

Contraceptive Self Reliance through
Financial Sustainability: A Market
Segmentation Approach

Executive Summary

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EXECUTIVE SUMMARY

The overall objective of the study is to develop a financial sustainability strategy for contraceptive self-reliance (CSR) in the Philippines using a market segmentation approach. The development of such a strategy is in keeping with the statement of the Department of Health (DOH) in its 2001 Family Planning (FP) Policy that PhilHealth shall be a key partner in the mobilization of investments in the FP program, and that the DOH will adopt the recommendations of the technical working group on the Contraceptive Independence Initiative (CII). In particular, the CII will segment the population and will ensure the availability of commodities for all segments through direct subsidy, health insurance, socialized pricing, and/or commercial procurement.

The specific objectives of the study are to:

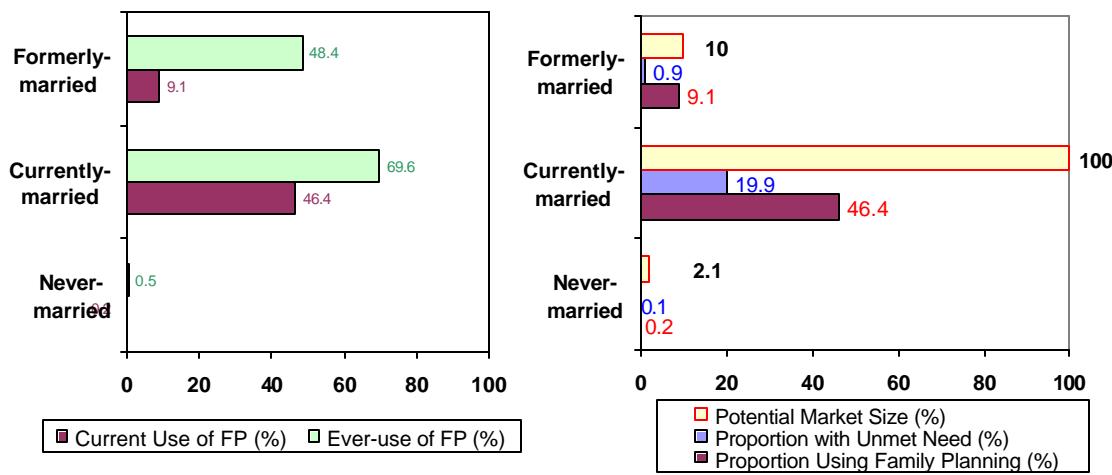
1. Analyse the Philippine FP market using results of the 1998 National Demographic Survey
2. Apply a market segmentation approach to develop an understanding of FP market segment behavior with respect to financing, contraceptive method, and provider choice
3. Do projections on various financing scenarios for FP, given present patterns and levels of FP financing sources
4. Propose strategies to shift such patterns to address financing gaps and ensure financial sustainability of contraceptive self-reliance, and
5. Develop operational policies and procedures in support of these strategies.

To meet its objectives, the study takes the following approach:

First, it redefines the coverage and segments of the Philippine FP market. Second, it interprets contraceptive self-reliance in terms of financial sustainability. Third, the next steps of the study take its findings beyond research into operations, identifying arenas for their implementation and partnership requirements of stakeholders.

REDEFINING THE PHILIPPINE FP MARKET

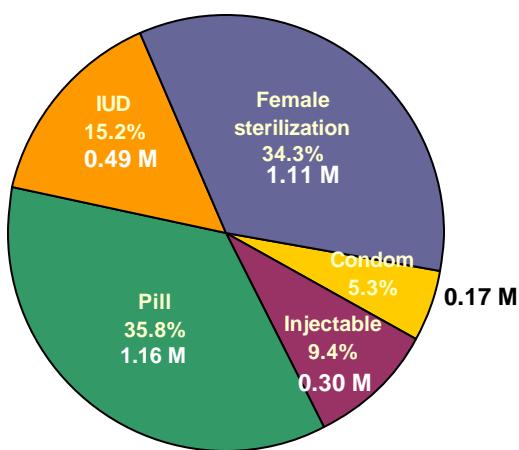
While earlier studies limit the FP market to currently married women, this study redefines it to include never-married women (NMW), currently married women (CMW), and formerly married women (FMW) aged 15 - 49, i.e., all women who, regardless of marital status, are at risk of being pregnant. According to the 1998 National Demographic Survey (NDS), CMW at 8,634 made up 62 percent of women of reproductive age (WRA) while NMW made up another 34 percent. As expected, the CMW registered the highest current use, at 46.4 percent, followed by the FMW at 9.1 percent, and the NMW at 0.2 percent.



