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HEALTH CARE EXPENDITURE PATTERNS IN THE PHILIPPINES: ANALYSIS OF NATIONAL HEALTH ACCOUNTS, 1991-1997

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1. Introduction

The system of national health accounts

A national health accounts (NHA) matrix describes the sources and uses of total expenditures on health services consumed in a given year. The columns of a typical matrix show how much funds are being channeled through sources like government budgets, national health insurance, and family out-of-pocket spending. On the other hand, the rows of the NHA matrix describe how funds are being spent on various types of health care services.

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*The estimation of the National Health Account (NHA) matrices, whose results are analyzed in this paper, was a joint undertaking of the University of the Philippines School of Economics (UPSE) through the UPecon Foundation and the National Statistical Coordination Board (NSCB). The authors of the paper represented both the UPecon team and the NSCB team. Alejandro N. Herrin and Orville Solon are Professor and Associate Professor, respectively, of the UPSE, while Maritess G. Manalo is a lecturer at UPSE. Rachel H. Racelis, formerly consultant at UPecon, is now Associate Professor at the University of the Philippines School of Urban and Regional Planning. Representing the NSCB team are Virginia N. Gañac, who is the Division Chief of the Health, Education and Social Welfare Division, and Glenita V. Amoranto, who is a Statistical Coordination Officer in the same division.

The NHA matrix is useful for descriptive and analytical purposes. The listing of sources not only describes existing financing institutions, but these can also be arranged according to the extent to which a source takes into account the uncertainty associated with health care spending as well as the size of the risk pool. On one end, there is the family (with the smallest risk pool and the least effective in handling risks), and on the other end, there is the national health insurance program (which explicitly accounts for risk and has the potential of becoming the largest risk pool). Of course, the interest of public policy is the effective use of channels that pools together resources and spread risks.

The health services on which funds are spent can also be grouped for analytical purposes. The broad category of public health services represents services with benefits that accrue to entire communities (e.g., disease-vector control). Personal health services, on the other hand, represent services with benefits that are private to the individual directly consuming them (e.g., appendectomy). The interest of public policy is to focus the use of public funds for public health services.

Using national health accounts for policy

There are two ways to make the NHA matrix useful for policy. One is to use the matrix as a shell for doing policy simulation. Using data from a cross-sectional survey of consumers and providers, key behaviors (e.g., consumer utilization and insurance demand, and provider cost and pricing) in the system can be built into the NHA matrix. One can then engage in numerical simulation exercises to determine how the system will likely respond to a policy change like the introduction of user fees or the provision of premium subsidies for the poor.[1] The downside to this approach is that it requires large, expensive and difficult to collect survey data.

[1] See for example Solon, O. and others (1995) and Solon, O. and C. Tan (1996).

The other approach is to discern the implications of policy changes by examining how health expenditure patterns change over time.[2] This approach is similar to that used in studying how policies affect economic growth and macroeconomic stability. The approach becomes more useful with the availability of NHA estimates for a number of years. This paper begins to explore what can be obtained from simple trend analysis using a series of preliminary NHA estimates from 1991 to 1997.

Highlights of major trends

The analysis of the NHA matrices from 1991 to 1997 reveals four main trends. One, total health expenditures have been increasing in both real and per capita terms. It has also grown faster than GNP so that the share of health expenditures in GNP rose from 3.0 percent in 1991 to 3.5 percent in 1997. But health and financial indicators suggest that the money has not always been spent wisely. More specific observations related to this one are discussed in Section 3.

Two, the share of family out-of-pocket spending has declined since 1994 in favor of government expenditures, but it remains the single largest source. This means that the financial burden on individual families remain heavy leaving access to care highly inequitable. Section 4 discusses more specific observations concerning the various sources of funding for health.

Three, the share of expenditures for public health services has increased after 1993, but the bias for personal health services remains high. Public health programs, however, have not been able to effectively absorb increased spending. Despite heavy spending bias for hospitals, quality services remain largely inaccessible especially to the poor. Issues concerning the uses of health care expenditures are discussed in detail in Section 5.

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[2] See for example Lazenby, H.C. et al. (1992).

Four, national government spending on health have increased mainly from national budget sources. However, increased spending by the Department of health have mostly been applied to the few hospital facilities it continues to operate. On the other hand, local health spending has increased beyond what was needed to maintain devolved health functions, and spending is focused on public health services, but local efforts remain uncoordinated. Section 6 focuses on the pattern of government health spending with attention to the Department of Health and local government units.

