

The Lived Realities of Health Financing: A Qualitative Exploration of Catastrophic Health Expenditure in the Philippines

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ABSTRACT

Objectives. Within the last two decades, studies worldwide have documented catastrophic health spending and out-of-pocket expenditure in low- and middle-income countries like the Philippines. This study sought to unpack patients and their families' lived experiences in dealing with such financial challenges.

Methods. This paper stems from a multi-sited qualitative project in the Philippines involving FGDs that sought to elicit people's long-term health goals and the barriers they encounter in attaining good health. Focusing on the domain of health financing, we used principles of grounded theory to analyze how low and middle-income Filipinos pay for their health needs.

Results. For many Filipinos, health financing often necessitates various actors' participation and entails predictable and unforeseen complications throughout the illness trajectory. We describe the lived realities of health financing through four domains: *'pagtitiis'* (enduring the illness), *'pangungutang'* (borrowing the money), *'pagmamakaawa'* (soliciting help from the government and non-government channels), and PhilHealth—the State-owned national insurance agency—whose (non-)role figures prominently in catastrophic expenditure.

Conclusion. Our paper illustrates how illness not only leads to catastrophic expenditure; expenditure-related challenges conversely account for poorer health outcomes. By exploring the health system through qualitative means, we identify specific points of intervention that resonate across LMICs (low and middle-income countries) worldwide, such as addressing predatory loan practices and 'hidden' costs; improving public health communications; expanding government insurance benefits; and bolstering health literacy to include health financial literacy in the school and community settings.

Keywords: *healthcare financing, health policy, health expenditure, health insurance, Philippines*

INTRODUCTION

Across low and middle-income countries (LMICs) worldwide, quantitative studies have explored the phenomenon of catastrophic health expenditure in the last two decades.¹⁻⁸ But how exactly do patients and their families experience health financing challenges?

This article unpacks that question by examining the case of the Philippines, where several significant healthcare reforms saw passage in the last ten years. For instance, the Philippine Health Insurance Corporation (PhilHealth), the State-owned national insurance agency, instituted the "No Balance Billing" (NBB) policy, which, under certain circumstances, provides completely free hospitalization for the duration of confinement.⁹ More recently, Republic Act 11223 officially became the Universal Health Care (UHC)

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Law, whose full implementation guarantees “holistic health care” and automatic coverage under a revamped national insurance scheme for every Filipino citizen.¹⁰

Such reforms could not be timelier, given the high rates of out-of-pocket (OOP) expenditure in the country. The National Objectives for Health 2017–2022, published by the Department of Health (DOH), notes that “the huge share of out-of-pocket (52.2%) still dwarfed the share of government subsidies (18.9%) and PhilHealth social insurance (16.7%) to total health expenditure.”¹¹ The very term ‘out-of-pocket expenses’ assumes that people can draw money from their pockets; else, it begs the question of how and from whom they get these funds and at which stage of their disease they do so. Attending to this question has attained greater relevance in light of the COVID-19 pandemic, which has led to rising unemployment and hunger and overwhelmed the country’s health system.

In what follows, we present findings from a multi-sited qualitative project to help fill the gap in the qualitative literature on OOP and catastrophic health expenditure, outlining the many ways ordinary Filipinos deal with the financial burden of health care. Xu et al. define health expenditure as ‘catastrophic’ “when a household’s [OOP] payments are greater than or equal to 40% of its capacity to pay”¹²; however, in keeping with the qualitative nature of our study, we adhere to the definition of ‘catastrophic health expenditure’ as an expenditure that implies, if not illustratively results to, financial difficulty, as in the work of Jeon et al.¹³ In this study, we conducted focus group discussions (FGDs) to elicit people’s health-related needs and expectations. Health financing emerged as a significant obstacle for poor Filipinos, validating quantitative studies that show high OOP expenditure even with PhilHealth coverage.^{14,15} This article narrates the physically and emotionally laborious strategies that patients and their families undertake to pay for their health needs and concludes by reflecting on both the local and global implications of our findings for policy.

MATERIAL AND METHODS

This paper draws on qualitative data gathered in the Ambisyon Natin for Health 2040 project, which sought to examine the health-related experiences and aspirations of low and middle-income Filipinos. Our team was composed of researchers from public health, anthropology, public policy, and mass communications. We conducted 30 FGDs from November 2018 to May 2019, covering ten field sites across the country and involving a total of 250 participants (Table 1). Maximum variation sampling was employed in selecting the FGD sites and the participants in each area to ensure the involvement of different age groups, geographies, and population and occupational sectors representative of low and middle-income Filipinos (e.g., public school teachers, overseas workers, health workers in hospital and community settings) (Tables 2 and 3). In selecting our study sites, this

