as a first phase of a larger study on the program. Along with a parallel study on the economic efficiency of the program, this study hopes to furnish an overall picture of the efficiency of running Medicare I and provide a basis for pinpointing areas for reform. It is the consolidation of the findings of the two project components which will underlie further studies on first or second best solutions to the problem of running a cost-effective compulsory social insurance.

B. *Organization of the study*

The study is organized into several chapters. The first chapter is a brief introduction to the nature and organization of the Medicare program. Chapter 2 reviews past works on Medicare management and organization. The framework of the study and the research methodologies used are detailed in Chapter 3. Chapters 4 to 12 form the core of the paper. They focus collectively on the administrative issues confronting Medicare. Topics of analysis and review include enrollment and coverage (Chapter 4), geographic distribution of Medicare services (Chapter 5), claims processing in GSIS and SSS (Chapter 6), management of the Medicare fund (Chapter 7), tradeoffs between fund viability and utilization (Chapter 8), licensing and monitoring of providers (Chapter 9), the administrative costs of GSIS, SSS and PMCC (Chapter 10), and expanding coverage (Medicare II) (Chapter 11). Chapter 12 evaluates a parallel health care organization, the ECC. Chapter 13 reviews the possibilities and prospects of restructuring the Medicare system. The final chapter restates the findings in concise form and offers some concluding remarks.

The study pulls together scattered, and often fragmented, information on Medicare management supplied by the above mentioned agencies. The scope of the study is limited. Several important topics, such as the need for

Medicare research and development, reimbursement concepts, and the HMO-Medicare tie-up, were excluded from the study. Supply-side considerations are limited to discussions of access to providers. The costs to providers of Medicare inefficiencies were not taken up. These are fertile areas for future research.

II. THE PHILIPPINE MEDICAL CARE PLAN

Republic Act No. 6111 and Presidential Decree No. 1519 established a Philippine Medical Care Plan which is being implemented and administered by the Philippine Medical Care Commission. Figure 1 shows the current Medicare setup. Program I, for wage-earning members of the Social Security System and the Government Service Insurance System, is currently in place, and a statutory expansion plan which will cover those in the informal sector (Program II) is being tested in several pilot provinces. PMCC supplies medical services to its beneficiaries through a nationwide system of accredited providers (hospitals/ clinics). PMCC likewise performs oversight functions over the Medicare program; it takes care of programming and structuring medical benefits. The monitoring and evaluation of the quality of provider services is additionally a major PMCC responsibility. In the disbursement of funds for the program, known as the Health Insurance Fund, the SSS and GSIS act as financial intermediaries, through a reimbursement scheme for the accredited hospitals. The collection and investment of HIF are undertaken by the SSS and GSIS independently of each other.

A major part of the environment of Medicare is the Employees' Compensation Program (ECP), a parallel but separate social insurance scheme. To begin with, it has a far longer history than the Medicare program, having been instituted during the American period under the Workmen's Compensation Act. The ECP fund, known as the State Insurance Fund (SIF) is generated only from employers, on the theory that work-related risks are a prime responsibility of these employers. No premium is collected from the employees, who are the beneficiaries of the system. The ECP also employs the SSS and GSIS for collection, reimbursement and investment of the SIF.

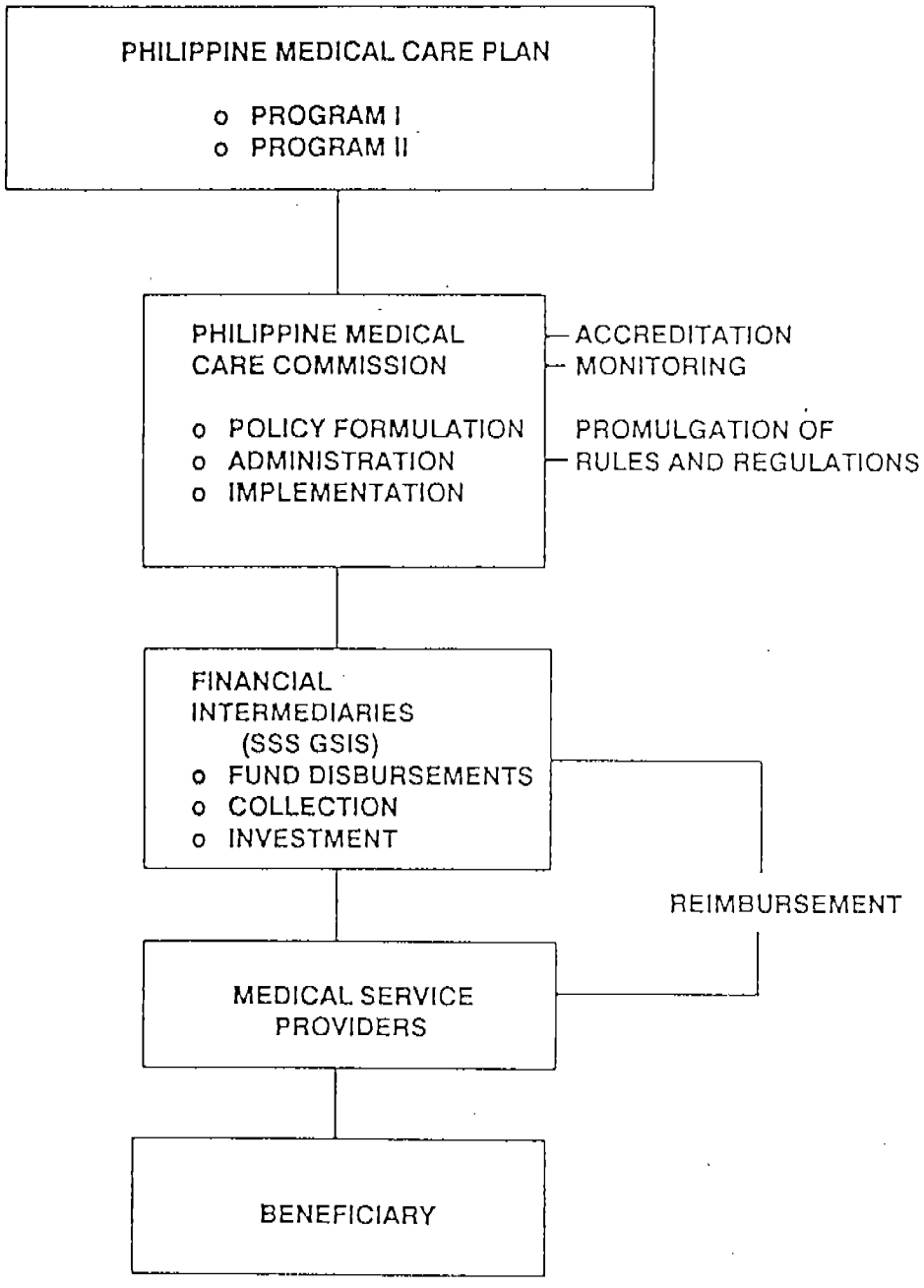
The legal basis for the current ECP is Presidential Decree No. 626, which took effect in 1974 and covers employment-connected injury, sickness, disability or death. Like Medicare, the ECP provides medical services benefits. Unlike Medicare, the ECP provides income benefits and rehabilitation services. The existence of both ECP and Medicare expands not just the availability of medical services, but the choices as well. When the illness or injury of a GSIS or SSS member is work connected or related, the member can avail of much higher benefits under the ECP. Indeed, "double recovery" of benefits from the two insurance systems is legally permitted (Gamboa, 1991).

The Employment Compensation Commission (ECC) is the body which formulates the policies of the ECP and reviews appealed cases from the GSIS and the SSS. In the manner of PMCC, the ECC also enforces an accreditation system for hospitals as well as physicians.

Under the SSS organizational makeup, Medicare personnel double as ECP staff. However, a reorganization plan which provides for the splitting of its Medicare department into two units, so that Medicare functions are exclusive to one, has just been implemented. In the case of the GSIS, the Medicare department is separate and distinct from the ECC department. Which one

Figure 1

MEDICARE I: ADMINISTRATIVE ISSUES
The Current Set-Up



offers a more efficient and streamlined setup is discussed elsewhere in this study.

For both the Medicare and ECP systems, fraud and abuses have been identified on the side of the providers, the administrators and fund managers (PMCC, SSS and GSIS) and the consumers. This has become a matter of public concern, and a sizable portion of the budgets of PMCC and the two Systems is expended in determining whether providers are "inducing" demand performing unnecessary services to be able to claim Medicare reimbursements. However, a cautionary note is needed here. When Medicare payments received by providers are determined retrospectively and is a function of endogenous decisions by hospitals and physicians as to length of stay and the resources deployed in the treatment of patients, there is little incentive to weigh costs against patient benefits. In other words, because of the emphasis on inpatient services, the system itself encourages "overuse" of medical resources. It produces an incentive to hospitalize rather than to utilize approaches that involve non-hospital inputs such as preventive services. In determining the forms and extent of abuses within the system, the moral hazard effect of insurance clearly needs to be factored in.

III. REVIEW OF LITERATURE

There is a paucity of literature on the subject of Medicare in the Philippines, much more so on the topic of administration and management. Of the small number of existing studies, of early vintage is Crisostomo (1976) which surveyed big private general hospitals in the Greater Manila. Crisostomo observed that big tertiary hospitals (100 beds and above capacity) had difficulties meeting high capital investments and fixed/operating capital requirements, because large amounts are tied up in receivables. The culprit, according to Crisostomo, was not existing Medicare contributions, as was generally believed, but the account portion not covered by Medicare and left as receivables by the hospital after a patient's dismissal.

Perhaps the most recent and relevant is that of Gamboa (1991). Although the study is an appraisal of the whole health insurance system in the Philippines, it devoted a major portion on Medicare and the Employees' Compensation Program. Much of Gamboa's discussions centered on the economics of social insurance, but they dealt with administrative issues as well.

Gamboa takes the Medicare system to task from four vantage points: organizational responsiveness, financial efficiency, operational efficiency and regulatory influence. His key finding is the "fragmentation of the Medicare program's policy and operational requirements among three (3) different independent government agencies" which "inhibits full exploitation of opportunities or economies of scale and for more coordinated operations". Gamboa cites as prima facie proof the contrasting styles and independent moves of SSS and GSIS: the former is decentralized and the other is centralized; each agency has its own probe team to monitor service providers; each issues its own accounting policies and financial reports which do not lend themselves easily to consolidation; likewise, the present system or structure does not allow for uniform investment policies and standards for premium collections performance and claims processing.

The Philippine Medical Care Commission (PMCC), on the other hand, has "limited organizational capacity to explore alternative benefit systems and improve the use of medical services." Gamboa cites specific flaws: a preponderance of administrative personnel rather than technical staff; a lack of critical research and planning capacities; the fact that the PMCC does not even have its own actuary and depends on the Social Security System (SSS) and the Government Service Insurance System (GSIS) for actuarial services. From the providers' point of view, Gamboa says that the PMCC may be more strongly felt as a regulatory agency because of its accreditation function. Yet PMCC has the potential as a development-oriented agency that could generate national consensus on social insurance.

In terms of financial efficiency, Gamboa notes that GSIS is lagging behind SSS in preserving (1) the stability or solvency of the program and (2) its responsiveness to the needs of members in terms of benefits. GSIS has a poor record in investment income performance possibly because prior to 1986, GSIS funds have locked in assets which did not generate much revenues; SSS' reserve capacity is stronger at six years while that of GSIS is 1.7 years. The disparity between the two Systems has inhibited the program from coming up with across-the-board benefit improvements. Future studies should look into the economics of integrating the Health Insurance Fund of the two systems.

The operational efficiency of the system is wanting, to the degree to which benefit payments do not accurately reflect actual services rendered. Fraud and abuses are endemic in any social insurance scheme, according to Gamboa, but this does not excuse the PMCC from having an effective monitoring system which would curb misuse of Medicare resources. An important pair of operational concerns of the PMCC are slow claims processing and inadequate information systems. Again, GSIS is taken to task for the snail-paced processing of claims, and PMCC, for the absence of an information system that can keep track of utilization and expenses, monitor providers and undertake risk studies.

Gamboa also devotes a major section on the Employees' Compensation Commission (ECC). The problems are strikingly similar: lack of an information system, dependence on the SSS and GSIS for data. These constrain decision making on the policy and operational levels. Unlike PMCC which gets a budgetary allocation, the ECC depends on the State Insurance Fund for its operating funds--a plus point, since it makes the system self-contained--except that the bureaucratic delays in the remittance of the share of SSS and GSIS has almost always cut into the operations of ECC.

ECC's current role in health care financing is limited since it focuses on workers and confines itself to work-related injuries. Gamboa suggests, however, the feasibility of integrating the medical, ambulatory and rehabilitative services of ECC with the Medicare program.

Another report, SGV (1990), was a cautious review of PMCC's MIS, or management information system, relative to its mandate and functions. The study examined the present PMCC-GSIS-SSS information sharing (or non-sharing) arrangements and determined whether they were consistent with the policy-formulation, regulatory, and administrative roles of PMCC. SGV (1990) also took a close look at the ways PMCC handled information pertaining to its operations, organization and finances.

Although the SGV study examined the major features of Medicare (coverage, benefit structure, financing and administration), its principal concern was to make a series of suggestions for PMCC to meet the increasing demand for timely and relevant management information. Many of its recommendations have a familiar ring, although they remain to be heeded: a centralized data base, housed in PMCC, for the Medicare threesome (PMCC/GSIS/SSS) to minimize redundancy; an overhaul of PMCC's reporting procedures; and well-defined access rights to the data. PMCC's Program Development Service would logically be the focus of reform, according to the study, because it has under its wing the Evaluation and Statistics Division. Much more importantly, the study proposed two "milestone" steps: (1) that PMCC switch into a high-tech information environment by acquiring computer hardware and customized software, and (2) that it create its own actuarial division. The latter would be later echoed in Gamboa (1991). Having its own actuary would enable PMCC to generate an "overall integrated perspective."

The SGV report ended on a note of warning: that considering PMCC's current difficulties in managing Medicare I information, its ability to reconfigure its MIS for Medicare II would be very much in doubt.

Other references have been reviewed for their relevance to this project. Dealing with the management of Medicare/Medicaid program in the US, from which important lessons for the local medicare care program can be drawn, are those of Holahan (1975) Roth (1974) and Fein (1986). Holahan looks at issues, concerns and areas for improvement of Medicaid, which has been designed for low-income Americans. Roth offers a detailed analysis of the control structures of the US Medicare law, comparing it with those of Medicaid. Fein discusses the pressure for systemic reform and the need for control mechanisms to be put in place.

On a more generic level, White (1987) presents management aspects of health services programs, dealing with decision-making processes, systems and procedures, organizational structures and manpower development. Hanlon and Pickett (1984) provide valuable insights on both medical care delivery and occupational health programs; it describes changing priorities and discusses the efficacy of current instruments as medical care provision has become very complex and as "atypical" organizational and management arrangements have become the norm.

A managerial insight into the conditions through which the production of goods and services takes place, and the part managers and workers play, is described in Hendrick and Moore (1985). A system approach is utilized by Mayer (1977) in the presentation of operations management relevant to service organizations. The production function is analyzed in relation to the needs of marketing, finance and personal relations.

Organizational configurations and strategies within the Philippine context of health service delivery described in Bautista (1989). A survey of existing health care models is found in OECD (1990). De Ferranti (1985), although basically an economic overview of policy issues in financing Third World health services, contains an important section on how to improve the organizational makeup of various medical care arrangements. Berman (1985), in an exhaustive study of primary health care in Indonesia, details sources of inefficiency in the management of health services in the area.

IV. CONCEPTUAL FRAMEWORK AND RESEARCH METHODOLOGY

Medicare is a risk-sharing social security scheme where medical users pay for coverage rather than directly for services. Current eligibility for coverage is limited to--and compulsory for--wage-earning individuals and their dependents, whether in the public or private sectors, although significant steps are being undertaken to include those in the informal sector to become part of the risk-coverage program. To finance the health insurance, employees in the formal salaried sector are taxed, through payroll deduction. Counterpart funds equal to those provided by the employees are put up by private sector employers and the government.

Figure 2 seeks to capture the key attributes of the Medicare program and simultaneously, identify the underlying administrative issues. Using the systems approach, a highly simplified input-output view of the Medicare program is shown. From that perspective, the salient question of interest is how a set of inputs undergoes a process (transformation) to produce the desired output(s).

The figure outlines the impact of key input components -- market (demand for services/volume of users), finance (costs and budget), personnel (skills availability and level of use) and facilities (equipment)--on the efficiency and effectiveness of the system, through a host of intervening processes that include accreditation, collection, disbursement, monitoring and evaluation and financial intermediation.

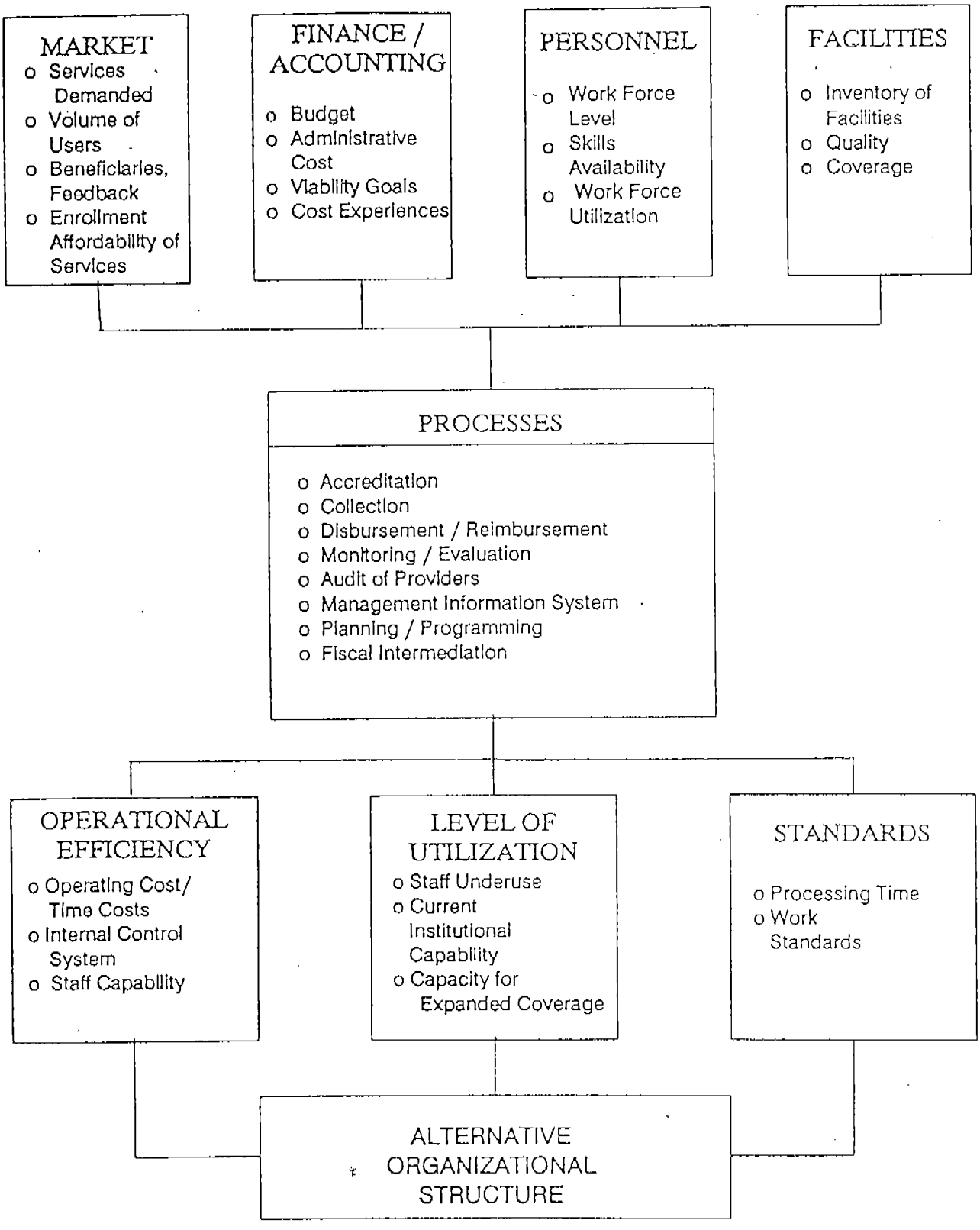
The operational efficiency and level of utilization of the system can be evaluated in both qualitative and quantitative terms. Procedural standards are also determined as a consequence. The framework also reflects additional considerations, such as the system's checks and balances and extent of leakages (wastage, corruption). Given the existing situation, attention also needs to focus on better coordination, simplification of procedures and possible integration of functions. Choices must be made about alternative organizational structures that will improve a complex system. In turn, organizational reforms must again be appraised, *ex ante*, in terms of market conditions (level of demand as a result of expanded coverage), viability goals, and availability of needed skills and facilities, to see if they have the capacity to carry out old and new mandates efficiently and effectively.

A slightly different way of viewing the framework is to consider the input components as independent variables, the process components as proximate variables and the output components as dependent variables. The central focus on the process components (accreditation, collection, disbursement, monitoring, fund management, etc.)--as intermediate variables causing changes in the form and extent of Medicare operations, level of utilization and work standards--highlights the impact of changes in the Medicare market, budgetary expenses, and level of use of human and physical capital. Both the pace and efficiency of operations are functions of incentives and controls generated by the various processes.

A. *Key areas of inquiry*

The discussion is presented in terms of eight major components, namely, enrollment, access to affordable and effective services, claims processing,

MEDICARE I: ADMINISTRATIVE ISSUES
Conceptual Framework



financial performance, tradeoffs between fund viability and utilization; accreditation and monitoring, administrative costs of current Medicare (and the Employees' Compensation Program) setup, alternative organizational structures, and capability to handle expanded coverage. These components also comprised the scope of the study. Under each component, researchable issues and questions were identified and given in-depth treatment. They are as follows:

Enrollment: target coverage and membership base vs. actual achieved; dependency rates; relation to labor force.

Access to effective and affordable services: regional distribution of providers; regional distribution of bed capacity; patterns of allocation of physicians and dentists.

Claims processing: the SSS and GSIS systems; personnel capacity; variations in processing time; volume of transactions and backlogs; determinants of the efficiency of processing.

Fund management: collection and investment patterns of GSIS and SSS; underwriting gain; financial indicators (liquidity, leverage, activity, profitability); efficiency of collection; reserve capacity.

Tradeoffs between financial viability and fund utilization: collection vs. benefits; coverage and recipients; benefits paid per recipient; operating expense per recipient; cost of insurance.

Accreditation and monitoring: the PMCC licensing system; monitoring/reporting: procedures, organization and coordination costs; nature, types and extent of fraud and abuses; determinants of length of confinement.

Administrative costs of Medicare I: operating costs of PMCC, SSS and GSIS; the 12 percent cap on costs.

Capability of PMCC to handle expanded coverage: organization and management; personnel profile; Medicare II performance;

Alternative organizational structures for Medicare I: *indicative* assessment of the extent to which existing Medicare mechanisms can be enhanced or reformed to lead to socially optimal allocations of Medicare resources; consolidation of GSIS/SSS HIF; Medicare/ECP consolidation; status quo with reforms/enhancements.

B. *Research methodology*

The study relied mainly on institutional sources of data. These are the PMCC, SSS, GSIS, and ECC. Secondary data include historical records of Medicare which contributed to the understanding of administrative issues facing the program. Information gaps were filled by other data sources, including the outcomes of diagnostic sessions with key informants in the PMCC, ECC, SSS, and GSIS.

Several analytical tools were employed:

Methods analysis: this basically ascertains and describes the claims procedures which are currently being employed by GSIS and SSS. Initially, a process flow chart--a graphic presentation of the sequence of operations occurring during a process--was made. It included information considered desirable for analysis such as time required. The operations and inspections performed by the Medicare units were described, as were the "motion" of documents, and the delays and bottlenecks experienced. Following the process chart approach, work simplification analysis was undertaken, incorporating the following: why/what to/where to/when to combine, what sequence to change, what responsibilities to alter, and what procedures to improve. It involved capacity evaluation, the determination of appropriate number of organizational units, the time element, and distribution (time/work sharing).

Regression analysis: the approach was to use a regression model in which the role of provider elements as determinants of the efficiency of claims processing and the length of hospital confinement was emphasized. Regression analysis was used in a very limited statistical sense to facilitate sensitivity analysis and to determine quantitative relationships among various variables relevant to the administration of the program. Such quantification was not uncovered in systems-type studies.

Secondary data analysis and diagnostic interviews with key informants in PMCC, ECC, SSS and GSIS.

V. ENROLLMENT AND COVERAGE

The target population base of Medicare is hypothetically the entire population of 63 million Filipinos. For Medicare to catch up with the expansion of population, the proportion of the population entitled to Medicare assistance should be growing. That proportion, between 1980-91, has fluctuated from a low of 36.5 percent in 1980 to highs of 51.8 percent in 1984 and 53.2 percent in 1986 (please see Table 1). These translate into an annual average growth rate of 2.3 percent, roughly equal to the country's annual population growth rate between intercensal years 1980 and 1990. That means that the Medicare coverage base--consisting of premium payors, their dependents, retirees and the self-employed voluntarily enlisting in Medicare--has been merely keeping pace with the population expansion on average. In absolute terms, the gap between those covered and those without coverage would continue to widen. In fact, as shown in Figure 3, the coverage dropped in 1987, and while it has picked up a bit in recent years, it has not quite attained the record set in 1984-86, when at least half of the population was covered.

TABLE 1
MEDICARE COVERAGE (In Millions)

YEAR	COVERAGE		DISTRIBUTION OF COVERAGE						POPULATION
	TOTAL NUMBER	AS PERCENT OF POPULATION	S S S	PERCENT	% CHANGE	G S I S	PERCENT	% CHANGE	
1980	17.56	36.51	13.22	75.26		4.34	24.72		48.10
1981	18.40	37.14	14.00	76.10	1.11	4.40	23.90	−3.28	49.54
1982	19.53	38.11	14.81	75.83	−0.35	4.72	24.17	1.11	51.24
1983	21.32	40.96	16.33	76.59	1.00	4.99	23.41	−3.14	52.06
1984	27.63	51.79	21.12	76.44	−0.19	6.51	23.56	0.62	53.35
1985	29.06	53.16	21.59	74.29	−2.81	7.47	25.71	9.11	54.67
1986	29.77	53.16	22.59	75.88	2.14	7.18	24.12	−6.17	56.00
1987	21.84	38.08	15.14	69.32	−8.65	6.70	30.67	27.19	57.36
1988	22.23	37.86	15.53	69.86	0.79	6.70	29.51	−3.80	58.72
1989	22.47	37.39	15.91	70.81	1.35	6.56	29.91	1.34	60.10
1990	23.19	37.72	16.47	71.02	0.31	6.72	28.98	−3.10	61.48
1991	24.17	38.45	17.45	72.20	1.65	6.72	26.07	−10.05	62.87
1992	23.82		17.52	73.55	1.88	6.30			

Sources of basic data: PMCC, NSO

A. *Discrepancy in coverage statistics*

There are reasons to believe that the extent of Medicare coverage may be less than what is suggested by the statistics. First, the sudden decline in coverage in 1987 was only partly the result of a sweeping government reorganization instituted by the Aquino administration during its first two years, in which quite a number of civil servants were permitted to retire early or were dropped from the rolls. The decrease was largely caused by the purging of inactive members, when SSS "cleaned" its registries.

Figure 3

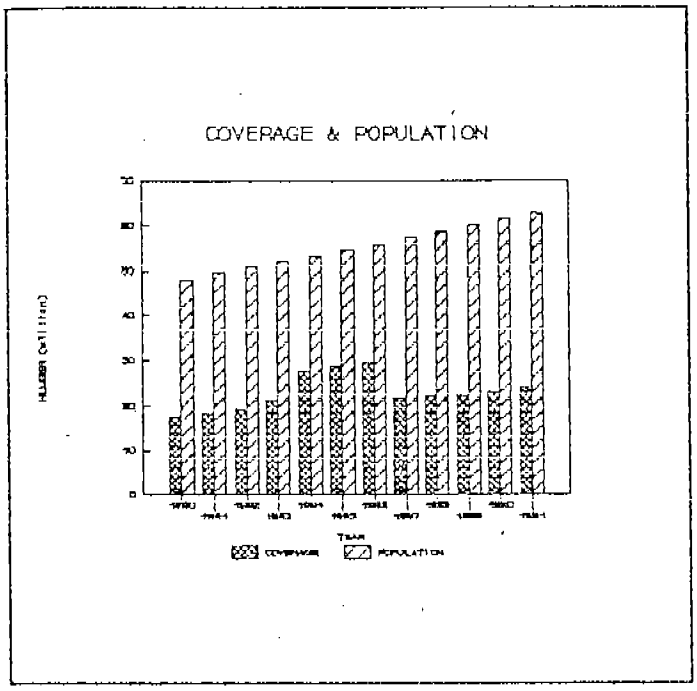
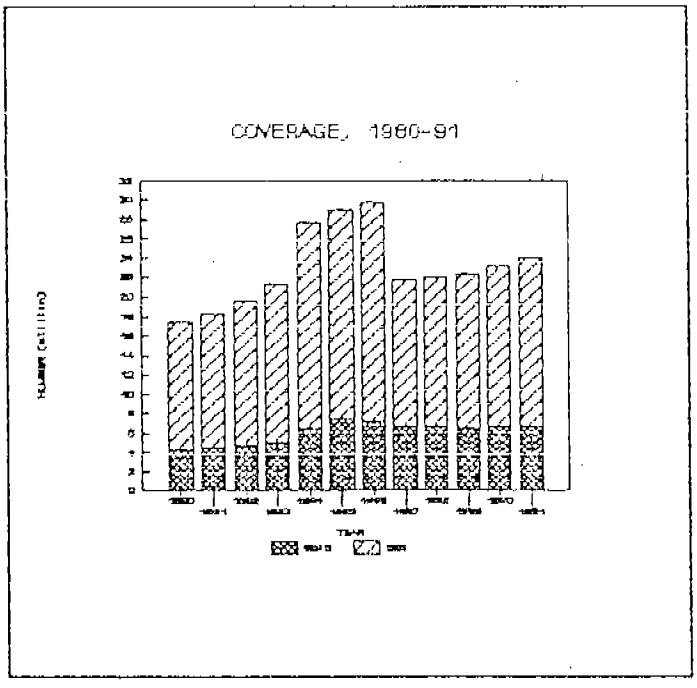


Figure 4



During the years prior to 1987, inactive members accumulated, bloating the SSS list. As shown in Table 1 and in Figure 4, SSS accounts for at least three-fourths of total Medicare coverage across the years. In 1992, SSS had over 17.5 million Filipinos insured for Medicare, compared to GSIS' 6.3 million Filipinos. Hence, when inactive members were scraped off the membership rolls by SSS, there was a dramatic impact on the depth of coverage. Second, the yearly estimates of the number of dependents, which make up the greater chunk of the coverage base, may be inflated. In 1980-83, the ratio of dependents to members was roughly 3 to 1; thereafter, it was close to 4 to 1. (The size of the dependents category may be read off Table 2, as well as off Figures 5 to 7). This was conceivably derived from the mean size of premium-paying households. The program dependency ratio, or the ratio of dependents and others to members, shown in Figure 8, in part reflects this picture, except that the ratio is a bit lower for GSIS because of the presence in the Medicare system of retirees.

TABLE 2
COMPOSITION OF MEDICARE COVERAGE (In Millions)

YEAR	ACTIVE MEMBERS*	SELF EMPLOYED	DEPENDENTS**	RETIREES	DEPENDENTS & RETIREES	TOTAL	DEPENDENCY RATIO (%)
SSS							
1980	3.30	0.00	9.91		9.91	13.22	3.00
1981	3.50	0.00	10.50		10.50	14.00	3.00
1982	3.70	0.00	11.11		11.11	14.81	3.00
1983	4.03	0.21	12.09		12.09	16.34	2.85
1984	4.18	0.23	16.71		16.71	21.12	3.79
1985	4.27	0.24	17.08		17.08	21.59	3.79
1986	4.47	0.25	17.87		17.87	22.58	3.79
1987	2.98	0.26	11.90		11.90	15.14	3.67
1988	3.05	0.27	12.21		12.21	15.53	3.68
1989	3.13	0.28	12.50		12.50	15.91	3.67
1990	3.21	0.29	12.83	0.14	12.97	16.47	3.71
1991	3.37	0.30	13.61	0.17	13.78	17.45	3.75
1992	4.09		13.03	0.41	13.44	17.53	3.29
GSIS							
1980	1.05		3.14	0.14	3.28	4.33	3.13
1981	1.06		3.18	0.15	3.33	4.39	3.14
1982	1.14		3.42	0.16	3.59	4.73	3.14
1983	1.20		3.61	0.18	3.79	4.99	3.15
1984	1.28		5.12	0.11	5.23	6.51	4.08
1985	1.47		5.89	0.11	6.00	7.47	4.08
1986	1.39		5.54	0.25	5.79	7.18	4.17
1987	1.28		5.12	0.30	5.42	6.70	4.23
1988	1.28		5.12	0.30	5.42	6.70	4.23
1989	1.25		5.00	0.31	5.31	6.56	4.25
1990	1.28		5.12	0.32	5.44	6.72	4.25
1991	1.28		5.34	0.10	5.44	6.72	4.25
1992	1.53		4.68	0.09	4.77	6.30	3.12
GSIS & SSS							
1980	4.35				13.19	17.54	3.03
1981	4.56				13.83	18.39	3.03
1982	4.84				14.69	19.54	3.03
1983	5.45				15.88	21.33	2.92
1984	5.69				21.94	27.62	3.86
1985	5.98				23.08	29.06	3.86
1986	6.11				23.66	29.76	3.87
1987	4.52				17.32	21.84	3.83
1988	4.60				17.63	22.23	3.83
1989	4.66				17.81	22.47	3.82
1990	4.78				18.41	23.19	3.85
1991	4.95				19.22	24.17	3.88
1992	5.62				18.21	23.83	3.24

*Includes self-employed in 1992 for SSS
**Includes retirees' dependents in 1992
Source of basic data: PMCC (As of April 1993)

Why the number of dependents is possibly an overestimate may be gleaned from a UP Population Institute finding on dependency patterns. For the country as a whole, the "dependency burden," or the number of population in the dependent ages (below 15 and over 65 years old) per 100 in the working ages (15-64 years) has been declining slowly and is expected to reach a level comparable to that of Japan by 2000. Considering this as the norm (alternatively, when a majority of those in the working ages start having separate Medicare membership, the number of dependents per household is effectively reduced), the program dependency ratio should decline rather than rise. If a lower ratio were adopted, especially for the later years, then the coverage base would be correspondingly smaller.

Figure 5

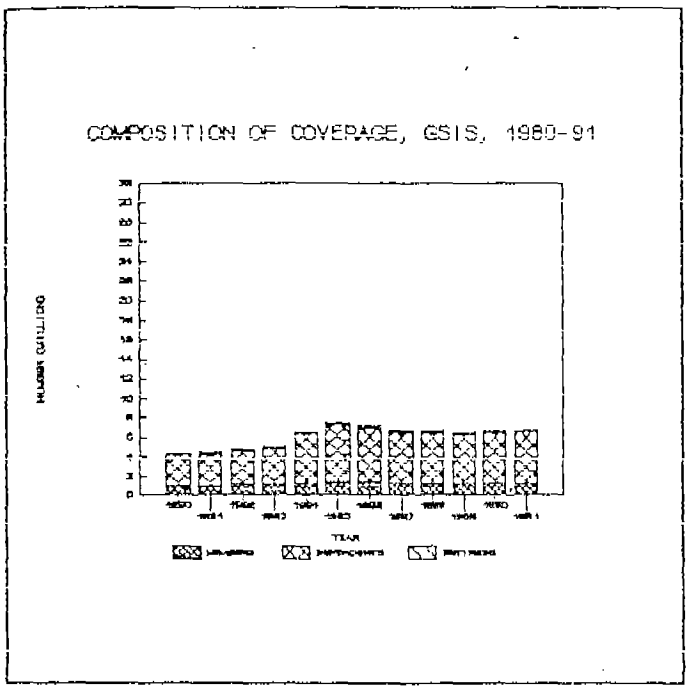
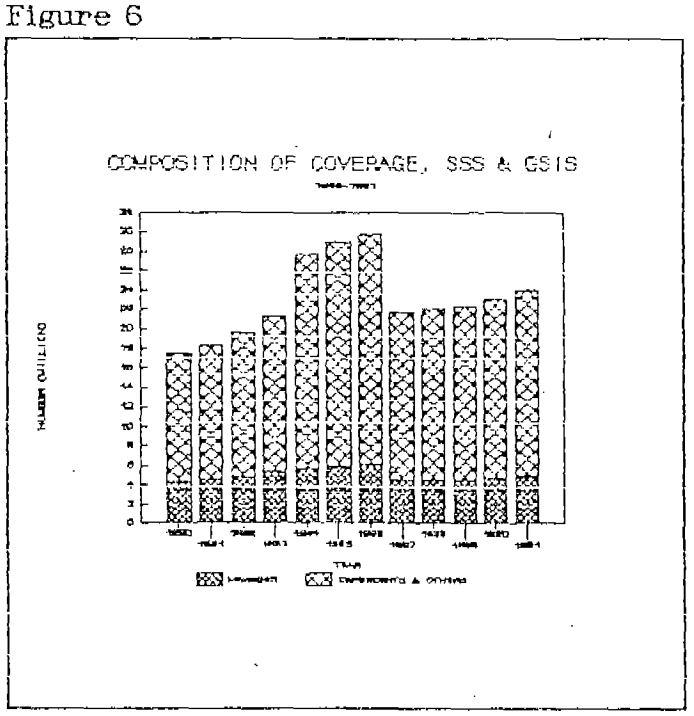


Figure 6



Overall, while Medicare has helped many obtain adequate medical care, over half of the population continue to be excluded from coverage. To understand why only a little over 38 percent have Medicare insurance to date, or roughly 24 million, one has to be aware that since its inception, Medicare has concentrated largely on the industrial and services sectors (through SSS) and the public sector (through GSIS)--at least under the initial phase of the program, called Medicare I for short. Although it is hard to generate information on Medicare membership by major industry or occupational groups, the major occupational groupings dependent on Medicare insurance include technical, administrative, executive and managerial workers, clerks and salespersons, and production workers and laborers. These are "captive markets," in the sense that subscription to Medicare by these workers is through an easy-to-enforce payroll tax. In general, Medicare coverage among the working population depends crucially on the type of job held. Full-time government workers are automatically covered through payroll

deductions; private sector employees are also far more likely to be enrolled because of Medicare's compulsory nature.

B. *Coverage among the self-employed*

Insurance coverage among the self-employed is low, as Table 2 indicates; those in the informal sector and in the farms are practically left to their own medical care devices. A disproportionate number of the working poor--farmers, fisherfolk, and rural workers--are among those without Medicare insurance. Although at least half of the labor force is found in this sector, the geographic dispersal of farms and fishing villages makes Medicare insurance difficult to provide. Regional patterns are unavailable, but it is widely held that poor agricultural regions and depressed areas are among those that have no coverage and few attractive alternatives. Because private insurance has hardly filled this gap, majority of the work force are still restricted in productive capacity because of illnesses that could have been remedied at early stages.

Figure 7

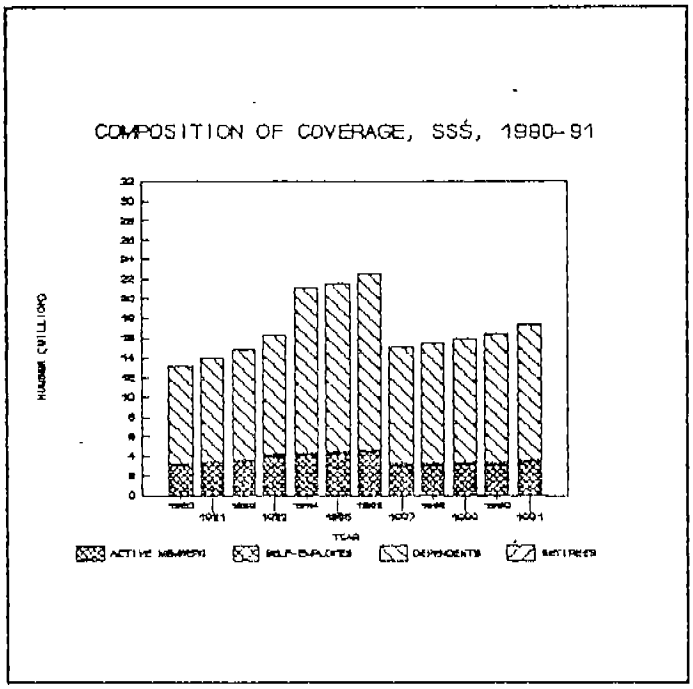
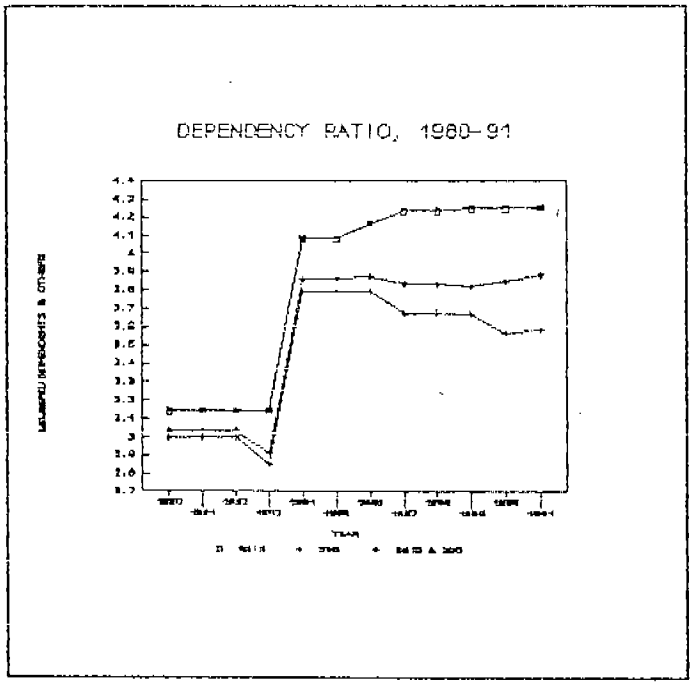


Figure 8



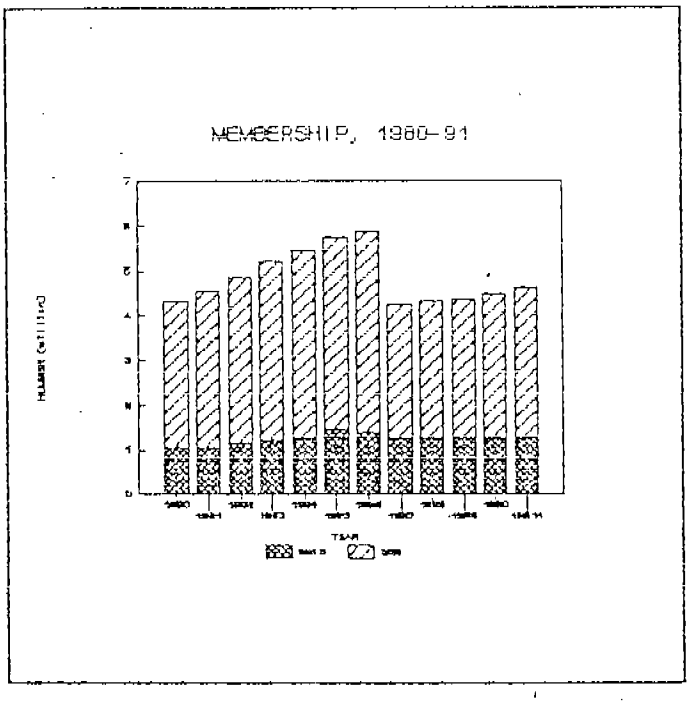
SSS has attracted few self-employed to Medicare, evidently because it offers social security insurance as a take-it-or-leave-it package with a variety of components, including retirement, disability, and education. Medicare is only one of these components. A prospective social insurance buyer will have to purchase all or nothing, giving him no choice at all to make a selection. Alternatively, he has to weigh the benefits of the entire social insurance package *against* the costs of non-participation. The package arrangement clearly acts as a disincentive, not only because of the high costs to the insurance buyer of paying a lot of premiums, but also because of the lack of freedom to discriminate among various insurance "goods," including those offered by private carriers. In 1991, social security coverage was formally

extended to self-employed farmers and fisherfolk earning at least P18,000 annually. This move is based on SSS findings that rural cooperatives are already quite developed and could serve as locus of collection and payment. SSS has launched an information campaign to attract new social security members among the rural poor. Still, it is unclear whether the "package deal" might not prove to be as unattractive to the farmers and fisherfolk as it is to the other self-employed.

C. *Slow growth in membership*

That Medicare is off the mark in reaching its target constituency is also strikingly indicated by the slow growth of its membership. Just as Medicare coverage needs to be extended to the whole population, so its membership ought to be extended to the entire labor force. And just as coverage appears not to be gaining ground, so too has the membership base been quite stagnant. Referring to Table 3 and Figure 9, during 1980-90, Medicare members numbered anywhere from 4.4 million to 5.9 million, about three-fourths of which was accounted for by SSS (again, the accuracy of the figures is doubtful--the overestimation noted in coverage applies as well to membership).

Figure 9



At any time during that period, the total number of members were at least a fifth of the labor force, but not more than a fourth. On average, the labor force grew by 3.6 percent annually during that time; Medicare membership grew only by 2.1 percent annually. If only the employed were to be considered (on grounds that the unemployed would not, after all, be able to afford the Medicare premium), the record would be as unpromising since the total number of employed grew by 3.2 percent per year. As a proportion of both the labor force and the employed, the membership base *actually declined*. As shown in Table 3 and Figure 10, the Medicare enrollees represented little more than one-fourth of the employed population in 1980; ten years after, despite an increase in absolute terms, membership went down to about 20 percent of the employed. That means that Medicare is failing to reach more than 80 percent of the working population.

If the program were to be judged only in terms of Medicare I, the outcome would be slightly different. To determine whether it has closed in on its target population, the growth of Medicare I must be charted as a proportion of the *salaried* employed. It is difficult to find statistics on the number of salaried employees in the government and private sector, but a fair approximation could be obtained by netting out agricultural workers from the total number of employed persons. Excluding agriculture would also sweep out

wage workers in fisheries and in the farms, and in any case the remaining figure would still retain the self-employed in the industrial and services sectors. It is assumed, however, that these would cancel each other out, and/or would not significantly affect the results. Examining Table 3 and Figure 11, a better picture emerges, as Medicare I is shown to have insured more than half of the wage workers, at least in the years 1981-86. As a percent of the employed (excluding agriculture), Medicare I membership reached its peak in 1982 (57.02 percent) and again in 1985 (56.18 percent) and in 1986 (56.21 percent), although the latter two would be overestimates (for reasons already cited above). There was a slippage of the membership base in 1987; its growth resumed later but at a slower pace. In 1990, the Medicare I members represented only 40 percent of the wage sector. By contrast, the number of salaried employed has had an uninterrupted steady growth rate, and this has widened the gap between the insured and uninsured. While this more conservative portrait puts the Medicare program in a much better light, still the bottom line is that Medicare is increasingly unable to provide a wider safety net to a growing work force.

Figure 10

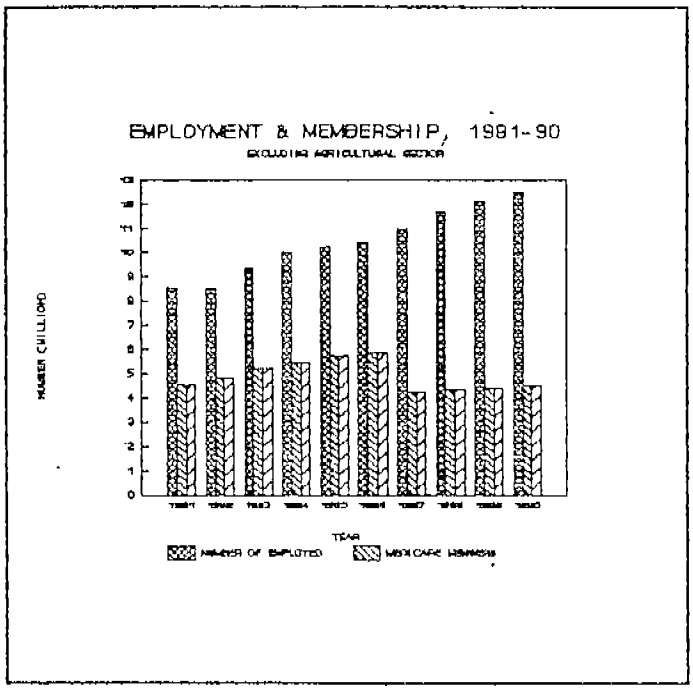
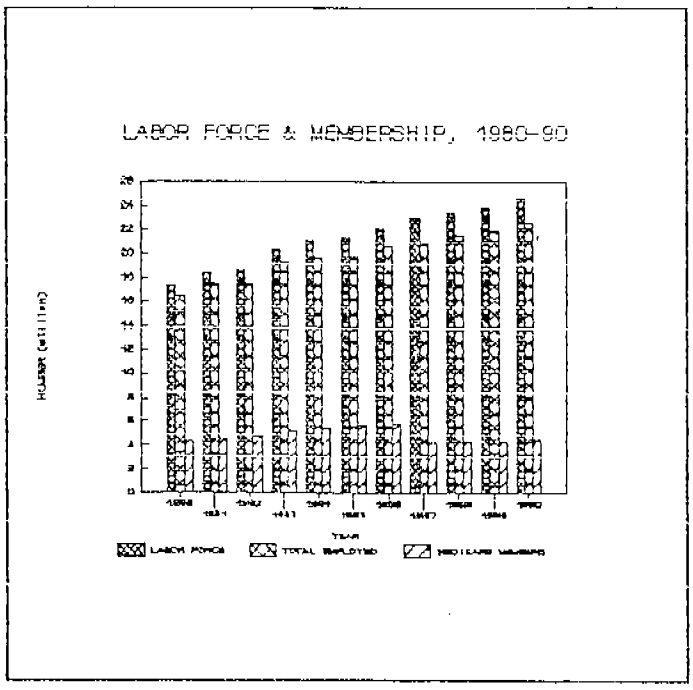


Figure 11



VI. ACCESS TO MEDICAL SERVICES**

All Medicare members and dependents should have access to affordable and effective high-quality medical care. At present this goal is far from being reached. In the past, PMCC tried to encourage uniform access among the regions by encouraging the growth of hospitals and clinics; in the

**Discussions in this section are based mostly on the traditional supply side approach. Medicare use patterns are analyzed, but generally, data constraints prevent a more multidimensional analysis of access to medical care.

