APPENDICES

QUESTIONS FROM THE AUDIENCE

A CLOSER LOOK AT THE UHC CUBE: WHAT AND WHERE?
Defining the Continuum of Health Care Services and Delivery Networks

Dr. Enrique Tayag

1. Who regulates the fees of the doctors and the fees of hospitals?

   DOH and PhilHealth will be the ones to regulate the fees through the No-Balance-Billing policy for indigent patients in public health facilities, as well as through the All Case Rates payment scheme. PhilHealth registered providers have standardized fees according to PhilHealth rules and regulations. However, Balance Billing and Extra Billing in private health facilities remain largely unregulated.

   The Bureau of Internal Revenue (BIR) requires doctors to post their fees in their offices and clinics, and prohibits them from directly billing and collecting separate fees from hospital in-patients.

2. How do you address the disintegrated values of some public health workers who have become materialistic rather than remain committed to true public service?

   We address this through just compensation. The salaries and benefits of public health workers should be made at par with their counterparts in the private sector.

   Also, by shifting payments at the primary setting from case-based or per provider payments to network-based payments, their financial incentives then would be based on how they efficiently institute cost-saving interventions to their populations – which would be health promotion and prevention, efficient gatekeeping, and prudent use of costly diagnostics.

   In addition, security of public health workers, particularly in conflict-affected areas, should also be ensured.

3. Referring to the data provided by Dr. Tony Leachon that shows the ratio of medical doctors to patients in the Philippines, how can one improve the referral system in order to address the problem of access when there seems to be a supply problem? Furthermore, how will large private institutions, which make up 60% of PhilHealth accredited HCIs, be engaged in the SDN?

   The supply problem is more of maldistribution. Through the creation of SDNs, it will give room for context-based arrangements to ensure that patients will be connected to a health care professional and physician at any time of need.

   Patients are now not limited to the providers within their municipality. Instead, they will be connected to the doctors and providers of the whole network. Involvement of private health facilities in Service Delivery Networks will address the supply problem, particularly on human resources for health. Private health facilities will be encouraged to join SDNs through financial (i.e. capitation) and non-financial (i.e. longer accreditation period) incentives from PhilHealth. Improvement

in gatekeeping mechanisms, through financial incentives and disincentives (i.e. full OOP if primary care is bypassed) coupled with improvement in health services at the primary care level, is envisioned to decongest the hospitals at the secondary and tertiary level of care.

4. How do you ensure that the primary care benefits work properly to gatekeep cases that do not need to be treated in hospitals? Why is there a deluge of inpatient claims that could have been treated at primary care facilities?

   The health services needed to provide the primary care benefits should be made available at the primary care level, not necessarily all in one facility, but through a network of providers. Cases that could be treated at primary care facilities should be reimbursed by PhilHealth only when managed at primary care facilities in order to reduce inpatient claims for these cases at secondary and tertiary levels.

   See also explanation in Number 2.

5. COO Sychua commented that when PhilHealth shifted from FFS to ACR, it resulted in operational efficiency, making it easier for members to know their benefits but it did not increase support value. He further raised his concern on issues that have been raised in summits, conferences and symposiums, and they have always been there and have yet to be addressed or resolved, such as:
   a. Who regulates prices of drugs and medicines?

      The Department of Health regulates the prices of drugs and medicines through the Maximum Retail Drug Prices (MRDP) and the Philippine National Drug Formulary (PNDF), as well as through the revised Generics Act (RA 9502). PhilHealth's inpatient benefit packages provides for reimbursement of expenses on drugs and medicines listed in the PNDF up to specified ceilings.

      Drug Price Reference Index and PNDF. The Commission on Audit is already oriented on these and should be able to incur audit findings when violations are made.
   b. Who regulates professional fees?

      (See explanation in Number 1)
   c. Who regulates the practices of professionals who go against their Hippocratic oath?

      The Professional Regulation Commission (PRC) and Professional Organizations particularly medical specialty groups regulate the practices of health professionals.

6. How come the issue of politics was never mentioned in the presentations?

Political will of our leaders, from the national down to the grassroots level, is a crucial factor no matter how excellent the policies and mechanisms are.

7. For BDRD. Is PhilHealth planning to increase the benefit packages for Orthopedic cases to mitigate the cost of implants and other orthopedic devices, especially since those implants and devices to be provided for by the HCIs to their NBB patients?

A regular review of the Z Benefits is conducted as stated in the guiding principles (Ref. PhilHealth Circular No. 0035-2015). PhilHealth has recently updated the Z benefits for selected orthopedic implants as a result of the review done with the Reference Hospital on the said policy.

Additional implants for pertrochanteric, femoral and tibial fractures were added (Ref. PC No. 2016-0020). However, further expansion of the coverage of the benefit may be considered in the next round of policy review

PROPORTION OF COSTS COVERED: WHO PAYS FOR WHAT?
Sharing the Responsibility for Financial Risk Protection

For Policy Reserch and Standards Development Division of Standards and Monitoring Department

1. Issue on non-PNF drugs: "*PhilHealth in Zamboanga is saying that they will not reimburse the case if drugs prescribed are not in PNF but PNF is not updated to keep up with treatment guidelines."*

   The issue is an ACR reimbursement rule. Under the ACR, there are no pre-payment medical evaluations. Also, the current claim forms do not list the drugs used thus it's a question of how PRO IX obtains such data. Use of non-PNF drugs shall still be paid but will become a post-audit finding in which cumulated offenses will result in non-renewal of a HCI's accreditation. The PNF list of drugs are regularly updated by issuances posted in the Philippine FDA website.

Ms. Raquel Dolores Sabenano

2. How much of the OOP could be due to patient's choice and increased willingness to pay due to increased disposable income? How much could be due to provider inefficiencies?

   The question is beyond the PNHA framework. Please take note that in slide 15 and 16 are not the standard statistics from the PNHA. For illustration purposes, distribution of OOP health spending was sourced from 2012 Family Income and Expenditure Survey (FIES) to be able to get a clearer picture, or to show more disaggregated statistics. Furthermore, 2014 Annual Poverty Income Survey was not utilized since it will not give detailed disaggregation.

   By the way these are some important notes on slide 15 and 16. For slide 15, close to half of OOP spending goes to pharmaceutical products, or we can say that a quarter or 27.8% of the total health expenditure is consumed in pharmaceutical products or drugs and medicines. To simplify, an average Filipino spends a quarter of his/her income in drugs and medicines.

   For slide 16, the first quintile represents the lowest earning 20 percent of households. Likewise, the fifth quintile represents the highest earning 20 percent of households - in this case, the households were divided into five categories with 20 percent each. As incomes rose, the total amount spent on healthcare increased from Php 13 billion or 4% for households in the lowest income quintile to Php 179 billion or 55% for those in the highest.

   The powerpoint can be accessed at this link: https://drive.google.com/file/d/0B3IY1Te3ozbBdnRDWHFKUVppZmc/view

POPULATION COVERED: WHO BENEFITS?
Ensuring the Inclusiveness of Policies and Programs

For the Department of Social Welfare and Development

1. Those enrolled in PhilHealth as indigents are not true indigents.

   Listahanan identifies poor households using the Proxy Means Test (PMT). The PMT estimates the households' annual per capita income using income-proxy variables, such as housing materials, employment and educational attainment of household members. Those with income less than their official provincial poverty thresholds are considered as poor. Like any other model-based methodologies, the PMT is not 100% accurate. There can be inclusion (non-poor misclassified as poor) and exclusion (poor misclassified as non-poor) errors. In Listahanan 1, which is PhilHealth's basis for selecting its current indigent beneficiaries, the overall error rate ranges from 22-35%.

   While validation of the initial list of poor, that was done as part of the project cycle, already decreased these errors, it is still important for the data user or in this case, PhilHealth, to validate their list of potential beneficiaries, accept grievances and complaints regarding beneficiary selection and provide feedback on these grievances to the NHTO. The coordination and partnership between DSWD and PhilHealth does not only lessen program leakage, but it also improves the targeting system in terms of identifying and determining who really deserves to be prioritized or included in the Indigent Program. It should also be noted that in Listahanan 2, the NHTO enhanced the PMT model to reduce the overall error rate from 22-35% to 6.9-19%.

2. Inconsistent data of enrollee and his/her dependents. Birth certificates are not available and some discrepancies occur vis-à-vis documents presented and BC.

   While some of the data collected by our field staff are based on information disclosed by our respondents, our enumerators do, however, require respondents to present any proof of identification such as birth certificates, identification cards or even proof of billing, whichever is available to verify basic information such as names, age and addresses.

   From our experience collecting data from poor households in Listahanan 1, we learned that some of them, especially members of Indigenous People's groups were unregistered or did not have birth certificates. Since this basic document is required for the enrollment of poor children to school, which is one of the conditions that Pantawid Pamilya beneficiaries need to comply with to receive their education grants, the DSWD partnered with DILG, PSA then NSO in the conduction of the Free Birth Registration Campaign. This activity provided birth certificates to beneficiaries of Pantawid Pamilya program.

   Discrepancies between names and other basic information indicated in the database, even in IDs and birth certificates occur especially in cases of late registrants. Thus, further validation of basic information through presentation of valid documents should be done as part of the process of program enrollment.

3. Non-availment of their PhilHealth – they do not like to comply with the requirements of PHIC, which nullifies the effort of our government for them to enjoy the benefit of a free hospitalization benefit.

    Several studies have concluded that lack of awareness on their enrollment to the PhilHealth Indigent Program and the process of availment as one of the factors that result to low utilization of PhilHealth benefits by poor households.

    We would like to clarify that it is mainly PhilHealth's responsibility to disseminate information about its program to their beneficiaries. The DSWD can only support PhilHealth by linking them to Pantawid Pamilya beneficiaries. PhilHealth can use the Family Development Sessions (FDS) as venue to communicate to their beneficiaries about the indigent program, enrollment requirements, and process of availment.

INTERVIEWS FROM THE AUDIENCE

What is the impact of today's symposium on the work that you do?

Of course for the Listahanan or the NHTS-PR, it is important for us to determine kung sino talaga, kung yung mga na-target namin na poor ay mag be-benefit talaga, especially the department or the the DSWD is very supportive na lahat ng mahihirap ay dapat na mabigyan. Isa sa mga instructions ng aming secretary na mabigyan talaga ang universal health coverage para sa mga mahihirap.

Who inspired you the most among the speakers and why?

"Former PhilHealth President Dr. Dodo Banzon was the one that provided me the most insightful perspective in terms of the universal health care, how we can achieve it, and then how we would be able to engage the middle incomers in terms of not just getting the funds from, but also being able now to diversify our funds to support universal health care."

What is the most relevant topic for you in today's event and why?

"That one that discussed the life cycle changes, the life cycle approach. As a family physician it would, it provided me with a good perspective in terms of what services I can give to my patients, especially since I see the patients in full spectrum from birth to death. So, technically, I'll be able to course through my practice into looking at the life cycle approaches in terms of primary health care."

What is the most relevant topic for you in today's event and why?

"The coverage and yung No Balance Billing that were presented, siyempre, unang una ang mag be-benefit dun is yung mahihirap or yung mga nasa informal sector natin, especially na walang pang contribute or paano ba sila makakapag avail ng mga services or ng PhilHealth na binibigay and then at the same time saan sila makakakuha ng mga ganyan? So dapat yung mga ganito satin na PhilHealth, na-ibababa yun sa kanila if in case nandun sa mga far flung areas na hindi talaga ma-reach, so yun lang naman yun e. Dapat talaga pinapa-abot natin sa kanila 'yun."

What is the topic that you like the most about the symposium?

"I like yung sinasabi nila na we should move on. We should move forward and now that we've realized the identified problems and we have already identified the people who we should work with 'di ba? And then solutions are now being laid out. Let's do some work na. Let's get out-of-the-box and think for the coverage of the whole Philippines.

I work with the community most of the time so naisip ko, paano natin maaayos yung mga healthcare na inooffer ng government - including finances? Information dissemination ang kailangan, even us in the executive. Hindi nila alam na it can already be accessed, and it's just a matter of informing our patients and clients na this is something that you have already received from the government and that the government is acting on it.

Sana marealize natin lahat 'yan. At sa ganoon, gumanda. Wag nating isipin yung negative. Let's be positive in all aspects. Minsan masakit, pero masakit na marealize mo na hindi alam ng pasyente na she can have the benefits - if only they knew. Kaya sabi ko nga whenever we go to the community service, just a one-time touch, and we don't do anything after that, no monitoring? Walang follow-up and who should we partner with? The government, the LGUs and RHUs - that's the only way we can monitor patients and yung mga iniwan namin sa community. And now we should realize and accept the reality. We cannot be an island; we have to work with each other – 'yan ang importante."

What part did you like the most in the symposium?

"Actually lahat ng mga topics ay relevant to PhilHealth; yun yung pinakamaganda dun sa symposium ay 'yung…

Well, siguro yung pag-aaddress sa mga issues ng PhilHealth for example yung squeezing the middle - isa ito sa mga main issues ng PhilHealth. Doc Dodo said several options and the ones that are being practiced by other countries.

So yun yung kumbaga, and I think isa pa rin is yung how the other government hospitals are able to do this despite the concerns of other government hospitals na sabi nila na 'di nila kaya because of procurement; pero sila nagawa nila so that means kaya. So 'yung mga ganung best practices that can be emulated by other hospitals that would be ano, at least, mashashare."

What are your recommendations to improve this symposium and what other topics do you want to hear in the future conferences?

"The topic would be… actually ang hindi naaddress would be kung anong kailangang gawin - UHC is a huge accountability, that PhilHealth cannot do it alone. So, yung collaborations among agencies, so yun yung kailangang, kumbaga macover pa.

For example, financing is it really only for PhilHealth? The other agencies like kanina, na-touch naman diba the gaming industry that they have this health medical fund that is being utilized for catastrophic incidences. So if it would just be transferred to another agency, there would more leverage pagdating sa PhilHealth and mas yung capacity to assess yung need would be manageable, especially kung hindi capability 'yun ng gaming industry diba.

So mas magiging rationalized ang paggamit ng funds. So, yung ganon yung collaboration ng agencies – 'yun yung topic na hinahanap ko...

And one more is advocacy ko talaga na data sharing from agencies kasi that's very important pagdating sa mga duplicated yung mga ginagawa. And I think yung may mga info kasi na kailangan din ng PhilHealth. Just getting the information of mga non-members for example, nag-pass away na, yung mga ganon. They don't have that kind of data that they can use para ma-update yung membership namin. It's more of kailangan pa naming magbayad sa PSA to get the information so hindi na rationalized and impractical - para bang government to

government, tapos para bang you need to pay just to get the information - that's why 'yung mga ganon."

How did the symposium influence or shape your understanding on Universal Health Coverage?

"Eto nga yung, number one the equality among health care and the quality of health care, and then dapat talaga from rich to poor. Kaya lang medyo, the implementation lang ang was questioned a while ago, but it's doable naman. It's a challange to PhilHealth; I know it's gearing towards that. At the same time mas maganda talaga sana na kung ang PhilHealth, kasi yung HMO is different. They can tap the HMO although HMO is using the RVS of PhilHealth, pero if siguro they can also get support from the HMO mas maganda."

How did the symposium influence or shape your understanding on Universal Health Coverage?

"Kasi specifically, although yung discussion about the coverage of the diseases, it was specified but yung pa-paano, how to, kasi it's general term. I'm expecting it more specific although siguro this is just new, universal health care, is just new kaya yung, kumbaga, although, alam ko you are ready, may pattern na tayo yung CDC. Ina-adopt na natin. Pero specifically, kung sa bagay, ano lang naman to, symposium, so siguro in the future we can discuss some more kung ano ang talagang specifically targeted na mga diseases and then ano talaga yung specific, how would you attack it, the management and then the part of the PhilHealth. Para matulungan talaga natin yung mga poorest among the poor."

What are your recommendations to improve this symposium and what other topics do you want to hear in the future conferences?

"About unity - like how we should unite with one another."

LIST OF ATTENDEES

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Bobby Julian	Phil. Academy of Ophthalmology
Dr. Mayumi Bismark	Phil. Obstetrical and Gynecological Society
Dr. Natividad G. Ko	Phil. Obstetrical and Gynecological Society
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Maria Lourdes Naguit	Treasury
Juvy Balolong	Comptrollership
Granielle Castillo	Treasury
Lorna Blaquera	Treasury
Mark Anthony Mariano	Treasury
Dennis Foramdero	HRD
Dr. PIlar Dela Rosa	HRD
Mary Emelyn MAlit	PRID
Rachel Rosete	HRD
Gerome Sancho	PRID
Robert Concepcion	PRID
Hazel De Guzman	PRID
Mary Elenette Malit	PRID
Emily Bocony	PRID
Irene Dela Cruz	PRID
Daisy Francisco	PRID
Mark Anthony Dacalcap	PRID
Janette Villamor	PRID
Romeo Joseph Valenzuela	PRID
Mishell Sarmiento	CorPlan
Vinya Paciente	PRID
Jibson Hernandez	MMG
Jennifer Enriquez	MMG
Jaime Julius Mabesa	MMG
Lourdes Irene Minoza	Mmg
Joseph Vergara	PRID
Leoncia Garcia	MSS
Luisita BErnabe	PRID
Remedios Gabuya	MMG
Kim Erro	MMG
Elizabeth Manga	MMG
Esperanza Ocampo	PHICEA
Zaiferraef Tiblani	HRD
Armando Gavina	PRID
Samson Fararin	PRID
Joseph Fontanilla	CorSec
Teresita Medicielo	HRD
Joanna Gono	ITMD
Jonathan Tonido	OAD
Rene Fariolan	PRID
Jonathan Balagay	OCOO
Moises Gatan	Comptrollership

Teddy Marquez	PRID
Roberto Mercado	PRID
Leandro Dela Cruz	TFITA
Guillermo Razon	ITMD
Olie Mae MAdredijo	Treasury
Manuel Villanueva	ILD
Florencio Tuazon	MMG
John Ramir Agbayani	NCR South
Robin Tenorio	CAG
Leo Rafael Guzman	HRD
Michellin Placente	Prosecution
Nestor Neron	Comptrollership
Grace Esmao	Treasury
Ayana Paragas	PRO NCR South
Alma MAcaldo	PRO NCR South
Faudia Subillaga	CorComm
Sharon Guballa	CorMar
Nida Legarda	PRID
Connie Bacolor	LHIO Manila
Servillano Medina	OAD
Maribeth Adsuara	HRD
Melody Ann Viterbo	CorMar
Claire Elaine Policarpio	CorMar
Janice Anastacio	CorMar
Lourdes Ivy Mendiola	SHIA
Roxan Vocales	SHIA
Angelyn Mae Gomez	CorSec
Michele Aikah Grey	SHIA
Aaron Ebot	CorMar
Jennifer Lim	CorMar
Melissa Montalban	CorMar
Ma Cristina Dela Cruz	PRID
Jay Oliver Omoso	PRID
Sandra Pilao	PRID
Maria Cristina Gabinete	CorMar
Allen Joseph Gavina	PRID
Leilani Formadero	Area 2
Dave Pagdilao	CorMar
Leslie Aquino	HRD
Sam Anthony Ramirez	ITMD
Bernie Mahusay Jr	ITMD
Mary Joy MAncilla	MMG

GUIDELINE TO PRESENTATIONS

Guide for Panel Speakers, Discussants/Reactors and Moderators

The symposium aims to celebrate PhilHealth's successes, share experiences and lessons learnt as well as learn from other countries' experiences towards Universal Health Coverage (UHC). It will be attended by around 500 participants consisting of public and private sector stakeholders including government agencies, local government units, health providers, the academe and civil society organizations, patient groups and media. An international expert will present various country experiences, best practices and lessons learnt in the implementation of UHC. PhilHealth, meanwhile, will share its journey towards UHC. The dimensions of the UHC cube, namely: (1) services covered; (2) proportion of services covered; and (3) population covered, will be discussed in moderated panel sessions.

Attire
Panel speakers, moderators and discussants/reactors are advised to be in business attire for the symposium.

Arrival
Please come to the venue at least 30 minutes before your session.

Introduction of Panel Speakers, Discussants/Reactors and Moderators

Please provide us your Executive Profile or resume/curriculum vitae and recent photo (electronic) for use in the symposium before 21 February 2017. May we request you to provide us a very short paragraph (up to 5 sentences max) on how you would like to be introduced during the symposium. You may send these thru email to symposiumphilhealth2017@gmail.com. These will be uploaded to the symposium website.

Mechanics for each Panel Session

- Each panel session will have a moderator to facilitate discussion.
- Each panel shall run for one and a half to two hours, inclusive of presentation, reactions and open forum.
- Each panel session will be composed of two to three speakers.
- Speakers are given up to 20 minutes each to present their topics.
- Reactors are given up to 15 minutes each to share their insights and recommendations on the presentation.
- An Open Forum shall run for 15 minutes at the end of each session after all the Speakers' and Reactors' allotted time.

Panel Speakers

Preparation for your Presentation

Panel speakers may use powerpoint or other methods for their presentation. In case powerpoint slides are used, we recommend to limit to 20 slides to help you stay in the 20 minute time frame and help you keep the presentation clear, concise and unrushed. You may use the following format:

- Introduction (*3-4 slides, 3 minutes maximum*)
  - To explain the context and rationale of the topic
- Discussion (*7-9 slides, 5 minutes maximum*)
- Conclusion (*1 slide, 1 minute maximum*)
  - Should be summarized into key phrases that capture the most significant ideas
- Recommendations (*4-6 slides, 6 minutes maximum*)
  - Focus on recommendations that can be undertaken by PhilHealth in achieving Universal Health Coverage
  - Discuss how these recommendations can help improve existing structures, operations and systems
  - Should be concrete and specific

Final version of presentation materials or speech should be submitted to symposiumphilhealth2017@gmail.com on or before Tuesday, 21 February 2017 to allow time for the discussants/reactors to prepare their comments. If your submission is final, please let us know so we can upload to the website. If you make any last minute changes, please email us through the same address above or notify a member of the registration desk staff on the day of the symposium. We will make arrangements to have your presentation updated and uploaded to the website on the day of the symposium.

If available, Executive Summaries or Abstracts (in Word file) of not more than 200 words may be submitted on or before 24 February 2017 so we can upload to the symposium website.

Presentation Proper

- Your presentation will preloaded onto a PhilHealth laptop. Prior to speaking, the first slide of your presentation will be on the screen
- You will be introduced using the introduction you have provided beforehand
- You will be reminded that you 10,5 and 1 minute of presentation time left (by the moderator or staff in the hall. At 1 minute left, please wrap up your presentation and turn over to the moderator.

Discussants/Reactors

A copy of the presentation materials for the panel session will be given at least a week before the symposium for you to prepare your discussion/reaction.

Discussants shall be allowed to speak after all the panel speakers have presented. Up to 15 minutes are allotted for each discussant. The discussant offers reflections on the topics presented – observations and areas for improvement. If there are obvious connections or commonalities among the topics presented, highlight these. Should the discussant want to use a powerpoint presentation, it should be limited to comments on the topics presented. It should be sent to symposiumphilhealth2017@gmail.com for uploading to the symposium website. You may offer recommendations on what PhilHealth or other partners in the health sector should undertake to improve the existing structures, operations and systems for achieving UHC. Please remember this is an opportunity to offer positive reaction, constructive criticism and/or to raise provocative questions.

Panel Moderator

Management of Session

A moderator shall be assigned to manage a session. His/her task shall be the following:

- Open the session through a brief introduction.
- Introduce the Panel speakers and the Discussants/Reactors of the session and shall ensure that the Open Forum proceeds in an orderly manner.
- Keep the panel speakers and discussants to their allotted times.
- Open the session to questions and serve as open forum traffic coordinator.
- Highlight take-away messages as you close the session.
- Make sure the session ends on time so the next session can start immediately after.

Further inquiries on the Panel Sessions may be directed to the Conference Program Sub-Committee thru email: symposiumphilhealth2017@gmail.com or call 637-9693 or 4417444 local 7583 and ask for Ms. Grace Carbungco, Ms. Daisy Ostaco or Ms. Bhem Sanchez.

POST CONFERENCE EVALUATION

Evaluation Scores of Prof. Nina Castillo-Carandang

Knowledge of the Subject Matter			
Scale	**Count**	**%**	**Average**
4	5	3.57%	
5	54	38.57%	
6	75	53.57%	
No Score	6	4.28%	
Grand Total	**140**	**100%**	**5.64**
Presents Views and Ideas Clearly			
Scale	**Count**	**%**	**Average**
3	1	0.71%	
4	12	8.57%	
5	61	43.57%	
6	59	42.14%	
No Score	7	5.00%	
Grand Total	**140**	**100%**	**5.59**
Ability to Handle Questions			
Scale	**Count**	**%**	**Average**
4	6	4.29%	
5	30	21.43%	
6	28	20.00%	
No Score	76	54.29%	
Grand Total	**140**	**100%**	**5.61**
Ability to Establish Rapport with the Participants			
Scale	**Count**	**%**	**Average**
3	2	1.43%	
4	23	16.43%	
5	61	43.57%	
6	40	28.57%	
No Score	14	10.00%	
Grand Total	**140**	**100%**	**5.61**

PHOTO DOCUMENTATION


PhilHealth at 22
Universal Coverage:
ZIKA
PhilHealth at 22
Universal Coverage:
Challenged by Change
Empowered by Unity

FULL VERBATIM TRANSCRIPTION

START OF THE SYMPOSIUM
(23:56 to 33:01)

By Sir Donald
PhilHealth's host

"Good morning ladies and gentlemen. May we request everyone to please stand for the singing of the Philippine National Anthem. May we call on the PhilHealth chorale."

(PhilHealth chorale sings the Philippine National Anthem)

"Please remain standing for the prayers."

(Prayers leaded by SM Rey Balena and Dr. Sainuddin Moti)
(PhilHealth Chorale sings the PhilHealth Hymn)

"Thank you PhilHealth Chorale. You may now all be seated."

INTRODUCTION OF THE SYMPOSIUM'S OVERALL MODERATOR
(33:10 - 41:15)

By Sir Donald
PhilHealth's host

"Good morning and welcome to "Bawat Pilipino Protektado: A PhilHealth Symposium," one of the major observances lined-up for the PhilHealth's 22nd Anniversary.

It's time to meet our overall moderator for today. She is a health social scientist and clinical epidemiologist. She is currently the Assistant Chair of the Department of Clinical Epidemiology College of Medicine, University of the Philippines, Manila.

Please welcome, Professor Nina T. Castillo-Carandang."

WELCOME REMARKS OF THE OVERALL MODERATOR
(33:10 - 41:15)

By Professor Nina T. Castillo-Carandang
Health Social Scientist and Assistant Department Chair
Department of Clinical Epidemiology
College of Medicine
University of the Philippines - Manila

"Magandang umaga po. Hindi pa? Konti pa o kulang pa ng konti. Maayong buntag. So, good morning everybody. It is my great pleasure and honor to be with you on our 22nd birthday. I am trying to recall how long I worked for PhilHealth's partners. Medyo matagal-tagal na rin po kasi 'yung mga kasama ko dito eh - aging population na rin pati po ako. So, it's been a long, long journey with my colleagues and PhilHealth and I'm very happy to be with you on this very special day.

I'd like to call on attention to your very beautiful logo. Can we flash this? If you notice, this is a very special logo for the anniversary and when they sent it to me this weekend, I said, 'what a beautiful idea to capture what PhilHealth is all about.' So, the multicolored vector images are the different publics that PhilHealth caters to and there's a halo - parang santo po ano - formed by three bright blue colors, which signifies the commitment of PhilHealth to protect the people from financial hardships due to medical necessities. And the solid green thing is associated with nature and health. Very beautiful.

I forgot to ask who made the logo. Does anybody know who made the logo? In-house? So, congratulations, because I thought it was a wonderful image of what you wanted to share with the rest of the public that we have. Tandaan niyo po, ngayong gabi, yung iba pong makakasama ngayong gabi, meron po kaming contest, so bawal pong matulog during the whole day, because we'll be asking you trivia questions tonight. And, it will start with this particular logo. So, if you'll be sleeping during the day, you will not be able to answer the trivia questions tonight, if you happen to join us tonight. Okay, so yun po ang ating logo for the anniversary.

It is also with great pleasure that I welcome our different dignitaries who joined us today on this very special occasion. From your PhilHealth Board members and then of course, you have PhilHealth, marami po akong cue cards po rito. We have Mr. Johnny Sy-Chua, who's the OIC Office of the Vice President, Chief Operating Officer, PhilHealth. Also, Mr. Ramon Aristoza, Jr. who's acting president and CEO of PhilHealth. I was very happy to see my two old friends from way back, now who's manning the organization, Manong Johnny and Manong Buddy, maayong aga. Okay, then we also have Mr. Raul Villamor, another old friend and we have Ruben John Basa. We have Atty. Deborah Sy. We have Atty. Shirley Domingo, another old friend. And we have Ms. Lolita Aragona. And we are also very pleased that we have people who have been part of PhilHealth's history, PhilHealth's past presidents, our very own Lorna Fajardo - hindi ka Ma'am tumatanda. And of course, the dashing Enrique Salamea, who hasn't also changed at all no'? So, thank you Ma'am Fajardo and Mr. Salamea for joining us today on this special occasion.

