



**The European Union's DCI-ASIA Programme for the Philippines**

# **Technical Assistance for the Philippine Health Sector Reform Contact**

**EuropeAid**\_\_\_\_

*Name of Report: Documentation of the 22<sup>nd</sup> Anniversary  
PhilHealth Symposium*

*Theme: Challenged by Changed, Empowered by Unity*

*Banner Title: Bawat Filipino, Protektado: A PhilHealth  
Symposium*

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## PREFACE

2017 is a milestone for PhilHealth as it marks the 22<sup>nd</sup> Anniversary of the Philippine Health Insurance Corporation. This symposium is one of the major events lined up in February, in celebration of the National Health Insurance Program Month. Here, almost 500 participants consisting of public and private sector stakeholders including government agencies, local government units, health providers, the academe, civil society organizations, patients groups, and the media, all came together in pursuit of one goal, Universal Health Coverage (UHC).

This year, its theme: *“Challenged by Change, Empowered by Unity,”* brought international and local speakers into one forum in order to share their experiences and the lessons learnt on working towards Universal Health Care as echoed by the banner title, *“Bawat Filipino, Protektado: A PhilHealth Symposium.”* Speakers from across the globe presented various country experiences and best practices in the pursuit of UHC. At the same time, local leaders and experts detailed the progress, the challenges, and the strategies and measures that PhilHealth is currently facing.

Supported by the European Union (EU), this activity showcased local and international experiences on achieving UHC. The one (1) day program began with a talk by Prof. Konrad Obermann who shared about other countries’ experiences in pursuit of UHC. This was followed by a narrative highlighting PhilHealth’s journey towards UHC. As the organization looked back to more than 20 years of service, the conference was able to recognize and pay tribute to the hard work and successes that each and every one made in order to bring PhilHealth to where it is today.

The symposium was divided into three (3) major parts, patterned after the three (3) dimensions of the Universal Health Coverage Cube namely, (1) the services covered or the depth, (2) the proportion of services covered or the height, and (3) the population covered or the breadth. Each dimension was discussed and moderated in panel sessions that fleshed out the trials and opportunities for early harvest in social health insurance. In the end, recommendations and strategies on how to expedite the process of fulfilling the dream of Universal Health Care for all.

An exhibit was also set-up outside the conference, which featured the history and journey of PhilHealth for 22 years, as well as a 3-D model of the UHC Cube.

## LIST OF ABBREVIATIONS

4Ps	Pantawid Pamilyang Pilipino Program
AO	Administrative Order
ARMM	Autonomous Region in Muslim Mindanao
ARPaC	Asean Region of Primary Care Physicians Associations
BHS	Barangay Health Service
BLES	Bureau of Labor and Employment Statistics
CAGR	Compound Annual Growth Rate
CAR	Cordillera Administrative Region
CDC	Center for Disease Control
CEO	Chief Executive Officer
CPG	Clinical Practice Guidelines
COA	Commission on Audit
COO	Chief Operating Officer
DALY	Disability Adjusted Life Years
DILG	Department of the Interior and Local Government
DOH	Department of Health
DPRI	Drug Price Reference Index
DSWD	Department of Social Welfare and Development
GDP	Gross Domestic Product
EU	European Union
FACP	Fellow of the American College of Physicians
FEC	Formulary Executive Council
FFS	Fee-for-Service
FPCP	Fellow of the Philippine College of Physicians
GDP	Gross Domestic Product
GHBP	Guaranteed Health Benefit Package
GOCC	Government Owned and Controlled Corporation
GSIS	Government Service Insurance System
HFEP	Health Facilities Enhancement Program
HFPS	Health Finance Policy Sector
HMO	Health Maintenance Organization
HTA	Health Technology Assessment
IEC	Information Education Campaign
IHME	Institute for Health Metrics and Evaluation
IRR	Implementing Rules and Regulations of Republic Act
IT	Information Technology
LGU	Local Government Unit
LMIC	Low and Middle Income Countries
MAP	Medical Assistance Programs
MCP	Maternal Care Package
MD	Doctor of Medicine

MDG	Millennium Development Goals
MHA	Masters in Health Administrations
MRDP	Maximum Retail Drug Prices
NAPC	National Anti-Poverty Commission
NBB	No Balance Billing
NCR	National Capital Region
NEDA	National Economic and Development Authority
NHIP	National Health Insurance Program
NHTS-PR	National Household Targeting System for Poverty Reduction
NKTI	National Kidney Transplant Institute
NSCB	National Statistical Coordination Board
NSM	National Statistics Month
NSO	National Statistics Office
OIC	Officer-in-Charge
OOP	Out-of-Pocket
OSEC	Office of the Secretary
PAFP	Philippine Academy of Family Physicians
PAPO	Philippine Alliance of Patient Organizations
PCARES	PhilHealth Customer Assistance Relation Empowerment Staff
PDP	Philippine Development Plan
PHA	Philippine Health Agenda
PhD	Doctor of Philosophy
PHIC	Philippine Health Insurance Corporation
PMT	Proxy Means Test
PNF	Philippine National Formulary
PNHA	Philippine National Health Account
POC	Point-of-Care
PRC	Professional Regulation Commission
PSA	Philippine Statistics Authority
PSDP	Philippine Statistical Development Program
RA	Republic Act
RHU	Regional Health Unit
SDG	Sustainable Development Goals
SDN	Service Delivery Networks
SHA	System of Health Accounts
SSS	Social Security System
STL	Sin Tax Law
SVP	Senior Vice-President
SWS	Social Weather Stations
THE	Total Health Expenditure
UHC	Universal Health Care
UNICO	Universal Health Coverage Study Series
UP	University of the Philippines
USAID	Unites States Agency for International Aid

UST	University of Santo Tomas
VP	Vice President
WHO	World Health Organization
WHO-EMRO	World Health Organization – Eastern Mediterranean Regional Office



# PROGRAM OF ACTIVITIES

## Journey Towards UHC

TIME	ACTIVITY	LEAD
9:00-9:15 AM	National Anthem Prayers PhilHealth Hymn	<b>PhilHealth Chorale</b>  <b>SM Rey Balena</b> Senior Manager, Formal Sector Membership Management Group  <b>Atty. Allan Panolong</b> Chief, Health Care Delivery Management Division PhilHealth Regional Office - ARMM
9:15-9:25 AM	Welcome Remarks	<b>Mr. Johnny Y. Sychua</b> <i>OIC-Executive Vice President and Chief            Operating Officer &amp; Concurrent            CARAGA Regional Vice President,            PhilHealth</i>
9:25-9:45 AM	Message of the Secretary of Health	<b>Dr. Paulyn Jean B. Rosell-Ubial</b> <i>Secretary, Department of Health</i>  <b>Delivered by Dr. Raul Quillamor</b> <i>Head of the Executive Staff, Office of            the Chairperson</i>
9:45-10:15 AM	Presentation of Medium Term Development Plan and Corporate Dashboard	<b>Mr. Ramon F. Aristoza, Jr.</b> <i>Acting President and CEO, PhilHealth</i>
10:15-10:30 AM	Message from the EU Delegation to the Philippines	<b>Mr. Loius Dey</b> <i>Acting Head of Development            Cooperation</i>
10:30-11:00 AM	Achieving UHC in the Philippines: an International Perspective	<b>Prof. Konrad Obermann, MD, PhD</b> <i>Senior Lecturer, MIPH            Mainheim Institute of Public Health,            Heidelberg University</i>
11:00-11:30 AM	The Philippines' Journey Towards UHC	<b>Mr. Ruben John A. Basa</b> <i>Senior Vice President for Health            Finance Policy Sector, PhilHealth</i>
<b>11:30-11:45 AM Photo Session</b>		
<b>11:45-1:00 PM Lunch</b>		

## A Closer Look at the UHC Cube

### *Title of Panel: What and Where? Defining the continuum of health care services and delivery networks*

Time	Topic	Presentor
1:00 – 2:30 PM	Life Stage Approach	<b>Dr. Maria Ofelia O. Alcantara</b> <i>Health Policy Specialist Department of Health</i>
	Service Delivery Networks	<b>Dr. Enrique Tayag</b> <i>Director IV Bureau of Local Health Systems Development Department of Health</i>
	Benefit Prioritization Process	<b>Dr. John Wong</b> <i>CEO Epimetrics, Inc.</i>
	Benefit Prioritization: Primary Care	<b>Hon. Anthony Leachon, MD</b> <i>FPCP, FACP Independent Director PhilHealth Representative of the Monetary Board</i>
	Discussion	<b>DISCUSSANT</b>  <b>Ms. Karen Ida Villanueva</b> <i>Philippine Alliance of Patients' Organizations</i>
Open Forum	<b>MODERATOR</b>  <b>Dr. Tessa Tan-Torres Edejer</b> <i>Coordinator, Unit Costs, Effectiveness, Expenditure and Priority Setting World Health Organization</i>	

### *Title of Panel: Who Pays for What? Sharing the responsibility for financial risk protection*

Time	Topic	Presenter
2:30 – 4:00 PM	Philippine National Health Accounts	<b>Ms. Raquel Dolores Sabenano</b> <i>Senior Statistical Specialist Philippine Statistics Authority</i>
	Implementation of No Balance Billing (NBB) Policy by a LGU-owned Hospital	<b>Dr. Elenila I. Jakosalem</b> <i>Chief of Hospital Bislig District Hospital</i>
	Implementation of No Balance Billing (NBB) Policy by a DOH-	<b>Dr. Soraya Pesy Abubakar</b> <i>Chief of Medical and Professional Staff</i>

	retained Hospital	<i>Zamboanga City Medical Center</i> <b>Represented by Ms. Michelle Libago</b> <i>Administrative Officer</i> <i>Zamboanga City Medical Center</i>
	Discussion	<b>DISCUSSANTS</b>  <b>Ms. Ma. Gilda Resurrecion, MHA</b> <i>Consultant</i> <i>National Kidney and Transplant Institute</i>  <b>Dr. Alejandro Herrin</b> <i>School of Economics</i> <i>University of the Philippines- Diliman</i>
	Open Forum	<b>MODERATOR</b>  <b>Dr. Beverly Lorraine Ho</b> <i>Chief, Research Division</i> <i>Health Policy Development and Planning Bureau</i> <i>Department of Health</i>

