

**IMPLEMENTING RULES AND
REGULATIONS
OF THE
UNIVERSAL HEALTH CARE ACT
(REPUBLIC ACT NO. 11223)**

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RULE I. GENERAL PROVISIONS

Section 1. Title

- 1.1. These rules and regulations shall be known as the Implementing Rules and Regulations of Republic Act No. 11223, otherwise known as the Universal Health Care Act, hereinafter referred to as the Act. Hereinafter, these rules and regulations shall be referred to as the Rules.

Section 2. Declaration of Principles and Policies

- 2.1. It is the policy of the State to protect and promote the right to health of all Filipinos and instill health consciousness among them. Towards this end, these Rules shall enforce the Act and its spirit in its entirety, embodying the following principles:
- 2.1.a. An integrated and comprehensive approach to ensure that all Filipinos are health literate, provided with healthy living conditions, and protected from hazards and risks that could affect their health;
 - 2.1.b. A health care model that provides all Filipinos access to a comprehensive set of quality and cost-effective, promotive, preventive, curative, rehabilitative and palliative health services without causing financial hardship and prioritizes the needs of the population who cannot afford such services;
 - 2.1.c. A framework that fosters a whole-of-system, whole-of-government, and whole-of-society approach in the development, implementation, monitoring, and evaluation of health policies, programs and plans; and,
 - 2.1.d. A people-oriented approach for the delivery of health services that is centered on people's needs and well-being, and cognizant of the differences in culture, values, and beliefs.

Section 3. General Objectives

- 3.1. The objectives of these Rules are to:
- 3.1.a. Progressively realize universal health care in the country through a systemic approach and clear delineation of roles of key agencies and stakeholders towards better performance in the health system; and,
 - 3.1.b. Ensure that all Filipinos are guaranteed equitable access to quality and affordable health care goods and services and protected against financial risk.

Section 4. Definition of Terms

For the purposes of these Rules, the following terms are defined as such:

- 4.1. *Abuse of authority* - Refers to an act of a person performing a duty or function that goes beyond what is authorized by the Act and RA 7875 (National Health Insurance Act of 1995), as amended, or their implementing rules and regulations (IRR), and is inimical to the public.
- 4.2. *Amenities* - Refer to features of the health service that provide comfort or convenience, such as private accommodation, air conditioning, telephone, television, and choice of meals, among others.
- 4.3. *Basic or ward accommodation* - Refers to the provision of regular meal, bed in shared room, fan ventilation, and shared toilet and bath.
- 4.4. *Co-insurance* - Refers to a percentage of a medical charge that is paid by the insured, with the rest paid by the health insurance plan.
- 4.5. *Co-payment* - Refers to a flat fee or predetermined rate paid at point of service, as may be determined by the Philippine Health Insurance Corporation (PhilHealth).
- 4.6. *Complementation/complement* - Refers to a strategic partnership of two or more healthcare organizations, particularly public and private providers, to deliver a comprehensive set of health services to a given population or group of people.
- 4.7. *Contracting* - Refers to a process where providers and networks are engaged to commit and deliver quality health services at agreed cost, cost sharing and quantity in compliance with prescribed standards.
- 4.8. *Direct contributors* - Refer to those who have the capacity to pay premiums, are gainfully employed and are bound by an employer-employee relationship, or are self-earning, professional practitioners, migrant workers, including their qualified dependents, and lifetime members.
- 4.9. *Emergency* - Refers to a condition or state of a patient wherein based on the objective findings of a prudent medical officer on duty, there is immediate danger and where delay in initial support and treatment may cause loss of life or permanent disability to the patient, or in the case of a pregnant woman, permanent injury or loss of her unborn child, or a non-institutional delivery.
- 4.10. *Entitlement* - Refers to any singular or package of health services provided to Filipinos for the purpose of improving health.

- 4.11. *Essential health benefit package* - Refers to a set of individual-based entitlements covered by the National Health Insurance Program (NHIP) which includes primary care; medicines, diagnostics and laboratory; and preventive, curative, and rehabilitative services.
- 4.12. *Financial integration* - Refers to the consolidation of financial resources exclusively for health services and health system development under a single planning and investment strategy by the province-wide and city-wide health system.
- 4.13. *Fraudulent act* - Refers to any act of misrepresentation or deception resulting in undue benefit or advantage on the part of the doer or any means that deviate from normal procedure and is undertaken for personal gain, resulting thereafter to damage and prejudice which may be capable of pecuniary estimation.
- 4.14. *Geographically Isolated and Disadvantaged Areas (GIDAs)* - Refer to barangays specifically disadvantaged due to the presence of both physical and socio-economic factors. For a barangay to be classified as GIDA, both physical factor and socio-economic factor must be present. The terms GIDA, unserved and underserved areas are used interchangeably in these Rules.
- 4.14.a. Physical factors are characteristics that limit the delivery of and/or access to basic health services to communities that are difficult to reach due to distance, weather conditions, and transportation difficulties.
- 4.14.b. Socio-economic factors are social, cultural, and economic characteristics of the community that limit access to and utilization of health services.
- 4.15. *Health care provider* - Refers to any of the following:
- 4.15.a. A *health facility* which may be public or private, devoted primarily to the provision of services for health promotion, prevention, diagnosis, treatment, rehabilitation and palliation of individuals suffering from illness, disease, injury, disability, or deformity, or in need of obstetrical or other medical and nursing care.
- 4.15.b. A *health care professional* who may be a doctor of medicine, nurse, midwife, dentist, or other allied professional or practitioner duly licensed to practice in the Philippines.
- 4.15.c. *Community-based health care organization* - Refers to an association of members of the community organized for the purpose of improving the health status of that community.
- 4.15.d. *Pharmacies or drug outlets* - Refer to establishments licensed under RA 9711 (Food and Drug Administration Act of 2009) which sell or offer to sell any health product directly to the general public or entities licensed by appropriate government agencies, and which are involved in compounding and/or dispensing and selling of pharmaceutical products directly to patients or end users as defined under RA 10918 (Philippine Pharmacy Act).
- 4.15.e. *Laboratories and diagnostic clinics* - Refer to licensed facilities where tests are done on the human body or on specimens thereof to obtain information

about the health status of a patient for the prevention, diagnosis and treatment of diseases.

- 4.16. *Health care provider network (HCPN)* - refers to a group of primary to tertiary care providers, whether public or private, offering people-centered and comprehensive care in an integrated and coordinated manner with the primary care provider acting as the navigator and coordinator of health care within the network.
- 4.17. *Health Maintenance Organization (HMO)* - Refers to an entity that provides, offers, or covers designated health services for its plan holders or members for a fixed prepaid premium.
- 4.18. *Health Technology Assessment (HTA)* - Refers to the systematic evaluation of properties, effects, or impact of health-related technologies, devices, medicines, vaccines, procedures and all other health-related systems developed to solve a health problem and improve quality of lives and health outcomes, utilizing a multidisciplinary process to evaluate the social, economic, organizational, and ethical issues of a health intervention or health technology.
- 4.19. *Indirect contributors* - Refer to all others not included as direct contributors, as well as their qualified dependents, whose premium shall be subsidized by the national government including those who are subsidized as a result of special laws.
- 4.20. *Individual-based health services* - Refer to services which can be accessed within a health facility or remotely that can be definitively traced back to one (1) recipient, has limited effect at a population level and does not alter the underlying cause of illness such as ambulatory and inpatient care, medicines, laboratory tests and procedures, among others.
- 4.21. *Managerial integration* - Refers to the consolidation of administrative, technical and managerial functions of the province-wide and city-wide health systems over its resources such as health facilities, human resources for health, health finances, health information systems, health technologies, equipment and supplies.
- 4.22. *Navigation* - Refers to the function of coordinating and directing the individual to obtain health services needed to manage a wide range of health needs.
- 4.23. *Population-based health services* - Refer to interventions such as health promotion, disease surveillance, and vector control, which have population groups as recipients.
- 4.24. *Prepayment* - Refers to an approach in the purchase of health services by which health care providers are paid in advance for the cost of goods and services for a specific package of health benefits based solely on a pre-determined and fixed budget.

