The New Normal for Health

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EDITORIAL TEAM
Undersecretary Mario C. Villaverde, MD, MPH, MPM, CESO I
OIC-Director Frances Rose Elgo-Mamaril, MPH
Maria Socorro Santos, MD
Napoleon S. Espiritu II, MPP
Mariecar Mangosong-Dela Cruz
Roland Philip Javier, RMT, MPH

GRAPHICS AND LAYOUT
Harvey Bislumbre

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INTRODUCTION

The Coronavirus Disease-19 (COVID-19) pandemic has caused drastic changes to populations across the globe. To control the transmission of this lethal disease, societies have halted majority of economic activities and permitted at most only the most essential activities such as those related to food and health. The Interagency Task Force Technical Working Group on Anticipatory and Forward Planning (IATF-TWG for AFP), comprised of different government agencies and led by the National Economic and Development Authority, was created to assess the impact of COVID-19 and the Enhanced Community Quarantine, and provide recommendations to stimulate the economy and adapt to the "new normal". In the report "We Recover as One" developed by the IATF-TWG for AFP, recommendations to mitigate the socioeconomic impact of COVID-19 are discussed and the new normal is described for various sectors. In general, this new normal is the resumption of activities in different sectors in light of the existing threat of COVID-19 after the Extended Community Quarantine is lifted

The policies and programs for health will be the cornerstone for this new normal. Various sectors will be depending on the Department of Health (DOH) for standards on how to safely resume activities, such that there is a "steady state of low-level or no transmission". The adequate capacity of the health sector to diagnose, manage, and treat those who are infected will reduce the risk of transmission and ensure best possible outcomes for the sick. Timely and appropriate information dissemination will guide individuals in making the right choices, so that they will be able to protect themselves and others from COVID-19.

The "New Normal for Health" provide details on how the health sector will adapt to the new normal. This document is meant to be a supplement to the National Objectives for Health 2017-2022; to guide DOH programs and units, Local Government Units, and stakeholders in health in updating policies and operationalizing plans and strategies to respond to the immediate and long-term requirements of controlling COVID-19 and mitigating its socioeconomic impacts.

I. THE "NEW NORMAL"

The new normal is characterized by volatility and uncertainty. Thus, the government is expected to implement interventions that will increase the confidence of society to optimize economic activities in the presence of COVID-19, support the population groups that are most affected, and deliver existing programs through efficient and effective approaches in light of the new normal. The following are the expected effects of the pandemic and the expectations of Filipinos of what will characterize the new normal based on the report of the TWG-AFP entitled "We Recover as One":

A. ECONOMIC RECESSION IS EXPECTED DUE TO THE PANDEMIC

A global economic recession was expected in 2020 due to the limitations in economic activities and travel restrictions. However, the economic effects are projected to be limited to 2020 if the pandemic is controlled by the end of the year. The Philippines reported a negative 9.5 percent full-year growth rate in Gross Domestic Product in 2020, the first time the economy contracted after 22 years. Many workers have also lost their jobs due to the changes in business activities during the lockdown. The Department of Labor and Employment estimates that as of December 2020, around four million workers have been displaced due to the pandemic. Remittances from Overseas Filipino Workers (OFW) is also expected to decrease, with more than one million OFWs returning as of March 2021.

B. ENHANCED CAPACITY OF NATIONAL AND LOCAL GOVERNMENT TO MANAGE MULTI-DIMENSIONAL RISKS ARISING FROM PUBLIC HEALTH EMERGENCIES AND DISASTERS

The effects of the COVID-19 pandemic are not only limited to the health sector, but affects almost all sectors at the societal and individual level. The pandemic has slowed down the economy and changed the priorities of the government towards interventions related to COVID-19 control and response. For individuals, work, leisure, and personal interactions have changed. There is limited mobility, access to goods, and access to leisure activities. Work opportunities have been reduced, with some being left unemployed due to the limitations in economic activity.

The management of the COVID-19 pandemic and other public health emergencies and disasters of similar scale, is an intersectoral effort requiring comprehensive strategies that address the different dimensions of its impact on the society. All sectors of the government have been mobilized as part of the country's COVID-19 response. Various Task Groups composed of different national agencies have been created to handle the different aspects of the response, reflecting the need for collaboration to address the multi-dimensional risks.

For the devolved health sector, the national government is expected to develop policies and standards, regulate health and health-related goods and services, and provide technical assistance to Local Government Units (LGUs). On the other hand, LGUs are expected to fund, manage, and implement health programs, and manage local health facilities.

Management of public health emergencies of national scale will require coordination between the national government agencies and LGUs for harmonized and effective sector-specific interventions. To adequately and quickly respond to public health emergencies, there should be institutionalized mechanisms for communication and response which link the national and local governments. The capacity of the government to manage a public health emergency, which includes clear protocols and chain of command, efficient information systems, adequate resources, and evidence-informed decisions, should be in place.

