

Caballes, Alvin B.

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## Analysis of Catastrophic Health Financing by Key Institutions

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Philippine Institute for Development Studies  
*Surian sa mga Pag-aaral Pangkaunlaran ng Pilipinas*

## Analysis of Catastrophic Health Financing by Key Institutions

*Alvin B. Caballes*

**DISCUSSION PAPER SERIES NO. 2014-51**

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For comments, suggestions or further inquiries please contact:

**The Research Information Staff**, Philippine Institute for Development Studies

5th Floor, NEDA sa Makati Building, 106 Amorsolo Street, Legaspi Village, Makati City, Philippines

Tel Nos: (63-2) 8942584 and 8935705; Fax No: (63-2) 8939589; E-mail: [publications@pids.gov.ph](mailto:publications@pids.gov.ph)

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# **Analysis of Catastrophic Health Financing by Key Institutions**

Final Report

By: **Alvin B. Caballes, MD, MDE, MPP**

## **Abstract**

Financial protection of patients is considered a key component of health systems, and has been a consistent policy goal of the DOH. Of paramount importance in this regard are catastrophic health expenditures, which can severely restrict the access to much-needed services, contribute to (further) impoverishment, or result in both, for the affected patients and families. This study was undertaken to determine the institutional mechanisms for addressing these expenditures, and develop a framework to improve the existing arrangements. To be able to do so, focus group discussions (FGDs) and consultations were conducted for this study.

The key responses gleaned from the FGDs were: 1.) The participants' appreciation of catastrophic health expenditures varied - from the personal hardship testimony of patients, the bottom-line view of providers, and the arbitrary payment thresholds of some financiers; 2.) The emergent-intensive-chronic categorization appeared to hold well by way of identifying risks for patients; 3.) Patients and providers wanted easier accessibility to and greater transparency in the support-seeking process, and lastly; 4.) Participants also pointed out that there were related issues which needed to be looked into - such as inadequate supplies and manpower at health facilities.

Based on the inputs from the FGDs, the following recommendations are made: 1.) A new definition of catastrophic health expenditures is proposed thus: "The situation applies when a patient's condition requires medical interventions which are life- or limb-saving and determined to be clinically appropriate and cost-effective, but attendant expenses are beyond the actual means of the patient (or family) at the time of need, whether due to time or resource constraints."; 2.) The burden of financial support will be assigned to specific agencies, depending on care requirements (e.g., facilities to absorb costs of urgent care, to be subsequently reimbursed by third-party payers; PHILHEALTH and PCSO to attend to intensive care, and; PHILHEALTH and DSWD to finance chronic care); 3.) A dedicated unit will be established to further develop relevant policies and strategies for the integrated financing of catastrophic health expenditures.

Key Words: catastrophic health expenditure, universal health care, financial risk protection

## **EXECUTIVE SUMMARY**

*Financial protection of patients is considered a key component of health systems, and has been a consistent policy goal of the DOH. Of paramount importance in this regard are catastrophic health expenditures, which can severely restrict the access to much-needed services, contribute to (further) impoverishment, or result in both, for the affected patients and families. This study was undertaken to determine the institutional mechanisms for addressing these expenditures, and develop a framework to improve the existing arrangements.*

*Focus group discussions (FGDs) were held separately involving patients (or family members), providers (clinical and support staff), and representatives of policy or financing agencies. Patient participation represented a range of clinical situations. Providers came from rural and urban settings, from both public and private sectors. Agency representatives came from the DOH, PHILHEALTH, PCSO, PAGCOR, private advocacy and philanthropic organizations, and Congress. Follow-up consultations were held with the concerned agencies for validation purposes.*

*The key responses gleaned from the FGDs were: 1.) The participants' appreciation of catastrophic health expenditures varied - from the personal hardship testimony of patients, the bottom-line view of providers (and the consequences of either over-utilized resources or the need to pass on costs to other patients), and the arbitrary payment thresholds of some financiers; 2.) The emergent-intensive-chronic categorization appeared to hold well by way of identifying risks for patients. The institutional financial support for emergent and intensive care was inadequate. There are more mechanisms for chronic care - but there is a bias for inpatient care and a paucity of support for outpatient services. 3.) Patients and providers wanted easier accessibility to and greater transparency in the support-seeking process. The possibility of having a point person, possibly a social worker, to attend to the packaging of financial support for hospital patients was also raised. The payers' group realized the importance of adopting a common working definition for catastrophic expenditures as well as developing a coordinating arrangement/body to more systematically address this; 4.) Participants also pointed out that there were related issues which needed to be looked into - such as inadequate supplies and manpower at health facilities.*

*Based on the inputs from the FGDs, the following recommendations are made: 1.) A new definition of catastrophic health expenditures is proposed thus: "The situation applies when a patient's condition requires medical interventions which are life- or limb-saving and determined to be clinically appropriate and cost-effective, but attendant expenses are beyond the actual means of the patient (or family) at the time of need, whether due to time or resource constraints."; 2.) The burden of financial support will be assigned to specific agencies, depending on care requirements (e.g., facilities to absorb costs of urgent care, to be subsequently reimbursed by third-party payers; PHILHEALTH and PCSO to attend to intensive care, and; PHILHEALTH and DSWD to finance chronic care); 3.) A dedicated unit will be established to further develop relevant policies and strategies for the integrated financing of catastrophic health expenditures.*

**Key Words:** *catastrophic health expenditure, universal health care, financial risk protection*

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# **INTRODUCTION**

## **Background of the Study**

The Department of Health (DOH) currently espouses the Kalusugan Pangkalahatan (KP) or Universal Health Care (UHC) policy initiative. This ultimately seeks to ensure that all Filipinos, especially the poor, have equitable access to quality health care (DOH, 2010). The three main thrusts of UHC are as follows: financial risk protection, health facility enhancement as well as public/private partnerships (PPP) in health, and strengthening public health programs to enable the country to achieve the Millennium Development Goals (MDGs).

The stress on financial risk protection implies that patients and their families should not be exposed to the possibility of financial ruin should they need to avail of health services or goods. The converse situation corresponds to the occurrence of catastrophic health expenditures. The latter is defined by the DOH UHC Administrative Order (AO 2010-0036) as being “out-of-pocket spending on health that can drive a household to poverty or further into poverty and is often expressed as a percentage of household income”.

No less than the president has recognized the impact of such expenses on patients and their families, and had, in August 2011, introduced the Catastrophic Illness Relief Fund. While meant to involve several government agencies, the initiative ended up being primarily supported by the Philippine Health Insurance Corporation (PhilHealth).

PhilHealth thereafter started the “Z Benefits” program, wherein sizeable but fixed amounts are provided for the care of “catastrophic cases”, such as cancer patients, in selected government hospitals. However, catastrophic expenditures need not refer only to severe illnesses. Other adverse health events, while not medically complex, can also entail costs which can impoverish patients and their families. An evaluation previously undertaken by the author regarding the combined support from hospital discounts and PhilHealth reimbursements has shown that the financial protection provided is still inadequate particularly for indigent patients (Caballes, 2011).



Hospitalized patients have also individually sought recourse from other funding institutions. Among these are the Department of Social Welfare and Development (DSWD), the Philippine Charity Sweepstakes Office (PCSO), other government agencies as well as private and even international humanitarian organizations. There has been no systematic documentation, however, of how these agencies actually select and support their beneficiaries. It also remains to be established whether, individually or in combination, these agencies effectively and equitably address catastrophic health expenditures.

## **Objectives**

The study's general objectives were:

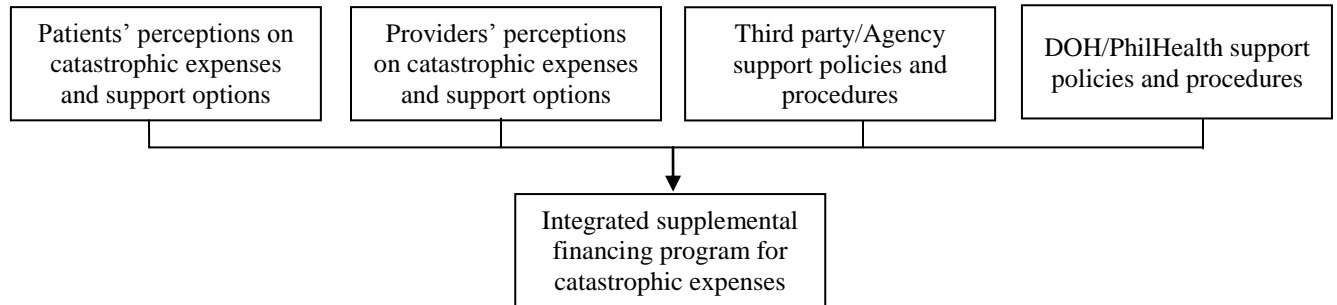
- To describe the participation of public and private agencies that provide financing support for patients faced with catastrophic health expenditures
- To develop a framework that can facilitate a coordinated supplemental third-party financing for such expenses

The specific objectives were the following:

- To ascertain stakeholders' understanding of catastrophic health expenditures
- To identify the government and private agencies that provide supplemental financing for catastrophic cases
- To characterize the operational capacities of these supporting agencies in addressing catastrophic expenses
- To determine their procedures for case selection
- To determine the extent of financial and other assistance
- To determine the institutional capability and willingness of the concerned agencies in coordinating financing support with DOH and PhilHealth
- To verify the conditions and arrangements that will enable an integrated financing support structure, in coordination with the DOH and PhilHealth

## Conceptual Framework

The conceptual approach utilized in this study is diagrammatically shown in Figure 1.



**Figure 1.** Conceptual framework of catastrophic health expenditure study

## Review of Literature

Taken in the aggregate, the occurrence of catastrophic health reflects poorly on the provision of both health and social safety nets by the government. Understandably, therefore, addressing these expenditures has been the subject of both inquiry as well as policy and program initiatives. There have been different attempts at qualifying what constitutes catastrophic expenses (Wagstaff, 2001; Murray, 2003). Regardless of the definition used, the concern remains, however, that, if disregarded, such certainly contributes to the inaccessibility of services, impoverishment, or even both, for the affected patients and households (Berki, 1986; Xu, 2003). In Cambodia, families who incurred debts to pay for the care needed by patients afflicted with dengue were unable to settle these after a year and continue to shoulder high interest rates - thus further making them more destitute (Van Damme, 2004). Expensive health payments have been shown to increase the poverty headcount in India from 27.5 to 31% (Bonu, 2007).

There are three key preconditions which have been postulated as being contributory to catastrophic expenditures, namely: health services requiring payment, low capacity to pay, and the lack of prepayment or health insurance (Xu, 2003). Nevertheless, such expenses have been documented in China despite the provision of health insurance, as the benefits were inadequate for the more expensive services – including those for chronic care (Yi, 2009; Sun, 2009).

The incidence of catastrophic expenditures has been reported to be relatively low in the Philippines, with drug purchases accounting for the greater part of such expenses (Doorslaer, 2005). Recently, however, there has been an increasing trend in the number of households so affected (Herrin, 2011). Hospital discounts and especially PhilHealth reimbursements have been of limited assistance particularly for poor patients (Caballes, 2011). Lower income households have been documented to be more prone to impoverishment, given the occurrence of catastrophic medical expenditures (Ico, 2008).

## **METHODS**

Focus group discussions (FGDs) were undertaken to obtain insights into the perceptions of all stakeholders as well as information regarding the policies and processes followed by providers and financing agencies. Three FGDs were held – separately involving patients (or family members), providers (administrative officers and clinical or support staff), and representatives of policy or financing agencies. These were held on 9 August, 2013, for the patients' group and on 12 August, 2013 for the others.