***Title of Panel: Who Benefits? Ensuring the inclusiveness of policies and programs***

<b>Time</b>	<b>Topic</b>	<b>Presenter</b>
4:00 – 5:30 PM	Implementation of Sin Tax Reform Act of 2012 (Republic Act 10351)	<b>Mr. Toomas Palu</b> <i>Regional Practice Manager</i> <i>The World Bank</i>
	Targeting the Poor Under the Listahanan 2	<b>Usec. Rosita Villar</b> <i>Undersecretary</i> <i>Department of Social Welfare and Development</i>  <b>Represented by Ms. Krupska Lenina Apit</b> <i>Project Coordinator, Listahanan 2</i> <i>Department of Social Welfare and Development</i>
	Squeezing the Middle and Other Sources of Funds	<b>Dr. Eduardo P. Banzon</b> <i>Principal Health Specialist</i> <i>Sustainable Development and Climate Change Department</i> <i>Asian Development Bank</i>
	Open Forum and Synthesis	<b>MODERATOR</b>

		<p><b>Mr. Manolito Novales</b>  <i>Professor, Ateneo School of Governance</i>  <i>Ateneo de Manila</i></p>
5:30-5:40 PM	Synthesis	<p><b>Prof. Konrad Obermann, MD, PhD</b>  <i>Senior Lecturer, MUH Mainheim</i>  <i>Institute of Public Health, Heidelberg University</i></p>
5:40-5:45 PM	Closing Remarks	<p><b>Mr. Gregorio Rulloda</b>  <i>Senior Vice President, Fund</i>  <u><i>Management Sector &amp; Chair,</i></u>  <u><i>Anniversary Committee</i></u></p>

## JOURNEY TOWARDS UHC

Promoting and protecting health is essential to human welfare and sustained development. 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 the attainment of the highest possible level of health is a 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 coverage (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 these services does not expose the user to financial hardship. As such, the Philippines embarked on the challenge to achieve Universal health coverage where everyone who gains access to health care will not be impoverished. In this context, UHC 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 (PhilHealth) towards the realization of this goal.

The program started with the singing of the Philippine National Anthem, followed by solemn prayers, and the singing of the PhilHealth Hymn. Professor Nina Castillo-Carandang, the overall moderator for the event, welcomed all the participants to the symposium. She credited those who made the special logo for the said celebration. She shared the meaning of this symbol as it symbolizes what PhilHealth is all about. She explained that the multicolored vector images indicate the different publics, which PhilHealth caters to while the halo formed by three bright blue colors signifies their commitment to protect the people from financial hardships due to medical necessities. Lastly, the solid green entity in the symbol was associated with nature and health.



Professor Carandang greeted the different dignitaries who attended this occasion such as the PhilHealth Board members, people who had been part of the PhilHealth history, the various partners who made this symposium possible, colleagues in the Department of Health, attendees from different private and government institutions and organizations, and league of provinces. She then introduced Mr. Johnny Sychua, OIC-Executive VP and COO of PhilHealth, to give the welcome remarks.

## MODERATOR

### **Prof. Nina T. Castillo-Carandang**

*Health Social Scientist and Assistant Department Chair  
Department of Clinical Epidemiology  
College of Medicine  
University of the Philippines - Manila*

A health social scientist and clinical epidemiologist.

She is currently the assistant department chair of the Department of Clinical Epidemiology, College of Medicine University of the Philippines Manila



## WELCOME REMARKS

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

Mr. Sychua opened the symposium mentioning its theme, “Bawat Filipino Protektado.” He described today’s activity as another exciting and learning opportunity as we take a closer look on how the National Health Insurance Program has been doing after 22 years of its creation and the establishment of PhilHealth on Feb 14, 1995. He explained that the presentations have been clustered according to how the universal health coverage in general and through social health insurance in particular can be achieved, assessed, and appreciated depending on the country’s health care needs, resources, and priorities.

To quote, he said, *“With this theme, this symposium will showcase international experiences in achieving Universal Health Coverage. It will also give 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.”*

He continued with, *“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.”*

He mentioned that they invited panelists who will be discussing their own perspectives on how the National Health Insurance Program will always make a positive difference in the lives of all Filipinos here and abroad. To end his remarks, he encouraged everyone to join in this journey by actively participating in the discussions, sharing their insights, and asking questions because at the end of the day all of us are stakeholders of National Health Insurance Program. He motivated all the participants to continue the initiatives that concern our health and reiterated that being involved in this symposium is a good start.



# MESSAGE OF THE SECRETARY OF HEALTH

By Dr. Paulyn Jean B. Rosell-Ubial - Secretary, Department of Health  
Delivered by Dr. Raul Quillamor - Head Executive Staff, Office of the Chairperson



*"(Greetings) 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."***

# PRESENTATION OF THE MEDIUM TERM DEVELOPMENT PLAN AND CORPORATE DASHBOARD

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 millennials.*

*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 unsatisfied 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 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 knowhow 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 care 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."*

# MESSAGE FROM THE EU DELEGATION TO THE PHILIPPINES

*By Mr. Louis 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 Quillamor, Head Executive Staff PhilHealth Board, Secretary Manuel Dayrit, Dean of Ateneo de Manila, Professor Konrad Obermann, friends, colleagues, partners, ladies and gentlemen, health is enshrined in the 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 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.*

*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.*

# ACHIEVING UHC IN THE PHILIPPINES: AN INTERNATIONAL PERSPECTIVE

By Prof. Konrad Obermann, MD

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



## INTRODUCTION

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 in international cooperation in non-European countries. His project and teaching practice covers more than 20 countries in European, Northern Africa, Sub-Saharan Africa, Central, South and Southeast Asia.

He is a senior lecturer at MIPH Mannheim Institute of Public Health, Heidelberg University.

Prof. Konrad Obermann talked about the international perspective of PhilHealth's journey and development - ideas to dig deeper, where PhilHealth can learn from other countries' successful experiences and make it even better.

The UHC Cube shows national averages and disparities in coverage. In order for the policymakers to have an idea of what's going on, the more important aspects of the UHC Cube were highlighted and are as follows: regions, socioeconomic status, how people feel with respect to being covered having the services, and not having to fear financial problems due to access in health care. This is something that several countries struggle to get data from.

On the brighter side, PhilHealth has covered 92% of the Philippines' population and the vast majority are indigents. Also, premiums, incomes and assets are rising. The sustainability of PhilHealth is strongly on track; they were able to use the rationale of the benefit packages. Finances, on the other hand, are not yet a success story. Firstly, GDP is roughly at 4% and has not reached the WHO recommended target of 5%. Secondly, there is stubbornly high level of Out-Of-Pocket (OOP) expenditure and it remains about 50% of the

total expenses. Nonetheless, PhilHealth has moved forward since 2006 but it needs to bring down the level of Out-of-Pocket expenses, and from an external point of view, it will need to cover a larger chunk of the total expenditure.

While achieving UHC equitably would require data in different regions, within different income quintiles, and ethnicities, status of how good the access, quality, coverage and financial hardship in these different regions and income quintiles should also be taken into consideration.

The Family Income and Expenditure Survey by NSO in 2006 showed 68% of the households' Out-of-Pocket expenses go to drugs and medicine. The main problem is that the people who cannot afford medicines should be included in their benefit packages. Additionally, according to L.J. Rivera of NAPC (2016), only 7 out of 10 poor mothers go to health care facilities to give birth and only 4 out of 10 used PHIC card. And mothers with PHIC cards still spend above Php 2,000.00 Out-of-Pocket. This is the reason why poor mothers fail to enjoy PhilHealth benefits.

There are currently 5 UHC studies, namely: Vietnam, Nigeria, Indonesia, Tunisia and Thailand, available from World Bank's Universal Health Coverage Study Series (UNICO), which describe how these countries are working towards UHC. It can identify "mechanisms" rather than "programs" like incentive-giving, rule-following, "how to pass on wisdom" like peer education, and detect the contextual differences. PhilHealth should be careful on how to do it because one that works in others, may not work in the Philippines. According to Cumming J., (2015), local context, values, costs of change, and political factors should also be considered.

PhilHealth is in a complex web of responsibilities in different institutions and connections. These influence the corporation's abilities and limitations - firstly, the use of technology for leap-frogging. Providing medicines to local government units by using technology on consignment at the RHU level. In this way, it can be used to check regularly if the doctors provide medicines, if prescriptions are being used and to whom were these medicines used for in the RHU level.

Secondly, PhilHealth should have a complete set of data structure and sources with a list of indicators like inputs, processes, outputs, outcomes and impact. With these information, the corporation will have a complete picture of what is going on with respect to the input and processes, what comes out at the different levels and at the different regions, and what are their impacts in health outcomes, risk protection, responsiveness and efficiency. A complete and coherent approach to this would help in moving this issue forward.

Furthermore, the corporation should work towards a clear goal with better data – using the Bibingka approach: to get data from the top and data from the bottom, to get data from LGUs, the overall general data and reconcile it. There is a need to institutionalize analysis, perhaps a research center for PhilHealth, looking for specific issues concerning social health insurance. This includes identifying key tasks at hand (e.g. balance billing,

medicines, quality of care in the rural areas) and being aware of the targets. An indicator as a target ceases to be a good indicator.

And lastly, PhilHealth should be relentless in their Information Education Campaign (IEC). Through this program, a lot of countries can learn from it and it can be harnessed for the further development of the corporation.

