The Republic of the Philippines

The Republic of the Philippines
Preparatory Survey on
Ambulatory Surgical Center and Hospital
Development Project
(PPP Infrastructure Project)
Final Report

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Japan International Cooperation Agency (JICA)

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LIST OF ABBREVIATIONS	
AAB	Authorized Agent Bank
ADB	Asian Development Bank
AHA	the Aquino Health Agenda
AHMOPI	the Association of Health Maintenance Organizations of the Philippines
ASC	Ambulatory Surgical Center
ASEAN	Association of South‐East Asian Nations
AZ	Azusa-Sekkei
BHFS	Bureau of Health Facilities and Services
BHS	Basic Healthcare Services
BIR	Bureau of Internal Revenue
BoC	Bureau of Customs
BOD	Biochemical Oxygen Demand
BPLO	Business Permit and Licensing Office
BSP	Central Bank of the Philippines
BTr	Bureau of the Treasury
CBD	Central Business District
CCO	Chemical Control Orders
CEO	Chief Executive Officer
CF	Cash Flow
CFA	Construction Floor Area
CHD	Center for Health Development
CHT	Community Health Team
CON	Certificate of Need
COR	Certificate of Registration
CPI	Consumer Price Index
CTC	Community tax certificate
CTO	City Treasurer's Office

DA	Department of Agriculture
DAO	DENR Administrative Order
DENR	Department of Environment and Natural Resources
DepEd	Department of Education
DILG	Department of Interior and Local Government
DND	Department of National Defense
DOF	Department of Finance
DOH	Department of Health
DOTC	Department of Transportation and Communications
DOTS	the Directly Observed Treatment Shortcourse
DPWH	Department of Public Works and Highways
DSG	Design Standards and Guidelines
DST	Documentary Stamp Taxes
DSWD	Department of Social Welfare and Development
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortization
ECA	Environmentally critical areas
ECC	Employees Compensation Commission
ECC	Environmental Compliance Certificate
ECP	Environmentally Critical Projects
NPO	Non-Profit Organization
EIS	Environmental Impact Statement
EMB	The Environmental Management Bureau
EMS	Electronics Manufacturing Services
EPC	Engineering, Procurement and Construction.
EPRMP	Environmental Performance Report and Management Plan
ESR	Event-based Surveillance and Response
GAIA	Global Alliance on Anti-Incinerators
GDP	Gross Domestic Product
GEF	Global Environmental Funds

GLA	Gross Leasable Area
GLO	Globe telecom Inc.
HC	Healthcare
HCWH	Healthcare without Ham
HFEP	Health Facility Enhancement Program
HMO	Health Maintenance Organizations
ICU	Intensive Care Unit
IDs	Individual Doctors
IEE	Initial Environmental Examination
IP	Interest Payments
JICA	Japan International Cooperation Agency
KP	Kalusugan Pangkalahatan
KPI	Key Performance Indicators
KRA	Key Result Areas
LGC	Local Government Code
LGU	Local Government Units
LRT	Light Rail Transit
LTO	License to Operate
MC	Memorandum Circular
MC	Mitsubishi-Corporation
MCH	Maternal Child Healthcare
MERALCO	Manila Electric-Railway and Light Co.,
MMDA	Metro Manila Development Authority
MRF	Materials Recovery Facility
NCR	National Capital Region
NG	the National Government
NGOs	Non-Governmental Organizations
NHIP	the National Health Insurance Program
NSO	the Philippines National Statistics Office

O&M	Operation and Maintenance
ODA	Official Development Assistance
OEM	Original Equipment Manufacturers
OSS	One-Stop Shop
OY	Operational Year
PCAHO	Philippine Council on the Accreditation of Healthcare Organizations
PCD	Printer's Certificate of Delivery
PCO	Pollution Control Officer
PD	Presidential Decree
PD	Project Description
PEIS	Programmatic Environmental Impact Statement
PEISS	Philippine Environmental Impact Statement System
PEPRMP	Programmatic Environmental Performance Report and Management Plan
PHIC	the Philippine Health Insurance Corporation
PNR	Philippine National Railways
POC	Pollution Control Officer
PPP	Public Private Partnership
PSIF	Private Sector Investment-Finance
PTC	Permit to Construct
PwC	PricewaterhouseCoopers
PWDs	Persons With Disabilities
RA	Republic Act
RGM	Rapid Growth Markets
RHU	Rural Health Unit
RVU	Relative Value Unit
SATS	Semiconductor assembly and test services
SEC	Securities and Exchange Commission
SHA	Share Holders Agreement
SPC	Special Purpose Company

SPEED	Surveillance in Post Extreme Emergencies and Disasters
SSS	Social Security System
STP	Sewage Treatment Plant
TCT	Transfer Certificate of Title
TIN	Taxpayer Identification Number
TSP	Total Suspended Particulates
UN	United Nations Special Division
UNDP	United Nations Development Program
UPMI	the University Physicians Medical Center
VAT	Value Added Tax
WACC	Weighted Average Cost of Capital
WHO	World Health Organization

Part1: NEEDS AND BACKGROUND OF THE PROJECT

Chapter 1-1 Analysis of current situations

1.1.1 Background and objectives of the project

1.1.1.1 Objective of the Project

This project aims to provide affordable and efficient healthcare services to the growing middle class. The project under this report aims to support the development, construction and operation of the selected two hospitals in Metro Manila

1.1.1.2 Rationale for the Use of Private Sector Investment Finance

JICA's PSIF is expected to be provided to the project. The rationale for the use of PSIF is that 1) the goal of the project meets both Filipino and Japanese development and partnership policies, and 2) building, operating and managing private hospitals, which are to provide more affordable and efficient healthcare services to the emerging middle class in rapidly growing Philippines, will be better done with Japanese know-how; JICA's technical assistance for medical and operational capacity development and the Study Team's advisory in construction, procurement and inventory control and business management. More details are shown below;

(1) Filipino and Japanese policies related to development and partnership

1) The Philippines

The Philippines developed the 'Philippine Development Plan 2011-2016', whose aim includes the achievement of universal healthcare. The government has taken various actions such as the enactment of the Sin Tax Law and implementation of Health Facility Enhancement Program (HFEP). However, the progress is still slow against the remaining challenges such as high population growth, disparity in health service delivery and utilization, fragmentation in health financing and service delivery, etc. The country's health system remains underfunded, as DoH budget aiming for upgrading health facilities is not fully admitted[1]. Therefore, the government still needs to largely focus on the poor, while the middle-class population is rapidly growing[2], as the attainment of goals to realize affordable

[1] For example, in 2011, Department of Budget and Management approved 1.4 billion pesos for DoH budget, one sventh of 9.6 billion pesos DoH applied for upgrading health facilities of 66 hospitals.

2 The middle-class population in the Philippines increased from 44% of the population in 1988 to 54% in 2006, which amounts to around 45

healthcare for all Filipino, the objective of National Health Insurance Act of 1995, has not been achieved[3]. Under these circumstances, the Filipino Government recognizes the private sector as a partner especially "in pursuing development objectives" as declared in the 1987 Constitution. The construction of hospitals by private sector has been also promoted since the improvement of social infrastructure is one of the most urgent issues raised in the Development Plan. Also, Health Facility Enhancement Program (HFEP) includes both public and private hospitals in its unified plan as bed to population ratio in the Philippines is lagging behind compared to the ASEAN countries and this situation seems difficult to be solved only with the initiatives led by DoH and municipal governments.

2) Japan

One of the priority areas of the Country Assistance Policy for the Philippines, developed by the Ministry of Foreign Affairs of Japan, is focused on 'Overcoming Vulnerability and Stabilizing bases for Human Life and Production Activity', whose approach includes 'the development of safety nets including healthcare'. The Japanese Government also states as one of its strategic goals "contribution utilizing Japan's healthcare industry and its technology" under "International Healthcare Development Strategy" announced in June 2013. It also should be noted that the Philippines is Japan's important partners for economic development as the country's location can serve as a hub of maritime activities of the East Asian countries and it is achieving strong economic growth with the English speaking population and abundant cheap and young labor force. The Philippines and Japan announced a Joint Statement on the Comprehensive Promotion of the "Strategic Partnership" between Neighboring Countries Connected by Special Bonds of Friendship in 2011. A number of Japanese companies have started business and are economically active in the Philippines.

(2) Development of private hospitals to serve growing middle class with Japanese know-how

The country's health sector is a public-private mixed system with the private sector dominating the market' and its private health expenditure is about 2.85% of GDP in 2012, which is approximately 65% more than that of the government[4]. Private hospitals' facilities

million people. As the ADB's 47th Annual Meeting emphasized the importance of fostering the middle class for healthier economic growth.

[3] Following the enactment of The National Health Insurance Act of 1995, a series of healthcare reform initiatives have been introduced to achieve Universal Health Care for all Filipinos, e.g. Health Sector Reform Agenda (HSRA) in 1999, FOURmula One for Health in 2006, and Aquino Health Agenda in 2010 by President Ninoy Aquino. Please refer to 1.1.3.6 Medical Insurance Systems.

4 http://www.wpro.who.int/health_services/service_delivery_profile_philippines.pdf

are generally perceived as better than public hospitals'[5], and it is estimated that almost half of the population who needed inpatient care was confined in private hospitals according to the DOH[6]. It is important to note that non-poor families including the middle class are more likely to use private facilities unlike poor families who rely more heavily on public ones[7] (e.g. an estimation shows that 42% of the population went to private health facilities in 2008[8]).

However, even though the private hospitals are of great importance in order to serve the increasing middle-class and wide range of diseases, and to deal with inpatient care and patients who are referred to by public providers in need of specialized care or special facilities such as ICU[9], it has been observed that the number of private hospitals decreased from 1,194 in 1980 to 1,082 in 2010 (-9.4%)[10] and the number of beds has been falling, too[11].

Japanese know-how in construction and operation of hospital and technical assistance will enable the new hospitals to provide affordable care to a wider range of population, mainly the emerging middle class who are the drivers of the Philippines's development.

More detailed social and economic situation of the Philippines are given in the section 1.1.5 onwards and Ch. 2.7.

1.1.1.3 PPP Feasibility Study

The JICA study team has conducted a Feasibility Study (hereinafter referred to as "F/S" or the "Study") to determine where the project is socially and economically viable, and to develop a better project scheme in collaboration with the Filipino counterparts. The study team's proposal aims to build a flagship hospital model for the Philippines by exporting Japanese healthcare services.

(1) Study Period

The Study has been conducted since June 2014 and is planned to be concluded in February

5 Same as above

6 http://dirp4.pids.gov.ph/ris/dps/pidsdps1105.pdf

7 Financing Health Care For Poor Filipinos. Working Paper Series No. 2004-8 (World Bank Working Paper); Solon, Orville, Quimbo, S. A. and Panelo, C. I. A., 2003

8 http://www.wpro.who.int/asia_pacific_observatory/hits/series/phl_living_hits_2_5_2_health_facility_planning.pdf

9 http://www.wpro.who.int/health_services/service_delivery_profile_philippines.pdf

10 In 2004, mandatory Certificate of Need has been introduced for establishing new hospitals. As this regulation has started to be recognized as an impediment for private hospital establishments, the regulation has been abolished for private hospitals in 2013. This regulasion is thought to be a background for the decrease in the number of private hospitals.

11 http://www.wpro.who.int/asia_pacific_observatory/hits/series/phl_living_hits_2_5_2_health_facility_planning.pdf

2015.

(2) Objective

The study has been conducted to develop a detailed business plan for the project, which includes demand forecast, business scope, cost estimation, financing structure, implementation schedule, construction method, organizational structure, O&M structure, socio-environmental impact and expected outcomes, and to provide JICA with necessary information for the PSIF screening.

(3) Study Team Structure

The study has been conducted by a consortium composed of MC, Azusa Sekkei (hereinafter referred to as "AZ") and PricewaterhouseCoopers (hereinafter referred to as "PwC"). The profiles of each company are as follows;

1) **Mitsubishi Corporation (MC):** As a prospective investor, MC has been in charge of business planning and scheme development. MC is a global integrated business enterprise that develops and operates businesses across various industries including environmental and infrastructure, industrial finance, hospital development/management support and etc.

2) **Azusa Sekkei (AZ):** AZ has developed basic design, construction plan and more detailed facility plan of the hospitals and provided cost estimates based on the operation plan. AZ has been engaged in a number of hospital construction projects and shared its expertise in about 40 other countries worldwide through Japan's ODA program.

3) **PricewaterhouseCoopers (PwC)**: PwC's Public Private Partnership (hereinafter referred to as "PPP") team and healthcare (hereinafter referred to as "HC") team have jointly supported MC for the business and scheme development. PPP team, with a great deal of experience in PPP/PFI (Private Finance Initiatives) market including hospital business and JICA projects as an exclusive financial advisor, has conducted legal, risk and financial analysis and developed a cash flow model. HC team on the other hand has conducted situation analysis and provided consulting services on hospital business. PwC is a global firm that provides industry-focused assurance, tax and advisory & consulting services to its clients and their stakeholders, with member firm offices in 157 countries.

(4) Study Schedule

The schedule of the study and the report submission is as follows;

Year	2014								2015	
Month	5	6	7	8	9	10	11	12	1	2
Development of base case		[redacted]								

Development of specific business plans		■	■	■	■	■	■	■	■	■
Examination for the expansion of the model business structure								■	■	
Environmental and social considerations					■	■	■	■		
Reports		▲ IC/R				▲ IT/R		▲ DF/R		▲ F/R

Source: JICA Study Team

1.1.2 Environment of the Philippines

1.1.2.1 History of the Philippines

The history of the Philippines can be sub-divided into: (1) Pre-Spanish Rule, (2) Spanish Colonial Rule, (3) American Rule, (4) The Philippine Republic, (5) Martial Law, and (6) Post-Martial Law to Present Time.

(1) Pre-Spanish Rule

The Austronesian-speaking people were the early inhabitants of majority of Southeast Asia and Oceania. They include the ethnic groups of Philippines, Malaysia, Indonesia, Taiwan, and other countries in the region. The Philippine archipelago was believed to have been settled at least 30,000 years ago. The basic communal unit was the barangay, which denoted a kinship group headed by a datu (chief). Prior to the Spanish colonization, the Philippines already had a thriving socio-economic system where they were trading with the Chinese and Japanese. Islam was introduced into the country by traders from the neighboring islands[12].

(2)Spanish Colonial Rule

In 1521 Ferdinand Magellan arrived in the Philippines during his circumnavigation of the globe, and in 1565 the Spanish established their first settlement in Cebu. In 1571, the Spanish set up their capital in Manila. During the Spanish colonial rule, Christianity became the dominant religion and trade centered around Galleon trading until 1815 when the Royal Company of the Philippines promoted direct and tariff-free trade between Spain. In1834, Free Trade was formally established in the Philippines and Manila became a bustling port servicing Asia, Europe, and North American traders. During this time, tobacco, abaca, and sugar were the dominant Philippine exports[13]. The Spanish rule was weakened

12 Country Profile: Philippines. (2006, March). (Division, Library of Congress - Federal Research) Retrieved October 2014, from The Library of Congress: http://lcweb2.loc.gov/frd/cs/profiles/Philippines.pdf

13 Philippines. (2006, March). (Division, Library of Congress - Federal Research) Retrieved October 2014, from The Library of Congress:

by the rise of nationalism through the writings and propaganda movement of the Ilustrados (Filipino elite and educated class) and the increasing activity of revolutionaries' intent on gaining national independence. One prominent Ilustrado was Jose Rizal, the national hero of the Philippines, and the most prominent revolutionary group was the Katipunan led by Andres Bonifacio and Emilio Aguinaldo. In 1897, the Spanish troops defeated the insurgents. The 336 years of Spanish Rule ended after the Spanish-American War, where Spain ceded the Philippines to the United States of America through the signing of the Treaty of Paris. On 12 June 1898 Aguinaldo issued a declaration of independence, and in 1989 the Malolos revolutionary congress promulgated a constitution that inaugurated Aguinaldo as the first Filipino president of the republic.[14]

(3)American Rule

A guerilla war broke out between the Filipino insurgents, led by Aguinaldo, and the Americans as a result of the United States not recognizing the Philippines' independence. In 1901, Aguinaldo was captured and swore allegiance to the United States. In the same year, William Howard Taft was appointed as the first U.S. governor of the Philippines, and his commission was granted legislative and executive powers. During this time the Philippines saw the establishment of a judicial system with a legal and municipal code, a constabulary, and a civil service. In 1916 the United States passed the Jones Act which established an elected Filipino legislature, composed of the House of Representatives and the Senate. In 1934 the US passed the Tydings-McDuffie Act which provided a transition period towards independence in 1946. This was also the means towards establishing a commonwealth in the Philippines. In 1935 Manuel L. Quezon was elected to the position of President of the Philippine Commonwealth.[15]

American rule was disrupted by the Japanese occupation of the country during World War II. The Commonwealth government went into exile in the United States and a guerilla war ensued between the Filipinos and the occupying forces. In 1944 the combined American and Filipino forces returned and liberated the country. In 1946 the Philippines became independent and the Republic of the Philippines was born. (Library of Congress - Federal Research Division, 2006)[16]

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http://lcweb2.loc.gov/frd/cs/profiles/Philippines.pdf

14 Philippines. (2006, March). (Division, Library of Congress - Federal Research) Retrieved October 2014, from The Library of Congress: http://lcweb2.loc.gov/frd/cs/profiles/Philippines.pdf

15 Philippines. (2006, March). (Division, Library of Congress - Federal Research) Retrieved October 2014, from The Library of Congress: http://lcweb2.loc.gov/frd/cs/profiles/Philippines.pdf

16 Philippines. (2006, March). (Division, Library of Congress - Federal Research) Retrieved October 2014, from The Library of Congress: http://lcweb2.loc.gov/frd/cs/profiles/Philippines.pdf

(4) The Philippine Republic

The United States of America ceded sovereignty to the Philippines on 4 July 1946, and Manuel Roxas was elected as the first president of the Republic of the Philippines. Since then general popular elections have been held, and the following presidents of the Philippines were elected: Elpidio Quirino, Ramon Magsaysay, Carlos P. Garcia, Diosdado Macapagal, and Ferdinand Marcos who later on established martial law.