None of the patients invited to join the FGD were personally known to the author. Their potential inclusion in the study had been made possible by personal inquiries made by the author to his associates regarding the recruitment of potential participants. There was a deliberate attempt to account for specific clinical situations, so the participation mix was designed to conform to these (e.g., a nephrologist was asked to refer a patient undergoing dialysis). Patient participants therefore represented a range of health service requirement scenarios – including urgent (e.g., trauma), intensive (e.g., ICU care) and chronic care (e.g., cancer). Most of the participants in the provider group had been directly known to the author, except for the two hospital employees (i.e., social worker and pharmacist) who had been sent by their superiors (whom the author had directly contacted). The composition of potential participants was designed to ensure the representation of distinct provider settings. Thus, providers came from rural and urban settings, from both public (either DOH or Local Government Unit, or LGU, facilities) and private sectors, and represented a range of service responsibilities (i.e., from administrative to front-line positions). Apart from the former member of Congress as well as the convener of patient advocacy group who were personally invited by the author, the other participants in the financing group attended as official

delegates of their respective agencies. All invitees were provided introductory materials on the study and were also given copies of the informed consent form prior to their scheduled participation.

Before starting each FGD, a more detailed common orientation regarding the objectives and conduct of the study was provided to the participants. Likewise, informed consents were obtained following an exhaustive explanation – with additional emphasis given to the participants’ options regarding the possible inclusion of their names and even pictures in the subsequent publication of the study. Attendees who were representing agencies were told they had the alternative of not participating any further, with the additional qualification that their respective offices will not be notified about such a decision. All the participants were provided honoraria at the end of the FGDs, with additional allowances given to those who would have to travel from outside of the National Capital Region (NCR).

Catastrophic Health Expenditure Topic of Inquiry	Catastrophic Health Expenditure Issue Addressed
Meaning	Meaning & Importance
Significance	
Mitigating measures	Existing Institutional Measures
Institutions & roles	
Problems with support	
Improving effectiveness	Ways to Improve

**Table 1.** The corresponding FGD catastrophic health expenditure topics and issues

The participants were tasked to react to a series of six discussion points, with the phrasing of some of these questions slightly modified to be more contextually relevant for a given group. The points covered, and the issues which these were meant to address, are shown in Table 1. The author served as the facilitator for all the FGDs. Assistants were also present to document the proceedings. The voice recordings from the discussions were subsequently transcribed by these assistants. The responses of the participants were used as the basis for

drawing the study's insights and recommendations. Validation consultations were subsequently done with the concerned government agencies.

## **RESULTS**

The patients' group was the most difficult to assemble, inasmuch as recruitment was done indirectly. Some of the referred patients could not leave the hospital (for those who were concurrently confined) or their family members could not attend in their stead, as the latter were taking care of them. For all the groups, two invited participants were not able to attend the actual FGDs, despite having earlier indicated their willingness to join. These included: two patients, one of whom was to come from Region VII; an administrator of a private chronic care facility from Region IV-A and a nurse employed in a private dialysis center, and; the CEO of a private health insurance firm and the official representative of a public welfare agency. Some relayed their reason for their absence just before the activities (e.g., medical emergency). It must be noted that there was inclement weather then, particularly on the second day of FGDs. It was therefore anticipated that more participants would have been absent. Just the same, there were at least six participants per group – though a few arrived late. The facility administrators, who came from as far away as Mindanao – who were also practicing physicians – were fortunately able to attend the FGDs. All those who arrived for the FGDs opted to participate after going through the informed consent process, though a few chose not to have their names or pictures made publicly available. The list of attendees and their corresponding participant characteristics is shown in Table 2.

The patients were initially very reserved in their participation, and even seated themselves some distance from each other. None of them were previously acquainted with the other attendees. There were two participants who were more vocal at the beginning – the former drug addict who spoke very fluently, and a government employee who was familiar with health issues. The rest of the participants eventually became less inhibited and there was a lively exchange for the greater part of the FGD. The same dynamics were not observed in the other FGDs. While none of those present in the providers' group were also personally known to the other participants, all of them were equally assertive during the discussion. As for the last group, several of the attendees knew each other beforehand – either on a professional or personal level. The participants were also more vociferous and, rather than the facilitator

having to encourage people to take part, the conduct instead had to be restrained at times if only to give equal opportunities for everyone to contribute to the discussion. The participant from the private philanthropic agency did have to be prodded to be more involved in the talks, as he frequently pointed out that the topic was an eye-opener for him and that he seemed to be learning more by just listening to the rest.

<b>GROUP</b>	<b>PARTICIPANT CHARACTERISTICS</b>	
<b>PATIENTS/ FAMILY</b>	<b>Care Requirements</b>	<b>Represented Conditions</b>
	Acute	Trauma
	Intensive Care	Congenital Heart Disease (pediatric)
	Chronic	Breast Cancer
		Diabetes
		Drug Rehabilitation
End Stage Renal Disease (on dialysis)		
<b>PROVIDERS</b>	<b>Service Level</b>	<b>Represented Institutions/ Offices</b>
	Facility Administrators	Urban Private Hospital (Region X)
		Urban DOH Hospital (Region I)
		Rural LGU Hospital (Region VIII)
	Frontline Service Providers	Pharmacist (DOH, NCR)
		Social worker (PGH)
Support Provider	Cerebral Palsy facility (NCR)	
<b>AGENCIES/ ORGANIZATIONS</b>	<b>Agency Type</b>	<b>Represented Institutions/ Offices</b>
	Policy	DOH
		Congress
	Financing	PAGCOR
		PCSO
		PHILHEALTH
		Private Philanthropic Organization
Advocacy	Private Advocacy Organization	

**Table 2.** Group and individual characteristics for the FGD participants

The results, by way of the insights garnered from the participants' responses, are presented according to the three issues of interest to the study. Summaries of the responses are correspondingly presented in Tables 3 to 5. Consultations were subsequently undertaken with

the concerned officers or staff of the DOH, PhilHealth, and DSWD to both validate the inferences from the FGDs as well as to obtain additional information on their pertinent programs and strategies.

## ***Meaning and Importance***

### **Patients' Perspective**

Patients (or their families) were exceedingly concerned with the exigency of obtaining care, and considered the attendant huge expenses as something that inevitably had to be dealt with. This was succinctly stated by a participant as follows, *“Of course ang bottom line, ang pinaguusapan, (ay) buhay.”* Urgent or intensive care were the most trying, as the suddenness of the circumstances greatly added to the gravity of the expenses as well as compounded the difficulty of the medical situation. A participant related thus, *“Dinala ko doon sa family doctor namin (ang bata). Hindi na pinauwi. Sabi (ay i-) takbo mo na iyan sa hospital, anytime puputok na ang appendix niyan. Di siyempre takbo kami sa emergency. Ayaw kaming tanggapin kasi wala akong dalang pera. Wala kaming pang-down. Iyon ang sistema na sana mabago na paano ang tao nga kung walang dalang pera? Mamamatay ang pasyente! Sasabihin nila kahit may doctor, sabihin nila wala pa tayong doctor - magtiyaga muna kayo, mag-antay kayo.”* Another recounted what he had to say when his wife went into premature labor, and they had to go to the nearest facility. Their newborn child apparently needed a ventilator, for which payment had to be advanced. He supposedly pleaded thus; *“Sir, may pera ako. This is an emergency. Kung tumatanggap nga kayo ng credit card, (gamitin) lang itong card ko. Hindi ko lang dala ang ATM (card) ko. Considering na (taga-City X kami at) nandoon na sa (City Y) - gusto mo bang umuwi muna ako (sa City X) at makabalik dito after four hours para bayaran lang utang ko?”* Both the husband and the wife were government employees, and the facility pertained to was a DOH hospital.

As the foremost consideration was to save the lives of patients, the family members had to immediately draw on all their personal resources to be able to access the needed medical care. The effort can become increasingly difficult and desperate. A parent relates, *“So ang iniisip ko lang agad (ay) paano gagawin ko? Baka mamatay ang anak ko - wala akong pera. Kahit na halimbawa may kaunti kaming naipon, may kaunti kang ari-arian, hindi mo naman*

*instant(ly) ma-li-liquidate. Or kung ma-liquidate mo agad, hindi pa din (sapat) kung tuloy-tuloy na pagpapagamot. Marami pong tumulong sa amin na mga tao. Pero ... hindi naman lahat ng tao ay (may) available na tutulong na family or friends ... Kahit mayroon kang kaunting naipon sa sarili mo - dahil nagtrabaho ka - mauubos at mauubos talaga.”* As the families’ immediate resources get to be progressively depleted, they then sought out other sources – at times guided by hospital staff, but often relying more on word of mouth from other patients or acquaintances. The effort required to try and find additional funds greatly added to the physical and psychological strain on the patients and families – making the illness situation all the more arduous for them. A mother, whose child had a congenital heart illness that required immediate surgery, had this to say, *“Malaking tulong po kasi na ang pasyente ay magco-concentrate lang sa pagpapagaling (at) hindi niya na propblemahin (pa) ang: Paano ba ako bukas? Ang gamot ko, papaano ba? Ang pamilya ko - hindi ko masuportahan kasi hindi ako makapagtrabaho.”* Such hardships are not limited to the poor, as even those who are economically better-off also get to be overwhelmed by the expenses. The same mother said, *“Honestly po, the families (on) both sides - sa akin at sa asawa ko – ma-pera sila. Kaming mag-asawa, mayroong enough para mabili pa namin (ang aming mga) gusto ... (Pero) sa ganyang sitwasyon, parang dalawa lang ang scenario eh - operahan siya ngayon na kailangan na namin agad ng isang milyon, or hintayin natin ... iyon lang po ang options ko. And I did not have one million that time.”*

Ultimately, funds run out – or are not readily available when most needed – and families are left with the difficult choice of accepting less than appropriate services or giving up on further care for their loved ones. The less attention given to patients unable to pay the costs of care was raised by the mother of vehicular accident patient, *“So nakikita ko po na ang anak ko (na) parang hindi inaasikaso. Dapat may pera ka... Nakakabit po ang anak ko sa mga makina. Hindi ko alam ang tawag (sa) lahat (na mga iyon), pero nakakabit po siya doon. I had to argue with the nurses na huwag niyong tatanggalin, huwag niyong aalisan siya ng ganyan just because hindi pa kami makabayad nang ngayon na ngayon na ...”* The experience of a patient who had pulmonary bleeding was recounted by his wife, *“Ayun, na-emergency siya. Tapos in-intubate siya kasi nga hindi na talaga siya makahinga. Kaso, ang problem (ay) ayaw siyang dalhin sa ICU kasi wala kaming 25,000 ... So nandoon kami sa ER. Wala atang ano, insufficient, ang oxygen or may oxygen kaso may bayad. So ako na ang*



*nag-a-ambubag sa kanya.*” A participant, whose family was not able to sustain dialysis for their father, and who also later on lost a daughter who required urgent care soon after birth, said, *“Buhay ang pinag-uusapan, eh. Pero darating at darating ang pagkakataon na ipagpipikit mata mo siya. Ipagkikibit balik mo siya both ways, either financially o sa proseso, sa sistema.”* The consequence of the loss of another father’s life, apparently from lack of adequate care, on the surviving children was recounted by another member of the group, *“... Now (the) two children, two boys, (have) to fend for themselves. So 11 years old and 14 years old who end up not (going to) school because of lack of information, lack of government assistance. Now these two guys are -what’s the opportunity for these kids now? They’re living in a little kubo, cutting grass for neighbors just to make fifty pesos to buy food.”*