- 4.25. *Primary care* - Refers to initial-contact, accessible, continuous, comprehensive and coordinated care that is accessible at the time of need including a range of services for all presenting conditions, and the ability to coordinate referrals to other health care providers in the health care delivery system, when necessary.
- 4.26. *Primary care provider* - Refers to a health care worker, with defined competencies, who has received certification in primary care as determined by the Department of Health (DOH) or any health institution that is licensed and certified by the DOH.
- 4.26.a. *Primary care practice* - Refers to the exercise of duties and responsibilities of multidisciplinary team of health workers which shall be eligible to be assigned to a catchment area/population in a primary care facility.
- 4.26.b. *Primary care facility* - Refers to the institution that primarily delivers primary care services which shall be licensed or registered by the DOH.
- 4.26.c. *Primary care worker* - Refers to a health care worker, who may be a health professional or community health worker/volunteer, certified by DOH to provide primary care services.
- 4.27. *Primary health care* - Refers to a whole-of-society approach that aims to ensure the highest possible level of health and well-being through equitable delivery of quality health services.
- 4.28. *Private health insurance* - Refers to coverage of a defined set of health services financed through private payments in the form of a premium to the insurer.
- 4.29. *Prospective payment* - Refers to a method of reimbursement in which payment is based on a predetermined, fixed amount. The payment amount for a particular service is based on disease or diagnosis-related groupings and validated costing methodologies.
- 4.30. *Public health emergency* - Refers to an occurrence or imminent threat of an illness or health condition that:
- 4.30.a. Is caused by any of the following: (i) bioterrorism; (ii) appearance of a novel or previously controlled or eradicated infectious agent or biological toxin; (iii) a natural disaster; (iv) a chemical attack or accidental release; (v) a nuclear attack or accident; or (vi) an attack or accidental release of radioactive materials; and,
- 4.30.b. Poses a high probability of any of the following: (i) a large number of deaths in the affected population; (ii) a large number of serious injuries or long – term disabilities in the affected population; (iii) widespread exposure to an infectious or toxic agent that poses a significant risk of substantial harm to a large number of people in the affected population; (iv) international exposure to an infectious or toxic agent that poses a significant risk to the health of citizens of other countries; or (v) trade and travel restrictions.
- 4.31. *Recidivist* - Refers to one who, at that time of hearing for an offense, shall have been previously found liable with finality by the Adjudication Office or by the Board of PhilHealth, for three (3) offenses, under these Rules.

4.32. *Unethical act* - Refers to any action, scheme or ploy against the NHIP, such as overbilling, upcoding, harboring ghost patients or recruitment practice, or any act contrary to the Code of Ethics of the responsible person's profession or practice, or other similar, analogous acts that put or tend to put in disrepute the integrity and effective implementation of the NHIP.

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RULE II. UNIVERSAL HEALTH CARE (UHC)

Section 5. Population Coverage

- 5.1. Every Filipino citizen shall be automatically included into the National Health Insurance Program, hereinafter referred to as the Program.
- 5.2. The Philippine Health Insurance Corporation (PhilHealth), shall coordinate with other national government agencies (NGAs) such as but not limited to the Department of Social Welfare and Development (DSWD), Department of Foreign Affairs (DFA), Department of Labor and Employment (DOLE), Department of Trade and Industry (DTI), Civil Service Commission (CSC), Bureau of Internal Revenue (BIR), Philippine Overseas Employment Administration (POEA), Overseas Workers Welfare Administration (OWWA), Philippine Statistics Authority (PSA), Social Security System (SSS), the Government Service Insurance System (GSIS), and health care facilities towards the inclusion of all Filipinos in its database at no cost. This is without prejudice to future laws or guidelines that may affect the identification or enumeration of Filipinos.

Section 6. Service Coverage

Immediate Eligibility to Benefits

- 6.1. Every Filipino shall be granted immediate eligibility and access to preventive, promotive, curative, rehabilitative, and palliative care for medical, dental, mental and emergency health services, delivered as population-based or individual-based health services; *Provided*, That a fair and transparent health technology assessment (HTA) process, as described in Section 34 of these Rules, shall govern the inclusion of health goods and services to which every Filipino is eligible to access through PhilHealth and DOH.
- 6.2. The DOH and PhilHealth shall define specific health service packages for population-based and individual-based health services in accordance with the provisions in Sections 17 and 18 of these Rules, respectively.

Comprehensive Outpatient Benefits

- 6.3. Within two (2) years from the effectivity of these Rules, PhilHealth shall implement a comprehensive outpatient benefit, including outpatient drug benefit and emergency medical services, in accordance with the recommendation of Health Technology Assessment Council (HTAC) as prescribed under Section 34 of these Rules. The benefits shall include, but are not limited to: services of health care professionals; diagnostic, laboratory, dental and other medical services; personal preventive services;

prescription drugs and biologicals, subject to the limitations of the Act; and other services deemed appropriate.

Provision of Primary Care Providers

- 6.4. The DOH and local government units (LGUs) shall endeavor to provide a health care delivery system that shall afford every Filipino a primary care provider, as defined in Section 4.26 of these Rules.
- 6.5. The primary care provider shall act as the navigator, initial and continuing point of contact in health care delivery system; *Provided*, That except in emergency or serious cases and when proximity is a concern, access to higher levels of care shall be coordinated by the primary care provider.

Registration of Filipinos to Primary Care Provider Networks

- 6.6. Every Filipino shall register with a public or private primary care provider of choice with due consideration to proximity and ease of travel of those seeking care, absorptive capacity of the provider for quality care, and provider capability to deliver the required services, among others.
- 6.7. The LGUs, with the assistance from DOH and PhilHealth, shall register their respective constituents to a primary care provider within their territorial jurisdiction; *Provided*, That the DOH, in coordination with PhilHealth, shall promulgate the guidelines on the registration of every Filipino to a primary care provider that stipulate the standard processes, procedures, guidelines, form, and data management, among others.
- 6.8. The DOH shall issue guidelines for the licensing of primary care providers in accordance with Sections 27.4 and 27.5 of these Rules.

Section 7. Financial Coverage

- 7.1. Population-based health services shall be financed by the national government through the DOH and provided free of charge at point of service for all Filipinos.
 - 7.1.a. The DOH, in coordination with PhilHealth, Department of Budget and Management (DBM) and the Department of the Interior and Local Government (DILG), in consultation with LGUs and health care providers and partners, shall identify the milestones for the transition of other sources of financing of health facilities to improve the prospective PhilHealth payment mechanism as described in Section 18 of these Rules.
 - 7.1.b. Other NGAs, LGUs, international health partners, and other stakeholders shall adhere to the UHC priorities set by DOH and ensure complementation in health financing.

- 7.2. The national government shall support LGUs in the financing of capital investments and provision of population-based health services.
- 7.3. Individual-based health services shall be financed primarily through prepayment mechanisms such as social health insurance, private health insurance, and HMO plans to ensure predictability of health expenditures; *Provided*, That the DOH and PhilHealth, in consultation with the Insurance Commission, private health insurance and HMOs, shall issue guidelines and monitoring schemes in order to rationalize financing schemes and to ensure that there is complementation in the financing coverage of individual-based health services in accordance with Sections 18 and 28.23 of these Rules.
- 7.4. Province-wide and city-wide health systems, as described in Section 19 of these Rules, shall ensure funding for effective health operations and conduct of activities such as but not limited to capacity building, research, and health promotion consistent with national guidelines and with support from the DOH.

RULE III. NATIONAL HEALTH INSURANCE PROGRAM

Section 8. Program Membership

- 8.1. Membership into the Program shall be simplified into two (2) types, direct contributors and indirect contributors, as defined in Section 4.8 and 4.19 of these Rules respectively, with their qualified dependents, namely:
 - 8.1.a. Legal spouse/s who is/are not an active member;
 - 8.1.b. Unmarried and unemployed legitimate, illegitimate children, and legally adopted or stepchildren below twenty-one (21) years of age;
 - 8.1.c. Foster children as defined in RA 10165 (Foster Care Act of 2012); and,
 - 8.1.d. Parents who are sixty (60) years old and above, not otherwise an enrolled member.