The implications for policy and a discussion of options that the government might consider in addressing these are summarized in the concluding section.

2. Definitions, Data, and Measurement Issues

Definitions

The construction of the NHA estimates is a complex and tedious undertaking. The estimation of the NHA matrices was a joint undertaking of the University of the Philippines School of Economics through the UPecon Foundation, and the National Statistical Coordination Board (NSCB).[3] In the course of building the system of

[3] The work on the NHA began in 1992 as part of the activity of the Health Policy Development Project of UPecon Foundation, with support from the Department of Health and the United States Agency for International Development. During the early part of the project, a number of individuals have contributed to the conceptualization and design of the NHA. Their participation has been duly acknowledged in earlier papers. A component of the project was the institutionalization of the NHA estimation process within the national statistical system. The NSCB was considered the most appropriate agency to continue with the development of the NHA. UPecon initially estimated the NHA matrices for the years 1991 to 1994. Technical assistance was then provided to the NSCB team, which estimated the NHA matrices for the years 1995 to 1997. Through joint efforts to achieve consistency of methodology and estimation approaches, the UPecon and NSCB teams finalized the estimates for the entire series 1991-1997. The NSCB board approved the series for planning purposes and for release to the public on March 18, 1999.

national health accounts, a number of issues had to be resolved, starting from how to define "health expenditures," to the choice of data sources to rely on, and to the estimation methods to employ. Many of these issues have been described in several past papers.[4]

The 1991-1997 NHA estimates refer to expenditures mainly on medical goods and services consumed or provided to the Philippine population for the purpose of improving health.[5] Such services are grouped into personal health care, public health care and administration (which includes expenditures for general administration, biomedical and policy research, monitoring and evaluation), and others. The NHA estimates do not include expenditures on food, shelter, public utilities and other such contributors to good health. The sources of health expenditures refer to the person or institution that directly pays health care providers. Other NHA designs trace the flow of funds from families to the various financial institutions.

Data and measurement issues

The NHA is estimated from a mix of data sources including national surveys and financial records of public and private institutions. Expenditure estimates for the Department of Health and other national agencies are based on records of the Department of Budget and Management. This means that estimates of national government health spending are based on obligated expenditures. Local government health expenditures, on the other hand, are based on reports

[4] See for example Herrin, A. N., O. Solon, and R. H. Racelis (1996).

[5] Health care services include preventive, curative, therapeutic, and rehabilitative care provided by public and private hospitals, medical clinics, as well as those by own-account physicians, dentists and non-MD health practitioners and traditional health attendants. Health care goods prescribed or consumed for home or self-care are also included. Administration include biomedical and operations research by government; non-degree training of health manpower by government; health policy-formulation and program planning activities of government; and administrative services by government, by public and private health insurance operations and other health care financing schemes.

submitted by local government units to the Commission on Audit. This means that estimates of local health spending are based on actual audited expenditures.

Spending by the social health insurance program are derived from reports of the Philippine Health Insurance Corporation (PHILHEALTH), the Social Security System (SSS) and the Government Service Insurance System (GSIS). Expenditures by private insurance companies are derived from records of the Insurance Commission (for commercial indemnity insurance) and from the Securities and Exchange Commission (for health maintenance organizations).

Estimates of health expenditures by households are based on the Family Income and Expenditure Survey (FIES) collected once in three years. Estimates for in-between years are interpolated taking into account price changes. Health spending by firms is estimated using a special one shot rider to the Annual Survey of Establishments. Using this data, average health expenditures were calculated for various types of firms (i.e., by industry group and number of workers). These averages were then used to estimate employer-based health expenditures for non-rider years.

A number of estimation issues arose mainly due to the nature of data sources used. One issue concerns cell entries where there are no data available (e.g., community financing and charitable institutions). In spite of serious attempts to collect them, no consistent and reliable data can be obtained. Estimation problems also arose when there were more than one data source available (e.g., health spending by government agencies). Readily accessible, timely and regularly reported sources (because the reports were required by law or were used for regular planning purposes) were used. Another issue is when the data available is known to be underreported as in the case of household spending. In this case the data were adjusted using the same procedures applied in national income accounting.

The task of estimating the NHA can become much less tedious once data reporting and collection are institutionalized. Institutionalization should also involve integrating core questions in special riders into the main surveys (e.g., health finance questions in the FIES and in the Annual Survey of Establishments). Moreover, as data sources improve, NHA estimates will also be able to show more detail (i.e., finer categories of uses of health care expenditures).

