Achieving sustainable and equitable cancer care: Leveraging policy to drive improvements in access and equity across health systems
Today’s session

Investing in Cancer Control: Why NCCPs are key to reducing the global cancer and NCD burden
Lisa Stevens, National Cancer Institute - USA (United States)

Developing an NCCP as part of health systems strengthening: the experience of Myanmar
Soe Aung, Pinlon Hospital (Myanmar)

Findings from key informant interviews: Challenges and opportunities associated with development and delivery of cancer care services and pathways – reflections from five countries
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Including cancer in Universal Health Coverage (UHC): The Philippines’ Phil Health ‘Z benefits package’
Clarito U. Cairo, Disease Prevention and Control Bureau (Philippines)
Investing in Cancer Control: Why NCCP's are key to reducing the global cancer and NCD burden

Lisa M. Stevens, Ph.D.
Deputy Director, CGH, NCI
World Cancer Congress
October 2018
What is a National Cancer Control Plan (NCCP)?

A strategic plan to control cancer based on the country’s cancer burden, cancer risk factor burden and the resources available to implement the plan in the context of the culture and health care system in that country

(Union for International Cancer Control)
Benefits of an NCCP

✓ **Increase** the use of evidence to guide policy and program decisions

✓ **Maximize** use of resources

✓ **Communicate** cancer challenges, needs, and path forward to the community, policymakers, and partners

✓ **Increase** financial, political and social support

✓ **Coordinate** efforts in cancer and other health areas to build on partner efforts and avoid duplication

✓ **Ensure** accountability

✓ **Improve** health outcomes
Opportunities to link to the global health & development agenda

Global Commitment
UN High-Level Summit and adoption of UN Political Declaration on NCDs

Global Action
WHO Global NCD Action Plan 2013-2020

Global Coordination
UN Task Force on NCDs and a Global Coordination Mechanism (GCM)

New Development agenda
SDG Target 3.4

Mid-term Review of Progress
UN HLM on NCDs

Global Accountability
“25 by 25” NCD mortality target adopted

Guidance for Implementation
WHA Cancer Resolution


Slide credit: UICC 2017
International Cancer Control Partnership

- supporting country cancer control planning efforts
- one-stop shop for cancer planners and policy-makers [http://www.iccp-portal.org/]
A global analysis of National Cancer Control Plans

National cancer control plans: a global analysis

Yannick Romero*, Dario Trapani*, Sonali Johnson, Zuzanna Tittenbrun, Leslie Given, Karin Hohman, Lisa Stevens, Julie S Torode, Mathieu Boniol, André M Ilbawi

There is increasing global recognition that national cancer plans are crucial to effectively address the cancer burden and to prioritise and coordinate programmes. We did a global analysis of available national cancer-related health plans using a standardised assessment questionnaire to assess their inclusion of elements that characterise an effective cancer plan and, thereby, improve understanding of the strengths and limitations of existing plans. The results show progress in the development of cancer plans, as well as in the inclusion of stakeholders in plan development.

NCCP Review Results

NCCP Review Results

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Remaining Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>Treatment</td>
</tr>
<tr>
<td>Early detection</td>
<td>Service Delivery</td>
</tr>
<tr>
<td></td>
<td>Health Workforce</td>
</tr>
</tbody>
</table>

NCCP Review Results

Implementation

- Mention Implementation: 72%
- Have detailed plan: 7%
- No: 21%

Budget

- Mention budget: 55%
- Have detailed budget plan: 11%
- No: 44%
Summary

• To achieve 2025 and 2030 goals there needs to be realistic priority setting, robust costing, and a sustained budget for cancer programs.

• Moving towards UHC will require evidence-based NCCPs that are financed and implemented.

• Planning → Effective investments to improve cancer outcomes.

