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A PROPOSED MONITORING SYSTEM AND EVALUATION PLAN FOR PHILHEALTH PLUS

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A PROPOSED MONITORING SYSTEM AND EVALUATION PLAN FOR PHILHEALTH PLUS[1]

I. Rationale

The current year, 2002, is a halfway mark in the implementation of the National Health Insurance Program (NHIP) which gives a timeline of 15 years to provide the Philippine population with universal coverage. The momentum for reforms has been set in place with the health sector reform agenda and convergence activities. Convergence sites are models for situating health financing initiatives in a broader health system reform arena. Through PhilHealth Plus, the NHIP shifts to a new gear with the provision of outpatient benefit package to indigent members. The benefit package is paid through a capitation mechanism that is directed to rural health units or health centers managed by local government units. Thus, financial access to quality health services is pushed closer to the level of communities and localities where it matters most.

A well-designed monitoring and evaluation system is expected to contribute to the development of enhanced capacities for information and management systems and the strengthening of the Philippine Health Insurance Corporation's (PhilHealth or PHIC) ability to manage an evolving and increasingly more decentralized social health insurance delivery system.

II. Goal and Objectives

The goal of a monitoring and evaluation (M/E) system for PhilHealth Plus is <u>to improve the over-all quality and efficiency of social health insurance delivery by PhilHealth</u>. A good and efficient M/E system is one which leads to measurements and analyses that capture improvements in the use of limited resources and maximize health outcomes for all Filipinos, particularly the poor and underserved.

Specific objectives of the monitoring and evaluation system for PhilHealth Plus are as follows:

1) To provide feedback for policy, priority setting and resource allocation;
2) To inform managers of stakeholder perceptions and problems; and
3) To provide evidence of a wider health system impact of PhilHealth Plus.

III. Issues

PhilHealth Plus is part of health sector – wide reform process which sees health financing as a primary driver for reforms. PhilHealth Plus is envisioned to provide social health insurance to marginalized groups (indigents and informal sector), in cooperation with the

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local government units (LGUs). A viable health insurance program for previously non-paying clients will provide revenues to rural health units and hospitals and bring about facility improvements through better supplies, and more efficient delivery of care. Funding from social health insurance is also expected to encourage LGUs into networking or district zoning arrangements, to improve service delivery, especially in public health programs. Inclusion of benefits in a basic package will encourage greater provision and lower prices, especially for drugs.

The mechanisms for the implementation of PhilHealth Plus are the convergence strategy program of the Department of Health and the Plan 500 program of PhilHealth, in conjunction with the State of the Nation (SONA) of July 2001 mandate from the Office of the President. Under the convergence strategy, PhilHealth Plus is rolled out in tandem with other health reform areas. Under Plan 500, PhilHealth Plus is a stand-alone project delivering an outpatient benefit package for indigents members focused on pre-identified urban areas. In Plan 500, PhilHealth is the lead agency, in partnership with LGUs. In the convergence strategy, the Department of Health is the lead agency responsible for monitoring and evaluation.

Given its historical and institutional origins, a PhilHealth Plus monitoring and evaluation system confront several issues discussed below.

1. Decentralized Operations and Local Coordination

On one hand, the monitoring and evaluation process for PhilHealth Plus is one which is linked to performance not only for the PhilHealth program but also in other reform areas. Monitoring activities will be largely coordinative, relying on data inputs and stakeholder actions to determine processes and progress towards health reform goals, drawn centrally and adapted locally.

On the other hand, under decentralized operations, the M/E system needs to be responsive to managers at local levels and at the same time feed into and fit to the central and national M/E systems, when available. M/E results can be useful for those who can respond and act on the shortcomings and challenges posed by the findings.

2. Evolving Systems and Re-organization at PhilHealth

Evolving systems and limited management- and information technology-base at PhilHealth make for highly vertical program implementation and a lot of ad hoc reporting requirements. M/E system design for PhilHealth Plus should ideally be built into or flow from the design of the operations' management systems.

Moreover, evolving systems need to establish performance criteria to determine effectiveness of resources (money, time, manpower) allocated to implementation and set benchmarks for moving on to succeeding actions and further allocations.

3. On Baseline and Routine Information

Decentralized and evolving systems pose a challenge to over-all M/E system design in so far as the baseline and other routine statistics collected have to be identified and inconsistencies and/or redundancies sorted out. To determine the validity of baseline information is a challenge as they form the bases for targets and results assessments.

While the M/E system should ideally make maximum use of routine statistics, the data however may not be reliable, nor appropriate to overall program objectives. Moreover, time and efforts may also be considerably spent merely reconciling different data sources instead of analysis.

4. Assessment Focus

Since PhilHealth Plus is a program involving other stakeholder partners, specifically LGUs for their premium counterpart, providers for service provision and member-beneficiaries as the subjects for delivery, the M/E design must take into account not only enrolment and payment target outputs but also impact and behavioral responses and changes. In health insurance, these changes refer to utilization and participation. The methodologies for M/E and the level of disaggregation of the information required will therefore merit due consideration.

