

Health Care Financing

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Abstract

Per capita health care expenditures grew in real terms over the past 25 years. Among the major sources of financing, the contribution of out-of-pocket payments to total health care expenditures was the largest, while organized public and private financing sources have remained relative small. The analysis further finds that health care expenditures among the poorest 40 percent of the population are the lowest. This pattern is consistent with a system that is heavily reliant on a fee-for-service system paid from out of pocket. The paper recommends that for the medium term, existing resources and subsidies be reorganized, reallocated, and targeted in a way that would allow poor families to have better access to quality care, whether publicly or privately provided.¹

Keywords: health care expenditures, social health insurance, out-of-pocket payments, national health accounts

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Introduction

The paper examines health care financing during the last 25 years against the backdrop of economic growth and population change. It is part of a larger health sector review, which aims to assess the long-term impact on health outcomes of health sector reforms that have been implemented in the past 25 years. The long-term view is taken to allow for a better appreciation of long-running fundamental structural strengths and weaknesses of the health sector that affect achievement of the full potential impact of health sector reforms.

The main source of data for the analysis is the National Health Accounts (NHA) produced by the then National Statistical Coordination Board and now under the Philippine Statistics Authority. The NHA provides information on the sources and uses of total health care expenditures of a given year. The data used to estimate the NHA comes from various sources, which include national income accounts, national surveys and financial records of public and private institutions. The data available is from 1991 to 2014. An earlier analysis of the NHA data from 1991 to 1997 (Solon et al. 1999) provided the basis for the formulation of the Department of Health's Health Sector Reform Agenda in 1999 (DOH 1999). This paper expands the analysis to cover the period 1991 to 2014.

The analysis of the observed changes in the way health care services are financed as revealed by the NHA revolves around the following questions: (a) how much are we spending on health care; (b) how are we raising money to pay for health services; (c) what services are we paying for; (d) who benefits from what we spend on health; and (e) how to improve access to health care by the poor? In the analysis, health expenditures are expressed in constant 2000 pesos and in per capita terms to control for inflation and population growth.

Health Care Expenditures

Real Per Capita Health Expenditures Grew from 1991 to 2014, but the Growth Has Been Uneven

A summary of how much is being spent on health is shown in figure 1. Real per capita health expenditures grew from PHP 1,219 in 1991 to PHP 3,528 in 2014, close to a three-fold increase in 24 years. However, the growth has been uneven. During the period 1991-2004 real per capita health expenditures were flat on average. The increases from 1991 to 1997 were followed by declines in spending from 1998 to 2004 owing to the effects of the Asian financial crisis (United Nations Population Fund and Australian National University 1998). From 2005 to 2014 real per capita health expenditures grew, with faster growth observed during the period 2010 to 2014.

Health Spending Moved with Economic Growth (Recovery from Crisis Raised Health Spending)

The trend in real per capita total health expenditures can be examined in relation to the trend in real per capita Gross Domestic Product (GDP), as shown in figure 2. The real per capita GDP growth over the 24-year period was interrupted by the Asian financial crisis of

1997 to 1998. The average real per capita GDP growth from 1991-2004 was 1.4 percent, and 3.6 percent from 2005 onwards. In comparison, the growth in real health spending per capita averaged 2.6 percent from 1991-2004, and 8.2 percent from 2005 onwards. Over the entire period, real health spending per capita rose much faster at 5 percent than the growth of real GDP per capita at 2.4 percent.

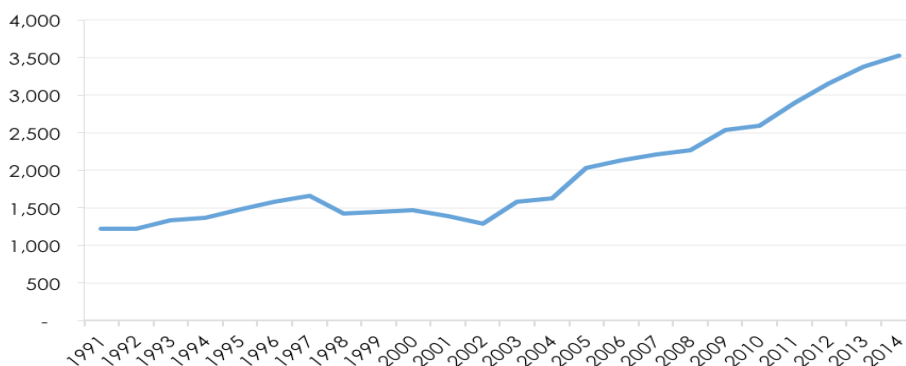


Figure 1. Per capita total health expenditures, 1991-2014 (at constant 2000 prices)

Sources: National Statistical Coordination Board 2004, 2013, 2015; Philippine Statistics Authority 2015; Racelis et al. 2016

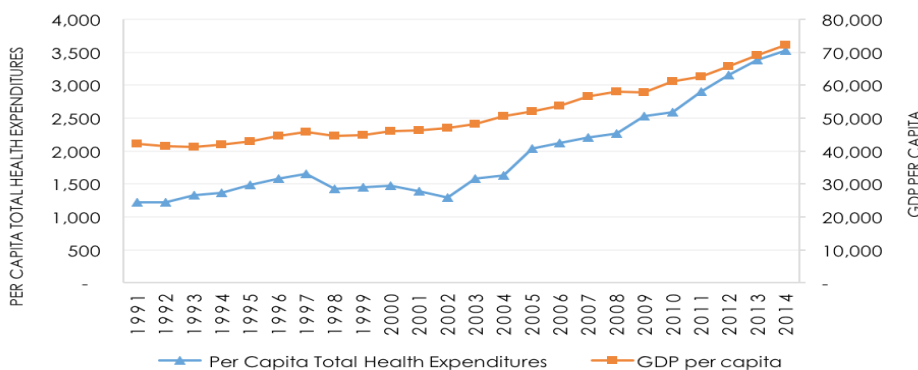


Figure 2. Per capita total health expenditures and GDP per capita, 1991-2014 (at constant 2000 prices)

Sources: National Statistical Coordination Board 2004, 2013, 2015; Philippine Statistics Authority 2015; Racelis et al. 2016

But Health Spending is Lower Relative to Countries with Higher Economic Growth

Real health spending per capita as a share of GDP per capita averaged 3.2 percent from 1991 to 1994. This share increased to 4 percent in 2005 to 2013. Levels of health spending

Health Care Financing

per capita as a share of GDP in Thailand are comparable at 4.1 percent from 2005 to 2013. However, real health spending per capita in the Philippines is less than half of that in Thailand due to Thailand’s much higher GDP per capita, as shown in figure 3.

