Appendix 10

PPP IN HEALTH MANILA 2012

DEVELOPING MODELS, ENSURING SUSTAINABILITY: PERSPECTIVES FROM ASIA AND EUROPE

DRAFT PROCEEDINGS OF THE REGIONAL FORUM

EDITED BY
CHANTAL HERBERHOLZ

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Foreword

Contributors

Short biographies of the main presenters at and contributors to the PPP in Health Manila 2012 regional forum are provided below.

Presenters (in alphabetical order by last name)

Eduardo P. Banzon

Dr. Eduardo P. Banzon was appointed the sixth president and Chief Executive Officer of the Philippine Health Insurance Corporation (PhilHealth) in October 2011. He was previously Senior Health Specialist at the World Bank and Clinical Associate Professor at the University of the Philippines. Dr. Banzon graduated from the College of Medicine of the University of the Philippines and received his M.Sc. degree in Health Policy, Planning and Financing from the London School of Economics and the London School of Hygiene and Tropical Medicine.

Cosette V. Canilao

Cosette V. Canilao is the Executive Director of the Public-Private Partnership (PPP) Centre. Prior to joining the PPP Centre, she was a Director of Standard Bank where she established and headed its distressed debt servicing business in the Philippines, and as President and CEO of the bank's various special purpose vehicle (SPV) companies. She is also a former partner of PricewaterhouseCoopers where she headed the Crisis Management Practice and Financial Services (FS) Industry consulting. Ms. Canilao holds a M.Sc. degree in Finance from the University of the Philippines.

Matthew Collingridge

As General Manager for GE Healthcare's Hospital & Healthcare Solutions in Asia Pacific, Matthew Collingridge is responsible for leading a multi-discipline team to develop long term strategic partnerships and health infrastructure development and delivery within the sector. Prior to joining GE, Mr. Collingridge was a commercial and business development manager for energy trading markets in the former Soviet Union, Scandinavia and Middle East. He is a graduate of Birmingham University, UK with a B.A. (Hons) in Russian.

Paul R. Daza

Governor Paul R. Daza has prioritised health, education, environment and livelihood in his agenda for local development in the province of Northern Samar since his election in July 2011. His commitment in pursuing the government's public health goals is demonstrated in Northern Samar's current efforts in the development of PPP in health enterprises. Under his leadership, the province of Northern Samar has also been expanding PhilHealth membership of indigent families. He obtained his Juris Doctorate from the University of California in Los Angeles (UCLA) in 1987 and was admitted to the State Bar of California in 1998. He obtained his B.A. in Economics/Business from the same university in 1984.

David H. Dombkins

Adjunct Professor Dr. David H. Dombkins is recognised internationally as a leader in project management. He has devoted his career to advancing the profession of project management and improving the delivery of projects, both in Australia and internationally. Dr. Dombkins has introduced and personally developed many of Australia's most significant project management reforms over the past thirty five years, many of which have formed the template for international developments in project management. Dr. Dombkins holds a Bachelor of Construction Management (University of New South Wales), a Masters of Project Management (University of Technology, Sydney) and was awarded Australia's first Doctor of Technology in the Project Management of Complexity (Deakin University).

Jaime Z. Galvez-Tan

Dr. Jaime Z. Galvez-Tan, a former Department of Health Secretary, is currently the Team Leader of ADB TA 7257 PHI: PPP in Health Project, a Professor of the University of the Philippines' College of Medicine and the President of Health Futures Foundation, Inc. He acquired his B.Sc. and Doctor of Medicine degrees at the University of the Philippines. He earned his graduate degree (Master in Public Health) and advanced studies at the Prince Leopold Institute of Tropical Medicine in Antwerp, Belgium and the Bill and Melinda Gates Institute of Leadership and Management at Johns Hopkins Bloomberg School of Public Health, Maryland, U.S.A.

Alberto Germani

Alberto Germani, Italian, Civil engineer and MBA holder, carries more than 25 year of professional expertise in public infrastructure project delivery, of which 15 specifically in PPPs and project finance

projects matured in Government Entities. After having worked from early '80s in the public works construction industry as engineer and project financier, in 2000 Alberto was appointed member of the PPP (Public-Private Partnership) Task Force by the Italian Ministry of the Treasury, chairing the Task Force in 2004. As PPP Expert of the Italian Treasury, Alberto has launched from 2001 onwards the first programme of PPP new Hospitals construction in Italy, being most of the projects already successfully completed and currently operational. In 2009 he moved to the UAE to take on the role of PPP Advisor by the Abu Dhabi Department of Transport. He's currently working as PPP expert and project director in the United Arab Emirates. From 2007 he's been appointed Member of United Nations Economic Commission (UNECE) PPP Team of Specialists headquartered in Geneva, Switzerland.

Stephen P. Groff

Stephen P. Groff, Vice-President (Operations 2) of ADB, who assumed office in October 2011, is responsible for the full range of ADB's operations in East Asia, Southeast Asia and the Pacific. He is also responsible for the Central Operations Services Office. His mandate includes establishing strategic and operational priorities in his areas of responsibility, producing investment and technical assistance operations amounting to USD 4-5 billion annually, managing an existing portfolio of about USD 23 billion, and leading about 700 staff. Mr. Groff holds a Master's degree in Public Administration from Harvard University and a B.Sc. degree in Environmental Biology from Yale University.

Geoffrey Hamilton

At present, Dr. Geoffrey Hamilton is Chief of the Cooperation and Partnerships Section of the Economic Cooperation and Integration Division in the United Nations Economic Commission for Europe (UNECE) in Geneva. His current responsibility is promoting public private partnerships for infrastructure development where he leads a programme on building the capacity of governments to undertake successful projects. Currently, he is setting up an International Centre of Excellence in PPP involving different countries around the world who will as part of the initiative be hosting specialist centres. These centres will be responsible for developing guides, maintaining information and training government officials on PPP best practices in sectors, such as health, roads, water, schools and sustainable energy. He holds a Ph.D. and a Masters from the University of Glasgow, Scotland.

Teodoro J. Herbosa

Professor Dr. Teodoro J. Herbosa was appointed Undersecretary of Health, Department of Health, Republic of the Philippines, in 2010. His initial DOH portfolio was Undersecretary for Hospital Operations for all the 70 DOH-retained hospitals of the DOH. Apart from that, Undersecretary Herbosa was concurrently the Chairman of the DOH Task Force for Public-Private Partnership and also the Health Facilities Enhancement Programme. Professor Dr. Herbosa graduated from the College of Medicine of the University of the Philippines.

Ramon Isberto

Ramon Isberto is the Head of Public Affairs of the Philippine Long Distance Telephone Company (PLDT), the country's leading telecommunications company, and its wireless subsidiary Smart Communications. Mr. Isberto has had 30 years of communications experience as a print journalist, television talk show host and corporate communications professional. He is the President of the Corporate Network for Disaster Response and Vice President for External Affairs of the Public Relations Society of the Philippines.

Jill Jamieson

Jill Jamieson, Senior PPP Advisor for Deloitte Consulting LLP (USA), has over twenty years of international experience managing projects and advising clients in all activities relating to infrastructure finance and public private partnerships. Since November 2010, Ms. Jamieson has provided strategic advisory services to a variety of public authorities on the development of Kazakhstan’s multi-sector PPP programme as well as on targeted PPP transactions in the social sector.

Matthew Khoory

Matthew Khoory is currently a Business Development Manager for GE Healthcare’s creating infrastructure and MES solutions for public and private healthcare operators across Asia Pacific. Mr. Khoory has played an integral role in the inception of the Managed Equipment Services (MES) concept globally since 2004, his background in risk management saw him lead the development of funding solutions, risk analysis, value for money assessment and financial models for MES. He holds a B.Sc. (Hons) in Physics with Medical Physics and a M.Sc. in Entrepreneurship in Science and Technology.

Jungwook Kim

Dr. Jungwook Kim first joined the Korea Development Institute (KDI) in 2007. After serving as a Director of the Policy and Research Division of the Public and Private Infrastructure Investment Management Centre (PIMAC), KDI, Dr. Kim is now working as a Director of the PPP Division since June 2012. Dr. Kim holds a B.A. and M.A. in Economics from Seoul National University and a Ph.D. in Economics from the University of Wisconsin-Madison. His research fields and specialty also include industrial organization, applied microeconomics, auction, competition theory and public finance.

Hilton Y. Lam

Dr. Hilton Y. Lam is a Senior Lecturer at the Department of Clinical Epidemiology of the University of the Philippines. His field of expertise is in Health Economics and Finance. At present, he is a consultant to the ADB funded TA for Public Private Partnership in Health (PPPH). Dr. Lam holds B.A. Biology and B.A. Economics degrees from Whittier College, a Master degree in Hospital Administration from the University of the Philippines and a Ph.D. in Health Economics from the University of Tokyo.

Magdalena Mendoza

Magdalena Mendoza is currently the Senior Vice President for Programmes of the Development Academy of the Philippines (DAP), overseeing DAP's five major operating centres. Among others, she serves as the Chairperson of the Academy's Core Business Group and the DAP Quality Management Representative. Ms. Mendoza earned her Bachelor's and Master's Degrees in Industrial Engineering from the University of the Philippines. She completed her Master in Public Administration from the Lee Kuan Yew School of Public Policy of the National University of Singapore.

Enrique T. Ona

Dr. Enrique T. Ona was appointed by President Benigno Aquino III as Secretary of Health, Department of Health, Republic of the Philippines, on June 29, 2010. He is devoted to the mission of Universal Health Care for Filipinos, including the promotion of public private partnership. Prior to his appointment as Secretary of Health, Secretary Ona was the Executive Director of the National Kidney and Transplant Institute. Secretary Ona was one of the Ten Outstanding Young Men in 1979 and he received his Doctor of Medicine degree from

the University of the Philippines in 1962. Secretary Ona was the first Filipino surgeon to be awarded the Honorary Fellowship of the American College of Surgeons.

Kai Hong Phua

Professor Dr. Kai Hong Phua holds a tenured appointment at the Lee Kuan Yew School of Public Policy, National University of Singapore. He graduated cum laude from Harvard University and received graduate degrees from the Harvard School of Public Health (Master's in Health Services Administration & Population Sciences) and the London School of Economics and Political Science (Ph.D. in Social Policy and Administration, specialising in Health Economics). Professor Dr. Phua has produced over 200 publications and papers in the field of health policy and management and related areas, including the history of health services, health and population ageing, health economics and financing.

Aquilino Q. Pimentel Jr.

Aquilino Q. Pimentel Jr., a former Senator of the Republic, left office in 2010 after having served three senate terms. Among the significant legislative output that he authored is the Republic Act No. 7160, The Local Government Code of 1991, which liberates provinces, cities, municipalities and barangay from over-dependence upon the central government by increasing their powers and share in the taxes and wealth of the nation. Mr. Pimentel Jr. graduated with an A.B. degree in Law from Xavier University in 1959 and holds several doctorate degrees honoris causa.

Florentino S. Solon

Dr. Florentino S. Solon is a champion of PPP for nutrition services in the Philippines. Over a span of 60 years, he promoted PPPs as a government officer, a private sector expert in nutrition and as a local government executive. He took his Doctor of Medicine in the University of Santo Tomas and his Master of Public Health degree in the College of Public Health at the University of the Philippines. Dr. Solon pursued diploma and postgraduate studies in nutrition at the London School of Hygiene and Tropical Medicine at the London University and Ibadan University in Nigeria.

Isabelle Wachsmuth-Huguet

Isabelle Wachsmuth-Huguet has been a project and communication officer of EVIPNet (Evidence Informed Policy Network) at the Knowledge Management and Sharing Department, WHO Headquarters, designing and bringing to life its social network, particularly in African countries, since 2003. She holds a

M.Sc., speciality in Biology, Pharmacology, Physiology and Computer Science at the Engineering School, University of Poitiers, France. Mrs. Wachsmuth–Huguet will finalise, in 2012, a Master in Public Health at the University of Geneva.

Facilitators (in alphabetical order by last name)

Bayani Agabin

Attorney Bayani Agabin set up the Tolosa Romulo Agabin Flores and Enriquez Law Offices in 2001, together with his partners. He is currently Director and Corporate Secretary for several multinational corporations listed in the Toronto Stock Exchange and Australian Stock Exchange. Attorney Agabin is the legal expert of ADB TA 7257 PHI: PPP in Health and assists the DBP in ensuring that the proposed PPP projects of the local government units comply with all legal requirements in the selection, procurement, and implementation stages. Attorney Agabin has a Bachelor of Law degree and a B.Sc. degree in Economics from the University of the Philippines.

Alvin Caballes

Dr. Alvin Caballes is an Associate Professor as well as head of the Social Medicine Unit at the College of Medicine of the University of the Philippines. Aside from his handling classes and cases in Pediatric Surgery, his clinical specialty, he also provides instruction in both undergraduate and graduate courses such as Medical Economics, Health Care Management and Political Economy of Health. On the non-academic side, Dr. Caballes has been engaged in various health policy and financing consultancies in behalf of several national and international agencies.

Solomon Castro

Solomon Castro is Managing Director & Senior Advisor of CFP Transaction Advisors. He has over 18 years of professional experience in PPPs, corporate finance and development consulting and his expertise spans all key stages of a project's development, from feasibility assessments, risk profiling and allocation, to transaction structuring, tender design, contract negotiations and project finance. Mr. Castro holds an LL.M. degree from Cornell University. He earned his law and business degrees with honors from the University of the Philippines.

Manuel de Vera

Professor De Vera graduated from Harvard University's Kennedy School of Government with a Master in Public Administration and holds a Bachelor's degree in Political Science from the University of the Philippines, Diliman. Professor De Vera is on the core faculty of the Centre for Development Management and he is currently the Programme Director of the Master in Development Management. Aside from his extensive public service management record, Professor De Vera has a decade of publishing experience in different industries. He has delivered conference papers for the ADB on public-private partnerships. Professor De Vera's current research interests include competitive strategy in public-private partnerships and business integrity measures

Jose Miguel R. de la Rosa

Jose Miguel R. de la Rosa is the Social Marketing Expert of the Technical Assistance team under the ADB-DBP programme of PPPH (ADB-TA 7257-PHI). Mr. de la Rosa holds an A.B. Communication degree from the Ateneo de Manila University and has done graduate work for the Master Programme for Professional Studies on International Development (Rural Sociology) at Cornell University, Ithaca, New York. He has a Master of Professional Studies degree in Development Communication from the University of the Philippines Open University. He is currently taking his doctorate degree in Communication at the University of the Philippines' College of Mass Communication at Diliman, Quezon City.

Ivanhoe C. Escartin

Dr. Ivanhoe C. Escartin is currently the Office-in-Charge-Director IV of the National Centre for Health Promotion of the DOH. He has worked in various programmes of the DOH, namely Mental Health Programme, Dangerous Drug Abuse Prevention and Treatment Programme and National Centre for Pharmaceutical Access and Management. Dr. Escartin is a graduate of the Institute of Medicine of the Far Eastern University.

Emiko Masaki

Dr. Emiko Masaki is a social sector economist from the Human and Social Development Division of the Southeast Asia Department of the Asian Development Bank (ADB). Dr. Masaki has a PhD in the field of health economics from the University of California at Berkeley. She has been managing ADB's health and social sector programmes in Southeast Asia, ranging from project implementation to policy dialogues. She also leads ADB's initiatives on PPP in health in the Philippines. Dr. Masaki is currently handling ADB

TA 7257 PHI: PPP in Health, an ADB technical assistance for the Philippine government, geared towards assisting the public sector particularly local government units in developing and implementing PPP in health initiatives which involves key government agencies including the Development Bank of the Philippines, the Department of Health, and the Philippine Health Insurance Corporation. She headed the Secretariat for the PPP in Health Manila 2012, held in the ADB from 23 to 25 October 2012, and attended by about 260 delegates from Asia and Europe.

Patricia Moser

Patricia Moser is Lead Health Specialist for the Regional Sustainable Development Department of the ADB. She provides strategic guidance and oversight to the ADB's health activities and serves as co-chair of the Health Community of Practice. She holds a Master's degree in health economics from the University of North Carolina and completed post-graduate studies in political economy at George Mason University in Fairfax, Virginia, USA.

Aileen Riego-Javier

Dr. Aileen Riego-Javier is presently the Executive Director at the National Kidney and Transplant Institute. Dr. Javier helped set up the Anatomic Pathology Division of the Philippine Children's Medical Center and Lung Center of the Philippines and organized that of the National Kidney and Transplant Institute. Dr. Javier earned both her B.Sc. and Medical Degrees at the University of the Philippines. She also finished the academic requirements of a master degree in Hospital Administration at the Ateneo Graduate School of Business.

Erwin Jason J. Zshornack

Erwin Jason J. Zshornack is the President and CEO of Planet Drugstore Corporation. He conceptualized and established it in 2007, in partnership with his wife, Darlene Zshornack. Planet Drugstore is currently the only Pharmacy Solutions and Management Services drugstore in the country. Mr. Zshornack's long experience in the pharmaceutical industry dates back in 1996 when he joined United Laboratories, Inc. as a Medical Representative and assigned in the Philippines' top hospitals such as the Cardinal Santos Medical Center, Our Lady of Lourdes Hospital, and the Makati Medical Center. Mr. Zshornack, a self-made entrepreneur with the passion for innovation and public service through PPP initiatives, finished a Bachelor of Science in Hotel and Restaurant Management from the University of Santo Tomas in 1993.

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Jose Miguel R. de la Rosa was the Master of Ceremony for the event. Presenters, reactors and facilitators for the three day forum (listed according to the forum agenda) included Stephen P. Groff (Vice-President (Operations-2), ADB), Enrique T. Ona (Secretary of the DOH), Geoffrey Hamilton (Chief of the Economic Cooperation and Integration Division, UNECE), Matthew Collingridge (General Manager, Hospital & Healthcare Solutions & PPP, GE Healthcare Asia Pacific), Isabelle Wachsmuth-Huguet (Project and Communications Manager, WHO), Jaime Z. Galvez-Tan (Former Secretary of the DOH and the Team Leader of the ADB TA 7257), Kai Hong Phua (Health Policy Professor, Lee Kuan Yew School of Public Policy, National University of Singapore), Jill Jamieson (Senior PPP Advisor, Deloitte Consulting LLP (USA)), Patricia Moser (Lead Health Specialist, Regional and Sustainable Development Department, ADB), Alberto Germani (member of the UNECE PPP Task Force and former member of the PPP Task Force in Italy), Solomon Castro (Managing Director and Senior Advisor, CFP Transaction Advisors), Paul R. Daza (Governor of Northern Samar), Bayani Agabin (Legal Expert, ADB TA 7257), Emiko Masaki (Social Sector Economist, Southeast Asia Department, ADB), Jungwook Kim (Director of PPP Division, Public and

Private Infrastructure Investment Management Centre (PIMAC), Korean Development Institute (KDI)), Cosette V. Canilao (Executive Director, PPP Centre, National Economic & Development Authority (NEDA)), Hilton Y. Lam (Senior Lecturer, Department of Clinical Epidemiology, College of Medicine, University of the Philippines), Eduardo P. Banzon (President, Philippine Health Insurance Corporation (PhilHealth)), Alvin Caballes (Associate Professor, College of Medicine, University of the Philippines), Aquilino Q. Pimentel Jr. (Former Senator), Aileen Riego-Javier (Executive Director, National Kidney and Transplant Institute (NKTI)), Juan Antonio Perez III (Director, Bureau of Local Health Development, DOH), Magdalena Mendoza (Senior Vice President for Programmes, Development Academy of the Philippines), Florentino S. Solon (Founder and President, Nutrition Centre of the Philippines), Ivanhoe C. Escartin (OIC Director IV, National Centre for Health Promotion, DOH), David H. Dombkins (Chief Executive Officer (CEO), Complex Programme Group), Manual de Vera (Professor, Centre for Development Management, Asian Institute of Management), Ramon Isberto (Public Affairs Group Head, Smart Communications), Matthew Khoory (Business Development and Finance Manager, Hospital & Healthcare Solutions, GE Healthcare Asia Pacific), Ivan Alexi Arota (Country Manager, GE Healthcare Philippines), Erwin Jason Zshornack (President, Planet Drugstore Corporation), Teodoro J. Herbosa (Undersecretary, DOH) and Luisito Maaño (Medical Director, POC).

Special thanks go to NKTI and Ospital ng Makati/Planet Drugstore Corporation, who accommodated the site visits, the resource persons who provided advice and guidance on the implementation of PPPs in health during the clinic sessions and, last not least, the government and private organisations in the health industry, who participated in the three day Marketplace and Exhibit.

Abbreviations

ABD	Asian Development Bank
ARMM	Autonomous Region in Muslim Mindanao
ASEAN	Association of Southeast Asian Nations
BAC	Bids and Awards Committee
BDC	Barangay Development Council
BIR	Bureau of Internal Revenue (Republic of the Philippines)
BLT	Build-Lease-Transfer model
BNB	Botika ng Barangay
BOT	Build-Transfer-Operate model
BTL	Build-Transfer-Lease model
CCT	Conditional Cash Transfer
CEO	Chief Executive Officer
COA	Commission of Audit
DA	Department of Agriculture (Republic of the Philippines)
DBP	Development Bank of the Philippines
DOH	Department of Health (Republic of the Philippines)
DOST	Department of Science and Technology (Republic of the Philippines)
DOTC	Department of Transportation and Communications (Republic of the Philippines)
DSWD	Department of Social Welfare and Development (Republic of the Philippines)
EDSA	Epifanio de los Santos Avenue
GDP	Gross Domestic Product
GNI	Gross National Income
GOCC	Government-Owned and Controlled Corporation
GP	General Practitioner
ICT	Information and Communication Technology
IRR	Internal Rate of Return
JCI	Joint Commission International
KDI	Korean Development Institute
KPI	Key Performance Indicator
LGC	Local Government Code (Republic of the Philippines)
LGU	Local Government Unit (Republic of the Philippines)
MMDA	Metropolitan Manila Development Authority
MOOE	Maintenance and Other Operating Expenses
NBB	No Balance Billing
NEDA	National Economic & Development Authority (Republic of the Philippines)
NGA	National Government Agency (Republic of the Philippines)
NGO	Non-governmental Organisation
NKTI	National Kidney and Transplant Institute (Republic of the Philippines)
NOAH	Nationwide Operational Assessment of Hazards
PCB	Primary Care Benefits
PFI	Private Finance Initiative
PhilHealth	Philippine Health Insurance Corporation
PHP	Philippine Peso
PIMAC	Private Infrastructure Investment Management Centre (Republic of Korea)
PITC	Philippine International Trading Corporation
PNDF	Philippine National Drug Formulary

PNR	Philippine National Railways
POC	Philippine Orthopedic Centre
PPP	Public Private Partnership
PSP	Private Sector Participation
RFP	Request for Proposal
ROE	Return on Equity
SEARO	WHO South East Asia Regional Office
SHINE	Secured Health Information Network and Exchange
TA	Technical Assistance
UHC	Universal Health Care
UNECE	United Nations Economic Commission for Europe
USD	United States Dollar
VFM	Value For Money
WHO	World Health Organisation
WPRO	WHO Western Pacific Region Office

Forum Synthesis and Summary

Chantal Herberholz[1]

Overview

The Asian Development Bank (ADB) in cooperation with the United Nations Economic Commission for Europe (UNECE), the Department of Health of the Republic of the Philippines (DOH), the Development Bank of the Republic of the Philippines (DBP) and the Philippine Health Insurance Corporation (PhilHealth) convened a regional forum on *PPP in Health* in Manila on October 23 to 25, 2012, under the theme *Developing Models, Ensuring Sustainability: Perspectives from Asia and Europe*. As part of the regional forum, the International PPP Specialist Centre on Health, a focal point for best practices in public-private partnerships (PPPs) in health, was launched on October 23, 2012. The International PPP Specialist Centre on Health is based in the DOH and affiliated with the UNECE International PPP Centre of Excellence.

The main objectives of the regional forum were to share case studies and best practices from mainly Asia and Europe, but also other regions of the world, highlight key lessons learned and initiate a policy dialogue to help build support for PPPs in addressing key health problems. The regional forum also aimed at identifying main barriers to the successful implementation of PPP projects in health and ways to circumvent these.

The regional forum underlined that PPPs in health mean different things to different people. The working definition of PPPs in health adopted for the regional forum included a very wide range of initiatives that engage, in varying degrees of involvement, the private sector to achieve health system goals, although the existence of alternative definitions was also acknowledged. The ADB, for example, delineates PPP for infrastructure development in general from private sector participation (PSP) and privatisation. While PSPs typically entail a transfer of risks to the private partner rather than risk sharing and comprise for example contracting arrangements, privatisation on the other hand involves the

[1] Chantal Herberholz, Ph.D., Lecturer and Executive Committee Member of the Centre for Health Economics, Faculty of Economics, Chulalongkorn University, Bangkok, Thailand.

outright sale of ownership shares[2]. This distinction is inter alia also reflected in the World Bank's definition of PPPs in infrastructure[3] and has been adapted and applied to PPPs in health[4].

The regional forum was structured around the following six main themes:

1. Overview of PPPs in health, including case studies and best practices
2. Governance issues
3. Financing options
4. Capacity development and social marketing
5. Information technology
6. Monitoring and evaluation.

Lectures were complemented by open forum discussions and clinic hours, which allowed delegates to interact with and consult resource persons, and site visits to PPP projects in health to gain first-hand experience.

Public sector and private sector partners were given the opportunity to showcase their services as well as current and future projects during a three-day exhibition and a parallel session on October 25, 2012 (Marketplace and Investors' Forum), creating a conducive environment for networking and market sounding.

The regional forum brought together 364 delegates (including organising team and resource persons) from 22 countries. 177 delegates were from the public sector, 133 from the private sector, 54 from international organisations, non-governmental organisations (NGOs) and the media allowing rich exchanges of experiences from different points of view. The delegates, of which 80 per cent were from the Philippines, comprised policymakers and decision-makers, local and international PPP health advocates, private and public sector health professionals, local chief executives, health sector business leaders and suppliers, academicians, researchers and media representatives.

The main conclusion from the three-day regional forum is that PPPs in health can be a powerful tool to achieve health systems goals. PPPs in health, like traditional PPPs for infrastructure, allow

[2] ADB, 2008. *Public-Private Partnership Handbook*, Philippines: ADB.
[3] World Bank, 2012. *PPP Arrangements / Types of Public-Private Partnership Agreements*. [Online] Available at: http://ppp.worldbank.org/public-private-partnership/agreements [Accessed November 2, 2012].
[4] A possible typology of PPPs in health based on the World Bank's definition of PPPs in infrastructure is presented in the Thailand PPP Country Report in Appendix C.

partners to combine the expertise and resources of the public and the private sector. The sharing of experiences and case studies highlighted that successful implementation of PPP projects in health, although highly contextual, generally requires careful analysis of long-term objectives and risk allocation, equitable perceived and actual risk sharing, flexible PPP contracts that allow renegotiation during the life of the PPP given rapid technological change and changing demographics and disease patterns, and a sound monitoring and evaluation process. Important for success is also that both, public and private, partners carefully conduct robust feasibility studies before rolling out PPP projects and ensure a focus on end user/patient-centred outcomes. While a sequencing of the types of private sector engagement in health emerged through the discussion of country experiences, where countries typically start with simple PPP arrangements before considering sophisticated partnerships which include clinical services[5], it also became apparent that these steps may not necessarily have to follow sequentially, but could be determined simultaneously through interrelated policy decisions. It was generally recognised that there is a need to produce and disseminate systematic and rigorous evaluations of PPPs in health, with the International PPP Specialist Centre on Health expected to meet this need and provide support in the areas of contract design and contract management.

Forum Highlights

The following section summarises forum highlights and key messages, while detailed verbatim transcriptions are presented in subsequent chapters.

Day 1

The five sessions delivered on the first day were aimed at providing an overview of and best practices in PPPs in health.

Session 1 Opening Ceremonies

The first day commenced with opening ceremonies. The welcome remarks were given by Stephen P. Groff, Vice-President (Operations-2), ADB, who highlighted that PPPs are the key drivers of ADB's 2020 strategy to generate greater economic growth in the region. ADB provides technical

[5] A detailed example that reflects this sequencing is given in the Thailand PPP Country Report, which is provided for reference purpose in Appendix C.

assistance to strengthen public-private partnerships in the Philippines. PPP projects in the Philippines have been increasing and sharing of knowledge on best practices for PPP in health is very important. The welcome remarks were followed by a keynote address, delivered by Secretary of Health Enrique T. Ona on behalf of the President of the Republic of the Philippines, Benigno Simeon Aquino III. The keynote speech addressed the relationship between health and economic growth. Empowering people and providing access to health care for the poor is important for achieving a virtuous cycle of inclusive growth. Secretary Ona noted that PhilHealth coverage has increased significantly and moved the country closer towards attaining universal coverage. The International PPP Specialist Centre on Health is expected to provide needed support in design and implementation of PPPs in health. Geoffrey Hamilton, Chief of the Economic Cooperation and Integration Division, UNECE, who subsequently addressed delegates, pointed out that identification of best practices on PPPs in the health sector is extremely difficult given that evaluations are often not objective but rather provide anecdotal evidence void of details about contract and financial arrangement, which in turn impedes replication. He added that the task of the International PPP Specialist Centre on Health will be to close this gap through the production and dissemination of knowledge. Secretary Ona and Geoffrey Hamilton then proceeded to exchange a plaque to officially launch the International PPP Specialist Centre on Health, which concluded the opening ceremonies.

Session 2 PPP in Health: An Overview

Geoffrey Hamilton, who presented an overview on PPPs in health, defined excellence in PPPs in health in terms of access, equity, efficiency and replicability and emphasised the need to not only define, but also measure excellence - both in terms of "*numbers and ratios*" and in terms of "*people*", while recognising that people respond to incentives and rewards. Two success stories were shared, Lesotho Hospital PPP and the Philippines' NKTI. Geoffrey Hamilton reiterated that the International PPP Specialist Centre on Health can contribute to making PPP excellence a worldwide benchmark.

Secretary Ona subsequently presented the Philippines' PPP policy framework and elaborated on two cornerstones of today's health care policy in the Philippines, universal health care coverage and PPPs for health care. A key message was that several successful small scale PPPs (including simple outsourcing arrangements) encouraged the DOH to engage in large scale PPP projects. Two major PPPs, namely the Pentavalent Vaccine Self-Sufficiency Project Phase II and the Modernisation of the Philippine Orthopedic Centre (POC) project, have already been initiated, while several other PPP projects are under consideration. Secretary Ona acknowledged that PPPs in health have several positive economic and

social impacts and formulated success parameters of the health PPP policy framework, which include (i) increased level of participation in the PPP programmes for health, (ii) increased capacity across all government levels to handle PPP projects, (iii) increased quality of life for Filipino patients and (iv) improved capacity as an investment in health destination.

Perspectives from the private sector on PPPs in Health were offered by Matthew Collingridge, General Manager, Hospital & Healthcare Solutions & PPP, GE Healthcare Asia Pacific. Mr Collingridge pointed out that other approaches apart from traditional PPPs, such as private finance initiative (PFI) infrastructure models, exist and that there is a need to understand what works and what doesn't, given risk and risk appetite of involved parties. He recommended a "*fail often but fail fast*" approach in light of the lack of systematic and rigorous evaluations of PPPs in health and underlined that a PPP framework should encourage patient-centred, innovative solutions. The International PPP Specialist Centre on Health was recognised to be well suited to become a repository of lessons learned from the manifold models that exist worldwide.

Isabelle Wachsmuth-Huguet, Project and Communications Manager, WHO, focused on Health Programme PPPs, especially PPPs in the area of public health, and noted that these have received somewhat less attention, but can achieve important improvements in efficiency, quality and equity. Several cases studies were presented as supporting evidence.

The three presentations were followed by open forum discussions during the course of which delegates were invited to ask questions and provide additional comments. Several questions were posed and comments offered. One delegate reiterated the need for PPP evaluations and their dissemination. The core problem behind the lack of evaluations was identified to be a lack of transparency. A second delegate added that evaluations must include feedback from end users given that the best infrastructure is useless if there is no demand. In addition, it was noted that the country context and the stage of economic development are important for the design of PPPs and attention was drawn to the availability of PPP toolkits.

Session 3 Case Studies and Best Practices in PPP in Health

Session 3 commenced with a presentation by Kai Hong Phua, Health Policy Professor, National University of Singapore, who offered a framework for understanding PPPs in health in Asia. He presented common types of PPPs and supporting evidence, noting that the evidence on equity is weakest and thus deserves special attention. PPP could not only be interpreted to mean public-private

partnership, but alternatively "*Public, Private, People*", emphasising people's role when there are government and market failures. Drawing on Asian PPP experiences, he concluded that there is no one-size-fits-all PPP solution and that the country context is extremely important. The key issue is to find the right balance – yin and yang.

The experience of PPP in health in Europe was subsequently reviewed by Geoffrey Hamilton, who concluded that it has been positive overall and added, borrowing Alan Milburn's words, that PPPs are in fact "*the only show in town*" given rising health costs due to population ageing and technological advances. Integrated hospital PPP models, which include supply of infrastructure and clinical services, were identified to offer most to developing and transition economies.

The regional experiences were followed by an introduction to general trends in health sector PPPs by Jill Jamieson, Senior PPP Advisor, Deloitte Consulting LLP (USA), the most important ones being (i) change in hospital design, (ii) shifting in government role from service provider to regulator and (iii) shift from assets to management services, who concluded that funding must not focus solely on hospitals and infrastructure but services instead, where most savings could be realised. In addition, it was emphasised once more that PPP initiatives are highly contextual and that PPP contracts must allow for flexibility and future adjustments, given for example rapid advances in technology.

Delegates actively participated in the open forum discussion asking several questions of clarification and questions reflecting concerns of implementers of PPPs in health.

Session 4 Risk Allocation in PPPs in Health

Alberto Germani, member of the UNECE PPP Task Force and former member of the PPP Task Force in Italy, focused on risk allocation in healthcare PPPs and introduced three major types of project risk, namely construction risk, availability risk and demand risk. Construction risk was defined to include, cost overruns during construction, time delays, non-conformity with design requirements or output specifications and failure in construction completion, while availability risk referred to lack of performance during operation and management. Demand risk, on the other hand, arises if users turn out less than expected, resulting in cash flow problems. Following a Eurostat decision[6], a classification of projects as PPP that depends on actual risk allocation was recommended. The experience of Italy, where

[6] STAT/04/18 dated 11/02/2004.

40 per cent of cases failed due to inter alia incongruence between private sector proposals and public sector interests, was then used to provide risk allocation examples.

During the subsequent open forum discussion, one delegate pointed out that expectations regarding risk transfer determine success or failure of a PPP, while the sharing of risk is the key to success. Expectations from the public sector about the risks that the private sector can handle may be unrealistic.

Sessions 5A and 5B

The first day of the PPP in Health Manila 2012 regional forum ended with two clinic sessions held in parallel.

One of the clinic sessions (clinic session 1A) was led by the Governor of Northern Samar, Paul R. Daza, who gave a succinct example from the province of Northern Samar of unbundling complex hospital services into manageable units. One of the resulting PPPs entails a lease, operation and management arrangement with a private pharmacy. The 3-year contract was signed recently and the project will soon be implemented. To assure the private sector partner, an irrevocable stand-by letter of credit was sought from a bank, guaranteeing that the government will make timely payments. Northern Samar developed its own PPP code and further PPP in health projects are in the pipeline. Identified success factors include (i) continuation amid political and leadership changes, (ii) financial viability, (iii) internal human resources, (iv) private sector appetite, (v) public acceptance, (vi) consistency with national government strategies and (vii) monitoring and evaluation.

The other clinic session (clinic session 1B) was led by Jaime Z. Galvez-Tan, Former Secretary of the DOH, who gave examples of public health programmes and explained that global disease eradication is a common example of public health programme PPPs. The Global Fund, for example, addresses eradication of HIV/AIDS, malaria and tuberculosis.

Delegates showed a strong interest in the subsequent clinic sessions that followed the introductions given by Paul R. Daza and Jaime Z. Galvez-Tan, where they were given the opportunity to consult individually a number of resource person and experts. Most delegates asked questions related to the actual implementation of PPPs in health on the ground.

Day 2

The second day of the regional forum was devoted to understanding operational issues and consisted of 5 sessions, including one parallel session.

Session 6 Financing Options for PPPs

Jungwook Kim, Director of PPP Division, PIMAC, KDI, presented a discussion of PPP financing options and issues in the Korean context. The Build-Transfer-Lease (BTL)[7] model was identified as the most popular PPP model for social infrastructure projects in Korea since it is easier for end users to understand as the ownership of the facility as well as the delivery of clinical services remain with the government. To inter alia realise economies of scale, Korea has increasingly become interested in PPPs for health care complexes, such as for example the Geriatric Health Management Centre (Complex) in Cheongdo-Gun. The speaker called for best practices to be established and underlined the need for better communication strategies to enhance the understanding of PPPs in health by end users.

Cosette V. Canilao, Executive Director, PPP Centre, NEDA, the reactor, noted that BTLs are not used for health infrastructure projects in the Philippines. The NKTI, for example, uses a lease agreement for dialysis machines, while the modernisation project of the POC is designed as a Build-Operate-Transfer (BOT)[8] type of model, under which the private sector is allowed to earn revenues from core (medical) and non-core services. The speaker underlined the importance of understanding the risks of contractual obligations of the parties involved and the need to develop sound principles of contract monitoring and evaluation, especially the formulation of key performance indicators (KPIs) for health services with low measurability. In addition, the speaker added that Build-Lease-Transfer (BLT)[9] models were used in the Philippines for the first social infrastructure project, a project under which classrooms were built all over the country.

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[7] The BTL model is defined by Kim, et al. (2011: 11) as a model under which "*Ownership of the infrastructure facilities is transferred to the government upon completion of the construction, and the concessionaire is granted the right to operate them and receive government payments (lease payment plus operational cost) based on operational performance (e.g., availability, service quality) for a specified period of time*." (Kim, J.-H., Kim, J., Lee, S.-Y. & Shin, S. H., 2011. *Public-private partnership infrastructure projects: Case studies from the Republic of Korea, Volume 1: Institutional Arrangements and Performance*, Manila: ADB.)

[8] The BOT model is defined by Kim, et al. (2011: 11,12) as a model under which "*The concessionaire assumes ownership of the infrastructure facilities for a specified period of time after completion of construction. Ownership is transferred to the government upon termination of the concession period.*" (Ibid)

[9] Kim, et al. (2011: 12) define the BLT as a model under which "*Upon completion of construction of the infrastructure facilities, the concessionaire leases the facilities to others for a period of time, and upon termination of the lease, transfers ownership to the central or local government.*" (Ibid)

Hilton Y. Lam, Senior Lecturer, Department of Clinical Epidemiology, College of Medicine, University of the Philippines, then presented a review of some literature on the linkages between health and the economy and concluded that health contributes to economic growth. To ensure that PPPs reinforce these links, PPP project designs should consider access, equity, timely and innovative efficiency, competitive effectiveness and cost-effective management.

During the subsequent open forum session, one delegate responded to the first presentation and pointed out that PFIs are just one PPP method and that other approaches exist such as alliancing and government contracts. Another delegate, in response to the presentation by Hilton Y. Lam, added that the relationship between health and economic growth is not a simple one due to confounders and reverse causality. It was also noted that PPP projects should be designed in such a way that risk is shared equitably between the partners and that PPP contracts specify conflict resolution measures. In addition, several questions of clarification were asked.

Eduardo P. Banzon, President of PhilHealth, introduced the national scheme PhilHealth as well as its recent reforms to the delegates and argued that it actually is a PPP in itself given its hybrid nature, for example in terms of financing and provider network, especially since private practice of government doctors is accepted in the Philippines. Premium payments are made to PhilHealth by the formal sector and the informal sector, overseas workers and lifetime members and sponsors (national and local governments). Membership in PhilHealth is family-based not based on individuals. While PhilHealth is by design a social health insurance scheme, the government subsidises the premiums of a large number of the poor. As of June 2012, 85 per cent of the population was reported enrolled in PhilHealth. It was noted that ensuring financial sustainability would entail e.g. earmarking sin taxes, collecting higher premium payments and improving the premium collection[10]. The universal health care vision of the Philippines was laid out in nine powerful Filipino words, which were translated as (i) All Filipinos Members, (ii) All Members Protected and (ii) Our Health Assured. Cornerstones of this vision are (i) a focus on necessary services (PhilHealth cannot cover non-essential items such as e.g. private rooms), (ii) a shift on the supply side from a high margin and low volume approach to a low margin and high volume approach and (iii) a primary care system under which primary care providers are assigned to all Filipinos.

Kai Hong Phua, the reactor, noted that PhilHealth is broad but not deep and that there is a need to identify the services that will deliver the best health outcomes. It is important to balance the role of

[10] An additional case study on contracting insurance enrolment in the Philippines, aimed at improving premium collections, is presented in Appendix C.

the government and the market, inter alia to reduce moral hazard risks. Once the balance has been found for a basic health care package, it can be complemented by expanding services and bringing in private insurance to cover these additional services. Future PPPs are possible options.[11]

During the open forum discussion several questions of clarification and questions reflecting concerns of implementers of PPPs in health were asked.

Session 7 was offered as a parallel session, with session 7A focusing on PPPs in Health in Decentralised Settings and session 7B dealing with Capacity Development and Social Marketing.

Session 7A PPPs in Health in Decentralised Settings

Aquilino Q. Pimentel Jr., Former Senator and Author of the Philippines' Local Government Code of 1991, opened his speech by acknowledging that health is a basic human right, enshrined in the Constitution of the Philippines. The experience of the Philippines with devolution in general and health services devolution in particular was subsequently discussed. Several solutions to ease the worsening of health delivery services were suggested, including PPPs in health at the local and the national level. PPPs in health that proceed on the premise that private partners are "*concerned and honest-to-goodness*" should be facilitated. The importance of ensuring that PPPs in health are not subject to partisan politics and corruption was underlined. Besides, more funds should be allocated for research and development of organic medicines to lessen the dependence on chemical-based medicines.

During the open forum discussion, the speaker further shared his experience with devolution of health services in the Philippines and acknowledged that devolution of human resources has only partially been successful in the Philippines due to inter alia problems caused by different compensation levels at the national versus the LGU level. In addition, problems surrounding the budget allocation process and procurement of and access to medicines were discussed.

Session 7B Towards Sustainability: Capacity Development and Social Marketing

Juan Antonio Perez III, Director, Bureau of Local Health Development, DOH, explained that devolution forced a PPP structure that is bottom-up and starts with LGUs making a gap analysis. The role of the DoH is to set standards and policies and to encourage local government delivery of health services. To make PPPs work at the local level, there should be alignment and convergence.

[11] An additional case study on contracting *primary care services* in the Thai context is presented in Appendix C.

Magdalena Mendoza, Senior Vice President for Programmes, Development Academy of the Philippines, the reactor, added that PPPs are considered a cornerstone of infrastructure and economic development in the Philippines. Yet, there is still a need to improve project selection and design. The challenge identified concerns building the human resources as well as the capacity in PPP management in the public sector.

Florentino S. Solon, Founder and President, Nutrition Centre of the Philippines, looked at innovative approaches in PPPs in health such as social marketing. Social marketing was defined as "*selling ideas, attitudes and behaviours employing the same marketing principles used to sell products to consumers*". The case of a successful social marketing PPP in health, in the form of a partnership in research, was presented. The research project focused on fortification of flour with vitamin A and iron to mainly benefit vitamin A and iron deficient children. Based on the research findings which provided evidence that food fortification is effective, an agreement was subsequently reached with 12 flour millers in the Philippines to include vitamin A and iron in wheat flour, which in turn has resulted in reduced vitamin A deficiency and anaemia in children. A Philippine Food Fortification Act became effective in 2000.

In the following open forum delegates shared their rich experiences with social marketing.

Session 8 Monitoring of PPPs in Health

David H. Dombkins, CEO, Complex Programme Group, introduced delegates to the UNECE PPP Contract Management How-To Manual, the UNECE PPP Readiness Assessment Tool and the standardised project classification systems to assess and categorise different projects. While several lessons learned in contract management were discussed, two main points emerged, namely (i) ensuring a focus on health outcomes ("*don't be driven by lawyers, bankers or insurers*") and (ii) designing the project contract and the contract management system, including the KPIs, to deal with change. The fact that PPPs should not entail a dumping of risks on the private sector but rather a sharing of risks across partners was reiterated. The speaker also pointed out that globally a shortage of human resources with expertise in the management of complex PPP programmes exists.

During the open forum discussion, one delegate added that an appropriate contract management structure would also lower costs.

Session 9 PPP in Health: Moving Forward

Ramon Isberto, Public Affairs Group Head, Smart Communications, introduced Smart Communications, a wholly-owned subsidiary of a telecommunications carrier that is involved in eHealth and mHealth, and emphasised that information and communication technology (ICT) players should work with the healthcare sector and vice versa. One of Smart Communications' programmes is the Secured Health Information Network and Exchange (SHINE) which records patient information, sends patient reminders and supports referrals. SHINE has already been implemented in selected areas and currently holds more than 30,000 patient records in 40 health facilities in Iloilo province and Quezon City. The main future challenge was identified to be the creation of a national eHub for the Philippines.

One delegate pointed out during the open forum discussion that privacy and confidentiality must be ensured, especially since cloud technology is used by SHINE.

Session 10 Suppliers' Hour

Matthew Khoory, Business Development and Finance Manager, Hospital & Healthcare Solutions, GE Healthcare Asia Pacific, opened the second clinic session with a brief introduction, emphasising that the optimal risk allocation of project risk is a key driver of value for money (VFM) in PPP projects. VFM together with affordability make projects economically viable. The speaker also pointed out that for some PPPs in health the useful life of the equipment de facto determines contract duration. Several PPP examples were given, including an on-going midwife programme in Indonesia.[12]

Delegates were subsequently invited to join the second clinic session, the Suppliers' Hour.

Day 3

The third day of the regional forum was devoted to the PPP in Health Marketplace. In the morning, delegates could either attend one of the two site visits (*Session 11A*) or the Marketplace Ideas Pitching Hour (*Session 11B*), which was the third clinic session.

Delegates who opted for a visit of the Hemodialysis Centre at the NKTI in Quezon City[13], learned from the NKTI team about major past problems at the NKTI that led to the PPP. The most pressing issues were identified as the insufficient number of hemodialysis machines, patient dissatisfaction with

[12] See also Appendix C, which contains a different, additional case study on contracting midwives in Indonesia.
[13] An additional case study on the PPP at NKTI is presented in Appendix C.

services, outdated equipment due to a lack of funds and the increasing costs due to maintenance and repairs. The PPP was designed to overcome these problems and upgrade the facility into a world class hemodialysis unit. Under the lease arrangement between NKTI and the private partner (Fresenius Medical Care since inception of the PPP) the latter is mainly responsible for (i) supplying all hemodialysis equipment (including water treatment and dialyser reprocessing machines), (ii) providing maintenance (including service technicians), (iii) ensuring availability of hemodialysis supplies, (iv) training NKTI staff and (v) upgrading technology. The NKTI is inter alia required to provide space, staff and utilities requirements as well as the interior design and to make timely lease payments (in the form of adjustable lease fees per treatment) to the private partner. The NKTI team further provided insights into the challenges the technical working group faced when formulating the terms of reference. For the first lease contract, the project timeline spanned 7 months, of which 4 months were needed to formulate the terms of reference, for the 5-year project. The project duration of 5 years is in line with the estimated useful life of the dialysis machines. The hemodialysis unit became fully operational in August 2003 and has since then reportedly achieved the goals of (i) increasing the number of hemodialysis machines and hemodialysis sessions (ii) providing state-of-the-art equipment, (iii) increasing patient satisfaction while offering competitive rates and (iv) providing continuous training for NKTI staff. In addition, the initial capital outlay under the PPP was reported much lower than it would otherwise have been and revenues, also from ancillary services, as well as net income have increased since 2003.

The second option was a visit to the Ospital ng Makati, a local, government-owned level four training hospital and a PhilHealth Centre of Excellence. The PPP involves Planet Drugstore (the private partner) and the Makati City Government (the public partner) and seeks to improve (i) the availability of medicines and (ii) the manual stock inventory system at the Ospital ng Makati. The partnership with Planet Drugstore began in 2009. Under the PPP, the pharmacy in the Ospital ng Makati is operated by Planet Drugstore. The PPP resulted in enhanced operational efficiency of the pharmacy as desired and Planet Drugstore was able to guarantee that patients will get the medicine they need on time. The transition, however, was reported as difficult, at least initially, since additional manpower was needed and new suppliers as well as standards and requirements were introduced. In light of the success of this PPP, the Makati City government is now considering expanding the scheme to community health centres, where ambulatory care is provided. After the open forum, delegates had the opportunity to visit the facilities. After the ocular, the group went to the City Hall and visited the Makati City Mayor, Jejomar Erwin Binay Jr., under whose leadership the PPP was initiated, for a courtesy call.

Parallel Session 12A PPP in Health Marketplace

Erwin Jason Zshornack, President of the Planet Drugstore Corporation, showed a short video presentation about the Makati City Government and Planet Drugstore PPP project on pharmacy outsourcing before commencing with the open forum that took off with a lively debate surrounding contract details and contract management. In addition, the delegates from the province of Northern Samar shared their positive experiences with a similar PPP involving Planet Drugstore.

Parallel Session 12B Investors' Forum

Parallel session 12B was organised by the DOH and the PPP Centre as a by-invitation only Investors' Forum to showcase possible DOH PPP projects, the focus being on the planned modernisation of the POC. The Investors' Forum was aimed at stimulating a dialogue between prospective investors, lending agencies and other interested stakeholders. Secretary Ona commenced the session with an overview of two areas for potential PPPs in health, namely (i) the establishment of radiation oncology centres in eight hospitals (infrastructure and equipment) and (ii) the modernisation of six hospitals across the country. The radiation oncology centre projects are proposed in light of the lack of facilities and the increasing incidence of cancer and other degenerative diseases in the Philippines, while the hospital modernisation projects aim at replacing old and outdated facilities and increase capacity. Other PPPs in health considered by the DOH range from the establishment of strategically located cardiovascular and transplant centres, upgrading of regional medical centres to provide third level care in neurosurgery and trauma, LGUs in health care facilities and services to health information technology. PPP Centre Executive Director Canilao reinforced the importance of health infrastructure, especially for promoting quality of life and facilitating sustained and inclusive growth. Undersecretary Herbosa then presented the modernisation plan for the POC, the DOH's first PPP venture of this kind. The 25-year project entails the construction of a 13-storey, 700-bed super-specialty, tertiary care hospital for musculoskeletal and neurological diseases, trauma and rehabilitation medicine as well as teaching and training, within the NKTI Complex, under a BOT type of model (operation and maintenance includes some clinical and non-clinical services) to overcome the problems surrounding the old facility, which in turn have resulted in low utilisation. The desired patient mix of a modernised POC consists of sponsored patients (60 per cent), patients covered by the operator (10 per cent) and partially sponsored as well as out of pocket paying patients, including medical tourists (30 per cent). The bidding process is tentatively scheduled to start in November 2012 and end in May 2013. The key bid award parameter was proposed as the "*lowest lump sum amount payable by DOH to the bidder for the first 5 consecutive years of*

operations", after which the project has been estimated to be self-sustaining. This is aimed at minimising the operation and management subsidy offered by the government to support the operations of the hospital for the first 5 years, after which the private sector is expected to bear the demand risk. Undersecretary Herbosa pointed out that the project foresees a balanced sharing of risks and would be profitable for the winning firm. The POC project obtained approval from the National Economic & Development Authority and a consortium was set up, which includes Deloitte Touche Tohmatsu India Pvt. Ltd. & PJS Law as transaction advisor.

The introduction was followed by an open forum with Secretary Ona, Undersecretary Herbosa, PPP Centre Executive Director Canilao and POC Medical Director Maaño as panellists. The questions that were posed can be divided into two strands, (i) technical questions about project features and (ii) questions about the impact of the PPP project on different stakeholders. Regarding the latter, the panellists emphasised that no government employees would lose their jobs although an estimated 10 per cent of employees are likely to be transferred to the DOH. The existing facility would be converted into a rehabilitation centre. In addition, a commitment to equity in health, as reflected in the desired patient mix under which 70 per cent of beds are to be reserved for sponsored patients and charity, was emphasised. Regarding the project features, several questions of clarification were asked ranging from the scope of clinical services, possible litigation, duplication of services offered by NKTI to the design of facilities. In response to a question challenging the assumption of sustainability after the fifth year, the panellists confirmed that the feasibility study would be shared with investors but emphasised that investors should also conduct their own studies. The panellists further confirmed that bids by foreign investors would also be welcome.

Session 13 Closing Ceremonies

As part of the closing ceremonies, three delegates were invited to provide a feedback on the PPP in Health Manila 2012 regional forum. The three representatives appreciated the efforts and support of the convenors and acknowledged that there are many opportunities to improve the quality of healthcare through PPPs. The workshop helped delegates to share experiences and explore tools in building successful PPPs in health.

The closing remarks were delivered by Teodoro J. Herbosa, Undersecretary of the DOH, who extended his gratitude to delegates, organisers and partners of the PPP in Health Manila 2012 regional forum. While he admitted initially considering this regional forum as somewhat too premature, since

PPPs in health have just started to take off in the Philippines, this historic regional forum revealed that there is a lot of demand for information about PPPs from neighbouring countries and the private sector, who is interested in joining the government. Having said this, the speaker noted that he preferred to refer to PPPs as "*Private support of Public sector Policy*" initiatives. It was further noted that low-income countries and lower-middle income countries in the region should learn from the experiences of other middle-income countries rather than high-income countries such as the United Kingdom, given contextual similarities among middle-income countries in the region. In light of the afore-mentioned, the Philippines were considered the right location for the International PPP Specialist Centre on Health and the right party to promote PPPs in health. The importance of PPPs in health was highlighted drawing on the experience of the Philippines with efforts to eradicate polio, malaria and leprosy, which were materialised through partnerships with Rotary International, Global Fund/Pilipinas Shell Foundation and Novartis Foundation respectively. The speaker noted that under the current administration a paradigm shift in health care financing occurred, under which the DOH focus shifted from the supply side to the demand side. The DOH followed the experience of the water, energy and other infrastructure sectors and started to consider PPPs in health given the striking lack of health infrastructure. Undersecretary Herbosa acknowledged that there is still a big divide, a general mistrust, between the public sector and the private sector in the Philippines. This mistrust could be eliminated through fora like the PPP in Health Manila 2012 regional forum, where all parties involved have the opportunity to discuss the same solutions to the same problems in healthcare.

Introduction to the Proceedings

The following sections provide verbatim transcriptions of the presentations and speeches delivered during the regional forum on PPP in Health. Welcome remarks, keynote address and the launch of the International PPP Specialist Centre on Health are documented first. The proceedings are subsequently structured around the daily themes

- PPP in Health: Overview and Best Practices
- PPP in Health: Operational Issues
- PPP in Health Marketplace

and also include transcriptions of the open forum discussions.

This is followed by closing remarks and appendices. The appendices contain the forum agenda, presentation slides used by resource persons, background papers, a list of resource persons and delegates and press releases.

Part I: PPP in Health: Overview and Best Practices

1. Opening Ceremonies

Facilitator: Jonathan Flavier

1.1. Welcome Remarks

Welcome remarks on the PPP in Health in Manila 2012 regional forum by Mr. Stephen P. Groff, Vice-President (Operations 2) of ADB

Thank you. Excellencies, distinguished guests, colleagues, ladies and gentlemen:

It's my distinct honour and pleasure to welcome you here today to this important knowledge sharing event, where success stories in public-private partnerships in the health sector from around the world will be discussed. It's our hope that through our collective experience, the key issues and challenges can be better understood and that through PPPs more health projects are ultimately realized. Despite considerable progress in recent years, emerging Asian countries continue to suffer from underdeveloped infrastructure. Our estimates indicate that the Asia Pacific region requires as much as 8 trillion dollars in infrastructure investments by 2020. And public finance alone cannot meet this massive investment need. PPP has offered the potential to tap significant resources from the private sector and to generate economic growth and development in the region. According to a recently published study by the Economist Intelligence Unit in Asia Pacific there is great optimism regarding the capacity of private sector participation to drive infrastructure development and service delivery. The study points to government's high levels of willingness to improve their regulatory environments and to establish the necessary institutions to develop and manage PPP projects. Well-developed policy and regulatory environments enable governments and development banks like the ADB to effectively engage with the private sector and help catalyse investments and commercial financing. Indeed, private sector development and private sector operations are one of ADB's key drivers of change in our long-term strategic framework, for strategy 2020, this is also known. In addition, ADB's recently approved PPP operational plan provides a framework for ADB support throughout the project cycle, beginning with first advocacy and capacity development, and moving on to improving the enabling environment and supporting PPP project development and, finally, providing finance for PPP projects themselves. This event today comes at a crucial time in the Philippines. The government is rolling out an array of PPP projects on a platform of transparency and good governance. ADB is privileged to support the Philippine government's PPP agenda. For example, ADB, in partnership with the governments of Australia and Canada, has provided some 25 million dollars in technical assistance grants to enhance government capacity and systems in PPPs and to establish a project development and monitoring facility to enhance the quality of PPP projects themselves. This facility administered by the PPP Centre, an agency attached to NEDA, is currently providing preparation and transaction advisory support to 13 PPP projects, and more projects are expected to be

supported by the facility in the future. ADB has also been supporting the development and promotion of PPP applications in the health sector to improve service delivery and to meet health infrastructure needs, through technical assistance and investment projects, and these experiences serve as a basis for some of the lessons to be shared and discussed at today's event.

Ladies and gentlemen, the large participation today from both public and private sectors demonstrates our collective interest and commitment to PPPs. I would like to thank our partner conveners, the Government of the Philippines' Department of Health, the Development Bank of the Philippines, the Philippine Health Insurance Corporation, the United Nations Economic Commission for Europe, and the World Health Organisation for organizing and supporting this event. Again, I welcome you all to our headquarters here in Manila and it is our honour to host the PPP in Health Manila 2012, and we certainly look forward to fruitful discussions during this important and timely event.

"*Maraming salamat po at magandang umaga sa inyong lahat*."

1.2. Keynote Address

Keynote address by Dr. Enrique T. Ona, Secretary of Health, Department of Health, Republic of the Philippines

Mr. Stephen Groff, Vice President Asian Development Bank, Jeffrey Hamilton, United Nations Economic Commission for Europe, Ms. Isabelle Wachsmuth of the World Health Organisation, PhilHealth President, Eduardo Banzon, SVP Brillo Reynes of the Development Bank of the Philippines, honoured guests and participants, fellow workers in government:

I am honoured this morning to speak on behalf of the President today. Allow me to share with you his speech for this occasion.

The world over, thousands of people have gathered in the plazas and streets of capital cities clamouring for their government to carry out their fundamental mandate, which is service to the public. These past two years, our administration has done its best to respond to this call. Our strategy for success has been two-fold, to right the wrongs in our system, so that we may maximize our resources and to empower our people. Empower them effectively turning them into true partners in the growth of our economy. The idea behind this being, if we equip our people with the necessary skills and the health care they need to become more productive members of the workforce and if we give them the wherewithal to consume more products and services, then naturally, our businesses will have to increase their work, hiring and empowering even more people. This is what we like to refer to as the virtuous cycle brought about by our focus on inclusive growth. Today, we witness the launching of the international PPP special centre for health in the Philippines, which will serve as the global centre for health

initiatives of the United Nations Economic Commission for Europe. Through this, we may not only increase awareness and cooperation on matters on health, but more importantly we expand our capacity to keep our people healthy and strong. We believe this will boost out efforts at social service, an area which we have so far been quite successful. In the two years we have been in office, we have expanded the scope of our Pantawid Pamilya Programme, from around 760 thousand households to a targeted 3.5 million in 2012. We are exceeding expectations as early as now. 3.4 million families already benefit from our conditional cash transfer programme. This means 3.4 million Filipino families are given the resources to lift themselves out of poverty. This means more than 1.6 million children from families in the margins are getting vaccinated for diarrhea and polio and others. It means also more than 1.6 million mothers are granted access to basic health services. Furthermore, with expanded PhilHealth coverage, which is made possible because of our principled and prudent budget allocation, 85 per cent of our population can now receive state-sponsored medical care. Now, 5.2 million of our poorest households can seek public medical treatment for common diseases such as dengue, pneumonia, asthma, among others. And this is essentially covered and free of charge without any out-of-pocket expenses. Through the so-called PhilHealth Z-benefit package, the lowest quintile of our society, especially those with early cancer, can also access to necessary health services. Not to mention we have deployed over 20 thousand nurses to communities in the countryside under our RN Hills programme. For this programme, we are partnering with the pharmaceutical companies getting better deals on medicine, which is yet another example of how successful collaborations between the public and private sectors can be. And I assure you our administration will always have an open door to projects that will ultimately benefit our people; through the government that stands by the true meaning of public service; and through a citizenry a world that is engaged, it is possible now to dream of a country where every child should be vaccinated, every mother is with access to health care, every retiree with support from the state, and it is now possible for the country to have advance medical research and development. In the past two years, we have proven that in a safe and a fair environment, nothing is impossible to an empowered people. With your help we can inspire more Filipinos to take on the challenges that beset our time. Thank you and good day.

