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ADOPTING THE SYSTEM OF HEALTH ACCOUNTS (SHA) 2011 IN THE COMPILATION OF THE PHILIPPINE NATIONAL HEALTH ACCOUNTS

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Vivian R. Ilarina, Alma S. Bello and Maegan S. Saroca

For additional information, please contact:

Author's name	Vivian R. Ilarina
Designation	Assistant National Statistician
Author's name	Alma S. Bello
Designation	(Supervising Statistical Specialist) OIC
Author's name	Maegan S. Saroca
Designation	Statistical Specialist I
Affiliation	Philippine Statistics Authority
Address	16th Floor, Eton Cyberpod 3, EDSA cor. Quezon Ave., Quezon City
Tel. no.	376-1954
E-mail	m.saroca@psa.gov.ph

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Abstract

Prior to the adoption of the System of Health Accounts (SHA) 2011, the annual series of PNHA was compiled by the Philippine Statistics Authority (PSA) using a methodology developed between 1991 and 1995. This methodology has not changed since the first publication of the said accounts in 1991 and the estimates produced then were not able to address specific policy questions such as "Who provides health care services?" "Under what type of financing schemes are health care services provided?" and "How much are invested into health care each year?", among others. Moreover, these estimates involved under coverage and the usage of old parameters, and were not comparable with Health Accounts estimates produced by other countries since they do not conform to the standards set by World Health Organization (WHO). The PSA addresses these issues by adopting SHA 2011, the current international standard for health accounting recommended by the Organization for Economic Cooperation and Development (OECD), European Statistical Office (Eurostat), and WHO. This paper describes the major changes in the PNHA that resulted from the adoption of SHA 2011 guidelines. It presents the 2015 to 2017 PNHA-SHA estimates on total health expenditures (THE) and current health expenditures (CHE) by the following health expenditure classifications: 1) revenues of health financing schemes (FS), 2) institutional units providing revenues to financing schemes (FS.RI), 3) health care financing scheme (HF), 4) financing agent (FA), 5) health care providers (HP), and 6) factors of health care provision (FP). It also presents the Health Capital Formation Expenditures (HK) in 2015 to 2017.

1. Introduction

The Philippine National Health Accounts (PNHA), which provides details on the total health expenditures of the country, is one of the satellite accounts being produced by the Philippine Statistics Authority (PSA). It differentiates between two (2) aggregates of health expenditure, namely: current health expenditures and health capital formation. It presents data on the country's health spending, health financing and health management over a defined period of time.

During the early 90s, the first framework used in producing the PNHA was developed under the Health Finance Development Project (HFDP) of the Department of Health (DOH), together with the National Health Accounts (NHA) Technical Working Group composed of the National Statistical Coordination Board (NSCB), National Statistics Office (NSO) and DOH. This led to the production of the first PNHA covering the year 1991. Following the success of the first PNHA compilation, NSCB staff underwent NHA training in preparation for the estimation of the first PNHA series, which was officially released in 1999, covering the years 1991 to 1997. The estimation methodologies for the compilation of PNHA were approved by then NSCB Board through Resolution No. 8, Series of 2011 or currently referred to as PSA Board Resolution 01, Series of 2017 – 170.

In 2011, the World Health Organization (WHO) completed the revised SHA 2011 edition and recommended its adoption by the member states of the United Nations. Subsequent to this, DOH advocated the adoption of SHA 2011 in the country, spearheading studies and a series of training activities with technical assistance from the WHO. In 2016, the PSA adopted the SHA 2011 for the compilation of the PNHA. This adoption process started with an orientation on SHA 2011 of concerned official and staff from PSA, DOH and the Philippine Health Insurance Corporation (PhilHealth), followed by a training workshop for sixteen intermittent days from January to March 2017. All these efforts resulted to the 2014 to 2016 estimates of PNHA-SHA, which was officially released in the PSA website on 6 November 2017. PSA has been producing and releasing these estimates since then, covering the years 2014 to 2017. Come

17 October 2019, PSA shall release online the revised 2016 and 2017 estimates and the preliminary 2018 estimates of PNHA-SHA.

The SHA 2011 is a framework stipulating the systematic description of the financial flows related to health care. This was developed by the Organization for Economic Cooperation and Development (OECD), European Statistical Office (Eurostat) and WHO with the objective of describing the health care system from an expenditure perspective both for international and national purposes. The SHA 2011 was crafted to address changes in health care systems in countries around the world, such as changes in demographics and disease patterns, rapid technological advances, more complex financing and delivery mechanisms, and to meet the current needs on detailed health expenditure information. With the adoption of this framework, PSA is now generating PNHA estimates which provide details on health care financing, provision and consumption of the country.