Table 1. Geographic distribution of FGDs

Location	Area Type	No. of FGDs
NCR		
Manila	HUC	3
Quezon City	HUC	3
DOH Central Office	HUC	2
Balance Luzon		
Quezon, Isabela	4 th class municipality	4
Zaragoza, Nueva Ecija	3 rd class municipality	2
Lipa City, Batangas	1 st class city	3
Sorsogon City, Sorsogon	3 rd class city	4
Visayas		
Libertad, Antique	5 th class municipality	3
Bacolod City, Negros Occidental	HUC	3
Victoria, Northern Samar	5 th class municipality	3
Total		30

HUC - Highly Urbanized City

Table 2. Distribution of FGDs according to sector

Sector	Total FGDs	Description/ examples
Health workers	4	Physicians, nurses, and other allied medical workers in public and private settings
Government workers	4	Public school teachers, local government workers
Formal workers	2	Young urban professionals, BPO agents
Urban poor	3	Residents of poor communities in urban areas, as defined by Philippine Statistics Authority
Local migrants	2	Inter-island and inland migrants
Farmers/ farming communities	3	Rice, high-value crops, upland, lowland, organized, unorganized
Fisherfolk	1	Coastal and inland fisherfolk
(Families of) overseas workers	2	Overseas Filipino workers or their family members
Disaster survivors	1	Natural or man-made crises
Youth	4	Students, out-of-school youth, workers
Persons with disabilities	1	Including caregivers
Other groups	3	Parents of children below 7 years old (1) Caregivers of the sick or elderly (2)

meant considering the urbanity and rurality of an area and the range of city and municipality classes within those areas. Cognizant of this principle, we eventually settled on sites where our team already had prior contacts for ease of access.

The FGDs sought to elicit the participants’ short and long-term health needs and expectations from various health and non-health-related contexts. They followed a three-part structure: The first allowed the participants to articulate their health-related visions and goals; the second confronted their challenges and constraints in attaining those visions and goals; and the third situated the participants as members of the country’s health care system, discussing their previously articulated visions and goals in that context. Throughout the

Table 3. Distribution of participants according to characteristics

	Percentage
Distribution by urbanity	
Urban	56%
Rural	44%
Distribution by age group, years	
16–30	47%
31–40	26%
41–50	16%
51–60	7%
>60	3%
Distribution by highest educational attainment	
Primary/elementary school	4%
Secondary/high school, incomplete	16%
Secondary/high school graduate	19%
Vocational/technical school	8%
College/university, incomplete	15%
College/university graduate	24%
Post-graduate	14%
Non-formal	1%
Distribution by civil status	
Single	35%
Live-in	12%
Married	47%
Separated	4%
Widowed	2%

discussion, the participants were encouraged to relate their experiences with the health care system, be it at home, in their communities, or the hospital setting.

The FGDs, averaging eight participants per session and lasting 45–90 minutes, were conducted in either English or Filipino, depending on participant consensus (the Filipino questionnaire was translated from English), and took place in secure venues within the communities (e.g., barangay conference halls). The research team had no prior connection to the interviewees and vice versa. Local facilitators from the same communities handled venue arrangements and face-

to-face participant recruitment, which was done through personal and professional referrals, but only the researchers and interviewees were allowed inside the venue. Informed consent was obtained before participation and iteratively throughout the session. The authors took turns in leading the discussions and taking notes to supplement the audio recordings. No repeat interviews or dropouts were noted. At the end of each session, participants received tokens equivalent to PhP 300 (US\$ 6) and reimbursement for ancillary costs such as transportation to the venue. The interview transcriptions ensured participant anonymity through the removal of identifying information; consent forms and background information sheets were kept separately from the transcripts and were accessible only to the research team.

Guided by the principles of grounded theory to allow for the emergence of various health-related concepts, three team members did preliminary coding via an open reading of the transcripts, identifying 14 major themes, from health service delivery to knowledge and financing. These were then analyzed through a second round of coding to identify themes within the domain of health financing. The final themes were decided by consensus, with the authors' different backgrounds helping address the inherent subjectivities that may have colored the analysis. NVivo 11 was used for coding. Ethics clearance for this study was obtained from the University Research Ethics Committee of Ateneo de Manila University (approval no. AdMUREC-18-016).

RESULTS

The lived realities of health financing

Our study shows that among low and middle-income Filipinos, health financing is often a multipart process necessitating various actors' participation and entailing predictable and unforeseen complications throughout the illness trajectory. We break down these findings into four levels, beginning with the individual and culminating with the State (Table 4). In presenting quotes from our data, we have provided the original Filipino and an accompanying English translation, where applicable.