# THE PHILIPPINES' JOURNEY TOWARDS UHC

By Mr. Ruben John A. Basa

Senior Vice President for Health Finance Policy Sector, PhilHealth

## INTRODUCTION

A graduate of Political Science from the Ateneo de Manila University and earned his Masters degree in Development Studies from De La Salle University. He was involved in the Health Finance Development Project of DOH and USAID (1993-1995) as a Health Policy and Legislative Fellow. He also served in the Senate as the Technical Staff Head of the Committee on Health and Demography until the signing of the National Health Insurance Act or RA 7875.

He held various executive positions in PhilHealth since 1997 aside from serving as Head Executive Assistant for four former President and CEOs of PhilHealth. Currently, he is the Senior Vice President for the Health Finance Policy Sector (HFPS) at PhilHealth.



Mr. Basa began his talk by playing a small part of the song, "I've got a feeling" by the Black Eyed Peas. He explained that just by hearing this song, it makes us feel that it seems like yesterday, but it was actually back in 2010 when the song first made it to the headlines. He used this as a reminder that a lot of things have already happened to PhilHealth in the last 6 years. He started with a question - "How far have we come in our national insurance program since 2010?" He stated that the symposium's theme, "Bawat Filipino Protektado was a truncation of their vision statement, "Bawat Filipino Miyembro, Bawat Miyembro Protektado and that the first part of his presentation is actually anchored on these two phrases..

The Philippine's current situation describes all employees of both private and public sectors to have been mandatorily covered by PhilHealth. With this, there are 29 million Filipinos from the employed sector, and about 1.6 Million Overseas Filipino Workers (OFW) that are currently covered as PhilHealth members and dependents. OFWs are required to enroll in the National Health Insurance Program before their deployment abroad. On the other hand, there are 46.5 million members covered in the indigent sector, which is far from the original numbers of enrollment back in the year 2000 to 2010. Mr. Basa shared that in the early years, the indigent program will always be heard with the word "marketing" as they would have programs previously called, "Enroll one, get one" and "Enroll a quarter and you'll get locked in the remaining 3 quarters."

But a lot has changed in the last 6 years, as the Republic Act 10351 or the Sin Tax Law was enacted, which provided the funding for the National Health Insurance Program. This was the first earmarking provision for the health sector and a big portion of it goes to the

enrollment in the NHIP. In 2010, the GAA provided only Php5 billion for the enrollment of the indigents. The actual remittance was only Php2 Billion for that year compared to the Php37 Billion for PhilHealth indigent program in 2017. He mentioned that there was a windfall of contributions from the national government because of the Sin Tax revenues. With the proceeds from sin taxes, PhilHealth was able to triple the number of the indigents from 5.2 million to 15 million families at a premium of Php2,400 per family, double the rate in 2010.

In addition to indigents, PhilHealth is now able to cover all senior citizens in the country through Republic Act 10645. To date, 7.6 million senior citizens are covered and about 2.1 million lifetime members in the program.

Mr. Basa positively then said in his speech that they were only talking about 15% of the population who are not yet covered by the national health insurance program. For this year 2017 and for the first time as mentioned, the National government provided P3 billion additional in the GAA for the enrolment of those who are not yet covered by the program. In summary, it was a windfall of P53 billion from the GAA for PhilHealth coverage in 2017.

Since PhilHealth has already covered a big chunk of the population, issues of membership, enrollment, and coverage have always been addressed. He then went on discussing the statement, "*Bawat Filipino Miyembro,*" with an agenda of ensuring the sustainability of the National Health Insurance Program and focused on two things. First, the enrolment for the premiums for the employed sector - they 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, the need for PhilHealth programs to reconsider premium as an entry for enrollment – it was reiterated that PhilHealth premium is not just used because one is covered but also, they must be start to consider that premiums should be the gateway to benefits. They would only be able to increase their benefits if they have the right level of contributions and for the longest time, they only have 1 singular premium schedule for the indigents, which they did the same for the senior citizens. He then uttered, "*I think it's about time that PhilHealth differentiate contributions according to different classifications. Again, PhilHealth premiums as the gateway to benefits.*"

For the 2<sup>nd</sup> part of his presentation, he then concentrated on the statement, "*Bawat Miyembro Protektado.*" The financial statement by the end of 2016 showed that PhilHealth paid about P94 billion in benefit payments and this does not include the P6 billion in approvals. If they have included the actual benefit payment and approvals, then they would have paid 100 billion last year alone. He mentioned that 6 years before, when the year 2009 ended, PhilHealth paid P24 billion in benefit payment. It took PhilHealth 13 years to pay P24 Billion and only 6 years to pay for the next P75-76 billion in benefit payments, excluding the 2 years from 1995 to 1997, as PhilHealth only assumed Medicare functions in the latter year.

He introduced the PhilHealth's new benefit alphabet for 4 years. He explained that they shifted from Fee-For-Service (FFS) to all case rates. Historically from the time of Medicare, they were paying through people service shifting from first 23 case rates in 2011 then to all

case rates in 2014. Then they presented the Z benefit for real catastrophic conditions followed by the introduction of KT, PD, MORPH, VSD, TOF, and CABG. With this, they showed 15 Z benefit packages that pay as much as P600, 000 per case. They also launched together with the ACR and the Z, that all indigents are entitled to NBB and expanded it from previous P300 per family to P500 per family. Despite this payment, they have quadrupled their payments for the last 6 years. They still need to address high OOP as high numbers of Filipinos face impoverishment in face of catastrophic spending. Aside from that, they have to address the relatively low support values, the mismatch between what PhilHealth pays and what the members actually need, and that members need to get hospitalized before they get reimbursements.

For the last part of his talk, he said that PhilHealth is working towards their benefits according to the burden of disease. They would want to have benefit package, which corresponds to what their members actually need. They also want to ensure the No Balance Billing for certain accommodations with maximum copay for all others. They would like to address the disease in each life stages and they would like to prevent the major cause of hospitalizations as the chunk of the PhilHealth reimbursements are from diseases that can actually be prevented in an early stage. Also, they want a health financing system that will boost referral system. Lastly, their PhilHealth benefits will provide fair provider mechanism to the providers.

With all of these visions, they are optimistic that PhilHealth would deliver their promise by 2020, *“Kalusugan ng lahat sigurado”*



## A CLOSER LOOK AT THE UHC CUBE

As PhilHealth celebrates its 22<sup>nd</sup> anniversary, its theme of “*Bawat Filipino, Protektado*,” is a resounding cry of the National Health Insurance Program’s dedication of turning Universal Health Care (UHC) a reality for the country.

In fact, the Philippine Health Agenda for 2016-2022 has made, “*All for Health Towards Health for All*” as its thrust in its campaign for achieving Universal Health Care for all. It has three guarantees: (1) “*ang bawat Pilipino ay may karapatan at kakayahan na manatiling malakas at malusog*,” (2) “*mapaglingkuran ng may respeto at dignidad sa lahat ng pagamutan*,” and (3) “*mabigyan ng angkop na serbisyong kalusugan na hindi maglulugmok sa kanya sa lalo pang kahirapan or paghihirap*.” All of these can be summarized as the government’s promise as stated, “*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*.”

Universal health coverage (UHC) 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. UHC ensures that all people obtain the health services they need without suffering financial hardship when paying for them. Hence, financial risk protection is an important component of UHC.

The afternoon sessions 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 in the health sector in improving access to quality health services, increasing recognition of shared responsibility among key players, and having a holistic approach of integrating public finance management with health reforms. All of these are important as we move towards achieving universal health coverage (UHC).

## WHAT AND WHERE?

### *Defining the Continuum of Health Care Services and Delivery Networks*

## INTRODUCTION

The path to Universal Health Care has three dimensions to consider: (1) the breadth or the population, which answers the question, *who is covered*, (2) the height or the direct costs, which deals with the issue of the proportion of costs to be covered, and (3) the depth or the services, which poses the dilemma, *which services are covered*?

This panel will particularly zoom in on one dimension of the cube, particularly, the depth of the UHC cube. The speakers and presentations in this segment put things into perspective; flesh out the real health needs of Filipinos and discuss how the health care system will

address these concerns. In here, people will see how the services are provided and where they will be provided – the main topics here are the services and their provision.

The first topic deals with Life Stage Approach and illustrates what particular benefit health packages Filipinos need as they age and grow old. The next topic talks about Service Delivery Networks and how these systems will make arrangements in the delivery of the prescribed interventions. Then, the following presentations highlight the Benefit Prioritization Process and emphasize the most burdensome diseases, and how refocusing and prioritization on these can be addressed by a functional, responsive and equitable primary health care network. The discussant shall share the thoughts and opinions of PhilHealth's clients, as she relates the personal experiences of patients.

## MODERATOR

### **Dr. Tessa Tan-Torres Edejer**

*Coordinator, Unit Costs, Effectiveness, Expenditure and Priority Setting  
World Health Organization*

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 produces technical guidance on these areas of work, generates data including those in the Global Health Expenditure database and the CHOICE (choosing Interventions that are cost-effective) database and provides technical assistance to countries. The unit is now also in-charge health technology assessment and the global monitoring of universal health coverage for the Sustainable Development Goals.



## INTRODUCTION OF THE RESOURCE SPEAKERS

### **Dr. Maria Ofelia O. Alacantara**

*Health Policy Specialist  
Department of Health*

A medical doctor with more than 20 years of experience in public health service. She headed the Foreign Assistance Coordination Office (now ILED) in PhilHealth and was the Head Executive Assistant of then PhilHealth President & CEO Dr. Francisco Duque III.

A health policy specialist, engaged with several development partners. She is currently a consultant of the Office of the Secretary of the Department of Health.



### **SERVICE DELIVERY NETWORKS**

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

He is a physician with training in infectious diseases and field epidemiology. He occupied various leadership positions when he moved to DOH in 1998. He is Member of the National Board of National Union of Career Executive Service Officers, a renowned organization of government technocrats.