3. National Health Expenditures

Levels and growth

The first set of questions that a series of NHA matrices can answer is how much is being spent on health and how has the level of spending changed over time. Table 1 shows that from 1991 to 1997, national health expenditures in current prices increased at an average annual rate of 15.5 percent. In real terms the growth rate was 7.1 percent per year.

Health expenditures, GNP and population

From 1991 to 1997, total health expenditures rose faster than GNP so that the share of health spending to GNP rose from 3.0 percent to 3.5 percent. The increase in health spending averaging 15.5 percent per year, compared to the average annual population growth rate of 2.3 percent, allowed per capita health expenditures (in current prices) to increase from 598 pesos in 1991 to 1,237 pesos in 1997. In real terms (1994 prices), the increase has been from 765 pesos in 1991 to 991 pesos in 1997 (see Table 2).

Table 1 - Total Health Expenditures and Share to GNP

Year	Total Health Spending (in billion pesos)	GNP at current prices (in billion pesos) [a/]	Population (in millions indivi-duals)[b/]	Share of Health to GNP (in percent)	Health Spending Growth Rate	Population Growth Rate	GNP Growth Rate
1991	37.3	1,255	62.4	3.0			
1992	41.7	1,375	63.8	3.0	11.8	2.2	9.6
1993	47.2	1,500	65.3	3.1	13.2	2.4	9.1
1994	55.4	1,736	66.8	3.2	17.2	2.3	15.7
1995	66.6	1,959	68.3	3.4	20.3	2.2	12.8
1996	*77.7*	*2,261*	*69.9*	*3.4*	*16.7*	*2.3*	*15.5*
1997	88.4	2,527	71.5	3.5	13.7	2.3	11.7

a/ 1946-1994 Annual Link Series of the National Accounts of the Philippines (for 1991-1994). National Accounts of the Philippines CY 1995 to CY 1997 (for 1995-1997).

b/ Annual Population Projection Link Series 1980-2005 (draft for Board approval), TC on Population and Housing Statistics

Table 2 - Health Expenditures, Total and Per Capita (at current and 1994 prices)

Year	Total Health Spending (in billion pesos at current prices)	Annual Health Expenditures per Capita	Total Health Expenditures (billion pesos at 1994 prices)	Annual Health Expenditures per Capita (pesos at 1994 prices)
1991	37.3	598	47.7	765
1992	41.7	654	49.0	768
1993	47.2	723	51.5	789
1994	55.4	829	55.4	829
1995	66.6	975	61.7	903
1996	77.7	1,112	66.0	944
1997	88.4	1,237	70.8	991

Perhaps a more meaningful way of presenting the value of total health expenditures is to show the average amount available to that portion of the population in need of medical attention. It is estimated that up to 30 percent of the population would fall into this category.[6] Using 1997 figures, around 4,000 pesos is spent by persons seeking health care services. This amount is equivalent to the cost providing two short-course therapies for TB or the cost of eight (8) outpatient visits including drugs. This figure is way below the cost of hospitalization (an appendectomy would cost around 20,000 in a tertiary government facility) implying that access to hospital care is highly skewed.

4. Sources of National Health Expenditures

Family spending vs. social risk pools

It was pointed out in the introduction that the various sources of funds are actually different insurance mechanisms with varying degrees of ability to pool resources and spread risk. The family is the least effective and most inefficient health insurance institution. Family income and size limit the resources that can be pooled. Moreover, since members often share or are exposed to similar health risks, the family has limited risk-pooling capacity.

The taxed-financed open access public health delivery system under central and local government units offer a larger resource pool. Since people are taxed before they actually realize the need for health services, government health budgets are actually insurance funds. But it is an inefficient form of insurance since individual contributions are often based on consumption or income rather than on health risk. Nonetheless, central and local health care delivery systems are much more effective forms of insurance than the family.

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[6] See Solon, O. and others (1996).

Limited progress has been made in expanding social risk pools (especially the national health insurance). In 1991, social risk pools (government and social insurance) financed only as much as 46 percent of total spending. The burden on individual families was also around 46 percent of total health expenditures. With the devolution of health services and with the new national health insurance program, the share of social risk pools has remained at 46 in 1997, equal to the share of family spending. Thus, the financial burden on individual families remained high (Table 3).

