Chapter 2

Financial Barriers to Access Health Care Services: A Case Study of the Philippines

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Abstract

This study analyzes people's financial barriers to access health care services based on the structure of the health financing system and recent experience in the Philippines. It suggests that functions in the health financing system, in particular payment schemes, have a powerful influence on the behavior of all actors in health systems and this determines who bears the financial risks and financial burdens of access to health services. In the Philippines, the current payment schemes appear to cause *moral hazard* to providers, and give a strong impetus to increasing health expenditures. In addition, providers may capture insurance benefits as *rent*, and this may critically impede reduction in the financial burdens of the poor. Using the accreditation function of PhilHealth would be a pragmatic policy tool to control health care costs in the Philippines. Monitoring will be crucial to realize the expected benefits of accreditation. In addition, the quality of free public health care services needs to be improved and informal payments (donations) need to be reduced.

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1. Introduction

Health financing is the mechanism in which money is mobilized, allocated, and used to finance health systems, of which the overall objective is to contribute to attaining better health outcomes. Accordingly, health financing includes various issues: availability of the fund, pool of financial risks, and payment for service providers/organizations. These factors will provide strong incentives that influence the behavior of all actors (institutions and individuals) in the health system, and will determine who has access to care and who is protected against catastrophic medical expenses. In this light, this study considers how it is possible to reduce the financial barriers of people, in particular the poor, to access health care services.

The objective is first, to present a simple structure of a health financing system and analyze the financial barriers, and second, to examine the case of the Philippines. The Philippines has been implementing health sector reforms since 1999. The Health Sector Reform Agenda (HSRA), which aimed at improving health sector performance, was implemented from 1999 to 2004. The second mid-term reform, *FOURmula ONE* for Health, began in 2005. Health financing has been a focal agenda in both reform programs. Against this, it is particularly interesting to analyze the health financing system in the Philippines and its recent experiences.

The remainder of this study is organized as follows. The next section describes a simple structure of a health financing system, and Section 3 analyzes the financial risks and barriers to access health care services. Section 4 examines the health financing system of the Philippines and its recent experiences. The last section discusses preliminary policy implications.

2. Structure of Health Financing System

The basic functions of a health financing system are revenue collecting (funding), pooling resources (risks), and purchasing goods and services (WHO, 2000, Ch.5; World Bank, 2006, Ch. 2). There are various mechanisms in each function. Table 1 presents a simple structure of a health financing system based on these three functions.

Table 1 Structure of Health Financing System

<table>
<tr><td colspan="2">Rvenue collecting</td><td>Pooling</td><td colspan="4">Purchasing</td></tr>
<tr><td colspan="2">Resource</td><td></td><td>Purchaser</td><td colspan="3">Payment</td></tr>
<tr><td colspan="2"></td><td></td><td></td><td>By purchaser</td><td colspan="2">By patient</td></tr>
<tr><td colspan="2"></td><td></td><td></td><td></td><td>Insured</td><td>Noninsured</td></tr>
<tr><td>Govt</td><td>Tax</td><td>National/
Region/Local</td><td>Govt</td><td>Budget,
Capitation,
Case-based,
Fee-for-service</td><td>Free</td><td>Free</td></tr>
<tr><td colspan="5"></td><td colspan="2">Informal Payment</td></tr>
<tr><td rowspan="2">Insurance</td><td>Tax
Premium</td><td rowspan="2">Fund pooling</td><td rowspan="2">Insurer</td><td rowspan="2">Capitation,
Case-based,
Fee-for-service</td><td colspan="2">Fee on schedule/Nonschedule</td></tr>
<tr><td></td><td>Coinsurance/
Copayment</td><td>All</td></tr>
<tr><td>Individual</td><td>OOP</td><td>None</td><td></td><td></td><td></td><td></td></tr>
</table>

Note: Author's compilation.

Revenue Collection

Revenue collection is a mechanism to raise funds to finance health systems. In general, revenue is collected from the government, social ins urance, or individuals, and the resource is tax, premium, or out-of-pocket payment (OOP). Although raising enough revenue is a fundamental of health financing to provide appropriate health services and financial protection for people against unpredictable medical expenses, developing countries frequently face a severe challenge to raise adequate funds, not only because of their low-income level, but also because of their limited institutional or administrative capacity. Hence, health funding is highly dependent on OOP in many developing countries (Table A1 in the Appendix).