Figure 1.1.1 Map of the Philippines

(5)Martial Law

In 1972 Marcos declared Martial law by virtue of Proclamation No. 1081. This curtailed civil liberties, closed Congress and media establishments, and resulted in the arrest of opposition leaders. During this time widespread corruption and civil unrest contributed to the decline of the economy. In 1983 opposition leader Benigno Aquino was assassinated and his widow, Corazon Aquino, decided to run for office. Martial Law ended with the People Power Revolution – a bloodless civilian-military uprising. This installed Corazon Aquino as president of the Philippines in 1986.[17]

(6)Post Martial Law to Present Time

Upon installation, then President Corazon Aquino ratified a new constitution in 1987 which restored the Presidential form of government and a bicameral congress. Her presidency was followed by the administrations of Fidel Ramos, Joseph Estrada who was later on impeached, Glorai Macapagal-Arroyo, and Benigno Aquino III - the present president of the Republic of the Philippines.

17 http://www.philippine-history.org/

1.1.2.2 Geography

The Philippines is located in the Southeast Asian archipelago between the Philippine Sea and the South China Sea, as seen in Figure 1. The country is comprised of 7,107 islands with a total area of 300,000 square kilometers, total land area of 298,170 square kilometers, and total water area of 1,830 square kilometers. These islands are divided into three major island groups, named Luzon, Visayas and Mindanao. From Tokyo to manila, it takes 4 to 4.5 hours by airplane. Because of the country's geographic features, various modes of transportation play distinct roles in the movement of freight and passengers in the country. Water and road transport dominate the flow of goods and people, respectively. Railways and air transport modes have their respective markets and geographic coverage.[18]

1.1.2.3 Climate

The climate of the Philippines is described as tropical and maritime. It is characterized by relatively high temperature, high humidity and abundant rainfall. This can be divided into two major seasons, namely the rainy and dry season. Rainy season is from June to November and dry season is from December to May. Typhoons have a great influence on the climate and weather conditions of the Philippines. A great portion of the rainfall, humidity and cloudiness are due to the influence of typhoons. The mean annual rainfall of the Philippines varies from 965 to 4,064 millimeters annually.[19] Monthly temperature and rainfall in Manila are shown in table and figure below.

Figure 1.1.2 Historical Monthly Rainfall and Temperature in the Philippines

Source: World Bank Climate Change Knowledge Portal (1990-2009)[20]

18 The World Factbook. Map of the Philippines. Retrieved October 2014, from https://www.cia.gov/library/publications/the-world-factbook/geos/rp.html

19 Climate of the Philippines. (n.d.). Retrieved September 2014, from Philippine Atmospheric, Geophysical, and Astronomical Services Administration: http://kidlat.pagasa.dost.gov.ph/cab/climate.htm

20 The World Bank. (2014.). Average Monthly Temperature and Rainfall in the Philippines from 1990-2009. Retrieved October 10 2014,

1.1.2.4 Demography

(1) Philippine Population

Based on the data from the National Statistics Office, the population of the Philippines was estimated at 100,617,630 as of July 27, 2014. The annual average growth rate increased from 1.9% year 2000 to 2010. As of 2014, the Philippines had become the 12th most populous country in the world.[21] 2014 data from the UN World Population Prospects illustrates trends and projections for the Philippine population, as shown in the graph below.

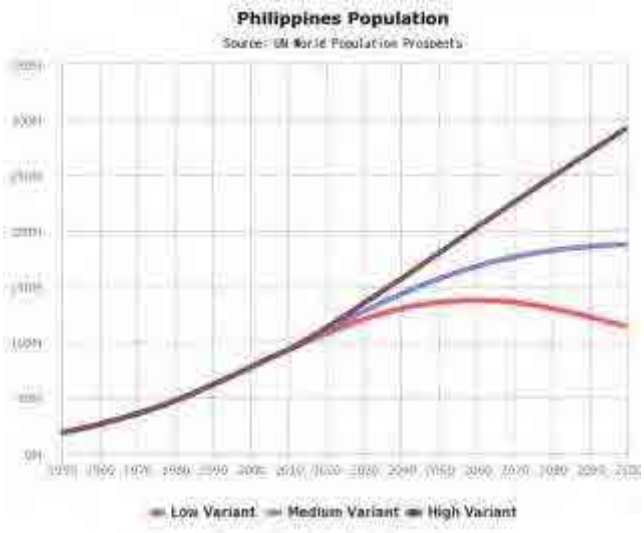

Figure 1.1.3 Philippines Population

Source: UN World Population Prospects, 2014
http://sdwebx.worldbank.org/climateportal/index.cfm?page=country_historical_climate&ThisRegion=Asia&ThisCCode=PHL

According to data from the UN[22], the life expectancy at birth of Filipino males and females, born from 2010 to 2015, are at 66.0 and 72.6 years respectively, and the birth rate is at 24.24 births/1,000 population (est. 2014)[23].

Together with the increase in the country's population, the population of the middle class

from http://sdwebx.worldbank.org/climateportal/index.cfm?page=country_historical_climate&ThisRegion=Asia&ThisCCode=PHL

21 Philippines Population 2014. (2014). Retrieved October 2014, from World Population Review:
http://worldpopulationreview.com/countries/philippines-population/

22 United Nations Statistics Division. (n.d.). Country Profile: Philippines. Retrieved October 2014, from UN Data:
http://data.un.org/CountryProfile.aspx?crName=Philippines

23 Central Intelligence Agency. (2014, October). The World Factbook. Retrieved from Central Intelligence Agency:
https://www.cia.gov/library/publications/the-world-factbook/geos/rp.html

has also been growing. In an Ernst and Young publication[24]– Rapid Growth Markets (RGM) Forecast, they identified countries that are projected to have a 6% growth rate by 2014. The Philippines, on average, has been posting a 6-7% GDP growth in 2013 and 2014, making it a high potential market -with several credit upgrades and a growing working-age population. As such, the report anticipates that in these countries (the Philippine included), the economies and governments will become stronger, and the middle class will expand through an increase in the peoples' purchasing power. When this occurs, global demand will be influenced by the expanding middle class whose spending power is expected to increase from $21 trillion to $51 trillion dollars in 2030. The middles class of RGM countries, defined as households with daily expenditures between $10 and $100 per person, are expected to be significant drivers then of the global economy.

(2) Regional Population in the Philippines

Below is the projected population by region in the Philippines according to the National Statistics Office and 2000 Census-based Population Projection in collaboration with the Inter-Agency Working Group on Population Projections. The interval is by 5-calendar year.

Table 1.1.1 Number of Licensed Government and Private Medical Institutions in the Philippines

	Projected Population (in thousands)	
REGION	2010	2015
ILOCOS	5,174	5,674
CAGAYAN VALLEY	3,365	3,651
CENTRAL LUZON	10,159	11,123
CALABARZON	11,905	13,143
MIMAROPA	3,018	3,417
BICOL	5,712	6,278
WESTERN VISAYAS	7,578	8,318
CENTRAL VISAYAS	7,029	7,741
EASTERN VISAYAS	4,447	4,912
ZAMBOANGA PENINSULA	3,809	4,197
NORTHERN MINDANAO	4,349	4,799
SOUTHERN MINDANAO	4,362	4,709
CENTRAL MINDANAO	4,080	4,524
NCR	11,552	12,221
ARMM	3,229	3,588
CARAGA	2,550	2,800
CAR	1,694	1,869
TOTAL	94,012	102,965

Source: Adapted from List of Licensed Government and Private Hospitals as of December 31, 2013, by Bureau of Health Facilities and Services.

24 Cruz, C. (2013). The growth of the global middle class. Retrieved October 2014, from SGV: http://www.sgv.ph/the-growth-of-the-global-middle-class-by-j-carlitos-g-cruz-september-09-2013/

(3) Population in the National Capital Region (NCR)

The population in the NCR region has grown over 2.0% on average in the last two decades. The region has 17 cities, Quezon, Manila, Caloocan, Pasig, Valenzuela, Marikina, Malabon, Mandaluyong, Novotas, and San Juan in the northern half, and Taguig, Paranaque, Las Pinas, Makati, Muntinlupa, Pasay, and Pateros in the southern half. The northern half of the region is more densely populated than in the South. Quezon City is the most densely populated area in the region with an estimated population of 2.8 million in 2010. Below is a table of population growth of the 17 cities in NCR.

Table 1.1.2 Estimated population of the cities in NCR 1990-2010

City	Population (persons)			CAGR	
	1990	2000	2010	'90-'10	'00-'10
NCR Total (Metro Manila)	7,948,392	9,932,560	11,855,975	2.02%	1.79%
NCR North	5,925,061	7,279,590	8,624,807	1.89%	1.71%
1. Quezon City	1,669,776	2,173,831	2,761,720	2.55%	2.42%
2. Manila, City of	1,601,234	1,581,082	1,652,171	0.16%	0.44%
3. Caloocan City	763,415	1,177,604	1,489,040	3.40%	2.37%
4. Pasig, City of	397,679	505,058	669,773	2.64%	2.86%
5. Valenzuela, City of	340,227	485,433	575,356	2.66%	1.71%
6. Marikina, City of	310,227	391,170	424,150	1.58%	0.81%
7. Malabon, City of	280,027	338,855	353,337	1.17%	0.42%
8. Mandaluyong, City of	248,143	278,474	328,699	1.42%	1.67%
9. Navotas, City of	187,479	230,403	249,131	1.43%	0.78%
10. San Juan, City of	126,854	117,680	121,430	-0.22%	0.31%
NCR South	2,023,331	2,652,970	3,231,168	2.37%	1.99%
1. Taguig City	266,637	467,375	644,473	4.51%	3.27%
2. Parañaque, City of	308,236	449,811	588,126	3.28%	2.72%
3. Las Piñas, City of	297,102	472,780	552,573	3.15%	1.57%
4. Makati, City of	453,170	471,379	529,039	0.78%	1.16%
5. Muntinlupa, City of	278,411	379,310	459,941	2.54%	1.95%
6. Pasay City	368,366	354,908	392,869	0.32%	1.02%
7. Pateros City	51,409	57,407	64,147	1.11%	1.12%

Source: Thomas Brinkhoff, http://www.citypopulation.de/php/philippines-admin.php

(4) Ethnicity, Religion, and Language

The Philippines contains diverse ethnicities, religions, and languages. Data from the latest census available in the Philippines states that as of year 2000, the Tagalog ethnic group makes up 28% of the country's population, the Cebuanos make up 13%, and the Ilocanos make up 9%. These are the top three biggest ethnic groups in the Philippines. They are followed by the Bisayas, Hiligaynon, and Bikol ethnic groups. (Philippines Population 2014, 2014) The religion in the Philippines has been highly influenced by its history and location. 80% of the country's population is Roman Catholics, 10% are from Christian

denominations, 5% are Muslims, and 5% are from other religious organizations. The Philippines has two official languages – Filipino (based on Tagalog) and English, along with numerous regional languages. The Philippines is considered the third largest English speaking country in the world.[25]

1.1.2.5 Politics and economy in the Philippines

(1) Economic growth of the Philippines

Philippine economic growth boosted to 7.2 percent in 2013 despite the impact of Typhoon Haiyan (Yolanda) and other natural disasters during the year. The country's strong macroeconomic fundamentals sustained domestic demand and safeguarded the economy from the enduring weakness of the global economy. Strong performance of consumption powered by strong remittances and services, supported by investment and manufacturing expansion, boosted growth. Private consumption grew by 5.6%, while private construction also grew by 8 percent due to low interest rates and the strong demand for office & residential spaces by workers in the business process outsourcing industry.

The Economy of the Philippines is the 38th largest in the world, according to 2013 International Monetary Fund statistics, and is also one of the emerging markets in the world. Goldman Sachs estimates that by the year 2050, the Philippines will be the 14th largest economy in the world. Goldman Sachs also included the Philippines in its list of the Next Eleven economies. According to HSBC, the Philippine economy will become the 16th largest economy in the world, 5th largest economy in Asia and the largest economy in the Southeast Asian region by 2050. Jim Yong Kim, the president of the World Bank, said the Philippines could be "the next economic miracle in Asia".

Relatively high rates of economic growth are projected over the forecast period, though easing from the fast pace in 2013. GDP growth is forecast at 6.4% in 2014 and 6.7% in 2015. Signs are optimistic for continued growth in investment. Improved business confidence and rising inflows of foreign direct investment will support private investment. Confidence has been reinforced by the achievement last year of investment grade sovereign credit ratings and improvements in several global competitiveness indices. For example, the Philippines' ranking in the World Bank's Doing Business survey jumped by 30 places to 108th of 189 economies in 2013. Other positive indicators for investment are sustained expansion in credit to businesses, increased investment in machinery and equipment, and a buoyant stock market, backed up by rising corporate earnings. Private consumption will

25 Department of Tourism. (2009). About the Philippines. Retrieved October 2014, from It's more fun in the Philippines: http://www.tourism.gov.ph/sitepages/history.aspx

continue to benefit from remittance inflows and positive consumer sentiment, though higher inflation and interest rates will likely reduce the pace of growth in consumer spending. The pace of increase in government spending is also expected to subside from 2013.

One of the contributors to the economic growth of the Philippines is its import-export sector, as can be seen in the table below which documents the five year trend of import and export by sector in the country.

Table 1.1.3 Foreign Trade of the Philippines from 1994 to 2013

(F.O.B. value in million U.S. dollars)

Year	Total Trade	Exports	Imports	Balance of Trade Favorable (Unfavorable)
2013	115,809.00	53,978.00	61,831.00	-7,853
2012	114,228.00	52,100.00	62,129.00	-10,029
2011	108,186.00	48,042.00	60,144.00	-12,102.00
2010	106,430.00	51,498.00	54,933.00	-3,435.00
2009	81,527.00	38,436.00	43,092.00	-4,656.00
2008	105,824.00	49,078.00	56,746.00	-7,669.00
2007	105,980.00	50,466.00	55,514.00	-5,048.00
2006	99,183.79	47,410.12	51,773.68	-4,363.57
2005	88,672.86	41,254.68	47,418.18	-6,163.50
2004	83,719.73	39,680.52	44,039.21	-4,358.69
2003	76,701.72	36,231.21	40,470.51	-4,239.30
2002	74,444.67	35,208.16	39,236.51	-4,028.35
2001	65,207.36	32,150.20	33,057.16	-906.96
2000	72,569.12	38,078.25	34,490.87	3,587.38
1999	65,779.35	35,036.89	30,741.46	4,294.43
1998	59,156.64	29,496.75	29,659.89	-163.14
1997	61,161.52	25,227.70	35,933.82	-10,706.12
1996	52,969.48	20,542.55	32,426.93	-11,884.38
1995	43,984.81	17,447.19	26,537.63	-9,090.44
1994	34,815.46	13,482.90	21,332.57	-7,849.67

Source: Adapted from National Statistics Coordination Board
Retrieved from: http://www.nscb.gov.ph/secstat/d_trade.asp

(2) Gross Domestic Product (GDP)

In 2013 the GDP of the Philippines was at$272.018 billion (at current US$). (Philippine Country Data) The services sector contributed 3.6 percentage points of the real GDP growth in the fourth quarter of 2013. This was followed by the industry sector with 2.8 percentage points and agriculture with 0.1 percentage points. Fourth-quarter growth on the

supply side was mainly boosted by manufacturing, trade, finance and real estate. Meanwhile, on the demand side, growth was heightened by household consumption, which added 4.2 percentage points, and net exports, which contributed 1.6 percentage points. Construction had the biggest setback in the fourth quarter. The subsector contracted by 0.8 percent due to stringent rules imposed on real estate lending in compliance with prudential regulations. Government spending also slowed down by 5.2 percent, dropping from the 9.5 percent growth posted in the fourth quarter of 2012. The deceleration was due to lower disbursements in personnel services and maintenance and other operating expenditures. For the full year, however, government spending jumped by 8.6 percent. Imports also slowed down by 1.9 percent during the last quarter of 2013 from the 8 percent posted in the same period in 2012. Aside from slowdowns in certain sectors, the combined impact of typhoons and other disasters may have also reduced the full year real GDP growth by at least 0.1 percentage points. The 2013 GDP growth is higher than the 6.8-percent posted in 2012. The country's GDP grew by 3.7 percent in 2011 and 7.6 percent in 2010.

Table 1.1.4 Annual GDP Growth Rate of the Philippines

YEAR	ANNUAL GDP GROWTH RATE (%)
2013	7.2
2012	6.8
2011	3.7
2010	7.6

Source: World Bank

The GDP growth trend of ASEAN countries, including the Philippines are shown in the table below. The Philippines remains as one of the best performing economies in the Asian region in 2013 with annual growth rate of 7.2 percent, second only to China, which grew by 7.7 percent.

Table 1.1.5 Historical GDP Growth Rates by Countries

GDP growth (annual %)					
SEA Country	**2009**	**2010**	**2011**	**2012**	**2013**
Brunei	-1.8	2.6	3.4	0.9	-1.8
Cambodia	0.1	6	7.1	7.3	7.5
East Timor	12.8	9.5	12	8.3	8.1
Indonesia	4.6	6.2	6.5	6.3	5.8
Laos	7.5	8.5	8	8.2	8.1
Malaysia	-1.5	7.4	5.1	5.6	4.7
Singapore	-0.6	15.2	6.1	2.5	3.9

Thailand	-2.3	7.8	0.1	7.7	1.8
Vietnam	5.4	6.4	6.2	5.2	5.4
Philippines	1.1	7.6	3.6	6.8	7.2

Source: Adapted from World Bank

(3) Industry Structure

Industries in the Philippines are categorized in three sectors: (1) agriculture, hunting, forestry and fishing sector, (2) industry sector, and (3) service sector. Under these sectors are their relevant industry divisions. As of 2011 the service sector accounted for 55.81% of the GDP, while the industry sector accounted for 31.40% and agriculture, hunting, forestry and fishing accounted for 12.79%[26]. The table below summarizes the growth rates of each industry from 2010 until 2013, and the next table summarizes the amount of foreign and Filipino investments made per industry from 2004 to 2010. Healthcare sector is categorized in "Service" sector inTable 1.1.6 and "Private Services" in Table 1.1.7.

Table 1.1.6 Historical Trend of Growth Rates per Industry

SECTOR	Labor Productivity (At Constant 2000 Prices)				Growth Rates (%)			
	2010	2011	2012	2013	2010	2011	2012	2013
PHILIPPINES	158,222	158,911	167,877	177,487	4.7.	0.4.	5.6.	5.7.
Agriculture, Hunting, Forestry and Fishing	55,425	55,420	57,799	59,706	0.6.	**	4.3.	3.3.
Industry	344,418	342,486	353,725	373,831	5.2.	(0.6.)	3.3.	5.7.
Services	170,183	172,033	181,227	188,715	2.8.	1.1.	5.3.	4.1.

