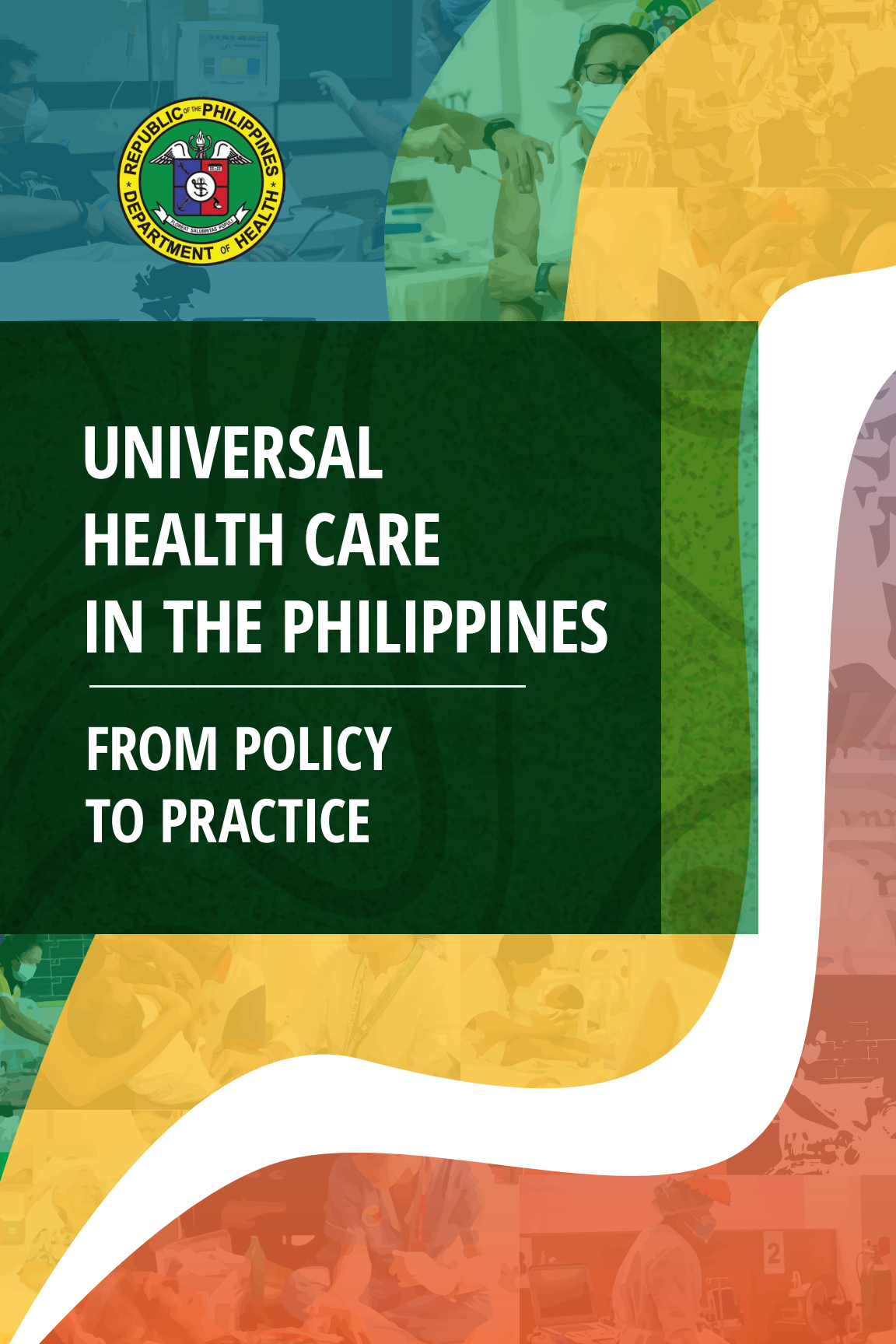

UNIVERSAL HEALTH CARE IN THE PHILIPPINES

FROM POLICY TO PRACTICE

UNIVERSAL HEALTH CARE IN THE PHILIPPINES

FROM POLICY TO PRACTICE

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UNIVERSAL HEALTH CARE IN THE PHILIPPINES
FROM POLICY TO PRACTICE

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

FOREWORD

Let me extend my gratitude to the Health Policy and Systems Development Team headed by Undersecretary Mario C. Villaverde for developing this book. I am optimistic that their unparalleled effort will immensely contribute to the implementation of Republic Act No. 11223 or the Universal Health Care (UHC) Act. This book will be a valuable reference for health managers, health care implementers, and other stakeholders as we continue our journey towards attaining UHC.

I once said that the UHC Act had laid out our North Star. It is actually an opportunity for us to reorganize our health system, with primary health care as the foundation. The law targets the provision of the full range of high quality health care services at affordable cost to all Filipinos. It enables the health system to slowly shift from its current hospital-oriented approach towards a health promotion and disease prevention paradigm.

The UHC Act has a lot in store for every Juan and Juana. For starters, health care provider networks with referral mechanisms from primary to tertiary levels of care will be established. In the public sector, local health systems will be integrated into province-wide and city-wide health systems in order to strengthen coordination and address the gaps in our devolved health system. Investments for health will be harmonized to ensure proper complementation of efforts among DOH, PhilHealth, LGUs, and the private sector towards improved health system functions and health service delivery.

Following the stipulation in the law, every Filipino will have a designated primary care provider. As the basic foundation of health care provider networks, primary care providers will be organized to: (1) be the first point of contact in the health care system; (2) provide essential health services at the least cost possible, if not free at the point of service; and (3) navigate

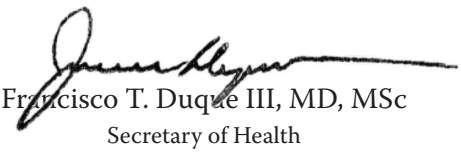
patients within the health system as they access higher levels of care. With the built-in coordination and referral mechanisms of such networks, health service delivery will be rationalized, and unnecessary hospitalization will be avoided. To ensure quality of care, the scope of DOH regulation is now expanded to cover primary care facilities. Aside from ensuring the safety and quality of health goods and services, mechanisms that would bring about affordability and equity are now being established. These efforts are complemented by the establishment of mechanisms that ensure better flow of health and health-related information from public and private sources.

Under the UHC Act, all Filipinos are deemed members of the National Health Insurance Program under a simplified membership categorization – either direct or indirect contributory members. Each member is immediately eligible to avail of a comprehensive set of essential benefit packages. These packages span the entire spectrum from health promotion and disease prevention, to curative, rehabilitative and palliative aspects of the continuum of care. The no balance billing policy will be shifted to no co-payment policy, shifting coverage from indigents only to all Filipinos. Provided, that they are admitted to basic or ward accommodations. Along this line, hospitals are also expected to allot beds exclusively for basic or ward accommodation. PhilHealth will be the national purchaser of individual-based health services. Simply put, funds intended for inpatient and outpatient medical and surgical services will be pooled into PhilHealth. This will ensure adequate negotiating power to lower the cost of health care and improve the quality of services. On the other hand, population-based health services such as disease surveillance, health promotion, and disaster risk reduction and management in health will now be financed by DOH in complementation with local budget.

Recognizing the importance of human resources for health (HRH) in all levels of the health system, the UHC Act establishes mechanisms that ensure adequate health workforce. Along this line, a support system to assist LGUs in their HRH needs is being created. Interventions to ensure continuous availability of health professionals are already being established. These include expansion of health-related degrees and training programs, and return service mechanism for government-funded scholars.

We hope that through this book, which serves as a reference material to the series of UHC online modules accessible in the DOH Academy, we will be able to level off understanding of the law and work in unison towards: (1) progressively realizing UHC in the country through a systemic approach and clear delineation of roles of key agencies and stakeholders towards better performance in the health system; and (2) ensuring that all Filipinos are guaranteed equitable access to quality and affordable health care goods and services, and protected against financial risk.

Finally, let me assure you that we remain committed to be inclusive and participatory in making UHC a reality. We will continuously find innovative ways to create avenues for learning, like this book. Let us all be mindful that the success of UHC can only be measured through the well-being of every Juan and Juana and how well our health systems respond to their health needs. I therefore call on each and everyone to help us bridge potential gaps in UHC implementation though effective collaboration and partnerships.



Francisco T. Duque III, MD, MSc
Secretary of Health

Chapter I

Framework and Mandates of Universal Health Care in the Philippines

The Universal Health Care (UHC) Act, also known as Republic Act 11223, was signed into law by President Rodrigo Roa Duterte on February 20, 2019. Its Implementing Rules and Regulations was signed by Health Secretary Francisco T. Duque III on October 10, 2019, thus paving the way for the Philippines to embark on a major health reform under the leadership of the Department of Health (DOH) and the Philippine Health Insurance Corporation (PhilHealth).

The conceptual framework of the law is based on the World Health Organization's three dimensions of universal health coverage, namely population coverage, service coverage, and financial coverage. The law mandated major areas of reform in the health sector, such as the organization of the health system into health care provider networks composed of primary, secondary and tertiary levels of care where primary care facilities serve as the gatekeeper and navigator of health services within the network; the classification of health services into two

major groups of health care packages consisting of population-based and individual-based health services; and the simplification of health financing mechanisms where population-based health services will be generally supported by tax-based financing while individual-based health services will be largely financed through premium-based social health insurance scheme.

In line with the conceptual framework and the major provisions and key action points provided by the law, the DOH and PhilHealth, in coordination with concerned agencies, sectors, and stakeholders, developed several operational policies and guidelines to lead the Philippines on a path toward progressive realization of universal health coverage.

Principles and Objectives of the Universal Health Care Act

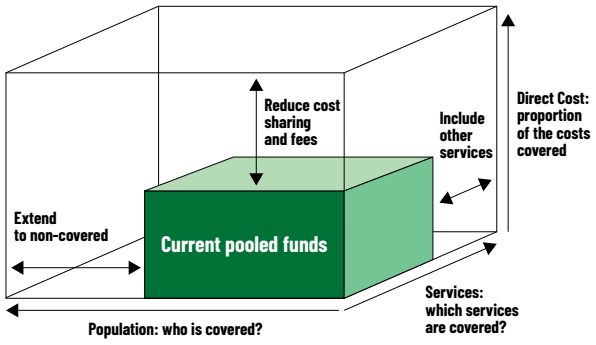
The UHC Act is guided by four key principles that the Philippines (1) adopts an integrated and comprehensive approach to ensuring health literacy, healthy living, and protection from hazards and risks; (2) develops a health care model that provides comprehensive health services without causing financial hardship to citizens, specifically the poor and marginalized members of society; (3) pursues a whole-of-system, whole-of-government, and whole-of-society approach in developing health policies; and (4) adheres to a people-oriented approach centered on people's health needs and well-being.

The law envisions a progressive realization of UHC through systemic approach and clear delineation of roles among stakeholders. This is seen to result in greater efficiency in the healthcare system. The law also aims to ensure equitable access to quality and affordable health care, and protection against financial risk, and thus improve equity and access across different vulnerable sectors in Philippine society.

Framework of Universal Health Care

The UHC Act introduces major reforms and important changes in the Philippine health care system. By adopting the universal health coverage framework of the World Health Organization, the law reflects three major dimensions of coverage[1] (Figure 1.1).

Figure 1.1 Three Dimensions of Universal Health Coverage



Source: World Health Report 2010. WHO.

The first dimension is *population coverage*, which basically answers the questions: "Who are covered?" and "Who will benefit from pooled financing?" Under the law, all Filipinos are automatically included in the National Health Insurance Program (NHIP), which essentially leads to all Filipinos becoming members of PhilHealth.

The second dimension is *service coverage*, which answers the question: "What services will be paid for by pooled financing?" The UHC Act expressly states that all Filipinos are immediately eligible to access two major groups of health care packages: population-based and individual-based health services.

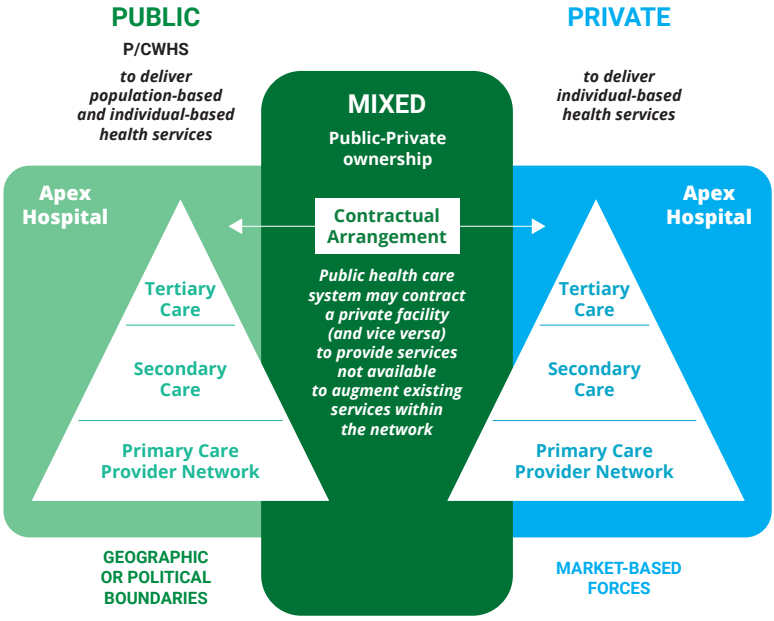
The third dimension is *financial coverage*. It answers the question: "Which proportion of the cost or health expenditure will be covered by pooled financing?" The law's intent is to reduce people's out-of-pocket expenditure for health.

Some recent literature[2,3,4] included quality of care as an essential dimension of universal health coverage. It answers the question: "What is the quality of the health services delivered?" Adding this dimension ensures that the quality of those services is good enough to improve the health of the people who receive them, thereby improving population health outcomes. This will also make health services more attractive to the people they serve. Under the UHC Act, safety and quality of health goods and services are ensured through licensing and accreditation processes, and continuous quality improvement mechanisms.

Organization of Health Care Provider Networks

The UHC Act paves the way for the government to institutionalize Health Care Provider Networks (HCPN), which refer to groups of primary, secondary, and tertiary care providers that offer comprehensive health care in an integrated and coordinated manner to their catchment population. A HCPN may be composed of purely public health facilities, or purely private health facilities, or a mix of public and private health facilities. A HCPN should be linked to at least one highly specialized apex or end-referral hospital (Figure 1.2).

Figure 1.2 Health Care Provider Networks



However, the UHC Act makes primary care a prerequisite for accessing higher levels of care by ensuring that PhilHealth pays for primary care services, and that secondary and tertiary care are reimbursed only for providing appropriate levels of care. Such scheme is expected to drive consolidation of health care providers into networks that practice gatekeeping and two-way referral mechanisms.

During the Philippine transition to UHC, PhilHealth and DOH will incentivize health care providers that form networks. DOH is tasked to determine which hospitals will be considered as apex or end-referral hospitals, while PhilHealth may contract these hospitals as stand-alone health care providers.

To ensure efficient and harmonized delivery of health services in the public sector, DOH, Department of the Interior and Local Government (DILG), PhilHealth and LGUs are endeavored to integrate local health systems into Province-wide and City-wide Health Systems (P/CWHS). Provincial or City Health Boards are mandated to (1) oversee and

coordinate the integration and delivery of health services across the healthcare continuum from primary to tertiary levels of care or beyond; (2) manage the Special Health Fund, which is the mechanism for pooling health funds at the local level; and (3) exercise administrative and technical supervision over health facilities and health workers within their respective territorial jurisdiction. Municipalities and component cities that commit to health system integration are entitled to representations in provincial health boards.

P/CWHS are mandated to pool and manage financial resources in their respective Special Health Fund. All income derived from PhilHealth accrues to the Special Health Fund and is credited as annual regular income of LGUs. Grants and subsidies from DOH, as well as financial assistance from development partners, are also pooled into the Special Health Fund. Financial and non-financial grants are made available by the national government to improve the functionality of local health systems. This assistance will be provided based on the approved Local Investment Plan for Health (LIPH) and its Annual Operational Plan (AOP).

Health Service Delivery

The law classifies health services into two major groups, namely individual-based and population-based health services.

Individual-based health services are health interventions that can be accessed within a health facility or remotely; can be definitely traced back to one recipient; have limited effect at a population level; and do not alter the underlying cause of illness. These include most of the medical and surgical services that are done in a hospital setting or ambulatory care clinical facility. For the provision of individual-based health services, PhilHealth is endeavored to contract public, private or mixed health care provider networks. These networks, however, must come to an agreement with PhilHealth in terms of (1) service quality and standards of care; (2) co-payment or co-insurance mechanism; and (3) data submission standards. These services are to be funded primarily through PhilHealth in complementation with private health insurers and health maintenance organizations (HMOs).

On the other hand, *population-based health services* refer to health interventions which have population groups as recipients, such that services cannot be specifically traced back to a single person or beneficiary. In terms of service provision, DOH is endeavored to contract P/CWHS to provide population-based health services. P/CWHS are required to institute the following minimum components: (1) primary care provider network; (2) epidemiological and disease surveillance system; (3) health promotion programs and campaigns; and (4) effective preparedness and response to public health emergencies and disasters. Other population-based health services such as vector control and water quality assurance, among others, may also be included. These services are to be funded by DOH in complementation with LGUs, and are provided free at the point of service.

Emphasizing the primary health care approach in the delivery of health services, national efforts on health promotion and preventive care are scaled up through the establishment of a Health Promotion Bureau that is tasked to formulate strategies for health literacy; coordinate health promotion policies across government agencies; implement or coordinate health promotion programs and activities across social determinants of health; and provide technical support to local research and development in the field of health promotion. Moreover, the Department of Education (DepEd) is tasked to incorporate health literacy and health rights in existing school curricula, and to establish criteria for public schools to become healthy settings. LGUs must also enact stricter ordinances to promote health literacy and healthy lifestyle.

National Health Insurance Program

With the enactment of the UHC Act, changes are expected in the way PhilHealth finances individual-based health services by (1) shifting towards paying providers using performance-driven, close-end, prospective payments based on diagnostic related groupings and validated costing methodologies, and without differentiating facility and professional fees; (2) developing differential payment schemes that give due consideration to service quality, efficiency and equity; and (3) instituting strong surveillance and audit mechanisms to ensure networks' compliance to contractual obligations.

In addition, the law simplifies PhilHealth membership into two types: direct contributors and indirect contributors. *Direct contributors* refer to members with capacity to pay premiums, or those gainfully employed or are self-earning professionals or workers. In contrast, *indirect contributors* refers to those whose PhilHealth premiums are subsidized by the government. The national government subsidizes the payment of their PhilHealth premium. This is expected to sustain 100 percent population coverage.

With UHC, patients can expect immediate eligibility in all health care services. The PhilHealth ID is no longer required in accessing such services. The no co-payment policy is applied in basic or service ward accommodation, whether in public or private health care facilities. This means that no other fees or expenses, including professional fees, must be charged to all PhilHealth members admitted in any basic or ward accommodation. Co-payment will apply only to patients who prefer to avail themselves of additional amenities over and above basic accommodation. Existing PhilHealth packages are maintained and, when necessary, additional benefits will be designed for directly paying members.

For PhilHealth's direct contributors, premium rates are set according to a specified schedule based on the monthly income floor and income ceiling per year of implementation (Table 1.1). In the case of indirect contributors, premium subsidy will be gradually adjusted and reflected annually in the General Appropriations Act (GAA).

Table 1.1 Schedule of PhilHealth Premium Contribution

YEAR	PREMIUM	INCOME FLOOR	INCOME CEILING
2019	2.75%	P10,000.00	P50,000.00
2020	3.00%	P10,000.00	P60,000.00
2021	3.50%	P10,000.00	P70,000.00
2022	4.00%	P10,000.00	P80,000.00
2023	4.50%	P10,000.00	P90,000.00
2024	5.00%	P10,000.00	P100,000.00
2025	5.00%	P10,000.00	P100,000.00

Source: Sec. 10, Universal Health Care Act

Other provisions of the UHC Act pertaining to the NHIP are (1) Program Reserve Funds, which come from accumulated revenues of PhilHealth

not needed to meet the cost of the current year's expenditure; (2) Administrative Expense of PhilHealth, which should not be more than 7.5 percent of actual premium collected; (3) PhilHealth Board of Directors, which is composed of a maximum of 13 members; (4) President and Chief Executive Officer of PhilHealth, who is appointed upon the recommendation of the PhilHealth Board; and (5) PhilHealth Personnel, to be considered as public health workers.

Human Resources for Health

On the management and development of human resources for health, a National Human Resources for Health Master Plan is institutionalized to include strategies for the production, recruitment, retraining, regulation and retention of the health workforce. Also, a National Health Workforce Support System is set up to address health workforce needs by deploying health professionals especially to geographically isolated and disadvantaged areas (GIDAs).

Scholarships and other training programs are also offered to improve production of needed health professionals. These include, among others, (1) expansion of health-related degree and training programs or expanding the current academic offering to include new trends in the health care sector; (2) regulation of enrollees based on health needs to minimize, if not completely eliminate, overproduction or underproduction of specific medical and allied health professionals; (3) expansion of scholarship grants for undergraduate and graduate programs to entice students to go into the health professions, especially in fields where major gaps or needs are present; (4) setting up of registry of medical and allied health professionals; and (5) reorientation of health professional education, certification and regulation for the provision of primary care services, to strengthen the curricula of health and allied professions, and improve actual practice.

Recipients of scholarship grants must enter into return service agreements (RSA) with the public sector. Government-funded scholars are required to serve in priority areas in the health sector for at least three years, with compensation and under the supervision of DOH. Additional incentives are provided to those who render additional two years of service.

Also, guidelines for non-compliance with the provisions of the RSA will be instituted by DOH, in coordination with the Commission on Higher Education (CHED) and the Professional Regulation Commission (PRC). Moreover, the UHC Act encourages graduates of allied and health-related courses from state universities and colleges, and private schools to serve in places designated as priority areas.

Health Regulation

The UHC Act includes several provisions related to health regulation. In terms of *safety and quality*, PhilHealth will establish a rating system under an incentive scheme to acknowledge and reward health facilities that provide better service quality, efficiency and equity. This may be done through the use of third-party accreditation mechanisms.

DOH, for its part, will institute a licensing and regulatory system for stand-alone facilities, including those providing ambulatory and primary care services, and other modes of health service provision. Standards for clinical care are set through the development, appraisal, and use of clinical practice guidelines in cooperation with professional societies and the academe.

In terms of *affordability* of health goods and services, the UHC Act seeks to ensure that prices of health goods and services are transparent, and that co-payments are fixed or predictable. Thus, DOH-owned health facilities and providers are required to procure drugs and devices guided by price reference indices following centrally negotiated prices, and sell them following the prescribed maximum mark-ups. They are obliged to submit to DOH the price list of all drugs and devices procured and sold in their facilities. An independent

Key Areas of Health Regulation under the UHC Act

- Safety and quality of health facilities and services
- Affordability of health services, pharmaceuticals and medical devices
- Equity in the development of health facilities and provision of health benefits

Price Negotiation Board is constituted to negotiate prices on behalf of DOH and PhilHealth. Drug outlets are compelled to carry, at all times, the generic equivalent of all drugs in the Primary Care Formulary. Health care providers and facilities are also required to make readily accessible to the public all information regarding prices of health goods and services. The UHC Act also mandates DOH, PhilHealth, HMOs, and private health insurers to develop standard policies and plans that complement PhilHealth's benefit schedule.

In terms of ensuring *equity*, particularly to benefit the poor, the UHC Act mandates DOH to annually update its list of underserved areas, which will serve as basis for preferential licensing of health facilities and contracting of health services. The law aims to guarantee the equitable distribution of health services and benefits by prioritizing GIDAs in the provision of assistance and support. The law also requires government hospitals to allocate at least 90 percent of their beds as basic or service ward accommodation. In the case of specialty hospitals, they are required to allocate at least 70 percent of beds as basic or ward accommodation. On the other hand, private hospitals are required to allocate at least 10 percent of beds for such accommodation. This provision is linked to the "no co-payment" scheme applied to all PhilHealth members admitted in basic or service ward accommodation.

Governance and Accountability

The UHC Act also aims to improve governance and accountability. All health-related entities are required to submit health data to PhilHealth, to help in planning and policy making for further enhancing UHC. Data generated using public funds will be made available to the public subject to the existing laws on data privacy. Moreover, the development of a cadre of health policy and systems researchers, experts and managers is instituted. The law also mandates the Philippine Statistics Authority (PSA) to conduct relevant modules of household surveys annually, while DOH is tasked to publish annual provincial burden of disease estimates.

Health Impact Assessment (HIA) is required for crucial health policies, programs and projects, while Health Technology Assessment (HTA)

is institutionalized to inform policy and decision-making of DOH and PhilHealth. For this purpose, a Health Technology Assessment Council (HTAC) is created under DOH, which will eventually be transferred to Department of Science and Technology (DOST) in order to make it an independent entity separate from the DOH.

Ethics in public health practice will also be strengthened. Specifically, declaration and management of conflict of interest will be required from decision makers, policy makers, staff members, consultants, and all stakeholders involved in policy-determining activities. Financial relationships between health care professionals and manufacturers of drugs, medical devices and supplies will also be tracked. To ensure compliance by stakeholders, a Public Health Ethics Committee is formed as an advisory body to the Secretary of Health.

All health service providers and insurers must each maintain a health information system consisting of enterprise resource planning, human resource information, electronic health records, and an electronic prescription log consistent with DOH standards. Data will be electronically uploaded on a regular basis through interoperable systems. A health information system will be developed and funded by DOH and PhilHealth. Capacity for digital health and telemedicine will also be developed as part of the health service package.

Appropriations and Other Relevant Provisions for Universal Health Care

To fund the implementation of the UHC Act, various sources of funds are pooled, particularly for financing individual-based health services. These sources are the government collection of "sin" taxes or excise taxes on tobacco and alcohol products; a portion of the national share from the income of the Philippine Amusement and Gaming Corporation (PAGCOR) and the Philippine Charity Sweepstakes Office (PCSO); premium contributions of PhilHealth members; national government subsidies to PhilHealth; and annual appropriations of DOH, as well as other supplemental funding.

The UHC Act provides specific penalties in cases of violations of any of its provisions committed by health care providers, PhilHealth members and their employers, and PhilHealth officers and staff.

A Joint Congressional Oversight Committee on UHC is created to conduct a regular review and systematic evaluation of UHC performance and impacts. At the same time, National Economic Development Authority (NEDA), PSA, National Institutes of Health (NIH), and other academic institutions are mandated to conduct studies to validate UHC accomplishments. The validation process will be funded by DOH and PhilHealth. Also, a Performance Monitoring Division is established in the DOH to monitor and evaluate the implementation of UHC.

Sources of Funding for Universal Health Care

- Total incremental sin tax collections
- 50% of the National Government share from PAGCOR
- 40% of the Charity Fund, net of Documentary Stamp Tax payments and mandatory contributions of PCSO
- Premium contributions of members
- Annual appropriations of the DOH
- National Government subsidy to Philhealth
- Supplemental funding

The UHC Act envisions the managerial integration, including technical integration, of P/CWHS within the first three years of its implementation. Thereafter, financial integration is also expected within the subsequent three years.

With DOH and PhilHealth taking the lead, the valuable support and active participation of every Local Chief Executive and every local health worker, including the private sector and civil society, are essential to the implementation of the UHC Act.

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Chapter II

Organizing the Local Health System

The service delivery design of Health Care Provider Networks (HCPNs) developed by the DOH serves as the general framework for organizing health care providers into networks and linking them to one or more apex or end-referral hospitals. In the public sector, LGUs are endeavored to organize their fragmented local health systems within the province, or highly urbanized or independent component city into integrated Province-wide or City-wide Health Systems (P/CWHS). In the private sector, the organization of a HCPN may or may not be limited to defined geopolitical boundaries. Its organization into a network of private health care providers and facilities may be contingent on market-based forces. In addition, a mixed-type HCPN composed of public and private health care providers and facilities may be organized based primarily on a contractual arrangement between public and private entities to provide health services jointly or cooperatively.

As the basic foundation of HCPNs, primary care providers and facilities are organized as primary care provider networks (PCPNs) to serve as gatekeepers and navigators of patients or constituents within the network. The implementing rules and operational guidelines of the UHC

Act also require all hospitals to establish public health units in order to facilitate the provision of public health programs and services; and to improve patient navigation within the hospital, and between the hospital and primary care facilities. Moreover, the UHC Act requires prioritization of health services in unserved and underserved areas to provide more equity to the marginalized sector of the population. To this end, DOH is required to identify geographically isolated and disadvantaged areas (GIDAs), improve their health system, and strengthen their links within the HCPN.

Service Delivery Design of Health Care Provider Networks

The UHC Act provides for the formation of HCPNs for the integrated and efficient delivery of population-based and individual-based health services[1]. HCPN is defined by law as a group of primary-to-tertiary health care providers offering people-centered and comprehensive care in an integrated and coordinated manner, with the primary care provider acting as the navigator and coordinator of health care within the network.

DOH has set the standards and guidelines for organizing HCPNs and designating apex hospitals to ensure the delivery of a continuum of care within the integrated health system[2]. Specifically, the guidelines consist of the basic components of HCPNs; the mechanism for a functional referral system; the criteria for classifying apex hospitals; and the establishment of public health units in all hospitals.

Types and Composition of Health Care Provider Networks

Based on network ownership, HCPNs can be classified into three types: public, private, or a mix of public and private health care providers (*see Chapter 1, Figure 1.2*). A *public HCPN*, also called a Province-wide or City-wide Health System (P/CWHS), is a network of public primary care providers and facilities linked to public secondary or tertiary care providers within the geographic or political boundaries of a province or highly urbanized or independent component city. A public HCPN provides both population-based and individual-based health services.

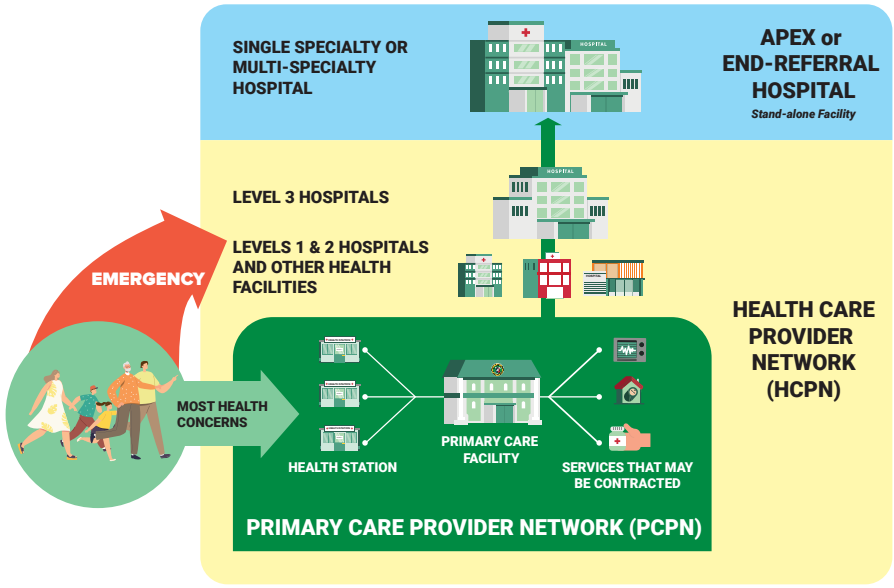
On the other hand, a *private HCPN* is composed of private primary-to-tertiary health providers and facilities that may or may not be limited to defined geopolitical boundaries. Its organization into a network of private health providers and facilities may be contingent on market-based forces. It provides only individual-based health services until a financing scheme or other incentive mechanisms are developed that will entice them to deliver population-based health services as well.

The third type is a *mixed HCPN*, composed of public and private health care providers and facilities. Ideally, it is a network co-owned by public

and private entities established as a single juridical entity. However, it can also be a mixed-type HCPN based primarily on a contractual arrangement between public and private entities to provide health services jointly or cooperatively while still maintaining their individual juridical personalities.

Regardless of type, HCPNs are composed of (1) primary care provider networks (PCPNs) that serve as the initial point of contact and navigator of patients; and (2) hospitals that deliver secondary and tertiary general health care services. They are characterized by functional care coordination within the network (Figure 2.1).

Figure 2.1 Components of a Health Care Provider Network



PCPNs act as the basic foundation of HCPNs and consist of health facilities such as rural health units, health centers, and medical outpatient clinics. They also include other primary care facilities like health stations, stand-alone birthing homes, stand-alone laboratories, pharmaceutical outlets, and dental clinics. These facilities provide population-based or individual-based primary care services and ensure proper coordination and service delivery across the network.

Health facilities that provide general inpatient care services are also part of HCPNs. These may be infirmaries and Level-1, Level-2 or Level-3 hospitals providing secondary and tertiary care services, as classified by DOH. In addition, HCPNs must ensure the availability of ambulances and patient transport vehicles for its catchment population. These networks must also be linked with drug abuse treatment and rehabilitation centers, and blood service facilities, among others.

At its minimum, HCPNs must institute the following systems within the network: (1) established patient navigation and coordination system; (2) unified patient records management system; (3) harmonized information and communication technology; (4) interconnected medical transport services; (5) standardized network mechanisms for operations; and (6) effective financial and performance management system.

Every HCPN is linked to one or more apex or end-referral hospitals and other facilities that provide highly specialized inpatient care and outpatient specialty care services as needed by its catchment population. In areas without LGU-owned or -managed secondary or tertiary care providers, the P/CWHS may link with DOH-owned hospitals or private hospitals. The level and service capability of these hospitals must meet DOH standards. Service augmentation or complementation require contractual arrangements between P/CWHS and private health facilities, with proximity between facilities among the important considerations.

Apex or End-Referral Hospitals

The terms "apex" and "end-referral" in relation to hospitals are used interchangeably, and refer to hospitals that offer specialized services as determined by DOH. These hospitals may be contracted as stand-alone health care providers by PhilHealth. The implementing rules and operational guidelines of the UHC Act also require all hospitals to establish public health units to facilitate the provision of population-based health services and patient navigation within the hospital and between the hospital and primary care facilities. This specific unit must be placed under the Office of the Medical Center Chief or Chief of Hospital.

HCPNs are linked to one or more apex hospitals, which can either be a single specialty hospital designated by law or licensed by DOH as such, or a multi-specialty general hospital. General hospitals can become apex hospitals upon accreditation for teaching and residency training in at least four major departments (i.e., Medicine, Pediatrics, Surgery, and Obstetrics-Gynecology), and the establishment of at least two specialty centers in accordance with DOH standards.

Apex hospitals have the ability and commitment to provide performance monitoring and technical assistance to HCPNs. These hospitals can provide quality, efficient, and patient-centered clinical services. They can assist in teaching and training human resource for health, and in implementing a functional referral system. Apex hospitals can also undertake clinical, public health, and operations research.

