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HEALTHCARE COMMITTEE

THE HEALTH OF NATIONS

Commitment to Improved Outcomes for Patients

Increase in Public Funding for Universal Health Care

Transparent & Collaborative Culture of Participation

Informing universal health care policy implementation in the Philippines through examining best practice approaches

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How Pooled Procurement of Medicine Works

5 So Patients Have Access to High-Quality Medicines

As prescribed by their doctors for very low cost thanks to pool procurement of prescription medicines.

4 Making Medicines Available to Patients

Through the universal health care system either for free or for a low cost flat rated prescription charge.

3 Gaining Lower Prices by Pooling Procurement

Of the medicines buying for the country's needs as a whole.

2 The Health Department Uses The Data

To negotiate with medicine manufacturers to achieve the best possible price based on the country's longer-term needs for bulk procurement of their requirements.

1 Government Collects Health Data

On the incidence of different diseases and illness to calculate the volume of prescription medicines they are likely to require.

CONTENTS

The benefits from universal health care provision have been achieved in many countries around the world. There is no one system for delivery of health services on a universal basis and each country's approach brings with it advantages and disadvantages. Each approach informs and provides learnings. Demographic and economic differences between countries, differing systems of government, as well as the various approaches taken to evolve their universal coverage all contribute to inform the Philippines' approach. The key aspect shared by these different approaches is the goal of improved clinical outcomes for patients. By recognising the importance of the health of nations to the wealth of nations, the role of public financing is crucial in delivering health services that are universally accessible to citizens. Health care is an investment. Such funding consistently proves itself to be unique amongst the various forms of government spending though its popularity and the willingness of taxpayers to contribute towards its continued development and improvement.

Universal Health Care in the Philippines

The Duterte Administration's successful passing of the Universal Healthcare Act opened, what was described by the World Health Organization in its praise, a new dawn for the Philippines. The UCA legislation starts the journey to recognise that health is a fundamental right for the Filipino people. The collective learnings from the examination of universal health care in other countries should inform three guiding principles for the Philippines as it seeks to implement the Universal Health Care Act:

Implement a commitment to improved health outcomes, at the heart of the system of universal health care provision, embracing a data-driven approach to enable informed decision-making; introducing, where needed, new systems and institutions to aid in the attainment of this goal

Fair and equitable provision of universal health care must embrace a patient-centric approach. Universal health care is

Manifesto for Universal Health Care in the Philippines

Implement a commitment to improved health outcomes, at the heart of the system of universal health care provision, embracing a data-driven approach to enable informed decision-making; introducing where needed new systems and institutions to aid in the attainment of this goal

Introduce a significant increase in public funding through general taxation for the implementation of universal health care in the Philippines; investing in appropriate care and treatment provision through the adoption of transparent and independent processes

Embrace a transparent and collaborative culture of participation in the operation of the universal health care system that is responsive to the evolving health needs of the Filipino people, ensuring value as well as quality of care.

greater than a safety-net of relief from financial calamity due to ill health. To build a sustainable system, universal health care must strive for continued national health improvements though disease prevention, treatment of urgent ill health, therapies for the management of acute disease as well as education and support for general health and well-being.

Decision-making should be informed, and in recognition of finite resources, be targeted to those areas of intervention where the greatest improvements in quality of patient outcomes can be achieved.

Introduce a significant increase in public spending for universal health care in the Philippines; investing in appropriate care and treatment provision though the adoption of transparent and independent processes

No successful system of universal health care provision exists, absent of substantial state funding for the system. Decisions over the degree of nationalisation of health care delivery can be taken at a national or on a regional basis to address the challenges for the underserved. The Philippine government along with other countries around the world are struggling with decisions over health investments, especially in light of the current COVID-19 pandemic. To achieve improved clinical outcomes, access to practitioners and medical facilities, as well as funding support for effective treatments need to be present. Government funding for universal health care provision must increase if the system is to be successful.

Embrace a transparent and collaborative culture of participation in the operation of the universal health care system that is responsive to the evolving health needs of the Filipino people, ensuring value as well as quality of care

Universal health care is a partnership between the government, the people, practitioners and professionals, carers, health technology and medicine providers, to name a few. Balance between competing demands driven by need and the ability to operate a sustainable system is created through active support for stakeholder collaboration within transparent and informed decision-making processes.

Delivering on the Promise of Universal Health Care

The advent of the Universal Health Care Act marks the start of a journey for the Philippines in achieving the benefits of a healthier nation. As seen in other countries, the journey towards universal health care will involve further reforms and will deliver better health care to the Filipino people.

The recent context of COVID-19 should demonstrate clearly that the 'Wealth of Nations' and the 'Health of Nations' are linked. As governments all over the world have been required to intervene in the economy on an unprecedented scale to avert an economic calamity flowing from a health catastrophe, the future requires new thinking and an increased role for government within the health care system to insure the future gains in a post Coronavirus world. Good healthcare must

no longer be seen as a cost or burden on the state, but as an investment in enhancing national resiliency against future health threats and earning the dividend from a healthier society.

The strategic approach for Universal Health Care in the Philippines tells only part of the story. The three guiding strategies seek to build a more equitable framework for access:

1. Financial risk protection through expansion in enrolment and benefit delivery of the National Health Insurance Program (NHIP);
2. Improved access to quality hospitals and health care facilities as well as access to competent health providers (doctors/nurses etc.);
3. Attainment of health-related United Nations Strategic Development Goals (SDGs).

To spur the wide-ranging reforms needed to bring about a more resilient and healthier society, a higher goal is needed: improving health outcomes.

Access to healthcare professionals and facilities is vital in achieving this goal, as is access to effective treatments and therapies. Improving health outcomes requires a national approach to disease detection, prevention and treatment. Medical facilities, healthcare professionals, medicines and treatments, public awareness and information form key components of universal health coverage. Investing public resources in delivering universal health care creates wider benefits in the country.

