



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

DEC 16 2010

ADMINISTRATIVE ORDER
NO. 2010 - 0036

SUBJECT: The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos

I. BACKGROUND AND RATIONALE

Health-related public policies and laws have provided the impetus for comprehensive reform strategies identified in the Health Sector Reform Agenda (HSRA) launched in 1999 and its implementation framework, the FOURmula One (F1) for Health in 2005. Since then, substantial gains in health sector improvements have been achieved in the areas of social health insurance coverage and benefits, execution of Department of Health (DOH) budgets and its use to leverage local government unit (LGU) performance, LGU spending in health, systematic health investment planning through the Province-wide Investment Plan for Health (PIPH)/ Citywide Investment Plan for Health (CIPH)/ Annual Operational Plan (AOP) process, capacities of government health facilities, and the implementation and monitoring of public health programs.

However, poor Filipino families have yet to experience equity and access to critical health services, despite all of these achievements.

DOH and PhilHealth recently conducted a joint Benefit Delivery Review highlighting the need to increase enrollment coverage, improve availment of benefits and increase support value for claims in order for the National Health Insurance Program (NHIP) to provide Filipinos substantial financial risk protection. More importantly, benefit delivery for the sponsored program (poorest quintile) was found to be lowest among our people. To date, only 53 percent of the entire population is covered by the program, with 42 percent availment rate, and 34 percent support value or a total benefit delivery ratio of 8 percent.

Public hospitals and health facilities have also suffered neglect due to the inadequacy of health budgets in terms of support for upgrading to expand capacity and improve quality of services. As of October 2010, eight hundred ninety two (892) rural health units (RHUs) and ninety nine (99) government hospitals have yet to qualify for accreditation by PhilHealth. Data have also shown that the poorest of the population are the main users of government health facilities. This means that the deterioration and poor quality of many government health facilities is particularly disadvantageous to the poor who needs the services the most.

Moreover, weaknesses in management and compensation of human resources for health have not been adequately addressed and inadequacies in health information systems to guide planning and implementation of health programs also need urgent attention.

Lastly, while the Philippines is on target for most of its Millennium Development Goals (MDG), it is lagging behind in reducing maternal and infant mortality. These two indicators are still at 162 per 100,000 live births and 25 per 1,000 live births respectively (2005 FPS and 2008 NDHS), with 2015 MDG targets at 52 and 19, respectively. There is

also wide difference in outcomes and program performance in these priority public health programs across geographic areas and income groups that particularly affect the poor.

To address these challenges, the Aquino Health Agenda (AHA) is being launched to improve, streamline and scale up reform interventions espoused in the HSRA and implemented under F1. This deliberate focus on the poor will ensure that as the implementation of health reforms moves forward, nobody are left behind.

To successfully implement the Aquino Health Agenda, the Philippine health system will require the following components: enlightened leadership and good governance practices; accurate and timely information and feedback on performance; financing that lessens the impact of expenditures especially among the poorest and the marginalized sector; competent workforce; accessible and effective medical products and technologies; and appropriately delivered essential services.

This Order provides the objectives, strategic thrusts, and implementation framework to implement the Universal Health Care (UHC)

II. SCOPE AND COVERAGE

This issuance shall apply to the entire health sector, including the public and private sectors, the DOH bureaus, national centers, hospitals, attached agencies especially PhilHealth and external development partners involved in the implementation of the Universal Health Care.

This Order shall also provide for the guidelines, approaches and resources needed to affect and influence public-private partnership, and benefit families, civil society, private and public health care providers, and local government units as they decide, behave and transact in the local health system that will provide the backdrop for the Aquino Health Agenda.

III. OVERALL GOAL AND OBJECTIVES:

Overall Goal:

The implementation of Universal Health Care shall be directed towards ensuring the achievement of the health system goals of better health outcomes, sustained health financing and responsive health system by ensuring that all Filipinos, especially the disadvantaged group in the spirit of solidarity, have equitable access to affordable health care.