Risk Pooling

It is important to manage limited resources by risk pooling. Risk pooling is to accumulate and manage raised funds to share financial risks among members. Together with a prepayment system, fund pooling will establish insurance in which financial risks will become predictable and will be spread between members. The pooling arrangements, i.e. pooling level, the membership, and cross-subsidies between pools etc., are critically important. The risk-pooling level depends on funding resource types as described in Table 1. OOP does not pool any risks, which means that individuals have to take all risks against unpredictable and even catastrophic health expenses. In general, public insurance applies first to public servants or formal employees in developing

countries. However, those who are the most vulnerable to unpredictable expenses are the poor who largely work at the informal sector. A tough challenge for developing countries is to include the poor in the public insurance system, and to arrange that their premiums are determined according to their capacity to pay.

Purchasing

Another function is the purchasing of health goods and services. Purchasing involves various elements: goods and services to buy, providers and purchasers, and payment for provided goods and services. The payment schemes create incentives that strongly affect the behavior of all actors (organizations, providers and patients) in a health financing system[2] (Kutzin and Barnum, 1992). In this sense, the payment scheme is a critical factor in the efficient and equitable distribution of limited resources.

Payment has two aspects: payment by purchaser and payment by patient. To assure the provision of basic health care services, the government provides free health care services through public health institutions. People, including the poor, can access free health care services if they can physically access public health institutions.

If people are charged user fees, those without insurance have to pay the full charge. Payments by insured people depend on their insurance schemes. Coinsurance means that patients need to pay for a certain percentage of the total costs. Copayment generally implies that patients need to pay for a certain fixed payment for each physician visit etc.[3] (Hsiao, 2004, p. 204). The other copayment scheme is to fix the payment of insurers[4]. Under this scheme, the insurer pays a defined payment for defined categories of services, and the remaining costs are borne by patients. This distinction in copayment schemes is critically important when we consider who bears financial risks.

The other important element is the fee schedule. Medical fees are on a schedule in most developed countries but not necessarily in developing countries. Physicians (providers) can freely determine the fee for provided services if it is not on the schedule. Under the nonfee-schedule system, medical costs are unpredictable and

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[2] *Moral hazard* is a classic incentive effect (Arrow, 1963).

[3] The other scheme is deductibles, which is to require payment by patients before insurance begins to benefit the insured patients (Hsiao, 2004, p. 204).

[4] For instance, the Philippines, analyzed later in this chapter, employs this type of copayment scheme. China (medical insurance in urban areas) sets a ceiling on maximum cost covered by insurance per patient per year.

costly, aggravating financial risks, particularly of the uninsured poor.

There are various schemes in purchaser payment. The most common payment schemes for public health institutions are line-item budgeting and global budgeting. In the former scheme, the payment (budget) is set based on specific line items, such as the number of staff, past budgets, and equipment maintenance etc. However, this type of payment scheme frequently causes inefficient fund management (Hsiao, 2004). The latter payment scheme includes all operating budgets to cover aggregate expenditure. Contrary to a line-item budget, a global budget gives managers the discretion to allocate the fund among line items. It is therefore expected that this scheme will use resources more efficiently and improve managers' accountability. However, whether the expected benefits are realized or not would depend on budget setting (Barnum et al., 1995). If budgeting is set based on cost per a certain facility/service (e.g., per hospital bed), managers will increase revenue (budget) by increasing the costs (number of hospital beds/length of stay, etc.).

The other common payment scheme in both developed and developing countries is fee-for-service in which the fee is paid to a provider based on provided health services. It is known that this payment scheme gives strong incentives for providers (doctors, clinics, hospitals etc.) to provide excessive services. The costly medical services easily consume health funds in developing countries where both public and private funding revenues are limited. If the cost is paid by OOP under a fee-for-service scheme, the poor have to bear heavy financial burdens.

The following are more cost-controlling payment schemes than fee-for-service. Capitation is a payment scheme in which purchasers pay a fixed payment per person to providers for the provision of defined services (WHO, 2000). It hence gives providers strong incentives to control costs; otherwise, they lose their profits. Another scheme is case-based payment in which providers are paid a fixed payment that is predetermined based on categories of services (Barnum, et al., 1995). The diagnostic-related grouping (DRG) is a case-based payment scheme that categorizes services by diagnosis characteristics. Under this payment scheme providers also have strong incentives to minimize their costs to provide a certain categorized service. A drawback of these payment schemes is that they tend to result in reduced care, because providing less care expands providers' profits.

Most countries generally employ a mixture of payment schemes. There exist numerous ways to combine payment schemes and connect the basic functions (revenue collecting, risk pooling, purchasing) that comprise the health financing system. Each component of a health financing system as well as the interaction between the components has a significant effect on providers' or patients' incentives to provide/demand health services. We need to direct careful attention to such an effect in order to analyze financial risks or barriers of the poor to access health care services.

3. Financial Risk and Barriers to Health Services

Financial Risk

Based on the structure of a health financing system, we analyze financial risks for health service costs.