Source: Adapted from Bureau of Employment and Labor Statistics (2010-2013)
http://www.bles.dole.gov.ph/PUBLICATIONS/Current%20Labor%20Statistics/STATISTICAL%20TABLES/PDF/tab31.pdf

Table 1.1.7 Total Approved Investments of Foreign and Filipino Nationals by Industry (in million PHP)

Industry	2004	2005	2006	2007	2008	2009	2010
Agriculture	212	770	4,734	1,856	2,498	2,873	2,272
Communication	-	2,079	47,042	14,222	2,186	6	-
Construction	1,140	83	3,857	14,090	216	179	1,080
Electricity	8,564	21,659	45,403	139,078	131,923	32,296	189,920
Finance & Real Estate	7,158	10,019	28,833	54,927	114,088	89,111	72,108
Gas	106,521	269	-	561	-	17	-
Manufacturing	54,330	150,161	151,984	94,667	75,518	106,300	215,153
Mining	1,512	8,294	16,147	13,776	48,269	2,019	8,108
Private Services	41,006	15,344	29,105	37,631	71,417	29,353	40,255
Storage	388	26	35	1,340	1,059	-	-
Trade	517	357	26,332	780	531	2,155	1,461
Transportation	467	22,172	3,530	10,329	16,516	2,830	12,248
Water	-	-	-	2,537	-	45,975	-

26 Economic Accounts. (2014). Retrieved September 2014, from Philippine Statistics Authority - National Statistical Coordination Board: http://www.nscb.gov.ph/secstat/d_accounts.asp

Total	221,815	231,233	357,002	385,804	464,221	314,114	542,605

Source: Adapted from National Economic and Development Authority (2004-2010)

The latest Economic Indicators for the Philippines for the first and second quarter of 2014 can be seen in the table below.

Table 1.1.8 Philippine Economic Indicators (2014)

Economic Indicator	2nd Quarter 2014	1st Quarter 2014
Gross Rate of Gross National Income (at Constant 200o Prices)	7.3%	7.2%
Growth Rate of Gross Domestic Product (at Constant 200o Prices)	6.4%	5.6%
Exports	USD 5,461 million	USD 5,483 million
Imports	USD 5,494 million	USD 4,821 million
Trade Balance	USD -33 million	USD 625 million
Balance of Payments	USD -340 million	USD 345 million
Broad Money Liabilities	7138,148 billion PHP	7,088,166 billion PHP
Interest Rate	2.0%	2.0%
National Government Revenues	169,980 million PHP	166,730 million PHP
National Government Outstanding Debt	5,713 billion PHP	5,683 billion PHP
Stocks Composite Index	7,050.9 PHP	6,6.8 PHP
Consumer Price Index (2006=100)	140.9	140.8
Headline Inflation Rate (2006=100)	4.4	4.9
Core Inflation Rate (2006=100)	3.4	3.4

Source: Adapted from National Statistical Coordination Board (2014)

(4) Balance of payments

The Philippines' balance of payments (BOP) surplus narrowed in 2013 on the doubt caused by the US Federal Reserve's withdrawal of its economic stimulus. Data from the Bangko Sentral ng Pilipinas (BSP/Central Bank of the Philippines) showed that the country's BOP surplus dropped by 45 percent to $5.085 billion last year from $9.236 billion in 2012, narrowly missing the central bank's target of $5.3 billion for 2013. In December alone, the surplus fell to $419 million or half the $837 million the month before. The narrower surplus

is attributed on uncertainties about global economic developments, plus the phasing of the retraction of monetary policy accommodation in the developed economies that have heightened external risks to the BOP outlook. It, however, bears pointing out that the BOP surplus continue to draw support from fundamentally-driven foreign exchange flows, such as those in the current account that remains in surplus, from which the economy can build resilience against external headwinds. The sustainability of the external payments surplus continues to be a real triumph given ongoing vulnerabilities and challenges in the global economy.

36% increase in last year's current account stemmed from higher net receipts from secondary income and services, and a lower trade in goods deficit. Global activity strengthened and world trade picked up in the latter part of 2013 arising from stable signs of recovery in advanced economies, particularly the US, Japan, and some core economies in the euro area.

The trade in goods deficit showed a moderate improvement of 2.1% as the reduction in imports surpassed that of exports. Exports of goods dropped by 3.6% to $44.7 billion in 2013 compared to $46.4 billion in 2012 due primarily to the decrease in shipments of manufactured goods from the previous year’s level. Imports of goods cut down by 3.1% to $63.3 billion in 2013, on account of lesser purchases of raw materials and intermediate goods, and mineral fuels and lubricants.

The surplus in the services account improved by 10.4% to $6.8 billion in 2013, due mainly to greater net receipts from telecommunications, computer, and information services, as well as personal, cultural, and recreational services. For the capital account, the country ended 2013 with a 21.8% increase to $115 million due mainly to higher capital transfers to the national government. The financial account however recorded net outflows of $635 million in 2013, a turnaround from the $6.7 billion net inflows in the previous year. Net outflows were posted in the other investment account, which were alleviated partly by inflows of portfolio and direct investments. Unstable capital flows during 2013 reflected sensitivity of financial markets to external developments. In particular, net inflows of portfolio investments declined as risk appetite for emerging market assets was burdened by the dreary recovery in the euro area as well as changing expectations on the US monetary policy.

For 2014, the BSP has set a financial account target of $3.6 billion in net outflows and a capital account goal of $135 million.

(5) Prices

Overall prices are anticipated to remain within a tolerance range for inflation. Consumer Price Index (CPI) in Philippines increased to 140.40 Index Points in July of 2014 from 139.60 Index Points in June of 2014. The CPI, which measures changes in the prices paid by consumers for a basket of common good and services, averaged 40.23 Index Points from 1957 until 2014, reaching a record high of 140.40 Index Points in July of 2014 and a record low of 1.30 Index Points in February of 1957. This is mostly driven by rising cost of food and non-alcoholic beverages.

Year-on-year, food and non-alcoholic beverages went up to 8.2% in July from 7.4 percent in June. Costs of education slightly rose to 5.1% in the month from 5.0% last month, while that of utilities were slightly up to 2.4% from 2.3% in May. Prices of health services in July recorded a 3.2% increase from 3.0% rise in June. Costs of transport and culture and leisure are also up to 1.5% from 1.3% in July and to 1.3% from 1.2% in June. The first table below shows the Consumer Price Index of the Philippines from 2006 until 2013. This data is being reported by the National Statistics Office of the Philippines. The second and third table below shows the exchange rates of the Philippine peso to the US Dollar (USD) and Japanese Yen (JPY) over a period of 20 years.

Table 1.1.9 Consumer Price Index (CPI) For All Income Households

Year	2006	2007	2008	2009	2010	2011	2012	2013
Philippines	100	102.9	111.4	116	120.4	126.1	130.1	134.0
National Capital Region	100	102.7	109.1	112.1	116.3	120.9	124.4	126.4
Areas Outside NCR	100	103.0	112.0	117.3	121.7	127.8	131.9	136.3

Source: Adapted from National Statistics Office (2006-2013)

Inflation rate in National Capital Region (NCR) in July was recorded at 3.9% on a yearly basis and standing higher at area outside the NCR with 5.1% in the month. The rising price adjustments happened in the heavily-weighted food items such as rice, fruits, vegetables, meat, fish, milk and eggs. Higher prices of gasoline nationwide and more expensive medicines and selected items for personal care in many regions were also recorded during the month.

Table 1.1.10 Headline Inflation Rates in the Philippines

Year	the Philippines		NCR		Outside NCR	
	Inflation rate (%)	CAGR	Inflation rate (%)	CAGR	Inflation rate (%)	CAGR
2013	3	-8%	1.6	-16%	3.3	-7%
2012	3.2	-9%	2.9	-10%	3.2	-9%
2011	4.6	-4%	4	-6%	5	-2%
2010	3.8	-9%	3.7	-9%	3.8	-9%
2009	4.1	-9%	2.8	-20%	4.6	-6%
2008	8.3	23%	6.2	6%	8.8	26%
2007	2.9	-47%	2.7	-51%	3	-45%
2006	5.5	n/a	6.2	n/a	5.3	n/a

Source: Adapted from National Statistics Office Retrieved From: http://www.nscb.gov.ph/secstat/d_price.asp

Table 1.1.11 Exchange rate of USD to PHP in past 20 years

Year	Average USD/PHP	Min USD/PHP	Max USD/PHP
2013	42.47	40.54	44.70
2012	42.22	40.79	44.20
2011	43.30	41.93	44.60
2010	45.08	42.28	47.12
2009	47.58	46.00	49.02
2008	44.46	40.22	50.04
2007	46.07	41.01	49.13
2006	51.29	49.01	53.58
2005	55.06	53.01	56.30
2004	56.08	54.84	58.18
2003	54.32	50.94	57.35
2002	51.58	49.28	54.04
2001	51.19	46.16	55.31
2000	46.43	42.29	51.79
1999	42.85	38.68	45.54
1998	40.34	37.25	42.20
1997	32.59	29.35	35.19
1996	27.14	26.15	27.84
1995	24.19	23.30	25.88
1994	24.83	22.95	26.71
1993	28.05	26.39	29.50

Source:
http://fxtop.com/en/historical-exchange-rates.php?A=1&C1=USD&C2=PHP&YA=1&CJ=1&DD1=01&MM1=01&YYYY1=1993&B=1&P=&I=1&DD2=31&MM2=12&YYYY2=2013&btnOK=Go%21

Table 1.1.12 Exchange rate of JPY to PHP in past 20 years

Year	Average JPY/PHP	Min JPY/PHP	Max JPY/PHP
2013	2.27	2.50	2.13
2012	1.89	2.08	1.75
2011	1.85	2.00	1.75
2010	1.96	2.13	1.85
2009	1.96	2.13	1.82
2008	2.33	2.70	1.89
2007	2.56	2.78	2.38
2006	2.27	2.44	2.08
2005	2.00	2.27	1.82
2004	1.92	2.04	1.82
2003	2.13	2.33	1.92
2002	2.44	2.63	2.22
2001	2.38	2.63	2.13
2000	2.33	2.56	2.08
1999	2.63	2.94	2.22
1998	3.23	3.57	2.94
1997	3.70	4.00	3.33
1996	4.00	4.17	3.85
1995	3.85	4.35	3.45
1994	4.17	4.35	3.85
1993	4.00	4.76	3.45

Source:
http://fxtop.com/en/historical-exchange-rates.php?A=1&C1=JPY&C2=PHP&YA=1&CJ=1&DD1=01&MM1=01&YYYY1=1993&B=1&P=&I=1&DD2=31&MM2=12&YYYY2=2013&btnOK=Go%21

1.1.3 Current situation and challenges of the health sector in the country

1.1.3.1 Morbidity and Mortality

The population of the Philippines is influenced by its mortality and morbidity. Seven out of the top ten causes of morbidity are infectious in origin, with tuberculosis, malaria, and HIV accounting for a significant number of deaths from infectious diseases. The Department of Health (DOH) maintains statistics on the Leading Causes of Morbidity and Mortality - the latest data of which are dated 2009 and 2010 respectively, as can be seen in the tables below.

Table 1.1.13 Top 10 Leading Causes of Mortality

		5-Year Average (2004-2008)		2009*	
Rank	Causes	Number	Rate**	Number	Rate**
1	Diseases of the Heart	82,290	94.5	100,908	109.4
2	Diseases of the Vascular System	55,999	64.3	65,489	71.0
3	Malignant Neoplasms	43,185	49.6	47,732	51.8
4	Pneumonia	35,756	41.1	42,642	46.2
5	Accidents***	34,704	39.9	35,990	39.0
6	Tuberculosis, all forms	25,376	29.2	25,470	27.6
7	Chronic lower respiratory diseases	20,830	24.0	22,755	24.7
8	Diabetes Mellitus	19,805	22.7	22,345	24.2
9	Nephritis, nephritic syndrome and nephrosis	11,612	13.4	13,799	15.0
10	Certain conditions originating in the perinatal period	12,590	14.5	11,514	12.5

Notes: Excludes ill-defined and unknown causes of mortality
*reference year
** per 100,000 populations
*** external causes of mortality
Source: Adapted from *Leading Causes of Mortality*. Retrieved from http://www.doh.gov.ph/node/198.html.

Table 1.1.14 Top 10 Leading Causes of Morbidity

		2010*	
Rank	Causes	Number	Rate**
1	Acute Respiratory Infection	1,289,168	1371.3
2	Acute Lower Respiratory Tract Infection and Pneumonia	586,186	623.5
3	Bronchitis/Bronchiolitis	351,126	373.5
4	Hypertension	345,412	367.4
5	Acute Watery Diarrhea	326,551	347.3
6	Influenza	272,001	289.3
7	Urinary Tract Infection	83,569	88.9
8	TB Respiratory	72,516	77.1
9	Injuries	51,201	54.5
10	Diseases of the Heart	37,589	40.0

Notes: *reference year
** per 100,000 populations
Source: Adapted from *Leading Causes of Morbidity.*
Retrieved from http://www.doh.gov.ph/kp/statistics/morbidity.html#.

1.1.3.2 Maternal and Child Health Situation in the Philippines

Maternal Mortality Ratio in the Philippines is defined as the number of women who die during pregnancy or within 42 days following pregnancy. The estimated figure was measured at 163 per 100,000 live births for the year 2010. The main causes of Maternal Mortality are (1) Complications related to pregnancy occurring in the course of labor, delivery, and puerperium, (2) Hypertension complicating pregnancy, childbirth, and puerperium, (3) Postpartum Hemorrhage, and (4) Pregnancy with abortive outcome[27]. Data on Maternal Mortality from 1993 until 2010 can be seen in the table below.

Table 1.1.15 Maternal Mortality in the Philippines

Year	Maternal Mortality Ratio (Per 100,000 live births	Source
2010	163E	National Statistics Coordination Board
2006	162	2006 Family Planning Survey
1998	172	1998 National Demographic and Health Survey
1993	209	1993 National Demographic Survey

Source: Adapted from National Statistics Office, *Family Planning Survey 2006*and *National Objective for Health 2011-2016.*
Retrieved from
http://web0.psa.gov.ph/content/maternal-mortality-slightly-declined-mdg-target-may-not-be-achievablel

In 2010, the Infant Mortality Rate, defined as the number of infants dying before reaching one year of age, was measured at 23 per 1,000 live births. Neonatal Mortality Rate was measured at 14 and Under-5 Mortality Rate was at 29. Data from the Philippines National Statistics Office (NSO) shows the trends in Child Mortality Rate, as can be seen in the table below:

Table 1.1.16 Child Mortality in the Philippines

Year	Neonatal Mortality	Infant Mortality	Under-Five Mortality
2008	16	25	34
2003	17	29	40
1998	17.7	35.1	48.4
1993	17.8	33.6	54.2
1990		57	80

Source: Adapted from *National Demographic and Health Surveys*.
Retrieved from http://www.doh.gov.ph/sites/default/files/3%20Chapter1.pdf.

As of 2010, the top 10 leading causes of infant mortality are (1) Bacterial sepsis of newborns, (2) Pneumonia, (3) Respiratory distress of newborns, (4) Congenital

27 Department of Health 2012, National Objective for Health 2011-2016, from
http://www.doh.gov.ph/content/national-objectives-health-2011-2016.html

malformation of the heart, (5) Disorders related to short gestation and low birth weight, not elsewhere classified, (6) Congenital pneumonia, (7) Neonatal aspiration syndrome, (8) Intrauterine hypoxia and birth asphyxia, (9) Other congenital malformations, and (10) Diarrhea and gastroenteritis of presumed infectious origin (DOH, 2010).

1.1.3.3 Total Health Expenditure (THE) in the Philippines

When a patient receives medical care in a medical facility, the result accumulates to the total health expenditure of a country. The figure in the Philippines is increasing over 10% annually.

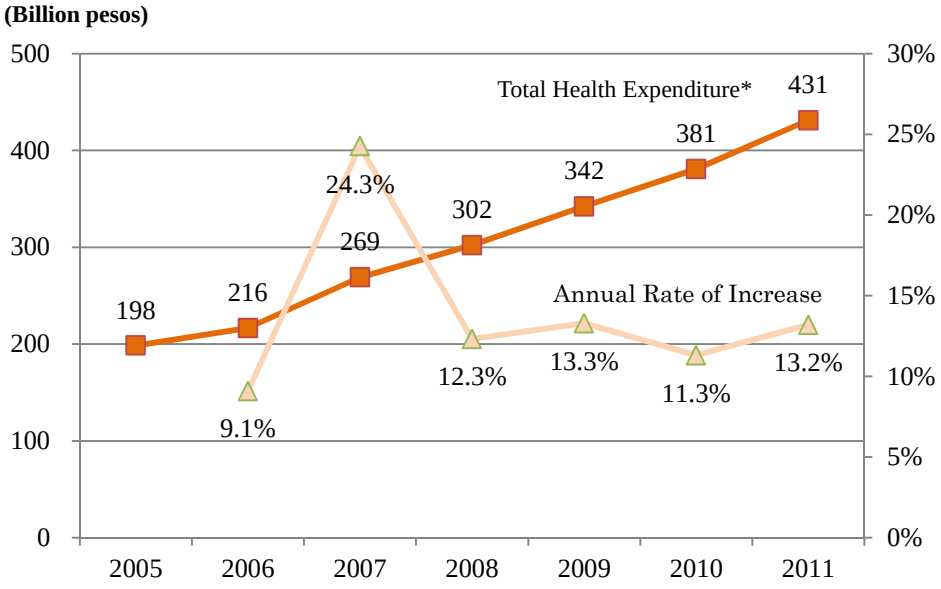

Figure 1.1.4 Total Health Expenditure and its Rate of Increase

*: Current price
Source: Philippine National Health Accounts 2005-2011
Retrieved from http://www.nscb.gov.ph/stats/pnha/publication/NSCB_PNHA%202005-2011.pdf

Looking at the funding sources of THE, out-of-pocket (OOP) from individuals constantly exceeds 50%. The share of the government stays at below 30%, that of National Health Insurance 9%, and the rest around 11%.

The reality is far lagging behind from the goals set by the Health Sector Reform Agenda where the optimal share is 40% from the government, 30% National Health Insurance, out-of-pocket from individuals 20%, and the rest 10%.