C. INCREASED CAPACITY OF HEALTH SYSTEM TO ADEQUATELY RESPOND TO COVID-19

Attaining a new normal requires a health system that can provide services to manage COVID-19 such that its transmission will be limited and sick patients will have the best possible outcomes. This capacity covers aspects such as, but not limited to, health promotion, information dissemination, surveillance, diagnosis, treatment, rehabilitation, mental health, and environmental health.

D. SHIFT IN SOCIETAL BEHAVIOR AND PREFERENCES TOWARDS BEING HEALTHIER

Individuals have become more conscious of being healthy and protecting themselves from being infected with COVID-19. Aside from precautions such as wearing masks and handwashing, people also choose to eat and live healthier. It is important to provide the general population with the right information and environment that supports their choice to be healthier. On the other hand, society may also respond negatively by neglecting minimum public health standards, particularly when knowledge and understanding of COVID-19 is limited and the perception of their vulnerability to the disease is underestimated.

> **“New normal is characterized by volatility and uncertainty. The government is expected to implement interventions that will increase the confidence of society to optimize economic activities in the presence of COVID-19.”**

E. PHYSICAL DISTANCING AND HYGIENE PROTOCOLS WILL BE EXPECTED IN ALL ESTABLISHMENTS

Economic activities will slowly resume after quarantine restrictions are lifted. When local businesses resume operations, they are expected to implement hygiene protocols to prevent transmission of the virus. As of publication of this document, the economy has reopened subject to compliance of the establishments to minimum public health standards. Health facilities and DOH units have also updated their standards and protocols for the safety of employees, clients, and patients. Strategies include alternative work arrangements, maximizing use of virtual platforms, and ensuring that infection control procedures are strictly implemented.

F. INCREASED DEPENDENCE ON E-COMMERCE AND DIGITAL TECHNOLOGY

Digital technology and e-commerce will be used more extensively in order to maintain physical distance. Mobility of individuals and social gatherings have been limited by community quarantines, travel restrictions, and minimum public health standards. Digital technology has made processes of communication easier in the new normal. Social media and mobile technology can also make information dissemination and data collection more efficient, as long as it is used appropriately and within the bounds of data privacy.

The pandemic has also increased the demand and supply of e-commerce. Since the start of implementation of community quarantines, consumers have shifted to purchasing goods online rather than going to physical stores. New e-commerce stores have entered the market and big businesses have also developed online stores. According to the 2020 Philippines Digital Economy Report[1], there has been an 80 percent drop in visits to retail stores in March 2020 compared to January 2020 while the interest of Filipinos for movie streaming and delivery services have increased from around 30 percent to 80 percent. In the report, the authors recommend that the government needs to take the lead in adoption of e-governance projects and pave the way for a society-wide digital transformation. At the same time, these platforms should be regulated by the appropriate government agencies to ensure the safety and well-being of consumers, especially those accessing health devices, goods, and medicines.

G. INCREASED DEMAND FOR HEALTH-RELATED TECHNOLOGIES AND INNOVATIONS TO MANAGE THE PANDEMIC

Unconventional and innovative procedures have been implemented in order to manage the pandemic. Telemedicine has been adopted by healthcare providers across the country to allow remote patient consultations; mobile applications are used by establishments for contact tracing; sensors are used for checking temperature; and in other countries, machine learning is being used for surveillance. This increased demand for health-related technologies and innovations is expected to persist in the new normal.

1 International Bank for Reconstruction and Development / The World Bank. 2020. Philippines Digital Economy Report: A Better Normal under Covid-19: Digitalizing the Philippine Economy Now

II. THE HEALTH SECTOR IN THE 'NEW NORMAL'

This section identifies expected changes in the new normal that may affect the health sector and provides recommendations on how the effects of the new normal in the health sector may be mitigated or addressed. The discussion will be divided into three parts: Health Financing, Service Delivery and Regulation, and Governance and Performance Accountability.

HEALTH FINANCING

Health financing covers the budget allocations for health and how effectively these funds are managed and spent. In a report by the Center for Global Development1, the authors identified the following factors that increase budgetary space for health: the annual public expenditure envelope, the public expenditure envelope allocated to health, and effective and flexible public expenditure management in health. At the national level, the allocation of funds for the health sector is dependent on the decisions of the Department of Finance, Department of Budget and Management, and legislators. However, it is up to the DOH to develop sound and convincing evidence to support the budget we are requesting. It is also up to the DOH to improve budget utilization through better budget planning and execution.

Fiscal space for health will be reduced due to the contraction of the economy, while the expenditures on health are expected to increase to adequately manage the pandemic. Despite increased priority given to health to address COVID-19, the health sector will need to review its priorities and strategies for 2020-2022[2] to ensure efficient allocation and use of resources. It is also expected that there will be increased support through alternative funding sources, such as loans or grants, and donations. The different sources of financial support should be efficiently managed by the health sector to optimize our response to the pandemic.