This paper aims to describe the major changes in the PNHA resulting from the adoption of SHA 2011 guidelines. It presents the 2015 to 2017 PNHA-SHA estimates on total health expenditures (THE) and current health expenditures (CHE) by the following health expenditure classifications: 1) revenues of health financing schemes (FS), 2) institutional units providing revenues to financing schemes (FS.RI), 3) health care financing scheme (HF), 4) financing agent (FA), 5) health care providers (HP), and 6) factors of health care provision (FP). It also presents the Health Capital Formation Expenditures (HK) in 2015 to 2017.

2. Methodology: PNHA and PNHA-SHA

2.1 PNHA (PSA Board Resolution 01, Series of 2017 – 170)

The earlier initiatives in PNHA compilation stemmed from the need to obtain information on the country's health expenditures. This resulted to the production of data on how much was being spent on health care, who paid for health care and what kind of health care was being provided. The methodology used, as provided in PSA Board Resolution 01, Series of 2017 – 170, defined total health care expenditures as the sum of expenditures on goods and services for the preventive, curative, therapeutic and rehabilitative care of residents of the Philippines for the primary purpose of improving health. However, programs which yield health effects but whose primary goal is not health improvement were excluded. Health care services were those provided by hospitals, medical and dental clinics, own-account health professionals and traditional healers, medical missions and mobile surgical/laboratory units, DOH (other than those by DOH health care facilities) and other non-DOH government agencies implementing health programs such as nutrition programs, health information campaigns and drinking water testing. The types of health care being provided were personal health care, public health care and others. These were paid for by the government, social insurance, private sources and the rest of the world. All of these made up the operational framework implemented in the compilation of PNHA, which presented the composition of total health expenditures *by uses of funds* and *by the sources of funds.* The *sources of funds* are composed of the institutional units defined to be the public and private entities who directly paid for health care consumption or provision. The *uses of funds,* on the other hand, are comprised of the health providers and the types of health care. These were all presented in a two-dimensional table where the *sources of funds* were listed along the columns and the *uses of funds* were enumerated along the rows of the table.

This compilation methodology sourced its government data from the Department of Budget and Management (DBM), Commission on Audit (COA), Department of Health (DOH), National Economic Development Authority (NEDA) and the Bureau of Local Government and Finance (BLGF). Data for Social Insurance were obtained from the Social Security System (SSS), Government Service Insurance System (GSIS) and the Philippine Health Insurance

Corporation (PhilHealth). Health expenditures from private sources were acquired through the Department of Education (DepEd), Commission on Higher Education (CHED), Philippine Statistics Authority (PSA) and Insurance Commission (IC). And finally, rest of the world data were sourced from the DBM, DOH and NEDA.

Nevertheless, this methodology had its share of limitations and one of these was the unavailability or lack of data needed for the compilation. Examples were the data on private schools and health maintenance organizations (HMOs). There was also the problem of limited and incomprehensive coverage of the data sources. Moreover, it entailed the usage of old parameters such as the 1994 PNHA survey on average health care expenditure of private schools and establishments by size and by group; and the percentage of the final consumption of non-profit institutions serving households (NPISH) to the household final consumption expenditure (HFCE), and of health care expenditure truly paid for by households. That is why, in the Philippine Statistical Development Program (PSDP) 2011 to 2017, a regular conduct of training and other capacity building programs for data producers in the compilation, analysis and utilization of health through SHA 2011 was included as one of the targeted plans by the Health and Nutrition Statistics group.

2.2 PNHA Based on the System of Health Accounts (SHA) 2011

Health Accounts are generated to define the health system of a specific country from an expenditure perspective. They relate financial flows to the consumption of health care goods and services. They are expected to provide inputs to improved analytical tools to monitor and assess the performance of health systems. With this, it is required that they present timely and comparable data.

The production of SHA 2011 began in 2007 as a collaborative project of health accounts experts from the OECD, WHO and Eurostat. It involved an extensive and wide-reaching consultation with the objective of gathering valuable inputs from national experts of various countries and other international organizations. The product of collective efforts of health accounts experts from around the globe is presumed to assist in the development of consistent methodologies for the compilation of health expenditure accounts. However, compilers of health accounts may opt to pursue different priorities to the different sections of SHA 2011. They may implement or adopt SHA 2011 with regards to the dimensions and levels of detail based on their own health expenditure priorities, policy information needs and statistical resources.