Spending from among social risk pools

Now which of the social risk pools have contributed the most to reducing the financial burden on the family? Table 3 shows that central and local health budgets are the main social insurance mechanisms. In particular, with the devolution, local health budgets have now become an important financing source for health services. This is the fastest growing source of health finance.

The national health insurance program (NHI) — the mechanism with the most potential — still lags behind. In 1991 it spent only 3.4 billion pesos or 9.1 percent of total health expenditures. In 1997, two years after the new NHI law was enacted, the program only spent for 6.4 billion pesos or 7.2 percent of total health expenditures. In fact, the share of NHI in total health expenditures has progressively declined after the enactment of the NHI law from 9.2 percent in 1995 to 8.5 in 1996, and to 7.2 percent in 1997.

Two interrelated reasons explain the poor performance of PhilHealth.[7] One, for every contribution made by members in 1998, the NHI program only spent 22 percent on benefits. Two, partly because benefits are low, the population covered has not significantly expanded beyond the formal wage sector. Between 1995 and 1998, the program only managed to enroll less than 2 percent of

[7] 1998 Annual Report of the Philippine Health Insurance Corporation.

Table 3 - Percent Share of Total Health Expenditures by Sources of Funds

Sources of Funds	Percent Share						
	1991	1992	1993	1994	1995	1996	1997
Government	36.5	34.1	33.8	34.6	33.3	35.7	38.6
National	32.8	30.0	21.3	18.8	17.7	19.6	21.1
Local	3.7	4.1	12.6	15.8	15.7	16.0	17.5
Social Insurance	9.1	9.5	9.8	10.1	9.2	8.5	7.2
PhilHealth	8.0	8.7	8.9	9.3	8.6	8.0	6.9
Employee's Compensation	1.0	0.8	0.8	0.8	0.6	0.4	0.3
Health Insurance Plan	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Private Sources	54.5	56.4	56.3	55.5	57.5	55.9	54.2
Out-of-pocket	45.8	47.0	47.9	46.8	49.4	47.7	46.3
Private Insurance	3.3	3.7	3.0	2.6	2.2	2.1	2.2
Health Maintenance Organizations	1.2	1.3	1.5	1.7	2.0	2.2	2.3
Employer-based Plans	3.3	3.4	3.0	3.3	3.1	2.9	2.5
Private Schools	0.8	0.9	0.9	1.0	1.0	0.9	0.9
Others							
ALL SOURCES	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Data sources: UPecon (1991-1994); NSCB (1995-1997). Percent share for health insurance plan under social insurance is less than 0.05 percent. The "Others" row include voluntary community-based insurance schemes; community drugs and nutrition funds, mutual benefit funds, and donors who pay for health services directly. Thus far there are no data available on these sources.

targeted indigent members whose premium contributions are fully subsidized from national and local sources. The strategy to cover indigents in the poorest provinces clearly failed. Insurance is unlikely to be effective in areas where local financing is severely limited and where administrative infrastructures are weak.

Private insurance (risk) pools

Relative to public sources, the combined share of private insurance and HMOs to total health expenditures remained at around 4.5 percent of total spending. However, the share of private insurance has declined from 3.3 percent in 1991 to 2.2 percent in 1997, while the share of HMOs increased from 1.2 percent in 1991 to 2.3 percent in 1997 (see Table 3). Considering that up to 90 percent of its clientele are corporate, the private health insurance market is vulnerable to changes in macroeconomic performance. Until the economy recovers from the current financial crisis, private health insurance and HMOs cannot be expected to increase its share in total health spending. Moreover, since private insurance companies and HMOs mainly provide supplementary coverage, future NHI expansion will reduce private insurance demand.

5. Uses of National Health Expenditures

Spending on health care services

Table 4 shows how total health spending have been allocated to various uses from 1991 to 1997. The share of personal health services declined from 76 percent in 1991 to 72 percent in 1997. The share of public health services to total health spending grew from 8 percent in 1991 to 14 percent in 1997. As discussed in a later section, the increase is largely driven by local health expenditures.