General Objective:

Universal Health Care is an approach that seeks to improve, streamline, and scale up the reform strategies in HSRA and F1 in order to address inequities in health outcomes by ensuring that all Filipinos, especially those belonging to the lowest two income quintiles, have equitable access to quality health care.

This approach shall strengthen the National Health Insurance Program (NHIP) as the prime mover in improving financial risk protection, generating resources to modernize and sustain health facilities, and improve the provision of public health services to achieve the Millennium Development Goals (MDGs).

IV. DEFINITION OF TERMS

1. **Benefit Delivery Ratio (BDR)**– the cumulative likelihood that any Filipino is (a) eligible to claim (registered, paid contributions); (b) aware of entitlements and is able to access and avail of health services from accredited providers; and (c) is fully reimbursed by PhilHealth as far as total health care expenditures are concerned.
2. **Catastrophic Expenditures** –out-of-pocket spending on health that can drive a household to poverty or further into poverty. This is often expressed as a percentage of household income. High incidence of catastrophic spending reflects poor financial risk protection in the health sector.
3. **Casemix system** – refers to a payment mechanism that reimburses or pays for health care costs in terms of case groups/ bundled cost categorized in terms of their resource use.
4. **Community Health Team (CHT)** – is a group of health volunteers assigned in each barangay/priority population area led by a midwife that tracks eligible population for public health services, assists families in assessing and acting on health needs, provides information on available services in the locality, and facilitates the organization of transportation and communication systems, outreach services and linkages with other providers in the service delivery network (e.g. Barangay Health Station, Rural Health Unit, other small private and public hospitals and facilities).
5. **Continuum of Services** – integrated and coordinated packages of health services that encompass health promotive and preventive services, to in-hospital care support and treatment services and post-hospital rehabilitative services. These packages of services are made available at strategic access points where utilization is maximized by clients who need them most.
6. **Geographically Isolated and Disadvantaged Area (GIDA)** – communities with marginalized population physically and socio-economically separated from the mainstream society such as island municipalities, upland communities, hard-to-reach areas, and conflict-affected areas.
7. **Income Quintiles**- economic classification of population based on average monthly income. The lowest income quintile (Q1) with an average monthly family income of P3,460.00 while the next lowest quintile (Q2) is P6,073.00.
8. **Local health system** – all organizations, institutions and resources devoted to undertaking local health actions. These include provinces, and their component LGUs, Cities, private and public health care providers, local partners, and families.
9. **Monitoring and Evaluation for Efficiency and Effectiveness (ME3)** – the monitoring and evaluation framework used by the health sector to assess the implementation of reforms in the country.
10. **National Household Targeting System (NHTS)** - a data bank and an information management system managed by the Department of Social Welfare and Development (DSWD) that identifies who and where the poor are. The system generates and maintains the socio-economic database of poor households.

11. **No balance billing policy** – refers to the policy that NHIP members who belong to the poorest income quintile and their beneficiaries will not be required to pay out of pocket for costs for their confinement subject to the specific terms and conditions of this policy.
12. **Public Private Partnership (PPP)** - A cooperative venture between the public and private sectors, built on the expertise of each partner, that best meet clearly defined public needs through the appropriate allocation of resources, risks and rewards. This partnership may range from health care provision to logistics management, from information and communication technology to capacity building of health providers.
13. **Service Delivery Network (SDN)** - a health service delivery structure composed of a network of health service providers at different levels of care. SDN can be as small as an Inter-Local Health Zone (ILHZ) or as large as a regional SDN with the regional hospital serving as the end referral hospital.
14. **Service Delivery Package (SDP)** – includes services that will be provided within the catchment area of the SDN and will 1) target the country's MDG commitments; 2) eliminate endemic diseases; 3) intensify disease prevention and control for both communicable and non-communicable diseases; 4) improve family health care; and 5) manage health emergencies and disasters.
15. **Support Value** – proportion of the health care bill covered by PhilHealth when confined to a health facility.
16. **Universal Health Care** - a focused approach to health reform implementation, ensuring that all Filipinos especially the poor receive the benefits of health reform. This is a deliberate focus on the poor to ensure that they are given financial risk protection through enrollment to PhilHealth and that they are able to access affordable and quality health care and services in times of needs.