The SHA 2011 enhances the cross-country comparability of health expenditure and financing data by providing an increased health information base which reflects health accounts that is more adaptable to rapidly evolving health systems around the world. It defines health care expenditures as “all activities with the primary purpose of improving, maintaining and preventing the deterioration of the health status of persons and mitigating the consequences of ill-health through the application of qualified health knowledge.” It presents a standard for classifying these health expenditures according to the three (3) axes of consumption, provision and financing. This is called the tri-axial perspective and it evaluates four (4) essential components of health systems: governance, resource generation (human, physical and knowledge), financing and service delivery. Governance covers the oversights of the health system, including that of policy making, regulation and monitoring, while resource generation includes investment in personnel as well as in key inputs and technologies. The financing component contains revenue raising for health, pooling of resources and purchasing services. Finally, service delivery component encompasses the combinations of inputs into a service production process which results to health intervention activities. To evaluate these components, the three axes of consumption, provision and financing are composed of various classifications to which all health expenditures are to be categorized. These classifications are the following:

a. Classification of health care functions (HC)

To achieve the tri-axial perspective of consumption, provision and financing, measuring consumption is the starting point. This is done by the classification of health care functions. The HC classification refers to the health care goods and services consumed by final users with a specific health purpose. The main functions of this classification are the grouping of health care goods and services by purpose, cross-classification of these groups with other relevant health accounting classifications and generation of indicators which may be used for national monitoring. The first-level categories of the HC classifications intend to sort health consumption according to the type of need of the consumer (i.e., cure, prevention, etc.), while the second-level classification reports the mode-of-provision of health care goods and services (i.e., outpatient, inpatient, day care, etc.).

b. Classification of health care providers (HP)

Health care providers comprise of organizations and actors that deliver health care goods and services as their primary or secondary activity. The classification of health care providers categorizes all organizations that contribute to or provide health care goods and services, grouping country-specific provider units into common, internationally applicable categories. The HP classification answers the question, “What is the organizational structure that is characteristic of the provision of health care within a country?” This is guided by the type of health care activities defined in the HC classification, as it offers guidance to the structuring of the HP classifications into homogenous categories.

c. Classification of financing schemes (HF)

One of the main responsibilities of health accountants and analysts is to achieve a clear and transparent picture of health financing systems. This means obtaining indicators which can aid in the evaluation of the performance of existing health financing systems. To meet the current health needs of the population, health financing systems mobilize and distribute money, while also considering future needs. The classification of health care financing schemes (HF) are the main types of financing arrangements through which people acquire health services (i.e., government schemes, social health insurance schemes, household out-of-pocket payment, etc.)

d. Classification of types of revenues of health financing schemes (FS)

Four sets of information are vital for health policy analysis: how much revenue is collected, in what ways it is collected, from which institutional units of the economy revenues are raised for each particular financing scheme and which financing schemes receive those revenues. The FS classification is the particular types of transactions through which the financing schemes obtain their revenues (i.e., transfers, contributions, voluntary prepayment, etc.). This classification makes it possible to distinguish between public and private funding of health care finance.

e. Classification of factors for health care provision (FP)

Information on the inputs needed to produce health care goods and services are tracked at national aggregate levels to ensure an efficient and appropriate allocation of

resources in the production of health care services. The classification of factors for health care provision (FP) supplies this information on the valued inputs used in the provision of health care. Provision encompasses not just health-specific resources such as labor, capital and materials and external services, but also non-health specific inputs used to produce health services.

f. Classification of beneficiaries: age, gender, disease and region

   There has been an emerging need in evaluating the distribution of national health expenditures across different population groups. Concerns about social disparities in health outcomes, political and societal interest in the allocation of health care resources, and the need to improve the sustainability and planning on health care systems have been raising national and international interest. The classification of beneficiaries, namely age, gender, disease and region, aim to provide policy-related information on variations in spending between population groups. These details can provide real support to policy makers for allocating scare resources and evaluating the access to these resources of all the population groups.

g. Health Capital Formation (HK)

   Health policy making and analysis is also concerned about how much a health system is investing in infrastructure, machinery and equipment. These could contribute to the estimation of health productivity, health capital intensity and rates of return to health services. In SHA 2011, this is measured by summing up gross fixed capital formation (e.g., hospitals or ambulances), changes in inventories (e.g., vaccinations kept in stock) and acquisitions less disposals of valuables (e.g., artworks).

The SHA 2011 recommends the production of two (2) aggregates of health, namely the current health expenditures (CHE) and the health capital formation (HK). This framework does not support summing up these two (2) aggregates as to distinguish final consumption from expenditures for future provision. The SHA 2011 introduces 12 health expenditure classifications, recommended to be presented through cross-tabulations for better use in policy and decision making. It is also accompanied by software called the Health Accounts Production Tool (HAPT) to ensure consistency in the application of SHA 2011 across countries and to assist health accounts compilers in systematizing, simplifying and mechanizing the health accounts estimation process.

3. Adoption of SHA 2011 in the Compilation of PNHA

With the adoption of the System of Health Accounts (SHA) 2011 in the compilation of the Philippine National Health Accounts (PNHA), the PNHA now consists of two major aggregates (CHE and HK), categorized in 12 classifications and presented in 12 tables. The measurement of the current health expenditures (CHE) is now based on four criteria as stipulated by the definition in SHA 2011. First is the primary intent or purpose, which requires activities to be included as those intended to improve, maintain, prevent the deterioration of health status and mitigate consequences of ill health. Second is the qualified health knowledge. Next is that consumption must be for the final use of health care goods and services of the resident population. And lastly is that there must be a transaction for the health goods and services.