The management of the COVID-19 pandemic is implemented by both national and local government. As the pandemic response is not part of the regular programming, national and local health budgets will shift priority to COVID-19 related service delivery and infrastructure. The investments for COVID-19 management also lead to strengthening of the health system in general and contribute to attainment of Universal Health Care (UHC). In particular, the systems and strategies for surveillance and health promotion should be well crafted such that their effects go beyond the duration of the pandemic.

On the other hand, there will be less funds available for expansion of public health programs that are not related to COVID-19. The funds available for these programs need to be efficiently spent in order to continuously provide necessary services.

2 Hélène Barroy and Sanjeev Gupta. 2020. "From Overall Fiscal Space to Budgetary Space for Health: Connecting Public Financial Management to Resource Mobilization in the Era of COVID-19." CGD Policy Paper 185. Washington, DC: Center for Global Development. https://www.cgdev.org/publication/overall-fiscal-space-budgetary-space-health-connecting-public-financial-management

Philhealth is also expected to face a challenge in decreased premium collection and increases in benefit payouts. further reducing the budgetary space for health. The payment of employer's contribution for the formal sector employees and OFW premium might be affected by the reduced income of businesses and employers, further reducing the budgetary space for health. Payouts have increased due to coverage of expenditures in managing COVID-19, such as testing and treatment. The benefit package for COVID-19, as well as other benefit packages, needs to be reviewed to determine the appropriate inclusions and obligations to ensure cost-effectiveness and quality of services.

Households will rely more on government to finance health care due to the negative financial effects of COVID-19. The government is thus expected to finance expenditures related to COVID-19 management as well as the increased demand for health services in general.

SERVICE DELIVERY AND REGULATION

Service delivery pertains to provision of quality health products and services that meet the needs of the population. Regulation is an important function of the government that goes in tandem with service delivery. Effective regulation protects the population by maintaining the quality of health products and services that they access.

Quarantine measures depend on the ability of the local government units (LGUs) to manage the pandemic. Thus, LGUs need to ensure that their respective health systems can support continued economic activities. The capacity of the health sector at local and national levels should be adequate to cater to the expected cases of COVID-19, both for non-pharmaceutical interventions (NPIs) and clinical interventions. NPIs are measures that can reduce transmission, contact rates, and duration of infectiousness of individuals without the use of vaccines or medications. NPIs include physical distancing, isolation, quarantine, hygiene and precautionary behavior, and external decontamination. Risk communication is another important aspect of pandemic management that should be implemented at national and local levels.

DOH Administrative Order (AO) No. 2020-0016 entitled "Minimum Health System Capacity Standards for COVID-19 Preparedness and Response Strategies" provides for minimum standards to achieve the following targets at the national level, to wit:

- National government-enabled, local government-led and people-centered sectoral policies for prevention, detection, isolation, and treatment of COVID-19;
- Increase national testing capacity to at least 30,000 tests per day through the development of laboratories and ensuring access to testing laboratories and related commodities that would enable health workers to accurately detect, isolate, and treat new and resurging cases;
- Increase supply of personal protective equipment to at least 15 million a month, and stimulate self-sustainability with local production in accordance with the standards of the Food and Drug Administration (FDA) with due regard on ease-of-doing business; and,
- Increase access to critical care capacity across the country through infrastructure and equipment investments for health care provider networks for adequate surge response capability.

The AO also provides the minimum health system standards for infrastructure, human resource for health (HRH), equipment, supplies, and organizational plans at the regional and provincial, and city levels. The DOH should review and update the licensing and monitoring standards for health facilities and establishments to capture requirements for COVID-19 management such as infrastructure, equipment, human resource, infection prevention and control protocols, and physical distancing. As hospital licensing standards are based on the Hospital Licensure Act, the law may need to be revised as needed.

Health services that are not COVID-19-related, especially those for public health and primary care, should continue to be provided and enhanced following the principles and goals of UHC such as equity, quality, affordability, patient-centeredness, and comprehensiveness. For LGUs that have existing quarantine restrictions, there may be growing demand for health services, particularly for vulnerable population groups such as the elderly and Persons with Disability. Services should be provided to these groups without putting them at risk. However, there will be modifications in the manner by which public health services are delivered so as to comply to standards for infection control and physical distancing. Protocols, guidelines and pathways to deliver primary care services may need to be updated to comply with physical distancing standards and provide continuous care for high risk patient groups. A decision guide for Rural Health Centers/Barangay Health Stations in categorizing which conditions require immediate medical attention, face-to-face consultations, home visits or those who can be scheduled on a later date will facilitate the delivery of quality services during a quarantine. Telemedicine such as virtual consultations may be explored as alternative modes of service provision. Consequently, there should be protocols and guidelines to ensure the quality of telemedicine services delivered, safety of patients, and best outcomes possible.

