



# National Objectives for Health

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Philippines  
2017-2022





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# Preface

- The National Objectives for Health (NOH) 2017–2022 serves as the medium-term roadmap of the Philippines towards achieving universal healthcare (UHC). It specifies the objectives, strategies and targets of the Department of Health (DOH) *FOUR*mula One Plus for Health (F1 Plus for Health) built along the health system pillars of financing, service delivery, regulation, governance and performance accountability. This ultimately leads to the three major goals that the Philippine Health Agenda aspires for: (1) better health outcomes with no major disparity among population groups; (2) financial risk protection for all especially the poor, marginalized and vulnerable; and (3) a responsive health system which makes Filipinos feel respected, valued and empowered.

This document was built on the initial draft of NOH 2017-2022 prepared by the DOH with the assistance of the Ateneo de Manila University School of Government (ASoG). The said draft, which was anchored on the Philippine Health Agenda, was updated to be consistent with the priorities and strategies of the F1 Plus for Health framework. Its people-centered goals, objectives and targets were hewn from a series of dialogues and consultations with policy- and decision-makers, implementers and other concerned officials from the government, private sector, selected local government units and non-government organizations. By vetting contentious policy issues, it was able to obtain direct technical and operational insights from these stakeholders, which were considered in defining the medium-term health sector goals, targets, strategies, and interventions across F1 Plus for Health pillars.

Through this document, the DOH hopes to ensure uniform understanding of the F1 Plus for Health and guide agencies, local government units (LGUs) and other stakeholders in translating medium-term health policy directions, strategies and benchmarks into concrete programs and projects that will allow all Filipinos, especially the poor, to readily access and use affordable quality care, and thereby boosting universal healthcare.

# Acknowledgment

The NOH 2017-2022 was produced by the Department of Health (DOH) under the technical guidance and supervision of Undersecretary Mario C. Villaverde. The WHO, under the leadership of Dr. Gundo Weiler, also provided technical support in the review and finalization of the health sector core indicators for the NOH and through the Strategic Engagement for Enabling Development (SEED) Inc. This publication was written by Rhodora Tiongson, Joyce Encluna, Napoleon Espiritu II, Donabelle de Guzman and Jocelyn Ilagan based on the earlier work of the Ateneo de Manila University School of Government. Consuelo Aranas served as senior technical resource person while Nayda Bautista and Ma. Alma Mariano provided technical as well as administrative support. The DOH Health Policy Development and Planning Bureau (HPDPB) and the WHO managed the conduct of consultative workshops on *FOURmula One Plus for Health* as well as the writing, editing and printing of the document.

The publication benefited from the comments and inputs of the DOH Health Policy and Systems Development Team, Procurement and Supply Chain Management Team, Health Facilities and Infrastructure Development Team, Public Health Services Team, and Health Regulation Team. The DOH Monitoring and Evaluation Technical Working Group provided its inputs through the review, harmonization and streamlining of NOH core indicators that will represent the overall performance of the health sector.

Special mention is made on the contribution of the following partners to the specification of NOH objectives and proposed interventions: the Department of Finance; Philippine Charity Sweepstakes Office; Bicol, Central Visayas and Davao Centers for Health Development; Philippine Health Insurance Corporation; Amang Rodriguez Memorial Medical Center; Batangas Medical Center; National Kidney and Transplant Institute; Philippine Heart Center; Quirino Memorial Medical Center; and the UP Diliman Department of Political Science. Also, the information and insights provided by the Association of Health Maintenance Organizations of the Philippines, Inc. and the Alternative Budget Initiative are much appreciated.

# Message from the Secretary

With the UHC law in its final stages of development, the health sector is poised to accelerate towards realizing UHC for all Filipinos. Our game plan to achieve UHC is F1 Plus for Health. This document, the National Objectives for Health, articulates our medium-term strategic plan for the health sector through the F1 Plus for Health.

UHC is summed up as equitable access to quality care without financial hardship. But what does this actually mean for the Filipino people? This has to be very clear to us before we start making plans and charting next steps. Let us begin with the end in mind.

Our development blueprint, the *Ambisyon Natin*, imagines the Philippines in 2040 as a prosperous nation with only one percent poverty rate. We are a modern society, with a growing formal sector. By this time, more than half of the country would have been residing in the urban area. Our efforts in education and the Conditional Cash Transfer program have indeed broken the intergenerational cycle of poverty. We shall have reached our own inflection point — think Japan and its technological advances. The same is true for health — Filipinos by then would have become among the healthiest in Asia.

Allow me to walk you through what awaits Juan and Juana in a regime of UHC.

Our heroine, Juana, is a young engineer. She lives in a vertical government housing with a fresh market on the ground floor, in a neighborhood surrounded by parks. At 30 years old, she remains in tip-top shape. Healthful food is available and affordable, and when she is unsure, packed foods are labelled with simple signs helping her to choose healthily. There is also generally no reason for her to drink soda over water, as it is now ten times the cost. Neither is there any incentive for smoking, let alone social smoking – tobacco tax among the highest in the world! She is able to bike to and from work with bike paths all over the metropolis. All these good habits she developed while still in school.

When she turned 21, she began having her own primary care provider (PCP). A primary care provider she can reach out to anytime she feels unwell or have health questions bugging her, especially those concerning reproductive health. During her first consultation, her primary care provider gave her a list of all the clinics, pharmacies, laboratory and diagnostic centers and hospitals that are in-network. She is made aware of where she can go when she needs the care, and that all her transactions are recorded. Her health records are neatly filed ‘in the cloud’ - available for her and her provider team to access when needed.

One time, when she was suspected to have hypertension, her PCP referred her to a specialist. After her consultation was done, she was referred back to her PCP. When she needed medicines, *botika ng bayan* is the nearest pharmacy. All she needed was to key in her National ID, and her prescriptions are filled. While not all medicines are free, choosing generics or certain drugs tagged as “*sulit*” means no co-payments are necessary. Moreover, she never has to worry about buying substandard medicines since health authorities are trusted to enforce regulation.

When she fractured her hip and had to be operated on, Juana only had to provide her biometrics and was only asked one question: “are you willing to co-pay or not”? Because she was sure she did not want to pay - she was operated and eventually wheeled into a ward shared by four people. Juana thought her experience to be pleasant - the room was clean, hygienic and while shared with others still allows privacy. When it was time to go home, the bill was sent to her room, and because of ‘no-balance billing’ (NBB) - she did not have to pay a single centavo. All her take-home medications were prepared, and the subsequent visits to her PCP also automatically scheduled.

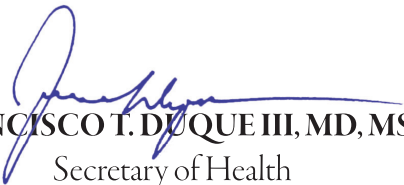
This is the UHC dream, the destination— one that our countrymen do deserve, but also one that is necessary to fuel our transition to become a high-income country status. A task of this magnitude requires renewed trust and coordinated efforts amongst key health stakeholders to carry and board 103 million Filipinos, in an **inclusive and equitable** manner.

Guided by the principles of **performance accountability** and **good governance**, let us judiciously manage our financial, capital and human resources, and at the same time raise adequate **financing** for health, which in turn will underpin the creation of integrated **service delivery** networks that deliver “best value” services compliant with our **regulatory** standards towards quality and affordability. Let these five F1 Plus for Health strategic pillars of performance accountability, good governance, financing, service delivery and regulation shuttle Filipinos comfortably towards being the healthiest in Southeast Asia by 2022, and in Asia by 2040.

Let us all move toward UHC, powered by a vibrant community of passionate and committed civil servants, people’s organizations, development partners and the private sector.

We have weathered the challenges of time. We survived the hard-pressed necessity to adapt to rapidly changing health systems. We achieved much, but now is not the time to be complacent.

Together, nothing is impossible. Together, we can deliver UHC!

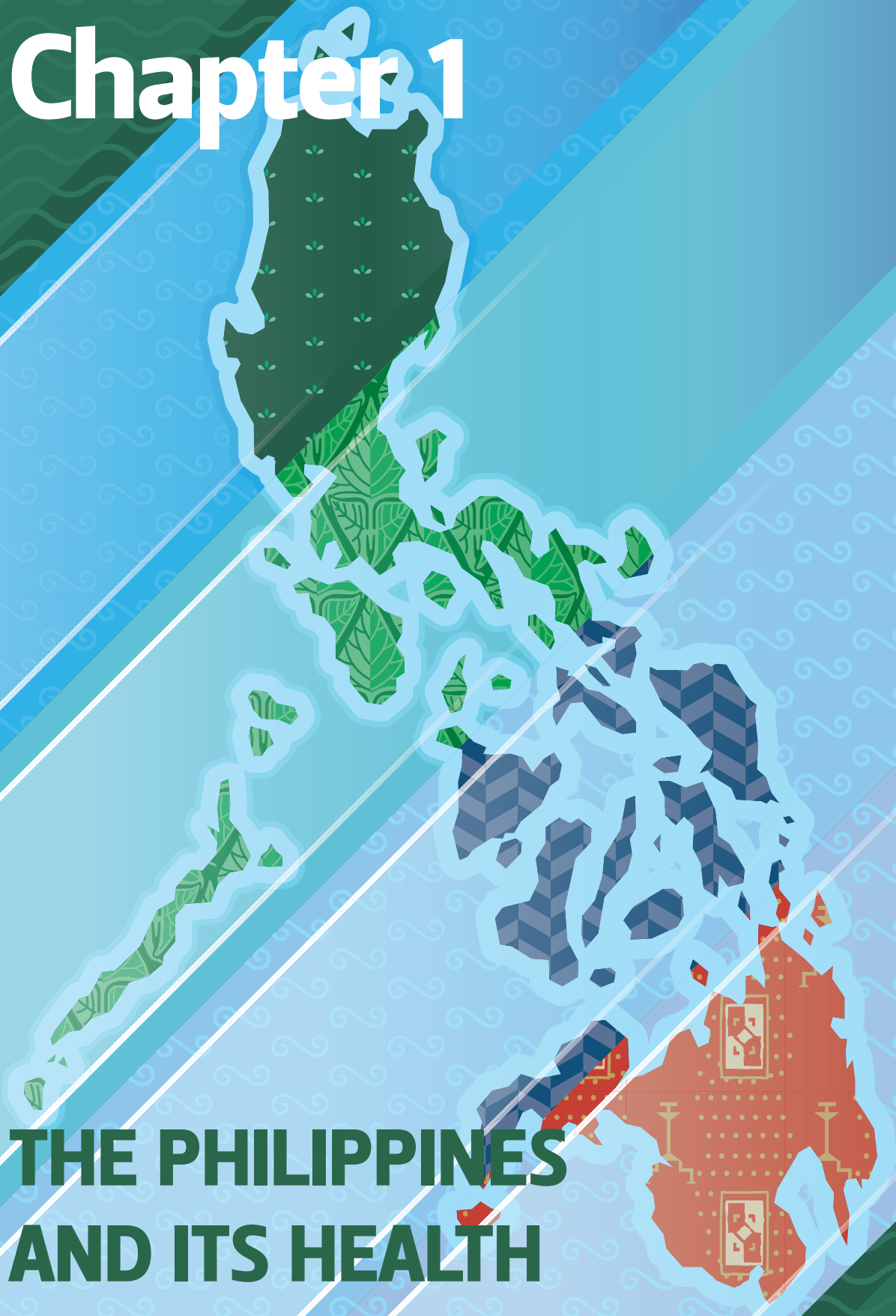
  
FRANCISCO T. DUQUE III, MD, MSc  
Secretary of Health





# Chapter 1

## THE PHILIPPINES AND ITS HEALTH SYSTEM





# OVERVIEW

## Geographic characteristics

The Philippines is an archipelago in Southeast Asia with 7,641 islands, only about 2,000 of which are inhabited. It is bordered by the West Philippine Sea on the west and the Pacific Ocean on the east, with Malaysia to the south-west, Indonesia to the south, Vietnam to the west, and mainland China to the north (WorldAtlas, 2018a). It is grouped into three geographic areas: Luzon, Visayas and Mindanao.

Being located along the seismic Pacific Ring of Fire and Pacific Typhoon Belt, the country regularly experiences earthquakes, typhoons and other natural disasters. The Philippine Trench – a deep-sea trench to the east of the islands, as well as the 22 active volcanoes, makes the country vulnerable to earthquakes and volcanic eruptions. According to the Philippine Institute of Volcanology and Seismology (PHIVOLCS), the country experiences an average of five earthquakes a day. Moreover, an average of 20 tropical cyclones visit the country every year – at least five of which are destructive (ADRC, 2008). It is likewise susceptible to tsunamis, storm surges, landslides, flooding and drought.

## Government and politics

The Philippines has a presidential form of government, with the President as head of government and of the State. Its Constitution mandates a tripartite system of governance where the powers of government are distributed equally among three branches: the Executive, the Legislative and the Judiciary (Pimentel, 2008).

The President heads the executive branch and appoints Cabinet members who lead the various government agencies organized into Cabinet Clusters. Under the administration of President Rodrigo Duterte, these include clusters on: Participatory Governance; Infrastructure; Human Development and Poverty Reduction; Security, Justice and Peace; Climate Change Adaptation and Mitigation; Disaster Risk Reduction; and Economic Development (Executive Order No. 24 s. 2017). Health, headed by the DOH, falls under the Human Development and Poverty Reduction cluster. Meanwhile, the Congress of the Philippines is a bicameral body composed of the Senate, which has 24 members and headed by a Senate President, and the House of Representatives with close to 300 members led by a Speaker. The Judiciary, on the other hand, rests its power with the Supreme Court, which is headed by the Chief Justice. The President, on the recommendation of the Judicial and Bar Council, is responsible for appointing the justices. Other types of courts in the Philippines include lower collegiate courts such as the Court of Appeals and the *Sandiganbayan*, regular courts such as the Municipal Circuit Trial Courts, and the Muslim courts such as the Sharia District Courts (WorldAtlas, 2018b).

The executive and legislative branches are replicated in each Local Government Unit (LGU), i.e. province, city and municipality in the different regions. The Philippines consists of 17 regions, 81 provinces, 145 cities, 1,489 municipalities and 42,044 *barangays* (PSA, 2018c). Each LGU is headed by a Local Chief Executive – governor for provinces, mayor for cities and municipalities, and chairpersons for *barangays*. Meanwhile, a local *Sanggunian* acts as the legislative body of the LGU.

In 1991, the enactment of the Local Government Code (LGC) transferred some national government powers and functions, such as the delivery of basic social services including health, to LGUs. Each LGU enjoys a certain level of autonomy (self-governance) and is legally entitled to an equitable share of the national wealth called the Internal Revenue Allotment (Nations Encyclopedia, n.d.).

## Socioeconomic trends

The Philippine Statistics Authority (PSA) data shows that the country's gross domestic product (GDP) was 28 percent higher in 2016 at PhP8.1 trillion compared to the PhP6.3 trillion in 2012. Full-year economic growth stood at 6.6 percent in 2012 (PSA, 2013) and at 6.8 percent in 2016 (PSA, 2017b). From 2010-2015, regional centers<sup>1</sup> grew the fastest, with the three most populous regions accounting for two-thirds (62.3 percent) of the Philippine domestic production: National Capital Region (NCR) at 37.9 percent; Cavite, Laguna, Batangas, Rizal and Quezon (CALABARZON) at 15.5 percent; and Central Luzon at 8.9 percent (PDP, 2017). With this, the National Economic and Development Authority (NEDA) projected an expansion of the economy by about 50 percent in real terms in 2017-2022, which is nearly double the 28 percent growth posted from 2012 to 2016.

Poverty incidence<sup>2</sup> declined from 25.2 percent in 2012 to 21.6 percent in 2015, and subsistence incidence<sup>3</sup> from 10.4 percent to 8.1 percent in the same period, but the magnitude of poor Filipinos in 2015 remained high at 21.9 million (PSA, 2016d). Among the nine basic sectors, farmers, fisherfolk and children belonging to families with income below the official poverty threshold posted the highest poverty incidence in 2015 at 34.3, 34.0 and 31.4 percent, respectively. These sectors consistently registered as the three sectors with the highest poverty incidence in 2006, 2009 and 2012. Five of the nine basic sectors, namely the farmers, fisherfolk, children, self-employed and unpaid family workers, and women belonging to poor families, had higher poverty incidence than the general population in 2015 (PSA, 2017a). Furthermore, the 2015 Family Income and Expenditure Survey (FIES) also shows that the share of health to the total annual family expenditure was lowest among the poorest income class.

1 Regions with established and large cities

2 The minimum income/expenditure required for a family/individual to meet the basic food and non-food requirements, as defined by PSA

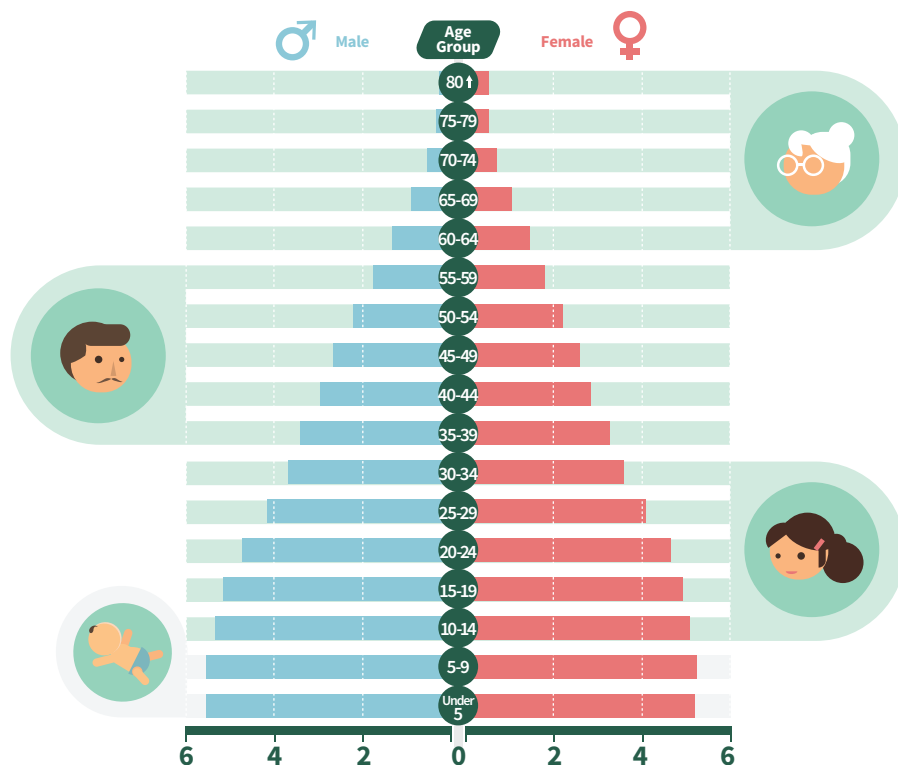
3 The proportion of Filipinos whose incomes fall below the food threshold, as defined by PSA.

## Demographic trends

Based on the 2015 Census of Population, the Philippine population went up from 92 million in 2010 to 101 million persons in 2015, which translated to an average population growth rate (PGR) of 1.7 percent annually for the period. Following the global trend, PGR declined over the years from the 2000-2010 level of 1.9 percent. Luzon comprises more than half (56.9 percent) of the country's total population, followed by Mindanao (23.9 percent) and then the Visayas (19.2 percent). Among the administrative regions, CALABARZON was the most populated at 14.4 million people while Cordillera Administrative Region (CAR) was the least populated at 1.7 million in 2015, comprising 14.3 percent and 1.7 percent of the country's total population, respectively. Twenty-seven of 81 (33 percent) provinces reached more than one million population in 2015, with the top five most populous provinces consisting of Cavite, Bulacan, Laguna, Pangasinan and Cebu (excluding its three highly urbanized cities). Meanwhile, Quezon City (2.94 million persons), the city of Manila (1.78 million persons), Davao City (1.63 million persons) and Caloocan City (1.58 million persons) had the highest population among the 33 highly urbanized cities (PSA, 2017c).

Figure 1.1 shows that the Philippine population in 2015 was young – with children aged zero to four years and 5 to 9 years comprising the largest age groups, each making up 5.2 percent of the household population. These are followed by those in age groups 10 to 14 years (5.1 percent) and 15 to 19 years (4.9 percent). The median age of the total population was 24.3 years, which means that half of the total population was below this age.

Figure 1.1. 2015 Household Population Age-Sex Pyramid



Males outnumber females in the age groups 0 to 54 but the situation is reversed in older age groups (55 years old and over). Dependency ratio slightly decreased from 60 to 58 dependents for every 100 persons in the working age group from 2010 to 2015 but remains relatively high nonetheless. Of the 58 dependents in 2015, 50 were young dependents and eight were old dependents (PSA, 2017c).

Source: Philippine Statistics Authority (PSA)

## Health system

**Health service delivery.** The Philippines has a mixed public-private healthcare system that operates within a fragmented environment. The private sector caters to only about 30 percent of the population but is far larger than the public system in terms of financial resources and staff (Oxford Business Group, 2018). It provides healthcare that is generally paid through user fees at point of service. About 65 percent of the 1,224 hospitals in the country in 2016 were private (DOH-HFSRB, 2016).

Both the national government and LGUs manage the delivery of promotive, preventive, curative and rehabilitative health services. The DOH supervises the government corporate hospitals, specialty and regional hospitals while the Department of National Defense (DND) runs the military hospitals. Both agencies provide tertiary care. At the local level, the provincial governments manage district and provincial hospitals. Meanwhile, municipal governments provide primary care including preventive and promotive health services and other public health programs through the RHUs, health centers and BHSs, which are the first point of contact for government-provided health services, (Dayrit, et al., 2018).

**Health financing.** The National Health Insurance Act of 1995 created the Philippine Health Insurance Corporation (PhilHealth) to provide health insurance coverage for all Filipinos but enrolment was not made compulsory. In 2013, it was amended, expanding the contribution-based national health insurance program (NHIP) beyond formal employment to include the underprivileged, sick, elderly, persons with disabilities (PWDs) and women and children. It strengthened the roles of the LGUs and health providers in NHIP enrolment.

PhilHealth serves as the national social health insurance agency which purchases services from public and private providers on behalf of its members. However, healthcare provision, health regulation, facility improvements and human resource deployment as well as capacitation are still subsidized by the government, mainly through the DOH. Government budget also flows through the health contributions of other central institutions such as DND, the Philippine National Police (PNP), the University of the Philippines (all of which manage large hospitals), the Philippine Charity Sweepstakes Office (PCSO), and the Philippine Amusement and Gaming Corporation (PAGCOR). PhilHealth administers the National Health Insurance Program (NHIP) to provide all Filipinos with financial risk protection. The government fully subsidizes the PhilHealth premiums of the poor identified through the National Household Targeting Survey for Poverty Reduction (NHTS-PR).



Total health expenditure in the Philippines grew by 39 percent to PhP655.1 billion from 2012 to 2016. Government expenditures likewise increased owing to incremental revenues from sin taxes allocated for health, which led to a dramatic increase in PhilHealth coverage from 84 percent in 2012 to 91 percent in 2016. Nonetheless, the huge share of out-of-pocket (OOP) payment (52.2 percent) still dwarfed the share of government subsidies (18.9 percent) and PhilHealth social insurance (16.7 percent) to total health expenditures, undermining financial protection.

**Health governance and regulation.** The enactment of LGC in 1991 led to dual governance in health, with the DOH governing at the national level and the LGUs at the subnational level. The DOH serves as the over-all steward and technical authority on health being the national health policy-maker and regulatory institution. It is mandated to develop national plans, technical standards, and guidelines on health. It is also in charge of licensing hospitals, laboratories and other health facilities through the Health Facilities and Service Regulatory Bureau (HFSRB), and health products through the Food and Drug Administration (FDA). PhilHealth automatically accredits DOH-licensed facilities. Meanwhile, the Insurance Commission (IC) regulates and supervises the operations of private insurance companies, and since 2015, of health maintenance organizations as well, except PhilHealth. The DOH also coordinates government, private sector and development partner assistance on health and leverages funds for improved health performance.

The LGUs, on the other hand, are in charge of the delivery of devolved primary and secondary health services at the subnational level. This is in response to the fragmented archipelagic nature of the country and the uneven distribution of its population. LGUs prepare plans, as well as manage and implement local health programs and services. The local health board, which consists of selected and appointed members, enjoys advisory powers, planning authority and responsibility for health services (Kelekar & Llanto, 2013).

Various reforms were implemented to address the weakened DOH political, technical and administrative control over the different levels of healthcare brought about by devolution. The Health Sector Reform Agenda in 1999 supported the development and strengthening of local health systems, facilitated the fiscal autonomy of government hospitals, increased funding for priority public health programs and expanded NHIP coverage. The *FOURmula One (F1) for Health* in 2005 sought to fill the remaining gaps in the health system not addressed by previous reforms by leveraging central government funds to promote inter-LGU collaboration in attaining desired health outcomes. In 2011, the Universal Health Care (UHC) or *Kalusugan Pangkalahatan* became a policy goal, leading to the expansion of SHI coverage mainly due to sin taxes earmarked for health, the introduction of no-balance billing (NBB) scheme for indigents, and intensified support to health facility construction and enhancement.

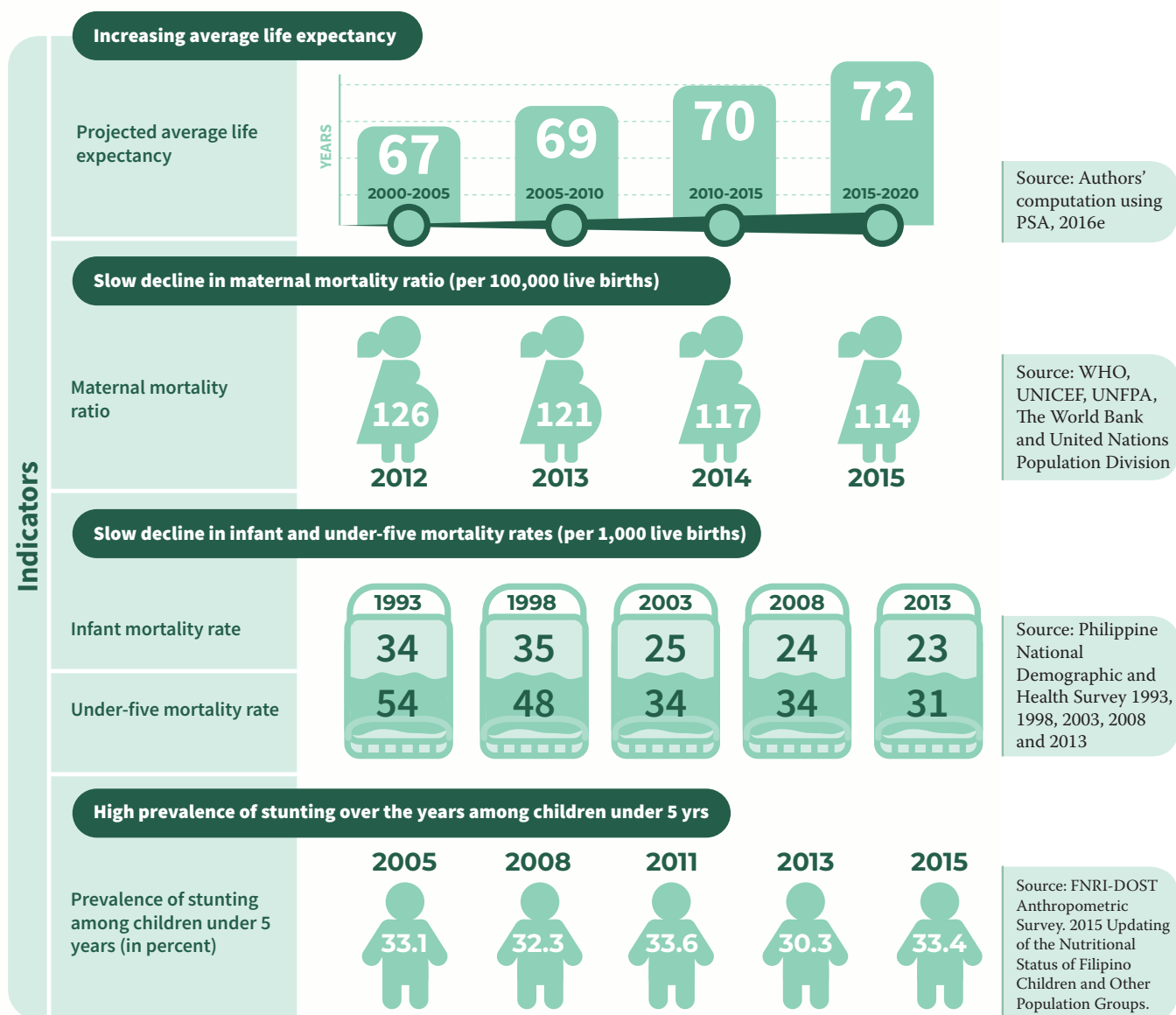


## Health trends

Selected indicators serve as proxy measure for determining if the strategies and interventions implemented by the health sector and other stakeholders led to overall improvements in health outcomes. Results using selected indicators such as life expectancy, maternal mortality ratio (MMR), infant mortality rate (IMR), under-five mortality rate (U5MR), prevalence of stunting among under-five children, and TB prevalence<sup>4</sup> showed mixed results. (Figure 1.2)

<sup>4</sup> Trend cannot be determined as TB prevalence in NTPS 2007 cannot be compared with that in NTPS 2016 due to changes in methodology

Figure 1.2. Summary of Selected Health Outcomes - Philippines



Based on PSA 2000 Census-based projections, the average life expectancy improved from 67.1 years in 2000-2005 to 71.6 years in 2015-2020. Modest gains were also achieved in infant and under-five mortalities as shown by mortality data from five demographic surveys conducted from 1993 to 2013. Infant mortality rate decreased from 34 per 1,000 live births to 23 per 1,000 live births and under-five mortality rate went down from 54 per 1,000 live births to 31 per 1,000 live births. The rates of decline, however, slowed down over the period. Meanwhile, the MMR has minimal progress from 126 per 100,000 live births in 2012 to 114 per 100,000 live births in 2015.

In terms of nutrition, the 8<sup>th</sup> National Nutrition Survey showed that stunting remained almost unchanged from 33.1 percent in 2005 to 33.4 percent in 2015. (Figure 1.2) Stunting was observed to be high among those residing in rural areas (38.1 percent) and those belonging to the poorest quintiles (49.7 percent)

According to the DOH 2016 Annual Report, TB case detection rate and treatment success rate both exceeded the national targets of 93.6 and 90 percent, respectively. Nonetheless, the Philippines remained to be one of the 30 high TB burden countries in the world, with an estimated incidence of 554 per 100,000 population in 2016 (WHO, 2017). The National TB Prevalence Survey (NTPS) 2016 estimated prevalence of smear-positive TB at 434 per 100,000 population, and of bacteriologically confirmed TB at 1,159 per 100,000 population.

**Figure 1.3. Health Outcomes Ranking of Southeast Asian Countries**

Rank	Indicators			
	Average Life Expectancy (2016)	Maternal Mortality Ratio (2015)	Infant Mortality Rate (2016)	TB Incidence Rate (2016)
1st (Best)	Singapore	Singapore	Singapore	Singapore
2nd	Brunei	Thailand	Malaysia	Brunei
3rd	Vietnam	Brunei	Brunei	Malaysia
4th	Thailand	Malaysia	Thailand	Vietnam
5th	Malaysia	Vietnam	Vietnam	Thailand
6th	Indonesia	Philippines	Philippines	Lao PDR
7th	Philippines	Indonesia	Indonesia	Cambodia
8th	Cambodia	Cambodia	Cambodia	Myanmar
9th	Timor Leste	Myanmar	Myanmar	Indonesia
10th	Lao PDR	Lao PDR	Timor Leste	Timor Leste
11th (Worst)	Myanmar	Timor Leste	Lao PDR	Philippines

Source: DOH presentation on F1 Plus: Boosting Universal Health Care

The leading causes of mortality in the Philippines in 2016 consisted of non-communicable diseases (NCDs) like ischemic heart disease, neoplasms or cancer, cerebrovascular diseases or stroke, hypertensive diseases, diabetes and other heart diseases, and communicable diseases like pneumonia, respiratory tuberculosis and chronic lower respiratory infections. Several NCDs share common lifestyle-related risk factors: cigarette smoking, hypertension, hyperglycemia, dyslipidemia, obesity, physical inactivity and poor nutrition (Asena et al., 2015). Ischemic heart disease remained to be the top leading cause of death in the country, followed by cancer and pneumonia (Table 1.1). While assault did not appear on this table, it was included in the top 10 leading causes of death for males in 2016. In the previous years, accident figured prominently in the list, ranking as the fifth highest among the leading causes of mortality from 2012-2014 (DOH, 2016a).

