DATA COLLECTION SURVEY
ON
UNIVERSAL HEALTH COVERAGE
IN
THE PHILIPPINES

DECEMBER 2016

JAPAN INTERNATIONAL COOPERATION AGENCY (JICA)

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LIST OF ACRONYMS/ABBREVIATIONS

Acronyms/ Abbreviations	Standard Nomenclature
ADB	Asian Development Bank
ANC	Antenatal Care
ANC01	Antenatal Care Package
AOP	Annual Operational Plan
ARMM	Autonomous Region in Muslim Mindanao
BEmONC	Basic Emergency Maternal Obstetrics and Newborn Care
BHS	Barangay Health Station
BHW	Barangay Health Worker
BMC	Bicol Medical Center
BRTTH	Bicol Regional Training and Teaching Hospital
CAR	Cordillera Administrative Region
CCT	Conditional Cash Transfer
CEmONC	Comprehensive Emergency Maternal Obstetrics and Newborn Care
CHT	Community Health Team
CHTF	Common Health Trust Fund
CS	Camarines Sur
DBM	Department of Budget and Management
DHS	Demographic and Health Survey
DMO	Development Management Officer
DOF	Department of Finance
DOH	Department of Health
DSWD	Department of Social Welfare and Development
EU	European Union
EVRMC	Eastern Visayas Regional Medical Center
FBD	Facility-based Delivery
FGD	Focus Group Discussions
FHSIS	Field Health Service Information System
FIES	Family Income and Expenditure Survey
GDP	Gross Domestic Product
GIDA	Geographically Isolated and Disadvantaged Areas
GNI	Gross National Income
GSIS	Government Service Insurance System
HMO	Health Maintenance Organization
ILHZ	Inter-Local Health Zone
IRA	Internal Revenue Allotment
IT	Information and Technology
I3QUIP	The Impact of Incentives and Information on Quality and Utilization in Primary Care
JICA	Japan International Cooperation Agency
KII	Key Informant Interview
KOICA	Korea International Cooperation Agency
KP	Kalusugan Pangkalahatan
LGC	Local Government Code 1991
IMR	Infant Mortality Rate
LGU	Local Government Unit
LHSD	Local Health Support Division
LIPH	Local Investment Plan for Health
MCH	Maternal and Child Health

Acronyms/ Abbreviations	Standard Nomenclature
MCP	Maternal Care Package
MDGs	Millennium Development Goals
MDR	Medical Data Record
MMR	Maternal Mortality Ratio
MNCHN/FP	Maternal, Neonatal, Child Health and Nutrition/ Family Planning
MNDR	Maternal and Newborn Death Review
MSW	Medical Social Worker
NBB	No Balance Billing
NCP	Newborn Care Package
NDHS	National Demographic and Health Survey
NEDA	National Economic and Development Authority
NGO	Non-Governmental Organization
NHIP	National Health Insurance Program
NHTS-PR	National Household Targeting System for Poverty Reduction
NSD	Normal Spontaneous Delivery
OBGYN	Obstetrics and Gynecology
ODA	Official Development Assistance
PCB1	Primary Care Benefit 1
PCPT	Per Capita Poverty Threshold
PhilHealth	The Philippine Health Insurance Corporation
PHRD	Policy and Human Resources Development
PI	Poverty Incidence
PMRF	PhilHealth Member Registration Form
PMT	Proxy Means Test
PNC	Postnatal Care
POC	Point of Care
PSPI	Population Services Philipinas, Inc.
PRISM2	The Private Sector Mobilization for Family Health Project – Phase 2
PSA	Philippine Statistics Authority
RHMPP	Rural Health Midwives Replacement Program
RHU	Rural Health Unit
SAEs	Small Area Estimates
SBA	Skilled Birth Attendant
SDGs	Sustainable Development Goals
SDN	Service Delivery Network
SSS	Social Security System
SSV	Supportive Supervision
TBA	Traditional Birth Attendant
TCL	Target/ Client List
TseKaP	Tamag Serbisyo para sa Kalusugan ng Pamilya
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
ZFF	Zuelling Family Foundation

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EXECUTIVE SUMMARY

Although the national infant mortality rate and under-five mortality rate have declined steadily, the maternal mortality ratio and neonatal death remain high and regional disparities exist in the Philippines. In the Philippine Health Agenda 2016-2022, President Duterte announced that the new administration would guarantee good health for all life stages by setting effective Service Delivery Networks and providing universal health insurance.

In 1995, the National Health Insurance Program (NHIP) was established, and as of the end of June 2016, 90 percent of Filipinos were enrolled in NHIP. However, the out-of-pocket expenditure rate is more than 50 percent, which is higher than many other Southeast Asian countries. Moreover, the knowledge of the LGU staff, the health care providers and the people is still limited and utilization rate remains low at 12 percent. The government budget increased substantially in 2014 due to increased tax revenue from the Sin Tax Reform Law of 2012 and about 40 percent of the indigent and near-indigent population are now sponsored by the national government. Nonetheless, the total health expenditure for the richest quintile is more than twice as much as that of the poorest quintile. The total health expenditure as a percentage of the Gross Domestic Product (GDP) in the Philippines is lower than most developed countries, however, comparable to other Southeastern Asian countries.

The Philippine health system is devolved and public health service providers are primarily local government units (LGUs). The public health services are financed by central government subsidy and the LGU budget. The LGU budget consists of local government tax revenues, user fees at health facilities, and payments from health insurance corporations. Health service quality highly depends on leadership of the executives of LGUs. Functional health service networks are indispensable particularly for emergency obstetric care. However, coordination between the primary health facilities and the referral hospitals within the multiple LGUs has been a challenge in the devolved Philippine health system.

While institutional delivery has been increasingly popular in the Philippines, quite a few women still prefer home delivery. There are geographical and cultural factors that affect their preference; however, the important factor is financial. When a woman delivers at a facility, she has to pay for medicine not in stock, some examinations, transportation fees, food for the attendant family members, payment of the child care-takers, and loss of income while hospitalized. These expenditures are a huge burden on poor families.

The survey team would recommend JICA to pursue the new technical assistance project, “UHC enhancement in the MCH services” with two approaches: improved access to quality essential health-care services and financial risk protection. Furthermore, a mechanism to fully up-scale the good results of the project to the entire country should be also sought in the new project.

Chapter 1 Overview of the Survey

1-1 Background

The Aquino administration launched the national Universal Health Care policy (Kalusugan Pangkalahatan, known as KP) in December 2010 to provide every Filipino with affordable and quality health services particularly the most vulnerable and remote populations through three strategic goals: 1) financial risk protection, 2) improved access to quality hospitals and health care facilities, and 3) the attainment of health-related Millennium Development Goals (MDGs). The first goal, financial risk protection, is intended to insure all citizens through the implementation of the National Health Insurance Program (NHIP) by the Philippine Health Insurance Corporation (PhilHealth).

The new President Duterte recently introduced the Philippine Health Agenda 2016-2022 with the theme "All for Health towards Health for All." The Agenda aims at attaining Health-Related Sustainable Development Goal (SDG) Targets, Financial Risk Protection, Better Health Outcomes and Responsiveness, and guarantees (1) All Life Stages & Triple Burden of Disease, (2) Service Delivery Network, and (3) Universal Health Insurance.

According to PhilHealth, 92,624,502 people or 90 percent of the total population[1] had become eligible beneficiaries of the NHIP by the end of June 2016 and the enrollment rate has been increasing somewhat.[2] Since the Sin Tax Law (RA 10351) was passed in December 2012, the increased tax revenue has enabled many of poor families to be enrolled as indigent members.

On the other hand, household out-of-pocket spending has increased by 150 percent from 2000 to 2012.[3] Although the out-of-pocket spending rate out of the total health expenditures has been decreasing lately, household out-of-pocket spending was still as high as 44 percent, and NHIP's utilization rate[4] remains low at 12 percent as of December 31, 2015.[5] In addition, it is reported that 7.7 percent of the households experienced catastrophic health expenditure in 2012 and the proportion had increased three-fold from 2000.[6,7] This data reveals that NHIP enrollment has not necessarily resulted in the improvement of access to health services and financial risk protection.

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1 On the basis of the Philippine 2015 Population Census, the total population of the Philippines as of August 1, 2015 is 100,981,437.
2 PhilHealth. (2016). Stats and Charts, December 31, 2015.
3 Bredenkamp C. & Buisman L. R. (2016).
4 Utilization rate = unique member claims reimbursed/ total eligible members
5 PhilHealth. (2016). Stats and Charts, December 31, 2015.
6 ibid
7 Bredenkamp C. & Buisman L. R. (2016).

The government of Japan stated promotion of universal health coverage (UHC) as a vision of Japan's Strategy on Global Health Diplomacy in 2013. The government also declared that Japan would take the lead in addressing global challenges including UHC, formulating international goals and guidelines, and making active efforts to achieve the goals in the Development Cooperation Charter in 2015.

Japan International Cooperation Agency (JICA) has been providing assistance to the Philippines for the improvement of maternal and child health (MCH) especially in remote and poor areas, such as the Cordillera Administrative Region and Eastern Visayas Region. While the evidence has shown that the JICA projects have improved the MCH service delivery in the target areas, it is suggested that mothers are still dying in childbirth due to personal, family and community factors as well as healthcare system factors that hinder their accessibility to health services.[8] In order for JICA to continue the efforts of MCH development in the context of the new Sustainable Development Goal (SDG) 3, aiming at reduction of maternal and neonatal mortality and improved access to sexual and reproductive health-care services, and start contributing to the new administration's health agenda, JICA dispatched the data collection survey team to clarify current issues affecting access to MCH services, particularly for the poor, and to explore JICA's future assistance in the Philippines to promote UHC in the area of MCH.

1-2 Objectives

The data collection survey had the following objectives:

1) To understand the current status of NHIP implementation in the Philippines and identify issues preventing access to basic health services with a particular focus on MCH services for the poor; and

2) To identify possible areas for JICA's future assistance in strengthening MCH services and promoting UHC in the Philippines.

1-3 Scope of the Survey

Based on the situation analysis and objectives described earlier, data collection activities of the survey were undertaken within the scope described in Table 1- 1.

[8] Saniel, O. P. & Bermudez, A. N. C. (2016, August). Why do mothers die? A Maternal Death Review in Camarines Norte.

Table 1- 1 Scope of the Survey

(1) Heath sector analysis
Status and issues concerning the overall health sector especially MCH
Regional progress in achieving MCH indicators
Status of health system at regional level
Donor assistance
Health sector priorities under the new administration
(2) Status of basic health service provision and access for the poor through the NHIP
Basic information about the NHIP
Size of population covered by the NHIP
Health services covered by the NHIP
Proportion of costs covered by the NHIP
(3) Analysis of factors affecting access to health services particularly economic access
Means of transportation and transportation fees for pregnant women's access and referral to health facilities including hospitals, RHUs and BHS
Psychological barriers for pregnant women at the time of referral to health facilities including hospitals, RHUs and BHS
Systems of DOH and PhilHealth to address the issue of economic access
Situation of out-of-pocket health expenditure paid by pregnant women
Implementation status of the No Balance Billing Policy at health facilities
Level of awareness of patients and service providers on the MCH service package and primary care benefits
(4) Suggestion of JICA's future cooperation program

1-4 Survey Areas

The JICA survey team reviewed the overall status of UHC and MCH efforts of the Philippines in **Manila**, and drew lessons learned from the currently conducted MCH project in the **Cordillera Administrative Region (CAR).** Moreover, the **Bicol Region** and **Eastern Visayas Region** were selected as field data collection sites based on the following criteria (see Table 1- 2):

- Unsuccessful MCH indicators including facility- based delivery (FBD), antenatal care (ANC) from skilled providers and postnatal care (PNC) in the first two days after birth according to National Demographic and Health Survey (NDHS) 2013
- 20 High Poverty Sites announced by the Duterte Administration as priority provinces
- High ratio of geographically isolated and disadvantaged area (GIDA), according to the Department of Health (DOH)
- Large population
- Accessible from Manila
- Acceptable security level based on JICA's standards

Figure 1- 1 Map pf the Philippines

Table 1- 2 Selection Criteria of the Field Data Collection Target Areas[9]

	Region	2015 Population[1]	FBD[2]		ANC[2]		PNC[2]		GIDA(%)[3]	High Poverty Sites
			%	Rank	%	Rank	%	Rank	Rank	
1.	Mimaropa - 4B	2,963,360	37	15	91	15	50	15	7	—
2.	Soccksargen - 12	4,545,276	49	13	92	14	54	14	14	○
3.	Zamboanga Peninsula - 9	3,629,783	43	14	94	13	55	13	14	○
4.	Northern Mindanao - 10	4,689,302	53	10	95	12	58	12	12	○
5.	Caraga - 13	2,596,709	56	9	97	9.5	63	11	24	—
6.	Cagayan Valley - 2	3,451,410	51	12	97	7	67	10	20	—
7.	Bicol Region - 5	5,796,989	51	11	97	9.5	74	7	19	○
8.	Eastern Visayas - 8	4,440,150	62	7	96	11	77	5	9	○
9.	Davao Region - 11	4,893,318	63	6	98	5	73	9	14	○
10	Western Visayas - 6	4,477,247	61	8	98	3	73	8	21	○
11	Calabarzon - 4A	14,414,774	66	5	97	8	77	4	2	○
12	Ilocos Region - 1	5,026,128	67	4	97	6	78	3	16	○
13	Central Luzon - 3	11,218,177	68	3	98	4	76	6	11	—
14	Central Visayas- 7	6,041,903	72	2	98	1	83	2	5	○
15	CAR	1,722,006	75	1	98	2	83	1	42	○

Source: [1]The Philippine Population Census (2015), [2]National Demographic and Health Survey (2013), [3]Bureau of Local Health Development, DOH, [4]DOH

1-5 Methodology

The survey consisted of a literature review and field data collection to derive situation analysis and strategic recommendations for JICA's future assistance in the Philippines:

(1) Literature review

Existing academic research papers and reports by government, donors and non-governmental organizations (NGOs) on the subjects mentioned in Table 1- 1 were collected and analyzed throughout the survey period.

(2) Field data collection

The JICA survey team conducted interviews and collected materials at the Philippine Government offices, including the Department of Health (DOH), PhilHealth, the Department of Social Welfare and Development (DSWD), the Department of Interior and Local Government (DILG) and the Philippine Statistics Authority (PSA), and development partners at the national level. At the sub-national level, the survey team collected information through key informant interviews (KIIs) and focus group discussions (FGDs) at the DOH/PhilHealth Regional Offices, other government offices, local government units (LGUs), health facilities, NGOs, community members and any other relevant parties.

[9] National Capital Region and ARMM are not included in the table as they are not likely to be JICA project target sites. NIR is also not included as it was newly created in 2015.

Table 1- 3 shows categories and sub-categories, sources and collection methods of data collected in the survey.

Table 1- 3 List of Data to be Reviewed During the Survey

	Data Category	Data Sub-Category	Data Source	Data Collection Method
1	Status and issues of the health sector especially MCH	• Overview of the health sector • Achievements and challenges pertaining to MCH	• Online • Statistical data • Japanese experts	• Desk review • KII
	Regional Progress in achieving MCH indicators	• MMR • IMR • MCH service utilization rates	• Online • Statistical data	
	Status of health system at regional level	• System of health service provision • Human resources • Budget • Number of NHIP-accredited facilities	• Online • Statistical data • Japanese experts	
	Donor assistance	• Status of assistance in health financing • Status of assistance in MCH • Status of assistance in health system	• Online • Japanese experts	
	New administration's health sector priorities	• Priority issues on MCH • Other priority issues on health	• Online • Japanese experts	
2	Basic information about the NHIP	• Organization and structure • Financial resources and budget • Payment mechanisms • Accreditation system • Awareness-raising activities	• Online • DOH and PhilHealth • Experts	• Desk review • KII
	Size of population covered by the NHIP	• Enrollment and utilization rates of each program (particularly for indigents)	• Online • DOH and PhilHealth • Beneficiaries including indigents	• Desk review • FGD • KII
		• Enrollment rates in each region	• DOH and PhilHealth	• Desk review • KII
		• Reasons for not enrolling	• Community members not enrolled in the NHIP	• FGD • KII
		• Characteristics of NHIP populations	• PhilHealth	• KII
	Health services covered by the NHIP	• Details of benefits and packages	• Online • PhilHealth	• Desk review • KII
	Proportion of costs covered by the NHIP	• Details of out-of-pocket spending	• DOH and PhilHealth • NHIP members	
		• Details of costs covered by LGUs	• DOH/LGU and PhilHealth • Health facilities	
		• Measures for indigents not enrolled in the NHIP	• Health facilities • PhilHealth • Indigents who are not enrolled in the NHIP	• Desk review • FDG • KII

	Data Category	Data Sub-Category	Data Source	Data Collection Method
3	Means of transportation and transportation fees for pregnant women's access and referral to health facilities	• Distance and conditions of infrastructure between facilities at different levels	• DOH/LGU • Healthcare providers/BHWs • Pregnant and lactating women • Barangay councilors/ Chairmen • Donors/NGOs • PhilHealth • Community members	• Desk review • KII • FGD
		• Transportation options and time required		
		• Transportation costs and household income sources/levels		
		• Existing transportation support by government/donors		
	Psychological barriers for pregnant women at the time of referral to health facilities	• Images/perceptions of health facilities and staff	• DOH/LGU • Healthcare providers/ BHWs • Pregnant and lactating women • TBAs • Traditional leaders • Donors/NGOs	
		• Actual experiences at or feedback on health facilities (including what they heard from families and friends)		
		• Determining factors for referral		
		• Household decision-making on referral		
		• Coping strategies when referral is not utilized		
	DOH and PhilHealth's systems to address the issue of economic access	• DOH and PhilHealth's measures to address the issue	• Online • DOH and PhilHealth • Community members	
		• DOH's measures to improve economic access to health services other than the NHIP (such as through social security and anti-poverty systems)	• Online • DOH and PhilHealth	• Desk review • KII
		• DOH's systems and mechanisms on referral and emergency transport		
		• LGU's systems to support transportation fees	• DOH/LGU	• KII
		• Details of PhilHealth's benefits and packages (in relation to economic access)	• PhilHealth	• Desk review • KII
	Out-of-pocket expenses paid by pregnant women	• Fees paid at health facilities for ANC, delivery and PNC services	• Women who gave birth in the past year • DOH and PhilHealth • Health facilities	• KII • FGD (during PNC and at community)
		• Reimbursements from the NHIP for healthcare expenses related to ANC, delivery and PNC services	• Women who gave birth in the past year • PhilHealth	• KII • FGD (during PNC and in community)
	Implementation status of the No Balance Billing Policy at hospital level	• Healthcare providers' level of awareness of the No Balance Billing Policy	• Healthcare providers	• KII
		• Implementation status of the No Balance Billing Policy	• Health facilities • DOH/LGU • Patients	• KII • FGD
	Awareness levels of patients and healthcare providers regarding the MCH service package and primary care benefits	• Awareness levels of pregnant women and healthcare providers on the MCH service package	• Healthcare providers/BHWs • Pregnant and lactating women • Patients • Barangay councilors/ Chairmen • Donors/NGOs	
		• Awareness levels of patients and healthcare providers on the primary care benefits		

The key informants interviewed in the survey are listed in Table 1- 4.

Table 1- 4 List of Key Informants During the Field Data Collection

	Informants
Government	DOH (national/regional officers)
	LGU (provincial/city/municipal health officers)
	Healthcare providers at DOH's regional/provincial/district/municipal hospitals, medical centers, RHUs and BHS
	BHWs
	Barangay Chairmen and Councilors
	Community Health Team (CHT)
	PhilHealth (national and LGU levels)
	DSWD (national/regional/provincial/municipal officers)
Development partners	WHO, UNICEF, UNFPA, World Bank, ADB, EU, USAID
	NGOs
Community	Pregnant and lactating women
	TBA
	Traditional/religious leaders
	Patients at health facilities
	Community-based organizations/women's groups
Other	Private hospitals and clinics covered by PhilHealth in survey areas
	Private insurance companies
	JICA Office, JICA Experts and the Embassy of Japan
	Ambulatory service providers (such as Lifeline Rescue)
	Universities and think tanks

1-6 Survey Team

The survey team consists of the members in Table 1- 5.

Table 1- 5 Survey Team Members

Name	Area of work	Affiliation
Ms. Haruyo Nakamura	Team Leader/UHC	Global Link Management, Inc.
Ms. Akiko Hirano	MCH /Health System Analysis	Global Link Management, Inc.
Ms. Nami Takashi	MCH /Needs Analysis	Global Link Management, Inc.
Mr. Shizuma Yokozawa	Health Financing	Deloitte Tohmatsu Financial Advisory LLC

1-7 Survey Schedule

The survey was conducted from July to December 2016. During this period field data collections were executed in the Philippines for three times. Please see Attachments 1-4 for the detailed schedules of the first to third field data collections. The work flow of the entire survey is shown in Figure 1- 2.

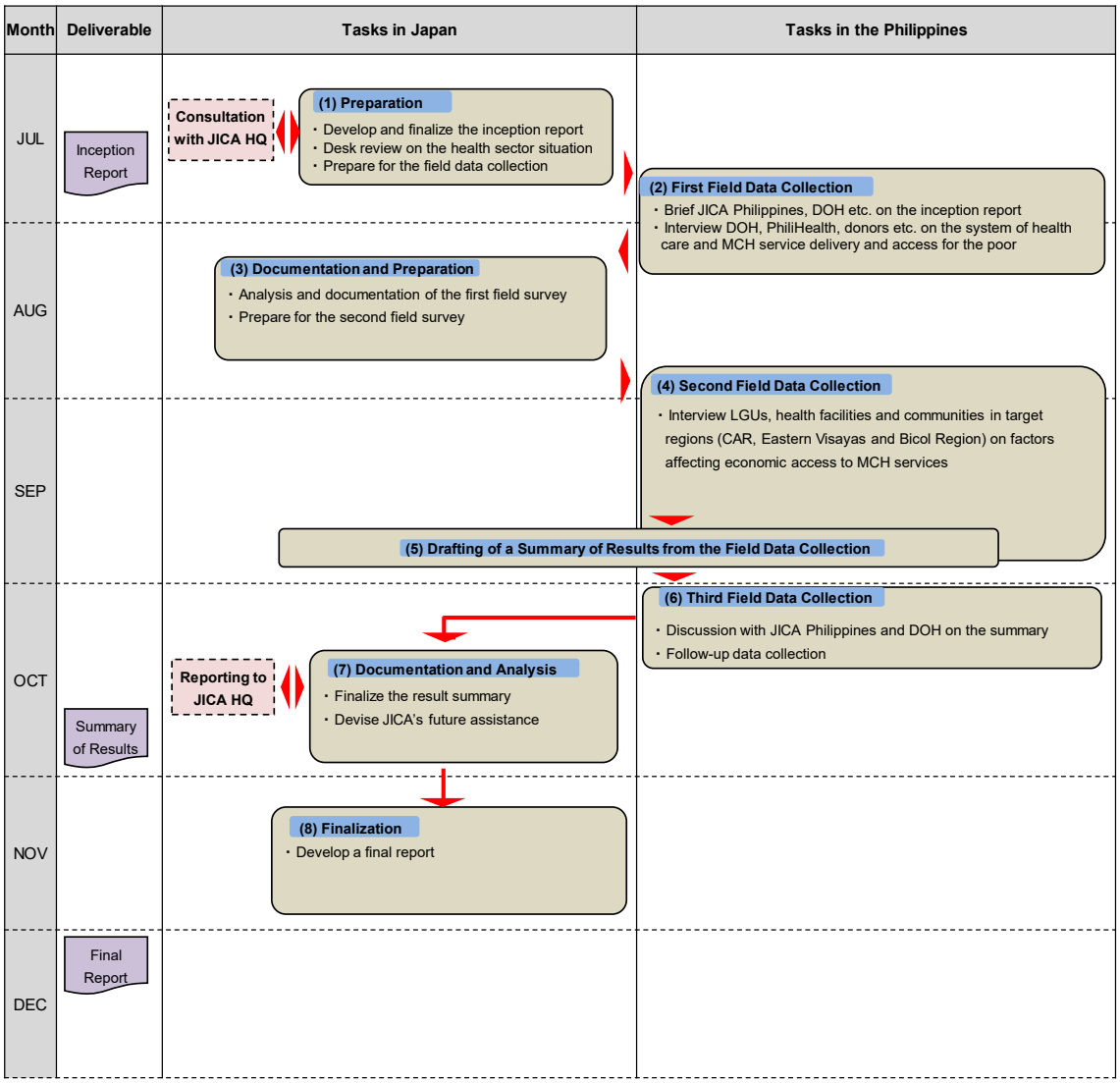

Figure 1- 2 The Work Flow of the Data Collection Survey on UHC in the Philippines

Chapter 2 Socio-Economic Situation in the Philippines

2-1 Geography, Ethnicity and Religion

The Philippines is an archipelago comprised of 7,107 islands in Southeast Asia. Its terrain is primarily mountainous with narrow to extensive coastal lowlands. It has a tropical and maritime climate, characterized by relatively high temperatures, high humidity and abundant rainfall. Because of its location in the typhoon belt of the Western Pacific, the Philippines experiences an average of twenty typhoons annually during its rainy season, from June to November. In addition, the country is along the "Pacific Ring of Fire," where large number of earthquakes and volcanic eruptions occur. These factors combine to make the Philippines one of the most disaster-prone countries on the globe.[10]

According to the 2010 Census of Population and Housing, 92.6 percent of the Filipinos are Christian, 80.6 percent of which are Roman Catholic, 5.6 percent are Muslim and 0.05 percent are Buddhist. There are approximately 180 ethnic groups which have their own languages. The largest linguistic group is Tagalog, which accounts for 24.4 percent of the population. Other ethnic groups include Cebuano, Ilocano, Hillgaynon (Ilongo), Bisaya, Bicol and Lineyte-Samarnon (Waray). The official language of the Philippines is Filipino, derived from Tagalog and English.

2-2 Population Statistics and Future Projections

The total population of the Philippines was 76,506,928 in 2000, 92,337,852 in 2010 and 100,981,437 in 2015 (see Figure 2- 1). The average population growth rate during the period varies from the highest in Calabarzon Region at 2.85 percent to the lowest in Negros Island Region at 1.14 percent (see Figure 2- 2).[11] The population in 2016 is estimated to be 102,250,133 (population growth rate: 1.54 percent, population density: 343 persons per km^2) and projected to continuously increase to 148,260,478 by 2050.[12]

[10] Kwon S. & Dodd R. (Eds.). (2011). The Philippines Health System Review, WHO Health Systems in Transition.

[11] The Philippine 2015 Population Census. https://psa.gov.ph/content/highlights-philippine-population-2015-census-population.

[12] Worldometers (www.Worldometers.info) Elaboration of data by United Nations, Department of Economic and Social Affairs, Population Division. World Population Prospects: The 2015 Revision. (Medium-fertility variant).

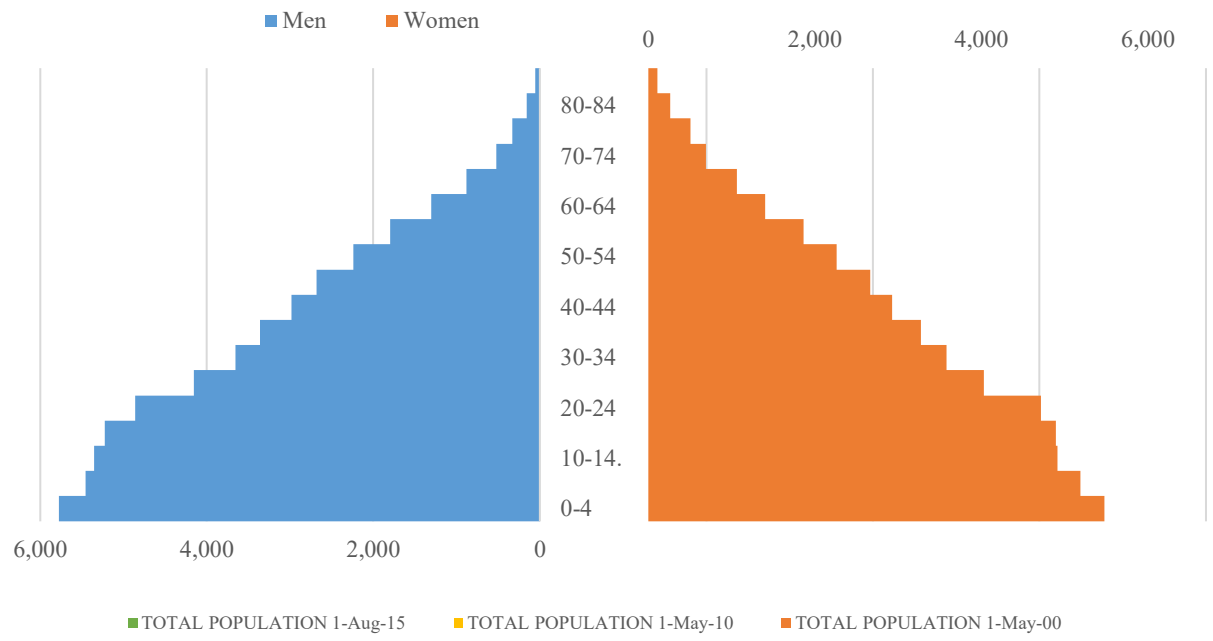

Figure 2- 1 Population pyramid of the Philippines, 2015 (in thousands)

Social Affairs, Population Division, United Nations

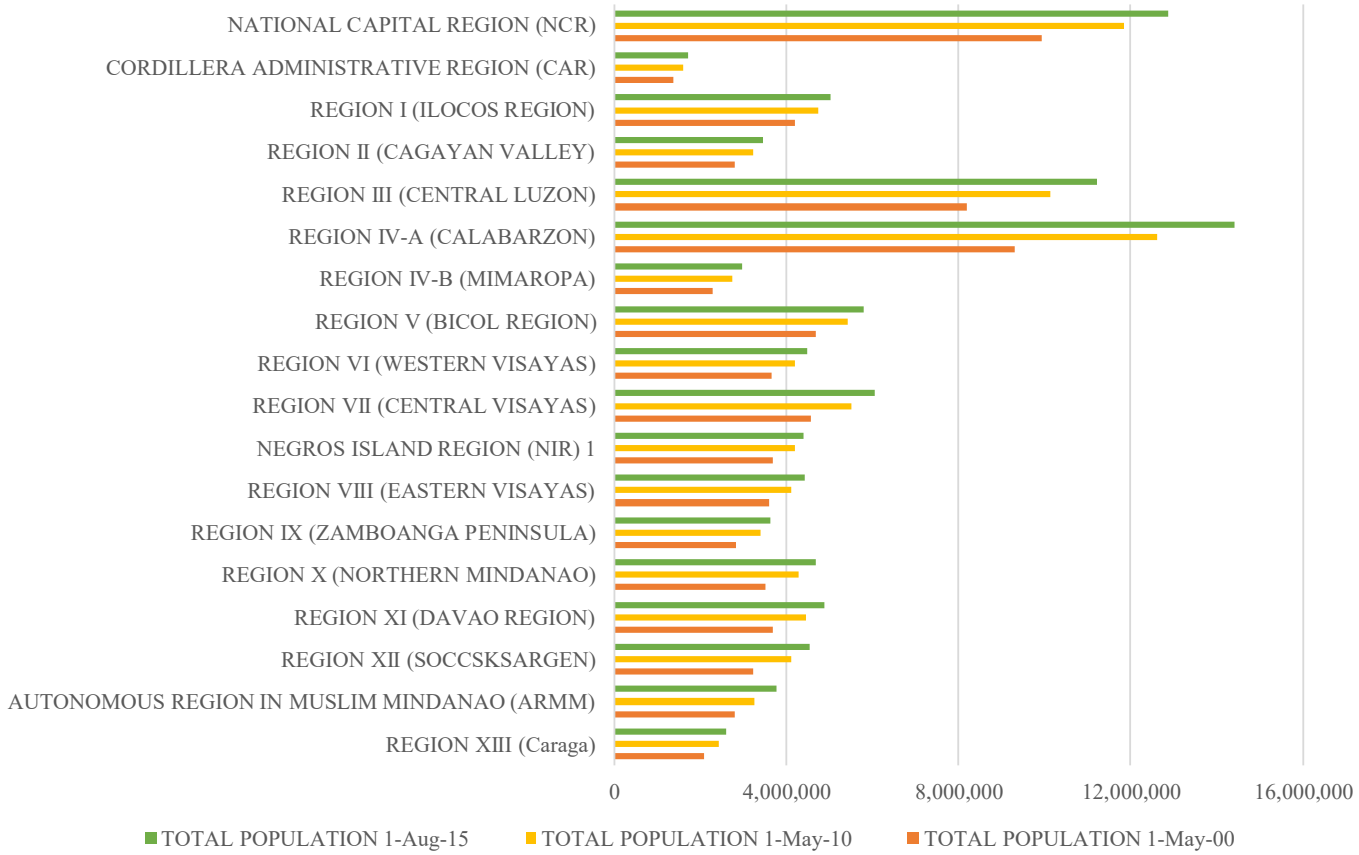

Figure 2- 2 National and Regional Population in the Philippines (2000-2015)

Source: The Philippine 2015 Population Census. https://psa.gov.ph/content/highlights-philippine-population-2015-census-population.

The proportion of age categories 0-14 years, 15-64 years and 65+ years are 31.9 percent, 63.5 percent and 4.6 percent, respectively, in 2015. The child dependency ratio[13] is 50.3, the old-age dependency ratio[14] is 7.2, and the total dependency ratio is 57.5.[15] The total fertility rate is 3.04, the under-five mortality rate is 30 per 1,000 live births, and average life expectancy is estimated to be 68 years.[16]

The total fertility rate is similar to Japan's in 1951-1952.[17] Life expectancy[18] and the population proportions of 0-14 years and 15-64 years are similar to Japan in 1960; however, the proportion of people 65+ years is lower than that of Japan in 1960 at 5.7.[19]

Aging is slowly becoming an issue in the Philippines.[20] The Philippines is forecast to become an aging society with 7 percent of aged people (65+ years) in 2030-2035 and an aged society with 14 percent of aged people in 2070-2075. The doubling time[21] is projected to be 35 to 45 years,[22] which is much longer than that of Japan at 24 years.[23]

It is predicted that the labor force ratio (15-64 years) will be 66.7 percent in 2055 at the highest point and then will decrease, while the dependency ratio will be 33.3 percent at the lowest in the same year and then will increase.[24] Japan experienced the same transition in the early 1990s.[25]

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13 The child dependency ratio is an age-population ratio of children under the age of 15 and those typically in the labor force (the productive part). It is used to measure the pressure on the productive population.

14 The old-age dependency ratio is an age-population ratio of those over the age of 64, not in the labor force, and those typically in the labor force (the productive part). It is used to measure the pressure on the productive population.

15 The Philippine 2015 Population Census. https://psa.gov.ph/content/highlights-philippine-population-2015-census-population.

16 United Nations, Department of Economic and Social Affairs, Population Division. (2015). World Population Prospects: The 2015 Revision. Volume II: Demographic Profiles.

17 National Institute of Population and Social Security Research. 2016. Population Statistics. http://www.ipss.go.jp/syoushika/tohkei/Popular/P_Detail2016.asp?fname=T04-03.htm.

18 Ministry of Health, Labour and Welfare. Abridged life table. http://kaiwa-kouza.com/contents/sub/statistics/longevity.html.

19 Statistics of Japan 2016, Statistics Bureau, Ministry of Internal Affairs and Communications. http://www.stat.go.jp/data/nihon/02.htm

20 All the population estimates here are moderate-range estimates.

21 Number of years required for the proportion of the aged population to move from 7% to 14%. It is an indicator that shows the speed of aging in each country.

22 United Nations, Department of Economic and Social Affairs, Population Division. Interactive data of World Population Prospects, the 2015 Revision. https://esa.un.org/unpd/wpp/.

23 National Institute of Population and Social Security Research. 2012. Population Statistics. http://www.ipss.go.jp/syoushika/tohkei/Popular/P_Detail2012.asp?fname=T02-18.htm

24 United Nations, Department of Economic and Social Affairs, Population Division. Interactive data of World Population Prospects, the 2015 Revision. https://esa.un.org/unpd/wpp/.

25 Statistics of Japan 2016, Statistics Bureau, Ministry of Internal Affairs and Communications. http://www.stat.go.jp/data/nihon/02.htm

In the Philippines, child dependency is currently much higher than old age dependency (child dependency: 50.3, old-age dependency: 7.2), however, it will become equal in 2090 (both child dependency and old-age dependency: 31.1) and then old-age dependency will become slightly higher.[26] Japan experienced the same transition in the late 1990s.[27]

2-3 Poverty and Economic Disparity

The Gross National Income (GNI) of the Philippines was US$357 billion[28] in 2015, GNI per capita was US$3,540,[29] and the real GDP growth rate has been on average 6 percent from 2010 to 2015. The Philippines is categorized as a "lower-middle-income economy" [30] by the World Bank.[31]

In the Philippines, the poverty incidence[32] was estimated at 21.6 percent in 2015.[33] Although the estimate was improved from 2012 at 25.6 percent, another poverty data, the poverty headcount ratio, has not shown much change in the past decade in the country, while other Southeast Asian countries, such as Cambodia, Thailand, Vietnam and Laos, have shown progress (see Figure 2- 3). The Philippines' poverty headcount ratio is in fact one of the highest in the region today.

