November 2021

PHILIPPINES NATIONAL HEALTH EXPENDITURE SURVEY

Round 1 Analytical Report

NOVEMBER 2021

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Suggested citation: Javier, X., P. Crosby, M.E. Ranchez-Vila, R. Ross, and M. S. Santos. 2021. *Philippines National Health Expenditure Survey: Round 1 Analytical Report*. Washington, DC: Palladium, Health Policy Plus.

ISBN: 978-1-59560-291-6

Health Policy Plus (HP+) is a seven-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-15-00051, beginning August 28, 2015. HP+ is implemented by Palladium, in collaboration with Avenir Health, Futures Group Global Outreach, Plan International USA, Population Reference Bureau, RTI International, ThinkWell, and the White Ribbon Alliance for Safe Motherhood.

This report was produced for review by the U.S. Agency for International Development. It was prepared by HP+. The information provided in this report is not official U.S. Government information and does not necessarily reflect the views or positions of the U.S. Agency for International Development or the U.S. Government.

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Acknowledgments

The Department of Health-Health Policy Development and Planning Bureau (DOH-HPDPB) led the first implementation of the National Health Expenditure Survey (NHES), conducted from 2018 to 2021. This first-ever effort to collect NHES data and analyze results would not have been possible without the continuous support of Dr. Maria Socorro Santos; Officer-in-Charge Director Frances Rose Mamaril and the team at the DOH-HPDPB; and Dr. Beverly Lorraine Ho of the DOH-Health Promotion Bureau and Disease Prevention and Control Bureau. We wish to acknowledge the work of the UPecon-Health Policy Development Program 2 and the European Union's Philippine Health Sector Reform Contract as well as Carlos Antonio Tan Jr., Dr. Carlo Irwin Panelo, Dr. Orville Solon, and Dr. Alejandro Herrin for their contributions to the formulation and design of the NHES.

Our most sincere appreciation is due to the households and health facility staff who took part in this survey. The Philippine Survey and Research Center collected the data, led by Judy Mercado, Nizza Bartolome, Ria Soluren, Ian Breboneria, and Ina Pamela Nocheseda. Data collection oversight, processing, and quality assurance were managed by Amy Zamora, Jo Escala, Patria Buco, Mel Siy, Louise Gacis, Eric Ranola, Celina Bartolome, Lulu Rivera, and Norman Garcia. We thank them for their responsiveness, flexibility, and professionalism in helping to complete this pioneering data collection effort.

Finally, we would like to thank Marichi De Sagun, Berhan Hagos, and Dr. Joseph Lachica of the U.S. Agency for International Development Philippines for their support and guidance throughout the study implementation and preparation of this report.

Abbreviations

4Ps	Pantawid Pamilyang Pilipino Program
CHE	catastrophic health expenditure
DHS	Demographic and Health Survey
DOH	Department of Health
DOTS	Directly Observed Short Course
GSIS	Government Service Insurance System
HC	household component
HMO	health maintenance organization
HP+	Health Policy Plus
MPC	medical provider component
NBB	No Balance Billing
NHES	National Health Expenditure Survey
OOP	out-of-pocket
PhilHealth	Philippine Health Insurance Corporation
PhP	Philippine peso
PPMD	public-private mix DOTS
PSA	Philippine Statistics Authority
SJREB	Single Joint Research Ethics Review Board
SSS	Social Security System
TB	tuberculosis
USAID	U.S. Agency for International Development

Executive Summary

The first round of the National Health Expenditure Survey (NHES) was spearheaded by the Philippine Department of Health-Health Policy Development and Planning Bureau to fill an evidence gap in health service utilization and associated expenditure data. This national survey is the first uniquely designed survey to collect data from both households and medical providers on the disease and health expenditure burden of households, sources of care, and care financing. As designed, the NHES will provide complementary data for the country's National Health Accounts and capture information not provided in the Philippines National Demographic and Health Survey or other household surveys. The NHES is intended to be conducted on a regular basis to inform health sector decision making, including implementation of the 2019 Universal Health Care Act and monitoring and evaluation of health sector reforms.

Methodology

The NHES has two components: a household component (HC) to collect household- and individual-level data on health service utilization, visits, and charges, payments, and financing sources, as well as a linked medical provider component (MPC) that allows for the household-reported data to be validated and provides additional details on services provided, diagnoses, and charges. The NHES is sampled at the household level and designed to capture most common conditions or service types—including newborn care, facility-based delivery, pneumonia, acute gastroenteritis, dengue, hypertension, and kidney problems.

The NHES HC employs a nationally representative multistage sampling design based on proportional provincial stratification, with probability proportional to size selection of primary sampling units (*barangays*) in the first stage and systematic sampling of dwelling units (secondary sampling units) in the second stage. This sampling methodology also accounts for anticipated nonresponse and attrition between panel rounds of data collection. In total, the HC sample comprised 503 barangays and 12,575 households.

Key Findings

Household demographic and social economic characteristics

A total of 11,017 households with 50,030 members were interviewed, with a near equal split of male (50.4%) and female (49.6%) household members; the majority (56.4%) were less than 30 years of age. A majority of the household heads (54.1%) had completed at least secondary education; half (50.2%) were employed in informal jobs, whereas 28.3% had formal jobs. Forty percent of household members belonged to households that spent less than 2,100 Philippine pesos (PhP) per month per capita. Individuals from households receiving conditional cash transfers from the Pantawid Pamilyang Pilipino Program (4Ps) comprised 16.6% of the total sample, but those who reported being eligible recipients comprised only 7.7% of all household members.

About three-fourths (72.1%) of households had at least one member with Philippine Health Insurance Corporation (PhilHealth) coverage. There was a discrepancy in PhilHealth coverage between household heads (63.2%) and household members (48.3%). Among household members with PhilHealth, the most common types of membership reported were formal or voluntary (32.3%) and sponsored or indigent (23.1%). At the individual level, PhilHealth membership increased with age and was higher among 4Ps members and rural

dwellers. One out of four households (25.4%) had no insurance of any form or the key informant was not aware of the household members' insurance coverage. The remaining households (1.2%) had at least one member with Social Security System or Government Service Insurance System coverage, health maintenance organization (HMO) coverage, and/or private insurance coverage.

Health-Seeking Behavior and Utilization

The majority of household members rated their overall health status as either "good" (37.3%) or "fair" (34.9%). Only 24.8% reported "excellent" or "very good" health status. Among those who experienced a health condition in the six months preceding the survey (23.7%), only 11.8% did not seek care or take medication. The most common reason for not seeking care was the household member thinking that they were not sick enough (37.2%). The top three conditions/services for which a facility visit was made were upper respiratory infection (11.6%), hypertension (10.7%), and immunization (8.2%). More than half of respondents (55.2%) had a usual source of primary care; among those who did not (43.3%), an overwhelming 75.3% said it was because they seldom or never got sick.

Regarding healthcare service utilization, 21.9% of household members utilized at least one care type in the last six months. On average, the number of visits for outpatient care was 1.9 and the number of visits for inpatient care was 1.1. Among household members who utilized healthcare services, the following was found:

- Service type: Of household members who utilized care, 53.4% utilized outpatient care, 9.9% used inpatient services, and only 2.0% used emergency room services.
- Facility type: Of household members who utilized care, 40.4% went to public facilities and 28.8% used private healthcare providers; the rest went to pharmacies, tuberculosis dispensaries, and/or medical missions. Utilization was higher in public hospitals (17.2%) compared to private hospitals (11.9%), whereas visits to private clinics (15.0%) were more frequent than to rural health units and barangay health stations (both at 13.4%).
- Trends by insurance status: private insurance holders made more visits to private health facilities whereas PhilHealth holders and those without insurance made more visits to public facilities.

Healthcare Billing

As expected, the average total bill for care received in private health facilities was higher than that in public facilities for both outpatient and inpatient care, as recorded in HC and MPC results. Household members reported that the average billed amount for private outpatient care was 1.4 times the amount charged by public facilities, whereas MPC data suggest private outpatient care was four times greater than that charged by public facilities. For inpatient care, the average total bill from private providers was 2.5 times the cost of publicly provided inpatient care; MPC data indicate this difference was twofold. Among patients who were charged for outpatient care, almost 80% of the total bill was allocated to the healthcare providers' professional fees. Individuals who accessed inpatient care were charged for professional fees (33%), medicines (17%), and room and board (16%).

Healthcare Expenditure

Two-thirds (64.2%) of outpatient care was provided free of charge. Although only 17.5% of outpatient visits in private health facilities were free of charge, 9 out of 10 outpatient care

visits in public clinics resulted in no charges to patients. Outpatient care, when billed, mostly was financed using out-of-pocket (OOP) resources, regardless of facility ownership type.

About a third (30.8%) of inpatient care at all facilities was provided free of charge (for care accessed within the six months preceding the survey). At public facilities, 37.3% of patients were not charged for care provided, whereas in privately owned facilities, only 19.7% of patients were not charged. Among patients with inpatient charges, more than half of the total bill was paid by PhilHealth (56.9%) and 28.9% through OOP payments. PhilHealth support was greater in public hospitals (67.6% of the total bill) than private facilities (43.3%). OOP payments were higher for patients at private facilities (42.6%) than public facilities (18.1%).

Financial Protection

Catastrophic health expenditure is defined as OOP health spending that exceeds either 10% or 25% of a household's total expenditure, possibly resulting in financial hardship and subsequent impoverishment for the household (Wagstaff et al., 2019). At the household level, the incidence of catastrophic health expenditure was 1.6% at the 10% threshold and 0.4% at the 25% threshold among those with at least one outpatient care event; the incidence of catastrophic health expenditure among those who had at least one inpatient care event was 30.4% at the 10% threshold and 15.4% at the 25% threshold. The percentage was higher for some population segments, including those with insurance, senior citizen members of PhilHealth, non-4Ps beneficiaries, and households belonging to the lowest and highest per capita expenditure quintiles.

Fifteen percent of inpatient care visits in the previous six months were deemed eligible to benefit from PhilHealth's No Balance Billing (NBB) policy. Eligible NBB beneficiaries include patients confined in public hospitals, 4Ps beneficiaries, and those 60 years of age and over. Those eligible for NBB should be able to use inpatient care without any OOP expenditure. Only about half (51.3%) of potentially eligible cases were reported as fully benefiting from that policy.

Quality of Care

More than half of respondents reported a positive experience when utilizing healthcare services, with 69.7% of patients in private facilities and 58.1% of those in public facilities, respectively, reporting a positive review. Patients who reported positive experiences during healthcare visits provided the same reasons for both public and private facilities: good services received, kind and accommodating staff, and fast service.

Among household members who went to a facility for an outpatient visit, emergency care, or inpatient care, the most commonly reported issue in both public and private healthcare facilities was the lengthy waiting time. Public facility patients also reported an insufficient supply of medicines and medical supplies, understaffing, and insufficient or malfunctioning equipment across all care types. Those who accessed emergency care services at public facilities also reported inexperienced staff and high fees. Private facility patients reported an insufficient supply of medicines and supplies (especially in emergency care) and high fees.

1. Introduction

This chapter explains the background and rationale for Round 1 of the National Health Expenditure Survey (NHES) and its objectives.

1.1 Background and Rationale for NHES

The Health Policy Development and Planning Bureau-Philippines Department of Health spearheaded the NHES to contribute to the evidence base for increased sustainable, predictable, and adequate health financing for key health programs. The Department of Health (DOH) was inspired by the U.S. Medical Expenditure Panel Survey to develop a local version that would provide complementary data to add to the analyses from the Philippines National Health Accounts; cover information not provided by the Philippines National Demographic and Health Survey (DHS), the Family Income and Expenditure Survey, and the Annual Poverty Indicators Survey; and also enable better evaluation of ongoing health financing reforms in the country, such as the deepening and further improvement of coverage under the Philippine Health Insurance Corporation (PhilHealth).

The NHES was designed to be a regularly recurring survey, like the Medical Expenditure Panel Survey in the United States, to provide long-term information on the impact of various health sector reforms in the Philippines and allow monitoring of indicators important to the achievement of universal health coverage. The linked design of the NHES household component (HC) and the medical provider component (MPC) provides for a richer data set for National Health Accounts analysis in the Philippines than is usually available in lower-income country contexts, including detailed information on health-seeking behavior, provider sources from which healthcare was utilized, and how the services were financed by clients. The HC enables detailed estimates of out-of-pocket (OOP) spending, disaggregated by socioeconomic and geographic categories, including details on what was consumed. It also provides detailed analysis of indicators important for understanding changes to the levels of financial protection, such as impoverishment due to OOP healthcare spending and level of catastrophic health expenditure. In addition to these considerations, the design of the NHES allows for a detailed examination of how PhilHealth has impacted healthcare utilization, OOP spending, and other indicators of interest for health equity. The survey will also be important in understanding who is still not covered by PhilHealth and the nature of their utilization and health spending outcomes. Overall, the evidence generation and policy advisory possibilities are significant.

1.2 Survey Objectives

The overarching goal of the survey is to provide policymakers, researchers, and health financers with comprehensive information on the type and frequency of health services used, and households' OOP expenditure on them. The specific objectives of this first-ever NHES were to:

- Provide detailed information on health service utilization and provider sources, (including primary care), and the financing used by clients for health services they utilized
- Determine households' health expenditures
- Provide detailed information on estimates of OOP spending and quantify the extent of catastrophic health expenditure

- Establish the nature of unmet needs for healthcare, factors affecting health-seeking behavior, and levels of patient satisfaction
- Provide lessons learned from the first-ever nationally representative healthcare survey with a linked household and provider design to inform future rounds of NHES implementation

2. Methodology

2.1 Survey Design

2.1.1 Survey Components

The DOH, with technical support from the U.S. Agency for International Development (USAID)-funded Health Policy Development Program 2, European Union's Philippine Health Sector Reform Contract, and the USAID-funded Health Policy Plus project, designed and developed the NHES. The survey comprised two major components—household and medical health provider—to provide information on healthcare-seeking behavior, sources of utilization of healthcare services, amounts paid, and sources for covering the cost for health services. Specifically, the components did the following:

1. **Household component (HC)**: Collected information on visits to healthcare providers and affiliated facilities (e.g., pharmacy), healthcare event types (e.g., hospital inpatient stay, emergency room visit, and outpatient visit), prescribed medicines, types of medical providers, specific health conditions that led to use of healthcare, details and disaggregation of health-related charges (e.g., specialist fees, hospital room and board, diagnostic tests, and medicines and commodities) and payments by sources of financing, health insurance coverage, OOP expenses, and any reimbursements. Households were also asked about household consumption expenditure, health status, and risky behaviors.

2. **Medical provider component (MPC)**: Collected information from healthcare providers to validate the information reported by HC respondents. With the informed consent of patients and authorization of healthcare institutions, medical records were accessed and collected to aid the validation process. The MPC asked about specific details on healthcare received by household members, such as date of access, services provided, diagnoses made, charges for each service, and payments, including the source of financing.

2.1.2 Questionnaires

As mentioned above, the HC collected detailed information on healthcare visits made by individuals in the 6 and 12 months before the interview. Specifically, across nine types of care (see Table 2.1), the HC collected details of medical providers and medical facilities, prescribed medicines, types of medical providers, specific health conditions and symptoms that led to the use of healthcare, and details and disaggregation of charges (professional fees, room and board, diagnostics, drugs, etc.) as well as of payments (by sources of financing), insurance coverage, OOP expenses, and reimbursements. Table 2.1 describes details of the healthcare event types in which utilization, charges, and payment information was collected.

The MPC aimed to validate the information reported by HC respondents directly from health providers via facility visits for outpatient, emergency, inpatient, and dental care visits and via phone for eye clinics, independent labs, special therapy, alternative care, and pharmacies to inquire about pricing. With informed consent of the patients during the HC, medical records were accessed and collected, including specific details on date of service, services provided, diagnoses/conditions, charges for each service, and payments (sources and modes of payments).

Table 2.1. Description of NHES Healthcare Events

Healthcare Type	Definition
Outpatient care	An event in the last 6 months for which any medical care or service is provided on an outpatient basis; that is, a person comes to a provider to receive care and services, leaves the same day, and does not require a written order for admitting the person as an inpatient.
Emergency care	A medical emergency event in the last 6 months that poses an immediate risk to a person's life or long-term health; provided in an emergency room at a hospital or infirmary open 24 hours a day and no appointment necessary to receive care.
Inpatient care	An event in the last 12 months for which any medical care or service is provided on an inpatient basis; that is, a person has a written order to be admitted as an inpatient to a hospital, infirmary, or birthing facility for a period of 24 hours or longer.
Dental care	An event in the last 6 months that includes a visit to a dental care provider for general work, such as fillings, cleaning, and extractions, as well as specialized work, such as root canals or fittings for braces.
Other facility visits	An event in the last 6 months that includes a visit to non-hospital-based social hygiene clinics; tuberculosis dispensaries or chest clinics; eye clinics/centers; clinical or independent diagnostics laboratories (e.g., Hi-Precision and Ace Diagnostics); testing facilities (e.g., drug testing laboratories); and other healthcare providers for diagnostic procedures, such as x-ray and other tests.
Special therapy visits	An event in the last 6 months that includes a visit to a healthcare provider for rehabilitation care or services, such as occupational therapy, physical therapy, psychological and behavioral rehabilitation, prosthetics and orthotics rehabilitation, or speech and language therapy.
Alternative care	An event in the last 6 months that includes approaches to healthcare different from those typically practiced by medical doctors, such as reflexology, acupuncture, massage therapy, and herbal remedies, among others.
Outreach/medical missions	An event in the last 6 months for which any medical care or service is provided by a government or nongovernment organization through an outreach or health-related mission in a non-healthcare facility within a community.
Home healthcare	An event in the last 12 months that includes home service healthcare, such as birth delivery, checkups, immunization, micronutrient supplementation, alternative care, or rehabilitation services.

2.1.3 Survey Research Methodological and Ethical Clearances

Following design of the instruments, one pre-test was completed for each component per language, for a total of six pre-tests overall. Pre-tests of questionnaires verified the flow of questions, skip logic, and respondent understanding of questions being asked. Survey instruments and field protocols were then finalized and prepared for submission to the Philippine Statistics Authority (PSA) and the DOH Single Joint Research Ethics Board (SJREB).

- Survey research methodological clearance: Methodological clearance for implementation of the NHES was sought from the PSA's Statistical Survey Review and Clearance System. NHES Round 1 materials were submitted in late September and October 2018; clearance and comments were received by October 29, 2018.

- Ethical clearance: National ethical clearance was sought in 2018 from the newly formed Philippines DOH SJREB, as per the National Ethical Guidelines for Health and Health-Related Research (2017).
- Regional ethics committee and hospital-level clearances were also sought for 43 healthcare facilities.

Clearances obtained from the PSA, SJREB, and facility-level ethics committees were extended throughout the implementation of NHES field activities.

2.2 Round 1 Sample

2.2.1 Sample Design

The HC employs a nationally representative multistage sampling design based on proportional provincial stratification with probability proportional to size selection of primary sampling units (*barangays*) at the first stage and systematic sampling of dwelling units (secondary sampling units) at the second stage. In the first stage—selection of primary sampling units—of the 117 major sampling domains in the 2013 PSA Master Sample Design, 115 domains were included in the HC sample frame. Barangays expected to be inaccessible to interviewers due to hazardous travel or security concerns were excluded from the sample frame.[1] In the second stage—selection of secondary sampling unit—the team randomly selected 25 households (without replacement) in each of the 503 study barangays. Households were sampled using interval sampling with a random starting point. The sampling measure of size was the number of households in each barangay, per updated 2015 census data. Ultimately, the HC sampled 12,575 households across 503 barangays.

2.2.2 Sample Protocol

The HC sampling strategy divided the barangays into 300 household segments up to a maximum of five segments per barangay. The segment-level sampling interval was calculated as the total number of households, divided by the number of segments, divided by 25 (segment sampling interval = nB/25).[2] Each segment assumed equal representation of the household population in the barangay. For odd-numbered segment sampling intervals, there was a random selection of segment assignment.

- 1 segment for barangays with 1–300 households
- 2 segments for barangays with 301–600 households
- 3 segments for barangays with 601–900 households
- 4 segments for barangays with 901–1,200 households
- 5 segments for barangays with more than 1,200 households

The number of random start locations to be selected was equal to the number of segments within the barangay. The procedure used to select the random start and the first sample household depended on the availability of detailed map information. Ultimately, 25 households were sampled per barangay.

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[1] Details available upon request.

[2] Note that a maximum of 12 sampling intervals was imposed.

2.2.3 Response Rates: Household Component

The following six areas were sampled but not included in data collection after they were identified as conflict zones and areas with a high concentration of separatist and communist movements:

- Gulang-gulang, Lucena City, Quezon
- Balogo, Guihulngan, Negros Oriental
- Kalingking, Malitbog, Bukidnon
- Ubanoban, Picong (Sultan Gumander), Lanao del Sur
- Cabasaran, Butig, Lanao del Sur
- Canibongan, Marogong, Lanao del Sur

Excluding these six areas from the sample (12,425 households targeted), there was an overall 12.1% refusal rate among households (see Table 2.2). Top reasons for refusal included the following:

- Respondent was busy or did not have/make time for the interview
- No qualified respondent was available during the time of the interview despite a valid call-back
- Respondent or household was distrustful and/or wary toward surveys
- Household did not want to share personal information

Table 2.2. Household Response Rate

Broad Region	No. of Barangays Sampled	No. of Sampled Households	No. of Households that Refused to Participate (%)
National Capital Region	69	1,725	551 (31.9%)
Regions I, II, and III	94	2,350	285 (12.1%)
Regions IV-A and IV-B	69	1,725	193 (11.2%)
Region V	65	1,625	20 (1.2%)
Visayas	99	2,475	356 (14.4%)
Mindanao	101	2,525	104 (4.1%)
Total	**497**	**12,425**	**1,509 (12.1%)**

Although there was a 12.1% refusal rate, if sampled dwelling units included more than one household, all were invited to participate in the survey.[3] Thus, the total number of households included in the HC was 11,107 households with 50,030 household members. Among them, event data were collected for the 15,055 healthcare visits (among 5,149 providers) that occurred in the 12 months previous to the survey for inpatient and home care, and six months for other types of healthcare. Around half (7,906) of these reported

[3] *Dwelling unit* is defined as "a separate and independent place of abode intended for habitation, or one not intended for habitation but occupied as living quarters by a household at the time of the census. A dwelling unit may be a group of rooms or just one room, barong-barong, boat or cave" (PSA, n.d.).

healthcare events received informed consent by the patient, parent, or guardian of the patient for MPC data collection.

2.2.4 Response Rates: Medical Provider Component

Of the events with consent for MPC data collection, 57.3% (4,528 event records) were collected from 2,053 healthcare facilities. Those not collected were either not found or not available (31.2%, 323 facilities), not within the reference period (5.4%, 67 facilities), or the facility did not consent to participate in the survey or was closed. There were 159 facilities—23 public (14.5%) and 136 private (85.5%)—that either refused to participate in the MPC data validation or were closed indefinitely during the survey period, the patient could not recall the facility name, the facility required personal appearance of the patient to respond, or the study team had to withdraw the application for facility-level ethics approval or post-ethics clearance facility approval due to an uncertain review timeline.

2.3 Fieldwork and Data Processing

2.3.1 Data Collection Training

Key personnel, including the DOH principal investigator, a local data collection firm (Philippine Survey and Research Center) management team, field supervisors, and group leaders completed a Good Research Practice Training to ensure that the ethical standards of research practice were implemented throughout the study. In November 2018, a three-day central briefing was conducted in Metro Manila for all HC field supervisors and group leaders to orient field management teams to the rationale of the study, scope of survey materials, and terminologies and protocols for sampling and fieldwork. Three-day enumerator trainings were conducted in Metro Manila for the Luzon teams, and then in Visayas and Mindanao, led by the respective field supervisors and group leaders. Similarly, three-day central briefings and succeeding three-day enumerator trainings for various local teams were held in January 2019 for personnel involved in the MPC data collection.

2.3.2 Data Collection

Fieldwork for the HC began on November 30, 2018, and lasted through May 26, 2019, with fieldworkers dispatched simultaneously in all regions and with some overlap between the HC and MPC to meet data collection deadlines. Data were collected with pen-and-paper assisted interview methodology. Two interviewers were deployed to at least two sampled barangays, supervised by a group leader and field supervisor. Upon arrival at the barangay, a courtesy call or visit to the barangay captain was made to explain the purpose of the survey and seek support before starting data collection.

MPC fieldwork began with courtesy calls to facilities on January 11, 2019; 99% of data collection was completed by February 2020. Data collection at the remaining 15 facilities lasted through May 2021 because of difficulties in scheduling hospital visits during the COVID-19 pandemic. A review of consent forms and the completed facilities-visited module in the HC were used to identify the health events for validation (i.e., outpatient, emergency, inpatient, and dental care). Rather than a facility visit, price inquiries were conducted by phone for healthcare services obtained from eye clinics, other facilities for lab tests, special therapy, alternative care, pharmacies, and medical supplies/equipment stores.

2.3.3 Data Management and Processing

Throughout the data collection process, completed questionnaires were reviewed by group leaders and mailed to a central office in Manila for quality assurance, data encoding, processing, and cleaning. A quality control team comprising 64 people (44 for HC, 20 for MPC) manually reviewed questionnaires for completeness and consistency. Back-checks were completed for a random 30% of surveys per field interviewer. The central quality assurance team called households to verify information. In cases in which the phone call did not go through, field supervisors and group leaders were sent to the household to verify information. At this stage, questionnaires containing errors were put aside for further investigation and verification of data, either for follow-up with the respondent or to compensate for the missing data. Any additional verification or clarification was relayed from the quality assurance team back to field supervisors and group leaders. When necessary, the quality assurance team manually edited the completed survey, based on this verification step, before sending the survey onward for encoding.

Data were double encoded using QPS Insight software, which automatically compared the two entries in the QPS system. This system was programmed to alert encoders to invalid entries, including numeric response versus letters, skip logic followed, and missing values, and to verify data ranges for numeric and alpha-numeric response options. Data processing supervisors reviewed the error logs generated by QPS and checked for consistency within modules and the structural relationship between questions. Stata was then used to check consistency and completeness within and between modules.

An audit team provided detailed feedback directly to the data collection firm, requesting that inconsistent observations be verified and edited in the raw database. Iterative reviews of encoded data, including random checks of accomplished questionnaires, were performed throughout the data processing stage to ensure data quality.

Data analyses were conducted in Stata 14. Missing or “did not know” values were excluded from analysis unless specified (as in knowledge of health insurance coverage). Sample weights used in the analysis were generated following the NHES household sample protocol, accounting for survey design and nonresponse.

2.4 Survey Limitations

The NHES, like other research approaches and data sources, has limitations. The sampling of barangays excluded the least accessible ones and those in areas with an increased security risk. Ideally, all members of sampled household would be interviewed, but that was not always the case due to time constraints and respondent fatigue. Thus, most modules of the HC relied on a key informant household member to be the respondent, such as the household head or the spouse of the household head. Members present in the household during the interview also were asked to participate, but if certain household members were not available (e.g., those who visited a health facility in the last 6 or 12 months), the interviewer asked the key informant. It was important that the respondent interviewed was the most knowledgeable of the persons living in the household.

In line with this approach and due to the self-reported nature of the HC, NHES data might have been limited by recall bias or misinformation from key informants. To mitigate this issue, information reported by the household respondents was subsequently validated by the MPC. For instance, 2.3% of the outpatient records collected during the MPC validation were deemed as “not matched” when cross-checked with respondents’ recall during the HC on

date of visits, reason for facility visit, and final diagnosis. An additional limitation is the potential effect of respondents' nonresponse to some critical questions, such as details of facility charges and components of health expenditures.

Due to limitations on resources and statistical power, the NHES was not designed to provide data on sources of financing by cost component. NHES data cannot inform which care components were paid by various financing sources—for example, whether OOP expenses were due to professional fees, medications, diagnostics, or surgical procedures. Additionally, the survey results cannot enable researchers to study details of drug prescriptions, such as specific prescribed dosages for each patient.

Finally, the NHES HC was designed to inform only on national-level representativeness of its priority indicators, as presented in this report. The corresponding MPC data, although used to validate and compare with the results of the HC survey, are not necessarily representative at the national level due to the high number of records not collected because of non-consent by the patient and records not found in the facilities.

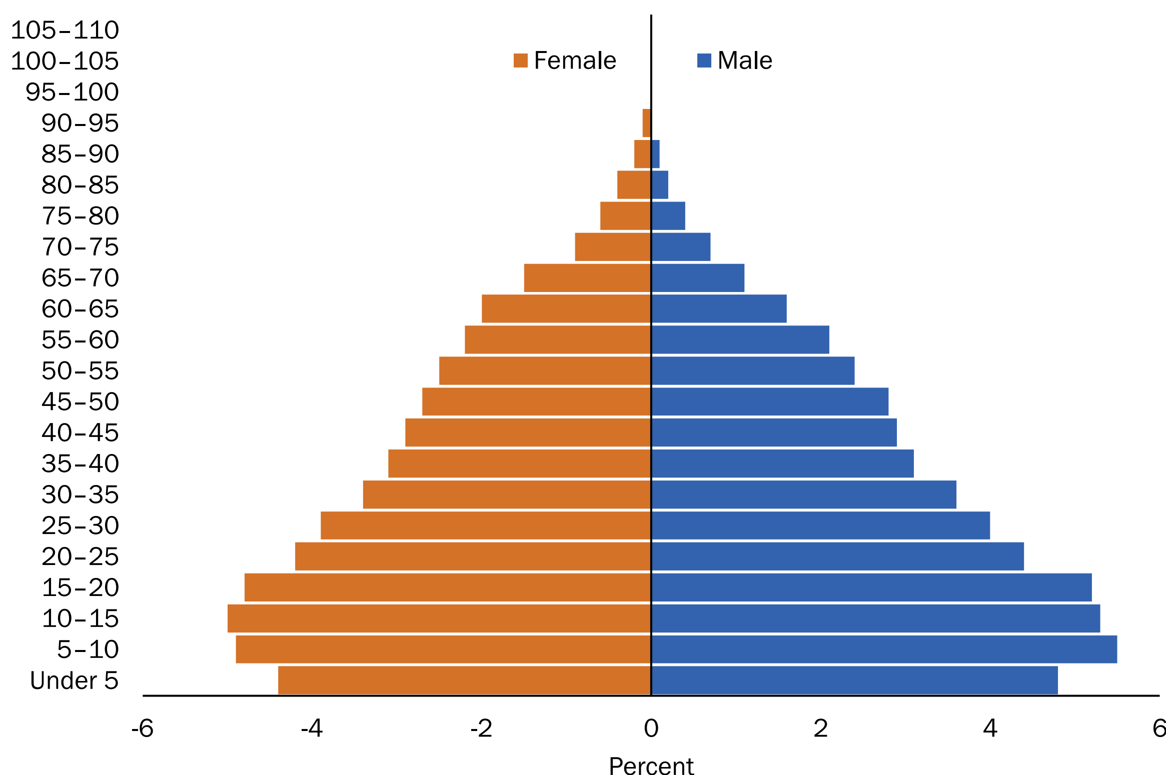
3. Household Characteristics and Health Insurance Coverage

This section describes the demographic and socioeconomic characteristics of survey respondents and their health insurance coverage. It is divided into two parts. Section 3.1 presents a profile of household members and their age, education, place of residence, marital status, employment, and wealth status. Section 3.2 presents information on household members' health insurance coverage.

3.1 Demographic and Socioeconomic Characteristics

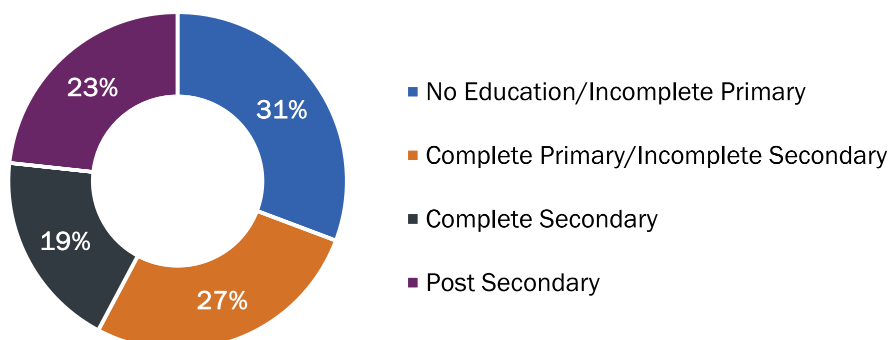
Age and Sex. A total of 11,017 households with 50,030 members were interviewed. The average household size was 4.53, of which 2.91 were adults and 1.62 were children ages 0 to 17 years of age. The sample had an almost equal split between male (50.4%) and female (49.6%) household members, with the majority (56.4%) less than 30 years of age. The age and sex distribution of the household members is illustrated in Figure 3.1, which shows an expansive pyramid—a characteristic of the Philippine population and indicative of a young and growing population with a high fertility rate. The ratio of male to female household members is almost equal for almost all age groups except the older age groups, in which females outnumber males, reflecting a longer female life expectancy.

Figure 3.1. Percentage of Total Household Members Shown by Age and Sex



Educational Attainment. More than half of household members (58.0%) had less than a secondary education, due to the large proportion of members under the age of 18 and likely still in school (Figure 3.2). Less than half of the household heads (45.9%) had less than a secondary education.