In its 2004 report "Investing in Health for Economic Development", the World Health Organization explains that in order to understand the impact of health on economic growth, it is necessary to look broadly: "Health is not only the absence of illnesses; it is also the ability of people to develop to their potential during their entire lives. In that sense, health is an asset individuals possess, which has intrinsic value (being healthy is a very important source of wellbeing) as well as instrumental value." Reductions in production losses and absenteeism coupled with increases in productivity are all tangible benefits flowing from improved health in addition to the ability to repurpose financial resources currently directed towards the treatment of ill health. As then Mexican health minister and chair of the OECD Health Ministers' Meeting noted in 2004, "Health performance and economic performance are interlinked." Good healthcare is a human capital investment.

In its 2014 report "Healthcare: the neglected GDP Driver" global consulting firm KPMG highlighted the positive impact of healthcare investment in four areas of economic activity: employment generation; productivity enhancement; foreign exchange generation, and driving innovation and entrepreneurship.

The Philippines has the third highest healthcare expenditure in the ASEAN region as a percentage of Gross Domestic Product but sits at the mid-point of the ten-nation group when examining public expenditure on health as a percentage of GDP. To deliver a health system that is truly universal in nature, the Philippines must take action to increase public financing. In doing this, the Philippines must evolve new structures and institutions to ensure good governance, as well as to promote a culture of decision-making based on furthering health

outcomes. The Philippines must embrace a whole-of-society approach involving all stakeholders responsible for making the approach to universal care and improved health outcomes an environment of partnership. To achieve this, the Philippines should look to evolve new systems and institutions where necessary, to allow for informed and transparent decision-making, as well as use a data-driven approach to create a culture of continuous improvement.

Learnings from other countries can inform the Philippines' experience as it moves forward with its implementation of universal health care. There is no one single approach which can be used as a template. The Philippines should look to develop a system that is responsive to local needs but informed by best practices from other countries.
Effective implementation of universal health care represents the opportunity to create an institution that Filipinos can be proud of. It is an investment in a shared future for the Filipino people and a recognition that the health of nations and the wealth of nations is linked like never before.

Aims of Universal Health Care Policies

Studying approaches from around the world provides insight into what underpins the much-used terminology known as universal health care. There is no single approach to delivering health services that are universal in nature, but there are a number of common themes:

Universal health care provision is much more than protection against financial calamity resulting from health calamity. Universal health care around the world focuses on the principle of improved clinical outcomes for patients. Provision is not limited to hospitalisation for emergencies and embraces a total care approach to treatment and disease management, embracing access to medicines, as well as supportive care and medical services. The multitude of systems and approaches embrace differing metrics for measuring improved patient outcomes. The United Kingdom model of "Quality of Adjusted Life Years" which is embraced within its health technology assessment process is perhaps one of the most interesting data-driven models for understanding a definition for 'improved clinical outcomes for patients' in a manner which informs decision-making within the system.

Universal health care provision requires substantial funding from the public purse. Consistent within all of the successful systems is substantial funding from the taxpayer in the provision of universal health care. This does not mean that the systems themselves need to be heavily nationalised as with the Kingdom of Thailand. Universal health care in Canada, and especially Australia, heavily utilise private sector delivery mechanisms both in terms of healthcare professionals and treatment facilities. Regardless of how health care and treatments are delivered, the majority of its funding is derived from public finances and while some 'ring-fenced' levies, co-pays and public insurance systems provide aspects of funding, the vast majority is provided through general taxation.

Universal health care systems are massively popular. While all countries face challenges and opportunities for improvements within their universal health care systems, the systems

themselves are viewed as symbols of national pride. Surveys and studies continue to affirm support for the health care systems and majority of populations in many countries confirm a willingness to pay more for their universal health systems. Countries spending on delivering universal health care ranges for 7-10% of their gross domestic product. And as Thailand successfully proves its ability to fund its health care system, universal health care spending is not limited only to developed economies. Successful universal health systems strive for continued improvement through constant evolution in processes that embrace collaboration with all stakeholders, commercial, professional and otherwise.

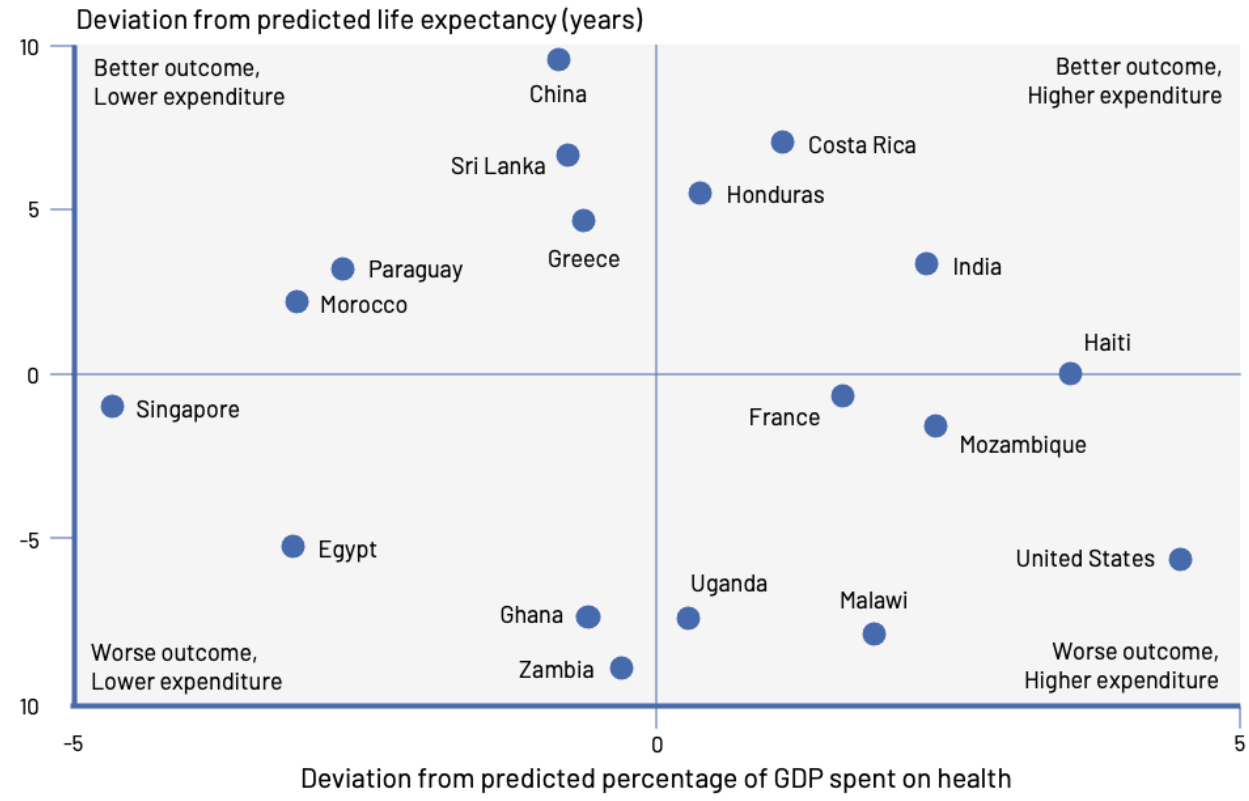
Assessing Universal Health Care Policies