Table 4. The four domains of health financing in the Philippines

Domain	Level	Illness Trajectory	Practices
<i>Pagtitiis</i>	Individual and family	Early to late	<ul style="list-style-type: none"> not seeking any treatment self-medication alternative/ traditional medicine
<i>Pangungutang</i>	Social networks	Early to late	<ul style="list-style-type: none"> borrowing money from family members or co-workers loaning schemes in the workplace moneylenders (e.g., "5-6") pawnshops "co-ops"
<i>Pagmamakaawa</i>	Government and non-government actors	Late	<ul style="list-style-type: none"> approaching individual politicians, government agencies, or non-government organizations employing social capital/ local patronage politics "health cards"
<i>PhilHealth</i>	State	Only during hospitalization	<ul style="list-style-type: none"> official membership enrollment by political patronage/social capital

1. *Pagtitiis: Enduring symptoms instead of risking expensive treatment*

For many of our participants, the first recourse in times of illness is not seeking immediate treatment—it is enduring the sickness. When they get sick, our informants described ‘*pagtitiis*’ (literally, ‘endurance of suffering’) as the initial, if not the most practical option, even if at times it leads to consequential results, as this FGD among families of overseas workers illustrates:

Participant 1: *Tiis-tiis muna talaga. Magastos din kasing pumuntang ospital.*

Interviewer: *‘Yang tiis-tiis’ muna, common ba ‘yan dito.*

Participant 2: *Sobra. Minsan namamatay na nga lang bago pa makarating ng ospital. ‘Yung tatay ni [redacted], may ulcer ‘yun, pero nung sumusuka na ng dugo, tsaka na lang pinatingnan sa doktor.*

(Participant 1: You must endure your illness first. Going to the hospital entails money.

Interviewer: Is this [*pagtitiis*] a common practice?

Participant 2: Very common, actually. Sometimes, people die before they reach the hospital. [Redacted]’s father had an ulcer, but his family only brought him to a doctor when he was already vomiting blood.)

As that passage indicates, informing our participants’ reluctance to seek professional help and just endure the illness is their assessment that they do not have sufficient funds to pay for professional health care—and frequently central to this financial insecurity is unstable low-paying work. In the words of a seamstress from a poor urban community, “It is difficult to get sick when you are poor.” An FGD with rice farmers in rural Northern Philippines, for instance, referenced the precariousness of agricultural livelihoods:

Participant 1: *Karamihan sa’ming magsasaka, walang ipon. Wala ring insurance. ‘Yung kinikita namin sa pagsasaka, pinapambayad sa utang. Walang emergency fund.*

Participant 2: *‘Yung tinanim mo, di mo naman aanihin bukas e. Maghibintay ka pa bago mo aanihin. So habang hinibintay mo, gumagastos ka. So pag nagkaroon ng emergency, automatic ‘yun, uutang talaga.*

(Participant 1: Most farmers have neither savings nor health insurance. What we earn from the harvest is used to pay off existing debts. We don’t have emergency funds.

Participant 2: While waiting for harvest season, we also accumulate expenses. When an emergency happens, we automatically have to seek out loans to pay for it.)

This financial insecurity is common in rural areas, but even formal workers—teachers, uniformed personnel, government-employed health workers—are not spared from such constraints.

However, it is not just the lack of personal funds that underlies ‘*pagtitiis*’; it is also the perception that seeking professional help entails additional, unforeseen, and/or hidden costs. Based on our interviews, this perception is not always unfounded; these ‘added’ costs of health care can take the form of ancillary expenses (hospital deposits, photocopying of paraphernalia) or even transportation costs from the home to the hospital, as these passages from an FGD in a poor urban community illustrate:

Participant 1: *Sa ER pa lang, binibilang na nila barwat oras na nandoon ka.*

Participant 2: *May sariling ambulansya ‘yung barangay namin, pero sa’min nanggagaling ang pang-gas. 300 na rin ‘yun bago ka pa naman makarating ng ospital.*

Participant 3: *Nagka-emergency ‘yung misis ko kaya dinala ko sa ospital. Public ‘yun. Libre kasi ang gamutan doon. Pagdating doon, sabi sa’min, out of stock daw ‘yung kailangan na gamot, kaya kinailangan ko pang bumili sa botika. Inabot din ng 800 ‘yung nagastos ko.*

(Participant 1: If you get admitted to the emergency room, just by staying there, the hospital already charges you by the hour.

Participant 2: Our barangay has its own ambulance, but residents are actually expected to cover the fuel costs. That’s PhP 300 (US\$ 6) out of your wallet before you even reach the hospital.

Participant 3: When my wife had an emergency, I brought her to a government hospital, where medicines are for free. But the hospital had no stock of the needed medicines, so I ended up shelling out PhP 800 (US\$ 16) to buy a few doses at a nearby drug store.)

Moreover, compared to government facilities, these costs—and the cost of professional health care in general—are markedly higher in private institutions. Thus, for people with limited finances, enduring their illness at home becomes a perceivably reasonable option when their only other choices are seeking help in expensive private hospitals or in public hospitals that, to their mind, may be cheaper but are overwhelmed with patients and lacking in resources. To quote another informant from a poor urban community:

Pipila ka talaga sa public. Di hamak na mas okay sa private, pero mamatay ka naman doon sa gastusin. Kung wala kang pera, ta’s kailangan mo talagang pumuntang ospital, pipili ka talaga.

(If you go to a public hospital, be prepared to endure long lines all the time. Everything is better in private hospitals, but there, you'll die from the expenses. If you're poor, and you really have to go to a hospital, you have to make a choice.)

