The Mentor Group

External Validation of Philhealth Performance Tool
(Balanced Scorecard)

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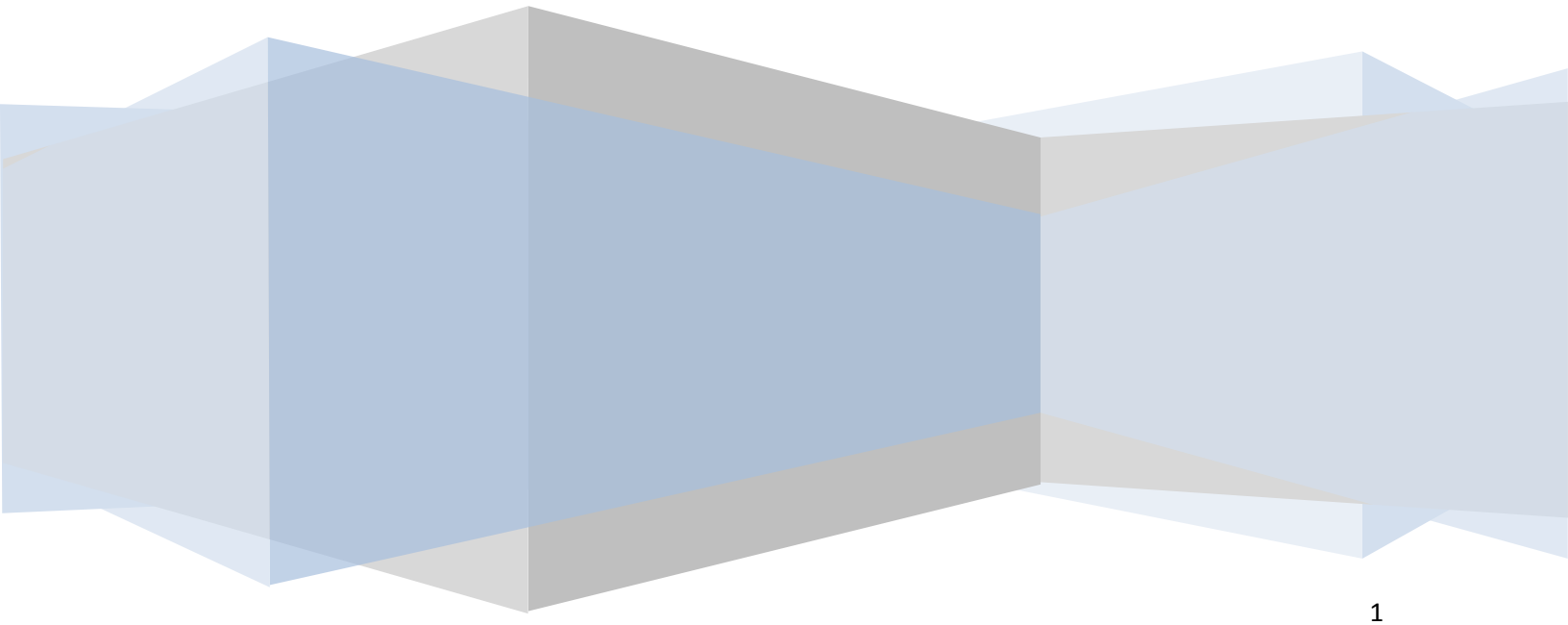

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Definition of Health Sector Reform and Preconditions for a Sustainable Health Sector Reform

The definition of Health Sector Reform is very difficult to define precisely. As reform means positive change, the Oxford English Dictionary defines it as to convert into another or better form, or the amendment or altering for the better of some faulty state of things. Reform, then, means changing what is being done, how it is being done and who is doing it.

For this paper, part of the analysis will be to define the preconditions for a sustainable health reform. Any strategy of health reform, health insurance included, cannot be sustained and implemented without passing the preconditions for sustainability. The Philippine government has long been laying out the groundwork for these preconditions. This section will define what these preconditions are from an international standpoint as applicable to developing countries.

For this section, health sector reform shall be defined as sustained, purposeful change to improve the efficiency, equity and effectiveness of the health sector. Health sector shall refer to the totality of policies, programs, institutions, and even the ones who are involved in implementing such --- all organized efforts to treat and prevent disease. Of course, the health sector can be affected by all other economic factors such as inflation, food prices, commodities, property development, and even education. Although these factors can greatly affect reform, from a practical perspective, discussions on such will not be included in this section.

It is common to describe a well-balanced health reform through characteristics such as efficiency, equity and effectiveness. Still, others include sustainability as an additional point for health sector reform. Change must be more than just a one-time effort. It must make sure it accounts for a real difference in the way things are currently working. Thus, as an example, if applied to health insurance reform such as Philhealth, a social insurance scheme without adequate flow of financing will result to little or even no real change in health care.

Health Sector Reform should also be purposeful and clearly defined by objectives and strategies in achieving those objectives, with an effort to monitor such changes and modify strategies as needed. Goals for efficiency, equity and effectiveness must always be translated to into specific objectives like increases in productivity, improvements in benefits and most of all, improvements in mortality or disability for health beneficiaries. Suffice it to say, goals of the state based on efficiency, equity and effectiveness should be clearly stipulated in order to appropriately convert them into objectives and strategies.

In general, the goals of Health Sector Reform are detailed into three (3):

a. Improving aggregate health status. This goal is used to mean cost-effectiveness analysis as the major resource allocation approach for specific governments to allocate limited resources to the provision of treatments for those diseases which have the highest health impact per dollar spent – this as cited in the World Development Report 1993.

b. Improving equity and reducing poverty. This goal emphasizes on who benefits from public spending on health, saying that it should differentially be the poor and not necessarily those who suffer from diseases. This then values health intervention more as a prerequisite for reducing poverty.

c. Improving individual welfare. This goal implies limiting public action for those things for which individuals can best make their own judgments in seeking and purchasing treatments. Priority, then, of public action should be towards health interventions with substantial market failures, leaving the rest to the private market to solve.

For these goals to materialize, the following pre-conditions for a health sector reform are emphasized:

- There is an important connection between health, the health sector, and the broader goals of sustainable human development. Health improvement and health sector reform have important externalities that affect social well-being;

- There should be a vision of the health sector as a whole, not just its parts. There is a growing awareness of the importance of non-government health care providers in many developing countries likes the Philippines and to be sure, reform efforts should involve more specific actions on sub-sectors within a broader health system;

- There should also be a change in the role of the government in the health sector. In a developing country like the Philippines, the government needs to redefine its role from one of service provider to a financier or manager of growth and change in the health sector;

- New tools for both public and private action should be developed by the government to manage a broader spectrum of fees, taxes, subsidies, and incentives to bring about desired change. Legal and administrative tools, such as regulation, licensing and even quality control plays a very big role in reform. Governments can also increase their provision of information to both providers and consumers to improve on the functions of the health sector. Private financiers and providers must also develop new skills as they are required to increase their provision for public and merit goods;

- A wide range of specific reform strategies is necessary to include strengthening of public management, explicit priority setting for a universal package of assured health interventions, decentralization, new methods of generating and managing finances for health; and the enhancement of the role of private providers in the national health systems.