Comparing the impact of health care policy across borders is inherently challenging. Relationships between healthcare spending and health outcomes show inconsistent patterns (as shown in chart). As a measure, predicted life expectancy is important. Nonetheless, equally important is the quality of life achieved from health expenditures, which is, however, more difficult to quantify on a comparative basis. The United Kingdom has done some important work in helping to define such a metric through its health technology assessment process.

Countries adopt different systems of health care delivery as well as have varying demographics and disease prevalence which, has an impact on performance metrics. The data collected is used to inform local systems and do not always lend itself to cross-border comparisons.

Where universal health care systems exist, they do so as a result of a policy decision by governments. Purely market-driven health care is not universal in its nature. There is, therefore, always a policy aim in adopting a universal approach to the delivery of health care.

Government structures and the mix of public and private care provision are also factors impacting the implementation of universal health care. Universal health care has most often evolved over years of policy change and experimentation. When faced with the potential for near infinite demand with finite resources, the way policy drives value in the health system is important to understand the different approaches that could be undertaken.



Source: World Bank

Accounting for the inherent challenges in benchmarking such a level of diversity, looking at the aims of universal health care provision alongside the policies implemented to meet these aims and the approaches taken to ensure sustainable cost-/care-effective delivery help to inform best practices. From a wide pool of countries examined, four countries offer policies of interest: United Kingdom, Canada, Australia and Thailand.

The delivery of universal health care in these countries can be seen through various lenses:

- The degree of nationalisation within the health care delivery system – the United Kingdom and Australia representing either end of the spectrum between public and private health systems
- The amount of regional diversity in delivery within the national health system as seen in Canada, with a more significant role for local and regional government in health care delivery
- The economic wealth of the country and how universal health care can be achieved in less-developed countries, such as Thailand.

The assessment is not seeking to answer which country has a better approach to universal health care, but to understand what lessons can be learned from each, and given their diversity, what does each have in common.

United Kingdom Universal Health Care Policy Examination

Overview of Aims

The United Kingdom's National Health Service (NHS) oversees the commissioning of health services in the constituent nations of the country (NHS England, NHS Wales, Health and Social Care in Northern Ireland and NHS Scotland). The National Health Service began in 1948 out of a principle that "good healthcare should be available to all, with access based on clinical need, not ability to pay."[1] While the NHS maintains its founding principle of putting patients first, with NHS Services delivered free of charge to patients, the original mandate focusing on the diagnosis and treatment of disease has evolved over the years to include an increased role in preventing ill health and improving the physical and mental health of the population.

The NHS Constitution sets out seven principles that govern the operation of the institution:

- The NHS provides a comprehensive service available to all
- Access to NHS services is based on clinical need, not an individual's ability to pay*
- The NHS aspires to the highest standards of excellence and professionalism
- The patient will be at the head of everything the NHS does

The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population

- The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources
- The NHS is accountable to the public communities and patients it serves

*NHS services are free of charge, except in limited circumstances sanctioned by Parliament[2]

The NHS Constitution additionally sets out a series of rights for those using the healthcare system. These range from protections against discrimination and access to quality care through the access to nationally approved treatments, drugs, and programmes. In order to determine the drugs and treatments that are approved for use in the NHS, an independent organization, the National Institute for Health and Care Excellence (NICE), produces guidance for relevant health bodies.

1 Guide to the Healthcare System in England (May 2013)
2 The NHS Constitution (Jul 2015)

Delivering Improved Health Outcomes

The concept of a national health institute came into existence as a policy response to regional disparities in healthcare provision during the late 1990s to set professionally agreed standards for clinical care. It was set up as the National Institute for Clinical Excellence in 1999 and joined with the Health Development Agency in April 2015 to become the new National Institute for Health and Clinical Excellence. Following the Health and Social Care Act 2012, NICE was renamed the National Institute for Health and Care Excellence in 2013 to reflect new responsibilities for social care and its status changed from a Special Health Authority to a Executive Non-Departmental Public Body. A key aspect of NICE's function is the explicit determination of cost-benefit boundaries for certain technologies that it assesses.

Through its assessment process analysing the most appropriate treatment regimes for different diseases, NICE must account for both desired medical outcomes and additional economic arguments regarding different treatments. To create clinical guidelines, NICE brings together expertise from medical colleges, professional bodies, as well as patient and caregiver groups throughout the country.

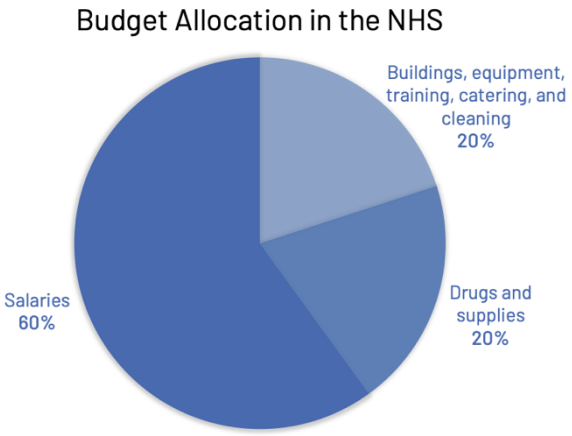
Under the Collaborating Centres, divisions known as Guideline Development Groups consisting of medical professionals, patient and carer groups, and technical experts work to develop clinical guidelines which are then subjected to two rounds of stakeholder consultation before being finalised by the Collaborating Centre and ultimately approved by NICE and issued the NHS.