This occasion will not possible without the support of various partners. We have our development partners, particular acknowledgement given to EU-EPOS, for their support to this activity. We also want to thank USAID, GAIZ, Equinosio, the Japanese Embassy, and World Bank. And of course, the other half of PhilHealth, the Department of Health, and we are also honored to have here the former Secretary, Dr. Manolet Dayrit. And we have also our other colleagues from the Department of Health.

Our other colleagues also include from TAO, the Philippine General Hospital, the Wallace Business Forum, Philippine Orthopedic Center, DSWD, DILG, Philippine Statistics Authority, Philippine College of Physicians, Regulations Commission, NEDA, Rizal Medical Center, Las Pinas General Hospital, Valuenzuela Medical Center, POCS, Quirino Medical Center, National Children's Hospital, the Commission on Audit and the Civil Service Commission. We also have our other partners from National Kidney Transplant Insitute, from PCSO, from Epimetrics, from Ateneo school of Medicine and Public Health and we also have the league of provinces and other executive of PhilHealth, Ms. Perez.

We will also acknowledge our other friends, who came in, if you notice, we started late. Is that Filipino time? Or will we give ourselves the excuse that it's Monday and there's a transport strike. It's traffic; the traffic is already a part of our way of life, 'di ba po? So, we're glad actually for a lot of people who attended because PhilHealth has prepared activities for you today. So, for all of you who braved the traffic, the transport strike, and the other reasons to go to Metro Manila. I live in Los Banos by the way. I left my house at 5:00 AM to get here and grabe po 'yung heavy ng traffic along SLEX - there were 2 accidents and I was telling myself, "OMG, 'wag ngayong araw na ito, dahil ako ay nakapangakong darating, dito ng maaga. Buti na lang nakarating naman po ako nang maayos I hope our other colleagues will be able to come and join us. So, ito po yung pasasalamat, pero siyempre po, marami pa pong pasasalamat na ibibigay ang ating mga pinuno ng PhilHealth. So, let me call on Mr. Johnny Sychua to give on the Welcoming Remarks."

WELCOME REMARKS
(41:37 to 45:05)

By Mr. Johnny Y. Sychua
OIC-Executive Vice President and Chief Operating Officer &
Concurrent CARAGA Regional Vice President, PhilHealth

"Thank you Nina for the kind words. I'd like to greet everyone a pleasant morning and thank everyone for gracing us with prayers at the Bawat Filipino Protektado: A PhilHealth Symposium. Today will be another exciting learning opportunity as we take a closer look at how the National Health Insurance Program is doing after 22 years of its creation and the establishment of PhilHealth on Feb 14, 1995. The presentations have been clustered according to how a National Program of Social Insurance can be achieved, assessed, and appreciated depending on the country's health care needs, resources, and priorities.

With this theme, "Bawat Filipino Protektado," this PhilHealth symposium will showcase international experiences in achieving Universal Health Coverage. It will also have in-depth discussions on the dimensions of Universal Healthcare, as well as interesting viewpoints from global experiences, and how the countries' culture play a vital role in the successful implementation of social insurance programs.

Of course, this day will not be complete without discussing Philippine's own journey towards Universal Health Coverage. We shall tackle on how far and how near are we to fulfilling the vision in seeing every Filipino, especially the disadvantaged, the underserved, the

underprivileged, is able to access healthcare services that are of highest quality, at the right time, with the right costs.

We have invited distinguished members of panels of experts who will be sharing with us their perspectives so that the National Health Insurance Program will continue to make a positive difference in the lives of countless Filipinos, here and abroad. Please join us in this journey towards a more meaningful conversation on social health insurance by actively participating in the discussions, sharing your insights, and asking questions because all of us anyway are stakeholders of the National Health Insurance Program. Let us continue to be part in initiatives that concern our health and being involved in this symposium is a good start. Thank you and we welcome you all."

OVERALL MODERATOR'S CONTINUATION OF THE WELCOMING REMARKS
(45:20 to 47:55)

By Professor Nina T. Castillo-Carandang
Health Social Scientist and Assistant Department Chair
Department of Clinical Epidemiology
College of Medicine
University of the Philippines - Manila

"Thank you Mr. Sychua for the welcome remarks. I purposely left acknowledging the different regions because I felt that the body and soul of this corporation is the people in the regions. Let me call them by table, 'yung parang sa wedding, 'yung tinatawag po kayo. 'Pag tumindig po kayo, kindly give a cheer for PhilHealth.

Nasaanpho ang CAR? There. Ano po ang cheer niyo? PhilHealth, go go go? Wala? Region 1 po? Thank you. Region 2? Region 3? Region 4A? Ayun may cheer doon. Region 4B? Region 5? Okay. Region 6? Region 7? Region 8? They're also here. Region 9? Region 10? Region 11? Region 12? CARAGA? Oo nga pala. ARMM. And last but not the least is NCR?

So, these are the men and women of PhilHealth who drive the corporation and I'm sure that our next speaker will be very happy to know that they are all here. It is with great pride that we call on Dr. Paulyn Jean B. Rosell-Ubial, the Secretary of the Department of Health, message to be delivered by Dr. Raul Villamor, the Head of the Executive Staff, Office of the Chairperson."

MESSAGE OF THE SECRETARY OF HEALTH
(47: 57 to 54:24)

By Dr. Paulyn Jean B. Rosell-Ubial
Secretary, Department of Health

Delivered by Dr. Raul Quillamor
Head of the Executive Staff, Office of the Chairperson

"Thank you, Nina. The Secretary of Health deeply regrets that she wasn't able to go this morning that's why I was tasked to deliver this message on her behalf.

Honored guests, speakers, representatives of the European Union and other partners, members of the PhilHealth board, friends. It gives me great pleasure to address the people who appreciate and pursue Universal Healthcare. The pursuit of Universal Healthcare underscores the values we aspire for real positive change that our countrymen can feel in line with President Duterte's promise of "Tunay na pagbabago."

Equity, efficiency, quality, and transparency - these values are the backbone of this administration's new health agenda, which we call the "Philippine Health Agenda or PHA."

The Philippine Health Agenda was the product of collaborative efforts of the people who heeded the call of the President's three marching orders, one of which is to help the poor. And in line with helping the poor, he instructed, yours truly, to go to Cuba to study their unitary health system with the hope that it can be replicated in our country.

The task at hand may seem insurmountable, as the Cuban health system is impossible to completely replicate in our setting. One main difference is our dichotomy in health care system wherein about 50% of our health services are delivered by the private sector causing a wide gap in the costs of the health services. As a consequence, only those who are rich can access decent health services, either through out-of-pocket payments or a hefty healthcare insurance coverage, while the lower middle class can become impoverished just so they can meet OOP payments. The situation is even more helpless for the poorest of the poor who don't have pockets to begin with. This is our reality that we have been enduring for the longest time - to meet the costs of health services.

Hence a paradigm shift is in order, to shift from a dichotomist health system to a unitary system through our National Health Insurance Program. Through the PHA, we aim: (1) to guarantee services that provide care for all life stages and address the triple burden of diseases, (2) to ensure services are available, acceptable, accessible, affordable, of quality, and equitable and (3) to sustainably finance the services through universal health insurance.

Every Filipino, most especially the poor, should have the ability to access both public and private health services without the fear of being unable to pay for these. Patients wanting to go to a private facility would now get quality health care assessments and the private facility will not be left wanting because NHIP will have the capacity to pay for these services.

On the other hand, our public health facilities will continue to be improved and developed, and be at par with the best private facilities out there so that our valued clients and patients will still be able to access same quality health services given in private facilities. This will create friendly competition between private and public health facilities with the hope that both of them will have the drive to improve themselves and be able to attract and cater to more clients and patients, leading health to be subsidized by one single payer, which is PhilHealth. Through this process, we will create a unified healthcare system.

We are now, therefore, seeing PhilHealth taking the center stage in guaranteeing the health of the Filipinos. This is the way forward if we are to ensure that every Filipino gets a shot in life to make sure that they reach their maximum potential and become productive citizens of our country. We hope to attain this through our strategy which we call ***ACHIEVE****:*

A*-dvance primary care and quality*
C*-over all Filipinos against financial health risk*
H*-arness the power of strategic health human resource*
I*-nvest in digital health and data for decision-making*
E*-nforce standards, accountability, and transparency*
V*-alue clients and respect patients*
E*-licit multistake holders for help*

If we achieve our goals for financial protection, responsiveness, and better health outcomes, then our commitment to the entire Filipino nation is fulfilled. We owe it to our sons and daughters so they wouldn't have to go to the same process on seeing their life-worth savings go down the drain just to meet the costs of getting well. We owe it to our parents and grandparents, who are now in the stage of their lives where they need insurance the most. We owe it to the Filipino people, especially the poor and the marginalized, because health is everyone's fundamental right.

I've always believed that health is everybody's concern, not just the government, but the whole of society as well. Hence, we have to rally behind our health agenda, the PHA, and make it a reality for every Filipino. Let us commit ourselves to work towards one share vision and this is, ***'ALL FOR HEALTH TOWARDS HEALTH FOR ALL.'*** *Thank you very much."*

INTRODUCTION TO MR. RAMON ARISTOZA JR.
(54:38 – 55:02)

By Prof. Nina T. Castillo-Carandang
Health Social Scientist and Assistant Department Chair
Department of Clinical Epidemiology
College of Medicine
University of the Philippines – Manila

"Thank you Dr. Villamore the message of the honorable Secretary of Health.

Our next speaker is Mr. Ramon Aristoza, Jr. who is the acting president, and chief executive officer for PhilHealth. Mr. Aristoza will share with us the Medium Term Development Plan and Corporate Dashboard of PhilHealth. Mr Bobby..."

PRESENTATION OF THE MEDIUM TERM DEVELOPMENT PLAN AND CORPORATE DASHBOARD
(55:28 - 1:24:28)

By Mr. Ramon F. Aristoza, Jr.

Acting President and CEO
PhilHealth

"Salamat Nina. Nina is my classmate way back… Never mind the years. As usual you always look good. Palakpakan natin si Nina. Thank you.

Good morning. Let me greet you in my signature greetings - magandang buhay. Please say it again. That means good life. I am tasked to present our medium term development plan while preparing for this material that I'm about to present. I'm thinking about how best to present corporate strategy map vis a vis PhilHealth's journey towards Universal Health Coverage.

I guess there's no other better way to do that than buy working along with our theme for today's symposium, which is, is it there? Bawat Filipino Protektado. How exactly do we march towards ensuring that every Filipino is able to access health care services without running on an empty pocket. I'm tasked to present this as defined our medium term development plan on what we plan to do from this year until the year 2022.

On the question of how do we improve equity and efficiency in financing? For almost 50 years now, financing health care and the Philippines has gained a lot of headway but admittedly it is still fragmented. We are seeing multiple funding streams that sometimes overlap. While the National Health Insurance Program (NHIP) has become the single biggest purchase of health care services in the country, it can still do a lot of leveraging to serve as catalysts for health sector development. It has yet to fully exercise its power to infuse, change and cultivate a culture of improved performance and accountability from its partner providers, while ensuring equitable access to health services.

Our vision, mission and values, indeed, we need to refocus our strategies from simply ensuring equality of opportunities. In other words, bawat miyembro, to improving equity in access to health care services. In other words, bawat miyembro, protektado and driving efficiency in resource allocation as we're saying kalusugan ng lahat, sigurado. We now aim to rapidly ensure that all Filipinos have the unique opportunity to gain access to health services at any stage of life, without experiencing financial burden.

We hear stories of individual and families losing their saving to a single incident of illness in the family. This is one major concern we wanted to put an end by offering a more rationalized benefits. We also want the NHIP to become sustainable in the long run. It is our duty to make sure that the NHIP is able to fulfill its obligation to the 100 million strong membership that includes today's digital members, the millenials.

On our PhilHealth corporate strategy map from 2017 to 2022, on your screen is the PhilHealth corporate strategy map from 2017 to 2022, it is a blueprint that is aligned with ambition, not in 2040, the country's development map. We are anchoring our journey on the overall goals of the health sector. Under the PHilippine Health Agenda until year 2022, the NHIP takes care of the health financing aspect to help realize the three guarantees that the said agenda has spelled out. We aim to see our fellow Filipinos awaiting themselves of quality medical services, services made possible by social health insurance.

All delighted customers. Among our major strategies is to provide our members that unique experience that will not only delight, but will also probe them to share their experience with their family, friends and acquaintances. Total customer delight should start from the moment of new member, a new member signs up to the NHIP to the next phase which will enable him to fulfill his obligation such as premium, payment and member data updating to that the very instance when a member accesses the benefits. We want them to feel secure and that they can seek medical help without worrying how to fund the health expenses.

All delighted customers quote, "I feel secured" to generate that assurance for members, we have two major objectives: push for total customer experience and develop slowly responsive benefit packages. For total customer experience, in the marketing world, the challenge is always to bring about the peak sales, encouraged by how engagement was carried out, in our case, the challenge is achieving customer delight is defined by the member's experience at the different touch points made available to our customers. A single unsatisfed member can easily spread that unfortunate incident to a thousand and one other members in the same way that one successful hassle free transaction at our service point can bring about positive vibes.

Among our key initiatives under these objectives are to cover difficult to capture segments and retain informal sector members - to expand contracting private sector and functional delivery networks, and improve delivery and quality of customer services by engaging our frontliners or frontlines, our collection partners, our partner providers. For responsive benefits, providing responsive benefit packages is also crucial to achieving customer delight. We recognize our member's desire to get value for their money that we should be able to reduce inefficiency in choosing and purchasing health care services.

Our key initiatives under these objectives are to expand primary care benefits for all, implement guaranteed health care packages and supplemental benefits. Strictly implement the no balance billing for ward accommodation and interior promote co-payment scheme for all other members and update the benefit package in view of the price differentiation across geographic areas. For responsive benefits in the area provider payment, we are looking at improving price negotiations and setting tariff for benefit packages in 2020. In terms of Philippine coverage it will be a step from identifying the minimum guaranteed health package per life stage to expansion of secondary outpatient benefits by 2019.

On how to sustain the funds, we now move on to our next major pillar in this strategy map, which is funding sustainability. We believe that we can only delight our customer if we are able to maintain and sustain the funding for a noble National program like the National Health Insurance Program or NHIP.

How do we plan to achieve funding levels that are sustainable? First, we must generate 3 billion in terms of premium levels and collection efficiency and optimize assets, not for profit but to better serve our members. We need to adapt a progressive premium contribution rates in the formal sector and adjust the premium levels for other categories. I believe consultation with the concerned stakeholders are already on-going. We are also strengthening our accounts management and monitor the revenue raising efforts. Full outsourcing of collection

of services of the electronic remittance system or otherwise known as EPRS, is now being realized through our hardworking account management, who is constantly keeping an eagle eye on critical accounts - on how to optimize the assets of the corporation as we can take care of public funds, we need to better our investment portfolio while coping measure to maximize productivity of our assets to proper aging, monitoring of asset performance and timely disposal of sets. Efficient resource management can actually do wonders for a government corporation that has invested in funding the health care requirements of the Filipino citizens.

The third major component of our strategy map is enhancing internal processes to better respond to the needs of our clientele. Despite the many accolades that we have earlier received for efficient client servicing, we still need to strive for excellence at a fairly consistent level so that we are able to provide our clients and stakeholders with highest quality of frontline services as possible.

Excellent processes is one major component of the strategy plan. Under this pillar of excellent processes are the three major objectives, that if met, will certainly put PhilHealth at the level of efficiency never been experienced. First is strengthening stakeholder relations. Second, ensuring operational effectiveness and efficiency. And third is boosting innovation in research policy and processes. On strengthening on customer and partner relation, improving the level of engagement and communication with our customers and program partners is crucial in bringing us to where we want to be as an institution. This can be achieved for development and implementation of an integrated marketing and communication plan that features markets segmentation and localization, and use of effective channels. We are also working towards strengthening customer relation and management system to better manage customer feedback and concerns. It is inevitable for feedback to come in from so many channels and the biggest channels here are to be able to attend to them and address the concerns in the soonest possible time.

In terms of managing our program partners, we need to enhance our performance with them by integrating clear performance incentives and penalties. We also aim to tap more private sector involvement for better program implementation to achieve operational effectiveness and efficiency. We are looking at implementing leaner frontline processes and improving our turn around time especially for basic structured transactions. At the same time, keeping track of the progress of our initiated program and projects will be a major undertaking. The corporation shall strengthen mechanisms to control and minimize fraud against it. This will address the leakage that will threaten or deplete the National Health INsurance program.

In boosting innovation and research, policy and process for years, we have always relied on research to generate sound policy decisions for our various operations. This time we need to bring in a different of the exploring and planning into policy making - policy making by tightening research collaborations with local and international partners and adapting globally recognized reporting standards for organizational transparency.

Strong foundation is a very vital component of our medium term development plan. This is a business mindset that says if you take care of your employees, then they will take care of your clients. Ladies and gentlemen, we have set our sights, early on to become the employer of

choice in government sector and the contest for this brand of employment will never cease. This is the reason why we are building this strong foundation hinged on leadership capacity, human capital development and information and knowledge results and resource management. These are the elements that will support our nationwide operations - collectively, if we want to forge ahead, armed with the skills, talents and technical know how that our mandate requires of us so that we can bring about the kind of government service that every Filipino deserves.

Three key items will keep us focused on building the strong foundation on which PhilHealth will stand. One, creating transformative leadership and culture. Two, aligning the organization and engaging the workforce. And lastly, integrating and optimizing the information system. Create transformative leadership and culture is one of among the vital components of our medium term plan and most takes place, the main actor has an understudy who rehearses the lines as the main character does. The same goes for our organization. We will continue to pursue fulfilling our leader's and developing the next line to ensure continuity of business operations. At the same time we will institutionalize the feedback mechanism such as the periodic review and the timely interventions to foster a culture of continuous learning.

One of the priorities is to fight corruption. Thus, the corporation shall ensure that it remains to be corrupt free organization. Just recently the board has improved a policy on whistle blowing and this is just the start of the many more initiatives to come along this line. Also I'm happy to say that our present legal sector is doing more for our policies to ensure that ensure that PhilHealth pays the right money to the right benefits. Ensuring organization and workforce engagement, it is also important that we create an environment that gives premium to employees engagement. The non-monetary benefits of work satisfaction can actually motivate to perform at their maximum capacity and such work attitude will lead to the benefit of the organization no less. Organizational alignment and workforce engagements is vital to our major development plan. We want to be forward looking as well and provide our employees with opportunities to deliver on their tasks despite the challenges of time. We have seen, just like NIna, the traffic condition, situation in the national capital region, has affected our employees. One study that the stress our commuters go through on a daily basis actually affect family relations. That's why all avenues are being explored such as teleconferencing, work from home, faultless schedule and arrangement, and the like. The best way to survive in this fast paced world is to keep up with the changing time and take advantage of today's information and communication technology.

On integrated and optimized information system, it is a national program, on a massive scope, as the national health insurance program, will definitely rely on an information system what the operations need and what management require for an effective and informed decision making. We will operate on a cost efficient computing environment, tapping available application and outsourcing stakeholders support for IT applications. We will continue to advocate knowledge resource management for learning can always be enriched by literature publication on the NHIP that the next generation of social health advocates can build upon.

As the Philippine Health Agenda gets off the ground, PhilHealth will take on the formidable task of continuous recalibration as it faces the challenge that is ensuring financial risk

protection that brings. We have weathered 23 years, the journey was not exactly smooth sailing but the lessons we have learned along the way will all the more prepare us for the bigger waves ahead. So all of this, ladies and gentlemen, I'm confident that this organization, this very organization that I have served for almost 19 years will continue to soar after every Filipino has social health insurance coverage that grants access to medical core services without necessarily being impoverished by the cost of these services. By then, universal health care or UHC, has been achieved. Thank you and maraming salamat po."

INTRODUCTION TO MR. LOUIS DEY
(1:24:30-1:25:26)

By Prof. Nina T. Castillo-Carandang
Health Social Scientist and Assistant Department Chair
Department of Clinical Epidemiology
College of Medicine
University of the Philippines – Manila

"Thank you very much Mr. Aristoza. Sabi niyo magclassmate kami pero po hindi po ako kasing tanda ni Manong Johnny at Manong Bobby. Nagkataon lang na magkasama kami sa isang health financing course.

Napakaganda po ng plano ng PhilHealth for medium term plan and everyone is aware the challenge on how to implement these beautiful plan. I helped with the previous medium term development plan… Around 7 years ago or so. And I didn't know what happened to that one. This is another beautiful plan, well thought of and well crafted and I wish you luck on implementing it. And of course you can call on our partners including myself for assistance to effectively implement this beautiful plan. Thank you again to Mr.Aristoza.

Now may I know call on Mr. Louie Day, the acting development corporation section of the European Union delegation to the Philippines for a message to the EU delegation to the Philippines."

MESSAGE FROM THE EU DELEGATION TO THE PHILIPPINES
(1:26:13 - 1:38:26)

By Mr. Loius Dey
Acting Head of Development Cooperation

"Honorable Paulyn Jean Rosell-Ubial, Secretary of Health; honorable Ramon Aristoza Jr, acting president and CEO of PhilHealth; honorable Johnny Sychua, chief operating officer; Dr. Raul Kiamore, chief executive head staff PhilHealth board, Secretary Manuel Dayrit, Dean of Ateneo de Manila, Professor Konrad Obermann, friends, colleagues, partners, ladies and gentlemen, health is enshrined in a 1987 Philippine Constitution as a fundamental human right for every Filipino. It is a great honor to share a few words with you today - at today's important symposium to celebrate PhilHealth's 22nd anniversary.

In doing so, I'd like to focus on three main messages. First, on behalf of the European Union, I would like to congratulate PhilHealth and the Department of Health on the noteworthy achievements in health made so far. We greatly appreciate the continued commitment of the Philippine government towards achieving Universal Health Care. Today's symposium entitled, Bawat Filipino, Protektado, highlights the health system – not just about improving health, but also protecting people from falling into poverty because of the financial consequence of illness and seeking medical care.

When PhilHealth was created in 1995, it only initially covered government and private sector employees. 22 years later, PhilHealth has made great strides in moving forward along the three dimensions of universal health care. Coverage now reaches 92% of population – that's almost 93 million people. By achieving the impressive coverage of the population, PhilHealth has helped put the Philippines at the forefront of global experience.

Another dimension of universal health care relates to the range of the services covered. The introduction of several benefit packages has enabled Filipinos access to a wide range of services. PhilHealth constantly continues to innovate and adapt benefit packages to meet the challenging demands of local and global health concerns of Filipinos.

With increased funding support from the government, the paid amount paid per benefit package reimbursements double from 47 million pesos in 2012 to 97 million pesos in 2015. And the number of claims have also increased, from 5 million in 2012 to 8.4 million in 2015. At the end of 2011, PhilHealth adopted the non-balance billing policy, which aims to ensure that the poor would not have to pay charges over and above what is reimbursed by the PhilHealth benefit packages. In public, as well as in private health accredited facilities, compliance of health facilities to the non-balance billing policy was initially was quite low, but significantly increased from only 7% in 2013 to 51% in 2015.

PhilHealth has also made considerable progress in terms of process improvement, strengthening its workforce and making access to PhilHealth benefits simpler. PhilHealth received ISO certification in December 2014. This demonstrates PhilHealth's commitment to continued improvement, customer focus and delivery of quality services.

PhilHealth has identified equity, accountability, customer focus and social solidarity as core pillars of its mission. The importance of PhilHealth is also well articulated in the Philippine Health Agenda – achieving universal health insurance is one of its three guarantees and puts special emphasis on leaving no one will be left behind and reaching the vulnerable populations who face financial, cultural and geographical barriers to access medical services.

These findings and the policies to enhance financial risk protection, the continued expansion of government subsidize health insurance for the poor, deepening of the benefit packages as well as provider payment reform aimed at cost containment are to be applauded. A heartfelt congratulations to these achievements (applause).

And this brings me to my second point, by emphasizing how much the EU values the opportunities to support PhilHealth, since 2007 when the first Philippine sector support

program was launched, the European Union has provided support to the National Health Insurance scheme through technical support in various domains such as costing, and design of benefit packages, improving data management, strengthening risk management and actual analysis. We consider PhilHealth an important pillar for continued progress for universal health coverage – one that helps to secure efficient and effective use of government resources and enables to improve access to medical services to the poor. We see huge opportunities.

We are also aware of the very strong capacity and long standing track record the country has in public health being a regional leader in so many areas. It is most encouraging to see so many key stakeholders represented here today: PhilHealth board directors, offices and employees from central, regional and provincial offices, Department of Health officers and hospital directors, local government and private sector representatives, civil society organizations, universities and professional bodies, media and development partners, thanks to the collective efforts of so many in this room. Many health indicators have significantly improved. Local executives are crucial partners and prime actors to ensure quality, affordable and accessible basic health services.

After the devolution of health services, a number of local government units especially in geographically isolated and disadvantaged areas, had difficulty responding to the new responsibilities. They lack behind in achieving the said targets. We appeal to governors and mayors to join and take up the challenge and seize the opportunities offered. We do believe that the overall success towards universal health care would heavily depend on whether it will be able to get local governments on board. Leave the expectations are huge and all hands are needed on deck.

This brings to my third and final point. Indeed, as we look to the future, it seems that more remains to be done. The remarkable progress made in many areas has not reached all Filipinos and many people still feel excluded from health care. Improve national averages, mask the remaining inequalities in many health outcomes and wide regional variations persists. Similarly, available data show consistently poorer health outcomes among indigenous people.

That's why today's symposium on exploring the dimension of universal health care is so important. It presents a unique opportunity to share experiences and best practices on policies. With your permission, there are some areas we would like to highlight.

Out of pocket spending, when sick remains rather high. Latest national health accounts estimated out of pocket spending remaining rather high at 57% of total health expenditures. This severely limits access to essential health care services for many Filipinos. PhilHealth share in total health expenditure with only 14%. Ensuring continued government subsidized of premiums of the poor and exploring other funding possibilities for PhilHealth, to further increase revenue will translate to increase in benefit package payments to reduce out of pocket spending. 80% of PhilHealth reimbursements going to in patient health care. Specialists treat many conditions that could be treated in the primary level. Many hospitals are congested and have high bed occupancy rates. Significant cost containment and efficiency gains can be achieved through investing and expansion of primary care benefit packages.

In addition, treating many chronic non communicable diseases at early stages, at the primary health care level, can prevent complications and avoid expensive treatments at high levels of care. The Philippine health system is composed of many strong elements. And the country has world class experts in multiple domains but the health remains fragmented. A strong health system is needed to deliver with each of its parts optimized: financing, procurement, human resources and strategic information.

The Philippines' health system financing the hybrid systems composed of tax based supply side funding by the Department of Health and the local government units, as well as the demand side through the National Health Insurance scheme. To increase efficiency of public funding, it is important to avoid overlaps among the different funding streams, ensure complementary and engage more strategic purchasing of health services.

Who is best placed to pay for what kind of cost? What mechanisms can help contain costs? What mechanisms can help drive quality and performance. Overall performance depends on how well the different parts work together. The European Union wants you achieve the set goal of health outcomes – that every Filipino will attain the best possible health outcomes with no disparity, that every Filipino will have the same access evidence based health care free from discrimination and without running the risk of financial hardship – no matter where they live, whether they are poor, member of an indigenous group, people who use drugs, men who have sexual relations with other men, people mental illness, disability and member of any other minority. We are confident that these points give us food for thought but at the same time, encourage us to continue the health reform cause in the Philippines.

Once again we want to express our congratulations for having made remarkable progress towards achieving universal health care. Looking ahead, continued investment in the national health insurance scheme will ensure that this vital instrument secures the health and well-being of every Filipino. We look forward to continue our good cooperation. We are cooperation as in the past, will live up to its commitment and will faithfully meet the challenges inherent towards the task of achieving Universal Health Care in the Philippines. Maraming salamat po."

INTRODUCTION TO PROF. KONRAD OBERMANN
(1:39:36-1:44:09)

By Prof. Nina T. Castillo-Carandang
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"At this point in time, we're going to shift. We're going to have some presentations here, two particular presentations. And there are sheets of paper which will be going around and ushers will be available to collect them. I doubt if we will have time time for an open forum but we

will still appreciate any questions or comments that you might have. We might not be able to discuss them in the forum, but of course you're more than welcome to discuss some with the speakers and of course, it will all be uploaded in the PhilHealth website. Ok.

