Institutional Financing of Catastrophic Health Expenditures

ALVIN B. CABALLES

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

Focus group discussions were held separately with patients (or family members), providers (clinical and support staff), and representatives of policy or financing agencies. Patient participation was meant to bring out a range of clinical situations. Providers came from rural and urban settings, from both public and private sectors. Agency representatives came from the DOH, Philippine Health Insurance Corporation (PhilHealth), Philippine Charity Sweepstakes Office (PCSO), Philippine Amusement and Gaming Corporation, private advocacy and philanthropic organizations, and Congress. Follow-up consultations were held with the concerned agencies for validation purposes. Key responses gleaned from the focus group discussions 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 overutilized resources or of passing on costs to other patients), and the arbitrary payment thresholds of some financiers; (2) The

1 Chief, Social Medicine Unit, College of Medicine, University of the Philippines, Manila. Email for correspondence: abcmd.health@gmail.com.
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 access 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; and (4) Participants also pointed out that there were related issues which needed to be looked into, such as inadequate supplies and manpower in health facilities.

Based on the inputs from the focus group discussions, the following recommendations are made: (1) A new definition of catastrophic health expenditures is proposed as thus: “The situation applies when a patient’s condition requires medical interventions that 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, which will be subsequently reimbursed by third-party payers; PhilHealth and PCSO to attend to intensive care; and PhilHealth and Department of Social Welfare and Development to finance chronic care); and (3) A dedicated unit will be established to further develop relevant policies and strategies for the integrated financing of catastrophic health expenditures.

INTRODUCTION

Background of the study
The Department of Health’s (DOH) Kalusugan Pangkalahatan or Universal Health Care (UHC) policy seeks to ensure that all Filipinos, especially the poor, have equitable access to quality health care (DOH 2010). Financial risk protection is one of the main thrusts of UHC, which implies that patients and their families should not be exposed to the risk of financial ruin when they avail of health services. The converse situation corresponds to the occurrence of catastrophic health expenditures (CHE). The latter is defined by the DOH UHC Administrative
Order 2010-0036 as “out-of-pocket (OOP) 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, and, 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). Thus, the Z Benefits program came about, wherein sizable but fixed amounts are provided for the care of catastrophic cases, such as cancer, in selected government hospitals. However, other adverse health events, while not medically complex, can also entail costs that can impoverish patients and their families.

Hospitalized patients are known to seek recourse from funding institutions other than PhilHealth. 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 CHE.

Objectives
The study’s general objectives were:

- To describe the participation of public and private agencies that provide financing support for patients faced with CHE; and
- 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 CHE;
- To identify the government and private agencies that provide supplemental financing for CHE;
- To characterize the operational capacities of these supporting agencies in addressing CHE;
- 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 to coordinate 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.
Review of literature
Many attempts have been made to qualify what constitutes CHE (Murray and Frenk 2000; Wagstaff 2008). Regardless of the definition, there remains the concern that such costs contribute to affected households’ inaccessibility of services, impoverishment, or even both (Berki 1986; Xu et al. 2003). In Cambodia, families that incurred debts to pay for the care of dengue patients were still in debt and destitute a year later (Van Damme et al. 2004). Expensive health payments have increased the poverty head count in India from 27.5 percent to 31 percent (Bonu et al. 2007). Three key preconditions were postulated to contribute to CHE; namely, health services requiring payment, low capacity to pay, and the lack of prepayment or health insurance (Xu et al. 2003). In China, such CHEs have been documented despite the provision of health insurance, as benefits were inadequate for the more expensive services (Sun et al. 2009; Yi et al. 2009).

The incidence of CHE has been reported to be relatively low in the Philippines (Van Doorslaer et al. 2005). However, there has been an increasing trend in the number of households so affected (Herrin and Lavado 2011). Hospital discounts and especially PhilHealth reimbursements were of limited assistance particularly for poor patients (Caballes et al. 2012). Lower-income households were more prone to impoverishment, given the occurrence of CHE (Ico 2008). The responses to a health financing survey indicated that patients either avoided medical care or self-medicated—which would have falsely lowered health expenditures (SWS 2010).

METHODS
Focus group discussions (FGDs) involving various stakeholders were undertaken to obtain insights and information regarding CHE-related issues. 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 August 9, 2013 for the patients’ group and on August 12, 2013 for the others.

None of the patients invited to the FGD were personally acquainted with the author, although they were recruited through associates. There was a deliberate attempt to account for distinct clinical situations, including urgent, intensive, and chronic care. Most participants in the provider group were directly known to the author, except for the two hospital employees (i.e., a social worker and a pharmacist) who were sent by their superiors. The composition 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 [LGU] facilities) and private sectors, and represented a range of service responsibilities. Apart from the former member of Congress as well as the
convener of a 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.

Informed consents were obtained from the participants. All were provided honoraria at the end of the FGDs, with additional allowances given to those who had to travel from outside of the National Capital Region. Participants were tasked to react to six discussion points, with the phrasing of each slightly modified to be more relevant to respective groups. The points were meant to address corresponding issues on CHE classified under Meaning and Importance, Institutional Measures, and Ways to Improve. The author facilitated all the FGDs, with assistants documenting the proceedings. Validation consultations were subsequently done with the concerned government agencies.