Since January 2005, the NHS in England and Wales has been legally obliged to provide funding for medicines and treatments recommended by NICE's technology appraisal board. The assessment process aims to be independent for government and The assessment process aims to be independent for government and making decisions is based on clinical and cost effectiveness. The independence and data-driven assessment of patient outcomes is a key benefit from the NICE process.

NICE then invites consultee and commentator organisations to take part in the appraisal. A consultee organization would include patient groups, organisations representing healthcare professionals, and the manufacturers of the product undergoing appraisal. Consultees submit evidence during the appraisal and comment on the appraisal documents.
An independent academic centre then draws together and analyses all of the published information on the technology under appraisal and prepares an assessment report. Comments are then taken into account and changes are made to the assessment report to produce an evaluation report. An independent Appraisal Committee then looks at the evaluation report, hears spoken testimony from clinical experts, patient groups, and carers. Once these comments have been taken into account, the final document is drawn up called the 'final appraisal determination'. This is submitted to NICE for approval.

Delivering Cost-Effective Treatment and Care

The National Health Service is 98.8% funded through general taxation and National Insurance (social security) contributions plus small amounts from approved patient charges for some services. The NHS accounts for the vast majority of the roughly 7% of GDP[3] spent on healthcare in the United Kingdom.



The NHS in England maintains a charge for prescription medicines of £9.15 per item (P587 equivalent) to be paid by the majority of adults. Children in full-time education under 18 years old and those over 60 are exempt from these charges along with certain categories of low-income individuals and some specific medical exemptions. Discounts are available to those requiring long-term use of prescription drugs under the Prescription Pre-Payment Certificates scheme for those requiring more that 12 prescriptions per year or more than three prescriptions each quarter. Prescription charges in the devolved NHS authorities of Wales, Northern Ireland and Scotland were abolished between 2007 and 2011.

2008 NICE guidance seeks to assess the cost–effectiveness of potential expenditures within the NHS to assess whether or not they represent 'better value' for money than treatments that would be neglected if the expenditure took place. It assesses the **cost–effectiveness of new treatments by analysing the cost and benefit of the proposed treatment relative to the next best treatment that is currently in use.**

NICE guidance uses the generic measure of disease burden known as Quality of Adjusted Life Years (QALY) which accounts for both quality and quantity of life lived as primary indicator quantifying expected health benefits with a given treatment regime. This approach compares the present value of an expected QALY flow with and without treatment (or relative to another treatment), the net/relative health benefit derived from such a treatment, and when combined with the relative cost of treatment, this information can be used to estimate an Incremental Cost Effectiveness Ratio (ICER).

Closely linked to NICE is the NHS Commercial Medicines Directorate, charged with helping patients to get the best outcomes and treatment, and to help the NHS and taxpayers achieve maximum value from the NHS's significant spend on medicines through its Commercial Framework for Medicines. This framework recognises a partnership between that National Health Service and the pharmaceutical industry as represented by the Association of British Pharmaceutical Manufacturers (ABPI) with its state objective to "drive earlier and more purposeful engagement between the pharmaceutical industry, NHS England and NICE, to enable better planning at both individual company level and at a wider industry level."[4]

[3] Institute of Fiscal Studies: Securing the future: funding health and social care to the 2030's (May 2018)
[4] NHS Commercial Framework for Medicines - Draft for Engagement (Nov 2019)

This collaborative framework brings together the NICE processes with NHS purchasing, as well s the commercial industry to streamline processes and reduce the administrative burden for all participants. This ensures patient access to the most clinically and cost-effective new treatments and technologies, while also maximising health outcomes and value for money for taxpayers.

Assessment

The United Kingdom approach to health provision represents more than 70 years of evolution in the delivery of Universal Health Care. Throughout this time, the principles of effective treatments delivered on the basis of clinical need are delivered free (or mostly free) to patients while recognising a requirement for value for money due to finite government resources have remained consistent. The success of the United Kingdom experience can be assessed by recognising its unwavering commitment to improving health outcomes over its history of universal health care provision. In seeking to quantify success and the ongoing work to create transparent and inclusive processes for its decision-making, the UK has evolved an ability to balance near infinite demand with the reality of finite resources. **The creation of the National Institute for Health and Care Excellence has been a major innovation in driving greater consistency in health care provision.** The UK experience also seeks to strike a balance between maintaining national standards while allowing for responsiveness to local healthcare needs.

The United Kingdom spent an average of £2,352 (P151,000) per person on health services in 2018/19.[5] Public funding is key to UK healthcare provision, yet it is not widely viewed as a 'burden on the taxpayer'. Indeed, a 2016 opinion poll appears to show support for higher taxation to pay for extra spending on the NHS with 70% of respondents demonstrating a willingness to pay an extra penny in the pound in income tax if the money were ring-fenced and guaranteed for the NHS. Two-thirds of respondents stated a willingness "to pay more taxes in order to maintain the level of spending needed" on the health service.[6] The same poll also showed a huge majority, 77%, believing the NHS to be "crucial to British society" and that it must be properly maintained.

Adopting a health technology assessment similar to the UK's NICE approach would benefit the Philippines in achieving its goal of universal health care provision. Such a data-driven approach, assessing the quantity and important quality of health improvements to patients from different therapies provides a transparent and objective decision-making framework when considering which therapies should be available for public funding support. This approach would allow the Philippines to make informed judgements over the costs and benefits for both innovative medicines and generic products on a comparative basis. The data generated from an approach similar to the UK would additionally inform the Philippines about disease incidence in the country and enable targeted pool-procurement to drive greater value for public expenditures on an effective universal health care system.