Table 2 Who Bears Financial Risk

Who		Payment method	Payment by patient	Risk-pooling system	
Purchaser	Govt	Fee-for-service/ Budget with adjustment, and unconstrained	Free	Yes	(a)
	Insurer	Fee- for-service, esp. unconstrained	Coinsurance	Yes	(b)
Provider	Public provider	Budget w/o adjustment, Capitation, Case-based		Yes	(c)
	Private provider	Capitation, Case-based		Yes	(d)
Patient	Insured	Fee-for-service	Copayment*	Yes	(e)
	Noninsured	Any	All except free provision	No	(f)
	Insured/noninsured	Informal payment	All	No	(g)

Notes: Copayment* is mentioned here is copayment by insurer.
Author's compilation.

Table 2 describes who bears the financial risks of health service costs, which depend on payment and insurance schemes. Patients do not have to bear any financial risk to have free public health care services. The government will take the financial risks if it provides free health care services and the payment method for providers is fee-for-service with no ceiling ((a), Table 2). If the payment method is budgeting without *ex post* adjustment, the financial risks are borne by the providers ((c), Table2).

If the payment method is fee-for-service and the insurance scheme is

coinsurance, the insurer will bear the financial risks ((b), Table2). Under coinsurance, patients pay part of the costs, but their financial burdens are limited (a certain percentage of the total costs) and are generally less than the insurer's burdens. If the insurance scheme is copayment[5], patients will bear the financial risks ((e), Table 2). Under the copayment scheme, patients have to pay the remaining costs that exceed the expenses covered by insurance. Payment by the insurer is defined for certain categories of services under the copayment scheme, whereas payment by patients is not predictable because total costs depend on provided services under the fee-for-service scheme. In this case, insurance does not control the risk of insured people but of insurers.

If the fee is not on the schedule, the insurance system might not pool members' financial risks but providers might capture insurance reimbursements as *rent*. Providers (doctors, clinics, hospitals, etc.) can charge insured people higher fees, and thereby take additional profits[6]. Consequently, the financial burden of patients will be reduced only minimally, even though they are insured.

Providers bear financial risks under a capitation scheme (Barnum et al., 1995; Hsiao, 2004) ((c), (d), Table 2). Because of this, capitation is a cost-effective/cost-controlling payment scheme. Capitation motivates providers to minimize costs in order to maximize profits. Case-based payment would also transfer the financial risks to providers. If the cost of provided services exceeds a predetermined case-based payment, the providers have to bear the excessive costs. Providers have an incentive to control the costs, because the differences between the actual costs and the predetermined payment will be their additional profits/losses.

If patients are not insured, patients have to bear all financial risks except when they have free health care services. In most developing countries, insurance covers a very limited number of people, mostly public servants or formal employees. Therefore, most of the poor, who are generally not employed in the formal sector, are not insured. While they are the most vulnerable to financial risks, they have to bear most of the

[5] The copayment mentioned here is copayment by insurer.

[6] Suppose there are two patients: one is insured, and the other is not insured. A physician is supposed to provide the same health care services for both patients. If the fee is not on the schedule, the physician can charge, for example, US$500 for the noninsured and US$1000 for the insured patient, of which US$500 is reimbursed by insurance. In this case, even though the patient is insured, insurance does not reduce the financial burdens of the insured patient; insurance benefits become additional profits for the physician.

financial risks. Both insured and noninsured patients have to bear all financial risks against informal payment ((g), Table2).

Financial Barriers

Table 3 describes financial barriers and cost predictability. Similar to financial risks, patient financial barriers and cost predictability depend on payment and insurance schemes.

Table 3 Financial Barriers and Cost Predictability

Payment Scheme		Financial barrier		Predictability		
Purchaser	Patient	Insured	Noninsured	Insured	Noninsured	
	Free (free provision)	None	None			(a)
Capitation		None				(c/d)
Case-based		Low		High		(c/d)
Fee for service	Coinsurance					
Schedule		Medium		Medium		(b)
Nonschedule		High		Low		(b)
Case-based		Low		High		(c/d)
Fee for service	Copayment					
Schedule		Medium+		Medium		(e)
Nonschedule		High+		Low		(e)
Fee for service						
Schedule	All by OOP		High		Low	(f)
Nonschedule			Very high		None	(f)
	Informal payment	High/very high	High/very high	None	None	(g)

Notes: The symbols (letters on the right end) correspond to those in Table 2.
Author's compilation.

Free public health care services cause no financial barrier to insured and noninsured patients ((a), Table 3). Free health care services play an important role in assuring the access of the poor, who are generally not insured, to basic health care services. However, free public health care services frequently do not function as expected. It is pointed that quality of public services is too low, physicians are often absent, and management is inefficient. In addition, the geographical distribution of public health institutions is frequently not equitable. In general, hospitals/clinics are concentrated in larger cities/urban areas. It might be physically difficult for the poor in rural areas to access health care services. Although free public health care services do

not present any financial barriers to patients[7], those obstacles would impede their access to health care services.