RESULTS
In all groups, two participants were not able to attend the actual FGDs. The actual attendees and their characteristics are listed in Table 1.

The insights gathered from participants’ responses are presented according to the three issues of interest to the study. Summaries of the responses are correspondingly presented in Tables 2 to 4.

Meaning and importance

Patients’ perspective
Patients (or their families) were primarily 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 thus: “The bottom line is, we are talking about lives.” Urgent or intensive care was the most trying, as the suddenness of the circumstances greatly added to the gravity of the medical situation and compounded the financial crunch. Among the many incidents narrated was the situation of a participant who had to plead with DOH hospital officials as he did not have enough money to rent a ventilator for his soon-to-be-delivered premature child.

Family members had to urgently draw on all their personal resources to pay for the needed medical care. The effort can become increasingly difficult and desperate. A parent relates, “Even if one has assets, these may not be easily convertible to cash and may also not be sufficient if the medical expenses are continuous….We stand to lose everything.” As the families’ resources get

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2 Discussions were conducted mostly in Filipino. To conform with editorial preferences, English translations of the participants’ quoted responses are used in the subsequent sections.
depleted, they then seek other sources. The effort required to find additional funds greatly added to the physical and psychological strain on the patients and families, making the health-care situation all the more arduous. A mother, whose child required immediate surgery, recounted, “If only a patient can just focus on his recovery and not be concerned about such matters as: ‘Will I still be able to receive my medications? How can my family survive?’” Such hardships are not limited to the poor, as even those who are better off also get to be overwhelmed by the expenses.

Ultimately, funds run out, and families are left with the difficult choice of accepting suboptimal services or giving up on further care. The reduced attention given to patients unable to pay the costs of care was raised by the mother of a vehicular accident patient, “…I couldn’t pay the charges for the equipment that were then supporting my son. I had to plead with the nurses not to take the machines away...” A participant, whose family was unable to sustain the payment for the dialysis of their father, said, “We are dealing with precious life. But because
Table 2. Summary of FGD responses on the meaning and importance of catastrophic health expenditures

<table>
<thead>
<tr>
<th>Group</th>
<th>Response</th>
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<tbody>
<tr>
<td><strong>Patients</strong></td>
<td>• 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)</td>
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<tr>
<td></td>
<td>• Need to ask help from outside of the family to be able to urgently meet health-care expenses, including having to borrow money</td>
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<td>• Acute situations (Emergency/ICU) most difficult to cope with</td>
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<td>• 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</td>
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<td></td>
<td>• Problem is not limited to the very poor</td>
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<tr>
<td><strong>Providers</strong></td>
<td>• Depends on the patient’s medical and economic status and choice of facility</td>
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<td>• Facility resources are limited, and patients requiring protracted and expensive care but are unable to pay for these add to the strain</td>
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<td>• Limits therapeutic options for some cases</td>
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<td></td>
<td>• Ethical and legal restrictions on handling nonpaying cases</td>
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<td>• Financial bottom line important for private providers</td>
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<tr>
<td><strong>Agencies/Organizations</strong></td>
<td>• Varying operational definitions – at times informal, with references to type and severity of illness, care requirements, and costs</td>
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<td></td>
<td>• PHIC – additionally concerned with rationalization of care</td>
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<td></td>
<td>• PCSO – concerned with fund rationalization</td>
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<td></td>
<td>• DOH is both health service/facility provider and financier</td>
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<td></td>
<td>• A human rights issue</td>
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Source: Author’s compilation

of all the financial and bureaucratic difficulties, we ended up having to close our eyes and giving it all up.”

**Providers’ perspective**

The occurrence of CHE, according to a hospital administrator, is a relative situation and is attributable to several factors, with choice of facility being one of them. 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. Once a patient is admitted in intensive care, their finances will really get drained. This is regardless of their initial economic status.” Catastrophic health expenditures were of interest to providers as these often adversely affect revenues—a particular concern especially in private hospitals—and can also lead to other patients being deprived access to needed resources. Front-line public providers associated such expenditures with OOP expenses inasmuch as the services and supplies required have exceeded PhilHealth claims ceilings and would have to be put on hold unless these are personally paid by patients. The problem seems to be more pressing among local government hospitals. An LGU facility administrator said, “We only have a fixed budget for the year, and the
### Table 3. Summary of FGD responses on institutional mechanisms for addressing catastrophic health expenditures