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[26] United Nations, Department of Economic and Social Affairs, Population Division. Interactive data of World Population Prospects, the 2015 Revision. https://esa.un.org/unpd/wpp/.

[27] Statistics of Japan 2016, Statistics Bureau, Ministry of Internal Affairs and Communications. http://www.stat.go.jp/data/nihon/02.htm

[28] At the time of the US$ market price.

[29] Calculated using Atlas method of the World Bank (Converted to the current US$).

[30] World Bank Open Data. http://data.worldbank.org/

[31] The World Bank's country classification by income level takes place in July every year and it uses GNI per capita of the previous years as an indicator. For the current 2017 fiscal year, lower middle-income economies are defined as those with a GNI per capita, calculated using the World Bank Atlas method, of between $1,026 and $4,035."

[32] Poverty incidence is the proportion of people below the poverty line to the total population. The poverty line refers to the minimum income required to meet food and non-food requirements. In 2015, a family of five needed at least PhP 9,064, on average, every month to meet both basic food and non-food needs. Source: Philippine Statistics Authority. https://psa.gov.ph/poverty-press-releases.

[33] Philippine Statistics Authority. (2016). Philippine Poverty Statistics. https://psa.gov.ph/poverty-press-releases

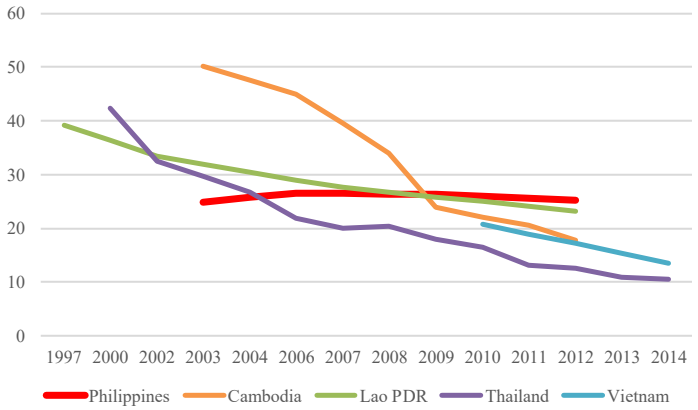

Figure 2- 3 Trends of poverty headcount ratio at national poverty lines (% of population) in ASEAN countries in 1997-2014

Source: World Bank. The World Development Indicators

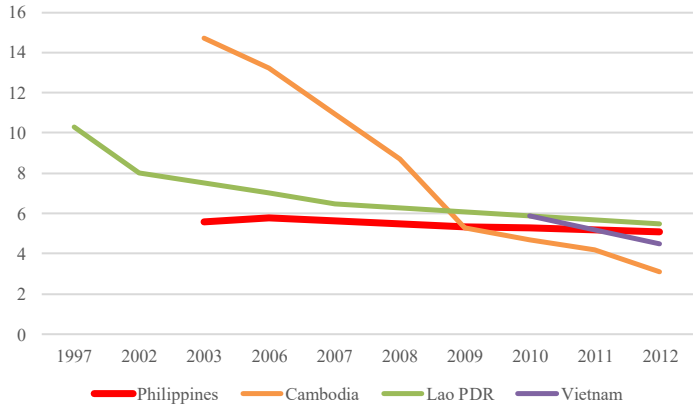

Figure 2- 4 Trends of poverty gap at national poverty lines (%) in ASEAN countries in 1997-2012

Source: World Bank. The World Development Indicators

Whereas the poverty gap ratio[34] in 2012 was 5.1 percent, which had slightly improved since 2003, showing that the depth and incidence of poverty in the country has been somewhat mitigated in the past decade. However, the country's progress is still minimal as compared with other Southeastern countries, such as Cambodia, Laos and Vietnam, and the Philippine poverty gap ratio was second highest among these nations in 2012 (see Figure 2- 4).

The GINI Index, which measures the degree of inequality in the distribution of family income in a country, shows that income is distributed quite unequally in the Philippines, at the highest

[34] Poverty gap ratio is the mean shortfall of the total population from the poverty line (counting the non-poor as having zero shortfall), expressed as a percentage of the poverty line. This measure reflects the depth of poverty as well as its incidence.

after 1996, and it has not improved over the past three decades. In fact, the Philippines' family income is the most unequally distributed in all of Southeast Asia (see Figure 2- 5).

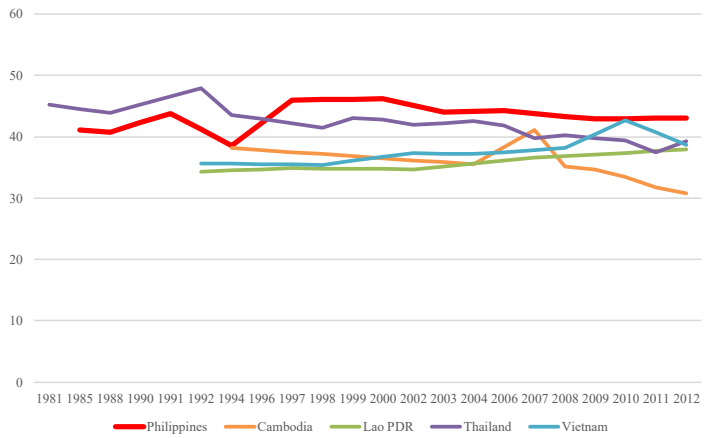

Figure 2- 5 Trends of GINI Index (World Bank estimate) in Southeast Asian countries in 1981-2012

Source: World Bank. The World Development Indicators

2-4 Industrial Structure and Labor Market

In the Philippines, the composition ratio by industry to GDP in 2014 was as follows: manufacturing (20.6%), trade (17.7%), agriculture (11.3%), finance (7.8%), and construction (6.6%). The composition ratio has not changed in the past three decades.[35]

The labor force[36] (ages 15-64) of the Philippines in 2014 was 41,379,000 people. Among the labor force, 38,651,000 people were employed and 2,728,000 were unemployed. The unemployment rate among the labor force is 6.6%.[37, 38]

[35] Asia Development Bank 2015. Key Indicators for Asia and the Pacific 2015. http://www.adb.org/sites/default/files/publication/175162/phi.pdf

[36] All persons who are 15 years old and over and are reported as (1) without work, (2) currently available for work, and (3) seeking work or not seeking work due to valid reasons.

[37] Proportion of people who are both jobless and looking for a job.

[38] Asia Development Bank 2015. Key Indicators for Asia and the Pacific 2015. http://www.adb.org/sites/default/files/publication/175162/phi.pdf

Chapter 3 Overview of the Health Sector

3-1 Health System with a Focus on Maternal and Child Health

(1) Health Governance

The Philippine health system is comprised of five administrative bodies. The Department of Health (DOH) in the central government is in charge of the development of policies, regulations and guidelines, and the provision of tertiary health care. The provincial governments are responsible for secondary health care, and the municipal/city governments are in charge of primary health care. The general term for a provincial government and a municipal/city government is a local government unit (LGU). Each municipality/city is divided into barangays and the barangay health station (BHS) provides public health services as the closest facility to the people.

In principle, LGU health personnel are employed and deployed by the LGUs. However, LGU health facilities also have human resources assigned by DOH, such as Development Management Officers (DMOs) who provide technical assistance to the municipalities, and monitor and report DOH programs, Nurses and Midwives posted at Rural Health Units (RHUs) and BHSs.

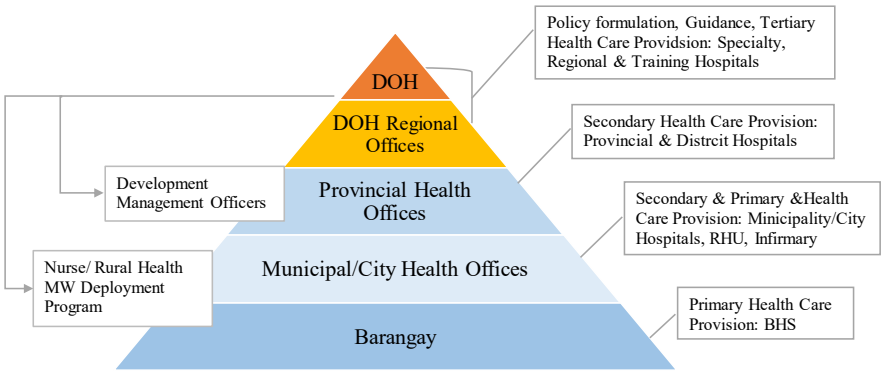

Figure 3- 1 Health Governance Structure in the Philippines

Source: Global Link Management

There are two types of health service networks in the Philippines, namely Inter Local Health Zone (ILHZ) and Service Delivery Network (SDN). ILHZ was adopted in the Philippines based on the District Health System [39] advocated by World Health Organization (WHO) in 1986, aiming at promoting coordination between the primary

[39] The means to achieve the end of an equitable, efficient and effective health system based on the principles of the primary health care (PHC) approach.

health facilities and the referral hospitals within the multiple LGUs in order to ensure the access of communities to better health services. Meanwhile, SDN was announced in Administrative Order No. 2014-0046 in 2014 during the Aquino Administration as a health service networking system established by the provincial or municipal government with the participation of the private sector. DOH reportedly planned to redefine the detail roles and functions of SDN in 2016 and scale up its implementation nationwide.[40]

DOH uses the LGU Health Score Cards with 30 indicators (see Attachment 5) as a tool of Monitoring & Evaluation on Equity & Effectiveness for each local health system. DOH requires LGUs to develop a three-year plan called the Local Investment Plan for Health (LIPH). The LIPH was introduced in 2014 to strengthen local health planning with significant consideration for building the capacities of health managers in the local government units (LGUs). The Annual Operational Plan (AOPs) is prepared every year of the planning cycle and the Service Level Agreement is signed. The results of the LGU Score cards are primarily used for the planning process. For LGUs whose scores of selected LGU Score Card indicators are positive, performance based grants are provided by the Bureau of Local Health Development, DOH. The data for LGU Score Cards are collected by the Department of Interior and Local Government (DILG) staff that have offices at the municipality/city level.[41,42]

(2) Health Policies

Under the Aquino Administration, the Government of the Philippines placed Universal Health Care (*Kalusugan Pangkalahatan,* known as KP) as a principle of national health policy and promoted to achieve the Millennium Development Goals (MDGs).

The new Duterte Administration recently presented the Philippine Health Agenda 2016-2022, as shown in BOX 3- 1.

[40] Interview with the Bureau of Local Health Systems Development, DOH (August 5, 2016).
[41] Interview with the Department of Interior and Local Government (August 1, 2016).
[42] Interview with the Bureau of Local Health Systems Development, DOH (August 5, 2016).

BOX 3- 1 Philippines Health Agenda 2016-2022

~ All for Health towards Health for All ~

Goals:

1. Ensure the best health outcomes for all, without socio-economic, ethnic, gender and geographic disparities
2. Promote health and deliver healthcare through means that respect, value and empower clients and patients as they interact with the health system
3. Protect all families especially the poor and vulnerable against the high cost of healthcare

Values: Equity, quality, efficiency, transparency, accountability, sustainability and resilience

Guarantees:

1. Population- and individual-level interventions for all life stages* that promote health and wellness, prevent and treat the triple burden of diseases, ** delay complications, facilitate rehabilitation and provide palliation
2. Access to health interventions through functional Service Delivery Networks (SDNs)***
3. Financial freedom when accessing these interventions through Universal Health Insurance

Strategy:

Advance Quality, Health Promotion and Primary Care
Cover all Filipinos against Health-Related Financial Risk
Harness the Power of Strategic Human Resources for Health Development
Invest in eHealth and Data for Decision-Making
Enforce Standards, Accountability, and Transparency
Value All Clients and Patients, especially the Poor and Vulnerable
Elicit Multi-sectoral and Multi-stakeholder support for Health

* All Life Stages refers to services for pregnant women, children, adolescents, adults and older persons.

** Triple Burden of Disease pertains to the (1) communicable diseases and neglected tropical diseases, (2) non-communicable diseases, and (3) problems related to globalization, urbanization and industrialization, including injuries and mental illness.

*** SDNs 1) consist of primary care networks (PCNs) linked to Level 3 hospitals, 2) ensure well-equipped and fully-staffed network of health facilities, 3) render services that are compliant with clinical practice guidelines and 4) practice gatekeeping and utilize telemedicine to expand specialty service.

Source: DOH Office of the Secretary & DOH Health Policy Development and Planning Bureau. (2016). Philippine Health Agenda 2016-2022 Healthy Philippines 2022.

The Philippine government agencies, including DOH, determine their agenda through the cabinet secretaries for approval of the President based on his 10-point socioeconomic agenda (see BOX 3- 2). This 10-point agenda is the basis for the Philippine Development Plan, the country's multi-sectoral development plan. The Philippine Health Agenda contributes to numbers 7 and 10 of the 10-point agenda. The Philippine Health Agenda

2016-2022 will be part of the Philippine Development Plan 2017-2022, under the Chapter on Social Development.[43]

BOX 3- 2 The 10-point Socioeconomic Agenda of President Duterte

1. Continue and maintain current macroeconomic policies, including fiscal, monetary, and trade policies.
2. Institute progressive tax reform and more effective tax collection, indexing taxes to inflation. A tax reform package will be submitted to Congress by September 2016.
3. Increase competitiveness and the ease of doing business. This effort will draw upon successful models used to attract business to local cities (e.g., Davao) and pursue the relaxation of the Constitutional restrictions on foreign ownership, except as regards land ownership, in order to attract foreign direct investment.
4. Accelerate annual infrastructure spending to account for 5% of GDP, with Public-Private Partnerships playing a key role.
5. Promote rural and value chain development toward increasing agricultural and rural enterprise productivity and rural tourism.
6. Ensure security of land tenure to encourage investments, and address bottlenecks in land management and titling agencies.
7. Invest in human capital development, including health and education systems, and match skills and training to meet the demand of businesses and the private sector.
8. Promote science, technology, and the creative arts to enhance innovation and creative capacity towards self-sustaining, inclusive development.
9. Improve social protection programs, including the government's Conditional Cash Transfer program, to protect the poor against instability and economic shocks.
10. Strengthen implementation of the Responsible Parenthood and Reproductive Health Law to enable especially poor couples to make informed choices on financial and family planning.

Moreover, the new administration prioritizes the 20 High Poverty Sites (see Table 3- 1) for development efforts and encourages development partners to provide assistance to the selected provinces.

[43] Information shared by Chief of Health Planning Division, Health Policy Development and Planning Bureau, DOH (October 31, 2016).

Table 3- 1　20 High Poverty Sites

CAR: Apayao
Ilocos Region: Pangasinan
Carabarzon Region: Quezon
Bicol Region: Masbate, Camarines Sur
Western Visayas Region: Negros Occidental, Ilo-ilo
Central Visayas Region: Cebu
Eastern Visayas Region: East Samar, North Samar, North Leyte
Zamboanga Peninsula Region: Zamboanga Del Sur, Zamboanga Del Norte
Northern Mindanao Region: Camiguin
Davao Region: Davao Del Sur
Soccsksargen Region: North Cotabato, Saranggani
ARMM: Sulu, Maguindanao, Lanao Del Sur

Source: Department of Health. (2016). 20 High Poverty Sites.

(3) Health Financing

Table 3- 2 shows the current circumstances surrounding health financing in the Philippines.

Table 3- 2　Health Financing in the Philippines

	2012		2013		2014	
1 Macroeconomic Indicator						
Population (million)[a]	96.0		97.6		99.1	
GDP (100 million US$)[b]	2,501		2,719		2,848	
GDP per capita (US$)[b]	2,605		2,787		2,873	
2 Government Budget						
Total Government Budget (100 million US$)[c]	296		323		363	
Total Government Budget as % of GDP	11.8%		11.9%		12.7%	
3 Government Budget for Health						
Govt Budget for Health (100 million US$)[c]	10.2		12.0		19.0	
Govt Health Budget as % of GDP	0.4%		0.4%		0.7%	
% of Total Government Budget	3.4%		3.7%		5.2%	
4 Government Expenditure on Health						
Total Health Expenditure (THE) (100 milllion US$)[d]	108.8		123.8		127.7	
THE as % of GDP	4.4%		4.6%		4.5%	
5 Disbursement of THE (100 million US$)[d]		Share		Share		Share
Government	30.8	28.3%	38.0	30.7%	39.5	30.9%
Central Government	11.1	10.2%	15.2	12.3%	12.3	9.6%
LGUs	7.2	6.6%	8.5	6.9%	8.4	6.6%
Social Security	12.5	11.5%	14.3	11.6%	18.8	14.7%
Other Government	0.03	0.03%	—		—	
Private Insurance	9.4	8.6%	10.8	8.7%	11.5	9.0%
Other Private Corporation	4.6	4.2%	5.0	4.0%	4.6	3.6%
Out-of-Pocket Expenditure	64.0	58.8%	69.9	56.5%	72.0	56.4%

Source: [a]World Population Prospects (2015), [b]World Development Indicator (2016), [c]Department of Budget and Management website (2016) and [d] Philippine Health Accounts Based on the 20111 System of Health Accounts for CY 2012, 2013 and 2014 (2016)

The substantial government budget increase in 2014 derives from the increased tax income due to the Sin Tax Reform Law of 2012. From 2012 to 2014, the Social Security budget steadily increased, while private insurance slightly increased. In 2014, about 30 percent of total health expenditure was from the Government, 9.6 percent of which was the Central Government, 6.6 percent LGUs and 14.7 percent Social Security, while 9.0 percent accounted for private insurance, 3.6 percent for private corporations, and 56.4 percent from household out-of-pocket expenditure. The total health expenditure as percentage of GDP in the Philippines is lower than most developed countries; but is comparable to other Southeastern Asian countries (see Figure 3- 2). The Philippines' out-of-pocket expenditure out of the total health expenditure was higher than many Southeast Asian countries from 2000 to 2014 and the proportion has not decreased over the years (see Figure 3- 3).

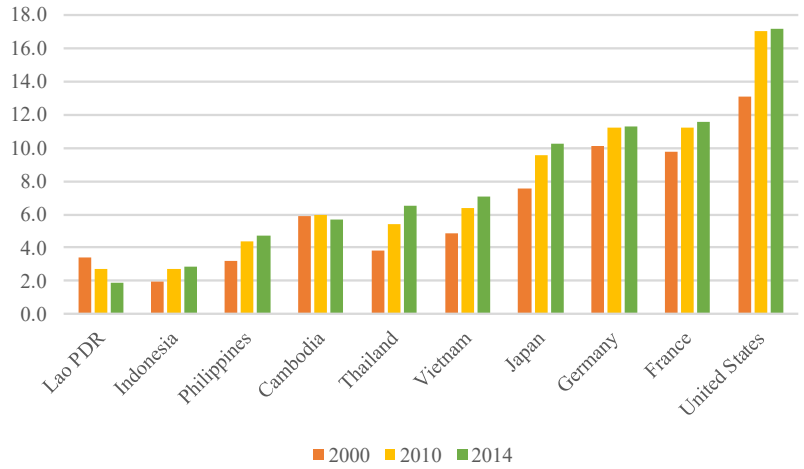

Figure 3- 2 Health Expenditures, total (% of GDP)
Source: The World Bank. (2016). World Development Indicators.

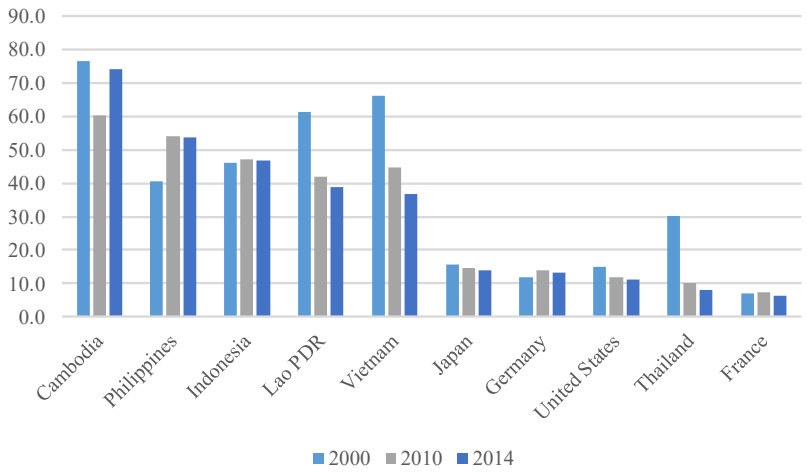

Figure 3- 3 Out-of-Pocket Health Expenditure (% of total health expenditure on health)
Source: The World Bank. (2016). World Development Indicators.

① Health Expenditure

Figure 3- 4 shows the breakdown of health expenditure in 2014. Pharmaceuticals account for 44.4 percent, the largest portion, followed by compensation of employees, which accounts for 26.4 percent, and these two categories account for over 70 percent of the total health expenditures in the Philippines.

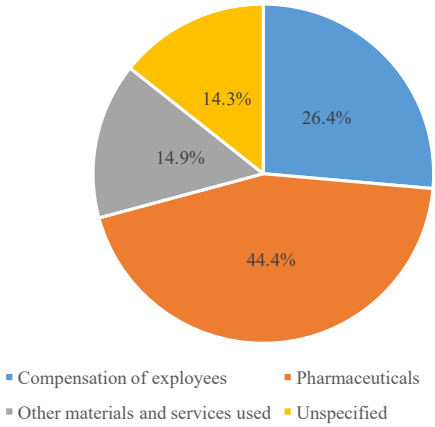

Figure 3- 4 2014 Health Expenditures by Factors of Health Care provisions
Source: Philippine Health Accounts Based on the 20111 System of Health Accounts for CY2012, 2013 and 2014 (2016).

Figure 3- 5 shows Health Expenditures by Health Services and Health Financing Schemes in 2014. Nearly 200 billion pesos was estimated to have been spent in pharmacies in 2014 and more than 99% of which was paid by household out-of-pocket. Similarly, a relatively high portion, 82.5 percent, of ambulatory or outpatient health care services were paid by household out-of-pocket. The high burden on the household out-of-pocket in these expenditures can be explained by the fact that the NHIP does not cover these costs.

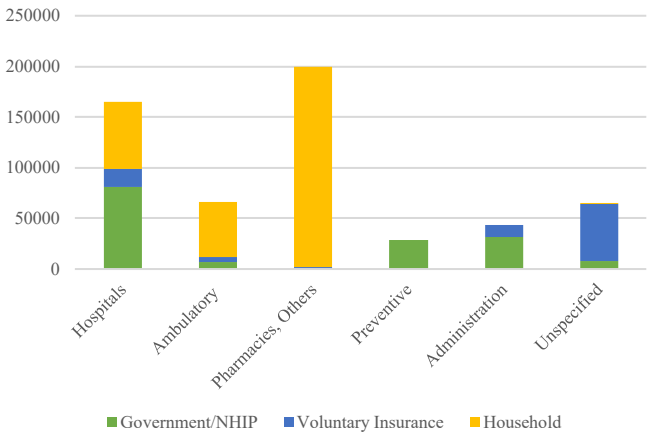

Figure 3- 5 2014 Health Expenditures by Health Services and Health Financing Schemes (in million pesos)
Source: Philippine Health Accounts Based on the 20111 System of Health Accounts for CY 2012, 2013 and 2014 (2016).

Figure 3- 6 shows health expenditures by income quintile groups in the Philippines from 2012 to 2014. Over the three years, the health expenditures of all groups increased, however, the health expenditure of the richest income group increased the most from 2013 to 2014. Moreover, throughout the three-year period, the lower three income quintile groups accounted for less than their equal share, while the richest income group accounted for more than twice its equal share.

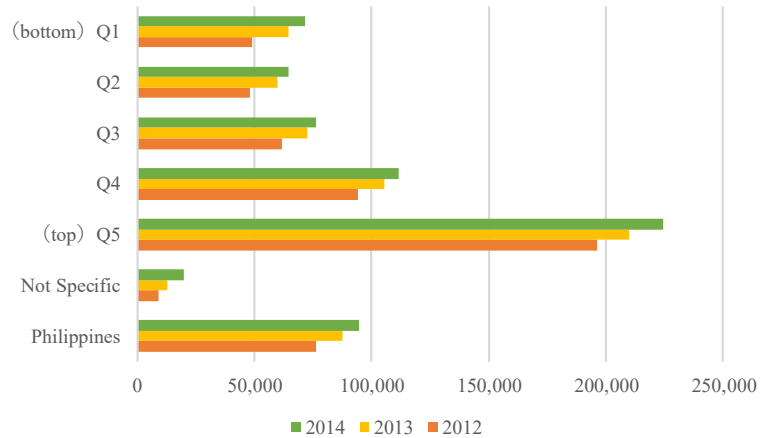

Figure 3- 6 Health Expenditures by Income Quintile Group: the Philippines, 2012-2014 (in million pesos)

Source: Philippine Health Accounts Based on the 20111 System of Health Accounts for CY 2012, 2013 and 2014 (2016).

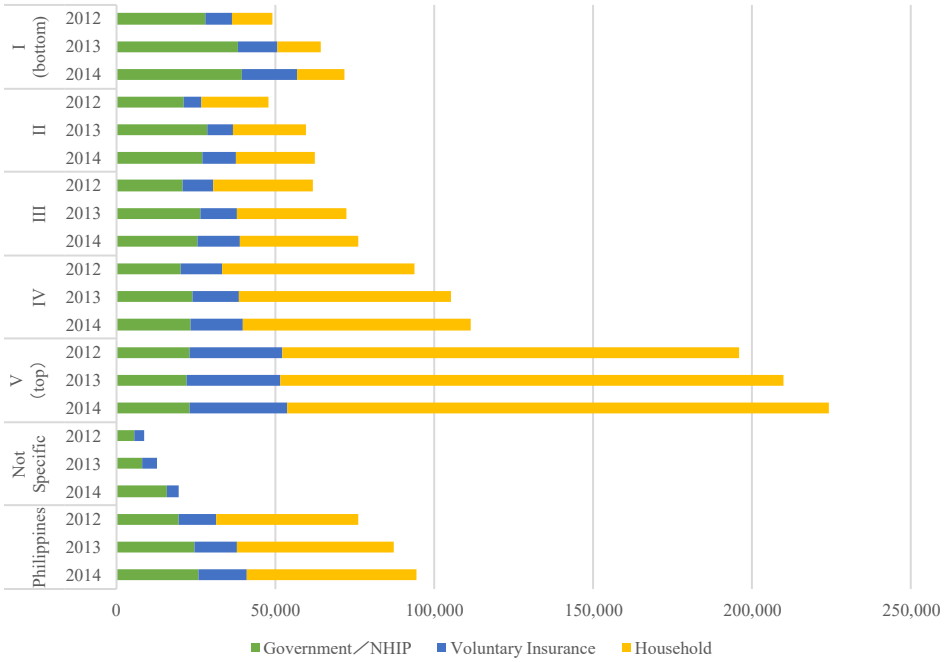

Figure 3- 7 Health Expenditures by Income Quintile Group and Health Financing Schemes: the Philippines, 2012-2014 (in million pesos)

Source: Philippine Health Accounts Based on the 20111 System of Health Accounts for CY 2012, 2013 and 2014 (2016).

Figure 3- 7 shows health expenditures by income quintile groups and health financing schemes. The overall health expenditures in the Philippines have increased from 2012 to 2014; however, the health financing schemes for the increased amounts differ among the income quintile groups. For the lowest quintile group, household out-of-pocket payment has not changed and voluntary insurance has slightly increased, while the government expenditures, including the National Health Insurance Program (NHIP), has substantially increased. Although PhilHealth announced that it would increase the Indigent Members to more than 40 percent of the total population in 2014,[44] the increase in the government health expenditures for the second quintile group was not seen. On the other hand, the government expenditure for higher quintile groups is not as much as the lowest quintile group, and the level of increase in the government expenditure for the higher quintile groups over the three years was also minimal. The increase in the higher quintile groups' health expenditure derives from household out-of-pocket.

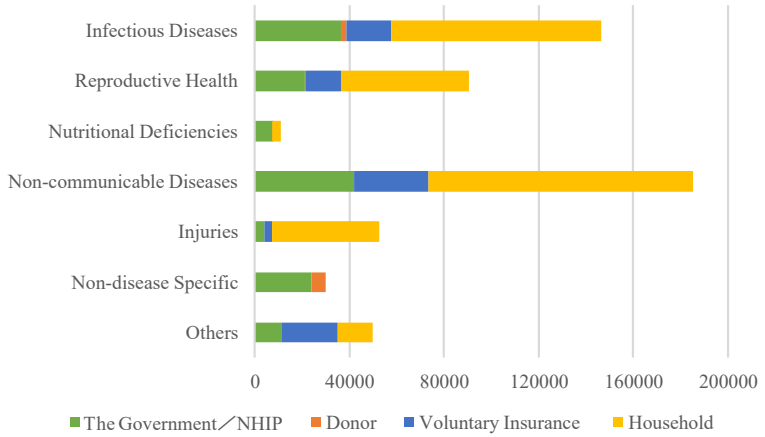

Figure 3- 8 Health Expenditures by Disease Groups and Health Financing Schemes: the Philippines, 2014 (in million pesos)

Source: Philippine Health Accounts Based on the 20111 System of Health Accounts for CY 2012, 2013 and 2014 (2016).

Figure 3- 8 shows health expenditures by disease groups and health financing schemes. Expenditures for noncommunicable diseases took the largest share of health expenditures in 2014 at about one-third, followed by infectious diseases and reproductive health. The proportion of household out-of-pocket expenditure was generally high, but injuries were mostly paid by households due to the fact that they are rarely covered by insurance. The proportion of donor assistance is generally small and limited to infectious diseases and reproductive health.

[44] PhilHealth. (2014). 2014 Stats and Charts.

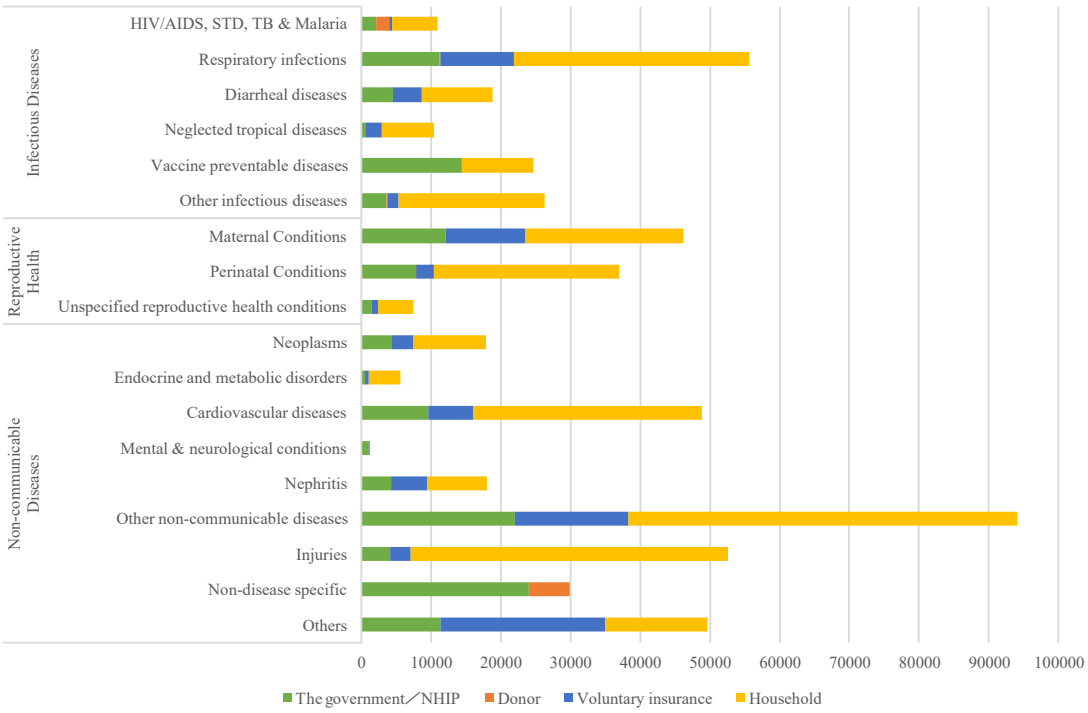

Figure 3- 9　Health Expenditures by Specific Disease Groups and Health Financial Schemes: the Philippines, 2014 (in million pesos)

Source: Philippine Health Accounts Based on the 20111 System of Health Accounts for CY 2012, 2013 and 2014 (2016).

Figure Figure 3- 9 shows health expenditures by specific disease groups and health financing schemes in 2014. Expenditures for respiratory infections took the largest share that accounts for 38 percent of the total health expenditures for infectious diseases. The majority of expenditures for vaccine-preventable diseases came from the government, but expenditures for other diseases were largely paid by household out-of-pocket. Regarding reproductive health, the majority of health expenditures for maternal conditions are paid by health insurance, but the household out-of-pocket payment rates are high for perinatal conditions due to limited insurance coverage for new-born cares. Among the non-communicable diseases, the household out-of-pocket rate is highest for endocrine and metabolic disorders at 81.1 percent.

② Health Budget

[Central Government]

Government health expenditures are funded out of general tax revenues collected by the Department of Finance (DOF). The DOH and the Philippine Health Insurance Corporation (PhilHealth) are allotted annual budgets by the Department of Budget and Management (DBM). The annual process of developing a DOH budget starts with the issuance of the

budget call and the budget ceilings by DBM around late February to the middle of March. DOH then prepares the annual budget proposal based on these set ceilings. The DOH proposal is consolidated into a national expenditure program, along with other line ministries' proposals, that is submitted to congress.[45]

In 1991, the management of provincial, district, and municipal hospitals as well as primary care facilities was transferred to LGUs. However, specialty hospitals, regional and training hospitals, and sanitaria[46] were retained under the management of the central DOH. While DOH-retained hospitals continue to be managed by the central DOH, they are also given authority to set and collect user fees with a ceiling for mark ups to a maximum of 30 percent of actual cost.[47]

Figure 3- 10 shows the health budget of 2011 to 2015 by the factors of health care provision. The substantial government budget increase, particularly the budget for health promotion and preventive medicine, since 2014 derives from the increased tax income due to the Sin Tax Law of 2012. The reason that only the budget for health promotion and preventive medicine increased was that health insurance subsidy is included in the budget for health promotion and preventive medicine, rather than that for curative medicine.

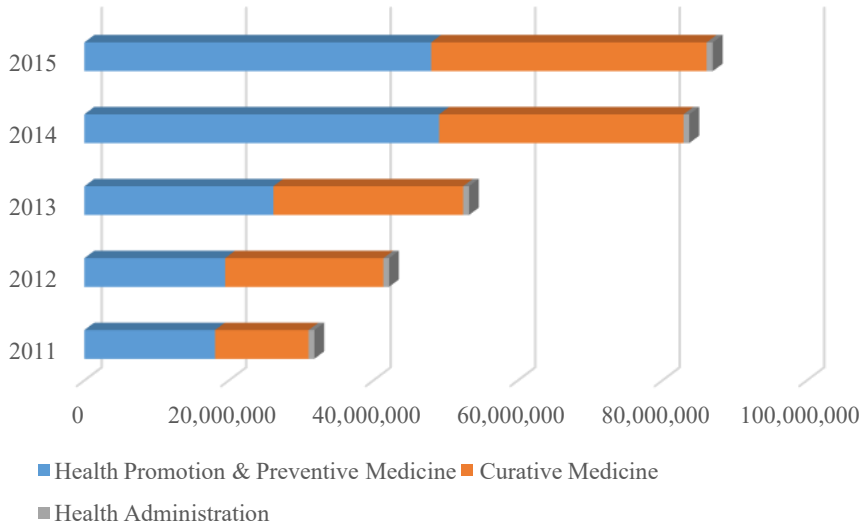

Figure 3- 10 Breakdowns of Health Budget, 2011-2015 (in pesos)

Source: DOH Annual Budget 2011-2015.

[45] The Philippines Health System Review 2011.
[46] Health facilities for the recuperation and treatment of individuals with leprosy.
[47] The Philippines Health System Review 2011.

Table 3- 3 Distribution of Sin Tax Incremental Revenue in FY 2016 DOH Budget Proposal

Prescribed Allocation	Detail of Prescribed Allocation	Allocation (in billion pesos)	%
Universal Health Care (80%)	Enrollment coverage of the poor (supporting NHIP premium)	31.26	45
	Health policy, regulations, general administration	7.56	11
	Hospital operations	6.41	9
	Health facilities enhancement including capital outlay of DOH hospitals	5.46	8
	Attainment of MDGs	4.24	6
	Quick response fund	0.51	1
	Health awareness program	0.04	0.06
	Subtotal	55.48	80
Medical assistance and facility enhancement (20%)	Facility enhancement	7.96	11
	Enhancement of doctors to remote areas	4.16	6
	Medical assistance to indigent patients confined in government hospitals	1.91	3
	Subtotal	14.03	20
Total		69.51	100

Source: DOH. Sin Tax Law Incremental Revenue for Health, Annual Report CY 2015.