[5] House of Commons Library Briefing Paper - NHS Funding and Expenditure (Jan 2019)
[6] King's Fund, IPSOS Mori Poll (2017)

Canada Universal Health Care Policy Examination

Overview of Aims

Canada's thirteen provincial and territorial governments provide the country's single-payer, publicly funded healthcare system guided by the Canada Health Act of 1984, informally referred to as 'Medicare'. The universal and public funding aspects of Canada's health system are considered to be a "fundamental value that ensures national health care insurance for everyone wherever they live in the country."[7] The responsibility of the provincial governments in healthcare dates back to as early as 1867, and it was not until the 1930s that the Federal Government was recognised as having responsibility of protecting the health and well-being of the population.

While provincial governments continue to hold responsibility for healthcare delivery, the Federal Government co-funds the costs through block-grants to the provinces, as well as taking responsibility for groups such as native people (First Nations).

The 1984 Canada Health Act set-out and reaffirmed five founding principles for health provision in the country:

- Public administration on a non-profit basis by a public authority
- Comprehensiveness – provincial health plans must insure all services that are medically necessary
- Universality – a guarantee that all residents in Canada must have access to public healthcare and insured services on uniform terms and conditions
- Portability – residents must be covered while temporarily absent from their province of residence in or from Canada
- Accessibility – insured persons must have reasonable and uniform access to insured health services, free of financial or other barriers

Canada's system, while a public one, is not nationalised and relies on a mix of public and private funding with around 70% on average representing public sources, with the rest paid privately (both through private insurance, and through out-of-pocket payments). This, however, leads to significant disparities in the scope of the public share of costs. 99% of physician services are paid by publicly funded sources whereas hospital care is only funded at 90%.[8] The Canadian system additionally leads to disparities between regions as health authorities take an individual approach to funding non-physician services. While pharmaceuticals, nursing care, and physical therapy must be covered for inpatients, there is considerable variation in the degree to which they are covered from province-to-province. Two-thirds of Canadians have some form of

[7] The Health of Canadians - A Federal Role: The Parliament of Canada (Jan 2017)
[8] Canadian Institute for Health Information (Sep 2004)

supplemental insurance either via their employer or a personal plan to supplement the government backed schemes.

Delivering Improved Health Outcomes

Canada sits apart from other countries adopting universal health care coverage as it lacks a system of subsidy for medicines which leads to differences in co-payment, cost ceilings, and special subsidy groups by private insurers and by provinces. While the Canada Health Act mandates coverage for in-patient pharmaceutical medicines, it is left to the provincial health authorities to develop their own systems for out-patient medicines. This leads to wide variations in which groups are covered with provinces such as Quebec, providing universal coverage through a public private funding combination, to others which cover only specific age groups or those of lower economic means. The Canadian Agency for Drugs and Technologies in Health (CADTH), established in 1989, is the national organization that provides research and analysis to healthcare decision-makers. CADTH is an independent, not-for-profit organization responsible for providing health care decision-makers with objective evidence to help make informed decisions about the optimal use of health technologies such as pharmaceutical drugs, diagnostic tests, medical, dental, and surgical devices and procedures. While operating nationally, CADTH services are delivered in support of the provinces which maintain their own provincial formularies. CADTH pools the purchasing power of the provincial formularies within a common formulary.

The Common Drug Review (CDR) process operated by CADTH makes recommendations on whether a drug will be eligible for public reimbursement. The CDR process conducts objective evaluations of the clinical, economic, and patient evidence on drugs. This evaluation informs reimbursement recommendations. Before the creation of CADTH, each drug plan conducted its own pharmaceutical drug reviews and decided independently which drugs it would pay for, with input from different expert groups. Differences in drug evaluations sometimes led to differences in reimbursement decisions. CADTH analyses studies that report on the clinical effectiveness, safety, and cost-effectiveness of the drugs under review. Drugs are compared with current accepted therapy to determine the therapeutic advantages and disadvantages of the new drugs, as well as the cost-effectiveness of the drugs in comparison to current therapeutic options. In addition to the clinical and economic evidence, the CDR process takes into account input by patients, drug manufacturers, and clinicians.

The CADTH Canadian Drug Expert Committee (CDEC), an appointed, independent, panCanadian advisory body comprised of individuals with expertise in disease management, drug evaluation and utilisation, and health economics, is responsible for making final reimbursement recommendations. The final decisions on reimbursement remain with the 18 drug plans operated by the provinces and Federal Government, and therefore what is reimbursed and how much is reimbursed can still differ depending on where individual patients live and which drug plan they fall within.

Delivering Cost-Effective Treatment and Care

The Canada Health Act sets standards for all provinces in the delivery of universal health care, requiring coverage for all medically necessary care provided in hospitals or by physicians; this explicitly includes diagnostic, treatment and preventive services, delivered to all regardless of income level. Canada spends around 10% of GDP on health services. Through the Canada Health Transfer (CHT), the Federal Government allocated funding for healthcare to the provinces on a per capita basis. This federal funding exceeded C$36 billion (P1.3 trillion) in 2016-17[9] with the amount of federal transfer increasing at a rate of 6% on average over recent years. Some provinces additionally charge annual healthcare premiums which are effectively a tax as they are compulsory in nature, not tied to actual service use nor local health expenditure, to provide increased funding for health services. As such, these healthcare premiums are not defined as a social insurance.

In order to maintain control over the costs of prescription medicines, the 1987 Bill C-22 established a new federal body, the Patented Medicine Prices Review Board (PMPRB). The PMPRB is an independent quasi-judicial body responsible to the Canadian Parliament.

