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**Working Paper**

## An Assessment of the Outpatient HIV/AIDS Treatment Package Provided by the Philippine Health Insurance Corporation

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Philippine Institute for Development Studies  
*Surian sa mga Pag-aaral Pangkaunlaran ng Pilipinas*

An Assessment of the Outpatient HIV/AIDS  
Treatment Package Provided by the  
Philippine Health Insurance Corporation

*Issa Reyes-Lao*

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# **An Assessment of the Outpatient HIV/AIDS Treatment package provided by the Philippine Health Insurance Corporation**

A Discussion Paper

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Ms. Issa Reyes-Lao

May 2013

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## Abstract

The Philippines is one of the few countries where the prevalence of HIV/AIDS remains relatively small. However, recent data show that while other countries have shown a decrease in the incidence rate for this disease, the Philippines has experienced a 25% increase in incidence rate for HIV infection. While the proportion of people living with HIV/AIDS accounts for less than 1% of the population, the country is clearly falling behind in attaining the Millennium Development Goal for this disease. Moreover, it is still evident that Filipinos continue to experience inequity and unequal access to health services for HIV/AIDS even with different interventions already in place.

The Philippine Health Insurance Corporation launched the Outpatient HIV/AIDS Treatment package in 2010 to improve accessibility and affordability of HIV/AIDS treatment. With already 3 years underway and continued growth in people infected with HIV/AIDS, an assessment of this benefit package looked into issues that hinder the utilization of this package. The benefit coverage, support value, and utilization rate for this benefit package were evaluated through a review of literature, costing analysis and key informant interviews.

The results of this study show that there is a need to enhance the OHAT package, as this is not fully utilized despite the increasing number of people living with HIV/AIDS who are in need of treatment. Addressing underutilization and retention among PHIC members will involve expanding coverage benefits to patients at different stages of the disease, increasing patient awareness, and improving claims processes. However, expanding access to treatment must also be coupled with preventive programs for HIV at the primary care level to maximize the benefits of this intervention and minimize financial out-of-pocket.

**Keywords:** Outpatient HIV/AIDS Treatment Package, Philippine Health Insurance Corporation, benefit coverage, support value, package utilization

## I. Background

The Aquino Health Agenda for achieving Universal Health Care (UHC) has three main components, two of which are focused on improving financial risk protection and providing health services to achieve the Millennium Development Goals (MDGs) (DOH, 2010). In the pursuit to attain *Kalusugan Pangkahalatan*, the Philippine Health Insurance Corporation (PHIC) has embarked on continuous improvements of member benefits as a response to increase member coverage and protection. In support of achieving the goal for MDG 6, PHIC issued the Outpatient HIV/AIDS Treatment (OHAT) package in 2010. This aims to increase the accessibility of HIV/AIDS treatment and patient education measures for the Filipino people. MDG 6 is aimed to combat HIV/AIDS, Malaria and other major diseases such as Tuberculosis. Its targets, particularly for HIV/AIDS, are to “have halted by 2015 and begun to reverse the spread of HIV/AIDS” and to “achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it” (WHO, n.d.).

HIV/AIDS prevalence in the Philippines accounts for less than 1% of the population (DOH, 2012). While this is within the national targets for the program, the number of new infections in the country has risen by at least 25% in the past ten years while other Asian countries, such as Thailand, India, and Myanmar, have reduced new infections for HIV/AIDS by more than 50% in same period (UNAIDS, 2012). Although this increase may be due to screening bias as more Filipinos are being tested, the continuous trend of increase in HIV cases in the country is likely to contribute to an increase in prevalence. Access to and utilization of HIV programs is also askew. While 85% of eligible HIV patients receive antiretroviral drugs, only 14% of HIV patient with TB co-morbidity receive treatment for both illnesses. Also, coverage of HIV testing for persons who inject drugs and males who have sex with males is below 25% (UNAIDS, 2012).

These figures show that the effects of the interventions in place to reverse the spread of HIV vary as some countries still show rising HIV infection rates and vulnerable groups remain at-risk of infection. Thus, the actions to be taken by the health sector, both public and private, to achieve and sustain the goals for this particular MDG is highly critical.

## II. Significance of the Study

The limited funding, persistent increase of incidence, and uneven access for HIV/AIDS programs show that there is a need to redefine the interventions implemented in the country – including, but not limited to, PHIC’s funding mechanism and remove constraints in accessing treatment and support mechanisms for this disease. This study aims to address the need to widen the scope of universal coverage for HIV/AIDS through comparing the support systems of different key players and looking at barriers that hinder patients from accessing and utilizing treatment. Improving universal coverage for HIV/AIDS treatment delves into the possibility of expanding services included in the OHAT package, covering current non-beneficiaries, and increasing the proportion of the cost to be covered (WHO, n.d.).