His interviews in all media on public health issues had prepared him well in becoming the Official Spokesperson of the DOH since 2005.

He is currently Assistant Secretary Designate and concurrent Director IV at the Bureau of Local Health Systems Development of the Department of Health (DOH).



## **BENEFIT PRIORITIZATION PROCESS**

*By Dr. John Wong  
CEO, Epimetrics, Inc.*

He obtained his degree in medicine and Master of Science in Epidemiology from the University of the Philippines.

He is the CEO of Epimetrics, Inc., an institution geared towards the achievement of health equity through rigorous and creative research conception, execution, translation, and communication. He was recently awarded the 2016 Roux Prize by the Institute of Health Metrics and Evaluation at the University of Washington and which is what he will be presenting in this session.

He currently sits in the DOH Formulary Executive Council (FEC) and also a lecturer in Ateneo de Manila School of Medicine and Public Health.



## **BENEFIT PRIORITIZATION: PRIMARY CARE**

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

He is an internist and cardiologist. He obtained his medical degree from the University of Santo Tomas (UST) Faculty of Medicine and Surgery.

He is known as an active leader and a health reform advocate - a lead proponent of the government and civil society in the passage of sin tax law for tobacco and alcohol and introducing innovative concepts for unhealthy diet in for our health care system. He has been recognized for authoring Executive Order No. 595 - Health Education Reform Order (HERO), which remains the largest physician-led advocacy on comprehensive health education and disease prevention. A former President of the Philippine College of Physicians, the country's premier organization of internal medicine specialists.



He currently sits as an Independent Director of the Board of Directors of PhilHealth.

## **DISCUSSANT**

*Ms. Karen Ida Villanueva*

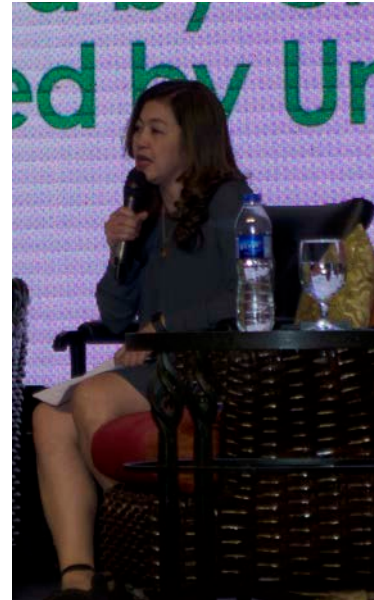
*Philippine Alliance of Patients' Organizations*

A graduate of UP Diliman BS Business Administration, Communications and Health Policy.

A former member of the Board of Directors of PhilHealth and Chair of its Benefit Committee. She was awarded as one of the 100 Most Influential Filipino Women 2016, Innovators and Thought Leader Category by the Filipina Women's Network.

She successively headed the communications and external affairs office of pharmaceutical corporations, namely Zuellig Pharma, Pfizer and Merck Sharp and Dohme from 1994 to 2015. Currently, she is the president and managing partner of Health PRX communications, a group of professionals from the communication, healthcare and development sectors aiming to merge various engagement platforms to help craft solid solutions to Filipino people's health issues and concerns.

She is also the Treasurer of The Philippine Alliance of Patients' Organizations (PAPO). The PAPO represents at least one million patients nationwide. It is a coalition of patient organizations advocating for universal access to healthcare and allied services. We aim to empower Filipino patients, including persons with disabilities (PWDs), through education, networking, policy advocacy and capacity building.



## SYNOPSIS OF PRESENTATIONS

### LIFE STAGE APPROACH

*By Dr. Maria Ofelia O. Alcantara*

*Health Policy Specialist, Department of Health*

There are many challenges facing the Philippine health care system, such as the lack of gatekeepers to ensure the provision of health services and the backsliding health indices that reveal the stagnant, and perhaps the deteriorating quality of health among Filipinos. These are all undermined by the lack of commitment to achieve the unattained Millennium Development Goals (MDGs) and the next Sustainable Development Goals (SDGs).

But the good news is, these plaguing problems present as an opportunity for change and improvement. And that is what the Philippine Health Agenda hopes to address in its three guarantees. First is universal coverage, which is a mandatory order to include all Filipinos. Next is the universal NHIP, which aims to increase benefit delivery rates and reduce OOP. And last is universal health care, which is an end in itself.

Most Filipino families overlook the primary level of care and prefer to go immediately to the highest provider of health services, the tertiary level. This behavior is grounded on the belief that these facilities have the best and most comprehensive level of care, which is very costly on the part of the patients. And if everybody goes to the tertiary level of care, then this creates bottlenecks and people have to queue in line – leading to further dissatisfaction in service. Hence, there should be proper mapping to the nearest provider of health services so that patients can easily navigate and seek early medical treatment.

So there should be emphasis on a primary care system that is functional, responsive and equitable at the local level. More than ensuring gatekeepers at these critical points of care, services should also shift to a systemic approach, so as to avoid overlaps in service delivery and payments. Collectively, with the support of both the local and national government, the Philippine Health Agenda can move towards achieving the Filipino's primary health goals – starting with the Life Stage approach as one of its guarantees.

The Life Course approach means that any individual across the spectrum of life, from *womb to tomb* so as to speak, will receive mandatory benefit health packages such as prenatal care and immunization, depending on their present life stage. This strategy caters to both well and sick patients in order to address the triple burden of disease, which includes non-communicable, communicable and diseases of rapid urbanization and industrialization. In other words, this guarantee will facilitate the services that Filipinos will need - where they will need it and when they will need it.

To develop the Life Stage health care packages, a criteria for inclusion and exclusion must be determined based on policies, clinical practice guidelines (CPGs) and expert opinion. But more than just simply identifying the needed services, these must be cost-effective, not just in terms of cost, but more importantly, in terms of early harvest. All of these must be based

on most common complaints and conditions of patients, and top burden of diseases that can become catastrophic.

In short, the different life stages from pregnancy to elderly will need various population- and individual-based services, depending if one is sick or well. The population-based services will primarily focus on surveillance and monitoring, prevention and control of epidemics, and quality protection and accessibility. Basically, they are the systems that ensure services are being provided. On the other hand, individual-based interventions are tailored to the patient's needs, depending if one is well or sick. The basic requirements are a good history and physical examination, but it may require further laboratory diagnostics and treatment to manage their illness. As a whole, the life stages that a person goes through are covered from the mandatory and specialized services provided in order to achieve better health outcomes.

The guidelines for the institutionalization of primary health care guarantees to all Filipinos follow a step-by-step process. The health care system needs to define what interventions are needed by patients, taking into consideration safety, household financial impact and social acceptability. These services will be reviewed by a health guarantee governing board, composed of leaders and experts in the fields of public health, clinical practice guidelines and formularies thereafter. And finally, the payment mechanism and financing agent shall be identified in order to determine the channels for funding.

All in all, the basic package of the Life Stage approach is dedicated to all Filipinos, most especially to the poor who are prone to catastrophic illnesses and payments. Hence, all the stakeholders must ensure the operationalization of providing these services. Everyone, including the Department of Health and LGUs, needs to work together to make the PHA and the Guarantee ONE a reality - to ensure universal health coverage and protection.

## **SERVICE DELIVERY NETWORKS**

*By Dr. Enrique Tayag*

*Director IV, Bureau of Local Health Systems Development, Department of Health*

Service delivery networks trace back its roots to more than 20 years ago when the local government code (RA 7160) was passed. This mandate passed the autonomy and authority down to the grassroots level, giving more power, responsibilities and resources to the local government units. This divided the system from a national government down to different administrative entities, fragmenting the health care system to private and public health sub sectors, and multiple payers and payment mechanisms.

But the Philippine Health Agenda (AO 2016-0038) paved the way to the future when it guaranteed all Filipinos equitable geographic and financial access to quality health services across different levels of care. It redefined service delivery networks as mandatory, non-prescriptive and adaptable, creating a network of organizations that provided and made arrangements for equitable, integrated and continuous health services to a defined

population. The goal was not just to deliver better medical services but rather, the purpose was to provide better health.

The main objective is to develop and enhance current and future service delivery networks because the assumption is that they are already in existence. The upgrades will include a focus on primary health care that maximizes participation, sensitive to the disadvantaged – namely the poor, marginalized and vulnerable. And most important of all, the system must focus on the needs of the family and community, not just the disease.

The network will be made up of three major components. The first component is composed of primary care services areas that assign health care providers as gatekeepers who will render services at the Barangay Health Station (BHS) and Regional Health Unit (RHU). The next component includes the intermediate service facilities with capacities for subspecialty and critical care. And the last component comprise of the apex hospitals that will deliver specialized services not available in the lower levels. The catchment area will be determined by the proximity of the population rather than the geo-political boundaries.

And these service delivery networks shall be managed by governing boards at different levels – at the regional level, the provincial level and at the managerial level. These will be sustained by funds coming from the national and local government budgets, a common health trust fund and a shift from facility-based payments to network-based contracting by PhilHealth. The service delivery networks will also serve as a means to assess and monitor the individual and population levels to assist in planning and service provision. It will also utilize the health information system for referrals and monitoring. These are all guaranteed because Filipinos are entitled to information and education, service and cost coverage, and most important of all, coordination of care.

In short, the Service Delivery Networks assures the following, *“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. May siguradong transportasyon at komunikasyon at may siguradong pagtanggap ng pasyente saang kang pasilidad pangkalusugan ayon sa antas ng kanyang pangangailangan. Responsibilidad ng bawat isa sa atin, na 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.”*

## **BENEFIT PRIORITIZATION PROCESS**

*By Dr. John Wong  
CEO, Epimetrics, Inc.*

Looking back at the UHC Cube, PhilHealth needs to fill the entire volume of the cube in order to achieve “ideal” UHC. However, PhilHealth is still behind in terms of reducing cost sharing and fees as Out-of-Pocket expenditures still remain high, and in terms of providing services that Filipinos actually need. The reasons for these shortcomings are the lack of



standardized processes and standards of care. As such, the present case rates are not able to cover all of the expenses. Hence, the Benefit Prioritization Process was developed, as a study for PhilHealth, funded by Unicef, aimed at identifying the services needed by the members of PhilHealth.