Meanwhile, morbidity in 2016 was caused mainly by acute respiratory infection, followed by hypertension, acute lower respiratory tract infection (ALRTI) and pneumonia. These were the same top three causes of morbidity in 2012, except that the second and third top diseases interchanged ranks. Leading causes of morbidity were all communicable diseases, except for hypertension (Table 1.2).

**Table 1.1. Ten Leading Causes of Mortality – Philippines, 2016**

	<b>Disease</b>	<b>Number of Deaths</b>	<b>Rate per 100,000 population<sup>5</sup></b>
1	Ischemic Heart Disease	74,134	71.8
2	Neoplasms	60,470	58.5
3	Pneumonia	57,809	56.0
4	Cerebrovascular Diseases	56,938	55.2
5	Hypertensive Diseases	33,452	32.4
6	Diabetes Melitus	33,295	32.3
7	Other Heart Diseases	28,641	27.7
8	Respiratory Tuberculosis	24,462	23.7
9	Chronic Lower Respiratory Tract Infections	24,365	23.6
10	Remainder of Diseases of the Genitourinary System	19,759	19.4

Source: Philippine Statistics Authority (PSA), 2018b

<sup>5</sup> Computed using the PSA 2016 projected Philippine population of 103,242,900 (medium assumption) and the number of deaths by cause

Table 1.2. Ten Leading Causes of Morbidity – Philippines, 2016

	Disease	Number of Cases	Rate per 100,000 population
1	Acute Respiratory Infection	3,080,343	2,970.2
2	Hypertension	886,203	854.5
3	ALRTI & Pneumonia	786,085	758.0
4	Urinary Tract Infection	288,588	278.3
5	Influenza	216,074	208.3
6	Bronchitis	200,176	193.0
7	Acute Watery Diarrhea	139,770	134.8
8	TB Respiratory	87,422	84.3
9	Acute Bloody Diarrhea	57,647	55.6
10	Dengue Fever	56,487	54.5

Source: 2016 FHSIS Annual Report

Despite living longer than in previous years, Filipinos now bear a triple burden of disease with the high prevalence of communicable diseases and NCDs. Filipinos are also susceptible to risks brought by the increasing impact of globalization and climate change, with the Philippines ranking third in the world in terms of exposure to disaster risks (Dayrit et al., 2018). Thousands have died from previous rapid onset disasters that struck the country, commonly owing to trauma, drowning or crush-related injuries. Moreover, flooding can increase transmission of certain diseases such as leptospirosis and dengue, while power cuts may disrupt water treatment and supply, exposing the population to the risk of water-borne diseases (WHO, 2018b).

# CHALLENGES AND IMPLICATIONS

## Mixed health outcomes

Modest gains in selected health outcome indicators and weak performance in others were not enough to realize the country's targets in the NOH 2011-2016 and the Millennium Development Goals (MDGs). Availability, accessibility and affordability of quality healthcare have impeded healthcare utilization. The archipelagic nature of the country, uneven distribution of its population and the varying levels of economic growth in the regions led to human resource for health maldistribution, with health workers, particularly doctors and nurses, concentrated in more urbanized and economically developed areas.

The country also lacked over 2,500 RHUs or health centers and more than 500 barangay health stations to serve the population in 2016, despite the DOH support to the new construction of 351 BHSs and 107 RHUs under the 2016 Health Facility Enhancement Program (HFEP). This has limited access especially of the poor to healthcare given that majority of those who go to these health facilities belong to the poorest income quintiles, as shown by the 2013 NDHS.

While the Philippines has already developed scorecards to measure the responsiveness of health service delivery to the needs of the population, these instruments have yet to exert pressure on health providers to influence the coverage, quality and cost of care.

## Disjointed health system

Overlapping and sometimes, conflicting mandates of the DOH and LGUs on health owing to devolution led to the disintegration of the originally integrated referral system that linked public health services and hospital services. Decentralization was pushed too far, leading to fragmentation in service delivery as each health unit was inefficiently assigned to a different local government rather than keeping the integrated provincial health system in place. The flow of health funds was also made more complicated and inequitable with the weak link between health budget allocation and devolved health functions. Even with the additional internal revenue allotment (IRA) in 1992, for instance, some LGUs inevitably suffered revenue shortfalls since the extra IRA was distributed without regard for the distribution of the cost of devolved functions (Capuno, 2017).

## High out-of-pocket expenditure

More than half of health expenditures remained to be funded by out-of-pocket (OOP) payments despite increased resources for health in recent years. While the huge budgetary infusion translated to higher PhilHealth coverage and led to the design of pro-poor schemes such as the No Balance Billing (NBB) policy, social health insurance remained inadequate in protecting Filipinos from the financial burden of healthcare. This may be indicative of issues such as low member awareness and availment of benefits, inadequate scope and amount of PhilHealth benefit packages, and unreadiness of health facilities to provide subsidized quality care.

The limited regulatory power of government over the prices of drugs and user fees for health services has taken its toll especially on the poor. The unpredictable and unregulated user fees contribute to high OOP payments, which can either impoverish the poor further or deter their access to healthcare. The lowest three income quintile groups accounted for less than their equal share (20 percent) of current health expenditures (CHE) in 2014. Spending less for healthcare meant they got less health services. Quintiles 1 (poorest), 2 and 3 contributed PhP64.5 billion (12.7 percent), PhP59.7 billion (11.1 percent) and PhP72.4 billion (13.5 percent), respectively, to current health expenditures but these accounted for only less than their equal share (20 percent) of CHE. Only the fourth quintile accounted for almost exactly its equal share of CHE, while the fifth or top quintile accounted for about double its equal share (Racelis, et al., 2016).

# STRATEGIC GOALS AND TARGETS

In response to the challenges identified in improving health outcomes and the health system, the DOH pursues *FOURmula One Plus* (F1 Plus) for Health, which aims to provide Universal Health Care (UHC) for all Filipinos in the medium to long term. The national policy on UHC espouses three strategic thrusts: better health outcomes, responsive health system, and equitable and sustainable health financing.

F1 Plus for Health has three strategic goals:

## STRATEGIC GOAL 1

### Better health outcomes

The health sector will sustain gains and address new challenges especially in maternal, newborn and child health, nutrition, communicable disease elimination, and NCD prevention and treatment. Improvements in health outcomes will be measured through sentinel indicators such as life expectancy, maternal and infant mortalities, NCD mortalities, TB incidence, and stunting among under-five-year-olds.

## STRATEGIC GOAL 2

### More responsive health system

The quality of health goods and services as well as the manner in which they are delivered to the population will be improved to ensure people-centered healthcare provision. This may be done through instruments that routinely monitor and evaluate client feedback on health goods used and services received.

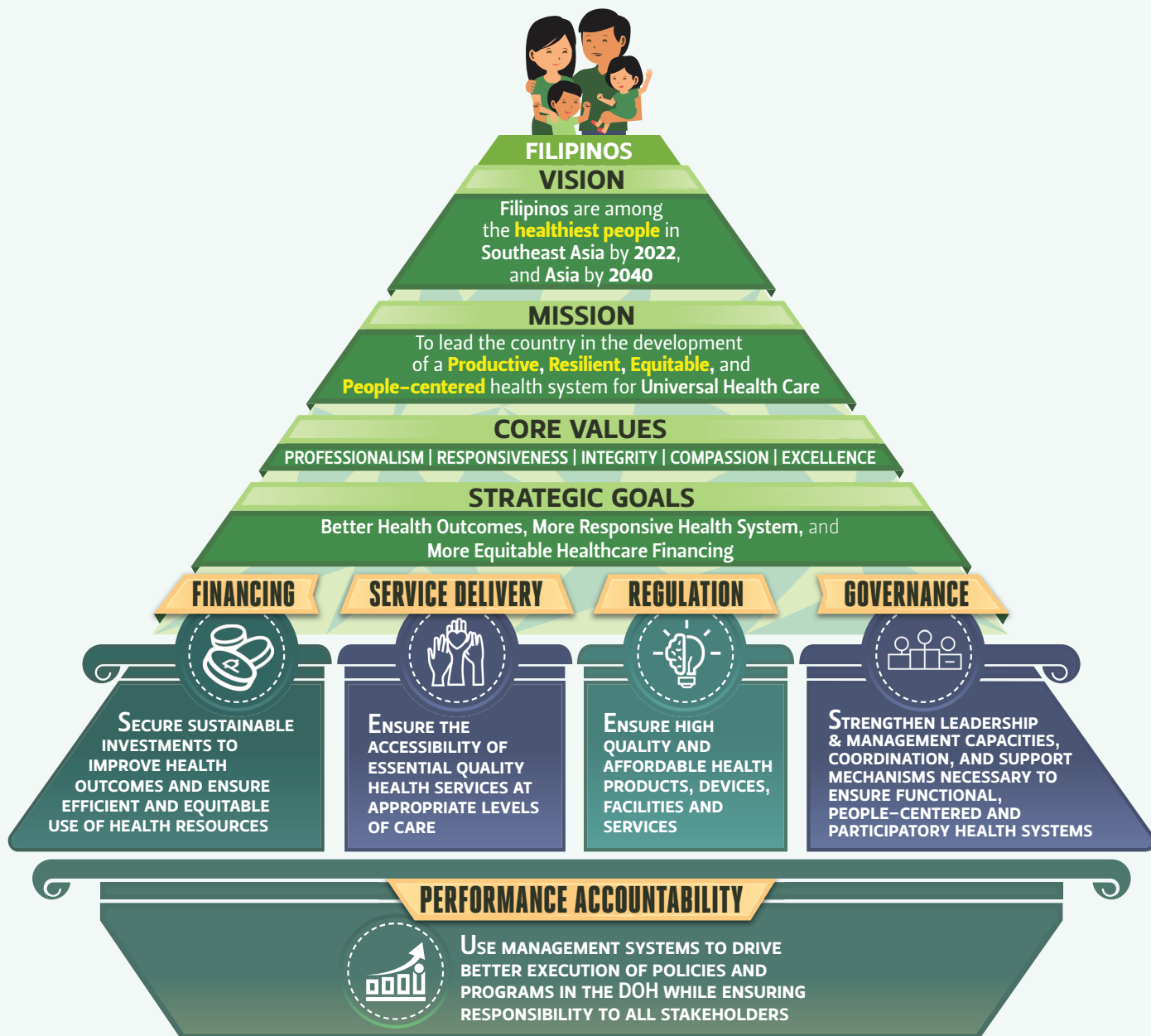
## STRATEGIC GOAL 3

### More equitable healthcare financing

Access of Filipinos, especially the poor and underserved, to affordable and quality health goods and services will be expanded through mechanisms that provide them with adequate financial risk protection from the high and unpredictable cost of healthcare. These may include efforts to reduce catastrophic OOP payments, such as through public subsidies targeted towards the poor.

The priorities of F1 Plus for Health hew closely to the thrusts of UHC, as shown by its strategy map (Figure 1.4). This policy reform envisions Filipinos to be among the healthiest people in Southeast Asia by 2022, and in Asia by 2040. It intends to lead the country in the development of a productive, resilient, equitable and people-centered health system towards the attainment of UHC, guided by the values of professionalism, responsiveness, integrity, compassion and excellence.

Figure 1.4. *FOURmula One Plus* for Health Strategy Map



Source: DOH, 2018



Critical to the attainment of these strategic goals are the reforms and interventions proposed in the four pillars of the initial F1 for Health – financing, service delivery, regulation and governance – as well as in the added cross-cutting pillar of F1 Plus for Health, which is on performance accountability. The latter introduces evidence-based metrics in the health system to objectively monitor and ensure its responsiveness to addressing the healthcare needs of Filipinos.

F1 Plus for Health builds on the previous policy on F1 for Health initiated by the DOH in 2005-2010, and the Philippine Health Agenda 2016-2022, which was committed to bringing “All for Health Towards Health for All”. As the medium-term strategic framework for health, it supports the attainment of the priority thrusts of the Philippine Development Plan (PDP) 2017-2022: *Malasakit, Pagbabago at Patuloy na Pag-unlad* (enhancing the social fabric, inequality-reducing transformation and increasing growth potential) by helping realize its health-related objectives in the following priority areas: accelerating human capital development, reducing vulnerability of individuals and families, building safe and secure communities, reaching the demographic dividend, and ensuring ecological integrity and clean and healthy environment (NEDA, 2017). Through this, F1 Plus for Health supports the achievement of *Ambisyon Natin 2040: Matatag, Maginhawa at Panatag na Buhay* – the long-term vision of the country, which sees Filipinos as having strongly rooted, prosperous and secure lives.

It is likewise vital in realizing the health targets of Sustainable Development Goals (SDG) 2030, particularly Goal 3 “Good health and well-being” and other health-related targets in Goal 1 “No poverty”, Goal 2 “Zero hunger”, Goal 6 “Clean water and sanitation”, Goal 7 “Clean energy”, Goal 11 “Sustainable cities and communities”, Goal 13 “Climate action”, Goal 16 “Peace, justice and strong institutions, and Goal 17 “Partnerships for the goals”.

F1 Plus for Health goals will be measured by a set of sentinel impact indicators which show the overall effectiveness of F1 Plus for Health strategies and interventions in improving health system performance and bringing about desired health outcomes for all, especially the poor (Table 1.3).

Table 1.3. National Objectives for Health 2017-2022  
Impact Indicators**Strategic Goal 1: Better health outcomes**

Indicator	Data Source	Baseline	2022 Target
Indicator 1: Average life expectancy (in years)	PSA	70 (2010-2015)	72
Indicator 2: Maternal mortality ratio per 100,00 live births	UN Estimates	114 (2015)	90
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	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	FNRI-DOST NNS	33.4 (2015)	21.4

**Strategic Goal 2: Responsive health system**

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

**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)	52.2 (2016)	50
Indicator 10: Percent of population who have spent less than 10 percent of their HH income on health	<i>TBD</i>		





# Chapter 2



**FINANCING:**  
SUSTAINED  
INVESTMENTS  
FOR EQUITABLE  
HEALTH CARE



# BACKGROUND

## Health expenditure

Funding for health care in the Philippines comes from government and private sources. Based on the Philippine National Health Accounts (PNHA), total health expenditure, which measures both government and private current health spending as well as health capital formation, increased by 39 percent from PhP471.1 billion in 2012 (PSA, 2015b) to PhP655.1 billion in 2016 (PSA, 2017f) but its share in GDP remains at 4.5 percent in both years. Per capita health expenditure also grew nominally for this period from PhP4,881 to PhP6,345 at current prices, averaging an annual increase of 6.9 percent. Adjusting for inflation, however, it only increased by 4.2 percent yearly on the average from PhP3,752 in 2012 (PSA, 2015c) to PhP4,406 in 2016 (PSA, 2017f). The country's 2015 current health expenditure per capita of US\$323 was one of the lowest in Southeast Asia – higher only than Cambodia and Lao People's Democratic Republic but lower than most countries in the region that had comparable GDP with the Philippines such as Vietnam (US\$334), Indonesia (US\$369), Thailand (US\$610) and Malaysia (US\$1,064) (World Bank, 2018).

## Sources of health funds

Private sector spending – consisting mainly of out-of-pocket (OOP) payments – continued to be the top funding source from 2012-2016 (Table 2.1 and Figure 2.1), exceeding all domestic general government expenditures combined, including those contributed by the national government, local government and social health insurance.

**Table 2.1. Health Expenditure by Source of Funds, 2012-2016 (in million pesos)**

	2012	2013	2014	2015	2016
<b>Domestic General Government</b>	142,504	160,124	174,289	209,579	233,089
National Government	55,694	62,827	53,731	67,623	78,441
Local Government	34,240	36,827	37,277	39,157	45,108
Social Health Insurance	52,570	60,440	83,281	102,799	109,541
<b>Out-of-Pocket</b>	269,419	296,539	290,422	315,411	341,929

*Note: National government expenditure from 2014-2016 included health spending of central government and social security agencies*

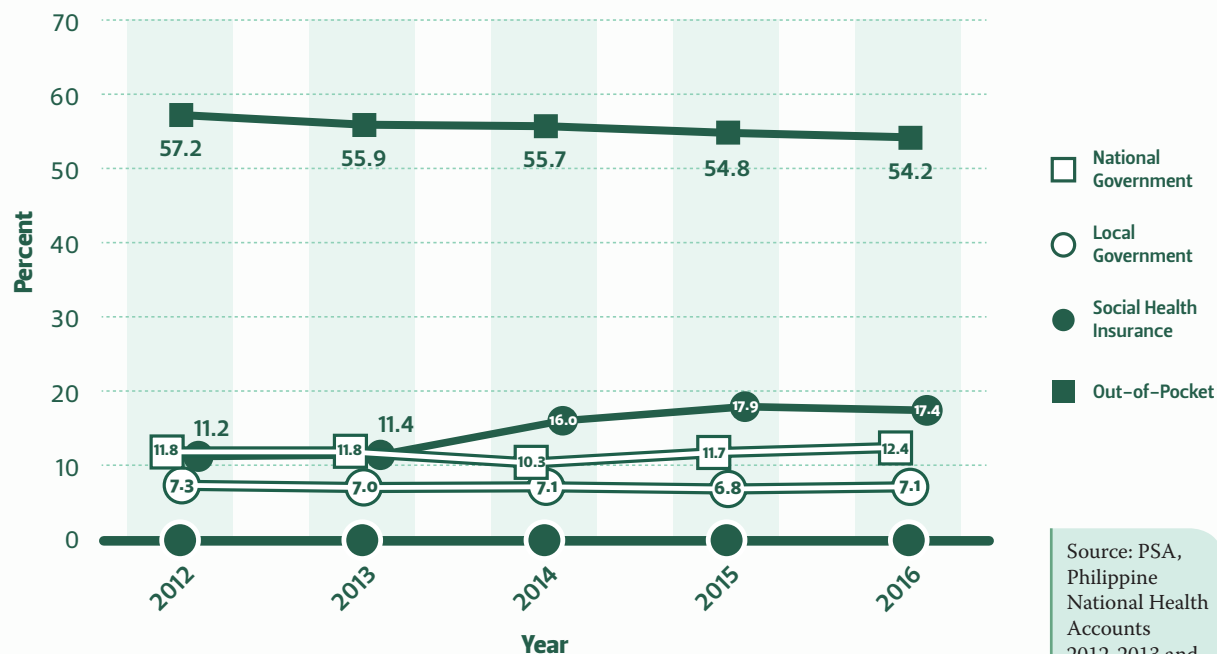
Source: Author's estimate using PSA, Table 4. Health expenditure by source of funds, 2012-2013; Estimate of 2014-2016 national government expenditure was based on PSA Table 3. Current health expenditures by financing agent, Philippines: 2014-2016

Health expenditure in 2016 amounted to P630.9 billion, including spending of general government, private insurance corporations as well as health maintenance and provider corporations, and households (including OOP payments).

Meanwhile, total health expenditures, which considered gross fixed capital formation, amounted to PhP655.1 billion for the year. Figure 2.1 shows the share of fund sources to current health expenditures from 2012-2016. Distribution of total health expenditure by source of funds, however, proves challenging as the actual shares of government and private sectors cannot be accurately determined without disaggregated data on gross fixed capital formation from 2014-2016 indicating public-private classification of health capital goods.



Figure 2.1. Health Expenditure by Source of Funds, 2012-2016 (in percent)



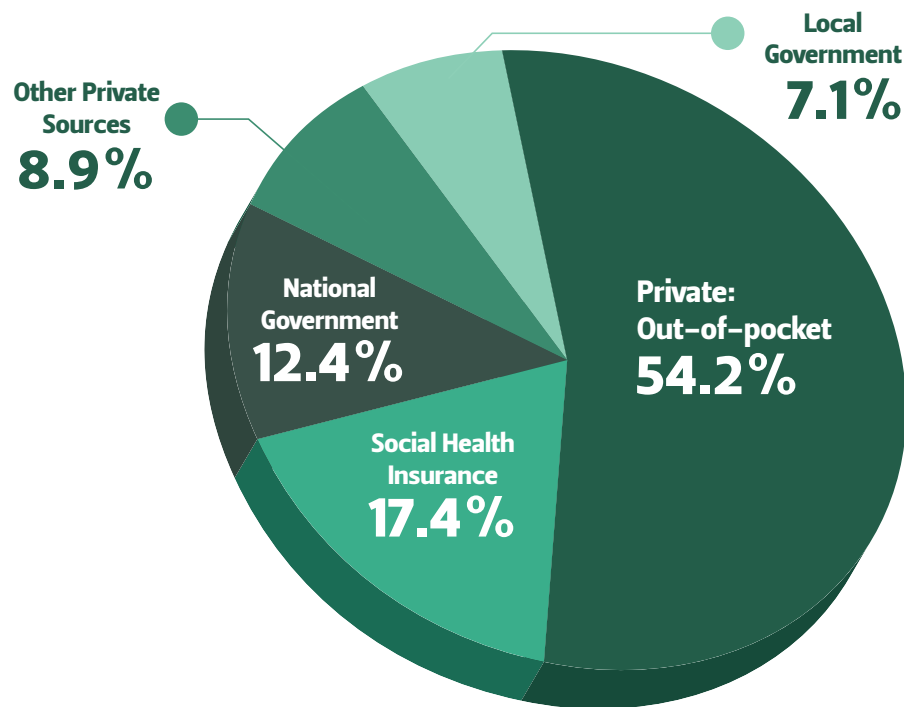
OOP spending on health decreased during the five-year period but it continued to be the top source of health expenditure (Figure 2.1). It comprised more than half (54.2 percent) of the PhP630.9 billion-current health expenditure in 2016 (Figure 2.2) – higher than the NOH 2011-2016 target of less than 50 percent. Hospitals were the major recipients of OOP for the year at PhP259 billion (41.1 percent), followed by pharmacies at PhP173 billion (27.5 percent) and providers of preventive care at PhP53.3 billion (8.5 percent) (PSA, 2017f).

The government came far second as the next biggest contributor with its 19.5 percent share (12.4 percent by the National Government and 7.1 percent by the Local Government) of the health expenditure pie, followed by social health insurance at 17.4 percent (Figure 2.2). Social health insurance, which is funded by the National Health Insurance Program (NHIP), more than doubled from PhP52.6 billion in 2012 to PhP109.5 billion in 2016 (Table 2.1) and its average annual rate of increase even outpaced that of government expenditure. Nonetheless, it remained to be a minor payor of healthcare in the country. Its 17.4 percent share in the total health expenditure in 2016 (Figure 2.1 and 2.2) failed to reach the NOH 2011-2016 target of 19 percent.

Combined government and social health insurance expenditure of PhP233.1 billion made up the country's domestic general government expenditure in 2016, which accounted for only 1.6 percent of GDP for the year (Table 2.1). Domestic general government expenditure per capita stood at PhP2,273<sup>6</sup> for the year.

6 Estimated by dividing domestic general government expenditure identified from PNHA 2016 by the 2016 population projected by PSA.

Figure 2.2. Health Expenditure by Source of Funds, 2016

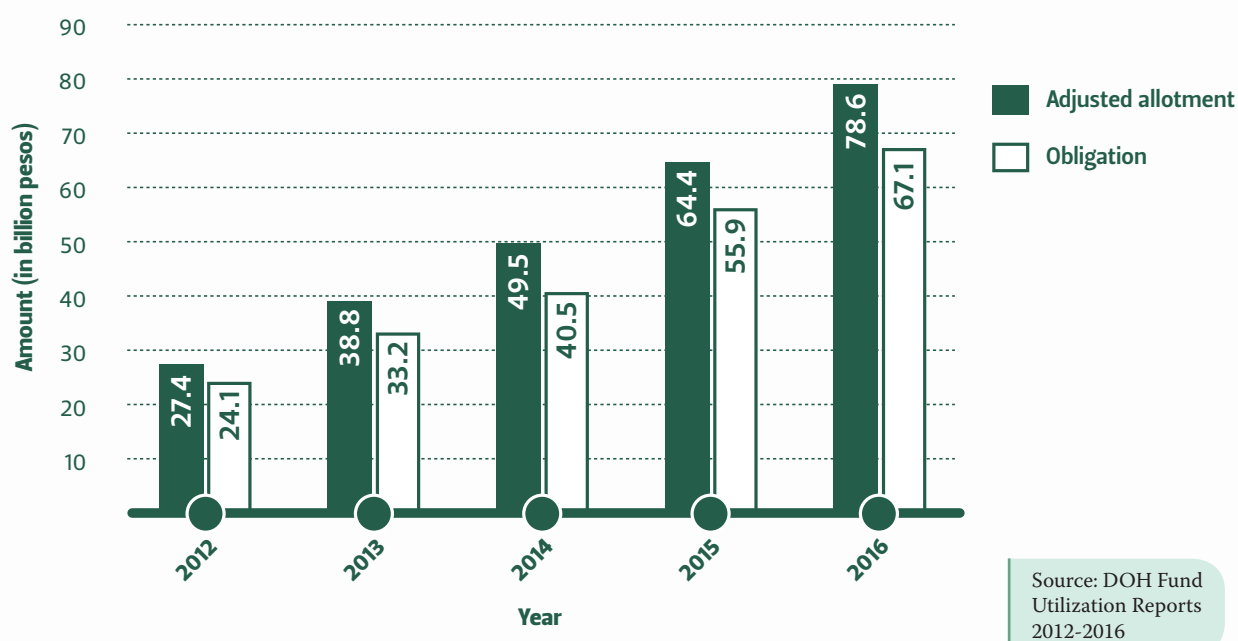


Source: PSA, Philippine National Health Accounts 2014-2016

Despite the Local Government Code (LGC) of 1991, which devolved the provision of basic health services to LGUs, the share of national government to current health expenditure remained higher than that of the local government from 2012-2016 (Figure 2.1). It increased by an average of 1.8 percent annually while local government share decelerated at an average of 1.3 percent annually despite an 11.9 percent average annual increase in internal revenue allotment (IRA) over the period, and the DBM's automatic and comprehensive release of IRA to LGUs at the start of every year beginning 2012 without any conditions. The PhP78.4 billion national government expenditure (sourced mainly from the DOH) in 2016 (Table 2.1) constituted 63 percent of government spending on health (excluding social health insurance) and 34 percent of total general government expenditure for the year.

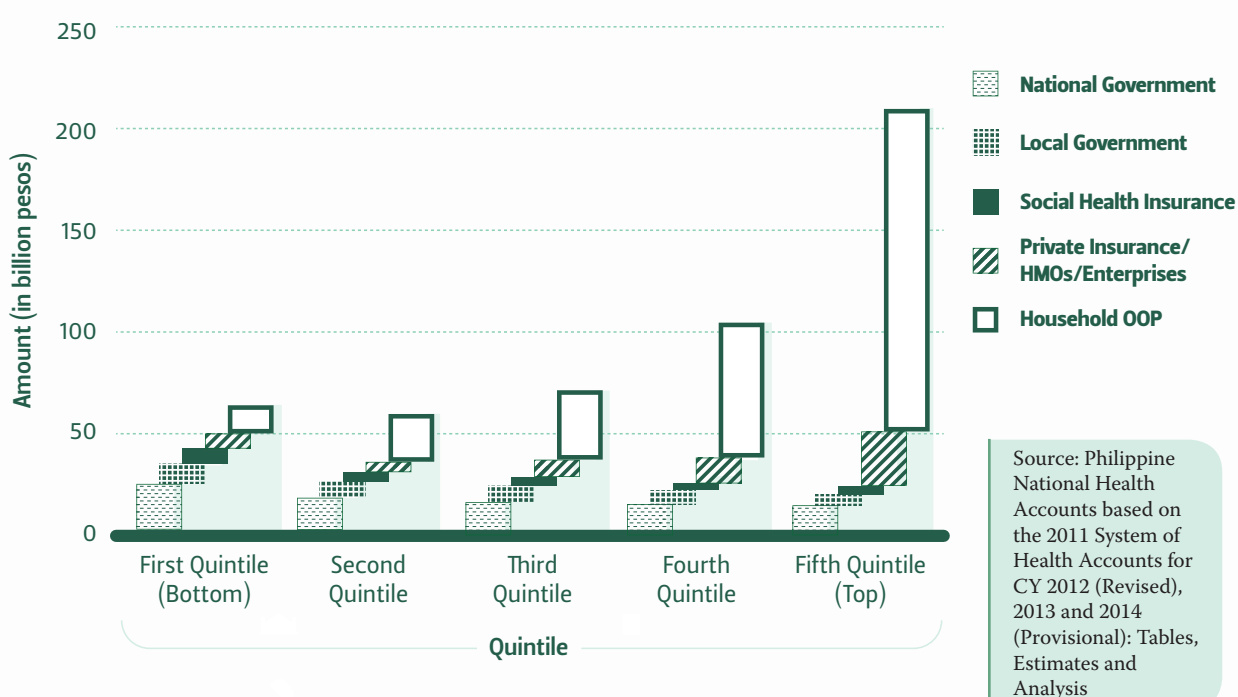
Figure 2.3 shows that the DOH budget nearly tripled from PhP27.4 billion in 2012 to PhP78.6 billion in 2016 but the DOH was not able to fully utilize these allocations. Including NHIP budget, the total DOH budget amounted to PhP122.6 billion in 2016, 51.2 percent of which was financed by sin tax revenues.

Figure 2.3. DOH Budget Allotment and Obligation, 2012-2016 (in billion pesos)



Government subsidies and social health insurance benefited the poor but remained inadequate. Significant portions of health expenditures of the first and second income quintiles (poorest and near-poor) in 2014 were paid for by government-based schemes – about 64 and 49 percent, respectively (Figure 2.4). Nonetheless, they continued to incur OOP payments, which accounted for about 21 and 40 percent of the total health spending of the first and second quintiles, respectively (Racelis et al., 2016).

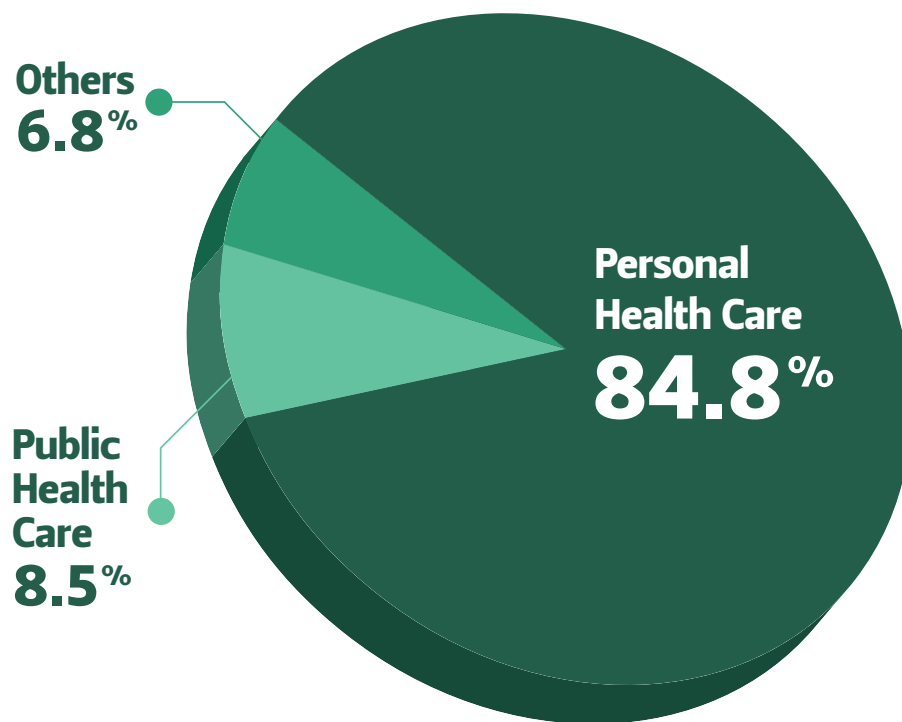
Figure 2.4. Current Health Expenditure by Income Quintile and Financing Scheme, 2014



## Uses of health funds

The bulk of total health expenditure went to personal healthcare, which consists largely of hospital-based and ambulatory curative care, pharmaceutical products and medical supplies as well as ancillary services. It steadily grew from PhP396.8 billion (84.2 percent) of total health expenditure in 2012 to PhP534.9 billion (84.8 percent) in 2016. Public healthcare expenditure, which includes promotive, preventive and primary care services, likewise grew from PhP41.5 billion to PhP53.3 billion but its share to total health expenditure dipped from 8.8 percent to 8.5 percent over the period (Figure 2.5).

