

## Who Pays and Who Benefits from Health Care Reforms? (A Quick Look at the Last 25 Years)

UPEcon Health Policy Development Program  
April 7, 2014

HPDP is a five-year United States Agency for International Development (USAID) health policy project (Cooperative Agreement No. AID-492-A-12-00016) implemented by the UPEcon Foundation, Inc. It supports the DOH-led policy formulation process for scaling up Universal Health Care.

The UPEcon-HPDP Health Sector Review research team is led by the following (in alphabetical order): Alejandro Herrin (UPSE Professorial Lecturer), Aleli Kraft (UPSE Professor), Carlo Panelo (UPM Professor), Rebecca Ramos, Orville Solon (UPSE Dean and Professor) and Carlos Tan. The following resource persons (in alphabetical order) were also consulted in the drafting of the HSR: Oscar Abadu, Gloria Balboa, Eduardo Banzon, Ruben John Basa, Vicente Belizario Jr., Esperanza Cabral, Joseph Capuno, Antonio Dans, Ernesto Domingo, Rhais Gamboa, Teodoro Herbosa, Jaime Lagahid, Mary Ann Lansang, Ella Naliponguit, Enrique Ona, Teodoro Padilla, Stella Quimbo, Mianne Silvestre, and Francisco Soria.

This document is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the sole responsibility of UPEcon-HPDP and do not necessarily reflect the views of UPEcon Foundation, Inc., USAID or the United States Government.



## **Pays and Who Benefits from Health Care Reforms? (A Quick Look at the Last 25 Years)**

UPEcon Health Policy Development Program  
April 7, 2014

### **Introduction**

The paper examines health care financing during the last 25 years against the backdrop of population change and economic growth. The current analysis is part of a continuing effort to monitor health sector reforms. It is expected to complement other efforts at reviewing health sector performance.

The main source of data for the analysis described in this paper is the National Health Accounts (NHA). 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 include national income accounts, national surveys and financial records of public and private institutions.

The first NHA estimate was for the year 1991 completed in 1994 by the UPEcon Health Policy Development Program (UPEcon-HPDP). This was presented to DOH officials and members of the Senate in 1994. The observation that the then Medicare constituted only 5 percent of total health care expenditures in spite of almost 20 years of implementation provided the motivation to strengthen the health insurance law, which eventually led to the enactment of the National Health Insurance Program (NHIP) in 1995.

UPEcon-HPDP continued to produce the first set of estimates for 1991-1994. Together with the National Statistical Coordination Board (NSCB), another set was estimated for 1995-1997. Through joint efforts to achieve consistency in methodology and estimation approach, UPEcon-HPDP and NSCB teams finalized the series for 1991-1997. The NSCB Board approved the series and released them to the public in March 1999. The NSCB (now PSA) continued the series to this day. An analysis of the 1991-1997 NHA series published in 1999 provided the analytical basis for the formulation of the DOH's Health Sector Reform Agenda of 1999 and the implementing framework of the DOH's FOURmula ONE for Health in 2005. It also served as the basis for continuing reforms under the Aquino Health Agenda in 2010.

The analysis of the observed changes in the way health care services are financed as revealed by the NHA revolves around the following questions:

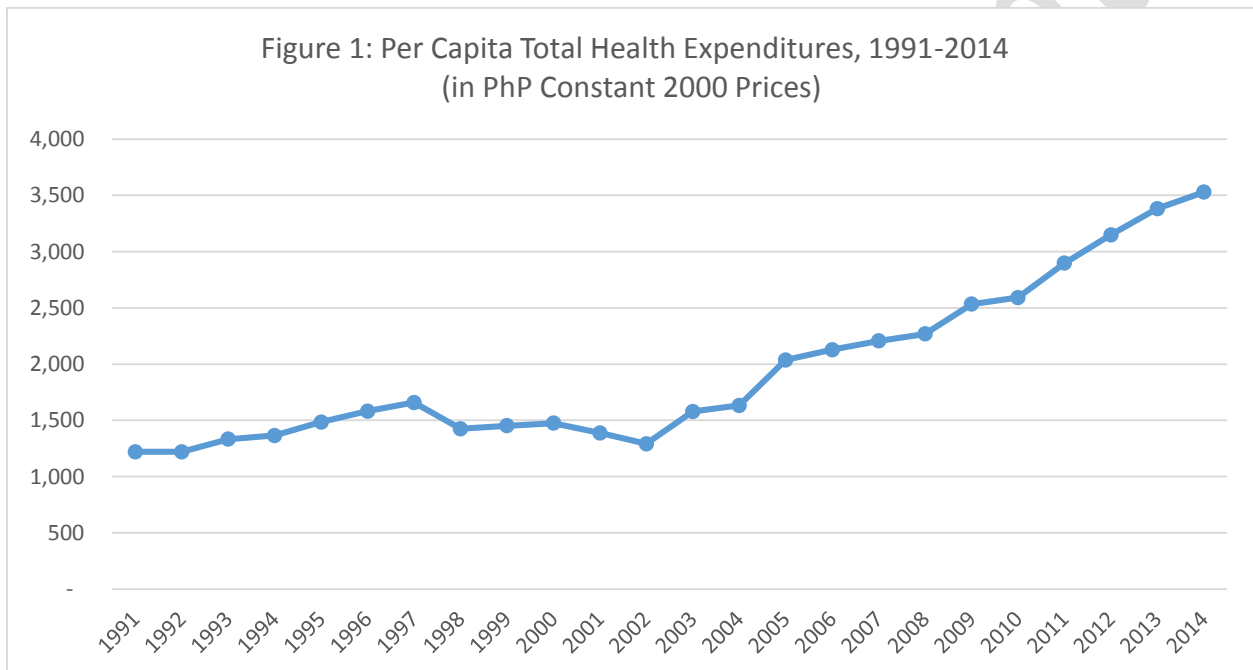
- How much are we spending on health care?
- How are we raising money to pay for health services?
- What services are we paying for?
- Who benefits from what we spend on health?
- Where do we need to be?
- How do we get there?

In the analysis, health expenditures are expressed in constant 2000 pesos and in per capita terms to control for inflation and population growth.

## How Much Are We Spending on Health Care?

*Health spending increased from P1,219 to P3,528 over 24 years*

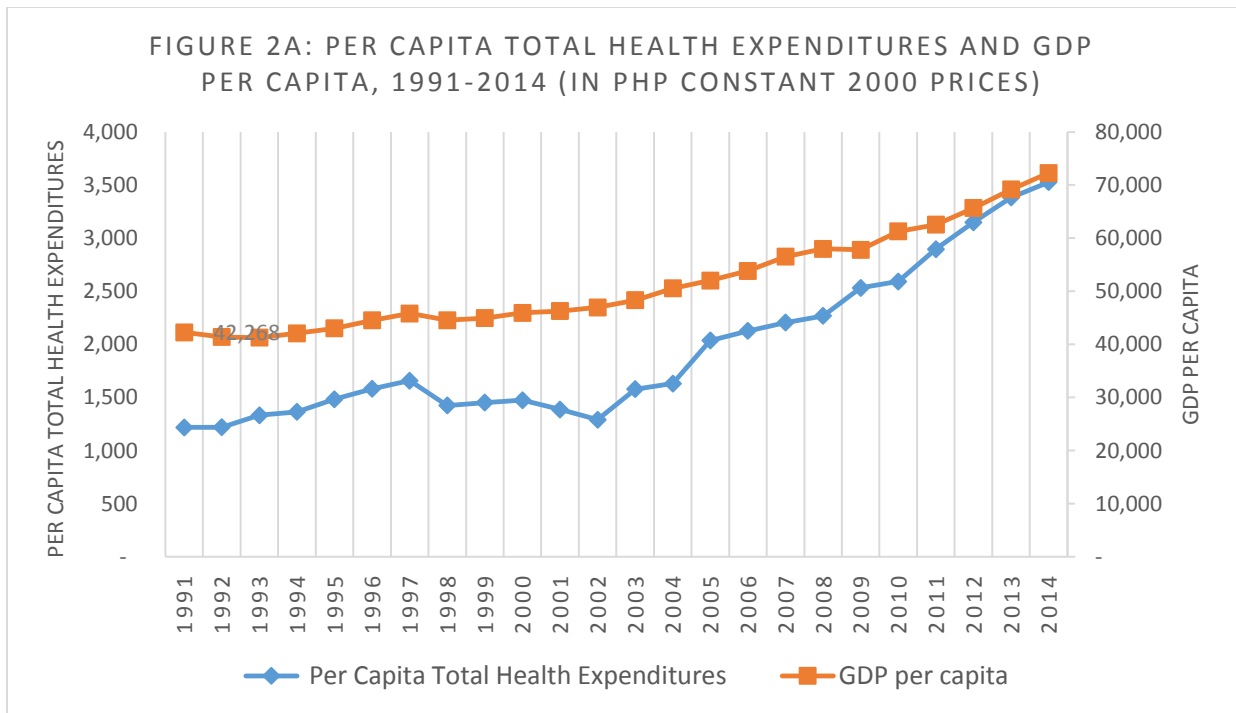
Real per capita health expenditures grew from PhP 1,219 in 1991 to PhP 3,528 in 2014, close to a three-fold increase in 24 years (Figure 1). However, the growth has been uneven. During the period 1991-2004, real per capita health expenditures was flat on average. The increases from 1991 to 1997 were followed by declines in spending from 1998 to 2004 owing to the effects of the Asian Financial Crisis. From 2005 to 2014, real per capita health expenditures grew, with faster growth observed during the period 2010 to 2014.