According to the South-South Knowledge Exchange Hub of the World Bank in a knowledge exchange program between the Philippines and Mexico beginning February 1, 2011 and ending June 30, 2011, reported under the title: Achieving Universal Health Care in the Philippines, poor households in the Philippines lack access to health care and proper financial protection against high out-of-pocket health expenses. And although the government has made it a priority for universal health care to improve the status of the poor, the Philippines is still in a struggle as regards duplication of services and responsibilities, institutional inefficiencies and gaps in insurance coverage. These problems are seen to be a result of the decentralized and fragmented arrangement of health delivery and financing in the country.

In line with this, a knowledge exchange program was driven between Philippines and Mexico by the World Bank for the latter to learn from the experiences of Mexico. Mexico, like the Philippines, was a low-spender on health but has since then increased funding for their Seguro Popular program more than tenfold during the last decade. As of 2011, the said program covers over 40 million previously ininsured people.

In the report, it was noted that in 2010, the Philippines identified universal health care (UHC) as a priority goal. While since then the Philippines has made some progress in the health sector, still, poor households were three to four times worse than middle class families in terms of out-of-pocket health expenses. To improve said statistic, the government prioritized poor households in the national health insurance program of Philhealth to ensure they have adequate access to health services and financial protection in times of sickness. The government has since then expanded health insurance combined with service delivery interventions as main mechanisms to propel universal health care. This plan, of course, was aligned with the World Bank's Country Assistance Strategy (CAS) of 2010-2012 which aims to improve access to health services in the Philippines.

Mexico, like the Philippines, also had the same problem dealing with a decentralized and fragmented health financing and service delivery arrangement. Despite being an upper middle-income country in Latin America, it is one of the most economically unequal nations in Latin America. Almost half of its population lives below the national poverty line. Since then, Mexico enacted a policy to extend health coverage to the poor and since then incrementally expanded coverage for the uninsured through its Seguro Popular program insuring 43.5 Million individuals or about 90% of the uninsured. The budget for the said program has also steadily increased from US $377 million in 2004 to almost US$4,355 million in 2010.

Learning from Mexico as part of the knowledge exchange forum organized by World Bank, the following points are taken into account as preconditions for a sustainable health sector reform with focus on universal health coverage:

- The exchange improved Philippine health officials' understanding of the implementation challenges and bottle necks in universal health care and how a need for appropriate organizational structures are imperative;
- Learning on how to create the right balance of incentives, accountability and innovation at the state/non-federal level was also important so much that the Philippines adopted a specific policy of outreach to include establishing community health advocacy and knowledge teams and officers to increase awareness among the poor households and to change their behavior about health, sickness and disease;

- The Philippine participants also learned about why it is necessary to link health financing and service delivery as the Mexican federal government directed budget policies to provide higher subsidies to poor and rural states, increasing solidarity contributions for health. With such an increase in spending for health, it is then imperative that the Department of Health and Philhealth of the Philippines work together to ensure that better quality and more accessible health care for its individual members are necessary.
- From this learning, the Philippines then began identifying a strong monitoring and evaluation (M&E) framework to track implementation of these said learning from Mexico on establishing long-term universal health coverage.

World Bank's Country Policy and Institutional Assessments (CPIA)

Aside from the preconditions for a sustainable health sector reform as detailed above, the World Bank also released in 2011 a Country Policy and Institutional Assessment (CPIA) tool. The CPIA assesses the quality of a country's present policy and institutional framework with "quality" pertaining to how conducive the framework of a country is to fostering poverty reduction, sustainable growth and its effective use of development assistance. The World Bank in the 1970s initiated country assessments to guide allocation of lending resources. The CPIA consists of a set of criteria per sector of governance to represent the different policy and institutional dimensions of an effective poverty reduction and growth strategy. The criteria has then evolved over time, reflecting lessons learned and mirroring the evolution of the development paradigm with the 2011 CPIA as current benchmark.

For Health, Nutrition and Population, the CPIA elucidates indicators to assess five (5) main dimensions deemed critical to the creation of improved health systems over time. For such, each country is assessed based on the following dimensions:

1. Health Policies and Strategy
2. Program Coverage
3. Stewardship
4. Health Financing
5. Data Availability

Health Strategy, Policies and Plan

The Health Strategy is a document, or a set of documents, to lay out context, vision, priorities, objectives and even key interventions of the health sector, multi-sector or disease program. It also includes guidance to inform a more detailed planning document on national health strategy. This provides the road map on how health goals and objectives are to be achieved.

Health Policies, on the other hand, would mean decision, plans and actions that governments undertake to achieve specific health care goals within the society it operates. This can define a vision for the future to help establish targets and even points of reference for short and medium term plans.

The Health Plan details how objectives are to be achieved, work time frame, responsible resource and costs. This may come in either annual plans or even a multi-year plan, supported by operational plans to allow for adjustments as programs gets implemented.

Depending on the country, development can range from being non-existent (rating of 1) to being comprehensive to address important elements relevant to the country context (rating of 6). Countries are assessed based on policies / strategies that address major health problems, equity and even financing framework, resource generation, human resources for health, other capacity constraints, surveillance, pharmaceutical and supplies management, sector governance, public-private partnerships, multi-sectoral action for health, monitoring and evaluation, etc.

Program Coverage

Increasing access to a package of health services is critical to increase program coverage and achieve improved health outcomes. Access is defined as timely use of services based on need and is considered to have four dimensions. These are: a) geographic or physical access; b) availability of the type of care that the population needs; 3) financial accessibility or the relationship of the price of the service to how willing and how able the user is to pay for said services; and 4) acceptability in terms of social and cultural expectations of the individual and community.

Stewardship

Stewardship contextualizes the overall health system. Mainly a function of the government, areas that form the core of stewardship include: a) a vision for health, with strategies and polices to support such; b) influence across sectors of government and the advocacy for better health; c) good governance to support the achievement of the goals of the health system; d) alignment of the health system design with said goals; e) use of legal, regulatory, and even policy instruments to steer the performance of health systems; and f) collection, dissemination and application of appropriate health information and research evidence.

Health System Financing

Health system financing pertains to the collection of revenues, pooling of financial risk and even the strategic purchase of service. Revenue collection makes sure that there is money to pay for health care services. This shall also include general taxation, mandatory social insurance contributions and household out-of-pocket expenditure. Financial risk pooling, on the other hand, pertains to the management of financial resources to spread financial risks from an individual to members to ensure financial protection. Lastly, purchasing refers to mechanisms to purchase services from public and even private providers.

Health Information Systems and Data Availability

A country's health information system (HIS) aims to produce quality and timely information to support health reform decisions and interventions. This should be able to integrate data from civil / vital registration, census, population surveys, facility surveys, individual records, service records and even resource records. Every country experiences challenges in the area of data availability with poor data collection and processing techniques as the primary problem. Due to this, health goals are heavily dependent on modeling rather than on empirical evidence.

For each of the criterion stated above, countries on the factor of health are rated on a scale of 1 (low) to 6 (high). A 1 rating corresponds to a very weak performance, and a 6 rating to a very strong performance. Intermediate scores of n.5 may also be given.

During the CPIA for 2013, the Philippines rated 3.38 on health reform as assessed by the World Bank. A low score of 2 was given to both Program Coverage and Health Financing. A score of 5 was given to Health Information Systems / Data Availability.