<table>
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<tr>
<th>Group</th>
<th>Response</th>
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| **Patients**  | • PhilHealth – deemed most responsive, but benefits are available only at time of discharge  
• PCSO – difficult to transact with, and benefits are unpredictable  
• PDAF, dole-outs from politicians – small amounts but these still help  
• DSWD – agency where PWD ID card is attributed to; card not accepted in all establishments  
• Private foundations – substantial support but only to a very few patients  
• Private insurance – very limited assistance (i.e., choice of providers and extent of benefits)  
• Others: physician discounts, hospital discounts, senior citizen’s discounts – often sizable but not uniformly accessible  
• Social services-enabled discounts are provided based on patient’s economic classification, which can be adjusted in the course of treatment  
• 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  
| **Providers**  | • PhilHealth reimbursements were deemed inadequate, and having to provide for all NBB patients’ care requirements results in losses for the facility  
• PhilHealth and PCSO payment comes after discharge, with the timing and amount unpredictable in PCSO’s case  
• PCSO does not support PhilHealth patients  
• PDAF available during confinement, but only small amounts can be availed of  
• Foundations are difficult to sustain  
| **Agencies/ Organizations** | • PhilHealth NBB still not fully implemented  
• PhilHealth Z Benefits initiated but still with limited scope  
• Significant expenses for patients prior to Z Benefits inclusions, which are therefore not covered (e.g., diagnostic workup for leukemia)  
• PhilHealth has unequal premiums (e.g., none for Sponsored Program members) and its Z program has unequal benefits  
• PCSO follows existing criteria but these are not publicized, and management has flexibility on awards  
• Employment-based insurance can provide substantial support  
• Private philanthropy can offer only limited and highly selective support  
• DOH is developing reference price for medicines  
• DOH, PCSO, PAGCOR, each procures drugs in bulk for indigent use  
• Minimal interagency coordination  

Source: Author’s compilation

allotments are never enough. Hospitals run out of supplies long before the year ends...”

Those requiring protracted critical care face other difficulties. Patients who cannot afford private services either self-direct or are referred to government facilities, where the care is deemed to be more affordable. However, the required services may be unavailable in the public facilities, particularly when these are already being used in excess of capacity.
Table 4. Summary of FGD responses on ways to improve the institutional mechanisms for addressing catastrophic health expenditures

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<th>Group</th>
<th>Response</th>
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| Patients           | • Support system navigator, possibly a social worker, is needed to map out measures and attend to these early in the course of treatment  
                    | • On-site (facility) or one-stop shop for support agencies              
                    | • Procedures to be facilitative                                         
                    | • Transparent criteria and consistent levels of benefits, especially for PCSO  
                    | • Expand conditions covered by PhilHealth (e.g., chronic psychiatric care)  
                    | • Increase level of support                                            
                    | • Discount mechanisms especially for medical supplies                  
                    | • "CCT-equivalent" integrated program                                   
                    | • Same optimal level of care, regardless of capacity to pay at point of service  
                    | • Ensure facilities are adequately staffed and equipped                 |
| Providers          | • Social worker to be the point person to coordinate support for the patient  
                    | • Need to define catastrophic health expenditures and establish distinct responsibilities for agencies  
                    | • National body to integrate related services, including ensuring service capacities  
                    | • For PhilHealth: aim for equity, which is defined as same benefits for members given the same medical condition |
| Agencies/Organizations | • Greater transparency for PCSO transactions                           
                    | • Establish PCSO desks in hospitals                                     
                    | • Greater coordination between DOH, PhilHealth, and PCSO               |

Source: Author’s compilation

As care cannot be withheld even for cases that can financially drain providers, there is increased pressure to have families secure additional funds or for limits to be set for the care being provided to the concerned patients. Physicians in fee-for-service arrangements often have no choice but to write off such cases. A rural practitioner remarked, “You give so much of your time and energy for these often complicated cases. And yet, in the end, you end up with nothing.” Any 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 less supplies for other patients. The situation is aggravated when a particular patient’s prognosis is poor, yet legal restrictions and ethical dilemmas deter rationing of resources. A case in a DOH facility concerning a patient with a poor prognosis for whom the family demanded continued inpatient care, illustrates the latter point.

Agencies/Organizations' perspective

Some agencies adhere to their operational definitions for CHE. A PhilHealth officer enumerated the factors that the agency takes into account: “A condition is considered catastrophic if it entails complicated procedures, uses a lot of technologies (drugs, devices, procedures), and requires the services of many
doctors. Long hospital confinements are often needed. Patients also often have multiple diagnoses.” References to specific conditions, need for intensive care unit (ICU) care, multiplicity of diagnosis and procedures, and overall cost of care were the factors considered by PCSO in deciding on whether cases are indeed catastrophic. The Philippine Amusement and Gaming Corporation (PAGCOR), which administers its own health fund for its members, has three qualifications for its catastrophic illness category: end stage or organ failure, ICU cases, and surgical conditions.

The agencies’ institutional interests also come into play. Thus, PhilHealth equates concerns with CHE with the rationalization of care (or lack thereof)—and its implications—on costs. Among other factors, physicians’ prescribing practices and even fee rates were deemed to be contributory to such expenditures. The PCSO is similarly focused on the judicious appropriation of its funds. The DOH likewise attaches significance to such expenditures because it is both a provider as well as a financing agency via individual grants (i.e., through its Public Assistance Unit) or subsidies to its facilities. Meanwhile, the PAGCOR supports its employees with CHE for productivity reasons: “If (employees) are not satisfied with how we handle them, they will not work well.”