Figure 3.2. Educational Status of Household Members Age Five and Above



Discrepancies in educational attainment of household members age five and above appear by gender, socioeconomic status, and location (Annex 1, Table S3.1). A slightly higher proportion of females (24.5%) than males (21.1%) had a post-secondary education, whereas more males (32.1%) had no education or an incomplete primary education compared to females (29.4%). Household members employed in the formal sector attained higher educational levels than those employed in informal sectors, unemployed, not looking for work, and students.[4] Households with higher monthly household per capita expenditure had more education. Similarly, Pantawid Pamilyang Pilipino Program (4Ps) beneficiaries had lower educational attainment (8.4% post-secondary level) than nonbeneficiaries (24.6% post-secondary level).[5] A larger percentage of urban dwellers had a post-secondary education (28.6%) compared to rural dwellers (17.2%), reflecting the limited availability of vocational and tertiary schools in rural areas.

Current Work Status. Close to half (48.5%) of household members were either unemployed, not looking for work, or students at the time of the household survey,[6] 29.0% were employed in informal jobs, and only 22.4% reported having formal jobs (Figure 3.3). Half of the households (50.2%) were employed in informal jobs, whereas 28.3% had formal jobs. Those with formal employment status were more likely to have access to government-mandated benefits, including health insurance and other social benefits.

Overall, formal employment was higher among males, urban dwellers, those with higher household per capita monthly expenditure, and those with higher educational attainment (Annex 1, Table S3.2). A higher proportion of females (63.6%) were unemployed compared to males (33.1%). There also were far fewer females employed in formal sectors of the economy (15.6%) compared to males (29.4%). Approximately 63.5% of household members over 60 years of age and 97.3% below 18 years of age were unemployed, not looking for work, or students. At the time of the survey, a higher proportion of urban dwellers had a formal job (27.2%) compared to those living in rural areas (16.8%). Informal employment was higher

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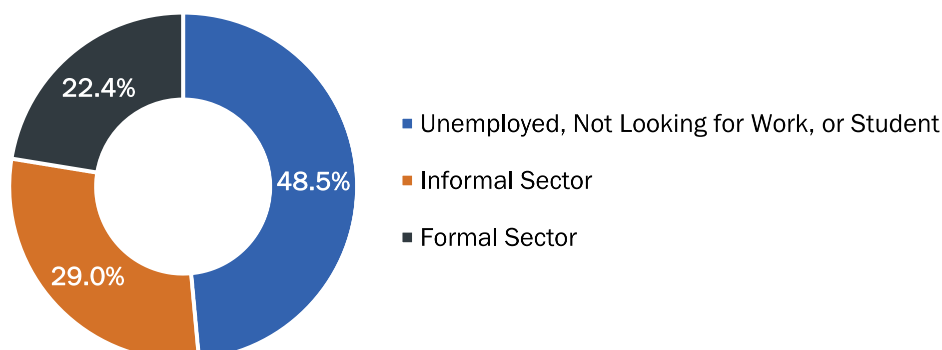
[4] Infomal workers include individuals working for private households, the self-employed, and employers of family-owned farms or businesses and their employees.

[5] 4Ps is the Philippines' national conditional cash transfer program that aims to provide social protection via cash grants to poor households with children 0–18 years of age to help them invest in the health, nutrition, and educational needs of their children. The lower educational attainment level among program beneficiaries could be due to the age of the target children (0–14 years of age) of the program beneficiaries for health and educational conditionalities required for poor families.

[6] Note: Employment questions were asked of all household members who were at least 15 years of age. Due to questionnaire design limitations, it was not possible to disaggregate household members not currently working because they were studying and/or not looking for work at the time of the survey.

among rural dwellers than those residing in urban areas, which could reflect the prevalence of agricultural and informal jobs in rural areas.[7]

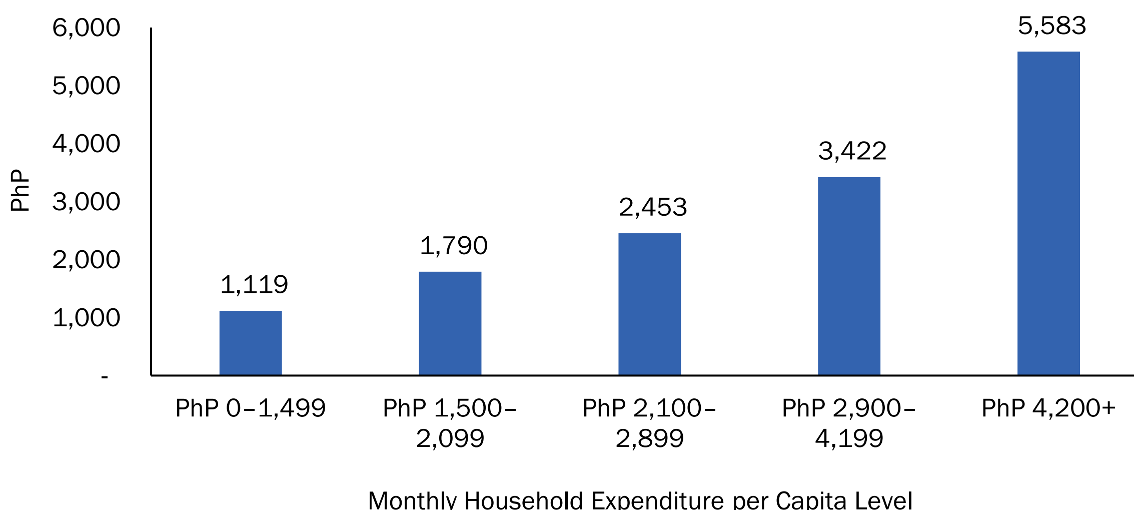
Figure 3.3. Work Status of Household Members at Least 15 Years of Age



Monthly Household per Capita Expenditure. Survey data on monthly per capita household spending were converted into quintiles by (a) converting all reported expenditures into monthly equivalent amounts; (b) dividing the computed total monthly household expenditures in (a) by household size; (c) finding quintile cut-off points using survey weights; and (d) rounding cut-off points to the nearest 100. The resulting expenditure groups are presented in Figure 3.4. The median per capita monthly spending of the households in the top 20% (expenditure group 4,200+ Philippine pesos [PhP], with median spending of PhP 5,583) was five times that of the bottom 20% (expenditure group PhP 0–1,499, with median spending of PhP 1,119).

Annex 1, Table S3.3 provides a detailed distribution of households by monthly household expenditure per capita. Forty percent (40.0%) of household members belonged to households that spent less than PhP 2,100 per month per capita. Among non-4Ps beneficiary households, 73.8% had at least PhP 1,500 monthly household expenditure per capita.

Figure 3.4. Monthly Household Expenditure per Capita, Median



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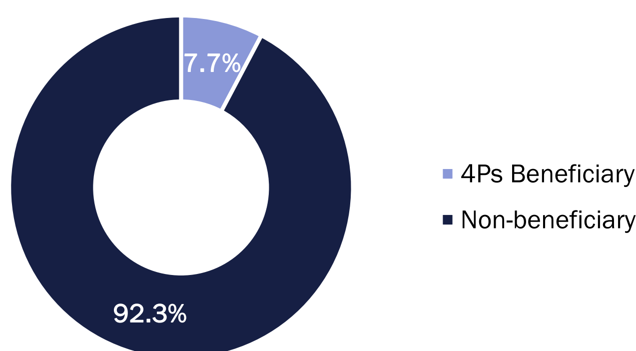
[7] Data from the Philippine Labor Force Survey show workers in the agriculture sector comprise the second largest group, at 23.1%, of the total employed; most if not all of these jobs are in rural areas (PSA, 2020a).

Membership in 4Ps Conditional Cash Transfer. Seventeen percent of household members belonged to a household that reported receiving conditional cash transfers from the 4Ps. This estimate is close to the 2017 estimate of 21% of the Philippine population, representing the majority of the nation's poor (Acosta et al., 2019). As expected, 4Ps membership was higher among the groups most likely to suffer from financial hardships: households in the lower expenditure quintiles (monthly per capita spending of less than PhP 2,100), individuals with less than a secondary education, those not currently working, and rural dwellers (Annex 1, Table S3.4). Although 16.6% of household members belonged to households with at least one individual who identified as benefiting from the 4Ps, only 7.7% of all household members were reported as beneficiaries of that program (Figure 3.5). This finding was to be expected, because 4Ps was designed to include only family members who met the education and health conditions set by the program—i.e., pregnant women using prenatal and postnatal care and attended by a trained health professional during child birth, children 0 to 5 years of age receiving regular preventive health checkups and vaccines, children 3 to 18 years of age enrolled in school with a class attendance rate of at least 85% per month, elementary school students receiving deworming pills twice a year, and parents attending monthly family development sessions.

Figure 3.5. Membership in 4Ps among Total Household Members

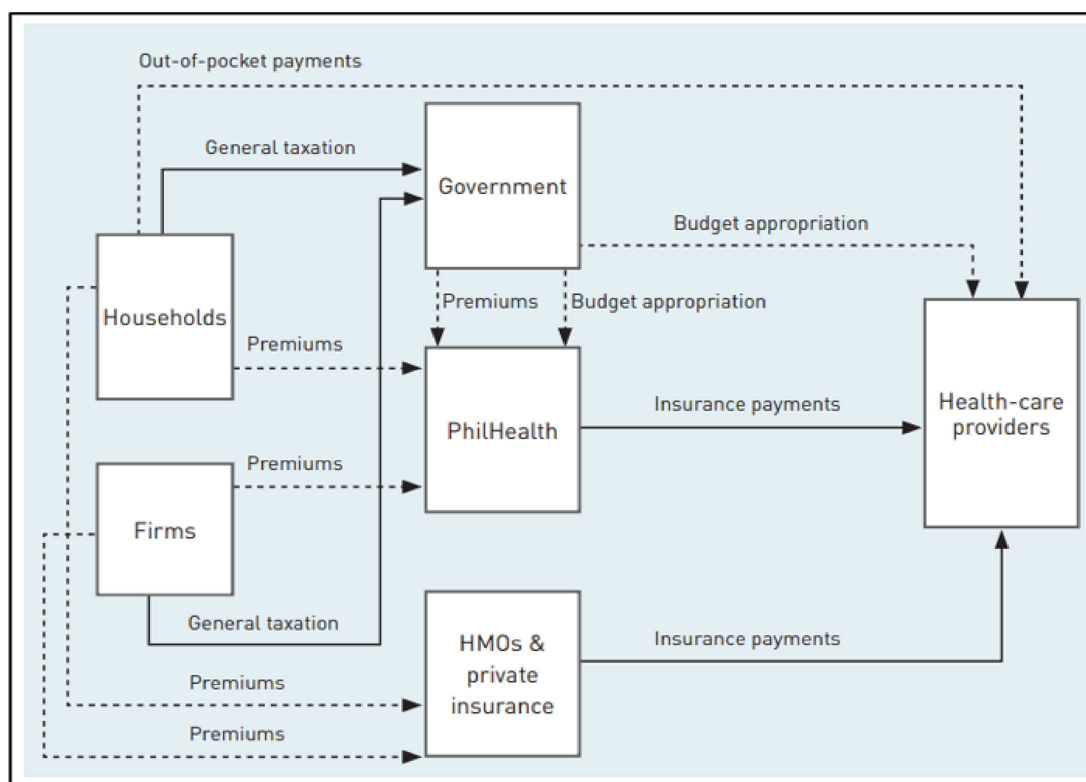


3.2 Knowledge of Health Insurance Coverage

In the Philippines, health insurance is provided by public and private entities, as illustrated in Figure 3.6. PhilHealth administers the National Health Insurance Program and provides public health insurance.[8] Since its inception in 1995, the National Health Insurance Program has aimed to increase coverage and enhance financial protection of the poorest of the poor and senior citizens, among others. With the Universal Health Care Act (Republic Act No. 11223) of 2019, PhilHealth coverage was extended to all Filipinos, guaranteeing equitable access to quality and affordable healthcare goods and services, as well as protection against financial risks.

[8] PhilHealth is a government corporation attached to the Department of Health, the principal health agency in the Philippines.

Figure 3.6. Financial Flows in the Philippine Healthcare System



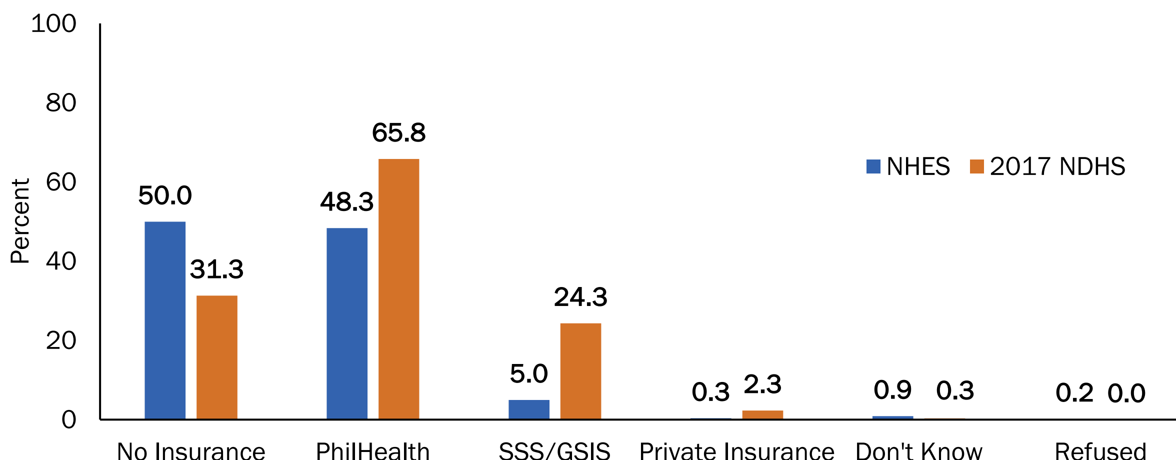
Source: WHO, 2011, p. 38

Other national government institutions, such as the Philippine Charity Sweepstakes Office, provide in-kind resources for health, but these resources are limited and cannot be used by everyone. Local government units may also give financial assistance to their constituents, but as with the former, this help is limited.

Private health insurance is another health financing source, either through health maintenance organizations (HMOs) or non-HMO health insurance. Most HMO members are on corporate plans that are not used as individual or family plans, given their high costs. Non-HMO insurance is a form of voluntary private health insurance that offers a range of benefits, such as inpatient and outpatient services, hospitalization and surgical benefits, cash assistance for loss of income due to accident or illness, or a lump sum payment for death, disablement, or dismemberment (Dayrit et al., 2018). Like HMOs, coverage is tailored and costed accordingly.

Household Health Insurance Coverage Reported by Key Informants. Seven out of ten households had at least one member with PhilHealth coverage (72.1%). Results indicate a discrepancy in the PhilHealth coverage reported by the household heads (63.2%) and household members (48.3%, Figure 3.7). The NHES-reported PhilHealth coverage of household members was significantly below the official figures reported by PhilHealth in 2019 (90.4%) and the 2017 DHS (65.8%; PSA and ICF, 2018).

Figure 3.7. Health Insurance Coverage among Household Members Reported by Key Informants



Similarly, the NHES reported coverage of the state-run Government Service Insurance System (GSIS) and Social Security System (SSS), as well as private health insurance providers, including HMOs, is small—5.3% in total—compared to published figures from the 2017 DHS. At the household level, only 1.2% had at least one member with SSS or GSIS coverage, HMO coverage, and/or private insurance coverage. As discussed in Box 3.1, the lower insurance coverage rates from the NHES could be attributed to limitations in questionnaire design.

Box 3.1. The NHES Health Insurance Module

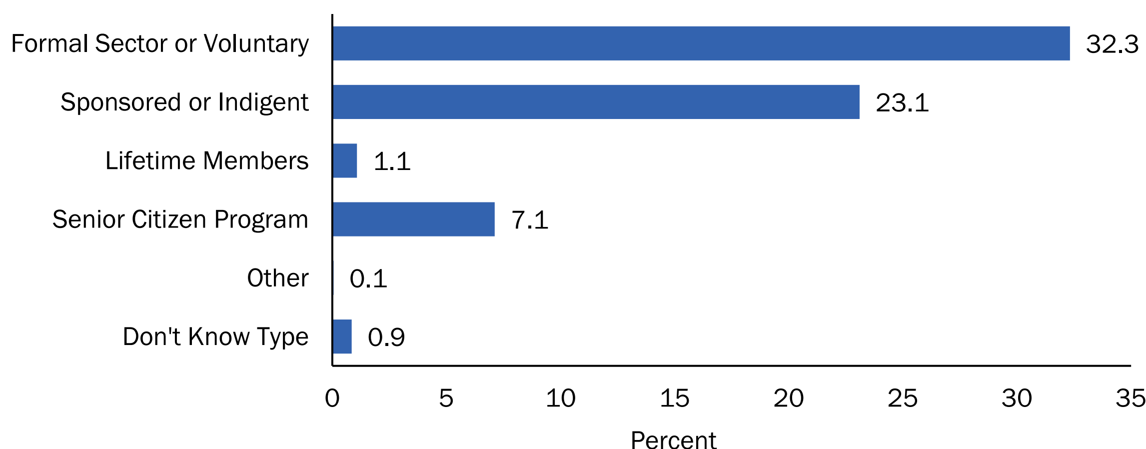
By design, the household key informant is initially asked whether any member of the household has any type of insurance or healthcare plan (HI1). If the key informant affirms that someone does, they are then asked the type of insurance owned for each household member (HI2). If the household key informant does not answer or responds "no" or "don't know" to HI1, a subsequent member-specific type of insurance matrix (HI2) is skipped.

This questionnaire design may result in biases common across household surveys with questions on insurance coverage. The key informant responding on behalf of the household or for individuals within the household may not be the best respondent or most informed member. As a result, with question HI1, the individual matrix is skipped if the key informant does not know or says "no" incorrectly. Also, the individual-level details may be inaccurate.

There are seven different types of PhilHealth coverage, determined by a member's employment and socioeconomic status. They include premium-paying PhilHealth member groups (for those working in the formal sector, voluntary or informal sector, and overseas) and non-paying groups (sponsored program, indigent program, lifetime members, and senior citizens program). Figure 3.8 illustrates the types of membership among those household members with PhilHealth insurance.[9] The most common types of PhilHealth membership are formal sector or voluntary (32.3%), sponsored or indigent (23.1%), and the senior citizen program (7.1%).

[9] Some household respondents provided information about more than one type of PhilHealth membership.

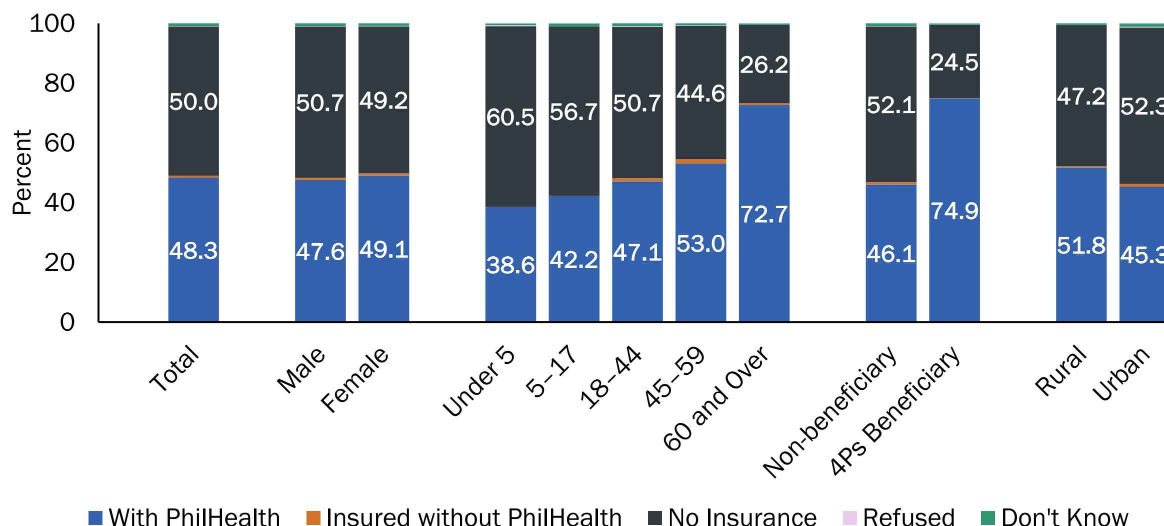
Figure 3.8. PhilHealth Membership among Household Members with PhilHealth



To better understand who has PhilHealth coverage, the analysis looked at PhilHealth ownership by household and individual characteristics (Figure 3.9). Overall, PhilHealth membership increased with age and was higher among 4Ps beneficiaries and rural dwellers.

- Age: PhilHealth coverage was higher among older individuals. The 60-and-over age group had the highest proportion of covered individuals (72.7%). Given the automatic and free enrollment of individuals who are at least 60 years of age into the senior citizen program, this proportion was lower than expected. This finding may be due to lack of awareness of the program by the household key informant (see Box 3.2). As expected, the coverage of the mostly working age population (18–44 years of age) was also high (47.1%) compared to the dependent-age groups of children under five years of age (38.6%) and 5 to 17 years of age (42.2%). The lower coverage of the qualified dependent-age groups compared with those 18–44 years of age may also have been caused by survey respondents' lack of knowledge of the coverage of the children within the household.
- 4Ps beneficiaries: As expected, knowledge of PhilHealth coverage was higher among 4Ps beneficiaries (74.9%) compared to non-beneficiaries (46.1%). Although reported coverage for 4Ps beneficiaries was high, many were still not aware of their automatic entitlement to PhilHealth benefits under the indigent program (25.1%).
- Locale: A higher share of rural dwellers had PhilHealth coverage (51.8%) compared to their urban counterparts (45.3%). This finding may be explained partly by the high concentration of 4Ps beneficiaries in rural areas, who are automatically covered under the indigent program.

Figure 3.9. Health Insurance Coverage among Household Members Reported by Key Informants



Box 3.2. Knowledge of PhilHealth Coverage among NHES Households Is Relatively Low

PhilHealth has reported "coverage rate" as the proportion of Filipinos registered or included in the PhilHealth database of members (PhilHealth, 2019a). To be a registered PhilHealth member, an individual must submit a PhilHealth Member Registration Form along with supporting documents, such as valid identification cards. Individuals in the formal economy—i.e., those employed in the public or private sector, including seafarers—then submit their registration form through their employer. On the other hand, retirees and pensioners, and those in the informal economy—self-employed/self-earning individuals, professional practitioners, and land-based overseas Filipino workers—enroll directly with their local PhilHealth offices. Senior citizens may submit their registration form to their local PhilHealth office or the Office for Senior Citizen's Affairs in the city or municipal government of their residence. Indigents, as identified by the Department of Social Welfare and Development, are enrolled into the insurance program by the agency, whereas individuals sponsored by a local government unit are registered by their respective unit. Under the point-of-care enrollment program, indigent patients who are not yet PhilHealth members and are hospitalized in DOH-retained hospitals or participating government hospitals are enrolled and sponsored by the health facility. As proof of PhilHealth registration, members are provided with a member data record and PhilHealth membership card.

With the signing of the Universal Health Care Act in February 2019, all Filipinos are "automatically included under the National Health Insurance Program" and are granted "immediate eligibility" and access to PhilHealth benefits by November 2019 (PhilHealth, 2019b). This provision means that the PhilHealth coverage rate reached 100% by the end of 2019. Automatic coverage does not equate to automatic inclusion in the PhilHealth database, however, as those not currently registered must still do so. Although the impacts of this provision have yet to be seen, NHES results indicate that there is an information gap regarding PhilHealth coverage at the household level.

The NHES results show that overall knowledge of PhilHealth coverage is low among households it surveyed compared to official figures from PhilHealth and the Philippine Statistics Authority. When looking at subgroups where coverage is expected to be very high

because of automatic enrollment and targeted information campaigns—senior citizens and 4Ps beneficiaries—the NHES estimates are still below PhilHealth's reported coverage rate (74.9% versus 90.4%, respectively). Even among those in the formal sector, who are required by law to be registered with PhilHealth and pay contributions, only 6 out of 10 (62%) reported having PhilHealth membership. The low coverage rate reported by the NHES HC could be explained by the survey respondents' lack of awareness of PhilHealth coverage of other household members. This observation is further highlighted by the coverage gap in dependent age groups: the NHES-estimated coverage rate among children was lower compared to that of adults in the household. These findings underline the need for comprehensive information dissemination efforts to increase awareness of PhilHealth insurance.

4. Health-Seeking Behavior and Utilization

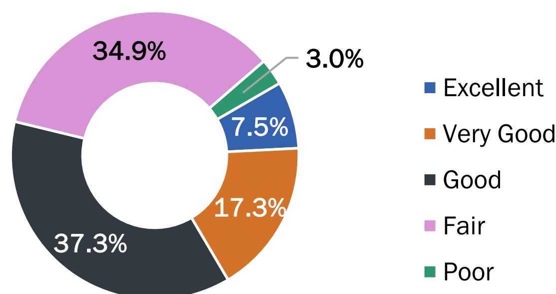
This section presents household members' reported health-seeking behaviors and utilization of healthcare services in the six months preceding the household survey. Understanding these behaviors is crucial in formulating effective policies and health promotion strategies aimed at maintaining a healthy population and preventing the spread of infectious diseases.

Section 4 is divided into four parts. Section 4.1 characterizes the overall health of the population and the prevalence of certain diseases. Section 4.2 presents the unmet needs for healthcare and reasons for not seeking medical care. Knowledge of where to seek care and reasons for having a primary care provider are discussed in Section 4.3. Last, Section 4.4 presents data on healthcare utilization.

4.1 Need for Healthcare

Self-reported overall health status. Philippine self-reported health status is fairly high, with 97% of the population rating their health status as fair or better. Only 3.0% of individuals reported their health was poor—the lowest quality on the scale (Figure 4.1). Analyzing responses by demographic and socioeconomic characteristics (Annex 1, Table S4.1) reveals that more children under 18 years of age (as reported by parents or guardians), household members with per capita expenditure below PhP 1,500, 4Ps beneficiaries, and rural dwellers rated their health status as "very good" or "excellent," whereas older individuals reported poorer health status, as expected. Self-reported health status appears to be similar among females and males, and across educational attainment and employment status.

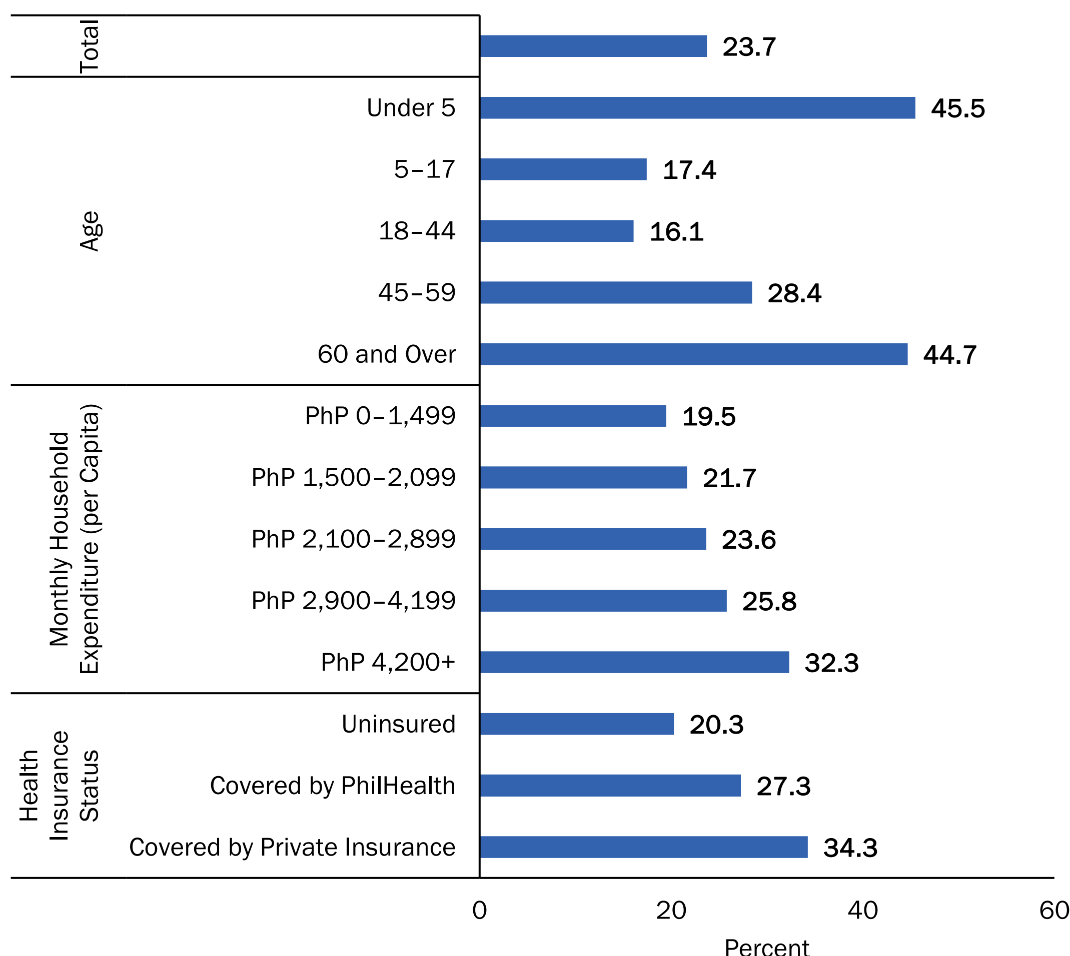
Figure 4.1. Self-Reported Overall Health Status of Household Members Present during the Interview



Any health condition experienced. Among household members, 23.7% of individuals experienced a health condition in the six months preceding the survey (Figure 4.2).[10] As expected, experiencing a health condition showed a U-shaped pattern across age groups, with rates higher among children under five years of age (45.5%) and those 60 years and over (44.7%), and lower for those 5–17 years of age (17.4%), 18–44 (16.1%), and 45–59 (28.4%). Reporting of health conditions was higher among those with higher household per capita expenditure and those covered by PhilHealth (27.3%) or private insurance (34.3%).

[10] Experiencing a health condition includes individuals who (1) visited a facility or a healthcare provider in the last six months; (2) did not visit a facility but consumed or purchased medications, vitamins, supplements, medical equipment, or a device for home to address certain health conditions; or (3) reported an illness in the last six months but did not visit a facility and did not self-medicate.

Figure 4.2. Proportion of Total Household Members with Any Health Condition in the Last Six Months



Specific health conditions experienced. Table 4.1 presents the top health conditions and services for which individuals sought medical attention at least once in the past six months. The top five conditions and services among those who utilized healthcare services were upper respiratory infection (11.6%); hypertension (10.7%); immunization (8.2%); supervision of normal pregnancy, including antenatal care and deliveries (5.7%); and flu (5.5%).[11] The top conditions presented in Table 4.1 were identified based on the frequency of visits to health facilities of all NHES household respondents. The associated International Classification of Diseases (ICD-10) codes for the top health events that led to a visit to a healthcare facility were determined using household member responses on the following questions: specific reason/s for visiting the health facility, type of care received (e.g., pregnancy-related), and final diagnosis given by the healthcare provider. This information was not available for health events addressed by self-medication only or taking maintenance medicines, as well as for individuals who reported having a health condition but not visiting a health facility.

[11] In 2018, the top five causes of morbidity in the Philippines were acute respiratory tract infection, hypertension, acute lower respiratory tract infection and pneumonia, urinary tract infection, and acute watery diarrhea (DOH, n.d.).

Table 4.1. Top Health Conditions for Which Individuals Sought Care in the Last Six Months

Condition/Health Services Sought	Proportion of Individuals Who Experienced in the Last 6 Months
Upper respiratory infection	11.6
Hypertension	10.7
Immunization	8.2
Supervision of normal pregnancy	5.7
Flu	5.5
Fever	5.2
Checkup	5.2
Fibromyalgia and muscle pain*	4.4
Asthma	4.2
Diabetes	2.7

* Category includes other unspecified soft tissue complaints, such as joint and muscle pain, as well as fatigue in various parts of the body not elsewhere classified.

Box 4.1. Respiratory Conditions and Fever Were Prevalent among Children under Five Years of Age

Respiratory conditions. NHES results showed that among children who sought healthcare in the six months preceding the survey, respiratory conditions were most prevalent: 6.7% had some form of upper respiratory infection, 2.8% had flu, and 1.4% had asthma. Although not directly comparable, DHS results showed that the prevalence of acute respiratory infections among children under the age of five declined from 15% to 2% between 1998 and 2017; however, acute respiratory infections remain the leading cause of death among the subpopulation.[i] PhilHealth claims in 2018 and 2019 (PhilHealth, 2018, 2019a) also show that respiratory diseases, particularly pneumonia and acute asthma, were among the 10 leading medical conditions among PhilHealth members who sought care from health facilities. Upper respiratory tract infection also was included in the 2019 list (PhilHealth, 2019a).