So we shift gears and talked really about the journey towards Universal Health Care. Promoting and protecting health is essential to human welfare and sustain this very often. This was recognized more than 30 years ago through the Alma Ata Declaration. The Alma Ata reaffirms that health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right. And that attainment of the highest possible level of health is the most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

According to WHO, Universal Health Care or UHC means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need of sufficient quality to be effective, while also ensuring that the use of services does not expose the user to financial hardship. As such, the Philippines embarked on the challenge to achieve Universal Health Coverag, where everyone who gains access to healthcare will not be impoverished. In this context, universal health care would require PhilHealth to extend coverage to more people, offer guaranteed services, and pay a greater part of the cost from pooled funds.

This morning, we have two distinguished speakers who will talk about their insights on how countries, including our own, have moved towards achieving Universal Health Coverage, including the role and contribution of the Philippine Health Insurance Corporation towards the realization of this goal.

Let me introduce our first speaker. The first speaker will talk about achieving Universal Health Care in the Philippines, an international perspective. I had a chance to briefly meet him earlier this morning and he seems like a Filipino veteran. He's been here many times, and his name is Professor Konrad Obermann. He is a German medical doctor and an economist with more than 25 years work in clinical care, research, strategic planning and consulting. His focus is on international health economics, health system development, and health care financing, social health insurance, as well as empirical health systems. He has broad national and international consulting experience, in depth theoretical and practical knowledge on health systems and hospital care, health care financing, social protection and policy applications with more than 15-year experience international cooperation in non-European countries. His projects and teaching practice cover more than 20 countries in European, North Africa, Sub-Saharan Africa, Central, South and Southeast Asia. He is a senior lecturer at the MIPH Manheim Institute of Public Health, Heidelberg University. It is a great pride and pleasure to invite Prof. Konrad Obermann."

ACHIEVING UHC IN THE PHILIPPINES: AN INTERNATIONAL PERSPECTIVE
(1:44:40 – 2:12:04)

By Prof. Konrad Obermann, MD PhD

Senior Lecturer, MIPH
Mainheim Institute of Public Health, Heidelberg University

"Good morning everyone. It's a truly great pleasure being back here again and I'm very pleased to have the opportunity talking to you. So far the veteran indeed. When I have been asked by EPOS of the European Union to come and give some thoughts on international perspective about PhilHealth's development, I was more than pleased and I tried to put together some ideas which might be stimulating, encouraging, to go deeper, to dig deeper and say where can we actually learn from other countries, what might be helpful and where can international experience help in developing PhilHealth's for making it even better.

These are the things I'd like to talk about. We don't have to talk about this, but we should talk about this. The cube sort of differentiated by say income level. So if you look at the cube, can I go back, this, just looks at the national average, right? It's everyone, including Asia, including the people on the streets, including the people from the northern part of Luzon right down to the very south of the country. But what you'd like to see really is the different areas, the different regions, the different socioeconomic status, and how do people feel with respect to being covered, having the services available and not having to fear financial problems due to access in healthcare. And this is something that many countries struggled to get good data, good information so policymakers have an idea what's going on here.

And I give you an example from Mexico, where you see, no need for the details really. You have 'seguro popular' sort of similar to the PhilHealth but you also have additional programs to cover specific services, for specific parts of the population and to what extent does it help to achieve UHC in specific population within the countries, within different regions, within different ethnicities and so on.

Before we go on criticising or commenting on PhilHealth, I would like to point the very many good things about PhilHealth. And it has been mentioned before just by my predecessor, pointing out that 92% of the population is covered now and it's really an impressive achievement here and you could see from the latest data a vast majority of the indigent population is also being covered. Also what we could see is income, so premium payments are rising, the assets are rising, what has been mentioned before by the acting CEO and president: sustainability, which I would think is strongly on track.

I am also pleased, I think John - yes there you are, it was a pleasure working with you - and that the Philippines is on track to actually use the rationale in defining the benefit package in the sense that you say right where the biggest issues here and in many countries people tend to forget psychiatric diseases, tend to forget you know drug abuse, alcohol abuse things like that which are simply not in focus and I think, looking at the real problems, the real burden of disease will really help to say, we are focusing on the efforts to those conditions, to those problems that really have the greatest impact on the whole of population and John has received a prestigious prize: the Roux Prize from the Institute of Health Metrics and Evaluation in Seattle for doing just like this and I think it's one of the first countries worldwide, if I say it correctly, where this concept has been applied saying, these are the

biggest issues we can measure them, now let's transform them to benefit package that tackles these problems.

I also like to point out the dialysis, it's an interesting case, if you visit the country, you see many dialysis centres well-equipped, excellent machines available for vast proportion of the population.

Now, what is not yet a full success story and that boils down to finances. If you look at this, number one, the GDP, it's moving forward towards the WHO 5%. It's an arbitrary figure but nevertheless it's there, it's 5% not quite yet at 4.7%. I think this is the latest. But probably more worrying is the stubbornly high level of out-of-pocket expenditures. It remains at about 50% and PhilHealth despite - oh no, I forgot my point… But nevertheless, you could see PhilHealth has moved forward but there is still that small proportion and the question is, to me, looking at this, from an external point of view, how to improve this proportion that PhilHealth covers, because at the end of the day what really matters is bringing the out-of-pocket down to some acceptable level however defined, 30-45% that would require a larger chunk being paid for by PhilHealth.

And if you want to achieve UHC equitably, you would have to ask, in the different regions, within the different income quintiles, probably within different ethnicities, how good is access? How good is quality? How good is coverage from financial hardships in these different regions, in these different income quintiles and for that, good data is required. Hardly any country has it and it would be most valuable to say 'right, let's look at region whatever, XIII and how are the different income quintiles covered with respect to these three aspects of universal healthcare'.

Who is affected? I'm just pointing out a few points here, household out-of-pocket expenditures 2/3 is you know, for medicines. Who are the people having to pay for the medicines? Having these problems that they cannot afford medicines, which should be included in the benefit package. This great story about cigarette excise tax going to health, still the question 'who pays? Who are the people paying the excise tax? And who is benefitting from it?'

A very nice paper by Lian Jumil Rivera, a National Anti-poverty Commission last year, 'Why Poor Mothers Fail to Enjoy PhilHealth's Benefits?' They don't know about it, they're afraid about it, you know excessing it, asking it, demanding their rights and it's still end up paying more than Php 2,000.00 despite having a PhilHealth card. So I think these are the things to really investigate and to see why is that happening and what could have been done about it.

Now, that was the initial presentation title 'learning from others' and I think that this is important but I would also like to voice a note of caution here because what works in one country doesn't necessarily work in a different country. So the very first question is, 'who is the peer group of the Philippines?' And if you look at it, we can be quite certain it's not Switzerland and it's not China right? For there is reason - due to level of wealth and income; due to sheer size of the country. So what I thought, it's a very initial phase, we'll look at countries with a GDP between $2,000 and $7,900 that's the lower and upper limit of middle income countries and a population which is just larger than 10 million because usually

countries with small population have many advantages when it comes to developing universal health coverage, if you can see this, you end up with 12 countries which might be considered a peer group for the Philippines. Some of which are your immediate neighbours, others are rather far away, up to Bolivia. But they all face similar problems in the sense in their sort of in similar situation with respect to national income per capita with respect to the size of the population they are looking at.

So if you look at this, there are in detail, in depth UHC studies available from The World Bank, it's the Universal Health Coverage Studies Series, the UNICO. And if you look at the countries, I'm just pointing out, there are 5 countries: Vietnam, Nigeria, Indonesia, Tunisia and Thailand were detailed studies are available with respect to how they're working towards UHC. Unfortunately, I did underline, it didn't come out here, there are some countries if you look at it that, oh it will come here, yes there we go, if you choose very simple measures to look at UHC say life expectancy, infant morality rate, maternal mortality rate and out-of-pocket in percent of total health expenditures, there are some countries who fair consistently better than the Philippines and that is Vietnam, Tunisia, Sri Lanka, Thailand and Malaysia and the question is 'what did they do?' 'how did they do it in details?'

I won't go into these details because I believe it doesn't make sense to point out specific items, it really requires going in-depth and say what happen, what was the historical pathway leading there. Just take Sri Lanka, they started with a hospital based coverage and hospital based insurance schemes - something you didn't do so because it's only partially applicable to this country. But nevertheless, those are the countries as a very first start to say. Wouldn't it make sense to look into more details here when working towards say lower out-of-pocket expenditures but at the same time trying to improve life expectancy, IMR and MMR.

Some experiences, you see here Thailand, it's by Leizel Lagrada, I don't whether she's here or probably not, and what you see interestingly enough, no need for the details, that the poorest quintiles actually improved with respect to catastrophic health expenditures from 5.6% to 2.3%. So that means the risk was lowered for the poorest quintile after introduction of the tie social health insurance scheme. But if you look at the richest quintile they also didn't improve but stay almost twice as high in, more than twice as high in the richest quintile. So the question what happened, why did the richest quintile not benefit as much. You could say 'well, they're rich it doesn't matter,' I don't share that because it's still catastrophic and you may want to inquire what as going on, why did that happen? It might have something to do with the quality of services and richer people say 'right, we're going to different countries and incur higher expenditures, so again that would be something an in depth analysis would be worth doing.'

Something I found very difficult if I just choose countries, it's here, it's India, China, Indonesia and the Philippines, and taking very rough measures and the same time saying, the process in China and India had negative effect, it's about decentralization because local government remains under fund. The question is 'what is the cause and what is the effect?' and a study like this I believe one has to be very careful to quickly identify this is the cause and this is the effect. Maybe there is something underlying which affected both. And it would be premature to argue that this worked in China, this worked in India, so this should work in Indonesia and

the Philippines. Countries with completely different geography, a tenth of the population, a different history on I think one has to be very careful drawing at such conclusions. And I have just mentioned here a few things that would need to be taken into account before you come up saying, 'right it worked here, so probably it will work on this field as well.'

That's a very nice quote from New Zealand from 2015, how the emphasis the reforms in New Zealand demonstrated an emphasis on developing international health economic theories to design a health system that can lead to major problems especially when local context, values, cost of change, and political factors are not adequately considered. These reforms cost New Zealand significant sums of money, distracted the sector's attention away from key issues, and have been shown to be detrimental to health outcomes. The reforms have left a legacy of a major aversion to significant organizational reform in the New Zealand health sector, and that is still evident today. And I think many countries I've been seeing and working in have a similar issue to say somebody comes in, has an idea how the world should work and they say it should in this country too and that they are trying to do it. And I think they often forget how important certain local values are and how relevant they become and I've just realised that when PhilHealth's choir sang the PhilHealth's, how shall I call it, anthem? It's great! I love it, it's fantastic. If you do that in Germany they would frown upon you saying, 'what? What are you doing here?' Right? It's a completely different attitude to these things, I'm not saying this is good or bad, it's just different, meaning to say if you do certain things it will be difficult to just take it to different country where different values exist.

So what does it mean or what could it mean for sharing experiences. I think it's more about mechanisms really, how things work instead of looking at specific programs. It's about a question of incentives, how can you astutely design incentives that might help people work towards certain goal. And we've just discussed it with colleagues, say the minute you use a certain indicator and transform it to a target, this indicator is no longer a good indicator because people will manipulate it. In order to achieve a target, in order to cash in any incentives that come with it, the question also is how do you pass on wisdom, how do you make sure that people will say right, we've talked about it, we've learned about it, how do you bring together these experts that will work with other experts in improving outcomes. And it's not about blaming or shaming, it's about saying why did it work or rather why did it not work? What was it, how can we prevent from falling to the same trap here? Also, Popper said science is about falsification, it's about you know, you see something how the world should work and then you work and try to falsify it. A lot of people want to verify it, they want to say I want proof that my thoughts on the world are correct and that's very very dangerous.

And finally the question of contextual differences, different histories to it and why certain things will probably not work on specific country because of historical pathways. Chapter 4 so to speak is about measurement. You may have heard he UN Data Revolution is in it's full swing. It's a big topic. I'm working on the EU project right now, exactly about social protection and data, and the question is, 'how can we make sure that data for development is available?' One of things that have been brought up by WHO are the core health indicators and there is the Southeast Asia region version where you can see all the data compared with your peer group. And I think I would really like to quote this, it's Lord Kelvin the famous British physicist, you know the Kelvin measurement, 'what cannot be measured, cannot be improved.'

You know, if you don't have any feeling where we are right now and are we moving towards some specified goal, it remains the level of yeah, felt temperature, sounds lukewarm, feels lukewarm, we don't know whether it's getting hotter or colder and of course you know, the smart thing on identifying the right indicators.

Look at this, there is the health, the system for health versus the burden of disease. The Philippines is on, no, let's take the right column, the total DALYS: Disability Adjusted Life Years. Composite measure of the burden of disease in the country. The Philippines ranks number 14 worldwide, right? In total DALYS, avoidable premature mortality and morbidity. What you can see is if you look at the left column? The Philippines is only on rank 25 when it comes to the level of development assistance in health, so the question how come? Why is that the case? What is the rationale that some countries fair substantially back to us sort of everybody's starving, you know, places people want to go and why do some countries do not fair as well? And it's something that shows to say, right, do we need more? Do we need a different kind of development assistance here? What is it? But you need data in order to make your point and to convince people, policy makers to make a change.

So some suggestions, as I said from the external perspective for PhilHealth. And the number one is PhilHealth is in a web of responsibilities, of different institutional connections and what could be a role for the corporation and things PhilHealth might be able to change and probably is restricted in other areas and where will be difficult to move forward without having, without keeping in mind the many intricacies of this complicated web. One thing and John and I worked on this, you may remember this slide John, it's for example, providing medicines to local government units and one of the thoughts we had here is to say 'can we use technology so that PhilHealth provides medicines on consignment on the RHU level?' and you check it from the regional level that the doctors provide the medicines, prescribe medicines, give it out and then you can regularly check whether these medicines have been used, for whom they have been used for, and that PhilHealth could restack these medicines. We're not going in to the details here, no need. I just wanted to point out that technology is there, there's a high level of interest, I suppose, there's a high level of technological savvy in this country that would allow for doing something this. And the question is 'is there a chance to try it out, some sort of pilot?'

If you look at data and structures, something that has been mentioned before by the acting president and CEO, can you have a complete set of data, of indicators looking at inputs, and processes, outputs, outcome impact? Where do you get the data from? And he mentioned it before, from different sources so that you have a full and almost complete picture of what is going on with respect to inputs and processes. What comes out at different levels in the different regions, and what is the impact really in terms of health outcomes, risk protection and responsiveness and efficacy. And I think something like that, we say we have a complete and coherent approach to this, would help in moving this issue forward.

Last slide from my side, I think a very important issue is working at the margins, to say, this is how our goal and it has been clearly pointed out and there's a clear corporate developmental plan for the next 5 years. What are, where can we work on these margins, because you are in a

web of responsibilities, sometimes conflicting thoughts and ideas. Where can the corporation itself make a change to work towards these goals?

Secondly, I learned it once from Dr. Talion, the bibingka approach, so you apply heat from the top, heat from the bottom and I think that is true when it comes to data. You want data from the top and you want data from the bottom. You need data from the NGOS, from the field. You need data from the top, general data, reconcile and say get a complete picture of where you stand and where to move forward. How about institutionalising analysis and research? Why not have a Phileahealth research institute, looking specifically at issues concerning social health insurance, looking specifically at comparing different social health insurance initiatives worldwide say, special emphasis on low and middle income countries? I think that would be something really worthwhile having and for once it doesn't come from I don't know, Heidelberg, London School of Economics, you know that usual suspect. And something that is done here in Manila is for you, for those people who would like to share experience in a dialogue.

Identify key tasks at hand that has been mentioned before, balance billing, medicines, quality of care particularly in the rural areas. Good examples that might work, I've just learned while preparing the presentation there is the Palawan Access to Medicines Project which seems to work quite well. To say we can use it, can we scale it up for the whole of the country's?

One thing I'm worried about, people don't like to hear very often, but I'd like to mention, you know, everybody talks about rights. Everybody has rights, which is good, I'm missing the responsibility a bit, because somebody's right is somebody else's responsibility. You can't have all rights and nobody the responsibility to do so and I would like to, at least mention it, or emphasise it to say, there is a need to say to people, yes, you have rights, but there is also a need yes you have responsibilities if only to fill out forms correctly, if only to regularly update your information, or whatever there is to make PhilHealth able to function better and I think that's something, that could help to mention more often and more clearly.

I'm very, how should I put it, very reluctant about this, carrot and stick approach, about targets, about paying for performance, paying for results, call it what you like. The minute you introduce a target, the indicator will be medled with, as like in Soviet times, right? You fulfill it, somehow. You go to NHS, in England, they have the four-hour target time for accidents and emergency, they fulfill it. If only to opt map a room, shovel the people in there to say right, we clear the room. We fulfil the target. There's no point in doing this but they'll do, of course. Because otherwise you are punished. And people are very innovative in, how should I call it, creative bookkeeping.

And I think something that can be learned from the Philippines. This relentless IEC, Information and Education Campaign and I've mentioned a few, I'm not trying to pronounce it, because it might not end up well. But these things really will help, and I think a lot countries can learn from you in this respect. You have a thriving NGO, you know the public scene, where a lot of people are involved and I think that can be something that can be fully harnessed for the further development of PhilHealth. Right with this, I thank you and welcome for questions. Thank you very much.

INTRODUCTION TO MR. JOHN A. BASA
(2:12:52 to 2:14:21)

By Professor Nina Catillo-Carandang
Health Social Scientist and Assistant Department Chair
Department of Clinical Epidemiology
College of Medicine
University of the Philippines - Manila

"Now we go to a local superstar. If we have a German superstar, we also have a local superstar in PhilHealth. We have Mr. Ruben Basa to discuss the Journey to UHC.

He is a graduate of Political Science in Ateneo De Manila University and has a Masters Degree in Development Studies from De La Salle University. He is also involved in health finance with USAID from 1993 to 1995 as a health policy and legislative fellow. He also served in the Senate as a technical staff head of the committee on health and demography under the signing of Republic Act 7875.

He assumed various executive positions in PhilHealth since 1997 aside from serving as Head Executive Assistant for former Presidents and CEOs of PhilHealth. Currently, he's the Senior Vice President of Finance and Policy Sector in PhilHealth. It is my pleasure to welcome Mr. John A. Basa. By this time, John is already an old colleague."

THE PHILIPPINES' JOURNEY TOWARDS UHC
(2:14:13 to 2:29:13)

By Mr. Ruben John A. Basa
Senior Vice President for Health Finance Policy Sector, PhilHealth

"Thank you, Nina. Magandang umaga sa inyong lahat. I am tasked to present to you the journey of the PhilHealth Insurance Program so far. And as this presentation separates you from the first opening session before lunch, I want to start of with 'I Got A Feeling' song by Apl D Ap of the Black Eyed Peas playing.

I won't sing and I won't dance. That's the last thing that the people in PhilHealth would expect me to do. But I just want to quote that as a transition point, because actually when you hear the song, it's like it's just yesterday. Actually, it was in 2010 that the song made headlines and in that year, the song made history. And that's the point that I want to differentiate PhilHealth from 2010 to 2016. Hearing the song, it feels like it was just yesterday. But in terms of the song, so much has happened in the last 6 years. So, basically the theme for this morning, for this symposium, 'Bawat Filipino Protektado' is a truncation of our vision statement, 'Bawat Pilipino Miyembro, Bawat Miyembro Protektado.' And for the first part, I anchored my presentation on those first 2 components of our vision statement, 'Bawat Filipino Miyembro.'

Currently, all employed members of both private and public sectors are mandatorily covered by PhilHealth. There are now 29 million members and dependents from the employed sector. After this, there are about 1.6 million Overseas Filipino workers. Before deployment they have to be members of the National Health Insurance Program.

At the other end of the spectrum, there are about 46.5 million members from the indigent sector enrolled into the program. 46.5 million members, but it hasn't always been like that. It has not always been like that and if you could remember this is not my ECG. This is actually the graph of PhilHealth membership back from the years 2000 to 2010. And you could see, the crest and troughs of the bar graph, and these are the times that our former presidents are here. And these are the times of our indigent program where you heard the word, 'marketing.' You hear the words, we have programs like, 'Enroll one, get one' program. We have here, 'Enroll one quarter and you'll get locked in the next a year and 3 quarters.' This is the era when our indigent ID card had at least 2 pictures - one of each is the picture of the member.

But a lot has changed in the last 6 years and I am talking about here, of course, the enactment of the Sin Tax Law or the Republic Act 10351 which provided the funding for the National Health Insurance Program. This is very significant in that it is the first earmarking provision, the soft earmarking provision, provision for the health sector and a big portion of that goes to the enrollment in the NHIP. In 2010, the GAA provided only P5 billion for the enrollment of the indigents and this is the one in the financial statements because the actual remittance was only P2 Billion for the tier compared to the 37 billion for the PhilHealth indigent program in 2017.

With the windfall of contributions from the national government because of the Sin Tax revenues, we were able to triple the number of the indigents at twice the premium schedule. Prior to the Sin Tax, our premium for the indigents stood at P1,200 but we were able to double that premium to P2,400 and even triple our enrollment figure from 5.2 million to 15 million families to date. But that's not all, in addition to indigents, we were now able to cover all senior citizens in the country through Republic Act 10645. So, right now, we have 7.6 million covered senior citizens and add to that we have about 2.1 million lifetime members in the program.

So, you could see, if we are only covering about these numbers in the employed sector, and about these numbers in the indigent sector, and the senior citizen, and the lifetime members of the program, we are only talking about 10%-15% of the population who are not yet covered by the National Health Insurance Program. And for this year 2017 and for the first time as mentioned, the national government provided P3 billion additional in the GAA for the enrollment of those who are not yet covered by the program. So, all in all, for the first time, it is a windfall of P53 billion from the GAA for PhilHealth coverage in 2017.

Now, with at least a big chunk of the population that is already covered by PhilHealth, the issues of membership, enrollment, and coverage are almost always being addressed with. So, when it comes to, 'Bawat Filipino Miyembro,' the next part of our agenda will be ensuring the sustainability of the National Health Insurance Program. And two things come into focus: one is the enrollment for the premiums for the employed sector - we need to ensure that their

employers are paying the right premium contributions, paying for all of their employees, and paying for each month of the calendar year. Secondly, I think it's time that PhilHealt's programs must reconsider premium as an entry for enrollment – PhilHealth's premium is not just used because one is covered. We should start to consider that premiums as the gateway to benefits. We would only be able to increase our benefits if we have the right level of contributions and for the longest time, we only have 1 singular premium schedule for the indigents, which we did the same for the senior citizens. And I think it's about time that PhilHealth differentiate its premium contributions according to different classifications. Again, PhilHealth premiums as the gateway to benefits. So, that brings me to the second part of the presentation.

'Bawat Miyembro Protektado,' Conrad and the president earlier discussed several of the items that we need to address when it comes to addressing the benefits. When the year ended 2016, our financial statement would show that PhilHealth paid about P94 billion in benefit payments and this does not include the P6 billion in approvals. So, if you include the actual benefit payment and approvals, then we would have paid 100 billion in 2016. But, only 6 years before, when the year 2009 ended, PhilHealth paid P24 billion in benefit payment. So, it took PhilHealth 13 years, this is excluding the 1st 2 years from 1995 to 1997 because Philhealth only assumed Medicare functions in the 199. It took PhilHealth 13 years to pay P24 Billion in benefit payments and only 6 years to pay for the next P75-76 billion in benefit payments. So, what happened in those years?

So, let me just go through some alphabets of our benefit package for the last 4 years. Of course, we shifted from Fee-For-Service (FFS) to All Case Rates (ACR). Historically, from the time of Medicare, we were paying through fee-for-service. We shifted from the first 23 case rates in 2011, then we finally shifted to all case rates in 2014. Then we introduced the Z benefit forthe real catastrophic conditions and there you have the alphabet of KT, PD, MORPH, VSD, TOF, and CABG. About now, we have 15 Z-benefit packages, which pay as much as P600,000 per case.

And also, we launched together with the ACR and the Z, all indigents are entitled to NBB and expanded it from previous P300 per family to P500 per family. Despite this payment, we have quadrupled our benefits payments in the last 6 years. We still need to address high OOP because high numbers of Filipinos are still facing impoverishment in the face of catastrophic spending. Relatively low support values, there is a mismatch between what PhilHealth pays and what the evidence our Filipino, our members actually need. And members, this is just an observation, members still need to get hospitalized before they get reimbursements.

So, in the face of challenges in health is clear. And this is the direction that your PhilHealth is taking, in terms of addressing these concerns on benefits. We are working towards our benefits according to the burden of disease. We would want to have a benefit package, which corresponds to what our members actually need. And when we do this, we would want to ensure the No Balance Billing for certain accommodations and a maximum copay for all others. We would like to address health concerns in each life stage of the member's life and we would like to have a primary care package to prevent the major cause of hospitalizations - a big chunk of the PhilHealth reimbursements are actually for the causes that can actually be

addressed at an earlier stage. We want a health financing system that will promote and boost a referral system. Lastly, our PhilHealth benefits will be only as good as our provider we would want to have fair provider mechanism to our providers. So, these are very tall orders, hopefully, in the next sessions in the afternoon, we will be able to discuss them.

We are very hopeful that we fulfill our promise that by 2020, 'Kalusugan ng lahat sigurado.' And I am very optimistic and I'm sure that all of you are also very optimistic, that PhilHealth will be able to deliver such promise. After all, this is the institution that the CSC awarded with the most number of excellent offices, with 88. With the next government agency, not even pooling to the next 3 quarters of what PhilHealth achieved. I am confident that we will be able to do this because this is the same agency that in the last 4 years, has rated excellent in Social Weather Stations net satisfaction. This is net, not the gross satisfaction four consecutive years. And lastly, according to the Philippine Statistics Authority, PhilHeallth registers the highest growth in net account outpacing the government, the private in the face of social financing.

So, I'm very confident that for the next years, PhilHealth will be able to deliver the promise. Happy 22nd PhilHealth. Good morning!"

END OF THE MORNING SESSION
(2:29:20 to 2:38:47)

By Professor Nina Castillo-Carandang
Health Social Scientist and Assistant Department Chair
Department of Clinical Epidemiology
College of Medicine
University of the Philippines – Manila

"Thank you very much, John. Ipapahiram ko sa'yo 'yung sombrero ko kung naiilang ka diyan sa maganda mong ulo na makinang. I can't remember John with or without hair, but I can lend you my hat kung naiilang ka diyan.

So, he also gave us an excellent update on what the current status of PhilHealth is throughout the past years and the challenge goes on. Thank you very much for Professor Obbermann and John Basa. "

Program Intermission
(0:00-13:19)

By Ms. Gila Salvacion A. Diaz
Senior Manager
Standards and Monitoring Department
PhilHealth

"We would like to invite everybody to view the exhibit outside, which talks about the different components of Universal Health Care. Kasama rin po yan sa trivia quiz mamayang gabi. So

kung competitive po kayo, lumabas po kayo at tignan niyo ang exhibit. We'll start at 1:00 PM. Thank you.

Good afternoon. We're about to start the afternoon session. We would like to request the following to please proceed to the stage: Dr. Maria Ofelia Alcantara, Dr. John Wong, our board member, Anthony Leachon and Ms. Karen Villanueva, to please proceed again to the stage. Thank you.

Once again we would like the following to proceed to the stage: Dr. Maria Ofelia Alcantara, Dr. John Wong, Dr. Anthony Leachon and Ms. Karen Villanueva. Thank you."

INTRODUCTION OF THE AFTERNOON SESSIONS
(13:19 – 18:21)

By Prof. Nina T. Castillo-Carandang
Health Social Scientist and Assistant Department Chair
Department of Clinical Epidemiology
College of Medicine
University of the Philippines – Manila

"Magandang hapon po. Nabusog po ba kay - hindi? Ay walang sagot – siguro gutom pa. Nabusog daw si Dr. Quillamor. Eh yung iba – nabusog ba kayo? Sana naman diba? It's your 22nd anniversary so we hope that you actually had a good meal. Thank you very much. Can we ask everybody to come back?

This will be an action-packed afternoon so we want you to take your comfortable seats so we can have the best view of whatever presentations will be made. While we're preparing, I'd like to acknowledge the presence of the representatives from the PhilHealth's Employees Association - nasaan po sila? They are a very important part of our celebration - the PhilHealth Employees Association. And then, the presence of Dr. Menguita Padilla, who used to be former executive assistant, Dr. Menguita and the founding director of Sta. Lucia Bank Foundation.

Game na – hindi pa? Marami pa pong pabungi-bungi pa, 'asan na po sila?

So this afternoon we're going to have a lot of different presentations, looking at aspects of the universal health care cube. How many of you have seen our display at the lobby? Please check it out because it's a very informative exhibit and there's a cube na paikot-ikot doon. Nakita niyo yung cube - ang galling no? Umiikot siya mag-isa. Tignan niyo po yun para mas maappreciate 'yung presentation ngayong hapon.