### **Providers’ Perspective**

The occurrence of catastrophic health expenditures, according to a hospital administrator, is a relative situation and is attributable to several factors – with the choice of facility being one of them. His statement was, *“... relative iyon sa pasyente: 1. titingnan natin (ang) economic status ng pasyente, 2. kung ano ang sakit, 3. kung ano ang event ng pagkasakit - emergency ba?, 4. anong hospital siya nagpa-admit?”* Opting for private care will necessarily be more costly – and can become unaffordable despite the patient’s initial economic status: *“We are in a private hospital (and) the moment (a) patient is admitted in intensive care (ay) ubos talaga ang pera. Regardless maski ano ka pa, maski pa lawyer ka pa, doctor ka pa, even regional director of the government agency - catastrophic talaga.”* The potentially adverse impact of such expenditures on the affected families was pointed out by the same participant, *“How (does) that affect the family as a whole? In terms of paano kaya (ang) pambayad ng tuition? Paano na kaya ang pambili ng bigas?”*

Catastrophic expenditures were of interest to providers inasmuch as these often adversely affect revenues – a particular concern especially in private hospitals – and can also lead to facility resources being over-utilized by the affected patients to the detriment of other cases. The view from a private provider was, *“Siempre ‘pag (may) mga catastrophic cases na nandyan sa intensive care (ay) number one talaga (na) it will affect (our) bottom line din.”*

Frontline public providers associated such expenditures with out-of-pocket patient expenses – inasmuch as the services and supplies required have exceeded subsidy ceilings and they would have to put on hold further provision if patients are not anymore able to pay for these. The problem seems to be more acute with local government hospitals, as their budgets and operational resources are more limited. The LGU facility administrator referred to such limitations and separately touched on the resulting shortages, saying, *“Even medicine(s), basic ER supplies, even gasa lang - walang supplies sa hospital (at) ubos na ... Fixed lang ang budget for the year, hanggang December 31. So sabi nga halos di naman (ito) adequate. So meron talagang times na you will run (out) of (these)...”*

The more difficult instances are those requiring protracted critical care. Patients who cannot afford to pay for services in private hospitals are either self-directed or channeled to government facilities, where the care is deemed to be more affordable. However, such arrangements are not possible when the required services are not available in the adjacent public facilities, either because these have not been put in place or are already being used in excess of capacity. Also, public facilities themselves are hard pressed in having to attend to cases requiring expensive treatments, given their limited budgets and supplies.

As care cannot be withheld even for cases that financially drain providers, there is increased pressure for families to secure additional funds or for limits to be set for the care being provided to the concerned patient. Physicians, in fee-for-service arrangements, are left with no choice but to monetarily write-off such cases, despite the added effort in handling patients who may have required complicated care. A rural practitioner remarked, *“As (an) individual health provider, as practice as a doctor, mabigat itong catastrophic health expenditures - kasi usually (ay) talagang bibigyan mo ng so much time, so much energy (ang) mga ganyang cases, tapos (at the) end of the hospitalization ay wala”*. The resulting deficit is passed on by private facilities to other patients, by way of higher charges, or recorded as tax deductions. For government hospitals, the financial loss translates to less subsidized care and supplies for the other patients patronizing such facilities. Quoting from the administrator of the private hospital, *“Private kasi. Ibig sabihin nyan, di naman in-a-absorb in the sense, pero nagiging promissory note kasi iyon. So later on, at the end of the day, mayroon tayong allowable sa budget (or) pwede mo i-apply sa BIR.”* The situation is aggravated when a particular patient’s prognosis is poor, yet existing legal restrictions and the lack of ethical guidelines

mean that resources cannot be held back and reallocated to other cases. A case in a DOH facility, concerning a patient with a guarded prognosis for whom the family demands continued in-patient care, illustrates the latter point. According to the administrator, “...*So nakatali ang mga resources mo ... (kasi) DOH has no policies, (and because of medicolegal concerns) ang mga doctor takot magdischarge ... So you take the chance away from the (other) charity patients.*”

### **Agencies/Organizations’ Perspective**

Some agencies adhere to their operational definitions for catastrophic health expenses. Thus, the institutions variously consider the type and severity of illness, care requirements, prognosis, and other aspects. The PhilHealth officer enumerated the factors that they take into account: “*Catastrophic ang isang condition if it will entail complicated procedures: if there is use of a lot of technologies - sometimes hindi pa proven - technologies that include drugs, use of procedures that includes devices; ... maraming doctor na nag-a-attend sa pasyente; ... (catastrophic) doesn’t necessary translated to a higher RVU; ... tapos matagal ang length of stay sa hospital; ... (at) maraming diagnosis - mayroong sakit dati ang pasyente or namatay ang pasyente.*” References to specific conditions (e.g., transplant for organ failure), need for ICU care, multiplicity of diagnosis and procedures, and over-all cost of care were the factors considered by PCSO in deciding on whether cases are indeed catastrophic. PAGCOR, which administers its own health fund for its members, has three qualifications for its catastrophic category: end stage or organ failure, ICU cases, and surgical conditions.

The agencies’ institutional interests also come into play. Thus, PhilHealth equates concerns with catastrophic expenses with the rationalization (or lack thereof) of care – and its implications on costs. Among other factors, physician’s prescribing practices and even fee rates were deemed to be contributory to such expenditures. Thus, the PhilHealth representative commented, “... *So ang mga doctor admittedly mag-pre-prescribe iyan nang mag-pre-prescribe, lalo na kung sponsored siya ng industry, sometimes even without basis of cost-effectiveness ...or hindi pa siya guided by evidence.*” PCSO, while desiring to support all affected patients, is similarly focused on the judicious appropriation of its funds. The DOH attaches significance to such expenditures because it is both a provider of care as well

as a financing agency – whether directly or indirectly, in terms of individual grants (i.e., through the Public Assistance Unit) or subsidies to its facilities. The DOH participant declared, *“As a provider, concern siempre especially (sa) mga medical centers namin - kasi we’ll be accepting patients. And although mayroon kaming nakukuhang budget from the national government, we (also) have to earn – and (from) Philhealth nga – to somehow supplement the income of the hospitals so (these) will be able to cater as well to more patients ... On the other hand naman, as financier, kasi sa amin din hihingi (ng) public assistance.”* PAGCOR gives importance to supporting its employees faced with catastrophic expenditures for productivity reasons; *“As an employer, we need to take care of our employees. If they are not satisfied with how we handle them, they will not work well.”*

While agencies were concerned with catastrophic expenditures as these directly relate to their financing obligations or organizational mandates, the politician and patient advocates considered foremost the consequences for patients – and the burden on society as a whole. The former member of Congress, based on her experiences with affected families, had this to say about such expenses, *“Parang kapit sa patalim ka na. So when you talk to people it means they’re desperate already. Tapos usually that means also that they have already, ano ho, naubos na ho ang family resources. Kasi po hindi naman congressman or mayor ang una (na lalapitan). Uutang ho muna yan sa mga kapitbahay, sa mga relatives...”* Later on, she affirmed, *“I think that as a society we should be concerned about this. Kasi hindi lang (ang may) sakit nila (o mga) namatay na. We have to deal with the economic disaster that it leaves behind to a family. Hindi lang family, (kung hindi) groups of people po iyan na talagang hindi na po makakapagtrabaho, hindi na po makakapag-aral at may utang pa po sila.”* The advocate additionally pointed out that, *“If you have healthy individuals, you know you’ll have happy families that are intact (and) will all be productive members of society. It’s the same thing. Hindi na-emphasize ang opportunity loss or the economic burden when all these diseases are not addressed and all families are burdened. It has a major impact on the country’s development and progress. So for me it’s a basic human right so it shouldn’t be ignored.”* In the end, the participants conceded that addressing catastrophic expenditures is a human rights issue, and effectively tackling the problem is an apt objective of government.

A summary of the responses regarding perceptions on catastrophic health expenditures, as garnered from the three groups, is provided in Table 3.

GROUP	RESPONSE
Patients	<ul style="list-style-type: none"> <li>• <i>Matter of life and death, and the means will have to be provided no matter what (until sources are fully exhausted, and care is withheld)</i></li> <li>• <i>Need to ask help from outside of the family to be able to urgently meet health care expenses – including having to borrow money</i></li> <li>• <i>Acute situations (Emergency/ICU) most difficult to cope with</i></li> <li>• <i>Attending to sourcing of money poses additional physical and psychological burdens and therefore makes the illness situation more difficult for the patient and the family</i></li> <li>• <i>Problem is not limited to the very poor</i></li> </ul>
Providers	<ul style="list-style-type: none"> <li>• <i>Depends on the patient’s medical and economic status and choice of facility</i></li> <li>• <i>Facility resources are limited, and patients requiring protracted and expensive care but are unable to pay for these greatly strain these</i></li> <li>• <i>Restriction of therapeutic options for some cases</i></li> <li>• <i>Ethical and legal restrictions on handling non-paying cases</i></li> <li>• <i>Financial bottom-line important for private providers</i></li> </ul>
Agencies/ Organizations	<ul style="list-style-type: none"> <li>• <i>Varying operational definitions of catastrophic health expenditures, at times informal, with references to type and severity of illness, care requirements, and costs</i></li> <li>• <i>PHIC additionally concerned with rationalization of care</i></li> <li>• <i>PCSO concerned with fund rationalization</i></li> <li>• <i>DOH both health service/facility provider and financier</i></li> <li>• <i>A human rights issue</i></li> </ul>

**Table 3.** Summary of FGD responses on the meaning and importance of catastrophic health expenditures

## ***Existing Institutional Mechanisms***

### **Patients’ Perspective**

Institutional support was sought by patients mostly after they had exhausted their own sources, including assistance from their immediate family as well as friends. Information on which institutions to approach, and the process involved, was more often obtained from

acquaintances, and, where available, eventually from hospital social workers. The patient who had breast cancer narrated how she herself helped guide other patients on how to seek assistance, “ ... *(sabi ko sa) kanila, katulad noong kasama ko sa ward, punta kayo doon para (may) makatulong sa inyo.* ”

Among the institutions that were accessed, it was PhilHealth which was most appreciated by the patients. The positive reaction to PhilHealth arose from the minimal bureaucratic requirements (“*Automatic naman po nila iyon binabawas*”, as a participant quipped), the facilitation provided by the hospitals themselves (“*Tatanungin kayo sa hospital - May Philhealth po ba kayo? Para makabawas, inuuna kaagad nila...*”), and the predictability of the benefits (“*May nakalagay po iyon na certain amount - kung ilang percent siya kunyari po sa (kung anong) sakit.*”). PhilHealth support was therefore equated as a convenient discount mechanism. When queried further, however, the participants admitted that they did not know beforehand – either prior to or during the confinement period – what the exact amounts were that they could actually expect from PhilHealth. The patient with end-stage renal disease complained about the inconsistency of the access to PhilHealth benefits among different facilities, saying, “...*(Sa) hospital kasi kailangang labas (ka), tapos reimbursement. Sa ibang ano naman, dialysis center, mayroon naman silang cash-out basis. Basta makabayad ka the whole year tapos, iyon, ok na na sila na (ang) magpa-process*”. PhilHealth policies are overly restrictive in some cases, as exemplified by this anecdote: “*Ang friend ko po, na-ER ang mom niya. Eh wala pa pong 24 hours (when) she passed away na doon na din ... sa ER. So nang (nag-file ng claim sa) PhilHealth (ay) hindi daw maa-avail kasi wala pang 24 hours (admitted) ang patient.*” None of the patients were aware of the Z Benefits program.