TABLE 3
MEDICARE MEMBERSHIP (In Millions)

YEAR	LABOR FORCE	NUMBER OF EMPLOYED: ALL SECTORS	NUMBER OF EMPLOYED: EXCLUDING AGRICULTURE	TOTAL MEMBERS	GSIS: MEMBERS	GSIS: PERCENT OF TOTAL	SSS: MEMBERS	SSS: PERCENT OF TOTAL	MEMBERS AS PERCENT OF EMPLOYED (ALL SECTORS)	MEMBERS AS PERCENT OF EMPLOYED (EXC AGRIC)
1980	17.31	16.43		4.35	1.05	24.06	3.30	75.94	26.48	
1981	18.42	17.45	8.59	4.56	1.06	23.26	3.50	76.74	26.13	53.10
1982	18.47	17.37	8.49	4.84	1.14	23.56	3.70	76.44	27.88	57.02
1983	20.31	19.21	9.41	5.24	1.20	23.00	4.03	77.00	27.25	55.65
1984	20.97	19.67	10.01	5.46	1.28	23.47	4.18	76.53	27.74	54.55
1985	21.32	19.80	10.22	5.74	1.47	25.64	4.27	74.36	29.00	56.18
1986	22.07	20.60	10.42	5.86	1.39	23.71	4.47	76.29	28.43	56.21
1987	22.98	20.81	10.94	4.26	1.28	30.09	2.98	69.91	20.45	38.92
1988	23.45	21.50	11.70	4.33	1.28	29.56	3.05	70.44	20.16	37.04
1989	23.86	21.85	12.13	4.38	1.25	28.54	3.13	71.46	20.05	36.11
1990	24.53	22.53	12.50	4.49	1.28	28.51	3.21	71.49	19.93	35.93
1991*	25.25	22.98		4.65	1.28	27.53	3.37	72.47	20.24	

*Labor force and employment figures as of October 1991

Sources of basic data: PMCC, NSO

seventies, PMCC itself undertook the construction and maintenance of a number of primary-level hospitals, in an attempt to supplement the existing facilities nationwide. Called Medicare community hospitals, or MCH's, they were sited in villages lacking medical care infrastructure. These community facilities were supposed to graduate into self-reliant local medical care centers, but financial hardships forced a few of them to close shop. The rest were gradually turned over to the Department of Health.

A. *Regional profile of providers*

PMCC at present fosters uniform access by exercising its regulatory powers over hospitals, clinics, and medical manpower, principally through accreditation. The goal is to equalize access by making sure a sufficient number of facilities and physicians are present in each region. A national health insurance plan such as Medicare that covers a host of medical services is likely to be of little benefit to a community without a physician, much less the specialists and facilities required to offer these basic services. Despite the national uniformity policy of the Medicare program, there are substantial variations in access to providers by location.

Figure 12

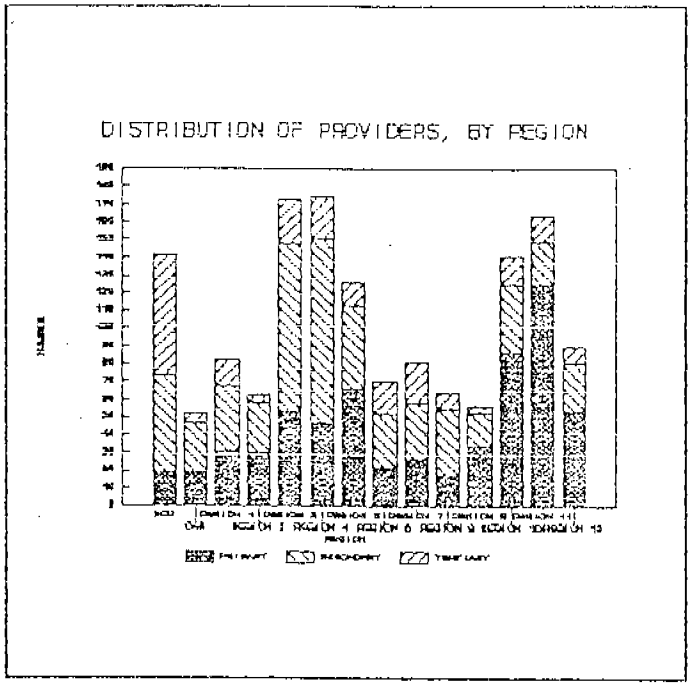


Table 4 gives a synoptic view of the regional distribution of medical facilities accredited by PMCC. Surprisingly, in terms of absolute numbers, it is not Metro Manila (National Capital Region) but Central Luzon (Region 3), Southern Tagalog (Region 4), and Southern Mindanao (Region 11) which have the most number of accredited hospitals. 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. 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. As Figure 12 shows, although Metro Manila has the biggest bed count, most of these are found in tertiary hospitals, which are concentrated in a few places. It is true that Metro Manila has a disproportionately large tally of tertiary providers (68), but they are not as numerous as primary clinics in, say, Southern Mindanao (125) or secondary facilities in Southern Tagalog (103). Many secondary facilities are found in Regions 3 and 4--which are relatively economically well-off areas--while small primary facilities abound in the more depressed areas, Regions 5, 10 and 11.

REGIONAL DISTRIBUTION OF MEDICAL FACILITIES BY TYPE AND BED CAPACITY

	PRIMARY		SECONDARY		TERTIARY	
REGION	NUMBER	BED CAPACITY	NUMBER	BED CAPACITY	NUMBER	BED CAPACITY
NCR	20	303	54	1959	68	20838
CAR	19	344	28	1075	5	793
REGION 1	31	418	37	1148	14	1816
REGION 2	30	349	28	878	5	900
REGION 3	54	647	94	2582	25	2650
REGION 4	47	683	103	3105	24	2759
REGION 5	66	857	47	1245	14	1127
REGION 6	22	349	30	1025	19	2704
REGION 7	26	504	33	1168	22	2908
REGION 8	17	226	38	1184	9	1100
REGION 9	34	432	19	694	4	325
REGION 10	87	1384	36	1531	16	1675
REGION 11	125	2545	24	857	15	1655
REGION 12	54	967	27	1072	9	894

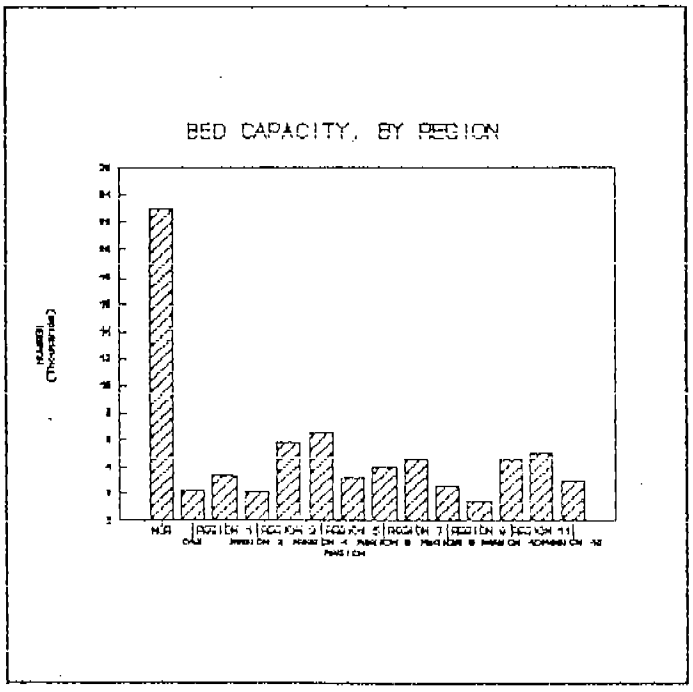
Source of basic data: PMCC, NSO

TABLE 4
(cont.)

REGION	TOTAL BED CAPACITY	TOTAL NUMBER OF FACILITIES	POPULATION (1990)	NUMBER OF BEDS PER THOUSAND	HOUSEHOLD POPULATION 15 YEARS OLD + (1990)	PERCENT IN LABOR FORCE (1990)	EMPLOYMENT RATE (1990)	NUMBER OF PERSONS IN LABOR FORCE (1990)	NUMBER OF EMPLOYED (1990)	NUMBER OF BEDS/THOUSAND IN LABOR FORCE	NUMBER OF BEDS PER THOUSAND EMPLOYED
NCR	23100	142	7.93	2.91	5.30	59.80	85.90	3.17	2.72	7.30	8.49
CAR	2212	52	1.15	1.93	0.71	73.90	96.20	0.53	0.51	4.20	4.36
REGION 1	3386	82	3.55	0.95	2.20	62.10	92.60	1.36	1.26	2.48	2.68
REGION 2	2127	69	2.34	0.91	1.50	66.70	95.30	1.00	0.95	2.13	2.24
REGION 3	5679	173	6.20	0.95	3.66	62.20	90.10	2.40	2.16	2.45	2.72
REGION 4	6547	174	8.27	0.79	5.02	64.20	91.30	3.22	2.94	2.03	2.23
REGION 5	3229	127	3.91	0.83	2.56	68.30	94.40	1.75	1.65	1.85	1.95
REGION 6	4078	71	5.09	0.76	3.41	65.00	92.30	2.22	2.04	1.84	1.99
REGION 7	4580	91	4.59	1.00	2.88	65.10	92.60	1.87	1.73	2.45	2.64
REGION 8	2510	64	3.06	0.82	2.02	71.00	94.10	1.43	1.35	1.75	1.86
REGION 9	1451	57	3.16	0.46	1.92	59.70	94.10	1.15	1.08	1.27	1.35
REGION 10	4590	141	3.51	1.31	2.21	69.00	92.70	1.53	1.42	3.01	3.24
REGION 11	5057	164	4.46	1.13	2.66	67.10	92.30	1.78	1.65	2.84	3.07
REGION 12	2933	90	3.17	0.92	1.77	63.30	95.40	1.12	1.07	2.62	2.75

Source of basic data: PMCC, NSO

Figure 13



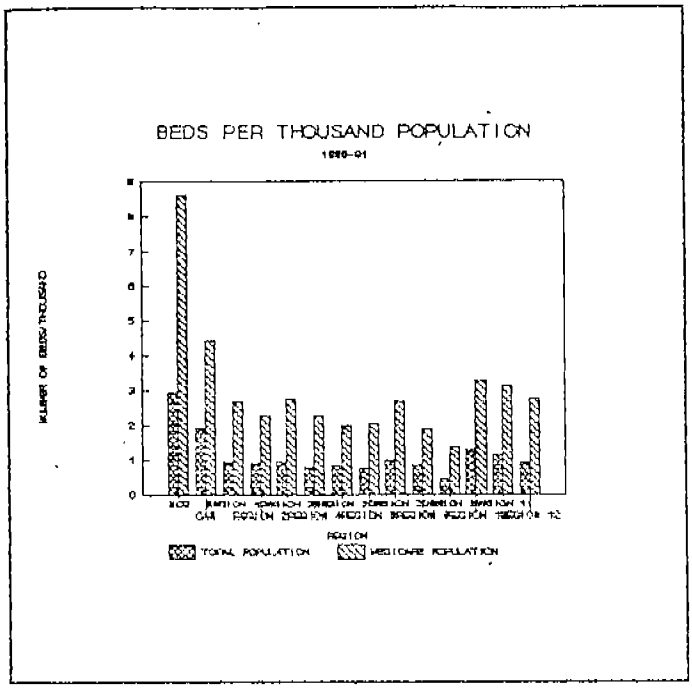
A good number of primary and secondary facilities are also located in other regions, all of them relatively poor. The Cordillera Administrative Region and Western Mindanao have the lowest overall number of facilities. Even within these needy regions, scatterings of tertiary facilities can be found. Broadly, the presence of a fairly large number of non-tertiary facilities in outlying regions suggest 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 above findings do not imply that the regional concentration of medical services has moved away from Metro Manila. Figure 13 summarizes the distribution of bed capacity, a more appropriate indicator of access at the regional level. The number of beds here are those specifically reserved for Medicare patients. As expected, Metro Manila is far too dominant in terms of Medicare bed capacity. Its total bed count, 23,100, is almost 4 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 topnotchers in terms of number of providers, have less than 6,000 beds each. Again, Cordillera and Western Mindanao have the least tally, with only 3863 beds between them.

B. *"Access to care" ratios*

Closer scrutiny requires evaluating the distribution of bed capacity among those insured by Medicare. Data on the regional breakdown of Medicare's coverage base are hard to come by, but a rough approximation can be obtained with the use of the regional disaggregation of the number of employed persons.

Assuming that Medicare members are distributed among the regions in much the same fashion as the employed (from which Medicare draws its members), then the Medicare population per region (which is proportional to the Medicare membership per region) can be estimated by multiplying the total Medicare coverage by the percent of employed found in that region. The number of beds per thousand Medicare population are then calculated by region. There are hardly any surprises in the findings (see Figure 14). 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, 4.4, despite having a low bed capacity. The reason is that this region has also the lowest estimated Medicare population (500,000). As

Figure 14



for the rest, the number of beds per thousand averages 2.4. In the final analysis, access to care is measured more appropriately by the above ratios if trends in utilization or availment, and epidemiological patterns are taken into account. But this is beyond the scope of the study, and the conclusions reached here must be somewhat qualified by this shortcoming.

C. *Regional allocation of health manpower*

The regional pattern of allocation of physicians (including dentists) accredited by Medicare (Table 5) looks very much like the regional distribution of health facilities. This is no accident, since these accredited doctors work within the accredited hospitals and clinics. More than a third of these physicians are found in Metro Manila, which supplies 3 doctors for every 1000 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.

Figure 15 shows the regional percentages for physicians. Figure 16, which must be compared with Figure 15, recaps the regional distribution of physicians and dentists per thousand population. Thus, while the introduction of Medicare caused the outlying regions as a whole to make rapid gains in the provision of medical services, they 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 on a per capita basis suggests that the accreditation program may be less than successful in areas removed from Manila.

TABLE 5
REGIONAL DISTRIBUTION OF ACCREDITED PHYSICIANS AND DENTISTS

REGION	NO. OF DOCTORS DENTISTS (1992)	PERCENT	POP'N (1990)	EST. MEDICARE POP'N	DOCTORS& DENTISTS/ THOUSAND POP'N	DOCTORS& DENTISTS/ THOUSAND MEDICARE POP'N
NCR	5332	36.088	7.929	1.761	0.672	3.027
CAR	417	2.822	1.146	0.255	0.364	1.638
REGION 1	574	3.885	3.551	0.789	0.162	0.728
REGION 2	365	2.470	2.341	0.520	0.156	0.702
REGION 3	1255	8.494	6.199	1.377	0.202	0.911
REGION 4	1453	9.834	8.266	1.836	0.176	0.791
REGION 5	565	3.824	3.910	0.868	0.145	0.651
REGION 6	895	6.058	5.393	1.198	0.166	0.747
REGION 7	1083	7.330	4.593	1.020	0.236	1.062
REGION 8	452	3.059	3.055	0.679	0.148	0.666
REGION 9	352	2.382	3.159	0.702	0.111	0.502
REGION 10	741	5.015	3.510	0.780	0.211	0.950
REGION 11	866	5.861	4.457	0.990	0.194	0.875
REGION 12	425	2.876	3.171	0.704	0.134	0.603

Sources of basic data: PHCC, NSO

Figure 15

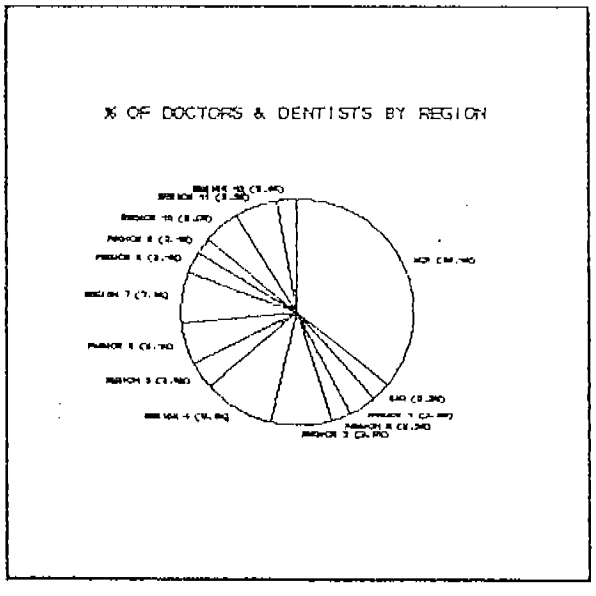
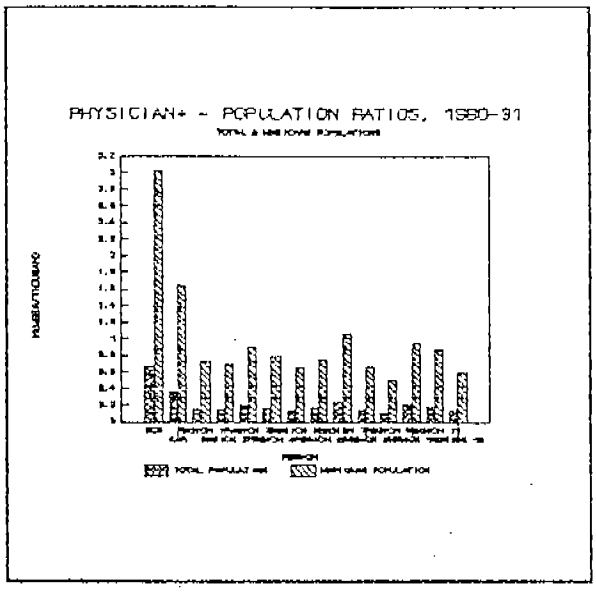


Figure 16



Only a few regions, specifically those with many tertiary facilities; have the full range of Medicare services. The majority apparently cover only a few. This comes as no surprise since few medical specialists are available to take on the more difficult and complicated Medicare cases. As Table 6

TABLE 6
MAJOR HEALTH MANPOWER TO POPULATION RATIOS

MEDICAL SPECIALTY	RECOMMENDED SPECIALIST–POPULATION RATIO* (PER 1000)	PHILIPPINES		NCR		CAR		1		2		3		4		5	
		NO.	RATIO	NO.	RATIO	NO.	RATIO	NO.	RATIO	NO.	RATIO	NO.	RATIO	NO.	RATIO	NO.	RATIO
GENERAL PRACTICE	0.05	8590	0.39	1925	0.72	307	0.61	410	0.33	297	0.32	839	0.39	982	0.34	432	0.27
SURGERY	0.10	327	0.01	137	0.05	11	0.02	16	0.01	2	0.00	24	0.01	36	0.01	10	0.01
EENT	0.07	379	0.02	213	0.08	7	0.01	9	0.01	5	0.01	32	0.02	34	0.01	4	0.00
OBSTETRICS – GYNECOLOGY	0.05	1195	0.05	709	0.26	17	0.03	30	0.02	7	0.01	86	0.04	86	0.03	20	0.01
PEDIATRICS	0.03	915	0.04	532	0.20	9	0.02	19	0.02	10	0.01	58	0.03	74	0.03	17	0.01
INTERNAL MEDICINE	0.03	936	0.04	564	0.21	19	0.04	22	0.02	6	0.01	41	0.02	59	0.02	14	0.01
ANESTHESIOLOGY	0.03	682	0.03	403	0.15	11	0.02	18	0.01	5	0.01	52	0.02	52	0.02	13	0.01
RADIOLOGY	0.02	65	0.00	28	0.01	2	0.00	3	0.00	1	0.00	3	0.00	5	0.00	1	0.00
UROLOGY	0.02	31	0.00	22	0.01	0	0.00	1	0.00	0	0.00	3	0.00	2	0.00	0	0.00
PATHOLOGY	0.01	30	0.00	12	0.00	0	0.00	0	0.00	1	0.00	1	0.00	1	0.00	0	0.00
DERMATOLOGY	0.01	16	0.00	13	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
NEUROLOGY	0.01	19	0.00	16	0.01	1	0.00	0	0.00	0	0.00	1	0.00	0	0.00	0	0.00
PSYCHIATRY	0.01	3	0.00	1	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
DENTISTRY	0.05	309	0.01	53	0.02	10	0.02	11	0.01	21	0.02	32	0.02	26	0.01	25	0.02
ESTIMATED MEDICARE POPULATION		22.212		2.682		0.500		1.246		0.938		2.130		2.696		1.629	

TABLE 6
MAJOR HEALTH MANPOWER TO POPULATION RATIOS (cont.)

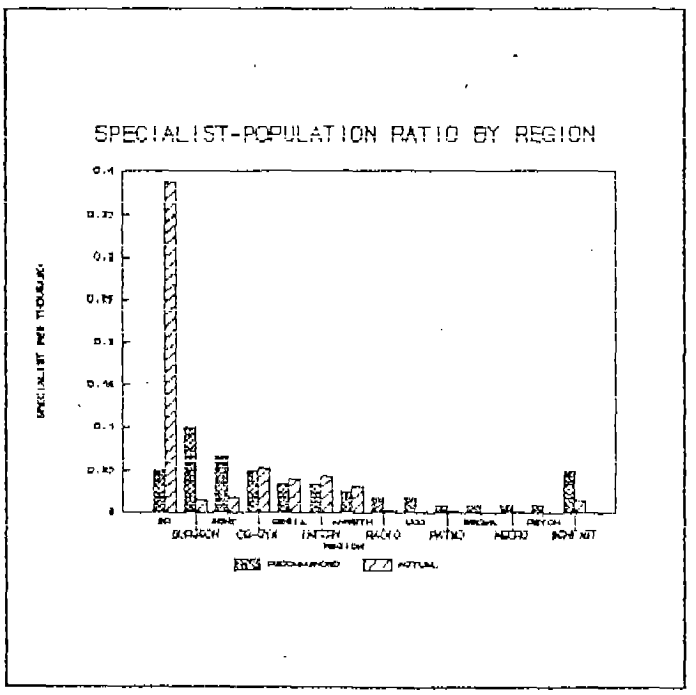
MEDICAL SPECIALTY	RECOMMENDED SPECIALIST–POPULATION RATIO* (PER 1000)	6		7		8		9		10		11		12	
		NO.	RATIO	NO.	RATIO	NO.	RATIO	NO.	RATIO	NO.	RATIO	NO.	RATIO	NO.	RATIO
GENERAL PRACTICE	0.05	908	0.30	620	0.36	358	0.27	292	0.27	583	0.42	592	0.36	345	0.33
SURGERY	0.10	22	0.01	25	0.01	5	0.00	3	0.00	5	0.00	19	0.01	10	0.01
EENT	0.07	18	0.01	25	0.01	0	0.00	4	0.00	11	0.01	15	0.01	2	0.00
OBSTETRICS – GYNECOLOGY	0.05	46	0.02	60	0.05	11	0.01	9	0.01	25	0.02	54	0.03	13	0.01
PEDIATRICS	0.03	39	0.02	72	0.04	15	0.01	5	0.00	20	0.01	35	0.02	10	0.01
INTERNAL MEDICINE	0.03	41	0.02	77	0.05	14	0.01	9	0.01	22	0.02	42	0.03	6	0.01
ANESTHESIOLOGY	0.03	24	0.01	39	0.02	11	0.01	7	0.01	8	0.01	27	0.02	12	0.01
RADIOLOGY	0.02	4	0.00	7	0.00	1	0.00	0	0.00	4	0.00	4	0.00	4	0.00
UROLOGY	0.02	1	0.00	0	0.00	0	0.00	0	0.00	0	0.00	2	0.00	0	0.00
PATHOLOGY	0.01	4	0.00	6	0.00	0	0.00	0	0.00	4	0.00	1	0.00	0	0.00
DERMATOLOGY	0.01	2	0.00	1	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
NEUROLOGY	0.01	1	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
PSYCHIATRY	0.01	1	0.00	1	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
DENTISTRY	0.05	24	0.01	29	0.01	21	0.02	9	0.01	20	0.01	22	0.01	10	0.01
ESTIMATED MEDICARE POPULATION		2.016		1.709		1.329		1.062		1.396		1.623		1.053	

Sources of basic data: PMCC, PMA

*Except for those of dentist and general practitioner, all ratios are recommended by the Philippine Medical Association

indicates, specialists are few and sparse, and badly allocated among the regions. It is the general practitioners who dominate the system, indicating that Medicare has as a whole not gone beyond simple curative services, which are ordinarily offered in primary clinics. Indeed, the number of general practitioners in the program per thousand population far exceeds the recommended ratio of 0.05, nationwide and in all the regions. Figure 17 summarizes the current specialist-population ratios at the national level. The only specialists which seem to be in oversupply (only in Metro Manila and Central Visayas, in any case) areobstetricians-gynecologists, pediatricians, internists, and anesthesiologists, all of which form the core of Medicare's more advanced health manpower. The rest, including surgeons, EENT doctors, radiologists, urologists, dentists and neurologists are grossly underrepresented in all regions. There is an excess demand for these specialist doctors even in Metro Manila, where most of them have established medical practice. Areas with few medical resources per capita reflect partly a low demand for highly differentiated medical services. On the supply side, too few numbers are being generated by the system. Lack of advanced facilities in poorer regions also constitutes a significant deterrent to the availability of medical specialties. Overall, practically no incentives exist to induce even a semblance of concentration of specialized medical resources in poverty stricken communities.

Figure 17



D. *Medicare use patterns*

Limited GSIS statistics contain data on use patterns for the system's Medicare beneficiaries across regions, as shown in Table 7 below, for the period July-December 1991.

Although Mindanao, with the western region excepted, does have a per capita bed count next only to Metro Manila's, the disparity is considerable, and it is a surprise to discover a disproportionately high number of Medicare users in that area. Whether this suggests overutilization, and by implication a high incidence of fraud, however, needs empirical verification.

While this sample of recipients is confined to the public sector, it does suggest major behavioral differences when groups are classified by eligibility, sex and location.

Overall, the figures suggest that use patterns need not necessarily correspond to health care access levels. Although Medicare accredited

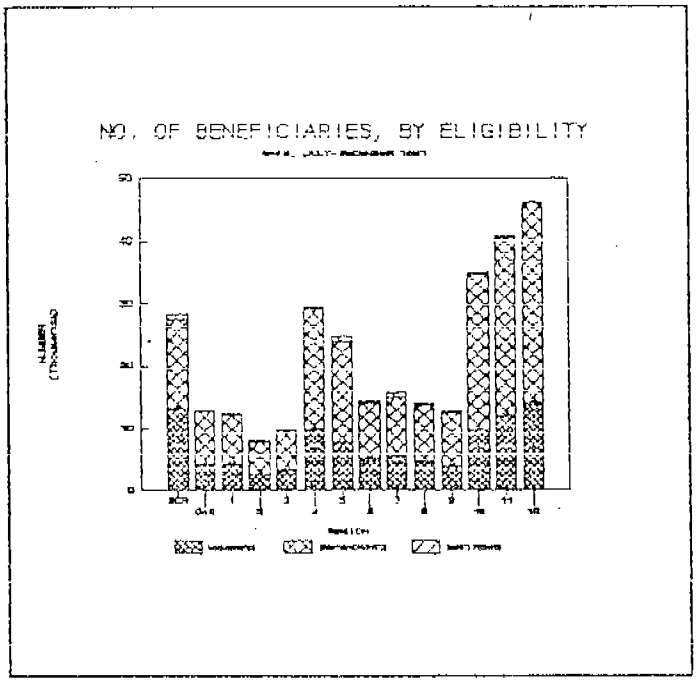
TABLE 7
NUMBER OF GSIS BENEFICIARIES, BY REGION, JULY-DECEMBER, 1991

REGION	ELIGIBILITY			SEX		LOCATION	
	MEMBERS	DEPENDENTS	RETIREES	MALE	FEMALE	RURAL	URBAN
NCR	13406	14121	589	6259	21857	0	28116
CAR	4378	8500	159	3336	9701	11450	1587
1	4589	7597	364	3458	9092	7239	5311
2	2722	5305	107	2248	5886	6636	1498
3	3694	5965	173	2350	7482	4071	5761
4	9810	19219	544	8443	21130	17220	12353
5	7884	16318	578	6480	18300	18246	6534
6	5484	8605	596	4401	10284	8843	5842
7	5578	9674	591	4536	11307	10120	5723
8	4698	9118	369	3892	10293	10811	3374
9	4107	8489	187	3541	9242	8930	3853
10	9970	24679	388	8865	26172	30133	4904
11	12205	28093	400	11278	29420	27606	13092
12	14399	31716	270	12387	33998	35138	11247

Source: GSIS

facilities and health practitioners tend to congregate in Metro Manila and other urban places, the consumption of Medicare services, at least within the public sector, is not monopolized by Medicare recipients in the National Capital Region. There is a higher number of users in Southern Tagalog (Region 4), and in Northern, Southern and Central Mindanao (Regions 10, 11, and 12). The highest tally is found in Region 12, with more than 46,000 beneficiaries, compared with Metro Manila's 28,000.

Figure 18



Although Mindanao, with the western region excepted, does have a per capita bed count next only to Metro Manila's, the disparity is considerable, and it is a surprise to discover a disproportionately high number of Medicare users in that area. Whether this suggests overutilization, and by implication a high incidence of fraud,

however, needs empirical verification.

The same regional use pattern, but disaggregated by eligibility, sex and location is graphically portrayed in Figures 18, 19, and 20. Medicare consumers among the dependents outnumber those among members, which is as it should be, if both members and dependents are equally likely to use Medicare when they contract illnesses. Recipients among the retirees are a negligible number. It is also evident that, if anything, female beneficiaries outnumber male beneficiaries by roughly two to one. This is an extraordinary finding, since it is often assumed that there is no greater likelihood that women would use Medicare facilities. One plausible explanation for this variance is that a larger proportion of public sector Medicare beneficiaries (principally teachers) are women who use medical services as much as, and possibly more, than men. Still, it could be argued that demand behavior for women follows the usual intuition: they are more health conscious, and are likely to get medical care than men.

Figure 19

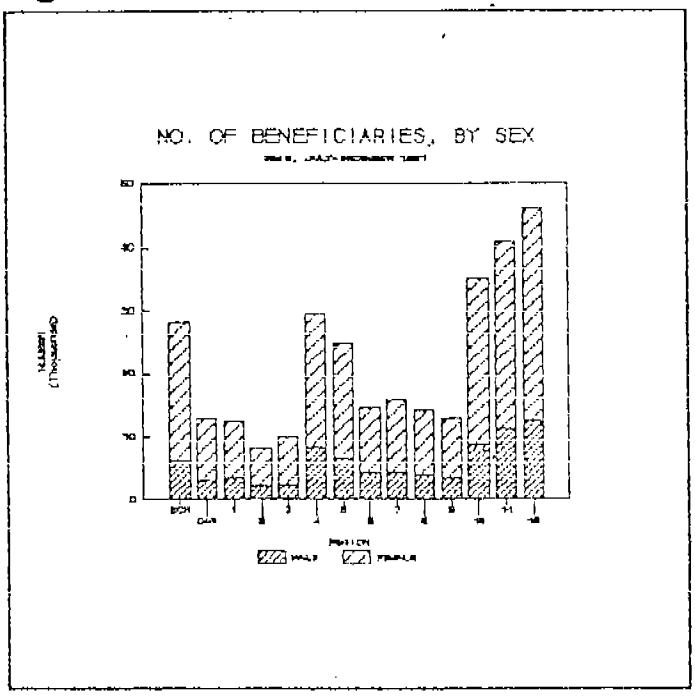
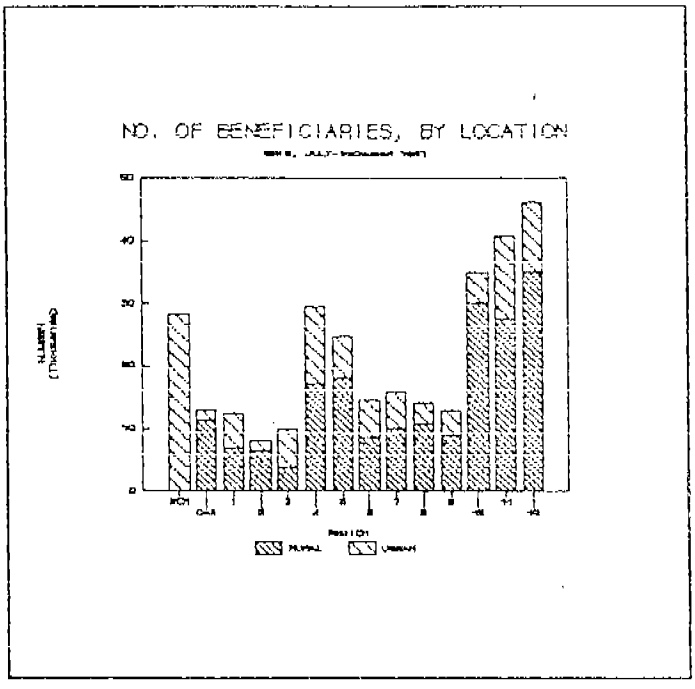


Figure 20



Except for Metro Manila, which is totally urban, all regions have hosted a larger number of rural beneficiaries. Again, the three regions of Mindanao have the highest record of rural beneficiaries. This might be a good signal of the distributional consequence of making Medicare available in rural areas. Primary clinics, for example, are targeted to low-income groups who come chiefly from rural regions. To repeat, the statistics are not definitive, and the numbers might supply misleading information, if not validated by other data.

VII. CLAIMS PROCESSING

A. *The GSIS Medicare claims processing system*

The Medicare Department of GSIS is the central unit which processes medical claims from health providers and beneficiaries. The department has the following major responsibilities: (1) receive, process, and control claims and release benefit payments; (2) perform medical evaluation of Medicare claims; (3) establish, maintain and update Medicare membership rolls; (4) maintain and update records of collectibles due each and every government office; (5) carry out claims processing and adjudication, computer encodings, cheques/vouchers examination and review; and (6) perform planning and administrative functions. These functions are prorated among the six divisions of the Medicare Department (see Figure 21).

The department routinely processes claims from Medicare recipients who have complied with the "requisites for availment." The claims are paid on a reimbursement basis. Under normal circumstances, the hospital and the medical practitioner net out from the hospitalization costs all expenses reimbursable by Medicare. The benefit expenses under the Medicare Act consist of the following: (a) allowance for hospital room and board; (b) allowance for medical expenses consisting of medicines, X-ray, laboratory examinations, among others; (c) professional fees which include surgical, medical/dental and anesthesiologist fees; d) operating room fees; and (e) surgical family planning procedures (sterilization benefits). In highly exceptional circumstances, the beneficiary may be directly reimbursed of his/her expenses allowable under Medicare rules.

B. *The procedures and flow of claims processing*

The processing of Medicare claims involves the Medicare Department's six divisions: the medical evaluation staff, membership division, the claims processing divisions I, II, III (adjudication divisions), and the data entry divisions. Other units involved in claims processing which are outside of the medicare department are the EDP department and the mailing department. The complete process flow is shown in Figure 22.

(1) Claims and Control Section (Claims Control and Data Entry Division)

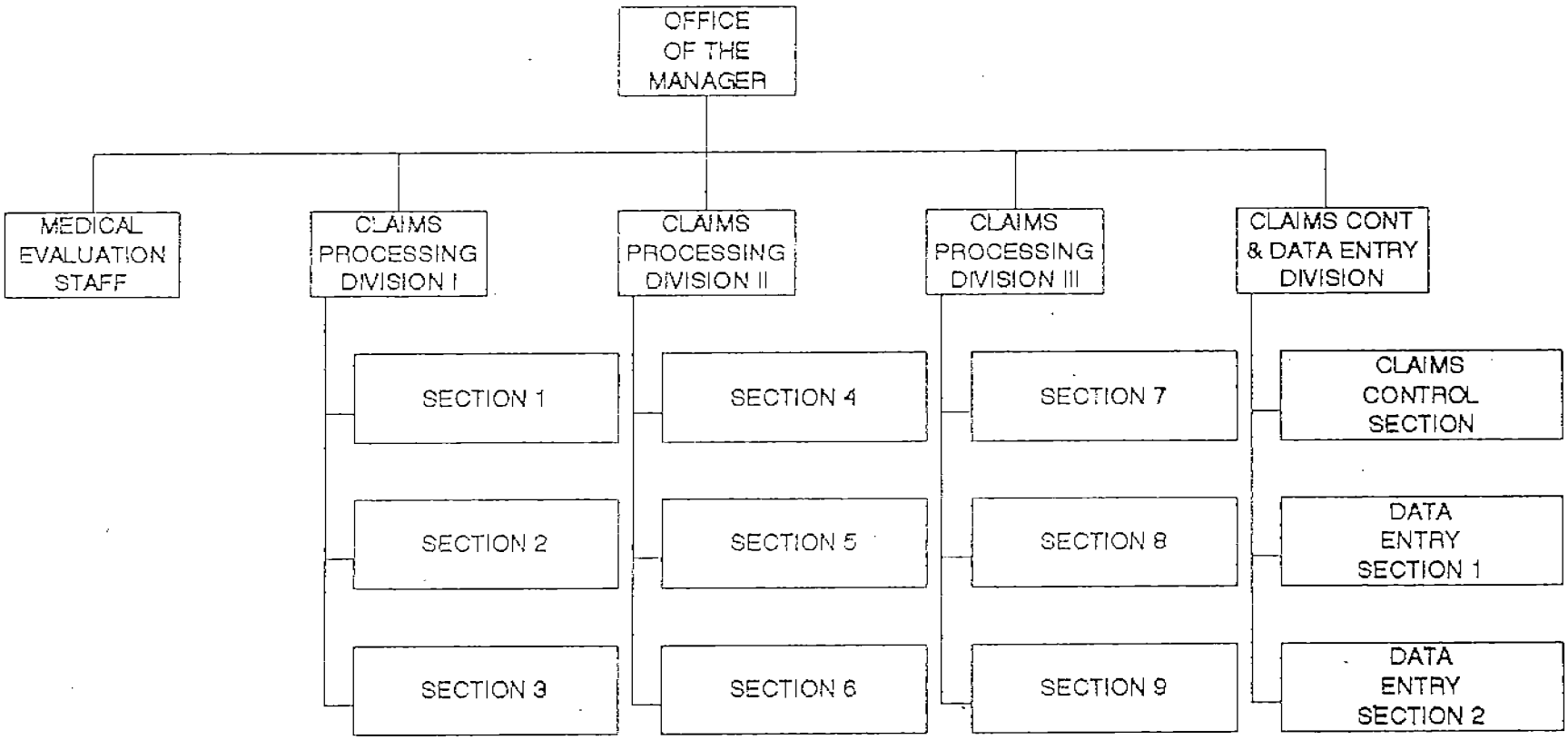
The Claims and Control Section receive, control and pre-process and batch all incoming claims from walk-in hospital representatives, mail messengers and other sources. After the claims have been pre-processed and segregated into completely filled-out and data-deficient claim forms, the former are bundled by groups of hospitals into 300-320 claims per bundle. Claims with deficiencies are returned to senders. The bundled forms are then forwarded to the Medical Evaluation Staff.

(2) Medical Evaluation Division

The Medical Evaluation Staff composed of medical doctors evaluate all claims according to the implementing rules and regulations prescribed by the PMCC and the standard operating procedures adopted by the Medicare Department. They determine the correctness of the medical information filed in the claim and ascertain the medical procedures and medication given the

Figure 21

ORGANIZATIONAL CHART
GSIS MEDICARE DEPARTMENT



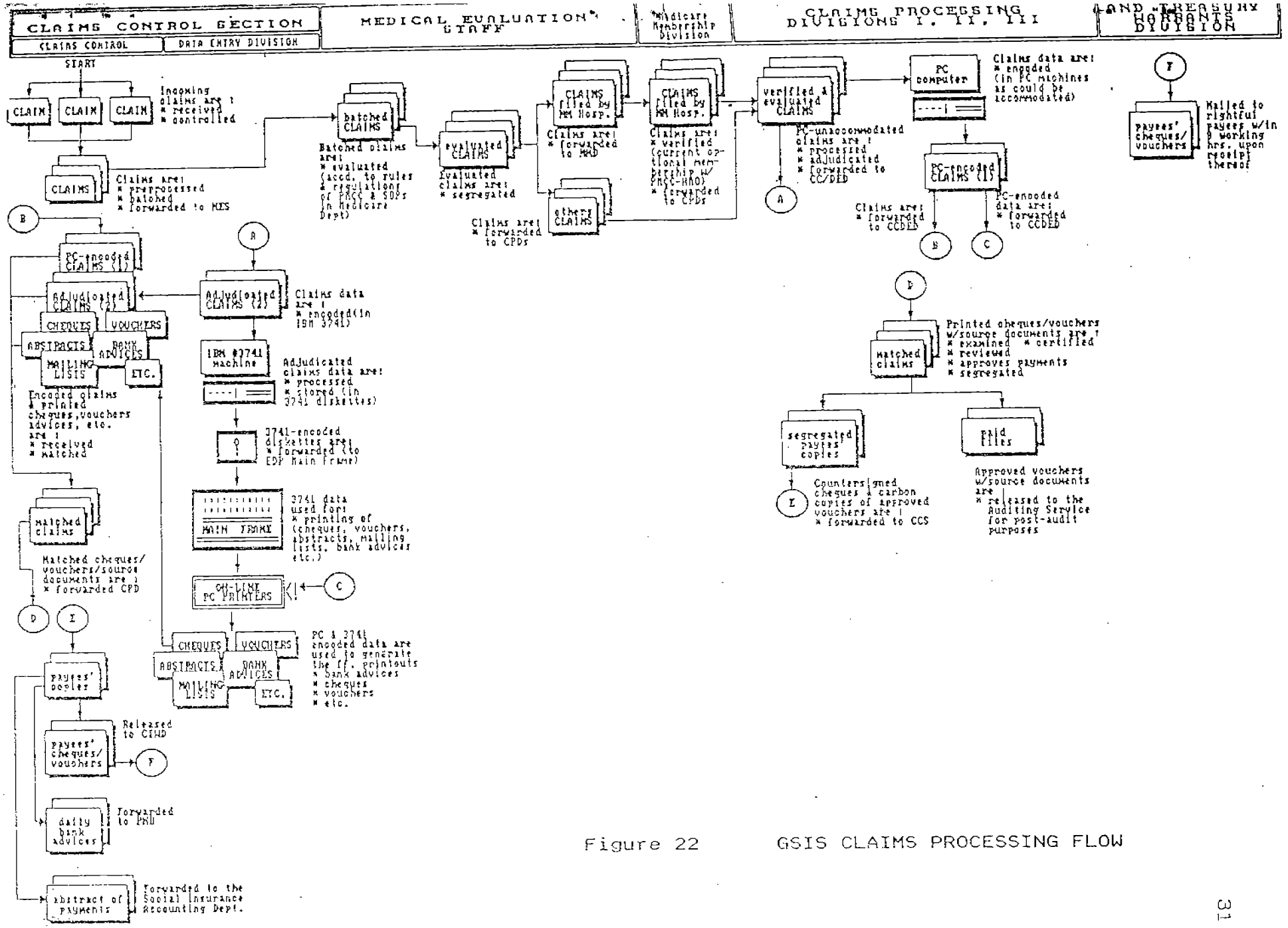


Figure 22 GSIS CLAIMS PROCESSING FLOW

patient for the specified illness. Should they decide that more information is needed or if inconsistencies in the medical procedures and/or medication are found, the claim is either denied or suspended, pending further information from the provider. In the latter case, the claim is sent back to the provider. Medically-approved claims are routed to any of the three Claims Processing Divisions for further evaluation.

(3) Claims Processing Divisions I, II, III

One of the Adjudication Divisions evaluates the eligibility of the claims in terms of the qualifications of the patient as a member or dependent as reflected in the PMCC forms 1 and 2. If the patient is qualified, then a computation of the benefits payable to the hospital or to the member is done. In other words, the division examines, reviews, certifies and approves payments of benefit cheques/vouchers.

All claims found to have adequately met the eligibility requirements are dispatched to the Data Entry Division. Those found to have failed the adjudication tests are either set aside, pending additional information, or denied and sent back to the provider. The Adjudication Division is also responsible for all succeeding verification procedures. For statistical purposes, the division prepares a daily accomplishment report indicating the number of members, dependents, retirees or military who have filed Medicare claims.

(4) Claims Control and Data Entry Division

The Claims Control and Data Entry Division encodes all adjudicated claims in a personal computer (the division uses an IBM 3741). A trial list, containing all encoded data, is produced to verify the correctness of the information. The Adjudication Division reenters the process when it does the verification. All inconsistencies are then reexamined for reprocessing. This phase is done repeatedly until all information is found satisfactory.

The encoded data are forwarded to the EDP mainframe computer for printing of cheques, vouchers, abstract, mailing lists and bank advices. The cheques and vouchers are again validated by the Adjudication Division. Cheques found not to have matching information are re-entered on a computer disk for reprocessing while those found satisfactory are sent to the Mailing Division for proper disposal.

C. *Personnel complement*

The Medicare Department has a manpower complement of 72. Apart from the department manager, the Department proper staff consists of two administrative officers and six insurance analysts (all casual employees). The Medical Evaluation Staff has eight medical doctors. The Membership Division is staffed by two senior social insurance specialists and four contractual social insurance analysts. The three Claims Processing Divisions have 32 processors(8 of which are contractual). The Claims Control And Data Entry Division is 20-odd strong; five of its staff belong to the Claims and Control Section. Except the administrative personnel, practically all are involved in the routine processing of claims. The manager, of course, gives the over all direction and attends to external matters which concern the department.

D. *Assessment of the system*

A hallmark of GSIS Medicare processing is the clear-cut separation of responsibilities and control among various entities. The present institutional arrangements have both positive and adverse features. The SOPs are generally adequate, but the downside has been the existing problem of the quality of processing, and backlogs. There may be understaffing because of the growing stockpile of half-processed claims. However, GSIS has not apparently 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.

Statistics on claims processing capacity are not unreasonably inaccurate, and can be the basis for assessing the efficiency of the system. The Claims Control and Data Entry Division can pre-process 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 daily surge of 2,000 incoming claims. This translates into a backlog of 50,600 claims a month (assuming there are 22 working days/month).

The hurdle begins at the medical evaluation phase since the Staff can process only 300 claims out of 1,250 pre-processed claims. But the real bottleneck is in the Claims Processing Division: it can only process 200 out of 300 claims. A total of 50,600 unprocessed claims per month when translated to days would be a 9-day backlog (assuming there are 6.5 productive working hours a day). For the Medical Evaluation Staff to be able to ease the backlog, eight additional doctors are needed. In turn, that would create a chain effect, e.g., 16 additional processors would automatically have to be added to the Claims Processing Divisions to complete all claims.

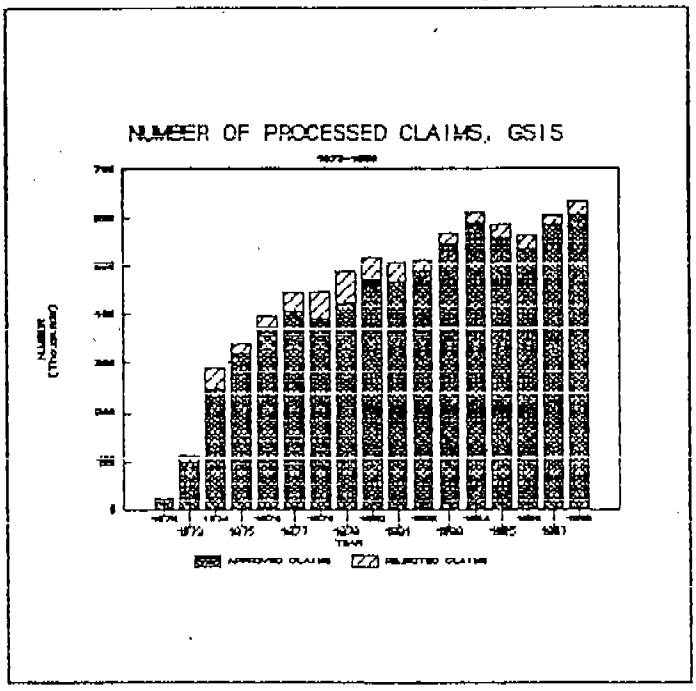
Each of the 200 claims goes through the processing mill in about 15 minutes, as a GSIS document claims. It takes half a minute to receive the claim. For the next three minutes, the claim is examined for proper identification at the Membership Division. The claim is then evaluated by the medical staff at an average clip of 1.5 minutes. When the Claims Processing Division takes over, it spends about seven minutes for adjudication. The last three minutes are consumed by the senior insurance analyst and the Division Chief who signs, prepares the reports, and transfers the claim to the other units.

A different picture and story will come out simply by reconstructing the statistics on claims processing. It is unclear which offers the more accurate picture. To begin with, 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 has been reduced significantly to 28,567. Yet the average monthly balance of unprocessed claims in 1991 is 50,615, which is very close to the 50,600 backlog computed earlier. To go a little bit further, if 200 claims are completely processed a day then 30.76 claims are processed in an hour. A claim then undergoes processing in only 1.95 minutes. That seems to imply undue haste in processing and suggest superficial assessment and evaluation of Medicare claims. The controls indicated in the process flow are very minimal as well as

very general.

There is further evidence that few claims are being disapproved. Figure 23 illustrates the situation. Except in 1974, 1978 and 1979 when disapproved claims reached 12-14 percent of the total number of processed claims, the proportion of rejected claims has not gone beyond 10 percent between 1972-1988. Since 1980 there has been a declining trend in the number of disapprovals. It has averaged only 4 percent 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 motion." It is unclear whether this lack of rigor actually encourages fraud; it is clear, however, that the system leaves much to be desired. There are no clear-cut 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 details in claims processing.