1.3. Launch of the International PPP Specialist Centre on Health

Launch of the International PPP Specialist Centre on Health through the symbolic exchange of a plaque, which was followed by opening remarks on the launch of the International Centre of Excellence on Health in Manila Philippines on 24 October 2012 by Geoffrey Hamilton, Chief of the Economic Cooperation and Integration Division, UNECE

Thank you very much Mr. Minister, your Excellences, distinguished participants:

Let me on behalf of my boss, the United Nations Economic Commission for Europe, extend my best wishes and welcome to you for this international conference. Let me, first of all, thank Mr. Groff for his excellent words of welcome, the ADB team who's given such manful support (but they are all women, so I should have changed my vocabulary), Emi Masaki, Mei, Lucy, Meerim, and all others. My boss, Mr. Sven Alkalaj, who's the Executive Secretary and Undersecretary General of the United Nations would sincerely like to be here this morning, but unfortunately, Mr. Bank I Moon, his boss, ordered him to stay in Geneva for an important meeting. However, he is looking very much to being in Manila on the 22nd and 23rd of November to sign the MOU as represented by this plaque; this Memorandum of Agreement between the United Nations Economic Commission for Europe and the Government of Philippines. Through this formal MOU, the UNECE commits to give its full support to the government and Dr. Ona in the International Centre of Excellence in Public-private Partnerships in Health in order to undertake the challenging work on international best practice in PPP. It is indeed a challenge. We were undertaking some research for the discussion paper and it showed many things, namely, a lack of objective evaluation. In fact, sometimes the lack of any evaluation on projects on PPPs, strong bias towards one side or another and typical of PPP as a whole, the absence of contract details and financial arrangements surrounding projects which prevents the replication of these models in other countries. We hope that the Centre of Excellence will fill this important gap and bring together knowledge, experts in projects in one body allowing the country to benchmark its own PPP programme against international best practice and to provide the international community with information on excellence that can make PPP programmes in health more efficient and successful. Well, it's a work of investigation, research, and analysis. And dare I say it, work like a scientist and even work like a doctor. I'm reminded of a conversation I had when I first met Dr. Ona. And I think he was prompted into this remark by understanding what an international centre of excellence in Manila would have to do. And he said, well of course, it would have to be doing some research, and he said that people were often under the wrong impression that doctors know exactly what they're doing, or that they know exactly what's going on with the patients. In fact, he said, I don't know if Dr. Ona remembers this, in fact he said that invariably doctors open up patients during surgery and have a look around. Now ladies and gentlemen, I assure you that the work of the International Centre of Excellence in Health will be going into in-depth investigations. Perhaps, not of the kind that Dr. Ona does so well in his excellent work on individual patients. What is sure, the Centre of Excellence would not be in existence without Dr. Ona. Now my experience with PPP is the world over, there are always a few individuals who are the people who make the public-private partnership programme happen. They provide outstanding leadership in support of public-private partnership. And this is exactly the case of the Philippines and its national champion, Dr. Ona. Now, all good generals need good lieutenants and Dr. Ona has none more so than Celso Manangan, who came a few years ago to Geneva to work with me in our PPP unit in the at the Palais des Nations. And I remember when I was mentioning to him the list of the countries that we were imagining who would be hosting specialist centres in specific sectors, many leading countries United Kingdom, France, Russian Federation, Qatar, Netherlands, Republic of Korea, and so on. I have to confess the Philippines was not on the original list. So, Celso began a very,

very effective campaign of argumentation and as I say the rest is history. Philippines is now very firmly on the list and its now going to be one of the leading exponents, which the other countries who will set up specialist centres in the respective areas will follow. An exciting journey, an exciting journey, but the journey is just at the beginning. A journey that will uncover the best that PPP has to offer in addressing some of the world's critical challenges: climate change, poverty alleviation, sustainable development. Inaugurating with Dr. Ona the International Centre of Excellence on PPP in Health, we wish it under his leadership, an exciting journey of discovery, sound judgment in identifying best practice, and the creative and dynamic energy to go forth disseminating this information to governments, business, the world over. Thank you very much.

2. PPP in Health: An Overview

Facilitator: Jaime Galvez-Tan

2.1. An Overview on PPP in Health

Speaker: Geoffrey Hamilton

I'm speaking on public-private partnerships in health and I entitled it "In search of Excellence" because I think that's an appropriate title given the fact that we are a party to the International Centre of Excellence on PPPs Health that will be established here in Manila and the questions that I raised in the slides, which may come, but let me go through it. First of all, defining what excellence is. Secondly, why we must find excellence in public-private partnerships in health. Can we find it? And I'm going to identify two or three projects where I think we can find excellence in PPPs on health. And, how we can make excellence in PPP in health into a worldwide benchmark.

So, what is excellence in public-private partnerships in health? Well, excellence is by no means a very easy concept to define. And I could go for the next hour into discussion about those categories and criteria, and if you allow me I won't, only to say that we considered PPPs in health and we thought access especially to socially and economically vulnerable groups in society should be part of what we mean about excellence in public-private partnerships. Equity is a very difficult and controversial subject because people don't like the notion of taking resources from the rich and giving them to the poor, though we basically mean here social justice. Efficiency, that relates to outputs and inputs and getting more of an output with less of an input, whether it's labour, capital, or whatever. So, efficiency is also part of excellence in public-private partnerships. And also something called replicability. This is that the project should be simple to be adapted, contextualized and induced in another country. Otherwise, it's all become a little bit ridiculous. So, it shouldn't be unnecessarily complicated or complex relative to the available skill levels within a country. We do not just need to have a definition of excellence in public-private partnerships, but we need to measure excellence in order to make this operational. So, how do we do it? Should we use measurement of excellence in ways used

in other industries? I'm aware of a bestseller that was done by Peters and Waterman, Tom Peters, on management in search of excellence. It's a major, major part of MBAs in all MBA programmes around the world. In this best-selling book, there were 9 aspects of management that were considered to be essential for success in modern day management. And it talked about the importance of managing the simple things, doing the simple things. And basically all these issues, for example, why is the Walt Disney world leader in hosting wonderful events and theme parks around the world. Because it's staff are trained. They are so magnificently trained in what they do and that's one of the attributes of their success. And basically in this book, Tom Peters argues that excellence is all about people. It's all about people that make excellence in their own companies. I think that is exactly true in health public-private partnerships and excellence. Let me take this a little further. Is it just people or is it also the number crunching? The actual things like infection rates, the length of stay and so on. I think we're getting closer to public-private partnerships when we say yes. PPP in health excellence is about people. But it's also about the conditions that motivate people to achieve excellence. PPPs are very good at that. It's based on the discipline of project finance and long-term contracts, the key performance indicators. So, it's about people and it's about the quantifiable indicators. Can we bring to health the measurements and practices used in other PPP sectors and industries? PPP ensure that people are motivated to deliver the best. If the key performance indicators are not respected, then the private operator is penalized. It's that incentive, which ensures performance and that is extremely important and that's what PPPs are very good at.

The second question I want to ask is why we must find excellence in public-private partnerships. Well, we have to first of all recognize that the rising cost of health here is a phenomenon not just for Europe or Asia. It's all over the world. The rising cost associated with the aging process, with technologies, with the chronic diseases that encumber many of our populations. All this is translated into rising cost, which cannot be met by the governments alone. That's why public-private partnerships are attracting so much attention. Also, the citizens now demand nothing less than the best. They want to have excellence treatment. In my mother's generation, the very fact that she could get health deserved one thing. Not whether it was a good service - all it deserved was thank you, because the state was providing a service. Nowadays we've moved on. We're looking at things in terms of excellence not just on meeting basic needs. There is also a very important notion now about the citizens' loyalty towards the health service. If you will remember the Olympic Games that were held in London recently. In the opening ceremony, everyone was probably looking at Mr. Bean and his mimic of chariots of fire and that wonderful skit that was shown when he was running along the beach trying to keep up with the athletes. But one other aspect of the opening ceremony which was probably missed by many people outside of the UK, was the special section devoted to the National Health Service. People are extremely proud in the United Kingdom of the National Health Service. And that was very interesting. So people are looking for excellence in their systems of health. That's why we must understand that. We need to have excellence as a criterion in order to benchmark what we do in public-private partnerships so that we can spread the models

around the world, and very importantly, train the people who will be working in these new public-private partnerships.

And the last point is we need to get away from what I call ideological sophistry. Anyone who remembers Aristotle will remember the sophists. These are the people who dealt with rhetoric and who deceived people that they were arguing not on reason and logic but on stupidities and deception. We need to get away from these ideological camps, either you're against private sector involvement or you're for it. And this is why we need to define excellence. All governments are looking for the best model and they cannot afford to do this themselves. They cannot afford also to make mistakes. Any mistake is tantamount to failure. And basically, it's impossible for governments to enter into these public-private partnerships without full confidence that they are not going to make mistakes. So, can we find it today in public-private partnerships? It's a journey. PPPs are moving forward and we're still searching. But there are actual projects in PPPs in health today, which are emerging and inspiring.

The first one I wanted to talk about was the public-private partnerships in the Lesotho Hospital. This is indeed a remarkable, remarkable story. Well, first of all it's extremely difficult to actually have any success stories coming out in Africa today. This, ladies and gentlemen, is a success story. This was doing PPP in one of the poorest countries of the region. The sheer ambition of the government authorities and its advisers, the IFC, were absolutely amazing. And what has happened is that with exactly the same budget, the authorities have vastly improved the coverage of the population. This is an integrated health infrastructure project dealing with the facilities and also with the delivery of clinical services and serving women, children, vulnerable groups in society with modern care, which previously did not exist. The hospital also is contributing to economic development in jobs, in income, in providing training also for health professionals, used by the whole country. And also, in a country like Lesotho it's made a special effort to promote women's groups in the running of the hospital. 40 per cent of the company's equity is owned by such groups, where women are also employed in numerous services. So this, I think, is a benchmark of success. If it can work in Lesotho, why can't it work in other countries? So, I think that's a very good model.

The other one I wanted to talk about was back closer to home. It's the NKTI project in Manila. This is a public-private partnership. It's a leasing contract, a BOT in the technology transfer from a private entity to the state authority, which has drastically improved the quality of care in Manila. There's a history as well because before Dr. Ona became the Minister of Health, he was the director of the NKTI and he took the initiative when he saw he wasn't able to give a good service to his patients and he needed a technology, which the budget didn't allow. So, he investigated a way of doing this and he came out with the PPP approach, this lease agreement, which has been extremely successful. Before public-private partnership, people were turned away from the facility. With PPP, access, equity and efficiency have all been achieved. They are able now to acquire the best and latest technology and expand the services at the same cost. You can see the graph the minute the PPP actually started and became operational. The

number of patients who flocked to the NKTI for their treatment was colossal and that amount of money meant that more people who would have not been able to pay, particularly the poorer, could now access this facility. So, more machines, more reliable ones that didn't break down, all those extended services to more Filipinos and it also intensified and improved training to the local staff.

The other PPP that I wanted also to mention comes within another category of PPPs, which is quite different. It's PPPs in the health programmes. My colleague, Isabelle Wachsmuth from the WHO is going to talk to you in more detail about this particular model. Let me also just conclude then about why we're in business today and what the importance of the International Centre of Excellence is. PPPs are intended to grow organically in the world today. Unlike in some other sectors where there are models, there are even guides on the specific subject, PPPs are happening all over the place but the information about these projects is not being collected on any systematic basis. We found this out very clearly when we started doing some research on the subject. I mean could people name the five best projects in the world in PPPs in health? It would be a very difficult task to find out about these projects. Believe me. I spent probably three days investigating Turkey only to understand after all the information I learnt that there wasn't a single PPP in health that actually was operational. Everything was anticipated but nothing that was actually operational. So what we need is science to actually evaluate because with the evaluations, we can then plan, make judgments and go forward. And that's what the International Centre is going to do. There are clear deliverables. It will review PPP experiences in health. It will prepare syntheses on recent trends, the models, the successes, and the failures. It will go into the detail that's required to replicate the projects. Not just skimming, with anecdotes, but actually looking into the contracts and the financial arrangements linked to that project. Very big problem in PPP is that much of the information about PPP is kept as a commercial secret and is not divulged and that is a barrier to the better dissemination of public-private partnerships. So the Centre of Excellence should identify three, four top projects, keep that contract and financing information and make it accessible to governments who are wanting to replicate these models worldwide. That's the principle and we'll also help disseminate through annual congresses every year, meaning for example, the best projects in the world and also in the training of government officials. PPPs are about contracts and contract management and that's a new skill, which the government sector doesn't have and which the Centre of Excellence I hope will be able to educate government officials around the world in doing. Thank you very much.

2.2. Strengthening PPP in Health Policy Environment

Speaker: Enrique T. Ona

Well, I'm supposed to speak on the Philippines' PPP policy framework, and maybe just to start I'd like to say that the integration of our Republic Act Number 7718 which is the Philippines' BOT law which was essentially defining the role of the private sector as the main engine of

growth and development and together with our Department of Health Administrative Order which defines the Aquino Health Agenda, with Universal Health Care, this integration is aimed to clarify the applicability, the concept and benefits of PPP in health in the Philippines. Well, it is also aimed to rationalize the processes for project selection, preparation, procurement, and implementation with project evaluation at each stage, with clear objectives and criteria for selection and evaluation. The health policy today, in the Philippines we have called it Kalusugang Pangkalahatan or Universal Health Care, and essentially the idea was that within three years, the Philippines would be able to achieve enrolment of all our people under our PhilHealth or Philippine Health Insurance System. In essence, under the leadership of our President, the Philippine government has set a bold agenda and indeed it is quite daunting for us to make sure that both the poor sections or poor segments of our population and the not so poor, and these groups belong to the informal sector, are indeed covered by PhilHealth, because those in the formal sector have been already enrolled in PhilHealth since actually in the early 70s. So, in short our programme of universal healthcare is backed by a commitment for a greater cooperation between the public and the private sector through the engagement of public-private partnership. And so PPP shall be encouraged and sustained in areas of health care where they would most contribute to the achievement of universal health care. The attainment of our Health Millennium Development Goals 4, 5 and 6 is a commitment of the national government and among others is that there must be a rapid expansion of our national health insurance coverage as I earlier mentioned, and there has to be an improved access of quality hospitals and health care. Now, we know that currently the Philippines has a fairly low health care expenditure even comparing ourselves with countries in South East Asia. Our current health care expenditure is still below 4% of GDP and so capacity is needed to be added both in our health facilities that need to be upgraded and modernized to enhance our health care service delivery. At present, the Department of Health has three initiatives to be able to achieve universal health care. One is making sure that there is financial risk protection for everybody, especially those that have been marginalised. They have to be able to access quality health care through improved and modernised facilities, and of course, to attain our Millennium Development Goals. So, this strategic plan of PPP is anchored in making sure that we are able to develop capacity, and therefore, capacity building is important for us. We have to upgrade our medical equipment and, of course, through improvement also of IT so that we would be able to make sure that those who are in the far-flung areas are able to access health care. And therefore, the development approach is to make sure that we have appropriated enough funds for this strategic approach, and that there must always be transparency in the process as well as in the decision-making. Now, among others, is to make sure that we have to increase the bed capacity of our hospitals. The next slide will show you that we have, among others, a fairly low ratio of patient to number of beds. As a matter of fact, for the past 25 years, no major government hospital has been built and this is just an example of one of our busiest maternity hospitals in the country today. Now, the health PPP programme therefore is based on infrastructure construction with making sure that modern equipment and services including IT systems are made available. There will be asset equipment maintenance that will go with it as well as partnership in the operations and management. Actually, there were several PPPs

initiated in small scale at the Department of Health. And these were all done by our chief of hospitals and medical centre chiefs, which actually varied from simple outsourcing of non-clinical services, some concession agreement and supply contract. However, with those small successes, I believe, it has emboldened us to embark on PPPs which will now involve what we called big ticket contracts, involving big investment in infrastructure. The need for this is perpetual and understood by our staff today and we look forward to this strategy now. Among others, let me mention for example, what will be presented in the later part of this meeting, I think on the third day, where we are going to discuss the modernisation of the Philippine Orthopedic Centre, which is a 40-year old specialty hospital, 800 beds today. And we intend to modernize it to be at the level that is comparable to the best orthopedic hospitals around the world. We also are looking into a PPP project for our Pentavalent Vaccine Self-Sufficiency Project, and we have identified various regions of the country, 8 oncology centres, 8 cardio vascular centres, and 36 of these DOH hospitals for upgrading and modernisation. For this year, the Department of Health has allocated 3 billion pesos just to support studies and some preparation for these 25 regional medical centres. This strategic support fund will provide the government in terms of some equity, infrastructure and initial equipment outlay and also for the financing of feasibility studies and master planning. So, the next pictures just give you an idea, for example, this is how our current orthopedic hospital is. You can see that it needs certainly modernisation, and that project has taken us about a year and a half to finalise and we have been approved already by the Office of the President and by the President himself. The next slide will show you how we envision this modern medical centre will be. At the same time we have currently an oncologist centre at Davao Regional Hospital, this is in the Southern part, the biggest city in the Southern part of the Philippines through some form also of PPP, and as I earlier mentioned, we are going to have 7 others and these are the proposed oncology centres, for example at the Western Visayas Medical Center. The next one is in Northern Luzon, and I proposed one also in the Bicol Region, this is the Southern part of Manila and this will entail the acquisition of modern linear accelerators and also operating rooms for our specialty centres, and of course, I think the other picture will show you some plans for our Pentavalent Vaccine programme.

Now of course, there are needed legislations today because there is a need for the establishment of a distinct legal entity for the hospital under which the government's role must be clearly defined and identified as the owner. Segregation of the company's assets, finances and operations from all the government operations must also be clearly defined and at the moment, we are also undertaking improvement and capacity building of our directors for managerial capacities, so that they will become both accountable not only to the government but also to the private sector. So in essence, good governance and its implication is very important to make sure that there is efficiency, customer orientation, capacity to innovate, as well as financial sustainability of these projects. Now the economic and social impact of PPPs in health is very important as we go through the rest of the Aquino administration. We need therefore to accelerate new infrastructure and upgrading to make sure that our hospitals attain international standards. Second is that it should be available, and that quality is maintained and

efficiency is also adhered to, and we must balance the regional development by creating regional referral and specialty centres, so that our people especially those outside the big cities need not come any more to Manila or Cebu to access these specialty services. So in short, the success parameters of health PPP policy framework in the Philippines is to make sure that there is increased participation in the PPP programme for health, we have to improve the capacity of our DOH retained medical centres, their chiefs, as well as our regional health departments, so that they should be able to develop, prioritise and prepare for tender. They should be able to negotiate and monitor PPP projects that are cleared by our PPP Centre here at the Department of Health. Hopefully, at the end of the day, we'll be able to improve the quality of life of our Filipino patients, by improving the access of everyone to health services and that the capacity of the Philippines as an investment in health destination can also be maintained. So again, thank you very much for your presence and good morning.

2.3. PPP in Health: Perspectives from the Private Sector

Speaker: Matthew Collingridge

Honourable Secretary Ona, distinguished guests, ladies and gentlemen, good morning:

I have the unenviable task of trying to represent what is a fairly significant breadth of the private sector and the role that we play in health PPP, and what the current state may be and what the future might look like. I would like to acknowledge and thank the Philippine Department of Health, the PPP Centre, the UNECE, and of course, our host the ADB for continuing to stimulate the discussion and the opportunity for private and public sectors to collaborate on developing health system that is sustainable into the 21st century. My focus today will be on a global, a regional, and a local flavour of the trends of PPP in our world and most importantly, or most controversially, what the future may hold. It is encouraging to hear both Geoffrey and the Secretary talk and use the words that unfortunately you are going to see and hear from me again: accessibility, equity, affordability, sustainability. Health care trends, I think, most of you in this room would probably acknowledge this as a short snap shot of some of the key trends that we now face in the 21st century for health care delivery. I think the interesting question is not "what" but "how" these trends may impact the PPP sphere. How will the public health systems adapt to the changing needs of either clinical models, the changing face of the infrastructure requirements, the development of technologies, ICT et cetera, and how will the private sector develop new and innovative business models to grapple with those trends. And I think that's the question that we should continue, through things like the International Centre of Excellence, ask ourselves. Look at the measurement of the today and what does that mean with the impending changes in health delivery.

A short snap shot on the ASEAN market, from our perspective particularly relevant I suppose is to hear about the region. The leadership position that the Philippines has now taken and has been taking in developing PPP in whatever shape of form that is, is encouraging ahead of the

more formalised ASEAN agreements that will be coming in the next few years. We all know that we are in an encouraging part of the world for investment and for being able to develop regionally specific sustainable models especially in health care. We can't ignore that we are in competition. There are the distractions if you like from an ASEAN perspective of China, of India. There is the competition for limited funds and for limited personnel. And I think one area that, I think, Geoffrey touched on, I think the Philippines as we all know is blessed with the clinical expertise and the professionalism of its clinical personnel. But what we see is the hospital management, the actual effectiveness of delivering health care services, by its cost efficiency in the private sector and in collaboration with the public sector, is an area that we would like to see more development in. The need is huge, however, is it about infrastructure? I'm not really going to go through this slide but just leave you with the thought that, yes at the moment, PPP certainly globally and regionally, and even in the Philippines, is infrastructure focused. Is that the future of health care? So, as we've heard, and certainly the Philippine Department of Health, the Philippine government as a whole, and the PPP Centre have been actively engaged, learning and educating. It's the buzzword at the moment. The world is talking about the private sector, the public sector, the delivery of those services now and into the future cost effectively. The private sector is ready. There's been a proliferation of companies, finances, legal, construction, technology providers and operators. I think now is the time to see how we can define the next generation of PPP within not only Asia but for the world. As you can see and as was referenced both by Geoffrey and the Secretary, here there is a lot of activity going on around the world, there are a lot of different projects, a lot of different models, whether its financial, clinical, there's a lot naturally of unmet need particularly in emerging markets. And I think the International Centre of Excellence is perfectly timed to embrace and to learn from those models, to learn from where the private sector is working with government, to import or to refine or to modify those models internationally, and to build as Geoffrey said, a collective of what works and what doesn't.

We do know that PPP means lots of things to lots of people. I think that this slide, well it is not necessarily directly related to PPP, lovely sums up in my opinion the approach that if you ask probably a number of people in this room but more importantly a number of people in both government and health care operators around the world, what is PPP and what does it mean to deliver effective public health services through the private sector, you are going to get a wide range of answers. And that's healthy. That's healthy. And I think again, with the progress made through the PPP Centre here in the Philippines, and now the Centre of Excellence, we'll be able to import and develop those models not only suitable for the Philippines, but also for ASEAN and ultimately, hopefully, for the rest of Asia.

A few observations, yes, infrastructure is needed; yes, it is unknown; it's quantifiable; it's a nation building activity. We acknowledge that. We also acknowledge the complexity and the cost that comes with building projects, especially as complex as health facilities. We also acknowledge that the fiscal, the regulatory frameworks are only associated components that make PPP in health care sustainable are still emerging, and as you've just heard from the

Secretary, the Philippines has certainly taken the leadership role in defining those government acts and the responsibilities, laws and regulatory frameworks to enable long term investment in collaboration with the private sector. But I will reinforce that efficiency doesn't come from building something cleverly, nor does it come from financing it cleverly, particularly in health. It comes from the optimisation of that interaction between people, processes, technology and space.

We've heard about the regulatory and legal frameworks. It's encouraging to see the establishment of the PPP Centre and we as the private sector as a whole encourage the on-going sponsorship of that interaction in the Philippines as a Centre of Excellence. We welcome the ability and opportunity to continue to dialogue openly, build trust not just contracts. We need that transparency. And certainly, I think we all agree that in the last few years, in ASEAN and in the Philippines, that transparency has started to come.

I think most people in the room would obviously understand or would see the basics of PPP in terms of the traditional model. I wanted to put it there as a key stake against which to measure my comments in a minute. But the point I did want to highlight is that at the moment, the availability, or the performance and the management of that performance has been proven globally in large and small projects in the health industry to be effective by the private sector. The question is, is that the best model going forward? We all know about these types of terms if you like. The various ownership models, the various contracting structures. I would ask and continue to encourage the Philippines' PPP Centre and the new International Centre of Excellence to explore more and beyond the boundaries of BOT. I think there is a role to play for a range, a menu, an à la carte approach to arrange contracting structures for the private sector to engage, and for us to build that trust to innovate and deliver health services across the spectrum not just for profit. And we have certainly seen a number of these models. Yes, we all understand where they sit relative to the fundamental of risk transfer. I think when I started in the PPP industry seven years ago, really, health care didn't understand risk. Really didn't understand risk. And certainly I think still to this day, doesn't understand some of the clinical and the future risks associated with the delivery of health care. But that said, neither did the private sector. The private sector was focused on de-risking infrastructure assets, financially, contractually. And we've now seen a number of these models and the green ones really represent toes in the water around the world, different types of models specialist projects, and certainly Secretary Ona has already alluded to one or two of those projects being piloted here in the Philippines. We need to create a spectrum based on the stability that we have now. We all know how complex hospitals are. We also know how complex health systems are. But one thing I wanted to just reiterate on this slide, at the moment up to 70 per cent of the time, effort and costs in developing PPP health infrastructure is up to the doors opening. And yet we all know fundamentally the costs of health are in the operational phase, the sustainability of health facilities and clinical services, and I would ask that as part of the International Centre of Excellence that these models that are being tested, that have yet to be developed, that private sector perhaps has ideas or opportunities to innovate around that after the doors opened, can

be explored. So what are the challenges? We've touched on a few of these. We all know the growth and the aging population challenges. We all know the rural and the significant access challenges for universal health care, the international guidelines, the clinical qualifications and the onerousness of standardized regulations in health practice. We also understand that people are starting […] in the number of those areas that the private sector requires for longer term investment health insurance reimbursement models. We also understand the dynamic between business model and care model. We don't have the perfect answer and I think the answer sits somewhere between us, as the private sector and the public sector. But ultimately, we all know that health care and education are the fundamentals of any country and its development, economically or otherwise. So, we hope that this starting process that we've got to today and for the next foreseeable future will allow the private sector to offer something.

In the specific context of the Philippines, you're blessed with a robust macroeconomic situation, currently. We've already noted the clinical personnel that you export, the dedicated government focus, the growth and the really encouraging growth in both conglomerate, corporatized and SME private health operators in this market. We need to give them an opportunity to support and play a role in growing the accessibility of health care in the Philippines. But these drivers will only sustain the initial investment. All above is that we need to look more holistically at creating this equity, this equilateral triangle where the patient is in the centre and it is not just about bricks and mortar. We need to understand as the private sector the risk of clinical service delivery, not just as operators, not just as technology companies, not just construction companies, but actually as a collective. And I believe, we believe, that by focusing on that, that we could create new and sustainable business models for the private sector. There are a number of alternatives, suggestions, and I think, Secretary you've already mentioned a few in terms of your regionalised centres, your specialist centres, the acknowledgment of tele-health, the question mark over personalised medicine and health as consumers. We encourage that more is done to look at this range of offerings. Some ideas focus on clinical and non-clinical services, again, let's roll those pilots out faster. The longer-term horizon and certainty, the plan, some of those points you have just made, Secretary Ona, are really encouraging. That pipeline if you like gives the private sector, not just the banks, not just the legal guys, but all of us, a greatest certainty of where the government of the Philippines is heading in developing and delivering health services with the private sector. And we will take more risk if given the opportunity.

A few short examples we've already touched on the example I think it's on dialysis at NKTI that Geoffrey talked about, and certainly the recent announcement in radiotherapy. We would like to see more of this; I think the challenges that it faced financially in deploying technology and certainly, as a technology company, we understand the cost associated with that. We are exploring models to give the government options to deploy that more cost effectively. That could incorporate […] revenue share, risk share and profit share. All these terms are on the table. They are all out proven examples in the market place of what can and can't work. So we are asking and encouraging for the dialogue. An example of what we've done as GE but I

suppose what it can be achieved in working with the government in Malaysia recently in building a distributed radiology IT system that will essentially capacity share between the public and private sectors. This is an investment made by a range of companies sponsored by the Malaysian government and I think it's these sorts of initiatives that can over time change the landscape of how health care is delivered between the private and public sectors. So, what would we like, I was asked, as a question in the briefing. Well, here's a few questions, a few pointers. I'm not pretending to cover the range of the private sector interests in health care, but I think the key ones, an opportunity to take more risk but acknowledge that the government values that risk. We are seeking collaboration. I think again Geoffrey talked on the equity piece. At some point a private sector has to acknowledge that we're in the gain, not only for an ROI but also to build nations.

And penultimately, I just wanted to share with you, this is the unadulterated pitch, and we as GE, amongst other companies, health care operators, health technology companies, we acknowledge the need not only to invest but to change the paradigm in a way that we do business and I think, certainly, of all of the businesses that I talked to across the functions of delivering private health care, everyone acknowledges this, I think we would like to see more of the private sector groups put their money where their mouth is. So in summary, I think the start that's been made, the focus to catch up, not only here in the Philippines but in ASEAN and to some extent in Asia, around traditional PPP and the development of infrastructure is needed, but is not sustainable. No country in Asia can afford to build, and nor can the private sector afford to build the infrastructure that's require to deliver health care services for the next 50 or hundred years. So we've got to start, we've got to acknowledge that we're making progress, but we've got to start looking for alternatives. And I would lastly, I suppose say that, collaboration, partnership, the words that are used probably too much, too often, but I think that the signs and the activities and the steps that have been taken in the Philippines to meet the public and private sectors to develop health care services are extremely encouraging, and I would welcome and continue to welcome not only for the benefit of the Filipino population but also for Asia and ASEAN as a whole. Thank you.

2.4. Best Practice in PPPs in Health: Health Programme PPPs

Speaker: Isabelle Wachsmuth-Huguet

Thank you everyone. I would like to present the analysis also of what with Geoffrey we did, some paper document about the identification of some best practices in public-private partnership in health sectors. And as you know PPPs in fact are very useful for the development of infrastructure in hospitals. But it is just one part of the possibility to use PPPs in this health sector and I would like to use this opportunity to show you what we can plan in fact for also health programme PPPs. I would present to you some examples of how we can apply that in different types of health programmes.

First, we will start with what health programmes PPPs are. Of course, like you know it is very focused on infrastructure development specifically for hospitals and health centres, but it is not a lot focused on health programmes. And in general when we will do the analysis for health programmes you will see, unfortunately, it is very short PPP initiative in health programme. In general it is for 3 to 5 years only because it is mainly financed by NGOs, for example, but also by international institutions and it is good initiative but sometimes it is not sustainable. The question we will have in these circumstances is how we will be sure that this type of health programme will be sustainable, you know, in this time and can be not establish on 3 or 5 years but maybe 30 years. I will give you some examples at the end. We should all think about integrated health programmes, which is holistic approach, and all collectively we can support maybe more these health programme approach. Because health programme PPP is very important to improve efficiency, to improve services, provision and management and also that it is critical to reduce the cost, but it is also to focus more on quality of care, and equity dimension. Quality will be to increase the expertise through capacity building, like it was mentioned. I think it is key and we need to think about that more deeply because like that we will be able also to have some impact, you know, on investment in infrastructure and specifically on new medical technologies. And in this type of area I will give you some examples on how we can apply PPP for example in mobile health, and specifically to address not just developing countries, low and middle income countries, because we need to think about that. All, for example, the countries from the North or the other regions from this world can contribute, you know, to improve also the country of not the same economic condition to grow, and I think that it is also important. Like that we will be able to increase the potential to attract and to retain better performing staff because motivation, you know, it is very key factor also in this PPP approach and of course, to address more clearly the equity dimension, to be sure we will reach remote areas and also poor areas.

In terms of criteria for successful health programme PPP, I think it is very important to be careful about the evaluation of the condition of success and sustainability, because it is also important we will have some command goal to this specifically, to have very strong commitment for public good, including what will be a better community approach, for example. But it is also about the legal and regulatory framework, and that includes of course the minimum standard for quality in services. Who will be sure we will use also health standards in health, for example, and guidelines provided by the World Health Organisation? It is also about transparency and accountability but also to develop some model of sharing of resources, you know, to be sure that at the end we will have mutual benefit and we will have a very effective system improvement. Today, we have these trends for health programme PPPs and I think it is very important that these will get your attention because it is about 3.6 trillion of dollars that is projected to be spent on health infrastructure but in the future it will be 68.1 trillion of dollars will be spent on non-infrastructure health in the next decade. So you can see, the figure it is very critical. So, I think we need to consider not just infrastructure today. And of course, we estimate you know it will be 7.5 trillion dollars annually and we need to have an effective international health specialist centre, you know, at our end to be sure we will identify the

success and failures, you know, it is to learn together. And of course, the idea is to spread this knowledge and this expertise to low and middle income countries and to address what it is called 4P – pro-poor public-private partnership to be sure it will be not just this PPP approach, just for this setting, but also for the resource-poor setting and all we will do that together. We have identified this in our paper document, and I hope you have access to that, the category of case today in health PPP programmes. We look specifically at research development, I will show you some examples. Improve of access to health products, also public advocacy and increasing awareness, regulation and quality assurance and also the training and education. For the research and development, how we will define that. In fact in research and development, we use the project development partnership, you know, it is focused on the development of new projects specifically against disease but you have some risk of inequity specifically for this pro-poor population. But I will give you some example, you know, in this low and middle-income country to demonstrate it is possible. And after, we have also the dimension of improvement of access to health product, to improve the access to commodity, but also schools technology transfer, local production and distribution. And also these programmes are very important because they are an integral part of the MDG and that supports the increase in the ability of the selection of generic medicine. And today it is estimated that 10.5 million lives could be saved by year and 4 million in Africa and Southeast Asia.

I will show you just brief example about mobile health technology. And here you can see, for example, the different dimensions, access equity, efficiency and replicability. You know you can see a type of agreement, here it is a coalition, in fact, between the different foundation and international UN organisations and we decided to resolve humanitarian crisis and improve the quality of diagnosis and for that deliver some free mobile phones and through this mobile phone have web based data collection systems. That was very effective because with this type of approach the access, of course, multiply very quickly and now in terms of efficiency, it is very useful everywhere, in fact, you can also easily replicate this type of approach.

So the case today we look about health product and we found some examples about essential health products, family planning and malaria prevention programmes. Here, you have the result of this study. You can see, for example, in one case it was not successful. It is the malaria prevention programme case and it was in fact for Africa. Why it was a failure because in fact the market was not ready for the deployment of the use of insecticide treated bed nets for malaria. This demonstrates your need to understand very well your context before to go in this PPP approach for health programme because the risk of failure can be very high. But you have also some good success, you know, like you can see from the essential health products and family planning programmes. These two cases were also in the Sub-Saharan African region, in Rwanda. You can see also the dimensions that were expected, for example, for family planning it was about how to deliver free of charge contraceptives and for essential products it was about the improvement of logistics and inventory management systems.

About public advocacy and increasing awareness, what is important is to have grassroots advocacy efforts to increase awareness about critical health issues but it is also how we will

mitigate their prevalence related to the local context including the factors like believes, habits, perceptions, constraint of the environment, economy and political situation and demonstrate how it is important to understand and evaluate the context in advance before to start this PPP health programme. And it is also important to think about curative and preventive aspects and we can use, for example, this type of health programme to consider also PPP in preventive dimensions. Like it was a case of hand washing in different countries in Central America to prevent diarrheal diseases. And you can also apply this type of PPP also in health promotion. Here you have some examples, very successful, for hand washing campaign for South America. The result of this study, I will not go into detail because we have no time but you can see more in our paper. And we have also as example, because we have little time I will not go in detail but you can apply in regulation and quality assurance also. Here you have some example about emergency obstetric care, emergency medical services and also in the case of health insurance, again I will not go into detail. And you can apply that also in training and education, you know, it is very important to improve in fact capacity building, you know. And here is an example about a residency programme and continuing medical education, it was also very successful case.

I think we need to consider, in my conclusion, to have some more integrated PPP health programmes and to consider at the same time how will be used the norms and standards but also how at the same time will be assured the quality, safety, and efficacy of all pharmaceutical products and to put in place the necessary infrastructure and procedure for quality assurance mechanisms and in the end to think also about building capacity, enforcing national laws and regulations. I think we need to think together in this dimension, you know. This is just an example of integrated health services. It was in Malawi, Saint Gabriel Hospital in Namitete, and I invite you to look up more details from the paper because it has been a very successful case for 20 to 30 years now, and I visited this hospital. The results are amazing. I will not go into details but you read more in our paper. And the questions for the debate will be:

- How to design relevant PPP Health programme approach between private, faith-based and NGOs organizations for specifically low middle income countries?
- How to extend and use contractual partnerships with for example faith-based organizations for PPP Health programme approach to have more integrated PPP health programme at hospital level?
- How we will design South-South collaboration or South-North PPP collaboration? I think we need to shift a paradigm like what you have described so well to design constructive future together and re-configurate our perception of health. How we will be able to address fragmented view of healthcare services and well-being through PPP approach in health for more holistic approach of health? And finally, how to design or replicate successful integrated PPP model in health?

Thank you for your attention.

2.5. Open Forum

Questions/responses from delegates:

1. **David Dombkins**: Just a couple of responses in respect to GE's comments about the scope of PPP programmes, the best practice guide in the toolkit we are developing in campuses is of very broad range and goes well beyond the traditional PFI to get into the high-end […] services that we model. So, the scope is very broad, and the research we will bring in comes from not just health but from other sectors. There's a whole stack of very innovative processes out there and I think that covers the words from the World Health Organisation given in the […], an integrated model. So, the scope of what we're doing in campuses covers those broad areas, I think, quite well.

2. **Soe Nyunt-u**: A couple of points. I think in Asian settings, Asian countries had quite a bit of long standing public-private partnership in health care experience in some of the Asian countries for decades. I came to the Philippines 13 years ago but I was in Malaysia for about 10 years. And during that period, Malaysia has gone into many, many public-private partnerships like corporatizing whole hospitals and even the central programming and dissolutions of medicals, so that essential medicines and all products go to the public hospitals through a corporatized entity. But one of the major problems, if you don't do a proper evaluation, you don't learn lessons from those things and as our colleague from GE Healthcare mentioned I think in the slides of many how would you interpret when I look at it, how do you monitor those things, you know? You don't have a problem monitoring evaluation systems? You can't document it? What are the results of those things? Before I left I was calling and discussing with my Malaysian colleagues to do a proper evaluation after 5 to 10 years of operation, those should be evaluated. If you don't evaluate, you don't share results and you don't share those lessons, success and failures. So that's one thing. Second thing I would like to point out in relation to Secretary's comment about transparency, because sometimes probably we don't do a proper evaluation because we don't really want to open the whole thing and if I don't ask those closest, of course, you can't really evaluate properly. But as Secretary has mentioned, transparency in dealing with public-private partnership in health care is so important. If you address transparency in governance issue in the forefront, when is that conceptualised? When is that developing? It has to be there. Otherwise, it is very easy to get PPP in healthcare side tracked into disputes or issue about corruption, nepotism, et cetera. So, I think we need to pay emphasis on transparency in governance in dealing PPP in health.

3. **Kai Hong Phua**: I just want to add on to Dr. Soe's point of good governance. But two basic principles, which is on the relevance of PPP in different contexts other than the consideration for different social and cultural contexts in different parts of the world. I just want to put the context in terms of PPPs under different financing systems especially in the context of economic development and coming from a health economics perspective,

countries and systems under different stages of economic development may need to use different strategies and different PPP models. I hope that will be considered in the coming sessions, so that this paradigm shift that we talk about either is based on historical experiences of people who have been there but within social and cultural consideration and acceptability in their own national context. But countries that are transitioning from say lower income to lower to upper middle transition economy to high income may have to have different perspectives. So I hope you can spend a little more time about that.

4. **Patricia Moser**: Fascinating presentations from every presenter thank you very much. One of the questions that seems to come up pretty early that was the capacity to manage performance based contracting and, Secretray Ona, I know that this is something you have to deal with for a very long time. So, if you could just make some statement about that or comments about that. Thank you.

5. **Selmo Doval Santos**: I am also tasked to form investor groups for different projects and I am the medical director of the bank, so I am riding two horses. In a recent investors' forum partly subsidized by PricewaterhouseCoopers, they were emphasising that majority of investment by 2020 would be non-infrastructure PPP and I saw that in the presentation. The other idea that came out is the Philippine government coming out with toolkits. PPP India has an infrastructure toolkit. You log in to the PPP India website, you put in your project, you put in your parameters, and it's evaluated for you in a toolkit. And they have models for value for money computations. That is easily done in an infrastructure PPP context. In non-infrastructure PPP context, there is very little data on the matter. That's why I'm very happy personally that we will have an International Centre for Excellence. In the PricewaterhouseCooper conference, we were emphasising that every nation in a group like the European Union or ASEAN should have national centres for excellence. So, my next question is I'm asking ADB, is ADB funding, promoting, national centres for excellence after the Manila Centre for Excellence and will the Manila model help in this development? The other thing that looms for most investors is very plain for in the Philippine context. ASEANization of health trade, ASEANization of medical practice. If our PPP programmes will not include that concept of a Thai doctor coming in or a Filipino doctor practicing in Thailand, we will have a disconnection with the planning effort done by very many private entities. And the private forum, investors forum I attended, they all have that in mind. In two and a half years, we will have international vision of ASEAN. ASEANization of medical practice. Are our hospitals prepared? And are our Asian hospitals prepared? So, a Centre for Excellence should have this in the background of its mind. And finally, there's the issue of legislative impediments, which Secretary Ona pointed out, as well as the accounting impediments. If you look at the financial statements of Makati Med, they have re-classified the accounts after MV Pangilinan took over. I reviewed the financial statements and it's very obvious that there was re-classification of accounts. This standardisation of accounting should be part of the PPP programme. That's why an International Centre for Excellence for PPP should be involved in this. That's why my last question for Secretary Ona is, how are we

going to integrate the efforts of the University of the Philippines, of which I'm part, with the DOH? It appears like they are two different entities. The UP also has a hub and spoke programme with tele-medicine. The DOH also has a hub and spoke programme with tele-medicine, yet they are all under the same political environment. Thank you very much.

6. **Willibald Zeck**: I just wanted to emphasise what Ms. Isabelle was showing at the end. Even if we have the best infrastructure, even if we have the best motivated health workers, if the demand is not there from the population, if we talk about equity, for instance, if the services are not used, we're not doing the right job in the area of PPP. My question is, is there any experience that you have, that you also have to get, the feedback of the end users? And in the Philippines, I think with the mobile technology that is coming up more and more, we have that opportunity. Would you be able to come up with an example from other countries, where you show the feedback from end users, and that also brings us to the quality of care? While I agree that contracts are very important but what I think what we see more and more in higher middle income and in high income countries is also that the patient has more rights. And I think Dr. Hamilton was saying in the beginning that the generation of his mother had this different perception of health services than we have now and I think we see that also in high middle-income countries, more court cases, patients are suing more of the details, they claim a certain right. And we have countries where for instance, young colleagues, are not enrolling into obstetrics residency anymore because they know that the court case rate is so high. So, what is your take on this? You know, contracts and quality versus also more court cases and patient rights.

7. **Teresa Jenna**: Hi, thank you to the panel. The private sector, the public sector, the multi-laterals, and the NGOs, they all have different ideologies and yet the goal for PPP is the same. Everyone wants to benefit by this kind of arrangement. I would like to know how the panel views the attitudes and behaviours of the stakeholders, and how they infringe upon or work to the benefit of all parties. Where there have been successes and failures - if you could give examples. I would like to also suggest because I cannot find this information. There's a lot of information saying that when these partnerships break up, it's because of accounting purposes, it's because people do not see the same way in numbers. But you all said that people are the ones that make this happen. So, I want to know, I want you to look at and tell me, and tell the rest of us what you know about how the financial models integrate with the personal models of behaviours and attitudes and then I'd love to give you some information in the field of what really happens on the ground.

Responses from the panel:

1. **Geoffrey Hamilton**: Well, Mr. Chairman, I was extremely impressed by the breadth, scope, and intelligence of the questions. There's something that also struck me was just how polite everyone was. And I honestly believe that if I was giving a speech in London or in any place in United Kingdom I would have the tomatoes being thrown over me because it is an

extremely controversial issue, particularly in something as fundamental as health. It's absolutely clear. PPP is the only show in town, the future 21st century PPP in health. There is no other way. The generation of my mother with the National Health Service is gone. Good governance in PPP is something also that we are very, very important about and these are the fundamentals also about doing PPP - a legislative framework that is clear and straightforward, open competitive procurement is absolutely critical. I agree with financial models, but let's keep people first, put people first in the projects. The people must want the project in order for the project to succeed and that when you've got lawyers and financial specialist in the room is not absolutely a hundred per cent clear. Also quality of advice, this is very important and is a big issue and a lot of governments say we are very unhappy with the quality we advise to set up some of these very complicated projects. How do we help this? Why, for example, is a similar project in Romania with respect to the national dialysis, the NKTI project in Manila, why did this project in Romania cost 35 million in terms of advice alone to get off the ground when for the project in Manila, I think it was zero. So that is quite important to know what the excellence and best practices are. Finally, auditing. We need to do more monitoring and auditing and to do more reports. At the moment, we don't have this auditing established excellence. There are, I think, one or two projects that were done in the UK. Most of the evaluations that have been done have been positive.

2. **Enrique T. Ona**: Maybe, I think it's very important to understand that there has to be a link between the level of a country's understanding of PPP and how it's going to be implemented. Now in the Philippines, for example, the Build Operate Transfer Law was passed in the early 90s. And essentially, the understanding of the people, among us, including us, was to build, to operate and to transfer. And that was how it was for I think about three years also and maybe a little bit longer. But after that, I think after some understanding of the various mainly infrastructure projects that were not essentially big ones, they came up with an amendment to the law that essentially opened up combinations of various options that we even called it a hybrid and it was not anymore a Build Operate Transfer. It could be build, you manage and own, or any of the combinations. And that's the reason why we said it opened up the whole thing about how a PPP project would come about. Now, in terms of how at least we in the Philippines experienced it, we have had a number of what I call bad experiences. Certainly with the issues on contracts, that's probably among what we would consider a weakness of the programme in the Philippines for the past I'd say 15 to 20 years. Contract agreements that had to be essentially changed or modified and even problems in terms of interpretation by the courts. That was one of the basic weaknesses that we had to go through. Now, yes I'd like to mention about toolkits, how to proceed and I think, that's going to be one of the most important result of this conference, to be able to fine tune the various ways of proceeding with a PPP project and how a particular combination or a particular hybrid could come up based on the need as well as on the perception or on how the stakeholders look at it. With regards to the so-called behaviour of stakeholders, I think that's what you mentioned, it's very important

because a particular project of PPP would be looked up differently, for example, in the Philippines today. Say, let's do some PPP on medical tourism. Medical tourism essentially would be upgrading our facilities in the context of attracting foreign patients to the Philippines. But there's right away a reaction from the sector that would say, well, you'd like to improve your hospitals, that's fine and good. What happens to the poor segment of the population? And that's the reason why we don't talk so much about PPP as a programme of medical tourism, although that should and must be part of our programme. But what we have decided is to strategize so that we must make sure that the poor segments of the population are indeed given attention until we go into other forms of PPP. So again, it's very important that the stakeholders understand very well the programme of how the so-called PPP in health should proceed. Indeed, it's true that harmonisation of medical practices is among the programme that's being addressed in the ASEAN region. However, I know very well that there has been no general agreement to that and it will take a lot of negotiation and meetings before I think we are able to go into that direction. Harmonisation is important but as mentioned, we even have yet to harmonise our own moves here in the Philippines and in the country itself, like for example, the DOH, the academe, like the University of the Philippines, or even the School of Economics, or even with our other government offices, like for example, NEDA and other government entities that are also concerned directly with health. So, I think that would be some of the comments I could give with regards to how we would intend to proceed with PPP but this is a programme that we are very serious in maximising and putting speed so that we should be able to do but most of this probably within President Aquino's administration.

3. **Mathew Collingridge**: I think I'd probably add a few comments back to the comments made. Dr. Dombkins, I agree with you, the pilots, the projects, the models, have been piloted in other parts of the world and I think with the International Centres of Excellence now here and established we want to encourage the Philippine government and the health system here and in ASEAN to pilot those kinds of models. I mean, I think the key point here is, "*fail often but fail fast"*. So, but equally, and I think part of the systemic problem of why we don't have much data that measures the effectiveness of PPP both at a programme level, at a clinical level, and of course at the infrastructure level is, it is our responsibility in the private sector to try and develop the mechanisms by which that transparency can occur, but also I think that there was so much time spent in analysing the what-if scenarios in developing and delivering a building that no one did stop to think about the quality of care and the impact on patients, and we are now faced with retrospectively trying to evaluate that and I think I encourage you from day one that doesn't need to be five or ten years of planning, that needs to be action about with a clear understanding between public or private sectors on how the metrics are going to be collected, measured, analysed, and then either utilised or discarded. We must remember though that we're talking about medicine and medicine doesn't do anything unless it's got ten, or twenty, or thirty years of proven efficacy in clinical practice so, I suppose to some ironic sense, you know, we have to deal with the fact that medicine up until very recently in the last ten or fifteen years has been doctor driven or

clinician driven, to a large extent. So, I welcome the opportunity to meet those measurements. Let's fail often but fail fast if needed, and I think the last comment I'd like to make is that anecdotally, the feedback has really been sourced from the clinical fraternity within PPPs, you know, but focused on infrastructure not necessarily on the patient, and I think that, certainly that, there is I would say a generalised comment that says PPP is a favourable environment to allow clinical staff to focus on practising and treating patients but I would welcome equally the opportunity to see closer engagement with the ultimate end user. Thank you.

4. **Isabelle Wachsmuth-Huguet**: I will be brief, but I will give you a concrete example, you know, how it is possible. I think it is. It was very recent. I was in Morocco and I had the chance to see from my eyes how public-private partnership can be applied in capacity building of the medical staff. And it was 25 private doctors from France decided to combine their effort to highlight, in fact, their specialty in gastroenterology. In fact, specifically proctology and decided to give their time, free time. I came to Rabat, in fact, to train 25 doctors from the public part and it was doctors from a military hospital in Rabat and it was training in life, it was about sharing, you know, practices, experiences, and it was so efficient. The result is beautiful because in fact these doctors operate together some patients. I think that it is one good model how, for example, private and public can work together for the best. And without financial interest, but to give maybe one week of your time in your life, you know, for other countries in the world.

3. Case Studies and Best Practices in PPP in Health

Facilitator: Patricia Moser

3.1. Case Studies in Asia and Europe

Case studies in Asia
Speaker: Kai Hong Phua

I want to congratulate the organisers of this very important forum because PPPs have been around for a long, long time but somehow have been sort of submerged when we went through the original crisis and it sort of like dropped off the agenda when the momentum was really building up about a decade ago and now were picking up again with the emerging economies in all over Asia. So my brief is to share the Asian experiences, but I was also told to fill in some of the gaps in terms of some of the conceptual framework for PPPs. I'm going to run through very quickly, this concept of having a public-private mix and to have the PPP in health, what is really the public role versus the proper role of the markets and the private players including the non-profits. Then, I'm going to go into the work that has been done by the World Bank all over the world one or two decades ago and to zoom in on some of the more contemporary experiences with hospital reforms and the public sector under a different guise,

so before concluding whether we meet the optimum public private mix. So, when you compare the experiences all over Asia, basically we are talking about the functions of government and how much of it could be merged with the private sector, including the non-profits and here we are talking about the four components of provision, financing, regulation and the provision of public information and education. But of course, we have to ask ourselves what is the changing role of the state versus the market as countries transition from one stage of development to another. You cannot have a one-size-fits-all. You have to have different strokes for different folks. So a lot of it will then hinge on financing, which is the thing that drives and makes the world go round. But we have to then be able to separate what is the public versus the private interest in a way we design the financing architecture, how we price public goods versus private consumption, how we charge fees, how we provide subsidies, how we cost-share society as an economy. Of course, with the growing biomedical industries and new technologies coming in, we have to ask ourselves if it is just healthcare or if it is medical care that we are talking about. Right now even the concept of what is national and what is foreign has been so blurred, you know, not just between public and private, but between what is considered as national versus what is international or foreign because there's a big […] of health services. Health workers are moving around the world. Patients are also moving around the world with the rise of medical tourism. So, it will be very important to then see what your proper role is in terms of serving your domestic needs versus the external market. And of course with the rise of the aging population in all over Asia it is not just providing medical care but say a lot of it would be social care, so you mix the social aspect of it including the traditional health systems, including the extended family and the community at large. There are a lot of private although non-profit elements that come in to support the traditional health care models.

So, what is health versus what is social or family care will be also all mixed up in this PPP model. So, PPPs mean different things to different people depending on which perspectives and which stakeholder interest you are representing. It is very contested, as you know, if you are into the literature, there are multiple interpretations, and somehow it is used as an umbrella term to just keep everything under the sun, you know, the non-profit as well as for profit organisations. But a lot of it is very confused. So you have to be very clear what we are talking about. Are you comparing apples to apples, oranges with oranges? What kind of purpose are we serving? What is the structure, what are the dimensions you are comparing whether it's finance or delivery and the need for proper rules and regulations? So, some examples that were quoted this morning and it's quite well known, I mean, your National Kidney and Transplant Institute of the Philippines has been around for 50 years or so, and it was one of the early models of the corporatization model except that it got stalled when the rest of the economy stalled but the momentum was picked up in many of the countries in the region especially in the hospital sectors in Singapore, Malaysia and Hong Kong and I'm going to share with you some findings of a World Bank study that we have done. And then in the recent times, medical tourism has been very, very hot. Originally, I intended to share some preliminary findings of medical tourism in Thailand, Malaysia and Singapore, but it's a little premature because many of the issues are

very different. But we have achieved it, for example, in a way in Malaysia the Ministry of Health has controlled it by setting up a Malaysian Health Trouble Association supported by the Ministry of Health but there were clear lines of the different roles of state and market. So, IMF of course places a very strong emphasis on different types of financing instruments. So, you look down these lists, it's very, very busy, I can't read from here, but just refer to some of the literature - many of the international financing agencies have got their own definitions. But the common types of public private financing models as you can see, we have separated out international financing initiatives. Usually it is in the area of pharmaceutical of drug/vaccine development and other R&D, or trying to increase access to many or new products and technologies in the market. These are the domestic financing concerns, which are usually in the form of contracting in or out, concessions that may be given to privatised entities, some to private financing initiatives or PFIs as they are called that involves privatisation or divestiture, the way public and private and non-profit share resources, franchising, social marketing, joint ventures, and even new vouchers schemes, that target subsidies for certain vulnerable groups.

There's a growing evidenced base for PPPs and if you look at some of the new type of schemes moving beyond PFI to contracting, to social marketing and voucher systems, and so on, they are very attractive. So you used the standard criteria of benchmarking in the gains, accessibility, equity, efficiency, quality and capacity, you find that the different capacities as you can see, some of them are higher than others. But the most indeterminate evidence really is in the area of equity. So we have to be very mindful as we are rushing into PPP and make sure that your equity concerns are addressed first. And this has to come through stronger regulations and better governance. The PPP models and some of the common issues range beyond what was discussed earlier this morning as you talked about mainly service contracts and corporate social responsibilities, social enterprises and so on, usually concerns with access, efficiency, equity and quality of the care. We go top-down which is government driven and heavily centralised or you look at bottom-up and take it from the ground. And there's a mismatch between what NGOs' views and perspectives are as compared to government sometimes. Many of the pilot and demonstration projects and there are numerous examples all over have never been properly evaluated, as mentioned by many speakers. And many of those pilots once may have had the "hold-on effect", effect of having a lot of attention, a lot of resources and that it may work but they are not sustainable, so as you scale up and try to replicate many of them fall short, you know, and they just disappeared from the stream. So we have to constantly watch out how sustainable many of these new initiatives are. Long-term sustainability will be a major factor. Well, the standard way in which we look at public private mix is to talk about different kinds of mixes, this is just two dimensions, financing and provision. But as you move on to consider types of long-term care, the aging population, then you may have to consider more of the volunteer sector's role in coming up with social care models. This is something that I took from Japan and increasingly in many aging societies like Singapore and Hong Kong. We're doing a study now, moving towards this model where you have to maybe separate out in a form of a different kind of segmented approach to see who is best to do the job, will it be for profits, will it be for non-profits, or where a government would be incentivised to do more of the

regulatory aspects rather than the provision. So, the mix maybe quite different but we are still trying to establish the evidence base to see where the optimum mixes.

As I said there are three sectors. PPP can mean public, private, and people's sectors, and the people's sectors must be your focus. So, increasingly as countries in Asia democratise and globalise, I think the agenda for civil society would be quite prominent. As a government, you have to manage people's sector and where there are market failures there could also be government failures. So, what are you left with then? You have to also then involve the people's sector. So you look at the three sectors. The power sector is not just for profit. It's also non-profit and it is perhaps different in the way it is organised, and so, somehow you have to find the balance, it's all about balancing these three sectors, the tripartite model. You know Asian culture is not alien, you know, we have always this balance between yin and yang, within hot and cold. In a way we treat healthcare between traditional and moderns practices. So in the Asian mind it is perfectly acceptable, you know, so you have to find that balance between this. So, where there are government and market failures, and as you can see the health sector is replete with many examples in the literature, because there is a lot of consumer influence and information asymmetry, with the various competition, so government has to then address many of these various competition and have to find out where the market fails and the government has to come in, and where the government fails too, the bureaucracy, the corruption, inefficiency and so on, then you may have to come up with the third sector.

So the role of the government really is to target balance, equity and efficiency concerns. In any kind of health care reforms, or in any kind of organisation, whether it is in provision, or mandates, or financing, government has to provide the social protection and to make it affordable, whether it is a mix of taxation, or targeted subsidies, on a right pricing and so on. A government would have to regulate and ultimately be responsible for public safety and quality standards. And another important role of government, which has often been neglected especially in Asia, is the role of government in providing information, because without information, how can you plan, how can you have a balanced health care system, how can the private sector then do its rightful role. So, the government has to be responsible for collecting the basic data and sharing it and putting it into the public domain, not just for research, not just for economics, but it has to be shared, so the three sectors can find the right balance.

The World Bank has been doing a lot of such studies. About 13, 14 years ago, there was a move towards privatisation and somehow the agenda got mixed up and so there was a backlash, so the half-way measure was then to do corporatization. But if you look at the World Bank's organisational modalities in public-private healthcare, if you look at the co-public sector in B, there you have the budgetary unit, the traditional way which governments allocate money, as you move more and more towards the markets and the private sector, you have to go through different intermediate stages, in terms of autonomous units and then corporatized units before you have a fully privatised. But if you look at the World Bank study of 17 or 18 countries here, many of the countries are still stuck in the budgetary mode, some have gone into the

autonomous mode, and some others have moved on into corporatized modes. Most of them are really the British type National Health Service, which are predominantly tax financed, heavily centralised. They've realised that there are limits to what government can do and are increasingly looking at new hybrid models. And so the corporatized models as you can see, really to the right side of the slide. And I have identified the ones in red - these are all Asian models. If you look at some of the Asian models in the region from China, Vietnam, Hong Kong, Indonesia, Singapore and Malaysia, we collectively have a lot of lessons. Although many of them are still in the stage of transitioning or even moving backwards, but some of them have moved on.

Now, look at this summary of incentive regimes for evaluating the reforms. It is very complicated so I will not bother you to look at it, except to say that the more you move towards the private sector, in the corporatized sector they are going to have a paradigm shift away from the traditional way in which you expect the government to deliver services. So when we apply this model to three systems in the region, Hong Kong, Malaysia and Singapore, which I consider as some of the most advanced in terms of hospital regimes you find that even between these three systems they are somewhere between the autonomized units and the corporatized units. The international panel of reviewers, in fact, put the Singapore model more towards the interface between corporatized and privatised units and the Hong Kong model is still stuck in the form of a statutory board. They have improved the financing and the infrastructure but the finance, sorry, the delivery and infrastructure but the not the financing. The financing is very much still tax financed. In the case of Malaysia and especially Singapore, we've moved towards a more diversified way of financing. We've user fees and of course in Singapore we've used the famous 3Ms – medical savings, insurance and taxation.

So, the World Bank study in fact summarises the lessons from this. This was done about 12, 13 years ago, that whatever you do, you have to have very coherent incentive regime. Incentives will be able to drive on the supply side what your providers, what your hospitals and your doctors would want. Does it cover all the critical elements, not just financing but also human resources? Human resources would be critical to the people working in the system and how they are incentivised to believe in real partnership. And of course, a complimentary reform has to come – it's not just about financing and changing the hospitals infrastructure, you have to talk about good governance, good leadership, stewardship and of course, purchasing has to be performance-based. You have to reward people for performing. So the incentives will drive it, and markets must be functioning. There must be more information available. The information asymmetries have to be narrowed and you have to have a lot more transparency and accountability. So, information is critical if you want PPPs to succeed.

There was another parallel study that I was involved with, which is to look at PPPs in social services in East Asia and Pacific. And basically what we found from that baseline study was that there's already a high level of private financing and provision in Asia Pacific. It may not be officially declared but even here in the Philippines when I was involved in the DOH study for

WHO I was surprised that when I went to the regional hospitals many of them were actually practicing some form of PPPs. But they are not in the radar screen of the Department of Health. They were actually doing their own very clever initiatives of involving private sector like leasing up part of the hospital for private care so that they could save more money and bring more revenue to provide some of the basic essentials to a large population base, patient base, for example. So we see a lot of growing private informal sectors increasing privatisation and deregulation but yet there's a lack of the regulatory and a legal framework. We don't have proper rules that tell us who should be keeping the profits, who should be benefiting from all the increased revenue and so on. So, there's also weak enforcement of the laws even if the laws are present. There's blatant infringement of copyrights and intellectual property rights, especially from the drug companies. And of course in the end, we are concerned about poor quality and potential safety risks. So this tells us that we have to address many of these first before we just change it. So, what is peculiar about the region? When you look at WHO regional statistics, that is in WPRO and SEARO which accounts for Asia or half of the world's population, we have the largest proportion of out of pocket payment, private financing already. So, the question you ask is that. Is it because our governments are sleeping, they have not done enough in terms of public financing in the form of introducing social insurance or new schemes? Or is it because the markets are very much alive? The markets are so alive that the private spending overtakes the public. So whatever the public sector wants to do the private sector overtakes it because our markets are growing so fast. If you look at the private health expenditure in selected Asian economies, it's more than half in China. I mean, this is of course a little outdated but many of the countries, emerging countries the private sectors are just rising far ahead in terms of consuming the lion share. This is a sort of a stylised graphical representation from the World Bank to show that, actually if you want to talk about spending more money as you move to the high expenditure in the form of catastrophic illness or long-term care, increasingly the private part will be lacking because private individuals and household can only afford up to a certain level. If the public sector's expenditures are all consumed to deal with the part that could be afforded by many individuals, instead of catering for the higher end of it, you have to have others. Where should public spending be directed at? Is it the higher end or is it the lower end? Or lower end should bring in more of private share, households income and so on. So, it's a good point. Where should the government direct its focus?