PCSO assistance was sought particularly by those requiring very costly care. Nonetheless, the process involved was considered as tedious and frustrating, with a lot of uncertainty regarding the extent and timing of support. The participants recounted the ordeal of attending to documentary requirements thus: “*Sa PCSO, tumutulong sila. Pipila ka. OK, fine, lahat naman ng tao kailangan ng tulong, eh. Pero ang dokumentong mga hinihingi nila - it takes a while to get those documents. That’s one (thing) kung makuha mo ang dokumento. Another pila ka na naman (at) ire-reassess ka nila.*”; “*Hihingi pa ako ng abstract sa DSWD munisipyo tapos dadalhin sa...maraming process bago mo madala sa PCSO*”; “*Mahirap*

*kasi pupunta ka nang madaling araw (sa PCSO). Pipila ka. Pag pila mo...hindi naman pera ang ibinibigay sa iyo eh. Inihahatid na lang (ang guarantee letter sa hospital). Kaso, mag-aantay ka ng one or one and a half months bago ma-aprubahan. Babalik ka na naman doon. Madaling araw na naman pipila ka. Para bang minsan kahit na gusto mo ng tulong, mahirap ka na, mas lalo ka pang nagmumukhang pulubi ... Ayaw na po ng husband ko. Sabi, tumigil ka na nga diyan... Tayo humihingi tayo ng tulong, pero minsan kasi (ay) parang kinakawawa ka...”; “Tiningnan ang asawa kong ganyan (ng PCSO social worker), tapos ang sabi sa kanya (ay) hindi ho kayo mukhang mahirap. Hindi siya binigyan.”; “Kasi, bago kayo bigyan ng tulong (ay) talaga(ng) i-interbyuhin mismo kayo – pasyente o (kung) may asawa kayo, kayong mag-asawa iinterbyuhin. Tapos (ay) mag-aantay kayo ng mahigit isang buwan. Kaya tumigil na po ako. Kailangan ko ng maoperahan, eh.” Patients also had no way of knowing how much support was to be granted to them, and even the basis for such awards. Such a perception was exemplified in this comment from a participant, whose earlier request for PCSO assistance was rejected, “Sa PCSO ang sinabi lang namin, pangalawa na ho ito, eh. Kung ayaw nyo kaming bigyan noong una, pangalawa na po ito – talagang walang-wala na kami. Siguro naniwala na sila, OK, and nagbigay naman. Hindi ko rin po alam kasi kung paano nila kinukwenta, kung magkano dapat bigay sa inyo. So hindi ko pa masabi sa ngayon kung ang binigay nila sa amin ay talagang sapat. Kaya lang kapag nandoon ka sa ganooong sitwasyon (ay) parang lahat ng makuha mo – malaki (o) maliit – (ay) tulong.”*

Financial assistance was also availed of from other sources. Some of these, however, were either difficult to transact with - though the aid provided could be substantial (“*Actually ang nagturo po sa amin (sa foreign foundation ay ang) kasabay naming nagpapatingin na sa doctor. Sinabi niya sa amin na huwag mong sasabihin na nanggaling sa (kanila) ang impormasyon. Sabihin mo nahanap mo lang sa internet kasi hindi sila nagpa-public. Pero ganoon kalaki ang tulong at instant iyon ... Binasa lang ng parang in-house doctor nila ang abstract. Tapos prinoseso na agad ang visa noong bata tsaka noong mother (at) alis agad (for treatment abroad)*”). Others provided only token support. Among the latter were contributions from politicians and even private insurance. Thus, the offices of senators, congressmen, and mayors were approached by some of the participants. The usual procedure was supposedly as follows, “*Magdadala kayo ng medical abstract. Hindi naman kayo haharapin (ng official). Ang haharap sa inyo (ay) staff (at) sasabihin (na) bumalik na lang*

*kayo sa (ganoong date).*” The amounts handed out – through guarantee letters addressed to facilities where politicians have set up accounts (e.g., financed by Priority Development Assistance Funds, or PDAF, the so-called pork barrel funds of legislators) – are not sizeable but are still considered helpful. *“Although ang isang guarantee letter (ay) parang 2,000 pesos (ang amount), parang ganyan, sabi nga malaki (o) maliit (ay) tulong (pa rin).”* Private insurance reportedly provided limited coverage and also restricted choice of or access to providers. *“My father (had this) before, pero 15,000 coverage (lang). (Kung) chronic kagaya noong sa amin na-experience – isang buwan lang kami sa hospital, tapos na iyon, eh”; “Three hospitals that didn’t accept my so-called medical insurance. So from that point, I would really (be) in dire need of medical attention”.*

Discount privileges were also available for selected groups – such as Persons with Disability (PWD) or senior citizens. Finally, providers also gave discounts, either on a personal or institutional basis. The dialysis patient pointed out that *“(ang) PWD card, parang senior citizen (card). Medyo nakakatulong din po iyon sa meds.”* The issuance of the PWD cards was regarded as a DSWD program. The breast cancer patient received pro-rated hospital discounts, as conferred by a social worker, in addition to her senior citizen privileges, *“ ... libre laboratory, ang (may) white (social service) card, dito po iyon sa (name of hospital) – pero sa gamot ay hindi. Mas nakakatulong ang sa senior citizen, na 20% (ang discount).”* A participant has this to say about concessions from providers, *“Sa amin, maraming doctor na nag-waive na ng fee nila para lang makatulong – which is a bigger help ... mas malaking tulong sa pasyente kaysa sa tulong ng government.”*

### **Providers’ Perspective**

Government hospitals directly subsidized part or all of the costs of care, or indirectly by providing discounts for their service charges. The latter, as described by a medical social worker working for a public university hospital, involved the assessment of the patients’ economic status as well as medical needs. Thereafter, the setting of proportionate discount schedules for charges as well as a determination of external institutions or groups which can be tapped to additionally support the patient’s financial requirements would be attended to. The social worker remarked, *“Isipin mo na lang sa cataract – gagastos ka ng 16,000 ... (at) isang mata pa lang iyon. Ang sagot lang ng Philhealth doon (ay) 9,000. So re-refer mo siya*



*sa congressman, sa senado. Isang mata (lang ) nya (ito), eh ang pangalawa - saan kukunin (ang pera)?”* The discount designations are modified during the confinement period by the social worker to better reflect the contemporaneous financial impact of in-patient treatment. Not all hospitals, and especially private hospitals, provided the same breadth of social service support.

PhilHealth was both a boon and a bane for hospitals. The administrator of an LGU facility noted that, with heightened PhilHealth enrollment in their province, he has observed a marked increase in the utilization of their local public hospitals. *“In my experience, case payment is really helpful for the indigent (patients) - although marami pa rin syang limitation ... I was asking myself, (before there was increased PhilHealth enrollment)... hindi pumupunta ng hospital (ang mga tao)... ang mga (may) pneumonia, ang na-stroke hinihintay (na lang) nila mag-subsidize ... Nakatulong talaga ang insurance.”* However, another participant, who had been involved with the administration of both LGU and private hospitals, opined, *“Tignan mo ang income ng (LGU) hospital, talagang lumiit (with case rates). Isipin mo, saan bibili ang hospital ng medicine? How will the hospital, let us say, maging self-reliant? ... so lugi nga ang mga government hospitals sa case rate. Walang problema sa mga private hospitals, kasi ... No Balance Billing will not apply.”*

PhilHealth requirements that patients’ charges for supplies or services sourced from external outfits still be made payable by the hospitals as well as the disallowance of any added charges to patients enjoying No Balance Billing (NBB) privileges apparently place undue strain on the facilities’ finances. The DOH hospital administrator commented thus, *“May policy di ba (ang) PhilHealth (to) provide (lahat) ng medicines (para sa) PhilHealth patient? I try to do that to the letter, kahit di available dito, ibibigay ko sa (emergency) purchase. So parang, wala nga ito tapos bibili pa ako sa labas. Iyon ang daming regulations ... (and) you don’t want to be found wanting when they evaluate.”*

Many of the participants were aware of the various PhilHealth benefit programs. The Z Benefits were not yet offered in their institutions. The pharmacist, who works in a hospital that primarily caters to urban poor patients, noted that, *“...kasi sa ngayon ang PhilHealth natin, may mga package na yan. May mga case rate na. Pero once ang sakit ng isang pasyente (ay) hindi pumasok sa package, may mga limit po. Once na-exhaust nila iyon, that’s*

*the time (na) mag out-of-pocket ang pasyente. Lalo na kung ang gamot minsan ay mahal, doon sila nagkakaroon minsan ng problema... Kailangan ma-sustain ang gamot na iyon (pero) wala na silang pambili.”* Even NBB patients are not actually spared from out-of-pocket payments, as they may still have to advance some funds, “... *magkakaroon pa rin ng time na kailangan pa rin sila ang mag out-of-pocket. Pero ang nangyayari doon (ay) ... babayaran pa rin sila nang hospital.”*

PCSO support can be more substantial than what can be availed of from PhilHealth, but the funds – similar to PhilHealth reimbursements – get to be received by the facilities several months after patients’ confinements. The funding variance has created perverse incentives, and also underscores the lack of coordination in public financing. One of the administrators articulated that, “*I know that PhilHealth has a ceiling paying back or reimbursing and PCSO doesn’t have such a ceiling. I would rather bring the patient to PCSO than enroll them to PhilHealth, di ba? So parang they are not working together.*” The participants were aware of the difficulties that patients have to go through to access PCSO. The social worker, however, commiserated with the PCSO staff, saying, “*Alam (ko) kung ano ang personality ng (mga) tao sa PCSO. Talagang pila sa lahat ... gumawa ka ng paraan kung papaano iikli ang pila na ito, paano matatapos ang pasyente. Iyon kasi, talagang walang (katapusan), (at) kalaban mo pa ang mga fixers... Hindi mo na din alam talaga kung sino ang totoong (pasyente), sino ang hindi. So kung minsan tinitingnan ang itsura... Kahit naman sa hospital makikita mo iyan. Kami nakikita namin paglabas ng kotse, magpapalit ng tsinelas.*” There was the general impression that patients who had already filed their PhilHealth claims were already excluded from seeking PCSO support, though this was disputed by the social worker.

PDAF could be availed of, but this option is contingent on the facilities being officially designated as repositories of such funds (as formalized in Memoranda of Agreement, or MOAs) and the patient meeting the inclusion criteria for such funding. The individual amounts, while awarded during the period of confinement, are very limited. With the exception of the university hospital, foundations or philanthropists were not looked upon as consistent sources of assistance. The social worker recounted, “*(May mga) donor na dumadating na regular – ang isa twice a week, ang isa twice a month. So pwede naming i-refer doon ang mga pasyente... Kunyari antibiotics iyan. Kung seven days ang antibiotic mo, na-parte mo na ang first two days (sa) family (at) the rest na 5 days baka dalawang donor*

*namin maghati noon, depende doon sa gamot...*” The participant from a chronic care facility lamented the lack of external support options for their patients. They have tried to obtain assistance from DSWD, but, she said, “... *iba kasi priorities eh... priorities nila (ay) Conditional Cash Transfer. We’ve been advised, the center has been advised, na kung lalapit kami sa DSWD, we (have to) pattern our request alongside their priority ...(at kung) babaybayin (ang ganitong) daan (ay) magkakaroon naman (ng) masyadong maraming red tape.*”

The apparent inadequacy of external support for patients who are unable to cope with catastrophic expenditures therefore result in the continued levying of user fees (and consequent out-of-pocket payments by patients) by public hospitals and, as discussed in the preceding section, the progressive draining of the facilities’ financial and physical resources – to the detriment of other patients.

### **Agencies/Organizations’ Perspective**

The agency representatives discussed the salient features of their support programs, stressing their anticipated positive effects as well as drawing attention to apparent shortcomings.