There will also be additional resource requirements in the management of patients in health facilities, such as more stringent screening of patients, donning protective equipment as necessary, and establishing an appointment system to limit the number of patients in the facility. The work arrangements of health facility staff need to be restructured to reduce the risk for infection and transmission. There should also be protocols and provisions for COVID-19 testing and quarantine for health facility staff.

The increase in service delivery requirements will strain the supply chain due to high volume of commodities for COVID-19 response, such as PPE procurement and donations which needed to be distributed immediately to ensure adequate supply to protect health workers. Procurement and delivery of commodities for other public health programs should not be neglected at this time so that the health condition of the population will not worsen.

Health-related goods and services are not only confined in health facilities. With online transactions being more predominant in light of the pandemic, the health sector also needs to adapt and expand its scope to ensure the safety of consumers. The emergence of new technologies and shifts in the market to e-commerce have underscored the need for the government to regulate establishments, devices, and technologies, particularly those that can easily be accessed online. To facilitate our response to the pandemic, the process of approval and validation for COVID-19-related devices and commodities, such as testing kits, need to be streamlined. Regulatory agencies should also enhance online applications for permits/ licenses to continue efficient provision of services while minimizing physical contact and reducing the risk of infection for employees and clients.

GOVERNANCE AND PERFORMANCE ACCOUNTABILITY

Governance is defined as "the structures and processes by which the health system is regulated, directed and controlled"[3]. In this section, we will describe how the governance in the health sector at the national and LGU levels may be affected by the pandemic and identify mechanisms to address them, including those for performance accountability.

As the leader in the health sector, the DOH needs to demonstrate decisive action, good judgment and empathy, to build the confidence of the general public in uncertain times such as a pandemic. The public has been clamoring for transparency with regard to the status of projects, provision of commodities, and utilization of funds, among others, in relation to COVID response. One of the mechanisms to increase transparency is better communication. The current initiatives of the DOH on updating the general public on COVID-19 through different media need to be sustained or enhanced. Aside from increasing the coverage of these communications, effectiveness also needs to be ensured through accurate content and appropriate delivery of the messages. Transparency on performance of DOH can also be improved by developing online versions of the scorecards that will be accessible to the general public.

LGU executives need to be more proactive in managing the health situation and implementing a multi-sectoral approach for COVID-19 in their respective jurisdiction. Therefore, the DOH, particularly the Centers for Health Development, needs to enhance its role in providing technical support for effective health governance for LGUs. Accountability among LGUs should also be improved, since they will be responsible for implementation of policies for COVID-19 management and control. Similar to the DOH Scorecards, platforms for monitoring and disseminating performance of LGUs may be developed.

There has been increased demand for information to guide policy and decision-making and alleviate the uncertainty brought about by the pandemic. Thus, the health sector should increase its investments on data systems that provide reliable information for different levels (LGUs, Regional, and National). Information should be accurate and timely so that decision-makers are able to respond to the pandemic and emergency situations quickly. Data systems need to be streamlined and fast, utilizing real-time data reporting through apps or online information systems and maximizing use of Information and Communications Technology. However, increased use of information also increases the risk of misuse. Threats to data security and data discrimination need to be addressed with adequate protocols. Measures should be in place to ensure that personal data are kept safe, without constraining the availability of data for decision making.

In terms of processes for health-related capacity building and trainings, these need to be done virtually as much as possible. Aside from reducing the risk of exposure and transmission of disease, this will also reduce the costs for trainings in terms of travel and accommodation so the funds can be used for more important aspects such as service delivery. However, the effectiveness of these methods for training also need to be evaluated.

3 Dwyer J, Eagar K. Options for reform of Commonwealth and State governance responsibilities for the Australian health system. Commissioned paper for the National Health and Hospitals Reform Commission. Canberra

III. UHC CATCH-UP PLAN IN THE NEW NORMAL

Public health programs will still aim to attain the goals of UHC in the new normal. There have been and will be disruptions in the delivery of services due to community quarantines. Some patients may not be able to access services if they do not have transportation or money. The services offered in public health facilities may be limited due to shifting among staff. Supply chains may be affected if there are constraints in transportation and human resources. The number of clients in facilities need to be limited to ensure physical distancing. Thus, the UHC Catch-up Plan will be focusing on the following areas:

1. *Integrating health systems into province-wide and city-wide health systems to strengthen capacity of LGUs to implement individual-based and population-based services*

As stipulated in Section 19 of the UHC Act, all operations that promote, restore, or maintain health which are managed by local health systems such as health offices, facilities, services, human resources, and other operations relating to health shall be integrated into province-wide or city-wide health systems. Integration is applicable to both public and private health facilities and pertains to technical, managerial, and financial integration. In the new normal, alternative mechanisms and modes of service delivery need to be explored to comply to infection control standards and the limited operations in some areas.