So universal health care and universal health coverage is fundamentally about equity – all people are covered with needed health services – promotion, treatment, preventive, rehabilitative and palliative, and available at all levels of the health system. Universal health coverage ensures that all people obtain the health services that they need without suffering

financial hardship when paying for them. Hence, financial risk protection is an important component of UHC.

This afternoon's session will take a closer look at the UHC cube which is often represented in three dimensions: population coverage or breadth, package and extent of services provided or depth, and level of financial protection or proportion of costs covered or height. Discussions shall focus on the current reforms on the health sectors in improving access to quality health services, increasing recognition of shared responsibility among key players and having a holistic approach of integrating public financial management with health reforms. All of these are important as we move towards achieving universal health care. So that's an introduction for our afternoon sessions.

And I'd like to introduce the first panel: What and where? Defining the continuum of health care services and providers. It's with great pleasure that I introduce an old colleague also – parang lahat nalang old or more senior, ano bang tawag?

She graduated from the University of the Philippines College of Medicine and did her residency in Internal Medicine and specialization in Infectious Diseases at the Philippine General Hospital. She has a Masters of Science degree in Design Measurement and Evaluation from the McMaster University, Ontario, Canada. She used to be my Chairman in the Department of Clinical Epidemiology, UP College of Medicine. And my other Chairman, current Chairman, Dr. Marissa Alejandria is also there on the side, and they are both Infectious Disease specialists.

Dr. Edejer is the coordinator of the unit on Economic Analysis and Evaluation in the Department of Health Financing and Governance, World Health Organization in Geneva. She has led the unit for more than 15 years and has managed the core work of WHO on costing, cost-effective analysis, economic burden and until recently, health accounts and priority setting. The unit is now also in-charge health technology assessment and the global monitoring of universal health coverage for the Sustainable Development Goals.

Dr. Tessa Tan-Torres Edejer will moderate this afternoon's first session."

INTRODUCTION TO THE FIRST PANEL
(18:27-27:15)

By Dr. Tessa Tan-Torres Edejer
Coordinator, Unit Costs, Effectiveness, Expenditure and Priority Setting
World Health Organization

I think I'll try if from here. Good afternoon everybody. It's always a pleasure to be back here. Actually medyo mahirap kasi 'yung… Susundan ba ako ng ilaw? Oo nga, sinusundan ako ng ilaw. Anyways…

Let me try this. Mas maganda boses ko dito. So welcome to this first session. This is going to look at one dimension of the UHC cube and I just want to bring it closer – para mas malapit sa inyo. If you look at the UHC cube, in the axis on population, if you lined up all the 105

individuals or population in the Philippines, you would need to plot for each one – which interventions are they entitled and for which intervention, what financial protection do they have?

If you want to look at it, 'yung pinakita kanina ni, our first speaker from Germany, he showed the UHC cube from Mexico, and I think the other was… Okay. We can make our own cube, but here, we can talk about these 105 individuals and just lined them up, end to end, and for each one, define which inteverventions can they get and what co-payment do you have to give?

Think about it now. Think about you as an individual. Think about your lolo and lola, your children, your parents, and just line them up and you can make your own cube. And this brings it really this to you and you can feel what it means if it's universal health coverage – do they have access to the needed health services without suffering financial catastrophy. That is how to bring the cube really personal; start with yourself; start with your family; start with your organization and just bring it out.

So what are we describing here at this panel? We are going to look at the services covered and of course, the services covered will have to be provided by somebody. So we're also looking at how the services and where they will be provided. So here we're talking about the services and their provision.

Now I will introduce the speakers, although kulang pa tayo… I need my kodigo. I will introduce them all in one go so that we will have a smooth presentation and discussions.

So we'll start with the life stage approach. This is to be done by Dr. "Ofel" Alcantara. Her full name is Maria Ofelia Alcantara. She is a medical doctor with more than 20 years of experience in public health service.

I have known for her a long time. She has particular experience in PhilHealth. She was then the head Executive Assistant of then PhilHealth President and CEO, Dr. Duque. She is now a health policy specialist, engaged in several development partners and she is currently a consultant of the Office of the Secretary of Health. And she will be talking about the Life Stage Approach, in describing what are the benefits, which will be provided.

The second one is supposed to be Dr. Eric Tayag and I will describe him now. He is probably arriving very soon. You know he is a busy person. He is a physician with training in Infectious Diseases and Epidemiology. You probably know him as the "Dancing Doctor." He does not really need to be introduced.

He is currently the Assistant Secretary designated and concurrent Director for the Bureau Local Health Systems Development of the Department of Health. He will be arriving very soon. He will be talking about the providers and how they will be organized. So he will be talking about service delivery networks and how the Department of Health envisions their development.

Then we will have two speakers to talk about how the Essential Package of Benefits will be elaborated and the first speaker will be Dr. John Wong.

He has been mentioned already at the start. He recently was awarded a very prestigious prize, the 2016 Roux Prize by the Institute of Health Metrics and Evaluation. Actually, that is a real prestigious prize. My boss back then, Dr. Chris Murray, was the one who awarded and he has very high standards. So I should think we should be rightly proud for having him (Wong), helping us with determining the Benefit Prioritization procedural part of the package.

And then we will have Dr. Anthony Leachon. He is a known as an active leader in health reform advocate. He is very active in advocacy for health reform. He is also a former President Philippine College of Physicians, the country's premiere organization of Internal Medicine specialists. At the moment, he is an independent director of the Board of Directors of PhilHealth.

And finally, we have Ms. Karen Villanueva. She is a graduate of UP Diliman Business Administration Communication in Health Policy. She is a former member of the Board of Directors of PhilHealth and the Chair of its Benefit Committee. I think more importantly, her role here, she is an officer or the treasurer of the Philippine Alliance Patients' Organization and this PAPO represents at least 1 million patients nationwide.

I think this is very important to have her view here, especially because we have all doctors in this panel. So I think she will give a very different, and maybe a challenging perspective.

So we have the organization of this session is, we will have three 20 minute or preferably, less presentations, and one of the presentations of 20 minutes will be split between Dr. John Wong and Tony Leachon. And I was told that there is a timer so that we can have time for about 30 minutes of discussion to be led by Karen and then we can have – do you have pieces of paper where you can write questions? They will distribute or if it has not been distributed, you will get soon.

So the idea is to please ask questions on the inteventions that are part of the benefit package or how the benefit package will be elaborated, and also about service providers. And then the subsequent sessions will handle financial protection and population covered.

So let's start with Ofel."

LIFE STAGE APPROACH
(27:15-48:55)

By Dr. Maria Ofelia O. Alcantara
Health Policy Specialist
Department of Health

"Thank you Tessa. It's good to have you back, especially after that consultancy for the Department of Health.

Ladies and gentlemen, good afternoon, isang magandang hapon para sa ating lahat – magandang hapon po! Parang mahina diyan? Sige nga. Nakita ko si Doc Moti. Dito sa kabila? Tignan ko ang gitna.

I'm happy to be back as one of your resource persons. I remember in the last symposum I was your synthesizer so I'm also to have our team and colleague to be part of this activity.

So I was tasked last Friday, last week, they asked me to present itong Life Stage approach. I'm representing the department as part of the technical working group, who's working on this service package for Filipinos as part of the Guarantee One. So I'll zero in my discussion, my 15 minute discussion on the Life Stage approach for, as part of the Guarantee ONE in terms of what the department is doing at this point so that we can move so we can achieve the goals of the Philippine Health Agenda.

Ito yung hi-tech – asan yung pinipindot? Ah okay. Thank you, Gitchi. Saan ipopoint ito? Anywhere. Panalo! Okay…

So I'll start my first slide on what are the challenges and opportunities? Uhm… The first is one big issue right now is, "how do we protect and ensure that there is gatekeeping, especially at the primary care health care and level?" Because this will actually facilitate or help PhilHealth, who is the overall or the manager of the National Health Insurance Program, move forwards its goal of universal coverage. So that's one big challenge for ensuring that the people will have its services that they need.

The second is how the National Health Insurance Program will make a dent on what's happening right now? We know for a fact that most of the health indices have backslided. Breastfeeding, for example, is no longer 6 months or 4 months exclusive, but it's 2 ½ years. And not just the breastfeeding program, but also other national programs - to include immunization. So there are a lot of programs or health indices that have actually have backslided. And it's really important, in terms of, how will we organize the provision of these services - so that it could make a big dent to the Filipinos, especially among the poor?

The next challenge is, we have strived our best in the last years to achieve the millennium development goals. We know for a fact, that we have achieved some of them but there are still that are quite challenging. And it has also become part of the commitment of the country for the SDG.

So medyo global pinresent kong challenges but I would like to present the next is with these challenges of ensuring one services to the Filipinos, especially among the poor, and a local health system that is responsive and a national environment that is favoring early harvest of outcomes, I would say that this is a big opportunity for this administration that we have three guarantees - that's actually what this administration is working on - the Philippine Health Agenda.

And in that Philippine Health Agenda, the one major, major, in the last... if you can hear in the news, is that universal coverage. All Filipinos must be covered and it's like a mandatory order coming from the President himself, and of course, from the Secretary who is taking this tall order from the President. And with that universal coverage, one big opportunity for us is that we will universal national health insurance program. Meaning, we have high benefit delivery rates; people are protected; out of pocket is reduced among others. And with this, because we know for the fact that National Health Insurance program is very important in terms of sustaining the business of providing health care - the universal health care itself.

Okay, so what is now the effect and what is it that we desire of? From the end of the family, zeroing in 3 areas, from the family, tayo, most of them... Been going around and I'm happy to see our RBPs here, going around and meeting them, and one big issue that they're handling, not just in Philhealth, but also in the Department of Health, is that most of the families would like to go to tertiary facilities. Their reasoning, they want to make sure that they have the service because if they go the rural health units or rural health office, or the next level of care, ang iniisip nila baka wala doon - so might as well go to the highest provider of services, which is actually a very expensive move of our families.

With that, ito yung sinasabi palagi ni Secretary, siyempre, by going to the tertiary facility even with primary health care, nakapila sila. Queuing - kapag may queing, nakasimangot sila and ang feeling, "I am dissatisfied with the government." So what we wanted is to have the families profiled para alam natin kung ano ang needs nila. Then, they are mapped to a health facility and they are navigated to the needed services, to where the nearest provider of services of quality care and they are protected - protected meaning they have social health insurance or, they are protected from this catastrophic illness and catastrophic payments.

So what is now the effect and the desire within the local health system - because we are implementing in the provision of services in this local health system? As I mentioned, the poor gatekeeping. So even the cases that should be treated at the primary care level, they go up to the highest level. The second still problematic approach, we personally tend to say, we used to say, when we go down that this is the program that needs to be implemented at the facility or at the city-level. We forgot that the bottom-line is that the services for the family is not programmed. That's why the shift of the programmatic to systematic - not only that, but also the overlap of service delivery. Overlaps not only in terms of providing services but in terms of payment. So DOH pays the same, PhilHealth pays same, LGU pays the same, and all of us, family or individual, pays the same. There are instances that this case happens.

So we're here to organize our interventions in terms of not just a systematic approach, but also ensuring that we will lower the burden of catastrophic illness and catastrophic payment. So what we would like to have is a functioning, responsive and equitable local health system which is now a guaranteed service delivery network, serving as a framework for implementation in the local health system.

So third, what is now at the national level? So with this investment in the family and the local health system with the local government as our stewards, and our Department of Health providing the health stewardship, that the national which is now the four values: equity and

inclusiveness, efficiency and sustainability, quality and comprehensive, transparent and accountability. I will not discuss them individually but i would say these are now the 4 core values in which the Philippine Health Agenda will move towards to so we can achieve our primary health goals. In a nutshell, with this intervention of life stage approach as part of the service guarantees, we are hoping that we can achieve now the SDGs.

Let me proceed to my main topic of guarantee ONE - all life stages and the triple burden of disease. But I'll zero in the life stage because this is the one requested of us to present.

The life course approach means that any individual – individual in that family, whoever is in that family, will be provided the services that is a mandatory service, regardless of life stage. So for example, if you're pregnant, as shown in the first life course, if you're pregnant, you deserve to have the mandatory services of prenatal care and the newborn will have the Unang Yakap or the newborn care package. Then going to the infant, there is immunization among others and continuing breastfeeding. As you move forward to become a child, to preschool then to school proper, you have the essential package, and then the most challenging group, the adolescent group. Then, we move to the adult men and women, and the elderly.

So these life stages have its services that is required or needed in this life course. And this life course that's why we call this the life stage approach. And the mandatory, the other burden is we don't stop from being well. We know for a fact that all of us will get sick, so now the Philippine Health Agenda will be part of the Guarantee ONE, so that the triple burden of disease will be reduced from communicable, non-communicable, including malnutrition and disease of rapid urbanization and industrialization.

So I just want to show this slide to illustrate what the family and the client needs. So the first column is about the life stages and the mandatory services that are being required. Parang non-negotiable ito - kailangan ma-receive ng ating mga clients or Filipinos, regardless of what stages they are. Now if they get sick while in the well part, we will not stop. So that's why we have that triple burden of disease infectious, non-communicable and environment. I put there the environment but that's actually urbanization, industrialization and globalization. That's when you provide direct services.

So now what is the importance of going to life approach or life stage? These guarantees will facilitate that the services that our families need will be there where it is needed and it's near to where they are. And they should also have a quality provider that provides the services.

The first discussion is how do we include this life stages or life care packages? First in the discussion is the criteria to being included or excluded as part of the primary or the basic health packages. One it should have existing DOH policies, which means importante 'yan dahil may policy siya at this point. Next, there is a clinical practice guideline and of course, our experts give their opinion – these are the most important: services that need to be included at this point. And of course, we need to prioritize what are the cost-effective interventions. The cost is not just about money. The cost is about how we can have early harvest of health outcomes. And then for identification of what the medical necessities or the common disease conditions, we identify the high burden of conditions which actually become catastrophic, not

just in terms of illness but in terms of payment. And then the most common complaint and conditions that need to be addressed by us, providers.

This is an example or the basic principle I may say in the primary health care guarantees. So you have the first column, the life stage. Now we need to determine that intervention is population-based services or individual-based services. In the individual, there are two: one is when you are well and second, when you get sick. So this is very important because these services will trigger the next question of how much is the cost of that service. And then the next question is, if we now have the cost, who will pay the service? Very important.

This life stage from pregnancy to elderly, like the population-based services, include delivery to populations such as… Ito 'yung basic surveillance and monitoring, prevention and control of epidemic, environment and occupational protection, and quality protection and accessibility. It's like the systems that is being provided to ensure the services. In the individual this now for the well – ano ba yung clinical na dapat makita: physical exam or requirement – laboratory and diagnostics, anong kailangan na gamot or vaccines, for example. Then when you get sick again, we look at the clinical requirement – what is the diagnostic requirement and then the third, what is the drug and the other commodities that is being required to manage your illness.

An example, we have a listing already, so far... we have a draft of I think 13, but I'll give an example of a pregnant woman, what is population and what is individual. Population meaning surveillance - we have pregnancy tracking. For the prevention, we will integrate control during epidemics, integrate vector control management among others, and high communication strategies to include the mothers. Sa pagdating naman sa well, is history and physical exam. That's why we have the Tsekap as part of the first basic services that should be provided to all Filipinos, especially among the poor: referral and nutritional assessment, laboratory for example; the diagnostics - ultrasound, pregnancy test, pap smear or the basic CBC and FBS, or urinalysis; drugs and commodities to include ferrous sulfate and calcium. These are the mandatory requirement for a pregnant woman so that the pregnant continue to be well. But if the pregnant becomes sick, we have to look again at the clinical signs and symptoms, the laboratories and treatments, and how other conditions that actually affects all that pregnant women gets sick.

So a work in progress is reporting to the body or team health financing group and stakeholders of health financing. The guidelines for the institutionalization of primary health care guarantees to all Filipinos: we must define the guarantee, the mechanism for prioritization and then define what is the payment mechanism. So in defining the guarantee of primary health care intervention that we need, we need to look at: magnitude, severity and equity, efficiency, cost effectiveness, and safety - safe ba 'yan, entirety of continuing care, kasama ba siya, legacy, household financial impact especially Filipino families and of course, social acceptability

Then paano naman natin marereview at mapriprioritize? The plan is to have this health guarantee governing board. So right now, we're moving the existing group to the councils to be. The reporting or the mechanism with which the discussed concerns will be delivered,

they'll be given to the health guarantee governing board. These are the councils like the formulary executive council and the national health among others.

Let me proceed ang crucial ngayon, that's why we're here - for us to determine, sino ngayon ang magbabayad? I think in my 3rd slide - we asked who is going to pay what because we have duplication of who's paying. 'Pag population-level intervention, DOH at LGU 'yan. 'Yan ang projection in the next ilang years 'yan, by 2022. Pero individual-level interventions, ang proposal is to have PhilHealth as a single payer for this. Nakatingin si Poch parang… Haha.

I think that's my last slide pero let me synthesize quickly. I have one minute. The basic package, bottom line, is for Filipinos. And the bottom line for catastrophic illnesses and catastrophic payments are the Filipino poor families. And so that's why all of us stakeholders that provide technical assistance like the Department of Health as health stewards and the local government need to ensure the operationalization of the providing of services. We need to work together so that this Guarantee ONE we are sure that we'll be protected. Thank you very much."

INTRODUCTION OF DR. ERIC TAYAG
(49:06 – 49:13)

By Dr. Tessa Tan-Torres Edejer
Coordinator, Unit Costs, Effectiveness, Expenditure and Priority Setting
World Health Organization

"Thank you very much, Ofel. Now we'll have Dr. Eric Tayag. Welcome Eric."

SERVICE DELIVERY NETWORKS
(49:13 - 1:07:03)

By Dr. Enrique Tayag
Director IV, Bureau of Local Health Systems Development
Department of Health

"Good afternoon everyone. Can I just request the one on the technical booth, when I say next slide please that's when you… Thank you.

First of all I would like to thank PhilHealth and congratulate PhilHealth on its 22nd year. How about a round of applause for PhilHealth. And this is our contribution to the PhilHealth's journey towards all for health, towards health for all. My topic is about service delivery networks. Next slide please.

We are redefining service delivery networks this afternoon. We came up with redefining service delivery networks after 13 months of consultations all over the country from different stakeholders. The secretary is about to sign the new issuance redefining service delivery networks. This is a preview of that issuance. Next slide please.

What are the some of the legal mandates for the service delivery network? Well it places its origin more than 25 years ago, when the local government code was passed. Those who have been working longer in public service would recall that the creation of those synced systems or interlocal zones was one of the default set-ups so that the local governments will be able to provide servicers and services.

Now two laws, the Sin Tax Law and the RPRH Law, also mentions about service delivery network so that in 2014, two Department of Health issuances were shared to those who needed to establish service delivery networks. And the latest one we have is an Administrative Order, last year, which defines these service delivery networks under the Philippine Health Agenda Framework. Ladies and gentleman, the service delivery networks that I'm going to present to you has morphed from the scenes from the issuances from 2014. It's still a work in progress but this is now the final framework as it is, based on our various consultations. Next please.
Aspirations. Ang bawat Pilipino ay may karapatan at kakayahan na manatiling malakas at malusog. Mapaglingkuran na may respeto at dignidad sa lahat ng pagamutan. Mabigyan na angkop na serbisyong kalusugan na hindi maglulugmok sa kanya, sa lalo pang kahirapan o 'paghihirap. How about a round of applause? Well it's my responsibility to excite you.

The Philippine Health Agenda three guarantees. The first one you've heard from the first speaker, Dra. Alcantara. It's about the services on the life course framework, the life stages and the triple burden of disease. The second guarantee is how, how do we provide the services? The guarantee is through service delivery networks. And how are we going to pay for it is the third guarantee. The rest of the speakers will deal on them. Next please.

Service delivery networks. Sisiguraduhin ng pamahalaan na ang lahat ng Pilipino una na ang mahihirap ay makakatanggap ng angkop at may kalidad na serbisyong pangkalusugan sa anumang oras at antas ng pangangailangan. How about a round of applause again, please? More. Next slide please.

The main feature. The service delivery network now, as we're going to share with you is non-prescriptive. It is adaptive. Non-prescriptive; it is adaptable. Next slide please. We show you the rationale for why we came up with a non-prescriptive framework for the service delivery networks. Imagine this: the Department of Health through all these years have been invested in many vaccines so that children as early as their birth, will be protected. What's the vaccine coverage now - it's less than 70 percent. The Department of Health has in so many years, many resources and we thank the lawmakers from over 12 years ago. We only had 12 billion pesos so now it's over 150 billion pesos. What's the maternal death rate - 12 years ago, it's 14 women who die during childbirth per pregnancy, it's about the same today. What's wrong with the picture? In so many years, the salaries and benefits of health providers and caregivers have increased - we also thank the lawmakers. And what do we have - we still have absences; we have vacancies; we have no takers or caregivers in areas where services are most wanted.

The Philippine Health Agenda guarantees three things as I've mentioned earlier. What do we have - we are providing services, yes, but what happens? As soon as we find out that we don't

have the caregiver, we don't have the equipment, we lack infrastructure, we stop at our tracks to provide the services. The burden is shifted to patients - they will take care of themselves.

The service delivery networks that we are redefining is a network of organizations that provide or, please write these two important words, make arrangements, so it is making arrangements - it's not providing services. What do we mean? Say for example, a woman who is pregnant about to deliver goes to a health facility suddenly finds herself with this dilemma. There's no midwife. There's no ambulance to take her to the next level facility because she requires one. And even if she reaches the next facility, there's no room; there's no team of doctors that can give her the treatment she needed - the services she needed. Making arrangements is not only having a network. Ladies and gentlemen, the service delivery network is not about better health care - it's about better health. It's not about building hospitals. It's not about providing more caregivers. It's not about buying all the medicines. It's not making sure that everything is free. Nothing is free. It's about better health.
So we're talking about performance of the health system of the service delivery network. It's making arrangements. So in that situation if we go back, a mother who needs the next care level facility for a safe delivery, if making arrangements was the framework, then we would have the situation - when she comes, the ambulance is ready; when she comes, the next care level facility has been notified - there's a room, a team of caregivers on standby even her children who will be left home will be taken care of, the husband who's in the farm, they will get him and make sure he will be there when she delivers the new member of their family. Next please.

Therefore the issuances objectives. We just want to develop and enhance the operation and organization of current and future service delivery networks. Why? The assumption, ladies and gentlemen, is that there are already service delivery networks. This is not something that has to be created still. There may be models. There may be networks that are struggling but there are already service delivery networks and thus, we tell you that is non-prescriptive.

And with the specific objectives as listed here, next please, and we have guiding principles. We're going to raise primary health care from health promotion, prevention, diagnosis and treatment, rehabilitation and even palliative care. There's equity. There's sensitivity for gender and culture issues, and it is people-driven. This is the very principle that tells us that is non-prescriptive. We are not going to have the list of what is and what are not available. We should listen to what are needed. And so therefore, it is people-driven. Next please.

The components of the network will include three big components. We start with the primary care service areas - these are made up of barangay station and the rest. Then there's the intermediate service facilities and then the apex hospital. We're not calling them end referral hospitals. Every time we call the end referral hospitals, they say this, we accept all patients, we cannot refuse and even dead patients should be accepted. That's the end referral hospital for you. So we're going to change that. So there is now a group of providers that will be aggregated into primary care services and then there's an intermediate service facility and apex hospitals. The primary care service areas will be the gatekeepers. They will navigate all individual seeking well and complicated cases in the network. Next please.

But how do we do this? Should we issue another memorandum telling everyone how we should do this? We have prepared this issuance because we are thinking of the possibility that we'll be having federal states or federalism. And so therefore, we want to mimic that situation. We have governing boards at different levels, we have a governing board at the regional level, another governing board at the provincial level, backed up by a management team. Next please

How do we finance this network? There will be multiple sources of funds and from our consensus there will be pooling of funds and PhilHealth has to consider other arrangements as well, from facility-based payments to network-based contracting by PhilHealth. Next please.

The functions of the SDN include but are not limited to the following, assessments will be made on the individual and population levels. There will be planning based on these assessments and services that are rational, that are cost effective will now be part of the services of these networks. Next please.

The functions of the SDN is not limited to referrals, health information system is one of them and monitoring performance is key. It's a key function of the SDN. It's about performance. Next please.

The entitlements of all of us Filipinos from these SDNs include information and education. We have to know what services are covered. We have to know if we have to pay for them, who foots the bill and if there's continuum of care. Ladies and gentlemen, this is non-prescriptive because a patient will not be seen as a disease or condition. A patient will not be seen as a PhilHealth member only. They will not be seen as a program - they will be seen as a whole. Next please.

Our messages: sa pamamagitan ng SDN, ang bawat Pilipino ay makakatamasa o matatamasa ang mabisa at organisadong ugnayan sa pagitan ng mga pasilidad pangkalusugan. Malinaw na daloy ng referral mula sa barangay hanggang sa malaking ospital ng rehiyon. No geographic batteries, ladies and gentlemen. Siguradong transportasyon at komunikasyon. Siguradong pagtanggap ng pasyente saang kang pasilidad pangkalusugan ayon sa antas ng kanyang pangangailangan. Responsibilidad ng bawat isa sa atin, sa bawat Pilipino, ang bawat Pilipino ay may responsibilidad na maging miyembro ng PhilHealth at alamin ang kanyang mga karapatan at ugnayan sa mga itinilaga na service delivery network. Next please.

The service delivery network framework has been shared to you. One, it's not non-prescriptive. Two, it's about performance; it's about the access and use according to needs. It's about quality services that results in benefits. It's about using resources, our scarce resources efficiently. And it's about allowing local governments to adapt, to learn and to grow. Maraming salamat po! Magandang hapon!"

BENEFIT PRIORITIZATION PROCESS
(1:07:24 - 1:16:40)

By Dr. John Wong
CEO, Epimetrics, Inc.

"Good afternoon. So I'm here to talk about the priority setting process of PhilHealth by which they would develop services, or identify the services for the packages. So this is a project we did for PhilHealth funded by Unicef. Among the recommendations would be that PhilHealth would develop a package of guaranteed health benefits based on high burden diseases and cost effective interventions. Second that they should have an explicit prioritization process using standardized set of criteria to identify which interventions and services to deliver or to include. And the third, PhilHealth should use a health technology assessment to guide coverage decision as required by law.

So we're all familiar with this. So the goal is to enlarge the PhilHealth box to fill up the cube. And one of the reasons, one of our diagnosis, as to why we have not able to achieve this – how benefits have been designed in the past? No standardized process, no explicit criteria, and no prescribed standards of care. And finally, case rates do not cover all of the hospital charges.

We're trying to address the two other dimensions of the cube – how to reduce out of pocket expenditures and how to provide more services – services that people actually need. So this has been how PhilHealth has been paying out over the past seven years, on the average about 8%. So we did a comparison between the highest burden of disease in the Philippines based on disability adjusted life years and what PhilHealth has been paying for.

So top 10 claims of PhilHealth represent 40% of all their payouts. There is some matching – lower respiratory infection in the burden list, is represented as pneumonia in the claim list. There's also stroke on both lists and preterm birth complications which represented as routine obstetric care, which is one of the best ways to prevent preterm birth complications. But aside from these three conditions, there's not much else that is similar between the list of high burden conditions and what PhilHealth is paying for. And this is the mismatch that we need to resolve.

So we've identified also some problems – priority setting processes were not explicit, there's unequal access and lack of transparency to the benefit development process, there are no prescribed standards of care, cost coverage is uncertain and there's insufficient focus on preventive clinical interventions and lack of delineation of who pays for what.

We made three recommendations and I'm going to go through each one of them briefly. Our first recommendations is to develop a guaranteed health benefit package based on the high burden diseases. So this is the analysis based on data from the Institute of Health Metrics and Evaluation, we've identified that out of 200 diseases, only for 48, already represent 80% of the DALYs of the Philippines. And this is the larger version of it.

So what this shows is that the 48 diseases – non-communicable diseases already represent a significant burden, followed by communicable, maternal and nutritional disease, and lastly by injuries. But in the top 10, only a few are infectious diseases – we one have one maternal

disorder and one that is injury related, but all the others are non-communicable. That's how PhilHealth and DOH should proceed.

So our second recommendation was that PhilHealth should have a explicit prioritization process and criteria to go with the process. So this is what we have recommended and I'll go into this in detail. The process of arriving to the prioritization process needs to be comprehensive, so we started up with the review of literature; we consulted a lot of stakeholders; there was a round table discussion with experts; and finally, validation and feedback from the stakeholders.

So the principles for the priority setting process are first, ethical soundness, inclusiveness and preferential required to the underserved, scientific rigor, transparency and accountability, efficiency, enforceability and availability of remedies and due process.

And then lastly, our last recommendation was PhilHealth should start to implement what was in their IRR – the corporation should use HTA in developing benefits, benefit packages and it should be a basis of inclusion and exclusion of services in these benefit packages. So HTA is not just cost effectiveness but it is a multi disciplinary tool that includes not just clinical effectiveness, but also ethics, budget impact, societal impact and safety.