For these three groups, the potential market is estimated, consisting of current users as well as immediate potential users, i.e., those who indicated that they intend to limit or space births and yet do not use any contraceptive method or the so-called unmet need population.

Nine percent (9.1 percent) of ever-married women are still using FP and about one percent have unmet FP needs. In the case of never-married or single women, very few have reported using FP or having unmet FP needs. However, in two recent surveys, 1998 National Demographic Survey and 1994 Young Adult and Fertility Survey, two percent of single women reported having had sexual encounters. Thus, this study considers this proportion of single women who had engaged in sex as a potential market for FP. For the currently-married, all (100 percent) are considered in the potential market, with a corresponding 10 percent for the formerly-married.

Whereas the earlier charts considered women using traditional and modern FP methods, the following chart focuses on the WRA using modern FP methods, specifically pills, condoms, IUDs, injectables, and bilateral tubal ligation (female sterilization). In terms of these methods, the largest shares of the market are those of pills (35.8 percent) and female sterilization (34.3 percent) followed by IUDs at 15.2 percent. It is this subset of the market whose contraceptive self-reliance is addressed by the study.



3.23 Million Women of Reproductive Age

ENSURING FINANCIAL SUSTAINABILITY

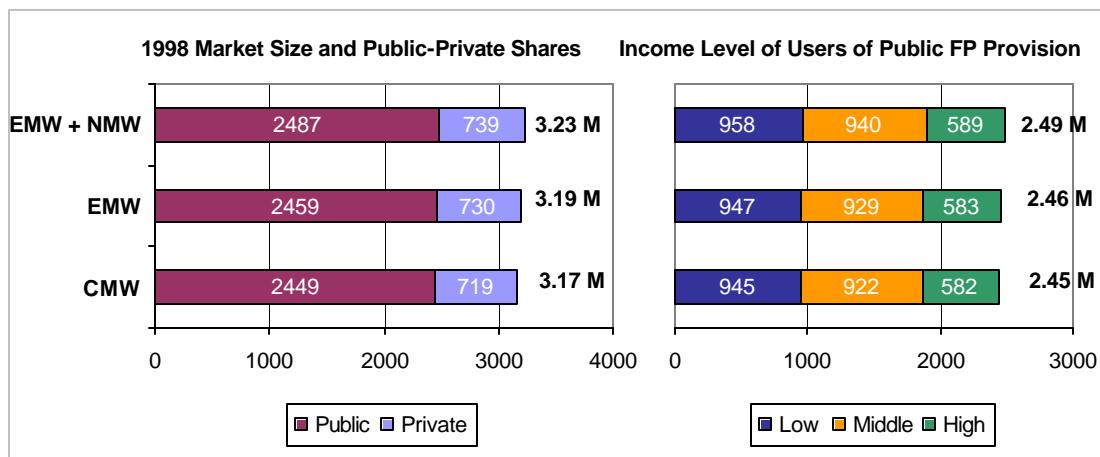
Using 1998 data as the base and inputting DOH FP targets, Spectrum (a computer model developed by the POLICY Project and described in Annex 2) was used to generate financing scenarios to quantify the requirements to reach the strategic goal of financial sustainability for contraceptive self-reliance.

The study defines two conditions for financial sustainability: first, adequate financing exists for the provision of free or subsidized services for the poor; and second, risk pooling is fully explored for those who can afford and are willing to pay for FP services. Thus, a two-pronged strategy is proposed: a shifting strategy to move the public sector non-poor clients to the private sector and a financing strategy for the remaining public burden. The financing scenarios focus on the public sector share of the FP market and take into consideration the National Health Insurance Program of PhilHealth.