- 8.2. Direct contributors, including their qualified dependents shall be composed of, but not limited to, the following:
 - 8.2.a. Employees with formal employment characterized by the existence of an employer-employee relationship, which include workers in the government and private sector, whether regular, casual, or contractual, are occupying either an elective or appointive position, regardless of the status of appointment, whose premium contribution payments are equally shared by the employee and the employer;
 - 8.2.b. *Kasambahays*, as defined in RA 10361 (Domestic Workers Act);
 - 8.2.c. All other workers who are not covered by formal contracts or agreements or who have no employee-employer relationship and whose premium contributions are self-paid, and with capacity to pay premiums, such as the following:
 - 8.2.c.i. Self-earning individuals; and
 - 8.2.c.ii. Professional practitioners;
 - 8.2.d. Overseas Filipino Workers, as defined in RA 10022 (Migrant Workers Act) and RA 10801 (OWWA Act) such as, but not limited to:
 - 8.2.d.i. Sea-based Filipino workers or seafarers; and,
 - 8.2.d.ii. Land-based overseas Filipino workers;
 - 8.2.e. Filipinos living abroad;
 - 8.2.f. Filipinos with dual citizenship;
 - 8.2.g. Lifetime members as defined in RA 10606 (National Health Insurance Act); and,
 - 8.2.h. All Filipinos aged 21 years and above who have the capacity to pay premiums.

- 8.3. Direct contributors shall register and/or update their records and premium contributions with PhilHealth upon the effectivity of these Rules.

- 8.4. Indirect contributors, including their qualified dependents shall be composed of, but not limited to, the following:
- 8.4.a. Indigents identified by the DSWD;
 - 8.4.b. Beneficiaries of *Pantawid Pamilyang Pilipino Program/Modified Conditional Cash Transfer (4Ps/MCCT)*;
 - 8.4.c. Senior citizens who are not currently covered by the Program;
 - 8.4.d. Persons with disability, as defined in RA 10754 (An Act Expanding the Benefits and Privileges of Persons with Disability);
 - 8.4.e. All Filipinos aged 21 years old and above without the capacity to pay premiums;
 - 8.4.f. *Sangguniang Kabataan* officials, as defined in RA 10742 (*Sangguniang Kabataan Reform Act*); and,
 - 8.4.g. Those previously identified at point-of-service (POS) or during registration, members previously sponsored by LGUs and those who are not yet in the PhilHealth database and are financially incapable to pay premiums.
- 8.5. PhilHealth shall authorize the DSWD or social welfare officers of the LGUs to determine those who are financially incapable to pay premiums.

Section 9. Entitlement to Benefits

Benefit Availment

- 9.1. Every member shall be granted immediate eligibility for health benefit packages without the need of presenting the PhilHealth identification card under the Program; *Provided*, That this does not preclude the necessity to present any valid identification for purposes of proving identity. Those who are not in the PhilHealth database shall be duly registered by health care facilities, subject to the guidelines that will be issued by PhilHealth.
- 9.2. Failure to pay premiums shall not prevent the enjoyment of any Program benefits. However, employers and self-employed direct contributors shall be required to pay all missed contributions with an interest, compounded monthly:
- 9.2.a. At least three percent (3%) for employers of private and government sector, sea-based migrant workers; and *kasambahays*; and,
 - 9.2.b. Not exceeding one and one-half percent (1.5%) for self-earning individuals, professional practitioners, land-based migrant workers, Filipinos living abroad; and Filipinos with dual citizenship.
- 9.3. Failure by the employer and self-employed direct contributors to pay premium contributions shall constitute an offense as provided for under Section 38 of the Act.

No Co-payment Policy

- 9.4. No other fees or expenses, including professional fees, shall be charged to all members admitted in any basic or ward accommodations.
- 9.5. Members who opt for basic or ward accommodations shall be provided all necessary services and complete quality care to attain the best possible health outcomes.
- 9.6. In the absence of available beds and transfer to another facility is not feasible, members who opt for basic or ward accommodation but admitted in non-basic accommodation shall be entitled to no co-payment for services, professional fees, and amenities.
- 9.7. In the event of change in level of care, members who opt for basic or ward accommodation shall be considered as such unless otherwise chosen by the patient or legal next of kin.
- 9.8. Members who opt for admissions in non-basic or non-ward accommodations may be charged co-payments/co-insurance for services, professional fees, and amenities.
- 9.9. PhilHealth shall issue guidelines to operationalize the no co-payment policy.

Co-Payments and Co-Insurance

- 9.10. The DOH and PhilHealth shall prescribe the guidelines for co-payment or co-insurance in determining the additional services that are not included in the minimum standards of care in the management of the conditions and charges for amenities outside the basic or ward accommodation.
- 9.11. The DOH, PhilHealth, and health facilities are required to regularly inform all members of the co-payment or co-insurance scheme, as prescribed by DOH and PhilHealth, for public health care providers and public-led health care provider networks, and of the co-payment or co-insurance scheme agreed upon by PhilHealth with private health care providers and private-led networks.
- 9.12. The DOH, PhilHealth, HMOs, and life and non-life private health insurance (PHIs) are required to regularly inform all members of the complementation and co-insurance policies as prescribed in Section 28.23 of these Rules.

PhilHealth Benefits

- 9.13. Existing benefit packages shall continue to be implemented or enhanced unless otherwise recommended by the HTA process established in Section 34 of these Rules.

- 9.14. PhilHealth shall issue the necessary guidelines on the additional Program benefits for direct contributors, where applicable.

Section 10. Premium Contributions

Direct Contributors

- 10.1. Premium rates shall be in accordance with the following schedule, and monthly income floor and ceiling, upon the effectivity of these Rules:

Year	Premium Rate	Income Floor	Income Ceiling
2019	2.75 %	Php 10,000.00	Php 50,000.00
2020	3.00 %	Php 10,000.00	Php 60,000.00
2021	3.50 %	Php 10,000.00	Php 70,000.00
2022	4.00 %	Php 10,000.00	Php 80,000.00
2023	4.50 %	Php 10,000.00	Php 90,000.00
2024	5.00 %	Php 10,000.00	Php 100,000.00
2025	5.00 %	Php 10,000.00	Php 100,000.00

Direct contributors earning below the income floor shall pay their premium contribution based on the income floor; *Provided*, That those earning above the income ceiling shall pay their premium contribution based on the income ceiling; *Provided further*, That for any income from the income floor to the income ceiling, the premium contribution shall be computed based on the basic monthly income.

- 10.2. The following special provisions shall apply to the following:
- 10.2.a. *Self-earning individuals and practicing professionals* – The premium contribution shall be computed based on the individual’s monthly income as shown in documents prescribed by PhilHealth. Non-submission of acceptable proof of actual income shall result in the charging of the rate based on the income ceiling. PhilHealth shall establish guidelines defining the acceptable proof of actual income.
 - 10.2.b. *Kasambahays* - Premium payments or contributions of *Kasambahays* shall be shouldered by the employer. However, if the *kasambahay* is receiving a wage of five thousand pesos (P5,000.00) and above per month, the *kasambahay* shall pay the proportionate share in the premium payments or contributions, in accordance with RA 10361 (Domestic Workers Act).

- 10.2.c. *Overseas Filipino Workers* - The premium contribution shall be salary-based as prescribed by the Act and shall require submission of acceptable proof of actual income. Non-submission of acceptable proof of actual income shall result in the charging of the rate based on the income ceiling. The Philippine Overseas Employment Administration (POEA) shall ensure that land-based overseas Filipino workers, whether new hires or returning (*balik manggagawa*), pay their PhilHealth premiums prior to issuance of the Overseas Employment Certificate (OEC). Specific guidelines shall be issued by the POEA and PhilHealth.
- 10.2.d. *Persons with disability* – Premium payments or contributions of formally employed persons with disability shall be shared equally by their employers and the national government.
- 10.2.e. All Filipinos aged 21 years and above who have the capacity to pay shall pay their premiums based on PhilHealth guidelines.