'Pagtitiis', however, does not necessarily mean doing nothing for one's illness. Often, it involves seeking alternatives to professional care. These include consulting traditional healers who only request 'donations' (i.e., a nominal amount based on one's ability to pay) or resorting to self-medication, like using herbal medicines freely available in the environment.

Furthermore, it must be emphasized that, although the preference for traditional medicine may be the inevitable result of ingrained cultural practices, it is nonetheless a product of financial insecurity. This passage from an FGD with rural health workers—trained in Western medicine—is demonstrative:

Sa albularyo muna. Ang mahal din kasi magpagamot sa doktor. 'Yung sa albularyo, donation lang, 10 pesos, ganyan, o di kaya bigyan mo ng mga kakailanganin niya. Barwang, itlog.

(I go to the 'albularyo' [traditional healer] first before seeing a doctor. [Western] medicines are just unaffordable. With the 'albularyo,' you only donate PHP 10 [US\$ 0.20], or give him the materials needed, like ginger or eggs.)

2. Pangugutang: Borrowing money to pay for health services

When they finally see a doctor or go to the hospital, our study participants see borrowing money as the foremost means of paying for health care, particularly in times of emergency. This holds across all population and occupational sectors in both rural and urban areas. "*Kung may mauutangan, uutang muna* [We borrow money first if there is someone to borrow from]," said an informant from a fishing community.

Family members are often the first to be approached for financial assistance, most of which are couched as loans to avoid embarrassment. From this FGD among rice farmers, for instance:

Interviewer: *Kanino kayo unang umuutang?*

Participant: *Sa pinsan, o 'di kaya sa tiyabin kong may pera.*

(Interviewer: From whom do you borrow money first?

Participant: A cousin. A well-off aunt.)

Among the formally employed, a common practice is approaching co-workers for loans. Sometimes these loans are informal, but others reported having organized loan schemes among themselves, as with this group of public school teachers:

Participant: *Nung manganganak na ako, kailangan kong i-Caesarian. Kaso kulang 'yung naipon ko.*

Interviewer: *Kanino ho kayo umutang?*

Participant: *Sa co-teacher ko lang na nagkakapursyento. May sistema na rin kasi kami.*

(Participant: I needed to have a Caesarian section but hadn't saved enough money to pay for it.

Interviewer: How did you pay for it?

Participant: My co-teacher lent me the money with interest. We have our own internal borrowing system in place here.)

But even with loans from family members or co-workers, often, the costs incurred from hospitalization are still too much. Thus, many end up approaching moneylenders - informally known as "5-6" because of the 20 percent interest rate attached to the loan. "*Ang taong may sakit, sa '5-6' kumakapit* [A sick person clings to '5-6' for aid]," quipped one informant. Access to money from this scheme is immediate, but the markedly steeper interest rate often only leads to more debt—and further impoverishment.

Other sources of loans include pawnshops, where material items are used as collateral, and where the loan is also usually paid off at a set interest rate; and local lending cooperatives—colloquially called "co-op"—organized by, among, and for community members themselves. In the former case, the pawned items are usually personal valuables like jewelry, but in rural communities, can even be things like coconuts, as one informant from a farming community shared.

All of the above provide relatively immediate funds, but they come at a financial or social cost. Relational conflicts within the family or community arise when debts fail to be paid off. As mentioned multiple times, and as exemplified by this FGD among local migrants to an Eastern Philippine town, the interest rates attached to loan schemes only add to the actual debt that needs to be paid off.

Interviewer: *Concerned ba kayo na at some point, 'di niyo mababayaran 'yung mga utang niyo?*

All: *Oo.*

Participant 1: *Kung walang pambayad sa utang, uutang ka talaga.*

Participant 2: *Baon talaga sa utang 'pag ganyan.*

(Interviewer: Are you concerned that, at some point, you won't be able to pay off your debts?

All: Yes.

Participant 1: If you have nothing to pay for the previous debt, you incur another loan.

Participant 2: That's how you get literally buried in debt [*'baon sa utang'*].)

Often, when the initial loan proves insufficient, family members are forced to seek additional work to augment their income, on top of juggling the added responsibilities that illness in the family has brought about. From this FGD in a poor urban community, for example:

'Nung na-ospital si lola, kailangan kong umekstra. Nagbabarbeque ako tuwing Sabado't Linggo para makatulong sa gastusin sa ospital.

(When my grandmother was hospitalized, I took on an extra job on top of my day job. I sold barbecued meat on the sidewalk during week-ends, just so I could contribute to paying off our hospital expenses.)

Moreover, it must be noted that the loans our informants incur do not only go to paying for the needed health services. Even before seeing a physician, they must already shoulder various expenses, many of which are not accounted for, let alone covered, by insurance schemes like PhilHealth. These expenses—be they 'hidden,' like the previously mentioned 'informal' fees for ambulance use, or legitimate costs, such as hospital deposits upon admission—ultimately influence health-seeking behavior and decision-making even from the level of the home.