Table 4 - Total Health Expenditures by Uses of Funds

Year	Amount (in billion pesos)				Percent share			
	Personal health care	Public health care	Others	Total	Personal health care	Public health care	Others	Total
1991	28.5	2.8	6.0	37.3	76.3	7.5	16.1	100.0
1992	32.6	2.9	6.2	41.7	78.2	7.0	14.8	100.0
1993	34.4	5.6	7.2	47.2	72.8	12.0	15.2	100.0
1994	39.9	7.0	8.5	55.4	72.1	12.6	15.3	100.0
1995	49.1	7.2	10.4	66.6	73.7	10.7	15.6	100.0
1996	57.6	9.3	10.8	77.7	74.1	12.0	13.9	100.0
1997	63.5	11.9	13.0	88.4	71.8	13.5	14.7	100.0

The problem with discussing the relative shares of personal health care and public health care services is that there are no reliable indicators as to how much is enough. It is possible that since public health care services tend to be highly cost effective, spending 12 out of 88 billion pesos in 1997 may be sufficient. It is also possible that even if we spent half the money on public health care, we would not realize any benefits at all.

Spending on personal health services

In Table 4, the share of personal health care has slightly declined. But the high levels reflect the influence of private and political interests over resource allocation decisions. The interest of individual families is to focus spending on health care services with benefits that accrue to the family (or members). Similarly, personal health care, being more visible and more effective in promoting patronage, is more likely to receive greater attention in political decision making.

The continued dominance of family out-of-pocket spending as a financing source would suggest that a large portion of health expenditures are likely to be spent on personal health care services. Individuals and families are expected to put greater priority on services that directly benefit its members. For example, data from a special rider on the 1994 FIES show that 46 percent of family health expenditures are for hospital services (see Table 5). An additional 24 percent was spent on services provided by non-hospital facilities like freestanding clinics. Families also spent 28 percent on drugs and other medical products as part of self-care.

Table 5 - Family Out-of-Pocket Health Expenditures in 1994

	Amount	Share
PERSONAL	25,919,680,123	100%
Government Hospital	8,968,209,323	35%
Private Hospital	2,890,044,334	11%
Non-Hospital MD Facilities	5,303,166,553	20%
Other Professional Facilities	381,019,297.8	1%
Dental Facilities	647,992,003.1	3%
Traditional Health Care	471,738,178.2	2%
Retail Outlets: Drugs and Other Non-Durable Purchases (self care)	7,112,360,226	27%
Retail Outlets: Vision Products and Other Medical Durables (self care)	145,150,208.7	1%

Source: UPecon special rider survey to the 1994 FIES.

Spending on public health services

With the increasing share of central and local health budgets, on the other hand, one should expect greater emphasis on public health care services. After all, public health programs and primary care services have been declared to be the priority of government. But information from studies in public health programs suggest that the fragmentation of local health networks and difficulties in managing centrally-run public health programs might have rendered funds for public health less

effective.[8] For example, a DOH project designed to deliver primary services including TB control to urban poor areas was only able to spend less than a third of programmed funds over a period covering two-thirds the project's life.[9] Similar performance was reported for a project targeted at promoting women's health and safe motherhood.

Spending on administration

In absolute terms, spending on "Administration," which include expenditures for administration, management, in-service training and research, has increased but, in relative terms, it has actually declined. The declining share of this item of expenditure is a cause for concern. This means fewer resources are now available for managing or administering programs. Effective program management is much more critical for public health programs (relative to the resources needed to running health facilities).

As Table 6 shows, spending on administration by national agencies (mainly the DOH) only increased by 58 percent from 1991 to 1997. This might be considered inadequate considering that these agencies not only deliver services but also perform critical regulatory functions like food and drugs administration. Spending on activities critical to effective leadership by government in the health sector like bio-medical research, operations and policy research and survey and monitoring did not change in absolute amounts despite the expansion of the health sector

[8] Solon, O. , A. N. Herrin and R. Capul (1998).

[9] WB mission reports on the Urban Health and Nutrition Project.

Table 6 - National Government Spending on Health Sector Administration, 1991 and 1997

	1991 (in billion pesos)	Percent share	1997 (in billion pesos)	Percent share
TOTAL	2.95	100	4.67	100
General Administration and Operating Costs	1.75	59	3.34	72
Bio-Medical Research	0.04	1	0.21	4
Operations/Policy Research	1.15	39	0.91	19
Survey and Monitoring	0.00	0	0.07	1
Manpower Training Activities	0.01	0	0.15	3

6. Government Expenditures

National government spending by source

The rapid increase in central health spending is largely driven by an increasing budget for health. This pattern is contrary to what many observers expected to happen after the devolution (the move was supposed to shift health financing away from central sources). National allocation for the DOH rose from 8.7 billion pesos in 1991 to 13.2 billion pesos in 1997 (Table 7).