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

*Health spending moved with economic growth (recovery from crisis raised health spending)*

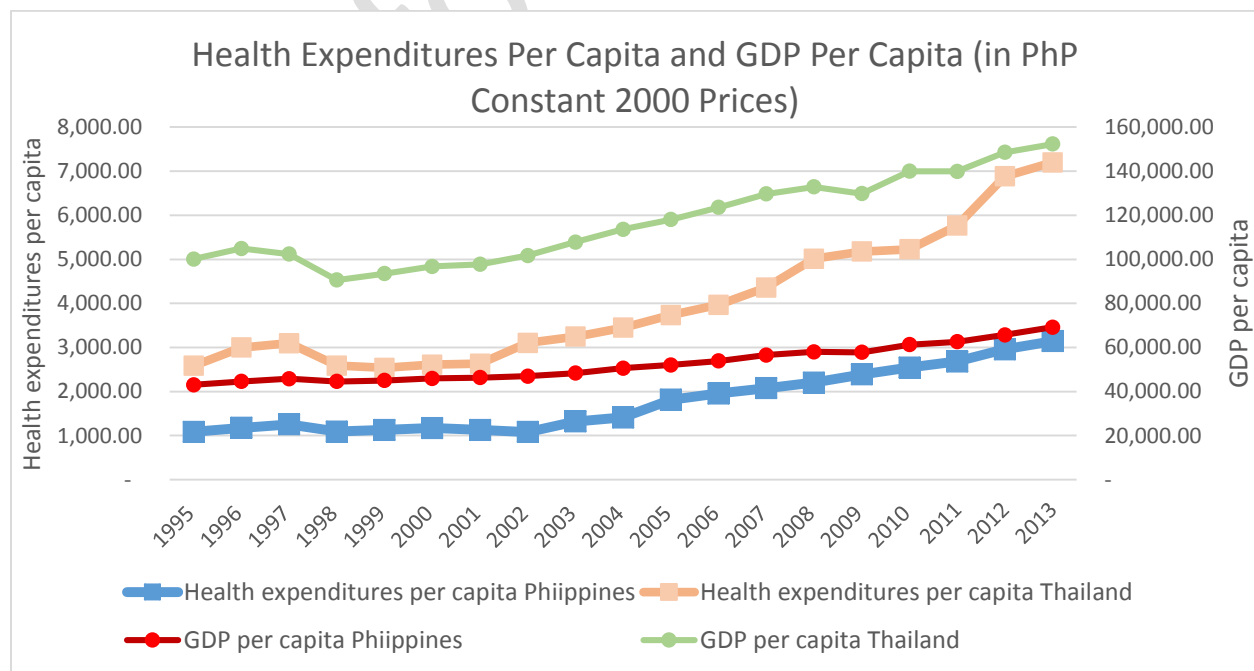
The trend in real per capita total health expenditures needs to be examined in relation to the trend in real per capita Gross Domestic Product (GDP) (Figure 2a). The real per capita GDP growth over the 24-year period was interrupted by the Asian Financial Crisis of 1997-98. The average real per capita GDP growth from 1991-2004 was 1.4 percent and 3.6 percent from 2005 onwards. In comparison, 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 (5.0 percent) than the growth of real GDP per capita (2.4 percent).



Source: PSA, various years and DOH/WHO NHA Project (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 1991-1994. This share increased to 4.0 percent in 2005-2013. Levels of health spending per capita as a share of GDP in Thailand are comparable 4.1 percent from 2005-2013. 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 (Figure 2b).



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

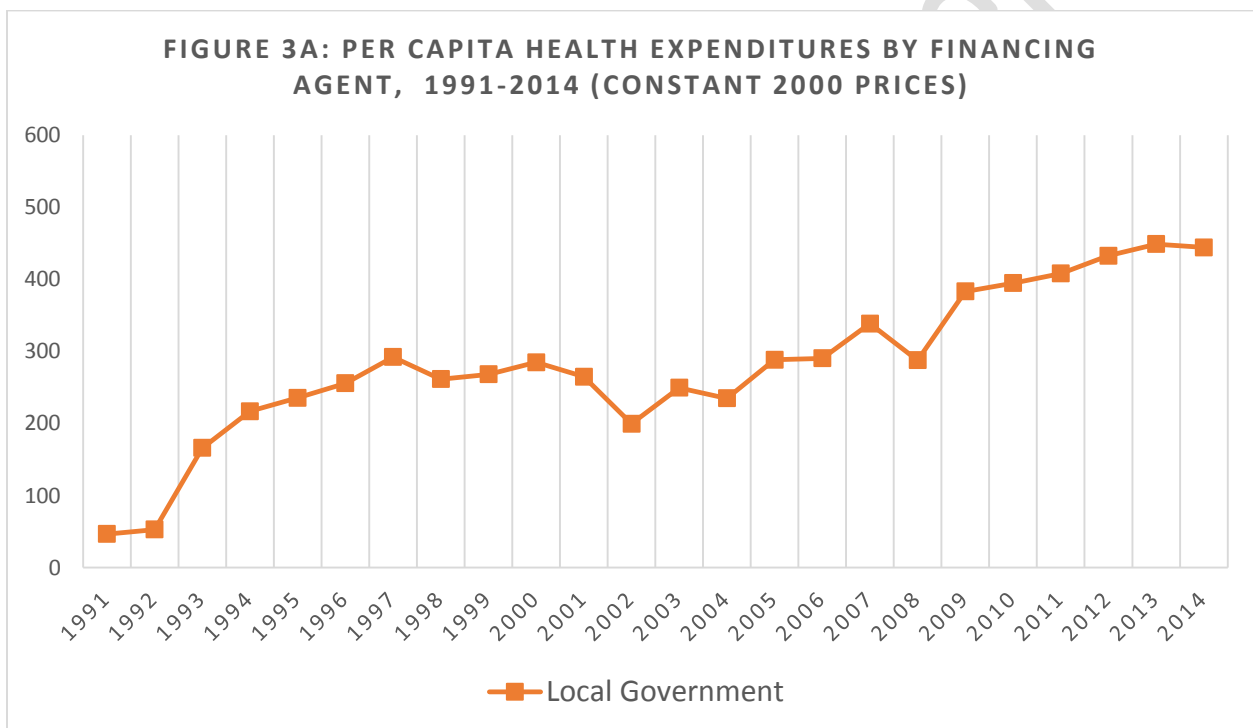
## How are we raising money to pay for health services?

In this section, we examine the sources of financing for health services (financing agents in the NHA) and their expenditure trends over time.

### Local Government

*With LGC implementation, local spending increased from P166 in 1993 to P444 in 2014*

Real per capita local government expenditures are shown in Figure 3a. During the period 1993-1997, real per capita local government health expenditures rose owing to devolution. From 1998 onward, local government health was relatively flat (net increase was only P150 over 16 years).