Indirect Contributors

- 10.3. The premium subsidy for indirect contributors shall be gradually adjusted and included annually in the General Appropriations Act (GAA) under the line item for PhilHealth and shall be released directly to PhilHealth. The DOH, in coordination with PhilHealth, may request Congress to appropriate supplemental funding to meet targeted milestones of the Act.
- 10.4. For every increase in the rate of contribution of direct contributors and premium subsidy of indirect contributors, PhilHealth shall provide for a corresponding increase in benefits, subject to financial sustainability; *Provided*, That PhilHealth shall coordinate with the DBM on the budgetary requirements for such increase.
- 10.5. PhilHealth shall issue specific and necessary guidelines for direct and indirect contributors with regard to membership registration and premium payment.

Section 11. Program Reserve Funds

- 11.1. PhilHealth shall set aside a portion of its accumulated revenues not needed to meet the cost of the current year's expenditures as reserve funds.
- 11.2. The total amount of reserves shall not exceed a ceiling equivalent to the amount actuarially estimated for two (2) years' projected Program expenditures.
- 11.3. Whenever actual reserves exceed the required ceiling at the end of the fiscal year, the excess of the PhilHealth reserve fund shall be used to increase the Program's benefits and to decrease the amount of members' contributions.
- 11.4. Any unused portion of the reserve fund that is not needed to meet the current expenditure obligations or support the abovementioned programs shall be placed in

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- 11.4. Any unused portion of the reserve fund that is not needed to meet the current expenditure obligations or support the abovementioned programs shall be placed in

investments to earn an average annual income at prevailing rates of interest and shall be referred to as the Investment Reserve Fund.

- 11.5. The Investment Reserve Fund shall be invested in any or all the following:
- 11.5.a. In interest-bearing bonds, securities or other evidences of indebtedness of the Government of the Philippines; *Provided*, That such investment shall be at least fifty percent (50%) of the reserve fund;
 - 11.5.b. In debt securities and corporate bonds of prime or solvent corporations created or existing under the laws of the Philippines; *Provided*, That:
 - 11.5.b.i. The issuing or its predecessor entity shall not have defaulted in the payment of interest on any of its securities;
 - 11.5.b.ii. The securities are issued by companies with high growth opportunities and earning potentials; and,
 - 11.5.b.iii. Such investments shall not exceed thirty percent (30%) of the reserve fund;
 - 11.5.c. In interest-bearing deposits and loans to or securities in any domestic bank doing business in the Philippines; *Provided*, That:
 - 11.5.c.i. In the case of such deposits, this shall not exceed at any time the unimpaired capital and surplus or total private deposits of the depository bank, whichever is smaller; and,
 - 11.5.c.ii. The bank is designated as a depository for this purpose by the Monetary Board of the Bangko Sentral ng Pilipinas;
 - 11.5.d. In preferred stocks of any solvent corporation or institution created or existing under the laws of the Philippines listed in the stock exchange with proven track record or profitability over the last three (3) years and payment of dividends for a period of at least three (3) years immediately preceding the date of investment in such preferred stocks;
 - 11.5.e. In common stocks of any solvent corporation or institution created or existing under the laws of the Philippines listed in the stock exchange with high growth opportunities and earnings potentials;
 - 11.5.f. In bonds, securities, promissory notes, or other evidences of indebtedness of accredited and financially sound medical institutions exclusively to finance the construction, improvement and maintenance of hospitals and other medical facilities: *Provided*, That:
 - 11.5.f.i. Such securities and instruments are guaranteed by the Republic of the Philippines or the issuing medical institution and the issued securities are both rated triple 'A' by authorized accredited domestic rating agencies; and,
 - 11.5.f.ii. Said investments shall not exceed ten percent (10%) of the total reserve fund; and,
 - 11.5.g. In debt instruments and other securities traded in the secondary markets with the same intrinsic quality as those enumerated in Sections 11.5.a. to 11.5.e. of these Rules, subject to the approval of the PhilHealth Board.

- 11.6. No portion of the reserve fund or income thereof shall accrue to the general fund of the national government or to any of its agencies or instrumentalities, including government-owned or -controlled corporations.
- 11.7. As part of its investments operations, PhilHealth may hire institutions with valid trust licenses as its external local fund managers to manage the reserve fund, as it may deem appropriate, through public bidding. The fund manager shall submit an annual report on investment performance to PhilHealth.
- 11.8. The PhilHealth shall set up the following funds:
 - 11.8.a. A fund to secure benefit payouts to member prior to their becoming lifetime members;
 - 11.8.b. A fund to secure payouts to lifetime members; and,
 - 11.8.c. A fund for optional supplemental benefits that are subject to additional contributions.
- 11.9. A portion of each of the above funds shall be identified as current and kept in liquid instruments. In no case shall said portion be considered part of invested assets.
- 11.10. The PhilHealth shall allocate a portion of all contributions to the fund for lifetime members based on an allocation to be determined by the PhilHealth actuary based on a pre-determined percentage using the current average age of members and the current life expectancy and morbidity curve of Filipinos.
- 11.11. PhilHealth shall manage the supplemental benefits and the lifetime members' funds in an actuarially sound manner.
- 11.12. PhilHealth shall manage the supplemental benefits fund to the minimum required to ensure that the supplemental benefit payments are secure.
- 11.13. PhilHealth shall formulate Specific Investment Guidelines with due and prudent regard for the safety, growth, and liquidity of the Fund, subject to the approval of the PhilHealth Board.

Section 12. Administrative Expenses

- 12.1. No more than seven and one-half percent (7.5%) of the actual total premium collected from direct and indirect contributory members during the immediately preceding year shall be allotted for the administrative cost of implementing the Program.

Section 13. PhilHealth Board of Directors

- 13.1. The PhilHealth Board of Directors, hereinafter referred to as the Board, is hereby reconstituted to have a maximum of thirteen (13) members, consisting of the following:

- 13.1.a. Five (5) *ex officio* members, namely: Secretary of Health, Secretary of Social Welfare and Development, Secretary of Budget and Management, Secretary of Finance; and Secretary of Labor and Employment;
 - 13.1.b. Three (3) expert panel members with expertise in public health, management, finance, and health economics; and,
 - 13.1.c. Five (5) sectoral panel members representing the direct contributors, indirect contributors, employers group; health care providers to be endorsed by their national associations of health care institutions and health care professionals; and, representative of the elected local chief executives to be endorsed by the League of Provinces of the Philippines, League of Cities of the Philippines and League of Municipalities of the Philippines.
- 13.2. At least one (1) of the expert panel members and at least two (2) of the sectoral panel members are women.
 - 13.3. The sectoral and expert panel members must be Filipino citizens and of good moral character.
 - 13.4. The expert panel members must:
 - 13.4.a. Be of recognized probity and independence and must have distinguished themselves professionally in public, civic or academic service;
 - 13.4.b. Be in the active practice of their professions for at least seven (7) years; and,
 - 13.4.c. Not be appointed within one (1) year after losing in the immediately preceding elections, whether regular or special.
 - 13.5. The Secretary of Health shall be an *ex officio* nonvoting Chairperson of the Board.
 - 13.6. All appointive members of the Board shall be required to undergo training in health care financing, health systems, costing health services and HTA prior to the start of their term. Noncompliance shall be a ground for dismissal.
 - 13.7. Within thirty (30) days following the effectivity of the Act, the Governance Commission for Government-Owned or -Controlled Corporations (GCG) shall, in accordance with the provisions of RA 10149 (Government-Owned or -Controlled Corporations (GOCC) Governance Act of 2011), promulgate the nomination and selection process for appointive members of the Board with a clear set of qualifications, credentials, and recommendation from the concerned sectors.

Section 14. President and Chief Executive Officer (CEO) of PhilHealth

- 14.1. Upon the recommendation of the Board, the President of the Philippines shall appoint the President and CEO of PhilHealth from the Board's non-*ex officio* members: *Provided*, That the Board cannot recommend a President and CEO of PhilHealth unless

the member is a Filipino citizen and must have at least seven (7) years of experience in the field of public health, management, finance, and health economics or a combination of any of these expertise.

Section 15. PhilHealth Personnel as Public Health Workers.

- 15.1. All PhilHealth personnel shall be classified as public health workers in accordance with the pertinent provisions under RA 7305 (Magna Carta for Public Health Workers) and shall be entitled to Magna Carta benefits for public health workers.