3. *Pagmamakaawa: Soliciting help from the government and non-government actors*

Beyond '*pangungutang*', our study participants approach government agencies and politicians for financial assistance. This set of actors ranges from mayors and Congress members to nationally elected officials like the president and vice president. They also approach agencies like the Philippine Charity Sweepstakes Office (PCSO), the Department of Social Welfare and Development, and the Philippine Amusement and Gaming Corporation.

To a lesser extent, they also approach non-government charitable institutions. For instance, a group of informally employed residents of a poor urban community narrated how their local parish tied up with nonprofit organizations such as Caritas, Inc. to organize a financial assistance system for its geographic members (i.e., those whose official addresses belonged to the said parish).

But be it from government or non-government channels, many of our informants still reported mixed results in actually securing funds. And in any case, the entire procedure that goes with seeking financial assistance requires time and effort on the part of family members.

First, there is the requisite emotional labor—a need to appeal to the emotions of those in positions of power. To quote an informant from the urban poor, "*kailangan mo talagang magmakaawa* [you really need to beg]." Doing so entails narrating the sick family member's ordeal and its toll on the family, while also providing physical proof

of need. Such evidence of illness and financial condition requires documentation, which entails its costs. Papers like clinical abstracts and laboratory results must be paid for—either because hospitals charge for their reproduction, or at the very least because they have to be photocopied. Moreover, securing these documents also requires time and effort: Family members must 'make time' to go to the hospital, and even consider the availability of personnel authorized to release such documents—and this presupposes that the patient is already admitted (which, as described above, already requires funding). All of that is illustrated in this exchange with two participants who are caregivers of persons with disability:

Participant 1: *'Pag sa public, kailangan mo talaga ng mahabang pasensya. Tapos dapat alam mo na kung saan ka tutungo para mabilis.*

Participant 2: *Kailangan 'pag pumunta ka kay mayor, dala-dala mo na labat. PhilHealth, abstract, 'yung indigency galing barangay, sulat para sa opisina ni mayor, pati mga reseta ng doktor.*

Participant 1: *Ta's 'pag nagawa mo na 'yun, minsan aabutin pa ng ilang burwan bago mo makuha 'yung pera.*

(Participant 1: Public hospitals require your patience. You have to know exactly where to go and whom to look for to save time and effort.

Participant 2: When you go to the mayor's office, you must have everything with you already: PhilHealth documents, clinical abstract, indigency certificate from the barangay, a letter addressed to the mayor's office, even doctors' prescriptions.

Participant 1: Once you've submitted the documents, sometimes it takes months before you receive the money.)

Social capital is also a decisive factor: Knowing someone influential can spell the difference. Especially in poor and/or rural communities, patronage systems strongly apply, as in this excerpt:

Kumpare-kumpare ang inuuna. 'Nung manganak na 'yung misis ko, ayaw pa kaming asikasubin sa barangay hall. Inasikaso na lang kami 'nung nalaman nilang kaibigan ni misis 'yung isang BHW. Pinagamit pa sa'min 'yung ambulansya.

(Friendships come first. When my wife was about to give birth, the people at the barangay hall accommodated us only when they found out she was friends with a local health worker. We were even taken to the hospital on the barangay ambulance.)

'Health cards' are also important. These refer not to those issued by insurance companies, but rather, by local government units, the color serving both as an identifier of the city or municipality that issues the card and, indirectly, as a political statement. As the following FGD excerpt shows, access to these cards is often determined by one's political allegiance, while their very existence—or inexistence—is dependent on who's in political power.

Participant: *Nung dinala ko 'yung biyenan ko sa [government hospital in Quezon City], ayaw kaming tanggapin. Kulang kasi 'yung pera namin pang-deposit. Tinawagan ko 'yung brother-in-law ko, ayun, sinabing may yellow card daw si mama. Pumunta kami kaagad sa Ospital ng Makati. Ambilis doon. Tapos halos wala na rin kaming binayaran.*

Interviewer: *'Di gumana 'yung yellow card sa ospital sa QC?*

Participant: *Sa Makati lang. Sa mga Binay kasi 'yun.*

(Participant: I initially brought my mother-in-law to [a government hospital] in Quezon City. The hospital wouldn't accommodate us because we didn't have enough money for a deposit. When I called my brother-in-law, he told me that she was actually a yellow-card holder of Makati City. So I brought her to Ospital ng Makati [the city public hospital]. We were immediately accommodated and almost didn't have to pay for anything.

Interviewer: The yellow card didn't work in Quezon City?

Participant: No, only in Makati, especially in Ospital ng Makati—that's the turf of the Binays [the city's prominent political dynasty].)