The success of health programs, which is ultimately through improvements on the health status of the population, depends on both its development and execution. It is imperative for DOH to review and update public health programs and policies for the following reasons:

- Compliance to public health standards under the new normal;
- Delivery of services based on need and risk profile of clients;
- Efficient budget utilization considering the limited fiscal space for health; and
- Service delivery integration for primary care in light of UHC.

Telemedicine and telehealth are opportunities for health programs to continue service delivery despite the limitations under the new normal. However, there should be adequate guidelines to ensure the quality of services, safety of patients, and data privacy for services delivered through these platforms.

The health and safety of patients and clients are always the goals of healthcare providers. Services that will be prioritized are based on need. While there may be restrictions in mobility and access to services, clear guidelines and protocols in the management of patients are to be clarified so that emergencies and critical services will not be foregone. Nonetheless, conditions that are not urgent may be scheduled on a later date for the safety of the clients and health workers alike.

By practice, health programs remain vertical in terms of development and cascading. Guidelines, updates and trainings are disseminated or provided by programs in a piecemeal manner. Thus, integration becomes the burden of the local chief executives, who are the administrators of public health programs. It is critical that true integration of public health programs also be attained as part of the integration of Province-wide and City-wide health systems. Thus, this can be manifested through a unified implementation guide for primary care, which will only be attained through thoughtful consideration of how primary care services can be most efficiently implemented in health facilities. Integration of governance and operations will improve the technical efficiency through coordinated planning and joint utilization of human resources and supplies, and improve allocative efficiency by allowing allocation of resources across interventions. Patients and clients will also benefit from less fragmented services and better referral systems, through reduced opportunity costs of health facility visits and more timely access to services.

LGUs have varied capacities in implementing health programs. The DOH needs to address gaps in program implementation through enabling policies and capacity building, which are among the major outputs stated in the DOH Strategy Map 2019-2022. Capacity building leading to development of province- and city-wide health systems for UHC Integration Sites (UHC-IS) and health system strengthening for non-UHC-IS will be prioritized by the DOH. Developing resilient health systems that are able to respond to health emergencies and pandemics require comprehensive capacity building which include technical, managerial, and financial support.

2. *Improving health system capacities to adequately respond to health emergencies, particularly for emerging infections*

LGUs need to update their plans for health system development to increase capacity in preparation for health emergencies and emerging infections. The implementation of the Supreme Court Ruling on the Mandanas Case will increase the Internal Revenue Allotment of LGUs and reduce the DOH budget. Corresponding increases in LGU investments for health will be needed to meet health system capacity requirements for infrastructure, human resources, and logistics. For human resources for health, LGUs shall incrementally increase the number of health worker positions to meet the national standards.

Geographically Isolated and Disadvantaged Areas (GIDAs) are priorities under the UHC Act especially in the provision of support for human resources for health, infrastructure, and services, among others. The National Health Workforce Support System will be established to serve as the mechanism to support equity in addressing human resource for health needs. These areas of concern will also be prioritized in licensing and accreditation for health facilities.

3. *Institutionalizing streamlined and digital processes and mechanisms, emphasizing enhanced and more instantaneous data generation and analytics*

Accurate, sensitive, and timely epidemiologic surveillance systems, proactive, effective, and evidence-based health promotion programs, and timely, effective, and efficient preparedness and response to public health emergencies and disasters are the minimum population-based health service components in province- and city-wide health systems. As stipulated in Section 17 of the UHC Act, surveillance systems and other population-based health services will be financed by the DOH.

Epidemiologic systems need to be enhanced to provide timely and quality data. Digital technology needs to be used more optimally to improve management of health data collection, recording, consolidation, storage and analysis. Processes and protocols also need to be updated to be more efficient. And lastly, human capacities also need to be improved following updated skills or human resource requirements in health data management.

4. *Maximizing multi-sectoral engagement - private, civil society, other local and international partners - to manage public health emergencies*

Managing public health emergencies and disasters covers both preparedness and response. As we have experienced during recent public health emergencies such as the Taal volcano eruption and the COVID-19 pandemic, there needs to be more emphasis on preparedness in order to mitigate the negative health effects. On the other hand, there are also gaps response, particularly in coordination, mobilization, and logistics.

Engagement of all stakeholders in health is necessary to effectively address the COVID pandemic. Each stakeholder can bring unique resources that significantly add up to the successful implementation of strategies to address COVID. LGUs and DOH need to ensure that the efforts of these stakeholders are aligned and contributory to national strategies through effective coordination and monitoring.