Figure 23



E. *Determinants of claims processing efficiency*

Since policy interventions may be necessary to make claims processing more efficient, it would first be necessary to see how a processing agency like GSIS behaves in relation to factors at the provider level affecting claims processing. The approach here is to utilize a regression model in which the role of institutional (provider) elements as determinants of the efficiency of claims processing is emphasized. The regression analysis is also important as a norm-setting technique for processing efficiency.

The choice variables are processing time (average number of days a claim is processed) and volume of transactions (number of claims processed). Each will be regressed against a number of independent variables which are described below. Time and volume are not exactly unrelated; if the processing setup is efficient, reducing the processing time translates into a larger volume processed, given the same time period. Hence, when regressed against the same set of explanatory variables, their respective outcomes would have opposing effects, that is, the dependent variables would move in opposite directions.

Processing time 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. Waiting times can be quite long, as suggested in an

earlier section. Government processing units might be so swamped with claims that it would require months before refund checks would be issued. Processing time is reckoned from the day the claim is received by the GSIS main office in Manila to the day the reimbursement check is issued. Although this choice variable does not include the shipping time at the beginning (when the claim form is mailed by the provider) and end (when the check is mailed to the provider), it does capture time lags when incomplete claim forms are returned to hospitals. These delays add to the processing time.

(1) **Explanatory variables**

The physical distance is the stretch of land, air and sea routes from the hospital site to the central processing agency (GSIS). Distance captures mailing costs, although admittedly this is only a small part of the total real cost of processing. Distance is also a deterrence for acquiring knowledge about Medicare benefits and procedures: there is a strong likelihood that providers located far from Manila, especially rural providers, may not be as much informed as their counterparts located near the center. Hence, the probability is higher that far-flung providers may be less equipped to provide accurate claims data, and may experience more delays in claims processing. Thus, the *a priori* assumption is that it takes more time to process claims from more distant providers.

Urban location is a proxy for an assortment of variables: availability of high-quality care, knowledge, adaptability to modern medical concepts (including medical insurance) and education. This location variable measures the efficiency with which Medicare-related activities are undertaken. The time required to perform such activities may be lower, including the accurate filling out and prompt filing of claim forms.

The type of institutional setting may influence the efficiency of claims processing. Private hospitals, may be more opportunity-cost conscious, and may desire a quicker payback period for their Medicare expenses. On the other hand, public hospitals often receive subventions from the government, or may perceive that they can always be financially bailed out by government should crisis situations occur, and this is clearly a disincentive to pursue prompt reimbursements. It is then more likely that private providers would follow up on filed claims. In a similar vein, tertiary providers may be less inclined to keep track of their Medicare repayments because of higher pre-financing capabilities (although this is offset by high opportunity costs if foregone earnings are quite large). By contrast, small primary providers, with relatively high unit operating costs, may be more eager to pursue a speedy resolution of their claims to stabilize their financial condition.

The higher the average Medicare charges, the more a provider would "chase" GSIS for reimbursement. Other things being equal, high Medicare reimbursable expenses act as an inducement for demanding quick action. Attending doctors may also require immediate payment for their services.

Properly speaking, processing time should be insensitive to the proportion of dependents who file claims. As to the proportion of female recipients, it is difficult to attempt to isolate the effect of sex on the efficiency of claims processing. The findings, if significant, might suggest implications on gender, but there is no guarantee that differentials are not

because of chance.

TABLE 8: DESCRIPTIVE STATISTICS

Variables	Definition	Mean	Std Dev
Dependent variables			
DAYSPROC	Average number of days Medicare claim is processed	46.29	24.40
VOLPROC	Total number of claims processed	213.10	272.27
Independent variables			
DISTANCE	Number of kilometers from hospital to Manila	705.50	596.69
RURBAN	Dummy = 1 if urban	0.3551	0.4787
PRIPUB	Dummy = 1 if public hospital	0.3270	0.4693
TYPE_PST	Dummy = 1 if primary provider	0.4106	0.4921
TYPE_SPT	Dummy = 1 if secondary provider	0.4137	0.4927
AVECHARG	Average Medicare charges (pesos)	1085.50	756.26
DEPRATIO	Ratio of dependent recipients to member recipients	2.55	3.95
FEMRATIO	Proportion of female recipients	0.7277	0.1232

Provider-level data came from aggregated computer records from GSIS. The variables, which are described in Table 8, were generated from information on number of claims processed (disaggregated by sex and member-dependent category), number of claims processed, type of hospital, and average Medicare charges. The files were merged with PMCC data on Medicare-accredited providers, to obtain the location variable. Distances--averages of land/sea/air routes linking each provider to Manila--were separately computed from data supplied by the Department of Transportation and Communication. The sample consists of 1315 observations, and covered the period July-December 1991.

Ordinary least squares estimation was used to estimate the impact of the specified explanatory variables on the speed of processing and volume of claims. The results are summarized in Tables 9 and 10. The most important finding from the two regressions is that only three variables--distance, public/private hospital dummy, and the proportion of female beneficiaries had opposing effects. As a whole, the results were not consistent with the prediction that the two sets of identical variables would move in opposite directions.

(2) Results

The distance variable is inversely related with processing time and directly related with volume of claims, which was not hypothesized. The more outlying the provider is, the better chances it has that its claims would be processed in a shorter time. That runs counter to conventional thinking, which associates distance with transport and information costs. Yet it is plausible that remotely located providers correlate distance with opportunity costs. In this scenario, distance is a deterrence to filing claims, because of the high opportunity costs of the extended processing period. The longer the distance, the less claims are filed, which correspondingly lessens the volume of processed claims. The other side of the coin is that with a lower tally of claims, swifter resolution of claims takes place.

TABLE 9: OLS RESULTS FOR PROCESSING TIME

Independent variables	Coefficient	t-ratio
DISTANCE	-0.0018	-1.448**
RURBAN	-2.8884	-1.831*
PRIPUB	5.1768	3.404*
TYPE_PST	-5.6160	-2.245*
TYPE_SPT	-1.3316	-0.631
AVECHARG	-0.0070	-5.875*
DEPRATIO	-0.0226	-0.135
FEMRATIO	5.8349	-2.905*

*Significant at the five percent level
**Significant at the ten percent level

TABLE 10: OLS RESULTS FOR VOLUME OF PROCESSED CLAIMS

Independent variables	Coefficient	t-ratio
DISTANCE	0.0485	3.649*
RURBAN	-53.499	-3.155*
PRIPUB	-73.943	-4.524*
TYPE_PST	-319.045	-11.866*
TYPE_SPT	-272.114	-11.994*
AVECHARG	-0.0203	-1.595*
DEPRATIO	-0.6229	-0.345
FEMRATIO	4.3109	1.439**

*Significant at the five percent level
**Significant at the ten percent level

Processing time is lower for claims filed by urban-based hospitals, as hypothesized, indirectly supporting the evidence that urban location makes providers and patients better equipped to satisfy pre-processing requirements. Yet the volume processed is also lower for urban claims, and this contraindication seems to suggest a bias for rural claims, at least in terms of numbers. It takes more time to process rural claims, but this is compensated by the fact that more of the claims processed come from rural providers. Essentially the same pattern holds for primary, secondary and tertiary providers. Since most of the tertiary providers are located in cities, it comes as no surprise that processing time is lower for these providers. Similarly, the tradeoff is that more of the claims processed originate from primary and secondary providers.

It also takes more effort to process claims from government hospitals; less claims are therefore processed. Roundabout ways are more associated with public hospitals (they are slower to complete filing requirements), which contribute to delays in processing. Efficiency in the use of time seems to be relatively better in private hospitals, at least in adhering to claims procedures.

Average Medicare charges are inversely associated with lengthy processing periods; the higher the charges, the shorter the time needed to resolve the claims. Again, there is a tradeoff. The lower the reimbursable expenses, the more claims are processed. Although claims with lower charges are probably scrutinized more thoroughly, more of these low-valued claims pass through the processing mill. If most of these claims come from primary providers, whose lifeline might conceivably depend on Medicare, then they would have strong incentives to press for immediate payment. As expected, the number of dependents has no influence on the efficiency of claims processing. Gender, however, seems to figure prominently: the proportion of women beneficiaries is positively associated with volume of claims processed and negatively associated with processing time. It could be that as a whole, female recipients are better educated and more skillful in following prescribed Medicare filing regulations.

The upshot of all these is that it is better provider skill in closely following Medicare claims filing procedures that might be making a difference between inefficiency and speed in processing. In turn, such knowledge is the outcome of a series of factors, including urbanization and modernizing traits, tendency to adopt market perspectives, the need to survive financially, and even gender educational level differences. Up to this point, it has been assumed that the determinants of claims processing efficiency are entirely exogenous to the processing system. Yet processing efficiency may be equally dictated by factors more internal to GSIS, such as the level of skills and motivation of the Medicare Department staff (quality of processing), staff sensitivity to rural-urban/regional disparity and gender issues, overcentralization of procedures, and extent of inter-departmental coordination. This deserves scrutiny as a separate research topic.

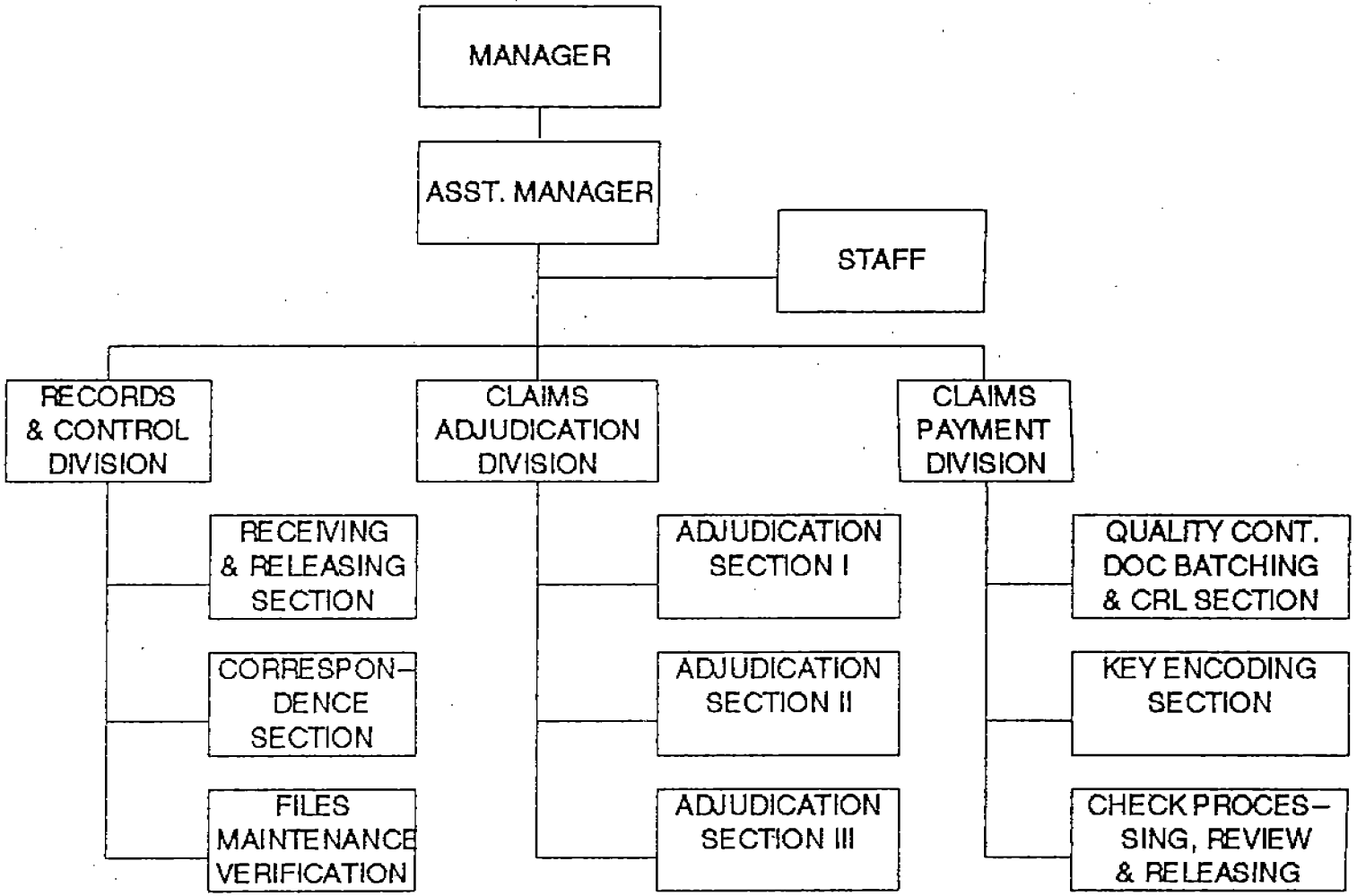
F. *The SSS claims processing system*

Unlike GSIS where all processing takes place in its central headquarters in Manila, SSS has completely devolved claims processing to its ten regional offices. Since SSS follows a decentralized system, variations in processing may exist among the regional offices. What is described in this section is the processing system in the SSS main offices in Quezon City, which entertain claims from Metro Manila only.

SSS Medicare claims go through seven departments but the departments with the major processing responsibilities are the Medical Evaluation Department and the Medicare Department. Shown in Figure 24 is the organizational configuration of the Medicare Department. The entire process flow is described graphically in Figures 25, 26 and 27. The Medical Evaluation Department receives, and validates the accuracy, completeness and eligibility of, claims applications. The Medicare Department reviews the claims, performs adjudication and makes adjustments if necessary) in the amount of the claims. Processing ends with the release of Medicare payment checks by the Medicare Department which also takes care of notifying the claimants. A more thorough description of the process is necessary to pinpoint areas where reforms may be needed.

Figure 24

ORGANIZATIONAL CHART
SSS MEDICARE DEPARTMENT



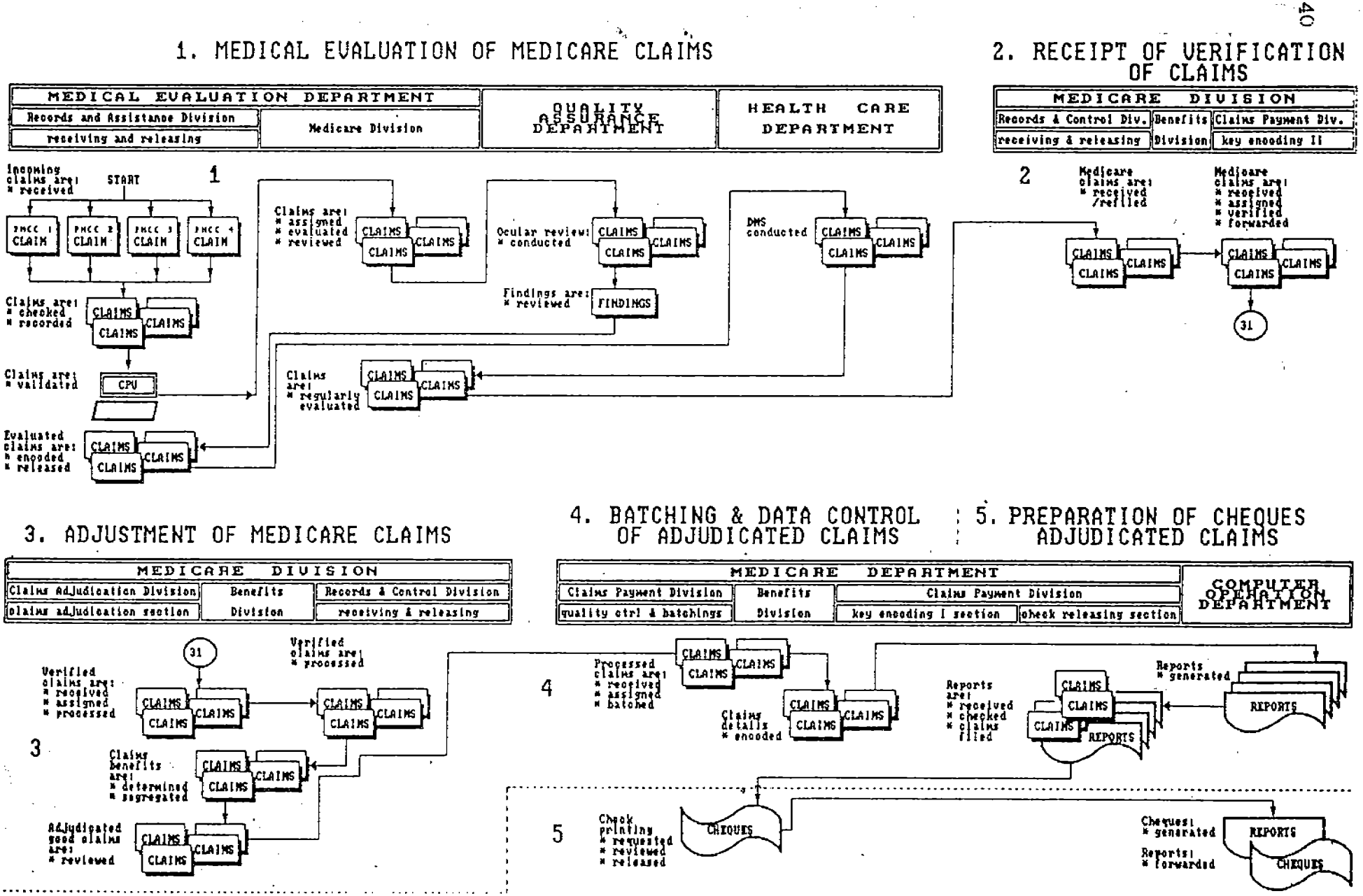


Figure 25 SSS CLAIMS PROCESSING FLOW

6. ADJUSTMENT OF MEDICARE CLAIMS | 7. MANUAL REPARATION OF CHEQUES | 8. REVIEW, REPLACEMENT & RELEASE OF CHEQUES - ADJUDICATED/ADJUSTED CLAIMS

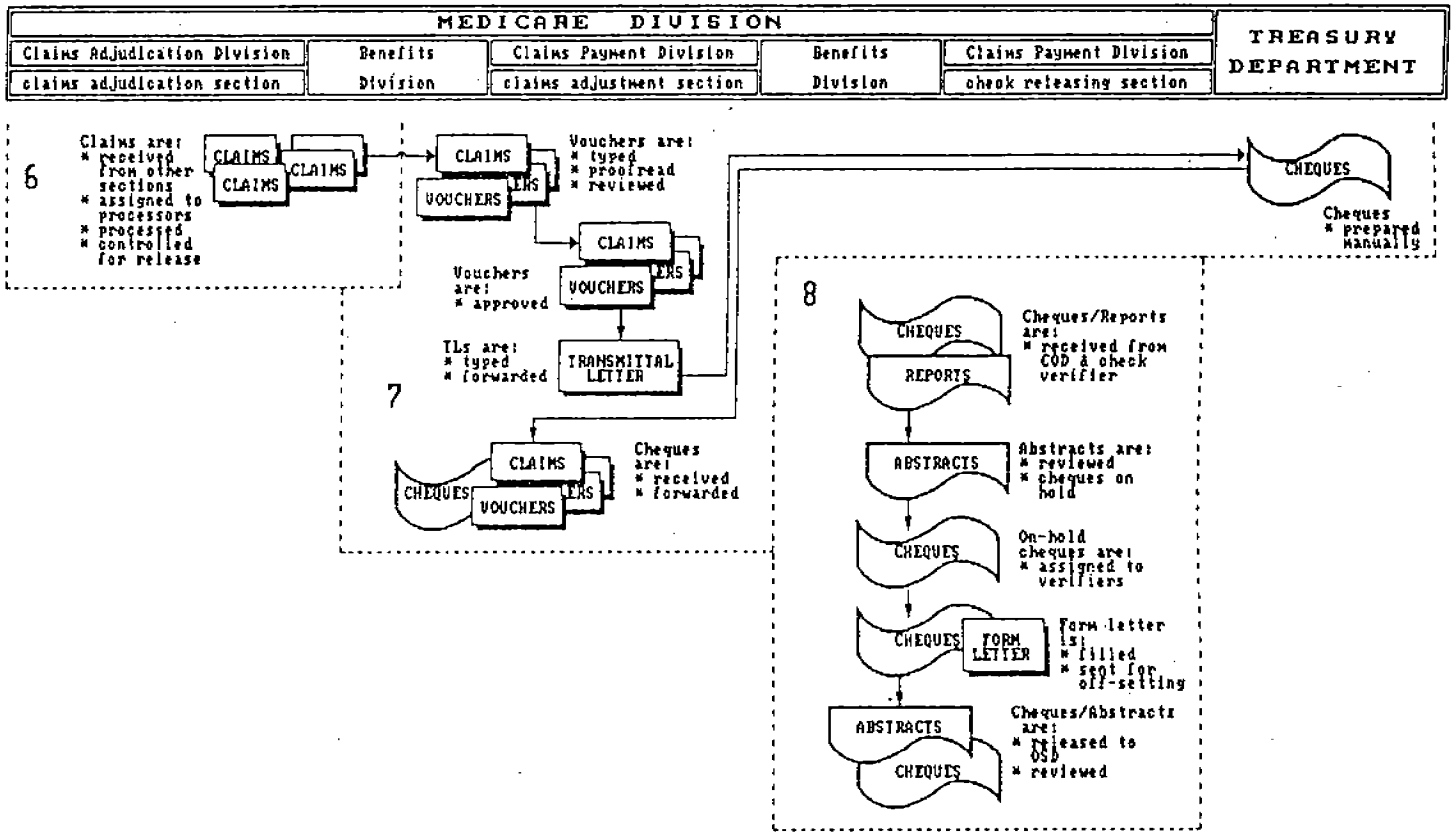


Figure 26 SSS CLAIMS PROCESSING FLOW (CONT'D)

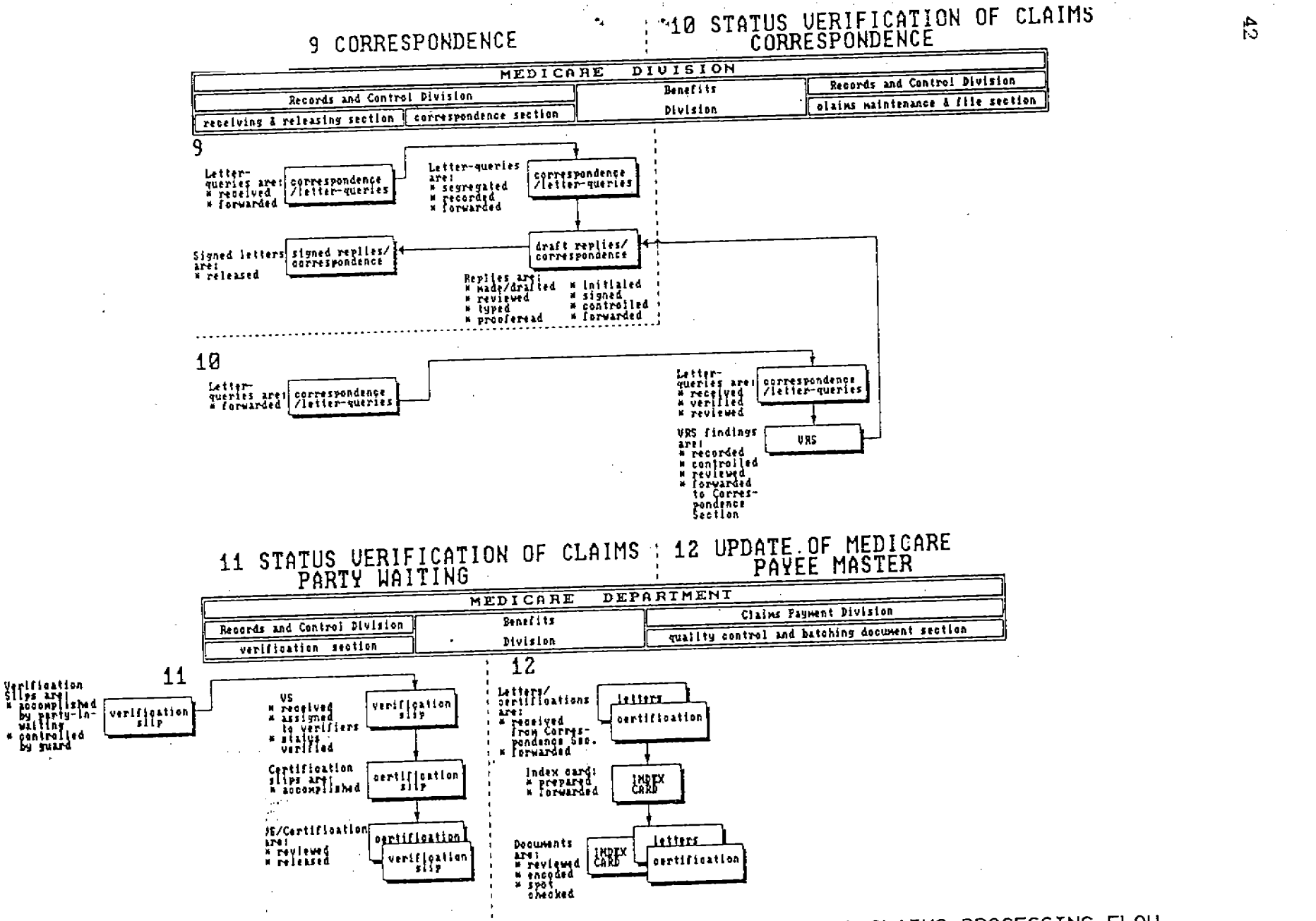


Figure 27 SSS CLAIMS PROCESSING FLOW (CONT'D)

(1) Medical evaluation of Medicare claims

Processing time and motion start at the Receiving/ Releasing Section, Records and Assistance Division of the Medical Evaluation Department. It receives Medicare claims documents (PMCC Forms 1 to 4) from hospital representatives or from Medicare members. The accomplished forms are checked to ensure they are completely filled out. They are then examined to see whether the claims are compensable. Next to be scrutinized are the nature of the illness, whether surgery has been done, confinement days, the correctness of the prescriptions and the prices of medicines, and other medical procedures--to see if they are in consonance with PMCC rules and regulations.

A concrete example of claims cases needing additional information to support application is when patients were admitted in questionable hospitals. Often, an ocular survey of hospitals with questionable records is undertaken to confirm the validity of Medicare claims applied for.

All claims which are correctly evaluated are appropriately encoded for the next stage. If the review process finds that the claims have not been properly evaluated, additional steps are taken before they move out of the Medical evaluation Department. If the claims are denied then they are returned to the provider.

(2) Receipt and verification of claims

The Receiving/Releasing Section of the Records and Control Division of the Medicare Department accepts the claim forms which have undergone scrutiny by the Medical Evaluation Department. The section also receives refiled claims from hospital representatives or Medicare members. Verification centers on whether data on the attending physician (e.g., PMCC number or tax identification number), the hospital code number, HMO number, are correct. Data on the patient (e.g., whether a claimant is a member, pensioner, self-employed) are also authenticated. If the claims pass the verification tests, they are forwarded to the Claims Adjudication Section of the Claims Adjudication Division. In the event the patient was admitted to a PMCC non-accredited hospital then it has to be forwarded to the Claims Adjustment Section of the same division.

(3) Adjudication of Medicare claims

Verification sets the stage for the next step. The Claims Adjudication Division of the Medicare Department focuses its attention on eligibility and entitlement questions, e.g., eligibility of patient in case of a dependent claim. It also routinely checks the signatures of the hospital representative, attending physician, employer, and member or spouse (if member is abroad or on jobsite as certified by employer) as well as accompanying documents (e.g., death certificate of deceased member). It also implements suggestions made by medical evaluation.

The Adjudication Division takes immediate discretionary actions if (1) members cannot sign, (2) the application is filed late, (3) the claim is approved for further processing but confinement period is more than one year, (4) the claim is without the signature of the authorized signatory of the hospital, (5) the patient is self-employed or a voluntary member, (6) the patient is a

dependent of a member, and (7) the patient is a dependent of a pensioner, self-employed member or a voluntary member.

Next, the benefits are determined and computed on the basis of the following: room and board (number of compensable days), medicines, laboratory/x-ray, and operating room fee. Valid claims are segregated from defective claims. Valid applications are forwarded to the Quality Control and Batching Section while faulty applications are routed to the Claim Maintenance and File Section.

(4) Batching and data control of adjudicated claims

The Quality Control and Batching Claims Payment Division cross-checks applications received against names listed in the transmittal letter, bundles applications by 50's, assigns an item number for each application, encodes claim details and generates a series of reports that include a Medicare claims review list (CRL), a Medicare suspect list, validation summary, and list of claims with deficiencies.

(5) Preparation of cheques for adjudicated claims

The Quality Control and Batching Claims Payment Division of the Medicare Department prepares, reviews, and releases requests for check printing to the Computer Operations Department. The latter generates Medicare checks, Medicare check vouchers, Post Office listings, Medicare payment notices, Medicare check abstracts and claims posting summaries. All of its reports are forwarded to the Medicare Department.

(6) Adjustment of Medicare claims

The Claims Adjustment Section of the Claims Adjudication Division inherits from the Claims Payment Division and Records and Control, claim applications from non-accredited hospitals that involve emergency cases; claims which are filed late; and staled/cancelled/returned cheques for replacement. These claims are processed and adjudicated in much the same way as previously described. Thereafter, such applications are released to the Records and Control Division for appropriate action.

(7) Manual preparation of cheques (for adjusted claims).

The Claims Adjustment Section, Claims Payment Division of the Medicare Department does manually on the typewriter the preparation (typing, proofreading, review and approving) of vouchers. Likewise it prepares the transmittal list indicating the payee names and corresponding amounts. It is responsible for releasing the checks.

(8) Review, replacement and release of cheques (for adjudicated/adjusted claims).

The Check Releasing section, Claims Payment Division of the Medicare Department receives checks reports, reviews abstracts/holds checks, verifies checks and releases checks/abstracts

(9) Correspondences

The Correspondence Section, Records and Control Division of the department receives letters-queries from various sources such as employers, members, hospitals or doctors. The Benefits Division, on the other hand, researches on the answers to each of these query letters and drafts the reply which is finally sent to the inquirer by the Correspondence Section.

(10) Status verification of claims - correspondence

The Claims Maintenance and File Section under the Records and Control Division entertains letters asking about the status of application. After locating the information through on-line inquiry, or from Medicare abstracts and/or transmittal list/index cards on file, a verification result sheet (VRS) is mailed as a reply.

(11) Status verification of claims - party waiting

The Verification Section, Records and Control Division entertains walk-in clients through verification slips which are properly accomplished. Again, the needed data are sourced through on-line inquiry, or from Medicare abstracts, index cards, and transmittal lists. A certification sheet is released to the waiting party.

(12) Update of Medicare payee master

The Quality Control and Batching Document Section updates, from time to time, the payee master, whenever there is a change of status of the payee-doctor, a change of address of the payee-doctor, a change of address of the payee-hospital, cancellation of the tax identification number (TIN) of the payee-doctor, a reclassification of the PMCC accreditation number of the payee-doctor, a change of hospital bed capacity, a change of hospital category or the death of a payee-doctor. These changes or updates are encoded.

G. *Assessment of the SSS system*

The processing system of SSS is an example of 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 in 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 an immediate rejection at the outset once an irregularity is detected. SSS Medicare Department officers claim, not without substantiation, that the only flaw which the system is ill-equipped to identify is the case of dual memberships, i.e., 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 a "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 backlogs are quite few. SSS has set a new standard of 10 days processing time for all claims that come in a particular day. There is plausibility to this since the number of claims which comes 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 traded off with a fewer number of beneficiaries. On the other hand, a spin-off 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.

Table 11 summarizes, in a comparative way, the features of the claims processing systems of GSIS and SSS.

H. *Postscript: recent developments in GSIS claims processing*

In January 1993, GSIS management appointed a new leadership in its Medicare Department to introduce reforms and changes in claims processing. The problem of backlog has been a persistent concern of the department, in addition to the need to set up control systems to check fraudulent claims. The changes focused on the work performance of the staff which meant addressing the needs of the staff.

Late-breaking developments that have taken place in the department include the following:

Reconstitution of the department as a stand-alone department/upgrading of the computer system. The department is now a stand-alone group with the installation of a Local Area Network (LAN) with 20 terminals and 600 megabyte capacity in place of its IBM 3471 which had a capacity of 300 megabytes and was connected to GSIS' EDP-mainframe. With a fully independent computer system, the department now has total control of claims processing, including the generation of checks for payment.

Redistribution and training of personnel. At the time of the assumption of the new leadership, the department had a 74 personnel, of which 10 were casuals. The data entry division has been disbanded (only as a group) and its staff and functions have been reassigned to the divisions of the claims processing group. The divisions now number four (instead of three), and each division has five processors and three encoders. In March, the department conducted a two-week training on the use of the new computer system. In April, the staff underwent an intensive values orientation program.

Streamlining of the medical evaluation staff. The number of doctors doing medical evaluation declined from eight to seven. Despite this reduction, backlog in medical evaluation was eliminated

Changes in office layout. The processors have been relocated in one area in the department, separated from their division chiefs who are likewise all grouped together. Simultaneously, arrangements have been made with the GSIS Security Office to refuse entry for follow-ups and 'fixers'. When proven necessary and important, follow-ups have to be transacted directly with the

TABLE 11
COMPARATIVE TABLE OF GSIS AND SSS CLAIMS PROCESSING FEATURES

INDICATORS	GOVERNMENT SERVICE INSURANCE SYSTEM (GSIS)	SOCIAL SECURITY SYSTEM (SSS)
DESCRIPTION OF SYSTEM	Centralized Manila Offices	Decentralized 13 Regions
MEMBERSHIP BASE	1.3 million nationwide	3.4 million nationwide
VOLUME OF TRANSACTIONS	2,000 per day	750 to 900 per day (NCR only)
NO. OF CLAIMS PROCESSED	200 per day (Average)	1,300 per day (NCR only, average)
NO. OF UNITS INVOLVED	6 Units all under a MEDICARE Department a. Claims and Control b. Medical Evaluation c. Claims Processing Divisions I,II,III d. Claims Control and Data Entry e. EDP Mainframe f. Mailing	7 Units under a Medical Evaluation Department and a Medicare Department a. Medical Evaluation Department –Receiving and Releasing –Records and Assistance b. Medicare Department –Receiving and Releasing Records & Control Division) –Claims Adjudication –Quality Control and Batching
NO. OF PERSONNEL	72	65 (NCR only)
PROCESSING TIME (STANDARD)	22 working days or 1 month	10 working days or 2 weeks (NCR only)
BACKLOG	50,600 per month	No backlog (NCR only)
COST PER CLAIM	P 16.98 as of 1991 P 13.54 as of 1990	P 105.65 as of 1991 P 92.62 as of 1990

division chiefs. Processors are thus not allowed to entertain any follow-ups, which were pinpointed to be the major cause of disruptions in the claims processing flow. The work of the processors can thus proceed in a straightforward way, and the department is able to enforce its "first in, first out" policy in processing. Transaction costs are effectively reduced.

Better distribution of workload. Under the new set-up, the quota system of processing has been replaced with the equal distribution of workload among the four divisions. Instead of stacking claims into 300-320 bundles, each division is assigned an equal number of claims coming from some 1,700 hospitals nationwide. Competition is encouraged among the four divisions with the provision of incentives for staff who garner the highest number of processed claims at the end of each month.

Attacking the backlog issue head-on. In March, an actual inventory of outstanding claims was made. A two-day count yielded 75,017 outstanding claims--the actual figure was found out to be 60 percent more than the normal monthly number of claims filed. The total claims to be processed reached a staggering 262,039. With this more accurate tally, the department accelerated the processing flow. As the department's accomplishment report (see Table 12) for the period January-May 1993 shows, the capacity of the department to process claims has substantially increased over the months. In March, the department processed over 75,000 claims, up from 36,000 processed in February. By May, the capacity has increased to about 95,000 processed claims. The department projects that if 75,000 is assumed to be average number of claims processed monthly and that an average of new 45,000 new claims are received monthly, the backlog would be eliminated by the month of September.

Daily monitoring of performance. The department has instituted a day-to-day performance oversight of the department's staff. The computer is programmed to automatically generate on a daily basis the output/capacity per processor by type of hospital (i.e., tertiary, secondary and primary).

Changes in performance standards. At present, the performance norm of the processing function is target setting. In February, for example, the desired output was set at 38,000 in paid claims. A total of 32,293 paid claims was achieved for the month. Beginning March when the actual count of claims outstanding was made, the monthly target became 100,000 per month for 21 working days. This comes up to 2,000 per day or 500 per division per day. By September, when the backlog is expected to reach its minimum or nil level, the department plans to install a permanent performance standard for the department, a standard based on actual performance of the staff.

Improved monitoring of fraudulent claims. To detect fraudulent claims, a Report on Patient Confinements and a Hospital Confinement Table will be issued by the department regularly. The Report on Patient Confinements is a computerized detailing of the claims made by each Medicare member. It records the frequency of claims and indicates if there are overlapping of claims. The Hospital Confinement Table is a computer-generated hospital record of the confinement of Medicare members and their dependents. It would show the dates of hospitalization. The department will thus be able to see if there is an unusual number of claims made by the hospital. Any sign of fraudulence of a specific hospital is cross-checked with the field monitoring report made by the PMCC on hospital confinement.

TABLE 12
CLAIMS PROCESSING RECORD, GSIS, JANUARY–MAY 1993
(IN UNITS)

	ACTUAL					PROJECTED**			
	January	February	March	April	May	June	July	August	September
BEGINNING BALANCE	95,618	119,191	127,741	185,651	157,126	120,000	90,000	60,000	30,000
Add: Receipts & Adjustments									
Receipts	44,956	44,609	58,281	41,345	59,602	45,000	45,000	45,000	45,000
Adjustments	0	0	75,017 *	0	0	0	0	0	0
TOTAL	44,956	44,609	133,298	41,345	59,602	45,000	45,000	45,000	45,000
TOTAL CLAIMS TO BE PROCESSED	140,574	163,800	261,039	226,996	216,728	165,000	135,000	105,000	75,000
Less: Processed Claims									
Paid Claims	18,592	32,293	71,218	65,905	88,063	75,000	75,000	75,000	75,000
Returned Claims	2,791	3,766	4,170	3,965	6,893				
TOTAL	21,383	36,059	75,388	69,870	94,956	75,000	75,000	75,000	75,000
ENDING BALANCE	119,191	127,741	185,651	157,126	121,772	90,000	60,000	30,000	0

*Variance as a result of actual count of claims outstanding in the month of March.

**Projection assumptions:

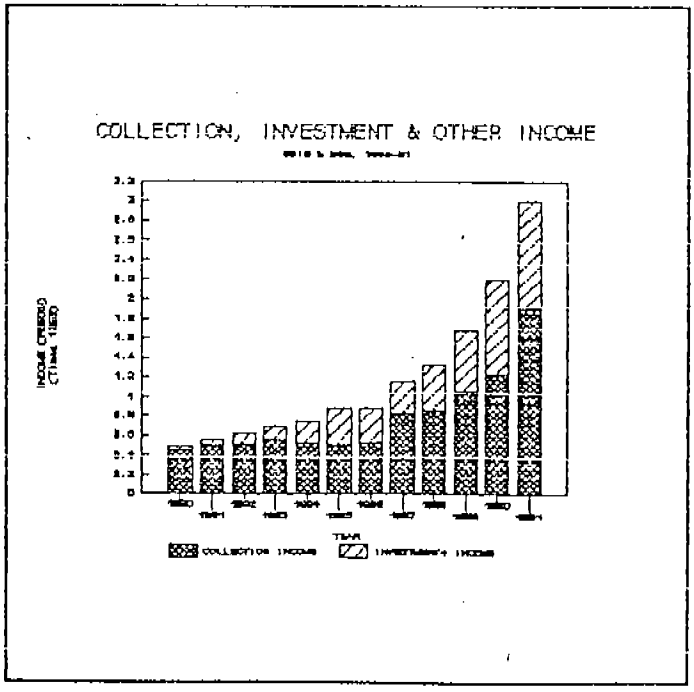
1. Average monthly receipts total 45,000 claims.
2. Number of processed claims is 75,000 monthly.

SOURCE: GSIS, June 1993

A simplified control system for check payments. The preparation and releasing of checks is now directly under the office of the Department Director. Only one staff, who is accountable to the director, takes care of preparing checks. In the past, checks were issued in amounts not exceeding P20,000 to offset ceiling requirements. The splitting of checks into small amounts is no longer allowed and no limits are set in the amount to be released. Replacement of checks is also not allowed to prevent changes in the amount paid.

VIII. MEDICARE FUND MANAGEMENT

Figure 28



The financial performance of Medicare has been varied and difficult to assess. The health insurance fund (HIF), or Medicare's reserves, has risen steadily, from P491 million in 1980 to P3 billion in 1991, a respectable record by insurance industry standards. That represents an average yearly increase of 18.4 percent. Figures 28, 29 and 30 illustrate this growth in the HIF for the system as a whole, and for GSIS and SSS in particular. As these figures suggest, along with Tables 13, 14, and 15, anywhere from two-thirds to three-fourths of the fund is accounted for by SSS. That is partly explained away by the larger membership base of SSS, which brings into the system a correspondingly bigger chunk of collection income. The proportion of the Medicare fund "housed" in SSS has been increasing, however, and deserves scrutiny.

A. *Growth in investment income*

In the early eighties, SSS' total income has been roughly double that of GSIS; by 1985, it has tripled, and SSS has pulled away since then. The growth of investment income explains why. As Table 16 shows (also Figures 28, 29, and 30), 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 1980, investment income made up a little less than 10 percent of Medicare's total income (over 90 percent being accounted for by premium collection and other incomes, such as penalties for delayed remittances). By 1990, 44.6 percent of Medicare's earnings came from investment interest payments alone. SSS has disproportionately contributed to this shift: thrice in ten years (i.e., in 1985, 1986 and 1990), its investment earnings surpassed collection income by a few percentage points. That is to say, more than half of total income was generated by investments in those years. As a percentage of collection income, SSS' investment earnings reached

TABLE 13
FINANCIAL EXPERIENCE, GSIS & SSS, 1980–1991

YEAR	PREMIUM INCOME	INVESTMENT & OTHER INC	TOTAL INCOME	BENEFITS EXPENSE	OPERATING EXPENSE	TOTAL EXPENSES	NET UNDER-WRITING GAIN	NET INCOME AMOUNT	NET INCOME AS PERCENT OF PREMIUM INCOME	CUMULATIVE RESERVES	RESERVE CAPACITY
1980	446.72	44.82	491.54	318.66	18.94	337.60	109.12	153.95	34.46	439.29	1.30
1981	494.67	66.91	561.58	339.73	26.40	366.13	128.54	195.46	39.51	613.17	1.68
1982	520.83	106.64	627.47	379.73	12.07	391.79	129.04	235.68	45.25	786.99	2.01
1983	550.21	137.51	687.72	406.76	14.62	421.38	128.83	266.33	48.41	996.59	2.37
1984	533.63	220.40	754.03	410.40	19.52	429.91	103.72	324.11	60.74	1353.72	3.15
1985	514.37	385.96	900.33	438.56	22.46	461.02	53.36	439.31	85.41	1801.45	3.91
1986	525.89	379.23	905.11	450.02	34.60	484.62	41.27	420.50	79.96	2118.60	4.37
1987	824.31	339.53	1163.83	574.75	42.40	617.15	207.16	546.68	66.32	2825.90	4.58
1988	861.53	464.50	1326.03	713.79	48.14	761.93	99.60	564.10	65.48	3380.31	4.44
1989	1056.64	646.62	1703.26	726.07	51.73	777.80	278.83	925.46	87.58	4280.84	5.50
1990	1223.66	985.74	2209.40	1126.96	68.69	1195.64	28.02	1013.76	82.85	5182.63	4.34
1991	1924.01	1091.48	3015.49	1731.59	97.82	1829.41	94.60	1186.08	61.65	6550.07	3.58

Source of basic data: PMCC

TABLE 14
FINANCIAL EXPERIENCE, GSIS, 1980–1991

YEAR	PREMIUM INCOME	INVESTMENT & OTHER INC	TOTAL INCOME	BENEFITS EXPENSE	OPERATING EXPENSE	TOTAL EXPENSES	NET UNDER-WRITING GAIN	NET INCOME AMOUNT	NET INCOME AS PERCENT OF PREMIUM INCOME	CUMULATIVE RESERVES	RESERVE CAPACITY
1980	156.17	5.49	161.66	114.83	15.12	129.94	26.23	31.72	20.31	83.97	0.65
1981	180.95	5.74	186.68	125.05	19.34	144.39	36.56	42.29	23.37	104.68	0.73
1982	190.05	21.16	211.21	128.23	4.95	133.18	56.88	78.04	41.06	120.84	0.91
1983	209.61	25.97	235.58	147.37	7.30	154.66	54.95	80.92	38.60	144.82	0.94
1984	191.15	30.87	222.02	171.04	10.61	181.65	9.50	40.37	21.12	218.20	1.20
1985	181.56	19.50	201.06	174.05	13.39	187.44	−5.89	13.61	7.50	240.23	1.28
1986	190.67	22.11	212.78	170.90	7.34	178.24	12.43	205.44	107.75	174.37	0.98
1987	278.15	4.25	282.40	224.50	7.66	232.16	45.99	50.24	18.06	385.00	1.66
1988	245.48	57.22	302.69	239.32	6.51	245.83	−0.35	56.86	23.16	436.39	1.78
1989	325.51	89.64	415.15	276.55	7.32	283.87	41.64	131.28	40.33	542.72	1.91
1990	446.22	147.13	593.34	416.45	8.47	424.92	21.30	168.42	37.75	598.39	1.41
1991	615.69	134.30	749.99	708.74	11.18	719.93	−104.23	30.07	4.88	824.73	1.15

Source of basic data: PMCC

TABLE 15
FINANCIAL EXPERIENCE, SSS, 1980–1991

YEAR	PREMIUM INCOME	INVESTMENT & OTHER INC	TOTAL INCOME	BENEFITS EXPENSE	OPERATING EXPENSE	TOTAL EXPENSES	NET UNDER-WRITING GAIN	NET INCOME AMOUNT	NET INCOME AS PERCENT OF PREMIUM INCOME	CUMULATIVE RESERVES	RESERVE CAPACITY
1980	290.55	39.33	329.88	203.83	3.82	207.65	82.89	122.23	42.07	355.33	1.71
1981	313.73	61.17	374.90	214.68	7.06	221.74	91.99	153.16	48.82	508.49	2.29
1982	330.78	85.48	416.26	251.50	7.12	258.62	72.16	157.64	47.66	666.36	2.58
1983	340.60	111.54	452.14	259.40	7.33	266.72	73.88	185.42	54.44	851.77	3.19
1984	342.48	189.53	532.01	239.36	8.91	248.26	94.22	283.75	82.85	1135.52	4.57
1985	332.82	366.46	699.27	264.51	9.07	273.57	59.25	425.70	127.91	1561.22	5.71
1986	335.22	357.12	692.34	279.12	27.26	306.38	28.85	385.96	115.14	1944.24	6.35
1987	546.16	335.27	881.43	350.25	34.74	384.99	161.17	496.44	90.90	2440.90	6.34
1988	816.05	407.29	1023.34	4774.47	41.63	4816.11	99.95	507.24	62.34	2943.92	5.70
1989	731.13	556.98	1288.11	449.52	44.41	493.94	237.19	794.17	108.62	3738.13	7.57
1990	777.44	838.62	1616.06	710.50	60.22	770.72	6.72	845.33	108.73	4584.24	5.95
1991	1308.32	957.18	2265.49	1022.85	86.64	1109.48	198.84	1156.01	88.36	5725.34	5.16

Source of basic data: PMCC

TABLE 16
COMPOSITION OF INCOME (in million pesos)

YEAR	GSIS AS PERCENT OF TOTAL INCOME			GSIS INVESTMENT INCOME AS PERCENT OF COLLECTION INCOME	SSS AS PERCENT OF TOTAL INCOME			SSS INVESTMENT INCOME AS PERCENT OF COLLECTION INCOME	GSIS & SSS AS PERCENT OF TOTAL INCOME			GSIS & SSS INVESTMENT INCOME AS PERCENT OF COLLECTION INCOME
	COLLECTION INCOME	INVESTMENT INCOME	OTHER INCOME		COLLECTION INCOME	INVESTMENT INCOME	OTHER INCOME		COLLECTION INCOME	INVESTMENT INCOME	OTHER INCOME	
1980	96.60	2.48	0.91	2.57	88.08	11.61	0.32	13.18	90.88	8.61	0.51	9.47
1981	96.83	3.05	0.02	3.15	83.68	16.12	0.19	19.27	88.09	11.78	0.14	13.37
1982	89.88	10.02	0.00	11.19	79.46	20.17	0.36	25.39	83.00	16.75	0.24	20.19
1983	88.88	11.02	0.00	12.39	76.33	24.19	0.48	32.12	80.01	19.68	0.31	24.60
1984	86.10	13.90	0.00	16.15	64.38	35.34	0.29	54.89	70.77	29.09	0.20	41.02
1985	90.30	9.70	0.00	10.74	47.59	52.21	0.20	109.69	57.13	42.71	0.15	74.76
1986	89.61	10.39	0.00	11.60	48.42	51.38	0.20	106.12	58.10	41.75	0.15	71.85
1987	98.49	1.51	0.00	1.53	61.96	37.95	0.09	61.24	70.89	29.10	0.07	41.09
1988	81.10	18.30	0.60	22.57	60.20	39.73	0.07	66.00	64.87	34.84	0.19	53.62
1989	78.41	21.56	0.03	27.50	56.76	43.02	0.23	75.78	62.04	37.79	0.18	60.91
1990	75.20	24.80	0.00	32.97	48.11	51.84	0.05	107.76	55.36	44.58	0.04	80.49
1991	82.09	17.73	0.17	21.60	57.75	42.12	0.13	72.93	69.80	30.05	0.14	56.50

YEAR	GSIS PREMIUM INCOME	GSIS INVESTMENT & OTHER INC	GSIS TOTAL INCOME	GSIS INVESTMENT INCOME	GSIS OTHER INCOME	SSS PREMIUM INCOME	SSS INVESTMENT & OTHER INC	SSS TOTAL INCOME	SSS INVESTMENT INCOME	SSS OTHER INCOME
1980	156.17	5.49	161.66	4.02	1.47	280.55	39.33	329.88	38.28	1.05
1981	180.95	5.74	186.68	5.70	0.04	313.73	61.17	374.90	60.45	0.72
1982	190.05	21.16	211.21	21.16	0.00	330.78	85.48	416.26	83.97	1.51
1983	209.61	25.97	235.58	25.97	0.00	340.60	111.54	452.14	109.39	2.15
1984	191.15	30.87	222.02	30.87	0.00	342.48	189.53	532.01	188.00	1.52
1985	181.56	19.50	201.06	19.50	0.00	332.82	366.46	699.27	365.07	1.39
1986	190.67	22.11	212.78	22.11	0.00	335.22	357.12	692.34	355.75	1.36
1987	278.15	4.25	282.40	4.25	0.00	546.16	335.27	881.43	334.46	0.81
1988	245.48	57.22	302.69	55.40	1.82	816.05	407.29	1023.34	406.58	0.70
1989	325.61	89.84	415.15	89.52	0.11	731.13	556.86	1288.11	554.06	2.80
1990	446.22	147.13	593.34	147.13	0.00	777.44	838.62	1616.06	837.80	0.82
1991	615.69	134.30	749.99	133.00	1.30	1308.32	957.16	2265.49	954.15	3.02

Source of basic data: PMCC

over 106 percent in the same years.