Fever. Fever of unknown origin was prevalent among children under age five, at 2.7%.[ii] The 2017 DHS noted that fever associated with infectious diseases was the most common reported health condition (17%) among children under age five two weeks before the survey.[iii]

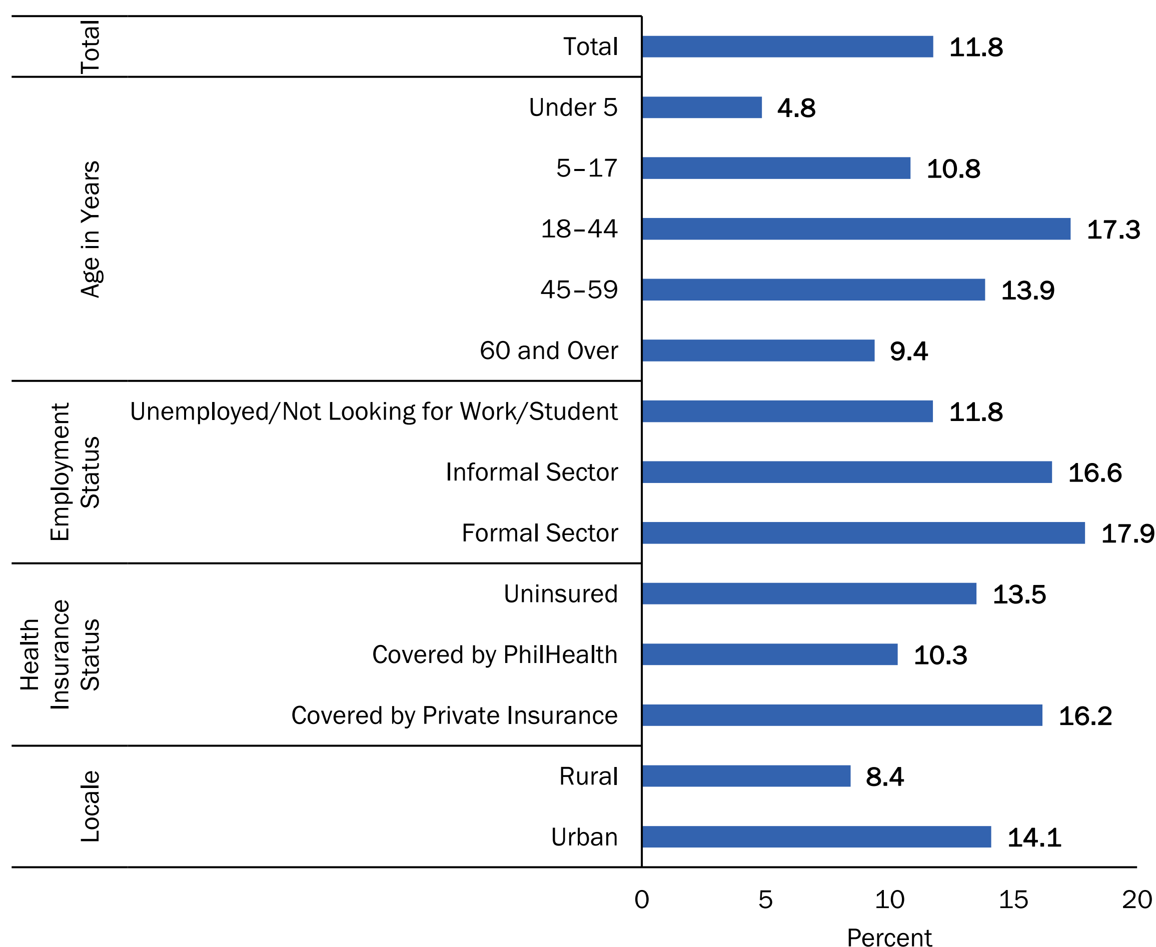
Notes:
[i] The NHES respiratory condition was determined based on the final diagnosis of the healthcare provider as reported by the household respondent. On the other hand, the DHS had specific questions to determine symptoms of acute respiratory infections, including short, rapid breathing that was chest related and/or difficult breathing that was chest related.
[ii] This NHES statistic refers only to fever of unknown origin for which a visit to a health facility was made in the past six months.
[iii] This information from the DHS is not limited to fever of unknown origin.

4.2 Unmet Need for Healthcare

Individuals with unmet need for healthcare refer to respondents with a reported health condition in the last six months who did not seek care from a health facility or use any alternative or home healthcare or any medication.

Proportion with unmet need for healthcare. Among those who experienced a health condition or illness in the six months preceding the survey, about 1 in 10 (11.8%) did not seek care in a healthcare facility or employ other means of medical attention, including alternative care, home care, or a pharmacy visit (Figure 4.3). Not seeking care was especially high among the middle-age group (18–44 years of age, 17.3%), those employed in the formal sector (17.9%), private insurance holders (16.2%), and urban dwellers (14.1%). These categories were not distinct—more formally employed individuals generally were 18–44 years of age and had private insurance, and urban areas were populated primarily by individuals 18–44 years of age.

Figure 4.3. Proportion of Individuals with Unmet Need for Care



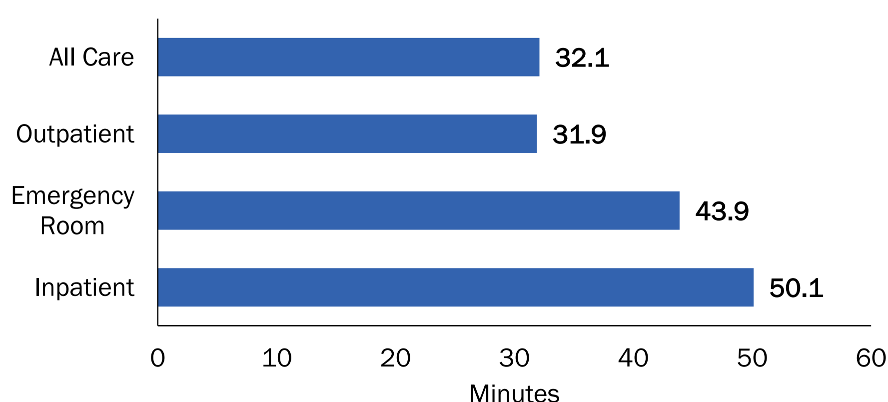
Reasons for not seeking care. When asked to identify the primary reason for not seeking care, most individuals with unmet healthcare need reported that they thought they were not sick enough to warrant visiting a healthcare provider (37.2%) or had household financial difficulties (33.5%) (Table 4.2). Other reasons for not seeking medical care were inability to visit a medical provider due to other commitments (8.5%) and not taking time off work (6.7%).

Table 4.2. Primary Reason for Not Seeking Care from a Medical Provider

Top Reasons	Proportion
Household member thought they were not sick enough	37.2
Financial difficulties	33.5
Had other commitments	8.5
Could not take time off work	6.7
Could not get an appointment soon enough	2.3
No transportation available	2.0

Transportation seemed to be another barrier to seeking care; this reason ranked sixth, reflecting the poor accessibility of healthcare facilities. On average, an NHES household member traveled 32 minutes to a health facility or provider for any type of care. This amount is double the DHS-reported average travel time of 23.25 minutes in 2017. For emergency care in particular, NHES estimates showed that the average travel time to a health facility was more than an hour (64.8 minutes) (Figure 4.4).

Figure 4.4. Average Travel Time to Health Facility (One Way)

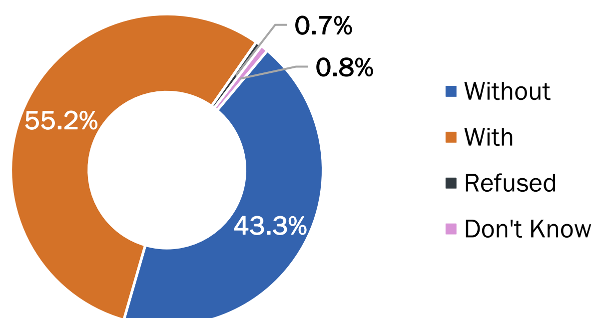


4.3 Usual Source of Primary Care

Without a usual source of primary care, the opportunity exists for lapses or lack of continuity in healthcare. In the Philippines, as in most lower-income countries, without centralized systems for patient records, doctors must rely on self-reported health histories, which may be inaccurate and incomplete. This situation can lead to poor diagnosis and delays in medical treatment, including preventive services such as immunization and screening tests.

Proportion of household members with primary care providers. The NHES defines a primary care provider as a medical professional, doctor's office, clinic, health center, or other place an individual usually would go if they are sick or need advice about their health. NHES results suggest the majority of individuals (55.2%) have a usual source of primary care (Figure 4.5). The proportion of household members with a usual source of care was notably higher among individuals under five years of age (57.3%) and at least 60 years of age (56.1%); 4Ps beneficiaries (60.5%), PhilHealth members (61.6%), and private health insurance holders (58.5%); and rural dwellers (58.9%) (see Annex 1, Table S4.4). Regardless of per capita monthly household expenditure, around half (53.1%–57.4%) of households had a usual source of healthcare.

Figure 4.5. Proportion of Household Members with Primary Care Provider



Reasons for not having a primary care provider. Among those who did not have a usual source of primary care, 75.3% of households reported that it was because they seldom or never get sick. Other reasons are detailed in Table 4.3.

Table 4.3. Reasons for Not Having a Primary Care Provider

Top Reasons	Proportion
Seldom or never gets sick	75.3
Recently moved into area	11.5
Cost of medical care	5.5
Don't use doctors/treat myself	5.1
No health insurance	2.1
Refused to answer	1.7
Don't know	1.7
Don't know where to go for care	1.1
Likes to go to different places for different health needs	0.6
Usual source of medical care in this area is no longer available	0.4
Other reason	0.2
Just changed insurance plans	0.2
Can't find a provider who speaks your language	0.2

Number of observations: 11,459

4.4 Healthcare Utilization

The NHES defines healthcare utilization as having visited a hospital, clinic, diagnostic laboratory, or alternative care provider to obtain healthcare services. Utilization also includes using healthcare provided by medical missions and outreach programs, as well as home health services and pharmacy visits.

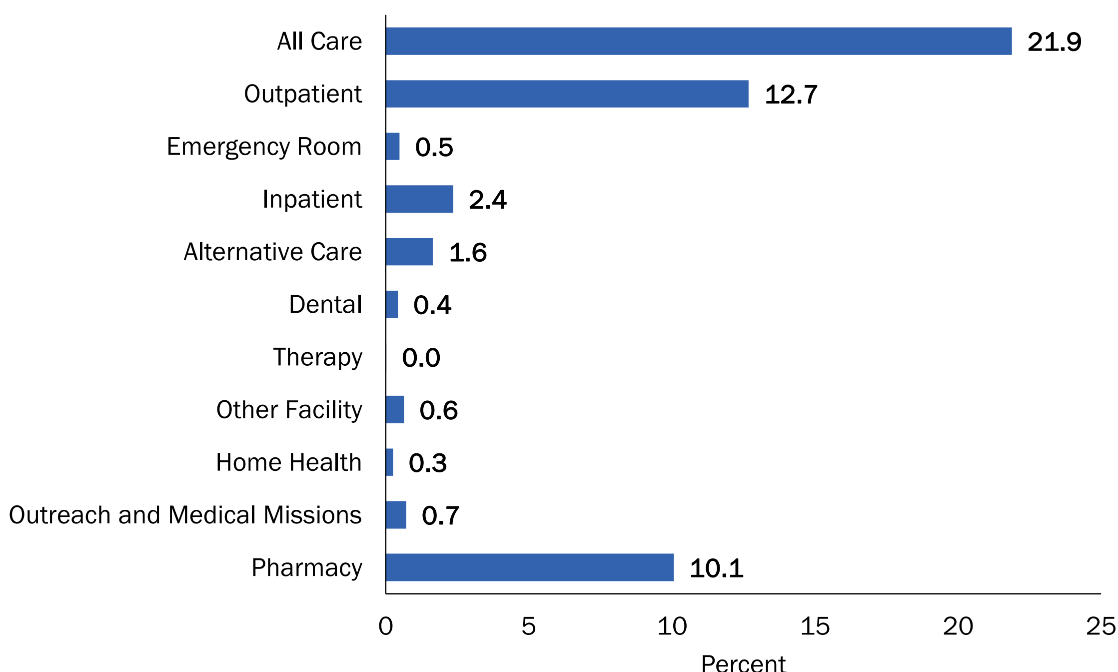
Healthcare services utilized. Figure 4.6 presents the healthcare services utilized by individuals in the six months preceding the survey.[12] On average, 21.9% of individuals utilized at least one care type, excluding pharmacy visits. Approximately 12.7% of individuals

[12] For a definition of healthcare services, see Section 2: Methodology.

utilized outpatient care, 10.1% had a pharmacy visit, and 2.4% had inpatient care in the six months preceding the survey. The average number of visits for outpatient care was 1.9 while the average number of visits for inpatient care was 1.1.

NHES-reported healthcare utilization differed from 2017 DHS results. Facility visits for outpatient care as reported for NHES household members was 4.7 percentage points higher than DHS respondents (8.0%). Inpatient care utilization in the DHS (4.0%) was almost twofold of that recalled by NHES respondents (2.4%). However, it should be noted that the DHS reference time period is the last 30 days for outpatient care and the last 12 months for inpatient care, whereas the NHES reference period used in Figure 4.6 was six months.

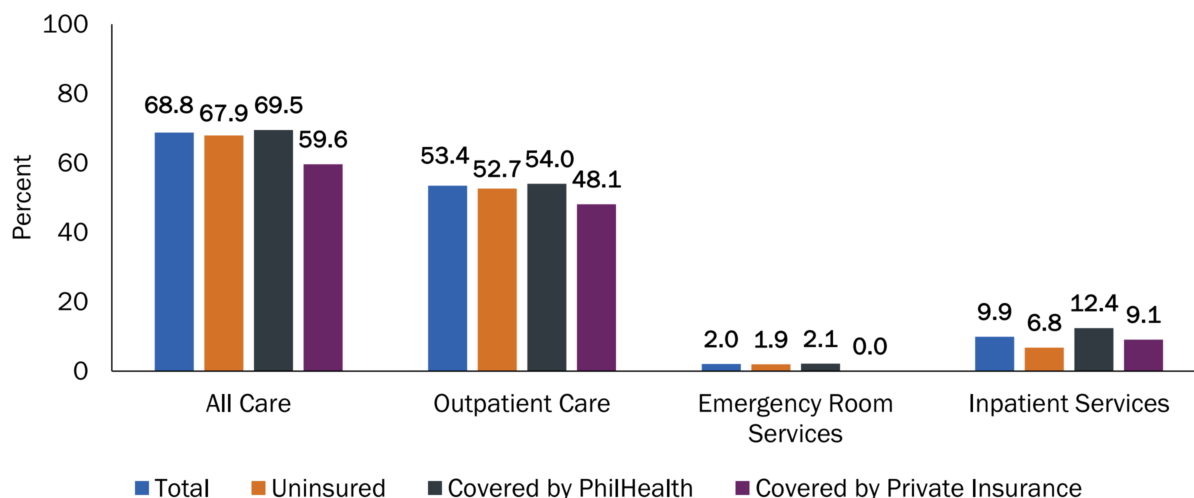
Figure 4.6. Utilization of Healthcare Services in the Past Six Months (At Least One Visit)



Type of healthcare services utilized. Most individuals who utilized healthcare accessed outpatient care (53.4%), followed by inpatient services (9.9%) and emergency room services (2.0%) (Figure 4.7). Individuals who reported PhilHealth coverage also reported higher utilization (69.5%) than those who were uninsured and privately insured. Among PhilHealth members, utilization was highest for outpatient care (54.0%), followed by inpatient care (12.4%) and emergency care (2.1%). Individuals with private insurance reported lower utilization of outpatient and emergency room care, whereas uninsured respondents reported the lowest utilization of inpatient care.

Members from households with monthly per capita expenditure of less than PhP 1,500 reported a higher utilization of healthcare, at 74.3%, when faced with a health condition (see Annex 1, Table S4.6). Compared with other expenditure groups, household members from the lowest expenditure group utilized more outpatient care and inpatient care. The same utilization patterns were observed for 4Ps beneficiaries. On the other hand, those in the highest expenditure group (with monthly per capita household spending of at least PhP 4,200) utilized more diagnostic laboratories and pharmacies. As explained in Box 4.2, children under five years of age and those who are 65 years of age and over tend to visit health providers more than other NHES subgroups.

Figure 4.7. Type of Care Utilized among Individuals with a Health Condition Who Utilized Care in the Last Six Months, by Insurance Status



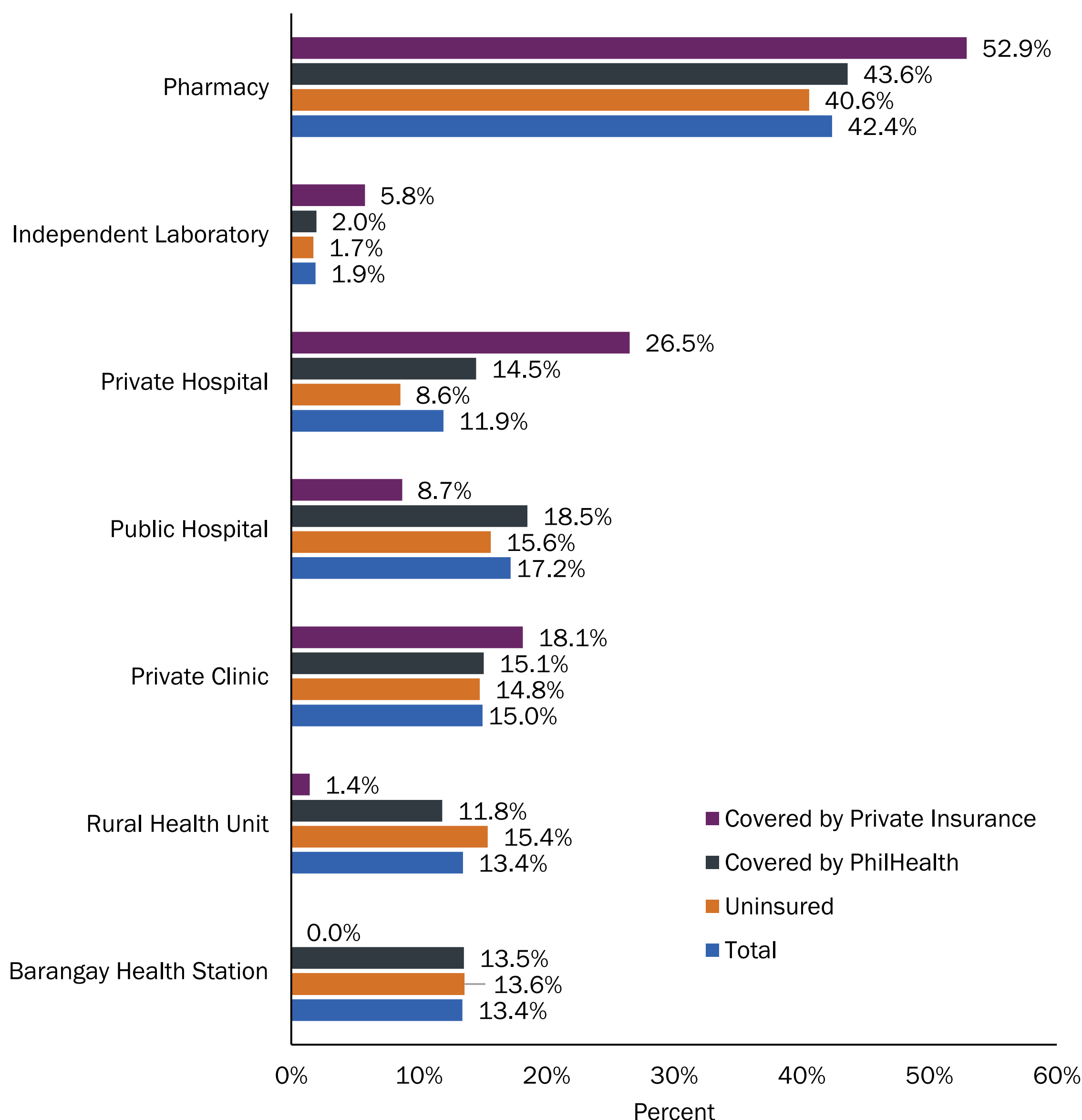
Box 4.2. Children and Elderly Tend to Visit Health Providers More Than Other NHES Subgroups

Children under five years of age and people 65 years of age and over visited a health facility or provider more than other subgroups in the six months before the NHES—about 4 in 10 rather than 2 in 10 for the 5–64-year age group. In comparison, the 2017 DHS estimated that nearly 2 in 10 children under age five (19.2%) and about 1 in 10 senior citizens (9%) visited a health facility or provider in the 30 days before the survey. The 2017 DHS also noted that children under age five were more likely to have sought care from a health facility or provider compared to other age groups.

Further, NHES results showed that 34.5% of healthcare utilization by children under age five was for immunization. Among those at least 65 years of age, 25.1% of healthcare utilization was to seek treatment or care for hypertension. In 2018 and 2019, high blood pressure was among the top 10 medical cases processed by PhilHealth for reimbursements (PhilHealth, 2018, 2019a).

Type of healthcare facilities visited. Among individuals who utilized healthcare services for at least one visit in the six months preceding the survey, utilization was highest at public facilities (40.4%), which includes public hospitals (17.2%), rural health units (13.4%), and barangay health stations (13.4%). See Box 4.3 for information on public facility utilization for family planning, pregnancy-related conditions, and tuberculosis. In private healthcare facilities, utilization was 28.8%: 11.9% in private hospitals, 15.0% in private clinics, and 1.9% in independent laboratories.

As illustrated in Figure 4.8, those with private insurance utilized private health facilities more than individuals with reported PhilHealth coverage and uninsured individuals. This trend was particularly evident in utilization of private hospitals (privately insured: 26.5% versus PhilHealth: 14.5% and uninsured: 8.6%).



Similarly, those without insurance or with PhilHealth utilized public health facilities at higher rates than did those with private insurance. This finding is evident for barangay health stations and rural health units, for which utilization by the uninsured and PhilHealth members was more than tenfold the use rates of private insurance holders. Utilization of public hospitals by individuals with reported PhilHealth coverage was double that of those with private insurance.

Pharmacy utilization was higher than utilization of health facilities, at 42.4%, regardless of type of residence, insurance coverage, or household monthly expenditure quintile (Annex 1, Table S4.7). Pharmacy utilization was three times the utilization of barangay health stations (13.4%) or rural health units (13.4%), the basic public health institutions in local communities.

As discussed earlier, household members with a health condition from the highest expenditure group (per capita spending of at least PhP 4,200) went to pharmacies more

frequently, at 54.2% (Annex 1, Table S4.7). As expected, these individuals also reported the highest utilization of private clinics (18.1%), private hospitals (20.9%), and independent laboratories (3.1%). Meanwhile, those with the lowest per capita household spending (less than PhP 1,500) more often went to barangay health stations (23.5%), rural health units (16.1%), and public hospitals (19.6%). The same pattern of healthcare use was observed among beneficiaries of the conditional cash transfer program.

Box 4.3. Most Outpatient Visits for Family Planning, Pregnancy-Related Conditions, and Tuberculosis Occurred in Public Facilities

Family planning. About 0.6% of women 15–49 years of age sought family planning-related outpatient care in the six months preceding the NHES. The vast majority of consults for family planning (93.6%) occurred in public facilities (versus 6.4% in private facilities). This finding could be attributed to intensified government campaigns to promote modern family planning in the last decade. Republic Act 10354, known as the Responsible Parenthood and Reproductive Health Act of 2012, mandated that all accredited public health facilities, from barangay health stations to hospitals, provide a full range of modern family planning services, from consultations to supplies and procedures.

Since enactment of the 2012 law, various policies have been put in place to promote government programs on modern family planning. Currently, these initiatives are implemented by the DOH, in partnership with local government units, through the National Family Planning Program. This program specifically aims to increase utilization and decrease unmet need for modern family planning services. Among the key strategies of the program is to generate demand for and deliver modern family planning information and services at the community level through outreach programs. The 2017 DHS reported that more than half (56%) of modern contraceptives were provided by the public sector—most commonly by barangay health stations. The 2017 DHS further estimated that a quarter of contraceptive users who went to public facilities utilized these services at barangay health stations.

Pregnancy-related conditions. More than half (66.3%) of outpatient visits for pregnancy-related conditions occurred in public facilities (versus 33.7% in private facilities). These visits included consultations and birthing or deliveries. The Responsible Parenthood and Reproductive Health Act of 2012 also mandated accredited public health facilities to provide maternal and newborn care services.

Under the National Safe Motherhood Program implemented by the Department of Health, pregnant women are encouraged to use the following maternal care services from accredited facilities: at least four antenatal care visits, delivery, and postpartum care. To promote facility-based maternal and newborn care services, PhilHealth offers a maternal care package, normal spontaneous delivery package, and antenatal care package to women about to give birth.

Tuberculosis. Less than 0.1% (0.08%) of all household members sought tuberculosis (TB) outpatient care in the six months preceding the NHES. Seven in ten (69.0%) of TB outpatient visits occurred in public facilities, with the rest in private facilities (3 in 10, or 31.0%). This trend echoes the results of the *National Tuberculosis Prevalence Survey* in 2016 (DOH, 2018b). The survey reported that of the following types of survey participants who sought care or treatment for TB-related conditions, the majority went to public facilities:

- Participants who reported being on TB treatment at the time of the survey and sought treatment: 75.9% sought care from a local health center/directly observed short course (DOTS) TB clinic

- Participants with self-reported screening symptoms of TB and who consulted a healthcare worker: 67% sought care from a public facility
- Participants identified by the field data collection team as symptomatic survey TB cases and who consulted a healthcare worker: 75.0% consulted a public provider
- Participants with previous TB treatment: 78.3% obtained treatment from public sector sources

Initiatives to control TB are organized under the National Tuberculosis Control Program, which started in 1978. Central to the government's efforts to provide accessible and effective treatments to the population are the TB-DOTS centers—facilities accredited by the government to provide TB services and commodities based on the WHO-recommended DOTS approach. To expand the reach of the National Tuberculosis Control Program, the government has tapped into private health providers through the public-private mix DOTS (PPMD) strategy. PPMD units are paid and provided with incentives through PhilHealth's TB DOTS package. Currently, however, TB services and goods are mostly provided by public providers, as incentive schemes were not sufficient to sustain private providers (Dayrit et al., 2018). DOTS centers were not captured within the NHES; however, extending NHES results, one could assume that public DOTS facilities are cheaper than private, though possibly less adequately equipped and staffed to detect and treat patients. Continued and expanded engagement of the private sector and reconsideration of incentive packages to revitalize the PPMD strategy against TB could help the Department of Health achieve its goal to decrease the incidence of TB from 434 per 100,000 population in 2016 to 427 by 2022 (DOH, 2018a).

5. Healthcare Charges

NHES data give insight into how much OOP expenditure households incurred for health services and whether PhilHealth provided sufficient support to pay for the care patients received. With detailed billing information, it is possible to understand which components are driving total expenditure of care.

This section presents provider billing information using data gathered from both the HC and MPC components of the NHES. MPC data are collected from those facilities and providers that household members mentioned as having sought outpatient and inpatient care in the 6 and 12 months before the HC survey, respectively. When available, patient records, including statements of accounts, were accessed during the MPC survey to complement the household responses provided during the HC data collection. Data collected for emergency and dental healthcare events are not included in the analysis because of the limited MPC sample collected for this type of care (fewer than 100 records). Events validated via phone calls for price inquiries (such as from independent laboratories) are also not included in this section.

The following is divided into two parts: Section 5.1 presents the average amount billed per healthcare visit, as recalled by the household member and validated during the MPC survey. Section 5.2 then describes the components of the total bill using the MPC data. Box 5.1 discusses the subset of observations used in this section.

Box 5.1. Analysis Sample

To ensure the consistency of results presented in Section 5.1 (Average Charges for Care at Health Facilities) and Section 5.2 (Cost Components), the analyses were limited to the subsample with the following characteristics:

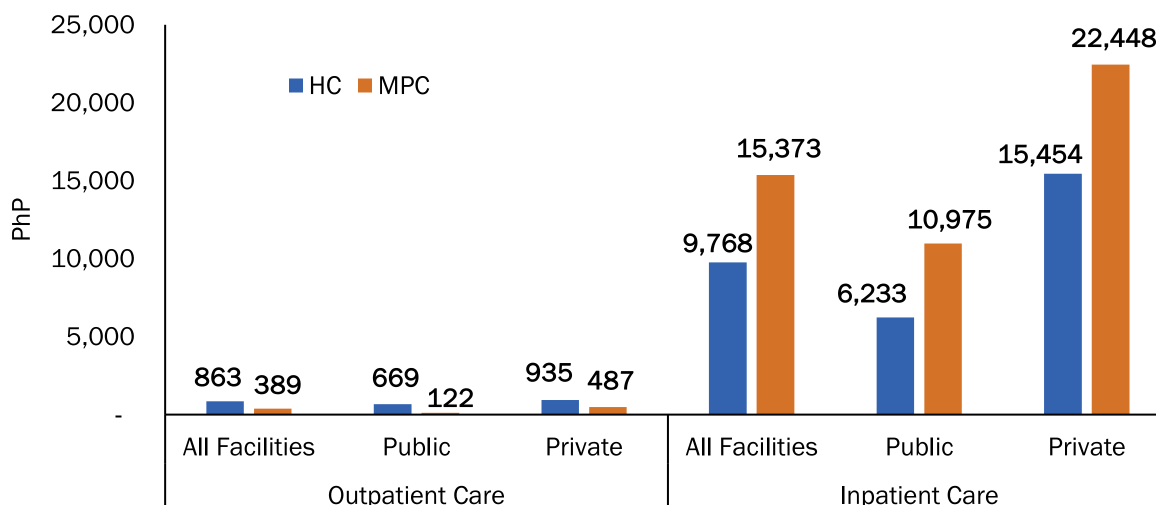
- Respondent visited a health facility in the last six months for outpatient or inpatient care
- Respondent was able to recall the total bill charged by the facility for the care event
- Respondent provided informed consent for collection of their patient records from the referenced health facility
- Matched MPC records were available: that is, reason for visit, final diagnosis, and date of visit consistent between HC and MPC data
- Matched MPC records had complete cost component information for the health visit

Thus, from the sample of 3,639 validated outpatient and 716 inpatient events, this section uses only the HC-MPC matched samples with complete information on 1,040 outpatient and 112 inpatient visits.

5.1 Average Charges for Care at Health Facilities

Figure 5.1 shows the average total billed amount (PhP) per visit for outpatient and inpatient care as reported by individuals in the HC survey and collected during the MPC. “Total billed” refers to the peso amount associated with services provided by the facility, including all deductions or discounts offered to the individual.

Figure 5.1. Average Billed Amount for Provided Healthcare Services, by Facility Ownership Type



Outpatient care. As shown in Figure 5.1, the average total billed per outpatient visit reported by individuals in the HC survey across all facility types (PhP 863) was more than the twice the MPC-validated amount (PhP 389). As expected, the average total billed in private facilities was higher than the amount billed by public healthcare providers in both HC and MPC results. The household results showed that private provider outpatient care was 1.4 times more costly than the care obtained from public facilities, but MPC-validated results indicated that the average billed amount for private provider outpatient care was four times the amount charged by public facilities.

Inpatient care. The average total billed of confinement cases reported by households in the HC survey was only two-thirds (PhP 9,768) of the total bill validated by the MPC (PhP 15,373) (see Figure 5.1). In both facility ownership groups, the MPC average total billed was higher than the recalled amount during the household survey. This difference may reflect household respondents remembering and reporting only the amount they actually paid directly to the facility. Because the HC survey relied on recall or knowledge of the breakdown of charges and payments, discounts, and amounts subsidized by other payment sources, such as PhilHealth and medical assistance programs, household members may not have reported these data or may have recalled them incorrectly.

As with outpatient visits, the average total billed for confinement was higher for care obtained from private hospitals than that provided by public facilities. This finding is not surprising, because professional fees, treatments and procedures, room and board, and other user fees are generally more expensive in private facilities. The 2017 DHS reported that individual payments for inpatient care at private facilities cost almost three times that of care at public facilities. Based on HC survey responses, the cost of obtaining inpatient care from private facilities was 2.5 times the cost of publicly provided care. The validated MPC records showed that the average total billed in private hospitals was twice the amount billed by public providers of confinement care.