5. *Instilling more responsible community behavior through enhanced health promotion and health literacy campaign*

Proactive, effective, and evidence-based health promotion programs have a wide scope that go beyond the health sector. The approach for health promotion and preventive care ensures that every Filipino has access to information that builds personal skills, opportunity to engage in strengthening of community action, and enable participation in creation of supportive environments. Health promotion policies and programs also address social determinants of health and behavioral risk factors.

For the COVID pandemic, preventing infection and transmission is the most effective approach. Modifications in the behavior of the general population through personal hygiene and physical distancing prevents unnecessary exposure to the virus and reduces the burden on the health system. Responsible community behavior allows for continued economic activities despite the threat of COVID. LGUs and DOH need to enhance health promotion campaigns to develop this sense of responsibility among the community during the pandemic. In the long-term, the health literacy of Filipinos needs to be improved through broader strategies such as universal basic education and improvements in socioeconomic status.

IV. UPDATES ON THE NATIONAL OBJECTIVES FOR HEALTH

The New Normal will require the updating of strategies and implementation plans while retaining the three goals of the health system: Better health outcomes, More responsive health system, and More equitable health financing. Targets may also need to be re-evaluated and adjusted accordingly, considering the challenges and opportunities in light of the new normal. This section provides the updated targets for the National Objectives for Health 2016-2022.

Strategic Goal 1: Better Health Outcomes

Indicator	Data Source	Baseline	2022 Target
Indicator 1: Average life expectancy (in years)	PSA	70 (2010-2015)	72 (2015-2020)
Indicator 2: Maternal mortality ratio per 100,00 live births	PSA-CRVS Estimates	111 (2015)	108
Indicator 3: Infant mortality rate per 1,000 live births	PSA-NDHS	23 (2013)	15
Indicator 4: Premature mortality attributed to cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases per 100,000 population	PSA-CRVS	458.9 (2016)	367.1
Indicator 5: Tuberculosis incidence per 100,000 population	National TB Prevalence Survey	434 (2016)	510
Indicator 6: Prevalence of stunting among under-five children	FNRI-DOST NNS	33.4 (2015)	30.8 (2020)

Strategic Goal 2: Responsive Health System

Indicator	Data Source	Baseline	2022 Target
Indicator 7: Client satisfaction rate	*To be determined through commissioned study* (TBD)		
Indicator 8: Provider responsiveness score	DOH	93% (2020)	TBD

Strategic Goal 3: Equitable Health Financing

Indicator	Data Source	Baseline	2022 Target
Indicator 9: Out-of-pocket health spending as percentage of total health expenditure	PSA Philippine National Health Accounts (PNHA)	51.70% (2016)	50
Indicator 10: Percent of population who have spent less than 10 percent of their HH income on health	*TBD*		

GENERAL OBJECTIVE 1:

Sustainable investments for health secured, efficiently used and equitably allocated for improved health outcomes

Specific objective 1. More resources for health efficiently mobilized and equitably distributed

Resources for health need to be efficiently utilized and allocated so that the health system will sustain its operations. With most resources being channeled towards response and management of COVID-19, there should be more strategic allocation of resources for health programs, which is among the cornerstones of good public financial management.

Specific objective 2. Health spending rationalized

Initiatives to rationalize health financing and spending will continue as part of implementation of the UHC Act.

Specific objective 3. Financial resources focused towards high-impact interventions

Prioritization of health interventions and linking financing and performance also contribute to more efficient health spending.

Indicator	Data Source	Baseline	2022 Target
Specific objective 1. More resources for health efficiently mobilized and equitably distributed			
Indicator 11: Domestic general government health expenditure as percentage of GDP	PSA-PNHA	1.4 (2016)	2.5%
Indicator 12: Domestic general government health expenditure per capita	PSA-PNHA	PhP 1.959 per person (2016)	PhP 4,674 per person
Indicator 13: Social health insurance as percentage of THE	PSA- PNHA	16.59% (2016)	30%
Indicator 14: Government financing (national and local) as percentage of THE	PSA- PNHA	19.31% (2016)	20%

Indicator	Data Source	Baseline	2022 Target
Specific objective 2. Health spending rationalized			
Indicator 15: Percentage of NBB-eligible patients with zero co-payment	PhilHealth	63% (2016)	100%
Specific objective 3. Financial resources focused towards high-impact interventions			
Indicator 16: Expenditure for public health packages as percentage of national government financing	TBD		
Indicator 17: Expenditure for human resource as percentage of national government financing	TBD		
Indicator 18: Expenditure for health infrastructure as percentage of national government financing	TBD		

GENERAL OBJECTIVE 2:

Access to essential quality health products and services ensured at appropriate levels of care

Existing strategies address diseases for elimination, non-communicable diseases, and emerging and re-emerging diseases. The COVID-19 pandemic has exposed the gaps in the health system. Thus, there is stronger emphasis on strengthening components of the health system to adequately respond to emergencies and pandemics and to make the health system more resilient. Investments are currently on epidemiologic and surveillance systems and increased capacity in terms of infrastructure and human resources for health for diagnostics and management of COVID-19 patients. These are in line with UHC, in order to provide quality services based on the need of the population.