• ICCP partners are committed to supporting cancer control planning efforts.
International Cancer Control Partnership

Learn More

Visit UICC Booth to learn more about ICCP

Visit NCI booth today from 17:15-17:45 (immediately following this session) for a “Meet the Experts Session” on the ICCP


Lancet Oncology Paper: https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(18)30681-8/fulltext
Saturday, October 20, 2018 (14:45-16:15)

Special Session: “The way to assure sustainable, accessible and affordable cancer care within National Cancer Control Plans”

- Speakers from Belarus, Czech Republic, Kazakhstan, Romania will share experience.
- Track progress since the Madrid session.
- Network with regional partners.
NCI Summer Curriculum in Cancer Prevention
Rockville, USA, July 8–August 9, 2019

- A free training program in cancer prevention and control open to health professional and scientists world-wide

- Includes two Courses
  - Principles of Prevention - four-weeks long
  - Molecular Prevention - one-week long

- Consists over 80 faculty of leading experts from federal agencies (NCI, NIH, and other Institutions), academia, cancer centers, and associations.

- Brings 40-55 international participants from more than 30 countries.

- Participants self-fund their travel/transportation, lodging, and food. The NCI Center for Global Health partially funds up to 14 individuals from Low and Middle Income Countries (LMICs) selected through the merit-based review.
Call for Application
November 15, 2018 to February 1, 2019

Application Review and Status Notification
March 2019

Registration for Accepted Applicants
April 2019

Check-out the latest program updates: https://cpfp.cancer.gov/summer-curriculum
For LMICs go to: https://www.cancer.gov/about-nci/organization/cgh/research-training/summer-curriculum-prevention
Questions to consider

How can the implementation of UHC interface with efforts outlined in the NCCP and NCD plans?

How have different health systems worked horizontally and vertically to integrate cancer programs?

What are the roles and responsibilities of different stakeholders in implementation of cancer services?

What evidence-based policies have you heard about at the Congress that you would consider integrating into the update of your NCCP?
Today’s session

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Developing an NCCP as part of health systems strengthening: the experience of Myanmar

Soe Aung
Myanmar
Disclosure

Nothing to disclose
Cancer Control Equation

Burden/Barriers

Resources + Governance
Implementation of NCCP

Burden
- Ageing
- Tobacco
- Lifestyle
- Infections
- Environment
- Genetics
- High-quality registry

Resources/Governance
- Insufficient human resource
- Drug availability/quality
- Financial barriers
  - SE Status
  - Social security system
- Other social determinants
- Geographical barriers
- Policies & interventions
  - NCCP; UHC; Legislations
Haematology Centre

Gynaecology

U Hla Tun Hospice

Paed Onco (2002)

Mandalay (1964)

Yangon (1958)

No. 2 Military Hospital

Gynaecology

Taunggyi (1962)

Naypyitaw (2007)

Military Onco Center (1973)

Zabuthiri (NPT) (2016)

One Cyberknife Center

PinLon (Ygn) (2013)

Radiotherapy

Med Oncology

Yangon Cancer Registry started in 1974.
Myanmar Comprehensive Cancer Control Plan (2017-2021) was developed to give strategic direction in order to attain the goal of reducing the incidence and impact of cancer in Myanmar by 2021.

Objectives

1. Reduce the incidence and mortality of cancer by 30% through primary prevention
2. Improve early detection of cancer by 30%
3. Improve effective diagnosis and treatment of cancer by 30% through cost effective interventions
4. Improve the quality of life of cancer patients by 30% through pain relief, rehabilitation and palliative care
5. Document (50%) of all cancer cases and establish a cancer registry for surveillance and research
6. Downgrade cancer incidence by evidence-based interventions
7. Increase the quantity and quality of cancer work force
Currently on-going Cancer Control Projects in Myanmar

I. NCCP
II. UNGJP Cervical Cancer Control Program
III. UICC: C/Can25
Collaboration with MoHS, WHO, IAEA, IARC in developing NCCP in Myanmar

Prioritized Areas

I. Prevention and early detection of cancer
II. To expand/upgrade diagnostic facilities
III. Management To increase and to upgrade cancer work force – Human and Material Resource Development and Training
IV. Documentation of cancer patients through PBCR
V. Radiation Safety

NB: Paediatric Cancer Control Activities to be integrated
It doesn’t matter how many resources you have.

If you don’t know how to use them, it will never be enough.

Source: Medical Statistics for Beginners, Ramakrishna HK
IMPORTANCE OF COORDINATION AND COOPERATION

CARBON ATOMS

Amorphous

Crystalline

Charcoal

Graphite

Diamond
Thank you for your attention!
Challenges and opportunities to develop and deliver policies in cancer care – reflections from key informants in five countries.