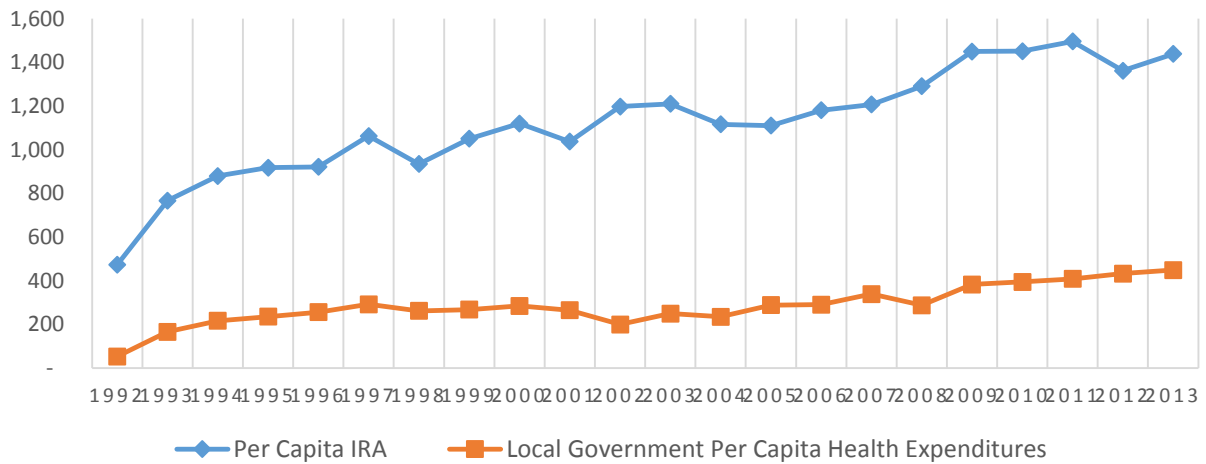


Source: PSA, various years and DOH/WHO NHA Project (2016)

*But local health spending did not rise as fast as the rise in IRA*

Note that during the same period, 1993-2014, there were rapid rises in Internal Revenue Allotment (IRA) as shown in Figure 3b. It seems that the LGUs have not been an effective or active financing source for health despite many attempts to leverage such spending, and despite health being one of the largest devolved sectors.

**FIGURE 3B: PER CAPITA INTERNAL REVENUE ALLOCATION (IRA) AND LOCAL GOVERNMENT PER CAPITA HEALTH EXPENDITURES, 1992-2013**



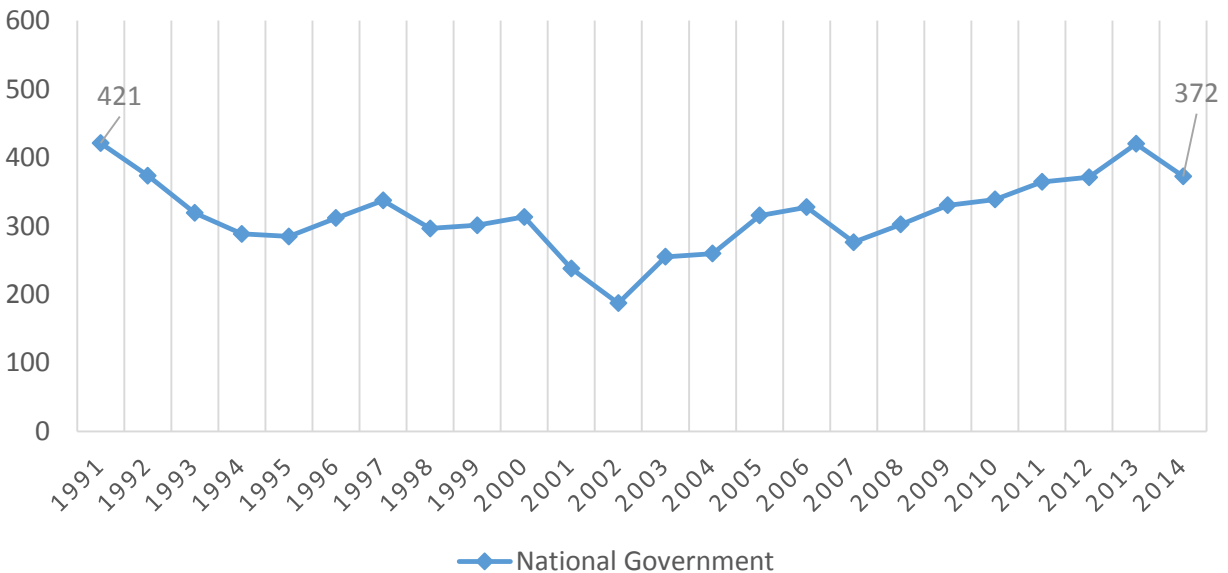
Source: PSA, various years and DOH/WHO NHA Project (2016)

**National Government**

*National government health spending barely recovered pre-devolution levels*

Real per capita health expenditures by the national government were relatively flat over the past 24 years (Figure 4). The increased national health budgets seen from 2010 barely recovered what has been lost to devolution.

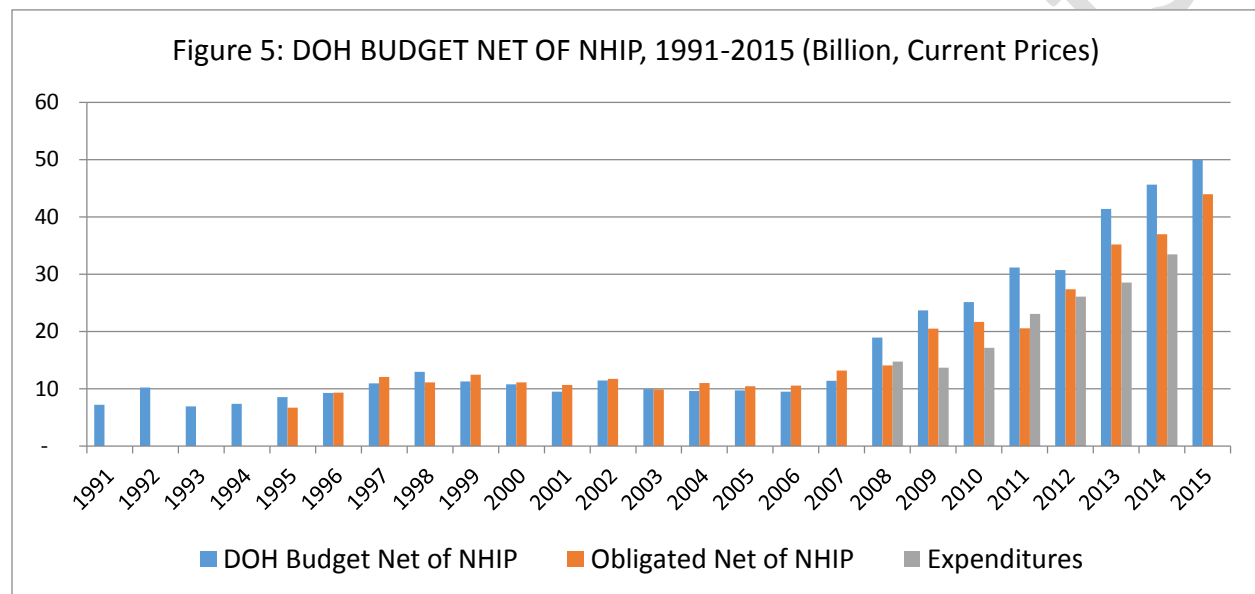
**FIGURE 4: PER CAPITA HEALTH EXPENDITURES BY FINANCING AGENT, 1991-2014 (CONSTANT 2000 PRICES)**



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

*As nominal health budgets increase, effective utilization became a challenge*

A closer examination of the DOH budget shows that levels were relatively low and flat from 1991 to 2007, but increased steadily thereafter so that the 2009 budget was twice that of 2007 (Figure 5). This trend continued through the Aquino administration such that by 2015, the DOH budget had grown to more than three-fold that of 2010 levels. In 2016, the DOH budget even rose higher to P122 billion or five 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 P40 billion each year has been attributed to proceeds from “Sin taxes”.



Source: DOH

However, as Figure 5 also shows, while these substantial increases in the DOH budget led to 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 90 percent of its budget for each budget cycle although 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 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 COBACs could be created to bid out and award civil works contracts. Moreover, there were insufficient technical personal available to monitor the pace of facility upgrading. Limited in-house capacity should have been addressed by pooling multiple projects into large packages that could then be outsourced.

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 is eventually

returned to the National Treasury. The DOH had to return to the National Treasury an average of P1B per year from 2011 to 2013. In 2014, the DOH returned P400 million.

