



UHC

UNIVERSAL HEALTH CARE

MEDIUM TERM

EXPENDITURE PROGRAM

2019-2022

***A Multi-Year
Spending Plan for the
Department of Health***

UPDATE for FY 2020 Budget Preparation

Developed by the
Health Policy Development and Planning Bureau

Department of Health 2019

Published by the Health Policy Development and Planning Bureau – Department of Health San Lazaro Compound, Rizal Avenue, Sta. Cruz, Manila 1003, Philippines

The mention of specific companies or of certain products does not imply preferential endorsement or recommendation by the Department. This report may be reproduced in full or in part for non-profit purposes without prior permission, provided proper attribution to the Department is made. Furnishing the Department a copy of the reprinted or adapted version will be appreciated.

EDITORIAL TEAM

Usec. Mario C. Villaverde
Dir. Maylene M. Beltran
Frances Rose Elgo-Mamaril
Lindsley Jeremiah D. Villarante
Josefa Mina B. Nieva
May Ann L. Liwanag
Ma. Leslie B. Ulmido

The following also provided technical assistance on the development of this document:

Christian Edward L. Nuevo
Emanuel Y. Gloria
Josefina Esguerra

CREATIVE TEAM

Harvey Bislumbre



Preface

This document the Universal Health Care (UHC) Medium Term Expenditure Program (MTEP) of the Department of Health - Office of the Secretary (DOH-OSEC) and PhilHealth is a multi-year spending plan covering the years 2019-2022. It features the estimated budgetary requirements for the attainment of *FOUR*mula One Plus for Health (F1 Plus for Health) framework. The process of the MTEP development involved the estimation of the fiscal space for health and the budgetary requirements using the two-tier budgeting approach with three scenarios (low, medium and high). This MTEP is annually reviewed and updated. Finally, this reference is intended for the budget preparation for fiscal year 2020 and for the consideration of the Development Budget Coordination Committee (DBCC) for the funding of UHC.

Table of Contents

1

Chapter 1 - Introduction

	page
Health Situation	3
Priority Framework and the Universal Health Care Act	5
Targets	7

Preface



11

Chapter 2 - Resources in the Health Sector

Philippine National Health Accounts	13
Department of Health Budget Trends	13
Absorptive Capacity	15
Estimated Fiscal Space for Health	16

Chapter 3 - Methodology

19

25

Chapter 4 - Budget Scenarios

High Cost-Estimate Scenario: UHC Implementation in All Barangays	27
Medium Cost-Estimate Scenario: UHC Implementation in Prioritized Areas	32
GIDA Barangays and 4th-6th Class Municipalities	32
Poor Performing Provinces that are Major Contributors to National Health Outcomes	34
Low Cost-Estimate Scenario: Status Quo	38
Tier 1: Cost of On-Going P/A/Ps	38
Tier 2: Cost of New and Expanding P/A/Ps	39

Chapter 5 - Estimated Resource Gaps and Ways Forward

Resource Gap	43
Ways Forward	44

Annexes

Annex A: Estimated Fiscal Space	48
Annex B: Average Proportion of Maternal and Infant Deaths per Province to Total Maternal and Infant Deaths of the Country, 2005-2015	48
Annex C: MMR Trajectory by 2022 under Status Quo vs. With Investment	51
Annex D: IMR Trajectory by 2022 under Status Quo vs. With Investment	52
Annex E: Tier 1 Budget Distribution per P/A/Ps, in Billion PhP	53

Chapter

1

Introduction





Chapter 1

Introduction

HEALTH SITUATION

Health is a fundamental human right. This is recognized by the Philippine government, hence health is given a priority, as shown by the exponential increase in the health budget from PhP 53.23 B in 2013 to PhP 166.71 B in 2018. However, despite reforms for the health sector, it still faces the issue of inequity in health outcomes, fragmented health system and high out of pocket (OOP) expenditures. The details of the findings in the sector is expounded below.

Marginal health outcomes

Disparities in the accessibility of essential healthcare services, uneven distribution of health workers and lack of economic resources across provinces led performance in selected health outcomes to be marginal. Tuberculosis infection remains high despite of it being preventable and curable with over 554 Filipino infected for every 100,000 population in 2016. Meanwhile, the maternal mortality ratio has minimal progress from 126 per 100,000 live births in 2012 to 114 per 100,000 live births in 2015. For infant mortality, the percent decrease is only at 32.35% over 20 years from 1993 to 2013 with 23 infants dying in every 1,000 live births. When compared to our Southeast Asian neighbors, the Philippines ranks in the bottom half among these indicators.



Disjointed health system

Due to devolution, the integrated referral system that once linked public health services and hospitals was disintegrated causing fragmentation in service delivery. Also, the overlapping functions of the DOH, PhilHealth and LGUs in delivering health services and financing the healthcare system and lack of clear accountability has caused inefficiencies in the health system and further exacerbated the fragmentation.

High OOP despite increased resources for health

In 2017, PhilHealth has already covered 93% (nearly 97 million) of the population and has subsidized the poor and near-poor families through earmarked revenues from tobacco and alcohol excise taxes. However despite increased coverage and resources for health, Filipinos continue to face financial risks. Out-of-pocket spending remains high, with the poor bearing the biggest impact of healthcare cost, which either impoverishes them further or discourages them outright to seek needed medical care.

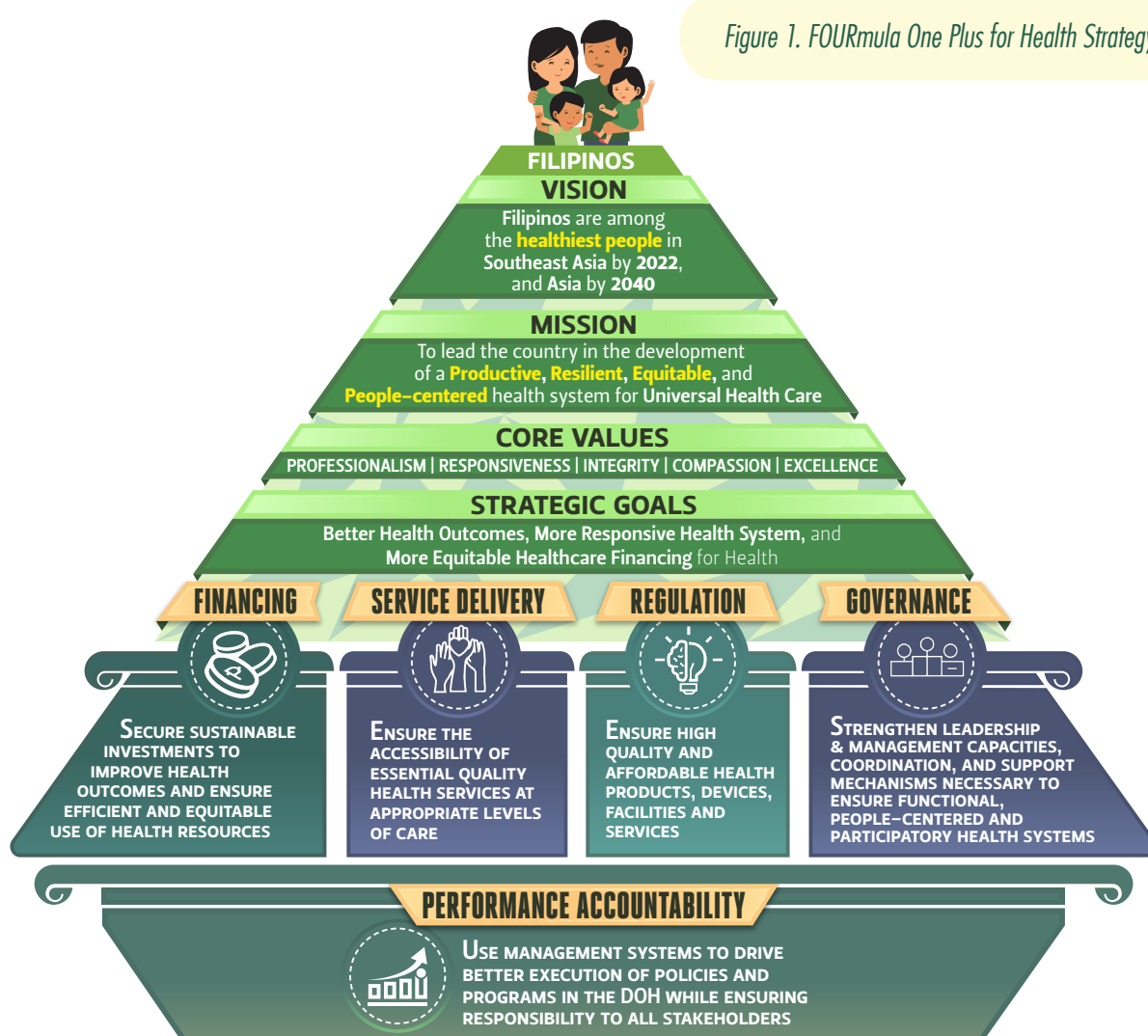
Table 1. Ranking of the Philippines in Selected Indicators compared to Southeast Asian countries

Ranking	Average Life Expectancy (2016)	Maternal Mortality Ratio (2015)	Infant Mortality Rate (2016)	TB Incidence Rate (2016)
1st (Best)	Singapore	Singapore	Singapore	Brunei
2nd	Brunei	Thailand	Malaysia	Singapore
3rd	Vietnam	Brunei	Brunei	Malaysia
4th	Malaysia	Malaysia	Thailand	Vietnam
5th	Thailand	Vietnam	Vietnam	Thailand
6th	Indonesia	Philippines	Philippines	Laos
7th	Philippines	Indonesia	Indonesia	Cambodia
8th	Cambodia	Cambodia	Cambodia	Myanmar
9th	Myanmar	Myanmar	Myanmar	Indonesia
10th (Worst)	Laos	Laos	Laos	Philippines



PRIORITY FRAMEWORK AND THE UNIVERSAL HEALTH CARE ACT

In response to the challenges in improving our health system, the DOH pursues the *FOURmula One Plus for Health* (F1 Plus for Health), which aims to provide universal health care for all Filipinos in the medium to long term. It envisions Filipinos to be among the healthiest people in Southeast Asia by 2022, and in Asia by 2040. This can be done by leading the country in the development of a productive, resilient, equitable, and people-centered health system.