Bill C-22 also established the ability to extend the "period of patent protection before compulsory licensing could be possible" as an incentive to industry. In practice, the process is entirely voluntary and the existence of the guidelines helps to shape decision-making amongst manufacturers. The guidelines state:

- The price of an existing patented drug cannot increase by more than the Consumer Price Index (CPI)
- The price of a new drug (in most cases) is limited so that the cost of therapy with the new drug is in the range of the costs of therapy with existing drugs in the same therapeutic class
- The price of a breakthrough drug is limited to the median of its prices in France, Germany, Italy, Sweden, Switzerland, Britain, and the United States. In addition, no patented drug can be priced above the highest price in this group of countries.[10]

It is important to note that the PMPRB does not set prices, instead reviewing the prices of individual products along the following guidelines:

- A new drug product that is an extension of existing or comparable dosage form of an existing medicine, usually a new strength of an existing drug
- The first drug to effectively treat a particular illness or that provides a substantial improvement over existing drug products
- A new drug or dosage form of an existing drug that provides moderate, little, or no improvement over existing drugs

If it is established that a price is excessive, the manufacturer can make what is called a Voluntary Compliance Undertaking (VCU) to adjust the price and take remedial action. This could

[9] What You Need to Know about Canada Health Transfer (Sep 2018)
[10] Pharmaceutical Cost Control In Canada: Does It Work? Devidas Menon (Feb 2019)

include a financial settlement with the federal government that reflects excess revenues earned, since the price first exceeded the guidelines. The board also can initiate formal proceedings and hold a public hearing. Following such a hearing, it can order the manufacturer to reduce the price so that it is no longer considered excessive, reduce it even further for a specified time period so as to offset previously earned excess revenues, reduce the price of one other patented drug of the same manufacturer, and, if required, order a payment to the government of Canada equal to excess revenues. The board has recourse to other legal action should compliance not be reached.

The PMPRB uses the Patented Medicine Price Index (PMPI) to measure and track the price of pharmaceutical medicines. The 2018 Annual Report of the PMPRB notes that of the 1,403 patented medicines in use, including 108 new medicines, only 7 products were in voluntary compliance proceedings and "Prices of existing patented medicines were stable, while the Consumer Price Index rose by 2.3%.[11]

Assessment

The Canadian approach to the delivery of universal health care benefits from a number of changes introduced over the last thirty-years. However, it remains challenged by wide variances in funding between provinces and this translates into a different experience, especially with regard to coverage, depending on when patients live. Canada's approach to voluntary price controls for medicines has arguably been successful and indeed, recent data show overall price reductions for patented medicines in real terms. The approach has been to work collaboratively with the pharmaceutical industry and offer incentives to a collaborative approach such as patent extensions. The system of provincial formularies can lead to differences in available treatments based on geographic location. Despite these regional differences, the provision of universal health care in Canada remains massively popular with 67% of Canadians satisfied with the quality of their healthcare.[12]

Canada's partnerships with its pharmaceutical suppliers with incentives and voluntary undertakings highlights a different approach to the Philippines' current policies on price regulation for specific products. The Philippines can learn much from the Canadian approach which creates the dual benefit of increasing availability of effective treatments as well as maintaining tax payer value for the therapies receiving public subsidies. Increasing availability of treatments while maintaining good value through partnership with industry would move the Philippines considerably closer to achieving its goal of universal health care provision.

[11] Patented Medicine Prices Review Board Annual Report (Dec 2018)
[12] Canada Institute for Health Information Survey (Feb 2018)

Australia Universal Health Care Policy Examination

Overview of Aims

Health care in Australia is largely funded by the government at national, state and local levels, as well as by private health insurance. The cost of healthcare is also borne by not-for-profit organisations, with a significant cost being borne by individual patients or by charity. Some services are provided by volunteers, especially remote and mental health services. At 67% of the total, the government provides the vast majority of health spending.[13]

Healthcare in Australia is governed by the Charter of Australian Healthcare rights. The seven rights in the Charter apply to anywhere healthcare is delivered, and relate to:

- Access—the right to health care
- Safety—the right to safe and high-quality care
- Respect—the right to be shown respect, dignity and consideration
- Communication—the right to be informed about services, treatment, options and costs in a clear and open way
- Participation—the right to be included in decisions and choices about care
- Privacy—the right to privacy and confidentiality of personal information
- Comment—the right to comment on care and to have concerns dealt with

The application of the Charter to the health system is informed by three guiding principles:

- The right of everyone to access health care
- The commitment of the Australian Government to international agreements recognising the right to health
- The acknowledgement of and respect for the different cultures and ways of life in Australian society

While the Charter is not enforceable, it reflects accepted standards and expectations across Australia and its territories. Australia's approach is described by its own government as: "[health system may be] more accurately described as various connected health systems, rather than one unified system."[14] The Australian Government, state and territory governments, and local governments share responsibility for it, including for its operation, management, and funding. While the overarching framework for the health system is laid out by the government, the private sector also operates and funds some health services. These include operating

[13] Australian Institute of Health and Welfare (2018)
[14] Australia's Health 2018 Report - Australian Institute of Health and Welfare (2018)

private hospitals, pharmacies and many medical practices, as well as funding through private health insurance.

Medicare is Australia's main delivery system for universal health care. It is publicly funded and operated by Services Australia (formerly the Department of Human Services). Medicare, relaunched in 1984, is an evolution of the Medibank system first introduced in 1975. Medicare's principles as reaffirmed by the Council of Australian Governments (COAG) in 2016 ensure:

- Eligible persons be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically provided by hospitals
- Access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period
- Arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location

These principles are typically incorporated within or accompany the funding agreements between the Commonwealth (National) government and the states and territories.

Delivering Improved Health Outcomes

Medicare is the primary vehicle of payment for healthcare in Australia, fully funding the cost of most primary care providing rebates for treatment by medical practitioners, eligible midwives, nurse practitioners, and allied health professionals (Medicare issues to eligible health professionals a unique Medicare provider number to enable them to participate in the Medicare scheme). Medicare is operated under Services Australia in collaboration with the Australian Department of Health which is responsible for supporting universal and affordable access to medical, pharmaceutical and hospital services, as well as helping people to stay healthy through health promotion, participation and exercise, and other disease prevention activities.