Specific Objective 4. Access to quality essential health products and services increased

Specific Objective 5. Equitable access to quality health facilities ensured

Specific Objective 6. Equitable distribution of HRH guaranteed

Specific Objective 7. Service delivery networks organized and engaged

Indicator	Data Source	Baseline	2022 Target
Specific objective 4. Access to quality essential health products and services increased			
Indicator 19: Modern contraceptive prevalence rate	PSA-NDHS	23.5% (2013)	30%
Indicator 20: Adolescent birth rate	PSA-NDHS	57/1,000 females aged 15 - 19 y/o (2013)	37/1,000 females aged 15 - 19 y/o

Indicator	Data Source	Baseline	2022 Target
Indicator 21: Percent of fully immunized children	PSA-NDHS	77% (2013)	95%
Indicator 22: Incidence of low birth weight among newborns	PSA-NDHS	21.4% (2013)	15%
Indicator 23: Road traffic deaths per 100,000 population	PSA-CRVS	10.7 per 100,000 population (2016)	7.9 per 100,000 population
Indicator 24: Prevalence of raised blood pressure	FNRI-DOST NNS	22.6% - for 18 years old and up (2015)	18.1%
Indicator 25: Prevalence of current tobacco use	DOH-GATS	23.8% (2015)	18%
Indicator 26: Treatment program completion rate for people who abuse drugs	DOH-DDAPTP	73% (2017)	88%
Indicator 27: Tuberculosis treatment coverage	Global TB Report	58% (2016)	90%
Indicator 28: Percent of antiretroviral therapy (ART) coverage	DOH, HIV/AIDS and ART Registry of the Philippines	47.65% (2016)	85%
Indicator 29: Percent of provinces that are malaria-free	DOH-DPCB	40% (2016)	91%
Indicator 30: Percent of provinces that are filariasis-free	DOH-DPCB	76% (2016)	100%
Indicator 31: Proportion of households using safely managed drinking water services	PSA-APIS	25.8% (2017)	62.5%
Indicator 32: Proportion of households using safely managed sanitation services	PSA-APIS	6% (2017)	53%
Indicator 33: Percent of disaster-affected area with no reported outbreaks (disaggregated by locus, e.g. within/outside evacuation centers)	DOH-HEMB	100% (2017)	100%
Specific objective 5. Equitable access to quality health facilities ensured			
Indicator 34: Percent of provinces with adequate hospital bed to population ratio (disaggregated by levels, public and private)	DOH-HFDB	27% (2017)	60%
Indicator 35: Percent of provinces with adequate RHU/Health Center to population ratio	DOH-HFDB	12% (Q3, 2018)	30%
Indicator 36: Percent of provinces with adequate BHS to population ratio	DOH-HFDB	73% (Q3, 2018)	85%

Indicator	Data Source	Baseline	2022 Target
Specific objective 6. Equitable distribution of Human Resources for Health (HRH) guaranteed			
Indicator 37: Percent of provinces with adequate physician to population ratio (disaggregated by locality/area)	DOH-HHRDB	31% (2016)	37%
Indicator 38: Percent of provinces with adequate nurse to population ratio (disaggregated by locality/area)	DOH-HHRDB	100% (2016)	100%
Indicator 39: Percent of provinces with adequate midwife to population ratio (disaggregated by locality/area)	DOH-HHRDB	75% (2016)	80%
Indicator 40: Percent of provinces/ HUCs/ ICCs with Service Delivery Networks (SDN) established	DOH-FICT/ DOH-BLHSD	0	100%
Indicator 41: Percent of households with primary care provider (within an SDN) (disaggregated by region, province, cities and GIDA/non-GIDA)	*TBD*		

GENERAL OBJECTIVE 3:

High quality and affordable health products, devices, facilities and services ensured

Specific Objective 8. Regulatory systems and processes harmonized and streamlined

Specific Objective 9. Innovative regulatory mechanisms developed for equitable distribution of quality and affordable health goods and services

Regulatory mechanisms need to be expanded to adapt to the changes in the New Normal, such as that for online transactions and telehealth.