### III. Objectives

#### A. General Objective

To assess the services covered, support value, and utilization of the current PHIC intervention system for HIV/AIDS treatment.

#### B. Specific Objectives:

- i. To determine the scope of the services offered by the package juxtapose to other social health insurance schemes
- ii. To determine the support value of the current benefit package
- iii. To determine the benefit utilization rates of the OHAT package from 2010-2012
- iv. To determine bottlenecks encountered in utilizing the OHAT package

### IV. Methodology

Each domain of interest in the study employed different methods of investigation. In order to assess the services included in the OHAT package, a review of literature was performed. HIV/AIDS insurance benefits offered by other social health insurance schemes of developing countries were compared to the current services under PHIC's benefit package. The support value was measured through cost estimates based on the recommended regimen by the DOH and the lowest price for the generic drugs available in the market. Secondary data, based on PHIC's claims database, was used to determine the utilization rates among HIV patients who were eligible for antiretroviral therapy (ART). Key informant interviews were also accomplished to determine barriers to patients' health seeking and utilization patterns.

### V. Results and Discussion

#### Review of HIV/AIDS benefits

The OHAT package was compared to benefit packages for HIV/AIDS offered by countries with social health insurance (SHI). The most common items covered in these packages were preventive services such as consultations, screening and diagnostic tests. ART was excluded from the package when a separate government program covered the cost for ART but the tests for monitoring HIV/AIDS were still covered under the SHI package. This was the case for Vietnam and Ghana (Joint Learning Network, n.d.). In 2003, Thailand included the provision of ART in their benefit insurance package (Joint Learning Network, n.d.). Additional services in other countries include prevention of opportunistic infections, nutritional support, psychosocial services, TB screening, and HIV/AIDS testing (table 1) to ensure a more comprehensive treatment and support for people living with the disease.

While majority of the services covered in the OHAT package are similar to those that are covered in other countries, other insurance schemes include preventive and rehabilitative services for HIV patients. However, access to the OHAT package is restricted to those that are qualified to avail of the ART. Diagnostic tests monitoring the HIV/AIDS status for unqualified patients are financed mainly through out-of-pocket payments.

Table 1. Treatment Programs for HIV/AIDs, summary

Country	Benefits
Thailand	Provision of ART Cost of preventing opportunistic infections is managed Comprehensive coverage of outpatient tests
Vietnam	Treatment for opportunistic infection Nutritional Care TB screening for people living with HIV Voluntary counseling and testing Pain management Treatment of common HIV-related infections
Kenya	ART Prevention of opportunistic infections Nutritional support Psychosocial services *Unlimited management of chronic illnesses, costs related to diseases that require a specialist
Philippines	ART Lab examinations (Cluster Difference 4 and monitoring for antiretroviral drug toxicity) Professional fees of providers *TB co-morbidity covered under TB-DOTS package

Sources: PHIC Circular No. 19 s.2010

Vietnam AIDS response progress report, 2012

Kenya AIDS epidemic update 2012

UNDP 2004

### Support Value

Based on the recommended regimen and dosage for ART (DOH, 2009) and quoted prices for developing countries from Medecins Sans Frontieres' guide to antiretroviral drug price reduction (2012), the cost of the first line regimen ranges from Php5,000 to Php11,000 per year. The cost for the second line regimen is significantly higher than the first line regimen. Table 2 shows the costs for each regimen recommended by DOH.



Table 2. Pricing for recommended regimen (and alternatives), by combination

Regimen	Price* (Php)
<b>First line regimen: NNRTI-based (2 NRTI + 1 NNRTI)</b>	
Zidovudine (AZT) + Lamivudine(3TC) + Nevirapine(NVP)	10,168
AZT + 3TC + Efavirenz(EFV)	10,742
Tenofovir(TDF) + 3TC + NVP	6,525
TDF + 3TC + EFV	7,011
Stavudine (d4T) + 3TC + NVP	5,576
d4T + 3TC + EFV	6,150
<b>Second line regimen: 2 NRTIs + Lopinavir/ritonavir (LPV/r)</b>	
AZT + 3TC + LPV/r	38,786
TDF + 3TC + LPV/r	35,055

\*Based on lowest quoted price from generic brands

\*Prices computed at Php41.00 exchange rate

The support value provided in the OHAT package is only sufficient to cover the cost of the first line regimen, laboratory tests needed to monitor ART toxicity, and administrative costs in public hospitals. Even then, the financial risk protection that this package offers will still depend on the prices of antiretroviral drugs available in the country when financial support from the Global Fund stops. Patients who are receiving the second line regimen are burdened financially as the package is clearly not enough to cover the cost of drugs. Patients experiencing opportunistic infections are also financially at-risk as treatment for these infections are more expensive and are not covered under this package.

