Policy Insight

The Philippines' Universal Healthcare Policy (Kalusugan Pangkalahatan) and the Poor

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Introduction

The Philippines is a developing democratic country with a population of over 100 million people (United Nations 2017). In 2017, it had a gross national income of $3,600 per capita, ranking 112th out of 169 other countries (World Bank 2011). It has a skewed distribution of income with 25 percent of the population sharing 6.6 percent of the country's wealth, placing 91st out of 158 countries on the Gini inequality index (World Bank 2015). In 2012, a quarter of the population (26 million people) lived below the national poverty line (NSO 2014) while 12 percent lived on less than $1.90 per day (World Bank 2015). The poor have worse health outcomes due to a lack of access to healthcare (Capuno 2006). For example, a child born to a poor family is twice as likely to die before the age of five than a child born to a rich family (World Bank 2005).

This essay examines the Philippines' universal healthcare policy, also called the Kalusugan Pangkalahatan (KP). In particular, the financial features of the policy and healthcare outcomes for the poor are discussed. This is important because approximately one quarter of the population of the Philippines live in poverty (Capuno 2006; Ulep & Dela Cruz 2016) and are therefore at high risk of disease with little means to pay for prevention or treatment. Furthermore, little is known about the social health insurance of the Philippines.

Social Healthcare in the Philippines Before the Kalusugan Pangkalahatan

In 1969, the Philippines was one of the first countries in Southeast Asia to implement a social health insurance scheme. While it included a provision for the poor, it failed to deliver to this demographic (Soriano et al. 2002) effectively, providing only for formal employees of the private and government sectors (Quimbo et al. 2013; Dayrit et al. 2018). In 1986, after the removal of a president who remained in power for 22 years, the government transferred the responsibility of healthcare from the national government to local jurisdictions in response to an analysis of healthcare in other countries (Grundy et al. 2003; United States Agency for International Development 1991). In 1995, the government established the National Health Insurance Program that was managed by the Philippine Health Insurance Corporation (PhilHealth). It mandated the "coverage of the entire population with at least a basic minimum package of health insurance benefits" (Republic Act No. 7875). On paper, the program was very generous as it covered the cost of a hospital bed, drugs, supplies, diagnostic tests, operating rooms, professional fees, and surgical procedures (Capuno 2006). However, it was subject to payout ceilings and only paid for goods and services provided by accredited facilities (Quimbo et al. 2013). In 1996, the scheme was extended to explicitly provide for the poor through the PhilHealth Sponsored Program whereby local government units were required by law to identify the poor households and their dependents in their jurisdiction and enroll them in PhilHealth (Obermann, Jowett, and Kwon 2018; Tobe et al. 2013). In principle, this meant that every poor person in the country should have free healthcare.

While PhilHealth membership for the poor was compulsory, many were not enrolled to become members (Dayrit et al. 2018). This was because a large burden of financing their insurance premiums was placed on 1,715 different local government units (Chakraborty 2013). This resulted in suboptimal enrollment of poor constituents as local authorities, specifically, had difficulty sourcing funds, decided that funds could be better spent elsewhere, and were reluctant to contribute to a pool of money that may be used to help constituents in other jurisdictions (Obermann, Jowett, and Kwon 2018; Dayrit et al. 2018). Lack of adequate monitoring and enforcement mechanisms, and preferential enrollment also occurred, where some non-poor constituents were enrolled in the program (Chakraborty 2013; Capuno

2006). According to Capuno (2006), in some jurisdictions, less than 10 percent of the poor were enrolled and the national government began fully subsiding some of them in an adhoc manner. Furthermore, the situation of funding, enrollments, and payouts were altered over time and between regions due to the shifts in local and national policies. In 2003, for example, the national government set a target to have five million poor people enrolled in PhilHealth by 2004, which was financed through the revenue from the Philippine Charity Sweepstakes Office (PCSO). In 2004, the number spiked to over six million. The following year the number of poor enrolled in PhilHealth was halved to less than 2.5 million (Capuno 2006).