Section 16. Additional Powers and Functions of PhilHealth

- 16.1. PhilHealth shall have the following additional powers and functions:
- 16.1.a. To fix the reasonable compensation, allowances and other benefits of all positions, including its President and CEO, based on a comprehensive job analysis and audit of actual duties and responsibilities, subject to the approval of the President of the Philippines. The compensation plan shall be comparable with government social security institutions and shall be subject to periodic review by the Board no more than once every four (4) years without prejudice to merit reviews or increases based on productivity and efficiency;
 - 16.1.b. To establish the organizational structure and staffing pattern of PhilHealth's central and regional offices to cover as many provinces, cities, and legislative districts, including foreign countries, whenever and wherever it may be expedient, necessary, and feasible; and to inspect or cause to be inspected periodically such offices subject to the approval by the Board;
 - 16.1.c. To maintain a Provident Fund which consists of contributions made by both PhilHealth and its officials and employees and earnings thereon, for the payment of benefits to such officials and employees or their dependents or heirs under such terms and conditions as may be prescribed by the Board; *Provided*, That any changes to the existing employer contribution shall be subject to the approval of the President of the Philippines, upon the recommendation of the PhilHealth Board; and,
 - 16.1.d. To adopt or approve the annual and supplemental budget of receipts and expenditures including salaries, allowances and early retirement of PhilHealth personnel and to authorize such capital and operating expenditures and disbursements as may be necessary and proper for the effective management and operation of PhilHealth; *Provided*, That this shall be subject to the budgetary limitations stated under Section 12 of these Rules; *Provided, further*, That the submission of the corporate budget to the DBM shall be for information purpose only.

RULE IV. HEALTH SERVICE DELIVERY

Section 17. Population-based Health Services

Definition

- 17.1. Health services shall be classified as population-based health services if they fulfill any of the following criteria:
- 17.1.a. Intended to be received by populations or identified groups of people, of which outcomes contribute to the general public health, safety and protection; and,
 - 17.1.b. Rendered in response to a public health emergency or disaster or any circumstance of equal magnitude, such as diseases for elimination, that has affected, or can potentially affect, a population.

Network Contracting

- 17.2. The DOH shall endeavor to contract province-wide and city-wide health systems as described in Section 19 of these Rules, including BARMM, through a legal instrument to ensure shared responsibilities and accountabilities among members of the health system for the delivery of population-based health services including those that impact on the social determinants of health.
- 17.3. Province-wide and city-wide health systems shall have the following minimum population-based health service components:
- 17.3.a. A primary care provider network, which refers to a coordinated group of public, private or mixed primary care providers, as the foundation of the health care provider network. The primary care provider network shall provide primary care services; serve as initial contact and navigator to guide patients' decision making for cost-efficient and appropriate levels of care, and coordinate patients to facilitate two-way referrals and remove barriers to health services; enable patient records to be accessible throughout the health system; and, implement public health services such as vector control and sanitation as may be determined by the DOH;
 - 17.3.b. Accurate, sensitive and timely epidemiologic surveillance systems, which refer to the continuous systematic collection, analysis, interpretation, and timely dissemination of health data for planning, implementation, and evaluation of public health programs, in accordance with Sections 31 and 36 of these Rules;
 - 17.3.c. Proactive, effective and evidence-based health promotion programs or campaigns, including an analysis of and strategies to address social determinants of health, as described in Section 30 of these Rules.; and,
 - 17.3.d. Timely, effective, and efficient preparedness and response to public health emergencies and disasters, and such other means to ensure delivery of population-based health services.

- 17.4. To facilitate the provision of population-based health services, a public health unit shall be established in all hospitals to support the implementation of national public health programs; institutionalize a coordination mechanism with primary care provider networks; and provide a one-stop shop patient navigation support mechanism within the hospital.
- 17.5. The DOH shall issue guidelines for contracting province-wide and city-wide health systems for the delivery of population-based health services.

Financing of Population-based Health Services

- 17.6. The DOH shall finance population-based health services and provide support in financing capital investments, human resources for health capacity building, health systems development, among others, to complement local government resources for health.

Section 18. Individual-based Health Services.

Classifying Individual-based Health Services

- 18.1. Health services shall be classified as individual-based, whether accessed through health care facilities or remotely through the use of digital technologies for health, if these can be definitively traced back to one (1) recipient, has limited effect at a population level, and does not alter the underlying cause of illness. Such services include, but are not limited to, ambulatory and inpatient care, medicines, laboratory tests and procedures.

Network Contracting

- 18.2. PhilHealth shall endeavor to contract public, private, or mixed health care provider networks through service-level agreements for the delivery of individual-based health services; *Provided*, That the following conditions are present:
 - 18.2.a. Members' access to services shall not be compromised;
 - 18.2.b. Networks agree to service quality, co-payment/co-insurance, and data submission standards;
 - 18.2.c. During the transition, PhilHealth and DOH shall incentivize health care providers that form networks; and,
 - 18.2.d. Apex or end-referral hospitals, as determined by the DOH, may be contracted as stand-alone health care providers by PhilHealth.
- 18.3. The DOH shall provide PhilHealth an updated list of public and private apex or end-referral hospitals within the last quarter of every year.



- 18.4. The contracted networks shall provide individual-based primary to tertiary health care services with the following minimum components:
- 18.4.a. Assurance of member access to all levels of the health care provider networks, including use of digital technologies for health;
 - 18.4.b. A primary care provider network, as described in Section 17 of these Rules, linked to secondary and/or tertiary care providers; *Provided*, That hospitals shall focus on providing specialist outpatient services, except in selected cases such as, but not limited to, gaps in the provision of primary care services and where proximity is a concern, subject to issuance of guidelines by DOH and PhilHealth;
 - 18.4.c. A patient navigation and coordination system that ensures a continuum of appropriate and coordinated care from primary to tertiary services, and back to primary care;
 - 18.4.d. Patient records management system, including electronic health records, that ensures records are accessible by all facilities or providers within the health care provider networks or among other facilities as necessary;
 - 18.4.e. Provider payment mechanism as provided in Section 18.9 and 18.10 of these Rules, based on the guidelines of PhilHealth, as appropriate;
 - 18.4.f. Networks exhibiting proof of legal personality; and,
 - 18.4.g. Mechanism of pooled fund management in the network.
- 18.5. Minimum requirements for contracting health care provider networks are as follows:
- 18.5.a. All health care facilities within the network shall be licensed or accredited by the DOH, as applicable; and,
 - 18.5.b. All health care providers within the network shall execute or sign a performance contract with PhilHealth.
- 18.6. Contracted networks and their health care provider members shall be subjected to the quasi-judicial powers of PhilHealth.
- 18.7. The DOH and PhilHealth shall determine the standards on service quality and data submission.
- 18.8. The DOH and PhilHealth shall incentivize health care providers that form networks in accordance with the guidelines to be developed for the selection and payment of health care provider network based on Section 41.6 of these Rules.

Financing of Individual-based Health Services

- 18.9. PhilHealth shall:
- 18.9.a. Continue to finance individual-based health services utilizing current payment mechanisms such as capitation and case rate payments. However, for contracted networks and apex hospitals, it shall endeavor to shift to paying providers using performance driven, closed-end, prospective payments based on Diagnosis-Related Groupings (DRGs) and validated

costing methodologies and without differentiating facility and professional fees;

- 18.9.b. Develop differential payment schemes that give due consideration to service quality, efficiency, equity, and public health outcomes; and,
 - 18.9.c. Institute strong surveillance and audit mechanisms to ensure networks' compliance to contractual obligations.
- 18.10. PhilHealth shall adopt any or a combination of closed-end, prospective provider payment mechanisms, such as capitation, global budget, case-based payment, per diem or daily charges, and other appropriate mechanisms; *Provided*, That PhilHealth, in consultation with stakeholders, shall issue guidelines for the implementation of provision.
- 18.11. All individual-based health services, including those transitioned from population-based health services, shall be covered by PhilHealth; *Provided*, That all current benefit packages of PhilHealth shall continue to be covered as individual-based services unless reclassified by the DOH as population-based services.
- 18.12. Services that meet both population-based and individual-based health services criteria, or neither of the criteria, shall retain its current financing mechanism; *Provided*, That these health services shall be subject to assessments by the DOH in determining the most efficient financing mechanism; *Provided, further*, That DOH and PhilHealth shall issue the guidelines for implementing this provision.