DOH will focus its program, activities and projects into five strategic pillars namely: Financing, Service Delivery, Regulation, and Governance, plus a cross cutting initiative on Performance Accountability. Through this framework, the Philippines aims to achieve better health outcomes, a more responsive health system and a more equitable health care financing.



UHC MEDIUM TERM EXPENDITURE PROGRAM 2019-2022

With the aim of providing health to every Filipino, the DOH is aligned with the Philippine Development Plan (PDP) 2017-2022, the first medium-term plan anchored to *AmBisyon Natin 2040* vision. Under the PDP, the health sector is recognized as contributory to its pillars namely; *Pagbabago* with the theme reducing inequality through accelerating human capital development and reducing the vulnerability of individuals, and *Patuloy na Pag-unlad* with the theme of increasing growth potential through reaching demographic dividend.

The Republic Act No. 11223 otherwise known as the UHC Act will concretize the reforms under F1 Plus for Health. It aims that every Filipino is matched to a primary care team who ensures that they can get the appropriate services they need in the most accessible facility without encountering any financial hardship. The law aims to focus on the following:

FINANCING - There will be a clear delineation on the financial roles of the DOH and PhilHealth. DOH will focus on financing of population-based services while PhilHealth will be on individual-based services. PhilHealth membership will be simplified into direct or indirect contributory to streamline the funds and ensure high premium efficiency of collection.



SERVICE DELIVERY – Primary care will be institutionalized as a prerequisite to access higher level of care, income retention will be enabled for all public providers, and fragmented providers will be consolidated into networks practicing client/patient navigation and referral.

REGULATION - Transparent pricing of medical services and fixed co-payments will be mandated. The health workforce will be strengthened which includes requiring return service for all health professional graduates of public universities for at least 3 years in an underserved areas.



GOVERNANCE - The PhilHealth will be assigned as the national purchaser of health goods and services. Health Technology Assessment (HTA) will be established to guide investments of DOH and coverage decisions of PhilHealth. Healthcare providers will be required to submit health/financial data and share publicly-funded data sets.



TARGETS

The goals of F1 Plus for Health will be measured by the following set of impact indicators which reflect the overall effectiveness of strategies and interventions in improving health system performance and achieving the desired health outcomes for all, especially the poor:

Table 2. Sectoral Goals and Impact Indicators, National Objectives for Health 2017-2022

Goal 1: Better health outcomes			
Indicator	Data Source	Baseline	Target 2022
Indicator 1: Average life expectancy (in years)	PSA Gender	70 (2010-2015)	72
Indicator 2: Maternal mortality ratio per 100,000 live births	UN Estimates	114 (2015)	90
Indicator 3: Infant mortality rate per 1,000 live births	National Demographic and Health Survey	23 (2013)	15
Indicator 4: Premature mortality attributed to cardiovascular diseases, cancer, diabetes or chronic respiratory diseases per 100,000 population	PSA-CRVS	188 (2014)	156
Indicator 5: Tuberculosis incidence per 100,000 population	National TB Prevalence Survey	434 (2016)	427
Indicator 6: Prevalence of stunting among under-five children (in %)	FNRI-DOST, NNS	33.4 (2015)	21.4



Goal 2: Responsive health system

Indicator	Data Source	Baseline	Target 2022
Indicator 7: Client satisfaction rate	<i>To be determined through commissioned study</i>		
Indicator 8: Provider responsiveness score	<i>To be determined through commissioned study</i>		

Goal 3: Equitable health financing

Indicator	Data Source	Baseline	Target 2022
Indicator 9: Out-of-pocket health spending as percentage of total health expenditure	PSA Philippine National Health Accounts (PNHA)	52.2 (2016)	50
Indicator 10: Percent of population who have spent less than 10 percent of their HH income on health	<i>To be determined through commissioned study</i>		

Chapter

2

Resources in the Health Sector





Chapter 2

Resources in the Health Sector

PHILIPPINE NATIONAL HEALTH ACCOUNTS

Funding for healthcare comes from both private and public (government) sources. Based on the Philippine National Health Accounts (PNHA), total health expenditure¹, increased by 20 percent from PhP 592.8 B in 2015 (PSA, 2015) to PhP 712.3 B in 2017 (PSA, 2018) but its share in GDP remains at 4.5 percent in 2017. Per capita health expenditure at current prices also grew nominally in the same period from PhP 5,834 to PhP 6,791, averaging an annual increase of 7.9 percent. However, accounting for inflation, the average annual growth rate is only 5.7 percent. The country's 2015 current health expenditure per capita of USD323 was one of the lowest in the ASEAN – higher only to Cambodia, Lao Republic and Bangladesh but lower than most ASEAN countries that had comparable GDP with the Philippines such as Vietnam (USD334), Indonesia (USD369), Thailand (USD610) and Malaysia (USD1,064) (World Bank, 2018).

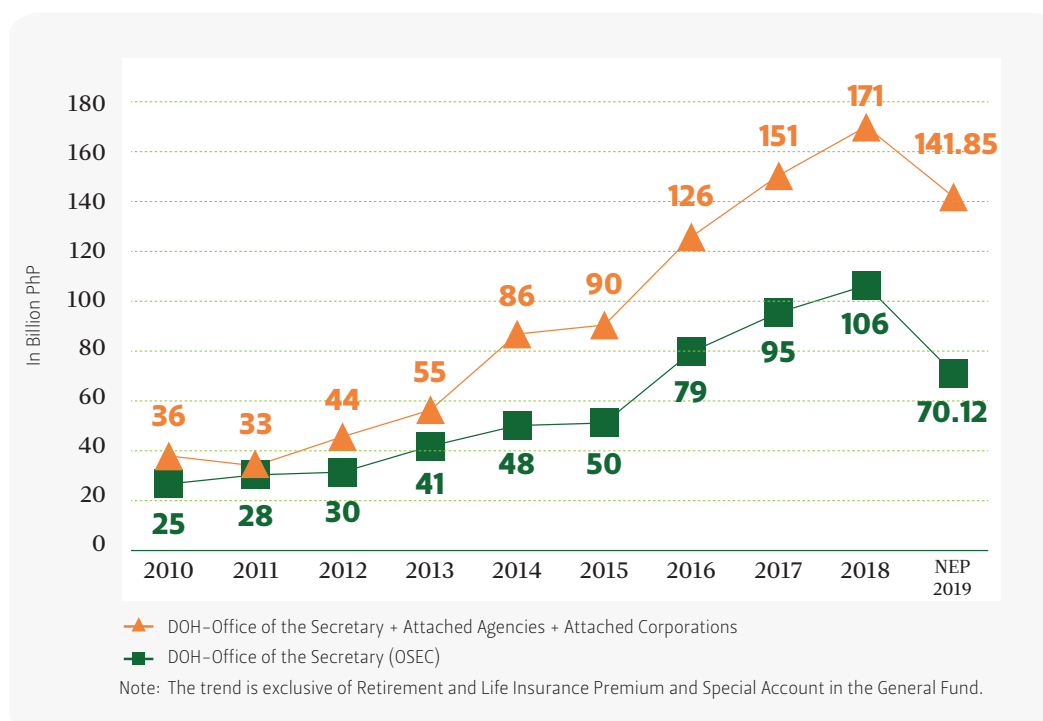
DEPARTMENT OF HEALTH BUDGET TRENDS

The budget for the Department of Health (DOH-OSEC, Attached Agencies and Corporations) has steadily increased from 2011 to 2018, with exponential increases that started in 2014 due to the ratification of the Sin Tax Reform Act of 2012 or Republic Act No. 10351 where an estimated 85% of the collected incremental revenues is allocated for health. The increased resources for health resulted to higher increase in allocation mostly for maintenance and other operating expenses (MOOE) and capital outlay (CO). Moreover, personnel hiring as a result of the approved hospital staffing expansion and the salary standardization has caused the increase in personnel services (PS).