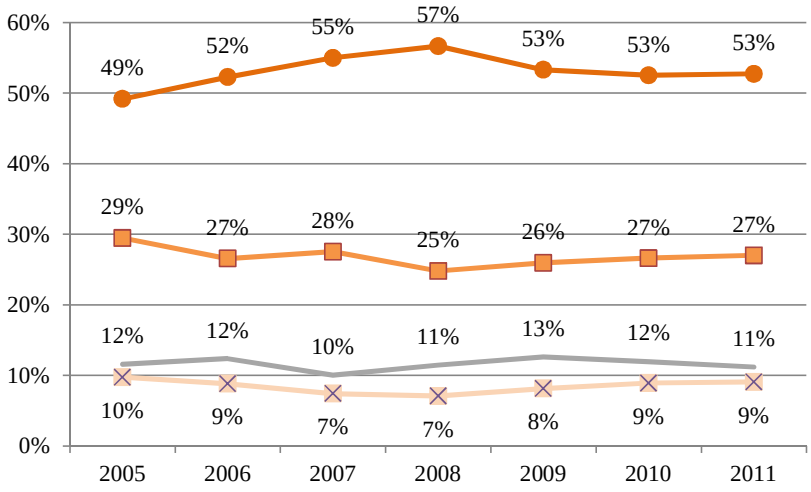

Figure 1.1.5 Source of Funds for Total Health Expenditure

Source: Budget Facts and Figures, by the Legislative Budget Research and Monitoring Office.
Retrieved from https://www.senate.gov.ph/publications/LBRMO%202013-02%20Budget%20Facts.pdf

1.1.3.4 Hospital Infrastructure in the Philippines

If we compare the number of beds per 1000 population with ASEAN countries, the Philippines is largely lagging behind as shown below.

Table 1.1.17 Comparison of Beds per 1000 Population in ASEAN Countries

Country	Beds per 1000 Population	Note
Brunei	2.8	2012
Thailand	2.1	2010
Singapore	2.0	2011
Vietnam	2.0	2010
Malaysia	1.8	2011
Lao	1.5	2012
Philippines	1.0	2011
Indonesia	0.9	2012
Cambodia	0.7	2011

Source: *The World Bank*、*Hospital Beds (per 1000 people)*
Retrieved from http://data.worldbank.org/indicator/SH.MED.BEDS.ZS

The table below shows the trend in the number of public and private hospitals. The number of public hospitals has increased by approximately 1.1% over a decade until 2010. On the other hand, the number of private hospitals has gradually decreased from 1999 until early 2000s and stays at its level thereafter.

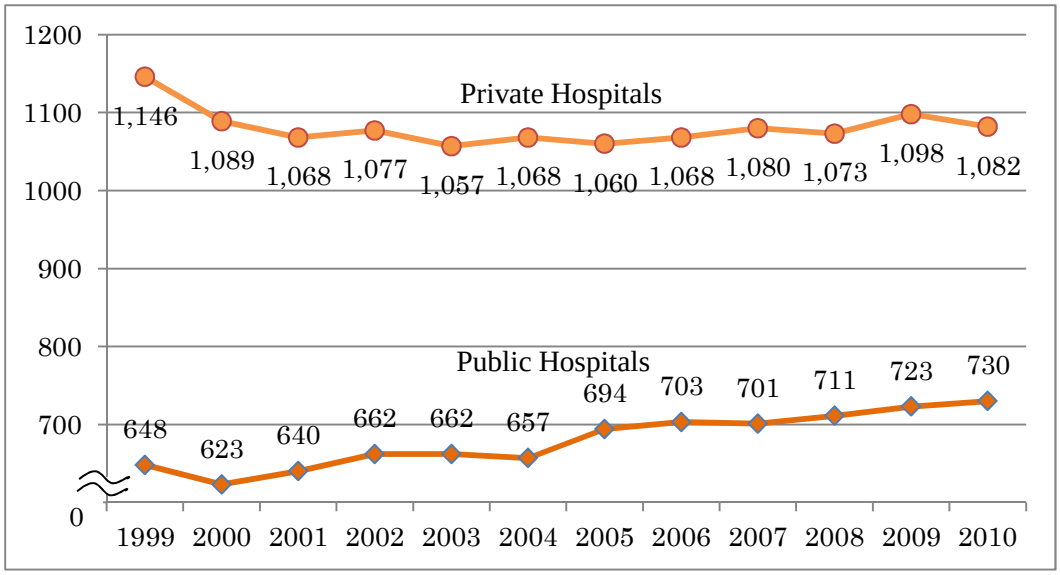

Figure 1.1.6 Trend in the Number of Private and Public Hospitals

Source: *National Statistical Coordination Board*、*Philippines in Figures2005～2014*.
Retrieved from http://www.nscb.gov.ph/secstat/d_vital.asp

From 2001, the total number of public and private hospitals has shown an increase by a little short of 1% due to the increase in the number of public hospitals, however, the number of beds per 10,000 populations remained unchanged due to the increase in the total population.

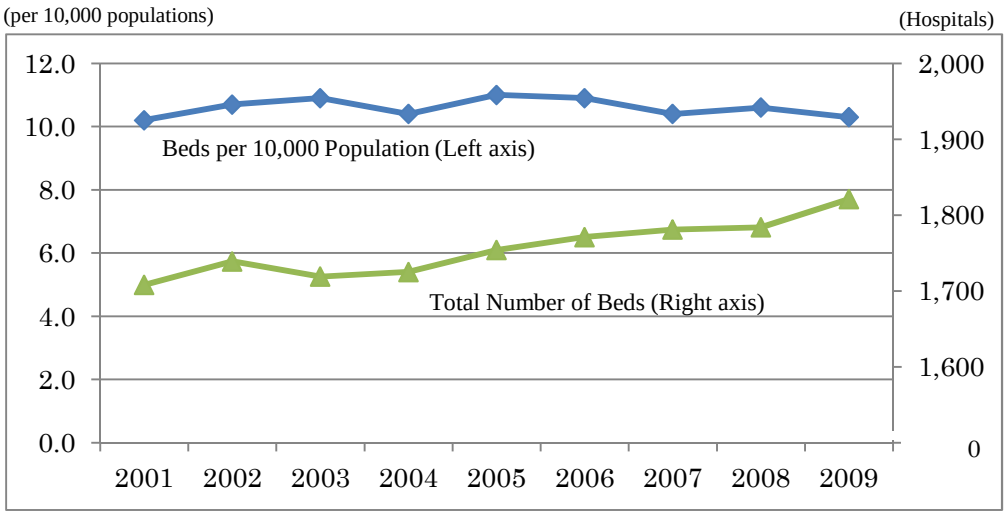

Figure 1.1.7 Trend in the Total Number of Hospitals and Beds per 10,000 Populations

Source: *National Statistical Coordination Board*、*Philippines in Figures2005～2014*.

When we look at the size of hospitals in the Philippines as shown below, there are a large number of small size hospitals and very small number of large size hospitals which has 250 and above bed size.

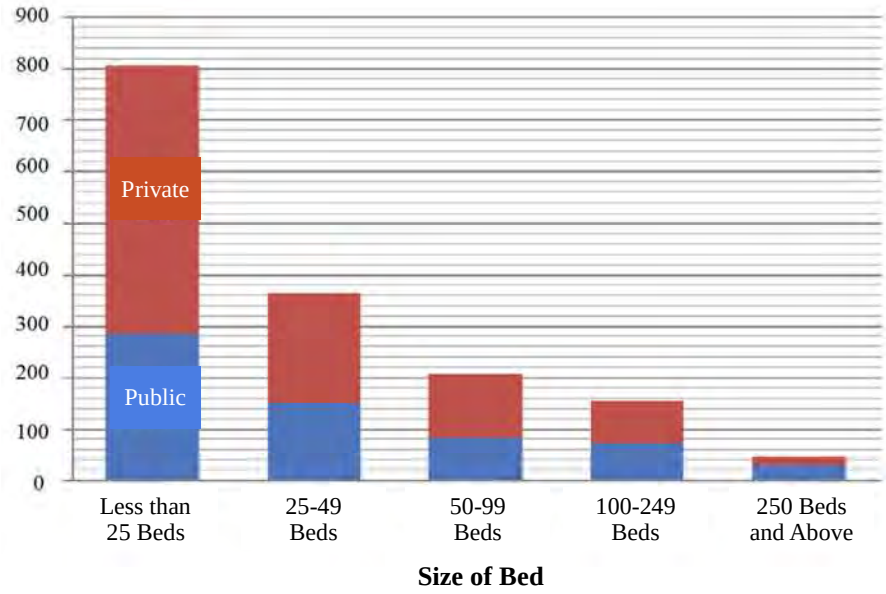

Figure 1.1.8 Number of Hospitals by Size of Bed（2007）

Source: *How Are Government Hospitals Performing? A Study of Resource Management in Government-Retained Hospitals*. Retrieved from http://www.eaber.org/node/22807

Some of the major challenges in the health sector infrastructures are (1) fiscal constraints for investments in modern and advanced hospital facilities and equipment, (2) limited access to health care in rural areas, (3) inefficient management of health services, and (4) lack of investments in advanced information technology (IT). Given these impediments, the National Government chose to invest and finance in Public-Private Partnership (PPP) Projects.

1.1.3.5 The Medical Institutions/Services

The official DOH Hospital Categories and corresponding characteristics based on Service Capabilities had been defined in DOH Administrative Order No. 2005-0029 (DOH Admin. Order No. 2005 – 0029, 2005) as listed below.

Table 1.1.18 Hospital Category and Levels under A.O.2005-0029

PhilHealth Hospital Category	Hospital Levels
Primary	Level 1
Secondary	Level 2
Tertiary	Level 3
	Level 4(Teaching and Training Hospital)

Source: Adapted from *Amendment to Administrative Order No. 147 s. 2004: Amending Administrative Order No.*

70-A series 2002 re: Revised Rules and Regulations Governing The Registration, Licensure And Operation Of Hospitals And Other Health Facilities In The Philippines, 2005.
Retrieved from http://www.doh.gov.ph/system/files/ao2005-0029_0.pdf.

This definition was reclassified in 2012 as it has become evident that some medical conditions and procedures that are compensable in a hospital setting could also be treated in a primary care facility without compromising the quality of care. This recognition together with studies conducted by DoH prompted the authority to revise the classification of hospitals and other health facilities in the Philippines.

Table 1.1.19 New Classification of Hospitals and Other Health Facilities under A.O.2012-0012

Hospitals	**Other Health Facilities**
General ・Level 1 ・Level 2 ・Level 3 (Teaching/Training)	A. Primary Care Facility
	B. Custodial Care Facility
	C. Diagnostic/Therapeutic Facility
Specialty	D. Specialized Out-Patient Facility

Table 1.1.20 New Classification of General Hospitals under A.O.2012-0012

Hospitals	**Level 1**	**Level 2**	**Level 3**
Clinical Services for in-patients	Consulting Specialists in: Medicine Pediatrics OB-GYNE Surgery	Level 1 plus all:	Level 2 plus all:
		Departmentalized Clinical Services	Teaching/training with accredited residency training program in the 4 major clinical services
	Emergency and Out-patient Services	Respiratory Unit	Physical Medicine and Rehabilitation Unit
	Isolation Facilities	General ICU	
	Surgical/Maternity Facilities	High Risk Pregnancy Unit	Ambulatory Surgical Clinic
	Dental Clinic	NICU	Dialysis Clinic
Ancillary Services	Secondary Clinical Laboratory	Tertiary Clinical Laboratory	Tertiary Lab with histopathology
	Blood Station	Blood Station	Blood Bank
	1st Level X-Ray	2nd Level X-Ray with mobile unit	3rd Level X-Ray
	Pharmacy		

Corresponding to the reclassification, PhilHealth reclassified its healthcare provider category.

Table 1.1.21 Reclassification of PhilHealth Institutional Health Care Provider under PhilHealth Circular s.2013-0014

DoH New Classification of Hospitals and Other Health Facilities (A.O. 2012-0012)	Old Hospital Category (A.O. 2005-0029)	New PhilHealth IHCP Category	PhilHealth Benefit Schedule
Hospitals			
Level 1	Level 2 (Secondary)	Hospital Level 1	Secondary
Level 2	Level 3 (Tertiary)	Hospital Level 2	Tertiary
Level 3	Level 4 (Tertiary)	Hospital Level 3	
Other Health Facilities			
Primary Care Facilities (with in-patient beds) – infirmaries/ dispensaries	Level 1 (Primary)	Primary Care Facilities (with in-patient beds) – infirmaries/dispensaries	Primary
Primary Care Facilities (with in-patient beds) – birthing homes		Primary Care Facilities (with in-patient beds) – birthing homes	
Primary Care Facilities (without beds) – Medical Out-Patient Clinics		Medical Out-Patient Clinics	Primary
Specialized Out-Patient Facilities – Dialysis Clinics	*Note: Categorized as Free Standing Dialysis Clinics (Secondary)*	Specialized Out-Patient Facilities – Dialysis Clinics	Secondary
Specialized Out-Patient Facilities – Ambulatory Surgical Clinics	*Note: Categorized as Ambulatory Surgical Clinics (Secondary)*	Specialized Out-Patient Facilities – Ambulatory Surgical Clinics	

The definition of hospital levels are as follows:

(1) Scope of services stipulated under Rule V. B. 1. b. of A.O. 2012-0012

1. General - A hospital that provides services for all kinds of illnesses, diseases, injuries of deformities. A general hospital shall provide medical and surgical care to the sick and injured, maternity, newborn and child care. It shall be equipped with the service capabilities

needed to support board certified/eligible medical specialists and other licensed physicians rendering services in, but not limited to, the following:

a. Clinical Services

1. Family Medicine;
2. Pediatrics;
3. Internal Medicine;
4. Obstetrics and Gynecology;
5. Surgery;

b. Emergency Services;

c. Outpatient Services;

d. Ancillary and Support Services such as, clinical laboratory, imaging facility and pharmacy

(2) Functional capacity of general hospitals stipulated under Rule V. B. 1. c. of A.O. 2012-0012

1. General Hospital

a. Level 1 General Hospital:

A Level 1 hospital shall have as minimum the services stipulated under Rule V.B.1.b.1.of A.O.2012-0012, including, but not limited to, the following:

1. A staff of qualified medical, allied medical and administrative personnel headed by a physician duly licensed by PRC;
2. Bed space for its authorized bed capacity in accordance with DOH Guidelines in the Planning and Design of Hospitals;
3. An operating room with standard equipment and provision for sterilization of equipment and supplies in accordance with:
   a. DOH Reference Plan in the Planning and Design of an Operating Room/Theater;
   b. DOH Guideline on Cleaning, Disinfection and Sterilization of Reusable Medical Devices in Hospital Facilities in the Philippines;
4. A post-operative recovery room;
5. Maternity facilities, consisting of ward(s), room(s), a delivery room, exclusively for maternity patients and newborns;
6. Isolation facilities with proper procedures for the care and control of infectious and communicable diseases as well as for the prevention of cross infections;

7. A separate dental section/clinic;
8. Provision for blood station;
9. A DOH licensed secondary clinical laboratory with the services of a consulting pathologist;
10. A DOH licensed level 1 imaging facility with the services of a consulting radiologist;
11. A DOH licensed pharmacy

b. Level 2 General Hospital:

A Level 2 hospital shall have as minimum, all of Level 1 capacity, including, but not limited to, the following:

1. An organized staff of qualified and competent personnel with Chief of Hospital/medical Director and appropriate board certified Clinical Department Heads;
2. Departmentalized and equipped with the service capabilities needed to support board certified/eligible medical specialists and other licensed physicians rendering services in the specialties of Medicine, Pediatrics, Obstetrics and Gynecology, Surgery, their subspecialties and ancillary services;
3. Provision for general ICU for critically ill patients;
4. Provision for NICU;
5. Provision for HRPU;
6. Provision for respiratory therapy services;
7. A DOH licensed tertiary clinical laboratory;
8. A DOH licensed level 2 imaging facility with mobile x-ray inside the institution and with capability for contrast examinations.

c. Level 3 General Hospital:

A Level 3 hospital shall have as minimum, all of Level 2 capacity, including, but not limited to, the following:

1. Teaching and/or training hospital with accredited residency training program for physicians in the four (4) major specialties namely: Medicine, Pediatrics, Obstetrics and Gynecology, and Surgery.
2. Provision for physical medicine and rehabilitation unit;
3. Provision for ambulatory surgical clinic;
4. Provision for dialysis facility;
5. Provision for blood bank;

6. A DOH licensed tertiary clinical laboratory with standard equipment/reagents/supplies necessary for the performance of histopathology examinations;
7. A DOH licensed level 3 imaging facility with interventional radiology.

Data below presents the number of Licensed Government and Private Medical Institutions in the Philippines categorized per region and level as of 2013.

Table 1.1.22 Number of Licensed Government and Private General and Specialty Hospitals in the Philippines 2013

REGION	Level 1		Level 2		Level 3		Total	
	Hosp.	Beds	Hosp.	Beds	Hosp.	Beds	**Hosp.**	**Beds**
ILOCOS	54	1,454	24	1804	3	536	**81**	**3,794**
CAGAYAN VALLEY	62	1,821	7	765	1	500	**70**	**3,086**
CENTRAL LUZON	124	4,300	35	2893	9	1,891	**168**	**9,084**
CALABARZON	149	4,698	56	4807	7	1,368	**212**	**10,873**
MIMAROPA	58	1,608	5	175	0	0	**63**	**1,783**
BICOL	64	985	43	2372	3	850	**110**	**4,207**
WESTERN VISAYAS	38	2,035	13	1298	8	2,200	**59**	**5,533**
CENTRAL VISAYAS	23	994	13	1478	9	2,760	**45**	**5,232**
EASTERN VISAYAS	31	1,455	9	835	2	290	**42**	**2,580**
ZAMBOANGA PENINSULA	30	1,319	8	754	1	300	**39**	**2,373**
NORTHERN MINDANAO	79	2,494	23	2503	3	560	**105**	**5,557**
SOUTHERN MINDANAO	82	1,826	17	1724	6	1,430	**105**	**4,980**
CENTRAL MINDANAO	33	1,568	13	1517	3	516	**49**	**3,601**
NCR	88	3,521	26	3155	59	22,220	**173**	**28,896**
CAR	31	574	22	1212	2	644	**55**	**2,430**
ARMM	32	705	5	225	0	0	**37**	**930**
CARAGA	11	614	7	675	0	0	**18**	**1,289**
PHILIPPINES	989	31,971	326	28,192	116	36,065	**1,431**	**96,228**

Source: Adapted from *List of Licensed Government and Private Hospitals as of December 31, 2013,* by Bureau of Health Facilities and Services.
Retrieved from http://bhfs.doh.gov.ph/images/listing/distribution/2013distribution_pg_specialty_hosp.pdf

1.1.3.6 Medical Insurance Systems

As diseases are increasing, evolving and threatening most Filipinos, their fundamental measure is to invest a portion of their fortune in health-care services to ensure, maintain and improve their overall well-being.

(1) National Health Insurance Program

To assist Filipinos in gaining access to quality healthcare, the Philippine government instituted the National Health Insurance Program (NHIP) in 1995, by passing Republic Act (RA) 7875[28], to provide universal health coverage for the Philippine population. In the Philippines, NHIP is the largest insurance program in terms of coverage and benefit payments.