The PhilHealth official enumerated the following elements of the Z Benefits Package: “*We have eight Z packages. (For) the first set, we have breast cancer – for early breast cancer. And then we have acute lymphocytic leukemia, standard risk, hanggang ten years old lang iyon. And then, prostate cancer – intermediate risk lang up to 70 years old. And then kidney transplantation, standard risk, hanggang 65 years old. Tapos ang second set namin is coronary artery bypass, standard risk. And then dalawang repair ng congenital heart disease: TOF, hanggang five years old, (and) VSD, hanggang ten years old. And then, cervical cancer all stages po. And then, ngayon po, we are coming out with benefits for devices para sa mga orthopedics implants and then external prosthesis.*” The package also prescribes for a more holistic approach to patient care, including an integrated monitoring system, “*..lalo na po sa mga cancer patients. Dapat educated sila kung kailan ang follow-up. (We) also introduced a tracking system. (So) for every patient (who) enters the Z Benefits (program), we track the patient until improvement, until death or loss ... (We are) developing the system in collaboration with UP NIH.*” The benefit package is intended to drastically minimize costs of care for patients; “*Dinesign po ngayon ang mga benefits na ... mayroon*

*pong mga selection criteria na kapag pumasa at kung ikaw ay napakahirap (ay) No Balance Billing ka. Lalabas ka ng hospital na wala kang binabayaran. Pero kung may kakayanan naman po magbayad, naka-design din po ang benepisyo na may fixed out-of-pocket na tinatawag naming “fixed co-pay”.*”

GROUP	RESPONSE
Patients	<ul style="list-style-type: none"> <li>•PHILHEALTH deemed most responsive, but benefits are available only at time of discharge</li> <li>•PCSO difficult to transact with and benefits are unpredictable</li> <li>•PDAF, hand-outs from politicians – small amounts but helps</li> <li>•PWD – attributed to DSWD; card not accepted in all establishments</li> <li>•Private foundations – substantial support but only to very few patients</li> <li>•Private insurance – very limited assistance (i.e., choice of providers and extent of benefits)</li> <li>•Others: physician discounts, hospital discounts, senior citizen’s discounts – often sizable but not uniformly accessible</li> </ul>
Providers	<ul style="list-style-type: none"> <li>•Social services-enabled discounts are provided based on patient’s economic classification – which can be adjusted in the course of treatment</li> <li>•Government hospitals, especially those administered by LGUs, have limited budgets to cope with costs of care of affected patients and need to rely on external sources</li> <li>•PHILHEALTH reimbursements were deemed inadequate, and having to provide for all NBB patients’ care requirements result in losses for the facility</li> <li>• PHILHEALTH and PCSO payment comes after discharge – and timing and amount unpredictable for PCSO</li> <li>• PCSO does not support PHILHEALTH patients</li> <li>•PDAF available during confinement, but only small amounts can be availed of</li> <li>•Foundations are difficult to sustain</li> </ul>
Agencies/ Organizations	<ul style="list-style-type: none"> <li>•PHILHEALTH NBB still not fully implemented</li> <li>•PHILHEALTH Z Benefits initiated but still with limited scope</li> <li>•Significant expenses for patients prior to Z Benefits inclusions, which are therefore not covered (e.g., diagnostic work-up for leukaemia)</li> <li>•PHILHEALTH with unequal premiums (none for Sponsored Program members) and, for the Z program, unequal benefits</li> <li>•PCSO follows existing criteria, but such not publicized and management has flexibility on awards</li> <li>•Employment-based insurance can provide substantial support</li> <li>•Private philanthropy can offer only limited and highly selective support</li> <li>•DOH developing reference price for medicines</li> </ul> <hr/> <ul style="list-style-type: none"> <li>•DOH, PCSO, PAGCOR separately procuring drugs in bulk for indigent use</li> <li>•Minimal interagency coordination</li> </ul>

**Table 4.** Summary of FGD responses on the institutional mechanisms for addressing catastrophic health expenditures

The limitations of the Z Benefits program were also raised, particularly by the non-PhilHealth participants. Apparently overlooked are the expenses as well as the expertise required to, for instance, establish the diagnoses that will enable patients to qualify for the program. The former member of Congress, a physician, noted, “...to see the GP, 500 (*ang gastos*), then the jeep 1,000 *kung malayo (ang) bahay nila*. And the GP (has to be) smart enough to tell you that’s leukemia. So you have to be (in) a good urban center ... Somebody (has to) do bone marrow biopsy, somebody (has) to read it ... Nobody (who is) indigent will be diagnosed.” The program was perceived to be not widely accessible, an opinion which seemed to be supported by what was known to the PhilHealth officers regarding its current effectiveness. Thus, of the 500 cases of breast cancer set as the initial target for the Z Benefits program, PhilHealth has, “(since) we launched it June last year, *meron kaming wala pang 200 patients (na) na-serve*.” The bias of the program’s support for indigents, such that the non-poor still end up having to pay significant out-of-pocket amounts, was criticized. Another participant said, “... ‘*pag sponsored, ka you will get 500 thousand. Pero ‘pag paying ka, you will get 200 thousand. Ang weird niya in the sense na hindi equal ang pag-deliver (ng benefits)*.”

The scope of the Z benefits program, by way of range of covered conditions, is still narrow – and does not include intuitively catastrophic conditions such as those requiring urgent care, as with trauma cases, nor does it provide support for other chronic illnesses, such as those requiring prolonged psychiatric care. A participant opined, “*Kasi we are still struggling with illnesses that we can physically see. Sometimes (ay) nahihirapan pa ho tayo. Our funding agencies are not yet in their maturity stage na to look at psychiatric illnesses. But definitely (these) are a huge burden not only to the family (but) even to society*.”

Another PhilHealth instrument, the use of case rates, has the potential to substantially reduce costs for patients, more so as it prescribes for no co-payments, or balance billing, from indigents enrolled in the Sponsored Program. However, the PhilHealth participants were unsure about the actual impact of the latter, and the NBB policy was perceived to be not yet fully implemented.

The support provided by PCSO was lauded by the former member of Congress as well as the patient advocate – inasmuch as they had seen how PCSO funding had greatly helped their constituents. The PCSO official, with respect to the assertion that patients needed to appear to be destitute to be able to qualify for the agency’s assistance, retorted thus, *“actually kahit nakadamit ka ng maayos, puede kang pumunta sa PCSO ... (in the event of service deficiencies) puede mag-comment, (you can) get the ID, get the name plate – mayroon kaming name plate – you can complain. Mayroon (din) kaming suggestion box doon.”* The perceived discrimination was attributed to the patients being too emotionally sensitive, or due to the actuations of non-employees; *“(Ang ibang pasyente ay) may inferiority complex...pag medyo stressed ka na, ganoon ba ...di namin controlado ang mga taong nakapaligid doon except ang aming sariling tao...”*

The inconvenience that patients had to go through in order to obtain PCSO support was a matter that was somewhat contentious. A participant felt that this was acceptable, if not necessary. Comparing the process to one that patients had to go through to avail of charity surgical services, *“... The patients will have this line – one after another sa upuan ... They keep on moving; pausog, pausog, pausog. Sa charity, there is no express lane. Walang singitan ... They have to go through this process. It’s not on a silver platter, eh. They have to work somehow to get it. Iyan ang that’s how I think. (If) you want to avail (of) PCSO, you have to go and work for it.”* The arduous transaction process was, however, deemed to be objectionable by others. One participant stated, *“Nagbabantay kami ng maysakit, namatayan ka na, pipila ka pa. Ang init-init doon.”* Another considered the issue in the context of the uncertainty associated with the PCSO grants process, *“Siguro, it will help us to convince people na nahihiya, natatakot, na-i-intimidate, naiiyak na sa buhay na it is worth to line up if they know how much (they are going to get). Para alam na nila kung dumaan sila sa prososeng ito, ito ang amount (na makukuha) nila. Kasi parang nahirapan ako talaga, kinakaladkad ko (pa) ang iba diyan. Galit na galit pa.”*

The PCSO representative clarified that, far from being uncertain, the agency actually followed set criteria in determining the amounts that are to be granted to patients. The procedure was described as follows, *“May classification process ... para pumasok ka doon – kahit sino pong may sakit, puwede mag walk-in, or puwedeng i-refer ng kahit sino, puede naming tanggapin. Pero ang criteria papasok na lang pag-ininterview na. Then, di naman*

*kayo puedeng i-deny doon unless wala ka sa policy. Kung бага, di kasama sa policy ang request mo, like reimbursement – sa interview malalaman mo.”* But even as there may be reference formulas, there is some flexibility exercised by the agency’s management in determining the actual award for particular patients will be, “ *... But there (is) discretion (by) management ... although minimal. Kung бага di na po siya tulad ng dati. Kasi may system (that) we institutionalized ... halimbawa CABG, ...classified privately 30 % if you are private C , for charity patient malaki makukuha mo ..100 %, charity B 25 %, charity C 19%. Nalalaman po ninyo pagdating sa evaluation.”* Additionally, while the PCSO grants requirements are publicized, the evaluation criteria are not, unlike those for PhilHealth.

PAGCOR has shifted its support to institutions, such as donating medical equipment to hospitals, and has steered away from helping out individual patients. Just the same, it has developed a health insurance scheme for its own employees. This is described as follows: “*We pay 50 pesos to help one patient. So kung 12,000 kami, computin mo ... that is how much na they can (raise) every time ... Ang natulungan namin from 2002 to 2012, (we) were able to give these people about more than 13 million ... na hindi namin naramdaman kasi 50 pesos lang iyon (na) inaawas sa salary namin. Di namin pinapansin iyon pero ang natutulungan niya can cover for the 6 sessions of chemo therapy. Right now, we can give as high as 150,000 kung ang chemotherapy (ay sa) private hospital – 100,000 times 6 iyan. For a kidney transplant,... we tell them, oh, mag-charity naman tayo sa NKTI. So ang gagastusin mo lang doon ay 350,000. So that when you go out, you still have 400,000 to buy immunosuppressants.”*

The private philanthropist relayed how much more personal their decision-making process was, and, in the light of their more limited financial capacity, they were more aware of the trade-offs involved and the implications on the patients. He said, “*... If you go out – sometimes we come close to the patients (na) terminal cases. Ang daming sakit; may problema sa puso, may diabetes, and then may cough or hospital acquired pneumonia. Which one would you support? Sometimes you just give them for the present needs, but it is a loss talaga ...We have debates among our members whether we will give them medicines ... Seven days ang requirement niya. We cannot support that. So ... we just give them for three days and then (the social worker) tries to source it from other places ... If the prognosis is good, you go all the way. If not, you have to cut now. You have to cut losses sometimes.”*

The DOH has responded to the problem of catastrophic expenditure by, among others, putting in place cost-containment measures. Along this line, it is developing a drug price reference system, which is expected to lower the costs for what accounts for the largest proportion of health expenses. The agency representatives also discussed how their own institutions have undertaken bulk procurement of certain drugs – ostensibly to provide these to indigent patients at much lower prices. Nonetheless, their purchase prices were dissimilar.

What also emerged during the discussion was that there were activities which involved several agencies, the resulting state of affairs were far from optimal. While, for instance, the funds which could be accessed from PhilHealth and PCSO were complementary, the procedures and programs were disparate. There are conditions for which several agencies have individually defined support packages – such as breast cancer, which aside from PhilHealth’s Z Benefits, also has provisions for free chemotherapy medications from DOH as well as possible PCSO funding – while others do not enjoy the same opportunities (e.g., trauma). The PhilHealth representative stated, in relation to the apparent overlap with PCSO in their agencies’ assistance to transplant patients, *“If the patient (needs) support for immune suppressants for the next 3 to 5 years, so ang pakiusap namin sa PCSO is not to duplicate the effort (that we) provide. Kung puede (ay ang) PCSO (na ang) sasalo ng immune suppressants.”*

The responses related to the roles of institutions as related to catastrophic health expenditures are paraphrased and listed in Table 4.

