Analysis of Out-of-Pocket Expenditures in the Philippines

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Objectives of the Study

• Determine the patterns of OOP over time
• Dissect the different sources of OOP
• Estimate the following:
  – PhilHealth Support Value
  – Utilization rates and other related indicators
• Estimate the burden of payments and impoverishment due to OOP.
• Inequities in health financing (not included in the presentation)
Data Sources

• Family Income and Expenditure Surveys (2000 to 2012)
• Annual Poverty Indicators Survey (2011)
• Hospital Statistical Reports (2011)
• Claims data of PhilHealth (results not included)
Out of Pocket: importance

- Highly catastrophic; impoverishing
- Signals ineffective and inefficient healthcare system
- Higher risk of forgoing care, delayed health seeking and non-compliance
- The goal is not to totally eliminate OOP:
  - Tame the rapid growth
  - Decrease it to rational levels
- The ‘realistic’ goal is to reduce OOP by less than 50% (by 2016) by increasing the share of social insurance.
OOP expenditures

“any direct outlay by households to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups”
Total Health Expenditures

Government (national & local) + Social insurance + Private sources + Others

OOP

Private insurance

HMOs

Private establishments
THE is growing in a fast rate!!
Is the growth rational?

Total health expenditure, Philippines, 1991-2011

in million PhP

- 500,000
- 450,000
- 400,000
- 350,000
- 300,000
- 250,000
- 200,000
- 150,000
- 100,000
- 50,000
- 0


current constant
OOP outpacing other sources of financing….

Sources of health expenditures, Philippines
1994-2011

Note: in constant terms using 2006 CPI
Source of raw data: NSCB 2006
More than 50 percent of the THE are accounted to OOP...

Source of raw data: NSCB
OOP across ASEAN.....
Average OOP health expenditure is increasing both in nominal and constant terms...

<table>
<thead>
<tr>
<th>Year</th>
<th>Current Q1</th>
<th>Current Q2</th>
<th>Current Q3</th>
<th>Current Q4</th>
<th>Current Q5</th>
<th>National Q1</th>
<th>National Q2</th>
<th>National Q3</th>
<th>National Q4</th>
<th>National Q5</th>
<th>National</th>
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</thead>
<tbody>
<tr>
<td>2000</td>
<td>301</td>
<td>624</td>
<td>1,114</td>
<td>2,210</td>
<td>7,084</td>
<td>2,267</td>
<td>416</td>
<td>862</td>
<td>1,539</td>
<td>3,053</td>
<td>9,785</td>
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<tr>
<td>2003</td>
<td>388</td>
<td>843</td>
<td>1,452</td>
<td>2,708</td>
<td>7,528</td>
<td>2,582</td>
<td>445</td>
<td>967</td>
<td>1,665</td>
<td>3,106</td>
<td>8,633</td>
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<tr>
<td>2006</td>
<td>506</td>
<td>1,083</td>
<td>2,054</td>
<td>3,807</td>
<td>13,516</td>
<td>4,193</td>
<td>506</td>
<td>1,083</td>
<td>2,054</td>
<td>3,807</td>
<td>13,516</td>
</tr>
<tr>
<td>2009</td>
<td>635</td>
<td>1,312</td>
<td>2,426</td>
<td>4,892</td>
<td>15,138</td>
<td>4,880</td>
<td>547</td>
<td>1,131</td>
<td>2,091</td>
<td>4,217</td>
<td>13,050</td>
</tr>
<tr>
<td>2012</td>
<td>1,379</td>
<td>2,424</td>
<td>3,850</td>
<td>8,240</td>
<td>19,283</td>
<td>7,035</td>
<td>1,075</td>
<td>1,889</td>
<td>3,001</td>
<td>6,422</td>
<td>15,029</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>AGR* 46%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>21%</td>
</tr>
</tbody>
</table>

Increasing OOP=increasing demand for care

Source: analysis of various rounds of FIES surveys
Medicines account for more than half of the out of pocket expenditures. The poorest spend less on inpatient and outpatient care services relative to their total OOP health expenditures. This suggests heavy reliance on medicines in lieu of actual visit to a health facility…

<table>
<thead>
<tr>
<th>Components</th>
<th>Quintile 1</th>
<th>Quintile 5</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ave exp</td>
<td>Share</td>
<td>ave exp</td>
</tr>
<tr>
<td><strong>Medical products</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>514.6</td>
<td>59%</td>
<td>10,189.6</td>
</tr>
<tr>
<td>Pharma products</td>
<td>329.7</td>
<td>64%</td>
<td>6,597.6</td>
</tr>
<tr>
<td>Nutritionals</td>
<td>148.5</td>
<td>29%</td>
<td>2,934.3</td>
</tr>
<tr>
<td>Other medical prep</td>
<td>20.1</td>
<td>4%</td>
<td>304.7</td>
</tr>
<tr>
<td>Other medical products</td>
<td>11.9</td>
<td>2%</td>
<td>129.2</td>
</tr>
<tr>
<td>Therapeutic appliance</td>
<td>4.4</td>
<td>1%</td>
<td>223.8</td>
</tr>
<tr>
<td><strong>Outpatient services</strong></td>
<td>113.7</td>
<td>13%</td>
<td>3,876.2</td>
</tr>
<tr>
<td>Medical services</td>
<td>86.9</td>
<td>76%</td>
<td>3,224.2</td>
</tr>
<tr>
<td>Dental services</td>
<td>3.3</td>
<td>3%</td>
<td>366.0</td>
</tr>
<tr>
<td>Paramedical services</td>
<td>23.5</td>
<td>21%</td>
<td>286.1</td>
</tr>
<tr>
<td><strong>Inpatient services</strong></td>
<td>242.2</td>
<td>28%</td>
<td>8,271.0</td>
</tr>
<tr>
<td>Public</td>
<td>179.7</td>
<td>74%</td>
<td>1,104.4</td>
</tr>
<tr>
<td>Private</td>
<td>62.4</td>
<td>26%</td>
<td>7,166.6</td>
</tr>
</tbody>
</table>