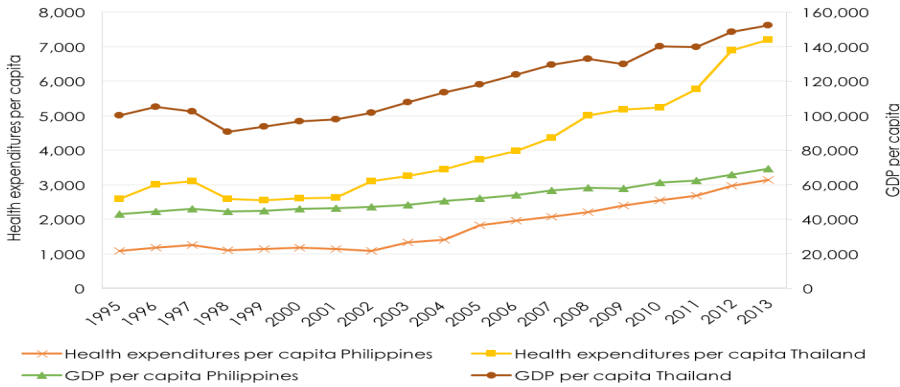


Figure 3. Health expenditures per capita and GDP per capita, 1995-2013 (in Philippine pesos at constant 2000 prices): Philippines and Thailand

Sources : National Statistical Coordination Board 2004, 2013, 2015; Philippine Statistics Authority 2015; Racelis et al. 2016; Authors calculation using World Bank, International Comparison Program database
 Note: GDP per capita for Thailand converted to 2000 PhP. Conversion factor estimated using GDP deflator

Sources of Funds to Pay for Health Services

The question of how finances for health are being raised will be discussed through various financing agents: (1) local government units; (2) national government agencies; (3) social health insurance; (4) private insurance, including HMOs; establishment-based health programs; and (5) family out-of-pocket spending.

Local Government Units

With LGC Implementation, Local Spending Initially Increased but Remained Relatively Flat since 1998

With the implementation of the Local Government Code of 1991, local spending increased from PHP 166 in 1993 to PHP 444 in 2014, as shown in figure 4. During the period 1993 to 1997 real per capita local government health expenditures rose owing to devolution. From 1998 onward local government health spending was relatively flat as the net increase was only PHP 150 over 16 years. Using data from 1992 to 2013, the report observes that the average increase in real per capita LGU spending for health over the same period is only PHP 12 per year. Meanwhile, the average increase in real per capita IRA is about PHP 36.

But Local Health Spending Did Not Rise as Fast as the Rise in IRA

However, local health spending did not rise as fast as the rise in internal revenue allotment (IRA). Note that during the same period, i.e., 1993 to 2014, there were rapid increases in IRA as shown in figure 5. Data from 1992 to 2013 show that for every one peso increase in real per capita IRA, only 33 centavos goes to health. It appears that the LGUs have not been an active financing source for health despite many attempts to leverage such spending and despite health being one of the largest devolved sectors.

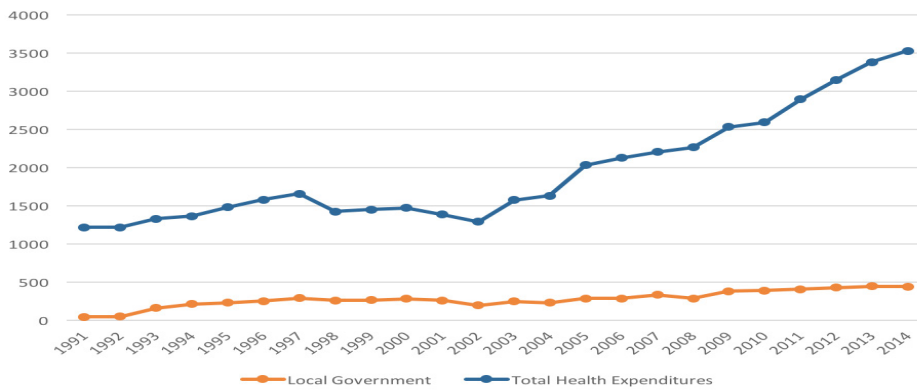


Figure 4. Per capita total health expenditures and per capita local government health expenditures, 1991-2014 (at constant 2000 prices)

Sources: National Statistical Coordination Board 2004, 2013, 2015; Philippine Statistics Authority 2015; Racelis et al. 2016

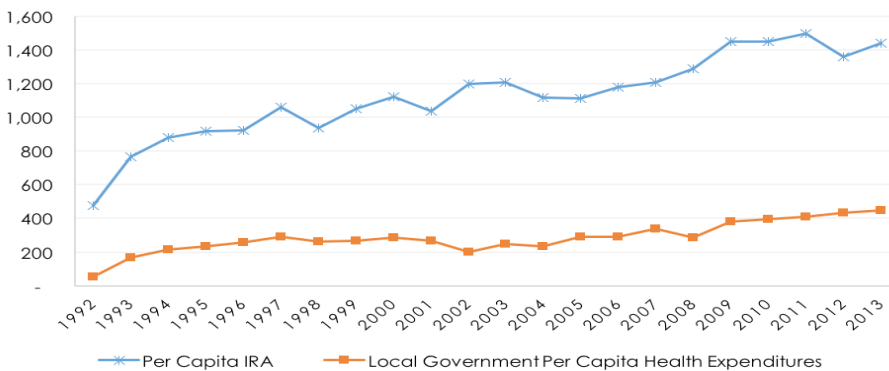


Figure 5. Per capita internal revenue allocation (IRA) and per capita local government health expenditures, 1992-2013 (in PhP Constant 2000 Prices)

Source: PSA, various years and DOH/WHO NHA Project (2016)

Health Care Financing

To put these increases in perspective, it should be noted that in 1992 the average real per capita health expenditure by LGUs was PHP 53, which then increased to PHP 449 in 2013, which is not much considering that per capita out-of-pocket spending was already at PHP 1,777 in 2013. Moreover, while the bulk of government health facilities and health workers were devolved to local government units after 1992, the share of LGU spending on health to total health expenditure increased from the pre-devolution level of 4 percent to 19 percent in 2000, only to decline to 13 percent in 2014.