Indicators for measuring Universal Health Coverage

In an effort to standardize indicators to measure success of a country's universal health coverage, the US government, through the US Agency for International Development (USAID) under the Health Systems 20/20 project conducted in 2012.

The scope and rationale of the study was based on a review of the health coverage program in five countries and was influenced by a theoretical framework that aims measure universal health coverage. The framework, developed in 2011, was attended to by its host being the World Health Organization and attended by members of the Bill and Melinda Gates Foundation, Erasmus University, the Health Systems 20/20 project, the Imperial College of London, the World Bank and the World Health Organization.

The study advances measurement of universal health coverage (UHC) through a practical, bottom-up approach to validate indicators of UHC as defined in literature while assessing the feasibility of measuring said indicators from available data sources.

By using the 2010 World Health Report's three-dimensional framework for UHC as a starting point, the authors of the study conducted research to address measurements of the three dimensions being:

- The range of services that are covered (service coverage);
- The proportion of the total costs covered through insurance or other risk pooling mechanisms (financial coverage); and
- The proportion of the population covered (population coverage)

The service coverage dimension pertains to the aspiration that all people should be able to have access to health services they need. The financial coverage, on the other hand, ensures that people do not suffer any financial setback as they pay for health services as they need them. The extent and distribution of coverage across various population subgroups is the aim of population coverage and highlights the importance of equity in coverage regardless of status.

Following literature review, the study selected indicators that are commonly available through surveys. These indicators, which will be detailed later on in this paper, were also validated using available data and reports from five benchmark countries as Bangladesh, Ethiopia, Peru, Uganda and Vietnam.

Findings of the study propose universal indicators in the assessment of an effective universal health coverage. These are:

Indicators of Financial Risk Protection / Financial Coverage

Indicator	Definition	Possible Source of Data
Insurance Coverage		
Self-reported insurance coverage	Percentage of population who reported being covered by any type of health insurance program	Expenditure surveys, demographic and health surveys
Catastrophic Payments		
Incidence of catastrophic health expenditure due to OOP payments	Percentage of population whose health expenditures exceed 10% of total expenditures	Estimations using household expenditure surveys
	Percentage of population whose health expenditures exceed 40% of non-food expenditures	Estimations using household expenditures surveys
Incidence of impoverishment due to OOP payments	Percentage of population whose health expenditures put them below the poverty line	Estimations using household expenditures surveys
Mean positive overshoot of catastrophic payments	Average amount by which OOP spending exceeds threshold, for those with catastrophic payments	Estimations using household expenditure surveys
Poverty gap due to OOP payments	Average amount by which expenditures fall below the poverty line, for those impoverished by OOP payments	Estimations using household expenditure surveys
Out-of-Pocket Expenditures		
OOP Expenditures on health as a percentage of total health expenditure		WHO database, National Health Accounts (NHA)

Indicators of Service Coverage

Indicator	Definition	Possible Source of Data
Service utilization indicator		
Birth delivered in a healthy facility	Percentage of live births in the previous five years delivered in a health facility	Demographic and Health Surveys
Births assisted by a skilled provider	Percentage of live births in the previous five years attended by a skilled health provider	Demographic and Health Surveys, UNICEF/UNFPA, WHO Global Health Observatory database
Women receiving any antenatal care (ANC) from a skilled provider	Percentage of women age 15-49 who gave birth in the previous five years who received ANC at least once from a skilled health provider	Demographic and Health Surveys, UN Millennium Development Goals Indicators, WHO Global Observatory database, UNICEF
Married women in reproductive age using modern family planning method	Percentage of women aged 15-49 years currently married on in union who are using (or whose partner is using) a modern contraceptive method	Demographic and Health Surveys
Family planning needs satisfied	Percentage of currently married women who say that they do not want any more children or that they want to wait 2 or more years before having another child, and are using contraception	Demographic and Health Surveys
Received all basic vaccines	Percentage of children aged 12-23 months who received a BCG vaccine, a measles vaccine and three doses each of DPT and polio vaccine excluding polio vaccine given at birth.	Demographic and Health Surveys, WHO Global Health Observatory database
Received measles vaccine	Percentage of children aged 12-23 months who are immunized against measles	Demographic and Health Surveys, WHO Global Health Observatory database, UNICEF
Received 3 doses of DPT vaccine	Percentage of children aged 12-23 months who received three doses of diphtheria, pertussis and tetanus vaccine	Demographic and Health Surveys, WHO Global Health Observatory database, UNICEF
Received BCG vaccine	Percentage of children aged 12-23 months currently vaccinated against BCG	Demographic and Health Surveys, WHO Global Health Observatory database
Received oral rehydration therapy for diarrhea treatment	Percentage of children under 5 with diarrhea who received oral	Demographic and Health Surveys for select countries, MICS,

	rehydration therapy (packets of oral rehydration salts, or recommended home fluids such as sugar-salt-water solution) and continued feeding	UNICEF
Sought treatment for acute respiratory infection (ARI)	Percentage of children aged 0-59 months who showed symptoms of ARI in the two weeks preceding the survey who sought care from a health provider	Demographic and Health Surveys, MICS
Received anti-malarial drugs	Percentage of children aged 0-59 months who had fever in the two weeks preceding the survey who received anti-malarial drugs	Demographic and Health Surveys for select countries, WHO Global Health Observatory database
Access to antiretroviral (ART) drugs	Percentage of population with advanced HIV infection with access to ART drugs	UN MDGs indicators
Other service coverage tracer indicators		
Households with at least one mosquito net	Percentage of households with at least one mosquito net (treated or untreated)	Demographic and Health Surveys for select countries
Children under 5 sleeping under insecticide-treated net (ITNs)	Percentage of children under five years of age who slept under an ITN the night before the survey	Demographic and Health Survey for select countries, WHO Global Health Observatory database
Pregnant women sleeping under ITNs	Percentage of pregnant women age 15-49 who slept under an ITN the night before the survey	Demographic and Health Survey for select countries
TH treatment success rate under directly observed treatment short course (DOTS)	Percentage of tuberculoses cases detected under DOTS	UN MDGs indicators
Percentage of women with serious problems in accessing health care	Percentage of women age 15-49 who reported that they have serious problems in accessing health care for themselves when they are sick	Demographic and Health Surveys for select countries

Population coverage, being the third dimension of Universal Health Care, reflects the extent by which coverage is distributed across various population sub-groups (e.g. race, ethnicity, minority). For the purpose of the USAID study, indicators for the population dimension were not assessed as they are primarily measures of equity.

The Department of Health's National Objectives for Health

Through the Aquino Health Agenda (AHA) or Administrative Order No 2010-0036, an operational strategy termed Kalusugan Pangkalahatan (KP) was launched to achieve universal health care for Filipinos.

The implementation of Kalusugan Pangkalahatan is directed towards achieving three (3) health system goals as follows:

1. Financial Risk protection aims to protect Filipinos, especially the marginally poor, against the catastrophic cost of illness. Through the National Health Insurance Program (NHIP), resources need to be generated to improve health facilities and provision of public health services to consequently achieve the Millennium Development Goals. This goal is directed towards the Philippine Health Insurance Corporation (Philhealth).

