



# Understanding Out-of-Pocket Expenditure for Outpatient and Inpatient Care

Philippine National Health Expenditure Survey, Round 1

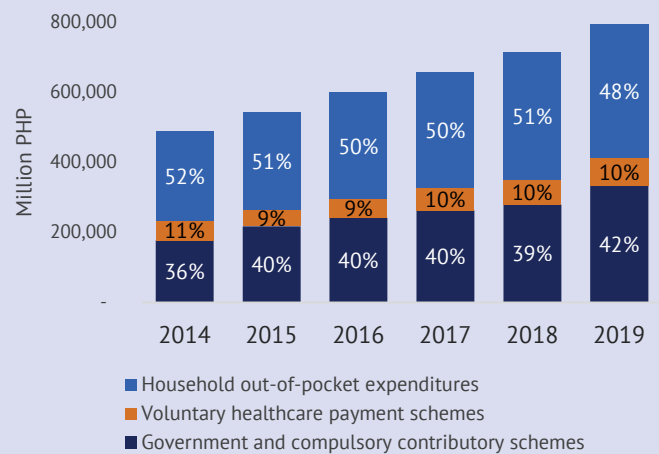
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## Introduction

High out-of-pocket expenditure for healthcare is associated with negative health outcomes. These can include impoverishment, poor habits on consumption spending, and decision making that can lead to failure to comply with prescribed treatment plans and the foregoing of preventive screening and tests. Ideally, out-of-pocket expenditure should be low—as low as 15–30 percent of total health expenditure—with alternative financing mechanisms provided by the government (Ulep and dela Cruz, 2013). Globally, out-of-pocket expenditure accounted for between 18.1 percent to 18.5 percent of current health expenditure from 2011 to 2018 (WHO, n.d.).

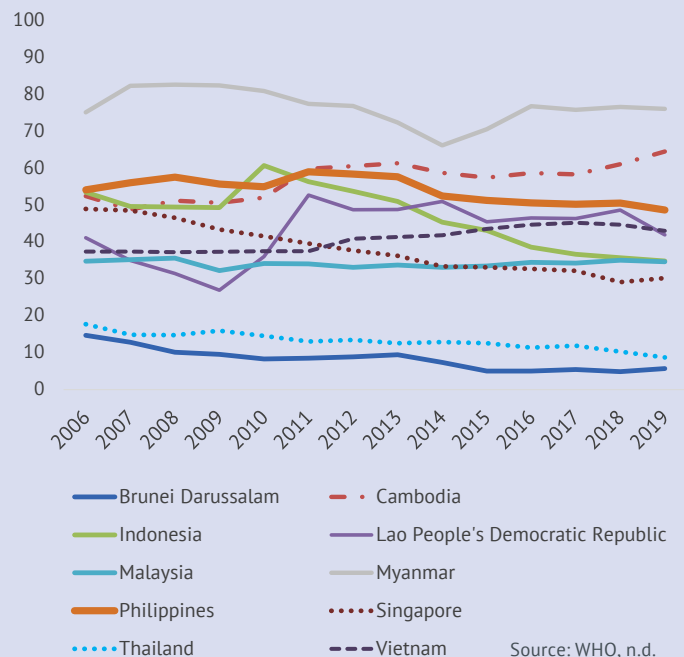
Despite having a national health insurance program (PhilHealth), the majority share of medical expenses in the Philippines is primarily paid for out of pocket by households (see Figure 1). In the Philippines, current health expenditure is financed with public sources, including national and local government transfers to public facilities and the Philippine Health Insurance Corporation (PhilHealth); private sources, including household out-of-pocket (OOP) expenditure and private insurance; and other sources, such as the Government Service Insurance System and the Social Security System. Current health expenditure increased more than 9 percent per year between 2014–2019, estimated at approximately 792.5 billion Philippine pesos (PhP) in 2019 (PSA, 2019). Meanwhile, household OOP as a share of current health expenditure decreased between 2014–2019.

Figure 1. Current Health Expenditure, 2014–2019



Source: PSA, 2020

Figure 2. Out-of-Pocket as a Percentage of Current Health Expenditure in Southeast Asia, 2006–2018



Source: WHO, n.d.