Rebecca Bergin

Achieving sustainable and equitable cancer care: Leveraging policy to drive improvements in access and equity across health systems. Union for International Cancer Control and Cancer Council Victoria.

Disclosure of interest: None
Policymaking for cancer

• Policy process in cancer care little researched
• Role of research evidence

• 13 key informant interviews
• 5 countries
• Levers & challenges to health service cancer policy/program development and implementation.
<table>
<thead>
<tr>
<th>Country</th>
<th>Policy / program</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>Regional Cancer Centres; Optimisation Cancer Surgery</td>
<td>4</td>
</tr>
<tr>
<td>Canada</td>
<td>Canadian Partnership Against Cancer (CPAC); CPAC priority populations program</td>
<td>2</td>
</tr>
<tr>
<td>Denmark</td>
<td>Cancer Pathways (diagnostic strategy); Multidisciplinary Cancer Group</td>
<td>3</td>
</tr>
<tr>
<td>Scotland</td>
<td>Cancer Quality Performance Indicators</td>
<td>2</td>
</tr>
<tr>
<td>New Zealand</td>
<td>Bowel Cancer Screening; Bowel cancer working group</td>
<td>2</td>
</tr>
</tbody>
</table>
The turning point...was the enthusiasm for providing capital funding for stimulating the economy that came out of the global financial crisis... (AUS1.2)

...multiple individuals see themselves as having key roles to play in driving improvements in clinical care... (SCOT2)

...when you first start out with a group that has not done public reporting on that, there were sensitivities about what that could mean. (CAN1)

It has been a 15-years-long organisational change. (DEN3)

They had clear guidance about improving cancer outcomes and reducing disparities. Most goals in the Ministry of Health have that dual goal... (NZ1)

...It’s not like other cancers where there is a strong survivorship which can be a part of that. That is probably the key challenge in that space. (AUS2.2)
Discussion

• Findings resonate with political science theories
  • ‘Muddling through’ – incremental policymaking (Lindblom, 1959; Heclo, 1974)
  • Multiple Streams – policy window (Kingdon, 1984)

• Factors specific to cancer policymaking
  • Clinical engagement / collaboration
  • Consumers
  • Policy context e.g. existing cancer plans, cancer pathway policies

• Research evidence is important BUT alone is not enough for successful change.

• Recognising and understanding factors impacting how cancer policymaking occurs could help future efforts to influence policy change.
Thank you

Rebecca.bergin@cancervic.org.au
The role of optimal care pathways in achieving system reform

Anna Boltong

Presenting on behalf of Kathryn Whitfield

Assistant Director Cancer Strategy & Development

Department of Health and Human Services

Victoria, Australia

Victoria Australia

- 8 geographic Integrated Cancer Services (ICS)
- 1 statewide Paediatric ICS
- Population: ~ 6.4 Million
- Metro 75%: Regional 25%
- New cancers ~ 31,000 pa
- Deaths ~ 11,000 pa
- 5-yr Survival 68%

MELBOURNE:
- 4 Million pop.
- > 200,000 pop.
- Approx 150,000 pop
- < 100,000 pop
System reform

• Reform / change → ‘optimal’ state

• Optimal care pathways a validated ‘tool’
  • Known and agreed standards of care
  • Evidence based and co-developed
  • Endorsed by government and peak bodies (CCA, CA)

• Reform requires multifactorial system response

• Victoria’s reform program
  • State-wide coordinated system response
  • Ongoing persistence and resilience

• Maintain and sustain
System policy context

Victoria
A cancer services framework for Victoria
Ministerial Taskforce for Cancer was established

Patient Management Frameworks & VCAP

Optimal Care Pathways (OCPs)

Victoria cancer plan 2016-2020

Statewide implementation

2003 2005 2010 2015
Known & Agreed resources for everyone:

- Detailed pathways for health professionals / services
- Quick reference guides for general practice
- ‘What to Expect’ guides for consumers / those affected

Reform program implementation

Health Service Priorities

Cancer Plan

Data Analysis

Tumour Summits

Service Redesign

Integrated Cancer Services

Consumer Voice

Primary Health Networks

iPACED

Optimal Care Pathways


EG: Service redesign

2 people...
Both have Lung cancer...
Both referred to outpatients in the past 12 months