Figure 2.5. Health Expenditure by Use of Funds, 2016



Source: PSA,  
Philippine National  
Health Accounts  
2014-2016

# CHALLENGES AND IMPLICATIONS

## Heavy reliance on out-of-pocket payments

Despite the nearly universal PhilHealth coverage rate of 91 percent (PhilHealth, 2016) or about 94 million of the country's population in 2016, OOP share in total health expenditures remains high. PhilHealth has implemented the no balance billing (NBB) or zero co-payment scheme for indigents, sponsored, senior citizen and lifetime member groups, but not all government health facilities designated to serve them can fully provide the medical supplies, commodities and services they need. This is often due to limited facility budget for operations. Hence, continuing reliance on outside purchases by patients persists. Moreover, PhilHealth benefit packages are not always sufficient to cover the full cost of healthcare. PhilHealth has set fixed reimbursements to limit its risk, with patients shouldering the remaining balance (except for Z-benefit package that has specified co-payment). This can be prohibitive as it is unpredictable owing to uncontrolled drug prices and unregulated user fees. PhilHealth support value stood only at 50 percent. Of the poor who filed claims, only 63 percent benefited from NBB in 2016<sup>7</sup> (PhilHealth, 2016). Without adequate financial protection, lower income groups are inclined to sacrifice prescribed medications or forego health provider visits entirely.

Analysis of the six rounds of the Family Income and Expenditure Survey (FIES) from 2000 to 2015 showed that the incidence of catastrophic spending<sup>8</sup> has more than doubled from 2.8 percent to 6.3 percent. The percentage of people impoverished by health spending also increased such that, by 2015, OOP spending on health added 1.4 percentage points to the incidence of poverty (when measured using the US\$3.10 per day poverty line), thus plunging more than 1.4 million into poverty that year (Bredenkamp, Gomez, & Bales, 2017). Meanwhile, higher income groups with capacity to pay tend to overutilize health services and spend on items considered 'not medically important', e.g. supplementary nutritionals (PIDS, 2013), which is evident in the significant increase in OOP spending as one moves up the income quintile. They also dip into government schemes and social health insurance, which could have otherwise been used to increase subsidies for the poor.

<sup>7</sup> Refers to those identified in the National Household Targeting Survey and PhilHealth Sponsored Program.

<sup>8</sup> Measured as the percentage of households whose health spending exceeds 10 percent of consumption.

## Fragmentation in health financing

The Philippine healthcare system is a mix of government tax-funded financing of DOH and LGU health facilities, PhilHealth premium-funded and tax-funded health insurance financing, small-pooled private prepayment schemes, and large unpooled financing comprised of OOP expenditure. Other institutions also provide additional subsidies and in-kind resources for health service provision, such as the Department of Social Welfare and Development (DSWD), Philippine National Police (PNP), Department of National Defense (DND), University of the Philippines (UP), Philippine Amusement and Gaming Corporation (PAGCOR) and the Philippine Charity Sweepstakes Office (PCSO) but their contributions are unpredictable and hence, not sustainable. Accountability in health financing has been ambiguous, with no defined mandate and arrangements on 'who pays for what'. This has resulted in gaming for resources by facility managers and program implementers, thus preventing rational resource allocation (Dayrit et al., 2018).

The DOH, for instance, is the main source of funds for public health or population-based health programs (e.g. malaria control, animal bite treatment/rabies prevention and control, HIV AIDS, TB control) but PhilHealth (through NHIP), other prepayment schemes, private sources and LGUs also finance certain primary care interventions including those falling under public health. The same is true with personal healthcare.

While PhilHealth serves as the national purchaser of health goods and services from public and private providers, the DOH still provides substantial subsidies to its hospitals, medical centers and specialty facilities. Subnational government units are also mandated to fund provincial, city and district hospitals. The absence of clear-cut policy on 'who pays for what' contributes to overlaps as well as inefficiencies in health financing. It also prevents PhilHealth from exercising its monopsony power to significantly influence reduction of health spending. Lodging health budgets in various central government agencies, corporations and independent accounts of LGUs (comprised of 1,489 municipalities, 81 provinces and 145 cities) likewise raises the transaction cost of accessing affordable healthcare due to the bureaucratic procedure in coordinating financing arrangements among various units.

## Limited financial coverage in health

Financial risk protection in health, especially for the poor, has been limited by challenges in PhilHealth premium payment collection and benefit utilization by PhilHealth members and dependents. PhilHealth has not fully maximized its potential revenues from premium payments. Enrolment in NHIP is mandated for all Filipinos and it is incumbent upon those neither employed in the formal sector nor indigent to actively enroll. Those who fail to enroll face no sanction (PhilHealth, 2014) – resulting either in missed premium collection in NHIP or added transactions cost for PhilHealth in finding and enrolling remaining uninsured population including difficult-to-capture segments such as the informal sector.

Moreover, premium payment based on income is not strictly enforced, especially among self-employed and those in the informal sector. In fact, most members from the informal sector pay the lowest rate regardless of income. The increase in premium payment over the years has also been marginal compared to the five percent provided by law.<sup>9</sup> The salary level at which the premium ceiling is reached is likewise set too low at PHP40,000. In terms of equity, the poor are not getting their substantial share of benefits from pooled PhilHealth resources, having received less (around 30 percent of all payments) than their membership share (50 percent) while the informal sector, which constitutes low- to high-income groups, receives greater share of claims payment (20 percent) than its membership share (9 percent) (Bredenkamp, Gomez, & Bales, 2017).

Availment of NHIP benefits has been low. One factor contributing to this is the low awareness of members, especially automatically enrolled indigents and senior citizens, on their health insurance entitlements. While 75 percent<sup>10</sup> of the poor know about NBB, only a minority know that their PhilHealth coverage includes free primary care consultation (Bradenkamp et al., 2017). Others are constrained by geographic as well as supply-side barriers in accessing healthcare. Based on 2016 Stats & Charts of PhilHealth, not all LGUs have accredited health facilities for outpatient, maternity care and TB DOTS benefit packages. This limits the access of NHIP members in those areas. Meanwhile, accredited facilities have raised concerns on operational constraints in implementing NBB (e.g. prescribed drugs not in the Philippine National Drug Formulary or PNDF hence, cannot be covered by NBB; and case rates not sufficient to fully cover the cost of selected medical procedures; limited outpatient benefits especially on drugs), delays in PhilHealth reimbursements and lack of guidelines to ensure use of reimbursements for facility operations.

9 Based on the initial outputs of the strategic planning activities of PhilHealth on its Medium Term Plan 2017-2022, as presented by Jake de Claro in the Consultative Workshop on NOH 2017-2022: Financing Pillar on June 28, 2018.

10 Based on a study conducted by World Bank and UPecon Foundation which used panel of household survey data (2011 and 2015).



## Low absorptive capacity of DOH

Significant increases in the DOH budget do not necessarily translate to significant gains in health outcomes, especially when a significant portion of the budget is left unspent.

The DOH was able to use only 85 percent of its budget in 2016 which lagged far behind the NOH 2011-2016 target of 100 percent for the year. Big budgetary infusion carries with it expanded scope of work and greater program coverage, which has overwhelmed the DOH system as it has to rely on a limited number of personnel (due to unfilled and reduced plantilla positions resulting from the DOH Rationalization Plan) and existing resources (e.g. warehouses for drugs, and health facilities) to effectively use the funds. It also faces procurement difficulties common among key agencies. On the supply side, these include delays in technical specifications and evaluation of bids as well as weak technical and management capacity of implementing agencies. On the demand side, these involve limited number of qualified bidders (Monsod, 2016). In some instances, reduced budget utilization results from changes in the procurement entity (e.g. transfer of drug procurement from the DOH Central Office to PITC Pharma Inc., which further delayed procurement), or from savings such as in the case of procurement of medicines at a lower price (e.g. Complete Treatment Packs).

Aggravating the low absorptive capacity of the DOH is the continuing delivery of healthcare under different bureaucratic and political units with complex interwoven mandates, which hampers disciplined spending of funds. While basic health services, for instance, were already devolved to LGUs, the DOH continues to augment, and sometimes even crowd out, LGU resources for health as it supports human resource deployment, facility enhancement and health commodity distribution to improve healthcare delivery. Implementation of health programs vertically and in silos also prevents rational investment programming, which could have consolidated interventions towards high-impact programs that could have prevented catastrophic illnesses.



# OBJECTIVES AND TARGETS

*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*

**Revenues from NHIP and innovative taxes.** The revenue base will be expanded to include not only regular government allocations for health through the General Appropriations Act (GAA) but also higher NHIP premium collection and earmarked funds from innovative taxes as well, such as sin taxes. PhilHealth will sustain initiatives (e.g. Point of Service or POS and Point of Care or POC) to capture those who are not yet enrolled in NHIP, thereby expanding the revenue base. It will engage a third party for the efficient administration of premium collection and will pursue innovations to expedite access to online NHIP services. NHIP premium payment will also be increased across membership categories to the maximum five percent level prescribed by law, and the possibility of eliminating NHIP premium ceiling will be reviewed. Moreover, the progressivity of premium rates for the formal sector will be ensured to allow cross-subsidy from the rich to the poor and from the healthy to the sick, with add-on benefits for those willing to pay higher premium. This will be done with regular PhilHealth review and adjustment of premium rates to ensure viable and sustained benefit payment package.

**Fiscal autonomy of government-owned health facilities.** The DOH will support the transition of all government hospitals at national and local levels into fiscally autonomous units that can provide quality care for all, especially the poor, even without heavy central office subsidies. Policies on hospital income-retention will have to be reviewed and government facility financial performance (i.e. revenue and expenditure) will be assessed. The DOH will develop facility performance benchmarks to facilitate assessment of overall hospital efficiency in providing and sustaining care. Technical assistance will likewise be provided to capacitate concerned personnel on hospital management and accounting, including costing of health services, design of socialized user fees, computation of quantified free service, and monitoring of hospital operations including financial status.

PhilHealth policies on case rates and reimbursement will be reviewed to ensure that facility reimbursements are proportionate to the full cost of medical procedures and services performed, taking into account the higher cost of operations in higher level facilities. Inclusions in the PNDF will also be reviewed to reduce, if not eliminate, OOP payments on commonly prescribed drugs not in the current formulary.

***Government and private sector complementation in health insurance coverage.*** Financial coverage from HMOs and private health insurance shall complement the NHIP. Implementing this strategy requires research and multi-stakeholder dialogues on the specific health services that the DOH, PhilHealth, private health insurance and HMOs will be exclusively covering to avoid overlapping subsidies (e.g. DOH to fund public health or population-based programs and activities, and PhilHealth as well as HMOs to cover personal or individual-based care).

Further studies will be conducted to explore the feasibility of having HMOs provide “first peso” coverage on medical cases up to a maximum amount payable to providers. Results of the studies will be used as technical basis of discussions with PhilHealth, HMOs, private insurers and other concerned stakeholders on the optimal complementation of NHIP and the appropriate provider payment mechanism that will be most effective in Philippine setting.

### *Specific Objective 2. Health spending rationalized*

***Financing for population-based and individual-based health interventions.*** Funding for these two major categories of interventions will be clearly delineated to reduce overlaps in health financing. Population-based interventions will be financed through line item budgetary sources (national and local), while personal insurable health interventions through the NHIP. The DOH will conduct dialogues with PhilHealth, private health insurance, HMOs and other concerned agencies, units and institutions to agree on the funding sources for population-based (usually public health-related) as well as personal health (particularly secondary and tertiary care) interventions. Consolidating all individual-based or personal health interventions under PhilHealth poses huge implications on the budget and operations of the DOH and hospitals. Hence, extensive discussions with health providers, PhilHealth and other concerned units will be pursued to ensure timely PhilHealth reimbursements and determine viable options for the eventual conversion of hospitals into financially autonomous health facilities.

***Consolidation of government funds for health into a single pool.***

Budgets of various national government agencies such as PCSO, PAGCOR and DSWD for medical assistance to indigents and vulnerable groups will be consolidated into a single fund to facilitate easier access of subsidies by the poor. The DOH and concerned agencies will explore arrangements that will simplify the cumbersome bureaucratic procedures encountered by patients and their relatives when soliciting financial support for health. One-stop-shops for the different funding sources will be established in PhilHealth-accredited health providers to streamline and expedite availment of financial support by indigent patients. This virtual pooling of health funds from different agencies will be an interim measure towards a long-term solution of creating a single pool of funds through PhilHealth, which makes it the single purchaser for individual-based health goods and services.

***Fixed co-payment for selected health packages.*** PhilHealth will set fixed co-payments for its non-indigent members.<sup>11</sup> A fixed co-pay scheme will help regulate the maximum amount of OOP for each confinement to shield patients from unwarranted fees charged by hospitals. This will also help the patients anticipate and prepare for their hospital bill. The DOH, together with PhilHealth and concerned stakeholders, will also identify the minimum guaranteed package per life stage, negotiate on setting fixed co-payments for selected health packages, and review the adequacy of the case rate system to ensure that NBB hospitals, which shoulder expenses in excess of the case rate, will not be overburdened with quantified free service.

PhilHealth has been gearing towards adopting the Diagnostic-Related Groups (DRGs)<sup>12</sup> as a primary mode of paying its healthcare providers. Under DRGs, providers are reimbursed at a fixed rate per discharge based on diagnosis, treatment and type of discharge. Therefore, DRGs have a strong incentive for cost containment (WHO, 2007). Given this direction, there is a need to assess the readiness of health facilities, providers and PhilHealth to undertake this payment scheme, and conduct activities pre-requisite to DRG implementation (e.g. strengthening of database through improvement of clinical data and costing information).

***Multi-year budget for priority health programs.*** A multi-year budget scheme will be developed to support selected priority programs that require long-term financing. Multi-year budgeting in health ensures predictable and sustained funding needed for medium- to long-term strategic interventions to bear fruit. To support this, the DOH, PhilHealth and concerned agencies will identify strategic programs and projects with long period of implementation, e.g. health facility construction, implementation research, behavioral interventions, and secure Multi-Year Obligational Authority (MYOA) for these from DBM before entering into multi-year contracts (MYC). Multi-year revenues and expenditures will also have to be projected to guide the annual budgeting as well as the development of medium-term public investment programs on health.

11 Fixed co-pay is defined as a negotiated fixed amount for quality care that may be charged by the contracted hospitals and approved by PhilHealth. Fixed co-pay consists of additional services other than those in the package or are not necessarily in the minimum standards of management of the condition (PhilHealth, 2012).

12 This scheme classifies patients into groups economically and medically similar, expected to have comparable hospital resource use and costs.

### *Specific Objective 3. Financial resources focused towards high impact interventions*

**Identification of priority health programs.** A unified, transparent and explicit process of identifying programs to be funded by the DOH, LGUs and PhilHealth will be institutionalized, with focus on basic and essential primary care, health programs targeted to the poor, marginalized and vulnerable, and programs contributing to the attainment of SDGs, PDP and *Ambisyon Natin 2040*. Technical discussions will be convened with concerned stakeholders in reviewing gray areas in the classification and funding of population-based and individual-based programs and interventions (including those in SDGs and PDP). Budget allocation for strategic and high impact health programs may also be influenced through DBM budget guidelines, which may encourage the inclusion of NOH-related programs, activities and projects in the plans and budgets of national government agencies and LGUs.

**Link between financing of health services and performance.** The financing and payment of health services will be linked to performance that is based on good quality services and better health outcomes. For LGUs, this will be done through the Local Investment Plan for Health (LIPH). In addition, health performance benchmarks of the DOH, hospitals, LGUs, PhilHealth, other related agencies and units will also be reviewed and aligned to PDP, SDG and NOH goals and targets through their health scorecards. Key performance indicators on the implementation of the NHIP, especially in terms of coverage and utilization, will be considered in performance incentive schemes of the government such as in the Performance-Based Bonus (PBB) of the DBM and the Performance Governance System of the DOH.

**Table 2.2. National Objectives for Health 2017-2022  
Financing Indicators**

**General Objective 1:** Sustainable investments for health secured, efficiently used and equitably allocated for improved health outcomes

Indicator	Data Source	Baseline	2022 Target
<i>Specific objective 1. More resources for health efficiently mobilized and equitably distributed</i>			
Indicator 11: Domestic general government health expenditure as percentage of GDP	PSA-PNHA	1.6% (2016)	2.5%
Indicator 12: Domestic general government health expenditure per capita	PSA-PNHA	PhP 2,258 per person (2016)	PhP 4,674 per person
Indicator 13: Social health insurance as percentage of THE*	PSA- PNHA	16.7% (2016)	30%
Indicator 14: Government financing (national and local) as percentage of THE*	PSA- PNHA	18.9% (2016)	20%
<i>Specific objective 2. Health spending rationalized</i>			
Indicator 15: Percentage of NBB-eligible patients with zero co-payment	PhilHealth	63% (2016)	100%
<i>Specific objective 3. Financial resources focused towards high-impact interventions</i>			
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	

\* Total health expenditure (THE) includes both current health expenditure (CHE) and capital formation.



# Chapter 3



**SERVICE  
DELIVERY:  
WIDER ACCESS  
TO ESSENTIAL  
HEALTH CARE**





# BACKGROUND

## Components of health service delivery

Provision of essential health care underscores people-centered and integrated delivery of quality and affordable health services at appropriate levels of care. Service delivery encompasses access to quality essential health products and services, quality health facilities, capable human resources for health (HRH) and functional service delivery networks (SDNs), which link all these elements to expand access to comprehensive care.

Essential health service packages refer to the minimum package of clinical and public health interventions, including the: (1) provision of family health care, which offers a continuum of interventions across the life-course to ensure health and well-being at various stages in life; (2) prevention and control of communicable and non-communicable diseases, which intend to reduce premature morbidities and mortalities through activities aimed at managing public health threats and promoting as well as strengthening preventive care; and (3) access to quality health products and medicines, which looks at the affordability of essential drugs and their availability at service delivery points.

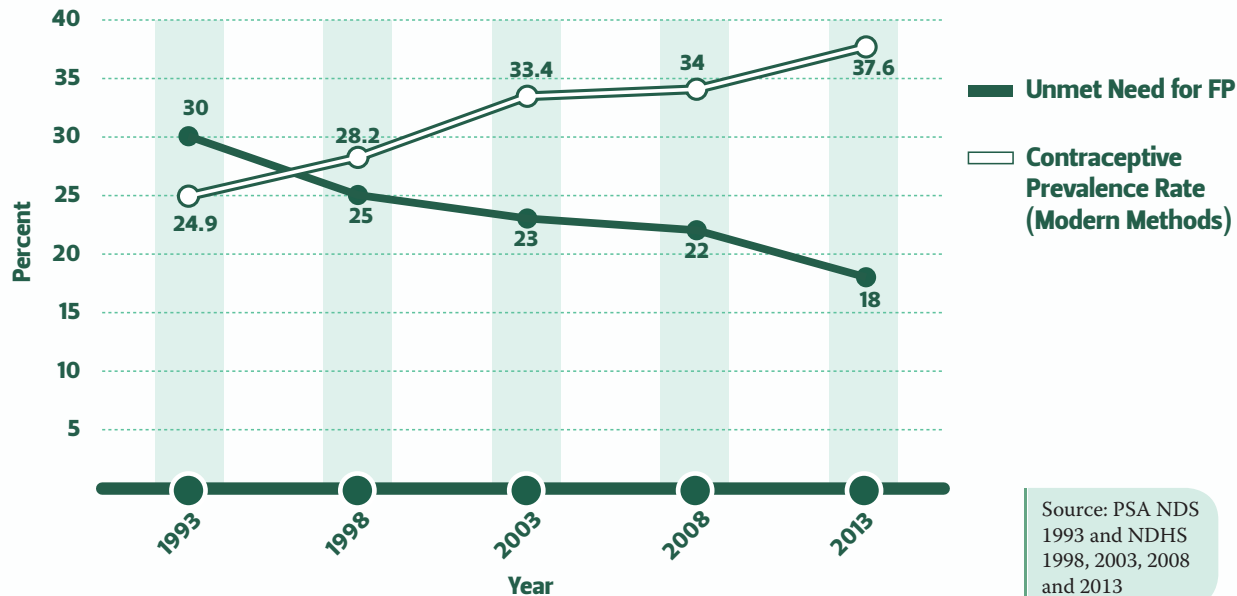
Access to quality health facilities looks at the adequacy of the different levels of healthcare facilities considering population size and distribution. Related to this is access to capable HRH, which looks at the sufficiency, production, quality and distribution of RHU/health center physicians, public health nurses, rural health midwives and dentists, among other health professionals. The SDN provides the platform for interlinking health products and services, health facilities and HRH.

## Essential health service packages

### Family health

**Maternal health.** The National Demographic and Health Survey (NDHS) shows that modern contraceptive prevalence rate (mCPR) among currently married women increased from 24.9 percent in 1993 to 37.6 in 2013 (Fig. 3.1). While DOH administrative data indicated a continuous rise in modern CPR level from 41.1 percent in 2014 to 45.1 percent in 2016 (DOH and POPCOM, 2017), the latter still fell short of the 65 percent-target in NOH 2011-2016. The mCPR among all women aged 15-49 years old is even lower at 23.5 percent in 2013. The Responsible Parenthood and Reproductive Health Care Act of 2012 is considered a landmark legislation in advancing reproductive health rights. However, the temporary restraining order issued by the Supreme Court on contraceptives in 2015 hampered its initial implementation and might have been partly responsible for lower than expected improvements in CPR.

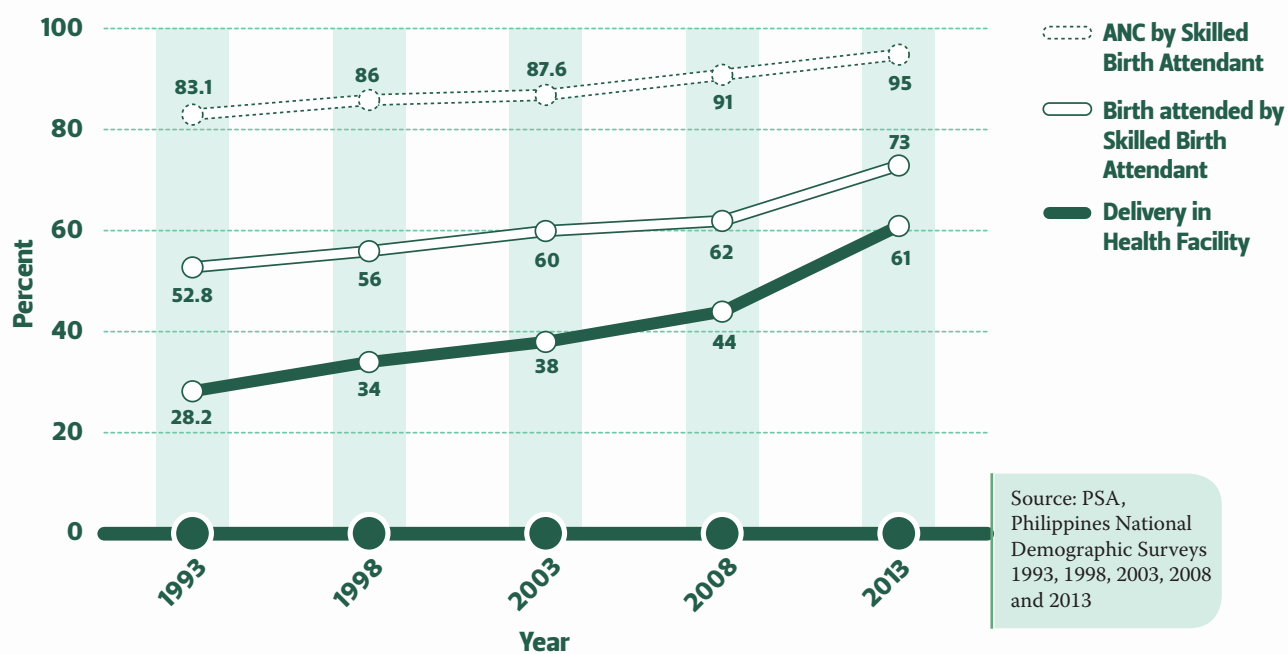
Figure 3.1. Unmet FP Need and Modern CPR among Currently Married Women, 1993-2013



Unmet need for family planning (FP) went down from 30 percent in 1993 to 18 percent in 2013 but its rate of decline slowed down from 1998-2008 (PSA and USAID, 2014). The 1.5 million modern FP acceptors computed by the DOH in 2016 covered only 16 percent of the estimated 9.5 million women with unmet need for modern FP method for the year (DOH and POPCOM, 2017).

Meanwhile, maternity care services improved from 1993 to 2013 with the increase in antenatal care (ANC), health facility delivery and skilled birth attendance (Figure 3.2). According to the 2013 NDHS, more than nine in ten Filipino pregnant women received some ANC from a trained health professional – 39 percent from a doctor and 57 percent from a nurse or midwife. While there is high percentage of pregnant women availing of ANC, only 61 percent deliver in a health facility. Facility births are most common among women having their first child (76 percent), and those who have made at least four ANC visits (71 percent). While three in four births (73 percent) are assisted by a trained health provider (doctor, nurse or midwife), four in 10 Filipino births are still occurring at home.

Figure 3.2. Utilization of Maternal Health Services, 1993-2013



MMR decreased from 126 per 100,000 live births in 2012 to 114 per 100,000 live births in 2015 when utilization of health services sharply increased. Mothers died mostly of conditions that were highly preventable with quality obstetric care such as eclampsia, gestational hypertension, abnormality of forces of labor, postpartum hemorrhage and complications of the puerperium (PSA, 2016c).

**Neonatal and infant health.** One-fourth of pregnant women were nutritionally at-risk of delivering low birth weight (LBW)<sup>13</sup> babies in 2011, 2013 and 2015. LBW proportions among children 0 to 3.9 years old increased to 14.4 percent in 2015, similar to the 2008 level of 14.2 percent, after declining to 11.5 percent in 2013 (FNRI-DOST, 2016). Coverage of fully immunized children (FIC) went down from 72.8 percent in 1993 to 67.6 percent in 2013 (NSO and MI, 1994; PSA and USAID, 2014). Left unchecked, the diminishing immunization coverage can increase the risk of outbreaks and re-emergence of fatal infectious diseases.

Neonatal mortality rate (NMR) declined from 18 per 1,000 live births in 1993 to 13 per 1,000 live births in 2013. Infant mortality rate (IMR) likewise decreased from 34 per 1,000 live births to 23 per 1,000 live births over the period (NSO and MI, 1994; PSA and USAID, 2014). These declining trends, however, were still insufficient to meet the MDG and NOH 2011-2016 targets of 10 per 1,000 for NMR and 17 per 1,000 for IMR (Villaverde, M., Gepte, A. and Baquiran, R, 2016).

**Child health.** NDHS showed no improvement in the percentage of children 12-23 months who were fully immunized (i.e. they received basic vaccinations: BCG, measles and three doses each of DPT, polio and Hepa-B) during the first year of life as it remained unchanged at 62 percent from 1993 to 2013. Under-five mortality rate decreased from 54 per 1,000 live births in 1993 to 31 per 1,000 live births in 2013 but such rate of decline was not enough to meet the MDG and the NOH 2011-2016 target of 25.5 per 1,000 live births. Stunting among children under-5 years remained high at 33.4 percent in 2015, which is almost the same as the 2005 level of 33.1 percent. The prevalence of diarrhea for this age group declined from 10 percent to 8 percent over the same period (NSO and MI, 1994; PSA and USAID, 2014). With regard to oral health, WHO reported that the mean number of decayed, missing and filled teeth (DMFT) among Filipino children aged 12 years old in 2011 was 3.3, higher than the Western Pacific regional mean average of 1.74. Such poor performance in oral health stems from the lack of public health dentists who can provide services in government facilities (Dayrit, et al., 2018).

**Adolescent health.** Teen pregnancy is a major concern in adolescent health. In 1993, only 6.5 percent of women aged 15-19 years at the time of the survey have begun childbearing. This rate steadily increased over the years to 10 percent in 2013, with 8 percent already mothers and 2 percent pregnant with their first child (NSO and MI, 1994; PSA and USAID, 2014). In terms of malnutrition, stunting among adolescents decreased from 35.3 percent in 2005 to 31.9 percent in 2015 but remained high over the years nonetheless, indicating chronic malnutrition in the country. Meanwhile, obesity among this group increased sharply from 6.1 percent to 9.2 percent over the period (FNRI-DOST, 2016). Adolescent mortality rate from injuries, particularly for the age group 10-14 years, was also on the rise as it steadily increased from 9.8 percent in 2009 to 10.3 percent in 2013, based on the Philippine Health Statistics.

<sup>13</sup> Defined by WHO as infants with birth weight less than 2,500 g

**Adult health.** Table 3.1 shows the leading causes of death among adult males and females aged 15-59 years old in 2016. The top causes are almost the same for both sexes except for ‘assault,’ which manifested only in males, and ‘remainder of diseases of the genitourinary system’ which appeared only in females. The Philippines Health Statistics 2013 reported that the mortality trend among adult men was gradually declining and projected to decrease further in succeeding years. In contrast, mortality rates for adult women presented a different picture with mortality trend on the uptrend and projected to increase in subsequent years.

**Table 3.1. Leading Causes of Death By Sex – Philippines, 2016**

Adult Males			Adult Females		
Leading Causes of Death	Number of Deaths	Deaths per 100,000 adult males	Leading Causes of Death	Number of Deaths	Deaths per 100,000 adult females
Ischaemic heart diseases	44,472	142	Neoplasms	30,954	101
Cerebrovascular diseases	31,675	101	Ischaemic heart diseases	29,662	97
Neoplasms	29,516	94	Pneumonia	28,816	94
Pneumonia	28,993	92	Cerebrovascular diseases	25,263	83
Hypertensive diseases	17,901	57	Diabetes Mellitus	16,911	55
Respiratory tuberculosis	17,288	55	Hypertensive diseases	15,551	51
Chronic lower respiratory infections	17,049	54	Other heart diseases	13,649	45
Diabetes Mellitus	16,384	52	Remainder of diseases of the genitourinary system	7,981	26
Other heart diseases	14,992	48	Chronic lower respiratory infections	7,316	24
Assault	13,662	44	Respiratory tuberculosis	7,174	24

*Note: Adult population covers 15-59 year old individuals*

Source: Authors’ calculation using PSA 2016b, 2016c, 2017c and 2018a Table 5 on Household Population by Age Group, Sex and Region, 2015

**Elderly health.** Most fatalities (46.3 percent or 61,558 deaths) from diseases of the heart were among the elderly belonging to 70 years old and over. More women than men in this age group die from heart diseases (DOH-EB, n.d.). Old age can also predispose a person to accidents and injuries that could result to impairments, disabilities or premature deaths. The DOH provided influenza and pneumococcal vaccines for the elderly and referred those needing palliative and hospice care to appropriate health facilities (Villaverde, M., Gepte, A. and Baquiran, R, 2016). Republic Act 10645 or the “Expanded Senior Citizens Act of 2010” became a landmark legislation for improving healthcare for the elderly as it provided all senior citizens – not just the indigent seniors – with mandatory health insurance. Their premium contributions are sourced from sin tax revenues.

**Environmental and occupational health**

**Safe water and sanitation.** Ninety-six percent of Filipino households had an improved source of drinking water. Use of bottled water was not recognized by DOH as improved source of drinking water unlike level 1 (tube wells, dug wells, spring and rainwater), level 2 (public tap), and level 3 (piped into dwelling) water systems. Dependence on bottled water may mean low confidence on level 1, 2 and 3 water systems. Drinking water sources of about 57 percent of the population had not been subjected to water treatment processes (PSA and USAID, 2014), which exposed this population to higher risk of infection. Only twenty-five percent of the households have a safely-managed basic drinking water services that meet the following criteria: located inside the household or within its premises, available 24/7, and free of faecal contamination. In terms of sanitation, ninety-two percent of households had sanitary toilet facilities. However, connections of these household toilet facilities to appropriate sewerage system remain largely inadequate especially in rural and urban poor communities. Only six percent of the households are using safely-managed sanitation services that meet the following criteria: sanitation facility is not shared with other households and excreta is safely-disposed in situ or excreta is contained, transported and treated off-site.