Finally, physical labor is inevitable, especially in the rural Philippines, where people hustle from town to town, region to region, to access funds through any means necessary. Narratives like the one below frequently figured in our interviews:

Na-stroke 'yung mother ko, dalawang burwan siyang nasa ospital. 'Yung bill namin, lagpas isang milyon. Kabit may PhilHealth, 'di pa rin namin 'yun mabayaran labat. 'Yung ginawa ko, taga-Batangas kasi kami, so lumuwag ho ako ng Maynila para maghanap ng pera. Pumunta akong ABS, tapos ibinato ho kami sa DOH. 'Yung DOH nakahanap ng paraan para mabawasan ng kalabating milyon 'yung babayaran namin sa ospital sa Batangas. Nakahingi din kami sa PCSO, malaki-laki rin, mga ilang daang-libo rin 'yun. Tapos 'yung the rest, hati-hati na kami ng mga kapatid ko.

(My mother had a stroke and was admitted for two months. In that time, our bill exceeded a million pesos. Even with PhilHealth, we could never pay it off. We live in Batangas, but I went all the way to Manila, first to ABS-CBN [the TV station], where I was directed to the DOH. The DOH coordinated with the hospital in Batangas to lower our expenses to half a million. We got a few hundred thousand more from PCSO. The remaining amount, my siblings and I divided amongst ourselves.)

Implicitly, all this also involves non-disabled family members not working for the time being—which means another opportunity cost adding to the burden of health care.

4. PhilHealth: The (non-)role of the national health insurance program

Besides exploring our participants' means of obtaining OOP funds for health care, we also interrogated PhilHealth's role in the process. When our study started, PhilHealth coverage in the country was estimated at 93 million individuals or roughly 90 percent.¹⁶ Our informants' responses, however, revealed contrasting sentiments: Many claimed they were not covered by PhilHealth or believed their poverty disqualified them from coverage. Some even viewed health insurance negatively, as in this exchange with male residents of a poor urban community:

Interviewer: *Kung mayroon kayong option na magbayad ng 200 burwan-burwan para sa PhilHealth, gagawin niyo ba?*

Participant 1: *Depende sa kita. Di naman ako palaging may trabaho.*

Participant 2: *Puwede pa 'yan pambili ng pagkain ng anak ko.*

Interviewer: *So okay lang sa inyo na walang PhilHealth?*

Participant 2: *Less din 'yun sa gagastusin.*

Participant 1: *Tsaka bakit ka magbabayad kung 'di naman sigurado na may makukuba ka sa binayad mo?*

(Interviewer: If you have the option to pay just PhP 200 [US\$ 4] per month for PhilHealth coverage, would you do it?

Participant 1: It depends on my income. I don't have a stable job.

Participant 2: That money can go to expenses for my child's food.

Interviewer: So you're okay with not having PhilHealth?

Participant 2: That's one less expense to think of.

Participant 1: Why even pay if you are not sure you will get anything out of it?)

Among those enrolled in PhilHealth, one common sentiment is that coverage is rarely sufficient. As an informant lamented: "Everyone is covered by PhilHealth, but

PhilHealth does not cover everything.” A local migrant to an Eastern Philippine island, for instance, shared how, when she was hospitalized, PhilHealth deducted only PhP 5,000 [US\$ 103] from her bill, and the hospital charged her the remaining PhP 100,000 [US\$ 2,063].

Another common sentiment is that the specific provisions of PhilHealth are hardly favorable to patients. From this FGD with health workers in the central Philippines, for example:

Patients can only use their PhilHealth when they get admitted to the hospital ward. Emergency-room admission does not count. Now when the wards are full, it can take two to three days before a patient can be transferred from the ER. By then, they can already be discharged and have to foot the bill themselves.

These particulars in the fine print appear to have led to confusion, if not a lack of understanding, regarding PhilHealth’s mechanisms. One informant, referring to his recent hospitalization, complained, “*Bakit ganoon, hindi ko man lang nagamit ang PhilHealth ko? [Why was I unable to use my PhilHealth?]*” More than one questioned why, despite being members, their hospitalizations weren’t for free; why they still had to pay for certain expenses.

Some informants, as in this FGD among farmers in Northern Philippines, even shared how PhilHealth has become politicized in the communities:

Interviewer: *Ano ‘yung sistema sa munisipiyo na sinasabi niyo?*

Participant 1: *Yung opisina ni mayor ‘yung magbabayad ng PhilHealth, pero pinipili lang nila. Kung di ka napili, e ‘di ikaw mismo ang magbabayad.*

Participant 2: *Yung problema, ‘pag napalitan ‘yung mayor tuwing eleksyon, pinapalitan din ‘yung listahan.*

(Interviewer: You mentioned that the municipal hall has a system in place?

Participant 1: Yes, the mayor’s office pays for your PhilHealth, but they select the beneficiaries. If you’re not chosen, you have to pay for it yourself.

Participant 2: The problem is, if a new mayor wins the election, the beneficiaries also change.)

Thus, while we encountered informants who spoke positively of PhilHealth—many respondents shared how they paid nothing for their hospitalizations, thanks to the NBB policy—they were a distinct minority. For many others, as in the following case of a public school teacher, PhilHealth’s existence has done nothing to spare them from the cycle of ‘*pagtitiis*,’ ‘*pangungutang*,’ and ‘*pagmamakaarwa*.’