Prior to the institution of NHIP, the government had administered a compulsory health insurance program for the formally employed known as the Medicare Program.

(2)PhilHealth

RA 7875 also created the Philippine Health Insurance Corporation (PHIC), more commonly known as PhilHealth, a government-owned and -controlled corporation. PhilHealth is mandated to administer the NHIP and to ensure that Filipinos have financial access to health services through payment of monthly premiums. In 1997, PhilHealth assumed the responsibility of administering the Medicare Program for government employees from the Government Service Insurance System (GSIS) and in 1998, for private sector employees from the Social Security System (SSS). These formally employed individuals constitute the PhilHealth's "regular program." In 1996, the sponsored program (SP) was launched to accelerate coverage of poor households. Three other programs were initiated primarily to expand PhilHealth enrolment of specific population groups. In 1999, PhilHealth launched the individually-paying program (IPP) that primarily targeted the informal sector and other sectors of society that are difficult to reach. The IPP covers the self-employed, those who were separated from formal employment, employees of international organizations, and other individuals who cannot be classified into other programs (e.g. unemployed individuals who are not classified as poor). In 2002, the non-paying program was introduced to target pensioners and retirees. Finally, in 2005, PhilHealth assumed the administration of the Medicare Program for overseas Filipino workers (OFWs) from the Overseas Workers Welfare Administration[29].

28 RA 7875 is titled, "An Act instituting a National Health Insurance Program for All Filipinos and Establishing The Philippine Health Insurance Corporation for the Purpose"

29 The Philippines Health System Review, The Asia Pacific Observatory on Health Systems and Polity

(3) Aquino Health Agenda (AHA) and Kalusugan Pangkalahatan (KP) Policy

Health reforms in the Philippines had seen enactment of National Health Insurance Act of 1995 and introduction of Health Sector Reform Agenda in 1999, aiming at introduction of the following objectives during 1999 and 2004:

1) Reform of health financing (achievement of Universal Health Insurance)
2) Reform of local health systems (improvement of access to quality healthcare)
3) Reform of public health (control of diseases and advancement of primary healthcare such as decreasing infant mortality rate)
4) Reform of the hospital system (improvement of facility, equipment and human resources)
5) Reform of health regulations (development of standards and improvement of ability for licensing)

.

During 2005 and 2010, "*FOUR*mula *ONE* for Health (F1)" was launched as the new health sector reform implementation framework. Instead of five reform areas described in the HSRA, the *FOURmula One* for Health reforms are packaged into four distinct components, especially aiming at expanding health services for the poor:

1) Health Finance
2) Health Regulation
3) Health Service Delivery
4) Good Governance in Health

This time also marked the enactment of two pieces of legislation: the Universally Accessible Cheaper and Quality Medicines Act of 2008 and the Food and Drug Administration Act of 2009. However, despite the important progress made, successive reforms have not succeeded in adequately addressing the persistent problem of inequity: NHIP universal coverage remained at 62% (2010); out-of-pocket expenditure continues to be the main source, accounting for 57 percent of the total health expenditure in 2007; and PhilHealth spending as % of Total Health Expenditure remained at 9% (2007).

With these backgrounds, President Aquino, who inaugurated in June 2010 and promised all Filipinos to propel the policies in his inaugural address, launched the Aquino Health Agenda (AHA), through Administrative Order No. 2010-0036, to achieve universal health care for all Filipinos. It contains the operational strategy called *Kalusugan Pangkalahatan* (KP) which aims KP seeks to ensure equitable access to quality health care by all Filipinos beginning with

those in the lowest income quintiles.

The three goals of AHA are the followings:

1) Financial Risk Protection
2) Better health outcomes
3) Responsive health system

Three strategic thrusts of AHA are established and each thrust has detailed measures as shown below:

1) Financial risk protection through expansion in NHIP enrollment and benefit delivery –The poor shall be protected from the financial impacts of health care use by:
   a. Redirecting PhilHealth operations towards the improvement of benefit delivery;
   b. Expanding enrolment of the poor in the NHIP to improve population coverage;
   c. Promoting the availment of quality outpatient and inpatient services at accredited facilities through reformed capitation and no balance billing arrangements for sponsored members, respectively,
   d. Increasing the support value of health insurance for the poor through the use of information technology upgrades to accelerate PhilHealth claims processing, among others, and
   e. A continuing study to determine the segments of the population to be covered for specific range of services and the proportion of the total cost to be covered/ supported.

2) Attainment of the health-related MDGs - This will be attained by:
   a. Deploying Community Health Teams (CHTs) that shall actively assist families in assessing and acting on their health needs;
   b. Utilizing the life cycle approach in providing needed services, namely family planning; ante-natal care; delivery in health facilities; essential newborn and immediate postpartum care; and the package for children 0-14 years of age;
   c. Aggressively promoting healthy lifestyle changes to reduce non-communicable diseases;
   d. Ensuring public health measures to prevent and control communicable diseases, and adequate surveillance and preparedness for emerging and re-emerging diseases; and
   e. Harnessing the strengths of inter-agency and inter-sectoral approaches to health especially with the Department of Education and Department of Social Welfare and the Department of Interior and Local Government.

3) Improved access to quality hospitals and health care facilities – This shall be achieved

through:

a. A targeted health facility enhancement program that shall leverage funds for improved facility preparedness to adequately manage the most common causes of mortality and morbidity, including trauma;
b. Provision of financial mechanisms drawing from public-private partnerships to support the immediate repair, rehabilitation and construction of selected priority facilities;
c. Fiscal autonomy and income retention schemes for government hospitals and health facilities;
d. Unified and streamlined DOH licensure and PhilHealth accreditation for hospitals and facilities;
e. Regional clustering and referral networks of health facilities based on catchment areas to address the fragmentation of services;
f. Access to quality drugs; and
g. Deployment of health professionals

(4) Revision of National Health Insurance Act

Republic Act (RA) no. 10606, which revised RA 7875 in 2013, mandates the State to provide comprehensive health care services to all Filipinos through a socialized health insurance program that will prioritize the health care needs of the underprivileged, sick, elderly, persons with disabilities (PWDs), women and children and provide free health care services to indigents. In practice, however, funding for indigent contributions has come either fully or partially from the national government, with the balance being shouldered by the local government.

A major difference from the previous law is that the law mandates that it shall be compulsory for all provinces, cities and municipalities but notwithstanding the existence of LGU-based health insurance programs.

Table 1.1.23 Total Enrollment by Sector per year (in million)

Sector	2007	2008	2009	2010	2011	2012	2013
1. Government-Employed	7.41	7.55	1.90	6.58	5.90	6.43	5.91
2. Private-Employed	24.89	23.35	7.01	22.63	18.10	19.51	20.43
3. Sponsored Program (SP)(active)	13.67	16.48	5.38	22.10	38.45	36.68	31.38
4. Individually-Paying Program (IPP)	11.09	12.36	3.33	10.92	9.91	11.82	11.99
5. Non-Paying Program (registered)	0.58	0.69	0.46	0.85	0.95	1.25	1.32
6. Overseas Workers Program	6.90	8.24	2.10	6.90	5.09	5.23	5.86

(registered)							
Total number of members	**64.5**	**68.67**	**20.18**	**69.98**	**78.39**	**80.92**	**76.89**

Source: Adapted from Stats And Charts.

The PhilHealth Budget for 2013 can be seen in the table below.

Table 1.1.24 Corporate Operating Budget CY 2013

Particulars	2013 (in million pesos)
Benefit Payments	76,420
Administrative Cost	5,914
a. Personal Services	3,665
b. Maintenance and Other Operating Expenses	2,249
Capital Expenditures	3,777
a. Infrastructure	3,559
b. Non-Infrastructure	218
Total	**86,111**

Source: Adapted from *Corporate Operating Budget CY 2013*, by Philippine Health Insurance Corporation [PhilHealth].
Retrieved from http://www.philhealth.gov.ph/about_us/transparency/COB_CY2013.pdf.

The NHIP covers six sectors as explained above: (1) government-employed; (2) private-employed; (3) sponsored program; (4) individually paying program; (5) non-paying program for retirees and pensioners (age 60 years old with 120 monthly contributions. Coverage also includes Parents who are 60 years old or above and Children below 21 years old and those with mental & physical disabilities); and (6) Overseas Filipino workers. Sponsored program is provided for members [30] including:

1) Sponsored members are PhilHealth members whose contributions are being paid for by another individual, government agencies, or private entities. Members of the informal economy from the lower income segment who do not qualify for full subsidy under the means test rule of the DSWD, whose premium contribution shall be subsidized by the LGUs or shall be through cost-sharing mechanisms between/among LGUs, and/or legislative sponsors, and/or other sponsors and/or the member, including the National Government;

2) Orphans, abandoned (children who have no known family willing and capable to take care of them and are under the care of the DSWD, orphanages, churches and other institutions) and abused minors, out-of-school youths, street children, persons with disability (PWD), senior citizens and battered women under the care of the DSWD, or any of its accredited institutions run by NGOs or any non-profit private organizations, whose premium contributions shall be paid for by the DSWD;

30 Sponsored Members (n.d.). Retrieved October 7, 2014, from http://www.philhealth.gov.ph/members/sponsored/

3) Barangay health workers, nutrition scholars, barangay tanods, and other barangay workers and volunteers, whose premium contributions shall be fully borne by the LGUs concerned; and

4) Un-enrolled women who are about to give birth, whose premium contributions shall be fully borne by the National Government and/or LGUs and/or legislative sponsors or the DSWD if such woman is an indigent as determined by it through the means test.

PhilHealth Members are entitled to benefits when: (1) at least 3 consecutive monthly contributions within the immediate 6 months prior to admission; (2) The 45 days allowance for room and board has not been consumed yet; and (3) Confinement in an accredited hospital of not less than 24 hours with the exception that it must be an Emergency case as defined by PhilHealth, patient died and patient was transferred to another hospital. There are established mandated benefits for: Inpatient Care such as subsidy for room and board, drugs and medicines, laboratory exam, use of operating room complex, and professional fees for confinements of not less than 24 hours; and Outpatient Care such as Day surgeries, dialysis and cancer treatment procedures such as chemotherapy and radiotherapy in accredited hospitals and free-standing clinics. Also available are: Special Benefit Packages for certain medical and surgical procedures; Treatment of new cases of pulmonary and extra-pulmonary tuberculosis in children and adults are covered through the Directly Observed Treatment Shortcourse or DOTS, the shortest and most effective internationally accepted treatment protocol for tuberculosis (TB); SARS and Avian Influenza; and Novel Influenza A (H1N1). However, the benefits granted shall not cover expenses for the services except when after actuarial studies, recommends their inclusion subject to the approval of the Board: (a) non-prescription drugs and devices; (b) alcohol abuse or dependency treatment; (c) cosmetic surgery; (d) optometric services; (e) fifth and subsequent normal obstetrical deliveries; and (f) cost-ineffective procedures. Confinement in a non- accredited hospital is possible when certain conditions are met (e.g. the case is emergency, the hospital has a current Department of Health (DOH) License, and transfer and referral to a PhilHealth accredited hospital is physically impossible). Claim benefits are also available for confinement abroad with proper documentary requirements.

The PhilHealth premium payments per salary bracket can be seen in the table below.

Table 1.1.25 PhilHealth Premium Contribution Table (in PHP)

Salary Bracket	Monthly Salary Range	Monthly Salary Base	Total Monthly Premium	Employee Share	Employer Share
*Employee share represents half of the total monthly premium while the other half is shouldered by the employer.					
1	8,999.99 and below		8,000.00	200.00	100.00	100.00
2	9,000.00 - 9,999.99		9,000.00	225.00	112.50	112.50
3	10,000.00 - 10,999.99		10,000.00	250.00	125.00	125.00
4	11,000.00 - 11,999.99		11,000.00	275.00	137.50	137.50
5	12,000.00 - 12,999.99		12,000.00	300.00	150.00	150.00
6	13,000.00 - 13,999.99		13,000.00	325.00	162.50	162.50
7	14,000.00 - 14,999.99		14,000.00	350.00	175.00	175.00
8	15,000.00 - 15,999.99		15,000.00	375.00	187.50	187.50
9	16,000.00 - 16,999.99		16,000.00	400.00	200.00	200.00
10	17,000.00 - 17,999.99		17,000.00	425.00	212.50	212.50
11	18,000.00 - 18,999.99		18,000.00	450.00	225.00	225.00
12	19,000.00 - 19,999.99		19,000.00	475.00	237.50	237.50
13	20,000.00 - 20,999.99		20,000.00	500.00	250.00	250.00
14	21,000.00 - 21,999.99		21,000.00	525.00	262.50	262.50
15	22,000.00 - 22,999.99		22,000.00	550.00	275.00	275.00
16	23,000.00 - 23,999.99		23,000.00	575.00	287.50	287.50
17	24,000.00 - 24,999.99		24,000.00	600.00	300.00	300.00
18	25,000.00 - 25,999.99		25,000.00	625.00	312.50	312.50
19	26,000.00 - 26,999.99		26,000.00	650.00	325.00	325.00
20	27,000.00 - 27,999.99		27,000.00	675.00	337.50	337.50
21	28,000.00 - 28,999.99		28,000.00	700.00	350.00	350.00
22	29,000.00 - 29,999.99		29,000.00	725.00	362.50	362.50
23	30,000.00 - 30,999.99		30,000.00	750.00	375.00	375.00
24	31,000.00 - 31,999.99		31,000.00	775.00	387.50	387.50
25	32,000.00 - 32,999.99		32,000.00	800.00	400.00	400.00
26	33,000.00 - 33,999.99		33,000.00	825.00	412.50	412.50
27	34,000.00 - 34,999.99		34,000.00	850.00	425.00	425.00
28	35,000.00 and up		35,000.00	875.00	437.50	437.50

Source Adapted from Premium Contribution Table, by PhilHealth.
Retrieved from http://www.philhealth.gov.ph/partners/employers/contri_tbl.html.

(5) Health Maintenance Organizations (HMOs)

An HMO is a prepaid health-care service provider that offers comprehensive health coverage to its members by contracting the services of hospitals, physicians and other health professionals. It operates on the idea of risk-sharing, with the prime objective of minimizing the financial loss of a member by covering the costs of the availed medical service through the HMO's common fund. The Bureau of Health Facilities and Services of the Department of Health (DOH), regulates the operation of Health Maintenance Organizations (HMO) in the Philippines. As of December 31, 2012, the Philippine HMO industry is comprised of 22 duly licensed HMOs operating in the country, which are either classified as investor-based,

community-based or a cooperative.

With the industry continuing to progress, government intervention has become instrumental. This intervention is currently limited to imposing conditions on HMOs. Clearances are issued upon the submission of several requirements. The official trade association of HMOs in the Philippines, the Association of Health Maintenance Organizations of the Philippines (AHMOPI), was established to somehow address the challenges brought by the evolving economic climate. Even complaints filed against AHMOPI-affiliated companies are examined by the association before they are elevated to the government bodies concerned. This arrangement would have sufficed, had it not been limited only to AHMOPI members, leaving non-affiliated HMOs still largely unregulated. Currently, AHMOPI members include Blue Cross Health Care, Inc.; Caritas Health Shield, Inc.; Cocolife Health Care; Fortune Medicare, Inc.; Health Maintenance, Inc.; Health Plan Philippines, Inc.; Insular Health Care, Inc.; Intellicare; Maxicare Healthcare Corporation (industry leader in the Philippines); Medicard Philippines, Inc.; Medocare Health Systems, Inc.; PhilHealthCare, Inc.; Star Healthcare Systems, Inc.; and Value Care Health Systems, Inc.

Depending on the HMO, there are categories for various levels of program with certain limit of peso value for coverage. Cards are issued to the beneficiaries and will be presented together with supporting identification cards bearing signature and photo to the accredited facilities of the HMO, which is usually true during emergency situations. Some HMOs allow you to proceed to non-accredited HMO Facilities, but the medical availment will be on a reimbursement basis based on your program's reimbursement provisions. For out-patient, there is usually a medical coordinator commissioned on-site who is also a medical practitioner to assess and prescribe the necessary medical treatment for the patient. For elective and non-emergency confinement, usually an admitting order from the physician must be secured in order to be admitted to the medical facility. Annual check-up and preventive care benefits might also be included in your program.

HMOs generally cover any health services that are medically necessary, apart from procedures which are experimental, investigational, or cosmetic. Many HMOs also do not cover pre-existing chronic medical conditions and dreaded diseases. Pre-existing conditions are any sicknesses that were developed prior to availing of the health care plan, such as hypertension, asthma, arthritis, etc. Dreaded diseases are serious sickness which have a significant impact on lifestyle, longevity, incur high costs, and cause significant and permanent morbidity. These diseases can include cancer and heart disease.

Most HMOs will not cover services rendered by non-HMO doctors, special or private nursing services, recuperation, quarantine, and rehabilitation medicine, pre-employment check-ups, procurement of medical appliances, out-patient medicines and supplies, reconstructive

surgeries, organ transplants, laser eye surgery, circumcision, fertility treatments, artificial insemination, sex change, congenital abnormalities, developmental delays, neurodevelopmental disorders, STD's, Guillaine-Barre syndrome, procedures related to pregnancy, morbid obesity, sleeping and eating disorders, and external forces such as wars, epidemics, and travel-related injuries.

In some cases, these exclusions can be waived with prior authorization ("Pamilya Care Health Services Plan," n.d.).

1.1.4 Laws and Regulations

This section summarizes the relevant laws and regulations in the Philippines for hospital construction and operation, establishment of a company and foreign investment.

1.1.4.1 Hospital Construction and Operations

(1) Hospital Construction

A hospital shall be planned and designed to observe appropriate architectural practices and to conform to applicable codes as part of normal professional practice. References shall be made to the following:[31]

- P. D. 1096 – National Building Code of the Philippines and Its Implementing Rules and Regulations
- P. D. 1185 – Fire Code of the Philippines and Its Implementing Rules and Regulations
- P. D. 856 – Code on Sanitation of the Philippines and Its Implementing Rules and Regulations
- B. P. 344 – Accessibility Law and Its Implementing Rules and Regulations
- R. A. 1378 – National Plumbing Code of the Philippines and Its Implementing Rules and Regulations
- R. A. 184 – Philippine Electrical Code

Excerpts from some of the above codes are as follows:

1) National Building Code of the Philippines

Hospital construction is firstly regulated as a building under Presidential Decree No. 1096, National Building Code of the Philippines, and its Implementing Rules and Regulations.