Now, I will just end by looking at a case study of Singapore. We have had about 25 years or more of experience now. We have our first hospital corporatized, the National University Hospital, in 1985 and we can share with you some of our lessons. So the World Bank in fact has in its review, in Alex Preker and April Harding's book, said it was the most advanced in terms of hospital corporatization. So, we have now what we believe is a workable hybrid model. It is pragmatic and we want to share that with you. The objective in our hospital reform is going back to the early 1980s. We wanted to avoid the extremes, if we had evolved from a welfare state model, the British National Health Service model, we said it's untenable with the aging of the population, with the shooting of the tax bases, and the increasing burden of the social care,

yet we do not want to move into the private markets model that you see in the United States where it is predominantly private insurance based that created a lot of inequities and moral hazards, and so on. So we want to actually avoid this too and the way you want to do it is to make sure you don't go to either extreme and somehow you muddle through in the middle. So what I got to show you is that well, in all standard outcome measurements which may have nothing to do with our hospital reform but more to do with our standards of healthy living, and so on. The Bloomberg's recent survey put Singapore as the healthiest country in the world, but I don't believe that because look at our mortality indicators and morbidity. We are among the top five or ten, but I don't think we have arrived yet. But yet because of our indicators in some of our public programmes now to promote healthy lifestyles and the study of some of our behaviours are going to propel us towards this. But look at the statistics at the end, look at the statistics here. You will be surprise that at the bottom, the user fees charge has a percentage of public expenditure has gone from 3 per cent to 20 to 60 per cent, 20 per cent at the level of outpatient and 60 per cent at the level of hospitals. Now, how is that possible in a predominantly public system like in Singapore? It's only when you have a public private mix in terms of financing which has taken place for the last 20 years that you can achieve this. That the government provides the services but then recovers it in the form of mixed financing model. So if you look at this, then on the balance the private expenditure on balance seems to be more than two times that of the government. But it doesn't mean that the government doesn't provide the services. Government provides the bulk of hospital services and yet is able to recover the cost in form of targeted fees, you know, differentiate it as fees but targeted subsidies to the poor. So you are able to recover more money back and then you can do more. So, on balance it looks like the private sector is spending more. So, if you look historically how we have done that if we go back to the extreme left that was the system we inherited from the British, predominantly public, predominantly public financing, as well as provision. But over the years the way we have segmented the market we were able to target the subsidies only for the poor and then we are able to privatise the higher wards. The people who want more than the basics, they have to pay for that. The only way to do that is to also differentiate your hotel services, without differentiating the quality of care. Quality of care is determined by medical needs but the hotel services allow patients to thus self-select what type of wards they want. Do they want the air-conditioning, do they want the single wards, or do they want a shared bathroom, and so on, and then you price it accordingly. But of course, that can only work after a certain stage when your total population has become more and more affluent, then they all want to have the luxurious services. So now, you have brought in means testing. So you have introduced means testing without a riot in the streets.

So, you look at public hospital bed distribution. Well, does it follow the income distribution by country? Yes, to a certain extent it has a lot to do with this. And then you look at the household elasticity of demand. How much they can afford to pay? We will then price and then also consider subsidies. If you go to the A class wards in the government hospitals, it is priced like the private hospitals - no subsidies. But if you enter the C-class, which is open ward, you got 80 per cent subsidy but somebody has got to have to pay for it, you know. But of course there are

waivers and there are also some other schemes to help the poor. But the result I can share to you this took place as soon as we did the hospital reforms and it worked from 1985 onwards to 1995, we saw there was a dramatic shift so there was no adverse effects on equity as you can see. The poor patients in C-class wards are heavily subsidised. It went up because they know where the subsidies are. So the poor people will be all going for the C-class wards. Whereas the rich people, you can see has not grown too much in the A-class. So this is how people gain the system until recently we have to bring in the means test because we find rich people also move into the heavily subsidised C-class wards, because they have been improved.

So you look at the price analysis of public and private hospital as a result of corporatization reform. The public hospitals in fact are suddenly attracting more patients than the private hospitals. In fact, the private hospitals suddenly are having a decline until the recently when they went for the foreign markets to attract medical tourism they were actually heading downwards, because of the competition from the new structured corporatized public hospitals. So the public private market shares I think are quite interesting. You see the reverse you expect the private sector to be growing but in the case of Singapore after the reforms the public corporatized hospitals, in fact, increased the market share. What has also happened is to look beyond just the infrastructure changes, the super structure changes, is to look at the way we incentivise doctors in the public sector and the way we pay our providers in the hospitals. We have a consultation fees scheme that allows consultants in the public sector to also see private patients and to receive fixed fees. These are the A-class patients. So, we incentivise them to have very clear rules that they are not supposed to collect the money from them. The money goes back to the hospital. It follows a fee scheme that is it fair, equitable and transparent. And it's only done by the hospitals. There is also a faculty practice plan for the teaching hospitals where a few specialists can work part time in the private sector and vice versa, especially those that are preparing for retirement. We have to say well, you know, we don't want to lose you but we want to retain you. In the public sector we allow you a limited private practice but with clear rules, so you have to declare all your income and the patient referrals and so on and that is done by the hospitals not by the doctors. We also have in the primary care a primary care partnership scheme, where we contract GPs so that those patients who will otherwise not get the service because the government polyclinics or health centres are too far away will be able to receive basic care from GPs but at rates that are set by the government. In other words, what the government is really paying for patients to attend their clinics will be charged, that's the same rate to private GPs who come into this scheme. So this has worked well in terms of expanding our outreach and our access. But going forward, I think that this is the kind of public private mix in provision and financing that we want to develop in Singapore. The government will have to be there to be the moderator to make sure that we develop new types of financing, way beyond taxation, to medical savings and medical savings would provide the premiums into social insurance and you also want now social insurance to be targeted at the basic essential package. Private insurance has come in to complement, because government cannot provide everything but you have a basic plan and then private insurance comes in to complement, not to compete, but to complement your basic scheme.

So my concluding slides, where is the public private optimum balance in health systems? Context, context, context; you have to take it in the context of your own national system, your history, where you are at now, in terms of the social, cultural, political system. So, I would like to say that the lessons we have learned looking around the world especially in Asia, is that we need to increase our universal health coverage of basic public healthcare. The floor has to be a level playing field for everybody. Then you have to allow some choice for those who want more, if they are not satisfied with the basic public scheme they can opt for the private schemes. You also have to allow for competition between the two sectors or between the three sectors. At the same time you have to integrate them, you have to integrate them in such a way that is complementary and is not unnecessarily competing unhealthily. So the proper mix of provision and financing will be very important, if you don't want to finance the rich but you want to target your subsidy for the poor and you want to select out the rich to buy other complimentary and private financing like insurance. So, co-payment to a form of means-testing will be very important but not every country can go through this. It'll probably be for the more advanced countries, who are able to ensure proper governance to target the subsidies or even charge higher fees and will collect the fees. So different fee schedules based on the affordability of your patients will be coming as far as I can see and of course, the government essentially has to set the benchmark for what is right pricing because that will send the signals to the public and private hospital too, and quality. So, government has to put its own house in order to set the benchmark so that the private sector can provide the complimentary services.

I don't have time now but just to let you know that we are embarking on another update of the evaluation. We have like 25 to 30 years now between these countries of corporatization. So we are now together with the former Secretary of Health in Hong Kong, Prof. EK Yeoh and some of the collaborates in Malaysia and Singapore to regularly compare. These three countries or three systems that have evolved from the British type national health tax system and how has it differed in terms of PPPs in the last 25 years or more. Thank you very much for your attention.

Case studies in Europe
Speaker: Geoffrey Hamilton

I'm going to speak about the experience of public-private partnerships in Europe, and my presentation is organized as follows: I want to start off with the definitions, we've got four types which we've identified focusing on hospitals, I want to discuss the potential benefits and the risks which have to be managed, the success factors, and then projects that are most appropriate for developing and transition countries, transition countries are the former socialist countries of Eastern Europe and now the Commonwealth of Independent States.

Well typically, in PPPs in hospitals the government signs the contract with the PPP operator for the provision of the facility, the equipment and services through the life of the project. The PPP

operator finances construction, builds the facility, maintains it and upgrades the equipment and provides specified services throughout the lifetime of the contract. Often the PPP operator is also responsible for designing as well, within the outputs specification. So, it's quite a considerable amount of tasks that has to be done. The incentive is provided by the periodic payments, which the government gives the private operator after the facility is commissioned and these payments are usually indexed to annual inflation. Now, payments are for something that, which is absolutely the critical distinction, that PPPs is different from normal public procurement. It's PPP for outputs rather than inputs. An output, for example, is the degree of light in a particular building. I think that's called loops. An input would be, for example, the number of light bulbs you need. I think that's the good distinction and a notion of an output is challenging the private sector to be very creative. It's up to them how they get to that specific output. And that's a very, very important distinction to be reminded when we are talking about PPPs. And payments are tied to specified performance targets, very difficult sometimes in a PPP contract to actually identify the output specifications in the key performance indicators, but the payments are critical to incentivise the operator. That is something that has to be properly monitored because as I said earlier this morning, it's that which gets the performance going, the penalties and the rewards, tied to the contract and its proper implementation.

There are four broad types of public-private partnerships. If we could start with the bottom one first, the one that's been practiced by the UK, Italy, Canada, Australia, is very strictly about the facility not about the clinical service. So, that's dealing with the buildings, the ancillary services, but it doesn't touch, if you like, the doctors, the clinical services. And this is the Holy Grail for some countries. I know the UK is concerned about the other model, the integrated model, which combines clinical services with the non-clinical services. Portugal started it. Spain has come, if you look in the discussion paper, there is an evaluation of the Alzira programme in Valencia, which is attracting a lot of interest where the private operators are paid on a per capitation scheme, which means that the private operator is basically given an incentive not to put people out of hospitals, so they're trying to, you know, not obviously incentivise, but they are trying to improve the health outcomes of the population, which is potentially, really absolutely amazing. Because what you're saying to the private sector is make people's health better. You're not just saying make sure that they've got decent beds and the cleaning has been done. You are really doing it very thoroughly and I like extremely much this integrated project model. And in Europe, there is a tendency now for the integrated model to be favoured. And as I mentioned, I think this is the model that would best suit developing countries.

The lease contract is where a private operator receives a license or right to operate, usually for five to ten years. Typically, the operator pays a lease fee to the government and assumes financial risk and the operator receives per treatment payments. Each person that is dealt with, the private operator receives a payment for that. The Philippines NKTI dialysis, which I think, is a marvellous project is a good example of that and there are others. The other one, which is rather simple, is the private wing in a public hospital, which is owned by a private operator but it's part of the public sector, public hospital.

Well, the potential benefits and risks to manage all these operations, well I think the first lesson is that the greater the transfer of the risk and responsibility to the private sector, the greater the potential gains in efficiency and service delivery. The private management, the delivery of health service and not just the infrastructure and non-clinical services that can result in higher patient volumes, lower cost and higher quality patient care. The downside though is that it's very important, therefore, and increases the need for technical assistance because as I said before, the public sector, the hospital staff, the people involved in the running of the hospitals, they haven't got experience of contracts. They don't know how to structure these contracts, and well, obviously, it would be very beneficial for lawyers and that's absolutely fine. I'm also very interested in the moment about using PPP for the renovation of buildings because would you believe, the Palais de Nations in Geneva, member states are wanting to look at the PPP model as a mechanism to refurbish the Palais des Nations in Geneva. This is the old League of Nations and all of the sudden this is now my responsibility to talk about this. So, I'm very interested to actually see the possible benefits and risks associated with the actual buildings related to public-private partnerships.

The risk in hospital public-private partnerships concerns particularly technological change, that's the major thing, and who is to bear the responsibility for it? Because you have to make sure that the new technologies are incorporated and this creates risk for the private operator if they are required to upgrade equipment. As they will not know when they signed the contract, how much this is going to take. So, this particular risk up to date now has been addressed by sharing the cost between public and private entities. Well, the success factors are, first of all, the new greenfield facilities that's starting from scratch. With new hospitals it's politically much easier to deal with then. Great attention is needed to regulate particularly in these PPP sectors to make sure that patient's safety and quality of care is protected. Generally, the public sector tolerates, I think, mistakes in a public hospitals much more than PPP. If you look at some of the Canadian experiences, just for a moment, there were a couple of fatalities just as a transition between a hospital and its mechanism to PPP was taking place, and the two people who died sadly, it had really nothing to do with the PPP, but it was perceived as being done through a PPP. Well, sadly people die in a hospital, that's sort of an inevitable but that created a huge outcry. And I think that is why I was talking about this ideological sophistry, the absolute intensity of debate around this and a need to have real regulation. There has to be, and as I say I mention here, when you saw privatisation taking place in the water sector, power, telecommunications, immediately set up an independent regulatory body but there is no similar entity for regulating health PPP contracts. So, that really has to be attached. Procurement is very difficult I won't go into too much detail only to say that it has to be open, transparent and fair, and again the approach is purchasing of services not assets or equipment. Finally, one of the aspects is what I call showstoppers, that is, when the whole thing goes belly up and it doesn't work, and here that happens in the legal frameworks. Here, first of all, the legislation when you look at actual countries, there's a clause, which publicly states that the delivery of services is a monopoly by the states. So, that is a showstopper. You have to start to

basically improve your legislation or make it possible for the private sector to come in. You have to remove the curbs in competitions related to the monopoly provisions in the legislation. Very important is international accepted standards of dispute resolution. Governments have to accept arbitration procedures externally. Again, Turkey for example, its whole PPP programme was put on ice for ten years because it wouldn't allow disputes to go to foreign courts, and literally speaking, it stopped. And also although Turkey has talked about and if you could read in the discussion paper, they've got a massive, massive, massive, PPP programme in hospitals for the next five to ten years, they want to increase the number of beds, that is absolutely massive. But what they don't do is to allow the creditor what's called stepping rights when things go wrong, the lender can come in and actually take over the operation. Turkey legislation doesn't say that's possible so there's a real barrier here and also internationally accepted termination provisions and compensation. That's another showstopper, if it's not balanced and if it's not properly negotiated and full foreign exchange convertibility obviously as well.

What projects do we advise if you like countries to take forward in private public partnership? If we take first of all poorly served areas, what we are talking about is primary care, rehabilitation centres, outpatient medical diagnosis and treatment centres, outpatient medical labs, these are excellent. These are very, very good as public-private partnerships, they are easier to regulate, it's cheaper to treat people in these areas than it is in a hospital, it's cost-effective that way, and there's a lot of evidence that these types of facilities run as a PPP lead to higher quality and lower costs. In types of projects related to the second category, that is, where the facility is low quality or where the management is inefficient, here the types of projects we are recommending is dialysis centres, special accommodation services, which is the sort of private wing in a public hospital and outsourcing of cleaning and catering, and here the advantages are, well, first of all with dialysis, there's a growing need for dialysis and it can be done in outpatient clinics. It's not necessary to have them done in hospitals and the private sector now is taking over the package of services - not just selling the equipment but actually servicing it and taking it away from the costly public sector's maintenance, which is for me an absolute win-win situation. I've always been a bit suspicious about private wings, private hospitals, private wards in a national health service having been brought up in the UK, I've been taught to be very suspicious of that. I can't tell you why I'm suspicious of it but for me I just, oh no, it's not fair it's something about jumping the queue. It's something you should not do. My father-in-law was getting an operation done just a few weeks ago and he was in a public ward. And first of all, I said well, can we get him to the private ward? He refused to even think of going into a private room. And this notion of jumping the queue is extreme. And incidentally, he's got the top, top class treatment and he's making a good recovery. So, this one I talk about the downside - maybe the equity considerations. Outsourcing services is probably the easiest but it doesn't have a huge impact on improving quality of healthcare. Frankly, the food in the hospital for me is never going to be particularly good for me whether it's private or not. Anyway, but that's individual preferences.

Now, what project with regards to the ones where there are high investment needs and high management needs? Well here, we are talking about the buildings, the hospital equipment, the managing of this public hospitals, and here, the equipping of oncology centres, the cancer hospitals and so on. These again are the sorts of projects that should be promoted and advised for the reasons that they do now tend to see as leading to improved management and service quality through, first of all, in the PPP cancer treatments, which are expensive. There is now evidence to say that these are quickly done on a PPP basis with the private operator taking charge particularly of the technology, the diagnostics, the radiotherapy and these would certainly be very useful to be done.

Well, finally the conclusions, I'm going to be quite bold and again, as I say I'm happy that there are not one or two well-known detractors of what I'm going to say, not in the audience, but you are very welcome to criticise me. I think the experience of PPPs in health have been very successful. A lot of criticism is made of the British PFI and how expensive it is. There has been a lot of discussion in the cost of changing light bulbs in PFI run hospital vis-à-vis the normal. And lots of stuff in that and I think these where I would call teething problems, teething trouble, but that's not to say the fact that a colossal number of hospitals has actually been built in the UK on time, and to the budget and has transformed the landscape of hospitals from the old Victorian hospitals to the new modern ones.

Rising health costs are due to what we all know with aging technology, these costs are here to stay. They're not going to fall in any way, so basically, the only show in town – that statement was made by Alan Milburn who was the first Minister of Health under the Blair government. And he was so confident. He said: PPP, PFI, only show in town. And I tend to see that as well.

I would like more information on the integrated hospitals. I think they offer most promise to developing countries, because in developing countries' situation, it's the package of management skills, the management of the clinical facility, as well as the management of the hospital. So it is that integrated approach which I think is best suited for countries, which lack that skill. And in my region, the transition economies, that's totally lacking. There's disability to provide that package of skills. Hospitals of course are very expensive to put patients in, and we could probably investigate primary sector, primary care, as well in the outpatient facilities and do that in public-private partnerships. The only problem is attracting private sector into primary care. It's desirable but sometimes it's difficult to attract private companies to go into outlying areas and to make a profit on that basis. Thank you very much. Thank you.

3.2. Reflections on Best Practices in PPP in Health

Speaker: Jill Jamieson

Thank you very much. I love this time. After lunch a couple of speeches behind us, everybody is sort of in that low. Some of you have jet lags so that's awesome as well. I actually went to a

presentation recently, and I'm not making this up and it was a Nobel Prize winner and he was speaking and there in the middle of the speech, he was seated, he fell asleep during his own speech. So, if you can put me at that expectations level, I try to exceed it a little bit. No, it's a pleasure to be here today. It's hard to follow such informative presentations like this. A lot of what I'm going to say has been discussed in some form or another. I'm going to try to drill down. It's not really so much the private sector perspective but it is how really to structure good PPP in health sector transactions. The case has been made by every speaker up here today, so let me do it one more time that there is indeed a pressing need for reform in the health sector in terms of financing. Increasing ages of the population, just revolutionary changes in technology, as well as the need for improved quality and reach in terms of public health has been driving a lot of reforms. Every country in the world is scratching its head right now collectively, looking for alternative ways to finance its infrastructure. So, governments are turning to the private sector, some more so than others, some are embracing the private sector, some are running away from the private sector, but all of them in some sense are looking to the private sector for ways to help them increase the accelerated delivery of infrastructure, deliver improvements more effectively and efficiently, more cost-effectively, and basically, to enhance the quality of service. A few of the truisms that probably should be discussed globally, healthcare is a government responsibility but every single country across the world, including North Korea, has some level of private sector participation. So, the term PPP in health is not a new one. There's always been some level of private provision whether its private sector financing of their own, you know, buying their own drugs, whether it is going to an alternative medicine doctor in the mountains of Ecuador, where they will blow flames on your face. Whatever it might be there has always been some level of private sector participation. Now, over the last 50 years there have been some great studies on this spending on healthcare by countries has increased 2 per cent above gross domestic product, which means that the cost of health care is increasing more quickly than our economies are growing and this puts an additional burden on each and every one of us, there's no doubt about that. Competing infrastructure in public service needs also to be taken into account. It's not only health sector but also it's education, it's infrastructure.

If you look at some of the numbers up there, globally in 2010, OECD countries spent about 9.9 per cent of gross domestic product on healthcare. That's expected to increase to 14.4 per cent by 2020. Brazil, Russia, India, and China are at 5.4 per cent increasing to 6.2 per cent by 2020. If you want to look at some extremes, the Philippines according to the World Bank spent 3.6 per cent in 2010, the US, which is the highest spent 17.9 per cent. I'm a proud American today, it's very expensive in America to get healthcare. But it's interesting because you say oh, does that that mean that in America it's harder to get healthcare? Not necessarily. In the US our government only pays for 47 per cent of our healthcare. In other countries, they may pay, for instance France, 92.9 per cent is actually paid by the government. So, the burden to the state will vary significantly according to how much of your GDP you are spending and what percentage of that is actually coming through public funding. That in turn will impact how desperate you are to turn to PPP in some form or another. There are also significant differences

in terms of jurisdiction that will affect significantly best practice. Take the case of Austria. In Austria, all doctors are civil servants. They're given full pension from the state and they have no incentive whatsoever to leave that cushy job and it really is quite good benefits. So they when turn to PPP, it's really only for facilities management. They want to build the hospital, they build the clinic, maybe they'll do the IT but the public sector provision is not something that's going to be considered. When you look at other examples like Spain, Canada, there have been examples where even public sector officials have gone to the private sector. So, there's a wide range of differences that can be contemplated when you're considering what is best practice in PPP. One thing that I think does need to be said because it's been referred to a number of times today is, infrastructure is really the smallest part of your health care cost in Asia. 5 per cent, only 5 per cent, 95 per cent of this is not in hospitals and facility maintenances, it's in your doctors, it's in your pharmaceuticals, it's in your IT and your equipment. This is really important because as Geoffrey and others have said, it's not about just building the infrastructure, it's about delivering healthcare, and of that infrastructure is just really a very small part.

This is just a graphic showing what the percentage of GDP or health care cost or percentage of GDP and what percentage of that is actually covered by the state. Almost impossible to see, I am sure the UNECE and ADB will publish these slide so you can take a look at, it's from the World Bank. But it really does show as I mentioned a great disparity in terms of what the public obligation is when it comes of healthcare spending across the globe. Everyone has referred today in some reference to the UK PFI system or private finance initiative system which is seen by many as being sort of the origin of healthcare PPP. In some regard its true, in the 1990s as you all know, Margaret Thatcher was driving privatisation, the Iron Lady was all over the place, and she pushed into the national health system and they did amazing things with PFI. PFI, is basically, for those of you who are not that familiar with it, is kind of like a long-term lease agreement where the private sector will finance, design, build an infrastructure facility, and the state then uses that facility based on a monthly availability payment, which is kind of a rent-like payment that can be deducted if parts of it are closed or not up to that standard and in some cases there are performance bonuses if it's being operated very well. Because of this in the 90s of the first 12 years, they built over a hundred hospitals, which is awesome, and really you know, for the entire programme I think it's 250 hospitals that have been built. So it's an amazingly successful story but it's not one that should be replicated by everyone. I worked in many, many countries across the globe and I see people out there saying we need to do a PFI for a hospital because we need to do a PFI for a hospital. It may not be in their master plan; it may not even be necessary. They may actually have excessive infrastructure facilities that they can even maintain and operate, but they think bright shiny new hospitals are exactly what they need. So, a word of caution, while the UK has mixed results, as I think Geoffrey rightly points out, there are many people who criticised this but they did build a lot of infrastructure, they needed the infrastructure at a minimum. A lot of countries are actually over-scoped in their infrastructure. It may not be the most modern; it may not be the most effective. But if the parts of your hospital system that you are not even utilising today, if you can't even maintain it, then

you might want to think twice before you go into full new facility. You may want to do some sort of rehabilitation, operate, transfer.

This has probably been referred to you a number of times today as well, but I'll give it to you in a different sense. When we talk about PPP it means a lot of different things to a lot of people. I'd like to use this graphic and I'm going to give you a nice analogy that you can take home with you. On the one side, we are looking at privatisation. Privatisation is what I like to call it's like a divorce, right. The state is getting rid of something, it's selling the assets, it's done with it. It doesn't mean your relationship is entirely over. There may be a regulatory requirement, kind of like we pay alimony, so there is only some sort of post-divorce hangover, right? In the middle, in the blue part, this is public-private partnership and here's a wide range of modalities and contracts, so it could be the BOT, it could be a concession, it could be PFI, it could even be management contract, lease agreement et cetera. Now, the difference between privatisation and PPP is whereas privatisation is like a divorce, PPP is like a marriage. And many of you probably know that marriage is much more difficult than divorce. It requires a lot more effort; it requires a lot more relationship management. There will be disputes. If any of you are married and have never had a dispute I would like to speak to you after this conference. But certainly, there are going to be all kinds of differences, and if you want to take the analogy kind of to an extreme, on the left hand side that's traditional works and services, that's where the government is outsourcing, you know, construction services et cetera. I'd like to think of that as bachelordom right? You're dating a lot of different companies. You're doing some more work for and the truth about bachelordom is many of you men out there don't probably know is that you're always bankrupt. You have no money left over at the end of the day. So when we talk about PPP, were talking about sort of the blue area. But again, your jurisdiction, where you are, the Philippines, your BOT law is going to be very different than a BOT law or a concession law in Latin America or Eastern Europe. So you're going to have to define this yourself in terms of best practice, regardless of there being a methodology for determining how to do PPP in the health sector and it's not really that different than what we do in other sectors. I like this graphic because it really does lay out systematically. There is a systematic process for determining what you want to do. You have always at the bottom; you have sort of your project components, so when I say, what is the service that you are delivering, whether it's a road, or a hospital, or a health facility, there's going to be probably design, build, financing operation, maintenance and ownership of the asset. Above that you determine, what is the public sector in your jurisdiction actually legally allowed to do? What's your responsibility, what's not your responsibility? What must you legally continue to provide and this might require some legislative changes if you want to send some things to the private sector. Then you define your project needs, this should be in the health sector particularly based on master plans. I've very, very meticulously done qualitative and quantitative analysis. If you just make this stuff up, you are going to have disasters. PPP is just part of the process for delivering infrastructure but the decisions about the infrastructure and services should be made as part of your sector planning and your long-term planning. Then you determine who gets what? Alright let's give financing to the private sector, let's give clinical services to the public sector, let's give catering to ... I don't know, somebody

else. You want to figure out how you're going to bundle these services and whose going to get what. So it's a pretty simple process, unless it's just another way of looking at it and sort of a health sector PPP. On the left here I have the financing, the design and construction, facilities, maintenance and catering then you go on to sort of support services, some IT, equipment and supplies, and as you move to the right in the completely illegible blue on blue graphic, we have things like clinical services, and those sort of things. So, you have to determine what it is in each of your cases. No contracts are going to be exactly alike because even in one region in the Philippines, you may not need the exact same things that you need in another region. So, you want to design these. It has to be tailor made. As somebody said earlier cookie cutter approach never works in PPP. It's as much an art as it is a science. In fact, it is not a science at all it really is an art. So this is essentially how one would go about structuring a contract. This I will not dwell on, because every single speaker before me has said it and I don't want to be the speaker that puts you all to sleep. But we have sort of a pretty standardised list of health sector PPPs, Whether its facilities co-location, which Geoffrey does not like but very common in other places. I understand why he doesn't like them, cutting the queue you know, when it's ripe for corruption as well, paying the doctor 50 bucks to get service before somebody else, management contracts, lease-back where you are actually leasing facilities to the state, PFI, BOTs, as well as divestitures. So you have a whole menu of options that you can choose between when you're designing your health sector PPP.

Now, this is your basic structure. This would be sort of a PFI model, the facilities model. It's a pretty simple model, you have the delivery of infrastructure, you have construction, you have lenders, investors, sponsors, et cetera. So, the private sector will come in, they'll build the facility, and they'll get paid back. If you see the line up top, availability payment, it is usually paid to some sort of standardised sort of lease-like payment that's paid back. Changing a little bit, if you add clinical services which, if you can see the differences on the upper left, it changes a lot of things. When you are using a clinical services based PPP, it includes facilities and it also includes the delivery of health care. In these cases, generally speaking, payment is made through a per patient payment. Usually insurance based or something along those lines. But it changes the dynamics. So, it is no longer a regular payment. It is actually based on a number of services so you have certain demand risk and other sorts of risks. Often it can be a hybrid or both, availability and a per patient payment. One of the critical things, and I think, the gentleman before, Matthew from GE, today was referring to this as well, is what happens in technology. Absolutely, the world has changed. You know, now a piece of technology might only be good for two years, three years, five years before a new shinier, nicer kind of thing comes out. In the health sector this is a difference between life and death, so requiring a private operator to put in the infrastructure, in the past, the IT and the technology, in the past actually was very risky. Very few investors were willing to take on that risk because they knew it will be obsolete and they couldn't project out their costs. Increasingly, we're seeing in consortiums, we're seeing actually groups like Siemens and GE and these guys are coming in as well and joining part of the consortium and are actually taking on some of this delivery risk, which is very important, and these cases that are usually also per patient but there are usually

some sort of automatic adjustment for new technologies that can come in. So that's the sort of the three models of PPP as we see them in health sector.

Interestingly, health sector PPPs represent only about 10 per cent of all PPPs in the world. In some countries like Canada it's as high as 30 per cent; in other countries, like the US, we don't even call them PPP because they were private hospitals. But as I said before health care infrastructure represents only a very small part about what is keeping people healthy - less than 5 per cent or at 5 per cent at the maximum. So, increasingly, in PPP we're seeing that shift that everyone has spoken about from infrastructure to service delivery. And it is an evolving science and art. There is no one-size-fits-all answer. Each jurisdiction is kind of making this up as they go along. This is the history of PPP. The first PPP we did, and this is the sad truth about me, that I was actually working in PPP before they even called it PPP, which is kind of sad about my age. But leaving that aside, this is how it started, you know, there was no best practice in terms of road concessions or airports, so we had to sort of figure it out as we got along and this is what people are doing and I do think it's a good initiative to try to create this Centre of Excellence, so there's a one-stop-shop for best practices. There is a shifting role as I mentioned before, from service provider to regulator from the state perspective, and again there's an increasing attention as well in terms of IT and technology solutions. Also, there's a changing in terms of the design of hospitals, as I'm sure most of you know. You can't design a hospital for 30 years any more. You have remote doctoring now, you have surgical centres that you don't need beds any more. What you need is radioactive controls, and I don't know, the doctors out there can tell this more than I can. So, you need adaptability in your infrastructure. And when you are designing these contracts, make sure that what you're asking for in your facilities is completely adaptable. And if you look at some of the examples that we'll point to right now, all of these new hospital facilities are absolutely adaptable. So, where you might put two or three beds, you can also put a surgical centre, you might also put a triad centre. They are completely different. Last year, it was a banner year for health sector PPP. In Europe, over 4 billion dollars in health sector PPP were announced. In Europe we had the Karolinska Hospital in Stockholm, which is heralded as a very significant event. McGill University Hospital, in Canada was also a very well-known and heralded 1.3 billion dollar facility completely state-of-the-art. There's not anything in there that allegedly will become obsolete for the next ten to fifteen years because it's all completely adaptable and very much tied into latest technologies. Ten billion dollar in health care in North America and Canada in the last five years, which is enormous for PPP. In Africa, I think, it was in 2010 we had in South Africa, the world's largest PPP, which was 2,964 beds. I can't say the name of Chris Hani Baragwanath Hospital, but it's South Africa, it's good enough. Royal Adelaide Hospital in Australia is also one. In Malaysia in 2011, 300 beds and capacity for 735 students, the International Islamic University in Malaysia. So, globally there's a lot of activity in this, but again, none of these two are exactly alike. And so, it's an interesting case. I think this morning, Geoffrey mentioned that a lot of these contracts are not available. Actually, a lot of them are as well, because they are led through administrative procedures. In South Africa, you can get their model contracts; in India you can get their model contracts; in Latin America it's obligatory to publish your contracts, as they are in other places. It doesn't

mean you should look at them and adopt them. It just means there are reference points out there and you can see which ones have gotten a financial close and maybe some of the determination agreements in that sort of things that are important.

Okay, so I told I wasn't going to allow you to sleep and so am not, I promised. Let's look at some take-aways from this. They are still doing a lot of studies on this but if we look at international experience over the last 20 years, they state that there have been between 20 to 30 per cent savings on the cost provided in the healthcare services through PPP. In Spain, in the Alzira model that Geoffrey mentioned earlier, very fascinating case study. If you haven't read about it, you should. It started out as a hospital PPP but because of the perverse incentives, to just get people out, they decided that they would make it into a regional primary care PPP which has been quite successful and it's a model that many countries are using. After about 15, 20 years they have done the analysis and it resulted in a 25 per cent savings in overall healthcare spending in that region which is actually quite remarkable. So, people who say that PPP are always more expensive, now you can say, ah, but have you heard about the Alzira model. And now you can cite 25 per cent savings. The majority of the savings are not derived from infrastructure, and this is key to know. It's actually derived from the other services including clinical services. Infrastructure facilities maintenance, okay, there can be and there should be life cycles saving or you shouldn't use PPP. But the majority of the savings that we found globally today have been not through facilities and not through infrastructure.

There has been quicker delivery of infrastructure, which is a good thing and more efficient infrastructure service provision so that's also good. These are positive aspects of PPP that have materialised. But there are some challenges in the PPP sector for health. Changing healthcare requirements as mentioned. It's a moving target. And you try to contract for 20 or 30 years on a moving target so you need to build in flexibility into your agreement and you need to build a renegotiation procedures that are fair and transparent. Labour issues and costs. The Philippines does not have this problem because you have a very broad and vibrant private sector, a healthcare sector. However, in other countries, where doctors are civil servants and unionised and other things, it can actually become quite difficult to negotiate the terms of agreements, things like what you do with the public pension if they're going to go to the private sector. These sort of issues will keep us late at night and greys the hair a little bit as well. But it is one of the challenges in health sector PPP. As everybody else has mentioned, there's also a greater need for oversight and monitoring. In my past life, not really this life but before I got to the Philippines, I was an inspector general overseeing PPP in multiple sectors. And so my job was actually performance monitoring and output based inspections. Very difficult. There are two ways to regulate these. One is, as Geoffrey mentioned, maybe putting together an independent regulatory agency, the other is regulating through contract. And if you regulate your contract, you need to set up the appropriate governance structures. So, who is going to be the independent inspector on this contract, what are going to be the remedies, what are going to be the penalties, and those sort of things. So, whether you create an entirely new institution,

which in many cases is not effective, or whether you do it through contract, you do need to win your developing the contract to establish those performance monitoring measures.

So, again and the last point I can't stress enough because really, it's amazing to me how many countries want to move into health sector PPP just because its bright and shiny. And it needs to be right-sized; you don't need mega hospitals if you don't need mega hospitals. Look for efficient use of your infrastructure because it will overall lower the cost of healthcare in your country. So, in terms of prospects and potential, certainly, there's significant need, this is a great area to be in, I think it's a fabulous idea to create a Centre of Excellence in no better place than the Philippines. PPP should be targeted to meet the country's specific healthcare needs. It cannot be generalised what's going on in Australia is not the same in Singapore, and is not the same as in the Philippines. Each country needs to identify its priorities and align its PPP initiative accordingly. New investments in healthcare should be linked to the right sizing of the hospital sectors as I've said redundantly now. PPP also should aim to address the full life cycle of assets including service provision. Again the savings have not been in facility delivery or maintenance it's been actually in other services and the authority should look beyond infrastructure to the broader based health care delivery. There are challenges. The legal framework is always a challenge as I think everyone has mentioned. And also because these are particularly complex, public authorities often don't have the capacity initially to manage these contracts well. And if we go back to my marriage analogy because I do like to talk about relationships a lot, if you go back to the marriage analogy, you know, a public private partnership is a marriage between the public sector and the private sector and both need to be competent spouses, right? So, to build up that capacity, all the women in the room know what I'm saying if you wish you could have built up a competent spouse right and the men probably are saying that about the women. You want to make sure that the public sector actually has the right toolset to resolve disputes, to renegotiate contracts, to regulate effectively without being combative. And this sort of things takes some time, so it's important to build up that capacity both internally and also whether it's an independent regulator. And as I said, the PPP need to be designed in a way that they are carefully tailored to meet the specific needs of your country. So, I leave it there because I think the rest of this is somewhat redundant from what has already been said. I thank you for your attention and I hope I didn't put too many of you to sleep. And I didn't fall as sleep so I think it's a great victory for us all. Thank you.

3.3. Open Forum

Questions/responses from delegates:

1. **Juan Antonio Perez III**: I'd like to inquire from Geoffrey about his statement that PPPs in primary care facilities could work well. It's just that in the Philippines, we are coming from a context of low investment in health for the past 20 years or more. So we have large needs in health infrastructure, we have 4,000 barangays or villages that we consider difficult areas, we call them geographically isolated disadvantaged areas and there is no infrastructure

there. It takes a great amount of sacrifice and expense for health services to be delivered there. And so, I actually think while you need investment in infrastructure, investments in primary care should not be seen as minimal but you know, it's also, because of our particular geographic context and I don't know maybe Indonesia and other archipelagic countries are in the same situation where there is a great geographic maldistribution of facilities and personnel. So, if you want a midwife to work in a distant island barangay, which is 5 hours from town by boat, and you can only travel by day, it's really more expensive to put up those primary care facilities and I wonder if that makes it more attractive for PPPs to work in that context or would it be more the voluntary organisations, relying more on corporate social responsibility, or maybe eventually LGUs have enough capacity because there are limits to what LGUs can do. They might contract out private providers for these areas but only if they have the resources. So, I was wondering if there are examples of where that has really worked, you know, investing more in primary care so that you can right-size in a way your infrastructure for hospitals, et cetera.

2. **Risma Sitorus**: Thanks for your question. That is part of my question actually because all the examples are from the rich countries. From your perspective what kind of PPP type is the best for a country like Indonesia? And second, perhaps I'm wrong, the goals of the public and the private are of course different. For public goals is that, how to serve or to give the best quality health services for people. For the private goal I think, to make much money. So, how to link these - I think there's a gap there. Now Indonesia is preparing to have the PPP programmes especially in health. Not done yet because a lot of things to be considered. So now perhaps you can explain how to fulfil the gap as I've said and also, what kind of PPP because a lot of method of PPP that you explained today. Thank you.

3. **Teresa Jenna**: My question is as I noticed that on the outline of Jill all the services there were hospital based. I'm wondering because I've been looking at efficiency in development of PPPs both from rural areas and for urban areas. If any of the models that you, any of you know, included emergency medical services, home care services in addition to the hospital services. And if you know the models, if you can give us an example.

Responses from the panel:

1. **Geoffrey Hamilton**: Thank you very much. These are, gosh, they are difficult questions but with regards to the Philippines in primary care, our analysis of the Lesotho project, the one in Africa, which I think is par excellence. Actually, part of the deal was refurbishing, modernisation of the hospital but also the primary care facilities, it involved 3 clinics in the sort of area but they were delivering private care in a public private partnership basis. So, obviously the deal was struck and I think it was actually one of a few contracts that we didn't get any information about. Actually we would be very interested to know what the deal was between the private entity and the government of Lesotho. There was a package there, maybe there was a negotiation and I would argue that you could maybe negotiate

with the private sector. If they take over a hospital they got those, perhaps, benefits but would they be able to actually go to some more difficult areas. I think that's the package you need to sell to the private operator. Take the clinics, take the hospital but you've got to do the clinics and that's the whole deal but heavens above it is difficult in geographically diverse areas. On the second question, on the model, I'm sorry. I think my reply to the Indonesia question is really, start with the low-hanging fruit. Basically get the easy winds. I think go for the lease contract with the dialysis model. That is a win-win situation and that can build up the expertise to advance public-private partnerships and spread them into the full-blown hospital sector. I think that's actually what the Philippines is doing, that's my understanding. I think that would be the way forward.

2. **Jill Jamieson**: Yes, they were very good questions. I was kind of hoping that you had dozed off there for a moment but no apparently you haven't. Actually I want to address the question of public and private sector having odds or being at odds with one another. You are absolutely right, the private sector does want to make money but when you're designing the contract, you need to design the incentives so they are aligned with that. If what you want to do is to make sure that they deliver world class highest quality services, you incentivise them to do that. So they only get paid when they reach a certain threshold in terms of quality. This is why these contracts are so complex. They have to be meticulously designed taking into account the incentives of each of the parties. And as Geoffrey has just pointed out, I absolutely agree. Rural health care is not outside of the scope of PPP. We often include it within what we call more generalised contracts. So, you can give somebody a hospital and then require them to the mobile maternity clinics throughout the entire region. We have a number of examples of that and I'll just get back to you individually with some examples of those cases. But hospital PPP will not work if you neglect the broader primary care in the regions and so it's an issue of tying those things together. They're very good questions.

3. **Kai Hong Phua**: Thank you for those questions. Those are precisely the kind of questions you should be asking about. What is appropriate for countries at different stages of development? And context here will be very important, and what works in one context, at a different level of development, that you know works somewhere else. You want to apply some of these basic principles of development economics and what is peculiar about health economics. Actually, a lot of lessons that you could apply. There is no point talking about the high-end, high quality stuff, we're not even there. I mean, you cannot hope to run when you don't know you can't walk. So, I would say you segment the market into different levels. And we have done that for WHO. The World Bank has its own three category scheme. Low-income - no matter how you slice the cake, you don't have money, you just have to then emphasise overall development before the country and economy can be on the take-off stage. Now, the countries that are in transition, take-off stage, the countries that have probably the best potential to address PPPs. Begin from a lower to a middle income country, a lot of development is going to tear the sectors apart, you know, if you don't watch it

there'll be a lot of inequity. Some people want higher quality and they can afford to pay. Some people want more efficiency. Others will then be left behind. So, the government therefore has to provide some form of governance to make sure that the disparities and the inequalities will not be accentuated in many, many transitional economies, among them, the Philippines. So, while we're chasing all these different kinds of arrangements, government has to play the moderating role of making sure that equity concerns will be addressed. And so, what is the best form of financing really would be some kind of income redistribution, some either from taxation or from a social insurance for risk protection for those who cannot afford it. So, you may have to then move away from your fee for service or your out of pocket payments into some form of a risk protection through insurance or some kind of income redistribution from new types of taxation modes. Well of course, if you're like developing, you are talking about maybe too much over-expenditure, over-consumption and then you're worried about cost containment and therefore some other kinds of financing will have to come in. If you were to look back at some of your concerns about the poor countries, how to serve the rural areas. There's no two ways about it. I mean, some kind of redistribution has to come, whether it is through mandates or regulations. Redistribution that has to come in terms of financing. But in terms of human resources, I think the old WHO formula, there's nothing new, utilisation of local resources, community participation, inter-sectoral collaboration, remember those terms? WHO? Those are PPPs! So, it's no new knowledge. I think we just have to reinvent the wheel and put it in today's context, how will be able to mobilise new resources, traditional resources, bottom-up approaches, together with government's good stewardship and governance. Having said that, then, what is that kind of mix that will ensure that many of those things that private sector does not want, where there is no money to be made like emergency services, and home care and adult care, what will you do? I think that will be the role of government. This is precisely where you have to decide where government wants to help out the ones that basically you can't hide of. In other words, there's no need for you to keep up subsidising the rich. If they want high quality and faster services, charge for it, bring in user fees and these save your limited tax resources for the public purpose, and continue to use it for planning health care in the preventive services. I think the financing mix will have to develop and evolve and you have to have some kind of allocative efficiency, because if you don't allocate efficiently, you end up with inequity. The problem with the health services they are already technically efficient - we try to reduce inputs to get more outputs and usually we are very good at that but the allocative efficiency was never addressed. All the resources will end up going to the high end services but government have to redistribute and government therefore have to segment the market and to be able to bring in new financing the way you can charge you have to charge. But where are you going to subsidise? You have to subsidise, otherwise you'll end up with a lot more inequities. Thank you.

Additional questions/responses from delegates:

1. **Catherine Miral:** Good afternoon. I'm from the geographically isolated and disadvantaged area of Northern Samar. I second the question of Dr. Perez. It's really hard to improve primary health care in terms of PPP also. But we are looking into another programme. I hope you have a model for us. We have started it already but it's now frozen actually. So, it's the tele-health or tele-medicine, do you think it can help us?

2. **Rostom Deiparine**: I have just noted from the speaker from Singapore that he put a question mark on the equity with regards to social franchising. I think just like PPP, for example, it really requires different sets of requirements and valuables. For example in the Philippines for social franchising, equity is very much guaranteed considering that we also have a national social health insurance wherein the poorest of the poor can actually avail of much needed public health services. Can you use social franchising for PPP?

3. **Vuong Anh Duong**: I just have two questions. First, when as a private investment in the health sector in general or in the hospital, should they be looking into getting the refund? When they invest in the hospital, they must look at how to get back the fund. And, whether the criteria of refundable in the service area should be the first priority in the private sector or not. And also joining these PPP programmes, the public hospitals they also have to pay for 30 per cent of the total fund, for example. And for such kind of funds should the government pay for it? Or the hospital, that the government subsidises? Does the hospital have to look at the interest from such kind of PPP programmes and then pay back to the government? And the other question is the project transparency in the programmes of the PPP. For example, the government requests the private sector to develop the feasibility study. And then based on the feasibility study, the government requires bidding in order to select the private company to join the PPP programmes. Right?

Additional Responses from the panel:

1. **Kai Hong Phua**: I'll take a step at the first question, which is the tele-medicine, potential of tele-medicine, e-health. I would say that with all kinds of new technologies in healthcare, in the initial stages before it becomes vitally diffused, the start-up cost could be a very, very substantial investment cost. So that will basically be much more affordable by rich countries and the potential for lost leadership is going to be very real. But over time as you can see when new vibrant technology becomes widely accepted, then the unit cost should drop. So we see for example like mobile phones and the Philippines is probably the highest per capita user is becoming so cheap now and to be able to call now all over the world. We should have seen that being applied in many areas of business enterprise not just health care, and the most remote villages would have some access to telecommunications. So, traders for example, in fisheries and supplying basic commodities like rice, will be able to use a kind of e-health to know when to increase their supplies. In healthcare, I don't know how you are going to apply that. What I can see is in the sharing of records, for example, doing public and private sectors and people are referred at different levels of health care system, the records are just filled along with them so there's no need to duplicate a lot of the diagnostic and so on which enough for the cost, just one area. The other thing if you look at how diagnostic facilities are outsourced around the world, you could be consulting a doctor in Singapore

and then the reading of the x-rays and so on, the scans and all that is done in India. That's another way in which we can compete and bring down the unit cost. So, I'm sure you can think of a lot more creative ways in which things we outsource to much cheaper sources. But what is important is the savings have to be passed back to the consumer and not necessarily to the providers and doctors alone who will make the money. So, I think there's a way the role of government could be very important to make sure that the benefits will accrue to the rest of the population. Having said that, then you asked a question about social franchising and the potential for addressing equity concerns. I'm not very familiar with what you do here in the Philippines but all I know is that the debate is very checkered, debating social health insurance whether it is in Indonesia or the Philippines. Because different people look at social insurance for different purposes. There's one group that says oh, it's an additional way of financing. But no matter how we design it, are we going to design it in such a way that it is regressive or going to be progressive? Will it be in some form of redistribution of the benefits under a social insurance? Or is it going to give more money, willing to benefit the formal sector? In fact, the government servants in many part of Asia are the ones that would be the major beneficiary. So, it depends on the where your target of a social health insurance will go. So design is very, very important. So, it may be population measure, say you are going to extend coverage but it could be very broad but it is not deep. What is more important is that in most social insurance system, you know, it's not even part of the benefit package or it is very narrowly captured say for those who are looking for an easy way to cross-subsidise. So social insurance systems are fine. While in principle it is there to extend risk protection and coverage but in fact we have to very careful who actually benefits from that.

2. **Jill Jamieson**: Well, I think that's a pretty good response to all of these things. Just a couple of additional comments. With regard to the feasibility studies and the affordability analysis, clearly, at the end of the day all of these projects have to make economic sense or they're not going to work. It might involve greater or lesser subsidies from the state, it may involve all kinds of things but the feasibility study is imperative and also are the affordability studies. Can the patients actually afford to pay this and this needs to be assessed objectively and honestly because a lot of PPPs that have been done have been under the assumption that people are willing to pay money that they may not even have for health services and if that's the case the money may not miraculously appear itself. I think affordability analysis is very important in this as well. And with regard to the tele-medicine, you know that is interesting. There are always ways to structure these things. I'm not aware of any PPP that's been done on the basis of tele-medicine, however, things like value based buildings and all kinds of structures have been used on sort of similar elements outside of the medical sector and I think it's an issue of just looking at the specifics of the project and trying to design something that works. But there are a multitude of contracting structures, as I said, that can be applied and the key is to see it if it will work

3. **Geoffrey Hamilton**: Yes, I was very intrigued also about the tele-medicine. Actually, one of the other specialist centres that is being discussed within this UN initiative is PPP in information communications technology. And there was a conference a few weeks ago and Trento in Italy where tele-medicine was actually discussed as one possibility. I can see it as a tripartite relationship between the doctor, the patient and the sort of manager, and the manager would be the sort of private entity ensuring the services are actually carried out

and delivered and I can see great prospects for chronic diseases like diabetes, where they don't need to come to hospitals to check up blood sugar and all that sort of thing could be done very well by that sort of a scheme. I think what we will do is since we're now in this transition phase of a centre for excellence is we will put that down as a challenge to investigate the success or otherwise these types of models. I think I've heard actually positive stories about it taking place and then, you know, once we've got a model that we can use we can then replicate it in the Philippines. I think that's a very good sort of suggestion and I think we can go forward with that.

4. **Jill Jamieson**: Just to add on that a little bit. I actually agree. I think that it becomes almost an issue of vernacular, and what we mean by PPP. I have heard the tele-medicine with value-based billing which is the basis of this actually successful case; the IT provider is given a certain percentage. There is some risk redistribution but it's not typically in any one's spectrum of options or list of possibilities. And I mentioned this because I think as this Centre of Excellence goes forward, I think it's also a particular challenge to the health sector in terms of terminology. Most of us here today when we refer to PPP, we're talking infrastructure, we're talking service delivery. This morning we also heard from the World Health Organisation and they were talking about PPP programmes. We often refer to those sort of things that you were mentioning this morning as alliances instead of PPP and some people refer to them as PPC, which is public private collaboration et cetera. I mentioned this only because if it's confusing to those of us in this industry, can you imagine how confusing it is to people outside of it? And I think that one of the objectives perhaps of this Centre for Excellence would also be to try to standardise the language. So that when people are referring to alliance agreements using the Gates Foundation or something like that we know that they are not referring to the construction of a hospital facility and a workplace because I think it is adding to a bit of confusion. That's just my own personal view.

4. Risk Allocation in PPPs in Health

Facilitator: Solomon Castro

4.1. Who Takes Care of What: Risk Allocation in PPPs in Health

Speaker: Alberto Germani

Thank you. Good afternoon to everybody. I hope I won't bother you so much. So I will take only a very limited portion of your time to explain you this concept of risk allocation. And I'm not supposed to be a good speaker and I'm not flawless in English so the combination of the two will shorten even my presentation.

So we start talking about general allocation of the risk as per the European experience. As you see the European Union, in order to understand how was the PPP run in every of the 27 member countries, decided to commit to every country a research on what the PPP was exactly meaning for those member countries - 27 countries. The results are shown there. So, basically, what the European Union said is that the PPP can be broken down into two categories,

contractual PPP and institutionalised PPP. Contractual PPP means that the contractor will be given the responsibility of funding the assets, building the assets, operating the assets and rewards. The repayment will be through either the user charges and this is called full concession or public payments and this is called normally PFI from the UK experience, public finance initiative. The basic difference from the two is that who allocates, who is taking on the market risk. In the first case, as you can imagine that private is fully bearing the risk of the traffic or the market risk as we call it since the concessions are being paid through user charges so directly paid by the users. In the second case the state is taking on the risk of the market and is paying the concessioners through regular public payments, which are not fixed payments, which are depending on the performance achieved as we heard this morning. So, that's the basic difference between these two models, in between of them there is a PPP healthcare that is probably mostly set into the PFI initiative rather than into the full concession risk. The healthcare PPP is based mostly on the contractual model and is based mostly on the repayment […] through public payments. Nobody's willing to take the market risk from the private sector, of course, and especially not in the case of the healthcare. Concessions are normally applied in cases such as high risk in transport system in which case effectively the risk is being shifted from the public sector to the private sector, but not in the healthcare normally, save for a limited portion of the risk which can be transferred to the private sector honestly, but not the big bulk, not the occupation is been transferred as a risk to the private.

Three risks have been amongst the many of the risks that have been identified by the European Union, by the Eurostat Union, with the decision published in 2004, construction risk, availability risk, and the demand risk. There are of course many more risks other than that. But just to make it simple. Simple allocation of the risk which will drive the way the state cost will be put on the balance of the state or off balance of the state. Eurostat came up with this decision, which has the beauty, has the goodness to be very simple, very straightforward. In essence, the European Eurostat body says that: First question, is the state the main payer? In case of healthcare the answer is yes, probably yes, because minor payments come directly through the users. The big bulk of payment is conveyed through the state funds and the like. Second question arising after that, saying that the response would be yes, is the private taking effective risk projects, although being paid through regular payments issued by the state, i.e. a big chunk of the risk has been shifted towards the private. If the answer is still yes, it magically happens that the project will be put off public balance although major state payments are involved in the project itself. It will be put off public balance and you can understand the advantages of it, to put a big expenditure off public balance nowadays to reduce the public burden of the debt. The response would be now of course in the opposite case when the risk is not transferred properly to the private sector. In this case although many nations, many countries can conceal or disguise this project as a PPP, Eurostat doesn't believe in them and says no, this is a public project because not enough risk is shifted to the private sector. That's clear. Let's go through the details of those risks. Construction risk is the first one. What does it mean? It means that this risk will be allocated to the private side normally is taken by the private side because probably the private side is governing construction, is governing design, resources doing

construction, timing, has full command over it. So, it cannot be taken by the state construction risk, absolutely it has no sense. Construction risk means taking full accountability over delay on times, cost overruns, and the like. So the government won't pay anything for these failures. It will pay only the cost contractual cost, even if there are extra costs to burden the private party. Ok? Of course, the private must be clever enough in order to improve its design, to make a better design, to take a better control over timing and the like.

Secondly, availability risk. This is the typical output based risk. This is linked on how the way the project is performing over the time of the concession. Is it performing good, is it performing bad? Of course there must be some KPI to be set, against KPI the performance will be measured and the bill will be paid. We are now renting a hospital for a fixed price. We are paying for the provision of the services associated to the health care, either being a facility management, either being no core, either being core activities. Any state payment will be linked to the performance in terms of volume, in terms of quality. Quality is essential, measurement of quality is essential in those projects. I cannot accept as a public site to pay anything and just to foot blindly the bill. This cannot be done. KPIs are essential but KPI must be checked every month, every day, every single moment. Ok?

Penalties. Sometime privates they complain about excessive penalties. Penalties normally in those projects according to Eurostat must be uncapped. There's no limit to the penalties given to the private party if it is not performing good. State cannot pay for something, which it does not get in return. This is the rule. State pays for something, which is to be provided according to the specs of the contract. If the penalties will reach a level in which default of the company will be envisaged, it's ok. There will be a stepping closer given by the banks to change the operator and to put another one to save the bank in this. But in no case, I can cap penalties.

The risk will be, demand risk. Demand risk is something, which is not normally taken by the private into health care projects. Of course, occupancy rate is normally taken by the health authority itself. So in such cases I can allow the health authority to give the minimum payment if the level of the services of the quantity is not get, is not matched, ok? Just to relieve the income from the private side. This is what I can do and no more than that. So I can support the private in having his contract paid back to pay back his debt with the bank and no more than that. Ok? Demand risk. In other context of course, the question would be totally different. In the case of the high risk, I will put them back on the risk of the demand so what they can collect on the road this will be the repayment of the project but only in such cases, and such cases it is very rare to give the full burden to the private. It has never happened so far. In some cases, the demand risk can be shared for gaining maximum efficiency. I can say, if I pay you a service based on the demand, demand based, I can give you a minimum threshold, which in the level in which you can repay your contract above better if you are smart enough to make more patient coming to the hospital because the hospital is properly managed or whatever, we can share the profits in excess. Share between them, 50-50 between the state, between the public party and between the private party, for example. It's a very clever tool and we adopted it a lot in Italy for

the demand driven services, such as catering, such as radiology, such as imaging analysis and whatever.

Let's say we jumped to the cases. At this juncture I will be presenting you a case to make your life easier, you know, probably it's better for you to see some practical cases than to be filled up with notions. I'm wary as well. Anyway, I will present you briefly some of the good outcomes we achieved during our 14 year experience in Italy dealing with healthcare projects in project finance. And the lessons we learned, so far. By far, Italy is ranked 3rd in the worldwide ranking for capital investment in health care projects. This is based on an international survey. First ranking is United Kingdom, followed by Canada, and third, followed by Italy. So we are particularly proud to have developed in less than 15 years quite good market for both the state party and the private parties. What we do is that. What the private can do according to the Italian law and what the private cannot do. Infrastructure is the core of the activity. They have to build new hospitals, they have to build new facilities and they have to run, they can run the so called no core clinical services within that. No core means everybody knows now, the maintenance, housekeeping, IT services, commercial services, in full, taking the full risk of that, plus some specific selected clinical services. For example radiology, analysis, imaging, diagnostic imaging and whatever, and they are taking responsibility for the equipment and for changing the equipment at the end of their working life. So they are taking the risk of replacing this equipment with a new one. Ok? What the privates cannot do into the Italian hospitals is normally anything related to the medical ruling of the hospital. They are prevented from taking responsibility of ruling hospitals, they cannot appoint doctors, they cannot appoint nurses or paramedic personnel. They cannot do. Apart from that they can do anything. So, this is what we did in Italy. We started from scratch in the year 2000. Let's briefly say that half of our hospitals were carrying an age more than 100 years old. In some cases, we have some hospital buildings dating back to the 11th century, 12th century - wonderful from the artistic point of view, but totally useless as a hospital, as you can imagine. With the ceiling painted by the Venetian artists of the 14th century, 15th century, monuments, monuments, but they cannot be defined as a modern hospital. This was the starting point. We were starting from that point. What we achieved as you see, this is the PPP distribution of the projects awarded, so this means projects are operational nowadays, operational, at the operating stage. Mostly located in Northern Italy but equally distributed among the peninsula. So far, we recorded 71 initiatives between let's say 2000 and 2012 based on major hospitals, new hospitals, new building of course. This is preferred by the privates to enter into a new buildings rather than to refurbish an existing one which wouldn't work under the PPP agreement which is too much risky for the privates to enter into an existing hospital having this ceilings painted by old Italian artist and not make any damage, so the risk would be too heavy in such cases. We are emptying the existing hospital and shift our patients into a brand new structure as happened in Venice, the case I will show you afterwards.

Ok? What did we learn? In 40 per cent of the cases, projects wouldn't go further. They haven't gone further, for many reasons. Basically, because based on the fact that the private proposals

were not matching the public interest, i.e. too costly, too demanding. The public couldn't afford the expenditure, and the like. Or changing the national policies, for example, which makes it harder to intervene and to step into the contract. However, in the 60 per cent of the cases we were successful and this is very good news for us and we achieved greater savings from public projects because on average, two thirds of the capital project has been provided through private funding, unlike before when all the bill was footed by the state. So we were capable to raise, let's say, in a range of two billion in Euro overall to invest into new hospital - big achievement, big achievement. Greater adherence to let's say "on time" and "on budget". Absolutely project on time and on budget comparing to what happened beforehand. Construction and norm risk is truly and fully borne but the private side and reduction of claims and disputes from the private side especially during construction period, which was really amazing, no major claim presented, operators are conscious of taking the wrong risk without claiming anything. This was absolutely wonderful for us.

I will introduce you now briefly to this case, which will conclude my presentation, I'm afraid if I have gone longer than that. Anyway, New Mestre. Mestre is the mainland city close to Venice, so we have to move the hospital from the island of Venice which was one of the ancient hospital I mentioned before painted by Tiziano, something like that, and to move into a more comfortable relocation to the Mestre, the mainland. The type of contract is the classical DBFO for concession, let's say for concession fully compliant to the European norms of delivery for the construction of a new 680 bed general hospital from scratch. Concession period that was 30 years because you cannot get anything less than that in order to let the private recover its investment he needs a long period of time. We experienced this. Concession of this kind can be only above 25 years, they will be doable. Less than that they won't be doable if we ask the privates to invest into the building. Actually, it's on the operational stage. It was amazingly finished in four years. For Italy this is a wonder. Never happened like that in Italy - we finished a hospital before 20 years, 20 years, believe me when finished, when finished and we were able to achieve this in four years, including permits, design, construction, furniture, anything in four years. It was the first case in Italy in which found less than 15 years, ok?