The Medicare Benefits Schedule (MBS) is a list of all health services that the Government subsidises. A team of medical experts keep the list up to date and safe. Many Australians have private health insurance cover as a supplement to Medicare. These private schemes can insure hospital cover for some (or all) of the costs of hospital treatment as a private patient or general treatment ('ancillary' or 'extras') cover for some non-medical health services not covered by Medicare, such as dental, physiotherapy and optical services.

Clinical Guidelines are developed by the National Health and Medical Research Council (NHMRC), a government agency under the Department of Health. The national formulary is compiled by the Pharmaceutical Society of Australia.

The Australian Government also operates the Pharmaceutical Benefits Scheme (PBS), a system which provides subsidised prescription drugs. PBS is a key component of Australian healthcare,

along with Medicare. PBS is governed under the National Health Act 1953 and benefits can only be supplied by pharmacists and medical practitioners approved under the Act and the scheme is administered by Medicare Australia. Benefits are only given on medications which are listed in the Pharmaceutical Benefits Schedule. The medication may be listed for general use as an unrestricted benefit, or for a specific indication as a restricted benefit.

The National Health Act 1953 provides that listed drugs be assigned to formularies identified as F1 or F2. Generally, F1 is intended for single brand drugs and F2 for drugs that have multiple brands or are in a therapeutic group with other drugs with multiple brands. Drugs on F2 are subject to the provisions of the Act relating to statutory price reductions, price disclosure and guarantee of supply. Allocation to F1 or F2 is determined by legislative instrument. Single brand combination drugs are not included in either the F1 or F2 formulary.

Delivering Cost-Effective Treatment and Care

Australia spends 9.6% of GDP on healthcare[15] which equates to an average of A$6,661 (P235,000) per person. The proportion of Australian tax revenue spent on the health system ranges from 25-26% of total revenue annually. In 2015–16, governments funded A$115 billion (P4.1 trillion) of total health expenditure (67%) with non-government sources funding the remaining A$56 billion (P1.98 trillion) (33%). The PBS covered over 85% of the total cost of pharmaceutical medications.

As with Medicare, PBS operates a Safety Net system (for those requiring long-term or ongoing prescription medications) for concessional patients such as low-income earners, pensioners and welfare recipients. Non-concessional patients pay the full contribution when medication is dispensed by the pharmacist. The patient contribution in 2020 is A$40.30 (P1,422), the current concessionary rate is A$6.50 (P230).

The Pharmaceutical Benefits Advisory Committee (PBAC) makes recommendations to the Minister for Health and Ageing regarding drugs which should be made available as pharmaceutical benefits, which are listed on the Schedule of Pharmaceutical Benefits.

[15] Australia's Health 2018 Report - Australian Institute of Health and Welfare (2018)

In considering a medication for listing on the PBS, the PBAC considers factors including:

- The conditions for which the drug has been approved for use in Australia by the Therapeutic Goods Administration. The PBAC only recommends the listing of a medicine for use in a condition which is in accordance with the Australian Register of Therapeutic Goods.
- The conditions in which use has been demonstrated to be effective and safe compared to other therapies.
- The costs involved. The PBAC is required to ensure that the money that the community spends in subsidising the PBS represents cost-effective expenditure of taxpayers' funds.
- A range of other factors and health benefits. These factors may include, for example, costs of hospitalisation or other alternative medical treatments that may be required, as well as less tangible factors such as patients' quality of life.

Decisions on PBS listing are generally made on a health economics perspective, using cost-effectiveness analysis. Cost-effectiveness analysis evaluates the cost and health effects of one technology versus the cost and health effects of another technology, which is usually standard of care. Innovative medicines whose incremental health benefit justifies its additional expense is deemed to be cost-effective and thus reimbursed by PBAC.

The cost of a medication to be reimbursed by the government is negotiated between the government, through the Department of Health, and the supplier of the drug. The agreed price becomes the basis of the dispensed price of the medication which is negotiated between the government and the Pharmacy Guild of Australia under the current Community Pharmacy Agreement.

Assessment

Australia's approach to universal health care delivery is not a unified system. This reflects Australia's federal system of Commonwealth government structures as well as a blend of public and private systems and individual contributions through co-pays and private insurance. The system offers increased choice and flexibility to Australians, but coverage can vary, especially in Australia's low population density areas.

Australians are satisfied with their health care system.[16] Satisfaction was highest with services provided by pharmacists, followed by private hospitals and specialist doctors. There is a high amount of confidence that the health care system would provide safe and quality care in the event of serious illness. Australians have some concerns about affordability, but most were confident in their ability to access care (including appropriate medical technology and affordable drugs).

A 2017 study of 11 developed countries by the Commonwealth Fund think-tank ranked Australia's healthcare system in second place (the United Kingdom placed first). Australia's approach

[16] Menzies-Nous Survey (2010)

creates a wide safety net for all with increased choice for those with greater economic means and ability to pay.

The Philippines can learn from the Australian experience in terms of incorporating a diverse mix of public and private provision under the umbrella of universal health care provision. Adopting approaches similar to Australia with increased support and subsidy for those with lower economic means while maintaining choice for those with greater financial resources can help to make the universal health care system in the Philippines relevant to local needs and relevant to the different communities being served by the Philippine health system.

Thailand Universal Health Care Policy Examination

Overview of Aims

Universal Health-care Coverage Scheme (UCS). launched in 2001. represents a major achievement for the Kingdom of Thailand in improving the health of the Thai people. UCS provides free health care at the point of service. The benefit package is comprehensive and includes general medical care and rehabilitation services, high cost medical treatment, and emergency care.

UCS covers the people previously served by a collection of different schemes and the people who were without health protection, particularly those in the informal sector, the latter being equal to 30% of the population. The scheme has increased access to health services and reduced the incidence of catastrophic health expenditures. While it is not dedicated to the poor, its universal nature has pro-poor impacts. For example, the UCS benefits the lowest income quintile of the population more than any other segment.