The politician and patient advocates considered the consequences for patients and the burden on society as a whole. The former member of Congress, referring to her experiences with affected households, had this to say about such expenses: “It’s as if one were holding on to a bladed weapon out of sheer desperation. This is the situation faced by these people, with entire families drained of their resources....” On CHE, she also affirmed, “We have to deal with the economic disaster that it brings to a family, where the breadwinner cannot earn a living, children unable to attend school, and the household further saddled with debts.” The advocate additionally pointed out that, “The opportunity loss or the economic burden of these costs are not recognized nor sufficiently addressed. These have a major impact on the country’s development and progress.” In the end, the participants conceded that CHE is a human rights issue, and effectively tackling the problem is an apt objective for the government.

Existing institutional mechanisms

Patients’ perspective

Institutional support was sought by patients mostly after they had exhausted their own sources, including assistance from their family and friends. Information on which institutions to approach and the process involved was more often obtained from acquaintances, including other patients and, where available, from hospital social workers.
Among the institutions that were accessed, it was PhilHealth which was most appreciated by patients. This positive impression arose from PhilHealth’s minimal bureaucratic requirements, the facilitation provided by the hospitals themselves, and the apparent predictability of the benefits. The support from PhilHealth was therefore considered a convenient discount mechanism.

When queried further, however, FGD participants admitted that they did not know the exact amounts to expect for inpatient care. The patient with end-stage renal disease complained about the inconsistencies in the access to PhilHealth benefits among different facilities. Also, PhilHealth policies were overly restrictive in some instances, as exemplified by this anecdote: “My friend’s mother was brought to an emergency room. It so happened that she passed away within a day. When a PhilHealth claim was filed, this was rejected on the grounds that the patient did not meet the 24-hour confinement period requirement.” None of the patients were aware of the Z Benefits program.

The PCSO’s assistance was sought particularly by those requiring very costly care. Nonetheless, the process involved was tedious, with a lot of uncertainty regarding the extent and timing of support. A participant recounted her ordeal: “….You have to be there early in the morning to line up. They do not give you any money, just a guarantee letter which is sent to the hospital more than a month later after your request gets approved. But you have to come back, line up again, to follow up on the approval. My husband told me to stop. He said that while we needed the assistance, we didn’t deserve having to go through so much.” Another participant related her husband’s experience when he applied for support, “(The PCSO staff) looked my husband over. He was told that he didn’t look poor, so his request was denied.” Patients also had no way of knowing how much support was to be granted, much less the basis for such awards.

Financial assistance was also availed from other sources. Some of these, however, were either difficult to transact with although the aid provided could be substantial. Said one participant: “We were referred to a foreign foundation by a companion of one of the other patients. We were told that arrangements should only be made through the Internet….The foundation supposedly had assigned a local physician to go over their patient’s clinical abstract. Then, even their visas were taken cared of by the foundation, and the patient, together with the mother, was sent abroad for treatment.”

Others, such as contributions from politicians and even private insurance payments, provided only token support. The usual procedure when soliciting from politicians was supposedly as follows: “One should bring the medical abstract. You will not really be able to speak with the official. Rather, a staff member will be the one to meet you, and you will be told to come back on a designated date.” Guarantee letters are addressed to facilities where officials have set up accounts
(e.g., financed by Priority Development Assistance Funds). The amounts, while not sizable, are still considered helpful. Private insurance reportedly provides limited coverage and also restricted choice of or access to providers.

Discount privileges were also available for selected groups such as persons with disability (PWD) or senior citizens. The issuance of the PWD cards was regarded as part of a DSWD program. The breast cancer patient received prorated hospital discounts, as conferred by a social worker, in addition to her senior citizen privileges. Finally, providers also gave discounts, either on a personal or institutional basis.

Providers’ perspective

Government hospitals directly subsidize part or all of the costs of care, or indirectly assist by providing discounts for their service charges. The latter, as described by a medical social worker working for a public university hospital, involves the assessment of the patients’ economic and medical status. Thereafter, the discount schedules are determined, and referrals to external agencies are made. The discount designations are modified during the confinement period by the social worker to be responsive to the changing financial status of the family. Not all hospitals, particularly private facilities, provide the same social service support.

Also, 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 local public hospitals. However, another participant who had been involved with the administration of both LGU and private hospitals opined, “For LGU hospitals, their incomes declined because of PhilHealth’s case rates. So how can they afford to procure medicines, for instance? There is no problem with private hospitals, as No Balance Billing will not apply.” Providing undue strain on the facilities’ finances are the PhilHealth directives specifying that patients’ expenses for supplies or services sourced externally be shouldered by the hospitals and the prohibition of any charges for patients with No Balance Billing (NBB) privileges.