So, how the major risks have been allocated in the case of Mestre? Of course, some of the payments are bulk, are lump sum, maintenance is a lump sum payment, monthly, in monthly instalment but lump sum payment it's not related to number. Other services are based on the demand, how many meals, how many analyses, how many x-rays I'm doing? For that, I will be paid. Even that the services have been performed appropriately according to the contract. Commercial revenues are accounting for the 10 per cent of the revenues, which is not that few and are fully taken by the private party. In both of these cases, we may say that the risks have been shifted in full towards the private party, save for that the state, the local authority takes the occupancy risk so if the hospital is empty I have to pay a minimum guarantee. Ok? And, but in case of the cost of the services for the state ranging above a certain level, there will be a sharing of the profits. Let's say the minimum guarantee is 20 per cent maximum is 60 per cent. Above 60 per cent, profit sharing. This is the rule. So, this was a way to curb the profits of the

private. With this contract, they cannot make a lot of profits. They can make good earnest profits. This is what we require them to do. They don't have to be greedy otherwise the whole system will collapse. They don't have to be mean. The private has to operate properly, making their own good profits, but not let them exceed those profits because otherwise there is going to be another system. There is going to be the private business-like healthcare system, which is totally different from the public health care. We are talking about public hospital run in a different way when the public interest is prevailing.

Couple of words about the achievements, which are not different from the one I showed before. Litigation is next to zero. Budget, it costs only 10 per cent overrun with respect to the initial budget, mainly due to the changings of the law for example, minor adjustment of the design and not certainly for failures. Something, which is worth thinking, is the lenders' repayment, this is absolutely essential. If you want to make a marriage with the private side we have to understand they have to make profit because lenders send the money and they have to be repaid in full. And at the end of the day, our surveys indicated that there was a really greater value for money achieved by public side. What is more important for us is that we got a new hospital, fully operational. This is what compensates all our efforts. Believe me. Okay, I finished. It's finished. Ok, thank you very much.

4.2. Open Forum

Question/response from a delegate:

1. **Patricia Moser**: Thank you very much. Very interesting. Just a couple of questions about risks. Two questions: The first one is, a couple of speakers earlier talked about technology risks and how you dealt with that in this particular setting. The other one was political risks. If you are a local government or a national government, what do the political risks look like from this? Second one, because it also seems to depended on a stream of income from the government, from the public sector, did the rates that you have to pay for the capital go up because of that or go down or was it neutral?

Response from the speaker:

Normally the financial risks are fully taken by the private side. Of course, given a constraint in time in which the contracts must be signed. If the contracts go longer than that you have to bear the risk of the financial indexes going up for example, interest rates going up. Similarly, if they are going down there will be reward for the state. Of course, it's bilateral absolutely. Political risks means for example the approval of the project, you have to give them a hand, absolutely. The private cannot be alone in approving the project or in dealing with the public party. Public party, public administration is to take its own burden in pushing for the project to be approved. This is the kind of political risk I would have research for this kind of project. If there will be a changing in the law of course, and this changing will imply

more expenditures they will trigger, of course, compensation for the private party of course, if anything will change whatsoever in the fire extinguisher system or in a parking system or in agreement, of course. The state is expected to give a compensation to the private party. This is the kind of risks I would have research and the way to deal with those risks. Technology of course is very important and we push back to the private party all the risks of the equipment because we pay them per analysis, per x-ray. So they have to take care of the whole process. Machinery, equipment, payment for the equipment, installation, running of the system and the changing the system at the end of it. But they will get compensated so beautifully that they are not complaining at all, believe me. Absolutely not, they are so happy to run the service on behalf of the hospital and pay in this way. Absolutely it was a success.

Question/response from a delegate:

2. **Matthew Khoory**: The thing with risks that we found again from the perspectives of the private sector is when structuring PPP projects risk transfer is at the heart of this and it's only through risk transfer that we are able to really demonstrate value for money in any given in PPP project. The caveat to that, however, and really the thing that divides a successful PP project from an unsuccessful one is really the expectations with regards to risk transfer and many project are being seen to be unviable due to an unrealistic expectation from the public sector which in turn leads to excessive risk that the private party has to manage which in turn leads to more being priced into the project. And really this serves more of a comment than a question really. When we sort of look at projects, it is a relationship, it is a discussion and it really does come down to a realistic degree of transfer or sharing of risks that will lead to either a successful or not so successful outcome.

Response from the speaker:

You have got to be fair in allocating risks basically. So you have to let them have their own honest profits but not profits raise too much. It's a public initiative; they are making money through a public concession so there's no risk of demand embedded in those contracts. So they are entitled to make profit in a range of any other public initiative I would say. In a sense it depends on the cost of the money in each country. In my country it makes sense having an IRR between 7 to 8 per cent and maximum 50 per cent, but not more than that. If they want to get higher money they can go for the business-like activity. So, they can establish they own private hospital, which are called clinics in Italy, and they run perfectly, because we have patients, which prefer to go there instead of getting cured in the public hospitals. This is the line. You have to choose the line between the public health care and the private health care and not let them to get overlapped with each other - absolutely not. In this case, you have to control the profits and to curb the profits. And they will give you a reward for it and they will make them a very, very nice job as in the case of these concessionaires.

Question/response from a delegate:

3. **Ahmad Zamri Bin Khairuddin**: I would just like to ask from your experience dealing with PPPs on leasing of medical equipment. We have a situation that the procurement process of medical equipment are done by the private sector and that is entirely borne by the private sector, but in the case that the government need to be involved in the procurement process in which because of the public expenditure that are involved and also the user and government doctors. If the government is asked to be involved in the procurement process, what will be the best model to be charged it so that it can be bankable?

Response from the speaker:

It's a question which takes another hour probably. We can discuss afterwards. But generally speaking when you think equipment will be embedded into the contract you are going for procurement as a whole. You are procuring the whole contract basically. You are not making any differences between building and maintenance, other services and equipment. Normally, it is embedded into the contract. This is what I saw in our experience basically. But if you want to have more details we can engage into discussion afterwards.

Question/response from a delegate:

4. **Teresa Jenna**: In relationship to risk, I'm going to come to back to something again with an EMS situation in this country. Emergency medical services. Ok, your hospital. In this country right now, the legislature is looking at proposed EMS emergency medical services laws. They're considering risk. In the Italian scenario, who do you know, did the private sector carry the risk of pre-hospital, that's ambulance services, or did the government carry the risk, do you have any idea?

Response from the speaker:

I have an idea, of course. Normally this risk is not taken by the private side in Italy. Emergency care, ambulances, normally are not taken by the private unless privately operated and this is business apart but is completely different story. So, under this kind of provisions you cannot push back the risk to the private of running the ambulances and primary health care. This wouldn't be possible, absolutely not. This is too risky.

*Follow-up question by **Teresa Jenna***: There's is a 911 system already in place?

Additional response from the speaker: Yes, which is sponsored by the state.

*Follow-up question by **Teresa Jenna***: With more infancy in this country and there's many things developing so all these models I'm looking at in relationship to how to deliver services streamlined and everybody is looking at it right now in the Philippines.

Additional response from the speaker:

Yes, yes. It could be envisaged anyway, it could be envisaged in the PPP service but at the later stage probably. But not initially, it's too risky for the private. In my opinion, at least.

Question/response from a delegate:

5. **Lito Villavicencio**: I noticed in your presentation you mentioned concession. I'm wondering what really is the character of this concession? Is it something that is geographically delineated by the government? In other words, you can set up, you have to get a permit to set up a hospital in for specific area, and that being the concession? Or is the concession a form of a subsidy that the government gives you?

Response from the speaker:

Normally it's a full contract in which the private is engaged for doing those things I mentioned. Construction of the facility, operation, maintenance and funding of the facilities, this is what we called concession contract. Concession means only that I can give you subsidy if the business case is of no sound for the private but mainly is a type of contract. This is what normally means concession.

*Follow-up question by **Lito Villavicencio***: But you do establish what the government is to bring in to the party. What you are going to bring in as well? And further, that would probably be the subsidy that the government will have to bring in.

Additional response from speaker:

Yeah, there is anything to the concession contract. Anything. And normally it is in the boundaries you know. You have to define exactly the object of the contract. And the object is the hospital to be built, or the highway to be built, or the metro to be built. This is the object of the concession contract.

5. Parallel session - Clinic Sessions 1

5.1. Governors and Mayors Hour

Facilitator: Bayani Agabin

Speaker: Paul R. Daza

Well, I was worried earlier when the group had to split up because Dr. Tan was in the other room that everybody would leave. I'm glad to see there's some people left. My portion is about Northern Samar. Before I do the short presentation, I want to share a story, a husband and a wife were talking one day and they were arguing, the wife said to the husband: health is better

than wealth. So three years later the husband passes away and the family is there with the lawyers, and the lawyers started reading the will. And the will said my Rolls Royce, my Mercedes Benz, my mansion and 50 million dollars I leave to my children, and then all my vitamins and supplements to my wife. You know when I heard that story, I laughed but, you know, when you think hard about it, it's somewhat funny but actually the wife is correct, you know, at the end of the day she's still there living her life, but it strikes me because the sad part, just like in our province and in many parts of the Philippines and in many parts of the world, people have neither, they have no good health and they have no wealth, and that's part of the reason why I'm here and why I think we're all here is to find solutions to at least many of the health issues that people face today. But before I do my short presentation, allow me to acknowledge some of our partners who are here. Of course, Undersecretary Herbosa of the Department of Health, I saw Undersecretary Perez earlier, of course, our friends from ADB, Ms. Emi Masaki, Mr. Stephen Groff, our friends from PhilHealth, NEDA, PPP, COA, UNECE, WHO, and the other partners of nation building who are here. We did something recently, in fact, I'm so happy to share with you that we through the efforts of ADB, which they funded the technical team, headed by Dr. Tan, we were able to come up with a terms of reference and a contract that we implemented and I signed a contract just about, I think, a little over week ago. If you'll see there, the Northern Samar is on the Eastern side facing the Pacific Ocean, right in the middle of the Philippines Eastern side facing the Pacific Ocean, right there. So, we're right in the middle of the Eastern seaboard. We have about 600,000 population with 24 towns and we are considered a poor province. We have one main provincial hospital and 8 district hospitals with about 350,000 square kilometres. If you see that graph, the province has basically spent almost the same in the last two years but as you can see there the national government has given us, their funding has increased for health, at least for Northern Samar, and I think that's correct, for really all provinces and for the whole country. The DOH funding has gone up quite a bit in the last two years. And that's good news for all of us, both for the public sector and the private sector. If you look at Northern Samar, we've been very active in PhilHealth. In fact, technically, we're universally covered. We've issued over 130, 140 thousand cards and there's that 150; our count is a 120thousand households. So everybody's pretty much covered. And you'll see there that DOH and DSWD, which is the 4Ps, the CCT. The Conditional Cash Transfer Programme has been effective in Northern Samar plus they get a free PhilHealth insurance for all the CCT beneficiaries. As a backgrounder, our ultimate objective in Northern Samar is to come up with the model, come up with a PPP model wherein at the end of the day, we would like the private sector to at least, substantially or fully, manage and operate the hospital. But it was so difficult to do that so what we did was we unbundled some of the services in the hospital and as you know one of the major components is the pharmacy. We had the classic problems of public hospitals where there are no medicines; when we need the medicines because of the procurement lag, it would take forever to get the medicines at the right time to the pharmacy. I'm sure all of you have already heard of all the nightmare stories and many, not some of the pharmacies in the government hospitals. So, through the help of the technical team, we came up with the terms of reference and the contract, which we bided out a few months ago and the contract was signed. It's basically, lease, operation and management of the pharmacy inside

the hospital. And we decided early on to make sure that the pharmacy will have a better chance in being successful. The other option was to retain the government pharmacy and then to allow another private pharmacy to operate within the hospital. But we decided after a lot of deliberations to just allow the private sector to run the pharmacy and to have, basically, a captured market within the hospital. And what we did was, we just replicated what many of the Philippine billionaires and billionaires around the world have done, just like Ayala Malls, SM Malls, Robinsons Malls, which is we did a minimum per square lease plus a percentage of gross sales. So, that in effect was the bided amount. In our case, the winning bidder was I think 5.5 per cent, was the highest bid. In effect, that would be the revenue or you can look at it as a discount for the hospital. But they have to operate the pharmacy 24/7, they have to fully stock it, and the private operator will follow the approved therapeutics lists that will be given by the community of the doctors in the hospital. And then as part of our PPP there will be monitoring team during the 3 years to counter check that the pricing is similar or lower than what the prices are outside the hospitals. So, I'm sure some of you have probably heard that in some cases medicines are more expensive in government hospitals. In this case, there's a check and balance and that's stipulated in a very thick contract. What we wanted to do was basically implement this province-wide. The other contract feature, I think one you'll find it interesting is, earlier somebody asked about political risk, you know, one of the issues was if you are a private operator and then you have to bill, and you're relying on billing and collection from the government, what protection do you have that you get paid on time. We included in the contract, what we called, an irrevocable stand-by-letter of credit. So, should the government not pay, the private sector operator can call on that letter and get paid by that stand-by LC. So I think that was something that was used in PPP infra-projects so we replicated and put it into pharmacy. There are many other PPPs that can be done. We're hoping as I said earlier that soon we would be bidding out lab and diagnostics for our provincial hospital. But at the end of the day, in fact, if any of you have any experience or are familiar with hospital contract management, that's really I think the ultimate that we would like to do in Northern Samar and I know many of my peers, other friends I have were governors and congressional members, are very much interested in trying to find a model where the private sector can help co-manage the entire hospital. And that's really, it think, one of the objectives that we have in ADB and DBP and the technical team.

We're also thinking about the idea of an emergency response, as you might know, right just next to us is the MRT, which I was involved with. I remember in first 6 months of our operations I was essentially one of the guys in charge, when we would have emergency in the train, somebody would, you know, slip and fall, have heart attack, we've even have cases where somebody would deliver, give birth in the train station, we would call those numbers that you would see outside, I think the 117, 168 and you know, it was tied in either to MMDA, DOTC, or one of local governments and they would take, if they came, they would take 2 hours and then many times, if not most of the time, they would come in, they would respond but would just say, you know, an ambulance with no equipment. So it was just for transport, it wasn't a response to stabilise an emergency situation. So, what we did in the MRT we actually bided out

an emergency response provider and I think they're still there called Lifeline Arrows and part of their performance parameters was they have to respond I think within 10 minutes and with an emergency medical technician, a nurse, and they had a basis within the EDSA, so, when we had emergencies, people falling off the stairs, whatever you have, they would actually get there, I think, in less than 10 minutes and we had very good performance. So we're thinking of doing something similar for Northern Samar and I hope DOH and PhilHealth would also try to think of other ways to improve our emergency response not just in my province but the entire country.

Our vision is to cover the whole province. We wanted to be sustainable. To make anything new work, whether it's PPP, especially PPP in healthcare, and any pioneering type of work you need political will. In my case, it was a little easier because our "*Sangguniang Panlalawigan*" which is similar to what you call to State Assembly was very cooperative with the governor so provincial ordinances, resolutions, and authority that I needed to get wasn't too difficult to get. As we all know, no less than the President has announced his advocacy for PPP and his advocacy in healthcare so it was just a natural fit for us. As you all know, local governments we get our annual funding, what we call the Internal Revenue Allotment, that we get the share in national taxes, in our case, we have stand by lines with DBP and Land Bank. We've gotten a lot of funds from DOH in fact, we're hoping to bid out within the next 2-3 months a new hospital in Northern Samar. And that's why I'm pushing very hard in finding a model for the hospital contract management because the last thing we'd like to do is build a new hospital and then the management is still problematic. That's why we're really working hard to do the additional PPP models. PhilHealth, PHIC is Philippine Health Insurance Corporation, which many of you know, is a big component of healthcare financing. That's why we're also optimistic. We've increased our PhilHealth reimbursement from the time I started which I think was 5 million pesos a year, 10 million pesos a year. We're now over almost 50 million pesos a year that we're getting from PhilHealth through higher enrolment and through better servicing within the hospital. But yet, I think, we've computed with PhilHealth that if we improve our hospital management we could increase our revenue from PhilHealth by at least another hundred million. So we're actually losing a hundred million a year by not operating the hospitals as efficiently as we can. Well, because of our involvement with ADB and the technical team, and DBP, DOH and PhilHealth, I think we now have a lot of talent in Northern Samar that's now familiar with PPP and healthcare issues. So, we're always interested and excited to talk to possible private sector partners. If there are any proposals, proponents, please consider Northern Samar. If there's anything you would like to test you won't find a friendlier province than Northern Samar I think. I forgot to mention to you that Northern Samar is the first province that passed a PPP code and actually did a PPP project in healthcare. We have a comprehensive public private partnership provincial code, which is even more extensive and more comprehensive than what the national government has. It filled in many of the grey areas and it made it easier for us to bid out the PPP in pharmacy with that provincial code. If anyone of you is interested, that's public document we are more than happy to give you a copy of that. Part of the requirement in the PPP code is to have a selection committee, which is your BAC. All LGUs already have a BAC, which is the Bids and Awards Committee. Under our PPP code we

retain the Bids and Awards Committee and just basically added a few more people in the BAC, which we call the PPP selection committee and then the regulatory authority, which is another group within the PPP code is specified, that will monitor the PPP project. Like this case in our pharmacy, part of the role of the regulatory authority or the monitoring team is to check that the medicines are really available, that they are 24/7 operating the pharmacy and its actually open and there's pharmacies and staff and that the prices will be checked periodically that the pricing is similar and lower as to the private pharmacies outside of the hospital. As part of our advocacy and to also make sure that any negative impact would be minimised, we had a basically a PR team, a media advocacy team that was created to advocate for PPP and for its advantages not just in the provincial government but really for the entire province. We're hoping that our PPP model would be sustainable. It's definitely going to be financially viable. We are retaining whatever subsidy we have for the hospital and for the medicines and supplies, and in fact, through the help of PhilHealth and the other partners we will have increased funding for medicine, supplies and other services. We're going around talking to other private sector proponents. As I said earlier, we will be bidding out soon the laboratory and diagnostics and we've already had a few private operators who've indicated their interest. Our model is consistent with whatever DOH is doing and NEDA, and all the laws out there, BOT law, joint venture laws, it's all incorporated in our PPP code which is reflected in our contract in the PPP in Pharmacy.

To conclude, I'm the luckiest governor in the whole country, and in the help of the technical team, which is funded by ADB. Dr. Tan and other consultants chose Northern Samar and we're happy to share that with any and all of you. We're hoping to continue our relationship with the technical team and to continue whatever improvements we can do in healthcare in our province. I think there's no better way to support this government, as part of our nation building efforts. I think there's really no better way to do it other than health. And with the many problems that we faced in healthcare in the Philippines, which is another topic, because of the devolution, but I think there are solutions to healthcare in the Philippines and one of which is PPP. We need to engage private sector expertise and experience and if we can keep on doing these models not just in Northern Samar but in the entire country I think we'll go along ways and we'll see a better Philippines. So thank you for having me, and again to ADB thank you for your continuing support for Northern Samar.

Question/response from a delegate:

1. **Hak Ham**: First of all thank you very much governor. Thank you very much for your presentation. Your presentation was insightful indeed. I have one question. Governor, you have mentioned about the contract of provisions of pharmacy for hospital in the province, what I want to know is that, is there any regular violation of the supplier of drugs something like that. So if it's okay, what is the mechanism to solve the differences, the problem something. Can you get my point?

Response from the speaker:

If I get you correctly, how does the contract deal with violations by the private partner? Well, the contract has provisions on dispute settlement. It's a pretty standard one, you have to go through mutual discussions, if that fails, you go through arbitration, and after arbitration then you go through a court case. The idea is you try to avoid litigation as much as possible. Now we also have defined criteria for instances whereby you can terminate the contract. That's also in the contract. We have what we call monitoring guidelines. Like the prices, for example, we want to keep it locally competitive so we have a monitoring team for that. So we have provisions on contract termination, we have provisions on arbitration, dispute settlement; we have provisions on penalties in case of violation. The principle being, you do not want to terminate the contract at the slightest violation. Of course, we want to make the partnership work. Did that answer your question?

Question/response from a delegate:

2. **Matthew Collingridge**: Just a quick question, or two quick questions. I'm curious to understand the thinking behind the three-year contract in the context of pharmacy and whether there was any specific driver behind that length of time. And secondly, a broader question, which is are you considering the use of PPP and your code for non-healthcare sector infrastructure.

Response from the speaker:

That's a good question, the first one. The team with the consultants had some discussions on how long we wanted it to be. One year seemed just to short because you know the operator would have to come in there, fix it up, and then fully stock it. But we don't want it too long, like five years seemed too long, I remember. And then, we settled on three years because it just seem to be just enough time for somebody to come in there and then we computed how much investment that they will have to put in, I mean that's substantial. So, it was basically by consensus, you know, Atty. Bayani was, you know, in the team and he's a lawyer and he was there, Dr. Tan and many others so we settle on three years because that seem to be the right number of years.

The second answer to your second question is yes. In fact, I'm also very excited. I've been meeting on a group on a PPP on water, on bulk water supply, transmission and distribution. So, in fact as part of our ways to improve and to show that we're serious on PPP, we assigned a business development officer who's in charge of PPP, and that's Abby, you know, she's here Abigail Catucod. So, most promises don't have that similar official so we designated somebody to be the PPP business development officer and in fact she's already talking to some possible proponents on water. Our problem also is power, so we're open to, you know, any proposals. And really anything that would make sense to both parties.

Additional comment from facilitator:

If I may add, Governor. The three years was driven by the numbers basically, we had a health economist predict and an enterprise development expert, developed a model and we determined that based on certain percentage, by the third year he would have recovered his capital investments and more. So, it gives the parties time to thresh out flesh problems.

Additional comment from speaker:

Under the BOT law, concessions can be as long as 25 years, in fact, renewable for another 25 years. In many cases in infrastructure, the range of the contract duration periods are anywhere from 10 to 20 years. But since this wasn't such a big amount, yes, I guess there were some computations made and we arrived at that three years, which is well within the statutory maximum period.

Question/response from a delegate:

3. ***Delegate (no introduction made)***: Good afternoon Governor. I would just like to ask a clarification question. You mentioned a while ago about the irrevocable letter of credit. Because we have been talking about risk, you know the private is very much concerned about investing because of the risk. Is it that the letter of credit is being issued by the province as a guarantee? And the other question is usually the private sector is a little bit apprehensive in entering into a contract of concession especially PPP with some government. When there's a change in the administration, so you know, the private companies, the new governors, the new congressman will take another direction. So, that's what the private companies are very much concerned. So, that's the second question. Thank you.

Response from the speaker:

Actually, both questions are related. You're correct. And that's part of the reason we incorporated that provision on irrevocable letter of credit because we knew there are many concerns from private sector and you know, the typical concern is, yeah we go there and we supply services or products and we then don't get paid on time and that's why that irrevocable stand-by letter was included in the contract as a some sort of I guess a safety mechanism for the private sector. The amount is equivalent to I think about a month or one month and a half of what we projected is one to two months' volumes. So, essentially we're supposed to pay the pharmacy operator the bill after 30 days, I forgot the exact time. And they can call on the letter of credit for non-payment after 30 days from billing. So, we're forced to pay them right away. Ok. That's the idea. I think it should work. We did something similar in the MRT in the contract of the EDSA MRT 3 we had something similar and that's why we put it in this one. You're right, I don't know how to answer you, you're right. People are worried when the governor is different; it's a new governor, new congressman then

things change. I guess the answer to that is we want the model to be successful by having, you know, accessible medicines at affordable prices and then that in itself should be enough incentive for any future governors to continue the programme. We could have made a 10 year contract and at least that takes care of, you know, here it's a maximum of three years. Three terms for the governor so we could have made a 9 year contract but because its new we did three years, if it's successful if I'm still governor we may even consider doing it for longer term. But that's the nature of government. Anywhere in the world there will always going to be new personalities in the government. The important thing is for the programme the project to work to incentivize future leaders to continue those programmes.

This introduction was followed by one-on-one consultation sessions

5.2. PPP in Public Health Programmes

Facilitator: Emiko Masaki

Speaker: Jaime Z. Galvez-Tan

Verbatim transcriptions are not available.

The introduction was followed by one-on-one consultation sessions

Part II: PPP in Health: Understanding Operational Issues

6. Financing Options for PPPs

Facilitator: Hilton Y. Lam

6.1. A Closer Look at PPP Financing: Options and Issues

Speaker: Jungwook Kim

Thank you Mr. Hilton and I appreciate ADB and UNECE to invite me for this valuable opportunity and it's my honour to present Korean case of PPP in health in front of you. I'm representing KDI PIMAC and PIMAC is Public and Private Infrastructure Management Centre, it's a long name, so you can call it PIMAC KDI. Also, I'm representing another patient, here you can see. It's really appropriate for the topic of this event. My presentation is about the PPP financing and options and issues based upon Korean experience on PPP. So, here's some kind of legal framework of Korean PPP. In the early 1994 PPP Act was legislated and at that time government tried to invite private resources into infrastructure, so that they can manage some of their fiscal aspect and also to fill the gap between the infrastructure demand and supply. But the PPP method was rarely used in Korea because it was complicated and government officials especially in local government and line ministry didn't want to implement PPP method. Why bother? Just to implement here the conventional procurement scheme, fiscal government projects. Why do we need to communicate with private sector and get some lengthy negotiation period and so, due to several reasons including my previous points, the PPP methods were rarely used until 1999. In 1997 and 1998, Korea was hit by the financial crisis so the Korean government borrowed money from IMF and the money was conditional, I mean, they are strict. Fiscal soundness was one condition, main condition. So government lack of money still they faced huge demand for the infrastructure. That's why we revised PPP Act to promote PPP markets. At that time, we introduced risk sharing, which includes minimum revenue guarantee and initial level of minimum revenue guarantee was 90 per cent during the entire operation period. You can't imagine how much is needed to like guarantee it for the revenue but at initial period of PPP markets in Korea that margin was somewhat kind of key driver to promote PPP markets especially to induce private participation into the infrastructure. And then 2005 PPP Act was amended to introduce BTL scheme, Build, Transfer and Lease schemes and expanded facility types to include social infrastructure. At that time welfare facility types were included for the eligible PPP types in Korea also that includes PPP in health facilities. So, the Korean government adopted the positive list system for eligible facilities so in the PPP legal issues and framework we have a list of eligible types of PPP. Beyond that we cannot implement facilities with PPP method. Among them, five categories for the 48 facility types were listed and you can see the welfare types here that include the health public and medical facilities or childcare facilities etc.

And currently also health PPP in Korea is listed on the table. So we got substantial road projects, seaport projects, and railway projects, educational facility type projects but we do have just a couple of PPP projects in health. We can see Gangjin Medical Centre and another is Hwasun Geriatric Hospital or medical centres and the total project cost is around 50 or less billion Korean won which is 50 and less million USD, you can exchange it easily. So, small PPP projects in health. The number is not so large so we are starting or initial area of facilitating health PPP in Korea.

Now I'm trying to show you some cases of PPP in health in Korea. So, Hwasun Geriatric Hospital, BTL project is one example and the total project cost is around 14 million USD and the total private investment cost is more than 15 million USD. Usually, in Korea total project cost consists of just a consortium cost and preparation cost just before finishing the construction and the total private investment cost includes the cost in operation and the amount of money differs in this. And equity is 780 thousand USD and that is for the rest. These payments from the governments consist of payments from the central government as well as debt from the local government, and showing you the sharing ratio is 50-50 so 50 per cent from the central government and 50 per cent from the local government and the number of sick beds is 190 for this project.

Here are some pictures, so it's a view from the front and this at the back side. And the location is the geriatric hospital is adjacent to Gwangju City. This city is number 5 city in Korean peninsula. That indicates that securing elder patients is not that difficult. And also near to Chonnam National University Hwasun Hospital so the operation part was consigned by the Chonnam National University Hwasun Hospital and the rest, the non-core services was implemented via the PPP method. So here is a kind of one general aspect of PPP project in health in Korea so non-core service can be implemented via PPP method but core service is still operated and provided via conventional method. You can think of it as similar as the educational facilities, schools. We have lots of school facilities which we were implemented via PPP method but it's only about the infrastructure so not about the core service, the educational services, will be provided with other agency, educational agency in local government or private sector like that. So we do not combine non-core service and core service in implementing PPPs in educational facilities and in health facilities yet. Yesterday, lots of speakers spoke about the core service provider in PPP or some kind of health programme PPP implementation like this. So this kind of real challenge to PPP Korean markets I believe. Another example is Uiryeong Geriatric Hospital BTL project – it's similar and the price is a little less, just a small hospital and the total project cost is less 4 million USD and the number of sickbed is similar to 192. The facility is based in a shut-down school. In Korea everyone wants to move to the big cities sort of metropolitan areas or other big cities so within the rural area and the number of citizens got decreased until you can count only on your fingers so the government decided to shut down certain fraction of schools in rural area and this hospital is located in that rural area and it can be an example of full use of closed school sites for future projects in rural area in Korea. And I'd like to talk about the financing options for PPP and based upon Korean experience, BTO and

BTL is kind of popular method in implementing PPPs. BTO is Build, Transfer and Operate. In the Philippines it's similar with BOT but just one difference is change of ownership just like the construction and then got the right to operate for 30 years or 50 years according to the facility types and the reason why we transfer the ownership just after the construction is as follows. In Korean culture it's unimaginable for private sector to own infrastructure. Something's wrong. It is kind of too harsh for citizen that's why they transfer the ownership or donate the facilities to the government or local government and then they got the right to operate for a certain period and that's the notion of BOT or BTO. And BTL is Build, Transfer and Lease. The difference is BTO facilities, the private sector can charge for the end users and it lies in their own facilities so user fees or construction subsidy are from the government is main method to recoup the investment but for the BTL, the fixed rent or fixed revenue from the government is main tools to recover investment for the private sector. So, the demand risk and those kinds of risk are upon the private sector for the BTO types but for the BTL types, there is virtually no risk to the private sector because the lease payment is kind of guaranteed only if the management and maintenance and operation expected is satisfactory. You can see other aspects in the table so I'm going to skip the other aspects and tried to convey a clear idea of the difference between BTL and BOT.

So, SPC is a special purpose vehicle, a special purpose corporation, this is private sector and they got borrowed money from the financial institutions mainly, in Korea it's a domestic bank or commercial bank or other infrastructure fund and then they deliver the infrastructure to the government. Then they allow private sector management and operation rights for a certain period and provide services from private sector to the end users and then they can pay fees to private sector and the SPC. The private sector is going to pay back the investment from the financial institutions. But for the BTL, the private sector borrows money from the financial sector and then transfers the ownership of facilities at the construction to the government and management and operation rights or lease allowed to SPC. Then, services are provided by government […]. Think about the school or hospital and lease payment is from the government based upon maintenance and operation performance and then payments and cost recovery for the financial institution is made afterwards. For the BTO projects, minimum equity ratio is around 15 to 20 per cent. SPC is led by big construction company in Korea, top ten construction company, and they put the money as equity around like 15 to 20 per cent and then the rest is from the bank. 80 to 85 per cent is for the loans, senior loans or subordinated loans. That is for the general BTO schemes but for the health it is almost always BTL scheme used. Minimum equity ratio is less than the BTO. More than 90 per cent is form the loan and so this is from the bank or financing institution and then paid back by the local government or central government. And then here is the re-pricing, every five years considering market interest rate or fluctuation or market condition, we adjust, re-adjust the interest rate so that we can adjust the level of lease so every five years the level of lease will be adjusted. That is the notion of the re-pricing in every five years.

So, most of the welfare and medical facilities are implemented using BTL method, because BTL method itself is not appropriate for making profits and another reason is it is regulated by the Korean law that the hospital or the medical centre should be operated by non-profit organisation so even though they are making profits, the profits should flow into another facilities in itself not just to the equity holders like that so hospital or educational facilitates of course are non-profit facilities so not appropriate for BTO type. So BTL schemes are almost always used for the welfare and medical facilities. And what about issues? So, as I said we implement health PPP projects only for the non-core service delivery. But should they include core service? But it is too early to discuss this aspect in Korea because as I said just a couple of hospitals were delivered via PPP method but all the core service aspect is regulated and managed by hospital rules and regulations and regulatory issues. Also in Korea, the Korean government sustained mandatory insurance coverage system. If you change the core service delivery you then you should modify and amend kind of insurance policy coverage system and there will be some kind of side effect for that. For example, in mandatory insurance coverage system we divided for like the covering area and non-covering area. So for the covering area, the citizens can get the service with lower fees, guaranteed fees, but for non-covering areas then the hospital can charge as much as they can. So it's not as much but for the profit for the private hospitals there is incentive to induce patients from the covering aspect to non-covering aspect like that. So, if you change kind of core service delivery dramatically for the PPP hospitals then you know, you should be careful about the impact of the change at first. For the economies of scale, so for the educational facility schools, one school is not enough to induce private sector's participation so usually we combine three or five schools in a nearby area to make one package deal for the projects and then make announcements in the market to invite proposals from the private sectors. The similar thing could be imagined in health PPP markets but it is hard to combine the hospitals in the nearby areas because usually one county is only one big hospital, and big hospital is not in a sense of the investment is compared to the other private hospital. So general hospital or medical centre is only one located in one county in rural area so combining another hospital in another area is really hard part and it is not appropriate for the PPP implementation. So instead of combining other hospitals we try to make some kind of complex. So we try to include some kind of medical and welfare services facilities into one complex and make one large project for inducing the private sector's participation in those projects. So, talk about the welfare complex, the health and medical facilities local medical centre has health centre and public convalescent hospital et cetera and infant and child care facilities can be accumulated and combine them to make it a large project for the PPP implementation. We do not have example for PPP projects for welfare complex yet but a similar example is a mixed use among county facilities in hospital in Cheongdo-gun county. So you can imagine that consist of health centre and one hospital and social welfare facilities and private hospital located here. And so the ministry and the PIMAC are thinking of this example for the future the PPP implementation method in health in Korea. And for the facilitation PPP projects in health sector in Korea, we need institutional some amendments […]. For the institutional arrangement it is necessary to develop standard for the BTL projects and mixed use of models that fit the medical and welfare services in each field. As I said, we focus on only

non-core service delivery, infrastructure, for the PPP in health but the goals, purposes, and characteristics of the health sector differs from other BTL facility types. Also the Department of Health and local government should implement projects and prepare that, I mean should acquire land beforehand so that they can decrease the land acquisition amounts for the future PPP method implementation. And the last one is technical review. So for the public health and medical facility BTL projects we recommend inclusion of welfare facilities so it's kind of suggestion of complex as before because that brings a kind of economies of scale effects such as the reduction of facilities maintenance and management expenses that is concentrated in certain limited area so we can decrease the maintenance cost. That's my expectation. But the local medical centres' experience modernisation recently, the demand or the need for this kind of approach should be reviewed or require further studies like that. So that's the end of my presentation I prepared but one thing I should mention is that, PPP is really hard because we are dealing with private sector and as a private sector is kind of too versatile or too flexible to adjust in changing the policy or changing this kinds of systems. But usually in developing countries, especially in developing countries, PPP is basically a partnership but assume that kind equal relationship between partners, that's private sector and public sector. Usually, the private sector is ready but for the public sector is not ready yet. But once the policy was set up, the PPP is kind of good way to implement and deliver infrastructure then the government just to push it and then sometimes they got lost during the implementation. So, almost always I took over the capacity building not just in studying the best or best example or best practice good practice not like that, try to get educated in practical way, I mean, what is the next step for implementing PPPs especially in health and what is our problem. Then get these kinds of experts from other countries as well. In Korea we have over 600 PPP projects but still we're struggling to managing, to manage and implement PPP projects. Also we got the criticism from the citizens. For example core service delivery PPP, then somebody will throw a stone at me. Why? Why is the welfare or the health aspect handed to the profit making private sector? Then we need to persuade them like with solid evidence then I need kind of history or performance evaluation research from other countries, United Kingdom or other countries, even in Philippines like that. So if you want to facilitate and implement PPP then you need help from other countries for sure and this event or workshop or conference in other countries are really useful to get the information and surely your position and your policy directions like that. So, my suggestion is try to make more events like that and do not hesitate to share your information, share your errors, mistakes as well as success stories so that we can get the PPP as good model and spread it to more countries as well and that we can do it in health sector as well, I believe. Thank you.

Reaction by ***Cosette V. Canilao***

Thank you for that kind introduction. I just prepared a short reaction to Mr. Jungwook's presentation especially on the evolution of PPPs in the Philippines. The PPP or the Build Operate Transfer Law was enacted in early 90s and amended mid 1990s but the focus of most of the projects then were power projects and hard infrastructure project. Although we already

had the Build Lease Transfer as one of the modalities under the BOT Law it was not used for social infrastructures such as for health sector and for education. However, despite that the first PPP project for the health sector is for the National Kidney and Transplant Institute, which is actually a lease scheme for the acquisition of 42-dialysis machines. So, one could argue that although the BOT Law was used it was only a service contract in effect or a lease for the purchase of such equipment. Now, since the PPP programme was re-launched two years ago, we are using the BOT Law not just for the traditional hard infrastructure projects such as roads, bridges and the ports but also for social infrastructure projects. Now, for the health sector, the first project under this new scheme would be the Philippine Orthopedic Centre. Before I talk about the Orthopedic Centre, I'd like to talk about the first social infrastructure, which is education, the construction of classrooms all over the country. That was the first social infrastructure that was done under this administration. And we used a Build Lease Transfer scheme and the private sector is tasked not to design, but to build and to finance 9,300 classrooms all over the country. Now the reason I mentioned that is because, that has an impact also on the health sector. Informally, I've discussed with Undersecretary Herbosa and Secretray Ona that maybe we could use the same scheme for the health centres, the barangay health centres, all over the country, and that's probably one of the things that were going to develop moving forward. Now the first major PPP project from the Department of Health is the modernisation of the Philippine Orthopedic Centre. And that includes the construction of a 700 bed capacity orthopedic specialty tertiary hospital for bone and joint diseases trauma and rehabilitation medicine. So, the project includes the construction of a 13-storey building on a 8,000 square meter lot and the private sector is being asked to design, engineer, build and finance, operate and manage not only the non-core or non-medical services, but also some of the core medical services. Since it's a BOT, we're using a Build Operate Transfer variant, we foresee, the Philippine government realises, that we need to support the hospital for the first 5 years. And the private sector will bear the commercial risks. So, aside from the availability payments for the first 5 years, for the rest of the concession of the 25-year concession period, the private sector is expected to bear the demand risk. Now the government's responsibility is to deliver the right of way, assisting of course in getting the government approvals, and we intend to hire independent consultants to monitor the construction as well as to monitor the service levels to be provided by the private sector.

Well, the general principles in doing PPPs for health are the following: We need to determine, as in all PPP projects, we need to determine the appropriateness of the private sector participation in a fact-based manner. We did this by doing market sounding early on if this project would gain attraction or interest from the private sector and here in the Philippines, most of the privately owned hospitals, there's already a transformation in the way they are being operated. So you just don't see hospitals where you go there to be healed but you see beauty salons, within the hospitals, fast foods and convenient stores inside the hospital so that is the reason I suppose that there is a very high interest from the private sector to participate in our first major PPP for health project. We also need to determine the fiscal cost and the risk of contractual obligations, which we need to identify and quantify right from the start and since

the private sector is being given a lot of room to generate non-core revenues not only user charges but also non-core revenues, we need to find a way where we can reinvent contingent liability on the core services because we cannot undermine the ability of the private sector to generate the non-core revenues and there's just a big unknown there which we cannot estimate at this point. Also, yes, contracts may also need to include viable payments level that allows appropriate benefits to be captured by the public sector. Like for the Orthopedic Centre we need to support the PhilHealth, the expanded coverage of PhilHealth because we estimate that 60 per cent of the users would be for PhilHealth insured individuals and even that the 30 per cent of the potential users would come from those that are partially covered by PhilHealth or fully, or those that will not use PhilHealth.

PPPs should also include well-defined objectives, clear visions, roles and responsibilities, risk allocation, and service levels. I was in a meeting yesterday with an airport operator we were talking about determining the KPIs of an airport and the first thing that came out of his mouth, like you know, aside from airports, hospitals, it's very hard to determine the service levels of hospitals because of obsolescence. So we need to provide a provision in the contract that that should take into consideration systems adjustments. That's why it's very, very critical that we need to be very clear with our minimum performance, specification and standards. I guess most of the issues that we identified for our first PPP project were already in the lessons learned presented by Mr. Jungwook. So, that ends my reaction to his presentation. Thank you so much.

Question/response from a delegate:

1. **Maria Teresa Dioko**: I just wanted to ask our presenter, particularly Dr. Jungwook. How did you incorporate measures of quality into the PPP and particularly like did you ask for particular outcomes when you establish hospitals, I mean patient outcomes or population outcomes also. And this is more of a curious question, is there a difference between private and public employees in terms of compensation or status, and what kind of status do employees get if they are in Build Transfer and Lease situations?

Response from the speaker:

Yes, the measure of quality, the fixed rent or lease payments during the operation is based upon performance and performance will be monitored by the competent authority usually local government. And that conscious of cleanliness and the quality of maintenance for the infrastructure, that's why I talked about non-core service delivery only for the PPP sector in health. The number of breaking lights or number of broken windows could be one measure to take the quality of the maintenance of course. And we have some checklist of those kind of categories to be measured for the performance in operation period. But for the core service is really hard and challenging for the measure of the quality of service. That could be one another holder to induce core service into PPP implementation I believe. But for the core service if the patients are not so satisfied then the hospital will be challenged to do the

law suit or like that or got several complaints even the hospital got no patients at all. So one broad idea is to just leave it to the market so they can self-increase the quality of service to the patient, so that induces more patients for the making profits like that but it's just a rough idea. For the employees in the BTL schemes, the maintenance and operation staff will be employed by private sector. They are separate from the doctors or nursery, or other core service delivery employees so we do not have any kind of problem with that and usually the private sector you see is outsourcing the persons for the cleaning and maintaining the facilities. For certain period they got employed but they got fired at the moment and the new employees will come up for another three years or two years by the private sector. That's the situation in Korea. Thank you.

6.2. Taking PPP Financing Further: Why PPP in Health is Good Economics

Speaker: Hilton Y. Lam

So, good health and public private partnerships in health, I was asked, is it good economics? The WHO in 2003 they actually published this. They showed that if they plot the life expectancy on the X-axis and the total health expenditure on the Y-axis, the relationship is almost one-to-one. This is an amazing finding. And they went further; they said that the total expenditure on health in relation to the GDP per capita, the R square is actually is .9. Very, very amazing. In the field of economics I rarely see correlations this high. And this was a study headed by Dr. Jeffrey Sachs, a well-known economist. So, in the WHO Commission on Macroeconomics and Health, they actually looked at it this way: the main purpose of that study was to show that if you spend money on health you can actually bring poor people out of poverty and so in effect, if you read through the whole document they are actually looking at if you give good health not only will it actually help the poor people become less poor but it actually has effects on education, peace and security, agriculture and employment resulting in better national development. The European Union, taking off from that study, actually said that health contributes to higher productivity, higher labour supply, better education and higher savings and investments. Because this is what the EU think will push the EU as the world's most competitive market, the world's most dynamic and knowledge-based market, ensuring sustainable growth with the best job and best social cohesion. So, now we have two major powerhouses in the world who believe that good health is good economics. Now, some of the studies that support this - being unhealthy is expensive, right? So you can see that at least in the UK, coronary heart disease actually will cost, how much is this? 7 million British pounds for the whole country. How much is 7 million pounds in peso? That's times 60 so we're looking at half a billion pesos. Coronary artery diseases only. So, being unhealthy is not good for the economy. Being healthy however is profitable. Contoyannis and Rise they actually showed that healthier males earn about 12 per cent more than unhealthy males; healthier females earn 16 per cent more than unhealthy females. Now this one is a little … the taller you are the more money you make. Now it doesn't say that you have to be naturally tall. So the use of high heels, the use of other aids… But the thing here to note it is not height per se. It's the relationship of

height to nutrition. Because most people, most employers they actually want to hire healthy people. And one rule of thumb is the taller you are compared to the next interviewee, the more likely you are going to be healthier than that person. I'm sorry but we are Asians. Just make sure that if you are going to be interviewed that you are not going to be interviewed together with Caucasians. Now being healthy longer is better, okay? Pelkowski and Berger showed that the occurrence of permanent illness between ages 30 to 39 is associated with 9.5 per cent lower income. However, if your permanent illness occurs after age 50, the lowering of income is smaller at 6.9 per cent. We know we will all get sick, sooner or later. It's better to be sick later. Then healthy people work 1 to 3 years more before permanent retirement. And healthy people are about 1,000 per cent or ten times more likely to receive full pension. I think I personally have this experience one of my cousins; he was on his last year before he could retire but he got sick, so no more retirement. And being unhealthy may lead to less development. Finkelstein, Luttner and Natourdigdo said that every incidence of permanent illness is associated with 11 per cent reduction in the satisfaction of economic consumption. This means the more sick you are the more often you are sick, the less happy you are with your money. Now, if you are happy with money you will save money because you want to use more money. But if you are not happy with money, you will not save money. Now, if you do not save money then there is no more money for PPP companies to come. So, if you look at this, let's look at this as the lifetime of the person, in the Philippines 67 years, 68 years. The red line, let's say is full health and then the black line is let's say that's the trajectory of unhealthy person, and the green line would be a trajectory of a relatively healthy person. So, if you compare the two, so from age 0 we don't really see major illnesses happening until maybe 20, 30, 40, right? So we can start seeing some, so that comparing the healthy one to the less healthy one, you actually get savings. So, this is from the household's point of view. And then where they are now active members of the labour force, they will earn more and therefore they will pay more taxes. Now the government and the community and the country benefit from better health. And then, you will notice here, that it's a little inclined because as shown in the earlier study, that healthier people retire much later than unhealthy people. So, actually you will see that they actually stay in the workforce longer, they generate more income, they pay more taxes. And then the healthier ones in their retirement age they have more savings and they can buy more condominiums for their children, for their grandchildren and contribute to the economy. WHO actually said that in the Western Pacific region, the main cause for impoverishment is catastrophic health. 50 million people are impoverished because of health and 80 million suffer catastrophic health and of these, 50 million become poor. That's about 60 per cent. 60 per cent of the population in the Western Pacific region become poor because of catastrophic health. Being healthy leads to greater economic growth. Every one-year increase in life expectancy is associated with 4 per cent increase in GDP. And this is borne out by two separate studies, one by Barro and one by Bloom, Canning and Sevilla. They looked at data series from 1960 to 1990. So, if you can make your population live longer by every year you can increase your GDP by 4% every year. Wow! Being unhealthy leads to terrorism. Actually, this is a true paper. I'm not making this up. I wasn't able to get the full paper, because it has some state secrecy in there. The American CIA, they actually have this study. State Failure Taskforce Report. So, if you try to

download it. You can download but it's not a full paper. And somehow parts of it are left blank. But they actually said that for a country, if it's not a democracy, it's 11 times more likely to end up being a state failure and therefore prime for terrorism to flourish. And then if the infant mortality is high it's two times more likely to end in terrorism and if it's a close economy its 1.9 times more likely to end up with terrorism. So, CIA alright? They don't look at health but in their study they actually saw that next to democracy, health is actually a very important factor. So, poor health is bad for the economy. Being healthy is a good investment for rich countries. McKee, Nolte and Suhrcke they actually show that in England, Sweden, France, Italy and Spain, the return on health expenditure is at least 47 per cent and as high as 274 per cent. For every 1 Euro spent on health, you can generate 47 per cent more up to 2.7 times more Euros. So, that's for rich country. Most of us don't belong in this list of rich countries. So, do we see the same thing happen? Can we expect the same good returns? It's actually very good. Jeffrey Sachs in his report, he actually said that for poor countries in the world, if we spend a hundred billion dollars every year for the next 20 years, we can expect up to 2015, we can expect for every 100 billion spent, we can expect to generate 558 billion. That's an economic return on investment of 452 per cent, if we do not use the economic returns it's a 187 billion, the financial return is 85 per cent. It's good business to invest in health. So, now how do we make sure that the PPPs will end up giving us good economics? PPP is not a magic pill, it's not just going to make it. We have to manage it. So based on our experience with the ADB TA, so this is not, so I don't put my name there because we haven't published this, but this is a team effort of the TA team. So, good economics, so we want to see access. So how do we make sure that your PPP in health gives good access? It's actually in the contract. When you write the contract, you make sure that there is a pro-poor bias. The main reason why we want the PPP is we don't want our poor to be marginalised. Next is equity. It has been discussed yesterday and even today that there should be appropriate profit and risk sharing compensation. The higher the risk, whoever takes the higher risk, should be entitled to higher compensation and that should be spelled out very clearly in the contract. And don't worry, based on our experience, the private partner will accept. And then, timely innovative efficiency. What is it in PPP in health that gives timely innovative efficiency? It's because they can borrow money cheaper than government. I'm sorry to some of our government bank partners. But we have actually met that conflict. The TA team would help the local government. We convinced them to go into PPPs but they end up saying, good, it's okay, I can borrow my own money somewhere else. We won't borrow money from this one bank because the interest rate is too high. That shows that with PPP you can actually access cheaper money so that's why it's good. And then it gives time-limited monopolies. As an economist trained by the western world, competition is what I like best. Managed competition is acceptable as well. So we want to include in the contract that we give them this monopoly but it's time limited. Just like in Korea they revisit their contracts every five years. When we did our TAs, we would revisit our contract, three years, five years, depending on the size of the investment and the private companies are actually accepting all that. And that's good for the economy too because you don't want to create a monster. You want to generate innovation in your areas and therefore limiting your contract to specific times is actually a good way to do that. And then market research. When we talk to the provinces we actually insist that they do

their own feasibility studies first before engaging the private sectors. Because I will bet you my whole savings that the private sector also does their own feasibility studies, which is something that most local government find mean. We actually have to help them with that. But they are open to that. Next is merit-based staffing. Most of the reason why drugs are not available in local government hospitals, beds are broken, ambulances are not running, x-rays machines are not repaired, it's because the person in-charge of it is sleeping on the job. They have tenure, they are not afraid. And then, quality-based outcomes. With the contract, with the KPIs, I'm glad everybody is looking at that. Then, strong maintenance of facility and equipment. This is one problem; at least, in the Philippines. We do not maintain our equipment and our facilities. And to make sure that that doesn't happen in a PPP, because the private knows, then they will say we will also not maintain your equipment and facilities. That's how they will then save on their cost but we make sure that is actually not going to happen based on the contract. So, one of the KPIs would be regular maintenance. And then competitive effectiveness. The effectiveness, in economics we distinguish between effectiveness and efficiency. So, effectiveness is doing the right thing and efficiency is doing it the right way. So, the main idea there of effectiveness with PPP is that we have to make sure that it's patient-centred, so, patient satisfaction. Notice, it's patient satisfaction; it's not doctor satisfaction; it's not nurse satisfaction; it's patient satisfaction. And also we have to insert there in the contract that they must provide it at the lower cost. Lower cost than what government is actually is producing at the moment. Then, cost-effective management. Well, I think that it actually comes into play very easily because with the private sector that's the nature of their system. They are actually in competition with the other players. And they also bring with them new ideas. The example that Ms. Canilao brought up, having a beauty parlour inside the hospital, having a concession inside the hospital. Those are private innovations that could be accommodated. And also they bring in IT, ISO certifications, JCI, […]. NKTI has […] and the reason why NKTI has […] is because of the leadership of Secretary Ona and he actually brought that in because of his experience from the private industry. Then, the other things that the PPP which is beyond good health economics, the market guarantee. Private will not go to you, to the governments, if they don't see a market. Now how do you entice the private to come to you? You actually help them by saying we guarantee the market for you; we will guarantee a minimum payment; this will help you create the demand. Because businesses are not so simple, they create the demand. And then conflict resolution space within the contract. Jill Jamieson actually talked about that yesterday. So we think that these are the components of PPP in health that would be good to have.

So now, PPP in health, well, for the local government at least, you only do it to meet unmet needs. Do not do it if there are no unmet needs, because if you do it without looking at the unmet needs, you actually introduce a lot of risk into your system. We recommend a system integrated PPP. So, your step one is you prioritise the disease according to the actual burden. You do not go to into PPP because one day somebody said you need an MRI. You must look at the actual need. So you look at the disease. So, since I'm partial to the disability adjusted life years, so we actually asked all the local governments to look at the disease patterns in their

localities so that then we can help them say, ok in your facility these are the diseases that you need to tackle, and therefore, these are the equipment you need, these are the number of beds and these are the staffing that you need. And then choose the most cost effective interventions to tackle these priority diseases. So, the presence of a formulary, a health technology assessment, adherence to clinical practice guidelines, cost-effectiveness analyses are helpful in this case. And then they must do the feasibility. So, demand analysis, the cost analysis, revenue projection, social marketing. Korea said that I think the culture of Koreans to doctors is at a more equal level than it is in the Philippines. We still hold our doctors as if they are demigods, we will not fight them; we will not go against them; we will just nearly go away from them. So there needs to be social marketing. The bad part is go away from them. So, if your nurses don't like you. They show up but they don't do their job, your med techs they show up but they don't do their job, so that's really very bad. You're paying them to do nothing. And then you must identify the expected financial mechanism. In all the scenarios that we looked at the crucial point there was PhilHealth reimbursement. Without a guarantee of PhilHealth reimbursement for this projects that we looked at, the projects would not have passed the minimum barriers that the private partners are looking for. Thank you very much.

Questions/responses from delegates:

1. **David Dombkins**: *Verbatim transcription is not available.*

Follow-up question by facilitator: *Verbatim transcription is not available.*

Additional response from **David Dombkins**: *Verbatim transcription is not available.*

2. **Kai Hong Phua**: *Verbatim transcription is not available.*

3. **Adrian Torres**: Thank you for the presentation. Just two questions for both the panels Dr. Kim and also Ms. Canilao. The return on equity investment for the investors in health, you mentioned that BTL is lower risk and BTO as a higher risk, so for our reference in Korea, what's the range of equity return that investor seek when they invest in PPP in health in Korea and also in the Philippines. And the other question I have, you mentioned, and I think it was raised before, you know this review every five years is actually quite a good thing, but in your example it only seems to support one stakeholder, which is the debts provider in terms of the change in interest rates, I'm assuming those investments are done in floating rates, but what happened to the operators themselves who have to hold this for 20 years or so, how do they get compensated. Last issue that I want to raise it that I have a different view to what Dr. Hilton mentioned with regards to private sector raising cheaper debt than the government. Unless of course it is higher rated than the sovereign, more often in the example that I looked at, is that government can actually raise cheaper debt than the private sector and that's the reason why they provide guarantee, some of this can provide liquidity. That's all. Thank you.

Response from the speakers:

1. **Jungwook Kim**: For the ROE in health sector, I believe that's less than 10 per cent as far as I remember. The return of equity, actually, it's not a return, it's a kind of the equity holder is a construction company or the leader of a consortium for the private sector. And the minimum equity ratio was you know mandated because equity is kind of assigned, or responsibility during the operation and so you can calculate with the excel files or financial statement but it's not realised until the end of operation I believe. So lower risk so the return of equity is lower than the BTO, slightly lower than but that's meaningful thesis. And changing interest rates will be reflected in the re-pricing every 5 years for the BTO schemes and the reason why we consider the changes or fluctuation in interest rates is, if you change the interest rates for the private financing, then the profitability or the rate of return will be changed so try to guarantee certain level of returns on the private investments. We try to modify the reference interest rates and then we try to adjust the level of lease so, considering changing interest rates mainly deals with adjustment of lease fixed payment to the private sector so not just considering only the financial investors, we mainly take care of consortium or SPC for adjusting changing or considering changing interest rates. So, I think that I may clarify your question. Thank you.

2. **Cosette V. Canilao**: For the Orthopedic Centre, the first highly engaged PPP project of the Department of Health. As I mentioned earlier we want the private sector to take on the demand risk or the market risk. As such, in estimating the return on equity, we looked at similar companies investing on PPP in other countries. And we estimated that a typical return on equity that they looked at would be lower teens and mid-teens. That's how we looked at it.

Questions/responses from delegates:

1. **David Dombkins**: In Australia, we did our first PPP in about 1998 the Sydney Harbour Tunnel, that was before the British PFI Law. And I was part of the team that did that. So we've been doing it now for almost 25 years. And we have learned a few lessons. One of the big ones that I see is a real problem and I have seen it all the time where governments think that they can dump risks and from the private sector all we do is price it into it. The recent example in Abu Dhabi where the government tried to dump the risks on the roads, not so much in demand but in being unwilling to stipulate truck size and loading and try to throw that risk onto the contractor and all that the contractors do is to price it up. We've seen the same happen in Australia time and time again and it results in two things: either the prices are absurd and the project won't go ahead and we've got examples. And the previous speaker raised the point - almost certainly governments can raise funds cheaper than the private sector. And numerous studies we've done. These projects, not uncommon, if they are done badly cost the community three times what they would if done through PPP but the government could have done with them privately. So if they are done badly in

dumping risk, the community pays and sometimes you'll pay three times what you would have paid if you had financed it yourself. And there's a range of studies to validate that. So there's got to be an equitable distribution of risk that is appropriate or you will pay for it. The other result and we've got a couple of good examples is Sydney Harbour Tunnel, sorry the Sydney Cross City Tunnel and the Sydney Airport Link. Both of those projects failed recently […], where the demand risks have been dumped on the contractor. The […] didn't materialise and we see failures and then the community comes back in having to bail the project out and the community pays again. If you are going to do these projects there's got to be real assessment and things like overly optimism we're seeing all the time where estimates of demand are regularly out by 50, 60 per cent, sometimes 70 per cent, regularly. […] PPP needs to be an equitable arrangement to be able to survive over the life of that contract to serve the community. There's no point coming up with some fictitious and economic models to validate the project and I think the British National Audit Office recently was condemning the fictions that were created by the accountants and economists to validate the project. This is about expending government money or the community's money to deliver service over a long period of time. And it needs to be treated like that. There's going to be change, there are complexities on it and we need to take those into consideration and develop models that can actually be sustainable over the life expectancy for the community.

2. **Ham Hak**: Thank you for the presentation and I have one two specific question to Dr. Kim Jungwook. In relation to BOT and BTL, I see that in your presentation BOT is now managed by the contractor or something and BTL is managed by the government. My questions are: What is the quality of service that is provided by these two modalities through PPP? And also, what is the utilisation of services of that people that go to use this in this through PPP managed facility and public facility but that is truly managed by the government? The other question is that, I would like to know if Ms. Canilao could tell us a bit more in details about build lease and transfer scheme. We want to have this experience. Thank you.

Response from the speakers:

1. **Jungwook Kim**: The quality of service for the BOT or BTO schemes, the operation risk, or commercial risk, or demand risk is upon the private sector so if the quality of service is not satisfactory then there's another one to use it. Basically, managing the quality of service is upon the consortium or private sector in a case of BTO but for the BTL the quality of service should be monitored and managed by the competent authority, the local government or other government agency and as I said the lease or fixed payment during the operation period is based upon the performance of the operation and maintenance and the quality of service can be guaranteed with these schemes. If performance is not satisfactory then they got the penalty so decrease or deduction of the payment for certain period like that. So, that's how we can guarantee the level of quality of service in the case of BTL, and the quality of service reference is delivered by government or conventional procurement

scheme facilities so basically we do not differentiate the quality of service the identification but usually according to the survey the quality of service in PPP is more satisfactory for the end users. So, that might be the answer to your first question. You are talking about BLT or BTL schemes, so it's basically, during the concession period, private sector make investment and make it and after delivering it, government pays back to the entire operation period for 20 years for school facilities or 25 years or 12 years according to the size or type of facility. And for the paying back or lease the profitability or rate of return was included so operation costs and some pay back of the construction, the capital investment during the construction. Then, some cushion I mean the rate of return on that. That was calculated and distributed over the entire operation period. So, the fixed rent is guaranteed by the government or public sector that's why they can get the money back or recover their investment and this is why BTL is low risk or lower demand risk project than the BOT or the BTO. Thank you.

2. **Cosette V. Canilao**: Yes, as for the build lease transfer model that we used for the Department of Education's first PPP project, as I mentioned earlier the private sector was tasked to construct 9,300 classrooms in 3 regions in the Northern part of the Philippines. They also would finance it and deliver it within a certain period of time. Now the annuity payments or the availability payments are based on, of course, the KPIs that were agreed on and the specifications that we've drawn up right from the start. Now, I'm speaking in general about the PPP programme of the Philippines. I'd like to comment on what the earlier mentioned about dumping risk to the private sector. Quite unfortunately in the early incarnation of our PPP programmes in the 1990, the government issued guarantees on almost anything, FX risk, off-take agreements, so we have several projects in the past which we are still paying for now and that's the reason why we when the programme was re-launched two years ago, a lot of investment went into ensuring that projects are properly prepared and properly identified and also that the risks are identified and appropriately shared. We are cognizant of the fact that we cannot dump all the risk to the private sector even in the Philippine Orthopedic Centre, the government is providing support to the first 5 years of operations. But thereafter full demand risk they will have to take on and that is based on the estimation of the financial modelling and the viability study of our transaction advisers. So, we'd like to think that we are better prepared now to roll out PPP projects. Of course, we are still far from what the ideal scenario is but we've amended the implementing rules and regulations of the BOT law quite recently to remove the ambiguities in the processes and to make the bidding process more transparent and to provide more assurance to the private sector, the President also recently signed an Executive Order mandating all PPP contracts to have a conflict resolution, so that's welcomed by the private sector and all implementing agencies most of them especially those that have PPP projects in the pipeline right now, we're doing a lot of capacity building not only in terms of project preparation and on PPPs but also on monitoring and later on evaluating the projects. We've been accused of delaying the rolling out of projects but you know we do not apologise for the delay because were doing this right this time around and

instead of just rolling out projects just so we have PPP projects that would later on be not beneficial to the public, we'd rather study the projects properly and then roll out as we've done or we've vetted out of the issues we could imagine. Thank you.