The right of every Thai citizen to access health care and the right of the poor to free health care are addressed in the country's 1997 and 2007 constitutions. However, despite the gradual extension of health coverage since the 1970s and several pro-poor social protection and health policies, at the turn of the millennium, approximately 47 million Thai people, mostly informal sector workers in lower socio-economic groups, had no health insurance or access to free health care. Furthermore, in 2001, out-of-pocket payments accounted for one third of total health expenditures.

UCS aims at covering the 76% of the population not covered by other social health protection schemes, such as:

- The Social Security Scheme (SSS) for private sector employees
- The Civil Servant Medical Benefit Scheme (CSMBS) for government employees and government retirees, as well as their spouses, dependents under 20 years old and parents

The Universal Health-care Coverage Scheme is defined by three key principles:

- It is a tax-financed scheme providing free health care at the point of service (the initial co-payment of 30 baht per visit or admission was terminated in November 2006)
- It has a comprehensive benefit package with a focus on primary care
- The budget is allocated based on a capitation payment mechanism for outpatient care and a global allocation based on diagnosis-related groups (DRGs) for inpatient care

The package has been almost identical to that of the SSS, covering: outpatient, inpatient and accident and emergency services; dental and other high-cost care; and diagnostics, special investigations, medicines (at least including those in the National List of Essential Medicines) and medical supplies. The UCS also includes preventive and health-promotion services.

Delivering Improved Health Outcomes

Healthcare in Thailand is overseen by the Ministry of Public Health (MOPH), along with several other non-ministerial government agencies. Thailand's network of public hospitals provide universal healthcare to all Thai nationals through three government schemes and can be supplemented by Thailand's private hospitals, although these are usually located in large urban areas.

The MOPH oversees national health policy and also operates most government health facilities. The National Health Security Office (NHSO) allocates funding through the universal coverage program. Other health-related government agencies include the Health System Research Institute

(HSRI), Thai Health Promotion Foundation ("ThaiHealth"), National Health Commission Office (NHCO), and the Emergency Medical Institute of Thailand (EMIT). While there have been national policies for decentralisation, there has been resistance in implementing such changes and the MOPH still directly controls most aspects of health care.

Different provinces in Thailand are arranged into different health districts by region. Each health district is responsible for about 3-6 million people living in those provinces. It aims to provide better quality medical services for citizens within that region and increased efficiency in terms of transferring patients to other hospitals if there is a lack in capability of care within that district.

Most hospitals in Thailand are operated by the Ministry of Public Health. Private hospitals are regulated by the Medical Registration Division. Other government units and public organisations also operate hospitals, including the military, universities, local governments and the Red Cross. As of 2019, Thailand's population of 68 million is served by 927 government hospitals and 363 private hospitals with 9,768 government health centers plus 25,615 private clinics.

Access to medicines under the Thai universal health care system is limited to the National List of Essential Medicines (NLEM). This list was expanded in 2008 when the Thai government introduced the 'high-cost medicines E2 access program' with a view to increase patient access to medicines, improve clinical outcomes and make medicines more affordable through expanding the procurement pool. A 2016 study found that the "E2 program was associated with an increasing number of patients receiving specialty medicines and may have improved

selected clinical outcomes, especially among universal coverage patients who constitute the majority of the Thai population."[17]

Delivering Cost-Effective Treatment and Care

Thailand spends 6.6% of GDP on health services, spending US$25.3 billion (P1.2 trillion) in 2016 and based on projected grow over 10 years, rising to US$47.9 billion (P2.3 trillion) by 2026. This equates to an average of US$367 (P18,000) on a per capital basis.

The bulk of health financing comes from public revenues (at around 75% currently), with funding allocated to contracting units for primary care annually on a population basis. This represents an increased role for the public sector as according to the WHO, 65% of Thailand's health care expenditure in 2004 came from the government, while 35% was from private sources.

Since the expansion of the NLEM to include high-cost medicines under the E2 access program, there were substantial decreases both in treatment cost per patient and annual healthcare expenditures after E2 policy implementation, mainly due to decreases in E2 medicines prices. The decrease in cost likely "resulted from pooled procurement of bulk volumes and special purchasing arrangements with the companies resulted in lower prices."[18]

UCS required radically different governance, organisational, and management arrangements with a view to ensure more transparency, responsiveness and accountability. The National Health Security Act promulgated in November 2002 mandated the establishment of the National Health Security Office (NHSO) and its governing body, the National Health Security Board (NHSB), chaired by the Minister of Public Health. The NHSO is responsible for the implementation of the UCS and hosts a common registry based on the Ministry of Interior's population database. This registry is shared with other social health protection organisations. Combined with the use of smart cards to identify entitlements at delivery points, this central database is crucial to ensuring the coverage of the entire population and preventing fraud. It has also allowed NHSO to produce data on the use of health services with a view to request an appropriate budget allocation and thereby better serve the population.

UCS contributed significantly to the development of Thailand's health information system through hospital electronic discharge summaries for DRG reimbursement, accurate beneficiary datasets, and data sharing.

Assessment

Thailand's implementation of universal health care has been widely recognised as a success, especially for a middle-income nation. UCS, along with SSS and CSMBS, have delivered health coverage to nearly all of Thailand's population. The creation of the regional health districts has helped with identifying underserved areas for future investments, while allowing patient transfer to ensure care remains available for those in need. Thailand has also demonstrated the

[17] Expanding access to high-cost medicines through the E2 access program in Thailand: effects on utilisation, health outcomes and cost using an interrupted time-series analysis - BJM (2016)
[18] Ibid.

ability to bring down the overall cost of pharmaceutical medicines through bulk purchasing following the implementation of the E2 access program within the National List of Essential Medicines. The ability to deliver these high-cost medicines within the universal health care framework has delivered improved clinical outcomes for patients in Thailand.

Thailand's experience demonstrates that not only can universal health care be achieved in emerging markets like the Philippines, it shows that emerging markets need not be limited to basic safety nets in their approach. In implementing its own approach, the Philippines could look to adopt a pool-procurement system for both essential and relevant innovative medicines for use within the universal health care system. This would help to significantly improve patient outcomes from UHC though expanded access to medicines and treatments, while driving greater value for money for the public purse in financing access to prescription therapies.

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