Regardless, out-of-pocket health expenses as a percentage of current health expenditure in the Philippines are consistently higher than in many other Southeast Asian countries (see Figure 2). Reforms instituted by the Philippine government to help reduce high OOP spending are summarized in Table 1.

In 2017, the Department of Health initiated a survey to further explore OOP spending by collecting comprehensive data on health utilization and associated details of expenditure. This brief uses data from the *Philippines' first National Health Expenditure Survey* (NHES) to provide a better understanding of OOP expenditures and,

**Table 1. Health Reforms Related to Out-of-Pocket Expenditure**

Year	Reform	Description
2008	Universally Accessible Cheaper and Quality Medicines Act (Republic Act No. 9502)	Allows the government to monitor and regulate the retail price of select drugs and medicines.
2011	PhilHealth shift from fee-for-service to case-based payment	Shifts to case-based payment for PhilHealth benefits packages, increasing price transparency for medical services and thereby providing financial protection to its members. This payment system adopts a standard pricing framework that provides equality in payments across healthcare providers for services of the same kind.
2011	PhilHealth introduction of “No Balance Billing” (PhilHealth Circular 2017-0006)	Provides free health services at accredited healthcare institutions for the most vulnerable segments of the society (elderly people, indigent populations, and domestic helpers).
2012	PhilHealth Primary Care Benefit I (PhilHealth Circular 2012-0010)	Provides a fixed amount subsidy for the package of outpatient care services and medicines for selected medical conditions for sponsored PhilHealth members and Filipinos working overseas who are PhilHealth members.
2012	PhilHealth Z Benefit Package (PhilHealth Circular No. 2012-0048)	Covers illnesses such as lymphoblastic leukemia (PhP 500,000 benefit), end-stage renal disease (PhP 600,000), and coronary artery disease (PhP 500,000).
2013	The National Health Insurance Act of 2013 (Republic Act No. 10606)	Shifts from premium sharing between national and local governments to that of full national subsidy of the indigent sector as defined and listed by the Department of Social Welfare and Development’s “Listahanan.”
2017	Medical Assistance for Indigent Patients (Department of Health Administrative Order No. 2017-003 and No. 2020-0060)	Grants medical assistance to indigent and financially incapacitated patients who demonstrate clear inability to pay for necessary expenditures for one’s medical treatment, such as catastrophic illness or any illness that is life or limb-threatening and requires prolonged hospitalization, extremely expensive therapies, or other special but essential care that would deplete one’s financial resources.
2018	PhilHealth Expanded Primary Care Benefit Package (PhilHealth Circular 2018-0017)	Includes health screening and assessment (based on life-stage essential services as provided in Department of Health Administrative Order No. 2017-0012), diagnostic services, follow-up consultations, and medicines for specific conditions of acute gastroenteritis, urinary tract infections, low-risk pneumonia, upper respiratory tract infections, asthma, hypertension, and diabetes mellitus type II. Covers all eligible beneficiaries in the formal economy (employed), lifetime members (retirees), and senior citizens.
2019	Universal Health Care Law (Republic Act No. 11223)	Enrolls all Filipinos into PhilHealth. There is a co-payment or co-insurance for those who can afford it while there is no balance billing for those admitted in basic or ward accommodation. There should be a comprehensive outpatient benefits package for all Filipinos. The prices of health goods and services must be published for transparency.
2019	Malasakit Centers Act (Republic Act No. 11463)	Directs Department of Health hospitals, identified local government unit hospitals, and the Philippine General Hospital to establish, operate, and maintain Malasakit Centers to harmonize the provision of financial assistance from government agencies, including financial medical assistance from agencies such as PhilHealth, the Philippine Charity Sweepstakes Office, and the Department of Social Welfare and Development.
2021	Implementation of Maximum Drug Retail Price (Executive Order No. 155, s. 2021)	Adds another 34 drug molecules or 71 drug formulations to the maximum retail price list to improve access to affordable and quality medicines and reduces health-related out-of-pocket expenses for Filipinos on other drugs and medicines commonly used for the leading causes of morbidity in the country.

ultimately, inform improvements to existing health policies and programs. The brief explores: (1) the population segments who have the highest OOP health expenditure, (2) the types of healthcare facilities with the highest ratio of OOP to total expenditure, and (3) inpatient health conditions that have the highest ratio of OOP to total expenditure.