Under the new framework, the PNHA is classified in 12 ways according to the three axes of consumption, provision and financing. According to Racelis et. al. (2014), based on a review of DOH policy documents, these were the classifications used for health policy and decision making in the Philippines. These are as follows:

a. Institutional unit of financing sources (FS.RI)
b. Financing source (FS)
c. Financing agent (FA)

d. Financing scheme (HF)
e. Health provider (HP)
f. Factor of health care provision (FP)
g. Health function (HC)
h. Disease group (DIS)
i. Age and sex group (AGE)
j. Income quintile (INC)
k. Region (REG)
l. Health capital formation (HK)

The SHA 2011 also initiated the expansion of the health financing dimension with the inclusion of the health financing scheme and revenues of financing schemes, which also comprises institutional units as reporting items. In the previous PNHA estimates, the main classification used to characterize health financing was financing agents. With the adoption of SHA 2011, the health financing dimension is now mainly defined by the health financing schemes (i.e., government schemes, insurance schemes, household out-of-pocket payment, etc.). The other health financing classifications describe the inflows of resources and the institutional units providing the revenues.

Since the base of the production of PNHA estimates is the availability of data, data collection as executed in the previous methodology is done by type of financing agent. Financing agents are the entities that keep records and compiles data on their respective activities and financial transactions (Racelis et. al., 2014). Actual estimation is performed for each financing agent referred to as *components*. Supplemental data called *distribution keys* were also utilized in the generation of breakdowns for basic health expenditure data which have no details, such as income and regional breakdown. These supplemental data were sourced from various studies, statistical reports, administrative reports, censuses, surveys and other data sources.

With the adoption of SHA 2011 in the compilation of PNHA, the national government component sourced its data from the National Expenditures Program (NEP) and Budget of Expenditures and Sources of Financing (BESF) of the DBM and Annual Financial Report (AFR) from COA. Foreign-assisted projects (FAPs) data were obtained from the BESF of DBM, FAPs report of DOH and summary reports on official development assistance/FAPs of NEDA. Data for Government Owned and/or Controlled Corporations (GOCCs) were acquired through the Philippine Charity Sweepstakes Office (PCSO) and the Philippine Amusement and Gaming Corporation (PAGCOR). Other GOCCs which sourced its data from AFR are as follows: Philippine Institute of Traditional and Alternative Health Care (PITAHC), Occupational Safety and Health Center (OSHC), and the four (4) specialty hospitals (i.e., Philippine Heart Center, National Kidney and Transplant Institute, Lung Center of the Philippines, and National Children's Hospital). The local government data were taken from COA, BLGF and annual audited reports of provinces and cities. Data for Social Insurance were obtained from Social Security System (SSS), Government Service Insurance System (GSIS) and the Philippine Health Insurance Corporation (PhilHealth). Health expenditures from private sources were acquired through the Insurance Commission (IC), Association of HMOs of the Philippines (AHMOPHI), Department of Education (DepEd), Commission on Higher Education (CHED) and Survey on 2012-2013 health care expenditures of private schools and establishments of the DOH and Philippine Institute for Development Studies (PIDS). Household Out-of-Pocket sourced it data from the Family Income and Expenditure Survey (FIES) and HFCE from the National Accounts of the Philippines. These were all the data sources for the current health expenditures.

The PNHA-SHA also produces aggregates on health capital formation. These are sourced from the National Expenditures Program (NEP) and Budget of Expenditures and Sources of Financing (BESF) of the DBM. At present, the PNHA health capital formation has yet to capture those of the private sector. Due to data limitations, it captures only those of the government sector.

The information which can be provided through the adoption of SHA 2011 can supply better indicators and statistics for health policy making and monitoring. Example of such is the pursuance of DOH to the *FOURmula One Plus (F1 Plus)* which aspires to grant Universal Health Care (UHC) for all Filipinos. This is to be implemented with three (3) strategic goals: 1) better health outcomes, 2) more responsive health system, and 3) more equitable healthcare financing. These goals may be measured, monitored and evaluated through obtaining health data by disease groups, health providers, factors of provision, health care functions, and health care financing schemes. Moreover, SHA 2011 framework can contribute more detailed information to better monitor and evaluate the national objectives for health, specifically the Philippine Health Agenda for 2016 to 2022. The PNHA-SHA can present better indicators with its more comprehensive set of classifications and cross-tabulations.

4. Results of the PNHA-SHA 2015 to 2017

Presented below are the highlights of the results of the Philippine National Health Accounts based on SHA 2011, from 2015 to 2017.