2. Responsive health system aims to improve the responsiveness of the health system and achieve client satisfaction through quality hospitals and health care facilities. Hospitals owned by the government, as well as, health facilities will be upgraded to expand their capacity and provide quality services to again help achieve the MDGs, attend to emergency injuries and manage non-communicable diseases including their complications.

3. Better health outcomes aim to attain health-related MDGs to focus on reducing maternal and child mortality, morbidity and more so, mortality from TB and malaria, prevalence of HIV / AIDS to add to preparedness for emerging diseases and prevention and control of non-communicable illnesses.

As mentioned previously, among the three (3) goals of DOH's Kalusugan Pangkalahatan, Financial Risk Risk Protection through the NHIP is Philhealth's primary responsibility. Thrusts for this goal shall include:

1. Redirection of Philhealth's operations towards the improvement of regional and national health benefit delivery;
2. Expansion of enrollment of the poor in the NHIP to improve coverage of the population;
3. Promotion of quality out-patient and in-patient services at accredited facilities through reformation of capitation and no balance billing arrangements for members;
4. Increase in the support value of health insurance especially for the poor through the use of information technology upgrades to accelerate Philhealth's claims processing, among others, and;
5. Study of segments of the population to be covered for specific range of services and the proportion of the total costs to be covered and supported by Philhealth.

Financial Risk Protection through the National Health Insurance Program

From the previously discussed World Bank's Country Policy and Institutional Assessments (CPIA) where the Philippines was rated as 2.0 on Health Financing, it is explained that the country has a public funding

for health that is very low, one of the lowest in the world. Out-of-pocket costs for users, especially the poor who need them most, are very high. Medicines cost very high and expenditures are transferred to LGUs. In addition, there is also a decrease in public subsidies from 1997-2007, slightly reverted under the new administration. From this rating, a high rate of 6.0 is expected based on the said assessment. To get a score of 6.0, public funding should be primary source of health financing with a well-targeted priority for public health and protection coverage of the poor.

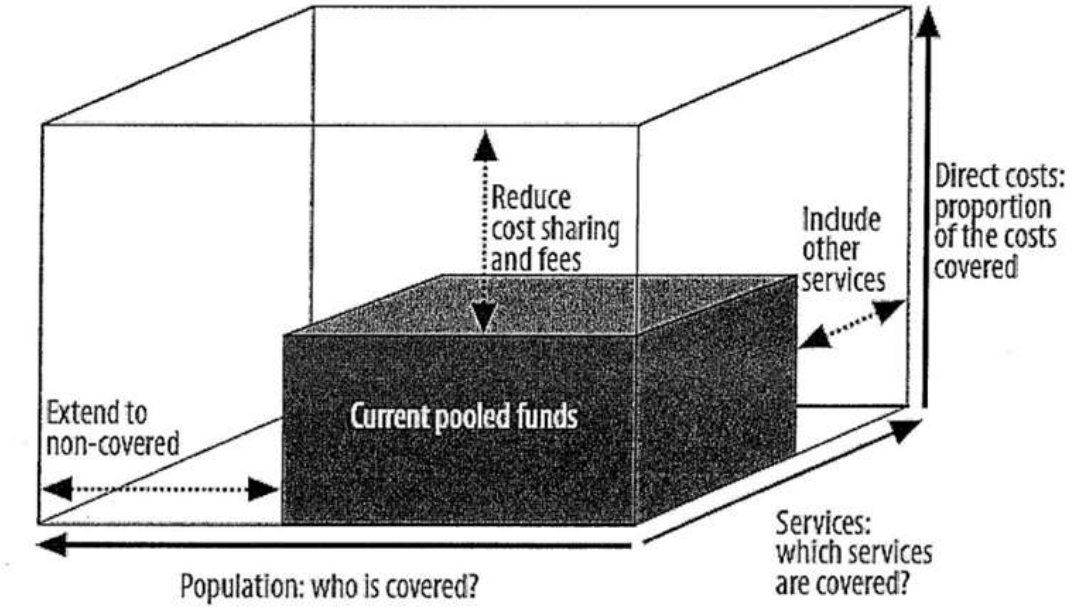
From the DOH report, total health spending is still increasing in nominal terms with out-of-pocket expenditure being the main source of total health expenditure based on a study by the National Statistical Coordination Board in 2007. High level of out-of-pocket expenditure pushed many families below the poverty line due to catastrophic payments during illness. Household surveys reveal that only one-third of the population is covered by the NHIP in 2008.

Given these data, alongside with other contributing factors, the Aquino government is struggling for sustainable policy reforms to increase the efficiency of Philhealth being the main source of financing for health. From the Kalusugan Pangkalahatan program, the thrust is to increase financial protection and targets the NHIP to be the main source of financing. This is to minimize out-of-pocket spending to lessen the financial burden shouldered by the members.

With this, an increase in utilization is also targeted with low NHIP utilization being accounted to factors like low benefits, lack of knowledge on healthcare benefits, complicated administrative requirements, etc. This is in addition to the most important reason being the lack of accredited health facilities. Inadequate health facilities remain to be a problem in many rural areas – if they do exist, lack of health personnel and medicines are still a challenge. It is through these reasons that Philhealth is mandated to build on initiatives to improve the present state of health financing in the Philippines.

Review of Philhealth's Compass 2011

As countries like the Philippines declare commitment to achieving Universal Health Coverage with the introduction of policies, strategies and initiatives to achieve goals, it is necessary to establish universal measures to monitor progress in the achievement of said goals. In 2010, the World Health Report outlined a conceptual framework that suggests the three (3) pre-requisite dimensions to achieve in Universal Health Coverage. These are:



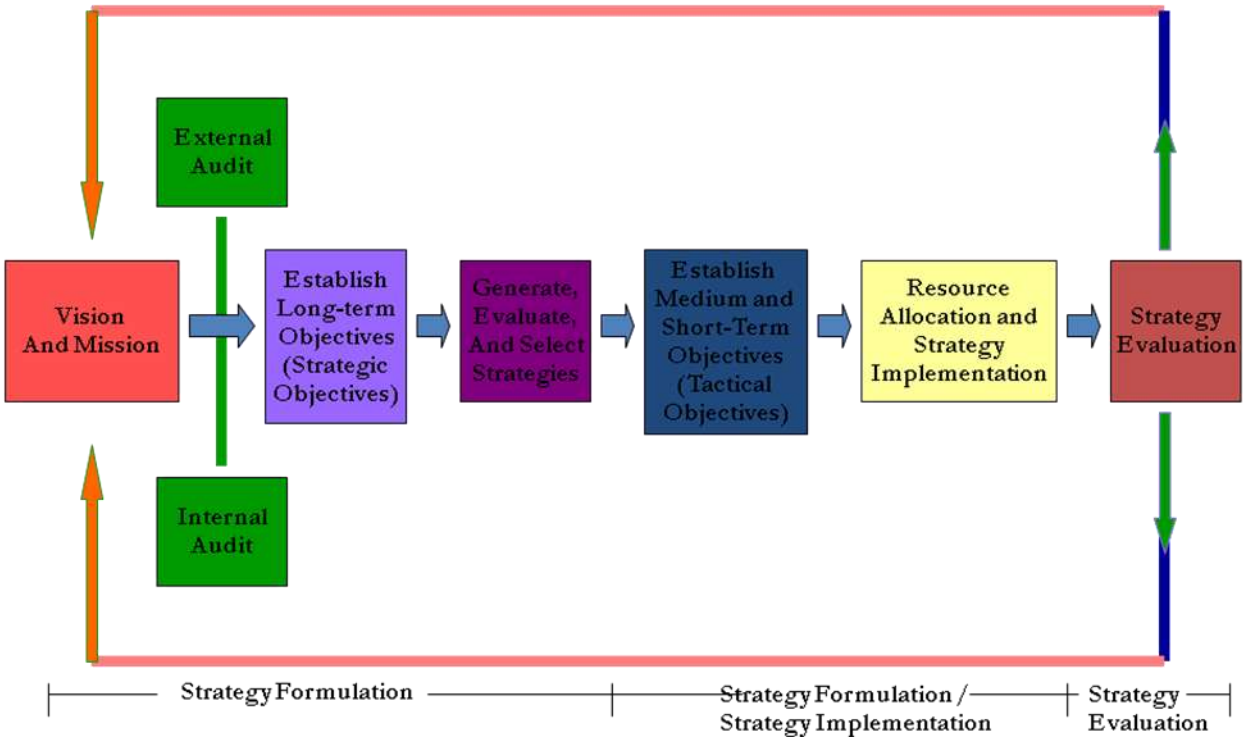
- The range of services covered **(Service Coverage)** which captures the intention that all people should obtain the health services they need;
- The proportion of the total costs covered through insurance or other risk pooling mechanism **(Financial Coverage)** which ensures that members do not suffer financial hardship linked to paying for health services as the time they are needed most;
- The proportion of the population covered **(Population Coverage)** being the extent and distribution of coverage across various population subgroups to highlight equity in coverage across factors as income, wealth, sex, age, place of residence, migrant status and even ethnic origin.