## Methods

This brief presents data on patient expenditures associated with visits to health providers for outpatient and inpatient care that were extracted from the NHES household component database. *Outpatient care* refers to any medical care or service—including such services as general check-ups, vaccination, pregnancy-related services, walk-in services, and family planning—sought without hospital admittance or an overnight stay occurring in the six months prior to the interview. *Inpatient care* refers to any medical care or services sought for which a person was admitted to a hospital, infirmary, or birthing facility for a period of 24 hours or longer.

The NHES captures, to the extent possible, most medical and surgical procedures from the 2015 PhilHealth claims and membership databases and from the 2015 Philippine Health Statistics top morbidity conditions. The nationally representative household survey was conducted between November 2018 and May 2019 using a paper-based survey interview method and sampled 12,575 households across 503 barangays. The subsample used for this analysis included 9,714 outpatient

visits and 1,071 inpatient visits, capturing visits in which respondents were able to recall complete information on total expenditures and financing sources.

The Health Policy Plus (HP+) project, funded by the U.S. Agency for International Development, analyzed individual outpatient and inpatient service utilization and financing data, with a focus on OOP medical expenditures incurred inside and outside of health facilities. HP+ estimated OOP spending by incidence and by share of total health expenditure.

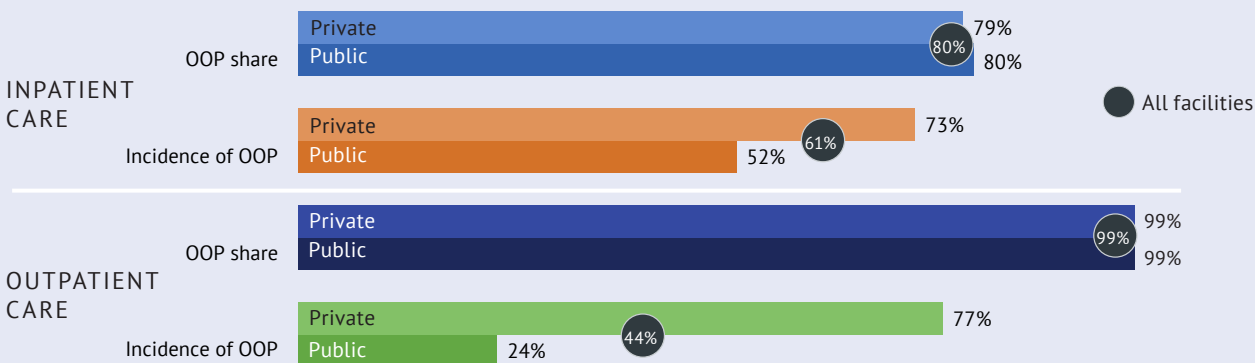
Due to the design of NHES, expenditure data cannot be disaggregated by financing source and cost component (professional fees, diagnostics, supplies, etc.). Data and results are limited by possible biases and misinformation reported during the survey. There is a possibility of self-selection bias, i.e., those who chose to participate in the survey may have experienced more health events or had more extreme experiences. Additionally, recall bias and misinformation from the household key informant may have led to inaccurate reporting. Lastly, the NHES sampling of barangays did not include the least-accessible barangays or areas with security concerns at the time of the survey.

## Results

### At What Type of Health Facility Is High Out-of-Pocket Spending Experienced?

The incidence of OOP expenses for inpatient care services was higher (61 percent) than for outpatient

**Figure 3. Out-of-Pocket Payment Incidence and Share of Total Expense**



care (44 percent) regardless of facility ownership type (see Figure 3). Incidence of OOP for inpatient services at private facilities was higher (73 percent) than at public facilities (52 percent). For outpatient care, incidence of OOP was much higher at private facilities (77 percent) compared to public facilities (24 percent).

Among those who accessed services incurring OOP expenditure, the proportion of OOP payments to total expenses per visit (“OOP share”) for all facilities was higher for outpatient care (99 percent) than for inpatient care (80 percent). Interestingly, the OOP share for inpatient care was close to the same whether the patient attended a public or a private facility, 79 percent for private and 80 percent for public. The share of OOP was even closer for outpatient care (both public and private OOP share was 99 percent).