National Government Agencies

National Government Health Spending Recovers Pre-Devolution Levels Beginning 2007

With the devolution, real per capita health expenditures by the national government declined from PHP 421 per capita in 1991 to PHP 187 in 2002. Note that it was around 2002 when the lowest post devolution per capita LGU spending was observed. However, beginning 2008 the national health budget increased so that by 2014 it was almost equal its pre-devolution per capita spending level (see figure 6). This rise in national spending corresponds to that set of reforms where national government began to compensate for gaps and weaknesses in local health systems.

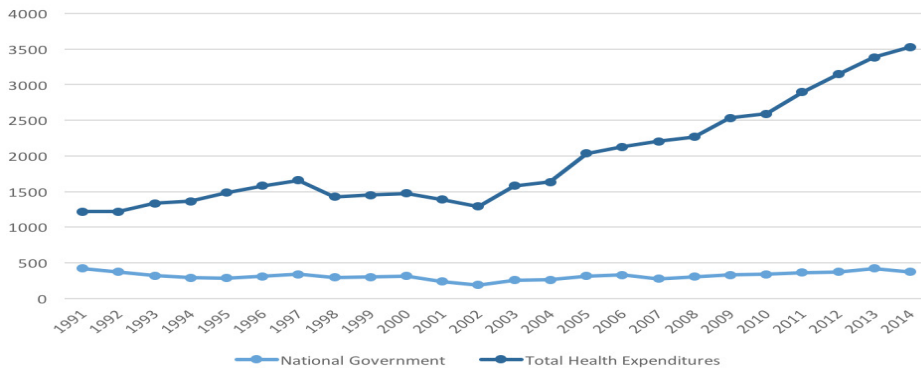


Figure 6. Per capita total health expenditures and per capita national government health expenditures, 1991-2014 (at constant 2000 prices)

Sources: National Statistical Coordination Board 2004, 2013, 2015; Philippine Statistics Authority 2015; Racelis et al. 2016

As Nominal Health Budgets Increase, Effective Utilization Becomes a Challenge

As shown in figure 7, a closer examination of the DOH budget reveals that levels were relatively low and flat from 1991 to 2007 but increased steadily thereafter so that by 2010, the budget was twice that of 2007. This trend continued so that by 2015 the DOH budget had grown to more than three-fold that of 2007 levels. In 2016 the DOH budget rose even higher to PHP 73.8 billion, or three times the 2010 budget levels. These increases in the budget may

be attributed to the expanded fiscal space and priority given to social services. Beginning 2014 around PHP 40 billion each year has been attributed to proceeds from “sin taxes” (Department of Health 2015).

However, as figure 7 also shows, while these substantial increases in the DOH budget led to the increased scale and scope of programs, the capacity of DOH to effectively utilize its budget has become strained. The DOH is able to obligate only about 82 percent of its budget for each budget cycle, albeit at larger allocations over time. Unobligated funds are then passed on as continuing appropriations to the following budget year. These unobligated budgets further add to the increasing amount that the DOH has to utilize the following year. More importantly, unutilized funds represent missed opportunities to provide health services.

Difficulties in fully utilizing the budget are reflective of the limited capacity of the DOH to address procurement bottlenecks. In the case of the Health Facilities Enhancement Program (HFEP), there were not enough engineers and architects to design facility upgrading, and not enough Central Office Bids and Awards Committees (COBAC) could be created to bid out and award civil works contracts. Moreover, there were insufficient technical personnel available to monitor the pace of facility upgrading. Limited in-house capacity could have been addressed by pooling multiple projects into large packages that could then have been outsourced (Picazo, Pantig, and dela Cruz 2015).

The data on expenditures indicate actual spending for the year for both the current allocation and any continuing appropriations from previous years. As such, the amounts spent do not necessarily reflect the spending for the corresponding budget year. Continuing appropriations that lapse are eventually returned to the National Treasury. The DOH had to return to the National Treasury an average of PHP 1 billion per year from 2011 to 2013. In 2014 the DOH returned PHP 400 million (UPEcon - Health Policy Development Program 2014).

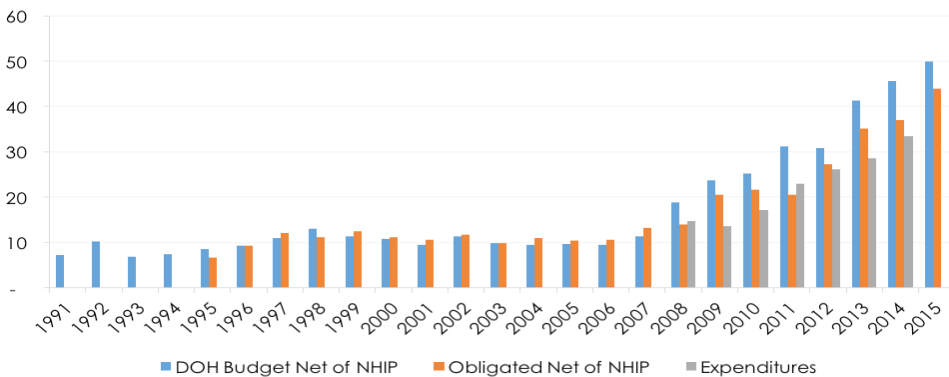


Figure 7. DOH budget net of NHIP, 1991-2015 (in billion pesos, current prices)

Source: General Appropriations Act from 1991 to 2015; Commission on Audit Reports for DOH from 2008 up to 2014; Department of Health Fund Utilization Reports from 2010 to 2015

Social Health Insurance (PhilHealth)

PhilHealth Benefit Spending Registered the Fastest Rate of Increase among Public Sources

Social health insurance benefit spending registered the fastest rate of increase among public sources, as shown in figure 8. From 1991 to 1998, health expenditures represent the expenditures of the Medicare program and the early years of PhilHealth. Average real per capita health spending was PHP 73, which represents 5.2 percent of total per capita health spending.