IV. Basic Principles of an M/E Systems' Design

The M/E program for PhilHealth Plus is designed and implemented with the following principles in mind:

1. **The monitoring and evaluation system should provide timely feedback for program and systems reforms.** In an evolving program system, feedback on action and responses below, coming from managers, beneficiaries and other partners, provide the needed bases for policy and program refinement. Therefore, the M/E system should consider the speed of data generation, retrieval and capture. Data requirements should therefore form part or flow into the operations' management information system. A visible tracking system can promote the efficiency of feedback mechanisms.

2. **The monitoring and evaluation system should underpin a performance-based mindset and implementation modalities**. This system is in place not so much to fulfill reportorial requirements but to track and guide performance. This requires the integration of the evaluation into the policy making and resource allocation assessment processes. An output-based system can be combined with a structure-process tracking mechanism.

3. **Utilizes and builds on existing and/or available capacities**. Certain capacities may initially not be available for M/E because of the nature of functional job assignments. On the other hand, capacities may not be fully utilized and the matter may be addressed just

by personnel deployment and training. With a performance-based mindset (identified in #3) all personnel can be geared up to achieve program goals. This ensures not only program replication but also innovation.

4. **Use of scientific methodology and credible assessment tools**: To an extent possible, comparison groups should be set-up, outcome measures defined and independent data collection processes are in place.

5. **The monitoring and evaluation system should take into account members', providers', and sponsors' (LGUs, other donors) perceptions and satisfaction.** Flowing from this principle therefore is the need for the monitoring approach to be participatory and involve the stakeholders to a large extent possible. This would involve a management system which is based on an overall service orientation – with a complaints and action desk.

V. Framework for M/E

PhilHealth Plus is a multi-stakeholder health insurance delivery mechanism. There are three levels in and for which the monitoring and evaluation system can be carried: a) Central; b) Local Managers; and c) Beneficiaries - Members, Providers, Payors/Sponsors

A stakeholder mapping framework would indicate the following interest matrix at each of these levels. The interest matrix is drawn to identify concerns at each level which can be used to identify the relevant indicators of program performance, at the bottom of the matrix.

Central	Local Managers	Beneficiary – Participants
Is enrolment expanded? Is the enrolment expansion achieved cost-effectively? Is the target population reached? Are contributions paid and paid on time? Are benefits delivered by qualified providers? Are costs of care delivery reasonable?	Is the target population reached? Are we expanding our enrolment base? Are we paying our providers reasonably on time and in appropriate amounts? Are our members satisfied? Are our staff satisfied?	*Mandated Members:* How can I be a member? *Members*: Am I getting value for money for my membership? Are my health needs sufficiently addressed? Do I get respect from providers and staff out of my membership?

Central	Local Managers	Beneficiary – Participants
Are there adequate safeguards against fraudulent claims and overutilization? Are we responding quickly enough to policy and operational needs, as the system is evolving?	Are our partners satisfied? Are we generating premium payments and renewals? Are we responding quickly enough to information needs at the central office?	*Providers*: Am I getting the amount I should be paid? Am I getting paid on time? Can the documentation requirement be made simpler? *Sponsors/LGUs*: Are those sponsored satisfied? Are they aware that I am sponsoring them? Am I getting good return of investment?
Bottomline: Outputs (enrolment, benefit payments, equity); Fund Protection; Quality of Health Services to Members	Operational Efficiency Client and Partners' Satisfaction Sustainability	Benefits, Value for Money, Continuity of care, lower out of pocket Dignity and Respect Prompt Payments Adequate Payments Political goals Return on Investment

Using this framework would imply that monitoring is directed at managing stakeholder interests and at the same time evaluation can be geared towards improved performance of the health insurance delivery system, especially one directed at coverage for the poor and underserved population.

Performance Measures and Indicators

From the above assessment of interests, the following measures and indicators of performance would be relevant for the M/E of PhilHealth Plus:

Over-all Efficiency - refers to the maximization of outputs at the least cost; considered as immediate outputs in a health insurance system are: enrolment, premiums and benefit payments, costs refer to the financial and human resources expended to deliver the program

Operational Efficiency – refers to the minimization of costs entailed in carrying out normal operations associated with the program; For PhilHealth Plus, operational efficiency should factor in the time and costs involved in securing LGU/ sponsor commitments and premium payments, accreditation of facilities, ID generation and distribution, conducting information and education campaigns, reimbursing providers, releasing capitation payments and managing complaints

Allocative Efficiency – the allocation of resources to different program aspects, like utilization of primary services vs. hospital services; capitation payments by municipality class; disease classification

Responsiveness to Beneficiaries- Participants – how the program responds to members/ funders/providers needs can be gleaned from data on support value and average value paid per claim; utilization rates; expanded enrolment; reimbursement and capitation levels and timing of pay-outs; number and amount of returned and rejected claims; number of complaints received