Key difference?
New Grampians Region Rapid Access Lung Lesion Clinic

His Journey
Time to Diagnosis: 7 Days
Time to Treatment: 51 Days

Hers
Time to Diagnosis: 38 Days
Time to Treatment: 132 Days

Optimal Care Pathway Timeframes for Lung Cancer

- Referral to Diagnosis: 28 Days
- Diagnosis to first treatment: 14 Days
- Referral to first treatment: 42 Days
## OCP Implementation Outcomes

<table>
<thead>
<tr>
<th>ICS</th>
<th>Health Service</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEMICS</td>
<td>Eastern Health</td>
<td><strong>100% of first specialist appointment now occurring in 14 days</strong>, up from 19%</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>83% of patients are commencing treatment within 42 days</strong>, up from 39%</td>
</tr>
<tr>
<td>LMICS</td>
<td>Mildura</td>
<td><strong>64% of patients have their ECOG status documented</strong>, up from 20%</td>
</tr>
<tr>
<td>BSWRICS</td>
<td>Portland DH</td>
<td><strong>99% of patients are being screened for their supportive care</strong></td>
</tr>
<tr>
<td></td>
<td>SW Health</td>
<td><strong>70% of patients are being screened for their supportive care</strong></td>
</tr>
<tr>
<td></td>
<td>Barwon Health</td>
<td><strong>60% of patients are being screened for their supportive care</strong>, up from 7%</td>
</tr>
</tbody>
</table>
USING A NATIONAL CANCER WORK PLAN TO ENDORSE UPTAKE OF PATHWAYS TO IMPROVE CANCER CARE AND OUTCOMES FOR ALL AUSTRALIANS

Ms Alice Creelman
Assistant Secretary
Cancer Policy and Services Branch
National Cancer Policy, Screening and Services Taskforce
Australian Government Department of Health
Council of Australian Governments Health Council

- Ministers with direct responsibility for health matters from:
  - the Australian Government,
  - state and territory governments, and
  - the New Zealand Government.
- Australian Government Minister for Veterans’ Affairs.

Australian Health Ministers’ Advisory Council

- Heads of:
  - the Australian Government health department;
  - each state and territory health department;
  - the New Zealand health authority; and
  - the Australian Government Department of Veterans’ Affairs.

Clinical Principal Committee

- Commonwealth and state/territory Chief Medical Officers

National Cancer Expert Reference Group

- Co-chaired by Commonwealth and Victoria
- Clinical and government representatives from each jurisdiction
- Representatives from: Cancer Australia, Cancer Council Australia, and Clinical Oncology Society of Australia
- Consumer Representatives
NCERG and National Cancer Work Plan

NCERG Membership

**Joint Chairs**
Victorian and Commonwealth Governments

**All states and territories**
- Cancer Australia
- Cancer Council Australia
- Clinical Oncology Society of Australia
- Consumer Representatives

**Priorities**

1. **Pathways of Cancer Care**
   - establishing best-practice pathways of care with agreed referral protocols
   - improving practical support for patients, their carers and families

2. **Efficient and effective cancer services**
   - innovative use of the cancer workforce
   - agreed capability frameworks for cancer services

3. **Evidence-based cancer treatment**
   - better use of multidisciplinary teams
   - implementation of new research and best practice treatment protocols
A Framework for Optimal Cancer Care Pathways in Practice

1. Engage and communicate
   - Facilitate awareness, understanding and commitment to Optimal Cancer Care Pathways

2. Collaborate
   - Facilitate reflection, sharing of knowledge and key lessons

3. Drive best practice care
   - Drive continuous improvement of best practice cancer care using data wherever possible

4. Monitor and act
   - Create opportunities to identify and address local variation in cancer care, while developing data collection
Key lessons from OCP implementation

- Policy recognition
- Consumer awareness
- Stakeholder engagement
- Integration with existing change programs
Future Directions

• Develop OCPs for more tumours and cohorts
• Review existing OCPs in light of new clinical developments and guidelines
• Build greater awareness of the OCPs amongst cancer clinicians and consumers
• Develop data sets that enable evaluation of cancer care pathways
• Develop a framework to support OCP sustainability in future.
Access to information regarding the National Cancer Work Plan, including the 2016-17 National Summary of OCP Implementation is available at:


Tools for OCP implementation are available at the following link:


Access to the detailed, clinical version of the OCPs and a quick reference for GPs are available through the Cancer Council Australia website at the link provided below.


