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A Review of the Outpatient HIV/AIDS Treatment (OHAT) of the Philippine Health Insurance Corporation

EXECUTIVE SUMMARY

Abstract

The PhilHealth Outpatient HIV/AIDS Treatment (OHAT) package was created to improve financial risk protection, access to services, and, eventually, health outcomes for people living with HIV/AIDS (PLHIV) in the Philippines. This review was done to assess the current OHAT package of PhilHealth in terms of effectiveness, economics, and equity. Under effectiveness, OHAT package benefit utilization, quality of care improvement, and health outcome contribution were measured. Under economics, contribution to financial risk protection was assessed and the cost of the OHAT benefit package delivery, in the perspective of service providers, was measured. Under equity, health service coverage, accessibility of services, and accessibility of different patient groups were measured.

Through this review, it was found that PLHIV, particularly among vulnerable groups benefit from the package in terms of access to services and medications, as well as in reducing out-of-pocket expenditure. In terms of effectiveness and economics, the current case rate is effective in covering for first line of treatment and for the primary need for laboratory tests. However, more support is needed as the range of out-of-pocket (OOP) expenditure varies for patients. In terms of equity, access to support from PhilHealth has been limited. This merits the need to acknowledge a wider range of conditions and to further characterize groups who are likely to utilize OHAT to help refine and improve the package. To achieve these, DOH and PhilHealth will have to jointly decide how to manage and rationalize funding streams as well as to explore the potential role of the private sector as providers.

Executive Summary

A. Introduction

The PhilHealth Outpatient HIV/AIDS Treatment (OHAT) package was created to improve financial risk protection, access to services, and eventually health outcomes for people living with HIV (PLHIV) in the Philippines. This review was done to assess the current PhilHealth OHAT package of PhilHealth in terms of effectiveness, economics, and equity.

Under effectiveness, OHAT package benefit utilization, quality of care improvement, and health outcome contribution were measured. Under economics, contribution to financial risk protection was assessed and the cost of the OHAT benefit package delivery, in the perspective of service providers, was measured. Under equity, health service coverage, accessibility of services, and accessibility of different patient groups were measured.

B. Methods

The study was divided into 3 different phases to fulfill the specific objectives for the review:

1. Chart Abstraction

The first phase used a chart abstraction tool to review patient records of current PhilHealth members to obtain knowledge on current package utilization and health outcomes of patients on the package. This phase also includes Key Informant Interviews with hub managers and/or experts as well as policy makers to gain their perspective on the management and implementation of the package.

Data collection involved: 1) a mixed-methods retrospective cohort design involving data collection in DOH-accredited treatment hubs for patient data from chart reviews, and 2) structured interview for qualitative feedback on OHAT implementation, in the context of policy development cycle. Eligibility criteria were defined as: PLHIV registered at treatment hubs, started ART on Oct 2010 to Jan 2015 (>1 year records data available), PhilHealth members, or OHAT package benefit utilizers. HIV status was confirmed by laboratory testing by the STD/AIDS Central Cooperative Laboratory (SACCL). The sample size was 932 PLHIV records, which was sampled according to the number of registered PLHIV in each of the 8 DOH-Accredited Treatment Hubs chosen (5 National Capital Region (NCR) tertiary hospital hubs, and the largest hub in each of Luzon, Visayas, and Mindanao).

Univariate, bivariate, and multiple regression were done for data analysis. Thematic analysis was used for qualitative data from key informant interviews.

2. Patient Survey

The second phase focused on individual patient surveys to get direct information from current OHAT users as well as from PLHIVs who are currently not enrolled under the OHAT package. This also gave an overview on the current needs of PLHIVs.

Data collection involved a mixed-methods analytic cross-sectional study involving both patient surveys and records review of PhilHealth OHAT claims data. Eligibility criteria were defined as: all PLHIV regardless of ART status, above 18 and confirmed by laboratory testing by SACCL or RITM. The sample size was 358 PLHIV registered in community-based support groups from each of the four geographic zones: Luzon, NCR, Visayas, and Mindanao. Univariate, bivariate, multiple regression and thematic analysis were done for data analysis.

3. Facility Costing

The third phase looked into the actual financial costs of treatment hubs and on the cost breakdown of the implementation of the OHAT package and treatment of PLHIVs.

A self-administered facility survey was used to measure variables for 20 DOH-accredited OHAT Treatment Hubs. Variables pertaining to facility characteristics, physical availability of interventions, human resources and cost of delivering OHAT from service provider perspective were measured.

C. Results and Discussion

The assessment of 978 charts revealed an increase of 23% in the maximum utilization of the package in 2015. The chart abstraction revealed an increase in the maximum utilization of the package. The number of patients who were able to utilize and claim the package increased from 7.38% in 2011(Reyes-Lao, 2013) to 23% by 2015. This could be explained by a number of factors that have changed in the latest OHAT circular since the 2010 version: 1) an increase in the number of treatment hubs, 2) a change in the claiming protocol – namely, the creation of alternatives to CF1 form for all employed members to address privacy concerns of members.

Using the Tanahashi framework for Health Service Coverage, acceptability coverage was seen as statistically significant among the respondents of the patient survey with 96% of patients reported being willing to avail of health services at the hub. This could show a continued satisfaction of patients with OHAT benefits, which is consistent with significant results on continuous drug utilization.

Analysis on the demographics of the patient survey found that there was no significant difference in the profile between package utilizers and never utilizers except in mean age where ever-utilizers were slightly older at 35 years old, compared to 31 years old for never utilizers. Further, age remained significant as those more than 25 years old were 4.5 times more likely to have utilized OHAT at least once.