**Air quality.** With the help of the Clean Air Act of 1999 which adopted the principle “polluters must pay”, the Department of Environment and Natural Resources (DENR), Land Transportation Office (LTO) and LGUs were able to penalize air polluters including industries, small businesses and motorists driving smoke-belching vehicles. Air quality slightly improved with the reduction in total suspended particulate (TSP) from 166 micrograms per cubic meter ( $\mu\text{g}/\text{Ncm}$ ) in 2010 to 120  $\mu\text{g}/\text{Ncm}$  in 2015, although this is still 30  $\mu\text{g}/\text{Ncm}$  above the standard safe level of 90  $\mu\text{g}/\text{Ncm}$  (DENR, 2015). Efforts on reducing air pollution are undermined by the high volume of vehicles. LTO reported that there were nearly eight million vehicles in Metro Manila alone, which contributed to a staggering 80 percent of the total cause of air pollution.

**Occupational health.** Occupational injuries showed a slight uptick in 2015, increasing by 3.8 percent from 49,118 in 2013 to 50,961. Across industries, manufacturing accounted for the highest shares of total occupational injuries, which also increased from 48.1 percent (23,641) to 50.4 percent (25,667) over the period. This was followed by wholesale and retail trade; repair of motor vehicles and motorcycles, which posted a decrease from 11.4 percent in 2015 to 11.7 percent in 2013 (PSA, 2017e).



## Prevention and control of communicable diseases

**Tuberculosis.** The National Tuberculosis Prevalence Survey (NTPS) 2016 estimated the prevalence of smear-positive and bacteriologically confirmed pulmonary TB in those 15 years or older at 434 per 100,000 and 1,159 per 100,000, respectively. The burden of TB remained high with 760,000 Filipinos (15 years and above) estimated to have pulmonary TB.

**HIV/AIDS.** There were already 39,622 HIV Ab sero-positive cases reported to the HIV/AIDS and ART Registry of the Philippines (HARP) from January 1984 (when the first AIDS case was reported) to December 2016 (Table 3.2). The age group with the biggest proportion of cases became younger, shifting from 35-49 years between 2001-2005 to 25-34 years beginning 2016. While the Philippines remains to be a low-HIV prevalence country, it has one of the fastest growing number of cases in Asia and the Pacific with the number of newly diagnosed with HIV per day increasing sharply from 1 in 2008 to 26 in 2016. There were 524 patients who started on anti-retroviral therapy (ART) in 2016 (DOH-EB, 2016a).

**Table 3.2. Newly Diagnosed HIV Cases in the Philippines**

Demographic Data	Jan-Dec 2016	Cumulative Jan 1984-Dec 2016
Total Reported Cases	9,264	39,622
Asymptomatic Cases	8,151	35,957
AIDS Cases	1,113	3,665
Male <sup>a</sup>	8,874	36,801
Female <sup>a</sup>	390	2,810
Total PLHIV on ART	524	17,940
Reported Deaths	439	1,969

*a* No data available on sex for 11 cases

Source: DOH Epidemiology Bureau, HIV/AIDS and ART Registry of the Philippines

**Dengue.** Dengue is another communicable disease that started with low incidence of less than one case per 100,000 population from 2006 to 2009. It peaked at 2.2 per 100,000 in 2013 but dipped to 1.3 per 100,000 in 2015. Case fatality rate for dengue showed a decreasing trend from 1.0 percent in 2006 to 0.3 percent in 2015 (Villaverde, M., Gepte, A. and Baquiran, R, 2016). The DOH reported a total of 126,386 suspect dengue cases in 2016, with most (39 percent) of the cases belonging to the 5 to 14 year-old group (DOH-EB, 2016b).

**Pneumonia.** Pneumonia is a public health threat that figured consistently in the top five leading causes of mortality in the past ten years. Most affected were children and the elderly. Pneumonia cases and death rates went up from 667.7 per 100,000 population in 2009 to 762.5 per 100,000 in 2013 (with fluctuations between years), and from 46.2 per 100,000 to 54.2 per 100,000, respectively, over the period (DOH, 2016a).

### Elimination of endemic diseases as public health threats

The DOH also targeted to eliminate malaria, filariasis, schistosomiasis, leprosy and rabies as public health threats in the Philippines. NOH 2016 elimination targets for filariasis and rabies were already attained even before 2016 but government initiatives to prevent their resurgence need to be sustained. The number of malaria-free provinces went up from 27 in 2012 to 32 in 2016 but the latter was still below the NOH 2016 target of 40 provinces. Forty-one provinces were on elimination status while the other nine remained as malaria-endemic areas in 2016 (DOH-EB, 2016c). Schistosomiasis prevalence rate sharply declined from 5.9 percent in 2010 to 2.7 percent in 2011 and 1.4 percent in 2014. Despite this and the increasing coverage in mass treatment of exposed population, there were no additional provinces reported in the last five years that reached the elimination level of less than one percent prevalence rate (Figure 3.3). Leprosy prevalence rates declined from 0.88 per 10,000 population in 2008 to 0.22 cases per 10,000 in 2013 but rose sharply to 0.4 per 10,000 population in 2014 possibly owing to the decline in case detection rate and treatment completion rate. Monitoring the resurgence of this disease remains a challenge owing to weaknesses in leprosy surveillance (Villaverde, et.al., 2016).

### Prevention and control of emerging and reemerging infectious diseases

High population mobility (mainly due to travel or tourism and economic activities), climate change, rapid urbanization and weak surveillance systems make the Philippines susceptible to the threats of emerging and reemerging diseases. The DOH developed Preparedness and Response Plans for the prevention and control of such diseases such as the Middle East Respiratory Syndrome-coronavirus (MERS-CoV) – a viral respiratory infection known as camel flu, and the Ebola Virus Disease from Africa, which causes severe and often fatal hemorrhagic fever in humans and mammals.

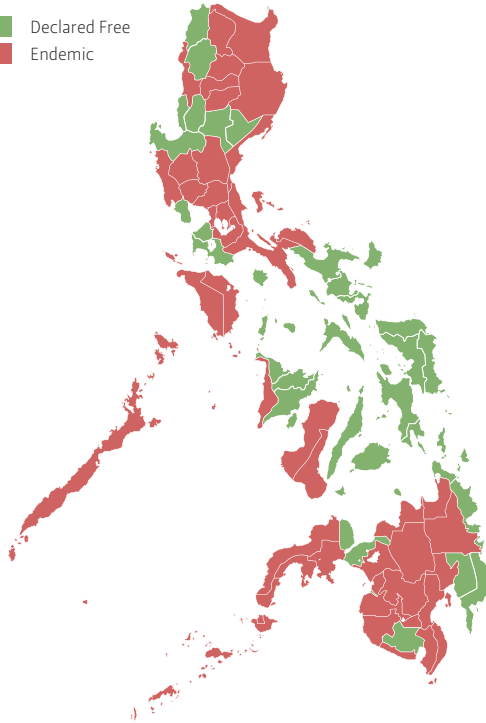
Interim guidelines were developed to: (1) ensure inter-agency coordination on the prevention or minimization of entry and spread of the disease; (2) provide procedures for isolation, case management and infection control; (3) establish disease surveillance and reporting; (4) ensure health security of overseas Filipino workers (OFWs) in affected countries; (5) ensure the health security of Filipino UN peacekeepers; and (6) conduct risk assessment for the disease in the deployment of OFWs (Suy, L, n.d.). The DOH likewise prepared guidelines for the clinical management of Zika Virus Infection, a mosquito-borne disease caused by flavivirus which can lead to neonatal malformation and neurological type of complication, i.e. Guillain-Barre's syndrome which is the sudden weakening of muscles.



Figure 3.3. Malaria, Filariasis and Schistosomiasis Endemicity Map – Philippines, 2017

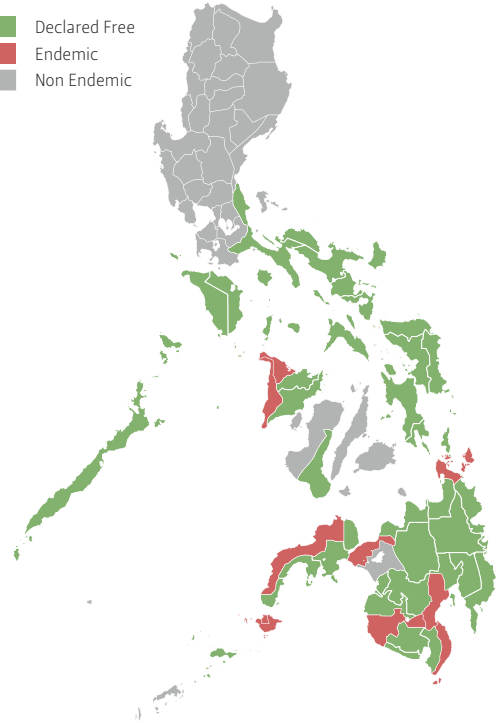
Malaria 2017

■ Declared Free  
■ Endemic



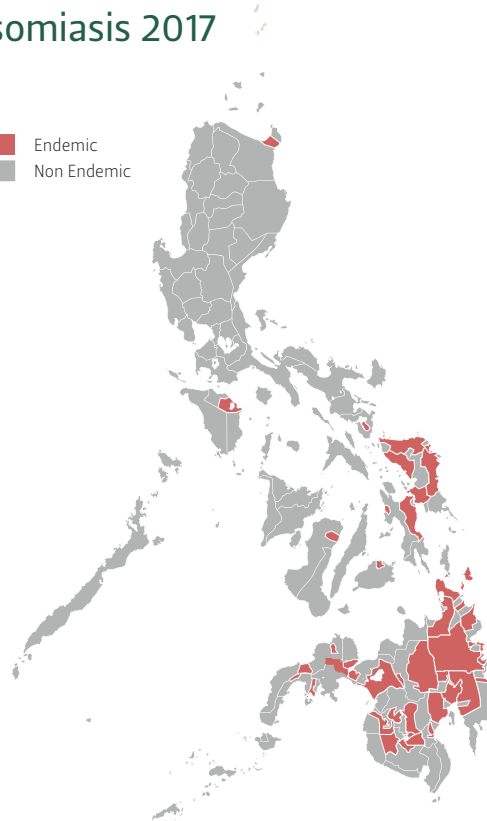
Filariasis 2017

■ Declared Free  
■ Endemic  
■ Non Endemic



Schistosomiasis 2017

■ Endemic  
■ Non Endemic



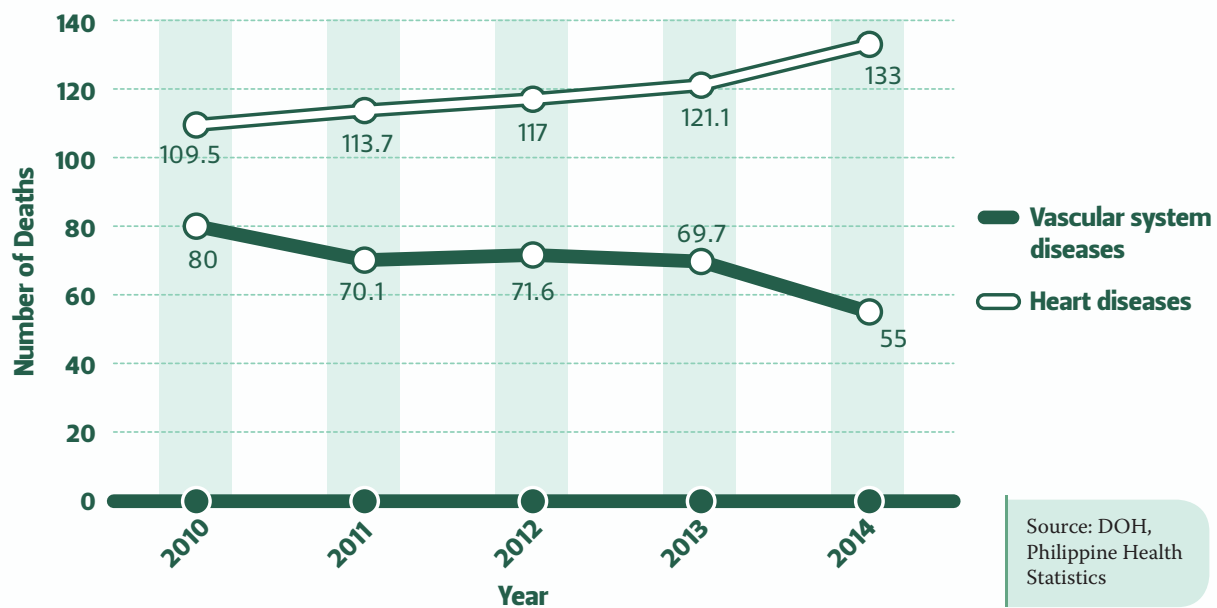
Source:  
DOH - Disease  
Prevention and  
Control Bureau

## Prevention and control of non-communicable diseases

Lifestyle-related non-communicable diseases (LRNCD) are diseases with common risk factors largely associated to unhealthy lifestyle such as unhealthy diet (i.e. high consumption of fats, sugar, salt and cholesterol), smoking, obesity and high blood pressure. Eight of the top 10 leading causes of mortality in the Philippines in 2016 were LRNCD – ischemic heart disease, neoplasms or cancers, cerebrovascular diseases, hypertensive diseases, diabetes mellitus, other heart diseases, chronic lower respiratory tract infections and remainder of diseases of the genitourinary system. Collectively, they accounted for 82 percent of reported deaths from the top 10 leading causes of mortality in the country.

**Cardiovascular diseases.** Based on the five-year trend drawn from recent Philippine Health Statistics, mortality rate for heart diseases steadily went up from 109.5 deaths per 100,000 population in 2010 to 133 deaths per 100,000 population in 2014, with sharp increase noted in the latter year. Mortality rate for vascular system diseases, on the other hand, gradually declined from 2010 to 2013, then dipped to 55 deaths per 100,000 population in 2014 (Fig. 3.4).

Figure 3.4. Mortality Rate for Vascular System Diseases and Heart Diseases - Philippines, 2010-2014 (per 100,000 population)



**Cancer.** Cancer was the second leading cause of death in the Philippines in 2016. Average mortality rate for this disease over the five-year period (2010-2014) was considered high at 53.7 deaths per 100,000 population (Fig. 3.4). PSA Vital Statistics Report identified the following as top five common types of cancer in 2011-2013: (1) trachea, bronchus and lung cancer, (2) breast cancer, (3) colon cancer, (4) leukemia and (5) prostate cancer. According to the Philippine Obstetrical and Gynecological Society, the Philippines topped 197 countries with the most number of cases of breast cancer in 2016.

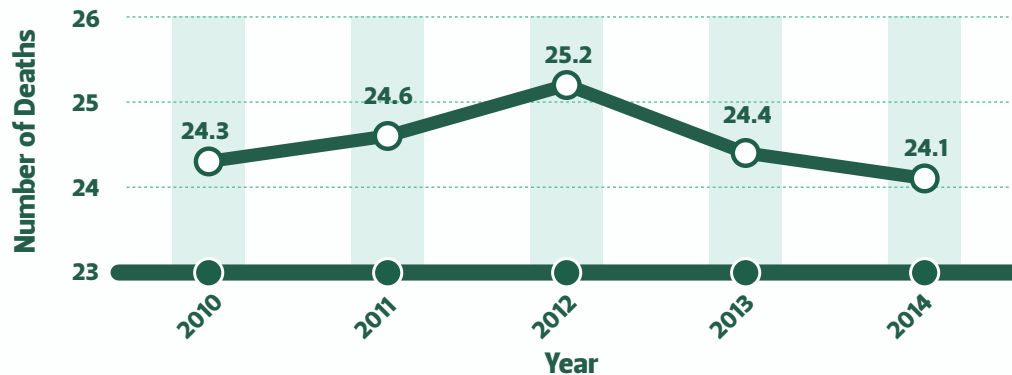
**Diabetes.** Mortality rate for diabetes has been on the rise, even accelerating from 23.8 deaths per 100,000 population in 2012 to 30.7 deaths per 100,000 population in 2014 (Fig. 3.5). Uncontrolled diabetes leads to serious complications such as stroke, heart attack, end-stage kidney disease and diabetic retinopathy, among others.

Figure 3.5. Mortality Rate for Diabetes, 2010-2014 (per 100,000 population)



**Chronic respiratory diseases (CRDs).** These diseases include asthma and other chronic obstructive pulmonary diseases (COPDs) like chronic bronchitis and emphysema. They are attributed to risk factors such as environmental pollutants like smoke (tobacco smoke as the single most important), allergens and noxious fumes. Other factors that may exacerbate the disease include emotional stress, fatigue, extreme temperature and humidity changes, infections, endocrine changes and genetic predisposition. COPD, a disease closely linked with tobacco use, remains one of the leading causes of respiratory diseases in the country (Villaverde et al., 2012). Mortality rate from this disease tapered to 24.1 deaths per 100,000 population after it increased from 24.3 deaths per 100,000 population in 2010 to 25.2 deaths per 100,000 population in 2012 (Figure 3.6).

Figure 3.6. Mortality Rate for Chronic Respiratory Diseases, 2010-2014 (per 100,000 population)



Source: DOH, Philippine Health Statistics

**Accidents.** PSA reported accidents as the fifth leading cause of mortality in the Philippines in 2014. Road traffic accidents, in particular, decreased from 7,670 in 2010 to 6,033 in 2013 but it picked up in 2014 with 10,599 reported accidents. Deaths from these accidents slightly declined from 1,262 in 2010 to 1,252 in 2014. Death rate due to road traffic injuries stood at 0.1 percent in 2016 (PSA, 2018c). The number of vehicles damaged from accidents decreased from 17,979 in 2010 to 8,169 in 2013 but it increased by 43 percent in 2014 at 15,195 (Table 3.3). Vehicles commonly involved in traffic accidents were automobiles (8,000), motorcycles (5,720) and trucks (2,773) (PSA, 2017f). According to WHO, road traffic crashes were predicted to become the seventh leading cause of death globally by 2030.

Table 3.3. Road Traffic Accidents, 2010-2014

Year	Number of Accidents			Damage to Property (number of vehicles)
	Fatal	Non-fatal	Total	
2010	1,262	6,408	7,670	17,979
2011	1,399	5,664	7,063	11,574
2012	1,129	4,904	6,033	9,153
2013	1,362	7,817	6,033	8,169
2014	1,252	9,347	10,599	15,195

Source: Based on 2017 Philippine Statistical Yearbook Table 13.23. Comparative Statistics on Road Traffic Accidents, 2001-2014

***Mental and neurological disorders.*** The most common cause of deaths related to mental and neurologic disorders (not considering “other diseases of the nervous system”) is intentional self-harm or suicide, which registered 2,111 deaths or 2.1 per 100,000 population in 2014 – similar to its 2013 level. All mental and neurological disorders listed in Table 3.4, except for Alzheimer’s disease, affected more males than females. Mortality rates for meningitis, other mental disorders and intentional self-harm slightly went down from 2010 to 2013 but other mental and neurological disorders either increased or were retained over the period.

These rates may still be low but mental disorders can heavily burden the society if left unaddressed. They can lead to loss of economic outputs and burden families with the high cost of treating potentially fatal conditions linked to them. Mental disorders with significant disease burden are depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs, and mental disorders in children. They interfere not only with learning, especially for children, but also with adults in interacting with the family, their work and in broader society (Mnookin, 2016).

**Table 3.4. Mortality Rate of Selected Mental and Neurological Disorders, 2010 and 2013**

Mental and Neurologic Disorder	2010				2013			
	Male	Female	Total	Rate (per 100,000)	Male	Female	Total	Rate (per 100,000)
Psychoses	419	83	502	0.5	431	161	592	0.6
Mental retardation	2	0	2	0	6	11	17	0
Other mental disorders	62	96	158	0.2	67	74	141	0.1
Meningitis	868	689	1,557	1.7	832	644	1,476	1.5
Parkinson’s disease	169	156	325	0.3	186	187	373	0.4
Alzheimer’s disease	129	242	371	0.4	122	266	388	0.4
Epilepsy	386	257	643	0.7	401	287	688	0.7
Other diseases of the nervous system	2,147	1,461	3,608	3.8	2,404	1,868	4,272	4.4
Intentional self-harm (suicide)	1,632	491	2,123	2.3	1,647	408	2,055	2.1

Source: DOH, Philippine Health Statistics

Certain mental disorders affected certain age groups the most. Mortality rate for suicide, for instance, was particularly high among the elderly (65-69 and 70+ age groups) and young adults (i.e. 20-24, 25-29 and 30-34 age groups) (Table 3.5).

**Table 3.5. Mortality Rate for Suicide, 2013**  
(per 100,000 population)

Age Group	Mortality Rate
Under 5	0.1
5-9	0.1
10-14	0.4
15-19	2.4
20-24	3.7
25-29	3.7
30-34	3.5
35-39	3.2
40-44	2.5
45-49	2.6
50-54	2.4
55-59	2.5
60-64	2.6
65-69	3.8
70+	3.6

Source: DOH, Philippine Health Statistics 2013

#### *Prevention and control of substance abuse.*

Results of the 2015 Nationwide Survey on the Nature and Extent of Drug Abuse in the Philippines showed that there are 1.8 million current drug users aged 18 to 69, and 4.8 million Filipinos have used illegal drugs at least once in their lives. The survey, which is done every 3 years, did not identify these individuals as “drug addicts” (PIDS, 2016).

Reductions in alcohol abuse as well as tobacco use were observed in 2015, possibly owing to the implementation of Sin Tax law. In terms of alcohol abuse, more than half (56.2 percent) of Filipino adults were engaged in binge drinking or heavy episodic drinking of alcoholic beverages, and it is more common among the 20 to less than 30-year-old age group at 63.0 percent. Among the regions, ARMM had the highest proportions of binge drinkers at 73.9 percent, followed by Bicol at 73.0 percent (FNRI-DOST, 2015).

Tobacco use prevalence significantly decreased among adults from 29.7 percent in 2009 to 23.8 percent in 2015 (from 49.5 percent to 41.9 percent among males; from 10.1 percent to 5.8 percent among females). The prevalence of current cigarette smoking among adults significantly decreased from 27.9 percent in 2009 to 22.5 percent in 2015 (from 47.2 percent to 40.1 percent among men and from 8.8 percent to 4.9 percent among women). While the Philippines has reduced tobacco use since 2009, nearly a quarter of Filipinos continued to use tobacco in 2015 (DOH, PSA, WHO and CDC, 2015).

## *Essential public health services*

**Disease surveillance.** The DOH developed the Manual of Procedures for the Philippine Integrated Disease Surveillance and Response (PIDSR) in 2014 to standardize the approach for indicator-based monitoring of notifiable diseases and other health-related events of public health importance. It was done in compliance with the International Health Regulations (IHR) which binds its member to develop core capacities to detect, assess, notify, and respond to public health threats. Its surveillance is targeted towards epidemic-prone diseases, diseases targeted for eradication or elimination, and other diseases or conditions of public health importance. The Event-based Surveillance and Response (ESR) complements the PIDSR by capturing information on new events that are not included in indicator-based surveillance, events that occur in populations which do not access health care through formal channels, and rare, unusual, or unexpected events (DOH-EB, 2017). Case detection activities, however, were hampered by challenges in the functionality of Epidemiology and Surveillance Units (ESUs) in cities and provinces, such as the limited time of health personnel to monitor the surveillance units given other competing tasks, weak analysis and feedback component of the surveillance system, and unstable or slow internet connectivity in LGUs.

**Health promotion.** Health promotion can help influence behavior towards improvement of family health, and prevention as well as management of communicable diseases and NCDs. However, its potential to reduce the cost of curative and rehabilitative health care, which constituted the bulk of the country's health expenditures over the years, was not maximized given the emphasis of the program on advocacy and information dissemination activities targeted to those who are already sick. The lack of clearly designed strategic and comprehensive program work plans partly contributed to the poor utilization of budget on health promotion.

WHO identified three basic strategies of the Ottawa Charter for health promotion: (1) Advocate to make political, economic, social, cultural, environmental, behavioral and biological factors favorable to health; (2) Enable people to achieve their fullest health potential through access to information, life skills and opportunities for making healthy choices; and (3) Mediate between differing interests in society for the pursuit of health. Health promotion in the country has focused mainly on advocacy, missing on the opportunity to translate policies into specific health programs and projects that enable the target population to use health services, and become a societal mid-field that mediates among various players in the health sector to harmonize efforts on healthcare delivery. Policies and programs dealing with other critical determinants of health such as the environment, infrastructure, housing, employment, peace and order, and governance, among others, are a shared responsibility requiring a multi-sectoral approach and more meaningful integration with concerned sectors [Villaverde et al, 2012].



**Disasters and health emergencies.** Based on the 2005-2015 data from the UN Office for Disaster Risk Reduction, the Philippines experienced a total of 181 disasters, making it the third most disaster-prone country in the world, next only to China (with 286 disasters) and the United States (with 212 disasters). Natural calamities have not only damaged properties but have taken human lives as well. The worst natural disasters that hit the country in recent years include Typhoon Yolanda (Haiyan) in 2013 with 7,212 casualties; Typhoon Pablo in 2012 with 1,901 casualties; and Typhoon Sendong (Washi) in 2011 with 1,439 casualties (EM-DAT, n.d.). Natural disasters affected about 10.5 million people, or 69 percent of the total number of people affected by disasters in 2010. Disasters caused by humans and natural hazards (e.g. fish kill, flood, landslide and red tide) affected 4.6 million people or 31 percent of the disaster-affected population while man-made disasters (e.g. armed conflict, fire, and development aggression) affected 121,970 people or one percent of the total disaster-affected population in 2010. Most affected by disaster-related displacement were CALABARZON, Bicol and NCR.

### *Essential health products*

Medicines and health products are indispensable to the prevention, early detection and treatment of diseases. Major legislations and policies were enacted to improve access to affordable and quality drugs and essential health products. One of these is the Generics Act of 1998, which sought to ensure adequate supply, distribution, use and acceptance of drugs and medicines identified by their generic names. It was supported by Executive Order (EO) 49, s. 1993, which directed the mandatory use of the Philippine National Drug Formulary (PNDF) as the basis for the procurement of drug products by the government. The Philippine National Formulary expanded the clinical content of PNDP and it is used as basis of tailored procurement of medicines in public health facilities while ensuring efficient use of limited resources. The societal right of patients in health and decision-making was recognized through Administrative Order 2017-0013 “Guidelines for Patient Engagement in the Activities of the Philippine National Formulary System”, which allowed civil society organizations (CSOs) to suggest drugs for inclusion or exclusion from the PNF list. Other major policies include: (1) R.A. 7581 or the Price Act, which mandated the DOH as the lead agency in identifying essential drugs as basic necessities, and in monitoring their corresponding prices; (2) R.A. 9502 of 2008 or the Cheaper Medicines Act, which intended to promote and ensure access to affordable quality medicines for all through an effective competition policy in the pharmaceutical sector; and the (3) Medicines Access Programs (MAP), which served as a strategic mechanism in addressing the needs of vulnerable patients especially the poor.



As part of the Cheaper Medicines Program (CMP), the DOH established *Botika ng Barangays* (BnBs) and *Botika ng Bayan* (BNB) nationwide, to provide low-cost generic medicines to far-flung communities. It implemented MAP by providing public primary care facilities with Complete Treatment Packs (ComPacks), which are prepackaged generic drugs priced PhP100 and below aimed to encourage patient adherence to their drug treatment regimen. Operational concerns, however, like logistics management, drug quality and financial sustainability, hampered BnB implementation. Problems with the availability of ComPack packages at service delivery points also became a problem since their allocation was not consumption-based, leading to stockouts of much-needed medicine packages and wastage of those with little or no demand at all.

DOH studies showed improvements in the availability of medicines in public health facilities from 2010 to 2013 but mean availability rate for RHUs, HCs and Level 1 public hospitals as well as Levels II-IV public hospitals remained low (Table 3.6).

**Table 3.6. Availability of Medicines in Public Health Facilities, 2010-2013**

Facility Level	Mean Availability 2010	Mean Availability 2011	Mean Availability 2012	Mean Availability 2013
Rural Health Units, Health Centers and Level 1 Public Hospitals	24.8%	51.7%	53.6%	65.9%
Level II to IV Public Hospitals	25.8%	37.8%	44.3%	41.3%

Source: DOH, Philippine Health Statistics

Drugs placed under the maximum drug retail pricing (MDRP) and government-mediated access prices (GMAP) became more accessible with their compulsory price reduction, which prompted slight reductions in the prices of several competitor drugs in 2011 as they settled near GMAP references levels. However, the number of drugs under MDRP/GMAP listing in the Philippines had been very small relative to the total list of essential drugs (Sarol, 2014), and may not make a dent in increasing overall drug accessibility. The Generics Act of 1998 appeared to be more effective than the Cheaper Medicines Act in bringing medicine prices down, creating increased competition between originator and generic manufacturers, which had led to the growing market share of generics even prior to MDRP and GMAP programs (Clarete and Llanto, 2017).

Patient access to medicines improved with the increasing rate of generic drug prescription by physicians from 66 percent in 2011 to 73 percent in 2014, higher number of branded medicines becoming off-patent, and the growing acceptance of generic drugs as shown by six out of ten Filipinos already using generics (Clodfelter, 2015 as cited in Dayrit, et al., 2018). However, the study conducted by Clarete and Llanto in 2017 showed that while medicine prices did fall, demand response remained low partly owing to low purchasing power of patients. PhilHealth, the national health insurer, has very limited outpatient service and medicine coverage. There were existing medical assistance funds for indigents from various government agencies such as PCSO, DSWD, DOH and PAGCOR but accessing these was not easy given bureaucratic complexities and requirements.

### *Health facilities*

There are multiple channels of service delivery in the Philippines – through private hospitals, clinics and providers, and government facilities such as DOH hospitals and specialty centers and LGU-managed barangay health stations (BHSs), health centers (HCs), rural health units (RHUs), district hospitals and provincial hospitals.

There were 20,065 BHSs and 2,590 RHUs providing primary care services in 2016 but the country still lacked 696 BHSs and 2,600 RHUs nationwide. While most regions already had adequate BHSs to cover their population, six (NCR, Regions 3, 4A, 5, 8 and ARMM) of 17 regions were unable to meet the BHS-population ratio of 1:5,000. The gap in RHUs is more pronounced with only CAR meeting the recommended 1 RHU to 20,000 population ratio. Wide regional variations persisted with one region (Region II) having 653 facilities more than the required BHSs, and another (Region IV-A) lacking 562 BHSs to serve its burgeoning population. Region IV-A had one of the biggest gaps in both BHSs and RHUs in 2016. While NCR may seem to be grossly lacking in BHSs, private clinics providing primary care proliferate in the city (Table 3.7).

The 2013 NDHS showed that the proportion of households – mostly from low-income groups – who sought care in public hospital facilities and providers is almost twice as high (7 percent) than those who used private providers (4 percent) and yet, private hospitals made up 65 percent (790) of total DOH-licensed hospitals in 2016 while government facilities constituted only the remaining 35 percent (434).