In 2011, Philhealth's Strategic Performance and Management System or COMPASS was developed to support the thrusts of Kalusugang Pangkalahatan by the Department of Health for Universal Health Coverage in the Philippines.

The task demanded a creation of an 8-member team to develop a corporate-level strategy map to initiate attainment of Philhealth's goals in support of the over-all health objectives of the country.

Consequently, an evaluation tool to measure performance based on said strategy map was employed in the form of a known management tool called the Balanced Scorecard which can also be applied as an evaluation tool when tactical plans are cascaded to Business Process Areas, Departments and consequently to the individual level who will be implementing the strategies on a day-to-day basis. Prior to the creation of a strategy map, it is imperative to also review the Vision and Mission of Philhealth, as well as, its core values to be the basis for strategy development. A review of the Vision of Philhealth accounts the presence of the three (3) pre-requisite dimensions of Universal Health Care as outlined by the framework developed by the World Health Report.

Strategies are developed based on a process flow as subscribed by most strategic analysts and developers. In the flowchart below, the usual process flow is seen to identify the various strategies and objectives that are expected as outputs per step:



It all starts with the development of a Mission and Vision of a company. For Philhealth, to dissect, Philhealth's Vision, it is as follows:

- Bawat Pilipino, Miyembro (population coverage)
- Bawat Miyembro, Protektado (financial coverage)
- Kalusugan Natin, Segurado (service coverage)

Given the above Vision statement, Philhealth's Compass is on the right track towards the development of strategies based on the process of strategy development and evaluation as it is keen towards the strategy development based on the vision and mission. And among the three (3) dimensions stated above, as mandated by the Department of Health, Philhealth should focus on the **FINANCIAL COVERAGE** aspect ("Bawat Miyembro, Protektado") of Universal Health Care being an insurance program.

Consequently, the next step is to perform a Strengths – Weaknesses – Opportunities – Threats Analysis. This consists of performing an external and internal analysis of Philhealth as a whole in the light of the demands for Universal Health Care targeted towards Financial Coverage. A competitive analysis is also included in this step where a tool by Michael Porter is commonly employed – the Five Forces Model of Competition. These sub-steps were no longer undertaken by the Compass team as they proceeded directly towards the development of strategies.

The next step in the process is the development of long-term objectives, which are also termed as STRATEGIC OBJECTIVES OR CORPORATE OBJECTIVES. These are objectives which represent the results expected from pursuing certain actions to be accomplished in the long-term. The time frame for objectives should be consistent, usually from two to five years. Clearly established long-term objectives provide direction, allow synergy, aid in evaluation, establish priorities, reduce uncertainty, minimize conflicts, stimulate exertion and aid in both the allocation of resources and the design of jobs. They are also an important measure of managerial performance.

For Philhealth, the Compass team was assigned to develop these long-term objectives or strategic objectives. And a review of these strategies will be undertaken in the succeeding parts of this paper.

Once strategic objectives are developed, and because there are a lot which can be resulted out of brainstorming and via strategy-development tools, the most appropriate ones are prioritized and are given metrics. Through this step, a Corporate Strategy Balanced Scorecard can be made to serve as the basis of all other objectives that will be developed in the departmental levels. This Corporate Strategy Balanced Scorecard, as it measures long-term objectives, will be evaluation tool for the entire organization, in this case, Philhealth. It is important to note this difference as all other objectives that will be developed to pursue the attainment of these corporate strategies will be termed as TACTICAL OBJECTIVES.

The development of Tactical Objectives then follows as the next step. Tactical objectives are medium-to-short term objectives and as was mentioned, they support the over-all Corporate Strategy Balanced Scorecard. These are the departmental objectives that will allow the attainment, hopefully, of the organizational objectives in the form of corporate strategies. Technically, upon the development of a Corporate Strategy Balanced Scorecard, each department should organized their own planning sessions with the same process of doing a targeted SWOT analysis and objective-setting based on the Corporate Strategy Balanced Scorecard and how their department can contribute to its attainment. This is where departmental or Tactical Balanced Scorecards are made. These Tactical Balanced Scorecard are owned by each of the departments, acting with their own responsibilities and contributing based on their own functions to the attainment of the Corporate Strategy Balanced Scorecard, or in Compass 2011's term – the Corporate Strategy Map.

And as the next steps follow, the Tactical Balanced Scorecards will then be defended to management to connect these to the Corporate Strategy Balanced Scorecard. Management will then allocate resources and prioritize based on impact of these tactical strategies to the overall corporate strategies. And year-on-year, an evaluation will be pursued to review how these strategies are impacting on the long-term objectives.

The Balanced Scorecard

Most companies measure performance through the use of standard financial and accounting measures like return on capital, return on assets, on investments, cash flow, net income and margins. The Balanced Scorecard has long been used as an evaluation tool to encourage managers to assess and evaluate company performance via four (4) different perspectives:

- How do our customers see us? (Customer Perspective)
- At what must we excel? (Internal Perspective)
- Can we continue to improve and create value? (Innovation and Learning Perspective)
- How do we look to shareholders? (Financial Perspective)

These definitions apply mostly to profit-oriented companies. In the case of Philhealth, definitions might come in differently to describe each of these components which will be later on tackled in the latter part of this section.

The Balanced Scorecard has several advantages compared to other traditional control processes which mainly focus on financial performance. Aside from it being "balanced" as the name implies – all four (4) perspectives stand in equal importance as a measure of performance – the Balanced Scorecard forces managers at all levels to set specific goals and measure performance in each of the four areas. Application of the Balanced Scorecard, then, does not change whether performance is assessed on a corporate-level, division-level, departmental- level or even an individual-level.