V. GENERAL GUIDELINES

- A. The Aquino Health Agenda (AHA) is a focused approach to health reform implementation in the context of HSRA and F1, ensuring that all Filipinos especially the poor receive the benefits of health reform. AHA shall be attained by pursuing three strategic thrusts:
 1. **Financial risk protection through expansion in NHIP enrollment and benefit delivery** - the poor are to be protected from the financial impacts of health care use by improving the benefit delivery ratio of the NHIP;
 2. **Improved access to quality hospitals and health care facilities** – government-owned and operated hospitals and health facilities will be upgraded to expand capacity and provide quality services to help attain MDGs, attend to traumatic injuries and other types of emergencies, and manage non-communicable diseases and their complications; and
 3. **Attainment of the health-related MDGs** - public health programs shall be focused on reducing maternal and child mortality, morbidity and mortality from TB and malaria, and the prevalence of HIV/AIDS, in addition to being prepared for emerging disease trends, and prevention and control of non-communicable diseases.

- B. The six (6) strategic instruments shall be optimized to achieve the AHA strategic thrusts:
1. Health Financing - instrument to increase resources for health that will be effectively allocated and utilized to improve the financial protection of the poor and the vulnerable sectors
 2. Service Delivery - instrument to transform the health service delivery structure to address variations in health service utilization and health outcomes across socio-economic variables
 3. Policy, Standards and Regulation - instrument to ensure equitable access to health services, essential medicines and technologies of assured quality, availability and safety
 4. Governance for Health - instrument to establish the mechanisms for efficiency, transparency and accountability and prevent opportunities for fraud
 5. Human Resources for Health - instrument to ensure that all Filipinos have access to professional health care providers capable of meeting their health needs at the appropriate level of care
 6. Health Information - instrument to establish a modern information system that shall:
 - a. Provide evidence for policy and program development
 - b. Support for immediate and efficient provision of health care and management of province-wide health systems
- C. The success of the AHA shall be measured by the progress made in preventing premature deaths, reduce maternal and newborn deaths, controlling both communicable and non-communicable diseases, improvements in access to quality health facilities and services and increasing NHIP benefit delivery rate, prioritizing the poor and the marginalized (such as the Geographically Isolated and Disadvantaged Area (GIDA) population, indigenous population, older persons, differently-abled persons, internally- displaced population, and people in conflict-affected areas). These performance measures are the results of effective interaction between families and health care providers (both public and private) in local health systems.
- D. The DOH shall facilitate the implementation of the AHA by influencing the manner by which Provinces and component LGUs, and Cities govern local health systems.
- E. In implementing the Aquino Health Agenda, the DOH recognizes that LGUs have the primary mandate to finance and regulate local health systems, including the provision of the right information to families and health providers.
- F. Consistent with the Presidential commitment of zero-corruption in the government, the implementation of UHC shall be founded on participatory governance, transparency and accountability at the national, sub-national, and local government levels to better respond to the health needs of all Filipinos.
- G. Broad and sustained participation among all stakeholders shall be purposive, coordinative, harmonized and productive. UHC shall harness the strength of revitalized public-private partnership especially in services needing heavy capital investments.

- H. UHC shall be client-centered and respond efficiently to the medical needs and social expectations consistent with accepted standards of care.
- I. In order to implement the Aquino Health Agenda, the DOH shall engage local health systems (Provinces and their component LGUs, Cities, private and public health care providers, local partners, and families) through the formation of regional clusters based on their catchment areas.