Integration of Local Health Systems into Province-wide and City-wide Health Systems

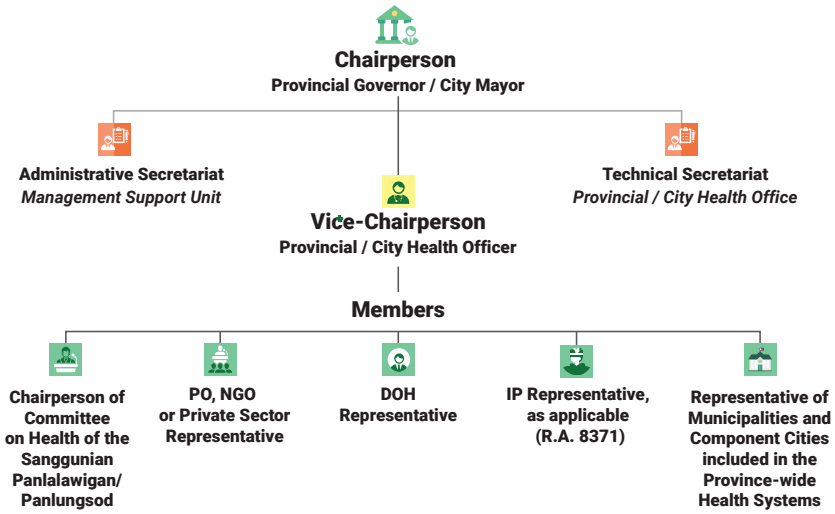
Health services were devolved to LGUs in 1992, after the enactment of the Local Government Code of 1991[3]. In this context, the UHC Act aims to address concerns with health systems fragmentation, disparities in access, and quality of public health services provided by LGUs. Specifically, the UHC Act provides for the integration of local health systems into P/CWHS.

The DOH operational guidelines on the integration of local health systems into P/CWHS[4] details the general procedures and mechanisms through which LGUs, together with national government agencies and stakeholders, can proceed with integration. These guidelines emphasize the autonomy of LGUs and their important role in implementing health care system reforms, as well as specify the scope and minimum level of functionality of each integrated local health system.

Management Structure of the Province-wide and City-wide Health Systems

The management structure of P/CWHS consists of the Provincial or City Health Board (P/CHB), the Provincial or City Health Office (P/CHO), and the Management Support Unit (MSU) (Figure 2.2).

Figure 2.2 Provincial or City Health Board and its Support Units



a. Provincial or City Health Board

The functions of the P/CHB under the Local Government Code[5] include proposing to the *Sanggunian* the annual budgetary allocations for health; serving as the *Sanggunian's* advisory committee on health matters; and creating committees to advise local health agencies consistent with DOH's technical and administrative standards.

The UHC Act expands these functions to include stewardship of the integrated local health system, and setting policy and strategic direction for P/CWHS. Also, the P/CHB is made responsible and accountable for managing the Special Health Fund. The Board also exercises administrative and technical supervision over health facilities and health human resources within its territorial jurisdiction, although LGUs retain general supervision and control over them.

Under the Local Government Code, the P/CHB is composed of the Governor or Mayor as Chairperson, and the Provincial or City Health Officer as Vice-Chairperson. Other P/CHB members are the Chairperson of the Committee on Health of the *Sangguniang Panlalawigan* or *Sangguniang Panlungsod*; a representative from People's Organization/Non-Government Organization/Private Sector; and the DOH Representative in the province

or city. The UHC Act and its Implementing Rules and Regulations (IRR) expand the composition of the Provincial Health Board to include representatives from municipalities and component cities in the Province-wide Health System. A representative from indigenous peoples (IPs) may also be included, as applicable.

The UHC Act does not specify the number of representatives of municipalities and component cities in the Provincial Health Board. The exact number of representatives may be determined through consultations and consensus between the province and its component LGUs, taking into consideration the province's size and geography, as well as the quorum and manageability of board meetings. The selection of an IP representative is based on guidelines issued by the National Commission on Indigenous Peoples (NCIP).

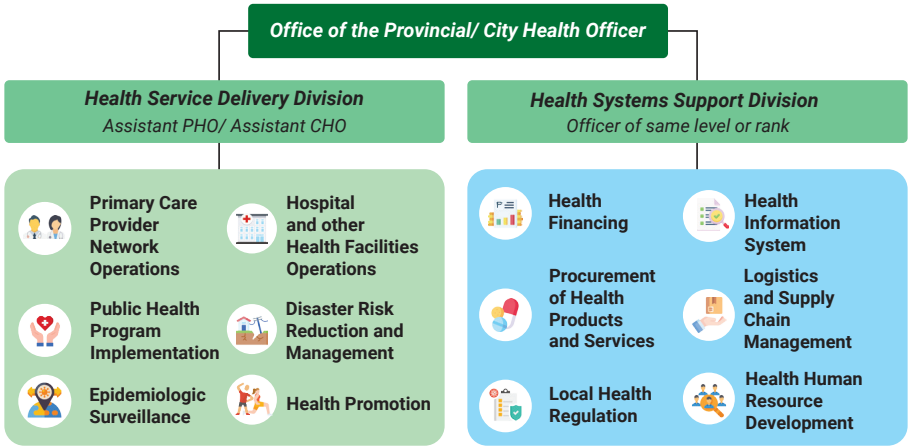
b. Management Support Unit

Given the additional roles of the P/CHB under the UHC Act, support units are established to ensure that the Board can efficiently and effectively execute its mandates. A MSU is created under the P/CHB to serve as its administrative secretariat. MSU functions include providing assistance in the management of the Special Health Fund; administrative and technical support; and coordination with P/CWHS stakeholders. At the minimum, the MSU is composed of an accountant, administrative officer, and liaison officer.

c. Provincial or City Health Office

The P/CHO serves as the technical secretariat of the P/CHB. It oversees the technical integration within the P/CWHS; provides technical supervision; and coordinates with relevant stakeholders. A recommended organizational structure and staffing complement for the P/CHO is specified in the UHC Act's IRR and DOH's Devolution Transition Plan. Based on this, the P/CHO is composed of at least two divisions: Health Service Delivery Division, headed by an Assistant Provincial or Assistant City Health Officer; and Health Systems Support Division, headed by another official in the province or city of equivalent rank to the Assistant Provincial or Assistant City Health Officer (Figure 2.3).

Figure 2.3 Recommended Provincial or City Health Office Structure



The *Health Service Delivery Division* manages the health service delivery operations of PCPNs, hospitals, and other health facilities; and oversees the implementation of public health programs including health promotion, epidemiology and surveillance, and disaster risk reduction management in health. On the other hand, the *Health Systems Support Division* manages the health financing (planning and budgeting), health information system, procurement and supply chain for health products and services, local health regulation; health human resource development; and performance monitoring, among others. This is in close coordination with the concerned offices of the provincial or city government. An Administrative Unit renders administrative-related support within the P/CHO.

d. Technical Management Committee

Adjacent municipalities and component cities may opt to form sub-provincial health systems with PCPNs linked to secondary or tertiary care providers. This is to ensure effective health service delivery and health systems management. Organizing sub-provincial health systems depends on the province's size, population, and geography. The Provincial Health Office and the DOH Center for Health Development (CHD) must assess and determine the need for such. Existing cooperative undertakings like inter-local health zones and service delivery networks may transition to sub-provincial health systems.

To supervise the operations of each sub-provincial health system, a Technical Management Committee may be created to determine funding requirements for the provision of health services; monitor and evaluate the integration of public health and hospital services within the sub-provincial health system; submit necessary reports and health data to the P/CHO; and initiate participatory health care needs assessment and integrated health planning.

Additionally, the Technical Management Committee may also recommend policies and guidelines for the establishment of management support systems; supervise navigation, coordination, and referral across component facilities; and ensure compliance to referral system protocols. At the minimum, the Technical Management Committee is composed of technical staff from the member hospital(s) and rural health units or health centers, DOH Representatives of municipalities or component cities, patients' representative, and others. The committee is to be assisted by administrative staff designated by the province, and participating cities and municipalities.

Areas of Integration

There are two major areas of integration: managerial integration and financial integration. *Managerial integration*, which includes *technical integration*, is defined as the consolidation of administrative, technical, and managerial functions of the P/CWHS over its resources such as health facilities, human resources for health, health finances, health information systems, health technologies, equipment, and supplies. Meanwhile, *financial integration* refers to the consolidation of financial resources exclusively for health services and health system development under a single planning and investment strategy by the P/CWHS.

The organization of local health systems into P/CWHS[6] is implemented among LGUs that express their commitment to integrate their local health system within the six-year transitory period from the enactment of the UHC Act. These LGUs are referred to as UHC Integration Sites. However, nationwide implementation will depend on the positive recommendation

of an independent study to be commissioned by the Joint Congressional Oversight Committee on UHC and the Secretary of Health. Existing mechanisms will continue to cover LGUs that opt not to integrate yet.

Network Contracting

Pursuant to the UHC Act, DOH and PhilHealth must enter into a contract with P/CWHS for the delivery of health services and ensure shared responsibilities and accountabilities among the members of the integrated health system.

DOH contracts the P/CWHS to provide population-based health services, including those that have impact on the social determinants of health, through the Terms of Partnership. At the minimum, the P/CWHS must have a PCPN with accessible patient records throughout the health system; accurate, sensitive and timely epidemiology and surveillance system; proactive, effective, and evidence-based health promotion programs or campaigns that include strategies to address the social determinants of health; and timely, effective, and efficient preparedness and response to public health emergencies and disasters.

PhilHealth, meanwhile, contracts the P/CWHS for the delivery of individual-based health services using Service Level Agreements. To be contracted, the P/CWHS must ensure the following: (1) access of its catchment population to all levels of care within the network, including the use of digital technologies for health; (2) presence of a PCPN that is linked to secondary or tertiary care providers; (3) availability of patient records management system that will ensure that patient records are accessible to all facilities or providers within the network; (4) a mechanism of payment for all the health facilities and health workers within the network; (5) a mechanism of pooled fund management in the network; (6) a patient navigation and coordination system to ensure the provision of appropriate and coordinated care from primary to tertiary level; and (7) a proof of its legal personality. In addition, health facilities participating in the network must be DOH-licensed or PhilHealth-accredited, whichever is applicable, and must sign a performance contract with PhilHealth.

Identifying Geographically Isolated and Disadvantaged Areas and Strengthening their Health Systems

For decades, DOH has been undertaking key structural reforms and has continuously built on programs to achieve UHC. However, the health situation in geographically isolated and disadvantaged areas (GIDAs) remains a persistent concern. GIDAs are characterized by high morbidity and high mortality due to poor access and delivery of quality health services, lack of health facilities, and inadequate logistical support.

The UHC Act mandates the prioritization of health services in unserved and underserved areas, or GIDAs as defined in its IRR[7]. To this end, DOH issued guidelines[8] to identify GIDAs as well as strategies for strengthening their health service delivery, human resources for health, financing and resource allocation, pharmaceuticals and medical supplies, regulations of health facilities, leadership and governance, and health information systems.

Definition and Criteria for Identification of Geographically Isolated and Disadvantaged Area

A barangay may be considered a GIDA depending primarily on physical and socioeconomic factors that limit the availability of, and accessibility to, basic health services among its population (Table 2.1). If a barangay is identified as a GIDA, through evaluation by DOH CHDs in coordination with the LGUs, then it becomes a priority in the provision of technical and financial assistance to improve health services.

Table 2.1 Criteria for Identification of Geographically Isolated and Disadvantaged Area

BARANGAY	PHYSICAL FACTORS (ISOLATED?)	SOCIOECONOMIC FACTORS (DISADVANTAGED?)	CLASSIFICATION
Barangay A	Yes	No	Non-GIDA
Barangay B	No	Yes	Non-GIDA
Barangay C	Yes	Yes	GIDA

For a barangay to be considered a GIDA based on physical factors, at least 25 percent of its *sitios*/*puroks* lack access to a rural health unit, health

center or hospital within 60 minutes of travel in any form of transport, including walking.

For a barangay to be considered a GIDA based on socioeconomic factors, at least one of the following conditions must be present:

1. at least 10 percent of its population are indigenous peoples (IPs);
2. at least 10 percent of its population are affected by armed conflict or are internally displaced, or the barangay is identified as a Communist Terrorist Group/Local Extremist Group area by the National Intelligence Coordinating Agency;
3. at least 50 percent of its population are enrolled in *Pantawid Pamilyang Pilipino Program*/Conditional Cash Transfer Program; and
4. the performance of the barangay in at least four of the following indicators is lower than the latest provincial data:

    a. infant mortality rate;
    b. under-five mortality rate;
    c. fully immunized child coverage;
    d. adolescent (aged 10-19 years) birth rate;
    e. contraceptive prevalence rate;
    f. proportion of pregnant women with four or more prenatal visits;
    g. proportion of deliveries attended by skilled birth attendant; and
    h. household with access to improved water supply.

Profiling and Annual Listing of Geographically Isolated and Disadvantaged Areas

Barangays are profiled using the GIDA Profiling Tool, a scoring system that assist decisions for prioritization. The profiling tool identifies and validates GIDA barangays; analyzes gaps in terms of the current availability and readiness of essential health service delivery, human resources for health, health facilities, medicines, and social health insurance, among others; and identifies priority areas and their needs.

DOH Central Office, through the Bureau of Local Health Systems Development (BLHSD), issues an official GIDA list that is updated annually. The list is shared with all stakeholders that are considered priority areas through the DOH website and technical reports. Subsequently, DOH CHDs issue individual certifications to barangays identified as GIDA. Moreover, DOH CHDs in coordination with LGUs are required to conduct mandatory GIDA profiling once every three years as part of the monitoring, evaluation, and further improvement of GIDA health systems.

Information System for Geographically Isolated and Disadvantaged Areas

An information system[9] for GIDA serves as the core monitoring and evaluation system to determine current health status and health intervention gaps. The system contains all data encoded and serves as the repository of all GIDA profiles to be used as basis for identifying priority areas for financial and technical assistance.

Data generated by the system are disseminated among relevant DOH offices, national government agencies, LGUs and other stakeholders through the DOH website and technical reports. This information system will be linked to the iClinicSys, which supports the functions of barangay health stations, rural health units, or other health care facilities providing primary care services to patients.

Chapter References

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8 Department of Health. (2020). *Guidelines on identifying geographically-isolated and disadvantaged areas and strengthening their health systems.* (Administrative Order No. 2020-0023).

9 Department of Health. (2019). *GIDA InfoSys.* https://gidais.doh.gov.ph/dashboard.php

Chapter III

Utilizing Local Health System Management Tools

Several management tools can be used to guide the integration of local health systems into Province-wide and City-wide Health Systems (P/CWHS) and to track the progress of all programs and activities to realize the goals of UHC.

First is the Local Health Systems Maturity Levels (LHS ML) monitoring tool. This monitoring tool can be used by LGUs to assess their current level of maturity concerning the integration of their P/CWHS. By using this tool, LGUs can identify the strengths and weaknesses of their local health systems and determine their level of compliance to integration. The tool can also guide LGUs in developing programs and activities that can be incorporated into their Local Investment Plan for Health (LIPH).

The LIPH is the second management tool. It is a medium-term public investment plan for health that specifies the strategic direction of the P/CWHS. With the development of the LIPH, a negotiation process can commence among P/CWHS and DOH, PhilHealth, or other health partners to determine available support mechanisms to implement the

investment plan. The Terms of Partnership (TOP) serves as the legal instrument or tool between DOH and the P/CWHS for contracting the delivery of population-based health services. On the other hand, the Service Level Agreement (SLA) serves as the legal instrument or tool between PhilHealth and the P/CWHS for contracting the delivery of individual-based health services.

Last among the tools is the LGU Health Scorecard. This is a performance monitoring tool to evaluate or assess the outcomes of health reforms in the P/CWHS. The results from the scorecard can aid local chief executives and local health managers in identifying the gaps and action points in the implementation of local health programs.

Local Health Systems Maturity Levels

In the first six years of implementation of the UHC Act, the organization of P/CWHS is implemented in UHC Integration Sites (UHC IS), which are the initial batch of provinces and highly urbanized or independent component cities that committed to integrate their local health systems. DOH developed the LHS ML as the general framework and tool in monitoring and evaluating the progress of UHC IS in integrating their local health systems[1]. In addition, the LHS ML is used to determine technical assistance and other support needed by these sites.

The LHS ML monitoring results can be used as one of the bases for formulation and updating of programs, projects and activities; and as reference of DOH, Ministry of Health-Bangsamoro Autonomous Region in Muslim Mindanao (MOH-BARMM), and local and international health partners in identifying the kind and level of assistance, incentives, and recognition and awards for LGUs to support implementation of the reform. Moreover, it complements the LGU Health Scorecard and other existing monitoring and evaluation systems that track LGU performance. It has to be emphasized that LGUs are the lead implementers of the integration reform.

Components of the Local Health Systems Maturity Levels

The LHS ML has four components: building blocks, integration characteristics, key result areas, and levels of progression (Figure 3.1).

The LHS ML is organized by adopting the World Health Organization framework of the six *building blocks* of a functional health system: (1) leadership and governance; (2) financing; (3) health workforce; (4) health information; (5) medical products, vaccines and technology; and (6) service delivery.

The next component is the characteristics of P/CWHS that have to be present in LGUs to achieve managerial and financial integration. There are ten *integration characteristics* included explicitly in the LHS ML. The eleventh characteristic, which is quality assurance or improvement, is already embedded in the other characteristics[2] (Table 3.1).

Figure 3.1 Components of the Local Health Systems Maturity Levels

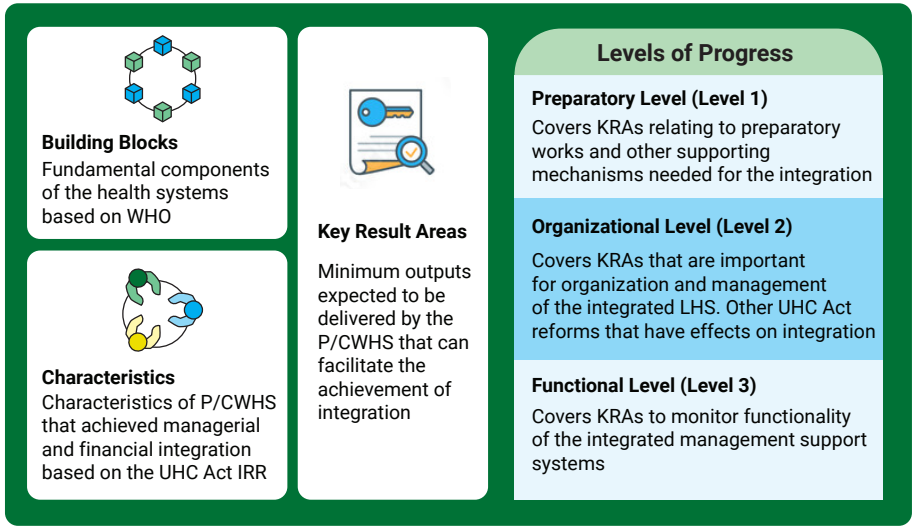


Table 3.1 Characteristics of Province-wide and City-wide Health Systems

BUILDING BLOCK	CHARACTERISTICS
Leadership and Governance	Unified governance of the local health system
	Strategic and investment planning
Health Financing	Financial management
Health Workforce	HRH management and development
Health Information	Information management system
	Epidemiologic system
Medical Products, Vaccines and Technology	Procurement and supply chain management
Service Delivery	Referral system
	DRRM-H system
	Health promotion programs and campaigns

The third component of the LHS ML is the *key result areas* (KRAs), which are qualitative indicators and are the minimum output expected to be delivered by P/CWHS as they undergo the integration process. Additionally, KRAs serve as the main reference of LGUs, DOH, PhilHealth, MOH-BARMM, and local and international health partners when planning for integration. In order to facilitate the monitoring of these indicators, means of verification (MOVs) are specified for each KRA. These MOVs

are documentary evidences that determine if a particular KRA has already been achieved, is still ongoing, or efforts have not yet started. The KRAs will be the basis for categorizing the level of maturity of the UHC IS.

The fourth component of the LHS ML is the three *levels of progression*, described as follows:

Preparatory level (Level 1): covers KRAs relating to preparatory works and other supporting mechanisms needed for the integration. If a UHC IS has progressed to this level, then the site has achieved all preparatory level KRAs. The UHC IS, with its component LGUs, has already been assessed on the readiness to managerially and financially integrate.

Organizational level (Level 2): covers KRAs that are important for organization and management of the integrated local health system. Other reforms in the UHC Act that affect the integration process are also included in this level. If a UHC IS achieves all preparatory and organizational level KRAs, then it has reached Level 2 and, therefore, can be categorized as an Organized P/CWHS. An Organized P/CWHS has available network-wide guidelines, and resources and management structures to facilitate and sustain the integration.

Functional level (Level 3): covers KRAs to monitor functionality of the integrated management support systems. This level mostly includes measurement of quantitative performance indicators and submission of reports. When a UHC IS achieves all KRAs of the LHS ML, it can be categorized as Level 3 or a Functional P/CWHS that has already operationalized and institutionalized network-wide management support systems.

Monitoring Process of Local Health Systems Maturity Levels

The LHS ML monitoring process starts with the self-assessment of the integration status of the UHC IS, through its respective Provincial or City Health Board. This will be followed by two levels of review and validation, first at the DOH CHD or MOH-BARMM, and second at the DOH Central Office. The last step in the process is the analysis and dissemination of the results to stakeholders.

Development and Implementation of Local Investment Plans for Health

The UHC Act and its Implementing Rules and Regulations (IRR) mandate that health-related financial and non-financial grants from the national government to LGUs are in accordance with their LIPH and Annual Operational Plans (AOPs). DOH requires the LIPH in the planning and provision of grants that cover capital outlay, human resources for health, and health commodities that support the improvement of the functionality of P/CWHS.

Development of Local Investment Plan for Health

The LIPH is a three-year medium-term public investment plan for health that specifies the strategic direction of the concerned LGU. It is translated into AOPs for the first, second, and third years of the LIPH period. It includes plans for improving delivery of population-based and individual-based health services; strengthening the health systems operations, including hospital investment and operating costs; and addressing social determinants of health. It also contains commitments of different local and international development partners.

The LIPH is developed by every province, highly urbanized and independent component cities, municipalities, and component cities based on local health situation and local objectives for health. Drafting the LIPH is guided by AmBisyon Natin 2040, Sustainable Development Goals, Philippine Development Plan, and National Objectives for Health.

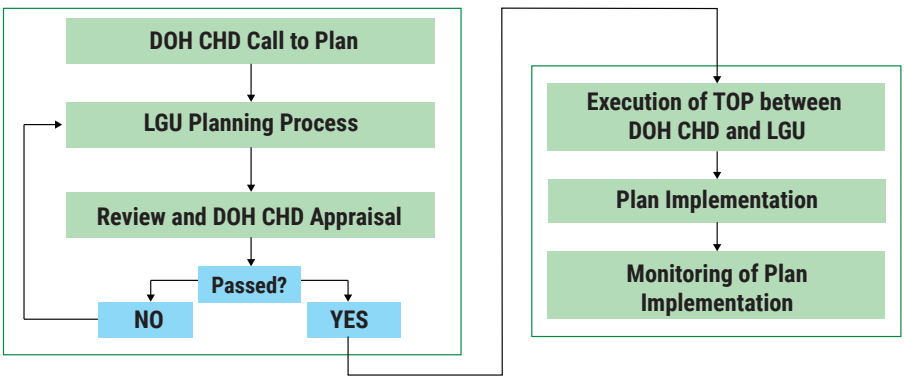
Inclusivity and equity require that the LIPH addresses the health needs of the local population and equally provide consideration to the health needs of vulnerable groups such as population in geographically isolated and disadvantaged areas (GIDAs), indigenous peoples, indigents, senior citizens, persons with disabilities (PWD), women, and children. It must also include activities on intra-governmental and civil society engagements, and private sector collaboration to address the social determinants of health.

As the major local health plan reference, the LIPH also serves as the basis for health inputs to the Regional Development Plan, and the Local Development Investment Program/Comprehensive Development Plan.

The LIPH employs a bottom-up planning process where health plans of municipalities and component cities are incorporated in province-wide health plans. In the case of highly urbanized cities and independent component cities, the health plans of each barangay are consolidated in the city-wide health plan. To facilitate the crafting of the LIPH, each province, city, municipality, and sub-provincial health system, as applicable, creates a planning team that includes key health actors at the local level.

The LIPH development process consists of four key steps: (1) call to plan; (2) LGU planning process; (3) review and appraisal; and (4) plan concurrence (Figure 3.2).

Figure 3.2 Steps in the Development of Local Investment Plan for Health



The call to plan is initiated by the DOH CHD. Following this, the concerned health office initiates the formulation of the LIPH. The LGU planning process includes situational analysis, identification of gaps, LGU investment needs, strategies and cost requirements, and consolidation, writing and submission of LIPH.

Subsequently, the LIPH undergoes a two-step review and appraisal. The first-level review is by the Provincial or City Planning Team, together with the Provincial or City DOH Representatives to the LGUs, program managers, and other stakeholders. Thereafter, the LIPH is submitted to the concerned DOH CHD for second-level appraisal using a prescribed tool. Once the plan hurdles appraisal, it is endorsed by the Province or

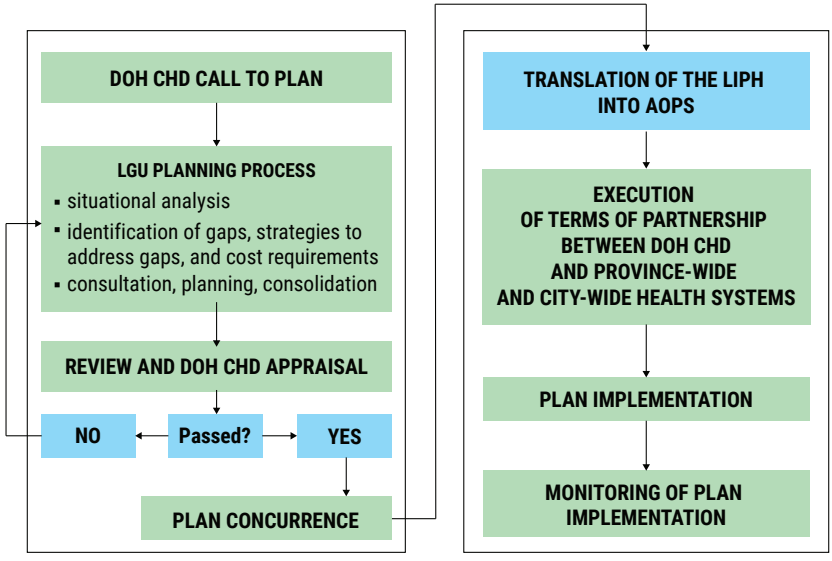
City Planning Team to the Provincial or City Health Board (P/CHB) for approval. Once approved, it is endorsed to DOH CHD for concurrence.

Implementation of Local Investment Plan for Health through Annual Operational Plans

To implement the LIPH, it is translated into AOPs that contain the details of each program and corresponding activities, targets and objectives, schedules or timeframe, resources needed, and accountable office or personnel in a particular year.

The development of the AOP follows the same process as the LIPH (Figure 3.3). The Year 1 AOP is developed on the same year as the LIPH development, while Years 2 and 3 AOPs update the LIPH, highlighting additional investments not previously indicated in the LIPH such as emerging needs, new priorities and directions, and unimplemented programs and projects from previous year's AOP. It is also important that the AOP is aligned with the LGU's Annual Investment Program to ensure local budget allocation. The review and appraisal process for the LIPH also apply to the AOP.

Figure 3.3 Steps in the Translation of Local Investment Plan for Health to Annual Operational Plans



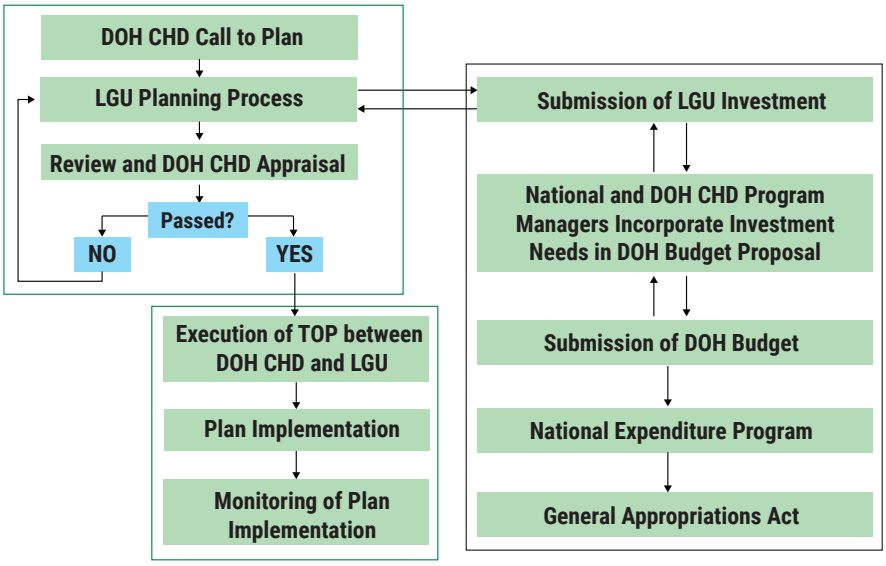
Once the AOP has been approved, the P/CHB and the DOH CHD enter into a contractual arrangement for its implementation, through a legal instrument called a TOP. After the approval of the TOP, the Provincial, City or Municipal Health Office leads the implementation of the plan in coordination with DOH CHD and other stakeholders.

A monitoring team organized by the P/CHB will track the implementation of the plan. The team monitors the status of the physical accomplishments of programs, plans and activities; DOH assistance for major cost drivers or investments, and local commitment through the Annual Investment Program; and other areas that may be identified for monitoring.

Alignment of DOH Plans and Budgets to the Local Investment Plan for Health and Annual Operational Plans

The national government ensures that DOH annual plans and budgets are aligned with the needs of the LGUs. This is done by considering AOPs of LGUs in the annual budget proposals of DOH. Provision of appropriate feedback to LGUs is also incorporated in DOH budget proposals (Figure 3.4).

Figure 3.4 Steps in Incorporation of Local Investment Plan for Health and Annual Operational Plans into the DOH Budget



Due to differences in national and local budget preparation timelines, LGUs are requested to submit to DOH a list of their investment needs in the first quarter of the current year for consideration in DOH's budget proposal for the succeeding year. DOH then provides feedback, which serves as reference of LGUs in updating or revising their proposed AOPs.

Contracting Province-wide and City-wide Health Systems

The IRR of the UHC Act[3] details how DOH enters into a contract with P/CWHS for the delivery of population-based health services.

Local Investment Plan for Health and Annual Operational Plans as Basis for Contracting

The LIPH and AOP serve as the basis for any contractual engagement between P/CWHS and DOH. LIPH is the medium-term strategic and investment plan for the implementation of the UHC at the local level. It is translated into three AOPs, which serve as basis for the provision of financial and non-financial grants from the national government and development partners. The contracting process is a major step in the implementation of the LIPH.

Contracting Parties

To initiate contracting, a TOP between P/CWHS, as represented by P/CHB, and DOH, as represented by the DOH CHD Director, is prepared as basis for the delivery of population-based health services. For individual-based health services, however, PhilHealth contracts health care provider networks through Service Level Agreements (SLAs), based on its guidelines.

P/CHB is responsible for the approval of the AOP and its endorsement to the appropriate DOH CHD for concurrence. Once concurred, the AOP becomes the basis for the contractual arrangement with DOH. P/CHB must ensure that the AOP is included in the LGU's Annual Investment Program for allocation and approval of the LGU's commitments in their budget. DOH CHD for its part, prepares the TOP agreement between parties. A TOP agreement serves as the

legal instrument for the provision of financial and non-financial grants from the national government and development partners to P/CWHS.

The contractual agreement is subject to the following conditions:

1. There must be a P/CHB resolution on the approval of the TOP. The authorized signatory may still be the local chief executive as the chair of the health board, or there may be additional signatories as deemed necessary by P/CHB.
2. There must be approved fund allocations for the AOP from the LGU or the Special Health Fund.
3. There must be adherence to other prerequisites inherent to an LGU entering into agreement with a national government agency, such as a *Sanggunian* Resolution.

Terms of Partnership as the Legal Instrument

TOP is the legal instrument or tool for contracting P/CWHS. Contracting is executed on an annual basis since it is based on the AOP, while DOH grants are released annually through the General Appropriations Act.

TOP contains the outputs and performance milestones to be attained by P/CWHS as well as the roles and responsibilities of contracting parties. It also details the resources, and the corresponding conditions for their release, whether financial or non-financial, coming from LGUs, DOH, development partners, and other institutions. However, if the amounts from approved national funds or grants are not yet available at the time of signing the TOP, indicative amounts of resources are specified based on the approved AOP.

Transfer and Use of Funds

Transfer and use of funds adhere to government budgeting, accounting, auditing rules and regulations, and other relevant technical guidelines. For UHC IS, funds will be transferred to the Special Health Fund. However, LGUs that have not committed to the integration of their local health systems are to follow the existing mechanisms for contracting with, and transfer of funds from, DOH.

Local Government Unit Health Scorecard

The monitoring and evaluation of local health system performance enables the tracking of national priorities and the identification of critical areas for improvement. This process assists the government in achieving better health outcomes from the local to the national level. With this, the UHC Act highlights the critical role of performance assessment to monitor and evaluate the outcomes of health sector reforms in P/CWHS.[4]

Since 2008, the LGU Health Scorecard (LGU HSC) has been used as a primary tool to assess and monitor the performance of LGUs in the implementation of local health reforms. Performance accountability also requires the integration of transparent and accountable measures such as reporting tools, systems, and processes at all levels of the health sector.

LGU Health Scorecard as Performance Assesment Tool

The LGU HSC is a tool that guides local health leaders, particularly local chief executives and health officers, in identifying the gaps and action points in the implementation of major public health programs. It is one of five scorecards identified in the Health Sector Monitoring and Evaluation Accountability Framework, to report the contribution of stakeholders in ensuring better health outcomes, more responsive health systems, and more equitable health financing espoused in the National Objectives for Health (Figure 3.5).

Figure 3.5 Health Sector Monitoring and Evaluation Accountability Framework

The revised guidelines on the implementation of the LGU HSC includes monitoring and evaluation of the performance of all P/CWHS[5]. The scorecard links performance criteria and scoring to desired health system outcomes using the best evidence possible. Moreover, the tool is harmonized and implemented with other DOH monitoring and evaluation systems. Processes to generate and publish performance results operate within institutional mechanisms. Data are collected and reported annually.

LGU Health Scorecard Rating System

The LGU HSC is presented in a way that can easily be understood by clients through the use of color codes and directional arrows (Figure 3.6).

Figure 3.6 LGU Health Scorecard Rating System

COLOR	INTERPRETATION
Green	"Excellent" (performance has reached the national targets)
Yellow	"Fair" (performance has reached the national average but not the national target)
Red	"Poor" (performance is below the national average)

SYMBOL	INTERPRETATION
↑	Current LHS performance is higher than the previous year
=	No change in current LHS performance as compared to the previous year
↓	Current LHS performance is not as good as the previous year

The color-coded rating system is used to assess the comparative performance of provinces, cities, and municipalities against the national target, using several Field Health Service Information System (FHSIS) and non-FHSIS indicators.