Secondly, the Balanced Scorecard minimizes sub-optimization. This occurs when performance improves in one area while decreasing another. According to a recent study by the Harvard Business Review, companies, for instance, which try to gain competitive advantage through production speed have lower sales and profits due to waste incurred through rework.

Thirdly, the Balanced Scorecard quantifies performance through measuring actual performance through targets and clearly shows gaps between them. It is important to note that regardless of an organization's function, what cannot be measured cannot be improved.

Defining the perspectives of the Balanced Scorecard in the Philhealth context

As mentioned previously, standard definitions of each of the perspectives of the Balanced Scorecard exist to guide companies on which measure / metric of performance of their organization should fall in each of these perspectives.

In the Philhealth context, these definitions can also be the basis to determine the applicable measures of performance. It is important to define such at the onset as these measures, from a corporate-level point of view, will then be the same measures cascaded to divisions, departments and individuals, re-developed as the measures are brought down to these lower-level objectives.

The Financial Perspective
How do we look to shareholders?

The traditional approach to controlling financial performance focuses on measuring performance based on cash flow analysis, balance sheets, income statements, financial ratios, and budgets. Though no one will argue that these accounting tools are important to measure via the financial perspective of the Balanced Scorecard, these measures, as previously stated, are "traditional". And as these measures may still be necessary tools to monitor at the corporate-level, once these measures are cascaded as initiatives via lower-level strategies, an employee, for instance, can hardly find his daily work relating to these measures.

What most companies do now is to find measures of the financial perspective which everyone in the organization can relate to and set up goals on the basis of how a good financial standing of the organization feels like to shareholders. In other words, instead of focusing on measuring financial viability and monitoring such, companies now look into how the company looks like from the shareholders' point of view when finances are doing well. With this shift in paradigm, cascading initiatives for measures of financial perspective becomes relatable to even lower-level individual performance.

This shift in paradigm in measuring financial viability can be well applied in the case of Philhealth. How does a good financial standing of Philhealth feel like from members' point-of-view?

The Customer Perspective
How do customers see us?

The second aspect of organizational performance that the balanced scorecard helps managers monitor is the customer perspective. Most companies try to answer the customer perspective through measures like customer satisfaction, customer awareness, and others. These are often misleadingly positive. As with most people, customers are reluctant to talk about problems they have with a company as they don't know who to complain to or that complaining will not be of any use. As with a study conducted by the Office of Consumer Affairs for South Australia, they found out that 96% of unhappy customers never complain to anyone about bad service received.

Another reason why customer satisfaction surveys can be misleading is that in this age of competitiveness, even very satisfied customers will leave to do business with competitors. And by so, rather than customer satisfaction surveys, most companies measure customer defections and retention. In its technical definition, customer defection relates to the number of customers leaving the company and measuring the rate by which they are leaving. Few organizations realize that obtaining a new customer costs ten times as much as keeping a current one. More so, the cost of replacing old customers with new ones is so significant that most companies could even double their profits and collection by increasing the rate of customer retention by just 5 to 10 percent per year. And aside from its effect on bottom line performance, customers who leave are more likely to tell a company what they were doing wrong. With this, companies can understand, too, why customers leave or are unable to maintain loyalty so that organizations can make changes to further prevent others from leaving or defecting.

The concept of measuring customer defections can well be applied in the context of Philhealth. When members are covered but still experience high out-of-pocket expenditures when illness happens, members may feel that coverage under the program is futile. Whether contributing or not, when out-of-pocket expenditures on health cut out a high percentage of total household expenses, for those mandatorily contributing, next time an illness happens, even with payment covered by Philhealth, with no longer enough money to pay via out-of-pocket contribution, though they cannot stop readily contributing to Philhealth due to their employment status, their satisfaction rating of Philhealth will naturally decrease. Consequently, for non-members who Philhealth who can well pay for contribution but are not employed and therefore, not mandatorily contributing, if out-of-pocket expenditure is higher than what Philhealth can cover, then they might as well not contribute as they see Philhealth as a non-value aspect in their health coverage.

The Internal Perspective
At what must we excel?

The third part of the Balanced Scorecard is the internal perspective which consists of processes, decision and actions that managers and workers do within the organization. The internal perspective focuses on internal processes and systems that add value to the organization which leads managers to focus on the quality of work the organization does.

Quality is typically defined and measured via three (3) ways: Excellence where an organization produces a product or a service that has unsurpassed performance and features; Value where customers perceive quality as excellent for the payment given; and Conformance to specifications where services and products measure up to standards by the customers, competitors and similar businesses.

From a Universal Health Care (UHC) standpoint, quality is can be measured based on enrollment rate. Similarly, from Philhealth's context, quality via excellence, value and conformance to standards can be measured through how many members are enrolled in the NHIP.

The Innovation and Learning Perspective
Can we continue to improve and create value?

The last perspective of the Balanced Scorecard is the innovation and learning perspective. This aspect involves continuous improvement as an ongoing activity in relearning and redesigning processes by which products and services are created. Continuous improvement as a major theme for this perspective, initiatives should be geared towards increasing value through service and process improvement.

Among the four perspectives, in the context of the requirements for Universal Health Care, the innovation and learning perspective melds well with targets of service coverage. Well meaning to answer the question "Can we continue to improve and create value?", via the Philhealth context, this may well be defined as continuously improving availability of service to members through increase in hospitals and facilities where services can be availed of.

Observations on Philhealth's Compass 2011

Philhealth's Strategic Performance and Management System, otherwise known as COMPASS 2011, is a comprehensive take on the process of developing a corporate strategy in support of the Kalusugang Pangkalahatan program of the Department of Health.

Prior to the creation of a corporate strategy, and consequently a strategy map through which a Balanced Scorecard is proposed to evaluate and monitor performance, the Compass 2011 team followed a series of activities to jump-off from in support of the development of said strategies.

As with any strategy development process, it is imperative to review the Vision and Mission of Philhealth, as well as, its core values to make sure that strategies that are to be developed are in line with what Philhealth believes in. As previously discussed, the Vision of Philhealth is in line with the necessary requirements for an effective Universal Health Coverage as discussed in the framework developed by the World Health Report.

With this introduction given, observations on Philhealth's Compass 2011 and its performance indicators are described below based on the review of literature prior to this section of the report:

- The Corporate Strategy is defined in the Vision of Philhealth. The three (3) components of membership (population coverage), protection and benefits (service coverage) and health security (financial coverage) serve as the primary corporate strategy of Philhealth. The strategy map should revolve around how to attain targets pertaining to each of the three (3) components. And in particular, the performance indicators should pertain more towards the Financial Perspective of the Vision. From observation, these performance indicators do not pertain directly towards financial risk protection as they are indicators that were not connected to any of the three (3) components of the vision and mission of Philhealth, more so, to the financial coverage aspect of it.

- To formulate the strategy map based on the Balanced Scorecard, the four (4) perspective of the said tool are of equal importance as components of evaluation. No perspective is higher than the other. In such a case, based on Compass 2011, putting the Customer Perspective higher than the other three (3) will make the Balanced Scorecard "unbalanced". The four (4) perspectives should equally support the corporate strategy written in the vision of Philhealth. The Corporate Strategy Balanced Scorecard always contains the LAG indicators. The Tactical Strategy Balanced Scorecard is the one that contain the LEAD indicators. From a Tactical Strategy Balanced Scorecard, all lead indicators should be balanced too. No perspective is higher than the other. They are of equal importance as LEAD indicators as they try to attain the LAG indicators in the Corporate Balanced Scorecard.