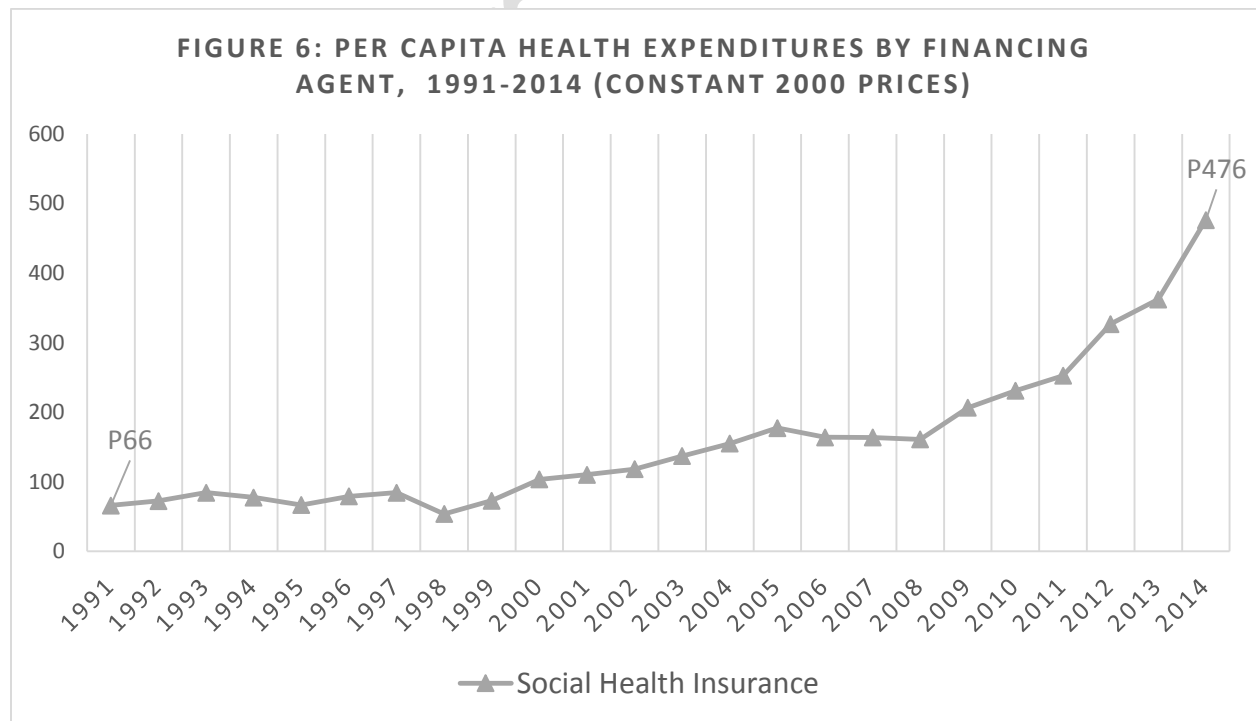
### Social Health Insurance (PhilHealth)

*PhilHealth benefit spending registered the fastest rate of increase among public sources*

PhilHealth spending in real per capita terms is shown in Figure 6. 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 P73, representing 5.2 percent of total per capita health spending.

PhilHealth spending increased during the period 1999-2008 with the introduction of the Sponsored Program. During this time, the average per capita spending was P136 (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, 144 cities, and 1,490 municipalities yearly.

Subsequently, with the introduction of new benefits and when national government assumed the full cost of premiums for the Sponsored Program, PhilHealth per capita spending for the period 2009-2014 rose to P309, representing 10.3 percent of total health spending per capita. By 2014, PhilHealth was spending P476 per capita, representing 14 percent of total health spending. However, this amount should be much larger given its claim to have covered 87 percent of all Filipinos in 2014, for nearly all ICD 10 conditions. What PhilHealth has managed to do is to pay a little bit of everything for all Filipinos.

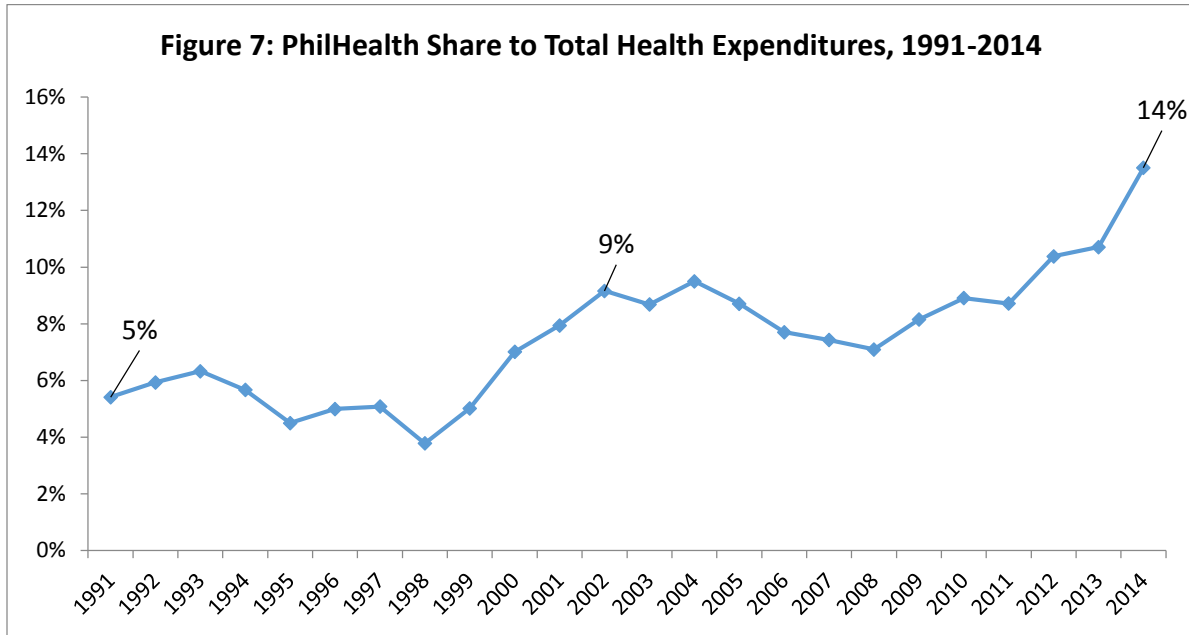


Source: PSA, various years and DOH/WHO NHA Project (2016)



*PhilHealth coverage at 87%, but its share to total health spending remains 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 (Figure 7). This falls short of the national target of 30 percent set in the 1999 DOH Health Sector Reform Agenda.



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

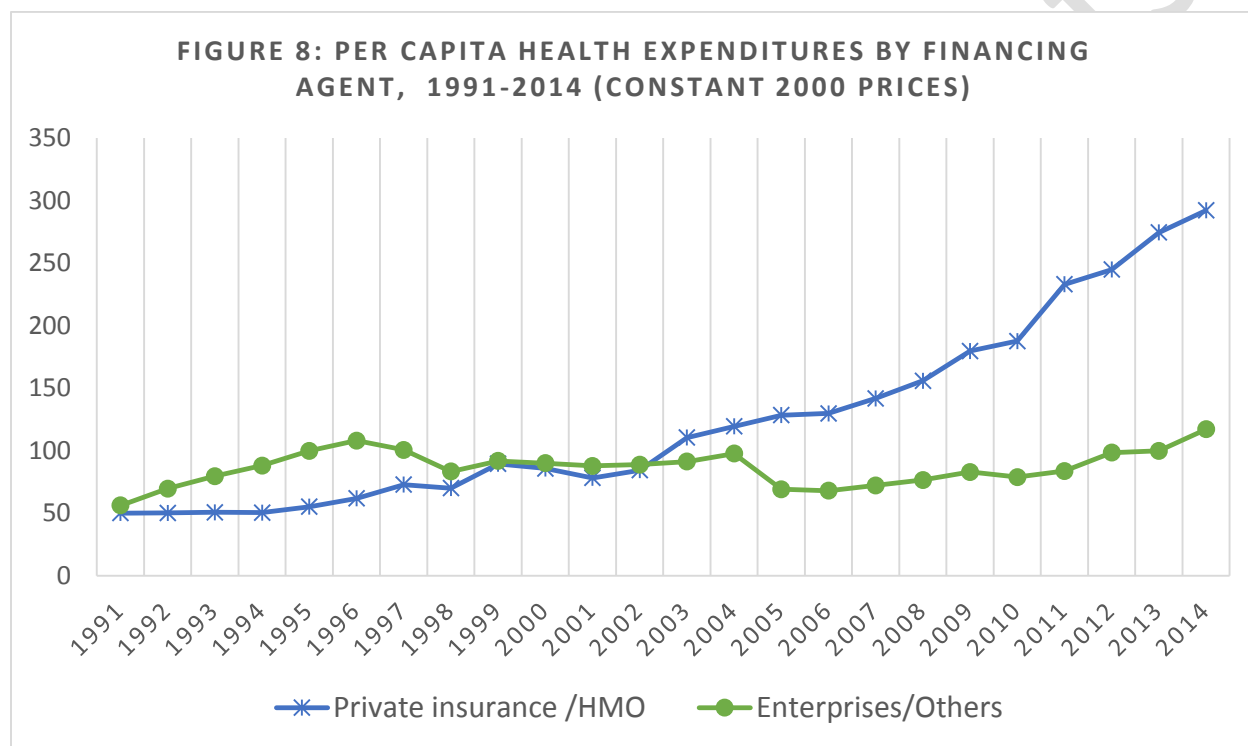
What factors limited the growth in social health insurance (PhilHealth spending)? First, for PhilHealth to deliver larger benefits, it must increase premiums. However, there has been no significant real increase in premiums during the period of relatively rapid economic growth, 2005-2014. Secondly, having “sin taxes” fund the premium subsidy of the poor simply shifts the burden of paying from LGU contributions to fully nationally-funded premium subsidies for the same benefit package. Thirdly, the lack of information as well as operational and procedural barriers prevent the premium subsidies to be translated into benefit spending.