Capitation does not cause financial barriers to patients either ((c/d), Table3). It is, however, applied only to members and provides defined services. In fact, capitation tends to generate *risk selection* (Frank, 1998). Providers who bear financial risks have a strong incentive to enroll low-risk (healthy) persons in order to minimize their costs/risks. Capitation would also cause under-provision of health services, which will expand providers' profits. Patients have to pay some part of the health service costs (a fixed amount/fixed percentage) under the case-based payment method. This scheme, however, predetermines the costs based on service categories; therefore, the costs borne by patients are rather predictable as well as limited ((c/d), Table3). Similar to capitation, case-based payment tends to provide less care. In addition, it may cause *case selection*. Providers tend to accept patients who are "at the low-cost end of the case-based predetermined payment category" (Barnum et al., 1995, p. 12).

Patients will shoulder a greater financial burden under the fee-for-service payment method than in the above two methods. Providers tend to provide excessive services in order to raise their profits under this payment method. Because of information asymmetries, patients generally demand services depending on the information of providers, who might be willing to provide more services than necessity. The service costs are financed both by patients and insurers, if the patients are insured. The financial burden of insured patients thus depends on the insurance scheme. As observed in Table 2, patients have to bear the remaining costs that exceed the insurance benefits under the copayment system. Therefore, the patient's financial burden would be heavier under the copayment system than coinsurance in which costs borne by patients are limited to a certain percentage of the total costs. If the service fee is not on the schedule, the patient's financial burden would be much heavier, and would not be predictable ((b), (e), Table3).

Those who are not insured have to bear all financial burdens. Apparently, patients' financial barriers to access health services are high ((f), Table3). If the fee is not on the schedule, the barriers would be higher, and the costs are not predictable. The most

[7] If informal payment is widespread, public free health care services also provide financial barriers.

vulnerable people are frequently the least protected. If free public health care services are available to them, they can access health services with less financial burden. However, in addition to the above-mentioned problems with free public health care, informal payment—*under-the-table* payment—is a critical problem.

Informal payment is a widespread phenomenon in developing countries, which harms free health care services and insurance systems ((g), Table3). Together with limited information for patients (information asymmetries), missing services or materials in free health care services will provide a good condition for spreading informal payments. In general, patients lack enough information on their necessary health care services. Patients will hence pay for the required services, if the required services are not available from free health care services (Killingsworth et al., 1999). The lack of materials or absence of physicians in public health institutions is common in developing countries, which might bring about widespread informal payment. If private services are available, people may prefer to seek private services. This would critically hinder the poor from accessing health care services, although the government officially provides free health care services that are supposed to assure the provision of basic health services to everyone, especially the poor.

The other element, which closely relates to a spread of informal payment, is reduction in or inadequate official payment for physicians. Widespread informal payment has been observed in many countries of the former Soviet Union, such as Kazakhstan. Because the major income source of physicians there is informal payment, insurance and fee scheduling have almost no meaning (Ensor and Savelyeva, 1998; Kutzin, 2001). Even if the payment method is capitation, under such situations, patients have to pay informal payments to providers to receive health care. A spread of informal payments would increase the financial barriers of the poor, and might corrode the whole health financing system.

4. The Case of the Philippines

The government has been implementing substantial health sector reforms in the Philippines since 1999. The first steps to improve health sector performance took place

from 1999 to 2004 and were known as HSRA (the Health Sector Reform Agenda) [8]. The HSRA arranged a single package of reforms that included social health insurance, public hospitals, local health systems, health regulations and public health, because these were interdependent.

The second step, known as *FOUR*mula *One* for Health[9], began in 2005 and will go on to 2010. The reform focuses on financing, regulation, service delivery and governance. The overall goals are better health outcomes, a more responsive health care system, and more equitable health care financing. With regard to reforms in health financing, five agenda items are set as specific objectives: mobilizing resources from extra budgetary sources, coordinating local and national health spending, focusing direct subsidies to propriety programs, adopting a performance-based financing system, and expanding the national health insurance program (NHIP: social health insurance). The reform aims at mobilizing adequate and sustained resources and managing them efficiently to ultimately achieve improved health outcomes, in particular of the poor.

Health Financing System in the Philippines

Table 4 describes the structure of the health financing system in the Philippines using the simple structure presented in Section 2.

Table 4 Health Financing Structure of the Philippines

Resource		Pooling	Purchasing			
			Purchaser	Payment		
				Purchaser	Patient	
					Insured	Noninsured
Govt	Tax	National/ Regional/ Local	Govt	Budget	Free	
					Informal Payment	
Insurance	Tax	Cross-subsidies between pools	Insurer		***Nonschedule***	
	Premium			Fee-for-service	Copayment	All
Individual	OOP	None				

Note: Author's compilation.