Among utilizers, high utilization was associated with the treatment hub frequented ($p<0.01$) in chart reviewed patients while high utilization was associated with the support group they are a member of ($p<0.01$) in those interviewed.

Another Tanahashi component, accessibility coverage was also seen as significant. Those who utilized OHAT at least once reported to spending more time travelling (127 minutes) to their treatment as compared to those who had never utilized it (87 mins) ($p<0.001$). However, when linked to analysis of accessibility under Penchansky's 5A's, the perception on the ease of travel was not seen as significant regardless if the patient was an OHAT utilizer or not.

Effective coverage, or the proportion of patients who do not develop immunologic failure while on ARV, was not seen as statistically significant on regression. However, upon measuring health outcomes, it is significant that high utilizers of OHAT were 1.39 times more likely to have had at least one opportunistic infection (OI) (CI 1.08, 1.79), and were also 1.59 times more likely to have had a CD4 test result below baseline (CI 1.20, 2.08). This could also be explained by a faster diagnosis for high utilizers compared to low utilizers who have regular follow ups, similar to studies in Vietnam and the US which found that having health insurance has been linked to more health-seeking behavior, specifically "health care utilization" and compliance to follow up consultations (Finkelstein, et al 2012 & Nguyen 2011). This was supported by significant findings in quality of care which showed that high utilizers were 1.43 times more likely to have a higher proportion of regular follow up visits (CI 1.04, 1.96, $p=0.03$) and were 1.51 times more likely to complete their bi-annual CD4 test (CI 1.10, 2.08, $p=0.01$). However, any correlation cannot be made with certainty due to the limitations in data management such as quality of records and non-uniform record-keeping.

To assess appropriateness of the health system as a service provider to patients, Penchansky's 5A's were measured for statistical significance. For accommodation, only the perception of privacy in the waiting area was seen as significant. OHAT utilizers were less satisfied as compared to non-utilizers. This was consistent with the significant finding in acceptability, which found that OHAT utilizers were also less satisfied with the over-all appearance of their hub facility as compared to non-utilizers. With regard to health literacy (knowledge of and independence in reading and filling up hospital information materials like brochures and forms), It was found that OHAT utilizers had a statistically significant higher score compared to non-utilizers, and this could explain why they are less satisfied as they are more likely to be aware of their rights to benefits under OHAT.

For financial risk protection, the current support value was computed at 267%. However, this does not include ART's, which are currently given for free to all PLHIVs on treatment. Instead, this covered the package inclusions stated in the circular, namely: drugs or medications, routine (and not baseline) laboratory exams, ART toxicity monitoring exams, and professional fees. Despite the high support value, OOP of many patients remain. Surveyed patients report 97% OOP expenses, with the median amount of Php 4,700 for one year. Segregating between members and non-members, current OHAT claimants reported a slightly higher mean OOP (Php 19.979.00) compared to non-members (Php 18,228.00). Using the median, however, showed that PLHIVs who never utilized OHAT reported 2.38 higher than those who have utilized the package at least once. The continuing OOP expense of members can be explained by multiple reasons such as: 1) the exclusion of baseline lab tests from the package, 2) vague rules on package inclusion, 3) price differences of services between public and private treatment hubs and throughout regions. Using Pechansky's factor on affordability, non-users were statistically

more likely to be satisfied with current OHAT benefits and OHAT claims process (100% satisfaction for both), than those who had used OHAT at least once. This could be explained by the fact that non-utilizers were only given an ideal scenario, during the survey, juxtaposed that to actual OHAT utilizers who may have experienced difficulty in claiming and had a higher mean OOP.

This review gave several recommendations for policy, action, and research. For policy makers, it recommended that consultations between DOH and HIV-AIDS specialists are to be done to prioritize and standardize package inclusion; an improvement in the service delivery network for services including potential partnerships with external laboratories for necessary tests that are currently not available in all hubs; regular hub satisfaction surveys to gain feedback from patients to gain a better insight on how to continuously improve services; and lastly, for opportunistic infections, which drive up OOP expenses, to be covered in a separate package; confidentiality of claims processing be improved; and forms for record keeping be standardized. Providers were recommended to improve confidentiality in claims processing and to have standardized forms of record keeping to allow for easier tracking of patients within hubs and also for those who decide to switch to a different facility. In terms of action, clear and specific guidelines on OHAT fund disbursement should be disseminated and OHAT coverage be properly oriented to all health hub providers. Assigning a designated PhilHealth OHAT officer can also be explored for hubs that experience a lot of patient congestion to decrease delays in claims processing and to also improve OHAT information dissemination to PLHIVs who normally would not get the chance for information to be given due to the lack of personnel to ask information from. Lastly, further research can be done in terms of the following: chart review of non-OHAT members, more diverse support groups, and evaluation of the potential role of private healthcare providers.

D. Conclusions and Recommendations

Through this review, it was found that many PLHIV, particularly among vulnerable groups benefit from the package in terms of access to services and medications, as well as in reducing out-of-pocket expenditure. In terms of effectiveness and economics, the current case rate was effective in covering for first line of treatment and for the primary need for laboratory tests. However, more support was needed as the range of out-of-pocket (OOP) expenditure varies for patients. In terms of equity, access to support from PhilHealth has been limited. This merits the need to acknowledge a wider range of conditions and to further characterize groups who are likely to utilize OHAT to help refine and improve the package. To achieve these, DOH and PhilHealth will have to jointly decide how to manage and rationalize funding streams as well as to explore the potential role of the private sector as providers.

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