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TRANSFORMING THE HEALTH SECTOR: ISSUES IN HEALTH CARE FINANCING IN THE PHILIPPINES

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INTRODUCTION

A review of recently available data reveals several disturbing trends regarding several indicators of health status in the Philippines (Herrin et al., 1993). Little progress has been made in reducing infant mortality in the 1980s, and regional differences have persisted. Chronic diseases, such as diseases of the heart, diseases of the vascular system and malignant neoplasm have emerged as major causes of death even while infectious diseases, such as pneumonia, tuberculosis and diarrhea are still the major causes of death. The nutritional status of specific subgroups of the population, notably preschool children and pregnant and lactating mothers, remains poor.

The slow improvement in health status during the past decade can be understood in terms of the interplay of several proximate and underlying socioeconomic determinants. The major proximate determinants (those that directly affect health status) include health care utilization, fertility, nutrient intake and environmental sanitation. The socioeconomic determinants, on the other hand, include household income and level of education. A review of the indicators of these determinants reveals the following. First, health care utilization has remained low despite the expansion of public and private health care services. This is partly evidenced by the very large proportion of reported deaths (60% in 1989) without medical (physician) attendance. Secondly, fertility levels have declined at a slower rate than those of neighboring countries, such as South Korea and Thailand. It is well known that high fertility is associated with high infant and child mortality. The slow decline in fertility is due primarily to low levels of contraceptive use, particularly of the more effective methods of contraception. There was no increase in contraceptive use between 1986 and 1988 when the national family planning program was non-operational. Thirdly, in addition to chronic deficiencies in dietary and micronutrient intake, the prevalence and duration of breastfeeding (an important factor in the health and nutrition of infants) have declined between 1978 and 1983,

especially among younger women, among women with low level of education and among women in the rural areas. There is no information to indicate whether this decline has been arrested in the most recent period. Finally, environmental sanitation conditions are still poor among a large proportion of households as indicated by the lack of a safe water supply and sanitary toilets.

Underlying the slow progress in the proximate determinants are slow economic growth, the persistently high poverty rates in the 1980s and the slow improvements in education. In the 1980s, per capita GNP declined by an average of 1.7 per cent annually, while the poverty rate was still close to 50 per cent in 1988. While the literacy rate of the country's population 10 years old and over was 90 per cent in 1989, the "functional" literacy rate (defined as those who can read and write and compute) was only 73 per cent. It is likely that the functional literacy rate for older people, say those 25 years old and over who currently represent the parents, is even lower. The level of education, particularly of mothers, has been found to be an important factor in the efficient use of health services for infants and children in particular, and in the effective promotion of health for the entire family in general

As suggested in the foregoing discussion, health care utilization is only one of many important factors affecting the health status of the population. With health care utilization as a factor affecting health, there is a popular belief that low levels of health care utilization stem largely from the inadequacy of health services to meet the needs of the growing population. Likewise, expanding health services, especially to the underserved population, would require additional financial resources. Since the government is faced with increasing budgetary constraints, it is argued that alternative ways of financing this expansion of health services must be found. Common in discussions on health care financing is a tendency to over-emphasize the need to generate additional financial resources by designing new schemes to the neglect of an equally important and related concern -- how to make the health sector more efficient and equitable. It can be argued that additional resources can be generated within the health care system itself without introducing new financing schemes by simply making the system perform more efficiently.

In another vein, it is increasingly being recognized that the economic performance of the health sector in terms of efficiency and equity is intimately linked to the way the system is financed. The existing financing schemes may be in fact the source of some of the observed inefficiencies and inequities of the system. Thus, it is possible to introduce new financing schemes and design them in ways that will promote greater efficiency and equity of the health system in addition to generating resources for health. Viewed in this light, discussions on new financing schemes cannot be separated from discussions of resource allocation in general.

The purpose of this paper is to outline basic issues in health care financing from the larger perspective of transforming the health sector toward greater efficiency and equity in resource allocation. This is done in the next section. The paper then describes what we know about health care financing in the Philippines, suggesting that we know so little with respect to both sources and uses of health care financing,

as well as the impact of specific health financing schemes on the efficiency and equity of health sector performance. The paper ends with a brief discussion on possible reforms that could be undertaken both within and beyond the health sector, and on where such reforms will likely lead us in future. The general areas of scientific research needed to support policy reforms with respect to health care financing from a broad resource allocation perspective are noted as they arise during the discussion of issues.