[8] Details are available from DOH website: http://www.doh.gov.ph/hsra/hsra-convergence.htm.

[9] Details are available from DOH website: http://www.doh.gov.ph/f1primer/F1-Page.htm.

Major funding sources are government (national/local), social insurance, and individuals in the Philippines[10]. Each tier of government directly provides health care services through public health institutions[11]. All public health institutions except regional hospitals/public medical centers provide free health care services, which comprise primary/secondary care. People are hence supposed to be able to access basic health care free of charge. NHIP (the national health insurance program) is managed by Philippine Health Insurance Corporation (PhilHealth). There are five programs depending on employment status[12], and the funds are cross-subsidized between the pools. The sponsored program, which is the program for the indigent, is financed by the national government and local government units (LGUs).

The following two schemes are the principle payment schemes in the Philippines: budgeting for public health institutions, and fee-for-service for private health institutions/providers. There is no fee schedule for health care services in the Philippines. Noninsured people have to bear all health costs based on fee-for-service and nonfee schedule schemes when they have private health services. The insurance system is copayment; that is, insurance covers defined costs for certain health services, and patients bear the remaining costs. Hence, the payment system for insured people is composed of fee-for-service, nonfee schedule, and copayment schemes in the Philippines.

Financial Barriers to Access Health Services

Based on the structure of health financing system in the Philippines, we analyze the financial risks and barriers to access health care services. Table 5 describes who bears financial risks of health costs in the Philippines.

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[10] There are also other private sources in the Philippines: private insurance, health maintenance organizations (HMOs), employer-based plans, and private schools.

[11] Details are summarized in Table A2 in the Appendix.

[12] The five programs are: (1) Employed-sector program, (2) Nonpaying program, (3) Individual paying program, (4) Sponsored program and (5) Overseas workers program. Details of the national health insurance program are available from the website of PhilHealth: http://www.philhealth.gov.ph/index.htm.

Table 5 Who Bears Financial Risk in the Philippines

Who		Payment method	Payment by patient
Purchaser/ Provider	Govt Public provider	Buget with adjustment and constraint	Free
Patient	Insured	Fee-for-service	Copayment
	Noninsured		All
	Insured/noninsured	Informal payment	All

Note: Author's compilation.

As explained above, the public health service is basically provided free of charge in the Philippines. Therefore, patients are supposed not to bear any financial risks when they access free public health care services. However, patients might be requested to make informal payments including donations. Patients also need to take financial risks when they access private health care services. Insurance covers a defined part of the medical costs for insured patients, and patients bear the remaining costs. Therefore, the support value of insurance is important when we consider patients' financial risks. Those who are not insured have to bear all financial risks to access private health services.

Table 6 Financial Barriers to Access Health Services in the Philippines

Payment method		Financial barrier		Predictability	
Purchaser	Patient	Insured	Noninsured	Insured	Noninsured
Free (free provision)		None	None		
Nonschedule		High+		Low	
Fee-for-service	Copayment				
Nonschedule			Very high		None
Fee-for-service	All				
Informal payment		High	High	None	None

Note: Author's compilation.

Table 6 presents patients' financial barriers to access health care services. Both insured and noninsured people are supposed to have no financial barriers to access free public health care services. However, as mentioned above, if patients are requested to make informal payments, financial barriers will be high for patients[13]. Informal payments are fully borne by patients, and are unpredictable.

Regarding private health services, financial barriers for noninsured people are high, because they have to bear all of the financial burdens to access health care services. Against this, a focal issue of current health sector reforms in the Philippines is to expand social health insurance, in particular the sponsored/indigent program (social health insurance for the poor). Expanding social health insurance will contribute to reducing the financial barriers of the poor. However, there are several concerns about not only the insurance scheme itself but also the combination of insurance and payment schemes.

The national government and local government units (LGUs) share the cost of the insurance premiums of the sponsored (indigent) program. This program is voluntary, so it needs LGUs to agree to sponsor the indigent program. If an LGU (Mayor) agrees to sponsor the premiums of the indigent program, all of the indigents under the LGU become enrolled in the sponsored insurance program. Likewise, if an LGU (Mayor) does not agree to be a sponsor, none of the poor under the LGU can enroll in the sponsored insurance program. As it depends on the LGU (Mayor) whether the poor can enroll in the social health insurance or not, the coverage varies between LGUs/regions.

The indigent are those belonging to the lowest 25% of the population defined through CBIS-MBN (community-based information system for minimum basic needs). We need to note that there exists over/under identification or misidentification. In addition, it is pointed that the indigent might be politically identified sometimes. It will be a tough but very important challenge for government to improve the identification of the poor in order to reduce their financial barriers appropriately. The other issue is the near poor who are very close to the poor, while not identified as the poor. Because they are not identified as the poor, they are not eligible to enroll in the sponsored program.