There were also issues regarding the inefficient utilization of PhilHealth benefits by the poor. Despite them being at the highest risk of illness and having free compulsory coverage, only four percent made a claim in 2007 (National Statistics Office 2009). This was due to a multitude of factors which include a lack of awareness that they were PhilHealth members, and of the corresponding benefits they were entitled to, difficulty in navigating the system, and lack of access to facilities that were accredited by PhilHealth (Dayrit et al. 2018; Chakraborty 2013; Quimbo et al. 2013; Obermann, Jowett, and Kwon 2018)—issues that were particularly relevant to the poor residing in remote areas. The disparity between the rich and the poor was highlighted in the *Annual Poverty Indicators Survey of 2007* (National Statistics Office 2009) showing that the richest 10 percent of the population were almost twice as likely to be admitted to the hospital than the poorest 10 percent, despite the latter being at greater risk of illness. This clearly shows that equitable access to healthcare is far from being achieved under the existing system (Chakraborty 2013).

The system also failed to protect the poor from financial stress associated with healthcare. The benefits that members could receive were capped (Capuno 2006) and PhilHealth had no legal mechanism to set the price that providers of healthcare goods and services charged, including those charged by government-owned public hospitals. In some cases, PhilHealth members were charged more by healthcare providers (Obermann et al. 2006; Gertler and Solon 2000). It was common for hospitals to ask their patients to purchase their medications for treatment whenever medications ran out of stock, which inevitably led to out-of-pocket expenses (Chakraborty 2013; Lam and Rivera 2017). From 2000 to 2009, out-of-pocket expenses had increased by 50 percent, and by 2009 it was estimated to be

pushing around one million people into poverty every year (Ulep and Dela Cruz 2016). After 15 years of this system, the poor had limited healthcare and little financial protection (Chakraborty 2013).

Kalusugan Pangkalahatan

In 2010, with another change of government, a new universal healthcare policy became a presidential priority (Dayrit et al. 2018). Called Kalusugan Pangkalahatan (KP; translated to "Universal Health Care"; Bredenkamp and Buisman 2015), the policy was different from the old system in that it aimed to actively enroll almost the entire Philippine population (Pantig 2013). It addressed many of the failures of the old system pertinent to the poor such as limited finances to pay for their healthcare needs, identification and enrollment of the poor, and their financial protection (Chakraborty 2013; Dayrit et al. 2018).

Financing

A reliable and stable stream of revenue to pay for the premiums of the poor was a major issue prior to KP. A "sin tax" law on tobacco and alcohol was introduced around the time KP was made into a law. Around 80 percent of the sin tax revenue was allocated to the funding of the PhilHealth insurance premiums for the poor (Department of Health 2017). In its first year, the sin tax raised PHP 30 billion ($700 million) and by 2016, it was contributing PHP 69 billion ($1.5 billion) or 57 percent of the entire public health budget (Department of Health 2017). In 2011 or prior to KP, PHP 3 billion was spent on PhilHealth insurance premiums for the poor (Action for Economic Reforms 2013). By 2016, PHP 55 billion was being spent to ensure a steady rise of government spending on healthcare for the poor from PHP 1,100 per capita in 2011 to PHP 1,900 per capita in 2016 (World Bank 2011). It also stabilized the country's total healthcare expenditure to 4.7 percent of the gross domestic product, similar to neighboring countries (Obermann, Jowett, and Kwon 2018; World Health Organization 2016).

As a result, the healthcare benefits offered to the poor under KP became more financially viable than those that were offered under past policies. This also reduced the potential volatility of the system from local and national politics, as seen previously. Centralizing the financing and pooling of funds also improved financial stability by allowing the risks to be distributed across socioeconomic groups and regions.

Healthcare Equity

The definition of who was classified as poor to have their healthcare insurance premiums paid for was somewhat arbitrary and subject to the discretion of local authorities prior to KP. Under the KP, the poor were defined as those whose visible means of income were insufficient to sustain their family, as well as any dependent family members (Pantig 2013; Chakraborty 2013). These individuals were actively identified from the National Household Targeting System for Poverty Reduction (NDHS-PR) database and automatically enrolled, with their premiums fully paid for by the national government (Chakraborty 2013). Furthermore, any poor person who was not in the database but turned up at any hospital could be enrolled at the time of admission and not be required to pay upfront. These initiatives saw a substantial increase in the number of the poor covered by the KP (Rajasekhar et al. 2011; Lavado 2010; World Health Organization 2011). The number of poor people enrolled in PhilHealth rose from 3.8 million in 2009 to 17.8 million in 2013 (PSA and ICF International 2014). The poor's awareness of enrollment also increased from 37 percent to 60 percent by 2013 (Action for Economic Reforms 2013).