6.3. UHC under a PPP Regime: Ensuring that the Health Insurance System Works

Facilitator: Alvin Caballes

Speaker: Eduardo P. Banzon

Let's talk more about what we are trying to do, universal health care under PPP regime. PhilHealth as you know is a government corporation, it's a GOCC, It's quite young and old, because if you go back to how its roots with its Medicare, which of course, I have really no role. Probably Dr. Tan and […], who were already doctors by then, started in 1969 which was part of the pension fund but essentially in 1995 we created a single national health insurance fund partly because the expertise in health insurance was not there in the pension fund. But in this point is something up to now a problem how to manage in PhilHealth. For quite some time, people in PhilHealth still consider itself a pension fund, prompting a very conservative approach in running a health insurance programme; very much afraid of expanding benefits, very much afraid of dealing with the private sector because this is the very nature of a pension fund. In a pension fund you want to save money, you want to make sure that nothing comes out. In health insurance fund, you should be open to negotiate, to leverage. And I think only this year that we finally resolved that PhilHealth is not a pension fund. So, its roots in 1969 have been part of the country's pension fund, was quite good and bad. But now were moving on, I think one thing also that is unique in PhilHealth which I think we need to also emphasise is that the membership in PhilHealth is family-based, it's not individual. Once you become a member, your wife, your mother, your father more than 60 years old, your children less than 21, are also members without additional premium.

Now, I argue that PhilHealth is essentially a PPP. In a sense that it is a public fund in the sense once money comes into PhilHealth whether it comes from premiums of members, or from taxes, because a big chunk of the membership in PhilHealth is essentially paid by taxes. Then it pays both public and private providers so it's a PPP. Just to emphasise, those of you who understand social health insurance to be purely paid by premiums, PhilHealth is not one of those. The way PhilHealth operates, the formal economy that means employees working in the formal sector essentially pay a premium, traditionally, employer-employee split just like a lot of other social health insurance schemes. But just like other schemes that recognised that in a country with large informal economy, it could not make it to be so difficult to collect premium from them. So the solution has been government who would subsidise the poor. So, a large chunk of the memberships of PhilHealth, nearly half now at this point, is basically subsidised by tax revenues. So, to bottom-hole PhilHealth as something tax financed, or premium financed, I think, is no longer the case. It is essentially a hybrid, which if you look at it globally, has become the model in way countries with large and formal economies are trying to roll out social health

insurance programmes. Our friends from Indonesia have basically the same approach and I think there are only very few countries that essentially use premiums now as the main financing scheme, or the only financial scheme for social health insurance programmes. So, and also another thing because the Philippines for quite some time always have a large private health, hospital sector. One can even argue if you look at the numbers we have about 60 per cent private of you talk about hospitals and beds but given the fact that in the Philippines, doctors who are even full time employees of government, so I'm looking at Dr. Vega here, can do private practice. In the Philippines, private practice of government doctors is not even an issue. In other countries, it's headline news; in other countries it's a topical study; in the Philippines, it's a way of life. So even if you consider the fact that private practice is very much tolerated, and that private rooms in government hospitals are a fact of life. Probably, private provision of care in the Philippines is much bigger than 60 per cent; could be as high as 80 per cent. So uniquely, probably not uniquely, the Philippines essentially have a health insurance that is a public fund paying mostly private providers, or quasi private providers, if you accept the term. So, it is a PPP. And I argue it is a PPP.

This slide shows you how broad the governance board of PhilHealth is, not ideal because 14 I think is too much. But nonetheless, if you look at the board it is mostly government but there is significant representation from the private sector. About 5 to 6 people are representatives from the private sector. PhilHealth is a national scheme; this is a devolved country. Those who are familiar with the Philippines knows that devolution has taken root in the Philippines partly, well significantly in response to the martial law regime that centralised power too much in Manila. So, in the Philippines, we really pushed for devolution that's why even the national ID system here is difficult to happen simply because it is construed as an attempt of the central government to again centralise power. But PhilHealth is quite unique that it operates a central office. It's the one programme, I argue, that is expected to cover all Filipinos. So, right now we have about 17 office, 106 local health insurance offices, we are now covering about 80 thousand or probably the better term, we have 80 thousand Filipino names in our data base with their birthdates and that's about I think the largest data base of Filipinos ever. And our work now is really to deepen that engagement, beyond having them in a list of names in our database but really take care of their health. And of course, our marching orders is to make sure that we cover all hundred millions of Filipinos wherever they are not just in Philippines but even those working overseas. That's why we do have a programme dealing with overseas Filipinos.

So, what have we been doing within the corporation? Well, as I said one of the first things we did when we start talking about universal healthcare is unpack the baggage. The baggage is a long list of thinking within PhilHealth. Unless we change the mindset, no programme will work. And the first thing we changed is the pension mentality. The thinking that it is a pension fund was killed that the first three months. Alvin [Caballes] is a bit incorrect, October 17 was the first year anniversary that I have and I'm now spending the last five, six days of October thinking why I did it. But nonetheless, so I'm just over a year now in PhilHealth. So we spend the first

three months unpacking the baggage killing the pension mentality, killing a rebate mentality, which unfortunately was something PhilHealth then had to do in order to bring local governments enrolled into the programme because the only way to convince mayors and governors to enrol their poor was to talk about it in a pesos and cents discussion. So there was a rebate mentality. That capitation which is supposed to be a benefit payment was construed not as a benefit payment for services but a rebate. So we have to kill that. There was also focused on what we call a transaction-based approach. Very government, in a sense that you manage that illness, you manage that event rather than taking care of families or the continuity of care. So, we are also addressing that. There's also a very short-sighted, short-term perspective. So the thinking is we have to stop fraud because if we don't do it now, they will run over the money, forgetting that what hospitals and members want in insurance is a long-term relationship. Yes, they can get away with fraud now but we'd always get even with them in the following year. So, to take on a long-term perspective was something we have to inculcate and introduce in PhilHealth. And finally of course, to stop doing things just because it's been done before, which is of course very bureaucratic approach to life. Just because we've been doing it then we keep on doing it. So we talked about provider payment scheme. Why keep on doing it? Because that's been how it was done. So we stop doing that and essentially what we have done, so as Alvin said, probably there's no process in PhilHealth, which we have not changed or are about to change. We essentially believe that in order for the country, for Philhealth to support universal healthcare, if we keep on doing the same things, we get and get the same results. So we have to change the way were doing things, and everything from benefits, to provider engagements, to the way we process claims, to the way we accredit hospitals we stopped accrediting hospitals, to the way we managed our membership, have to change, or have changed, or will be changed.

We are also strengthening internal communication because we are a large organization. We're all over the country at the end of the day, I've been around the country twice, so I've been to all the regional offices twice already including twice in ARMM and in the wonderful island of Tawi-Tawi and of course, the beautiful city of Marawi. And we realised that at the end of the day that a lot of people in the frontlines sometimes have difficulty understanding what Manila is talking about. People expect that if you come out with an order, that's enough for people to understand. We realised that unfortunately that's not true and so we're now in the process of making sure that the instructions and policies being developed in the central office are done together with people on the ground and really efforts to explain the process internally, including the instructions […]. We have something a nice project code "*tamang sagot*" in English it means the correct answer. Among the things I realised when I went around was that people were giving me different answers. So I got tired. So I said I want the right answer. So I launched "*tamang sagot*". So soon, when you talk to PhilHealth, there will only be one right answer. Not different answers because you talked to somebody else, to somebody in the regions, somebody in central office, or you talked to your wife or a friend with different answers. And I think it's very government because the same problem is quite present in other government agencies. We're also flattening the organisation that means we're deepening the

bench. […] And we've essentially brought in a lot of people from the regional offices and younger people empowering them and I probably show to you that organisationally, we have changed the way we do things now. We are rewarding innovations, we have introduced concepts really strengthened accountability within the corporation and there's now a team approach to the way we do things. So, this is for example, this is how we did our membership. We broke it up into segments and each of the segments has a team running and managing it. The products are now run like the way you do product teams in private corporations. So, one thing called is also a PPP. We have very actively developed product teams for each product. Somebody makes sure they all coordinate with each other. But this has moved the work to the point that we have expanded our benefits quite quickly the last 12 months.

So, there are other steps that we need to do towards universal healthcare. At the end of the day, we cannot talk about universal healthcare unless we talk of more money. And so the first thing we've been talking about is that there should be increased financing not just from budget but premiums. It's difficult. People keep on asking for more without the willingness to pay more premiums. The 2.5 per cent in the Philippines that we pay is too small. If we want a deeper comprehensive universal healthcare the premium have to go up. Of course, that would also mean higher budgetary allocations because there will be a current increase in the premium subsidy that government has to pay for the poor. We also in a sense want some more what we called paid for. If you are, if you listen to the news recently, there was this debate between private charity beds in PhilHealth wards. Unfortunately, the Philippines did not finish the discussion. We did not really fully shift to an insurance-based system so we still have free charity beds, then you have PhilHealth wards. We're arguing we should fully give up a supply-side approach and do demand side. And in that sense redefine the concept of free. You're free because you are insured. You're not free because the bed is free. That means when you got a free charity bed or a free hospital bed or a free care. You got it free because you are paid for it. Not only is it empowering, but it will simplify processes. It will also make sure that the current practice that only prescriptions are given and not medicines will stop. It will also make sure that the current relationship where Filipinos sort of beg and think the doctors […] because they are being seen in government hospital will end. Because the relationship will now have empowered patient saying give me the care because I'm paid for. So were pushing really for the shift to the demand side. Of course, we recognised that without supply-side improvement and we're working closely with the Department of Health on this, a lot of this will not happen.

So, what's the vision of PhilHealth? It's nine words; it's in Filipino, but I think it's easily understood in English:

"*BAWAT PILIPINO, MIYEMBRO*" – All Filipino members

"*BAWAT MIYEMBRO, PROTEKTADO*" – All members protected

"*KALUSUGAN NATIN, SEGURADO*" – Our health assured

There's actually a song on this but I've been warned by […] here not to sing it. But probably in the open forum I just might do it. So, "*bawat Pilipino miyembro*", sustained enrolment. That's a key word for us "sustained." That's why we want a sin tax earmarked to us because we will be able to hit 100 per cent. But without the earmarking that assures guaranteed revenue to pay for the enrolment of the poor it cannot be sustained. That means we have to go back to Congress every year and that would be a problem. So having that earmarking of sin tax revenues, which is part of the amendment of the sin tax would be very crucial in sustaining universal healthcare.

"*Bawat miyembro, protektado.*" We recognised that at this point, we really cannot pay for private rooms, suites and all of that. To do that, we probably would need to, based on the numbers we have crunched, we need a premium that is probably six times what we're probably charging in order for us to pay for private rooms and suites in this country. So, what we're trying to do is something probably consistent with the Pareto optimality, if you're familiar with that, where we just want to makes sure that every Filipino who desires a room, which he doesn't have to pay anything, will always have that choice. The term we use now is NBB. We're trying to change that into something much more understandable by Filipinos. A term we're floating right now is "*sapat na*" which is it's enough. Because not only we are saying it should be enough, we are also challenging doctors and hospitals who for the longest times just charge whatever the market can bear, to accept what we pay. Okay. It's easy to argue that we should do costing and all of that. But the reality is that in the market in the Philippines, nobody is doing costing for quite some time. It has operated in high margin, low volume market and essentially, they charge whatever the market can pay. We're arguing a low margin, high volume market is the way we should be doing things. So, in the sense the way we look at "*bawat miyembro, protektado*" is find a way where every member of PhilHealth who desires to go inside of hospital and not pay or probably go into a fixed co-payment regime will always have that choice and once that happens we're sort of comfortable that "*bawat miyembro, protektado*" has happened.

And finally, "*kalusugan natin segurado*. If you're familiar with stories about the Philippines, there's this legendary statistics that say 60 per cent of Filipinos die without seeing a doctor. I'm always shocked at that. Because there's too many handsome doctors out there, so how come Filipinos don't see us. Well it's an incorrect statistics. Okay. The correct statistics is about 60 or probably 40 per cent, the number really changes, of Filipinos die without being attended by a doctor. That means they died at home, they died in the streets, they do not die in a hospital, or probably they went to hospital and decided to die at home. So, it's really a health system failure if such a large percentage whether 40 per cent or 60 per cent of Filipinos are dying without being attended by a doctor. So, for us a simple solution is this. A primary care system should be in place in the country. A primary care system where each and every Filipino member is assigned to a doctor should happen and that's "*kalusugan natin segurado*". So we're now pushing hard to assign primary care providers for all Filipinos. And of course, that will ensure

continuity of care and rational hospital admission but that's something that we will work on not now, probably in the subsequent years.

So what happens now? "*Bawat Pilipino miyembro*." We essentially have 85 per cent on the assumption that the total Filipinos are 95 million. Of course, if its 100 million the percentage will change. So let's look at the hard number, it's 80 million. About 80 million Filipinos right now are in our database registered. Not all of them at this point can avail of benefits because a lot of them may have missed payments; their employers have not paid; or they lost their jobs. So, we are in the process of really trying, you know, it's difficult to manage 80 million claims. So, in the process really to make sure that at any time we'll be in a position we could actually say how many of these are actually eligible for membership. Nearly all of the poor if we accept that those in the national household targeting system are poor, and I think ADB like the World Bank has no choice given that you partially finance the roll out of the national household targeting system. All of them are covered by PhilHealth including those what we call additional PhilHealth families. Because in the national household targeting the household is different from the definition of a PhilHealth family. So, the additional PhilHealth family is about two million. And it was quite sad for a while because significant number of CCT families were not the original households so there was a situation for a while that CCT families were not covered with PhilHealth. We have resolved that. But in order to sustain it and make sure that the premium is always available to cover these households and families. We have also continued and we are able to sustain the enrolment of the local governments despite the higher premium, not only did we get them to enrol we got them to lock in until 2013. So, right now the enrolment of LGUs is two years. In 2014 the dream is three years. Soon, we will no longer accept enrolment that is just for a year because that would politicise the process but to make them lock in the enrolment for three years will depoliticise and sustain membership in PhilHealth. We are also actively working in registration simply we realised at the end of the day, studies have shown, the cost of PhilHealth is not that expensive. You know, hundred pesos, two hundred pesos, that's not expensive, but it was the convenience, inconvenience that was the killer. So we need to make it convenient for members and that's why we're working on, including bringing them down, Philhealth bringing down, we're bringing the office down, we call it PhilHealth moves and we do move like "jogger;" we have PhilHealth express and soon we have about 60 of this in all major malls in the country and probably hopefully all malls; we brought in nurses about 530 of them, we call them PhilHealth cares, and of course, were trying to make sure that an ID card, we started rolling this out, that is a transactional ID card and hopefully with a picture which we are going to call PhilHealth Face, will be available to all Filipinos by the end of 2013. It's difficult to take pictures of ten million of twenty million Filipinos.

We're also making and explaining the programme because part of the challenge is really people do not understand social health insurance. They want to pay, if they don't get ill they want their money back. So we're now using all types of media, including social media working with the papers, lecturing to them, which we call SHINES, and doing movement and we're all over, and frankly I'm inviting all of you on February 17, 2013 to join a nationwide run in 18 cities. First

time ever that government is going to do this. We're expecting a hundred thousand Filipinos, including of course staff from ADB, to run with us, to celebrate universal healthcare, 18 cities, simultaneous, we are going to call it PhilHealth run, it's going to be a party, it's going to be a celebration. That the country is calling out, we are doing UHC, universal healthcare. So, it's also the 18th year of PhilHealth. So be with me in PhilHealth run. I'll be running. I have a special five hundred meter run for me and for […]. And whoever wants to and whoever cannot run, the shortest is 3K but if you want 500 metres, we have a special, just for us exclusively.

We're also, of course, working on improving collections. At the end of the day, collections inefficiency was a problem that I saw when I came in so we're working hard including online payments. So, that's a PPP if you look at it. We're also changing the way we deal with hospitals, no longer are we are going to accredit them. We are going to do contracts. We thank ADB for the help that they provided to us. It's improving the capacity of PhilHealth to manage contracts. So we are going to have formal agreements with them and we are really going to treat them differently, you know. So, if you are a nice hospital, a trusted hospital, preferred provider, you know, good to me I'll pay you in 7 days. That means you agree, no balance billings, you follow our rules, if you don't want to follow our rules, it's ok, will pay you in 90 days. Then probably for the good hospitals, no documentary requirements, we simplify life. For those who do not, probably you have to submit to me whole story of the patient including where he was born, how many children, things like that. I am going to use market leverage, market power to make them behave because soon, we'll be paying 70, 100 billion pesos of benefits, which will roughly translate probably to one-third of the whole market. We are going to use that power. We are going to make sure that people who are with us we would treat well and those who are not with us, okay, I don't want to say anything. And I think that's the next slide. So we hope to change the behaviour of doctors and hospitals, because clearly, if we expect that the Philippines would have universal healthcare in a setting, that we just pay whatever the doctors charge, whatever the hospitals charge and that the patient can just go to any doctor he wants for outpatient care, it will never happen. Primary care has to happen, case payment has to happen, contracts have to happen, a shift to a low margin, high volume market has to happen. So, we have been working hard in expanding our benefits. So, as you know were hopefully we can have with the board yesterday just approved that we'll shift to all case payment, hopefully it will happen by April 1. We're expanding what we call catastrophic benefits, we call it a Z but its more than just a Z benefit because it's also an attempt for us to really control not just who'll you go to but also the quality of care. Gate keeping has started among the poor and we hope to roll this out to all the membership. We call it 1 to 4 because 1 is the primary gate keeping, 2 is medicines, 3 is diagnostics and 4 specialist care. The running joke is that eventually there'll be PCB 12 and we haven't decided what it is. And again, thanks to ADB. We started at global budget where hospitals that follow our rules will pay you the benefit right then and there, and we started contracting with two hospitals, one hospital group which is Misamis Oriental Hospital group, so all the hospitals of Misamis Oriental and the Philippine Children's Medical Centre. I think there are other hospitals that will soon be joining us in the global budget scheme.

We negotiate also. So what we've also done is we're not afraid of private industry. We're just very good negotiators. So for example, the discounts on the right if you see that, that smiling girl, it's what we call a benefit, that's not a benefit because essentially a discount, 600 hundred pesos that they agreed to sell the vaccine for PhilHealth members 50 years old and above. We're not paying anything we just sort of leverage a large membership database to make sure that they agreed to the discount. And similarly, the Z benefits, we have friends here from pharma, similar discounts were given to us just for the PhilHealth benefit. So, we have also seen that we don't have to pay in order to have PPP relationship. We are guaranteeing a market, we can guarantee a volume of patients and that allows us to get this kind of lower cost, and of course, that brings down the price for everybody else. For IT, we've realised that in government, what we pay for IT can never be enough, so were working closely with private sector and we have now accredited what we call health information technology providers because we expect to shift by 2013 to pure electronic links. It cannot happen without these guys and so we have started accrediting them and they'll be the one to talk to hospitals and other healthcare providers. And of course, again, the PhilHealth run. I always end with this; I hope you know, if I can run, see how big I am. I cannot imagine why none of you can run with us. So, "*bawat Pilipino, miyembro"*, all Filipino members, "*bawat miyembro, protektado*", all members protected, "*kalusugan natin, segurado*", our health assured. I believe, universal healthcare is going to happen sooner than we expect. Thanks a lot!

Reaction by ***Kai Hong Phua***

Thank you. This is a value added report here. I was originally asked to participate in this session but I have to catch a plane at 2:30 so I thought I have to be very quick and get out as fast as I can at 12:00 o'clock. So, I didn't volunteer myself at this session but instead I got placed in yesterday's session on sharing Asian experiences. But I cannot let Banzon get away with this because we go back a long, long, way, you know, I think 20 years, when you were in the dream team with Dr. Romualdez, you know, and the World Bank flagship programmes and then we went back to the Harvard flagship programme with the World Bank and then of course we went to the same schools as well, London School, so I'm very pleased to be here so I could react to some of the things that are happening. But based on what you have said, I am actually quite encouraged compared to the last few times that I have been looking at your social insurance programmes here. I have actually prepared some slides but didn't know what you are going to present. But I won't go too much on my slides I will just react to what you have presented, and first is to see now the role of PhilHealth as the major social health insurance financing mechanism or should it be the dominant financing scheme. You will have to ask yourself, are there other types of financing that could be used to complement your dominant scheme. Of course, we are also referring to the usual taxation scheme, which DOH has control over. We're talking about the devolved funds have gone to the provinces and of course, in the context of pork barrel politics in the Philippines, that could also be very difficult. But we're also looking at the prospects of the future in PPPs, whether we can bring in new complimentary private

insurance to complement your social insurance. But before we get into that let me just ask the basic questions, what is insurance, what is insurable in terms of the package of health services? Is social insurance going to be a catchall situation to cover everything under the sun for which then it will not be enough? But at the same time, I think you have to then, decide whether or not to use social health insurance to achieve some of the goals of the health system, which is not only to increase access but at the same time, there are many forces to push for quality, and of course, what you have said now about driving up efficiency and putting the value added services in terms of greater technical efficiency and claims processing, in terms of allocative efficiency, in terms of making sure that you get the things right in the first place, and then doing the right things right. I think Dodo, what you have presented basically you are moving along the right direction and all power to you in terms of driving more efficiency, whether it is allocative or technical, but at the same time, when you are moving to providing more access and again we are encouraged that your coverage is potentially up to 85 per cent but then the question is, is it broad but not deep, you know? And this is where we ask the question, what is insurable? Are you going to take the place of the public covering all the public goods, including immunisation and all that, which really should be provided by the government in the first place? Or are you going add on to more transaction cost, collecting the premiums and then giving them back to providers. But in the context of the Philippines, I think, you have no other choice, in the sense because if you are going to have lot of private providers and very devolved healthcare system, you may have to do that. So that will add to the transaction cost but it is very necessary in order to get the money there.

The other question is, are you going to cover more on the demand side to cater for a lot of things which could be picked out-of-pocket in terms of pricing, or are you going to shift it all to the catastrophic side of it. Remember yesterday, I showed the graph of the public-private mix for a lot of spending at the primary care level. If it's non-essential it could be equivalent to moral hazard. But you targeted at a basic package, which is for all the preventable services some of those immunisation packages that you talked about, which are so essential and very cost effective, then really you're not creating moral hazard. You are actually creating the investment value and I think that should be encouraged. But at the same time, the more you collect then there'll be a lot of pressures now to push for greater coverage. Then you have to be very clear where exactly you want your money to be going to. So some criteria on benefits if it is based on cost effectiveness will be called for. In other words, are you going to be allocating the resources to the things that get you more returns in terms of more health outcomes or just mere consumption? You have to ask that question. So there'll be a lot of pressures and political pressures, they will be pushing you cover this, cover that, you know, everybody wants the money, wants to see the money is there. So, to a large extent I think part of your problems in the past was that people are quite reluctant about expanding it because they don't want the money to be just consumed and to create moral hazard. But at the same token you do not bring more money into the pie, how much more can you do? If you are so obsessed with just sustainability you tend to err on the side of conservatism in the sense that you don't do very much. If you don't do anything then of course you don't spend money right? But if you want to

collect money then you will come up with a lot of pressure to do more. And so, to do more means that you have to be very clear exactly where you want to put your money. And here the iron triangle of healthcare, which is to balance access, cost, quality, I think when you push for one or two of the triangle, something has to go somewhere. So I think, again the public health perspective is that you want it not only to give more access and equity but at the same time you may have to trade off a little bit more on the quality side. So, this is where the trade-off has to come in, you cannot have everything under the sun. And the same thing has to be traded between supply and demand. If you are going to bring in a lot more money to increase your premiums on the demand side, you expect that you have a more vocal population, demanding for more, you also then have the balance of relationship with the supply side, which means that if you want it to make it affordable and to increase your access you may have to then negotiate harder on the providers. And again the whole question of equity on both supply and demand has to be kept in balance. But your strategy of high volume and low cost and especially in differential pricing I think has a lot to be saved, you know, and that should be encouraged because in the past we just assumed that all social health insurance should be free but where is the money coming from. But the more you differentiate the prices and you target it, in other words, you have to take into account the public role of government financing which is to have zero co-payment for the poor, if they use public hospitals, but a fixed co-payment if they use private hospitals, I think that is a trick. The question then is that if people want more from the private sector, you may have again to differentiate a little bit more. Because I don't know where your fixed co-payment is going to be. What is it going to be based on? Is it going to be based on prevailing market rates or is it going to be differentiated for different packages? I think that's where you expect a lot more pressures from the doctors on the supply side. The other thing that I want to comment on is your social marketing. It's incredible. I mean your social marketing have also included what you call social contracting as well. You put it into your contracts all the things that will matter in terms of getting the best value for money. You will get the high returns on your public health investment. And you have a part of a lot of behavioural economics, which is now a catch phase of everybody. Behavioural economics that address incentives not only on the supply side but also on the demand side. Moderating expectations and then getting the right kind of behaviour from providers and hospitals to provide cost-effective services, not just to provide more and more of higher quality, that'll only benefit to themselves, but really to channel them to what's the public good. I think the use of behavioural economics in that perspective should be encouraged.

Now on the future options available in the context of PPPs, I think, there's a lot to be said about balancing the proper role of governments versus the markets. I think once you get your basic package right, which is the rightful role of social health insurance then you can talk about complementing it with private financing and use of private insurance. But if you have not fixed your basic package then I wouldn't encourage that, otherwise you end up confounding and confusing the whole role of social insurance all about. But you will have to then bring in some complementary aspects expanding benefits to go on a high end to cover for some of the latest drugs and technologies and also to cater for say an aging population in long-term care; there's a

lot to be said about bringing in more financing to complement your basic package and this is where private insurance can add some new ideas and value-added. But private insurance may not be brought in to capture the good risks and then select all the good benefits and then end up with adverse selection for the rest of what you have done. So, you have gotten it all right in terms of allocative efficiency and I think it holds very well for the equity perspective. So thank you very much Banzon. Well done, all power to you.

6.4. Open Forum

Question/response from a delegate:

1. **Teresa Jenna**: Dr. Banzon, Dodo, I must commend you on excellent steps taken forward to communicate to the poor what PhilHealth is. I would like you, since many of these people in the audience heard Governor Daza yesterday speak, tell a little bit about how PhilHealth and the Government of Northern Samar have been making steps forward in PPP arrangements with the private sector.

Response from the speaker:

Sorry, I missed Paul yesterday. So there's something which we have done. Allow me please to just give a short response to Phua. So, it was not 20 years ago, you know? They may think I'm that old Phua. No. One of the things we're looking into for supplemental health financing is PhilHealth Plus. We've actually scanned the market in the Philippines on supplemental insurance. The market here is not ready to step in. They really cherry-pick everybody. They follow the American model too much, so they cherry-pick individuals, they won't give you coverage once your 60 years old or a fat like me, and I think the level of maturity is not there, the market has also not consolidated. So, what we're actually doing in PhilHealth is to come up with our own supplemental health insurance scheme called PhilHealth Plus, the long-term plan eventually after we do this we'll give it to the private sector but I think at this point, government, that means us, has to step in, and sort of catalyse some level of maturity in the supplemental health insurance schemes and we now roll out PhilHealth Plus soon, probably in the middle of next year.

Now, what we are doing in Eastern Visayas in general is something called PhilHealth Link. We're actually working with the government to make sure that the people actually avail of benefits. One of the things we realised and I think this is not just unique for PhilHealth, is that a lot of processes we developed including forms are designed for the middle class. It's the middle class or lower middle class or bureaucrats who designed the forms. So we thought that the process of availment of insurance is easily understood by us, but not the poor. So when we started bringing in the poor into PhilHealth, they just could not understand why they have to fill up forms, they have to bring birth certificates, and to do these things. For us it's simple. It's you know, I always have my birth certificate in my house

to make sure my wife doesn't get angry. But for the poor they don't have it; these are difficult things for them; these are onerous for them. And so, what we have now designed is since we could not change a lot of these processes and requirements and rules overnight, we simply brought in, in the case of the region, PhilHealth Link. So there are now people in the hospital paid by the provincial government who would access to our database so there's a call centre in regional offices and when there's anybody who needs to verify it goes to that and the form requirement is no longer required. So you don't have that onerous requirement that usually asked in your PhilHealth.

The push for a transactional ID is a long-term solution. Because with the transactional ID you don't need any forms. That ID would be enough but that entails that the hospitals are willing to invest in IT connectivity and computers. And I always want to cry when I hear government hospital say that they cannot afford a computer or an internet connection. My god! You know, it's a very sad response given that these are not expensive. To invest in IT connectivity in probably 20 computers in your hospitals, government hospitals is something that should be done tomorrow. But nonetheless, these are among the things that we are doing and we're also working on a global budget that means that we are going to pay upfront the hospital that is now negotiated in Northern Samar. We're working on something called payment hold, because government sometimes have difficulty spending the money and paying to the, let's say, drug stores or PPP partners so the payment hold, that means that we hold on to part of the payment, and you're now legally allowed to assign it to a private provider. So the rules on the payment hold and the assignment of the payment holds will happen soon. So, we're working on that. As we moved on we're quite open to discussions on other options because if the supply side is not there, then all of our efforts in enrolling all Filipinos will be for naught. So these are our efforts to make sure that the supply side is steady enough with the demand that we're generating which will be increasing as we improve on PhilHealth

Question/response from a delegate:

2. **Rostom Deiparene**: It is really admirable, Dodo, that you were able to inspire, if not implement, the desire of the country's President when it comes to universal healthcare. And your decision to use the members' premium to primarily cover for the poorest of the poor while the bill on sin tax is still pending in Congress. My question is that: Could you share with us how are the LGUs catching up with the demand that you have created considering that the needs of many Filipinos are really situated in the rural areas and confined primarily on primary health care?

Response from the speaker:

The one that pays for the poor is not the premium money of members. It's the tax revenues. So what happened is that this year, it increased from 3 billion to 12 billion. Next

year we will have about 12 billion and 14 billion that's un-programmed but if the sin tax is approved it comes in. So potentially next year we'll have 36 billion to subsidise the enrolment of the poor. So, admittedly, the total number, the total headcount of the poor that are now enrolled has really gone up. So how are the LGUs responding? Because they are essentially the ones that provide the services. Well, one which is not resolved, a very difficult question. Whether the LGU should be an enrolee or a payer of premium, or a provider? And as we expand let's say the money that's available for us to enrol potentially we may no longer have to talk to the LGUs to become a payer of premium. Why would that be good? Because then the role confusion makes it difficult for us to engage them. Because if they are going to be a payer of premium and a provider, it's difficult to discipline somebody whom you also trying to market the programme. How can you get angry at somebody whom you also want to pay you right? So hopefully, as the sin tax gets amended and we get the money to enrol everybody, now, we don't have to ask them to pay premium. Once that happens then the rule now for us as a provider of services, what are we seeing? Essentially what we're seeing is I think just like any market response. If the money is there, they scale up. Now what's key? The money has to be felt by the health staff. If the local government refuses to have any flow back of the PhilHealth revenues into the staff or into the health centre that means they get money and keep in the general fund, you don't see any response. You know, you see the same level. So what? So, why would I do extra work? So incentives really count. So, it's critical at this point that when you talk about these local governments that some of the reimbursements of PhilHealth will flow back to the staff. It's legally allowed and really some level of fiscal autonomy is given to the health staff in order to use it to the improvement of health facility. If this does not happen, I don't think you will see any scale up of the LGU services. If the right incentives are there, it's beautiful and we've seen lots of lots of wonderful stories all over the country right now in which the local governments together with their health providers have scaled up services to the point that they look like private. At the end of the day, and I don't want to use it but the way I look at local government providers they are like private sector. At the end of the day, if you look at their relationship, you know, if you talk about government, they are probably government in the sense that they are government-owed. But essentially the way they act for me is like just like any private sector provider. And probably once the DOH hospitals become autonomous we will treat them the same way. And that means the kind of tools we use dealing with private are the kind of tools I will do with you. That means contracts, negotiate, show you the money and hopefully once you see the money you'll be nice to our member. That's how we will deal with LGUs.

Question/response from a delegate:

3. **Uy Vengky**: My question concerns with the benefit package and also the selection of the modality case based payment for the insurance. Among the other modality payment, what was the reason behind what could be the advantage for the selection of this case based payments? And on the benefit package, do you have any public goods outside of the

benefit package covered by the insurance? If so what other mechanism is in place to cover the non-covered under the benefit package? Regarding the sin tax. Question whether the sin tax is earmarked sin tax or from a general allocation based on the needs of the insurance and the common level of the subsidy to the insured. On co-payment because the arrangement of the co-payment for private and public. There is co-payment for private sector and I think the idea is to balance between the public and private encouraging the insured to use the public sector. What is your observation after introduction of these two mechanisms, co-payment and non- co-payment in the public sector? Thank you very much.

Response from the speaker:

Ok, I'll probably start answering your last question. For sure, co-payment has always been allowed in the Philippines and it's really bad co-payment because it's purely unregulated co-payment. So the concept of fixed co-payment or co-payment with rules is something new, so we haven't really done studies there. But we've started with really mandating no co-payment first. At this stage, the problem in the Philippines is lack of utilisation so if we talk about, let's say, the extent of ulcer surgeries here. Probably of people who need surgery 30 per cent are only getting it so the need for co-payment at this point to deter moral hazard is not that necessary. But nonetheless, what we actually have here is pure unregulated co-payment so we started to do fix co-pay. So, probably, I'll answer you 6 months from now. As to the question of earmarking, the Philippine fiscal managers really do not like earmarking. They want general funds and even if there are laws here that specifically allow earmarking the way it's implemented it has never got followed. That's why it's really great now in this whole discussion of sin taxes, because it's the fiscal manager themselves, the finance minister, the budget minister are the ones talking about earmarks. I was so shocked the first time I heard it, the fiscal managers agreeing on earmarks? So it's them who're pushing for earmarks. And so for us how did this happen? I really don't know. Will this be implemented in the way in which enough controls will put in place that the earmark is not really an actual earmarks in implementation but this will finally be a real earmark where revenues will come in and we get the money? I hope the second one will happen because if we will do that it will be easier for us to do planning for expansion of the programme. The country hasn't really come out with the clear story on financing in general. So, for example we still have PhilHealth in there but the budget financing isn't in there. We haven't resolved who pays what. Ok, so there is no clear delineation here that you pay this insurance, you pay this. There's an extent of overlap, which I prefer to call redundancies. So, for example, when PhilHealth pays for tuberculosis care it spends large money from the government. I think at this point this discussion of who pays what will be resolved but I have no problem with redundant payment. You can call it inefficiency; I just call it redundancies. Given the fact that part of the challenge we have as a country is to scale up spending for health. I'd rather have spending for health even if it is going to pay for the same thing, but we will resolve these redundancies as we move forward.

As to the selection of benefits, the Philippines operate in a negative list. That is essentially, everything is paid for except for cosmetic surgery. Right? Now we see two hands up here. No, no the ladies are too beautiful here. So, we don't need insurance to pay for cosmetic surgeries so we approach negative list so that's the problem. Because as you shift to case payment, then there's a positive list approach, right? So how do we do that? So we start with a very a sort of operational way. What's the most number of cases, so pick the 50. The 20 plus that accounts for 50 per cent of claims. The next step is now to do all. So hopefully you can do all case rates and so we're essentially done now and see the lesson that we've learned for the past 11 months is essentially case rates work so we're shifting to all case rates. So the challenge now is to have case rates for about 14,000 diagnosis and 7,000 procedures. Ok, if I get American consultants it becomes 50,000 diagnosis so I'm pushing back to make sure that we get advice that's much more simple. I like the Japanese model. Actually the diagnosis procedure that Japan actually does is quite elegant and so we're looking at that. But we are going to do case rates. My stand is this. All case rates in the Philippines may not be perfect but it's much better than doing fee for service. Cambodia please don't go into that. I know that you're setting up a health insurance programme. Do not listen to doctors. Ok. Do not do fee for service. Look at the Koreans. They could not do 100 per cent case rates. The Korean doctors were too tough. Ok. So don't make that mistake that we did.

7. Parallel Session

Facilitator: Aileen Riego-Javier

7.1. PPPs in Health in Decentralised Settings

7.1.1. Decentralised Health Governance: Boon or Bane for PPPs?

Speaker: Aquilino Q. Pimentel Jr.

Thank you very much for that very kind introduction. The only thing that I do not like about that is when you call me the father of the Local Government Code (LGC). My problem is that my wife might suspect that I have other kids other than the legitimate ones. But thank you nevertheless for those beautiful words. That is the kind of talk that I wish to hear when I am already lying in state so that it cannot be changed anymore. Let me greet immediately our Secretary of Health, Dr. Ona, the and other officials of the DOH, and the organisers of course of this forum, particularly the DOH, DBP, PhilHealth Corporation, UN Economic Commission for Europe, WHO and ADB.

Now, when I was invited to give this talk I was wondering what kind of talk would I give. And finally, after a little reflection, we decided to discuss whether or not the devolution of health from national government to the local government units was a bane or bone to our nation's health system. And so, our first slide will show you a guide to our discussion,

namely the basic premise, constitutional provisions, local government provisions and some suggestions. The basic premise is that health is of utmost importance. And, I believe that after the basic right, the human right of life, health should come as one of the most important human rights of the person. And in our situation, that idea is reflected in our basic law, the Constitution. The Constitution says even from the very preamble the promotion of the common good, and of course that includes the good of the individual, the human being. And if you go to Article 2 which deals with the basic principles of the Constitution, Section 5 speaks of the promotion of the general welfare. And incidentally, take note of that phrase "general welfare". Because, I have always told our participants in local government seminars, we are holding monthly seminars for the last two years now for local government units. I've always send this message to them that even if a power is not specifically granted, enumerated for example in the LGC, but if that power is for the general welfare of your people, you can do it. Provided it is not barred by the Constitution. Provided it is a power that is not handled by a higher-level authority and provided of course it is not against the law. But otherwise, you can do it. I will try to expand on that idea as we go along.

Then you go to state policies, this is also in the Constitution. Provide improved quality of life. And certainly, quality of life must include health because otherwise what kind of quality of life would that be without health. And then Section 13 speaks of protecting the physical and well-being of the youth. That is focusing now on more particular sectors of our society. And Section 15 speaks of the protection and promotion of the right of health of the people, and of instilling health consciousness among them. So it is not just a matter of what you need to be healthy, but to be proactive in your appreciation of what you need to become healthy – health consciousness. And then we speak of the health rights. Also these are in the Constitution I want you to understand that, in the basic law of the land. Section 16, protect and advance the right of the people to a balanced and healthful ecology. At that time when the Constitution was crafted in 1986 I think the buzzword was ecology not environment. But of course we know that's essentially the meaning of it. And this is very important nowadays because of the advent of so many pollutants and reliance on things that should not be. For example, there are LGUs now which we have been able to convince to ban the use of plastics, plastic bags, and so on. And there are some stores now even here in Pasig and in Makati, which ban the selling of plastics. Because obviously, you know, I have been a mayor once, and one of the things I get reports from my Department of Public Works people that our sewerage system usually gets disabled because of so many plastics pieces thrown by irresponsible users. And so, this is one area I am trying to say. And also smoking, because I think smoking is one vice that is of absolutely no use. You burn your money, you burn your lungs and you pollute the atmosphere, and even contaminate those who otherwise would have no lung ailments and be affected by your vice. So, absolutely of no use. And therefore LGUs could, under the principle of general welfare, provide for the banning of smoking. And that is why you know very well in the US and in Europe certain offices are banning smoking, and I suppose also here, where offices are also banning smoking in order to respect the rights of others. Then Section 17

speaks of promotion of total human development. Again, when you speak of total human development you include health as an aspect of these human rights. Then in Article 13, again, this is a Constitutional provision. The duty of the state on health is to adopt integrated and comprehensive approach to health development, you see? Integrated and comprehensive approach to health development and to make essential health services available to all the people at affordable costs. And I might as well, you know, fast track this conversation a little bit more and say, this is probably where the private partners of government can come in on the issue of affordable cost. Because if many of our people are unable to access health services, the inhibiting factor is usually the cost. Then we proceed to Section 11 of article 13, because the Constitution lays down the priorities for the underprivileged, for the sick, for the elderly, the disabled and the women and children. And endeavour to provide free medical services to paupers of which we have a lot. Every now and then you see even when you are passing through the main roads of this metropolis, you see beggars who have no homes of their own and are actually vagrants. And the state is mandated to endeavour to provide free medical services to these paupers. But you will see the word "endeavour" because the truth of the matter is our financial situation may not really suffice to address that part of the problem. Then in Section 12 of Article 13, the State shall undertake appropriate health manpower development and research responsive to the country's health needs and problems, which is easier said than done. Because, you know very well how expensive research is. And again, probably this is one area where, if we can get honest-to-goodness private health people involved in the research and development of medical products in this country that would go a long way towards alleviating the massive deprivation of health services to our people. And then again Article 13, Section 13, the State shall establish a special agency for the rehabilitation of people in need, self-development and self-reliance and integration into the mainstream of society.

Alright, those are the principles embodied in the Constitution, the basic law of the land. In 1991, I was in the Senate and I was able to help craft the so-called Local Government Code which devolved a number of functions that used to be exclusively exercised by the central government. And please take note of this, there are three departments, mainly that used to be run exclusively by the central government which were now devolved to LG. What are these? DA, DOH, DSWD. I want all of you to know that when we were doing this, we got a lot of resistance from the national agencies concerned. Because, it was a question of turf. No one wants to loss turf in a bureaucracy. And it took a long time before we were able to get the law passed. In this country when you craft a law in the Senate a similar bill has to be filed in the House of Representatives. And any conflicting provisions will have to be harmonised. Usually, in my experience, if there were conflicting provisions of ordinary bills, the Bicameral Conference Committee would probably have three or four meetings then everything is settled. But in the LGC, my assistant tells me that we ran over 50 Bicameral Conference Committee meetings before we got things finally settled. For the record, I want to give credit where credit is due. The main reason why the LGC was passed during that time, the reason for that was President Corazon Aquino had no attachment to

power. And she called the Secretary of Health, Secretary of Agriculture and Secretary of Social Welfare and all the other departments parts of whose functions were also affected. You know you let the bill that Senator Pimentel is advocating, let it pass because it is good for our country. That is the reason, among other things why the bill was passed.

[…] of which is the province, followed by the city then you have the municipality and then the barangay, which is smallest unit of government. In other countries, I have been to a number of international conferences on local governance. They were surprised and they would ask me to speak on local government here, and I tell them that in the smallest unit of government in this country, the barangay, the leaders are elected. Because in many places, the so-called village leaders are simply appointed or traditional leaders which are just continued and then they would not get a specific amount of the money that government would appropriate for the running local government units, but not in this country. In this country the province receives a specific amount, the city also, then the municipality and the barangay. And just to give you an idea, the entire collection of the government from the Bureau of Internal Revenue (BIR) taxes, let me repeat that, from the BIR taxes, because there are collections that are not embraced by that phraseology: "BIR taxes". From the BIR taxes, the LGUs of this country follow a formula by which they get a certain percentage of the totality of the collections of the BIR taxes. And the division in general is 60/40, i.e. 60 per cent for the central government and 40 per cent for the LGUs. And among the LGUs they divide the 40 per cent. Let's make that 100 per cent now. And 23 per cent of that goes to the province, 23 per cent goes to the City and 24 per cent goes to the municipalities and 20 per cent goes to the barangays. So you see, the barangay whether it is the smallest unit of government or not actually receives a certain amount. Many of them are complaining to me today, asking why they are receiving a small amount. I said please remember that money is never be enough. Even Bill Gates is still trying to earn more money. You know it is a question of prioritisation. You cannot say you add more money if there is no more money to divide, how can that be? Essentially therefore, what I am trying to say is that under the local government system that we have adopted, the LGUs have specific functions and they have money. Maybe not enough for all their needs, but with prioritisation they can move along. Alright?

So, let us go to health. What are the powers of the barangays in health? Let us start with the smallest unit.

1. In general, to deliver all basic health services.
2. Promote the general hygiene
3. Promote sanitation
4. Construct and maintain health centres.

Where incidentally the common complaint is, we have health centres but we have no doctors and nurses. So you see, I am just trying to picture out to you the specific problems that are encountered by what we are trying to do for our people. And then, 5. Provide solid waste disposal system.

Then the next higher level of LGU is the municipality. What are the health powers of the municipality in general?

1. In general, deliver primary health services
2. Promote general hygiene
3. Promote sanitation
4. Provide access to secondary and tertiary health services
5. Construction and maintenance of health centres, clinics, and other health facilities.

That is for the municipality.

Then you go to the province, the province has in general the power to deliver all health services, primary, secondary and tertiary and even specialised health services. Construct and maintain health centres and tertiary health clinics. What about the city. The city, my dear friends, in this country encompasses, embraces all the powers of the other LGUs from the barangays all the way up to the provinces. So you will therefore see that the devolution of health functions of government essentially has been divided into two parts mainly. The more specifically concrete health services that are immediately felt by the people are devolved to LGUs. But I am not saying that it is the totality of the health services that has been devolved because obviously when epidemics come you cannot expect the LGUs to fight an epidemic hitting the province of Baguio which will be affecting Benguet to do it on their own. There has to be some national presence in that. And so, that is what we are trying to say, I am jumping ahead in my presentation but I would like you to say already that it's a sort of a qualified kind of devolution. In other words certain health powers have to be retained by the central government. Now, in the LGU, the provinces, the cities and the municipalities, are supposed to create their own Local Health Boards. That's what we call them. And among the functions of these health boards are, proposed annual budgetary allocations for the maintenance and operation of health facilities in the LGUs, advise the "*Sanggunian*", that's the law making body of the LGU, of the funds needed for public health services, and then create advisory committees about administrative matters, personnel selection, discipline, budget review and so forth and so on.

Let us go back to what powers still remain with the DOH. Basically, because of the devolution what I am saying is that, on matters that illness that defy boundaries that should be the domain of the DOH. Because obviously you cannot, no longer, entrust that to the LGUs whose functions are limited to their own specific territorial boundaries, and provide medical care and expertise, facilities beyond the capacities of LGUs to deliver. Now this is very important because you go to a province, you see hospitals that may not have the facilities even if they are so-called tertiary hospitals but they do not have facilities to deliver tertiary health care because of lack of facilities. Therefore, it is a question of funding; therefore it's a question of devolving more funds to enable LGUs to address those needs.

Now, I would now like to go into the question of where the private sector is urgently needed. Making medicine and medical treatment accessible and affordable. Believe it or not, this is a very real problem and I'm sure this is also true of other, so-called developing countries. It's not only here but I'm sure other countries likewise suffer this kind of same problem. Medicines and medical treatments to combat at least the ten of the most dreaded diseases afflicting the masses of our people and incidentally, this might create lot of problems among users but on the personal level I cannot understand why the government will appropriate 500 billion pesos for the purchase of condoms. Condoms are not medicines. I don't think it's 500 billion, it's million not billion but that's a lot of money. And I think that's a misplaced priority. Anyway. Some examples are lung, health, heart ailments, of course diabetes, many Filipinos are getting fatter than you know the body can bear, which is not too good if I may say. And then pneneumonia, and other pulmonary diseases. Then lastly, I'd like them, the private health sector to validate their claims of the curative powers of organic medicines. There are so many claims here and then there's a label saying therapeutic claim, "*ano yun*" not included. But it is true that many of our native products are really curative. For example, during the war, during the Japanese war I was already a young boy and a lot of my friends, my uncles etc. were suffering from malaria. The main cure was the sap of the cinchona tree. You know, it's just a question of validating. And just at lunch today, I have a friend who is from Davao. He said his son who is 19, 20 years old had an attack of dengue. He was hospitalised for dengue and then his uncle from Davao came here and said "I have got a cure for dengue". He asked, "What is that?" He said "durian." You know he brought him durian and he got well. I'm not saying never to use the chemical-based pills to combat dengue, but we should attempt to validate precisely this claims because many of our products here are validated by foreigners and then they come and get our basic natural resources, like seaweeds for example from Bohol. A friend of mine, who was dying of cancer, got well by eating seaweeds. And then some Swiss doctors went over to validate and I think they are now selling the products to us. So, what I'm really trying to say is that if we can get private health sectors interested in such things, it will go a long way to make the delivery of medical services to our people a reality. Rather than continuously being dependent on chemical-based medicine when organic-based medicines can do the thing but it has to be validated. But this has to be validated I'm not just saying that just because somebody claims it can be done, it doesn't mean that we automatically take that for granted. Now, private health sector problems with the LGU's lack of fund, lack of money as usual, so many activities that have to be funded. And then the private health sector would probably find problem haggling with local authorities because every city has its own jurisdiction, province, and of course, the matter of corruption. That's something that will have to be addressed and I am happy when I heard that Commissioner Heidi Mendoza is attending this session. If she is not yet here, she will be attending the session because she is our Commissioner in our Commission on Audit and one of the respected names in our bureaucracy. Then, what about the private health sector dealing with the national

government? The advantage is you negotiate with only one entity. You negotiate only with Department of Health. The disadvantage is that there is an absence of concern for the specific needs of a given community. Do not tell me that the Department of Health knows all the specific health problems of localities. The localities know that better than any national bureaucrat. Now, of course, corruption also comes in. When I was framing the LGC, one of the arguments on the floor when we were debating it was that they said "ah, you are multiplying corruption". I said for heaven's sake, if you talk of corruption, there is a much bigger corruption in the central government than in the local governments. In the central government, whole bulldozers disappear. In the LGUs, small things … But we need to say, when we talk about corruption that's another matter completely. The laws against corruption should apply. The problem in this country, of course, is that, many laws are there but are not implemented. So, on the issue on corruption, this will have to be tackled by the laws applicable to corruption and that shouldn't in any way inhibit the delivery of basic services to our people. Then, this might be my second or third to the final slide. You look at the DOH budget from 1991 to 2013. From 1991 we only have 7.17 billion, and then, it went down to 6.9 billion in next year, but after that, it began to rise. And then today, it seems to me that it has gone to the stratosphere, higher than the place in the sky, where Felix Baumgartner dived into human consciousness for popularity. So high, 54.6 billion. National budget, not for local government budget. National budget for health. And I am saying that, the reason for this, the main reason, tactfully stated, diplomatically said is practical politics. Why? Because the congressmen, the congresswomen and the senators would do what? It is easier for them to approach the central government official here "I need certain amount to appropriate for my district" rather than for them to go to their local government official who might be their political adversaries. So, you see, that is the practical reason why the budget of the Department of Health instead of going down has gone up all the way. I don't know. As I said, higher than the platform of Felix Baumgartner when he dived from the sky, 39 kilometres from the surface of the earth.

So I have some suggestions to ease the worsening health delivery services.

1. To harmonise powers and coordinate delivery of health services by the national government and the local government code, which again of course, is easier said than done. We know that. But it can be done with good faith and with the general welfare of our people at heart. I think it can be done.
2. Facilitate entry of concerned honest-to-goodness private health sectors into the delivery of health services, nationally as well as locally. And then, putting up specialised hospitals or units in existing hospitals maintained and operated by the national government. In an effort to help complete the delivery of health services needed by our people in localities which do not yet enjoy those kind of services to assure accessibility which is ordained by the Constitution and affordability of services for the people in need.
3. Put an end to the establishment of district or satellite government hospitals. You know this is what I would like to emphasise, the Department of Health should

object to any attempt by any congressmen or senators to put up satellite hospital. Because very often this satellite hospital are being put as a legacy to which congressmen and senators would say ”You know, I built that satellite hospital” even if there’s no doctor, no nurse and no equipment. And I think the DOH should put its foot down that it should not be done. To deter such kind of wastage of so much money and effort on the part of efforts on the part of government just to address the health problems of our nation.

4. Then, national government should concentrate on trans-boundary diseases, epidemics and the like. Then, give leeway to the local government units to treat diseases devolved to them. And in this end to augment in terms of funds and equipment whatever they lack and put funds into research and development of organic medicines to lessen our dependence on chemical-based medicines.

These are the opinion of the layman on health subject to the better judgment of those who know best. “*Salamat po sa inyong lahat*”. Thank you very much.

7.1.2. Auditors: Allies or Enemies of PPPs? A Look at Auditing Dynamics in PPP Regimes

Speaker: Heidi Mendoza

Cancelled since the speaker could not attend.

7.1.3. Open Forum

Question/response from a delegate:

1. **[…] Santos**: Senator, thank you for your lecture. I am from the University of the Philippines and I am also with a private bank, I am a medical director of a bank. One trend we heard from Undersecretary Herbosa is that the reverse of devolution will be a something to expect in which some devolved hospitals could be returned to the national government, and some hospitals that were devolved will be reacquired depending on the strategic plan that will arise in the coming years and depending on the need. The question I have, Sir, is that the common cry in our university is fragmentation. Fragmentation of health care, and they usually blame the LGC and devolution for the fragmentation. In the college of Public Health it is often part of the lecture in HPAD 201, Health Policy Administration 201, and the students are asked to react to it. So, therefore, any idea on the positive and negative side. It will be our honour if you would wish to give your insights to this, since it was explained this morning. And also for our foreign guests to understand devolution was also a reaction to centralism of the martial law regime. And it was part of the deconstruction of the process of the administrative hierarchy of the Marcos era. So has that led to

deconstruct or to decentralize as a reaction to authoritarianism […], and therefore, a new era is now in place? Thank you, Sir.

Response from the speaker:

Thank you very much for that question. Let me say that of course the LGC was a reaction to the over-centralisation that we experienced during the martial law regime, where everything was of course decided by the authoritarian ruler. Everything, including your life, your liberty. As a matter of fact in my own personal experience, I was only jailed four times, only four times, not too many. And all because I was speaking out, not for armed struggle but for the curtailment of the concentration of power in the hands of one man. I do not believe that one man has the right to tell everybody else you follow me because I am the only one who is right. That's not the essence of democracy at all. So when we were able to finally oust President Marcos with President Cory Aquino, as I said, she had no attachment to power to begin with. And so it was more or less free territory as it were to map a plan where government powers could be shared by various units of government throughout the nation. And I'd like to tell you that even before the LGC was passed in 1991, the Marcos regime was ousted in 1986, so you see from 1986 to 1991, I remember that when I was in Cagayan De Oro, I was a member of the National Assembly at that time. Misamis Oriental my province is adjoining Agusan del Norte. But in between Agusan Del Norte and Misamis Oriental there's a huge river that has to be spanned by a bridge to enable people to cross. You know even building that bridge needed approval by Manila in so far as the plans are concerned, the expertise of the engineers from Manila to come over and the funding from Manila to construct that bridge. You see how tedious the process of development would be if everything is decided from a central government perspective, so far away from the place where the action is supposed to take place. The reason is that, especially we are an archipelagic country we are not one landlocked nation, which you can traverse by just going by car or by bus. You have to take a plane or boat before you can reach the farthest nook and corner of this land. Therefore it is important that we apply what I have tried to justify the local government for apply the principle of subsidiarity. Where, what can be done by the smallest unit of government should not be interfered with by the higher level of government. Allow the smallest unit under the principle of subsidiarity to do it. But it has to be somehow defined, because you cannot just allow everyone to do his own thing without consideration of the welfare of other communities. So that is basically why we crafted the LGC in an attempt to diffuse too much concentration of power in the central government and enable the LGU as it were to plan out their course of their own development without too much interference from Manila.

Question/response from a delegate:

2. **Uy Vengky**: It's interesting to see the decentralisation of health in the Philippines. One thing that is not clear to me is about the human resource management in relation to the decentralisation. Have these human resources been decentralised to the local health authority? Second is the drug supply. Whether these are localised and what level of decentralisation of the procurement of drugs and other medical equipment for local facilities has occurred? Thank you.

Response from the speaker:

On the issue of personnel. I want you to know that we had a big problem here. Because when the functions of health, agriculture and social welfare were devolved, the objective of the law was to also transfer the personnel to the LGUs. We were only partially successful in that because the Department of Agriculture, Department of Health and Department of Social Welfare maintained a good portion of their personnel instead of devolving them to the LGUs. And one of the problems that confronted the LGUs then was that at least on the issue of salary, the national government employees had a higher salary levels than the local governments. So we have now a question of adjusting the salary levels of those who will be absorbed by the LGUs. And that was a terrible time for us. It took time before that could be adjusted. But I want you to know that it was a real problem, really. Now when the devolution was already more or less in place, the choices of who will be the local City Health Officer, for example, that would now belong to the City. Who will be the health employees that would belong to the city? That matter will no longer be within the purview of the authority of the central government. So that is as far as how to deal with civil service employees.

On the second question, procurement of medicines is essentially a function of LGUs already. But, the problem of course as I intimated to you, quite often the national government still comes in. I have not heard of any complaints under the secretaryship of Secretary Ona. But in the previous administration I have heard a lot of complaints. Or not a lot, but some complaints. Where for example a certain province the official there told me, "Senator, we do not need these medicine, why were these medicine sent to us?" We have no need for this. But it was bought by the central government. And the central government had to apportion the medicines, one container to this province and one to another even if it was not needed. You see that's the problem there. In the procurement of medicine, it is better that it is done at the LGU level where they know what their needs are. But of course subject to accountability and transparency. Of which we are having problems incidentally I also want you to know that. But essentially procurement should be a local matter, because otherwise medicines that are not needed are dumped into your place. You're stuck with it, medicines unneeded so they are just you know wrapped in your warehouses.

Question/response from a delegate:

3. **Benjamin De Leon**: I am not going to argue with former Senator Pimentel about his views on condoms because I differ with him. But at any rate I have this easy to raise question. You know Senator Pimentel is the author and framer of the devolution in this country and he is being recognised and respected for that. It has been 21 years now since 1991, and I wonder on the issues raised by Senator Pimentel and the solutions and recommendations and analysis of the past 21 years, what would you suggest if the law is going to be amended on that to ensure that somehow the issues that you have raised will be solved or at least will help in ensuring that the local government gets autonomy which is good for the province?

Response from the speaker:

As a former local government official, I know that the actuations of local governments are often influenced by incentives. Meaning to say you do this and you get a certain amount to add to your coffers. Maybe that is one way of doing it. Maybe. So that if this particular government unit is weak in addressing the lung air problem of their constituency but if you address this issue then you get a little amount more for your, not only for those needs but for your other needs as well, that would very well be a good way of promoting and encouraging the LGU to do their thing. And incidentally, I might as well mention that the Conditional Cash Transfer (CCT) which is being implemented in this country. I understand that you had a speaker here the other day Mr. [Santiago] Levy. The CCT here in this country, again has a noble intention to directly address the needs of those in need. My problem is that it is being implemented by a national agency that is so far away from the constituencies that really need it. So, my suggestions has always been, that instead of the DSWD administering the CCT, it should be the LGUs because they are the ones more familiar with who are the people who actually need of services. Then secondly, that we should depart from the dole out mentality that these money is given to you and you only account for it in terms of sending your children to school or having them medicated but you do not need to work for it. My goodness! I think they should be made to work for it. There are thousands and one things that people who have no work and do in their own locality. You clean the "*esteros*", cut the grass in the public plaza, clean the marketplace. A thousand and one, it is only a question of innovation I think. Then that programme can become a very real way of addressing the problem of poverty of our people without sacrificing their dignity as a human being. Because if you promote dole out mentality you are erasing the dignity of our people.

Question/response from a delegate:

4. **Roland Cortez**: Good afternoon, Sir. Of course, just like the comment with regards to our budget now. It's very, actually high as mentioned by the Honourable Senator. But I would like to point out too that the majority of the functions or the things that should be done by our LGUs are not being undertaken, like for example, rehabilitations of health centres and so forth and so on. And majority of our budgets now are being infused back to the LGUs to actually address all the needs of those from the lowest level to the highest level. But this is not my question, Sir. My question is, if devolution is actually one of the best strategies to give to our people, to give them the power to decide on their own, why was education and the other departments not included?

Response from the speaker:

Let us tackle education, as a matter of fact, the truth of the matter is that, when we were crafting the LGC I was really thinking that we should devolve education also. The problem that bothered me was, remember that teachers are poll watchers. Can you imagine if, you know, they are all appointed by the mayor and they become poll watchers. They become instruments of partisan politics instead of being vehicles for the more noble purposes of education. That was the inhibitory factor on the matter of devolving education also. The question of the teachers becoming poll watchers. Even as of now they are still the poll watchers, that is why one of the things that I want to do as an amendments to the LGC is to remove the teachers from poll watching duties and replace them by voluntary organisations of the ROTC? There's an ROTC (Reserve Officers Training Corps), which is supposed to be non-partisan, and therefore can probably be expected to be a little more conscious of their duty to ensure the true expression of the will of the people. And then, having done that, then we can devolved education already to the hands of the LGUs, but always subject also to some kind of an over-all mandate so that if your child for example is a second grade in Davao and he wants to transfer to Manila, he will still be recognised as a second grader. You understand what I am saying? In other words, the curriculum will have to be more or less on the some level, except for some specialisation. For example you cannot insist that people in the Cordillera should be taught deep-sea fishing because there is no sea in the Cordilleras. But other than that, variations can happen but the basic theme of education should be maintained. Now, what about the other departments? I do not want to experiment with so many. I wanted a more limited kind of experimentation that's why we chose only have three.

Question/response from a delegate:

5. **Teresa Jenna**: Hi Senator! There are a lot of foreign businesses in this room, and I wonder how you feel about this issue. Does it help or hinder foreign businesses to

lobby government officials? Now, many of us, as Americans, do not want to give any privileges. We want to lobby legally, to get laws passed. I know the EMS law's being considered of course in a business we're looking at that. But what is your feeling about foreign businesses that want to bring in products and want to lobby the government officials, for passages of laws?

Response from the speaker:

There is no question that lobbying can promote certain activities, but I think foreigners should be a little sensitive to the peculiarities of the Filipino. We are a very hospitable people but at the same time we don't want to be pushed around Meaning to say, if a certain group wants to lobby, they should, I think, appeal to the higher sensibilities and noble intentions of the programmes that you are pushing for rather than for other matters. And it will surely help if the objective is the promotion of the common good, the usual buzzword for everything that the government has to do. So, that's about all I can say regarding that matter.