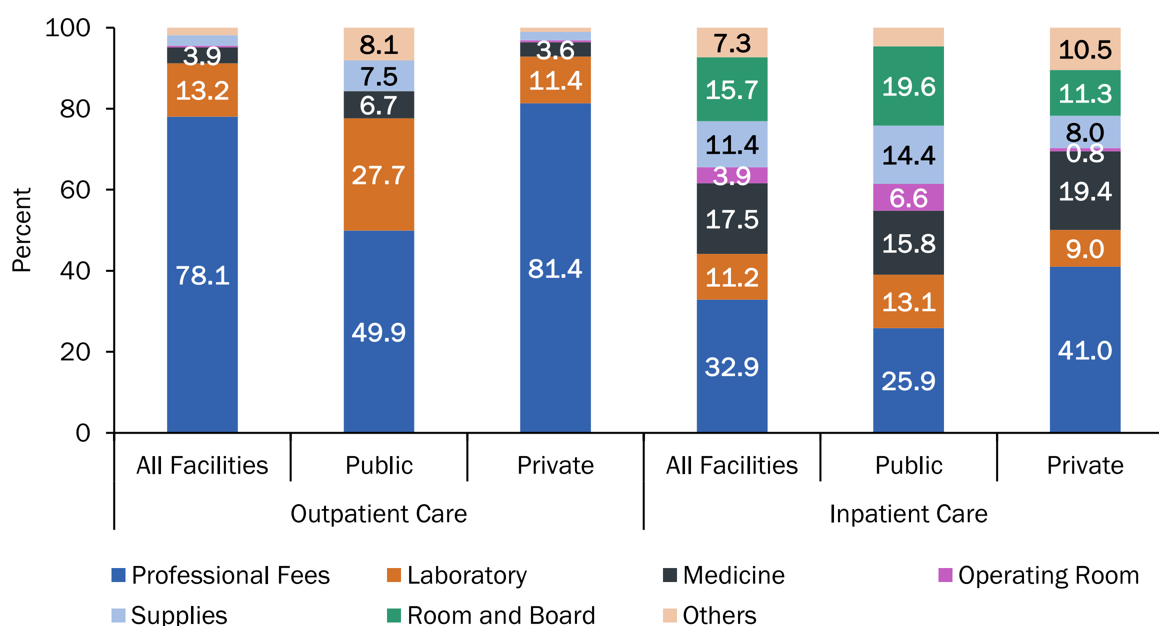
5.2 Cost Components

The NHES also collected information on the breakdown of charges for cost components of each health event, including the following:

- Professional fees for physicians, specialists, and other healthcare workers who assisted during care
- Surgical procedures, including the use of an operating room
- Diagnostic and laboratory procedures—laboratory test, sonogram or ultrasound, x-ray, mammogram, magnetic resonance imaging (MRI) or computerized axial tomography (CAT) scan, electrocardiogram (ECG or EKG), electroencephalogram (EEG), vaccination, and other diagnostic tests
- Medicines—all drugs prescribed and bought during the health visit were included; however, in the case of inpatient care, drugs that the patient took home, i.e., medicines prescribed during discharge that were to be continued at home, were not included in the estimation of total expenditure
- Medical equipment and supplies
- Other medical services, such as blood banks, dietary services, issuance of medical certificate, among others
- Room and board, including private room (e.g., small private, large private, large premium, suite, and presidential suite), semi-private room, charity room, intensive care unit, neonatal intensive care unit, labor room, high-risk pregnancy unit, Lamaze room, among others

Using health facility records data gathered during the MPC survey, Figure 5.2 presents the average share of each cost component allotted to the total billed amount for outpatient and inpatient care by facility ownership type. Because Figure 5.2 presents shares of the average total billed, health events with zero total charges are excluded. Thus, 328 of the 1,040 outpatient records (210 public and 118 private facility patients) and 31 out of the 112 inpatient cases (25 public and 6 private hospital patients) used in Figure 5.1 were not included in the analysis of cost component shares of the total billed. Implications of NHES cost component results are discussed Box 5.2.

Figure 5.2. Average Billing Share by Cost Component and Facility Ownership Type



Outpatient visits. As shown in Figure 5.2, 78.1% of the total billed consisted of the professional fees of the physicians and other healthcare providers who assisted in the outpatient care. The share of professional fees was higher (81.4%) in private facilities than with public providers (49.9%). The next largest cost component for outpatient care was diagnostic and laboratory tests; at public facilities, the share of these tests (labs) comprised 27.7% of the total billed, whereas the share at private facilities was 11.4%.

Inpatient care. Inpatient care total charges mostly comprised professional fees (32.9%), medicines (17.5%), and room and board (15.7%). As expected, professional fees charged by private hospitals comprised a greater share (41.0%) compared to those at public facilities (25.9%). Curiously, records from public hospitals showed that 26.2% of the total billed was for the use of operating rooms and room and board, whereas these costs constituted only 12.1% of total charges at private facilities.

Box 5.2. Implications of NHES Results in Calibrating Regulations for Pricing and Provision of Health Services and Commodities

The Department of Health has acknowledged that the government has no mechanism to regulate professional fees, and existing laws and programs are insufficient to address the high cost of medical services and commodities in the country (DOH, 2018a). Although professional fees in public facilities were only two-thirds of the amount billed by private providers (Figure 5.2), unpredictable user fees in health facilities in general contribute to high household spending for healthcare or unforeseen medical expenses. To address this issue, the Department of Health has proposed a review and revision of existing laws and the national fee schedule for goods and services as part of its mandate as the primary implementing agency of the Universal Health Care Act (DOH, 2018a). NHES data—with its detailed information on the cost of care components, including for specific diseases—can help calibrate the proposed national fee schedule for services and commodities.

Existing policies or programs that regulate medical services and commodities:

- *Generics Act of 1988 (R.A. 6675)*—An act to promote, require, and ensure the production of an adequate supply, distribution, use, and acceptance of drugs and medicines identified by their generic names.
- *Price Act of 1992 (R.A. 7581)*—An act mandating the Department of Health as the lead agency in identifying and monitoring essential drugs.
- *Executive Order (EO) 49, s. 1993*—An order directing the mandatory use of the Philippine National Drug Formulary as the basis for the procurement of drug products by the government.
- *Universally Accessible Cheaper and Quality Medicines Act of 2008/Cheaper Medicines Act (R.A. 9502)*—An act to promote and ensure access to affordable, quality drugs and medicines.
- *Botika ng Bayan and Botika ng Barangay*—Drug outlets managed by a legitimate community organization/nongovernment organization, and/or local government unit, with a trained operator and a supervising pharmacist wherein primary, non-prescription generic drugs listed in the Philippine National Drug Formulary, as well as selected prescription drugs, are sold/made available.

6. Healthcare Expenditure

Analyzing health expenditures and financing is critical for developing healthcare policies that are both beneficial and inclusive. Lack of financial resources is a barrier to seeking care, especially in lower-income countries. In the Philippines, PhilHealth—the country's social health insurance program—gives financial risk protection to its members by providing access to free and/or subsidized healthcare services. Since its inception in 1995, PhilHealth has expanded its coverage to make healthcare more accessible, especially for the poor, through its indigent program, and for people 60 years of age and over through its senior citizen program. PhilHealth also has expanded benefits packages to include catastrophic health conditions—those that trigger prolonged hospitalization and very expensive treatments (Z Benefit Package), for instance.

This section describes health expenditure and financing in the Philippines, focusing on how much households are paying OOP for healthcare and what support PhilHealth provides. The results of the MPC survey, including complete information on sources of financing, are analyzed to understand the extent to which households pay for healthcare out of pocket and the support provided by the national government's social health insurance program; these results could have significant policy implications. Again, only the outpatient and inpatient care data are analyzed due to the limited sample for other healthcare events.

6.1 Household Out-of-Pocket Expenditure and PhilHealth Support for Outpatient Care

The expenditure or payment data collected in the NHES refers to the amount paid on behalf of the individual for care received for a specific health event or condition experienced in the six months preceding the NHES. The total bill, as described in Section 5, is not necessarily equal to "total payment," which refers to peso amounts paid by all financing sources for healthcare services provided and may be adjusted based on discounts or other allowances.

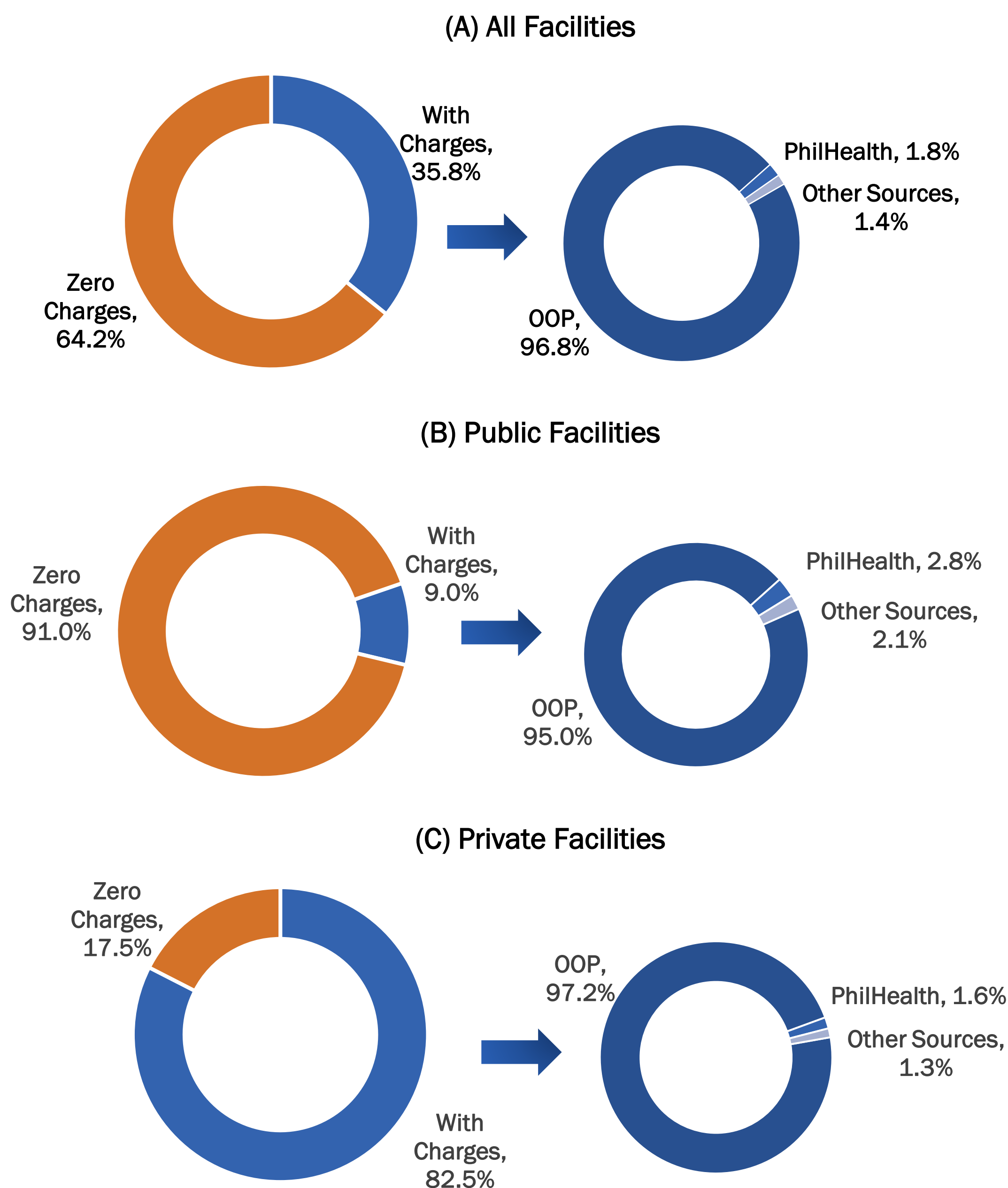
Sources of financing include households' own resources (savings or income); personal loans (including from agencies such as the Pag-IBIG Fund, Social Security System, and Government Service Insurance System, or loans from family members not living within the same household); donations or gifts from charities; transfers, donations, or gifts from the local government; Philippine Charity Sweepstakes Office; and insurance (PhilHealth, private insurance/HMO, Social Security System, Government Service Insurance System, and other sources). Out-of-pocket is defined as the sum of the payments made using household resources (savings or income), personal loans, and sale of properties.

Figure 6.1 presents the proportion of outpatient cases that incurred any charge and, of those that had charges, the proportion of the total bill paid OOP, by PhilHealth, or by other sources.[13] Panel A shows the data for all facilities; panels B and C display the results for public and private providers, respectively. Overall, two-thirds (64.2%) of outpatient care validated by the MPC survey was provided by facilities free of charge (Figure 6.1, panel A). Nine out of ten outpatient care visits to public clinics and hospitals (91.0%) had zero recorded charges (panel B), whereas only 17.5% of such visits were free of charge at private healthcare institutions (panel C). Overall, of the outpatient visits for which there were

[13] If there are no charges for the healthcare visit, OOP is zero.

charges (35.8%), 96.8% were financed primarily using OOP resources.[14] The PhilHealth share of the total bill was higher for public facilities than private facilities.

Figure 6.1. Proportion of Outpatient Visits with Facility Charges and Average Percentage of Total Bill Paid by OOP and PhilHealth



Number of observations with zero charges: all facilities: 2,283; public: 2,057; private: 226.
Number of observations with charges: all facilities: 1,272; public: 204; private: 1,068.

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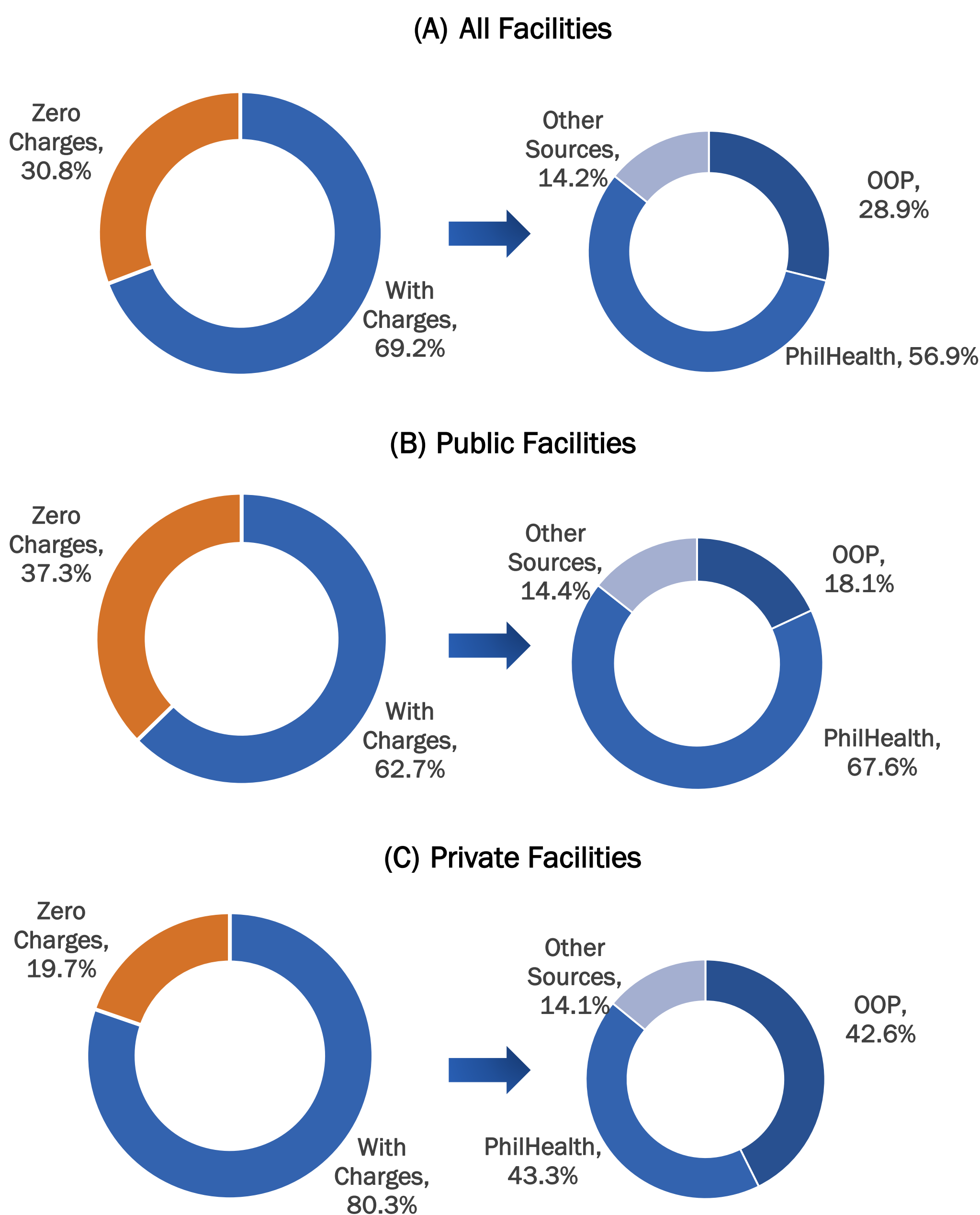
[14] See Annex 2 for a detailed discussion of total charges and payments using the NHES HC sample. The findings in this section for outpatient care are consistent when the full HC is used. See Annex 3 for supplemental analyses of expenditure, charges, and sources of payment using the NHES MPC sample.

6.2 Household Out-of-Pocket Expenditure and PhilHealth Support for Inpatient Care

Figure 6.2 presents the proportion of MPC-validated inpatient care visits that had any charges and the financing sources—OOP and PhilHealth—used to finance the bill for confinement services provided by the facility. As shown in panel A of Figure 6.2, about a third (30.8%) of all MPC-validated inpatient care obtained in the six months preceding the NHES was free of charge. Around one-third (37.3%) of patients in public healthcare institutions used facility services free of any charge (panel B), whereas one in five patients (19.7%) in private hospitals were confined in the facility without any charge (panel C).

Figure 6.2. Proportion of Inpatient Visits with Facility Charges and Average Percentage of Total Bill Paid by OOP and PhilHealth



Number of observations with zero charges: all facilities: 169; public: 129; private: 40.
Number of observations with charges: all facilities: 380; public: 217; private: 163.

Overall, more than half (56.9%) of the total inpatient bill was paid by PhilHealth, whereas OOP resources financed 28.9%.[15] PhilHealth support was greater in public hospitals (67.6%) compared to private facilities (43.3%). With significant PhilHealth support in public healthcare institutions, patient OOP payments were lower (18.1%) compared to private facilities (42.6%).

6.3 Out-of-Pocket Expenditure by Household Member Characteristic

The following section presents OOP payments by household and individual characteristics, merging MPC and HC data, to understand who benefits from free care and who finances care with OOP resources. Tables 6.1 and 6.2 present OOP financing as a percentage of the total bill for outpatient and inpatient care health events.

Table 6.1. Proportion of Outpatient Care Visits with OOP and Proportion of Total Bill Financed by OOP

Category	Household Member Characteristic	All Facilities		Public		Private	
		% with OOP	Among those with OOP, % OOP to total bill	% with OOP	Among those with OOP, % OOP to total bill	% with OOP	Among those with OOP, % OOP to total bill
Total	**–**	**35.7**	**98.9**	**8.9**	**99.6**	**80.8**	**98.8**
Insurance	Uninsured	32.9	99.7	7.7	99.2	84.0	99.8
	PhilHealth	37.4	98.4	9.9	99.9	78.4	98.1
	Private	*	–	*	–	*	–
Age	Under 5	24.1	99.7	5.0	100.0	80.7	99.6
	5–17	45.1	99.9	15.6	100.0	87.0	99.8
	18–44	33.5	99.5	8.6	98.9	79.2	99.7
	45–59	44.0	99.5	11.8	100.0	78.6	99.4
	60 and over	45.7	96.1	11.0	99.4	79.8	95.7
Monthly household expenditure (PhP per capita)	0–1,499	21.6	99.6	8.0	100.0	78.2	99.4
	1,500–2,099	28.8	99.7	7.0	100.0	79.4	99.6
	2,100–2,899	35.9	99.4	7.7	100.0	82.2	99.3
	2,900–4,199	42.5	98.9	11.6	98.7	82.3	99.0
	4,200+	51.1	97.8	11.7	99.5	80.1	97.6
4Ps beneficiary	Non-beneficiary	36.0	98.9	8.7	99.6	80.9	98.8
	Beneficiary	30.1	99.4	11.7	100.0	78.5	99.1

* Insufficient number of observations.

[15] Annex 2 shows that NHES households recalled paying 86.5% of inpatient care expenditures using OOP resources.

Table 6.2. Proportion of Inpatient Care Visits with OOP and Proportion of Total Bill Financed by OOP

Category	Household Member Characteristic	All Facilities		Public		Private	
		With OOP	Among those with OOP, % OOP to total bill	With OOP	Among those with OOP, % OOP to total bill	With OOP	Among those with OOP, % OOP to total bill
Total	**–**	**33.7**	**58.6**	**17.8**	**60.5**	**59.0**	**57.7**
Insurance	Uninsured	32.8	75.6	18.0	76.2	65.6	75.3
	PhilHealth	34.1	52.0	18.0	52.9	56.9	51.6
	Private	*	–	*	–	*	–
4Ps Beneficiary	Non-beneficiary	34.2	59.6	18.0	62.4	59.4	58.2
	Beneficiary	26.6	40.3	16.0	32.0	51.9	46.4

* Insufficient number of observations.

Among those who sought outpatient care, OOP payments did not differ by insurance coverage. This finding was expected, as few outpatient care events are covered by PhilHealth case rates. Outpatient visits for children under five years of age were more often free of charge, particularly in public facilities, in which only 5.0% of visits had OOP payments.

The proportion of outpatient visits with OOP payments increased with per capita monthly household expenditure level: only 21.6% of those with less than PhP 1,500 per capita household expenditure had an OOP expense, but more than half in the top quintile had to pay using their own resources. Although there was a large discrepancy between household expenditure groups in the proportion of outpatient visits with an OOP expense, all visits with facility charges entailed paying more than 90% of total payments using household finances, regardless of the household's monthly expenditure level.

About 1 out of 10 patients (8.9%) who obtained outpatient care at public facilities had OOP payments regardless of their 4Ps or conditional cash transfer program beneficiary status (Table 6.1). Similarly, around 80% of patients (program beneficiaries or not) who visited private facilities paid OOP.

As shown in Table 6.2, the proportion of inpatient care visits to private facilities partly or fully financed using OOP resources was much higher, at 59%, compared to only 17.8% of inpatient care events in public hospitals with OOP expenses. Among patients with OOP expenditure, the share of the total bill paid using their own resources was the same for both types of facilities, at around 60%.

The share of inpatient care events financed by OOP resources did not differ much between PhilHealth members and those who were uninsured when confined in a public hospital (18%). More than half of PhilHealth members (56.9%) who used a private facility for inpatient care had an OOP expenditure, but the incidence of OOP payment for confinement was highest among those who were uninsured, at 65.6%. Across facility ownership types, the OOP proportion relative to the total bill was lower among PhilHealth members than for the uninsured. This finding may imply that although PhilHealth may not fully prevent a patient from paying OOP during confinement, it may reduce the financial burden.

Although 4Ps beneficiaries had a lower share of OOP to total bill compared to non-beneficiaries, 16% of inpatients still incurred OOP expenditure in public hospitals. Among 4Ps beneficiaries who utilized private facilities, about half of the confined patients financed their hospital bill partially or fully with OOP resources.

The significant share of household OOP in health expenditure highlights the shortcomings of the National Health Insurance Program in reducing the financial burden of using healthcare services. Other studies (DOH, 2018a; Dayrit et al., 2018; PhilHealth, 2019a) have identified some of the reasons for household OOP spending on healthcare. Although these reasons were not probed during the NHES, the following observations warrant further analysis:

- Limited PhilHealth financing for outpatient services and medicines contributes to high household OOP expenditure for outpatient visits, highlighting the need for a more comprehensive outpatient benefits package.
- Pricing for health services and goods remains unregulated in the country (DOH, 2018a), resulting in unpredictable and high user fees in health facilities. This observation may also explain why household OOP spending is not lower among indigent PhilHealth members. As reported by PhilHealth (2019a), the three main causes of OOP expenses are medicines, medical supplies, and laboratory and diagnostics services.
- The current service delivery system in the country lacks a gatekeeping mechanism at the primary level of care (DOH, 2018a; Dayrit et al., 2018). The limited capacity of primary healthcare facilities, such as barangay health stations or health centers, to provide basic healthcare services due to poor maintenance, understaffing, and lack of equipment has led to them being bypassed. The result is an influx of patients to hospitals, which provide more expensive services (DOH, 2018a; Dayrit et al., 2018). The Department of Health has proposed assigning families to primary care providers who will serve as their first touchpoint in the healthcare system. Aside from promoting primary care, it is also part of the mandate of primary care providers to facilitate timely referrals to higher-level health facilities as needed. In this way, patients can avoid unnecessary visits to secondary or tertiary facilities and the corresponding spending for non-essential services and commodities.

Additionally, the NHES results show that respondents' knowledge of PhilHealth coverage was low relative to the coverage rate reported by PhilHealth and the Philippine Statistics Authority (see Section 3.2). Limited knowledge or awareness of PhilHealth coverage, membership, or benefits, especially among those automatically enrolled into the National Health Insurance Program (i.e., indigents and senior citizens), may result in non-use of insurance benefits during health facility visits.

7. Financial Protection

Financial protection is the primary pillar of universal health coverage. In 2019, the Universal Health Care Act was enacted to guarantee equitable access to quality and affordable healthcare for all Filipinos. As detailed in Section 6, out of pocket spending for health constitutes a significant portion of health spending. Monitoring financial protection against catastrophic or economically crippling health expenditures is necessary to ensure that alternative sources of payment are available and accessible to those who need them most, such as the indigent and senior citizens.

This section presents a key indicator of financial protection—catastrophic health expenditure. It also assesses PhilHealth's No Balance Billing Policy, a program created to provide financial protection to the vulnerable segments of society.

7.1 Catastrophic Health Expenditure

Catastrophic health expenditure (CHE) is defined as OOP health spending that exceeds a certain proportion of a household's expenditure, with the possible consequence that the household will suffer financial hardship and subsequent impoverishment. It is calculated as an incidence: the proportion of households (or individuals) for which a health event's OOP is greater than a threshold of household total expenditure. Thresholds of 10% and 25% are used in this report to align with standard practice (e.g., Sustainable Development Goal 3.8.2 and Wagstaff et al., 2019).

The incidence of CHE is low overall: only 0.8% of all individuals have OOP health spending greater than 10% of total household expenditure. At the 25% CHE threshold, 0.4% of individuals have OOP spending that is greater than 25% of total household expenditure (Figure 7.1). At both thresholds, incidence of CHE is higher among PhilHealth members and populations 60 years of age and above.

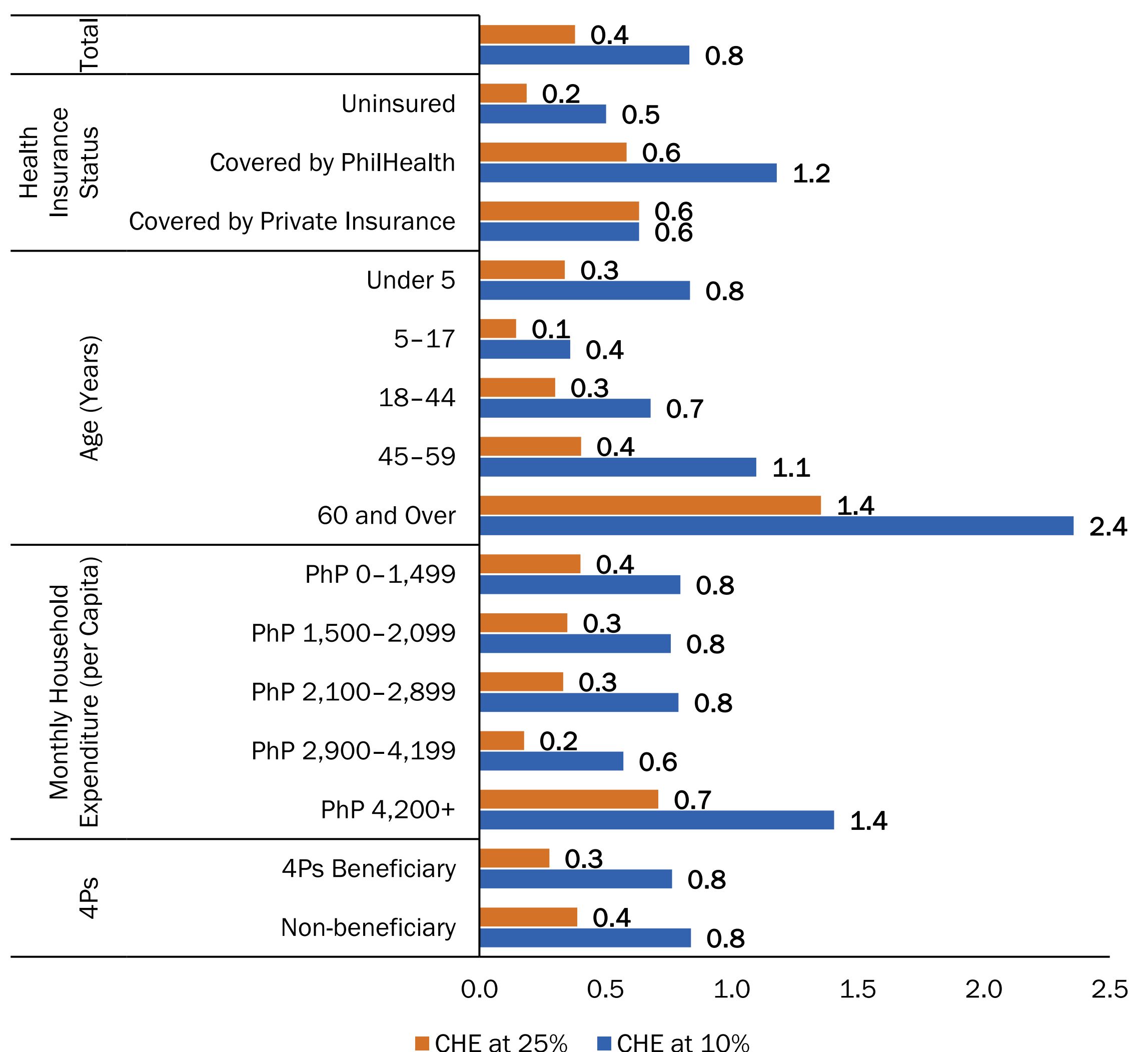
Individuals who reported PhilHealth coverage had a higher incidence (1.2%) of CHE (10% threshold) than those with private insurance (0.6%) or no reported insurance (0.5%). As described in Section 4.4 (Healthcare Utilization), uninsured people sought care at facilities less often than insured individuals.

The incidence of CHE was highest among those 60 years of age and over (2.4%), a group that should be automatically enrolled in PhilHealth's senior citizen program if they are not already lifetime members. Similarly, 4Ps beneficiaries had the same incidence of CHE (0.8%) as those who were not beneficiaries at the 10% CHE threshold (see Box 7.1). Individuals who qualify for these PhilHealth and Department of Social Welfare and Development support programs are considered more vulnerable because they are older or lack a viable source of income. They are automatically enrolled into PhilHealth and should receive free services under the No Balance Billing Policy; however, they still were experiencing CHE.

The incidence of CHE decreases with increasing household expenditure until the fourth quintile, after which it increases significantly (Figure 7.1). To illustrate, the incidence of CHE drops from 0.8% at the lowest quintile to 0.6% at the fourth and jumps to 1.4% for households with expenditure of PhP 4,200 or greater. The high incidence of CHE among individuals from households with higher per capita expenditure could be explained by the utilization of healthcare from private and possibly expensive institutions. As shown in Annex 1, Table S4.7 and described in Section 4, these individuals had the highest use rate of private

clinics (18.1%), private hospitals (20.9%), and pharmacies (54.2%) for illnesses that had occurred in the previous six months.

Figure 7.1. Incidence of Catastrophic Health Expenditure



Box 7.1. Subsidies for 4Ps Beneficiaries May Not Be Enough to Prevent Catastrophic Health Expenditure

Ideally, 4Ps/conditional cash transfer beneficiaries can access needed care from public health centers free of charge and use the health grant (PhP 500 per month before 2020) for commodities unavailable at the facility or other visit-related expenses, such as travel costs. However, the same incidence of CHE among 4Ps beneficiaries and non-program beneficiaries may indicate that the health grant is insufficient to cover expenses during facility visits for the former.

NHES results indicate that 4Ps beneficiaries spent an average of PhP 1,377 per visit OOP—three times the amount covered by PhilHealth (PhP 442) and more than twice the amount of the 4Ps health cash grant. The large gap for the vulnerable population between household OOP spending and government support, either from PhilHealth or the Department of Social Welfare and Development, indicates a need to recalibrate the health subsidy.

Table 7.1 presents incidence of CHE among households with members who accessed outpatient and inpatient care in the six months preceding the interview. Among those who utilized outpatient care, incidence of CHE was 1.6% using the 10% threshold (i.e., the OOP expenditure for care was greater than 10% of the household total expenditure for 1.6% of individuals from households with at least one outpatient care event in the last six months). At the 25% threshold, the CHE incidence was 0.4% of households. Among households with inpatient care utilization, being confined in a healthcare facility led to catastrophic OOP expenses in one of every three households (30.4%) using the 10% CHE threshold. At the 25% CHE level, almost one out of five (15.4%) households experienced catastrophic expenses due to inpatient care health events.