As a side note to the extent that the rapid growth in health expenditures could generate inflation, the growth in spending in the entire sector will exert pressure on social health insurance in terms of support value, especially for the members who use the private sector services. The expansion of health services covered by PhilHealth over the years, which more recently includes PCB, Z-package, cannot be expected to substantially raise social health insurance share in total spending because all these have been introduced within the same budget envelope. PhilHealth will eventually end up paying a little bit of everything. Moreover, having PhilHealth extend benefits to population groups without corresponding premium contributions, e.g., senior citizens will not increase the share of PhilHealth to total health care spending.

## Private Health Insurance/HMO and Private Enterprises

*Private insurance/HMO spending increased but spending by enterprises remained flat*

Real per capita health expenditures by private health insurance/HMO increased over the period specially since 2005 although its level is still relatively low (Figure 8). Spending by private enterprises include direct health service spending or reimbursement of employee health expenses as part of employee fringe benefits. It has remained flat. This could be due to slow growth of formal wage sector employment or could be crowded out by rising private insurance/HMO and social health insurance (PhilHealth).

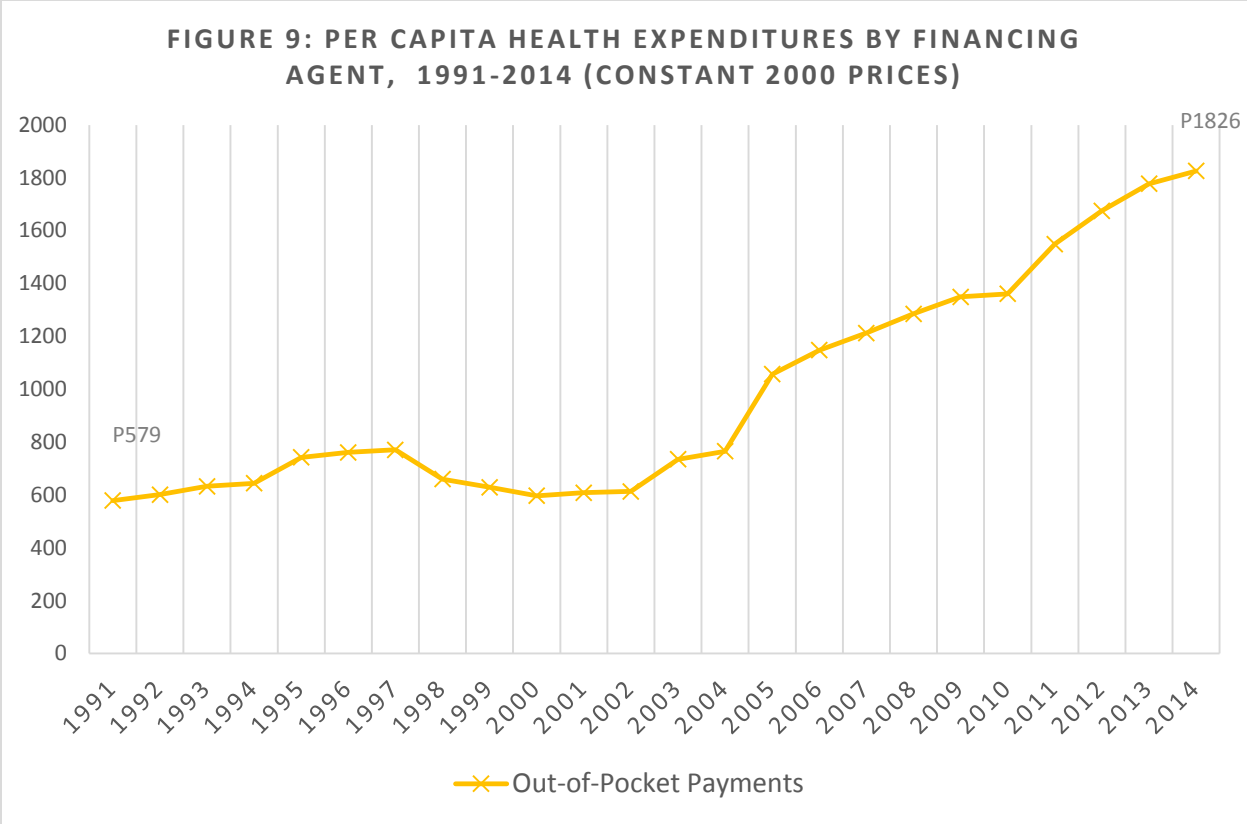


Source: PSA, various years and DOH/WHO NHA Project (2016)

## Household Out-of-Pocket Payment

*Family out-of-pocket payments remain the biggest and fastest-growing financing source*

Household out-of-pocket spending remains the largest source of financing health expenditures, even larger than the combined public and private institutional and organized sources, especially in the period since 2005 when economic growth was higher (Figure 9). It has been the real, dynamic and responsive source of financing. The increase in out-of-pocket payments was driven by increasing disposable incomes of people.



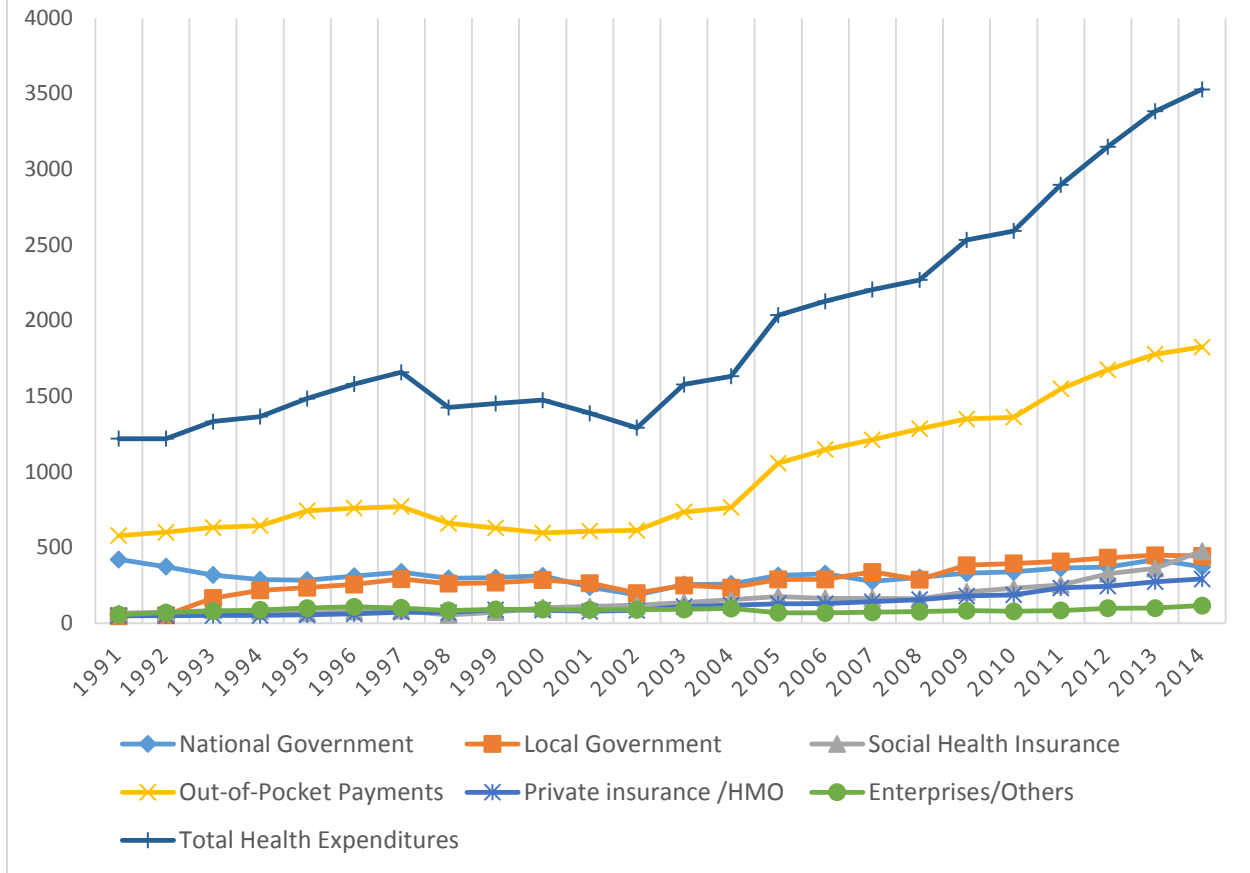
Source: PSA, various years and DOH/WHO NHA Project (2016)

However, there are concerns regarding large out-of-pocket payments in relation to total spending. The first is with regard to equity: given the uneven distribution of income, only those with capacity to pay can access needed health care. The second is with regard to efficiency: the lack of risk pooling. On the other hand, there are efficiency gains: it is choice-based, it can instill cost discipline, it can drive innovations and it can make quality of care available. All the above raises the question: are we better off regulating private health care markets rather than replacing them with institutions like DOH, LGUs and PHIC? But we also need to consider the capacity, willingness and incentives for self-regulation.