For GSIS too, investment earnings have slowly, if unevenly, been rising as a proportion of total revenues, reaching a modest 24.7 percent (of total income) in 1990. In lean years (1980, 1981, 1987), however, GSIS barely earned from its investment portfolios. As a proportion of collection income, investment interest earnings for GSIS have not gone beyond 33 percent, but had gone down to as low as 1.5 percent in the last decade. It is interesting to note that even during periods of economic downturns (1983, 1985-86, 1990), both systems posted healthy investment income figures, suggesting sound fund management decisions were taken, at least during those years. The bulk of both GSIS and SSS contributions are invested in high-yielding Treasury Bills and Treasury Notes.

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 (and because of a modest expansion of the membership base), may actually decline in real terms. As Medicare's dependence on premium income weakens, its risk-sharing capability can also be expanded. GSIS' relatively unimpressive investment income performance is a matter of serious concern, however.

Figure 29

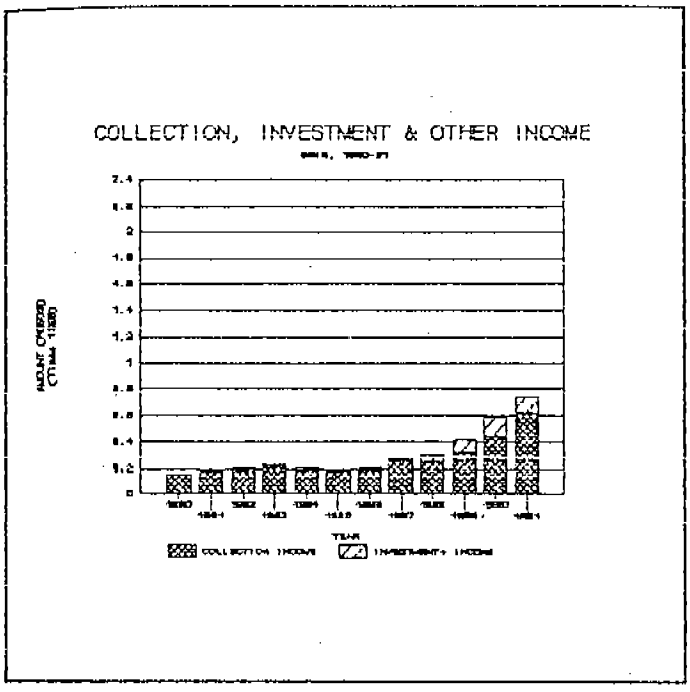
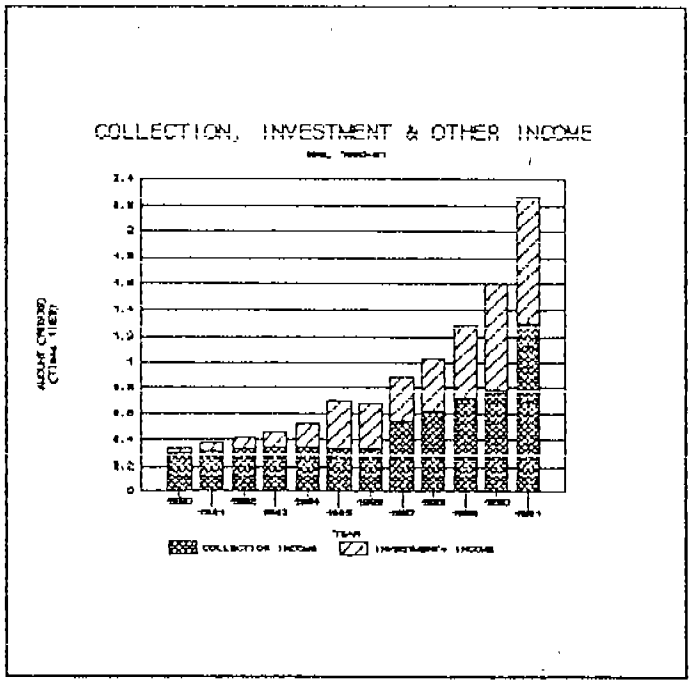
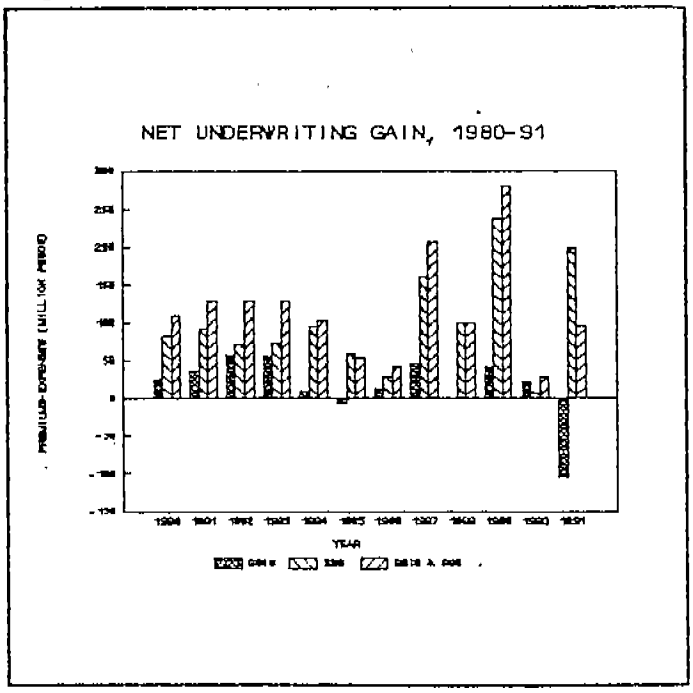


Figure 30



As Gamboa (1990) suggests, GSIS may be paying a high price for unsound investments (which were locked in unproductive assets) made prior to 1986. Yet it may be as much due to GSIS' high level of benefit expenditures, which exerts tremendous strains on its collection income and leaves little for investment and reserve capacity building.

Figure 31



B. *Underwriting gains*

To determine how much of collection income goes to investment, it is worthwhile looking at the program's net underwriting gain (Figure 31), measured as the difference between premium payments and total expenditures. This indicator determines whether the yearly Medicare contributions are sufficient to cover all expenses, including benefit expenditures and administrative expenses. It is thus a good measure of the amount that is potentially investable. The net underwriting gain has varied across the years. The financial experience of Medicare suggests (Tables 13-15) that at no point within the years 1980-90 has the entire system suffered from any underwriting shortfall. The net underwriting gain exceeded P200 million in two instances (1987 and 1980); it did fall to P40 million in 1986 and to a precarious level of P28 million in 1990. But a close look at the financial record of both GSIS and SSS reveals that the positive gains mostly came from SSS. It was not necessary for SSS to draw from investment revenues to defray expenses; indeed the net gain has become a significant source of investable funds, permitting the SSS to further "deepen" its investment income base. 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 P104 million, was made up to a large degree 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.

C. *Pressures on collection income*

The picture remains unchanged when viewed in terms of net income, which is a less conservative measure of fund adequacy for covering expenditures (here it is premium income *plus* investment income which are ranged against total expenditures). While the system as a whole has been experiencing rising net income--net earnings have swelled almost eight times, from P154 million in 1980 to P1186 million in 1991 (see Figure 32)--it is SSS which has been mostly responsible for the increase. In Figure 33, SSS' total income has steadfastly pulled away from total expenses, allowing net income to grow; since 1984, net income has overtaken total expenses, a further proof of SSS' phenomenal investment record. In 1991, SSS' net income of P1156 million accounted for 97.5 percent of Medicare's net revenues. By contrast, GSIS' total expenditures have kept pace with its total income across the years, thus maintaining constant pressure on both investment and collection incomes (Figure 34). As a result, GSIS' net income has been for the most part below the P100 million level, except in years 1986, 1989 and 1990 when it posted healthier net

earnings (P205M, P131M and P168M, respectively).

GSIS' net income is on average only about 32 percent of premium income during the years 1980-91, further illustrating the strain on GSIS' earnings from premium payments. That is in sharp contrast to SSS' net income, which averaged 83 percent of premium income in the same period.

To better appraise Medicare's financial well-being, and identify both strong points and weak spots, it is helpful to look at four sets of financial indicators: liquidity, activity, leverage and profitability.

D. *Upward trend in liquidity*

Medicare's liquidity, or current ratio (current assets/current liabilities) has seesawed, although the trend has been generally upward (see Table 17 and Figure 35). Low ratios are identified with GSIS, and in recent years these have indicated difficulties in paying claims from its current assets. High ratios are identified with SSS, especially in the years 1989 and 1990, when the ratio shot up to 1750 and 1533, respectively. These ratios are flagged down as they reflect excessive levels of current assets. Investable funds were quite idle, with very high opportunity costs.

Figure 32

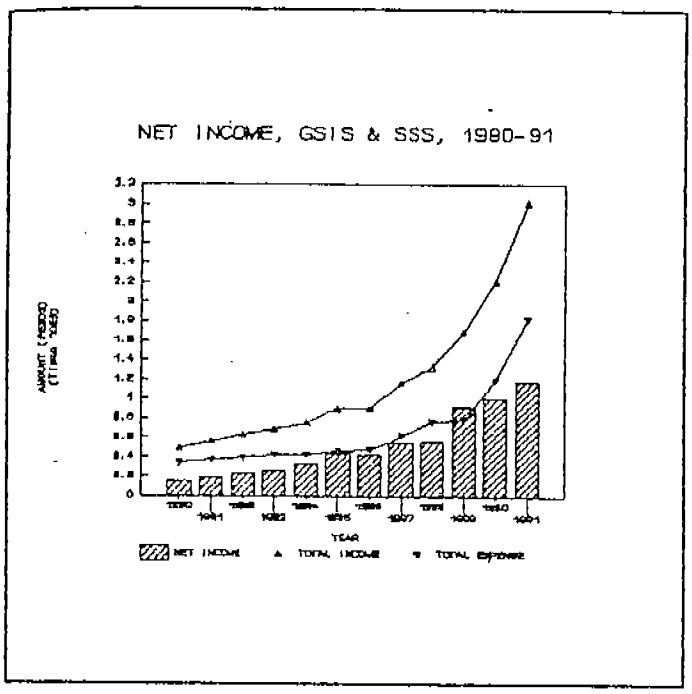
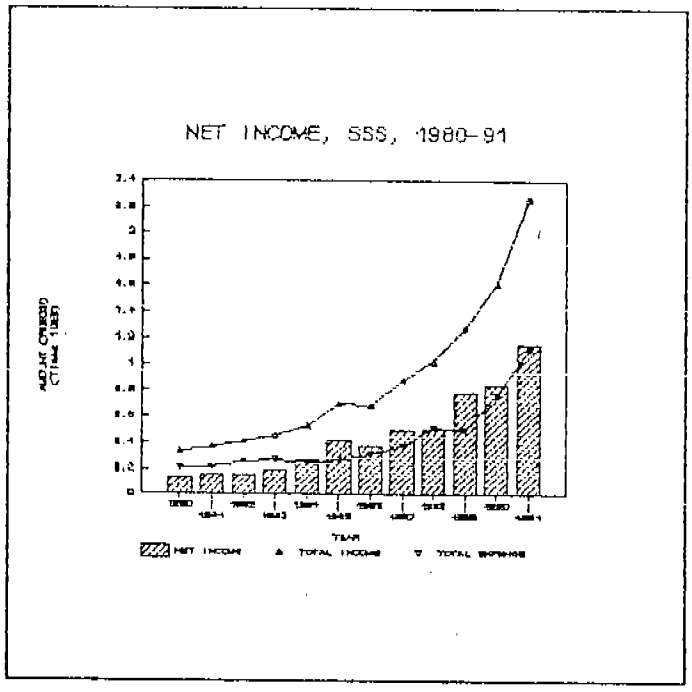


Figure 33



E. *The day's cash*

If the objective is to have enough assets but not too many, then Medicare has not fared well, as reflected in the activity ratios. The days' cash, or the number of days Medicare can do without collections and still meet its benefit and operating expense obligations, has oscillated wildly, from 0 to 1305 days. As shown in Table 18 and Figure 36, GSIS has swung from too lavish levels of current assets (the days' cash hovered between 104 and 572 in 1982-87) to precarious levels (between 0 and 7 in 1988-1991), suggesting it had too much cash early on and was illiquid in later years.

TABLE 17
LIQUIDITY RATIO

YEAR	GSIS CURRENT ASSETS* (million pesos)	GSIS CURRENT LIABILITIES (million pesos)	GSIS LIQUIDITY RATIO	SSS CURRENT ASSETS** (million pesos)	SSS CURRENT LIABILITIES (million pesos)	SSS LIQUIDITY RATIO	GSIS & SSS CURRENT ASSETS (million pesos)	GSIS & SSS CURRENT LIABILITIES (million pesos)	GSIS & SSS LIQUIDITY RATIO
1980	55.502	6.759	8.212	7.124	1.944	3.665	62.626	8.703	7.196
1981	10.006	7.849	1.275	9.952	2.858	3.482	19.958	10.707	1.864
1982	54.976	9.003	6.106	15.533	2.000	7.767	70.509	11.003	6.408
1983	88.977	16.645	5.346	15.201	1.901	7.996	104.178	18.546	5.617
1984	122.880	16.867	7.285	31.789	1.637	19.419	154.669	18.504	8.359
1985	211.230	17.858	11.828	70.873	1.675	42.312	282.103	19.533	14.442
1986	388.400	18.920	20.529	694.831	19.994	34.752	1083.231	38.914	27.837
1987	461.587	41.693	11.018	1127.286	14.766	76.343	1588.873	56.659	28.043
1988	328.059	38.530	8.514	2169.807	32.040	67.722	2497.866	70.570	35.396
1989	321.405	65.453	4.910	3195.485	1.826	1749.992	3516.890	67.279	52.273
1990	241.351	40.507	5.958	3066.973	2.000	1533.487	3308.324	42.507	77.830
1991	527.699	38.271	13.788	1324.165	4.268	310.254	1851.864	42.539	43.533

*Short-term investments excluded from GSIS current assets in 1980-85 to make it comparable with SSS figures
**SSS current assets exclude short-term investments in 1980-85
Sources of basic data: GSIS, SSS

TABLE 18
DAYS' CASH

YEAR	GSIS CASH ON HAND & IN BANKS (million pesos)	GSIS TOTAL APPLICATIONS (million pesos)	GSIS NUMBER OF DAYS	SSS CASH ON HAND & IN BANKS* (million pesos)	SSS TOTAL APPLICATIONS (million pesos)	SSS NUMBER OF DAYS	GSIS & SSS CASH ON HAND & IN BANKS (million pesos)	GSIS & SSS TOTAL APPLICATIONS (million pesos)	GSIS & SSS NUMBER OF DAYS
1980	53.64	129.94	150.66	2.97	207.65	5.22	56.60	337.60	61.20
1981	2.94	144.39	7.44	−0.26	221.74	0.00	2.69	366.13	2.68
1982	36.28	133.18	104.92	3.67	258.62	5.17	41.95	391.79	39.08
1983	59.74	154.66	140.98	3.15	266.72	4.31	62.89	421.38	54.48
1984	94.15	181.65	189.18	4.07	248.26	5.98	98.22	429.91	83.39
1985	196.77	187.44	383.17	3.51	273.57	4.68	200.28	461.02	158.57
1986	331.97	178.24	679.81	0.00	306.38	0.00	331.97	484.62	250.03
1987	364.07	232.16	572.39	0.00	384.99	0.00	364.07	617.15	215.32
1988	1.22	245.83	1.81	−23.03	516.11	0.00	−21.81	761.93	0.00
1989	5.46	283.87	7.02	2776.28	493.94	2051.57	2781.75	777.80	1305.39
1990	7.52	424.92	6.46	2612.23	770.72	1237.10	2619.75	1195.64	799.74
1991	0.11	719.93	0.06	1048.70	1109.43	345.02	1048.82	1829.36	209.26

Sources of basic data: GSIS, SSS

Figure 34

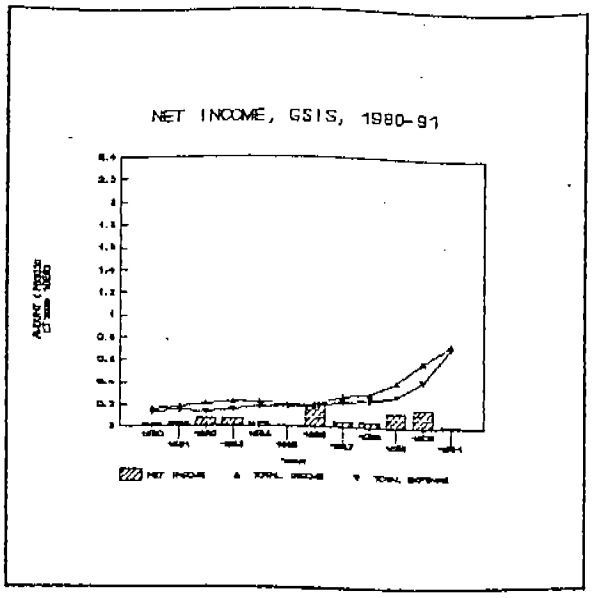


Figure 35

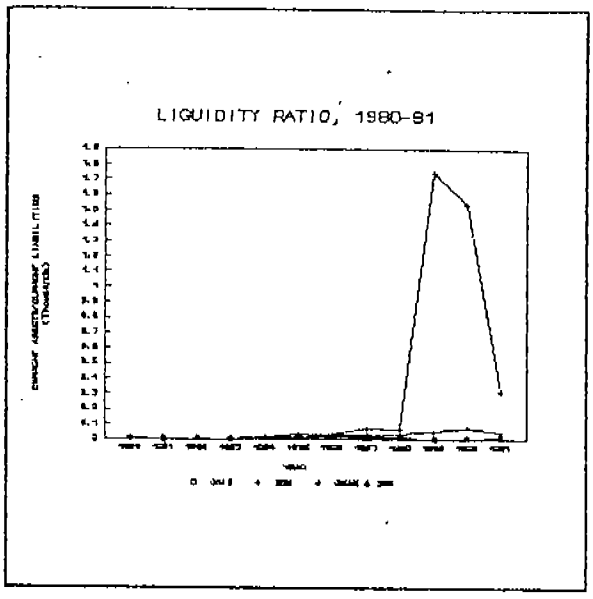
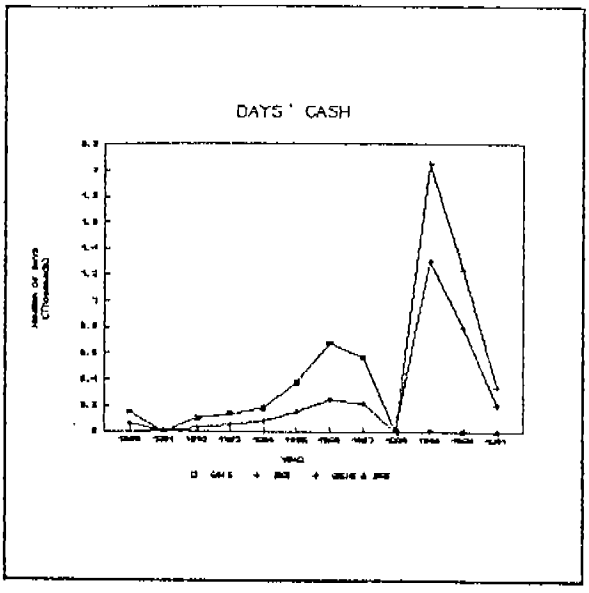


Figure 36



SSS provides the reverse picture: a tight position from 1980-88, when the days' cash did not go beyond five days, and an overly relaxed position since 1989, when it was awash with cash. This must be qualified somewhat by the fact that beginning 1989, SSS pulled out treasury bills from its investment account and assigned them to its current asset account. Both financial institutions have apparently not found a good formula for trading off pressures to maintain a reasonable level of cash on hand to meet expense obligations against investment opportunities that would increase Medicare's reserve capacity.

F. *Total collection efficiency*

Total collection efficiency, which is a measure of how well the system is able to redeem premium and investment interest payments (or alternatively, how well it is able to reduce accounts receivable), has been generally on the decline for Medicare as a whole, and for GSIS, in particular (see Table 19 and Figure 37). From a high of 99 percent in 1980, GSIS' total collection efficiency went down to 87 percent in 1984, made a slight improvement in 1985-86, and then precariously fell to 75 percent in 1991. An identical picture is depicted in Table 20, which shows that GSIS' unpaid premiums have risen from zero in 1980 to an all-time high of P160 million in 1991, inducing a sharp decline in collection efficiency.

Figure 37

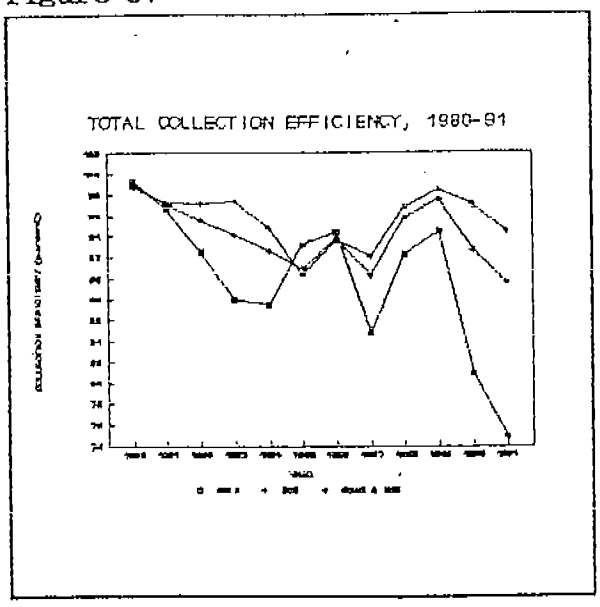


TABLE 20
COLLECTION EFFICIENCY, GSIS
(in millions)

YEAR	COLLECTION INCOME	PREMIUMS DUE BUT UNPAID*	COLLECTION EFFICIENCY(%)
1980	156.169	0.000	100.000
1981	180.945	5.086	97.189
1982	190.054	12.401	93.475
1983	209.611	23.701	88.693
1984	191.146	23.702	87.600
1985	181.555	11.656	93.580
1986	190.665	10.475	94.506
1987	278.149	41.366	85.128
1988	245.476	9.358	96.188
1989	325.512	10.292	96.838
1990	446.215	99.317	77.742
1991	615.691	160.371	73.953

Source of data: GSIS
*Includes premiums receivable in years 1981-87

This steep descent reflects GSIS' difficulties in compelling a quick turn over of its collection income from the Department of Budget and Management, a situation which has put severe pressures on its cash position.

SSS has a better collection record--its total efficiency has not gone down below 94 percent. Yet the big number of late-paying firms (see third paragraph below) raises questions on the accuracy of SSS' high collection efficiency record. If it includes only companies regularly remitting SSS

TABLE 19
TOTAL COLLECTION EFFICIENCY

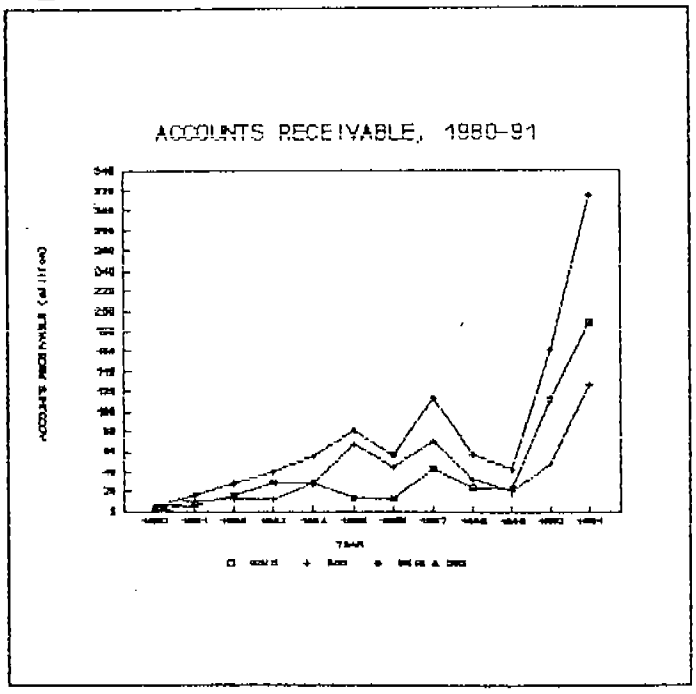
YEAR	COLLECTION INCOME (million pesos)	INVESTMENT & OTHER INC (million pesos)	TOTAL INCOME (million pesos)	ACCOUNTS RECEIVABLE (million pesos)	TOTAL EFFICIENCY (%)
GSIS					
1980	156.17	5.49	161.66	1.06	99.35
1981	180.95	5.74	186.68	6.25	96.65
1982	190.05	21.16	211.21	15.88	92.48
1983	209.61	25.97	235.58	28.43	87.93
1984	191.15	30.87	222.02	27.92	87.43
1985	181.56	19.50	201.06	13.64	93.21
1986	190.67	22.11	212.78	11.80	94.45
1987	278.15	4.25	282.40	43.19	84.71
1988	245.48	57.22	302.69	23.40	92.27
1989	325.51	89.64	415.15	23.14	94.43
1990	446.22	147.13	593.34	113.72	80.83
1991	615.69	134.30	749.99	188.09	74.92
SSS					
1980	290.55	39.33	329.88	4.09	98.76
1981	313.73	61.17	374.90	10.11	97.30
1982	330.78	85.48	416.26	11.85	97.15
1983	340.60	111.54	452.14	11.99	97.35
1984	342.48	189.53	532.01	27.71	94.79
1985	332.82	366.46	699.27	67.34	90.37
1986	335.22	357.12	692.34	43.94	93.65
1987	546.16	335.27	881.43	70.10	92.05
1988	616.05	407.29	1023.34	32.79	96.80
1989	731.13	556.98	1288.11	19.60	98.48
1990	777.44	838.62	1616.06	48.30	97.01
1991	1308.32	957.18	2265.49	126.32	94.42
GSIS & SSS					
1980	446.72	44.82	491.54	5.14	98.95
1981	494.67	66.91	561.58	16.36	97.09
1982	520.83	106.64	627.47	27.73	95.58
1983	550.21	137.51	687.72	40.42	94.12
1984	533.63	220.40	754.03	55.62	92.62
1985	514.37	385.96	900.33	80.99	91.00
1986	525.89	379.23	905.11	55.75	93.84
1987	824.31	339.53	1163.83	113.29	90.27
1988	861.53	464.50	1326.03	56.19	95.76
1989	1056.64	646.62	1703.26	42.74	97.49
1990	1223.66	985.74	2209.40	162.02	92.67
1991	1924.01	1091.48	3015.49	314.41	89.57

Sources of basic data: GSIS, SSS

contributions, then the figures are plausible. Note, however, that even this recorded 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. For the system as a whole, 1991 marks the first time in a decade that total efficiency has gone down below 90 percent.

An examination of accounts receivable, shown in Table 21 and Figure 38, corroborates these observations. Both GSIS and SSS' receivables have been in an upward trend. In 1980, the receivables amounted to only about P5 million; in 1991, the amount was already a staggering P314 million. The years 1989-91 witnessed an unprecedented accumulation of receivables, with both systems experiencing a steep 116.67 percent annual increase, on average. At the heart of GSIS' problem is the dilatory remittance of premiums by DBM, which holds the bulk of government payroll deductions. While this readily lends itself to a quick solution--GSIS has only to run after DBM (plus a few more government corporations)--the downside is that GSIS has nothing to fall back on in case DBM refuses to release the collection income.

Figure 38



On the other hand, SSS has to deploy more resources to track down hundreds of late-paying employers. At time of interview, an SSS official indicated that SSS could deploy only a dozen field staff (full staffing would require another 12 employees) to hunt some 15,000 to 20,000 offender firms in Metro Manila alone, 60 percent of which are considered hardcore delinquents. This process is time-intensive since SSS collectors have to pour through the records of the Securities and Exchange Commission. Even if delinquents start complying, they pay only the "bigger" insurance premiums, leaving the smaller payroll taxes such as Medicare with larger receivables. This situation considerably raises transaction costs. Still, SSS does a better job at collecting since it is not singularly dependent on just one premium income source or repository.

G. *Leverage ratios*

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 prone to destabilizing factors. The predictability of premium income (due to the regularity of payroll deductions), and sound investment decisions, have largely kept both debt to total assets ratio (total liabilities/total assets) and debt to equity ratio (total liabilities/ reserves) exceedingly low (at less than 0.1) during the 1980-91 interval. Tables 22-23 and Figures 39 and 40 show

TABLE 21
DEBT TO EQUITY RATIO

YEAR	GSIS			SSS			GSIS & SSS		
	TOTAL RESERVE FUND (million pesos)	TOTAL LIABILITIES (million pesos)	DEBT/ EQUITY	TOTAL RESERVE FUND (million pesos)	TOTAL LIABILITIES (million pesos)	DEBT/ EQUITY	TOTAL RESERVE FUND (million pesos)	TOTAL LIABILITIES (million pesos)	DEBT/ EQUITY
1980	83.965	6.759	0.080	355.326	1.944	0.005	439.291	8.703	0.020
1981	104.684	7.849	0.075	508.487	2.858	0.006	613.171	10.707	0.017
1982	120.636	9.003	0.075	666.358	2.000	0.003	786.994	11.003	0.014
1983	144.819	16.645	0.115	851.772	1.901	0.002	996.591	18.546	0.019
1984	218.200	16.867	0.077	1135.521	1.637	0.001	1353.721	18.504	0.014
1985	240.230	17.858	0.074	1561.222	1.675	0.001	1801.452	19.533	0.011
1986	174.368	18.920	0.109	1944.235	19.994	0.010	2118.603	38.914	0.018
1987	385.001	41.893	0.109	2440.903	14.766	0.006	2825.904	56.659	0.020
1988	436.387	38.530	0.088	2943.906	32.040	0.011	3380.293	70.570	0.021
1989	542.716	65.453	0.121	3738.127	1.826	0.000	4280.843	67.279	0.016
1990	598.394	40.507	0.068	4584.238	2.000	0.000	5182.632	42.507	0.008
1991	824.728	38.271	0.046	5721.075	4.268	0.001	6545.803	42.539	0.006

TABLE 22
DEBT TO TOTAL ASSETS RATIO

YEAR	GSIS TOTAL ASSETS (million pesos)	GSIS TOTAL LIABILITIES (million pesos)	GSIS DEBT/ TOTAL ASSETS	SSS TOTAL ASSETS (million pesos)	SSS TOTAL LIABILITIES (million pesos)	SSS DEBT/ TOTAL ASSETS	GSIS & SSS TOTAL ASSETS (million pesos)	GSIS & SSS TOTAL LIABILITIES (million pesos)	GSIS & SSS DEBT/ TOTAL ASSETS
1980	79.04	6.76	0.09	357.27	1.94	0.01	436.31	8.70	0.02
1981	122.59	7.85	0.06	511.34	2.86	0.01	633.94	10.71	0.02
1982	201.56	9.00	0.04	668.36	2.00	0.00	869.92	11.00	0.01
1983	290.56	16.65	0.06	853.67	1.90	0.00	1144.24	18.55	0.02
1984	315.47	16.87	0.05	1137.16	1.64	0.00	1452.62	18.50	0.01
1985	333.82	17.86	0.05	1562.90	1.68	0.00	1896.71	19.53	0.01
1986	389.22	18.92	0.05	1964.23	19.99	0.01	2353.45	38.91	0.02
1987	462.41	41.89	0.09	2455.67	14.77	0.01	2918.08	56.66	0.02
1988	532.08	38.53	0.07	2944.50	32.04	0.01	3476.58	70.57	0.02
1989	690.69	65.45	0.09	3739.95	1.83	0.00	4430.64	67.28	0.02
1990	834.67	40.51	0.05	4586.24	2.00	0.00	5420.91	42.51	0.01
1991	863.82	38.27	0.04	5725.34	4.27	0.00	6589.16	42.54	0.01

Sources of basic data: GSIS, SSS

TABLE 23
DEBT TO EQUITY RATIO

YEAR	GSIS TOTAL RESERVE FUND (million pesos)	GSIS TOTAL LIABILITIES (million pesos)	GSIS DEBT/ EQUITY	SSS TOTAL RESERVE FUND (million pesos)	SSS TOTAL LIABILITIES (million pesos)	SSS DEBT/ EQUITY	GSIS & SSS TOTAL RESERVE FUND (million pesos)	GSIS & SSS TOTAL LIABILITIES (million pesos)	GSIS & SSS DEBT/ EQUITY
1980	83.97	6.76	0.08	355.33	1.94	0.01	439.29	8.70	0.02
1981	104.68	7.85	0.07	508.49	2.86	0.01	613.17	10.71	0.02
1982	120.64	9.00	0.07	666.36	2.00	0.00	786.99	11.00	0.01
1983	144.82	16.65	0.11	851.77	1.90	0.00	996.59	18.55	0.02
1984	218.20	16.87	0.08	1135.52	1.64	0.00	1353.72	18.50	0.01
1985	240.23	17.86	0.07	1561.22	1.68	0.00	1801.45	19.53	0.01
1986	174.37	18.92	0.11	1944.24	19.99	0.01	2118.60	38.91	0.02
1987	385.00	41.89	0.11	2440.90	14.77	0.01	2825.90	56.66	0.02
1988	436.39	38.53	0.09	2943.91	32.04	0.01	3380.29	70.57	0.02
1989	542.72	65.45	0.12	3738.13	1.83	0.00	4280.84	67.28	0.02
1990	598.39	40.51	0.07	4584.24	2.00	0.00	5182.63	42.51	0.01
1991	824.73	38.27	0.05	5721.08	4.27	0.00	6545.80	42.54	0.01

Sources of basic data: GSIS, SSS

that of the 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. The continuous inflow of incomes has led to the strong buildup of assets and reserves, providing a big cushion for the Medicare program as a whole.

H. *Return on investment*

A look at Medicare's "profitability," or degree of success in earning a return on investment or on equity, provides further proof of the system's long-term robustness (Tables 24-25 and Figures 41-42). Overall, the system's ROI has alternated between respectable lows (e.g., 10 percent) and exceptional highs (38 percent). Individually, GSIS and SSS were raking in good investment returns. In 1986, not exactly a good year for the Philippine economy, GSIS managed to post a windfall ROI of 50 percent. SSS' turn came in 1990, a year marked by natural catastrophes, when it posted a record high ROI of 44 percent. During the crisis years of 1983-84, GSIS was able to earn an ROI of 16 percent, and SSS, of 13-17 percent. In the main, Medicare's high investment performance--the system now relies less on premiums since interest incomes make for almost half of total incomes--means any further slackening of collection efficiency may be offset by high investment incomes. This is especially true for SSS, whose investment income is almost half of its total income base. It may not be quite as true for GSIS, whose financial foundation continues to be hobbled by a relatively small investment income base. Even with high investment returns, a tiny investment income buffer has limited usefulness. GSIS still has to get by with the help of premium incomes.

Figure 39

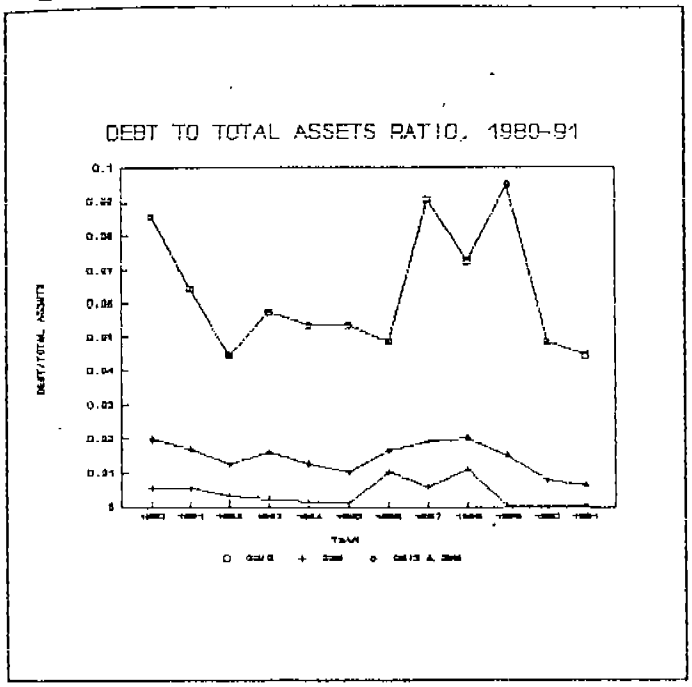


Figure 40

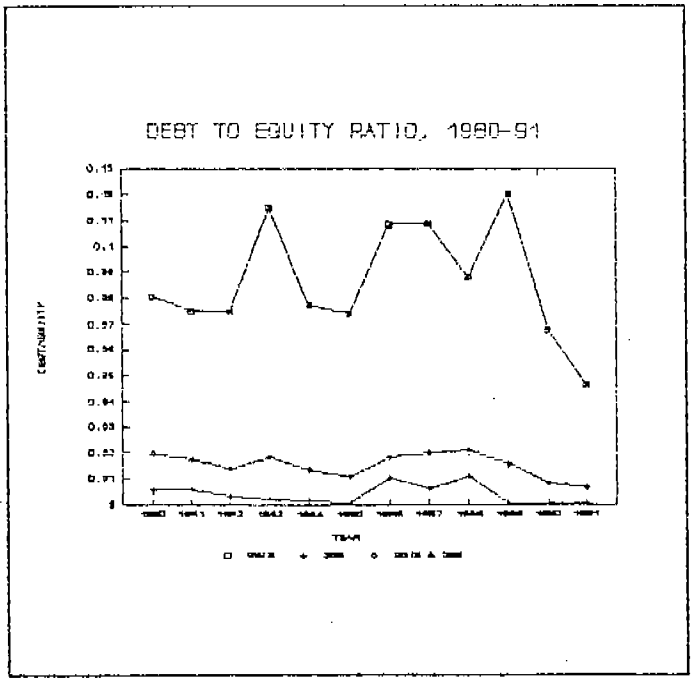


TABLE 24
RETURN ON INVESTMENTS

	YEAR	INVESTMENT INCOME (million pesos)	TOTAL INVESTMENTS (million pesos)	RETURN ON INVESTMENTS
GSIS				
	1980	4.02	22.72	17.70
	1981	5.70	111.77	5.10
	1982	21.16	145.77	14.52
	1983	25.97	200.77	12.94
	1984	30.87	191.77	16.10
	1985	19.50	121.77	16.01
	1986	22.11	43.81	50.47
	1987	4.25	54.33	7.83
	1988	55.40	506.64	10.93
	1989	89.52	661.26	13.54
	1990	147.13	712.61	20.65
	1991	133.00	674.80	19.71
SSS				
	1980	38.28	350.15	10.93
	1981	60.45	501.39	12.06
	1982	83.97	652.83	12.86
	1983	109.39	838.47	13.05
	1984	188.00	1105.37	17.01
	1985	365.07	1492.02	24.47
	1986	355.75	1898.92	18.73
	1987	334.46	2366.02	14.14
	1988	406.59	2933.91	13.86
	1989	554.08	3754.18	14.76
	1990	837.80	1868.47	44.84
	1991	954.15	4448.18	21.45
GSIS & SSS				
	1980	42.30	372.86	11.35
	1981	66.15	613.16	10.79
	1982	105.13	798.59	13.16
	1983	135.36	1039.24	13.02
	1984	218.87	1297.14	16.87
	1985	384.57	1613.79	23.83
	1986	377.87	1942.74	19.45
	1987	338.72	2420.35	13.99
	1988	461.98	3440.55	13.43
	1989	643.61	4415.44	14.58
	1990	984.92	2581.08	38.16
	1991	1087.16	5122.98	21.22

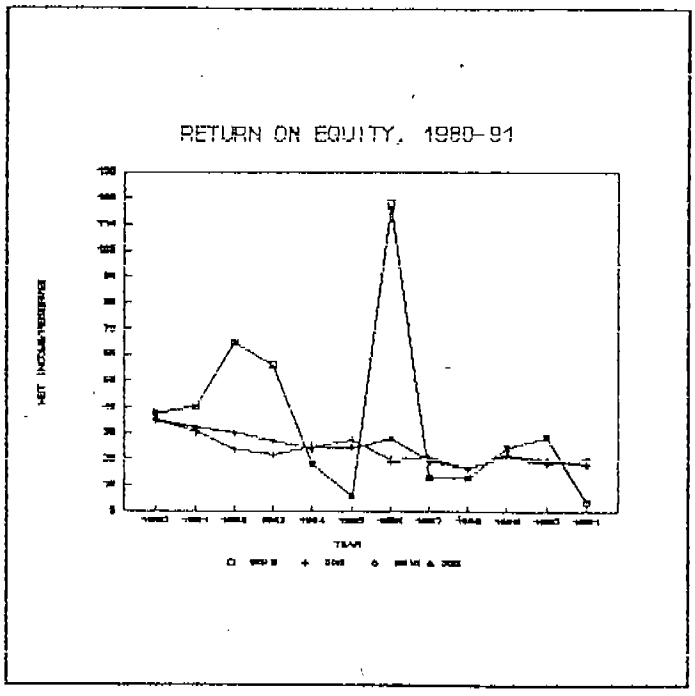
Sources of basic data: GSIS, SSS

TABLE 25
RETURN ON EQUITY

	YEAR	NET INCOME (million pesos)	TOTAL RESERVE FUND (million pesos)	RETURN ON EQUITY
GSIS				
	1980	31.72	83.97	37.77
	1981	42.29	104.68	40.40
	1982	78.04	120.64	64.69
	1983	80.92	144.82	55.88
	1984	40.37	218.20	18.50
	1985	13.61	240.23	5.67
	1986	205.44	174.37	117.82
	1987	50.24	385.00	13.05
	1988	56.86	436.39	13.03
	1989	131.28	542.72	24.19
	1990	168.42	598.39	28.15
	1991	30.07	824.73	3.65
SSS				
	1980	122.23	355.33	34.40
	1981	153.16	508.49	30.12
	1982	157.64	666.36	23.66
	1983	185.42	851.77	21.77
	1984	283.75	1135.52	24.99
	1985	425.70	1561.22	27.27
	1986	385.96	1944.24	19.85
	1987	496.44	2440.90	20.34
	1988	507.24	2943.92	17.23
	1989	794.04	3738.13	21.24
	1990	845.33	4584.24	18.44
	1991	1156.01	5725.34	20.19
GSIS & SSS				
	1980	153.95	439.29	35.04
	1981	195.46	613.17	31.88
	1982	235.68	786.99	29.95
	1983	266.33	996.59	26.72
	1984	324.11	1353.72	23.94
	1985	439.31	1801.45	24.39
	1986	591.40	2118.60	27.91
	1987	546.68	2825.90	19.35
	1988	564.10	3380.31	16.69
	1989	925.32	4280.84	21.62
	1990	1013.76	5182.63	19.56
	1991	1186.08	6550.07	18.11

Sources of basic data: GSIS, SSS

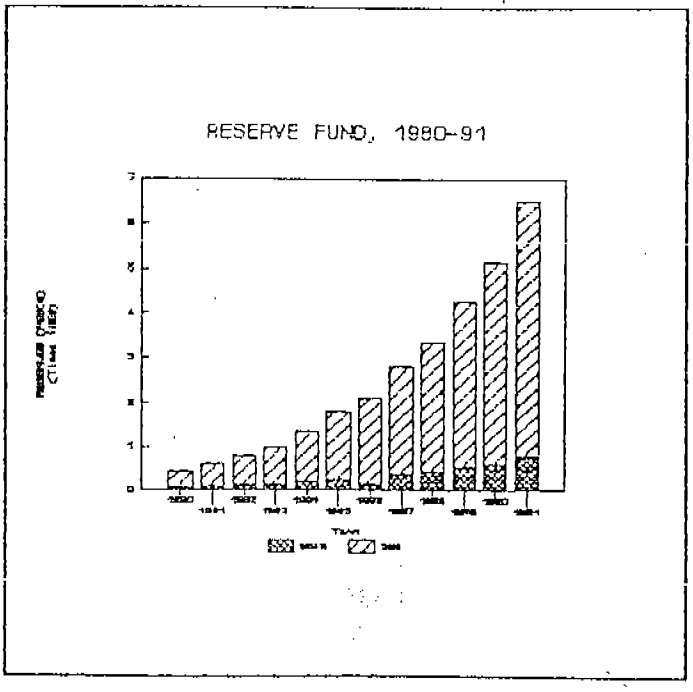
Figure 41



Medicare's ability to offset by high incomes correspondingly high benefits and operating expenses, as measured by return on equity, is likewise generally in good shape. During the period 1980-91, the program's return on equity has averaged 24.6 percent yearly, suggesting that positive income gains have shielded Medicare's reserves from erosion. On average, GSIS has posted a higher return on equity (35.2 percent annually) compared to SSS' 23.2 percent per year. GSIS' performance has been highly uneven, however: in 1986, the ROE went up to 118 percent, only to nosedive to 13 percent the next year. Again, from 28 percent in 1990, GSIS' ROE dropped precipitously to 3.6 percent in 1991. Thus, GSIS has been struggling to maintain a positive net income. Although it has yet to be forced by circumstances to dip into its reserves, its equity position remains highly vulnerable, especially to a sudden surge of benefit expense.

I. *Reserve capacity*

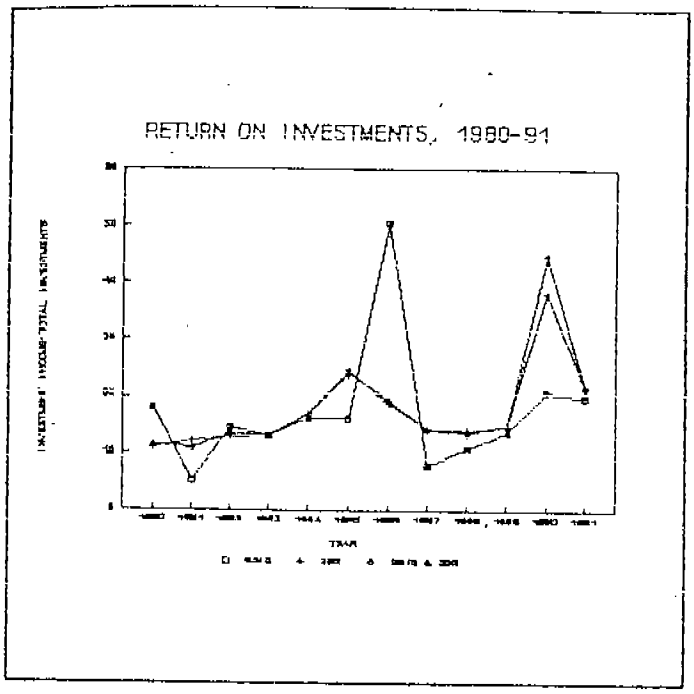
Figure 42



Just how long will Medicare survive anyway if its reserves were actually used to defray current levels of expenses? Reserve capacity, or reserve levels as a percent of total expenses, reflects the number of years current reserves can sufficiently cover Medicare disbursements. For the entire system, as cumulative reserves shot up fifteen-fold from P439 million to P6.55 billion (Figure 43), the reserve capacity (Figure 44) also went up from 1.3 years to as high as 5.5 years (in 1989). On average, it will take about 3.4 years before Medicare funds dry up, given current levels of expenditures. SSS has been spectacular in maintaining an inordinately high reserve capacity. As its reserves piled up incessantly--by 1991 it has accumulated P5.7 billion!--SSS' ability to

sustain current operations was averaging 4.8 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 2 years reserve capacity. Given this, the SSS stockpile of reserves seems too far in excess of the actuarial norm. Health care insurance often tends to be more claims-intensive than other types of insurance, such as life or casualty.

Figure 43

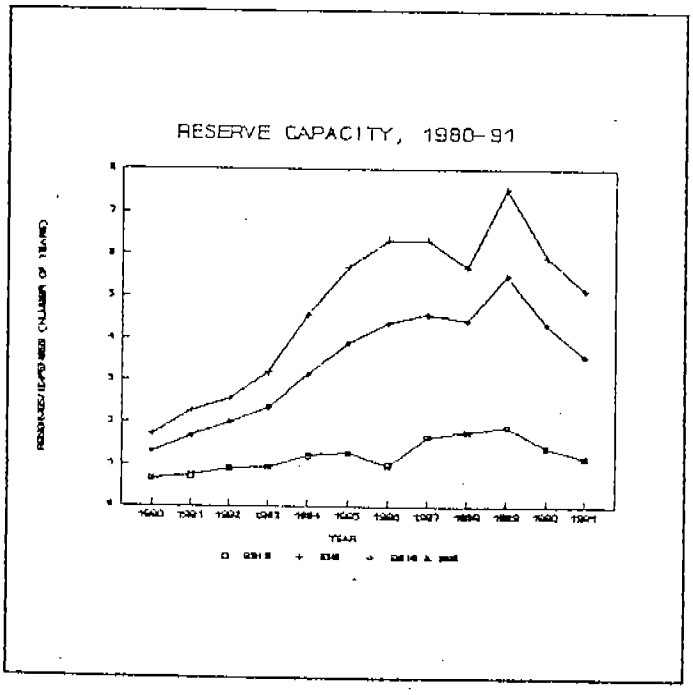


GSIS' reserves have grown tenfold, from P84 million in 1980 to P825 million in 1991. High expenditure levels, however, have kept it from attaining satisfactory capacity increases. In 1980-91, its reserve capacity averaged only 1.2 years, a precariously low level of sustainability.