1 It measures both government and private current health spending as well as health capital formation



Figure 2. Budget Trend of DOH-OSEC + Attached Agencies, GAA 2010 - NEP 2019



In 2019, the DOH budget decreased by 17% due to the government transition to cash-based programming by FY 2019. This reform limits the contractual obligations and disbursing of payments for goods and services within the fiscal year. In the 2019 National Expenditure Program (NEP), almost half (49.44%) of the whole DOH budget goes to DOH-OSEC (PhP 70.12 B) while PhP 67.35 B (47.48%) is allocated to the Philippine Health Insurance Corporation (PHIC/PhilHealth) to fund the premium subsidies under the National Health Insurance Program (NHIP). The remaining 3.08% of the budget is distributed to DOH attached agencies and corporations such as the National Nutrition Council (PhP 0.44 B), Commission on Population (PhP 0.47 B), Lung Center of the Philippines (PhP 0.23 B), National Kidney and Transplant Institute (PhP 0.86 B), Philippine Children's Medical Center (PhP 1.07 B), Philippine Heart Center (PhP 1.16 B), and the Philippine Institute for Traditional & Alternative Health Care (PhP 0.14 B).



ABSORPTIVE CAPACITY

The DOH absorptive capacity is measured through the obligation rate and disbursement rate. Obligations include liabilities committed to be paid in the future while disbursements are payments of cash to budgetary obligations. In 2018, the obligation rate of the DOH is at 94%, however disbursement over total allotment is only 60%. This is driven by low disbursement in MOOE and CO. For MOOE, delays are due to non-delivery of goods and non-disbursement of funds. While for CO, this is mainly due to the billing process for infrastructure projects and billing at various stages of project completion.

Table 3: Budget Utilization in 2018², in Billion PhP

Expense Class	(a) Allotment	Obligation		Disbursement		
		(b) Amount	(b/a) %	(c) Amount	(c/b) %	(c/a) %
PS	36.79	36.30	99%	35.43	98%	96%
MOOE	41.41	37.82	91%	20.43	54%	49%
CO	31.46	29.18	93%	9.88	34%	31%
Total	109.67	103.29	94%	65.75	64%	60%

In order to address bottlenecks and issues contributory to low absorptive capacity, the following steps have been undertaken by the DOH:

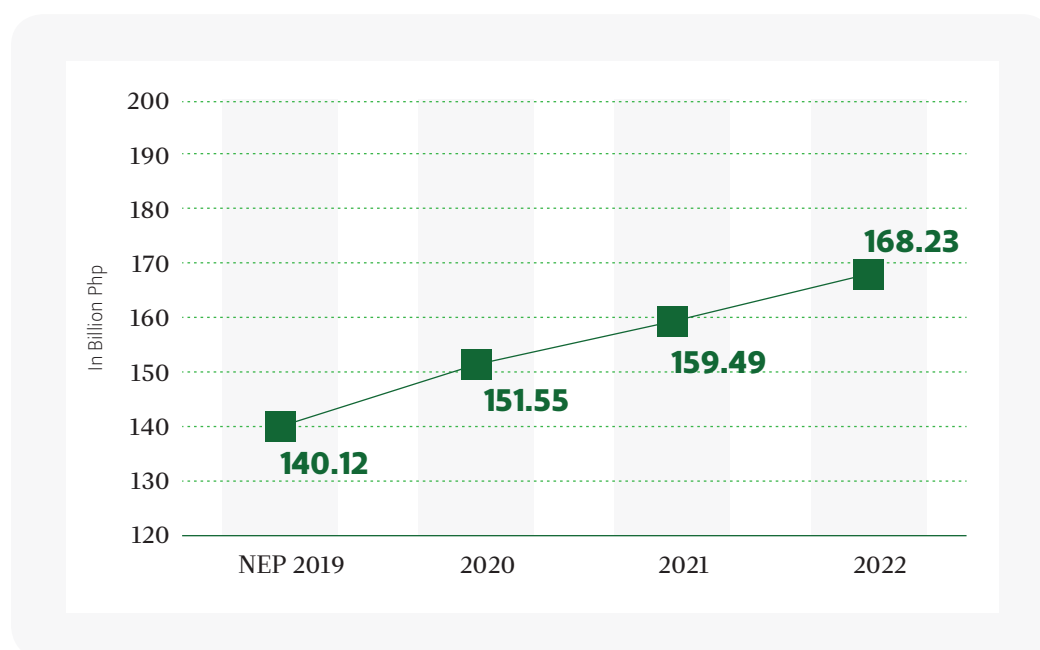
- Establishment of the Procurement and Supply Chain Management Team which is responsible in implementing procurement and logistics management support to the Department. This unit is headed by an Undersecretary of Health;
- Establishment and expansion of the capacity of Supply Chain Management Office (SCMO) commensurate to the volume of procured commodities;
- Assignment and training of dedicated staff to perform quantification and forecasting activities
- Development of a shared and integrated procurement strategy for common or high value supplies (i.e. use of framework agreement and pooled procurement);
- Bundling of the delivery of essential commodities
- Application of digital technologies (e.g. process automation, archiving, tracking bar, coding, etc.)
- Establishment of the Health Facilities and Enhancement Program Implementing Unit which is responsible for the timely implementation and monitoring of HFEP projects. This unit is headed by two (2) Directors.



ESTIMATED FISCAL SPACE FOR HEALTH

The resource envelope is computed by adding the DOH-OSEC budget based on NEP 2019 subjected to 10% annual growth and adding the PhilHealth subsidy. The sum is further subjected to 3% inflationary adjustments (*See Annex A for the breakdown of computation*). The fiscal space obtained amounted to **PhP 619.39 B** for FY 2019-2022. The annual growth of 10 percent is applied to DOH-OSEC budget considering that health is one of the priority sectors of the administration while the PhilHealth Subsidy is carried over the medium term³. The annual increase is also based from the 10-year average increase of the DOH agency budget, normalized through the forecasted economic growth of up to 8%⁴ annually in the medium-term.

Figure 3. Estimated Fiscal Space for Health FY 2019-2022



³ Same assumption with UHC Costing

⁴ Source: National Economic and Development Authority, 2017

Chapter

3

Methodology





Chapter 3

Methodology

In estimating the required resources of the DOH-OSEC and PhilHealth in the medium term, the two-tier budgeting approach was utilized. This approach separates the discussion and deliberation of (a) ongoing programs/activities/projects (P/A/Ps) or Tier 1 and (b) expanding or new P/A/Ps or Tier 2. Three possible budget scenarios are presented in this MTEP namely;

(a) High Cost-Estimate Scenario

In line with the enactment of UHC Act, this scenario presents the costing requirement of UHC implementation assuming that ***all barangays nationwide will be covered*** and the DOH has already improved its absorptive capacity. Below are the cost items and assumptions;

- *PhilHealth Premium Subsidy* –Covers the subsidy and capitation of all indirect contributory population which is estimated as 65% of the total projected population every year
- *DOH Continuing Support to LGUs* – Covers the existing support given (e.g. commodities, HRH, technical assistance) by DOH to LGUs and building of new RHUs and BHS
- *DOH Hospital Subsidy* –Includes the subsidies given to the hospitals by the DOH and building of new hospitals to achieve the ratio of 1 hospital bed per 800 population⁵.
- *DOH Governance and Health Regulation* – It focuses on improving the governance and regulation in a macro-level
- *DOH Support to Municipal Health* – Covers the additional support given by DOH to Municipal Health particularly the salaries and other remuneration of personnel of new facilities

(b) Medium Cost-Estimate Scenario

The medium cost-estimate scenario presents the costing requirement of UHC implementation assuming that ***select priority areas will only be covered***. The assumptions for PhilHealth Premium Subsidy and DOH Governance and Regulation under this scenario are the same with the high cost-estimate scenario. Only the HFEP and HRH will vary with the following assumptions:

5 Target stated in the Philippine Health Facility Development Plan 2017-2022 (From the original ratio of 1 bed: 1000 population)



- *Capital Expenditure (CapEx)* - Assumes that the building of new BHS will be in GIDA barangays only while the establishment of new RHUs will be in 4th to 6th class municipalities only in a span of two years.
- *Human Resources for Health (HRH)* - Includes the costing of the existing HRH and the additional supply of health workers to the new facilities that will be established in GIDA barangays and 4th to 6th class municipalities

(c) Low Cost-Estimate Scenario

This scenario presents the required resources of the DOH-OSEC and PhilHealth *in status quo* with slight adjustments taking into account the inflation. *In status quo* means that it gives an estimate of how much is needed by the offices of DOH to carry its existing functions. The allocation per program is still subject to approval of the management.

Chapter

4

Budget Scenarios





Chapter 4

Budget Scenarios

HIGH COST-ESTIMATE SCENARIO: UHC IMPLEMENTATION IN ALL BARANGAYS

Under this scenario, it is assumed that the first three years of UHC implementation will cover all barangays nationwide. The estimated costs are evenly spread out in the medium term due to the shift to cash-based budget system (i.e. to consider the DOH absorptive capacity).

