

What the Philippines can learn from other countries in financing catastrophic health expenditures

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As efforts to pursue universal health care are escalating, so is the demand for a deliberate, well-studied strategy for achieving it. The methods of high-performing countries around the globe provide a rich source of guidance. Based on the study “Around the globe: Financing catastrophic health expenditures in selected countries”, this *Policy Note* summarizes and synthesizes the strategies employed by three low to upper middle-income countries, namely, the Kyrgyz Republic, Sri Lanka, and Thailand, which have relatively successful health financing schemes. It also describes common themes that were observed in the strategies of the three countries, for the consideration of policymakers in crafting a strategy for the Philippines.

The countries were selected based on income level, health outcomes, coverage outcomes,

cost-effectiveness, and the availability of information on their health financing schemes. Each one has the best health outcomes within their income group in terms of infant mortality, maternal mortality, life expectancy, and immunization rates. Each one also has the best coverage outcomes within their income group, specifically in terms of the share of out-of-pocket (OOP) expenditures to total health expenditures. All three achieved a good level of performance while spending less for health per capita.

The availability of published literature also narrowed down the selection to these three countries.

PIDS Policy Notes are observations/analyses written by PIDS researchers on certain policy issues. The treatise is holistic in approach and aims to provide useful inputs for decisionmaking.

This *Policy Note* was culled from one of the component studies of the Health Systems Research Management (HSRM) Project conducted by the Philippine Institute for Development Studies (PIDS) and funded by the Department of Health (DOH).

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Designing health financing schemes

While there appeared to be no country-specific definition of catastrophic expenditures, all three countries specifically and deliberately targeted high OOP. The causes behind these expenditures varied per country, as did the structures of their health systems, political dynamics, sociocultural contexts, and other pertinent factors. Thus, their strategies also varied greatly, highlighting the need for the Philippine strategy to be context specific, i.e., appropriate not only from a technical perspective but also in view of existing structures and the current social and political climate.

Health financing schemes either targeted the whole population or, in the case of Thailand, formulated schemes for specific segments. Thailand had five pre-existing schemes, each covering different but not necessarily exhaustive segments of the population and each with distinct objectives. Hence, an added challenge was to merge some of these schemes and extend their coverage to account for the entire population while preserving the benefits given by the previous schemes to certain segments.

The decision to opt for supply-side financing through direct provision, demand-side financing through social health insurance, or a mix of the two was determined by several factors, including existing structures (i.e., Thailand's pre-existing insurance schemes), beliefs on whether government should directly provide social services or not (i.e., Sri Lanka), cost-effectiveness given the amount of

funds that can be raised for health (i.e., an important factor for all, particularly Kyrgyz Republic's post-independence fiscal crisis), and the portion of the population that can afford to pay insurance premiums (i.e., a key consideration for all).

All countries required significant increases in funding for health. Given the amounts needed to be raised by countries with many poor households, taxation was by and large the major means of generating more resources. Which sector or industry bore the tax increases varied depending on factors like the size of the formal versus the informal sector, which industries were the highest-grossing, and whether sin taxes could be expanded, among others. Nonetheless, all reforms aimed to raise funds in a progressive manner.

Benefits basically covered the full range of health-care services. However, the extreme ends of the spectrum—preventive or primary care and tertiary care—received special attention: the former because strong gatekeeping mechanisms prevent illness and thus avoid costs and the latter because advanced care is financially catastrophic to majority of the population. Exceptions were mostly determined based on whether high-cost treatments are considered cost effective, though strong pressure from lobbyists can, at times, lead to the inclusion of such treatments, or on the availability of equipment and supplies.

Payment methods were designed to maximize the available funds. As mentioned, the

allocation of more resources to preventive and promotive care was intended to resolve health issues inexpensively by addressing them earlier. Meanwhile, advanced care had to become more cost effective. Capitation and case-based payments—coupled with quality standards and treatment protocols—were established to incentivize providers to produce better health outcomes for larger markets while limiting the amount of resources spent on each person or condition.

A summary of the specific features of the financing schemes in the three countries is given in Table 1.

Managing change

Beyond formulating an appropriate health financing structure, successful countries invested effort, influence, and resources on enacting the changes fully and rapidly. However, several factors assisted their effective implementation.

At times, a difficult event or period, such as a social and economic crisis or epidemic, highlighted the need for reforms, lending a sense of urgency to them or revealing that some strategies are better than others.