## ***Ways to Improve***

### **Patients’ Perspective**

The patients gave several suggestions on how the institutional support for catastrophic expenditures may be improved. These basically concerned schemes which can facilitate transactions as well as initiatives which will increase the breadth and depth of support. With regards to the former, having a navigator – a case or social worker – attend to individual patients was deemed to be important. According to a participant, *“For me, for example, I wish during my addiction time there was a social worker for my parents. Ako, hindi (na) cause I was the addict. Ang isip ko nandoon din but my mom and father were the stable ones*



*that were troubled financially. Ang labas nila ng pera (ay) grabe for me – to heal myself – pero there was a point in time (when) my mom and dad were running out of money because of me. So I think they should have a program for social workers para to guide them to: eto kung financially struggling ka dito kayo lumapit; kung emotionally ano kayo eto kausapin nyo itong counselor na ito. Just a medium for them to be able to branch out to what they need kasi it's very important.”* Having been tremendously helped by a social worker during their time of need, another group member reaffirmed this, *“Dumadaan ang pamilya o ang pasyente sa isang agaw-buhay na sitwasyon – and (for a social worker) to direct them to the right people is a very big help already.”* Agencies' receiving offices should be located within the facilities themselves – for easier transmission of hospital-related documentary requirements as well as to minimize the inconvenience and cost of travel – or may be jointly situated as one-stop shops: *“Hindi po ba pwede ang halimbawa may tao na taga-PCSO sa isang hospital – may isang opisina sila na doon na lang pupunta? Naka-confine ka, naka-confine pasyente mo. Doon ka pupunta – automatic doon maqua-qualify na nila kung maysakit ka o wala ... nandoon ang dokumento sa hospital, nandoon ang actual na bed eh.”;* *“If there's government entity na you could take (na) parang one-stop shop. Kung pwedeng nandoon ka pupunta. Ako dito – sa isang booth na ito SSS, ito isang booth na ito Philhealth, ito ... doon na lahat.”;* *“Para po sa akin, dapat po ang bawat ahensiya na tumutulong sa mga taong nangangailangan dapat bawat hospital meron silang representative ... para ang tao na hindi masyadong nakakaintindi (ay) may mapagtatantuan. Kasi nga po emergency eh kung paano sila tutulungan.”;* *“So it's either magtayo ang lahat ng (mga) hospital ng isang information business center doon o magtayo ng call center na lang.”*

Corollary to agencies being made more accessible, the related procedures and requirements should be made more streamlined. Likewise, the evaluation criteria as well as corresponding benefit rates should be made transparent – and the awards adjusted to the financing needs of the patient. This was described accordingly, *“... parang guidelines na kung ito ay bumabagsak sa ganitong category ng sakit ganito ang pwede nilang makuha regardless na mayaman ka o mahirap ka. Basta kumpleto ang requirements sa iyo naibigay ... kunwari po malaki, halimbawa 100,000, maaari niyang makuha (o) may option siya to get this staggered or to get it intact. Kasi depende sa need niya eh. Halimbawa ngayon kailangan ko nang operahan – ngayon kailangan ko na ang 100,000 ko. Or hindi naman po (at) gagamutin daw*

*po muna (sa) iche-chemo muna ako. Ganyan, pwede po bang unti-untiin ko ang kuha? Parang meron pong mga adjustment procedures.”*

Enhanced support was called for, through programs such as additional discounts especially for the pharmaceutical needs of the affected patients, increased subsidies or PhilHealth benefits, and even a more encompassing system analogous to the Conditional Cash Transfer Program currently in place for indigent families. The latter was brought up as follows, “*Di ba if the government (has) such programs na nagbibigay ka ng Conditional Cash Transfer to the poor - bakit hindi ka pwede magkaroon ng programs for the life of the people? Di ba sa buhay ng tao kaya sinasabi nga natin, buhay ang pinag-uusapan – hindi ba pwedeng na-iinvest ang gobyerno sa 4P’s sa CCT program?Bakit hindi tayo pwedeng mag-invest para sa kalusugan, sa buhay ng mga tao, sa health, kagaya niyan sa catastrophic health?”*

Having experienced substandard medical care, many of the participants emphasized that improved financial protection, while important, will be incomplete if services remain inefficient and inequitable. To drive home this point, a member of the group related this anecdote, “*You know, ang perfect example, close to my heart (was) my uncle (who) passed away (at) 2 o’clock in the morning ... he felt tightness of his chest ... (and) my mom called me. Anak takbo ka dito ... So we ran (and) came into the hospital. And (they were) doing chest compression on (him)... (At the) emergency room, they said we’re gonna need, ah, whatever to inject in. You know what he said? To get his heart jumpstarted – adrenaline. So can you please go (and) buy at (this drugstore)?... I think every emergency room here (has) their (ER) cart. (This) should be complete. I am not going to rush into an emergency room to have my son go buy the medicines needed to bring you back to life and I don’t know – only the universe knows – if my uncle would have lived if they had it on hand. And they can pay. My uncle had all the money in the world to pay! But they didn’t have (the) stuff in their tray in their little cart...”*

### **Providers’ Perspective**

The facility administrators had more ideas on how support mechanisms can be improved, and generally adopted a systems approach. One echoed the proposal earlier raised by patients in the need for having identified navigators – specifically social workers – who will attend to

the needs of the affected patients and families. As broached by the official, *“Siguro, from the hospital, maybe a social worker. Probably kasi alam na ng social worker ang network (na) i-ta-tap niya. And may background naman sila kung ano na ang catastrophic health so the patient – whether out-patient siya o in-patient siya – alam niya (at) may access siya doon. So magandang siya ang magsasabing catastrophic ito and then matri-trigger niya ang network ... sa agencies – Philhealth, PCSO – ang specific programs for these subsets. Di bahala silang mag interconnect. Kung ayaw nilang mag-duplicate ng assistance or whatever di ba? Ah but even the DILG might also have a certain package of services and then meet at one point ... Kung mayroong forum na ganoon, maganda sana. Para complete, comprehensive, ang program ...”*

The last proposal hinges on a clear operational definition of catastrophic health expenditures, particularly by way of identifying patients or families eligible for institutional support. As espoused by another participant, a uniform definition will have to be adopted by the concerned agencies. There should be a *“general working definition (and) identify agencies ... (para) pare-pareho ang kanilang definition – PCSO, Philhealth ...”*

A clear national policy and a dedicated unit may have to be established, to ensure the proper coordination of the involved agencies. A group member said, *“... We have to make a stand para magkaroon ng national policy on financial assistance. And at the same time, parang kung sa hospital the point person will be the social worker, on a national (level), there (should be) a system, a coordinating body, working with all these agencies, the PCSO and Philhealth. This is not saying na it should be the Secretary of Health who will take over, who will parang control, pero ...a central coordinating body who will network, who will coordinate, the financing activities involved ... Kasi hindi lang naman ito actually health related na mga organizations ito eh – even DILG, at times DSWD ... the way they did it siguro for the CCT, the 4P’s, na mayroong organized na coordinating na unit.”*

### **Agencies/Organizations’ Perspective**

The recommendations from the last group centered on the then represented agencies – DOH, PhilHealth, and PCSO. For PhilHealth, the differences in benefits that may be received by the poor and non-poor, as exemplified by the provisions of the Z Benefits Program, was the

basis for the suggested improvement – which also touched upon one of the institution’s fundamental pillars. The alternative put forward was that PhilHealth’s adherence to the principle of social solidarity, wherein the better-off should support the needy, should be interpreted as meaning to apply mainly to enrollment. Thus, the tax-financed enrollment of indigents under the Sponsored Program fulfills this tenet. However, the distinction need not apply to the benefits – which should be equal. Parity of benefit rates should therefore be the norm. As interpreted by a participant, this still meets the social solidarity objective, “*Kung iyan talaga, (dapat) pantay. Everybody would be happy because (everyone) will get the same benefit.*” The proposals for PCSO centered on improving the accessibility of its services as well as the transparency of its transactions. As stated by a member of the group, “*Siguro we have to establish a system ... na hindi na tayo pupunta sa PCSO, na hindi na tayo pipila doon. ...Bakit ikaw na ang may sakit, ikaw na ang nagbabantay, kailangan mo pang pumunta doon? This is not a failing of PCSO. This is a failing of (our) government system na. Kailangan pag may sakit ka, the government should be willing to assist you – and you should assist yourself siymepre...*” The PCSO representative mentioned that the institution is already considering this, “*Actually isa iyan sa program na nai-propose this year ... Di namin nalalaman, di pa namin siya mai-implement, pero isa iyon sa pinropose nang direction ng office to put up PCSO desk in hospital... para diretso na sa hospital mabibigay o doon mag-assess ng mga request. Actually po meron naman po tayong endowment fund sa mga hospitals na di kailangan pumunta ng PCSO.*” Finally, the need for better inter-agency cooperation was emphasized. The DOH official said, “*Close coordination (between) DOH and Philhealth. Kasi iyon na nga (sa) medicines, ang alam ko until 2014 ang budget ng DOH to provide all the medicine sa mga government facilities for the Z package. So after 2014, ano na? Wala pang phasing-in phasing-out... So kailangan magkaroon ng closer coordination, tapos planuhin talaga ang proseso. Kasi, kung minsan, nabibigla na lang kami (at) meron na naman silang niluluto and then di kami prepared for that. .. Dapat sabay, dapat sabay iyan na inaayos (at) isa lang naman objective natin. Di ba isa lang (tayong) family?*”

A listing of the abridged responses from the last FGD is provided in Table 5.

GROUP	RESPONSE
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Patients	<ul style="list-style-type: none"> <li>• <i>Support system navigator needed, possibly a social worker, to map out measures – and attend to these early in the course of treatment</i></li> <li>• <i>On-site (facility) or one-stop-shop for support agencies</i></li> <li>• <i>Procedures to be facilitative</i></li> <li>• <i>Transparent criteria and consistent levels of benefits, especially for PCSO</i></li> <li>• <i>Expand conditions covered by PHILHEALTH (e.g., chronic psychiatric care)</i></li> <li>• <i>Increase level of support</i></li> <li>• <i>Discount mechanisms especially for medical supplies</i></li> <li>• <i>“CCT-equivalent” integrated program</i></li> <li>• <i>Same optimal level of care, regardless of capacity to pay at point of service</i></li> <li>• <i>Ensure facilities are adequately staffed and equipped</i></li> </ul>
Providers	<ul style="list-style-type: none"> <li>• <i>Social worker to be the point-person to coordinate support for the patient</i></li> <li>• <i>Need to define catastrophic health expenditures, and establish distinct responsibilities for agencies</i></li> <li>• <i>National body to integrate related services, including ensuring service capacities</i></li> </ul>
Agencies/ Organizations	<ul style="list-style-type: none"> <li>• <i>For PHILHEALTH: aim for equity, as defined as different costs but same benefits for members given the same medical condition</i></li> <li>• <i>Greater transparency for PCSO transactions</i></li> <li>• <i>Establish PCSO desks in hospitals</i></li> <li>• <i>Greater coordination between DOH, PHILHEALTH, and PCSO</i></li> </ul>

**Table 5.** Summary of FGD responses on ways to improve the institutional mechanisms for addressing catastrophic health expenditures

## VALIDATION

A validation meeting was held on 6 September 2013, and was attended by officials from PhilHealth, PCSO, and DSWD. The PhilHealth and PCSO representatives had also been present in the earlier FGD. A summary of the study’s findings and draft recommendations was presented. The attendees concurred, in general terms, with the results. There were a few items which were discussed further, and suggested revisions were taken into consideration.