VI. SPECIFIC GUIDELINES

- A. Financial risk protection through improvements in NHIP benefit delivery shall be achieved by:
 - 1. Redirecting PhilHealth operations towards the improvement of the national and regional benefit delivery ratios;
 - 2. Expanding enrolment of the poor in the NHIP to improve population coverage;
 - 3. Promoting the availment of quality outpatient and inpatient services at accredited facilities through reformed capitation and no balance billing arrangements for sponsored members, respectively;
 - 4. Increasing the support value of health insurance through the use of information technology upgrades to accelerate PhilHealth claims processing, etc.; and
 - 5. A continuing study to determine the segments of the population to be covered for specific range of services and the proportion of the total cost to be covered/supported
- B. Improved access to quality hospitals and other health care facilities shall be achieved by:
 - 1. A targeted health facility enhancement program that shall leverage funds for improved facility preparedness to adequately manage the most common causes of mortality and morbidity, including trauma;
 - 2. Provision of financial mechanisms drawing from public-private partnerships to support the immediate repair, rehabilitation and construction of selected priority health facilities;
 - 3. Fiscal autonomy and income retention schemes for government hospitals and health facilities;
 - 4. Unified and streamlined DOH licensure and PhilHealth accreditation for hospitals and health facilities; and
 - 5. Regional clustering and referral networks of health facilities based on their catchment areas to address the current fragmentation of health services in some regions as an aftermath of the devolution of local health services.
- C. Health-related MDGs shall be attained by:
 - 1. Deploying Community Health Teams that shall actively assist families in assessing and acting on their health needs;
 - 2. Utilizing the life cycle approach in providing needed services, namely family planning; ante-natal care; delivery in health facilities; essential newborn and immediate postpartum care; and the *Garantisadong Pambata* package for children 0-14 years of age;
 - 3. Aggressively promoting healthy lifestyle changes to reduce non-communicable diseases;
 - 4. Ensuring public health measures to prevent and control of communicable diseases, and adequate surveillance and preparedness for emerging and re-emerging diseases; and

5. Harnessing the strengths of inter-agency and inter-sectoral cooperation to health especially with the Department of Education and Department of Social Welfare and the Department of Interior and Local Government.

VII. ROLES AND RESPONSIBILITIES

A. DOH shall:

1. Develop guidelines and protocols to organize the community health team and service delivery network, implement a functional referral system, deliver health service packages, contract with private providers, implement clinical practice guidelines, generate, retain, and use hospital revenues, and establish hospital pricing system to maximize benefits from PhilHealth;
2. Institutionalize the PIPH/CIPH/AOP as a process to engage and guide the LGUs in identifying their needs and proposing interventions based on these needs, pooling resources at the regional level, and strengthening the coordination among provinces, their component LGUs, and cities;
3. Utilize its resources for public health grants and commodities to leverage the performance of LGUs in organizing the community health team and service delivery network, delivering health service packages, and providing critical inputs like supplies, drugs and commodities;
4. Engage partners in policy development and implementation of strategies including the media in providing accurate and timely information to the public regarding the implementation of the AHA;
5. Advocate with Congress to pursue legislation that will support health reform priorities;
6. Engage professional groups, the academe, NGOs and other private sector partners in establishing clinical guidelines, collaborative networks for service provision and fees, training, advocacy, and monitoring and evaluation, using systems that have been developed in HSRA and F1 (e.g. ME3);
7. Consolidate available resources and provide grants for upgrading of local health facilities to comply with PhilHealth accreditation standards, especially in areas where most of the poor are found; and
8. Operate DOH-retained hospitals and facilities to become effective instruments to influence local systems performance.