Financing of Health Care

a. By Revenues of Health Financing Schemes (FS)

Total current health expenditures (CHE) were estimated at PhP 575.7 billion, PhP 635.1 billion and PhP 684.4 billion in 2015, 2016 and 2017, respectively. Large contribution was consistently posted in these years by *domestic revenues from households*, with shares of 54.8 percent, 53.9 percent and 54.5 percent, respectively. Meanwhile, *transfers from government domestic revenue (allocated to health purposes)* steadily accounted for the second largest share to the total CHE from 2015 to 2017. *Social insurance contributions* and *voluntary prepayments* together made up the next largest share, while *transfers distributed by government from foreign origin* accounted for the lowest share in years in review (Table 1).

TABLE 1. Current Health Expenditures by Revenues of Health Financing Schemes: 2015-2017 (In million pesos)

Revenues of health care financing schemes	2015[r]	2016[r]	2017	Percent Distribution			Growth Rate	
				2015	2016	2017	2015-2016	2016-2017
TOTAL	**575,694.5**	**635,117.0**	**684,384.3**	**100.0**	**100.0**	**100.0**	**10.3**	**7.8**
Transfers from government domestic revenue (allocated to health purposes)	**156,291.4**	**175,342.0**	**180,967.5**	**27.1**	**27.6**	**26.4**	**12.2**	**3.2**
Internal transfers and grants	156,291.4	175,342.0	180,967.5	27.1	27.6	26.4	12.2	3.2
Transfers distributed by government from foreign origin	**7,988.3**	**13,861.9**	**14,921.3**	**1.4**	**2.2**	**2.2**	**73.5**	**7.6**
Social insurance contributions	**24,979.3**	**25,004.8**	**25,186.8**	**4.3**	**3.9**	**3.7**	**0.1**	**0.7**
Social insurance contributions from employees	12,489.6	12,502.4	12,593.4	2.2	2.0	1.8	0.1	0.7
Social insurance contributions from employers	12,489.6	12,502.4	12,593.4	2.2	2.0	1.8	0.1	0.7
Voluntary prepayment	**61,016.9**	**67,406.2**	**79,829.6**	**10.6**	**10.6**	**11.7**	**10.5**	**18.4**
Voluntary prepayment from individuals/households	20,173.0	20,764.4	23,554.8	3.5	3.3	3.4	2.9	13.4
Other voluntary prepaid revenues	40,843.9	46,641.8	56,274.8	7.1	7.3	8.2	14.2	20.7
Other domestic revenues n.e.c.	**325,418.5**	**353,502.0**	**383,479.1**	**56.5**	**55.7**	**56.0**	**8.6**	**8.5**
Other revenues from households n.e.c.	315,410.7	342,596.6	372,790.9	54.8	53.9	54.5	8.6	8.8
Other revenues from corporations n.e.c.	10,007.8	10,905.3	10,688.2	1.7	1.7	1.6	9.0	(2.0)

Source: Philippine Statistics Authority

b. By Institutional Units Providing Revenues to Financing Schemes (FS.RI)

Among institutional units providing revenues to financing schemes from 2015 to 2017, *households* is the largest provider, followed by the *government*. The former posted three-year average share of 59.4 percent, while the latter with 28.1 percent. Meanwhile, *corporations* and *the rest of the world (ROW)* accounted for the lowest three-year

average shares of 3.1 percent and 1.9 percent, respectively. Health funds from *government*, *ROW*, and *households* grew from 2016 to 2017 by 8.1 percent, 7.6 percent, and 6.4 percent, respectively (Table 2).

TABLE 2. Current Health Expenditures by Institutional Units Providing Revenues to Financing Schemes: 2015-2017 (In million pesos)

Institutional units providing revenues to financing schemes	2015[r]	2016[r]	2017	Percent Distribution			Growth Rate	
				2015	2016	2017	2015-2016	2016-2017
TOTAL	**575,694.5**	**635,117.0**	**684,384.3**	**100.0**	**100.0**	**100.0**	**10.3**	**7.8**
Government	**160,215.3**	**179,065.5**	**193,553.9**	**27.8**	**28.2**	**28.3**	**11.8**	**8.1**
Corporations	**18,573.6**	**19,684.3**	**19,774.5**	**3.2**	**3.1**	**2.9**	**6.0**	**0.5**
Households	**348,073.4**	**375,863.5**	**399,859.9**	**60.5**	**59.2**	**58.4**	**8.0**	**6.4**
Rest of the world	**7,988.3**	**13,861.9**	**14,921.3**	**1.4**	**2.2**	**2.2**	**73.5**	**7.6**
Bilateral donors[1/]	4,151.1	5,448.0	7,864.4	0.7	0.9	1.1	31.2	44.4
Multilateral donors[2/]	3,837.2	8,413.9	7,056.8	0.7	1.3	1.0	119.3	(16.1)
Unspecified institutional units providing rever	**40,843.9**	**46,641.8**	**56,274.8**	**7.1**	**7.3**	**8.2**	**14.2**	**20.7**

[1/] Germany, Japan, Korea, Spain and United States (USAID)

[2/] AsDB, EU Institutions, Global Fund, UNAIDS, UNDP, UNFPA, UNICEF, WHO, World Bank (except for IDA + IBRD), other and unspecified multilateral donors

Source: Philippine Statistics Authority

c. By Financing Agent (FA)

Among financing agents or institutions through which funds are channeled, *households* accounted for more than half of the total current health expenditures from 2015 to 2017. This was followed by *general government* with shares equal to 36.4 percent in 2015, 37.0 percent in 2016, and 35.7 percent in 2017 (Table 3).