A green rating means the local health system's performance has reached or exceeded the national target. It signals local health managers to sustain the current level of performance. The yellow rating means the local health system performed above the national average, but fell short of the national target. As a general recommendation, local health managers are encouraged to maintain their progress. The red rating means the local health system performed below the national average. It calls for local health managers to improve efforts and focus resources on necessary interventions to improve constituents' health.

For symbols, the equal sign means there is no change in local health system performance compared from the previous year. The up-arrow sign means improvements in previous year's performance must be sustained, while the down-arrow sign means comparative weakness from previous year's performance, thus the need for substantial improvement.

Local Government Unit Health Scorecard Process Flow

The LGU HSC Manual of Procedures[6] describes the process flow of the implementation of the LGU HSC (Figure 3.7). The process starts at the municipal level, with data collected going through the four phases of implementation, and through various stakeholders with corresponding roles, until all information reaches the DOH Central Office.

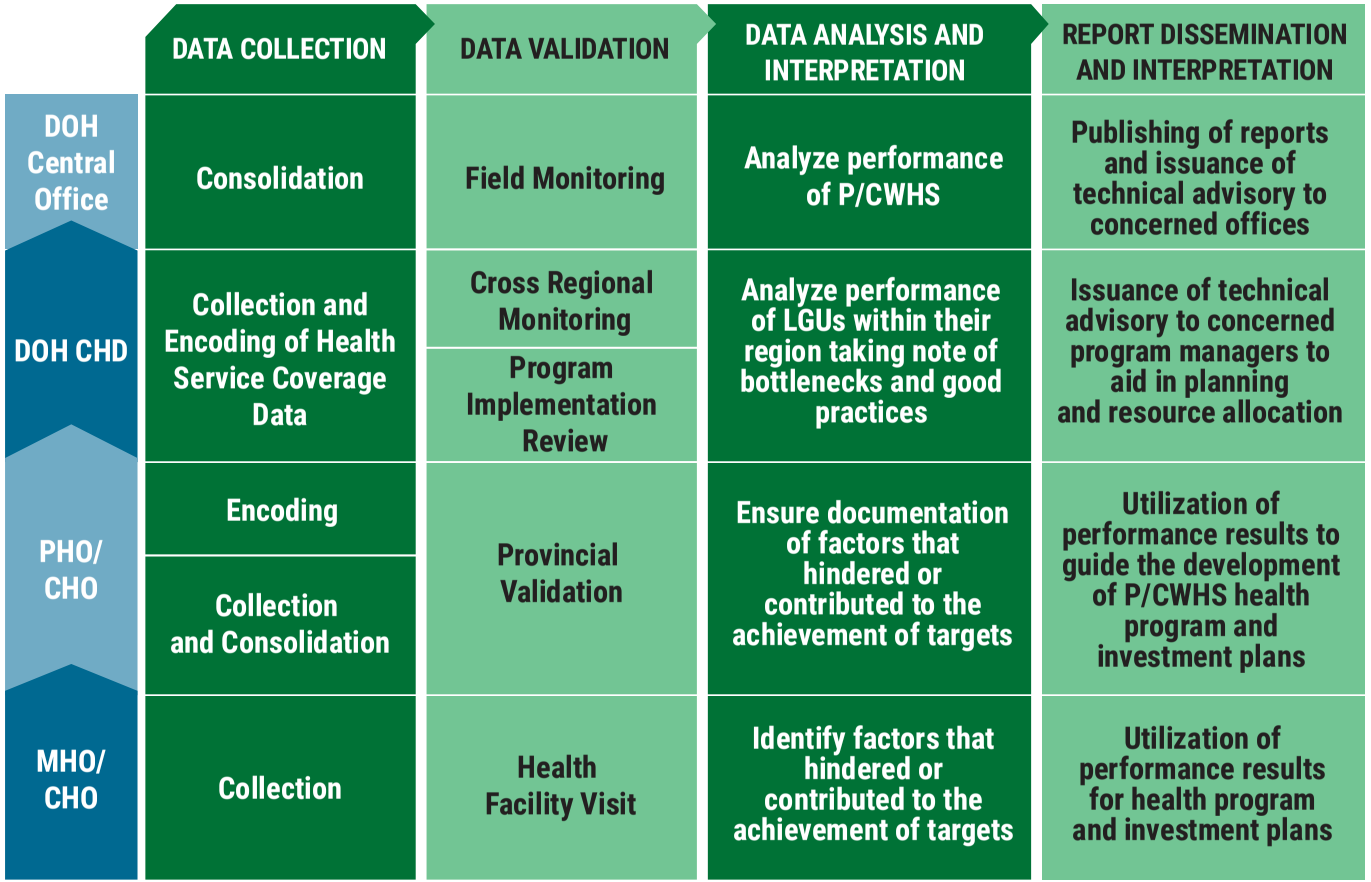
a. Data Collection

The data collection process starts from primary care facilities and undergoes several layers of validation such as data quality check in the municipal level, and data reconciliation in the provincial and regional level, prior to submission to DOH Central Office.

Data or information in the FHSIS come from the Regional Epidemiology and Surveillance Unit or the DOH Epidemiology Bureau. For data or information that are not in the FHSIS, the collection process begins with local health officers spearheading the collection of health service, financing, and governance data in their respective LGUs. A standard Data Capture Form is a paper-based form that is used to record the raw and computed values of LGU's performance in each of the indicators.

For the MOH-BARMM, the Chief of Technical Division is in charge of providing technical assistance to the Municipal, City, and Provincial Health Officers in the region, consolidating the report submission, and ensuring the accuracy and validity of the information recorded in the Data Capture Form.

Figure 3.7 LGU Health Scorecard Process Flow

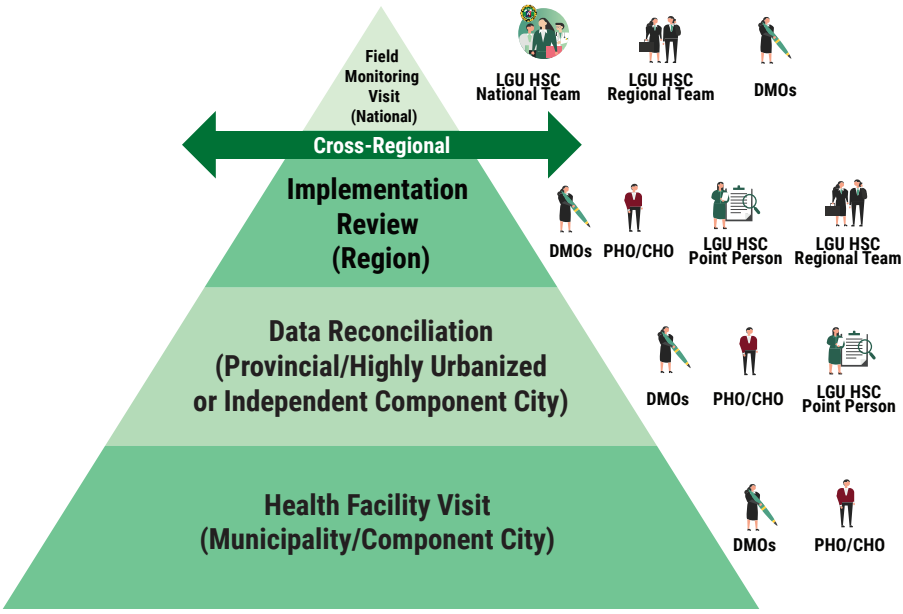


b. Data Validation

The validation process allows standardization of data quality in each of the reporting levels to improve data accuracy and reliability. The process consists of four core phases (Figure 3.8). First, municipal or component city looks into data accuracy and completeness. Second, provincial, or highly urbanized or independent component city also looks into data accuracy and completeness as well as implementation issues and good practices. Third, at the regional level, implementation issues and best practices are identified, and policy recommendations are issued. Lastly, national validation is undertaken where policy inputs and program design are considered.

In DOH CHDs and MOH-BARMM, the DOH Representatives and the Chief of Technical Division, respectively, take part in all levels of the validation process, which also introduces additional initiatives such as cross-regional validation, to enrich process quality.

Figure 3.8 LGU Health Scorecard Validation System



Encoding of non-FHSIS data of the LGU HSC is done at the level of the province. The DOH Representatives and the Chief of Technical Division facilitate and ensure encoding of the validated Data Capture Form in the LGU HSC web-based system

c. Data Analysis and Interpretation

Once validated, the LGU HSC performance results are reviewed to provide deeper understanding of local health systems' situation. The process of analysis and interpretation allows local health officers and national and subnational policy makers to assess the overall implementation of health reforms, and determine whether reforms helped improve the local health conditions.

In DOH CHDs and MOH-BARMM, the DOH Representatives and the Chief of Technical Division, respectively, together with the local health officers, are responsible for reviewing the LGU HSC performance results of their respective LGUs, and for providing evidence-based recommendations on local health programs and plans.

Several approaches can be used to assess LGU HSC performance results:

1. Review data against the goal or target;
2. Review data over time;
3. Review data by geographical division;
4. Review equity in local government performance; and
5. Correlate results with related indicators or with social determinants of health.

d. Report Dissemination and Utilization

Report dissemination and utilization involve the translation of LGU HSC performance results into information relevant for decision making. They require packaging, communication, and dissemination of information in a format and language appropriate for intended users of the information.

DOH Representatives and the Chief of Technical Division of MOH-BARMM communicate to decision makers and other stakeholders the performance results and findings from the LGU HSC, and promote the use of results as basis for the formulation of the LIPH or AOPs.

Moreover, LGU HSC data and analysis can be used to educate, convince, and engage stakeholders through a participatory process to help organizational learning, and to record and create institutional memory. The dissemination of reports also enforces proper accountability and serves as reference for policy formulation and decision making. Further, the performance results can trigger the conduct of in-depth study. The LGU HSC may also serve as a mechanism to give recognition, incentives, and awards to LGUs with excellent performance.

Chapter References

1 Department of Health. (2020). G*uidelines on the implementation of the local health systems maturity level (LHS ML)*. (Administrative Order No. 2020-0037)

2 Department of Health. (2020). *Implementing rules and regulations of the Universal Health Care Act.* (s. 41.4).

3 Department of Health. (2020). *Implementing rules and regulations of the Universal Health Care Act.* (s. 17.2).

4 Department of Health. (2020). *Implementing rules and regulations of the Universal Health Care Act.* (s. 40.1).

5 Department of Health. (2021). *Revised guidelines on the implementation of the local government unit (LGU) health scorecard (HSC).* (Administrative Order 2021-0002).

6 Department of Health. (2020). *Dissemination of the local government unit health scorecard manual of procedures (LGU HSC MOP).* (Department Memorandum No. 2020-0275).

Chapter IV

Enhancing Primary Care Services

The UHC Act recognizes the crucial role of primary care provider networks (PCPNs) as the basic foundation of Health Care Provider Networks (HCPNs). In this line, the DOH developed the Primary Care Policy Framework, which highlights the sectoral policies and strategies to make primary care services more responsive to people's needs. To ensure that primary care facilities within the PCPNs are providing effective, equitable, and quality basic and essential health services, four critical requirements have been mandated under the law.

The first requirement is the licensing of primary care facilities, such as health centers, rural health units, and private medical clinics, as well as stand-alone birthing facilities, dental clinics, laboratories, and diagnostic facilities, to ensure that only safe and quality primary care services are being delivered to the Filipino people. The second requirement is the accreditation of these facilities by PhilHealth to qualify them to provide the primary care benefit package under the Konsultasyong Sulit at Tama or Konsulta Package, and other outpatient benefit packages. The third requirement is the certification of primary care health workers, such as doctors, nurses, midwives and other allied health professionals, to ensure

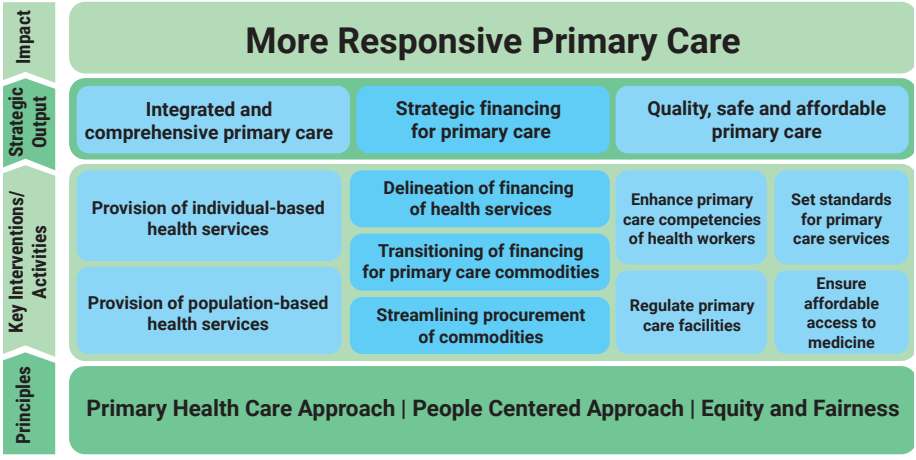
that they have appropriate competencies and skills to deliver quality standards of primary care. The fourth requirement is the registration of every Filipino by LGUs, in coordination with DOH and PhilHealth, to a public or private primary care provider of choice within their territorial jurisdiction.

Primary Care Policy Framework and Sectoral Strategies

The UHC Act emphasizes the strengthening of primary care so that Filipinos are guaranteed access to quality and affordable health care goods and services, and protection against financial risk. Moreover, it provides that the health care delivery system must afford every Filipino with a primary care provider that serves as the navigator, and initial and continuing point of contact to the health system. The law also emphasizes that PCPNs serve as the foundation of HCPNs.

To meet these objectives, the DOH developed the Primary Care Policy Framework focusing on the delivery of integrated and comprehensive primary care services; presence of more strategic financing for primary care; and availability of safe, quality, and affordable primary care services (Figure 4.1)

Figure 4.1 Primary Care Policy Framework



Principles of Primary Care

In pursuing responsive primary care, *Primary Health Care* should serve as the guiding philosophy and approach of the health sector. People's needs are the centerpiece of any intervention, while equity and fairness guide health and health-related decisions. Considering that individual and community health and well-being do not solely depend on effective delivery of health care services, health workers should set effective avenues to work

closely with the community. Partnerships with diverse stakeholders within and outside the health sector should be fostered, and investments should be directed to shape and support primary care-led integration. *People-centeredness* can be achieved by empowering all Filipinos to make their own decisions related to their health, well-being, and provider preferences, and by ensuring that the right of every Filipino to quality, accessible, and affordable health care are always upheld. *Equity and fairness* guide the path towards access and universality. This can be achieved by ensuring that all Filipinos have access to quality primary care services and are covered by the same set of benefits under UHC.

Primary Care Strategic Outputs and Key Interventions

Strengthening primary care can be accelerated by focusing on three identified strategic outputs: integrated and comprehensive primary care services; strategic financing for primary care; and quality, safe, and affordable primary care.

Integrated and comprehensive primary care services refer to the provision of population-based and individual-based health services. Improving access to individual-based primary care services include setting up mechanisms for the registration of every Filipino to a primary care provider of choice, whether public or private, that will act as the navigator and coordinator of care. Moreover, improving service accessibility includes developing comprehensive outpatient benefit packages at the primary care level. Following this, PhilHealth is expected to expand its outpatient benefit package to cover more drugs and diagnostics as well as other primary care services, turning it into one comprehensive outpatient benefit package. Access can be improved through a technology-enabled primary care system by operationalizing electronic records management systems and telemedicine.

Strategic and efficient financing for primary care refers to determining the most appropriate financing scheme for health services. First, it is important to delineate which services are population-based and which are individual-based. Second, this delineation will guide the transition in the financing of health services and commodities, such that DOH and LGUs

provide financing for population-based health services, and PhilHealth, in complementation with private health insurers and health maintenance organizations (HMOs), for individual-based health services. Lastly, the procurement process has to be streamlined to ensure availability of supplies and commodities. This can be done through pooled procurement platforms and mechanisms at the national and regional levels as well as hospitals and HCPNs. Capacity building on procurement and supply chain management should also be conducted.

The last strategic output focuses on *ensuring quality, safe, and affordable primary care services*. This covers improving the primary care competencies of health workers through development of learning packages, and setting standards and processes for engaging primary care workers. Moreover, there should be a shift from hospital- and curative-focused medical and allied health curriculum to a primary care- and public health-focused curriculum. Primary care practice guidelines and standards for primary care facilities must be developed, while a regulatory system for primary care facilities must be institutionalized. The Health Technology Assessment process, another reform under the UHC Act, can help determine which primary care interventions should be funded by the government or by social health insurance. Lastly, the establishment of appropriate measures to facilitate affordability and safety of drugs and medicines must be undertaken.

Strong primary care processes lead to improved accessibility to comprehensive, continuous, and coordinated quality primary care services. All these can contribute to the eventual achievement of health goals related to better health outcomes, financial risk protection, and health systems responsiveness.

Licensing of Primary Care Facilities

The UHC Act envisions primary care facilities to deliver initial-contact, accessible, continuous, comprehensive and coordinated care to their respective catchment communities. In this line, it mandates DOH to license and regulate stand-alone health facilities, including those providing ambulatory and primary care services, and other modes of health service[1].

Thus, facilities such as rural health units, health centers, and private medical outpatient clinics are now subject to DOH licensing standards and requirements[2]. This is to ensure all these facilities deliver safe and quality primary care services. However, barangay health stations, which are under the supervision of rural health units or urban health centers, are not required to secure a License to Operate.

Primary Care Facility Service Capability

A primary care facility can be either government or privately owned. Both types are expected to provide individual-based health services. While only government-owned primary care facilities are currently expected to provide population-based health services. In the future, privately owned facilities may also be capacitated and remunerated to provide population-based health services.

Government and privately owned primary care facilities must both provide medical consultations, minor surgical services, and ancillary services within their premises. They may also outsource, within or outside their respective premises, ancillary services such as clinical laboratory, diagnostic radiologic services, pharmacy, birthing services, dental services, and ambulance services.

Assessment of Primary Care Facility

DOH issues a License to Operate to a primary care facility upon the latter's compliance with DOH standards and technical requirements for safety. DOH regulatory officers, along with stakeholders, use an assessment tool to evaluate the compliance of primary care facilities with licensing requirements. The same tool is used by DOH inspection and monitoring teams, and can be utilized by owners of primary care facilities for self-assessment.

The assessment tool uses seven major licensing criteria:

1. Personnel: facility must have the adequate number of qualified, trained, and competent staff to ensure efficient and effective delivery of quality primary care services.

2. Physical Facilities: facility must conform with national and local regulations for construction, renovation, maintenance and repair, as well as with DOH planning and design guidelines for primary care facilities.
3. Equipment and Instruments: facility must ensure availability and consistency of equipment, instruments, and materials and supplies, with the package of health services that it provides.
4. Service Delivery: facility services to patients must comply with standards stipulated in the assessment tool and other relevant issuances.
5. Quality Improvement: facility must establish and maintain a system for continuous quality improvement.
6. Information Management: facility must maintain an information system for communicating, recording, reporting, and releasing patient's results that adheres to relevant laws.
7. Environmental Management: facility environment must be safe for its patients and staff, including the general public.

Steps in Licensing a Primary Care Facility

The licensing of a primary care facility starts with its application with DOH for a Permit to Construct a new facility or for expansion or renovation. After construction, expansion, or renovation, the facility applies for a License to Operate and pays the necessary application fees. Upon compliance with all requirements and after monitoring and inspection by DOH, a facility may be issued a license with three-year validity. During the transition period of the UHC Act, all existing primary care facilities need not apply with DOH for a construction permit and proceed directly to applying for an operating license.

a. Applying for a Permit to Construct

A Permit to Construct is required for the construction of new primary care facilities and for the renovation or expansion of existing ones. An application form for this can be downloaded from the DOH website, and then filled up manually or online. The form is then submitted to the appropriate DOH Center for Health Development (CHD).

During the transition period of the UHC Act, the need for a construction permit is waived for primary care facilities already existing and operating prior to the effectivity of rules and regulations on the licensing of primary care facilities[3]. In lieu of such requirement, however, the applicant primary care facility must submit an "as-built" plan to the DOH CHD.

b. Applying for a License to Operate

An application form must be submitted to the appropriate DOH CHD. All applications, whether new or for renewal, are processed manually or through the Online Licensing and Regulatory System. The licensing process follows the One-Stop Shop Licensing System.[4]

For ancillary services owned and located within the premises of a primary care facility, a Certificate of Compliance for diagnostic radiology or pharmacy must first be sent to the DOH CHD by the Food and Drug Administration (FDA).

During the transition period of the UHC Act, an existing primary care facility that cannot comply with the licensing standards for ambulance service is given a grace period. In the interim, the facility can use a DOH-registered Patient Transport Vehicle. Also, an existing primary care facility that does not have the required dental equipment and instruments is given a grace period to comply.

Upon filing of a license application, the applicant primary care facility pays the necessary fee to the appropriate DOH CHD. The application fee follows the schedule of fees prescribed by DOH or FDA.

Once licensed, a single License to Operate is issued to the primary care facility. The license indicates the facility's category, ownership, and validity period of three years. It can be renewed following the prescribed cutoff dates.

During the transition period of the UHC Act, the primary care facility that cannot fully comply with the requirements for providing ancillary services must submit a Memorandum of Undertaking in accordance with guidelines issued by DOH.[5]

Violations and Sanctions

A primary care facility can be penalized or sanctioned for failing to comply with any of the licensing standards indicated in the assessment tool; or for failing to comply with the requirements for ancillary services, regardless of location and ownership, within the compliance period provided by DOH CHD. Sanctions may not apply if a primary care facility with more than one outsourced ancillary service has at least one ancillary service of the appropriate category that is fully compliant.

The primary care facility or the ancillary service is cleared of its violation after it complies with the necessary corrective actions and the prescribed sanction. A facility may appeal a sanction by DOH CHD within 10 days after its receipt of the notice of decision, through a notice of appeal to the Secretary of Health, whose decision on the matter is deemed absolute and executory.

Accreditation for Primary Care Benefit (Konsulta) Package

The UHC Act ensures that all Filipinos are guaranteed equitable access to quality and affordable healthcare goods and services while being protected against financial risk.[6] Further, it provides that every Filipino is granted immediate eligibility and access to preventive, promotive, curative, rehabilitative, and palliative care for medical, dental, mental, and emergency health services, delivered either as population-based or individual-based health services.[7]

Currently, PhilHealth is providing *Konsultasyong Sulit at Tama* (Konsulta) as its primary care benefit package. However, it aims to eventually transform this into a comprehensive outpatient benefit package as mandated by the UHC Act. This comprehensive outpatient benefit package will later be provided by contracted HCPNs. In this line, PhilHealth defined the standards and guidelines for accreditation of publicly owned or privately owned primary care providers to deliver the Konsulta Package.[8]

Accreditation Standards

During the transition for the licensing process of primary care facilities, PhilHealth will continue to accredit both DOH-licensed and non-licensed

primary care facilities. Non-licensed primary care facilities, including those previously accredited for primary care benefit and expanded primary care benefit packages, can be accredited as long as they submit required documents[9]; accede to surveys; and comply with mandatory input standards[10] of the Konsulta package.

As for DOH-licensed primary care facilities, they can be accredited upon submission of the required list of documents, even without conducting the survey. However, these facilities need to provide proof of a functioning electrocardiogram (ECG) machine.

For services not available in the accredited facility, the PhilHealth Konsulta provider may establish referral, or contracting or service agreements with nearby DOH-licensed laboratory, pharmacy, or x-ray facility. The provision of an ECG machine may also be outsourced from a licensed or a non-licensed facility, as long as the provider signs the Certification of Service Delivery Support.

Accreditation requires having a health human resource complement that is either employed, contracted, or detailed. A PhilHealth-accredited primary care physician[11] must also be available, and likewise accredited as a provider for the Konsulta package. Moreover, all workers in the facility must be registered PhilHealth members.

If the required personnel can no longer deliver or are no longer authorized to deliver the service within the validity of accreditation of the facility, or when the health facility closes, or when the accreditation of the health facility is suspended or not renewed, then the facility must facilitate the referral and transfer of eligible beneficiaries to a nearby PhilHealth accredited provider.

Within one month from accreditation, the Konsulta provider is required to have fully functional signages that conform to the required specifications.[12]The signage must be illuminated when the health facility is operating at night, and must be installed near the entrance of the health facility to guide clients.

The Konsulta provider must also maintain a PhilHealth-certified electronic information system that may be developed in-house or outsourced. The health facility must have electronic copies of patients'

records, while ensuring the fidelity of information or data it holds. The facility must institute appropriate safeguards to protect data.

Accreditation Process

There are specific rules to follow in the accreditation[13]. Upon evaluation, a Konsulta provider with a DOH License to Operate may be granted three years accreditation, while a non-licensed Konsulta provider may be granted a maximum of one year accreditation. PhilHealth will use the Health Care Provider Performance Assessment System in monitoring accredited facilities and healthcare professionals. Administrative data must be made available to PhilHealth by Konsulta providers, when warranted.

Certification of Primary Care Workers

In 2020, DOH and the Professional Regulation Commission (PRC) established the eligibility requirements, standard competencies, training mechanisms, and post-graduate certification process for primary care workers (PCWs).[14] This is aligned with the law's objective of producing competent and practice-ready health workers to deliver primary care services.[15] Within 10 years from the effectivity of the UHC Act, only health workers certified by DOH and PRC will be eligible to provide primary care services[16].

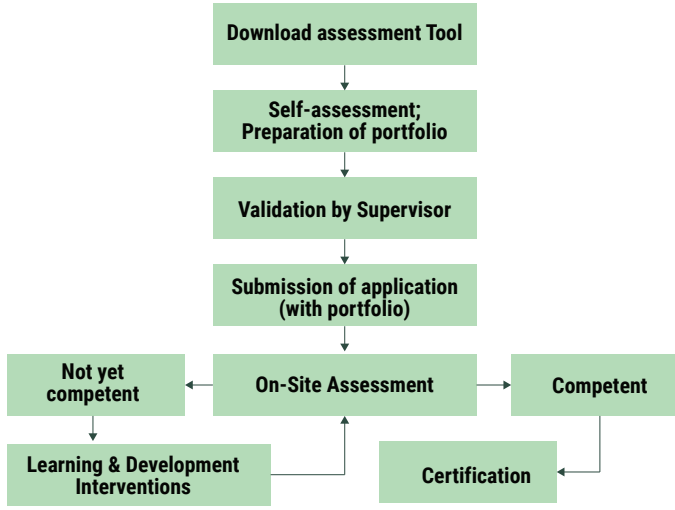
Initially, DOH prioritizes the PCW certification process for doctors, nurses, and midwives working in primary care facilities. This will be expanded later to include other health professionals engaged in or intending to provide primary care services.

Primary Care Worker Certification Process

PCW certification is a pre-requisite for the licensing and accreditation of a primary care facility. Such certification follows a step-by-step process (Figure 4.2).

The current competencies of licensed health professionals are first assessed using a self-assessment tool that can be downloaded from the DOH and PRC websites. The portfolio of evidence in support of the

Figure 4.2 Primary Care Worker Certification Process



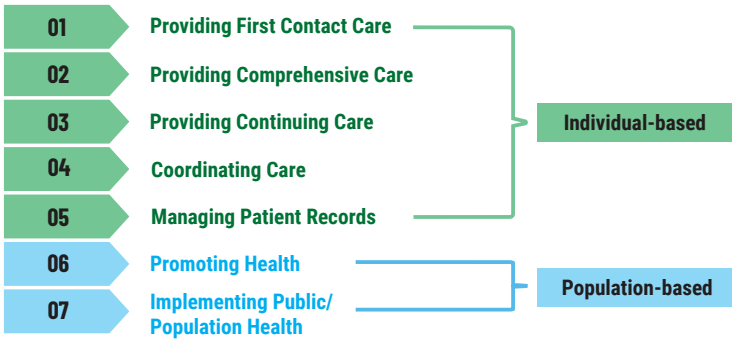
self-assessment is then validated by the supervisor prior to submission. Thereafter, the designated assessor conducts an online and onsite assessment to validate the results of the self-assessment and the portfolio. A certification is then issued to a health professional evaluated as "competent" by the DOH-PRC Technical Working Group. Health professionals who fail to qualify for certification may attend DOH learning and development interventions and online courses to address competency gaps.

Primary Care Worker Competencies

In certifying PCWs, health professionals have to be declared "competent" in five individual-based and two population-based competencies (Figure 4.3).

Among PCW competencies is providing *first-contact care*, or the provision of health services within a time frame appropriate to the urgency of health problems. A competent PCW establishes effective partnership with patients; assessing and managing patients and administering initial treatment within the scope of profession; and recognizing when patients require higher levels of care either within or outside of primary care facility.

Figure 4.3 Primary Care Worker Competencies



A PCW is also expected to provide *comprehensive primary care*, or a wide range of health services that meet common needs across life stages. Primary comprehensive care also considers the patient's context in planning for care management to implement individual-based and population-based health services such as screening, diagnostic, therapeutic, and preventive measures within the scope of profession. Such care includes counseling services to patients on general disease prevention and health promotion, including house remedies.

Continuing care refers to providing a sustained partnership with the patient in the management of his or her condition. A PCW must sustain a harmonious and continuing relationship with patients, especially those with chronic and persistent health challenges that can be managed at the primary care level. Planning for continuing care must also be done for patients with chronic conditions, post-discharge, and those referred back to primary care.

Coordinating care refers to the transfer and sharing of responsibility across disciplines and higher levels of care, as necessary. A PCW must participate in multidisciplinary care and interprofessional care teams. When the patient needs to be referred to a higher level of care, a PCW must communicate effectively with care providers within the facility and the HCPN. In addition, the PCW is expected to assist patients in navigating through other agencies and resources in the community during referrals for medications, diagnostic tests, and health care services.

Managing patient records refers to the coordination of care through accurate and timely integration of medical records in the HCPN. A PCW ensures quality of patient records in terms of accuracy, completeness, reliability, and timeliness using standard protocols, and maintains privacy and security of data collected. A PCW demonstrates familiarity on the use of existing and mandated health information systems.

Promoting health refers to identifying, describing, and implementing programs, policies, and other health promotion interventions that are empowering, participatory, holistic, inter-sectoral, equitable, sustainable, and multi-strategic in nature. A PCW must explain fundamental concepts of health promotion and disease prevention within the scope of profession, including national and international health goals. This entails effective communication with patients, families, and communities that promote health by contextualizing health information to their needs.

Promoting health also requires the development and implementation of strategies that support inclusivity and improved access to primary care, considering unique health needs of priority and vulnerable groups.

Another important PCW competency is *implementing public health programs* and *delivering population health care services*. A PCW implements public health programs, measures their progress and results, and establishes a feedback mechanism. This competency also covers the engagement of community leaders and stakeholders in the implementation of public health programs.

Provisional Certification

During the transition period (2021-2022), DOH is issuing provisional certificates to health professionals who are currently employed in primary care facilities and have completed the required online courses at the DOH Academy eLearning platform (learn.doh.gov.ph). These provisional certificates can be used to meet the requirements for licensing and accreditation of primary care facilities. The full implementation of the PCW certification program commences in 2023.

This transition period is expected to bridge the current limitation in the certification process leading to the attainment of the UHC goal of strengthening primary care services.

Registration of Filipinos to a Primary Care Provider

Strengthening the primary care system is a key reform of the UHC Act. Every Filipino is expected to be registered with a public or private primary care provider (PCP) of his or her own choice[17]. DOH and PhilHealth have issued guidelines and instituted processes on the registration of Filipinos to a PCP[18]. PhilHealth has also issued a circular on its Konsulta Package to operationalize registration[19].

Eligibility and Criteria for Registration

All Filipinos are eligible to register with a DOH-licensed or certified and PhilHealth-accredited or contracted PCP of their choice through self-registration, or assisted registration, or other modalities to be identified by PhilHealth. Due consideration is given to enable minors, senior citizens, persons with disabilities (PWDs), indigents, and those without internet access to register.

During registration, proximity and ease of travel of the registrant to the PCP, and absorptive capacity and capability of the PCP to deliver the required health services, must be considered.

Availment of Services

Filipinos registered with a public PCP are entitled to receive both individual-based and population-based health services from that PCP. Those registered with a private PCP are to receive individual-based health services from that private PCP. Population-based health services can be provided to them by the public PCP, until such time that the private sector is capacitated to also provide population-based health services.

Data Management

To facilitate data management and for the efficient and effective monitoring of health status and availing of health services, all PCPs are expected to have electronic health records. Such records will also be utilized for patient navigation and coordination mechanisms for higher levels of care within the HCPN, and to support the provision of continuous and comprehensive primary care services.

PCPs must establish, maintain and update the master list of their respective catchment population or Filipinos registered with the facility. Moreover, LGUs are required to monitor the number of registered Filipinos in each city and municipality, regardless of whether they are registered with a publicly owned or privately owned primary care facility.

Electronic health records and registration data will be used by LGUs and DOH to approximate market saturation and identify gaps in the health system as basis for planning and budgeting, research, and in designing and developing health programs. All information generated through the registration must be kept confidential, secure, and private in compliance with the Data Privacy Act of 2012.

LGUs must also maintain a database to check if there is adequate number of PCPs within their catchment area. With assistance from DOH and PhilHealth, LGUs must ensure and facilitate the registration to PCPs of Filipinos living and residing within their respective territorial jurisdiction. DOH and PhilHealth have developed operational guidelines and tools on how to organize the health system and health providers to enable client's choice in selecting a PCP.

Modalities and Registration Process

Multiple modalities such as self-registration and assisted registration are made available to Filipinos to enable them to register to a PCP. Modalities are governed by policies and guidelines set by PhilHealth. Mechanisms for the portability of benefits are being explored by PhilHealth such as interoperability of electronic health records or information, and registration and access to services by those seeking care outside of their geopolitical boundaries. LGUs are responsible for ensuring people's registration with PCPs, and that resources are available to facilitate registration.

Chapter References

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2 Department of Health. (2020). *Rules and regulations governing the licensure of primary care facilities in the Philippines*. (Administrative Order No. 2020-0047).

3 See 2.

4 Department of Health. (2018). *Revised guidelines in the implementation of the one-stop shop licensing system*. (Administrative Order 2018-0016).

5 Department of Health. (2020). *Amendment to administrative order (A.O.) No. 2020-0047 entitled "Rules and regulations governing licensure of primary care facilities in the Philippines"*. (Administrative Order No. 2020-0047-A)

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9 See 8.

10 See 8.

11 See 8.

12 Philippine Health Insurance Corporation. (2009). *New PhilHealth signage.* (PhilHealth Circular No. 13 s-2009).

13 See 8.

14 Department of Health & Professional Regulation Commission. (2020). *Guidelines on the certification of primary care workers for universal health care.* (DOH-PRC Joint Administrative Order No. 2020-001).

15 *Universal Health Care Act 2019* (Rep) s. 25.d (Phil.).