- Dissecting through the Balanced Scorecard, goals and objectives indicated to measure performance in each of the perspectives should support a particular corporate strategy. Goals and objectives cannot be measured without particularly impacting a corporate strategy. For example, via Compass 2011, a goal / objective of "Leadership and Culture" should be a support objective to either population coverage, member coverage or service coverage and that the link should be well-defined. Each of the indicators should be connected towards the attainment of

the vision and mission and its components. If performance indicators are developed in silos, it will be very hard to evaluate success based on the attainment of what the organization is ultimately aiming for.

- Ideally, a goal or objective in each perspective should be measurable – more importantly, a standard should be set to measure performance against it. In the Corporate Strategy Balanced Scorecard, standards are well-defined so as targets are seen as a way of an end-result of initiatives to reach them. Consequently, when targets have been set and reached, it should also link towards its effect on the component of the corporate strategy it pertains to. One outstanding observation as regards the performance indicators in the current Compass 2011 is it non-measurability. And if they are indeed measureable, they are not measured via a standard that can be attributed to universal standards of health care, even so, financial coverage. Philhealth is a means towards the attainment of Universal Health Care. And as such, Universal Health Care as a worldwide standard across countries. Digressing from these standards through development of a different set of performance indicators would result to an absence of benchmark indicators to compare them with. This is the reason why a significant amount of literature was presented at the beginning of this paper to explain what universal health care means and what has been done to universalize these indicators.

- Regardless of the level of management the Balanced Scorecard is cascaded to, the goals and objectives do not change – they are simply reworded to apply to initiatives that will be divisionally driven, departmentally driven and even individually driven. As for individuals, this measure will become the basis for individual performance metrics. This is the value of converting these overall corporate strategies into tactical objectives. They become more realistic to attain if they are cascaded and converted into “baby steps” rather than big ones which can be attained in the long-term.

- The interim 2013 targets that were submitted via a scorecard last November 2013 proved also to be a scorecard that mixed both corporate and tactical objectives. As they may all look like strategies from a corporate-level point-of-view, it is necessary to dissect them based on whether they are strategic or tactical in nature. Commendable, of course, would be the quality of data collection as detailed, as well, in the submission. These were clear directions as to how to make sure the right formula is employed to clearly measure the said metric. However, for the purpose of review, this is how these measures are categorized differentiating those from the corporate-level to the tactical-level:

Performance Indicator	Target	Strategic	Tactical
Enrollment rate	85%	Yes	
Coverage rate	70%	Yes	
% of DOH-licensed hospitals with Philhealth engagement	≥95%	Yes	
% of LGUs with engaged	85%		Yes

PCB providers			
Net Customer Survey	>85%		Yes
%NHTS – PR poor families enlisted to PCB providers	50%		Yes
Utilization Rate	2013		Yes
Timeliness	40 days		Yes
Collection	65%		Yes
%NBB of sponsored program claims	7%		Yes
QMS Implementation	100%		Yes

Validation and Reliability of the current performance accomplishment and indicators as key measures in tracking expected outcomes

Based on the interim Performance Scorecard as detailed above, Philhealth's performance based on said indicators are evaluated below with performance for year 2013-2014:

Performance Indicator	Weight	Target	Actual 2013-2014
Enrollment rate	5%	85%	79%
Coverage rate	20%	70%	67%
% of DOH-licensed hospitals with Philhealth engagement	20%	≥95%	96.23%
% of LGUs with engaged PCB providers	10%	85%	93.70%
Net Customer Survey	5%	>85%	78%
%NHTS – PR poor families enlisted to PCB providers	5%	50%	55%
Utilization Rate	0%	2013	-
Timeliness	5%	40 days	39.5 days
Collection	5%	65%	68.8%
%NBB of sponsored program claims	20%	7%	7%
QMS Implementation	5%	100%	100%

From the reports submitted, investigation reveals that all indicators were fairly measured with the right measurement tool and results are valid from the data and reports submitted.

It should be accounted that of the ten (10) metrics detailed above, Philhealth was not able to meet targets for three (3) metrics as Enrollment rate, Coverage rate and Net Customer Survey. These shall be discussed below.

Enrollment Rate / Coverage rate

From Philhealth's report, the primary cause why targets for Enrollment and Coverage rates were not fulfilled were due to member names that could not be located from the NHTS – PR list due to calamities and other fortuitous events during the said year. There were also a number of replaced names due to duplicates and clean-up done from the member list of the NHTS – PR for the validation and confirmation of the DWSD based on the their own criteria. This is agreeable as in fact, based on the report of Mr. Eduardo Banzon, former Philhealth President, when he shared the Philhealth Coverage Experience in New Delhi as part of a review of the Universal Health Coverage experiences of various countries, he said that a key problem for Philhealth, and the Philippines as a whole, is the keep track of covered and enrolled members while simply maintaining a dependent list of each member. He mentioned that total headcount of sponsored members and their dependents cannot be generated electronically and that the current number of used / reported member remains always an estimate based on the number of sponsored members multiplied by a factor to estimate the number of dependents. Much of the reporting is still done manually and as such, poses a challenge to measuring the results accurately.

It should also be noted that the key decision-makers for enrollment are the Local Government Units (LGUs), and as such, enrollment starts with them. In fact, roll-out of out-patient primary care benefits for the sponsored members / poor was driven by the need to convince the various LGUs to enroll their poor households. Once enrolled, it was expected that this will empower the poor to demand for a sustained subsidized or sponsored enrollment which had "politicized" then the identification of poor households by the LGUs, telling the national government that enrolment should be on the national level, which then hampers enrolment and quality care from accredited LGU-owned and managed health facilities.

As mentioned previously, one of the main thrusts of Kalusugan Pangkalahatan is increasing the financial protection and targets of Philhealth as the main source of financing. The overall goal is to maximize government and Philhealth spending in order to minimize the out-of-pocket spending of the poor and lessening their financial burden. The poor shall be the main target for health financing and once identified, they shall be enrolled in Philhealth for their utilization.

Also, the Individual Paying Program (IPP) such as the Kasapi (Kalusugan Sigurado at Abot Kaya sa Philhealth Insurance) will convince organized groups, such as micro-financing institutions, cooperatives, non-government and civic organization and other various associations, towards group membership enrollment. Through this, Philhealth can improve its informal sector membership.

Net Customer Survey

From the Social Weather Station (SWS) survey, net customer survey is computed as *Satisfied minus Dissatisfied members* of Philhealth. It should be accounted that the highest percentages of satisfied members came from the Luzon, Visayas and Mindanao with 85% satisfaction rating as reported while NCR got 82% satisfaction rating with the highest dissatisfaction rating of 8% among all regions. From this

report, some questions need to be answered based on investigation. Are targets set too high for Net Customer Survey? It should be noted that targets are based on benchmarks and as it is, no benchmark has been set as to where targets were based from. Connected to this, should the base targets be from the tiers as set by the SWS? Again, the question on benchmarks needs to be answered before a reasonable target should be made.