In the short term that there are tools that WHO has that we can use, like WHO Choice and ONE Health tool, but in the long term, both DOH and PhilHealth have to develop the capacity to be able to do their own cost-effectiveness analysis and HTA. So these are just examples from the WHO Choice database – so for example, if we're able to do our own HTA we would be able to line up the different interventions in this manner and show for example that these are outcomes – as we go up, we are able to produce more health life years, these are caused as we move to the right, as we're spending more, the goal is to be able to fund more interventions on the left-upper corner – least costs but highest outcomes, and be able to chart a path where we're able to fund a set of interventions and as we have more money, fund additional interventions.

So these were our recommendations to PhilHealth and they have adapted all of these as policies. Thank you!"

BENEFIT PRIORITIZATION: PRIMARY CARE
(1:16:50 - 1:29:20)

By Hon. Anthony Leachon, M.D.
FPCP, FACP
Independent Director of PhilHealth
Representative of the Monetary Board)

"*Thank you very much. While they prepare the slides, let me give you a perspective of my presentation. After the presentation of my esteemed colleagues, my presentation will be on benefit prioritization based on primary care. Some disclosure, I'm an independent director of PhilHealth as represented as monetary board. My mandate is to protect public funds*

particularly from the Sin Tax Law. My leaning is basically towards basic health and primary care.

So this would be the flow of my presentation. I'd like to give you a snapshot of the Philippine health care. In the book of __ in 1995, perhaps that you should know that there is a crisis right now. We have a health human resource crisis right. Perhaps this is the reason why we have a coalition of experts in this particular ballroom. And how can PhilHealth add value to that particular problem? And the recommendation, in my humble view, is to establish a primary care system, perhaps mandated and legislated. Not mere advocacy but more of a blueprint or a template.

So where are we right now and strategically, basically 47% or about 50% of deaths among Filipinos are not attended by medical doctors or allied health care provider. The farther you are from Manila, the lower is the number of doctors and the number of infrastructures in the countryside. 50% of doctors are actually practicing in Manila.

This is Universal Health Care Law Republic Act 10606 that the government's mandate is basically to ensure that every Filipino should have the right and privilege for human resources, health facilities and health financing. So at PhilHealth 2022, all along, it's a catch 22 questions – whether you have the finance right now, whether you have the health facilities – but if you don't have human resources to man this basic resources and facilities, then I think Universal Healthcare would still be a failure or be a pipeline dream.

So the Philippine Health Care system is actually beset with three chronic problems. The first problem is a chronic healthcare workforce shortage. We're the number one exporter of nurses in the world. We're the number two exporter of doctors in the world, next to India – that's a billion population and we are only a 100 million people. So by default we are actually number one. We are a fragmented system characterized by 4-6 separate programs and driven by doctor initiatives, rather than the population needs. And this has hindered our progress because of the loss of harmony and integration. And the last one is basically our deepest problem, we are manned by local government units because of the devolution of funds. So that the Department of Health may actually not effective. If you are not well versed in your management and your engagement with the local government executives.

Now we have here the profession regulation commission, my mentor Dr. Noche. We have a problem in healthcare – we have 70,000 doctors right now but the ones employed in the government is actually a measly 3,000 doctors, 5,000 nurses and 17,000 midwives. So a total of about 2.3 health care worker per 10,000 when the ideal ratio should be 24 health care workers over 10,000 population.

So why are health care workers leaving? This is based on research, unemployment, underemployment, misemployment, unjust working condition particularly because of the appointments of the local government side. Why do healthcare workers stay despite these chronic problems? Basically of love of country – that's patriotism, and to be able to be with their families.

Now as mentioned, we have a triple burden of disease – non-communicable, infectious diseases, and lifestyle problems. But according Dr. John Wong, are the patients benefitting? And this is a one slide summary of the presentation of Dr. Wong: PhilHealth pays for the top conditions – pneumonia, hemodialysis because of the rising costs of diabetes and hypertension. There are 30 million hypertensives and 10 million diabetics. And 3 out of 10 Filipinos are actually overweight or obese. So we have an epidemic right now of non-communicable diseases. And then we have infections, and then we have caesarean sections and cataract surgeries. So this is the main problem right now – we have a mismatch on the burden of illness and what PhilHealth is paying right now.

So this is a study in 2003 that coverage is different from utilization. So before, the poorest would actually utilize 18% and the richest would utilize 33%. So after 10 years of intervention before the passage of the Sin Tax Law, we see the poorest utilizing only 33% and the richest and the middle class are using about 80%. But this particular administration of President Duterte will try to manage the out of pocket expenses because the poor are actually in a quandary or in a question – whether to be admitted because of the high cost outpatient expenses.

Now the passage of the Sin Tax Law on December 20 2012, which is RA10351, brought enormous amounts of money. But what are the health measures? The prevalence of smoking from 31% to 23%. This means 4 million less smokers. The drop is not from people who stop smoking but from people who avoid starting to smoke. At least 70,000 deaths were averted and the affected ones are basically related to the price – the vulnerable segment of the population, the poor, the rural folk and both extremes of life, the young and the very old.

But how about in financial revenue? Since 2012, because of the Sin Tax Law, you have right a trickling of the DOH budget. And the Sin Tax right now has contributed to the National helpers – 70 billion or 80% will go to Universal Health Care and 20% for drugs and of course, HPET or the public utilities.

So where do we want to go? Ideally a primary health care system. So we have a problem right now in the countryside where there is actually too little care, this is exemplified by Mr. Jose, a 42 year old male from Busuanga with high blood pressure, diabetes, tuberculosis. No consultations done; no medications at all; and here, you have Mrs. Rosete, a 50 year old female from Quezon City who went to a tertiary hospital. And the patient actually had diarrhea, referred to a gastro; a stroke referred to a neurologist; a high blood pressure, referred to a cardiologist; a diabetic, referred to an endocrinologist and a kidney problem referred to nephrologist; and then gout, this is what we call the Syndrome X; and of course pneumonia, referred to a pulmonologist. So basically we have a problem here of too little care, on the left side, and too much health care. So we have a discrepancy in the treatment of the countryside and of course, treatment in the urban side.

So the funds have increased but the services have deteriorated. And this is now the challenge for this administration, so we have inequity in human resources, financing now corrected because of the Sin Tax and the budget given the President – an additional 3 billion. Now we are suggesting that, perhaps, we need to expand the PhilHealth and the outpatient PhilHealth,

a primary package so that you can actually fund the workforce, fund the facilities and fund also the tests for this particular set of patients.

So primary care system will work like this – you have a first contact and a comprehensive care; you have a gatekeeper that will coordinate all of this laboratories, pharamacies, specialists and facilities; and at the principal point of care.

But how do we get there? So there are 5Rs and winding down to my last five slides. So there are 5Rs – to recruit, you have a threshold of 5 is to 1,000, retrain, not only in this age of specialization but perhaps a knowledge on primary care that specialists like surgeons will be able to see patients at the primary care setting, to retain, pave for outpatient care because people will only be paid because PhilHealth only pays inpatient but not so much on the outpatient side, to regulate, we have the regulatory bodies here, we need electronic records, the patients should be empowered as well, and the last is to reassess, so we need a scorecard so that we can actually evaluate the quality of care.

So in summary, the roadmap to primary care is to recruit, retrain, retain, regulate and reassess. So despite the rising budget and increasing tin the PhilHealth coverage, health in the country is still deteriorating. But the silver lining in the next 6 years as presented by Dr. Alcantara and Dr. Tayag, I think this will be accomplished. The deterioration has led to the shortage of the workforce, the health workers who stay, who want to serve the country – I think we need to inspire them. The government should take better care of those who care for our health because we think that primary care is vital in achieving genuine health care. Maraming salamat."

INTRODUCTION TO THE DISCUSSION
(1:29:37-1:31:25)

By Dr. Tessa Tan-Torres Edejer
Coordinator, Unit Costs, Effectiveness, Expenditure and Priority Setting
World Health Organization

"We'll start with the discussion now. Anong pakiramdam niyo – are you overwhelmed or are you still feeling ambitious? Hindi ko kayo makita kapag nakaupo. It's a series of four very well informed presentations.

How do you feel right now before we ask our patient representative to talk – anong pakiramdam niyo? How many of you are feeling hopeful – please raise your hands. How many of you are sort of feeling overwhelmed by, 'yung mga problema – wala?

Okay, so we're here – we have good start! ACHIEVE! R-R-R-R-R! Marami tayong dapat gawin. But at this point in time, as we are celebrating the 22nd anniversary, I think people are saying they still feel hopeful so let's hear from the patient's group first before we start a discussion among the panel members. Kayo habang nagsasalita na si Karen, please write down your questions but limit it to questions about providers, questions about the package of services, and about how you develop that package of services. So pakibigay niyo lang yung mga tanong

niyo para makaabot sa amin dito. But now I'll ask Karen to please talk about what she heard from the patient's, representing the patients perspective."

DISCUSSION
(1:31:25 - 1:42:40)

Led by Ms. Karen Ida Villanueva
Philippine Alliance of Patients' Organizations

"Thanks Tess and good afternoon everyone. I've worked for 30 years in the private sector and had this stint in the government, the last of which was being a board member of PhilHealth. So I saw some of the very important reforms that we're talking about now. But now, from a patient group perspective. APO is the Philippine Alliance of Patient's Organization so we're the umbrella organization of patients group and we're aligned with the International alliance of patients in the organization. (Ms. Karen Ida Villanueva)

So we welcome all these developments. And I actually have a lot of questions about each of the presentations. (Ms. Karen Ida Villanueva)

First, I would like to ask about the life stage approach. We're envisioning a system wherein it's no longer vertical approach and programmatic approach. How do we envision the bureaucracy, particularly the Department of Health to go beyond these programs and align the work that they do towards this very ambitious approach. (Ms. Karen Ida Villanueva)

Thank you for this questions, Karen (Dr. Tessa Tan-Torres Edejer). I do but I can listen and proceed later, and also to give other members in the assembly who may have questions (Ms. Karen Ida Villanueva).

I think I would answer that in 3 levels. The national will work on setting the standards. And with the prioritization as one of the key factors to have what are the basic services in the life stages. So national will do its standards and policies. And second is, how this will be implemented, which is actually addressed by the SDN, which is not prescriptive bottomline, that the services becomes the third, are being provided or make arrangements at the facility, family, community-levels. 'Yun 'yung third but I'll pa the one but sustaining the standards to be implemented in an SDN is a very important intervention, which is who is paying what? And that becomes a big pie for the National Health Insurance. (Dr. Maria Ofelia O. Alcantara)

I can say that it is an overwhelming intervention or guarantee that may not be responded or attained. But at this point, in the process, we are not just discussing at the national, we involve the local government in the discussion to come up with what services should be part of that life stage approach services. (Dr. Maria Ofelia O. Alcantara)

In terms of timeline, how quickly are we going to roll out the packages, that's one; and how do we influence the behavior of the providers so that we get them to participate in the service delivery network in a cost-effective and, because I have seen how, there's a lot of inefficiencies in the system, a lot of fraud as well, and the fact that we don't really take majority of the

health expenditures, how will government enforce that kind of behavior unless we spend more or regulate more? (Ms. Karen Ida Villanueva)

Maybe we can have Eric answer the questions (Dr. Tessa Tan-Torres Edejer).

Karen thank you so much. First of all, the service delivery network is non-prescriptive. There's already an assumption that they already exist and we are working on a scenario wherein we are gathering evidence through model service delivery networks. And we are confident that this service delivery network have pathways of how they can make sure that providers are encouraged and be part of the networks. (Dr. Enrique Tayag)

Now when we presented this to Secretary Ubial, she was repeating this important scenario wherein the private sector will have to have a big stake in the service delivery networks because they can fill in the gaps in the service delivery networks. Exactly how we're going to tackle the timeline, right now, the different regions have submitted to us model service deliery networks. We're going to have a registry of service delivery networks this year - yes, a registry of service delivery networks. Anyone can access it so you can navigate through the networks. We're going to have a monitoring and evaluation tool so that we can track the progress. We are looking at this year that up to 8-10% will have service delivery networks and it' going to happen. 8-10% of each region so for example, this year, because there are already existing models, they will have reconfigure the rate limiting step is actually the establishment or creation of governing boards. That's why our target is only up to 10%. (Dr. Enrique Tayag)

So we need to speak about this ng mga incentives sa private sector, I actually have a question from the audience. It's a long question but it's along that same line, which is… why it is that, PhilHealth has tried to do many things, including fast track payments of claims, increase the support value, simplify the payment mechanism, and they have tried to improve - the problem he is saying is that there is still a lot of out of pocket expenditures and so how can we, i think it's a very important question, how can we inculcate the hippocratic oath to medical professionals to encourage and practice medical and ethical standards. And he, I have to say this because this is personal plea, I hope we can do something about these concerns. If we can't address this meetings or symposium with the same or the similar or recycled concerns. (Dr. Tessa Tan-Torres Edejer)

This is a very heartfelt comment and one of the things that they're concerned is out of pocket expenditures and to a large extent, this person is putting, based on what he is suggesting, a question about why are the physicians charging… I don't know how you can describe this but their charges are causing a lot of out of pocket expenditures. (Dr. Tessa Tan-Torres Edejer)

In terms on the timeline, based on the Republic Act 10606, which will address human resources, health financing and public health. But I think it's not a dynamic picture because you don't have the process or the timeline. To me, the burning issues are basically on number one, human resources. Because even if you have PhilHealth and everything but you don't have people to man, that's a problem. Number two for PhilHealth, you have enormous amount of money but we cannot treat all types of diseases. You need to use here the Pareto principle,

John based on John Wong's analysis that you have to focus on certain illnesses, killing the most number of Filipinos. (Hon. Anthony Leachon, MD)

We need to reevaluate 10,000 case rates and trim it down to 250 or 100, and then identify the public health structures that will need immediate care. So to me, in terms of timeline, human resources, that should be solved in 1-2 years, out of pockets should be in the next 3 years, and the public health infrastructure should be solved within this administration. So you have to earmark certain money for this particular health structures. So in a nutshell, that is my suggestion. (Hon. Anthony Leachon, MD)

O sige, one minute, John can you say something about the prioritization process and what do you need to do in order to make sure it will be implemented in terms of this 20-80? What do you think is the most important thing to do considering that PhilHealth is now providing a lot of things and still have, described as having, different - pneunonia, hemodialysis, infections and cataracts, how do you shift from that PhilHealth to the PhilHealth which actually addresses the 80% of the burden of disease? (Dr. Tessa Tan-Torres Edejer)

I think the most important thing that they need to in which I think they have started to do is to start develop the benefit package for the 48 diseases. If they've identified the diseases, the process of identifying the interventions and the next steps will be costing it out and deciding on a provider payment method. (Dr. John Wong)

I think we have many more questions but we don't have the time. I'm sorry for those questions na hindi na nakarating dito but hopefully maaddress ng ibang panel. I would like to thank the panel but actually, I think as a very short summary…" (Dr. Tessa Tan-Torres Edejer)

SYNTHESIS
(1:42:40 - 1:44:28)

By Dr. Tessa Tan-Torres Edejer
Coordinator, Unit Costs, Effectiveness, Expenditure and Priority Setting
World Health Organization

"As a very short summary, I think at this point right now, PhilHealth has a lot of funding, has spent a lot already, but actually our gain in health is actually not that much, commensurate with the additional funding that we have received, and the out-of-pocket expenditures is still the same and we see inequities in terms of utilization. Okay?

So for those outcomes, I think we still have problems and we are not using our budget efficiently. We have heard the wonderful plans from this morning, as well as from our first two speakers, from Ofelia and Eric, about the SDN and the life cycle approach in providing benefits, but on the other hand, we have also heard about the problems with human resources, infrastructure and maybe the really need to prioritize to address this 80% of the burden of disease.

I think the wonderful thing we have right now, on this 22nd anniversary is we have the political will; we have the budget. And with the a very good Department of Health, and all the people here, and all your hopeful ambitions, i think we will be to do something as early as 2022 or even earlier, BUT… it requires focus. It requires that we prioritize, and it really requires focus on implementation. Magaling tayo magplano, halina, ano ba yung dati - pwede pa bang sabihin yun? Let's DOH it! Okay, so it's just implementation. We know what we want to do. Thank you to all."

"*So meron po ba tayong mga tanong from the floor? We'll entertain one or two questions… So meron po ba?... So I think it was a long day."*

TRANSITION TO THE NEXT PANEL
(1:45:04 to 1: 51:28)

By Professor Nina Castillo-Carandang
Health Social Scientist and Assistant Department Chair
Department of Clinical Epidemiology
College of Medicine
University of the Philippines – Manila

"The question which was asked earlier was a very pointed one. What do we do to curb the costs of medical care, the costs of drugs, the costs of professional services? I don't know if we can address that this afternoon, but let's think about that because no matter what we do, except we actually address those basic costs, drugs, professional services then we still have a problem. Don't we? Thank you for that panel.

Some reminders. You are all given an evaluation sheet. And sabi ko, kaliwaan tayo, hindi kayo makakatanggap ng certificate of disappearance, kapag 'di kayo nagbigay ng evaluation form. I think that is but fair. Actually, sabi ko, dapat 'yung mga emergency kit, hindi dapat binigay until nagsubmit kayo ng evaluation sheet. So, please fill it up because we want to do a better job next time.

And another reminder, the presentations today will be uploaded in the PhilHealth website. There's actually a tab in the website where you can actually access, hopefully tomorrow afternoon, all the presentations will be up there, and probably recordings of today's presentations if you weren't able to join us today, and for the questions - a lot of questions which we are able to gather. We don't have time to address all of them, but all your questions will be collected and answers will be provided in the documentation, so just put the questions on your table, and we will ask our ushers and resource persons to respond to them. So, para doon sa mga nagbigay ng tanong, ay mayroon pa pong pagkakataon.

(Can we all just stand for a moment? We have obesity and overweight rate, so let us stand and stretch po kayo. Kaliwa kanan, taas pababa, as far as your knees can handle it. Sa mga nakakatanda kahit hanggang baywang lang.)

So, we are about to proceed to our next panel. Let me turn it over to Mr. Donald to call them on all stage."

Introduction by Sir Donald
PhilHealth Host

"Our next panel discussion will be answering the question, "who pays for what? Sharing the responsibility for financial risk protection." Our moderator for this panel discussion will be Dr. Beverly Lorraine Ho. May we call on her on stage. We would also like to call Ms. Raquel Dolores Sabenano, Dr. Elenila Jakosalem, Dr Soraya Pesy Abubakar to be represented by Ms. Michelle Libago, Ms. Ma. Gilda Resurreccion, NHA, and Dr. Alejandro Herrin."

Professor Nina Castillo-Carandang
Health Social Scientist and Assistant Department Chair
Department of Clinical Epidemiology
College of Medicine
University of the Philippines – Manila

"So, magandang hapon po muli. It is with great pleasure that we introduce our moderator for the next session. The second panel discussion is how much & who pays and sharing the responsibility for financial risk protection.

The panel moderator for the second session is Dr. Beverly Lorraine Ho. She is a graduate of UP College of Medicine, with a degree of Masters in Public Health, HealthCare Policy and Management in the Harvard School of Public Health. She was an Executive Assistant of PhilHealth's to then President/COO Dr. Banzon, and soon after a Public Health Consultant of the Asian Development Bank and a Faculty of Ateneo Loyola Schools. Beverly is one of the younger colleagues and my student before. In fact, I had her in my healthcare policy class last Friday as a resource person for the Department of Health."

INTRODUCTION TO THE SECOND PANEL

By Dr. Beverly Lorraine Ho
Chief, Research Division
Health Policy Development and Planning Bureau
Department of Health

"Thanks, ma'am Nina. Good afternoon, everyone. So, in this discussion, we will try to look at the level of financial protection that the Filipinos are currently experiencing. As we talk about the 3rd dimension of the UHC cube we will be tackling about cost coverage.

Basically, we are saying how much is the cost of healthcare that is being borne by the patient or the families and whether it leads them to being poor or to them staying poor. To help us answer these questions, we have here our panel to discuss this for us.

Our first speaker is Ms. Raquel Dolores Sabenano. She is from the Philippine Statistics Authority. She finished her BS Applied Statistics and completed her academic requirements leading to her MS Applied Statistics. She also earned her Masters degree in Development Management and is currently the lead technical specialist in the compilation of The Philippine National Health Accounts at the Philippine Statistics Authority. A round of applause please for Ms. Sabenano.

Our next speaker is Dr. Elenila Jakosalem, Chief of Hospital at Bislig District Hospital, Surigao Del Sur. She is a graduate of Cebu Doctors College of Medicine, has Masteral degree in Community Health and a Fellow of Philippine Medical Specialist. She is the Chief of Hospital at Bislig District Hospital for more than 2 decades now, and under her administration, the hospital has received numerous awards including a Presidential award in 2008 and Red Orchid award for 2 consecutive years. More importantly, Bislig District Hospital is considered excellent in implementing the NBB Policy and we'll hear from her later. Again (a round of applause).

Our next speaker is representing Dr. Soraya Abubakar. She is a Family Physician and a Dermatologist, yeah, from Zamboanga City Medical Center. Ms. Michelle Libago is representing her today. Ms. Michelle Libago graduated with Bachelor of Science in Management Accounting and Bachelor of Laws. She has been with Zamboanga City Medical Center for 12 years now where she is an administrative officer in the said hospital. A round of applause.

We will also be joined by our 2-esteemed discussants. First is, Ms. Gilda Resurreccion, familiar to all of us, a Faculty Member of Ateneo Graduate School of Business where she teaches Economics, Finance & Accounting. She also holds a Masters in Hospital Administration and at present, a consultant at the National Kidney Transplant Institute.

Finally but not the least, Dr. Alejandro or Alex Herrin, a professor of Economics. He is a professor at the Conrado Benitez Demographic and Economics at the UP School of Economics from 1978 until his retirement in 2004. He is currently the professorial lecturer in University of the Philippines – Diliman, School of Economics.

Without further ado, let's start the ball rollin' with our first presenter, Ma'am, take it away."

PHILIPPINE NATIONAL HEALTH ACCOUNTS
(1:54:53 to 2:13:29)

By Ms. Raquel Dolores Sabenano
Senior Statistical Specialist, Philippine Statistics Authority
Professor in Economics, University of the Philippines - Diliman

"A pleasant afternoon everyone. I'll be presenting the Philippine National Health Accounts, one of the products annually being released by the Philippine Statistics Authority. For the outline of my presentation, I will start with the introduction of the PNHA. Afterwards, I will

proceed to its conceptual framework then to its estimates. Lastly, I'll present to you the way forward that will include the recommendations.

The Gross Domestic Product (GDP) rate grew at 9.6% in 2014, which is higher than the growth rate of 9.3% in 2013. Among the three major economic sectors, services fostered the highest share with 57.4%, followed by industry with 31.3% and agriculture, hunting, forestry and fishing came last with 11.3% in 2014. As you can see in the slide, of 57.4% expenditure, the service sector having the highest expenditure, 4.6% of it came from the PNHA.

The next topic is the conceptual framework. On the screen, you can see the schematic diagram of the PNHA conceptual framework. The conceptual framework shown come as simple and straight-forward as the Philippine's total health expenditure is simply the sum of the aggregate expenditures on health care goods and aggregate expenditures on health care services.

But, the question is who is paying for health care? The sources of funds are persons or institutions that directly pay the health care providers or the final payer. So, under the government: there are national, local, and government owned and controlled corporations or GOCCs. In the social insurance: there are the national health insurance program or Philhealth and the employees' compensation. And the third is the private sources, which are the out-of-pocket, ito po 'yung nanggagaling sa ating bulsa - they are the private insurance, Health Maintenance Organizations or the HMOs, private establishments and private schools. Lastly, the source is the rest of the world.

The uses of funds are divided into 3 categories. First is personal health care that is the government hospitals, private hospitals, other professional care facilities, dental care facilities, and traditional health care. Next, is public health care, which includes expenditures from the Department of Health programs for the production or the provisions of both health care goods and services with economic externalities that are characterized as public goods. Examples of these are the government programs are the breastfeeding check, 4S laban sa Dengue, Zika virus, STOP HIV/AIDS, and Oplan Iwas Paputok. And the last on the uses of the funds is others, which is the general administration, operating costs, and research and training

In the next slides, the questions will be answered. So, what's the PNHA telling us? Are we on track on achieving our targets? What is the way forward for us?

The country's total health expenditure showed improvement between 2013 and 2014. It increased by 10.4%, from Php 530 Billion to Php 585 Billion, respectively. At constant 2006 prices, total health expenditures rose by 6%. The per capita health expenditure in the country rose by 8.5%, from Php 5,400 in 2013 to Php 5, 859 in 2014. On the other hand, per capita health expenditure increased by 4.2%, at constant 2006 prices.

The distribution of health expenditure can be computed by this illustration - assuming that one has Php 100 as total health expenditure, this amount will be divided as follows: for the private sources - Php 68, for the government – Php 17, for the social insurance - Php 14, and

for the rest of the world - Php 1. One can take note that under the private sources, the out-of-pocket has the highest share with Php 56 compared to the other private sources, which is only Php 12.

In this illustration, it only shows that Pinoy households continue to bear the heaviest burden for spending for their own health needs as they still contribute with high out-of-pocket payments accounted for 56% of the Total Health Expenditures in 2014.

Out-of-pocket (OOP) spending is continuously rising over a 10-year period. The OOP group increased from Php 115 Billion in 2005 to Php 327 Billion in 2014. This is an average annual increase of 12.40% at current prices. However, OOP as percentage of the Total Health Expenditures did not fluctuate much overtime. There were only slight movements with the share of OOP health expenditures and other type of healthcare in the Total Health Expenditures from 2005 to 2014. The share of OOP health expenditures range from 52%-58%, while the other types of healthcare comprise 42%-48% of the Total Health Expenditures. Close to ½ of OOP spending goes to pharmaceutical products, or we can say that ¼ of T.H.E. is consumed in drugs or medicines.

To simplify, a person spends ¼ of his income in drugs and medicines alone. Please take note that this is not part of the PNHA Statistics, for illustration purposes, OOP health spending was sourced in 2012's family health income survey to get a clearer picture or show more disaggregated statistics. Furthermore, a 2014 poverty indicator survey was not utilized since it will not give detailed disaggregation.

With the given illustration in the presentation, it shows that the lower quintile households have the least share in total health spending. Income is positively associated with most household expenditures, this means the higher the household income, the greater the peso amount is spent on goods and services. For this slide, the first slide, shows the lowest earning 20% of the household. Likewise, the fifth slide shows the highest 20% of the household. In this case, the household was divided into 5. As income rose, the total amount spent on healthcare increase, from Php 13 Billion or 4% in the household of the lowest income quintile to Php 179 Billion or 55% for those in the highest quintile.

Are we on track on achieving our targets? Based on the 2010 to 2020 healthcare financing strategy, 3 out of 8 healthcare financing indicators surpassed the respected targets, namely: (1) Total Health Expenditures as percentage of GDP with 4.6%, which is slightly higher with the 4.5% target, (2) the national government spending as percentage of the Total Health Expenditures is 10.6% compared to the 10% target and (3) the national government spending for public health is at 21.6% which is more than twice the 10% target.

Out-of-pocket spending and social insurance as percentage of the Total Health Expenditures consistently missed the target. Over the years, it is clear that OOP as percentage of the THE has been missed around 7% to 13% for the last 10 years while Social insurance is below the target which is between 5% to 12% with the lowest gap of 5% in 2015.

The Philippine Statistical Development Program or we called as PSDP is a mechanism for setting the direction and trust of strategies of the Philippine Statistical System and for defining the priorities of statistical development programs and activities to be undertaken in the medium term. It also addresses the data requirement of the PDP or the Philippine Development Plan of NEDA and other sectoral development plans.

In chapter 17 of the Health and Nutrition statistics, the following programs are listed: (1) enhancement of the statistical framework on health and nutrition, which is to review the statistical framework of the benefit package of the social insurance program specifically on support value, (2) improvement and compilation of the PNHA, which is the conduct of special surveys to update estimation parameters and generation of more disaggregated information on OOP health expenditures, and (3) regular conduct of training and other capacity building programs for data producers in the compilation, analysis, and utilization of health and nutrition statistics such as the System of Health Accounts 2011 or the SHA.

In keeping with the National Statistician's vision to be solid and responsive, the Philippine Statistics Authority will continuously come up with relevant products and services that will support the national development, as well as international competitiveness. Specifically, in the health sector, PSA will work towards adapting the SHA 2011, which is the current international standards for health accounting, as the framework of PNHA. This will provide detailed information needs by giving more expenditure breakdown by financing agent, health financing schemes, health care functions, health provider, by region, age group, sex, disease group and income quintile.