In December 2012, the reformed Sin Tax Law, which increased taxes on all tobacco and alcohol products was passed. 85% of the incremental revenue from reformed Sin Tax Law was earmarked for DOH, 80 percent of which is to be transferred to PhilHealth in order to promote the initiative of Universal Health Care under the previous administration (promotion of NHIP, achievement of MDG goals, increasing health awareness, etc.). The remaining 20% is to be used to finance medical assistance and facility enhancements.[48] Table 3- 3 summarizes the allocation of the Sin Tax increments in the 2016 DOH budget proposal. DOH's budget increase attributable to Six Tax increment revenue was first seen in 2014.

[Local government Units]

Provincial and district hospitals are funded out of the provincial government's budget while municipal/city hospitals are financed by the municipal/city budgets. Financial management is determined primarily by the local chief executive and the local hospital chief.[49]

Local health expenditures are funded from a variety of sources, including the Internal Revenue Allotment (IRA) from the national government, the LGU's own budgets, user fees, transfers from DOH, PhilHealth, congressional discretionary funds, such as Priority Development Assistance Funds and the Philippine Charity Sweepstakes Office, and the

[48] DOH. (2016). Sin Tax Law Incremental Revenue for Health, Annual Report CY 2015.
[49] The Philippines Health System Review 2011.

Bottoms-up Budgeting, initiated by the Aquino administration, to provide additional assistance to poor LGUs in class 4 to 6.[50,51] The health financing system is complex and uncoordinated.

The LGU budget calendar is governed by a Local Budget Memorandum and typically issued in the middle of June by DBM. Following the process prescribed by DBM, each local health office and facility prepares a medium-term strategic plan and an annual health plan to be submitted for review.[52] These plans are meant to be consistent with the LIPH.[53]

DBM issues the budget notification stating the Internal Revenue Allotment (IRA), which is part of the tax revenue automatically released by the national government to LGUs on a quarterly basis. The IRA is first subdivided among the different levels of LGUs using the following distribution: provinces 23 percent, cities 23 percent, municipalities 34 percent, and barangays 20 percent. The shares for each level of LGU are then allocated horizontally for provinces, cities and municipalities based on the following formula: population 50 percent, land area 25 percent and equal sharing 25 percent. For barangays, the horizontal sharing is based on population for 60 percent and equal sharing for 40 percent. However, past studies have suggested that the formula for distributing the IRA across the different levels of LGUs has been inconsistent with the distribution of expenditure responsibilities among the different levels (see Figure 3- 4).[54]

Table 3- 4 IRA Distribution vs. Estimated Share of Devolved Functions

	% IRA Share	% Share of Devolved Functions
Provinces	23%	46%
Cities	23%	7%
Municipalities	34%	46%
Barangays	20%	Undefined

Source: World Bank. (2011). Philippines: Study on Local Service Delivery.

DOH transfers have come through direct subsidies, in-kind transfers, that is public health commodities such as vaccines, and grants for national programs, such as maternal and

[50] LGUs are divided into income classes according to their average annual income during the previous four calendar years.
[51] Interview with the Department of Interior and Local Government (August 1, 2016).
[52] World Bank. (2011). Philippines: Study on Local Service Delivery.
[53] Bureau of Local Health Systems Development (BLHSD) DOH & UNICEF. (2015). Local Investment Planning for Health Handbook on Principles, Guidelines, Procedures, and Processes.
[54] World Bank. (2011). Philippines: Study on Local Service Delivery.

child health. For PhilHealth, transfer comes to health facilities to reimburse the medical costs of the members[55,56]

Table 3- 5 Local Taxes

Local Tax	Cities	Provinces	Municipalities	Barangays
On Real Property Transfers	X	X		
On Business of Printing and Publication	X	X		
On Franchises	X	X		
On Sand, Gravel, and other Quarry Resources	X	X	*	*
On Amusement Places	X	X	*	
On Professionals	X	X		
On Delivery Vans Trucks	X	X		
On Real Property	X	X	*	*
On Idle Lands	X	X		
On Businesses	X		X	X
On Community Tax	X		X	*

Source: World Bank. (2011). Philippines: Study on Local Service Delivery.

X Types of local tax assigned to LGUs
* Local tax allocated from a higher LGU to a lower LGU

Table 3- 5 summarizes the various taxes that are assigned to LGUs by Local Government Code 1991 (LGC). Cities are assigned with the widest range of taxes available, while provinces and municipalities have either no access to certain tax measures or are required to share the proceeds with sub-levels of LGUs. Cities are generally allowed higher tax rate ceilings compared to provinces and municipalities, and their urbanized economies serve as larger and more dynamic tax bases. As a result, on average, cities rely much less on the IRA and other transfers compared to municipalities and provinces (see Table 3- 6).[57]

Table 3- 6 2003-2007 Case Studies of Visaya and Luzon: LGU Annual Income Breakdowns

	Provinces	Cities	Municipalities
IRA & Other Transfers	83.0	43.8	78.7
Own-source Revenues	15.1	53.7	19.6
-Tax revenues	*8.8*	*43.0*	*12.1*
-Non-tax revenues	*6.3*	*10.7*	*7.6*
Loans	1.9	2.5	1.6

Source: World Bank. (2011). Philippines: Study on Local Service Delivery.

[55] PhilHealth reimburses health facilities in two checks: 1) addressed to the facility as payment for procedures and supplies (drugs, medical supplies, laboratory, room and board), and 2) addressed to the facility chief as payment for professional fees.
[56] World Bank. (2011). Philippines: Study on Local Service Delivery.
[57] ibid

While the national average of health expenditures out of total budget of LGU is 18.6 percent, the World Bank's case study of LGU health care expenditures[58] has shown that there is a considerable divergence in spending levels among the different levels of LGUs from 6.3 percent in a city to 39.4 percent in a province in Luzon; as well as different provinces: from 20.1 percent in a Visaya province to 39.4 percent in a Luzon province. The difference derives from the presence/absence of a tertiary provincial hospital with its higher cost implications. It was reported by DOH that health expenditures per capita were 8.5 percent greater for provinces that operated a tertiary hospital compared to those where DOH continued to operate the tertiary hospitals.

Despite the fact that LGUs allocate the majority of the health sector budget to payment for personnel salaries, wages and benefits, LGUs often have difficulty maintaining the level of staff minimally accepted by DOH. In order to mitigate the problem of under-funding and under-staffing, the LGU health facilities could charge user fees. However, in practice, the local chief executives and Local Council are reluctant to raise rates.[59]

Devolution has created a fragmented health system. The typical planning and budgeting process has become compliance-oriented rather than needs-oriented. Budgetary decisions are in the hands of the local chief executives and the LGU accounting officers, and participation of the local health officials is minimal. Consequently, it is questionable whether the resource allocations for health are reflective of actual health needs of the LGUs.

③ Health Financing Flow

Figure 3-11 shows revenue sources and flows within the public health system in the Philippines. DBM transfers the general tax revenues collected by the DOF to DOH, PhilHealth, as well as LGU. DOH further distributes the budget to the DOH-retained hospitals and LGUs that operate hospitals and other health facilities. PhilHealth, Health Maintenance Organizations (HMOs) and other private insurance companies reimburse the accredited health facilities for healthcare costs of the members, and households are responsible to pay for health expenses not covered by health insurance.

[58] World Bank. (2011). Philippines: Study on Local Service Delivery & Bureau of Local Government Finance. (2007).

[59] World Bank. (2011). Philippines: Study on Local Service Delivery.

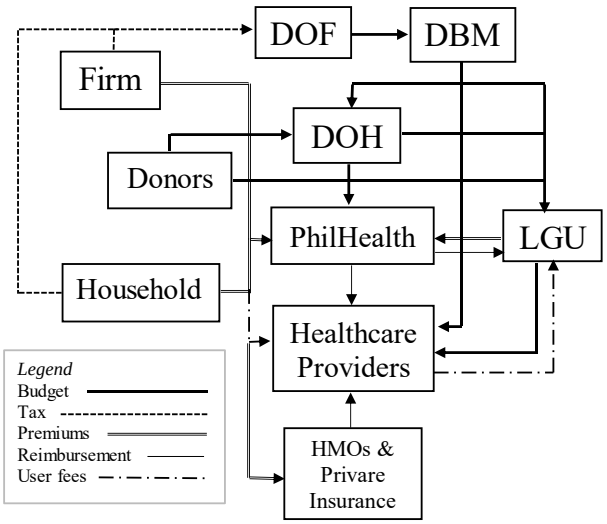

Figure 3- 11 Revenue sources and flows within the public health system in the Philippines

Source: The Philippines Health System Review (2011) & Philippines: Study on Local Service Delivery (2011)

(4) Health Facilities and MCH Service Delivery

Table 3- 7 shows the public health facilities under DOH, province and municipality/city. The private sector plays an important role for the provision of health services in the Philippines. While it is reported that the number of beds is almost equal for private and public facilities, 763 out of 1,971 hospitals (38.7 percent) are public and 1,208 hospitals (61.3 percent) are owned by the private sector.[60]

Table 3- 7 Public health facilities

Responsible entity	Health facility
DOH	National, specialized and regional hospitals
Provincial government	Provincial and district hospitals, and other health facilities, e. g. infirmary[61]
Municipal/City government	Municipal/City hospitals, RHU, BHS and other health facilities, e. g. infirmary

Source: JICA Survey Team

The Philippine health facilities are classified as hospitals and non-hospitals on a basis of the functions. Moreover, hospitals are classified into Level 1 to Level 3 hopitals. Non-hospitals include infirmaries and birthing homes. The basic functions of each health facility determined by DOH is shown in Table 3-8.

[60] The Philippines Health System Review 2011.
[61] Infirmary is the facility not certified as DOH level 1-3 hospitals but with beds.

Table 3- 8 Basis Functions of Health Facilities

Health facility	Functions
Non-hospitals	Ambulatory care and basic health care including normal spontaneous delivery is provided. The average period of hospitalization is 1 to 3 days.
Level 1 Hospitals	Health care in the areas of internal medicine, pediatrics, obstetrics and gynecology, (including cesarean section), ssurgery, dentistry and emergency medical care are provided. Pharmacy, secondary clinical laboratory (DOH standard), primary image analysis laboratory and/or blood station[62] are often attached.
Level 2 Hospitals	In addition to the health care provided by the Level 1 Hospitals, specialists are assigned to each diagnosis and treatment department. ICU, pediatric ICU, respiratory therapy, tertiary clinical laboratory, and secondary image analysis laboratory are attached.
Level 3 Hospitals	In addition to the health care provided by the Level 2 Hospitals, dialysis clinic, rehabilitation center, blood bank, tertiary clinical laboratory and tertiary image analysis laboratory are attached. It is also functioned as a training institution.

Source: JICA Survey Team

Table 3- 9 Major MCH services by various health facilities

Facility	MCH services	Human resource
BHS	ANC, immunization, health education, consultation, referral	Nurse, midwife (RHU personnel make regular visit where there are no personnel stationed at BHS), Barangay Health Worker (BHW), Barangay Nutrition Scholar
RHU	In addition to BHS services, laboratory test (no ultrasound), normal delivery (at selected RHUs), PNC	Doctor (mainly internal medicine), nurse, midwife, lab technician, etc.
Municipal/ District/Provincial Hospital, Infirmary	ANC, normal delivery, PNC, laboratory test and others as delivered at BHS/RHU. Accredited with BEmONC and HIP-MCP. Caesarean Section can be conducted where/when the obstetrician and anesthetist are available.	Doctor, nurse, midwife, lab technician etc.
Regional Hospital	All services are provided at two regional hospitals as CEmONC.	Obstetrician, anesthetist, pediatrician, nurse, midwife, paramedical etc.

Source: JICA Survey Team

Table 3-9 shows MCH services provided at each level of facility and the personnel serving the services. In the Philippines, one can seek health care at any level of facility without a medical referral letter. Generally, an expectant mother is to receive ANC at the nearest

[62] At a bank station, whole blood and concentrated red blood cells are stored and provided, and red blood cells fit inspection is performed. Whereas at a blood bank, all blood components are stored and provided, and red blood cells fit inspection, red blood cells antibody screening, transfusion reaction test and transfusion safety monitoring test are performed. (Administrative Order No. 2001-0008, Rules and Regulations Governing the Regulation of Blood Service Facilities)

BHS, RHU or private clinic, and deliver a child at a RHU with a lying-in facility, a municipal hospital or a district hospital for normal spontaneous delivery. A high-risk expectant mother delivers at a Comprehensive Emergency Obstetric and Newborn Care (CEmONC) facility, such as a provincial hospital or a regional hospital. However, it is not uncommon, especially in urban areas, that an expectant mother receives ANC and performs normal spontaneous delivery at a tertiary health facility.

Barangay Health Workers (BHWs) are trained health volunteers to provide basic health care in a community. They receive fixed amount of rewards from barangay. They visit households on a regular basis and record the information of the household members, check with expectant mothers, mothers and infants, follow them up after they receive health care, provide them with health information and advice, and refer them to health facilities when necessary. Meanwhile, some women still deliver a child at home attended by a traditional birth attendant (TBA).

(5) Health-related Information

There exist a variety of information systems dedicated to the Philippine health sector. The basic health data on health service delivery and selected program accomplishment at the barangay, municipality/city, provincial and regional levels are collected through the Field Health Service Information System (FHSIS) developed by DOH. The fundamental building block of the FHSIS is the Recording Forms and Reporting Forms for the DOH and LGU staff with managerial or supervisory functions in facilities and program areas. The second building block of the FHSIS is the Target Client Lists (TCL) for nurses/midwives with planning and operation of patient care, monitoring and supervision of service delivery activities, reporting of delivered services, and clinic-level data provided for further studies. There are various kinds of TCLs including those in areas of Prenatal Care, Post-Partum Care, Under 1-Year-Old Children, Family Planning, Sick Children, National TB Program Register, and the National Leprosy Control Program. Midwives in BHS collect this data on a monthly basis and consolidate it in the Summary Table composed of (1) Health Program Accomplishment and (2) Morbidity Disease.[63]

Institutional delivery is usually recorded on a basis of where a woman delivers a child in FHSIS. However, the JICA project in CAR encouraged the health workers to record institutional delivery on a basis of where a woman lives. Likewise, the project team also

[63] Scribd. The field health service information system (FHSIS) https://ja.scribd.com/doc/27872414/The-field-health-service-information-system-FHSIS

instructed them not to use an estimated number of expectant and nursing mothers, but use a real number as a denominator of a consultation rate of ANC and PNC. These efforts enabled them to understand the real situation of maternal and child health. Today, DOH is introducing the above efforts to other areas of the country.

A census is conducted every ten years by Philippine Statistics Authority (PSA).[64] Although the first Census was conducted in 1878 by the colonial Spanish government, the regular practice was adopted in 1960, and an inter-censal survey was added in 1995. The last Census was conducted in 2010 and the inter-censal survey measured the size of the population in 2015. The public-school teachers are assigned to collect data in the Census and the PSA staff train and supervise them at the Regional, Provincial, and Municipal/City levels. The households are enumerated based on the information obtained through Local Chief Executives and Barangay Captains. PSA establishes the Census Board some time before the data collecting period and tasks the Barangay Captains to confirm households in their barangays. For migrants and people living on the streets, data collectors visit them on an ad hoc basis. For overseas migrant workers, the data collectors ask each household whether there is any household member working overseas and count the person if he/she stays overseas shorter than five years.[65]

The Vital Statistics Division of PSA provides DOH with the data of births and deaths. A Birth Certificate has to be submitted to the Local Civil Registry Office in the municipal/city office within 30 days and registered within six weeks after the birth. Likewise, a Death Certificate has to be submitted to the Local Civil Registry Office in the municipal/city office within 48 hours and registered within 30 days after the death. PSA only provides supervision to the Local Civil Registry Office, and the registration is managed by LGUs. For indigenous people, the Local Civil Registry Office goes to their residential area and resisters them. For people living on the streets, the Department of Social Welfare and Development (DSWD) does the registration. According to the Census 2010, 93.5 percent of births and 66.0 percent of deaths had been registered. Vital statistics were initiated in 1939 and became computerized in 2000 in the Philippines.[66]

The National Demographic and Health Survey (NDHS), globally known as the Demographic and Health Survey (DHS), also provides DOH with health information with

[64] On the basis of the Philippine Statistical Act of 2013 (Republic Act No. 10625), National Statistics Office, National Statistical Coordination Board, Bureau of Agricultural Statistics and Bureau of Labor and Employment Statistics were merged to be National Statistics Authority.

[65] Interview with the Population and Housing Census Division, PSA (October 7, 2016).

[66] Interview with the Vital Statistics Division, PSA. (August 1, 2016).

a specific focus on reproductive health. The enumeration is conducted based on the Census data. The latest NDHS 2013 used the Census 2000. The data collectors are called for each survey and trained by ICF International, supervised by the PSA staff. The contents of the questionnaires are modified on the basis of requests by the United States Agency for International Development (USAID), the sponsor of NDHS, and the Philippine government. The survey is usually conducted every five years, but the next NDHS survey will be conducted in 2017, one year earlier than originally scheduled, as the government wishes to collect the SDG baseline data through the NDHS results.[67]

Other health-related information sources include the Family Income and Expenditure Survey (FIES) and Small Area Estimates (SAEs) conducted by PSA. There is also the community-based household information system called the Household Profile, primarily developed for the community-based monitoring system in which community health teams (CHTs) are engaged. The Household Profile will be collected by Barangay Health Workers (BHWs) in the future.[68]

3-2 Maternal and Child Health Conditions

(1) Maternal conditions

Although a decline of the Maternal Mortality Ratio (MMR) has been observed in the Philippines since 1990, it has slowed done in recent years. The MMR was estimated at 112 per 100,000 live births in 2015,[69] which was higher than the MDG target of 52 per 100,000 live births.[70] There are regional disparities exist according to the available information from the DOH at the regional level.[71]

With regard to antenatal care (ANC), nationally 95 percent of pregnant women received at least one ANC from skilled providers in 2013, which is an increase from 2008 at 91 percent. Facility-based delivery (FBD) at the national level also improved from 44 percent in 2008 to 61 percent in 2013 and 72 percent of mothers received post-natal care (PNC) during the first two days after birth.

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67 Interview with the Demographic and Health Statistics Division, PSA. (October 5, 2016).
68 Interviews with LGUs in Eastern Visayas and Corderilla Administration Regions.
69 WHO, UNICEF, UNFPA, World Bank Group and United Nations Population Division Maternal Mortality Estimation Inter-Agency Group. (2015). Maternal Mortality in 1995-2015 – Philippines.
70 The Philippines Fifth Progress Report MDGs, NEDA, 2014.
71 Based on some of the available websites by regional health offices, CAR and Central Visayas recorded MMR lower than the MDG target while higher in Caraga (at 120-150 per 100,000 live births) between 2013-2015.

Regionally, Autonomous Region in Muslim Mindanao (ARMM) had a much lower ANC rate at 53 percent compared to other regions. About 12 percent of women deliver a child with assistance by a TBA and the most common skilled birth attendant is a midwife in ARMM. Regarding FBD rates, it is the highest in the National Capital Region, lower in Mindanao (except for Davao), Cagayan Valley, Mimaropa and Bicol and the lowest at 12 percent in ARMM. The factors associated with the low FBD include low educational attainment of mother, low income, having more than six children, resided in remote area, and not receiving ANC. It was reported that the major reason for not having FBD is the financial burden, followed by not found necessary, distance to a health facility, and non-availability of transportation.[72]

(2) Child mortality

The National Infant Mortality Rate (IMR) and the under-five mortality rate have both declined steadily (IMR: 23/1000, U5MR: 31/1000) and are predicted to achieve the respective MDG targets (IMR: 19/1000, U5MR: 27/1000). However, regional discrepancies also exist with Mindanao and Mimaropa having higher rates than the national average, although discrepancy is not as large as that seen for maternal mortality in ARMM. National average of early neonatal death and still birth rates remains high at 22/1000. In general, mortality rates are higher in remote areas than urban areas. Like FBD, mothers' lower educational attainment and income level are associated with higher child mortality rates. As compared with the first child, the seventh and later children is five times more likely to die before his/her first birthday.[73]

(3) Teenage Pregnancy

Teenage pregnancy and motherhood is becoming a social and health concern in the Philippines. It was found that teenage women are at higher risk of having anemia, premature birth, and low-birth-weight baby. It is also reported that the risk of still birth or child death within a week after birth is 50 percent higher for a child born to a teenage mother than a child born to a mother in twentieth. While the total fertility rare decreased from 6.0 in 1973 to 3.0 in 2013, the age-specific fertility rate of women ages 15-19 has remained somewhat constant during the same period (see Figure 3- 12).[74]

[72] Philippine National Demographic and Health Survey 2013.
[73] ibid
[74] ibid

Socioeconomic concern includes the fact that many of teenage mothers drop out of school and therefore it is not easy for them to make living by themselves. Another issue of teenage pregnancy is that many of their children are born outside of marriage. Childbirth outside of marriage results in social and economic disadvantages for both teenage mothers and their children, such as ineligibility for public health insurance and social stigma.

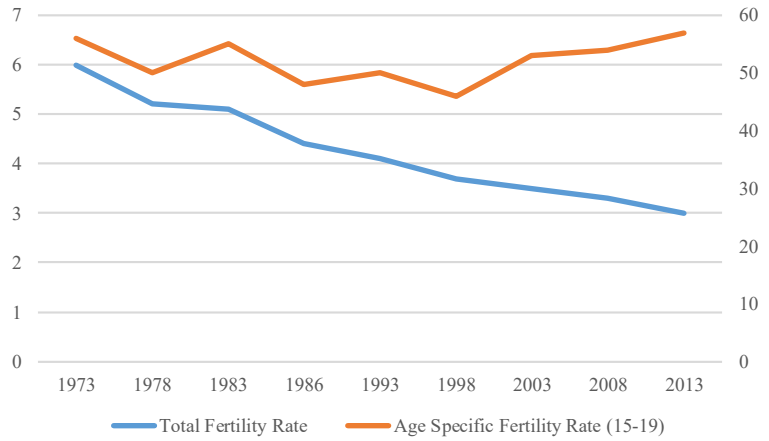

Figure 3- 12 Trends of Total Fertility Rate and the Teenage Fertility out of Total Fertility Rate from 1973 to 2013 in the Philippines

Source: National Demographic Survey for 1973, 1983, 1993, Republic of the Philippines Fertility Survey for 1978, Contraceptive Prevalence Survey for 1986 and National Demographic and Health Survey for 1998 to 2013

3-3 Assistance of Development Partners

(1) Development Partners in the Philippine Health Sector

Figure 3- 13 shows the breakdown of official development assistance (ODA) by development partners for ongoing projects as of the end of 2015.

In terms of the amount, USAID, the Global Fund and the European Union (EU) are the three top development partners, accounting for 37%, 27% and 17%, respectively. JICA accounts for 5% of the total ODA of development partners to the health sector.

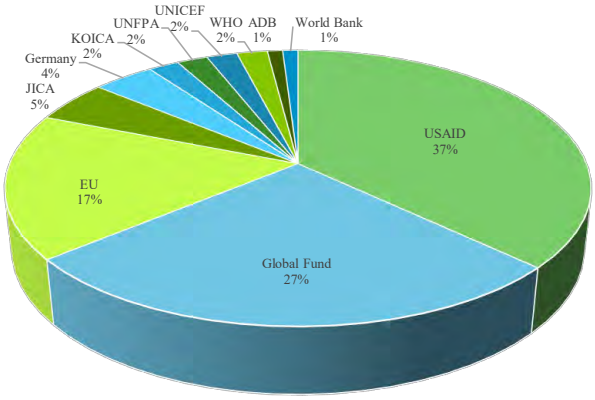

Figure 3- 13 Donor Contributions in Philippine Health Sector as of the End of December 2015

Source: Bureau of International Health Cooperation of DOH (2016). The Official Development Assistance on Health.

In terms of the areas of assistance, MDG 4 (child mortality) and MDG 5 (maternal mortality) are by far the major areas, accounting for 43% of the total, in which development partners are providing their assistance (See Figure 3- 14).

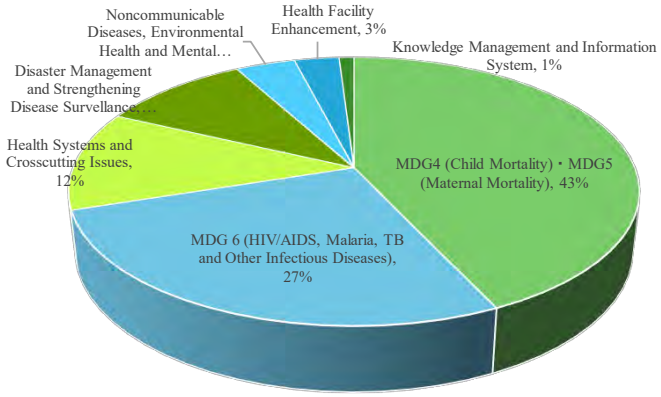

Figure 3- 14 Areas of Assistances by Donors as of the End of December 2015

Source: Bureau of International Health Cooperation of DOH (2016).
The Official Development Assistance on Health.

(2) Trends of the Assistance by Development Partners in the Philippine Health Sector

Figure 3- 15 compares DOH budgets and the amount of ODA by development partners in the past 18 years, subtotaling every 6 years. While the DOH budget has increased significantly especially since 2011, the increase in the amount of assistance by development partners has not kept up.

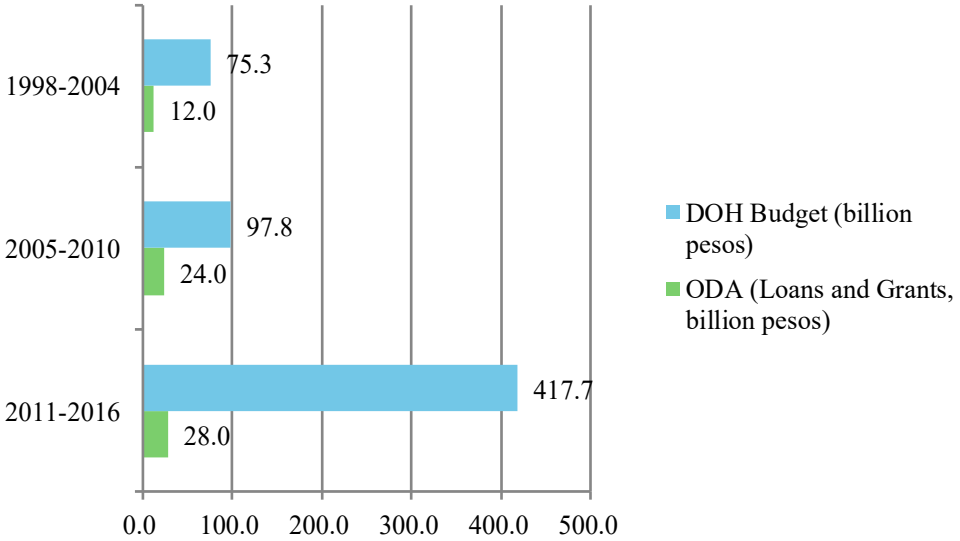

Figure 3- 15 DOH Budgets and Amount of Donor Assistances (1998-2016)

Source: Bureau of International Health Cooperation of DOH (2016).
The Official Development Assistance on Health.

(3) Details of Assistance by Development Partners

Major development partners assisting the Philippine health sectors, other than JICA, include the World Bank, USAID, EU, WHO, Asian Development Bank (ADB), United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA). Below describes the content of the assistance from each development partner.

① World Bank[75]

The World Bank provides assistance in maternal and child health (MCH), health finance and health policy and systems.

[Maternal and Child Health]

BlueStar Output Based Project

From April 2012 to December 2015, the World Bank piloted the output-based project (Global Partnership on Output-based Aid) to improve the poor population's health, particularly in the area of maternal and reproductive health, in the provinces of Leyte, Southern Leyte, Samar, Northern Samar and Eastern Samar in the Eastern Visayas Region.[76]

[75] Interview with World Bank
[76] World Bank. Global Partnership on Output-based Aid, Grant Reporting and Monitoring Report: Ref. TF0101757.

The project was implemented by BlueStar, a franchise developed and owned by Marie Stopes International, the United Kingdom-based non-profit organization. The project intends to promote enhancement and accreditation of maternal health facilities by PhilHealth, especially in hard-to-reach areas. Population Services Philipinas, Inc. (PSPI) is the national franchisor of BlueStar. The World Bank gave grants to PSPI when third-party organizations[77] had verified the following three outputs:

1. Private birthing facility becomes accredited by PhilHealth.
2. Private birthing facility completes refurbishment of facility as agreed.
3. Private birthing facility completes staff training as agreed.

By the end of the project, refurbishments of 27 birthing facilities as well as construction of seven Barangay Health Stations (BHSs) were completed, and US$ 3 million was paid out in total.

According to the World Bank, this mechanism could be employed in other areas of the country if a private institution is willing to take on the financial risk until the required output targets are achieved.

Voucher Project

In conjunction with the BlueStar Output-Based Project described above, the World Bank carried out the subsidized voucher project.

Under this project, a voucher is sold for 50 pesos at a franchised birthing facility in Northern Samar and Eastern Samar, relatively poor provinces. The voucher allows a woman to receive maternal health services, such as ante-natal and post-natal care, free of charge, and she redeems the voucher for a total of 1,500 pesos at the bank designated by the project when she completes necessary care at the birthing facility. A redemption method can be either a single redemption or a redemption on the milestone basis at a time of receiving a maternal health service.

The project sold a total of 10,000 vouchers in one year, 60 percent of which were redeemed. Concurrently, World Bank placed two series of 30-second advertisements with AM and FM radio to educate the target group of people with PhilHealth benefits. However, the World Bank learned that radio was not effective media as residents do not listen to the radio today: they watch television instead.

[77] PRIMEX, local consulting firm, served as the third-party inspector

[Health Finance]

Healthcare Finance Strategy

In 2010, DOH published the Health Care Financing Strategy of the Philippines 2010-2020 – Toward Financial Risk Protection that provides a roadmap towards attaining the strategic goals of increasing the overall level of health spending, promoting universal coverage, improving allocative efficiency, and promoting technical efficiency. The World Bank, DOH and PhilHealth are currently reviewing the Strategy.

Japan Policy and Human Resources Development: PHRD UHC Window

World Bank and the Japanese government have formulated a proposal of a technical assistance project on Health Financing Review and Systems Strengthening by utilizing the Japan Policy and Human Resources Development Fund (PHRD) established under the partnership between World Bank and the Japanese government to achieve the goals of the Aquino Administration's Kalusugan Pangkalahatan - Universal Health Care (KP) program in the Philippines. The project is to start in 2016.

[Health Policy and System]

Primary Care Package

To study the best implementation mechanism for the primary care benefit package of NHIP (Primary Care Benefit 1, or PCB1), the World Bank, in conjunction with PhilHealth and the Korea Development Institute – School of Public Policy and Management, is carrying out the study, the Impact of Incentives and Information on Quality and Utilization in Primary Care (I3QUIP).[78]

The I3QUIP studies the impact of different implementation mechanisms to boost effectiveness of the PhilHealth's performance-based payment for PCB1. The World Bank is currently working on the baseline report that describes the current status of primary care package implementation and compliance by LGUs and primary health providers.

② USAID[79]

USAID is assisting the Philippine health sector with the following three pillars:[80]

1. Improving the supply of integrated family health services

[78] World Bank. (February 2016). Philippines Impact of Incentives and Information on Quality and Utilization in Primary Care: Baseline Survey Report.
[79] Interview with USAID
[80] USAID website

2. Developing healthy behaviors and practices

3. Improving health policies and systems

Within the assistance framework of the three pillars, USAID is currently providing the Philippine government with assistance in the following areas:[81]

- Maternal and Child Health (MCH)
- Service Delivery Network (SDN)
- Health finance
- Health policy and system

[Maternal and Child Health (MCH)]

To improve the quality of Maternal, Neonatal, Child Health and Nutrition/Family Planning (MNCHN/FP) services, USAID is carrying out the following three regional projects:

1. VisayasHealth Project
2. MindanaoHealth Project
3. LuzonHealth Project

The project period for all three is from 2013 to 2018. Table 3- 10 summarizes the target regions and provinces for each project.

Table 3- 10 Target Regions and Provinces for the USAID Assisted MNCHN/FP Programs

Project	Regions	Province
VisayasHealth	Western Visayas	Iloilo, Negros Occidental
	Central Visayas	Bohol, Cebu
	Eastern Visayas	Leyte, Southern Leyte, Samar, Northern Samar
MindanaoHealth	Zamboanga Peninsula	Zamboanga del Sur, Zamboanga del Norte, Zamboanga Sibugay
	Northern Mindanao	Misamis Oriental, Bukidnon, Lanao del Norte
	Davao	Davao del Sur, Compostela Valley, Davao Oriental
	Soccsksargen	Cotabato Province, South Cotabato, Sultan Kudarat
	Caraga	Agusan del Sur, Agusan del Norte
	Autonomous Region in Muslim Mindanao	Lanao del Sur, Basilan, Maguindanao, Sulu, Tawi-Tawi
LuzonHealth	CAR	Benguet
	Ilocos	Pangasinan
	Cagayan Valley	Cagayan, Isabela
	Central Luzon	Neva Ecija, Balacan, Tarlac
	Calabarzon	Quezon, Batangas, Laguna, Cavite, Rizal
	Mimaropa	Oriental Mindoro
	National Capital Region	(City of) Caloocan, Malabon, Marikina, Pasig, Quezon, Taguig, Valenzuela
	Bocol	Albay

Source: USAID website

[81] USAID website and Interview with USAID

USAID is planning on post-2018 MNCHN/FP projects. Regions for assistance are expected to be selected from a list of the 20 poorest provinces, for which DOH is calling for donor assistance. Given the direction of the current administration, USAID will place emphasis in assisting the poorest families with difficulties in accessing health facilities.

[Service Delivery Network (SDN)]

The Private Sector Mobilization for Family Health Project – Phase 2 (PRISM2) was implemented from 2009 to 2014 with the goal to strengthen SDN and to assist the DOH and the LGUs in engaging and mobilizing private sector resources in delivering family planning and MCH services and products. Involvement of the private sector in the network has been successful in some areas. It was reported that there was one province in which the number of SDNs increased from just a few to more than 100.[82]

USAID has tested and fine-tuned various models in the PRISM2 project. Illoillo and Cavite provinces were cited as examples in which more advanced and mature SDN networks exist.

[Health Financing]

Since 2014, USAID has assisted Tacloban City in their efforts to re-establish the functional health system and maximize the income of health facilities facing devastations from Typhoon Yolanda.[83]

USAID studied the status of service delivery in the area and recommended the following to maximize the income of health facilities.

- USAID advised Tacloban City to open a bank account, called the Trust Fund, to exclusively receive PhilHealth reimbursements.[84] By securing the health budget through this arrangement, it was expected to motivate the City to provide better health services.
- USAID advised Tacloban City to use some of the PhilHealth reimbursements to incentivize the volunteers and barangay health workers (BHWs) who had taken

[82] Interview with USAID

[83] UPecon-Health Policy Development Program. (2015). Concept Note on the Establishment of a Service Delivery Network for Tacloban City

[84] PhilHealth reimbursements are to be redistributed to health facilities and professional, and LGUs are to open a Trust Fund bank account for PhilHealth related transactions. However, it is reported that some LGUs have not opened the bank account and the said LGUs may not be making appropriate redistributions, as PhilHealth reimbursements are accounted for as part of the general budget. According to PhilHealth, health LGU-owned institutions are not able to open a bank account as they are not legal entities.

expectant mothers to health facilities. Through this arrangement, it was expected that the number of facility-based deliveries (FBD) would increase and subsequently reimbursement for the Maternity and Child Package (MCP) would also increase in Tacloban City.

Both of these measures became city ordinances in 2015, and Tacloban City saw significant increase in PhilHealth reimbursement. For instance, the Tacloban City Hospital received 4.2 million pesos for PhilHealth reimbursement in 2014, but the amount increased up to 22.8 million pesos by October 2015. Moreover, in the first quarter of 2016, 9.4 million pesos, equivalent to 6.3 times as much as that in 2014 and 2.8 times as much as that in 2015, was paid to Tacloban City by PhilHealth.

[Health Policy and System]

Health Policy

Health Policy Development Program – Phase 2 is a five-year (2012-2017) health policy project in partnership with the UPecon Foundation, Inc. It supports the DOH-led policy formulation process by scaling up the Government of the Philippines' Universal Health Care initiative.[85] So far, USAID has supported DOH with the following initiatives:

- Development of guidelines for implementing the Responsible Parenthood and Reproductive Health Law
- Design of the 2015 National TB Prevalence Survey
- Implementation of monitoring operations for Universal Health Care
- Assessment of family planning logistics and promotion of new logistics for provider participation
- Training on planning and contracts management for the staff of DOH Regional Offices

Health Governance Related

In October 2013, USAID and DOH entered into a three-year Global Development Alliance with the Zuellig Family Foundation (ZFF).[86] ZFF has implemented leadership and governance capacity building programs for health in various rural municipalities in the Philippines since 2008.