In 2020, the total cost required for the implementation of UHC amount to **PhP 257.54 B.** Tier 2 is computed as the difference between the total cost of implementing UHC under this scenario and Tier 1. In 2020, Tier 2 under high cost estimate scenario amounted to **PhP 116.45 B.** The breakdown of this costing is further discussed below.



Table 4. Summary of Estimated UHC Cost for CY 2020-2022 under High Cost-Estimate, in Billion PhP

PARTICULARS	2019 NEP	UHC Costing (High Cost-Estimate Scenario)			TOTAL (2020-2022)
		2020 Year 1	2021 Year 2	2022 Year 3	
TIER 1	140.12	141.09	142.08	143.10	426.27
TIER 2	0	116.45	128.94	143.23	388.62
UHC TOTAL Costing	140.12	257.54	271.02	286.33	814.89



UHC MEDIUM TERM EXPENDITURE PROGRAM 2019-2022

Table 5. Breakdown of the UHC Cost Items under High Cost-Estimate Scenario

Particulars	Cost Item	Objective	NEP 2019	Year 1 2020	Year 2 2021	Year 3 2022
PhilHealth Premium Subsidy	PhilHealth Premium	To cover all indirect contributory (65.2 M population) at P3500/family/year	70.00	103.98	104.71	106.19
	PhilHealth Premium Primary Care (Capitation)	To cover all indirect contributory (65.2 M population) with P1000/person/year	-	25.00	25.31	39.73
		Sub-total	70.00	128.98	130.02	145.92
DOH continuing support to LGUs	Deployed HRH	To cover salaries and other remuneration of existing HRH with annual adjusted due to population growth	1.17	16.35	19.94	25.68
	Commodities	To cover public health commodities based on program requirement	15.24	15.24	15.24	15.24
	TA/Training	To cover cost of technical assistance and trainings provided to LGUs (at 3% of DOH operating budget)	0.95	0.95	0.95	0.95
	HFEP	To achieve ratios: BHS (1 BHS: 1 Brgy), RHU (1 RHU: 20,000 population)	0.05	7.07	7.07	7.07
		Sub-total	17.41	39.61	43.20	48.94
DOH Hospital Subsidy	Personnel	To cover salaries and other remuneration of existing DOH hospital personnel with annual adjusted due to population growth	26.62	26.62	26.81	30.20
	MOOE	To cover government subsidy to DOH Hospitals to augment operating cost	3.48	3.48	3.48	3.48
	HFEP	To achieve ratio: Hospital Bed (1: 800 population)	-	16.42	16.42	16.42
DOH Governance and Health Regulation		Sub-total	30.10	46.52	46.71	50.10
	Policy Development and Monitoring	To cover cost of DOH operations (e.g. for policy development and monitoring, etc.)	15.31	22.54	24.90	27.48
	Regulation	To cover cost to implement the FDA business plan and expand the functions of HFESRB	0.82	2.93	2.93	2.93
	IT Support	To cover cost of expanding electronic medical records	0.87	3.56	3.56	3.56
	MAIP	To cover cost of medical assistance to confined indigent patients	5.63	5.63	5.63	5.63
DOH Support to Municipal Health		Sub-total	22.63	34.67	37.02	39.61
	Personnel	To cover salaries and other remuneration of personnel of new facilities	-	7.76	14.08	15.49
TOTAL			140.12	257.54	271.02	286.33



PhilHealth Premium Subsidy

PhilHealth Premium

Assuming that PhilHealth continues to receive PhP 70 B worth of premium subsidy every year over the medium term, an additional budget of **PhP 104.88 B** for CY 2020-2022 is still needed to cover the premium subsidies of all non-contributory group in order to protect them from the catastrophic and impoverishing effects of unexpected healthcare costs. In the next 12 years, it is expected that 65% of the total population will belong to the non-contributory group. A premium subsidy of PhP 1500 per person for a year will be provided. This is derived by dividing the proposed increased standard premium of PhilHealth per family (PhP 3600 from PhP 2400) by 2.3 which is the family size determined by PSA.

PhilHealth Premium for Primary Care (Capitation)

Capitation refers to the fixed amount per person being paid to health providers based on the total population in a geographical area or facility, regardless of how much care is actually delivered. Under the new costing of UHC, it is assumed that there will be a differential payment of capitation for public and private providers to avoid double financing. Private providers will be paid 100% capitation (PhP 1000) while public providers will receive 55% only of the full capitation since the remaining 45% is already being paid to them in the form of their salary from the government.

In 2019, there is no capitation required under PhilHealth since the procurement of commodities will still be under the DOH. However for CY 2020-2022, it is assumed that only the purchase and allocation of select population-based drugs, medicines and vaccines will be under the DOH while the individual-based will be under PhilHealth.

DOH Continuing Support to LGUs

This includes the following cost items namely; deployed HRH, commodities, technical assistance and capital expenditures (i.e. HFEP). Since the first three years of UHC implementation (CY 2020-2022) is considered as a transition phase, the Commodities is still charged under DOH. However in the succeeding years, it will be under PhilHealth in the form of Capitation. The amount allotted under Technical Assistance is 3% of the total operations of the DOH-OSEC.

Assuming that the existing HRH will be funded by the LGUs, a total of **PhP 61.97 B** is needed in CY 2020-2022. Also, a total budget of **PhP 21.21 B** is allocated for HFEP. This costing includes the building of new facilities (1 BHS per barangay and 1 RHU per 20,000 population) to cover areas with deficits. The deficits are computed based on the needed facilities of the projected population in 2029.



Although the total costing in achieving these ratios is evenly spread out across 10 years, it does not take into account the cost required to upgrade current facilities. For the building of RHUs in areas with deficits, it is assumed that only 60% of these nationwide will be covered by the public sector since the private sector will likely come in. However, for the building of BHS per barangay with deficits, 100% of these will be covered by the government.

DOH Hospital Subsidy

Similar to DOH Continuing Support to LGUs, this cost item includes the following; Personnel, MOOE and Capital Expenditures (HFEP). Under Personnel, a total budget of **PhP 83.63** is needed to supply the existing HRH in DOH hospitals. For Capital Expenditures (HFEP), a total budget of **PhP 49.26 B** is needed to build new hospitals with bed capacity ratio of 1 per 800 population in areas with deficits. Only 60% of the deficit across the country will be covered for the public sector.

DOH Governance and Health Regulation

A total budget of **PhP 111.81 B** is needed for the overall health sector management in the next three years. This includes the following cost items namely; Policy Development and Monitoring, Health Regulation, IT Support, and Medical Assistance to Indigent Patients⁶ (MAIP).

Under Health Regulation, a total of PhP 2.93 B every year is allotted to expand the functions of Food and Drug Administration (FDA) and strengthen the regulatory capacities of DOH regulatory units (i.e. Human Resources Development Bureau and Health Facilities and Services Regulatory Bureau). For IT Support, a total of PhP 3.56 B every year is required to create IT infrastructures, expand health allied courses and establish Health Technology Assessment (HTA) unit.

Table 7. Breakdown of the UHC Cost Items under Medium Cost-Estimate Scenario

DOH Support to Municipal Health

A total budget of **PhP 37.33 B** is needed to cover the salaries and other remuneration of the personnel that will be deployed in new facilities.

⁶ In the UHC Act, there is no specific provision which states what will happen to the medical assistance program of DOH. This can be further explored in the IRR drafting



MEDIUM COST-ESTIMATE SCENARIO: UHC IMPLEMENTATION IN PRIORITIZED AREAS

Due to limited resources, there is a need to prioritize areas that need the resources the most. In this MTEP, two recommendations on prioritization of areas were given namely; 1) focusing on GIDA barangays and 4th to 6th class municipalities and 2) poor performing provinces in selected health indicators⁷ (i.e. Infant Mortality Rate and Maternal Mortality Rate) that are major contributors to the national health outcomes.

GIDA Barangays and 4th-6th Class Municipalities

By providing more resources to these areas, it is assumed that equity in access to healthcare services and facilities will be achieved. In 2020, the total costing for the implementation of UHC in GIDA barangays and 4th to 6th class municipalities amounted to **PhP 241.84 B**. Tier 2 was computed as the difference between the total cost of the implementation of UHC under this scenario and Tier 1. In 2020, Tier 2 amounted to **PhP 100.75 B**.

Table 6. Summary of NEP 2019 and UHC Costing CY 2020-2022 under Medium Cost-Estimate, in Billion PhP

PARTICULARS	2019 NEP	UHC Costing (Medium Cost-Estimate Scenario)			TOTAL (2020-2022)
		2020 Year 1	2021 Year 2	2022 Year 3	
TIER 1	140.12	141.09	142.08	143.10	426.27
TIER 2	0	100.75	112.35	113.98	327.08
UHC TOTAL Costing	140.12	241.84	254.43	257.08	753.35

Table 7 presents the breakdown of the major cost items under this scenario.