Incidence of OOP was particularly high for people who utilized other facilities (e.g., independent diagnostic laboratories, testing facilities, and healthcare providers for diagnostic procedures), alternative care facilities, and private eye clinics (see Figure 4). Outpatient incidence of OOP in public facilities varied widely from 12 percent in barangay health stations and 16 percent in rural

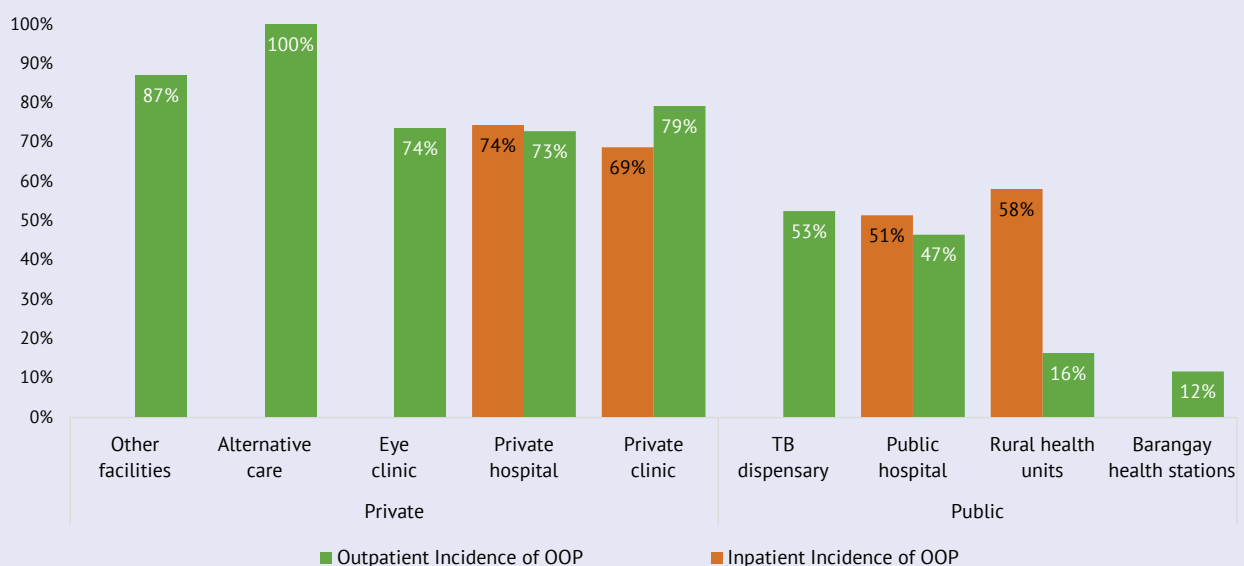
health units—where care is often provided free of charge—to as high as 53 percent in tuberculosis (TB) dispensaries. OOP incidence was high at private hospitals and private clinics for both outpatient and inpatient services.

Among those who paid OOP, the bulk of payments was used to pay for professional care and medicines for both outpatient and inpatient care events. In the case of outpatient care, professional fees accounted for 39 percent and medicines for 34 percent. For inpatient care, payment for doctors and other health professionals was almost half (49 percent) of total expenses while medicines accounted for 21 percent.