RULE V. ORGANIZATION OF LOCAL HEALTH SYSTEMS

Section 19. Integration of Local Health Systems into Province-wide and City-wide Health System

Roles and Responsibilities in the Integration of Local Health Systems

- 19.1. The DOH, DILG, PhilHealth, and LGUs shall endeavor to integrate all local health systems into province-wide health system to be composed of municipal and component city health systems; and city-wide health systems to refer to Highly Urbanized City (HUC)- and Independent Component City (ICC)-wide health systems.
- 19.2. The local health system refers to all health offices, facilities and services, human resources, and other operations relating to health under the management of the LGUs to promote, restore or maintain health; *Provided*, That community-based health care facilities administered or operated by LGUs are considered to form part of the local health system.
- 19.3. The private sector shall also be encouraged to participate in the integrated local health system, which is a public-led health care provider network, through a contractual arrangement with the province-wide or city-wide health system, subject to existing laws and policies, *Provided*, That private health care providers, whether an individual provider or a network of providers, may provide health services to complement health services provided by public health facilities; *Provided, further*, That other services to support the management of the province-wide health system/city-wide health system may also be contracted out to private entities.
- 19.4. In the case of the Bangsamoro Autonomous Region in Muslim Mindanao, the adoption of the integrated province-wide and city-wide health systems shall be in accordance with Article IX Section 22 of RA 11054 (Organic Law for the Bangsamoro Autonomous Region in Muslim Mindanao) and subsequent laws and issuances to be enacted by the Bangsamoro Government.
- 19.5. The DOH shall provide or facilitate the provision of necessary support and incentives to assist the LGUs in integrating their local health systems into province-wide and city-wide health systems that are resilient, sustainable, and responsive to the needs of the population; *Provided*, That the assistance shall include financial and non-financial matching grants to strengthen health systems management and health service delivery; *Provided, further*, That the DOH shall provide an environment that promotes the exchange of knowledge and good practices among the levels of the health care delivery system.

- 19.6. The DILG and the DOH shall facilitate the integration of local health systems into province-wide and city-wide health systems through a mechanism of cooperative undertakings among the LGUs to ensure the effective and efficient delivery of health services, provided under Section 33 of RA 7160 (Local Government Code of 1991).
- 19.7. PhilHealth and DOH shall issue and provide incentives to health care providers that would form networks, whether public, private, or mixed, in accordance with Section 18.2 of these Rules.
- 19.8. Province-wide and city-wide health systems shall deliver both population-based and individual-based health services.
- 19.9. LGUs that commit to province-wide and city-wide integration shall ensure managerial and financial integration and provide the needed resources and support mechanisms to make the integration possible and sustainable.

Provincial Integration

- 19.10 The municipalities and component cities shall endeavor to integrate their Municipal Health Offices, Component City Health Offices, Municipal Hospitals, Component City Hospitals, and LGU-managed health care providers, with the Provincial Health Office, Provincial Hospital(s), and District Hospitals to constitute the province-wide health system. The municipal and component city shall retain their existing functions over their respective health facilities and personnel under RA 7160 (Local Government Code of 1991); *Provided*, That the Provincial Health Board shall exercise administrative and technical supervision over health facilities and services, health personnel, and all other health resources within their territorial jurisdiction; *Provided, further*, That the concerned LGU may opt to transfer the control of such health resources and services to the province-wide health system through a mechanism of cooperative undertakings provided under Section 33 of RA 7160 (Local Government Code of 1991).
- 19.11. The province-wide health system, through the Provincial Health Office, shall be responsible for the delivery of the promotive, preventive, curative, rehabilitative and palliative components of health care within the province. The province-wide health system shall be linked to at least one (1) apex or end-referral hospital.
- 19.12. The Provincial Health Office, headed by a Provincial Health Officer, shall be responsible for health service delivery and health systems management; *Provided*, That the appropriate organizational structure and staffing pattern shall be implemented in consideration of the size, population and geography of the province, subject to the minimum qualification standards and guidelines approved by the Civil Service Commission (CSC).
 - 19.12.a. Each Provincial Health Office shall have at least two (2) divisions, the Health Service Delivery Division headed by an Assistant PHO, and the Health Systems Support Division headed by another official of equivalent rank;

- 19.12.b. An enabling provincial ordinance shall be passed to create the Assistant PHO and another official of equivalent rank as plantilla items, if not yet existing, subject to the minimum qualification standards and guidelines approved by the Civil Service Commission (CSC);
- 19.12.c. The health service delivery function refers to the management of the health service delivery operations of primary care provider networks, hospitals and other health facilities, clinical services, and public health programs including health promotion, epidemiologic surveillance, and disaster risk reduction and management, within the province-wide health system;
- 19.12.d. The health systems support function refers to the management of health financing, health information system, procurement and supply chain for health products and services, local health regulation, health human resource development, and health resilience, among others, in close coordination with the concerned offices of the provincial government; and,
- 19.12.e. In consideration of the size, population, and geography of the province, a group of adjacent municipalities and component cities may form sub-provincial health systems for effective health service delivery and management of health systems.

City Integration

- 19.13. HUCs and ICCs shall endeavor to integrate their health offices, health centers or stations, hospitals, and other city-managed health facilities to constitute the city-wide health system; *Provided*, That the city-wide health system, through its City Health Office, shall be responsible for the delivery of the promotive, preventive, curative, rehabilitative and palliative components of health care within the city; *Provided further*, That the city-wide health system shall be linked to at least one (1) apex or end-referral hospital.
- 19.14. The City Health Office, headed by a City Health Officer, shall be responsible for health service delivery and health systems management; *Provided*, That the appropriate organizational structure and staffing pattern shall be implemented in consideration of the size, population and geography of the city, subject to the minimum qualification standards and guidelines approved by the Civil Service Commission (CSC).
- 19.15. Each City Health Office shall have at least two (2) divisions, the Health Service Delivery Division headed by an Assistant CHO, and the Health Systems Support Division headed by another official of equivalent rank.
 - 19.15.a. An enabling city ordinance shall be passed to create the Assistant CHO and another official of equivalent rank as plantilla items, if not yet existing, subject to the minimum qualification standards and guidelines approved by the Civil Service Commission (CSC).
 - 19.15.b. The health service delivery function refers to the management of the health service delivery operations of primary care provider networks, hospitals and other health facilities, clinical services, and public health programs including

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health promotion, epidemiologic surveillance, and disaster risk reduction and management within the city-wide health system.

- 19.15.c The health systems support function refers to the management of health financing, health information system, procurement and supply chain for health products and services, local health regulation, health human resource development, and health resilience, among others, in close coordination with the concerned offices of the city government.

Provincial and City Health Boards

- 19.16. In addition to the existing composition in accordance with RA 7160 (Local Government Code of 1991), municipalities and component cities included in the province-wide health system shall be entitled to a representative in the Provincial Health Board. As applicable, indigenous cultural communities or indigenous peoples, in accordance with RA 8371 (The Indigenous Peoples' Rights Act of 1997), shall also be represented in the Provincial and City Health Boards.
- 19.17. The Provincial and City Health Boards, in addition to their existing functions and in accordance with RA 7160 (Local Government Code of 1991), shall:
- 19.17.a. Set the overall health policy directions and strategic thrusts including the development and implementation of the integrated strategic and investment plans of the province-wide and city-wide health system;
 - 19.17.b. Oversee and coordinate the integration and delivery of health services across the health care continuum for province-wide and city-wide health systems;
 - 19.17.c. Manage the Special Health Fund (SHF); and,
 - 19.17.d. Exercise administrative and technical supervision over health facilities and health human resources within their respective territorial jurisdiction.
- 19.18. The Provincial and City Health Board shall create its own management support unit to assist its operations including the management of the SHF.
- 19.19. The Provincial and City Health Boards shall meet at least once a month or as often as may be necessary.
- 19.20. A majority of the members constitutes a quorum for the purpose of conducting ordinary business of the Provincial and City Health Boards; *Provided*, That the chairperson and the vice chairperson must be present during meetings where local investment plan for health (LIPH), annual operational plan (AOP) and annual budgetary proposals are being prepared or considered. The affirmative vote of a majority of all members of the Board is necessary to approve the health system plans and budgetary proposals; *Provided, further*, That the affirmative vote of a majority of the members present is sufficient to approve matters relating to ordinary business.
- 19.21. The chairperson, vice chairperson and members of the health boards shall perform their duties without compensation or remuneration. Members thereof who are not government officials or employees shall be entitled to necessary traveling expenses and

allowances chargeable against the SHF, subject to existing budgeting, accounting, and auditing rules and regulations.