[85] USAID website
[86] ibid

The goal of the capability-building programs is to improve health outcomes in the areas of maternal and child health, family planning and tuberculosis by enhancing the leadership and governance capabilities of local chief executives and local health officers of the 121 LGUs.

Health Information Improvement

As statistical data collected in the Philippines is not highly reliable, USAID verifies the accuracy of data, such as the Family Income and Expenditure Survey (FIES), before it utilizes it. On the basis of this experience, USAID has recently developed a data standardization tool, which is now recommended by DOH and adopted by some development partners, including UNICEF.

③ EU[87]

The EU provides budget support to DOH. The current budget support is for the period of 2015-2017 and this is the third offer by the EU, followed by 2007-2010 and 2011-2013 support. Funds are paid out to DOH through the Department of Finance (DOF) upon meeting targets, many of which are based on the FIES.[88]

Current assistance by the EU for the Philippine health sector is provided in the following areas.

- Service Delivery Network (SDN)
- Health financing
- Health policy and system

[Service Delivery Network (SDN)]

The EU launched the SDN project in August 2016. As there are similar SDN projects carried out by other development partners, the EU hopes to differentiate this project by uncovering valuable information, such as why public hospitals with no PhilHealth accreditation still exist today.

[Health Finance]

In December 2015, the EU proposed a technical assistance program to update PhilHealth case rates. The EU believes that the new administration is positively considering the proposal.

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87 Interview with EU

88 Most targets are based on the indicators in FIES

[Health Policy and System]

The EU has provided following the Information and Technology (IT) -related assistance projects:

· **Project to link provincial-level electronic medical records to PhilHealth**

The EU normally provides technical assistance and DOH prepares the necessary hardware; however, there are some cases in which development partners provide the hardware, such as in Calabarzon Region by the Korea International Cooperation Agency (KOICA).

· **Project to ensure privacy and security of data**

DOH has been working on this subject since 2014 to manage electronic data records at the LGU level.

· **Project to improve the monitoring capacity of health enterprise architecture**

The project aims at data transfer and connection through digitization of the health data.

· **Project to build up the health information system in which DOH, PhilHealth and hospitals play clearly defined roles**

Health information systems have been adopted by merely 10 to 15 percent of hospitals, and even when adopted, quality of data is low, both in medicine and finance.

As IT is a broad arena in which assistance by only the EU and KOICA is not sufficient, the EU has recommended to JICA to join them and start providing similar assistance.

④ WHO[89]

Current assistance by WHO for the Philippine health sector is in the following areas:

- Service Delivery Network (SDN)
- Health policy and system

[89] Interview with WHO

[Service Delivery Network (SDN)]

WHO considers SDN as important as healthcare finance for better health in the Philippines, and it is currently carrying out the SDN project in Davao City, Mindanao. WHO is carrying out this initiative with KOICA, and would welcome JICA to join the initiative in this or another region.

On the basis of the belief that motivation and morals of local government officials, especially barangay chiefs, are keys to success in building an effective SDN, WHO recently expressed interest in assisting LGUs to strengthen their governance structure.

In addition to the Davao project, WHO, together with UNFPA, UNICEF and DOH, is currently carrying out a project to formulate the guidelines for MCH-related SDNs in Cotabato City, Soccskasargen Region of Mindanao.

[Health Policy and System]

WHO is currently assisting the Asian Pacific Observatory to update the Philippine Health System Review – Health in Transition.

⑤ ADB[90]

Asian Development Bank (ADB) currently provides assistance to the Philippine health sector in the areas of health policy and systems.

In early 2016, the National Economic and Development Authority (NEDA) drafted a 25-year strategic master plan, Philippines Strategy 2040. ADB provided comments and suggestions with respect to the said draft from the viewpoint of universal health coverage. This draft is the product of the former administration, and if the current administration were to pursue the same strategic master plan, ADB would assist NEDA and DOH. Aside from the above, ADB provides US$ 300 million budget support for the Conditional Cash Transfer (CCT) program.[91]

⑥ UNICEF[92]

UNICEF currently assists the Philippine health sector in the following areas:

- Maternal and Child Health (MCH)

[90] Interview with ADB
[91] Refer to 2-12 (4) “Supporting Indigents of Section 2 for details of CCT,
[92] Interview with UNICEF

- Service Delivery Network (SDN)
- Health financing

[Maternal and Child Health (MCH)]

The Maternity Care Package (MCP) of NHIP has not substantially changed in the last ten years and there is no benefit package for premature care. UNICEF is working towards improvement of the situation.

· **MCP**: MCP data of ten million cases are now available. On the basis of this large data analysis, UNICEF plans to make recommendations for improvement of the MCP.

· **Package for Premature Baby**: UNICEF is working with PhilHealth on the creation of a pre-mature benefit package, as the premature death rate remains high, while the neonatal death rate has been stabilized in the Philippines.

[Service Delivery Network (SDN)]

As previously mentioned, UNICEF, together with WHO, UNFPA, UNICEF and DOH, is working to formulate guidelines for MCH-related SDN in Cotabato City, Soccsksargen Region of Mindanao.

[Health Finance]

Primary Care Package

As the primary care package, named Tamag Serbisyo para sa Kalusugan ng Pamilya (TSeKaP Program), does not cover sufficient drugs for asthma and tuberculosis, UNICEF, together with WHO and UNFPA, has been working towards improvement of the program since 2014.

The original proposal was submitted to DOH at the time of Secretary Ona, but no progress was seen after his resignation. The new DOH Secretary Ubial is keen on taking this initiative further.

Rational Prioritization of Benefit Packages

Prioritization of benefit packages of NHIP tends to reflect the preference of those with power. However, UNICEF is advising PhilHealth to rationally prioritize benefit packages.

⑦ UNFPA[93]

Assistance by UNFPA for the Philippine health sector is provided in the following areas:

- Maternal and Child Health (MCH)
- Service Delivery Network (SDN)

[Maternal and Child Health (MCH)]

UNFPA is assisting the Philippine MCH service delivery in the following three areas:

1. **Facility Based Deliveries (FBD)**: UNFPA sees the following issues in deliveries in the Philippines.
   - There are facilities that are not meeting minimum requirements for Basic Emergency Maternal Obstetrics and Newborn Care (BEmONC).
   - Many facilities have a shortage of drugs.
   - There are areas where accessible birthing facilities do not exist for expectant mothers.
2. **Skilled Birth Attendant (SBA)**: A higher proportion of births attended by a SBA was one of the targets of MDG5. Although the Philippines was closer to the target,[94] it has room for improvement.
3. **Family Planning**: The Philippines is not likely to achieve the MDG 5 targets in respect to contraceptive prevalence and unmet needs for family planning.[95] While neo-natal deaths are a large proportion of all child mortality cases in the Philippines, the study conducted by UNFPA in 2013 revealed that 50 percent of the deaths could have been prevented if proper family planning was practiced.

[Service Deliver Network (SDN)]

UNFPA is currently involved with the following two SDN related projects.

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93 Interview with UNFPA

94 Indicators of MDG 5 Target 5.A: reduce the maternal mortality ratio by three quarters between 1990 and 2015 include 5.1 - maternal mortality ratio and 5.2 - proportion of deliveries attended by skilled health personnel.

95 Indicators of MDG 5 TARGET 5.B: achieve, by 2015, universal access to reproductive health include 5.3 contraceptive prevalence rate, 5.4 adolescent birth rate, 5.5 antenatal care coverage, and 5.6 unmet need for family planning.

- **A project targeting indigenous people in Soccskasargen, Mindanao**

  As their residential areas extend to more than two administrative divisions, special consideration needs to be given in building SDNs in those areas.

- **A project to formulate guidelines, together with other development partners, for MCH-related SDNs in Cotabato City, Soccskasargen of Mindanao.**

  As previously mentioned, UNFPA is carrying out this project with WHO, UNICEF and DOH.

Chapter 4 National Health Insurance Program (NHIP) – Overview and Utilization

4-1 Current Framework of NHIP

The National Health Insurance Act of 1995 (RA No. 7875) institutionalized social health insurance in the country through the National Health Insurance Program (NHIP), in order to provide health insurance coverage and ensure affordable, acceptable and necessary health care services for all citizens of the Philippines. Also in the same year, the Philippine Health Insurance Corporation (PhilHealth) was established as the implementing agency of NHIP by integrating the health insurance sections of the Government Service Insurance System (GSIS), the insurance system for government employees, and the Social Security System (SSS) for private sector employees. Although the operation became unified, there exist several membership categories as described in 4-3, and premium collections are carried out based on the methodology designed for each membership category. The goal of the Philippine government is to cover all citizens under the NHIP.[96]

4-2 PhilHealth

PhilHealth is the part of the Department of Health (DOH), and is governed by a board of directors composed of seventeen members, chaired by the secretary of DOH. Figure 4- 1 is the simplified organizational chart of PhilHealth.

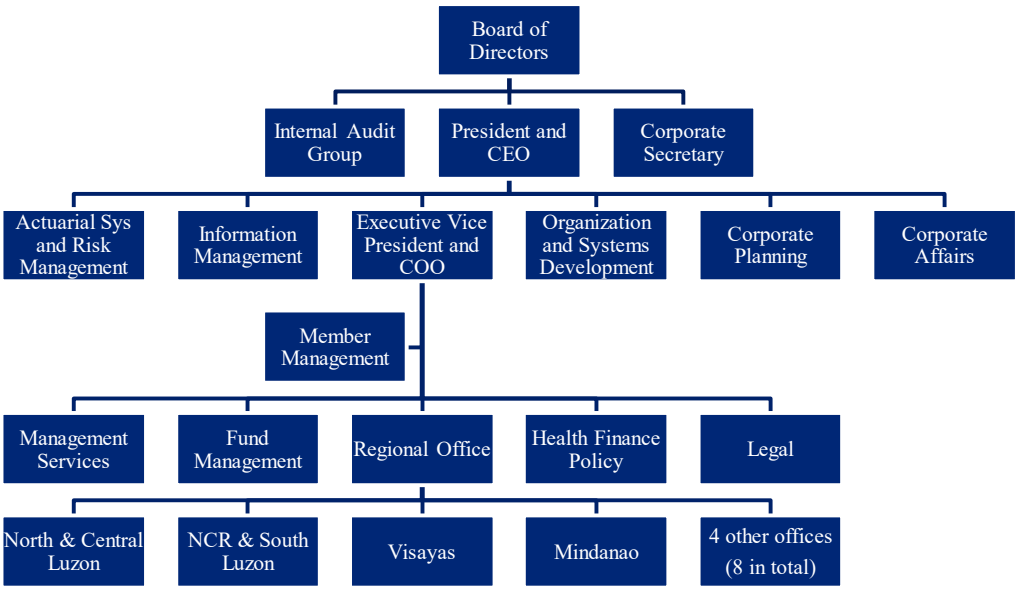


Figure 4- 1 Organizational Chart of PhilHealth

Source: PhilHealth website.

[96] PhilHealth website

Approximately 6,400 employees work for PhilHealth and 800 of them work at the headquarters in Quezon City.

At the local level, more than 100 branch offices (PhilHealth Local Health Insurance Office and PhilHealth Business Center) are administered by the eight Regional Offices. Moreover, approximately 70 express offices (PhilHealth Express) are situated at convenient locations, such as shopping malls.

The following authorities and responsibilities are allocated to PhilHeath.

- To administer the NHIP
- To formulate and promulgate policies for the NHIP administration
- To formulate and implement guidelines on the above, namely premium collection, claim procedure, cost containment, quality assurance of health care, and health care provider accreditation, payment, and referral systems

4-3 Goals for the Philippine Health Agenda

As mentioned earlier, under the new Duterte administration, DOH has launched the Philippine Health Agenda 2016-2022 and one of the three Guarantees is Universal Health Insurance. With respect to Universal Health Insurance, PhilHealth has set the following goals:

- National Health Insurance Program (NHIP) enrolls 100% of Filipinos where formal sector premiums are paid through payroll and non-formal sector premiums are paid by tax subsidies.
- NHIP's support value is 100% (or zero-copayment) for the poor and those admitted in basic accommodation, and predictable (fixed co-payment) for those admitted in non-basic, private accommodation.
- NHIP covers a comprehensive range of services and becomes the main revenue source of public health care providers.

4-4 Membership Category

Today, the PhilHealth memberships are classified into six categories as shown below. Table 4-1 summarizes qualifications for each category.

1. Formal Economy
2. Informal Economy
3. Lifetime Members
4. Senior Citizens
5. Indigent Members
6. Sponsored Members

Table 4- 1 PhilHealth Membership Category

	Membership Category	Qualification
1	Formal Economy	・ Workers in the government and private sectors who have established employee-employer relations (includes housewife and driver employed by an individual) ・ Business entrepreneur
2	Informal Economy[97]	・ Migrant Workers: Filipinos who are engaged in a remunerated activity in another country of which they are not citizens ・ Informal Sector: includes among others, street hawkers, market vendors, taxi drivers, small construction workers, and home-based industries and services ・ Self-Earning Individuals: individuals who render services or sell goods as a means of livelihood outside of an employer-employee relationship or as a career. These include professional practitioners including but not limited to doctors, lawyers, engineers, artists, architects and the like, businessmen, entrepreneurs, actors, actresses and other performers, news correspondents, professional athletes, coaches, trainers, and such other individuals
3	Lifetime Members	・ Individuals aged 60 years and above and have paid at least 120 monthly contributions to PhilHealth and the former Medicare Programs – i.e., Social Security System (SSS) and Government Service Insurance System (GSIS) ・ Uniformed personnel aged 56 years and above and have paid at least 120 monthly contributions to PhilHealth and the former Medicare Programs of SSS and GSIS ・ SSS underground miner-retirees aged 55 years above and have paid at least 120 monthly contributions to PhilHealth and the former Medicare Programs of SSS and GSIS ・ SSS and GSIS pensioners prior to March 4, 1995
4	Senior Citizens	・ Filipino citizens who are residents of the Philippines, aged sixty (60) years or above and are not currently covered by any membership category of PhilHealth
5	Indigent Members	・ Persons who have no visible means of income, or whose income is insufficient for family subsistence, as identified by the Department of Social Welfare and Development based on specific criteria. Indigent Members are identified under the National Household Targeting System for Poverty Reduction (the "NHTS-PR"), will automatically be enrolled and covered as PhilHealth Members.
6	Sponsored Members	・ Individual whose premium is paid for by a sponsor such as an institution or another individual ・ Orphans, abandoned and abused minors, out-of-school youths, street children, persons with disability (PWD), senior citizens[98] and battered women under the care of the Department of Social Welfare and Development, or any of its accredited institutions run by NGOs or any non-profit private organizations ・ Barangay health workers, nutrition scholars, barangay police officer, and other barangay workers and volunteers ・ Those enrolled through the Point of Care program of PhilHealth

Source: PhilHealth website and Title III Section 5 of the Implementing Rules and Regulations (IRR) of RA 7875 as amended otherwise known as the National Health Insurance Act of 2013

[97] Formerly there was a category for "Overseas Filipinos", which is now merged into Informal Economy. Interview with PhilHealth (October 26)

[98] A citizen is classified under the Senior Citizen category if a citizen is 60 years old or above and is not under the care of the DSDW or NGO

Qualified dependents of the members are entitled to PhilHealth benefits without additional premiums. Following are qualified dependents:[99]

- Legitimate spouse who is not a member
- Unmarried and unemployed legitimate, legitimated, acknowledged, illegitimate children, legally adopted or step children below 21 years of age
- Children who are twenty-one (21) years old or above but suffering from a disability that renders them totally dependent on the member for support, as determined by PhilHealth
- Foster child as defined in Republic Act 10165 otherwise known as the Foster Care Act of 2012

A qualified dependent is claimed by a member and enlisted in the member's Member Data Record (MDR). MDR proves that the individuals enlisted are the PhilHealth Members.

4-5 Enrollment Procedures

Enrollment procedures to PhilHealth slightly differ depending on the membership category. Table 4- 2 summarizes enrollment procedures to PhilHealth.[100].

Table 4- 2 Enrollment Procedures by Membership Category

	Membership Category	Enrollment Procedure
1	Formal Economy	· Submission of PhilHealth Member Registration Form (PMRF") or other personal identification number in the PhilHealth ID card to employer (employer will proceed to enroll the employee to PhilHealth)
2	Informal Economy	· Submission of PMRF to PhilHealth Local Health Insurance Offices or PhilHealth Express outlets nationwide · For Migrant Worker, if in the Philippines, submission of PMRF to either PhilHealth Regional Office, PhilHealth Local Health Insurance Office, PhilHealth Business Center or PhilHealth Express outlet. If overseas, electronically submitting PMRF from any branch of accredited collecting partners of PhilHealth – i.e., iRimit, Inc. and Ventaja Corporation
3	Lifetime Members	· Submission of PMRF and other necessary documents to PhilHealth Local Health Insurance Office
4	Senior Citizens	· Submission of PMRF and other necessary documents to either Office for the Senior Citizen Affairs or PhilHealth Local Health Insurance Office
5	Indigent Members	· Indigents are automatically enrolled to PhilHealth
6	Sponsored Members	· Submission of PMRF and other necessary documents to sponsors or at PhilHealth offices

Source: PhilHealth Website

[99] PhilHealth website
[100] ibid

4-6 Premium Contributions

Premium payment procedure varies depending on the Membership category, as summarized in Table 4- 3.[101]

Table 4- 3 Premium Payment Procedures

<table>
<tr><th></th><th>Membership Category</th><th>Premium Payment Procedure</th></tr>
<tr><td>1</td><td>Formal Economy</td><td>・ Members in the formal economy shall pay the monthly contributions to be shared equally by the employer and employee at a prescribed rate set by PhilHealth not exceeding 5 percent of their respective basic monthly salaries. Below is the excerpt from the Formal Economy contribution table for 2016 (in pesos).
<table>
<tr><th>Salary Bracket</th><th>Salary Range</th><th>Base Salary</th><th>Total Monthly Premium</th><th>Employee Share</th><th>Employer Share</th></tr>
<tr><td>1</td><td>~8,999.99</td><td>8,000</td><td>200.00</td><td>100.00</td><td>100.00</td></tr>
<tr><td>2</td><td>9,000~9,999.99</td><td>9,000</td><td>225.00</td><td>112.50</td><td>112.50</td></tr>
<tr><td>3</td><td>10,000~10,999.99</td><td>10,000</td><td>250.00</td><td>125.00</td><td>125.00</td></tr>
<tr><td>…</td><td>…</td><td>…</td><td>…</td><td>…</td><td>…</td></tr>
<tr><td>27</td><td>34,000 ~ 34,999.99</td><td>34,000</td><td>850.00</td><td>425.00</td><td>425.00</td></tr>
<tr><td>28</td><td>35,000~</td><td>35,000</td><td>875.00</td><td>437.50</td><td>437.50</td></tr>
</table></td></tr>
<tr><td>2</td><td>Informal Economy</td><td>・ Annual premium of 2,400 pesos are paid monthly or yearly for those earning P25,000 or less per month.
・ Annual premium of 3,600 pesos are paid monthly or yearly for those earning more than 25,000 pesos per month.</td></tr>
<tr><td>3</td><td>Lifetime Members</td><td rowspan="3">・ Annual premium of 2,400 pesos for each member is shouldered by the National Government based on the General Appropriations Act.</td></tr>
<tr><td>4</td><td>Senior Citizens</td></tr>
<tr><td>5</td><td>Indigent Members</td></tr>
<tr><td>6</td><td>Sponsored Members</td><td>・Annual premium of 2,400 pesos for each member is shouldered by LGU, Department of Social Welfare and Development (DSWD), healthcare institutions, national government, private individuals, private corporations, etc.[102]</td></tr>
</table>

Source: PhilHealth website & Interviews with PhilHealth

[101] PhilHealth website and Title III Section 5 of the Implementing Rules and Regulations (IRR) of RA 7875 as amended otherwise known as the National Health Insurance Act of 2013, annual audit report for the year ended December 31, 2015

[102] Healthcare institutions tend to pay the premium and become sponsors of the uncovered indigents upon admission of the indigents under Point-of-Care enrollment program that enrolls them into PhilHealth on site, offered by public healthcare institutions. As public healthcare institutions (DOH retained hospitals and LGU owned hospitals) are subsidized by the national government and/or LGUs, they are effectively supporting the Sponsored Members. Based on an interview with PhilHealth (October 26)

4-7 Payment Mechanisms

Previously, PhilHealth had employed the payment mechanism called Fee-for-Service, which determines the fee based on the health services provided, the type of health facility and the severity of illness. In 2011, aiming to reduce payment cost and claim document processing, PhilHealth introduced the Case Rate Payment method for the following 11 medical cases and 12 surgical cases shown in the Table 4- 4. Case Rate Payment is a payment method that reimburses health facilities a predetermined fixed rate for each treated case. PhilHealth had selectively used the Case Rate Payment method for such conditions as outpatient malaria treatment, HIV/AIDS, tuberculosis treatment and cataract surgery. However, with this introduction, approximately 50 percent of all claims filed to PhilHealth came to be reimbursed through the Case Rate Payment method.

Table 4- 4 Case Rate Payment Introduced in 2011 – Cases and Rates (in pesos)

	Medical Case		Surgical Case	
	Case	Rate	Case	Rate
1	Dengue I (Dengue Fever and DHF Grades I & II)	8,000	Radiotherapy	3,000
2	Dengue II (DHF Grades III & IV)	16,000	Hemodialysis	4,000
3	Pneumonia I (Moderate Risk)	15,000	Maternity Care Package	8,000
4	Pneumonia II (High Risk)	32,000	Cesarean Section	8,000
5	Essential Hypertension	9,000	Appendectomy	6,500
6	Cerebral Infarction (CVA I)	28,000	Cholecystectomy	19,000
7	Cerebro-Vasluar Accident (hemorrhage) (CVA II)	38,000	Dilatation & Curettage	24,000
8	Acute Gastroenteritis (AGE)	6,000	Thyroidectomy	31,000
9	Asthma	9,000	Herniorrhaphy	21,000
10	Typhoid Fever	14,000	Mastectomy	22,000
11	Newborn Care Package in Hospitals and Lying-in Clinics	1,750	Hysterectomy	30,000
12			Cataract Surgery	16,000

Source: Dr. Francisco Z. Soria, Jr. (2016). PhilHealth Benefits.

In 2014, PhilHealth introduced the All Case Rate payment mechanism when reimbursing health care providers and professionals. Through this introduction, members came to know how much PhilHealth is paying for their illness or injury at the PhilHealth website by searching for illness/injury, operation, ICD 10[103] or RVS codes.[104,105,106]

[103] International Statistical Classification of Diseases and Related Health Problems Tenth Revision (ICD 10)

[104] PhilHealth. (2014). Annual Report 2014

[105] PhilHealth. (January 30, 2015). Get to know your PhilHealth benefit in just one click.

[106] International Statistical Classification of Diseases and Related Health Problems Tenth Revision (ICD 10) and Relative Value Scale (RVS) are codes used by PhilHealth in identifying specific rates for every reimbursable medical condition and procedure.

Moreover, introduction of the Case Rate Payment curtails prolonged hospital stay, over-utilization of diagnostic tools, and provision of un-necessary healthcare services. In some areas of the country, turnaround time taken from claim receipt to payment was shortened from 70 days under the Fee-for-Service method to 17 days with the introduction of Case Rate Payment method.[107]

Generally speaking, for medical cases, healthcare professionals are allocated 30 percent of PhilHealth reimbursements, with 40 percent allocation for surgical cases.[108] Figure 4- 2 is the sample of Case Rate Payment for Pneumonia II (High Risk). A Case Rate of 32,000 pesos is first reimbursed to a healthcare facility or the LGU that operates the healthcare facility. Then 30 percent of the reimbursement is redistributed to healthcare professionals and the remaining 70 percent goes to the healthcare facility.

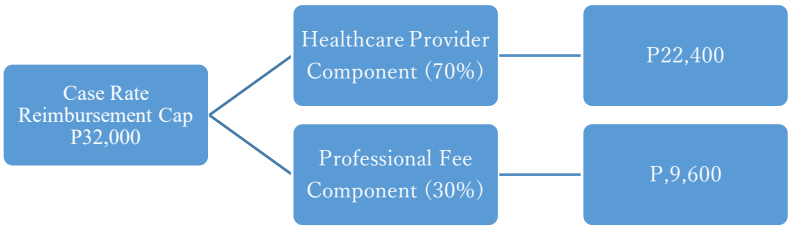


Figure 4- 2 Reimbursement Flows under Case Rate for Pneumonia II (High Risk)

Source: Dr. Francisco Z. Soria, Jr. PhilHealth benefits

4-8 Benefit Packages

Broadly speaking, the following four types of benefit packages are offered by PhilHealth.[109] Benefit packages include room and board, and doctors', lab, procedure, and medicine fees.

1. Inpatient Benefit Packages
2. Outpatient Benefit Packages
3. Z Benefit Packages
4. MDG-related Benefit Packages

The following sub-sections describe each of the benefits.

(1) Inpatient Benefit Package

Inpatient benefits are available to all PhilHealth members.

[107] Leopoldo J. Vega, Southern Philippines Medical Center. Shifting to Case Rates: Efficiency Gains.
[108] There are exceptions – e.g., P500 fixed payment to healthcare professional for dialysis treatment. (Dr. Francisco Z. Soria, Jr., PhilHealth. PhilHealth Benefits.)
[109] PhilHealth website

(2) Outpatient Benefit Package

PhilHealth offers outpatient benefit packages targeting primarily indigents.[110] In 2012, PhilHealth amended its primary benefit package and introduced the Primary Care Benefit 1 (PCB1) package in order to promote the utilization of the service. In 2014, PhilHealth re-branded PCB1 Package into TSeKaP (see Table 4- 5). TSeKaP consists of essential services aimed at prevention and early detection of diseases, as well as interventions for healthy living.[111]

Sponsored Members, Indigent Members and Senior Citizens can access the TSeKaP benefit free of charge.[112] The maximum benefit is 1,800 pesos per year per family, 800 pesos of which is reimbursed to health facilities for their services, and 1,000 pesos are paid to accredited drug stores.[113] Benefits are basically available through public health service providers though limited privately owned facilities.

Table 4- 5 Primary Care Service Offered under TSeKaP Program

	i. Preventive Services	ii. Diagnostic Examinations	iii. Drugs and Medicines
1	Consultation	Complete blood count	Asthma including nebulization services
2	Visual inspection with acetic acid	Urinalysis	Acute Gastroenteritis (AGE) with no or mild dehydration
3	Regular BP measurements	Fecalysis	Upper Respiratory Tract Infection (URTI)/Pneumonia (minimal and low risk)
4	Breastfeeding program education	Sputum microscopy	Urinary Tract Infection (UTI)
5	Periodic clinical breast examinations	Fasting blood sugar	
6	Counseling for lifestyle modification	Lipid Profile	
7	Counseling for smoking cessation	Chest x-ray	
8	Body measurements		
9	Digital rectal examination		

Source: PhilHealth website

Aside from TSeKaP, outpatient benefits in Table 4- 6 are currently available for non-Indigent Members free of charge.

[110] PhilHealth. (2014). Annual Report 2014.
[111] PhilHealth website
[112] This program also covers Household Help, such as drivers and housekeepers, as defined in the Republic Act 10361 or "Kasambahay Law."
[113] Dr. Francisco Z. Soria, Jr, PhilHealth. PhilHealth Benefit Packages: Understanding the Role of Quality Medicines and Quality Pharmaceutical Care.

Table 4- 6 Outpatient Benefit Packages Offered by PhilHealth (other than TSeKaP)

	Service	Case Rates (in pesos)
1	Day Surgeries (ambulatory or outpatient surgeries)	All Case Rate applies
2	Radiotherapy Using Cobalt Using linear accelerator	 2,000/session 3,000/session
3	Hemodialysis	2,600/session
4	Outpatient Blood Transfusion	3,640 (including drugs & medicines, X-ray, lab, operating room)

Source: PhilHealth website

(3) Z Benefit Package[114]

In 2012, PhilHealth launched the new Z Benefit Package (Z Benefit) that gives substantial financial risk protection for the treatment of catastrophic illnesses. Since its introduction, the coverages have expanded annually.

Table 4- 7 Z Benefit Package: Year of Introduction and Case Rates (in pesos)

2012 (Initial implementation)	
Acute Lymphoblastic Leukemia in Children (standard risk)	210,000
Breast Cancer (early stage)	100,000
Prostate Cancer (low to intermediate risk)	100,000
Low Risk Kidney Transplantation	100,000
2013 (Z benefit expansion)	
Elective Surgery for Coronary Artery Bypass Graph	550,000
Tetralogy of Fallout or "Blue Baby Syndrome"	320,000
Ventricular Septal Defect (VSD)	250,000
Cervical Cancer (stage IIIB) Low dose High dose	 120,000 175,000
Prosthetic limb	15,000
2014 (Z benefit expansion)	
Selected Orthopedic Implants 9 types of implant including Total Hip Prosthesis	 48,740~103,400
Peritoneal Dialysis	270,000/year 10,384.60/tranche
2015 (Z benefit expansion)	
Colon Cancer Stage I-II (Low Risk) Stage II (High Risk) - III	 150,000 300,000
Rectum Cancer Stage I (Clinical and Pathologic) Stage II-III (Clinical and Pathologic) Use of linear accelerator as mode of radiotherapy Use of cobalt as mode of radiotherapy	 150,000 400,000 320,000

Source: PhilHealth. Annual Report 2014 and PhilHealth website

[114] "Z" of Z Benefit package stands for "zero," meaning that the program requires no co-payment.

Table 4- 7 summarizes current offerings of the Z Benefit Package.[115] Currently, 20 percent of the Z Benefit reimbursement is allocated to healthcare professionals, with some exceptions, such as Cervical Cancer whose professional fee is 15 percent of the case rate.[116]

Z-benefits are only offered at hospitals contracted with PhilHealth for a specific illness or treatment in the Z Benefit Package. Table 4- 8 is the list of hospitals contracted for the Elective Surgery for Coronary Artery Bypass Graph.[117]

Table 4- 8 Contracted Hospitals for Elective Surgery for Coronary Artery Bypass Graph

Province	Contracted Hospitals for Elective Surgery for Coronary Artery Bypass Graph
National Capital Region	Philippine Heart Center University of Philippines - Philippine General Hospital
Central Luzon	Angeles University Foundation Medical Center
Central Visayas	Vicente Sotto Memorial Medical Center
Northern Mindanao	Northern Mindanao Medical Center
Davao	Southern Philippines Medical Center

Source: PhilHealth website

(4) MDG related package

A MDG-related package is aimed at promotion of MDG target achievements in the Philippines, which include a maternity package such as MCP, Normal Spontaneous Delivery Package (NSD) and Antenatal Care Package (ANC01), New Born Care Package (NCP), and benefit packages summarized in Table 4- 9. PhilHealth Circular No. 026 requires that no fees be charged in excess of the relevant benefit package provided that the patient pays for the full amount of the required annual premium.

[Maternity Care Package[118]]

The MCP provides for comprehensive coverage from pre-natal to post-natal care, and NSD encourages normal low risk deliveries in birthing homes and maternity clinics in a safe environment, as opposed to deliveries at homes.[119] As Table 4- 9 shows, MCP related benefits differ depending on the type of health care facilities. Case rates for hospitals are different from that for other facilities, such as, infirmaries, birthing homes and maternity clinics.

[115] PhilHealth website and "Annual Report 2014", PhilHealth
[116] Dr. Francisco Z. Soria Jr., PhilHealth. (2016). PhilHealth Benefits.
[117] PhilHealth website.
[118] PhilHealth. Circular No. 26, 2015.
[119] PhilHealth. Annual Report 2014.

Table 4- 9 Maternity Care Package (in pesos)

	Hospital	Non-hospital facility	Services, Conditions, etc.	Allocation
MCP	6,500	8,000	Covers the essential health services during antenatal period, normal delivery and immediate post-partum period including follow-up visits within the first 72 hours and 1 week after delivery. Minimum stay of mother in the facility shall be 24 hours. Avaliment of this package shall be charged to the annual 45-day benefit limit.	40% to professional 60% to facility
NSD	5,000	6,500	Covers the essential health services during normal delivery and immediate post-partum period including follow-up visits within the first 72 hours and 1 week after delivery. Minimum stay of mother in the facility shall be 24 hours. Avaliment of this package shall be charged to the annual 45-day benefit limit.	
ANC01	1,500	1,500	At least 4 doctor check-ups are required with that last check-up being in the last part of pregnancy - i.e., last 3 months before delivery	
Non-hospital facility→ eventual referral to hospital		650		
Cesarean Section	19,000			
Complicated Vaginal Delivery	9,700			
Breech Extraction	12,120			
Vaginal Delivery after Cesarean Section	12,120			

Source: PhilHealth. Circular No. 26, 2015.

[New Born Care Package (NCP) [120]]

The NCP covers health services that newborns must receive within the first hours of life regardless of the method of their delivery and presence of co-morbidities. Table 4- 10 summarizes the benefits and case rates.

[120] PhilHealth. Circular No. 26, 2015.

Table 4- 10 Newborn Care Package (in pesos)

Services Offered under NCB Package	Reimbursement	Allocation
Essential Newborn Care (including vitamin K administration, first dose of hepatitis B and BCG vaccine)	1,000	40% to professional 60% to facility
Newborn Screening Test	550	100% to facility
Newborn Hearing Test	200	
Total	1,750	

Source: PhilHealth. Circular No. 26, 2015.

[Others]

Other MDG-related benefit packages are summarized in Table 4- 11.

Table 4- 11 Other MDG Related Packages (in pesos)

	Benefit Packages	Case Rates
1	Outpatient Malaria (MDG6) Diagnostic malaria smears and other laboratory procedures; drugs and medicines & consultation service	600
2	Outpatient HIV-AIDS (MDG6) Drugs, medicines and laboratory examinations	30,000/Year (7.500/Quarter)
3	Outpatient Anti-Tuberculosis Treatment (MDG6) ・ Diagnostic exams, consultation services, drugs, health education and counseling during treatment	4,000
4	Voluntary Surgical Contraception (MDG5) ・ Health facility charges such as room and board, drugs and medicines ・ Physician fee ・ Post-operative consultation within 90 days from day of surgery	4,000
5	Animal Bite Package (MDG4) ・ Rabies vaccine ・ Rabies immune globulin ・ Local wound care ・ Tetanus toxoid and anti-tetanus serum ・ Antibiotics ・ Supplies such as syringes	3,000

Source: PhilHealth website

4-9 Claim Procedures

In order for members to claim PhilHealth benefits, members are to submit the following documents to health service providers.

■ PhilHealth ID and/or MDR

PhilHealth provides ID cards to members. Membership is good for one year, after which renewal is necessary. MDR proves that individuals are enlisted as PhilHealth Members and dependents must be enlisted in the MDR.

- Document evidencing premium payments

  Members must have made a payment of at least the 3-month premium for the last 6 months. In some cases, including MCP and NCP Packages, one-year premium payment is required at the time of facility visit.

- Claim Form 1, 2 and 3

  If necessary documents are properly submitted, the value of PhilHealth case rate is deducted from the total medical bill upon discharge. PhilHealth will later send a benefit payment notice to the PhilHealth members.

4-10 Accreditation Processes[121]

Accreditation is a process whereby the qualifications and capabilities of health care providers are verified in accordance with the guidelines, standards and procedures set by PhilHealth. Health facilities and health care professionals need PhilHealth accreditation in order to receive reimbursements to PhilHealth.

(1) Health Facilities

The conditions that a health facility must satisfy before applying for PhilHealth accreditations are (1) no record of a medical accident for at least 3 years (with some exceptions) following the approval of its practice by DOH, (2) provision of an official quality standard program, and (3) accountability for its own medical practice. The following facilities may apply for accreditation.

- Hospitals
- Dialysis clinics
- Outpatient clinics (Rural Health Unites/ Health Centers, Dispensaries, Birthing Homes, etc.)
- Ambulatory surgical clinics
- Birthing Homes (Normal Spontaneous Delivery)
- TB Clinics

Table 4- 12 is the number of the accredited facilities as of the end of December 2015.

[121] PhilHealth website

Table 4- 12 Institutional Providers with PhilHealth Accreditations

Category of the Institutional Providers	Private	Public	Total
Level 1: Offers primary care services	444	310	754
Level 2: Institution situating between Level1 and Level3, equipped with general ICU and ICU for newborns	254	49	303
Level 3: Highest level institution offering education, emergency care, and etc.	67	48	115
Other than above	370	345	715
Total	1,135	752	1,887
% Total	60%	40%	100%

Source: PhilHealth (2016). 2015 Stats & Charts.