### What Are the Characteristics of Clients Paying Higher Out-of-Pocket Fees?

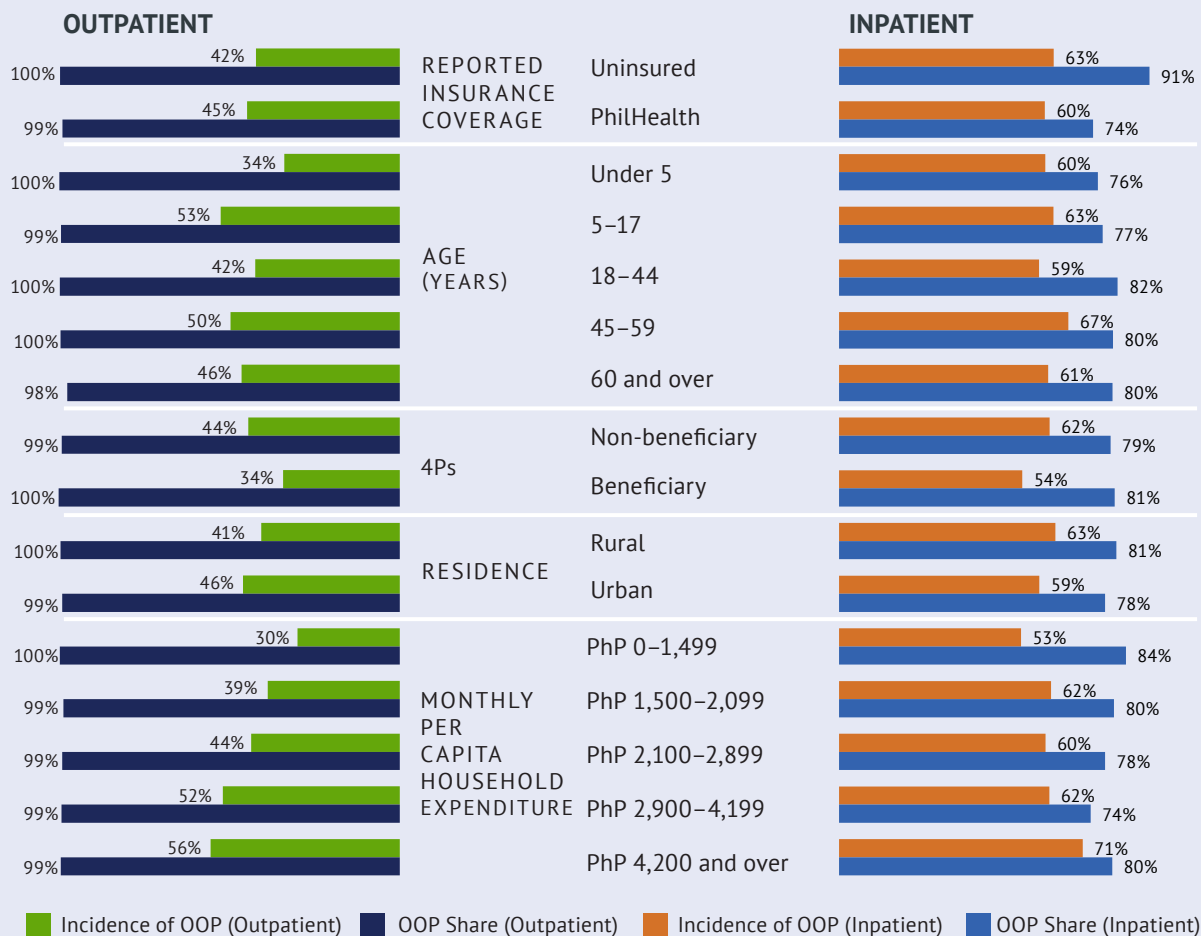
Figure 5 shows the share and incidence of OOP spending disaggregated by patient characteristic. For both the uninsured and PhilHealth members, OOP incidence was lower for outpatient care than inpatient care.<sup>1</sup> Patients under 5 or over 60 years of age reported paying OOP despite health reforms targeting youth and elderly populations. Beneficiaries of the Pantawid Pamilyang Pilipino Program (4Ps)—a national conditional cash

**Figure 4. Incidence of Out-of-Pocket in Total Expenses, by Facility Type**



<sup>1</sup> 40.1 percent of outpatients and 28.9 percent of inpatients were uninsured.

**Figure 5. Out-of-Pocket Incidence and Share of Total Expense, by Individual Characteristic**



transfer program that aims to provide social protection to poor households with children—had lower incidence of OOP for healthcare when compared to non-4Ps beneficiaries, regardless of care type. Those residing in urban areas had lower OOP incidence for inpatient care (59 percent) than rural residents (63 percent). But the opposite was true for outpatient care—urban residents had higher OOP incidence (46 percent) than rural residents (41 percent).

OOP incidence for outpatient care increased (from 30 percent to 56 percent) as per capita household expenditure increases.<sup>2</sup> According to Mishra and Mohanty (2019), the increase of OOP relative to wealth suggests that wealthier individuals might be seeking better-quality care from private health centers. Analysis of the NHES data has shown that households in the highest per capita expenditure

groups (at least Php 4,200 per month) utilized private clinics almost twice as much as did the lowest expenditure group. The same pattern was observed in the usage of private hospitals—household members from the highest per capita expenditure level utilized private hospitals 3.3 times more often than did the lowest group (Javier et al., 2021).