As of now, there are ongoing trainings that PSA is conducting with DOH, PhilHealth, WHO consultants as trainers, and it will end by March 9, 2017. So, the next activities are the adaptation and institutionalization using the SHA. The proposed release of PNHA SHA and the 2016 preliminary NHA, using the PNHA, will be released in December 2017 based on the new methodology. So, kung dati pong naglalabas ang PSA ng 1 table, this time po, maglalabas po ang PSA ng more disaggregated tables, we will come up with 11 tables.

Based on the PSA, the following recommendations may be undertaken by PhilHealth in achieving universal health coverage. First is to strengthen the advocacy and intensify the information campaign about PhilHealth coverage and its various programs especially among the low-income families. Second is to monitor proper implementation of policies related to lower prices of pharmaceutical products. Third is to ensure that the government health care services reach the poor and the disadvantaged. And fourth is to consider the periodic review of PhilHealth benefit packages to identify possible improvements that can be implemented and ensure its relevance and usefulness.

The out-of-pocket spending of the lower income quintile should be minimized by providing extensive information dissemination. To improve utilization of medicines, nationalization in identifying beneficiaries, particularly the outpatient benefit packages, is needed. Covering out-patient medicines may also prevent in-patient visits and decrease the OOP health expenditures on pharmaceutical products. The current benefit packages are limited to certain

group of the population. Thus, to reduce the household OOP expenditures, the government needs to further expand the benefits to cover the whole population.

So, in slide 16, concerning quintile, more than 50% of the total out-of-pocket expenses are in the upper quintile which means more people, not only the poor, would need help to bring down the OOP expenditures. So, let me borrow this slogan ACHIEVE. Yes, we are looking forward on achieving Bawat Filipino Protektado, ALL for HEALTH, HEALTH FOR ALL. Thank you and mabuhay ang bawat Pilipino."

INTRODUCTION TO DR. ELENILA JAKOSALEM

By Dr. Beverly Lorraine Ho.
Chief, Research Division
Health Policy Development and Planning Bureau
Department of Health

"Thank you for that macro picture you've provided for us. We see that the increases in Total Health Expenditures is largely driven by increases in Out-of-Pocket spending and this is largely consumption of the rich. And then maybe, a more important and a happier point is that maybe after a long time of Philhealth's share of the Total Health Expenditure has been sleeping at 9%, it's finally up to about 14%. So, it probably tells us that reforms maybe really impacting the system.

But, this is the macro picture, we still need to hear from our next 2 speakers about how patients are experiencing these reforms in the hospital. First is we have Ma'am Elenila."

IMPLEMENTATION OF NO BALANCE BILLING (NBB) POLICY BY A LGU-OWNED HOSPITAL
(2:13:37 to 2:25:58)

By Dr. Elenila I. Jakosalem
Chief Hospital, Bislig District Hospital

"Ladies and gentlemen. It is a great pleasure to be here and be part of the 22nd PhilHealth Anniversary. Thank you for inviting me to speak with you about our No Balance Billing policy at Bislig District Hospital which is a Local Government Unit – Owned hospital which is located at Surigao Del Sur, CARAGA region.

To better appreciate my presentation, let me start with a brief description about our hospital. The Bislig District Hospital is a 50-bed capacity health facility and the only government hospital in the locality located at Bislig City. It is classified as level 1 category based on the new classification of the Department of Health. Its funding support comes from the provincial government of Surigao Del Sur by virtue of its devolution from the national government in 1993.

It has 2 catchment areas, which includes Bislig City composing of 24 barangays with a 91,400 population, and the municipality of Lingig comprising 18 barangays with a population of 33,403. The total catchment areas have a total of 42 barangays and an overall population of 124,803. All in all, the hospital is designated as the co-referral center of the Camayo local area health development zone. It has also been serving the municipalities of Tabina, Hinatuan, and Lingig.

In the next few minutes allow to me tell you about Bislig District Hospital, the No balance billing implementation and the performance in the last 5 years, its strategies and initiatives done, and the lessons we have learned. As we know, the No Balance Billing policy, known as the zero co-payment, is among PhilHealth's initiatives towards achieving Universal Healthcare Coverage. We, at Bislig Hospital started the implementation in 2012 wherein the indigent families are enrolled to PhilHealth through the following: (1) Bislig hospital's partnership with Bislig's local government unit (LGU) under the leadership of Mayor Navarro, (2) Kanami health insurance, which is the tri-party scheme for indigent family sponsored by Non-Government Organizations (NGOs), Local Government Units (LGUs), and National Health Insurance Program (NHIP), and (3) Innovation of Bislig's LGU through Bislig's city health office, from the congressman's office to our former Congressman Garay, and from the NGO in the locality

In the last 5 years, there is an increasing rate of occupancy in the Bislig hospital. The total number of patients admitted is 30,880 in which 2,375 patients were admitted with PhilHealth in 2012, 3,071 in 2013, 4,714 in 2014, 4,853 in 2015, and 5,193 in 2016 respectively. In total, there is 20,836 admitted patients with PhilHealth. 70% of our patients admitted in the last 5 years are with PhilHealth. On the other hand, the number of patients admitted without PhilHealth decreased over a 5-year period. The figures are as follows: 2,639 in 2012, 2,500 in 2013, 2,253 in 2014, 1,451 in 2015, and 1, 201 in 2016 with a total of 10,044 patients without PhilHealth in the last 5 years and 30% have no PhilHealth.

The next slide is a visual presentation of the increasing trend of the number of patients with PhilHealth and in comparison, to the decreasing trend of the number of patients without PhilHealth from 2012 to 2016. This graph shows the summary of the total number of patients admitted in the hospital. The one in red color is the number of patients with PhilHealth, the one without PhilHealth is the green color. It really shows the increasing rate of patients with PhilHealth. Here, the table shows the increasing number of patients benefitting from the NBB policy at Bislig Hospital. In 2012, there was 1,799 patients who benefitted, while in 2016 there were 4,174, which is twice the number of NBB patients in 2012. A sum of 17,031 clients was helped by the No Balance Billing policy, which is 80-85% of the total number of patients admitted in the last 5 years. While this graph shows in green color, the number of patients without PhilHealth, the one in orange color shows the number of patients in NBB for the last 5 years.

If you take a look in the number of patients enrolled, we can see an upward trend on the number of patients enrolled in the point of care, wherein there's an augmentation from 74 patients in 2014, 124 in 2015, and 206 patients just last year. The entirety amounted to 404 total enrolled clients in point of care in the last 3 years (2014 to 2016). In the financial

accomplishment of the point of care enrollees, Php 969,600 was paid in PhilHealth, while the PhilHealth reimbursement is Php 3,674,800. With this, the Bislig Hospital benefitted an amount of Php 2,375,930 in PhilHealth and this became a valuable contribution in the hospital operations and the communities we are serving.

The slide shows the strategies and initiatives we have done. Bislig District hospital is the 1st hospital in Surigao Del Sur to implement the point-of-care program, which is of great help and with regard to this, we formed strategies and initiatives. They produced income generating activities such as dinner-for-a-cause and Raffle Pamaskong Alay back in 2014. The hospital had a net income of Php 148,800 from the dinner-for-a-cause and earned Php 90,854 from the raffle draw activity. We also made an intra-agency collaboration where free services of licensed social workers from the LGUs of Bislig City were utilized in the implementation.

Aside from these, we also built partnership with the provincial government through our former Governor Johnny Pimentel, who passed a provincial ordinance that utilizes 5% of their trust fund for the enrollment in the point of care program in all district hospitals. Thus, this sustains the NBB program in Bislig District Hospital. Another important initiative is the linkages with the local health agencies such as the city health office through their Kanami health insurance. And lastly, a strategy was also formed through the inter-local health zone collaboration with the municipality of Lingig, the municipality health facility, and the Lingig Community Hospital, as well as the community participation, was practiced by having barangay visit every month with an advocacy of reinforcing the NBB policy of PhilHealth.

Based from our experience in the implementation in the No Balance Billing policy, we have come to realize that NBB is a noble project that is helping the marginalized people of our society. This provides equitable access to the health services that our people need. Thus, political will and commitment is a need to sustain this program. Also, we want to appreciate and recognize the local health insurance office of Bislig under the leadership of Ma'am Juliet Golez, our local health insurance officer, for contributing to the success of the program implementation of our policy together with the PCARES that is the PhilHealth Customer Assistance Relation Empowerment Staff assigned in the hospital who assisted our patients, significant others in the completion and submission of the vital documents needed in filing PhilHealth claims and benefits.

Allow me to conclude my PhilHealth presentation with some points to remember. Let us all keep in mind that what we are doing in the health sector is for our people. The bottom line is serving our people in the community and a great partnership with our stakeholders is they key towards enhancing our health care system and delivery. Together, let us pursue quality health, consistently keeping in mind of the people's best interests.

Thank you so much for listening and I hope you gained something from my sharing about the NBB policy implementation experience. Allow me to convey my thankfulness to PhilHealth's 22nd Anniversary. Once again, thank you and may we all have a productive afternoon. God bless us all."

IMPLEMENTATION OF NO BALANCE BILLING (NBB) POLICY BY A DOH-RETAINED HOSPITAL
(2:26:16 to 2:41:17)

By Dr. Soraya Pesy Abubakar
Chief of Medical and Professional Staff, Zamboanga City Medical Center

Delivered by Ms. Michelle Libago
Administrative Officer
Zamboanga City Medical Center

"Good afternoon, everyone. It was supposed to be Dra. Abubakar but unfortunately, she got sick, so good luck to me. Hindi ko na nga po alam kung nakailang beses na po akong pabalik balik sa CR eh. So, Zamboanga City Medical Center implemented the no balance billing policy when it started. It was never easy at first. Our attention has always been called by PhilHealth's regional office when exit conferences are conducted.

So, as for the background, Zamboanga City Medical Center started as General Hospital on September 1, 1918. In 1962, the hospital was designated as the training hospital for Region 7, thereafter it was renamed as Zamboanga Regional Training Hospital for Region 9. On March 24, 1992, through Republic Act No. 7272, the hospital was converted to Zamboanga City Medical Center upgrading it from 200 to 250. In August 28, 2013 by virtue of RA No. 10613, the hospital was upgraded to 500 beds corresponding IRR was issued through DOH AO No. 2014-0018 dated May 29, 2014.

Our vision is to be a leading socially accountable medical center of choice and partner for All in Zamboanga Peninsula while our mission is to help promote Health development in the Zamboanga Peninsula thru Hospital Tertiary Service, training and Research. The hospital was ISO Certified in 2015. This hospital is authorized to operate with a bed capacity of 500 beds per RA 10613 however, the implementing bed capacity is at 400 beds. It is a medical center, DOH licensed-to-Operate (2016) Level 3 Teaching-Training General. It was accreditted by PhilHealth last 2016 at 400 beds.

The total number of admissions at Zamboanga Medical Center are: 24,255 in 2013, 27,776 in 2014, 36,600 in 2015, 37,562 in 2016. With these given figures, the total number of PhilHealth clients are as follows: 10,385 in 2013, 20,293 in 2014, 31,495 in 2015, 33,552 in 2016 in which the Percentage of PhilHealth Clients: 43% in 2013, 73% in 2014, 86% in 2015, 89.32% in 2016.

The number and cost of new PhilHealth enrollees through point-of-care are as follows: 112 (268,800) in 2013– 3,862 (9,268,800) in 2014 – 5,838 (14,011,200) in 2015 – 7,602 (18,244,800) in 2016, this includes Badjaos who are living in the islands who are not yet members of PhilHealth.

For in-patients: out of total claims filed which is 31,495 in 2015, 77 of which is covered by NBB. In 2016, there were 32, 341 total claims filed, in which, 82.49% is NBB. On the other

hand, for the out-patients which includes hemodialysis, radiotherapy, yung OHAD, Minor Operations, Animal Bite, Emergency Room cases, and Chemotherapy, 1,313 claims were filed.

'Di ba I said earlier that the implementation of NBB policy was never easy. With regardst to this matter, we identified reasons for the OOP spending and were able to develop Good Practices such as: (1) bills of emergency patients are being charged to bill to ensure no out-of-pocket expenses, (2) NBB patients in Out-Patient Department who are referred for admission within the same day and have incurred out-of-pocket expenses are being reimbursed within confinement period - this is the main reason for OOP spending incurred by NBB patients, and (3) proper tagging of NBB-eligible members upon admission – PhilHealth provided them with portal and the hospital was given the NBB card. This is our NBB card, given to qualified NBB clients with PhilHealth requirements and emphasized na libre lahat.

So, we also have a Petty Cash Fund that is granted to the supply officer to address issues on non-availability of drugs and medicines, medical supplies, and laboratory examinations. This is alarming because of the big amount of money being spent on this, which is million in values. Likewise, there are field biddings that take place due to low Drug Price Reference Index (DPRI) wherein no supplier wants to bid because of the additional costs that freight from Manila to Zamboanga gives and they said nga na the DPRI is low.

Outsourcing of Laboratory and Diagnostic Tests is done siyempre 'di ba hindi naman laging available. We have existing Memorandum of Agreement executed between Zamboanga City Medical Center and Ciudad Medical Zamboanga to address issues on non-availability of laboratory and diagnostic tests. This is what we do. First, billing & claims will issue a letter of Authority to have the diagnostics done. Then these will be conducted via an ambulance without any additional cost. Next, the Ciudad Medical Zamboanga will bill Zamboanga City Medical Center. It shall be Zamboanga City Medical Center's exclusive responsibility to bear the cost of such services

Also, when we are short for blood. We do outsourcing of blood, the blood bank personnel will issue a letter of Authority for retrieving of blood in Philippine Red Cross. Then, Red Cross will bill Zamboanga City Medical Center. It shall be Zamboanga City Medical Center's exclusive responsibility to bear the cost of such

Next is we go forward. Problems were encountered in Zamboanga City Medical Center, especially the long queues in claiming PhilHealth benefits. We always go forward to address this because NBB patients sometimes opt not to avail PhilHealth due to long queues. We formed a "PhilHealth Express" counter that is updating the records of their members and printing the Member's Data Record, so that patients don't have to go out of the hospital premises. Likewise, PCARES is present to assist them in the completion and submission of the vital documents needed to have their claims filed. We currently have a 2-year contract with PhilHealth which they hope to be extended for the benefit of the NBB patients.

We also have a 24-hour front liner duty in the admitting section for PhilHealth requirements before admitting to the birthing clinic to lessen the length of stay. We have the main billing

and claims unit from 8am to 6pm and its schedule is from Monday to Sunday and then we have in ward 1 and then one in ward 8. So, this is our issue and our recommendations.

As for our experience, we have a problem with our 4Ps members who are bearing the surnames of their partners. So, when they go to the hospital to deliver, and when they look at the information in the birth certificate is different from the one declared to their 4Ps information. But, then, we have solved this one. So, we talked to DSWD, and they incorporated yung sa, this blank is used to certify that blank uses his surname, nung kanyang single's name is same dun sa person. Then, kasama kung single or married. Sabi ni doc, all case rates also must be visited.

Despite the No Balance Billing implementation, we have excess in NBB. Yung sum of the actual hospital charges and less PhilHealth case rate which is equals po dito sa excess ng NBB. The figures are as follows: in 2014 Php 77,228,283.76, in 2015 Php 115,197,735.52, and in 2016 Php 146,886,115.34 with a total of Php 339,312,134.62 for 3 years charged against the hospital funds.

To conclude, the Zamboanga City Medical Center is basically the home of NBB patients considering in 2015, only 20% are regular PhilHealth members, and 19.2% in 2016. So, it is our pride to say that even though our good practices are just simple, our NBB Compliance is 99.33% in 2016. Since Zamboanga City Medical Center also caters to different barangays, Zamboanga Del Norte, Zamboanga Del Sur, Sulu, Tawi-Tawi, we practice 'yung giving of instructions to their own dialect.

Once their PhilHealth requirements are complete, we will tell them, walang babayaran libre na lahat. (The speaker said different ways on saying thank you in their own dialects when they inform them that everything is free.) So, on a personal note, thank you to PhilHealth for without you, I will not hear the sincerest thank yous ever said. Thank you to Sir Alberto and Dr. Paraguya in implementing the NBB policy."

INTRODUCTION TO THE DISCUSSION AND OPEN FORUM
(2:41:17 to 2: 42:25)

By Dr. Beverly Lorraine Ho
Chief, Research Division
Health Policy Development and Planning Bureau
Department of Health

"So, in that 2 presentations, we heard how patients now have allies in government hospitals. This picture that we once see in the private hospitals where largely the funds came from out-of-pocket spending and private sources of funds, we say that we now see that patients have now allies to the grounds.

But the challenge now is DOH. PhilHealth has to ensure that financing is sustainable and that our financing mechanism or our provider mechanism are able to force or drive our hospital to

be more driven. Siguro mamaya, 'yan siguro ang tanong natin kay Ma'am kung 'yung excess NBB ba dun is 'yung required services and how much of it is extra services."

DISCUSSION AND OPEN FORUM
(2:42:32 to 3:10:43)

By Ms. Ma. Gilda Resurrecion
Consultant
National Kidney and Transplant Institute

"Good afternoon, just a few thoughts 'no? I got the materials in advance, so I have my notes ready. I was just asking doktora, from my experiences in other hospitals, apparently, the PhilHealth benefit package is very, very effective for primary, level 1 hospitals. As you go up the edge, that's where you see the differences.

One of the things that I noticed in most of the hospitals is that, we don't do honest-to-goodness costing, so we really don't know how much is the cost of our services to the patients. And when PhilHealth mixes up this information from the claims that we filed, misleading po siya - you're not able to provide the right information that has to be reimbursed.

A good example would be a urinalysis. There would still be a urinalysis at a hundred pesos. When the cost of a urinalysis would go up to as high as P125-150, there's not much cost recovery there. But for hospitals that are primary, especially the LGUs, getting paid is already a big deal for them because they're used to just getting subsidies born from the LGUs.

Now they're getting the money from PhilHealth. There's another source and these could help them improve the hospitals. I was asking doktora. It helped them a lot. For Zamboanga, which has 400 beds - I've seen the hospital. You will notice that there is P339 million in terms of excess. That's what I'm trying to mention - this is a level 3 hospital. See, as you go up, pneumonia for this big hospital bill will not be the same as the pneumonia for Zamboanga City Medical Center and the Lung Center of the Philippines, so that's where you see the big difference. I remember looking at the bills of the Lung Center - the PhilHealth package of 13,000, 18,000 for pneumonia, 15,000? So, 15,000 is just a 1 to 1 ½ days at Lung Center, so it's not able to cover if you go higher the echelon or the level of hospital care.

So, I guess what we need to see here is a revisit. There is a revisit of the case rates but PhilHealth may want to see it from the different perspectives of the three levels of hospital. Plus, you may want to look at this also - if this were to be rolled out in private hospitals as well because the element of profit comes in and will kick in.

The other thing I did notice is that these are two government hospitals here - at least Zamboanga City said something about excess. We would've wanted to see how those money came in to support their operations. PhilHealth has already provided another source of revenue and I normally turn to them as internally generated, meaning I don't have to ask the LGUs, I don't have to ask donors to bring in the money - meaning internally generating through good system in PhilHealth. So should these translate into improvements in facilities,

improvements in availability of supplies, because at the end of the day, if I improve my facilities, I improve my availability of supplies, I am able to improve my PhilHealth reimbursement as well. So that could be part of their financial monitoring of the effects of PhilHealth.

The other one that I noticed is that there was a slide – I forgot which of the hospitals – where out-patient services had to be reimbursed through their admission, something like that. There are certain cases of these patients: what happens is that they have to be admitted to get their PhilHealth, but their cases can be done on out-patient basis. So, we'd like to see a strengthening of the Outpatient Benefit Package.

You see in the health care industry, hospital operations, you're trying to shift in-patient services to outpatient. This is two-pronged: You help the patient reduce his out-of-pocket at the same time as far as the hospital is concerned, this is less cost exposure for the hospital if they do outpatient rather than inpatient, so PhilHealth should support that shift. See if you were to look at the out-of-pocket expenses, a good number of them are on pharmaceutical and some services. If this were covered by PhilHealth then, this could reduce your out-of-pocket.

Also on how PhilHealth can influence the suppliers in terms of certain --- well, my experience right now for peritoneal dialysis, peritoneal dialysis is influenced by almost 80-90 % of the suppliers' cost of the piggy banks. So if PhilHealth cannot help us control that cost, their services or their PhilHealth Z package would not be as substantial as they would have wanted it to be in terms of coverage.

And lastly, I was looking at a statement by an earlier speaker: increase rates to increase benefits where premium payment will be the gateway to benefits. I'd like to parallel this to the hospital. You review your rates with proper costing so you will be able to provide more benefits in terms of PhilHealth benefits or PhilHealth accommodations. Thank you.

By Dr. Alejandro Herrin
School of Economics, University of the Philippines – Diliman

First of all, thank you for inviting me to being part of this panel discussion. You know professors cannot talk without a black board but in this case, a powerpoint will be enough. I'll try to be brief given the timekeeper there, and I use the work of the previous speakers as some sort of a framework.

The first thing, the presentation by Ms. Sabenano on the national health accounts. The national health accounts is a long history, and she concentrated on the most recent 2013, 2014 although she had a longer series 2005 – 2014 on the out-of-pocket payments and so on. This is going back to the first year of the series 1991 – 2014, so you actually have a 24-year series of the national health accounts that can serve as a reminder of how well we're moving along in terms of the financing the healthcosts.

These are expressed in terms of per capita, constant pesos so that we control population and inflation. As you can see, the yellow one there is the out-of-pocket. As you noticed, it is

increasing, and what seems to be happening is that, in spite of the rapid economic growth especially in the last few years, the growth in dispensable income has not been translated into greater financial protection, and so we can take a look at the trends in 1991 (first series), that share of PhilHealth in particular, which was then the Medicare program, was around 5%, and I know I don't have much time but let me give you a back with a short story regarding what was year 0 like since you're celebrating 22 years.

So what was year 0? Year 0, the 1991 national health accounts was produced. That was in 1994. It was presented by DOH with a group of senators and some congressmen. The first thing they noticed in that table was the share of Medicare in the total health expenditures and at that time it was something like 5%, and immediately, they noticed: how come it's only 5% when in fact Medicare program has been there for 22 years? This has to change.

We expect that it should cover a lot more share of total health expenditures. So, they considered that as a problem, and they had a solution. They are legislators so their solution is legislation. I think one of the senators, Senator Angara, called on then Secretary Flavier and said "Johnny, can you prepare a draft bill?", and things moved on very quickly so on February 14, 1995, you have an act, the Health Insurance Act of 1995, so that was the first day of your 22 years. So that's how the health accounts are being witness into event.

But as mentioned, from 5%, it has been mentioned that it has been only up to 9%, and it's only recently that it's 14% in the last year. How can the share of that healthcare insurance increase? I think the answer to that was given this morning by President Aristoza, you can't really increase the share unless you increase your revenues because no matter how much benefit packages you bring in, you will be constrained by the total amount of resources that you have, and these suggested revenues through premium payment increases among other things, and that is clearly what needs to be done.

And the question is in his aggregate claims, how can premiums be increased? Can we ask the government to increase the premium of the indigent? That would be great. We still have the Sin Tax money before everybody stops smoking and we run out of sin taxes. The other one, which is more tricky, is how do you increase premium payments for the formal sector? For many years that has not been adjusted and even in the recent adjustments, the ceiling is still relatively low. I think the ceiling, salary ceiling is around P30 000. So the person earning P30,000 pays the same amount of premium as the person earning P300,000, so is it possible to, if not increase the rates, to increase the ceiling?

But how far can you raise the ceiling? Of course, there are implications regarding the cost of production to the employers. Will they take it, or will they demonstrate? And there's also impact on employment. So, there are things that need to be addressed there. In the question of how much money do you need to raise, so that's where actuarial comes in.

The answer to that was in the previous session. Perhaps, we should look at, in answering that question: what is it really that we need to spend on? And, that is the cost effect, those that reflect disease burden, which I will come to later on.

The next two papers talk about the no-balance billing, and here, this is how we transform out-of-pocket payments into premium payments. From the national health accounts, the more recent, more detailed system that is recommended by the WHO, in which Raquel is very much into, this aggregates the total health expenditures into various categories: one of them is income quintile, and you can see we broke down the total expenditures by quintile and the sources by each, to each of the quintile is supporting their total expenditures. So the blue one is the local government, then national government and then social health insurance then you have private insurance and HMOs and enterprises and others. And as for the green one, is out-of-pocket payments, so what NBB does is to eliminate that green portion in the bottom or even in the second quintile via no balance billing.

Well, the two presentatios have given us exactly how that is done and innovations that they've made. One of the critical comments before this started is some survey show that there is still out-of-pocket payments and these came from when drugs are not available. Drugs are bought outside, and for some reason these never get reimbursed, although it should be. When they have to get diagnostic procedures outside, which are not reimbursed and so on. I'm happy to see that in the report of our presenters that that particular element has been addressed and so the true NBB has actually been materialized and so on.

So, in effect it can be done, and even If certain expenditures are done outside, these are eventually reimbursed as part of the bill. But having said that, we could actually improve access to healthcare by eliminating extra out-of-pocket costs for the very poor.

Perhaps another question is let's not be content by just taking out the green ones in financing the bottom and second bottom quintile. What if we raise the consumption of healthcare? So, it's not enough that we take out out-of-pockets. What is probably more important is how to raise their level of consumption? Because it's hard to imagine that the poorer are more healthy that the rich. That's why they don't need as much healthcare. So more likely they won't be able to access more healthcare because before there was out-of-pocket payments and even if there were no out-of-pocket payments, there are still a lot of costs needed to access those care.

So how can we increase the level of consumption? Of course, we know that those who are not able to access out-of-pocket payments or any means to support other expenditures other than health care, in accessing that we cannot be in this graph, they'll be in another graph: the poor who are not able to access healthcare - they are in the graph called mortality rates. So one approach is to reallocate or can we reallocate the subsidies? The blue and the red from the 4th and 5th quintile and reallocate it to the 1st, 2nd and may be 3rd that way you reduce subsidies here and increase the total consumption and subsidies on the left side, so that's one option.

On how it can be done, what could be the political economic issues there can be discussed. The other one of course, is going back to the earlier solution of increasing the revenues is to actually increase the share of PhilHealth to increase in the revenues. That grey bar there would increase for everybody, particularly for the bottom quintiles. But again, how to work on those mechanics might be something that's needed to be discussed if you have ideas.

The third idea is - this is just to summarize, again I'll use the health accounts in view of its - well, it gets exciting because we don't have anymore tables so that's one thing to talk about. This is looking at expenditures by disease category. So this is broad. There's more specific diseases, and for each disease group, we also look at who's paying for them, and you can see the greens are there, but there are more greens in the non-communicable diseases, infectious and reproductive diseases which include HIV-AIDS perhaps, reproductive health and injuries. Injuries is practically out-of-pocket. The expenditures are small probably because it relies mostly on out-of-pocket, so the question is if we want to reduce out-of-pocket through the mechanisms that we mentioned, we are already heating up, perhaps what John Wong would say the more important diseases if they are under non-communicable, infectious and reproductive, so the question is how do we finance this?

And going to what was mentioned by John Wong and Tony Leachon about looking at the most cost-effective tactics that can be funded to this category. Next idea is while we all agreed about the need to reduce financial risk, perhaps another complimentary approach would be to reduce health risks in the first place. It was mentioned by Anthony and the others, Tony about the primary care. John Wong addressed the need to really determining what should be paid in terms of how well they contribute to the disease burden and that might be how can address to how we need to pay for what needs to be paid. But there's also another way beyond the health sector, on how the sizes of the expenditures can be addressed. but that would be working on the social determinants of health.

Just to give you an idea of things that we have done already, we are considering about many things that we can do for let's say price changes. That is what the economists favour because they think what is behaviour change, communications and so on might take a long time but if you change the price, you'll probably get results quickly.

So taxes and producers affect pollution rates and perhaps cancer rates, tobacco use. We have already seen how our sin tax is working, harmful alcohol use, they're also part of sin tax. Notice that in tobacco use, they just say tobacco use but, in alcohol there is such thing as harmful alcohol use and presumably harmless alcohol use. Poor diet, I think this is being discussed about the increase excise tax on sugar and other foods. Is that easier to do that another approach, which is on laws and regulations and I think in some countries, instead of taxing high salt content or high sugar content, they regulate it in such a way that your salt or sugar content declines gradually so that people don't notice that it is now less salty and more healthy. But they don't mind because the presumption is if you don't change the composition of the product, not only will the manufacturers complain because their pockets will decline quickly, but the consumers will also complain because now, it doesn't taste like it used to be.

But perhaps there are other things that can be done, and your ideas on what might be the kind of innovations regarding how these can be implemented will be most welcome. Thank you."