- 19.22. The local health boards of the municipalities and component cities shall retain their existing compositions and functions.

Section 20. Special Health Fund

- 20.1. The province-wide and city-wide health systems shall pool and manage all resources intended for health services through a SHF. Sources for the SHF shall include financial grants and subsidies from national government agencies such as the DOH in accordance with Section 22 of these Rules; income from PhilHealth payments in accordance with Section 21 of the these Rules; and other sources such as, but not limited to, financial grants and donations from Non-Government Organizations, Faith-Based Organizations, and Official Development Assistance; *Provided*, That the concerned LGUs may opt to transfer their local budget intended for health to the SHF through a mechanism of cooperative undertakings as provided under Section 33 of RA 7160 (Local Government Code of 1991).
- 20.2. As determined and approved by the Provincial or City Health Board, the SHF shall be allocated for:
- 20.2.a. Population-based and individual-based health services;
 - 20.2.b. Capital investment such as, but not limited to, infrastructure, equipment, and information technology;
 - 20.2.c. Health system operating costs;
 - 20.2.d. Remuneration of additional health workers;
 - 20.2.e. Incentives for all health workers in accordance with RA 7305 (Magna Carta for PHW), RA 7883 (BHW Benefits and Incentives Act), PD 1569 (Strengthening Barangay Nutrition Program), RA 11148 (*Kalusugan at Nutrisyon ng Mag-Nanay* Act) and other relevant laws.
- 20.3. The allocation of the financial grants from DOH and income from PhilHealth payments shall be based on the contractual obligation of the Provincial and City Health Boards with the DOH and PhilHealth for population-based services and individual-based services, respectively; LIPH; and SHF guidelines.
- 20.4. The Provincial and City Health Boards shall assume full responsibility for the management of the SHF.
- 20.5. The DOH and PhilHealth shall require the creation of a SHF for contracting city-wide and province-wide health system; *Provided*, That LGUs shall appropriate, through an ordinance, counterpart funding to finance health programs based on the local investment plan for health; *Provided, further*, That the LGUs that opted to transfer the control of health resources to the province-wide health system shall transfer the funds intended for health to the SHF and shall be entitled to additional financial and non-

financial incentives, given that these incentives shall be solely allocated for health-related services; *Provided, finally*, That upon full financial integration, health expenditures of participating LGUs that are in accordance with these Rules shall be chargeable to the SHF.

- 20.6. The DOH and PhilHealth shall establish and maintain a SHF utilization tracking system to allow real-time collection, consolidation, and analysis of data on the use of such fund. Required data for this system shall be considered as health and health-related data as described in Section 31.1 of these Rules.
- 20.7. For this purpose, the DOH and PhilHealth, in consultation with the DBM, DILG, Department of Finance (DOF), Commission on Audit (COA) and the LGUs, shall issue guidelines that specify the allocation and utilization of the SHF.

Section 21. Income Derived from PhilHealth Payments.

- 21.1. All income derived from PhilHealth payments of LGU-owned and managed health offices, facilities, and services shall accrue to the SHF to be allocated by the LGUs exclusively for the operations and improvement of the province-wide and city-wide health systems.
- 21.2. PhilHealth payments shall be credited to the annual regular income (ARI) of the provinces, cities, and municipalities, subject to the SHF guidelines.

Section 22. Incentives for Improving Competitiveness of the Public Health Service Delivery System

- 22.1. The national government, through the DOH, shall make available commensurate financial and non-financial matching grants, including capital outlay, human resources for health, health commodities, and such other management support and technical assistance, to improve the functionality of province-wide and city-wide health systems; *Provided*, That DOH shall issue the annual guidelines on the provision of such grants.
- 22.2. Underserved and unserved areas, as defined in Section 4.14 of these Rules, shall be given priority in the allocation of grants.
- 22.3. The province-wide and city-wide investment plans for health, also known as the LIPH, and the annual operational plans (AOP) shall serve as the basis for the grants from the national government, to account for complementation of public and private health care providers and public or private health sector investments to national investment plans.
- 22.4. Municipalities and component cities that opted to organize themselves to form sub-provincial health systems shall submit a consolidated investment plan to the Provincial Health Board as an input to the LIPH.

RULE VI. HUMAN RESOURCES FOR HEALTH

Section 23. National Health Human Resource Master Plan

- 23.1. The DOH shall lead and institutionalize a multi-stakeholder Human Resources for Health (HRH) Network, composed of both public and private organizations and agencies, to formulate and oversee the sustainable implementation, monitoring, periodic evaluation, and reformulation of the National Health Human Resource Master Plan, a long term strategic plan for the management and development of HRH; *Provided*, That the Plan shall be implemented at the national and local levels by both government and private sectors; *Provided, further*, that the following components shall be included:
- 23.1.a. Comprehensive health labor market study adopting a whole of society approach;
 - 23.1.b. Standards for HRH, in both public and private sector, on staffing requirements, appropriate generation, recruitment, retraining, regulation, retention, productivity mechanisms, and reassessment of the health workforce that would be updated to accommodate changing population health needs; and,
 - 23.1.c. Outcomes pertaining to sustainable production, appropriate skill mix retention in the health sector, equitable distribution and practice-ready training and education for HRH.
- 23.2. The DOH, DBM and the CSC, shall establish mechanisms to create new positions as necessary to meet staffing standards, as set by DOH, for health professionals and health workers in government-owned and -controlled health facilities needed to provide health services or implement health programs in priority areas of the government.
- 23.3. All health professionals and health workers required for continuity of health services and implementation of health programs in priority areas shall be hired in permanent positions in province-wide and city-wide health systems under CSC rules and regulations and receive competitive salaries based on prevailing laws on salaries of civil servants; *Provided*, That the DOH, DILG and other concerned agencies, shall issue and enforce guidelines in accordance with Section 20 of these Rules and other relevant laws and guidelines that provide standard and competitive benefits and incentives for public health workers, barangay health workers and barangay nutrition scholars and, security of tenure to those with eligibility.
- 23.4. All private and non-government health facilities, including laboratories, pharmacies, and other such facilities licensed by the DOH, shall comply with the minimum required health care professionals and health care workers based on staffing standards as set by the DOH and shall ensure that those needed for continuity of health services are hired under regular employment and provided with competitive salaries, as set by competent government authorities.

- 23.5. Relevant national government agencies, LGUs, and the private sector, shall ensure the availability of sufficient resources to implement the National Health Human Resource Master Plan; *Provided*, That the province-wide and city-wide health systems shall align their investment needs with the Plan.

Section 24. National Health Workforce Support System

- 24.1. For purposes of these Rules, the National Health Workforce Support System refers to a mechanism that includes: human resource management and development systems; salaries, benefits, and incentives; and, occupational health and safety of deployed health care professionals or health care workers to support equity in local public health systems.
- 24.2. To augment health workforce needs of local public health systems, the DOH shall secure positions to hire health professionals and health workers for deployment under the National Health Workforce Support System.
- 24.3. Deployment of health professionals and health workers shall prioritize GIDAs; *Provided*, That graduates of medical and allied health professions who are recipients of government-funded scholarship programs as defined in Section 25 of these Rules, shall be prioritized in the recruitment and selection to the allocated positions.
- 24.4. Compensation rates of deployed health professionals and health workers shall follow national rates.
- 24.5. Subject to the integration of the province-wide or city-wide health systems, LGUs shall implement incremental creation of positions to hire the required health care professional and health care worker based on standards, as determined by the DOH; *Provided*, That, in the interim, LGUs that are unable to achieve the standards for health care professional and health care worker are eligible to receive deployment augmentation from the National Health Workforce Support System.
- 24.6. The DOH shall assess the performance of the National Health Workforce Support System and LGUs' health workforce complement. The assessment shall also include feasibility of hiring additional human resources for health in permanent positions under province-wide or city-wide health systems to meet standard staffing requirements for health facilities. Upon consideration of the assessment results, the DOH, DBM and DILG shall determine the feasibility of absorbing public health workers under province-wide or city-wide health systems.