Table 3.7. Gaps in Barangay Health Stations and Rural Health Units By Region, 2016

Region	Projected Population 2016 <sup>1</sup>	Barangay Health Station			Rural Health Unit		
		Number	Needed <sup>2</sup>	Gap	Number	Needed <sup>3</sup>	Gap
NCR	14,139,224	20	2,828	2,808	493	707	214
CAR	1,752,141	789	350	(439)	97	88	(9)
Region I (Ilocos Region)	5,085,436	1,159	1,017	(142)	150	254	104
Region II (Cagayan Valley)	3,497,659	1,353	700	(653)	97	175	78
Region III (Central Luzon)	11,351,673	1,856	2,270	414	294	568	274
Region IV-A (CALABARZON)	14,775,143	2,393	2,955	562	224	739	515
Region IV-B (MIMAROPA)	3,022,331	1,103	604	(499)	82	151	69
Region V (Bicol Region)	5,908,871	1,146	1,182	36	134	295	161
Region VI (Western Visayas)	7,640,385	1,879	1,528	(351)	147	382	235
Region VII (Central Visayas)	7,513,769	2,027	1,503	(524)	163	376	213
Region VIII (Eastern Visayas)	4,521,849	902	904	2	160	226	66
Region IX (Zamboanga Peninsula)	3,691,852	757	738	(19)	92	185	93
Region X (Northern Mindanao)	4,761,986	1,305	952	(353)	121	238	117
Region XI (Davao Region)	4,983,355	1,119	997	(122)	68	249	181
Region XII (SOCCSKSARGEN)	4,631,636	1,095	926	(169)	53	232	179
CARAGA	2,649,422	698	530	(168)	82	132	50
ARMM	3,876,300	464	775	311	133	194	61
<b>TOTAL</b>	<b>103,803,033</b>	<b>20,065</b>	<b>20,761</b>	<b>696</b>	<b>2,590</b>	<b>5,190</b>	<b>2,600</b>

Notes:

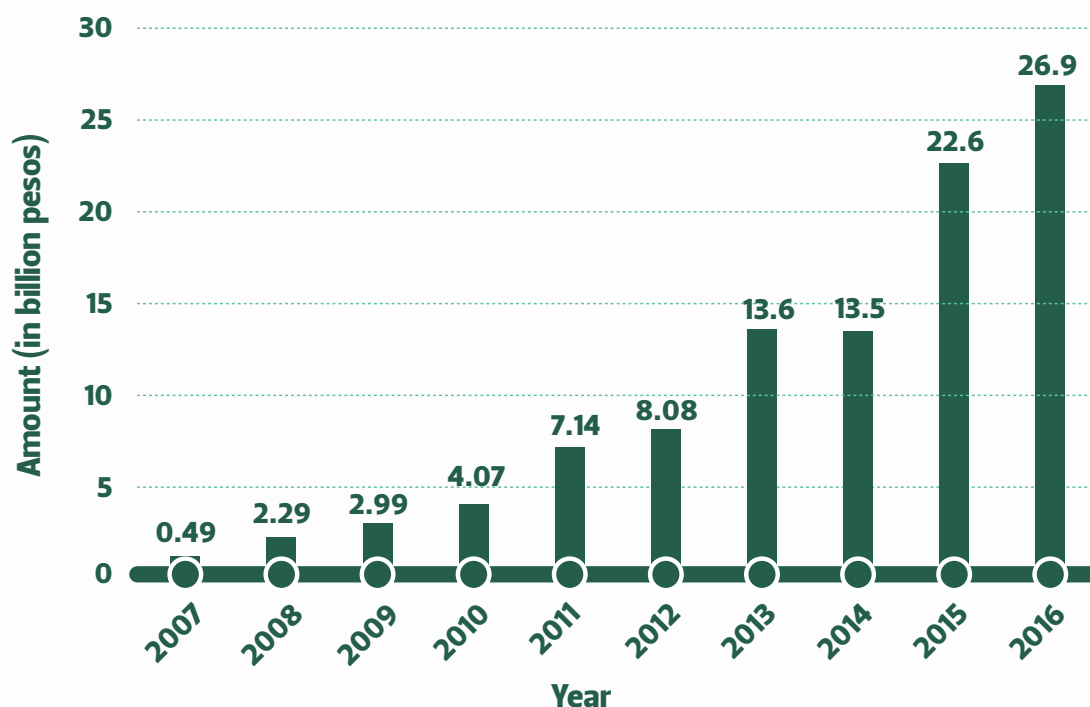
<sup>1</sup>Estimated using PSA 2016 b and PSA 2016c and DOH 2016 Health Facility Registry data<sup>2</sup>Based on 1 BHS:5,000 population ratio<sup>3</sup>Based on 1 RHLI:20,000 population ratio

Source: DOH 2016 Health Facility Registry data and authors' calculations

The total hospital bed capacity of the country is 101,688 beds, with government hospital beds accounting for 47 percent (47,371) and private hospitals beds for 53 percent (54,317). On the average, one hospital bed served 1,010 people in 2016, which was almost the same as the DOH-recommended ratio of one hospital bed per 1,000 population, though it still indicated a gap of 1,022 hospital beds. Nearly half of the regions (NCR, CAR, Cagayan Valley, Western and Central Visayas, Northern Mindanao, Davao and SOCCSKSARGEN) had enough hospital beds to cover their population. ARMM, CARAGA and MIMAROPA had the least coverage at 0.2-0.5 hospital bed per 1,000 population, which translated to one hospital bed covering as much as 2,000 to over 4,200 population.

The DOH has implemented the Health Facilities Enhancement Program (HFEP) for the construction, upgrading, expansion, repair and equipping of national and local government health facilities. Fig. 3.7 shows an exponential increase in HFEP budget from PhP500 million in 2007 to P26.9 billion in 2016. While the 2013 budget declined by P100 million in 2014, funds for HFEP nearly doubled from P13.5 billion in 2014 to P26.9 billion in 2016. On the average, it took one year to complete a birthing clinic, 1.8 years for an RHU, three years for an infirmary, 3.7 years for a Level 1 hospital and four years for a Level 2 hospital (Picazo, et. al., 2015).

Figure 3.7. Annual HFEP Budget, 2007-2016



Source: PSA 2016d and 2016e and DOH Health Facilities HFDP

## *Human resources for health*

Health workers in the Philippine context include physicians, nurses, midwives, community/barangay health workers, pharmacists, supply officers or supply chain managers, laboratory technicians, public health associates/staff, dentists and oral health professionals, as well as all others who provide, deliver or support preventive, promotive or curative health services. The DOH implemented the following programs to strengthen the deployment of human resources for health (HRH) especially in areas where they are most needed:

- Medical Pool Placement and Utilization Program (MP-PUP) – Physicians and/or medical specialists are assigned in DOH hospitals and/or provincial hospitals based on needs and program criteria;
- Doctors to the Barrios (DTTB) Program – Physicians are assigned, for two years primarily in 4th to 6th class municipalities that had not had a doctor for at least 2 years;
- Nurse Deployment Program (NDP) – Deployed nurses are assigned for six months in the community (Rural Health Units) and then another six months for hospital service;
- Rural Health Midwives Program – Midwives are assigned in Barangay Health Stations and Rural Health Units for improved maternal and child care. These facilities can then provide Basic Emergency Obstetrics and Newborn Care (BEmONC);
- Rural Health Team Placement Program (RHTPP) – Dentists, medical technologists, and nutritionist-dietitians are assigned in field health facilities to complement existing RHU personnel; and
- DOH Pre-Service Scholarship Program – Medical and midwifery students are granted full scholarships, and in return, will render return service for two years for every year of DOH scholarship.

HRH occupying permanent plantilla positions at the local level remained generally insufficient to serve the needs of the country in 2016. Table 3.8 shows that only two regions (NCR and CAR) had sufficient RHU/HC physicians; seven regions (CAR, Ilocos, Cagayan Valley, MIMAROPA, Western Visayas, Northern Mindanao and Caraga) had enough rural health midwives; and only three regions (NCR, Ilocos and Caraga) had adequate number of public health dentists. None of the regions had adequate public health nurses with permanent appointment to cover the entire population. These translate to a shortage of 2,013 RHU/HC physicians, 4,467 public health nurses, 3,966 rural health midwives and 148 public health dentists appointed on a permanent basis. Scarcity of government HRH is most palpable in ARMM, Davao, Zamboanga Peninsula and CALABARZON. The number of HRH cited in Table 3.8, however, does not reflect the HRH deployed on a temporary basis by the DOH, such as the 16,703 nurses deployed under the Nurse Deployment Program and the physicians under the Doctors to the Barrios Program.

The quality of doctors being produced is continuously challenged by the poor performance of medical schools in the country. Only 14 of 51 medical schools were accredited by the Philippine Accrediting Association of Schools, Colleges and Universities or PAASCU. The average passing rate of medical schools in the Philippine Licensure Examinations from 2012 to 2016 stood at 75 percent (Roxas, 2018).

HHR has been maldistributed, with health personnel more inclined to practice in urban areas, resulting in doctorless health facilities in certain regions. There has been difficulty filling up the Municipal Health Officer (MHO) post especially in far-flung and marginalized municipalities in the country. The DOH implemented DTTB Program to aid in the administrative transition to health devolution but despite the financial autonomy granted to LGUs, most were unable to offer adequate incentives to entice health personnel to practice in their localities.

Table 3.8. Number and Distribution of Government Health Workers in the Philippines By Region, 2016

Region	Projected Population 2016	RHU/HC Physician		Public Health Nurse		Rural Health Midwife		Dentist	
		Number	Ratio <sup>1</sup>	Number	Ratio <sup>2</sup>	Number	Ratio <sup>3</sup>	Number	Ratio <sup>4</sup>
NCR	14,139,224	718	1.02	1,103	0.78	1,248	0.44	597	2.11
CAR	1,752,141	102	1.16	331	1.89	716	2.04	32	0.91
Region I (Ilocos Region)	5,085,436	169	0.66	329	0.65	1,030	1.01	103	1.01
Region II (Cagayan Valley)	3,497,659	105	0.60	230	0.66	813	1.16	61	0.87
Region III (Central Luzon)	11,351,673	304	0.54	600	0.53	1,652	0.73	180	0.79
Region IV-A (CALABARZON)	14,775,143	264	0.36	784	0.53	2,016	0.68	205	0.69
Region IV-B (MIMAROPA)	3,022,331	131	0.87	233	0.77	623	1.03	57	0.94
Region V (Bicol Region)	5,908,871	162	0.55	287	0.49	1,002	0.85	81	0.69
Region VI (Western Visayas)	7,640,385	262	0.69	465	0.61	1,719	1.12	143	0.94
Region VII (Central Visayas)	7,513,769	233	0.62	385	0.51	1,481	0.99	121	0.81
Region VIII (Eastern Visayas)	4,521,849	159	0.70	219	0.48	848	0.94	78	0.86
Region IX (Zamboanga Peninsula)	3,691,852	89	0.48	144	0.39	483	0.65	41	0.56
Region X (Northern Mindanao)	4,761,986	127	0.53	215	0.45	982	1.03	60	0.63
Region XI (Davao Region)	4,983,355	78	0.31	147	0.29	669	0.67	58	0.58
Region XII (SOCCSKSARGEN)	4,631,636	121	0.52	289	0.62	885	0.96	52	0.56
CARAGA	2,649,422	86	0.65	152	0.57	628	1.19	59	1.11
ARMM	3,876,300	67	0.35	96	0.25	405	0.52	25	0.32
<b>TOTAL</b>	<b>103,803,033</b>	<b>3,177</b>	<b>0.61</b>	<b>5,913</b>	<b>0.57</b>	<b>16,795</b>	<b>0.81</b>	<b>1,928</b>	<b>0.93</b>

Notes:

<sup>1</sup> Based on 1 RHU/HC Physician:20,000 population ratio<sup>2</sup> Based on 1 public health nurse:10,000 population ratio<sup>3</sup> Based on 1 public health midwife: 5,000 population ratio<sup>4</sup> Based on 1 public health dentist: 50,000 population ratio

Source: PSA 2016b and 2016c and Table 3B.1. of the Field Health Service Information System 2016 Annual Report, and PSA



## *Service delivery network*

Service delivery network (SDN) refers to a “network of health providers from both public and private sectors within a province-wide or city-wide health systems offering a core package of health services in an integrated and coordinated manner as a form of health referral mechanism” (DOH, 2014a). DOH Administrative Order 2017-0014 expanded the term by redefining SDN as a network of organizations that makes arrangements to provide equitable, comprehensive, integrated and continuous good quality health services to a defined population, with minimum duplications and inefficiencies. SDN responds to some of the fragmentation issues resulting from the devolution of health services by linking all elements of service delivery – health products and services, facilities and HRH – to provide different levels of healthcare: from first contact level of care that offers basic health services to levels of care involving emergency services, up to specialized hospital care and the provision of continuing and long-term health care. Under this set-up, every family in a local health system is designated to a health service provider or health facility within the network to ensure sustained access to quality healthcare across political, geographical and administrative boundaries.

The SDN derived the concept of health service delivery integration within a province-wide health system from the Inter-Local Health Zone (ILHZ), which has a ‘defined geographical area and comprises a central (or “core”) referral hospital (usually district or provincial hospital) and a number of primary level facilities such as RHUs and BHS’ (DOH 2002). LGU contributions mainly funded the ILHZs. SDN improved on this as it expands the referral system to include apex (Level 3) hospitals, relies mainly on PhilHealth reimbursements for funding, matches families to designated providers of comprehensive health service packages, and puts in place gatekeeping and referral system to decongest tertiary health facilities of cases that can be managed at lower levels of care. The DOH plans to integrate all ILHZs in the province-wide SDN such that eventually, there will no longer be a distinction between the two.

The DOH introduced the SDN approach in the DOH Manual of Procedures for Maternal, Newborn, Child Health and Nutrition in 2011. It eventually adopted the guidelines for the establishment of SDN through DOH

Memorandum 2014-0313, which aimed at linking all elements of health service delivery in a way that enables families to easily access affordable quality health care. The Responsible Parenthood and Reproductive Health Act of 2012 mandated the DOH to integrate family planning, emergency obstetric care, maternal and newborn care as well as reproductive health services into SDNs or local health referral systems. The DOH also issued AO 2014-0046 promoting the establishment of Service Delivery Networks (SDNs) to efficiently and effectively cover the health needs of the population, specifically identified priority groups, under UHC programs and projects.

The Local Investment Plan for Health (LIPH) will serve as the planning and investment tool for ensuring provision of needed support for SDN, such as commodities, HRH, training and health facility enhancement. Meanwhile, subnational government performance in organizing and operating SDNs may be routinely measured through the LGU Scorecard. Capacities required to set up and manage SDNs may be integrated in local health governance courses.

# CHALLENGES AND IMPLICATIONS

## Limitations in health service packages and facilities standards

Treatment and management of infectious diseases, child care and maternal care all have well-defined health service packages at different levels of care but there was none for NCDs and for emergency health care provision. There is also a need to train health personnel in RHUs and health centers (HCs) on health promotion and NCD prevention and management protocol especially at first level of care to avoid varying standards of services on NCD detection, screening, treatment and palliative care provision. High impact NCD interventions at the primary health care level need to be identified to intensify efforts on NCD prevention and early treatment.

Given the country's vulnerability to disaster risks, it is also important to ensure quality care even in emergency situations. However, ensuring compliance to standards for the delivery of quality health services in an unregulated, chaotic setting is challenged by inadequate local support to disaster preparedness, response and management. There is also a need for greater local awareness on the importance of enforcing standards on health-related services during emergencies, such as on patient/victim transfer, environmental hygiene, nutrition management, resource mobilization and communications management.

Design standards for BnB facilities, including storage areas for medicines, facilities for basic laboratory services at primary levels (RHU/HC) need to be developed and incorporated in the current standards for health center designs. Community pharmacy practice standards also have to be made to ensure provision of quality, safe and effective dispensing of drugs in BnBs.



## Inequities in the access to health goods and services

Hospitals were concentrated in Regions IV-A, III and NCR in 2016. Taking into account population size, NCR, which had a million and a half less population size than Region IV-A, had more than double the hospital beds. There are, in fact, more government as well as private hospitals in Region IV-A but tertiary level facilities with higher bed capacities remained concentrated in NCR as health providers tend to gravitate in regional growth centers, thus the higher hospital bed to population ratio.

Access to health services had also been limited by geographic barriers, leading to widespread disparities in the coverage rates of various public health programs. Child immunization coverage, for instance, fell below the national average in most LGUs. This is typical in difficult-to-reach island provinces, mountainous areas and areas of armed conflict. ARMM, for instance, has been registering the lowest coverage rates for the past years because of its hard-to-reach island provinces and conflict-affected areas. Low coverage rates were also found in the poorest quintiles of the population, among rural areas and among families with uneducated mothers. These groups often lack understanding of their health risks and struggle with navigating the complex health system.

## Inadequacy and maldistribution of health personnel

There are multiple national government agencies involved in overseeing the production, regulation, capacitation, distribution and management of HRH in public and private sectors. The absence of a central database on the quantity and the geographic distribution of general practitioners, specialists, subspecialists and other health personnel, as well as the lack of evaluation studies on health labor market and the appropriate skill mix have also impeded analysis of the human resource situation in the country and development of a long-term and holistic strategic plan for HRH.

Health personnel distribution is skewed towards hospital-based services and in urban areas where economic opportunities are perceived to be better. Incentives to encourage doctors, dentists and other health personnel to practice in GIDAs and conflict-affected areas are mostly inadequate. Moonlighting in private hospitals has been a common practice among government physicians to augment income.

## Fragmentation of health service delivery system

Operation of health facilities and the delivery of health services have become fragmented with different levels of authority involved in the system – several national government agencies, thousands of LGUs and private providers. Various health facilities run by LGUs have been poorly maintained, poorly equipped and poorly staffed due to local budgetary constraints or the lack of priority given to health by certain local officials. Consequently, regional and national hospitals have become congested, with patients bypassing primary health facilities even for simple illnesses due to insufficient gatekeeping mechanisms at the local level.

Clearly, the presence of various levels of authority and numerous stakeholders at the national and subnational levels has impeded the harmonized, strategic and directed delivery of health products and services on the ground. It has also prevented functional complementation of health services offered by primary care providers and secondary as well as tertiary health facilities especially in the provision of public health and personal care services.

# OBJECTIVES AND TARGETS

*General Objective 2. Access to essential quality health products and services ensured at appropriate levels of care*

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

**Comprehensive essential health service package and specialized health services for all life stages.** Comprehensive essential health service packages including preventive, curative, palliative and rehabilitative services as well as health promotion activities will be provided in areas where they are most needed in order to expand access to quality healthcare. Service delivery will cover both the sick and the healthy, and cater to all income groups and all social groups, with preference for the poor and those in underserved areas such as geographically isolated and disadvantaged areas (GIDAs). Service delivery will be organized to provide an individual with continuity of care across networks of services, health conditions, levels of care, and over life-stages.

**Intensified strategies to reduce public health threats.** Strategies to reduce public health threats will be intensified through the acceleration of disease-free zone initiatives for endemic diseases targeted for elimination as major public health problems (e.g. Malaria, Filariasis, Rabies). In addition, implementation of strategies for the prevention and control of communicable diseases (e.g. TB, HIV/AIDs), NCDs and emerging and reemerging diseases will be strengthened alongside efforts to improve disease surveillance. Data systems will be reviewed, streamlined and harmonized. Opportunities for improving the current health information system in the country will likewise be explored given new technologies and emerging systems that are getting more affordable.

Promotion of healthy lifestyle will also be intensified to reduce the prevalence of LRNDs and degenerative diseases such as diabetes mellitus, hypertension, cardiovascular diseases, and cancer. Standards of care and CPGs will be developed for priority NCDs to guide health providers, especially those at the primary care level, on the minimum package of services they need to provide to ensure prevention and early treatment of these diseases. Current strategies and interventions on health promotion will also be reviewed and scaled up through: (1) strengthening of monitoring and evaluation for policy development; (2) institutionalization of the use of health and environmental impact assessment in the development of plans, policies, programs, and projects; (3) assessment of

policy gaps and inclusion of health promotion in health legislative agenda; (4) empowerment of communities to establish healthy settings using evidence-based interventions; and (5) collaboration with different sectors to mainstream health in their policies, plans and programs.

The DOH will work towards a resilient health system, which is defined as the capacity of a health system to absorb, adapt and transform when exposed to a shock such as pandemics, natural disasters or armed conflict and still retain the same control on its structure and functions in order to help the country prepare for and respond to disaster risks (Blanchet, et.al., 2017). It will adopt a holistic, comprehensive and community-centered approach – the *Kaligtasang pangKalusugan sa Kalamidad sa Kamayng Komunidad* (5K) or the “disaster health safety in the hands of the community” approach to ensure continued provision of quality care even in disasters and emergency situations. LGUs will be capacitated to enable communities to be the prime mover of Disaster Risk Reduction and Management in Health (DRRM-H), which will be institutionalized in all levels of governance by: (1) developing and implementing DRRM-H plans, (2) organizing trained and equipped health emergency response teams, (3) ensuring availability and accessibility of health emergency commodities, and (4) ensuring functionality of Operation Centers (OPCEN).

The DOH will ensure that its programs and interventions will be directed towards the following: (1) reducing vulnerabilities and enhancing capacities of communities; (2) building and strengthening capacities of communities to anticipate, cope and recover from the negative impacts of emergencies and disasters; (3) supporting life preservation and addressing basic subsistence needs of affected population; and (4) helping restore and improve facilities, livelihood and living conditions and organizational capacities of affected communities, in line with “building back better.” The National Disaster and Epidemic Management Systems will be enhanced by strengthening epidemiology and surveillance units especially in provinces, cities, municipalities and barangays. The private sector will be engaged in surveillance and response. The health system will be resilient only when there is continuity in the delivery of health services in emergencies and disasters, and when the number of preventable morbidities and mortalities is reduced, thus, averting emergency and disaster-related outbreaks.

**Quality diagnostic and therapeutic products and services.** The DOH will pursue quality in diagnostic and therapeutic products and services through the following key interventions: (1) engaging pharmacies to provide selected essential medicines to specific population groups under a revitalized *Botika ng Bayan* (BNB) program; (2) enhancing the management capacities of hospitals in sustaining pharmacies offering affordable quality medicines; (3) expanding local health center services to include basic laboratory services; and (3) facilitating access to quality and affordable health products and medicines, such as through the promotion of generics. In addition, standards will be developed for the manufacture, quality control and marketing of different traditional and alternative health care materials, natural and organic products.

### *Specific Objective 5. Equitable access to quality health facilities ensured*

#### ***Access to quality basic and specialized health facilities.***

The DOH will enhance access to quality basic and specialized health facilities by supporting the conduct of comprehensive needs assessment of critical health facilities engaged or will be involved in service delivery networks (SDNs), which may be the basis for its HFEP support for the upgrading, equipping or expansion of existing facilities or the creation of new ones, especially in underserved areas where they are grossly lacking. It will also develop standards of care and facilitate routine monitoring of health provider compliance to CPGs and DOH standards of care to ensure delivery of quality care in all health facilities, even those in GIDAs or conflict-affected areas.

***Facilities for step-down and chronic care.*** The DOH will develop standards for step-down care providers to help bring quality chronic care closer to the population. Step-down care providers include nursing homes, home health care providers and convalescent care facilities. These providers decongest tertiary hospitals so they can deal with emergencies and critical cases while offering specialized transitional care and recovery for the aged and patients after surgeries and long-term illness. In line with this, the DOH will consider appropriate innovations in health like telemedicine and digital health tools that can help those with chronic illness manage their health. Sensors and apps, for instance, can monitor primary vital signs that enable health care professionals to remotely adjust treatments. Information from these devices can provide early warnings about potential problems, which can help patients prevent or delay complications from chronic conditions.

### *Specific Objective 6. Equitable distribution of HRH guaranteed*

#### ***Alignment of HRH requirements with population needs and health facilities expansion.***

HRH requirements of health facilities will be identified and aligned to their service capacity as well as to the needs of the population they serve. Staffing pattern and structure of expanded health facilities will be reviewed to determine the type and number of doctors, nurses and other health personnel to be deployed. The DOH will assist LGUs in coordinating with the DBM on the creation of needed regular plantilla positions in health facilities, especially those serving priority population groups such as the poor.

***Adequate production of quality HRH.*** Other government agencies such as the Commission on Higher Education (CHED), the Technical Education and Skills Development Authority (TESDA), the Professional Regulation Commission (PRC) and professional societies will be engaged to: (1) ensure adequate production of quality HRH especially in health professions with insufficient supply, and (2) attain a high level of competency and ethical standards in the practice of health professions. The DOH will work together with concerned institutions in establishing quality assurance mechanisms in medical and allied health sciences schools and in post-graduate education. It will likewise strengthen the deployment of permanent health personnel and continuously develop training programs to keep them abreast of developments and innovations in the health professions.

***Equitable distribution of HRH.*** The DOH will respond to the problem of inequitable access to healthcare owing to rural-urban disparities in the distribution of HRH by commissioning labor market studies to understand the dynamics of health professional choice on where they seek employment and its impact on the provision of health services, especially primary care. It will also develop competitive remuneration and benefit packages, and facilitate good working conditions to entice health providers, especially doctors, nurses, midwives and dentists, to consider working in GIDAs. This will entail regular inventory of HRH in regions and provinces as well as systematic matching and deployment of health professionals in health facilities nationwide. The DOH will also support the establishment of medical and health sciences schools in other regions where HRH is inadequate.

### *Specific Objective 7. Service delivery networks organized and engaged*

***Organization of public and private providers into SDNs.*** LGUs will be engaged in organizing management groups and technical units for SDN, which will formalize agreements on collaboration with public and private health providers as well as transport and communications networks to be organized into SDNs. For SDN to provide connected overall service experience, arrangements will be made with public and private groups and institutions on ways to remove or manage financial, geographic, cultural and socioeconomic barriers to health care use. The DOH, together with PhilHealth and other concerned units, will help ensure the functionality of health facilities by instituting routine assessment of health provider capacities and regular monitoring of their adherence to CPGs and other recognized health standards. The possibility of instituting network accreditation for SDNs will also be explored. In addition, the DOH will leverage central office funds for increased LGU and private sector investments in the deployment of required personnel in health facilities, procurement of supplies and commodities, and provision of logistical support for the supervision, operation and monitoring of SDNs.



***Assignment of families to primary care providers.*** Concerned subnational government agencies as well as LGUs will locate households, especially indigents, get their health profile and assign them to the nearest primary care provider in the SDN, who will serve as their first touchpoint in the healthcare system. Designated primary care providers will oversee assessing their health needs, and in treating them or referring them to higher level facilities as appropriate.

***Strengthened gatekeeping at the primary level of SDN.*** Supporting mechanisms will be developed to strengthen primary care providers in SDNs, enabling them to effectively promote primary care, assist in the social health insurance coverage and utilization of the target population, and provide treatment or facilitate timely referrals to appropriate health facilities as needed. Local area health SDNs and concerned officials will be mobilized to work with different types of providers across various levels of healthcare, which may be within or outside political jurisdictions. The DOH will provide policy support and expedite institutional arrangements with concerned sectors (e.g. DSWD, community organizations, private entities, NGOs) to facilitate coordinated and complementing interventions among various sectors. It will work with concerned units in facilitating the construction as well as enhancement of needed health facilities in SDNs, and in deploying the required health personnel in participating facilities.

***Two-way referral mechanisms at all levels of the SDN.*** The DOH will utilize two-way referral mechanisms - arrangements between physicians at the same level or different levels of healthcare system. Guidelines and protocols will be developed to help facilitate effective communication and coordination between health providers. They will have to specify the responsibilities, accountabilities and limitations of the referring physician and the physician in the receiving hospital and provide service protocols of care. Referral mechanisms will have to be backed by readily accessible transport and communications networks available 24/7.

**Table 3.9. National Objectives for Health 2017–2022**  
Service Delivery Indicators

**General Objective 2:** Accessibility of essential quality health products and services ensured at appropriate levels of care

Indicator	Data Source	Baseline	2022 Target
<i>Specific objective 4. Access to quality essential health products and services increased</i>			
Indicator 19: Modern contraceptive prevalence rate (all women)	PSA-NDHS	24.9% (2017)	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 21: Percent of fully immunized children	PSA-NDHS	62% (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	8.6 per 100,000 population (2014)	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-DDAFTP	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% (32/81) (2016)	91% (74/81)
Indicator 30: Percent of provinces that are filariasis-free	DOH-DPCB	76% (35/46) (2016)	100%
Indicator 31: Proportion of households using safely managed drinking water services	PSA-APIS	25.8% (2017)	62.5%

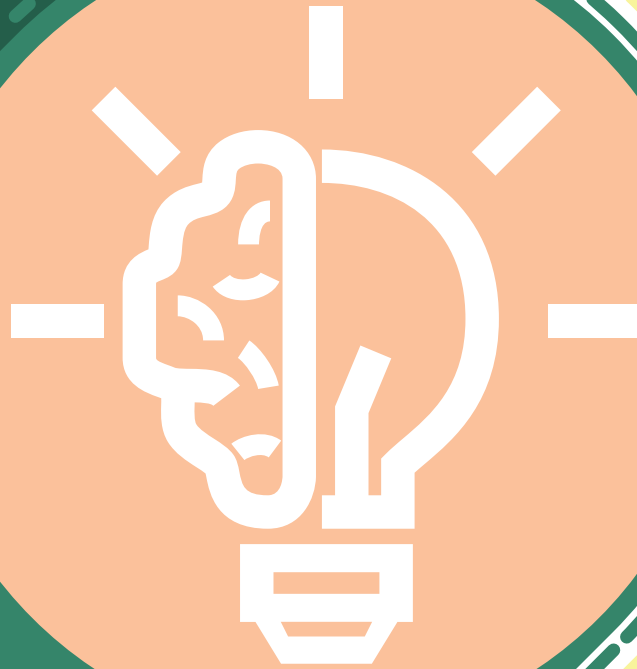


**Table 3.9. National Objectives for Health 2017–2022  
Service Delivery Indicators**

Indicator	Data Source	Baseline	2022 Target
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	TBD	100%
<i>Specific objective 5. Equitable access to quality health facilities ensured</i>			
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%
<i>Specific objective 6. Equitable distribution of human resources for health (HRH) guaranteed</i>			
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%
<i>Specific Objective 7. Service delivery networks (SDNs) organized and engaged</i>			
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	



# Chapter 4



**REGULATION:**  
SAFE, QUALITY  
AND AFFORDABLE  
HEALTH CARE



# BACKGROUND

## Regulatory bureaus in the DOH

Health regulation is a line function of the DOH. The DOH regulates health goods, services and facilities through issuance of license to operate (LTO). The DOH exercises regulatory power through its three units, namely: (1) Health Facilities and Services Regulatory Bureau (HFSRB), formerly known as the Bureau of Health Facilities and Services (BHFS); (2) Food and Drug Administration (FDA), formerly Bureau of Food and Drug (BFAD); and, (3) Bureau of Quarantine (BOQ).

***Health Facilities and Services Regulatory Bureau.*** The HFSRB ensures safety and quality of healthcare services being provided by public and private health facilities. Under RA No. 4226, otherwise known as the “Hospital Licensure Act of 1965,” HFSRB is tasked to develop a system to classify hospitals as to general or special, based on service capabilities, bed capacity and whether they are training facilities or not. The Bureau ensures that regulatory policies and standards of licensing, accreditation and monitoring of health facilities and services are in place to ensure quality healthcare. In addition to licensing hospitals, HFSRB, through the Regulation, Licensing and Enforcement Division (RLED) of DOH Centers for Health Development (CHDs), is in charge of licensing specific types of clinics, laboratories and other health facilities.

In previous years, a prerequisite for the grant of LTO to a hospital is the acquisition of separate licenses for its ancillary services and facilities for blood services. In 2007, the DOH established the One-Stop-Shop Licensure System for Hospitals, which simplified the processing of LTOs and consolidated it into a single regulatory process. It enabled the issuance of a single LTO to hospitals, which also covered ancillary and other services. Another initiative is the decentralization of selected licensing processes to the DOH regional offices. These two major policies harmonized and streamlined the processes and made health regulation more rational and client responsive. Years later, initiatives to further streamline DOH licensing and PhilHealth accreditation processes were established. All hospitals licensed by the DOH are now deemed automatically accredited by PhilHealth. As such, hospitals are no longer surveyed by PhilHealth prior to accreditation.

**Food and Drug Administration.** The FDA is responsible for safeguarding safety, efficacy and quality of health products and devices. RA No. 9711, otherwise known as the “Food and Drug Administration Act of 2009,” strengthened the administrative and technical capacity of the FDA to regulate health products, pharmaceutical products, drug manufacturers, wholesalers and retailers, and medical devices. Under the law, four specialty areas were established: (1) Center for Drug Regulation and Research (to include veterinary medicine and vaccines); (2) Center for Food Regulation and Research; (3) Center for Cosmetics Regulation and Research (to include household hazardous/ urban substances); and (4) Center for Device Regulation, Radiation Health and Research, which subsumes the functions of the defunct Bureau of Health Devices and Technology.

Entities involved in the manufacture, importation, exportation, sale, distribution, transfer, non-consumer use, promotion, advertising or sponsorship of any pharmaceutical or health product are required to secure LTOs and certificates of product registration (CPRs) from the FDA. RA No. 9502, known as the “Universally Accessible and Affordable Quality Medicine Act of 2008,” mandated the FDA to ensure that all drugs authorized for marketing in the Philippines conform to international standards for content, purity and quality. Furthermore, RA No. 9502 states that the President of the Philippines, upon recommendation of the Secretary of Health, shall have the power to impose maximum retail prices (MRP) over any or all drugs and medicines. To implement the MRP, a price monitoring and regulation system for drugs and medicines was established.