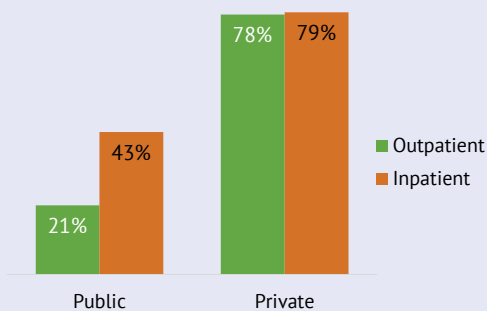
Groups that experienced high incidence of OOP for outpatient care include individuals 5–17 years of age (53 percent) and households with monthly expenditure per capita greater than Php 4,200 (56 percent). Among those who paid OOP for outpatient care, approximately 99 percent of the total expense was paid with OOP resources. Groups that experienced high incidence of OOP for inpatient care include those 45–59 years of age (67 percent) and households with monthly

<sup>2</sup> See Javier et al. (2021) for the method used in determining per capita household expenditure groups.

expenditure per capita of PhP 4,200 and above (71 percent). Among those who paid OOP for inpatient care, more than 70 percent of the total visit expense was paid with OOP across all population segments, including those who were covered by PhilHealth.

NHES analyses suggest that vulnerable individuals, including 4Ps beneficiaries and individuals who are 60 years of age and over, incurred OOP expenses even when care was sought in a public facility. For instance, considering only 4Ps beneficiaries, 21 percent of those who went to a public facility for outpatient care incurred OOP expenses (see Figure 6). For these individuals, OOP constituted 100 percent of total expenses paid. The incidence of paying OOP was higher for inpatient care at 43 percent for 4Ps beneficiaries, with OOP comprising 84 percent of total payments. Care for 4P beneficiaries in private hospitals and clinics had higher OOP incidence for both outpatient (78 percent) and inpatient (79 percent) care.

**Figure 6. Incidence of OOP among 4Ps Beneficiaries, by Type of Care and Facility Ownership**



### Which Inpatient Conditions Had the Highest Ratio of Out-of-Pocket to Total Expenditure?

The conditions (per ICD10 code) with the highest percentage of OOP are presented in Table 2. On average, the OOP share of total expenses for these conditions was at least 61 percent. Among the top inpatient care health services that necessitated

**Table 2. Percentage Share of Out-of-Pocket Payments in Total Expenses, by Top Inpatient Conditions**

Conditions (per ICD10 code)	Percent of OOP	Number of Observations (with complete information on sources of payment)
Urinary system disorders	78%	48
Essential hypertension	75%	41
Single spontaneous delivery, unspecified	73%	125
Infectious gastroenteritis and colitis, unspecified	72%	30
Dengue fever, unspecified	70%	53
Unspecified bacterial pneumonia	62%	35
Pneumonia, unspecified organism	61%	35

OOP payments, urinary system disorders had the highest share of OOP observed (78 percent) followed by essential hypertension (75 percent). Among people who utilized inpatient care for a single spontaneous delivery, 73 percent of the total expense was paid out of pocket.

## Policy Implications

Despite increases in the share of government financing of current health spending,<sup>3</sup> the share of OOP in total health payments is not significantly lower (PSA, 2020). Out-of-pocket payments decreased to below 50 percent of total spending in 2019, but still were the largest single source of funding among total health payments. When

<sup>3</sup> Including funds from the National Health Insurance Program and other government social security providers, such as the Government Service Insurance System and the Social Security System.

facility visit expenses are disaggregated, the contribution of OOP in total health payments is magnified. For instance, the NHES data from the medical provider component show that among patients who paid out-of-pocket costs, those payments covered 95 percent of outpatient care and 18 percent of total charges for inpatient care in public facilities, where healthcare goods and services are expected to be more accessible and affordable than at private facilities.