Consumer versions of the OCPs are available at the following link:

Including Cancer in Universal Health Coverage (UHC): The Philippines’ PhilHealth Z Benefits Package

CLARITO U. CAIRO, JR., MD, FPSVI, FPCOM
Program Manager
Philippine Cancer Prevention and Control
Department of Health - Disease Prevention and Control Bureau
clarcairo@dokclar@dokclar@gmail.com

No financial interest or affiliation concerning material discussed in this presentation
# ESTIMATED NEW CANCER CASES AND DEATHS

**Source:** 2015 PHILIPPINE CANCER FACTS AND ESTIMATES

<table>
<thead>
<tr>
<th>Cancer Sites</th>
<th>Male</th>
<th>Female</th>
<th>Both Sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New Cases</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOP TWELVE (BOTH SEXES)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. BREAST</td>
<td>20,267</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. LUNG</td>
<td>13,679</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. COLON/RECTUM</td>
<td>9,625</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. LIVER</td>
<td>8,649</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. CERVIX UTERI</td>
<td>7,289</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. PROSTATE</td>
<td>5,526</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. ADULT LEUKEMIA</td>
<td>4,270</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. THYROID</td>
<td>3,288</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. STOMACH</td>
<td>2,715</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. OVARY</td>
<td>2,657</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>109,280 CASES</strong></td>
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</table>

<table>
<thead>
<tr>
<th>Cancer Sites</th>
<th>Male</th>
<th>Female</th>
<th>Both Sexes</th>
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</thead>
<tbody>
<tr>
<td><strong>Deaths</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>TOP TWELVE (BOTH SEXES)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. LUNG</td>
<td>11,775</td>
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</tr>
<tr>
<td>2. LIVER</td>
<td>8,335</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. BREAST</td>
<td>7,384</td>
<td></td>
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</tr>
<tr>
<td>4. COLON/RECTUM</td>
<td>5,523</td>
<td></td>
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</tr>
<tr>
<td>5. ADULT LEUKEMIA</td>
<td>3,386</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. CERVIX UTERI</td>
<td>3,151</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. PROSTATE</td>
<td>2,912</td>
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<td></td>
</tr>
<tr>
<td>8. STOMACH</td>
<td>2,301</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. PANCREAS</td>
<td>1,666</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. OVARY</td>
<td>1,610</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>66,151 DEATHS</strong></td>
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</tbody>
</table>

**ESTIMATED ANNUAL PEDIATRIC CANCER CASES:** 3,923

Laudico A, Lumague, Mapua, del Rosario, Rizal and Manila Population based Cancer Registry
AmBisyon Natin 2040: Matatag Maginhawa Panatag na Buhay

 Philippine Health Agenda (Universal Health Care)
 - Financial Risk Protection
 - Better Health Outcomes
 - Responsiveness

UN Sustainable Development Goals 2030:
- End poverty
- Protect the planet
- Ensure prosperity for all

ASEAN 2025
- Peace
- Stability
- Prosperity

Philippine Health Agenda (Universal Health Care)
- Financial Risk Protection
- Better Health Outcomes
- Responsiveness

Comprehensive Cancer Care and Optimized Cancer Survival in 2025

DOH
- PhilHealth
- WHO
- DSWD
- DOST
- PAGCOR
- PCSO
- PCSI
- PHAP
- CARE Phil.
- Specialty Societies
- UP-NIH
- NEDA
- Jhpiego Philippines
- Hospice Philippines
- CCPH
- SM Supermalls
- Other Relevant Stakeholders

Healthy Lifestyle Program
Research, Genomics, Training
Cancer Registry (Mobile App) & Data Analytics
Cancer Screening Access Program & Sub-program Management
PhilHealth Benefits
Medicines Access Program & HPV & HBV Vaccination
National Integrated Cancer Control Act
Universal Health Care Act
Primary Care including Palliative/Hospice Care and Survivorship Care
Philippine Cancer Prevention and Control Program
Vision: Comprehensive Cancer Care and Optimized Cancer Survival in 2025