16 *Universal Health Care Act 2019* (Rep) s. 41.i (Phil.).

17 Department of Health. (2019). *Implementing rules and regulations of the Universal Health Care Act.* (s. 6.6).

18 Department of Health & Philippine Health Insurance Corporation. (2020). *Guidelines on the registration of Filipinos to a primary care provider.* (DOH-PHIC Joint Administrative Order No. 2020-0001).

19 Philippine Health Insurance Corporation. (2020). *Implementing guidelines for the PhilHealth Konsultasyong Sulit at Tama (PhilHealth Konsulta) Package.* (PhilHealth Circular No. 2020-0022).

Chapter V

Delivering Population-based and Individual-based Health Services

With the enactment of the UHC Act, health service packages are now classified as either population-based or individual-based. Population-based health services are health interventions which have population groups as recipients, such that services cannot be specifically traced back to a single person or beneficiary. Health care providers, particularly in the public sector, are required to provide health promotion programs and campaigns, epidemiological and disease surveillance systems, and disaster risk reduction and management in health. Water quality assurance, food sanitation, vector control, among others, may also be included as critical population-based health services.

Individual-based health services, on the other hand, are health interventions that can be accessed within a health facility or remotely, definitely benefiting one recipient, and have limited effect at a population level. These health packages are exemplified by medical and surgical procedures provided as inpatient services in a hospital setting, or as outpatient services in ambulatory care facilities, or as health interventions provided remotely through digital health services.

The classification of health service packages into population-based and individual-based follows a set of criteria based on the economic concept of a public good. First is the concept of rivalry, that is, if one person's use of a health good or service diminishes other people's use. Second is in terms of excludability, that is, if the use of a health good or service can be limited to only paying customers. Third is from the standpoint of externality, that is, if there is minimal to no external effect beyond the one person availing the health package. Health goods and services that are rival, excludable, with minimal to no external effects to the general population, and with a sole intended recipient, are classified as individual-based health services. Otherwise, they are classified as population-based health services. Such classification is crucial in the context of the law's mandate for individual-based health services to be funded through premium-based financing by PhilHealth in complementation with private health insurers and health maintenance organizations (HMOs); and for population-based health services to be funded through tax-based budget allocation by DOH in complementation with LGUs.

Criteria for Classifying Population-based and Individual-based Health Services

Health goods and services must be classified as either population-based or individual-based to guide DOH, PhilHealth, LGUs and other stakeholders on the appropriate financing mechanisms and contracting arrangements in the provision of such health services. Under the law, population-based health services will be funded by the national government through DOH in complementation with the budget allocated by LGUs for health services, and provided free of charge at the point of service. Individual-based health services will be financed by PhilHealth in complementation with private health insurers and HMOs. The classification process of health service packages follows a set of criteria based on the economic concepts of a public good: rivalry, excludability, and externality (Table 5.1).

Table 5.1 Classification of Individual-based and Population-based Health Services

CRITERIA	INDIVIDUAL-BASED	POPULATION-BASED
RIVALRY "Will there be rivalry among recipients when this service is rendered?"	Individual-based health services are rival. These health services may only be provided to one person at a time to ensure that full benefits of the good are imparted to the receiver. One person's use of a health service diminishes other people's use, which is why this service is provided to one person at a time.	Population-based health services are non-rival. When one person receives a health service, it does not prevent others from accessing and benefiting from it. When provided, the full benefits of these health services are enjoyed by more than one person up to a maximum area of effect.
EXCLUDABILITY "Is this service and its benefit only accessible to one person when rendered?"	Individual-based health services are excludable. Only persons who avail and pay for these services may access and benefit from these health services.	Population-based health services are non-excludable. The benefits from these services may be accessed and enjoyed by people not paying for these services.
EXTERNALITY "Are there external effects beyond one individual when this service is rendered?"	Individual-based health services have minimal or no external effects. There is little to no effect of health service provided beyond the one person directly availing this.	Population-based health services have external effects. Effect of health service provided extends beyond the well-being of one person, indirectly affecting the rest of the population who neither pays for nor is compensated for the effect of the intervention.

Rivalry

A health good or service is considered "rival" if one person's use of a health good or service diminishes other people's use. The guide question is: "Will there be rivalry among recipients when this service is rendered?" The concept of rivalry is true in individual-based health services where the health good or service may only be provided to one person at a time to ensure that full benefits are imparted to the receiver (e.g., surgical procedures such as appendectomy and caesarean section, or medical procedures such as dialysis and chemotherapy, etc.)

In contrast, a health good or service is considered "non-rival" if one person's use of a health good or service does not prevent other people from accessing and benefiting from it. This is true for population-based health services where the full benefits are enjoyed by more than one person up to a maximum area of effect (e.g., health promotion and advocacy, disease surveillance, and disaster risk reduction, etc.)

Excludability

Excludability is another essential characteristic. The guide question is: "Is this service and its benefit only accessible to one person when rendered?" A health good or service is deemed "excludable" if access can be limited to only paying customers, or the degree to which the health provider can prevent "free" consumption of the good or service. In this context, individual-based health services are considered excludable.

A health good or service is "nonexcludable" if the benefits may be accessed and enjoyed by people, even those who are not paying for such good or service. Thus, these people cannot be excluded from benefiting from such services. Therefore, population-based health services are considered nonexcludable.

Externality

For externality, the guide question is: "Are there external effects beyond one individual when this service is rendered?" A health good or service is classified as individual-based if there is minimal to no external effect

beyond the one person availing the package. In contrast, a health good or service is population-based if there is either an effect beyond the well-being of the person availing the package, or an indirect effect to the rest of the population who neither pays for the positive effect of the intervention nor is compensated for its negative effect.

The delineation of health goods and services as either population-based or individual-based determines the appropriate financing mechanism for specific package of services. Individual-based health services will be funded through premium-based financing by PhilHealth in complementation with private health insurers and HMOs. Conversely, population-based health services will be funded through tax-based budget allocation by the national government through DOH in complementation with LGUs.

Population-based Health Services

Health care providers, particularly Province-wide and City-wide Health Systems (P/CWHS), are required by the UHC Act to provide health promotion programs and campaigns, establish and maintain epidemiologic surveillance systems, and provide a functional system for disaster risk reduction and management in health. However, other health programs such as vector control, water quality assurance and sanitation services, among others, may be included as part of critical population-based health packages provided by P/CWHS.

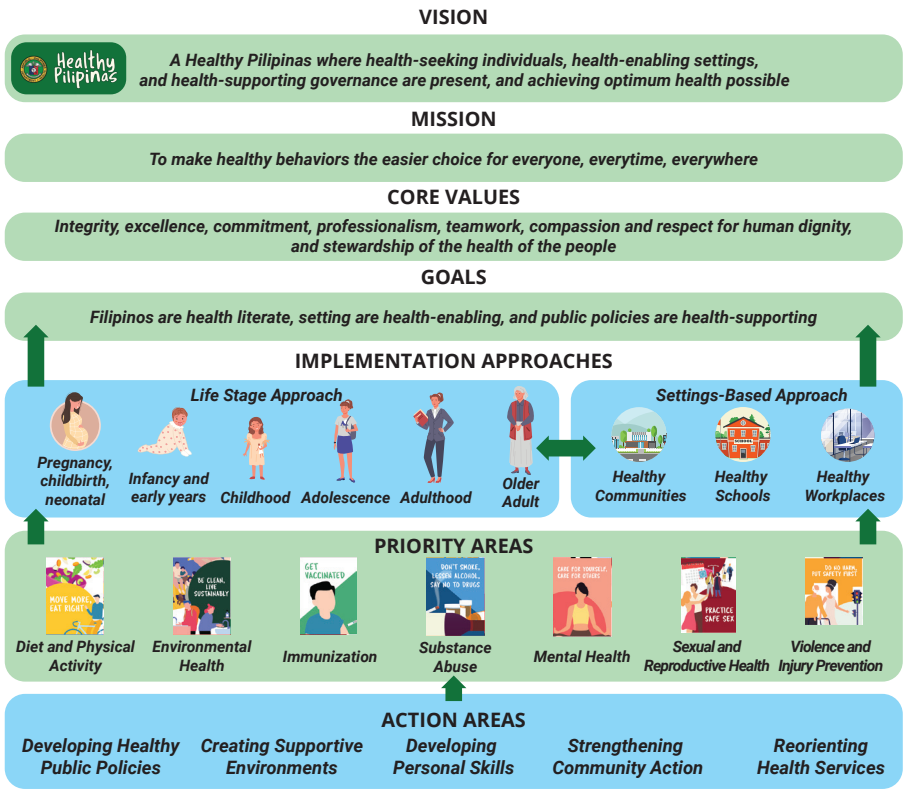
A. Health Promotion

DOH is committed to strengthen health promotion and preventive care by ensuring that every Filipino has access to health information that build personal skills, opportunity to engage in strengthening community action, and enable participation in the creation of supportive environments. Guided by the UHC Act, DOH is mandated to ensure that all Filipinos are health literate; provided with healthy living, schooling and working environments; and protected by public and social policies that positively impact, directly or indirectly, their health status.

Health Promotion Framework Strategy

DOH, through the Health Promotion Bureau, developed the Health Promotion Framework Strategy (HPFS) as basis and roadmap for all health promotion policies, programs, and activities at the national, regional, and local levels (Figure 5.1).

Figure 5.1 Health Promotion Framework Strategy



The HPFS is guided by the following principles:

1. *Equity*, that the needs of population groups, especially of the marginalized, must be prioritized in planning and implementation of health promotion interventions;
2. *Participation*, that meaningful stakeholder and community involvement must become an integral part of problem-solving and decision-making processes for health;

3. *Partnerships*, that health promotion interventions must foster a whole-of-system and collaborative spirit, conducted in ways that build public trust and confidence, and protect the institution's independence, effectiveness, and reputation; and
4. *Responsiveness,* that all health promotion initiatives remain responsive, useful, acceptable, and appropriate to the evolving needs and emerging social determinants of the health of all Filipinos.

DOH envisions a *Healthy Pilipinas* where health-seeking and health literate individuals, health-enabling environments, and health-supportive governance are present to make healthy behaviors the easier choice for everyone, every time, everywhere.

In HPFS, the *life-course approach* is adopted to account for the health promotion needs of Filipinos of all ages. Similarly, the *settings-based approach* of the World Health Organization is also championed as a strategy, to ensure that health considerations are integrated and built into people's living, learning, and working environments.

To realize this vision and ensure that interventions are impactful, HPFS identifies seven *priority areas* on which health promotion initiatives must be anchored, namely diet and physical activity; environmental health; immunization; substance abuse; mental health; sexual and reproductive health; and violence and injury prevention. These priority areas correspond to the behavioral and environmental risk factors that contribute most to the leading causes of mortality and morbidity in the Philippines.

Implementation Strategies of the Health Promotion Framework

Health promotion interventions on priority areas must be operationalized by:

1. developing healthy public policies such as legislation, fiscal measures, and administrative or organizational policies that promote health and well-being;
2. creating supportive environments by ensuring healthy natural and built environments;

3. developing personal skills through appropriate, useful, and effective communication efforts, and life skills and capacity building activities for specific target populations;
4. strengthening community action through meaningful participation of community members in decision-making processes that contribute to their health status; and
5. reorienting health services to increasingly shift towards health promotion and disease prevention.

To accelerate the operationalization of health promotion at all levels, HPFS specified the following key implementation strategies to assist national, regional, and local level champions and implementers:

1. *Healthy Governance, Intersectoral Action and Partnerships*. Health promotion must aim to influence both health and nonhealth sectors at the national and local levels that are crucial stakeholders in promoting health equity and in addressing the social determinants of health. Partnerships and intersectoral actions must be entered into in accordance with the goals and objectives, strategic directions, and norms and standards of the public health sector.

2. *Healthy Settings*. Health promotion measures must be strategically integrated and embedded into people's living, learning, and working environments through the settings-based approach. The priority settings in which health promotion interventions must be ensured include healthy communities, healthy learning institutions, and healthy workplaces.

3. *Health Literacy*. Health literacy interventions must be developed and implemented to improve the population's ability to (1) understand and use health-related information, (2) inform health-related decisions, and (3) increase health-seeking behaviors.

Localization of the Health Promotion Framework

The UHC Act directs LGUs to issue and implement effective health promotion policies, programs, and activities that promote health literacy and healthy lifestyle among their constituents[1]. The law emphasizes the critical role of LGUs in health promotion by requiring P/CWHS to have

proactive and effective health promotion policies or ordinances, programs, and campaigns as key components of its population-based health services[2].

To enable LGUs to facilitate the development, implementation, and monitoring of health promotion policies, programs, and activities at the local level, the following governance mechanisms must be put in place:

1. Health Promotion Committee created by the Local Health Board to provide guidance on health promotion-related matters;
2. Health Promotion Unit under the Local Health Office to ensure the day-to-day operationalization of LGU's health promotion programs;
3. Public Health Unit in all hospitals to facilitate the provision of population-based health services[3] with a Health Education and Promotion Officer ensuring the conduct of activities related to health promotion; and
4. designation of volunteer Barangay Health Workers as on-the-ground health promotion officers.

The Local Health Board, through the Health Promotion Committee and Health Promotion Unit, must monitor and evaluate the implementation of health promotion in P/CWHS, and must submit periodic reports to DOH and the Department of the Interior and Local Government detailing the progress and impact of health promotion policies.

B. Epidemiology and Disease Surveillance

The UHC Act requires the establishment and maintenance of an accurate, sensitive, and timely epidemiologic surveillance and response system as a component of population-based health services.[4] Affirming this mandate are the implementing rules and regulations of the Notifiable Diseases Act[5], which require the mandatory reporting and upgrading of the list of notifiable diseases and events of public health concern. Further, it requires public and private entities at national and local levels to actively participate in disease surveillance and response, while respecting rights of people to liberty, bodily integrity, and privacy as they maintain and preserve public health and security.

Classification of Diseases, Syndromes, and Conditions Targeted for Surveillance

The DOH Epidemiology Bureau (EB) regularly updates the list of notifiable diseases and events of public health concern, with their corresponding case definitions[6]. The priority diseases, syndromes, and conditions targeted for surveillance are selected and categorized based on mode of transmission: (1) diseases spread by droplet; (2) airborne diseases; (3) diseases spread by direct contact; (4) vehicle-borne diseases; and (5) vector-borne diseases. They are further categorized into Category I (immediately notifiable) or Category II (notifiable on weekly basis).

A disease, syndrome, or condition may be added to the list if it is an international or national concern; has an outbreak or epidemic potential; or is targeted to be eliminated as a major public health concern. Likewise, it is included on the list if it is in the top ten leading causes of morbidity and mortality; causes both large numbers of serious or long-term disabilities and deaths; the characteristics of the disease, syndrome, or condition change over time; or DOH considers the disease a priority, and fulfills critical surveillance goals. On the other hand, a disease, syndrome, or condition can be delisted if it no longer meets any of the criteria for inclusion.

Mandatory Reporting of Notifiable Diseases and Events of Public Health Concern

DOH, in close coordination with its local counterparts, implements the mandatory reporting of notifiable diseases and events of public health concern. The reporting is also required from public or private persons and the following entities:

1. licensed public and private medical and allied health professionals;
2. health facilities and offices;
3. workplaces;
4. public and private educational institutions;
5. prisons, jails, or detention centers;
6. transportation passenger terminals, seaports and airports;

7. dining and hotel and other accommodation establishments;
8. communities including household members, punong barangays, health emergency response teams, homeowners' associations, indigenous peoples communities, and community-based organizations;
9. government agencies providing health and emergency frontline services, border control, and other critical services; and
10. professional societies, civic organizations, and other nongovernment organizations.

Epidemiology and Surveillance Units

Every province, city, and municipality must establish or designate an Epidemiology and Surveillance Unit (ESU). Together with the citizenry and other entities, such LGUs are required to report notifiable diseases. ESUs are required to have a trained human resource complement and adequate resources. The list of designated staff of ESUs is submitted to the respective DOH Centers for Health Development (CHD).

A functional ESU must capture and verify all reported notifiable diseases and events of public health concern. The unit must provide timely, accurate, and reliable epidemiologic information to appropriate agencies. It must conduct disease surveillance and epidemiologic response activities, including contact tracing. Moreover, an ESU must recommend needed responses related to epidemics and events of public health importance. It must also facilitate capacity building in applied field epidemiology, and disease surveillance and response, as organized and provided by DOH EB.

DOH EB regularly monitors Regional Epidemiology and Surveillance Units (RESUs). Together with RESUs, they provide technical assistance to the Provincial, City or Municipal Epidemiology and Surveillance Units (P/C/MESUs) in determining appropriate organizational structure to ensure efficient and effective operation. In addition, RESUs monitors P/C/MESUs.

The Provincial, City or Municipal Health Officer determines the establishment and composition of an ESU as approved by the Local Health

Board. The minimum composition of the P/C/MESUs is at least one trained disease surveillance officer and one epidemiology assistant, who is an allied health professional.

The City or Municipal ESU is tasked to:

1. organize and gather epidemiological data;
2. analyze and interpret the data collected;
3. provide feedback to local health facilities and local leaders;
4. inform concerned personnel when disease or condition exceeds an epidemic threshold, or occurs in locations where it was previously absent, or affects more often a population group than previously reported, or presents unusual trends or patterns;
5. carry out outbreak investigations;
6. coordinate with appropriate laboratories for collection and transport of specimens;
7. liaise with other agencies whose assistance is needed to complete outbreak investigations;
8. implement preliminary control measures immediately;
9. forward epidemiological data to the next level on a regular basis and in accordance with the protocol; and
10. use epidemiological data to plan and implement communicable disease control activities.

The Provincial ESU is tasked to:

1. establish, operate, and maintain a public health epidemic preparedness and response plan;
2. confirm and assess the status of reported events;
3. provide onsite assistance;
4. notify DOH Central Office of all reported urgent events within 24 hours; and
5. support municipal and city surveillance teams in strengthening surveillance and epidemiologic response through training and supervision.

Disease Surveillance and Response

During disease surveillance, the only personnel authorized to process personal data and information, consistent with the Data Privacy Act of 2012, are the Municipal, City or Provincial Health Officer, the Regional Epidemiology and Surveillance Unit Head, and staff of the Public Health Surveillance Division of DOH EB.

The role of DOH EB during disease surveillance is to assess all reported epidemics within 24 hours and to notify the World Health Organization when the assessment indicates that the event is a public health emergency of international concern. DOH EB must also coordinate with other DOH offices. Meanwhile, the DOH Bureau of Quarantine (BOQ) ensures compliance with protocols and field operation guidelines on entry or exit management in international ports and airports. Further, the DOH BOQ provides quarantine services; conducts surveillance in ports, subports, and airports; and monitors public health threats from other countries.

At the regional level, RESUs provide onsite assistance to supplement local epidemic investigations and control. They coordinate with appropriate laboratories for collection and transport of specimens. Moreover, they establish, operate, and maintain regional epidemic preparedness and response plans that include the creation of multidisciplinary or multisectoral teams to respond to events that may constitute a public health emergency of local or international concern. RESUs also advocate mandatory reporting by LGUs and persons and entities to ensure functionality of ESUs; actively participate in disease surveillance and response through information drives; and establish systems for mandatory reporting and response to health events.

During disease response activities, communities and the general public are expected to comply with public health standards and nonpharmaceutical interventions as may be enforced. It is the responsibility of all to ensure that no acts of discrimination will be inflicted upon persons, including frontline workers, identified as having notifiable disease or event of public health concern.

Prohibited Acts and Penalties Related to Notifiable Diseases

Under the Notifiable Diseases Act and its IRR, any person or entity found to have committed any of the following prohibited acts[7] will be penalized accordingly:[8]

1. unauthorized disclosure of private and confidential information pertaining to a patient's medical condition;
2. tampering of records;
3. intentionally providing misinformation;
4. non-operation of disease surveillance and response systems;
5. non-cooperation of persons and entities required to report;
6. non-cooperation of those required to respond;
7. non-cooperation of persons or entities identified as having notifiable disease; and
8. non-cooperation of persons or entities affected by a notifiable disease or event of public health concern.

C. Disaster Risk Reduction and Management in Health

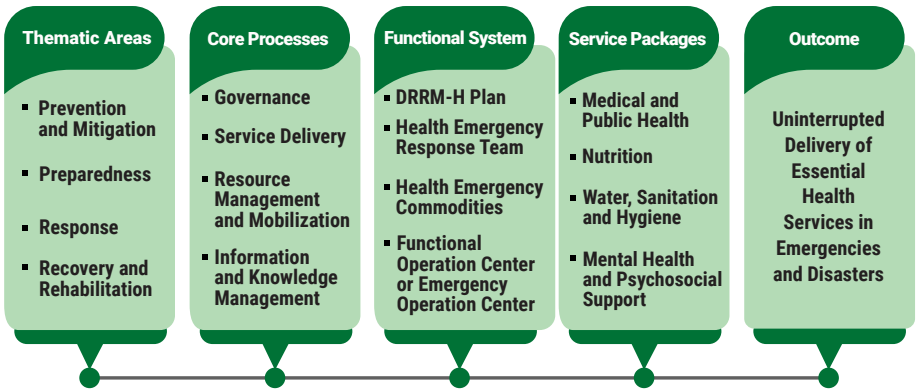
The IRR of the UHC Act provides for a functional system for disaster risk reduction and management in health (DRRM-H) among the minimum components of population-based health services. This system aims to ensure timely, effective, and efficient preparedness and response to public health emergencies and disasters.[9] DRRM-H is the systematic analysis and management of health risks or consequences posed by emergencies and disasters. It has four thematic areas: prevention and mitigation, preparedness, response, and recovery and rehabilitation.

DOH provides the guidelines on institutionalizing DRRM-H in P/CWHS.[10] These guidelines set the roles and responsibilities of key stakeholders in the operational framework, scope and minimum level of functionality, relevant activities, mechanisms, and resources of a DRRM-H System within a local health system. For DRRM-H, the ultimate societal goal is to have safer, adaptive, and disaster-resilient Filipino communities towards sustainable development.

Operational Framework of DIsaster Risk Reduction and Management in Health

Instituting DRRM-H in P/CWHS guarantees the uninterrupted delivery of essential health services during emergencies and disasters. To make health systems resilient, the objectives in each of the DRRM-H's four thematic areas must be addressed. Institutionalization starts with critical inputs anchored on increased investments in DRRM-H. This is concretized by the conduct of core DRRM-H processes that allow for the means and resources to deliver health sector service packages in emergencies and disasters (Figure 5.2).

Figure 5.2 Operational Framework of DIsaster Risk Reduction and Management in Health



a. Thematic Areas

Successful institutionalization of DRRM-H in P/CWHS starts with systematic analysis and management of health risks that result from emergencies and disasters across the four thematic areas: (1) prevention and mitigation, (2) preparedness, (3) response, and (4) recovery and rehabilitation.

b. Core Processes

The DRRM-H vision is concretized by investments and conduct of core processes: (1) governance, (2) service delivery, (3) resource management and mobilization, and (4) information and knowledge management. These core processes should be integrated in local health systems.

c. Functional System

LGUs can integrate DRRM-H management and services into P/CWHS and pool their resources together in order to respond to the needs of a much larger population and a much wider catchment area. The minimum requirements of a functional DRRM-H system are the following:

1. approved, updated, tested and disseminated DRRM-H strategic plan;
2. organized Health Emergency Response Teams with trained and self-sufficient members[11] (i.e., Basic Life Support and Standard First Aid, Public Health Emergency Management in the Philippines, Mass Casualty Incident Management, Health Emergency Response Operations, and Hospitals Safe from Disasters);
3. available and accessible essential health emergency commodities[12,13], along with an equipped, servicing ambulance or patient transport vehicle, and arrangement for a field implementation facility; and
4. functional Operations Center or Emergency Operations Center capable of command, control, and coordination that can be shared and interoperable with its local Disaster Risk Reduction and Management Office (DRRMO) or under the supervision of the Provincial/City Health Office.

d. Service Packages

The institutionalized DRRM-H allows for the means and resources to deliver essential health service packages in emergencies and disasters: (1) medical and public health; (2) nutrition; (3) water, sanitation, and hygiene; and (4) mental and psychosocial support.

The mechanisms that operationalize the DRRM-H framework contribute to the final outcomes: ensuring uninterrupted delivery of health services; averting preventable morbidity, mortality, and other health effects; and ensuring that no outbreak results secondary to emergencies and disasters.

Individual-based Health Services

Individual-based health services include most of the medical and surgical procedures provided as inpatient services in a hospital setting, or as

outpatient services in ambulatory care facilities, or as health interventions provided remotely through digital health services. For the provision of these services, PhilHealth is endeavored to contract purely public, purely private, or mixed health care provider networks. As stipulated in the UHC Act, individual-based health services will be funded primarily through PhilHealth in complementation with private health insurers and HMOs.

A. Outpatient Benefit Packages and Other Special Benefits

Under Republic Act 10606 or the National Health Insurance Act of 2013, PhilHealth is mandated to provide outpatient benefit packages for its members and their dependents, which include the following: (1) services of health care professionals; (2) diagnostic, laboratory, and other medical examination services; (3) personal preventive services; and (4) prescription drugs and biologicals.

Coverage of Outpatient Benefits

PhilHealth's outpatient benefits cover treatment, procedures, or surgeries for patients confined for less than 24 hours or on an outpatient basis in any PhilHealth-accredited health care facilities such as hospitals, ambulatory surgical clinics, primary care facilities, dialysis clinics, maternity or lying-in clinics, animal bite treatment centers, and TB DOTS clinics nationwide. This coverage includes the payment of facility and professional fees, through case-based payment mechanisms with a fixed rate across all member categories.

Other Special Benefits

PhilHealth created special benefit packages in response to the country's efforts to meet Sustainable Development Goals. It increased the case rates of maternity care packages and normal spontaneous delivery in non-hospital settings to encourage its members to avail these packages in non-hospital facilities such as lying-in and birthing homes accredited to provide these services. This will decongest the patient load of hospitals and allow them to take care of more serious illnesses.

To support the government's campaign against drug addiction, PhilHealth provides a medical detoxification package. This package ensures the provision of the minimum standards of medical interventions to safely manage acute physical symptoms of withdrawal associated with ending drug use, including treatment of comorbidities, on a one-time availment basis[14].

PhilHealth also responds to emerging diseases by providing coverage for leptospirosis, ebola, MERS-CoV, and Zika disease. Also, at the onset of the global pandemic, PhilHealth covered COVID-19 testing; hospitalization for mild, moderate, severe, or critical cases; and community and home isolation.

Availment of Outpatient Benefits

PhilHealth members and their dependents are entitled to immediate eligibility for health benefit packages. However, to avail themselves of outpatient benefits, the following conditions must be met: (1) the services are being provided by a PhilHealth-accredited health care facility; (2) the attending physician must be PhilHealth-accredited; and (3) the PhilHealth Claim Form 1 is duly accomplished, as applicable.

The PhilHealth identification card need not be presented when applying for health benefits. Additionally, failure to pay premiums must not prevent the enjoyment of program benefits. However, employers and self-employed direct contributors are required to pay all missed contributions with an interest, compounded monthly, of at least three percent for employers, and not exceeding 1.5 percent for self-earning, professional practitioners, and migrant workers.[15]

Limit for Outpatient Benefits

PhilHealth members are entitled to a 45-day annual limit for outpatient and inpatient benefits. All their dependents are also entitled to share a similar 45-day limit. However, for outpatient session there is a corresponding number of days to be deducted from the 45-day benefit allowance. For chemotherapy, one cycle is equivalent to two days of confinement, regardless

of the number of days or sessions per cycle and procedure done during confinement. For outpatient blood transfusion, one transfusion session is equivalent to a single case rate, which counts as one-day deduction from the 45-day limit, regardless of number of bags consumed.

Exemption to the 45-day benefit limit is applied only to Konsulta package and hemodialysis. Specifically, for hemodialysis, one session is equivalent to one-day deduction from the 45-day limit. However, the 45-day limit for members can be extended up to 90 days if shared with qualified dependents or vice versa, if the dependent is also a patient.

Payment of Outpatient Benefits

Payments for outpatient procedures are generally made directly to the PhilHealth-accredited facility. The health facility deducts the case rate amount, inclusive of facility charges and professional fees of attending physicians, from the member's total bill.

With the modification on the payment rules of benefit packages under All Case Rates Policy, including COVID-19 benefit packages, PhilHealth pays providers based on actual charges reflected in the Statement of Account or its equivalent (including itemized billing statement) and the claim form, after deduction of mandatory discounts (for senior citizens, persons with disability, etc.) not exceeding the applicable package amount.[16]

PhilHealth is currently expanding its benefits to provide comprehensive services that include outpatient drug benefit and emergency medical services, in accordance with the recommendation of the Health Technology Assessment Council.[17]

B. Primary Care Benefit Package (Konsulta Package)

As an initial step towards adopting a comprehensive approach to deliver health services, PhilHealth is expanding its existing primary care benefit package presently known as the Konsultasyong Sulit at Tama (Konsulta) Package.[18] This will enable better access to quality health goods and services through the adoption of a responsive financing mechanism at the primary level of care.

Coverage of Konsulta Package

Primary care benefit refers to a health service package that covers initial and follow-up primary care consultations, health screening and assessment, and access to selected diagnostic and laboratory services and medicines. These services are currently available to people registered with PhilHealth-accredited Konsulta providers, which offer health professional services, diagnostic tests, and drugs and medicines.

Health professional services at Konsulta providers refer to services that can be rendered by a primary care physician like consultation, case management, and preventive health services such as health screening and assessment, according to life stage and health risks.

Basic laboratory and diagnostic examinations deemed necessary are also available in primary care facilities.[19] Otherwise, the Konsulta provider may provide assistance in accessing such services in subcontracted or partner facilities, and referral to specialty and higher level of care. Aside from consultation and laboratory tests, qualified beneficiaries may also avail themselves of drugs and medicines prescribed for common conditions such as asthma, colds and coughs, pneumonia, diarrhea, urinary tract infection, hypertension, and diabetes.

Registration with a PhilHealth-accredited Konsulta Provider

To become a qualified beneficiary of primary care benefit, a PhilHealth member must first register with a preferred PhilHealth-accredited primary care facility. Online registration requires the member's PhilHealth Identification Number (PIN) and updated records. There are two options: self-registration or assisted registration.

For self-registration, the member can log-in and register on the Member Portal or Member Online Registration on the PhilHealth website. After registration, the member can take a screenshot or print the confirmation message as proof of registration. For assisted registration, the member may register through the employer; social worker of the PhilHealth-accredited

primary care facility; LGU or the Office for Senior Citizens Affairs; or the PhilHealth local office or PhilHealth employees assigned to PhilHealth-accredited health facilities called P-CARES. The PhilHealth Corporate Action Center may also assist in the registration with a Konsulta provider. A registrant can call the center and follow the instructions for registration.

Availment of Konsulta Package

To avail the benefits of the Konsulta Package, the PhilHealth member must first secure an authorization transaction code (ATC) from the PhilHealth local health insurance office and give this to the PhilHealth-accredited Konsulta provider. The ATC is a system-generated unique code given to an eligible beneficiary prior to receiving benefit. If the ATC is not available, the beneficiary can proceed to his or her chosen Konsulta provider, and give consent to the facility to take his or her photograph as proof of the transaction.

The facility physician will then conduct the primary care consultation, health screening and assessment, as well as dispensing of medicine, if necessary. After the consultation, needed forms such as Electronic Konsulta Availment Slip (eKAS) and Electronic Prescription Slip (ePresS) are to be accomplished by the PhilHealth-accredited Konsulta provider. The ePresS is proof of availment of medicines, while the eKAS is proof of availment of services by an eligible beneficiary. Both slips are generated by the PhilHealth-accredited Konsulta provider for every patient encounter, and then submitted to PhilHealth.

C. Inpatient Benefit Packages

Under the National Health Insurance Act of 2013, PhilHealth members and their dependents may avail of the following health services for inpatient care: (1) room and board; (2) services of health care professionals; (3) diagnostic, laboratory, and other medical examination services; (4) use of surgical or medical equipment and facilities; and (5) prescription drugs and biologicals.

Coverage of Inpatient Benefits

PhilHealth's inpatient benefits cover both medical cases and surgical procedures for illnesses requiring hospitalization, allowing its members to receive the full spectrum of medical care. These confinements should not be less than 24 hours and should be availed by members or their dependents through any of the PhilHealth-accredited health care facilities such as hospitals, infirmaries, or dispensaries nationwide. These benefits cover services such as hospital room and board fees, supplies, drugs and medicines, x-ray and other diagnostic examinations, use of operating room complex, and professional fees of attending physicians. For these services, PhilHealth uses case-based payment mechanisms with a fixed rate across all member categories.

Availment of Inpatient Benefits

PhilHealth members and their dependents are entitled to immediate eligibility for health benefit packages. However, to avail themselves of inpatient benefits, the following conditions must be met: (1) the patient must be confined for at least 24 hours for an admissible case; (2) the patient must be confined in a PhilHealth-accredited health care facility; (3) the attending physician must be PhilHealth-accredited; and (4) the PhilHealth Claim Form is duly accomplished, as applicable.

The PhilHealth identification card need not be presented when applying for health benefits. Additionally, failure to pay premiums must not prevent the enjoyment of program benefits. But employers and self-employed direct contributors are required to pay all missed contributions with an interest, compounded monthly, of at least three percent for employers, and not exceeding 1.5 percent for self-earning, professional practitioners, and migrant workers.[20]

Limit for Inpatient Benefits

PhilHealth members are entitled to a 45-day annual limit for both outpatient and inpatient benefits per year. All their dependents are also entitled to a similar 45-day limit. Each day of confinement is deducted from the 45-day annual benefit allowance, subject to certain conditions provided by PhilHealth.

Single Period of Confinement

While all admissible confinements are eligible for inpatient benefit packages, the rule on single period of confinement (SPC) is simultaneously applied. This rule states that no benefit for the same illness can be availed of within a 90-day period, subject to certain exemptions provided by PhilHealth such as, but not limited to, the following:

1. OPD blood transfusion;
2. cataract surgery, as long as there's a one-day gap between procedures;
3. hemodialysis, and other forms of dialysis;
4. radiotherapy;
5. simple debridement;
6. brachytherapy;
7. chemotherapy; and
8. asthma in acute exacerbation.

Payment of Inpatient Benefits

Inpatient benefits are generally directly paid to PhilHealth-accredited health care facilities through a case-based mechanism. All illnesses have an equivalent fixed amount of benefit or case rate. These case rate amounts include professional fees of accredited attending physicians, and are deducted by the facility from the member's total bill prior to discharge. Thereafter, the member will only have to pay the remaining balance.

With the modification on the payment rules of benefit packages under the All Case Rates Policy, including COVID-19 benefit packages, PhilHealth pays providers based on actual charges reflected in the Statement of Account or its equivalent (including itemized billing statement) and the claim form, after deduction of mandatory discounts (for senior citizens, persons with disability, etc.) not exceeding the applicable package amount.[21]

The allotment of case rate payments for facility and professional fees will depend on whether the case is medical or surgical. For medical cases, the facility gets 70 percent, while professional fees get the remaining 30 percent of the case rate. For surgical cases, generally, the facility gets 60 percent, while professional fees get the remaining 40 percent of the case rate.