J. Disparity in financial performance

Overall, Medicare's financial management is in a good shape, 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 fail every financial test applied to its HIF. Only a good leverage ratio--and even this is dependent on the predictable regularity of collection income--somehow provides the saving grace for GSIS. The disparity in the financial management record of the two system raises disturbing questions on economies of size. Increasing efficiency is associated with a reasonably large operational scope, and GSIS may have a difficult time reaching that level, given that its market--government employees--is a small one. Indeed, its operational base is sensitive to the size of the public sector; the

Figure 44



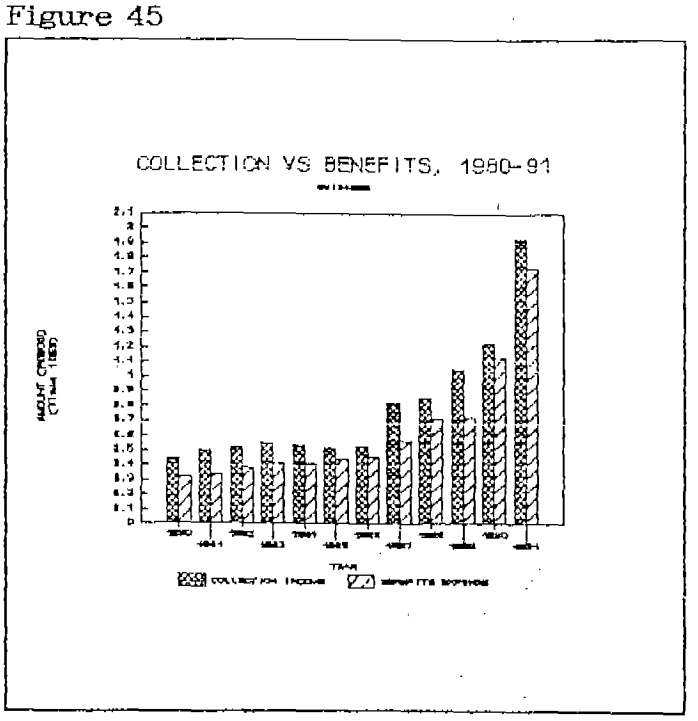
tendency--although not often carried out in practice--is always to downsize the bureaucracy rather than expand it. Additionally, GSIS and SSS perform *identical and completely substitutable* Medicare functions, even if SSS may be particularly proficient at some of them. GSIS staff do not need to change tools to carry out Medicare operations. This brings to the fore the issue of the possible merging of GSIS and SSS (not just on the Medicare front but on all social security operations) since maintaining two separate but functionally identical bodies makes no economic sense. Gamboa (1990) concedes, however, that any step that leads toward integration (at the very least of the two HIFs) requires strong political consensus in government and Congressional initiative.

IX. INCREASING BENEFIT EXPENSE: TRADEOFFS BETWEEN FINANCIAL VIABILITY AND FUND UTILIZATION

Insurance is actuarially fair when the premium exactly equals the expected payout. Of course, insurers routinely charge something more than the actuarially fair price to cover administrative costs. To know the expected payout, one must know the probabilities of each of the possible contingencies as well as the associated payouts. Estimations of this sort are within the domain of insurance carriers; what can be answered, however, using financial analysis, is whether the insuree is able to claim back at least a good portion of what he put in.

The growth of Medicare expenditures has kept pace with the growth of collection and investment incomes. As Table 26 shows, they have ballooned rapidly in recent years, from P338 million in 1980 to P1.8 billion in 1991, or by an average of 17.9 percent a year. The growth rate of expenditures was particularly stiff in 1990-91, when it reached over 53 percent.

Figure 45



A. The growth of benefits expense

The single largest expense of Medicare goes to benefit claims. Benefit payments reached P1.1 billion in 1990 and P1.7 billion in 1991, which are only 8-10 percent shy of collection income for those years (see Figure 45). As a proportion of collection income, benefits expense captured anywhere from 68 percent to 92 percent, again indicating that without healthy reserves, the HIF would be vulnerable to depletion. Tables 27 and 28 detail the breakdown by agency. As expected, benefit expense for GSIS grew faster than that for SSS, 19.7 percent to 17.4 percent, a 2.3 percentage point difference. Figure 46 also displays the relatively larger claim of GSIS benefit expenditures on collection income.

TABLE 26
MEDICARE FUND UTILIZATION, GSIS & SSS

YEAR	COLLECTION INCOME (million pesos)	BENEFITS EXPENSE AMOUNT (million pesos)	BENEFITS EXPENSE ANNUAL INCREASE(%)	BENEFITS EXPENSE PERCENT OF COLL INC	BENEFITS RECIPIENTS NUMBER* (million)	BENEFITS RECIPIENTS ANNUAL INCREASE	BENEFITS PAID PER RECIPIENT** (pesos)	PERCENT CHANGE PER RECIPIENT (pesos)	BENEFITS PER CAPITA*** (pesos)	RECIPIENTS AS PERCENT OF COVERAGE	RECIPIENTS AS PERCENT OF MEMBERS	COVERAGE (million)	BENEFICIARIES SERVED (million)
1980	446.72	318.66		71.33	1.21		262.70		16.16	6.91	27.68	17.55	1.31
1981	494.67	339.73	6.61	68.68	1.23	1.24	276.65	5.31	16.47	6.67	26.92	18.40	1.34
1982	520.83	379.73	11.77	72.91	1.38	12.70	274.37	−0.82	19.44	7.08	28.58	19.54	1.43
1983	550.21	406.78	7.12	73.93	1.46	5.56	278.41	1.47	19.28	6.92	27.91	21.12	1.55
1984	533.63	410.40	0.89	76.91	1.41	−3.70	291.68	4.77	15.63	5.36	25.76	26.27	1.44
1985	514.37	436.56	6.66	85.26	1.49	1.49	307.11	5.29	15.22	4.95	24.44	26.62	1.46
1986	525.89	450.02	2.61	85.57	1.36	−4.48	329.93	7.43	15.25	4.62	23.78	29.51	1.51
1987	824.31	574.75	27.72	69.72	1.35	−1.10	428.05	29.14	26.41	6.20	22.48	21.77	1.56
1988	861.53	713.79	24.19	82.85	1.48	10.01	480.99	12.90	32.11	6.68	31.89	22.23	1.96
1989	1056.64	726.07	1.72	68.72	1.23	−16.85	568.39	22.33	32.31	5.49	25.63	22.47	1.31
1990	1223.66	1126.86	55.21	92.10	1.23	−0.65	918.21	58.23	48.60	5.29	23.66	23.19	1.23
1991	1824.01	1731.59	53.65	90.00	1.37	11.75	1263.93	37.50	71.64	5.67	25.51	24.17	1.48

*Number of claims paid
**Average value paid per claim
***Benefits paid as percent of coverage

TABLE 26
(cont'l)

YEAR	OPERATING EXPENSE AMOUNT (million pesos)	OPERATING EXPENSE PERCENT OF COLL INC	OPERATING EXPENSES PER BENEFICIARY* (pesos)	PERCENT CHANGE PER BENEFICIARY	OPERATING EXPENSES PER ENROLLEE (pesos)	OPERATING EXPENSES PER CAPITA (pesos)	COST OF INSURANCE LOADING FACTOR** (pesos)	COST OF INSURANCE LOADING RATE***	MEMBERSHIP
1980	18.94	4.24	14.46		4.35	1.08	128.06	28.67	4.35
1981	26.40	5.34	19.70	36.28	5.79	1.43	154.94	31.32	4.56
1982	12.07	2.32	8.44	−57.18	2.49	0.62	141.10	27.09	4.84
1983	14.62	2.66	9.43	11.80	2.79	0.69	143.45	26.07	5.24
1984	19.52	3.66	13.55	43.67	3.58	0.74	123.23	23.09	5.46
1985	22.46	4.37	15.38	13.49	3.84	0.76	75.61	14.74	5.84
1986	34.60	6.58	22.81	48.97	6.03	1.17	75.87	14.43	5.74
1987	42.40	5.14	27.18	18.63	7.07	1.95	249.56	30.28	6.00
1988	48.14	5.59	35.40	30.23	10.94	2.17	147.74	17.15	4.65
1989	51.73	4.90	39.49	11.56	10.83	2.30	330.56	31.28	4.78
1990	68.69	5.61	55.84	41.41	19.25	2.96	96.70	7.90	5.18
1991	97.82	5.08	66.09	18.35	18.22	4.05	192.42	10.00	5.37

Source of basic data: PMCC
*Operating expense/beneficiaries served
**Loading factor = cost of insurance = collection income − benefits payments
***Loading rate = cost of insurance/premium collection

TABLE 27
MEDICARE FUND UTILIZATION, GSIS

YEAR	COLLECTION INCOME (million pesos)	BENEFITS EXPENSE: AMOUNT (million pesos)	BENEFITS EXPENSE: ANNUAL INCREASE(%)	BENEFITS EXPENSE: PERCENT OF COLL INC	BENEFITS RECIPIENTS: NUMBER* (million)	BENEFITS RECIPIENTS: ANNUAL INCREASE	BENEFITS PAID PER RECIPIENT** (pesos)	PERCENT CHANGE PER RECIPIENT	BENEFITS PER CAPITA*** (pesos)	RECIPIENTS AS PERCENT OF COVERAGE	RECIPIENTS AS PERCENT OF MEMBERS	COVERAGE (million)	BENEFICIARIES SERVED (million)
1980	156.17	114.83		73.53	0.47		246.84		26.51	10.73	44.41	4.33	0.51
1981	180.95	125.05	8.90	69.11	0.47	0.22	266.35	8.67	26.49	10.60	43.92	4.40	0.51
1982	190.05	128.23	2.54	67.47	0.49	4.94	262.23	−2.28	27.12	10.34	42.86	4.73	0.55
1983	209.61	147.37	14.92	70.31	0.55	12.07	268.92	2.55	29.52	10.98	45.51	4.89	0.62
1984	191.15	171.04	16.06	89.48	0.59	7.30	290.89	8.17	26.28	9.03	45.90	6.51	0.58
1985	181.56	174.05	1.76	95.87	0.56	−4.99	311.36	7.04	23.29	7.46	37.98	7.47	0.57
1986	190.87	170.80	−1.81	89.03	0.54	−4.28	318.44	2.59	23.81	7.45	42.16	7.18	0.82
1987	276.15	224.50	31.36	80.71	0.59	9.53	383.10	19.93	33.88	8.84	45.78	6.83	0.66
1988	245.48	239.32	6.60	97.49	0.59	1.19	403.58	5.34	35.72	8.85	44.45	6.70	0.58
1989	325.51	276.55	15.56	84.96	0.52	−12.98	535.95	32.80	42.16	7.87	36.94	6.56	0.62
1990	446.22	416.45	50.59	93.33	0.58	11.63	723.01	34.90	61.97	8.57	41.06	6.72	0.54
1991	615.69	708.74	70.19	115.11	0.62	7.29	1146.83	58.62	105.47	9.20	41.20	6.72	0.66

Source of basic data: PMCC
*Number of claims paid
**Average value paid per claim
***Benefits paid as percent of coverage

TABLE 27
(cont)

YEAR	OPERATING EXPENSE: AMOUNT (million pesos)	OPERATING EXPENSE: PERCENT OF COLL INC	OPERATING EXPENSES PER BENEFICIARY* (pesos)	PERCENT CHANGE PER BENEFICIARY	OPERATING EXPENSES PER ENROLLEE (pesos)	OPERATING EXPENSES PER CAPITA (pesos)	COST OF INSURANCE: LOADING FACTOR** (pesos)	COST OF INSURANCE: LOADING RATE***	MEMBERSHIP
1980	15.12	9.68	29.64		14.44	3.48	41.34	26.47	1.05
1981	19.34	10.69	37.92	27.94	18.23	4.40	55.90	30.89	1.06
1982	4.95	2.60	9.00	−76.26	4.34	1.05	61.82	32.53	1.14
1983	7.30	3.48	11.77	30.81	6.06	1.46	62.24	29.69	1.20
1984	10.61	5.55	18.29	55.45	8.26	1.63	20.10	10.52	1.28
1985	13.39	7.38	23.49	28.42	9.10	1.79	7.50	4.13	1.47
1986	7.34	3.85	11.84	−49.60	5.78	1.02	19.76	10.37	1.27
1987	7.66	2.75	11.61	−1.95	5.89	1.16	53.65	19.29	1.28
1988	6.51	2.65	11.22	−3.32	4.88	0.97	6.16	2.51	1.33
1989	7.32	2.25	11.80	5.16	5.24	1.12	48.96	15.04	1.40
1990	8.47	1.90	15.68	32.83	6.04	1.26	29.76	6.67	1.40
1991	11.18	1.82	18.94	8.08	7.45	1.66	−93.05	−15.11	1.50

Source of basic data: PMCC
*Operating expense/beneficiaries served
**Loading factor = collection income − benefits payments
***Loading rate = cost of insurance/premium collection

TABLE 28
MEDICARE FUND UTILIZATION, SSS

YEAR	COLLECTION INCOME (million pesos)	BENEFITS EXPENSE AMOUNT (million pesos)	ANNUAL INCREASE(%)	PERCENT OF COLL INC	BENEFITS RECIPIENTS NUMBER* (million)	ANNUAL INCREASE	BENEFITS PAID PER RECIPIENT** (pesos)	PERCENT CHANGE PER RECIPIENT	BENEFITS PER CAPITA*** (pesos)	RECIPIENTS AS PERCENT OF COVERAGE	RECIPIENTS AS PERCENT OF MEMBERS	COVERAGE (million)	BENEFICIARIES SERVED (million)
1980	290.55	203.83		70.15	0.75		272.50		15.42	5.66	22.64	13.22	0.80
1981	313.73	214.68	5.32	68.43	0.76	1.87	281.73	3.39	15.33	5.44	21.77	14.00	0.83
1982	330.78	251.50	17.15	76.03	0.90	17.45	281.00	−0.26	16.98	6.04	24.18	14.81	0.88
1983	340.60	259.40	3.14	76.16	0.91	2.01	284.11	1.11	16.09	5.66	22.65	16.12	0.93
1984	342.48	239.36	−7.73	69.89	0.82	−10.30	292.25	2.87	12.12	4.15	19.81	19.78	0.86
1985	332.82	264.51	10.51	79.48	0.87	6.11	304.36	4.15	12.39	4.07	18.89	21.35	0.89
1986	335.22	279.12	5.52	83.26	0.83	−4.60	336.69	10.62	12.50	3.71	18.56	22.33	0.89
1987	546.16	350.25	25.48	64.13	0.76	−7.96	459.04	36.34	23.13	5.04	16.17	15.14	0.90
1988	616.05	474.47	35.47	77.02	0.89	16.78	532.52	16.01	30.55	5.74	26.84	15.53	0.78
1989	731.13	449.52	−5.26	61.48	0.72	−19.42	626.07	17.57	28.25	4.51	21.24	15.91	0.69
1990	777.44	710.50	58.06	91.39	0.65	−9.47	1093.08	74.59	43.14	3.95	17.20	16.47	0.69
1991	1308.32	1022.85	43.96	78.18	0.75	15.69	1360.17	24.43	58.62	4.31	19.43	17.45	0.82

Source of basic data: PMCC
*Number of claims paid
**Average value paid per claim
***Benefits paid as percent of coverage

TABLE 28
(cont)

YEAR	OPERATING EXPENSE AMOUNT (million pesos)	PERCENT OF COLL INC	OPERATING EXPENSES PER BENEFICIARY* (pesos)	PERCENT CHANGE PER BENEFICIARY	OPERATING EXPENSES PER ENROLLEE (pesos)	OPERATING EXPENSES PER CAPITA (pesos)	COST OF INSURANCE LOADING FACTOR** (pesos)	LOADING RATE***	MEMBERSHIP
1980	3.82	1.32	4.78		1.16	0.29	86.72	29.85	3.50
1981	7.06	2.25	8.51	78.02	2.02	0.50	99.05	31.57	3.50
1982	7.12	2.15	8.09	−4.93	1.92	0.48	79.28	23.97	3.70
1983	7.33	2.15	7.88	−2.61	1.82	0.45	81.20	23.84	4.03
1984	8.91	2.60	10.35	31.47	2.13	0.45	109.13	30.11	4.18
1985	9.07	2.72	10.19	−1.63	2.07	0.42	68.91	20.52	4.97
1986	27.26	8.13	30.63	200.68	6.10	1.22	56.10	16.74	4.47
1987	34.74	6.36	38.60	26.04	7.36	2.29	195.91	35.87	4.72
1988	41.69	6.76	53.37	38.27	12.54	2.68	141.58	22.98	3.92
1989	44.41	6.07	64.37	20.60	13.14	2.79	281.60	38.52	3.98
1990	60.22	7.75	87.28	35.59	15.93	3.66	66.84	8.61	3.78
1991	88.64	6.62	105.85	21.05	22.99	4.96	265.47	21.62	3.97

Source of basic data: PMCC
*Operating expense/beneficiaries served
**Loading factor = cost of insurance = collection income − benefits payments
***Loading rate = cost of insurance/premium collection

compared to that of SSS (Figure 47). In 1991, GSIS' benefit expense claimed 115 percent of collection revenues, the first time in twelve years that claims payments in either GSIS or SSS ever exceeded premium payments.

During the same period, the number of people receiving Medicare benefits only rose slightly, from 1.2 million in 1980 to 1.37 million in 1991--increasing by a measly 1.4 percent each year. The number of recipients topped 1.4 million only in 1983-85 and again in 1988.

B. *Unchanging proportion of beneficiaries*

Although conceivably more people were brought into the program (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. As Tables 26-28 starkly depict, the number of beneficiaries hardly changed in 1980-91.

As a proportion of the Medicare coverage base, only about 5.7 percent had received benefits in 1991. In earlier years, the proportion was a little higher--6 to 7 percent--but has not even reached 10 percent. Between the two agencies, GSIS has given benefits to a higher percentage of Medicare eligibles within its own coverage base--always about twice those of the SSS (refer to Figures 48 and 49). For instance, in 1980, 10.7 percent of those covered within the public sector received benefits from GSIS; the corresponding figure for SSS is 5.7 percent.

Figure 46

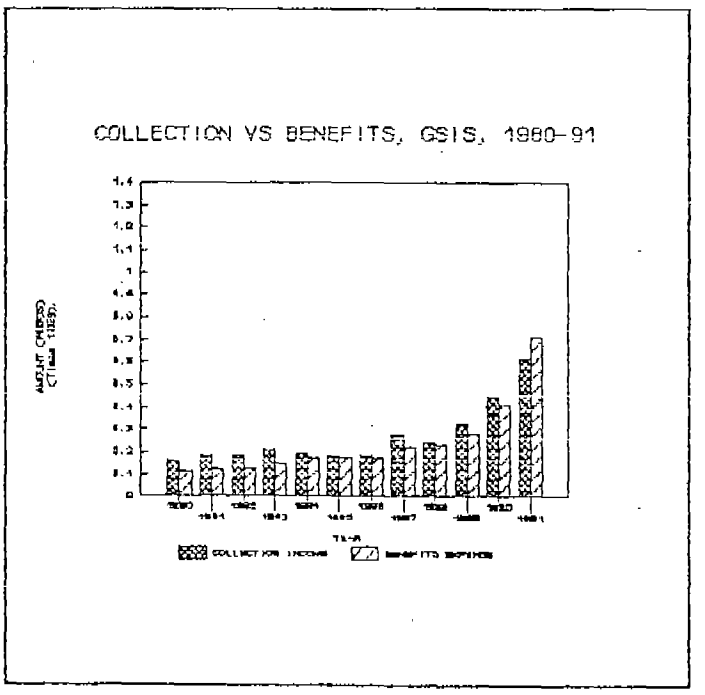


Figure 47

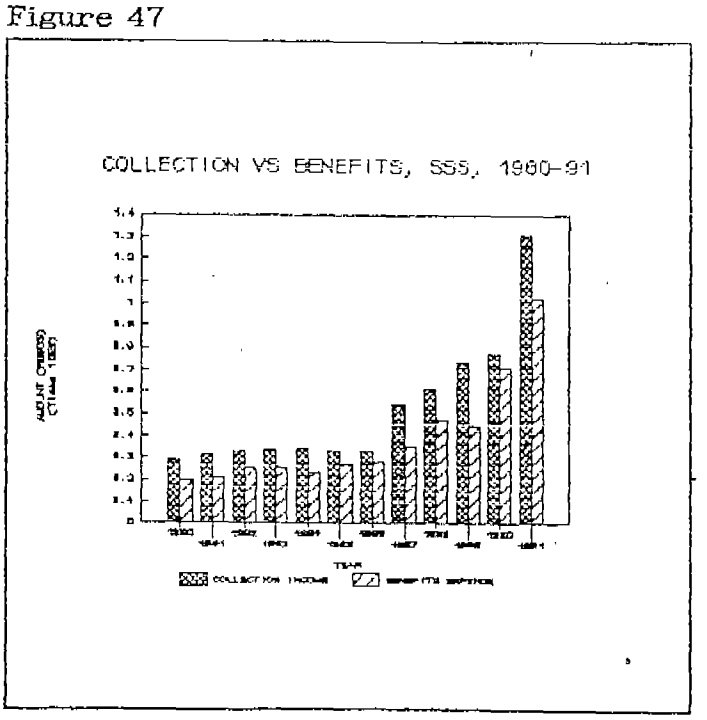


Figure 48

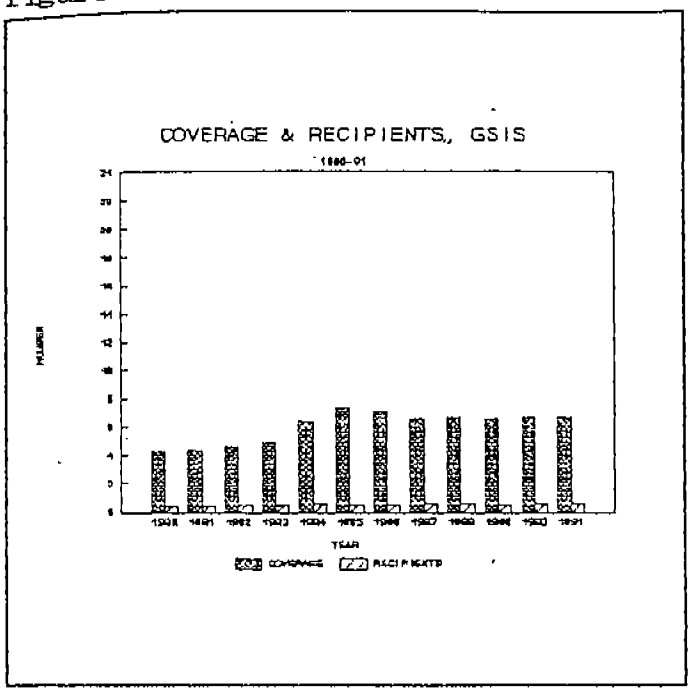
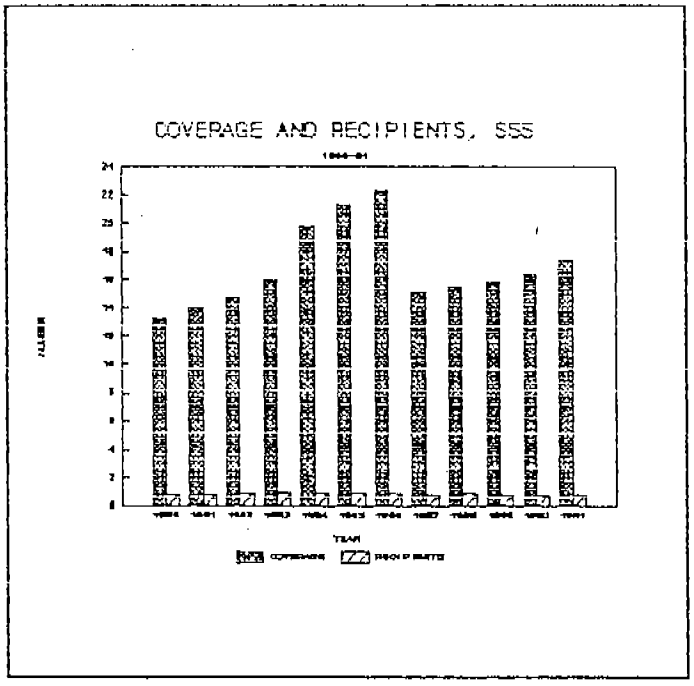


Figure 49



In a leaner year such as 1991, GSIS gave out Medicare assistance to 9.2 percent of covered government employees; SSS handed out benefits only to 4.3 percent of those it insured in the private sector. Many more public sector workers are apparently dependent on Medicare, presumably because Medicare is the only medical insurance available to them; in the private sector, many firms offer comparable social security benefits to their workers quite apart from Medicare, resulting in a lower usage of Medicare. Ad hoc observations made by SSS managers also point to the relatively stricter rules on office hours in the private sector, which discourage lengthy follow-ups (with their high transaction costs) of Medicare claims. On the other hand, leakages in the GSIS system may be quite high, and this translates into less rigorous adjudication of claims.

C. De facto duality in benefit structure

Quite unlike the almost negligible increase in numbers, the average payment to each Medicare recipient rose between 1980 and 1991. The benefits paid per recipient was P262.70 in 1980; it increased gradually in the years 1981-86, and then rose steeply in the succeeding years. In 1991, the average benefits paid per recipient was P1263.93. SSS paid higher average values per claim. Between 1980 and 1986, SSS paid out an average of P293.24 per recipient; GSIS disbursed an average of P281.16. The difference was P12.08. Between 1987 and 1991, the corresponding figures were P814.18 for SSS and P638.50 for GSIS. The difference was now P175.68. The curves in Figure 50, which show the gradual then steep growth of average values per claim, also illustrate that the gap between the two agencies hardly existed prior to 1986, but widened after that year. This has created a de facto duality within the same benefit structure, although not sanctioned by Medicare officials, who have always favored across-the-board

benefit changes.

On a per capita basis, the upward trend in benefits paid is also evident, as portrayed in Figure 51. The difference is that GSIS pays higher benefits per capita--by as much as two-thirds more than what SSS pays, on average. The reason for this is that GSIS has a bigger proportion of beneficiaries in its coverage base. 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 (Gamboa, 1991). 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. (Besides, Medicare covers a population with presumably average health problems, so 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.

Figure 50

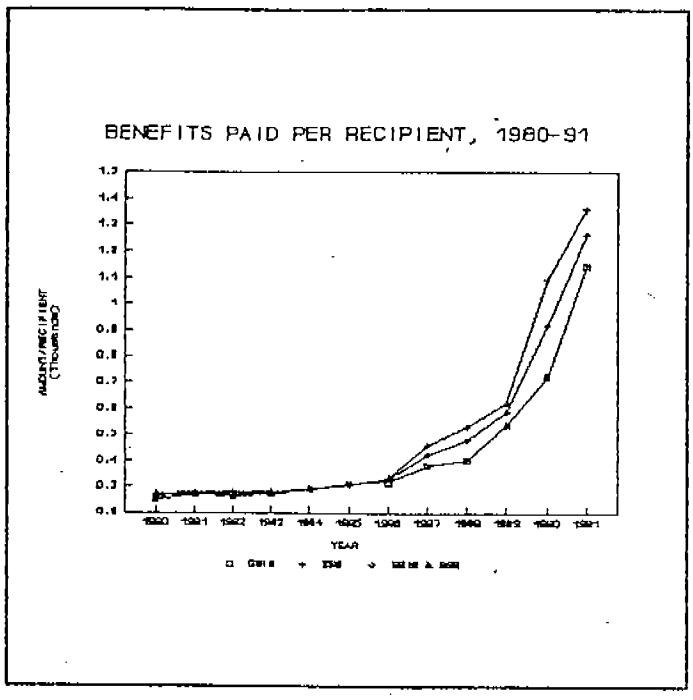
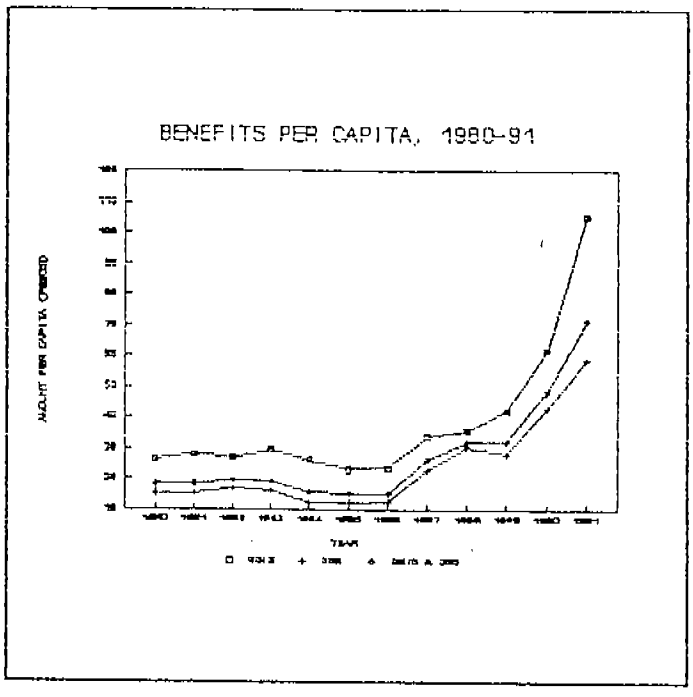


Figure 51



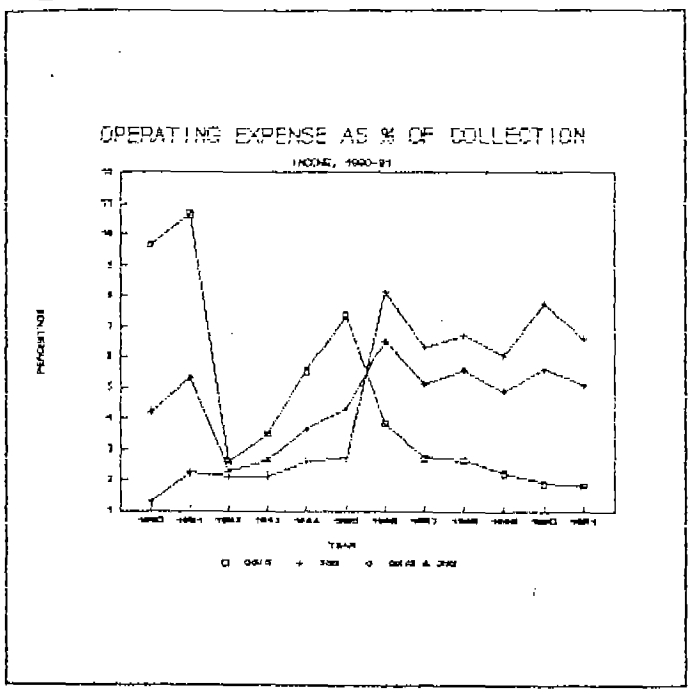
D. *Growth in operating expense*

Operating expense as a percent of collection income averaged 4.62 percent between 1980 and 1991, well below the 12 percent ceiling prescribed by the Medicare law (Table 26). It has generally stayed above the 5 percent level since 1986, in part because the system is experiencing an observable upward trend in operating expense by SSS (Table 28), the more dominant of the two Medicare fund managers. Between 1980 and 1986, SSS' operational expenditures were below the P10 million mark, or equivalently, it was spending for overhead and administration only an average of 2.2 percent (of collection income). In 1986, the amount went up to P27.3 million; by 1991, SSS had incurred P86.6 million in operating costs, or about 88 percent of the cost of running the entire system. As a percent of collection income, SSS'

operating expenditures averaged a high 8.34 percent between 1987-91. This is somewhat offset by a downward trend in GSIS' operating expenses (Table 27). As a percent of collection income, administrative costs incurred by GSIS went as high as 10.7 percent in 1981, but since 1986, had settled to an average of 2.3 percent. GSIS hit the P19 million mark in 1981--its highest so far--but after 1985, its operating expense has settled to the P7-P8 million level. It climbed to more than P11 million in 1991, but this is still below the 1981 figure, and in any case represents less than 2 percent of collection income. Figure 52 summarizes the trends in operating costs for the entire system as well as for GSIS and SSS.

That SSS is proportionately spending more to manage Medicare seems odd, since scale economies would suggest otherwise, that is, that SSS should actually be spending less as a percent of collection income. This deserves further scrutiny. Operating expense, as a measure of administrative efficiency, is sensitive to the size and frequency of claims, including their monitoring and evaluation. Operating expenses per Medicare eligible served (whether the claim is settled or disapproved) have been steadily on the upswing since 1984, going up from P13.55 to an average of P60.95 in the last two years. Since the number of claims have declined slightly, the rise in per beneficiary costs for both GSIS and SSS presumably reflects inflationary trends in the economy.

Figure 52

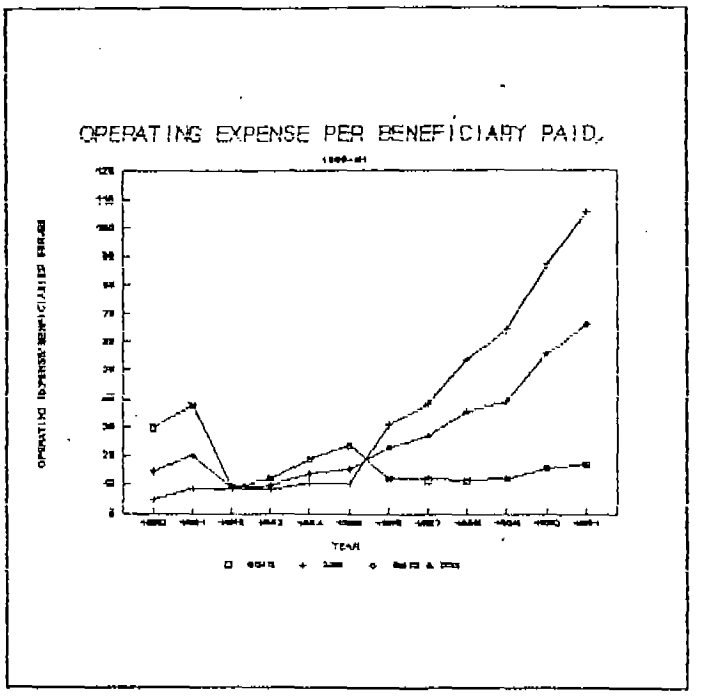


For GSIS, operating costs per eligible served have settled to an average of P13.18 beginning 1986, after highs of P29.64 and P37.92 and a low of P8.99. That means much of the upward pattern in operating expenses, at least after 1986, is being contributed by SSS. For SSS, operating expenses per beneficiary increased from P4.78 in 1980 to a high P105.65 in 1991. The latter figure alone is more than six times the amount spent by GSIS. 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, despite struggling to achieve scale economies, which has been successful in containing unit operating costs.

For the system as a whole, the rate of growth of operating expenses in 1980-91 has averaged 19.7 percent yearly. The breakdown by agency depicts contrasting situations: the average annual growth rate of operating costs for SSS was 40.2 percent; for GSIS it was 5.2 percent. One way of balancing the picture is to determine whether the growth rate of benefit payment per recipient *exceeds* that of per beneficiary costs. As a whole, the rate of change in benefit expense on a per recipient basis was 16.5 percent during the

same period. For SSS, benefit payments were growing at the rate of 17.3 percent; for GSIS the rate was 16.2 percent, which was not far behind. Thus, it is costing SSS much more to maintain a healthy 17 percent growth rate in benefits. For GSIS, the administrative costs per peso of benefits is low. In a manner of speaking, for one-eighth of the price, GSIS could offer practically the same growth pattern in benefit payments.

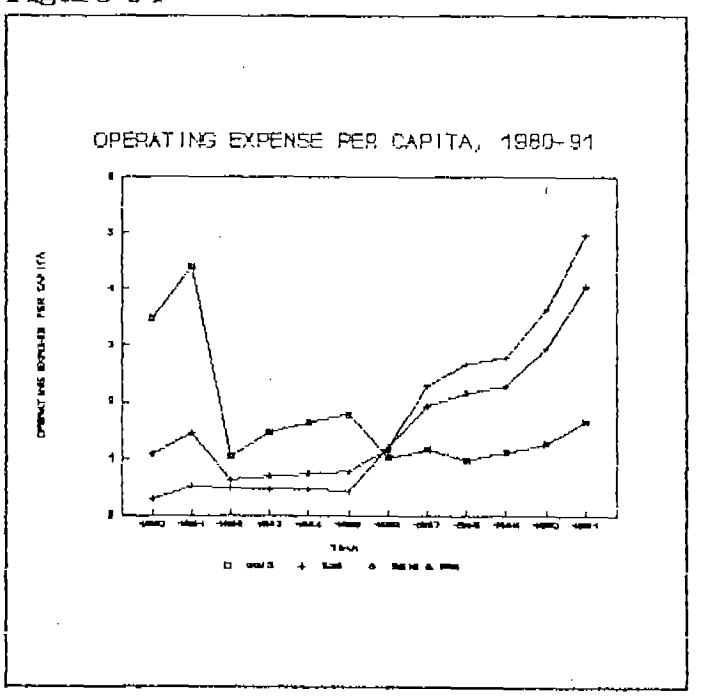
Figure 53



E. *Higher costs for SSS*

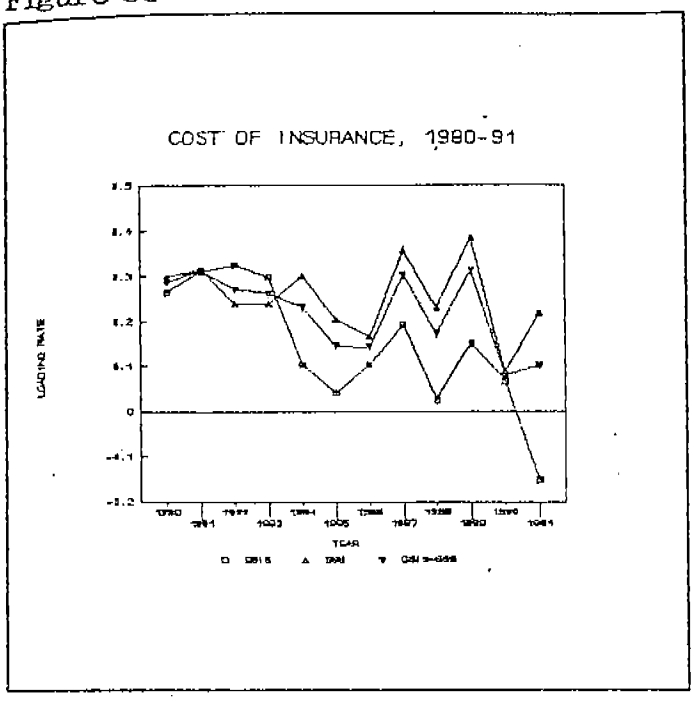
It is interesting to note, finally, that using other related indicators, such as operating expense per enrollee or operating expense per capita, leaves the picture essentially unchanged. Whether the administrative costs are distributed among Medicare members (who, after all, pay for the operational expenses) or among a broader set (members plus dependents), the consequences are the same. It is SSS which has incurred higher costs on either per enrollee or per capita basis (Figure 54). Gamboa (1991) surmises that SSS' operating costs might have gone largely to monitoring and investigating leakages, or reduction of unnecessary Medicare availments. Low operating expenses, after all, may reflect excessive benefit expenses if claims are not carefully monitored. Low operating expenses may not necessarily imply efficient operation. Still, this raises questions on whether such monitoring costs had been excessive--an area that requires further research.

Figure 54



Regardless of the real reasons for the contrasting administrative expense patterns of GSIS and SSS, 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

Figure 55



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 (see Figure 55). On average, the cost of insurance for public sector employees has been 14.4 percent of premiums during the period 1980-91; for private sector workers, it averaged 25.4 percent of premiums. Thus it costs SSS members 11 percentage points more to underwrite their own medical care. Not surprisingly, the loading rate--the cost of insurance as a percent of premium collection--is also lower for GSIS during the same period. The cost of GSIS Medicare insurance averaged 14.4 percent of subscription income; the cost of SSS Medicare insurance averaged 25.4 percent of premium income. Thus, the average cost of medical care for an insured government employee was 11 percent less than that of a private firm worker. If SSS' rigorous claims settlement procedures were the only major cause of the high cost of insurance, there would be little reason to correct the imbalance through relaxation of rules. Unfortunately, a number of other forces give rise to the low benefits expense 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.

X. ACCREDITATION AND MONITORING

A. *The PMCC provider accreditation system*

A major regulatory function of the PMCC is to make sure that effective and affordable medical services are delivered to Medicare members. That function is carried out through accreditation. All hospitals and clinics--the channels through which medical services are distributed to the population--are required to register with the Department of Health 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 accredit government and private hospitals and medical and dental practitioners.

The implementing rules and regulations of PMCC's Providers Service, which has accountability for the accreditation of hospitals, define accreditation as "the authorization or privilege granted by the PMCC to qualified hospitals and medical and dental practitioners to participate in the

delivery of adequate medical care service under the Medicare program. Accreditation has two key objectives: (1) to assure that adequate and high quality medical care is maintained and rendered to Medicare beneficiaries; and (2) to assure that legitimate medical services rendered to beneficiaries are compensated from the Medicare fund. These objectives imply that licensing is not the only responsibility of PMCC; accreditation involves applying sanctions as well to providers caught violating PMCC rules.

Accreditation begins at the office of the Assistant Provincial Health Officer of the province where the provider is located. The APHO receives and verifies applications, undertakes fact-finding, and endorses the applications--along with the findings and recommendations--to the PMCC, through the Assistant Regional Health Director. Copies are furnished the Provincial Health Office. The ARHD reviews the accomplished applications, and affixes his own endorsement to the PMCC.

The Providers Service Group, through its Accreditation Division screens the applications forwarded by the ARHD. The division checks whether the applicants meet the standards set for hospital facilities, equipment and manpower restrictions by the DOH and the PMCC. The nature of the department's functions is recommendatory, since it is left to the Accreditation Executive Committee to approve, deny or suspend the licensing of hospitals and physicians/ dentists. The committee has 30 days to act on the application and release its decision.

The Accreditation Division has a staff of seven, of which three are medical doctors. The Providers Service Department's other unit, the Inspection Division, has eight staff, and can utilize the doctors as the need arises. The field staff of PMCC number about 172 and are utilized mainly for monitoring.

B. *Assessment of the PMCC accreditation system*

The accreditation system of PMCC depends substantially on the capacity of the Assistant Provincial Health Officer as well as the Assistant Regional Health Officer to perform evaluation of hospitals. The basic recommendation for accreditation emanates from them. At first glance, this "decentralized" nature of accreditation seems to be a sound setup, since a local health official would be in the best position to determine how well equipped a provider is to deliver medical care. It also predates the Local Government Code, which mandates a devolution of many of central government functions. Yet the fact remains that the accreditation papers go through these local channels only because of the inherent incapacity of PMCC to exercise a basic function. PMCC's field staff, which should be directly participating in field assessment (verifying and investigating the capacities of providers) are insignificantly involved in the process. Only routine clerical and administrative tasks are assigned to them. (Of late, initiatives have been taken to improve the technical capacities of the field staff. They include skills enhancement workshops undertaken jointly with the Development Academy of the Philippines. A "wet clinic" will follow to better equip them in accreditation, verification, spot inspections and more intensive monitoring.)

Since this system is tied up with the Department of Health, devolution will in fact affect the setup. At present, PMCC needs to deal only with central DOH

authorities to ensure the continued participation of the APHO and the ARHD in the process. As decentralization makes significant strides, PMCC will have to face the prospect of coordinating with hundred of local executives to retain the existing arrangement.

Medicare accreditation is based on DOH licensing standards. In fact, both DOH and PMCC perform separate "credentialization" functions, considerably raising costs to both the government and the providers. Of course, secondary and tertiary hospitals need only show their DOH license to operate to gain PMCC accreditation. In theory, simplifying rules are meant to facilitate, rather than hinder accreditation. In the first place, it makes no sense to have two (three, counting the ECC provider accreditation scheme) separate but identical licensing systems. A "first best solution" is to immediately unite these equivalent functions under a single licensing body. In the meantime, given the reality that these separate systems exist, a "second best" solution is for PMCC (and ECC) not to impose requirements that are quite divergent from what DOH requires of providers.

Yet what is clearly lacking in PMCC accreditation procedures is transparency. Appropriate norms on 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 precisely determined. This leaves too much discretion to those who recommend and approve licensing and runs counter to a basic rule-of-thumb that procedures must be unambiguously clear. Neither is the accreditation scheme explicit on time standards, responsibility centers, and the itemized and detailed identification of hospital activities and tasks. A comprehensive manual of operations on how accreditation is to be done, in a context of a more professionalized process, is clearly necessary. It cannot be supplanted by current rules and regulations as well as memorandum-circulars that serve as guidelines in the process.

C. *The PMCC monitoring system*

The task of monitoring all accredited hospitals and practitioners is implemented by PMCC's Providers Service through the Inspection Division. The Inspection Division makes sure that accredited providers comply with the Medicare Law and its implementing rules and regulations. This is done through ocular and spot inspections of Medicare accredited hospitals.

PMCC's surveillance system has two key objectives: (1) to make sure there are actual hospital staff on duty and to validate their existence before the Accreditation Division; licensure and license renewals depend on field reports filed by the Inspection Division; and (2) 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 strong oversight powers over all accredited hospitals and medical practitioners. It has full access rights over the medical records of Medicare patients, exercised through duly authorized representatives. These agents are likewise authorized to inspect the physical plant and equipment of each hospital. If considered necessary, and with the consent of the patient or the attending physician, or the director of

the hospital, the representative may conduct examinations on Medicare patients during confinement to determine whether laboratory procedures were actually performed and whether appropriate medication and/or treatment was actually administered.

PMCC's monitoring system is supposed to be synchronized with SSS and GSIS' own surveillance mechanisms. A coordinating committee exists to make sure all monitoring activities are harmonized and implemented regularly. In practice, however, PMCC's monitoring scheme differs from those of the two systems in terms of frequency, and manner, of inspections. PMCC monitors the hospitals 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 non-routine activity. The implementors of the system are the administrative assistants and clerks, numbering 172 to date, who are dispersed thinly all over the country. Since there are some 1,400 Medicare-accredited hospitals and clinics, each field staff ought to cover about nine providers. Ten medical doctors stationed in the central office evaluate field reports and make recommendations concerning violations of the implementing rules and guidelines. In special cases, the PMCC doctors themselves do actual field inspections.

The mechanics of the system is that hospitals in each province are grouped into clusters based on location and adjacency, for easy accessibility. Clerks are assigned one cluster each, and are required to visit the hospitals regularly every other day (everyday, in areas considered problematic) for one month. Each clerk files his/her findings to a supervising administrative assistant within ten days after each monitoring period. The administrative assistants submit detailed reports to the Inspection Division and to the Assistant Provincial Health Officer.

Since monitoring is essentially dependent on information, PMCC has devised forms intended to capture as much information as needed. Basically there are four forms which try to catch relevant data.

(1) Patient's interview headcount. This form contains the patient's name, age, address, membership (SSS, GSIS or Non-Medicare), date and time of admission, purpose of confinement (chief complaints), whether medication was given, and whether the patient underwent X-ray or laboratory routines. The medical chart is also included. This form is filled out daily during inspection tours for purposes of headcounting and for future reference.

(2) Logbook entries. This is a logbook journal which requires these details: case number, name of patient, date and time of admission, home address, employer, membership (SSS, GSIS, Non-Medicare), admission diagnosis, time and date of discharge, final diagnosis, and number of days confined. The inspector and the hospital representative sign this form for authenticity. The logbook entries are required of all accredited hospitals. The logbook is updated daily.

(3) Staff complement. This includes the name and designation/position of the staff whether he/she is a physician, nurse, nursing aide, medical technologist, pharmacist and others. The inspector and hospital representative sign for authentication.

(4) Inspector's summary report. Apart from routine information (name

of hospital, category, address and period of inspection), the data which fill this form include (a) patient-service features (date and time of inspection, number of patients (GSIS, SSS, and Non-Medicare) per physical count, number of patients entered into the logbook (total), number of patients discharged, number of patients interviewed, and total confinement days of patients; (b) service delivery (in-patient) particulars: number of patients given laboratory examinations and X-Ray examinations. The signatures of the Assistant Provincial Health Officer and the inspector also appear on this form.

A spot inspection report (SIR) accomplished once or twice a year, supplements the four basic reports. It is a comprehensive form which includes practically all the information in the four basic forms but also data on hospital plant and facilities, services, and record management. The report also chronicles significant findings of the inspection team in areas like environmental sanitation, uncorrected defects or deficiencies earlier noted or recorded by previous inspectors. Further, a clinical monthly report is also required by the Commission's Provider Service. The CMR essentially reflects the daily services rendered to the Medicare recipients.

These forms are the sole bases for comparing whether the number of current claims are reasonably close to the historical average established by previous statistics, that is, to the average number of claims filed in the past years covering the same time period. Thus they are a crucial element of PMCC's monitoring system.

D. *Assessment of the PMCC monitoring system*

A comprehensive, systematic and workable monitoring system serves three key purposes: (1) to guarantee that hospitals and practitioners adhere to the basic requirements of accreditation, (2) to make sure quality services are given to Medicare members and dependents, and (3) to deter fraudulence in claims of Medicare benefits.

PMCC's monitoring performance has been mixed. On the basis of the First Quarter Monitoring Program in 1991, PMCC has monitored 88.82 percent of the targeted number of primary clinics, 79.17 percent of secondary hospitals, and only 25 percent of the targeted tertiary hospitals. These performance figures have come through only a small sample of providers: 227 primary hospitals, 72 secondary hospitals and 4 tertiary hospitals. Of these, 118 primary hospitals, 57 secondary hospitals and 1 tertiary hospital were actually observed during the period.

This monitoring pattern indicates that PMCC can put under surveillance only 15 percent of the total number of providers all over the country, estimated at 1543. This means that 85 percent of Medicare-accredited hospitals are not being overseen. The quarterly pattern of reporting aggravates the situation since monitoring (which requires immediate response to pressing problems) should be done every other day. Sampling is not necessarily an inadequate monitoring procedure, especially since PMCC has only a limited capacity in the field, but there is no indication that PMCC is following a proven statistical sampling technique. What it does in practice is to attempt to cover the geographic spread of providers bit by bit.