TABLE 3. Current Health Expenditures by Financing Agent: 2015-2017 (In million pesos)

Financing agents	2015[r]	2016[r]	2017	Percent Distribution			Growth Rate	
				2015	2016	2017	2015-2016	2016-2017
TOTAL	**575,694.5**	**635,117.0**	**684,384.3**	**100.0**	**100.0**	**100.0**	**10.3**	**7.8**
General government	**209,432.1**	**234,973.2**	**244,630.3**	**36.4**	**37.0**	**35.7**	**12.2**	**4.1**
Central government	67,498.8	82,031.8	79,438.5	11.7	12.9	11.6	21.5	(3.2)
Department of Health	51,670.3	67,548.1	64,862.0	9.0	10.6	9.5	30.7	(4.0)
Other ministries and public units (belonging to central government)	15,828.5	14,483.6	14,576.5	2.7	2.3	2.1	(8.5)	0.6
State/Regional/Local government	39,104.5	43,363.2	48,082.8	6.8	6.8	7.0	10.9	10.9
Social security agency	102,828.8	109,578.3	117,109.1	17.9	17.3	17.1	6.6	6.9
Social Health Insurance Agency (PHIC)	102,799.1	109,541.0	117,073.7	17.9	17.2	17.1	6.6	6.9
Other social security agency (GSIS, SSS)	29.7	37.3	35.4	0.0	0.0	0.0	25.7	(5.2)
Insurance corporations	**10,138.9**	**11,044.5**	**14,906.9**	**1.8**	**1.7**	**2.2**	**8.9**	**35.0**
Corporations (Other than insurance corporations)	**40,712.8**	**46,502.7**	**52,056.1**	**7.1**	**7.3**	**7.6**	**14.2**	**11.9**
Health management and provider corporations	30,704.9	35,597.3	41,367.9	5.3	5.6	6.0	15.9	16.2
Corporations (Other than providers of health services)	10,007.8	10,905.3	10,688.2	1.7	1.7	1.6	9.0	(2.0)
Households	**315,410.7**	**342,596.6**	**372,790.9**	**54.8**	**53.9**	**54.5**	**8.6**	**8.8**

Source: Philippine Statistics Authority

d. By Health Care Financing Scheme (HF)

Total CHE from 2015 to 2017 was shared by three (3) financing schemes: 1) *household out-of-pocket payment* (54.4%), 2) *government schemes and compulsory contributory health care financing schemes* (33.7%), and 3) *voluntary health care payment schemes* (11.9%) (Table 4).

TABLE 4 Current Health Expenditures by Health Care Financing Scheme: 2015-2017 (In million pesos)

Financing schemes	2015[r]	2016[r]	2017	Percent Distribution			Growth Rate	
				2015	2016	2017	2015-2016	2016-2017
TOTAL	**575,694.5**	**635,117.0**	**684,384.3**	**100.0**	**100.0**	**100.0**	**10.3**	**7.8**
Government schemes and compulsory contributory health care financing schemes	**193,660.9**	**219,270.1**	**225,870.5**	**33.6**	**34.5**	**33.0**	**13.2**	**3.0**
Government schemes	116,769.8	138,244.7	138,899.8	20.3	21.8	20.3	18.4	0.5
Central government schemes	77,665.3	94,881.5	90,817.0	13.5	14.9	13.3	22.2	(4.3)
Domestic revenue-based central govt schemes	69,677.0	81,019.6	75,895.8	12.1	12.8	11.1	16.3	(6.3)
Foreign assistance-based central govt schemes	7,988.3	13,861.9	14,921.3	1.4	2.2	2.2	73.5	7.6
State/regional/local government schemes	39,104.5	43,363.2	48,082.8	6.8	6.8	7.0	10.9	10.9
Social health insurance schemes	76,891.2	81,025.4	86,970.6	13.4	12.8	12.7	5.4	7.3
Voluntary health care payment schemes	**66,622.9**	**73,250.3**	**85,722.9**	**11.6**	**11.5**	**12.5**	**9.9**	**17.0**
Voluntary health insurance schemes	61,016.9	67,406.2	79,829.6	10.6	10.6	11.7	10.5	18.4
Government-based voluntary insurance	20,173.0	20,764.4	23,554.8	3.5	3.3	3.4	2.9	13.4
Life and non-life insurance schemes	10,138.9	11,044.5	14,906.9	1.8	1.7	2.2	8.9	35.0
Managed health care schemes (HMOs)	30,704.9	35,597.3	41,367.9	5.3	5.6	6.0	15.9	16.2
Enterprise financing schemes	5,605.9	5,844.1	5,893.3	1.0	0.9	0.9	4.2	0.8
Household out-of-pocket payment	**315,410.7**	**342,596.6**	**372,790.9**	**54.8**	**53.9**	**54.5**	**8.6**	**8.8**