Some apparent misconceptions and imprecise statements from the FGDs were corrected. It was clarified that the assertion that PCSO benefits can no longer be availed of by patients who have filed PhilHealth claims, as raised in the providers’ FGD, was unfounded. The PCSO does, however, deduct the amount claimed from PhilHealth from whatever benefit the

agency will grant to the concerned patient. A rephrasing of the statement regarding the extent of discretion that the agency's management had on PCSO's benefit awards was also requested. The patients' allusion to PWD cards being sourced from DSWD was queried by the PhilHealth attendee. The clarification made was that LGUs actually provide this service, and that the DOH is taking steps to establish a PWD registry and eventually directly attend to the distribution of cards. It was also mentioned that PhilHealth was developing benefit packages for disabled members. On the other hand, the DSWD official pointed out that social workers employed by LGUs were the ones who were mostly tasked with the distribution of PWD cards, *"Actually, DSWD po siya, pero local level po."* The possibility of involving another government department, the Department of Interior and Local Government, DILG, was also raised, *"... kasi we're developing benefits for PWD. So nakita namin na ang DILG pala dapat ang nandoon sa pinakatuktok, not even the Department of Health. Sa paningin namin, DILG siya."* References to the relevant legislation, the Magna Carta for PWD, or RA 7277 as amended by RA 9442, were also raised. The somewhat confusing state of affairs regarding the administration of the PWD service epitomizes the need for better coordination among government agencies.

The current extent of inter-agency cooperation was repeatedly brought up. It was apparent, however, that most existing initiatives are in the very preliminary stages (e.g., planned coordination between PhilHealth and PCSO for transplant support). Related to this was the mention of the existence of the DSWD's Crisis Intervention Unit (CIU). The bearing of the latter on the issue of catastrophic health expenditures was discussed as follows, *"Lumalabas (sa) initial na data gathering po namin (na) isa po ang medical assistance sa mga talagang hinahanap ng mga tao. Hinihingi po ng mga tao, and ilan nga sa doon ay dialysis, na nabanggit po kanina, mga chemotherapy... So iyon po ang mga madalas nahihingi (sa) CIU. Kasi po, iyong CIU, hindi lang po medical assistance, pati transport assistance, pwede – basta po mga crisis intervention na po talaga. And karamihan nga po, nabanggit ko, based on sa initial data gathering, (ay) medical."* It was subsequently revealed that patients who received CIU benefits were also the ones who requested for PCSO assistance, *"... sa experience namin, (the) clients who came from DSWD (are those) who are coming to us, (in) general lang."* The financial support of DSWD's CIU, while smaller in magnitude compared to what may possibly be obtained from PCSO, is, however, given directly and immediately to

the patients (as opposed to guarantee letters directed to facilities). The CIU support is therefore more applicable for emergency cases, *“Kasi ang sa kanila, sa CIU, more on emergencies. Halimbawa kasi gabi, tapos walang gamot, tapos sa ER, they go to the CIU. So parang pangtawid lang. Pang fill-in.”* The DSWD support is not limited to financial assistance, but also includes other services, such as employment referrals to concerned agencies. A national database of the department’s clients is maintained, such that duplication of assistance by its offices is avoided. Such information is, however, not accessible to other agencies.

The participants reaffirmed the soundness of most of the recommendations. There were some questions raised regarding the possible mechanics for the proposed strategies – but these mainly arose from the difficulty of the participants in envisioning the new systems, given their greater familiarity with the current operational set-ups. This train of thought was voiced out by the DSWD official, *“Pini-picutre ko lang din po kung ganoon ang magiging scenario. Parang, okay, Philhealth ang sa health side, then cost of living (sa) DSWD. I-picture ko lang po – saan po pwedeng pumasok kasi devolved nga po...”* The attendees also expressed their appreciation for the FGD experience and insights, and requested that the proceedings be made available to their own agencies. There were subsequent communications with the same officials for additional inquiries as well as exchanges of reference materials.

## **DISCUSSION**

The three prerequisites for the occurrence of catastrophic expenditures – health services requiring payment, low capacity to pay, and the lack of prepayment or health insurance (Xu, 2003) – apply in whole or in part to the prevailing situation in the country. User fees are the norm in government facilities. Social health insurance, through PhilHealth, is in place and even has the Sponsored Program to purposely assist the poor. An input from the FGD, from a hospital administrator commenting on the marked increase in facility utilization following an intensified PhilHealth enrollment program in the province, indicates that patients may have previously foregone care rather than be further impoverished. While PhilHealth coverage is gaining ground nationally, it is still far from universal – with wide disparities in enrollment rates across regions (Silfverberg, 2013). The supposed greater coverage for the poor enabled by PhilHealth’s Sponsored Program, if the FGD responses are to be a gauge, appear not to

have effectively achieved this objective and may have unfavorably affected other patients. From a qualitative point of view and judging by what were both stated as well as implied during the FGDs, catastrophic health expenditures, were strongly felt by the affected patients and families. The patients were emphatic in stressing that the precarious life-and-death situations that they experienced were only aggravated by the imposed financial burdens. There were negative externalities, both for the affected patients and families, by way of the added personal difficulties and uncertainties regarding the clinical and economic outcomes, as well as for the other stakeholders – ultimately other patients – as these are adversely affected when budgeted funds and facility resources get to be expended. The latter social costs provide additional impetus for greater public intervention to more definitively tackle catastrophic expenditures.

While an effective and adequate tax-financed health system (with no point of service charges) could have rectified the problem, the Philippine health sector has, for all intents and purposes, veered away from this structure. Nonetheless, given the windfall revenues generated from the recently introduced so-called sin taxes, greater direct subsidies to patient care can again be reconsidered by the government (Official Gazette, 2012). While social health insurance, as administered by PhilHealth, has long been viewed as the key to improving the health financing situation, this expectation is still to be fulfilled. A recent review of the sources of revenue for DOH hospitals, as contained in an assessment of the Philippine health sector, indicates that PCSO funds exceed PhilHealth reimbursements in some facilities (Kwon, 2011). That the patients and institutions that were part of this study have had to resort to a variety of other sources to still compensate costs of care attests to PhilHealth's current insufficiency. This was despite the generally positive view of PhilHealth from the participants – though this was based mainly on its perceived efficiency in providing assistance (as compared to other agencies), rather on actual adequacy of support.

Institutions, by and large, have categorical definitions of what constitutes catastrophic health expenditures – but these are premised on their organizational financing objectives and operational capacities. For the most part, these overlook the relative nature of such expenditures, as well as the social and economic impact on patients and families. There is therefore an incongruity between what patients perceive as a severely distressing situation – both clinically and financially – with what most institutions consider as merely



programmatic. The dissimilarities lead to, among others, a glaring discrepancy in terms of patients' urgency of need and the institutions' timeliness of response. An almost cavalier attitude, if not culture, prevailing in some public agencies is sensed by patients – and was even rationalized by an FGD participant as a way of having patients demonstrate that they are either needy enough or desperately in-need to be really deserving of support. Existing catastrophic expenditure interventions, as exemplified by PhilHealth's Z Benefits, have a narrow diagnosis-based and treatment-centered scope (e.g., only covers for illnesses commonly perceived as requiring very expensive care) which neglects related costs (e.g., diagnostics-related expenses) as well as a wide array of other expensive conditions (in either absolute – such as trauma care – or relative terms – such as protracted psychiatric care). Tellingly, many of the participants were unaware of the existence of such a benefits program.

Patients or family members, for the most part, individually approached the concerned support agencies at various stages during the course of medical treatment. While a social worker can direct patients to such institutions, such assistance is not universally available in all facilities. Likewise, with the exception of a social worker directly soliciting aid from philanthropic organizations, the actual legwork for the support-seeking process is left to the patients or their family members. The documentary and procedural requirements of the agencies are variable. While the latter claim that these are published, the patients' awareness of these as well as ability to comply readily with the prerequisites were evidently limited (and necessitated several trips for the affected patients or family members, thereby causing undue delays in processing). What added to the patients' confusion was the seeming arbitrariness particularly in reference to the assistance criteria of PCSO. The comparison was repeatedly made with that of PhilHealth benefits – which, despite the underlying computations not being fully comprehended by patients, was nonetheless deemed as being based on an objective and impartial system. For its part, PCSO attributed its position on withholding the basis of funding from patients as a means for better managing or rationalizing the utilization of its financial resources.

As pointed out in the FGD responses, the amount and timing of financial support varied for the different agencies. In terms of magnitude, PhilHealth and PCSO appeared to provide more substantial support – though the former can be accessed only at the end of hospital confinement (and thereby viewed by patients as a discount and by providers as a receivable,

subject to settlement by subsequent reimbursements) and the latter can only be expected to be made available weeks later, by way of guarantee letters which authorize the transfer of funds to the concerned hospitals (and thus similarly treated by providers as receivable accounts). Some sources of funds could be accessed early in the course of confinement, such as private foundations, PDAF and DSWD – but these generally provide only limited support. Only DSWD handed money directly to patients, while the financial assistance of the others was routed directly to the institutions. And though DSWD assistance presumably goes to paying actual costs of care, it is also plausible that these were utilized for indirect expenses, such as transport and related items. The early gap in financing severely restricted the assistance available for urgent and intensive care cases.

Several misapprehensions came out in the course of the FGDs – and some of these were difficult to dispel. On the part of the patients, these pertained to agency policies and procedures. The common belief was that those lining up at PCSO had to appear impoverished to qualify for assistance. The PWD card was inaccurately ascribed as being part of a DSWD program. Private insurance was not found to be as advantageous as patients had initially thought these would be. Administrators had the impression that patients who had filed PhilHealth claims were ineligible for PCSO benefits. There was some basis to these notions, however. A patient's father was supposedly told that he did not look poor and was thus denied PCSO support. And while PWD cards are issued by LGUs, the local social worker is often given this task. For some of the institutions – at least going by what their representatives stated – the prevailing stance was that only the poor are affected by catastrophic health expenditures. Consequently, there was a bias in their support mechanisms for the poor – with assistance extended to those who were not impoverished only if they subsequently became so in the course of the adverse health situation.

## **SUMMARY OF FINDINGS**

From the foregoing discussion, it is evident that while several mechanisms exist to purposely mitigate catastrophic health expenditures, the available institutional response can best be described as disparate, untimely, and generally (both individually and collectively) inadequate. A general illustration of the hodgepodge of routes and institutions and alternative

options and outcomes that affected patients are forced to contend with, is provided in Figure 2.