Many of the discussants were aware of the various PhilHealth benefit programs. The Z Benefits were not yet offered in their institutions. The pharmacist noted that, “Under the PhilHealth case rate system, there are reimbursement limits. Once these are exceeded, patients have to pay for these on an out-of-pocket basis. So the problem arises when the patient still needs medicines, yet the family cannot afford these anymore.” Even NBB patients are not actually spared from OOP payments, as they may still have to advance some funds: “…it does happen that even these patients have to make out-of-pocket payments. But the hospital is obligated to pay them back later on.”
The PCSO’s support can be more substantial, but the funds—similar to PhilHealth reimbursements—are only received by the facilities several months after patients’ confinement. The funding differences have created perverse incentives and also underscore the lack of coordination in public financing. One of the administrators articulated that, “I know that PhilHealth has a (reimbursement) ceiling, which the PCSO doesn’t have….I would rather bring the patients to PCSO than enroll them with PhilHealth, right?” The FGD participants were aware of the difficulties that patients go through to access PCSO’s services. The social worker, however, commiserated with the PCSO staff, saying, “Everybody needs to line up, and fixers are always around. It gets to be difficult to distinguish who the true indigent are. So you need to consider their appearance…” There was the general impression that patients who had already filed their PhilHealth claims were excluded from seeking PCSO’s support, although this was disputed by the social worker.

The Priority Development Assistance Funds (PDAF) could be availed of, but this option is contingent on whether the facilities are officially designated as fund repositories (as formalized in memoranda of agreement) and whether the patient meets the inclusion criteria for such. The individual amounts, while awarded during the period of confinement, are very limited. With the exception of the university hospital (where the social worker who participated in the FGD came from), foundations or philanthropists were not looked upon as consistent sources of assistance. The participant from a chronic care facility lamented the lack of external support options for their patients. They tried to obtain assistance from DSWD but the bureaucratic requirements overwhelmed them.

**Agencies/Organizations’ perspective**

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—specifically, for early breast cancer. And then we have acute lymphocytic leukemia, standard risk, for patients up to 10 years of age. And then, prostate cancer, intermediate risk, for patients not exceeding 70 years old. And then kidney transplantation, standard risk, for patients aged up to 65 years. For our second set, we covered coronary artery bypass, standard risk. We also included repairs for two congenital heart conditions: Tetralogy of Fallot for patients until five years of age, and ventricular septal defect, until 10 years old. Thereafter, we added cervical cancer, for all stages. We are now coming out with benefits for devices, such as orthopedic implants and external prosthesis.” The package also prescribes for a more holistic approach to patient care, including an integrated monitoring system. The benefit package is intended to drastically minimize costs for patients: “…There is a selection criteria. For qualified indigents, they get to
fall under NBB. For those with means, there are set limits for OOP payments, or ‘fixed co-pay’.

The limitations of the Z Benefits program were also raised. Apparently overlooked are the expenses as well as the expertise required to establish, for instance, the diagnoses that will enable patients to qualify for inclusion. The program was perceived to be not widely accessible. Of the 500 cases of breast cancer set as the initial target for the program, PhilHealth has served only 200 patients. The bias of the program’s support for indigents was criticized. Another participant said, “…Sponsored Program members get PHP 500,000, but if you are a paying patient, your PhilHealth benefit amounts only to PHP 200,000. So the benefits are not equal.” It bears to note that indigents under the Sponsored Program do not pay for their enrollment as these are publicly subsidized, while other members have to shoulder their own premium payments. Thus, non-indigents not only personally spend more to qualify for PhilHealth membership; they also end up receiving less benefits as well as having higher provider charges.

The scope of the Z Benefits program is still narrow as it does not include intuitively catastrophic conditions such as those requiring urgent care. The program also does not provide support for other chronic illnesses, such as those requiring prolonged psychiatric care. A participant opined, “It seems we are still focused on illnesses that we can physically see….Our funding agencies are not yet in a maturity stage as far as how they view psychiatric illnesses. But definitely these (illnesses) are a huge burden not only to the family but even to society.”

Another PhilHealth instrument—i.e., payments based on case rates with the added NBB feature for qualified indigents—was deemed by PhilHealth officials themselves as not yet being fully implemented, much less objectively evaluated.

PCSO’s support was lauded by the former member of Congress as well as the patient advocate, having seen how their constituents had benefited from the funding. The PCSO official reacted strongly to the assertion that patients needed to appear destitute to be able to qualify for the agency’s assistance. The perceived discrimination was attributed to the patients being too emotionally sensitive, or due to the actuation of persons who are not even PCSO employees.

The inconvenience that patients had to go through to obtain PCSO’s support was a contentious issue, with a participant saying that this was acceptable, if not necessary. He said, “…For charity cases, there is no express lane. Everyone has to fall in line. They have to go through the process. The assistance should not be given on a silver platter, and they have to work somehow to get it.” The arduous transaction process was, however, deemed objectionable by others. One participant stated, “We have to look after the sick (but we have to leave them). And even if the patient dies, you still have to line up (to apply for support).” Another considered the issue in the context of the uncertainty associated with the PCSO grant process,
“Perhaps it will help to convince people who are embarrassed, afraid, intimidated, or saddened by their situation that it is worth lining up if they knew beforehand how much assistance they are going to get.”

The PCSO representative clarified that, far from being uncertain, the agency actually followed set criteria in determining the amounts to be granted to patients. She described the procedure this way: “There is a classification process. But the criteria is applied only after the interview has been conducted. No one who falls within the criteria can be rejected.” Even as there may be reference formulas, there is some flexibility exercised by the agency’s management in determining individual awards, “…Management still exercises some discretion, albeit minimal, and certainly not to the same extent as before.”