II. BASIC ISSUES IN HEALTH CARE FINANCING

Health care financing is not just a question of raising funds to finance the expansion of health services or of recovering the cost of existing services; nor is it simply containing or reducing costs. Since health care financing affects the efficiency and equity of health sector performance, it is necessary to view health care financing issues within a broader resource allocation perspective. Viewed from this perspective, health care financing involves the following basic issues or questions:

1. What health services are to be financed? This question, in turn, includes the following questions: what services are to be produced (output-mix); how should such services be produced (input-mix); and who should use such services and how are such services to be used (utilization)?
2. Who should finance what health care services? This question involves issues regarding the proper role of the public and private sectors in financing.
3. How should health care services be financed? This question involves consideration of alternative private and public modes of financing health care: first, narrowly, with respect to the criteria of financial efficiency and financial equity; and second, broadly, with respect to their impact on the economic performance of the health care sector.
4. How much financing should the health sector receive relative to the other sectors of the economy (intersectoral resource allocation)?

Below we describe some basic principles that could guide our attempt to answer these questions.

What Health Services are to be Financed?

It is obvious that one would want to finance only those health services that are most effective in generating health impact from a given level of resources; those that are produced at least cost; and finally, only those that will actually be used by the population with health needs to produce the expected health impact.

These considerations lead us to issues regarding service structure (output mix), the production of specific services (input mix) and the utilization patterns of health care facilities and services.

Health Service Structure. The health sector can produce various kinds of services that will improve health status. Broadly, these services would include community health services and personal health services. Community health services include such services as public information and education, health surveillance, environmental health services and research and training. Personal health services, on the other hand, include both outpatient and inpatient care. Given the resources available for the health sector, how much should be allocated to each of these different services?

For a given level of resources available, greater efficiency in resource allocation can be achieved by producing that combination of services that is the most effective in improving health status. We shall call this type of efficiency the ***service structure efficiency.*** This implies, in part, choosing the combination of health services of given quantity and quality that adequately addresses the most important health problems/diseases. Choices once made are difficult to reverse once the health service infrastructure is set in place. It is, therefore, important to inform such choices with the findings of scientific research on the persisting and evolving patterns of disease as well as on the demonstrated relative cost-effectiveness of alternative health service.

Health Service Production. A particular health service, whether community or personal service, can be produced using different kinds of inputs, e.g., different types of human resources, medical equipment and facilities and drugs. What resource inputs are needed? In what combination should these be employed in the production of health services of given quality? Greater efficiency can be achieved by choosing that combination of health inputs that is the least costly among alternative combinations given the relative prices of various inputs and given the prevailing medical tehcnology. We shall call this type of efficiency ***service production efficiency.***

The effective application of this principle requires not only the consideration of substitution possibilities among different types of inputs that already exist, but also the expansion of the range of substitution possibilities through research and careful experimentation. Moreover, there is a need to review certain established practices in health care provision that, while designed with lofty objectives, such as ensuring high quality of service, unintentionally tend to restrict input substitution, and hence, the achievement of greater efficiency.

Health Service Utilization. A common approach adopted by many governments in response to the perceived unmet health needs of their population is the provision of more facilities and services closer to where people live. The approach, however, has not been found to be entirely successful. Instead, one finds the seemingly incongruous coexistence of unmet needs and inappropriate or excessive use of services, on the one hand, and of underutilized service capacity in

certain health facilities and overcrowding in others, especially at the higher levels of the delivery structure, on the other.

Greater ***service utilization efficiency*** can be achieved if: 1) those with real health needs as medically defined, do seek and get care; 2) those who do get care do not demand or are not provided excessive or unnecessary services as medically defined; and 3) those who do seek care for real health needs seek and are provided with necessary services at the most appropriate health facility in the service delivery structure. In addition, greater ***access equity*** can be achieved by ensuring that health care is obtained by those who need them irrespective of income or geographic location.

It is necessary to understand, through careful research and analysis, both the demand and supply factors influencing health service utilization. This in turn is important to achieve greater service utilization efficiency through: 1) the design of mechanisms or incentive structures which will modify the behavior of consumers and providers with respect to service utilization; and 2) the design of a delivery structure which will optimize the utilization of services and facilities.

Who Should Finance What Health Services?

In some countries, health care expenditures are financed largely by the government mainly through tax revenues, while in others, they are financed largely by the private sector through user fees or health insurance. What should be the respective roles of the private sector and the public sector in health care financing? In particular, which services should best be financed by the public sector and which services should be left to the private sector to finance?