The UHC Act stipulates that no co-payment must be charged to patients admitted in basic or ward accommodation in both public and private health facilities. In addition, the case-based payment mechanism will eventually transition to a global budget mechanism as the UHC Act is progressively implemented.

D. Z Benefit Packages (Catastrophic Packages)

Filipinos face a variety of primary disease conditions commonly referred to as economically and medically "catastrophic" due to their seriousness. These illnesses push many into poverty, even as PhilHealth provides relevant financial risk protection especially for the poor. PhilHealth is improving and expanding its benefit packages for catastrophic conditions, known as Z Benefit. "Z" is not an acronym but it just represents the letter "z", which is the end of the alphabet. Medical conditions covered by Z Benefit packages are those that are at the end of the health spectrum.

Coverage of Z Benefits

Z Benefit covers both inpatient and outpatient services at contracted government and private health facilities. Covered health services include mandatory services such as minimum standards for the totality of care essential for the treatment of the catastrophic condition including surgical procedures; diagnostics and laboratory tests; drugs and medicines; and rehabilitation or habilitation therapy. These may also include other services or alternative recommendations that may be needed by the patient. Medicines for patients may be negotiated with pharmaceutical companies.

Availment of Z Benefits

Currently, Z Benefit packages may be availed of by PhilHealth members and their qualified dependents in contracted government or private health facilities. However, availing the benefit is not automatic. Case-based payment is implemented across all member categories. The Z Benefit coordinator in the contracted health facility must first evaluate if the patient fulfills the selections criteria for a specific Z Benefit package. Also, an approved preauthorization checklist and request is needed prior to the provision of services.[22]

The Z Benefit packages[23] that may be availed by members and their qualified dependents cover the following, among many others: early-stage breast cancer; low-to-intermediate risk prostate cancer; different stages of colon and rectal cancer; end-stage renal disease requiring peritoneal dialysis or kidney transplantation; standard risk elective coronary artery bypass graft surgery; mobility, orthosis, rehabilitation, and prosthesis help for lower and upper limb; and orthopedic implants for hip arthroplasty, hip fixation, and femoral shaft fracture.

There are also various Z Benefit packages available for premature babies and small newborns and mothers who are at risk of preterm delivery; and for children ages 0 to 17 years with childhood disabilities such as developmental disabilities, and mobility, visual, and hearing impairment.

Payment of Z Benefits

The principal member and their qualified dependents are covered by the Z Benefit packages. However, for the payment of Z Benefit, the eligibility of members will first be ascertained. The rules on immediate eligibility must then be applied. Patients with approved pre-authorization will be deducted five days from the 45-day annual benefit limit. Nevertheless, a member with only one day remaining from the 45-day annual benefit is still eligible to avail of Z benefits.

For Z Benefit, unlike other individual-based benefits, the contracted health care facility must submit a request for pre-authorization approval to the PhilHealth Regional Office-Benefits Administration Section. Pre-authorization request and checklist, and Member Empowerment Form must be accomplished. Z claims are evaluated based on mandatory expenses of health care facilities, offices and services, and there should be no existing return to sender claims. Z claims are processed within 30 days, but can be denied in cases when any mandatory service was not given, or when there are missing required signatures in the prescribed forms, or when the claim was filed late.

Z claims are reimbursed to the health care facilities, and members are not allowed to file directly their claims with local health insurance offices.

The amount is fixed per illness, and will be paid per tranche. All contracted health care facilities are subjected to monitoring rules as stipulated in both the performance commitment and Z Benefit contracts. In instances that a violation is committed, sanctions and penalties are applicable as provided in both contracts.

Chapter References

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Chapter VI

Financing Health Services

The UHC Act stipulates several financial mechanisms to guarantee all Filipinos equitable access to quality and affordable healthcare services while being protected against financial risk.

First is the establishment of the Special Health Fund, which will be the repository of all financial resources for health that are pooled and managed by Province-wide or City-wide Health Systems (P/CWHS). Sources for the Special Health Fund include financial grants and subsidies from the national government, more specifically from DOH; income from PhilHealth payments; and other sources such as grants and donations from local and international development partners. Subject to local ordinances, LGUs may also pool their corresponding local health budgets to the Special Health Fund.

Second is PhilHealth's shift to the global budget scheme, a prospective provider payment mechanism that allocates a fixed amount for a specified period to cover aggregate expenditures for the delivery of an agreed-upon set of services. The global budget can be used with flexibility and is not tied to specific line items for input expenses. Based on PhilHealth's framework for provider payment, the global budget for hospital or inpatient benefits

will be based on diagnosis related groups (DRGs), while the global budget for individual-based outpatient primary care services will be based on capitation.

Third is the adoption of the no co-payment scheme, a takeoff from the no balance billing scheme. The no balance billing scheme covers specifically five membership categories, namely indigent, sponsored, kasambahay, senior citizens, and lifetime members. Whereas, the no co-payment scheme covers all PhilHealth members and their dependents, whether direct or indirect contributors. The eligibility to the no balance billing scheme is anchored on the membership category. In contrast, the no co-payment scheme is anchored on the accommodation type during hospital confinements.

Health Financing Functions

An effective health financing system has three core functions, namely revenue generation, pooling of funds, and purchasing of services.

Revenue Generation

PhilHealth requires sufficient revenues to have enough purchasing power to acquire health services. Thus, insurance premiums are collected from direct contributors, that is, the segment of the population with the capacity to pay for premiums; and from government subsidies, largely from the sin tax collection, for indirect contributors. Other sources of funds for PhilHealth include a portion of the national government share from Philippine Amusement and Gaming Corporation and from the Charity Fund of Philippine Charity Sweepstakes Office, which are generally intended for improving benefit packages. On the part of DOH, the source of funding is almost entirely the annual budget appropriations for health programs and services.

Pooling of Funds

For individual-based health services, financial resources from premium contributions and other sources provided by law are pooled within PhilHealth. This allows for greater coverage of the population, particularly for hospital services and outpatient benefit packages, regardless of socioeconomic status. For population-based health services, financial resources largely come from the tax-based budget appropriation of DOH, in complementation with the LGU budget for health.

Health Financing Functions

- **Revenue Generation**
  Raising and collecting resources to pay for health services
- **Pooling of Funds**
  Redistributing risk and resources across population groups
- **Purchasing of Services**
  Leveraging resources towards high-value services and desired provider performance

Purchasing of Services

Considering revenue generation and pooling of funds, it is imperative for PhilHealth and DOH to ensure

that resources are spent wisely on healthcare services that ensure optimal health outcomes at reasonable costs. On the part of PhilHealth, strategic purchasing and an effective provider-payment mechanism are key components of its financing strategy. For DOH, efficiency in the allocation and utilization of resources is a key strategy to optimize limited resources for health.

Special Health Fund

The UHC Act[1] provides for the creation of the Special Health Fund (SHF) as a means to integrate health financing at the local level. The SHF is a pool of financial resources intended to augment local funds for the management and operation of Province-wide and City-wide Health Systems (P/CWHS) and for the provision of health services. Select LGUs that have expressed commitment to integrate their local health systems into P/CWHS must manifest managerial and financial integration within the six-year transitory period from the enactment of the law and the issuance of its implementing rules and regulations in 2019.

DOH, DBM, DOF, DILG and PhilHealth, comprising the Inter-Agency Special Health Fund Technical Working Group (SHF-TWG), jointly issued guidelines[2] to ensure the strategic allocation, efficient utilization and monitoring, and clear accountability on the use of the SHF. These guidelines were developed together with representatives of the Union of Local Authorities of the Philippines, League of Provinces of the Philippines, League of Cities of the Philippines, and League of Municipalities of the Philippines.

Types of LGU Funds

Based on the Local Government Code of 1991, there are two types of funds being maintained by LGUs at all levels (i.e., provinces, cities, and municipalities): the general fund and the special fund.[3]

The *general fund* consists of monies and resources of the local government that are available for the payment of expenditures, obligations, or purposes not specifically declared by law as accruing and chargeable to,

or payable from, any other fund. The release of funds from the general fund is subject to the appropriation ordinance from the *Sanggunian* concerned.

The *special fund* consists of monies and resources used to pay for specific purposes and considered automatically appropriated for purposes indicated. The special fund is subdivided into two types, trust fund and Special Education Fund.

Under the UHC Act, a third type of special fund was created, the SHF. Unlike the first two types of special funds created by the Local Government Code, the SHF is only for provinces, highly urbanized cities, and independent component cities.

Sources of the Special Health Fund

The Implementing Rules and Regulations of the UHC Act[4] specifies the sources of the SHF (Figure 6.1). Among these are financial grants and subsidies from national government agencies such as DOH, as included in the General Appropriations Act, which can be transferred to the SHF through Terms of Partnership agreements. Members' premium payments to PhilHealth can also accrue to the SHF[5] through Service Level Agreements between PhilHealth and Provincial or City Health Boards (P/CHBs). Donations and financial grants from international health partners, nongovernment organizations, and faith-based organizations, among others, can also be transferred to the SHF through Memorandums of Agreement (MOAs).

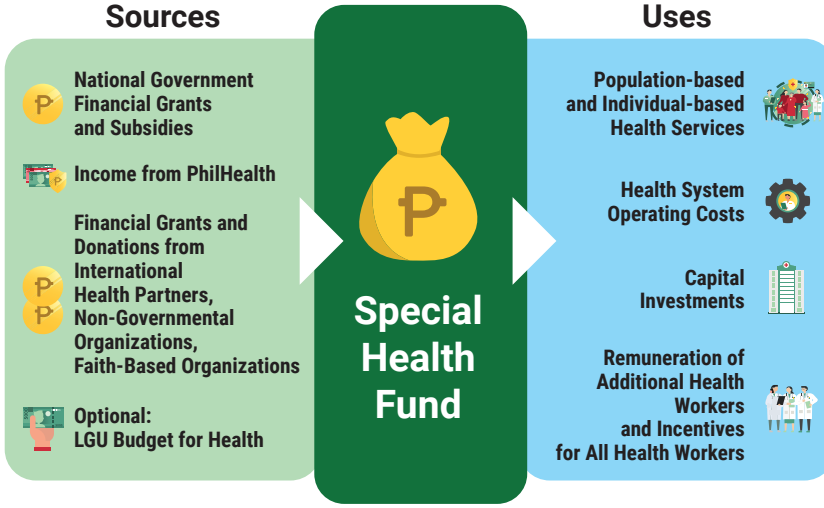
Other sources of the SHF may include the annual budget for health of LGUs, subject to the approval of the *Sanggunian*. While LGUs are mandated by law to allocate annual budget for health service delivery and health systems operations, pooling such fund into the SHF is optional. However, if LGUs choose to do so, their contribution must be covered by a MOA between the component LGUs and the Provincial Health Board.

Uses of the Special Health Fund

The UHC Act details the allowable expenses for the SHF (Figure 6.1). In general, the fund can be used to augment LGU funds for the delivery

of population-based and individual-based health services, health systems operating costs, capital investments, remuneration of additional health workers, and incentives for all health workers.

Figure 6.1 **Sources and Uses of Special Health Fund**



Population-based health services that can be funded by the SHF are environmental health services, including vector control, water quality and sanitation; health promotion programs and campaigns; services related to disease elimination; epidemiological and disease surveillance; services related to preparedness and response to public health emergencies or disasters; and other health services to be classified by DOH as population-based health services.

Individual-based health services that can be charged to the SHF are ambulatory and inpatient care; medicines; laboratory tests and procedures; and other health services to be classified by DOH and PhilHealth as individual-based health services.

Another allowable use of the SHF is for health systems operating costs. These include support to the management of the P/CWHS; learning and development interventions or capacity building activities; fees that form part of accreditation and licensing requirements; conduct of trainings,

seminars, conferences or conventions relevant to the management of health systems and delivery of health services; gasoline for ambulances, patient transport vehicles, and vehicles used for delivery of health services; and transportation of health commodities and diagnostic specimens.

The SHF can also be used to finance capital investments based on the health facility development plan of the P/CWHS. Health infrastructure that can be funded under this category are facility improvements related to direct delivery of health services; health equipment and instruments; information technology and equipment for health facilities; ambulances and patient transport vehicles; and mobile clinics and other ambulatory health services.

Remuneration of additional health workers may also be sourced from the SHF until such time that LGUs have implemented incremental creation of plantilla positions to hire the required or necessary number of health care workers based on the standards determined by DOH. Salary schedule is based on the prevailing Salary Standardization Law, and the salary rate must not exceed those set by the concerned LGU. The P/CHB can also decide to give incentives to health workers, including Barangay Health Workers and Barangay Nutrition Scholars, within its territorial jurisdiction.

Mandatory LGU Funding for Health

LGUs appropriate an annual budget for health programs, projects, and activities as required by law. In this line, there are expenditure items charged against LGU funds that may not be pooled to the SHF.

The mandatory expenses of health facilities, offices, and services under the supervision and control of the concerned LGU are sourced from the annual LGU budget for health. Only the remuneration of "additional health workers" can be charged against the SHF. Salaries of existing health personnel under civil service positions are charged against the LGU budget. Moreover, the physical office and administrative expenses of the concerned P/CHB and its Management Support Unit (MSU), and land acquisition and development for construction or upgrading of health facilities and services, are paid for by the concerned LGU.

Management of the Special Health Fund

The P/CHB assumes full responsibility for the management of the SHF. It must ensure that the SHF is optimally utilized to help achieve desirable health outcomes within its territorial jurisdiction. The P/CHB is assisted by the Provincial or City Health Office (P/CHO) as its technical secretariat, and by the MSU as its administrative secretariat, to ensure effective and efficient management of the fund. The P/CHB, together with its secretariat, must also closely coordinate with the Provincial or City Budget Officer, Treasurer, Accountant, and other concerned offices in the component LGUs.

Upon the creation of the SHF, a depository bank account is created in accordance with existing guidelines of the Bureau of Local Government Finance on Authorized Government Depository Banks and other relevant issuances. A separate SHF book of accounts must be created and maintained at the provincial, highly urbanized city, or independent component city levels. Subsidiary ledgers are also created for each identified fund source. If the province and its component LGUs agree to transfer money from the SHF to the component LGUs, these funds are transferred to the trust fund of component LGUs with a subsidiary ledger created for the purpose.

The management of SHF is an iterative process where outputs of one step serve as inputs to another. First is *planning and budgeting*. The P/CHB, through the P/CHO, and with the assistance from DOH Centers for Health Development (CHDs), facilitates the formulation of the Local Investment Plan for Health (LIPH) and corresponding Annual Operational Plans (AOPs). The LIPH and AOPs serve as the bases for the P/CHB in the planning and budgeting for the SHF, as well as for their contractual agreements with DOH and PhilHealth. A P/CHB Resolution on the SHF budget must be deliberated, endorsed, and approved by the Chairperson, Vice-Chairperson, and a majority of the members of the P/CHB. To uphold the fiscal autonomy of LGUs, the government's Joint Memorandum Circular on the creation of the SHF does not prescribe a specific allocation criterion.

Second is the *disbursement and utilization of funds*. In addition to existing government budgeting, accounting, and auditing rules and regulations, only specified expenses are allowed to be charged against the

SHF.[6] Also, expenditure items to be funded by SHF must be based on the LIPH and AOP of the P/CWHS. Due consideration is also given to the contractual arrangement of the P/CHB with DOH and PhilHealth, as well as with civil society organizations and international health partners, as applicable. The Provincial/City Budget Officer, Treasurer, and Accountant are also provided with a copy of the approved P/CHB Resolution on SHF Use as basis for the issuance of the certificate of availability of funds, disbursement, and recording. Approval of disbursement must also be in accordance with the Local Government Code and UHC Act.

The last process is SHF *monitoring, transparency, and accountability*. Under this process, the P/CHB furnishes DOH and PhilHealth, through their respective regional offices, copies of the LIPH, AOP, and P/CHB Resolution containing, among others, the expenditure items to be funded by the SHF. To ensure the proper management of the SHF, erring P/CHB and local government officials are subjected to disallowances and other penalties under existing laws and regulations. Also, the monitoring of the utilization of the SHF follows existing accounting and auditing rules and regulations. DOH and PhilHealth are also tasked to facilitate the creation of the SHF utilization tracking system.

Global Budget and other Provider Payment Mechanisms

The UHC Act mandates PhilHealth to shift to paying providers using performance-driven, close-end, prospective payments based on disease or diagnosis-related groupings and validated costing methodologies, and without differentiating facility and professional fees.[7] PhilHealth is likewise required to develop differential payment schemes that give due consideration to service quality, efficiency, and equity. These must be coupled with strong surveillance and audit mechanisms to ensure health care provider networks' compliance with contractual obligations.[8] In moving towards UHC, policy objectives for better financial risk protection, cost containment, efficiency and equity, quality of care, and prevention of fraud have become more important. By strengthening the strategic purchasing role, and by developing robust provider payment systems, DOH and PhilHealth can take substantial steps in improving these key policy areas.

Strategic purchasing answers three questions: (1) "What to pay for?", which relates to the design of benefit packages; (2) "Whom to pay?", which means the choice of providers to contract; and (3) "How to pay?", which involves the methods for provider payment.

With the cost of hospital services accounting for one of the largest shares in total health expenditure, improving hospital payment mechanisms is pivotal. As the single biggest national purchaser of individual-based health services, PhilHealth practically "sets the rules" of the game. It enjoys the power to determine how providers behave as it determines how providers are paid.

Provider Payment Mechanisms

Provider payment mechanism refers to how PhilHealth pays healthcare providers to deliver services. It is the primary way to motivate providers to increase their efficiency, or to provide greater volumes of quality care at lower costs. PhilHealth used to pay providers through a fee-for-service mechanism. However, this turned out to be the least effective in driving efficiency, as it motivated providers to over-provide services. Thus, in 2011, PhilHealth shifted to case-based payments, which entailed bundling together sets of services and resources into single payment amounts.

With the enactment of the UHC Act, PhilHealth is considering a comprehensive set of provider payment reforms to promote integrated care and greater efficiency to achieve better health outcomes and financial risk protection. In this line, it will transition to a global budget mechanism. For inpatient or hospital-based health services, the global budget will be based on diagnosis-related groups. For outpatient primary care services, the global budget will be based on capitation.

PhilHealth recognizes the importance of shifting to a provider payment mechanism that is responsive to the complexity of patient needs; flexible to differences in resource use among service capabilities and adjustments over time; and open to iteration.

a. Global Budget

Global budget is a type of prospective provider payment method to cover aggregate expenditures of a healthcare provider over a given period (usually one year) to provide a set of services that have been broadly agreed on by the healthcare provider and the purchaser, in this case, PhilHealth. Through a global budget, providers will receive a fixed amount that can be spent flexibly and is not tied to line items.

The global budget method is going to employ a prospective, network-based payment mechanism. Payments for individual-based health services will be advanced to P/CWHS. Initially, this payment method will be available only to public providers, while the formation of healthcare provider networks in the private sector is under study. Prospectively, this provider payment mechanism will also cover the private sector, but using a case-based payment mechanism.

The global budget will be estimated based on historical reimbursements for inpatient care, historical reimbursements for outpatient specialist packages, and capitation for primary care service based on population within catchment areas, as defined by geographic access.

b. Diagnosis-Related Groups

The use of *diagnosis-related groups* (DRGs) is a provider payment mechanism through which each case is classified into a group with the same characteristics in terms of diagnoses, procedures, and expected resource use. Cases that fall into the same group are paid the same rate, though this rate can also be adjusted depending on health facility ownership, service capability, and other factors.

An important characteristic of each DRG is clinical homogeneity, or that each group contains conditions that have procedures and treatments that are similar in nature. This is a patient classification system that utilizes an algorithm in assigning a case to a specific group by using a special software

called a "grouper". A DRG system classifies hospital cases into groups that are clinically similar, and are expected to use similar amounts of hospital resources.[9]

Provided that each DRG achieves clinical homogeneity, payments become more responsive to unique patient cases when other factors, such as patient attributes, length of stay, diagnosis and procedures, and facility characteristics, are taken into account. DRGs will be mutually exclusive and will be designed in such a way that each group is clinically homogeneous, based on local clinical practice. Thus, a critical aspect of DRG development are consultations with medical societies and related stakeholders.

DRGs are also expected to provide more comprehensive financial coverage as compared to case-based payments, owing to the nature of the DRG system accounting for all the diagnoses, procedures, and patient attributes surrounding each clinical case. As mentioned, cases within each DRG are expected to exhibit the same levels of resource use or have similar treatment costs. The DRG payment rate is computed for cases within the same hospital that fall into different DRGs, unless there are adjustment factors to be considered.

Take the case of three patients with the same condition of pneumonia moderate risk. There are several factors that are different for each patient:

1. Different socio-demographic factors such as age and gender, in which studies have shown affect health needs and can also be risk factors;
2. Presence of other complications, which may aggravate a case, thus making care needs more intensive; and
3. Varying levels of facilities or services, which may also affect how much care is provided and what are its costs.

These three are examples of adjustment factors taken into account by a DRG system. These are embedded in an algorithm, and the DRG system automatically computes the rates for each patient. In contrast, in case-based payments, all three are paid using the same rate. With the DRG system, rates are meaningfully calibrated.

Disease-related based payment follows these steps:

1. Patients receive inpatient or hospital-based care in an accredited health facility.
2. Prior to the discharge of patients, an inpatient summary is accomplished which details clinical history, the course in the ward, all treatments received, and all procedures done.
3. Upon discharge, the final diagnosis is encoded with the corresponding International Classification of Diseases (ICD) code.
4. Claims are filed and submitted through the health facility.
5. Claims are entered into the DRG by Grouper Software.
6. Payment is made after claims are analyzed and computed by the software.

To effectively implement the DRG system, it must be supported by strategic and institutionalized costing exercises; strong provider engagement to ascertain largest possible consensus on groupings; and reliable and well-designed information technology systems.

c. Capitation

Capitation is a payment mechanism where a fixed rate, whether per person, family, household, or group within a catchment area, is negotiated with a primary care facility (e.g., rural health unit, health center, and private clinic) responsible for delivering or arranging for the provision of health services required by the covered person, under the conditions of a healthcare provider contract.[10] Capitation refers to the scheme or form of paying the primary care facility for specific services it provides for a particular period. This is computed based on predetermined criteria under the condition that any savings from the agreed amount accrues to the benefit of the primary care facility. In case of payment insufficiency, the particular services due to covered beneficiaries must be delivered at the cost of the primary care facility.[11] This payment mechanism is applied to the Konsulta package and other primary care benefit packages.

Cost-sharing Mechanisms

Cost-sharing refers to the direct payment of a portion of healthcare costs by an insured person when receiving health services, or simply describes the practice of dividing the cost of healthcare services between the patient and the insurance plan. It includes co-payment and co-insurance. *Co-payment* refers to the flat fee or predetermined rate paid at point-of-service, while *co-insurance* refers to the percentage of a medical charge that is paid by the insured, with the rest paid by the insurance plan.

Co-Payment and No Co-Payment Policies

With the passage of the UHC Act, PhilHealth is mandated to implement a cost-sharing scheme to include no co-payment, co-payment, and co-insurance schemes.[12] Under the law, no co-payment will be charged for services rendered in basic or ward accommodation, while co-payment and co-insurance for amenities in public hospitals will be regulated by DOH and PhilHealth. In this line, PhilHealth issued guidelines on cost-sharing schemes for accredited and contracted healthcare providers.[13]

The no co-payment policy stems from the no balance billing (NBB) policy (Table 6.1), which states that no other fee or expense can be charged to the indigent patient, subject to the guidelines issued by PhilHealth.[14] The NBB policy covers only five specific membership categories: indigent, sponsored, kasambahay, senior citizens, and lifetime members. In contrast, the no co-payment policy will cover all PhilHealth members and their dependents, whether direct or indirect contributors, admitted in basic or ward accommodation. The eligibility to NBB policy is anchored on the membership category, while no co-payment policy is anchored on the accommodation type of hospital confinement.

Basic or ward accommodation refers to confinement in a shared room, with a shared toilet and bath, and with the provision of regular meals and fan ventilation. *Non-basic accommodation* refers to confinement with the provision of accommodation that includes fringe and additional amenities provided by the facility, at the option of the patient. The fringe or additional benefits include features of the health service that provide better

Table 6.1 Comparison between No Balance Billing and No Co-payment Policies

POINTS OF COMPARISON	NO BALANCE BILLING	NO CO-PAYMENT
Legal basis	Section 43 of the IRR of the National Health Insurance Act (RA 10606)	Chapter 3 Section 9 of the Universal Health Care Act (RA 11223); and Rule III Section 9 of its IRR
Coverage as to member category	Indigent, sponsored, kasambahay, senior citizens, and lifetime members	All direct and indirect contributors
Coverage as to benefits	• All Case Rates • Z Benefit Packages • Primary Care Benefit • Other covered benefits: a. Middle East Respiratory Syndrome Coronavirus (MERS-CoV) Benefit b. Ebola Virus Disease (EVD) Benefit Package	All benefits
Policy Anchor	Membership category	Accommodation type (basic or non-basic)

comfort or convenience, such as private accommodation, air conditioning, telephone, television, and choice of meals, among others.

PhilHealth benefit packages cover the costs necessary to deliver the minimum standards of care, and presently set the appropriate and specific co-payment schemes. Members who opt for non-basic or non-ward accommodation will be charged hospital fees for services, professional fees, and fringe and additional amenities, thus, co-payment applies. Co-payment applies when there is the provision of added comfort. In the future, the setting of co-payment rates will depend on new provider payment mechanisms that PhilHealth will implement. Moreover, PhilHealth will be using its standard costing framework and methodology in determining payment and co-payment rates under its benefit packages.

During the transition from no balance billing scheme to no co-payment scheme, all existing policies that have provisions pertaining to no co-payment, such as COVID-19 inpatient benefits, and co-payment pertaining to other benefits, such as Z Benefit, will remain in effect subject to further review. PhilHealth will issue guidelines to fully implement the no co-payment policy in both government and private healthcare facilities.

Bed Allocation for Basic or Ward Accommodation

- All **government hospitals** are required to allocate at least 90 percent of their approved bed capacity as basic or ward accommodation.
- All **specialty hospitals** are required to allocate at least 70 percent of their approved bed capacity as basic or ward accommodation.
- All **private hospitals** are required to allocate at least 10 percent of their approved bed capacity as basic or ward accommodation.

Healthcare providers must comply with the prescribed allocation of basic and non-basic accommodation within their facilities, in accordance with the bed ratios stipulated in the UHC Act and corresponding rules and guidelines of DOH. Compliance with bed ratios is among PhilHealth's requirements for accreditation or contracting of a healthcare facility. Accredited and contracted hospitals will also be regularly monitored for compliance with rules on no co-payment and other related policies, and will be subject to performance assessment.

Chapter References

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6 See 2.

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8 See 7.

9 Klein, A., Mathauer, I., Stenberg, K., & Habicht, T. (2020). *Diagnosis-related groups (DRG): A question & answer guide on case-based classification and payment systems*. Geneva, Switzerland: World Health Organization.

10 *National Health Insurance Act of 1995* (Rep) s. 4.c (Phil.).

11 Philippine Health Insurance Corporation. (2000). *Implementing guidelines for outpatient consultation and diagnostic package under the Medicare Para sa Masa Program.* (PhilHealth Circular No. 40 s-2000).

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13 Philippine Health Insurance Corporation. (2020). *Governing policies on no co-payment/no balance billing for Philhealth benefit packages.* (PhilHealth Circular No. 2020-0024).

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Chapter VII

Developing Human Resources for Health

The country's human resources for health (HRH) are among the most significant components of the health system. It is imperative to ensure that these health professionals are able to answer the needs of the Philippine health system, now and in the future. As a strategic roadmap toward the desired future for the country's HRH, the UHC Act provides for the development of the National Human Resources for Health Master Plan (NHRHMP) with the primary aim of formulating multisector goals, targets and strategies for the improvement of HRH planning, management, and development. One of the strategies to achieve the goals of the NHRHMP is the setting up of the National Health Workforce Registry, indicating, among others, the current number of medical and allied health practitioners and the location of their practice. In addition, the law stipulates the reorientation of health education curricula and training programs to focus on primary health care, and to put importance on public health and the provision of health services at the primary level. This includes emphasis on primary health care in the scope of licensure examinations for the health professions, and the post-graduate certification processes for primary care workers.

On the production side of HRH, scholarships for the health professions will be expanded to increase production and improve local retention of

identified cadres of health professionals and health managers. Subsequently, all graduates of health courses who are recipients of government-funded scholarship programs will be employed by the government through return service agreements with DOH or the academic institution. To address the demands for HRH, the National Health Workforce Support System (NHWSS) ensures the equitable distribution and deployment of the health workforce. This system supports LGUs that are unable to employ the recommended HRH due to factors such as geographic location, income class, poverty incidence, existence of armed conflict, and personnel services limitation. Moreover, the NHWSS provides for the strengthening of human resource management and development systems; improvement of salaries, benefits and incentives; and ensuring occupational health and safety of deployed health care professionals.

National Human Resources for Health Master Plan

The National Human Resources for Health Master Plan (NHRHMP) is a strategic document developed through a multisectoral approach to guide policies and approaches for the appropriate generation, recruitment, retraining, regulation, retention, and reassessment of the health workforce based on population health needs.[1] The NHRHMP aims to ensure the sustainable production, equitable distribution, and continuous development of compassionate and responsive HRH at all levels to deliver health care.

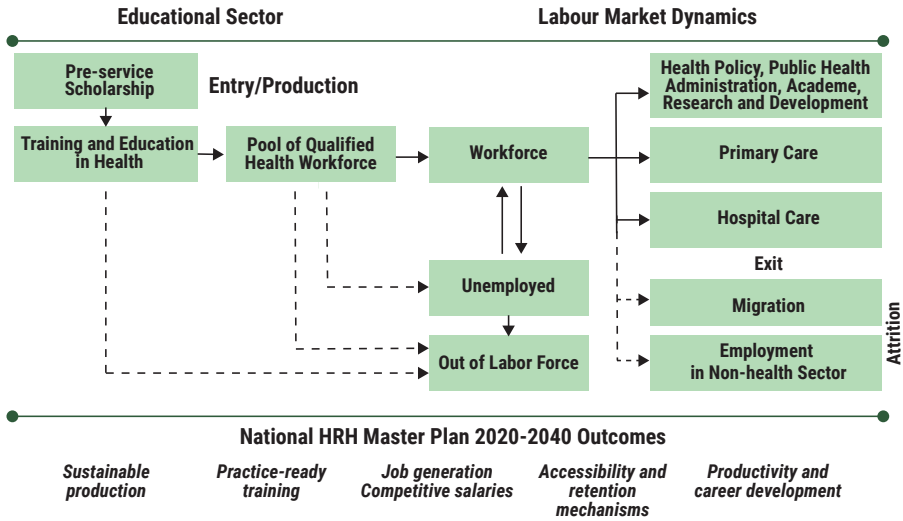
The NHRHMP was developed with the following principles: (1) it is a *multisectoral plan* that requires a whole-of-society, whole-of-government approach; (2) it is built with *social system architecture,* ensuring harmonized and concerted efforts through accountable governance and agile management; (3) it is *strategic* rather than prescriptive; (4) it *considers the different characteristics of local health systems* wherein implementers are given flexibility to prioritize what is most feasible and adopt and calibrate strategies to make it more compatible and applicable to their context; and (5) it is intended to be *a living document* that is regularly updated to consider significant events that might affect the health system.

Framework of the National Human Resources for Health Master Plan

The NHRHMP adopts the health labor market approach (Figure 7.1) in analyzing factors that affect key strategies to be implemented throughout the life cycle of the HRH, from production and entry, to being part of, and then exiting from or reintegrating to, the health workforce.

The framework analyzes two markets, namely the education market and the labor market. The e*ducation market* for health workers covers the production of a qualified health workforce through the provision of scholarships, training, and education for health professionals. The *labor market***,** meanwhile, depicts the spectrum of workforce demand where health professionals may navigate across any of several career paths. These career paths may be in non-clinical practices, such as health policy, public health administration, the academe, research and development; and in

Figure 7.1 Health Labor Market Framework



clinical practices, such as primary care health services and hospital care, including specialty services.

The framework also captures the attrition of HRH due to unemployment or employment in the non-health sector, and migration to other countries. Moreover, the framework highlights the goals of sustainable production, practice-ready training, job generation, competitive salaries, accessibility and retention mechanisms, productivity, and career development. All of these lead to providing the right number, competence, and skill mix of health workers performing the right work at the right place and time, with the right compensation.

Key Result Areas of the National Human Resources for Health Master Plan

Following the health labor market framework, situational analysis reveals several problems in HRH management that contribute to persistent challenges on inadequate and inequitable distribution. These are (1) lack of accurate information on the health workforce to guide planning and policy; (2) limited collaboration among stakeholders with multiple roles in the HRH sector; (3) fragmented HRH governance and unclear accountabilities; and (4) poor implementation and monitoring of policies.

To address these issues, the NHRHMP focuses on six key result areas (KRAs) that span the whole health labor market spectrum. Each KRA includes general objectives (Table 7.1).

Table 7.1 Key Results Areas and Objectives of the National Human Resources for Health Master Plan

KEY RESULT AREA		GENERAL OBJECTIVE
	**KRA 1:** HRH Data Governance and Information Management	Strong data governance and information management for evidence-informed HRH workforce planning, strategy and policy formulation, program design, execution, and oversight
	**KRA 2:** Health Education Strengthening and Regulation	Practice-ready HRH responsive to local health needs, and improved retention in the local health sector
	**KRA 3:** HRH Welfare, Protection, and Career Development	Raised HRH productivity and responsiveness by promoting job satisfaction and motivation at all levels, thereby improving retention in health sector
	**KRA 4:** HRH Migration and Reintegration	Migration managed to maintain a sustainable health workforce and reintegration programs established for returning health workers
	**KRA 5:** NHRHMP Institutionalization and Localization	Efficient and effective implementation of the NHRHMP through a collaborative and participatory approach, in both the national and local levels
	**KRA 6:** Institutionalization and Strengthening of the HRH Network	Harmonized and strengthened inter-sectoral governance for HRH

Localization of Master Plan Strategies

The realization of NHRHMP goals can be achieved only through a multisectoral approach with shared vision, responsibility and accountability, and inclusivity among key stakeholders such as legislators, policy makers, regulatory bodies, academe, local leaders, private sector, international partners, and health workers.

It is important to align priorities at the national and local levels to effectively implement the strategies towards attainment of the objectives in each KRA. LGUs are accountable for human resource development under their jurisdiction as provided by the Local Government Code of 1991.[2]

Corollary to this, LGUs are expected to localize the NHRHMP by adopting and implementing strategies based on their identified needs and priorities, applicability, and feasibility given their current context.

The localization of the NHRHMP will be assessed based on the integration of the strategies in the Local Investment Plan for Health (LIPH) and other local development plans. The LIPH endorsed by local health boards must reflect priority strategies under the health workforce pillar.