Mayroon akong APAS. Nung buntis ako, araw-araw may iniinject ‘yung doktor sa’kin, para daw maging stable ‘yung pagbubuntis ko. E kailangan pang umipon, so di ko siya tinake ‘nung first month, nilakasan ko lang ‘yung pananalangin ko sa taas. Sa private ako nanganak. Caesarian. ‘Yung bill, inabot ng 120, tapos 19,000 lang ‘yung binarwas ng PhilHealth. Kulang ‘yung 60k na inipon namin ni mister ko, tapos naka-leave pa ‘ko for nine months kaya wala akong inaasahang sabod. ‘Nung nakita na namin ‘yung bill, on the spot umalis si mister para humagilap ng perang pambayad. Pulis kasi asawa ko, so madali lang makapagloan sa katrabaho. Ako naman, teacher, madali ring makapag-loan, may sistema naman kami. Tapos ito pa, ultimo 1,000 kinulang pa!

(I have antiphospholipid antibody syndrome. When I got pregnant, the doctor prescribed daily doses of a certain medicine to stabilize the pregnancy. To save money, I didn’t take the medicine for the first month. I just prayed to God to keep me safe. I gave birth at a private hospital through a Caesarian section. The bill amounted to PhP 120,000 [US\$ 2,475]. PhilHealth deducted only PhP 19,000 [US\$ 390]. Now my husband and I had set aside only PhP 60,000 [US\$ 1,238], and I’d had no income for the last nine months because I was on unpaid leave. Upon seeing the bill, my husband instantly left the hospital to look for money. He’s a policeman, so he borrowed from his colleagues. I also took a loan from our borrowing system with my co-teachers. When it was time to pay, we discovered we were short of PhP 1,000 [US\$ 20]!)

DISCUSSION

Beyond ‘out-of-pocket’ expenses

Our findings build on the global literature on OOP expenditure in health care, resonating with existing work from and on other LMICs that document the impoverishing effects of catastrophic illness.⁴⁻⁸ While updating the body of work that has specifically focused on the Philippine experience,^{2,3,17} our study illuminates the tangible steps people take to produce funds by plotting a temporal profile of spending through three domains of action.

The first domain, ‘*pagtitiis*,’ is informed by both the physical lack of financial resources and the *perception* that seeking professional care entails unaffordable costs. This practice of ‘enduring the illness’ invariably leads to the worsening of patients’ conditions and, consequently, a more significant financial burden: By the time patients reach the hospital, their illnesses have often progressed to more complicated stages requiring longer and costlier interventions.

In the domains of *'pangungutang'* and *'pamamakaawa'*, where people actively exhaust all means of paying for their expenses, we documented not just the financial costs of health care but also the social and emotional labor that goes into securing those funds—both of which take their toll on the patients and their family members who undertake these tasks. Moreover, while specific money-related practices in the communities have been dissected extensively, our study explicitly links these practices to health financing. Kondo, for instance, delves into the details of “5-6” by distinguishing two types of lenders—Filipinos who operate as financiers within the community and, more stereotypically, Indian nationals—and while this distinction did not readily surface in our interviews, the prominence of this practice in our discussions suggests the centrality of loan schemes to health financing.¹⁸ At worst, if not by actual health expenditure, Filipinos find themselves at risk of impoverishment from the high interest rates of predatory schemes.

Regarding the (micro-)politics of health that constitute *'pamamakaawa'*, our study further underscores the influence of politics in health care in the larger picture of national policy and the day-to-day affairs of local government with its constituents. As far as existing practices and conditions are concerned—from ‘hidden,’ if not outright illegal fees, to small-town patronage systems—political capital remains a barrier to health, especially for the marginalized majority. Ultimately, these findings suggest the same conclusion reflected in researches from other LMICs, either in the Southeast Asian region¹⁹⁻²⁰ or in other continents²¹: In the conversation of health reform, the prevailing top-down political and bureaucratic climate always plays a considerable role and should never be discounted.

Implications for policy and practice

The recognition of *'pagtitiis'* as patients' default initial response, informed in part by their resource-allocation practices, has clear clinical and public health implications, especially for conditions that require early intervention. The fact that patients' financial status often discourages them from seeking professional or hospital care—unless their illness becomes unbearable—should lead to more proactive policies that usher patients into the system at the stage of their illnesses when interventions can still make a favorable impact—and understanding the medical and financial thresholds for people to move from *'pagtitiis'* to other responses. Currently, PhilHealth prioritizes inpatient care, leaving people with no financial protection at the earlier stages of illness or for conditions deemed minor but which nonetheless impact their quality of life—in contrast to the more comprehensive national coverage schemes of neighboring LMICs.²²⁻²³ And while the influence of traditional medicine and local conceptions of illness at these earlier stages cannot be discounted, our participants' reliance on *'pagtitiis'* is a recognition that, at least in some instances, they should *ideally* receive professional care.