Public sector financing to improve the efficiency of health sector performance is appropriate in such cases where information is imperfect, or when there are externalities in consumption or production or where services are simultaneously enjoyed by all. The presence of externalities in the consumption of certain health care services, e.g., immunization, could lead to underutilization of such services. Efficiency in utilization could improve with public subsidies to consumers of such services. Moreover, there are certain health services or activities, such as health education/information through mass media, epidemic control and vector control where the benefits can be enjoyed by all including those who do not pay for such services. In this case, the private sector is unlikely to provide such services due to the difficulty of collecting payments from the users. To ensure that such services are provided, government financing is necessary either to directly provide such services or to subsidize private producers. Public sector financing can also be justified on equity grounds. Government financing may be needed to improve equity of access to services either by subsidizing people who could not otherwise finance the high cost of services due to low incomes, or by subsidizing private producers to provide services at lower costs that are within the reach of lower income groups.

How Should Health Services be Financed?

Health care services can be financed publicly through various means: direct and indirect taxes or a payroll tax in social insurance schemes. Private financing can also take several alternative forms: user chargers, employer-based financing, private insurance, community financing and capitation schemes. Which of these alternative financing modes should be adopted?

In deciding which of these alternative financing modes (or combinations thereof) are to be adopted, it is necessary to examine each in relation to the various criteria of efficiency and equity, first with respect to the financing scheme itself, and second with respect to its impact on health sector performance. Among health care financing schemes that can generate the same level of financial resources, the more efficient scheme is the one that requires lower administrative cost of generating such financial resources. We shall call this type of efficiency ***financial efficiency.*** Moreover, among alternative schemes, the scheme wherein beneficiaries with higher incomes make progressively higher contributions relative to those with lower incomes would be a more financially equitable scheme than other schemes where the beneficiaries are required either to contribute amounts proportional to their incomes, or worse to contribute equal absolute amounts toward the financing of helath services. We shall call this type of equity ***financial equity.***

In addition to the criteria of financial efficiency and financial equity, the choice of which scheme or combination of schemes to adopt must be based on a careful assessment of its ability to promote efficiency in service structure, service production and service utilization as well as promote equity in access. Among health care financing schemes, the scheme or combination of schemes that promotes greater efficiency and equity in these aspects of health sector performance is to be preferred to those that do not.

How Much Financing is Needed?

The question policymakers frequently ask and in which they show great impatience when a definite figure cannot be readily provided is: how much should the country spend for health services?

A basic principle based on economic theory can be given: greater efficiency in resource allocation can be achieved by allocating relatively more of the additional resources available to those sectors that offer larger contribution to social welfare and relatively less of the additional resources to those sectors that offer smaller contributions to social welfare. We shall call this type of efficiency ***intersectoral resource allocation efficiency.*** This is perhaps the most abstract of all performance indicators. Unfortunately, there is no practical procedure that can be routinely applied to measure this performance indicator (de Ferranti, 1983). The problem lies in the difficulty of measuring social welfare of which health is but one of the components. This problem persists even when the concept of social benefit is

narrowly defined in terms of health status improvements. This is due largely to the difficulty of adequately measuring health status on the one hand, and the relative contributions to health status improvements of various health-promoting sectoral activities, on the other.

Several approaches have been used in the past to deal with this question. These include inter-country comparisons of total health care spending as a percentage of GNP, and intra-country comparisons of historical trends in health care expenditures vis-a-vis other expenditures, either in terms of percentage of GNP or rates of growth, in conjunction with other information, such as the trends in mortality and morbidity, changes in disease patterns, access to health care delivery services, changes in population composition and others. Although none of these approaches is entirely satisfactory, each may provide some basis for making qualitative judgments as to whether or not, at the margin, more spending on health services is likely to promote greater social welfare than if the same resources were spent elsewhere.

III. HEALTH CARE FINANCING SYSTEM IN THE PHILIPPINES

The Current System

The Philippine health care financing system consists of a number of financing sources. These include: 1) central government-financed services; 2) local government-financed services; 3) social insurance (Medicare); 4) private health insurance including Health Maintenance Organizations (HMOs); 5) employer-financed health services; 6) community-based health financing schemes including cooperatives; and 7) direct household spending. At present, our information regarding both the amounts financed from each of these sources and the uses of financing is quite limited. We also know little about the impact of each financing scheme on consumer and provider behavior which eventually influences efficiency and equity of health sector performance according to the criteria described earlier.