Shifting Public Sector Non-poor Clients to the Private Sector

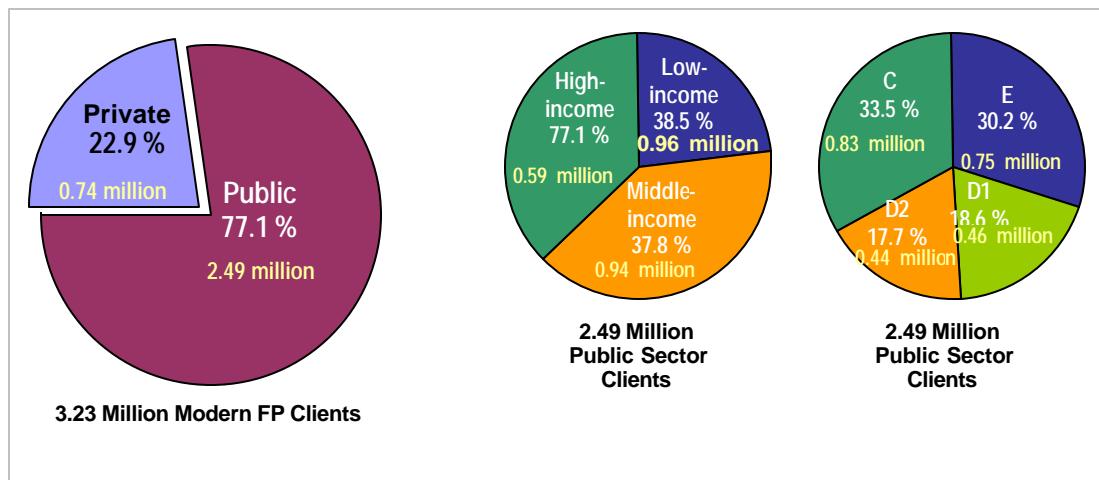
Two major arguments make the shifting strategy compelling.

The first is found in the various market segmentation studies, including this one, which documents the continued provision by the public sector of the FP requirements for the non-poor.

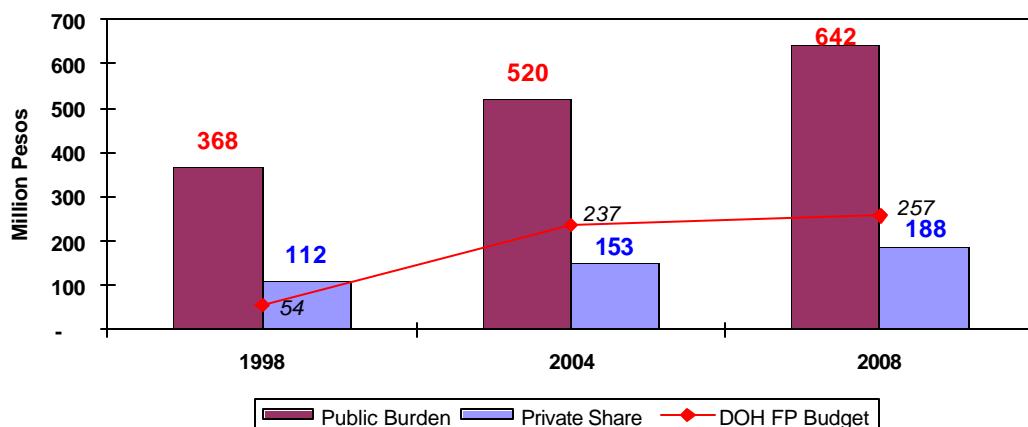


The above chart presents the estimated market size of the modern FP market according to the three market groups. If the market is limited to women who are either married or living together with their partners, there were an estimated 3.17 million women in 1998 with modern FP needs. Of these, 2.45 million went to the public sector and 719 thousand went to the private sector. When this market is expanded to include formerly married women, it increases to 3.19 million women. The integrated market, which further includes singles comes up to 3.23 million women. Of this market, an estimated 77 percent or 2.49 million rely on the public sector for their FP needs, whereas about 739 thousand women seek FP services from the commercial sector. Of the 2.49 million who go to the public sector, 61.5 percent or 1.53 million women come from middle and high-income classes (69.9 percent are non-poor or above the poverty threshold).

When the low, middle, and high income classes of the market segmentation study are made to correspond with the ABCDE socioeconomic classification, the low income group can be classified as Class E, households with an income of PhP5,028 and below/month. Since this corresponds to the National Statistical Coordination Board (NSCB) definition of the poverty threshold for the Philippines, this group can be considered as the poor. All non-poor households will be shifted to the private sector, with the poor remaining as the public burden.