Key actions include the plan for filling-up of vacant plantilla positions for health personnel, including timelines and recruitment strategies; mechanism on sharing of health workforce within the Health Care Provider Network (HCPN) through a memorandum of agreement or service contracts with healthcare providers; incremental creation of plantilla positions for health personnel, including funds for the creation of such positions; and learning and development plan or interventions for health personnel as part of the overall human resource development plan of the LGU along with the investments needed to implement such plan.

National Health Workforce Registry

The inequitable distribution of HRH results in challenges in the delivery of health care services in certain parts of the country. There are areas where HRH may be relatively adequate, while in other areas HRH are either deficient or even in critical shortage. Addressing these challenges requires data-driven and evidence-informed planning and management of HRH.

To enable the collection of accurate and up-to-date HRH data, DOH and the Professional Regulation Commission (PRC) jointly developed a National Health Workforce Registry (NHWR)[3]. The NHWR is tasked to collect, process, and generate up-to-date reports on the number of HRH practitioners and their location of practice nationwide, as prescribed in the UHC Act.[4]

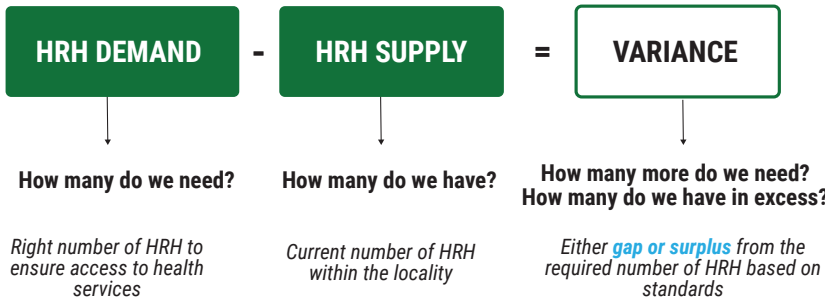
Eventually, this registry will be expanded to accommodate other HRH-related data such as production and migration, to align it with the National Health Workforce Accounts. The latter is a system developed by the World

Health Organization to monitor indicators for achieving UHC, Sustainable Development Goals, and other health goals. Further, the NHWR will be incorporated into the National Health Data Repository.

Analysis of Gaps in Human Resources for Health

Understanding the HRH situation hinges on an analysis of HRH demand and supply (Figure 7.2). The analysis defines the sufficiency, or excess, or gaps in the health workforce by determining HRH demand, or the number of HRH needed to ensure access to health services in a locality; and HRH supply, or the number of HRH working in health facilities and offices in the same locality. The difference between demand and supply is the starting point for determining staffing requirements or standards.

Figure 7.2 Determining Gap or Surplus of Human Resources for Health



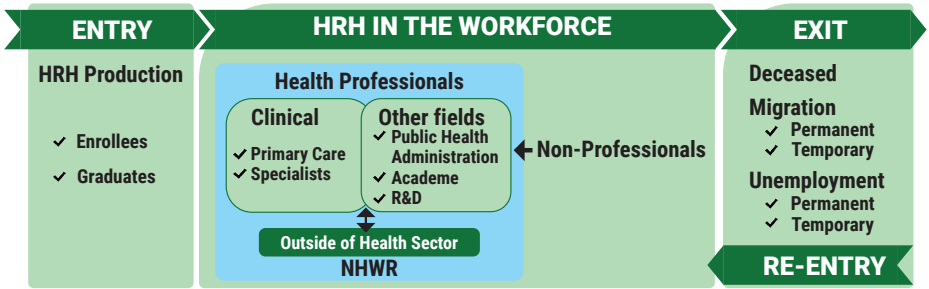
To determine HRH demands or requirements of a health facility or locality, DOH uses the standards stipulated in the (1) *Manual of Standards for Primary Care Facilities*[5], and (2) *Staffing Standards for Government Hospitals*[6]. At the individual facility level, other HRH planning tools may be used to determine HRH demands, including the WHO-developed *Workload Indicators of Staffing Need (WISN)*[7], which determines HRH requirements based on facility workload. To help determine HRH supply, data from the NHWR may be used.

Framework of the National Health Workforce Registry

The NHWR is an automated information and communications system that serves as central repository and main platform for sharing of HRH

data. The scope of data collection encompasses HRH production and participation in, or eventual exit from, the health workforce (Figure 7.3). The registry also collects and processes HRH data from national agencies and other stakeholders to promote multisectoral HRH data ownership, accessibility, and accountability. The initial phase of NHWR development focuses on collecting data on health professionals currently employed within and outside the health sector. Succeeding phases will also cover other health and allied health care workers.

Figure 7.3 Data Scope of National Health Workforce Registry



System Design of the National Health Workforce Registry

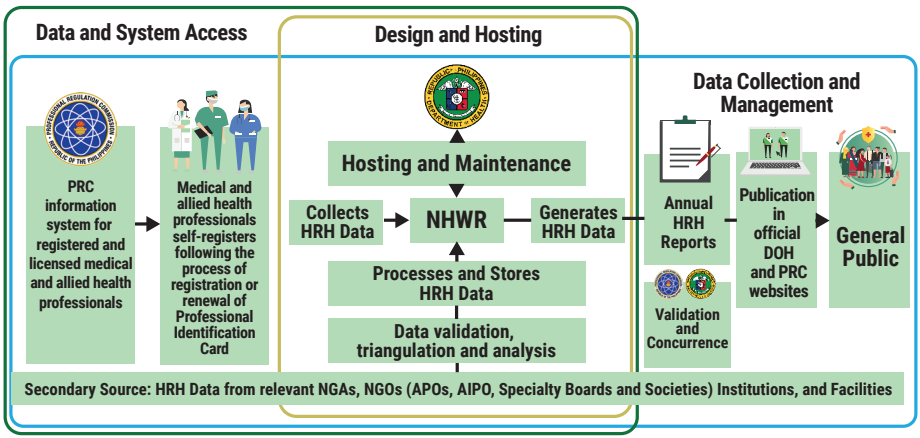
The NHWR system design (Figure 7.4) allows for (1) collection of HRH data from various sources such as existing databases, information systems, and shared data from other agencies and relevant stakeholders; (2) collation of HRH data into a single registry; and (3) processing and translating HRH data into informative reports.

The registry contains relevant data on PRC-registered medical and allied health professionals, which will be matched with data on areas of practice. This system design is intended to harmonize, match, and validate data on PRC-registered and licensed HRH against data from relevant national government agencies, nongovernment organizations, private organizations, institutions, and facilities.

In future developments of the registry, HRH data from other information systems used for certification, registration, and other human resource

processes may also be integrated in NHWR. Data gathered through the registry can be processed, validated, triangulated, analyzed, and translated into comprehensive reports that can be used to make informed decisions and policies.

Figure 7.4 System Design of the National Health Workforce Registry



Sources of Data for the National Health Workforce Registry

For health facilities, HRH data can be collected through the National Database on Human Resources for Health Information System (NDHRHIS). The NDHRHIS is a web-based information system and registration platform developed to collect, store, summarize, and generate data on the demographic and geographic distribution of selected health providers in health facilities.[8] NDHRHIS is capable of creating health facility and affiliation records; updating health provider and affiliation data; generating statistical reports; and publishing statistical data.

NDHRHIS data form part of the HRH supply data from local health systems and health facilities that will be integrated into NHWR. Thus, it is critical that all individual professionals, health facilities, institutions, and other stakeholders that employ any of the health professional cadres actively participate in registration and regular updating of HRH information in NDHRHIS and NHWR as well as other platforms.

NHWR's effective implementation is crucial in determining HRH needs at all levels of the health care system. The registry aims to guide the implementation of key strategies and activities geared towards ensuring the adequate number of HRH with the right skills and attitude; working with the right team; and doing the right work in the right place, at the right time, and with the right working conditions to meet public need.

Reorientation of Health Professions Education Curricula to Primary Health Care

The Philippine Qualifications Framework Act mandates the establishment and maintenance of an education system that is relevant to the needs of Filipinos.[9] In addition, the UHC Act mandates the strengthening of primary health care and the development of a cadre of health professionals competent to deliver primary care services.

For this purpose, DOH, PRC, and the Commission on Higher Education (CHED), in coordination with medical and allied health professional societies, are required by law to (1) reorient health care professional and health care worker curricula towards primary health care, with emphasis on public health and primary care; (2) determine recommended areas of study in public health to be incorporated in the curriculum of all health sciences education; and (3) incorporate educational outcomes focusing on primary care in the education programs, the scope of licensure examinations, and continuing professional development.[10]

The reorientation of the health profession education curriculum towards primary health care is pivotal in the development of the Philippine health workforce. This aims to ensure that all health professionals are primary care-ready upon graduation and passing the licensure examinations, making them equipped to deliver primary care services.

Primary Health Care Approach in Reorienting Health Professions Education Curricula

Primary Health Care is the overarching approach or philosophy in strengthening the health care delivery system with primary care as the foundation. This approach serves as the basis of reorienting the health professions education curricula.

This Primary Health Care approach can be integrated in the 13 health professions education programs being regulated by the PRC: medicine, nursing, midwifery, dentistry, medical technology, pharmacy, physical therapy, occupational therapy, nutrition-dietetics, optometry, radiologic technology, respiratory therapy, and speech pathology. However, this may also include new degree programs that will be regulated by PRC in the future.

Implementation Strategies for Reorienting Health Professions Education Curricula

The curricula of health professions can be reoriented towards Primary Health Care through six strategies:

1. inclusion of UHC in student orientations, including counseling programs that promote careers in public health and primary care;
2. inclusion of Primary Health Care in learning outcomes with focus on public health and primary care to support UHC;
3. conduct of faculty development programs like faculty immersion in primary care facilities aimed at shifting the approach towards prioritizing Primary Health Care over curative or "hospitalist" approach;
4. inclusion of primary care competencies in student internship and immersion program objectives;
5. incorporation of Primary Health Care areas of study in the Table of Specifications of the licensure examinations of all health professions; and
6. implementation of return service obligations for government scholars in priority primary care facilities.

Areas of Study on Primary Health Care

The recommended Primary Health Care areas of study cover both population-based and individual-based health services (Table 7.2). Population-based health services may include mass interventions in public health, health promotions and communication, and health program management; while individual-based health services may include

counseling, screening and diagnosis, and treatment. These areas of study can be incorporated by CHED in the curricula of the various health professions education programs, and by PRC in the health professional licensure examinations. Graduates and licensure passers of the reoriented curriculum will then be considered "primary care-ready" for employment or assignment in primary care facilities.

Table 7.2 Areas of Study on Primary Health Care

PRIMARY HEALTH CARE	
PUBLIC HEALTH	PERSONAL CARE
POPULATION-BASED PRIMARY CARE	INDIVIDUAL-BASED PRIMARY CARE
Mass Interventions Community vaccination, vector control, water quality monitoring, sanitation **Health Promotion and Communication** Community engagement, policy-making and enforcement, social and behavior change campaigns and identifying enablers for health needs **Health Program Management** Research and publication, clinical practice guidelines or clinical pathways, monitoring and evaluation, capacity building and training, epidemiologic and disease surveillance, disaster risk reduction and management in health	**Counselling** Nutrition, lifestyle modication, reproductive health **Screening and Diagnostics** Laboratory and imaging procedures **Treatment** Medical outpatient, pharmacy services, minor surgeries, birthing services

Scholarships and Return Service Agreements

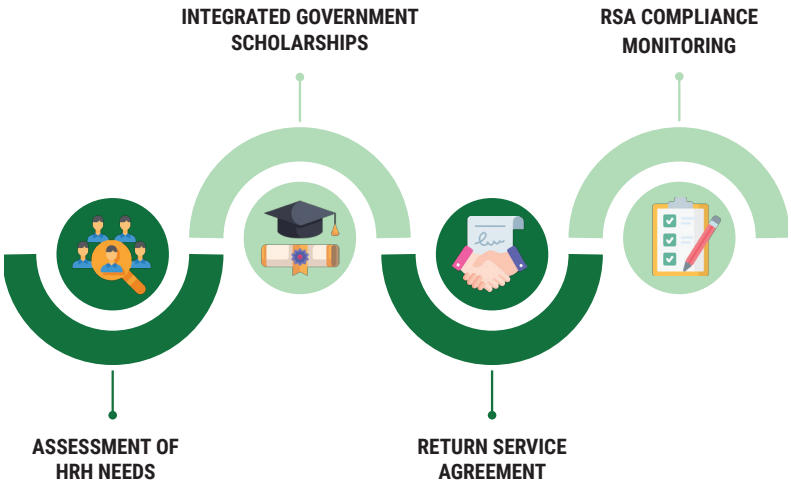
The adequate supply and equitable distribution of the Philippine health workforce are essential to a responsive local health system. The synergistic relationship between the health and education sectors ensures the balance between the supply and demand of health professionals. A robust pool of eligible students with adequate scale and wide-based scope of education institutions forms the bedrock of fortifying the education system to support the industry need in the health system. In line with the overall goal of UHC, a policy shift is critical to reorient the Philippine health system from being curative-focused and hospital-centric to a primary health care approach with emphasis on the preventive and promotive side. With this, all government-funded scholarships and training grants for health are

integrated and refocused on the delivery of quality primary care services for all Filipinos.

Scope of Scholarship Expansion for Health

Concerned government agencies have jointly issued guidelines to expand scholarships, linked with return service agreements, for existing and new allied and health-related degree and training programs based on population health needs (Figure 7.5).[11] These guidelines aim to produce adequate and capable HRH critical to UHC implementation; establish roles and collaborative work of concerned government agencies; and install partnership mechanisms on monitoring scholarship service obligations.

Figure 7.5 Salient Points in the Expansion of Scholarships and Return Service Agreements



The prioritization of scholarships considers the data of HRH needs per population, the special needs per geographical area, and HRH market supply and demand studies. This covers health professions education programs under CHED and regulated by PRC such as medicine, nursing, midwifery, dentistry, medical technology, pharmacy, and other allied health professional courses.

In addition, prioritization may also include health-related technical-vocational education and training programs under the Technical Education

and Skills Development Authority (TESDA) and co-developed with DOH. Expansion of scholarships also covers public health practitioners such as policy and systems researchers, technical experts, and managers. For this purpose, DOH and the Department of Science and Technology (DOST), through the Philippine Council for Health Research and Development (PCHRD), implements training grants for health policy and systems research (HPSR).

Assessment of Needs for the Production of Human Resource for Health

HRH production is targeted for priority areas of need, to maximize gains from government investments in health worker training and education, and to promote equity. The prioritization in the expansion of scholarship programs for health professionals and health workers is based on data and assessment of needs through the HRH-to-population ratio; HRH needs per geographical location, especially the underserved and unserved areas; and health labor market supply and demand studies. Geographical distribution of higher education institutions (HEIs) and technology institutions is also mapped to prioritize areas for the establishment of new centers and facilities.

Integrated Government Scholarships

A major issue prior to the entry of HRH into the workforce is the lack of collaborative planning and implementation in terms of production of HRH. The education, health, and labor sectors have different priorities and program conceptualizations, leading to the inequitable production of HRH, and adding to budgetary and administrative constraints and inefficiencies. Thus, partnerships among DOH, CHED and TESDA must be strengthened to harmonize their programs and align their priorities with the goals and objectives of UHC.

In addition, training grants for health policy and systems researchers, technical experts, and health system managers are prioritized based on country needs. The postgraduate scholarship of DOH prioritizes courses for health policy and systems research, health-related technical expertise, and health systems management.

Partner schools to be engaged for scholarships prioritize state or local universities, TESDA vocational institutions, and those located in autonomous regions, geographically isolated areas, and indigenous people communities. Private HEIs may be engaged in cases where there are no existing learning facilities providing health professional education programs and health worker training in a particular city or municipality. The selection of partner HEIs is based on the presence of a culture of service, nation-building, and integrity.

Education to Employment through Return Service Agreement

The Return Service Agreement (RSA) is a mechanism to lessen the marginal loss of government investments in the program. Consistent with policies optimizing the utilization of public funds for capacity building, all recipients of government-funded scholarships and training grants for health must enter into a RSA wherein service obligations prioritize government service and deployment in primary care facilities in line with the thrust towards primary health care.

Scholars and grantees must render mandatory return service as part of the pool of health workers and health professionals under the National Health Workforce Support System (NHWSS) or any government-initiated deployment programs and employment in primary care facilities. The beneficiaries of scholarships must serve a minimum period of three full years within one year upon graduation or after acquiring the necessary license or certification to practice.

Moreover, recipients of training grants of DOST-PCHRD and postgraduate scholars of DOH must serve their return service obligation in DOH, PhilHealth, and other relevant government agencies. The corresponding RSAs of HPSR scholars is under the supervision of DOH.

Compliance Monitoring of Return Service Agreements

The Unified Student Financial Assistance System for Tertiary Education (UNIFAST) monitors all government-funded scholars until graduation for all health and allied health professions. TESDA, DOST and CHED also

maintain a database of all scholars. DOH also utilizes the NHWR and a database for RSA compliance monitoring in coordination with relevant government agencies.

National Health Workforce Support System

The demand for HRH and services will be aligned with public needs through the creation of a NHWSS, a mechanism that encompasses human resource management and development systems; salaries, benefits, and incentives; and occupational health and safety of deployed HRH.[12] NHWSS also serves as the tangible link between HRH supply, or the production of health professionals and their eventual entry to the workforce; and HRH demand, or the minimum number of health professionals required to adequately deliver health services. At its core, NHWSS is a redistributive mechanism that intends to carry out and provide processes and resources with preferential regard for the unserved and underserved.

Operationalization of the National Health Workforce Support System

Annually, DOH hires additional health professionals such as physicians, nurses, midwives, and other allied health workers for deployment to LGUs. Under NHWSS, the process of HRH deployment begins with LGUs identifying their HRH needs and gaps; incorporating such needs in their respective Local Investment Plans for Health (LIPH); and DOH evaluating their request for augmentation.

Deployment is prioritized based on the following:[13] (1) socioeconomic classification of the area; (2) critical gaps in HRH in relation to approved staffing standards for hospitals and primary care facilities; (3) unmet needs for specialized care or services as mandated by law and as part of the Philippine Health Facility Development Plan (PHFDP); and (4) persistent failure of a hospital or health facility to obtain licensing or accreditation due to lack of HRH. Moreover, LGUs are expected to implement incremental creation of positions to hire the required number of health professionals and health care workers based on staffing standards for health facilities.[14] This is to promote sustainability of health services and to strengthen public health systems while decreasing dependence on HRH deployment.

The DOH Health Human Resource Development Bureau (HHRDB), DOH Centers for Health Development (CHDs), and the Ministry of Health-Bangsamoro Autonomous Region for Muslim Mindanao (MOH-BARMM) conduct pre-deployment activities to properly orient hired HRH on their rights and obligations under contractual service, the nature of their work including potential risks in the field, and mechanisms of support to HRH, among others. Workers hired under NHWSS are primarily deployed to primary care facilities, while graduates of residency training from DOH Teaching and Training Hospitals and Specialty Hospitals are sent to priority Levels I and II government hospitals. In addition, the *Espesyalista para sa Bayan* is being initiated to deploy specialists in provinces with critical needs for specialized health services.

Graduates of medical and allied health professions who are recipients of government-funded scholarships, and graduates of DOH residency training programs, are prioritized in the recruitment and selection for HRH under NHWSS. As part of RSAs in scholarship and training programs, the beneficiaries of government-funded scholarships for medical and allied health courses are preferentially selected for deployment under NHWSS. In the case of medical scholars, the return service to the government is rendered for at least three years through the Doctors to the Barrios Program.

While there is recruitment preference for recipients of government-funded scholarships, eligible walk-in applicants may also be considered in the recruitment pool, as long as they are willing to be deployed to DOH-identified priority areas such as geographically isolated and disadvantaged areas (GIDAs), indigenous cultural communities, and other areas prioritized for poverty reduction and peace-building efforts.

Compensation and Benefits

Health professionals deployed under NHWSS composite programs and projects are entitled to compensation and benefits based on existing laws. Under the UHC Act, deployed HRH will receive salaries based on prevailing national rates. They are also entitled to receive mandatory benefits for public health workers and other incentives and benefits based on existing guidelines and policies.

Provision of these benefits is not just a strategy to induce the movement of labor to areas of need, but also to promote productivity, satisfaction, and welfare of HRH. Learning and development interventions and other opportunities for continuing professional development are also provided to deployed HRH to enhance their competencies in primary care, local health systems development, and other relevant skills for their career growth.

Redeployment of Human Resources for Health

Redeployment of HRH is one of the strategies to sustain health services and strengthen health systems during public health emergencies. Redeployment is the temporary transfer of assignment of deployed HRH from original workstation to another area of need. Redeployment may be from primary care facilities or government hospitals to other public or private health facilities or evacuation centers; or it may be from one unit to another within a health facility with critical need for HRH augmentation.

Redeployment and hiring of HRH under NHWSS are subject to conditions such as (1) critical gap in the number of local HRH in a specific area of need to respond to sudden or overwhelming health needs; (2) urgent need for additional HRH in specific hospitals, facilities or areas; and (3) the number of HRH required to be hired for emergency response exceeds the financial or administrative capacity of the concerned health facility, or Province-wide or City-wide Health System (P/CWHS).

Furthermore, HRH redeployment must not result in undue disruption of essential services, both individual-based and population-based, especially in GIDAs. The security and safety of redeployed HRH must also be taken into consideration, including provision of adequate logistics and supplies, as applicable.

Safety and Security of Human Resources for Health

Circumstances that threaten the safety of deployed HRH are at times encountered due to the nature of their work and the context of the areas of deployment. DOH CHDs and MOH-BARMM are responsible for the

direct provision of technical assistance to P/CWHS on any issue pertaining to safety and security of deployed HRH. They are also responsible for regularly evaluating the effectiveness of safety protocols of local health systems to ensure their responsiveness to the context of deployment areas, and to provide feedback and make modifications, as necessary.

P/CWHS and its components must provide reasonable and hazard-free working environment and conduct occupational safety awareness sessions to deployed HRH within their jurisdiction. The local health system is also responsible for the creation and activation of the Safety and Health Committee or the Special Investigation Committee to address the safety and security concerns of deployed HRH within its area.

If there are indications of threat to life, whether verified or not, deployed HRH must be pulled out by DOH CHDs or MOH-BARMM or Provincial DOH Offices (PDOHOs) within 24 hours. An investigation can be done thereafter. Until such time that threats and risks are cleared, pulled-out HRH must report and temporarily render service to any of the following: DOH CHD or PDOHO; Provincial Health Office; and in the case of HRH deployed to hospitals, to the nearest DOH regional hospital. Transfer may also be justified when there is political instability or breach of agreement between DOH and P/CWHS.

Monitoring and Evaluation

Deployed HRH must be monitored at least twice a year by DOH CHD or MOH-BARMM using the prescribed monitoring and evaluation tools for the program. The DOH Assistant Regional Director, or the BARMM Assistant Minister of Health, or the next lower ranking medical officer, is designated as the HR coordinator to oversee and manage the deployment of HRH in their respective regions, in close coordination with DOH HHRDB.

NHWSS effectiveness is evaluated in terms of HRH absorption under P/CWHS; improvement in access to quality health facilities and services; progress in health outcomes; and attainment of UHC targets and Sustainable Development Goals.

Chapter References

1 *Universal Health Care Act 2019* (Rep) s. 23 (Phil.).

2 *Local Government Code of 1991* (Rep) s. 77 (Phil.).

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13 Department of Health. (2020). *Guidelines on the deployment of human resources for health under the National Health Workforce Support System.* (Administrative Order 2020-0038).

14 See 13.

Chapter VIII

Strengthening Health Information System

The UHC Act requires all health service providers and insurers to maintain a health information system consisting of enterprise resource planning, human resource information, electronic health records, and an electronic prescription log consistent with DOH standard, among others. DOH and PhilHealth are tasked to develop and finance this health information system taking into consideration patient privacy and confidentiality at all times in accordance with the Data Privacy Act of 2012.[1]

Crucial to this mandate is the implementation of integrated health information systems (iHIS) to reduce or eliminate overlaps, and ensure generation and reporting of quality and timely reports for operation and delivery of health services. Also important is conformance to the national health data standards and interoperability validation, to enable different health information systems and other e-health solutions of health care providers, insurers, and health-related entities to seamlessly communicate, share, exchange, process, and submit health and health-related data and reports. Such data must be submitted to PhilHealth through a central hub of health information exchange that supports health care provider networks.

PhilHealth is also mandated to establish and maintain a National Health Data Repository to ensure that quality health and health-related data and reports are readily available and made accessible to every stakeholder in the right way, and processed in a lawful, ethical, secure, consistent, and efficient manner at all levels of the health care system. The processing and submission of such data to PhilHealth through the National Health Data Repository ensures data protection at all levels of data processing at all times, and promotes better health system performance.

The UHC Act and its IRR also provide for remote access and delivery of individual-based health services through the use of digital technologies for health. From recent events of public health concern, one digital health technology that has been widely adopted is telemedicine to ensure access and delivery of continuous, coordinated, and integrated health services and information.

Integrated Health Information System

Health information, a major building block of a functional health system, involves the collection, storage, management, and transmission of health and health-related data from various sources for policy and decision-making. Integrating health information systems is crucial to implementing UHC in areas such as electronic medical records, health insurance claims, disease registries and surveillance, and supply chain management, among others.

In this regard, the UHC Act requires DOH and PhilHealth to develop and maintain an integrated health information system (iHIS) and adopt a national health data standard for interoperability; provide standards conformance and interoperability validation; and provide a platform for submission and processing of health and health-related data.

Integrated Health Information System Implementation Model

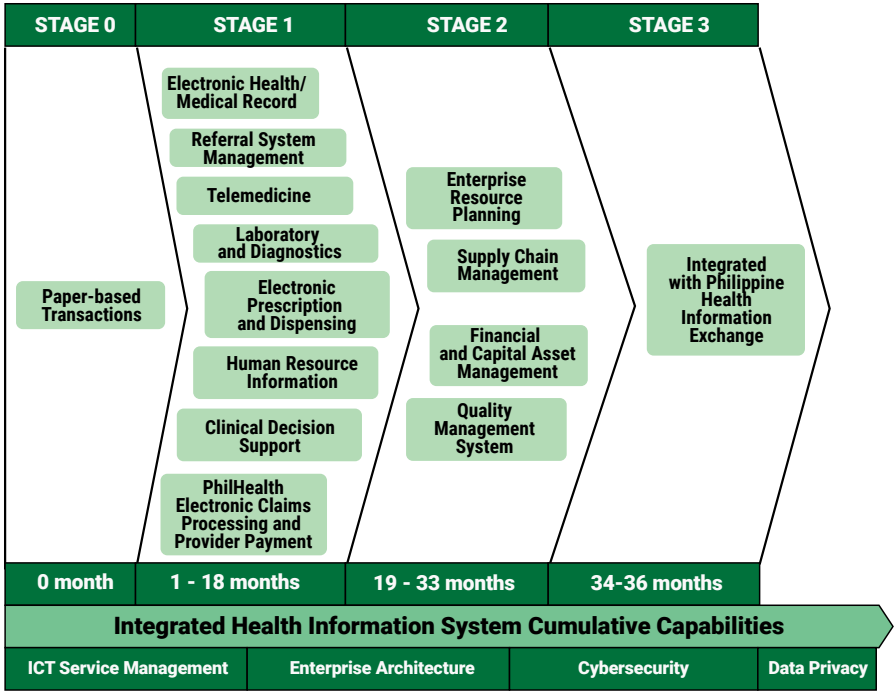
iHIS refers to an integrated automated system for communication and processing of health and health-related data and reports needed for the following: (1) operations and delivery of individual-based and population-based health services; (2) response to health emergencies and health events of public health concerns; (3) health policy development; (4) decision-making; and (5) program planning and implementation at all levels of health care utilization.

To this end, an iHIS implementation model (iHISIM) has been introduced to guide all health care providers and insurers in integrating their existing or planned iHIS. The iHISIM provides the core modules, required functionalities, implementation areas, and other standard requirements for iHIS implementation and maintenance (Figure 8.1).

iHISIM has three components:

1. *General Functionalities* that refer to the minimum features that an iHIS should demonstrate, such as:
    a. automation and linking of core clinical and non-clinical workflows and processes;

Figure 8.1 Integrated Health Information System Implementation Model



b. generation, processing, and submission of health and health-related data and reports at the local and national levels;

c. operationalization of an ICT-enabled, integrated, and functional referral system within the Health Care Provider Network (HCPN); and

d. integration with the Philippine Health Information Exchange (PHIE).

2. *Core Modules* that form the clinical and non-clinical modules, which can be deployed in three progressive stages within 36 months:

   a. Stage 1 - consisting of eight clinical modules deployable within 18 months;

   b. Stage 2 - consisting of four non-clinical modules deployable in the succeeding 14 months; and

c. Stage 3 - consisting of iHIS integration into the PHIE within the remaining four months.

3. *Implementation Areas* that refer to framework areas of information and communication technology (ICT) best practices and standards, namely ICT service management, enterprise architecture, data privacy, and cybersecurity

Accordingly, all health care providers and insurers must have access to user-friendly clinical and non-clinical software modules, which they can buy or independently build. These modules should easily automate processes in a secure environment while ensuring data privacy. Moreover, modules that are built independently must pass standards conformance and interoperability validation by DOH, PhilHealth, and the Department of Information and Communications Technology (DICT). Incidentally, DOH can provide free iHIS modules to health care providers and insurers that lack the means or capacity to develop and implement their own systems.

Eventually, iHIS will be part of DOH and PhilHealth licensing and accreditation requirements. In addition to health care providers and insurers, all health-related entities that are not under DOH and PhilHealth but collecting and processing health and health-related data must also comply.

DOH and PhilHealth defined the strategies and standards in the implementation of iHISIM, and monitor implementation through designated regional iHIS coordinators. These coordinators provide administrative, coordination, and technical assistance or support. Further guidance will be provided through an iHISIM maturity document.

National Health Data Standards for Interoperability, Conformance and Validation

Interoperability refers to the ability of different information systems to process, share, and exchange data cohesively. More specifically, this refers to the ability of different information systems, devices, and applications to access, exchange, integrate, and cooperatively use data in a coordinated manner, within and across organizational, regional, and national boundaries

to provide timely and seamless portability of information, and optimize the health of individuals and populations.

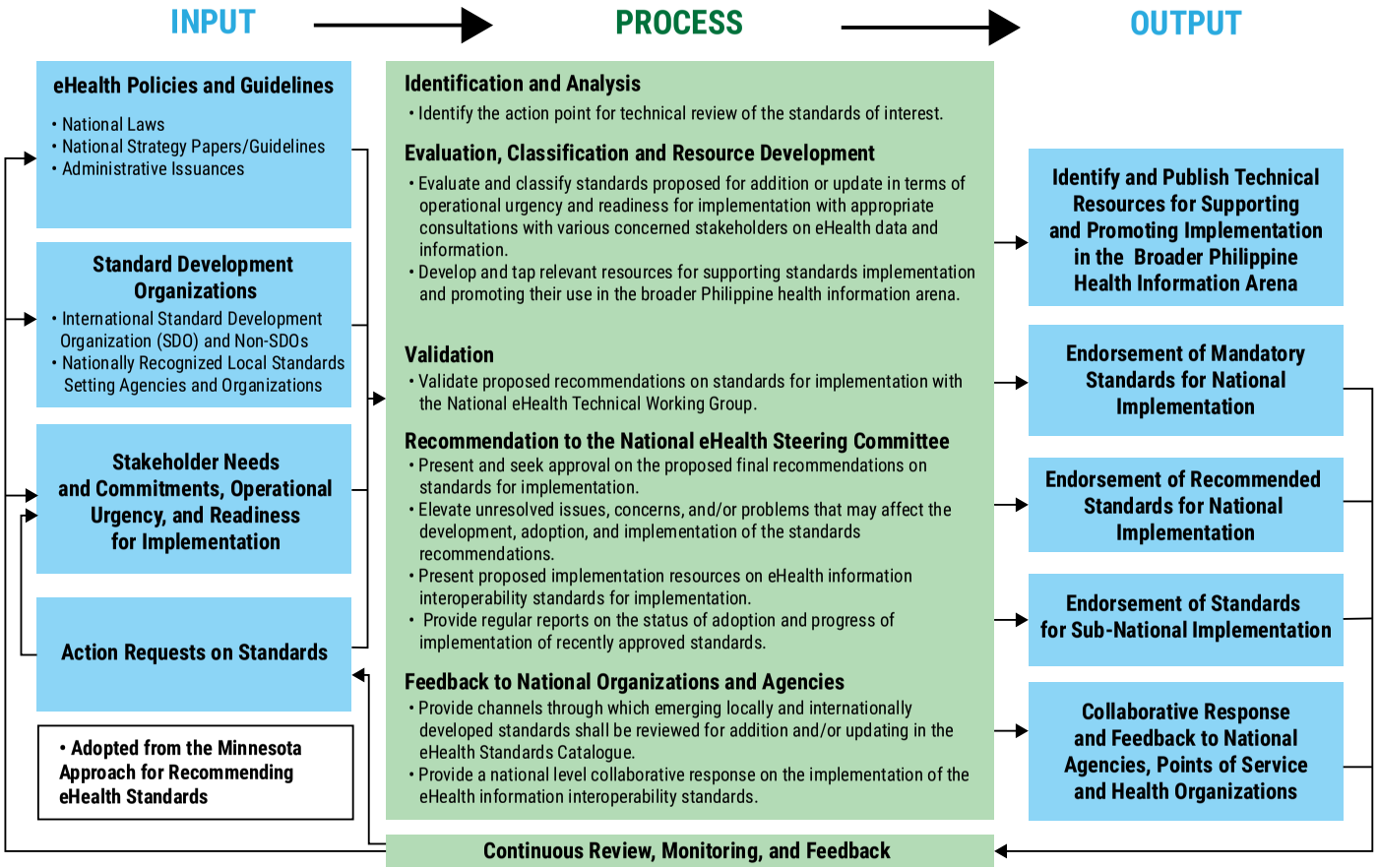
One of the ways to achieve interoperability is by standardizing the way data are collected and presented, also known as "form"; and by validating or checking the data's capability to be submitted and analyzed, also known as "function." By ensuring form and function, data can be used for both local and national levels.

To ensure a consistent form of health and health-related data, DOH and PhilHealth are standardizing the definition, representation, and organization of all concepts and terminologies used in health. This enables uniform and consistent interpretation, processing, and submission of health and health-related data and reports at all levels of healthcare utilization.

The complete and updated list of the mandatory national health data standards, including their structure, is published in a standard health data catalogue. This is also made available electronically in the DOH-maintained National Health Data Dictionary (NHDD), which can be accessed at *www.nhdd.doh.gov.ph* until such time that a national Terminology Service is established. A change management protocol (Figure 8.2) is implemented to keep the standards accurate and up-to-date. DOH and PhilHealth will annually update the national health data standards and evaluate its adoption and use every two years.