Meanwhile, PAGCOR has shifted its support toward institutions and 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: “All employees individually shell out PHP 50 to help a patient. Inasmuch as there are 12,000 of us, then the amount we can raise for each case is quite substantial.”

The private philanthropist in the FGD relayed how much more personal his decisionmaking process was. Given the limited funds, he was more aware of the attendant trade-offs. He said, “…Which one would you support?… If the prognosis is good, you go all the way. If not, you have to cut your losses now.”

The DOH has responded by, among others, adopting cost-containment measures. It is developing a drug price reference system so as to lower medicine costs, which accounts for the largest proportion of health expenses. The agency representatives also discussed how their own institutions had undertaken bulk procurement of certain drugs. The discussion also highlighted that while there were activities involving several agencies, the resulting state of affairs was far from optimal. For instance, although the PhilHealth and PCSO funding were complementary, the procedures and programs were disparate. There are health conditions—such as breast cancer—where several agencies have individually defined support packages, while other conditions (e.g., trauma) had none at all. In reply to the apparent overlap with PCSO in their agencies’ assistance to transplant patients, the PhilHealth representative stated, “If the patient will need support for immune suppressants for the next three to five years, our request is for the PCSO not to duplicate the support that we already provide.”

**Ways to improve**

*Patients’ perspective*

The patients’ reform suggestions basically centered on schemes that can facilitate transactions as well as increase the breadth and depth of support. Having a
navigator—a case or social worker—attend to individual patients was deemed important. Having been tremendously helped by a social worker during their time of need, an FGD participant reaffirmed, “Patients and their families are going through a very difficult situation, and having a social worker available to direct them to the right people is a very big help already.” Agencies’ receiving offices should be located within the facilities themselves, jointly situated as one-stop shops, or even have business or call centers.

Corollary to agencies being made more accessible, the related procedures and requirements should also be 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.

The FGD participants also called for enhanced support such as additional discounts especially for medicines, increased subsidies or PhilHealth benefits, and even a more encompassing system analogous to the conditional cash transfer (CCT) program.

Several 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, “... The perfect example was what happened to someone close to my heart, my uncle... My mother called and told me to rush to the hospital ... So we went posthaste to the hospital. And they were doing chest compression on him at the emergency room. We were told that adrenaline was needed to jump-start his heart. So we were asked to go and buy this from the drugstore!”

Providers’ perspective
The facility administrators generally adopted a systems approach. One official echoed the patients’ proposal on the need for having identified navigators, specifically social workers, who will attend to the affected patients and families. As broached by the official, “It is probably because social workers already know support networks that can be tapped. They have the background in helping out patients in difficult circumstances, whether as in- or outpatients. So, they are in the best position to identify patients in catastrophic situations and thereafter trigger the appropriate network.”

The need for a clear operational definition of CHE was raised, as this will facilitate the identification of patients or families eligible for institutional support. A clear national policy and a dedicated unit may also be established to ensure the proper coordination of the involved agencies. A group member said, “…We have to make a stand so that there can be a national policy on financial assistance…On a national (level), there (should be) a system, a coordinating body, working with all these agencies,…A central coordinating body who will network and coordinate
the financing activities involved....This should involve not only the health-related organizations, but also agencies like the Department of the Interior and Local Government and even the DSWD,...the way it was done for the CCT, the 4Ps, which relied on a coordinating unit.”

Agencies/Organizations’ perspective
The differences in PhilHealth benefits that may be received by the poor and nonpoor, as exemplified by the Z Benefits program, were discussed. The alternative put forward was for the benefits to be equal. This will still adhere to PhilHealth’s principle of social solidarity, wherein the better-off should support the needy. The tax-financed enrollment of indigents under the Sponsored Program already fulfills this, so parity of benefits regardless of economic status should therefore be the norm.

The proposals for PCSO centered on improving accessibility and transparency. As stated by a member of the group, “We probably have to establish a system wherein people will not have to go and line up to apply for PCSO assistance. That the latter is the case clearly indicates the failings in our system of government.” The PCSO representative mentioned that the institution is already considering this. “Actually, we had proposed such a program this year... The plan is to put up PCSO desks within hospitals....We currently have endowment funds in the hospitals so patients need not go to PCSO [to obtain the monetary assistance].”

Finally, the need for better interagency cooperation was emphasized. The DOH official said, “With regards to medicines, I know that the DOH has committed only up to 2014 to provide these to patients availing of the Z packages in government hospitals. But what happens after 2014? Clearly, there needs to be closer coordination with the other agencies [to address this gap].”