[31] Guidelines in the Planning and Design of a Hospital and Other Health Facilities, Department of Health, November 2004

Table 1.1.26 Examples of Hospital related regulations under National Building Code of the Philippines (P.D. 1096)

Related Articles	Contents
CHAPTER III PERMITS AND INSPECTION Section301	**Building Permits.** No person, firm or corporation, including any agency or instrumentality of the government shall erect, construct, alter, repair, move, convert or demolish any building or structure or cause the same to be done without first obtaining a building permit therefor from the Building Official assigned in the place where the subject building is located or the building work is to be done.
CHAPTER VII CLASSIFICATION AND GENERAL REQUIREMENT OF ALL BUILDINGS BY USE OF OCCUPANCY Section701	**Occupancy Classified.** (a) Buildings proposed for construction shall be identified according to their use or the character of its occupancy and shall be classified as follows: (1) to (3) omitted. (4) Group D. Institutional Group D Occupancies shall include: Division 1. Mental hospitals, mental sanitaria, (omitted). Division 2. (Omitted), hospitals, (omitted). (5) Group E. Business and Mercantile Group E Occupancies shall include: Division 1. (Omitted). Division 2. Wholesale and retail stores, office buildings, (omitted).
CHAPTER VII CLASSIFICATION AND GENERAL REQUIREMENT OF ALL BUILDINGS BY USE OF OCCUPANCY Section702	**Section 702. Change in Use.** No change shall be made in the character of occupancy or use of any building which would place the building in a different division of the same group of occupancy or in a different group of occupancies, unless such building is made to comply with the requirements of this code for such division or group of occupancy. The character of occupancy of existing buildings may be changed subject to the approval of the Building Official and the building may be occupied or purposes set forth in other Groups: Provided the new or proposed use is less hazardous, based on life and fire risk, than the existing use.

CHAPTER VII CLASSIFICATION AND GENERAL REQUIREMENT OF ALL BUILDINGS BY USE OF OCCUPANCY Section703	**Mixed Occupancy.** (a) General Requirements When a building is of mixed occupancy or used for more than one occupancy, the whole building shall be subject to the most restrictive requirement pertaining to any of the type of occupancy found therein except in the following: (omitted)
CHAPTER XII GENERAL DESIGN AND CONSTRUCTION REQUIREMENTS Section1207(b)(3)	Arrangement of Exits. If only two exits are required they shall be placed a distance apart to not less than one-fifth of the perimeter of the area served measured in a straight line between exits. Where three or more exits are required they shall be arranged a reasonable distance apart so that if one becomes blocked, the others will be available.
CHAPTER XII GENERAL DESIGN AND CONSTRUCTION REQUIREMENTS Section1207(b)(4)	Distance to Exits. No point in a building without a sprinkle system shall be more than 45.00 meters from an exterior exit door, a horizontal exit, exit passageway, or an enclosed stairway, measured along the line of travel. In a building equipped with a complete automatic fire extinguishing system the distance from exits may be increased to 60.00 meters.
CHAPTER XII GENERAL DESIGN AND CONSTRUCTION REQUIREMENTS Section1207(d)(4)	Corridors and Exterior Exit Balconies. Dead Ends. Corridors and exterior exit balconies with dead ends are permitted when the dead end does not exceed 6.00 meters in length.

Source: National Building Code of the Philippines
Retrieved from http://ray.dilg.gov.ph/files/national_building_code_of_the_philippines.pdf.

The party who intends to construct a building needs to obtain a Building Permit from local

authorities before starting construction. A Building Permit is a collective term used for permissions issued for constructions such as civil engineering, electric work, fit-out work, etc., and can be obtained at a municipal office, which has jurisdiction over the construction work.

Regulations related to the Permit are governed by municipal governments based on the Presidential Decree No. 1096, National Building Code. The party needs to confirm the regulations as each municipality has different regulations.

A Building Permit is issued after assessment by a City Engineer. Constructions may not be initiated without obtaining the Permit. Generally, the contractor drafts the necessary documents and presents to the client for signing.[32]

2) Republic Act No.9514, Revised Fire Code of the Philippines 2008, and its Implementing Rules and Regulations

Section 2 of the Revised Act defines that it is the policy of the State to ensure public safety and promote economic development through the prevention and suppression of all kinds of destructive fires and promote the professionalization of the fire service as a profession. Towards this end, the Revised Act also stipulates that the State shall enforce all laws, rules and regulations to ensure adherence to standard fire prevention and safety measures, and promote accountability for fire safety in fire protection service and prevention service.

In order to realize the content of this article, the Implementing Rules and Regulations stipulate more detailed items and include rules and regulations regarding hospitals.

Table 1.1.27 Excerpts of Hospital related regulations stipulated in the Implementing Rules and Regulations (IRR) of Revised Fire Code of the Philippines 2008 (RA 9514)

Related Articles	Contents
RULE 9. DIVISION 4.	ENFORCEMENT AND ADMINISTRATION OF FIRE SAFETY MEASURES FIRE SAFETY INSPECTION CERTIFICATE
SECTION9.0.4.1	FSIC AS A PRE-REQUISITE FOR ISSUANCE OF PERMIT/LICENSE Upon compliance of the fire safety requirements under Rule 10 of this IRR, a Fire Safety Inspection Certificate (FSIC) shall be issued by the

[32] System of Construction Work in the Philippines（p8）, Japan External Trade Organiation, March 2014

	BFP as a pre –requisite for the issuance of Business or Mayor's Permit, Permit to Operate, Occupancy Permit, PHILHEALTH Accreditation for Hospitals, DOH License to Operate and other permits or licenses being issued by other government agencies.
RULE10 CHAPTER2 DIVISION3	FIRE SAFETY MEASURES FIRE SAFETY IN BUILDINGS, STRUCTURES AND FACILITIES CLASSIFICATION OF OCCUPANCY A. A building or structure shall be classified as follows: 1. Assembly (omitted) 2. Educational (omitted) 3. Health Care a. Health care facilities are those used for purposes of medical or other treatment or care of persons where such occupants are mostly incapable of self preservation because of age, physical or mental disability, or because of security measures not under the occupants' control. b. Health care facilities include: hospitals; nursing homes; birth centers; and residential custodial care centers such as nurseries, homes for the aged and the like. 4. (omitted)
RULE10 CHAPTER2 DIVISION10	HEALTH CARE OCCUPANCIES GENERAL REQUIREMENTS A. Definitions 1. Hospitals A building or part thereof used for the medical, psychiatric, obstetrical or surgical care, on a 24-hour basis, of four (4) or more inpatients. Hospitals, wherever used in this Chapter, shall include general hospitals, mental hospitals, tuberculosis hospitals, children's hospitals, and any such facilities providing inpatient care. 2. (Omitted) B. Fundamental Requirements 1. All health care buildings shall be so designed, constructed, maintained, and operated as to minimize the possibility of a fire emergency requiring the evacuation of occupants. (omitted)

	C. Emergency Rooms, Operating Rooms, Intensive Care Units, Delivery Rooms and Other Similar Facilities Emergency rooms, operating rooms, intensive care units, delivery rooms and other similar facilities shall not be located more than one (1) storey above or below the floor of exit discharge. (omitted)
SECTION10.2.10.2	EXIT DETAILS A. Number and Types 1. Exits shall be restricted to the following permissible types; a. Doors leading directly outside the building b. Stairs and smoke-proof enclosures c. Ramps d. Horizontal exits e. Exit Passageways 2. At least two (2) exits of the above types, remote from each other, shall be provided for each floor or fire section of the building. 3. Elevators constitute a supplementary facility, but-shall not be counted as required exits. (omitted) C. Access to Exit 1. (omitted) 2. Travel distance shall comply with the following: a. Between any room door intended as exit access and an exit shall not exceed thirty (30) meters; b. Between any point in a room and an exit shall not exceed forty six (46) meters; c. Between any point in a health care sleeping room or suite and an exit access door of that room or suite shall not exceed fifteen (15) meters. d. Travel distance shall be measured in accordance with Section 10.2.5.2 of this IRR. e. The travel distances in para (2) (a) and (b) above may be increased by fifteen meters (15 m) in buildings completely equipped with an automatic fire suppression system. (Omitted.)

SECTION10.2.10 .3	PROTECTION A. Subdivision of Building Spaces 1. Smoke Partitions Required - Smoke partitions shall be provided, regardless of building construction type, as follows: a. To divide into at least two (2) compartments every storey used by inpatients for sleeping or treatment and any storey having an occupant load of fifty (50) or more persons. b. To limit on any storey the maximum area of each smoke compartment to no more than two thousand one hundred square meters (2,100 m2), of which both length and width shall be no more than forty six meters (46 m). (Omitted.)

Source: Revised Fire Code of the Philippines of 2008
Retrieved from http://www.lawphil.net/statutes/repacts/ra2008/ra_9514_2008.html

3) Code on Sanitation, PD856

The Code was enacted in 1975 under the President Marcos administration by compiling all public health related laws and regulations that had been scattered in numerous volumes of statute books. The Code stipulates functions and authorities of the Department of Health, water supply, food establishment, public laundry, school sanitation and health services, industrial hygiene, public spaces such as public baths, accommodations and airports, vermin control, sewage and refuse disposal, nuisance and offensive trades and occupations, environmental pollutions, and disposal of dead persons, among others.

Examples of hospital related regulations are as follows:

Table 1.1.28 Examples of Hospital Related Regulations under Code on Sanitation, PD856

Related Articles	Contents
CHAPTER V PUBLIC LAUNDRY Section 39	Special Requirements The following requirements shall be enforced: (a) All articles to be laundered coming from hospitals and infected sources shall be treated by exposure to a sufficient quantity of hot water detergents or by other effective means of disinfection.

	(b) All linen, bed clothes, pajamas, towels, bedsheets, pillow cases, etc. that have come in contact with any form of radioactivity should be isolated in a certain area and monitored by Radiation Safety personnel before sending these articles for laundry. If any amount of radioactive contamination is found, the affected article should be set aside and the radioactivity allowed to completely decay before said article is sent for laundry. (Omitted.)
CHAPTER XVII SEWAGE COLLECTION AND DISPOSAL, EXCRETA DISPOSAL AND DRAINAGE Section 80	Special Precaution for Radioactive Excreta and Urine of Hospitalized Patient. (a) Patients given high doses of radioactive isotope for therapy should be given toilet facilities separate from those used by "non-radioactive" patients. (b) Radioactive patients should be instructed to use the same toilet bowl at all times and to flush it at least 3 times after its use.

Source: Code on Sanitation
Retrieved from http://www.doh.gov.ph/sites/default/files/code_on_sanitation_phils.pdf

(2) Hospital Operations

The National Health Insurance Act, Republic Act No. 7875 enacted in 1995, has been revised twice by RA 9241 and RA 10606 and is now dubbed as The National Health Insurance Act of 2013. Hospitals are required to abide by the rules under the Act and its Revised Implementing Rules and Regulations.

1) Regulations of the Revised Implementing Rules and Regulations of the National Health Insurance Act of 2013

Table 1.1.29 Major Regulations on Hospital Operations under The National Health Insurance Act of 2013 (RA10606)

Related Articles	Contents

Article IV. THE PHILIPPINE HEALTH INSURANCE CORPORATION **SEC. 16.**	**Powers and Functions.** – The Corporation shall have the following powers and functions: (Omitted.) m. to visit, enter and inspect facilities of health care providers and employers during office hours, unless there is reason to believe that inspection has to be done beyond office hours, and where applicable, secure copies of their medical, financial, and other records and data pertinent to the claims, accreditation, premium contribution, and that of their patients or employees, who are members of the Program; (Omitted.) t. to conduct post-audit on the quality of services rendered by health care providers; (Omitted.)
Article VIII. HEALTH CARE PROVIDERS **SEC. 31**	**Authority to Grant Accreditation.** - The Corporation shall have the authority to grant to health care providers accreditation which confers the privilege of participating in the Program.
SEC. 33	Minimum Requirements for Accreditation. – The minimum accreditation requirements for health care providers are as follows: a. human resource, equipment and physical structure in conformity with the standards of the relevant facility, as determined by the Department of Health; b. acceptance of formal program of quality assurance and utilization review; c. acceptance of the payment mechanisms specified in the following section; d. adoption of referral protocols and health resources sharing arrangements; e. recognition of the rights of patients; and f. acceptance of information system requirements and regular transfer of information.
SEC. 34	Provider Payment Mechanisms. – The following mechanisms for public

	and private providers shall be allowed in the Program: a. Fee-for-service payments – payments made by the Corporation for professional fees or hospital charges, or both, based on arrangements with health care providers. This fee shall be based on a schedule to be established by the Board which shall be reviewed periodically but not less than every three (3) years; b. Capitation of health care professionals and facilities, or networks of the same including HMOs, medical cooperatives, and other legally formed health service groups; c. Case-based payment; d. Global budget; and e. Such other provider payment mechanisms that may be determined and adopted by the Corporation. Subject to the approval of the Board, the Corporation may adopt other payment mechanisms that are most beneficial to the members and the Corporation. (Omitted.)
SEC. 34-A	**Other Provider Payment Guidelines.** – No other fee or expense shall be charged to the indigent patient, subject to the guidelines issued by the Corporation. **(Omitted.)**
SEC. 35	**Reimbursement and Period to File Claims.** – All claims for reimbursement or payment for services rendered shall be filed within a period of sixty (60) calendar days from the date of discharge of the patient from the health care provider. (Omitted)
SEC. 37	**Quality Assurance.** – Under the guidelines approved by the Corporation and in collaboration with their respective Offices, health care providers shall take part in programs of quality assurance, utilization review, and technology assessment that have the following objectives:

	(Omitted.)
SEC. 38	Safeguards Against Over and Under Utilization. – It is incumbent upon the Corporation to set up a monitoring mechanism to be operationalized through a contract with health care providers to ensure that there are safeguards against: a. over-utilization of services; b. unnecessary diagnostic and therapeutic procedures and intervention; c. irrational medication and prescriptions; d. under-utilization of services; and e. inappropriate referral practices. The Corporation may deny or reduce the payment for claims when such claims are attended by false or incorrect information and when the claimants fails without justifiable cause to comply with the pertinent rules and regulations of this Act.

Source: National Health Insurance Act of 2013
Retrieved from http://www.philhealth.gov.ph/about_us/irr_nhia2013.pdf

Table 1.1.30 Major Regulations on Hospital Operations under Revised Rules and Regulations of The National Health Insurance Act of 2013

Related Articles	Contents
Rule III SECTION 64	PERFORMANCE MONITORING OF HEALTH CARE PROVIDERS The Corporation shall develop and implement a performance monitoring system for all health care providers. The monitoring system shall provide for, among others: a. Periodic actual inspection of facilities and offices when necessary and appropriate; b. Analysis of mandatory monthly hospital reports and other reportorial requirements as determined by the Corporation; c. Periodic review of health facility data and patient's chart review for purposes of determining quality and cost-effectiveness as well as adherence to practice guidelines by health care providers; d. Conduct of utilization review;

	e. Peer review, adverse reports and other pertinent information; f. Conduct of patient satisfaction surveys; g. Periodic assessment of the performance of all health care providers based on performance commitment and standards; h. Inspection and audit of books, records, billing statements, medical charts, doctor's notes, and other documents and processes deemed important by the Corporation to complete a thorough review; i. Inspection of books of accounts, ledgers, invoices, receipts and other accountable forms deemed relevant by the Corporation; and, j. Other mechanism or analogous process, as may be determined by the Corporation that would be necessary to conduct a complete audit and investigation.

Source: National Health Insurance Act of 2013
Retrieved from http://www.philhealth.gov.ph/about_us/irr_nhia2013.pdf

1.1.4.2 Labor Management

(1) Labor Code of the Philippines

Presidential Order No. 442, Revised Labor Code of the Philippines Chapter II regulates occupational health and safety. Article 162 specifically provides Safety and Health Standards as follows:

"The Secretary of Labor and Employment shall, by appropriate orders, set and enforce mandatory occupational safety and health standards to eliminate or reduce occupational safety and health hazards in all workplaces and institute new, and update existing, programs to ensure safe and healthful working conditions in all places of employment."

(2) Occupational Safety and Health Standards

Based on the Revised Labor Code Article 162, Occupational Safety and Health Standards are enacted. Rule 1960 provides as an obligation of employers to introduce health examinations to employees as occupational health services which is described as follows:

Table 1.1.31 Obligation of Employers under Rule 1960 of Occupational Safety and Health Standards

Related Rules	Contents
1961	(1) Every employer shall establish in his place of employment occupational

General Provisions	health services in accordance with the regulation and guidelines provided for under this rule. （omitted）
1961.01 Coverage	(1) This Rule shall apply to all establishments whether for profit or not, including the Government and any of its political subdivisions and government-owned or controlled corporations. （omitted）
1966	Occupational Health Program
1966.01	The employer shall organize and maintain an occupational health program to achieve the following objective: （omitted）
1966.02	The Health Program shall include the following activities: (1) omitted (2) Health Examinations: a) Entrance; b) Periodic; c) Special examination; d) Transfer examination; e) Separation examination. （omitted）
1967	Physical Examination: (1) All workers, irrespective of age and sex, shall undergo physical examination: a. before entering employment for the first time; b. periodically, or at such intervals as may be necessary on account of the conditions or risks involved in the work; c. when transferred or separated from employment; and d. when injured or ill. (2) All examinations shall: a. be complete and thorough; b. be rendered free of charge to the workers; and c. include X-ray or special laboratory examinations when necessary due to the peculiar nature of the employment.

	(omitted)
1967.01	Pre-employment/Pre-placement Physical Examinations: (1) Pre-employment Physical examination shall be conducted: a. to determine the physical condition of the prospective employee at the time of hiring: and b. to prevent the placement of a worker on a job where, through some physical or mental defects, he may be dangerous to his fellow workers or to property. (2) Pre-employment physical examination shall: a. be a general clinical examination including special laboratory examinations when necessary due to the peculiar nature of the workers prospective employment; b. include chest x-ray examinations. Under the following circumstances, x-ray examinations be rendered free of charge. (omitted)
1967.03	Periodic Annual Medical Examinations: Periodic annual medical examinations shall be conducted in order to follow-up previous findings, to allow early detection of occupational and non-occupational diseases, and determine the effect of exposure of employees to health hazards. These examinations: (1) Shall be as complete and as thorough as the pre-employment examinations and include general clinical examinations. (2) Shall include all special examinations and/or investigations deemed necessary for the diagnosis of these diseases which will be free of charge in case the workers are exposed to occupational health hazards. (3) Shall include, whenever feasible, a chest x-ray examination at least once a year which shall be rendered free of charge to the workers. (omitted)

Source: Occupational Safety and Health Standards (As Amended, 1989)
Retrieved from
http://www.oshc.dole.gov.ph/UserFiles/oshc2010/file/OSH_Standards_Amended_1989_Latest.pdf

1.1.4.3 Law on Company

(1) Types of companies

There are 3 major types of domestic companies: Single Proprietorship, Partnership and

Corporation.