To ensure the uniform function of health and health-related data, DOH, PhilHealth, and DICT issued guidelines on standards conformance and interoperability validation (SCIV). With this, all health information systems, their corresponding modules, and other software solutions will follow the desired design, like the integration of technologies in health facilities, among others. The SCIV policy describes the whole process of checking health information systems and other software solutions. This can address prevailing inaccuracies and inconsistencies in local and national health data reporting, while also preventing widespread managerial and operational inefficiencies. These inefficiencies are usually the result of different information systems, data definitions, terminologies, elements, and structures being used by various implementers.

Figure 8.2 National eHealth Information Interoperability Standards Change Management Protocol



Health care providers, insurers, and health-related entities can apply, free of charge, for certification online through the Centralized Online SCIV System, or physically through the designated regional SCIV administrators of DOH, PhilHealth, and DICT. The SCIV program will be updated annually and evaluated every two years as it meets the UHC goals.

National Health Data Repository

The UHC Act requires all public and private, national and local health-related entities to submit health and health-related data to PhilHealth. These include administrative, public health, medical, pharmaceutical, and health financing data[2], which must be submitted through the National Health Data Repository (NHDR).[3] Such data will be made accessible to all stakeholders at all levels for health care utilization, after being processed in a lawful, secure, consistent, and efficient manner. NHDR is seen as critical in the establishment of Province-wide and City-wide Health Systems (P/CWHS).

In this line, DOH and PhilHealth jointly issued a memorandum circular on processing and submission of health and health-related data to NHDR, to ensure that quality health data and health-related data and reports are readily available for public access.[4] NHDR will be the national health data center of the country, and PhilHealth is tasked to establish and maintain it.

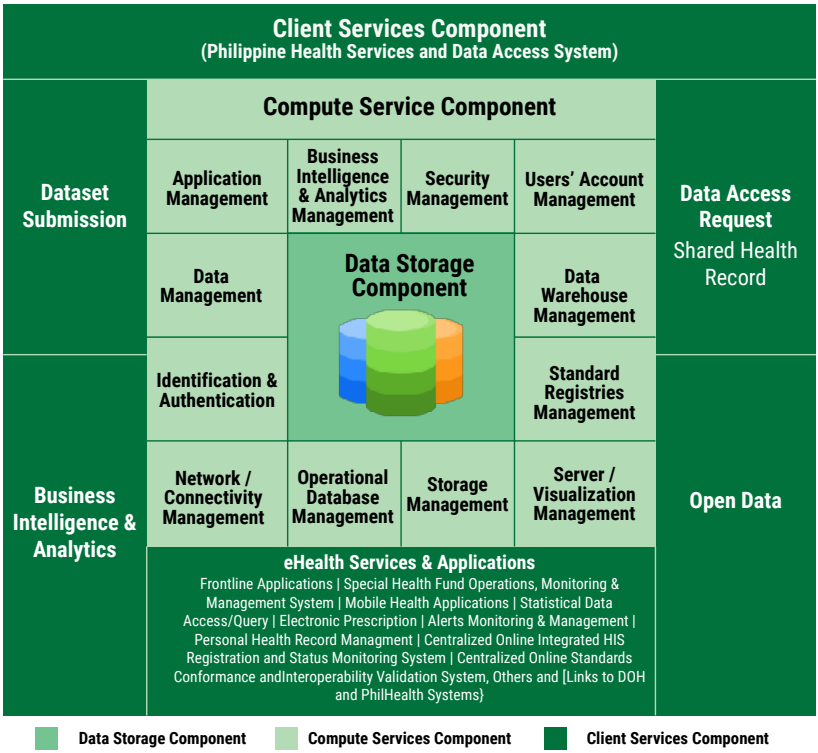
Components of the National Health Data Repository

NHDR is a single point-of-submission, evidenced-based, and authoritative repository of health and health-related data. It is a data platform serving as a unified, end-to-end central repository of all health and health-related data, for effective management of UHC. However, NHDR is not just data storage. Its components are data storage, compute services, and client services (Figure 8.3). These work together to ensure that NHDR operates successfully, and delivers expected services and applications.

a. Data Storage

Data storage involves physical storage of health and health-related data submitted and processed through NHDR, in accordance with standards

Figure 8.3 National Health Data Repository Framework



and rules on the Mandatory Adoption and Use of National Health Data Standards for Interoperability,[5] and other subsequent issuances.

The following data are required to be stored:

1. licensing of health facilities or primary care providers and stand-alone health facilities;
2. network contracting, like contracting through Service Level Agreement;
3. service quality;
4. data submission standards;
5. membership, like registration of Filipinos to primary care providers or network;
6. contributions, like PhilHealth premiums of members;
7. health services for population-based and individual-based health services;

8. health or medical data, like patient's key clinical data and medical history, demographics, vital signs, diagnoses, medications, treatments, progress notes, allergies, immunization, and laboratory and test results;
9. birth and death data from Philippine Statistics Authority;
10. human resources for health, like multistakeholder network, scholarships and training programs or registry, registered health professionals and workers, primary care competencies of health professionals, and health worker curricula; and
11. regulations, like standards for clinical care; drug price reference index; price mark-up for drugs, medical devices, and supplies; price information by all healthcare providers; and monitoring of prices of health goods and services.

Health-related entities required to submit data to NHDR include academic and research institutions, civil society organizations, health professional associations, development partners, ICT service providers, national and local government agencies, providers of health services or processors of health and health-related data, and other stakeholders identified by DOH and PhilHealth.

b. Compute Services

Compute Services cover resources, tools, systems, and other services that ensure NHDR is available, accessible, and serves client services' components. These include application management, business intelligence and analytics management, security management, users' account management, and data management.

Compute Services also cover data warehouse management, identification and authentication, standard registries and codes management, network and connectivity management, operational database management, storage management, and server or virtualization management.

c. Client Services

Client Services cover processes in submitting, accessing, and using health and health-related data in NHDR by entities involved in providing

health services. These processes include health information exchange, which enables health care providers and patients to appropriately access and securely share health data.

Client Services include eHealth services and applications. eHealth is the use of ICT for health to improve the efficiency and effectiveness of health system management and health care delivery. Specifically, these services and applications are frontline applications, mobile health applications, statistical data access and query, electronic prescriptions, alerts monitoring and management, telemedicine, personal health record management, and chronic disease management. eHealth services can be accessed through online or mobile health technologies, which include mobile phones, handheld computers, and wearable devices.

Client Services also include big data analysis, which enables the generation of meaningful data or information to assist health care providers in making decisions; and open data, which enables the wide dissemination, access, use, and sharing of health and health-related data. This particular service can be linked to Open Data Philippines, which collects datasets from different government agencies deemed "open".

Benefits of the National Health Data Repository

NHDR envisions full integration for the wide availability of health data to all stakeholders. It aims to provide a single point of data submission and access to health evidence, and quality data and information. Up-to-date reports can be readily made available to support decision-making by government and other stakeholders. NHDR also addresses the information needs of various stakeholders to strengthen planning, monitoring, risk management, and research, among others.

NHDR aims to promote efficient health service delivery through integrated records management. It improves access to public health and health-related data, and enables better management of patients' medical records. This, in turn, improves consultations and coordination of care as health information is easily exchanged between healthcare providers. It also paves the way for early detection and treatment of preventable communicable and non-communicable diseases, and reduction of costs

of health services by eliminating, for example, the need for repeated diagnostic tests.

NHDR benefits patients and clients by improving their access to healthcare services. NHDR allows them to find specific medical assistance as well as physicians, with information on their experience, services, and fees. It also assists them in looking for health insurance institutions and the scope and cost of their packages. NHDR also allows them access to information on DOH-licensed and PhilHealth-accredited health care facilities; accredited products and equipment; cheapest drugs and laboratory examination services; and the location of nearest pharmacies and health care institutions.

NHDR likewise benefits health care providers by giving them access to patient records and medical history at the point of care, and by improving the exchange of patient information throughout all levels of health care provider networks with the use of digital technologies. NHDR helps facilitate referrals and patient navigation for a coordinated system of care from primary to tertiary services and back. NHDR gives health care providers accurate, sensitive, and timely epidemiologic surveillance data through continuous systematic collection, analysis, interpretation, and dissemination of such data.

For health practitioners and researchers, NHDR provides greater access to evidence-based information to support clinical decision-making, treatment design and assessment, technological innovation, and access to other networks and resources.

To the government as a whole, NHDR supports evidence-informed sectoral policy and planning for UHC. It can improve the determination whether health action plans are delivering expected results, and improve as well the identification of issues and challenges affecting the delivery of results. NHDR can aid decision-making to support the development of program interventions, and enhance the analysis of disease patterns and trends to help prepare better for critical health interventions. It will provide support to the National Health Workforce Registry and the National Health Workforce Support System. It will also help integrate DOH licensing and PhilHealth accreditation systems.

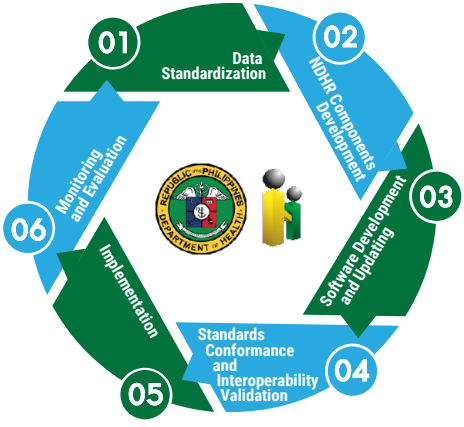
At the local level, NHDR will address data and information needs for the integration of local health systems into P/CWHS. It will help LGUs deliver reliable, responsive, and timely reporting on public health, and aid in the operationalization and management of the Special Health Fund.

Lastly, NHDR benefits health-related businesses as it provides health content as a commodity to the public and health professionals, and facilitates research and development of new products and services like electronic health records, information systems, and clinical registries. It can also enable broad and cost-effective marketing of health products and services to businesses and governments, both locally and abroad.

Establishment and Implementation of the National Health Data Repository

The establishment of the NHDR follows a process that starts with PhilHealth and DOH updating and completing their national data standards catalogue. This is followed by the complete development of NHDR components. Once data are standardized, health-related entities can develop or update their respective software or systems, which must comply with or pass the SCIV process. After these steps, NHDR implementation commences and undergoes continuous monitoring by PhilHealth and DOH to observe its progress, evaluate the performance of the system and the implementers, identify and address risks, and identify opportunities for further innovations, updates or enhancements (Figure 8.4).

Figure 8.4 Establishment and Implementation of National Health Data Repository



Telemedicine for Individual-based Health Services

The UHC Act provides for the use of digital technologies for health, such as telemedicine. Accordingly, DOH, PhilHealth and the Department of the Interior and Local Government (DILG) jointly issued an order to establish integrated and coordinated local telemedicine services in all provinces, highly urbanized cities (HUCs), and independent component cities (ICCs).[6]

Telemedicine refers to the delivery of health care services, where distance is a critical factor, by all health care professionals using ICT to exchange valid information for the prevention, diagnosis, and treatment of diseases and injuries. Telemedicine, or more aptly, telehealth, is also used for the exchange of information on research and evaluation, and for the continuing education of health care providers, all in the interest of advancing the health of individuals and their communities.

LGUs must establish integrated and coordinated telemedicine services that reference and complement the service delivery design of HCPN and service classification of individual-based health services.[7] LGUs are required to finance telemedicine services using their own administrative funds and with the supervision of an organized LGU telemedicine operations team.

Implementing Telemedicine in Health Care Provider Networks

All HCPNs are required to determine, provide, and regularly monitor their telemedicine services, human resources, equipment, infrastructure, and other standard requirements from all health care providers, including their telemedicine operations team. Likewise, they must issue a comprehensive communications strategy to generate demand for telemedicine considering the population and local context, alongside a functional telemedicine referral within HCPNs. Furthermore, they have to standardize their telemedicine service operations in their catchment area allowing only licensed health professionals to provide such services.

The Practice of Telemedicine in the Country

Currently, the practice of telemedicine is limited only to licensed physicians, following the standard practice of medicine based on the

Medical Act of 1959. All licensed physicians practicing telemedicine must uphold the same standard of care as in a face-to-face consultation. Minimum health services to be provided in telemedicine include medical diagnosis, health advice and counseling, issuance of electronic prescription, and referral services.

The nature of individual-based health services and information that are provided through telemedicine is based on the following criteria: (1) service capability; (2) mode, purpose and timing of consultation; (3) persons involved; (4) specific conditions of the individual patient; and (5) localized standard telemedicine service protocol.

Moreover, it is governed by the following principles:

1. Patient-physician relationships shall be founded on mutual trust and respect.
2. Proper informed consent must be obtained.
3. Patient-physician relationships shall be based on full knowledge of the patient's medical history and physical examination, given the circumstances of a lack of physical contact.
4. Patient-physician relationships shall respect both patient and physician autonomy.
5. Right to privacy of health information shall be protected at all times.
6. Principle of privileged communication between the physician and the patient shall be observed.

All telemedicine consultations need to be properly documented specifying consultation details, patient and provider location, family members or other companions present during the consult, and patient consent. Such consultations include a patient feedback mechanism that encourages and facilitates patients to provide feedback on the quality of the consultation and experience. Eventually, such patient feedback must enable refinement and improvement of future telemedicine consultations. However, the issuance of an electronic prescription and dispensing of medicine are governed by the Food and Drug Administration Act of 2009, the Philippine Pharmacy Act, and other relevant laws.

Encouraging Good Practice of Telemedicine

DOH, Professional Regulation Commission (PRC), and the University of the Philippines Manila-National Telehealth Center (UPM-NThC), in collaboration with medical associations, specialty societies, patient groups, and other stakeholders, are required to adopt a code of ethics and clinical practice guidelines (CPG) to guide all licensed physicians in the practice of telemedicine. The good clinical practice certification process eventually forms part of the credentials for the certification of primary care providers, and the renewal of the license of physicians assigned to practice telemedicine within a HCPN, or those who intend to practice telemedicine as part of their continuing professional development requirements.

In the interim, all HCPNs must initiate capacity building and mentoring activities of health care providers on the practice and use of telemedicine. HCPNs or any of their component health facilities may opt to contract third-party telemedicine providers using their own administrative funds. These providers are required to conform and comply with the minimum standards for LGU telemedicine services prior to onboarding. The contract, or any equivalent legal document, between the HCPN and the third-party telemedicine provider is legal and binding only to the contracting parties.

On the other hand, PhilHealth, in coordination with DOH, is tasked to implement a telemedicine benefit package and reimbursement mechanism for health care providers. Also, DOH, UPM-NThC, medical associations, and specialty societies are tasked to jointly issue a handbook on recommended rates for telemedicine services. Consultation rates for telemedicine services are based on the standardized claims rate of PhilHealth and the recommended rates from medical associations and specialty societies, among others. Health care providers may charge a consultation fee that is appropriate, reasonable, and commensurate to the telemedicine services provided, pending established rates.

Telemedicine Implementation Governance

DOH, DILG, and PhilHealth are tasked to create a Telemedicine Sub-Working Group under the policy and strategic guidance of the interagency

National eHealth Technical Working Group (Figure 8.5). This sub-working group is responsible for the following:

1. developing the strategies, standards, and guidelines on telemedicine;
2. establishing support mechanisms;
3. overseeing the provision of technical assistance on the development of localized telemedicine strategy, plans and protocols, capacity building, evaluation of third-party telemedicine providers, among many others;
4. conducting research to constantly improve the implementation of telemedicine in the delivery of individual-based health services; and
5. performing the evaluation of the telemedicine implementation every two years.

Figure 8.5 Telemedicine Implementation Governance

The National eHealth Program Management Office of the DOH Knowledge Management and Information Technology Service (KMITS) serves as the general technical and administrative secretariat on all matters relating to the implementation of telemedicine.

Likewise, interagency Regional Telemedicine Coordination Teams are created to provide administrative, coordination, and technical support, including resolving technical and other operational issues and problems. These teams are also tasked to lead the evaluation of third-party telemedicine providers, with the assistance of DOH, and conduct performance monitoring of telemedicine service operations of LGUs within their jurisdiction, in coordination with the LGU Telemedicine Operations Teams. Monitoring results serve as the basis for annual advisory updates.

As telemedicine has its benefits as well as risks, sanctions for any violation and complaint may be imposed in accordance with the following: (1) Medical Act of 1959 and the Philippine Medical Association Code of Ethics; (2) Food and Drug Administration Act of 2009 and other relevant issuances of FDA; (3) Philippine Pharmacy Act; (4) Data Privacy Act of 2012 and other relevant issuances from National Privacy Commission; (5) Civil Code; (6) Revised Penal Code; and (7) all other relevant laws.

Chapter References

1 *Universal Health Care Act 2019* (Rep) s. 36 (Phil.).

2 *Universal Health Care Act 2019* (Rep) s. 31 (Phil.).

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Chapter IX

Regulating Health Goods and Services

Regulation is one of several policy instruments, and probably one of the most commonly used by governments, to influence the behavior of providers and consumers of goods and services. In the health sector, regulation refers to several measures imposed by the government to control quality, safety, and efficacy of health products and services. Regulation may also be imposed to improve equity, accessibility, availability, and affordability of such health products and services.

Several regulatory measures and approaches to ensure the safety and quality of health goods and services have been specified in the UHC Act and its implementing rules. One such approach is the adoption of National Practice Guidelines, which assure safety and quality of health services, and guide health care providers and professionals to efficiently utilize limited resources for health. These guidelines form the bases of our national policies, standards, and regulations on patient care. The health technology assessment (HTA) process is another fundamental strategy provided by the law that warrants the shift from passive purchasing to strategic purchasing. This will ensure that limited resources for health are used and allocated more appropriately, efficiently, and cost-effectively.

With UHC, equitable access to health services, especially in geographically isolated and disadvantaged areas (GIDAs), must be ensured. Hence, DOH developed the framework and guidelines on appropriate service capability for purposes of preferential licensing and contracting of health facilities and services in underserved and unserved areas. The implementation of the maximum retail price on drugs and medicines; the mandatory provision of fairly priced generics in all drug outlets; the regulation of price mark-ups of essential medicines in DOH-owned health facilities; and the promotion of price transparency on products and services offered by health care providers and facilities in both public and private sectors are but some of the measures to ensure affordability of health goods and services.

National Practice Guidelines Program

The UHC Act and its Implementing Rules and Regulations mandate the DOH to regulate and ensure the safety and quality of health care services, and set standards for clinical care. This is through the development and use of clinical practice guidelines (CPGs) in cooperation with professional societies and the academe[1].

CPGs provide recommendations, informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options, and are intended to optimize patient care. CPGs that are high-quality and evidence-based can help bridge gaps between policy, best practice, local settings, and patient choice.

DOH established a national CPG development program[2] that laid out the governance structure, development process, general conflict of interest policy, and integration with the HTA program. The program is envisioned to standardize the processes of the development, quality review, and utilization of CPGs.

Roles of Clinical Practice Guidelines

Health care providers utilize recommendations from CPGs pertaining to screening, diagnosis, management, and monitoring of clinical conditions to improve effectiveness and quality of care. The increasing use of CPGs arises from the need to reduce unexplained variation in practice; to monitor inappropriate care; and to manage costs of health care. Further, CPGs may be used as educational tools for health science students and health professionals; benchmarks for quality control or audit purposes; and sources of priorities for future research.

Process of Clinical Practice Guideline Development, Adoption and Dissemination

The CPG development process follows the global standard known as the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) approach[3]. Transparency and conflict of interest management are considered throughout the development process, which is composed of seven steps:

Step 1. Topic Nomination

Topic nomination for CPG development is done annually. Nominations may come from several entities such as DOH offices, professional societies, non-profit advocacy organizations, public and private hospitals and health facilities, health care networks and providers, patients, and the general public. Nominations may be submitted on a wide range of focal areas, covering *topics* such as health promotion and disease prevention, screening and diagnosis, management of diseases and conditions, rehabilitation, palliation, and end of life care; *life stages* such as neonatal and infancy, childhood and adolescence, adulthood, and advanced age; and *levels of care* such as primary, secondary, and tertiary care.

Step 2. Topic Selection and Prioritization

Several criteria guide the selection and prioritization of CPG topics for DOH funding, namely disease burden, public contention, cost-effectiveness, new evidence, potential impact, variation in care, timeliness, and other factors such as alignment with current policy directions. The CPG topics shortlisted based on these criteria must be posted publicly for transparency, and an appeals process is made available to all relevant stakeholders.

Step 3. Practice Guideline Development and Adoption

The development of CPGs, whether DOH-funded or externally funded, must follow internationally accepted methodologies consistent with the characteristics of trustworthy CPGs as identified by the Institute of Medicine (2011). The general process of a CPG development project includes guideline preparation, evidence synthesis, translation of evidence to decision, and dissemination and evaluation.

Step 4. National Practice Guideline Clearinghouse Appraisal, Adoption, and Indexing

The developed CPGs, whether DOH-funded or externally funded, will be appraised by the National Practice Guidelines Program (NPGP) Quality Review Panel (QRP) using the tool known as the Appraisal of Guidelines for Research and Evaluation (AGREE-II). The NPGP QRP must be composed of content experts, methodology experts, and DOH end-user representatives.

If the CPG is 100 percent compliant in all domains of the tool and gets at least 75 percent rating in AGREE-II, it is considered as a National Practice Guideline (NPG). However, if the CPG is compliant only in certain domains of the AGREE-II tool, then it is classified as an interim NPG and returned to its CPG developer for further improvement. The Secretary of Health approves NPGs and interim NPGs as endorsed by the NPGP QRP. All NPGs are collected in the National Practice Guidelines Clearinghouse for indexing and easy reference of relevant stakeholders.

Step 5. National Practice Guideline Utilization

NPG is used by health care professionals, the academe, and health care stakeholders to guide clinical practice and policy development. It may be translated into DOH policies such as Omnibus Guidelines, and used as standards in the delivery of health services across the entire lifespan, continuum of care, and different levels of care. DOH offices may use NPG in their procurement decisions, policy issuances, and program activities, among others. NPG may also be used by PhilHealth in developing and updating benefit packages. Lastly, NPG may also serve as the basis of knowledge translation materials and other derivative products, such as clinical pathways, algorithm flowcharts, pocket cards, mobile applications, and websites.

Step 6. National Practice Guideline Dissemination

The NPGP Secretariat provides a dissemination plan for NPGs and its associated derivative products and knowledge translation materials. All NPGs indexed in the NPG Clearinghouse must be tagged with quality appraisal results and must bear the DOH logo during mass dissemination. The DOH Disease Prevention and Control Bureau or other guideline developers may disseminate CPGs and derivative products through print and online publication, scientific presentations, and public consultations.

Step 7. National Practice Guideline Monitoring and Evaluation

The NPGP Secretariat monitors and evaluates NPGs based on a framework developed in consultation with stakeholders. Monitoring and evaluation of NPG utilization and impact must be led by guideline developers, in collaboration with the NPGP Secretariat. The monitoring

and evaluation of NPGs must include process evaluation using validated instruments and processes, quality of care indicators, practice surveys of healthcare workers, and impact on health outcomes.

Action Points and Implications for UHC Implementers

While DOH Centers for Health Development (CHDs), hospitals, LGUs and local health offices are not expected to develop CPG per se, UHC implementers are encouraged to be actively involved in other aspects such as: (1) identifying topics in their locality or area of practice that need evidence-based guidance from CPGs; (2) using high quality CPGs in their everyday clinical practice; (3) keeping updated with DOH evidence-based resources such as CPGs, pathways, algorithms, issuances, and policy notes; (4) participating actively in the DOH process of CPG development, adoption, and dissemination; and (5) providing feedback to DOH and the lead CPG developers regarding the utility and effectiveness of CPGs in their locality or area of practice. More importantly, UHC implementers must utilize Omnibus Guidelines, once issued, as unified reference for policies and actions needed to strengthen primary care.

Health Technology Assessment

In pursuing UHC, among the major challenges for any health system is the appropriate allocation of limited resources across the needs of the entire population, and considering different levels of health services and costs. In this line, the UHC Act provides for the use of health technology assessment (HTA) as a rational, evidence-based, consultative process supporting priority setting in identifying health technologies to be financed or procured by the government.

Scope and Objective of Health Technology Assessment

HTA is defined as the systematic evaluation of properties, effects, or impact of health-related technologies, devices, medicines, vaccines, and other health-related interventions developed to solve a health problem and improve quality of lives and health outcomes utilizing a multidisciplinary process to evaluate the clinical, economic, social, organizational, and ethical impact of health technology. Health technologies refer to any intervention used to promote health; prevent, diagnose and treat diseases; or provide

rehabilitation to patients and organize health care delivery in order to improve both individual and population health.[4]

HTA implementation is anchored on the following core principles: evidence-based and scientific defensibility; transparency and accountability; inclusiveness and preferential regard for the underserved; efficiency; availability of remedies and due process; ethical soundness; and enforceability.

HTA supports the goals of UHC by institutionalizing a systematic, unified priority-setting mechanism for identifying health technologies to be financed by government; increasing transparency and accountability; improving efficiency in the allocation of resources; and negotiating for better prices of health technologies.

Under the UHC Act, DOH and PhilHealth must employ the HTA process when considering the procurement or financing of the following health technologies: (1) medicines to be listed in the Philippine National Formulary (PNF); (2) vaccines to be introduced in the National Immunization Program; and (3) health technologies or services to be funded by PhilHealth as part of their benefit packages.[5,6] Aside from DOH offices, attached agencies, and decision-makers, the HTA process also involves public and private health sectors as primary stakeholders in evidence-informed policy-making.

Health Technology Assessment Council

The Health Technology Assessment Council (HTAC) is created to oversee and ensure the effective implementation of HTA. It provides coverage recommendations on health technologies to be financed by DOH and PhilHealth. The council is composed of a Core Committee, with subcommittees on drugs, vaccines, clinical equipment and devices, medical and surgical procedures, preventive and promotive health services, traditional medicine, and other health technologies.

The Core Committee is composed of members specializing in different fields. It makes final recommendations to policy and decision-makers based on reviews conducted at subcommittee level. Subcommittees perform initial topic prioritization, supervise assessment teams, conduct initial appraisal, and develop recommendations. The DOH Health Technology Assessment Division (HTAD) supports HTAC in its operation.

Decision Framework for Health Technology Assessment

In developing recommendations for policy-makers, HTAC is guided by a set of criteria (Table 9.1) in determining coverage decisions for health technologies, as stipulated in the UHC Act.

Table 9.1 Criteria in Determining Coverage Decisions for Health Technologies

CRITERIA	DESCRIPTION
Responsiveness to Magnitude, Severity and Equity	Interventions must address medical conditions placing the heaviest burden on the population and conditions of the poorest and most vulnerable populations
Safety and Effectiveness	Best available evidence must show intervention to be safe and effective
Affordability and Viability	The intervention must be affordable and costs must be sustainable to funding agents
Cost-Effectiveness	The intervention must provide overall gain to the health system and outweigh opportunity costs
Household Financial Impact	The intervention must reduce out-of-pocket expenses

While HTAC is only a recommendatory body to decision-makers, DOH and PhilHealth cannot procure or fund a health technology without the Council's positive recommendation.

Transition of Health Technology Assessment Council as an Independent Entity

Within five years after the establishment and effective implementation of HTAC, it must transition into an independent entity separate from DOH but attached to the Department of Science and Technology (DOST). As DOH partner in leading the Philippine National Health Research System, DOST spearheads the creation of the HTA Research Network along with universities and other research institutions. The Network is seen as boosting the country's HTA capacity in producing assessments and in designing HTA training programs.

Preferential Licensing for Health Facilities in Geographically Isolated and Disadvantaged Areas

The UHC Act mandates DOH to ensure equitable access to quality health care services through policy formulation, standards development,

and regulations. In this line, DOH developed a system to prioritize the application for License to Operate as well as Certificate of Accreditation by health facilities in geographically isolated and disadvantaged areas (GIDAs).[7]

Scope of Preferential Licensing

Preferential licensing refers to prioritizing the processing of applications of newly established and unlicensed government and private health facilities in GIDAs. A barangay is considered GIDA based on physical and socioeconomic factors that limit the availability of basic health services in the area, or limit their accessibility to the population.

Process of Preferential Licensing

All health facilities to be established in GIDAs must secure appropriate DOH authorization (Table 9.2). They should also be compliant with licensing standards and requirements set by the DOH Health Facilities and Services Regulatory Bureau (HFSRB), Food and Drug Administration (FDA), and the Philippine Nuclear Research Institute (PNRI).

Table 9.2 DOH Authorization for non-GIDA and GIDA Health Facilities

DOH Authorization for Health Facilities	Health Facilities in non-GIDA	Health Facilities in GIDA
Certificate of Need (Hospitals)	Required	Not required
Permit to Construct	Regular Lane	Priority Lane with technical assistance
License to Operate or Certificate of Accreditation	Regular Lane	Priority Lane with technical assistance
	Physical inspection	Physical or virtual inspection
	No automatic issuance of license or certificate	Automatic issuance of license or certificate (if virtual inspection is not possible)
	No post-licensing monitoring	Post-licensing monitoring

Upon request of applicants, technical assistance on licensing standards and requirements may be sought from DOH HFSRB, the regional licensing and enforcement division of various DOH CHDs, or the Ministry of Health

of the Bangsamoro Autonomous Region for Muslim Mindanao (MOH-BARMM). Applicants can do self-evaluation of their readiness to comply with licensing standards using the appropriate assessment tool for their type of health facility.

For the establishment of a health facility in a GIDA, applicants must get from DOH a Permit to Construct, and a License to Operate or Certificate of Accreditation. All valid applications from areas in DOH's official list of GIDAs[8] are processed through priority lanes at DOH HFSRB, regional licensing offices, or MOH-BARMM. Guidelines for the One-Stop-Shop Licensing implementation are strictly followed. Inspection is scheduled the soonest time possible. Virtual inspection is allowed in cases when physical inspection cannot be done due to extreme weather conditions; unavailability of transportation; time of calamity or disaster; declaration of quarantine; and other events beyond human control. If virtual inspection is also not possible due to unavailability or instability of internet connection, or other constraints, a License to Operate or a Certificate of Accreditation is automatically issued to comply with the provisions of the Anti-Red Tape Act. However, the health facility will still be subject to post-licensing monitoring.

Ensuring Affordability of Essential Medicines in the Philippine Market

High costs of medicines and out-of-pocket spending for health care are among the biggest challenges to the health system as they are major barriers to patient treatment access and medication adherence, especially for major diseases.

In 2019, the Philippine government embarked on landmark reforms to regulate drug prices, including the use of maximum retail price, and the promotion of fairly priced generics in drug stores and health facilities. Both measures are consistent with the mandates of the Generics Act of 1988, Cheaper Medicines Act of 2008, and the UHC Act. These laws are envisioned to ensure better access to lower-priced medicines as well as promote better competition, ultimately protecting patients and consumers from high out-of-pocket expenses.

Maximum Retail Price on Drugs and Medicines

Maximum retail prices (MRP) on drugs and medicines were implemented by the national government through two Executive Orders[9,10] signed by the President upon the recommendation of DOH, consistent with the goals of the Cheaper Medicines Act. The maximum retail price refers to the government's mandated ceiling price on selected medicine deemed to be disproportionately costly, and therefore contributing to the impoverishment of people.

a. Drug Price Advisory Council

DOH created the Drug Price Advisory Council (DPAC) for technical guidance on the selection of medicines for price regulation, guided by a clear framework, set of criteria, and methodology and processes in implementing the MRP. This council is composed of experts in medicine, economics, health economics, trade, research, jurisprudence, and epidemiology.

b. Criteria for Selecting Medicines for Maximum Retail Price

DPAC recommends several criteria for selecting medicines for MRP. A medicine is subject to MRP if it is indicated for a disease with the highest burden in terms of magnitude and severity, such as hypertension, atherosclerotic cardiovascular disease, diabetes, asthma, cancer, pain syndromes, and neonatal diseases. This also includes recommendations of patient groups and medical societies for hematological conditions, non-ischemic heart disease, chronic kidney disease, chronic liver disease, psoriasis, rheumatoid arthritis, and others. Since the criterion favors common conditions, this will include entertaining recommendations from patient groups and medical societies, in order to represent the marginalized and disadvantaged population. Medicines with monopolies or oligopolies and those with prices that are higher than other countries are also considered for MRP.

DPAC determines maximum retail prices through external reference pricing with other countries, and by setting an acceptable mark-up as discussed by DOH with stakeholders. Additionally, a Technical Working Group composed of representatives from DOH and the Department of Trade and Industry (DTI) reviews the list of other drug molecules that may be subject to price regulation.

c. Enforcement and Monitoring of the Maximum Retail Price

In February 2020, the President issued an Executive Order regulating the prices of an initial list of 87 drugs. This was followed by a second order in December 2021 covering another 34 drugs. Both orders reduced retail prices at an average and median of 50 percent.

In general, MRP is inclusive of Value Added Tax (VAT), except for those that are VAT-exempt in accordance with existing laws[11,12]. Special discounts for senior citizens and persons with disabilities continue to be honored for drugs and medicines under MRP. Administrative fines are imposed upon any person, manufacturer, importer, trader, distributor, wholesaler, retailer, or any other entity, for violations of the Maximum Wholesale Price (MWP) and MRP approved by the President under the said Executive Orders.

Provision of Fairly Priced Drugs

As defined in the Cheaper Medicines Act, a fair price refers to the lowest price of an available quality, non-branded, generic drug. The World Health Organization also defines "fair price" for medicines as "one that is affordable for health systems and patients and that at the same time provides sufficient market incentive for industry to invest in innovation and the production of medicines."

To complement the Generics Act and the Cheaper Medicines Act, DOH mandated[13] all drug outlets to carry at all times the generic equivalent of all drugs in the Primary Care Formulary. Retailers or drug outlets cannot withhold sale or refuse to sell fairly priced generic equivalents of drugs. Additionally, during the filling of prescriptions or any transactions, drug outlets are required to provide customers with a list of therapeutic equivalents together with their corresponding prices, in a conspicuous location or in a booklet that must be updated regularly.

Drugs included in the Primary Care Formulary are selected based on common causes of mortality and morbidity, local needs, and prevailing community disease patterns. Essential medicines included in the Primary Care Formulary are reviewed and updated periodically by HTAC in coordination with DOH Pharmaceutical Division, based on current operational guidelines.

In November 2021, DOH issued the list[14] of generic medicines under the Primary Care Formulary with their corresponding fair prices. All drug outlets are required to carry these medicines and are required to submit the price data for monitoring purposes. The list of fairly priced generics is reviewed and updated annually through the Drug Price Watch by DOH Pharmaceutical Division. To give drug outlets ample time to make supplies available, implementation of this provision takes effect one year after the publication of the Primary Care Formulary with their corresponding fair prices.

Noncompliance with the provisions of the administrative order on the Primary Care Formulary is subject to existing rules and administrative sanctions as stipulated in the UHC Act and other relevant laws, such as the Food and Drug Administration Act of 2009, Cheaper Medicines Act of 2008, and Consumer Act of the Philippines.