The power to monitor *all* accredited hospitals all over the country has not been fully implemented because of budgetary constraints, and lack of orchestration of efforts within the Medicare system. The Providers Service Department is grossly understaffed, to begin with. Only 10 medical doctors and 172 field personnel (administrative assistants and clerks) are doing the monitoring function. On average, each field worker has to observe 9 providers; in turn, each doctor has to be accountable to at least 150 providers. PMCC hardly coordinates with GSIS and SSS, both of which also have surveillance powers over the hospitals. A coordinated attack on this problem would have resolved some of the capacity constraints being experienced by PMCC, and perhaps would have achieved economies of scale in monitoring.

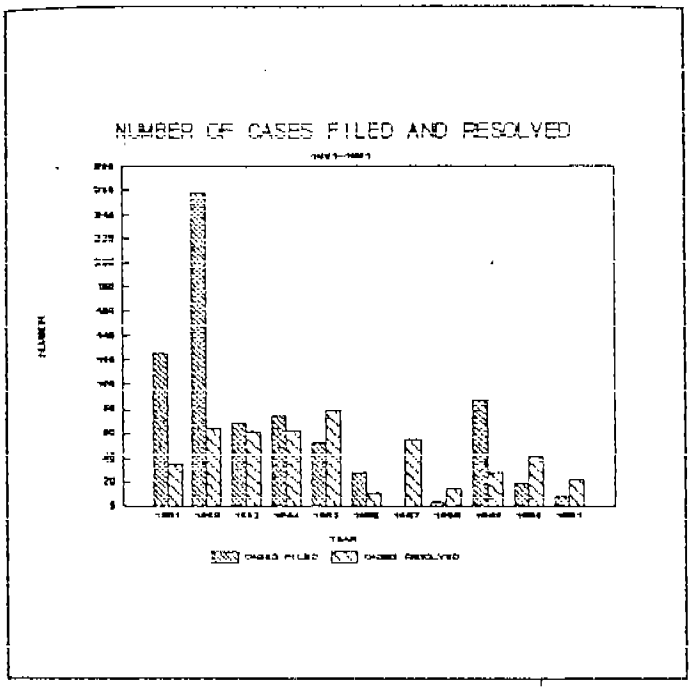
A serious consequence of this inability to monitor to the fullest the health providers has been the overutilization of the Health Insurance Fund. For instance, on the GSIS side, total Medicare collection in 1991 was P480,474,426.58. However, benefits disbursed in the same year was P683,085,969.65, indicating a deficit of P202,611543.10. Although financial analyses suggest that the shortfall could be attributed to unsatisfactory financial management, it could also have been caused by poor monitoring. Perhaps if PMCC (together with GSIS) had monitored more hospitals, a substantial amount of savings would have been realized. The quarterly report estimates that anywhere from P2,937,600 to P20,563,200 could have been saved in the first quarter of 1991 with good monitoring performance. That would not wipe out the deficit, but at least it could narrow it down.

Of particular concern is the monitoring forms. The forms are to a great extent the tools needed to capture the information on occupancy rates, patient admission, confinement days and the percentage of Medicare patients served against the total sick population of hospitals. The major problem is that monitoring data collection is weak, unreliable and in some cases, non-existent. The monitoring forms that reach the Providers Service Department are often incompletely filled out: some statistics in the forms do not tally, or are inconsistent. The forms have no practical value for forecasting, or trend extrapolation. Again, the quarterly report mentions that out of the 246 hospitals monitored, only 150 provided data; 96 hospitals were without data. Poor compliance in the submission of forms is compounded by an inadequate supply of qualified statisticians, actuaries and other technical personnel. Attempts to provide a solid evaluation of providers' performance have been frustrating at all levels.

Efforts to reform the system have met with little success. A series of PMCC circulars, the latest of which were Medicare Circular No. 273, S-1990 and Medicare Circular No. 276 S-1991, attempted to deal decisively with the subject of proper accomplishment of PMCC forms and made mandatory the filling of all applicable blanks in all forms, specifically Forms 1 and 2. But such steps have been largely ignored by providers, since compliance rates remain quite low. Part of the problem lies with the nature of the forms themselves. The forms are often lengthy and redundant, and try to provide answers to too many objectives without consideration of how things could be simplified. Filling in the forms in many ways leads to cumbersome procedures and wastage in the use of scarce field personnel. The urgent need is for PMCC to reexamine these forms and "streamline" them, eliminating parts that may not be too necessary for monitoring purposes.

PMCC officials who were interviewed feel that mounting an all-out offensive against erring providers would considerably increase the number of fraud cases. Probing what was already committed is often a daunting task, however, especially when PMCC has to run after hundreds of small providers in many provinces and cities. In many instances, the costs of investigation far exceed the gains; savings from false claims held off due to fraudulence are typically small compared to expenditures of investigating teams on travel, pre-trial hearings, and prosecution.

Figure 56



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. Using the assumptions of PMCC in computing the amount of savings realized if vigorous monitoring were undertaken, the resources saved would run into millions. At the conservative rate of P480 per claim, total savings in 1991 would amount to P120 million. If the GSIS benefit expense rate of P878 per claim were used, savings would run to over P221 million, more than enough to dispose of the total deficit of GSIS amounting to P202.6 million. The huge amount of monetary losses is important, but much more crucial is the extent of opportunity costs: the widely-held perception that Medicare is corrupt results in employers and employees avoiding Medicare. The lack of trust has costs as well.

Despite the existence of fraudulence, a word of caution may be necessary. Medicare has emphasized coverage for short hospital stays; patients may prefer to be hospitalized even when outpatient care would have cheaper social costs. 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 produced and worth the resources devoted to them. If Medicare insurance has conceivably lessened the cost of medical care to working families, this provides an incentive both to purchase more medical care than it would have without Medicare. It is to the family's advantage to behave in this way since the premium is scarcely affected by the choices the family makes.

E. *Determinants of length of confinement*

The period of confinement for Medicare recipients is a crucial factor in PMCC's monitoring efforts. There is a widely-held perception that Medicare beneficiaries connive with the provider to extend the period of confinement

to cover expenses beyond Medicare benefits. From a moral hazard point of view, lengthy hospitalizations may be associated with nonessential usages, like confinement for simple curative diseases that are better treated with domiciliary care. In this section, regression analysis is 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.

Several ingredients within the provider setting affect patient behavior with respect to duration of confinement. The number of beds allotted to Medicare patients is important in allocating scarce resources. Because hospital beds are the most expensive of medical services, they ought to be filled with the most appropriate people, namely those who need surgery or tests. The higher the bed capacity, the more beds become available for patients requiring more complicated treatment. GSIS Medicare statistics, however, indicate that medical cases disproportionately outnumber surgical cases, suggesting that less of hospital beds are being used for the more serious compensable illnesses, that is, catastrophic and intensive care cases requiring surgical procedure and extensive examinations. In turn, this suggests that the higher the bed capacity, the shorter the average length of stay ought to be. A corroborating indicator is the ratio of surgical cases to medical cases. The higher this ratio--indicating a bigger volume of catastrophic and intensive care cases--the higher the period of confinement.

All hospitals provide in-patient care, as do small private clinics. Primary clinics, however, have fewer facilities, and could handle ordinary cases needing routine laboratory examinations but not the more serious ones. Tertiary providers, mostly big hospitals in urban areas, have adequate capacity for handling intensive care and catastrophic cases because of sophisticated facilities. Secondary providers can perform general surgery. If length of stay is reflected in the differential use of these resources, then the lower the capability of the hospital, the shorter the confinement period should be. Also, most of the government hospitals are DOH district hospitals of the secondary type, while private providers are either the small number of big urban hospitals or the large volume of small private clinics. It is unclear how this situation would influence the length-of-stay variable. Rural hospitals, however, are clearly more associated with lower capability and fewer facilities, and thus should be able to provide only simple curative care. This implies that the presence of rural providers is negatively associated with long confinement periods.

Average medical charges are price variables reflecting the costs of compensable Medicare treatment. It is assumed that patients react negatively to price. This should be somewhat mitigated by the knowledge of Medicare insurance. However, Medicare coverage itself has a broader impact other than just a simple price effect: it cuts down on hospital costs but it also lowers the amount of household resources available for emergencies. This is especially true today when Medicare average support value has been ravaged by inflation. Generally, then, the higher the average charge, the lower the length of hospitalization should be.

Two other interesting variables that ought to be considered are the ratio of female beneficiaries to total beneficiaries, and the ratio of dependents to Medicare members, which measures the "dependency burden" of

Medicare members. The *a priori* relationship of these variables to confinement cannot be clearly defined, but the former should reveal some gender implications of hospitalization, while the latter might be important in considering whether Medicare households try to maximize the use of Medicare resources for family members.

(1) Data and variable selection

The data have been assembled from computer files of GSIS on Medicare claims. Information on length of stay, provider types, average Medicare expenses, and number of claims (disaggregated by sex and recipient category) was aggregated at provider level. A suitable period, from July-December 1991, was selected for estimation purposes. The GSIS records were merged with PMCC data at the provider level, in order to introduce the bed capacity variable. The sample yielded 1360 observations. Table 29 lists the descriptive statistics of the variables selected.

(2) Estimates and discussion

Using ordinary least squares procedures, the outcome is shown in Table 30. Complete regression results are in Appendix B.

TABLE 29: DESCRIPTIVE STATISTICS

Variables	Definition	Mean	Std Dev
Dependent variable			
CONFIN	Average length of confinement (days)	3.74	1.88
Independent variables			
BEDCAP	Number of hospital beds allocated to Medicare	50.27	105.91
SURRATIO	Ratio of surgical cases to medical cases	.1024	.2577
PRIPUB	Dummy = 1 if public hospital	.3213	.4672
TYPE_PST	Dummy = 1 if primary provider	.4140	.4927
TYPE_SPT	Dummy = 1 if secondary provider	.4125	.4924
RURBAN	Dummy = 1 if urban	.3213	.4672
AVECHARG	Average Medicare charges (pesos)	1073.10	745.27
DEPRATIO	Ratio of dependent recipients to member recipients	2.53	3.89
FEMRATIO	Proportion of female recipients	.7367	.1305

Bed capacity is directly associated with length of stay, which runs counter to the a priori assumption. The impact of more hospital beds is to encourage longer confinement periods, in a context where majority of the patients are not surgical/intensive care cases. The inverse relationship between the ratio of surgical cases to medical cases and confinement time

TABLE 30: OLS RESULTS FOR LENGTH OF CONFINEMENT

Independent variables	Coefficient	t-ratio
BEDCAP	0.0046	9.895*
SURRATIO	-1.1190	-5.970*
PRIPUB	1.1484	11.831*
TYPE_PST	0.6802	0.162
TYPE_SPT	0.3101	0.141
RURBAN	0.0051	0.053
AVECHARG	0.0013	14.888*
DEPRATIO	0.0174	-1.635**
FEMRATIO	-1.4831	-4.681*

*Significant at the five percent level
**Significant at the ten percent level

also goes against the predicted behavior; on the basis of the OLS estimation, the more surgical cases there are, the lower the confinement period. The results for these two determinants, both of which are highly significant at the five percent level, reinforce the observation that hospital time and space are being dominated by cases requiring only simple curative services, leaving less space for more serious cases.

The private-public hospital dummy is also highly significant, implying that differences in institutional settings do have an effect on length of hospitalization, with confinement time being much longer in government hospitals. This is corroborated in Griffin, et. al. (1985) which also finds that surgical cases are disproportionately found in public hospitals. Hospital type and location, however, have insignificant dummy-variable coefficients. Thus, neither the sophistication of hospital facilities, nor the urban or rural setting, has an impact on confinement time.

Hospital costs, however, do have a highly significant effect on confinement period, but again the result reverses the prediction of an inverse relationship. Indeed, high medical charges lead sharply to longer hospital stays. This result is puzzling, unless Medicare is able to cover most of the hospital expenses. But since support value is low, a strong disincentive exists against lengthening hospitalization time. It is of course possible that higher average charges are associated with more serious illnesses, in which case the length of confinement is not an endogenous decision of the patient. More scrutiny is needed, and factors other than price effects need to be taken into account. A plausible scenario is that providers may be influencing the behavior of patients in order to cover expenses not compensable under Medicare.

The ratio of dependents to members who benefit from Medicare is inversely associated with length of stay. As the number of dependents rise, the duration of confinement is shorter, although not by any substantial degree. It could be that Medicare-insured households do attempt to promote equity in the use of Medicare resources by prorating compensable confinement time among dependents. It must be remembered that although Medicare members

are fully entitled to exhaust the 45-day yearly room and board allowance. Medicare dependents have to share among themselves the other set of 45 days within the year. That means less hospital time is available for each dependent.

Finally, the proportion of women recipients has a negative impact on length of stay. As more women avail of Medicare benefits, their hospitalization time is lessened. GSIS data reveal that in every institutional setting, there is a higher proportion of women beneficiaries. Majority of them are probably dependents, in which case, the confinement time-sharing arrangement among households also applies. Even then, further investigation is needed to ascertain whether the inverse relationship is the outcome of (1) differential health characteristics among males and females, and (2) gender discrimination in the allocation of hospital beds.

Overall, there is evidence that Medicare facilities are inappropriately used. The regression results show that the demand for hospital time and space (confinement) is significantly affected by bed capacity, volume of serious cases, type of setting, and hospital costs, but not in the anticipated way. The larger the hospital capacity, the more tendency there is to lengthen the use of hospital time and space, often not by those requiring surgery and intensive care. This is apparently a moral hazard dilemma. However, high Medicare charges are no disincentive to longer hospital stay, and surprisingly this happens in an environment in which the cost in money associated with using inpatient services can be quite high for a household--considering the high cost of Medicare insurance (low support value).

There is clearly inefficient use of Medicare resources; inefficiency might conceivably be higher in government hospitals, if length of stay is a good efficiency indicator (bureaucratization in public hospitals lead to slower patient discharge procedures). An important question is whether such inefficiency is traded off with equity in the use of hospital time. In the case of serious illnesses, Griffin, et.al. (1985) hypothesizes that surgical cases requiring long hospitalization periods are treated in public hospitals if there is a great likelihood of high expenditures being incurred by the patient. Public hospitals generally charge less because of the existence of public subsidies. The role of public hospitals in this instance is that of an equalizer. Finally, inefficient hospital use could be as well caused by a possible collusion between providers and patients in order to transfer even non-compensable costs to the Medicare program. This seems to be indirectly supported by the regression results, and investigation should be pursued more vigorously both in research and operational terms.

XI. ADMINISTRATIVE COSTS

The costs of implementing Program I are borne by SSS, GSIS and PMCC. The two social security agencies have derived their resources for administrative expenditures from the HIF. Sec. 17 of R. A. 6111 states that "the SSS and GSIS may disburse each for operational expenses not more than 12 percent of the total contributions and investment earnings collected during the year." PMCC, on the other hand, depends fully on the central government for its financial resources. Sec. 29 of the same act provides that "Funds as may be necessary to finance the operation, program and projects of the Commission in carrying out this decree are hereby authorized to be included in the Annual Appropriations Law."

Operational expenses have varied from year to year, depending on need, availability of funds, and the attitude of government (in the case of PMCC) toward granting a bigger budget. In practice, PMCC has a more limited financial base because of its reliance on government appropriations, which is often subject to political pressures. SSS and GSIS, as long as they manage the HIF well, can bank on a bigger resource base for administrative expenditures. (This scheme, where the coordinating agency is supported by the national budget and the two fund managers are supported by HIF, is somewhat different from the system followed in employees' compensation. The ECC gets its operating funds from the State Insurance Fund (SIF) rather than from government appropriations. As in the HIF, however, the SSS and GSIS charge their operating expenses for employees' compensation to the SIF.)

In analyzing the administrative costs in implementing Program I, only the operating costs shouldered by SSS and GSIS have an impact on the HIF, since PMCC has an annual appropriation from the national budget.

A. *PMCC: declining expenditures equal declining appropriations*

An examination of the obligations and expenditures, or budget, of the PMCC for a six-year period (1987-1992) shows that its appropriations have continued to decline since 1988, at one time dropping by as much as 60 percent. In 1987, PMCC's appropriation was P72.781 million; by 1992, it was down to half, P37.325 million. PMCC's lowest allotment was in 1988 when it was only P28.3 million. Among the reasons cited for the decline were the transfer of the budget for Medicare community hospitals to DOH in 1988, the Salary Standardization Law, and the attrition process in the civil service which accelerated during the Aquino administration. By 1990, casuals, which made up the bulk of PMCC's extension service, were dropped from the rolls, and this appeared to hobble its capacity for field monitoring and supervision.

TABLE 31
ANNUAL BUDGET, PMCC, 1987 - 1992
(In thousands of pesos)

YEAR	APPRO-PRIATED	ACTUAL	VARIANCE	(%)
1987	2,781.00	49,596.00	23,185.00	0.32
1988	28,300.00	10,728.00	17,572.00	0.62
1989	30,724.00	12,861.00	17,863.00	0.58
1990	33,422.00	17,347.00	16,075.00	0.48
1991	32,711.00	20,489.00	12,222.00	0.37
1992	37,325.00	n.a.	n.a.	

Source: PMCC

A major reason, however, for the budgetary "attrition" is that PMCC has been consistently spending below its budget. As Tables 31 and 32 suggest, the variance between appropriated and actual expenditures has averaged 47.4 percent. PMCC experienced a variance of 32 percent in 1987 and a high 62

percent in 1988. 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 might have been the result of poor planning and weak administrative structure--an inability to handle a large volume of funds and 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 should be mitigated somewhat by the fact that the central government often imposed mandatory cutbacks in agency expenditures to reduce the government's fiscal deficit. At any rate, such a record would make it difficult for PMCC to justify any increases in its annual appropriations.

Three key items in the PMCC budget deserve closer examination. These are personal services, maintenance and other operating expenses (MOOE) and capital outlay. In both appropriated budget and actual expenditures, personal services almost always took the lion's share. The only exception was in 1988 when MOOE took 52 percent vs. 47 percent for personal services in the appropriated budget. Still, in terms of actual expenditures for that year, personal services picked up 65 percent while MOOE took only 33 percent--a

TABLE 32
SUMMARY OF OBLIGATIONS AND EXPENSES, PMCC, 1987-1990
(In thousands of pesos)

Appropriated

YEAR	PERSONAL SERVICES	(%)	MAINT & OPERATING EXPENSES	(%)	CAPITAL OUTLAY	(%)	TOTAL
1987	45,925	0.63	26,160	0.36	696	0.01	72,781
1988	13,232	0.47	14,832	0.52	236	0.01	28,300
1989	16,601	0.54	13,985	0.46	138	0.00	30,724
1990	17,619	0.53	15,688	0.47	115	0.00	33,422
1991	19,281	0.59	13,450	0.41	0	0.00	32,731
1992	22,387	0.60	13,599	0.36	1,339	0.04	37,325

Actual

YEAR	PERSONAL SERVICES	(%)	MAINT & OPERATING EXPENSES	(%)	CAPITAL OUTLAY	(%)	TOTAL
1987	34,794	0.70	14,271	0.29	531	0.01	49,596
1988	7,026	0.65	3,531	0.33	171	0.02	10,728
1989	8,392	0.65	4,354	0.34	115	0.01	12,861
1990	10,953	0.63	6,297	0.36	97	0.01	17,347
1991	15,377	0.75	5,112	0.25	0	0.00	20,489

Source: PMCC

flagrant indication that actual expenditures have usually not matched planned priorities.

What occurred rather than what was targetted is a better indicator of how well PMCC has allocated its financial resources. Looking at PMCC's composition of expenditures in the last six years, personal services averaged 67.6 percent of actual expenditures; MOOE, 31.4 percent; and capital outlay, a very low 1 percent. Salaries and wages are the key ingredients of personal services, which also consist of fringe benefits like amelioration benefits, cost-of-living allowance, housing (Pag-ibig), Medicare and salary adjustment. For MOOE, there are two main expense items. These are travelling expenses and rent. Travel costs are incurred mainly in the process of monitoring, and investigating erring providers, especially those in far-flung areas. Rent, which is the highest expenditure component under MOOE, goes to the maintenance of PMCC's offices at the Philippine Heart Center. To date, PMCC owns no offices/building to house its staff.

Although salaries and wages ordinarily get the biggest chunk of budgetary resources, PMCC's slice for personal services is quite hefty. This pattern has characterized 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 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 PMCC's policy and planning, since it is clogged with manpower whose impact on PMCC output has been relatively small. The decline in budgetary resources also has unduly disruptive effects on 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/or 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.

The kinds of adjustment that need to be made by PMCC management will depend on how strongly it could manifest its political will. Painful adjustments have be made, for example, by pruning down its administrative staff, adopting a "lean but mean" posture by reconcentrating its PS resources on upgrading the technical skills of its operations staff or hiring experts, investing more of its resources on research and development, and focusing its attention on appropriate and inexpensive technical innovations that are apt to have more important consequences for medical care. There is considerable room for improvement even in PMCC's shrinking field staff. PMCC can give close attention to the needs of its field personnel by making the provider-monitoring format simpler and easier to implement, and by making sure field operations escape the normal bureaucratic hazards.

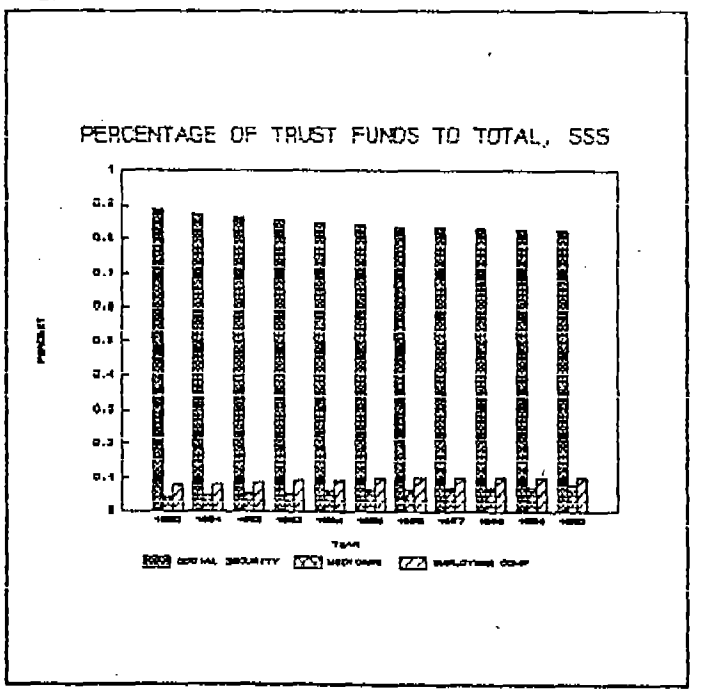
B. *SSS: rising operating expenses*

The HIF is one of three funds administered by the SSS. The other two are social security and employees' compensation. Social security adds up to 82 percent of the total SSS fund; employees' compensation makes for 11 percent while Medicare contributes about 7 percent. In terms of contributions/earnings for the year 1990, Medicare has a 10 percent share.

compared to 8 percent for employees' compensation. As a component of the corporate fund, the HIF is subject to the administrative policies of the SSS.

Since 1987, SSS has adopted an accounting policy which tacks administrative costs to the level of benefit expense. The benefit payment ratio in the distribution of expenses is calculated and charged against the SSS corporate fund, the HIF and the SIF. This means that a particular fund's share of expenses is proportional to its benefit payments for any particular year. In 1990, the formula yielded the following allocation pattern: social security fund, 85 percent; HIF, 12 percent; and SIF, 3 percent. In 1987, Medicare's share was 13.81 percent and in 1988, 12.98 percent (see Figure 57). Thus, Medicare-related costs, on average, sum up to around 12-13 percent of the institution's total expenditures.

Figure 57



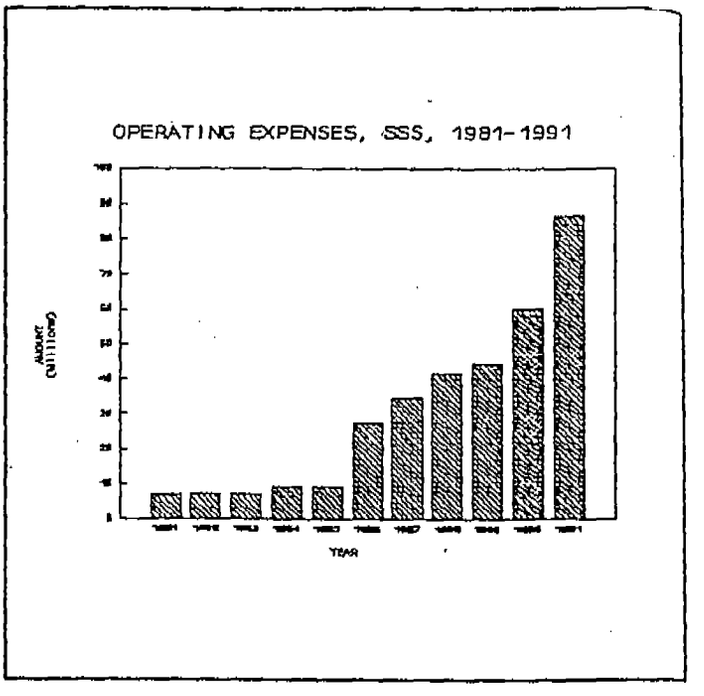
For 1981-1991, the operating expenses of the Medicare program under SSS were on the upswing. In 1981 administrative expenses were estimated at P7 million, and by 1991 has reached P86.635 million, a 12-fold increase over a 10-year period. Since 1986, SSS operating expenses for Medicare have been increasing at an average rate of 26.73 percent (Figure 58). The rate was much faster in 1985-86, during the transition from the Marcos regime to the Aquino government, when operating expenses shot up three-fold to P27.3 million, from a level of P9.1 million. During the same period, the HIF increased by only 25 percent.

Early on, it was suggested that the increase in SSS' administrative costs for Medicare might have been the result of pouring more resources to the detection and reduction of fraud and abuses, which was justifiably necessary as long as the benefits of deterrence outweighed the costs of enforcement.

Available evidence does not support this hypothesis. The increase is more attributable to fringe benefits given by the SSS management to its employees, in light of the "SSS administration's commitment to make the total compensation package received by its employees comparable and competitive with those received by employees of other government financial institutions (GFIs)." The compensation package included a series of new salary adjustments and new fringe benefits to its employees.

For the period 1988-1991, personal services got the biggest chunk of Medicare expenditures, at an average of 67.5 percent. Although the salary standardization law has somewhat evened out wages and salaries for each pay level across government agencies, SSS employees get more in terms of

Figure 58



additional benefits than their counterparts in other agencies, and for that matter, in a sister agency, the GSIS. Excluding benefits that traditionally come with public sector employment (e.g., cost of living allowance, clothing allowance, overtime pay, employment compensation, terminal leave pay) as well as deductibles (e.g.,retirement insurance premium, Medicare premium), SSS pays for over 15 other fringe benefits, including bonuses, provident fund contributions, rice grant, meal expenses, medical benefits, amelioration allowance, longevity pay, gratuity benefits, life insurance premium, Christmas gift, dependents' allowance and medical care, training and personnel improvement, stabilization allowance, anniversary expenses, incentive allowance, and funeral expense assistance benefits. Other benefits, such as housing allowance, car allowance, athletics and cultural expense, and hazard pay, are tucked in "other expenses."

This is not to suggest that these benefits are excessive and ought to be discontinued, since these are productivity rewards reaped from SSS' almost spectacular financial performance. SSS has been, moreover, religiously observing the 12 percent cap on administrative expenses: there have been no administrative cost overruns since the inception of Medicare in 1972. In fact, claims processing costs in SSS have gone down. The cost per claim for 1990 amounted to P92.62 for a total of 650,359 beneficiaries/ claimants and total operating expenses of P60.2 million. In 1989, the cost of processing each claim slid to P61.84. Even with a higher number of claimants--around 717,864--however, operating expenses dropped to P44.4 million.

The real issue, however, is whether on the basis of per peso of benefits, it is becoming costlier to be insured in Medicare under SSS as a result of accelerating administrative costs. In an earlier chapter, it was observed that although benefit payments per recipient have grown slowly, administrative costs have remained high. The cost of insurance as a proportion of premiums has increased for each enrollee. That means that the expected payout has decreased over the years, leaving Medicare members worse off than before. SSS could make the necessary adjustments by revising the Medicare benefit structure, or simply increasing medical care benefits, so that the balance between benefits and operating costs is restored.

The obverse, 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 (see Table 33). Expense items for deterring fraud and abuses, such as travelling expenses, trial allowance, and communication expenses compete with special projects, maintenance and repairs, equipment rental, and supplies and materials for "other expenditures"

TABLE 33
BREAKDOWN OF OPERATING EXPENSES, SSS-MEDICARE
(In pesos)

YEAR	PERSONNEL SERVICES	(%)	OTHER EXPENDITURES	(%)
1988	27,832,889	0.67	13,693,292	0.33
1989	31,784,543	0.72	12,628,995	0.28
1990	40,363,609	0.67	19,858,196	0.33
1991	55,518,202	0.64	31,117,046	0.36

Source: SSS

that in the same period 1988-1991 averaged 32.5 percent of total operating expenses.

Other cost items have ambiguous results. For instance, in 1987, SSS discontinued its practice of releasing checks to member-claimants in person. This meant a considerable increase in postage expenses, but this is attenuated somewhat by a reduction in the transportation and transaction costs of each beneficiary. It is unclear whether the tradeoff results in more benefits (or less costs) for Medicare recipients.

Overall, even with the marked increase in operating expenses, SSS has remained way below the allowable 12 percent ceiling (Figure 59). From 1980 to 1990, the ratio of operating expenses to total income averaged a mere 2.9, with a high of 4 percent and a low of 1 percent. That is quite low by any insurance industry standard.

C. *GSIS: declining costs*

The Government Service Insurance System administers six funds of which Medicare insurance is one. The other five are social insurance, optional life insurance, employees' compensation, general insurance and property replacement. Figure 60 and Table 34 show the breakdown of these funds. Note that the HIF, or Medicare fund, represents only about 2 percent of the total actual reserves of GSIS. The comparative table of incomes of these funds shows that Medicare contributed 5.5 percent to the total earnings of GSIS in 1990; employees' compensation, 4.1 percent; and social insurance, 79.3 percent. As a proportion of the total operating expenses of GSIS, Medicare contributed 11.1 percent compared to the 72.6 percent for social insurance.

GSIS uses direct costs charging as the basis of its accounting process. GSIS classifies its operating expenses for Medicare into non-controllable and controllable items. Non-controllable items include salaries, allowances, fringe benefits and extra remuneration, statutory expenses, and bonds/awards. Controllable costs are incurred for overtime work, computer use, public relations, travel, supplies and materials, furniture and equipment, and miscellaneous expenses.

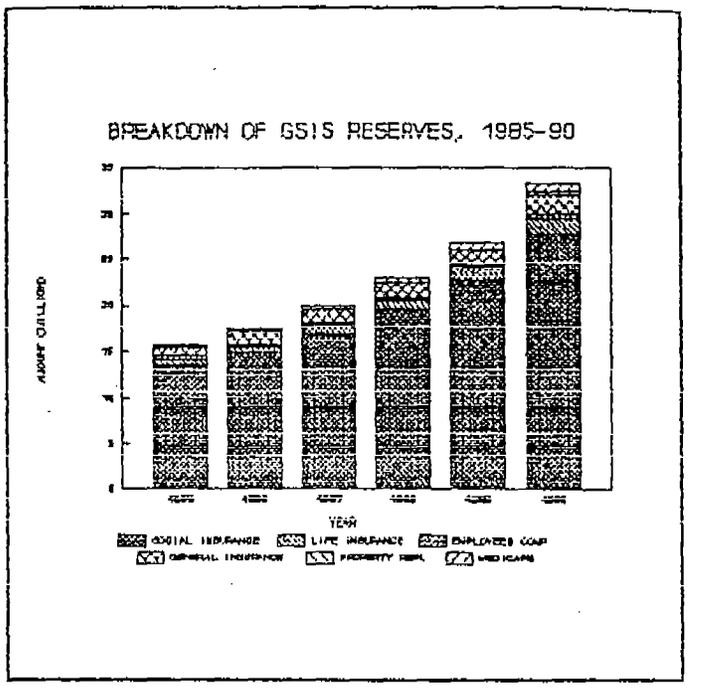
TABLE 34
BREAKDOWN OF ACTUAL RESERVES, INCOMES AND OPERATING EXPENSES OF GSIS FUNDS

	YEAR	SOCIAL INSURANCE	(%)	OPTIONAL LIFE INSURANCE	(%)	MEDICARE INSURANCE	(%)	EMPLOYEES' COMPENSATION INSURANCE	(%)	GENERAL INSURANCE	(%)	PROPERTY REPLACEMENT	(%)	TOTAL
ACTUAL RESERVES														
	1985	13.55	0.86	0.62	0.04	0.32	0.02	0.45	0.03	0.82	0.05	0.00	0.00	15.75
	1986	14.81	0.84	0.72	0.04	0.37	0.02	0.41	0.02	1.25	0.07	0.00	0.00	17.55
	1987	16.87	0.84	0.86	0.04	0.42	0.02	0.42	0.02	1.41	0.07	0.00	0.00	19.97
	1988	19.47	0.85	1.06	0.05	0.49	0.02	0.37	0.02	1.56	0.07	0.00	0.00	22.95
	1989	22.81	0.85	1.28	0.05	0.62	0.02	0.37	0.01	1.65	0.06	0.00	0.00	26.75
	1990	27.85	0.84	1.60	0.05	0.79	0.02	0.48	0.01	2.08	0.06	0.53	0.02	33.32
INCOMES														
	1989	5546.40	0.79	337.58	0.05	415.15	0.06	246.50	0.04	444.16	0.06	0.92	0.00	6990.71
	1990	8563.34	0.79	451.99	0.04	593.34	0.05	441.71	0.04	641.48	0.06	110.41	0.01	10802.27
OPERATING EXPENSES														
	1989	486.56	0.83	30.52	0.05	7.32	0.01	8.71	0.01	55.95	0.10	5.11	0.01	585.46
	1990	559.55	0.73	37.61	0.05	8.47	0.01	11.59	0.02	69.43	0.09	84.01	0.11	770.66

Source: GSIS

For 1980-1991, non-controllable expenses, chiefly salaries and wages, ate up almost the entire allocation for GSIS Medicare. The proportion of non-controllable expenditures rose by as much as 95 percent (see Table 35). The short respite was in 1987 when the proportion went down to 70 percent--still a high share compared to the SSS figures. During that year, GSIS made capital investments in computer equipment. Generally, however, the share of controllable expenses is only between 5 percent and 9 percent of total operating expenses.

Figure 59



Despite this seeming lack of balance between controllable and non-controllable expenditures, Medicare operating costs under GSIS are declining; by contrast, SSS-Medicare operating costs are in an upward trend. In 1980, GSIS operating expenses were placed at P15.116 million; by 1991, however, the amount was down to P11.182 million. From 1982 to 1990, operating expenses fluctuated between P4.95 million to P13.39 million.

When it was first implemented in 1972, Medicare operations cost GSIS only P720.000 (see Table 36). But the all-time high of P19.34 million came in 1981 when the cost of processing each claim was relatively high at P38.24 (the cost per claim was highest in 1973 at P39.31, however). This was also the time when administrative expenses as a percent of revenues was a high 10.36 (the double-digit percentage occurred only once before, again in 1973 when it reached 10.36 percent)--which was less than two points shy of the maximum allowable percentage. The cost per claim was lowest in 1982 at P9.72. In 1991, operating expenses as a percent of Medicare revenues was 1.48 percent. Processing cost per claim was P16.98.

Figure 60

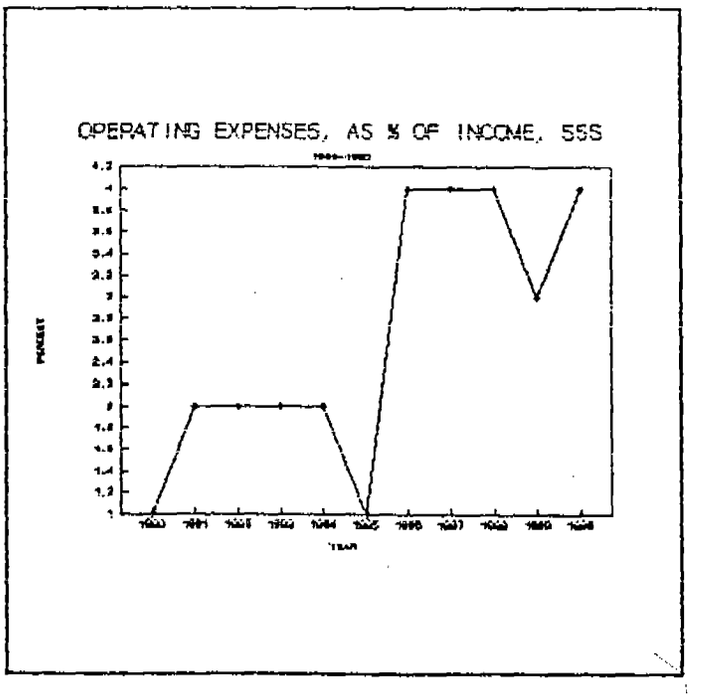


TABLE 35
BREAKDOWN OF OPERATING EXPENSES, GSIS-MEDICARE, 1980-1991
(In pesos)

YEAR	NON-CONTROLLABLE	(%)	CONTROLLABLE	(%)	TOTAL
1980	12,008,171	0.79	3,107,761	0.21	15,115,932
1981	*		*		19,340,034
1982	*		*		4,947,857
1983	*		*		7,295,639
1984	*		*		10,610,406
1985	*		*		13,390,117
1986	*		*		7,340,084
1987	5,353,935	0.70	2,306,760	0.30	7,660,695
1988	6,213,415	0.95	295,254	0.05	6,508,669
1989	6,632,492	0.91	684,627	0.09	7,317,119
1990	8,035,343	0.95	430,017	0.05	8,465,360
1991	10,462,417	0.94	719,387	0.06	11,181,805

NON-CONTROLLABLE ITEMS	CONTROLLABLE ITEMS
Salaries	Overtime expenses
Allowances	Computer expenses
Fringe benefits	P.R. expenses
Extra remuneration	Travelling expenses
Statutory expenses	Supplies and materials
Bonds/awards	Furniture and equipment
	Miscellaneous expenses

Source: GSIS
*Data not available

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

D. *Overall assessment*

Combining the costs incurred by SSS and GSIS in administering the Medicare program, total operating costs have risen to P97.62 million in 1991, compared to P26.34 million in 1981, reflecting an increase of 370 percent. Between the two institutions, SSS rather than the GSIS has dictated the pattern of increases, as the summary of administrative costs (Table 37) shows. Needless to say, SSS has the larger amount since it has a bigger membership base from which it collects revenues. All other things equal, however, SSS' level of salaries, allowances and other benefits are bigger compared to that of GSIS.

There are reasons to believe that actual operating costs may be either

TABLE 36
OPERATIONS STATISTICS, GSIS–MEDICARE, 1972–91
INCOME AND EXPENSES (In Millions of Pesos)

YEAR	PREMIUM INCOME	INVESTMENT INCOME	MISC. INCOME	TOTAL REVENUES	ADMINIS. EXPENSES	COST OF PROCESSING PER CLAIM (Unit Cost)	% OF ADM. EXP. TO TOTAL REV. (Max. = 12%)
1972	43.96	0.44	0.00	44.40	0.72	32.60	1.63%
1973	39.74	1.59	0.00	41.33	4.30	39.31	10.41%
1974	57.90	2.30	0.00	60.20	5.14	17.69	8.54%
1975	63.30	5.20	0.00	68.50	6.43	18.73	9.39%
1976	71.72	4.38	0.02	76.12	5.62	14.15	7.39%
1977	70.39	2.29	0.43	73.11	4.79	10.78	6.56%
1978	83.76	1.70	0.05	85.51	6.03	13.49	7.05%
1979	138.21	1.63	1.65	141.49	8.89	18.25	6.29%
1980	156.17	4.02	1.47	161.66	15.12	29.29	9.35%
1981	180.95	5.70	0.04	186.69	19.34	38.24	10.36%
1982	190.05	21.16	0.00	211.21	4.95	9.72	2.35%
1983	209.61	25.97	0.00	235.58	7.30	12.86	3.10%
1984	191.15	30.87	0.00	222.02	10.61	17.34	4.78%
1985	181.55	19.50	0.00	201.05	13.39	22.86	6.66%
1986	190.66	22.11	0.00	212.77	7.34	13.04	3.45%
1987	278.15	4.25	0.00	282.40	7.66	12.60	2.72%
1988	245.48	57.24	1.82	304.53	6.51	10.24	2.15%
1989	325.51	89.52	0.12	415.15	7.37	22.21	1.76%
1990	446.21	148.48	0.00	594.69	8.46	13.54	1.42%
1991	615.69	133.41	1.30	750.40	11.18	16.98	1.48%

Source: GSIS

TABLE 37
SUMMARY OF ADMINISTRATIVE COSTS, MEDICARE I
(In million pesos)

Year	SSS	GSIS	Sub-Total	PMCC	Total
1981	7.00	19.34	26.34	*	-
1982	7.10	4.95	2.05	*	-
1983	7.30	7.30	14.60	*	-
1984	9.00	10.61	19.61	*	-
1985	9.10	13.39	22.49	*	-
1986	27.30	7.34	34.64	*	-
1987	34.74	7.66	42.40	49.60	92.00
1988	41.53	6.51	48.03	10.73	58.76
1989	44.41	7.32	51.73	12.86	64.59
1990	60.22	8.46	68.69	17.35	86.03
1991	86.64	11.18	97.82	20.49	118.31

Sources: PMCC, GSIS, SSS
Data not available

larger or smaller than what is reflected in the financial statements of the two institutions. The source of the discrepancy is the accounting system. SSS and GSIS adhere to different accounting procedures. To achieve uniformity, only one government accounting system--prescribed by the national appropriations law--must be in place. But both SSS and GSIS are allowed certain deviations because they have corporate status. The SSS accounting system is "centrally organized" while that of GSIS is "responsibility accounting" (SGV, 1990). Under the SSS system, all accounting responsibilities are handled by its accounting department. In the GSIS method, each department participating in the Medicare process prepares its own accounting report.

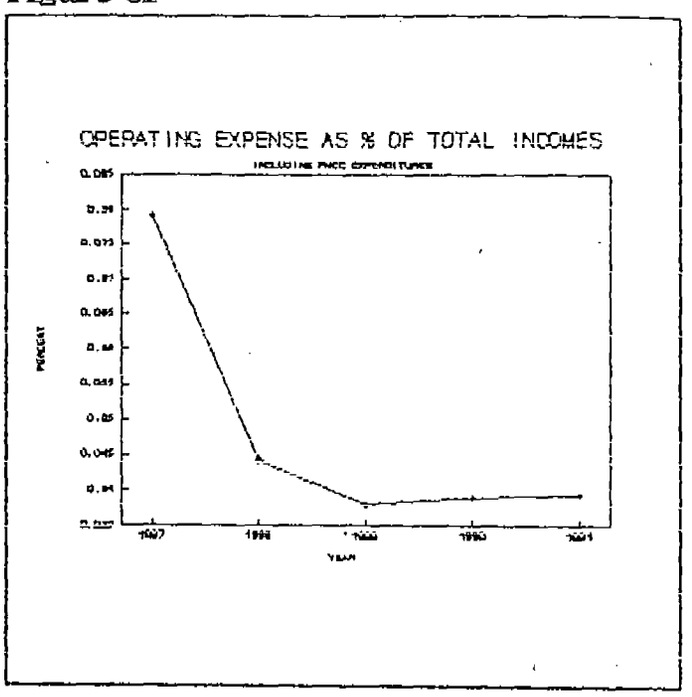
How are expenses treated by the two systems? Of the two institutions, it is SSS which does "full accounting or costing" in the sense that it includes supportive costs like rent (office space), equipment rental, light and water. As pointed out earlier, SSS uses the benefit payment ratio in charging the Medicare program for these supportive costs. This, according to SGV (1990) means that the Medicare Fund is "billed" by some SSS groups not doing any Medicare-related activities, at the same rate charged by departments doing Medicare-related work. Likewise, SSS charges computer rental to the program, suggesting that the SSS-Medicare program does not own any computer (or by extension, any other) equipment. A 1989 Commission on Audit (COA) ruling that all fixed assets be purchased by SSS and GSIS explains why no fixed assets have appeared in the SSS Medicare balance sheets since 1990. Purchases below P1,500 are charged to furniture and equipment expense in compliance with the COA ruling.

A close examination of GSIS' expense statements indicates that controllable items are limited to overtime pay, computer use, public relations, travel, supplies, furniture, and miscellaneous expenses. This implies that

GSIS considers direct costs as expense items, and excludes overhead expenses like rent, light and water. GSIS charges actual direct expenses on the basis of Medicare-related activities. This also explains the low level of operating expenses of GSIS. Given this difference in accounting rules, it would be safe to say that the operating expenses of GSIS are understated, and those of SSS, overstated. In particular, it appears that SSS has been overcharging some expense items.

Still, SSS and GSIS have kept operating expenses below the halfway mark of the 12 percent cap. Even when the annual expenditures of PMCC are included in the total administrative costs, the new total for 1991 would be P130.528 million. That would keep the total costs still below the 12 percent ceiling. With PMCC included, total operating expenses would be 4.3 percent of total incomes, on average (see Figure 61). (The high percentage in 1987--about 8 percent--reflects the high operating costs of running Medicare community hospitals, which were turned over to DOH beginning 1988). The way the two systems allocate the costs, however, does have an important effect on keeping the Medicare program on schedule and on track.

Figure 61



Whether it is remarkable that the operating costs have been well below the 12 percent cap is open to question, however, since the level of collections has continued to increase--indicating that if operating costs were frozen at, say, the 3 percent level, they would still rise in absolute terms.In short, reasonable controllable costs (e.g., fringe benefits), would have been accommodated even without increasing the percentage level of administrative expenses.

The relative net gain accruing from high fixed costs (non-controllable expenses) which constitute salaries, allowances and fringe benefits is in question because both systems have not progressed well in improving the Medicare program. 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 would 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 same goes for PMCC, although the latter is at the same time hamstrung by lack of technical manpower. All three institutions seem to have a misplaced emphasis on regulation, rather than development. SSS and GSIS are visible only in claims processing, while PMCC is routinely making headway only in accreditation and monitoring.

XI. THE CAPACITY OF PMCC TO HANDLE EXPANDED COVERAGE

A. *The organization and management of PMCC*

The Philippine Medical Care Commission, or PMCC, is organized and operated along relatively simple lines. The strategic apex of PMCC includes top decision makers of the organization, and is separated into a governing board and an executive director. The middle line includes managers and line supervisors who supervise four major divisions. A small "technostructure," consisting of doctors, lawyers and technical staff, seeks ways to organize and standardize the work of PMCC.

PMCC is recognized as the focal point of the Medicare program. Republic Act No. 6111 or the Medicare Act is the enabling legislation that details the organizational character of PMCC. R.A. 6111 mandates the PMCC to carry out three vital functions: "formulate policies, administer, and implement the Philippine Medical Care Plan, consistent with the National Health Plan". At the time of this writing, PMCC is directed by an extensive governing board consisting of the following: (1) the secretary of health (chair), (2) the undersecretary of health (vice-chair and commission administrator), (3) the SSS administrator, (4) the GSIS general manager, (5) the secretary of finance, (6) the secretary of interior and local government, (7) the secretary of labor and employment, (8) the president of the Philippine Medical Association, (9) the president of the Philippine Hospital Association, and (10) two private sector representatives, appointed by the President. The board through its chairman nominally exercises supervision and control over all operations of the Commission. Figure 62 shows PMCC's organizational configuration. The board is also known collectively as "commissioners."

The executive director, PMCC's rough equivalent of a chief executive officer, is appointed by the President for a term of six (6) years. R.A. 6111 specifies that he must have at least ten (10) years experience in technical and administrative fields related to the purposes and objectives of the Philippine Medical Care Plan. He serves on a full-time basis and can only be removed for a cause. The executive director is responsible for the general conduct of operations and the administration of the Commission.