Question/response from a delegate:

6. **Catherine Miral**: This is maybe a naïve observation coming from a simple doctor from a small province but this is what's happening in a small province like ours. After the devolution I was not yet a doctor then, I was in college. But after the devolution there was no improvement in any health facility in our province. That's very true. So we are now thanking the DOH for the big budget that they are receiving from the DBM and that budget is now directed or given to us directly. And we are one of the recipients of that budget because right now we are going to repair our provincial hospital. That is very good. Thank you the national office. And also, we are having too much difficulty in improving our services, the quality of services that we provide for our patients, because we have this tight budget because most of our budget is being given for the personal services. That is after the transfer of the employees from national office to the local government without transferring the budget. So, we have this up to the ceiling personnel services that the local government will be paying and nothing is spared anymore for the services that we need to give to our people. So I think there is a need to review the LGC with regards to health and health services and health system. Thank you.

Response from the speaker:

Certainly, I agree with you, there are so many areas relative to health that have to be addressed because the LGC was not intended to be a cure all and be all at all times for these situation of health in this country. It is not a static document. You have to move on and adjust it to the demands of the times. Now, here's one thing that I would like

you to know. The budgets of the barangay have to start from the Barangay Development Council (BDC). And if you want the barangay to at least allocate some funds to health, you work through that BDC. And it is important to do that because the BDC has a unique kind of membership where the representative of the congressman or woman is a member of the BDC. So you see, if you are able to put in some money there for the development of health services in the barangay, you can expect the congressman to push that to a higher level where the budget of the national government will be considered because it is the Congress that will do the budgeting. So yes, I agree with you, and certainly, one of the things that I find rather disturbing is that the LGC says that the maximum of personnel services allocation should only be 55 per cent. That is the maximum. It does not say that you ought to hit the ceiling of that maximum. If there are other priorities than just put it in a messenger or put it in a "*compadre*" of the mayor, for heaven's sake, but that has to be addressed to their own appreciation of what is good for the community. That is a difficult thing. Incidentally, not all the things in this world can be solved by legislations. In other words, there is room for ingenuity and human compassion

Question/response from a delegate:

7. **Delegate (no introduction made)**: This is with regards to the LGUs score card. In this scorecard, there's this portion there that asks the LGU the amount of budget allocated as MOOE for health. But usually it's red. In all LGUs it's red. And I believed the LGUs scorecard is implemented up to the level of municipal unit but not to the barangay level. So, I think if it is a true local government unit devolution and it should be up to the barangay level because they are the one that affects the health of the people. They are the ones that really take care of the health of the people. So the LGU scorecard should be also implemented at the barangay level not only at the municipal level. And there should be at least curative measures. What do we have to do for all local executives to really comply with the 25 per cent or above MOOE for health?

Response from the speaker:

Well, first, I want you to know that under the LGC, there are already requirements of accountability. From the time the LGU receives what is known as the Internal Revenue Allotment (IRA), there is an obligation to publicise that already in a newspaper. Unfortunately, I could not require publication in newspapers because at that time when we crafted the local government code, not all localities had newspapers. So what we did was in lieu of, or if there are no newspapers of local circulation you can publish the money that you received by posting in three visible, accessible places, not in the "*kubeta*", not privately. You put it out in the public. That's the whole concept after receipt of the money. When the money is appropriated, another requirement for publication you see, so that there will be less

hocus pocus on how the money will be used. But of course that is better done in saying than in observance. It that being actually followed? It is one instance of a law that is there but is not being implemented. And this is where the proper implementation of the law can come in. But you have the need the vigilance of the people to make the law followed in your own community. If the people do not speak out, then to hell, I'm sorry, "*bahala kayo, buhay nyo*" you are not speaking out on your needs. Who cares? You see? That is why good governance is a matter of active participation of the community and the ones who are running the government.

Question/response from a delegate:

8. **Risma Sitorus**: Thank you, Sir. Actually, devolution and decentralisation, I think almost same, Senator. And all your explanations are almost same as in our country. Human resource problem, limited budget, medical and drugs, also transportation, access, everything, it has happened also in my country. But I am interested in your explanation about the practical political issues. Back to the PPP in health, what is the role of the political here in Manila to set up the PPP? Because you explained already more about corruption, about everything what happen in the national level. I will be thankful of your explanation. Thank you Sir.

Response from the speaker:

Thank you for that question. If I got you right. First let me say that there is a difference between decentralisation and devolution. Decentralisation is merely transferring central government power to another locality but is still controlled by the central government. While devolution is transferring power to another unit of government and leaving that unit of government to function and do their thing under a devolution of power. Now, relationship about PPPs in Manila and as well in local governments, the important thing is goodwill and honest-to-goodness intentions. And of course, the government, the domestic government in Manila as well as in localities has to ensure that whatever is entered into by PPPs for the delivery of health services will not be tainted by corruption, will not be frustrated by other partisan motivations because otherwise that will destroy the whole effort. That is about the general principle that I can talk about. As I said, not everything that is done by government is covered by law. Not true. Many areas where discretion and good judgment will come into play to deliver the services that are defined in agreements.

7.2. Towards Sustainability: Capacity Development and Social Marketing

Facilitator: Ivanhoe C. Escartin

7.2.1. Can Governments Do It? A Closer Look at Local and National Capacity Development in PPP in Health

Speaker: Juan Antonio Perez III

Reactor: Magdalena Mendoza

Verbatim transcriptions are not available.

7.2.2. Social Marketing: What Do We Want to Communicate?

Speaker: Florentino S. Solon

Verbatim transcriptions are not available.

7.2.3. Open Forum

Verbatim transcriptions are not available.

8. Monitoring of PPPs in Health

Facilitator: Manuel de Vera

8.1. Keeping Tab of Failures and Successes: A Guide to KPIs and Monitoring of PPPs in Health

Speaker: David Dombkins

Thank you, it is a pleasure to be here. We've been working towards this moment with the launch of the centre for almost 3 years. So it is great to see that it's finally happening. What I would like to do is use the UN Contract Management Manual, which will launch this part of the PPP toolkit. It's a basis for this discussion. But there are a number of key issues that I think need to be clarified. On the first day and then today a number of things have come out and I think need to be made clear. So I'll just cover some of those at first. This is a tool called P-cat. Project categorisation is based on a model developed in the Defence Department called ACAT - Acquisition Categorisation, which is used worldwide to look at projects based on different levels of complexities. And it is equally applicable to PPP. This document, what I'm giving you now is available, we developed it up as part of the UNECE toolkit, is available freely to you. And it's an automated tool that categorises projects at the varying levels of complexity. Now why

would you bother doing that? I am going to give you some data as to why we would do that. The reality is that when you apply an inappropriate methodology to a complex programme, you almost certainly got to fail. That is why. If you are embarking on health programmes of the type where we are getting into service delivery, all we got to suffer from technological change, they are becoming very, very complex. And traditional approaches, the PFI taught models that were developed back in 1988 nearly are inapplicable they are going to lead you to failure. And I dare say who amongst us today would dare to predict what healthcare, what technologies are going to be like in 20 years time? And tie a contract to that. Health is an area of high emergence where things change and change rapidly. And the methodologies that you use to manage these complex programmes are fundamentally different. The UN PPP toolkit includes a full range of approaches to PPP that gives you the ability to understand the level of complexity what you are dealing with and selecting, putting in place an appropriate methodology to deal with that project diverse life-cycle. So PCAT is a tool I think you should use. It is available freely. It has been proven internationally for over more than 20 years. You might find it surprising to actually go through and start assessing some of your projects where you have had successes and failures against it and see how it looks.

The other tool from the UN that is worth having to look at is the Readiness Assessment Tool. We developed this tool to help countries understand their capabilities to manage PPP programmes. It looks at the country across 8 criteria and has a self-assessment methodology, where it gives you a spider diagram for each of the sub-elements and an overall. The key advantages of this tool for you are, even in a country like the Philippines, that it is well advanced in looking and using PPP, to look at in a way where your strengths and weaknesses are. And particularly as you move away from as what we discussed this morning the most simple projects of roads and the like and you want to start moving in towards outcomes-based products by looking towards projects where you're looking towards the contract taking what we call a custodial responsibility or a stewardship role, where you expect them to take responsibility for outcomes not just outputs. And you expect them to be able to deal with change over the life of the contract. So I think you will find the Readiness Assessment Tool is a very good diagnostics model for you to look at yourself and identify areas where you may need to put a bit of effort in. Now, the main thrust of today's talk is contract management. Unfortunately in most PPP programmes, the emphasis gets driven by the bankers, by the lawyers and insurance companies. And you think the project was nothing more than having finalised the deal. You hear consultants talk about, we finalised that deal. How often do they talk about what the outcomes that were delivered from that project are? Because that's what matters, not that you finalised the deal. So contract management starts on the day you start the project. It does not come in some side event of it half way through the project […]. The groups that have to contract manage that programme over 20 years need to be part to set up the contract, defining the KPIs, designing the ICT systems, designing audit and governance systems etc. They need to be there from day 1, and they need to have a key role in the development of the contract, its negotiation and then take over full responsibility for its management. The UN model uses a systemic approach. As I said, stewardship to me is the key

issue. You look towards the contractor who will take that stewardship responsibility. Now with the Readiness Assessment Tool it gives you a guide to look at the where you sit in that maturity model for PPP. In my own country we have put many projects together and unfortunately found that neither the client nor the contractor possess the maturity that we might like for that project. Almost certainly one of those two would be lacking more than often, both parties would lack the maturity that's required to deliver what you want. As such, you are embarking on a journey together, where you are looking towards developing up that maturity. That means that over the contract, you probably got to have to start up with the KPIs and the like that aren't what you wanted. And you are going to have to do that methodology that will actually drive you down that journey. You can also have a methodology to cope with significant changes that regularly occur on these projects over their life cycles.

The UN PPP contract management manual deals with the full spectrum of projects from traditional PFI right down to the most complex defence, health and ICT programmes where change management in fact is a core part of the project. So, some of the interesting tools you will see in it, and I come to these in a moment, are the reward designs. But I'll explain that in detail. How do you design reward systems that drive contractors? One of the speakers or one of the commenter's correctly stated, industry is driven by one thing – profit. They don't deny that. So let's harness it. Rather than deny it, accept that's what drives them and design systems, they can take us on that journey and gives us the flexibility to steer where that contract places its emphasis. The other interesting part of the document, it breaks contract management up into three core areas.

1. You have got the service delivery cluster
2. You have got the administration cluster
3. And the relationship management cluster.

And each of those breaks down into these other ones. It gives you detailed tools to actually design and manage a project throughout its full life cycle. So I encourage you to spend some time having to look at the manual. What I'll do is going through some of the details of it. The central aims of it are very simple, to maintain governance. How do we ensure governance in the process, how do we ensure probity and avoid obviously corruption? But then how do we ensure that that we actually deliver something, that there is value for money, fit the purpose, for the community. That delivers the customer the outcome? The first that we put in place is one of bringing together what we see around the world as best practices. As part of developing this manual I got all, no, in fact, I got the majority of the PPP manuals from around the world and we put them together and mapped them. Some of them have significant strengths in some areas, others have significant weaknesses. So we have taken all of that and brought them together and then pulled out the gaps and so we end up with a complete document that represents best practice internationally. That document is available from the UNECE website. I would suggest that it should be used as a core document in the development of any PPP programme. There is one thing in the bottom there, it's managing change. I just have to hit that quickly. If I am building a jail, and jails are very good for PPPs under the traditional PFI model. Courts lock up prisoners or put sentenced prisoners for extended periods in prison, it seems

there is an unending supply of people who wanted to go to jail. So we have a set demand under set conditions so I can very easily predict a demand and my business model and my specifications for over 20 years. So from the PPP perspective jails are great to use PFI on. When I come into things like ICT and health, who can predict what the demands are? Who can predict what the disease threats are? Who can predict what the clinical solutions are? Who can predict what the change is in our environment, physically and socially? Let alone the innovations in technology and solutions. If you say you can, you are a liar. I worked with my own government's Department of the Prime Minister and Cabinet and one of the key issues they are having in policy development is abandoning a traditional approach to strategy because it doesn't work and accepting that the world is complex, the world is emerging, and developing methodologies to understand that a hospital is part of a much broader system or that a sustainability policy is part of a much broader system or an education programme, and how that project or how that policy can manage a system that they don't control and the system is going to consistently change. In developing a hospital, the health care solution, the hospital is but one element in a much broader system that's going to change. To be effective it must be part of that system and it must change in tandem with that system.

Where does contract management start? It starts with a policy. Do the Philippines have a contract management policy, a clear policy that says how you are going to manage your contracts? Most countries don't. And yet it is something that is needed from a contractor's perspective and a policy position, a contract management policy is a mandate that clearly defines what contract management means and how we implement it. If you develop a draft policy for you to look at and I again strongly suggest that you consider establishing a policy in respect of contract management.

The next thing is, how many transaction advisers have actually ever delivered a project? Your transaction advisers, are they involved in actually operating the projects they delivered? Do they take responsibility for managing the project after it's completed? Contract managers are the people that take position of this project and are responsible for delivering it over ten, fifteen, twenty years. They need to be a key part of the transaction advisory team as shown in the early slide, that is, they need to be […]. They need to model the system understanding how these projects are going to fit into the broader operational system, the administrative system, the payment system, the audit and review systems, the change management systems. Then, there's need to be a clear policy established, a strategy for contract management, and a very, very clear governance model for how contract management is going to be handled over the life of the programme. I mentioned reward design. If the person, the group that's going to manage this don't have a key role in defining the KPIs, and I'll get into that in the moment, and how they are going to be measured and reported, you are denying them a key tool that's going to be critical towards driving that programme over its life. It's inappropriate to have a transaction advisory team who are not responsible for the management of that project, defining the KPIs. At least to be the people who are actually going to be managing this deal, this programme over its life.

The organisational design. What's does the organisational design look like from managing this project, within the client and the contractor? In another country in the Middle East, I've recently been through this journey, where the organisation has a very, very traditional procurement model and yet they are embarking on a highly complex programme involving multiple contracts as in PPP type relationships and they are expecting to be able to project or contract manage that using a traditional approach to contract management. That project will fail and fail quickly. There is no way it can work. If you don't in fact put in place appropriate structures and changes within your own organisation or put in place an intermediary an organisation that operates between yourself and the contractor, you are destining your projects to fail. That might be harsh words but that's reality. And I can show you good examples in Saudi Arabia and Abu Dhabi and other countries, in my own, where these projects have collapsed because of that simple issue.

Selecting the team. The people that can work in complex PPP programmes are very, very different from those who manage commodity-based contracts, the skills sets, the tools, the processes you need, are fundamentally different. I'm not trying to lecture, I'm just telling you what happens. Now we've got the luxury of having been through this process and having closed out projects that have been through 20 years of PPP life and looking back at what happened and what did and what didn't work. The selection of the team is critical and their abilities to understand what this project is and manage it and doesn't happen quickly. In my own country we recognised we didn't have key people to do this. America and Britain realised the same. In fact the Americans, from their own assessments in the American Defence Department believe they have 90 per cent shortfall of people capable of managing complex programmes. 90 per cent shortfall. In my own country, the government recognised this as a critical skills shortfall that was a threat to the country and established a programme to identify and fast track the development of individuals to be able to manage these programmes as a key activity of the government. We did that 5 years ago and it has been very successful. So, these areas of contract management, […], and it needs to be addressed. I heard the previous speaker talking about the importance of training and again in Malaysia and other countries we've hit this wall. Where the existing structure and pay structure has limited the ability to employ appropriately confident people. You get what you pay for; there are small number of people that can manage these projects and you can take on the opportunity to develop them yourself as we did in Malaysia, we set up the programme over there to fast track the development of people for the future to deliver the 9th and 10th Malaysian plans and the PPP programme that's there now flowed out from that. But it's got a core of people that we have developed over 5 years, almost 7 years now to support its implementation. So you either train them yourself and put the effort into it or you employ the best. If you don't do that you leave yourself at significant risk. Now the contract management manual breaks the project into 6 separate phases and looks at them across these three clusters and identifies the key activities within them. What it also it does is using a thing called "wave planning". "Wave planning" is used by the American government as the best practice model for managing complexity. It's a vehicle for actually driving a process

which is recursive and non-linear, and in that sense stupid, that it drives […] and forces you to come back and reconsider what is project is about, what its objectives are and how you manage it. So the process is actually designed not only to review the project upfront using tools like gateway and valued entry, which I think the Norwegian model of […] or quality-at-entry, is probably one of the best in the world for valuation programmes. But also the Gateway Process […] is a very powerful tool to use over the life of the project. But when combined with the wave planning type of approach, it forces you to come back and reconsider why this project is established, is it achieving, should it be stopped, should it be modified, and how do we manage that process and its very important that those concepts are built into the contract. We had a discussion this morning talking about this 5 or 7-year review of contract positions. That's not enough. The scope and right of technological change and market change, 5 to 7 years is too long. You need to review the process annually. So, the contract rather than denying change needs to accept the change is fact a core part of the project and you have to manage it proactively rather than hope that in 5 or 7 years, you'll be able to cope at this a much larger change so it deals with it on a modular basis rather than a revolutionary change every 7 years.

Now as I've said the contract management manual has 3 clusters; service delivery. And are we there? At the simple level of PFI you have things like availability. Is the hospital available? Is the road available? At the high end we have a contract that looks at patient outcomes; that looks at actually delivering a measurable outcome and this is where the concept of stewardship comes into it. Is that contractor willing; does that contractor have the maturity to actually take on that responsibility and in doing that the government and the contractor form a very different relationship, that's not one of dumping risks, it's one of working together and designing a reward structure that drives the contractor commercially to deliver what you want. Now this isn't an up-in-the-sky, we've actually been doing this for over 15 years on some very complex programmes and done very successfully. The real issues you will have in implementing this, resistance to change within your own country, from your legal departments, your procurement departments. In Malaysia it took us years to get the few the documents straight and many, many intensive fights. In my own country we had similar issues. We've got them through and they have been very successful. But there is a fight; let's not pretend. That people will always gravitate back and pretend that we'll go to tender; we will get certainly from tender and that will be it. You've only got to look at what happened to the ICT industry to see the fallacy of that position, where contracts were let, outsourcing, using PPP type models for ICT and clients found fairly rapidly within 12 months to two years that the contract price has tripled. This contract […] that there is going to be a radical change and they rely on that and make windfall profits from it. Scope change is very significant. Scope definition by clients is usually very difficult; in clients almost always the data sets are inadequate or wrong when we got to predict our model, you cannot take models from overseas and extrapolate them back in your own country. In my doctor, where I remember my professor of stats said "I can have a million points; give him one and he'll give you any answer you like." I can like as can anybody very effectively stats and in fact the National Audit Office in Britain has been very, very damning of the models that have been used to put forward PPP projects. I think the models used by the

Norwegians, as I have said quality-at-entry and […] are much more robust and should really be looked at as key in this process. But issues such as the bias at entry from promoters or people within the government are endemic and need to be dealt with, as a real problem this is long-term money. You're talking commitments of 20 years sometimes with vast sums of money; and from my own country, we are probably the best place to learn what not to do. We've had hospitals fail, we've had multiple railways fail, we've had roads fail, you name it, we've had multi-billion dollar fails and in almost every sector you could name. We also learned a lot on that journey, on what to do and not to do. Having said that, I think the key part of the approach we adopt from the UN, is that each country has to adapt this to themselves, because you can't take on what's done in my country, or in America or Britain and think that it will work here. Culturally, systemically, you got to take and adapt it for yourself but there's a lot and lot to see what others have done and learn from.

KPI. KPIs change. They change by the phase of the project, and they change over time. There is no point having one set of KPIs. If you haven't got a matrix that looks at what are the key KPIs you want at inception and procurement and in implementation, service delivery and exit as a start and then a way of waiting them so they drive behaviours if you haven't got valid and reliable measures for them, then you're not in the game. Key theories in support of this are expectancy theory and instrumentality. Very simple things, does the person have the competences, do they understand what they are doing, do they get reliable feedback, do they value the rewards because they think they are going to get the reward. Very simple criteria. If you do not comply with that, you don't have a reward design. The other thing is, two things happen. All of those projects […] almost certainly you are going start it without the competences you want, in the client and the government. And you are going have the journey of change. If you want to drive them up high level issues over that period of 25, 20, 30 years, you have got a journey where you are going to have to manage and change those KPIs as that journey unfolds and you'll move away from low level KPIs to more outcomes KPIs. You will also as the circumstances with technology and the like change and demand changes need to re-write those and re-structure them and we do that periodically. We normally go to that change process as a formal review process annually.

Governance. There's been some great work done from the United States with the development of partnering and then the development of a thing called integrated process in product development. Big words that are very simple in nature. One is how do you make people work together […] to identify and deal with issues and understand the climate within an organisation and measure and use that to drive behaviours, partnering, and how do you bring multiple stakeholders together to manage complex systems. So there's been a significant body of knowledge developed and how we do that. We're very happy to steal. We've taken information from the US and we've integrated it into this manual. In gives you a very robust methodology for governance of those projects of multiple levels and a way of dealing with the multiple stakeholders by integrating a governance structure with three key elements, layers, and using

partnering as a tool in driving at. Now the toolset is well defined and is defined in the document.

Let's just go quickly over a couple of lessons learned. Focus on the health outcomes, not on, I love the words "you would think the project was financially closed, we have built the project, we have finished everything because we have a financial close" Now you haven't, you are not even at start gate. Why is there such a focus? Is that when you get your fees? That's why. That's where the consultant of the bank gets their fees. It's not the project. The project is delivering an outcome to the society. Whether it'll be a health outcome, or water outcome, it makes no difference. It's about delivering an outcome. Get the focus right first.

Match the strategy, the contract management approach and the contract to the level of complexity. Make life easy for yourself and give yourself the tools to manage the project over its life from the beginning. Use P-Cat to help you with guidance and do that. The start conditions are almost always determined to a large extent by what's going to happen over the next 20 years. If you start off wrong, if you have the wrong person, who is the first project manager or the first contract manager, and they start driving this into a win-lose-model from day 1, or your payment system doesn't pay the contractor when they said they are going to get paid, then you started and you're setting path a journey that is going to drive where you don't want to go. You need to very careful from day 1, who the person is and how you manage the start conditions last a long time. We always say "first impressions"; think about it, it's the same thing.

How much change will occur over the life of the project? Design the contract and the contract management system to deal with change. It is real, it's going to be there and there is going be a lot of it. Over 20 years there's going to be a lot of change. […] Complicated financial deals have one impact. They really make the administration process win-lose-oriented and they drive you to fail and I'll show you a picture of one in a moment. This is a project in Australia, a multi-billion dollar deal and it has just collapsed. Another one. When you see the diagram you'll see why. Projects need competent and robust transaction advisers. People who have real skills doing this and that have done it. Not people that come off the street and think that financial close is the deal. If they don't understand what this project is about, what your objective is and they aren't committed to delivering that then you are talking to the wrong people. You need to have the contract advisors and contract managers work and operate as a dialectic, you want strengths in both, not one or another. You need strong transaction advisors and strong contract managers working together to drive that process for you and plan for contract management from the beginning.

Now just a last little thing. This is a model of a financial, this financial model for deal has just collapsed. Gives you some idea why we have failed. And I expected that to be managed with a whole series of […] contracts, in a highly complex environment with technological change over 20 years, it didn't even make the completion of the construction before it collapsed. […] It's another good example of what not to do. Don't allow the project to be driven by lawyers, banker, and insurers. If you are a health system, have a project driven by health professional

supported by these other people, not driven by them. Just to give you a quick example. Looking at the traditional project, we had Alberto Germani, the Italian gentleman speaking yesterday. Alberto has done, I think, about 20 hospital projects. So, extensive experience. But the projects that Alberto does are building a hospital, design a construction using PFI with maintenance in it. With the contractor doesn't take responsibility for any health clinical services delivery, at all. That project, I can deal with it. I can put clear bounds around what I'm got to do. It's not that hot, the uncertainty is relatively low, the level of change, provided I'm not dealing with medical technology, is low, PFI contract is perfectly alright, output-based KPI are great. But I think it's really interesting to look at the dollars. And we saw a number of people put up slides yesterday, that set out over the next period that the capital expenditure in hospitals is going to be around 3.5 trillion. Now assuming I get a 10 per cent benefit, as a community we going to save that 3.5 billion dollars. That's all. Now let's go to more complex ones, the alternative, where we have integrated clinical services where we have a contractor take on clinical services delivery. What have you got there? You've got uncertainty high, you've got emergencies high, the contract type you have got is going to have alliancing or government's contracting. Very, very different contractual models, requiring very different contract management processes and skills sets. The KPIs are going to be outcomes based, they can be based on what you're looking towards in your own country from your health system and that will change over the life of the contract. The projected spend was 65 trillion. Using that form of PPP, we are going to save 6.5 trillion. So, there's a very, very clear economic argument to move away from this traditional approach because the savings we are going to generate in that are mega. The […] savings that we are going to make and the […] benefits that are going to be delivered from PPP come from accepting we are dealing from complex issues and harnessing the private sector to deal with that efficiently for us but using a structure that drives their behaviour and gives us the capacity to work with emergence that's going to happen the system. A very, very different strategy but one that is a significantly more rewarding to that community. Thank you.

8.2. Open Forum

Question/response from a delegate:

1. **Geoffrey Hamilton**: Thank you. I'm interested in the training government officials to perform the tasks of contract management. Is it a one-week event a year? Or how do you do that successfully, David?

Response from the speaker:

Unfortunately it is not a one-week event. I think, the British government started off a very good idea with the Senior Responsible Officer Programme. I think that was a very good initiative and we have carried it through in Australia where we take our senior executives and put them into a one-week programme. And we did the same in Malaysia as our first round. We didn't have the capacity at the very beginning. So we were unable to take these

key people offline for extended periods. But we put in place a senior responsible officer programme to give them a clear understanding, a base understanding. The other thing we did in Australia, I think what was useful, we have set up a coaching team. We took a course for small group of people and developed the coaching team to support a much larger community. Where they could come, when they had issues, and look towards getting real support for their problems. The main thing I think we did very well in both Malaysia and Australia was accepting that we really needed these people for the future. The British have done the same, the Americans have done the same, Singapore has been doing a programme similar to this for over 25 years. They have had a very sophisticated programme that is really developed in the future leaders in a similar programme. We have learned a lot of them. […] We have spent a lot of time together. Looking at the similarities between what we are doing, and then what they have done and learning from them. We have actually taken people offline. People aged 35 to 45. Put them into […] for 12 months with this programme, specifically aimed at developing to do this. Now we had a 90 per cent shortfall of people. 5 years on now we've got a hundred people in the government capable of managing this and they have become a key resource to the government. In Malaysia, there's this core team they are developing people every year and they have gone across all levels of government to take key leadership role and driving it. So, if you start now, in 4 or 5 years time, you can actually be very well advanced and in the short-term what you can really do is things like the coaching, bringing an outsider as a mentor but I don't like the idea of bringing in outsiders to take over. There is got to be a sunset clause, they need to come in, develop some skills and be gone because at the end of the day there's no point in me coming into the Philippines and try to help the Philippines on how to do things. I can't. No matter what I do, I can ever be a Filipino. They have got to do the contextualisation, we can help to mentor them but it's got to be this.

Question/response from a delegate:

2. **Jill Jamieson**: This is really more of a comment than a question. I think it's also important to take a different perspective on this and that is the one the financing institution and the private sector investor. They are going to be highly interested in knowing the level of competence of the oversight agency and the contract governance structure. It will lower the cost to the government of the Philippines or whichever government to have a suitable contract governance structure in place. It lowers the political and regulatory risk in these sort of things. And indeed many of the things that were discussed in this presentation need to be conceptualised from the very beginning of the project. KPIs and these sort of things should be included in the RFPs and contract documents as early as the initial launched of the project because bidders will want to bid to that level of that expectations so absolutely everything that was said was right and I think that it's important to know that it's not only good for the country but it's also good for the investment climate in general terms.

Response from the speaker:

Couldn't agree more. We found in places like Abu Dhabi, I'll talk about that for a moment, a contractor's willingness to tender a project is very heavily influenced by those who are going to manage it. If they got an intermediary that they know and trust then their willingness to enter into a contract is significantly different than if they've got a local procurement team driving it. Now, radically different because they have that comfort. The real problem is they need surety that the team is to survive the journey and we don't have that because all too often people change their minds and the ones that are good get dumped and you and I end up with something altogether different. The other one I think that comes out is that KPIs are critical and I think these projects are the one hit. Normally, we would ask the contractors to give us advice on what they think the KPI should be and have I think the process should work so we go out and we actually invite the feedback from the industry in development of what will be the RFP. But then in the RFP unfortunately many of the procurement systems in this part of the world and in the Middle East don't support competitive dialogue. This competitive dialogue is a key part of the Australian model, we call it convergence but in that process scope uncertainty is reduced dramatically and the flow out from that is that it normally results in significant cost saving, 5 to 10 per cent regularly flow out of that convergence model when the risk is better understood and dealt with. So not having competitive dialogue as a key part of the procurement model really undermines your ability to have effective projects. Now as I said you should have it as a core part of the procurement guidelines. Britain does the same. Australia does the same. I think you really should consider how you actually design your procurement model to get what you need out of this. And I think the two issues you have raised that competence fundamentally affects the industries willingness to participate and the process they put onto it. We have seen that in Abu Dhabi where the process was absurd because the risk transfers and the consequential risks of the management, contract management.

Question/response from a delegate:

3. **Risma Sitorus**: Thank you, Sir. You said that the contract perhaps we could make flexibility. It means once we say we don't achieve the target of the goal, so we can review it, that's my understanding. But I cannot imagine if we do that for the PPP, in my country for example for a loan project, we still have a problem with the agreement or the MOU. Once we sign the MOU or the contract, we still find out a lot of problems. For example, the flow of funds from the Ministry in Health is not matched yet. I cannot imagine if we do the PPP in health, what will happen if the situation is like that?

Response from the speaker:

We expect that. My expectation is that there will be change. That the initial brief would be wrong, that the clients will change their mind; that technologies will change. My expectation

from day 1 in the health project is all sorts of things are going to happen and the contract needs to be designed to support those changes while still maintaining governance and performance. Now as I said there are contracts available today that have been well and tested, well and truly proven to work while still maintaining governance. The first one of this contracts I did in Australia was restructuring of civil aviation in Australia and the National Audit Office. Two auditors had to sit with me daily for 6 months while I went through that process to make sure we satisfied compliance. Now we've been through this and validated it. It works, so there are some tools available to you today that can give you an ability to deal with that change without having to come back to these major variations or renegotiations.

*Follow-up question from **Risma Sitorus***: Does it mean we have to prepare very carefully?

Additional response from the speaker: No matter how careful you are you could still get it wrong.

*Follow-up question from **Risma Sitorus***: Why, because we have to engage the bankers, the lawyers there […] for the information?

Additional response from the speaker: A banker's world is very simple. They want certainty. Their ideal world is this is my project and I'll build a big wall around it and won't allow any change and then they're perfectly happy. Unfortunately, that's not the real world. So you can't let them drive you. You can actually in the structuring separate the interest-based risk and the repayment risk from performance risk. There's a series of strategies you can put in place, which will still allow you to get very competitive bank rate. Or you use interim financing to stabilise the project and then refinance it, competitive tender for finance. There's a whole series of tools and strategies you can do, which will allow you to move through this and gives you flexibility while still maintaining competition and the KPIs and the structuring of the KPI become critical to that.

*Follow-up question from **Risma Sitorus***: One question, is there a punishment stated in the contract?

Additional response from the speaker: Oh yes. We build into the project from day 1 exit plans. So from day 1 we take the assumption that we are going to sack the contractor and we protect ourselves with […] provisions and the like and staff transfer provisions. So if things go wrong we can step in and replace the contractor. We also have a pain gain. But the research is pretty clear, the American Construction Industry Institute, probably one of the largest research institutes looking at projects in the world did some great work over many decades and the reality is that penalty provisions don't work and in fact, they drive contractors the other way. If I'm the contractor what I'll do, and my world has been

contracting for most of my life, what I do is to immediately put in place defensive mechanisms to protect myself. All you have done is create is a win-lose from day 1.

*Follow-up question from **Risma Sitorus***: This is for the private sector, how about for the government side. For example, the government cannot pay timely for something, an activity in the PPP?

Additional response from the speaker: But the government only pays as per the agreement. The agreement clearly defines based on the level of performance, the contractor will receive usually […] say depending on the level of performance and where you set the boundaries in structuring that pay […] where they get no fee versus a high fee is dependent on the level of performance and you use that as the key vehicle to drive behaviours and it is amazing how motivated contractors are where they can significantly improve their profit but only achieve that when they deliver outcomes that are valued by the client. In my own country, the Department of Finance, usually get involved and validating that those extra payments are justified and […], so they are not just arbitrary. They're tied back to the real benefits delivered. But it really drives the contractor's mind set. My background, as I have said is contracting. When I read a contract document, if I see it's going to be a provision that's penalty, I'm going out on that, I'm going put my rules up, I'm going to put my management systems in place. And back in the early 70's in Australia, we used to be educated at the Privy Council in America. I was taught by the very best and how to fight legal cases and take them to the highest court in land and win, with contract documentation management. Now if you want to do that great, but it's going to cost a fortune and the idea of actually delivering health outcomes is totally forgotten. Because I am not interested in that, all I'm interested in is protecting my commercial position against the rules you have set up. If on the other hand you put in place a structure where we have got transparency, competition, and more rewards are link to performance against KPIs that relate to reflect what you want, other than […]. I'm going to make a profit and I am going to go for it. That drives behaviours very quickly. And we proved that over many, many years.

Question/response from a delegate:

4. **Delegate (no introduction made)**: Speaking from the point of view of a local government. What will you recommend, a national body that will look into contract management, a body developed by the local government itself, or a third-party evaluator, or whatever you call it?

Response from the speaker:

That's really got to be a local government. I think at the national level, there should be a contract management policy and provisions in place and toolsets in place, but really it's got to be done at the local level. You don't want to have some central body doing this. There's national standards and processes agreed but there's no reason why you can't have these

systems flow down and use very simply on very small projects. This stuff works just as well on a very small programme as it does on a mega programme.

9. PPP in Health: Moving Forward

Facilitator: Jose Miguel R. de la Rosa

9.1. eHub in PPP in Health: Prospects

Speaker: Ramon R. Isberto

Good afternoon everyone. I know it's been a long day so I'll try to be brutally quick. Let me start by just introducing the company that I worked for because this is the company that's involved in the activities in mobile health. I work for Smart and PLDT the parent company and Smart is the largest mobile phone operator in the country. We're part of a group of companies that includes a whole bunch of infrastructure companies and by the way, also parenthetically, six of the country's major hospitals. That's one the reasons also why we have got interested in health. Although for those of you who are familiar with the telecommunications scene worldwide, health, M-health, tele-health is one of the areas in which many telecoms operators are showing greater and greater interest to, in rather, and discovering in varying degrees that is not an easy place to go to.

This slide is just trying to tell you that we've been involved in one or another kind of health activity in the past. It all actually started I remember, with this pandemic flu scare in 2004. And we set up this pandemic flu reporting system and hotline in cooperation with DOH and we've been doing a number of other things, but I think the one that's relevant here which I will discuss later on is last year we launched what we call the SHINE programme, which is basically an electronic recording and reporting system which I will explain later on and that's why we're here actually.

Just a few words about our approach. We're seen as a technology company but we've learned that you know technology actually is the easy part of this process. The really hard part is the people part. And as I'm sure all of you know, in varying degrees but here it's really working with people to make the technology work to address the situation. That's what where we have spent 70-80 per cent of our time really. So, we like to build coalitions of the willing until somebody pointed out to me that's the same name of the alliance of western countries that launched the war on Iraq. But the reason why I bring that out is because we've learned from experiences better to work with people who want to do the same thing that you want to do. You know, we have a saying here in the Philippines, you try to convince somebody to win him over to do something with you and you end up owing a debt of gratitude to that person. Now we don't want that. We want to work with people who want to do the same thing we do so it's kind a selective process that we have developed over the years.

Ok, many points I want to bring to provide the context. This is from the perspective of telecoms world but it actually impinges on all of our worlds. These are the 3 key sets of technologies that are changing the world. The one that's most easily noticeable is the one that's in your pockets, these are smart phones that many of you are using. Oh just a quick survey, how many of you are using smart phones in this audience? Can I have a show of hands? Ok, then you know what I'm talking about. And you know that these devices are getting smarter and smarter. They're no longer phones they're actually computers that happen to make phone calls and they will get smarter and smarter, faster and faster. So the other thing, the other component, the other pillar or key technology of the digital economies, the advanced communications networks that I work for Telecom Company, and the networks are now much, much more capable of handling data, the projection is that in the next four, five years the traffic will quadruple, largely because people are using video more and more. And the last element, which we will discuss much later on, is the cloud. When I talk with people about cloud, they tune out, what is a cloud? Very simple, how many here use Facebook? Ok, if you use Facebook then you're in the cloud. That's basically what it is. It's not residing in any single server in your house or in the office, no it's out there in the internet and that's basically, that's where all these new services are going to, it's going to the cloud. It's going to reside in some anonymous […] server somewhere in the world and they serve increasingly the kind of services that we will be using. The thing is, major point that we're trying to make here is that these technologies are disrupting everybody. They're changing the business models of many industries; some just faster than others. If you want some just everyday examples of how this disruption is taking place, well, take a look at retail. Are you familiar with the consumer chain, the US consumer chain Best Buy? It used to be a very, very successful business. Five, six years ago its stocks were very high. And its business is to sell electronic goods but today it's in trouble. Why? […] have a lot of stores and a lot of people go to their stores but when they go to the stores they look at the goods, they try out the cameras, the laptops, the smart phones, and then they go home and then they order it online. They buy it from somebody else, who's probably offering the same thing cheaper and Best Buy becomes the show window for everybody else. And in my own business, telecoms, the world's largest carrier of international voice traffic is not a telephone company. Can anybody hazard a guess? Skype. Skype carries about 20 to 25 per cent of the world's traffic, which is huge. And it doesn't even own its own network. It just rides on everybody else's network. Who says life is fair? But you will increasingly see this kind of logic operating in more and more industries and I would hazard to say, in healthcare as well. It's just that it's taking quite a bit longer to happen in healthcare for reasons that I think you are much more familiar with. But let's go on. So, what I'm saying is that these major changes are taking place; these technologies are really having an impact. Education is one of those industries that are ripe for this confabulation. […]

First, I've been asked to talk about prospects for e-hubs in PPP in health. What I would like to say, the simple message I would like to deliver is that, we think, I think there are many ways, several ways to look at e-hub. The traditional model for an e-hub is you've got a physical centre somewhere, and that becomes your hub of activity. What we're trying to say is that I think,

more and more, although you will some physical centres. But more and more it will be a virtual hub. The hub will be in the cloud. Somewhere in the clouds. Somewhere in the world where you don't exactly know, but the hub will in the cloud. Because increasingly the power of this technology is making itself felt. It is simply easier to do, faster to execute, cheaper to operate and ultimately more flexible and more scalable than the traditional approaches. I am going now to the experiences that we have had. The project, the current project, that I am going to share with you, the work that we are doing right now is a cloud service. You can access it anywhere in the world you just go to the web all you need is web connection. That's the important thing, you need a web connection. We call it SHINE, and that's what it means. It is hosted in the cloud. It basically does four things.

1. It records patient information
2. It reminds patients in a timely way, in the way that is programmed by the health care provider
3. It refers them to the appropriate institutions or a partner health clinics or institutions when it is needed, and then
4. It reports.

And for DOH it is very important, the reports are so important especially there are so many. We pilot implemented this system in Iloilo, the province and city of Iloilo. Thank you to the Department of Health Regional Office as well as the National Office for their acceptance and support. The idea was to install it in rural health clinics as well as the city clinics and connect them to the provincial and regional hospitals of the region. And so far we have 30 thousand patient records. I understand by this time we should be approaching 40 thousand patient records in 40 health clinics, facilities in Iloilo. And in Quezon City we partnered with TBLink programme, this is for tuberculosis. They wanted a module specifically for tuberculosis. It has not been easy, a lot of bumps here and there but we have been getting there. Basically this is what we do. We designed the web-based application and then we've also provided free internet connectivity. And here is the fun part, lots and lots of trainings. When I think about this, since it's web-based it is easy to do the training. We have created the website and then people just access the website and the training materials are there as well. Just has to be supervised in the right way.

SHINE is just one model in its very early stages, although I think we have made a good deal of progress in the short time that we have been doing it. But we think there's going to be more and more where I think the health system would go, there will be more hubs, virtual hubs. What are the advantages for example if you have ever tried to maintain a local area network system in a rural health clinic, good luck in keeping your people! If you can find people at all. If you do it through the cloud, no maintenance. You just keep it in the cloud. Of course using cloud services raises its own sets of questions, primarily security and privacy of data. The funny part about this is story is that, consumers have beaten business to the cloud by a mile. Nobody is afraid in putting up their personal data in Facebook while in so many of the other cloud-based consumer services, businesses have been trailing behind, deciding whether they can live with host, putting their information, many of them vital information up in the cloud-based

system. But the way things have been going in the past year, more and more businesses are coming to the realisation that yes, if you design it properly and the proper systems are maintained you can do your business in the cloud. And I think the same question now is being posted for the health care system. And it is easy, in the case of the Filipinos, it is easy because, if people do not understand and say what you mean by putting things into the cloud? When you asked people do you have Facebook accounts? 95 per cent of Filipinos who are in the internet are in Facebook. So the introduction part is relatively easy.

Now, getting comfortable with cloud - businesses are starting to do that and also increasingly government agencies as well. I don't know if some of you here know that the Department of Education has decided to put their entire email system in gmail. So they are now going gmail. So their system is going to be all in the cloud. Another example, and this one we also have partnership arrangement here. This is not in the health field, but they are in the disaster preparedness. It's not here in my slides – DOST, the Department of Science and Technology in the Philippines has set up a website called project NOAH in which they have consolidated all of their weather information from different parts of the country. So its website is over there, it's in the cloud. So what they are doing now is working with individuals and organizations like SMART. We help them design the first mobile app for android, and the application draws information from that cloud service. Because the mandate of the DOST from the President, is you have got the info share it. Get it out there, push it to the public. And of course one of the ways to do that is through mobile applications. So, we designed a very nice application, actually the story there is that the application was designed by a son of a fisherman. He was a scholar of the DOST. He became a computer programmer. And he was so interested in the weather because his father every time he went out to work was playing dice with the weather. He is smart-stage hackathon. Are you aware of what hackathons are? Hackathons are when you bring together applications, developers, mobile applications developers, you give them a problem and then they create a solution and in a very short fashion, one or two days, and in this case this person Mr. Rolly Rulete, who is this DOST scholar, a son of a fisherman, had been working on an application for weather for some time, fine-tuned his application and created an application for project NOAH, and that we just launched last week. And the application created, set up in a month's time. If you try to do that under normal processes, it will take you 6 months to a year. This is a way of cloud sourcing innovation. In a way, DOST is doing a different kind of PPP. Not the very elaborate and very structured one, but a very rough and ready. We had a long discussion with the DOST people, and my suggestion to them is that, you want this to happen, you want to communicate to the public, you want to work with the private sector people, you got to do it quick and dirty. Even if it is not perfect, even if there is a better model, get it done, get it out there and define it as you go along. And that's what happened. So, this is another version of PPP that is quite as systematic as the ones that we have been discussing here. But there are many ways. In short I would like to close on that point. I am talking to you on perspective of a private sector person who usually follows the rules of business. We realized, having worked with the health sector, the DOH, both the regional offices and the national office, that in the health sector it is very different. There are a lot of things that you

need to take into consideration and do things very systematically because we are talking about people's lives. But having said that, the big question I think is, how can we introduce innovation into this set-up in a faster more effective way, not necessarily quick and dirty but in a way that allows for greater diversity, more experimentation and at the same time protecting the welfare and health of patients? That's the challenge. I think that there is something to be said, something to be achieved if we pursue that question. And we certainly are because the way we do our businesses, we do it in a way that is quick and dirty. We built our network, how do I say, we were driving it while we were putting on the tires. Ok so, that have been our experiences so far, in a way we are thankful for the opportunities that we have gotten with the assistance and cooperation of the DOH and look further forward to more cooperation while forward into the future, thank you.

Question/response from a delegate:

1. **Hilton Y. Lam**: Thank you for a very interesting presentation. You mentioned that cloud exists because people have been able to take advantage of the infrastructure that has been put in place by telecommunication companies. So therefore it's almost as if an illegal thing, is that right? And since you are there for business, what is the risk that eventually you will be able to stop that?

Question of clarification by speaker: I'm not sure I understand the question, stop what? I'm sorry.

Clarification by **Hilton Y. Lam**: Stop the fact that people could use the cloud for free.

Response from the speaker:

I'm not sure I understand the question. But maybe if I answer this way, well there are all sorts of business models out there, some of them are for free use others are paid and it's not clear to me exactly how the, what kind of business model will work particularly for the health sector. I suspect it will have both, it will really depend on what models will work out. All I am saying is that there are key advantages that are available if you use this kind of technology. It's just that I think we need to develop the kind of protocols and the kind of practices that would be consistent with the objectives and mission of the health care sector. We realised from our experience working in this field that there are very special requirements in this field. It's just that we would like to add that other sectors, just as equally […] for example financial sector. They deal with people's money and then learn to live with the cloud in one way or the other. But we realise it's a gradual process, if you are a business person, if you are a business organisation you feel naturally uncomfortable about delegating, outsourcing control of information that is so vital for your business. It's just that businesses large and small given that caveat are finding it to their own interest to pursue that approach as well.

*Question from the facilitator, **Jose Miguel R. de la Rosa***:

I have a phone-in question from my SMART phone, this will not count as one of the three questions that we will allow. Mr. Esberto, as I mentioned earlier, the international PPP Centre in the Philippines is a joint programme of the UNECE and the DOH, what can we do to connect to the international e-hub?

Response from the speaker:

Well, it is something that we'd have to discuss. I mean I would need to know what the technical parameters of the requirements are. But, as you know, communication today is global. I mean communication in the internet is a global phenomenon. I don't think it's really a technical issue, so we just need to work on the parameters

Question/response from a delegate:

2. **Jocelyn Kara Alikpala**: My question is I would like to know what it's been like and if you have worked with community or barangay health workers and city health offices, which city health offices are very wired and what was the technology like for the health workers, were they at home with it?

Response from the speaker:

The experiences are varied they range wide. There are some LGUs and some local areas, that are better prepared than others, But I think, generally we have to start at the low level especially if you are talking of rural health units, there is a heavy component of training, the thing is, it's easy when you're working with younger people, younger people get it very quickly. What we do is if we are working with older people, we tell them, if you don't understand this ask your children. Now it actually works. The kids help them out. In Iloilo, we chose Iloilo aside from other reasons, also for political reasons. The political reason is that the governor, the provincial governor and the city mayor are on good working terms. And the reason why we needed to take that approach is because many of the tertiary institutions of care in the cities and in some of the provincial hospitals in the province. So we wanted the two sides to be able to work together. And it worked out well so far in Iloilo. And it certainly helped that the provincial DOH director is very aggressive and very visionary guy. I think these are the key factors you need to get those factors together. Our experience in terms of the actual usage again is mixed. There are some rural health units that it takes such a long time to get something done. But there are others who move quickly, and they are the real beneficiaries of this effort. So there is no easy formula. I think you really have to just get onto the ground and see what happens. Our hope is that those who really embraced the technology will have a demonstration effect, in the sense that if the technology really works, if the system really works, they will have an easier time doing

what they are supposed to do than those who don't. And we hope that it will have the positive effect.

Question/response from a delegate:

3. **Delegate (no introduction made)**: Good afternoon. If it is in the cloud, how can you protect patients' right to confidentiality of records?

Response from the speaker:

That's a work in progress actually mam. There are basic confidentiality rules. The rules are defined not by us, but by the health care providers. That's number 1. And number 2, of course, the discussions on this matter are still in the early stages. We have actually helped sponsor a number of meetings to precisely address this question. There are models that are available from other countries in the world but it's really a question of us here in the Philippines agreeing on what kind of protocols should be observed and what principles should be observed. On our side, our interest is for the health sector to get together and to agree. It's not really for us. We will abide by whatever is the convention that is agreed upon by the different players in the health sector. And we would like to encourage that process. And in fact we've sponsored a couple of meetings in that direction to help people to come together and agree. Because, although you know, we can always raise questions. There is always a question that can be raised. But then, I think the bottom line is, then you weigh the pros and cons. What are the benefits and what are the potential risks. At the end of the day it is always like that. And for me, I am biased for anything that will improve the situation. Because if you look for a perfect system, you might not find the perfect system and you got stuck where you are. And I don't think it's a nice and sensible approach, a better approach is how do we keep moving forward and gradually and consistently improve the way we deliver our services to our people.

Question/response from a delegate:

4. **Jose Mari Bigornia**: I am just looking at the infrastructure where DOH is serving other rural areas where signal is very weak. I mean, these are the most crucial areas. Most of the telecoms that I know are not supporting those areas because it is not making money, right? So I don't know if telecoms would look into this as part of their social responsibility putting signals to rural areas where it's really needed.

Response from the speaker:

The answer to that is yes, Sir. It just takes a little bit more time. Normally the way telecommunications networks are deployed is we start from the population centres because that is where it makes the most sense not only from a business standpoint but for

social good standpoint, because if you put it up in population centres, you serve a large population immediately. But eventually we are going out more and more. For example, let me cite one case, Southern Leyte, perhaps the most disaster prone province in this country or one of the most, anyway. They have earthquakes, landslides, typhoons, etc. etc., and tsunamis. When we started the project there, we set up a Disaster Communications Project for Southern Leyte, funded by the World Bank. Our signal did not extend too far outside of the "*poblacions*". But over the past 3 years we have been augmenting our signal and building more cell sites in the area. So now our signal is reaching more and more areas in the country on that particular area. The provincial government which has been running the Disaster Communication Network using our technology has been increasingly encouraged by the results that they have been getting from the programme. What I am saying is that, we have actually about 99 per cent of the population covered for voice and SMS service. And increasingly something like about seventy to eighty per cent of the country's population covered in terms of internet service, mobile internet service. In short, it can only get better. In three to four more years we probably will be able to cover more and more areas. By the way, we have a mobile broadband, wi-fi service in the island of Kalayaan in the Spratlys. So you have internet there.

10. Clinic Session 2: Suppliers' Hour

Speaker: Matthew Khoory

Thank you and good afternoon everyone, and welcome to the graveyard shift and thanks for staying. This is preamble to the Suppliers' Hour whereby we've got clinic sessions at the back, we will be happy to advise you on certain aspects of PPP projects. Just as part of this quick 15 minutes, all I would like to talk about is the private sector and PPP and I think really to touch on how we talk about and look to develop economically viable projects. We are going a bit more, I think a lot of this has been covered from the materials we have seen over the last couple of days but really to see again from a private sector's perspective where we look for and what we can offer in PPP. I am just to run through some examples. So really, you know, private sector is here to collaborate and to work with public sector to develop projects focusing on health care needs. And I think as Dr. Lam mentioned previously, the focus should not be on we want to build a brand new hospital. It should not be about having twenty MRI scanners or an amazing laboratory. It should be focused on specific health care needs or problems that are defined very early on and where you work through developing a project to meet those needs. And quite often we see that really needs worthwhile investment in human capital to develop successful projects. Do you want to work with the private sector? Come and challenge us. PPP is an opportunity to put your requirements out there and come to us to seek innovation to look for new ways of doing things and to succeed in achieving the outcomes you desire. We spoke across these two days about the sort of conflict between what the public sector is looking for and what private sector is looking for. We touch on equity. And the question is, how do you make projects equitable for both parties? To come back to classic PPP

theory […] Working together collaboratively to share roles, responsibilities, and risks, with parties best able to manage those to achieve the best outcomes.

And just a note on, you know, specific consideration of payment mechanism. You know, what is the business model around, what is the economic model around the PPP projects? You know, to come back to David's points earlier where, for example your KPIs may be determined by advisers or lawyers. I just want to reiterate this point that you know these are real life projects. These are actually hospitals, facilities or programmes to treat patients and the KPIs and the focus on what we would like to achieve should be based on that. And ultimately, what economically viable projects, is the optimal transfer of risk, which ultimately drives value for money in these programmes. We have covered a lot of this in the last couple of days and you know as I said the materials have been very good up to this point. I would say first and foremost what both parties, whether it's private or public, should look for is to build a relationship. It comes down to the people behind the project, and how both the public and the private party look to work together to achieve the desired outcomes. You know this is a cultural shift. In certain countries there is a lot of scepticism toward working with the private parties. As Geoffrey mentioned yesterday, it's quite welcoming, I think the open forum. It's really the transparency and accountability, it's only when we have this that we are able to build relationship, work together and achieve the common goals. And as David pointed out earlier, it's the leadership and the management capability to run these projects. Not just in times of negotiating and signing the deal but through the operational phase as well. This is really the way that contract management ties back into the relationship where you are able to foster a good partnership and a successful project at the back of it.

In terms of, you know, private sector providers can offer, it's long-term commitment to projects, the human and the capital elements, the knowledge transfer, enhancing models, enabling optimization and innovation across the health care network. And really to come back to what we look for is we look for equitable projects where there is a real vision for successful outcomes. And when we define successful outcome it is something, projects or initiatives, that will either increase access, improve quality or lower cost of healthcare. And I will still add, without compromising any of the others too much. But really, it is about faith, it is about partnership to come back to Jill's point yesterday. It really is like a marriage. You live together, you work together, you solve your problems together. To talk about economically viable projects, I must admit I only started tweaking this presentation just last night after having seen several of the materials. I did not want to reiterate everything that has been covered. But no one really touched on this. By economically viable, we come to two criteria, and the first one is the PPP. It is working with the private sector provider. Is it a more cost effective method of delivering the same objectives? Or is it just going to cost, or is it cheaper, more cost-effective to do it yourselves as the public sector. I am going to explain that in a bit more detail. But secondly, even if you do have projects, which demonstrate value for money, we come to affordability and the two are very different. Affordability is does the client have the means to pay for the project. And it's in nobody's interest to enter into agreement and to work especially with long term PPP contracts only to bankrupt your customers or put them on a financial strain. The relationship, the types of projects, they are not transactional. It is not a case of selling, providing the

project, building the hospital and running. They are long-term contracts where there is long-term commitment.

Just to talk about value for money. Here is a very sort of classical PPP method of measuring value for money of the project. But, as any business case that you write or look at, you compare the cost of what would it cost the public sector to do it themselves, and this time the Public Sector Comparator, which is an equivalent model to help quantify that, and you then look at what the cost of the PPP will be. What will be the cost to deliver, have the same outcomes by engaging with the private partner? And into this you include not just the hard costs, like the cost of building, the cost of maintaining and the cost of finance. But you also consider the value of risk transfer that you are transferring to the public sector. And this is a key point; we have discussed this in Alberto's presentation on risk transfer where, the term dumping risks on the private sector was used. I mean ultimately if the transfer of risk is not well thought out, then as David was saying, that just ultimately gets priced into the project and ultimately the projects then become unaffordable and unviable.

So, I'll just talk about three different types of projects of different types of PPP that we have done across the globe. Each one is very different. This project was the first stand-alone medical technology PPP, otherwise known as a "managed equipment service" borne out of the UK, off the back of the PFI programmes, with which a number of hospitals were built. The story behind this hospital is that it built great shining new hospitals in the 90's. […] 2005 and 2006, there had been a lack in investments in new technology and a lack of investments in the operations and maintenance of those technologies which let to them having outdated technological facilities. So, this is an example of PPP which was not based around building but just based around equipment. Over a 20 year term to consider all the imaging equipment in the hospital. And as part of that 20 year time, the hospital pays a flat monthly fee and in exchange for that they get fully maintained and updated and fully managed medical equipment. They have essentially outsourced the radiology technology to the private partner. And that gives them predictability, enables them to budget for the technology and there are no surprises as a result of that. And they are not going to find themselves in year three requiring to raise an unobtainable amount of capital expenditure. The way this project was reviewed in […] was through a value for money analysis, it's not just as I was saying the financial benefits of the PPP programme but also the risk transfer in the operational benefits that are considered as well. And you can reach some of them there; you know, like the quality, access to new technology. Even things such as staff morale. Just knowing that they are going to show up, knowing that technicians, radiologist, radiographers, are going to have working equipment really does make a change in the hospital setting.

Another PPP programme. Again, when we are generally asked for example PPPs in Asia, we come from UK and our supposed understanding of PPP to be about infrastructure. We scratched our heads and thought what have we done? But given the broad definition of PPP, anywhere where private and the public sectors working together, we thought, yeah! We do work with the public sector. We do have other initiatives. An example in Indonesia, which is currently on-going, is a midwife programme. And this were really driven by the country being behind the WHO's MDG 5

programme which relates to mortality rates. Being a technology company, the need became how can we help improve the maternal mortality rates and maternal and infant care in Indonesia? One way in which a technology companies have worked with governments is to look at bringing ultrasound closer into the community and to midwives. And this is done through collaborative efforts, which is really based around trying to change policy to allow midwives to use ultrasounds to detect birth defects earlier and to be able to do more about them earlier and to be able to refer complex cases to specialist centres or hospitals in a timely manner. So, we have gone through some extensive research with an external research company. Let's say the goal is […] with policy reform. And there is an equitable model driven out at the back of this. And this is a training driven programme whereby a midwife can be trained to use a small handheld ultrasound device. Some of you may have seen this in our booth; it is called the V-Scan. And, we involved a financing partner to enable the accessibility of this system or of this device to midwives. So, we are bringing this as a complete package to midwives across Indonesia to enable them to detect birth defects early and to improve their maternal and infant mortality rates.

Another example, my colleague Matthew touched on this yesterday in his presentation. This is another example in Malaysia of collaboration between public and private parties. So this is a tele-radiology network that allows for public hospitals to send images through the network to be read by radiologists who can be sitting anywhere in the country. There is a whole range of other examples. And I am not going into these. But this just demonstrates your whole range of the classic design, build, finance and maintain projects, which we have seen. And a lot of them were borne out from the UK and that's where it has been exposed as we've we heard […] Australia and Canada. Again, each one of these is different, the successful ones, if I may say again, are based on the clinical needs, whether it is a cardiac centre or a dedicated cardiovascular centre. Or even focused around a certain care area or type of equipment. So for PPP, I think the point has been made many times over the last couple of days, it can mean many things, it is scalable, it can be applied to whatever health care need there is. I guess this sort of leads on to the clinic sessions that we will have. And that's all. Thank you.

This introduction was followed by one-on-one consultation sessions

Part III: PPP in Health Market Place

11. Parallel Session

    11.1. Site Visits

        11.1.1. The National Kidney and Transplant Institute (NKTI) Hemodialysis Unit

        Verbatim transcriptions are not available.

        11.1.2. PPP in Pharmacy in Ospital ng Makati

        Verbatim transcriptions are not available.

    11.2. Clinic Session 3

        11.2.1. Marketplace Ideas Pitching Hour

        Verbatim transcriptions are not available.

12. Parallel Session

    12.1. PPP in Health Marketplace

        12.1.1. GE Healthcare Philippines

        Speaker: Ivan Alexi Arota

        Thank you, Sir. Good afternoon. Ladies and gentlemen, thank you very much for staying on until this last segment of the PPP in Manila 2012. Despite the weather and the traffic situation outside I'm glad to see some people are still here today. My presentation will be brief this afternoon, really intended to be an introduction to GE Healthcare as well as a little bit of GE's history and experience in the region and even here in the Philippines, wherein the company has actually embarked for a long time with partnerships with the government. So, this is more or less is just an overview of our company, GE. So, company was founded by Thomas Edison, you know, who personally invented the light bulb way back in 1878. So, the company has now spanned three centuries, 18 hundreds, 19 hundreds and now into the millennium. It's the only company that was part of the original list of companies listed in the New York stock exchange that still exists today and it has almost 300,000 employees, a 150 global locations worldwide. GE is in a lot of businesses in different areas, of course, healthcare is our concern in this programme, but the company has interest as well in energy, aviation, transportation and consumer.

In ASEAN, the company has been here for more than a century actually starting out here in the Philippines and represented well in all the countries in the region. I don't know if you see this very clearly, but in the Philippines, GE Healthcare actually was the one who installed the first street lights in Metro Manila, way back in 1898. So more than a hundred years ago. And then the company here GE Healthcare Philippines was actually incorporated in 1935 before WWII so the company has really invested and has been part of the country for more than a hundred years as well as other countries in the region, Indonesia, Singapore, Malaysia, in the different businesses. Malaysian Airlines has used GE engines in 1975, Philippine Airlines as well currently uses GE engines. If I'm not mistaken I think, 30 locomotive trains, the original trains of the PNR, are actually GE locomotives way back before WWII. But unfortunately, I don't think they were replaced as of this time. They're still using those same locomotives. Talking about healthcare as a unit, it's a 17 billion business globally made out of 53 thousand employees and really is in every corner of the world. For those who probably stop by our booth, you have seen this product, the V-scan ultrasound. The ultra-portable pocket sized ultra sound system that my colleague Matthew Khoory talked about yesterday in terms of being used in Indonesia's rural setting to be able to detect early pregnancy complications outside of medical facilities. And that is a study that was started one or two months ago, that will run for a few more months, and I think very early on I understand that the results have proven that early diagnosis has already demonstrated an improvement in maternal and infant morbidity. GE is keen on research and development, you know, we want to take on the world's toughest challenges. So we have a lot of research and development activity going on in different locations around the world. In Asia we have two facilities in China and in India dedicated for R&D, as well as manufacturing facilities all over the world. Basically, healthcare if you group it in different products and services will fall under these six. So we have the healthcare systems and surgery categories, which are basic medical equipment. And then you have the healthcare IT, these are technology solutions; life sciences are research-based that cater to the pharmaceutical industry; and then medical diagnostics are contrast media used when you're going for diagnostic imaging test where you want to highlight certain subject or region in the body and as well as performance solutions, more management consulting services. Our key costumers of course are, you know, healthcare professionals, hospitals, governments, private practitioners, basically the whole scope of healthcare. Healthcare IT is the information technology solution that we have. We have a few systems out here in the Philippines that's located in some of our leading hospitals. Healthcare systems primarily are the iron equipment you know, the big iron equipment, city scanner, MRI systems, x-rays systems, all fall under this, ultrasound as well. And then life sciences again is more on research and development catering to pharmaceutical industry, and contrast media, surgery equipment and performance solutions. Performance solution is a global programme of the company but here in Asia we call it Healthcare and Hospital Solutions. Some of my colleagues are here from that group who spoke earlier in the programme, Matthew Collingridge and Matthew Khoory are from the healthcare and

hospital solutions team which is basically like a sub-unit of our performance solutions group. So, this group really can help healthcare providers or institutions plan and partner to make sure that outcomes are met. So, exactly what we're trying to achieve here with PPP. We also have financial services, another one of my colleagues who has just left based in Singapore, ASEAN, Keith Png, he's our PPP finance guy and he's the one involved really in making sure feasibility of certain projects are actually met. And all of this now because of what, because of the environment that we are facing today in healthcare. So basically, you know, it's patient focused, we talked about PPP being an investment programme, however, it really is focused on catering to patients, improving access. The challenges today are really geared towards treatment while we move that to prevention, you know, more patients in the Philippines or other developing nations actually go for medical care when their condition is already serious. Whereas in more developed nations, you would see more prevention programmes before they get to a serious state. So, that's where we want to drive healthcare.