It should also be of concern that utilization of Philhealth benefits is still lowest among the sponsored program members as reported by Mr. Banzon in his report in New Delhi. He asks, "Is it because the sponsored members are not aware of their benefits OR are the benefits not fully responsive to their health needs". The answer to this question seems significant as satisfaction ratings are based on expectations of customers as to whether or not a service is doing them any good or not.

Much has been done to increase customer satisfaction. In the Benefit Delivery Ration study by the DOH and Philhealth, it is noted that the average support values of Philhealth benefits is only at 35 percent. As an effort then to increase financial protection, Philhealth implemented the "No Balance Billing Policy" for all sponsored program members who are hospitalized in government facilities. Challenges remain for this effort but the glide path towards getting through obstacles seem positive.

Philhealth is also shifting from fee for service to case rate system. As of current, almost 23 case rate packages which is about 50% of the benefits are now available in various institutional health care facilities, among which are for Dengue, Pneumonia, Essential, Cerebral Infarction, Cerebro-vascular Accident and Hemorrhage, Acute Gastroenteritis, Asthma, Typhoid Fever, and Newborn Care Package.

Utilization Rate

Of Utilization, low utilization can be attributed to various factors e.g. low benefits, lack of knowledge on healthcare benefits, tedious administrative documentation required, etc. It may also be reasoned out that one of the more important reasons may be the lack of accredited health facilities available for the sponsored members. In 2010, it is commendable that Philhealth was able to accredit 91% of private hospitals, 88% government hospitals and 59% of RHUs. The decentralization of the accreditation process contributed to an increase in health provider sourcing and the addition of new benefit packages such as Outpatient Benefit Package, Maternity Care Package, Newborn Care Package and Tuberculosis Directly Observed Treatment Short course (TB DOTS).

Even with this, inadequate health facilities remain in many rural areas. Even if they are available, however, the lack of health personnel and unavailability of drugs and medicines remain a serious concern. It is reported that accredited hospitals remain focused in NCR and Region 10 and are limited in regions like the CARAGA and ARMM. This may also apply for accredited RHUs, TB DOTS clinics and other outpatient facilities.

Recommended Balanced Scorecard based on USAID and DOH-mandated indicators

From the discussion on the definitions of the four (4) perspectives of the Balanced Scorecard in the Philhealth context and an elucidation of the observations as seen above, a recommended Balanced Scorecard is proposed below based on indicators mandated by the USAID, also as previously discussed, and by the DOH in Chapter 3 of the Kalusugang Pangkalahatang initiative:

CORPORATE STRATEGY
Vision: Bawat Pilipino, Miyembro. Bawat Miyembro, Protektado, Kalusugan Natin, Segurado
Measures and Targets by 2016:

- Membership at >90% (Population Coverage)
- Protection and Benefits at >95% (Service Coverage)
- Health Security at <50% Out-Of-Pocket Expenses (Financial Coverage)

Please note that the Corporate Strategy Balanced Scorecard as given below is based solely on the FINANCIAL COVERAGE part of the Vision and Mission of Philhealth as it is its primary objective being part of the Kalusugan Pangkalahatan Program of the DOH as well as from the perspective of the USAID standards. Availability of these data are also universal – it might be that the Philippines might need to invest on a more accurate data collection to exactly measure based on the scorecard below but, based on the current data sources suggested in Compass 2011, there are pseudo-measures which can be used as an alternative to measure each of the indicators suggested.

Please also note that the 2013 interim scorecard need not be put to waste as the three strategic objectives identified in that section are also included in the scorecard below. The challenge will then just be to connect the tactical objectives in the interim scorecard to pertain to the attainment of any of the metrics shown below and to develop new ones along the way.

STRATEGY MAP
The Proposed Balanced Scorecard

PERSPECTIVE	STANDARDS	MEASURES
Customer Perspective		
Low incidence of catastrophic health expenditure due to out-of-pocket expenses *(USAID indicator, supports financial coverage component of UHC)*	Health Expenses <10% of Total Health Expenditure (THE)	Percentage of population whose health expenditures exceed 10% of total expenditures
	Health Expenses <40% of non-food expenditure	Percentage of population whose health expenditures exceed 40% of non-food expenditures
Financial Perspective		
Low incidence of impoverishment due to out-of-	Greater than $1.25 / day / person after out-of-pocket	Percentage of population whose health expenditures put them

pocket payments *(USAID indicator, supports financial coverage component of UHC)*	payment (International Poverty Line)	below the poverty line
Low poverty gap due to out-of-pocket payments *(USAID indicator, supports financial coverage component of UHC)*	Less than 1% lower than $1.25 / day / person	Average amount by which expenditures fall below the poverty line, for those impoverished by out-of-pocket expenses
Low mean positive overshoot of catastrophic payments *(USAID indicator, supports financial coverage component of UHC)*	Less than 10% positive overshoot from threshold of 10% of THE	Average amount by which out-of-pocket spending exceeds threshold for those with catastrophic payments
Internal Perspective		
High percentage of National Health Insurance Program Enrollment rate *(DOH indicator, supports population coverage component of UHC)*	Greater than 90% of the population	Percentage of population covered by Philhealth
Innovation and Learning Perspective		
High percentage of hospitals with NBB for CCT /NHTS families *(DOH indicator, supports service coverage component of UHC)*	100% in government hospitals	Percentage of hospitals with NBB
High percentage of Accredited facilities *(DOH indicator, supports service coverage component of UHC)*	95% Accredited facilities	Percentage of accredited facilities

From the strategy map, formulation of strategies from a corporate, divisional, department and individual-level can then commence.

Conclusion

For a corporation to function effectively, it should have a unique purpose and a reason for being. This competency or uniqueness is reflected in its vision and mission which helps achieve a heightened sense of purpose during strategy formulation. As known management guru Drucker says, developing a clear mission is the first responsibility of strategists. A good mission and vision statement reveal direction for all planning activities. And as such, a well-designed mission statement and vision statement are essential in formulating, implementing and evaluating strategies. Without this, a firm's short-term actions can be counterproductive to its long-term interests.

For Philhealth, the clarity of its vision and mission supports the ideal direction towards universal health coverage. It is aligned to what the global perspective see as an effective way of providing health care to the impoverished majority. It has set targets alongside each of the vision components and has timelines in the achievement of such.

The vision and mission statements provide a jump-off point in the creation of a strategy map. Under a normal process, a SWOT analysis is done to start formulation of strategies, intersecting each of the

entries via the TOWS matrix to come up with strategies to implement. The Balance Scorecard is then used to evaluate the effectiveness of these strategies after implementation.

For Philhealth's case, the Balanced Scorecard was used not as an evaluation tool but rather, a target scoreboard. From such, strategies will be formulated to achieve the targets identified in the scoreboard. This process can work knowing that the USAID and DOH have identified targets for financial security objectives as deemed applicable for Philhealth in support of UHC. And as recommended, the Balanced Scorecard needs to show the scoreboard by which targets and measures are set. Once approved, formulation of strategies on a corporate, divisional, departmental and individual-level will follow to make sure the targets are met.

It is important that after the visual representation of the Balanced Scorecard has been understood by all in Philhealth, everyone should then move towards achievement of the targets as identified.