Source: Philippine Statistics Authority

Provision of Health Care

a. By Health Care Provider (HP)

For years 2015 to 2017, the bulk of CHE was paid to hospitals with three-year average share of 41.9 percent. It was followed by *pharmacies* and *providers of ambulatory health care* with three-year average shares of 27.6 percent and 8.8 percent, respectively (Table 5).

TABLE 5 Current Health Expenditures by Health Care Providers: 2015-2017 (In million pesos)

Health care providers	2015[r]	2016[r]	2017	Percent Distribution			Growth Rate	
				2015	2016	2017	2015-2016	2016-2017
TOTAL	**575,694.5**	**635,117.0**	**684,384.3**	**100.0**	**100.0**	**100.0**	**10.3**	**7.8**
Hospitals	**247,719.1**	**263,434.8**	**280,948.8**	**43.0**	**41.5**	**41.1**	**6.3**	**6.6**
General hospitals	241,243.2	257,286.8	273,280.6	41.9	40.5	39.9	6.7	6.2
Public general hospitals	108,281.1	114,814.2	119,576.1	18.8	18.1	17.5	6.0	4.1
Private general hospitals	132,962.1	142,472.6	153,704.5	23.1	22.4	22.5	7.2	7.9
Mental health hospitals	938.4	939.2	752.1	0.2	0.1	0.1	0.1	(19.9)
Specialised hospitals (Other than mental health hospitals)	4,355.5	3,932.0	3,607.1	0.8	0.6	0.5	(9.7)	(8.3)
Unspecified hospitals (n.e.c.)	1,181.9	1,276.8	3,309.0	0.2	0.2	0.5	8.0	159.2
Residential long-term care facilities	**280.5**	**261.0**	**309.4**	**0.0**	**0.0**	**0.0**	**(7.0)**	**18.6**
Mental health and substance abuse facilities	280.5	261.0	309.4	0.0	0.0	0.0	(7.0)	18.6
Providers of ambulatory health care	**51,357.6**	**55,214.3**	**60,142.1**	**8.9**	**8.7**	**8.8**	**7.5**	**8.9**
Providers of ancillary services	**1,486.8**	**1,564.9**	**1,636.9**	**0.3**	**0.2**	**0.2**	**5.3**	**4.6**
Retailers and Other providers of medical goods	**159,377.7**	**174,190.9**	**189,285.9**	**27.7**	**27.4**	**27.7**	**9.3**	**8.7**
Pharmacies	159,052.3	173,754.1	188,775.0	27.6	27.4	27.6	9.2	8.6
Retail sellers & Other suppliers of durable medical goods & medical	325.5	436.8	510.9	0.1	0.1	0.1	34.2	17.0
Providers of preventive care	**45,258.9**	**53,823.6**	**60,450.7**	**7.9**	**8.5**	**8.8**	**18.9**	**12.3**
Providers of health care system administration and financing	**34,079.3**	**45,061.0**	**44,817.5**	**5.9**	**7.1**	**6.5**	**32.2**	**(0.5)**
Government health administration agencies	16,610.7	24,885.7	21,296.7	2.9	3.9	3.1	49.8	(14.4)
Social health insurance agencies	5,764.6	7,788.5	6,583.6	1.0	1.2	1.0	35.1	(15.5)
Private health insurance administration agencies	10,660.3	11,234.6	15,684.5	1.9	1.8	2.3	5.4	39.6
Other administration agencies	1,043.8	1,152.2	1,252.7	0.2	0.2	0.2	10.4	8.7
Unspecified health care providers (n.e.c.)	**36,134.6**	**41,566.5**	**46,793.0**	**6.3**	**6.5**	**6.8**	**15.0**	**12.6**

** More than 1,000

Source: Philippine Statistics Authority

b. By Factors of Provision (FP)

From 2015 to 2017, *materials and services used* in providing health care, such as pharmaceuticals, consistently received the bulk of the total CHE, followed by *compensation of employees* with three-year average shares of 58.6 percent and 30 percent, respectively.