Table 4- 13 summarizes the number of accredited outpatient clinics, the number of cities and municipalities with accredited outpatient clinics and the proportion of cities and municipalities with accredited clinics for Primary Care Package (PCB1), Maternity Care Package (MCP) and TB/DOTS Package (DOTS Package.). PCB1 is available in nearly all cities and municipalities with more than 80 percent available for MCP and DOTS Package.

Table 4- 13 Number of Accredited Outpatient Clinics, Number and Percentage of Cities and Municipalities with Accredited Outpatient Clinics

	PCB1	MCP	DOTS Package
Number of accredited outpatient clinics	2,553	2,981	1,739
Number of cities and municipalities with accredited outpatient clinics	1,567	1,268	1,286
Percentage of cities and municipalities with accredited outpatient clinics	99%	80%	81%

Source: PhilHealth (2016). 2015 Stats & Charts.

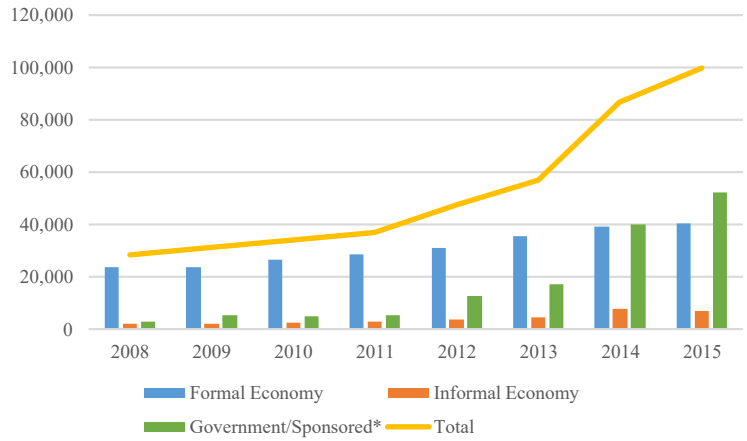
(2) Professionals

Physicians, dentists and midwives need to be accredited in order to receive PhilHealth reimbursements. To ensure continuous accreditation from NHIP, renewal must be completed annually by no later than 45 days prior to their birthday.

4-11 Funding for PhilHealth

Figure 4- 3 shows the premium contributions to PhilHealth for the years between 2008 and 2015. Significant increase in the government subsidy for the year 2014 is attributed to Republic Act (RA) 10351, or the Sin Tax Reform Act of 2012.[122]

[122] 15 percent of the incremental revenue collected from the excise tax on tobacco and alcohol products shall be allocated for programs to promote economically viable alternatives for tobacco farmers and workers. Out of the remaining 85 percent of the incremental tax revenue, 80 percent is allocated for



*Government/Sponsored includes Indigent Members, Sponsored Members, Senior Citizens and contributions from Special Government Programs

Figure 4- 3 Premium Contribution to PhilHealth by Membership Categories (in pesos)

Source: PhilHealth. (2010-2015). Annual Report 2009-2014 and PhilHealth. (2015). Annual Audit Report on PhilHealth for the Year Ended December 31,2015.

4-12 Cross Subsidy among PhilHealth members

NHIP consists of Members with different professions and income levels. Consequently, some Members pay higher contributions and claim less benefits than others.

Table 4- 14 Premium Contributions and Benefit Claims for 2015 by NHIP Members

Premium Contributions for 2015 (million P)

Membership Type	Amount	%	
Formal Economy	40,544	*40.7%*	
Informal Economy	6,803	*6.8%*	
Indigent-NHTS	36,258	*36.4%*	
Senior Citizens	13,045	*13.1%*	
Sponsored	2,893	*2.9%*	40,544
Special Gov't Program	82	*0.1%*	(15,594)
	99,625	***100.0%***	**24,950**

Benefit Claims Expense for 2015 (million PhP)

Membership Type	Amount	%
Formal Economy	24,950	*25.7%*
Informal Economy	20,173	*20.8%*
Indigent-NHTS	25,056	*25.8%*
Senior Citizens	19,328	*19.9%*
Sponsored	7,528	*7.8%*
	97,035	***100.0%***

Formal Economy claims PhP 15,549 million less in benefits than they contributed. This means that Formal Economy effectively subsidizes the other members of PhilHealth

Source: Annual audit report for the year ended December 31, 2015

universal health care under the NHIP for the attainment of MDGs and health awareness programs, and 20% for medical assistance and health enhancement facility programs.

Table 4- 14 are the breakdowns of premium contributions and benefit claims for the year ended 2015. Members of the Informal Economy, the Senior Citizens and the Sponsored tend to claim for benefits more than they contribute premiums, while Members of the Formal Economy and the Indigent-NHTS-PR contribute more premiums than they claim for benefits. This means that the formal economy and the public fund are subsidizing other members' healthcare costs through NHIP.

4-13 Enrollment and Utilization

(1) Population Coverage

Table 4- 15 summarizes the number of eligible beneficiaries[123] and population coverage of PhilHealth as the fraction of the total population from 2010 to June 2016. Population coverage as of the end of June 2016 stands at 90 percent.[124] It should be noted that there is no consistency of data within the same membership categories. For example, while the NHTS-PR was under Sponsored Members for the years 2010 to 2013, they are changed to Indigent Members[125] for the years 2014 and 2016.

Table 4- 15 Number of Covered Members and Coverage Ratio from 2010 to 2015

Membership Category	2010	2011	2012	2013	2014	2015	6/2016
Formal Economy	29.21	24.00	25.94	26.34	27.05	28.32	28.89
Informal Economy	9.91	9.91	11.82	11.99	7.38	8.46	8.31
Overseas Filipinos	5.09	5.09	5.23	5.86	-	-	-
Lifetime Members	0.95	0.95	1.25	1.32	1.61	1.73	2.05
Senior Citizens	-	-	-	-	4.34	7.12	7.42
Indigent Members	-	-	-	-	43.73	45.41	44.35
Sponsored Members	22.10	38.44	36.68	31.39	2.12	2.41	1.59
NHTS-PR	-	18.90	20.43	21.01	-	-	-
LGU/Regular	-	19.55	16.25	10.37	-	-	-
Covered Members	**67.26**	**78.39**	**80.92**	**76.90**	**86.22**	**93.44**	**92.61**
Projeted Population	90.89	95.60	95.88	97.70	99.56	101.45	102.90
Coverage Ratio(%)	**74**	**82**	**84**	**79**	**87**	**92**	**90**

Source: PhilHealth. (2010-9/2016). 2010-1st September 2016 Stats &Charts

[123] Enrolled Members include those that are recorded as Members and their dependents having gone through the enrollment procedure in the past, and includes those currently not paying contributions (Interview with PhilHealth).

[124] PhilHealth. 2015 Stats & Charts.

[125] Indigents are defined by the National Household Targeting System for Poverty Reduction

(2) NHIP Utilization

Table 4- 16 summarizes the NHIP utilization rate, unique member claims reimbursed out of the total eligible beneficiaries, from 2012 to June 2016. The rate has gradually increased.

Table 4- 16 NHIP Utilization from 2012 to 2015NHIP

Year	Ratio of the Unique Member Claims Reimbursed to the Total NHIP Members
2012	6%
2013	8%
2014	11%
2015	12%
6/2016	8% (January-June)

Source: "2012-2015 Stats & Charts", PhilHealth

4-14 Supporting Indigents

(1) Facilitating Enrollments for Indigent Members

In 2011, PhilHealth adopted the National Household Targeting System for Poverty Reduction (NHTS-PR) of the Department of Social Welfare and Development (DSWD) as a means to identify indigent families. This has proved to be successful in increasing the number of the Indigent Members in NHIP.[126] Families identified as indigent under the NHTS-PR automatically become PhilHealth Members without any premium payment.

NHTS-PR is the system to determine whether a household is indigent through a proxy means test[127] (PMT) that estimates the level of economic welfare of a household based on its socioeconomic and demographic characteristics. DSWD, in collaboration with the National Statistics Office (currently Philippines Statistics Authority), conducted a pilot survey in 2007, thereafter conducting the first nationwide assessment in 2011.

NHTS-PR identifies indigents from the selected groups of population in order to make the process efficient. On the basis of the Family Income and Expenditure Survey (FIES) and Small Area Estimates (SMEs) results, all municipalities nationwide are classified as a "very poor municipality," which has more than 50 percent of Poverty Incidence (PI), and the "moderate poor municipality," which has less than 50 percent of PI. In the very poor

[126] PhilHealth. 2011 Annual Report.

[127] Income estimate survey based on the analyses of FIES and LFS, covering such items as household members, their educations and professions, conditions of their house, access to basic services. Face-to-face interviews are conducted based on the Household Assessment Form that consists of 34 questions on one double-sided sheet (Second survey is based on the Household Assessment consisting of 52 questions.) There are two PMT Models – one for urban areas and one for rural areas

municipalities, all households are assessed. For the moderate poor municipalities, full assessment is conducted only in pockets of poverty and for the rest of the moderate poor municipalities, on-demand application was applied in which households are actively encouraged to submit applications for assessment. In the first NHTS-PR assessment, 10,909,456 households in 489 very poor municipalities and 1,045 moderately poor municipalities/cities were covered.[128] Interviews were conducted based on the Household Assessment Form that consists of 34 questions. For the second NHTS-PR assessment, it was converted into a Family Assessment Form as family is a more common unit to receive social services (see Attachment 6). Reportedly about 55 million individuals, equivalent to 57 percent of the nationwide population, were covered in the first NHTS-PR assessment.

Thereafter, based on the latest Per Capita Poverty Threshold (PCPT) of each province, as determined by the Philippine Statistics Authority (PSA), indigent households are identified and listed in the Listahanan.[129] After posting the Listahanan in each community for some period of time for the community members to request reinvestigation,[130] the Listahanan is finalized and used for various social services.

Listahanan is mandated for renewal every four years, and the second assessment was conducted from April to September in 2015. The data are currently analyzed. While the first assessment was conducted on a household basis, the second assessment was performed on the basis of the "family" unit, as are many social services, including NHIP, are provided for a "family" (parents and children under 21),[131] instead of a household.

(2) No Balance Billing Policy[132]

In addition to the NHTS-PR, PhilHealth adopted the No Balance Billing (NBB) policy for the most common medical and surgical conditions in the country in 2011, to provide optimal financial risk protection for the most vulnerable group, through PhilHealth Board Resolution No. 1441, 2010. The NBB policy provides that no other fees or expenses shall be charged or be paid for by the indigent patients above and beyond the packaged rates.[133]

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[128] The National Household Targeting Office of the Department of Social Welfare and Development. (2015). Listahanan.
[129] Means list of household in Tagalog
[130] On-site visits confirmed the postings of Listahanan at a community level. However, few residents were aware of their rights for petitions.
[131] Interview with DSWD (October 6th, 2016)
[132] PhilHealth Circular No. 011-2011, New PhilHealth Case Rates for Selected Medical Cases and Surgical Procedures and the No Balance Billing Policy
[133] PhilHealth Circular No. 0003, s. 2014

The characteristics of NBB policy are as follows:[134]

- The NBB policy is always applied when members are admitted to government health facilities, while some private hospitals have adopted the NBB policy.
- The NBB policy is also applicable to non-indigent members for specific benefit packages, such as the Maternity Care Package (MCP) and New-born Care Package (NCP) in all accredited facilities.

In 2014, the NBB policy was expanded to cover Household Help, such as a household driver and a housekeeper, as defined in the Republic Act 10361 or "Kasambahay Law."[135].

(3) Point-of-Care Enrollment Program[136]

As mentioned earlier, the NHTS-PR is not able to reach all indigents in the Philippines. Therefore, PhilHealth introduced another measure called the Point-of-Care (POC) enrollment program in 2013 in order to cover non-NHTS-PR indigents. At health facilities with POC accreditation, a Medical Social Worker (MSW) checks to see if the patient is included in the list of PhilHealth Members, and if not, he/she conducts an interview. If the patient is deemed indigent, the healthcare facility pays the annual premium of 2,400 pesos and enrolls him/her into NHIP. POC is valid for a year and the patient is obligated to pay a premium the following year to renew the membership. POC does not necessarily mean a net cash outflow for a health facility because PhilHealth's reimbursement usually makes up for the premium payment of 2,400 pesos upon POC enrollment.[137] Adoption of POC is mandated at all DOH-retained hospitals. LGUs and other health facilities need to obtain approval by PhilHealth.

In enrolling patients through POC, an MSW estimates the patient's monthly income based on the interview compared with the PSPT[138] of the Region where the health facility exists, and classifies the patient from A to D as stipulated in the DOH Administrative Order No. 51-A s. 2001, Implementing Guidelines on Classification of Patients and on Availment of Medical Social Services in Government Hospitals (see Table 4- 17). The patient becomes eligible for POC if she/he is categorized as C-3 or D. It should be noted that POC is the PhilHealth program; however, the poverty threshold is set by PSA, while the patient categorization into A to D is set by DOH.

[134] PhilHealth Circular No. 011-2011
[135] PhilHealth Circular No. 0003, s. 2014
[136] PhilHealth Circular No. 0032. s.2013, October 14, 2013.
[137] Interview with Jose Fabella Hospital
[138] Refers to the PCPT for the region where a healthcare facility is located.

Table 4- 17 Patient Categories Based on the Ability to Pay and Respective Payment Amounts

Patient Category	Conditions for Qualification	Payment by Patient
Class A	Patient whose monthly per capita income is over 220% of the latest PCPT for the region in which the hospital is located, using a private room	Patient pays 100% of the medical fee not covered by PhilHealth
Class B	Patient whose monthly per capita income is over 220% of the latest PCPT for the region in which the hospital is located, using a shared room for 3 or more patients	Patient pays 100% of the medical fee not covered by PhilHealth
Class C-1	Patient whose monthly per capita income is between 180% and 220% of the latest PCPT for the region where the hospital is located	Patient pays 75% of the medical fee not covered by PhilHealth
Class C-2	Patient whose monthly per capita income is between 140% and 180% of the latest PCPT for the region where the hospital is located	Patient pays 50% of the medical fee not covered by PhilHealth
Class C-3	Patient whose monthly per capita income is equal to but not more than the 140% of the latest PCPT for the region where the hospital is located	The patient shall share any affordable amount for medicines provided and ancillary services rendered.
Class D	Patient whose monthly per capita income is less than 140% of the latest PCPT for the region where the hospital is located	The patient shall not pay for incurred hospital charges.

Source: Administrative Order No. 51-A s. 2001, "Implementing Guidelines on Classification of Patients and on Availment of Medical Social Services in Government Hospitals"

Despite the stipulation that POC can be utilized only once per Member, in reality, annual membership renewal is not observed in many cases and some members wait until they are hospitalized again and repeat POC.[139] Also there are some cases that A to C2 patients insist that they cannot pay premiums and the health facilities have the MSW look for a sponsor or become a sponsor himself/herself. When the MSW is unable to find a sponsor, the MSW intentionally categorizes such patients as C3 or D. The patients classified as C1 and C2 are required to pay 25 percent and 50 percent of the medical bills respectively, and encouraged to pay for the annual premium.[140]

(4) Conditional Cash Transfer

The Conditional Cash Transfer (CCT) program in the Philippines, known as Pantawid Pamilyang Pilipino Program (4Ps), is the social welfare program offered by DSWD. It was introduced in 2008 with the objectives of providing monetary as well as social assistances

[139] Interview with Dr. Jose Fabella Memorial Hospital
[140] Interview with DOH Health Facility Development Bureau (October 4, 2016)

for poor families with children 0-18 years old.[141] Although CCT is outside the framework of NHIP, this subject is briefly touched herein as both CCT and NHIP support indigents.

[Eligibility]

Poor households are identified by the NHTS-PR that employs a statistical model to estimate income, as explained earlier. The following criteria must be satisfied to become eligible for the CCT program.[142]

- Residents of the poorest municipalities, based on the 2003 Small Area Estimates of the National Statistical Coordination Board (incorporated into the Philippine Statistics Authority today)
- Households are deemed to be "indigent" whose economic conditions are equal to or below the provincial poverty threshold[143]
- Households that have children 0-18 years old and/or have a pregnant woman at the time of assessment
- Households that agree to meet conditions specified in the CCT program

As of August 26, 2015, there were 4,353,597 active household beneficiaries, 570,056 of whom are indigenous households. The program also covers 10,235,657 schoolchildren aged 0 to 18.[144]

Eligible members are provided with ID cards and assigned to a health facility.

[Cash Grants and Conditions for Payment]

Two types of cash grants are provided to the household-beneficiaries:

- Health Grant: 500 pesos/ household every month totaling 6,000 pesos per year
- Education Grant: 300 pesos/ child every month for 10 months, totaling 3,000 pesos per year

Cash grants are distributed to the household through the Land Bank of the Philippines or any other alternate payment scheme, such as rural bank transactions.

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[141] Official gazette of the government of the Philippines. Pantawid Pamilyang Pilipino Program.
[142] ibid
[143] Poor Household, is identified through a "Household Assessment" survey conducted by DSWD, recorded onto NHTS-PR by the same. First Household Assessment was conducted in 2009 and 2010 covering 17 million households, with the latest conducted in 2015 covering 20 million households. Results of the 2015 survey are being complied as of the date of this writing.
[144] Official gazette of the government of the Philippines. Pantawid Pamilyang Pilipino Program.

To receive the cash grants, all of the following conditions must be met by the household beneficiaries.[145]

1. Pregnant women use pre- and post-natal care, and be attended during childbirth by a trained professional
2. Parents or guardians attend family development session with topics, such as responsible parenting, and health and nutrition
3. Children aged 0-5 receive regular preventive health check-ups and vaccines
4. Children aged 6-14 receive deworming pills twice a year
5. Children-beneficiaries aged 3-18 enroll in school, and maintain an attendance of at least 85 percent of class days every month

Compliance rates are generally high. In March and April 2015, for instance, the lowest compliance rate was 94.84 percent for the condition 2 above.[146]

[Promotions of NHIP Benefits to CCT Beneficiaries]

Although the CCT beneficiaries are automatically enrolled with NHIP, 5-6 percent of the CCT beneficiaries are not aware of this fact.[147] Also, their NHIP utilization rate is low. In order to promote NHIP utilization by CCT beneficiaries, DSWD is engaged in the following promotional activities:

- PhilHealth representatives conduct seminars to explain PhilHealth benefits to CCT beneficiaries.
- DSWD recommends health facilities place signboards indicating that the CCT beneficiaries will not need to shoulder medical bills as they are automatically covered under the NBB policy of NHIP, as there are many cases wherein patients are hesitant to go to health facilities for fear of having to pay medical bills.

[145] Official gazette of the government of the Philippines. Pantawid Pamilyang Pilipino Program.
[146] ibid
[147] Interview with DSWD

Chapter 5 Maternal and Child Health Services in Bicol and Eastern Visayas Regions

5-1 Bicol Region (Region V)

(1) Regional Profile

① Socioeconomic Profile

Bicol region is comprised of the southern part of Luzon with six provinces. Legaspi city and Naga city are the center of commerce, finance and transportation, while the main industries of the region are agriculture and fishing. The economic growth rate in 2015 was the highest in the country at 8.4 percent, however, the GDP per capita was the second lowest with 25,648 pesos after ARMM.[148] Provincial populations in Bicol region is shown in Table 5- 1.

Table 5- 1 Provincial populations in Bicol Region (in thousand)

	Population			Population Growth Rates
	2000	2010	2015	2010-2015
Albay	1,091	1,233	1,315	1.22
Camarines Norte	471	543	583	1.38
Camarines Sur	1,552	1,822	1,953	1.32
Catanduanes	215	246	261	1.11
Masbate	708	835	892	1.28
Sorsogon	651	741	793	1.30
Region	4,688	5,420	5,797	1.29

Source: Philippine Statistics Authority

② Maternal and Child Health (MCH) Status

Figure 5- 1 shows the trend of maternal mortality rate (MMR) in Bicol based on FHSIS data, which are different from that of the Albay Provincial Health Office whose number of matarnal death was 44 in 2014, 29 in 2015 and 6 up to July 2016. Although it is generally believed that quality of FHSIS data is not high, the number of maternal death differs depending on whether it is counted based on the patient residential area or the area of occurrence. On the other hand, the DOH Regional Office reported that, since 2015, the number of deaths has been registered based on the patient residential area and the data of the private health institutions have been included in the Field Health Service Information System (FHSIS) to enhance credibility. However, as a result, it has become difficult to compare the data before and after 2015. In Bicol region, maternal and newborn death review was introduced in 2015 as requested by the central government.

[148] Philippines Statistics Authority 2016

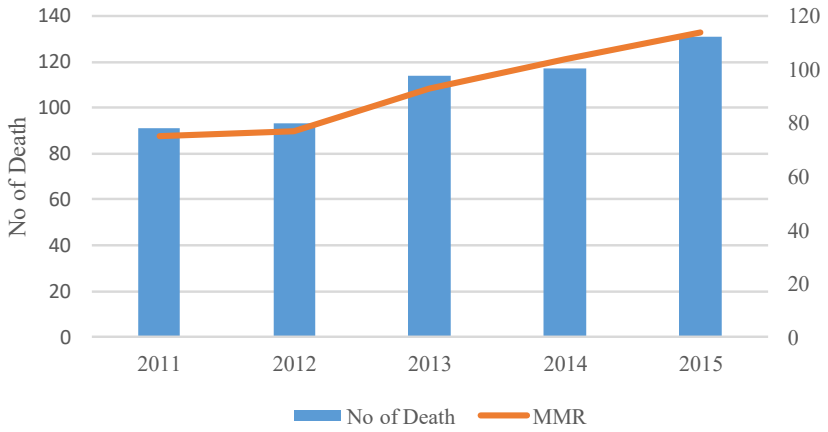

Figure 5- 1 Trend of maternal deaths and MMR in Bicol

Source: FHSIS from DOH Bicol Regional Office

Most of maternal deaths have occurred at Level 3 hospitals or on the way to hospitals in the Philippines. Table 5- 2 shows the number of deaths at two regional hospitals in Bicol. It has slightly improved in 2016.

Table 5- 2 Number of maternal deaths at tertiary hospitals

	2013	2014	2015	2016
Bicol Regional Training and Teaching Hospital (BRTTH)	34	47	35	16 (Aug)
Bicol Medical Center (BMC)	38	36	38	5 (June)

Source: BRTTH and BMC

Facility-based delivery (FBD) has been increasing in all areas as shown in Table 5- 3. On the other hand, the rate of antenatal care (ANC) visits has been around 50 percent in the region and no major change has been seen over the last few years.

Table 5- 3 Proportion of FBD (%) by province/city

Province/City	2011	2012	2013	2014	2015
Albay	67.7	76.5	90.1	87.7	93
Cumarines Norte	41	38.2	68.5	81.7	86
Cumarines Sur	19.9	38.7	37.2	58.6	63.7
Catanduanes	79.1	85.7	88.6	90.3	90.4
Masbate	30.5	39	42.6	75.4	83
Sorsogon	85.9	91.9	93.8	94.8	96.1
Iriga city	13	34.5	7.8	13.5	89.6
Legaspi city	44.9	100	33.1	95.4	98.2
Naga city	42.1	44.8	71.2	83	88.2
Region	46.5	57.2	61.9	78.9	86.2

Source: FHSIS from DOH Bicol Regional Office

The infant mortality rate (IMR) in Bicol is shown in Table 5- 4. While it has been static over the last five years, it is lower than the national average.

Table 5- 4 IMR by province/city

Province/City	2011	2012	2013	2014	2015
Albay	8.1	8.4	5.6	4.5	4.2
Cumarines Norte	15.3	14	13.2	9.6	9.9
Cumarines Sur	11.8	8	4.9	5.3	4.4
Catanduanes	8.6	7.4	8.9	18.7	7.9
Masbate	7.3	0	18.1	20.5	11
Sorsogon	6.2	9.1	7.3	6.9	5.1
Iriga city	12.8	5.2	9	19.3	14.4
Legaspi city	10.6	8	2.4	14.2	5.6
Naga city	12.8	15.9	10.9	35	20.8
Region	9.7	8.8	8.5	10.5	7.1

Source: FHSIS from DOH Bicol Regional Office

③ Health Governance

The DOH Bicol Regional Office is composed of the Local Health Support Division (LHSD), Licensing, Regulation and Procurement Division and Management Support Division. LHSD is in charge of technical projects and the Family Health Cluster under LHSD is responsible for MCH. The LHSD total budget in 2016 is 194 million pesos and the budget of the Family Health Cluster in 2016 is 26 million pesos. Provinces develop a three-year Local Investment Plan for Health (LIPH) and receive their budget from the DOH regional office based on the approved plan.

The number of hospitals registered in the region is shown in Table 5- 5. Several hospitals have been downgraded to infirmaries in 2015 through the new DOH hospital criteria. While private hospitals are mainly located in the urban areas, private lying-in clinics exist in most of the municipalities.

Table 5- 5 Registered number of public and private hospitals (2015-2016)

Type	Public	Private
Level 3 hospital	2 (DOH)	1
Level 2 hospital	4 (LGU)	12
Level 1 hospital	16 (LGU)	15

Source: DOH Bicol Regional Office

(2) Overview of Study Sites

The study was conducted in two provinces – Albay and Camarines Sur (CS) out of the six provinces in Bicol.

[Albay]

Albay province is the center of Bicol region and the Provincial Health Office and the PhilHealth Regional Office exist. The provincial health budget was 220 million pesos in 2016. In principle, 20 percent of the provincial budget should be allocated to the health sector, however, the proportion is lower than that now. There is also the fund based on the three-year LIPH.

Regarding public health facilities, the Bicol Regional Training and Teaching Hospital (BRTTH), Level 3 hospital, is in Legaspi City, and there are four Level 1 hospitals as of 2015. FBD rate and the proportion of women receiving more than 4-time ANC are higher than the national average.

[Cumarines Sur]

Cumarines Sur (CS) is located in the center of Bicol region and it has the largest land area and population in the region. The provincial health budget was 20 million pesos in 2016. There is also transferred budget from DOH, but it is usually insufficient. It was also reported that size of the staff is also insuffient in order to execute all the health programs.

Another Level 3 hospital in the region, the Bicol Medical Center (BMC), is located in Naga City and there are three Level 1 hospitals, including the Naga City Hospital, in CS. Currently, a provincial hospital is being constructed. In Naga City, outside the provincial governance, there is the Naga City Hospital and an infirmary. In CS, FBD rate is lower than other provinces.

(3) Study Findings

[Study sites]

The study sites in Albay and CS provinces are shown in Table 5- 6. The visits/interviews were conducted with LGU health offices, RHU, BHS, public and private health facilities, PhilHealth offices and community members.

Table 5- 6 Study Sites and Community Interviewees

Province	City/Municipality	Barangay	Interviewees	No
Albay	Malinao	Balading, Burabad	Pregnant and lactating women	39
Camarines Sur (CS)	Naga City (Independence city)	Panicuason, San Isidro	Husbands	3
	Pamplona	Batang, Poblacion	Women with grand children	3
	Sipocot	Binahian	TBA	1

Source: JICA Survey Team

[Supply Side]

1) Service Delivery

While all the RHUs were supposed to be equipped with a delivery facility, the study team observed that some of them did not have a delivery facility due to the lack of human resources or insufficient infrastructure. It is desirable for RHUs to have a delivery facility particularly in remote areas where no public hospitals or private lying-ins are available. The cost of MCH services at visited RHUs is free based on municipal policy, which could be user-friendly for community members, but it could also burden health facilities unless enough resources are provided by the municipal government.

Some of the district or municipal hospitals, which were downgraded to infirmaries in 2015, explained that the high-risk cases are now immediately referred to the regional hospital as they can no longer take care of high-risk cases under the current mandate. There are two Regional hospitals in Bicol that are located in Albay and CS provinces. Most caesarean sections and/or high risk cases in the Region are referred to the two hospitals. In addition, many women prefer the well-equipped Regional hospital even for normal delivery; caesarean section accounts for approximately 30 percent of total deliveries at the regional hospitals. Consequently, those two Regional hospitals are always highly overcrowded and it could at times effect the implementation of emergency operations, their original mandate. It was observed that two to three women and their babies were sleeping in one bed. The regional hospital is considering establishing a BEmONC for normal delivery within the compound of the hospital, so that the Regional hospital as CEmONC could focus on high-risk cases as mandated.

2) Referral and SDN

Figure 5- 2 Rural Health Unit in Camarines Sur

The DOH regional office has been strengthening/reactivating the delivery networking system in the Region with the assistance of LuzonHealth. In Albay, the province was divided into three zones and Inter-local Health Zone (ILHZ) and Service Delivery Network (SDN) have been established in each zone. ILHZ is led by municipalities and its purpose is to coordinate public health issues among

concerned municipalities. In terms of SDN, the province issued the ordinance of the MCH SDN and it included the public as well as private health facilities. Collaboration with private facilities was obtained by providing them with free training and information. Regular meetings are held separately for ILHZ and SDN.

In CS, there was one functioning ILHZ, called CASILI, with the three municipalities of Cabusao, Sipocot and Libmanan. It started activities in 2005 when three municipalities issued a joint ordinance on the MCH ILHZ. This joint ordinance enabled ILHZ to continue functioning for the last 10 years even with a change of mayors as the joint ordinance could not be invalidated unless all mayors agree. They hold a joint trust fund with approximately 500,000 pesos of annual budget and developed a three-year plan for the fund. Activities include joint procurement of drugs from the Regional stock yard, bulk printing of reporting formats/booklets, death review, and discussions on common issues. Private facilities were also involved in ILHZ and vaccines were provided free of charge by the municipality health offices. ILHZ reactivation in the other areas was planned; however, the issuance of joint ordinance with multiple municipalities appeared to be challenging.

BOX 5- 1 Story of RHU Medical Doctor outside CASILI Zone

When an ambulance referring a pregnant woman to BMC passed by our RHU, I received a call from them. I immediately went to the ambulance and gave the woman oxygen, but I could not save her. There was only her husband and no medical staff attended her in the ambulance. I wished I had received a call earlier, so that I could have collaborated with other medical staff and provided her with better service. However, unfortunately, one can only receive medical services from the RHU in the residential area.

There is also a plan led by the DOH regional office to establish an inter-facility referral system in CS. Based on the successful experience in Albay, a meeting is going to be held with various stakeholders including public and private health facilities – both hospitals and non-hospitals – to discuss the issues, such as the development of referral policies/guidelines and the standardization of the referral format.

3) Maternal Death Review

Figure 5- 3 BRTTH

The majority of maternal deaths reportedly occur at referral hospitals or on the way to the hospitals. A death confirmed within 72 hours from arrival is registered as non-institutional and such cases account for around half of the deaths at the Regional hospitals in Bicol. The two Regional hospitals attempt to strengthen death review activities that lead to concrete actions to reduce the number of maternal deaths.

Bicol Regional Training and Teaching Hospital (BRTTH) receives referral cases within and outside the province including Catanduanes and Sorsogon. It accounts for the highest number of deaths in the region. The hospital strengthened its efforts on maternal death review in 2015.

BOX 5- 2 BRTTH leadership (Story of DOH Regional Officer)

The maternal death review has been given strong leadership from the hospital chief. The comprehensive and in-depth review of all deaths, namely route cause analysis, identification of three delays, referral condition, direct death cause audit and so on was conducted at an internal conference in 2015. Concrete recommendations and action plans have been developed as a result. BRTTH also sought to improve collaboration with other health facilities through participation in SDN/ILHZ meetings, provincial death review or other opportunities and advocacy for promotion of effective referral policies/guidelines.

4) NHIP Implementation and Utilization

The number of NHIP accredited health facilities has been increasing annually in Bicol. As of August 2016, there were 292 NHIP-accredited health facilities, 187 of which were primary health facilities and 105 were hospitals, and 186 NHIP-MCP accredited health facilities, 99 of which are public facilities and 87 are private facilities. The PhilHealth office conducts regular monitoring including surprise visits to the health facilities to ensure adherence to various policies including the No Balance Billing (NBB) Policy. The office also visits municipalities once a year and conducts awareness-raising campaigns for communities.

Figure 5- 4 PhilHealth Bicol regional office

Two regional hospitals follow the NBB Policy and Point of Care (POC) program. However, as described below, there were some cases in which indigent people could not utilize POC at the public hospitals. PhilHealth-accredited private facilities are also supposed to follow the NBB and the POC Policies. The adherence rate has been increasing due to PhilHealth regular monitoring. Full implementation by private facilities is PhilHealth's current challenge.

The online system has been gradually operationalized in Bicol. The improvement/correction of the database is required for smooth and full scale operation. Also, it is ideal to make online payment claims possible as it is currently only accepted in the PhilHealth provincial office. The disbursement of NHIP benefits for LGU-owned hospitals is made to LGU bank accounts and some LGUs do not allocate facility fees properly to the appropriate health facilities.

According to the PhilHealth Bicol Regional office, currently there are more benefit claims than collected premiums in Bicol. Loss has been offset by other regions; however, there was a concern that the premium amount would have to be reviewed soon if utilization keeps increasing. The current challenges include full implementation of NBB Policy for both public and private facilities, behavioral changes of the community in remote areas and an increase in the number of PhilHealth officers in provincial and regional offices.

Overall, NHIP introduction is seen to have contributed to the improvement of public health services in the Region (see BOX 5- 3).

BOX 5- 3 Story of Provincial Health Officer

Public hospitals used to lack medical specialists, such as obstetricians or anesthetists, due to a deficiency in the market. Now that the NHIP professional fees are available, specialists go under contract with multiple public hospitals and receive payment per service. The experienced doctors have improved the quantity and quality of services at the public hospitals in Bicol. The regional hospitals are also making efforts to provide incentives for the retention of experienced doctors, by providing them with private rooms where patients receive exclusive care with extra professional fees.

5) NHIP Awareness

Awareness of NBB Policy and the POC program varies from facility to facility. In general, the knowledge level of NHIP is found to be sufficient among LGU and regional hospital personnel and adherence to NHIP policies was established in the regional hospitals.

On the other hand, the knowledge level among barangay personnel, including BHWs, seems to be limited. The NHIP Indigent Member list was produced by the DSWD and PhilHealth distributed Member Data Record (MDR) based on the list to the members via RHUs. The personnel at visited barangays mentioned that while they were aware of the NHTS-PR assessment mission to have visited their community for the purpose of producing the NHIP Indigent Member list, they did not receive feedback from the assessment team and did not know how the list was produced.

Figure 5- 5 Barangay Health Station in Camarines Sur

For the community members, information on NHIP was usually provided through the PhilHealth advocacy campaign held annually at all municipalities, monthly education sessions for 4P beneficiaries and household visits and health education by BHWs. Some of the BHWs, who were members of Community Health Team (CHT) or focal persons for NHIP, have opportunities to receive information from LGUs or PhilHealth. However, in general, there is limited opportunity for the BHWs. Therefore, community members, except for 4P beneficiaries, tend to have limited knowledge about NHIP.

6) LGU Financial Assistance

Most of LGUs, barangays, and RHUs own ambulances or public transportation, such as police or security vehicles, that can be used free of charge or with a nominal fuel fee for emergency cases, including delivery. Some barangays established emergency

transportation funds to hire registered private vehicles to be used for delivery for free. At the same time, interviews with pregnant and lactating women reveal that many are in fact paying for transportation to go to a health facility. Details will be described below. Provision of NHIP sponsorship by LGUs varies depending on the LGU's priority issues and budgetary situation.

LGUs informed TBAs of the prohibition on home delivery, and some of them are proactively involved in safe-motherhood efforts by providing incentives for bringing pregnant women to health facilities.

7) Effects of Devolution

The level of health service delivery depends on the capacity and leadership of the LGU. The LGU leader is elected every three years and this can make it challenging to maintain a high level of commitment and resources. The collaboration among health facilities managed by different LGUs is also not easy. Under these circumstances, the DOH Bicol Regional Office showed strong leadership to strengthen the Service Delivery Networking and coordination mechanism among concerned facilities and LGUs, and expanded good practices in different provinces. The DOH Reginal Office would play an important role under the devolution in improving the collaboration among various stakeholders and assisting resource-limited LGUs.

[Demand Side]

1) Health Service Utilization

There are still 15 percent home deliveries occurring in Bicol and it appears to be more prevalent in the remote areas. However, it has been decreasing rapidly mainly due to the issuance of the LGU ordinance on home delivery prohibition. Midwives/health care providers at BHSs/RHUs constantly advise pregnant women to deliver at a health facility. Family members also tend to suggest the same for the sake of safe delivery.

Figure 5- 6 Group discussion with pregnant and lactating women

The majority of women responded that they respected health care providers at BHS/RHU or hospitals and followed their advice for safe motherhood. Most of those who were diagnosed high risk

had additional laboratory tests at a private facility or were referred to the regional hospital.

On the other hand, several negative opinions were stated that the public health facilities were overcrowded, required long wait times, provided insufficient treatment/services, and the health care providers had disrespectful attitudes. Particularly the over-crowdedness of the regional hospitals was emphasized by women and BHS/RHU health workers. However, many of them took it for granted and they said that they do not have high expectations for the public health facilities. There were a few cases of home delivery that could have been avoided if addressed in better ways at the facility or health care providers, as described in BOX 5- 4.