Through these policies, DOH aims to keep medicines within the reach of Filipino consumers by working with all stakeholders in a consultative and collaborative approach. Continuous monitoring and regulatory impact assessments are conducted to ensure that patients get better access to medicines without compromising the viability of the pharmaceutical industry.

Ensuring Affordability of Essential Medicines in DOH Hospitals and Facilities

Poor affordability is one of the obstacles to medicine access especially among the marginalized sector, who spend on medicines about fifty-nine percent of their out-of-pocket expenses for health. Under the UHC Act, the government must ensure equitable access to quality and affordable health care goods and services. The UHC Act also provides for central price negotiations by DOH and PhilHealth to address emerging issues on access such as the launch of innovative but high-cost health commodities, and fragmentation in procurement leading to variability in price and availability of essential medicines especially to indigents.

DOH sets the rules for the price mark-up of medicines[15], as well as the enforcement, implementation, and monitoring of mark-up mechanisms. In

this line, DOH aligns its medicine pricing policies with the UHC Act and its Implementing Rules and Regulations.

Mark-up Price Regulation

In 2018, DOH analyzed hospital pharmacy operational costs in different levels of government hospitals nationwide. The mark-up structure was then revised following consultations with hospital pharmacies as well as financial agents and managers. The new price regulation applies to all essential medicines being dispensed and sold to patients in all DOH-owned health facilities nationwide.

a. Mark-up Structure for Drugs and Medicines

The mark-up structure applies to common medicines, highly specialized drugs, and total parenteral nutrition preparations that need compounding. Such structure generally follows a mixed model with a fixed cost to account for the operational cost of the pharmacy, plus an allowable profit margin represented by the regressive percentage mark-up scheme where the allowable percentage mark-up decreases as the acquisition cost increases (Table 9.3).

For example, for a medicine with an acquisition cost ranging from one centavo to Php 50, the suggested mark-up on price is 40 percent. The corresponding rate is inclusive of the 12 percent value added tax (VAT), except for VAT-exempt medicines, and other operational expenses such as overhead costs. The mark-up and price remain the same regardless of the quantity supplied by hospital pharmacies.

Table 9.3 Mandated Mark-up Structure for Regular Medicines

Acquisition Cost (Php)	Suggested Mark-up (Php)
0.01–50.00	40%
50.01–100.00	20 + 30% of the excess of P50
100.01–1,000.00	35 + 20% of the excess of P100
1,000.01–10,000.00	215 + 10% of the excess of P1,000
10,000.01 above	1,115 + 5% of the excess of P10,000

For highly specialized drugs, total parenteral nutrition, and other medicines that need to be compounded, the retail price is computed similar

to common medicines but with the addition of a compounding fee capped at Php 310 as of 2020.

Note that for medicines sold to senior citizens[16] partially subsidized by the government through the Philippine Charity Sweepstakes Office (PCSO), Medical Assistance for Indigents Program (MAIP), PhilHealth, and senior citizens or persons with disabilities (PWD), discounts will no longer be applied.

b. Enforcement and Monitoring of the Mark-up Regulation

The UHC Act and relevant laws such as the Cheaper Medicines Act and the Consumer Act provide for sanctions for noncompliance with the mark-up structure for medicines sold in DOH health facilities.

Under the mark-up scheme, expensive medicines become more affordable to patients, but with fair margins that allow hospitals to recoup pharmacy operational costs plus a reasonable profit. This is seen to lead to more effective coverage by PhilHealth and reduced out-of-pocket costs for patients. It also provides for more transparent pricing and application of price mark-ups and clarification on discount policies on essential medicines in DOH hospitals. Further, it corrects system inefficiency where prices of the same medicine are not standard even within the same hospital.

Central Price Negotiation

The UHC Act provides for the creation of an independent Price Negotiation Board, which centrally negotiates prices on behalf of DOH and PhilHealth. The Board aims to improve efficiency through centralized negotiation, and consolidate the government's purchasing and bargaining power. It promotes transparent price-setting for innovative, proprietary, patented and single-sourced health commodities; improve efficiency

Composition of the Price Negotiation Board

Representatives of the following:

- Department of Health
- Department of Trade and Industry
- Philippine Health Insurance Corporation
- Local Chief Executives
- Health Care Institutions
- Health Care Professionals
- Civil Society Organizations/Patient Groups

in government spending; and guarantee access to affordable and quality health commodities by using centrally negotiated prices as leverage for more homogenous and affordable price points. The Price Negotiation Board is composed of representatives from different government agencies and sectors.

a. Health Commodities Covered by Price Negotiation

Consistent with the UHC Act and the Government Procurement Reform Act, the Price Negotiation Board can negotiate innovative, patented, proprietary, and single-sourced health commodities as defined below:

Innovative health commodities refer to novel drugs, like active pharmaceutical ingredients or molecules, or a medical device. This does not include new indications, products, or brand names of existing registered molecules with the FDA.

Patented health commodities refer to drugs or medical devices that have been granted intellectual property rights, providing its patent holder the legal right to exclude others from making, using, selling, and importing an invention for a limited period of years.

Proprietary health commodities refer to drugs or medical devices that are used, produced, or marketed under exclusive legal right and protected by patent.

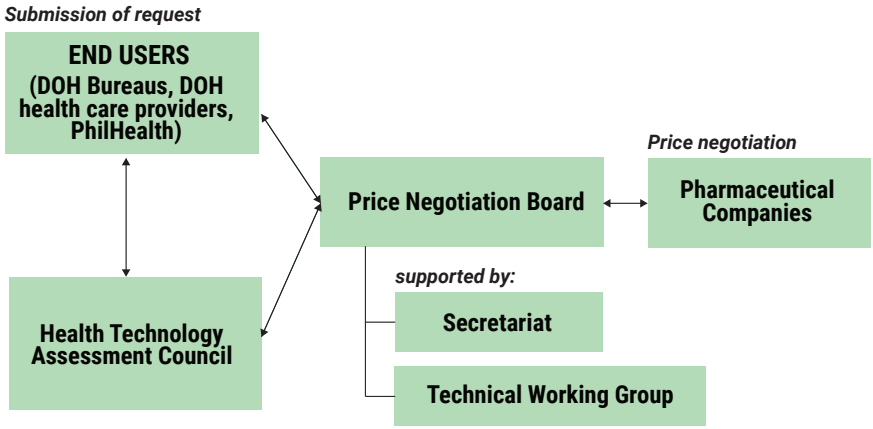
Single-sourced health commodities refer to drugs or medical devices that have only one registered supplier with FDA.

b. Price Negotiation Process

The price negotiation process involves various stakeholders from both the public and private sectors and follows a general framework (Figure 9.1).

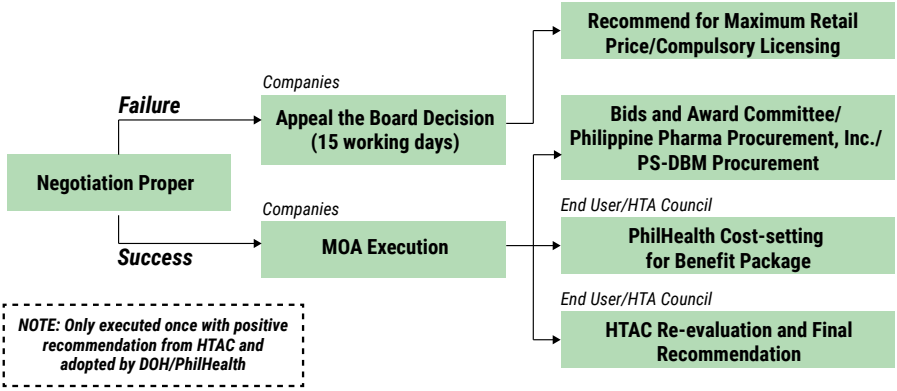
The price negotiation process is triggered by the submission of requests by end-users of health technologies such as DOH offices or bureaus, DOH health care providers, PhilHealth, or HTAC. The Price Negotiation Board then negotiates prices with the pharmaceutical or device industry on behalf of the government.

Figure 9.1 Framework of Price Negotiation in the Philippines



The Board adheres to the principles of transparency, accountability, good governance, fairness, and sustainability when conducting price negotiations with companies. The Board is assisted by its Secretariat and the Technical Working Group. DOH Pharmaceutical Division, DTI Consumer Policy and Advocacy Bureau, and PhilHealth provide joint secretariat support to the Board. Negotiations may result in success or failure (Figure 9.2).

Figure 9.2 Outcomes of Price Negotiation



If the negotiation fails, companies are given 15 working days to appeal the Board decision. Should this period lapse, the commodity may be recommended for other access pathways such as Maximum Retail Price and Compulsory Licensing.

If the negotiation succeeds, a memorandum of agreement is executed if the commodity also obtains a positive recommendation from HTAC and is adopted by DOH or PhilHealth. Once completed, the Bids and Awards Committee of the procuring entity may proceed with the procurement process, and PhilHealth may commence with cost-setting for benefit packages. For commodities requested by HTAC, these can be evaluated and given a final recommendation.

Successfully negotiated prices are generally only valid for one year unless otherwise subject to a multiyear agreement. The final agreed prices are made public. Negotiated prices are subject to allowable price mark-ups. Prices may be reviewed and renegotiated by the Board depending on appropriate circumstances such as changes in prices in the global and local markets, changes in the epidemiology of the disease, and developments in clinical evidence.

Through the regulation of price mark-ups, and the use of central price negotiations, the government can ensure the affordability of medicines, medical devices, and other health technologies in DOH-owned health facilities.

Public Access to Price Information of Health Goods and Services in Health Facilities

Price transparency empowers the public in making informed decisions when choosing health goods and services. The UHC Act aims to reduce out-of-pocket expenses for health by promoting price transparency, and requiring health care providers and facilities to make public all pertinent, relevant and up-to-date information regarding their pricing of health goods and services, and submitting such information to DOH and PhilHealth.[17]

DOH has issued guidelines on public access to price information on all health goods and services in health facilities, whether government or

privately owned.[18] This is to ensure that updated price lists are accessible and available at all times.

The Price List

The price list of health goods and services must be itemized, and all fees must be indicated clearly, including outsourced services, if applicable. Health facilities must ensure complete transparency of all prices and fees. There should be no hidden charges. The DOH HFSRB, the Regional Licensing Enforcement Divisions of DOH CHDs, or the Regulation, Licensing and Enforcement Cluster of MOH-BARMM monitor[19] the compliance of all health facilities.

The price list includes, but is not limited to: type of accommodation, critical care unit, and emergency room; medical and surgical procedures; laboratory tests and imaging diagnostic tests; professional fees; drugs, medicines, and medical supplies; and health service packages. If applicable, the corresponding PhilHealth case rate packages and Z benefit packages, and the corresponding rates used by health maintenance organizations must be included on the publicly available price list.

Prices and fees may be presented as ranges. The price list can be presented in various forms, such as printed handout, menu booklet, interactive digital form, and posters. It must be readily available in conspicuous areas, such as the lobby, reception area, information kiosk, and business office.

The price list is updated by health facilities at least annually, or more frequently as needed. The date of the last update must be indicated. Moreover, the patient or patient's guardian must be informed of the price list upon admission or before provision of any health service or procedure.

All health facilities must submit the information regarding their prices and charges for all goods and health services, including professional fees, through the DOH Health Facility Price Advisory online system.[20] The availability of an updated price list is a requirement for issuance and renewal by DOH of a health facility's License to Operate or Certificate of Accreditation.

For health facilities not complying with the required public access to price information, penalties are imposed in accordance with existing guidelines on the One-Stop Shop Licensing System[21,22] and other relevant issuances or guidelines. Violations of provisions of other relevant laws, such as the Consumer Act of the Philippines, have corresponding penalties as well.

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Chapter X

Ensuring Good Governance and Accountability in Health

According to the World Bank, good governance is epitomized by predictable, open, and enlightened decision-making that is transparent; a bureaucracy imbued with a professional ethos; an executive arm of government accountable for its actions; and a strong civil society participating in public affairs; all behaving under the rule of law.[1]

The UHC Act highlights the importance of good governance and accountability to strengthen the implementation of UHC. First, it requires the declaration and management of conflict of interest of all persons involved in policy-determining and decision-making activities related to health. Likewise, the law requires the tracking of financial relationships of health care providers and health professionals with manufacturers of pharmaceuticals and other health products. It is imperative that such risks of conflict arising from either financial or non-financial relationships do not affect the integrity and impartiality of decisions relative to health policies, plans, and programs. Hence, a Public Health Ethics Committee is institutionalized to review conflict-of-interest declarations, and act as advisory body to the Secretary of Health in upholding ethical standards in public health practice.

Furthermore, to enable evidence-informed decision-making, all health, nutrition, and demographic-related administrative and survey data generated using public funds are made publicly available and accessible, subject to relevant provisions of the Data Privacy Act. In addition, the law requires a strong monitoring and evaluation system to track the performance of the health system and assess the accountability of stakeholders. The availability of data, and the monitoring and evaluation results, can also improve policy development and program planning, investment planning and budgeting, and advocating support from various stakeholders.

Ethics in Public Health Policy and Practice

The UHC Act mandates stakeholders to abide by ethical principles in public health practice[2]. As described in the law, this covers (1) declaration and management of conflict of interest; (2) tracking financial relationships between health and health-related commodity manufacturers, and healthcare providers and health professionals; and (3) creation of a Public Health Ethics Committee (PHEC) in DOH.

Conflict of Interest

Conflict of interest (COI) refers to acts or omissions arising from situations when public or private persons or entities involved in conducting research or making recommendations and decisions have substantial interest, whether personal, financial, or any other, that may influence their policy-determining activities.[3] In addition, the UHC Act's implementing rules define policy-determining activities as actions taken in aid of public policy development leading to impartial decisions in adopting and implementing a policy option or policy recommendation using best available evidence.[4]

DOH prescribes a clear, specific, and standard process in the declaration and management of COI by "covered individuals", or persons involved in policy-determining activities of agencies and advisory bodies and committees implementing the UHC Act. COI declaration and management aims to ensure integrity and impartiality in agency decisions, as well as address potential graft and corruption practices.

COI declaration and management are anchored on principles of public health ethics:

1. Beneficence - public health involves a moral obligation to promote and protect the welfare of individuals and communities.
2. Professionalism - public health institutions must ensure professional practice from their employees at all times.
3. Respecting rights of individuals and the community - public health must achieve community health in a way that respects the rights of individuals in the community.

COI may be classified into financial or non-financial interests (Table 10.1). *Financial interests* refer to monetary interests gained during the preceding five years, such as salary or other payments for employment or consultancy, or shares in a business that is being regulated by DOH. *Non-financial interests* refer to nonmonetary interests, such as career or personal advancement that may be perceived as unduly influencing one's judgment.

Table 10.1 Sources of Conflict of Interest

Type	Financial Conflict of Interest	Non-financial Conflict of Interest
Definition	Monetary interests which may be perceived to impair a person's ability to be impartial and act in the best interests of the government.	Non-monetary relationships that may be perceived as unduly influencing one's judgment.
Examples	• salary from employment • payments for services such as from consultancy or membership to advisory bodies • equity interest such as stocks or stock options • intellectual property rights • commercial sponsorships of events and other activities	• personal, religious or political beliefs • career advancement or promotion • institutional, organizational or business affiliations • personal advocacy or policy opinions • personal experiences

Source: DOH AO 2021-0011

a. Responsibilities of Covered Individuals

All covered individuals must accomplish the COI Declaration Form[5] where financial, non-financial, or any other interests relevant to their function, as well as any interest that can be affected by the outcome of their function, must be disclosed. They are also required to declare substantial interests (financial, non-financial, or any other interests) of their relatives up to the fourth civil degree of consanguinity or affinity[6] that may be perceived as unduly influencing their judgment.

Accomplished COI Declaration Forms are submitted, as prescribed by applicable policies, to the Heads of Office. Any falsification made in declaration forms or summary reports is to be dealt with according to law, such as but not limited to, the 2017 Revised Rules on Administrative Cases in the Civil Service as well as the Revised Penal Code.

b. Responsibilities of Heads of Office

The Head of Office, or his or her designated staff, collects and ensures the completeness of all declaration forms, accomplishes a summary report, and transmits these to the PHEC Secretariat of DOH. In case the Head of Office has a conflict of interest, this must also be immediately reported to the PHEC Secretariat.

c. Management of Conflict of Interest

A COI Management Plan describes the methods for reducing or eliminating identified COI. The presence of potential or actual COI does not mean the person with COI is automatically excluded from policy-determining activities. COI can actually be mitigated or eliminated.

The simplest way to manage COI is by declaring it. Declaring COI allows the person to realize the conflict and be conscious about this while making or acting on decisions. The user of information can also decide whether to accept or reject the information in view of the conflict of interest declared.

Examples of Actions to Manage Conflict of Interest

- public disclosure of interest
- modification of policy or program implementation plan
- severance of relationships that create interests (e.g., divestment of equity)
- change of personnel responsibility or reassignment of personnel
- definition of boundaries or prohibitions
- disqualification from involvement in discussions and decision-making activities

Other ways to minimize or eliminate the source of conflict is by reassigning the person with COI to tasks that will not influence policy-determining activities. That person may also be removed from the team, if the COI is found to have a high level of risk to influence one's judgment. For advisory bodies or committees, recusing from participating in discussions and decisions of the body or committee may be done.

Financial Relationships between FDA-licensed Establishments and Health Care Professionals and Providers

The UHC Act mandates all manufacturers of drugs, medical devices, and biological and medical supplies licensed by the Food and Drug Administration (FDA) to disclose and submit to DOH all financial relationships with health care providers and professionals[7]. Financial relationship refers to any form of emolument that may be contractual or noncontractual in nature such as, but not limited to, cash, cash equivalent, in kind, stock, stock option or any ownership interest, dividend, profit or other return of investment, and transfers of value.

a. FDA Online Disclosure Reporting System

FDA created the Online Disclosure Reporting System (ODRS)[8,9], which is an online submission platform for FDA-licensed manufacturers, traders, re-packers, distributor-importers, and distributor-wholesalers of drugs, medical devices, and biological and medical supplies. This is to ensure that financial relationships and ethical interactions between FDA-licensed establishments and health care providers and professionals are declared. This aims to guarantee that decisions are made for the best interest of the public. Transparency and disclosure make the clinical evaluation and approval of innovative health products, including formulation of regulatory policies, more efficient. These are seen to lead to more affordable and better access to basic and essential health care services, especially for marginalized sectors.

Examples of financial relationships that are required to be reported are as follows:

1. for health care providers, all sponsorship of events, research and educational grants; payment of services; space rentals or facility fees; and donations for patients;
2. for health care professionals, all donations, educational grants, and research funding; sponsorships related to events, travel, and accommodation; registration fees, honoraria, and support for continuing professional development; royalties; current or prospective ownership or investment interest; and consultancy and

speakership fees; among other health care professional services arrangements; and

3. payments to drugstores for disease awareness partnership programs; training of drugstore pharmacists conducted by companies; training of drugstore pharmacists conducted by third parties on behalf of companies; and similar nature of financial relationships.

These ODRS reports do not include regular commercial or trade transactions among drug or medical device outlets as well as hospitals, hospital pharmacies or clinics, and other establishments or organizations. However, PHEC may request for relevant information in the course of conducting investigations.

b. Responsibilities of FDA-licensed Drug and Medical Device Establishments

All manufacturers, traders, re-packers, distributor-importers, and distributor-wholesalers of FDA-registered drug, medical device and biological products, and medical supplies are required to document, disclose, maintain records, track, and submit all their financial relationships directly or indirectly made with health care providers and professionals, both in the private and public sectors. They are mandated to establish and maintain an electronic database, procedures, and system on financial relationships. Disclosure reports are updated and submitted semiannually through the ODRS: for the first semester, every fifteenth of July of the same year; and for the second semester, every fifteenth of January of the following year.

Failure to submit and update disclosure reports on the part of the manufacturers, traders, re-packers, distributor-importers, and distributor-wholesalers constitute violation of the UHC Act and can be a basis for PHEC investigation and FDA inspection. In this line, FDA may institute penalties based on the provisions of the FDA Act of 2008[10] and other relevant laws.

c. Responsibilities of Food and Drug Administration

FDA maintains and secures data reports submitted through the ODRS. As requested, FDA provides PHEC updated reports for the purpose

of determining potential or actual conflict of interest, especially when assessing, evaluating, or monitoring government or DOH projects or programs.

Public Health Ethics Committee

The UHC Implementing Rules and Regulations mandates the creation of the PHEC as an advisory body to the Secretary of Health to help assess the ethical soundness of public health practice. PHEC is tasked to monitor and manage COI declarations as well as the tracking of relationships of drug manufacturers, medical devices, and biological and medical supplies with health care professionals and providers[11]. PHEC's main objective is to ensure that risks of conflict arising from actual, perceived, or potential financial and non-financial relationships of individuals, groups, organizations, and institutions do not affect DOH's decision-making process relative to policies, plans, and programs.

a. Composition and Responsibilities of the Public Health Ethics Committee

PHEC is composed of a public health expert, an ethics advisor, a lawyer not affiliated with DOH, a representative from a nongovernment organization or patient groups, and a lay person. Committee members undergo nomination, screening, and selection. They are appointed by the Secretary of Health for a three-year term. They may be reappointed for another three years. To ensure continuity of functions, at least half of the current members must be retained or reappointed for one year before a new set is appointed.

PHEC determines the presence of actual or potential COI and financial relationships among individuals involved in the development, institutionalization, financing, procurement, implementation, and evaluation of public health programs, projects, and activities. The committee checks, keeps track, addresses, and manages all COI declaration reports and determines actual and potential COl that can affect or impact DOH and other government health-related projects, programs, activities, commitments, or events. It also provides recommendations or actions to manage or eliminate actual or potential COI. PHEC also conducts

inquiries as may be necessary to address COI. The committee also provides recommendations to the Secretary of Health based on its review of COI declaration forms and other supporting documents.

The PHEC Secretariat, guided by the PHEC Chairperson, reviews the submitted documents and determines whether the declared COI is significant based on set criteria. The PHEC Secretariat uses records of financial relationships of manufacturers of drugs, and data on medical devices and biological and medical supplies being collected and tracked by FDA, to verify information in relation to the submitted declarations.

b. Review Process of the Public Health Ethics Committee

Prior to actual PHEC review, the preceding steps are identification of actual or potential COI; agreement between declaring person and Head of Office on a COI Management Plan; and submission of COI declaration and management plan to the committee.

The PHEC review process (Figure 10.1) commences upon the submission of documents to the PHEC Secretariat. The secretariat checks the completeness of submitted documents and evaluates them according to set criteria. Significant COIs, as determined by the secretariat, are reviewed by PHEC. The committee then recommends an appropriate course of action.

Figure 10.1 Key Steps in the Public Health Ethics Committee Process

Upon assessment, a concerned individual's participation in a deliberation or decision-making process can be categorized as full participation, partial participation, or total exclusion. *Full participation* allows a concerned individual to actively take part in all activities and decision-making processes. *Partial participation* limits him or her to actively take part only in certain activities and decision-making processes, subject to the approval of members fully participating. *Total exclusion* prohibits a concerned individual from taking part in any step of the deliberation and decision-making process. The PHEC reports its recommendations to the Secretary of Health.

Making Public Health Data Publicly Available and Accessible

Health data is vital to ensuring good governance and accountability. It enables evidence-informed decision making, which affects the overall quality of health services. However, data must be timely, transparent, accurate, and useful. Such data are also crucial in monitoring and evaluating the implementation of the UHC Act.

The UHC Act mandates all health, nutrition, and demographic-related administrative and survey data generated using public funds to be considered public records and thus publicly accessible, unless otherwise prohibited by law. In addition, any person who requests a copy of such public records may be required to pay the actual costs of reproduction and copying.[12] To implement this mandate, DOH and the Philippine Statistics Authority (PSA) jointly issued guidelines to make publicly funded data as public record, and to define the roles of concerned government agencies in this regard[13].

Covered Public Data

Covered public data are publicly funded health, nutrition, and demographic-related administrative and survey data approved by the PSA Board to be made public record.

Administrative data are information held by offices in the government, collected and used for nonstatistical purposes. It is the byproduct of administrative data systems, developed primarily for administrative

and operational purposes, such as registration, transaction, and record-keeping.[14] Examples of administrative data on health are Field Health Service Information System (FHSIS), DOH registries, vital statistics reports, and PhilHealth claims.

Survey data are obtained from a sample of a population used to estimate their characteristics through the systematic use of statistical methodology.[15] Examples of survey data may include those from research results, such as the National Demographic and Health Survey and the National Nutrition Survey.

Roles and Responsibilities of Implementing Agencies

There are several agencies designated to implement the guidelines in making data publicly available and accessible.

The Interagency Committee on Health and Nutrition Statistics (IACHNS), established through a PSA Board Resolution, reviews the proposed list of covered public data and recommends it to the PSA Board. To assist the IACHNS, a technical working group was created to identify and endorse a list of sources for all publicly funded health, nutrition, and demographic-related administrative and survey data. The technical working group updates the list annually or as may be deemed necessary.

Based on the recommendation of IACHNS, the PSA Board issues a resolution approving the list of data and enjoins all government agencies and instrumentalities to make it publicly accessible. National government agencies ensure that public records identified are generated in public use files readily made available for access by the general public, other

Public Use File

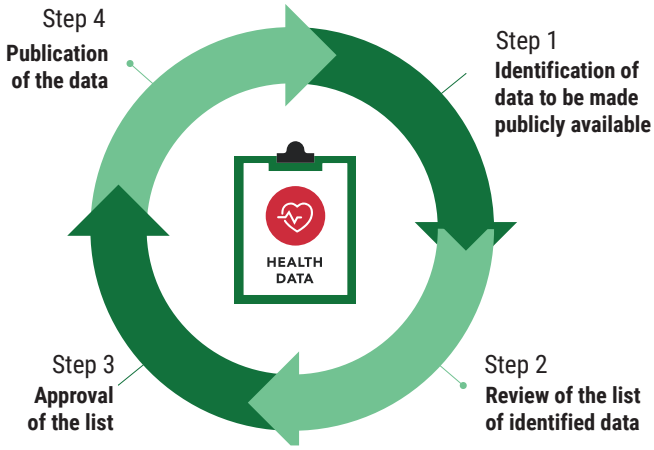
- Public use files are data files characterized by low disclosure risk or anonymized data. They are prepared and shared to provide access to full coverage of data for maximum utilization of data users.
- Low disclosure risk is when the risk that released records can be linked to specific respondents are kept low.
- Anonymized data refers to a type of information in which data anonymization tools encrypt or remove personal identifiable information from datasets for the purpose of preserving data subject's privacy.

government agencies, and other entities. They also facilitate the requests of individuals or entities to access covered public records.

Steps in Making Public Health Data Available and Accessible

There are four steps in making covered public data available and accessible, which are repeated when the approved list of data is updated annually or as may be deemed necessary (Figure 10.2).

Figure 10.2 Steps in Making Public Data Available and Accessible



Step 1. Identification of data to be made publicly available - determination by technical working group of all publicly funded health, nutrition, and demographic-related administrative and survey data; their adherence to statistical standards; and their metadata and relevance to policy making, including the monitoring of the UHC Act;

Step 2. Review of the list of identified data - consultation, validation, and confirmation of the list by IACHNS with different agencies that generated the data;

Step 3. Approval of the list - issuance of a resolution by PSA Board approving the list of covered public data, and enjoining all government agencies and instrumentalities to make this available and accessible to the public with due consideration to the Data Privacy Act; and

Step 4. Publication of the data - posting of data by national government agencies through their official websites, which must be properly linked to PSA and DOH websites for greater public accessibility; includes all microdata and metadata of the approved list of data in public use files, which are made available in either electronic format or hard copies.

Metadata and Microdata

- Metadata is a set of data that describes and gives information about other data.
- Microdata are unit-level data obtained from sample surveys, censuses, and administrative systems

Access to Covered Public Data

The process of requesting public data must also be in accordance with processes and provisions under the Executive Order on Freedom of Information[16]. The public can get a copy of the covered public data free of charge. However, they may be required to shoulder reproduction and copying costs.

Individuals, entities, or agencies that access and use these data need to observe that documents, notes, papers, records, researches, or other publications on any materials included in the covered public record are protected by copyright laws, vested exclusively on the creator of the material, and cited accordingly with the title of public record, source, and date of publication.

Individuals, entities, or agencies that fail to comply with the provisions of this policy will be penalized according to the Data Privacy Act and the Executive Order on Freedom of Information, and other related laws. A Data Sharing Agreement may also be executed between PSA and DOH, or any other Agency Data Source, to cover the rules on online access to data; transfer of data from Agency Data Source to another agency; and security of data and responsibilities of the parties, so as to avoid unauthorized collection, use, disclosure, or access to data.

Universal Health Care Monitoring and Evaluation

The UHC Act specifies the mechanisms to monitor and evaluate its implementation. A Joint Congressional Oversight Committee on Universal Health Care, composed of legislators from the House of Representatives and the Senate, is mandated to conduct a regular review of the implementation of the Act.[17] This review includes a systematic evaluation of performance and impact.

The National Economic and Development Authority, in coordination with PSA, National Institutes of Health, and other academic institutions will undertake studies to validate and evaluate the accomplishments related to the UHC Act. These validation studies and annual reports on the performance of DOH and PhilHealth will be submitted to the oversight committee. PSA is also required to conduct an annual household survey module during the first 10 years of the law's implementation.[18]

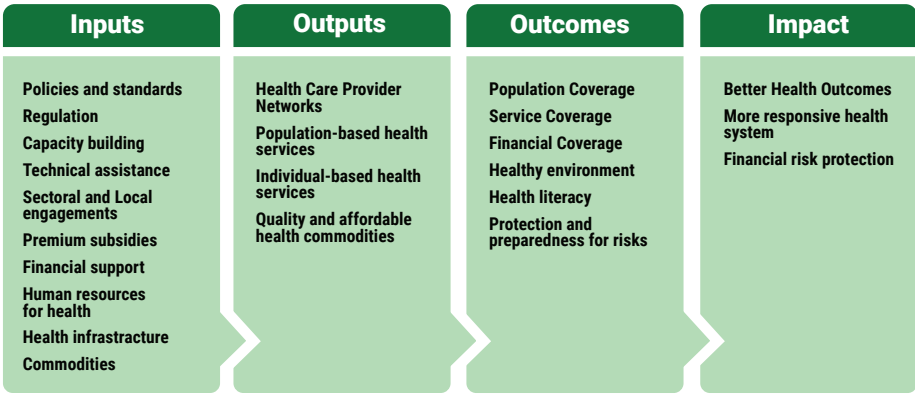
The law and its implementing rules and regulations also mandate the creation of a Performance Monitoring Division, as well as performance monitoring units at the regional levels and in all DOH hospitals, to develop an inclusive and effective platform in assessing the performance of the health sector.[19] In this line, the Performance Monitoring and Strategy Management Division was created under the DOH Health Policy Development and Planning Bureau in 2020. To identify the type of data to be collected and analyzed, and to guide how the performance of the health system will be monitored and evaluated, DOH issued the UHC Monitoring and Evaluation (M&E) Framework.[20]

UHC Monitoring and Evaluation Framework

The UHC M&E Framework describes the relationship and expected effects of investments and reforms on identified health outcomes. It is the basis of reporting the progress of implementation and designing evaluation activities for UHC. Further, results of M&E can be used in planning to identify accountability and in advocating support from various stakeholders.

The UHC M&E Framework uses the Logical Framework or LogFrame (Figure 10.3). This enables easier use and communication of results from the necessary inputs to produce the targeted outputs in the health sector, and to the outcomes and impact on population.

Figure 10.3 UHC Monitoring and Evaluation Framework



Inputs are the resources needed to implement the program. These come from various stakeholders: DOH, LGUs, private sector, civil society organizations, international health partners, and other implementers of health programs. DOH provides policies, standards, and regulation; capacity building and technical assistance; and sectoral and local engagements. LGUs and the private sector are responsible for human resources, infrastructure, and commodities for health. DOH also provides financial support for high poverty and other priority areas, while the national government provides premium subsidies to PhilHealth to cover indirect contributors.

Outputs are the goods and services provided by the health system to the population as a result of the activities and processes using the inputs or resources. The identified outputs in the UHC Act that must be made available to our citizens include, among others, organized health care provider networks, provision of population-based and individual based health services, and availability of quality and affordable health

commodities. Inputs from all stakeholders are needed to generate these outputs. Among the different components of the LogFrame, outputs need to be more effectively monitored.

Outcomes are the measures of coverage or access of health services among the general population or target population. The outcomes are the three dimensions of universal health coverage – population coverage, service coverage, and financial coverage. It also includes healthy environment, health literacy, and preparedness for risk, which are social determinants outcomes.

Impact measures the health status of the population, reflecting the effect of all efforts towards the achievement of the goal. The impact of UHC is better health outcomes, more responsive health system, and financial risk protection, which are the major goals of the health sector. Health is multidimensional as it is affected not only by physical, social, and economic conditions, but also by political, environmental, cultural, and even philosophical factors. Impact is not only because of efforts of the health sector alone. It is the result of all efforts at the level of the individual, community, whole of government, and whole of society.

Implementing UHC Monitoring and Evaluation

Monitoring implementation ensures timely action from implementing units. In the short- and medium-term, expected effects will be primarily on the inputs and outputs of the health sector. Effects of the UHC Act on the outcomes will be observed in the long-term.

Monitoring UHC does not require the creation of a new system or one that is separate from existing monitoring systems in the health sector. The goal is to have a streamlined and efficient monitoring system. Thus, UHC monitoring has been integrated into existing M&E systems, such as the performance assessment of the National Objectives for Health (NOH), DOH's Budget Accountability Reports (BAR), various scorecards, and local health systems maturity level monitoring (Table 10.2). DOH will also publish an annual monitoring report to document and disseminate the progress of UHC implementation based on identified indicators.

Table 10.2 UHC Monitoring Systems per LogFrame Component

Responsible Unit	Monitoring System	Input	Output	Outcome	Impact
DOH	Performance Governance System Scorecard	✓	✓		
	DOH Hospital Scorecard	✓	✓		
	Budget Accountability Report	✓	✓	✓	
	Performance Assessment of the National Objectives for Health		✓	✓	✓
PhilHealth	PhilHealth Scorecard	✓		✓	
LGU	Local Health Systems Maturity Level Monitoring	✓	✓		
	LGU Health Scorecard	✓	✓	✓	✓
	LGU Hospital Scorecard	✓			
Health partners	Health Partner Scorecard	✓			

Evaluation is the other process needed to assess program performance, particularly for a program or project that is new and subject to expansion. For example, only some provinces, and highly urbanized and independent cities have currently committed to integration. Eventually, an evaluation is necessary to determine the effectiveness of UHC strategies and the appropriateness of expanding the integration process to the remaining provinces, and highly urbanized and independent cities.

A comprehensive impact evaluation is best done by an independent institution to ensure objectivity and adequate capacity. Similar to the plans of other programs, the M&E plan for UHC should be established before implementation starts so that necessary monitoring mechanisms are in place, and baseline data are collected. Results of the evaluation will be publicly available, not only for dissemination of knowledge but more importantly, for transparency and accountability.

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