⁷ Only two indicators were used in this MTEP due to limitations on the availability of data



UHC MEDIUM TERM EXPENDITURE PROGRAM 2019-2022

Table 7. Breakdown of the UHC Cost Items under Medium Cost-Estimate Scenario

Particulars	Cost Item	Objective	NEP 2019	Year 1 2020	Year 2 2021	Year 3 2022
PhilHealth Premium Subsidy	PhilHealth Premium	To cover all indirect contributory (65.2 M population) at P3500/family/year	70.00	103.98	104.71	106.19
	PhilHealth Premium Primary Care (Capitation)	To cover all indirect contributory (65.2 M population) with P1000/person/year	-	25.00	25.31	39.73
		Sub-total	70.00	128.98	130.02	145.92
DOH continuing support to LGUs	Deployed HRH	To cover salaries and other remuneration of existing HRH with annual adjusted due to population growth	1.17	16.35	19.94	25.68
	Commodities	To cover public health commodities based on program requirement	15.24	15.24	15.24	15.24
	TA/Training	To cover cost of technical assistance and trainings provided to LGUs (at 3% of DOH operating budget)	0.95	0.95	0.95	0.95
	HFEP	To achieve ratios: BHS (1 BHS: 1 GIDA Brgy), RHU (1 RHU: 20,000 population in 4 th -6 th class municipalities)	0.05	7.97	7.97	-
		Sub-total	17.41	40.51	44.10	41.87
DOH Hospital Subsidy	Personnel	To cover salaries and other remuneration of existing DOH hospital personnel with annual adjusted due to population growth	26.62	26.62	26.81	30.20
	MOOE	To cover government subsidy to DOH Hospitals to augment operating cost	3.48	3.48	3.48	3.48
	HFEP	To achieve ratio: Hospital Bed (1: 800 population)	-	-	-	-
DOH Governance and Health Regulation		Sub-total	30.10	30.10	30.29	33.68
	Policy Development and Monitoring	To cover cost of DOH operations (e.g. for policy development and monitoring, etc.)	15.31	22.54	24.90	27.48
	Regulation	To cover cost to implement the FDA business plan and expand the functions of HFSRB	0.82	2.93	2.93	2.93
	IT Support	To cover cost of expanding electronic medical records	0.87	3.56	3.56	3.56
	MAIP	To cover cost of medical assistance to confined indigent patients	5.63	5.63	5.63	5.63
DOH Support to Municipal Health		Sub-total	22.63	34.67	37.02	39.61
	Personnel	To cover salaries and other remuneration of personnel of new facilities	-	7.22	13.00	9.73
		Sub-total	0.00	7.22	13.00	9.73
TOTAL			140.12	241.84	254.43	257.08



Capital Expenditures (HFEP)

A total of **PhP 15.94 B** is allocated for capital expenditures in the medium term. This will cover the building of new BHS in GIDA barangays and establishment of new RHUs in 4th to 6th class municipalities, assuming that everything will be concluded in 2 years. For the building of 1 BHS per GIDA barangay and RHU in 4th to 6th class municipalities, the government will cover 100% of the deficits since it is assumed that the private sector is less likely to come in these areas.

Human Resources for Health (HRH)

A total of **PhP 175.55 B** is needed for the existing human resources and to supply the additional health workers in the new facilities that will be established in GIDA barangays and 4th to 6th class municipalities.

Poor Performing Provinces that are Major Contributors to National Health Outcomes

Aside from attaining equity across the provinces, the DOH has set national targets per indicator which is targeted to be achieved by 2022. By doing provincial analysis, poor performing areas which have the greatest impact on the national health performance were identified. The indicators used are Maternal Mortality Ratio (MMR) and Infant Mortality Ratio (IMR).

Analysis of MMR and IMR to identify high burden provinces/areas

Maternal Mortality Ratio

For MMR, the DOH aims to reduce the MMR from 114 per 100,000 live births⁹ in 2015 to 90 per 100,000 live births by 2022. In order to increase the likelihood that this target will be achieved, areas where there are high maternal deaths across the country should be prioritized. Based on the provincial analysis conducted using the adjusted MMR data from Civil Registry and Vital Statistics from the years 2006 to 2015, 25 provinces were identified as a priority.

Table 8 presents the Top 25 provinces/ areas and its average proportion to the total maternal deaths in the country from 2006 to 2015. Cebu has the highest average proportion contributing 7.29% of the total maternal deaths in the country. (*Refer to Annex B for the breakdown of average proportion per province to the total maternal deaths in the country*)

8 Source: UN Estimates, 2013



UHC MEDIUM TERM EXPENDITURE PROGRAM 2019-2022

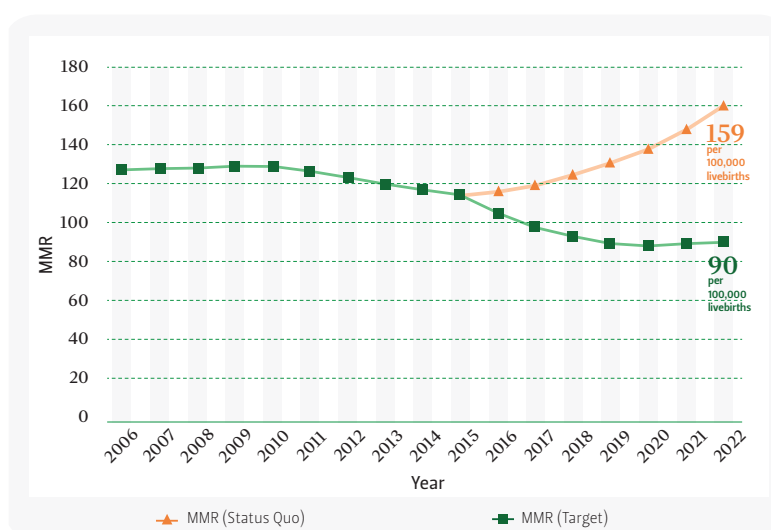
Table 8. Top 25 Province/Areas which are Major Contributors to Maternal Deaths

Rank	Province/Area	Average Population	Rank	Province/Area	Average Population
1	Cebu	7.29%	14	NCR-4th District	2.47%
2	NCR-2nd District	5.74%	15	Leyte	2.29%
3	NCR-Manila	4.24%	16	Albay	2.24%
4	Negros Occidental	3.15%	17	Iloilo	2.10%
5	Bulacan	3.01%	18	South Cotabato	1.77%
6	Camarines Sur	3.00%	19	Davao	1.72%
7	Pangasinan	3.00%	20	Batangas	1.70%
8	Laguna	2.99%	21	Misamis Oriental	1.68%
9	Davao del Sur	2.86%	22	Negros Oriental	1.68%
10	Cavite	2.77%	23	NCR-3rd District	1.66%
11	Quezon	2.71%	24	Nueva Ecija	1.65%
12	Rizal	2.60%	25	Bukidnon	1.59%
13	Zamboanga del Sur	2.51%	Total		68.42%

Note: The proportional contribution of each province to the national performance was computed by dividing the number of maternal deaths in each province by the total maternal deaths in the country that year. Then, the average from 2006-2015 was computed

Figure 4 shows the trajectory of MMR until 2022 (orange line graph) which was derived from the projected values of maternal deaths and live births using the average growth rate from the previous years (2006-2015). In 2022, assuming that all factors is in status quo, the MMR will be at 159 per 100,000 livebirths. In order to reach the target MMR at 90 per 100,000 livebirths by 2022 (represented by the green line graph), there is a need for the government to focus on provinces/areas which contribute the most to the number of maternal deaths.

Figure 4. MMR Trend under Status Quo Scenario vs. Target Scenario



Note: In both scenarios, MMR values from 2016-2018 were both projected since there is still no actual data available for these years. The MMR was derived from projected values of maternal deaths and live births using the average growth rate from the previous years



Infant Mortality Rate

On the other hand, for the infant mortality rate, DOH aims to reduce the IMR from 23 per 1000 live births¹⁰ in 2013 to 15 per 1000 live births by 2022. Similar to MMR, areas where there are high infant deaths across the country were determined. Based on the provincial analysis conducted using the data from Civil Registry and Vital Statistics from the years 2006 to 2015, 9 provinces were identified as a priority.

Table 9 presents the Top 9 provinces and its average proportion to the total infant deaths in the country from 2006 to 2015. Among the provinces, NCR-Manila has the highest average proportion contributing 9.49% of the total infant deaths in the country. (*Refer to Annex B for the breakdown of average proportion per province to the total infant deaths in the country*) It is worthy to note that these nine provinces were also part of the 25 prioritized provinces under the MMR indicator.