Although the absolute amounts have fluctuated from 1.2 billion pesos to 2.0 billion pesos, the share of foreign assistance (i.e., loans and grants) has generally been declining. For some observers, this means less dependence on foreign assistance that can then allow the DOH to have an independent agenda. But foreign assistance is often spent to support public health services and investments in effective management. This financing source also provides for the means to secure funding over periods longer than the usual budget cycle, allowing priority programs to pursue long-term goals.

The concern is that as foreign assistance diminishes in relative proportion there is less pressure to put greater priority on public health and capability building. Moreover, priority public health programs become more vulnerable to the politics of the annual budget cycle. These might lead to a more pronounced bias for personal health care services.

DOH spending by use

DOH spending constitute more than 70 percent of all national government spending on health (74 percent in 1997). The rest are spent by other national agencies including the defense department, which maintains its own hospitals and other health facilities.

Table 7 - National Government Expenditures by Source of Fund

	Amount (in billion pesos)					Percent share				
YEAR	DOH	Other National	Loans	Grants	Total	DOH	Other National	Loans	Grants	Total
1991	8.7	1.5	0.8	1.2	12.2	71.2	12.3	6.9	9.6	100.0
1992	9.4	1.8	0.6	0.7	12.5	75.2	14.7	4.6	5.4	100.0
1993	6.3	2.2	0.6	0.9	10.1	62.8	22.2	5.8	9.3	100.0
1994	6.6	2.2	0.5	1.0	10.4	63.9	21.5	4.7	9.9	100.0
1995	7.6	3.0	0.3	0.9	11.8	64.6	25.1	2.6	7.6	100.0
1996	9.8	3.5	0.8	1.1	15.3	64.3	22.9	5.4	7.4	100.0
1997	13.2	3.7	0.4	1.4	18.6	70.8	19.6	2.1	7.5	100.0

The DOH had an opportunity to focus its resources and efforts on public health concerns when the devolution was implemented. In 1993, spending on personal health (i.e., hospital-based services) dropped to 3.0 billion pesos. At this point it had less than 50 hospitals to operate, allowing it to focus on national public health programs like TB control. Beginning in 1994, the DOH budget picked up and then surpassed the level it had prior to the devolution. But the share given to public health increased up until 1993 and then declined thereafter. In 1997, the share of public health was 24 percent to total DOH expenditures (Table 8).

The DOH is now spending more than half of its resources (54 percent in 1997) on around 50 hospitals — this is not a very effective way of targeting subsidies to the poor. Table 9 shows how inequitably the DOH distributed hospital subsidies. Regions where infant mortality rates are higher (an indicator of socioeconomic status) tend to receive lower subsidies. In 1998, 53 percent of subsidies are accessible only to residents of Metro Manila (compared to 24 percent in 1991). The same amount could still have been kept for hospitals but could have reached more people if it were channeled through devolved facilities rather than to urban-based tertiary facilities. Alternatively, the same amount could have been channeled directly to consumers through health insurance premium subsidies.

Local government expenditures

Local health expenditures have increased beyond what would have been required to support the cost of devolved health functions. Moreover, a significant portion is being spent on public health services, about half on the average (see Table 10). Local government spending is becoming the main source of funding for public health services. Also note that local government facilities, especially, rural health units run by municipalities, are the main channels for delivering services of national public health programs.

Table 8 - DOH Expenditures by Use of Funds, 1991-1997

YEAR	Amount (in billion pesos)				Percent share			
	Personal health care	Public health care	Other	TOTAL	Personal health care	Public health care	Other	TOTAL
1991	6.0	1.3	1.4	8.7	69.0	14.4	16.6	100.0
1992	6.5	1.2	1.7	9.4	68.8	13.0	18.2	100.0
1993	3.0	2.0	1.3	6.3	47.1	32.0	20.8	100.0
1994	3.8	1.7	1.1	6.6	57.8	25.9	16.3	100.0
1995	4.8	1.4	1.4	7.6	63.5	17.8	18.7	100.0
1996	6.4	1.9	1.5	9.8	65.5	19.4	15.0	100.0
1997	7.2	3.2	2.8	13.2	54.3	24.3	21.4	100.0