Key to what the government wants to do in the country today is to developed and modernise healthcare facilities. One is the POC, there's an investors' forum going on at the same time and of course it was already highlighted that the cancer, the eight cancer institutes that they want to establish, the eight cardiac centres as well as modernisation forum more hospitals all over the country are exactly addressing the issues that we are seeing globally, cancer, heart disease and also brain disorder. How can we help? Those are big health issues, we cannot do it on our own and we believe that collaborating with our partners in the government as well as other third parties interested to help promote healthcare will be the way to make it successful. "*Healthymagination*" if you were here in the first day, Matthew mentioned this. This is really an aim of the company to try to lower the cost of healthcare but at the same time improve the quality and access to more people. So, basically reducing the cost by different solutions, products or services. Improving quality, you know, it doesn't mean that if it's low cost, it's low quality, and improving access, you know, products that are really practical, products that can be used and be felt by more and more people, where healthcare is needed and this is exactly what our country needs, in the Philippines. If you look at the mortality rate, the infant mortality rate, it's highest in those far hard to reach regions. And ironically, most of our developed medical facilities are in the urbanised areas. So there's quite an imbalance you know. High quality medical care is in the major cities of our country where actually healthcare can we say is needed the least. Where in those far to reach, hard far-flung areas, health care is needed more we have facilities that are underdeveloped, which is why we are so excited to hear about this PPP programme and want to really take a big role in it. So, basically we want to see that underserved people will be reached and have access to healthcare. People ultimately do not have to travel just to get healthcare. The goal really you could get your healthcare from the home; more doctors and hospitals will have access to lower costing more practical

technologies, and also to the IT infrastructure, you can always connect all these technologies and manage all the data on a centralised basis.

So, basically that's really all I had to share this afternoon.

Question/response from a delegate:

1. **Teresa Jenna**: Hi! I just have really a quick question because it came to me. The ultrasound device, the small one ok? I just thought about something. In the field that's so small, I could see it disappearing very easily and go out on the market, on the black trade market. Whether or not people know how to use it, does it have a GPS?

Response from the speaker:

Yes, GPS? I don't believe so. Thanks, thanks. Because it's very portable right, you can put it in your pocket. You know, just like a cell phone and you know how fast cell phones go nowadays in the black market. That's good comment, thanks.

Question/response from a delegate:

2. **Catherine Miral**: Good afternoon. Do you train the, for example, the nurses or the doctors who are going to use the V-scan. Because it has a lot of use like for the ultrasound of the heart, for pregnancy ultrasound, even for blood circulation. It's very good, but I agree with the previous delegate. A lot of things get lost along the way.

Response from the speaker:

Yes mam, we have to be careful. Actually, the manager handling V-scan ultrasound is a trained application specialist. She was the one doing training for nurses for healthcare practitioners around ASEAN before she took on this new role. So that's actually part of GE's commitment, to educate and train our users on how to effectively use our products; so that programme is key really to the success. A nice low gadget like that, you know, you do not get any value out of it if the users don't know how to use it properly. Even my colleague here, he's our city application specialist. We want to make sure that our customers get technical and educational support needed to use our products to benefit them the most.

Question/response from a delegate:

3. **Maria Victoria Garalza**: How do you play things on a PPP project? I know GE is a manufacturer, you're more of the products, the end products, and then do you come in as a partner or are you just a supplier of the equipment?

Response from the speaker:

Yes, we'd like to be more involved not just a supplier of equipment. There have been many different models to look at that were shared in the first day by my colleagues in different parts of the world. There are projects where GE has gone directly and been involved in terms of building infrastructure aside from the technology. However, here in the region in Asia, because relatively PPP is new, you know, in health, we're willing to explore different ways of doing it, like partnering with third-party investors as well. And we've identified and had dialogues with other interested parties who are willing to partner with us to pursue PPP initiatives in the Philippines.

Follow-up question from delegate: […]

We're open right now mam, we don't have a concrete plan yet. In fact, that's the main reason why we have participated here to really understand what the programme and the direction is and then we'll build the plan based on what we learned from this event. But right now, we're open to any form of collaboration or partnerships. Thank you, mam.

12.1.2. Planet Drugstore Corporation

Speaker: Erwin Jason Zshornack

Video presentation showing Planet Drugstore in Ospital ng Makati PPP Project

Question/response from a delegate:

1. **Teresa Jenna**: Hi! I want to come to your benefit this moment. I don't know, you remember we met? I'm Governor Daza's assistant. I want to say this to the audience. This is a very good time to ask about the practical set up of PPPs between the government and the private sector. Because we really know in Northern Samar, what it is like on the ground. The two of us we've been working at different ends, and the team is in here. So ask questions about what you may be thinking of, what your fears are for setting up, ask what you think some of the problems might be. Ask anything that comes to mind, maybe we can answer. Because we are finding out, in bringing out the pharmacy, bringing it to the province is an interesting challenge. But things are working to move forward. The building started this week and so that's moving forward. HR is moving forward, operations is moving forward, so it's really a good chance for you guys to ask some more questions.

Response from the speaker:

Maybe you could stay beside me here. Just joking. So if you have any questions, queries how we did it.

Question/response from a delegate:

2. **Delegate (no introduction made)**: Before I ask this question may I ask first how long your contract with this programme is?

Response from the speaker:

With the Hospital of Makati Sir, it's a yearly bidding.

Follow-up question from a delegate: So, this is only good for one year?

Response from the speaker

Yes, we do a yearly bidding.

Follow-up question from a delegate: I think I don't have to ask the question anymore because if it's a long term or medium term programme I would have asked how will these prices be evaluated since prices of medicines fluctuate. So, if it's only for one year maybe I don't. Are you going to participate in a bidding every year?

Response from the speaker:

Yes, we do it because it is one of the policies of the government. But in Northern Samar it's a three-year contract.

Follow-up question from a delegate: If it's a three-year contract, so you are going to indicate the prices of what you're going to offer, and then will that be good for three years despite the fact that, for instance, during the middle of the budget year, there are changes in the prices of medicines?

Response from the speaker:

Prices of medicines, I can assure you that we are at par with the current market price, but in a year maybe I can fix the current price for a year.

Follow-up question from a delegate: So, what if there are changes in the succeeding year? How do you?

Response from the speaker:

We will just adapt what's the current price for that year. If it goes lower, then we can lower it. If it goes higher, sometimes, we could just go a little bit higher.

Follow-up question from a delegate: Will that be allowed under existing terms and conditions?

Response from the speaker:

Yes, it's allowed as long as it's at par with the current market price.

Follow-up comment from a delegate: So, you are going to use the current market price as the benchmark. Ok, thank you.

Response from the speaker:

I'm going to explain about the price. Sometimes in government, you always compare which is much more affordable or cheaper. You know, our package here, if you are going to look at the whole picture, the city government gets the value for money. Because I assure you that the price is competitive. Number 2, there's no expiration because all hospitals, government hospitals, they may get the cheaper price of medicine but in the pharmaceutical industry, I came from the pharma company, sometimes when I deal with the government I tell them to buy by bulk, they get discounts but half of those medicines are expired or going to be expired. So, where's the savings there? In our partnership, I give them the best price, value for money, no pilferage, no expiration. You pay what you consume, so that's big savings for the government. Don't compare me with a supplier who just deliver the medicines; oh, this is a special price for you, but you don't know where those medicines go because there's no proper utilisation, there's no monitoring. But in this case, I've been with the City of Makati since 2009 and they haven't received any complaints. They have seen my medicines; it's a quality medicine. There are no more complaints of patients not receiving medication. So, I guess if they are not happy with the pricing scheme or with our services, I guess we won't be winning these bids every year. I mean, the bidding every year assures me that they want me in and I give the best service to the City of Makati. Even in Northern Samar they did a bidding and I had a lot of competitors and they see my services will be the one that would suit them and I think Planet Drugstore, we will assure our clients that this PPP would be a winning partnership. Just like a marriage, it should win. It's a cooperation between the two parties.

Question/response from a delegate:

3. **Rostom Deiparine**: My question is that, do you have a contract manager dealing with your contract with LGU and if do not have then I suppose it's you who really manages it. Could you share with us what's the worst scenario you have had dealing with the provincial council or the city council of Makati in terms of presenting the idea, you know, to those who really guard the decision of the governor and of that the mayor.

Response from the speaker:

Well, I can only share to you our experiences in Ospital ng Makati even in my experience in one of these private companies. Any change in any system, any new ways of doing business or doing a procedure, there would always be some strains, some disagreements, because basically, in the government or in private, in government hospitals especially in the provinces, where there is a lack of medicines or medicines are unavailable, the doctor, or there may be some doctors, but don't put me a bad light, doctors in provinces since they want to really serve their patients and there are no available medicines in the hospitals, they try to own or have drug stores outside the hospitals, so it's a service that they want since the government cannot provide it they do it themselves, they own the drugstores. So, when I will be coming inside the hospital to provide the full line of medicines, definitely there will be a conflict between me and that doctor. But I don't blame him. He wants to serve his patients and there's a way to do it by owning a drug store outside. So maybe he has benefited from the drugstore outside. So there will be a new change in the scheme since I will be coming in. There will be a complete line of medicines and PhilHealth will be covering if the patients are confined, the patient will not spend any money because if the patient goes out, he will be shelling out money but if the pharmacy is already inside and complete with all lines of medication, why go out and shell out money so you can just get your medicines inside and the services will be complete. Definitely, there will some changes in the system. So number 1, that doctor would really go against it at first, there will be some resistance but eventually if he sees the whole benefit, he would approve of it. Now, in some government, here in the Philippines, suppliers are sometimes co-terminus with who is the current mayor or the governor, that's the problem here. If there's a change in the leadership, there will be a change in the supplier. So I hope this PPP since it's for health, I'm requesting if it could be a joint venture - it should not be under the local government. I think the PPP for pharmacy should be under PhilHealth, DOH and the Office of the President. So, regardless of who is the current governor or mayor, the programme of providing health services would continue regardless of who is the current politician who is sitting. Health should not be political. Health for the people

should be universal regardless of who is the leader, health should be available anywhere, anytime. That's it.

Question/response from a delegate:

4. **Teresa Jenna**: The other thing to think about this question, is market forces deemed that the more competitive our market is, the more players. There's enough room for both a hospital to have its in-house pharmacy and for the community to have pharmacies where people can go to and have choice. So it isn't dominant that it's in the hospital but the hospital has its market and people have to keep that in mind without fear. The other thing is, in this scenario what we are seeing to is to think about your drugs and the safety of your drugs and counterfeit drugs. And it is in putting into place in the government that ensures a safer drug and a drug that has been checked because many of the local pharmacies if they're not franchisees, where there are some systems or a standard operating procedure in place that checks for the drugs. There are drugs out there that are not safe and have come from somewhere. So this is also strengthening the community. And then the last thing I think I want to say is, something comes up, is that in the HR side, one key thing that everybody in this room must think about, and you heard me say this the other day, perceptions, attitudes and behaviours. Now, in the way staffing will be, the way private sectors sometimes is thought of, is the thought of us as the moneybags. You know, people in government get so much money, ok, private sector's coming in and if they go to work for private sector they're going to make a lot more money. That's not necessarily the case. The case is the private sector's working for profit. So you have to look at also the attitudes, behaviours, and perceptions of the people that will be going into the in-house outsourced business coming into your operation in the government and you have to think about that. So I tossed that out because that's HR and what's going to make a PPP work its people and I really can see this in all areas that I've work with in all different organisations, including this one.

Question/response from a delegate:

5. **Delegate (no introduction made)**: I'd like to ask questions about procurement. And I understand you bid every year for the contract in Makati and then of course three years for the Northern Samar. Now what are your parameters or indicators on solicited proposals from LGUs wanting pharmacy to be PPP? What are you looking at?

Response from the speaker:

> Well, number 1, if they have a need for it, I would like to see if the local government there is really serious about the health situation of […] Yes, before we go inside the government contract, I want to see first if they are really serious about the health of the people because there are some governments that just do it for politics only, buying medicines this and that - more of a show off. But there are some government officials here that are really serious in curbing and treating or providing excellent health services and that one is Ospital ng Makati. So, they want a continuous supply of medicines. Now, for the success of this programme or project, there should be cooperation between the LGU and my side because if there's no cooperation then this programme will not be successful.

Follow-up question from a delegate: What cooperation are you expecting from the LGU?

Response from the speaker:

> Well, number 1, they should tell their doctors to support the new change in the pharmacy system because my main obstacles there are doctors […]. They would not approve of me. If the mayor has the political will to really provide excellent service, then he would not encourage his doctors to own drugstores in front.

Follow-up question from a delegate: So would you demand exclusivity if you are to go into a PPP, you want exclusivity to provide medicine for hospitals that you service and not compete among doctors who do it on the side?

Response from the speaker:

> Yes, definitely, the doctors should not be the one selling the medicines. I'm not saying exclusivity. I'm only marketing here in the in-patients. If the patient is confined, he's a PhilHealth member then he gets his medicines from me. But if the patient has, the patient still has a choice whether he wants to buy it outside, that's his choice. It's a free market. If it's only an OPD patient having a check-up the doctor can say, you can buy at Planet or you can buy it in my drugstore. That's it.

Follow-up question from a delegate: But people from outside can buy medicine from your store?

Response from the speaker: Yes.

Question/response from a delegate:

6. **Catherine Miral**: I'll probably have something to say here. First, in Northern Samar what we did is, before considering Planet Drugstore as our exclusive distributor of medicines, we contemplated of having our in-house pharmacist co-exist with Planet Drugstore. But then again, […] it's our duty also for the Planet Drugstore to gain profit from the services that they're going to provide us. But there are some measures that we really need to put in. Like for example, one, the prescriptions of doctors, this should be monitored and probably ask them to help the people by not prescribing what is outside the PNDF or what is outside the guidelines. Because sometimes if the doctors do not follow the guidelines and if the patient is indigent, the doctors will prescribe Ceftriaxone immediately for a simple cough and cold. So, you'll end up with too much expense for the medicine but that will not be reimbursed totally by PhilHealth. So, the provincial government will end up paying Planet Drugstore. So it will be a loss for the province. So we have to really to ask the cooperation of the doctors for this to work. […] So, it's a win-win actually if we will be able to reimburse everything that we will use; reimburse it by PhilHealth. We are going to gain also and at the same time no losses.

Question/response from a delegate:

7. **Delegate (no introduction made)**: Thank you, Sir. In my country for pharmacy activities, we have various players. We have medical representatives, we have doctors who give the prescription, we have also pharmacy manufacturers […] which produce some medicines. So, a lot of questions. So, when you explained your Planet Pharmacy, does it mean there is no role of the medical representative at all in your hospital?

Response from the speaker:

There is still a role. I was a medical representative from Unilab before. In the Philippines, we have Mercury Drug Corporation, Watsons, South Star Drug. I'm just like those drugstores. Maybe in your country, it's Watsons or I don't know. I'm a drugstore and we have a license to dispense medicines. The difference between Planet and these drugstores, I'm not directly competing with them because say Mercury is outside. What I do is a pharmacy solution in management services. I locate my drugstores inside companies or hospitals needing my services. So medical representatives, they still have a role; they promote to the doctors, they tell them the latest trends in managing a disease and I order from these reputable pharmaceutical companies. Like I have Glaxo, Pfizer, Unilab and they inform the doctors what are the best or new trends in managing a disease and I make sure that these drugs are available in my pharmacy. So, it's a partnership also between my

drugstore company and these pharmaceutical companies and the advantage of it like some pharma companies like in my hospital, in Ospital ng Makati, they provide some freebies to the patients. Like if they buy ten tablets of this, they get some freebies from pharma companies so generally it makes some medicines more affordable if you purchase at Planet.

Question/response from a delegate:

8. **Delegate (no introduction made)**: Are there any private hospitals there? Private hospitals in Makati? Why am I asking that? Because in the public hospitals in my country compared to the private hospitals, the price of the medicine in each pharmacy is different.

Response from the speaker:

Usually private hospitals here have a higher price.

Follow-up question from a delegate: But if you're saying that in Planet Drugstore medicines are cheaper, what about the private sector, still growing up, or will all people get treatment from your hospital then?

Response from the speaker:

No. Basically pricing is the same as the current market price. So there's actually no problem in the pricing but I can actually assure you is that compare to other private hospitals, we are lower. And in Ospital ng Makati they only cater to almost all yellow cardholders. So, if you are a paying patient definitely you won't go to Ospital ng Makati and share a bed or a ward with the indigent. Usually, the paying patients they go to St. Luke's, Makati Med, or Cardinal Santos. I do have a drugstore also inside the Cardinal Santos, which is a private hospital. So I cater only to the OPD patients there. Instead of buying their medicines from a drugstore outside, after their check-up from doctors, they can easily buy their medicines from my drugstore at the same price in that of the drugstores outside. It's offering them convenience. So the pricing here is not an issue really. What it's really solving here is at least there's available treatment, there's no pilferage, no expiration. So with those, I think the government wins with this kind of partnership.

Question/response from a delegate:

9. **Delegate (introduction not clear)**: I actually have two sets of question, one question is for Ospital ng Makati and the other is for Northern Samar. We were talking about risk, you know, in venturing in private public partnership we have to weigh the risk.

We in the private companies we have to weigh the risk before we enter into contract with the government. Now since you have mentioned a while ago the contract with Makati is only for a year. Is the contract outsourcing, or is it management and supplies management? So what are the specs of the agreement you have with Ospital ng Makati and if it's only for year how would you be able to manage the risk, for example after a year, imagine if you handle all the pharmacy it's your staff, staffing, supplies, management […] Risk on your part because you have to invest a lot. The next question is how would you be able to, you know, to manage, at least make safety mechanism?

Response from the speaker:

Definitely we have to study it first. Number 1, I need to know if the LGU is serious about the health issues of its constituents and number 2, maybe I would study first if they are capable because definitely I'll be honest, this is a business partnership, I'm a business man, it should be a win-win proposition. I won't go into business that I would lose because definitely if I'm in the losing end, I won't be able to sustain the benefits for the patient. It should be a win-win. If what I did in Makati will be duplicated in all, maybe not. But we will be more specific per LGU or per hospital. It will depend on what kind of situation is that hospital in. But definitely we would adjust on the needs of the hospital and their capabilities. So, we cannot really duplicate. Definitely, Makati is a rich government.

Follow-up question from a delegate: Second richest LGU, the richest now is Quezon City. Thank you. Last question. Now going to Northern Samar, you mentioned a while ago that for this to the health services, and this solutions provider, you know, to really be successful it must be managed from the central. You mentioned some time ago that the programme must be central so that any changes in the leadership in the LGU will not affect the programme. That's very high risk and we cannot do that for the moment because of the devolution. […] So in Northern Samar you entered into a contract for 3 years. How would you be able if for example the governor next coming May election is a different governor, so, how are you protected, what is the mechanism in place for you to be able to continue managing?

Response from the speaker:

[…] It's part of the contract that if we don't get paid for 3 consecutive billings we would stop the release of medicines and you can't blame me, but you have to blame who is then the current governor.

Follow-up question from a delegate: So, for Northern Samar you manage, everything is under your care, supplies, management, staffing? So when you bid with specification, the requirements are what?

Response from the speaker:

In the bidding you put the pharmacy management and services and supply and delivery of services. Thank you.

Question/response from a delegate:

10. **Teresa Jenna**: Governor Daza also put the private sector law in place to secure to work with that. So there's a new code to look at what you should evaluate. A private sector partnership code is on the books now in Northern Samar. So, that is a safety guard for the partners. It's a new code, the first one in the country.

Question/response from a delegate:

11. **Richard E. Caballero**: Good afternoon. So my question is aside from providing pharmacy solutions and management services specifically for example for this contract that you have for Samar, is there also a component for training, because the example by the doctor from Samar is quite alarming, a physician is prescribing Ceftriaxone for a simple colds or cough, I think it's more of a question of the competence of these doctors that they have there? And secondly, my question is that from the presentation that you have it looks like the project that you have with Makati is a solicited PPP. My question is that, did you have any experience providing unsolicited PPP to other local government in needs and if you would answer yes, how did these LGUs respond? Lastly, all LGUs take health as a priority.

Response from the speaker:

Yes, we do have out regular training. But in Northern Samar, before they get their medications it should pass through their pharmacy first, they should have been practicing clinical pharmacy. Like in Makati, they don't actually release at once. The request of the doctor will be validated by the in-house pharmacy if the request is alright, and if it's validated by the in-house pharmacy then we release the medicines. No validation, no release. In Northern Samar, all the prescription there will be passing through the in-house pharmacy to validate. For example it's just a simple cough and cold, they gave you a high-end antibiotic. I think they can just question the doctor before we release it. So, there are some safeguards before we release the medicines. On your second question, regarding unsolicited, I don't usually propose this to government institutions. If they know their problem, I want

them to call me then I will be their answer, I just don't want to force my issue or force my company to go inside, because definitely, even if there's a need I still have difficulties convincing them, especially in the government if you're going to present this to the mayor, definitely their existing suppliers who might think that I'm going to grab this. So, I just want those LGUs to call me. And if they call me then I will go to them and provide the solution.

Question/response from a delegate:

12. **Uy Vengky**: I have a very nice visit to the hospital and when we came back from the hospital we saw a lot of pharmacies around the hospital. The concern is whether there is strong competition from the Planet that provides the hospital with attractive management services. Another concern is, who are the clients of this pharmacy store because it's like 85 per cent they are insured under insurance? So there are a lot of private pharmacy stores around the hospital. So, could you please explain?

Response from the speaker:

Well, basically by markets in Ospital ng Makati all the in-patients if they are in the yellow card programme, definitely they get their medicines from me. Because if they are in the yellow card, it will be shouldered by the government. But there are some patients in Ospital ng Makati that come from different municipalities and are not really covered by the yellow card. Sometimes they just get the free medical service and the doctors would tell them you can buy either at Planet or the drug store outside. I'm not there to compete with the drug stores outside. It's their choice, if they want to buy outside, it's ok. There's also an OPD section in the hospital wherein patients just go there to have their prescription and they are free to buy anywhere. I won't force them to buy at my drugstore. But we have some freebies for the patients that if they buy this much medicine they'll get free. It's still their choice. If they prefer to buy in a drug store outside, it's their right.

Question/response from a delegate:

13. **Lady Kristine Cruz**: One of our priorities is promotions to the community. So, there is a system in place, the "*Botika ng Barangay*", so these are the community pharmacies. Actually the model is already PPP since you have a volunteer who will be manning the pharmacy and then the government will be providing assistance in sending a pharmacist like you have a scheduled visit to this. It's a small pharmacy in the community. So one of the suggestions during the summit that was held among the BNB operators is that they want to come up with a warehouse where they can

get products. Since you're already coming up with contracts with the government or the LGUs, this is just looking forward, are you open to like being or operating that warehouse like if its lodged in a city or public hospital where these BNB operators can access the products and purchase through you?

Response from the speaker:

I think that's possible. Maybe later we can talk about the details of that. If that's possible.

Question/response from a delegate:

14. **Catherine Miral**: Actually, we encountered the same problem right now in Northern Samar. Congressman Raul Daza just texted me a week ago that Amoxicillin is worth five pesos in the "*Botika ng Barangay*" and two pesos in the Generics Pharmacy. So there are a lot of problems with the BNB operation system. One, they can only buy the products in Philippine National Pharmaceutical Foundation or in PITC. They cannot buy medicines outside or in any local distributor. We cannot buy them so we need to follow the rules of DOH. I think there's a need to revise these operations so as to provide access to medicine, quality medicine, affordable medicine at the barangay level.

Question/response from a delegate:

15. **Lady Kristine Cruz**: We're seeing different practices already. Some like in Cebu the provincial government is facilitating the inventory of all the drugs so they provide the warehousing and stuff. For other areas where there is no clear function being taken by the LGU so any BNB can just go to any distributor. However, the practice is not standardised. That's what we are seeing right now. Though the initial design really is to course all procurement through PITC because they will provide a lower price but since some of the areas are not accessible or they cannot go or it will be more expensive to access the products from the PITC or where the warehouses are, they just go to any drug store or distributors.

Response from the speaker:

Maybe I can suggest that you could restructure your process, so that there will be some measures in order to avoid some of these. Because if you have no clear-cut processes, there might be some abuses in it. So, maybe before we talk or I could just give some suggestions first. Because I don't want to go inside a scheme wherein there will be some loopholes that would definitely affect my business. So I just want make a clear-cut process, that's beneficial for both the patient, and even the

government

Question/response from a delegate:

16. **Catherine Miral**: The easiest one is to put up "*Botika ng Lalawigan*", the warehousing for every province.

12.2. Investors Forum

12.2.1. Opening Remarks

Verbatim transcriptions are not available.

12.2.2. The POC Modernisation Project: An Overview

Verbatim transcriptions are not available.

12.2.3. Open Forum

Verbatim transcriptions are not available.

13. Closing Ceremonies

Feedback from delegates on PPP in Health Manila 2012

Speaker: Abigail Myra Catucod

Good afternoon and thank you for this opportunity. What can I say? I think, first of all, I think it has been a great opportunity for most of us here. And I think what PPP in health has done is like a big bang that is expanding our universe. We are looking at different directions now. From a local government perspective, it has debunked our theory of having budget and technical constraints because PPP is at the tip of our fingers. We can go into an MOU or a MOA that could help solve our problems.

Speaker: Bekhbat Sodnom

Thank you. We are very much pleased to be here in this seminar, workshop, because in Mongolia probably we are the youngest nation in PPP. We have adopted our state policy on PPP in 2009. And we have adopted a law on concession in 2010. So it's only 2 or 3 years. So we did not implement much. So we have signed just a few contracts, concession contracts on infrastructure. So, in Mongolia concessions and PPPs are understood as a tool to improve the infrastructure by most people, by most politicians. So it mostly uses PPP for roads, for railways or power plants. So, I see

my role, because our ministry has been newly established, there is a new department. But I am not new in the PPP because I was advising parliament to adopt those policies and laws on concessions. And I see my role as expanding the role of PPPs in all sectors. And especially in social sectors because the government's role or responsibilities to deliver services to the public, especially the services including not only roads and water supply but also health sector and education, and good quality services equal to everybody. So that's why we need more money because budget fund is not enough, always not enough. So we need more money, we need the experience and the good management skills of the private sector. So, I hope that we can attract more in the coming years. Not only from internal private sector from Mongolia but also from other countries. Thank you.

Speaker: Ricardo Gutierrez

Thank you very much. Well, as a private sector participant to this gathering, of course we would like to see definitely an opportunity to work with government. Would this government be serving as a catalyst for change and win the private sector, and maybe even the non-formal sector who would be participants to this change because health is something very close to us? We have seen PPPs already done in tollways, in water. But health, at least for the Philippines, this is a pioneering effort. We really appreciate the support of the other convenors. We see a lot of interest as far as the PPP is concerned. And I think the response from the private sector is a renewed interest in really finding an opportunity to work together, to improve the lives of people to improve health care quality in this country. I think the gathering of this nature just, you know, starts the ball rolling. I'm quite pleased also of the turn-out from the other countries as well. We have representatives from practically all our neighbours who have joined this gathering. And I think this will snowball in terms of how health care can improve, not just here in the Philippines but also in our neighbouring countries. With the support coming from the multi-laterals, even the bi-laterals for that matter, I think we can see health care really becoming a very critical component in improving people's lives all over. Thank you very much.

Closing remarks

Speaker: Undersecretary Teodoro J. Herbosa

Let me recognise first all the leaders of this particular first regional event on Public Private Partnership in Health in Manila. I would like to recognise our own Secretary of Health, the Honourable Secretary Enrique T. Ona. I would like also to recognise the support of the Asian Development Bank Vice President, Mr. Stephen Groff. And of course our United Nations Economic Commission for Europe PPP Unit, Mr. Geoffrey Hamilton, the World Health Organisation, through Ms. Isabelle Wachsmuth, our PhilHealth President Dr. Eduardo Banzon, the Development Bank of the Philippines, representing the finance sector, all our private corporations who have actually actively participated for the past three days, distinguished guests from the other countries in the ASEAN region, all the other participants from the Philippines, a pleasant good afternoon to all of you.

We have come to the end of three days of this first regional event, a truly historic one. And on behalf of the Department of Health, I would like to extend my sincere gratitude to all of you who participated. And I would like to specially mention three people who have actually contributed to the success of this, Ms. Emi Masaki of the ADB, let's give her a big hand. Mr. Celson Manangan from our Centre of Excellence for PPP at the DOH, and also the people of the Development Bank of the Philippines represented by Mr. Brillo, the Senior Vice President.

We are really pleased that the response to this particular conference was really overwhelming. When it was presented to me few months ago that we will hold the conference here, I said it might be too premature because we're just rolling out our first PPPs. But suffice it to say that I now realised there is a lot of interest among our neighbouring countries and the private sector to actually join government. Actually my definition of PPP is not public-private partnership or private-public partnership, my definition of it is "*Private support of Public sector Policy*". And as part of government I think that is very clear because we have had that for a very long time in the Philippines. In the Philippines we eradicated polio with the help of Rotary International. Last year, this year it was reported to me that we only had nine thousand plus cases of malaria in this country. And the reason for that is the Global Fund contracted a local foundation the Pilipinas Shell Foundation that was able to distribute the mosquito nets, the microscope and the diagnostic kits and education to decrease malaria in this country and move from eradication phase to elimination phase. We also are in the elimination phase of leprosy. Unknown to many we have eliminated leprosy and the help was actually given by Novartis Foundation. The owner of the company gives the drugs for free, not only in the Philippines but worldwide. So we are actually in a phase called post elimination phase. So contrary to the reports earlier in the first day, the things like public-private partnership didn't work in Africa, somehow they have been working in the Philippines. And you visited a couple of hospitals today that showed some of these prime examples. Now, the bigger impetus that happened is that, this national government went on a different route in financing health care. We went to a route of what is called universal health care wherein what we did is, from a previous effort where government kept funding hospital institutions and service delivery networks and the money was never enough. What we did different for this administration is, we funded the demand side. So we kept putting money on the supply side - building public hospitals, giving free services to the people, but it never was enough. And what we did is we just shared tablets with the different people and no one got better. Suddenly we changed our mode and what we did is we enrolled 5.2 million families at the cost of PHP 12 billion. That's about 25 million people, that's about the size of Australia or the size of Malaysia, five times the size of Singapore. Now the other countries are looking at us. Because, unlike other countries that did the universal health care programme, our facilities are low. We have a hospital to population ratio of only .8 per 1,000 population. And how do you solve that problem? If I ask my government to give me money and I build hospitals, many people will actually die before I even finish building all these several hundred hospitals needed to care for the people. So, what did the President say? Go into the public-private partnership. And we were one of the first agencies in government, after following the framework of most of our friends that did water, energy, tollways, railways and airports, we went into the project

of implementing PPP in health. And on the first day you actually saw the roll out or the pipeline of projects that Secretary Ona has put on the table. And this afternoon we have just actually had the Investors' Forum for our very first approved by the President PPP project for a hospital, a whole hospital, a greenfield project. We are indeed very happy with the response of the private sector in the Investors' Forum. I think what is important is that we understand where we implement the PPP projects. Whether we implement them in different systems. On the first day I had clinics with my friends from Myanmar and we saw that there is a lot to be learned from the middle income countries. What I've discovered when I attended many of the PPP conferences internationally, is apparently a lot of the middle income and low middle income countries look at the other middle income countries for solutions of problems

And they just cannot implement solutions implemented in the UK, in the EU or in Canada and Japan. So it seems basically the Philippines is in the right footage to actually promote the international Specialist Centre for Health. I think the establishment of the International Specialist Centre by UNECE in the Philippines is logical. And that we can be the collective body for the information whether you are in the private sector, whether you are in finance or in the healthcare, you will be able to actually collect data, share experiences. I'd rather share the failures because it's actually in the failures of the PPP that we've learned. And in the Philippines we have had many. In the airport industry, in the energy sector. And this is the experience that comes in as we start to do PPPs in the social sector or social infrastructure.

In the end, what I've seen is still a very big divide between private sector and public sector. There seems to be a general mistrust. Someone wants to be the first in billing even in the name PPP. […]. And then in the Investors' Forum, we also saw the distrust in government of private sector and that they will be regulated. We also saw the distrust of government of private sector that they will gain too much profit out of concessions. So I think the correct answer will be fora like this wherein we all sit down together. The bankers, the businessmen and the public sector people, talk together, make friends, have coffee together and find out how we can have the same solution to the same problem, which is health care. "*Magandanghaponposainyonglahat at mabuhaypokayonglahat*". Thank you very much for attending the first regional PPP conference.

Acknowledgements

Speaker: Emiko Masaki

Hi, on behalf of the secretariat, we are very delighted to see this three day event has completed, and successfully. And also we didn't have anybody injured, anybody hospitalised. This is good, although probably this is the best venue to have good doctors. So in any case we are very delighted. And also as I have said earlier, this event has been put together in a very intensive manner and despite that the team worked very hard over nights and weekends and sleepless evenings and I have seen some of our teams sending emails at 3 in the morning and 4 in the morning just to make sure that everything is done right. So with that, I would like to acknowledge our team, the secretariat who has put their efforts on this event. So first, for the DOH colleagues, of course Celso, thanks very

much, and Ms. Cora, who has been attending our weekly meetings. Also, our friends from DBP Kristine, Bryan and John, who have been working closely with us. Our partners from SMEC, Phillip who managed all the budgetary issues and bought everybody their tickets to come here and Mari, who has been arranging the marketplace, working with the private sector. The presence of the private sector was made possible because Mari has worked over nights and weekends too for this event. And Timmy had been preparing a lot of registrations. And also Connie, Gay, Aldrin, and Laarni, and all of them have been doing all the administrative works for this event. So once again thanks very much. And also I would like to thank our creative team, Jason and Rustum for doing all our graphics and web design. I hope these are quite done well in a very little time we had. And also I would like to recognise Jimmy doing the photographing for his work. And I also would like to thank the students who are sitting at the back who have been assisting throughout the 3 day event, Monique, Kit, AJ, Jan and Aya, they are all from UP and working with us for this event. And lastly I would like to thank our TA team working very hard on this. And Lucy who was doing all the international participants' registrations and arrangements. I think she gets to know many of you well. And lastly, I would like to mention two people from our team that have worked so hard, of course Mike and Ms. Mei, please stand up, she has the brain of this event and she has put so much effort on this. So without her, I would say this event would not have been possible. I wish to thank all for your participation. I wish you all have a very safe journey back home. Thank you.

Appendices

A. Forum Agenda

PPPs in Health Manila 2012
Developing Models, Ensuring Sustainability: Perspectives from Asia and Europe
October 23-25, 2012
Manila, Philippines
Auditoriums A and B | Asian Development Bank

SESSION TITLE	Speakers/Resource Person	Room Assignment
DAY 1 • Oct. 23, 2012	**PPP in Health: Overview and Best Practices**	
*Registration begins at 8:00 am. Delegates are advised to be seated by **8:45 am**.*		
Session 1 | Opening Ceremonies		
9:00 – 10:00 am ***Opening Ceremonies***		
9:00 – 9:10 am **Welcome Remarks**	**Stephen P. Groff** Vice-President (Operations 2) Asian Development Bank	Plenary Hall (Auditoriums A&B)
9:10 – 9:30 am **Keynote Address**	**Benigno Simeon Aquino III** President, Republic of the Philippines (Speech to be delivered by Enrique T. Ona Secretary, Philippines' Department of Health)	
Launching Ceremonies International PPP Specialist Centre on Health 9:30-10:00 am	*To be led by:* *Secretary Enrique Ona of DOH and Mr. Geoffrey Hamilton of the United Nations Economic Commission for Europe*	
	A press conference immediately follows after the Opening Ceremonies.	DER Briefing Theater 1
COFFEE BREAK and GROUP PHOTO SESSION **10:00 – 10:30 am**		ADB Courtyard
Session 2 | PPP in Health: An Overview		
10:30-12:00 pm		
An Overview on PPP in Health *(Part of A Paper Presentation)*	**Geoffrey Hamilton** Chief of the Economic Cooperation and Integration Division, UNECE	Plenary Hall (Auditoriums A&B)
Strengthening PPP in Health Policy Environment	**Enrique Ona** Secretary Philippines' Department of Health	
PPP in Health: Perspectives from the Private Sector	**Matthew Collingridge** General Manager Hospital & Healthcare Solutions & PPP, GE Healthcare Asia Pacific	
OPEN FORUM	**Jaime Galvez-Tan** Former Secretary Philippines' Department of Health Team Leader, ADB TA 7257 PHI: PPP in Health	
LUNCH BREAK **12:00 – 1:30 pm**		Executive Dining Room
Session 3 | Case Studies and Best Practices in PPP in Health		
1:30 – 3:30 pm ***Case Studies in Asia and Europe***	***Asian Experiences*** **Kai Hong Phua** Health Policy Professor National University of Singapore	Plenary Hall (Auditoriums A&B)
	European Experiences **Co-Presenter** **Isabelle Wachsmuth** Project and Communications Manager World Health Organization	
Reflections on Best Practices in PPP in Health *(Part of A Paper Presentation)*	**Jill Jamieson** Senior PPP Advisor Deloitte Consulting LLP (USA)	
Open Forum	**Patricia Moser** (Facilitator) Lead Health Specialist ADB Regional and Sustainable Development Department	
COFFEE BREAK **3:30 – 3:45 pm**		
Session 4 | Risk Allocation in PPPs in Health		
3:45 – 4:30 pm ***Who Takes Care of What: Risk Allocation in PPPs in Health***	**Alberto Germani** Member, UNECE PPP Task Force, and former Member of the PPP Task Force in Italy	Plenary Hall (Auditoriums A&B)
Open Forum	**Solomon Castro** (Facilitator) Managing Director and Senior Advisor CFP Transaction Advisors	
Parallel Sessions		
Session 5A | Clinic Session 1A		
4:30 – 6:00 pm **Clinic Session 1A:** ***Governors and Mayors Hour***	***Session Leader:*** **Paul R. Daza** Governor of Northern Samar	Plenary Hall (Auditoriums A&B)
	Bayani Agabin (Facilitator) Legal Expert ADB TA 7257 PHI: PPP in Health	
Session 5B | Clinic Session 1B		
Clinic Session 1B: ***PPP in Public Health Programs***	**Jaime Galvez-Tan** Former Secretary Philippines' Department of Health Team Leader, ADB TA 7257 PHI: PPP in Health	Briefing Theater 2
	Emiko Masaki (Facilitator) Social Sector Economist Asian Development Bank	
Welcome Reception and Cultural Night 7:00 – 9:30 pm	*There will be cultural presentation. Delegates are requested to attend in their national costumes.*	Executive Dining Room
DAY 2 • Oct. 24, 2012	**PPP in Health: Understanding Operational Issues**	
Session 6 | Financing Options for PPPs		
*Delegates are requested to be seated by **8:45 am** for the wrap-up session.*		
9:00 – 10:45 am ***A Closer Look at PPP Financing: Options and Issues***	**Kim Jungwook** Director of Public Private Partnership Division Public and Private Infrastructure Investment Management Center (PIMAC) Korea Development Institute (KDI)	Plenary Hall (Auditoriums A&B)
	Cosette V. Canilao (Reactor/Panelist) Executive Director, PPP Center, NEDA	
Taking PPP Financing Further: Why PPP in Health is Good Economics	**Hilton Lam** Senior Lecturer Department of Clinical Epidemiology College of Medicine, University of the Philippines Manila	
Open Forum	**Hilton Lam**	
COFFEE BREAK **10:45 – 11:00 am**		
11:00 – 12:00 am ***Universal Health Care under a PPP Regime: Ensuring that the Health Insurance System Works***	**Eduardo Banzon** President Philippine Health Insurance Corporation	Plenary Hall (Auditoriums A&B)
Open Forum	**Alvin Caballes** (Facilitator) Associate Professor College of Medicine University of the Philippines-Manila	
LUNCH BREAK **12:00 – 1:30 pm**		Executive Dining Room
Parallel Sessions		
Session 7A		
1:30 – 2:45 pm ***Decentralized Health Governance: Boon or Bane for PPPs?***	**Aquilino Q. Pimentel Jr.** Former Senator, and Author of the Philippines' Local Government Code of 1991	Plenary Hall (Auditoriums A&B)
Auditors: Allies or Enemies of PPPs? A Look at Auditing Dynamics in PPP Regimes	**Heidi Mendoza** Commissioner Philippines' Commission on Audit	
Open Forum	**Aileen Riego-Javier** (Facilitator) Executive Director National Kidney and Transplant Institute	
Session 7B **Towards Sustainability: Capacity Development and Social Marketing**		
1:30 – 2:45 pm ***Can Governments Do It? A Closer Look at Local and National Capacity Development in PPP in Health***	**Juan Antonio Perez III** Director, Bureau of Local Health Development DOH	Briefing Theater 2
	Magdalena Mendoza (Reactor/Panelist) Senior Vice President for Programs Development Academy of the Philippines	
Social Marketing: What Do We Want to Communicate?	**Florentino Solon** Founder and President Nutrition Center of the Philippines	
Open Forum	**Ivanhoe Escartin** (Facilitator) OIC Director IV National Center for Health Promotion Department of Health	
COFFEE BREAK **2:45 – 3:00 pm**		
Session 8 | Monitoring of PPPs in Health		
3:00 – 4:00 pm ***Keeping Tab of Failures and Successes: A Guide to KPIs and Monitoring of PPPs in Health***	**David Dombkins** Chief Executive Officer Complex Program Group, Sydney, Australia	Plenary Hall (Auditoriums A&B)
Open Forum	**Manuel de Vera** (Facilitator) Professor Center for Development Management Asian Institute of Management	
Session 9 | PPP in Health: Moving Forward		
4:00 – 4:30 pm ***eHub in PPP in Health: Prospects***	**Ramon Isberto** Public Affairs Group Head Smart Communications	Plenary Hall (Auditoriums A&B)
	Jose Miguel dela Rosa (Facilitator)	

	Social Marketing Expert ADB TA 7257 PHI: PPP in Health	
	Session 10 | Clinic Session 2	
4:30 – 6:00 pm **Clinic Session 2:** ***Suppliers Hour***	***Session Leader:*** **Matthew Khoory** Business Development and Finance Manager Hospital & Healthcare Solutions GE Healthcare Asia Pacific	Plenary Hall (Auditoriums A&B)
DAY 3 • Oct. 25, 2012	**PPP in Health Marketplace**	
	Parallel Sessions	
	Session 11A | Site Visits	
*Delegates who are joining the site visits are requested to be in the assembly point (ADB driveway along ADB Avenue, by the fountain) by **8:45 am.***		
9:00 am – 12:00 nn **Site Visit**	***Site 1:*** The National Kidney and Transplant Institute (NKTI) Hemodialysis Unit ***Site 2:*** PPP in Pharmacy in *Ospital ng Makati*	NKTI, Quezon City *Ospital ng Makati*, Makati City
	Session 11B | Clinic Session 3	
9:00 am – 12:00 nn **Clinic Session 3:** ***Marketplace Ideas Pitching Hour***	***Session Leader:*** **Ronilo Quinio** Managing Director Fresenius Medical Care	Plenary Hall (Auditoriums A&B)
LUNCH BREAK **12:00 – 1:00 pm**		Executive Dining Room
	Parallel Sessions	
	Session 12A | PPP in Health Marketplace	
1:00 – 4:30 pm **Marketplace**	*The Marketplace begins on Day 1. The participating firms are offered opportunities to give presentations in this session.* **Ivan Alexi Arota** Country Manager GE Healthcare Philippines **Erwin Jason Zshornack** President Planet Drugstore Corporation Other partners *(to be announced)*	Plenary Hall (Auditoriums A&B)
	Session 12B | Investors Forum	
Investors Forum	This session aims to give an overview and allow stakeholders' discussions on the ***Modernization of the Philippine Orthopedic Center Project***. Participation is by invitation only and coursed through DOH Center for Excellence for PPP in Health and the NEDA PPP Center.	Briefing Theater 2
1:15 – 1:45 pm **Opening Remarks**	**Enrique Ona** Secretary Philippines' Department of Health	
The POC Modernization Project: An Overview 1:45 – 2:15 pm	**Cosette V. Canilao** Executive Director PPP Center, NEDA **Teodoro Herbosa** Undersecretary Philippines' Department of Health	
Open Forum 2:15 – 4:00 pm	**Panelists** Enrique Ona, DOH Teodoro Herbosa, DOH Luisito Maaño, Medical Director, POC Cosette Canilao, PPP Center, NEDA	
	Session 13 | Closing Ceremonies	
4:30 – 4:50 pm **Closing Ceremonies**		
4:30 – 4:40 pm **Response from the Participants**	TBA (To be nominated by the participants)	Plenary Hall (Auditoriums A&B)
4:40 – 4:50 pm **Closing Remarks**	**Teodoro Herbosa** Undersecretary, Philippines' Department of Health	

B. Presentations

Session 2.1	PPPs in Health: In Search of Excellence
Session 2.2	Strengthening PPP in Health Policy Environment
Session 2.3	PPP in Health: Perspectives from the Private Sector
Session 2.4	Best Practice in PPPs in Health: Case of Health Programme PPPs
Session 3.1	Public Private Participation in Health: Asian Experiences
	PPP Experiences in Europe
Session 3.2	Delivering Healthcare through P3 – Reflections on Global Best Practices
Session 4.1	Risk Allocation in Healthcare PPPs
Session 5.1	PPP in Health in Northern Samar
Session 6.1	A Closer Look at PPP Financing: Options and Issues
Session 6.2	Good Health and PPPH: Good Economics
Session 6.3	Universal Health Care under a PPP Regime – Ensuring that the Health Insurance System Works
Session 7.1.1	Decentralised Health Governance: Boon or Bane for PPPs?
Session 7.2.1	Can Governments Do It? A Closer Look at Local and National Capacity Development in PPPs in Health.
Session 7.2.2	Social Marketing – What Do We Want To Communicate?
Session 8.1	Monitoring of PPPs in Health – UNECE PPP Toolkit
Session 9	eHub in PPP in Health: Prospects
Session 10	Clinic Session 2: Suppliers Hour
Session 12.1.1.	GE Healthcare Philippines

C. Background Paper and Further Readings

a. Background Paper

A Preliminary Reflection on the Best Practice in PPP in Healthcare Sector: A Review of Different PPP Case Studies and Experiences

[*revised background paper to be inserted here*]

b. Further Readings on Asian Experiences

This section presents a PPP country report on Thailand. It proposes a typology of PPPs in health, provides a description of major PPPs in health employed in Thailand as well as information about the legal system of PPPs in Thailand and concludes with some lessons learned. Thailand was selected for this section, since (i) the public sector dominates the health care system while a sizable private health sector exists and (ii) it achieved universal health care coverage as early as 2002 at relatively low levels of per capita income of USD 1,880.

i. PPP Country Report

PPP Country Report (Thailand)

Chantal Herberholz and Siripen Supakankunti[14]

Introduction

A large private health sector exists in most countries, yet its role in the overall health system is quite different across countries. Thailand's health system, for example, exhibits some features of a Beveridge-style system, with its main scheme, the universal coverage scheme (UCS) which was introduced in 2002, being tax financed. Nevertheless, a sizable (mostly for profit) private health sector has contributed to the country's health system for decades. The purpose of this country report is to review private sector involvement in the Thai health system, the focus being on PPPs.

PPP means different things to different people and no consensus definition of PPPs and especially PPPs in health has emerged to date. Edelenbos, et al. (2007, cited in Lehto & Tynkkynen (2009: 2)), for example, define PPPs as "*a more or less permanent cooperation between public and private actors, through which the joint products or services are developed and in which the risks, costs and profits are shared*". The World Bank provides an overview of possible forms of private sector involvement in infrastructure projects, which can be distinguished on the basis of the degree of risk sharing between the public and the private

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partner, and the PPP definition ranges from management and operating contracts; leases and affermages; concessions, build–operate–transfer (BOT), design-build-operate (DBO) to joint ventures and partial divestiture of public assets. Neither service contracts, e.g. procurement and contracting out, nor full divestiture of public assets are viewed as PPPs (World Bank, 2012). Similarly, the ADB distinguishes PPPs in infrastructure and other services from private sector participation (PSP), which typically entails a transfer of risks to the private partner rather than risk sharing and comprises for example contracting arrangements, and privatisation (ADB, 2008). The European Commission on the other hand, while not proposing a definition, views PPPs in a broader sense and refers to "*forms of cooperation between public authorities and the world of business which aim to ensure the funding, construction, renovation, management or maintenance of an infrastructure or the provision of a service*", also taking the distribution of risks among public and private partners into consideration (Commission of the European Communities, 2004: 3). PPPs are referred to as long-term arrangements and include purchases of services on a regular basis; equity stakes; guarantees; build-and-delivery contracts; leases; concessions and services purchased by government on the basis of dedicated assets (European Commission, 2004). The key characteristic of the last category is that the government is the main purchaser of the services that are delivered by a specific asset, which is particularly relevant for many PPPs in health. A broad definition of PPPs in health is supported by Loevinsohn (2008: 11), who explicitly states that "*Contracting is one form of public-private partnership. A partnership sometimes implies that both parties bring financial or other resources into the relationship, but this is not always the case.*" This report inter alia draws on Loevinsohn (2008) and defines PPPs in health in a broader sense to include contracting arrangements as shown in Table 1 below. The typology of PPPs in health proposed in Table 1 focuses on the delivery of health services and largely ignores how these services are paid for.

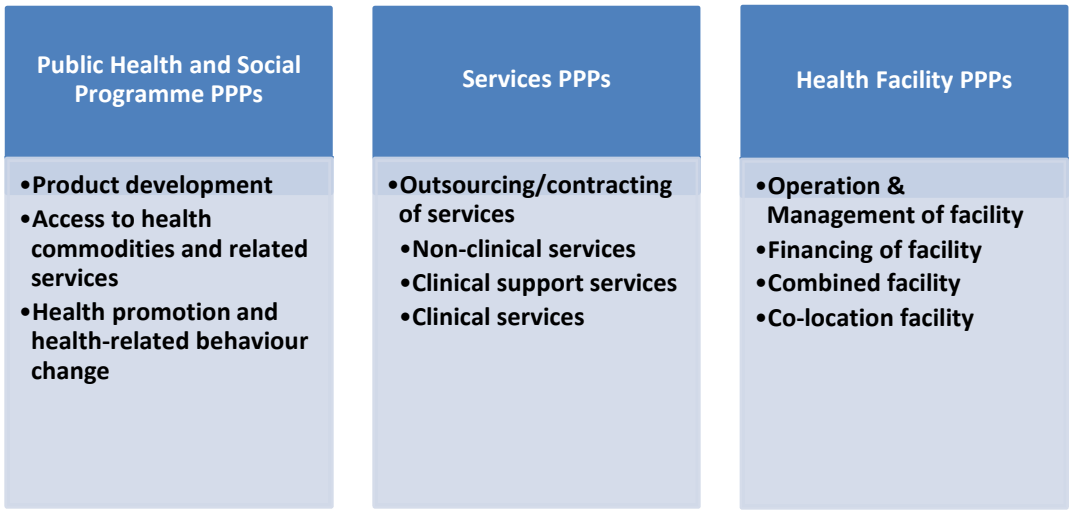
The first type of PPPs in health comprises Public Health and Social Programme PPPs, which are programme-based and typically aim at disease control and prevention as well as health promotion and health-related behaviour change. Following De Pinho Campos, et al. (2011) PPPs in the area of public health can be further divided into product development PPPs, which focus on research and development to create drugs and vaccines, especially for neglected diseases as well as HIV/AIDS, malaria and tuberculosis, and access to health commodities PPPs[15],

[15] De Pinho Campos, et al. (2011) focus on access to medicines not health commodities in general.

which seek to improve the distribution system of health commodities, such as for example contraceptives, oral rehydration solutions, bed nets and zinc tablets and related services. In addition, Public Health and Social Programme PPPs are used to address challenges in health promotion and health-related behaviour. Public Health and Social Programme PPPs can either be implemented employing traditional approaches or more innovative techniques, including for example social marketing and social franchising.

The second type comprises Services PPPs, at the core of which are services. Services PPPs are in essence mostly outsourcing or contracting initiatives to improve availability and quality of health services. Following Langenbrunner (2011), three types of services provided by the private partner are distinguished, (i) non-clinical services (e.g. cleaning, catering, laundry, security and parking), (ii) clinical support services (e.g. radiology and laboratory services) and (iii) clinical services (specific services, e.g. dialysis and cataract removal, but also the purchase of a range of agreed upon primary or hospital care services). Like Public Health and Social Programme PPPs, Services PPPs may also include innovative techniques such as for example clinical social franchising, e.g. in the form of contracting with social franchise networks.

Figure 1 Typology of PPPs in health



Source: Authors

The third type of PPPs in health, the Health Facility PPPs, is centred on specific health facilities and typically also aims at improving the availability and quality of health services. In line with Harding & Montagu (2012)[16] and Langenbrunner (2011), four models are distinguished. Under the first model, Operation & Management, a private partner operates and manages a public health facility and provides health services within the public health facility, while under the second model, Financing, a private partner typically finances, designs, builds and operate a new public facility but does not provide health services. The third model, the Combined model, is simply a combination of the first two models. Under the fourth model, the Co-location model, a private partner uses a portion of a public facility's land and/or premises to provide health services.

The typology presented in Table 1 is a first attempt to define and classify PPPs in health and it is important to point out that borderline cases exist and that the categories may not be mutually exclusive. Some PPPs, on the other hand, may fit neither category. The above typology, however, allows a meaningful classification of a large majority of PPPs in health, including the PPPs in health reviewed for this study.

Information for this country report was obtained from secondary resources and semi-structured interviews with representatives from the Thai Ministry of Public Health (MoPH) and public and private hospitals in Thailand in 2011 and 2012.

This report is structured as follows. First, the country context is briefly introduced, the focus being on key characteristics of the Thai health system. Second, existing PPP in health in Thailand as well as the literature seeking to analyse these are reviewed. Next, the institutional framework is examined, the focus being on legislation and institutions. The last section concludes with lessons learned and some recommendations on how to engage the private sector further in the future.

Country context[17]

[16] While the Hospital PPP typology proposed in Harding & Montagu (2012) focuses exclusively on hospitals, their definition is adapted in this paper to also include other types of health facilities such as for example primary care clinics.

[17] Socio-economic data are taken from the World Bank's World Development Indicators Database (World Bank, n.d.), while data about Thailand's health service system are from the Bureau of Policy and Strategy, Ministry of Public Health (2011) unless otherwise indicated.

With a gross national income (GNI) per capita (Atlas method, current USD) of 4,420 in 2011, Thailand is classified as an upper middle income country. Trade stood at 148 per cent of GDP in 2011, which indicates that Thailand's economy is highly dependent on external demand. In 2009, in the wake of the global financial crisis, Thailand's GNI contracted by 2.8 per cent, although GNI growth on average exceeded 4 per cent over the past 10 years. The poverty headcount ratio at the national poverty line was 8.1 per cent of the population and the Gini coefficient 40 in 2009, reflecting inequalities which have prevailed, especially between urban and rural areas. In 2011, 66 per cent of the population were living in rural areas. As of 2011, 9.1 per cent of Thailand's population of 69.5 million people were aged 65 and above. With a life expectancy at birth of 74.1 years, a fertility rate of 1.6 births per women and a population growth rate of 0.6 per cent as of 2011, Thailand ranks among the fastest ageing countries in Asia. In fact, it is the second most aged country in South-eastern Asia (UN, 2006).

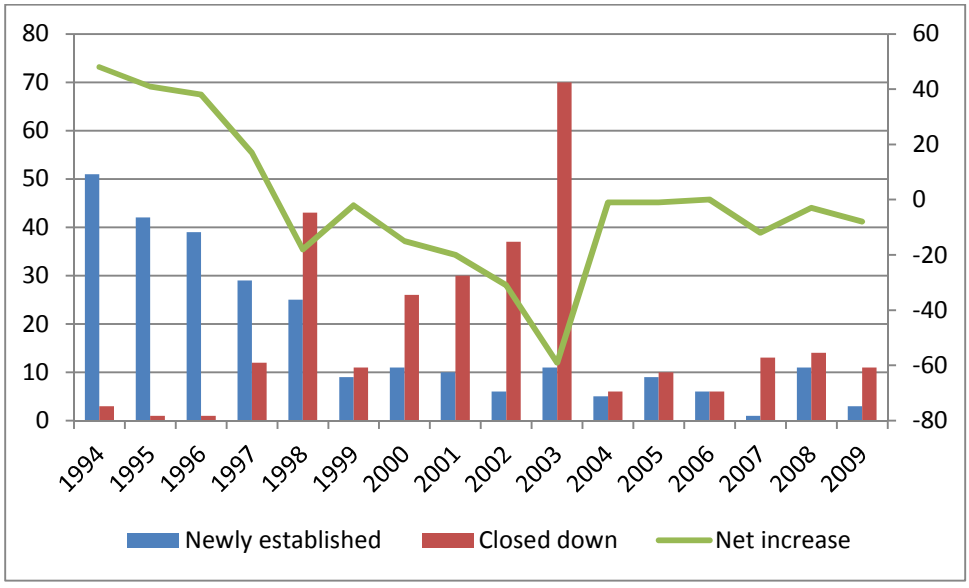
Thailand achieved the health Millennium Development Goals two decades ago. Both, the maternal mortality rate of 12 per 100,000 live births (national estimate, 2005) and the infant mortality rate of 10.6 per 1,000 live births (2011) are low compared with other countries in the region. Total health expenditures on health stood at 3.9 per cent in 2010, a ratio that has remained fairly stable over the past decade. While public health expenditures were 2.9 per cent of GDP in 2010, private health expenditures stood at 1.0 per cent of GDP in the same year. Out of pocket health expenditure amounted to 55.8 per cent of private expenditures on health.

A rapid demographic and epidemiological transition has influenced disease patterns in Thailand. Non-communicable diseases such as diabetes and hypertension have increased rapidly, posing challenges for Thailand's health system.

At present there are three major health insurance schemes, the Civil Servant Medical Benefit Scheme (CSMBS, since 1980), a non-contributory fringe benefit scheme for civil servants, the Social Security Scheme (SSS, since 1990), a contributory social insurance scheme for private employees in the private sector, and the UCS, a non-contributory tax-based scheme. The UCS was introduced in 2002 at a GNI per capita (Atlas method, current USD) of only 1,880, largely made possible by the existence of extensive public health infrastructure. Around two thirds of all hospitals in Thailand are controlled by the MoPH. One of the major problems public hospitals are facing nowadays, however, is the lack of capital for expansion or modernisation, which in turn affects operations and patient satisfaction.

As of 2009, the following public health facilities existed: 11 medical school hospitals, 25 regional hospitals, 95 general hospitals, 61 specialised hospitals, 734 community hospitals, 10,120 municipal health centres, 151 community health posts, 3,108 urban community primary health care centres and 48,049 rural community primary health care centres. Despite the prominent role of the public sector, a large private sector exists. In 2009, private health facilities comprised 322 private hospitals, 17,671 clinics, 11,154 modern pharmacies and 4,047 pharmacies selling only packaged drugs, 1,986 traditional medicine drugstores and 1,268 allied health places (e.g. spas and wellness centres). Figure 1 shows that following financial liberalisation in 1993, a total of 161 new private hospitals were established over the period 1994 to 1997. Since 1998, however, in the wake of the Thai financial crisis, the net change in the number of private hospitals (shown on the right hand side axis) was negative. In 2003 alone, 70 private hospitals were closed. In 2008, hospitals under the MoPH had the highest bed-occupancy rate (83 per cent) followed by hospitals under the Ministry of Education (71 per cent), while private hospitals, hospitals under independent agencies and hospitals under the Ministry of Defence had the lowest bed occupancy rate (60 per cent, 54 per cent and 48 per cent).

Figure 1 Number of private hospitals in Thailand, 1994-2009



Data source: Bureau of Sanatorium and Art of Healing, Department of Health Service Support, MoPH. In Bureau of Policy and Strategy, Ministry of Public Health (2011)

While 70 per cent of private hospitals and 78 per cent of private clinics are located outside of Bangkok, 72 per cent of large private hospitals (with more than 200 beds) were located in Bangkok in 2009. The geographical distribution of public and private hospitals shows that in 2008 the Northeast, which is Thailand's least developed region, still had the highest population to bed ratio of 779 compared to 312 in Bangkok, although much progress has been achieved since 1979 when the ratios were 1,511 for the Northeast and 337 for Bangkok. Data on population per doctor ratios also confirm that regional discrepancies prevail despite significant improvements over the past decades. In 2008, the population to doctor ratio was 5,028 in the Northeast but only 955 in Bangkok. The same observation can be made when looking at the ratio of population to other health professionals such as dentists and professional nurses.