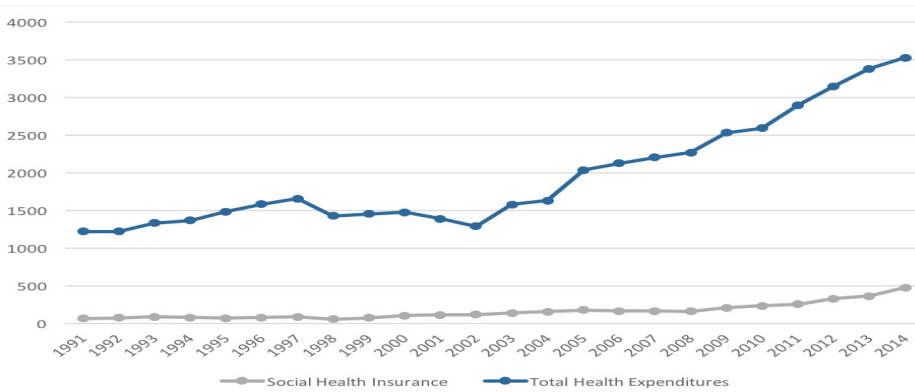


Figure 8. Per capita health expenditures of social health insurance, 1991-2014 (at constant 2000 prices)

Sources: National Statistical Coordination Board 2004, 2013, 2015; Philippine Statistics Authority 2015; Racelis et al. 2016

PhilHealth spending increased during the period 1999-2008 with the introduction of the sponsored program. During this time the average per capita spending was PHP 136 (7.8 percent of total health spending), representing an 86 percent increase over the previous period. However, further increases were constrained by the cost of negotiating and collecting premium counterparts from 81 provinces, 143 cities, and 1,459 municipalities yearly (UPEcon - HPDP 2013a; 2013b).

Subsequently, with the introduction of new benefits and when national government assumed the full cost of premiums for the poor as identified by the National Household Tracking System for Poverty Reduction (NHTS-PR), PhilHealth per capita spending for the period 2009-2014 rose to PHP 309, representing 10 percent of total health spending per capita. By 2014 PhilHealth was spending PHP 476 per capita, representing 14 percent of total health spending. However, this amount could have been much larger given PhilHealth’s claim to have covered 87 percent of all Filipinos in 2014 for nearly all International Classification of Diseases ICD) 10 conditions. What PhilHealth has managed to do is to pay a little bit of everything for all Filipinos.

PhilHealth Coverage is at 87 Percent, but Its Share to Total Health Spending Remains Low

While PhilHealth coverage was at 87 percent in 2014, its share to total health spending remained relatively low. The share of PhilHealth in total health spending in real per capita terms increased from 5 percent in 1991, to 9 percent in 2002, and to 14 percent in 2014, as shown in figure 9. This fell short of the national target of 30 percent set in the 1999 DOH Health Sector Reform Agenda (HSRA).

Factors Limiting the Growth in PhilHealth Spending

The challenges facing the National Health Insurance Program were already described way back in 1999 by the DOH HSRA which specified the following actions: 1) increase PhilHealth share of total spending from 5 to 30 percent; 2) enroll the poorest 25 percent Filipinos; 3) link PhilHealth payments to quality care; 4) cover out-patient benefits; and 5) accredit public and private facilities. In response to these challenges, innovations were introduced, including the introduction of the out-patient benefit package paid through a capitation scheme, Tuberculosis-Directly Observed Treatment, Short Course (TB DOTS) package, and Maternal Care Package (MCP), among others. It should be emphasized, however, that these additional out-patient packages were introduced without the accompanying premium increases.

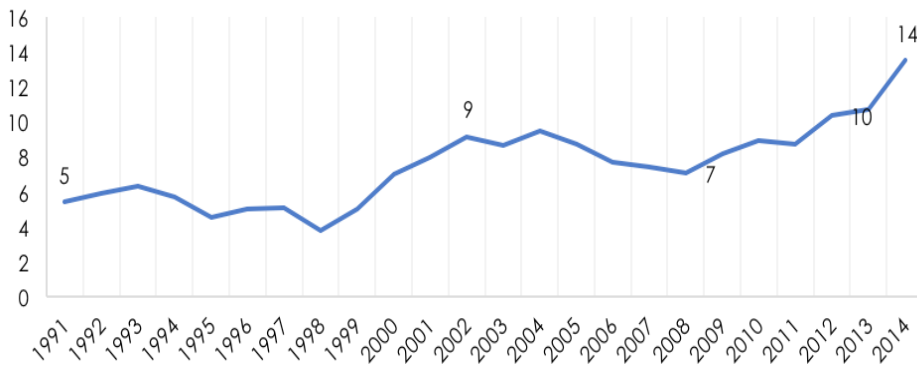


Figure 9. PhilHealth share in total health expenditures, 1991-2014 (in percent)

Sources: National Statistical Coordination Board 2004, 2013, 2015; Philippine Statistics Authority 2015; Racelis et al. 2016

The next wave of reforms (under FOURmula ONE for Health) focused on enrolling the poorest 25 percent Filipinos into PhilHealth. PhilHealth regional offices were strengthened and given the autonomy to negotiate with LGUs. PhilHealth offered the following to encourage enrolment and remittances of LGU premium counterparts: (1) paid capitation payments without clear accountabilities with respect to benefits to be delivered and members to be served (capitation payments were essentially used as rebates for enrolment); (2) LGUs were left to their own devices to determine who the poor were in their jurisdictions, allowing local chief executives (LCEs) to use enrolment to enhance political patronage; (3) accreditation requirement for rural health units (RHUs) and LGU hospitals were essentially waived,

Health Care Financing

creating a double standard between public and private facilities; and (4) implementation of the mandated gradual reduction of national subsidy share premiums provided by law were not implemented.

Moreover, a host of novelty benefit packages were also introduced to respond to popular demands. Examples were the malaria package, influenza, HIV/AIDS, etc. Again, these packages were introduced without corresponding adjustments in premiums.