Indicator	Data Source	Baseline	2022 Target
Specific objective 8. Harmonized and streamlined regulatory systems and processes			
Indicator 42: Percent of applications for permits, licenses or accreditation processed within the citizen charter timeline (disaggregated by LTO for facilities and CPR for products)	DOH-HFSRB/ CHD-RLEDS FDA BOQ	88.72% (2018)	100% (HFSRB)
Indicator 43: Percent of all newly registered pharmaceutical products able to be subjected to post-marketing surveillance	DOH-FDA	100% (2019)	TBD

Indicator	Data Source	Baseline	2022 Target
Indicator 44: Percent of Epidemiologic Surveillance Units that can detect and respond to public health emergencies of international and national concern	DOH-BOQ/ DOH-EB	BOQ: 61% (2019) EB: 65% (2019)	TBD
Specific objective 9. Innovative regulatory mechanisms developed for equitable distribution of quality and affordable health goods and services			
Indicator 45: Hospital-acquired infection rate	DOH-HFDB IPC Unit	0.68% (2016)	<1%
Indicator 46: Median consumer price ratio of selected essential medicines	DOH-PD	Innovator Brand • Private: 37.10 • Public: 30.23 Generic Equivalent • Private: 10.76 • Public: 9.78 (2008)	Less than 2x the international reference price
Indicator 47: Percent of targeted health facilities, establishments, services and products continuously compliant to licensing standards	DOH-HFSRB FDA	HFSRB 100.5% FDA: 64.7% (2018)	96% (HFSRB)

GENERAL OBJECTIVE 4:

Strengthened leadership and management capacities, coordination, and support mechanisms necessary to ensure functional, people-centered and participatory health systems

Specific Objective 10. Strengthened sectoral leadership and management

The role of the DOH as a leader and steward in the health sector determines the overall direction and strategies. Implementation still largely depends on Local Government Units, who have control over the outcomes of health programs. With the Supreme Court ruling that increases the Internal Revenue Allotment of LGUs, also known as the "Mandanas Ruling", there will be increased responsibility for LGUs, as expected from the Local Government Code. The DOH needs to strengthen its capacity and role as an enabler and provider of technical assistance, in terms of skills, expertise, and knowledge, for LGUs. In line with the UHC Act, the DOH shall support the development and integration of local health systems to strengthen their capacity to deliver the full continuum of health services.

Specific Objective 11. Improved organizational development and performance

Specific Objective 12. Improved processes for procurement and supply chain management that ensure the availability and quality of health commodities

Procurement and supply chain management does not only refer to commodities that re procured and distributed by the DOH. In order for the health system to be well-capacitated, the supply chain management for LGUs also needs to be well-organized and developed through the Province and City-wide health systems.

Specific Objective 13. Ensured generation and use of evidence in health policy development, decision making, and program planning and implementation

There was a high demand for timely and accurate information during the COVID-19 pandemic. Fragmented information systems and inefficient reporting mechanisms needed to be upgraded to respond to the needs for quick decision-making and to inform the general public. The investments started during the COVID-19 response need to be expanded and sustained so that health information is always relevant.

Indicator	Data Source	Baseline	2022 Target
Specific objective 10. Strengthened sectoral leadership and management			
Indicator 48: Percent of Provinces/ HUCs/ ICCs with approved Local Investment Plan for Health (LIPH)	DOH-BLHSD	62.39% (2016) 2014-2016 LIPH	100% of LGUs with 2023-2025 LIPHs
Specific objective 11. Improved organizational development and performance			
Indicator 49: % of DOH units that are PGS-certified (disaggregated by PGS stage)	DOH-OSM	2.82% (2016)	100%
Specific objective 12. Improved processes for procurement and supply chain management in order to ensure availability and quality of health commodities			
Indicator 50: % of health facilities with no stock out of essential drugs and vaccines (disaggregated by type of facilities to classify essential drugs per level)	DOH-PD	51%	90%
Specific Objective 13. Ensured generation and use of evidence in health policy development, decision making, and program planning and implementation			
Indicator 51: % of new products/devices funded by DOH that have undergone HTA review	DOH	0% (2019)	100%
Indicator 52: % of health facilities with functional electronic medical records (EMR) systems that regularly submit data	DOH-KMITS	5.7% (2016)	100%

GENERAL OBJECTIVE 5:

Better health attained through transparent, responsive and responsible health sector management

Specific Objective 14. Transparency and accountability measures at all levels institutionalized

Specific Objective 15. Outcome-based management approach used

Indicator	Data Source	Baseline	2022 Target
Specific Objective 14. Transparency and accountability measures at all levels institutionalized			
Indicator 53: Proportion of health facilities publicly reporting performance data	DOH-OSM	86% (2019)	100
Specific Objective 15. Outcome-based management approach used			
Indicator 54: % of health organizations with overall excellent rating in their health performance scorecards	DOH-OSM	*CHD: 100% (16/16) TRC: 93% (13/14) Hospital: 71% (44/62) (2019)*	*100%*
Indicator 55: Average budget utilization rate of government health facilities (disaggregated by obligation and disbursement rate)	DOH-FMS	84% (DOH – Obligation rate) 65% (DOH-Disbursement Rate) (2016)	99% (Obligation Rate) 85% (Disbursement Rate)

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