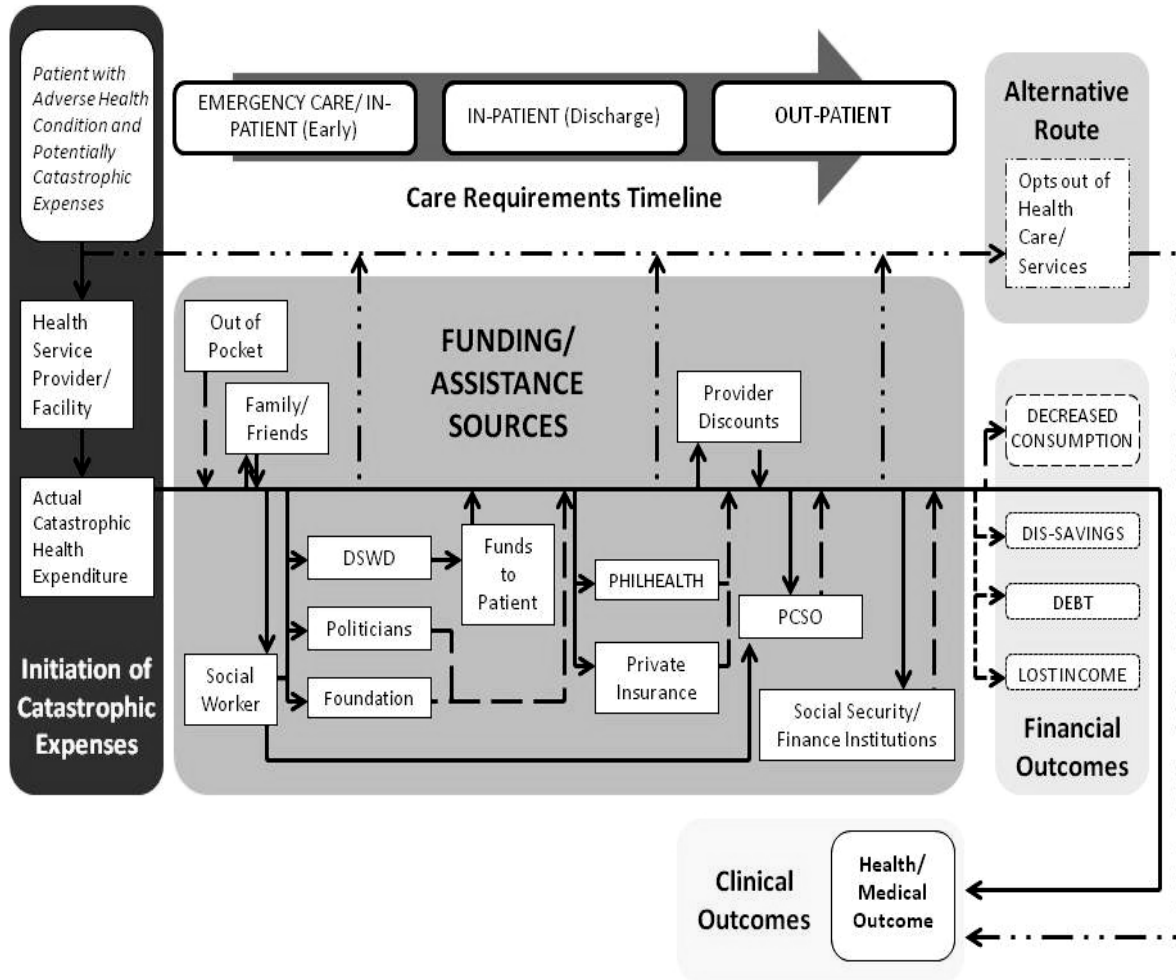


Figure 2. Diagram of institutional support pathways, patient's perspective. Physical routes (in solid lines), timeline of health care requirements (superimposed), opt-out pathway (dot-dash lines) and consequent financial flows (dotted lines) and outcomes are indicated.

While the illustration provides a graphical summary of the consequences of catastrophic expenditures on patients and families, the reality is far from being as precise or tidy. The onus is on patients and families, already encumbered with serious illnesses and their social costs, to stumble from one financing source to another. Clearly, institutional support will

need to be better integrated, and the system will have to be made more efficient and responsive.

## **CONCLUSIONS AND RECOMMENDATIONS**

There is therefore a manifest need to improve the scope and depth of institutional support. Such may translate to across-the-board increases in the magnitude of funding from all the involved agencies or to more selective enhancements for specific agencies for defined conditions. With either approach, inter-agency coordination, and thereby overall efficiency, will need to be improved. Such will minimize the overlapping requirements, redundant measures, and heretofore ignored areas. Certainly, efforts should be made to make the financial protection response of agencies timelier. The institutional representatives were cognizant of the need for greater cooperation – but were also concerned that there are administrative and political hindrances to these.

The fundamental step to systematically address the problem of catastrophic health expenditures is to adopt a uniform operational definition for such expenses. This will enable the involved institutions to at the least have a unifying concept upon which their relevant policies and strategies can then be based. The proposed definition in this regard is stated as follows, *“The situation applies when a patient’s condition requires medical interventions which are life- or limb-saving and determined to be clinically appropriate and cost-effective, but the costs for which are beyond the actual means of the patient (or family) at the time of need, whether due to time or resource constraints.”* While catastrophic health expenditures inherently refer to financial concerns, the provided definition offers a different perspective – emphasizing the gravity and urgency of the underlying medical condition. The considerable financial requirement and its unfavorable impact is not disregarded, but placed in the equally important medical and temporal contexts. With the emphasis on the chronological dimension of such expenditures, then the exigency with which these should be attended to is also highlighted. There are no direct references to impoverishment, to remove the consequent bias against the non-poor. The medical condition and the needed interventions are further qualified – in terms of the severity of the former and the effectiveness of the latter. Such lay the foundation for the operational prioritization of cases and therapies, thereby also promoting rational health services. The clinical scope is also expanded – as, for instance,

trauma cases will fall under the definition – and will be more in line with actual disease burdens (IHME, 2010). The definition by no means covers all angles of import to catastrophic health expenditures, as emphasis is preferentially given to areas which are presumably of greater functional significance. The definition deliberately excludes simpler medical conditions – even as the consequent expenses may be unaffordable for the poorest households – as these can still be addressed within existing health and support systems. In any case, more relevant details and qualifiers can be added by the concerned agencies.

The other recommendations are as shown in Table 6. There is a progression from the relatively easier to accomplish, to the more complicated strategies. The measures for improving responsiveness can conceivably be undertaken by individual agencies within a reasonably short period of time. These involve mostly a re-tooling of current systems, with the end in view of making these more client-friendly. These interventions will necessarily require changes in organizational cultures. A change management process will therefore have to be planned for and implemented within the involved agencies. Included here are actions that will facilitate transactions – developing simpler forms and procedures, establishing accessible business centers, implementing transparency in the beneficiary selection and awards processes, and enabling the earlier release of benefits. Increased access may be provided through a range of measures, from establishing receiving offices for agencies or common one-stop-shop service centers within hospital premises. Alternately, call centers or electronic business centers may be set up for the same purpose. The value of transparency of the benefits processes cannot be underestimated. This will greatly minimize perceptions of arbitrariness, if not impropriety, in the selection of beneficiaries and corresponding awards. Such will of course have to go hand in hand with simplified application requirements and procedures, as well as an effective social marketing campaign to inform the public at large regarding the streamlined procedures.

The succeeding enhancements will entail a more thorough revision of policies and practices as well as greater coordination among agencies. An integrated financing arrangement may be put in place, with distinct responsibilities assigned to respective institutions. As proposed, no out-of-pocket payments will be required from patients requiring emergency services. The costs, while initially shouldered by the facilities, will eventually be recompensed by tax-derived or third-party payments (on a facilitated basis). Patients requiring intensive care will

be financed by PhilHealth, with supplemental PCSO assistance provided for those cases which are exceptionally costly (the threshold for which will have to be prospectively determined by both agencies). Expanded PhilHealth coverage will also have to be relied upon for chronic care, with additional cost-of-living support from DSWD. The proposed assignments draw upon the recognized competencies of the individual agencies (e.g., PhilHealth has closer links to providers and can also better actuarially assess the health financing needs of most conditions). Such arrangements will have to be adapted to be consistent with the mandated financial management systems for the different types of provider facilities (e.g., LGU vs. DOH operated hospitals).

The final recommendation is for the establishment of a dedicated organizational unit that will oversee the development of policies and implementation of strategies directed to the alleviation of catastrophic health expenditures. This may be an organic element within DOH, or be a semi-autonomous body. Not the least of the unit's responsibilities will be the monitoring of the incidence of affected patients as well as the effectiveness of concurrent interventions. A possible product of such a unit is the creation of a comprehensive benefits program for patients and families with catastrophic health expenditures – similar in some respects to the current Conditional Cash Transfer (CCT) program for indigent families as administered by the DSWD. The latter will involve an identification system as well as incrementally packaged services, inclusive of financial support for both direct and indirect medical costs, as well as other welfare safety nets. The President's Catastrophic Illness Relief Fund may be tailored to serve this organizational purpose. A similar mechanism, the Catastrophic Illness in Children Relief Fund Program, exists in the US but is restricted to pediatric patients (Department of Human Services, 2013). The designated unit will also have to coordinate particularly with regulatory offices, to ensure that improved financing is complemented by health services which are readily available and of an optimal quality.

The insights and recommendations garnered from this study were based largely on the responses of the participants in the FGDs. There are limitations which are both intrinsic and extrinsic to the adopted methodology. The responses could certainly have been different with another set of participants. The elicited reactions cannot be claimed to indicate the norm, as those who attended cannot be assumed to faithfully embody the sentiments of the majority of those faced with similar medical or financial circumstances. Admittedly, not all

groups or localities were even represented. For instance, while there were facility administrators from rural areas, a similar profile did not apply for the respondent patients. Concerns, like the accessibility of PCSO support, would have expectedly been different for those from more far-flung localities. Providers, and even patients, had a hospital-centric perspective. While health delivery can be accessed from other levels or types of facilities and providers, it may nevertheless be presupposed that hospital-related expenditures warrant greater concern for most stakeholders. Likewise, other institutions were not represented, such as private health insurance corporations, banks, and public financing institutions such as the Social Service System (SSS), the Government Service Insurance System (GSIS), the Employees Compensation Commission (ECC), and even the DILG. Their involvement will therefore have to be considered in the subsequent implementation of enhanced inter-agency cooperation. A more thorough survey is needed, which should specifically take into consideration foregone health services due to unaffordability to patients and households, to more accurately gauge the prevailing burden of such expenditures. The temporal incidence of adverse health conditions and their associated expenses will also have to be taken into consideration – as the financial impact of sudden as opposed to gradual dis-savings are intuitively different. Given these limitations, the FGDs had nonetheless been productive, in terms of having successfully drawn out impressions – most being sensible, some surprisingly astute – from a wide array of health stakeholders. The validation consultations, while involving only a few officials, nevertheless substantiated the FGD responses and the study’s recommendations.

<p>A. Improve agency responsiveness</p>	<ul style="list-style-type: none"> <li>a. Simplify transactions</li> <li>b. Establish Point of Service desks, whether physical or virtual</li> <li>c. Implement transparency in beneficiary selection and quantity of assistance</li> <li>d. Ensure early provision of benefits</li> </ul>
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<p>B. Integrate financing arrangements</p>	<ul style="list-style-type: none"> <li>a. Emergency cases <ul style="list-style-type: none"> <li>i. Facility to initially shoulder all expenses</li> <li>ii. Third-party payments to subsequently offset facility costs: additional subsidies for public facilities, tax credits for private facilities, and PhilHealth or other insurance reimbursements for accredited providers</li> </ul> </li> <li>b. ICU cases <ul style="list-style-type: none"> <li>i. Primarily supported by enhanced PHILHEALTH coverage, with supplemental support by PCSO for exceptionally expensive situations</li> <li>ii. Ethical, legal, and administrative guidelines to be provided by DOH on the terms of medical support</li> </ul> </li> <li>c. Chronic cases <ul style="list-style-type: none"> <li>i. Primarily supported by expanded PHILHEALTH coverage with regards to medical costs</li> <li>ii. DSWD to provide supplemental assistance for family's welfare and living requirements</li> </ul> </li> </ul>
<p>C. Establish dedicated organizational unit</p>	<ul style="list-style-type: none"> <li>a. Develop related policies and strategies</li> <li>b. Coordinate programs of public and private agencies</li> <li>c. Monitor outcomes</li> <li>d. Collaborate with other agencies to ensure provider compliance with service standards</li> </ul>

**Table 6.** Recommended strategies to address catastrophic health expenditures

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