This requires bridging the gap between what Ico calls subsistence spending (money needed to survive) and health care spending—and formulating pro-people interventions that will not entail sacrificing one in favor of the other.³ Mirroring the experience in other LMICs,^{1,8,24} informal or ‘hidden’ costs—such as transportation and food expenses, and the opportunity cost incurred by family members who must stop working to care for the patient—are additional barriers to health care that contribute to OOP expenditure in the Philippines. Though not without their foreseeable bureaucratic challenges, hospital- and local-level policy changes, like improving rural and barangay health outposts, reimbursing transportation allowances from home to the hospital, or eliminating ancillary fees for the reproduction of hospital paraphernalia, will not only reduce expenses but make medical care more accessible to patients.

In this vein, it is worth noting that in both in- and outpatient settings, medicines still comprise the bulk of patient expenditure, as reported by the study participants—an observation validated by previous research.^{2,17} Thus, efforts to reform drug pricing and analyze medication-purchasing practices (akin to James et al.) should be redoubled,²⁵ in addition to further investigating how best to maximize PhilHealth coverage, in the vein of Picazo et al.²⁶

As with similar universal coverage schemes in many countries, the UHC Law furnishes legal support for accessibility—for example, by calling for “proactive and effective health promotion programs or campaigns.”¹⁰ To fulfill this goal, however, policymakers must not ignore the geographic, cultural, and *local political* variations inherent to the Philippines, similar to policy work that has been done in Thailand and Indonesia.^{27,28} In fact, these variations must be explored in terms of people's attitudes to health and the government's role in shaping people's health-financing practices—especially in light of the social and political capital required in the domains we identified earlier. Beyond expanding population and service coverage, primary care programs and social protection schemes should address the physical, social, and financial effort patients and their families undertake to procure funds, offer alternatives to predatory loan schemes, and offset the ‘hidden’ costs identified above.

Finally, our study points to information gaps that serve as barriers between patients and their (pre-)existing financial entitlements—from confusion over PhilHealth membership to uncertainty over what exactly is covered by insurance. Health literacy should involve health *financial* literacy: a practical, working understanding of the health care system regarding financial matters (e.g., the specific stipulations of PhilHealth membership) that will empower patients to navigate the system, avail of their rights, and avoid unnecessary expenses throughout the illness trajectory. Although existing literature from high-income countries and LMICs has identified the relationship between health literacy and increased health expenditure,^{29,30} our study calls specifically to explore the implications of health financial

(il)literacy as an avenue for future research. In unpacking how people fall into debt from catastrophic health spending, it is also crucial to understand how they fail to navigate the existing bureaucratic structures of the health care system and to shape educational and community policies that address this shortcoming.

CONCLUSION

Our article describes three major domains through which ordinary Filipinos finance their health care: *'pagtitii'* or enduring illness, *'pangungutang'* or borrowing money, and *'pagsamakawwa'* or begging for help. The first bears consequences for the medical system; the second unpacks the nature of debt vis-à-vis health financing; while the third questions the interrelation of politics and health—how politics continues to undermine health financing, how health undermines politics. PhilHealth can be considered a fourth domain, but due to its insufficient coverage and the rampant lack of information about it, it has made a relatively insignificant impact on many Filipinos' financial needs. Taken together, all of the above illustrates how illness not only leads to catastrophic expenditure; expenditure-related challenges conversely account for poorer health outcomes

Our study has limitations. First, despite our sites' relative breadth, there remains a need to probe deeper in different directions, accounting not only for the temporal profile of health spending but also for how disparate demographics, regions, and social classes vary in their lived experiences in health financing. Economic analyses (including micro-costing studies), especially in the era of UHC and COVID-19, should be done to validate further and quantify the impact of health financing among Filipinos. Moreover, some of the practices we explored—from borrowing schemes to patronage politics—would benefit from more in-depth qualitative research. Lastly, while this article already hints at the broader health-related structures intertwined with and which impact health financing, further studies that unpack these structures individually—from health service delivery and primary care to local political climates—would inarguably enrich our understanding of contemporary public health in the country.

Nonetheless, through this qualitative exploration of catastrophic health expenditure in the Philippines, we identified specific points of intervention for both the short and long term: addressing predatory loan practices and 'hidden' costs; communicating PhilHealth entitlements (especially in light of the UHC Law); expanding benefits to include outpatient care and medicines; addressing and bolstering health literacy to include health *financial* literacy in both the school and community settings. In removing the barriers to health, we must necessarily address the obstacles to health financing that have long led many Filipinos to disrupt the foundations of their families, borrow money at the risk of impoverishment, expend all manner of labor to beg for assistance—or simply endure their suffering.

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Statement of Authorship

Dr. Gideon Lasco, conceptualization, data acquisition and analysis, drafting, revision, final approval. Dr. Vincen Gregory Yu and Dr. Clarissa David, data acquisition and analysis, drafting, revision, final approval.

All authors approved the final version of manuscript submitted.

Author Disclosure

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