BOX 5- 4 Home delivery cases

One case involved a woman who went to the hospital with her husband for delivery, but the midwife told them it was not time and sent them back home. As soon as they reached home, the woman's water broke and she went into labor. They immediately called a TBA and the woman delivered at home.

Another case was a teenage mother who went to a private lying-in facility but was advised to go to the hospital as a maternal age below 19 years old could not be accepted at a non-hospital to receive the NHIP benefits. She did not consult with anyone and did not go to the hospital, then ended up with a stillbirth delivery at home.

Better off families tend to pay extra fees, around 20,000 pesos, and use a paid room in the public hospital where they can have an exclusive doctor and nurse with better facility conditions. Private facilities are also cleaner and the health care providers have a better attitude compared to the public facilities. Therefore, many women prefer the private facilities despite additional fees for drugs or bed linens.

2) NHIP Enrollment and Utilization

NHIP Enrollment rate in the Bicol region is 89 percent as of June 2016. The detail is summarized in Table 5- 7. Utilization rate of MCP has been rapidly increasing in recent years (see Figure 5- 7).

Table 5- 7 NHIP coverage by sector and by province in Bicol as of June 2016

	Formal economy	Informal sector	Indigent	Sponsored	Migrant worker	Lifetime	Senior citizen	Coverage rate
Albay	273,987	42,941	671,515	28,795	13,438	26,110	96,068	87%
Camarines Norte	88,589	38,390	329,253	9,573	7,037	10,844	43,136	89%
Camarines Sur	329,270	73,356	1,087,065	15,161	21,081	28,805	83,202	83%
Catanduanes	44,502	6,939	176,247	1,620	2,070	6,524	13,831	95%
Masbate	91,445	10,327	707,892	15,552	1,920	7,660	23,333	95%
Sorsogon	125,518	24,711	619,876	2,439	5,822	11,065	34,748	113%
Region	953,311	196,664	3,591,848	73,140	51,368	91,008	294,318	89%

Source: PhilHealth regional office V

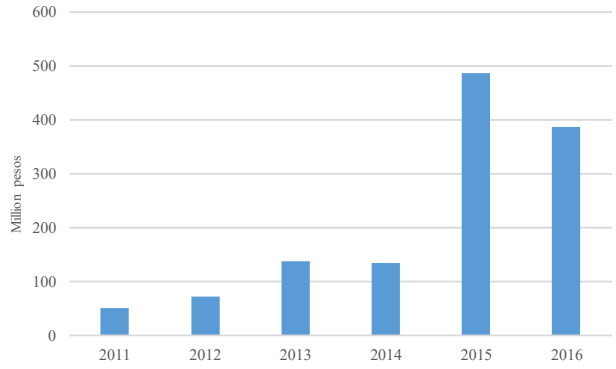

Figure 5- 7 MCP utilization amount in Bicol (up to June in 2016)

Source: PhilHealth regional office V

Among the interviewed women, all of them were NHIP members and had utilized MCP benefits. They unanimously stated that this was extremely helpful. It was reported that around 75 to 90 percent of households were indigents in the visited barangays. In the ANC session, they were advised to save money as part of a birthing plan, but most of them did not have enough income for saving. Many of them previously used to borrow money from relatives or friends for delivery costs. However, thanks to NHIP benefits, they said that they do not have to borrow money or reduce expenses on food or other essential items anymore.

Figure 5- 8 Barangay houses in Camarines Sur

However, not all indigents are covered by the NHIP and availability of LGU sponsorship varies as stated earlier. The coverage of indigents by NHIP was reportedly around 30-50 percent in the visited barangays.

In terms of the knowledge among communities, the majority of women knew about free MCH services by NHIP benefits at PhilHealth accredited facilities. However, the information, requirements and conditions for the NBB and POC Policies were unknown to most of them. Regional hospitals reported that many referred women who were indigents could not receive POC as they could not submit the required documents of birth and marriage certificate on time. Community members, except for 4P beneficiaries, did not seem to have enough opportunities to receive NHIP-related information.

3) Barriers to health services

Meanwhile, there were many women among the interviewees who would still prefer home delivery if there were no ordinance. Barriers or challenges inhibiting their access to health facility services mentioned during the interviews are described below.

<Economic Factors>

- **Medical Fee**: In principle, the MCH-related medical fees are covered by NHIP for its members at the PhilHealth accredited facilities. However, there were many cases that out-of-pocket payment was required for some purposes, such as (1) drugs as the facilities often run out of stock and patients need to purchase outside the facility, (2) gloves or baby's diapers, and (3) new-born screening. The amount of payment ranges from 200 to 3,000 pesos at public and private facilities. The laboratory test, such as ultrasound for high-risk cases, is usually not available at BHSs/RHUs and it costs a woman 750-1,000 pesos at a private health center.

  For those without NHIP, the public hospitals usually charge 2,000 to 5,000 pesos for a normal delivery. Even without NHIP, indigents are supposed to be covered by POC. However, in fact, some of the indigents report that they had made payments at a public hospital. There are also cases, as described earlier, that POC cannot be utilized due to the failure of document submission within the defined period.

- **Transportation**: As previously mentioned, most hospitals or LGU health offices provided public transportation for free or with nominal fees for delivery. The transportation fees were claimed to be big burden. However, interviews revealed that more than half of the women had paid for transportation. Those who lived in the center of a city or municipality 10-20 minutes from a health facility paid 200 – 300 pesos round trip, and those who lived in remote areas 1 – 1.5 hours from a health facility required 1,000 pesos to reach a district hospital by boat and vehicle, and 1,500 pesos to reach a regional hospital. It would take much more time and

cost for people living in very remote areas or outside two provinces, to reach a referral hospital.

- **Others**: In addition to the cost for accompanying family members for accommodation, food and transportation, some indigent women buy new clothes as they feel embarrassed to wear old clothes in front of other people. Additionally, payment is required for caretakers for their children or other family members while they are away from home.

<Sociocultural Factors>

The majority of women answered that they could make the decision on where to deliver on their own. Many pregnant women, who had previously delivered at home, stated that they were planning to give birth at a facility this time as home delivery had been prohibited. Their mothers, who predominantly delivered at home, also suggested to have a facility-based delivery for their safety.

On the other hand, a few women answered that they had followed the advice of their mother, husband or TBA for the first delivery. There was a case of a husband who decided on home delivery due to financial constraints and his wife had no say. The TBA charges 1,500 – 2,500 pesos, but payment on credit or installments is usually accepted. However, health facilities do not discharge the patient unless payment is complete.

Women who have experienced home delivery frequently mention that they never experienced complications or problems at home and never heard of maternal death in their communities.[149] Therefore, it seemed that they do not feel they face risk in delivery. They said that the home delivery was more convenient as they could do housework until the last minute and almost right after the delivery. Facility-based delivery requires time, money and preparation work. It was also mentioned that finding a caretaker for children is not easy. Several of them had home deliveries due to unavailability of caretakers.

BHSs/RHUs and hospitals regularly conduct pregnancy educational sessions and encourage women to come with their partners. However, it was reported that not many men actually participated in the session. In terms of family planning, the majority of interviewed women were using or had used some kind of contraceptive devices, despite

[149] Doctors, midwifes or nurses at BHSs/RGUs reported a few cases of maternal and neonatal deaths and still births in the community and inappropriate practices of TBA or birth attendants in the home deliveries.

the fact that all of them were Catholic. Some mentioned that they had received information on family planning at the church. Thus, it was inferred that the access to family planning was not a big challenge for most of women. However, it was still not rare to have a big family with more than 10 children.[150]

5-2 Eastern Visayas (Region VIII)

(1) Regional Profile

① Socioeconomic Profile

Eastern Visayas Region is located in the eastern part of the Visayan islands in central Philippines, composed of Samar, Leyte and Biliran islands. It has six provinces, one independent city (Ormoc city), 1 highly urbanized city (Tacloban city) and five component cities with 4.4 million population in 2015.[151] Tacloban is considered as a regional center for commerce, transport, culture and trade. Main industries of Eastern Visayas include farming (such as rice and coconuts), fishing, mining and tourism. Nevertheless, the region has the second highest poverty incidence among families in the country.[152] In November 2013, Typhoon Yolanda devastated the region. Table 5- 8 shows populations of provinces and a highly-urbanized city. The population of Leyte province except that of Tacloban City is the largest, followed by Samar province.[153]

Table 5- 8 Provincial populations in Eastern Visayas Region (in thousand)

	Population			Population Growth Rates
	2000	2010	2015	2010-2015
Biliran	140	162	172	1.13
Eastern Samar	376	429	467	1.64
Leyte	1,414	1,568	1,725	1.83
Northern Samar	501	589	632	1.36
Samar	641	733	780	1.19
Northern Leyte	360	399	422	1.05
Tacloban City	179	221	242	1.73
Region	3,611	4,101	4,440	1.52

Source: Philippine Statistics Authority

[150] The total fertility rate in Bicol Region was 4.6 on the basis of the NDHS 2013. cf. The national total fertility rate was 3.0 and that in Eastern Visayas was 4.0.
[151] Philippines Statistics Authority, 2016.
[152] The poverty incidence among families in Eastern Visayas is 37.4% in 2012 according to the Philippines Statistics Authority.
[153] Samar province is also called Western Samar province.

② Maternal and Child Health (MCH) Status

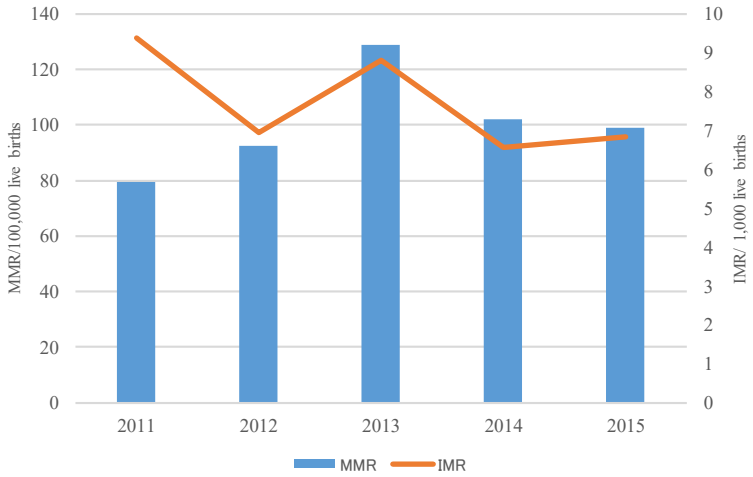

Figure 5- 9 MMR and IMR of Eastern Visayas

Source: DOH Eastern Visayas

Although MMR and IMR of Eastern Visayas Region declined after 2013, not much improvement has been observed in the past five years (see Figure 5- 9). With regard to FBD rates, all provinces have experienced significant improvements (see Table 5- 9).

Table 5- 9 Provincial FBD Rates in Eastern Visayas

Province	2011	2012	2013	2014	2015
Biliran	95.7	95.93	99.1	97.45	97.2
Eastern Samar	64.5	74.5	82.9	88.26	91.92
Northern Leyte	7.8	80.21	87.19	90.7	92.99
Nothern Samar	29.36	41.94	52.93	64.3	77.8
Southern Leyte	78.56	64.87	74.68	97.08	98.55
Samar	34.33	30.84	57.82	72.49	81.56
Calbayog City	26.32	34.37	38.4	47.01	66.94
Massin City	84.8	90.56	96.85	99.17	98.02
Ormoc City	75.15	86.43	91.17	90.88	96.87
Tacloban City	86.72	89.6	86.62	85.51	94.64
Region-wide	**62.21**	**66.25**	**75.81**	**83.08**	**89.05**

Source: DOH Eastern Visayas

On the other hand, the FHSIS data for maternal deaths and infant deaths collected by the DOH are calculated based on the location of the occurrence of death instead of the residential location of the deceased. For instance, MMR in Tacloban city (359.42 per 100,000 live births) and Ormoc city (185.19 per 100,000 live births) are higher due to the

presence of high level hospitals[154] while in Leyte province excluding those cities has a low MMR (41.51 per 100,000 live births). Such calculations make it difficult to have a grasp of the situation of maternal deaths in different areas.[155]

Health facilities registered at the DOH Regional Office in Eastern Visayas are listed in Table 5- 10. It shows that 44 percent of them are located in Leyte province where Tacloban city is. In addition, Level 3 hospitals are limited to one government hospital (EVRMC: Eastern Visayas Regional Medical Center) and one private hospital in the entire Region.

Table 5- 10 Registered Health Facilities in Provinces of Eastern Visayas (As of August 2, 2016)[156]

Province	Government or Private	Hospital			Infirmary	Birthing Home	Other
		Level 1	Level 2	Level 3			
Biliran	Government	1	0	0	0	11	0
	Private	0	0	0	0	0	6
Leyte	Government	10	0	1	7	33	10
	Private	3	5	1	4	16	66
Eastern Samar	Government	1	1	0	9	9	1
	Private	6	0	0	0	3	12
Northern Samar	Government	2	0	0	6	15	5
	Private	1	0	0	2	1	10
Samar	Government	4	0	0	2	21	2
	Private	2	1	0	1	3	12
Southern Leyte	Government	2	1	0	4	16	3
	Private	4	0	0	3	0	15

Source: DOH Eastern Visayas

In addition to the fact that there is only one government Level 3 hospital, due to the improved referral system and resultant increased facility-based deliveries in recent years, the numbers of deliveries and maternal deaths are increasing at the EVRMC as shown in Table 5- 11. According to the obstetrics and gynecology (OBGYN) doctors, normal deliveries at the EVRMC have decreased because more BEmONC facilities were established, but the number of referred cases with complications has gone up.

[154] Other data are as follows: Eastern Samar 103.26, Northern Samar 99.29, Biliran 98.72, Samar 60.73, and Southern Leyte 18.44.

[155] In addition, in Leyte province, the deaths of residents were counted between 2010 and 2014 while the location of occurrence was considered in 2015, which makes it impossible to analyze changes over time.

[156] Leyte province here includes Tacloban city and Ormoc city. The category of "other" includes clinical labs, dental labs, drug testing labs and x-ray.

Table 5- 11 Deliveries and Maternal Deaths at EVRMC

	2013	2014	2015
Total No of deliveries	4,498	5,152	5,426
(No of live births)	4,346	4,992	5,254
(No of stillbirths)	152	160	172
No of maternal deaths	18	20	23
No of OB referral cases	1,546	1,650	2,415

Source: EVRMC

③ Health Governance

Under the leadership of the Regional Director, the DOH Regional Office of Eastern Visayas is composed of the Local Health Support Division, the Health Standards Regulation Division and the Management Support Division. Maternal and child health is handled by the Family Health Unit under the Local Health Support Division.[157]

The role of the Regional Office includes (1) implementation of policies developed by central DOH, (2) technical assistance and monitoring and evaluation of programs and facilities under LGUs (provincial and municipal/city levels), (3) provision of vaccinations, contraceptives and medicines, and (4) compilation of FHSIS data. Moreover, each province submits its three-year Local Investment Plan for Health through the Regional Office and is given budget support of approximately 1.6 million pesos of Fixed Tranche and 0.7 million pesos of Variable Tranche[158] each year.[159]

Based on the devolution of power in the Philippines, health governance of provincial and municipal/city levels is under the jurisdiction of the respective LGUs. Nevertheless, by deploying several Development Management Officers (DMOs) who have coordination, technical assistance and data collection responsibilities to each province, the Regional Office has a direct management mechanism at the LGU level.[160] The office also deploys

[157] The Local Health Support Division is composed of the Health Systems Development Section which manages the Health Systems Development Unit, the Hospital Systems and Other Support System Unit and the Health Facility Development Unit and the Local Health Technical Assistance and Program Management Section which manages the Family Health Unit, the Communicable Disease Unit, the Non-Communicable Disease and Health Promotion Unit and the Environmental and Occupational Unit.

[158] Variable Tranche is determined by the performance of the previous fiscal year according to the LGU Scorecards.

[159] Some of the support for the LIPH includes activities by ILHZ, trainings and procurement of medicines.

[160] In Northern Samar, there are 8 DMOs, 283 NDPs and 64 RHMPPs. In Eastern Samar, there are 6 DMOs, 219 NDPs and 55 RHMPPs.

nurses and midwives to RHUs through the Nurse Deployment Program and the Rural Health Midwives Placement Program (RHMPP) for human resource strengthening.

The DOH Regional Office of Eastern Visayas has recently set regional strategies under the Strategic and Operational Plan (2017-2021). The Plan identifies five strategic goals: (1) development, enhancement and maintenance of health systems and health financing, (2) quality standardization of health facilities including PhilHealth accreditation, (3) development and enhancement of health human resources, (4) health information strengthening, and (5) building the Service Delivery Network.[161]

(2) Field Study

Among six provinces in Eastern Visayas region, the Survey conducted field studies in Eastern Samar and Northern Samar.

[Northern Samar]

More than half of the 24 municipalities and 569 barangays in Northern Samar province are identified as GIDA areas. The Northern Samar Provincial Hospital in Catarman city, registered as a Level 1 hospital, is the end referral within the province.[162] There are six district hospitals, five private hospitals, 24 RHUs and 108 BHS. As indicated in Table 5-12, MMR and FBD rates have improved. However, it has the second highest MMR (after Eastern Samar)[163] and the lowest FBD in the region. Table 5- 13 shows facility based delivery rates in each municipality. Although the issue of data quality still remains, there is disparity between municipalities where facility-based delivery rate has been high and those facility-based delivery rate remains low even in 2015.

Table 5- 12 Maternal and Child Health Indicators in Northern Samar

	2011	2012	2013	2014	2015
MMR	135	304	172	181	99
IMR	18.3	9.3	9.73	5.1	3.3
FBD (%)	31.26	41.9	52.6	65	77
ANC (%)	86	67.79	72.42	82.95	62
PNC (%)	77	58	62	71.34	65

Source: Northern Samar Provincial Health Office

[161] The Plan will be finalized by the end of 2016.

[162] The Provincial Hospital used to be Level 2 but it was downgraded to Level 1 after the DOH's revision of hospital standards. It is currently under construction for expansion and plans an upgrade to Level 2 during 2016.

[163] The analysis is made across provinces and excludes Calbayog City, Maasin City, Ormoc City and Tacloban City.

Table 5- 13 Facility Based Delivery in Municipalities of Northern Samar Province (2012 - June 2016)

Municipality	2012	2013	2014	2015	June/2016
Allen	68	92	93	99	99
Biri	80	86	45	87	94
Bobon	30	38	63	64	80
Capul	3	38	100	98	95
Catarman	40	N/A	44	82	91
Catubig	53	76	76	86	89
Gamay	42	59	85	91	93
Laoang	37	52	76	91	87
Lapinig	50	70	63	97	98
Lasnavas	36	16	25	42	45
Lavezares	91	96	97	98	100
Lope de Vega	8	9	21	35	42
Mapanas	55	53	58	74	88
Mondragon	22	38	51	71	76
Palapag	65	70	84	93	93
Pambujan	24	32	36	34	46
Rosario	62	69	64	75	76
San Antonio	76	93	87	88	59
San Isidro	44	N/A	90	74	0
San Jose	35	43	95	95	87
San Roque	47	63	77	88	88
San Vicente	81	100	94	100	100
Silvino	2	N/A	57	29	39
Victoria	5	16	32	36	95
Province	**42**	**59**	**65**	**77**	**80**

Source: Northern Samar Health Office

[Eastern Samar]

Out of one city, 22 municipalities and 597 barangays in Eastern Samar, four municipalities and 145 barangays are identified as GIDA areas. The Eastern Samar Provincial Hospital in Borongan city is registered as a Level 2 hospital, which is the end referral as well as the only CEmONC facility in the province.[164] There are nine hospitals registered as infirmaries and 25 RHUs (out of which nine are registered as birthing homes). According to the maternal and child health indicators in Table 5- 14, while FBD has improved in the recent years, MMR reversed in 2015 to be the lowest in the Region.[165]

[164] The Felipe Abrigo Memorial Hospital in Guiuan (southern part of the province) was a CEmONC facility until recently; however, it became a BEmONC facility after the OBGYN Specialist (who was also the Hospital Chief) passed away in 2016.

[165] The analysis is made across provinces and excludes Calbayog City, Maasin City, Ormoc City and Tacloban City.

Table 5- 14 Maternal and Child Health Indicators in Eastern Samar

	2011	2012	2013	2014	2015
MMR	183	141	93	92	103
IMR	11.3	8.56	11.05	7.8	2.63
FBD (%)	66	74	85	88	91
ANC (%)	65	63	82	82	77
PNC (%)	69	67	75	75	69

Source: Eastern Samar Provincial Health Office

Table 5- 15 shows facility based delivery rate in each municipality of Eastern Samar province. Facility-based delivery rates are steadily increasing with exception of Jipapad where nearly half of women deliver a child at home.

Table 5- 15 Facility Based Delivery Rate in each municipality of Eastern Samar Province (2012 – June 2016)

Municipality	2012	2013	2014	2015	June 2016
Arteche	43	56	84	90	91
Balangiga	78	92	95	95	98
Balangkayaan	57	86	97	95	98
Borongan I	90	79	97	95	98
Borongan II	64	79	83	82	82
Can-avid	70	76	79	84	90
Dolores	62	72	77	83	89
Gen. MacArthur	84	86	90	91	89
Giporlos	82	83	85	92	97
Guiuan I	96	98	98	97	97
Guiuan II	37	97	94	96	99
Hernani	93	96	97	95	98
Jipapad	35	33	43	53	52
Lawaan	91	99	99	98	100
Llorente	73	71	75	80	89
Maslog	71	80	71	76	97
Maydolong	89	94	93	97	96
Mercedes	99	100	98	98	100
Oras	62	71	80	90	86
Quinapondan	76	83	75	97	99
Salcedo	84	93	99	98	92
San Julian	91	88	86	89	99
San Policarpo	88	96	99	97	94
Sulat	99	99	100	100	100
Taft	94	93	97	100	100
Province	**74**	**85**	**88**	**91**	**93**

Source: Eastern Samar Provincial Health Office

(3) Study Findings

[Study sites]

In the field study in Northern Samar and Eastern Samar provinces, interviews were conducted with health officers, RHU and BHS staff, Barangay Captains, provincial and

municipal hospitals, a private hospital and birthing clinic, PhilHealth provincial offices and a DSWD office as shown below.[166] In addition, individual and group interviews were conducted with pregnant and lactating women, their family members and TBAs (see Table 5- 16).

Table 5- 16 Study Sites and Community Interviewees

Province	City and Municipality	Barangay	Interviewees	No
Northern Samar	Catarman City	Barangay Polangi	Pregnant and lactating women	17
	San Roque Municipality	Barangay Balnasan		
Eastern Samar	Borongan City	Barangay Balacdas	Husbands	5
	Llorente Municipality	Poblacion and Barangay Naubay	Women with grandchildren	6
	Can-avid Municipality	Barangay Carolina	TBAs	3

Source: JICA Survey Team

[Supply Side]

1) Service Delivery

According to interviewed healthcare providers, a majority of deliveries are now taking place in facilities and fewer people are practicing home delivery. Some of the facilitating factors they pointed out include the improvement of facility services, referral and the adoption of LGU ordinances prohibiting home deliveries, and providing incentives to mothers who deliver at facilities and BHWs who facilitate the mothers.

On the other hand, the number of hospitals (excluding Infirmary level) in each province remains low: two in Northern Samar and one in Eastern Samar.[167] Although there is only one government-owned CEmONC facility in the province, the provincial hospital is under-capacity to respond to increasing needs.[168] As the end referral hospital is either Level 1 in Northern Samar or Level 2 in Eastern Samar that does not have a blood bank, referred pregnant women died due to the absence of an immediate blood transfusion. Furthermore, more deaths tend to occur in areas with limited access to the provincial hospitals. In Eastern Samar, most of the maternal deaths occur in five LGUs (one city and four municipalities) in the northern part, far from the CEmONC facility.[169] It is

[166] In Leyte province, the Survey Team interviewed regional actors including the DOH Regional Office, the PhilHealth Regional Office and the DSWD Regional Office.

[167] Namely, they are the Provincial Hospital and Allen District Hospital in Northern Samar and the Provincial Hospital in Eastern Samar.

[168] Bed occupancy at the Northern Samar Provincial Hospital (including OB Department) is 140-160 percent on average and 103 percent at the Eastern Samar Provincial Hospital (as of 2015).

[169] Namely, Canavid, Dolores, Borongan, Oras and Artetche are considered “hot spots” where more maternal deaths occur according to the Provincial Health Office (it is high in Borongan city due to the presence of the provincial hospital). On the other hand, in the southern part of the province, due to the

illustrated by the fact that many maternal and neonatal deaths occur while they are transferred from the residential areas to the facility.[170]

Figure 5- 10 RHU staff of Can-avid municipality in Eastern Samar

With regard to RHUs, most of them function as BEmONC facilities and are MCP-accredited by PhilHealth. Some of the RHUs covering GIDA barangays have maternity waiting homes. Because BHSs are not established in each and every barangay and the majority are not BEmONC-capable, RHU serves as the most accessible facility for many pregnant women. Nevertheless, these RHUs are faced with various human resource issues such as the lack of doctors[171] and many midwives not equipped with BEmONC skills.[172] Furthermore, while the DOH defines the rate of ANC as more than four visits, some of the health officers pointed to the tendency to only focus on the quantity (the number of visits) and not the quality. In particular, without sufficient equipment (especially ultrasound) at RHUs, appropriate laboratory tests are not conducted for pregnant women for early detection of risks, resulting in deaths during or after delivery despite more than four ANC visits, as revealed by Maternal and Newborn Death Review (MNDR).

Public health facilities also include district hospitals and municipal hospitals. However, except for one hospital in Northern Samar, they are all at the Infirmary level.[173] Hence, these hospitals provide almost the same maternal and child health services as RHUs. Therefore, for example, they are not able to assist deliveries of women 18 years old and

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presence of the government hospital in Guiuan being CEmONC until recently, there was less of an access issue.

[170] Out of the nine deaths reviewed by Maternal Death Review in 2015, four occurred at hospitals, four while in transit and one at home.

[171] Although one doctor is assigned to work in each RHU, they are often away due to conferences, etc.

[172] For example, 64 percent of midwives in Northern Samar have not received BEmONC training and at least one midwife in each RHU is trained in Eastern Samar. On the other hand, it was clarified that the midwives who are not trained in BEmONC skills had training in Life Saving Skills, which was implemented prior to the introduction of BEmONC. The main reason so many midwives are not trained in BEmONC is a lack of trainers: there are only four trainers at EVRMC and they are unable to respond to all the training needs, according to LGU health officers (they said they have sufficient budget to organize the training).

[173] The only government hospital registered as Hospital Level in the two provinces is Allen District Hospital. Other district hospitals, municipal hospitals and community hospitals (6 hospitals in Northern Samar and 9 hospitals in Eastern Samar) are all registered as Infirmary Level.

below and older than 35 years old (for the first pregnancy). According to the healthcare providers interviewed, some of the Infirmary level hospitals are better equipped with personnel, medicines and equipment than RHUs, and therefore RHUs can refer their cases. Nevertheless, some areas are in need of rationalization of the hospitals such as by upgrading them to Level 1 hospitals given the overlap with nearby RHUs or converting them to specialized facilities.

Figure 5- 11 Interview with Mayor of San Roque, Northern Samar

Although Supportive Supervision (SSV) is considered key to improving the quality of BEmONC services, it lacks systematic implementation in the provinces. Provincial officers conduct regular visits to RHUs in Northern Samar but without standardized tools, such as checklists. In Eastern Samar, SSV is only conducted when there are issues with particular facilities. Moreover, follow-up assessments of BEmONC trainings occur only once after six months by EVRMC trainers' visits. This suggests a lack of regular mentoring and coaching, which is an important element to ensure the retention of healthcare providers' knowledge and skills as well as their motivation.

Figure 5- 12 BHS destroyed by Typhoon Ruby

At the barangay level, midwives mobilize BHWs and implement ANC, PNC and health education regularly. While most of the BHS do not handle deliveries, based on the interviews with pregnant and lactating women, many of them access BHS for ANC and PNC. In fact, since TBAs do not conduct ANC and PNC in most cases, even those who had home deliveries said they visited BHS or RHU for check-ups.

Challenges faced by BHSs include midwives being overburdened with various tasks at the community level and some of the BHSs not being rehabilitated after Typhoon Ruby hit both provinces in 2014. On the other hand, it was pointed out that the southern part

of Eastern Samar heavily hit by Typhoon Yolanda in 2013 received a large amount of assistance from donors to rehabilitate its health facilities, which contributed to more improvements than pre-Yolanda while unaffected areas were left under-developed.

2) Referral and SDN

In Eastern Samar and Northern Samar, many ILHZ are deemed functional by the local health authorities,[174] and Common Health Trust Fund (CHTF) are established in some of the zones. As part of the process to strengthen ILHZ, the awareness of health systems increased among local chief executives, particularly Mayors,[175] and resources, such as staff, ambulances and funds were shared in an efficient manner among LGUs. This contributed to the strengthening of the referral system. ILHZ also implements MNDR.[176] Nevertheless, some issues were raised pertaining to management: a gap in LGU's contributions to CHTF depending on the commitment,[177] a change in LGU's level of commitment after the turnover of local chief executives, and a slow procurement process because CHTF is managed by the provincial government.

Together with ILHZ, each province is currently in the process of establishing the SDN.[178] While ILHZ aims to strengthen a referral system among public facilities particularly by linking city and municipal governments, SDN is sought under the leadership of the provincial health office with objectives to not only strengthen a referral system, including private facilities, but also identifying and creating a manual on the services available at each facility (including the contents of services, information about healthcare providers and service schedules) and connecting the available services with the health needs of poor households. The LGU health officers and healthcare providers interviewed confirmed that some progress has been made in the mapping of health facilities and healthcare providers and the profiling of poor households in accordance with the DOH manual. With regard to the household profiling, CHT/BHWs collect relevant information of pregnant women, newborns, adolescents, elderly, etc. from each household using DSWD's indigent household list. However, many mentioned that they

[174] There are six ILHZ in Northern Samar and five in Eastern Samar.
[175] In the process of strengthening ILHZ, Zuellig Family Foundation (ZFF) has assisted the Leadership and Governance Program for policy makers and health workers at LGU level.
[176] In Northern Samar, the MNDR manual developed by JICA's maternal and child health project in Eastern Visayas was utilized in implementing MNDR. MNDR is implemented at both ILHZ level and provincial level.
[177] There was a case where the most resource-rich LGU was not contributing to the CHTF.
[178] With USAID's assistance, the DOH Regional Office is particularly accelerating the effort to build the SDN in Leyte province as a pilot site.

do not know how to conduct the following step, which is matching, based on the information collected through the mapping and profiling.

3) NHIP Implementation and Utilization

In Eastern Visayas Region, the total number of NHIP-accredited health facilities was 70 in 2010, increased to 139 by 2011 and 308 by 2015.[179] As Eastern Visayas was heavily effected by Typhoon Yolanda in 2013, the central government is implementing a special measure called the "Avail All" policy for the region until the end of 2016. This policy entitles all residents to NHIP benefits, including those who stopped paying premiums or who were not enrolled due to their financial constraints. As Table 5- 17 shows, 80 to 90 percent of the population is enrolled in each province, and 92 percent are enrolled in the entire region. More than 60 percent are Indigent Members in all provinces and more than 70 percent in the three provinces of Samar island. The NHIP enrollment and facility-based delivery have increased recently not only because of the special policy, but because of the PhilHealth Regional Office's advocacy efforts to LGUs to adopt an ordinance to provide an incentive of 1,500 pesos to mothers who deliver at facilities and that of 500 pesos to BHWs and TBAs who facilitate mothers to health facilities out of the reimbursement from PhilHealth. Moreover, the MCP benefit payments have also increased in recent years (see Figure 5-13).

Table 5- 17 Numbers of NHIP Members in Eastern Visayas (as of June 2016)[180]

Province	Formal Sector	Informal Sector	Indigent	Sponsored	Lifetime	Senior Citizens	Total	Coverage Rate
Biliran	21,531	6,596	98,806	30	2,744	12,934	142,641	82%
Eastern Samar	69,020	14,735	336,650	62	9,401	22,547	452,415	96%
Leyte	377,878	90,310	1,229,798	199	35,849	144,052	1,878,086	94%
Northern Samar	78,714	9,619	443,879	203	7,365	29,734	569,514	89%
Samar	95,197	21,839	549,567	100	8,866	39,230	714,799	90%
Southern Leyte	70,555	10,941	232,269	37	10,944	37,115	361,861	85%
Region	712,895	154,040	2,890,969	631	75,169	285,612	4,119,316	92%

Source: PhilHealth Eastern Visayas

[179] Interview with the DOH Eastern Visayas Regional Office

[180] The numbers include both members and their dependents. The coverage rate is based on the estimated population.

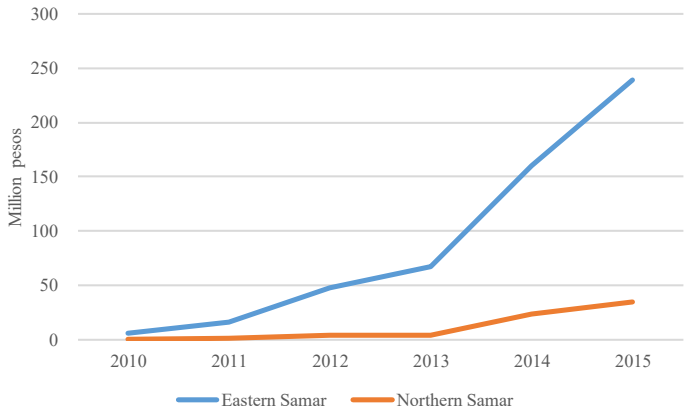

Figure 5- 13 MCP Benefit Payments in Eastern Samar and Northern Samar[181]

Source: PhilHealth Province Offices of Eastern Samar and Northern Samar

Upon termination of the special policy at the end of 2016, LGUs are required to resume their own sponsored programs to take over the assistance. Interviews with healthcare providers and community members revealed the concern that some of the LGUs do not have enough funds for the sponsored programs, which could result in increased numbers of drop-outs and unenrolled. The Survey also confirmed the presence of an RHU that plans to charge a delivery fee once the Avail All policy expires. Therefore, there is a risk that many non NHTS-PR poor households will be excluded from the NHIP in Eastern Visayas Region.

The NHIP benefit payments are deemed essential to improve the services of health facilities. The healthcare providers interviewed also mentioned that the regular bonus they receive from the payments helps motivate them. Nevertheless, an issue was pointed out with regard to the benefit payments for facilities. Because health facilities owned by the provincial government receive benefit payments from PhilHealth through the general fund, it is unclear how the money is spent.[182] According to the PhilHealth guidelines, LGUs are requested to establish a trust fund to receive benefit payments

Figure 5- 14 PhilHealth Northern Samar Office

[181] The data excludes the hospital level.

[182] According to the city and municipal health facilities interviewed, their LGUs have trust funds for NHIP reimbursement.

specifically for the improvement of facility services.[183] However, neither province has established a trust fund and therefore it is not known how much of the NHIP reimbursed fund is in fact used for the relevant facilities or health purposes. At the Northern Samar Provincial Hospital, a lack of medicine has become a major issue, leading to out-of-pocket payments by patients. The establishment of the trust fund can help ensure the transparency and effective use of benefit payments to respond to such needs.

In many communities, more than half of the community members are enrolled in NHIP's Indigent Program based on the NHTS-PR. However, the interviews at barangay level revealed that many poor households are not included in the list and therefore they are not NHIP members. In addition, according to the BHWs and midwives who conduct regular household profiling based on the NHTS-PR list, the list has various issues, such as non-poor being included as indigents, the double counting of people on the list, and the listing of the deceased and those who have moved to other communities.

Private health facilities are also accredited by PhilHealth and many are linked with public facilities through referral systems. The private BEmONC facility interviewed said 99 percent of its clients are indigent and the NBB Policy is implemented. On the other hand, the private CEmONC hospital interviewed said while it implements the NBB Policy, it limits the coverage to 10 percent of total patients from the business perspective. Hence, in the provinces where government-owned CEmONC facilities are extremely few, private hospitals seem to be limited in availing services to the poor.

[Demand Side]

1) Health Service Utilization

According to the BHS and RHU staff interviewed, the facility-based delivery rates are approximately 80 to 90 percent of the total deliveries between 2015 and 2016 in their communities, showing much improvement in the past few years. Some of the factors discouraging home deliveries include improved facility services, awareness raised through community activities and the implementation of LGU ordinances prohibiting the practice and penalizing TBAs who assisted home deliveries. Some of the TBAs are now playing the role of a BHW to facilitate facility-based deliveries. The women who delivered at the facilities mentioned that the choice ensured a safe delivery with the help of professional staff.

[183] In both Northern Samar and Eastern Samar, benefit payments by PhilHealth are made in the form of check.