VALIDATION
A validation meeting on September 6, 2013 was attended by officials from PhilHealth, PCSO, and DSWD. While the attendees concurred in general terms with the results, there were a few items discussed in more detail. First, the assertion that PCSO benefits can no longer be availed of by patients who have filed PhilHealth claims was deemed unfounded. The PCSO does, however, deduct the amount claimed from PhilHealth from what the former will grant to the concerned patient. Second, the confusion over the administration of PWD benefits was acknowledged during the discussions. The DOH is reportedly taking steps to establish a PWD registry and eventually attend to the distribution of the cards while PhilHealth is developing benefit packages for disabled members as well. The DSWD official, on the other hand, emphasized that social workers employed
by LGUs were the ones tasked to distribute PWD cards. In the course of the discussion, it was even suggested that the Department of the Interior and Local Government (DILG) should be the lead agency in assisting PWDs, in accordance with the Magna Carta for PWD (RA 7277 as amended by RA 9442).

The current scope of interagency cooperation was repeatedly brought up. It was apparent that most existing initiatives are in their very preliminary stages (e.g., planned coordination between PhilHealth and PCSO for transplant support). Related to this was the involvement of the DSWD’s Crisis Intervention Unit (CIU), which has been allocating the bulk of its support for medical assistance. The CIU also lent support for indirect costs of care. The DSWD representative pointed out that “...the CIU does not only offer assistance for medical expenses. Support is also given for other expense items, such as transportation.”

It was subsequently revealed that patients who received CIU benefits were also the ones who requested for PCSO assistance. Although the assistance from the former is smaller in magnitude compared to PCSO’s funding, the amount is given directly and immediately to patients. The CIU support is therefore applicable for emergency cases. Other DSWD support services include employment referrals to concerned agencies. To avoid duplication of assistance by DSWD offices, a national database of the department’s clients is maintained. Such information is, however, not accessible to other agencies.

DISCUSSION

The three prerequisites for CHE—health services requiring payment, low capacity to pay, and the lack of prepayment or health insurance (Xu et al. 2003)—exist, in whole or in part, 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. This has had a favorable impact in terms of improved access for the poor, presumably due to the removal of cost constraints especially for hospital services. The hospital administrator in the FGD surmised as much when a marked increase in facility utilization was observed following an intensified PhilHealth enrollment program. Nonetheless, while PhilHealth coverage is gaining ground nationally, it is still far from being truly universal as disparities in enrollment rates still exist across regions (Silfverberg 2013).

From a qualitative point of view, CHE continues to be strongly felt by the affected patients and families. The patients were emphatic in stressing that the precarious situations they experienced were aggravated by the attendant financial burdens. There were negative externalities both for the affected patients and families (by way of personal difficulties as well as uncertainties regarding the clinical and economic outcomes). The social costs extend to other stakeholders—
particularly other patients—as these are adversely affected whenever budgeted funds and facility resources get to be expended. PhilHealth’s Sponsored Program may have aggrivated this situation. According to the facility administrators in the FGD, the NBB provision for Sponsored Program members often lead to the attendant outstanding charges being levied to other patients. The presence of these externalities provide the impetus for greater public intervention to more definitively tackle CHE.

While social health insurance as administered by PhilHealth has long been expected to improve the health financing situation, such expectation is yet to be fulfilled. A 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 and Dodd 2011). That the patients and institutions that were part of this study had to resort to other financing sources attests to the insufficiency of PhilHealth support. And though the FGD participants generally held a positive view of PhilHealth, this was conjectured on the agency’s perceived efficiency in providing assistance rather than on actual adequacy of support. While an effective and adequate tax-financed health system could have averted the problems associated with social health insurance (PhilHealth), the Philippine health sector has essentially veered away from this structure. Nonetheless, given the windfall revenues generated from the recently introduced sin taxes, greater subsidies for patient care can again be considered by the government (Official Gazette 2012).

Institutions, by and large, have categorical definitions of what constitutes CHE, premised on their organizational mandates 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, discrepancies in terms of patients’ urgency of need and the institutions’ timeliness of response. An almost cavalier culture prevailing in some agencies is sensed by patients. Such an attitude was even rationalized by an FGD participant as a way of having patients demonstrate that they are desperately in need and thus really deserving of support.

Existing CHE interventions, as exemplified by PhilHealth’s Z Benefits, have a narrow diagnosis-based and treatment-centered scope that neglects related costs (e.g., diagnostics-related expenses) as well as a wide array of other expensive conditions. What was more telling is that many 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 always available in all facilities. The actual legwork for the support-seeking process is mostly left to the patients or their relations. Likewise, the documentary and procedural requirements of agencies are variable. While agencies claim that these requirements are disseminated and published, the patients’ awareness of the prerequisites and ability to comply readily were evidently limited. What added to the patients’ distress was the seeming arbitrariness particularly in reference to PCSO’s assistance criteria. The comparison was repeatedly made with the PhilHealth benefits system, which, despite the underlying computations not being fully comprehended by patients, was nonetheless deemed as based on an objective and impartial system.

The amount and timing of financial support vary across different agencies. In terms of magnitude, PhilHealth and PCSO provide more substantial support, although the former can be accessed only at the end of a hospital confinement while the latter is expected to be made available weeks later, as enabled by guarantee letters. Benefits from sources of funds such as private foundations, PDAF, and DSWD could be accessed early in the course of confinement but these generally provide only limited support. Only DSWD hands money directly to patients. The early gap in financing severely restricts the assistance available for urgent and intensive care cases.