*Putting it all together: 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*

Figure 10 shows all the sources of financing. The good news is that real per capita health spending went up. But 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 grew with economic growth, organized sources of financing were not able to cash in on the increase in disposable income. For example, PhilHealth could have increased premiums on the economic upswing.

**FIGURE 10: PER CAPITA HEALTH EXPENDITURES BY FINANCING AGENT, 1991-2014 (IN PHP CONSTANT 2000 PRICES)**



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

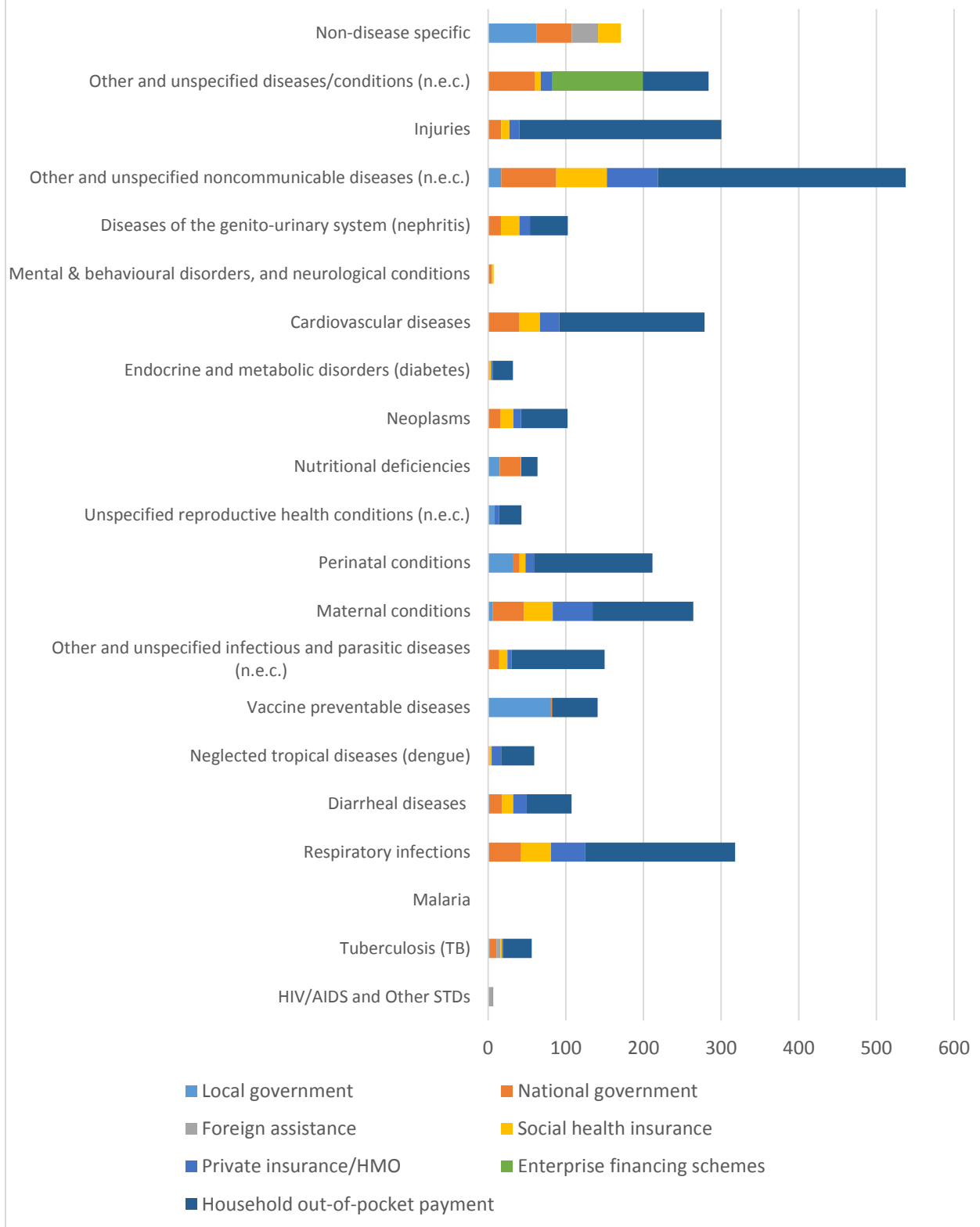
### What services are we paying for?

An important piece of information that provide a comprehensive view of what services are we paying for is data on real per capita health expenditures by disease group shown in Figure 11. The data come from a new set of NHA based on International System of Health Accounts (SHA) developed by WHO, OECD and Eurostat that allows for a more detailed breakdown of health expenditures (e.g., by disease groups and income quintile). This new set of data has recently been developed for the Philippines for the years 2012, 2013 and 2014 (provisional).

*Most health services are paid for by family out-of-pocket payments even for services with public health benefits*

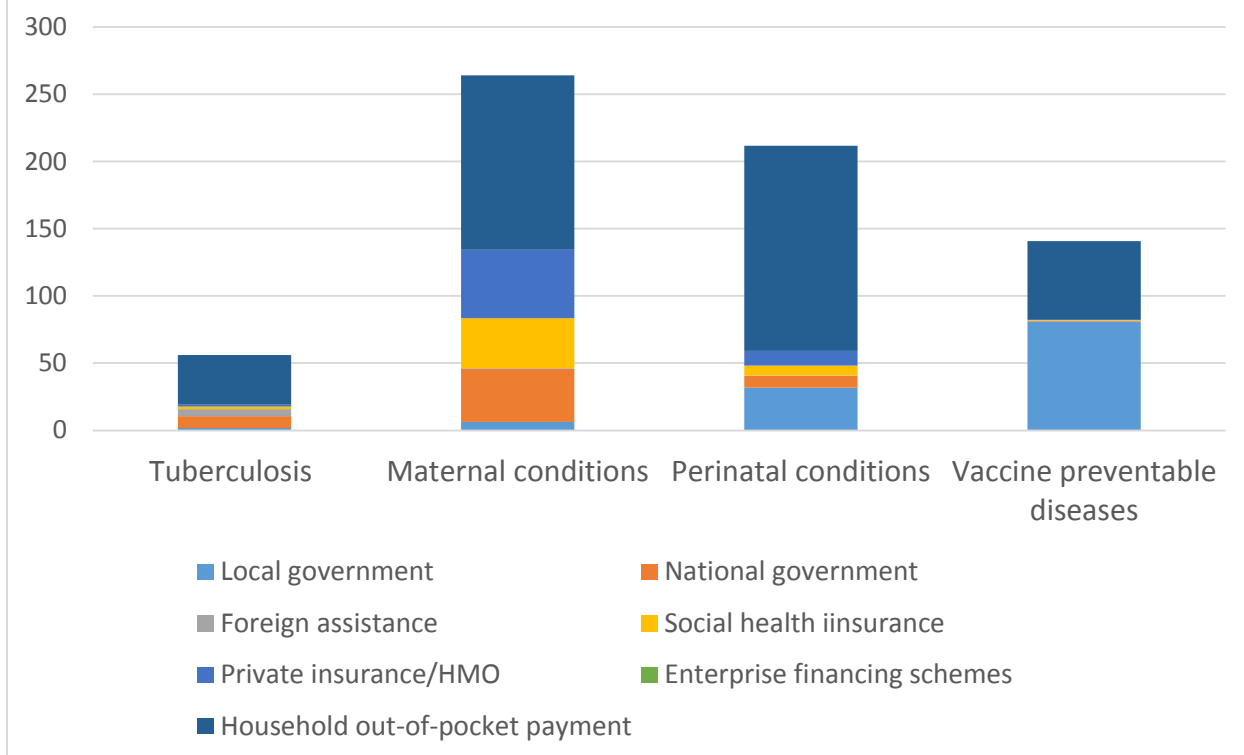
Broadly, the data suggest that there seems to be little or no willingness to pay from out-of-pocket for the following diseases: malaria, mental health, HIV/AIDS. But there is significant out-of-pocket spending on public health concerns: MNCHN services, respiratory infections, TB, diarrhea and other infections and parasitic diseases. Government sources pay for less than half of total spending on these same public health concerns. Of course, there is much more out-of-pocket spending for diseases such as injuries, NCDs, and cardiovascular diseases.