The national health insurance program law of 1995 allows for premiums to be collected in a progressive manner. The implementing rules provide for a contribution rate of no more than 3 percent of salaries be contributed as premium payment for regular members. However, only a 2.5 percent contribution rate has been applied since. In addition, salary caps have been set too low with infrequent adjustments, preventing PhilHealth from collecting sufficient and progressive premiums. For example, in the year 2000, members with monthly salaries of PHP 7,500 and above only contributed PHP 187 per month to cover the principal and dependents. Note that in the same year, the salary cap was below the average family income of PHP 12,000 per month. From 2012 to the present, the salary cap is set at PHP 35,000 per month, implying a maximum monthly premium of PHP 875 per month per family. In comparison, a local health maintenance organization offers health benefits up to PHP 60,000 for a premium of PHP 865 per month per individual. This suggests that, while the salary cap has been adjusted upwards, the implied premium imposed on top earners are way below that charged by a basic package offered in the market.

A number of factors have prevented total PhilHealth spending from increasing significantly. First, for PhilHealth to deliver larger benefits, it must increase premiums, as noted above. While some adjustments in the premiums were made, there has been no significant real increase in premiums during the 2005–2014 period of relatively rapid economic growth.

Second, using sin taxes to fully fund the premium subsidy of the poor simply releases LGUs from their obligation to contribute to premiums. The only real effect on benefit spending comes from the certainty of a fully nationally-funded premium subsidy.

Third, the lack of information, as well as operational and procedural barriers, prevent the premium subsidies to be translated into benefit spending (Quimbo et al. 2008). Operational barriers include heavy documentary requirements, lack of information about membership status and benefit entitlements, and lack of access to accredited facilities.

Fourth, rising real per capita out-of-pocket spending suggests that families are accessing better quality, more expensive medical services. Because PhilHealth benefits have a fixed ceiling, its support value declines as the total health care bill increases. This pressure increases as both public and private facilities respond to rising demand.

Finally, the introduction of new benefit packages without a corresponding increase in premiums also reduce support value. For example, recently introduced benefits, like the Primary Care Benefit (PCB) and Case Type Z Benefit Package (Z-Package), cannot be expected to substantially raise the PhilHealth share in total spending because all these have been introduced within the same budget envelope. Moreover, having PhilHealth extend

benefits to population groups that do not pay the appropriate premium contributions, e.g., lifetime members, will not increase the share of PhilHealth in total health care spending.

The overall impact of increasing population coverage, the introduction of new benefits, raising benefit ceilings, expanding accreditation, and raising benefit utilization can be measured in terms of the Benefit Delivery Rate (BDR) developed by UPecon-Health Policy Development Program for DOH and PhilHealth (Millar et al. 2011). The BDR—defined as the product of population coverage, benefit utilization, and support value—essentially approximates the share of PhilHealth in total health expenditures given existing premium revenues. In 2008 the BDR was estimated at 9.5, meaning that the total payments made by PhilHealth would only be able to fully reimburse one out of 10 patients. After expanding population coverage and introducing new benefit packages, the BDR only managed to increase to 13.4 in 2012. This suggests that reforms by way of coverage, better benefits, and more effective provider payments can only do so much without raising premiums. Hence, the next wave of reforms might have to involve raising premium contributions, but conditioned on changing specific program elements to improve efficiency and equity.

Private Health Insurance

Private Insurance and HMO Spending Increased, but Spending by Enterprises Remained Flat

Real per capita health expenditures by private health insurance providers and HMOs increased over the period, especially since 2005, although its level is still relatively low compared to total health expenditures as shown in figure 10. Spending by private enterprises, which includes direct health service spending or reimbursement of employee health expenses as part of employee fringe benefits, has remained flat relative to total health expenditures. This could be due to the slow growth of formal wage sector employment

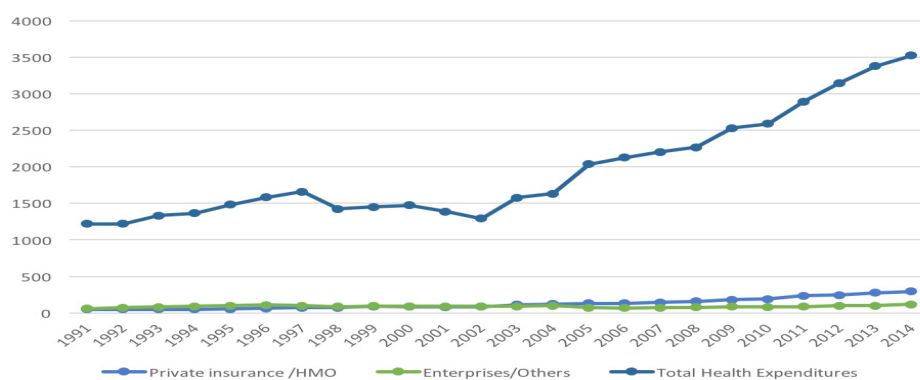


Figure 10. Per capita total health expenditures and per capita health expenditures of private insurance/HMO and enterprises/others, 1991-2014 (at constant 2000 prices)

Sources: National Statistical Coordination Board 2004, 2013, 2015; Philippine Statistics Authority 2015; Racelis et al. 2016

Health Care Financing

and the shift of direct spending by enterprises to private insurance providers and Health Maintenance Organizations (HMOs), and PhilHealth payments.

Family Out-of-Pocket Payments

Family Out-of-Pocket Payments Remain the Biggest and Fastest-Growing Financing Source

Family out-of-pocket payments remain the biggest and fastest-growing financing source as shown in figure 11. It is even larger than the combined amount from public and private institutional and organized sources, especially in the period since 2005 when economic growth was higher. It has been the real, dynamic, and responsive source of financing. The increase in out-of-pocket payments is mainly driven by increasing disposable incomes of people, as shown in figure 11, as changes in out-of-pocket spending coincide with changes in GDP per capita.