Several misapprehensions came out during the FGDs. Among patients, 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 it to be. Administrators had the impression that patients who had filed PhilHealth claims were ineligible for PCSO benefits. For some institutions, the prevailing stance was that only the poor are affected by CHE. Consequently, there was a bias in their support mechanisms for the impoverished. Assistance was therefore extended to those who were not categorically poor only if they subsequently became so in the course of the adverse health situation.

From the foregoing discussion, it is evident that while several mechanisms exist to purposely mitigate CHE, the available institutional response can best be described as disparate, untimely, and inadequate. A general illustration of the routes, institutions, alternative options, and outcomes that affected patients have to contend with is provided in Figure 1. While the illustration provides a graphical summary of the consequences of CHE on patients and families, the reality is far from being as 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.
CONCLUSIONS AND RECOMMENDATIONS

There is a manifest need to improve the scope and depth of institutional support for CHE. Such may require across-the-board increases in the magnitude of funding to selective policy and procedural enhancements for specific agencies. With such approach, interagency 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 agencies’ responses timelier.

The fundamental step to more systematically address CHE is to adopt a uniform operational definition for such. This will enable the involved institutions to at least have a unifying concept on which to base their own policies and strategies. The proposed definition of CHE is stated as: “The situation applies when a patient’s condition requires medical interventions that 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 CHE inherently refers
to financial concerns, the provided definition offers a different perspective by emphasizing the gravity and urgency of the underlying medical condition.

With further emphasis on the chronological dimension of such expenditures, the exigency with which these should be attended to is also highlighted. There are no references to impoverishment to remove the bias against the nonpoor. 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 allows the prioritization of cases and therapies, thereby also promoting rationalization of health services. The clinical scope is also expanded—enabling trauma cases, for instance, to fall under the definition—and will be more in line with actual disease burdens (IHME 2010).

The definition by no means covers all possible angles. It excludes simpler medical conditions—even as the consequent expenses may be unaffordable to 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 concerned agencies.

The other recommendations are as shown in Table 5. There is a progression from the simple to the more complicated strategies. Measures for improving responsiveness can be undertaken by individual agencies within a reasonably short period of time. These involve mostly a retooling of current systems, thereby making these more client friendly. These interventions may require changes in organizational cultures and adoption of a change management process. 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. Patients’ access to agencies’ services may be improved through measures such as 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 benefits processes cannot be underestimated. This will greatly minimize perceptions of arbitrariness, if not impropriety, in the selection of beneficiaries and corresponding awards. All these have to go hand in hand with an effective social marketing campaign to inform the public at large about the streamlined procedures.

The succeeding enhancements as proposed during the FGDs 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. No OOP 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.
Patients requiring intensive care must be financed by PhilHealth, with supplemental PCSO assistance for those cases that are exceptionally costly (the threshold for which will have to be determined by both agencies). Chronic care will have to be covered by the expanded PhilHealth coverage, with additional cost-of-living support from DSWD. Such proposed assignments are based on the recognized competencies of the individual agencies (e.g., PhilHealth has closer links to providers and can also actuarially assess the health financing needs of most conditions), but also need to be adapted to be consistent with the mandated financial management systems of specific providers (e.g., LGU- versus DOH-operated hospitals).

Finally, the establishment of a dedicated organization that will oversee the development of policies and implementation of strategies regarding CHE is recommended. This may be organically within DOH or 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. Such a unit may create a comprehensive benefits program for patients and families with CHE (similar in some respects to the current CCT program for
indigent families). The program may involve an identification system as well as incrementally packaged services, inclusive of financial support and other safety nets. The president’s Catastrophic Illness Relief Fund may be tailored to serve this purpose. A similar mechanism—the Catastrophic Illness in Children Relief Fund Program—exists in the United States but is restricted to pediatric patients (DHS 2013). The designated unit will also have to coordinate with regulatory offices to ensure that improved financing is complemented by readily available and quality health services.

The insights and recommendations garnered from this study were based largely on the responses of participants in the FGDs. Note, however, that there are inherent limitations to this study’s adopted methodology. The elicited reactions cannot be claimed to indicate the norm, as those who attended cannot be assumed to faithfully represent all those who face CHEs. Admittedly, not all groups or localities were even represented. Providers and even patients had a hospital-centric perspective. While health delivery can be accessed from other levels of health providers, it may nevertheless be presupposed that hospital-related expenditures comprise the greater concern of most stakeholders.

Likewise, other institutions—such as private health insurance corporations, banks, and public financing institutions such as the Social Security System, the Government Service Insurance System, the Employees’ Compensation Commission, and even the DILG—were not represented. The involvement of these agencies will therefore have to be considered in the subsequent planning and implementation of enhanced interagency cooperation.

There is also the need for a more thorough survey—which should take into account foregone health services as these were not affordable 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 looked into because the financial impact of sudden, as opposed to gradual, dissavings is intuitively different. Given these limitations, the FGDs had nonetheless been productive in having 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.

REFERENCES