Figure 11: Per Capita Health Expenditures by Disease Group and by Financing Agent, 2014 (Constant 2000 Prices)



Source: DOH/WHO NHA Project (2016)

Figure 12: Per Capita Health Expenditures on Tuberculosis, Maternal and Perinatal Conditions and Vaccine Preventable Diseases, 2014 (Contant 2000 Prices)



Source: DOH/WHO NHA Project (2016)

The pattern seems to suggest that concerns about out-of-pocket payments are mostly equity concerns rather than efficiency (i.e., failure of the market to pay for services with external benefits does not seem to be the case; if services are underprovided, it is because people do not have money to pay for them and not because a market failure exists for these).

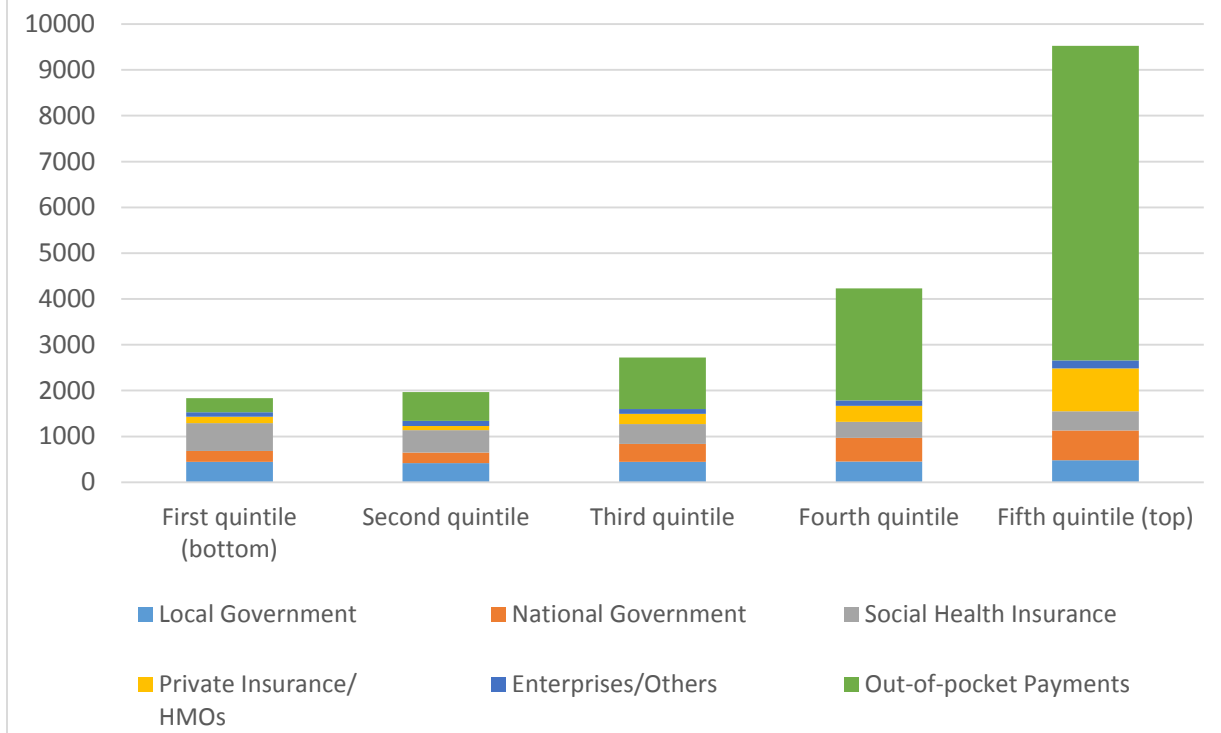
### Who benefits from what we spend on health?

*The poor do not receive adequate support from public financing sources*

The real per capita health expenditures by income quintile in 2014 are shown in Figure 13. As expected, out-of-pocket payments is the main financing source for higher income groups; but, higher income groups also dip into public sources (LGU, DOH, and PHIC), crowding out the poor. In total, higher income groups get more subsidy from various public financing sources. There is no preferential access for poor families. Note that it is the first three quintiles have similar financing patterns.

This pattern has essentially remained the same in 2012 and 2013 where data are available (not shown here), and mostly likely to be the same overall pattern over the 25-year period. This suggests that the rising real per capita spending on health does not necessarily mean that more people have access to care, but rather that the same/few families are getting better, more sophisticated services.

Figure 13: Per Capita Health Expenditures by Financing Agent and by Income Quintile, 2014 (Constant 2000 Prices)



Source: DOH/WHO NHA Project (2016)

### *Equity implications*

The data above show that it is mainly the higher income groups who are able to access health care services. It is important to note that this figures fails to capture those who maybe sick or in need of care but are unable to seek care. Funds delivered through the public sector (national, local government, and social health insurance altogether) do not provide preferential access for the poor. Should the decline in government spending continue, public facilities will increasingly depend on “outside purchases” so that patients from lower income families will continue to be crowded out by patients who can pay.

In the absence of a viable insurance scheme that effectively pools risks, a fee-for-service system puts the not-so-poor and middle income families at greater financial risks. For families from these income groups, hospitalization could easily wipe out savings if not put the family put into debt, thus compromising future investments including that of human capital. Another way of expressing this concern is that those who manage to escape from poverty could easily slide back if they are hit by some financially catastrophic illness.

### *Efficiency implications*

A fee-for-service system financed by family out-of-pocket payments misses out on the efficiency gains from risk- pooling. This means individual families will have to put 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 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 the total spending in 2014 (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 uncoordinated stand-alone programs. The 13 percent share of local government units is spent by 81 provinces, 144 cities, and 1,490 municipalities- each managing its own fund independently and addressing a widely heterogeneous set of local health issues. While social health insurance share has moderately increased to 14 percent, its influence over both the public and private health care delivery sector grows weaker as it introduces more and more benefit packages, all funded by a fixed budget envelope.

The Philippines being dominated by a fee-for-service funded by family out-of-pocket payments has always been described in terms of the inequity that it creates. There are efficiencies, however, that need to be understood. First, it is choice-based - families go to wherever they think they can get the best care. Secondly, services are not rationed. Thirdly, this system drives innovation. And finally, this system ensures that quality care is available. (Public delivery systems and social health insurance have been introduced as alternative to fee-for-service system mainly to address equity concerns, but such systems have yet to deliver on the efficiencies leading to innovation, quality, and choice).

An out-of-pocket funded fee-for-service system also instills discipline on the demand side. Because the families pay for the full cost of care, they are less likely to be wasteful and more likely to be careful in making choices. Health care costs could even lead families to invest in disease prevention and health promotion. This particular effect of health care costs on prevention and promotions is something that current social health insurance programs has completely missed. 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. Higher benefit ceilings can be given to families who do not smoke, who exercise or lead healthy lifestyle allowing them more high benefits for unpreventable diseases like those associated with ageing.