To put things into perspective, the benefit payout of PhilHealth has been increasing to 8% of Compound Annual Growth Rate (CAGR). However, despite the growing payouts, the money is not spent wisely due to a mismatch between the top 10 claims of PhilHealth, which represents almost 40% of payouts, and the burden of disease that patients actually face. At the very least, only 3 conditions, namely pneumonia, stroke and routine obstetric care, match both lists, which means that funding are not allocated appropriately to address the major illness plaguing its members. These are rooted to issues in lack of focus and prioritization, unequal access and lack of transparency, and uncertain cost coverage.

Overall, the study has three main recommendations. First, PhilHealth should develop a package of guaranteed health benefits for all Filipinos, based on the high burden of diseases and cost-effective interventions. Information from the Institute of Health Metrics and Evaluation (IHME) show that only 48 out of 200 diseases already represent 80% of the Disability Adjusted Life Years (DALYs), most of which are non-communicable diseases. Therefore, more focus and attention should be given to this category so that the developed benefit packages become more appropriate and responsive. And the approach to this two-fold; one is to *spend more* in order improve cost coverage and reduce OOP, and the other is to *spend wisely* so as to maximize outcomes.

Second, the corporation should have an explicit prioritization process based on a set of standardized criteria to guide decisions on coverage. This is done through extensive research and consultations that starts with a comprehensive review of literature, followed by focus group and round table discussions with experts and finally, validation and feedback from stakeholders. All of these should be grounded on the principles of ethics, inclusion and preference to the underserved, scientific rigor, transparency and accountability, efficiency, enforceability, availability of remedies and due process.

And third, this priority-setting process should be complemented by the Health Technology Assessment (HTA) tool to guide coverage decisions as required by law, found in Implementing Rules and Regulation of Republic Acts (IRR), Sec 76. This tool will make an impact not only in clinical and cost effectiveness, but also in terms of ethics, budget impact, societal impact and safety. In the long run, this aims to determine cost-effective interventions that have the least costs but the highest outcomes so that PhilHealth will be able to maximize its resources and fund more programs in the future.

All in all, the Benefit Prioritization Process aims to provide financial support to all Filipinos, prioritizing the most burdensome diseases – in order to provide and deliver the best care for the patient at the best price. And this can be achieved by developing guaranteed health benefits based on the burden of disease while covering the most cost-effective interventions at the proper costs. This can be supported by efforts in designing an explicit

and transparent priority setting process that consists of interventions not found in the GHBP, and in utilizing the HTA to determine cost-effective interventions.

### **BENEFIT PRIORITIZATION: PRIMARY CARE**

*By Anthony Leachon, M.D.*

*FPCP, FACP, Independent Director of PhilHealth, Representative of the Monetary Board*

The sad reality is that almost half of the deaths among Filipinos are not attended by a medically trained professional. In fact, as one sets out farther away from the city, the less likely that they will be seen by a doctor. So, despite the progress that PhilHealth has made in acquiring the funds and setting up the basic health facilities, Universal Healthcare fails to be realized without the much needed manpower.

There is a chronic healthcare workforce shortage as the country faces an exodus of its doctors and nurses. Health care workers are leaving because of unemployment, underemployment, misemployment, and unjust working conditions because of politicization of appointments and non-issuance of benefits. And this overwhelms the remaining health allies because they are undermanned with 2.3 health care workers per 10,000 population, as compared to the ideal ratio of 24.

At the same time, Filipinos are not receiving the best level of care because of the mismatch between the top conditions paid by PhilHealth and the priority of health conditions that befall its members. Due to this discrepancy, payouts are allocated to costly interventions and OOP spending still remains high at 57%, putting more strain on the poor. In fact, the poorest quintile has the lowest level of PhilHealth utilization at 33%, as compared to the 80% usage of the higher income quintiles, due to the financial burden brought by the amiss in treatment interventions. The poor cannot afford medical treatment.

This dilemma has been partially augmented by the passage of the Sin Tax Law (RA 10351) last December 20, 2012. Aside from discouraging Filipinos from engaging in hazardous vices – leading to less smokers and averting at least 70,000 deaths, the bill has also brought in additional funding to the National Health Budget. In fact, in 2016, the Sin Tax Revenues for Health amounted to P69.4 million, 80% of which was allocated for universal health care expenditure and the remaining 20% for medical assistance, drugs and public utilities.

To review, the Philippine health system wants to establish a solid primary health care system. But as mentioned, there is a discrepancy between too little care in the rural areas and too much care in the urban areas. While the funds have increased, the services have deteriorated – there is still inequity in human resources. Primary health care requires gatekeepers who will act as the first contact of patients, providing comprehensive care and if needed, coordinating diagnostics, treatments and referrals to specialists at the principal point of care.

In order to arrive at these reforms, the health care system should remember the five Rs.

- **Recruit** - Recruit medical practitioners in both the public and private sector
- **Rertrain** - Retrain them in primary care focusing on the top burden of disease and health navigation
- **Retain** - Retain its members by shouldering the costs of outpatient care as well
- **Regulate** - Regulate the workforce and facilities for quality and accreditation
- **Reassess** - Reassess the quality of care and health that Filipinos are receiving, primarily through reducing health expenses and OOP

All in all, the government should not just focus on the patients; they should also take better care of the health workforce so that they will stay and provide quality service to the Filipino people, which is vital in achieving genuine health care.

## DISCUSSION

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

*Q1 (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 a vertical 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?*

*A1 (Dr. Maria Ofelia O. Alcantara): I think I would answer that in 3 levels. The national level will work on setting the standards and with the prioritization as one of the key factors to have, determine what are the basic services in the life stages? So the national level will develop standards and policies. And second is, how will this be implemented, which is actually addressed by the SDN, which is non-prescriptive bottomline. The services that are being provided or making arrangements at the facility, family, community-levels, 'yun 'yung third. But I'll add pa the one about sustaining the standards to be implemented in an SDN, which is a very important intervention, and that is who is paying what? And that becomes a big pie for the National Health Insurance.*

*I can say that it is an overwhelming intervention or guarantee that may not be immediately responded or attained. But at this point in the process, we are not just discussing at the national level, we are involving the local government in the discussion to come up with what services should be part of that life stage approach services.*

*Q2 (Ms. Karen Ida Villanueva): 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?*

*A2 (Dr. Enrique Tayag): 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 on how they can make sure that providers are encouraged and be part of the networks.*

*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 various model service delivery 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%.*

*Q3 (Dr. Tessa Tan-Torres Edejer): 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 in these meetings or this symposium, then we will have the same or similar or recycled concerns.*

*This is a very heartfelt comment and one of the things that they're concerned about 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.*

*A3 (Hon. Anthony Leachon, MD): In terms on the timeline, based on the Republic Act 10606, this 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, based on John Wong's analysis that you have to focus on certain illnesses, killing the most number of Filipinos.*

*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-pocket expenditure should be solved 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.*

*Q4 (Dr. Tessa Tan-Torres Edejer): John can you say something about the prioritization process and what do we 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?*

*A4 (Dr. John Wong): I think the most important thing that they need to do, which I think they have already started, is to start developing 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.*

## SYNTHESIS

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

*In summary, PhilHealth has made significant progress in achieving UHC, but its efforts have not translated into concrete and felt gains in health yet – as Out-of-Pocket expenditures still remain high and inequities in utilization remain abound. Despite designing benefit packages for each life stage and putting up networks for service delivery, the health system still faces big challenges in terms of human resources, infrastructure and addressing the real problem of the burden of disease.*

*But the corporation remains confident and hopeful. As PhilHealth celebrates its 22<sup>nd</sup> anniversary, the political will is there – the health system has the budget and the support of the national government in making UHC a reality. The dream of universal coverage could happen very soon, perhaps even before 2022, as long as there is prioritization on the pressing needs and focus on implementation – translating thought, plans and dreams into concrete and proactive action. Dr. Edejer closes the first panel and rallies the participants with a familiar resounding battle cry from the late former Senator and Secretary of Health, Juan Flavio, “let’s DOH it!”*

# PROPORTION OF COSTS COVERED: WHO PAYS FOR WHAT?

## *Sharing the Responsibility for Financial Risk Protection*

### INTRODUCTION

The moderator for this panel discussion, Dr. Beverly Ho, started to give a gist on what to expect for this part of the symposium. They were trying to look at the level of financial protection that the Filipinos are currently experiencing. As they will be talking about the 3<sup>rd</sup> dimension of the UHC cube which is depth, they will be tackling the cost coverage.

Basically, they will be discussing 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 for them staying poor.

### MODERATOR

#### ***Dr. Beverly Lorraine Ho***

*Chief, Research Division*

*Health Policy Development and Planning Bureau*

*Department of Health*

A graduate of UP College of Medicine, with a degree of Master in Public Health, Healthcare Policy and Management at the Harvard T. H. Chan School of Public Health.

She was an Executive Assistant to then PhilHealth President & CEO Dr. Eduardo P. Banzon and soon after a Public Health Consultant at the Asian Development Bank.

Currently, she is Chief of the Research Division, Health Policy Development and Planning Bureau, DOH and part time Faculty of Ateneo Loyola Schools and an Independent consultant of Alliance for Improving Health Outcomes, Inc. (AIHO)



## RESOURCE SPEAKERS

### PHILIPPINE NATIONAL HEALTH ACCOUNTS

*By Ms. Raquel Dolores Sabenano*

*Senior Statistical Specialist, Philippine Statistics Authority*

Ms. Sabeñano finished BS Applied Statistics and completed the academic requirements leading to MS Applied Statistics. She also earned her Master in Development Management.