Payouts to the poor also increased from 22 percent before KP was introduced, to 35 percent in 2013 (Pantig 2013). While the number of claims made by the poor increased, the difference between the monetary value of the claims between the poor and those classified as non-poor also improved. Prior to KP, the average value of claims paid for the poor was PHP 4,000 compared to PHP 6,000 for those not classified as poor. By 2013, the average payout for both the poor and non-poor were similar, at around PHP 9,000 (Pantig 2013; Lam and Rivera 2017).

Consequently, since the introduction of KP, health insurance has become more pro-poor in terms of both coverage and benefits (Dayrit et al. 2018). The poor also have a greater awareness of their coverage and benefits (Bredenkamp and Buisman 2015). However, awareness is still at unacceptable levels, especially for the poor, who have the greatest need for healthcare (Bredenkamp and Buisman 2015).

Financial Risk Protection

Financial risk protection is one of the main goals of universal healthcare as defined by the World Health Organization (2010): "A situation where all people who need health services (prevention,

promotion, treatment, rehabilitation, and palliative) receive them without undue financial hardship." The KP recognized this and states risk protection as a fundamental objective: "Financial risk protection through expansion in enrollment and benefit delivery of the National Health Insurance Program" (Department of Health 2016). It aimed to achieve this by introducing the No Balance Billing (NBB) policy (Dayrit et al. 2018). This means that poor patients in government hospitals will not be charged for in-patient services and standard medications. The hospital would either make a profit or cover the additional cost of admission, depending on the fees charged (Cabalfin 2016). Furthermore, increased resources facilitated the enforcement of the no balance billing policy, and it was forbidden for hospitals to ask patients to purchase medications that were out of stock (Obermann, Jowett, and Kwon 2018; Dayrit et al. 2018; Chakraborty 2013).

However, despite these measures, 39 to 49 percent of poor patients reported having to pay a proportion of their hospital bill (Villaverde, Gepte, and Baquiran 2016) and 64 percent were asked to pay for medicines (Action for Economic Reforms 2013). Furthermore, the total out-of-pocket spending by the poor continued to rise from approximately PHP 200 in 2000 to PHP 1,100 in 2012, where 76 percent of which was spent on medicines (Bredenkamp and Buisman 2015). In addition, many of the poor's expenditure on medicines is unnecessary, as non-generic medications and non-essential supplements are commonly used (Dayrit et al. 2018; Obermann, Jowett, and Kwon 2018).

Therefore, KP falls short in providing adequate financial protection for the poor, with out-of-pocket expenses exceeding half the poor's total healthcare expenses that can be partly addressed by better enforcement of the No Balance Billing scheme. Bearing in mind that medicines are 5 to 30 times more expensive in the Philippines than in other countries such as India (Reyes et al. 2011), the cost of medicines needs to be controlled as this constitutes the biggest expense for the poor, and much of it appears to be unnecessary. PhilHealth, as a major contributor to the funds that go toward purchasing medicines, could be more strategic in pushing down prices.

Conclusion

The Kalusugan Pangkalahatan recognized and addressed many issues and concerns, resulting to some improvements in healthcare provisions for the poor. It created a more financially stable healthcare system with greater resources allocated to the poor, drawing increased

access to healthcare. This is commendable as it is common for national healthcare policies of developing countries to be not beneficial for the poor (Bredenkamp and Buisman 2015; Pantig 2013). Other countries can then learn from the 50-year experience of social healthcare in the Philippines.

However, several major problems still remain. First, it is very difficult to obtain detailed information on outcomes, more so to attribute these directly to particular interventions. Outcomes for this essay were captured from sporadic household surveys and annual reports that vary in what they report from year to year. These must be improved so that outcomes can be more clearly examined in relation to policy interventions. Second, the poor's awareness of their healthcare benefits is still very low, which is particularly important since they are at greater health risks and have the least means to avail treatment. Finally, despite the recognition of the importance of financial protection, out-of-pocket expenses are unacceptably high and continue to increase. Other policy reforms need to be implemented to achieve the goal of financial protection.

In conclusion, while KP moved the Philippines closer to universal healthcare, it appears to be hindered by its design, where a contribution is required for a citizen to be entitled to healthcare. A cultural shift, where healthcare is seen as a right of citizenship, may be necessary to obtain universal healthcare and further improve the health of the poor.

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