[13] In addition to financial barriers, there are other problems regarding public free health care services in the Philippines. A critical problem is quality of care. Low quality makes patients avoid utilizing public health institutions. People prefer accessing private services to public free services. The other critical issue is the geographical distribution of public health institutions. The poor who live in remote areas might have physical difficulties of access to public health institutions.

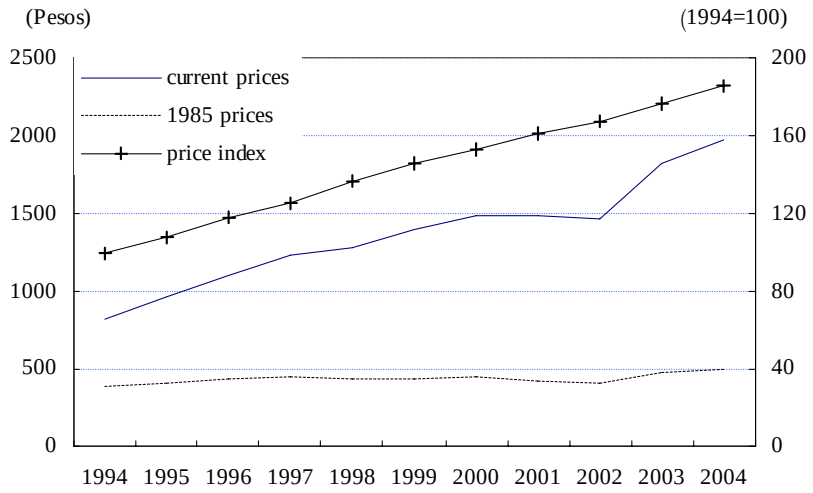
Therefore, they have to pay the full premium by themselves to enroll in social health insurance[14]. This is a common issue relating to targeting: how to treat the near poor is a crucial issue in the Philippines where the quality of indigent identification is low.

Under the current insurance system (copayment by insurer), patients pay for the remaining costs that exceed the insurance benefits. Because the service fee is not on a schedule, physicians (providers) are able to set provided service fees. This scheme makes financial costs unpredictable and raises people's financial barriers to access health services. More critically, physicians might capture insurance benefits as *rent* under the current system[15]. If insurance benefits become *rent* for physicians, insurance will not in practice reduce people's financial burdens to access health services.

Health Cost and Finance in the Philippines

Health financing is one of the focal issues on the health sector reforms in the Philippines. How has health expenditure been changing? Has the health finance structure changed?

Figure 1 Per Capita Health Expenditure in the Philippines



Note: Author's compilation based on data from Philippine National Health Accounts 2004.

Figure 1 presents changes in per capita health expenditure in the Philippines from 1994 to 2004. This figure clearly shows that health costs have substantially risen in

[14] If the person is formally employed, employer and employee share the premium.
[15] Details of this issue are in page31 of this text and footnote 6.

these years. Health expenditure in terms of current prices increased by about 140% from 1994 to 2004, whereas expenditure in terms of real prices (1985 prices) increased by 30%. The health expenditure price index increased by 85.2% over the period, which is higher than the increase in CPI by 75.8%.

Table 7 shows family expenditure on medical costs in which we observe the changes in medical costs from the demand side.

Table 7 Total Family Expenditure on Medical Care, 1997 and 2000

	Current prices (pesos)			1997 prices		
	1997	2000	% Growth	1997	2000	% Growth
Total	30,449,072	34,630,519	13.7	30,449,072	28,385,671	-6.8
Drugs and medicines	14,900,215	16,085,226	8.0	14,900,215	13,184,611	-11.5
Hospital room charges	6,892,646	8,344,267	21.1	6,892,646	6,839,563	-0.8
Medical charges	6,230,152	7,521,702	20.7	6,230,152	6,165,330	-1.0
Dental charges	754,240	759,873	0.7	754,240	622,847	-17.4
Other medical goods and supplies	1,193,116	1,203,927	0.9	1,193,116	986,825	-17.3
Other medical and health services	478,704	628,991	31.4	478,704	515,566	7.7