She has been in the public service for almost 20 years, specifically in the three major statistical agencies in the Philippines - National Statistics Office (NSO), Bureau of Labor and Employment Statistics (BLES), and National Statistical Coordination Board (NSCB), prior to their merger into what is now known as the Philippine Statistics Authority (PSA).

She is currently the Senior Statistical Specialist at the Philippine Statistics Authority (PSA). She is the PSA lead technical specialist on the compilation of the Philippine National Health Accounts estimation. Ms. Sabeñano has been involved in the estimation of health care spending in the country since 2002.



### IMPLEMENTATION OF NO BALANCE BILLING (NBB) POLICY BY A LGU-OWNED HOSPITAL

*By Dr. Elenila I. Jakosalem*

*Chief Hospital, Bislig District Hospital*

Dr. Elenila Irizari Jakosalem is a graduate of Cebu Doctor's College of Medicine. She has a Masteral Degree in Community Health and is a Fellow of the Philippine Society of Medical Specialist. She is the Chief of Hospital of Bislig District Hospital for more than 2 decades, 27 years to be exact and just finished her Diplomate Course in Occupational Medicine.

Under her administration, Bislig District Hospital has reaped several awards including the Red Orchid Award for 2 consecutive years, Presidential Award last 2008 and





has been consistently high on its NBB implementation. This committed public servant is married and a mother of two children

### **IMPLEMENTATION OF NO BALANCE BILLING (NBB) POLICY BY A DOH-RETAINED HOSPITAL**

*By Dr. Soraya Pesy Abubakar*

*Chief of Medical and Professional Staff, Zamboanga City Medical Center*



She is a medical doctor, earning her medical degree from the UP College of Medicine. A family physician and a dermatologist, she earned her Masters Degree in Hospital Administration at UP-PGH.

She is a former President of the Philippine Academy of Family Physicians (PAFP), the biggest organization of primary health care and family medicine specialist in the country. During her stint, she visited the chapters of the academy all over the country and advocated universal health care with quality health care for all through continuing medical education. She served for three terms owing to her dynamic and active involvement in training and credentialing of family physicians all over the country.

She is the first Filipina to become elected President of the ASEAN Region of Primary Care Physicians Association (ARPaC), a spearhead organization for the ASEAN harmonization of medical standardization for the integration of the ASEAN Health Centers.

She is also an educator - a faculty member of the Ateneo School of Medicine. Currently, she is the Chief of Medical and Professional Staff of the Zamboanga City Medical Center.

*Represented by Ms. Michelle Libago*

*Administrative Officer IV and Health of Billing and Claims  
Zamboanga City Medical Center*

She graduated with degrees of Bachelor of Science in Management Accounting and Bachelor of Laws. She has been with Zamboanga City Medical Center for 12 years now, 9 years in the Accounting Section and 3 years as the head of Billing and Claims. Currently, she is Administrative Officer-IV of the Zamboanga City Medical Center.



## **DISCUSSION**

*By Ms. Ma. Gilda Resurrecion*

*Consultant, National Kidney and Transplant Institute*

A faculty member of the Ateneo Graduate School of Business: Economics, Finance and Accounting. She holds a Masters Degree in Hospital Administration.

At present, she is a Consultant at the National Kidney and Transplant Institute (NKTl).



*And Dr. Alejandro Herrin*

*School of Economics, University of the Philippines – Diliman*

He was Professor of Economics and Conrado Benitez Professor of Demographic Economics at the UP School of Economics from 1978 until his retirement in June 2004.

He specializes in population, health human resource, and development economics. He has extensive professorial experience spanning 45 years including teaching, research, providing technical advice to international organizations and ministries, and working with various government agencies in policy development, program assessments, and capacity building.

His is currently a Professorial lecturer at the University of the Philippines (UP)- Diliman, School of Economics.



## SYNOPSIS OF PRESENTATIONS

### PHILIPPINE NATIONAL HEALTH ACCOUNTS

*By Ms. Raquel Dolores Sabenano*

*Senior Statistical Specialist, Philippine Statistics Authority*

*Professor in Economics, University of the Philippines - Diliman*

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. With the service sector having the highest expenditure, 4.6% of it came from the PNHA.

The conceptual framework shown came 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 people or institutions that directly pay the health care providers or the final payer. Under the government: there are national, local, and government owned and controlled corporations or GOCCs. In the social insurance: there is the national health insurance program or PhilHealth and the employees' compensation. While for the private sources which are the out-of-pocket: there are private insurance, Health Maintenance Organizations (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 that comes from government hospitals, private hospitals, other professional care facilities, dental care facilities, and traditional health care. Second 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 government programs are the breastfeeding check, 4S laban sa Dengue, Zika virus, STOP HIV/AIDS, and Oplan Iwas Paputok. And the third is others, which is the general administration, operating costs, and research and training

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 - Php17, 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 example, it only shows that Filipino households continue to carry 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% to 58% while the other types of healthcare comprise 42% to 48% of the Total Health Expenditures. Close to  $\frac{1}{2}$  of OOP spending goes to pharmaceutical products, or  $\frac{1}{4}$  of T.H.E. is consumed in drugs or medicines. To simplify, a person spends  $\frac{1}{4}$  of his income in drugs and medicines alone.

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. In regards to this, the total amount spent on household increased 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.

Based on the 2010 to 2020 healthcare financing strategy, 3 out of 8 healthcare financing indicators surpassed the respected target, namely, (1) Total Health Expenditures as percentage of GDP with 4.6% which is slightly higher with the 4.5% target, 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. OOP 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 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 sectors.

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 (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 for 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.

Currently, there are ongoing trainings that PSA is conducting with DOH, PhilHealth, WHO consultants as trainers, and it will end by March 9, 2017.

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.

Lastly, 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.

## **IMPLEMENTATION OF NO BALANCE BILLING (NBB) POLICY BY AN LGU-OWNED HOSPITAL**

*By Dr. Elenila I. Jakosalem*

*Chief Hospital, Bislig District 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 govt 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 health development zone. It has been serving the municipalities of Tabina, Hinatuan, and Lingig.

No Balance Billing policy, known as the zero co-payment, is among PhilHealth's initiatives towards achieving Universal Healthcare Coverage. 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, 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. 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.

In conclusion, it just shows that the number of patients admitted in the Bislig hospital with PhilHealth increased, accounting to the 70% of the totality and those patients without PhilHealth decreased as part of the remaining 30% over the last 5 years.

At the same time, there is also a growing 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.

One 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 they are serving.

Bislig District hospital is the 1<sup>st</sup> hospital in Surigao Del Sur to implement the point-of-care program and with regard to this, they 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. They 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, they also built partnership with the provincial government thru their 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. Community participation was practiced by having barangay visit every month with an advocacy of reinforcing the NBB policy of PhilHealth.

No Balance Billing 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 must to sustain this program. *“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.”*

In the end, the Philippine local health insurance office of Bislig City under the leadership of Ms. Juliet Golez, local health insurance officer, for contributing to the success of the NBB program together with the PCARES - PhilHealth Customer Assistance Relation Empowerment Staff assigned in the hospital who assisted their patients and their significant others were recognized and appreciated on the completion and submission of vital documents needed for filing and claiming PhilHealth benefits.

## **IMPLEMENTATION OF NO BALANCE BILLING (NBB) POLICY BY A DOH-RETAINED HOSPITAL**

*By Dr. Soraya Pesy Abubakar*

*Chief of Medical and Professional Staff, Zamboanga City Medical Center*

*Represented by Ms. Michelle Libago*

*Administrative Officer*

*Zamboanga City Medical Center*

When Zamboanga City Medical Center started, it was never easy implementing the NBB policy. That is why the hospital has always been called by PhilHealth's office when exit calls are being conducted.

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.

Its vision is to be a leading socially accountable medical center of choice and partner for All in Zamboanga Peninsula while its 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 accredited 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, Minor Operations, Animal Bite, Emergency Room cases, and Chemotherapy, 1 313 claims were filed.

The implementation of NBB policy was never easy. With regard to this matter, they 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, 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 given to qualified NBB clients with PhilHealth requirements and emphasized that all is free.



Petty Cash Fund 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.

Outsourcing of Laboratory and Diagnostic Tests is done with 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 they 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

On the other hand, for the 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

Problems were encountered in Zamboanga City Medical Center, especially the long queues in claiming Philhealth benefits. They always go forward to address this because NBB patients sometimes opt not to avail PhilHealth due to long queues. They 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. They currently have a 2-year contract with PhilHealth which they hope to be extended. They 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. They have the main billing and claims unit from 8am to 6pm and its schedule is from Monday to Sunday.

Here are the problems that they are facing: the 4Ps members are using the surname of their partners and when they go to the hospital to deliver, the information given in the birth certificate of the baby is different from the declared information in 4Ps data record. To remedy the situation, they reported it to the Department of Social Welfare and Development. With this, they made a form that includes the civil status of the patients and that the form certifies the partner's surname and the woman's maiden name is the same for the baby. Likewise, they recommended that All Case Rates must be revisited.

Moreover, Zamboanga City Medical Center has an excess No Balance Billing which is the sum of the actual hospital charges and less PhilHealth case rate. 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.

In conclusion, the Zamboanga City Medical Center is basically the home of NBB considering in 2015, only 20% are regular Ph members, and 19.2% in 2016. *“It is our pride to say that even though our good practices are just simple our NBB Compliance is 99.33%.”*

## DISCUSSION

**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.*

**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 presentations 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 than 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 4<sup>th</sup> and 5<sup>th</sup> quintile and reallocate it to the 1<sup>st</sup>, 2<sup>nd</sup> and may be 3<sup>rd</sup> 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 favor because they think that behavior change, communications and so on might take a long time, but if you change the price, you'll probably get results quickly.*

*So taxes might 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**

*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

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.”*

# POPULATION COVERED: WHO BENEFITS?

## *Ensuring the Inclusiveness of Policies and Programs*

### INTRODUCTION

The moderator, Prof. Manolito Novales introduced the session which will talk about Who Benefits or the Breadth dimension of the UHC Cube: Ensuring the inclusiveness of the policies and programs.