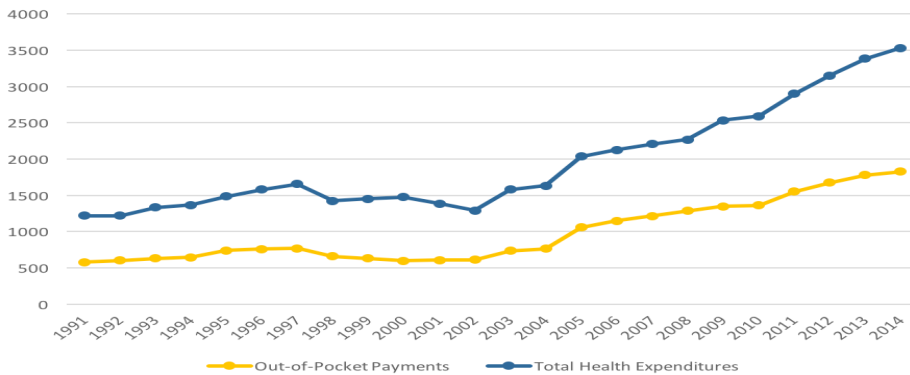


Figure 11. Per capita total health expenditures and per capita out-of-pocket payments, 1991-2014 (at constant 2000 prices)

Sources: National Statistical Coordination Board 2004, 2013, 2015; Philippine Statistics Authority 2015; Racelis et al. 2016

There are two concerns, however, regarding large out-of-pocket payments in relation to total health spending. The first is with regard to inequities where, given the uneven distribution of income, only those with the capacity to pay can access needed health care. Equity concerns shall be discussed in detail when the question, who benefits? is addressed.

The second concern is with regard to inefficiencies from lack of risk-pooling. A fee-for-service system financed by out-of-pocket payments misses out on the efficiency gains from risk-pooling. Individual families will have to set aside resources equivalent to the average cost of hospitalization in the face of health risks. With a viable insurance system, individual families will have to save only the equivalent of a premium.

The efficiency gains expected from social health insurance and the public delivery system ultimately rest on their ability to leverage performance for the entire system. While social

health insurance and the public delivery system account for 37 percent of total spending in 2014, which is down from 43 percent in 1991, their ability to leverage for performance is impaired by their being highly fragmented. While national government accounts for 11 percent of total health care spending, this fund is spent on various stand-alone programs. The 13 percent share of local government units is spent by 81 provinces, 143 cities, and 1,459 municipalities, each managing its own fund independently and addressing a widely heterogeneous set of local health issues. While the social health insurance share has moderately increased to 14 percent, its influence over both the public and private health care delivery sectors grows weaker as it introduces more and more benefit packages, all funded by a fixed budget envelope.

However, there may be efficiency gains from out-of-pocket spending. First, it is choice-based so that it can instill cost discipline, drive innovations, and make high quality care available. Being choice-based, families can go to wherever they think they can get the best care. Second, services are not rationed, allowing families to access care according to capacities to pay. Third, the system being funded on a fee-for-service basis also drives innovation, thus ensuring that quality care is available. On the contrary, public delivery systems which operate on fixed budgets have less incentive to innovate and provide quality care. Fourth, an out-of-pocket funded fee-for-service system also instills discipline on the demand side. Since families will be paying for the full cost of care, there is a natural incentive for them to be less wasteful and more careful in making choices.

The features of a fee-for-service system that generates the above efficiency needs to be carefully understood and applied in public settings. Premium discounts, expansion of benefits, and the expansion of co-pays can take the place of market-driven costs to instill discipline among PhilHealth members. For example, premium discounts can be given to the families whose children are completely vaccinated. Families who do not smoke or who exercise or lead healthy lifestyles may be given higher benefits to cover unpreventable diseases like those associated with ageing.

The Contribution to Total Health Expenditures of out-of-Pocket Payments as the Largest, while Organized Public and Private Financing Sources Have Remained Relatively Small

In summary, the contribution to total health expenditures of out-of-pocket payments was the largest, while organized public and private financing sources have remained relatively small, as previously shown in figure 12. The good news is that real per capita health spending went up. The question, however, is who was responsible for the increased spending? One can see the contrast between out-of-pocket payments and the rest of the sources of spending. While out-of-pocket payments increased with economic growth, organized sources of financing were not able to cash in on the increase in disposable incomes. For example, PhilHealth could have increased premiums at the economic upswing.

Health Care Financing

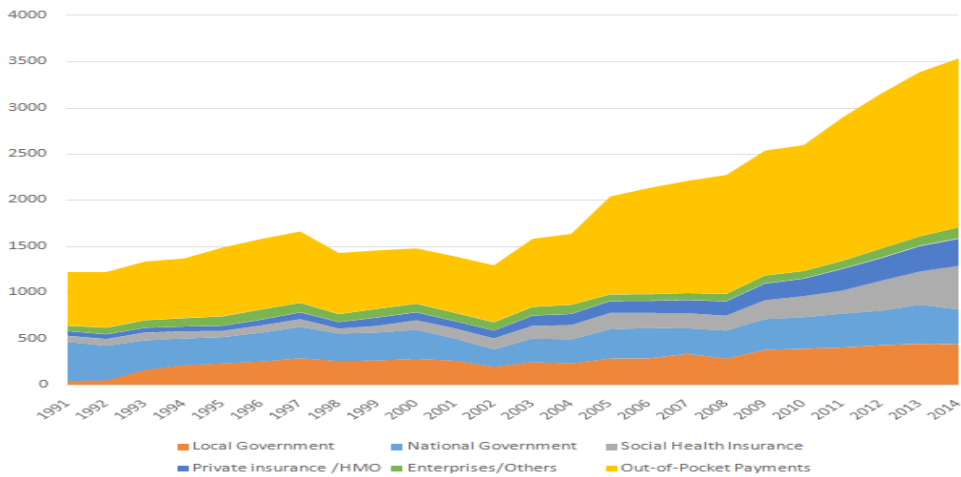


Figure 12. Per capita total health expenditures by financing agent, 1991-2014 (at constant 2000 Prices)

Sources: National Statistical Coordination Board 2004, 2013, 2015; Philippine Statistics Authority 2015; Racelis et al. 2016

Expenditures on Health Services

Most Health Services are Paid for by Family Out-of-Pocket Payments Even for Services with Public Health Benefits

Most health services are paid for by out-of-pocket payments even for services with public health benefits. Figure 13 shows that there is significant out-of-pocket spending for public health concerns like maternal, neonatal and child health and nutrition (MNCHN) services, respiratory infections, tuberculosis, diarrhea, and other infectious and parasitic diseases. Contrary to expectations, government sources pay for less than half of total spending on these public health concerns. However, there seems to be little or no willingness to pay from out-of-pocket for mental health, malaria, and HIV and AIDS.