Recent attempts have been made at estimating total health care expenditures and sources of financing (Intercare, 1987; Solon, et al. 1992; Herrin et al., 1993). Preliminary estimates show that total health care expenditures for 1985 and 1991 were less than 2 per cent of GNP (Table 1). The estimates are obviously biased downwards because they do not include expenditures from other sources for which no information is available, i.e., local government, employer-financed services and community financing. The expenditures from these other sources are probably small compared to those for which we had some information, hence a rough estimation of around 2 per cent of GNP might be a reasonable first approximation of total health expenditures in the Philippines. Real GNP per capita increased between 1985 and 1991, hence total spending per capita for health was also increasing in real terms during this period, But real GNP per capita in 1985 and 1991 was lower than it was in 1981. Hence, if health expenditures in 1981 were also around 2 per cent of GNP, then real per capita spending has declined during the 1985-1991 period.

About half of total health sector expenditures are financed by households in terms of direct payments to providers. While this implies, on the one hand, that households can and do pay for health services, it also means that those without money incomes to pay for services can not easily get access to such services (inequity in access). Moreover, among the very poor, paying for health services would likely involve shifting present or future resources away from alternative uses which could have both short-run and long-run adverse consequences, e.g., borrowing money to pay for health care now could mean less consumption in the future or less investment in other forms of human capital, such as the education of children.

About 40 per cent of total health sector expenditures were from the government, financed largely from taxes. In view of the regressiveness of the current tax structure, the burden of financing public sector expenditures falls heavier upon lower income groups than the highest income groups (financially inequitable).

Social insurance thorugh Medicare is still a minor source of health sector financing, constituting 8 per cent of total health sector financing in spite of its having been in operation for 20 years. A major factor in the slow growth of social insurance is the slow structural transformation of the economy which makes it extremely costly (financially inefficient) to expand Medicare coverage to the population outside of the formal employment sector.

Possibilities for Expanding Resources for Health Care

There are several possibilities for expanding resources for health care while achieving greater efficiency and equity in the health sector. The first set of possibilities lies beyond the health care sector. The first is tax reform and administration: getting more taxes from higher-income groups who are currently undertaxed to make the burden of taxation more equitable and at the same time raise more tax revenues to finance government activities, particularly health. This improves financial equity while generating additional resources. The second is economic reforms to speed up growth and development that takes into account the large labor force and agricultural potentials of the country. With faster structural transformation, the expansion of (the reformed) Medicare Program will be facilitated. With increased incomes and equitable distribution, demand for health services provided by the private sector will increase, thus facilitating the growth of the private sector particularly in the hospital industry. The growth of the private sector, in turn, will relieve government from providing hospital services in urban areas, thus facilitating the reallocation of government resources to rural health services.

The second set of possibilities lies within the health sector. The most important of this is the reforms in the Medicare Program: restructuring contributions and benefits, better fund management (to manage it like a health fund rather than a social security fund), strict enforcement of enrolment of employees to the program, expansion of memberships outside of the formal employment sector through the

use of cooperatives (e.g., rural electric cooperatives) or other large organizations and the reduction of fraudulent claims. These reforms would make the Medicare Program more financially efficient and equitable and better able to provide additional benefits and to expand coverage in tandem with structural transformation. Also, it would be prudent to proceed with caution with respect to user charges until we have more information on their impact on utilization, and on community-based financing schemes. That is, unless we are sure that government intervention can do a better job than current community initiatives.

With these reforms, we might see in the future a national financing system with the following structure: 1) government funds (about 20 per cent of total financing) will be used mainly for public good, for preventive care and for the hospital care of the poor in rural and urban communities; 2) social insurance will constitute the main source of financing (about 60 per cent of total financing), mainly for hospital services (Cost containment measures, however, will have to be developed to reduce the excessive use of health care services which could arise from the scheme.); 3) user fees in the form of co-payments and direct payments for inexpensive outpatient care and drugs will constitute about 15 per cent of total financing; and 4) other sources of funds (about 5 per cent of total financing) will serve to supplement the three main sources above especially in emergency cases during calamities.

IV. SUMMARY AND CONCLUSION

The basic issues in health care financing viewed from the larger perspective of resource allocation invariably include such questions as: what health services are to be financed, who should finance what health care services, how should health care services be financed and how much financing is needed? The ability to address these questions in the Philippine context is greatly hampered by the lack of basic information on the health care sector, ranging from the basic information on health outcomes to the structure of the delivery system particularly the private sector component. There is also a dearth of information on the production and cost structures of major service providers, the utilization of health care services and sources and uses of health care financing.