#### Coverage and Benefit Utilization

This study covered claims filed under the OHAT package for years 2011 and 2012. The study population consisted of 645 people living with HIV (PLHIV) for 2011 and 1,009 PLHIV for 2012 (Table 3). Of the 646 patients who filed claims in 2011, 543 (84.06%) continued to file claims for 2012. This meant that there were 46.18% of patients in 2012 were new patients. The number of claims increased by 51.82% in 2012.

In 2011, only 5 out of 16 treatment hubs filed claims for the OHAT package. This increased in 2012 by 80%. Majority of patients and claims filed, for both years, came from the Research Institute for Tropical Medicine (RITM) and UP-PGH. These numbers reflect findings from the Department of Health's (DOH) Philippine HIV and AIDS registry in 2012 where more than half of HIV cases are in the National Capital Region (NCR). Region 4A does not have an accredited treatment hub and no claims were filed in the treatment hub in Regions 3 despite the high proportion of HIV cases in these regions.

Table 3. Distribution of HIV/AIDS patients and OHAT claims per hospital, 2011-2012

Hospital	2011		2012	
	PLHIV patients	OHAT claims	PLHIV patients	OHAT claims
Baguio General Hospital & Medical Center	15 (2.33)	33	26 (2.58)	47
Corazon Locsin Montelibano Mem Reg. Hosp.	0	0	15 (1.49)	15
Research Institute for Tropical Medicine	382 (59.22)	604	558 (55.30)	883
San Lazaro Hospital	0	0	4 (0.40)	4
Southern Philippines Medical Center	48 (7.44)	49	82 (8.13)	99
The Medical City (TMC)	0	0	59 (5.85)	96
UP-Philippine General Hospital	143 (22.17)	253	180 (17.84)	289
Vicente Sotto Memorial Medical Center	0	0	3 (0.30)	3
Western Visayas Medical Center	57 (8.84)	107	82 (8.13)	165
Total	645	1,046	1,009	1,588

Source: PHIC database (date extracted: January 2013)

The UNAIDS Global AIDS response progress report estimated that 1,992 PLHIV were on ART by the end of 2011. This increased by 56.38% by September of the following year (DOH, 2012). These figures show that, for both periods, roughly one-third of PLHIV who received ART used the OHAT package at least once. In the 4<sup>th</sup> quarter of 2011, only 19.48% of PLHIV who received ART filed for claims in PHIC. This decreased in the next 3 quarters. Utilization rates per quarter for 2012 remained consistently below 20%.

The retention rate for this package is considerably low as well. Only 9 out of the 122 PLHIV (7.38%) who started treatment on the first quarter of 2011 submitted all 4 claims for that year. The average number of claims per PLHIV who utilized the package is only 1.62 and 1.57 for 2011 and 2012, respectively. It can be said that the benefits for this package was not maximized.

Table 4. Utilization rate of OHAT package for 2012, by quarter

Quarter	2011			2012		
	Number of claims filed	Number of PLHIV on ART*	Utilization	Number of claims filed	Number of PLHIV on ART*	Utilization
1	122	-	-	397	2,278	17.43%
2	234	-	-	457	2,761	16.55%
3	302	-	-	532	3,115	17.08%
4	388	1,992	19.48%	(202)	-	-

Sources: PHIC database (date extracted: January 2013)

DOH, December 2012

UNAIDS, 2012

(Note: Claims for this quarter may have not been filed or is still being processed by date of extraction.)

### Barriers to utilization

Key informants from the UP-PGH and TMC's treatment hubs were interviewed to shed light on the low numbers of utilization and retention for the OHAT package. Reasons for not availing for the package vary. Non-members who need ART usually pay out-of-pocket for service treatments while those who cannot afford the treatments rely heavily on charity. Accessibility of the treatment hubs was also an issue for patients. Patients living far from the treatment hubs would sometimes delay their quarterly visits due to travel costs and time. Requests to receive antiretroviral drugs to last for more than a quarter were common, especially if patients were from other provinces.