Beneficiaries of Health Spending

The Poor Do Not Receive Adequate Support from Public Financing Sources

The question of who benefits from health spending is discussed by looking at health expenditures by wealth quintiles. The poor do not receive adequate support from public financing sources as shown in figure 14. As expected, higher income groups use out-of-pocket payments, but they also dip into public sources provided by the DOH, PhilHealth, and LGUs. The policy concern is that the poor are crowded out from public subsidies. In total, higher income groups get more subsidies from various public financing sources. There is no preferential access for poor families in the Philippine health system.

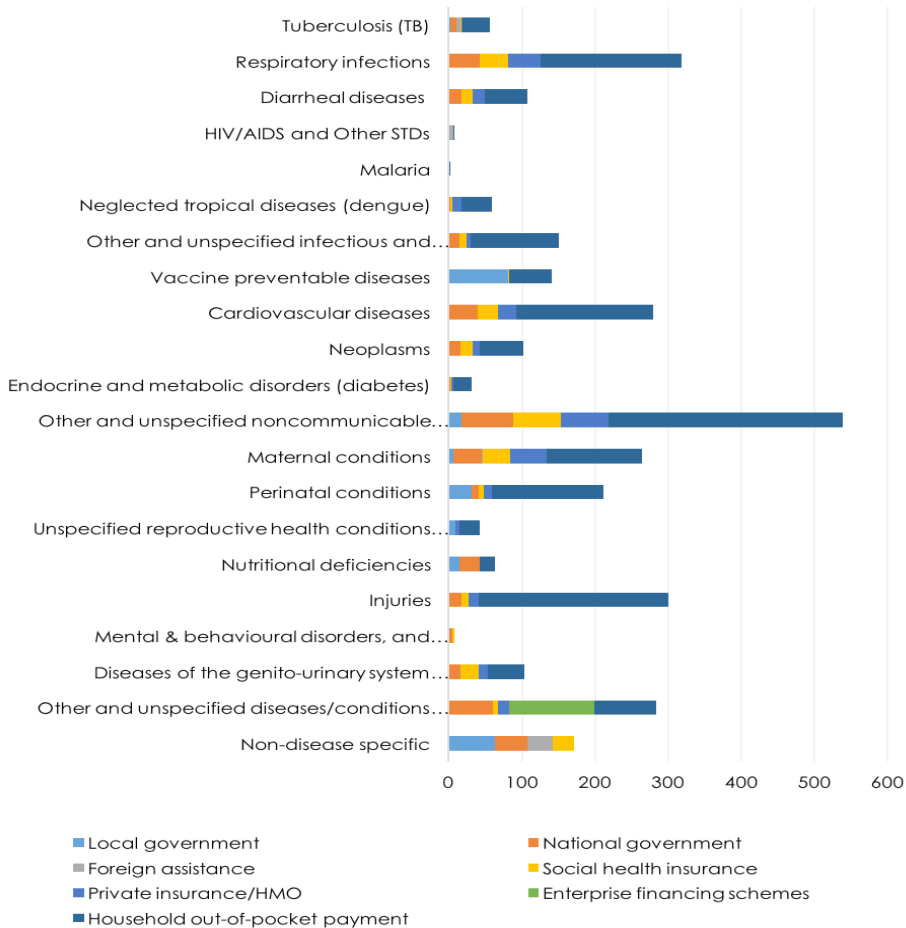


Figure 13. Per capita current health expenditures by disease group and by financing agent, 2014 (constant 2000 prices)

Source: Racelis et al. 2016

On the whole, mainly higher income groups are able to access health care services. Funds delivered through the public sector do not effectively target the poor. Moreover, where budgets are lacking, public facilities will increasingly depend on “outside purchases” that see patients who can pay crowding out patients from lower income families. Under the current situation, the poor are unable to access health care because of their own limited resources and their inability to capture public subsidies.

A fee-for-service system exposes the near-poor and middle income families to greater financial risks. The near-poor and middle income families are put into a precarious situation owing to the absence of a viable insurance scheme that effectively pools risks. Under a largely fee-for-service system, hospitalization could easily wipe out family savings

Health Care Financing

and compromise future investments, including human capital. Another way of expressing this concern is that those who manage to stay above the poverty line could easily fall below if hit by a financially catastrophic illness (van Doorslaer, et al. 2006, 2007 and 2008; Ulep and dela Cruz 2013; Bredenkamp and Buisman 2016).

Recommendations to Improve Access to Health Care by the Poor

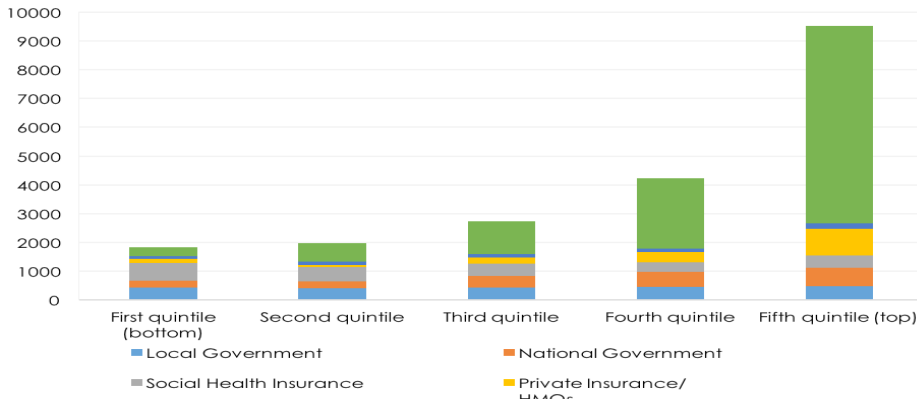


Figure 14. Per capita current health expenditures by financing agent and by income quintile, 2014 (at constant 2000 prices)

Source: Racelis et al. 2016

Where We Can Be, Given Current Public Resources

The approach to improve access to health care by the poor using public financing can be discussed under two scenarios. The first assumes that there are no additional resources so that improvement in access to health care by the poorest three quintiles can only be obtained by removing all subsidies from the higher income quintiles and transferring these to the bottom quintiles as shown in figure 15. This can be done by charging users from the top quintiles the full cost of care through user fees. If these users continue to access public services and pay, the revenues can be used to cross-subsidize services for the poor. On the other hand, if they stop going to public facilities, health budgets will be freed up, allowing more resources for the poor. To complement user fees, the premium contributions of families from the richer quintiles need to be increased to a level commensurate to the benefits that they receive. These will free up enough funds to raise the health care expenditure of the lowest two quintiles without increasing out-of-pocket payments. Furthermore, the distribution of publicly procured commodities needs to be redirected to facilities that serve poor communities. In figure 15 the desired result is shown in the right panel where the potential expenditures of the two poorest quintiles are now increased.