B. PhilHealth shall:

1. Expand NHIP coverage by ensuring the annual registration and enrolment of poor families while leveraging for local counterparts and providing member and provider services to promote utilization of NHIP benefits;
2. Secure financial risk protection for outpatient services by linking capitation payments with discrete outpatient services;
3. Secure financial risk protection for inpatient services by implementing a no-balance-billing policy in government hospitals for our poorest population;
4. Improve management of the NHIP by investing in modern information and communication technology to link members and providers with PhilHealth offices.
5. Seeking other financial instruments and strategies to maintain/improve financial sustainability

C. Local Government Units are encouraged and assisted to:

1. Develop policies and plans appropriate to their locality and consistent with the implementation of the AHA, including the installation of instruments to sustain provision of services such as systems covering logistics management, health information, monitoring and evaluation, and referrals within the service delivery network;
2. Mobilize and utilize resources such as Internal Revenue Allotment (IRA), PhilHealth reimbursements, user-fees, capitation fund, and other resources to organize and sustain the community health teams and service delivery networks including provision of supplies, drugs and commodities;
3. Allow their local hospitals and other public health facilities appropriate incentives such as income retention, socialized pricing, and improved hospital pricing to improve their capacity to deliver services; and
4. Organize Community Health Teams and Service Delivery Networks in partnership with the private sector for effective delivery of health service packages, and whenever appropriate, contract private providers to supplement available services or provide other services that cannot be delivered by existing public providers (e.g. family planning services such as tubal ligation or perform caesarean sections).

D. The Development Partners, within the context of Sector Development Approach for Health and subject to agreements with the DOH, shall:

1. Provide official development assistance consistent with the national thrusts and directions for health as further articulated in this Order;
2. Align and harmonize their systems and processes with government procedures and institutional reform processes to the best extent possible;
3. Cooperate in the establishment of mechanisms to track development assistance for the AHA; and
4. Ensure the sustainability and institutionalization of assistance projects to appropriate agencies/offices.

VIII. IMPLEMENTATION ARRANGEMENTS

1. DOH offices shall be clustered according to the three major strategic thrusts of UHC especially in ensuring access to health by the poor.
 - a. Financial risk protection – health care financing cluster
 - b. Attaining MDGs – policy, standards and regulation cluster
 - c. Health facilities enhancement – service delivery cluster

The sectoral and internal management support cluster shall provide governance and management support to all the clusters.

The functional clusters and their specific tasks shall be described in a separate Department Order to be issued in line with this AO.

2. Strengthening of local health systems shall be facilitated and coordinated by the Centers for Health Development through the regional clusters. These are aggregations of local health systems at the regional level organized for the purpose of inter-LGU cooperation. It shall assume the following functions:
 - i. Oversee operations and concerns of hospitals covering the same catchment;
 - ii. Pool resources from the DOH Central Office, LGUs, PhilHealth, the private sector and development partners to allow for consortium of training, sharing,

- hiring and management of hospital personnel, procurement of essential drugs and commodities and construction/upgrading of facilities;
- iii. Decide on equitable allocation of budgets in support of improving hospital and health facility operations; and
 - iv. Provide policy directions that will facilitate private-public sector partnership in the provision of health care and promote corporate practices that will sustain provision of quality and affordable health care.
3. The UHC implementation plan and operational guidelines shall be jointly formulated by the DOH and other stakeholders within two (2) months after issuance of this AO. All DOH offices, DOH attached agencies especially PhilHealth, and DOH-retained hospitals shall ensure coherence of their activities, projects and individual operational plans to the UHC strategic thrusts. All clusters shall advocate for the adoption and implementation of UHC plan by all stakeholders and partners.
4. Progress of AHA implementation shall be monitored and evaluated quarterly. All cluster heads shall be responsible for achieving the agreed targets for 2011-2016. By end of 2012, at least eighty five (85) percent of all UHC targets by reform component should have been achieved. By end of 2014, all UHC targets should be sustainable and supported by the appropriate policy issuances.

IX. REPEALING CLAUSE

The provisions of previous Orders and other related issuances inconsistent or contrary to the provisions of this Administrative Order are hereby revised, modified, repealed or rescinded accordingly. All provisions of existing issuances which are not affected by this Order shall remain valid and in effect.

X. EFFECTIVITY

This Order shall take effect immediately.



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