Table 7.1. Incidence of CHE, among All Households with at Least One Outpatient or Inpatient Care Visit

Category	Household Member Characteristic	Outpatient Care			Inpatient Care		
		Incidence of CHE (10%)	Incidence of CHE (25%)	No. of House-holds	Incidence of CHE (10%)	Incidence of CHE (25%)	No. of House-holds
Total	**–**	**1.64**	**0.42**	**4,291**	**30.37**	**15.40**	**946**
Reported insurance coverage	Uninsured	1.76	0.51	696	29.95	9.03	79
	Covered by PhilHealth (at least one in household)	1.58	0.49	3,253	30.27	15.60	814
	Covered by private insurance (at least one in household)	*	*	*	*	*	*
PhilHealth member (at least one in household)	Paying members	1.55	0.58	1,906	31.99	16.37	452
	Sponsored or indigent	1.59	0.38	1,930	30.34	16.73	527
	Lifetime members	2.14	1.01	85	35.67	14.35	18
	Senior citizen program	2.28	0.64	839	35.94	22.29	219
	Other types of programs	*	*	*	*	*	*
	Don't know type of program	*	*	*	*	*	*
Monthly per capita household expenditure (PhP)	0–1,499	2.31	0.91	1,007	27.45	14.70	250
	1,500–2,099	1.72	-	781	31.14	19.08	178
	2,100–2,899	1.54	0.50	918	28.86	12.25	196
	2,900–4,199	1.06	0.12	810	20.11	6.45	162
	4,200+	1.48	0.43	775	45.29	24.80	160
4Ps beneficiary	Beneficiary	0.90	-	314	24.45	12.39	74
	Non-beneficiary	1.70	0.45	3,977	30.85	15.65	872
Residence	Rural	1.75	0.42	2,013	29.65	15.19	493
	Urban	1.56	0.42	2,278	31.07	15.60	453

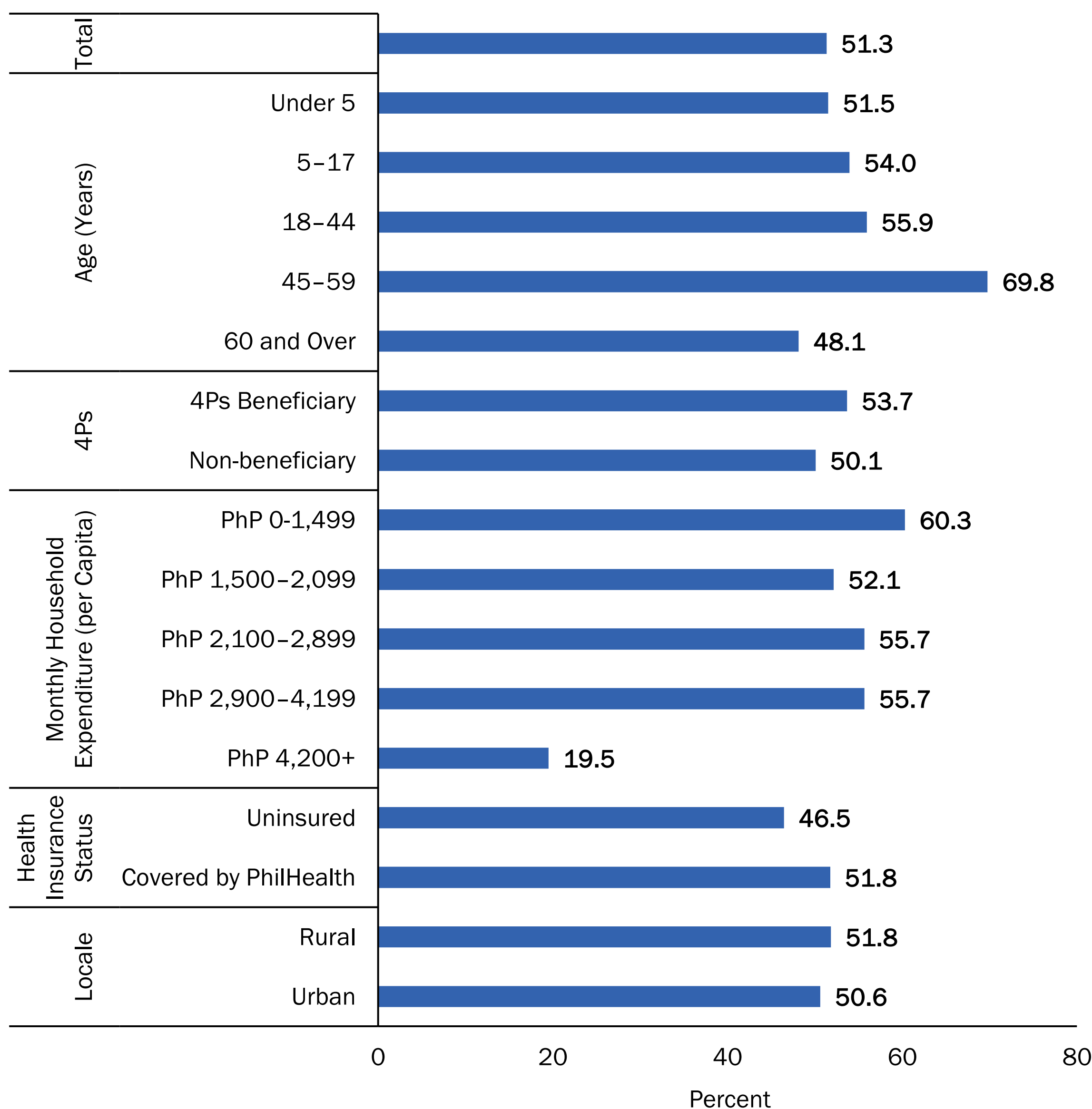
* Cells with less than 50 observations are not presented in this report.

7.2 No Balance Billing Policy

The No Balance Billing (NBB) Policy is a PhilHealth program that enables vulnerable sectors of the population, such as the poor and elderly, not to pay anything in excess of their PhilHealth coverage when confined in government facilities. That is, their treatment and care are entirely free at public facilities.

For this analysis, eligible NBB beneficiaries included those who self-identified as beneficiaries of the 4Ps and those 60 years of age and over who used public hospitals for inpatient care. Using these qualifications, around 15% of inpatient care visits in the last six months were deemed eligible to benefit from the NBB program. Figure 7.2 shows the proportion of eligible individuals who utilized inpatient care at public hospitals and were covered by the NBB—i.e., they did not incur any OOP expenditures for the care received.

Figure 7.2. Percentage of NBB-Eligible Inpatient Cases with No Reported OOP Expenditure



Note: No privately insured household members in the NHES sample were NBB eligible.

Overall, only about half (51.3%) of eligible cases fully benefited from the NBB policy (i.e., 51.3% of eligible individuals did not make any OOP payments for inpatient care received at public hospitals). As expected, the rate was higher among those dwelling in rural areas (51.8%), where a larger share of the indigent population lives; the lowest spending quintile (60.3%); and those informed about their PhilHealth membership (51.8%). These groups constituted some of the ones targeted by the program. Surprisingly, a large proportion of the elderly, who should benefit more from the NBB program, still paid OOP for their NBB-eligible care events (48.1%). These results imply that even though 4Ps beneficiaries and the elderly should automatically be covered by the NBB program when confined in a public healthcare facility, half of them did not benefit from the free hospital services and medicines due to them. In future surveys and analysis, it is recommended to determine whether these discrepancies are due to the assessment process done at the facility level, including the documentation requirements (e.g., certificate of indigency) expected from patients. For the elderly, it is also possible that non-indigents were unable to use NBB benefits.

This high incidence of non-utilization of NBB benefits among the program's target groups could also be explained by the limited financial protection the program provides for actual healthcare spending. The 2019 National Health Accounts report (PSA, 2020b) shows that the elderly and the poor recorded high healthcare spending in 2019. According to the document, those 65 years of age and over had the highest healthcare spending (13.7%) in 2019 compared to other age groups. Meanwhile, the poorest sector of the population—i.e., the first income quintile group—registered the second highest health spending, at 18.3% share, constituting half of the health spending among the fifth quintile group. However, PhilHealth's subsidy for confinements is fixed and limited to the amount in the case rate packages, which may not be sufficient to cover all medical expenses, even in public hospitals (as discussed in Section 6). Although public health facilities are instructed not to charge beyond the amount of the case rate packages, professional fees and costs for medicines and procedures are not regulated (as explained in DOH, 2018a) and could lead to OOP spending.

8. Quality of Care and Patient Experience Issues

Patient experience is as important as effectiveness and safety in providing healthcare. Positive patient experience is associated with important clinical processes and beneficial health outcomes, such as greater self-management skills, better quality of life, and greater adherence to medical advice and treatment plans (Agency for Healthcare Research and Quality, 2017).

This section presents two indicators related to quality of care and patient experience. The first presents the quality of service patients received in the healthcare facility; the second indicator describes the top issues patients encountered during their health facility visit. Each household member who visited a healthcare facility for outpatient or emergency care in the last six months was asked to describe any issue they encountered in their last visit to the clinic or hospital. If the patient did not report any negative issue, they were then asked to describe the positive experience during the facility visit. If an individual had at least one outpatient or emergency care visit with a public and private provider, they were asked to describe both healthcare visits. For inpatient care utilization, all events in the past 12 months were included in the patient satisfaction survey questions.

Positive experience with facility. Across all care types, more than half of all patients reported a satisfactory experience with the provider (Table 8.1). Among those who had a positive experience, the following qualities were highlighted: good services received (41.1% public, 37.4% private), immediate assistance (17.5% public, 18.1% private), and kind and accommodating staff (16.6% public, 19.6% private).

Overall, positive experiences were more frequently reported by individuals who accessed care in private facilities (69.7%) than those who accessed care in public facilities (58.1%). Among those who sought care in private facilities, positive experiences were more often reported among inpatient care clients (74.4%) than outpatient care (68.8%) and emergency care clients (59.3%). Similarly, patients in public facilities reported more positive experiences in inpatient care (60.2%) than outpatient (57.8%) and emergency care (53.6%).

The discrepancy between inpatient and emergency care experiences (15.1 percentage points for private facilities) may reflect a possible lack of continuity in the quality of care provided. This issue could be further explored in future studies. Currently, literature on good practices regarding patients' experiences in Philippine settings is limited or not readily accessible (HRH2030/Philippines, 2019; Doroteo et al., 2020). To fill in this gap, USAID's Human Resources for Health 2030 Philippines project has developed a patient experience framework and assessment tool based on cross-case analysis of patient experience practices of 10 healthcare providers—primary healthcare facilities and hospitals in the City of Manila and nearby areas. One finding of the study was that personnel from both the primary care facilities and hospitals were able to effectively communicate with the patients and attended to patients' concerns or queries with courtesy (Doroteo et al., 2020).[16] The NHES results presented in Table 8.1 show that positive patient experience could have been driven by the quality of the interpersonal aspect of care received during facility visits. This aspect of care is shown by the comparatively larger proportion of patients who, regardless of type of care received, reported that they were provided with good services or were treated well. Many of

[16] Highlights from each of the 10 case studies are presented in HRH2030/Philippines, 2019.

those who reported positive patient experience also mentioned that facility staff was kind or accommodating.

Table 8.1. Proportion of Household Members Reporting Positive Experience with Facility

Positive Experience Identified	Public Facility				Private Facility			
	All Care	Out-patient Care	Emer-gency Care	In-patient Care	All Care	Out-patient Care	Emer-gency Care	In-patient Care
Total	**58.1**	**57.8**	**53.6**	**60.2**	**69.7**	**68.8**	**59.3**	**74.4**
Accessible/facility is nearby	0.3	0.4	–	–	0.9	0.4	–	3.1
Clean and/or good facilities	8.6	8.2	14.1	9.7	13.4	12.4	12.3	18.0
Complete medicine	0.6	0.6	–	0.4	0.2	0.3	–	–
Doctors are good/staff are skilled or competent	1.4	1.4	5.5	1.1	3.1	3.4	2.2	1.8
Easy to request meds	0.4	0.5	–	–	0.1	0.1	–	–
First come, first served	0.1	0.1	–	–	0.0	0.0	–	–
Free services and/or medicines	4.9	5.5	2.2	2.3	1.2	1.2	2.3	1.1
Immediately assisted/fast service/no long lines	17.5	18.7	10.4	12.2	18.1	19.0	13.7	14.4
Inexpensive services and/or medicines/discounted services and/or medicines	0.4	0.3	–	1.0	1.2	1.4	–	0.3
Just okay/no comment	13.1	13.4	9.7	12.2	12.4	11.9	15.9	14.4
Kind/accommodating staff	16.6	15.7	16.7	21.3	19.6	19.5	7.6	21.3
Services are good/treated well in the facility	41.1	40.1	52.0	45.1	37.4	37.1	57.9	36.8
Well-equipped facility	0.8	0.7	–	0.9	1.0	1.1	4.0	0.5
With privileges and benefits available (i.e., priority lane)	0.5	0.5	–	0.6	0.5	0.5	–	0.2

To ensure a more "responsive health system" as part of its commitment to achieve the goals of the Universal Health Care Act, the Department of Health will use client feedback to assess and monitor the quality of health goods and services, and the manner by which they are delivered to the population (DOH, 2018a).[17] However, data sources and baseline data on client feedback, which will be evaluated through client satisfaction and provider responsiveness, were not identified in the National Objectives for Health 2017–2022, the latest policy master plan for the Department of Health. This could be attributed to lack of data. Results on patient experience from the Human Resources for Health 2030 Philippines case studies and the NHES could inform future research to address this limitation.

[17] The goal for a "responsive health system" is referred to as Strategic Goal 2 of the *FOURmula One Plus for Health* strategy in the National Objectives for Health 2017–2022.

Top issues encountered during health facility visits. The topmost issue reported by patients in both public and private facilities was the long waiting time: 23.0% for public and 18.5% for private facilities. The highest proportion was reported by emergency care patients (27.5% private; 33.8% public) (Table 8.2).

The next most common issues varied between public and private facilities. In public facilities, the top issues after long waiting time were insufficient supply of medicines (13.2%); insufficient stocks of medical supplies (11.5%); understaffing (5.3%); and insufficient or malfunctioning equipment (4.6%). In addition, emergency care patients in public facilities also complained of inexperienced staff (6.3%) and expensive fees (5.4%). In private facilities, after long waiting time, the next most common issues were expensive fees (4.6%) and insufficient supply of medicines (4.5%) and supplies (3.5%), especially in emergency care (5.7%).

Table 8.2. Top Issues Encountered during Health Facility Visits

Issues Identified	Public Facility				Private Facility			
	All Care	Out-patient Care	Emer-gency Care	In-patient Care	All Care	Out-patient Care	Emer-gency Care	In-patient Care
Long waiting time to receive care needed	23.0	23.0	33.8	21.1	18.5	18.9	27.5	15.1
The health facility is understaffed	5.3	5.1	10.3	5.5	2.4	2.4	3.3	2.5
The health facility's staff are inexperienced	1.7	1.4	6.3	2.1	0.7	0.8	2.2	0.1
The health facility's staff are uncaring or rude	2.0	2.1	2.7	1.6	1.0	1.0	1.4	0.9
There is unfair treatment among clients	3.6	3.6	4.5	3.2	1.5	1.4	4.7	1.8
The health facility's supply of medicines is insufficient; needed to buy medicines outside the facility	13.2	13.9	5.3	10.2	4.5	4.6	7.4	3.8
There is a medical supplies shortage or insufficiency; needed to buy supplies outside the facility	11.5	12.1	7.8	8.8	3.5	3.8	5.7	2.0
Their equipment is insufficient and/or malfunctioning; needed to utilize procedures/ services outside the facility	4.6	4.6	4.7	4.3	1.5	1.6	2.6	1.1
The facility's environment is poor or dirty	1.2	1.1	–	2.1	1.0	1.1	2.2	–
They charge too much expensive; services were too expensive	1.8	1.8	5.4	1.5	4.6	4.5	2.5	5.0
They required under-the-table payment	0.3	0.3	1.9	0.4	0.1	0.1	–	–
Other issues, problems	1.3	1.1	0.6	2.5	0.9	0.7	–	1.8
Number of observations	**5,621**	**4,649**	**131**	**841**	**3,101**	**2,549**	**55**	**497**

Issues were reported for both public and private facilities, but a higher proportion of non-satisfactory experiences were reported in public facilities. For both facility types, long waiting time was the primary concern. Also, the quality of emergency room care seemed to be poorer in both facility types, as was evident in the higher proportion of issues reported compared to the other types of care.

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Annex 1. Supplementary Tables

Table S3.1. Educational Status

Characteristic		Educational Status				Number of Persons
		No Education/ Incomplete Primary	Complete Primary/ Incomplete Secondary	Complete Secondary	Post Secondary	
Sex	Male	32.1%	27.6%	18.2%	22.1%	22,707
	Female	29.4%	26.4%	19.7%	24.5%	22,479
	Total	30.7%	27.0%	18.9%	23.3%	45,186
Age (years)	5–17	63.6%	34.8%	0.8%	0.9%	13,276
	18–44	10.7%	24.5%	27.2%	37.6%	19,605
	45–59	21.2%	22.1%	29.5%	27.2%	7,285
	60 and over	37.9%	24.3%	18.7%	19.2%	4,838
	Total	30.7%	27.1%	19.0%	23.2%	45,004
Monthly Household Expenditure (per capita)	PhP 0–1,499	40.4%	30.5%	16.0%	13.1%	12,330
	PhP 1,500–2,099	33.5%	29.5%	19.9%	17.1%	9,106
	PhP 2,100–2,899	29.3%	27.3%	21.0%	22.3%	9,346
	PhP 2,900–4,199	25.2%	24.6%	19.9%	30.3%	8,084
	PhP 4,200+	18.6%	20.1%	18.9%	42.3%	6,320
	Total	30.7%	27.0%	18.9%	23.3%	45,186
Membership in Pantawid Pamilyang Pilipino Program (4Ps)	Non-beneficiary	30.0%	26.0%	19.4%	24.6%	41,226
	Beneficiary	38.7%	38.7%	14.1%	8.4%	3,960
	Total	30.7%	27.0%	18.9%	23.3%	45,186
Employment Status	Unemployed/not looking for work/ student	16.8%	37.2%	21.6%	24.4%	16,450
	Informal sector	22.5%	24.9%	29.1%	23.6%	10,010
	Formal sector	8.6%	15.9%	25.3%	50.2%	7,503
	Total	16.6%	28.8%	24.6%	30.0%	33,963
Locale	Rural	35.4%	29.2%	18.2%	17.2%	22,408
	Urban	26.7%	25.2%	19.6%	28.6%	22,778
	Total	30.7%	27.0%	18.9%	23.3%	45,186

Table S3.2. Employment Status

Characteristic		Employment Status*			Number of Persons
		Unemployed/ Not Looking for Work/Student	Informal Sector	Formal Sector	
Sex	Male	33.1%	37.5%	29.4%	16,877
	Female	63.6%	20.8%	15.6%	17,228
	Total	48.5%	29%	22.4%	34,105
Age (years)	5–17	97.3%	1.7%	1.0%	2,816
	18–44	43.9%	27.2%	28.9%	19,242
	45–59	32.1%	44.8%	23.1%	7,122
	60 and over	63.5%	29.0%	7.5%	4,740
	Total	48.5%	29.0%	22.4%	33,920
Monthly Household Expenditure (per capita)	PhP 0–1,499	52.3%	30.5%	17.3%	8,651
	PhP 1,500–2,099	50.7%	28.7%	20.7%	6,668
	PhP 2,100–2,899	48.1%	30.0%	21.9%	7,157
	PhP 2,900–4,199	47.1%	27.4%	25.5%	6,367
	PhP 4,200+	42.7%	27.8%	29.5%	5,262
	Total	48.5%	29.0%	22.4%	34,105
Membership in Pantawid Pamilyang Pilipino Program (4Ps)	Non-beneficiary	47.5%	29.2%	23.3%	31,595
	Beneficiary	62.7%	27.0%	10.3%	2,510
	Total	48.5%	29.0%	22.4%	34,105
Educational Status	No education	64.3%	26.8%	9.0%	348
	Incomplete primary	48.2%	40.1%	11.8%	5,459
	Complete primary	47.5%	40.6%	12.0%	1,797
	Incomplete secondary	65.8%	21.7%	12.5%	8,145
	Complete secondary	42.5%	34.4%	23.1%	8,327
	Vocational course	33.8%	30.2%	36.0%	1,236
	Incomplete college	48.8%	23.3%	27.8%	5,001
	Complete college	28.3%	19.8%	51.9%	3,557
	Total	48.5%	29.1%	22.5%	33,963
Locale	Rural	49.8%	33.5%	16.8%	16,679
	Urban	47.5%	25.3%	27.2%	17,426
	Total	48.5%	29.0%	22.4%	34,105

* Percentages for each characteristic do not equal 100 percent due to rounding.

Table S3.3. Monthly Household Expenditure

Characteristic		Monthly Household Expenditure per Capita (PhP)*					Number of Persons
		0–1,499	1,500–2,099	2,100–2,899	2,900–4,199	4,200+	
Sex	Male	27.2%	20.1%	20.8%	18.3%	13.7%	25,257
	Female	27.2%	19.7%	20.7%	17.8%	14.6%	24,773
	Total	27.2%	19.9%	20.7%	18.0%	14.2%	50,030
Age (years)	Under 5	34.1%	22.3%	20.9%	14.7%	8.0%	4,615
	5–17	31.8%	21.8%	20.1%	16.1%	10.1%	13,337
	18–44	25.3%	20.1%	21.1%	18.8%	14.7%	19,667
	45–59	23.1%	17.4%	20.8%	20.2%	18.5%	7,308
	60 and over	21.8%	15.6%	21.0%	19.8%	21.7%	4,875
	Total	27.2%	19.9%	20.8%	18.0%	14.1%	49,802
Membership in Pantawid Pamilyang Pilipino Program (4Ps)	Non-beneficiary	26.1%	19.5%	20.8%	18.6%	14.9%	45,919
	Beneficiary	40.3%	24.5%	19.5%	10.7%	4.9%	4,111
	Total	27.2%	19.9%	20.7%	18.0%	14.2%	50,030
Educational Status	No education	38.6%	22.8%	17.9%	12.1%	8.6%	794
	Incomplete primary	34.6%	21.3%	19.9%	15.3%	9.0%	13,341
	Complete primary	30.6%	22.5%	19.7%	16.4%	10.8%	1,899
	Incomplete secondary	29.7%	21.2%	21.2%	16.8%	11.0%	10,490
	Complete secondary	22.3%	20.7%	23.0%	19.3%	14.7%	8,508
	Vocational course	17.3%	16.8%	23.6%	23.7%	18.6%	1,263
	Incomplete college	16.8%	16.0%	20.8%	23.5%	22.9%	5,125
	Complete college	11.1%	11.7%	17.2%	24.8%	35.0%	3,623
	Total	26.5%	19.7%	20.7%	18.4%	14.8%	45,186
Employment Status	Unemployed/not looking for work/ student	26.5%	19.9%	20.8%	18.5%	14.3%	16,543
	Informal sector	25.9%	18.8%	21.7%	18.0%	15.6%	10,036
	Formal sector	18.9%	17.6%	20.4%	21.7%	21.3%	7,526
	Total	24.6%	19.1%	21.0%	19.1%	16.2%	34,105
Locale	Rural	36.3%	21.3%	19.7%	14.0%	8.7%	24,760
	Urban	19.3%	18.7%	21.6%	21.6%	18.9%	25,270
	Total	27.2%	19.9%	20.7%	18.0%	14.2%	50,030

* Percentages for each characteristic do not equal 100 percent due to rounding.

Table S3.4. Membership in Pantawid Pamilyang Pilipino Program (4Ps) Conditional Cash Transfer

Characteristic		Membership in 4Ps		Number of Persons
		Beneficiary	Non-beneficiary	
Sex	Male	6.5%	93.5%	25,257
	Female	9.0%	91.0%	24,773
	Total	7.7%	92.3%	50,030
Age (years)	Under 5	3.0%	97.0%	4,615
	5–17	13.7%	86.3%	13,337
	18–44	6.0%	94.0%	19,667
	45–59	8.0%	92.0%	7,308
	60 and over	3.4%	96.6%	4,875
	Total	7.8%	92.2%	49,802
Monthly Household Expenditure (per capita)	PhP 0–1,499	11.5%	88.5%	14,008
	PhP 1,500–2,099	9.5%	90.5%	10,208
	PhP 2,100–2,899	7.3%	92.7%	10,341
	PhP 2,900–4,199	4.6%	95.4%	8,774
	PhP 4,200+	2.7%	97.3%	6,699
	Total	7.7%	92.3%	50,030
Educational Status	No education	8.0%	92.0%	794
	Incomplete primary	10.5%	89.5%	13,341
	Complete primary	9.7%	90.3%	1,899
	Incomplete secondary	12.2%	87.8%	10,490
	Complete secondary	6.2%	93.8%	8,508
	Vocational course	3.4%	96.6%	1,263
	Incomplete college	3.6%	96.4%	5,125
	Complete college	2.0%	98.0%	3,623
	Total	8.3%	91.7%	45,186
Employment Status	Unemployed/not looking for work/student	9.0%	91.0%	16,543
	Informal sector	6.5%	93.5%	10,036
	Formal sector	3.2%	96.8%	7,526
	Total	6.9%	93.1%	34,105
Locale	Rural	11.1%	88.9%	24,760
	Urban	4.8%	95.2%	25,270
	Total	7.7%	92.3%	50,030

Table S3.5. Proportion of Household Members Covered by PhilHealth, by Type of Program

Characteristic		No Insurance of Any Type	With Other Health Insurance (except PhilHealth)	With PhilHealth Coverage	Type of PhilHealth Membership						Don't Know	Refused to Answer	Number of Persons
					Paying Members	Sponsored or Indigent	Lifetime Members	Senior Citizen Program	Other Types of Program	Don't Know Type of Program			
Total	–	50.0%	0.7%	48.3%	32.3%	23.1%	1.1%	7.1%	0.1%	0.1%	0.9%	0.2%	50,030
Age (years)	Under 5	60.5%	0.0%	38.6%	34.3%	23.8%	0.5%	0.3%	0.1%	0.1%	0.6%	0.3%	4,615
	5–17	56.7%	0.1%	42.2%	31.3%	31.3%	0.8%	1.4%	0.1%	0.1%	1.0%	0.1%	13,337
	18–44	50.7%	1.0%	47.1%	36.4%	20.1%	0.6%	0.9%	0.0%	0.1%	1.0%	0.2%	19,667
	45–59	44.6%	1.4%	53.0%	36.2%	25.1%	1.1%	4.3%	0.0%	0.1%	0.7%	0.2%	7,308
	60 and over	26.2%	0.6%	72.7%	11.9%	10.3%	4.0%	58.2%	0.0%	0.1%	0.5%	0.0%	4,875
Sex	Male	50.7%	0.7%	47.6%	32.6%	23.4%	1.0%	5.8%	0.0%	0.1%	0.9%	0.2%	25,257
	Female	49.2%	0.7%	49.1%	32.1%	22.8%	1.1%	8.5%	0.1%	0.1%	0.8%	0.2%	24,773
Monthly Household Expenditure (per capita)	PhP 0–1,499	55.9%	0.4%	42.8%	18.6%	32.4%	0.8%	5.8%	0.1%	0.1%	0.8%	0.1%	14,008
	PhP 1,500–2,099	52.9%	0.6%	45.7%	27.2%	27.4%	0.7%	5.5%	0.0%	0.1%	0.5%	0.2%	10,208
	PhP 2,100–2,899	49.4%	0.7%	48.9%	33.1%	23.1%	0.9%	7.4%	0.1%	0.1%	0.9%	0.2%	10,341
	PhP 2,900–4,199	46.2%	0.7%	51.9%	42.8%	15.8%	1.7%	7.5%	0.0%	0.2%	0.9%	0.3%	8,774
	PhP 4,200+	40.0%	1.4%	57.2%	51.3%	8.4%	1.7%	11.0%	0.0%	0.2%	1.3%	0.1%	6,699
Beneficiary of 4Ps	No	52.1%	0.8%	46.1%	33.6%	18.9%	1.0%	7.4%	0.0%	0.1%	0.9%	0.2%	45,919
	Yes	24.5%	0.1%	74.9%	16.6%	72.7%	1.7%	3.6%	0.2%	0.1%	0.4%	0.1%	4,111

Characteristic		No Insurance of Any Type	With Other Health Insurance (except PhilHealth)	With PhilHealth Coverage	Type of PhilHealth Membership						Don't Know	Refused to Answer	Number of Persons
					Paying Members	Sponsored or Indigent	Lifetime Members	Senior Citizen Program	Other Types of Program	Don't Know Type of Program			
Educational Status	No education	57.9%	0.3%	41.0%	19.0%	29.4%	0.4%	7.7%	0.0%	0.0%	0.5%	0.2%	794
	Incomplete primary	53.3%	0.2%	45.6%	23.7%	29.1%	1.0%	9.1%	0.1%	0.1%	0.8%	0.1%	13,341
	Complete primary	44.0%	0.4%	55.1%	16.2%	28.5%	1.5%	21.4%	0.1%	0.1%	0.4%	0.1%	1,899
	Incomplete secondary	55.4%	0.3%	43.4%	28.0%	29.2%	0.9%	5.1%	0.1%	0.1%	0.8%	0.1%	10,490
	Complete secondary	45.0%	0.8%	53.1%	35.3%	20.4%	1.0%	7.6%	0.0%	0.1%	0.9%	0.2%	8,508
	Vocational course	42.1%	1.5%	55.6%	44.7%	14.8%	1.3%	6.2%	0.0%	0.2%	0.7%	0.2%	1,263
	Incomplete college	46.4%	1.3%	51.1%	42.9%	12.9%	1.1%	6.2%	0.0%	0.1%	1.0%	0.2%	5,125
	Complete college	29.0%	3.2%	66.1%	57.1%	6.0%	2.4%	7.2%	0.0%	0.1%	1.4%	0.2%	3,623
Employment Status	Unemployed/not looking for work/student	51.7%	0.5%	46.7%	26.1%	22.1%	1.7%	13.3%	0.1%	0.1%	0.9%	0.3%	16,543
	Informal sector	46.5%	0.9%	51.9%	28.0%	24.7%	0.6%	9.4%	0.0%	0.1%	0.7%	0.1%	10,036
	Formal sector	35.2%	2.2%	61.7%	52.6%	12.7%	1.1%	2.8%	0.0%	0.1%	0.9%	0.1%	7,526
Locale	Rural	47.2%	0.4%	51.8%	22.9%	33.1%	0.7%	7.7%	0.1%	0.0%	0.5%	0.1%	24,760
	Urban	52.3%	1.0%	45.3%	40.5%	14.5%	1.4%	6.6%	0.0%	0.2%	1.2%	0.2%	25,270

Note: There are respondents who provided more than one type of PhilHealth membership; cannot separate formal sector versus voluntary because the question was patterned similarly to the 2013 Demographic and Health Survey; percentages for each characteristic do not equal 100 percent due to rounding.