**Bureau of Quarantine.** R.A. No. 9271, also known as the “Quarantine Act of 2004,” enhanced the mandate of BOQ in preventing the entrance and spread of public health emergency of international concerns in the country with minimum interference to international travel and trade. To effectively implement its mandate, the following undertakings were institutionalized: (1) effective surveillance and control measures on infectious diseases and other health concerns with global impact through local and international networking, (2) strong and comprehensive national sanitation programs in all seaports and airports of entry in partnership with local counterparts, and (3) partnerships in research and development.

## Regulatory function of PhilHealth

As an attached agency to the DOH, PhilHealth through its accreditation process also has a regulatory function, which overlaps with that of the DOH (Romualdez et al., 2011). The DOH issued Administrative Order 2011-0020, which provided the guidelines for the streamlining of licensure and accreditation of hospitals. At the same time, RA 10155 otherwise known as the General Appropriations Act of 2012, mandated that all government healthcare providers are deemed accredited by PhilHealth. In compliance to these issuances, PhilHealth adopted a new engagement process that modifies the transactions between PhilHealth and healthcare providers. All hospitals and other facilities certified, licensed or accredited by the DOH are deemed accredited by PhilHealth and will no longer undergo pre-accreditation survey. Furthermore, government-employed healthcare professionals holding plantilla positions and duly licensed by the Professional Regulation Commission (PRC) shall be deemed accredited as a professional provider of the applicable PhilHealth benefit (PhilHealth, 2012).

## Other regulatory agencies with health-related concerns

RA No. 10607 or the Insurance Code of 2013 mandated the Insurance Commission (IC) to regulate and supervise the operations of private insurance and reinsurance companies, including life and non-life insurance companies, health insurance companies, pre-need companies, mutual benefit associations, insurance agents and brokers, underwriters, adjusters and actuaries. In 2015, Executive Order No. 192 of November 2015 mandated the transfer of all regulatory powers over HMOs from the DOH to the IC.

Meanwhile, CHED regulates both public and private institutions of higher education, as well as degree-granting programs in all tertiary educational institutions, including health science schools in the Philippines (CHED, 2009). On the other hand, the PRC is the institution that conducts and administers licensure examinations to aspiring professionals and regulate and supervise the practice of the professions, including all health and allied professions.

LGUs, on the other hand, have some forms of regulatory functions that impact on health. For example, certain regulatory functions of the DOH by virtue of Presidential Decree No. 856, otherwise known as the Sanitation Code, were devolved to the LGUs by the enactment of RA No. 7160 or the Local Government Code of 1991. These functions include the issuance of sanitary permits, inspection of markets and food establishments, enforcement of smoking ban, setting taxes for private health services, among others.

Table 4.1 provides a summary of laws on regulatory functions in health.

Table 4.1. Philippine Laws Related to Health Regulation

Law	Description
R. A. No. 4226: Hospital Licensure Act of 1965	An Act mandating the DOH to act as the licensing agency for all public and private hospitals and to ensure equity, access and quality of health-care services through policy formulation, and development of standards and regulations
R. A. No. 9711: Food and Drug Administration (FDA) Act of 2009	An Act strengthening and rationalizing the regulatory capacity of the Bureau of Food and Drugs (BFAD) by establishing adequate testing laboratories and field offices, upgrading its equipment, augmenting its human resource complement, giving authority to retain its income, renaming it the Food and Drug Administration (FDA), amending certain sections of Republic Act No. 3720, as amended, and appropriating funds thereof. This Act aims to protect and promote the right to health of the Filipino people and to establish and maintain an effective health products regulatory system.
R. A. No. 9271: Quarantine Act of 2004	An Act strengthening the regulatory capacity of the DOH in quarantine and international health surveillance, which aims to protect and promote the health of the people by ensuring maximum security against the introduction or spread of diseases subject to the International Health Regulations, particularly emerging diseases and public health emergencies of international concern, from foreign countries into the Philippines and from one port to another within the country.
R. A. No. 9502: Universally Accessible and Affordable Quality Medicine Act of 2008	<p>An Act amending the Pharmacy Law (Republic Act No. 5921), the Intellectual Property Code (Republic Act No. 8293), and the Generics Act of 1988 (Republic Act No. 6675);</p> <p>The Intellectual Property Code amendments allow for parallel importation of cheaper drugs and medicines from abroad whose local patents have not expired. On the other hand, the amendments to the Pharmacy Law allow pharmacies and licensed retailers to sell OTC products. The Act gives power to the President to impose price ceilings on various drugs based on recommendations from the Health Secretary. These include drugs for prevention of disease, for chronic illness, and others listed in the Philippine National Drug Formulary Essential Drug List. The Act also ensures that all drugs authorized for marketing in the Philippines conform to international standards for content, purity and quality.</p>



Law	Description
R. A. No. 7160: Local Government Code of 1991	The Local Government Unit (LGU) has some form of regulatory functions that has impact on health. These involve issuance of sanitary permits, inspection of markets and food establishments, enforcement of smoking ban, setting local taxes for private health services, among others.
R. A. No. 10607: Insurance Code of 2013	The Code provides the rules and regulations regarding the contract of insurance and classes of insurance, which cover guidelines on a wide range of topics such as the parties to the contract, insurable interest, the written insurance policy, warranties and premium
R. A. No. 7875: National Health Insurance Act of 1995, as amended by R.A. No. 10606: National Health Insurance Act of 2013	The National Health Insurance Program (NHIP) is implemented by PhilHealth which determines healthcare benefits for its members. In addition, PhilHealth accredits health facilities and service providers, determines the cost of services, and pays providers.
R. A. No. 7722: Higher Education Act of 1994	An Act creating the Commission on Higher Education (CHED) to act as the governing body that regulates both public and private institutions of higher education, as well as degree-granting programmes in all tertiary educational institutions
R. A. No. 8981: Professional Regulation Commission (PRC) Modernization Act of 2000	An act enforcing government policies on regulation and licensing of the various professions and occupations.

# CHALLENGES AND IMPLICATIONS

## Obsolete or insufficient regulatory mandates

The hospital licensing system and standards are influenced by the Hospital Licensure Act of 1965 or RA No. 4226. This mandate, however, may not be applicable anymore with the current health system. The current applicable regulation does not allow flexibilities in granting LTOs to health facilities. For example, a health facility with capability to handle complicated or specialized pediatric or maternal conditions, could not be granted an LTO beyond that of an infirmary. Current standards require hospitals to provide surgical and ancillary services to qualify as at least a Level 1 facility. Without these services in place, the facility will not be given LTO as hospital because the definition of hospital as stipulated in Sec 8 of RA 4226 on Minimum Standards and Construction of a Hospital states that “In order that a permit to construct a hospital be issued, the hospital plan should provide sufficient space for hospital bed capacity, laboratory room, operating room including work room/space for sterilization, anesthesia preparation, x-ray room, pharmacy, dispensary or outpatient department, delivery room, among others.” This will also affect the status of accreditation of the facility.

There are also no policies regulating emerging types of health facilities and services such as those concerning geriatric care, nursing homes, convalescent care, mobile healthcare, telemedicine or telehealth services, among others. Because of the increasing proportion of population aged 60 years and above, an increasing number of private organizations, NGOs and government agencies have started operating nursing homes, home for the aged, and senior residential, retirement and assisted living care facilities. While such services improve health and well-being of this population group, the DOH currently has no mandate to regulate the quality of health services provided by these facilities.

Moreover, the advent of technology has escalated the sale and distribution of goods and services particularly drugs and medicines online. The proliferation of internet-based or online pharmacies complicates the current fight against counterfeit medicines that pose danger to the health of Filipinos. While the FDA has managed to shut down local online pharmacies, the challenge is for FDA to institutionalize IT infrastructure development to address illicit activities by those based abroad. Aside from this, advancement in health technology has yielded new services and products that could affect public health.

There are also issues in the production and deployment of healthcare professionals that are beyond the regulatory regime of DOH. Moreover, there is currently no mechanism to regulate the price of professional fees as well as drugs and medicine.

While there is the Universally Accessible and Affordable Quality Medicine Act of 2008 that stabilized the price of drugs and medicine, the Philippines still has the most expensive drugs and medicine within the ASEAN region. Under this Act, price control measures for drugs and medicines (i.e. Maximum Drug Retail Price) is vested on the President of the Philippines.

## Complex regulatory system

In the past, the issuance of LTO to a hospital is independent of the issuance of LTO for its ancillary and other services such as clinical laboratory, pharmacy and x-ray facility. Furthermore, other services (e.g. blood bank, blood collection unit or blood station, and HIV testing) critical to the operation of a hospital require a separate LTO or authority to operate. Such requirements necessitate high transaction cost on the part of the hospital, which must subject itself to the procedures of different regulatory offices in the DOH. These units, in turn, would conduct inspections under a schedule, which proves to be cumbersome due to the following reasons: numerous documentary requirements, long queue of applications, difficulty in finding common time among regulatory staff, and scarcity of resources such as regulatory personnel and means of transportation.

There is also an issue in regulating health facilities that have been constructed through the Health Facilities Enhancement Program (HFEP). There were instances when LGUs were forced to accept health facilities constructed by DPWH which do not comply with the minimum set standard established by HFSRB for the grant of LTO (Villaverde, Gepte, & Baquiran, 2016).

Moreover, centrally procured commodities by the DOH are required to be tested and cleared by FDA. While there is a dedicated FDA unit for laboratory testing of DOH commodities, there is still a need for the DOH to inform FDA in advance to ensure that reagents and logistics for product testing are readily available. The long process of procurement and the subsequent product testing result in delays in the distribution process and stock-out of commodities at the frontline level.

Also, some products are being procured by the DOH despite the absence of certificate of product registration (CPR). This is brought about by the inconsistencies between Administrative Order 2016 – 0003: Guidelines on the Unified Licensing Requirements and Procedures on the Food and Drug Administration, and the Food and Drug Administration Act of 2009 or RA 9711 as amended.

## Limited training and support systems for regulatory functions

The current plantilla positions in all regulatory bureaus of the DOH are already inadequate relative to the number of health facilities and services being established or the number of health products and devices being manufactured and sold in the market. In the BOQ, for example, several ports and airports were opened to serve the increasing number of local and international travelers. The DOH has not been able to meet the demands of new developments due to limited number of quarantine officers to manage new international ports and airports all over the country.

Moreover, the current set of regulatory officers in all regulatory units in the DOH is oriented and trained mostly on the clinical side of health. They are composed of doctors, nurses and other allied professionals who have been trained on hospital work. Available executive courses do not offer topics on regulatory functions. Most of the staff hired by the DOH assigned in the different regulatory units are not adequately familiar with the concepts and practice of regulation.

## Weak enforcement of regulatory policies

The current mandate of HFSRB lacks the enforcement mechanism and possesses weak regulatory sanctions. It still needs to coordinate with law enforcement agencies when enforcing regulatory sanctions. This stems from a law that has become obsolete over time (i.e. RA 4226, otherwise known as the Hospital Licensure Act of 1965). FDA, on the other hand, possesses quasi-judicial power. Pursuant to Section 19 of RA 9711, the FDA has a Regulatory Enforcement Unit (REU) whose members are classified as law enforcement agents (Philippine Congress, 2009). This policy enables them to execute and serve search and arrest warrants issued by the courts in connection with the regulation of health products.

## Unclear accountabilities

Currently, there are limited operational guidelines that will ensure transparency and accountability in DOH regulatory bureaus. Moreover, performance assessment and accountability mechanisms are yet to be institutionalized in DOH to minimize transgression. While a number of guidelines have been developed to improve performance of DOH regulatory units, there are still some gaps in accelerating resolutions of regulatory concerns. At present, there is no unit within the DOH to resolve issues concerning conflicts of interest among regulatory officers.

# OBJECTIVES AND TARGETS

*General Objective 3. High quality and affordable health products, devices, facilities and services ensured*

*Specific Objective 8. Regulatory systems and processes harmonized and streamlined*

***One-stop-shop licensing system for hospitals.*** The DOH will operationalize a one-stop shop for hospital licensing, building on Administrative Order No. 2007 s. 0021 entitled “Harmonization and Streamlining of Licensure System for the Hospital”.<sup>z</sup>Certain amendments will be initiated to allow data sharing among regulatory agencies including PhilHealth. To realize the full benefits of the scheme, full automation of the following processes will also be developed: submission of application, payment of processing fee and processing of LTO applications. The streamlining and harmonization of licensing systems is pursuant to RA No. 9485 otherwise known as “Anti-Red Tape Act of 2007”. It aims to improve and speed up the delivery of government services through the simplification of the issuance of permits and licenses, and elimination of overlaps and unnecessary requirements.

***Enhancement of mandates and enforcement mechanisms.*** The DOH will continue advocating the amendment of its regulatory mandates in Congress. However, among such mandates, regulation of health facilities is most urgent. In particular, the DOH will be pushing for a health facilities regulatory mandate that includes the following elements: well-defined scope and coverage, quasi-judicial powers, income retention, expansion of plantilla positions and regional operation, and enforcement. There is a need to define the bounds of which health facility types, technologies, and services should be subjected to regulation. Quasi-judicial power, i.e. issuance of subpoena, contempt order and alike, is also necessary to ensure compliance. Income retention is important to sustain operation and expand coverage. The expansion of plantilla positions as well as regional operation, on the other hand, should allow for flexibility in implementation. Lastly, the authority to enforce the law especially against unlicensed facilities shall be strengthened.

***Management of conflict of interest among regulatory bureaus and interest groups.*** The DOH will manage conflicts of interest within and among regulatory bureaus and their staff, and clarify inconsistencies in policies. The processes of regulatory units vis-à-vis their respective mandates will be ascertained and made known to other units of the DOH so that regulatory processes are fully understood and integrated in program execution. Conflicts of interest are also attendant in the exercise of functions by regulatory officers. Mechanisms to manage regulatory capture and other transgressions by regulatory officers should also be established and implemented. It is also necessary to review and identify specific inconsistencies and possible amendments to A.O. No. 2016-0003 Guidelines on the Unified Licensing Requirements and Procedure of the Food and Drug Administration (FDA) and RA 9711 to clearly establish and follow procedures regarding procurement of commodities in relation to the product's CPR.

***Engagement of third-party accreditors.*** Third party accreditors will be engaged to improve accountability and performance. This will ease the burden of managing numerous applications for licenses and certifications by health facilities. The legal structure and scope of work of third-party accreditors will be developed to ensure sustainability of the system. Operational management, selection of the third-party accreditation agency, training and supportive supervision will be the responsibility of the DOH. The third-party agency that will be engaged by the DOH will develop and execute, with clearance from the DOH, decision criteria in granting accreditation to health facilities and healthcare providers. Criteria should be developed in response to certain situations such as significant incident affecting quality and safety, change of ownership and major construction, among others.

***Internationally accepted health regulatory standards.*** The processes of DOH regulatory units will be harmonized, benchmarked and made compliant to health regulations among regional (e.g. ASEAN) and other international communities. An example is the need to implement the Mutual Recognition Agreement with ASEAN countries, which advocate for reciprocity in the implementation of regulations among ASEAN Member States. Such concept of reciprocity, however, does not only apply to health facilities but its application is intended to benefit the country in terms of international exchanges of health workers, products and services.

***Public information on safety, quality and price of health products and services.*** A mechanism that enables the public and consumers to keep abreast and educated on the safety, quality, and prices of health goods and services will be adopted. Public awareness will be increased in order to influence behavior towards accessing goods. The same kind of mechanism will also be adopted for health facilities and services.



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

**Regulation-specific capacity building and training.** Regulation-specific capacity building and training will be regularly provided to staff of regulatory offices. The DOH will develop training modules to address these gaps. Academic institutions will be tapped to support DOH in building the capacities of its personnel on regulation.

**National fee schedule to regulate prices of health goods and services.** The DOH will advocate and pursue revision of fee schedule to regulate health goods and services. Furthermore, a mechanism to regulate the price of professional fees as well as drugs and medicine will be established. The Cheaper Medicine law may be revisited and amended to address regulation of price of drugs and medicine. In terms of professional fees (PF), the price of PF may have to consider the different skill sets of professionals. The DOH may issue guidelines on how to inform the citizen of the PF to make it more transparent (e.g. PF may be posted in the website of the hospital).

**Network licensing and accreditation.** A Regulatory Impact Analysis (RIA) will be conducted to determine the feasibility of adopting a network licensing and accreditation scheme for health facilities prior to the full implementation of this scheme. Network licensing and accreditation encourages efficient and effective managed care processes and continuum of care. It provides a method of evaluation and accreditation of providers under a network and managed care programs. In crafting a network licensing and accreditation guideline, at least the following elements may be considered: (1) development of legal mandate expressing the legality or approval to implement network licensing; (2) crafting of standards that will be used to evaluate the eligibility of network of providers; (3) licensing and accreditation process specifically for health system providers; (4) implementing guidelines that will articulate how DOH will operationalize the proposed system (e.g. who will be accountable for non-compliance to the standards of licensing by a member health facility, and effect of revocation of license or accreditation due to violation of a member facility to the entire network); and (5) determining type of services that will be committed to be delivered by network of facilities or services to be licensed by the DOH.

***Risk- and outcome-based regulation.*** DOH regulatory offices will adopt a risk-based approach in facilitating compliance to regulatory standards as well as in identifying and enforcing instances of non-compliance. A shift in the approach from input to outcome-based approach (e.g. Regulatory Impact Assessment) will also be used to assess both the efficiency and effectiveness of regulatory actions and outcomes, respectively. The DOH will review its licensing system to determine if it is responding to the emerging developments. For example, granting of license to the facility may be based on service capacity or on its location (it may be provided as incentive to facilities in GIDAs). While this type of strategy may be tedious for the licensing officer, this can be an opportunity for the facility to improve its service capability. This may also complement with the policy of PhilHealth on reimbursement based on service capability.

***Regulatory measures on the production and distribution of human resources for health (HRH).*** The DOH will advocate and pursue regulation of HRH production and distribution, whether in Congress or with the agency tasked to implement the same, like the Professional Regulation Commission (PRC) and the Commission on Higher Education (CHED), and medical societies, among others. Ensuring increase in production and equitable distribution of HRH and rational incentives are expected to redound to better accessibility of health facilities and services in the country.



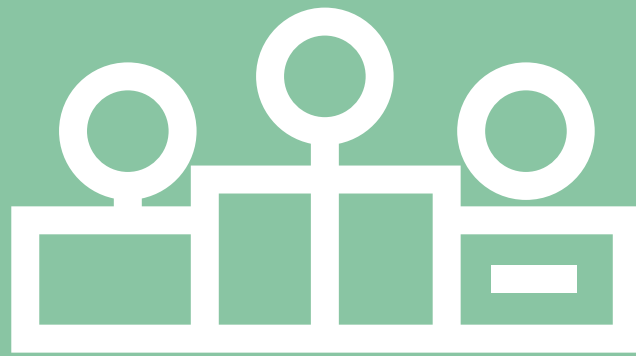
**Table 4.2 National Objectives for Health 2017–2022  
Regulation Indicators**

**General Objective 3:** High quality and affordable health products, devices, facilities and services ensured

Indicator	Data Source	Baseline	2022 Target
<i>Specific Objective 8. Harmonized and streamlined regulatory systems and processes</i>			
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/ RO-RLEDS FDA BOQ	TBD	100% (HFSRB)
Indicator 43: Percent of all newly registered pharmaceutical products able to be subjected to post-marketing surveillance	DOH-FDA	TBD	TBD
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	TBD	TBD
<i>Specific Objective 9. Innovative regulatory mechanisms developed for equitable distribution of quality and affordable health goods and services</i>			
Indicator 45: Hospital-acquired infection rate	DOH-HFDB IPC Unit	TBD	<2%
Indicator 46: Median consumer price ratio of selected essential medicines	DOH-PD	Public: • Originator brand = 3.52 • Lowest price generic = 3.24  Private: • Originator brand = 20.52 • Lowest price generic = 3.75	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	TBD	96% (HFSRB)



# Chapter 5



## **GOVERNANCE: FUNCTIONAL AND PEOPLE-CENTERED HEALTH SYSTEM**



# BACKGROUND

## Stewardship of the health sector

The DOH is the steward of the entire health sector. Its main responsibility is to ensure that health and health-related programs and activities are geared towards improving health outcomes, increasing financial risk protection and enhancing responsiveness to the health needs of the people. In order to lead the entire health sector more efficiently, the DOH needs to strengthen its organizational capacities in terms of the following aspects: (1) policy development, (2) fund management including harmonization of available funds for health, (3) human resources for health, (4) health information system development, and (5) procurement and supply chain management.

The devolution of health service delivery functions made LGUs the stewards of their respective local health sectors. They have been implementing public health activities and providing personal health care to their constituencies as well as dictating the health outcomes in the localities. This arrangement makes LGUs necessary partners of the DOH in the pursuit of health sector goals.

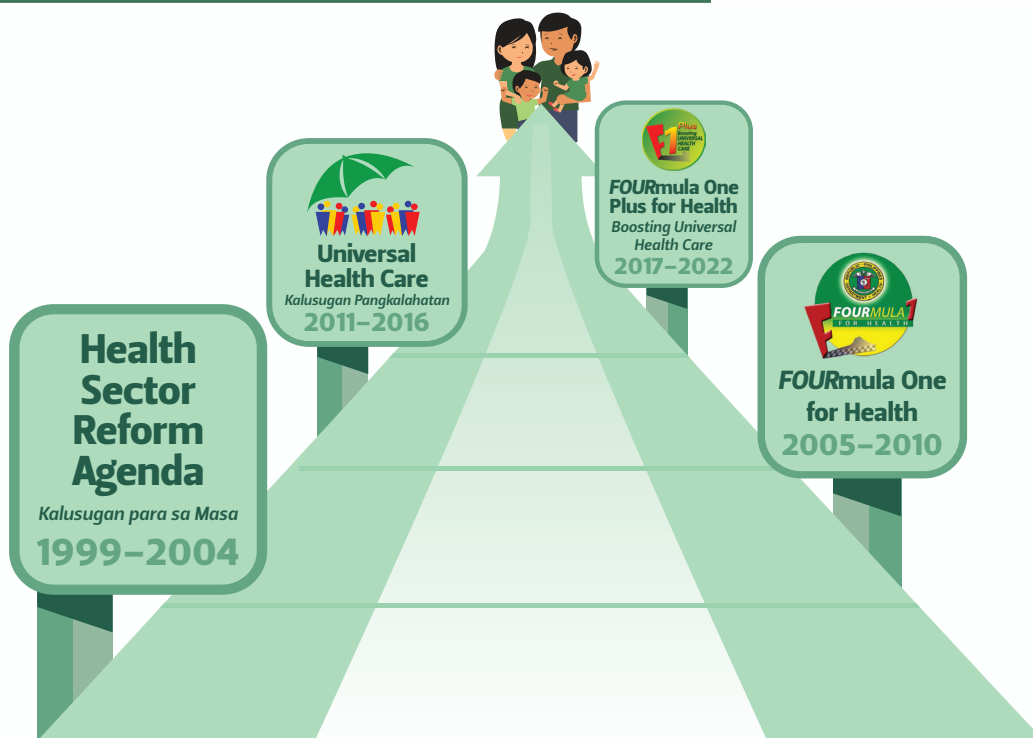
In line with its mission of developing a people-centered health system, the DOH capitalizes on robust engagement of the private sector, civil societies, international health partners, other national government agencies and non-government organizations. It has continuously honed mutual cooperation with this sector for the attainment of desired health outcomes. The private sector has been a necessary multiplier in the delivery of health services as well as a valuable resource provider in areas or aspects with insufficient government support.

## Sector reforms and resource management

**Health reforms.** The DOH continues to steer the sector towards better health by continuously instituting reforms - from the Health Sector Reform Agenda (HSRA) or *Kalusugan Para sa Masa* in 1999-2004 to FOURmula One (F1) for Health in 2005-2010 to Universal Health Care (UHC) or *Kalusugan Pangkalahatan* in 2011 to 2016. HSRA, focused on key reform areas: health financing, health regulation, public health programs, public hospitals and local health systems. The next wave of reform (F1) streamlined these areas into health financing, health regulation, health service delivery and good governance in health. UHC focused on health financing; policy, standards and regulation; service delivery; governance for health; human resources for health; and health information. F1 Plus for Health reform reverted to the original four pillars of F1 and added performance accountability as a cross-cutting pillar for better execution of policies and programs. It builds on the gains, good practices and lessons from past reforms (Figure 5.1). These major reforms were made in response to health sector fragmentation issues resulting from the devolution of basic health services to LGUs.

Nonetheless, DOH sectoral leadership continues to be challenged by: (1) inequities in access to essential health services and health outcomes across regions and provinces; (2) fragmentation in the health system, with blurred accountabilities; and (3) potential shift in governance structure.

Figure 5.1. Continuing Reforms in the Health Sector



Source: DOH, Philippine Health Statistics 2013

**Health sector resource management.** Despite previous health reform initiatives, local government support to the provision of comprehensive quality care remained wanting, as shown by its decreasing share in health expenditures. This has prompted constant DOH augmentation of LGU resources for critical service delivery components such as human resource for health, trainings, commodities and health facility enhancement.

The DOH also provides fund transfers and technical assistance to LGUs to support the implementation of health-related activities on the ground. In addition, the DOH is aligning the efforts of development partners to its thrusts and strategies through the Sector Development Approach for Health (SDAH), wherein all forms of support by development partners are managed by the Bureau of International Health Cooperation (BIHC) to coordinate and maximize use of resources for health.

## Organizational development and performance

**Organizational structure, staffing pattern and skills mix.** In August 2013, the DOH Rationalization Plan was implemented pursuant to Executive Order 366 of 2004, reducing the number of Central Office personnel by 16 percent (from 1,180 to 986) and that of CHD personnel by half (from 4,733 to 2,386). This move, however, did not complement the substantial increase in DOH budget, which translated to more programs and projects that required increased personnel complement. The resulting shortage of personnel was temporarily resolved with the DOH engagement of 14,714 Job Contractors. The DOH needs to work closely with its managers and experts in determining the appropriate staffing and skills mix requirements for its workforce in all healthcare settings.

**Competency-based HRH system.** The DOH adopted a competency-based system in its recruitment and selection, performance management system, career development, learning and development, workforce analysis and planning, succession planning and reward management. Specifically, competency-based assessment tools, job descriptions, training needs assessment, curriculum development and design, and promotion criteria were developed to ensure that its current HRH, as well as the succeeding ones, are capacitated as leader in health, enabler and capacity builder as well as technical assistance provider. In line with this, the DOH conceptualized the DOH Academy to offer courses on health leadership and health management like program planning, financial management, health governance, health information system, health policy development and HRH programs. The DOH Academy will be established in partnership with higher education institutions.

## Procurement and logistics management

**Procurement and logistics management system.** Procurement and logistics management are currently performed by individual units of the DOH: the central office, CHDs, hospitals, treatment and rehabilitation centers, as well as various local government units and government agencies implementing health programs and services. The central office, based on the Project Procurement Management Plans of the various offices and health programs, procures and manages warehousing and distribution of goods for selected public health programs of national importance and distributes stocks to CHDs, hospitals, and local health units. These include bulk procurement for vaccines, drugs and medicines, micronutrients, therapeutic food, family planning commodities, and medical and dental laboratory supplies to maximize economies of scale. On the other hand, the peripheral units purchase the goods, services and infrastructure that are considered crucial to the efficient discharge of their functions and those required for their day-to-day operations in pursuit of their primary mandate. DOH procuring entities, LGUs and other health facilities have appropriately established a systematic and well-designed procurement system organizations in compliance with RA No. 9184, otherwise known as the Government Procurement Reform Act, such as Bids and Awards Committee (BAC), BAC Secretariat, Technical Working Groups and Observers including a procurement practitioners' professionalization system and use of government-wide standard tools, forms and documents.

**Warehousing facilities.** Currently, DOH has only six existing warehouses. Three are in the NCR (i.e. DOH Central Office compound, Quirino Memorial Medical Center Compound, and POPCOM), in addition to three other rented warehouse spaces. In sum, the DOH currently has a total of 12,000 sq.m of warehouse space, which is way below its total requirement of 30,000 sq.m. Moreover, the CHDs have their respective warehouses, which are also insufficient for their requirements.

At the central level, the Procurement Service provides the overall organizational, monitoring and administrative support to the DOH procurement process while the Logistics Management Division (LMD) takes charge of the warehousing and distribution of centrally-procured goods to the CHDs, hospitals (e.g. cancer and mental health drugs, and selected maintenance drugs) and to LGUs. Both offices have continuous improvement process (CIP) programs and have been developing and implementing systems using ICT in some processes to address problematic challenges in procurement and logistics.



## Health policy and program development and implementation

**Policy and decision-making.** A main function of the DOH is the development of policies and guidelines that will assist the health sector in the attainment of the national health goals. In addition, the DOH, through its CO units and CHDs, has been guiding all its partners, especially the LGUs, towards the attainment of desired health outcomes. The CHDs serve as DOH field units responsible for ensuring that LGU goals are aligned with the national health system goals, and that the health performance targets of their respective catchment provinces and cities are met. In addition, these units have been managing all available resources for health and leveraging them with the LGUs for performance of activities that are aligned with F1 Plus for Health. A major tool being used to assist the LGUs in attaining their health performance targets is the Local Investment Plan for Health (LIPH), which is managed by the Bureau of Local Health Systems Development (BLHSD). As of August 2015, 44 out of 81 provinces and 18 out of 38 HUCs/ICCs<sup>14</sup> have submitted their LIPH 2014-2016 to CHDs for review.

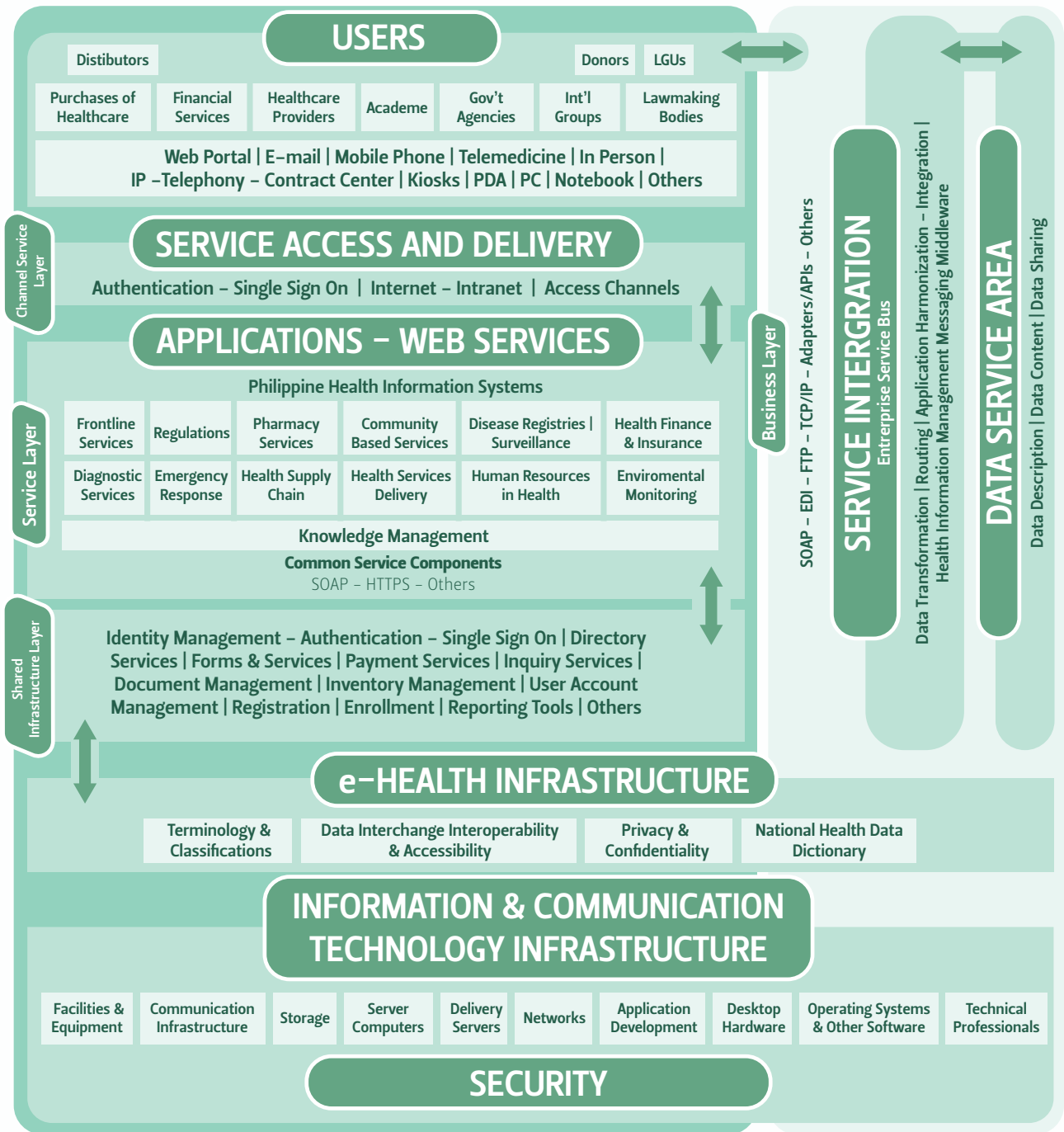
The DOH is now applying available tools and methods in its policy development and planning processes. The different units and programs of DOH, especially those involved in public health and health facilities development, have been developing policies and standards that apply to the different players in the health sector. This is in recognition of the role of DOH as sector leader. In addition, the DOH already implements a policy and standard development process being managed by the Health Policy Development and Planning Bureau (HPDPB). While standards or guidelines development are generally left at the discretion of the implementing unit or program with technical assistance from HPDPB, policies go through a more rigorous process. This process culminates with its ratification by the DOH Executive Committee headed by the Secretary of Health and composed of the undersecretaries and assistant secretaries of DOH.