LEGISLATION, PRIMARY CARE, NCD REGISTRY, DATA ANALYTICS, AND RESEARCH

PREVENTION
- Cancer Awareness Campaigns including Community Engagement Approaches/Strategies
- Vaccination
- Healthy Lifestyle Program
- Genetic Testing and Genomics

SCREENING
- PhilPEN
- Screening Access Program (SAP)
- Mobile Health Care Services

DIAGNOSIS
- Medical Assistance Program (MAP)
- Precision Medicine

TREATMENT
- Medicines Access Program (MAP)

PALLIATIVE AND HOSPICE CARE
- Palliative and Hospice Care Program

REHABILITATION/SURVIVORSHIP
- Rehabilitation and Survivorship Program

PHILHEALTH BENEFITS

#PurposeGritCollaboration
## Z Benefits

Mga beneisyong nakalaan para sa mga malubhang sakit na nangangailangan ng magastos at mahabang panahon na pagpapagamot

<table>
<thead>
<tr>
<th>ANG MGA BENEPISYONG KASAMA SA Z BENEFITS</th>
<th>HALAGA</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAGGAMOT/OPERASYON/ INTERVENTION</td>
<td></td>
</tr>
<tr>
<td>Coronary Artery Bypass Graft</td>
<td>P 550,000</td>
</tr>
<tr>
<td>Tetralogy of Fallot</td>
<td>320,000</td>
</tr>
<tr>
<td>Ventricular Septal Defect</td>
<td>250,000</td>
</tr>
</tbody>
</table>

**BREAST CANCER (Early Stage)**
- Stage 0 to IIA
  - Low to Intermediate Risk
  - Halaga: P 100,000

**PROSTATE CANCER**
- Halaga: P 100,000

**CERVICAL CANCER**
- Chemoradiation with Cobalt and Brachytherapy or Surgery
  - Halaga: P 120,000
- Chemoradiation with Linear Accelerator and Brachytherapy
  - Halaga: P 175,000

**COLON CANCER**
- Stage I to II (Low Risk)
  - Halaga: P 150,000
- Stage II (High Risk)*** to III
  - Halaga: P 300,000

***Malaki ang posibilidad na bumalik at tumatalo sa ibang bahagi ng katawan matapos tumatamad sa colon resection ang mga pasyenteng may histological grade III - T4, lymphatic/vascular invasion at bowel obstruction.

**RECTUM CANCER**
- Stage I (Clinical and pathologic)
  - Halaga: P 150,000
- Pre-operative clinical stage I but with post operative pathologic stage II - III
  - Using linear accelerator as mode of radiotherapy
    - Halaga: P 400,000
  - Using cobalt as mode of radiotherapy
    - Halaga: P 320,000
  - Clinical Stage II - III
    - Using linear accelerator as mode of radiotherapy
      - Halaga: P 400,000
    - Using cobalt as mode of radiotherapy
      - Halaga: P 320,000

**ACUTE LYMPHOCYTIC / LYMPHOBLASTIC LEUKEMIA (PEDIATRIC)**
- Halaga: P 210,000

**ACUTE LYMPHOCYTIC / LYMPHOBLASTIC LEUKEMIA**
- Halaga: P 210,000
Only a few hospitals can offer Z benefits package to priority cancers

Low uptake/utilization of Z benefits for cancer patients

Misplaced healthcare priorities

Cost-Benefit Analysis has yet to be conducted

Only indigent patients are covered by Z benefits

Some oncologists are not amenable to the package
Major reforms are required:

- Universal Health Care Law
- PAGCOR 27B (USD509.4M)
- PCSO 20B (USD134.3M)
- Sin Tax 40B (USD754.7M) - Increase in benefit payment as supported by increase in premium and gov't subsidy 215B (USD4.05B)
- Sin Tax 2 pooled funds to PhilHealth

Starting January 2018, premium contribution of all employed members in the Formal Economy shall be adjusted to sustain the enhancements to PhilHealth benefits to effectively respond to the growing health care financing needs of all members, such as:
Much needs to be done to improve our healthcare system, which remains highly fragmented, resulting in disparity in health outcomes between the rich and the poor in the urban areas and rural.

**TO THIS END, I URGE THE SPEEDY PASSAGE OF THE UNIVERSAL HEALTH CARE BILL.**