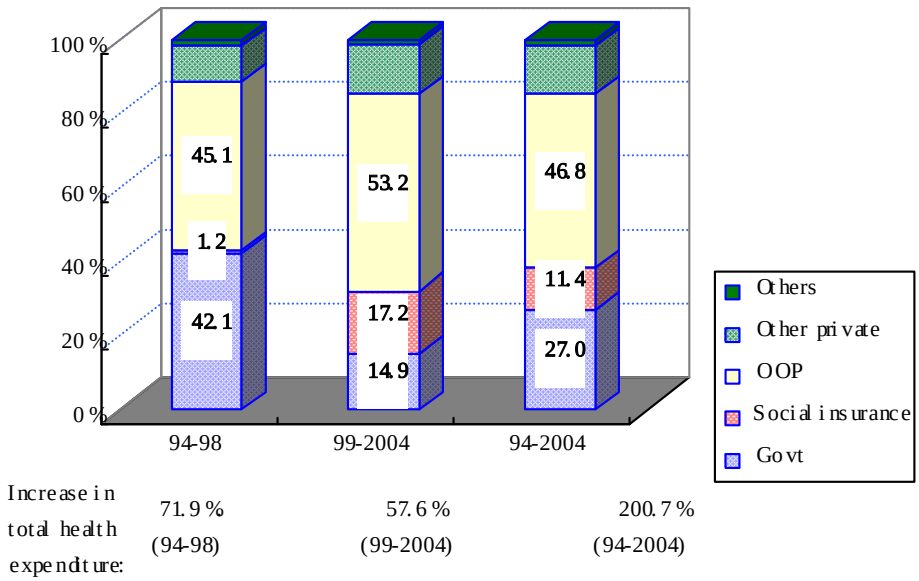
Source: 2000 Family Income and Expenditure Survey(FIES).

Demand-side data also confirm that medical costs have been inflated. In particular, hospital room charges and medical charges surged by more than 20% from 1997 to 2000. On the contrary, both items decreased in terms of real prices (1997 price), which suggests real consumption of these items decreased over the period. Even though health expenditures have soared in recent years, people's actual consumption of health services has not increased in the Philippines.

Which funding sources pay for such increases in (nominal) health expenditure? Major funding sources are government, social insurance and out-of-pocket

payment (OOP) in the Philippines. Figure 2 shows the percentage contribution of each funding source to the increase in health expenditure in these years.

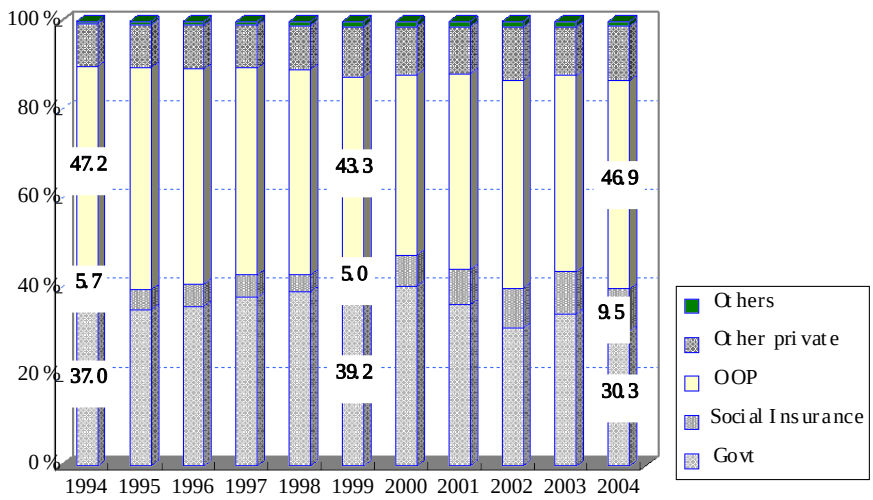
Figure 2 Contribution (%) to Health Expenditure Increase by Source of Funds



Note: Author's compilation based on data from Philippine National Health Accounts 2004.

As we observed in Figure 1, total health expenditure (current price) surged from 1994 to 2004. The right-hand bar graph in Figure 2 shows the percentage contribution of each funding source to the health expenditure increase from 1994 to 2004. OOP is the highest contributor in this increase. The middle ba r graph shows that social health insurance has become a more important contributor to health expenditure since health sector reforms began in 1999. However, it appears that increases in social health insurance contributions brought reductions not in OOP but in the government contribution. This implies that people's financial burden to access health services has been reduced by only a minimal amount even though social health insurance has expanded.

Figure 3 Health Expenditure by Source of Fund



Source: Philippine National Health Accounts 2004.

Figure 3 describes sources of funding for health expenditure from 1994 to 2004. As we observed, the percentage share of social health insurance in total health expenditure has increased. OOP, however, have reduced only marginally. The new health reform, *FOUR*mula *One* for Health, began in 2005. Our figures do not reflect the impact of the reforms, and thereby are very limited. However, they show that people's financial barriers have not been much reduced in recent years. What has caused the surge in health expenditure? Why has OOP not been reduced, even though the government has been trying to reform the health financing system in the Philippines?