**Health information system.** The establishment and implementation of various health information systems is lodged in the Knowledge Management and Information Technology Service (KMITS). It is currently implementing the Philippine eHealth Strategic Framework and Plan (2014-2020) that is composed of the following: (1) legislation, policy and compliance; (2) governance; (3) strategy and investment; (4) standards and interoperability; (5) eHealth solutions; and (6) human resource. Data collection from the LGUs has also suffered under the devolved set-up. It is with the end in view of establishing an effective information system that can aid in meaningful policy and decision making on the needed programs.

<sup>14</sup> Highly urbanized cities (HUCs) are those with a minimum population of 200,000 inhabitants and latest annual income of at least 50 million pesos; independent component cities (ICCs) prohibit their voters from voting for provincial elective officials (Senate of the Philippines, 2013).

Figure 5.2 shows the DOH Enterprise Architecture for the health information system for the entire health sector of the country. It is a product of assessments done by DOH and partners on health information gaps and needed capabilities for e-government implementation.

Figure 5.2. DOH Enterprise Architecture



Source: DOH - KMITS

# CHALLENGES AND IMPLICATIONS

## Sector leadership and management

### *Fragmented governance structures*

The Local Government Code of 1991 fragmented the overall health governance system with the devolution of the operation of provincial and municipal hospitals, RHUs, BHSs and almost all public health programs to LGUs. The DOH role has shifted from being the sole provider of health services to being the “servicer of servicers” that provide technical assistance in policy development, health regulation, M&E, capacity building, and specialty care provision. On the other hand, the LGUs have generally assumed the role of health service provider but not all were prepared to take on such a role. Health financing has also become more complicated as funds for health programs and services have been lodged to individual LGUs and different agencies with health-related interventions. The thin line between DOH and LGU mandates on health governance has created complex interactions and resulted in lack of coordination among institutions in the sector.

### *Impending shifts in governance structures*

The President’s SONA 2018 urges the speedy passage of the Universal Health Care bill, highlighting the following: (1) streamlining of the various sources of financial assistance for the people with various health related needs, (2) establishing province-wide and city-wide health service delivery networks, (3) institutionalizing primary care as a prerequisite to access higher level of health care, and (4) supplementing human resource gaps of LGUs through a national health workforce support system. As this proposal is a priority of both executive and legislative branches, its eventual passage is to be expected. In this scenario, F1 Plus for Health implementation could serve as a transition phase. However, preparation of the IRR and the shifting activities will take time and may prove to be difficult due to the measure’s implications on the health sector. This will also be a challenge to the DOH in terms of its stewardship function as well as the daunting task of explaining to the people that the changes in the health system will not be immediate.

Another probable change in the health sector structure is the effect of the proposed federalism. The President is strongly advocating to Congress for a change in government structure to federalism. If this becomes successful, the structure of the entire health sector and the DOH organization will correspondingly shift depending on the provisions on how health will be managed.

## Organizational development and performance

### *Uncoordinated human resource interventions*

The succession planning being prepared by DOH would apply only on its organization. While its framework is yet to be completed, the career maps for the different positions are already completed. Job and competency standards are not always the basis for recruitment and selection despite the competency-based framework adopted by the DOH. The learning development plans are not related to performance management and career management, and learning development interventions are not specific to job functions. There is no system for tracking investments for learning development in CHDs and LGUs. The DOH Academy designed by the DOH offers courses that have yet to be made more sectoral in approach to be relevant not only to DOH but to LGUs as well. In terms of succession planning, mentorship has yet to be deliberately made part of central office supervisor functions and implementation of HRMD systems must be led by organic personnel to ensure sustainability.

## Procurement and logistics management systems

### *Complex system of procurement and logistics management of health products and services*

The procurement process is well-defined in R.A. 9184, but health products have special requirements for assuring product safety and quality required by other laws and guidelines. Safety and quality of these products is primarily a regulation function of FDA for medicines and medical equipment including invasive devices and supplies that need to be sterile. Medicines to be procured must be in the Philippine National Formulary. Moreover, the product must have a valid Certificate of Registration and suppliers must have License to Operate. Special handling, storage and distribution are also required to

maintain an optimum efficacy. Some products also need to comply with international quality assurance standards. These standards have to be considered during procurement stage and adhered to before products are released for use by the health professionals and the public.

Forecasting and planning are done by program managers, while the procurement is done by the Bids and Awards Committees assisted by the technical working groups and the PS. The delivery, warehousing and distribution are managed by Logistics Management Division (LMD) with third party logistics service providers.

### *Inadequate staff and limited technical expertise in procurement and supply chain management*

Most DOH officials are apprehensive in participating in the procurement process due to the sensitivity of the responsibilities involved, unfamiliarity with R.A. 9184 and other related laws, and expectation to accomplish similar urgent tasks. The Procurement Service has 49 organic staff with around 17 Job Order Contractors while LMD has only 10 organic positions which necessitate hiring of Job Order Contractors as well. These staff complement are managing the acceptance of deliveries, storage and nationwide distribution of goods costing around PhP15 billion pesos annually. In addition, LMD also manages at least three DOH warehouses and several third-party logistics providers. The CHDs, hospitals and local health units have similar problems of availability of adept staff to undertake planning, procurement and logistics management. With these circumstances and limitations, the processes are viewed as separate and unrelated transactions.

In addition to the inadequacy of competent staff, the skills and efforts in implementing the procurement and logistics management systems are scattered and uncoordinated due to limited synergy and cooperation, and harmonization of various processes, from planning and forecasting to distribution of commodities. Furthermore, the exodus of many DOH technical staff due to the recent rationalization is another factor that contributes to poor procurement system. Most of them were replaced by Job Contractors who could leave the service anytime. These contractual staff are usually assigned to take on all the procurement tasks due to the workload of regular staff. There are times when this arrangement results in poor procurement management because the delegated tasks are perceived to be mere routine and transactional business activities from the point of view of these contractual staff.

### *Lack of information for proper procurement planning and delivery of logistics*

There is no harmonized information system on DOH procurement and logistics. There are instances when program managers request commodities for immediate procurement and delivery without consideration or knowledge of the same commodities in the pipeline scheduled for delivery. Even the inventory of stocks shared by the Logistics Management Division (LMD) with the program managers does not present a clear picture of the stock status. Inventory reporting is low, delayed and uses different reporting formats which makes inventory reports unreliable. Consumption data of distributed commodities is limited. This leads to absence of reliable and timely information and improper planning. A single repository of data is also needed to facilitate accurate and updated information-sharing on the quantities of commodities to be procured, product specification and price lists, deliveries and available stocks, which can guide procurement planning.

Movement of commodities is not monitored meaningfully to link it with the timing of delivery. Coordination among all supply chain stakeholders including service delivery points, health facilities, provinces, cities, CHDs and central office needs to be strengthened to avoid rejection of and delays in deliveries, stockout and oversupply of commodities and product safety concerns. The facility storage capacity is unknown even at the regional level. This means that although they know the size of the warehouse, they do not know the available space at the period of delivery. When rejected, the commodities are returned to the Central Office by the courier and will be charged for double handling fee. Delays in transit can affect the quality of commodities.

### *Inefficient logistics management process*

Poor storage process and allegations of corruption have made logistics management very inefficient. The heavy documentation requirements and high number of allocation orders burden the already inadequate personnel who also face challenges in warehousing know-how or capacity. Other identified warehousing gaps are as follows: (1) short-term contract of the courier and the warehouses; (2) heavy burden on documentation; (3) inaccessible data on the stock and shipment status, warehouse capacity and space availability; (4) no location management system in place; and (5) increased inventory holding time due to prolonged release of quality control tests from FDA. These challenges are more pronounced because of the slow movement of commodities from the warehouses to the intended recipients, which results from a fragmented supply chain management as discussed above. The inability to adequately address the problem of slow movement of commodities costs additional budget and effort on the part of DOH as it rents and manages additional warehouse space.



The increase in health budget has tripled the procurement of commodities. This resulted in high volume of current inventory, without an increase in the already limited space of the current warehouse facilities. Delays are encountered in different steps in the supply chain cycle including during the preparation of allocation list, repacking of commodities, and actual deliveries. Because of these delays, inventories unnecessarily occupy space in warehouses.

There have been periodic rejections of delivered commodities by the CHDs and service delivery points such as hospitals, RHUs, BHS, due to the following reasons: (1) near expiring commodities, (2) overstocking, (3) items that are not commonly used by recipients, (4) lack of trained personnel to distribute or administer the items, and (5) rejection upon call out (due to lack of space).

## Health information system and evidence-based policy development

### *Constraints in the generation and use of health information*

Manual collection of data needed for the different health surveys conducted by the DOH and the various reports it requires from field offices has burdened local health coordinators and personnel who are already preoccupied with regular work (e.g. Field Health Service Information System or FHSIS). Overlaps as well as duplication in the content of related reporting forms result in tedious work on the ground with similar indicators repetitively being requested by the different DOH offices and concerned units. Submission of health-related data by private health providers has also been a challenge, especially given the Data Privacy Act of 2012, which aims to protect the right of privacy of personal data. Given that healthcare in the country is provided by both public and private sectors, lack of private sector information would diminish the effectiveness of health information system in providing evidence to address health challenges.

There is also a need for a common set of database and standard indicators to be used officially for policy and program monitoring and evaluation. The interoperability of the different health information systems such as the Hospital Operations Management Information System (HOMIS) for hospital-based morbidity data and the FHSIS for RHU/HC-based morbidity data, for instance, also needs to be looked into. Ways to increase utilization of health information for evidence-based decision-making on health likewise needs to be considered.

### *Fast-paced technology affecting health management information system*

The health management information system of DOH is heavily affected by rapid advancement in information technology. It has to determine the balance between developing a “hi-tech” system, as desired by the different programs, and maintaining connectivity at the “last mile,” which would enable data submission even from GIDAs. At the same time, it is faced with the challenge of ensuring interoperability between its eHealth intervention and the various “telehealth” systems that have mushroomed in different localities as well as the hospital operation management information systems that have been independently developed in some of the DOH hospitals. Because of this, the health management information system remains fragmented. It started building a data exchange platform called the Philippine Health Information Exchange Lite, a platform shared with PhilHealth. To complicate things further, the DOH is currently burdened with the development of various health management information systems by virtue of different laws and health policies.

### *Limited use of research results in policy development*

In order to craft a good policy, evidences from researches and journals all over the world as well as data collected from the field should be easily accessed and assist the DOH policymakers in developing evidence-based policies. Aside from this, the different policy and standard development units of the DOH should be able to select and utilize appropriate information from all these sources. The crafting of policy issuances (e.g. administrative or administrative order, position papers on legislative proposals, manuals of operation, and guidelines) should be a product of good research. DOH technical staff are yet to veer away from developing these documents from mere anecdotal account, stock knowledge or circumstantial evidence. While there is a unit in HPDPB that manages the research agenda of DOH (i.e. the Research Division), their research results still have to find their way through the policy development mill. These practices should be replicated all throughout the DOH system, including the CHDs. Nonetheless, it is worth noting that scientific researches on the use of traditional, alternative, preventive and curative health care modalities are currently undertaken through PITAHC in accordance with government standards on medical practice.



# OBJECTIVES AND TARGETS

*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*

***Stepping up sectoral leadership and stewardship role.*** The DOH will intensify its leadership and stewardship of health partners such as international development partners, LGUs, NGOs, GOs and other government agencies through the development and implementation of sector wide policies. To ensure bias for health in all policy discourse, technical support will be provided to DOH units, as sector-wide policies are developed. Health impact studies will be commissioned to develop a strong position and basis for policy oversight. Program directions, data and other relevant information will be disseminated and advocated to local and international partners for them to align their respective programs, projects and activities. On the ground, the CHDs will ensure that these partners adhere to the directions set by CO. Effective communication measures of policy messages across the health sector will be developed.

***Fostering participatory governance in the health sector.*** Participatory governance will be promoted by developing and instituting mechanisms for community and patient engagements at the local level. This is to be undertaken in the context of SDN with regular consultations with health partners such as CSOs, NGOs, POs, and development partners. As public-private partnership becomes a new public management strategy, prioritization of health policies that would be developed with respect to infrastructure, service packages, drug abuse and treatment package and information and communication technology (ICT) will be ensured. Lastly, the different service units of the DOH are strongly urged to execute their functions in compliance to the mandates of the Citizen's Charter.

**Preparing for possible governance shift.** The DOH will ensure that all policies that would be issued will internalize the possible impact on health of proposed shifts in governance systems like federalism and universal health care. It will play an active role in arguing in favor of health in discussions in the Congress and other government agencies.

**Matching technical assistance with local investment plan for health (LIPH) needs.** The DOH will extend technical assistance to LGUs through the LIPH. This entails local health planning, localization of the health sector reforms, identification of actual needs, and directing partners and stakeholders on the type of assistance that could be offered to LGUs. It would transform the planning activity into a sector-wide undertaking where all the stakeholders participate and contribute their resources.

### *Specific Objective 11. Improved organizational development and performance*

**Adopting responsive organizational structure, staffing patterns and skills mix.** The DOH will ensure that all interventions are geared towards improving organizational development and performance at all levels of the health system. In parallel, responsiveness to the need of the sector by applying the appropriate staffing pattern and skills mix in hiring health personnel will be ensured. In the case of health personnel in devolved health offices and facilities, continuous advocacy for the staffing pattern and skills mix that are appropriate for the respective needs of LGUs will be observed.

**Linking of competency-based learning and development with succession planning.** The DOH will develop and implement competency-based learning and development interventions linked with succession planning. These should apply not only to DOH personnel but to LGU health staff as well. This initiative will be implemented with the end in view of ensuring continuity in the execution of programs, projects and activities, regardless of shifts in political leadership, throughout the health sector.

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

**Improving procurement and supply chain management systems.** The DOH will strengthen the capacities of concerned personnel in tightening the link between planning, procurement, budgeting and logistics management. It will also refine mechanisms that will strengthen coordination among the different units with functions relevant to procurement and logistics management. Special attention will be given to the improvement of planning and forecasting processes.

***Delivering on time at service delivery points.*** Necessary policies and timely advisories that would synchronize related activities of all involved units will be issued, with consideration to the challenges in procurement and logistics processes (i.e. identification of actual needs, heavy documentation, inadequate storage space and delays in delivery.) A strong linkage between PS and LMD with the end users and the CHDs will be developed to ensure efficient delivery and regular reporting of stock status in localities.

***Institutionalizing electronic procurement and logistics IT system.*** The DOH will establish and maintain an electronic procurement and logistics IT system. This initiative aims to utilize available technologies that are appropriate to all levels of the health sector. It will be linked with the CHDs in order to allow expedient exchanges of information regarding stock levels, status of delivery, etc. that would be useful for planning purposes.

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

***Instilling culture of research and evidence use.*** A culture of research and evidence use among the different units of the DOH will be instilled. Policies issued will be backed up by research and empirical data. In addition, scientific research on both traditional and alternative medicine and modern health care systems that impact on public health will continuously be enhanced.

***Providing access to quality and timely research and health data.*** The DOH will ensure that the result of researches, whether done in-house or commissioned, are made available to the public, in accordance with RA no. 10173, otherwise known as the “Data Privacy Act of 2012” and other existing data access policies. A library of all health and health-related researches will be developed, as well as an electronic platform to allow access to information by the public as well as health partners.

***Conducting regular surveys and implementation assessment.*** Regular surveys will be conducted to determine the general sentiments of the people regarding implemented projects, programs and activities. Regular program implementation review (PIR) to enable adjustments in the execution of their functions will be conducted. Units will also be encouraged to undertake policy impact evaluation to determine if corrective policies are necessary.

***Integrating data from various sources.*** A system that will enable the public and private actors in the health sector to upload clinical, administrative and financial information will be developed. The different health data systems will eventually be consolidated into the Unified Health Management Information System (UHMIS). It will be composed of data from various sources that would be brought together in order to allow the pertinent DOH units to assess diseases, injuries, disabilities, health service access, and deaths, among others. It is envisioned that the UHMIS will improve the standard of policy determination, data collection and transmission, data analysis, presentation, reporting and utilization in DOH (DOH UHMIS, 2018).

***Establishing evidence generation and appraisal.*** The capacity for evidence generation will be strengthened. Routine and timely generation of disease surveillance data such as mortality, morbidity and program coverage statistics will be ensured. Program managers, on the other hand, will be regularly conducting program analytics while the bureau in charge of health policy development will be providing health system analytics to assess and refine strategies on health, feeding into health systems improvement necessary to attain health sector goals and targets.

***Providing access to local and international publications.*** DOH officials and employees will be given access to local and international researches as well as other publications. This would make them aware of emerging technologies that could be applied to policy development and implementation.

***Institutionalizing Health Technology Assessment (HTA).*** The DOH will establish a unit to implement HTA at a wider coverage. HTA will be used to assist the DOH in policy development and planning, as it is a tool for deciding whether a health intervention, product or technology is appropriate to use.

**Table 5.1. National Objectives for Health 2017–2022  
Governance Indicators**

**General Objective 4:** Management capacities for functional and people-centered health systems strengthened

Indicators	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) <i>2014-2016 LIPH</i>	100% of LGUs with 2023-2025 LIPHS
Specific Objective 11. Improved organizational development and performance			
Indicator 49: Percent 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: Percent 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: Percent of new products/devices funded by DOH that have undergone HTA review	DOH PhilHealth	TBD	100%
Indicator 52: Percent of health facilities with functional electronic medical records (EMR) systems that regularly submit data	DOH-KMITS	5.7% (2016)	100%



# Chapter 6



## **PERFORMANCE ACCOUNTABILITY: TRANSPARENT AND RESPONSIVE HEALTH SECTOR**





# BACKGROUND

## The DOH Accountability Framework

Through the years, the DOH has developed monitoring programs and tools to determine the progress of implementing policies, programs and interventions. It also has collaborated with partner agencies such as the Philippine Statistics Authority (PSA) in determining which data to collect, methodology of data collection, and data sources of appropriate indicators for measuring progress.

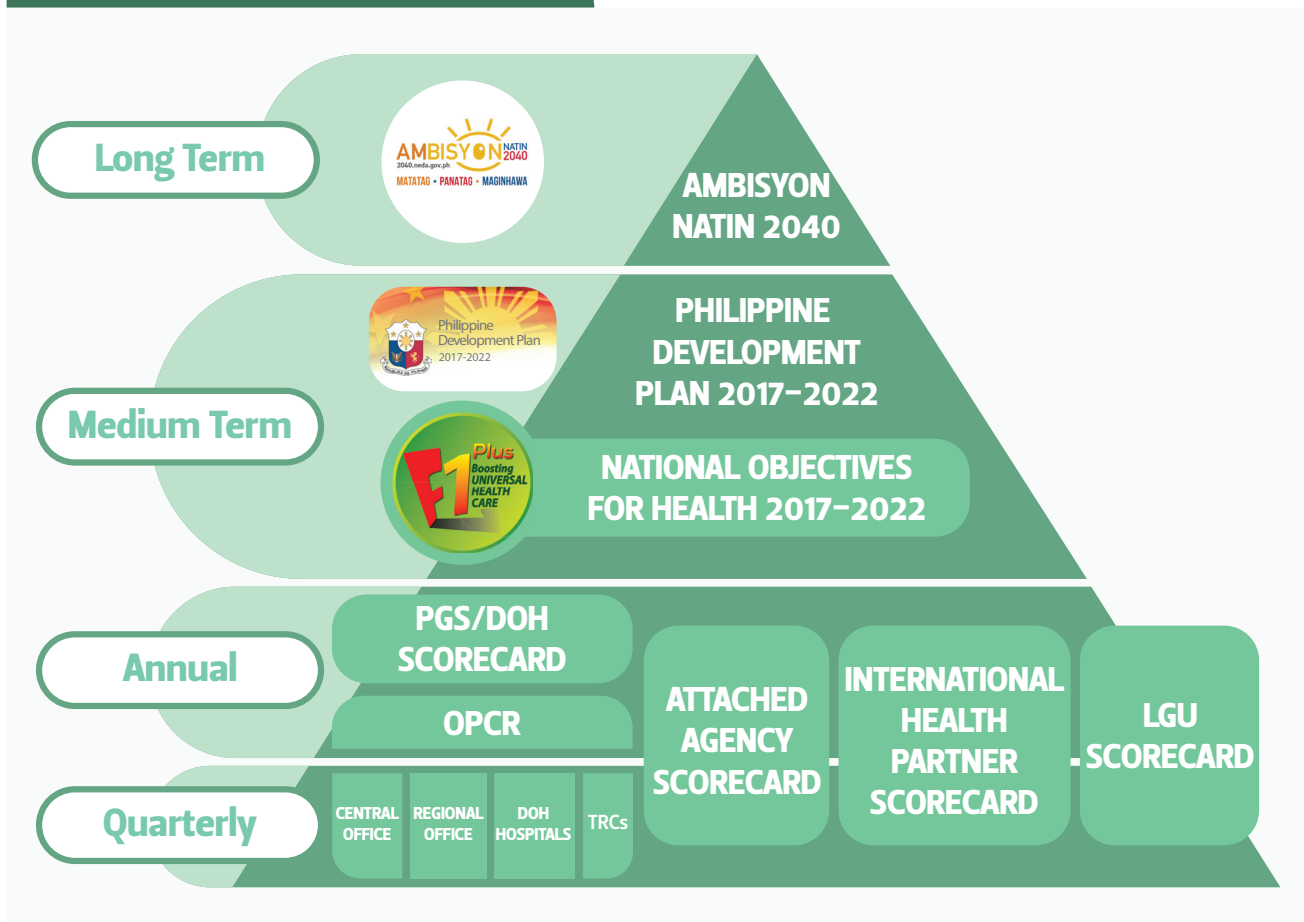
The DOH created a monitoring and evaluation (M&E) and data governance committee, which is composed of HPDPB, KMITS, EB, BLHSD, HFSRB and DPCB (DOH, 2016c). It serves as a clearinghouse for M&E data that should be collected based on the identified performance indicators. Data to be collected would come from all members of the health sector especially the LGUs. Certain DOH ad hoc units have been providing technical support to the committee, namely: (1) eHealth Governance Steering Committee, which takes care of information and communications technology (ICT) component; (2) Health Sector Performance Monitoring (HSPM) unit, which collects data from various DOH units including the CHDs; and (4) Office of Strategy Management (OSM), which tracks performance using the ISO and PGS. Certain interventions have been initiated in order to improve the M&E system, namely: (1) rationalization of national surveys, (2) revision of death certificate forms, (3) improvement of FHSIS, and (4) improvement of the LGU scorecard and linking it with FHSIS.

DOH has been using performance assessment measures such as the Strategic Performance Management System (SPMS); Quality Management System ISO 9001:2015 certification; Performance-Based Bonus (PBB); Integrity Management Program; and M&E Accountability System using scorecards. In the implementation of F1 Plus for Health, all these measures are to be integrated and aligned with the Performance Governance System (PGS).

Performance accountability involves measuring the physical performance and the financial performance of the DOH. The physical performance will be assessed through the PGS using the scorecards; while the financial performance will be measured through the quality of processes that improves an agency’s budget utilization rate (i.e. obligation and disbursement rates). Aside from having a high budget utilization rate, the DOH should not have disallowance, graft and corruption and similar cases. Proper reporting of these two components will generally measure the overall efficiency of DOH.

The DOH Accountability Framework (Figure 6.1) ensures an alignment of M&E tools and indicators with *Ambisyon Natin 2040* through the Philippine Development Plan 2017-2022 and the succeeding PDPs, with the goal of “Filipino people living long and healthy lives.” The scorecards serve as an instrument for the annual performance assessment of major stakeholders in health. The National Objectives for Health 2017-2022 as well as the PDP provide the medium-term health goals and targets against which health sector performance in the medium term may be assessed.

Figure 6.1. Accountability Framework



Source: Department of Health - Health Policy Development and Planning Bureau

## The Performance Governance System (PGS)

The PGS is a performance management system that uses balanced scorecard technology. It does not only measure an organization's output but also the impact of programs, projects and activities to its human resources, clients and patients, stakeholders and partners (IPO, 2018). It is a governance framework and a management tool that promotes participatory and strategic partnership between the organization and its partners. It has four stages, namely: initiation, compliance, proficiency, and institutionalization. PGS is not new to DOH as it was already adopted in 2009. However, it was stopped in 2011 when DOH decided to focus on ISO as means to improve its standards of operations.

The DOH is institutionalizing the PGS as a governance framework to implement the F1 Plus for Health. This tool will ensure that the programs, projects and activities are all geared towards contributing to the attainment of the health sector goals, and that commitments from each cluster, bureau, division and employee are drawn and monitored. The PGS serves as basis for the development of scorecards for the DOH Central Office, CHDs, hospitals, attached agencies, LGUs and international health partners.

These scorecards will help the DOH monitor and evaluate its programs, projects and activities; formulate needed policies and standards; and continually adjust and align with the health sector vision, guided by the Philippine Development Plan 2017-2022, *Ambisyon Natin 2040*, the F1 Plus for Health strategy map, and the Sustainable Development Goals (SDGs).

## The Health Scorecards

### *Sectoral Scorecard*

The Sectoral Scorecard contains 10 impact indicators to which the overall performance of the health sector will be measured. The indicators were categorized according to their impact on the attainment of better health outcomes, responsive health system and financial risk protection. All disease groups were represented and include respective indicators on the country's ranking in Southeast Asia in terms of health outcomes. The sectoral scorecard guides the government in its vision to make Filipinos among the healthiest people in Southeast Asia by 2022. Attainment of sector-wide indicators, however, requires the cooperation of the DOH, other government agencies, LGUs, NGOs, the private sector, CSOs and other concerned stakeholders.

### *DOH Scorecard*

The DOH Scorecard measures whether the operational activities of the DOH as an organization are aligned to its larger-scale and longer-term objectives and strategies. The performance indicators of the DOH scorecard will be the basis of the Office Performance Commitment Review (OPCR) strategic indicators of the different DOH units. The OPCR consists of three components: (1) core processes that measure performance of each unit based on its mandate, (2) strategic processes that measure whether or not the PGS commitments of an agency have been attained, and (3) administrative processes that measure the routine work of a unit including its budget utilization.

### *Hospital Scorecard*

The Hospital Scorecard reflects the performance of the hospitals (DOH-retained, LGU-owned and private) in the execution of their mandates, on health outcomes expected of hospitals, and the production of goods and services desired by their clients. While performance of DOH-retained hospitals will be measured using the three components of the OPCR, only the core indicators shall be applicable to LGU-owned and private hospitals. The core indicators will be harmonized to allow generation of one consolidated report for all hospitals.

### *Attached Agencies Scorecards*

The DOH Attached Agency Scorecard reflects the performance of the DOH attached agencies, such as, National Nutrition Council (NNC), Commission on Population (POPCOM), Philippine Health Insurance Corporation (PhilHealth), and the Philippine Institute of Traditional and Alternative Health Care (PITHAC). It will be used to track progress in the execution of their mandates in relation to programs, projects and activities that contribute to the overall goal of the health sector.

### *International Health Partners Scorecard*

The International Health Partners Scorecard monitors the alignment of development support from partner agencies to the thrusts and directions of the F1 Plus for Health. It reflects the contribution of international development partners in the attainment of Philippine health sector goals. The scorecard will be used as a tool for dialogue with the aim of enhancing the partnership towards the attainment of the F1 Plus for Health goals and will not be used to rank development partners.

### *LGU Health Scorecard*

The LGU Health Scorecard monitors and evaluates the performance of the LGUs in implementing and achieving the results of the health sector reforms as well as progress in meeting the national health targets based on the priority programs, projects and activities of the government. This is the most mature form of scorecard as it was actually introduced and used since 2008 to track the LGUs' performance in terms of implementing the health sector reforms using F1 as framework.<sup>15</sup> In order to improve collection and data management, a partnership agreement was forged between the DOH and DILG, which took effect in 2009 until 2016. It increased the turnout of data due to the clout of DILG over the LGUs. In 2017, KMITS developed a web-based system to automate the collection and generation of report cards.

<sup>15</sup> This was done through the issuance of DOH AO 2008-0017, entitled: "Implementing Guidelines for the LGU Scorecard".

# CHALLENGES AND IMPLICATIONS

## Poor data collection and reporting of performance measures

The information system within the health sector is not fully developed. It could not be easily accessed, which makes data collection very difficult. The collection of numerous data from LGUs has led to numerous health indicators (around 600) and definitions that are not standardized. The data governance guidelines are also poorly defined as it does not provide a protocol for determining accurate data that can be officially released. There are also no existing sources for the new SDG and SDN indicators. Moreover, the source of private sector data is inadequate. Reporting is inefficient due to existence of multiple reporting forms, manual submission of reports, and the lack of a central repository of available data. There are also too many disease registries and information systems. Some are functional (i.e. ITIS on TB, ILIS on Leprosy, and MAP); while some are not (i.e. hypertension and diabetes registry). These systems are not unified. Data are not shared and used by all program managers, which leads to poor utilization.

## Overlapping and uncoordinated performance monitoring system

Several performance monitoring systems and tools, if not integrated, will not faithfully show the actual performance of a DOH unit or individual. Some indicators are confusing and do not complement one another in describing a performance. Different units sometimes have different perspectives regarding a specific indicator. For example, in terms of modern contraceptive prevalence rate, the FHO-DPCB has different targets as compared to POPCOM.

## Poor utilization of the results of performance measures in improving health service delivery

Performance accountability measures are not fully appreciated by the employees. While it is linked to the granting of bonuses, the rating process of employees is just considered as a routine part of the regular salary. Hence, rating does not reflect the actual performance. This shows a poor link between actual performance and incentives and accountabilities.

# OBJECTIVES AND TARGETS

*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*

***Integrating performance and reporting tools, systems and processes.*** The DOH will standardize an M&E system as well as plan its implementation. This will include the selection of indicators, defining data, and determining official data source thereof. An M&E system will be developed for each of the following: DOH organization, DOH units and programs, DOH attached agencies, hospitals (both government and private), international health partners, and LGUs. They will be issued as “scorecards” that will be vetted with concerned units and stakeholders.

***Identifying performance metrics with accountable implementers.*** A data governance policy will be developed. The mode and the unit or person responsible for reporting on the attainment of specified indicators will also be specified. The M&E systems developed will promote performance accountability as units or persons would be made accountable for the attainment of each specified indicator.

***Publishing user-friendly scorecards and performance reports.*** The DOH will harmonize the current health information system with all existing databases. This will promote the provision of real time data availability and improve data utilization on the part of program managers through a data-sharing platform or dashboard. DOH units will be able to meaningfully formulate policies based on evidences that would result from the M&E systems.



***Aligning M&E to PDP, Ambisyon Natin 2040 and SDGs.***

The DOH will ensure that all the scorecards are aligned with the government health strategies as contained in PDP, *Ambisyon Natin 2040* and SDGs. By providing regular feedback on sentinel health system indicators, these instruments will help validate and refine government strategies for attaining the country's medium and long-term goals and targets on health as they show where operational challenges lie and when performance improvements are most needed.