Table 9 - DOH Spending on Hospitals by Region, 1991 and 1998

	1991 (in billion pesos)	Percent share	1998 (in billion pesos	Percent share	1995 Infant Mortality Rate
TOTAL	4.79	100%	6.69	100%	48.9
Metro Manila	1.13	24	3.52	53	32.2
Ilocos	0.26	5	0.26	4	45.7
CAR	0.18	4	0.19	3	54.9
Cagayan Valley	0.21	4	0.19	3	53.7
Central Luzon	0.37	8	0.29	4	40.4
Southern Tagalog	0.53	11	0.25	4	44.9
Bicol	0.31	6	0.40	6	58.3
Western Visayas	0.35	7	0.32	5	55.2
Central Visayas	0.29	6	0.34	5	47.3
Eastern Visayas	0.26	5	0.12	2	64.3
Western Mindanao	0.21	4	0.13	2	58.6
Northern Mindanao	0.26	6	0.21	3	53.7
Southern Mindanao	0.25	5	0.29	4	51.8
Central Mindanao	0.17	4	0.09	1	53.5
CARAGA	0.00	0	0.06	1	
ARMM	0.00	0	0.00	0	63.4

Table 10 - Uses of Local Government Health Expenditures, 1991-1997

YEAR	Amount (in billion pesos)				Percent share			
	Personal health care	Public health care	Other	TOTAL	Personal health care	Public health care	Other	TOTAL
1991	0.3	0.7	0.4	1.4	20.0	52.7	27.4	100
1992	0.3	0.9	0.5	1.7	19.2	50.6	30.2	100
1993	1.7	2.9	1.4	5.9	27.9	48.1	23.9	100
1994	2.3	4.4	2.1	8.7	26.0	50.1	23.9	100
1995	2.8	5.2	2.4	10.4	26.9	50.0	23.1	100
1996	3.4	6.1	3.0	12.5	27.4	48.9	23.7	100
1997	3.9	7.9	3.7	15.5	25.3	50.9	23.8	100

However, the overall impact of local health spending may have been weakened by administrative and technical fragmentation arising from the devolution. In particular, district hospitals that were designed to be the base for the technical supervision are now cut-off from rural health centers. Moreover, there are concerns that district hospitals are unable to compete with provincial hospitals for funding from provincial governments. But where the links between effective health care delivery and votes are recognized, provincial and municipal governments have formed cooperative arrangements that address fragmentation.

7. Some Implications for Health Financing Reform

The analysis of the 1991-1997 national health accounts presented here points at the need to change where the money goes and how expenditures are financed. On the use side, there is clearly a need to spend more on public health care and administration especially from government sources. On the source side, the financial burden on families from paying for personal health care need to be shifted to social risk pools, especially to the national health insurance program. But how can these changes be effected?

A package of health financing policy reforms focusing on three interdependent areas needs to be introduced. One, the financing of hospitals operated by the DOH need to be changed in a way that would free up resources to finance increased spending in public health programs and on premium subsidies needed to expand NHI coverage. DOH hospitals might have to be turned into public corporations that would be able to exercise fiscal autonomy over revenues collected from socialized user charges. As this transformation proceeds, budget support for these facilities can then be reduced.

Two, funding for priority public health programs should be increased with three elements in mind. First, investments need to be made on the administrative and technical capacity of national programs to improve its absorptive capacity. Second, support for public health programs must be coursed through multi-year budget appropriations to allow the pursuit of public health goals sufficient time free of the uncertainties of the annual budgetary process. But disbursements from multi-budgets should be clearly based on performance or on meeting well-defined targets. Third, investments should be directed at local public health systems, especially at district hospitals and rural health units, considering that these are the main channels for national public health programs. However, national subsidies for local health systems should leverage for local counterpart spending, as well as the formation of inter-LGU cooperative arrangements to address the problem of fragmentation of the local health delivery system.

Three, the NHI program should increase benefit spending and increase its population coverage. The first step in getting the NHI going would be to increase benefits spending even under the current benefit design package. The second step is to use improved benefits to actively enroll members, focusing on cities and rich provinces. After all, here local government units have greater capacity to put up premium counterparts, the administrative infrastructure needed to operate health insurance programs exist, and a mix of workers, the self-employed and indigent families are concentrated. In the meantime, the poor provinces will continue to be provided with better targeted government subsidies. The third step would then be to use greater spending and coverage to leverage for the introduction of alternative benefits, provider payments schemes and quality assurance standards. Without NHI reforms, hospital autonomy will likely fail or adversely affect access by the poor. In turn, much needed investments for public health may not materialize.