The panel will particularly focus of the population coverage of the Universal Health Care. Guaranteeing that all people will benefit from the national health insurance.

Among the topics to be discussed is the Implementation of Sin Tax Reform Act of 2012 to be discussed by Dr. Toomas Palu. How the law significantly helped the overall tax structures and supported overall health expenditures.

Another topic to be discussed is the Listahanan 2 by Ms. Krupska Apit. This topic will focus on how the government particularly DSWD identified who and where the poor are nationwide. She will also tackle the phases of the project, the results and the recommendation of DSWD to PhilHealth.

Lastly, the Universal Population Coverage to be discoursed by Dr. Eduardo Banzon. This particular session will focus on the issue on how the informal sector of the population will be able to pay for the health insurance. Also, to be discussed are ways in achieving universal population coverage and where can we actually get other sources of funds for the national health insurance program.

### MODERATOR

#### ***Mr. Manolito Novales***

*Professor, Ateneo School of Governance  
Ateneo de Manila University*

He got his degree of Master in Public Management from the Ateneo de Manila University.

He has worked in various fields: Governance and Institution Building, Public Policy, Health Financing, Social Reform and Poverty Alleviation, Program Monitoring and Evaluation, among others.

He is Faculty Adviser, Master in Public Management and Development Program (PMDP), Development Academy of the Philippines. He is a Consultant with Government and



International Agencies such as with PhilHealth on developing its capacities for Policy Development and Analysis, and on Extending Social Health Insurance to the Informal Economy Workers, UNDP on developing its Governance Framework towards an Integrated Approach to Safe Water, Sanitation and Hygiene, and with DOH on Developing the Policy for Civil Society Engagement in the Budget Process among others.

Currently, he is Professor at the Ateneo School of Government (ASoG), Ateneo de Manila University

## RESOURCE SPEAKERS

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

By Mr. Toomas Palu

Regional Practice Manager, The World Bank

He is a medical doctor with special interest in public policy and 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 a Director in the Estonia Social Health Insurance Fund Management Board and as a Deputy Director of the Tallinn Emergency Care Hospital in Estonia.

Currently, he is the Global Practice Manager for Health, Nutrition, and Population at the World Bank.



### TARGETING THE POOR UNDER LISTAHANAN 2

33333 By Ms. Krupka Lenina Apit

Project Coordinator

She holds a Bachelor's Degree in Communication Arts obtained from the University of the Philippines in 2009.

She is a Project Coordinator for the Listahanan or National Household Targeting System for Poverty Reduction (NHTS-PR). Before this, she was the Social Marketing Specialist for said project and an Information Officer for Pantawid Pamilyang Pilipino Program.



During her tenure with the Department, she has organized numerous fora, workshops and other events that promote the NHTS-PR project and the Pantawid Pamilya program to both its external and internal stakeholders. These include the learning forum entitled "*People at the Edge: Defining the Near Poor in the Philippines*", which was awarded with Best Information Dissemination Activity in the 25th National Statistics Month (NSM) Awards and the more recent launching of the Listahanan 2 database in April 2015.

Now, in her capacity as Project Coordinator, she continues to represent the Department in activities that engage various stakeholders of Listahanan.

## **UNIVERSAL POPULATION: SQUEEZING THE MIDDLE AND OTHER SOURCES OF FUNDS**

*By Dr. Eduardo P. Banzon*

*Principal Health Specialist, Sector Advisory Service Cluster,  
Sustainable Development and Climate Change Development, Asian Development Bank*

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 former President and Chief Executive Officer of the Philippine Health Insurance Corporation (PhilHealth) and Regional Adviser for Health Economics and Financing of the World Health Organization-Eastern Mediterranean Regional Office (WHO-EMRO) where he advised countries in the Middle East and North Africa on improving their health systems and achieving UHC. He was also a Health Economist in WHO-Bangladesh and Senior Health Specialist for the World Bank.

Currently, he is a Principal Health Specialist in the Asian Development Bank where he champions Universal Health Coverage (UHC) all over Asia and the Pacific, supports countries pursue UHC, and provides advice on designing and implementing country UHC strategies.

# SYNOPSIS OF PRESENTATIONS

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

*By Mr. Toomas Palu*

*Regional Practice Manager, The World Bank*

The Sin Tax Law of 2012 has simplified overall tax structures, reduced tiers and shifted to unitary over time. It has also increased taxes on cigarettes, beer and spirits – including higher floor prices, and it has indexed tax increases to inflation. Additionally, the Sin Tax Law significantly increased the pro-poor earmarking for health by deducting the (enhanced) historical allocation for tobacco farmers of around 15%. Almost 80% of the remainder goes to NHIP to cover the poor and near poor and later, through the subsequent law, also the elderly. The attainment of the Millennium Development Goals, health awareness programs and the remaining 20% goes to Medical Assistance Programs (MAP) and Health Facilities Enhancement Program (HFEP). Earmarking was used to position the reform and associated tax increases in the interests of the health of the poor and mitigating the risk of adverse poverty and social impacts. The reform was framed as a health issue rather than a tax issue.

But the reform was not an easy passage as it had different impacts on the tobacco industry and on alcohol industries. The health and poverty impact of the reform was central to the debate.

The impact of the SIN Tax Law has been profound. It has increased the tax revenues from 0.4% of the GDP to combined tax revenues of about 1%, providing significant proceeds to health sector. Moreover, the DOH budget allocations in 2010-2016 showed significant increase in the allocation. In 2017, the DOH budget is Php151 billion, of which, Php53 billion is allocated to PhilHealth.

There has also been a dramatic increase in the share of the population covered by PhilHealth, in terms of both individuals and families, from 53 million in 2010 to more than 90 million families in 2015 (2000-2006 PhilHealth Corporate Planning Department; 2007-2015 PhilHealth Stats and Charts). Additionally, there has been a positive impact on coverage among the poor since the Sin Tax Law earmarks kicked in from 2014 (PhilHealth Stats and Charts) and the coverage of people rose over 60 steeply after STL (Sin Tax Law) was subsidized.

Subsequently, the shift from reliance on LGU identification, and sponsorship of the poor to use of National Household Targeting System for Poverty Reduction (NHTS-PR) list and national government sponsorship was also a “good governance” reform. Another impact of STL was the decline in smoking, though the process is slow, but still encouraging. The 2015 Global Tobacco Survey results showed 22.5% adults currently smoke cigarettes, with only 21.5% smoking manufactured cigarettes and only 18.7% smoking daily. According to Social Weather Stations (SWS) surveys, even sharper reduction in smoking among the youth (18-

24 years): 35% to 22%, between 2012 and 2015 and even a sharper decline in smoking among the poorest (38% to 27%) than among the middle class (constant at 26%.)

Issues pertaining to population coverage transpired. One concern is household surveys confirm an upward trend of PhilHealth coverage, but there is a persistent gap between coverage estimates from PhilHealth administrative data and household surveys. There have been measurement issues like difficulty in translating NHTS-PR “households” into PhilHealth “families” and the changing definition of “PhilHealth” family. More importantly, in a system where people are “automatically enrolled,” by virtue of being on the NHTS-PR list, administrative data captures the number of people entitled to free health insurance (*de jure* coverage), not the number of people who know that they have subsidized coverage (*de facto* coverage). To ensure that those who are entitled to free insurance know about it, there should be more public information campaigns, probably issue health insurance cards to all those with free health insurance and expand health insurance coverage to everyone, thus removing any question about who is entitled and who is not.

Coverage should become more pro-poor and equitable. Nevertheless STL gives free health insurance to 15.3 million poor families and senior citizens, effectively giving free health insurance to almost half of the population and the use of national targeting mechanism has made identification of the poor much more credible and transparent.

Another issue is that, are PhilHealth contributions equitable or pro-poor? PhilHealth premiums are not risk-rated; the poor and near poor do not pay any premiums. However, all senior citizen members, even those who are wealthy, do not pay any premiums; should a means test (e.g. NHTS-PR) be applied to them, too? Furthermore, formal sector premiums increase proportional to salary, but only up to a fairly low salary ceiling after which premium payments become aggressive. Should the ceiling be increased above Php35,000.00?

Premiums for the formal sector in the Philippines are low by international standards. At 2.5 % in total, 1.25% employer and 1.25% employee respectively, they are far below than the 5% maximum allowable law. But it doesn't automatically mean that PhilHealth should increase the premium. There are a number of questions to be asked first like, what is the need to increase the premium; do premiums cover actuarial cost of the formal sector beneficiaries, and does benefit package require expansion?

Benefit structure should be equitable. The poor is covered and the non-poor is not. Primary health care is not really a financial protection issue but there are points, those in terms of efficiency and effectiveness, that this benefit should be expanded to all. Policy of No Balance Billing (NBB) for the poor and senior citizens ensures providers that they do not charge patients anything beyond the PhilHealth benefit package and the lack of predictable and formal co-payment policy that actually protects from catastrophic costs.

The total value of benefits going to the poor have increased, in 2015 the indigents received the most benefit payments comprising of almost 50% of the enrollment population; consuming about 34% of the resources. In that case, the use of PhilHealth resources per



capita basis is not pro-poor. Moreover, higher health insurance coverage is not translating into improved financial protection but achievement of these financial protection goals depends only partly on the expansion of health insurance coverage and it also depends on other health financing and service delivery arrangements of PhilHealth, as well as the Department of Health and LGUs.