On the other hand, the Survey Team acknowledged the presence of women who had home deliveries. Some of the GIDA barangays still have 30 to 40 percent of home deliveries. The healthcare providers in these communities are concerned about the risk of more dangerous home deliveries without the help of TBAs due to the strict ordinance while the women still have limited access to health facilities.

One of the key issues regarding access to health services highlighted by many healthcare providers is increased teenage pregnancies. Interviews also identified many teenage couples with children. The teenage girls, being ashamed of their pregnancies, tend to hide them as much as possible. Because BHWs have a hard time tracking them, there are many cases of late referral. Moreover, although these couples live together and have children, many are unmarried. As a consequence, they cannot be enrolled in the NHIP together as a family. The Survey Team identified some teenage pregnant girls who said their partners are enrolled in the NHIP as dependents of their parents as the parents are the NHTS-PR members, and the girls themselves are not enrolled.

2) Enrollment and Utilization of the NHIIP

The field interviews confirmed that many pregnant women were enrolled in the NHIP as a result of the awareness-raising efforts by BHWs and the Avail All policy and were benefitting from the maternal and child health services. However, the Survey Team also identified some women who did not know whether they were NHIP members or if their memberships were updated. Their impression was that the insurance is beneficial only when they have to be admitted to a hospital because RHUs provide free services regardless of the enrollment status. Therefore, for the women who have only been to RHUs, they do not feel like they have utilized the insurance program. Furthermore, some of the women who delivered at hospitals expressed that they did not see the benefits of the NHIP because they still had to pay for drugs out of their own pockets.

Despite the Avail All policy, there were pregnant and lactating women who were yet to be NHIP members, including unmarried teenage girls who were due to deliver in a few months. They are required to deliver at a hospital based on the NHIP guidelines. These women's vulnerability will increase particularly once the Avail All policy ends at the end of 2016.

In addition, BHWs who play a pivotal role in awareness-raising activities seem to lack sufficient knowledge about the NHIP. Many were specifically unaware of the NBB Policy and POC. Because the Avail All policy which automatically provides the NHIP

benefit in Eastern Visayas Region, it is likely not only BHWs but also the LGU personnel and healthcare providers who have less understanding about the NHIP regulations.

3) Barriers to Health Services

Figure 5- 15 Rural household interviewed by the Study

The pregnant women interviewed by the Study are between the ages of late teens into their 30s, many of whom are high school drop-outs or high school graduates. Their husbands are farmers, tricycle drivers or daily workers such as construction workers. Their income is unstable: they are paid 100 to 200 pesos a day or 1,500 to 4,000 pesos per three months for coconuts farming. Most of the women identified themselves as housewives. Some of them help their husbands' farming, but they do not earn income. The women who earn income are engaged in small businesses, such as selling vegetables and rice, getting 300 to 500 pesos a week.

The interviews with women of above-mentioned socio-economic attributes revealed that they are continuing to face various economic, geographic and socio-cultural barriers effecting their access to health services.

<Economic Factors>

- **Medical Fees**: In principle, PhilHealth covers most medical fees, and RHUs essentially provide free services regardless of enrollment status in the NHIP. Nevertheless, the field study found many cases in which the families of delivering mothers had to go to pharmacies and pay for drugs while being admitted in health facilities due to no stock at the facilities. These out-of-pocket payments include IV fluids, vitamins and syringes. In particular, the payments at a CEmONC hospital could cost them as much as 2,500 to 6,000 pesos, which is a significant amount for poor households. Some of them said they had to get donations from relatives and the LGU. Other out-of-pockets include newborn screening for 600 pesos and ultrasound for 500-600 pesos that were not available at the RHUs.

As opposed to the above-mentioned fees involved in maternal and child health services, fees for TBAs are either free or range between 50 and 1,500 pesos. According to the TBAs and mothers interviewed, the fee is often not fixed and the service users can decide the amount based on their financial capabilities. Given the financial implications, some women still choose to deliver at home. There was a case of a mother who suffered from high blood pressure, however, decided to deliver at home as she was afraid of medical bills at hospital, and consequently lost her newborn (see BOX 5- 5). There was also a mother who was told that she was at high risk at the time of ANC but did not follow the advice for financial reasons to take an ultrasound test. These examples indicate that medical fees still burden many poor women even if they are covered by NHIP.

BOX 5- 5 Experience of a 35-Year-old Woman

I delivered my four children at home. When I was pregnant with my fifth child in 2014, I was advised to deliver at the hospital due to high blood pressure. But because I had no problem with my past home deliveries and I was afraid of hospital bills, I delivered at home and the baby died. When I was pregnant again in 2015, because home delivery was prohibited, I was planning to deliver at a facility. When I went into labor, I went to the RHU. However, I was referred to the Provincial Hospital due to high blood pressure. I gave birth in transit and lost the baby. My husband is a vegetable farmer and I help him. We earn about 200 pesos every four days and buy rice from the income. We also consume vegetables we grow at the farm. I am now using contraceptives because we cannot afford to have any more children.

- **Transportation**: Hospitals and RHUs normally own one or two ambulances, but some of them require the users to pay for the fuel. In addition, ambulances are not available for non-urgent cases, and therefore the women and their families have to find a means of transport such as a motorbike, tricycle or boat and bear the cost. The actual amount depends on the access: however, even relatively accessible areas can cost between 20 and a few hundred pesos. The fee fluctuates depending on the time and it tends to be more expensive during evenings. Among the communities interviewed, one barangay owns a motorbike and the mothers can use it for free including the fuel.

- **Others**: Other than the above-mentioned out-of-pocket payments, there are also costs for transport, food and accommodations for family members who accompany the women. Furthermore, the majority of women said their husbands accompany

them throughout the time at the hospital, which creates a concern for the loss of family income during the period.

<Geographical Factors>

Related to transport fees, in both provinces surrounded by islands, mountains and upstream, community members depend on the local means of transport such as motorbikes, boats and tricycles. Nevertheless, these are not available regularly and therefore it is difficult to transfer the pregnant women from the remote areas, especially at night. Additionally, there are communities, even those located 30 minutes away from the provincial capital on the main road, that do not have a network signal. Prompt referral of pregnant women from such areas is a challenge. Furthermore, in the typhoon-prone provinces, women are sometimes forced to deliver at home in the aftermath of a typhoon. Many experiences in the communities revealed that these geographical barriers delayed referral of mothers and they were forced to deliver in transit on a tricycle or boat, causing a maternal or newborn death.

<Sociocultural Factors>

The majority of mothers interviewed said they themselves made the decision where to deliver. In addition, their husbands accompanied them throughout the period of admission. The husbands interviewed expressed that they prefer their wives to deliver at facilities. As for their mothers and mothers-in-laws, they had home deliveries because there was no accessible facility for their communities and they had no choice but to deliver at home. However, they said they recommended to their children to deliver at facilities for their safety.

Among the women from poor households who did not access facilities for ANC, PNC or delivery, they mentioned gender-related reasons, such as the husband's rejection for his wife's facility-based delivery, the woman's overwhelmed reproductive and productive responsibilities at home, and unavailability of a caretaker during the woman's hospitalization (see BOX 5- 6, BOX 5- 7). In addition, while contraceptive prevalence has improved in recent years, all the interviewed women and men using contraceptives are in fact using female contraceptives, mostly pills and injectable. There was also a woman who said she cannot use contraceptives because her husband is against family planning.

BOX 5- 6 Experience of a 35-Year-old Woman

My husband is engaged in daily labor as a coconut farmer and earns 1,000 pesos every three months. I earn 2,000 pesos a month from my laundry business. I gave birth to my five children at home. I delivered my sixth child at the Provincial Hospital because it was a breech delivery. For my five-day stay at the hospital, we paid about 6,000 pesos out of our pocket for IV fluids, syringes and food for my husband. When I was pregnant with my seventh baby, I was doing heavy labor, doing laundry at the river and noticed my baby was not moving in my womb. I went to the hospital and found the baby was gone. I am currently pregnant with my eighth child. A BHW comes to my house and recommends me to take ANC, but I am busy with preparing meals for my family, helping my children to go to school, and doing my laundry business, and cannot find time to go to the RHU.

BOX 5- 7 Experience of a 19-Year-old Woman

My 27-year-old husband is currently unemployed and I am a housewife. Together with our five-month-old baby, we live with his parents. We are not married. He is a member of the Indigent Program, so our baby is listed as his dependent but I'm not. I delivered the child at home with the help of my grandmother who is a TBA. I visited BHS once for ANC when I was still pregnant. I wanted to go back again but my husband didn't agree with the idea because he was afraid that we would have to pay. My husband has control over our household expenses. I want to use contraceptives but my husband is against it because he wants to have more children.

Some women also prefer not to deliver at health facilities because they consider the services unsuitable for their traditional customs. According to their customs, a mother is allowed to drink soup and eat vegetables, dried fish and noodles for at least one month after delivery and is prohibited to eat meat. However, according to them, hospital meals include meat, such as chicken. There was even a case where a mother died after delivery due to hemorrhage and her family still believes it was due to the fact that she had buffalo meat at the hospital.

There are also negative perceptions of health facilities. Some women described a health facility as "scary" because they had never been to a facility, "lonely" without the company of their families, and "no privacy." Because of these perceptions, even women in urban communities with good access to health facilities choose to deliver at home. For them, home delivery is preferable particularly because it allows them to have a comfortable environment with attendance of their family members. The BHWs in communities expressed that it was challenging to change the perceptions and behaviors of these women despite intensified awareness-raising efforts. At the same time, among

the health facilities, RHUs are more preferred than hospitals because they tend to be closer to home, provide free service, and are staffed with midwives and nurses that they are familiar with. In this respect, there are cases of women who were advised to deliver at a hospital due to high risks but waited until the last minute so they could deliver at RHU.[184]

[184] In such a case, the RHU would assist the delivery but cannot get a benefit payment from PhilHealth even if the mother is a PhilHealth member.

Chapter 6 Good Practices and Challenges of JICA Projects

This Survey reviewed two JICA projects on maternal and child health in the Philippines and identified good practices and challenges that are considered relevant for its future programming.

6-1 Surveyed Projects

The followings are the summary of the JICA technical cooperation projects reviewed by the Survey.

The Project for Cordillera-wide Strengthening of the Local Health System for Effective and Efficient Delivery of Maternal and Child Health Services was developed based on the outcomes of JICA's pervious health projects in Benguet and Ifugao provinces in the Cordillera region. Its objective is to achieve UHC through health system strengthening and building frameworks for efficient and effective maternal and child health services. The project has been implemented in Benguet, Abra and Apayao provinces with the Regional DOH Office from February 2012 to March 2017. Some of the activities include facilitation of BEmONC and MCP accreditations of target health facilities, strengthening of ILHZs, promotion of enrollment in NHIP among pregnant women, development of a referral manual, implementation of MNDR and Supportive Supervision (SSV), enactment of ordinances and resolutions on maternal and child health and dissemination of the project region- and nation-wide.

The Project for Strengthening Maternal and Child Health Services in Eastern Visayas was implemented in partnership with the Regional DOH from July 2010 to July 2016, targeting Leyte province and Ormoc city in Eastern Visayas region. The project objectives were to increase facility-based delivery with skilled birth attendance and strengthen community-based activities with involvement of local decision makers so as to improve the quality of BEmONC and services and reduce maternal deaths. The project activities included equipping target health facilities to provide BEmONC services and facilitating them to be MCP-accredited, provision of BEmONC training, implementation of MNDR and SSV, enactment of ordinances and resolutions on maternal and child health and organization and facilitation of management of CHT.

6-2 Interview Sites

The Survey team conducted phone interviews with Japanese experts for the above-mentioned projects and subsequently conducted interviews with the DOH Regional Office, the PhilHealth Regional Office and Provincial Health Officers of Benguet and Apayao provinces in the Cordillera region. Healthcare providers and community members were also interviewed in

Apayao province. Furthermore, a few project counterparts were interviewed in Eastern Visayas. The details of the interviewees are indicated in Table 6- 1.

Table 6- 1 List of Interviewees

JICA Project	Interviewees
Project for Cordillera-wide Strengthening of the Local Health System for Effective and Efficient Delivery of Maternal and Child Health Services	◆ Benguet province: DOH Regional Office, PhilHealth Regional Office, Benguet Provincial Health Officers ◆ Apayao province: Apayao Provincial Health Officer, Conner Municipality Health Officer, Far North Luzon General Hospital, PhilHealth Provincial Office, RHU of Pudtol Municipality, BHS of Barangay Cabatacan and Barangay Buluan, pregnant and lactating women (14 people)
Project for Strengthening Maternal and Child Health Services in Eastern Visayas	◆ DOH Regional Office, PhilHealth Regional Office, Leyte Provincial Health Officers

6-3 Survey Findings

(1) Good Practices

According to the achievements of goals and project purposes as shown in Table 6- 2 and Table 6- 3, both projects contributed to increasing facility-based deliveries, ANC and PNC. This successful outcome seems to be attributable to five facilitating factors. First, in order to increase BEmONC facilities, the projects invested in both facility and human resources of target health facilities. In particular, in the Cordillera region where there are many remote areas, a strategy was employed to upgrade many BHS to become BEmONC-capable for the improvement of access to essential health services. Additionally, by facilitating the NHIP accreditation of BEmONC facilities and promoting the enrollment in NHIP among pregnant women, benefit payments by PhilHealth increased, which in turn contributed to the improvement of maternal and child health services.[185] Second, the projects mobilized CHT and BHWs effectively to conduct grassroots-level awareness raising and tracking of pregnant women, which shifted women's awareness and behavior from home to facility. Third, the revitalization of ILHZ

Figure 6- 1 BHS supported by JICA

[185] As of August 2016, there were 87 BHS that are MCP-accredited in Cordillera, which is the highest in the country.

strengthened referral systems through increasing the commitments of local executive chiefs and sharing necessary resources among LGUs. Fourth, as a result of advocacy to LGUs, policies were adopted to promote service access including ordinances on prohibition of home delivery and payment of incentives to mothers and BHWs and Barangay Maternal, Newborn, Child Health and Nutrition (MNCHN) emergency plans for provision of transport.[186] Fifth, the project in Cordillera addressed cultural factors hindering access to services such as the introduction of culturally-sensitive service protocols and working with TBAs as 70 percent of the regional population are indigenous peoples.[187] At one BHS where the survey team visited, 64 percent of deliveries were done at home in 2011 but it was gradually reduced and achieved zero home delivery by 2015. Furthermore, a group interview with women who had deliveries in the past year revealed all of them had the last delivery at facilities while previous deliveries were done at home.

Table 6- 2 Outcome of the JICA Project in Cordillera

	#	Indicator	Baseline	Target	Year 2015	Source
Goal	1	Regional MMR (per 100,000 live births)	62	Reduced	45	FHSIS
	2	Regional IMR (per 1,000 live births)	11	Reduced	11	
	3	Regional FBD (%)	74	85	92	
Project Purpose	1	FBD in project sites (%)	79	85	93	FHSIS, residence-based, TCL analysys, project monitoring
	2	ANC in project sites (%)	63	80	84	
	3	PNC in project sites (%)	90	90	98	
	4	N0 of functional ILHZ in the region	7	Increased	17	
	5	No of LGUs implementing MNDR in the region	0	Increased	7	
	6	No of BEmONC dacilities in the region				
		Hospital	0	37	36	
		RHU	0	50	48	
		BHS	0	90	104	
	7	No of MCP accredited facilities in the region				
		RHU	12	53	51	
		BHS		78	93	

Source: JICA

Because FHSIS data were found to have issues with counting deaths based on the location of the occurrence (i.e. in which facility the death occurred) and applying an estimated number of pregnant women as a denominator, the projects promoted the employment of residence-based calculations (i.e. where the deceased resided) and an actual number of pregnant women as a denominator. This enabled the stakeholders to understand the situations accurately. In particular, in Cordillera, a system was established to tap into

[186] By incorporating an MNCHN Emergency Plan into each Barangay Disaster Risk Reduction and Management Plan, a system was established to provide emergency transport to pregnant women and their newborn children.

[187] For example, the protocols reflected traditional customs to have husbands attend delivery and mothers deliver in a squatting position.

BHWs' Client Target Lists (CTLs) to collect residence-based data through the project. Cognizant of the advantage of the system, the DOH Regional Office has adopted this methodology (in addition to FHSIS) for the entire region and has requested the central DOH to review the FHSIS methodology.

Table 6- 3 Outcome of the JICA Project in Eastern Visayas[188]

	#	Indicator	Baseline	Target	Year 2015	Source
Goal	1	MMR (per 100,000 live births)				FHSIS
		Leyte province	74.5	Reduced	41.5	
		Ormoc city	64.2	Reduced	185.2	
	2	NMR (per 1,000 live births)				
		Leyte province	No data	Reduced	2.3	
		Ormoc city	6.2	Reduced	14.5	
	3	IMR (per 1,000 live births)				
		Leyte province	6	Reduced	5.9	
		Ormoc city	10.3	Reduced	18	
	4	No of maternal deaths				
		Leyte province	23	Reduced	12	
		Ormoc city	3	Reduced	13	
	5	No of neonatal deaths				
		Leyte province	No data	Reduced	67	
		Ormoc city	29	Reduced	102	
	6	FBD (%)				
		Leyte province	56	90	93	
		Ormoc city	65	90	97	
Project Purpose	1	FBD in project sites				FHSIS
		Leyte province	56	80	93	
		Ormoc city	65	80	97	
	2	ANC in project sites (%)				
		Leyte province	22	45	46	
		Ormoc city	29	45	63	
	3	PNC in project sites (%)				
		Leyte province	53	80	71	
		Ormoc city	61	80	75	

Source: JICA

In addition, many counterparts noted that stakeholders were involved in the project activities. From the beginning of project design and planning, efforts were made to coordinate and discuss with all project stakeholders (e.g. provincial and municipal health officers, PhilHealth and local chief executives). Throughout the implementation period, regular meetings were organized to set project targets, address challenges, establish partnerships and document project outputs. These approaches are considered sustainable and good practice unique to JICA.

[188] The ANC and PNC rates under the project purpose are calculated based on the FHSIS data using an estimated number of pregnant women (2.7 percent for the entire country) as a denominator, and therefore they are underestimated. According to the JICA project, the ANC rates become 63 percent in Leyte and 84 percent in Ormoc in 2015 and the PNC rates became 96 percent in Leyte and 99 percent in Ormoc in 2015 by using the actual number of deliveries as a denominator.

The project in the Cordillera region increased impact by supporting the regional DOH's project expansion plan. Good practices of the project such as ILHZ, TCL, CHT and MNDR were scaled up to non-project sites in the region with strong ownership by the Regional Office. In Eastern Visayas, the regional DOH is planning to expand SSV to other provinces in the region based on the experience with the JICA project.

Figure 6- 2 BHS staff interviewed by the survey team

(2) Challenges

The Survey identified MCP-accredited BHS that had not received benefit payments from PhilHealth. Other related issues included midwives' lack of understanding of distribution ratios of the payments received by the LGUs for facility and personnel and the lack of LGU's resolution to enable such payments to BHS. In the case of LGU-owned health facilities, benefit payments from PhilHealth are not made directly to the respective facilities but to the LGUs, and PhilHealth does not track if they are actually utilized for the relevant facilities. In this respect, health facilities and LGUs should make further efforts to increase healthcare providers' understanding of the PhilHealth guidelines and improve the distribution processes and management of the payments.

Figure 6- 3 MCP-accredited BHS

While more pregnant women are now enrolled in the NHIP, many of them still do not understand the program.[189] In fact, group interviews with pregnant and lactating women revealed that some were not yet enrolled and expressed financial concerns for facility delivery. In this sense, there are existing issues of poor families left out from the NHTS-PR, less frequent update of the NHTS-PR list, and LGU's limited resources for the Sponsored program. Furthermore, some of the LGU-owned hospitals do not have sufficient

[189] Interviews with BHWs also revealed that some of them did not know the NBB Policy and POC.

funds to implement the NBB Policy and POC. In this sense, more efforts are required for the financial protection of the poor.

Despite the strengthening of the referral system through ILHS, there remain various challenges for the poor to access health services due to financial, geographical, cultural and social factors, and home delivery is still practiced. Especially in remote and mountainous areas like Cordillera, pregnant women have to walk for more than half a day to reach health facilities and pay out of pocket as much as a few thousand pesos for one-way transport,[190] food and newborn screening. In addition, according to the group interviews with pregnant and lactating women, one of the main reasons to deliver at the facility is that home delivery with the help of TBA is prohibited by municipal ordinance. This may suggest that poor women living in remote areas without appropriate transport to health facilities have a lack of options, and in fact are forced to look for more risky alternatives. In this regard, assistance should be accompanied with other approaches to facilitate access, such as the provision of incentives to mothers and the establishment of maternity waiting homes.

With the improvement of the referral system, more maternal deaths are occurring while being transferred or at high-level facilities. Under these circumstances, comprehensive efforts should be made to tackle the factors attributing to the "three delays": unavailability of transport, lack of immediate and appropriate treatments with drugs and blood shortages at health facilities, and cultural and financial factors hindering women from seeking services.[191] Future assistance should focus on these issues to devise solutions.

While DOH Regional Offices report project outcomes and provide feedback on policies to the central DOH, it was indicated that these efforts had not resulted in improvement of the policies. Some policies require fundamental improvements, such as that of the FHSIS data and the standards of midwife placement.[192] In this respect, the future project should not only share results with the central DOH, but also fully involve them from the stage of project design and planning.

[190] According to the BHS interviewed, when an ambulance is dispatched for referral, the patient has to pay 1,500 pesos for fuel.

[191] For example, among some of the indigenous people in Cordillera, the traditional customs require them to conduct a ritual before going to the facility and use herbal medicines.

[192] According to the DOH standards, one midwife is deployed for a population of 5,000. Some interviewees commented that it should not only consider the size of population but also the distance as an issue in remote communities.

Chapter 7 Recommendations for JICA's Future Assistance

On the basis of the survey findings and good practices and challenges of the former JICA projects in maternal and child health (MCH), the following recommendations are made for JICA to take into consideration when formulating future assistance projects/programs for the Philippines.

7-1 Points to be Considered

The following four points were especially considered when consolidating the recommendations for JICA.

- JICA's knowledge and experience in the Philippines, particularly MCH projects.
- Universal Health Coverage (UHC), "equitable health service delivery and financial risk protection," the Japanese government's diplomatic strategy, is incorporated.
- Philippine Health Agenda: ①All Life Stages & Triple Burden of Diseases, ②Service Delivery Network and ③Universal Health Insurance are addressed.
- Achievement of the Sustainable Development Goals (SDGs), particularly in reduction of maternal and neonatal deaths, promotion of access to sexual and reproductive health-care services and achievement of UHC,[193] is considered.

7-2 Recommendations for JICA's future activities

The survey found that inequality among Filipinos has not diminished, even though the country's economy has been thriving over the past decade. Consequently, poor families are still suffering financially when they receive medical services, even if they are enrolled in NHIP. The quality of health services highly depends on capacity and leadership of the local executives. The survey team recommends JICA to pursue the new technical assistance project, "UHC enhancement in the MCH services," with two approaches: improved access to quality essential health-care services and financial risk protection. Each component of the recommended project is described below.

(1) Access to Quality Essential Health-Care Services

① Service Delivery Network (SDN)-Building

Effective SDN is indispensable for all women to have a safe delivery. However, the policy and guidelines of SDN are not clear in the Philippines at this moment and there is a variety

[193] United Nations. (2016). Sustainable Development Goals: 17 Goals to Transform Our World.

in the state of progress in SDN establishment in different areas of the country. It is recommended that JICA provide technical assistance to target provincial government officials in re-defining the "SDN" and building the SDN in the way that necessary health services are delivered to people in need when needed.

The Japanese secondary medical area[194] could be a model when re-defining the "SDN" in the Philippines. The Japanese secondary medical area is the zone that is set for each prefecture, in which hospital beds serving general inpatient care are prepared pursuant to the provision of the Medical Care Act and connected to referral care. Ideally, the DOH Regional Office should set the SDN zones as there is a chance that a SDN zone extend over more than two provinces. SDN zones should be carefully set while taking geographical relationships and traffic condition into consideration.

Additionally, actions are needed to mitigate the overconcentration of patients in tertiary health facilities. While continuing efforts to upgrade RHUs into BEmONCs as performed in previous JICA projects for hard-to-reach areas, the new project should consider setting a secondary or primary health facility near a tertiary health facility. Upgrading a primary health facility to a secondary health facility was intended to bring better health care close to the people. However, now that many women are reaching a tertiary health facility, a place for women having a normal delivery should be established near the tertiary health facility, so that these women can stay close and the tertiary health facilities are available for complicated cases. Moreover, maternal waiting homes nearby a tertiary health facility would improve accessibility for women living in hard-to-reach areas, such as GIDAs. The women can stay at the maternal waiting homes several days prior to delivery, so that they can receive prompt emergency care if necessary.

② Continued Supportive Supervision for Health Care Providers

The survey found that most maternal deaths are occurring within or in transit to health facilities in the Philippines. Inadequate referral systems, poor facilities and a lack of medical supplies are some of reasons behind this, but inadequately trained and poorly motivated health staff are another major factor in maternal death. Health staff need to make

[194] The Japanese secondary medical area is set by the Ministry of Health, Labor and Welfare based on the Medical Law, considering various factors, such as the geographical and traffic conditions. The medical service system within the area is designed based on the necessary number of medical treatment beds. It aims at providing general medical services, including surgery and emergency care within the area. The Japanese secondary medical area consists of plural municipalities and a prefecture is divided into 3 to 20 secondary medical areas. In general, municipalities provide primary care and prefectures provide tertiary care.

a correct decision in emergencies at a primary or a secondary health facility to refer a patient to a higher-level facility, and in a higher-level facility, the staff should properly provide emergency care. The survey found that untrained midwives, without BEmONC training, are working in health facilities. Thus, training and supportive supervision in ANC, referral services, delivery and PNC should be continually provided to health staff at all levels of health facilities based on previous JICA experience, and the training and supervisory process and tools utilized in the efforts should be properly compiled. These efforts to strengthen the emergency obstetric care system should lead to prevention of maternal mortality. In case the target area is facing a scarcity of the trainers, the new project team should consider exchanging memorandums with a university or an academic institution to have them send trainers to the project sites.

③ Technical Assistance for LGUs in Administration and Public Finance

Previous JICA projects assisted LGUs to issue ordinances banning TBA practices and home delivery, and providing mothers and BHWs with incentives when they come to a health facility for delivery. While it is recommended to continue these efforts, new projects should also provide technical assistance in public financial management to LGUs.

The following are examples of the activities:

1. Support establish ordinances at barangays and municipalities to incentivize BHWs and mothers for FBD and to give penalties for home delivery.

2. Support establish a system to regularly monitor the PhilHealth reimbursement to the LGU or hospital trust fund and the utilization for the original purposes, such as purchase of medicine.

3. Support conduct leadership trainings for local executives of LGUs, particularly in local governance and public financial management. Through the trainings, the project team should convince the local executives that they should provide enough budget to the health sector as quality health care leads to healthy population and prosperity of LGUs.

As these activities are similar to other development partners', it is recommended for the project team to plan on the activities through discussions with such stakeholders.

(2) Financial Risk Protection

① Financial Support System Development at the LGUs

The survey found that some LGUs are reluctant to sponsor near-poor people to be enrolled in NHIP and many women are still financially burdened by health services even if they are enrolled in NHIP. It is recommended that the new project assist LGUs to pilot a financial support system to mitigate and eliminate this burden on child-bearing women.

The following are examples of the activities:

1. Support establish a common pooled fund, collected out of the PhilHealth reimbursement and religious, community and charity events, and provide childbearing women with lump sum fund.

2. Support establish a system to provide some monetary assistance to the poor families identified by LGUs when they receive medical services. The LGU poor families should be identified by barangay captains and LGU officers. The monetary assistance is provided out of the above common pooled fund and it is used for transportation to a health facility, medicine and laboratory tests, the health expenses not covered by NHIP.

3. Support establish a labor exchange system without monetary exchange within a barangay or a municipality. The system allows a childbearing woman to receive child care and/or housekeeping while she is hospitalized and she can return the similar support to the child care taker and a housekeeper later.

② Promotion of Awareness-Raising Activities

The survey found very few people thoroughly understood NHIP. In fact, it is not only the beneficiaries who have insufficient knowledge, but health administrators, BHWs and health service providers also lack knowledge of NHIP. Hence, it is recommended that the new project select the most effective media and the most important messages for each group of people and try to convey only the selected messages in clear and simple words. For BHWs, who are in charge of raising the awareness of the beneficiaries, the awareness-raising training should be standardized by the project team.

③ Effective utilization of the BHWs' Household Profiling

Barangay Health Workers (BHWs) are collecting and updating household data monthly in an assigned area. The data are consolidated in various forms, including Household Profiling (see Figure 7- 1) and the Target Client List (TCL). Previous JICA projects mobilized the activities of the BHWs and strengthened tracking of the ANC, PNC and facility delivery status of women primarily with the Target Client List (TCL) for prenatal care. Based on the experiences, the new project team should first study the availability and quality of the data-collecting system in the target areas, and use the most reliable data for the extended purposes. The survey revealed that there are many women who do not know whether they are enrolled in NHIP or if they have paid premiums to renew their membership. It would be helpful if the BHWs can use the database not only for checking people's health, but the status of their NHIP enrollment and premium payment, when they visit each household. BHWs can support the households with procedures for NHIP enrollment or premium payment. That way, people can maintain an active enrollment in NHIP and their health expenditures are covered by NHIP when necessary. It would be more effective if BHWs raise the people's awareness regarding NHIP through the household visits.

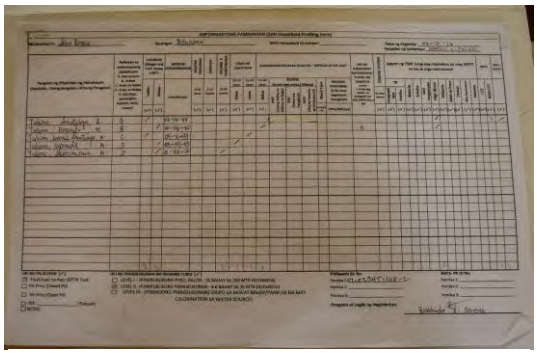

Figure 7- 1 Household Profiling

④ Third-Country Training and Training in Japan

PhilHealth has been evolving for the past twenty years; however, it is still facing new challenges. In fact, improvement of the NHIP system itself is necessary to eliminate financial burdens on poor women in provinces. Through the survey, it was found that PhilHealth is eager to learn how other countries are dealing with various challenges. Hence, it is recommended for the new project to invite PhilHealth staff to Japan or other countries such as Thailand where JICA is implementing the Partnership Project for Global Health and Universal Health Coverage to promote Universal Health Coverage (UHC) in ASEAN countries as well as other regions of the world. It would help PhilHealth to improve NHIP policies through trainings and discussions with other participating countries and observe universal health coverage in Japan. As the Philippine government suggests to pay non-formal sector premiums by tax subsidies in the new Philippine Health Agenda, the Universal Coverage Scheme in Thailand could be a model. On the other hand, Japanese

medical fee schedule and some management systems could assist solve the current issues that PhilHealth is facing.

7-3 Project Sites

Eastern Samar and Northern Samar provinces in Eastern Visayas are recommended as the next project sites. These two provinces are among the 20 High Poverty Sites. A good relationship with the DOH Eastern Visayas Regional Office has been already established through long-time assistance in the region. It is expected that the Leyte provincial office where JICA assisted for the past six years could transfer the knowledge and skills gained through the project into Eastern Samar and Northern Samar provinces.

In case Eastern Samar and Northern Samar provinces are chosen as the new project sites, however, the project team should thoroughly uphold safety management as the Communist Party guerrilla organization, New People's Army, is hiding in the provinces. Also, after Super Typhoon Yolanda hit the Eastern Visayas Region, a special measure, the Avail All, was taken in the Region to support the enrollment of people in NHIP. As the Avail All is going to end in 2016, new sponsors should be found for those who are currently enrolled through the Avail All, for the next year on. It is also necessary for those people to be re-educated about NHIP as they did not have to pay premiums for the past few years.

7-4 Enhancement of Project Up-scaling Mechanism

Although JICA has been assisting the Philippine health sector for a long time, its good practices were not necessarily utilized to improve national policies. The primary reason should be that the health policy makers do not fully understand importance of JICA's achievement. For the next project, JICA should build up a mechanism to fully up-scale the good results of the project to the entire country (see Figure 7- 2).

The JICA health advisor or a project member assigned at the DOH headquarters should play an important role in the mechanism. The health advisor or the project member should involve the Family Health Office, the division in charge of MCH, the Bureau of Local Health Systems Development, the division in charge of SDN, the DOH Regional Office in the target region, and the PhilHealth headquarters, throughout the project planning process. It is important that all the stakeholders recognize that JICA will pilot the project for the entire nation from the planning phase and periodically and continually share the project updates.

The counterparts of the project are primarily the DOH Regional Office and the target LGUs. The project team works with the counterparts and periodically reports to the JICA Health Advisor/the project member in charge, so that the Health Advisor/the project member in charge can update the stakeholders.

Now that the Bureau of Local Health Systems Development has started reviewing the SDN policy, it is a good time for JICA to start being involved in the area of SDN policy. When good communication is maintained among the stakeholders in the central offices, JICA's good practice should be taken into account when the SDN new policy is formulated. Likewise, other lessons learned through the new project should be utilized to improve the policies of MCH as well as NHIP as long as the project outcomes are shared with the stakeholders. It would take approximately five years to show exactly how LGUs can take action towards enhancing UHC through MCH services in the project sites, and simultaneously build the project up-scaling mechanism. Afterwards, it is expected that the Philippine government would continue the efforts towards UHC in the entire nation based on their own policies.