The generation of such basic information is urgently needed to address the above questions, and more urgently so to address specific policy questions that are now being deliberated upon by health policymakers, health administrators and legislators. These specific policy questions are: a) how well did the current social insurance program for government and private employees perform in providing health benefits to its members and what reforms are needed to improve performance; b) with an increasingly overburdened government budget, can the cost of publicly provided health services be recovered and by what means; and finally c) given that a large segment of the population is still not covered by any type or risk coverage or health insurance, how can the benefits of the existing social insurance scheme be expanded to cover the rest of the population or what is the most appropriate way to develop a national health insurance program?

Table 1. Estimated total health care expenditures by source of financing: 1985 and 1991 (in current prices)

Source	1985		1991	
	Billion Pesos	*Per cent of Total*	*Billion Pesos*	*Per cent of Total*
Government	3.78	38.4	7.42	36.3
Households	5.36	54.5	10.94	53.6
Medicare	0.55	5.6	1.73	8.5
Private insurance	0.15	1.5	0.33	1.6
Total	9.83	100.0	20.09	100.0
Percent of GNP	1.64		1.63	

Source: Department of Budget and Management, Family Income and Expenditure Surveys of 1985 and 1991, Philippine Medicare Commission and Gamboa, R.M., 1991, *Background Paper on Health Insurance in the Philippines*, Report prepared for the United States Agency for International Development as reported in Herrin, A.N., A.D. Kraft, O.F. Picazo, O.C. Solon, M.M. Taguiwalo and M.S. Zingapan, *Health Sector Review: Philippines*, Health Finance Development Project Monograph No. 3, Department of Health, Republic of the Philippines and United States Agency for International Development.

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SYMPOSIUM II

Symposium	:	**Issues in Health Care Financing in the Philippines**
Moderator	:	**National Scientist Jose Encarnacion Jr.**
Rapporteur	:	**Dr. Anna Miren Gonzales-Intal vice Fr. Bienvenido F. Nebres**
Speaker	:	**Dr. Alejandro N. Herrin**

SUMMARY/HIGHLIGHTS OF DISCUSSION

Health, being a produced commodity, involves the use of resources. Hence, the issue is resource allocation. In this regard, health care financing is not just a matter of raising funds but that the economic performance of the health sector in terms of efficiency and equity is intimately linked to the way the system is financed.

There are four basic issues in health care financing from the larger perspective of transforming the health sector toward greater efficiency and equity in resource allocation. The research challenge is that we know so little about the sources and uses of health care financing. These basic issues are:

1. What health services are to be financed? What appropriate mix of primary and tertiary health care services should be provided by the government or the private sector to various clientele groups?
2. Who should finance such sources? What is the efficient and equitable mix of public and private sector financing of the appropriate mix of health care services?
3. How should health care services be financed either by the government or by the private sector in terms of financial efficiency and equity?
4. How much financing should the health sector receive relative to the rest of the economy?

Dr. Herrin described some basic principles in addressing the above questions. With respect to what health services are to be financed, the objective is to finance only those health services that are most effective in generating health impact from a given level of resources; those that are produced at least cost; and those that will actually be used by the population with health needs to produce the expected health impact.

On the issue of how health services should be financed, the choice of which mode of government and private sector financing depends on: a) which provides the most financial resources at the least administrative cost; and b) which forces encourage the rich health care beneficiaries to make progressively higher contributions than the poor health care beneficiaries.

On the question of how much financing is needed, Dr. Herrin points out that this is the most difficult to answer because there are no clear-cut methodologies to use. Also, it is difficult to measure the impact of improvements in health status relative to other social investments.

With respect to the health care financing system in the Philippines, preliminary estimates showed that health care expenditure by the government and households was less than 2 per cent of national income in 1991. About one-half of total health expenditures is paid for by households directly to health care providers; about 40 per cent is provided by government through taxes which is regressive; and of the rest, about 8 per cent is provided by social insurance through MEDICARE.

There are several possibilities for expanding resources for health care. The first set of options involves reforms outside the health care sector, specifically, improved taxation and tax administration and economic reforms to speed up economic growth and more rapid structural change. The second set of options involves reforms within the health sector. These are reforms in the MEDICARE program and the need to study user charges and community-based financing schemes.

Several issues, were raised during the open forum: 1) the tentativeness of Dr. Herrin's data due to lack of systematic data on health care financing in the Philippines; 2) the efficiency of Philippine health expenditures for every peso spent and how this compared with those of other countries; 3) the emphasis on preventive health services thereby reducing the cost of health care; 4) how the primary health care program is to be financed; and 5) the wisdom of the devolution of health, education and social services to local governments whose personnel may not be very knowledgeable in these areas. Preventive and health promoting activities affecting the whole nation need to be centralized while unique health issues and problems might be better localized or decentralized.