Table 1.1.32 Types of companies in the Philippines

Type	Description
Sole Proprietorship	Sole Proprietorship is a business structure owned by an individual who has full control/authority of its own and owns all the assets, personally owes and answers all liabilities or suffers all losses but enjoys all the profits to the exclusion of others.
Partnership	Under the Civil Code of the Philippines, a partnership is treated as juridical person, having a separate legal personality from that of its members. Partnerships may either be general partnerships, where the partners have unlimited liability for the debts and obligation of the partnership, or limited partnerships, where one or more general partners have unlimited liability and the limited partners have liability only up to the amount of their capital contributions. It consists of two (2) or more partners. A partnership with more than three thousand pesos (3,000.00) capital must register with Securities and Exchange Commission (SEC).
Corporation	Corporations are juridical persons established under the Corporation Code and regulated by the Securities and Exchange Commission with a personality separate and distinct from that of its stockholders. The liability of the shareholders of a corporation is limited to the amount of their share capital. It consists of at least five (5) to fifteen (15) incorporators each of whom must hold at least one share and half of the incorporators must be residents of the Philippines. It must be registered with the Securities and Exchange Commission (SEC). Minimum paid up capital: five thousand pesos (5,000.00). A corporation can either be stock or non-stock company regardless of nationality. Such company, if 60% Filipino-40% foreign-owned, is considered a Filipino corporation; If more than 40% foreign-owned, it is considered a foreign-owned corporation.

Source: Investphilippines Website http://investphilippines.gov.ph/setting-up/types-of-business-enterprises/

(2) Procedure for the establishment of a company

Procedures for starting a business in the Philippines are described in 2.2.4.1.

1.1.4.4 Laws on Foreign Investments

(1) Restriction on Investments

The Foreign Investment Act (Republic Act No. 7042) prescribes the Foreign Investments Negative List which lists industries and business activities where foreign investments are allowed, and is composed of two lists;

· List A - consists of areas of activities reserved to Philippine nationals where foreign equity participation in any domestic or export enterprise engaged in any activity listed therein shall be limited as prescribed by the Constitution and other specific laws; and

· List B - consists of areas of activities where foreign ownership is limited pursuant to law such as defense or law enforcement-related activities, which have negative implications on public health and morals, and small and medium-scale enterprises.

(2) Incentive for foreign investor

The Omnibus Investment Code (Executive Order No. 226) prescribes incentives and rights of foreign investors. The requirements to receive preferential treatment are as follows:

· The industry and/or project are included in the "Investments Priorities Plan" which is published by the Board of Investment annually.

· To be approved by the Board of Investment.

The incentive is the exemption of corporate tax for 4-8 years, etc.

(3) Land ownership by foreign investors

Under the Constitution of the Philippines (1987), land owner is generally limited to Filipino citizens and corporations or partnerships of which at least 60% shares are owned by the Filipino citizen.

Under Investor's Lease Act (RA No. 7652), a foreign investor is allowed to lease commercial lands in the Philippines for a maximum of 75 years. Under this law, any foreign investor infusing capital into the country can lease private lands, in observance of Philippine laws and the following:

1. Lease contract shall first be for 50 years, renewable only once for another 25 years.

2. Leased area will be used solely for investment.

3. Lease contract will conform with the Comprehensive Agrarian Reform Law and the Local Government Code.

1.1.4.5 Law on borrowings, foreign exchange and remittance

Foreign borrowings require prior approval of and/or registration with the Bangko Sentral ng Pilipinas in order that repayment of principal and remittance of interest, distribution of dividends or benefits and divestment of capital may be distributed by using foreign exchange purchased from the Philippine commercial banks.

1.1.4.6 Tax regulation

(1) Corporate income tax

- Tax rate

The basic rate is 30%.

- Minimum Corporate Income Tax

A minimum corporate income tax of 2% of the gross income as of the end of the taxable year is imposed on a corporation which is subject to normal income tax of 30% on the fourth taxable year when the minimum income tax is greater than the normal income tax for the taxable year.

(2) Withholding tax

The Philippines and Japan have a tax treaty. Based on the treaty, the rates for distribution of money from the Philippines to Japan are as follows:

- Repayment of interest: 10%
- Distribution of dividend: 10% (more than 10% ownership), 15% (less than 10% ownership)
- Distribution of royalty: 10-15%

(3) Value added tax

Value added tax is 12%.

(4) Real property tax (RPT)

RPT is computed in the following way:

RPT = RPT Rate x Assessed Value

Maximum RPT rates are different from region:

Taxing Authority	RPT Rate
City and Municipality in Metro Manila	2%
Province	1%

Assessed value is computed in the following way:

Assessed Value = Fair Market Value x Assessment Level

Fair Market Value is defined as follows:

"Market value — is defined as "the highest price estimated in terms of money which the property will buy if exposed for sale in the open market allowing a reasonable time to find a purchaser who buys with knowledge of all the uses to which it is adapted and for which it is capable of being used." It is also referred to as "the price which a willing seller would sell and willing buyer would buy, neither being under abnormal pressure."

Sec.3(n) of "The Real Property Tax Code of Presidential Decree No. 464"

Assessment Level for hospitals is defined as follows:

"Special Classes — The assessment level for all lands, buildings and other improvement thereon, actually, directly and exclusively used for educational, cultural or scientific purposes, as well as hospitals not owned and operated by the government or by any of its instrumentalities shall be ***fifteen per cent*** *of the market value of such property and for those exclusively used for recreational purposes, thirty per cent of their market value."*

Sec.18(d) of "The Real Property Tax Code of Presidential Decree No. 464"[33]

(5) Customs

The rates are different for products. Imported medical equipment are imposed a 3% tariff duty and a 10% value-added tax (VAT).[34]

33 http://www.chanrobles.com/presidentialdecreeno1812.htm#.VK44prVfmBo

34 http://www.ita.doc.gov/td/health/philippines_meddev05.pdf

Chapter 1-2 Analysis of market conditions

1.2.1 Trends in the relevant policies, plans, budget/source of funds

1.2.1.1 Fiscal affairs

The National Government (NG) recorded a PHP 164.1 billion budget deficit for 2013, which is within the PHP 238 billion deficit ceiling for the period. The fiscal gap narrowed by 32% or PHP 78.8 billion in contrast with 2012 levels after improved revenue collections and sustained prudence in expenditures. The fiscal deficit fell to 1.4% of GDP, lower than both the 2% target and the 2.3% recorded in the previous year. Meanwhile, NG incurred a PHP 52.6 billion deficit for December 2013.

Revenue collections reached to PHP 1,716.1 billion. Full-year collections grew 12% or PHP 181.2 billion, with tax effort of 13.3% in 2012 and 12.9% in 2013. Tax revenues amounted to PHP 1,535.3 billion, making up 89% of the total, while non-tax sources contributed PHP 180 billion. Bureau of Internal Revenue (BIR) and Bureau of Customs (BoC) collections for 2013 stood at PHP 1,216.7 billion and PHP 304.6 billion, reflecting 15% and 5% year-on-year revenue growth, respectively. BIR and BoC revenue reached PHP 96.7 billion and PHP 23.8 billion, respectively, in December. Meanwhile, Bureau of the Treasury (BTr) and other government offices contributed PHP 81.0 billion and PHP 113.9 billion for the year, respectively. Collections from other offices grew 10% year-on-year, while BTR income reflected a 4% decline due to lower remittance of dividends from shares of stocks.

Table 1.2.1 Trend in annual revenue of the Government in past 5 years

Source of Income (in Million PHP)	**2009**	**2010**	**2011**	**2012**	**2013**
I. Tax Revenues	981,631	1,093,643	1,202,066	1,361,081	1,535,698
Bureau of Internal Revenue	750,287	822,623	924,146	1,057,916	1,216,661
Bureau of Customs	220,307	259,241	265,108	289,866	304,925
Other Offices	11,037	11,779	12,812	13,299	14,112
II. Non-Tax Revenues	141,389	113,877	157,621	173,752	180,074
BTr Income	69,912	54,315	75,236	84,080	81,013
Fees and Other Charges	19,253	22,820	26,048	27,793	30,541
Privatization	1,390	914	930	8,348	2,936
Others	50,834	35,828	55,407	53,531	65,584
III. Grants	191	406	255	99	321
Total Revenue	1,123,211	1,207,926	1,359,942	1,534,932	1,716,093

Source: Adapted from Bureau of the Treasury (2013)

NG disbursements in 2013 totaled to PHP 1, 880.2 billion. Expenditures accelerated by 6% or PHP 102.4 billion in 2013 despite a 16% year-on-year decline in disbursements for December. Of the total expenditures, interest payments (IP) amounted to PHP 323.4 billion which is within the PHP 332.2 billion program for the period. The Government realized PHP 8.8 billion in IP savings versus program notwithstanding the inclusion of unprogrammed interest payments on Retail Treasury Bonds issued in 2012. Broken down, domestic IP amounted to PHP 222.3 billion in 2013, up 10% year-on-year as the Government concentrated on domestic sources of financing to take advantage of substantial domestic liquidity and minimize forex risk. On the other hand, IP on foreign debt dropped 9% in 2013, settling at PHP 101.1 billion as an effect of the financing program. Total IP for 2013 is down to 18.8% of total revenues from 20.4% in 2012, indicating the country's improved capacity to service its debt. Likewise, IP is down to 17.2% of expenditures for the year from 17.6% in the previous year, freeing up space for productive Government spending.

Netting out interest payments from expenditures, NG managed a PHP 159.4 billion primary surplus for 2013, surpassing the Government's target of PHP 94.2 billion and improving upon the PHP 70.0 billion primary surplus in 2012. Government spending by sector showing the trends from 2012 to 2014 is detailed in Table 1.2.2, while top ten budget allocations per department in 2013 can be seen in Table 1.2.3. The bulk of the government is primarily used for Social and Economic Services, while Debt Burden and Defense received the least.

Table 1.2.2 Trend in Annual Budget of the Government by Sector

Sector	2011		2012		2013		2014	
	Amount (in billion pesos)	Percentage	Amount (in billion pesos)	Percentage	Amount (in billion pesos)	Percentage	Amount (in billion pesos)	Percentage
Social Services	521,445	31.99	567.9	31.3	698.8	34.8	842.8	37.2
Economic Services	361,926	22.20	439.5	24.2	511.1	25.5	590.3	26.2
General Public Services	288,090	17.27	338.1	18.6	346.1	17.3	364.5	16.1
Debt Burden	357,090	21.91	356.1	19.6	333.9	16.6	377.6	16.6
Defense	101,449	6.22	114.4	6.3	89.7	4.5	92.9	4.1

Source: Adapted from Department of Budget and Management (DBM) (2011-2014)

The different budgetary sectors are Social Services, Economic Services, General Public Services, Defense, and Debt Burden. Social Services represent government spending to

improve the living conditions of citizens, particularly the poor, through education, health, social security, and others. Economic Services are government expenditures that are intended to support economic development, including agriculture, transport, infrastructure, tourism, and others. General Public Services are expenditures for general administration (such as fiscal management, foreign affairs, lawmaking, etc.), and public order and safety. Defense refers to expenditures that support the general effort to ensure national security, stability, and peace. Debt Burden includes interest payments on national government's domestic and foreign debt, as well as net lending to government corporations for their debt that are guaranteed by the national government. (Management)

Table 1.2.3 2013 Budget of the Government by Sector (Top 10 Departments)

Department	Acronym	Budget (in Billion pesos)
Department of Education	DepEd	292.7
Department of Public Works and Highways	DPWH	152.9
Department of National Defense	DND	121.6
Department of Interior and Local Government	DILG	121.1
Department of Agriculture	DA	74.1
Department of Health	DOH	56.8
Department of Social Welfare and Development	DSWD	56.2
Department of Transportation and Communications	DOTC	37.1
Department of Finance	DOF	33.2
Department of Environment and Natural Resources	DENR	23.7

Source: Adapted from Department of Budget and Management (DBM) (2012-2014)

In 2013, the Philippines' long history of junk-debt ended. The country got investment-grade status first from Fitch Ratings, second by S&P and then by Moody's Investors Service. Fitch Ratings has upgraded the credit rating of foreign and local bond ratings in March of 2013 to "BBB-" and "BBB," respectively. Standard & Poor's Ratings Services gave a long-term sovereign credit rating status of "BB+" from "BBB-" in May of 2013 while Moody's Investors Service, known to be the most conservative among the three major credit watchdogs, also raised its ratings in October of 2013 to Ba1 from Baa3.

The Debt-to-GDP ratio of the Philippines also continues to improve. In a recent article by

the Philippine Star[35], one of the country's leading news publications, it cited that the government's debt in proportion to the size of the economy has improved due to more efficient spending. As of March 2014, government debt was at PHP 4.49 trillion or 38.1% of the gross domestic product of the country. This is down from 38.5% the same time last year. The table below shows the consolidated general government debt from 2006 to 2012.

Table 1.2.4 Annual Debt-to GDP Ratio

Department	2006	2007	2008	2009	2010	2011	2012
Domestic	24.5%	22.3%	20.8%	20.4%	21.3%	20.6%	22.7%
Foreign	27.2%	22.0%	23.4%	24.0%	22.2%	20.8%	17.9%
Total Consolidated Government Debt	51.6%	44.2%	44.2%	44.3%	43.5%	41.4%	40.6%

Source: Adapted from Department of Finance

1.2.1.2 DOH Major Programs and Projects

(1) DOH Major Programs and Projects Classified According to the Five KRA's of the Social Contract and Kalusugan Pangkalahatan (Universal Health Care)

Inequality is a pervasive problem in the Philippines, including in the health sector. To address the gaps of inequality, the Aquino Health Agenda (AHA), through Administrative Order No. 2010-0036 was implemented. This contained the Kalusugan Pangkalahatan (KP) strategy of the DOH. The implementation of KP shall be directed towards the achievement of the health system goals of financial risk protection, better health outcomes, and responsive health system. KP is a means to fulfill the social contract of President Benigno Aquino with the Filipino people[36] .

In 2011 Benigno Aquino, the President of the Philippines, released Executive Order No. 43, *Pursuing our Social Contract with the Filipino people through the organization of the Cabinet Clusters*. This established Key Result Areas (KRA's) for the different government departments. The Key Result Areas for the Department of Health (DOH) are (1) Transparent Accountable and Participatory Governance, and (2) Poverty Reduction and Empowerment of the Poor and Vulnerable. These KRA's determine the major programs and projects of the DOH, as illustrated in the tables below (DOH, n.d.).

35 Dela Pena, Z. (2014, September 24). Debt-to-GDP ratio continues to improve. Retrieved October 2014, from Philstar.com: http://www.philstar.com/business/2014/09/24/1372404/debt-gdp-ratio-continues-improve

36 Department of Health (2012). National Objectives of Health 2011-2016. Retrieved October 10, 2014, from http://www.doh.gov.ph/content/national-objectives-health-2011-2016.html

Table 1.2.5 DOH Programs According to the Five KRA's of the Social Contract and the Kalusugan Pangkalahatan (Universal Health Care)

KRA 1: Transparent Accountable and Participatory Governance	
ISO Certification	The DOH is the first government agency in the country certified to have a department-wide ISO 9001. It aims to institutionalize the quality management system in the Department.
Kalusugan Pangkalahatan Monitoring and Evaluation (Universal Health Care)	The KP M&E will ensure that progress and performance against KP goals and objectives are clearly defined on the basis of valid and reliable data. It shall assess and report program progress, effectiveness and impact to promote informed decision making. The KP M&E is composed of the following systems: KP dashboard, Cabinet Assistance System (CAS), LGU scorecard, CHD scorecard, donor scorecard, Performance Governance System, Expenditure Tracking System, among others.
KRA 2: Poverty reduction and empowerment of the poor and vulnerable	
Kalusugan Pangkalahatan Strategic Thrust 1: Financial Risk Protection	
National Health Insurance Program (NHIP)	Aims to protect all Filipinos, especially the poor, from the financial burden of accessing/availing preventive and curative healthcare services. It was establish to serve as the means to help the people pay for health services; and prioritize and accelerate the provision of health service to all Filipinos, especially the segment of the population who cannot afford these services.
Kalusugan Pangkalahatan Strategic Thrust 2: Improve Access to Quality Health Facilities and Services	
Health Facility Enhancement Program (HFEP)	Aims to improve access of all Filipinos to quality health facilities by building new or upgrading the capacity of existing public health facilities such as barangay health stations, rural health units/ health centers, LGU and DOH hospitals to help attain the public health- related Millennium Development Goals, attend to traumatic injuries and other types of emergencies, and manage non- communicable diseases and their complications.
DOH Complete Treatment Pack (ComPack) Program	A medicines access program designed to reach the poorest of the poor with complete treatment regimens for the top most common diseases in the country.
Human Resource for Health Deployment –	Physicians, nurses, and midwives are deployed in 4th to 6th class municipalities or identified Conditional Cash Transfer (CCT) areas
Doctors to the Barrios; RNHeals and Rural Health Midwife	With lacking or with limited numbers of HRH that can deliver health services. They are deployed in these areas so that health services can be more efficiently and effectively delivered, e.g. contribute better maternal and child health care and therefore attain the Millennium Development Goals (MDGs).
Community Health Team (CHTs)	The community health team is composed of the barangay health workers, community volunteers, barangay officials and health providers who will communicate directly with the poor families to ensure early identification of health problems of family members, effective access to accredited health providers and facilities, and timely utilization of needed health services to improve health outcomes. The CHTs are crucial to break the barriers limiting the access by the poorest households to quality health care and services.
National Telehealth Service Program	Help in improving access to health services through the use of ICT especially in Geographically Isolated and Disadvantaged Areas
Kalusugan Pangkalahatan Strategic Thrust 3: Attainment of Health-related MDGs	
Expanded Program on Immunization	To reduce mortality and morbidity among children 0-11 months against the vaccine preventable diseases. Specific goals include the following: (1) Sustain the polio-free status of the country; (2) eliminate measles; (3) eliminate maternal and neonatal tetanus and (3) control hepatitis b infections, diphtheria, pertussis, extrapulmonary tuberculosis, meningitis/ invasive bacterial diseases and severe diarrhea caused by the rotavirus.

