Policy Brief #5

PhilHealth became more pro-poor between 2013 and 2017 owing to the policy of not permitting hospitals to charge poor patients in excess of their reimbursement ceiling.

UPecon Foundation

How Much has PhilHealth Been Able to Protect Filipino Households from the Financial Risks of Sickness?[1]

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Introduction

Health insurance provides financial protection by replacing a member-household's out-of-pocket payments with reimbursements to health care providers. To what extent has PhilHealth, the country's social health insurance program, been able to do this? A number of studies have been done on the distribution of the benefits of health financing in the Philippines but this question has not been given a direct answer. The purpose of this study is to answer this question by analyzing the distribution of PhilHealth insurance benefits between poorer and richer patients, and between higher and lower cost treatments. The study also documents that the deepening of benefits of PhilHealth appear not to have been due primarily to the expansion of population coverage among the poor, but rather to the deliberate attempt to protect poor patients from excessive payments through the "No Balance Billing" policy.

In the years leading to the landmark legislation on Universal Health Care (UHC) of 2019, the National Government pursued several reforms to extend population coverage, widen service benefits, and deepen financial protection of PhilHealth. The key thrusts during this period were: Phased membership coverage expansion between 2011 and 2016; Introduction in 2011 of the No Balance Billing (NBB) policy that prevented government hospitals from charging poor patients in excess of the case rates of PhilHealth. NBB was further extended to outpatient surgery, hemodialysis, and radiotherapy, and maternity and newborn care in 2012; Expansion of the case rate provider payment system from 11 to 22 medical and surgical procedures, duly revised in 2015 and 2016; Providing catastrophic cover for the treatment of high-cost conditions referred to as case types Z, from four conditions in 2012 to 16 conditions in 2017.

The objective of this study is to find out to what extent these reform initiatives, among others, could have contributed to the financial protection of PhilHealth.

[1] Based on the article "Filling Potholes on the Road to Universal Health Coverage in the Philippines" by Joseph J. Capuno, Aleli D. Kraft, and Owen O'Donnel. *Health Systems & Reform*, **7**:2 (2021) DOI: 10.1080/23288604.2021.1911473

Data and Methods

This study uses household data from 2013 and 2017 Philippine National Demographic and Health Surveys (NDHS) on reported payments for inpatient care that are made by households' out-of-pocket (OOP) expenses and by PhilHealth reimbursements to hospitals. These data were used to estimate changes in the fraction of costs of inpatient care that were paid by PhilHealth. The study estimated separately mean OOP payments, PhilHealth payments, the aggregate of the two payments, and the fraction paid by PhilHealth out of the aggregate. The analysis covered only households in 2013 and 2017 that made use of inpatient care, i.e., were admitted to a PhilHealth-accredited hospital, public or private.

The study uses the household as the unit of analysis. It estimated PhilHealth coverage rates in 2013 and 2017 for the whole population as well as subgroups such as (a) households with at least one senior, i.e., aged 60 years or older, (b) households who are recipients of the conditional cash transfer program known as 4Ps, (c) households deemed the 40 percent poorest using a wealth index.

Next, using only households which experienced having a member admitted to a health facility, the study estimated the following: (a) the average amount of hospitalization OOP paid by households, (b) the average amount of hospitalization paid by PhilHealth, (c) the average amount of hospitalization paid by OOP and by PhilHealth, i.e., (a + b), and (d) the fraction of the total amount of hospitalization paid by PhilHealth. The estimation was done first for all households and then for households with PhilHealth membership. The study used local polynomial smoothing regression to illustrate how the proportionate contribution of PhilHealth for inpatient hospitalization varied with the magnitude of the payment.

Finally, to assess whether PhilHealth benefits were predominantly received by poorer or richer households, the study used concentration curves to trace the incidence of PhilHealth benefits in relation to location in the distribution of household wealth.

Findings

Expansion of population coverage – The fraction of households covered by PhilHealth increased from around two-thirds in 2013 to around three-quarters in 2017. The coverage rate increased for all groups of households.

Table 1. Percent of Households Covered by PhilHealth, 2013 and 2017

TYPES OF HOUSEHOLDS	2013	2017
All households	66.8	74.6
With senior citizens	63.9	84.5
Without senior citizens	67.9	70.4
Households covered by 4Ps	89.6	94.4
Households not covered by 4Ps	61.3	70.8
Poorest 40 percent of households	62.5	67.5
Richest 60 percent of households	69.5	79.4

[2]To see the distribution of the sample households across sites and survey periods, the reader is referred to Figure 1 (Participant Flow) in the paper.