Table 9. Top 9 Provinces Areas which are Major Contributors to Infant Deaths

Rank	Province/Area	Average Population
1	NCR-Manila	9.49%
2	NCR-2nd District	8.57%
3	Cebu	5.78%
4	NCR-4th District	3.88%
5	Pangasinan	3.55%
6	Bulacan	3.42%
7	Laguna	3.10%
8	Cavite	2.99%
9	Batangas	2.95%
Total		43.73%

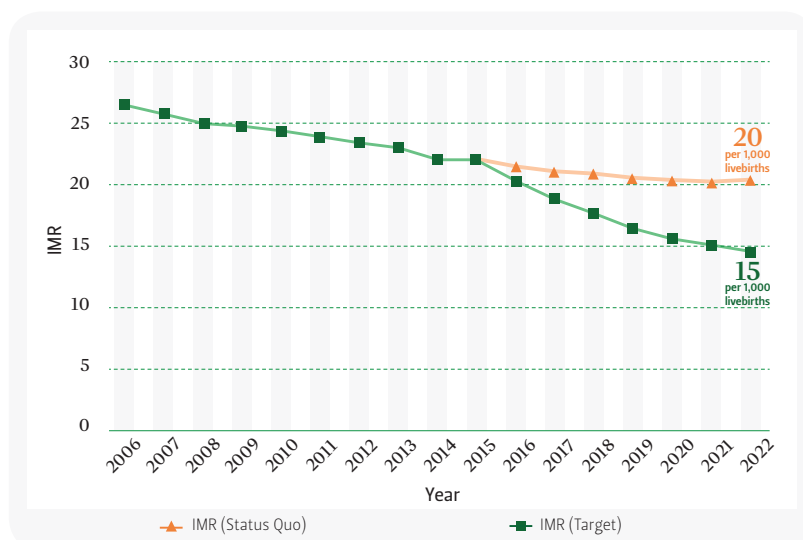
Note: The proportional contribution of each province to the national performance was computed by dividing the number of infant deaths in each province by the total infant deaths in the country that year. Then, the average from 2006-2015 was computed

Figure 5 shows the trajectory of IMR until 2022 (orange line graph) which was derived from the projected values of infant deaths and live births using the average growth rate from the previous years (2006-2015). In 2022, assuming that all factors is in status quo, the IMR will be at 20 per 1000 livebirths. In order to reach the target IMR at 15 per 1000 livebirths by 2022 (represented by the green line graph), there is a need for the government to focus on provinces/areas which contribute the most to the number of infant deaths.

9 Source: UN Estimates, 2013



Figure 5. IMR Trend under Status Quo Scenario vs. Target Scenario



Note: In both scenarios, IMR values from 2016-2018 were both projected since there is still no actual data available for these years. The IMR was derived from projected values of infant deaths and live births using the average growth rate from the previous years

In addition, the Human Development and Poverty Reduction Cluster (HDP RC) has identified priority areas based on poverty incidence and magnitude. These areas will be recipient to convergence strategies among HDP RC agencies¹¹. This strategy is anchored on improving education, health, social protection, and capacity development which will yield a decrease in the poverty rate and improve human development index. Thirty one provinces were identified as focus areas (Refer to Table 10). Out of these 31 provinces, 11* were identified as poor performing provinces in selected health indicators (i.e. MMR and IMR) that contribute to national health outcomes. The DOH will review the possible inclusion of the focus areas in the selection of UHC advanced implementation sites.

Table 10. Focus Areas Identified by NEDA

Rank	Province/Area	Poverty Incidence	Rank	Province/Area	Poverty Incidence
1	Lanao del Sur	66.3	17	Catanduanes	33.6
2	Sulu	49.6	18	Surigao del Sur	32.0
3	Siquijor	48.9	19	Sorsogon	31.7
4	Maguindanao	48.8	20	Apayao	30.9
5	Northern Samar	47.9	21	Camarines Sur	27.1
6	Saranggani	47.3	22	Leyte*	23.6
7	Bukidnon*	47.0	23	Negros Occidental*	21.9
8	Zamboanga del Norte	41.1	24	South Cotabato*	19.8
9	Western Samar	39.5	25	Nueva Ecija*	18.6
10	Sultan Kudarat	39.2	26	Zamboanga del Sur*	18.6
11	Negros Oriental*	38.7	27	Cebu*	17.9
12	Eastern Samar	37.4	28	Quezon*	17.1
13	Agusan del Sur	37.0	29	Iloilo*	14.9
14	Lanao del Norte	36.3	30	Davao del Sur*	12.0
15	Masbate	35.5	31	Pangasinan	11.2
16	North Cotabato	34.5			

10 Members include DOH, DSWD, DOLE, DA, PMS, OP, NAPC, NEDA



Additional Costing

Assuming that other factors to be considered are all ideal and the provinces mentioned above will be prioritized in the budget allocation, it is more likely that the national targets for MMR and IMR will be achieved by 2022. The additional investments on these prioritized provinces will go directly to its CapEx and HRH, however the exact amount is still to be determined. It is expected that the presence of additional facilities will improve the access of the people to primary care, thus preventing the high number of maternal and infant deaths in the future.

LOW COST-ESTIMATE SCENARIO: STATUS QUO

Under this scenario, the cost of on-going P/A/Ps (Tier 1) and the cost of new and expanding P/A/Ps (Tier 2) were discussed.

Tier 1: Cost of On-Going P/A/Ps

Due to the shift to cash-based budget system this FY 2019, the 2019 NEP already considered the absorptive capacity of DOH through its fund disbursement rate. This budget level is used as the basis for Tier 1 or Estimated Regular Budget.

The **Tier 1** or the cost of **on-going P/A/Ps** was computed by subjecting the MOOE and CO of NEP 2019 to inflationary growth of 3%¹² over the medium term combined with the PS. The PhilHealth Subsidy worth PhP 70 B which was assumed to be carried over the medium term was added. In 2020, the Tier 1 amounted to **PhP 141.09 B**. (*Refer to Annex B for the detailed Estimated Regular Budget Allocation per P/A/Ps*)

11 National Budget Memorandum No. 129, DBM



Tier 2: Cost of New and Expanding P/A/Ps

The **Tier 2** or the cost of **new or expanding P/A/Ps** is computed based on the difference of the estimated fiscal space and Tier 1. This amount is the subject of distribution by the management to reflect the administration's priorities. In 2020, the Tier 2 amounted to **PhP 10.46 B.**

Table 11. Summary of Cost in a Low Estimate Scenario, in Billion PhP

PARTICULARS	NEP 2019 (Baseline)	2020	2021	2022	TOTAL (2020- 2022)
TIER 1	140.12	141.09	142.08	143.10	426.27
<i>DOH-OSEC Budget</i>	70.12	71.09	72.08	73.10	216.27
<i>PhilHealth</i>	70.00	70.00	70.00	70.00	210.00
TIER 2	0	10.46	17.41	25.13	52.99
TOTAL	140.12	151.55	159.49	168.23	479.27

Under this scenario, there will be insufficient funding for the implementation of the UHC Act. Among those that will be severely affected by this limited funds are human resources for health, capital expenditures and PhilHealth premiums. Health system gaps will still persist and would sustain the level of inequity in health. In the long run, inaction on identified system gaps would result to failure in achieving the health goals namely; better health outcomes, financial protection, and health equity.

Chapter

5

Estimated Resource Gaps and Ways Forward



Chapter 5

ESTIMATED RESOURCE GAPS
AND WAYS FORWARD

RESOURCE GAP

Over the medium-term (CY 2020-2022), the DOH-OSEC and PhilHealth will require a total budget of **PhP 479.27 B, PhP 753.35 B and PhP 814.89 B, under low, medium and high estimate scenarios respectively** to fund the implementation of its priority programs and the UHC Law. The MTEP requirement exceeds the estimated fiscal space in both medium and high estimate scenarios but not in the low estimate scenario.

The resource gap is the difference between the estimated fiscal space and total MTEP requirements. In a low estimate scenario, there will be no resource gap since it is in status quo. The estimated resource gap for the medium term is **PhP 274.08 B in medium cost-estimate scenario while PhP 335.62 B in high cost-estimate scenario.**

Table 12. MTEP Requirements in Billion PhP, FY 2019-2022

Year	Fiscal Space	Tier 1	Tier 2			TOTAL			Resource Gap		
			Low	Medium	High	Low	Medium	High	Low	Medium	High
2020	151.55	141.09	10.46	100.75	116.45	151.55	241.84	257.54	0	90.29	105.99
2021	159.49	142.08	17.41	112.35	128.94	159.49	254.43	271.02	0	94.94	111.53
2022	168.23	143.10	25.13	113.98	143.23	168.23	257.08	286.33	0	88.85	118.10
TOTAL	479.27	426.27	52.99	327.08	338.62	479.27	753.35	814.89	0	274.08	335.62



WAYS FORWARD

Due to UHC law, the total medium term requirement of the health sector is **PhP 814.89 B** for CY 2020-2022. However, there are obviously limited resources, as such there is an option to focus interventions to GIDA areas or those 4th to 6th class municipalities. The total MTEP requirement for the implementation of UHC in GIDA areas is **PhP 753.35 B**. Prioritization of these areas aims to achieve equity in access to healthcare services and facilities.

In addition, provincial analysis vis-à-vis of health outcomes resulted to a need to prioritize areas whose performance have greater impact on national targets (i.e. MMR and IMR). By investing in these areas, assuming that other factors are ideal, there is a possibility that the targets of improving national health outcomes by 2022 will be achieved.

Since this MTEP covers only the costs of UHC implementation at the macro-level, there is a need to do micro-costing from the field particularly the Advance Implementation Sites. The following activities will be undertaken by the DOH in the medium term. A diagnostic tool will be developed to standardize the conduct of an in depth province/city wide health system review. A local development partner will be contracted for each AIS for the in depth review as input to an updated 2020-2022 Local Investment Plan for Health. The AIS steering committee will review the LIPH for provision of support through a Special Health Fund.