***Specific Objective 15. Outcome-based management approach used***

***Establishing monitoring and performance review.*** The Performance Governance System (PGS) will be institutionalized and strengthened to ensure that programs, projects and activities lead to the attainment of health sector goals. Regular monitoring of performance commitments from the different bureaus, regional offices, attached agencies and units in the DOH, as well as the LGUs and international health partners, will be conducted through the use of scorecards. This will ensure that performance outputs and outcomes are attributed to specific offices and units mandated to perform specific tasks. This will also ensure that health sector performance measures are transparent and stakeholders are made accountable for health outcomes.

***Linking performance to appropriate incentives.*** The DOH will institutionalize a mechanism to leverage central-based health resources for improved health performance, as reflected in the health outcome indicators contained in the scorecards. In addition, financial incentives, such as performance-based bonus (PBB) for its personnel will consider the financial performance (i.e. budget utilization) of the DOH as well as its attainment of physical targets. PBB will be used to bring about desired changes in health outcomes through improvements in service delivery, financing, regulation and governance.



**Table 6.1. National Objectives for Health 2017–2022  
Performance Accountability Indicators**

**General Objective 5:** Better health attained through transparent, responsive and responsible health sector management

Indicators	Data Source	Baseline	2022 Target
<i>Specific Objective 14. Transparency and accountability measures at all levels instituted</i>			
Indicator 53: Proportion of health facilities publicly reporting performance data	DOH-OSM	TBD	100%
<i>Specific Objective 15. Outcome-based management approach used</i>			
Indicator 54: Percent of health organizations with overall excellent rating in their health performance scorecards	DOH-OSM	TBD	TBD
Indicator 55: Average budget utilization rate of government health facilities (disaggregated by obligation and disbursement rate)	DOH-FMS	85% (DOH – Obligation Rate)  65% (DOH-Disbursement Rate) (2016)	99% (Obligation Rate)  85% (Disbursement Rate)





**PERFORMANCE  
INDICATORS  
AND TARGETS  
AT A GLANCE**



## Strategic Goals

Data Source

Baseline

2022 Target

## GOAL 1 – BETTER HEALTH OUTCOMES

Indicator	Description	Data Source	Baseline	2022 Target
Indicator 1:	Average life expectancy (in years)	PSA	70 (2010-2015)	72
Indicator 2:	Maternal mortality ratio per 100,00 live births	UN Estimates	114 (2015)	90
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	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	FNRI-DOST NNS	33.4 (2015)	21.4

## GOAL 2 – RESPONSIVE HEALTH SYSTEM

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

## GOAL 3 – EQUITABLE HEALTH FINANCING

Indicator	Description	Data Source	Baseline	2022 Target
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>(TBD)</i>		

## Strategic Pillars

## Financing

**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*

Indicator	Description	Data Source	Baseline	2022 Target
Indicator 11:	Domestic general government health expenditure as percentage of GDP	PSA-PNHA	1.6% (2016)	2.5%
Indicator 12:	Domestic general government health expenditure per capita	PSA-PNHA	PhP 2,258 per person (2016)	PhP 4,674 per person
Indicator 13:	Social health insurance as percentage of THE*	PSA-PNHA	16.7% (2016)	30%
Indicator 14:	Government financing (national and local) as percentage of THE*	PSA-PNHA	18.9% (2016)	20%

	Data Source	Baseline	2022 Target
<b>SPECIFIC OBJECTIVE 2</b> <i>Health spending rationalized</i>			
Indicator 15: Percentage of NBB-eligible patients with zero co-payment	PhilHealth	63% (2016)	100%
<b>SPECIFIC OBJECTIVE 3</b> <i>Financial resources focused towards high-impact interventions</i>			
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	

## Service Delivery

**GENERAL OBJECTIVE 2** Accessibility of essential quality health products and services ensured at appropriate levels of care

<b>SPECIFIC OBJECTIVE 4</b> <i>Access to quality essential health products and services increased</i>			
Indicator 19: Modern contraceptive prevalence rate (all women)	PSA-NDHS	24.9% (2017)	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 21: Percent of fully immunized children	PSA-NDHS	62% (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	8.6 per 100,000 population (2014)	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-DDAFTP	73% (2017)	88%
Indicator 27: Tuberculosis treatment coverage	Global TB Report	58% (2016)	90%

	Data Source	Baseline	2022 Target
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% (32/81) (2016)	91% (74/81)
Indicator 30: Percent of provinces that are filariasis-free	DOH-DPCB	76% (35/46) (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	TBD	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%

## 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%

## SPECIFIC OBJECTIVE 7

*Service delivery networks (SDNs) organized and engaged*

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		

Data Source

Baseline

2022 Target

### Regulation

**GENERAL OBJECTIVE 3** High quality and affordable health products, devices, facilities and services ensured

**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/ RO-RLEDS FDA, BOQ	TBD	100% (HFSRB)
Indicator 43:	Percent of all newly registered pharmaceutical products able to be subjected to post-marketing surveillance	DOH-FDA	TBD	TBD
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	TBD	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	TBD	<2% (2020)
Indicator 46:	Median consumer price ratio of selected essential medicines	DOH-PD	Public: • Originator brand = 3.52 • Lowest price generic = 3.24  Private: • Originator brand = 20.52 • Lowest price generic = 3.75	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	TBD	96% (HFSRB)

### Governance

**GENERAL OBJECTIVE 4** Management capacities for functional and people-centered health systems strengthened

**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
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**SPECIFIC OBJECTIVE 11** *Improved organizational development and performance*

Indicator 49:	Percent of DOH units that are PGS-certified (disaggregated by PGS stage)	DOH-OSM	2.82% (2016)	100%
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Data Source

Baseline

2022 Target

**SPECIFIC OBJECTIVE 12**

*Improved processes for procurement and supply chain management in order to ensure availability and quality of health commodities*

Indicator 50:	Percent 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%
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**SPECIFIC OBJECTIVE 13**

*Ensured generation and use of evidence in health policy development, decision making, and program planning and implementation*

Indicator 51:	Percent of new products/devices funded by DOH that have undergone HTA review	DOH PhilHealth	TBD	100%
Indicator 52:	Percent of health facilities with functional electronic medical records (EMR) systems that regularly submit data	DOH-KMITS	5.7% (2016)	100%

## Performance Accountability

**GENERAL OBJECTIVE 5**

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

**SPECIFIC OBJECTIVE 14**

*Transparency and accountability measures at all levels instituted*

Indicator 53:	Proportion of health facilities publicly reporting performance data	DOH-OSM	TBD	100%
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**SPECIFIC OBJECTIVE 15**

*Outcome-based management approach used*

Indicator 54:	Percent of health organizations with overall excellent rating in their health performance scorecards	DOH-OSM	TBD	TBD
Indicator 55:	Average budget utilization rate of government health facilities (disaggregated by obligation and disbursement rate)	DOH-FMS	85% (DOH – Obligation rate) 65% (DOH- Disbursement Rate) (2016)	99% (Obligation Rate) 85% (Disbursement Rate)



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# **ACRONYMS**



<b>ARMM</b>	Autonomous Region of Muslim Mindanao
<b>BHS</b>	Barangay Health Station
<b>BNB</b>	Botika ng Barangay
<b>BOQ</b>	Bureau of Quarantine
<b>CAR</b>	Cordillera Administrative Region
<b>CHD</b>	Center for Health Development
<b>CHED</b>	Commission on Higher Education
<b>COPD</b>	Chronic Obstructive Pulmonary Disease
<b>CPR</b>	Contraceptive Prevalence Rate
<b>CSO</b>	Civil Society Organizations
<b>CVD</b>	Cardiovascular Disease
<b>DBM</b>	Department of Budget and Management
<b>DND</b>	Department of National Defense
<b>DOH</b>	Department of Health
<b>DOST</b>	Department of Science and Technology
<b>DPCB</b>	Disease Prevention and Control Bureau
<b>DSWD</b>	Department of Social Welfare and Development
<b>DTTB</b>	Doctors to the Barrios
<b>EB</b>	Epidemiology Bureau
<b>FDA</b>	Food and Drug Administration
<b>FHSIS</b>	Field Health Service Information System
<b>FNRI</b>	Food and Nutrition Research Institute
<b>FP</b>	Family Planning
<b>GDP</b>	Gross Domestic Product
<b>GIDA</b>	Geographically Isolated and Disadvantaged Areas
<b>HARP</b>	HIV/AIDS and ART Registry of the Philippines
<b>HFEP</b>	Health Facilities Enhancement Program
<b>HFSRB</b>	Health Facilities and Services Regulatory Bureau
<b>HIV-AIDS</b>	Human Immunodeficiency Virus - Acquired Immune Deficiency Syndrome
<b>HMO</b>	Health Maintenance Organization
<b>HOMIS</b>	Hospital Operations Management Information System
<b>HPDPB</b>	Health Policy Development and Planning Bureau
<b>HRH</b>	Human Resource for Health

<b>HRMD</b>	Human Resources Management and Development
<b>HTA</b>	Health Technology Assessment
<b>HUC</b>	Highly Urbanized Cities
<b>ICC</b>	Independent Component Cities
<b>ICT</b>	Information and Communication Technology
<b>ILHZ</b>	Inter-Local Health Zone
<b>IMR</b>	Infant Mortality Rate
<b>IRA</b>	Internal Revenue Allotment
<b>KMITS</b>	Knowledge Management and Information Technology Service
<b>LGC</b>	Local Government Code
<b>LGU</b>	Local Government Unit
<b>LIPH</b>	Local Investment Plan for Health
<b>LMD</b>	Logistics Management Division
<b>LTO</b>	License to Operate
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MAP</b>	Medicines Access Program
<b>MCHN</b>	Maternal and Child Health and Nutrition
<b>MDRP</b>	Maximum Drug Retail Price
<b>MHMAP</b>	Mental Health Medicines Access Program
<b>MMR</b>	Maternal Mortality Ratio
<b>NBB</b>	No Balance Billing
<b>NCD</b>	Non-Communicable Disease
<b>NCR</b>	National Capital Region
<b>NDHRHIS</b>	National Database of Human Resources for Health Information System
<b>NDHS</b>	National Demographic and Health Survey
<b>NGOs</b>	Non-Government Organizations
<b>NHIP</b>	National Health Insurance Program
<b>NHTS</b>	National Household Targeting System
<b>NOH</b>	National Objectives for Health
<b>OHS</b>	Occupational Health and Safety
<b>OOP</b>	Out-of-pocket
<b>PAGCOR</b>	Philippine Amusement and Gaming Corporation
<b>PBB</b>	Performance-Based Bonus

<b>PCSO</b>	Philippine Charity Sweepstakes Office
<b>PDP</b>	Philippine Development Plan
<b>PGS</b>	Performance Governance System
<b>PHA</b>	Philippine Health Agenda
<b>PHAP</b>	Pharmaceutical and Health Care Association of the Philippines
<b>PIDS</b>	Philippine Institute for Development Studies
<b>PNDF</b>	Philippine National Drug Formulary
<b>PNHA</b>	Philippine National Health Accounts
<b>PNP</b>	Philippine National Police
<b>POPCOM</b>	Commission on Population
<b>PRC</b>	Professional Regulation Commission
<b>PS</b>	Procurement Service
<b>PSA</b>	Philippine Statistics Authority
<b>PWD</b>	Person with Disability
<b>RA</b>	Republic Act
<b>RHU</b>	Rural Health Unit
<b>RLED</b>	Regulation, Licensing and Enforcement Division
<b>SDG</b>	Sustainable Development Goals
<b>SDN</b>	Service Delivery Network
<b>SHI</b>	Social Health Insurance
<b>TB</b>	Tuberculosis
<b>TESDA</b>	Technical Education and Skills Development Authority
<b>TFR</b>	Total Fertility Rate
<b>THE</b>	Total Health Expenditure
<b>TRAIN</b>	Tax Reform for Acceleration and Inclusion
<b>UHC</b>	Universal Health Care
<b>UHMIS</b>	Unified Health Management Information System
<b>UNDP</b>	United Nations Development Programme
<b>UNICEF</b>	United Nations Children's Fund
<b>USAID</b>	U.S. Agency for International Development
<b>WHO</b>	World Health Organization
<b>WPRO</b>	Western Pacific Regional Office





The background features a composition of overlapping geometric shapes. A large, dark teal circle is positioned in the upper left. A diagonal band of medium teal runs from the top left towards the bottom right. A large, light yellow shape occupies the bottom right corner. A dark teal circle is also visible at the bottom center, partially overlapping the yellow area.

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The background consists of several overlapping geometric shapes. A large, dark teal shape is in the top-left corner. A medium teal shape is in the top-right. A large, medium teal shape covers the middle and bottom-left. A bright yellow shape is in the bottom-right. The word "ANNEX" is centered in the medium teal area.

**ANNEX**





Republic of the Philippines  
Department of Health  
**OFFICE OF THE SECRETARY**

**MAY 30 2018**

**ADMINISTRATIVE ORDER**

No. 2018 - 0014

**SUBJECT: Strategic Framework and Implementing Guidelines for *FOUR*mula One Plus for Health (F1+)**

**I. BACKGROUND AND RATIONALE**

In response to the challenges brought about by the devolution of health services to local government units (LGUs) as mandated by RA 7160 (Local Government Code of 1991) and the enactment of RA 7875 (National Health Insurance Act of 1995) providing all citizens with mechanism to gain financial access to health services, the DOH developed in 1999 the Health Sector Reform Agenda (HSRA) as the policy framework for crucial reforms in the health sector. The HSRA culminated in the adoption of the *FOUR*mula One (F1) for Health as the implementing framework for health reforms for 2005-2010. F1 for Health established four major pillars, namely, financing, service delivery, regulation and governance, as a single package of targeted reforms in the health sector. As a result of its implementation, service capacities and performance of government health facilities at national and local levels were enhanced. This resulted in improvement of health outcomes among Filipinos and made the DOH one of the most trusted government agencies by 2009. Building on the successes of F1 for Health, the DOH adopted the Universal Health Care or Kalusugang Pangkalahatan (KP) as its strategic framework for 2011-2016. KP expanded the National Health Insurance Program (NHIP) and intensified investments in health infrastructure in line with the increased fiscal space from sin taxes. In 2016, with the change of administration, the Philippine Health Agenda 2016-2022 was issued to make health services better felt by the Filipino people.

With the fiscal space provided by the sin taxes, the coverage of the National Health Insurance Program (NHIP) rose from 51 percent in 2010 to 91 percent in 2016 (*PhilHealth Stats and Charts, 2010 and 2016*), while total health expenditures grew from about 381 billion pesos in 2010 to 655 billion pesos in 2016 (*Philippine National Health Accounts, 2016*). Despite the increase in health expenditures, improvement of health outcomes has been marginal, where the NDHS shows infant mortality rate lower at 21 per 1,000 live births in 2017 compared to 25 in 2008; 33.4 percent of children under-five are stunted compared to 32.3 in 2008; and the proportion of children aged 12-23 months given all basic vaccinations at 69.9 percent in 2017 compared to 79.5 percent in 2008 (*NDHS, 2008 and 2017*). Also, protection from financial risk has continued to be inadequate with NHIP support value averaging at 50 percent and compliance to no balance billing policy for indigent and sponsored members at 63 percent (*PhilHealth Stats and Charts, 2016*).

With the aim of attaining the goals outlined in the Philippine Development Plan 2017-2022, Ambisyon Natin 2040, and the Sustainable Development Goals, and building on the concept of *FOUR*mula One for Health 2005-2010, the medium-term strategic framework for 2017-2022 expands the four pillars of health reforms and highlights greater focus on performance accountability towards the Filipino people, thus, *FOUR*mula One Plus for Health or F1+, with its tagline “Boosting Universal Health Care”.

## II. OBJECTIVES

This Administrative Order aims to:

- A. Provide the overall policy directions for DOH offices, its attached agencies, and local government units in terms of prioritizing activities related to the *FOURmula One Plus for Health 2017-2022*; and,
- B. Provide guidance to development partners, other government agencies, and private stakeholders in identifying priority areas for health services and support.

## III. SCOPE AND COVERAGE

This issuance shall apply to the DOH central office bureaus and units, regional offices, hospitals and attached agencies; all public and private health care facilities; health care providers and support staff; LGUs; other national government agencies; development partners; civil society organizations; academic institutions; medical societies and organizations; and all other institutions relevant for the implementation of the F1+ for Health.

## IV. GENERAL GUIDELINES

- A. F1+ for Health shall organize critical initiatives in health into four strategic pillars, namely: Financing, Regulation, Service Delivery, Governance, plus a cross cutting initiative on Performance Accountability.
- B. The implementation of F1+ for Health shall focus on sustainable, manageable, and critical interventions that optimize available resources, supported by evidence and sufficient groundwork, and produce tangible results that are felt by Filipinos.
- C. The reforms shall be implemented under the concept of a whole-of-society, whole-of-government, and whole-of-system approach that encompasses the entire health sector and other social determinants impacting health.
- D. The functional management arrangements shall be defined in terms of specific offices and institutions having clear mandates, performance targets, and support systems, within well-defined time frames in the implementation of reforms within each pillar.

## V. POLICY FRAMEWORK

- A. **Vision** – The DOH envisions Filipinos as among the healthiest people in Southeast Asia by 2022, and in Asia by 2040.
- B. **Mission** – The DOH shall lead the country in the development of a productive, resilient, equitable, and people-centered health system.
- C. **Core Values** – The DOH shall embody at all times integrity, excellence, and compassion in carrying out its tasks and responsibilities.
- D. **Goals** – The F1+ for Health aims to ensure better health outcomes, a more responsive health system, and a more equitable health care financing.

- E. **Strategic Pillars** - The DOH shall organize health sector initiatives into four (4) pillars, namely: Financing, Service Delivery, Regulation, Governance, plus a cross-cutting initiative on Performance Accountability.

Each strategic pillar shall have its own objective, sub-pillars and key interventions, as follows:

**a. Strategic Pillar 1: Financing**

- i. **Objective** - The objective of the financing pillar is to secure sustainable investments to improve health outcomes and ensure efficient and equitable use of health resources.

ii. **Sub-pillars and Key Interventions**

1. **Efficiently mobilize and equitably distribute more resources for health**

- a. Sustainable resources for health shall be secured and equitably distributed by making NHIP premiums more progressive, improving efficiency in collecting premiums, and increasing revenue allocation from innovative health taxes.
- b. Fiscal autonomy and income retention shall be pursued in all government-owned health facilities to ensure that income generated is used for health services.
- c. Financial coverage from health maintenance organizations and private health insurance shall complement that of the NHIP.

2. **Rationalize health spending**

- d. The financing of health interventions shall be clearly delineated, where population-based interventions is financed through line item budgetary sources (national and local), while personal insurable health interventions shall be financed through the NHIP.
- e. National resources allocated for financing medical services for the poor and vulnerable (e.g., PCSO, PAGCOR, DSWD Medical Assistance, etc.) shall be consolidated into a single fund to prevent overlaps of financing, and provide easier access by the poor.
- f. Fixed co-payments for selected health packages shall be collected to prevent overutilization of health products and services.
- g. No additional co-payments shall be charged for patients in wards or basic accommodation, while only fixed co-payments shall be allowed for additional amenities and higher-level accommodation.
- h. A multi-year budget scheme shall be developed to support selected priority programs that require long term financing.

3. **Focus financial resources towards high impact interventions**

- i. A unified, transparent and explicit process of identifying priority programs to be funded by the DOH, LGUs, and PhilHealth shall be institutionalized with a focus on the following:
  - i. basic and essential primary care services;
  - ii. health services and programs for the poor, marginalized and vulnerable; and
  - iii. programs and services to achieve the Sustainable Development Goals, Philippine Development Plan, and AmBisyon Natin 2040.
- j. The financing and payment of health services shall be linked to performance that is based on good quality services and better health outcomes.

b. **Strategic Pillar 2: Service Delivery**

- i. **Objective** - The service delivery pillar's objective is to ensure the availability of essential quality health products and services at appropriate levels of care.

ii. **Sub-pillars and Key Interventions**

1. **Increase access to quality essential health products and services**

- a. A comprehensive essential health service package for all life stages and specialized health services shall be made available through designated health providers in strategic locations.
- b. Implementation strategies to reduce public health threats shall be intensified through:
- i. disease-free zone initiatives for diseases targeted for elimination as public health problems;
  - ii. disease prevention and control strategies for endemic communicable, non-communicable, and emerging and re-emerging diseases;
  - iii. disease surveillance and monitoring strategies;
  - iv. health promotion and communication strategies; and
  - v. resilient health systems and provision of essential health goods and services during times of disasters and emergencies.
- c. Access to quality diagnostic and therapeutic products and services shall be ensured by:
- i. engaging pharmacies to provide selected essential medicines to specific population groups under a revitalized Botika ng Bayan program;
  - ii. capacitating local health centers to ensure access to basic laboratory services; and
  - iii. facilitating access to quality and affordable health products and medicines (i.e., promotion of generics).

2. **Ensure equitable access to quality health facilities**

- a. Access to quality basic and specialized health facilities shall be assured through:
- i. upgrading of existing and constructing new health facilities based on a comprehensive needs assessment of service delivery networks (SDNs); and
  - ii. compliance of health facilities to accepted standards of care and clinical practice guidelines.
- b. Facilities for step-down and chronic care, and synergies provided through novel medical technologies shall be explored and developed.

3. **Ensure equitable distribution of human resources for health (HRH)**

- a. HRH requirements commensurate to the needs of the population shall be mapped and aligned with the strategies for expanding health facilities.
- b. Other government agencies (such as CHED, TESDA, and PRC) and professional societies shall be engaged to ensure adequate production of quality HRH especially in health professions with insufficient supply.
- c. Equitable distribution of HRH shall be assured through competitive compensation and benefit packages, and good working conditions for those assigned in GIDAs.



4. **Engage SDNs to deliver comprehensive package of health services**

- a. Public and private providers shall be organized into SDNs that will be responsible for the health needs of a defined population, including GIDAs.
- b. All families and individuals shall be assigned to a primary care provider in the SDN.
- c. Gatekeeping mechanisms at the primary level of the SDN shall be strengthened.
- d. Two-way referral mechanisms at all levels of the SDN shall be strengthened through an effective and efficient information, communication, and transport system.

c. **Strategic Pillar 3: Regulation**

- i. **Objective** - The objective of the regulation pillar is to ensure high quality and affordable health products, devices, facilities and services.

ii. **Sub-pillars and Key Interventions**

1. **Harmonize and streamline regulatory systems and processes**

- a. Mechanisms to streamline regulations through a one-stop-shop licensing, interagency data sharing, automation of systems and processes, regulatory impact assessments, and removal of overlaps and unnecessary regulatory requirements shall be established.
- b. Mandates and enforcement mechanisms to regulate health facilities, products and services, including emerging technologies, systems, and processes shall be expanded and strengthened.
- c. Conflicts of interest among regulatory bureaus and their officers, staff, and consultants shall be reviewed and managed.
- d. Third party accreditors shall be engaged to improve accountability and performance of health care providers.
- e. Health regulations shall be harmonized, benchmarked, and made compliant with regional and international standards.
- f. The public and consumers shall be informed and educated on the safety, quality, and prices of health goods and services.

2. **Develop innovative regulatory mechanisms for equitable distribution of quality and affordable health goods and services**

- a. Regulation-specific capacity building and training shall be provided for the staff of regulatory bureaus and offices.
- b. A national fee schedule to regulate prices of health goods and services shall be advocated and pursued.
- c. Network licensing and network accreditation of health facilities shall be adopted.
- d. Regulatory agencies shall apply risk and outcome-based regulation.
- e. Regulatory measures on the production and distribution of HRH shall be advocated and pursued to ensure equity of distribution and access.

d. **Strategic Pillar 4: Governance**

- i. **Objective** - The governance pillar aims to strengthen leadership and management capacities, coordination, and support mechanisms necessary to ensure functional, people-centered and participatory health systems.

## ii. Sub-pillars and Key Interventions

### 1. Strengthen sectoral leadership and management

- a. The DOH shall step up its leadership and stewardship role in the health sector through a stronger position on the social determinants of health and strategic oversight on policies that impact health.
- b. Participatory governance shall be fostered in the health sector through community and patient engagements, public-private partnerships, and citizen's charters.
- c. The DOH shall assess and prepare for possible shifts in governance structures that impact on the health sector (e.g., federalism, re-nationalization, devolution, etc.).
- d. Technical assistance from the DOH shall be consolidated and matched with the needs outlined in the Local Investment Plans for Health.

### 2. Improve organizational development and performance

- a. Responsive organizational structure, staffing patterns and skill-mix shall be adopted at all levels of the health system.
- b. Competency-based learning and development interventions linked to succession planning shall be implemented at all levels of the public health system.

### 3. Improve processes for procurement and supply chain management to ensure availability and quality of health commodities

- a. Systems for planning, forecasting, coordination and determination of health goods and commodities shall be improved.
- b. The entire procurement and logistics management system shall be strengthened to ensure timely delivery of health goods and commodities at all service points.
- c. Electronic procurement and logistics IT system shall be institutionalized at all levels (e.g., tagging of commodities with barcodes, QR codes).

### 4. Ensure generation and use of evidence in health policy development, decision making, and program planning and implementation

- a. A culture of research and evidence use shall be instilled in the DOH and its attached agencies.
- b. The public shall be provided access to quality and timely research and health data while complying with the Data Privacy Act of 2013.
- c. Regular surveys shall be commissioned and regular implementation reviews and impact evaluations of health-related laws and DOH programs and projects shall be conducted.
- d. Regular submission of encoded clinical, administrative, and financial data shall be required for all health-related entities enabling the integration of public and private sector data.
- e. Capacity for high quality evidence generation and appraisal shall be built in the health sector.
- f. DOH program managers and employees shall be provided access to international and local research journals.
- g. Health technology assessment shall be institutionalized to inform policy and program development.

- e. **“PLUS”: Performance Accountability across all Pillars**
- i. **Objective** - The objective of the Performance Accountability initiative is to use systems that would drive better execution of policies and programs in the DOH while ensuring responsibility to all stakeholders.
  - ii. **Sub-pillars and Key Interventions**
    1. **Institute transparency and accountability measures at all levels**
      - a. Performance and reporting tools, systems, and processes shall be integrated to improve management of the health sector and DOH performance.
      - b. Performance accountabilities in all health programs, projects, and activities shall be fostered by identifying performance metrics and assigning units or individuals primarily responsible for the attainments of targets.
      - c. User-friendly scorecards and performance reports shall be published in easily accessible platforms.
      - d. Monitoring and evaluation of health sector performance shall be aligned and linked to the Philippine Development Plan, Sustainable Development Goals, and AmBisyon Natin 2040.
    2. **Shift to outcome-based management approach**
      - a. Regular monitoring and performance reviews and assessments shall be conducted.
      - b. The mechanisms to link performance to incentives shall be improved by the DOH.

## VI. IMPLEMENTING GUIDELINES

- A. All DOH offices, units, hospitals, and attached agencies shall align their policies, programs, and activities to the F1 Plus for Health. Policies, programs and activities that are adherent to the F1 Plus for Health are to be levelled-up and enhanced. They shall advocate as well for the F1 Plus for Health to all stakeholders and partners.
- B. All national government agencies/entities with funds and activities related to health, such as but not limited to the Government Service Insurance System, Philippine Charity Sweepstakes Office, Philippine Amusement and Gaming Corporation, Philippine General Hospital, hospitals of state universities and colleges, Department of Education, Department of Social Welfare and Development, agencies under the Housing and Urban Development Coordinating Council, and Department of Labor and Employment, are strongly encouraged to align their policies, programs, and funds for health with the F1 Plus for Health.
- C. The DOH shall use the Performance Governance System (PGS) along with other performance management systems such as Quality Management System, Integrity Management Program, and Strategic Performance Management System in ensuring the implementation of F1 Plus for Health. The DOH shall be proficient on the use of PGS by 2019 and be institutionalized by 2022.

- D. The FOURmula One Plus for Health shall be supplemented by the National Objectives for Health, which shall provide the specific objectives, targets and strategies for each pillar. Performance Scorecards that are stratified to different levels shall also be developed to ensure accountability of all stakeholders in the implementation of F1 Plus for Health.

## VII. REPEALING CLAUSE

All orders, rules, regulations, and other issuances inconsistent with or contrary to this Order are hereby repealed, amended, or modified accordingly. All provisions of existing issuances which are not affected by this Order shall remain valid and in effect. In the event that any provision or part of this Order is declared unauthorized or rendered invalid by any court of law or competent authority, those provisions or parts not affected by such declaration shall remain valid and in effect.

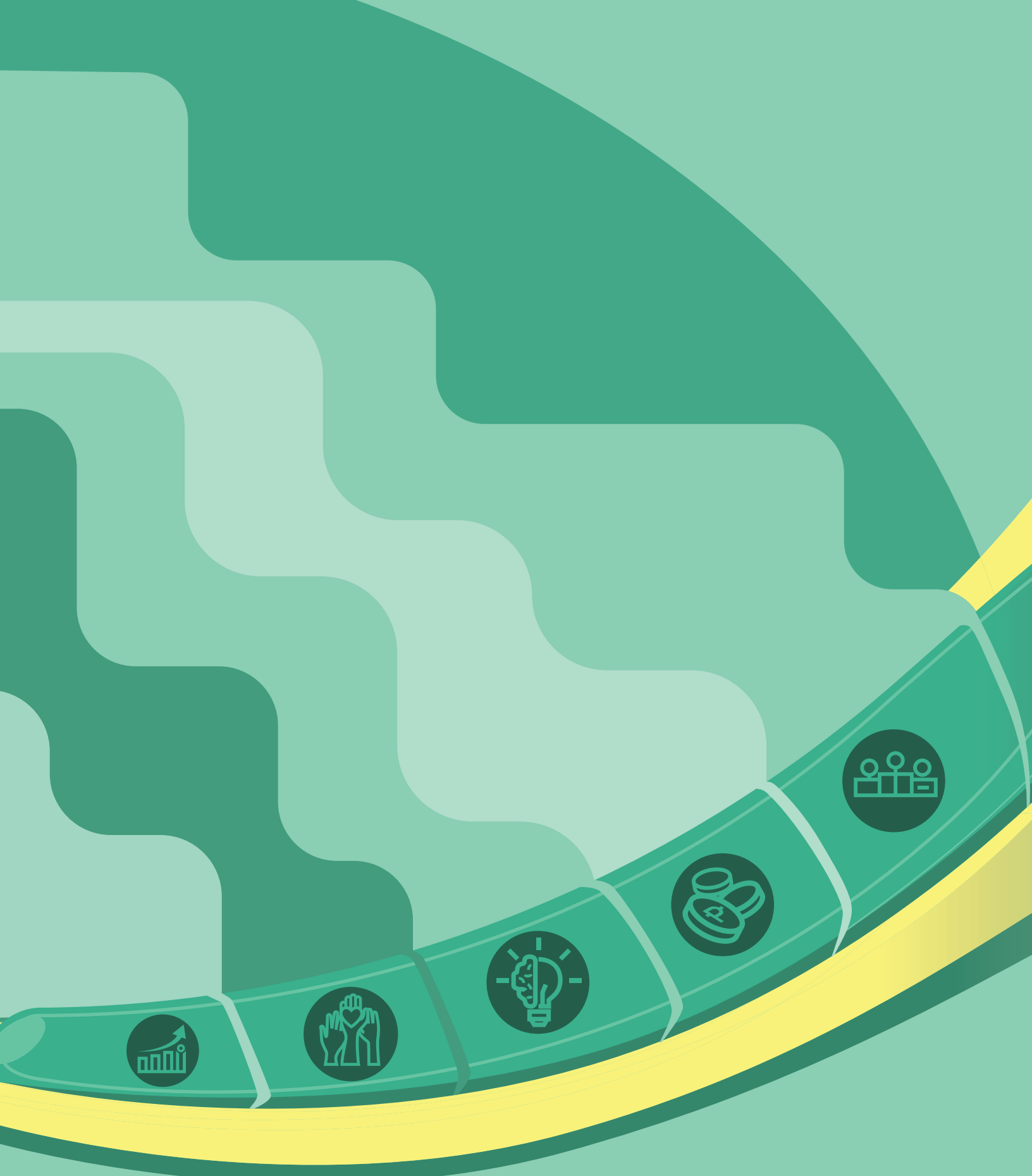
## VIII. EFFECTIVITY

This Order shall take effect immediately.



FRANCISCO T. DUQUE III, MD, MSc  
Secretary of Health





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