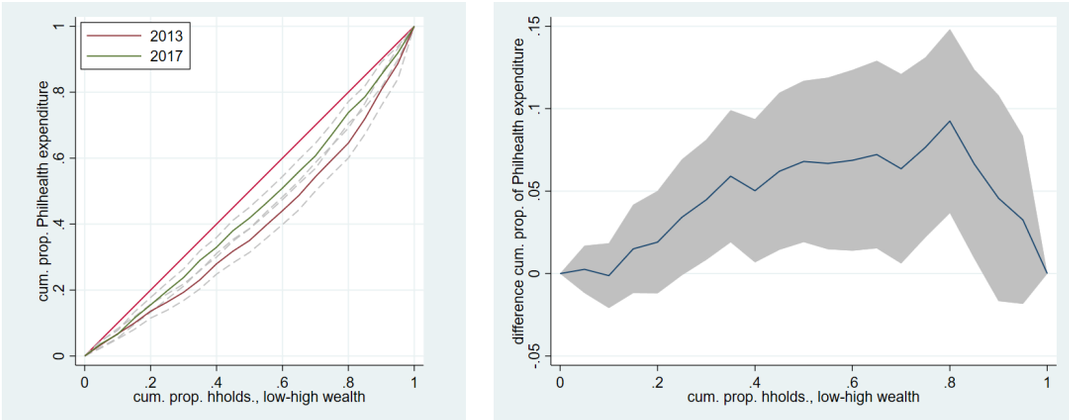
Payment for hospital inpatient care – (a) The mean total payment to hospitals (household OOP + PhilHealth reimbursements) increased from around PhP 18,200 in 2013 to PhP 21,600 in 2017 (US$ 1 = PhP 50), an increase of almost 20 percent. (b) The mean household OOP payment to hospitals did not show significant change between 2013 and 2017. In contrast, the mean PhilHealth payment to hospitals increased significantly in the same period, confirming that PhilHealth has been replacing what would have been the household OOP payment. (c) As a result, PhilHealth payment increased by two-thirds, and the fraction of the cost paid by PhilHealth rose by 21 percentage points. (d) Moreover, the fraction paid by PhilHealth shifted up in 2017 throughout the distribution, but to a much greater extent in the bottom third of households than at the top. The peak shifted down in 2017, such that the fraction paid by PhilHealth reached a maximum of about 70 percent at around the 35th percentile. At the very top of the distribution, the fraction paid by PhilHealth increased by only around 6–7 percentage points.

Table 2. Mean Payments to Hospitals for Inpatient Care, 2013 and 2017

ITEMS	ALL HOUSEHOLDS		PHIHEALTH ENROLLED HOUSEHOLDS	
	2013	2017	2013	2017
Mean payment to hospital (PhP)	18,183.98	21,612.11	20,544.42	22,750.32
Mean household OOP payment to hospital (PhP)	12,584.74	12,283.59	13,528.91	12,527.06
Mean PhilHealth payment to hospital (PhP)	5,599.24	9,328.52	7,015.51	10,223.26
Mean fraction of hospital bill paid by PhilHealth	33.7%	54.6%	42.6%	59.8%

Greater equity in the distribution of PhilHealth inpatient benefits – The study also constructed concentration curves of PhilHealth payments for hospital inpatient care. In Figure 1, the x-axis shows the cumulative proportion of households ranked from poorest (left) to richest (right) according to the wealth index; the y-axis shows the cumulative proportion of PhilHealth payments for hospital inpatient care; and the diagonal line shows perfect equity. The figure shows a significant inward shift from 2013 to 2017 towards the line of equity, indicating that PhlHealth payments became more equitable (except for the top-most and bottom-most part of the curves). A formal test confirms that the 2017 concentration curve dominates the 2013 curve, indicating that there was a significant decrease in the pro-rich distribution of PhilHealth benefits. The concentration index decreased from 0.215 in 2013 to 0.1176 in 2017 which is also indicative of a significant decrease in pro-rich inequality.

Figure 1. Concentration Curves of PhilHealth Payments to Hospitals for Inpatient Care, 2013 and 2017



Payment for medicines and lab tests – Households without PhilHealth coverage, and even those with coverage, used to spend inordinate amounts of OOP money for medicines and lab tests, especially if these are purchased outside the hospital, which was the case in 2013 and earlier. With PhilHealth expansion in enrollment and deepening of benefits, this problem has eased. While PhilHealth only covered 2.4 percent of these costs in 2013, it covered 28.0 percent in 2017, and this dramatic increase in coverage was observed in all socioeconomic groups. On average, PhilHealth spending on medicines and lab tests increased from only PhP 289 in 2013 to PhP 5,249 in 2017.

Conclusions

PhilHealth payments for inpatient care were for a long time pro-rich, but during the period 2013-2017, they became substantially less so, possibly because policies no longer permitted hospitals to charge poor patients in excess of reimbursement ceilings. Overall, prepayment of inpatient costs increased and became more pro-poor, reflecting gains in insurance and equity.

While it is true that during this period, PhilHealth was also expanding population coverage especially to cover more poor and low-income households, other policies such as expanded benefits, the adoption of case rates, the “No Balance Billing” policy, and making members more aware of their benefits contributed to deepening PhilHealth benefits and thereby, increasing financial protection.