Some of the PhilHealth's extraordinary powers to get health results are: it has opportunities to maximize the value for money and the value for health. The process of accreditation sets quality standards for providers such as the MCP package, inpatient and Z-package; the ability to contract with both public and private providers expands access to services. The population coverage is now greater than 90%, giving leverage to negotiate with providers – and influence health care for almost all Filipinos, reducing people's vulnerability to the discretionary decisions of the LGUs in which they happen to live, shift from LGU sponsorship of health insurance coverage to national government targeting and financing of premiums; and the purchasing of health services guarantees people access to a nationally-defined PhilHealth package of services, rather than being reliant on whatever LGUs may be able to provide. Purchasing provides income to hospitals and providers even the poorest locations, with the professional fee share encouraging retention of health staff.

PhilHealth can its powers better to get more health and value for money by revising the case rates to include evidence-based clinical practice guidelines will allow PhilHealth to better use its power to get more health and value for money. Furthermore, the corporation should make all case rates realize their potential by complementing them with a policy of fixed co-payments, while also considering reforms in provider payment methods to incentivize quality, as well as building a state-of-the-art information system. The national government could channel more resources through PhilHealth and the LGUs should ensure PhilHealth accreditation of all their facilities to guarantee that people everywhere can benefit from health insurance coverage.

In conclusion, the Philippines is recognized as a global leader in sin tax reform for (i) STL design that maximizes revenue and health, and (ii) monitoring its impact. Also, STL has brought tangible benefits, potential to further strengthen the use of STL expenditure through policy reform and program implementation to get more health and value for money. And continued public and political support for the Sin Tax – and of recent DOH/PhilHealth reforms – will depend on showing that the reform benefits the people.

## **TARGETING THE POOR UNDER LISTAHANAN 2**

*By Ms. Krupska Lenina Apit  
Project Coordinator*

Listahanan is an information management system that identifies who and where the poor are nationwide. It makes available a socioeconomic database of poor households as basis in prioritizing beneficiaries of social protection program and services. E0867 Series of 2010 mandated all government agencies to utilize the Listahanan Database. The Listahanan was

a result of 2 problems encountered by social welfare programs: (i) poverty incidence continued to increase despite implementation of anti-poverty programs, and (ii) 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.

There are 4-phases in the project cycle. The first phase is the preparatory phase, which includes geographic targeting, and data collection strategy, assessing households in rural barangays and in identified poverty locations. It also includes hiring and training of field workers, and orientation of LGUs. The second phase includes data collection and analysis. During this phase, enumerators conducted household interviews using assessment forms. Information collated by field staffs using paper forms were endorsed for encoding and data processing using the Proxy Means Test (PMT) Model.

PMT has been proven effective in Latin American countries with large informal sectors. In the Philippines, 40% of the population belongs to the informal sector, whose income is hard to measure. PMT, however, is not perfect or 100% accurate like any model-based methodologies. Listahanan 2 tightened the quality control on operations and enhanced the PMT model to minimize errors.

After generating the initial list of the poor based on the results of the PMT, this list is posted at the barangay level for the community to validate as part of the third phase of the project. The local verification committee at the municipal city level assessed the complaints made. The re-assessed households were subjected to the PMT model to generate the final list of poor. Final results of the assessment were shared through generation of national and regional profiles of the poor, which was the last phase of the project.

Through this process, there were 5,166,351 identified as poor households out of 15,242,397 households assessed in the second round of assessment. The regional breakdown showed ARMM remains the most number of poor households followed by Region X and Region VII. The statistics were further aggregated based on basic information like name, address, socio-economic factors such as housing and water, and program related information such as persons with disability and overseas workers.

Several datasets can also be generated from the database such as Magnitude of Poor, Housing Condition, Health, Education, Labor and Employment and others.

Listahanan 2 is a rich data resource, which contains about 70% of the 22 million estimated household populations. It is recommended that maximizing this database can extend PhilHealth's services to those with income slightly above the poverty threshold. Also, to validate one's socio-economic status, name matching between POS clients and Listahanan 2 is recommended. Lastly, efforts directed to extending coverage to day care workers in 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> class municipalities that have difficulties in paying for health insurance of staff due to inadequate internal revenue allotment should be made.

## **UNIVERSAL POPULATION: SQUEEZING THE MIDDLE AND OTHER SOURCES OF FUNDS**

*By Dr. Eduardo P. Banzon*

*Principal Health Specialist, Sector Advisory Service Cluster,*

*Sustainable Development and Climate Change Development, Asian Development Bank*

Health was considered a human right after World War II and the WHO Constitution talks about universal access. The Alma Ata Declaration in 1987 comes from a unified desire of universal access, which is one of the core elements of UHC.

Universal Health Coverage provides all people with access to needed health services of sufficient quality to be effective. It ensures that the use of these services does not expose the user to financial hardship.

UHC became part of the United Nations' Sustainable Development Goals: Good Health and Well-being, which talks about not only financial protection but to have quality health care services, medicines and vaccines.

Extending coverage to the middle layer of the population is one hindrance in attaining universal population coverage. The formal public private sector employees and dependents are on the top layer. Paying premiums is an easy way to get money. And this sector pays premiums based on their job and income quintile.

The bottom layer includes the poor families, measured by poverty or other arbitrary measures. This layer is the government-subsidized sector of the population. The question was never whether we subsidize the poor into health insurance or not; it was always who is the poor, which is a continuing debate until now.

The middle layer consists of the informal sector, the borderline poor and non-poor. This sector consists of about 35% from the top layer and about 65% from the bottom layer. Subsidizing this sector is politically difficult because when the non-poor is subsidized, the educated people will start to question the method and it becomes a non-health issue. Hence, the Disability Act and Senior Citizens Act were created, among others.

The WHO's universal population-based general budget revenues funded for all is one way of achieving UHC, and this includes funding the coverage of the informal sector from general budget revenues. The formal sector is covered by compulsory health insurance scheme. Given this, the approach is relatively not good as the Philippines will not attain the UHC, and at the same time, it will end up indirectly subsidizing in a very inefficient manner. Another thing is, fund coverage for poor and other vulnerable informal population from general budget revenues: the non-poor informal sector voluntarily pays. Another consideration is selective universalization of budget-funded services in order to achieve UHC.

There are two necessary and sufficient conditions for UHC: subsidize and compel - subsidization because some people will be too poor to be able to afford voluntary coverage

and compulsion because some of them who can afford it are unwilling to buy it. Subsidies alone are not sufficient because the rich and health will not join and compulsion without subsidies imposes a heavy burden on the poor and sick. Compulsion is a major challenge for Low and Middle Income Countries (LMICs).

The Philippines should utilize and adopt evidence-based coverage of needed health services. Also, the use and implementation of health technology assessment will be helpful in achieving UHC. Another thing is, always ensure financial risk protection. It is not always enough to cover people; there should always be financial protection. According to the World Health Assembly Resolution 58.33 (2005), a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care should be included and the transition to universal coverage of the citizens should be planned.

The Philippines does not operate as an individual country. UHC should not only be country-specific but global as well. Getting countries to work together and having access to these services when most of the population is working overseas should be put in place. PhilHealth should put in resources and demand the receiving countries to work with Philippines to make sure that UHC is global.

## OPEN FORUM

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

*Q1 (From the audience): “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 to say that they will not pay for benefits unless they pass gatekeepers; if patients 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 the question is, is PhilHealth ready not to pay unless you pass through a gatekeeper? It will also solve a lot of fraud. It will also solve a lot like the portability clause that must be re-examined. This has gone too far because it gives excuses for communities not to be responsible for their people.*

*A1 (Dr. Eduardo Banzon): “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 that were the case, then you would imagine wider resistance. We should start seeing gatekeeping really as like polyclinics.*

*Let’s talk Cuba, Cuba basically their strength is the polyclinics, somewhere 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 gatekeeper will not be there. Because as I understand, before, people reasoned, ‘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 sort of envision being well equipped, then they can actually manage a lot of conditions already. I can imagine the gatekeeping system will actually work. It’s easy to make that happen in the Philippines. So you that service delivery aspect can be managed quite rapidly.”*

A point raised here was the readiness of the PhilHealth not to pay and pass through a gatekeeper, and if so, it will solve a lot of fraud. Dr. Banzon discussed that the Gatekeeping system in the Philippines will actually work and would be easy to implement. But the problem discussed was that there would be a wider resistance of the patients not to go to healthcare facilities, unless the physicians are fully equipped to manage a lot of conditions. Consequently, the service delivery system in the Philippines would be managed quite rapidly as well.

The Sin Tax Law Reform is a milestone. The NHTS-PR or the Listahanan 2 was also highlighted by Prof. Novales. Also, it was mentioned that looking into the bigger chunk of the population, specifically the informal sector, is very important and it is compelling them to contribute to the system.

The challenge at the end of the discussion was Philippines should make the final decision to achieve universal health care and move forward.

# SYNTHESIS

*By Prof. Konrad Obermann, MD, PhD*

*Senior Lecturer, MIPH Mannheim Institute of Public Health – Heidelberg University*

There are three suggestions that Prof. Konrad discussed. First is focus. There are so many issues that have been discussed and it would be helpful if PhilHealth would focus on the things that it can do as a corporation and least on the things that it cannot do on its own, but rather requires support from other government institutions.

Second is the issue of monitoring. PhilHealth should know in which areas they are getting better and getting worse. The income quintile is a very good starting point and the suggestion is to cover from the richest to the poorest. The Listahanan 2 is also a very good approach to monitor who among the population is poor.

Last is research. There is the idea of setting up a research institution. The need to conduct research in health financing, health insurance, and benefit packaging is tremendous and the need is constant. It would be worthwhile to develop a facility and let people, who are experts, provide answers to questions that are posted by policy makers.

## CLOSING REMARKS

*By SVP Gregorio Rulloda  
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 and sustaining Universal Health Coverage. Right now, we are challenged by change and this change will translate 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 your expectations on this symposium. And our prayer this morning was realised as we were given the opportunity to learn and deepen our understanding on the opportunities 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 Gilda Salvacion (Diaz) 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!”*