Under the UCS, contracting with the National Health Security Office (NHSO), the managing body of the UCS, is mandatory for public providers but elective for private providers, which are screened before being admitted to the UCS delivery network. As stated in Bureau of Policy and Strategy, Ministry of Public Health (2011) among others, the workload of public health facilities, most notably at health centres and community hospitals, increased significantly post-UCS. Under the UCS, health care is provided by gatekeeper Contracting Units for Primary Care (CUP) for a catchment area of approximately 50,000 persons. A CUP typically comprises primary care units (one for 10,000 to 15,000 registered beneficiaries) and the contracted hospital and may include both public and private health care facilities. Monitoring takes place through audits, a KPI system, claim reviews and management of patient complaints (Sriratanaban, 2009). The SSO also contracts with public[18] and private hospitals. Like the UCS, the SSS uses a referral system and patients are referred from main contractor hospitals to tertiary hospitals. Monitoring takes place through annual quality audits (Sriratanaban, 2009). The UCS and the SSS both provide incentives for hospitals to obtain Thai Hospital Accreditation (Sriratanaban, 2009).

With the introduction of the UCS, a merger of all existing schemes was proposed but this proposal subsequently temporarily faded away as stated in Hughes, et al. (2011). Pronounced differences across the three major insurance schemes exist and their key characteristics are shown in Table 1 below. Given these different features and in light of the challenges each scheme is facing, proposals have re-emerged that foresee a further

[18] Participation of public hospitals in the SSS is also mandatory (Sriratanaban, 2009).

harmonisation, most notably in the form of placing all schemes under a single management or merging the three schemes as originally envisaged.

Table 1 Key characteristics

	CSMBS	SSS	UCS
Nature of scheme	Fringe benefits (public reimbursement scheme)	Social security	Social welfare
Managing body	Comptroller General Department (Ministry of Finance)	Social Security Office (SSO)	NHSO
Beneficiaries (%, 2008)	8	16	76
Source of funds	General tax	Tripartite contributions (employer, employee, government)	General tax
Choice of provider	Free choice	Some choice (Registration required)	None (Registration with nearest CUP required)
Payment mechanism			
- **OPD**	FFS	Capitation	Capitation
- **IPD**	DRG	Capitation	DRG under global budget
Package	Comprehensive	Comprehensive	Comprehensive
Cost-sharing	Yes (e.g. private hospitals)	Yes (e.g. maternity services)	None
Major challenges	Financial sustainability	Quality of care	Financial sustainability and quality of care

Source: Sakunphanit (2006); NHSO (2008); Sriratanaban (2009)

Characteristics of current PPP in health in Thailand

This section reviews major existing PPPs in Thailand. Health Facility PPPs have just started to emerge in Thailand and most PPPs are Services PPPs and involve contracting. Public Health and Social Programme PPPs, on the other hand, have somewhat lost relative importance over time and are thus not reviewed in this report. Assessments of PPP were typically conducted for internal use with the objective of identifying problems. Published, systematic evaluations of

PPP in terms of access, equity, quality of services, value for money, replicability and sustainability are hardly available. Hence, drawing conclusions from this review must be done carefully, bearing in mind that the private sector in Thailand is mostly for profit and strongly influenced by financial incentives. This in turn may result in overutilization as reported in Sriratanaban (2012).

1. Services PPP

1.1. Contracting (SSS): Buying services from private providers

The SSS is based on a contract model under which the SSO contracts with so-called main contracted (public and private) hospitals. Main contracted hospitals are accepted into the delivery network of the SSO upon meeting certain standards, which are set by the SSO (SSO, 1994 cited in Kositanurit, et al., 1998), and are permitted to subcontract with providers that either provide lower levels of care (so-called subcontractors) or high levels of care (so called supracontractors) (Janjaroen, et al., 2001). The SSS pays providers using capitation for inpatient and outpatient services, which in essence transfers the risk associated with the service provision from the SSO to the providers. On the other hand, the capitation model reduces uncertainties surrounding future cash-flows. An early study by Kositanurit, et al. (1998) examined if private hospitals are interested in becoming main contracted hospitals of the SSO and revealed that 55 per cent of the 94 private hospitals in Bangkok and vicinity that participated in the study wanted to be main contracted hospitals under the scheme, reflecting that the SSS was considered profitable by these hospitals. Participation in the SSS, however, affects market positioning and in the aftermath of the 1997 Thai financial crisis, when many private hospitals went bankrupt, private hospitals repositioned themselves either towards the SSS (and later the UCS) or the high end of the market[19]. A later study by Janjaroen, et al. (2001) analysed the impact of capitation payments under the SSS on the use of resources, market structure and management of contracted hospitals. The results inter alia showed that the SSS market had become increasingly competitive, especially since beneficiaries enjoy the right to change their provider once a year,

[19] Thai hospitals targeting affluent patients from Thailand and abroad achieved or aspire to achieve Joint Commission International accreditation to underline this repositioning.

resulting in higher cost of services for private and public hospitals alike, perhaps reflecting higher quality although this could not be confirmed using data from rural areas. As stated in the 2009 annual report of the SSO, of the main contracted hospitals, 152 were public hospitals, 98 were private hospitals and 2,313 were network hospitals indicating that the private sector continues to plays an important role in service delivery.

1.2. Contracting (UCS): Buying services from private providers

Given the success of contracting in terms of cost containment in case of the SSS, a contracting approach was also chosen for the UCS. The purchaser-provider split of the UCS was inter alia designed to ensure participation by the private sector across all levels of care and increase access to health care services as well as improve the quality of care (Hughes, et al., 2011). Private provider participation in the UCS has remained low though. According to the 2008 annual report of the NHSO, registered providers included 836 hospitals of the MoPH (including more than 10,000 health centres), 75 other public hospitals, 55 private hospitals, 93 public PCU and 150 private clinics. While the number of contracted private hospitals decreased from 71 in 2004 to 40 in 2010, the number of private clinics increased from 89 to 169 over the same time period (Health Insurance System Research Office, 2012). As mentioned above, the UCS is structured around CUPs, which may include both public and private health care facilities. A CUP centred on a private hospital contracts directly with the central NHSO (Hughes, et al., 2011) and is monitored and evaluated by the regional NHSO office (NHSO, 2009). As reported in Hughes, et al. (2011) contracts, however, are hardly monitored by the NHSO. In addition, private hospitals may contract as Contracting Unit for Secondary Care (CUS) or Contracting Unit for Tertiary Care (CUT). Besides, stand-alone clinics in Bangkok and vicinity contract with the NHSO (Hughes, et al., 2011).

Two main reasons have been identified for the low participation of the private sector as UCS providers. The first reason is that providers are inadequately paid, which is particularly relevant for private hospitals, and the second reason may be that the way in which the number of beneficiaries is allocated to private hospitals is considered as biased as stated in Hughes, et al. (2011) among others.

1.3. Contracting (public hospitals): Buying services from private providers[20]

As mentioned above, the workload of public health facilities increased significantly post-UCS. In response, three contracting models in which public hospitals directly contract private hospitals have emerged, namely the (i) rural model, (ii) urban model and (iii) urban model with university teaching hospital. Of the three models, only the latter has been implemented, however, given legal uncertainties. The key features of these three models will be briefly outlined in the following paragraphs.

The first model, dubbed the rural model, was initiated by a regional public hospital in the North of Thailand based on personal relations, with the objective of increasing (i) the availability of operating rooms and (ii) the availability of beds for postoperative recovery of patients. The target group of this model comprises CSMBS beneficiaries and patients who pay out of pocket. Two types of services are covered under this model, namely the use of operating room and hospital inpatient care for simple illness types. Patients would register at the private hospital and the private hospital would in turn pay a doctor fee to public doctors for operations and receive a fixed rate for the hospital bed in addition to DRG or fee for service payment for the inpatient care. Due to legal uncertainties and resulting resistance by hospital staff, however, implementation of this model has remained pending.

The second model, the urban model, was also initiated by the public sector (a general public hospital in the Bangkok Metropolitan Area) based on personal relations. The goal of the urban model, which targets UCS beneficiaries, is to increase availability of beds for postoperative recovery of patients and chronic care. Under the urban model, only inpatient care for selected illness types is covered. Patients register at the public hospital, while the NHSO pays a fixed rate for the inpatient service to the private hospital. The NHSO recommended three private hospitals as partners for the public hospital. The first hospital was interested, but located in a different geographical zone which has implications for provider payments. The second hospital rejected the invitation to participate in the urban

[20] This section is based on Herberholz & Supakankunti (2011).

model on the grounds that the UCS capitation payment is too low, while the third hospital was simply too small. Implementation of the urban model has also remained pending. The three main reasons given are (i) the lack of support by the public hospital since the model would have negative implications for the provider payments it receives from the NHS0 as well as (ii) the unclear division of liability and (iii) the unclear regulatory framework.

The third model, the urban model with teaching hospital, is the only model that has already been implemented. The public partner is a public teaching hospital in Bangkok with 1,500 beds that has a high average occupancy and mostly serves CSMBS patients. The private partner hospital has 550 beds with initially low average occupancy serving mostly out of pocket paying patients or patients covered by private health insurance. The third model was also initiated by the public sector based on personal relationships and aims at increasing the availability of beds for postoperative recovery of patients. The target population comprises CSMBS beneficiaries and services covered are hospital inpatient care for selected illness types. Patients register at public hospital and the public hospital is reimbursed using DRG. A fixed rate per hospital bed is paid by the public hospital to the private hospital. The negotiations started in 2007 and progressed in three phases. During the first phase, the private hospital reserved a total of 10 beds, which were not all used by public hospital. In light of increased occupancy at the private hospital, the private hospitals subsequently refrained from reserving any beds and only made beds available if these could not be sold elsewhere increasing uncertainty at the public hospital. The third phase started in 2011 with the signing of a memorandum of understanding outlining the rights and obligations of both parties in an attempt to overcome past problems. The main problems up to the third phase were identified to be the lack of responsibility and accountability as well as insufficient marketing skills at the public hospital, which was partially driven by legal uncertainties.

1.4. Outsourcing (public hospitals): Contracting specific clinical services and clinical support services

A number of public hospitals contract with private hospitals for specific clinical services (e.g. hemodialysis services and cataract operation) to overcome resource constraints (and implicitly problems of access and equity) or to offer a larger range of specialised medical services. These outsourced services are commonly paid according to set fee schedules (Sriratanaban, 2012). In addition, several public hospitals outsource clinical support services such as laboratory services and pharmacies to the private sector.

Partnerships for the provision of medical equipment and related clinical and non-clinical services, especially for high-cost non-removable medical equipment such as for example CT Scan, MRIs and mammography machines but also removable medical equipment such as mobile X-ray equipment, are also quite common. Options employed in the case of non-removable medical equipment include lease or rental agreements. Under these agreements either the public provider rents/leases the medical equipment (including related services) from a private entity or the private entity rents space at the public health care facility to operate the medical equipment, the latter of which may be viewed as co-location depending on the details of the contract.

The duration of these agreements, however, must not exceed one year to ensure compliance with Thai law. In addition, depending on the budget involved, approval from other government institutions is required, a process which is deemed time-consuming and inflexible.

1.5. Outsourcing (public hospitals): Contracting non-clinical support services by public hospitals

In an early study, Mills & Broomberg (1998) report that contracting of non-clinical support services in Thailand is done by only a few hospitals mostly located in large cities and is mainly restricted to cleaning, security and grounds maintenance. Since then, the landscape for outsourcing non-clinical services has changed dramatically and contracting of non-clinical support services by public hospitals has

become widespread include for example billing, laundry, catering, ATM, parking and equipment maintenance although legal uncertainties have remained.

2. Health Facility PPPs

Health Facility PPPs have only recently started to emerge in Thailand. At present, two pilot projects have been implemented. Both pilot projects can be classified as Operation and Management arrangements, although one of the two pilot projects is likely to also entail a co-location arrangement. The first pilot project was initiated by a local administrative authority in the South of Thailand, which bought and renovated a private hospital that went bankrupt in the aftermath of the 1997 financial crisis to improve the public supply of hospital services. A private hospital group was subsequently brought in to manage the facility as a not-for-profit hospital subject to certain KPIs. Under the second pilot project, which was initiated on the Eastern Seaboard, the local administrative authority built the hospital and then solicited bids for the management of the hospital by a private sector partner. A portion of this public hospital's land is used for a primary care clinic, which is likely to be managed by another private partner under a separate arrangement. Both hospital PPPs have the potential to generate revenue from private and medical tourists and benefit the public health system through cross-subsidisation, especially since Thailand's position as an important destination for medical tourism in ASEAN is likely to strengthen after the ASEAN Economic Community comes into being.

Institutional framework

A dedicated PPP unit does not exist in Thailand as yet. In general, private participation is governed by the Private Participation in State Undertaking Act B.E. 2535 (1992) (ERIA, n.d.). At present, the Royal Thai government is considering the establishment of a central PPP unit. Also, new PPP legislation and amendments to the Private Participation in State Undertaking Act B.E. 2535 (1992) have been drafted and are going through the legislative process. Under the ADB's country operations business plan 2012-2014, one of the pillars for cooperation between the ADB and the Royal Thai government focuses on PPP and a "*TA: Mainstreaming PPPs in 2010 to streamline processes and guidelines and improve sectoral, legal, and regulatory frameworks for catalysing PPP investments in Thailand*" was initiated (ADB, n.d.). Recent efforts explicitly

include PPPs in the health sector and have involved the MoPH in addition to the State Enterprise Policy Office. A PPP model and pilot projects have already been proposed by the ADB team.

Lessons learnt

Although the Thai health care system is publicly dominated the sizable private health sector has contributed to the country's health system for decades. Unlike in other countries in the region, the private sector in Thailand is largely for profit. Like other countries, Thailand started involving the private health sector through Public Health and Social Programmes PPPs as well as Services PPPs before considering Health Facility PPPs, suggesting a sequencing of PPPs.

Various forms of PPPs in health exist in Thailand, but their full potential has been impeded by legal uncertainties in the form of for example (i) a rigid budget approval process and (ii) a lack of supportive regulations. The review of major PPP initiatives further suggests that personal relationships, which has implications for replicability, as well as the involvement of all stakeholders is important and that there is no "one-size-fits-all" approach.

This review has clearly highlighted that there is a lack of evidence supporting or rejecting types of PPPs in health. Yet, rigorous and published evaluations are needed for discussions and decisions about future PPP, particularly emerging Health Facility PPPs.

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ii. Selected Case Studies from Asia

This section introduces PPP project case studies in selected countries in Asia. Each case study includes a description of the project and an assessment of the impact based on a review of available literature. The purpose of these case studies is to underline key concepts and lessons learned during the three-day PPP in Health Manila 2012 regional forum.

1. Indonesia: Contracting Midwives

Case Study: Targeted-Performance-Based Contracts for Midwives

Chantal Herberholz

Description

Indonesia has made remarkable progress in maternal health and the maternal mortality ratio decreased from 600 in 1990 to 220 per 100,000 live births in 2007 (modeled estimate, World Bank, n.d.). Yet, Indonesia's maternal mortality rate still exceeds that of other countries in the region and maternal health has remained a priority. The progress over the past decades is the result of several initiatives, at the core of which is the 1989 "*Bidan di Desa*" (BDD; skilled village midwives) programme (World Bank, 2010). The key features of the BDD programme are that village midwives (i) receive training, (ii) can charge for their services and (iii) receive compensation from the government[21] (Giles, et al., 2010). Initially, implementation of the BDD was not very successful and in 1997 the Ministry of Population/National Family Planning Coordinating Board and the Ministry of Health launched a Safe Motherhood Project financed by the World Bank. The objective of the programme was to increase the utilisation of village midwives by the poor (World Bank, 1997) focusing on the demand and the supply side. As part of the Safe Motherhood project a Targeted-Performance-Based Contracts for Midwives (TBC) pilot project was launched in ten districts, located in two provinces, with the support of district health authorities. Under the TBC pilot, pre-paid vouchers for services provided by contracted (and trained) midwives were distributed to make the services of private midwives affordable for poor women. Vouchers covered a basic package of mother and child care and family planning

[21] Initially, with the aim of eventually privatising midwives, contracts were meant to be given for the first years only to enable midwives to establish a reputation and increase demand for their services. Since 2002, however, unlimited contract renewals have been permitted by the government (Tan, 2006).

services and were distributed by village leaders and representatives of village organisations to the target population (defined as poor women who are either pregnant or who have a child under one year old) (Knowles, 2000 cited in Gorter, et al., 2003). Contracted midwives in turn were reimbursed, upon presentation of the vouchers, by the district health authorities[22] on a monthly basis and were free to provide services to and charge women without coupons (Gorter, et al., 2003). In 2003, the TPC pilot ended earlier than planned due to a number of government policy changes, including the permission by the government to extend BDD contracts for a longer period than initially foreseen (i.e. more than six years).

Impact

Project assessment was done based on four intermediate outcomes, namely (i) improving demand for and utilisation of quality maternal health services, (ii) strengthening the sustainability of maternal health services at the village level, (iii) improving quality of family planning services and (iv) preparing adolescents to lead a healthy reproductive life (World Bank, 2005). Problems with baseline data in terms of quality were reported in World Bank (2005).

Access

The TPC pilot is reported to have increased demand for and utilisation of quality maternal health services. Susenas (Indonesian national socio-economic survey) data in World Bank (2005) show that the number of institutional deliveries increased in the ten project districts, although the targeted performance of at least 50 per cent increase was only achieved in four districts. It must be noted though that the progress is not only due to the TPC pilot, but also other government programmes implemented at the same time. Yet, given the Asian financial crisis that erupted in Thailand in 1997, the increase was remarkable. In addition, in Pemalang district, utilisation of PTT midwives[23] was lower than utilisation of TPC midwives (Tan, 2006).

Equity

The target population of the TPC pilot included poor women who are either pregnant or who have a child under one year old. The voucher scheme was designed in such a way that it

[22] The district health authorities were also in charge of evaluating the midwives on a monthly basis (Tan, 2006).
[23] PTT midwives are government-paid, contacted midwives (i.e. "*Pegawai Tidak Tetap Bidan Di Desa*" or BDD PTT) (Tan, 2006). PTT midwives are distinct from midwives in the civil service.

encouraged TPC midwives to actively attract the target population since reimbursement was tied to the presentation of vouchers.

Quality

While some studies sought to assess the performance of TPC midwives relative to non-TPC midwives in terms of certain service delivery measures, the results turned out to be inconclusive (World Bank, 2005).

Efficiency

Since the TPC pilot was performance-based (i.e. midwives received a base wage plus a variable wage component based on the number of poor patients treated) it implicitly encouraged efficiency. Tan (2005) reported that in Pemalang district the TPC pilot cost consisted of (i) base wages and voucher reimbursements for 30 TPC midwives of more than IDR 1.2 billion (USD 134,000) for the period 1999 to 2004, (ii) IDR 300,000 for two staff from the District Health Bureau for their monitoring activities and (iii) an undisclosed amount for the District Project Monitoring Unit. Comparative data especially for the overlapping PTT midwife system, however, are not referred to. Besides, the overlapping TPC and PTT midwife system in Pemalang district caused uncertainties with potentially negative implications for efficiency (Tan, 2006).

Replicability

As mentioned above, the TPC pilot ended in 2003. However, some districts, including Pemalang district, continued the voucher system using their own funds until the government enabled midwives contracted under TPC to obtain unlimited PTT contracts in 2004 (Tan, 2006). In addition, some of the Safe Motherhood project's salient components were considered for implementation in other districts, including TPC (World Bank, 2005).

Lessons learned

A number of lessons can be learned from the TPC pilot. First, guidance and support of lower levels of government is important. In Pemalang district, for example, the district health authorities, contrary to the project design, let the TPC midwives themselves distribute the vouchers, resulting in conflicts of interest. In general, it must be noted that identification of the poor is extremely difficult. Second, the existence of overlapping schemes resulted in

inefficiencies as outlined above. Third, the government's policy changes resulted in TPC ending earlier than anticipated with the effect that the programme's full potential could not be assessed. Overall, this case underlines, however, that vouchers are a powerful tool to harness the private sector and improve access to important health services.

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2. Philippines: Contracting Insurance Enrolment

Case Study: KaSAPI

Chantal Herberholz

Description

The KaSAPI or "*Kalusugang Sigurado at Abot-kaya sa PhilHealth Insurance*" programme was designed by the Philippine Health Insurance Corporation (PhilHealth) to fulfil its mandate under the National Health Insurance Act of 1995 of achieving universal health care coverage through social insurance (Llanto, 2007). The programme evolved from the PhilHealth Organised Group Interface (POGI), which started in 2003 (Philippine Health Insurance Corporation, 2012b). PhilHealth's members can be categorised into five groups, (i) the Employed Sector Programme (43.7 per cent of total members as of 2010), (ii) the Overseas Workers Programme (10.4 per cent of total members as of 2010), (iii) the Individually Paying Programme (16.7 per cent of total members as of 2010), (iv) the Sponsored Programme (26.9 per cent of total members as of 2010) and (v) the Non-paying Programme (2.2 per cent of total members as of 2010) (Manasan, et al., 2012). As of 2010, PhilHealth had around 70 million beneficiaries or 79 per cent of the total population (Manasan, et al., 2012). The KaSAPI programme was launched in 2006 and aimed at providing social health insurance to individually paying members in the informal sector via organised groups such as cooperatives, NGOs and rural banks (Couttolenc & Miranda, 2009, Philippine Health Insurance Corporation, 2012b). During the initial programme phase, KaSAPI was financed by a donor, namely GIZ (Couttolenc, 2009). After a pilot in 7 regions, KaSAPI was replicated nationwide in 2008 (Couttolenc & Miranda, 2009). The partnership was structured around four distinct steps, ranging from (i) initiation and selection of the organised group, (2) training of staff and recruitment of potential KaSAPI members, (iii) collection of premium payments and distribution of PhilHealth cards to (iv) monitoring (Couttolenc & Miranda, 2009). In essence, the organised groups functioned as marketing and premium collection agencies and in exchange received a discount on the premium contributions if they enrolled at least 70 per cent of their eligible members (Manasan, et al., 2012). However, inter alia due to high group size requirement and cumbersome documentary requirements, enrolment under KaSAPI (and previously POGI as a matter of fact) remained very low (Philippine Health Insurance Corporation, 2012b).

Impact

An independent assessment was prepared by Llanto (2007) for PhilHealth and GIZ.

Access

The annual premium rate used to be PHP 1,200 (approximately USD 30), but was increased to PHP 2,400[24], with the option to lock-in, by means of advanced premium payments, for two years the original rate of PHP 1,200 per year (PhilHealth, 2012), the impact of which remains to be assessed. The premium for the sponsored programme also amounts to PHP 1,200, but is paid by the national government and lower levels of government where the indigents live (Couttolenc, 2009). Competition with the sponsored programme was reported to have contributed to low KaSAPI enrolments. As of 2008, 23,332 informal sector families were enrolled in KaSAPI compared with 1,863 in 2006 (Manasan, et al., 2012). In addition, the physical location of providers may have impeded access (Llanto, 2007).

Equity

KaSAPI targets the informal sector and the target population is thus likely to come from lower income brackets.

Quality

Information about patient satisfaction is not available. In addition, a mechanism for handling patient complaints did not exist initially, but was proposed in Llanto (2007).

Efficiency

Administrative inefficiencies are reported in Llanto (2007) and include (i) inefficiencies in the KaSAPI Members Information System and (ii) incomplete implementation of the claim verification and monitoring system. Evidence of the relative efficiency of enrolling informal sector members via KaSAPI versus other approaches does not seem to exist.

Replicability

[24] Effective July 1, 2012, but the increase in the premium was subsequently deferred.

Due to the challenges surrounding KaSAPI, the programme was eventually terminated and replaced in 2012 by the iGroup programme for registered organised groups. iGroups seeks to enrol members from the informal sector to the Individually Paying Members Programme. Under the iGroup group enrolment scheme, the iGroup programme partner receives a group policy contract, provided that a minimum group size of at least 30 qualified members, which are not registered under any of the other PhilHealth membership categories, are enrolled (Philippine Health Insurance Corporation, 2012b). Premium incentives and other value-added benefits continue to apply. iGroup programme partners are trained to use an enhanced e-group system to promote administrative efficiency.

Lessons learned

PhilHealth's recognition of the importance of covering the informal sector by social health insurance is very important for other countries in the region, most of which also have a large informal sector. In addition, the chosen approach of involving private partners to increase insurance enrolment is innovative and promising. KaSAPI thus offers important lessons, the most important being the need for policy coherence, given that one of the problems of KaSAPI was reported to stem from its competition with the sponsored programme, and stronger involvement of private partners in the programme design.

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3. Philippines: NKTI Lease Agreement for Hemodialysis Machines

Case Study: NKTI

Chantal Herberholz

Description

Kidney diseases, especially end stage renal disease (ESRD), are estimated to be the 7th leading cause of death among Filipinos (National Kidney and Transplant Institute, n.d.). ESRD incidence rates in the Philippines (87 per million population in 2008) are still low in international comparison (e.g. 363 per million population in the US in 2008) (United States Renal Data System (USRDS), 2011), however, they are likely to increase in the future given the increase in risk factors such as obesity and hypertension. The NKTI in Manila, formerly known as the National Kidney Foundation of the Philippines founded in 1981, is a public tertiary medical specialty centre specialised in renal diseases and organ transplantations and functions as a referral centre for regional hospitals in the Philippines (Miranda, 2010). In 2010, NKTI was awarded the title of "Centre of Excellence" by the Philippine Health Insurance Corporation (PhilHealth) (National Kidney and Transplant Institute, n.d.). Back in 1995, however, NKTI was far from being a "Centre of Excellence" since it experienced management problems in its hemodialysis unit, caused by outdated equipment, long machine down times for maintenance and low quality of services coupled with high personnel cost (Miranda, 2010). Given the lack of capital, outsourcing of clinical support services was considered. As reported in Miranda (2010), in 2002, NKTI approached the BOT Centre (since 2010 the Public Private Partnership Centre of the Philippines) and a feasibility study indicated that an outsourcing option, based on a lease agreement, was the best choice. Under the lease agreement, NKTI covered the cost of constructing a hemodialysis centre and the private sector partner the provision of 39 state-of-the-art hemodialysis machines, reverse osmosis water system supplies and training. A bidding process was initiated and Fresenius Medical Care was selected as the successful bidder in 2003. The Hemodialysis Centre (a PHP 54 million or around USD 1.35 million facility (Philippine Institute for Development Studies, 2011)) started operations in the same year. Fresenius Medical Care, a business unit of the German-based health care group Fresenius, is the "*world's leading provider of products and services for patients with chronic kidney failure*" (Fresenius Medical Care, n.d.). After expiration of the agreement in 2008, Fresenius Medical Care also emerged as the

successful bidder of the second bidding process and the outsourcing arrangement was renewed despite concerns raised by the audit commission and a controversial bidding process (Miranda, 2010). The second contract is due to expire in 2015.

Impact

There are two main studies that seek to assess the impact of the NKTI PPP, namely Miranda (2010) and Philippine Institute for Development Studies (2011).

Access

The lease agreement with Fresenius Medical Care allowed NKTI to offer quality services without the need to raise capital for investment in a fast manner. According to Miranda (2010) the partnership resulted in an increase in dialysis sessions from 15,185 in 2002 to 41,701 in 2009. The total number of dialysis patients from 2007 to 2010 amounted to 27,522 (Philippine Institute for Development Studies, 2011).

Equity

The target population is not defined and basically includes all Filipinos that need to undergo dialysis. Utilisation data by socio-economic background of patients, however, are not available in the public domain. As stated in Philippine Institute for Development Studies (2011), the cost of treatment was not affected by the PPP according to interviews with NKTI administrators and access for those who cannot afford services provided by private hospitals was increased, with the primary source of funding being the government.

Quality

The technical quality of the specific services was stipulated in the contract and required adherence to standards set by NKTI, the US Association for the Advancement of Medical Instrumentation (AAMI), Bureau of Foods and Drugs (BFAD) and general industry standards, with the second contract being somewhat more stringent than the first (Miranda, 2010). In addition, the PPP entailed training of staff thus developing human resources at NKTI (Philippine Institute for Development Studies, 2011).

Efficiency

According to Miranda (2010), the increase in dialysis sessions translated into increases in hospital income from dialysis (from PHP 42 million in 2002 to PHP 130 million in 2009) (Miranda, 2010). In fact, hemodialysis revenues are reported to have exceeded lease payments continuously since 2003 (Philippine Institute for Development Studies, 2011).

Replicability

Although other hospitals expressed interest in replicating the initiative, none has so far materialised. Yet, the demonstration effect of the NKTI PPP is not to be underestimated, especially since the Department of Health is actively promoting PPP in health.

Lessons learned

The NKTI case highlights the important role PPPs can play in overcoming a lack of capital. Assessments of the impact of the PPP suggest improvements in access, equity, quality and efficiency, yet the Philippine Institute for Development Studies (2011) pointed to a general lack of systematic assessments of PPP in the Philippines which could help shape and improve future PPP.

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4. Thailand: Contracting Services

Case Study: Contracting Primary Care Services[25]

Chantal Herberholz and Siripen Supakankunti

Description

Thailand achieved universal health care coverage in 2002 with the introduction of the so-called universal coverage scheme (UCS). Under the UCS, health care is inter alia provided by gatekeeper Contracting Units for Primary Care (CUP) for a catchment area of approximately 50,000 persons. A CUP typically comprises primary care units (PCUs, one for 10,000 to 15,000 registered beneficiaries) and the contracted hospital and may include both public and private health care facilities (Health Insurance System Research Office, 2012). The services provided by the CUP include curative care, health promotion, preventive care, rehabilitation as well as community services (National Health Security Office (NHSO), 2009). According to the 2008 Annual Report of the NHSO, the managing agency of the UCS, registered providers included 836 hospitals of the Ministry of Public Health (MoPH; including more than 10,000 health centres), 75 other public hospitals, 55 private hospitals, 93 public PCU and 150 private clinics (National Health Security Office (NHSO), 2009). Private providers are screened to assess if they pass minimum quality standards, whereas all public facilities are automatically accepted to serve UCS beneficiaries (Health Insurance System Research Office, 2012). While most UCS beneficiaries receive services from public facilities, 2010 data of registration profiles reveal that 41 per cent of the 3,664,652 UCS beneficiaries in Bangkok are registered with private clinics and 14 per cent with private hospitals (Health Insurance System Research Office, 2012). The UCS has around 47 million beneficiaries nationwide.

The CUP chosen for this case study is located in the Bangkok Metropolitan Area and consists of a general public hospital with approximately 450 beds, public PCUs and a network of private, for-profit clinics (private clinics are staffed with 1 doctor and 2 to 3 nurses and do not operate inpatient facilities) under single ownership. UCS beneficiaries typically register with one of the public PCUs or with one of the private clinics and are referred to the general hospital

[25] This case study is based on Herberholz & Supakankunti (2012). Corresponding author: Chantal Herberholz, Ph.D., Centre for Health Economics, Faculty of Economics, Chulalongkorn University, Bangkok, Thailand. Email: Chantal.H@chula.ac.th.

if necessary. The private clinic network was established at the end of 2005 and has since its inception joined the CUP. The objective of this model is to add to existing publicly provided services given their limited capacity. The model is results-focused since providers have to compete for business within the CUP. In addition, the contract with the private clinics will not be renewed in case of non-performance.

Impact

While internal evaluations, which are mainly aimed at problem identification, exist, none have been released so far. This case study thus draws on in-depth interviews conducted with representatives of the general public hospital and the network of private clinics in the first half of 2012. Any conclusions must be understood as indicative only and interpreted cautiously.

Access

Two main indicators are employed by the NHSO to assess the performance of the private clinics. The first indicator, in line with the objective of this model, looks at the expansion of the number of patient visits per year, while yearly quality evaluations by the NHSO and the Public Health Office are used as the second indicator. Regarding the former, the number of patient visits at the private clinics has increased steadily over the past years. From 2010 to 2011 alone, the number of patient visits increased by 21 per cent (from 244,874 in 2010 to 296,661 in 2011), which may reflect increased access. Corresponding data for public PCU, however, are not available. The services provided to the 122,795 UCS beneficiaries registered with the private clinics, like the services provided by the public PCU, are free at the point of service. Under the contract model employed by the UCS, capitation payments are used by the NHSO for outpatient services and are paid to the CUPs (Sriratanaban, 2012).

Equity

Thailand's UCS scheme has generally been recognised for its pro-poor stance (Jongudomsuk, et al., 2010 among others). Data that would allow a breakdown of UCS beneficiaries by socio-economic characteristics across public PCU and private clinics within this CUP, however, are not available.

Quality

While UCS beneficiaries are in general satisfied with UCS services (National Health Security Office (NHSO), 2009), a comparison of patient satisfaction across public PCU and private clinics within this CUP has also not been conducted yet.

Efficiency

Likewise, a systematic comparative assessment of the efficiency of the model has remained at large.

Replicability

The private network of clinics is satisfied with the arrangement and interested in its continuation, implying that it is sustainable and allows cost recovery. The fact that the annual contract was again renewed in 2011 also reflects that performance indicators were met.

Lessons learned

This case study highlights the important role that the private sector can play and cautiously suggests that the model could be expanded or replicated further in the Bangkok Metropolitan Area or other urban areas. Indeed, the number of contracted private clinics under the UCS has been increasing from 89 2004 to 169 in 2010 (Health Insurance System Research Office, 2012). The model may not be expanded on a country-wide basis though, since many private clinics in rural areas are unable to provide the required comprehensive range of services as reported in Health Insurance System Research Office (2012) among others. Most importantly, however, this case study also underlines the need for producing rigorous evidence to enhance policy choice and decision-making.

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D. List of Delegates

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Asian Development Bank
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List of Delegates from the Government Sector

	Name	Organisation	Country
1	Abadu, Osar	Philippine Health Insurance Corporation	Philippines
2	Abarte, Kenneth	Department of Finance	Philippines
3	Acluba, Emmanuel	Department of Health	Philippines
4	Agne, Alma Mae	National Economic & Development Authority	Philippines
5	Aguilar, Julyn	Philippine Orthopedic Center	Philippines
6	Alcantara, Ma. Gerry Lyn	Philippine Health Insurance Corporation	Philippines
7	Ali, Faleh Mohammad Hussain	Supreme Council of Health	Qatar
8	Alibanto, Ma. Teresa	Philippine Health Insurance Corporation	Philippines
9	Almajose, Cecilia	Rizal Province for Governor Ynares	Philippines
10	Altaikhuu, Dulguun	Ministry of Economic Development	Mongolia
11	Alvarez, Micaela	Department of Budget & Management	Philippines
12	Alzate, Rina P.	National Economic & Development Authority	Philippines
13	Andin, Ma. Eliza	Provincial Government of Davao del Norte	Philippines
14	Antonio, Jeffrey	Philippine Orthopedic Center	Philippines
15	Antonio, Zenaida	Department of Health	Philippines
16	Aquino, Gerardo	Department of Health	Philippines
17	Aquino, Nicole Dominique	Philippine Health Insurance Corporation	Philippines
18	Aristoza, Ramon	Philippine Health Insurance Corporation	Philippines
19	Bacareza, Walter	Philippine Health Insurance Corporation	Philippines
20	Banzon, Eduardo	Philippine Health Insurance Corporation	Philippines
21	Baquilod, Mario	Department of Health	Philippines
22	Basa, Ruben	Philippine Health Insurance Corporation	Philippines
23	Belga, Michelle	Development Academy of the Philippines	Philippines
24	Beltran, Maylene Meniado	Department of Health	Philippines
25	Bilbao, Alexander	Local Government	Philippines
26	Borbe, Dick J.	National Economic & Development Authority	Philippines
27	Boulavong, Sayduangvanh	Ministry of Finance	Lao PDR
28	Bugnosen, Monique	Local Government	Philippines
29	Caballes, Alvin	University of the Philippines	Philippines
30	Cabrera, Ramon	American Chamber of Commerce, Philippines	US/PHI
31	Calansingin, Kara Denise	PPP Center of the Philippines	Philippines
32	Caluen, Imelda	Development Academy of the Philippines	Philippines
33	Canilao, Cosette	PPP Center of the Philippines	Philippines
34	Canlas, Josephine	Development Bank of the Philippines	Philippines
35	Canuto, Rommel	Department of Health Task Force on PPP	Philippines
36	Caparas, Romeo	Department of Health, National Center for Health	Philippines
37	Castillo, Noelle Riza D.	PPP Center of the Philippines	Philippines
38	Castro, Belinda	Department of the Interior & Local Government	Philippines
39	Catibog, Honarata	Department of Health	Philippines
40	Catucod, Abigail Myra	Provincial Government of Northern Samar	Philippines
41	Chan, Jose	Department of Health, Cagayan de Oro	Philippines
42	Charunwattana, Watchai	Ministry of Public Health	Thailand
43	Chau, Pham Thi Minh	Ministry of Health	Viet Nam
44	Coligado, Judy Ann	Development Bank of the Philippines	Philippines
45	Concordia, Feroisa Francisca	PPP Center of the Philippines	Philippines
46	Cortez, Roland	Department of Health	Philippines
47	Cuneca, Romell	National Economic & Development Authority	Philippines
48	Daguman, Teresita	Department of the Interior & Local Government	Philippines
49	Damalerio, Alfonso	Local Government Unit, Bohol	Philippines
50	Danguilan, Romina	Department of Health	Philippines
51	Darunday, Grace	Department of Budget & Management	Philippines
52	Dator, Jose	National Kidney & Transplant Institute	Philippines
53	Daza, Paul	Provincial Government of Northern Samar	Philippines
54	de Guzman, Ria	Local Government	Philippines
55	de la Cruz, Teresita	Department of Health Task Force on PPP	Philippines
56	de Leon, Daniel	Philippine Health Insurance Corporation	Philippines
57	De leon, Rosalia	Department of Finance	Philippines
58	Dee, Yolanda	Department of Health	Philippines
59	Diaz, Gilda	Philippine Health Insurance Corporation	Philippines

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	Name	Organisation	Country
60	Dimatingkal, Dimarin	Local Government Unit, Cotobato	Philippines
61	Dizon, Mae	Philippine Health Insurance Corporation	Philippines
62	Domingo, Shirley	Philippine Health Insurance Corporation	Philippines
63	Dominguez, Maria Rosario J.	Board of Investments	Philippines
64	Duong, Vuong Anh	Ministry of Health	Viet Nam
65	Dy, Eugene	Philippine Orthopedic Center	Philippines
66	Encarnacion, Arlyn	Commission on Audit	Philippines
67	Escartin, Ivanhoe	Department of Health, National Center for Health	Philippines
68	Estrella, Maribel	Department of Health	Philippines
69	Factora, Manuel	Baguio General Hospital	Philippines
70	Fermin, Jose Mari	Department of Health, Ilo-Ilo	Philippines
71	Forbes, John	American Chamber of Commerce, Philippines	US/PHI
72	Gako, Nemesio	Department of Health	Philippines
73	Gamit, John	Development Bank of the Philippines	Philippines
74	Gancia, Rachel	UK Trade & Investment, British Embassy, Manila	UK/PHI
75	Garalza, Maria Victoria	Local Government Unit, Batangas	Philippines
76	Giango, Cristina	Department of Health	Philippines
77	Guia, Ariel	Department of Health, National Center for Health	Philippines
78	Guico, Zaldy	Department of Health, Region 1	Philippines
79	Gundram, Carlos	Department of Health	Philippines
80	Gutierrez, Blesilda	Department of Health	Philippines
81	Gutierrez, Leticia Barbara	Department of Health Task Force on PPP	Philippines
82	Gutierrez, Ricardo	Philippine Hospital Project Development	Philippines
83	Ham, Hak	Ministry of Health	Cambodia
84	Herbosa, Teodoro J.	Department of Health	Philippines
85	Hizon, Irene	Department of Health	Philippines
86	Holgado, Helen	Department of Budget & Management	Philippines
87	Htwe, Ye Min	Ministry of Health	Myanmar
88	Huong, Sea	Ministry of Health	Cambodia
89	Ibay, Jerry	Philippine Health Insurance Corporation	Philippines
90	Iqbal, Riki	Ministry of Health	Indonesia
91	Jenna, Teresa	Provincial Government of Northern Samar	Philippines
92	Jungwook, Kim	Korea Development Institute	Korea
93	Khairuddin, Ahmad Zamri Bin	Prime Minister's Office	Malaysia
94	Khemanith, Pavith	Ministry of Health	Lao PDR
95	Kovindha, Orasa	Ministry of Health	Thailand
96	Kyaw, Kyaw	Myanmar Yangon General Hospital	Myanmar
97	Lapuz, Hubert	Department of Health	Philippines
98	Lavadia, William	Philippine Orthopedic Center	Philippines
99	Layonmingi, Catherine	Provincial Government of Northern Samar	Philippines
100	Leister, Emma	UK Trade & Investment, British Emb Manila	UK/PHI
101	Lindawan, Rosemarie	Local Government Unit, Ifugao	Philippines
102	Maano, Luisito	Department of Health	Philippines
103	Macabato, Khaliquzzamman	Philippine Health Insurance Corporation, Marawi	Philippines
104	Magat, Dennis	Philippine Health Insurance Corporation	Philippines
105	Manalo, Jeffrey	PPP Center of the Philippines	Philippines
106	Manangan, Celso	Department of Health/UNECE	Philippines
107	Marcelo, Alvin	Philippine Health Insurance Corporation	Philippines
108	Mateo, Kristine	Development Bank of the Philippines	Philippines
109	Mejia, Joseph Roland	Department of Health, Region I Medical Center	Philippines
110	Mendoza, Laurita	Department of Health	Philippines
111	Mendoza, Magdalena	Development Academy of the Philippines	Philippines
112	Miral, Catherine	Provincial Government of Northern Samar	Philippines
113	Nery, Ramon	Department of Health	Philippines
114	Nitta, Junichi	Embassy of Japan in the Philippines	Japan/PHI
115	Ochoa, Gladys	PPP Center of the Philippines	Philippines
116	Ona, Enrique	Department of Health	Philippines
117	Ona, Mary	National Kidney & Transplant Institute	Philippines
118	Ong, Jensy	Local Government, Bicol Medical Center	Philippines

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List of Participants from the Government Sector (continued)

	Name	Organisation	Country
119	Ong, Romeo	Department of Health	Philippines
120	Ortile, Neil G.	National Economic & Development Authority	Philippines
121	Osias, Tomas	Commission on Population	Philippines
122	Palma, Ancy	Australia Trade Commission	AUS/PHI
123	Perez III, Juan Antonio	Department of Health	Philippines
124	Pham, Minh	Ministry of Health	Viet Nam
125	Phousavath, Phisith	Ministry of Health	Lao PDR
126	Phua, Kai Hong	National University of Singapore	Singapore
127	Pimentel, Aquilino	Former Senator	Philippines
128	Poyim, Sunisa	Ministry of Public Health	Viet Nam
129	Pujalte, Jose	Department of Health	Philippines
130	Puyat, Elizabeth	Philippine Health Insurance Corporation	Philippines
131	Quijano, Armando	Department of Health	Philippines
132	Quion, Analia	PPP Center of the Philippines	Philippines
133	Ramos, Johnny	Philippine Agricultural Development and	Philippines
134	Ravara, Corazon	Department of Health Task Force on PPP	Philippines
135	Repelente, Paquito	Department of Health	Philippines
136	Resmundo Jr., Leopoldo	Development Bank of the Philippines	Philippines
137	Resurreccion , Gilda	Department of Health Task Force on PPP	Philippines
138	Reyes, Mary Ann L.	Board of Investments	Philippines
139	Reyes, Yolanda	Department of Budget & Management	Philippines
140	Reynes, Brillo	Development Bank of the Philippines	Philippines
141	Ricote, Eleazar	National Economic & Development Authority	Philippines
142	Riego-Javier, Aileen	National Kidney & Transplant Institute	Philippines
143	Ronquillo, Kenneth	Department of Health	Philippines
144	Rosete, Dennis	Department of Health Task Force on PPP	Philippines
145	Runez, Ricardo Jr.	Baguio General Hospital	Philippines
146	Salazar, Jomil	Local Government	Philippines
147	Sanoria, Minerva	Department of the Interior & Local Government	Philippines
148	Sitorus, Risma	Ministry of Health	Indonesia
149	Sodnom, Bekhbat	Ministry of Economic Development	Mongolia
150	Soe, Htin Zaw	University of Public Health	Myanmar
151	Solangon, Marian Mae	Development Academy of the Philippines	Philippines
152	Soria, Francisco	Philippine Health Insurance	Philippines
153	Sy, Marie Irene	Local Government, Taguig Health Office	Philippines
154	Taleon, Juanito	Department of Health	Philippines
155	Theerapuncharoen, Weerapol	Ministry of Public Health	Thailand
156	Tongco, Arlene	Local Government, Surigao Del Norte	Philippines
157	Torres, Arsenia	Philippine Health Insurance Corporation	Philippines
158	Tsogtbaatar, Tuvshintur	Ministry of Economic Development	Mongolia
159	Tuan, Nguyen Huu	Ministry of Health	Viet Nam
160	Tuazon, Bryan	Development Bank of the Philippines	Philippines
161	Valdez, Donn Mac	Department of Health	Philippines
162	Valdez, Francisco	Department of Health	Philippines
163	Valera, Madeleine	Department of Health	Philippines
164	Vega, Leopoldo	Department of Health, Southern Phils Med Ctr	Philippines
165	Vengky, Uy	Ministry of Health	Cambodia
166	Vergeire, Rosette	Department of Health	Philippines
167	Victorino, Ernesto	Local Government Unit, City of Mandaluyong	Philippines
168	Villaraza, Everette	Department of Finance	Philippines
169	Villasis, Primo	Department of Health	Philippines
170	Villegas, Jan Irish P.	National Economic & Development Authority	Philippines
171	Viravann, Theme	Ministry of Health	Cambodia
172	Vongpreseurt, Phengkit	Ministry of Planning & Investment	Lao PDR
173	Win, Maung	Mandalay General Hospital	Myanmar
174	Yap, James April	Board of Investments	Philippines
175	Yazon, Eva	Australia Trade Commission	AUS/PHI
176	Yogyasswari, Indri	Ministry of Health	Indonesia
177	Yu, Oliver	Local Government Unit, Bohol	Philippines

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	Name	Organisation	Country
1	Alanguilan, Elaine	Smart Telecommunications	Philippines
2	Almazar, Allan	Hospira Philippines	Philippines
3	Aquino, Carmina	Center for Health Solutions Innovations Philippines Inc.	Philippines
4	Arota, Ivan Alexi	GE Health Care	Singapore
5	Avelino, Michelle	Ayala Fund Access HealthInternational	Philippines
6	Averia, Angela	GE Healthcare	Philippines
7	Basangan, Arthur	Daewoo International	Philippines
8	Bayaborda, Hans Voltaire	HP Philippines	Philippines
9	Beltran, Joel	Phillips HealthCare Philippines	Philippines
10	Bienvenida, Alberto	Allied Bank	Philippines
11	Bigornia, Jose Mari	Global Village Consulting Asia Pacific	Philippines
12	Bradley, Scott	Philips Healthcare Solutions	Singapore
13	Brown, Dan	DLA Piper, Australia	Australia
14	Buensuceso, Jose Benjamin	Metro Investment Corp.	Philippines
15	Bufi, Arnold	Sumitomo Banking Corp.	Singapore
16	Bugayong, Ramil	Puyat Jacinto & Santos Law Office	Philippines
17	Bulos, Ma. Lourdes	Smart Telecommunications	Philippines
18	Caballero, Richard Erick	Handicap International, Phils	Philippines
19	Carino, Pamela Christine	Medical City	Philippines
20	Castillo, Rex	Health Solutions Enterprises	Philippines
21	Castro. Solomon	CFP Transaction Advisors	Philippines
22	Cheng, Gary	Fortman Cline Capital Markets Philippines	Philippines
23	Chotrani, Johnny	I-Medicatus	Philippines
24	Cojuangco, Robert	SGV & Co.	Philippines
25	Coles, Yasmin	Iron Ladder	Philippines
26	Collingridge, Matthew	GE Health Care	Singapore
27	Concepcion, Noemi	Smart Telecommunications	Philippines
28	Cristobal, Romeo	United Laboratory, Inc.	Philippines
29	Dacanay, Alexander	Ernst & Young Philippines	Philippines
30	de Dios, Jocot	GE Health Care	Singapore
31	De Guzman, Virgilio S.	San Miguel Corporation	Philippines
32	de Jesus, Ian	Smart Telecommunications	Philippines
33	De La Paz, Jose Noel	Metro Pacific Investments Corp	Philippines
34	de Leon, Benjamin	Forum for Family Planning	Philippines
35	de Vera, Manuel	Asian Institute of Management	Philippines
36	Deiparine, Rostom	Population Services Pilipinas Inc	Philippines
37	Delos Reyes, Elsa	SMEC International	Philippines
38	Delos Santos, Larry	TIM Corporation	Philippines
39	Dimanlig-Manuel, Patricia	Asian Institute of Management	Philippines
40	Dioko, Maria Teresa	Novartis Healthcare Philippines	Philippines
41	Dombkins, David	Complex Program Group	Australia
42	Domingo, Jimmy	SMEC International	Philippines
43	Doval -Santos, Rosel l	Philtrust Group	Philippines
44	Dumancas, Jeehan Heider	Healthscope Medical Solutions Corporation	Philippines
45	Dutt, Apurv	Deloitte Touche Tohmatsu India Pvt. Ltd.	India
46	Enriquez, Medielyn	Bank of Commerce	Philippines
47	Erazo, Fernando	Philips Healthcare Solutions	Singapore
48	Espallardo, Noel	Deloitte Philippines	Philippines
49	Fernandez, Edric	Bank of Commerce	Philippines
50	Ferrer, Louie	Megawide Const Corp	Philippines
51	Flores, Debbie	Samsung C&T Corp	Philippines
52	Flores, Jim	Makati Medical Center	Philippines
53	Franco, Stephanie	Novartis Healthcare Philippines	Philippines
54	Gabriel, Daisy	Asian Institute of Management	Philippines
55	Gamboa, Gay	SMEC International	Philippines
56	Gamboa, Rhais	Mt. Grace Hospital Ventures	Philippines
57	Gay, Richard Gerard	Smart Telecommunications	Philippines
58	Gillego, Ma. Venicia	SMEC International	Philippines
59	Golamco, Angelina	Asian Institute of Management	Philippines

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	Name	Organization	Country
60	Guerra, Warlito	Benchmark Economic Devt Consulting	Philippines
61	Guevarra, Cherry	PKU Founder Commodities Group Co Ltd	Philippines
62	Guy, Alex	DLA Piper, Australia	Australia
63	Herrera, Ronillo	Health Solutions Enterprises	Philippines
64	Hilado, Elenor M.	BDO Capital Investments Corporation	Philippines
65	Hormillosa, Hazel	New World Diagnostic Inc.	Philippines
66	Isberto, Ramon	Smart Telecommunications	Philippines
67	Jackson, Alan	Healthscope Medical Solutions Corp.	Philippines
68	Jamieson, Jill	Deloitte Consulting	USA
69	Javier, Rosanna	PwC Financial Advisors, Inc.	Philippines
70	Jose, Nathalyn	SMEC International	Philippines
71	Khoory, Matthew	GE Health Care Asia-Pacific	Singapore
72	Kurtz, Eliza	JTA International, Australia	Australia
73	Laggui, Evangeline	SMEC International	Philippines
74	Lapaz, Bienvenido	GE Healthcare	Singapore/PHI
75	Libutan, Elizabeth	Security Bank Corp	Philippines
76	Maga, Brigida	Smart Telecommunications	Philippines
77	Magalang, Timoteo	SMEC International	Philippines
78	Magno, Ma. Sari	Security Bank Corp	Philippines
79	Malaluan, Antonette	Smart Telecommunications	Philippines
80	Malanao, Ruth	Planet Drugstore	Philippines
81	Malyutin, Kiril	Vnesheconombank	Russia
82	Monge, Arturo	Leighton	Philippines
83	Munoz, Albert	CFP Transaction Advisors	Philippines
84	Musngi, Allan	Planet Drugstore	Philippines
85	Nario, John Patrick	Smart Telecommunications	Philippines
86	Natividad, Concepcion	SMEC International	Philippines
87	Navarro, Gregorio	Deloitte Philippines	Philippines
88	Noferi, David	TTG Strategic Consulting	USA
89	Nolasco, Ivy	Handicap International	Philippines
90	Nuñez, Ria	Phillips HealthCare Philippines	Philippines
91	Ong, Yolanda	Campaigns and Grey	Philippines
92	Park, Andrew	GE Health Care	Singapore
93	Park, Jaeki	GE Health Care	Singapore
94	Pasion, Nolasco	M+W High Tech Projects Philippines	Philippines
95	Perez, Jesus	Central Escolar University	Philippines
96	Pijuan, Erlinda	Roche Philippines Inc.	Philippines
97	Plunkett, Steve	GE Health Care	Japan
98	Png, Keith	GE Health Care	Singapore
99	Pranavant , P.	Deloitte Touche Tohmatsu India Pvt. Ltd.	India
100	Ramos, Luther	Puyat Jacinto & Santos Law office	Philippines
101	Rand, Susan	Global Village Consulting Asia Pacific	Philippines
102	Reinoso, Myra	Private Infra Development Corporation	Philippines
103	Relova, Robert	Philips Healthcare Solutions	Philippines
104	Riel, Josefina Leona	PITC Pharma, Inc.	Philippines
105	Robillo, Miguel	Puyat Jacinto & Santos Law Office	Philippines
106	Rontal, Mary Rose	Access Health International	Philippines
107	Roque, Rhizzy Ann	Allied Bank	Philippines
108	Ruvivar, Oscar	TTG Strategic Consulting	Philippines
109	Sacci, Inna	University Research Co., LCC	Philippines
110	Sales, Marites	GE Healthcare	Singapore/PHI
111	San Jose, Phillip	SMEC International	Philippines
112	Sandico, Reynaldo	Benchmark Economic Devt Consulting	Philippines
113	Santiago, Maria Ana	SMEC International	Philippines
114	Santos, Jennifer	Megawide Const Corp	Philippines
115	Sibbison, Mathew	Macquarie Infrastructure & Real Assets	Philippines

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	Name	Organization	Country
116	Singhai, Sharad	Deloitte Touche Tohmatsu India Pvt. Ltd.	India
117	Soliman, Carlito	Mount Grace Hospital Ventures	Philippines
118	Solon, Florentino	Nutrition Center of the Philippines	Philippines
119	Sumabat, Kit	Smart Telecommunications	Philippines
120	Swertvaegher, Jennifer	Ghent University	Belgium
121	Sy, Howard	Macquarie Infrastructure & Real Assets	Philippines
122	Temple, Trevor	SMEC International	Philippines
123	Tiongson, John Jerusalem	The Medical City	Philippines
124	Torres, Tria Marie	Card MBA	Philippines
125	Valenzuela, Edgardo	TIM Corporation	Philippines
126	Villavicencio, Lito	Zanbato	Philippines
127	Viloria, Dinah	Deloitte Philippines	Philippines
128	Wilwayco, Nora Imelda	Smart Telecommunications	Philippines
129	Yauder, Ammable	Planet Drugstore	Philippines
130	Yu, Sherwin	PKU Founder Commodities Group Co Ltd	Philippines
131	Zamora, Arturo	Health Solutions Enterprises	Philippines
132	Zshornack, Darlene	Planet Drugstore	Philippines
133	Zshornack, Erwin	Planet Drugstore	Philippines

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List of Participants from International Organisations, NGOs and the Media

	Name	Organization	Country
1	Abon, Aura	Asian Development Bank	Philippines
2	Agabin, Bayani	ADB TA Team Consultant	Philippines
3	Alegado, Siegfrid	Business World	Philippines
4	Alikpala, Ma. Jocelyn Kara	ICANSERVE	Philippines
5	Asana, Olga	KfW Development Bank	Germany/PHI
6	Atienza, Wilfredo	ADB TA Team Consultant	Philippines
7	Bautista, Nestor	ABS-CBN	Philippines
8	Bayking, Julinette	International Finance Corporation	Philippines
9	Bellinger, Cristophe	Asian Development Bank	Philippines
10	Bernatas, Jean-Jacques	Asian Development Bank	Philippines
11	Bodart, Calude	Asian Development Bank	Philippines
12	Bredenkamp, Caryn	World Bank	Philippines
13	Bustamante, Maria Rita	European Union-Delegation Philippines	UK/PHI
14	Canoy, Becky	Asian Development Bank	Philippines
15	Cardona, Jose	GIZ GmbH	Germany/PHI
16	Corpuz, Nina	ABS-CBN	Philippines
17	Cruz, Lady Kristine	PRISM International	Philippines
18	dela Rosa, Jose Miguel	ADB TA Team Consultant	Philippines
19	Duncil, Rhea	Asian Development Bank	Philippines
20	Farnhammer, Hans	European Union-Delegation Philippines	UK/PHI
21	Finlayson, Bob	Asian Development Bank	Philippines
22	Flavier, Jonathan	PRISM International	Philippines
23	Fuarmin, Ailen	Asian Development Bank	Philippines
24	Galvez-Tan, Jaime	ADB TA Team Consultant/Team Leader	Philippines
25	Germani, Alberto	United Nations Economic Commission for Europe	Switzerland
26	Gomez, Vida	World Bank	Philippines
27	Groff, Stephen	Asian Development Bank	Philippines
28	Hamilton, Geoffrey	United Nations Economic Commission for Europe	Switzerland
29	Herberholz, Chantal	ADB TA Consultant	Thailand
30	Jimenez David, Rina	Phillippine Daily Inquirer	Philippines
31	Kachkynbaeva, Meerim	United Nations Economic Commission for Europe	Switzerland
32	Kaiser, Kai	World Bank	Philippines
33	Lam, Hilton	ADB TA Team Consultant	Philippines
34	Linsey, Charilou Joan	Growth with Equity in Mindanao (USAID funded)	Philippines
35	Masaki, Emiko	Asian Development Bank	Philippines
36	Moser, Patricia	Asian Development Bank	Philippines
37	Nañagas, Juan	ADB TA Team Consultant	Philippines
38	Nyunt-u, Soe	World Health Organization	Philippines
39	Ortega, Maria Rosa	Asian Development Bank	Philippines
40	Pauso, Katryn	ADB TA Team Consultant	Philippines
41	Pimentel, Ebrian	ABS-CBN	Philippines
42	Pladet, Roland	Asian Development Bank	Philippines
43	Quintela, Minerva	ADB TA Team Consultant	Philippines
44	Remonde, Rey	PRISM Inernational	Philippines
45	Rosadia, Roberto	World Bank	Philippines
46	Sampath, Srinivas	Asian Development Bank	Philippines
47	Soleta, Perla	ADB TA Team Consultant	Philippines
48	Suzuki, Kasushi	Japan International Cooperation Agency (JICA)	Japan/PHI
49	Tiwana, Omar	Asian Development Bank	Philippines
50	Tom, Adrian	Asian Development Bank	Philippines
51	Velas-Suarin, Mary Anne	ADB TA Team Consultant	Philippines
52	Villareal, Maria Theresa	Asian Development Bank	Philippines
53	Wachsmuth, Isabelle	World Health Organiation	Switzerland
54	Zeck, Willibald	UNICEF	Philippines

E. Press Releases

a. ADB

[press release to be inserted here]

b. DOH

DOH takes a bolder step towards PPP strategy

An October 23, 2012, press release from the Department of Health

The Department of Health (DOH)—Development Bank of the Philippines (DBP), and the Philippine Health Insurance Corporation (PhilHealth) today takes a bolder move to strengthen Public-Private Partnership (PPP) in the country through the "PPPs In Health Manila 2012" scheduled on October 23-25.

The regional learning event's theme, "Developing Models, Ensuring Sustainability: Perspectives from Asia and Europe," recognizes the ever-changing socio-political and environmental challenges that the world faces today. These situations range from lack of transparency in governance, food insecurity, and inequity in access to basic services such as education.

At the backdrop of the said event is the need for government to tackle the complexities in the changing disease patterns, the need to improve healthcare service delivery while at the same time ensuring equitable access to healthcare for its population.

The situation calls for government's urgent action to explore innovative approaches such as PPP.

"PPPs are innovative, long-term contractual arrangements for developing infrastructure and providing public services by introducing private sector funds and expertise to assist government in providing social services, infrastructure, among others," explained Secretary of Health Enrique T. Ona. He added that if PPPs are structured and executed in accordance to international best practices, this would be a big help to government in facing present-day challenges, especially those in the health sector.

Having spent several years promoting successful PPPs in the world, the Asian Development Bank (ADB) and the United Nations Economic Cooperation in Europe (UNECE) found a common ground with the DOH, DBP, and PhilHealth.

The event aims to showcase salient case studies and best practices in Asia, Europe and in other parts of the world, initiate a policy dialogue on the adoption of PPPs in addressing key health problems, and discuss the main barriers to the implementation of successful PPP projects in health.

The event will be two days of presentations, open forums, clinic hours to be attended by private and public practitioners and experts. The third day will be devoted to site visits

to the National Kidney and Transplant Institute Hemodialysis Center and the Planet Drugstore at the Ospital ng Makati.

“PPP will take us closer to meeting our desired goals in upgrading healthcare delivery in the county, improving health facilities and ultimately achieving Universal Health Care or Kalusugan Pangkalahatan,” Ona said.

Source: Department of Health, 2012. *Official Gazette*. [Online] Available at: www.gov.ph. [Accessed 23 October 2012]