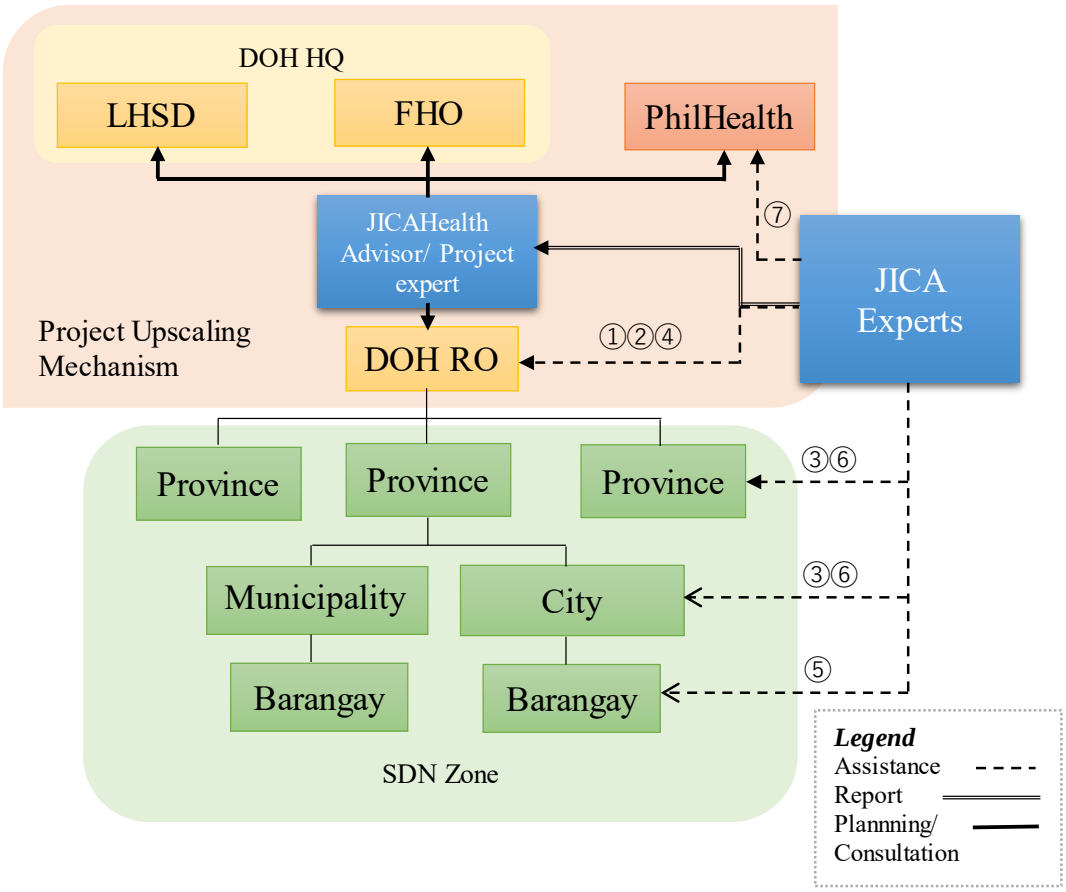

Figure 7- 2 Recommended JICA New Project and Project Upscaling Mechanism

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ATTACHMENTS

		Time	Venue	Agency	Contact
2016/7/24	Sun	17:30			Arrive (PR427)
2016/7/25	Mon	0830-0900	JICA PP Office	JICA PP office	SR Mr. Morita, Ms. Itsuki
		0900-0945	JICA PP office	JICA PP office	Ms. Marry Ann, Ms Mendoza Teresa
		1000-1200	UNFPA, 31/F Yuchengco Tower, RCBC Plaza, 6819, Ayala Ave	UNFPA	Dr Angelito Umali
		1400-1600	UNICEF	UNICEF	Dr Raoul Bermejo, Health & Nutrition United Nations Children's Fund
2016/7/26	Tue	0900-1100	JICA PP Office @Meeting Room 2	EU Consultant Team	DR. UTE SCHUMANN Team Leader/Health Policy Planning & Financing Expert EU PHILIPPINES HEALTH SECTOR REFORM CONTRACT Mrs Melahi Pons. Interim Financing Expert
2016/7/27	Wed	0900-1100	ADB	ADB	Dr. Eduardo Banzon Regional Adviser for Health, Economics and Financing Asssitant: Raygie dela Cruz (Ms)
		1400-1500	Richmonde Hotel Ortigas	NKTI	Dr Enrique Ona Former Secretary of Health (2010-2014) Medical Doctor, National Kidney and Transplant Institute (NKTI)
2016/7/28	Thu	0730-0900	DSWD Central Office, Batasan Complex, Quezon City, Philippines	DSWD	Mr. Leonardo C. Reynoso, CESO III, National Program Manager (Conditional Cash Transfer Program) Mr. Gil R. Tuparan, Senior Technical Officer Ms. Johhanna Acebes. Technical Assistance Unit
		1000-1130	Jose Fabella Hospital Lope de Vega St., Sta Cruz Manila, Philippines	Jose Fabella Hospital	Dr. Esmeraldo T. Ilem Medical Center Chief II Dr. Jose Fabella Memorial Hospital
		1300-1400	WHO country office	WHO	Dr. Benjamin D Lane, PhD Coordinator Health Systems, WHO Philippines
2016/7/29	Fri	0900-1100	World Bank 26th Floor, One Global Place 5th Ave. corner 25th St. Bonifacio Global City	World Bank	Ms. Tomo Morimoto, Senior Operations Officer Health, Nutrition & Population Global Practice Dr. Roberto Antonio F. Rosadia, Health Specialist
		1300-1400	DOH San Lazaro Compound, Tayuman, Sta. Cruz, Manila	DOH	Ms. Georgina Ramiro, Dr. Grace Fe R. Buquiran, Medical Officer N BIHC Project Monitoring Division, Bureau of International Health Cooperation
		1400-1600	DOH San Lazaro Compound, Tayuman, Sta. Cruz, Manila	DOH	Ms. Zeny Dy Recidoro Chief Health Program.Officer, Program Manager of National Safe Motherhood Program, Family Helath Office, Disease Prevention and Control Bureau, Department of Health
2016/7/30	Sat				
2016/7/31	Sun				
2016/8/1	Mon	10:00-11:00	Department of Interior and Local Government located at EDSA corner at Quezon Avenue in Quezon City	DILG	Ms. Girlie Zkra, Division Chief/Local Governance Performance Management Supervision/Bureau of Local Government Supervision
		13:30-14:30	Bureau of Local Health Development	DOH	Mr. Raul R. Alamis, Bureau of Local Health Systems Development, Health System Development Division of DOH
		16:15-16:45	National Statistics Authority	NSA	Ms. AURORA T. REOLALAS, OIC-Division Chief, Vital Statistics Division
2016/8/2	Tue	1000-1200	DOH San Lazaro Compound, Tayuman, Sta. Cruz, Manila	DOH	Ms. Frances Mamaril, Division Chief Planning, Health Policy Development and Planning Bureau
		1400-1500	Makati Medical Center Credit and Collections Department	Makati Medical Center	Dr. Flor Cruz, Patient Billing Unit、2. Ms. Janet Medina, Billing and Collections Unit, 3. Ms. Grace Salvador, Billing and Collection Unit, Makati Medical Center , Credit and Collections Department
2016/8/3	Wed	1000-1100	USAID	USAID	Dr. Yolanda E. Oliveros, MD MPH, Development Assistance Specialist, Ms. Reynalda L. Perez, Project, Management Specialist, Office of Health, USAID
		1330-1500	PhiHealth	PhilHealth	Ms. Evelyn C. Bangalan, Senior Manager, Ms. Christine Frances D. Limson, Project Planning and Development Officer in International and Local Engagement Department Dr. Mary Antonetter Rimon
		16:00-17:20	Mandaluyong City Hall	Mandaluyong City Office	Dr. Recos Reyes Ibanes Camarinesm MD, MHA, Obstetrician-Gynecologist, Mandalyuong City Health Officer Dr. Cesar Tutaan, Mandaluyong City Health Officer
2016/8/4	Thu	14:00-15:00	Executive Office Manila Doctors Hospital #667 United Nations Avenue, Ermita, Manila	Manila Doctors Hospital	Ms. Dr.Bernadette Hogar-Manlapat, Quality Management Representative Ms. Julie S. alvamz@maniladoctors_com.joh Head, SCRO, Social Sector, Ms. Ma Thresa A. Acosta, PhilHealth Specialist Ms. Estrella M. Garcia, Finance Director Mr. Noel Jonathan T. See, Officer In Charge, Business Development Division, Manila Doctors Hospital
2016/8/5	Fri	10:00-11:00	Bureau of Local Health Development	DOH	Ms. Rosario S. Torralba, Supervising Health Program Officer, Bureau of Local Health Systems Development, Department of Health
		12:30-13:30	Health Human Resource Development Bureau DOH	DOH	DOH OIC-Asec Kenneth G Ronquillo, Director IV Health Human Resource Development Bureau
		15:30-16:30	DOH	JICA PP office	Ms. Itsuki, Mr. Kanamori
2016/8/6	Sat	14:40			Leave (PR432)

Bicol schedule (28th August - 10th September)

Date		Time	Activity	Venue	Accomodation
2016/8/28	Sun		Arrived in Manila (PR 427: 17:30)		Manila
2016/8/29	Mon	10:00-12:00	Mtg with JICA		
		14:00-16:00	Internal meeting		
2016/8/30	Tue	7:25-8:25	Move from Manila to Legaspi, Albay (5J 319)		Legaspi
		11:00-13:00	Mtg with DOH regional office	DOH regional office V, Legaspi	
		14:00-15:00	Mtg with MHO Malinao@RHU	RHU in Malinao Municipality	
		16:00-17:00	Mtg with local consultant (Meg)	Villa Amanda hotel	
2016/8/31	Wed	9:00-:10:30	Mtg with Albay Provincial health officer (MNCHN coordinator)	Albay provincial office	Legasipi
		11:00-12:00	Mtg with PhilHealth regional director	PhilHealth Albay regional office	
		13:00-15:30	Visit to Bicol regional training and teaching hospital	BRTTH, Legaspi	
		18:00-19:00	Luzon Health (NGO)	café	
		(parallel conduct by consultant: FGD at Burabad)		Burabad Barangay/Malinao	
2016/9/1	Tur	9:00 - 12:00	FGD/interiew at Balading Barangay	Balading & Burabad Barangay/Malinao	Legasipi
		13:00-13:40	DSWD officer in Municipalty, Municipal social worker		
		14:00-15:00	Interview with BHWs at Burabad Barangay		
2016/9/2	Fri	6:00:-9:00	Moving to Naga city, Camarines Sur (by car)		Naga
		9:00-11:00	Mtg with PHO Camarines Sur	Eurotel hotel	
		15:00-16:00	Visit to Bombon lying in clinic (privte)	Bombon Municipality/Naga city	
		17:00-18:00	Mtg with Naga City health officer	Naga city office	
2016/9/3	Sat	9:00-12:00	FGD/visit to BHS at Panicuason Barangay in Naga city	Panicuason Barangay in Naga city	Naga
		13:00-15:00	Internal meeting	Hotel	Naga
2016/9/4	Sun		Report writing		Naga
2016/9/5	Mon	9:00-12:00	FGD/visit to BHS at San Isidro Barangay in Naga city	San Isidro iBrangay in Naga city	Naga
2016/9/6	Tue	9:00-10:30	Municipal health office/RHU in Pamprona Municipality	Pamprona Municipality	Naga
		11:00-12:30	FGD/visit to BHS at Batang Barangay in Pamprona Municipality		
		15:00-16:00	FGD/visit to BHS at Poblacion Barangay in Pamprona Municipality		
		18:00-19:00	Interview with MHO of Sipocot Municipality	Hotel	Naga
2016/9/7	Wed	10:00-15:00	FGD/visit to BHS at Binahian Barangay in Sipocot Municipality	Binahian Barangay in Sipocot Municipality	Naga
		17:00-18:00	Visit to Sipocot District hospital	Sipocot District hospital	
2016/9/8	Tur	9:30-12:00	Visit to Bicol Medical Center	BMC	Naga
		14:00-16:00	PhilHealth Cum Sur provincial office in Naga	PhilHealth Cum Sur provincial office	
2016/9/9	Fri	10:00-10:30	Internal meeting	Hotel	Remington Hotel, Manila
		12:30-13:20	Move from Naga to Manila (PR 2262)		
2016/9/10	Sat		Leave for Japan (PR 432: 14:40)		

CAR and Eastern Visayas schedule (28th August - 21st September)

Date		Time	Activity	Venue	Accomodation
2016/8/28	**Sun**	17:30	Arrive in Manila (PR 427)		Manila
2016/8/29	**Mon**	10:00	Meeting with JICA	Starbucks at Greenbelt 1	
2016/8/30	**Tue**	AM	Travel from Manila to Baguio (road)		Chalet Baguio
		13:30	Benguet PHO	DOH-Benguet Office	
		15:00	CAR Regional DOH	DOH-CAR RO	
		16:00	PhilHealth Regional Office	PhilHealth Regional Office	
2016/8/31	**Wed**	All day	Travel from Baguio to Luna (road)		Luna
2016/9/1	**Thu**	8:00	Farnorth Hospital	Farnorth Hospital	Tuguegarao
		10:00	PhilHealth Provincial Office	Farnorth Hospital	
		11:00	Main Health Center (RHU) in Pudtol	RHU Pudtol	
		13:00	BHS (midwife) and BHWs in Barangay Cabatacan	BHS Barangay Cabatacan	
		20:00	Apayao PHO	Las Palmas Hotel	
2016/9/2	**Fri**	8:00	BHS (midwife) and BHWs in Barangay Buluan	BHS Barangay Buluan	
		10:00	2 FGDs with women beneficiaries (pregnant and lactating women)	BHS Barangay Buluan	
		13:00	Conner MHO	BHS Barangay Buluan	
2016/9/3	**Sat**	12:55	Travel from Tuguegarao to Manila (5J505)		Manila
2016/9/4	**Sun**	13:00	Travel from Manila to Tacloban (PR2985)		Tacloban
2016/9/5	**Mon**	9:00	DOH Region VIII	DOH Regional Office	
		13:00	PHO Leyte	PHO Leyte	
		15:00	EngenderHealth (VisayasHealth)	DOH RO	
		17:00	PhilHealth Regional Office	PH R08 (Burgos St.)	
2016/9/6	**Tue**	8:30	EVRMC	EVRMC	Catarman
		PM	Travel from Tacloban to Northern Samar (road)		
2016/9/7	**Wed**	9:00	PHO Northern Samar	Provicial Health Office	
		11:00	PhilHealth Northern Samar	PhilHealth Office	
		13:00	Nothern Samar Provincial Hospital	Provincial Hospital	
		15:00	Catarman RHU	RHU	
2016/9/8	**Thu**	8:00	Catarman Doctors Hospital Incorporated	CDHI	
		10:00	Barangay Balnasan: Barangay Captain	Balnasan Barangay Hall, San Roque	
		12:00	Barangay Balnasan: Midwife and Nurse	Balnasan Barangay Hall, San Roque	
		13:30	Barangay Balnasan: Pregnant women who received ANC and will deliver at RHU	Balnasan Barangay Hall, San Roque	
		14:30	Barangay Balnasan: Women who delivered at home	Balnasan Barangay Hall, San Roque	
		16:00	Barangay Balnasan: Wome who delivered at hospital	Balnasan Barangay Hall, San Roque	
2016/9/9	**Fri**	9:00	Barangay Balnasan: Grandmothers I	Balnasan Barangay Hall, San Roque	
		10:30	Barangay Balnasan: Grandmothers II	Balnasan Barangay Hall, San Roque	
		11:15	Barangay Balnasan: Husbands of pregnant and lactating women	Balnasan Barangay Hall, San Roque	
		13:00	San Roque MHO and PHN	San Roque RHU	
		14:30	Mayor of San Roque Municipality	Municipal Office	
		16:00	Barangay Balnasan: BHWs	Balnasan Barangay Hall, San Roque	
		17:00	Barangay Balnasan: TBA/BHW	Balnasan Barangay Hall, San Roque	
		18:00	Barangay Balnasan: Woman who had neonatal deaths	Balnasan Barangay Hall, San Roque	
2016/9/10	**Sat**	10:00	Barangay Polangi: BHWs	Polangi Barangay Hall, Catarman	
		12:00	Barangay Polangi: Woman who had neonatal death	Private home, Barangay Polangi	
		19:00	DOH Northern Samar (DMO)	Local restaurant	
2016/9/11	**Sun**	PM	Travel from Northern Samar to Borongan		Borongan
2016/9/12	**Mon**	All day	Report Writing (*national holiday)		
2016/9/13	**Tue**	8:00	Eastern Samar Provicial Hospital	Provincial Hospital	
		9:30	PHO Eastern Samar	PHO	
		11:30	Borongan RHU1	RHU Borongan	
		15:00	Eastern Samar PhilHealth	PhilHealth	
		16:30	PHO Eastern Samar	PHO	
2016/9/14	**Wed**	8:00	Borongan CSWD	City Hall	
		10:00	Llorente RHU	RHU	
		11:30	Barangay Naubay: Pregnant women	BHS Barangay Naubay	
		13:00	Barangay Naubay: Women who had home deliveries	BHS Barangay Naubay	
		14:00	Barangay Naubay: BHWs	BHS Barangay Naubay	
		16:00	Llorente Municipal Hospital	Municipal Hospital	
2016/9/15	**Thu**	8:00	DOH Eastern Samar (DMO)	CHD Borongan	
		10:30	Dr. Leon Domingo Memorial Maternity Clinic	Dr. Leon Clinic	
		13:00	Barangay Balacdas: Pregnant and lactating women who accessed facilities	Private home, Barangay Balacdas	
		14:30	Barangay Balacdas: Woman who had a home delivery	Private home, Barangay Balacdas	
		15:00	Barangay Balacdas: TBA/BHW	Private home, Barangay Balacdas	
		15:45	Barangay Balacdas: Midwife	BHS Barangay Balacdas	

CAR and Eastern Visayas schedule (28th August - 21st September)

Date		Time	Activity	Venue	Accomodation
2016/9/16	**Fri**	10:00	Llorente Poblacion 1: Women who had home deliveries	Barangay Hall	Borongan
		10:50	Llorente Poblacion 1: Husbands of pregnant women	Barangay Hall	
		11:30	Llorente Poblacion 1: TBA	Barangay Hall	
		12:10	Llorente Poblacion 1: Grandmothers	Barangay Hall	
		17:00	MHO Llorente Municipality	Dona Vicenta Hotel	
2016/9/17	**Sat**	10:30	MHO Can-avid Municipality	Can-avid RHU	
		13:00	Barangay Carolina: Woman who had home deliveries	Private home, Barangay Carolina	
		14:00	Barangay Carolina: Woman who delivered at RHU	Private home, Barangay Carolina	
2016/9/18	**Sun**	PM	Travel from Borongan to Tacloban (road)		Tacloban
2016/9/19	**Mon**	10:00	JOCV (RHU San Isidro)		
		13:30	EVRMC (data collection)	EVRMC	
		14:00	Regional DSWD	Patawid Panilya Regional Program Management Office	
2016/9/20	**Tue**	14:55	Travel from Tacloban to Manila (PR2986)		Manila
2016/9/21	**Wed**	6:45	Depart Manila (PR428)		

Manila schedule (2nd - 8th October)

Date		Time	Venue	Agency	Contact
2016/10/2	Sun	17:30	Arrive(PR427)		
2016/10/3	Mon	9:00-16:30	Mandalyon City	Mandalyon City Hall, City Hospital, Balangay Health Center & private clinic	Ms. Milagros Lagaran, Focal Person of Pantawid Pamilya Pipilino Program, Mandaluyon City Ms. Arlene Gampal, CSWD Social Worker, Mandaluyon City
2016/10/4	Tue	10:00-12:00	Room 1701 on the 17th Floor of PhilHealth, Citystate Center, 709 Shaw Boulevard, Pasig City	PhilHealth	Dr. Israel Francis A. Pargas, M.D., OIC, Vice President Corporate Affairs Group Ms. Evelyn C. Bangalan, Senior Manager, International and Local Engagement Department Dr. Joy Maala, Primary Care Benefit Team Head Ms. Abcean Estrada, MDG Team Ms. Zarah Jane E. Ignacio Ms. Christine Frances D. Limson, Project Planning and Development Officer, International & Local Cooperation Department
		14:00-15:00	DOH San Lazaro Compound, Tayuman, Sta. Cruz, Manila	DOH	Ms. Madelaine Gabriel Doromal DOH, Health Facility Development Bureau
2016/10/5	Wed	15:00-16:30	PSA Eton Centris 3, Queson City	PSA, DHS Division	Ms. Plenee Castillo, Division Chief Ms. Wima Suit Mr. Jeremias Luis Mr. Val Salting Demographic and Health Statistics Division (DHSD)
2016/10/6	Thu	9:00-10:30	JICA PP Office	JICA PP office	SR Mr. Morita, Ms. Kawaguchi of JICA Philippine Office Mr. Kanamori, JICA Health Advisor Mr. Yoshida, Ms. Ito of JICA HQ
		14:00-16:00	DOH San Lazaro Compound, Tayuman, Sta. Cruz, Manila	Jose Fabella Hospital	Dr. Minerva Vinluan, Program Manager, Family Helath Office, Disease Prevention and Control Bureau, Department of Health
2016/10/7	Fri	10:00-12:00	Meeting Room 3, 17th floor, Cyberpod III, Eton Centris, EDSA Quezon City	PSA, Population and Housing Division	Ms. Minerva Eloisa P. Esquivias, Assistant National Statistician for National Censuses Service, Ms. Maribelle Baluyot, OIC, Population and Housing Census Division, Mr. Raul Ludovice, Supervising Statistical Specialist, PHCD Ms. Jana Flor Vizmanos, Statistical Specialist I, Office of ANS, Population and Housing Census Division
2016/10/8	Sat	8:45	Leave(PR422)		

DCF Year: 2014

ID	Performance Indicator	Performance Level		Reference Table			
		External Benchmark	Internal Benchmark	Health Data 2014	Health Data 2013	Nat'l Ave. 2012	Nat'l Target 2016
1.1	Increase LGU Investment for Health						
201401	Percentage of Provincial/City (HUCs or ICCs) Budget Allocated to Health	🔴	↓	15.00	16.50	21.71	22
201403	Percentage of MOOE Allocated to Health	🟡	↑	42.00	14.40	33.94	45
201404	Percentage of Provincial/City/Municipal Health Expenditures	🔴	↓	61.40	83.40	85.12	100
2.1	Local Health Facility Services						
201405	Bed Occupancy Rate in all LGU-administered Hospitals	🔴	↓	50.44	137.80	96.10	80-85
201406	Gross Death Rate in all LGU-administered Hospitals	🟢	↑	0.00	0.78	2.73	<1
3.1	Adequate Human Resource for Health						
201407	RHU/Health Center Physician to Population Ratio	🔴	↓	48287	26157	35497	20000
201408	RHU/Health Center Midwife to Population Ratio	🔴	↓	16096	12390	6591	5000
201409	RHU/Health Center Midwife to Population Ratio	🔴	↓	16096	12390	22947	20000
3.2	Essential Drugs/Medicines						
201410	ComPack Anti-Hypertensive Drugs	⚪		N.D.		88.53	100
201411	ComPack Anti-Diabetic Drugs	⚪		N.D.		87.72	100
3.3	Health Emergency Management						
201412	Percentage of LGUs with Operational HEPRRP	🟢		100.00		22.88	100
3.4	Support to Health Human Resource						
201413	Percentage of LGUs Providing Full Magna Carta Benefits	🔴		0.00		20.66	100
3.5	Client Satisfaction Survey						
201414	Client Satisfaction Survey	⚪		N.D.		71.66	100
3.6	Blood Voluntary Program						
201415	Blood Donation Rate	🔴		0.01		0.93	1
4.1	Disease Free Zone Initiatives						
201416	Percentage Coverage of Target Population in Endemic Area(s) with Mass Treatment for Filariasis	⚫	⚫	N.A.	ND	71.72	85
201417	Annual Parasite Incidence for Malaria	⚫	⚫	N.A.	NA	0.69	0.8
4.2	Intensified Disease Prevention and Control						
201418	TB Case Detection Rate (All Forms of TB)	🟢	↓	95.00	105.00	82.78	90
201419	TB Treatment Success Rate	🔴	↓	66.00	88.00	82.53	90
4.3	Child Health						
201420	Percentage of Fully Immunized Child	🔴	↓	62.00	78.00	76.91	95
201421	Percentage of Infants (0-6 months old) Exclusively Breastfed	🟡	→	68.00	68.00	61.81	70
201422	Prevalence of Underweight and Severely Underweight 0-59 Months Old Children	⚪	⚪	N.D.	5.87	7.15	5

DCF Year: 2014

ID	Performance Indicator	Performance Level		Reference Table			
		External Benchmark	Internal Benchmark	Health Data 2014	Health Data 2013	Nat'l Ave. 2012	Nat'l Target 2016
4.4	Maternal Health						
201423	Percentage of Facility-Based Deliveries	🟢	↑	92.00	85.60	73.87	90
201424	Percentage of Deliveries Attended by Skilled Health Professionals	🟢	↑	93.00	85.60	83.15	90
201425	Contraceptive Prevalence Rate for Modern Family Planning Methods	🟡	↓	57.00	58.30	39.31	65
201426	Percentage of Functional Community Health Teams	🟢	⚪	100.00	ND	78.01	100
4.5	HIV and AIDS						
201427	Percentage of HIV and AIDS local response core criteria adopted at the LGU	🔴		25.00		16.81	100
4.6	Environmental Health						
201428	Percentage of Households with Access to Safe Water	🔴	↓	70.00	81.74	84.06	88
201429	Percentage of Drinking Water Sources Complying with Microbiological Standards	⚪		N.D.		68.10	100
201430	Percentage of Households with Sanitary Toilet Facilities	🔴	↓	63.00	69.50	80.90	90
5.1	Accreditation of Health Facilities						
201431	Percentage of RHUs/Health Centers Engaged with PHIC on Primary Care Benefits (PCB)	🟢	↑	100.00	72.72	37.54	100
201432	Percentage of RHUs/Health Centers Engaged with PHIC on Maternity Care Package (MCP)	🟢	→	100.00	100.00	34.93	100
201433	Percentage of RHUs/Health Centers Engaged with PHIC on TB-DOTS	🟢	↑	100.00	18.18	31.20	100
201434	Utilization Rate of Enrolled NHTS Families of the PCB Package	⚪		N.D.	0.00	35.07	100

Note: Highlighted in Blue are 2014 National Averages used as baseline for new indicators.

Summary of Results

No.	Strategic Thrusts	External Benchmark					Internal Benchmark				
I	Efficient Health Sector Spending (PPAs 1.1)	0	1	2	0	0	1	0	2	0	0
II	Health Facilities Enhancement Program (PPAs 2.1)	1	0	1	0	0	1	0	1	0	●
III	Governance for Health – Internal Management Support (PPAs 3.1 - 3.6)	1	0	5	3	0	0	0	3	0	0
IV	Scaling-Up Public Health Intervention for MDGs (PPAs 4.1 - 4.6)	4	2	5	2	2	2	1	6	2	2
V	Financial Risk Protection (PPAs 5.1)	3	0	0	1	0	2	1	0	0	0

Legend:	
External Benchmark	Performance Descriptions
🟢	Performance in current year is equal to or better than 2016 National Target
🟡	Performance in current year is lower than 2016 National Target but equal to or better than 2012 National Average
🔴	Performance in current year is lower than 2012 National Average
⚪	No Data
●	Not Applicable / Non-endemic LGU

Legend:	
External Benchmark	Performance Descriptions
↑	Performance in current year is better than previous year
→	No change in performance
↓	Performance in current year is not as good as previous year
⚪	No Data
●	Not Applicable / Non-endemic LGU

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Department of Social Welfare and Development
National Household Targeting Office

Family Assessment Form

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Time Started: ___ : ___ ○ AM ○ PM

SYSTEM GENERATED:
Household ID (to be filled up by the encoder) ☐☐☐☐☐☐☐☐☐ – ☐

☐ Encoded ☐ Verified

I. IDENTIFICATION

1. Household Number ☐☐☐☐☐☐☐☐

2. Address
Region *Province* *City / Municipality* *Barangay*
Purok / Zone / Sitio *Street Address*

3. Number of Households in the housing unit ☐☐

4. Contact Number

5. Length of Stay of Household in Barangay ☐☐☐ yrs

6. Number of Sleeping Rooms ☐☐

II. SOCIOECONOMIC INFORMATION

7. In what type of building/house does the household reside?
   - ○ 1. Single House
   - ○ 2. Duplex
   - ○ 3. Apartment / accessoria / condominium / townhouse
   - ○ 4. Commercial / industrial / agricultural building / house
   - ○ 5. Other housing unit (e.g. cave, boat)

8. What type of construction materials are the roofs made of?
   - ○ 1. Strong materials (galvanized iron, aluminum, tile, concrete, brick, stone, asbestos)
   - ○ 2. Light materials (cogon, nipa, anahaw)
   - ○ 3. Salvaged / makeshift materials
   - ○ 4. Mixed but predominantly strong materials
   - ○ 5. Mixed but predominantly light materials
   - ○ 6. Mixed but predominantly salvaged materials

9. What type of construction materials are the outer walls made of?
   - ○ 1. Strong materials (galvanized iron, aluminum, tile, concrete, brick, stone, wood, plywood, asbestos)
   - ○ 2. Light materials (bamboo, sawali, cogon, nipa, anahaw)
   - ○ 3. Salvaged / makeshift materials
   - ○ 4. Mixed but predominantly strong materials
   - ○ 5. Mixed but predominantly light materials
   - ○ 6. Mixed but predominantly salvaged materials

10. What is the tenure status of the housing unit and lot occupied by the household?
    - ○ 1. Own or owner-like possession of house and lot
    - ○ 2. Rent house / room including lot
    - ○ 3. Own house, rent lot
    - ○ 4. Own house, rent-free lot with consent of owner
    - ○ 5. Own house, rent-free lot without consent of owner
    - ○ 6. Rent-free house and lot with consent of owner
    - ○ 7. Rent-free house and lot without consent of owner

11. Does the household own another house and lot?
    - ○ 1. Yes, please specify where the property is located ______________________
    - ○ 2. No

12. What kind of toilet facilities does the household have in the house?
    - ○ 1. Water-sealed
    - ○ 2. Closed pit
    - ○ 3. Open pit
    - ○ 4. Others (pail system, etc.)
    - ○ 5. None

13. Is there electricity in the building / house?
    - ○ 1. Yes
    - ○ 2. No

14. What is the household's main source of water supply?
    - ○ 1. Own use, faucet, community water system
    - ○ 2. Shared, faucet, community water system
    - ○ 3. Own use, tubed / piped well
    - ○ 4. Shared, tubed / piped well
    - ○ 5. Dug Well
    - ○ 6. Spring, river, stream, etc.
    - ○ 7. Rain
    - ○ 8. Peddler

15. How many of each of the following items does the household own? (Input numbers from 0 to 9)
    - ☐ a. Radio
    - ☐ b. Television Set
    - ☐ c. VTR / VHS / VCD / DVD
    - ☐ d. Stereo / CD
    - ☐ e. Refrigerator / Freezer
    - ☐ f. Washing Machine

Continuation of 15
   - ☐ g. Air Conditioner
   - ☐ h. Sala Set
   - ☐ i. Dining Set
   - ☐ j. Car / Jeep
   - ☐ k. Telephone / Cellphone
   - ☐ l. Personal Computer
   - ☐ m. Microwave Oven / Gas Range
   - ☐ n. Motorcycle / Tricycle

16a. Has any household member experienced displacement in the last 12 months?
   - ○ 1. Yes
   - ○ 2. No (*proceed to item 17a*)

16b. If yes, what are the causes? (check all applicable)
   - ☐ 1. Natural / Manmade Disaster
   - ☐ 2. Armed Conflict
   - ☐ 3. Infrastructure Development Project
   - ☐ 4. Other

17a. Has any household member received programs / services from government agencies, LGUs or NGOs?
   - ○ 1. Yes
   - ○ 2. No (*proceed to item 18*)

17b. If yes, what are the programs / services received? (check all applicable)
   - ☐ 1. Scholarship
   - ☐ 2. Day Care Service / ECCD
   - ☐ 3. Supplemental Feeding
   - ☐ 4. Subsidized Rice
   - ☐ 5. Philhealth
   - ☐ 6. Skills / Livelihood Training
   - ☐ 7. Housing
   - ☐ 8. Microcredit
   - ☐ 9. Self-Employment Assistance
   - ☐ 10. Pantawid Pamilya, please specify ID number/s
     - a. ☐☐☐☐☐☐☐☐☐ – ☐☐☐☐☐ – ☐☐☐☐☐
     - b. ☐☐☐☐☐☐☐☐☐ – ☐☐☐☐☐ – ☐☐☐☐☐
     - c. ☐☐☐☐☐☐☐☐☐ – ☐☐☐☐☐ – ☐☐☐☐☐
   - ☐ 11. Other Cash Transfer Program
   - ☐ 12. Other

18. Do you consider your household as part of an Indigenous People's Group?
    - ○ 1. Yes, please specify ______________________
    - ○ 2. No

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19 TOH Type of Household
- ○ 1. Single Family
- ○ 2. Extended Family
- ○ 3. Two or more non-related families / persons

III. HOUSEHOLD ROSTER (PART 1)

Line No	20 Name: Last	First	Middle	Ext	21 Date of Birth: Month	Day	Year	22 Age	23 Sex	24 Preg	25 MS	26 SP	27 RH	28 FN	29 RF	Line No
1																1
2																2
3																3
4																4
5																5
6																6
7																7
8																8
9																9
10																10
11																11
12																12
13																13
14																14
15																15
16																16

CODES

20 Name
Write the complete name of the household member

21 Date of Birth
Write the date of birth of the HH member.
If complete (MDY), proceed to 23 Sex

22 Age
Write the age of the HH member.

23 Sex Sex
1 - Male 2 - Female
If Code 1, proceed to 25 Marital Status

24 Preg Currently Pregnant
1 - Yes 2 - No

25 MS Marital Status
1 - Single
2 - Married
3 - Widowed
4 - Divorced/Separated
5 - Annulled
6 - Unknown

26 SP Solo Parent
1 - Yes 2 - No

27 RH Relationship to Household Head
01 - Household Head
02 - Wife/Spouse
03 - Son/Daughter
04 - Brother/Sister
05 - Son-in-Law/Daughter-in-Law
06 - Grandson/Granddaughter
07 - Father/Mother
08 - Other Relative
09 - Boarder
10 - Domestic Helper
11 - Non-Relative

28 FN Family Number
Write the corresponding number.

29 RF Relationship to Nuclear Family Head
01 - Family Head
02 - Wife/Spouse
03 - Son/Daughter
04 - Brother/Sister
05 - Son-in-Law/Daughter-in-Law
06 - Grandson/Granddaughter
07 - Father/Mother
08 - Other Relative

30 Dis Disability
1 - Yes 2 - No

31 See Seeing
Does ___ have any difficulty/problem in seeing, even when wearing eyeglasses?
1 - Yes 2 - No

32 Hear Hearing
Does ___ have any difficulty/problem in hearing, even when using a hearing aid?
1 - Yes 2 - No

33 Walk Walking or Climbing Steps
Does ___ have any difficulty/problem in walking or climbing steps?
1 - Yes 2 - No

34 Rem Remembering or Concentrating
Does ___ have any difficulty/problem in remembering or concentrating?
1 - Yes 2 - No

35 Care Self-Caring
Does ___ have any difficulty/problem in self-caring (bathing or dressing)?
1 - Yes 2 - No

36 Com Communicating
Does ___ have any difficulty/problem in communicating using his/her usual language?
1 - Yes 2 - No

37 AHF Attending Health Facility
1 - Yes 2 - No
If Code 2, proceed to 39Attending School

38 Name of Health Facility
Write the name of the health facility the HH member goes.

39 AS Attending School / Day Care / Preschool
1 - Yes 2 - No
If Code 2, proceed to 41 Highest Education Attained

40 School / DCC / Preschool
Write the name of school the HH member attends.

41 Educ Highest Education Attained
00 - No Grade Completed
01 - Kinder or Day Care
02 - Grade 1
03 - Grade 2
04 - Grade 3
05 - Grade 4
06 - Grade 5
07 - Grade 6 or Elementary
08 - Grade 7 (1st Year HS)
09 - Grade 8 (2nd Year HS)
10 - Grade 9 (3rd Year HS)
11 - Grade 10 (HS Graduate)
12 - Grade 11
13 - Grade 12
14 - 1st Year College
15 - 2nd Year College
16 - 3rd Year College
17 - 4th Year College or Higher (Undergraduate)
18 - College Graduate
19 - Above (M.A./M.S./Ph.D.)

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ROSTER LIST [ ] of [ ]
count max

III. HOUSEHOLD ROSTER (PART 2)

Line No	30 Dis	31 See	32 Hear	33 Walk	34 Rem	35 Care	36 Com	37 AHF	38 Name of Health Facility	39 AS	40 School / DCC / Preschool	41 Educ	42 Emp	43 JB	44 Primary Occupation / Business	45 PSOC	46 CW	47 BP	48 NE	49 Ove	50 OFI	51 SM	52 HO	Line No
1																								1
2																								2
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CODES

42 Emp Employment
Did _____ do any work/business for at least an hour during the past week?
1 - Yes 2 - No
If Code 1, proceed to 44 Primary Occupation / Business

43 JB Job or Business
Although_____ did not work, does ____ have a job or business?
1 - Yes 2 - No
If Code 2, proceed to 49 Overseas

44 Primary Occupation / Business
Write the primary occupation / business of the HH

45 PSOC Philippine Standard Occupation Code
Leave this column blank. Your AS will fill this out.

46 CW Class of Worker
Where does _____ work? (mention the choices listed)
0 - Worked for private household
1 - Worked for private establishment
2 - Worked for gov't/gov't corporation
3 - Self-employed without any paid employee
4 - Employer in own family-operated farm or business
5 - Worked with pay in own family-operated farm or business
6 - Worked without pay in own family-operated farm or business
If Code 3, 4, 6, proceed to 48 Nature of Employment

47 BP Basis of Payment
What is the basis of the payment that _____ receives? Is it (mention the choices listed below)?
0 - In kind, imputed (received as wage/salary)
1 - Per piece
2 - Per hour
3 - Per day
4 - Monthly
5 - Pakyaw
6 - Other salaries / wages
7 - Not salaries / wages

48 NE Nature of Employment
Is _____'s work permanent, short-term, or on a day-to-day/week-to-week basis?
1 - Permanent job / business / unpaid family work
2 - Short-term or seasonal or casual job / business / unpaid family work
3 - Worked for different employers or customer on day-to-day or week-to-week basis

49 Ove Overseas
Is _____ overseas?
1 - Yes 2 - No
If Code 2, proceed to the next HH member

50 OFI Overseas Filipino Indicator
Is _____ Overseas Contract Worker?
1 - OCW
2 - Workers other than OCW
3 - Employees in Phil Embassy, Consulates & other missions
4 - Students abroad/tourists
5 - Others
If Code 4 or 5, proceed to the next HH member

51 SM Sending money to the household
Does _____ send money to the household?
1 - Yes 2 - No
If Code 2, proceed to the next HH member

52 HO How often member sends money in a year
How often does _____send money?
1 - Once or twice
2 - 3 to11 times
3 - 12 & above

Republic of the Philippines
Department of Social Welfare and Development
National Household Targeting Office

Family Assessment Form

NHTO Rev v2.2.15 - Apr.8.2014

S/N - 1234567890

IV. DECLARATION

I declare that the data set forth herein is true and I authorize its use for social protection programs.

Name of Respondent

Signature of Respondent

Thumbmark of Respondent

V. CERTIFICATION

I declare that the data set forth herein was obtained / reviewed by me personally.

Signature over Printed Name of Enumerator

Date Accomplished: MM - DD - 2 0 1 YYYY

Signature over Printed Name of Field Supervisor

Date Reviewed: MM - DD - 2 0 1 YYYY

REMARKS

Time Ended: ☐☐ : ☐☐ ○ AM ○ PM