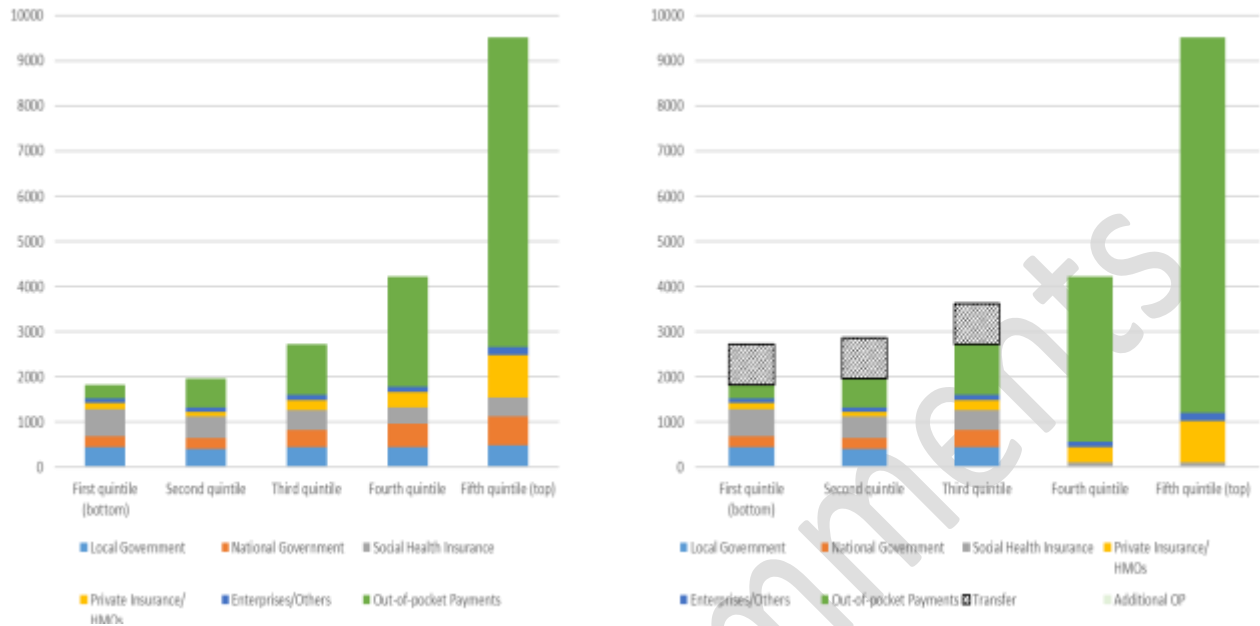
### **Where do we need to be?**

*Where we can be given current resources?*

Given current distribution of income, how can we improve equity (access to health care by the poor) through the way we finance health services? In the first case where there are no additional resources, improvement in access to health care by the poorest three quintiles can be obtained by removing all subsidies from the two top income quintile and put them in the bottom three quintiles. This can be done by charging the top quintiles the cost of care (user charge). If they pay, there will be more money for the poor. If the stop going to public facilities, there will be money from the budget (subsidies) for the poor. The illustrative result is depicted in Figure 14.



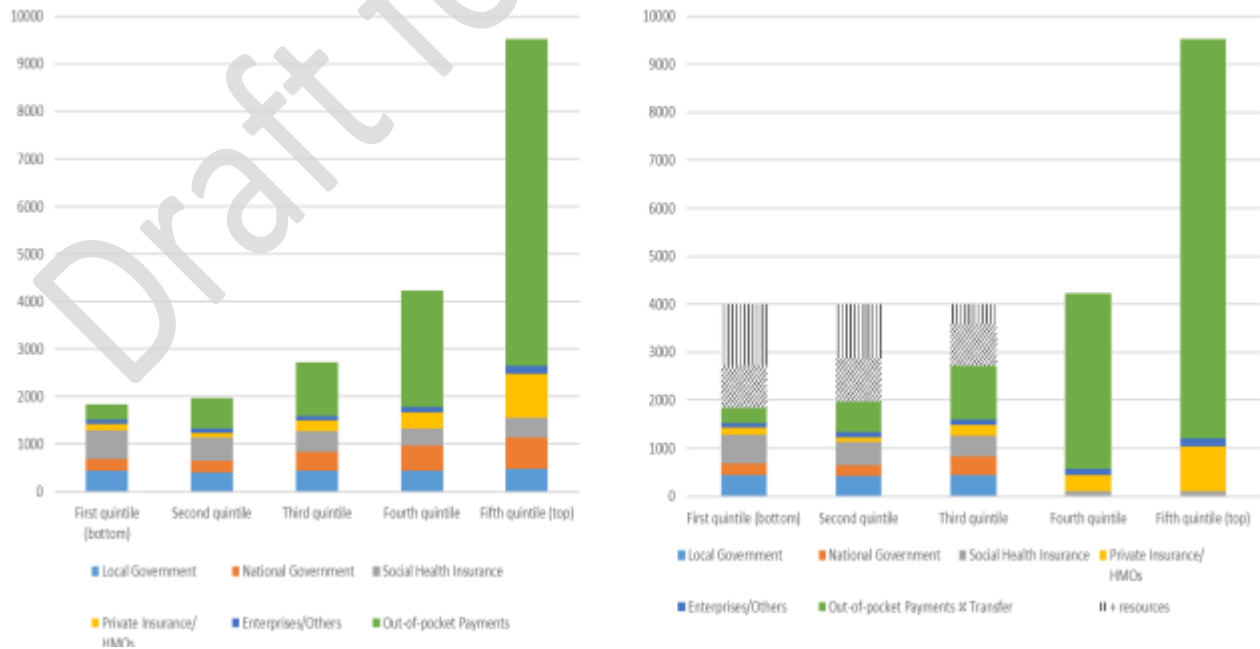
Figure 14: Where we can be with current public resources



Where can we be given additional resources?

In the case where more resources are available, more subsidies can be provided to the poor. This is illustrated in Figure 15.

Figure 15: Where we can be with additional resources



## How do we get there?

Step 0: Watch out for stumbling blocks

Identify three fundamental weaknesses that would require structural change:

- Highly fragmented local health financing and delivery systems
- Non-competitive compensation packages for government workers to attract competent health reform managers
- Lack of basic information to track progress of the proposed reforms (i.e., information on quality, costs, prices, behaviors, and health outcomes)

Step 1: Remove inequities in the way we finance public health services

- Introduce socialized pricing in government facilities
- Raise premium ceilings but possibly with lower contribution rates
- Explicitly target the poor in the distribution of centrally procured commodities
- Raise public subsidies for health as the economy grows

Step 2: Ensure that the poor have access to quality care

- Explicitly link social health insurance payments to quality, i.e., pay for performance
- Engage private providers through incentivized government procurement contracts

## References

Department of Health (DOH). 1999. *Health Sector Reform Agenda, Philippines 1999–2004*: HSRA Monograph No. 2. Manila: Office of the Secretary, Department of Health

Department of Health (DOH). 2005. Administrative Order No. 2005-0023 Implementing Guidelines for *FOURmula ONE* for Health and Framework for Health Reform.

Herrin, Alejandro N., Orville Solon and NHA Team. 1993. "National health accounts, health care financing and health sector performance". Paper prepared for the Health Policy Development Program-UPecon Foundation NHA Seminar Series, Quezon City, 14 July.

Herrin, Alejandro N., Orville Solon and Rachel H. Racelis, 1996. "The development of national health accounts of the Philippines". Paper presented at the International Conference on National Health Accounts, International Health Policy Program (IHPP)/World Bank, Mexico City, 16–17 May.

National Statistical Coordination Board. 2013. *Philippine National Health Accounts 2005-2011*.

National Statistical Coordination Board. 2004. *Philippine National Health Accounts 2002* (covers estimates for 1991-2002)

Orville Solon, Alejandro N. Herrin, Rachel H. Racelis, Maritess. G. Manalo, Virginia N. Ganac and Glenda V. Amoranto. 1999. "Health Care Expenditure Patterns in the Philippines: Analysis of National Health Accounts, 1991-1997". *Review of Business and Economics*, Volume XXXVI, No. 2, December 1999, pp. 335-365

<http://pre.econ.upd.edu.ph/index.php/pre/article/view/76/518>

Racelis, Rachel H. and A.N. Herrin. 1994. "National health accounts of the Philippines: partial estimates as of November 1994". Paper presented at the Pesos for Health Part Two Conference: Emerging Results of Current Research on Health Care Reform, DOH-Health Finance Development Project and UPecon Foundation, 8–9 December, Quezon City.

Racelis, Rachel H. and A.N. Herrin. 1995. "National health accounts of the Philippines: data and estimation procedures". Quezon City: Health Policy Development Program /UPecon Foundation, School of Economics, University of the Philippines.

Rachel H. Racelis, Fe V. N. Dy-Liacco, Raquel V. Sabenano, Mylene M. Beltran and Thiel B. Manaog, "The National Health Accounts of the Philippines: Continuing Development and New Findings". 2006. *Philippine Journal of Development* Number 61, First and Second Semesters, Volume XXXIII, Numbers 1 & 2.

<http://dirp3.pids.gov.ph/ris/pjd/pidspjd06-healthacct.pdf>

Rachel H. Racelis, Fe V.N. Dy-Liacco, Lilibeth C. David and Lucille Nievera. "Health Accounts Estimates of the Philippines for CY2012 Based on the 2011 System of Health Accounts: Tables, Data Sources, Estimates and Analysis". 2014. Posted on the DOH Integrated eLibrary System.

[http://elibrary.doh.gov.ph/InmagicGenie/opac\\_report.aspx?ReportName=OpacBrief&AC=QBE\\_QUERY&Type=opac](http://elibrary.doh.gov.ph/InmagicGenie/opac_report.aspx?ReportName=OpacBrief&AC=QBE_QUERY&Type=opac)

Rachel H. Racelis, Fe Vida N. Dy-Liacco, Alejandro N. Herrin, Lilibeth C. David, Lucille F. Nievera and Laurita R. Mendoza. "Philippine Health Accounts Based on the 2011 System of Health Accounts for CY 2012 (Revised), 2013 and 2014 (Provisional): Tables, Estimates and Analysis". 2016. DOH/WHO NHA Project "Continuing Training on the System of Health Accounts (SHA) 2011 and Updating of the Philippine National Health Accounts Based on the SHA (PNHA-SHA)".