The NHES results showed that regardless of a patient's age, residence, monthly per capita expenditure, and insurance status, the contribution of OOP in total health expense was especially high for outpatient care (not lower than 97% of total visit expenses) compared to inpatient care. The NHES report (Javier et al., 2021) and other studies (Ulep and dela Cruz, 2013; Lavado et al., 2011) have noted that the limited PhilHealth coverage of outpatient services such as consultations, laboratory or diagnostic exams, and medicines may be a contributor to high household OOP for outpatient visits and are possibly the drivers of high OOP in the country.

The NHES data also indicate that the incidence of OOP among PhilHealth members and individuals with no insurance were comparable regardless of the type of facility visit, suggesting that insurance may not be providing enough financial protection. Before the implementation of the Universal Health Care Law in 2019, a person was required to have paid three monthly premiums in the six months prior to a facility visit before they could access PhilHealth benefits—unless the members were classified as indigent. This requirement may explain the NHES data showing that insurance benefits were not available to many PhilHealth members.

The NHES revealed that a large number of PhilHealth members using inpatient services still must pay out-of-pocket. These findings suggest that facility charges exceed the case rate ceiling amounts provided by insurance and indicate that adjustment to PhilHealth case rates may help lower OOP payments. The combination of unregulated, unpredictable, and high-priced goods and services and the limited and fixed

financial coverage of PhilHealth packages may also explain why people incur OOP expenses for medical conditions and procedures that ostensibly are included in PhilHealth benefits packages (DOH, 2018). The Ulep and dela Cruz study (2013) mentioned that drugs continued to be the main OOP expenditure in 2012, consistent with the findings of a related study conducted by Lavado et al. (2011). PhilHealth (2019) also identified that medicines, medical supplies, and laboratory and diagnostic procedures are the main reasons for OOP expenses.

PhilHealth has a No Balance Billing (NBB) policy, envisioned to zero-out the OOP expenses of target beneficiaries (patients admitted to public hospitals, 4Ps beneficiaries, and those who are 60 years of age and over). The NHES data suggest it is not fully effective. People eligible for NBB should be able to use inpatient care without any OOP expenditure; however, only about half (51 percent) of potentially eligible cases were reported as fully benefiting from the policy. This discrepancy may arise because NBB beneficiaries must be admitted to basic or ward accommodation within Department of Health-licensed government facilities to secure NBB benefits, unless such accommodation was not available or because a transfer to a non-basic or non-ward room was necessary.

NHES results and data from other studies presented in this brief underline the need for the recalibration of existing government interventions in easing the burden of health payments among Filipinos. NHES data suggest that the OOP share of total expense is too high and the most vulnerable populations do not have sufficient insurance coverage or knowledge of the benefits they might enjoy.

Health reforms on outpatient care—such as those outlined in the 2018 PhilHealth Expanded Primary Care Benefit Package—are not sufficient, highlighting the need for a more comprehensive outpatient benefits package. The high incidence of OOP spending and the significant share of OOP in total health payments call for more effective regulatory measures to reduce the cost of healthcare goods and services and for the expansion of existing financing schemes

to eliminate the unpredictability of health expenditures.

PhilHealth benefits packages should be reviewed and expanded in terms of service and financial coverage (i.e., increasing the case rates) to fully support the health needs of the people. The observations presented in this brief could inform reforms to the Universal Health Care Law, specifically its provision for automatic insurance coverage to all Filipinos through PhilHealth, granting of automatic eligibility for PhilHealth benefits packages, the elimination of co-payments during hospitalization, and the expansion of PhilHealth's outpatient benefits package.

## Acknowledgements

This brief would not be possible without the support of OIC-Director Frances Rose Mamaril of the Department of Health-Health Policy Development and Planning Bureau; Dr. Beverly Lorraine Ho of the Department of Health-Health Promotion Bureau and Disease Prevention and Control Bureau; Marichi De Sagun, Berhan Hagos, and Dr. Joseph Lachica at the U.S. Agency for International Development (USAID) Philippines; Carlos Antonio Tan and Dr. Carlo Irwin Panelo with USAID's ProtectHealth Project; the Philippine Survey and Research Center; and the households and health facility staff who took part in the survey.

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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 publication was produced for review by the U.S. Agency for International Development. It was prepared by HP+. The information provided in this document 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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