Adolescent Health Program	Aims to promote the total health and well-being of young people through youth-friendly comprehensive health care and services on multiple levels—national, regional, provincial/city, and municipal.
Women's Health and Safe Motherhood Project	Contribute to the national goal of improving women's health by: 1.Demonstrating in selected sites a sustainable, cost-effective model of delivering health services access of disadvantaged women to acceptable and high quality reproductive health services and enables them to safely attain their desired number of children. 2. Establishing the core knowledge base and support systems that can facilitate countrywide replication of project experience as part of mainstream approaches to reproductive health care within the *Kalusugan Pangkalahatan* framework.
Micronutrient Malnutrition Program	Aims to contribute to the reduction of disparities related to nutrition through a focus on population groups and areas highly affected or at-risk to malnutrition and micronutrient deficiencies and to provide vitamin A, iron & iodine supplements to treat or prevent specific micron nutrient deficiencies.
Family Planning Program	A national mandated priority public health program to attain the country's national health development: a health intervention program and an important tool for the improvement of the health and welfare of mothers, children and other members of the family. It also provides information and services for the couples of reproductive age to plan their family according to their beliefs and circumstances through legally and medically acceptable family planning methods.
National TB Control Program	The program aims to reduce morbidity and mortality from tuberculosis by scaling-up and sustaining coverage of DOTS implementation, ensuring provision of quality TB Services and reducing out-of-pocket expenses related to TB care.
National HIV, AIDS and STI Prevention and Control Program	Aims to prevent the further spread of HIV infection and reduce the impact of the disease on individuals, families, sectors and communities by improving the coverage and quality of prevention programs for persons at most risk, vulnerable and living with HIV
Malaria Control Program	Aims to significantly reduce malaria burden so that it will no longer affect the socio-economic development of individuals and families in endemic areas.
National Dengue Control Program	The NDPCP is directed towards community-based dengue prevention and control in endemic areas.
National Rabies Prevention and Control Program	The Rabies Program is jointly implemented by the DOH with the Department of Agriculture (lead agency and the responsible for canine immunization), Department of Education and the Department of Interior and Local Government (DILG). It aims to eliminate rabies in the Philippines by 2020.
National Filariasis Control Program	Aims to eliminate filariasis as a public health problem through comprehensive approach and universal access to quality health services
Schistosomiasis Control Program	Area-based schistosomiasis case-finding and treatment program concurrent with vector control and environmental engineering measures.
Tobacco Control Program	Aims to reduce the prevalence of tobacco use and decrease the overall ill effects of tobacco through policies and legislation on tobacco control.
Healthy Lifestyle Program	It aims to inform and encourage Filipinos from all walks of life to practice a healthy lifestyle by making a personal commitment to physical activity, proper nutrition, and the prevention or cessation of smoking and alcohol consumption.
Cancer Prevention and Control Program	Aims to develop a comprehensive approach and strategies to increase awareness, information and continuing education of health personnel, high-risk individuals and patients.

Chronic Respiratory Diseases Prevention and Control Program Cardiovascular Disease Prevention and Control Program Diabetes Mellitus Prevention and Control Program	Aims to develop a comprehensive approach and strategies to increase awareness, information and continuing education of health personnel, high-risk individuals and patients. It utilizes early detection through the risk assessment at the primary, secondary, and tertiary levels of health care with the appropriate medical/therapeutic management.
Health Development Program for Older Persons	The program intends to promote and improve the quality of life of older persons through the establishment and provision of basic health services for older persons, formulation of policies and guidelines pertaining to older persons, provision of information and health education to the public, provision of basic and essential training of manpower dedicated to older persons and, the conduct of basic and applied researches.
Persons with Disabilities	Aims to reduce the prevalence of all types of disabilities; and Promote, and protect the human rights and dignity of PWDs and their caregivers.
Environmental Health Program	The primary mission of the program is to lead and synchronize all efforts in environmental health towards a healthy and safe community. Its primary goal is to reduce human exposures to various environmental hazards thereby reducing incidence of water and sanitation related diseases.
Violence and Injury Prevention Program	This program is designed to reduce disability and death due to violence and injuries in the following areas: road traffic injuries, burns and fireworks-related injuries, drowning, falls, sports and recreational injuries, interpersonal violence-related injuries, bullying, animal bites and stings, self-harm, occupational or work- related injuries, poisoning and drug toxicity.
Occupational Health Program	The primary mission of the program is to lead and synchronize all efforts in occupational health towards a healthy and safe working environment. Its primary goal is to reduce the incidence of work- related diseases and injuries due to poor working condition
Event-based Surveillance and Response (ESR)	This is an organized and rapid capture of information about events that are a potential risk to public health including those related to the occurrence of a disease in humans and events with potential risk-exposures to humans. It is designed to complement the existing indicator-based surveillance. In the revised 2005 International Health Regulations (IHR), there was a call to its Member States to designate a National Focal Point for the IHR. The members were also encouraged to maintain and strengthen their core capacities for surveillance and response. In response to IHR, the Secretary of Health through Administrative Order 2007-002 designated the National Epidemiology Center (NEC) as the International Health Regulations Focal Point for the Philippines.
Surveillance in Post Extreme Emergencies and Disasters (SPEED)	The project is developed as an early warning system designed to monitor diseases (both communicable and non-communicable), and health trends, that can be harnessed as a powerful tool by health emergency managers in getting vital information for appropriate and timely response during emergencies and disasters.

Source: Adapted from *Major Programs and Projects*.
Retrieved from http://www.doh.gov.ph/Major%20_Programs%20and%20Projects.html.

1.2.1.3 Health Sector Budget and its Source of Funds

The budget and expenditure trends for the health sector during the years 2005-2011 are indicated in the two tables below.

Table 1.2.6 Health Expenditure by Source of Fund, 2005-2011 (in million pesos)

Source of Funds	2005	2006	2007	2008	2009	2010	2011
Government	**58,474**	**57,475**	**74,036**	**74,875**	**88,722**	**101,378**	**116,433**
National Government	30,416	27,001	32,749	36,554	36,949	43,375	53,069
Local Government	28,058	30,475	41,288	38,320	51,773	58,003	63,364
Social Insurance	**19,360**	**19,098**	**19,972**	**21,434**	**27,897**	**33,925**	**39,126**
National Health Insurance Program	19,270	19,005	19,838	21,345	27,791	33,799	39,022
Employees' Compensation	90	93	134	88	107	126	104
Private Sources	**118,293**	**135,376**	**173,987**	**202,054**	**217,865**	**239,139**	**272,009**
Private Out-of-Pocket	97,562	113,087	147,873	171,116	182,370	199,983	227,215
Private Insurance	4,112	3,924	4,175	5,108	6,083	6,401	7,222
Health Maintenance Organizations	8,853	10,097	13,123	15,638	18,199	21,170	24,570
Employer-Based Plans/Private Establishments	5,699	5,813	5,996	7,043	7,809	7,937	9,297
Private Schools	2,068	2,455	2,820	3,148	3,404	3,649	3,706
Rest of the World	**2,271**	**4,463**	**933**	**3,682**	**7,681**	**6,384**	**3,478**
Grants	2,271	4,463	933	3,682	7,681	6,384	3,478
ALL SOURCES	**198,398**	**216,413**	**268,928**	**302,043**	**342,164**	**380,826**	**431,047**

Source: Adapted from *Budget Facts and Figures*, by the Legislative Budget Research and Monitoring Office. Retrieved from https://www.senate.gov.ph/publications/LBRMO%202013-02%20Budget%20Facts.pdf.

Table 1.2.7 Health Sector Budget Allocation Breakdown per year

Health Sector Budget Allocation Breakdown per year									
PARTICULARS	2005	2006	2007	2008	2009	2010	2011	2012	2013
Department/Agencies	**12,080,177**	**12,175,623**	**15,085,999**	**15,653,482**	**22,203,383**	**26,348,159**	**31,924,642**	**44,901,259**	**42,473,715**
Department of Health	10,431,864	10,557,562	13,424,090	14,551,499	21,153,725	25,170,053	30,618,385	43,471,914	40,969,880
Office of the Secretary	*10,320,960*	*10,397,759*	*13,062,005*	*13,962,645*	*20,345,660*	*24,359,796*	*30,041,718*	*42,847,536*	*40,324,535*
Commission on Population	*110,904*	*113,118*	*184,835*	*282,507*	*438,008*	*327,462*	*303,522*	*299,455*	*313,867*
National Nutrition Council		*46,685*	*177,250*	*306,347*	*370,057*	*482,795*	*273,145*	*324,923*	*331,478*
Other Executive Offices	172,846	122,517	160,154	185,340	138,500	145,727	172,034	170,842	181,946
Dangerous Drugs Board	*172,846*	*122,517*	*160,154*	*185,340*	*138,500*	*145,727*	*172,034*	*170,842*	*181,946*
Department of Agriculture	45,928								
National Nutrition Council	*45,928*								
Department of National Defense	1,327,347	1,394,351	1,367,358	686,606	746,631	792,156	863,981	836,767	861,827
Armed Forces of the Philippines Medical Center	*753,170*	*816,547*	*710,747*						
Veterans Memorial Medical Center	*574,177*	*577,804*	*656,611*	*686,606*	*746,631*	*792,156*	*863,981*	*836,767*	*861,827*
Department of Science and Technology	102,192	101,193	134,397	230,037	164,527	240,223	270,242	421,736	460,062
Food and Nutrition Research Institute	*62,774*	*63,900*	*81,445*	*165,227*	*98,992*	*117,200*	*169,132*	*159,448*	*221,260*
Phil. Council for Health Research and Devt	*39,418*	*37,293*	*52,952*	*64,810*	*65,535*	*123,023*	*101,110*	*262,288*	*238,802*
Budgetary Support to Government Corporations	**1,772,891**	**3,893,007**	**3,128,342**	**2,912,019**	**1,189,078**	**4,649,796**	**8,584,270**	**1,294,360**	**948,265**
Local Water Utilities Administration							52,800		
Lung Center of the Philippines	*211,510*	*210,810*	*222,440*	*191,230*	*169,583*	*184,205*	*288,083*	*257,560*	*173,400*
National Kidney and Transplant Institute	*268,371*	*244,591*	*232,045*	*498,996*	*305,164*	*305,341*	*337,282*	*264,800*	*202,865*
Philippine Children's Medical Center	*238,025*	*236,825*	*242,120*	*272,600*	*251,650*	*269,920*	*640,858*	*445,000*	*345,000*
Philippine Heart Center	*210,423*	*200,438*	*325,709*	*464,314*	*291,915*	*303,557*	*631,511*	*287,000*	*187,000*
Phil. Inst. for Traditional and Alternative Health Care	*40,000*	*40,000*	*40,000*	*30,000*	*40,000*	*40,000*	*37,000*	*40,000*	*40,000*
Philippine Health Insurance Corporation	*804,562*	*2,960,343*	*2,066,028*	*1,454,879*	*130,766*	*3,546,773*	*6,596,736*		
Other Special Purpose Funds	**10,451**	**5,143**	**23,904**	**75,743**	**22,305**			**4,363,205**	**16,958,062**
Allocation to Local Government Units	10,451	5,143	23,904	75,743	22,305				
Municipal Development Fund	*10,451*	*5,143*	*23,904*	*75,743*	*22,305*				
Premium Subsidy for Indigents under the NHIP									
Miscellaneous Personnel Benefits Fund								2,513,825	1,612,047
Calamity Fund								150,000	150,000
Tax Expenditure Fund								330,430	269,000
Priority Development Assistance Fund								1,368,950	1,368,950
Health Facilities Enhancement Program*									13,558,065
TOTAL HEALTH SECTOR ALLOCATION	**13,863,519**	**16,073,773**	**18,238,245**	**18,641,244**	**23,414,766**	**30,997,955**	**40,508,912**	**50,558,824**	**60,380,042**

Source: Adapted from Budget Facts and Figures, by the Legislative Budget Research and Monitoring Office. Retrieved from https://www.senate.gov.ph/publications/LBRMO%202013-02%20Budget%20Facts.pdf.

According to a publication by the National Statistical Coordination Board, titled "Philippine National Health Accounts," total health expenditure has increased gradually over the years. The majority of total health spending has been shouldered by private sources, made up of accounts from private out-of-pocket, private establishments, private schools, private insurance and health maintenance organizations (HMOs).

Although most of the country's private health expenditure came directly from the pockets of the public, most Filipinos are not financially equipped to address their health concerns. Given the increased awareness on various medical issues, the rate of availing medical services to alleviate these issues loses by comparison. The increasing costs of receiving medical attention do not help improve the situation, either.

1.2.1.4 Budget Reservation for Achieving Universal Healthcare

In December 2012, Republic Act No. 10351, An Act Restructuring the Excise Tax on Alcohol and Tobacco Products, was signed by President Aquino and took effect in January 2013.

The Act focused on the following two points: 1) the ratio of excise tax to the total tax revenue fell 6.2 points, from 14.4% in 2002 to 8.2% in 2010, and within the 6.2 point decrease, 1.9 points were from the decline for alcohol and tobacco, from 8.4% to 6.5%; 2) more men and the young smoke than women and the old, and the poor smoke more and take alcohol more than the rest of the income class.

Under the Act, the Philippine Government is expected to generate additional 34 billion pesos of tax revenue, of which 15% is allocated to the safety nets for tobacco farmers, and 80% of the remaining balance of the incremental revenue shall be allocated for the universal health care under the National Health Insurance Program, and 20% shall be allocated nationwide for medical assistance and health enhancement facilities program (Section 8(C)).

As a result, Department of Health ranked up from 6th in 2013 to 5th in 2014 budget allocation, passing Department of Agriculture.

Table 1.2.8 Budget Allocation by Department（2013-2014）

Department	2013		2014		Difference	
	Rank	Amount	Rank	Amount	Amount	Increase (%)
Department of Education	1	293.400	1	336.900	43.500	14.83
Department of Public Works and Highways	2	152.400	2	213.500	61.100	40.09
Department of Interior and Local Government	3	121.800	3	135.400	13.600	11.17
Department of National Defense	4	121.600	4	123.100	1.500	1.23
Department of Health	6	59.900	5	87.100	27.200	45.41
Department of Agriculture	5	75.000	6	80.700	5.700	7.60

Source: *Budget Facts and Figures, September 2013, by the Legislative Budget Research and Monitoring Office.*
Retrieved from https://www.senate.gov.ph/publications/LBRMO%200913%20Budget%20Facts.pdf

1.2.2 Infrastructures

Since 1995, the Department of Health has been working on the improvement of hospital system by crafting the Philippine Hospital Development Plan (PHDP) which was then expanded and renamed the Philippine Health Facility Enhancement Program (HFEP) in 2008. In 2012, as a framework to enable physical improvements of government healthcare facilities, DOH issued Administrative Order 4 Series of 2012 as a commitment to engage in more public–private partnerships (PPPs). With this document, DOH aimed to prioritize PPPs that would support the universal healthcare goals and other DOH-set priority areas. Through the DOH Center of Excellence for Public–Private Partnerships in Health, DOH started various partnerships with the private sector, such as the Modernization of the Philippine Orthopedic Center etc. Below is the current list of Public-Private Partnership (PPP) projects and its status as of October, 2014.

Table 1.2.9 PPP projects in healthcare sector

Project Name	Estimated cost (PHP)	Agency	Private Proponent	Location	Status
Philippine Orthopedic Center Modernization (construction of a 700-bed capacity super-specialty tertiary orthopedic hospital)	5.69 Bn	DOH	Megawide-World Citi Consortium	Quezon city	Contract awarded, target completion date Jan 2017
Trimedical Complex (The Tri-Medical Complex will involve the modernization and integration of the three medical centers proposed to be located at the Tayuman Compound of DOH)	TBD	DOH	TBD	Manila	Ongoing procurement of Consultants
Vicente Sotto Memorial Medical Center Modernization (Upgrading the facilities and expanding the bed capacity)	TBD	DOH	TBD	Cebu City	Ongoing procurement of Consultants
Rehabilitation of National Center for Mental Health (the relocation and modernization of the National Center for Mental Health)	TBD	DOH	TBD	Manila	Under conceptualization/ development
PhilHealth IT Project (computerization of PhilHealth)	TBD	PhilHealth/ DOH	TBD	TBD	Under conceptualization/ development

Source: Adapted from List of PPP Projects by Public-Private Partnership Center

Retrieved from Public-Private Partnership Center – Status of PPP Projects as of 27 Aug 2014.pdf

1.2.3 Projects position within the partner country's policy such as its development plan

As mentioned earier, the Philippines developed the 'Philippine Development Plan 2011-2016', whose aim includes the achievement of universal healthcare. The government has taken various actions such as the enactment of the Sin Tax Law and implementation of Health Facility Enhancement Program (HFEP). However, the progress is still slow against

the remaining challenges such as high population growth, disparity in health service delivery and utilization, fragmentation in health financing and service delivery, etc. The country's health system remains underfunded, as DoH budget aiming for upgrading health facilities is not fully admitted. Therefore, the government still needs to largely focus on the poor, while the middle-class population is rapidly growing. Under these circumstances, the Filipino Government recognizes the private sector as a partner especially "in pursuing development objectives" as declared in the 1987 Constitution. The construction of hospitals by private sector has been also promoted since the improvement of social infrastructure is one of the most urgent issues raised in the Development Plan.

1.2.4 Foreign Initiatives

According to the WHO Country Cooperation Strategy for the Philippines (2011–2016), ODA for health from more than 10 development partners, consisting of multilateral banks, bilateral agencies and the United Nations system reached US$ 747.8 million. ODA was used for the following projects in support of MTPDP (Medium Term Philippine Development Plan) 2005-2010. The table below is the list of the past and ongoing projects conducted by foreign development partners.

Table 1.2.10 Foreign funded health sector projects (in PHP)

Agency	Project
ADB	The Health Sector Development Project
World Bank	National sector support for Health Reform Project and the Second Women's Health and Safe Motherhood Project
European Union	The health sector policy support
KOICA	Improving Disease Prevention and Control in Cavite through the Construction of a Public Health Collaboration Center; Korea-Philippine Friendship Hospital (2010-2012, Cavite)
KOICA	Development of the Lung Center of the Philippines as the National Referral Center for Multi Drug Resistant-Tuberculosis (MDR-TB) (2008-2011, Quezon city)
World bank	Pilot interventions that improve the health status, particularly maternal and reproductive health, of poor populations (2011-2015, World Bank)
The Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
MDG-Fund	MDG-F 2030: Ensuring Food Security and Nutrition for Children 0-24 months in the Philippines
The United Nations Joint Programme	on Reducing Maternal and Neonatal Mortality (supported by the Australian Agency for International Development, AusAID)
Bloomberg	The tobacco free initiatives
UNDP	Health care waste management
European Union	Mindanao Health and Population Sector Programme
KFW, USAID, GIZ, JICA, AECID and KOICA	Health Sector Reform Project in selected sites by

Source: KOICA website and World Bank website