Table S4.1. Self-Reported Overall Health Status

Characteristic		Status: Poor	Fair	Good	Very Good	Excellent	Number of Persons
Total	–	3.0%	34.9%	37.3%	17.3%	7.5%	28,495
Age in Years	Under 5	1.7%	32.8%	38.3%	19.5%	7.7%	4,615
	5–17	1.6%	32.0%	38.8%	19.4%	8.3%	9,163
	18–44	2.3%	36.6%	36.1%	16.7%	8.4%	7,676
	45–59	4.5%	37.4%	36.0%	15.8%	6.3%	4,084
	60 and over	9.1%	39.2%	35.8%	11.5%	4.4%	2,948
Sex	Male	3.1%	33.9%	37.9%	17.5%	7.6%	11,853
	Female	2.9%	35.6%	36.8%	17.2%	7.5%	16,642
Monthly Household Expenditure (per capita)	PhP 0–1,499	2.6%	34.2%	36.1%	19.3%	7.8%	8,197
	PhP 1,500–2,099	2.4%	36.3%	36.4%	17.8%	7.2%	5,793
	PhP 2,100–2,899	3.4%	33.8%	40.2%	15.9%	6.7%	5,782
	PhP 2,900–4,199	3.4%	35.8%	37.9%	15.8%	7.1%	4,909
	PhP 4,200+	3.4%	34.9%	35.9%	16.6%	9.3%	3,814
Beneficiary of 4Ps	No	3.0%	35.4%	37.1%	17.0%	7.5%	25,953
	Yes	2.5%	29.4%	39.3%	20.6%	8.1%	2,542
Educational Status	No education	4.9%	36.7%	32.6%	17.7%	8.2%	564
	Incomplete primary	2.8%	33.6%	38.0%	18.0%	7.6%	10,193
	Complete primary	6.1%	44.4%	34.3%	11.5%	3.7%	1,019
	Incomplete secondary	3.2%	36.4%	36.5%	16.3%	7.6%	3,859
	Complete secondary	3.5%	36.9%	36.3%	16.6%	6.8%	4,117
	Vocational course	4.7%	36.5%	38.1%	14.9%	5.8%	528
	Incomplete college education	3.0%	34.1%	37.1%	16.1%	9.6%	2,066
	Complete college education	3.0%	33.3%	37.8%	17.6%	8.3%	1,387
Employment Status	Unemployed/not looking for work/student	4.7%	38.2%	35.0%	15.3%	6.8%	8,016
	Informal sector	3.8%	37.1%	37.5%	14.4%	7.2%	4,730
	Formal sector	2.8%	33.7%	37.1%	18.1%	8.3%	2,167
Health Insurance Status	Uninsured	2.5%	34.9%	37.9%	17.9%	6.8%	13,847
	Covered by PhilHealth	3.5%	34.8%	36.7%	16.7%	8.3%	14,260
	Covered by private insurance	2.0%	21.7%	38.4%	23.0%	14.9%	76
Type of Residence	Rural	3.1%	35.5%	36.5%	16.5%	8.4%	14,269
	Urban	2.9%	34.3%	38.0%	18.1%	6.7%	14,226

Table S4.2. Proportion of Household Members with Any Condition in the Past Six Months

Household Member Characteristic		With Any Condition, Past Six Months	Number of Persons
Total	–	23.7%	50,030
Age in Years	Under 5	45.5%	4,615
	5–17	17.4%	13,337
	45–59	16.1%	19,667
	60 and over	28.4%	7,308
	65 and over	44.7%	4,875
Sex	Male	20.1%	25,257
	Female	27.5%	24,773
Monthly Household Expenditure (per capita)	PhP 0–1,499	19.5%	14,008
	PhP 1,500–2,099	21.7%	10,208
	PhP 2,100–2,899	23.6%	10,341
	PhP 2,900–4,199	25.8%	8,774
	PhP 4,200+	32.3%	6,699
Beneficiary of 4Ps	No	24.0%	45,919
	Yes	20.9%	4,111
Educational Status	No education	24.8%	794
	Incomplete primary	23.5%	13,341
	Complete primary	25.3%	1,899
	Incomplete secondary	17.3%	10,490
	Complete secondary	22.1%	8,508
	Vocational course	22.3%	1,263
	Incomplete college	21.8%	5,125
	Complete college	21.4%	3,623
Employment Status	Unemployed/not looking for work/student	25.0%	16,543
	Informal sector	22.2%	10,036
	Formal sector	15.9%	7,526
Health Insurance Status	Uninsured	20.3%	24,865
	Covered by PhilHealth	27.3%	24,377
	Covered by private insurance	34.3%	145
Type of Residence	Rural	21.1%	24,760
	Urban	26.0%	25,270

Table S4.3. Proportion of Individuals with Unmet Need for Care

Household Member Characteristic		With Health Condition and Did Not Seek Care	Number of Persons (with Health Condition)
Total	–	11.8%	11,762
Age in Years	Under 5	4.8%	2,092
	5–17	10.8%	2,283
	18–44	17.3%	3,147
	45–59	13.9%	2,087
	60 and over	9.4%	2,134
Sex	Male	12.6%	5,007
	Female	11.2%	6,755
Monthly Household Expenditure (per capita)	PhP 0–1,499	10.1%	2,720
	PhP 1,500–2,099	11.9%	2,228
	PhP 2,100–2,899	12.0%	2,444
	PhP 2,900–4,199	13.4%	2,238
	PhP 4,200+	11.6%	2,132
Beneficiary of 4Ps	No	12.0%	10,910
	Yes	8.2%	852
Educational Status	No education	8.0%	199
	Incomplete primary	11.6%	3,120
	Complete primary	9.2%	471
	Incomplete secondary	17.0%	1,778
	Complete secondary	13.3%	1,859
	Vocational course	10.9%	272
	Incomplete college education	16.1%	1,114
	Complete college education	11.6%	765
Employment Status	Unemployed/not looking for work/student	11.8%	4,071
	Informal sector	16.6%	2,210
	Formal sector	17.9%	1,195
Health Insurance Status	Uninsured	13.5%	4,969
	Covered by PhilHealth	10.3%	6,600
	Covered by private insurance	16.2%	56
Type of Residence	Rural	8.4%	5,232
	Urban	14.1%	6,530

Table S4.4. Proportion of Household Members with Primary Care Provider

Household Member Characteristic		Without	With	Refused	Don't Know	Number of Persons
Total	–	43.3%	55.2%	0.7%	0.8%	28,499
Age in Years	Under 5	40.8%	57.3%	0.9%	1.1%	4,615
	5–17	43.0%	55.3%	0.8%	0.9%	9,165
	18–44	44.3%	54.6%	0.5%	0.6%	7,678
	45–59	45.6%	53.5%	0.5%	0.5%	4,084
	60 and over	42.7%	56.1%	0.6%	0.5%	2,948
Sex	Male	43.2%	55.1%	0.8%	0.9%	11,854
	Female	43.5%	55.3%	0.6%	0.6%	16,645
Monthly Household Expenditure (per capita)	PhP 0–1,499	43.7%	55.3%	0.6%	0.4%	8197
	PhP 1,500–2,099	45.4%	53.1%	0.6%	0.9%	5793
	PhP 2,100–2,899	44.0%	54.5%	0.7%	0.9%	5782
	PhP 2,900–4,199	41.9%	56.8%	0.7%	0.6%	4913
	PhP 4,200+	40.7%	57.4%	0.7%	1.2%	3814
Beneficiary of 4Ps	No	43.8%	54.8%	0.7%	0.8%	25,957
	Yes	38.6%	60.5%	0.5%	0.4%	2,542
Educational Status	No education	48.1%	50.8%	0.2%	0.8%	564
	Incomplete primary	43.3%	55.2%	0.8%	0.7%	10,193
	Complete primary	47.8%	51.5%	0.5%	0.2%	1,019
	Incomplete secondary	45.4%	53.4%	0.4%	0.8%	3,861
	Complete secondary	43.4%	55.7%	0.4%	0.5%	4,117
	Vocational course	43.6%	55.9%	0.2%	0.4%	528
	Incomplete college	45.2%	52.9%	0.9%	1.0%	2,066
	Complete college	38.1%	60.9%	0.5%	0.5%	1,389
Employment Status	Unemployed/not looking for work/student	44.2%	54.7%	0.4%	0.7%	8,018
	Informal sector	44.8%	54.1%	0.6%	0.4%	4,730
	Formal sector	43.3%	55.4%	0.9%	0.5%	2,169
Health Insurance Status	Uninsured	49.3%	49.0%	0.8%	1.0%	13,851
	Covered by PhilHealth	37.4%	61.6%	0.5%	0.6%	14,260
	Covered by private insurance	40.4%	58.5%	1.1%	0.0%	76
Type of Residence	Rural	40.2%	58.9%	0.5%	0.3%	14,273
	Urban	46.1%	51.9%	0.8%	1.2%	14,226

Table 4.5. Utilization of Healthcare Services in the Past Six Months (At Least One Visit)

Household Member Characteristic		All Care	Outpatient Care	Emergency Room Services	Inpatient Services	Alternative Care	Dental Care	Therapies	Other Facility Services	Home Health Services	Outreach and Medical Missions	Pharmacy*	Number of Persons
Total	–	21.9%	12.7%	0.5%	2.4%	1.7%	0.4%	0.0%	0.6%	0.3%	0.7%	10.1%	50,030
Age in Years	Under 5	44.5%	32.6%	0.9%	3.9%	3.6%	0.1%	0.0%	0.3%	0.9%	1.3%	17.0%	4,615
	5–17	16.1%	8.9%	0.5%	1.3%	1.7%	0.4%	0.0%	0.3%	0.3%	0.8%	6.2%	13,337
	18–44	14.0%	7.9%	0.3%	2.3%	1.1%	0.5%	0.0%	0.6%	0.1%	0.3%	5.3%	19,667
	45–59	26.0%	13.5%	0.5%	2.0%	1.7%	0.4%	0.0%	0.9%	0.2%	0.8%	14.6%	7,308
	60 and over	42.4%	22.7%	0.8%	4.4%	1.7%	0.3%	0.1%	1.8%	0.3%	1.3%	26.2%	4,875
Sex	Male	18.3%	10.2%	0.4%	1.7%	1.4%	0.3%	0.0%	0.5%	0.2%	0.6%	8.5%	25,257
	Female	25.5%	15.2%	0.5%	3.0%	1.9%	0.5%	0.0%	0.8%	0.3%	0.8%	11.6%	24,773
Monthly Household Expenditure (per capita)	PhP 0–1,499	18.2%	11.3%	0.3%	2.3%	1.7%	0.2%	0.0%	0.2%	0.3%	0.6%	7.0%	14,008
	PhP 1,500–2,099	19.8%	11.7%	0.5%	2.1%	1.9%	0.4%	0.0%	0.4%	0.2%	0.7%	7.9%	10,208
	PhP 2,100–2,899	21.7%	12.7%	0.5%	2.3%	1.6%	0.5%	0.0%	0.6%	0.3%	1.0%	9.3%	10,341
	PhP 2,900–4,199	23.5%	13.1%	0.6%	2.2%	1.6%	0.6%	0.0%	1.0%	0.2%	0.6%	12.0%	8,774
	PhP 4,200+	30.0%	16.2%	0.7%	3.2%	1.5%	0.6%	0.1%	1.3%	0.3%	0.7%	17.5%	6,699
Beneficiary of 4Ps	No	22.1%	12.7%	0.5%	2.4%	1.6%	0.4%	0.0%	0.7%	0.3%	0.7%	10.3%	45,919
	Yes	19.7%	12.4%	0.3%	2.1%	2.3%	0.5%	0.0%	0.4%	0.1%	0.8%	6.9%	4,111
Educational Status	No education	23.5%	13.9%	0.1%	2.8%	2.7%	0.3%	0.0%	0.4%	0.5%	0.6%	9.2%	794
	Incomplete primary	21.8%	12.1%	0.5%	1.9%	2.1%	0.4%	0.0%	0.4%	0.2%	1.0%	9.8%	13,341
	Complete primary	23.5%	12.2%	0.5%	2.3%	1.3%	0.3%	0.0%	0.5%	0.1%	0.8%	12.8%	1,899

Household Member Characteristic		All Care	Outpatient Care	Emergency Room Services	Inpatient Services	Alternative Care	Dental Care	Therapies	Other Facility Services	Home Health Services	Outreach and Medical Missions	Pharmacy*	Number of Persons
Educational Status (continued)	Incomplete secondary	15.2%	8.3%	0.4%	2.0%	1.1%	0.4%	0.0%	0.6%	0.0%	0.5%	6.8%	10,490
	Complete secondary	19.9%	11.1%	0.5%	2.6%	1.1%	0.5%	0.0%	0.6%	0.2%	0.5%	9.8%	8,508
	Vocational course	20.6%	10.3%	0.4%	2.2%	0.8%	0.6%	0.1%	1.2%	0.1%	1.0%	10.1%	1,263
	Incomplete college	19.6%	10.5%	0.5%	2.6%	1.3%	0.6%	0.0%	0.9%	0.3%	0.6%	9.9%	5,125
	Complete college	20.0%	10.2%	0.3%	2.0%	1.2%	0.7%	0.0%	1.3%	0.2%	0.1%	11.0%	3,623
Employment Status	Unemployed/not looking for work/student	23.1%	13.1%	0.5%	3.4%	1.3%	0.5%	0.0%	0.9%	0.2%	0.6%	11.4%	16,543
	Informal sector	19.7%	10.3%	0.3%	1.7%	1.6%	0.5%	0.0%	0.7%	0.2%	0.6%	10.1%	10,036
	Formal sector	13.8%	6.6%	0.3%	1.3%	0.9%	0.4%	0.0%	0.7%	0.1%	0.4%	7.0%	7,526
Health Insurance Status	Uninsured	18.4%	10.7%	0.4%	1.4%	1.4%	0.4%	0.0%	0.5%	0.3%	0.7%	8.2%	24,865
	Covered by PhilHealth	25.5%	14.7%	0.6%	3.4%	1.9%	0.4%	0.0%	0.8%	0.3%	0.7%	11.9%	24,377
	Covered by private insurance	29.9%	16.5%	0.0%	3.1%	1.1%	0.0%	0.3%	2.0%	0.0%	0.0%	18.1%	145
Type of Residence	Rural	19.9%	11.9%	0.3%	2.5%	2.0%	0.2%	0.0%	0.3%	0.2%	0.5%	7.9%	24,760
	Urban	23.6%	13.3%	0.7%	2.2%	1.4%	0.6%	0.0%	0.9%	0.3%	0.9%	11.9%	25,270

* Excluding health events for which care was sought from a provider.

Supplementary Table S4.6. Proportion of Household Members with a Health Condition Who Utilized Healthcare Services in the Last Six Months, by Type of Healthcare

Household Member Characteristic		All Care, Excluding Pharmacy	Outpatient Care	Emergency Room Services	Inpatient Services	Alternative Care	Dental Care	Therapies	Other Facility Services	Home Health Services	Outreach and Medical Missions	Pharmacy*	Number of Persons
Total	–	68.8%	53.4%	2.0%	9.9%	7.0%	1.8%	0.1%	2.7%	1.1%	3.0%	42.4%	11,762
Age in Years	Under 5	83.1%	71.6%	2.1%	8.7%	8.0%	0.3%	0.0%	0.6%	2.1%	2.8%	37.3%	2,092
	5–17	70.8%	50.9%	2.6%	7.6%	9.9%	2.5%	0.2%	1.7%	1.5%	4.7%	35.6%	2,283
	18–44	67.9%	49.2%	2.0%	14.2%	6.9%	3.3%	0.1%	3.5%	0.8%	2.1%	33.3%	3,147
	45–59	60.6%	47.5%	1.7%	7.1%	6.0%	1.4%	0.1%	3.2%	0.6%	2.8%	51.5%	2,087
	60 and over	62.2%	50.7%	1.8%	9.8%	3.8%	0.7%	0.2%	4.1%	0.7%	3.0%	58.6%	2,134
Sex	Male	66.4%	50.9%	2.2%	8.7%	7.2%	1.6%	0.1%	2.3%	1.1%	3.0%	42.6%	5,007
	Female	70.6%	55.3%	2.0%	10.9%	6.8%	1.9%	0.1%	3.0%	1.1%	3.1%	42.3%	6,755
Monthly Household Expenditure (per capita)	PhP 0–1,499	74.3%	57.9%	1.7%	11.6%	8.5%	1.0%	0.0%	1.2%	1.3%	2.9%	35.9%	2,720
	PhP 1,500–2,099	70.4%	54.0%	2.2%	9.8%	8.9%	1.7%	0.0%	1.9%	1.0%	3.3%	36.6%	2,228
	PhP 2,100–2,899	70.5%	53.7%	2.0%	9.6%	6.6%	2.0%	0.1%	2.4%	1.1%	4.4%	39.5%	2,444
	PhP 2,900–4,199	65.0%	50.8%	2.2%	8.5%	6.2%	2.4%	0.1%	4.0%	0.9%	2.2%	46.5%	2,238
	PhP 4,200+	63.0%	50.1%	2.3%	9.8%	4.5%	2.0%	0.3%	4.1%	1.0%	2.3%	54.2%	2,132
Beneficiary of 4Ps	No	68.1%	53.0%	2.1%	9.9%	6.7%	1.7%	0.1%	2.8%	1.1%	2.9%	43.1%	10,910
	Yes	78.2%	59.2%	1.5%	9.9%	10.8%	2.3%	0.1%	1.8%	0.6%	4.0%	32.9%	852
Educational Status	No education	73.6%	55.9%	0.6%	11.2%	11.0%	1.0%	0.0%	1.8%	2.1%	2.4%	37.0%	199
	Incomplete primary	68.4%	51.6%	2.0%	8.2%	8.9%	1.6%	0.1%	1.9%	1.0%	4.0%	41.5%	3,120
	Complete primary	62.5%	48.2%	2.0%	9.0%	5.1%	1.2%	0.0%	2.0%	0.4%	3.1%	50.9%	471

Household Member Characteristic		All Care, Excluding Pharmacy	Outpatient Care	Emergency Room Services	Inpatient Services	Alternative Care	Dental Care	Therapies	Other Facility Services	Home Health Services	Outreach and Medical Missions	Pharmacy*	Number of Persons
Educational Status (continued)	Incomplete secondary	65.3%	48.0%	2.3%	11.3%	6.4%	2.6%	0.1%	3.6%	0.2%	3.2%	39.6%	1,778
	Complete secondary	64.3%	50.1%	2.1%	11.8%	5.1%	2.1%	0.1%	2.9%	1.1%	2.3%	44.2%	1,859
	Vocational course	64.2%	46.1%	2.0%	9.8%	3.6%	2.8%	0.4%	5.2%	0.6%	4.3%	45.2%	272
	Incomplete college education	65.6%	48.2%	2.2%	11.8%	6.1%	2.5%	0.1%	4.4%	1.4%	3.0%	45.3%	1,114
	Complete college education	62.1%	47.4%	1.5%	9.2%	5.7%	3.1%	0.1%	6.0%	0.8%	0.7%	51.1%	765
Employment Status	Unemployed/not looking for work/student	67.8%	52.3%	2.1%	13.6%	5.1%	1.8%	0.1%	3.7%	0.7%	2.6%	45.6%	4,071
	Informal sector	60.8%	46.4%	1.5%	7.7%	7.0%	2.2%	0.1%	3.3%	0.7%	2.6%	45.7%	2,210
	Formal sector	57.4%	41.4%	2.0%	8.0%	5.9%	2.3%	0.1%	4.2%	0.6%	2.4%	43.7%	1,195
Health Insurance Status	Uninsured	68.0%	52.7%	1.9%	6.8%	7.0%	2.2%	0.1%	2.3%	1.3%	3.5%	40.6%	4,969
	Covered by PhilHealth	69.5%	54.0%	2.1%	12.4%	7.0%	1.5%	0.1%	2.9%	1.0%	2.6%	43.6%	6,600
	Covered by private insurance	59.6%	48.1%	0.0%	9.1%	3.3%	0.0%	1.0%	5.8%	0.0%	0.0%	52.9%	56
Type of Residence	Rural	73.1%	56.6%	1.3%	11.8%	9.3%	1.1%	0.1%	1.5%	0.7%	2.5%	37.6%	5,232
	Urban	65.7%	51.2%	2.6%	8.6%	5.3%	2.3%	0.1%	3.5%	1.3%	3.4%	45.7%	6,530

* Excluding health events for which care was sought from a provider.

Table S4.7. Proportion of Household Members Who Utilized Healthcare Facilities in the Last Six Months

Household Member Characteristic		Barangay Health Stations	Rural Health Unit	Private Clinic	Public Hospital	Private Hospital	Eye Clinic	TB Dispensary	Independent Laboratory	Alternative Care Provider	Special Therapy Provider	Medical Mission	Others	Pharmacy*	Number of Persons
Total	–	13.4%	13.4%	15.0%	17.2%	11.9%	0.8%	0.0%	1.9%	7.4%	0.0%	2.8%	0.3%	42.4%	11,762
Age in Years	Under 5	26.2%	23.2%	17.2%	15.8%	9.5%	0.1%	0.0%	0.6%	8.3%	0.0%	2.5%	0.1%	37.3%	2,092
	5–17	9.9%	13.3%	15.3%	19.0%	9.7%	0.5%	0.0%	1.2%	10.5%	0.0%	4.6%	0.2%	35.6%	2,283
	18–44	12.4%	12.1%	15.4%	19.2%	10.7%	0.9%	0.1%	2.7%	7.5%	0.0%	2.0%	0.3%	33.3%	3,147
	45–59	10.7%	10.0%	11.9%	14.7%	13.5%	1.4%	0.0%	1.9%	6.4%	0.0%	2.4%	0.6%	51.5%	2,087
	60 and over	9.2%	9.7%	15.0%	16.0%	16.4%	1.4%	0.1%	2.8%	4.2%	0.0%	3.0%	0.4%	58.6%	2,134
Sex	Male	12.2%	12.2%	14.0%	17.0%	11.8%	0.5%	0.0%	1.8%	7.6%	0.0%	2.9%	0.1%	42.6%	5,007
	Female	14.3%	14.4%	15.7%	17.3%	12.0%	1.1%	0.0%	2.0%	7.3%	0.0%	2.8%	0.5%	42.3%	6,755
Monthly Household Expenditure (per capita)	PhP 0–1,499	23.5%	16.1%	9.8%	19.6%	6.3%	0.5%	0.0%	0.7%	8.7%	0.0%	2.7%	0.3%	35.9%	2,720
	PhP 1,500–2,099	16.4%	16.2%	12.7%	18.0%	8.4%	0.5%	0.0%	1.5%	9.2%	0.0%	3.1%	0.4%	36.6%	2,228
	PhP 2,100–2,899	12.1%	14.3%	17.0%	17.6%	12.0%	0.9%	0.0%	1.5%	7.4%	0.0%	3.9%	0.2%	39.5%	2,444
	PhP 2,900–4,199	8.3%	11.7%	17.9%	16.1%	12.7%	1.1%	0.1%	2.9%	6.7%	0.0%	2.2%	0.3%	46.5%	2,238
	PhP 4,200+	5.6%	8.6%	18.1%	14.5%	20.9%	1.1%	0.0%	3.1%	5.1%	0.0%	2.2%	0.4%	54.2%	2,132
Beneficiary of 4Ps	No	12.5%	13.3%	15.4%	17.0%	12.2%	0.9%	0.0%	2.0%	7.2%	0.0%	2.8%	0.3%	43.1%	10,910
	Yes	25.4%	15.3%	9.2%	19.6%	8.8%	0.6%	0.0%	1.2%	10.9%	0.1%	3.6%	0.1%	32.9%	852
Educational Status	No education	22.1%	10.4%	14.6%	16.6%	8.9%	0.9%	0.0%	0.9%	11.0%	0.0%	2.4%	0.0%	37.0%	199
	Incomplete primary	12.1%	13.5%	13.6%	17.7%	9.5%	0.8%	0.0%	1.0%	9.4%	0.0%	3.9%	0.1%	41.5%	3,120
	Complete primary	11.7%	11.3%	11.8%	15.4%	12.5%	1.3%	0.0%	0.9%	4.8%	0.0%	2.6%	0.9%	50.9%	471
	Incomplete secondary	11.1%	11.1%	14.0%	20.5%	9.8%	0.9%	0.0%	2.7%	6.6%	0.0%	3.1%	0.5%	39.6%	1,778

Household Member Characteristic		Barangay Health Stations	Rural Health Unit	Private Clinic	Public Hospital	Private Hospital	Eye Clinic	TB Dis-pensary	Indepen-dent Labora-tory	Alterna-tive Care Provider	Special Therapy Provider	Medical Mission	Others	Pharmacy*	Number of Persons
Educational Status (continued)	Complete secondary	12.6%	11.8%	15.1%	18.3%	11.9%	0.8%	0.1%	2.2%	5.7%	0.0%	2.2%	0.6%	44.2%	1,859
	Vocational course	5.8%	9.4%	12.7%	14.3%	19.3%	1.5%	0.0%	3.7%	4.3%	0.0%	4.3%	0.6%	45.2%	272
	Incomplete college education	7.2%	10.9%	15.1%	16.0%	16.5%	1.2%	0.1%	3.4%	7.1%	0.1%	2.5%	0.2%	45.3%	1,114
	Complete college education	3.9%	5.3%	19.6%	13.3%	21.9%	1.8%	0.1%	4.1%	6.5%	0.0%	0.6%	0.3%	51.1%	765
Employment Status	Unemployed/not looking for work/ student	12.1%	11.4%	14.9%	20.2%	13.5%	1.3%	0.1%	2.5%	5.6%	0.0%	2.5%	0.4%	45.6%	4,071
	Informal sector	11.0%	10.8%	13.4%	13.8%	11.1%	1.2%	0.1%	2.2%	7.7%	0.0%	2.3%	0.4%	45.7%	2,210
	Formal sector	6.1%	7.0%	13.4%	13.7%	15.8%	1.0%	0.0%	3.2%	6.2%	0.1%	2.4%	0.1%	43.7%	1,195
Health Insurance Status	Uninsured	13.6%	15.4%	14.8%	15.6%	8.6%	0.6%	0.0%	1.7%	7.3%	0.0%	3.2%	0.4%	40.6%	4,969
	Covered by PhilHealth	13.5%	11.8%	15.1%	18.5%	14.5%	1.0%	0.0%	2.0%	7.6%	0.0%	2.4%	0.3%	43.6%	6,600
	Covered by private insurance	0.0%	1.4%	18.1%	8.7%	26.5%	0.0%	0.0%	5.8%	3.3%	0.0%	0.0%	0.0%	52.9%	56
Type of Residence	Rural	18.7%	14.7%	13.1%	18.8%	10.2%	0.7%	0.1%	0.9%	9.6%	0.0%	2.3%	0.4%	37.6%	5,232
	Urban	9.7%	12.5%	16.3%	16.0%	13.2%	0.9%	0.0%	2.6%	5.9%	0.0%	3.2%	0.3%	45.7%	6,530

* Excluding health events for which care was sought from a provider.

Tables S5.1. Average Billed Amount for Provided Healthcare Services, by Facility Ownership Type

Weighted Means: Outpatient Care

Household Member Characteristic		Household Component (HC)			Medical Provider Component (MPC)			Number of Persons
		All Facilities	Public	Private	All Facilities	Public	Private	
Total	–	863	669	935	389	122	487	1,040
Age	Under 5	665	255	793	354	90	436	204
	5–17	797	1,065	643	250	132	318	188
	18–44	683	366	798	347	200	400	269
	45–59	877	970	830	289	89	392	175
	60 and over	1,375	603	1,517	702	38	824	204
Sex	Male	871	779	914	389	182	486	405
	Female	858	572	947	388	69	487	635
Monthly Household Expenditure (per capita)	PhP 0–1,499	873	754	950	306	212	367	162
	PhP 1,500–2,099	593	467	660	243	59	340	185
	PhP 2,900–4,199	804	447	915	340	151	400	220
	PhP 4,200+	1,155	1,272	1,128	637	96	760	263
Membership in Pantawid Pamilyang Pilipino Program (4Ps)	No	871	690	934	390	126	481	988
	Yes	708	442	970	365	79	646	52
Educational Status	No education*	483	240	803	192	29	406	17
	Incomplete primary	915	1,126	818	284	144	349	247
	Complete primary*	840	465	949	221	64	267	42
	Incomplete secondary	719	672	741	360	224	422	170
	Complete secondary	884	691	980	331	64	465	170
	Vocational course*	642	279	706	294	–	346	25
	Incomplete college	794	346	871	513	119	580	82
	Complete college	1,717	327	1,939	1,016	140	1,156	76

Household Member Characteristic		Household Component (HC)			Medical Provider Component (MPC)			Number of Persons
		All Facilities	Public	Private	All Facilities	Public	Private	
Employment Status	Unemployed/not looking for work/student	772	642	807	357	104	427	401
	Informal sector	784	592	860	309	60	408	181
	Formal sector	1,950	684	2,612	1,181	352	1,615	83
Health Insurance Status	Uninsured	845	688	922	330	148	420	404
	Covered by PhilHealth	874	664	938	426	102	524	616
	Covered by private insurance*	2,550	–	2,550	538	–	538	2
Locale	Rural	809	488	956	323	76	436	422
	Urban	892	803	920	425	156	510	622

* Less than 50 observations.

Weighted Means: Inpatient Care

	HC			MPC			Number of Persons
	All Facilities	Public	Private	All Facilities	Public	Private	
Total	9,768	6,233	15,454	15,373	10,975	22,448	112

Median: Outpatient Care

Household Member Characteristic		HC			MPC		
		All Facilities	Public	Private	All Facilities	Public	Private
Total	–	400	300	450	250	–	300
Age	Under 5	350	105	400	250	–	300
	5–17	350	350	400	250	–	300
	18–44	400	150	400	250	–	300
	45–59	500	500	500	200	–	300
	60 and over	500	500	500	250	–	300
Sex	Male	485	350	500	250	–	300
	Female	400	250	400	250	–	300
Monthly Household Expenditure (per capita)	PhP 0–1,499	350	250	470	200	–	250
	PhP 1,500–2,099	350	300	400	136	–	250
	PhP 2,100–2,899	400	300	400	270	–	300
	PhP 2,900–4,199	500	300	500	300	–	300
	PhP 4,200+	420	500	400	280	–	300
Membership in 4Ps	No	400	300	450	250	–	300
	Yes	380	190	600	75	–	350
Educational Status	No education*	300	130	300	–	–	300
	Incomplete primary	450	350	500	250	–	300
	Complete primary*	600	300	629	250	–	300
	Incomplete secondary	420	363	427	120	–	250
	Complete secondary	500	400	500	250	–	350
	Vocational course*	400	200	400	200	–	250
	Incomplete college	400	250	409	300	–	300
	Complete college	400	150	400	300	–	350
Employment Status	Unemployed/not looking for work/student	400	300	400	250	–	300
	Informal sector	500	500	500	240	–	300
	Formal sector	500	200	600	200	–	300
Health Insurance Status	Uninsured	400	300	430	200	–	300
	Covered by PhilHealth	400	300	450	250	–	300
	Covered by private insurance*	4,500	–	4,500	300	–	300
Locale	Rural	450	250	500	250	–	300
	Urban	400	310	400	250	–	300

* Less than 50 observations.

Median: Inpatient Care

	HC			MPC		
	All Facilities	Public	Private	All Facilities	Public	Private
Total	3,200	1,500	9,600	7,840	5,342	13,594

Standard Deviation: Outpatient Care

Household Member Characteristic		HC			MPC		
		All Facilities	Public	Private	All Facilities	Public	Private
Total	–	1,992	2,012	1,981	1,316	535	1,493
Age	Under 5	939	328	1,028	667	392	714
	5–17	2,079	3,347	611	339	222	375
	18–44	924	489	1,015	675	970	522
	45–59	1,593	2,319	1,057	395	209	428
	60 and over	3,488	467	3,775	2,772	91	3,002
Sex	Male	1,474	1,857	1,258	1,028	755	1,121
	Female	2,271	2,141	2,304	1,477	176	1,675
Monthly Household Expenditure (per capita)	PhP 0–1,499	2,446	3,306	1,690	710	1,021	394
	PhP 1,500–2,099	704	543	769	381	178	422
	PhP 2,100–2,899	1,264	462	1,426	401	395	377
	PhP 2,900–4,199	875	454	944	469	280	500
	PhP 4,200+	3,075	2,833	3,134	2,422	178	2,669
Membership in 4Ps	No	2,032	2,096	2,007	1,336	557	1,505
	Yes	782	523	909	804	160	1,059
Educational Status	No education*	624	228	842	335	84	426
	Incomplete primary	1,943	3,188	912	387	263	418
	Complete primary*	778	408	829	192	140	182
	Incomplete secondary	1,046	1,107	1,021	832	1,134	649
	Complete secondary	1,748	2,165	1,499	460	218	490
	Vocational course*	576	195	599	355		361
	Incomplete college	1,145	411	1,212	1,747	212	1,882
	Complete college	5,107	525	5,472	3,915	298	4,205
Employment Status	Unemployed/not looking for work/student	1,296	1,780	1,128	500	246	530
	Informal sector	1,193	705	1,332	444	199	475
	Formal sector	5,228	1,395	6,293	4,476	1,546	5,378
Health Insurance Status	Uninsured	1,321	1,281	1,336	677	741	626
	Covered by PhilHealth	2,341	2,517	2,284	1,608	238	1,820
	Covered by private insurance*	2,896	–	2,896	353	–	353
Locale	Rural	1,140	836	1,228	469	197	512
	Urban	2,337	2,549	2,268	1,606	684	1,795

* Less than 50 observations.