The payment method, i.e., fee-for-service and nonfee schedule, might be a critical factor in rising pressures on health expenditure in the Philippines. As we observed, the health expenditure price index has increased at a faster pace than increases in the CPI. Health service providers (physicians, etc.) may have a strong incentive to provide excessive services under fee-for-service. In addition, they are able to set the fee of provided services under nonfee schedule, which would provide a strong impetus to increase health expenditures (costs).

In addition to the payment method, the social health insurance scheme might be another factor behind the steady OOP ratio in total health expenditure. Social health

insurance covers defined expenses of certain health services, and the excess costs are borne by patients. Physicians set the fee of provided health services; therefore, how much social health insurance will be able to reduce the patient financial burden will depend on the fee set by physicians. If physicians set the higher fee for an insured patient[16], the patients' financial burden would not much reduce even when they are insured. Our data analysis is very limited and primitive; therefore, we cannot provide a conclusive view on this issue. However, we still infer that insurance might not function as expected under current payment and insurance schemes, and this appears to be a critical factor in keeping the OOP at a high level.

The other possible source might be informal payments including donations. Patients are supposed to be able to access free public health care services. However, if informal payment is widespread, patients' financial burden will not be much lessened.

5. Discussion

We analyzed the structures of health financing as well as of financial barriers to patients' access to health services. Based on a simple structural framework, we studied the case of the Philippines and found several issues in its health financing:

- a surge in nominal health expenditures
- heavy financial burden due to the increase in health expenditure borne by OOP
- still relatively high ratio of OOP in total health expenditure.

The following payment methods and insurance schemes might be critical factors:

- nonfee schedule and fee-for-service payment
- copayment (by insurer) scheme
- insurance coverage.

While to fix a fee schedule would be a necessary action, it would not be a realistic option in the Philippines because it would be very difficult to define the fee practically. Moreover, enforcement would be a crucial problem. If the fee schedule was not enforced appropriately, it would facilitate the spread of informal payment.

What will then be a pragmatic option to address the problems? It would be to use

[16] Gertler and Solon (2002) and Obermann et al. (2006) suggest that insurance payment is captured as *rent* by providers in the Philippines.

the accreditation function of PhilHealth. Together with the accreditation function, monitoring is very important. Through PhilHealth accreditation with appropriate monitoring, government could encourage health institutions to:

- be more cost effective/cost controlling
- improve the quality of health care services.

The other important factor is to improve utilization of public health institutions and reduce informal payment, including donations. The keys are quality of care and adequate funding. People are not willing to access public health services because of low quality of care. Major factors in the low quality are:

- insufficient financial resources
- low motivation for improvement.

Against these problems, the government has begun to apply the reimbursement and accreditation functions of PhilHealth to public health institutions. Public health institutions are funded by tax, however, many of the public health institutions suffer from inadequate financial resources. That brings about low quality of care and might encourage informal payment (donations). By accrediting and reimbursing public health institutions, the government would be able to:

- inject additional funds into public health institutions in order to improve quality of care
- motivate them to improve their services
- substitute reimbursement for informal payment (donations).

However, the actions of PhilHealth are not a panacea. It is quite important to monitor how the health institutions use additional funds (reimbursements) and whether or not they continue requesting informal payment from patients.

We discussed the issue of Philippines' health financing. These problems, i.e. expanding health care costs and inadequate funding of public health institutions, are also common to other developing countries. Our analysis is still very limited. Future study will need to examine these problems empirically to provide more conclusive findings. In addition, there is a need to examine empirically the impact of current health reforms on health outputs as well as outcomes to evaluate the reforms.

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Appendix

Table A1 Out-of-Pocket Payment (OOP) in Asian Developing Countries, 2002

	Private expenditure on health as % of total expenditure on health	OOP as % of private health expenditure on health	**OOP as % of total expenditure on health**
Bangladesh	74.8	85.9	**64.3**
Cambodia	82.9	85.2	**70.6**
China	66.3	96.3	**63.8**
India	78.7	98.5	**77.5**
Indonesia	64	76.1	**48.7**
Malaysia	46.2	92.8	**42.9**
Philippines	60.9	77.9	**47.4**
Thailand	30.3	75.8	**23.0**
Viet Nam	70.8	87.6	**62.0**

Note: Author's compilation based on Philippine National Health Accounts, 2004.

Table A2 Public Health Institutions in the Philippines

Health institution	Own by	Service	Fee	Fund
Rural health unit/ Urban health center	LGUs (Mayer)	Preventive	Free	Tax, Reimbursement
District hospital	Province (Governor)	Curative	Free	Tax, Reimbursement
Provincial hospital	Province (Governor)	Curative	Free	Tax, Reimbursement
Regional hospital/ Public medical center	DOH	Curative	User fee	Tax, Reimbursement, User fee

Note: Author's compilation.