OPEN FORUM

By Dr. Beverly Lorraine Ho

Chief, Research Division
Health Policy Development and Planning Bureau
Department of Health

Q1 *(Dr. Beverly Lorraine Ho): "How do we sustain health financing to increase help benefit package if we become too reliant on sin tax redemptions when it might decrease in the long run?"*

A1 *(Dr. Alejandro Herrin): "Well, I think we should we should not think of - well I mentioned it before: sin tax is a source of revenue. But what you should be concerned is that it will reduce smoking and alcohol use. So going back to how it is financed transforming and increasing into out of pocket into social insurance premiums was discussed by Aristoza this morning."*

Q2 (*Dr. Beverly Lorraine Ho*)*: "This is for the first speaker on the slide on OOP expenses, can you suggest what measures should be taken by DOH, being a regulatory body on prices of drugs and medicines, professional fees and ethical practices and government hospitals and doctors?*

A2 *(Ms. Raquel Dolores Sabenano): "For the PSA, we have no data for the prices and drugs and medicine for the professional fees. So maybe we can ask for, I think it's in Philhealth that we can have this data for the prices of drugs because in the PNHA, we do not collect for these statistics. Professional fees also, we have no data for this. So, collect the data first before we can decide on what can be done."*

Comment by Hon. Leachon: *"May I answer first the sin tax before I give my comment? Well, we cannot be forever dependent on the Sin Tax, and I would agree with the two discussants on this matter.*

It's an interagency collaboration. Basically, improving the risk of the socio-determinants. One thing that we can imitate is actually the Singapore approach, in which they increase the sin tax and then penalized who are going to smoke. For example if you want to smoke, the prices of cigarettes in the Philippines is relatively low compared to let's say Singapore P50 for one (Philippines), then in Singapore, it's P400 right. So more or less we can have the readiness that we want aside from the other problems to solve the out-of-pocket payments because the number one killer in the country is smoking so we swing on the non-communicable diseases and then put it away on the out-of-pocket in care. So at least we can decrease the Z packages which is actually enormous - it's curative and is actually more expensive, so we have to swing at that.

But my last comment if I may, is that Philhealth at 22, and then President Duterte at 2022, it's a Catch 22 situation meaning to say, Webster would define it as a difficult dilemma or circumstances which is not actually solved or there's no escape because of conflicting or mutually dependent conditions. For example you cannot achieve universal healthcare without addressing human resources. You cannot address financing problem without addressing public health infrastructures, so fragmented pa rin eh.

I was thinking of an interagency collaboration with a national scorecard with a traffic green blue and yellow with a signature coming from the president, the DOH, DILG, DBM secretaries and the LGU heads addressing the all the metrics related to the three parameters universal health care, and publish that into the newspaper yearly and we will see who will be the lagers here addressing all of this because as we can see right now, we cannot solve all of our problems right now the way we see the problems before. It's quite fragmented. The date presented here is only the first time that I was able to see those statistics, so we need to look at it at a helicopter view, so that we can address the problem and more town hall meetings nature on a quarterly or semestral basis, so that we can follow up.

The problem is in the plan of action but the problem is when the rubber meets the road, and that will be an enormous problem."

SYNTHESIS
(3:10:45 to 3:11:53)

By Dr. Beverly Lorraine Ho
Chief, Research Division
Health Policy Development and Planning Bureau
Department of Health

"*The Total Health Expenditure (THE) is increasing, thus this is actually good news. But, we also see that the Total Health Expenditure is largely driven by Out-of-Pocket spending and most of these are highly consumption of the rich. Nevertheless, the more important point is that, after a long time that PhilHealth's share of THE has been sleeping at 9% it's finally up to 14%. It probably tells us that reforms may be really impacting the system. However, the previous presentation was only a macro-picture, so we still have to hear from the 2 next colleagues about how the patient is experiencing the reforms in the point of service in the hospital.*

In summary, here are the issues that were discussed. First is that Philhealth will need to invest more in financing primary care and working on reducing risks especially the social determinants of health. Next would be the need to institutionalize cost accounting among our various healthcare providers so that we are able to get the true cost of providing care. Third would be to raise the consumption of the poor. How this can be done, we need to think about and work on it. And lastly, to pay for outpatient services in a more efficient manner. So these are the four (4) main points we got in this discussion."

END OF THE SECOND PANEL AND INTRODUCTION OF THE THIRD PANEL

By Professor Nina Castillo-Carandang
Health Social Scientist and Assistant Department Chair
Department of Clinical Epidemiology
College of Medicine
University of the Philippines – Manila

"Thank you very much for our panel two participants, Dr. Ho for moderating the session, Ms. Sabenano, Dr. Jakosalem, the representative of Dr. Abubakar, Ms. Libago, Ms. Resurreccion, and Dr. Herrin. Maraming salamat.

For those of you who have questions, unfortunately, we cannot accommodate all of them live, if you submit all your questions, then they will be collated and be as part of the documentation in the PhilHealth website.

INTRODUCTION TO THE THIRD PANEL
(3:12:46-3:14:21)

Professor Nina Castillo-Carandang
Health Social Scientist and Assistant Department Chair
Department of Clinical Epidemiology
College of Medicine
University of the Philippines – Manila

"We proceed to the last session for today and the question is "Who benefits: inclusiveness of the policies and the programs, and may I invite our moderator, Mr. Manolito Novales, professor of Ateneo De Manila to come up on stage and may I also ask Mr. Donald to call our panelists.

So while our panelists are setting themselves up, let me introduce the moderator for this session. The moderator is Professor Manolito Novales or Chito. He haD his Masters of Public Management from the Ateneo de Manila University. He's worked in various fields and he is also a faculty adviser, Master in Public Management Development Program, Development Academy of the Philippines. Currently, he's a professor at Ateneo School of Government, Ateneo de Manila University. Professor Chito."

INTRODUCTION OF THE PANEL SPEAKERS
(3:14:25-3:20:08)

By Mr. Manolito Novales
Professor, Ateneo School of Governance
Ateneo de Manila

"Thank you. Thank you Prof. Nina. Again, welcome to this session this afternoon. Apparently, this is the last session in today's symposium. And we are going to talk about a very specific concern.

Again, reviewing what we have done so far. Since this afternoon, we have been talking about several topics in relation to ensuring Universal Health Care and the first session talked about the service provision and we have distinguished speakers related to those topics. The second session dealt into the proportion of costs covered and we have significantly looked into the

issues and the challenges concerning the costs related to ensuring financial protection in terms of our services that need to be accessed by our members.

But at the.. But again, nothing will really materialize if at the end of the day we are not able to resolve a fundamental issue. After all, the reforms that we have been talking about since this morning talks about Universal Health Care and ensuring that the population that needs to be served in terms of our health sector reform are adequately covered. And in the end, those who should be benefiting from those reforms are properly ensured. So the for topic this afternoon, is 'who benefits? Ensuring the inclusiveness of policies and programs' and for this particular session we have three distinguished speakers.

The first will be talking about the implementation of Sin Tax Reform Act of 2012. He is a medical doctor with special interest in public policy, medical sociology and health economics. His areas of experience include health policy and health sector reforms in middle income transition economies, and health systems strengthening in developing countries. In his prior engagements, he led World Bank health programs in several countries in eastern Europe and former Soviet Union served as Director in the Estonia Social Health Insurance Fund management board and a Deputy Director of the Italian Emergency Medical Hospital in the Estonia. Currently he is the global practice manager for health, nutrition and population of The World Bank. So please welcome, Dr. Toomas Palu.

The second speaker holds a Bachelor's Degree in Communication Arts obtained from University of the Philippines. She's a project coordinator for the Listahanan or National Household Targeting System for poverty reduction and during her 10-year work with the Department of Social and Welfare Development, she organized numerous fora, workshops and other events that promoted the NHTS Poverty Reduction Project and the Pantawid Pamilya Program to both external and internal stakeholders. Now, in her capacity as project coordinator, she continues to represent the department and its activities that engage various stakeholders of the Listahanan program. So she will be talking about targeting the poor. Please welcome Ms. Krupska Lenina Apit.

And the third speaker, who is also very familiar, I'm sure you know him very well because he is the former president of PhilHealth. He will be talking about 'Squeezing the Middle and other sources of funds. He completed his medical degree at the University of the Philippines College of Medicine and later, his degree Master of Science in Health Policy, Planning and Financing from the London School of Economics and the London School of Hygiene and Tropical Medicine. He is the regional adviser for health economics and financing of the World Health Organization Eastern Mediterranean Regional Office where he advises countries in the Middle East and North Africa on improving their health systems and achieving Universal Health Care. He was also a health economist in WHO Bangladesh and the senior health specialist for The World Bank. Currently he is the principal health specialist in the Asian and Development Bank, where he champions Universal Health Coverage all over Asia and the Pacific, supporting countries pursue UHC and providing advise on designing and implementing country UHC's strategies. So we will be talking about 'Squeezing the Middle and other sources of funds.' Please welcome, Dr. Eduardo Banzon.

So, joining the panel also is of course, Professor Konrad Obermann who will be giving us the overall synthesis for today's session, referring not only to this particular session, but the prior sessions as well. So without further delay, may I call on Dr. Tommas Palu to give his presentation about the Implementation of Sin Tax Reform Act of 2012."

IMPLEMENTATION OF SIN TAX REFORM ACT OF 2012 (RA 10351)

By Mr. Toomas Palu
Regional Practice Manager, The World Bank

"Thank you chair. Happy birthday PhilHealth. I thought it will be a party but it turned out to be pretty serious discussion.

So, I also want to thank you very much for the invitation, for the World Bank to be here. We really appreciate it. Our long standing partnership with PhilHealth. And we look forward to our continued partnership.

It's also good to be here. As I have said, that in one of my past lives, I'd been also involved in health insurance - being a director of my own country. It's just that PhilHealth aims to provide coverage for 400 million, my country was just 1 million. But I have to say the issues are just the same - you just have to write a couple of more zeroes behind every number discussed.

So today I'm going to present the work, that is based on The World Bank team when we supported the preparation of the Sin Tax reform, and also the monitoring of it. And then a couple of policy notes that the Philippines Health Team has developed. So the structure of the presentation - I will just give a quick overview of the main features. You know very well I'm sure, a couple of slides of the impact so far, what came out of the monitoring report. And then we get to the issue of discussion of this session, which is the population coverage. And then I will end up with some discussion on how PhilHealth could use it leverage to improve, maximize health and value for money.
So the Sin Tax law of 2012, that significantly simplified the tax structures that our economists and public finance economists would like a lot. On cigarettes, it went to 2 tiers, that have converged over time. And it makes sense because from the health perspective - every cigarette is the same. On the alcohol side, it was the converging of two tiers, and also applying universal ad valorem and specific taxes on all alcohol. This is a best practice reform on Sin Taxes internationally so, and one of your own leaders of the reform is currently advising WHO on the same.
And with very significant pro-poor earmarking for health, and I think it was already discussed earlier on the key allocations, but when funds are taken away for the compensation of the tobacco farmers, the rest goes to health, most of it goes to PhilHealth to expand the coverage among the poor and near poor - basically, the bottom 40%. And then they call the Millennium Development Goals, special medical assistance programs and investing into the supply side through the facility enhancement program.

Just want to say that I have handled the health Sin Tax reform before. It was attempted since late 1990s, in the beginning tax argument. Then the health argument came in, and finally the universal health coverage. So far, the reform has actually won in the political landscape through health and Universal Health Coverage argument.

And it was not an easy passage as all of you must know, and in the end passed the Senate by 1 vote, but it is an area that has a lot of vested interest involved. And tax monitoring report that actually we completed just last summer, also looks at the older dimensions that are listed on the impact of the reform since they were raised at the debate. And I understand that the parliament has commissioned also the review of Sin Tax Law implementation as for envisioned in the law.

So four years later, what we have found about the impact of the reform? While we've seen very significant increases in tax revenues, it has dropped to about 0.4% of the GDP but it's now getting to combine tax revenues close to 1% GDP. This is providing significant additional revenues to the health sector. As it has already been mentioned, the budget has essentially tripled compared to, of the Department of Health, compared to pre Sin Tax law and it goes to PhilHealth, as I have mentioned before, the facility enhancement program and the other usage by the Department of Health. And in 2017, the numbers right now goes to the 2016, so I understand that the budget is expected to be around 150 billion pesos. So PhilHealth gets about a third.

It has been dramatic, quite a dramatic increase in population coverage, in terms of both the individuals and the families. It grew from 5 million from 2010 to about 15 million families, and to estimate the total members of 91 million. We can see that the expansion of coverage has been proper if we are interested in that. It has been quite sharp uptick in membership among the poor. Once the Sin Tax Law earmark kicked in. And also the specific additional law passed in 2014, about coverage of people over 60, has been also significant reaching to about 9 percent of total of the proportionally, about 8 million elderly being covered.

Another important aspect we've seen through the implementation of Sin Tax Law is a much more transparent in the way the indigent or the poor are identified using the National Household Targeting System. And you can see the decline of the blue bars that used to be proportional to the beneficiaries identified by local governments and the significant uptake of the red bar using the National Targeting System. That has in a way universalized the membership criteria for PhilHealth.

Already mentioned today, another expected impact from the Sin Tax Law - the decline in smoking. There are various surveys that are being used to measure that. Decline in smoking is a slow process but it's very encouraging news coming our 2015 Global Tobacco Survey that show that smoking has dropped to 22%. And I think also the important aspects of Sin Tax Law impact, although we have to say that attribution is always complicated or a complex matter, that we see most significant decline among the youth and the poor.

That was the idea. We know that one of the arguments that were used during the debate was were the taxes progressive, were they for the poor? The counter argument forced that the poor as a group will benefit more since they are more price sensitive and we actually see the large decline of smoking among the poor. Some decline in the number of cigarettes smoked, from 9-10 per day. So it also has a marginal health impact.

So we now get to the population coverage issues. Issue number one - there is mismatch between the official data and the survey data. We claim that the coverage is 93%, which is administration data, but survey data converge somewhere between 96-97% coverage. And of course, the survey data depend how people report, whether they are covered or not. For people to say that they are not covered then this social insurance is not effective.

So why are these estimates different? I think there are assumptions, and I understand that PhilHealth used to use assumptions of the family size, and they calculate the aggregate numbers. There is another added complexity - household surveys look at households, and households are not equal families that they may be comprised of several families. And the point that the administrative system include people who are automatically enrolled because they are in some list. This coverage doesn't necessarily mean that actually the number who are on the list are actually true.

So what can be done about this? There are some recommendations made on the slide and they are all in questions marks, because in one study that we conducted in the Philippines together with the University of the Philippines, that the public information campaigns on their own are not particularly effective of actually getting coverage. But the same study also show that if they are accompanied by hands-on assistance of helping people to enroll, now they are more successful. But that's clearly one challenge there.

Issue number two - have the subsidies made the system more equitable? Well on the plus side, we see that giving insurance to 15 million poor families, may be identified in a transparent manner, is a pro-poor mechanism. But if you look at the survey data and there is a mix of survey data, that the annual poverty indicator survey for example shows really quite strong pro-rich gradience, in terms of membership. But in general, we see a convergence and quite a high coverage among the poor and the near poor.

Are the PhilHealth contributions equitable and proportional? Yes, because they are restricted government subsidized the poor and they don't pay any premiums. But we know that the PhilHealth contributions rates are capped at a certain level of incomes. So at that time, the progress of the system disappears. All senior citizens are automatically covered by the 2014 law. It doesn't take into account their actual socio-economic status - whether they are poor or not, it's not obvious that.

So I think the overall, if you look at the macro numbers, even the number of people who are behind the second vertical red line, which is at P35,000 monthly income. So they're not too many people who are reaching that level of income that can be taxed. So we can see that, in terms of impact, we can't expect perhaps much additional revenue from PhilHealth if we keep the same tax rates. But from the perspective of equity, from the left hand side of the graph, the proportion of the income, the poorer parts still pay more.

Premiums for the formal sector in the Philippines are low by international standards. It doesn't automatically mean that the Philippines should consider increasing the premium, although this issue has already been mentioned. There are a number of questions that need to

be asked first: what is the need to increase premium, do the premiums cover the actual formal sector benficiaries? Or is there a point of expanding benefit package? The copayments have been raised. The poor have exempt but the non-poor are paying - whether this is the point of increasing the rates of the formal sector. But the bottomline is that there is space if need be that international comparison in increasing the rates of the formal sector. And our economists are saying not to diificult in terms of the global competitiveness context - if the payroll taxes will go up a little bit.

Also, issues that have been raised durign the day are what to do the primary care coverage? The poor is covered but the non-poor are not. Perhaps primary health care is not a finacial protection issue but there are clearly points that in terms of efficiency and effectiveness, that is a benefit that should be expanded to all. And another important issue is the balance billing, the lack of co-payment policies that is predictable, that is actually protecting against catastrophic costs, is missing in the Philippines.

We see that the total value of benefits going to the poor have increased. In 2015, the indigent received the most payments as a group. But then we see, if we look at another angle, then we see that they make up 51% of the enrollment population of PhilHealth, they only consume 34% of the resources. So in that sense, the use of PhilHealth resources are proportional. Who benefits? We see that the new group, over the 60s, they get about 2 times the resources and the informal sector as well. We can also see or think that there is adverse selection.

Lack of financial protection, progress of financial protection has been listed already. And the discussion about the reasons why is it there, the pharmaceuticals that are not covered, in particular the outpatient context; and also the balance billing questions, the co-payments, I think these are two issues that need to be tackled to improve the financial protection.

Now to the last point, I'm being flagged that I'm ready to wrap up. PhilHealth can have extraordinary opportunities to improve the value for money, the health for money in the Philippines. There are a number of points in the slides, what are the channels, the accreditations, the supply and demand side, being the monopsonic buyer of services, ability to contract with both private and public - so many instruments that PhilHealth, like many social health insurances like Indonesia, or in Vietnam we talk about the same whether their social health insurance agency. But how to use all these instruments smartly, to leverage the service delivery that provides better health - in particular in the Philippine context, the decentralization leaves little instruments for the Department of Health to leverage service delivery upon the local level - contracting is the answer.

Here is the number of things that one can consider in using this power, closing the gap of the coverage, no balance billing, the co-payment policy, the primary health care benefits expansions, including not only as an accreditation measure that improves the quality of inputs, but also using contracts to improve quality of processes and outcomes. Service delivery networks is actually an opportunity not to pay per point of service delivery, but let's say, you pay per hypertensive patient, capitate to service delivery networks where the patient is involved. And if the patient ends up in the hospital, then it's the problem of the service delivery

network to absorb the cost. So they have an incentive to actually do better chronic case management.

Provider payment reform, all case rates, I hear a lot of issues about that. But it is a beginning to actually move away from fee-for-service and offer more prospective payments - perhaps accompanied by global budgets. The co-payment reforms that were already mentioned. And it is not only PhilHealth; I think other government agencies should support the agenda and play the game - if PhilHealth provides incentives and tools, then the local government should respond to the national government legislators that should also postulate the recollections that would enabling that environment.

And this is my last slide. We have to report that the Sin Tax reform in the Philippines, it is available in this website, and I understand that all the presentation will be uploaded in the PhilHealth website. I suggest that the interested parties would go and download it. It came out before the summer, it falls during the government transition so it has not been disseminated yet, systematically. But this is a good review of the first four years of the implementation of the Sin Tax reform.

Philippines is recognized as a global leader in terms of designing the refort. It has brough tangible benefits. There are ways to better manage the Sin Tax Law revenues and the expenditures. And I just want to say that currently political enviroment in the Philippines should cease reviewing the progress of the law and making their own conclusions. But for the continued public and political support for the Sin Tax Law will depend on showing that it actually works for the people and for health. Thank you very much."

INTRODUCTION TO MS. APIT
(3:45:37-3:47:41)

By Mr. Manolito Novales
Professor, Ateneo School of Governance
Ateneo de Manila

"Thank you. Thank you Dr. Palu for that very insightful discussion about Sin Tax. So just to recap a bit about this talk, it basically communicates a very important message that there has already been reforms with the Sin Tax Law and how it has afforded resources, specifically in terms of promoting better health outcomes for the population. But again, the key there is not the resources that are afforded to us in terms of… in terms of the funds that need to be… that needs… this afforded by mechanism but more importantly, the use of those funds and how we should strengthen the utilization of those funds to make sure that the… that the intended population are properly covered and have adequate provision and access to healthcare.

So there was a specific issue that was mentioned about the, you know the discrepancy, in terms of the data and that I think has already been discussed this morning, and this has been actually an issue that has been raised over and over again, in terms of the data, discrepancies of data, the weaknesses in terms of our information systems - to make sure that we have the

right targeting approach. And now, apparently, it is good that the national government, is you know, going into this mechanism, in which targeting of the poor is need more efficient and effective programs. And now, to give us the second talk about 'Targeting the Poor Under Listahanan Program,' may I call on Ms. Apit to give the presentation."

TARGETING THE POOR UNDER LISTAHANAN 2
(3:47:44 – 4:02:58)

By Ms. Krupska Lenina Apit
Project Coordinator

"To our guest, fellow panel speakers, partners from PhilHealth, a pleasant afternoon to all. On behalf of the Department of Social Welfare and Development, I will be discussing the process undertaken to target poor households in Listahanan 2 or the second round of assessment.

My presentation will encompass the following topics shown on the slide. First, a brief introduction on Listahanan so this answers the question, 'what is it, why is it important? Second, the project phases or how we conducted the Listahanan. Third, the proxy means test or how we identified the poor. Fourth, its results - basically the magnitude of poor nationwide and by region. Fifth, the data items - our specific data that can be generated from the Listahanan 2. Last but not the least, our recommendations on how PhilHealth can achieve Universal Health Care with our support and assistance.

My presentation will not delve though into technical aspect of the PMT model. So if you have prepared questions regarding this matter, you may email it to us after my presentation.

The partnership between PhilHealth and the Listahanan since 2010 has been strategic for the government. It allowed PhilHealth to save on significant resources and overhead on its services targeting the poor. So, Listahanan is an information management system that identifies or targets who and where the poor are. It makes available, a socioeconomic database of poor households as basis in prioritizing beneficiaries of social protection programs and services.

Executive order 867 series of 2010, which provides for the adoption of NHTS-PR, mandated all government agencies to utilise the Listahanan database. Well, the need to have a unified objective and scientific targeting system, such as the Listahanan resulted from two problems that persisted after decades of implementing social welfare programs. One is that, poverty incidence continued to increase despite implementation of well meaning anti-poverty programs. To be specific, poverty incidence rose from 24.4 in 2003 to 26.9 in 2006. The other is that, poorly targeted social services resulted in the exclusion of the poor from the necessary social services and leakage of resources on those who are not actually poor. Listahanan came out as a response to these problems. It ensured that resources of programs and services meant to help the poor, benefitted the poor and that targeted programs and services address the actual needs of their beneficiaries.

Listahanan, has been around since 2008, conducting its first assessment in 2009. This activity resulted to the identification of 5.2 million poor households. When we are proud to acknowledge that PhilHealth enrolled these identified poor households in their indigent program.

In 2015, Listahanan conducted its second round of assessment to update the database. The process for identifying the poor in Listahanan 2 followed a 4-phase project cycle beginning with the preparatory phase. The preparatory phase includes geographic targeting and data collection strategy so in Listahanan 2, we assessed all households in rural barangays, and in identified pockets of poverty in urban barangays. Also, part of the preparatory phase is hiring and training of field staff, and orientation of local government units and other stakeholders. While LGUs have a huge role in the assessment, they help identify pockets of poverty and they also provide logistical support to our field staffs, especially in reaching those residing in geographically isolated and disadvantaged areas.

So, preparatory phase is followed by data collection and analysis phase. During this phase, enumerators conducted household interviews using the household assessment form. So the HAF is a questionnaire with 52 items lifted from the family income and expenditure survey and the labor force survey. For data collection tools, we used paper and pen in urban barangays and tablet computers. We used paper and pen in rural barangays and tablet computers in urban barangays.

Simultaneous with the household enumeration, area supervisors also conducted assessment of barangays using the barangay community characteristics form. It is derived from the 2010 census of population and housing. It profiles barangays based on presence or absence of community features, such as health and education facilities, commercial establishments, street patterns among others. This information collated by our field staff using paper forms are then endorsed for encoding and processing using the proxy means test, while those collated thrpugh tablet devices are transmitted directly for PMT processing.

This slide shows you the two data collection strategies employed in the second assessment as mentioned in the previous slide. The proxy means test is a statistical model that estimates a household income's based on non-income, non-food, non-cash variables, such as educational attainment of household members, housing materials and employment among others. These are income proxy variables that we consider as both observable and verifiable. The PMT was selected among other targeting methodologies because it has been proven effective in Latin American countries with large informal sectors, such as Costa Rica, Chile, Colombia, and Mexico. In the Philippines, 40% of the population belong to the informal sector whose incomes are hard to measure. Well for example, a tricycle driver or a street vendor cannot give you exactly how much he or she earns in a month or in a year because their incomes vary on a daily basis.

While the PMT has been proven effective as a targeting mechanism, it is not perfect or 100% accurate like any model based methodologies. It is possible to have inclusions or exclusions error; inclusion errors refer to when true non poor households are misclassified as poor, while exclusion errors are when a true poor household is misclassified as non-poor. So for the

Listahanan 2, we tightened on quality control on operations and enhanced the PMT to minimize these errors. The following slide will show the enhancement done in the 2015 model in comparison with the PMT model in Listahanan 1.

To ensure that we will have lesser error rates in the second assessment, we shifted from using urban-rural models to NCR and the rest of the Phiippines sub-models. As you may know NCR is unlike any other region in the country. As it is composed mostly of highly urbanized areas, to be exact we have 16 cities and 1 municipality in NCR, and its cost of living is higher compared with other regions with urban areas. We also installed another layer in the PMT application, one approximates income, while the other minimizes exclusion inclusion errors. We updated the variables and indicators used by referring to the 2009 labor for surveys and NFIES. We also added variables from the 2010 CPH, the latter was due to a recent study on poverty revealing that characteristics of communities or barangays influence or affect the living condition of its residence.

In 2009, during the first assessment, we used the 2006 threshold as basis in determining poor households. This was because 2009 thresholds were released only in 2011. But now with PSA releasing the poverty thresholds and estimates per semester, we were able to use the 2015 threshold for the second round. These enhancements reduced the overall error rates of the PMT from 22 to 35% in Listahanan 1 to just 6.9 to 19% in Listahanan 2.

So how does PMT work,? First, the PMT computes for the household estimated per capita income using the household data collected from the half. So each variable is assigned a specific weight then the PMT classifies household to poor and non-poor using the 2015 official provincial per capita poverty threshold as reference. Now as you can see from the slide, households with estimated per capita income higher than the threshold are classified as non-poor while those households whose estimated incomes are lower than the threshold are classified as poor.

So after we generate the initial list of poor based on the results of the PMT, these lists are posted at the barangay level for the community to scrutinize. The community may file a complaint or appeal to the assigned supervisor if they know someone who should or should not be included in the list of poor, or if they weren't assessed during the collection phase. We have a local verification committee at the municipal city level comprised of the social welfare development officer, planning officers and three other members who are representative of civil society organization, which acts and recommends resolution to these complaints. These households may be reassessed and subjected to the PMT model to generate the final list of poor.

Results of the assessment is shared through the production of national and regional profiles of the poor, while the list of poor will only be shared through the execution of a memorandum of agreement between the requesting party and the DSWD. This is to ensure the security and confidentiality of personal information shared and it's use only for purposes agreed upon by both parties.

Well, through this process, we were able to identify 5.16 million poor out of the 15.2 million housholds covered in the second round of assessment. The regional breakdown of this result is shown on the next slide. As you can see, ARMM remains to have the most number of poor households followed by Region X and Region VII. These statistics can be further disaggregated based on the following data items: basic information such as names, telephone, age, date of birth, gender, marital status, education occupation, socioeconomic such as housing features, water, electricity, toilet facility, appliances and motor vehicle and other program related information such as persons with disability, overseas workers, indigenous people's group, displaced persons, and those who have received programs and services.

Several data sets can also be generated from the database as listed in the slide. So we have the magnitude of poor, housing conditions, health, education, labor and employment, and other program details. So, the most requested data is actually the magnitude of poor, followed by magnitude of poor by basic sector, socioeconomic information and family roster, access to basic services and individuals with disability.

For our recommendation, Listahanan is a rich data resource, which contains about 70% of our 22 million estimated household population. Our recommendation is for PhilHealth to maximize the use of the databasem which can sort poor households by income levels through this, PhilHealth will be able to extend their services to those with income slightly above the poverty threshold provided that they are not gainfully employed or paying PhilHealth contributions. Also having the database will allow them to conduct name matching of point of services clients with Listahanan 2 identified poor. This will enable PhilHealth to validate their socioeconomic status and provide the necessary assistance. Likewise, this will enable us to check which of these households were not covered by the assessment. Last is to extend the coverage to daycare workers in fourth, fifth and sixth class municipalities that have difficulties in paying health insurance of staff due to inadequate internal revenue allotment.