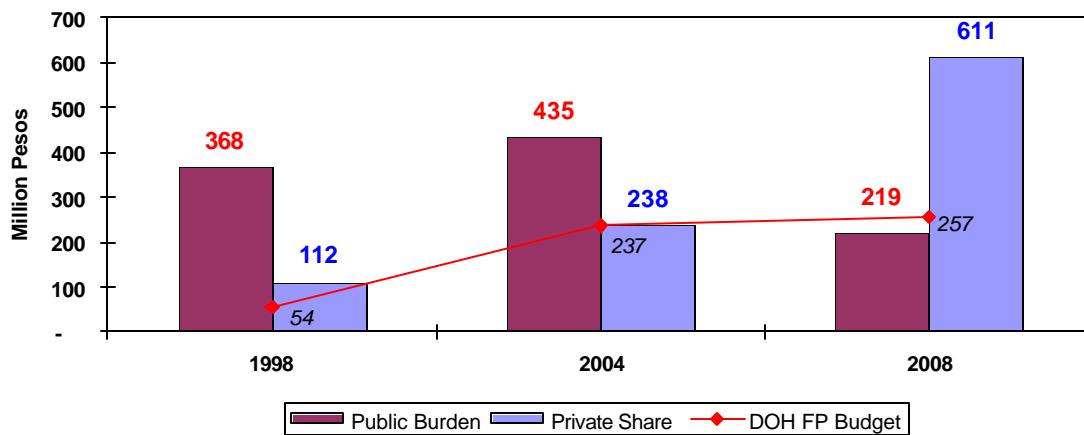


The second argument has to do with the resulting public burden should no shift occur. Using the Spectrum software, the commodity funding requirements of the public sector for the modern methods under consideration were projected using the historical rate of increase in order to estimate the resulting public burden. This base scenario shows the public burden increasing by 74 percent from 368 million pesos in 1998 to 642 million pesos in 2008. To get a sense of how affordable this burden is, the projected amounts are compared with the projections of the LGU Internal Revenue Allotment (IRA) share that is estimated for health and is set at 10% of IRA (henceforth referred to as the LGU health budget) and the DOH FP budget. The table shows the public burden under the base scenario to be 3.7 percent of the LGU health budget in 2004, growing to 4.2 percent in 2008. Compared to the DOH FP budget, the public burden is huge, amounting to 219.3 percent of the budgetary level in 2004 and 250.4 percent in 2008. Clearly, the resulting public burden is overwhelming.



	2004	2008
Public burden as a proportion of DOH FP Budget	219.3 %	250.4 %
Public burden as a proportion of LGU Health Budget	3.7 %	4.2 %

The shifting strategy will not only reduce the public burden (public burden is expected to decrease by 66 percent as compared to the base scenario estimate for 2008). It will also encourage and nurture the growth of the private sector (in this scenario, the private sector is expected to increase by 225 percent as compared to the base scenario estimate for 2008) in the Philippine FP market, a market long dominated by free public goods which have forced commercial players to concentrate on the high-end niche with correspondingly high-priced commodities. The client shift is expected to create a larger private sector market for lower-priced commodities.



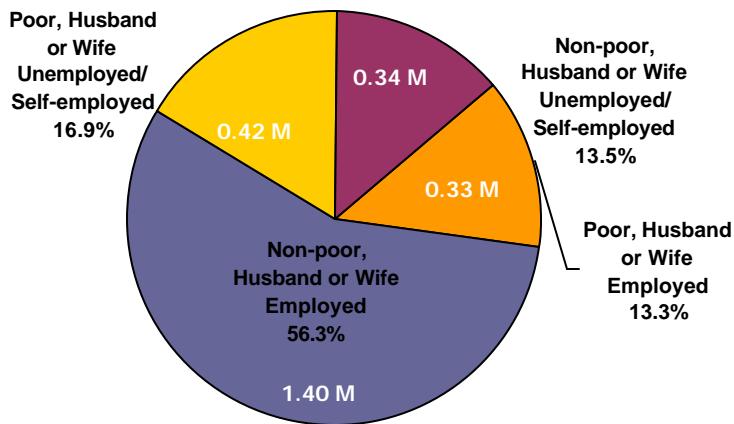
	2004	2008
Public burden as a proportion of DOH FP Budget	183.6 %	85.5 %
Public burden as a proportion of LGU Health Budget	3.1 %	1.4 %