Standard Deviation: Inpatient Care

Household Member Characteristic		HC			MPC		
		All Facilities	Public	Private	All Facilities	Public	Private
Total	–	14,143	9,924	17,770	24,343	19,102	29,881
Health Insurance Status	Covered by PhilHealth	13,705	10,143	16,129	21,429	17,257	24,840
Locale	Rural	11,742	10,049	13,309	16,349	10,433	20,465
	Urban	16,232	9,946	21,182	27,755	22,684	34,052

Tables S5.2. Average Billing Share by Cost Component and Facility Ownership Type

Outpatient Care: All Facilities

Household Member Characteristic		Professional Fees	Laboratory	Medicine	Operating Room	Supplies	Others
Total	–	78.0%	13.1%	3.9%	0.4%	2.6%	1.8%
Age	Under 5	83.4%	5.5%	7.6%	–	0.8%	2.8%
	5–17	83.2%	8.7%	2.6%	–	2.0%	3.5%
	18–44	71.2%	22.5%	2.8%	–	2.8%	0.6%
	45–59	78.1%	12.0%	4.5%	–	3.2%	2.2%
	60 and over	76.4%	13.9%	2.5%	1.9%	4.5%	0.7%
Sex	Male	78.0%	11.8%	4.0%	0.2%	2.6%	3.4%
	Female	78.1%	13.9%	3.9%	0.5%	2.7%	0.9%
Monthly Household Expenditure (per capita)	PhP 0–1,499	78.6%	11.3%	5.3%	–	3.8%	78.6%
	PhP 1,500–2,099	77.7%	13.1%	5.1%	–	2.0%	77.7%
	PhP 2,100–2,899	86.2%	7.6%	4.7%	–	1.4%	86.2%
	PhP 2,900–4,199	83.0%	9.2%	3.7%	–	0.8%	83.0%
	PhP 4,200+	67.8%	21.4%	2.3%	1.4%	4.9%	67.8%
Membership in 4Ps	No	78.3%	13.2%	4.0%	0.4%	2.5%	1.6%
	Yes*	70.9%	11.8%	3.2%	–	7.1%	6.9%
Educational Status	No education*	82.0%	10.6%	–	–	7.3%	–
	Incomplete primary	83.4%	8.8%	3.8%	–	0.9%	3.1%
	Complete primary*	87.1%	6.8%	5.4%	–	0.8%	–
	Incomplete secondary	70.2%	17.4%	3.3%	–	7.7%	1.4%
	Complete secondary	74.0%	18.8%	1.9%	–	4.4%	0.9%
	Vocational course*	80.3%	13.1%	4.6%	–	2.0%	–
	Incomplete college	78.9%	15.3%	1.6%	0.8%	2.0%	1.4%
	Complete college	64.3%	26.9%	2.3%	3.4%	2.2%	0.9%
Employment Status	Unemployed/not looking for work/ student	74.3%	17.3%	2.7%	–	4.7%	1.0%
	Informal sector	82.8%	10.9%	3.7%	–	2.0%	0.7%
	Formal sector	62.7%	25.6%	2.8%	5.5%	2.0%	1.3%
Health Insurance Status	Uninsured	79.3%	10.9%	5.0%	–	2.0%	2.8%
	Covered by PhilHealth	76.9%	14.6%	3.5%	0.7%	3.0%	1.3%
	Covered by private insurance*	100%	–	–	–	–	–
Locale	Rural	78.6%	9.1%	7.5%	–	2.2%	2.6%
	Urban	77.8%	15.4%	1.9%	0.6%	2.9%	1.4%

* Less than 50 observations

Outpatient Care: Public Facilities

Household Member Characteristic		Professional Fees	Laboratory	Medicine	Operating Room	Supplies	Others
Total	–	49.9%	27.7%	6.7%	–	7.5%	8.1%
Age	Under 5	52.2%	15.9%	17.3%	–	8.7%	6.0%
	5–17	64.0%	15.3%	5.5%	–	–	15.2%
	18–44	35.6%	47.7%	2.1%	–	14.6%	–
	45–59	45.1%	24.6%	4.4%	–	14.1%	11.8%
	60 and over	43.2%	48.9%	7.9%	–	–	–
Sex	Male	56.3%	20.0%	9.4%	–	2.8%	11.6%
	Female	43.5%	35.5%	4.1%	–	12.3%	4.6%
Monthly Household Expenditure (per capita)	PhP 0–1,499	54.0%	19.4%	4.7%	–	21.5%	0.4%
	PhP 1,500–2,099	47.4%	18.0%	16.4%	–	6.7%	11.6%
	PhP 2,100–2,899	74.5%	18.1%	5.4%	–	–	2.1%
	PhP 2,900–4,199	57.8%	14.8%	5.7%	–	–	21.7%
	PhP 4,200+	22.7%	66.4%	2.9%	–	8.1%	–
Membership in 4Ps	No	48.5%	28.5%	7.5%	–	8.7%	6.7%
	Yes*	58.6%	22.8%	1.9%	–	–	16.8%
Educational Status	No education*	100.0%	–	–	–	–	–
	Incomplete primary	60.5%	13.8%	9.1%	–	3.0%	13.6%
	Complete primary*	47.3%	29.6%	14.2%	–	8.9%	–
	Incomplete secondary	39.5%	47.8%	–	–	7.0%	5.7%
	Complete secondary	52.2%	10.7%	–	–	27.1%	10.0%
	Vocational course*	–	–	–	–	–	–
	Incomplete college	20.0%	80.0%	–	–	–	–
	Complete college	27.7%	72.3%	–	–	–	–
Employment Status	Unemployed/not looking for work/ student	43.2%	36.7%	3.8%	–	9.6%	6.7%
	Informal sector	36.4%	35.7%	10.2%	–	17.8%	–
	Formal sector	38.3%	50.5%	–	–	11.2%	–
Health Insurance Status	Uninsured	50.6%	18.6%	8.8%	–	9.6%	12.3%
	Covered by PhilHealth	50.5%	32.3%	5.5%	–	6.3%	5.5%
	Covered by private insurance*	–	–	–	–	–	–
Locale	Rural	36.6%	22.5%	14.5%	–	6.7%	19.7%
	Urban	58.5%	31.1%	1.7%	–	8.1%	0.6%

* Less than 50 observations.

Outpatient Care: Private Facilities

Household Member Characteristic		Professional Fees	Laboratory	Medicine	Operating Room	Supplies	Others
Total	–	81.4%	11.4%	3.6%	0.4%	2.1%	1.1%
Age	Under 5	87.2%	6.8%	4.6%	–	1.5%	–
	5–17	86.3%	8.5%	3.4%	–	0.9%	0.9%
	18–44	71.8%	17.4%	2.3%	1.6%	4.7%	2.3%
	45–59	87.2%	6.8%	4.6%	–	1.5%	–
	60 and over	86.3%	8.5%	3.4%	–	0.9%	0.9%
Sex	Male	81.7%	10.4%	3.1%	0.2%	2.6%	2.0%
	Female	81.2%	11.9%	3.9%	0.6%	1.8%	0.6%
Monthly Household Expenditure (per capita)	PhP 0–1,499	83.8%	9.6%	5.4%	–	–	1.1%
	PhP 1,500–2,099	82.0%	12.4%	3.6%	–	1.4%	0.7%
	PhP 2,100–2,899	87.2%	6.8%	4.6%	–	1.5%	–
	PhP 2,900–4,199	86.3%	8.5%	3.4%	–	0.9%	0.9%
	PhP 4,200+	71.8%	17.4%	2.3%	1.6%	4.7%	2.3%
Membership in 4Ps	No	81.5%	11.6%	3.6%	0.5%	1.8%	1.1%
	Yes*	78.2%	5.4%	4.0%	–	11.3%	1.1%
Educational Status	No education*	79.3%	12.2%	–	–	8.5%	–
	Incomplete primary	87.7%	7.8%	2.9%	–	0.5%	1.1%
	Complete primary*	91.1%	4.4%	4.5%	–	–	–
	Incomplete secondary	75.6%	12.1%	3.8%	–	7.8%	0.7%
	Complete secondary	76.1%	19.6%	2.1%	–	2.2%	–
	Vocational course*	80.3%	13.1%	4.6%	–	2.0%	–
	Incomplete college	84.5%	9.2%	1.7%	0.8%	2.2%	1.5%
	Complete college	65.8%	25.0%	2.4%	3.5%	2.3%	1.0%
Employment Status	Unemployed/not looking for work/ student	77.4%	15.4%	2.6%	–	4.2%	0.5%
	Informal sector	85.3%	9.5%	3.4%	–	1.1%	0.7%
	Formal sector	68.1%	20.1%	3.5%	6.8%	–	1.6%
Health Insurance Status	Uninsured	83.1%	9.9%	4.4%	–	1.0%	1.6%
	Covered by PhilHealth	79.9%	12.6%	3.3%	0.7%	2.6%	0.9%
	Covered by private insurance*	100%	–	–	–	–	–
Locale	Rural	84.1%	7.4%	6.5%	–	1.6%	0.3%
	Urban	79.9%	13.7%	2.0%	0.7%	2.3%	1.5%

* Less than 50 observations.

Inpatient Care

	Professional Fees	Laboratory	Medicine	Operating Room	Supplies	Room and Board	Others	Number of persons
All facilities	32.91%	11.23%	17.47%	3.94%	11.42%	15.72%	7.31%	81
Public	25.88%	13.13%	15.79%	6.63%	14.42%	19.57%	4.58%	–
Private	41.05%	9.03%	19.4%	0.82%	7.95%	11.26%	10.48%	–

Annex 2. In-Depth Analysis of Household Reported Charges and Expenditures for Outpatient, Emergency, and Inpatient Care

This annex contains additional information about healthcare expenditures, charges, and sources of payments using the National Health Expenditure Survey household component survey data. Whereas section 5 of the report presents only the household component data that was "matched" with medical provider component data, this supplemental analysis uses the full sample from the household component on reported healthcare facility visits for the following: outpatient care, emergency care, and inpatient care. For each of these three care types, this annex discusses the following indicators:

- *Knowledge of Breakdown of Total Medical Charges and Expenditures*—This indicator is based on key informant response to questions about knowing their complete or partial charges/payments, disaggregated by inside/outside of the facility.
- *Average Medical Charges and Expenditures*—This indicator represents the average amount per visit when information on total charges/expenditures was provided by the key informant, disaggregated by inside/outside of the facility. If a visit did not include any outside components, then "outside charges and expenditure" is treated as PhP 0.
- *Components of Medical Charges and Expenditures*—This indicator represents the average amount per visit, disaggregated by charges/payments by component—professional care, surgical procedures, medicines, medical equipment, diagnostic/laboratory work, and other medical services—for visits in which the informant knew the complete breakdown of charges and payments.
- *Payment Sources for Medical Expenditures*—This indicator represents the average amount reported per visit, by source, for all visits with complete information on sources used, disaggregated by inside and outside expenditure.
- *Components of Non-medical Expenditures*—This indicator represents the average amount reported for those with complete information on non-medical expenditures (travel, food, accommodation, and other).

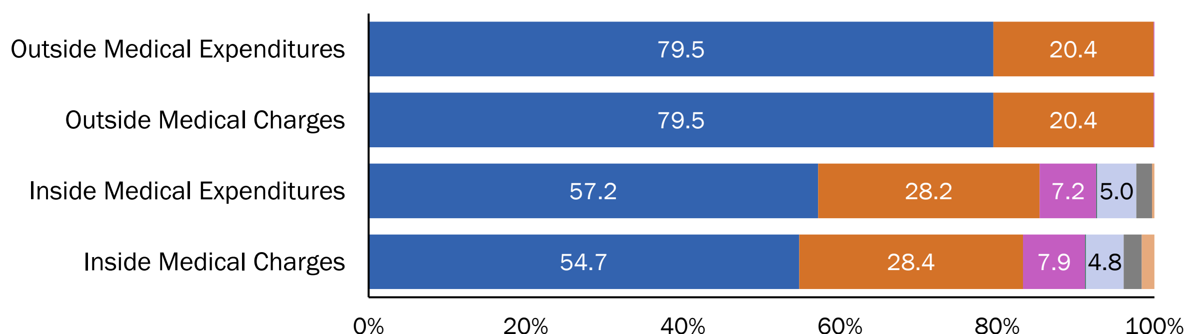
Additional indicators are presented for inpatient care visits related to PhilHealth coverage and membership in the government's Pantawid Pamilyang Pilipino Program (4Ps).

Outpatient Care in the Past Six Months

Knowledge of Breakdown of Medical Charges and Expenditures

Figure A2.1 shows the informants' level of awareness of the breakdown of their medical charges and expenditures incurred both inside the health facility and outside the facility in the past six months. More than half of outpatient care visits had zero charges and expenditures inside the facility and around 80% incurred no charges and expenditures outside the facility.

Figure A2.1 Knowledge of Breakdown of Medical Charges and Expenditures, Outpatient Care

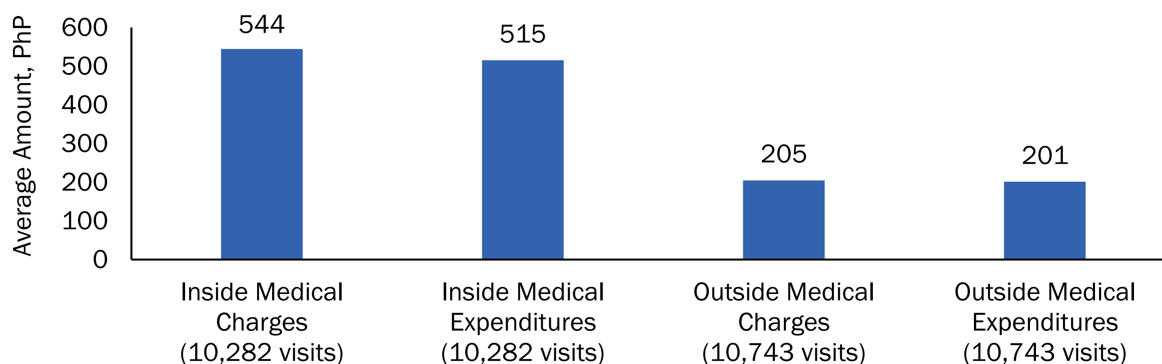


	Inside Medical Charges		Inside Medical Expenditures		Outside Medical Charges		Outside Medical Expenditures	
	n	%	n	%	n	%	n	%
Zero charges/expenditure	5,880	54.7	6,146	57.2	8,539	79.5	8,539	79.5
Complete breakdown	3,056	28.4	3,026	28.2	2,196	20.4	2,196	20.4
Incomplete breakdown	0	0.0	0	0.0	0	0.0	0	0.0
Knows total only	851	7.9	774	7.2	8	0.1	8	0.1
Knows partial only	13	0.1	12	0.1	0	0.0	0	0.0
Paid donation only	521	4.8	542	5.0	0	0.0	0	0.0
Don't know	250	2.3	212	2.0	2	0.0	2	0.0
Refused	174	1.6	33	0.3	0	0.0	0	0.0
Total visits	10,745	100	10,745	100	10,745	100	10,745	100

Average Medical Charges and Expenditures

Figure A2.2 shows the average amount charged and spent per outpatient care visit. To compare charges and expenditures (disaggregated by those inside and outside of the facility), the sample was limited to those visits for which the informant knew the complete breakdown of inside and outside charges/expenses. Visits with zero charges or expenditures and those with no outside component charges or expenditures were included. The average medical expenditure per visit was slightly lower than the average medical charges per visit, with a difference of only PhP 29 for inside medical charges and expenditures and PhP 4 for those incurred outside the facility.

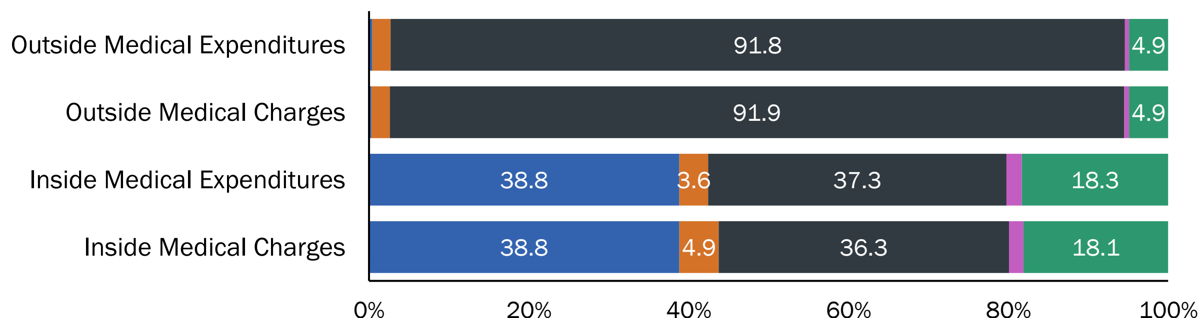
Figure A2.2. Average Medical Charges and Expenditures, Outpatient Care



Components of Medical Charges and Expenditures

Figure A2.3 presents a breakdown of average total charges and payments, by component, for outpatient care visits with a complete breakdown of charges and payments. Results show that the proportion of the component relative to the total charges/expenditures were equivalent for inside and outside charges/expenditures groups. Professional care and medicine received or provided inside the health facility each constituted about 39% of total charges and expenditures, whereas medicines constituted about 36% to 37%. Medicines accounted for the bulk (around 92%) of outside facility charges and expenditures, followed by diagnostics/lab fees (5%).

Figure A2.3. Average Total Medical Charges and Expenditures by Component, Outpatient Care

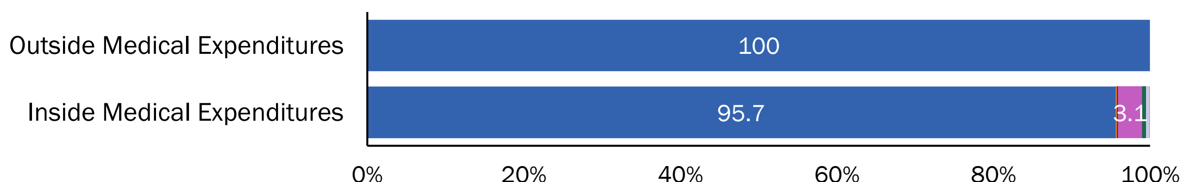


Component	Inside Medical Charges (n=9,252 visits)		Inside Medical Expenditures (n=9,252 visits)		Outside Medical Charges (n=10,735 visits)		Outside Medical Expenditures (n=10,735 visits)	
	PhP	%	PhP	%	PhP	%	PhP	%
■ Professional care	147	38.8	142	38.8	1	0.3	1	0.4
■ Surgical procedures	19	4.9	13	3.6	5	2.3	5	2.3
■ Medicines	138	36.3	136	37.3	187	91.9	183	91.8
■ Medical equipment	7	1.8	7	1.9	1	0.6	1	0.5
■ Diagnostics/lab	69	18.1	67	18.3	10	4.9	10	4.9
■ Other medical	0	0.0	0	0.0	0	0.0	0	0.0
Average total	379	100	365	100	203	100	199	100

Payment Sources for Medical Expenditures

Figure A2.4 shows average medical expenditure broken down by payment source for inside and outside outpatient care expenditures. Note that the analysis was limited to respondents who knew the complete breakdown of their payment sources and those who had zero expenditure. Average out-of-pocket payments for inside expenditures per care visit was PhP 494 in the last six months, or 95.7% of total inside expenditures per visit. Average expenditures for outside medical needs requiring an outpatient care visit was PhP 202, of which 100% was paid for using out-of-pocket resources.

Figure A2.4. Average Total Medical Expenditure by Payment Source, Outpatient Care

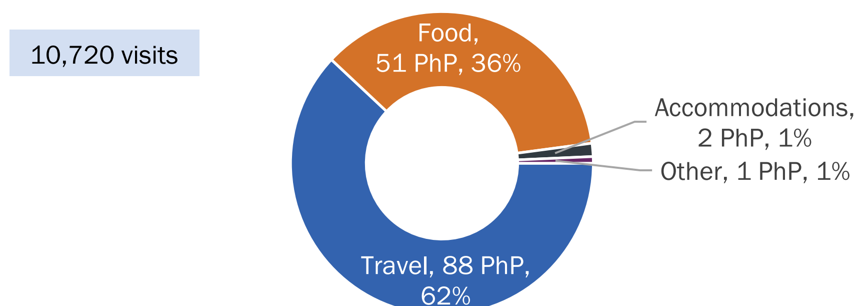


Source	Inside Medical Expenditures (n=10,596 visits)		Outside Medical Expenditures (n=10,629 visits)	
	PhP	%	PhP	%
■ Out-of-pocket	494	95.7	202	100
■ Charity	1.1	0.2	0	0.0
■ Local government	0.3	0.1	0	0.0
■ Philippine Charity Sweepstakes Office	16	3.1	0	0.0
■ PhilHealth	3	0.5	0	0.0
■ Private insurance (e.g., health maintenance organization)	2	0.4	0	0.0
■ Other insurance (e.g., Social Security System; Government Service Insurance System)	–	0.0	0	0.0
■ Other	1	0.1	0	0.0
Average total	517	100	202	100

Components of Non-medical Expenditures

Figure A2.5 presents the average amount and share of non-medical expenditures for outpatient visits. Respondents who answered “refused” or “don’t know” when asked about their expenditures on travel, food, or accommodation were not included in the sample. Travel accounted for 62% of average non-medical expenditures, whereas food accounted for 36%.

Figure A2.5. Average Amount and Share of Non-medical Expenditures, Outpatient Care

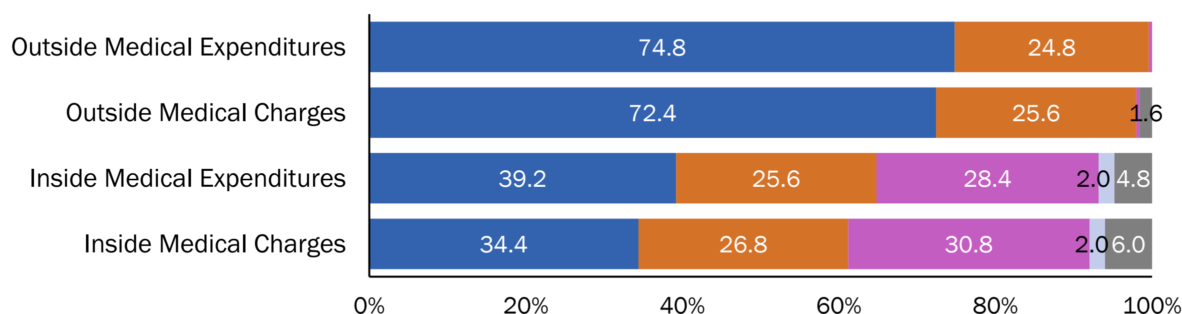


Emergency Care in the Past Six Months

Knowledge of Breakdown of Medical Charges and Expenditures

Figure A2.6 shows key informants' level of awareness of the breakdown of their medical charges and expenditures inside and outside of the health facility for emergency care in the past six months. Outside of the health facility, about three out of four informants' emergency care events had zero medical charges (72.4%) and expenditures (74.8%) incurred. Inside the facility, the share of informants with zero charges and expenditures was lower (34.4% and 39.2%, respectively). More than half of household informants knew the complete breakdown or the total only of charges (57.6%) and expenditures (54.0%) for visits inside the facility.

Figure A2.6. Knowledge of Medical Charges and Expenditures, Emergency Care

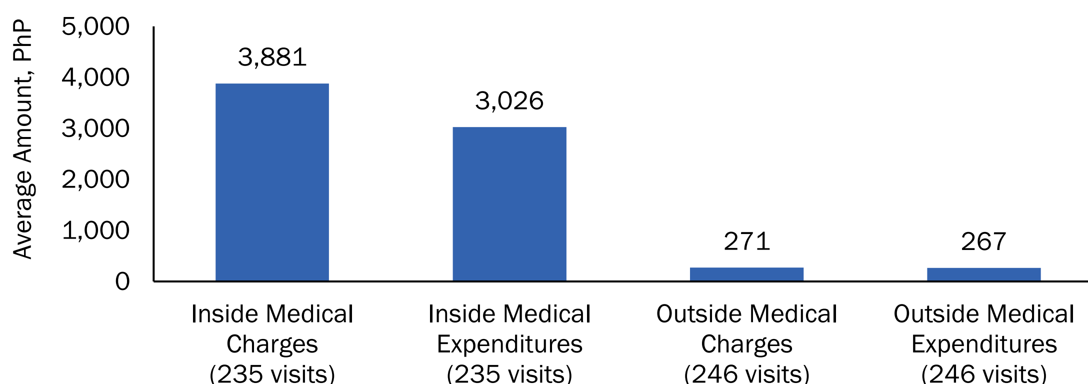


	Inside Medical Charges		Inside Medical Expenditures		Outside Medical Charges		Outside Medical Expenditures	
	n	%	n	%	n	%	n	%
Zero charges/expenditure	86	34.4	98	39.2	181	72.4	187	74.8
Complete breakdown	67	26.8	64	25.6	64	25.6	62	24.8
Incomplete breakdown	0	0.0	0	0.0	0	0.0	0	0.0
Knows total only	77	30.8	71	28.4	1	0.4	1	0.4
Knows partial only	0	0.0	0	0.0	0	0.0	0	0.0
Paid donation only	5	2.0	5	2.0	0	0.0	0	0.0
Don't know	15	6.0	12	4.8	4	1.6	0	0.0
Refused	0	0.0	0	0.0	0	0.0	0	0.0
Total visits	250	100	250	100	250	100	250	100

Average Medical Charges and Expenditures

Figure A2.7 shows the average amount charged and spent per emergency care visit. To facilitate comparing charges and expenditures (disaggregated by inside and outside of the health facility), the sample is limited to those visits for which the informant knew the complete breakdown of inside and outside charges/expenditures. Visits with zero charges or expenditures and visits with no outside component charges or expenditures were included. Medical charges per visit tended to be higher than expenditures; the difference is larger for inside (PhP 855) than outside (PhP 4) the facility.

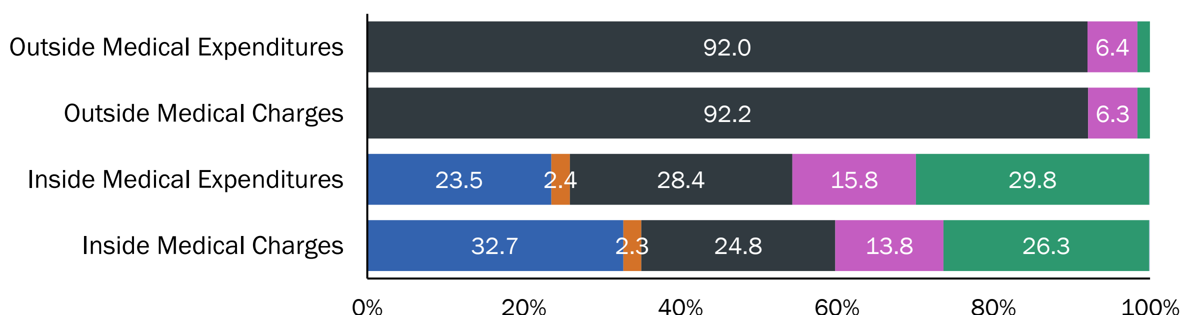
Figure A2.7. Average Medical Charges and Expenditures, Emergency Care



Components of Medical Charges and Expenditures

Figure A2.8 presents the breakdown of total charges and payments, by component, for emergency visits with complete information of the breakdown of charges AND payments (i.e., does not include visits in which the patient was not aware of the details of the components of care received). The proportion of professional fees charged inside the facility (32.7% of PhP 924 on average) was higher than the inside payments reported for that component (23.5% of PhP 807 on average). On the other hand, the shares of average inside payments for medicines, medical equipment, and diagnostic work all were higher than the share of those same components relative to inside charges. Meanwhile, the bulk of reported outside charges and expenditures for emergency care visits were for medicines (92%) and medical equipment (6%).

Figure A2.8. Average Total Medical Charges and Expenditures by Component, Emergency Care

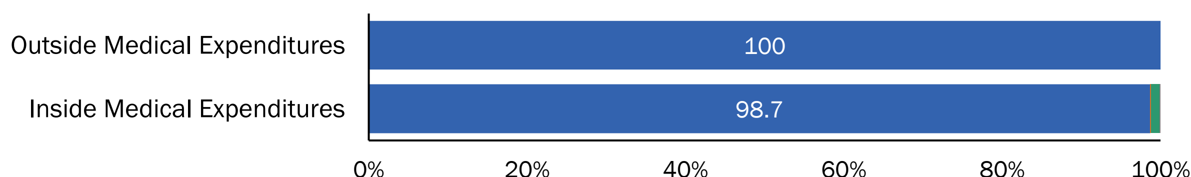


Component	Inside Medical Charges (n=246 visits)		Inside Medical Expenditures (n=246 visits)		Outside Medical Charges (n=154 visits)		Outside Medical Expenditures (n=154 visits)	
	PhP	%	PhP	%	PhP	%	PhP	%
■ Professional care	302	32.7	189	23.5	0	0.0	0	0.0
■ Surgical procedures	21	2.3	19	2.4	0	0.0	0	0.0
■ Medicines	229	24.8	229	28.4	244	92.2	240	92.0
■ Medical equipment	1,287	13.8	127	15.8	17	6.3	17	6.4
■ Diagnostics/lab	243	26.3	241	29.8	4	1.6	4	1.6
■ Other medical	1	0.1	1	0.1	0	0.0	0	0.0
Average total	924	100	807	100	264	100	260	100

Payment Sources for Medical Expenditures

Figure A2.9 shows average medical expenditure broken down by payment source for inside and outside emergency care expenditures. Note that the analysis is limited to respondents who knew the complete breakdown of their payment sources and those who had zero expenditure. The average medical expenditure outside the facility was PhP 254 per emergency care visit, of which 100% was paid for using out-of-pocket resources. The average out-of-pocket expenditure incurred inside the facility per emergency care visit was PhP 2,975, or 98.7% of total inside expenditures in the last six months. PhilHealth accounted for only a small share of inside medical expenditures, at 1.1%.

Figure A2.9. Average Total Medical Expenditure by Payment Source, Emergency Care

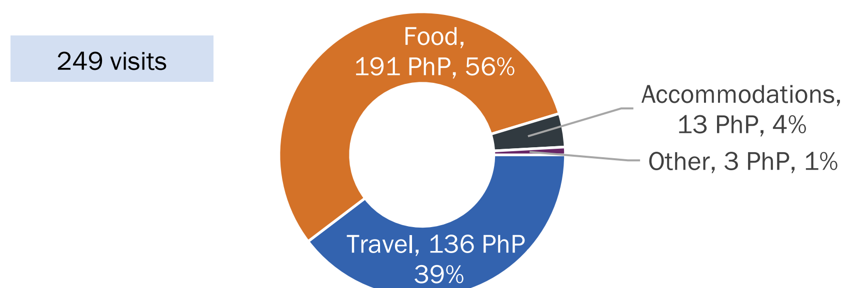


Source	Inside Medical Expenditures (n=250 visits)		Outside Medical Expenditures (n=250 visits)	
	PhP	%	PhP	%
Out-of-pocket	2,975	98.7	254	100
Charity	2	0.1	0	0.0
Local government	0	0.0	0	0.0
Philippine Charity Sweepstakes Office	0	0.0	0	0.0
PhilHealth	33	1.1	0	0.0
Private insurance (e.g., health maintenance organization)	0	0.0	0	0.0
Other insurance (e.g., Social Security System; Government Service Insurance System)	4	0.1	0	0.0
Other	0	0.0	0	0.0
Average total	3,014	100	254	100

Components of Non-medical Expenditures

Figure A2.10 presents the amount and share of non-medical expenditures for emergency care visits. Respondents who answered "refused" or "don't know" when asked about their expenditures on travel, food, or accommodations were not included in the sample. Food accounted for 56% of average non-medical expenditures, whereas travel accounted for 39%.

Figure A2.10. Average Amount and Share of Non-medical Expenditure, Emergency Care

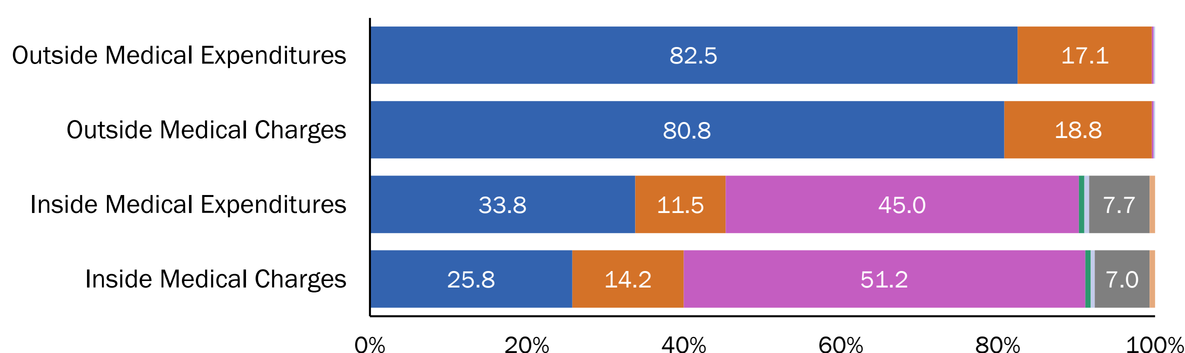


Inpatient Care in the Past Six Months

Knowledge of Breakdown of Medical Charges and Expenditures

Figure A2.11 shows informants' level of awareness of the breakdown of their medical charges and expenditures for inpatient care inside and outside of the health facility received in the six months preceding the household component. More than 99.0% of respondents' who made inpatient care visits had information on the complete breakdown of medical charges and expenditures incurred outside of the health facility. About one-fourth of visits had zero inside charges (25.8%) and more than one-third (33.8%) of confinement cases were either free or no payments were made by the patient. More than half of informants reported that they knew the total amount of inside medical charges and expenditures.

Figure A2.11. Knowledge of Medical Charges and Expenditures, Inpatient Care

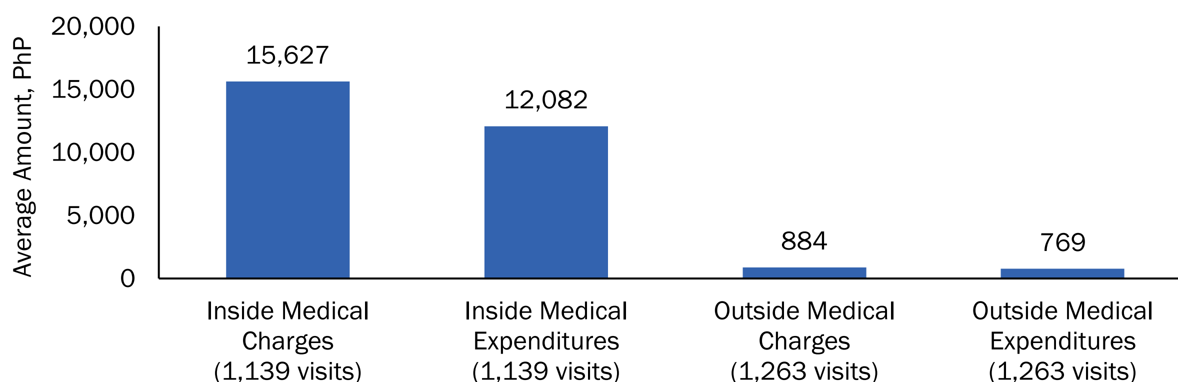


	Inside Medical Charges		Inside Medical Expenditures		Outside Medical Charges		Outside Medical Expenditures	
	n	%	n	%	n	%	n	%
Zero charges/expenditure	326	25.8	428	33.8	1,023	80.8	1,045	82.5
Complete breakdown	180	14.2	146	11.5	238	18.8	216	17.1
Incomplete breakdown	0	0.0	0	0.0	0	0.0	0	0.0
Knows total only	648	51.2	570	45.0	2	0.2	2	0.2
Knows partial only	9	0.7	9	0.7	0	0.0	0	0.0
Paid donation only	6	0.5	7	0.6	3	0.2	3	0.2
Don't know	88	7.0	97	7.7	0	0.0	0	0.0
Refused	9	0.7	9	0.7	0	0.0	0	0.0
Total visits	1,266	100	1,266	100	1,266	100	1,266	100

Average Medical Charges and Expenditures

Figure A2.12 shows the average amount charged and spent per inpatient visit. To facilitate comparing charges and expenditures (disaggregated by inside and outside of the health facility), the sample was limited to those visits for which the informant knew the complete breakdown of inside and outside charges/expenditures. Visits with zero charges or expenditures and visits with no outside component charges or expenditures were included. As expected, average medical charges and expenditures for care received in the health facility were higher than those outside. In addition, medical charges tended to be higher than expenditures; the difference was greater inside (PhP 3,545) than outside (PhP 115) the facility.