Often, strong public demand and participation were key to launching and sustaining the reforms. As long as political structures gave a voice and power to citizens and political incentives for leaders to protect the interests of the populace, social issues like health were addressed aggressively and continuously pursued despite changes in administration.

Successful reforms also began with a clear and comprehensive strategic plan. Often, this required technical assistance, but in all cases, the strategies were highly context specific and aligned all aspects of the health system toward the achievement of objectives, as opposed to addressing issues in a piecemeal manner. All strategies reflected a high degree of commitment as well, reflected in the radical changes and tough decisions that were made and, more importantly, in the implementation that immediately followed.

In all cases, implementation proceeded rapidly. From pilot testing to scale-up, Thailand took less than a year. Kyrgyz completed the reforms within a three-year period. Many did so in a phased manner, beginning with one area or aspect then later scaling up. They tended to launch the radical structural changes first then improve quality and efficiency later. Rapid implementation was also intended to take advantage of the momentum and political support that had already been generated.

Throughout the implementation period, leaders of the reforms had to display both grit and responsiveness. The resistance and political difficulties they encountered tested their commitment to the strategy. At the

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Table 1. Country-specific features of financing scheme

	Kyrgyz Republic	Sri Lanka	Thailand		
			Universal Coverage Scheme (UCS)	Civil Servant Medical Benefit Scheme (CSMBS)	Social Security Scheme (SSS)
Target segments	General population	General population	All those not covered by CSMBS and SSS	Government employees and pensioners	Private and temporary employees
Revenue collection	Primarily payroll taxes	General taxation	General taxation	General taxation	Tripartite
Benefit packages	Primary care Inpatient and outpatient services Drugs and medicines	Preventive care Inpatient and outpatient services Drugs and medicines	Health prevention and promotion Maternity benefits Ambulatory and inpatient services Selected high-cost illnesses Annual physical checkup	Health prevention and promotion Maternity benefits Ambulatory and inpatient services Selected high-cost illnesses Annual physical checkup	Health prevention and promotion Maternity benefits Ambulatory and inpatient services Selected high-cost illnesses
Exclusions		Family planning commodities, services requiring certain high-technology equipment, private paying wards at government hospitals, services at one foreign-funded hospital, drugs when these are out-of-stock at public hospitals	Coverage for 15 diseases	None	Coverage for 15 diseases
Provider		All public facilities; outpatient care mostly ceded to private facilities	Limited to nearby facilities where members are registered; mostly public, some private	All providers included; mostly public facilities for ambulatory and inpatient services	Limited but less restricted than UCS; all public and private facilities for ambulatory and inpatient services
Payment mechanism	Primary care package - Capitation for eligible poor/vulnerable groups Drugs and medicines - Capitation for eligible poor/vulnerable groups All other services (inpatient and outpatient care) - Case-based payments with fixed and progressive co-payments	Direct provision of preventive care Direct provision of inpatient care User fees for outpatient care at private facilities	Inpatient services - Global budget using DRGs Outpatient services - Age-adjusted capitation	Fee-for-service	Capitation

Sources: Kyrgyz Republic - Bonilla-Chacin et al. (2005), Kutzin et al. (2009), Akkasieva et al. (2010); Sri Lanka - Bjorkman (1985), Rannan-Eliya and Sikurajapathy (2008); Thailand - Chunharas et al. (1997), Thammarangsi (2004), Hughes and Leethongdee (2007), Wibulpolprasert and Thaiprayoon (2008), Damrongplaisit and Melnick (2009), Evans et al. (2012)

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same time, strong and/or valid challenges to the plans arose. Leaders had to strike a good balance between being unyielding and discerning when adjustments had to be made and how these could be made without deviating from the larger vision.

Finally, this responsiveness was made possible by a sound monitoring and evaluation system. The progress and impact of the reforms were closely watched so that issues could be addressed promptly and appropriately.

To sum, the keys to improving performance were generating more funds for health and designing benefits and payment methods to make the use of those funds more cost effective.

In addition, success was fueled by a broader enabling environment—by the kind of social participation and decisive leadership that fuel the disruption of detrimental structures and practices amid difficult conditions. 

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The *Policy Notes* series is available online at <http://www.pids.gov.ph>. Entered as third class mail at the Quezon City Central Post Office under Business Mail Permit No. 3C-15-12-494. Valid until December 31, 2016.