Financing Scenarios for the Public Burden

Given the various policy options available to the government, two possible financing scenarios emerge:

Scenario 1: Additional PhilHealth Funding is Available

An important potential financing source for FP is the National Health Insurance Program. At present, PhilHealth is evaluating the expansion of its FP benefits from bilateral tubal ligation and vasectomy to include pills, IUDs, and injectables. Using employment status as a proxy for PhilHealth membership, estimates show that a policy that withdraws the provision of free public goods from the non-poor coupled by PhilHealth coverage of FP supplies would significantly reduce the public burden to 16.9 percent of those presently being serviced by the public sector. Despite the large reduction shown, this projection of the public burden may, in fact, be an overestimate as it does not account for the possible coverage expansion of PhilHealth programs for the indigent and self-employed.



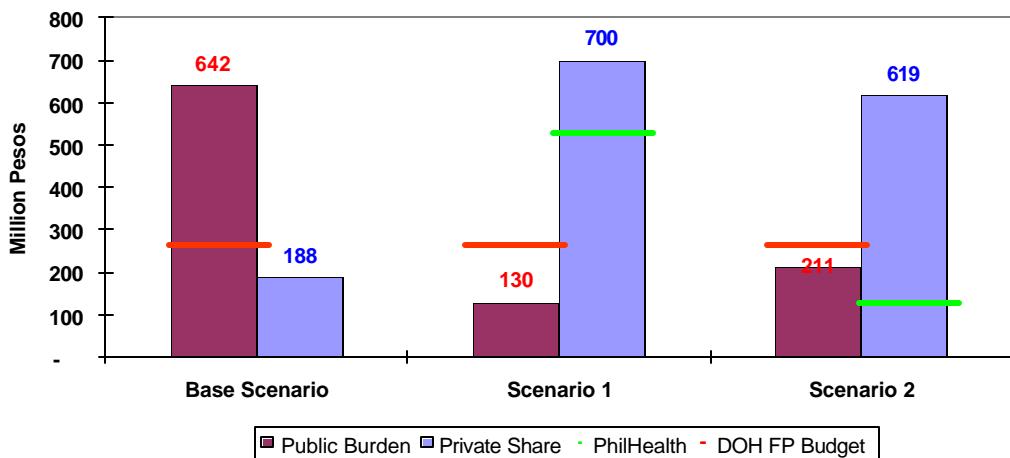
Scenario 2: No Additional Philhealth Financing

In the absence of additional Philhealth funding, other policy options will have to be pursued more aggressively. Among these are:

1. Encouraging the shift through means testing, user fees, and the establishment of a referral system to private facilities and NGOs.
2. Collaborating with the Employers' Confederation of the Philippines (ECOP) and the trade unions in incorporating FP benefits into the collective bargaining agreements and upgrading the capability of company clinics to deliver FP services.

Since option 2 is still in the conceptual stage and its feasibility depends on the willingness of the private stakeholders to cooperate, only the impact of option 1 shall be considered in this simulation as the success of this option is mainly dependent on government action. Shifting the non-poor public sector users to the private sector would leave 30.2 percent of present public sector users as part of the public burden.

The following chart highlights the 2008 public burden and private sector shares of the FP market in the context of the projected budget requirements of DOH and the LGUs. Clearly, the baseline scenario cannot hold given a resulting public burden that is more than two times the FP budget (indicated by the red line) of the DOH and almost five percent of the LGU health budget. As expected, the shifting strategy produces a smaller public burden. Scenarios 1 and 2 show how this public burden can be financed. Scenario 1 shows a smaller burden, since the FP needs of the employed, poor population are covered by insurance. Under Scenario 1, the resulting public burden is reduced to 51 percent of the DOH FP budget (from 676 percent in 1998) and less than one percent of the LGU health budget (from 4.5 percent in 1998) by 2008. Scenario 2, on the other hand, assumes that the FP needs of all poor clients, regardless of employment status, are covered by the public sector. The public burden is consequently higher, amounting to 211 million pesos in 2008, which is 1.4 percent of the projected LGU health budget and 82.4 percent of the DOH FP budget. In 2008, PhilHealth financing (indicated by the green line) is estimated to support private share by 75.4 percent for Scenario 1. Should FP benefits be limited to VSS (Scenario 2), only 19.4 percent of private share would be financed by PhilHealth.