Where We Can Be, Given Additional Resources

Under the second scenario, it is assumed that additional public resources can be generated. The overall approach is to use the additional resources to even out health spending as shown in figure 16. The desired result in the right panel shows that the potential expenditures for families belonging to the poorest three quintiles have now been increased to the level of health spending by families from the second richest quintile. Expressed in terms of total expenditures for the three lowest quintiles in 2014 prices, the required increase is roughly 30 percent of total spending. It should be emphasized that the introduction of user fees, increases in premiums, and targeting of public commodities should still be undertaken.

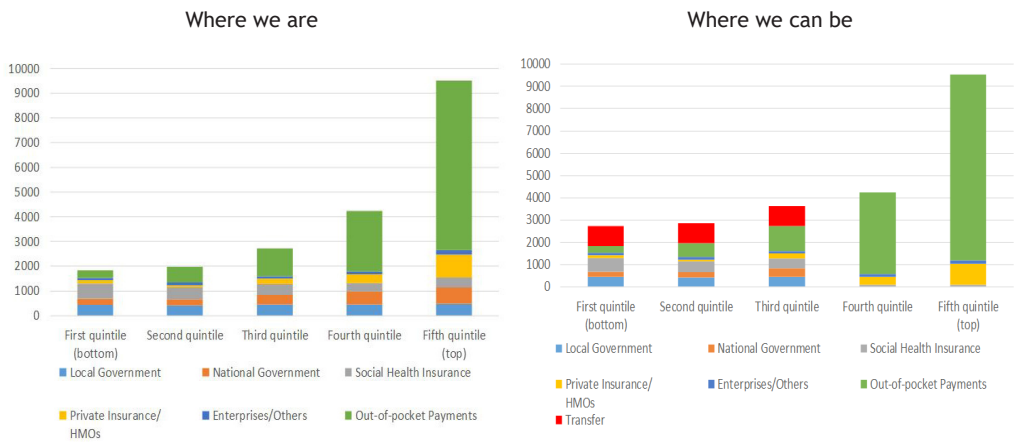


Figure 15. Where we are and where we can be with the current public resources

Source: Authors calculation using the 2014 NHA as reported in Racelis et al. 2016

Conclusion

Per capita health care expenditures grew in real terms over the 25-year period, following the pattern of economic growth. A major finding is that among the various sources of financing, the contribution to total health expenditures of out-of-pocket payments was the largest while organized public and private financing sources have remained relatively small. The analysis further finds that health care expenditures among the poorest 40% of the population are the lowest. This pattern is consistent with a system that is heavily reliant on a fee-for-service system paid from out-of-pocket.

The paper notes that several innovations have been introduced to raise the impact of public health budgets and improve the performance of the national health insurance program. These include changes in insurance coverage, introduction of new benefit packages, and better measures and mechanisms to monitor quality of care. However, difficulties were encountered in trying to scale up these innovations, largely owing to the transactions cost of engaging a highly fragmented service delivery and financing system that arose as a consequence of devolution.

Health Care Financing

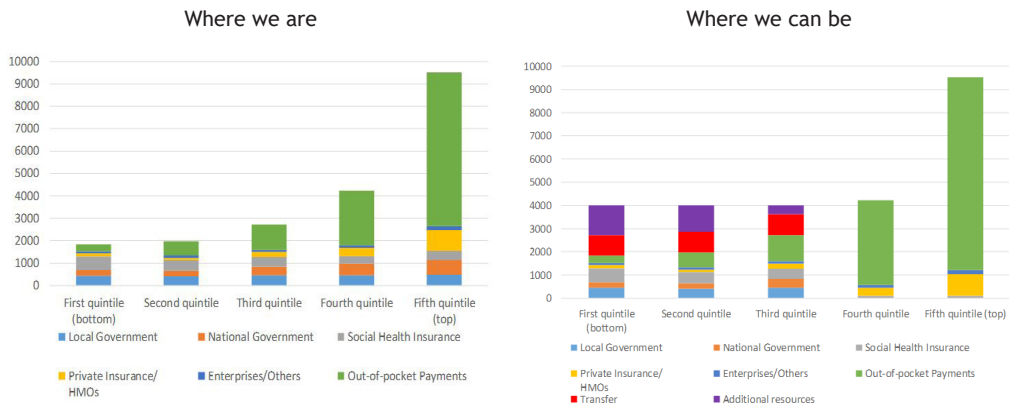


Figure 16. Where we are and where we can be with additional public resources

Source: Authors calculations using the 2014 NHA as reported in Racelis et al. 2016

The paper recommends that for the medium-term, existing resources and subsidies need to be reorganized, reallocated, and targeted in a way that would allow poor families to have better access to quality care, whether publicly or privately provided. In the larger report, it is recommended that for the long-term, substantial investments in technical and managerial capacities need to be made so that the DOH and PhilHealth are better able to assess problems, devise solutions, and implement innovations at scale.

Note

1. This is part of a larger report “The Challenge of Reaching the Poor with a Continuum of Care: A 25-Year Assessment of Health Sector Performance” by the UPecon Health Policy Development Program. It is a slightly revised version of the health care financing chapter of the report. The report is edited by Orville Solon, Carlo Panelo, Alejandro N. Herrin, Rebecca Ramos, Carlos Antonio Tan Jr., and Aleli Kraft.

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