Source: analysis of various rounds of FIES surveys
Healthcare overutilization and underutilization among the richer and poorer segments remain to be a problem. The lack of effective policy and regulatory instruments (direct and indirect) that control health expenditure in richer segments may not lead to decrease in the total value of OOP.

**Share of OOP health expenditure by quintile groups, Philippines, 2000-2012**

Source: analysis of various rounds of FIES surveys
Burden of OOP payments is rising....

Share of OOP to capacity to pay, 2000 to 2012

Source: analysis of various rounds of FIES surveys
Higher number (percentage) of HH experiencing catastrophe due to OOP payments.

If burden of payments [OOP/income], exceeds a specified threshold. World Health Organization researchers use 40 percent as threshold when “capacity to pay” (roughly, total expenditure minus food) is used as the denominator (Xu, 2005).

Source: analysis of various rounds of FIES surveys
Increasing number (and percentage) of impoverished HH due to OOP.

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>headcount pre-OOP</td>
<td>23.1%</td>
<td>19.2%</td>
<td>19.8%</td>
<td>18.4%</td>
<td>19.4%</td>
</tr>
<tr>
<td>headcount post-OOP</td>
<td>23.7%</td>
<td>19.9%</td>
<td>20.6%</td>
<td>19.2%</td>
<td>20.4%</td>
</tr>
<tr>
<td>% of impoverished HH</td>
<td>0.6%</td>
<td>0.7%</td>
<td>0.9%</td>
<td>0.8%</td>
<td>1.0%</td>
</tr>
<tr>
<td>poverty gap before OOP</td>
<td>231.8</td>
<td>191.8</td>
<td>222.0</td>
<td>240.6</td>
<td>282.1</td>
</tr>
<tr>
<td>poverty gap after OOP</td>
<td>239.1</td>
<td>199.4</td>
<td>232.7</td>
<td>252.6</td>
<td>299.7</td>
</tr>
<tr>
<td>difference</td>
<td>7.2</td>
<td>7.5</td>
<td>10.7</td>
<td>12.0</td>
<td>17.5</td>
</tr>
</tbody>
</table>

Source: analysis of various rounds of FIES surveys
Why OOP is continuously growing?

• Are we covering everyone?
• Are the people utilizing their benefits? Especially the poor?
• Is PHIC doing enough to increase the support value?
• Is PHIC doing enough to control healthcare cost?
Low benefit utilization vis-a-vis demand for care…

**Benefit utilization and demand for care, 2011**

Source: authors’ calculation using APIS 2011
Why significant number of patients are not covered with PhilHealth? And why private hospitals are more efficient in admitting PhilHealth patients?

patient discharges, PHIC status, 2011

Source: authors’ calculation of 2011 HSR
Why government hospitals are still saturated with non-PHIC ‘charity’ cases?

Source: authors’ calculation of 2011 HSR; number of hospitals: 963
Low support value of PhilHealth…

PHIC Support value, by socio-economic status, 2011

Significance (chi-square): p:0.000 (significant)

Source: authors’ calculation using APIS 2011

PHIC Support Value, by CCT membership, 2011

Significance (chi-square): p:0.000 (significant)
Are we covering the most vulnerable age groups?

Support value of PHIC, by age group, 2011

Significance (chi-square): p:0.01 (significant)

Source: authors’ calculation using APIS 2011
Why there is regional variation in SV?

Support value of PHIC, by region, 2011

Significance (chi-square): p:0.000 (significant)

Source: authors’ calculation using APIS 2011
Highly variable and dispersed value of reimbursements...

PHIC reimbursements by quintile, 2011

Source: authors’ calculation using APIS 2011
Key Findings

• OOP continue to rise despite the enormous programmatic and policy reforms in the health financing system.

• The growth in OOP is outpacing other key financial sources like social insurance and government spending.

• Healthcare demand is increasing as manifested by the increasing average household OOP health expenditures (both in nominal and constant terms). The growth is notable in all SES groups.

• Drugs continue to be the major source of OOP expenditure.
Key Findings

• The prevalence of catastrophic payments and incidence of impoverishment due to OOP are increasing.

• There is a compelling evidence of underutilization and overutilization of healthcare services and goods.
Key Findings

• The support value of PHIC is less than 50 percent. Highly variable across SES, regions, age groups.

• The support value of vulnerable groups are low.

• Significant portion of patients in hospitals are not PHIC members. Private hospitals are more efficient in admitting patients with PHIC.