The reform strategy described is about spending existing resources more effectively in order to expand the coverage of public health programs and to increase access to personal care services. But to implement reforms, total health spending will have to increase. Hospital reforms would require investments to ensure that autonomous facilities can compete in the hospital market. The freeing up of hospital budgets will take place gradually so that much-needed investments in public health will have to be advanced. NHI expansion will mean increased spending for premium subsidies from national and local sources. Moreover, spending on program administration will have to keep up with increased benefit spending and population coverage.

Annex
1991-1997 Summary NHA Tables

The tables that follow are the summary tables derived from the National Health Accounts, 1991 to 1997, released to the public by the National Statistical Coordination Board last March 18, 1999. The column (sources of funds) categories were aggregated to reflect the main payors. Government sources include the national government (NAT GOV) and local government units (LOCAL GOV). Insurance sources include social insurance (SOC INS), which contains the national health insurance program; and private insurance and HMOs (PVT INS). Private sources include private schools and private employers (OTHER PVT), and family out-of-pocket spending (FAMILY). Column totals do not add up due to rounding.

The rows (uses of funds) categories were aggregated to reflect the main services. These include personal health services (PERSONAL), public health services (PUBLIC), and general administration, and other support services (ADMIN). Row totals do not add up due to rounding.

1991 NHA Summary Table (in billion pesos)

	NAT GOV	LOCAL GOV	NHIP	PVT INS	OTHER PVT	FAMILY	Total
PERSONAL	7.19	0.28	1.82	0.58	1.52	17.10	28.49
PUBLIC	2.09	0.73					2.82
ADMIN	2.95	0.38	1.57	1.12			6.02
Total	12.23	1.38	3.39	1.70	1.52	17.10	37.32

1992 NHA Summary Table (in billion pesos)

	NAT GOV	LOCAL GOV	NHIP	PVT INS	OTHER PVT	FAMILY	Total
PERSONAL	7.94	0.33	2.20	0.71	1.82	19.63	32.63
PUBLIC	2.03	0.87					2.91
ADMIN	2.53	0.52	1.77	1.37			6.19
Total	12.51	1.73	3.97	2.07	1.82	19.63	41.73

1993 NHA Summary Table (in billion pesos)

	NAT GOV	LOCAL GOV	NHIP	PVT INS	OTHER PVT	FAMILY	Total
PERSONAL	4.62	1.66	2.84	0.80	1.87	22.62	34.40
PUBLIC	2.79	2.85					5.64
ADMIN	2.64	1.42	1.80	1.32			7.18
Total	10.05	5.93	4.64	2.12	1.87	22.62	47.23

1994 NHA Summary Table (in billion pesos)

	NAT GOV	LOCAL GOV	NHIP	PVT INS	OTHER PVT	FAMILY	Total
Personal	5.50	2.27	2.94	0.93	2.37	25.92	39.92
Public	2.60	4.37					6.97
Admin	2.32	2.09	2.63	1.44			8.48
Total	10.41	8.73	5.57	2.37	2.37	25.92	55.37

1995 NHA Summary Table (in billion pesos)

	NAT GOV	LOCAL GOV	NHIP	PVT INS	OTHER PVT	FAMILY	Total
Personal	6.80	2.81	2.73	1.19	2.67	32.88	49.08
Public	1.93	5.22					7.15
Admin	3.02	2.40	3.37	1.58			10.38
Total	11.76	10.43	6.10	2.77	2.67	32.88	66.62

1996 NHA Summary Table (in billion pesos)

	NAT GOV	LOCAL GOV	NHIP	PVT INS	OTHER PVT	FAMILY	Total
Personal	9.12	3.42	3.50	1.54	2.95	37.12	57.65
Public	3.21	6.10	0.00	0.00	0.00	0.00	9.31
Admin	2.93	2.96	3.09	1.81	0.00	0.00	10.79
Total	15.26	12.48	6.59	3.36	2.95	37.12	77.75

1997 NHA Summary Table (in billion pesos)

	NAT GOV	LOCAL GOV	NHIP	PVT INS	OTHER PVT	FAMILY	Total
Personal	9.89	3.92	3.87	1.91	2.95	40.96	63.51
Public	4.07	7.88					11.95
Admin	4.67	3.68	2.49	2.12			12.96
Total	18.64	15.48	6.37	4.03	2.95	40.96	88.42

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