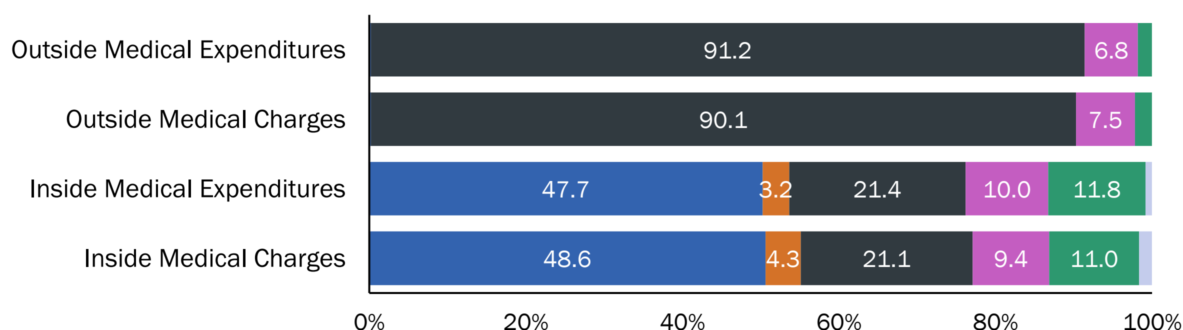
Figure A2.12. Average Medical Charges and Expenditures, Inpatient Care



Components of Medical Charges and Expenditures

Figure A2.13 presents the breakdown of total charges and payments, by component, for inpatient care events with data on the complete breakdown of charges AND payments (i.e., does not include visits in which the patient did not receive all components of care). The results show that for visits both inside and outside the facility, charges and expenditures were similar for the various components. Professional care constituted about 48% of total charges and expenditures provided inside the health facility, followed by medicines (21%), and medical equipment (9–10%). Medicine accounted for the bulk (more than 90%) of outside facility charges and expenditures, followed by medical equipment (around 7%), and diagnostics/laboratory work (2.0%).

Figure A2.13. Average Total Medical Charges and Expenditures by Component, Inpatient Care

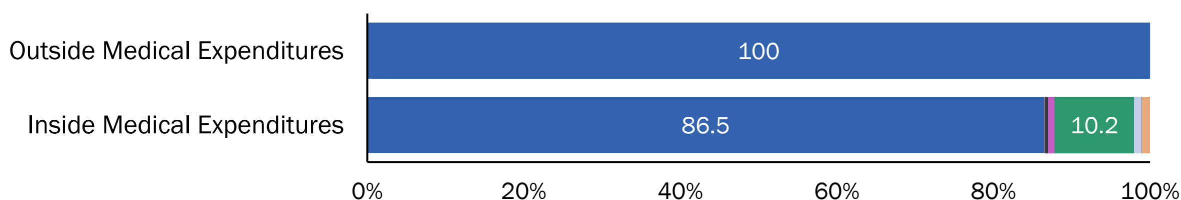


Component	Inside Medical Charges (n=1,260 visits)		Inside Medical Expenditures (n=1,260 visits)		Outside Medical Charges (n=478 visits)		Outside Medical Expenditures (n=478 visits)	
	PhP	%	PhP	%	PhP	%	PhP	%
■ Professional care	2,141	48.6	1,812	47.7	1	0.2	1	0.2
■ Surgical procedures	190	4.3	121	3.2	0	0.0	0	0.0
■ Medicines	931	21.1	811	21.4	633	90.1	594	91.2
■ Medical equipment	415	9.4	381	10.0	53	7.5	44	6.8
■ Diagnostics/lab	486	11.0	448	11.8	15	2.2	12	1.8
■ Other medical	70	1.6	30	0.8	0	0.0	0	0.0
Average total	353	8.0	194	5.1	n/a	n/a	n/a	n/a

Payment Sources for Medical Expenditures

Figure A2.14 shows average medical expenditure broken down by payment source for inside and outside inpatient care expenditures. Note that the analysis is limited to respondents who knew the complete breakdown of their payment sources and those who had zero expenditure. The total average outside medical expenditures per inpatient care visit was PhP 862 in the last six months, of which 100% was paid using out-of-pocket resources. The average out-of-pocket expenditure incurred inside the facility per inpatient care visit was PhP 11,114, or 86.5% of total inside expenditures. PhilHealth accounted for 10.2% of inside inpatient care expenditures but was not reported to have contributed to inpatient expenses incurred outside of the health facility.

Figure A2.14. Average Total Medical Expenditures by Payment Source, Inpatient Care

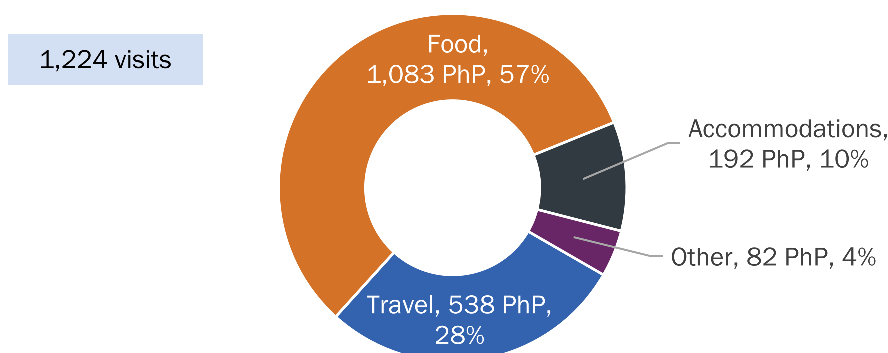


Source	Inside Medical Expenditures (n=1,085 visits)		Outside Medical Expenditures (n=1,085 visits)	
	PhP	%	PhP	%
■ Out-of-pocket	11,144	86.5	862	100
■ Charity	17	0.1	0	0.0
■ Local government	52	0.4	0	0.0
■ Philippine Charity Sweepstakes Office	97	0.8	0	0.0
■ PhilHealth	1,314	10.2	0	0.0
■ Private insurance (e.g., health maintenance organization)	117	0.9	0	0.0
■ Other insurance (e.g., Social Security System; Government Service Insurance System)	9	0.1	0	0.0
■ Other	129	1.0	0	0.0
Average total	12,878	100	862	100

Components of Non-medical Expenditures

Figure A2.15 presents the amount and share of non-medical expenditures for inpatient visits. Respondents who answered "refused" or "don't know" when asked about their expenditures on travel, food, or accommodations were not included in the sample. Food accounted for 57% of average non-medical expenditures, whereas travel accounted for 28%, followed by accommodations (10%).

Figure A2.15. Average Amount and Share of Non-medical Expenditure, Inpatient Care



Expenditure Among PhilHealth and Pantawid Pamilyang Pilipino Program Members

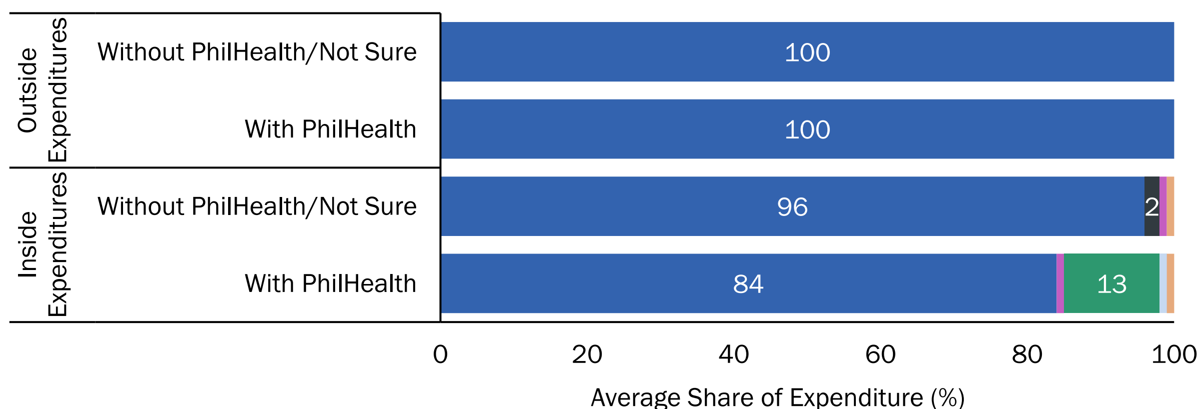
This section takes a closer look at financial risk protection for inpatient care visits among populations expected to have coverage under PhilHealth and the 4Ps—specifically, (1) respondents who confirmed they had PhilHealth coverage and (2) respondents/members of households who reported being a beneficiary of the 4Ps.

Patients with Knowledge of PhilHealth Coverage

As shown in Figure A2.11, one-fourth (25.8%) of all inpatient visits had zero medical charges inside the health facility and 80.8% of inpatient visits had zero medical charges outside of the facility. Among PhilHealth members, 25.9% of confinement cases were obtained free of charge inside the facility, whereas for those who were non-members or unaware of their PhilHealth coverage, 24.6% were billed zero. Regarding outside components, 81% of both members and non-members of PhilHealth had zero charges.

Figure A2.16 compares the sources of expenditure between PhilHealth and non-PhilHealth members (n=497 and n=205, respectively) with charges for inpatient care. As discussed earlier, 100% of total outside expenditures was paid for out-of-pocket by the patient. For expenditures inside the facility, PhilHealth members paid 84.3% of total expenditures using their own resources, whereas non-members paid 96.1% out-of-pocket. PhilHealth provided 12.6% support to members for inside expenditures.

Figure A2.16. Share of Expenditure by Source among PhilHealth Members and Non-members, Inpatient Care



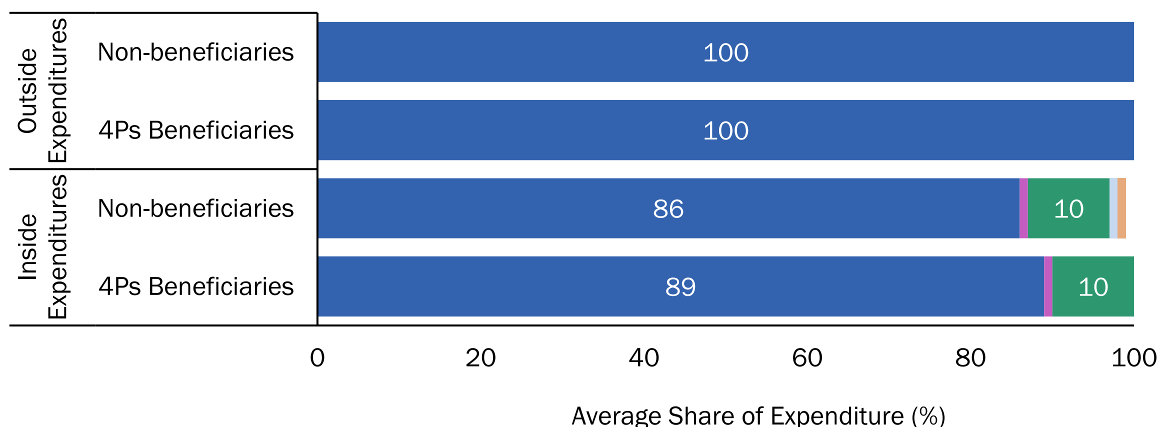
Source	Inside Expenditures		Outside Expenditures	
	With PhilHealth (%)	Without PhilHealth/ Not Sure (%)	With PhilHealth (%)	Without PhilHealth/ Not Sure (%)
Out-of-pocket	84.3	96.1	100	100
Charity	0	0.3	0	0
Local government	0.2	1.7	0	0
Philippine Charity Sweepstakes Office	0.7	1.0	0	0
PhilHealth	12.6	0	0	0
Private insurance (e.g., health maintenance organization)	1.1	0	0	0
Other insurance (e.g., Social Security System; Government Service Insurance System)	0.1	0.1	0	0
Other	1.1	0.8	0	0

Pantawid Pamilyang Pilipino Program Beneficiaries

Regarding inpatient care expenditures by beneficiaries of the 4Ps, about a third (35.0%) of visits had zero inside charges, whereas only 24.8% of non-beneficiaries' confinement care was obtained free of charge inside the facility. Regarding outside charges, three-fourths (75.4%) of inpatient visits by 4Ps beneficiaries had zero charges, whereas more than 80% of non-beneficiaries had no outside charges.

As shown in Figure A2.17, benefits received by 4Ps beneficiaries (n=43) and non-beneficiaries (n=659) did not differ among those who made inside facility payments. Both groups reported having a 10% share of total payments covered by PhilHealth within the confinement hospital. Meanwhile, payments for all outside expenses were covered by patients using out-of-pocket resources.

Figure A2.17. Share of Expenditure by Source among 4Ps Beneficiaries and Non-beneficiaries, Inpatient Care



Source	Inside Expenditures		Outside Expenditures	
	4Ps Beneficiaries (%)	Non-beneficiaries (%)	4Ps Beneficiaries (%)	Non-beneficiaries (%)
Out-of-pocket	88.5	86.1	100	100
Charity	0	0.1	0	0
Local government	0	0.4	0	0
Philippine Charity Sweepstakes Office	1.3	0.7	0	0
PhilHealth	10.1	10.5	0	0
Private insurance (e.g., health maintenance organization)	0	1.0	0	0
Other insurance (e.g., Social Security System; Government Service Insurance System)	0	0.1	0	0
Other	0.1	1.1	0	0

Annex 3. In-Depth Analysis of Facility Data on Charges and Expenditure for Outpatient and Inpatient Care

This annex contains supplemental analysis of healthcare expenditures, charges, and sources of payments using the NHES medical provider component (MPC) survey data. Whereas Section 5 of the main report used only the matched samples of the MPC data and Section 6 used only the subset of MPC records having complete sources of payment information, this annex uses a larger sample of data from outpatient and inpatient care records.[18] A total of 3,555 outpatient and 716 inpatient care events were used in the following analysis; data from 87 events (one of which was inpatient) were excluded because of inconsistencies with the reported health events in the household component (HC). Emergency care facility data are not included in this annex because of a limited number of observations (fewer than 100 records). For both inpatient and outpatient care, this annex discusses the following indicators:

- *Total medical charges and payments:* Availability of total medical charges information collected from patient files accessed at the facility in each module and the total average amount per visit for those visits in which total charges and total payments data were collected from facility records.
- *Components of medical charges:* The total average amount per visit broken down by charges/payments per component—professional fees, laboratory fees, medicines, supplies and devices, operating room services, other cost components, and room and board for inpatient cases. If a visit did not include a particular component of care, that component is assumed to have a cost of zero PhP.
- *Payment sources for medical expenditures:* The average amount by financing source recorded per visit.

For inpatient visits, additional information is presented related to PhilHealth coverage and membership in the government's Pantawid Pamilyang Pilipino Program (4Ps). PhilHealth and 4Ps membership status was based on the reported knowledge of the household members in the HC survey.

[18] See Box 5.1 for the definition of matched records.

Outpatient Care in the Past Six Months

Total Medical Charges and Payments

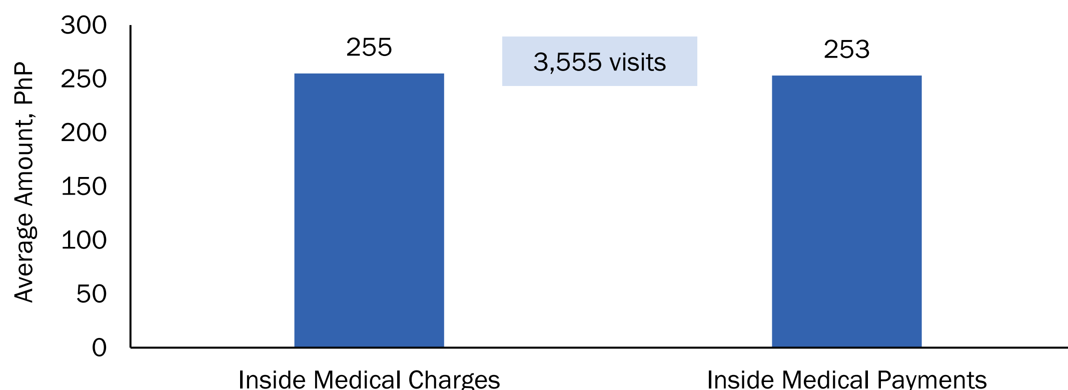
Two-thirds (64.2%) of all analyzed outpatient care visits (3,555) were provided free of charge by the facility (Table A3.1). The average total outpatient charge, including those without charges, zero bill, or an unknown charge equivalent, was PhP 255, whereas the average total payment per outpatient visit was PhP 253 (see Figure A3.1).[19] The average total payment amount was lower than the average total charges because of discounts applied to payment after the charge was filed. Senior citizen discounts were applied to 16 patients who were 60 years of age and over and two patients benefited from hospital or provider discounts.

These MPC average total charges and expenses per outpatient visit were lower than those reported by household members in the HC survey as inside charges (PhP 544) and payments (PhP 515) per outpatient event.

Table A3.1. Availability of Total Medical Charges and Payments, Outpatient Care

Response	n	%
Total charges and payments known	1,262	35.5
No charge/zero bill or unknown charge equivalent	2,282	64.2
No charge/charge equivalent only	11	0.3
Total number of observations	3,555	100

Figure A3.1. Average Total Medical Charges and Payments, Outpatient Care



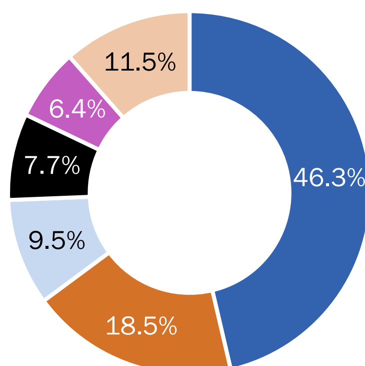
[19] Some records (85) collected were not included in the analysis because the dates of outpatient care and reason for the visit did not match the reported information of the household members in the HC survey.

Components of Medical Charges

Figure A3.2 shows the components of medical charges for outpatient visits. Professional fees accounted for close to half (46.3%) of total charges; laboratory fees were 18.5% of total charges; supplies and devices were 9.5%; medicines were 7.7%; operating room services were 6.4%; and other cost components comprised 11.5%.

HC respondents reported a lower percentage (38.8%) of the total cost allocated to professional fees. Patients also recalled a higher proportion of charges allocated to medicines (36.3%) in the HC. The charges allocated for laboratory fees were nearly equivalent between provider records and patient recall (18.1%).

Figure A3.2. Components of Medical Charges, Outpatient Care

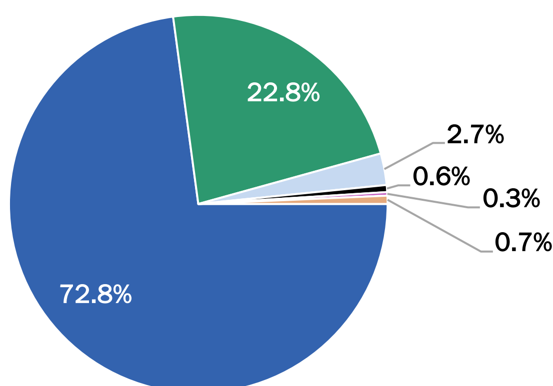


Component	PhP	%
Professional fees	118.2	46.3
Laboratory fees	47.2	18.5
Supplies and devices	24.3	9.5
Medicines	19.7	7.7
Operating room services	16.4	6.4
Other cost components	29.3	11.5
Total	255.3	100

Payment Sources for Medical Expenditures

Figure A3.3 shows the sources of payment for outpatient care provided. A majority (72.8%) of the total payments made to the facility (PhP 253) were paid by the patient using out-of-pocket resources (i.e., funds from the patient or the patient's family), 22.8% from PhilHealth, and 2.7% from private insurance and/or a health maintenance organization (HMO). Local government, Philippine Charity Sweepstakes Office, Social Security System or Government Service Insurance System, and other sources together accounted for 1.6%. These results differ from those of the HC survey, according to which 95.7% of inside medical expenditures for outpatient care reportedly were paid for using out-of-pocket resources.

Figure A3.3. Payment Sources of Medical Expenditure, Outpatient Care



Source	PhP	%
Out-of-pocket	184.1	72.8
PhilHealth	57.7	22.8
Private insurance (e.g., HMO)	6.9	2.7
Local government	1.6	0.6
Philippine Charity Sweepstakes Office	0.8	0.3
Social Security System or Government Service Insurance System	0.0	0.0
Other	1.7	0.7
Total	252.8	100

Inpatient Care in the Past Six Months

Total Medical Charges and Payments

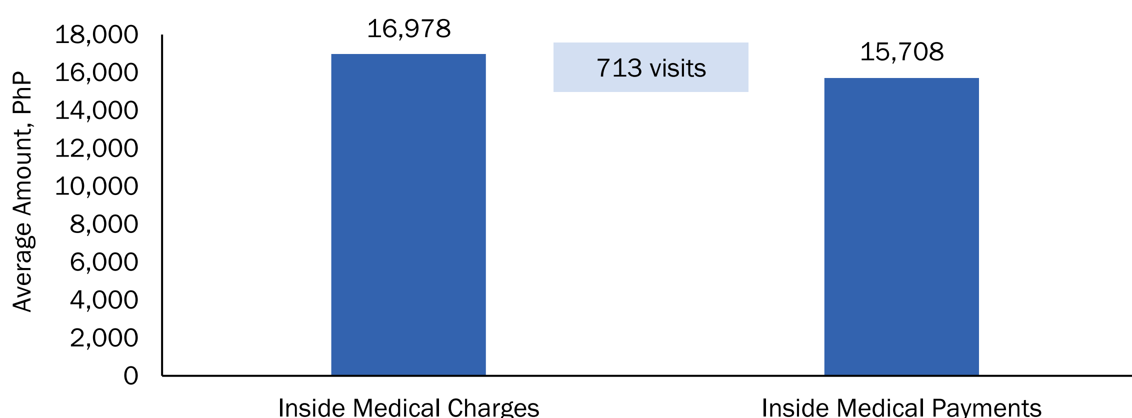
Approximately 29% of all analyzed inpatient care visits (716) were provided free of charge by the facility (Table A3.2). The average total inpatient charge was PhP 16,978 (see Figure A3.4), including those without charges, a zero bill, or unknown charge equivalent (28.9%). The average total charge per inpatient care visit (PhP 16,978) was higher than the average total payment (PhP 15,708).

The HC-reported total payment per confinement at a health facility (PhP 12,082) was more than 20% lower than what was validated during MPC data collection. On the other hand, the average total charges per MPC data were lower by only 8% when compared to the average total inside charges for inpatient visits as reported by HC respondents (PhP 15,627). It is possible that patients were able to approximate their total charges during confinement because detailed statements of accounts were provided during the facility visit. However, payments could have been reported incorrectly due to the inability of patients (or the household key informant who answered the HC survey) to recall the support received from other financing sources, such as PhilHealth and local government programs.

Table A3.2. Availability of Total Medical Charges and Payments, Inpatient Care

Response	n	%
Total charges and payments known	506	70.7
No charge/zero bill or unknown charge equivalent	204	28.5
No charge/charge equivalent only	3	0.4
Total charges and payments not in record	3	0.4
Number of observations	716	100.0

Figure A3.4. Average Total Medical Charges and Payments, Inpatient Care

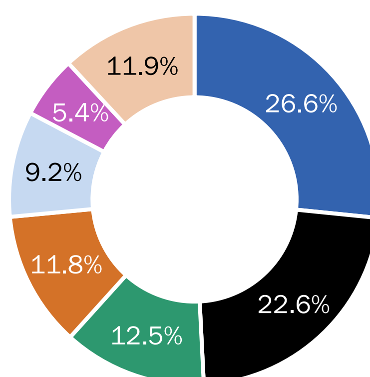


Components of Medical Charges

Figure A3.5 shows the components of medical charges for inpatient visits. Professional fees accounted for about 27% of total charges, and medicines for about 23%, together accounting for 50% of total inpatient charges. The other cost components accounted for the remaining 50% of charges: room and board (12.5%), laboratory fees (11.8%), supplies and devices (9.2%), operating room services (5.4%), and other components (11.9%).

Unlike the comparison for outpatient cost components, the HC reported that the proportion of professional fees per inpatient visit was higher (48.6%) than the MPC estimate (26.6%). Although the proportions for the medicines and laboratory fees were similar between the HC and MPC, the other cost components were higher (11.9%) in MPC data than the HC-recalled proportion (1.6%).

Figure A3.5. Components of Medical Charges, Inpatient Care

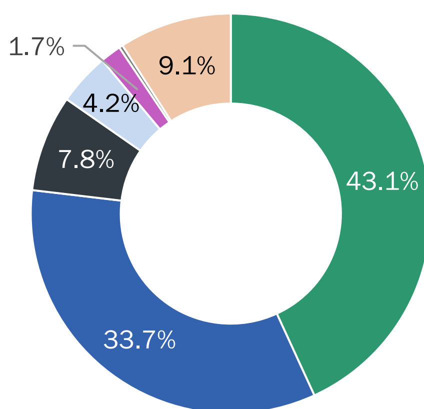


Component	PhP	%
Professional fees	4,509.0	26.6
Medicines	3,837.2	22.6
Room and board	2,128.2	12.5
Laboratory fees	1,999.7	11.8
Supplies and devices	1,560.4	9.2
Operating room services	923.2	5.4
Other cost components	2,020.0	11.9
Total	16,977.7	100

Payment Sources for Medical Expenditures

Figure A3.6 shows the financing sources of the payments made to the facility for inpatient care provided. The majority of payments were from two sources: PhilHealth (43.1%) and out-of-pocket resources (33.7%). Private insurance/HMOs accounted for only 4.2%. Other payment sources included local government (7.8%), Philippine Charity Sweepstakes Office (1.7%), Social Security System or Government Service Insurance System (0.3%), and other sources (9.1%). These findings vary from the reported payment sources reported by household respondents—patients queried during the HC survey recalled that 86.5% of total inside medical expenditures were covered by out-of-pocket resources and only 10.2% by PhilHealth.

Figure A3.6. Payment Sources of Medical Expenditure, Inpatient Care



Source	PhP	%
PhilHealth	6,774.9	43.1
Out-of-pocket	5,301.2	33.7
Local government	1,229.8	7.8
Private insurance (e.g., HMO)	654.2	4.2
Philippine Charity Sweepstakes Office	267.7	1.7
Social Security System or Government Service Insurance System	47.3	0.3
Other	1,433.1	9.1
Total	15,708.3	100

Expenditure Among PhilHealth and Pantawid Pamilyang Pilipino Program Members

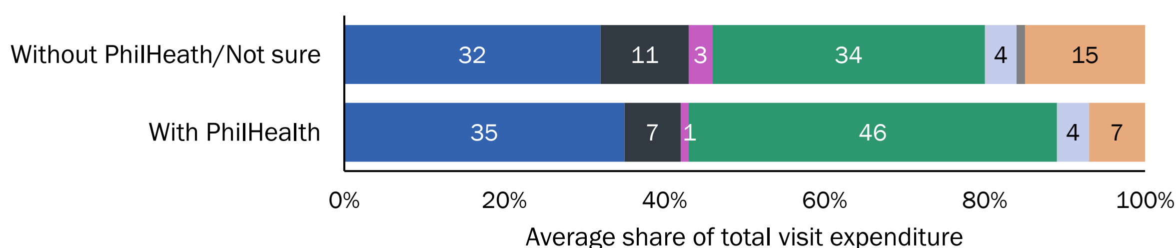
This section provides information on the financial risk protection of populations expected to have coverage through PhilHealth or the 4Ps, using the inpatient facility records collected during the MPC survey. The analysis is limited to patients who confirmed that they had PhilHealth coverage and those who reported being a beneficiary of the 4Ps program during HC data collection.

Patients with Knowledge of PhilHealth Coverage

As shown in Table A3.2 earlier, almost one-third of all inpatient visits had zero charges. Among those who reported PhilHealth membership, 27% of confinement cases were obtained free of charge, whereas for those who were non-members or not aware of their PhilHealth coverage, 31% were billed nothing.

Figure A3.7 compares the sources of expenditure between PhilHealth and non-PhilHealth members for charges during inpatient care (n=506). Out-of-pocket expenditures accounted for 35% of total expenditure among PhilHealth members (n=351)—slightly higher than the 32% among patients who were uninsured or did not know their membership status (n=155). Among those who reported PhilHealth coverage, almost half of their total payments (46%) were paid by PhilHealth. Interestingly, facility records showed that PhilHealth benefits covered confinement expenditures among those who did not know their membership status. Among this group, more than one-third (34%) of the total confinement expenditure was paid by PhilHealth.

Figure A3.7. Share of Expenditure by Source Among PhilHealth Members and Non-members, Inpatient Care



Source	With PhilHealth	Without PhilHealth/Not Sure
Out-of-pocket	35%	32%
Charity	0%	0%
Local government	7%	11%
Philippine Charity Sweepstakes Office	1%	3%
PhilHealth	46%	34%
Private insurance (e.g., HMO)	4%	4%
Other insurance (e.g., Social Security System or Government Service Insurance System)	0%	1%
Other	7%	15%

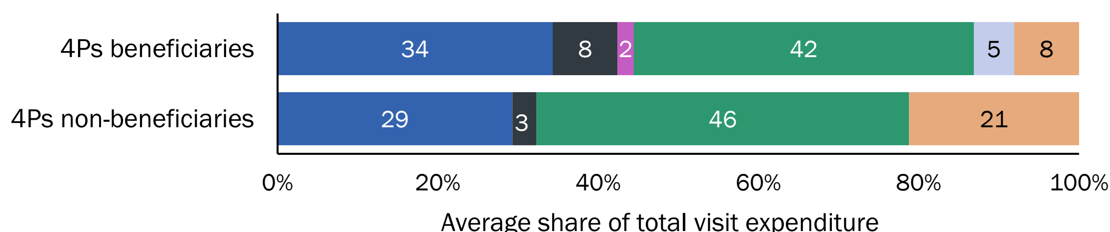
These findings are very different than what was recalled by the household members as presented in Figure A2.16 of Annex 2. Based on the HC survey, only 13% of the total inside payments to the facility were covered by PhilHealth for its members, and none for non-members. HC respondents recalled making 84% of total payment with out-of-pocket resources compared to the MPC-estimated 46% among individuals reporting PhilHealth coverage and 34% among those who were not members or unaware of their PhilHealth coverage. Non-PhilHealth members recalled that 96% of their total expenditure for inpatient care was from out-of-pocket resources, but facility records showed that only 32% of charges were covered by the patient's personal finances.

4Ps Beneficiaries

Around 43% of inpatient healthcare by 4Ps beneficiaries (n=53) was obtained free of charge. Among non-beneficiaries (n=639), inpatient visits with zero charges comprised 28% of all cases.

Figure A3.8 compares the sources of payments between 4Ps (n=30) and non-4Ps beneficiaries (n=476) with non-zero hospital charges. Support from PhilHealth and other sources (including facility discounts) was higher for 4Ps beneficiaries by 4 and 13 percentage points, respectively. Out-of-pocket spending by 4Ps beneficiaries was lower than those not benefiting from the national government's conditional cash transfer program.

Figure A3.8. Share of Expenditure by Source Among 4Ps Beneficiaries and Non-beneficiaries, Inpatient Care



Source	4Ps	Non-4Ps
Out-of-pocket	29%	34%
Charity	0%	0%
Local government	3%	8%
Philippine Charity Sweepstakes Office	0%	2%
PhilHealth	46%	42%
Private insurance (e.g., HMO)	0%	5%
Other insurance (e.g., Social Security System or Government Service Insurance System)	0%	0%
Other	21%	8%

These results differ greatly from those reported by patients or key informants during the household survey, as shown in Figure A2.17 in Annex 2. Household respondents who were 4Ps beneficiaries recalled paying 89% out-of-pocket for facility charges and receiving 10% support from PhilHealth. Non-program beneficiaries reported the same percentage covered by PhilHealth (10%) and out-of-pocket (86%). These differences could be due to recall issues, but the small sample of 4Ps beneficiaries with non-zero hospital charges should also be considered.

Overall, these findings imply that PhilHealth and the 4Ps are not providing sufficient assistance to its members. Considerable support still needs to be provided to relieve the burden of their healthcare expenditure. It is also necessary to improve awareness of the program among its members, because although some patients are already receiving PhilHealth benefits, their coverage by social health insurance remains unknown to them, which could lead to non-utilization of benefits or healthcare.

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