TABLE 6 Current Health Expenditures by Factors of Health Care Provision: 2015-2017 (In million pesos)

Factors of health care provision	2015[r]	2016[r]	2017	Percent Distribution			Growth Rate	
				2015	2016	2017	2015-2016	2016-2017
TOTAL	**575,694.5**	**635,117.0**	**684,384.3**	**100.0**	**100.0**	**100.0**	**10.3**	**7.8**
Compensation of employees	**169,548.9**	**193,159.4**	**205,766.2**	**29.5**	**30.4**	**30.1**	**13.9**	**6.5**
Wages and salaries	169,548.9	193,159.4	205,766.2	29.5	30.4	30.1	13.9	6.5
Materials and services used	**345,389.0**	**369,232.7**	**395,105.0**	**60.0**	**58.1**	**57.7**	**6.9**	**7.0**
Health care goods	255,063.4	273,928.3	293,900.6	44.3	43.1	42.9	7.4	7.3
Pharmaceuticals	250,211.8	269,800.2	291,560.3	43.5	42.5	42.6	7.8	8.1
Other health care goods	4,851.6	4,128.0	2,340.4	0.8	0.6	0.3	(14.9)	(43.3)
Other materials and services used (n.e.c.)	90,325.7	95,304.5	101,204.4	15.7	15.0	14.8	5.5	6.2
Unspecified factors of health care provision (n.e.c.)	**60,756.5**	**72,724.9**	**83,513.1**	**10.6**	**11.5**	**12.2**	**19.7**	**14.8**

Source: Philippine Statistics Authority

Health Capital Formation (HK)

The *gross capital formation on infrastructure (residential and non-residential and other structures)* posted highest in 2015 and 2016 at PhP 13.5 billion (78.9%) and PhP 17.1 billion (70.6%), respectively. In 2017, it declined to PhP 13.2 billion or 47.2 percent share. In the same year, *machinery and equipment* amounted to PhP 14.6 billion with the largest share of 52.1 percent (Table 7).

TABLE 7 Health Capital Formation Expenditures: 2015-2017 (In million pesos)

Gross fixed capital formation	2015[r]	2016[r]	2017	Percent Distribution			Growth Rate	
				2015	2016	2017	2015-2016	2016-2017
TOTAL	**17,073.1**	**24,207.2**	**27,956.4**	**100.0**	**100.0**	**100.0**	**41.8**	**15.5**
Gross capital formation	**17,073.1**	**24,207.2**	**27,956.4**	**100.0**	**100.0**	**100.0**	**41.8**	**15.5**
Infrastructure	13,476.6	17,096.4	13,191.1	78.9	70.6	47.2	26.9	(22.8)
Residential and non-residential	13,355.7	17,096.4	13,046.5	78.2	70.6	46.7	28.0	(23.7)
Other structures	120.9	-	144.5	0.7	-	0.5	-	-
Machinery and equipment	3,498.0	6,943.6	14,565.9	20.5	28.7	52.1	98.5	109.8
Medical equipment	3,389.9	6,525.6	13,872.9	19.9	27.0	49.6	92.5	112.6
Transport equipment	2.2	216.2	-	0.0	0.9	-	**	-
ICT equipment	9.6	154.5	655.3	0.1	0.6	2.3	**	324.2
Machinery and equipment n.e.c.	96.3	47.2	37.7	0.6	0.2	0.1	(50.9)	(20.2)
Intellectual property products	98.6	167.2	199.5	0.6	0.7	0.7	69.7	19.3
Computer software and databases	98.6	167.2	199.5	0.6	0.7	0.7	69.7	19.3

Source: Philippine Statistics Authority

5. Ways Forward

At present, PNHA based on SHA 2011 produces one-dimensional tables on seven (7) classifications: 1) institutional unit of financing sources (FS.RI); 2) financing source (FS); 3) financing agent (FA); 4) financing scheme (HF); 5) health provider (HP); 6) factor of health care provision (FP); and 7) health capital formation (HK). This year, PSA aimed to release the remaining one-dimensional tables on five (5) classifications: 1) health function (HC); 2) disease group (DIS); 3) age and sex group (AGE); 4) income quintile (INC), and 5) region (REG). Moreover, PSA intends to publish this year the SHA 2011 recommended cross-tabulations of estimates, which can provide better indicators for health policy and decision making. These two-dimensional tables will be very relevant today since DOH, among other health policies, is pursuing the Universal Health Care for all Filipinos. A more

comprehensive set of data will be able to aid the DOH in its various health agendas and monitor its targets in health. This detailed information may also promote more research and innovations in the health systems, which in the present is deemed inadequate due to data limitations.

Even though this framework had already been established in the production of the Philippine National Health Accounts, more developmental activities on this matter may still be executed. Better research/studies on the *distribution keys* employed in the PNHA-SHA may be carried out to improve the statistics on the beneficiary characteristics of health consumers. The methodologies of the estimation of some of the components may also be enhanced further, and data sources which can provide more detailed information may be sought for more accurate estimates. This will be the track of the PNHA-SHA team of PSA in 2020 to pave way for the production of a more reliable and relevant statistics on health.

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