Equity - refers to the extent to which the range of accredited health services offered for indigent clients are accessible and affordable

Sustainability - refers to aspects of health insurance delivery that indicate increased sharing arrangements between LGUs and national government and other sponsors; fund pay-outs are within acceptable levels of premium payments; staffing pattern and turnover rates

Impact – refers to the influence the program has on health system outcomes and stakeholder behavior; measurable in terms of performance in broader health indicators and market performance (effects on prices, supply and delivery mechanisms)

These measures are by no means exhaustive nor are indicators limited to the measures. For example, over-all health system impact can answer some of the questions on value for money, quality of care delivery, etc. But considerations in the choice of indicators dictate a bias for verifiability (same result for different observers), feasibility (ease of collection of data) and measurability (discrete / quantifiable).

VI. Data Clusters and Data Sources

A summary of the data sets and possible sources are shown in the table below.

Performance Measure	Indicator	Type of Data	Data Source	Timing for feedback
1. Over-all Efficiency	• Population Coverage / Enrolment • No. LGUs participating • Premiums Collected • Benefit Payments • Capitation Fund releases	Structure & Output data	Administrative / routine	Monthly
2.Operational Efficiency	• Time costs • Financial costs of key PH+ operations: LGU buy-in, ID generation/Distribution, Accreditation, IEC, reimbursement, cap releases, complaints management; • No. of returned claims vs. processed;	Process data	Time and Motion – Operations Research or Systems Review	Bi-Annual
3. Allocative Efficiency	• Costs, Utilization, Disease Patterns: Primary vs. Hospitals; By Municipality type;	Structure, Output	Administrative;	Updated quarterly
4. Equity	• Distribution of accredited facilities • Distribution of members	Structure, Output	Routine; Geographic Information Systems (if available)	Updated monthly
5.Sustainability	• Number of participating	Output And Process	routine	Annual, updated quarterly

Performance Measure	Indicator	Type of Data	Data Source	Timing for feedback
	and renewing LGUs; • Loss ratios • Staffing pattern			
6. Impact	• Availability and distribution of providers; • Prices: fees, essential drugs, diagnostics, procedures • Share of health insurance in over-all health spending • Mortality and morbidity (for critical conditions) rates	Process and Outputs	Surveys and/or Geo-information systems (GIS)	Two- to-three year Cycle

VII . Baseline and Data Gathering Plan

Determining performance and progress toward goal achievements requires **baseline information**. Baseline information needed to include:

- the number and proportion of indigent population to total population
- number of other NHIP health insurance members (by program type)
- mapping of facilities: accredited or non-accredited; private vs. public; by type-- primary, secondary, tertiary
- mapping of LGUs in the region currently with IP and IP+ enrolment
- current operating expenses at regional levels
- current incomes from premiums in the region
- amount of claims paid to all facilities, past year
- number of returned claims, past year
- number of technical staff
- budget for marketing or IEC

These information are critical to establish baseline performance and are useful for determining per enrollee or per capita figures .

Since the collection of this baseline information is likely to be ongoing in some areas where the intervention has taken place, it will be difficult to establish the "before" situation in the evaluation. A comparative analyses involving regional data would be useful for **benchmarking** performance.

The greatest danger with reporting for monitoring and evaluation purposes is the tendency to fudge the figures, especially if they are to be used for resource allocation purposes. As a possible **initial step** to the M/E process, the information can be gathered from administrative or routine data culled by a designated monitoring unit. Baseline information on impact variables can be gathered by a specially commissioned survey, that can similarly similar to the Rand Health Insurance Study. This would however require investment of resources that may not be available at present. But riders can already be instituted in National Statistics Office surveys for impact and market performance variables.

The operations' research and process data can be gathered initially by an independent group and subsequently transferred to a unit at the central office. Data for annually assessed data can be contracted out.

VIII. Data Processing, Analyses, and Feedback

The design of this M/E makes use of administrative and routinely collected data. Reports from the field can be compared with the data gathered by the different units at central office for which the data are relevant.

Administrative, routine and operations research data can generate the following types of analytical routines:

- institutional mapping (facilities, enrollees, partners, spread of PH+)
- operations research
- cost-effectiveness analysis
- over-all program performance analyses
- variance report (performance vs. targets set locally or centrally)
- best practice documentation

Feedback

Monthly and quarterly data can be more visual and more prominently displayed in monitoring boards. Actions and responses resulting from the monitoring data has to be documented to assist in the creation of standards of operations. Quarterly assessments on the performance indicator can be undertaken at the field levels and feed on to central level planning and policy processes. Annual performance reviews should be undertaken. The results of which can form the basis for performance-based resource allocation mechanism.

PhilHealth can also come up with quarterly reports disseminated to a subscription-based audience. The PhilHealth web-page should contain updated information based on this monitoring and evaluation system.