Well, thank you, this ends my presentation."

INTRODUCTION TO DR. BANZON
(4:03:02-4:04:01)

By Mr. Manolito Novales
Professor, Ateneo School of Governance
Ateneo de Manila

"Thank you. Thank you Ms. Apit for giving that information to all of us regarding the Listahanan Program. It's a very good handle in terms of really targeting the poor, specifically in those regions that need health care the most. So, yes I'm sure you have some questions regarding the topics that were just presented this afternoon, especially for this particular session.

So again just like in the other previous sessions, may I request everybody to put your questions in a piece of paper and I'll read them later on so that our speakers can respond to them as

need be. Ok? So for our final topic for this particular session, we are going to discuss the 'Squeezing the Middle and other sources of funds' Dr. Banzon."

UNIVERSAL POPULATION: SQUEEZING THE MIDDLE AND OTHER SOURCES OF FUNDS
(4:04:09-4:29:50)

By Dr. Eduardo P. Banzon
Principal Health Specialist, Sector Advisory Service Cluster,
Sustainable Development and Climate Change Development, Asian Development Bank

"Magandang hapon po. Maayong hapon. I was looking at the logo, it says 22 years; it makes me realize probably how old I am. Because it was… it has been 18 years since things started being evolved with PhilHealth.

First time around was I got into this committee called the Health Technology Assessment Committee; it was 18 years ago. And it was quite funny, because in a sense, the resistance are probably there. To the idea of using evidence to drive benefits was quite significant and I think 18 years after we still have that. But more than that, what really got me to think, as I was listening, was that I remember 17 years ago, I think there are people here who have been around.
When we talk about coverage - population coverage - what was the discussion then? The discussion was how can we collect money from the formal sector? It was a very formal sector discussion. The discussion on the IPP event, although they're paying it was like… it's nice to do and then nobody talked about it. The informal sector was sort of, let's do a pilot and that's how of course the whole IPP, the indigent pilot started in about three provinces if I remember it.

The whole discussion that the PCB, now OPB, was essentially something that came out because Governor Lina, for those of you who remember, was complaining why her premium was much more than the benefits she was getting. And so that triggered the creation of OPB based on an old study by Medicare, which is essentially then of course marketed as a rebate.

In a sense, that was the discussion, right? For those of you who are old enough, and that is the discussion that happened. Then we question now, what happened in 2004? Was it 2000, even before 2004? And then, the elections happened. And then basically, that was when you had that rapid scale up. I remember the discussion when we say, okay let's cover half a million - that was 2002. If I remember that, half a million poor that became the target and it was something that people reacted. How would you cover the poor? 2004 elections, elections of course triggers a lot of reforms and it is something that we have to recognize, not just in the Philippines, but also in a lot of countries.

And so what was in a sense, the reform, not a full scale reform, was in a sense. The resistance to cover the poor lessened and we have about 4 million household that got enrolled. There will always problems. The selection of the poor was done from below. It was political, there are questions about names, you will always have problems with reforms.

Now, as quite interesting, is the discussion has moved forward. And so in a sense 18 years have happened, PhilHealth is still trying to solve a lot of problems as I listened to my former boss Thomas, the problems are so many. But yet, it's so enlightening to hear that the discussion is a little bit much more mature, much more forward looking. And now we're gonna talk about whether it is dapat ba, or should we enroll the poor or not, which was the discussion then. But how do we do it 100%?

So it's a different discussion we have right now. Now the people are talking Universal, not the 85% Universal which was elegantly used before by PhilHealth to justify the UHC where 15% of people will not be covered, which created a lot of snickers, giggles and laughter whenever I go to any conference globally - because how can we call it universal 85% into really covering everybody now.

And so as we reflect on universal as 100%, let's step back a bit and start thinking you know what really drives because you know when you talk about Universal, where does this come from? People say Alma Ata and I love to use this, because people talk about Cuba. But in a sense, Alma Ata comes from the whole desire of Universal access, that's what one of the core element that was there. Alma Ata is when they start talking 'health for all.'

And why did we need to have Alma Ata, 'cause despite the fact that health was considered a human right in 90s, right after World War II, 1946 and the WHO constitution talks about Universal access. In the 60s and 70s, this was not really there, people don't really talk about 'health for all,' so we need to have that out and spoken to, and so the Alma Ata came about. Then, since then, it took years you know, the 80s you know, people started grappling what is health for all, how will you do it.

Then something happened. There was again, I think 2005, yeah 2005, people say you know, let's do it. And there were little changes. Now, people started realizing, you cannot talk about health for all, unless you talk about money. It's not just about having service, it's not just population, it's about making sure that enough money is mobilized. Even of course prior to this, there are a lot of other things that has happened. I think there are too many slides if I do it. I don't want to be told to wrap up.

So in a sense, this led to something we called UHC, came out, I think I always say around 2005, people started talking about Universal Coverage. They started, they said let's invigorate primary health care and it came out in a World Health report around 2008 and 2010, it came out in a report, WHO, I think. Tessa was a part of this, were you a part of the report? A report came out that said, you know, unless you fix health financing, then you cannot have Universal Health Coverage. And this is important, because health financing in the Philippines, would always include the discussion of PhilHealth. And in the sense that the Philippines made a decision by having PhilHealth and mobilizing government money and budget into PhilHealth, that it's part of the instrument, the government would have in order to achieve Universal Health Coverage.

So what's Universal Coverage? I think you understand what this means right? I'm making sure and am emphasizing all people okay? It's not just the poor, it's not just the informal sector. It's

all people and of course, there are other parts of the definition that was discussed earlier - needed health services, you know. I think John knows more about needed health services than we're having right now. And we need to make sure when that's being accessed, there's financial protection. I think that was discussed earlier by the panel by Alex and our good friends from PSA.

So, this UHC of course, is more than now a health thing, it's now a UN thing. So it's actually there and the sustainable development goals. It's part of sustainable development goal point 3. They worded it a little nicely because part of the reaction when the UHC, when people start talking about UHC kasi it's too much about financing, it's all about money, and of course a lot of health people say, push this, push back, it's not just about money. So the way it was finally defined in the SDG 3.8, it's not just about financial protection. They actually tried to explicitly talk about healthcare services, medicines and vaccines. Okay. So just to highlight the fact that this is not just about financial protection, this is also about the making the services that are actually spelt out quite explicitly as part of the SDG agenda.

So let's go back to the cube and let's go back to what was then. Gitchi asked me to give this talk, I was a bit surprised and I actually said no. But it's difficult to say no to Gitchi at a certain point, right? She knows probably too many secrets since I was here 18 years ago but nonetheless this slide was a slide by a friend from Thailand. Okay so, I copied this, stole this, forgot to put the reference I think I should, I could not actually spell his family name but this slide that Veroge, if you heard of him, a number of you have actually been sitting because he's been going to Manila quite recently from Thailand - actually shows this slide and basically what's the message here? Okay. Unless we are a country that made a decision, I think the Philippines made the decision I said earlier, you have not made the Cuban decision, okay. You have not decided in the universal coverage where everybody gets services out of their budget, where everything is free, so imagine the government healthcare delivery system, everything free, no private and that's where all the resources of the government come in. In the sense the Cuban approach.

So the Philippines made a decision way back in the 70s, when they came out with Medicare and then PhilHealth that the private sector becane part of the ballgame in the Philippines. Okay. We will tolerate the private sector, we even harness the private sector and so in a sense, Medicare, you and the government's decision was to use purchasing. Okay. To discipline the private sector or attempt to discipline the private sector, and Tony's here so I don't know how well, you can discipline the private sector - that's probably another presentation.

But nonetheless, so we are in effect sort of, there's still that universal part you have that… You have that for lots of services where everybody is supposed to get that service no matter what. You talk about vaccines; you talk about family planning because by law it's there. But then everything else basically, everybody gets their coverage. In a sense now, to use into PhilHealth. So the Philippines is a bit confused admittedly, we're still in that mix thing. Eventually certain decisions have to be made where the country will go. But if we assume that the general direction on how coverage or access to needed health services would be done, this purchasing approach then this is how we could imagine the population being covered right now.

The formal sector will be there. It's an easy way. If you look at premiums, it's an easy way to get money, right? It's a very easy way. You know, you just deduct from somebody's salary. And it's just political whether it's going to be 2.5%, 4%, 5%. If the political will is actually there, right? It's the easiest way. It's not that difficult to get, to collect premium. Of course, once the size of the company - sorry if the business becomes smaller then it becomes a problem. But as long as the business is actually complying, you know, pays their taxes, and needs to make sure that they comply with government. A little bit afraid of DOLE because they have to comply with work standards, easy money.

And so the question really is can you actually get more money from them? That means can you manage the employer's confederation of the Philippines and the labor unions whether you can have that, can you actually get the finance ministry to agree whether or the trade, more on the trade of ministry of this country, whether that would create lesser jobs because investors won't come here to put up business because there'll be so much money that they have to pay for health insurance and other social security requirements. Can you actually capture in the sense, smaller companies?

In a lot of countries, a number of countries basically gave up and they said, if you are small, less than 10 people, less than 20 employees, okay we won't do compulsory because we you can't actually do the job. But in the Philippines, and I think given the technologies that are evolving right now, the point that you actually track small businesses much more easier, you know the phones, the smartphones, IT, a little bit different than it was. I think this is something you should focus on, so that's the top. And frankly to continue to do that, the Philippines has gotten lucky that we have a single fund already.

Then your bottom is basically subsidy, politically it's easy to justify, so the question is… The question was never whether you shall subsidize the poor in the Philippines, into Medicare then or even PhilHealth. That was never the question because people will always say yes. The question has always been, 'who is the poor?" Okay.

And that's still a continuing debate right now. Traditionally our approach is two ways, either the hospital say you're poor or you politician, oh sorry, barangays, municipalities basically will make a determination that you're poor. We changed that with NHTS. What was this Listahan Approach? It was a top-down approach. Central government basically said who is poor, that was an amazing reform. For the first time, it's not the hospital; it's not the barangay captain; it's the top, somebody a more, sorry, somebody in Manila who was saying that.

So in the Philippines we did that, so it was easy to politically justify what Thomas presented SIN Tax because then the discussion was okay, let's use SIN tax for the poor then it's easy to say it's going to be used for insurance for the poor. The health argument has already been connected, it was much more easier to have it passed because you say added money, the incremental revenues will go to health. It was easy to justify it's going to subsidize the poor. Okay.

Then you're stuck na with the middle, in the Philippines, of course this perspective is a little different because now I think we're hitting about 35% from the top, the bottom is about 60% so you have the middle. Okay. Always have been a dilemma, how do we cover them? Some people say well politically, it's difficult to subsidize them because when you start subsidizing non-poor then the education people will say, 'why are you giving money there, give it to me.' So it's not just a health issue anymore, it's going to be the other sectors that are demanding also government budget saying why would you give money to cover non-poor into PhilHealth when you should give it to me.

Now the Philippines needs a very elegant way to cover non-poor, you call it the Senior Citizens Act. So, now, if you look at it, if this is poor, sorry, you could slice that a bit and in the sense you're already covering a lot of non-poor senior citizens then you have something else that you call the Disability Act, because now also those who are disabled will now be covered.

So now, you have a very slim, mostly sliver of non-poor that is being covered. Makes you think, why not you just do the 100 miles and cover everybody. Because in effect, the Philippines is already subsidizing this, how do you subsidize it? Well, it's called, for every peso premium that you collect from the informal sector, you're paying three (3) pesos of benefits. That's a subsidy, it's we called 'Point of Care'. That's a subsidy, but you sort of do some calisthenics to make it politically acceptable by not calling it explicit subsidy. So, is there a point that you could actually do just cover everybody just who is in informal sector – A.K.A. the 'Thai approach.' Politically you'll be able to argue and get this pass congress I hope you can. Okay.

So, let's just do this, because I was told to do a discussion on what's happening globally. So how do we do it? Okay. Number one is Cuba, okay. And if you look at Asia and the Pacific, sorry I work now in the Asian and Development Bank, partly Sri Lanka but not fully because in Sri Lanka a significant chunk of the population now is actually getting health care services from private hospitals. So in the universal population basis of things, I copied this slide. And in the sense you have this key form, the informal - you fully funded the informal sector with the budget. That's Thailand, okay.

So, remove the middle, formal sector you pay, compulsory. Everybody else you subsidize. The third is you have a subsidy, an explicit subsidy, and a lot of countries. So Vietnam is doing it, Philippines, in effect. And a lot of and so if you look at the stories of a lot countries, the formal sectors compel the poor to be subsidized, then the middle, partial or significant partial subsidy. Then you have this the middle, we just ask them to pay. Now this approach is quite bad. Because at the end of the day you won't fit universal coverage, and at the same time, you'll end up implicitly subsidizing in a very inefficient manner and so in the sense, the Philippines is here right now. Then of course you could also do, in some countries where they just have certain services as universal. As I said earlier, the Philippines still has a universal population based, general budget revenues for certain services, so we're a mixed system and in a sense that's part of the dilemma that the country has to address. Okay.

So moving forward, what are the things, well, let's not forget okay, PhilHealth came from Medicare. Okay. Are there people, friends from Medicare here? No, no. Okay Medicare basically started from the employment part, so in a sense, coverage was always considered as

your right because you're a worker, okay. I hope that in PhilHealth here in the Philippines that thinking has been removed. You're covered because you're a Filipino, I will even argue, your coverage is because you are staying in the Philippines, so even if you are a non-Filipino, you should be covered. And that you stop looking at it as a how do you call that be smart, beverage, these are dead people. It's a system; it's an approach to cover, it's a cover for everybody.

I wait for the day that when you start hearing this you start, it's been described as the heroine system. I'm just saying if you're listening Alex. Sorry, so in a sense, there are two things that need to be done: you need to subsidize and you need to compel. Okay. And so, PhilHealth, how good are you in compelling? How good are you to get old enough subsidy, enough money to subsidize everybody whom you cannot compel, or in a sense provide substantial subsidy to the point that there is no reason for that person to pay anymore? Okay, so that will be the challenge for you - to cover universal coverage.

Is this something happening only in the Philippines now? It's happening all over the world, wherever you go and this was in the 2014 slide from Inky; I never got to update this. So wherever you go, whether Latin America, you go to the Middle East, you even go to Japan, Korea, you know you're looking into these systems, even European countrie. I think Conrad will agree with that. The poor are subsidized in a lot of these countries so it's just discussed. The subsidies are just so done so cleanly but what really is happening is that this combination of subsidizing the informal sector, the poor, is a given now in lots of countries so it's really taking that next step that I think is necessary, I think in the Philippines should consider, 'where's the money coming from?' Okay.

So before developing countries like the Philippines, of course if you are a middle income, sorry, or an upper middle income country, or even like Thailand, you could actually mobilize the money out of your budget and pay for it. But in the more middle income or low middle income countries, you have to really be elegant in a way you get your finances schemes. So in the Philippines, we're getting it of course from tobacco and alcohol taxes. Of course though, let's think about it right now, you could now justify drinking because you're doing it for the sake of a poor person you want to subsidize. But oh you're listening, so but we're not unique okay. So everybody, a lot of countries are actually considering it, and part of the reason I think that June Paul is in the States, I'm sorry is in Geneva, is because they could now argue how Sin Taxes, and… Debbie's here so… and in a sense how to get sin taxes mobilize and use for health.

Now there are other ways, gambling okay. Is there gambling in the Philippines? Ah, we have Lotto. There's no gambling, no. There is gambling but there's for. So it would nice if all of the money… I'm trying to get a target here of one of you guys that you lose somewhere in Solaire or somewhere there, gets part of it goes into premiums, they actually do it in a number of countries. Carl Chua is trying to make our taxes for cars higher, right? So excise tax, some countries use that particularly, excise taxes for 4x4's and expensive cars and they usually end up in health insurance.

VAT is another one, very clean way to get money. Admittedly, some of these may be regressive in a sense that the poor end up paying more. But this can be you know, you could never have

perfect progressivity and so the challenge really is that this happens and you make sure you fix the other parts. Okay.

What are the other parts? One of course, this is what John, you know, you should, the Philippines have reached a point that have always done of what we call negative list - that means we cover everything except for some, then we cover up to a very low level. Now, the Philippines wants to move ahead, it really needs to be a little bit more evidence-based. I think you have already done the work. Now, luckily for us, these guys somewhere in the States have been doing this global burden of disease, somebody is doing the work already for lots of countries and all we have to do is to use the work that they're doing and adopt it for the Philippines.

Same thing with HTA. I remember 18 years ag, it was so difficult to get things done. Now, this is not rocket science, there's a lot of expertise on the ground, lots of things have been done here. It's usually a question of adopting this. And at the day of course, let's not forget, never forget, whenever you make any decision, this is rationing decisions, there will always be trade-offs. And always ensure, of course that after you've covered everybody, then you start talking financial risk protection, sorry this is very interesting, I'd just like to show this slide. Because right now within the SDG discussion, there are two indicators that are being developed. The first one is quite, I don't know how to fix this, they say, they call it as service indicator. So they're using a tracer on a number of services. The second one is quite interesting, because initially, we only want population coverage. So number of people who are covered by insurance or a public or a government scheme, and that's enough. Now of course, this was resisted because as we said earlier, it's not enough to cover people, you need make sure there's financial protection.

Sorry, let's talk about WHA. One the things said here you know, you talk about purchasing. Do not forget that the power of purchasing is strongest if you're a single purchaser. Okay. All you have to do is look at SM or these big monopolies: Mercury Drugstore, okay. And how they could actually drive down prices because of the purchasing power. That's what you're doing, really. Sorry, my last. My last slide, sorry. The Philippines, let's not forget, does not on an island. We're an island so I cannot say that - it does not operate as an individual country and I love and I think I love to emphasize this point particularly when we have presidents like Trump and a lot other economic nationalists taking over lots of countries at the West.

One of the things you have to talk is that UHC also needs countries to work together. If 10% of Filipinos, sorry I really need to check those numbers, but if 10% of Filipinos are actually working overseas, we should be arguing that UHC is not just country specific, but it should be global that when you start talking about having access, then mechanism should be put in place. There are 10 million countrymen, whenever they go anywhere, should also have coverage, where in a sense PhilHealth do not look at it, that you go you pay, it's enough. But you actually put in resources and demand the receiving countries to work with the Philippines to make sure that UHC is global. So, at the end of the day, finally, to move forward, this is about implementation. As I have said, it's been 18 years. I feel old and this is probably not the first workshop that I sa in that I've been part here in Shangri-La. I blame this hotel for part of the reason I gained weight because there's just too many meetings I have to attend here - sit

and listen to experts and talk about a lot of the things that I probably said and what probably you heard already. Okay.

The challenge for the Philippines is this, you know. Time of talking, well you already moved ahead but I think it's really time - it's about time for implementation. Time to stop listening and talking, and listen to the words of the guy, I've liked this guy, he's the guy who introduced CCT in Mexico, president Ernesto Cedillo. I said you know, CCT implement, as long as you have clarity of purpose, clarity of design, clarity of financing and clarity of incentives, you get things done. Now that sounds confusing but you know in a sense, it's all about implementation at this point. Thanks a lot."

TRANSITION TO THE DISCUSSION/OPEN FORUM

By Mr. Manolito Novales
Professor, Ateneo School of Governance
Ateneo de Manila

"Thank you Doc Dodo - very comprehensive 'yung kaniyang presentation. So, I think there is one key buzzword that I remember from all the talk. The bottom line is implementation - enough of talk. So, the decision is up to, well for the Philippines to really move ahead. We have heard a lot of things in terms of recommendations, where the gaps are, the challenges, but at the end of the day it's about decision and the moving ahead with that particular decision to make things work. So…"

DISCUSSION/OPEN FORUM
(4:30:30-4:36:26)

By Mr. Manolito Novales
Professor, Ateneo School of Governance
Ateneo de Manila

"*So meron po ba tayong mga tanong from the floor? We'll entertain one or two questions. So meron po ba? So I think it was a long day."*

"Just a comment…"

"Yes Ma'am."

"Actually I just wanted to stress again what Dodo Banzon said 'too much talk and not enough action.' I was gonna ask I heard… Dr. Erick Tayag. We've talked about gatekeepers. Is PhilHealth ready now to say 'we will not pay for benefits and they do not pass gatekeepers, if they go straight to the tertiary hospitals who's gonna put this all together?

Because I've gone through so many meetings and really too much talk and you see the ideas but they're all fragmented, so questions, PhilHealth is ready not to pay unless you pass thru a gatekeeper, it will also solve a lot of fraud, it will also solve a lot like the portability clause

must be re-examined, it's gone too far because it gives excuses for communities not to be responsible for their people.

The nice thing about the Thai model is that they have really structured 'you're in-charge and you can only go out if it's not available.' So are we ready to really do this? This implementation and that's why Dodo I want to second what you said…There's so many good ideas, but they're not put together and we need to really move forward.

"Yeah… Doc Dodo."

"Gatekeeping, sorry. It's how we understand gatekeeping. I don't know whether I'm the only one here, but we this traditional view that a gatekeeper is a single physician, if it's that, then you could imagine wider resistance, but if we start gatekeeping really as like polyclinics.

Let's talk Cuba, Cuba basically their strength is the polyclinics, something like that where people are actually comfortable that when they go there, they get all the necessary primary care services. Then your resistance why people won't go to the gate keep, won't be there. Because as I understand before the reason that people don't like is because 'why would I have to go to the midwife, why we have to go to the single physician/doctor who's not there?' So if the primary care providers in the Philippines can be sort of envision to be much more, you know, well equipped and if you look the Thai's, the primary care unit is not, are well equipped. They can actually manage a lot of conditions already. Then I could imagine the gatekeeping system will actually, it's easy to make that happen in the Philippines. So you that service delivery aspect that has also to be managed quite rapidly."

"So, another question from the floor? So I guess, wala na.

So, and it's, well, everything has been clearly communicated to all of us regarding all the issues, the challenges since the first presentation, the Sin Tax law is really a milestone reform in terms of making sure that funds are available or even to augment the existing funds in terms of a mechanism for ensuring resources are provided to the health sector to ensure reform. And as what mentioned in that particular talk by Dr. Palu, it's that, while there are resources afforded to our, to the health sector in terms of making sure that people get access to universal health care, but there are also certain segments of the population that are not contributing to that particular funding mechanism.

And that is quite a challenge that we need to look into so that if you're going to make policies and programs work. These particular mechanisms have to be more effective and responsive to the needs of the Philippines as a context in terms of pursuing health care reform. There are systems; there are targeting mechanisms that are instituted to do a way with the politics of targeting the poor more specifically, but again the challenge is looking into the bigger chunk of the population which we called the informal sector, and doc Dodo has particularly mentioned in his particular talk that there are several ways for us to target the informal economy workers in such a way that they would be compelled to contribute to the system.

Now, the challenge is, what do we decide in this particular context? How are we going to go about it? What particular policies need to be in placed? What is the funding mechanism that we need to pursue? And all of these have to be looked at in terms of clarity and that I close this particular, with that particular message, the bottom line is moving ahead after all that has been said and done, with what we need to now is make that final decision and move forward. Ok? So to give us the final synthesis for this particular forum, I turnover the floor to Dr. Konrad Obermann."

SYNTHESIS
(4:36:26-4:42:58)

By Prof. Konrad Obermann, MD, PhD
Senior Lecturer, MIPH Mannheim Institute of Public Health – Heidelberg University

"What do you want me to say? What do you want me to say? Okay. It's been tricky isn't it? I mean it's 5:30, we had 8 ½ hours since 9:00 AM this morning. We had a lot of excellent presentations, fact-filled, very dense and now I'm standing here. I'm supposed to put it all together. Instead of recapping everything, and I don't think I would do justice to all the excellent presentations, I think I would like to put forward three suggestions and those three could be very briefly summarized as: focus, monitor, and research research.

Let me go through it one by one, and it shouldn't take more than 5 minutes really, and I think all of you will be happy and it's rather short and snappy. So number one is really focus. I don't know, at the end, mentioned clarity quoting the Mexican president and I think pretty that goes into the same direction - there are so many issues that could be tackled. There are so many issues where we know things could be improved. There are so many issues where we have some data but the key is really to say, 'where do we put our focus? Where do we start.'

And I think it wouldn't be as helpful to differentiate what PhilHealth can do as a corporation and what PhilHealth probably cannot do on its own but rather, it requires supports from higher or other governmental institutions, and for the first one, I would think a few things that could be done is talk about gatekeeping which was mentioned. I think that's a very important issue.

Talk about reimbursement rates. You know, proper calculus, what does reimbursement rate include, does it include the depreciation of hospital buildings or is it something that could be covered by the LGU or respectively the federal government or central government? Look at the question of No Balance Billing. We've heard about this, look at the question of medicines - the level of medicines that will be reimbursed and moved from a sort of negative list to a positive list, sounds better anyway. Positive list, but of course, it is fiercely contested by many.

So these are a few things that I think should immediately be tackled and could go, could be delegated to task force. If you look at other issues, like Dr. Herrin was mentioning, the question for example, the current rate of premium rate of 2.5% could go up to 5% according to the law, but of course that's not something up to PhilHealth to decide. But there's a need to push it to be the advocate, to work the system, and to lobby. And in order to bring that

forward, because at the end of the day you need more money if you want to catch a larger charge, a larger portion of the overall health expenditure in the country.

Secondly, the issue of monitoring. If you don't know where you are, if you don't know whether things are getting better or probably getting worse, and Dodo was mentioning the middle class here, it's very difficult to say, where are we now? What are the best policies to move forward? And I very much like this differentiation of the National Health Account according to quintiles, where you can quite clearly see that the non-OOP is pretty evenly distributed amongst the five quintiles, which I think is a very good starting point. But of course the question is, should you move more of this from the richest to the poorest quintile?

So these are the key things here. And I liked Mrs. Sabeñano's presentation very much on the National Health Account and also showing the Listahanan results where you can clearly see, where are we moving, what sort of data have we gotten what sort of data do we not have for the time being.

Thirdly, the issue of research. It was mentioned, and we've heard about it - there's an idea of setting up, well it's not an idea, it's really getting real health technology assessment with the Department of Health becoming its sort of independent institution. The question is, what could be PhilHealth's roles? Is the money or is the will to say we set up a research institute on social health insurance research institute on evidence on health financing, on evidence on benefit packages there? Because the need is tremendous and the need is constant so it would be worthwhile to develop a carder of experts who could provide answers to questions that are posted by policy makers.

Yes, and I think with these three issues of focusing - you may want to call it clarity, the issue of monitoring and finally, the issue of research - of improving research and enhancing research capacity. I would like to finish - to me it was an extremely stimulating and helpful event. I tremendously enjoyed. I can say that I learned a lot and it's very good to see how things do move forward. It just takes time I suppose and wherever you go, people would say, 'oh it's not moving and it's so slow,' when it's also very political. But I think, it's wherever you go and this maybe just the level of political influence change, but probably not too much in the end. So the number of problems you encounter, probably the same wherever you go, it's just the different type of problems. Okay with that, I thank you very much and wish you a good evening."

CLOSING REMARKS

SVP Gregorio C. Rolluda
OIC Senior Vice President, Fund Management Sector, PhilHealth
Chairperson, Anniversary Committee

"Thank you Nina, the most awaited. I'm not here to present to you the financial status of PhilHealth. Achieved!

Today's activity comes to an end and based on the proceedings of the activities. It was a productive and challenging one. Sharing of ideas based on international and local experiences

and perspectives. The dynamic discussion most probably gave us, we, in PhilHealth and our stakeholders, points to consider on how we move forward in attaining nd sustaining Universal Health Coverage. Right now, we are challenged by change and this change will translate to policy development, evidence-based researchers and holistic approach on how we will provide a reasonable level of financial risk protection to all Filipinos. Bawat Filipino, Protektado.

I hope PhilHealth was able to respond to your expectations on this symposium. And our prayer this morning was realized as we were given the opportunity to learn and deepen our understanding on the opporunites and challenges in the implementation on the National Health Insurance Program.

Special thanks to our development partner, the EU, PhilHealth board of directors, the Department of Health, national and local agencies, Constitutional Commissions, other government and private institutions and organisations. Maraming maraming salamat po!

PhilHealth executive management would like also thank the members of the 22th Anniversary Committee, the technical working group headed by Senior Manager Hilda Salvacion and Senior Manager Evelyn Bangalan, the registration staff, staff of HFPS, SMD, ACRE, BDRD, QA, the iLED, corporate marketing, internal audit, corporate affairs group, corporate communication, HRD, FMS, and of course the transportation, ushers and usherettes, PhilHealth Chorale, maraming maraming salamat, and of course, the Shangri-La Hotel Management.

I will end by a quotation by Helen Keller, "Alone we can do so little. Together, we can do so much."

Ladies and gentlemen, let us be one in making the PhilHealth agenda specifically Universal Health Coverage a reality to our country. Once again maraming maraming salamat at mabuhay tayong mga Pilipino!"