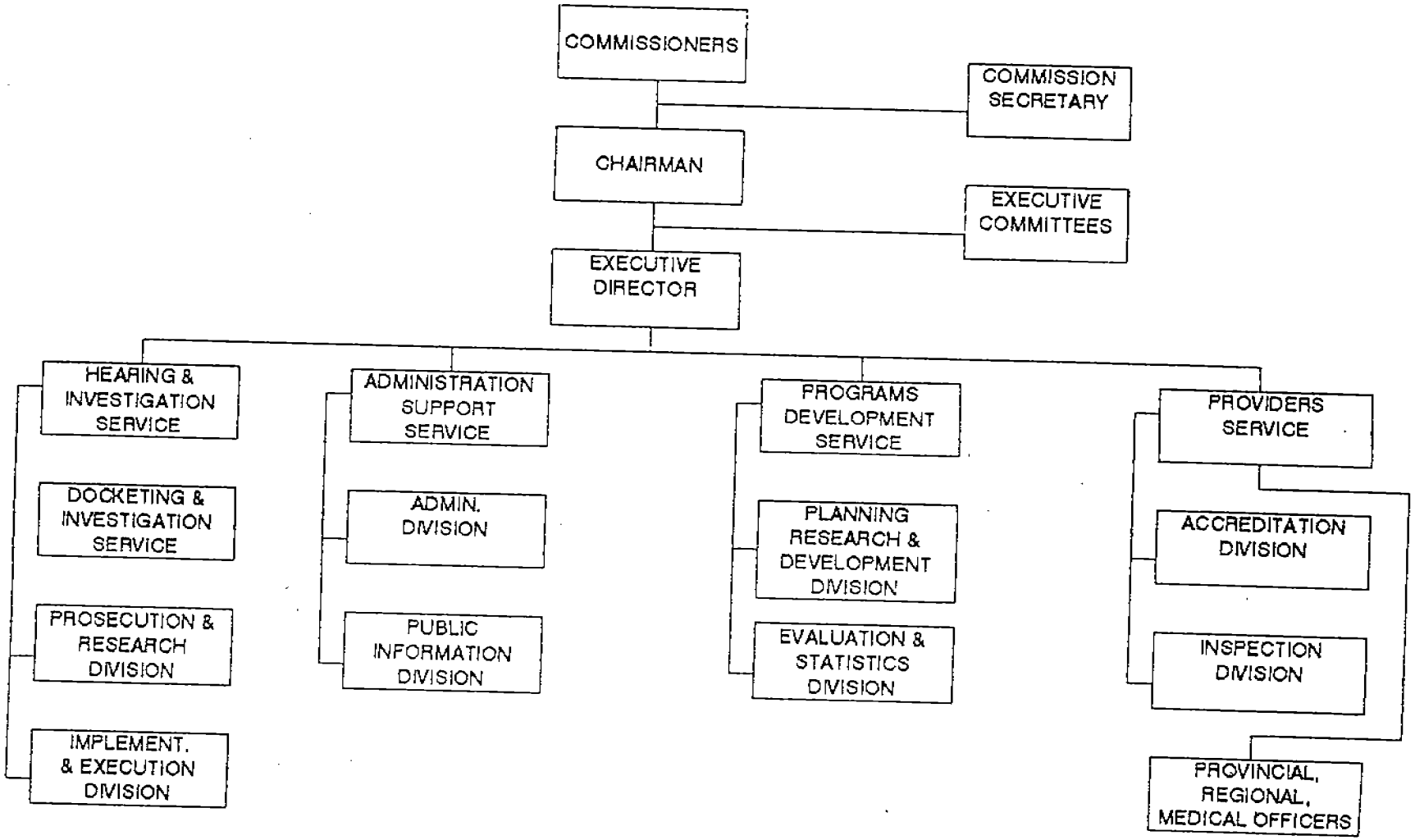
There are four (4) services, each headed by a service chief, which function according to a strict set of mandated responsibilities. The organization of these services has been in accord with the current trend, which is to provide a small number of relatively large major divisions, each with a major purpose and differentiated on the basis of functional definition. This results in a relatively narrow span of control which permits the executive director to exercise tight supervision over a limited number of more or less self-contained units. The services, including their divisions are the following:

(1) Hearing and Investigation Service

1.1 Docketing and Investigation Division
1.2 Prosecution and Research Division
1.3 Implementation and Execution Division

Figure 52

PHILIPPINE MEDICAL CARE COMMISSION
ORGANIZATIONAL CHART



This group, as its name implies, hears and investigates cases on violations of Medicare rules and regulations. It also provides legal services and monitors compliance and implementation with the decisions taken. It is also a repository of violations reported by the SSS and GSIS and can act on these reports.

(2) Administration Support Service

2.1 Administrative Division
2.2 Public Information Division

As the two divisions of this component suggest, this group provides general administration and support, as well as information dissemination. The administration division handles accounting, treasury, manpower and personnel, logistics support, supplies management and housekeeping. The public information division prepares and disseminates information about Medicare, principally through public seminars, primers, print and media advertisements and other
public relations methods.

(3) Programs Development Service

3.1 Planning Research and Development Division
3.2 Evaluation and Statistics Division

Sec. 25 of R.A. 6111 states that "the Commission shall undertake a continuing monitoring, study and research to improve the Program". On this basis, this group performs planning and statistical research functions for the PMCC. Its responsibility includes developing new programs/special projects and monitoring and evaluating those under implementation. Its main thrust is the improvement and the expansion of the Medicare Program. The group is also responsible for data collection, storage and retrieval. The Health Insurance Fund (HIF) reports periodically submitted by SSS and GSIS are logged with the evaluation and statistics division, which compiles, integrates and analyzes them.

(4) Providers Service*

4.1 Accreditation Division
4.2 Inspection Division
*includes provincial and regional officers

The task of licensing qualified hospitals and physicians and making sure they comply with the Department of Health and PMCC regulations on accreditation is carried out by the this group. It makes sure that health care providers meet the standard requirements and manpower restrictions. A field complement of provincial and regional staff, numbering about 172, monitor compliance with the Medicare Law through regular ocular inspections and surveillance of the hospitals. The staff check providers' facilities, occupancy rates and the confinement behavior of Medicare patients.

Within the organization of PMCC are four executive committees which have some real governing authority over the program.

(1) Hearing and Investigation Committee

Representatives from hospital, medical and dental associations and the private sector designated by the commission make up this committee, which can conduct inquiries and investigations into reported violations of the Medicare law or its implementing rules and regulations. The committee need not be bound by the technical rules of evidence. It has quasi-judicial powers, e.g., subpoena powers to compel the attendance of witnesses and the production of books, papers and other records which could shed light into any question arising under the law.

(2) Appealed Claims Committee

Because in practice the SSS and GSIS can disallow, reduce or deny certain claims, this committee would enable the claimant to appeal his case.

(3) Accreditation Committee

It is through this committee where applications for accreditation as a Medicare hospital or clinic are either approved, denied, and/or suspended after a thorough evaluation made by the Providers Service.

(4) Rules and Regulations Committee

This committee determines the rules and regulations for the Medical Care Plan. It can review, establish and/or amend rules which could be initiated by the Board, Congress, the PMCC Services or the committee itself.

The hearing and investigation committee was created by the Medicare law. The other three were activated by the PMCC Board. Together, these four committees, which report directly to the Chairman, constitute what could be dubbed as a "Management Committee of Body" which would facilitate the process of decision making.

B. *Organizational assessment*

PMCC is basically a regulatory body, depending on inspections and rules to carry out its purpose. At first glance, that seems to accord well with the intent of the Medicare Act for PMCC "to promulgate or prescribe rules and regulations" in order to implement the Medicare program. But that is supposed to be only the "downstream" part of its major mandate, which is policy formulation. PMCC is required by law to handle a more formidable "upstream" task: to plan for a wide coverage base, to devise a contribution and benefit structure on the basis of "sound actuarial procedures," and to propose "alternative systems in order to insure adequate financing and effective delivery of medical care to all beneficiaries of the plan." On the supply side, PMCC is required by law "to ensure a homogeneous distribution of adequate hospital accommodations for inpatient care through a national network of government and private medical care facilities," and to "coordinate with appropriate government agencies in the development of medical and allied manpower based on the needs of the health care delivery system."

From time to time, the PMCC board formulated long-term strategies which called for substantial growth in Medicare membership, expansion and improvement of benefits, and increased financial management efforts on the part of SSS and GSIS. In the seventies, it undertook the construction and

management of community-based facilities, now called Medicare Community Hospitals. PMCC made considerable progress in these areas, but the obvious issue of the degree of autonomy in decision-making with respect to Medicare financial resources made the division of responsibilities among the various components of the Medicare program uneven. Obviously, there were many possibilities with respect to financial control, but the *fait accompli* was SSS and GSIS supervising the direction and economic consequences of the management of the Medicare fund, thus giving them undue leverage over general policy. Whenever PMCC did policy-making, it was always in association with the two fiscal intermediaries.

The minor role played by PMCC tended to reduce the potential of new reform initiatives and held back the development of its policy capacity severely. Organizationally, PMCC lacks focus. The commission, which nominally should formulate overall policy and make decisions in the financial field, has little authority. It does not undertake research and development--an area it could very well play a central role since neither GSIS and SSS has shown any interest in it. Budgetary attrition and low levels of expenditures on program development have further gnawed at its policy-making and administrative capacity. On a more basic level, the commission is unable to build up an independent data base. PMCC does not have its own actuarial division and relies solely on the actuarial expertise of SSS and GSIS. Neither can it force the two systems to unify their differing accounting systems. As a result, its baseline research function has been reduced to preparing a generalized HIF report, which ironically, even the PMCC Board (with both SSS and GSIS concurring) has declared "too shallow" (SGV, 1990). Perhaps the only headway PMCC is making is in building up a solid data base on Medicare-affiliated hospitals and accredited physicians. Computerization has helped PMCC in easing up licensing procedures and monitoring providers. This suggests, however that it is precisely in a regulatory area--setting standards and regulations to protect the population from unethical practitioners--where PMCC has shown more consistency and competence.

By contrast, the Programs Development Service has yet to go full-scale on the recommendation to develop its own information database which would facilitate the process of decision making within the organization. PDS' planning activities have been limited to providing inputs to the NEDA Medium-Term Development Plan. In practice, planning is a process that ought to permeate the whole PMCC and be undertaken throughout the year, or at least periodically. Planning is to administration as epidemiology is to disease prevention. PMCC's lack of clout within the Medicare system has a number of unfortunate implications for the PDS. It could not beef up its technical competence, thus avoiding the pressure to concentrate on long-range planning. It is more involved in immediate-problem solving tasks, in the process intruding into the domain of the other services.

Until the Aquino administration took over in 1986, PMCC had a full-time board chairman, who could, theoretically, assume policy and leadership. The Board chair is now occupied by the Secretary of Health, making the entire Board a part-time preoccupation by its members. Yet the Board has to perform a myriad of functions, including *operational* ones: the watchdog function, provision of feedback from top government health officials, acting as final hearing panel for complaints, development and analysis of Medicare-related legislation, and promulgation of Medicare regulations.

In a situation like this what would be required is a strong full-time chief operating officer who can manage the operations of the PMCC with least supervision. A strong and capable Executive Director would be important for the organization. Yet balance is important. It is easy for the Board to draw power away from the Executive Director; on the other hand, the director can become passive and fail to deliver the kind of technical and goal-oriented leadership needed. In theory, details of policy are usually delegated to a chief executive officer who is charged with the development of necessary rules to carry out the broad purpose of Medicare. The executive director is responsible for carrying out PMCC's mission, which is expressed in statutory language, and has three key functions: policy execution, operational initiative and management of the commission's resources. Since the inception of PMCC, however, operational leadership has not been particularly strong, and the gap between authority (the right to make a decision) and power (the ability to execute it), has in fact widened. 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 with powerful assistants.

In the future, PMCC must work toward achieving a delicate balance between the executive officer and the board, wherein both parties must be constantly alert to their own responsibilities and prerogatives and those of the other party. The field of operation and policy implementation (as opposed to purely administrative tasks) belongs to the executive director, who in turn must respect the policy-setting actions of the board, as well as keep them informed, asking their advice and including them in planning.

The setting up of the Executive Committees has reinforced the idea of PMCC as a regulatory, rather than a developmental, body. PMCC has, from the very start, court powers, through a Hearing and Investigation Committee, and this had the effect of shaping up its regulatory muscle. The task description of the other four committees--Appealed Claims, Rules and Regulations, and Accreditation-- shows that these revolve around the regulatory functions of the PMCC.

These technical bodies, moreover, were created to assist the service officers in the formulation of plans and in the development and application of various techniques of value in the Medicare program. In actuality, the committees forcefully intrude on the operational domain. Major decisions are made in these committees; the service departments function only as support staff to 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. Such a set-up could be a have a double-edged nature: it either speeds up or merely delays the decision-making process within the organization. As the organizational chart of PMCC shows, the executive committees are in fact only a mirror image of the service groups. As if by design, Providers Service corresponds to the Accreditation Committee; the Hearing and Investigation Service, to the Hearing and Investigation Committee and the Appealed Claims Committee; Programs Development Service, to the Rules and Regulations Committee. There is an apparent increase in the complexity and cost of decision-making, and it is unclear whether these parallel structures may be a necessary price to pay for the work that has to be done, or may just be needless duplications. Complaints are often voiced of another bureaucratic layer and an additional source of directives and report requirements.

What does seem to be important is consistency in the organizational design. The design should be seen as a dynamic blueprint: one that can and will change to facilitate needed improvements. The mirroring of the service departments in the committees seemed to have evolved from PMCC's continuing attempt to define its purpose and to make adaptive adjustments. But that type of structure seems to fit organizations with a wide diversity of expectations and requirements. Given the lack of diversity in the functions of PMCC, however, the committee-department pairings may be an inappropriate structure and style for the operating core of the commission. Counterpart arrangements in this case only lead to roundabout ways, thus eroding operational efficiency.

As already pointed out, the delegation of the financial management of the Health Insurance Fund (HIF) has left the PMCC without much muscle to directly manage it. Yet Sec. 17 of R.A. 6111 is emphatic that "the deposit, investment, administration and disbursement of the funds conform with the policies established by the Commission." Ironically, there is no executive committee to look solely into the management of the fund. The PMCC routinely expects the SSS and GSIS to submit the HIF reports which are logged and analyzed by the Evaluation and Statistics Division of the Programs Development Service. But with the heads of SSS and GSIS sitting in the PMCC board as the law provides, it appears that PMCC was not really envisioned to handle the financial matters of the Medicare program. In theory, PMCC can rely on Sec. 17 of R.A. 6111 and with an organizational will assert its clout over the Health Insurance Fund (HIF). Yet there is reason to believe that in the early stages of the Medicare program, ineffectual PMCC leadership allowed the imbalance to occur by letting too much financial power drift into SSS and GSIS. This spin-off of authority--and the subordination of Medicare into the two systems' own program priorities-- has resulted in a poorly articulated program of benefits and a confusing portrayal of policy to the public and the personnel of PMCC.

C. *Personnel profile*

Tables 38 and 39 provide a profile and distribution of the personnel of PMCC. PMCC has both central and field staff, with the field staff outnumbering the central staff at a ratio of 172:126, or 1.36:1. In all, PMCC's workforce is 298 strong.

In the central office, the distribution of its staff is lopsided in favor of the Administrative Support Service which has 50; Providers Service, 15; Programs Development Service, 22; Hearing and Investigation, 16. Since personnel who perform administrative chores are also found in the technical departments, the adjusted total number of people performing administrative work is 77 versus 26 assigned to technical work. The ratio thus of administrative persons to technical persons is almost 3 is to 1. That is inordinately high, by any standard. In fact, a ratio of 1:1 would be already considered too askew in favor of administrative skills. Ideally, the reverse should occur: a ratio of 3 technical persons to 1 administrative person would be more likely the industry norm.

The lopsidedness is all the more conspicuous when those serving in the field are considered. For all practical intents and purposes, PMCC's field staff--numbering 172--are basically administrative/clerical personnel. In

TABLE 38
PERSONNEL PROFILE, PMCC, 1992

NO. OF EMPLOYEES	EDUCATIONAL BACKGROUND	CENTRAL OFFICE	FIELD OFFICE
112	BSC/BSBA graduates (Acctg./Management Major)	52 3 CPA 4 w/MBA units	70
31	BSE/BSEEd/BSIE graduates	7 4 w/MPA/MBA units	24
23	A.B. graduates (Mass Com/Political Science/ Eco./Math majors)	5	18
3	Doctor of Medicine	3	
10	Bachelor of Laws Graduate	10 5 Underbar 1 CPA–Lawyer	
19	Undergraduate (2nd yr & 3rd Yr. College)	8	11
16	Secretarial Graduate (Medical Secretarial/ Associate in Sec. Science)	5	11
4	Midwifery Graduate		
3	BS Social Worker graduates		
3	BS Med Tech. graduate		
1	A.B. Theology		
1	B.S. Tourism		
1	B.S. Agricultural Tech.		
1	B.S. Psychology		
4	High School/Vocational graduate		
19	Undergraduate		

Source: PMCC

TABLE 39
PERSONNEL ASSIGNMENTS, PMCC, AS OF JULY 1992

DISTRIBUTION OF PERSONNEL	CENTRAL	FIELD
HEARING AND INVESTIGATION SERVICE	16	
ADMINISTRATIVE SUPPORT SERVICE	50	
PROGRAM DEVELOPMENT SERVICE	22	
PROVIDERS SERVICE	24	
KEY POSITIONS	14	
Sub–Total	126	
FIELD OFFICE		172
TOTAL	298	

DISTRIBUTION OF CENTRAL OFFICE STAFF	
ADMINISTRATIVE	77
TECHNICAL	35
KEY POSITIONS	14
TOTAL	126

Source: PMCC
Note: Field Staff of 172 are considered administrative personnel.

1990, this field staff numbered about 300, suggesting that the attrition rate has been quite high in recent years. If the tally of field workers is included with the 77 in the central office, the ratio of administrative to technical would be an unbelievable 7.78 to 1. Interviews with PMCC administrative officials reveal that most of PMCC's administrative positions are protected civil service positions. In theory, civil service protections provide continuity in expertise and insulate employees against attempts to use agencies for partisan purposes. Continuity, however, must be purchased at the expense of a certain amount of inflexibility in agency staffing. The same procedures that discourage firing of employees for unwarranted purposes make it hard to weed out the incompetent and unproductive. 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. Over the years, as PMCC's more competent personnel resigned for various reasons, the Commission was left with a high proportion of the least wanted, often those found in administrative positions. Low salaries compound the situation; salary standardization, which provides less opportunity for differentiation, only tends to underreward the most productive and overreward the least productive.

If quality is to be maintained, PMCC must take new initiatives in hiring and keeping qualified technical staff. But a slow and complicated hiring and career enhancement system has reduced the ability of PMCC officials to activate new programs quickly. Since it has to bear the burden of keeping a high concentration of protected administrative positions, PMCC has practically lost the leverage to gain additional slots from Department of Budget and Management for its technical staff. The administrative-technical imbalance must be resolved soon, for otherwise PMCC's capability to meet the needs of medical insurance effectively will continue to be undermined. Whether the safer course of action is to retool those already in the civil service system, or to "trim off" excess administrative staff in order to let in a new bunch of technical personnel, remains to be seen. The more often these sorts of decisions are left hanging for the sake of expediency, the more difficult it is for PMCC to operate efficiently in the long run.

Within the technical group, the present personnel capability of PMCC does not show any particular strength in financial management. While the presence of an MBA or a fiscal management graduate is no assurance of financial expertise, its lack within PMCC, and correspondingly, the wide variation of educational backgrounds among the technical staff, indicates a serious incapacity to handle more specialized tasks, such as financial analysis and actuarial assessment. PMCC sorely needs statisticians as well to beef up the PDS Statistics and Evaluation Division. For an agency which develops health insurance policy, it should also have a health care economist/analyst in its staff. Only the Providers Service, which has 10 MDs on-board, and the Hearing and Investigation Service, which has 10 law graduates, seem to have the appropriate mix and concentration of required skills.

A vital function that often has the least priority is public information. PMCC must disseminate information about benefits and procedures to help consumers deal effectively with providers and reimbursers. Because information asymmetry is often inherent in any social insurance scheme, a public awareness program is never out of the question. Information is a necessary ingredient in reducing the uncertainty in the Medicare system: 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 misallocation of time and money resources. PMCC's Public Information Division is supposed to take care of information planning and dissemination. Severely understaffed, it also seems out of place in Administrative Services, where it is currently housed. Not surprisingly, it has been reduced to doing perfunctory jobs, such as over-the-counter information dissemination. It would be more appropriate for it to be under the Programs Development Service, where it could render more aggressive frontline services, as well as orchestrate a systematic public information campaign. The information dissemination should provide Medicare users effectively 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 would exceed the marginal social cost, the information campaign is justifiably necessary.

D. *Expanding coverage through Medicare II*

The issue of expanded coverage refers to the implementation of Program II, which embraces, according to R.A. 6111, "those not covered under Program I". Sec. 31 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."

When SSS began insuring the self-employed, including farmers, fisherfolk and vendors in 1983, Program II virtually started, inasmuch as the self-employed were outside the range of Program I, which includes only workers in the wage sector. But PMCC takes a differing view on Program II coverage, arguing that the beneficiaries of Program II should be those who will not be served by SSS. This contention deserves closer scrutiny.

SSS' implementation of Program II closely follows Program I's "package deal" approach, which means, those self-employed will have to enroll in every SSS social security insurance component, instead of being allowed to purchase only those which they demand. Since the start of this program, SSS has managed to enlist 363,784 self-employed in its rolls, or an increase of 71.5 percent over a nine year period. Yet, as PMCC officials observe, most of these self-employed members come from Metro Manila, or the National Capital Region, and presumably are relatively well-off, since they can afford to pay all the SSS premiums. Hence, the poorest occupational groups, such as farmers, agricultural workers, domestic servants, and fisherfolk remain excluded from Medicare.

A Medicare II for indigents was probably what PMCC had in mind when it kicked off its own small projects in 1983 in selected rural areas to ascertain whether its own version of Program II was feasible. The projects were piloted in Bauan, Batangas in 1983; in Unisan, Quezon in 1984; in Nueva Valencia, Guimaras 1985, and in Laguna in 1992.

The single most important innovation in PMCC's scheme was that *members pay only Medicare contributions*. By eliminating any "package deal" arrangement,

PMCC systematically excluded SSS and GSIS from the project. Another important change the PMCC instituted was the decentralization of the program, at least as far as collection and disbursements are concerned. The scheme called for the assistance of the local government in the area. The PMCC enjoined the municipal treasurer to perform the function in close coordination with the PMCC field staff and the Department of Health which closely monitors each project. Permitting premiums to be collected and retained at the point of service delivery made economic sense: where many people are isolated from the medical care mainstream, communication is difficult, and administrative resources are scarce, decentralization was one possible way to strengthen efficiency.

When premiums are retained locally, rather than add to central Medicare funds, there is more local incentive for collection. Local health providers have also less of an incentive to enter into a collusion with Medicare patients, since fund use could be easily monitored by local staff (and the service users as well). It also ensures, within limits, that the choice of medical resources accord with local needs. Because the transaction and information costs of collecting and administering financial resources are quite high in a dispersed program such as Medicare II--the smaller the amount being collected, the more frequent is the collection--there is more reason to control revenues close to the point of service delivery.

The PMCC projects grew modestly, expanding coverage of rural areas and the poor within the pilot areas. Its strength has been the consistently high support value of the program. As the Program II comparative statistics show (see Table 40), Medicare support value went up by as much as 86.04 percent in Bauan, 80.95 percent in Nueva Valencia; and 61 percent in Unisan. PMCC often aims for a 70 percent support value. The exceedingly high values are surprising since there is less of a chance that size economies could be developed in each of these isolated areas. Conceivably, given greater responsibility for financial discipline, the local staff were more sensitive to signals as to what resources are valued by observing the spending behavior of providers and patients. However, the high support value is also explained by the fact that members could avail only of primary health care services, in the absence of hospitals and a strong referral system. Whether the primary care costs consist of payments for small routine curative services is of course a serious matter, since it is inefficient to return the same amounts to Medicare members, as the predictably needed services are provided, after collecting them from each enrollee.

Table 40 also shows that the membership base remains quite small despite a good headstart for the program. The membership base in Bauan is 1,123 over a nine year piloting period, 1,579 in Unisan over a 8-year period, and 641 in Nueva Valencia over a 3-year period. The static coverage base might be more the result of administrative difficulties than outright policy failure. High transaction costs might have exacted a toll on the program. The immediate cost of financial management is the staff time needed to enforce payments and monitor disbursements, but given PMCC's constrained field capacity, overall administrative performance was weak. Also, field staff had little training and experience in managing revenues and expenditures, which is a considerable obstacle in attaining efficiency in the pilot areas. High information costs could also have been the culprit. Again, given the limited resources of PMCC, not much attention was given to ensuring that the potential Medicare users in the covered areas were given information and

TABLE 40
PHILIPPINE MEDICAL CARE COMMISSION
PROGRAM II COMPARATIVE STATISTICS
AS OF DECEMBER 31, 1991

	UNISAN, QUEZON	BAUAN, BATANGAS	NUEVA VALENCIA, GUIMARAS
TOTAL COLLECTION	139,249.33	205,908.63	55,976.26
PREMIUM COLLECTION	130,580.00	168,845.00	45,550.00
INTEREST INCOME	8,669.33	37,063.63	10,426.26
TOTAL DISBURSEMENT	77,087.85	77,515.55	32,965.82
BENEFIT PAYMENT			32,200.70
OPERATING EXPENSES			785.12
CUMULATIVE COVERAGE	5,530.00	5,159.00	2,754.00
MEMBER	1,579.00	1,123.00	641.00
DEPENDENT	3,951.00	4,036.00	2,113.00
ACTIVE COVERAGE	3,302.00	971.00	1,865.00
MEMBER	940.00	255.00	411.00
DEPENDENT	2,362.00	716.00	1,454.00
BENEFICIARIES SERVED	786.00	494.00	204.00
MEMBER	238.00	184.00	67.00
DEPENDENT	548.00	310.00	137.00
AVE. VALUE PAID/CLAIM	173.30	375.87	175.30
SUPPORT VALUE	61.00%	86.04%	80.05%

Source: PMCC Evaluation and Statistics Division, Program Development Office

understanding on the benefits of the program. A nontrivial proportion of the target population apparently has not been exposed to Medicare; alternatively, schemes that seek to educate them in medical care insurance have not been effective.

E. *Expanding capacities*

A recent study stressed that "given its existing mandate and present set-up, PMCC is already experiencing difficulties. Should its mandate be enlarged to include Medicare Program II to cover even more problematic sectors of the economy, these difficulties will be magnified" (SGV, 1990). Because Program I zeroes in on only a minority of the population, under expanded coverage, Program II will have to reach the vast majority in the rural areas, a membership base which is far larger and with a set of needs and problems that in many senses might be different from the requirements of current wage-earning members. Will such an expansion to be undertaken under existing conditions take its toll on the commission?

Not necessarily. As the pilot projects suggest, there are viable and easily administrable ways of providing Medicare benefits in rural regions. Communities can be organized for funding Medicare services. No doubt this requires a great, many small Medicare projects that are dispersed throughout the countryside. But this is probably one of only a few ways to attract the poor majority to a social insurance scheme like Medicare. The key is to find out how a large number of such Medicare communities could emerge under favorable conditions.

PMCC has a major role in helping rural people to become organized for Medicare. It could provide the stimulus necessary for community mobilization, since the rural poor are unlikely to organize themselves spontaneously. The need to implement Program II is a signal for PMCC to re-examine its mandate vis-a-vis Program I. PMCC's comparative advantage does not lie in either Program I or Program II at the moment, but the latter offers the Commission more maneuverability and opportunity to do program innovations on a broader scale. Given the entrenched financial powers of SSS and GSIS, one could argue that any reforms short of giving PMCC a fresh mandate within Program I may accomplish relatively little. The extent to which minor modifications in the current setup results in genuinely greater coordination or improved operational relationships is debatable. Often, little ensues beyond making procedures a bit less complicated and difficult for Medicare recipients. The centralized policy formulation existing at present only supports a slow-moving bureaucratic apparatus that does little to help poor occupational groups. It is incapable of flexibly adopting to local conditions in the countryside. By its very nature, Program II needs to be planned locally. Its desirability and feasibility cannot be appraised at the center.

That does not necessarily require legislation; the current Medicare law is sufficient to transform PMCC into a new organization better equipped to handle Medicare planning at various levels, especially at community levels. That, of course, might mean creating a wholly different organizational structure and leadership which is prepared to undertake Program II. Organization and management will remain key constraints, particularly PMCC's field service, which must reach a significant number of villages for some scale economies to develop. Given limited manpower and institutional capability, it

may be necessary over the next decade to focus efforts on regions where premium payments are at least affordable, that is, on less economically depressed areas.

PMCC could very well serve as a vertical coordinator of rural-based Medicare projects. At each pilot project site, it could assess the capability of the community to sustain the growth of a local health insurance fund, or converting the proceeds into a larger pool to maintain a steady flow of region-wide funding. It could determine the impact of changing local economic conditions on the structure of benefits to be adopted, and the factors affecting the availability and price of health manpower and drugs.

That does not imply any loss of central control over broad policy development. While implementing Medicare projects at local levels, PMCC can retain control over such areas as training policy, field assignments, and accreditation an overall direction. It can also explore possibilities of Program I subsidizing Program II, to the extent that the relatively better-off workers in the wage sector can pay the costs not only of their own care but part of the health care of poor groups. The important matter is that an institutional progression is created which permits PMCC to exploit advantages of scale economies in major, strategic activities alongside undertakings that are small enough to ensure responsiveness to local needs.

The paradox is that it is Program I which is more problematic for PMCC, and its attempts to reclaim authority and leadership in the field might require Congressional approval. The designation of SSS and GSIS as the collecting, disbursing and financial managers of the MEDICARE fund will continue to pose authority and accountability problems for PMCC. If the PMCC-SSS-GSIS tie-up were to be maintained, PMCC would remain locked in a Catch-22 situation: it would need control over the HIF for it to move more authoritatively; but at the same time it would have to assert its authority to gain substantial control over the HIF. Instead, its continued dependence on government appropriations may be a deterrent to its organizational development.

Clearly, the issue here is the possibility of developing PMCC into a corporate body which is able to fully assert its leading role in the Medicare program. If PMCC is to be strengthened as a coordinating agency for Program I, it needs to be endowed with a corporate capability to improve its leverage over all the components of the Medicare system. If that seems politically unfeasible at this time, the more reason why PMCC needs to reconcentrate its efforts on Program II. In order to "trailblaze," it must hammer out new initiatives that would lead toward decentralizing the Medicare system, and make it more broad-based.

XII. THE EMPLOYEES' COMPENSATION PROGRAM

Like Medicare, the Employees' Compensation Program is a risk-sharing arrangement where salaried employees and to a lesser extent, their dependents, secure coverage, or assurance of future access to medical services. The program offers medical or related benefits for any work-related injury or sickness. Unlike Medicare, the ECP covers work-connected disability or death, and provides income benefits.

A. *The Employees' Compensation Commission*

The Employees' Compensation Commission was created by Presidential Decree No. 626 on December 27, 1974 and formally started operations in 1975. It superseded an existing, but largely ineffective workmen's compensation system. By law, the ECC is mandated to initiate, rationalize and coordinate the policies of the Employees' Compensation Program. Unlike PMCC, the ECC has the status of a government corporation but is attached to the Department of Labor and Employment (DOLE) "for policy coordination and guidance".

Administratively, the ECC has an operational structure not unlike that of PMCC. Four of the PMCC's board members sit on the ECC's governing body: the Secretary of Labor, the General Manager of the GSIS, the Administrator of the SSS, and the Secretary of Health. This time, however, it is the Secretary of Labor which chairs the ECC board; the SSS and GSIS heads alternate as vice-chair yearly. Two other members, one representing the employees and the other the employers, are appointed by the President. An Executive Director heads the Secretariat and takes care of the day-to-day operations of the Commission.

B. *The State Insurance Fund*

The State Insurance Fund is to the ECP as the HIF is to the Medicare program. Unlike in Medicare, the employee does not shoulder any part of the contribution to the ECP. The SIF is fully borne by the employer. Like the Medicare fund, the SIF is accumulated in two separate accounts, one for public sector employees and managed by the GSIS, and the other for private sector employees managed by the SSS. The two funds are invested, administered and disbursed in the same manner as the Medicare fund. Indeed, for a long period, only one department in the SSS handled claims processing and benefit payments for both Medicare and the ECP, indicating that identical operating procedures were observed for both programs.

C. *ECP coverage and membership base*

The ECP program furnishes compulsory coverage for all employees not over 60 years old in the private sector as well as in the public sector, including elective officials and the military. Those over 60 years can continue receiving benefits if they had been paying contributions to qualify for retirement and insurance benefits given by either the SSS or GSIS. Employees are covered on the very first day of their employment. Employers are likewise covered. In addition, employers and employees of the Philippine Tuberculosis Society and the Philippine National Red Cross are subject to coverage, as do Filipinos employed abroad.

Theoretically, the membership base for both ECP and Medicare must be identical, or close to being the same. That seems true as far as the membership profile for the public sector is concerned. On the basis of health statistics compiled by the Center for Research and Communication, the ratio of ECP members to Medicare members in GSIS has averaged 100 percent over the years, fluctuating between 92 percent and 111 percent. It is another story as far as private sector ECP membership is concerned. As the following table for SSS shows (also see Figure 63), ECP members outnumber Medicare members by more than two to one.

The difference within SSS may be explained by the fact that ECP is an older program, and has probably been better experienced in sustaining much of its sector membership base in the private sector. If Medicare could access ECP files, it could run after employers already covered by ECP but are not covered by Medicare. The possibility that the ECP membership base has not been "cleaned," and may contain a large block of inactive members has also been suggested. On the other hand, it is much easier for GSIS to maintain a single roster for both ECP and Medicare members because of the ease with which public sector employers (government agencies) could be tracked down and compelled (through DBM) to pay their contributions.

Figure 63

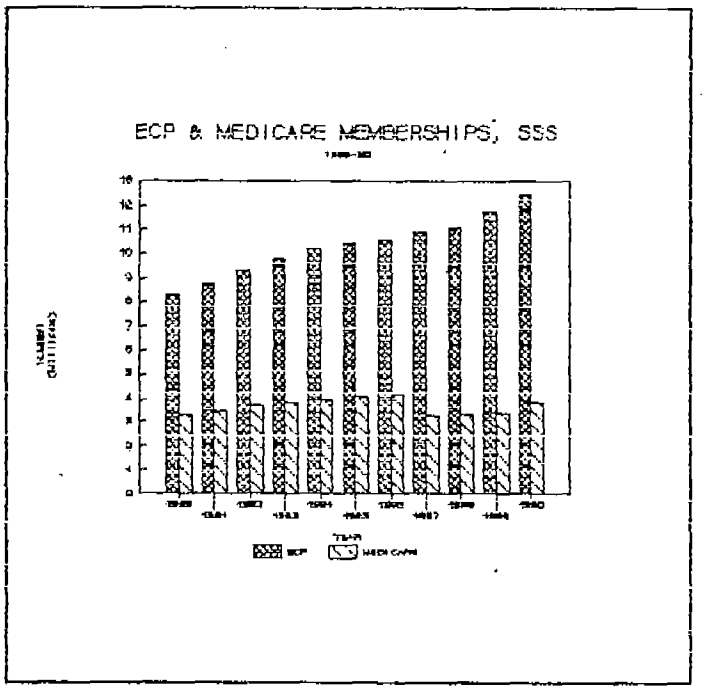


TABLE 41
EMPLOYEES' COMPENSATION PROGRAM
SSS MEMBERSHIP BASE
(IN THOUSANDS)

YEAR	ECP	MEDICARE MEMBERS	% ECP TO MEDICARE
1980	8289	3304	2.5
1981	8774	3500	2.5
1982	9279	3702	2.5
1983	9785	3819	2.6
1984	10134	3951	2.6
1985	10384	4034	2.6
1986	10572	4221	2.5
1987	10898	3240	3.4
1988	11071	3320	3.3
1989	11775	3380	3.2
1990	12453	3870	3.2

Sources: ECC, CRC

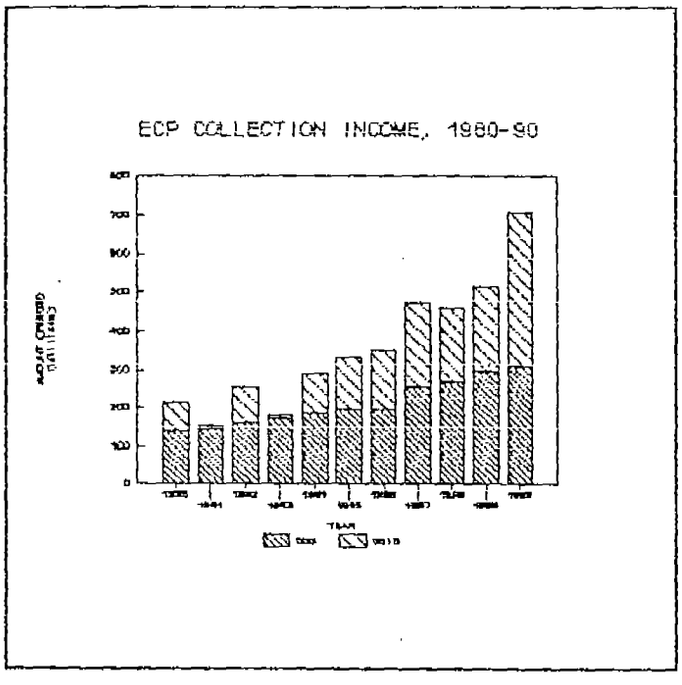
Because of the disparity in the SSS membership base, ECP has a wider national membership base than Medicare. ECP covers about half of the total employed force in the country, compared to Medicare's 22 percent. Medicare, however, has still a larger coverage base because of the presence in the

program of dependents, retirees and the self-employed. Like Medicare, the ECP has experienced a steady slowdown in membership growth rates in recent years.

D. *Contributions: structure and magnitudes*

ECP contributions are basically a tax on the employer, and are based on a fixed percentage of wages. But the tax burden is not equitably borne by the private sector and the public sector. Public sector employers must remit to the GSIS a monthly contribution equivalent to 1 percent of the actual wages and salaries at the end of each month (this should not exceed P30 per employee per month). Private sector employers, on the other hand must remit monthly to the SSS, 1 percent of the monthly salary of each employee, but not to exceed the amount of P10 per employee per month.

Figure 64



Since 1980, the collections of the SIF have been on an upward trend. From P213 million in 1980, the contributions have shot up more than threefold to P708 million in 1990 (see Table 42 and Figure 64). Collection income has grown at a healthy clip of around 19 percent yearly, on average. SIF collections have been anywhere from 48 percent to 73 percent of HIF collections (average: 55 percent). There was never a time when the SIF collections exceeded that of Medicare, although the former's membership base is higher (see Figure 65). This can be attributed to the lower contribution schedule of the ECP.

Collections of GSIS grew at an average of 30 percent annually, and have been the source of the overall growth momentum of the SIF. In absolute terms, however, the GSIS fund is only about half the SSS HIF. Despite being bigger, the SSS fund has grown more sluggishly at 11 percent annually. This comes as a surprise, since SSS carries in its ECP roster a membership base that is up to two times the Medicare list. Plausibly, the SSS is experiencing employer compliance problems. If this is the case, collection enforcement in the private sector is a considerably big headache, since the lower ECP contribution schedule for private companies should enable them to comply much more easily with the payments on a regular basis. This is an area that needs further investigation.

E. *Benefit structure and payments*

The ECP compensates any work-connected injury or sickness. The compensation includes (a) cash income for disability or death; (b) medical and/or related services, for injury or sickness; and (c) rehabilitation

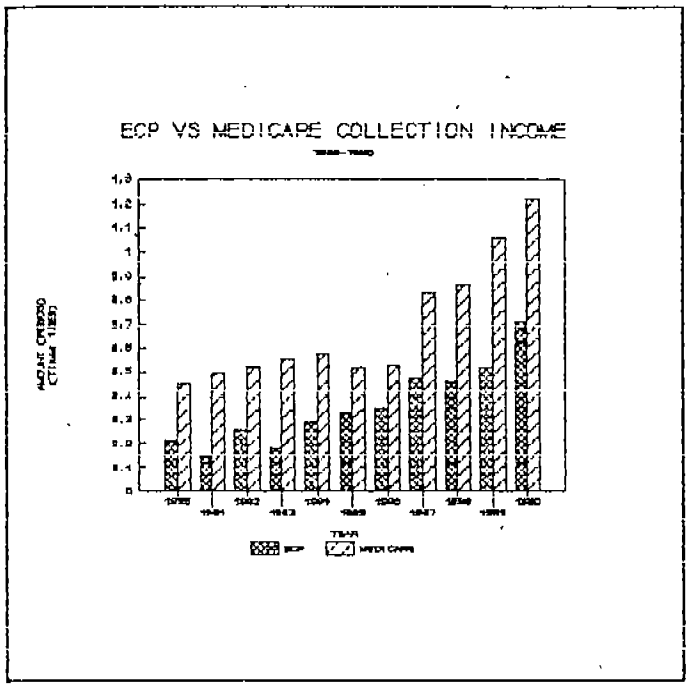
TABLE 42
EMPLOYEES' COMPENSATION PROGRAM
COLLECTION INCOME (In Thousands)

YEAR	SSS CONTRIBUTIONS			GSIS CONTRIBUTIONS			TOTAL CONTRIBUTIONS	
	AMOUNT	MEDICARE COLL.	% TO MEDICARE	AMOUNT	MEDICARE COLL.	% TO MEDICARE	AMOUNT	% TO MEDICARE COLL.
1980	140586	290550	0.48	72200	156170	0.46	212786	0.48
1981	145605	313720	0.46	7000	180940	0.04	152605	0.31
1982	163546	330780	0.49	92800	190050	0.49	256346	0.49
1983	173353	340600	0.51	10300	212600	0.05	183653	0.33
1984	186851	342400	0.55	105100	233900	0.45	291951	0.51
1985	195766	332800	0.59	136000	181500	0.75	331766	0.65
1986	198074	335200	0.59	152600	190700	0.80	350674	0.67
1987	256650	546200	0.47	217900	278100	0.78	474550	0.58
1988	268000	616100	0.43	192284	245480	0.78	460284	0.53
1989	297700	731100	0.41	214803	325510	0.66	512503	0.49
1990	314000	777400	0.40	394272	446210	0.88	708272	0.58

Sources: CRC, ECC

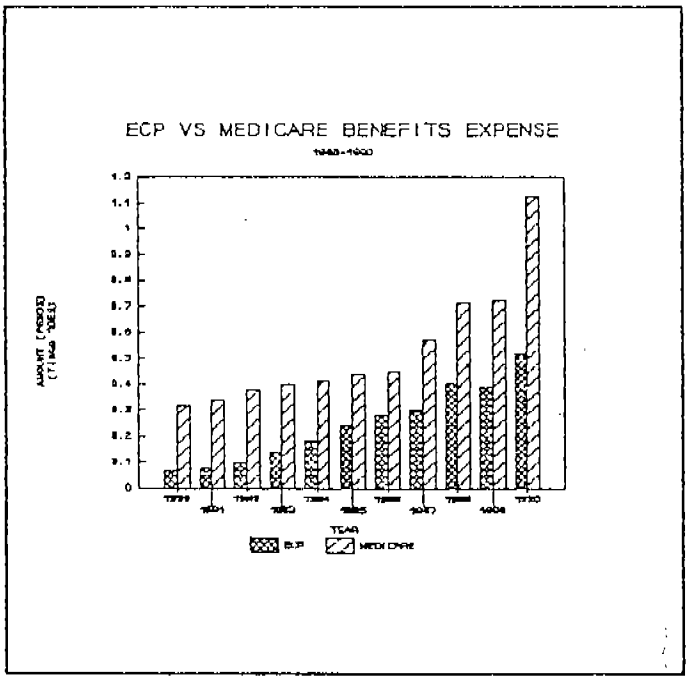
services (in addition to monthly cash income benefits) for permanent disability. Specifically, the beneficiary is entitled to an income benefit for temporary disability for every day of disability, or in the case of permanent disability or death, a lifetime cash income. Dependents receive income benefits only in cases of work-related deaths. Medical care includes hospital expenses, medicines, laboratory and x-ray examinations, nursing services and professional fees. It is roughly similar to Medicare, but provides higher benefits. Rehabilitation services cover medical-surgical services during confinement in an accredited hospital, vocational training, medical appliances, subsequent domiciliary care by an accredited physician, and medicines.

Figure 65



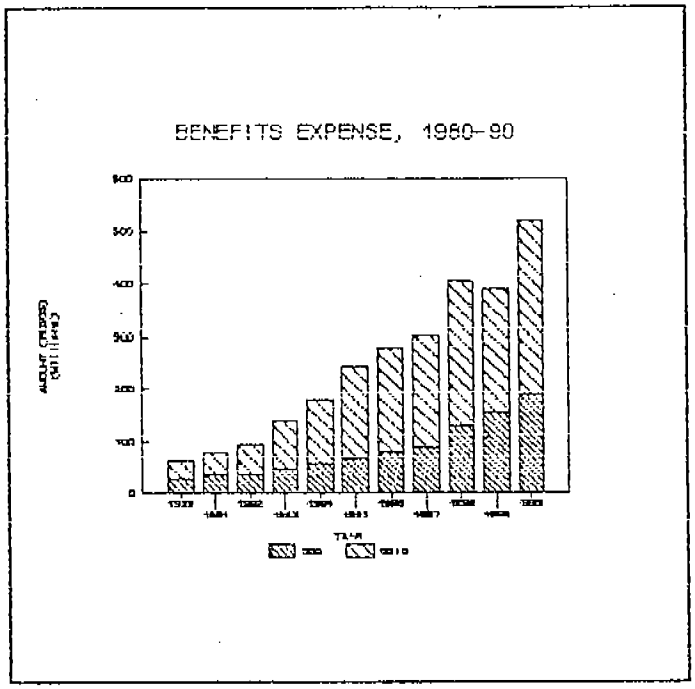
Data obtained in Gamboa (1991) show that among the various categories of ECP in-patient services, demand for medical services is highest and averages about 28 percent of the total benefits expense. Payments for disability benefits add up to only 13 percent of the benefits expense, but are on the upswing. Rehabilitation services have a share lower than 1 percent, which is quite puzzling, since it is this particular feature which sets ECP apart from Medicare. Setting aside the cash outlays that may have gone to income support (which comprise over 60 percent of the total ECP benefits, according to the Gamboa study), the benefits expense of ECP shows a structure similar to that of Medicare. This indicates that if Medicare could introduce rehabilitation services in its benefit package, the ECP program could be cost-effectively integrated with Medicare. Consolidation of the two programs would also eliminate duality in payments now allowed by law (Gamboa, 1991). Since 1984, employees have been permitted to file both Medicare and ECP claims for hospitalization expenses

Figure 66



arising from work-related injury. GSIS had honored dual recovery claims since 1984; SSS, since 1989.

Figure 67



Benefit payments under the ECP ballooned from P66 million in 1980 to P520 million in 1990, an eight-fold increase over a decade (see Table 43 and Figure 66).The annual growth rate has been about 32 percent. On average, ECP benefits expense is about 30 percent of Medicare benefit payments (see Figure 67). Of the total ECP benefit expenditures, a bigger proportion comes from GSIS. That proportion is rising--GSIS expenses for benefits have grown by an average of 52 percent yearly. By contrast, SSS benefits expense has a growth rate of only 20 percent yearly. For SSS, ECP expenses are on average less than a fifth of Medicare disbursements on benefits, and have not exceeded 34 percent. With GSIS, there were years when ECP payments outstripped Medicare payments, but otherwise, since 1984, benefit payments for both ECP and Medicare have been almost equal to each other. Prior to 1984, the ECP benefit payments of GSIS were significantly lower than those of Medicare.

For both GSIS and SSS then, the annual increase in ECP benefit expenditures has outpaced the annual increase in ECP collection income considerably. This is starkly depicted in Figures 68 and 69. Note that GSIS has had a record of benefits payments exceeding its membership contributions, beginning in 1984. This has exerted tremendous strain on its collection income, especially in the absence of substantial investment earnings (see discussion on financial performance) that could cover the shortfalls arising from excessive benefit payments. SSS is on the opposite end, by contrast. It has exercised too much caution in granting benefits, which on average, have only been 41.7 percent of premiums collected. That has allowed SSS to build SIF reserves far more than what financial viability requires.

F. *Per capita benefits*

On the basis of per capita benefits, SSS has on average paid P1698.91 during the period 1980-1990 (Table 44). GSIS, on the other hand, paid P8707.87 on average, which is more than five times that of SSS. Gamboa (1991) surmises that two factors have contributed to this uneven benefit payment structure: (a) adverse selection is at work in GSIS, since it covers nearly all high-risk people, including military personnel and police forces; and (b) differing compensation formulae followed by the two systems. When the basis of payment is the average monthly salary credit, for example, SSS takes the average

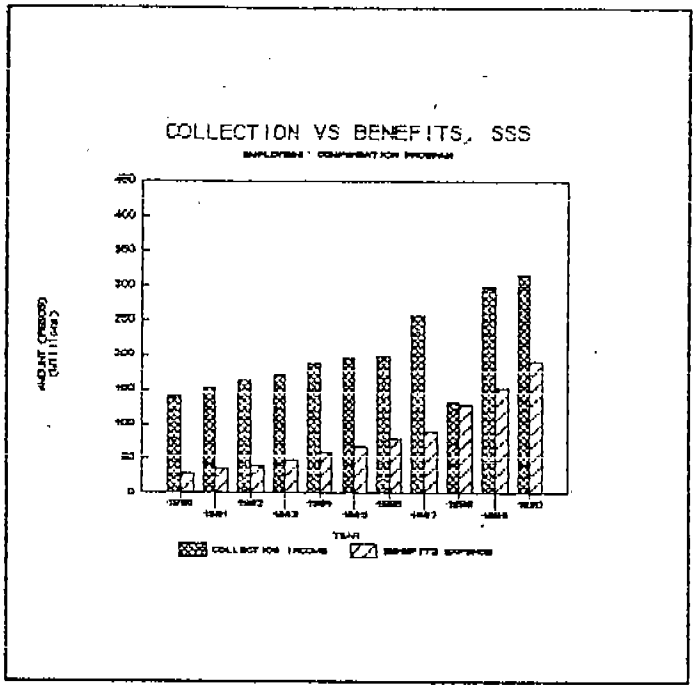
TABLE 43
EMPLOYEES' COMPENSATION PROGRAM
BENEFITS EXPENSE (In Thousands)

	SSS PAYMENTS			GSIS PAYMENTS			TOTAL PAYMENTS	
YEAR	AMOUNT	MEDICARE PAYMENTS	% TO MEDICARE	AMOUNT	MEDICARE PAYMENTS	% TO MEDICARE	AMOUNT	% TO MEDICARE PAYMENTS
1980	29297	203830	0.14	36800	114820	0.32	66097	0.21
1981	36462	214680	0.17	41500	125050	0.33	77962	0.23
1982	39306	251500	0.16	55600	128230	0.43	94906	0.25
1983	49407	259100	0.19	90300	141200	0.64	139707	0.35
1984	59027	241200	0.24	124700	173200	0.72	183727	0.44
1985	67623	265100	0.26	175700	174000	1.01	243323	0.55
1986	80381	280300	0.29	199400	170900	1.17	279781	0.62
1987	88668	350200	0.25	214100	224600	0.95	302768	0.53
1988	129000	474500	0.27	276891	239320	1.16	405891	0.57
1989	153500	449500	0.34	235784	276552	0.85	389284	0.54
1990	189900	710500	0.27	330216	416453	0.79	520116	0.46

Sources: CRC, ECC

salary of the employee over the last five years, while GSIS takes the average pay over the last three years. The lower compensation equation used by SSS does not seem to jibe with the fact that it holds proportionately the bigger chunk of ECP resources.