Furthermore, with the implementation of the UHC Law, the health sector will have a wider resource gap. In order to close or at least lessen this gap, there is a need to align other funding sources such as PCSO and PAGCOR to the health sector.

Lastly, in coherence with the price and tax measure impact required to achieve health goals on non-communicable diseases and smoking prevalence, the initiative to raise the Sin taxes to PhP 60-90 per pack will generate an estimate of PhP 50 B that can be added to the health budget. Therefore the support for this legislation is critical in funding the UHC Act.



Annexes



ANNEX A: ESTIMATED FISCAL SPACE

Particulars	NEP 2019	2020	2021	2022	Assumptions
DOH-OSEC Budget	70.12	77.13	84.85	93.33	Subjected to 10% annual growth
PhilHealth	70.00	70.00	70.00	70.00	Carry over
Total	140.12	147.13	154.85	163.33	Subjected to inflationary growth of 3%
Estimated Fiscal Space	140.12	151.55	159.49	168.23	

ANNEX B: AVERAGE PROPORTION OF MATERNAL AND INFANT DEATHS PER PROVINCE TO TOTAL MATERNAL AND INFANT DEATHS OF THE COUNTRY, 2006-2015

Code	Region	Province	Maternal Deaths		Infant Deaths		Live Births	
			Average (Mean) Proportion	Rank	Average (Mean) Proportion	Rank	Average (Mean) Proportion	Rank
1	CAR	Abra	0.19%	71	0.23%	63	0.25%	68
2	R13	Agusan Del Norte	1.09%	34	0.48%	50	0.68%	44
3	R13	Agusan Del Sur	0.55%	52	0.18%	66	0.57%	50
4	R6	Aklan	0.60%	48	0.52%	48	0.59%	47
5	R5	Albay	2.24%	16	1.52%	19	1.58%	23
6	R6	Antique	0.48%	55	0.62%	43	0.51%	55
7	ARMM	Basilan	0.11%	80	0.05%	81	0.08%	81
8	R3	Bataan	0.58%	50	0.63%	41	0.80%	41
9	R2	Batanes	0.06%	86	0.02%	86	0.02%	86
10	R4A	Batangas	1.70%	20	2.95%	9	2.83%	9
11	CAR	Benguet	0.47%	57	0.79%	36	0.99%	32
12	R7	Bohol	1.15%	32	1.18%	26	1.40%	27
13	R10	Bukidnon	1.59%	25	0.77%	37	1.47%	25
14	R3	Bulacan	3.01%	5	3.42%	6	3.07%	8
15	R2	Cagayan	1.27%	28	1.10%	30	1.29%	30
16	R5	Camarines Norte	1.13%	33	1.00%	31	0.71%	42
17	R5	Camarines Sur	3.00%	6	2.29%	13	2.39%	14
18	R10	Camiguin	0.10%	81	0.07%	77	0.10%	79
19	R6	Capiz	0.65%	46	0.60%	46	0.68%	43
20	R5	Catanduanes	0.34%	61	0.42%	53	0.31%	65



UHC MEDIUM TERM EXPENDITURE PROGRAM 2019-2022

Code	Region	Province	Maternal Deaths		Infant Deaths		Live Births	
			Average (Mean) Proportion	Rank	Average (Mean) Proportion	Rank	Average (Mean) Proportion	Rank
21	R4A	Cavite	2.77%	10	2.99%	8	3.14%	7
22	R7	Cebu	7.29%	1	5.78%	3	5.85%	1
23	R11	Davao	1.72%	19	1.47%	22	1.13%	31
24	R11	Davao Del Sur	2.86%	9	2.16%	15	2.72%	12
25	R11	Davao Oriental	0.55%	53	0.23%	62	0.38%	61
26	R8	Eastern Samar	0.25%	68	0.11%	71	0.36%	62
27	CAR	Ifugao	0.13%	76	0.13%	70	0.19%	72
28	R1	Ilocos Norte	0.47%	56	0.84%	34	0.54%	52
29	R1	Ilocos Sur	0.55%	51	0.68%	39	0.67%	45
30	R6	Iloilo	2.10%	17	2.70%	11	2.27%	16
31	R2	Isabela	1.20%	30	1.14%	28	1.63%	22
32	CAR	Kalinga	0.08%	85	0.04%	82	0.21%	71
33	R1	La Union	0.67%	45	1.16%	27	0.86%	35
34	R4A	Laguna	2.99%	8	3.10%	7	3.24%	5
35	R10	Lanao Del Norte	0.87%	39	0.76%	38	0.91%	34
36	ARMM	Lanao Del Sur	0.12%	78	0.09%	75	0.11%	78
37	R8	Leyte	2.29%	15	1.49%	21	1.97%	19
38	ARMM	Maguindanao	0.25%	67	0.10%	73	0.32%	64
39	NCR	Ncr - Manila	4.24%	3	9.49%	1	4.42%	3
40	R4B	Marinduque	0.27%	63	0.40%	55	0.27%	67
41	R5	Masbate	1.27%	29	0.61%	44	0.84%	38
42	R10	Misamis Occidental	0.81%	41	0.56%	47	0.62%	46
43	R10	Misamis Oriental	1.68%	21	1.52%	20	1.75%	21
44	CAR	Mountain Province	0.15%	73	0.17%	67	0.17%	74
45	R6	Negros Occidental	3.15%	4	2.27%	14	2.77%	11
46	R7	Negros Oriental	1.68%	22	1.13%	29	1.33%	28
47	R12	Cotabato	0.90%	37	0.49%	49	1.30%	29
48	R8	Northern Samar	1.28%	27	0.81%	35	0.41%	60
49	R3	Nueva Ecija	1.65%	24	1.78%	17	2.05%	18
50	R2	Nueva Vizcaya	0.27%	64	0.33%	57	0.53%	53
51	R4B	Occidental Mindoro	0.64%	47	0.46%	51	0.48%	56
52	R4B	Oriental Mindoro	0.72%	43	0.96%	33	0.81%	40
53	R4B	Palawan	1.18%	31	0.65%	40	0.86%	36
54	R3	Pampanga	1.41%	26	1.45%	23	2.77%	10



Code	Region	Province	Maternal Deaths		Infant Deaths		Live Births	
			Average (Mean) Proportion	Rank	Average (Mean) Proportion	Rank	Average (Mean) Proportion	Rank
55	R1	Pangasinan	3.00%	7	3.55%	5	3.27%	4
56	R4A	Quezon	2.71%	11	2.79%	10	2.16%	17
57	R2	Quirino	0.13%	77	0.15%	68	0.19%	73
58	R4A	Rizal	2.60%	12	2.03%	16	2.51%	13
59	R4B	Romblon	0.26%	66	0.37%	56	0.30%	66
60	R8	Samar	0.87%	38	0.21%	64	0.55%	51
61	R7	Siquijor	0.09%	83	0.06%	78	0.08%	80
62	R5	Sorsogon	0.94%	36	0.63%	42	0.85%	37
63	R12	South Cotabato	1.77%	18	1.42%	24	1.56%	24
64	R8	Southern Leyte	0.37%	60	0.44%	52	0.41%	59
65	R12	Sultan Kudarat	0.54%	54	0.26%	61	0.57%	49
66	ARMM	Sulu	0.17%	72	0.05%	80	0.07%	82
67	R13	Surigao Del Norte	0.71%	44	0.40%	54	0.42%	58
68	R13	Surigao Del Sur	0.47%	58	0.27%	60	0.44%	57
69	R3	Tarlac	0.77%	42	1.27%	25	1.44%	26
70	ARMM	Tawi-Tawi	0.09%	84	0.02%	84	0.03%	85
71	R3	Zambales	0.96%	35	0.97%	32	0.98%	33
72	R9	Zamboanga Del Norte	0.86%	40	0.60%	45	0.84%	39
73	R9	Zamboanga Del Sur	2.51%	13	1.59%	18	1.76%	20
74	NCR	Ncr - Second District	5.74%	2	8.57%	2	5.68%	2
75	NCR	Ncr - Third District	1.66%	23	2.44%	12	2.29%	15
76	NCR	Ncr - Fourth District	2.47%	14	3.83%	4	3.17%	6
77	R3	Aurora	0.21%	70	0.14%	69	0.21%	70
78	R8	Biliran	0.24%	69	0.21%	65	0.17%	75
79	R6	Guimaras	0.10%	82	0.10%	72	0.14%	76
80	R12	Sarangani	0.27%	65	0.10%	74	0.33%	63
81	CAR	Apayao	0.15%	74	0.05%	79	0.11%	77
82	R11	Compostela Valley	0.44%	59	0.28%	58	0.58%	48
83	R9	Zamboanga Sibugay	0.59%	49	0.28%	59	0.53%	54
85	R13	Dinagat Island	0.12%	79	0.02%	85	0.05%	83
97	R2	Isabela City	0.14%	75	0.02%	83	0.04%	84
98	ARMM	Cotabato City	0.33%	62	0.08%	76	0.25%	69