	Base Scenario	Scenario 1	Scenario 2
Public burden as a proportion of DOH FP budget	250.4 %	50.8 %	82.4 %
Public burden as a proportion of LGU health budget	4.2 %	0.9 %	1.4 %

NEXT STEPS

The implementation activities necessarily follow from the shifting/financing strategy discussed. They fall into the two broad categories of national level activities that would be favorable to the growth of the private sector and provide alternative sources of financing, and LGU level activities that flesh out as well as support the national directions.

National Level: Department of Health

At the national level, the DOH has to restate its FP policy especially with respect to its continued provision of services for the poor. It has to be accompanied by a strategy of encouraging the non-poor to pay for FP services and supplies. This is very much in keeping with the pro-poor stance of the present administration. But as it focuses its services on the poor, the DOH should see to it that alternative sources of supplies and services for those who will be denied free services are first in place and are easily accessible. Other less critical but nevertheless important policy decisions at the national level involve issues that would make contraceptives and the correct information about them more accessible to the public, particularly the potential users.

National Level: Philippine Health Insurance Corporation

The decision of PhilHealth to include additional FP benefits – oral contraceptives, injectables, and IUDs in particular – in its basic package has tremendous financial implications. A critical input to the decision is a cost-benefit study that should be able to show the health impact of contraception on PhilHealth members, as well as PhilHealth itself. The result of the cost-benefit exercise should be used to advocate at both technical and political levels. The technical arguments could be derived directly from the study. The political arguments, on the other hand, should build on the government's objective to focus public resources on the poor. Scenario 1 shows that shifting the financing burden on to PhilHealth would accomplish such an objective as the non-poor clients would be shifted out of the public sector. This would allow public facilities to provide more free services and supplies to the poor and underserved sectors of the population. Such a strategy

should also sit well with the oppositors of the FP program who have been advocating for a diminished role by government and a more dominant role by the private sector. The strategy would shift much of the service delivery burden to the private sector, aside from shifting the financial responsibility to individuals and their employers.

Local Level: LGU as the Coordinator of Services

The shifting/financing strategy serves to recast the role of the LGU from just a provider of public health services to a coordinator of public and private health services as well. Effective implementation of the strategy requires that stakeholders in the community assume ownership over it. One way to ensure this would be to convene a multi-sectoral body consisting of stakeholder representatives for a planning exercise to formulate ways of operationalizing the strategies. Having the LGU executives act as convenor would serve to introduce them to their role as coordinator of health services and they shall begin to be seen as such by other stakeholders.

The planning exercise, to be most useful, should be knowledge-driven. It should therefore be supported by background studies which would give a sense of the contraceptive supply and demand situation and the state of the contraceptive service delivery system, with a focus on existing delivery gaps. It should also look into present and potential financing sources for FP, including PhilHealth.

The shifting/ financing strategy should be carried out with a mind to minimizing the risk of drop-outs from the program and ensuring that services and supplies to the poor remain uninterrupted. To help achieve this multi-faceted objective, the following need to be put in place:

- An effective means testing scheme. Experience has shown that such a scheme, to be effective, has to have the support of the political leadership and its constituents. Public sector clients have come to view free public health services as their right, no matter what their economic situation in life. The decision, therefore, to deny access to free goods and services to clients deemed capable of paying, carries with it some political risk. This means that the means testing mechanism should not only be politically sound, it should be well-packaged as well.
- A system of referring public sector clients to the most accessible private clinics. The shift could be eased if low-priced goods and services are made easily accessible. Studies have shown that proximity of supply and service sources encourages contraceptive use.
- A procurement and delivery scheme that would make low-priced supplies available at the LGU facilities. This would avoid having to direct shifted clients elsewhere for their supplies. To implement this, the LGU should explore the feasibility of resource pooling as well as the use of existing parallel importation mechanisms.
- Identification of sustainable financing sources for FP ranging from PhilHealth, LGU budget, and community financing schemes to LGU bond float.