PHIC members preferred paying out-of-pocket or using HMOs for minimal diagnostic and laboratory fees, since the drugs are provided for free, than go through the process of filing for claims for this package. One of the main issues that was brought up for the employed sector was that all claim forms needed to be signed by their employer. PLHIVs were wary that having a claim form signed every quarter would raise questions from the employers and they, in turn, may be discriminated in the work place. To avoid this circumstance, some employed PLHIVs would even opt to enroll in PHIC as an individually paying member despite having their salaries already deducted for PHIC contributions every month.

Stigma also hinders patients of availing the package. In cases where the patient is a dependent, the dependent would rather not file a claim in fear that the parents will find out about the infection. Non-members who are encouraged to join under the sponsored program of their local governments were reluctant due to the possibility that members in their community will know about their conditions.

The possible barriers mentioned above are parallel to reasons associated with underutilization of health insurance in the Philippines. These reasons include high transaction costs, lack of patient awareness, lack of resources, and taxing claims process (Quimbo, et al., 2008).

## VI. Conclusion and Recommendations

The assessment of the OHAT package showed that there is a need to enhance the OHAT package in order to attain universal coverage among PLHIVs. The package is not fully utilized despite the increasing number of PLHIVs on ART. Low utilization and retention among patients should be addressed to prevent new infections and HIV drug resistance. Improved access to ART is needed for eligible PLHIVs to prevent disease incidence, improve survival rates among the infected and improve quality of life. With the expansion of ART, attention should also be given to the implications of treatment in regards to preventing new cases and sexual behavior of recipients.

Studies have shown that prolonged access and exposure to ART may lead to behavioral disinhibition as patients adjust their behavior to perceived changes in risk (Walque, Kazianga & Over, 2011). While access to treatment may provide incentives for HIV testing and adoption of safer sexual behavior, decreased fear of contracting HIV may increase risky behavior among high and low risk groups (Mechoulan, 2007). Also, as HIV has become a manageable chronic condition, incidence of exposure to HIV-infected partners may increase (Hammer, et al., 2006). The positive effect of ART administration may be offset if increased in risky behavior is translated to increased incidence (Walque, Kazianga & Over, 2011). Thus, expanding access to ART must be coupled with preventive programs for HIV to maximize the benefits of this intervention.

### Research

This study has relied heavily on qualitative data in determining the obstacles faced by PLHIVs availing of the OHAT package. Thus, further studies are recommended to fully understand the reasons for underutilization and minimal retention rate of this package. Risk factors for patient dropout may be determined through a prospective cohort study comparing member and patient profiles using the package. Risk factors may include socio-demographic factors, type of insurance or membership type, transaction costs, and access to treatment and prevention programs. Appropriate interventions can then be based on the findings of the study.

### Policy Implications

The current design of the ART program relies heavily on specialists in select accredited treatment hubs to provide the medicine. This approach may not be sustainable for patients who need ART and other HIV services but are required to travel long distances every so often. As the results of this study has shown, utilization and retention for the OHAT package is low and access to treatment hubs has been raised as one of the barriers among users. Integrating ART and other HIV programs down to the level of primary care or with other health care programs (i.e. TB-DOTS, reproductive health) is crucial to address accessibility issues. Access to HIV prevention and treatment in the primary health care setting will minimize required additional resources from patients. While assessment and initial treatment for ART may occur in the main treatment hubs, adherence and monitoring of patients may be done in local hospitals. This will lessen the burden of treatment hubs in the long run and lead to improved services and financial support in the primary health care facilities.

Improving claims processes for the OHAT package is also critical in addressing underutilization and retention among members. Eligibility to avail of the package and

tracking patients' availment should be done electronically, as is done in Type Z Benefit packages. Electronic claims will lessen the demand for patients to go through taxing processes and allow them to use the package without prejudice.

In order to achieve universal coverage for HIV/AIDS, additional services and financial support is essential for PLHIVs. While the services and the support value financially protects patients who are on the first line regimen, PLHIV who are either not eligible for ART, on second line regimen or cases with opportunistic infections are financially at-risk. Expanding support to PLHIVs not yet qualified for the package, as a preventive measure, should be explored. A separate package for those who are "off-treatment" should be offered because these patients also require routine laboratory exams to monitor their HIV status and overall health. Costing studies for this package, as well as for the second line regimen, should be evaluated to alleviate the financial burden of patients and their families. Improved monitoring systems for program should be enforced to prevent loss to follow-up and possible default among patients.

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