ANNEX C: MMR TRAJECTORY BY 2022 UNDER STATUS QUO VS. WITH INVESTMENT

Year	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Maternal Deaths	3000	3000	3000	3000	3000	2937	2876	2816	2757	2700	2762	2845	2965	3119	3316	3562	3868
Live Births	2354834	2347487	2340162	2332860	2325581	2334087	2342623	2351191	2359790	2368421	2374363	2381178	2388884	2397497	2407038	2417530	2428996
MMR (Status Quo)	127	128	128	129	129	126	123	120	117	114	116	120	124	130	138	147	159

Year	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Maternal Deaths	3000	3000	3000	3000	3000	2937	2876	2816	2757	2700	2577	2493	2451	2452	2500	2597	2751
Live Births	2354834	2347487	2340162	2332860	2325581	2334087	2342623	2351191	2359790	2368421	2451517	2539359	2632164	2730182	2833690	2942989	3058400
MMR (w/ Investment)	127	128	128	129	129	126	123	120	117	114	105	98	93	90	88	88	90



ANNEX D- IMR TRAJECTORY BY 2022 UNDER STATUS Quo vs. WITH INVESTMENT

Year	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Infant Deaths	62216	60332	58504	57591	56691	55806	54935	54077	51915	52105	51143	50309	49623	49123	48867	48952	49535
Live Births	2354834	2347487	2340162	2332860	2325581	2334087	2342623	2351191	2359790	2368421	2374363	2381178	2388884	2397497	2407038	2417530	2428996
IMR (Status Quo)	26	26	25	25	24	24	23	23	22	22	22	21	21	20	20	20	20

Year	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Infant Deaths	62216	60332	58504	57591	56691	55806	54935	54077	51915	52105	48970	46317	44115	42356	41061	40295	40186
Live Births	2354834	2347487	2340162	2332860	2325581	2334087	2342623	2351191	2359790	2368421	2413351	2460811	2510867	2563607	2619134	2677562	2739015
IMR (w/ Investment)	26	26	25	25	24	24	23	23	22	22	20	19	18	17	16	15	15



ANNEX E: TIER 1 BUDGET DISTRIBUTION PER P/A/PS, IN BILLION PHP

Particulars	TIER 1 Estimated Regular Budget				Total 2019- 2022
	2019 NEP	2020	2021	2022	
General Administration and Support	8.33	8.34	8.36	8.37	33.40
Support to Operations	2.04	2.07	2.10	2.14	8.35
Health Information Technology	0.87	0.90	0.93	0.95	3.66
Operations of Regional Offices	1.17	1.17	1.18	1.18	4.70
OO1: Access to Promotive & Preventive Health Care Service Improved	21.21	21.81	22.43	23.06	88.51
Health Policy Standards Development Program	0.22	0.22	0.22	0.23	0.88
<i>International Health Policy Development</i>	0.05	0.05	0.05	0.05	0.19
<i>Health Sector Policy and Plan Development</i>	0.04	0.04	0.04	0.04	0.16
<i>Health Sector Research Development</i>	0.13	0.13	0.13	0.14	0.53
Health Systems Strengthening Program	2.55	2.61	2.67	2.74	10.57
<i>Service Delivery Sub-Program</i>	0.92	0.95	0.98	1.01	3.86
<i>Health Facilities Policy and Plan Development</i>	0.19	0.20	0.20	0.21	0.79
<i>Health Facilities Enhancement Program</i>	0.05	0.05	0.05	0.05	0.21
<i>Local Health Systems Development and Assistance</i>	0.27	0.27	0.28	0.29	1.11
<i>Pharmaceutical Management</i>	0.42	0.43	0.44	0.46	1.74
<i>Health Human Resource Sub-Program</i>	1.33	1.36	1.39	1.42	5.49
<i>Human Resources for Health and Institutional Capacity</i>	0.16	0.16	0.17	0.17	0.66



Particulars	TIER 1 Estimated Regular Budget				Total 2019- 2022
	2019 NEP	2020	2021	2022	
<i>Human Resources for Health Deployment</i>	1.17	1.19	1.22	1.25	4.83
<i>Health Promotion Sub-Program</i>	0.29	0.30	0.31	0.32	1.22
Public Health Program	17.41	17.92	18.44	18.97	72.74
<i>Public Health Management Sub-Program</i>	4.05	4.15	4.26	4.36	16.82
<i>Public Health Management</i>	4.04	4.14	4.25	4.36	16.78
<i>Operation of PNAC Secretariat</i>	0.01	0.01	0.01	0.01	0.03
<i>Environmental & Occupational Health Sub-Program</i>	0.03	0.03	0.03	0.03	0.13
<i>National Immunization Sub-Program</i>	7.55	7.78	8.01	8.25	31.58
<i>Family Health Sub-Program</i>	2.47	2.55	2.62	2.70	10.34
<i>Elimination of Infectious Diseases Sub-Program</i>	1.13	1.16	1.20	1.23	4.72
<i>Elimination of Diseases as public health threat such as Malaria, Schistosomiasis, Leprosy and Filariasis</i>	0.22	0.23	0.23	0.24	0.92
<i>Rabies Control</i>	0.91	0.94	0.96	0.99	3.80
<i>Prevention & Control of Infectious Disease Sub-Program</i>	1.63	1.68	1.73	1.78	6.83
<i>Prevention & Control of Other Infectious Disease</i>	0.74	0.76	0.78	0.81	3.09
<i>TB Control</i>	0.88	0.91	0.93	0.96	3.68
<i>Assistance to Philippine TB Society</i>	0.01	0.01	0.01	0.01	0.06
<i>Prevention and Control of Non-Communicable Diseases Sub-Program</i>	0.56	0.57	0.59	0.61	2.32
Epidemiology & Surveillance Program	0.26	0.27	0.28	0.29	1.10



UHC MEDIUM TERM EXPENDITURE PROGRAM 2019-2022

Particulars	TIER 1 Estimated Regular Budget				Total 2019- 2022
	2019 NEP	2020	2021	2022	
Health Emergency Management Program	0.77	0.79	0.82	0.84	3.22
<i>Health Emergency Preparedness and Response</i>	0.27	0.28	0.29	0.30	1.13
<i>Quick Response Fund</i>	0.50	0.52	0.53	0.55	2.09
OO2: Access to Curative & Rehabilitative Health Care Service Improved	32.09	32.24	32.39	32.55	129.27
Health Facilities Operation Program	32.09	32.24	32.39	32.55	129.27
<i>Curative Health Care Sub-Program</i>	30.94	31.07	31.20	31.34	124.54
<i>Ops of Blood Centers and NVBSP</i>	0.53	0.55	0.56	0.58	2.22
<i>Ops of Hospitals in Metro Manila</i>	8.56	8.60	8.64	8.68	34.48
<i>Ops of DOH Regional Hosp & Other Health Facilities</i>	21.54	21.60	21.67	21.74	86.55
<i>Ops of National Reference Laboratories</i>	0.31	0.32	0.33	0.34	1.29
<i>Rehabilitative Health Care Sub-Program</i>	1.16	1.17	1.19	1.21	4.74
<i>Ops of DATRCs</i>	1.16	1.17	1.19	1.21	4.74
<i>Dangerous Drug Abuse Prevention and Treatment Program</i>	0.18	0.19	0.19	0.20	0.76
OO3: Access to Safe & Quality Health Commodities, Devices & Facilities Ensured	0.82	0.82	0.82	0.83	3.29
Health Regulatory Program	0.82	0.82	0.82	0.83	3.29
<i>Health Facilities and Services Regulation Sub-Program</i>	0.34	0.35	0.35	0.36	1.40
<i>Regulation of Health Facilities and Services</i>	0.08	0.08	0.08	0.09	0.34
<i>Regulation of Regional Health Facilities</i>	0.26	0.26	0.27	0.27	1.06



Particulars	TIER 1 Estimated Regular Budget				Total 2019- 2022
	2019 NEP	2020	2021	2022	
<i>Consumer Health and Welfare Sub-Program</i>	0.32	0.32	0.32	0.32	1.28
<i>Regulation of Health Establishment and Products</i>	0.32	0.32	0.32	0.32	1.28
<i>Routine Quarantine Services and International Health Services</i>	0.15	0.15	0.15	0.15	0.61
<i>Provision of Quarantine Services and International Health Services</i>	0.15	0.15	0.15	0.15	0.61
OO4: Access to Social Health Protection Assured	5.63	5.80	5.98	6.16	23.57
Assistance to Indigent Patients either Confined or Out-Patients in Government Hospitals/ Specialty Hospitals/LGU Hospitals/Philippine General Hospital/West Visayas State University Hospital	5.63	5.80	5.98	6.16	23.57
DOH-OSEC SUB-TOTAL	70.12	71.09	72.08	73.10	286.40
PHILHEALTH SUBSIDY	70.00	70.00	70.00	70.00	280.00
TIER 1 TOTAL	140.12	141.09	142.08	143.10	



**Health Policy Development and Planning Bureau
Department of Health**