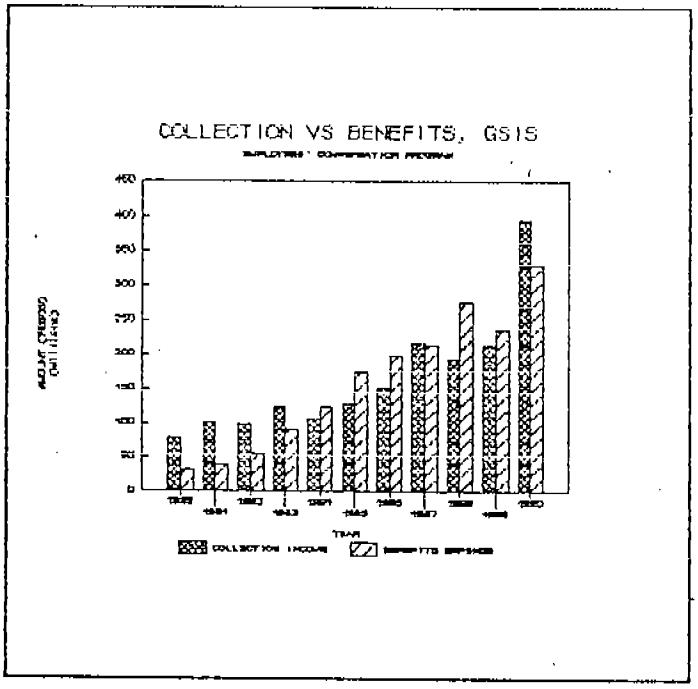
Figure 68



G. *Administrative costs*

Under the ECC-SSS-GSIS setup, all three agencies are allowed to charge their operating expenses for the program at no more than 12 percent of the ECP contributions and investment earnings. That is in marked contrast with the Medicare arrangements, where PMCC operational expenses are funded from the national budget, and are, strictly speaking, outside the 12 percent cap similarly imposed by the Medicare law. What ECC charges as its operating expenses is reflected as SSS or GSIS contribution to ECC operations, as shown in Table 45.

Figure 69



During the decade of the 80s, SSS consistently spent more, averaging P11 million annually compared with GSIS' P8 million yearly average. The cost per claim tells a different story, however. Except in 1987, GSIS has consistently outspent SSS many times over on a per capita basis. The average cost per claim within the period for SSS was P148.90. For GSIS, it was P477.24, which is more than three times that of SSS. If administrative expense is a function of the number of benefit claims, a lower volume of claims would cause a high administrative expense per claim. All things being equal (e.g., capability of both SSS and GSIS personnel assigned to handle ECP transactions), SSS appears to be more efficient than GSIS in handling ECP operations. Further research, however, into the wide gap in the cost per claim is warranted.

The contributions of the two systems to ECC operational expenses are

TABLE 44
ECP PER CAPITA BENEFITS

Year	SSS		GSIS	
	No. of claims paid	Benefit payment/ claim (pesos)	No. of claims paid	Benefit payment/ claim (pesos)
1980	71180	407.42	11751	2808.27
1981	83751	429.85	12687	3231.65
1982	94023	414.79	13433	4094.39
1983	86456	566.76	15813	5754.76
1984	72208	817.09	20013	6245.94
1985	52015	1307.32	24711	7081.87
1986	45443	1760.33	12875	15533.98
1987	39452	2255.91	22228	9582.51
1988	28013	4605.00	10593	11045.03
1989	54610	2810.00	n.d.	n.d.
1990	57310	3313.56	15216	21701.00

Source: ECC

TABLE 45
ECP ADMINISTRATIVE EXPENSE
(in million pesos)

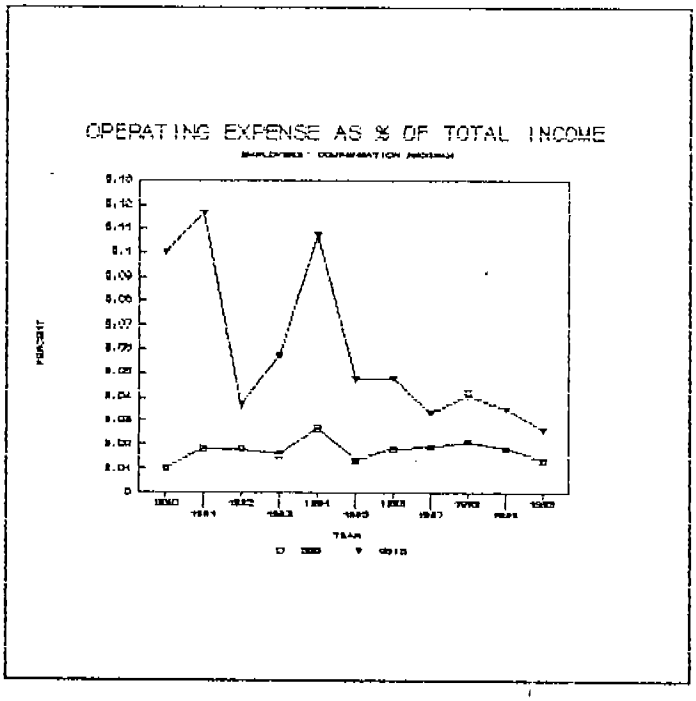
Year	SSS				GSIS			
	Admin. exp	Admin. exp/ claim	Contr. to ECC oper.	ECC oper/ claim	Admin. exp	Admin. exp/ claim	Contr. to ECC oper.	ECC oper/ claim
1980	2.3	8.43	1.4	19.67	8.4	714.83	1.0	85.10
1981	4.6	35.82	2.0	23.88	13.0	1024.67	1.0	78.82
1982	5.4	31.91	2.0	21.27	3.0	223.33	2.0	148.89
1983	5.6	34.70	2.0	23.13	7.0	442.67	2.0	136.48
1984	12.2	124.64	3.0	41.55	13.0	649.58	2.0	99.94
1985	10.4	115.35	5.0	96.13	5.0	202.34	2.0	80.94
1986	12.8	187.04	4.3	94.62	5.0	388.35	3.2	248.54
1987	13.3	228.13	4.3	108.99	5.5	224.94	2.5	112.47
1988	14.7	157.07	1.5	53.55	7.9	424.81	1.3	122.72
1989	19.5	357.08	*	*	8.7	n.d.	*	*
1990	20.5	357.70	*	*	11.6	761.70	*	*

Source: ECC
*Included in administrative expense

also shown in Table 45. Except in the years 1982-83 when both systems provided the same amount to ECC, SSS has shouldered considerably more of ECC's operational budget. The ECC cost per claim again reverses the picture, much like the system-based per capita expenses. ECC is absorbing more than twice of the costs originating from GSIS. On average, ECC operational costs per claim for GSIS have added up to P123.76, compared with ECC expenses per claim for SSS, which was lower at P53.64.

How did the two systems fare with respect to the 12 percent ceiling on operating costs? Adding the portion of the ECC operating budget contributed by a particular system to the administrative expenses of that system gives the total operating costs borne by that system. Normalizing costs by the agency's total ECP income, the outcome is as portrayed in Figure 70. For SSS, costs per income have averaged a low 2 percent; for GSIS, they have come up to 6 percent across the 1980-90 period. Thus, neither of the two systems has gone near the 12 percent cap in terms of administrative expense. SSS has managed likewise to reduce the fluctuations in administrative costs. The same is not true of GSIS, which came precariously close to the limit, once in 1981 when costs reached 11.7 percent of total income, and in 1984, when costs climbed to 10.7 percent of gross income. Containing both benefits expense and administrative costs is clearly a major problem of GSIS.

Figure 70



H. *ECC operations*

The ECC operates as a government-owned and -controlled corporation. That makes it quite unlike PMCC, which operates like a regular government agency. But ECC's statutory functions in relation with the ECP are similar to that of PMCC in relation with Medicare. The ECC performs the tasks of accreditation, monitoring, policy formulation, review of appealed cases, research (including actuarial studies) and public information.

ECC is substantially dependent on the two systems for its operating budget, and it is a matter of judgment whether ECC has a harder time dealing with its corporate financiers (that is, SSS and GSIS) than PMCC dealing with DBM. Such financial dependence is widely perceived as giving the two systems unwarranted policy influence over ECC. Yet as a GOCC, the ECC has been able to generate earnings distinct from its SIF-based revenues. Its profit and loss statement shows that in 1991, it earned a net income of P1.34 million. In 1990, its net earning was much higher, P7.82 million. These came mostly from

interest income from its own bank savings, certificates of deposit, treasury bills and other investments. Other income sources include rent income, insurance income and miscellaneous earnings like lease purchase of rehabilitation equipment and copying services. The assets of ECC include its building in Gil Puyat Avenue, Makati, which generates rent income, and a host of technical and scientific equipment.

Operating expenses for ECC in 1988-1989 have averaged P8.2 million. Comparing this with the level of PMCC expenditures, the latter spends a much higher amount for maintenance and operations. In 1991, for instance, the appropriated budget of PMCC is P32.7 million, which was thrice ECC's operating expense of P10.8 million for the same period.

ECC's workforce is currently 61. PMCC's is five times bigger at 300. Understandably, expenses for personal services were higher for PMCC. ECC spent P8 million for its personnel in 1991; PMCC spent P19 million. ECC's leaner staff does not mean it has a more efficient setup. As Table 46 suggests, ECC

TABLE 46
EMPLOYMENT COMPENSATION COMMISSION
DISTRIBUTION OF PERSONNEL, 1992

	FILLED-UP	VACANT	TOTAL
Commission proper	8	6	14
Secretariat			
Office of the Executive Director	3	0	3
Office of the Deputy Director	2	0	2
Internal Control Unit	1	1	2
Administrative Division	15	3	18
Finance Division	6	1	7
Legal Division	7	2	9
Medical Division	7	0	7
Public Information Division	8	3	11
Management Services Division	4	2	6
TOTAL	61	18	79

Source: ECC

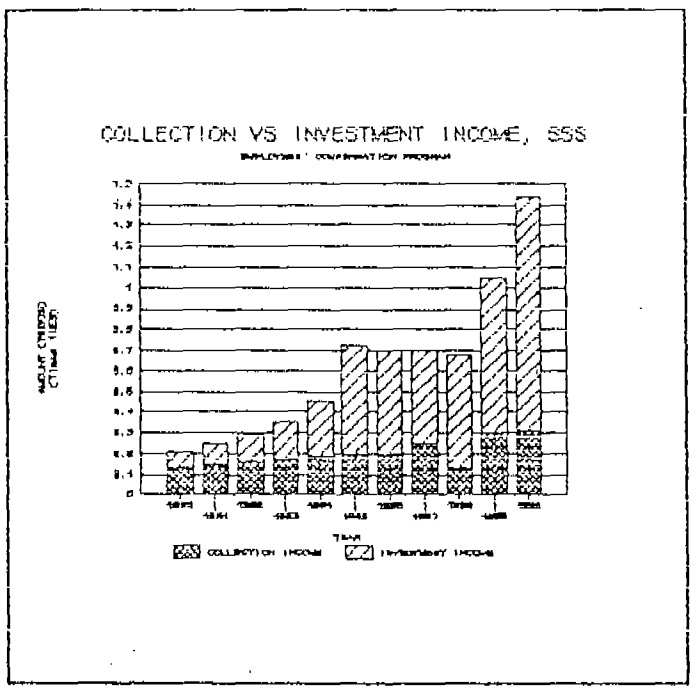
has a large administrative division, although it is not as bloated as that of PMCC. Both the legal and medical divisions are apparently understaffed, which makes deficiencies in monitoring and accrediting providers almost a certainty. Like PMCC, ECC has no resident actuary, and an extra lean management services division would suggest that MIS concerns are not adequately addressed. Interviews with ECC officials indicate that the build-up of technical personnel is hamstrung by civil service attrition rules. Like PMCC, ECC has not devoted resources for research and development. This lack is most clearly seen in the absence of epidemiological studies on injury/disability-causing factors in the workplace, such as industrial pollution and the presence of deadly chemicals.

I. *Financial performance*

SIF reserves have piled up incessantly, from P950 million in 1980 to P6.6 billion 1990, or more than twice Medicare's reserves. Much of this reserve buildup is being contributed by SSS, which accounts for about 93 percent of the total HIF fund. As in Medicare, SSS has steadily left GSIS by the wayside in terms of fund buildup, and it is safe to say that a GSIS-ECP bankruptcy would scarcely leave a dent in the SIF reserves. The growth in total incomes (see Figures 71 and 72; also Table 47) reflects the financial strength of SSS-SIF.

In 1980, SSS' ECP income was a little over twice that of GSIS (P211.5 million to P94 million); by 1990, it was more than thrice (P1.4 billion to P441 million). As in the case of Medicare, it is the phenomenal pickup of SSS investment income that is fueling the growth of the SIF. At the beginning of the 80s, investment earnings for SSS accounted for only a third of total income; at the close of the decade, about three-fourths of total earnings came from investment income. The opposite is true for GSIS, and in a worse way (Table 48). In the early eighties, from a fifth to a third of its aggregate income was supplied by investment income. This went down to an even lower proportion (10 to 12 percent) in the late eighties. This was due mainly to the excesses in benefit payments, which left GSIS with no investable funds. On the other hand, the benefits expense of SSS has only been about 15 percent of collection income.

Figure 71



GSIS' net insurance gain, shown starkly in Figure 73 (see also Table 48) has been negative throughout 1980-90, strongly suggesting that a large volume of claims had been eating up GSIS-SIF reserves. SSS, on the other hand, had steady underwriting proceeds, and was on the losing end only once, in 1988 (see Table 47). A corroborating picture is presented by the two systems' net income (see Figure 74).

Finally, to test how long the SIF will last if the reserves were used up without replenishment, the reserve capacity of each system was calculated. Figure 75 graphically illustrates the situation. For GSIS-ECP, reserve capacity has declined precariously from 6.3 years in 1980 to just 1.4 years in

TABLE 47
EMPLOYEES' COMPENSATION PROGRAM
SOCIAL SECURITY SYSTEM
REVENUES AND EXPENSES (In Millions)

	REVENUES						EXPENSES			RESERVES	
YEAR	MEMBERS CONTRI.	% of TOTAL REVENUE	INVESTMENT INCOME	% of TOTAL REVENUE	OTHERS	TOTAL	TOTAL DISBR.	NET INSURANCE GAIN	NET INCOME AMOUNT	SHARE IN TOTAL SIF	RESERVE CAPACITY
1980	141	0.67	69.5	0.33	1.0	211.5	31.6	109.4	179.9 681	71.62	21.55
1981	153	0.61	96.5	0.39	0.6	250.1	40.8	112.2	209.3 889	71.55	21.79
1982	163	0.55	131.9	0.45	0.9	295.8	44.7	118.3	251.1 1142	74.27	25.55
1983	173	0.50	173.4	0.50	1.1	347.5	55.0	118.0	292.5 1435	77.61	26.09
1984	187	0.41	268.5	0.59	0.9	456.4	71.2	115.8	385.2 1820	78.51	25.56
1985	196	0.27	535.7	0.73	0.8	732.5	78.0	118.0	654.5 2475	84.22	31.73
1986	198	0.28	498.3	0.71	0.8	697.1	93.2	104.8	603.9 3067	88.24	32.91
1987	257	0.37	438.5	0.63	1.3	696.8	102.0	155.0	594.8 3662	90.00	35.90
1988	131	0.19	548.5	0.81	0.3	679.8	143.6	−12.6	536.2 3972	91.15	27.66
1989	298	0.28	756.1	0.72	2.3	1056.1	173.0	124.7	883.1 4855	92.84	28.06
1990	314	0.22	1120.5	0.78	0.4	1434.9	210.4	103.6	1224.5 6079	92.73	28.89

Source: ECC

TABLE 48
EMPLOYEES' COMPENSATION PROGRAM
GOVERNMENT SERVICE INSURANCE SYSTEM
REVENUES AND EXPENSES (In Millions)

	REVENUES					EXPENSES			RESERVES	
YEAR	MEMBERS CONTRI.	% of TOTAL REVENUE	INVESTMENT INCOME	% of TOTAL REVENUE	TOTAL	TOTAL DISBR.	NET INSURANCE GAIN	NET INCOME AMOUNT	SHARE IN TOTAL SIF	RESERVE CAPACITY
1980	78	0.83	16.0	0.17	94.0	42.4	−13.1	67.0 269	28.28	6.34
1981	101	0.84	19.0	0.16	120.0	55.0	−16.8	57.2 354	28.45	6.44
1982	99	0.73	37.0	0.27	136.0	60.0	−20.7	58.3 395	25.73	6.58
1983	126	0.80	32.0	0.20	158.0	100.0	−50.6	18.0 414	22.39	4.14
1984	107	0.76	33.0	0.24	140.0	140.0	−81.0	−24.2 498	21.49	3.56
1985	130	0.88	18.0	0.12	148.0	183.0	−115.4	−65.0 446	15.28	2.44
1986	153	0.89	19.0	0.11	172.0	207.2	−126.8	−102.4 409	11.76	1.97
1987	218	0.97	5.8	0.03	223.8	221.5	−132.8	−66.5 415	10.00	1.87
1988	193	0.86	30.7	0.14	223.7	286.2	−157.3	−298.8 371	8.85	1.30
1989	215	0.87	31.7	0.13	246.7	244.7	−91.2	−120.0 374	7.16	1.53
1990	394	0.89	47.0	0.11	441.0	341.6	−151.7	−238.0 476	7.27	1.39

*Incorporated with Admin. Exp.
Source: ECC

Figure 72

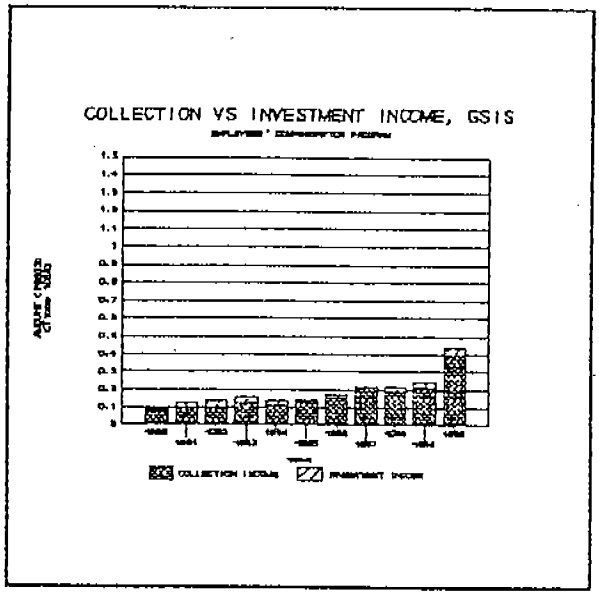


Figure 73

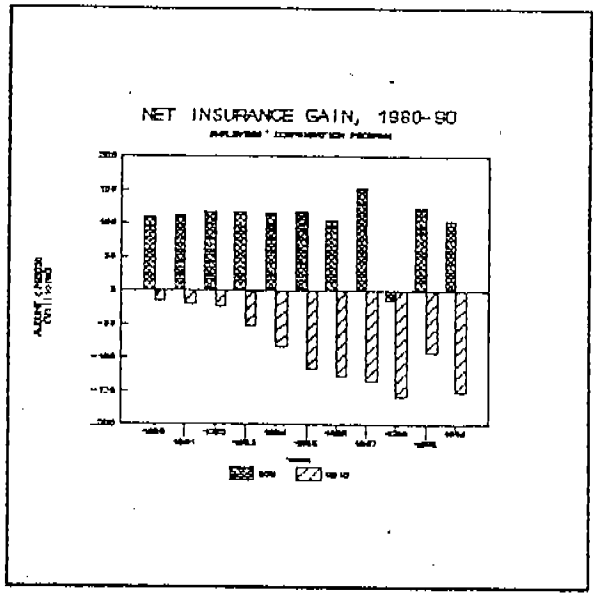


Figure 74

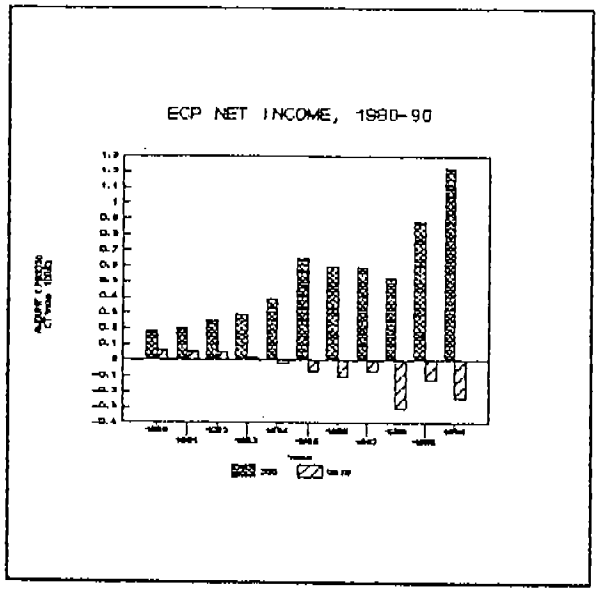
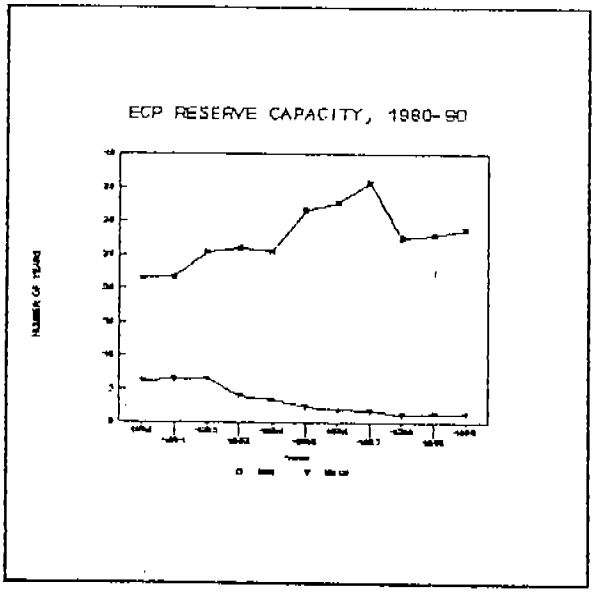


Figure 75



1990. It is clearly unsustainable. By contrast, SSS-ECP's reserve capacity, already uncomfortably high at 21.5 years in 1980, has swelled to 28.9 years(!) in 1990. That is unjustifiably excessive, by any standard. Reforms are without doubt necessary. SSS can considerably reduce its high SIF reserve levels by enlarging the scope of ECP benefits (although this will exacerbate the dual benefit structure) or by considering cross-subsidies to GSIS beneficiaries.

Table 49 summarizes the major features of both the ECP and the Medicare program.

TABLE 49
COMPARATIVE TABLE OF MEDICARE AND ECP

INDICATORS Legal Mandate	MEDICARE R.A. 6111 of 1969	ECP P.D. 626 of 1974
Administering Agencies	Philippine Medical Care Commission (PMCC) Social Security System (SSS) Government Service Insurance System (GSIS)	Employees' Compensation Commission (ECC) Social Security System (SSS) Government Service Insurance System (GSIS)
Nature of Lead Agency	PMCC – Government Agency with Allocation fron National Budget	ECC – Government Owned and Controlled Corporation (GOCC)
Functions of Lead Agency	PMCC – accreditation, monitoring, policy formulation, review of appealed cases, research and planning	ECC – accreditation, monitoring, policy formulation, review of appealed cases, research and planning
Governing Body of Lead Agency	PMCC – Board of Commissioners Chairman, Sec. of Health Vice–Chairman and Administrator, Undersecretary of Health Members: Administrator, SSS Gen. Manager, GSIS Sec. of Finance Sec. of DILG Sec. of DOLE Pres. of Phil. Medical Association Pres. of Phil. Hospital Association 2 private sector reps.	ECC – Board of Commissioners Chairman, Sec. of DOLE Members: Administrator, SSS Gen. Manager, GSIS Chairman, PMCC 2 reps. from employees and employers
Collecting and Disbursing Agencies	GSIS and SSS	GSIS and SSS
Fund Management	GSIS and SSS	GSIS and SSS
Membership Base	GSIS and SSS members	GSIS and SSS members
Mode of Payment	Compulsory salary deduction and employers' counterpart	Compulsory employers' contribution only
Beneficiaries	Medicare member and dependents	ECC member; dependents entitled only to cash income benefits in case of death
Benefits	Medical and dental services	Medical and/or related service for work–connected injury or sickness; rehabilitation services for permanent disability; cash income benefits for disability or death
Sources of Revenues	Premium Collections and Investment Income	Premium Collections; Investment Income; Rent Income
Reserves	1991: GSIS – P 749.992 M SSS – P 2,265.493 M	1990: GSIS – P 441 M SSS – P 1,434.9 M
Operating Expenses	PMCC – National Budget Allocation GSIS & SSS – not more than 12% of Medicare Fund 1991: PMCC – P 20.49 M SSS – P 86.64 M GSIS – P 11.18 M TOTAL – P 118.31 M	ECC, GSIS, and SSS – not m than 12% of EC fund 1991: ECC – P 10.822 M SSS – P 20.5 M GSIS – P 11.590 M TOTAL – P 42.912 M
Workforce	PMCC – 300 SSS – 65 GSIS – 72	ECC – 61 SSS – 77 GSIS – 62

J. Some conclusions

That ECC draws its resources from the SIF and to a lesser extent from its own investments proves that drawing from funds external to the ECP is unnecessary. That opens the same possibility for PMCC. If PMCC expenses could be absorbed by the HIF, a significant budgetary outlay could be freed for other purposes, such as primary health care. The tradeoff is further erosion of autonomy in policy and decision-making, as the organization would become more dependent on the two systems. Right now the practice of the two systems to release funds to ECC on a quarterly basis is contributing to a ECC budgetary squeeze.

A major finding is that the behavior of the costs incurred by both Medicare and the ECP follows an almost similar pattern. Both the HIF and the SIF of GSIS demonstrate overutilization of funds. Medicare and ECP funds resident in SSS are largely underutilized. For both funds, SSS has been the more dominant of the two systems. Differences in fund utilization have been largely institutional in character. SSS has proven to be a cautious and conservative financial institution; GSIS has been more of a generous "spender," although this must be qualified somewhat by widely held perceptions that it is fraud rather than financial liberality which has compromised GSIS' viability. If anything, the nearly identical pattern of unsustainable utilization of two different funds in GSIS illustrates the hard road ahead for GSIS to attain scale economies. For SSS, the challenge is to reduce its unreasonably high reserve levels by making available to private sector workers more benefit packages.

Coupling ECC benefits with Medicare benefits means taking a hard look at ECC services that ideally could be part of the Medicare program. ECC's medical and rehabilitative services are the logical candidates for inclusion in Medicare. That would not only eliminate double recovery of benefits currently practiced by both public and private employees hospitalized for work-related injuries, it would also streamline the whole medical insurance setup and lessen transaction costs. For that matter, many of the regulatory functions that both PMCC and ECC perform independently of each other, such as accreditation (also done by DOH) and monitoring of providers, can likewise be cost-effectively combined under a single jurisdiction. Putting research and development, a largely neglected area within the health insurance system, under one operational roof would also produce breakthroughs that would confer efficiency to the whole system. Over the long haul, combining the HIFs of the two systems, and likewise their SIFs, and then again consolidating both in a single fund within a unified PMCC-ECC setup, would make both economic and administrative sense.

XIV. CONSIDERATIONS ON ALTERNATIVE OPERATIONAL STRUCTURES

The manner by which Medicare is managed can have important effects on the quantity and quality of medical care provided, and the efficiency and equity with which scarce resources are utilized. Under the current setup, Medicare is besieged by conflicting pressures rooted in resource allocation inefficiencies and administrative bottlenecks. In particular, its GSIS program segment is faltering in its struggle to contain costs in the face of increasing benefits expense and declining reserves. At SSS, conservative fiscal policies tend to limit health gains by Medicare beneficiaries. PMCC's feeble authority

and influence within the Medicare organizational structure compound the problem.

Conceptually, the issues of resource allocation, financing and administrative efficiency are intertwined with each other and with existing organizational structures. It is not feasible to deal with the one effectively in operational situations without simultaneously zeroing in on the others. One would want to know how the various pieces of the puzzle fall into place. Yet, the only practical thing to do is to begin with a key aspect of a larger problem. Perhaps the key aspect that weaves through the various strands of Medicare is "restructuring."

This section then examines the arguments for and against the major options in reconfiguring Medicare available to health policy makers, and proposes priorities for action and for research. Evidence compiled in this study suggests that the prevailing setup, in which the Medicare fund is divided between two financial intermediaries (GSIS and SSS) with differing priorities and past performances, and in which the main developmental body (PMCC)is more at ease performing regulatory functions, is inadequate for either present Medicare needs or future requirements. These alternatives answer the question: how can Medicare best be structured to reinforce desired incentives?

From an efficiency standpoint, incorrect incentives are encouraged by the current institutional arrangements. All three institutions behave in a fashion that does not minimize resource misallocation (high cost of collecting premiums, excessive reserve levels, lack of scale economies, difficulty in controlling excessive benefits expense) and administrative inefficiencies (weak PMCC management, underspending by the commission, claims processing backlogs). This is aggravated by exogenous factors such as civil service/DBM constraints and cost-ineffective congressional interventions. From an equity standpoint, existing inequalities in the distribution of health resources are exacerbated by the current institutional arrangements. Medicare accreditation patterns, for example, have failed to redistribute providers to favor disadvantaged groups. Beneficiaries either have to travel far to reach tertiary hospitals or risk being confined in primary clinics offering low quality services.

A. *Alternative structures*

Several options exist which could alter the way Medicare is overseen and managed. A central topic in debates on Medicare reforms is the merging of the two HIF funds--and since consolidation has to take place outside either SSS or GSIS, their management by a third party, preferably a restructured PMCC. Arguably, this alternative is "loaded" with benefits. It could effectively rescue the GSIS Medicare fund, which by all accounts, has fallen on difficult times because of burgeoning cost burdens. It could streamline claims processing, and avoid costly backlogs. It could also strengthen PMCC, allowing the commission to reclaim many policy initiatives and reverse prevailing trends. The new structure will conceivably remove dualities in per capita benefit payments and administrative expense, reduce adverse selection by distributing risk more evenly, and maintain a better symmetry between the benefit structure and the pattern of premium collections--thus attaining the dream of national solidarity. Perhaps an equally important gain would be a

sustained attack on "rent-seeking," with the unified institution being able to orchestrate hitherto disparate efforts on monitoring providers and imposing appropriate sanctions. Financially, neither SSS nor GSIS will be severely affected by the pullout of the Medicare funds: the SSS-HIF constitutes only 10 percent of the total SSS trust funds; the GSIS-HIF, only 8 percent.

A consolidated fund and a single Medicare institution should also be able to widen coverage to include segments of the population that do not have sufficient protection against the high costs of medical care or are unable to access the supply of medical resources. At present, approaches to increase the extent of population coverage are unsystematic and unrelated to each other. It is unclear which has the responsibility--SSS or PMCC--to wage a promotional campaign that could attract the self-employed. Instead, the two institutions have gone their separate ways in launching programs for non-wage earners. SSS merely included the self-employed in its existing social insurance scheme, a multi-coverage arrangement where Medicare is only a small component, and which is affordable only to urban based constituents. PMCC has a sluggish, rural based Medicare II program whose benefits are limited to primary-type medical services. Combining efforts through a single institution to reach out to the uncovered population would reduce transaction costs, realign benefit packages to serve the rural poor, and eliminate duality in services.

These are compelling reasons for a merger, and the minuses are few. A frequently cited objection to fund consolidation concerns ownership questions. The contention is that SSS funds are a property of private sector employees and employers, and enforcement of the one-fund concept could draw Medicare into legal entanglements. A single fund also raises questions about rewards and punishment: should SSS be penalized, despite good behavior, by pulling out its Medicare fund?

A variation of the one-fund idea is the proposal to integrate the SIF into the HIF. This would raise the potential gain a notch higher, and would remove what could be the remaining source of dualities. It would also eliminate double recovery claims and rationalize in one sweep the benefit structure with the absorption into the system of rehabilitation and ambulatory services. It would also make possible the integration of three separate licensing and accreditation processes, perhaps one of the most wasteful practices in the health sector. That DOH, PMCC and ECC have to independently accredit providers and health professionals makes neither economic nor administrative sense. In the final analysis, the syndicated PMCC-ECC setup, as proponents argue, might serve as the nucleus of a truly comprehensive national health plan since it will have all the elements required for supplying adequate medical services to a wide segment of the population.

Much can be learned from past experiences on the one-fund concept. The Pag-ibig fund is one such program whose major institutional features could be traced analytically. The Pag-ibig fund is a provident fund dedicated to housing and development financing. It also provides provident benefits (retirement, death, disability) to its members, a feature that should be looked into since it might have significant overlaps with the ECP. Like Medicare, Pag-ibig draws on the same wage-earning population for its coverage base and has an existing Pag-ibig II program (in the fashion of Medicare II). Unlike Medicare, Pag-ibig combines under a single setup all the functions of policy making, collection, monitoring, fund management and claims processing. Although

cursory evidence shows that the Pag-ibig fund has some of the adverse features of SSS-HIF (e.g., high investment and reserve levels, low benefits expense), many lessons can be learned on how efficiently it delivers provident-type services. Of particular importance is also the way it is able to maintain, until recently when Pag-ibig fund contribution was made compulsory, the voluntary nature of its membership--an aspect that could provide valuable insights for Medicare II. Still another feature of Pag-ibig is the fact that the public wage sector accounts for 80 percent of total membership. Its coverage base is thus roughly similar to that of GSIS. Yet Pag-ibig has been a profitable venture while the GSIS-HIF continues to flounder financially.

Another set of alternatives puts the spotlight on public/private mixes (not taken up in this study, however). A deliberate move to engage the services of private health care intermediaries, such as health maintenance organizations, or HMOs, can substantially influence the ease with which efficiency in the delivery of medical services can be enhanced, and costs contained. Medicare in fact experimented with an HMO tie-up, and the lessons learned are still being evaluated. The incentive effects of the PMCC-HMO linkage were purportedly similar to health care privatization, but without anything approximating a private/public role realignment.

Still another cluster of options deals with incremental reforms. A little initiative here and there, according to advocates, would be more practical (or politically feasible, if enabling legislation were required) and would lend itself much more easily to implementation. This line of reasoning recognizes explicitly that Medicare is a highly entrenched system that has evolved a life of its own and is generally resistant to change. It would be more cost-effective to focus on small components that are vulnerable to second-best improvements and to keep big slippages at bay. While this strategy might yield significant progress in some areas without considerable losses elsewhere, its weakness is that small initiatives would not always lead to overall improvements in efficiency.

B. *Reviewing the options*

In making choices, the concern is to make sure the most crucial concerns are answered when alternatives are evaluated. The single most important question is, how would the efficiency of services be affected? One would want to know whether the alternative could guarantee that the quality of service is upgraded, and the quantity improved. Equally important is the extent of population coverage. Each new context (practicality of objectives, political feasibility, ease of implementation, sustainability, flexibility over time, etc.) might call for different handling and must be appraised in its own right.

For the one-fund concept, many of the arguments for it appear solid in light of the evidence presented in this study. It is a standard yardstick of sorts, and departures from it will have to be rigorously justified. Yet it cannot be automatically assumed that it would be a politically viable proposition. That is an area requiring further research. Various stakeholders' interests in Medicare are not exactly coincident, and closing the gap is a big challenge for reformers. There is little evidence the disagreements have lessened. Promotional effort will have to be initiated and sustained to win over or neutralize many of its detractors. On the HIF-SIF

consolidation, issues relating to political feasibility would be even more daunting. It is still a long road ahead for concrete practical and politically acceptable recommendations. The same is true for the Medicare-HMO tie-up wherein the complex of administrative efficiency issues surrounding public/private roles, adverse selection, and the structure of financing should first be untangled and sorted out (this is a topic for separate research).

Overall, it probably would make sense to begin reasonably with reforms that arrest the drift toward greater inefficiencies (but not end with them, as incrementalism suggests), and approach the more difficult, underlying issues with great care. Given what is known now, there is enough basis for making progress in the direction of the one-fund concept; the initial steps to be undertaken will help in gathering additional data needed in pursuing that direction. That leaves the actual job of charting the next crucial steps to a subsequent research effort.

C. *Filling research gaps*

The shortcomings of current research studies, including this one, points to further inquiries in a diverse set of areas. As already mentioned, much can be distilled from past experiments with the one-fund concept, such as the Pag-ibig Fund. This issue is politically sensitive, and even investigations along this line may be resisted by some Medicare stakeholders. Nevertheless, progress in clarifying one-fund issues is badly needed, and should not be postponed.

Some of these research priorities might help:

(1) Studies should be conducted which examine the critical elements of a national health insurance plan and determine whether Medicare has the key attributes that could accelerate efforts toward that goal. The practical consequences of unifying Medicare should be modelled, so that the generalizable features accounting for the success or failure of the new setup could be predicted with reasonable accuracy, especially in terms of its implications for equity and efficiency. Staffing, funding, timing, organization and management are crucial factors to consider.

(2) A stakeholder analysis might prove useful in charting the levels of support and resistance that might ensue from seriously pursuing the one-fund concept. That would guide health policymakers in designing strategies that would beef up advocacy of and support for consolidation and substantially neutralize opposition to the one-fund idea.

(3) Sustained effort must be exerted to improve the Medicare information system. The serious lack of baseline data, sufficiently disaggregated to permit micro analysis, is hampering a better understanding of the workings of Medicare. Data reporting and organization suffer from time-lags, inconsistencies and fragmentation. Electronically-linking the Medicare system (PMCC, SSS, GSIS) through a local area network, or LAN, would be a significant step in improving baseline information, and would facilitate the clarification of some of the intractable issues facing the one-fund concept.

XV. SUMMARY OF MAJOR FINDINGS AND CONCLUDING REMARKS

This final chapter summarizes the most important findings and conclusions of the study.

Enrollment

(1) In its 20 years of implementation, Medicare has managed to cover only 38 percent of the population. This is attributed to the concentration of membership on the wage sector, namely the industrial and service sectors through SSS and the public sector through the GSIS. Even among wage-earning population, Medicare has yet to reach a larger number of uncovered employees.

(2) The self-employed and the informal sector remains a wide area of opportunity for the program to cover, and efforts to reach them have been minimal.

(3) The growth of Medicare membership has been slow. Through the years, the growth in the labor force has outpaced the growth in Medicare membership. More than 80 percent of the working population has not been reached by Medicare.

Access to Medicare services

(4) Where access to Medicare means access to affordable and effective high quality medical care, inequitable distribution of providers, by location or region, persists. The goal to equalize access by making sure a sufficient number of facilities and physicians in each region has not been reached. The Cordillera and Western Mindanao regions have lagged behind other regions like the National Capital Region, Central Luzon and Southern Tagalog.

Claims processing

(5) The SSS and the GSIS follow similar procedures in the processing and payment of Medicare claims prescribed by PMCC. Owing to its larger active membership base of about 4 million salaried employees and the self-employed, the SSS uses a decentralized system of processing. By contrast, GSIS employed a centralized system principally because of a smaller membership base of 1.5 million in the public sector.

(6) GSIS experiences backlogs in its processing by as much as two months. The volume of claims of 2,000 per day is overmatched with a capacity of only 200 claims completely processed per day. By contrast, SSS has no stockpile of unprocessed claims.

Medicare fund management

(7) The SSS and the GSIS have gone to extremes in the management of the Health Insurance Fund. The SSS-HIF is *too* well managed while the GSIS-HIF is poorly managed. Anywhere from two-thirds to three-fourths of the fund is accounted for by SSS, a factor that has allowed it to enjoy economies of scale and post high underwriting gains. In turn, underwriting windfalls have enabled SSS to deepen its investment income base, which now accounts for half of the

its HIF yearly gross revenues. While this development secures the SSS-HIF against erosion due to inflationary medical care costs, the downside has been the buildup of reserves that are too high by actuarial standards--the reserve capacity stands at about five years-- especially considering that health insurance is claims-intensive.

(8) The GSIS-HIF, on the other hand, was locked in unprofitable investments early on, a factor that led to underwriting losses and a weak investment income buffer. The GSIS fund would not last another year in terms of its reserve capacity.

(9) Both Medicare funds have been accumulating large receivables. Collection efficiency for both has been on the decline, especially with the GSIS-HIF. The SSS-HIF is slightly ahead in terms of other financial indicators such as liquidity, debt-to-assets ratio, and return on investments. The disparity in the financial management record of the two systems raises disturbing questions on economies of scale. GSIS may have a difficult time reaching size economies, given that its market--the public wage sector--is a small one. In any case, maintaining two separate but identical bodies makes no economic sense.

Financial viability and fund utilization tradeoffs

(10) Benefits payments are the single biggest expense of the HIF. Between the two systems, the SSS gives higher benefits per recipient but it is the GSIS which has given benefits to a higher percentage of Medicare eligibles within its own coverage base or as much as twice that of SSS. Overall however, the number of people who received Medicare benefits for the period 1980-91 rose only slightly by a measly 1.4 percent.

(11) The growth rate of benefit expense on a per recipient bases--17.3 percent for SSS and 16.2 percent for GSIS--should be compared with the growth rate of per capita operating expenses--40.2 percent for SSS and 5.2 percent for GSIS. Thus, for one-eighth of the price, GSIS could offer the same growth pattern in benefit payments. The cost of insurance as a proportion of premiums--a cost that is shouldered by Medicare enrollees is also substantially lower for GSIS members than for SSS members. It costs SSS members more to underwrite their medical care. This should be qualified somewhat by the widely-held perception that fraud has undermined the GSIS-HIF.

Accreditation and monitoring

(12) The accreditation system of PMCC depends substantially on the capacity of the DOH regional health officials to perform the evaluation of hospitals. PMCC's field staff--which is badly undermanned--perform only routine clerical and administrative tasks in the whole process. Medicare accreditation is based on DOH licensing standards, raising cost-efficiency questions as to why providers have to be subjected to more than one (three including a separate licensing performed by the ECC) accreditation process.

(13) PMCC accreditation seems to lack transparency. Appropriate norms on the number of medical personnel, number of beds, facilities, location, manpower and facilities-to-population ratios and other relevant indicators as reflected in the applications forms are not precisely determined.

(14) Evidence shows that PMCC can put under surveillance only about 15 percent of the total 1,543 Medicare-accredited hospitals throughout the country. Monitoring forms have no practical value for forecasting and trend extrapolation. Poor compliance in the submission of forms is compounded by an inadequate supply of qualified statisticians, actuaries and other technical personnel.

(15) With limited personnel in the field, monitoring is done through sampling on a quarterly basis, but there is no indication however that a proven statistical sampling technique is being followed. Budgetary constraints and lack of orchestration of efforts within the Medicare system hamper the monitoring system.

(16) Of more than 724 cases filed within the period 1981-1991, 472 were resolved for a yearly efficiency rate of 65 percent. Sanctions given to offending parties are disproportionately light. Major offenses have been confinement violations and false claims. Warnings and one to three month suspensions have been common resolutions.

(17) Overall, there is evidence that Medicare facilities are inappropriately used. Regression analysis shows that the larger the hospital capacity, the more tendency there is to lengthen the use of hospital time and space, often not by those requiring surgery and intensive care. Inefficient hospital use could as well be caused by a possible collusion between providers and patients in order to transfer even non-compensable costs to Medicare.

Administrative costs

(18) Only the GSIS and SSS can claim operational expenses from the Medicare Fund but not exceeding 12 percent of the total income. The PMCC has an annual allocation from the national budget. Neither GSIS nor SSS has ever exceeded the 12 percent cap. Most of the expenses go to salaries and wages, and few resources are devoted to monitoring and evaluation, much less to research and development.

(19) Between the two systems, SSS has experienced a higher level of administrative expenses. But differences in accounting procedures may somewhat bloat the SSS figures. Total costs have increased for the entire system by 370 percent between 1980-91. SSS has disproportionately contributed to the pattern of increases.

(20) When the annual appropriations of PMCC are included in the costs, total costs would still be below the 12 percent ceiling. If the operating expenses of both SSS and GSIS are combined, costs would average 3.2 percent of total income. With PMCC included, it would be 4.3 percent.

(21) On a comparative basis, the cost of processing each claim was higher in SSS. The cost per claim in 1990 was six times higher in SSS than in GSIS; it was almost three times more in 1989.

(22) PMCC has consistently been spending below the level of appropriations. Such a record would make it difficult for PMCC to justify any increases in its annual appropriations.

Capacity of PMCC to handle expanded coverage

(23) PMCC is nominally the focal point of the Medicare program but in practice lacks clout and authority, except in purely regulatory functions such as accreditation and monitoring. It has neither planning nor fiscal powers, which have been delegated to SSS and GSIS. In practice, it is the SSS and the GSIS which supervise the direction and economic consequences of the management of the HIF, thus giving them undue leverage over policy.

(24) Internally, PMCC is saddled with a weak management structure (power rests on a governing board of part-timers), parallel structures that increase red tape and raise administrative costs, and a thin layer of technical personnel (the ratio of technical personnel to administrative personnel is 1:3) which does not even include actuaries, insurance economists, R & D experts and planners. PMCC is hampered by exogenous factors such as the CSC attrition law and budgetary constraints.

(25) Despite constraints, PMCC has started piloting small Program II projects in Bauan, Batangas in 1983, in Unisan, Quezon in 1984, in Nueva Valencia, Guimaras in 1985, and in Laguna in 1992. The scheme involves LGU participation through the municipal treasurer who handles the collection and disbursement of funds in coordination of the PMCC field staff and DOH. High support value has been a hallmark of the pilot projects but this is explained by the fact that members avail only of drugs and to a very limited extent, primary health care services. Expansion has been slow due to problems of economies of scale, the difficulty of devolving functions to local officials, and the administrative complexities of handling small but numerous projects scattered throughout the country. PMCC will require an appropriate organizational overhaul in order to be the lead agency for Medicare II. In its present organizational condition, it will be difficult for PMCC to respond to Program II on a full scale level.

Employees' Compensation Program

(26) The Employees' Compensation Program offers medical or related benefits for any work-related injury or sickness. Unlike Medicare, the ECP covers work-connected disability or death, and provides income benefits. The State Insurance Fund is to the ECP as the HIF is to the Medicare program. Unlike in Medicare, The SIF is fully borne by the employer. Like the Medicare fund, the SIF is accumulated in two separate accounts in GSIS and SSS.

(27) Theoretically, the membership base for both ECP and Medicare must be identical, or close to being the same. SSS-ECP members outnumber Medicare members by more than two to one. Because of the disparity in the SSS membership base. ECP covers about half of the total employed force in the country, compared to Medicare's 22 percent.

(28) SIF collections have been about 55 of HIF collections on average. GSIS has been the source of the overall growth momentum of the SIF, although the GSIS fund is only about half the SSS HIF. On average, ECP benefits expense is about 30 percent of Medicare benefit payments. Of the total ECP benefit expenditures, a bigger proportion comes from GSIS. For both GSIS and SSS, the annual increase in ECP benefit expenditures has outpaced the annual increase in ECP collection income considerably.

(29) Under the ECC-SSS-GSIS setup, all three agencies are allowed to charge their operating expenses for the program at no more than 12 percent of the ECP contributions and investment earnings. During the decade of the 80s, SSS consistently spent more, but GSIS has consistently outspent SSS many times over on a per capita basis. SSS has shouldered considerably more of ECC's operational budget. Neither of the two systems has gone near the 12 percent cap. PMCC's workforce is five times bigger at 300. ECC has a large administrative division, although it is not as bloated as that of PMCC.

(30) As in the case of Medicare, it is the phenomenal pickup of SSS investment income that is fueling the growth of the SIF. GSIS-ECP reserve capacity shows that it is unsustainable. By contrast, SSS-ECP's reserve capacity is uncomfortably high at 28.9 years(!) in 1990. That is unjustifiably excessive, by any standard.

(31) Coupling ECC benefits with Medicare benefits means taking a hard look at ECC services that ideally could be part of the Medicare program. ECC's medical and rehabilitative services are the logical candidates for inclusion in Medicare. That would streamline the whole medical insurance setup and lessen transaction costs. Over the long haul, combining the HIFs of the two systems, and likewise their SIFs, and then again consolidating both in a single fund within a unified PMCC-ECC setup, would make both economic and administrative sense.

Considerations on alternative operating structures

(32) Consolidation could effectively rescue the GSIS Medicare fund. It could streamline claims processing, and avoid costly backlogs. It could also strengthen PMCC, allowing the commission to reclaim many policy initiatives and reverse prevailing trends. The new structure will conceivably remove dualities in benefit payments and administrative expense, reduce adverse selection by distributing risk more evenly, and maintain a better symmetry between the benefit structure and the pattern of premium collections. There would be a sustained attack on "rent-seeking," with the unified institution being able to orchestrate hitherto disparate efforts on monitoring providers and imposing appropriate sanctions. A consolidated fund and a single Medicare institution should also be able to widen coverage to include uncovered segments of the population. It would also make possible the integration of three separate licensing and accreditation processes, perhaps one of the most wasteful practices in the health sector. In the final analysis, the syndicated PMCC-ECC setup, as proponents argue, might serve as the nucleus of a truly comprehensive national health plan.

(33) In making choices, the concern is whether the alternative could guarantee that the quality of service is upgraded, and the quantity improved. Equally important is the extent of population coverage. Each new context (practicality of objectives, political feasibility, ease of implementation, sustainability, flexibility over time, etc.) might call for different handling and must be appraised in its own right.

(34) For the one-fund concept, it is a standard yardstick of sorts, and departures from it will have to be rigorously justified. Yet it cannot be automatically assumed that it would be a politically viable proposition. That is an area requiring further research. Various stakeholders' interests in Medicare are not exactly coincident, and closing the gap is a big challenge for

reformers. It is still a long road ahead for concrete practical and politically acceptable recommendations.

Concluding remarks

Some of the research priorities have been outlined in the preceding section. But although research is desperately needed in order to settle some of the more crucial question on unifying Medicare, delays in the research process need not lead to interruptions in policy. Making a few significant changes (e.g., harmonizing the SSS and GSIS accounting systems, electronically linking the management information system of the two institutions and PMCC, removing dualities in the benefit payment structure) would create efficiencies which outweigh the costs of non-action. Indeed, even in the case of policy-oriented studies that deal with the bigger issues of integration, it does not make sense to wait for the outcome before embarking on major policy changes. Research must "chaperon" policy rather than come before it.

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