Section 25. Scholarship and Training Program.

Expansion of Degree and Non-Degree Training Programs

- 25.1. The CHED, TESDA, PRC and DOH shall develop and plan the expansion of existing and new allied and health-related degree and training programs based on the health needs of the population especially those in GIDAs. It shall be incorporated into the National Health Human Resource Master Plan which becomes the basis of the number and cadre, including categories, where applicable, of health care professionals and health care workers needed to meet the health needs of the population, especially those in underserved and unserved areas.

- 25.2. The PRC and its accredited organizations shall:
 - 25.2.a. Review and update, if necessary, the accreditation standards and admission policies or requirements for medical residency and sub-specialty training and specialization tracks for allied health professions to support reducing trainee attrition rates;
 - 25.2.b. Regulate the number of trainees per program in favor of producing enough medical and allied health professionals with appropriate competencies for primary and specialty practice, based on the health needs of the population and priorities identified by the DOH, especially those in GIDAs; and,
 - 25.2.c. Assist national government agencies, LGUs, and the private sector in the establishment of accredited programs for medical residency and sub-specialty training, and specialization tracks for allied health professions, where feasible, in provinces where specialists or sub-specialists and allied health professionals are in shortage.

- 25.3. The Commission on Higher Education (CHED) and the Technical Education and Skills Development Authority (TESDA) shall:
 - 25.3.a. Review and update, as necessary, all recognition or accreditation policies and guidelines for health education programs, prioritizing the expansion of undersubscribed courses;
 - 25.3.b. Develop support programs to assist graduates acquire necessary and relevant qualifications, such as professional licenses for practice or civil service eligibility for those who wish to be employed in government;
 - 25.3.c. Develop new programs in coordination with the DOH to supply the health care provider networks with practice-ready health and allied health care professionals and health care workers to meet health workforce requirements;
 - 25.3.d. Regulate the number of enrollees per program in favor of producing sufficient allied and health-related degree graduates based on the health needs of the population, especially those in the underserved and unserved areas, and enforce stricter admission policies and guidelines to reduce student and trainee attrition rates;

- 25.3.e. Promote and support the establishment of medical and health science schools and technology vocational training providers in regions where health care professionals and health care workers are inadequate and production capacity is limited by the lack of accessible training facilities or health professional education programs; and,
 - 25.3.f. Regulate the quality of education of medical and allied health schools and technical-vocational education and training providers and take necessary actions to enforce quality standards.
- 25.4. The DOH shall:
- 25.4.a. Assist national government agencies, LGUs, and the private sector in the establishment of accredited programs for medical residency and sub-specialty training, and specialization tracks for allied health professions to produce specialists and sub-specialists in underserved and unserved areas; and,
 - 25.4.b. Regularly provide updates to the PRC, CHED, and TESDA of the number and distribution of the health workforce to support the coordinated and balanced production of health professionals and health workers, as well as the health service needs of underserved and unserved areas and populations.

Expansion of Scholarships for Health

- 25.5. The DOH and CHED shall increase production of identified cadre of health professionals and health managers as determined by the National Health Human Resource Master Plan through the expansion and redirection of government-funded scholarship programs that would support the production of needed cadre of health care professionals, health care workers, and health managers and improve local retention.
- 25.6. The DOH and CHED shall source funds for scholarship grants; refer to a modality of financial assistance that they provide to eligible individuals through government-funded scholarship programs, which include full or supplementary payment for subsidies to complete tuition fees and other school fees such as living, book and uniform allowances; and require corresponding return service obligation to national or local government; *Provided*, That bona fide residents of underserved and unserved areas or members of indigenous peoples shall be prioritized for scholarship grants from the national government, LGUs, NGOs or private entities, and international bodies.

Registry of Health Professionals and Workers

- 25.7. The PRC and the DOH in coordination with duly registered medical and allied health professional societies shall set up a registry of medical and allied health professionals indicating, among others, their current number of practitioners and location of practice.

- 25.8. The DOH shall determine the human resources for health data required for the national health workforce registry, and act as a repository of the data collected and manager of the registry.
- 25.9. The PRC, together with their accredited medical and allied health professional organizations and other national and local bodies, within their mandates, shall provide the DOH with relevant health care professional and health care worker data. For this purpose, the DOH is authorized to collect data and information for the national health workforce registry from relevant agencies, including NGOs, private organizations and facilities.

Inclusion of Primary Care Competencies in Health Professional and Health Worker Curricula

- 25.10. The CHED, the PRC, and the DOH in coordination with duly registered medical and allied professional societies, shall:
- 25.10.a. Reorient health care professional and health care worker curriculum towards primary health care, with emphasis on public health and primary care;
 - 25.10.b. Determine recommended areas of study in public health to be incorporated in the curriculum of all health sciences education; and,
 - 25.10.c. Incorporate educational outcomes focusing on primary care in the education programs; scope of licensure examinations, continuing professional development programs for health professionals; and, certification programs for health care workers.
- 25.11. The DOH and the PRC shall issue guidelines for the eligibility requirements, standard competencies, training mechanisms, and post-graduate certification process for primary care workers. This is without prejudice to any transitory process that may be adopted to implement Section 6 of these Rules.

Section 26. Return Service Agreement

- 26.1. All graduates of allied and health-related courses who are recipients of government-funded scholarship programs, as described in Section 25 of these Rules, must enter into a return service agreement (RSA) with both the academic or training institution or training facility and the DOH. Graduates entering into an RSA shall be required to serve in one of the DOH-specified priority health facilities or fields of practice, within the public sector in the Philippines, on a full-time basis for at least three (3) full years, within one (1) year upon graduation or acquiring the necessary license to practice; *Provided*, That those who will serve for additional two (2) years shall be provided with additional incentives as determined by the DOH.
- 26.2. The DOH shall issue guidelines that specify conditions for admission of scholarship recipients into post-graduate degree programs or specialty training courses under the RSA.

- 26.3. Graduates of allied and health-related courses who are recipients of government-funded scholarship programs shall be prioritized for government employment and training opportunities, including permanent positions under province-wide or city-wide health systems, positions for medical residency and sub-specialty training, and specialization tracks for allied health professions in government facilities, and shall receive standard compensation and benefits based on prevailing national rates for civil servants.
- 26.4. The DOH and academic or training institutions, whether public or private, with government-funded scholarship programs shall set up a monitoring system to track scholarship recipients and graduates and monitor compliance to return service and assess effectivity of the RSA.
- 26.5. The DOH and CHED, in consultation with State Universities and Colleges, Local Universities and Colleges, and private academic and training institutions with health professional education programs shall institutionalize mechanisms to encourage their graduates to serve in priority areas and field of practice in the public sector.
- 26.6. The DOH, CHED, and PRC shall develop guidelines for noncompliance and mechanisms to define obligations for recipients of scholarship grants who fail to render return service.

RULE VII. REGULATION

Section 27. Safety and Quality

PhilHealth Rating System

- 27.1. PhilHealth shall establish an incentive scheme for health facilities to provide better service quality, efficiency, and equity based on a rating system.
- 27.2. The rating system shall include, but not limited to the following: measures on provision of complete and appropriate care, health outcomes, patient satisfaction, fund utilization and allocation of resources across health care providers and different levels of care; compliance to standards of clinical practice as approved by DOH; submission of price information of health goods and services; compliance to guidelines and standards as prescribed by DOH and PhilHealth and other applicable laws; and, other measures or indicators as deemed necessary.
- 27.3. PhilHealth shall prescribe the standards and requirements for third party accreditation mechanisms. These may be used as basis for granting incentives to healthcare providers to be identified by PhilHealth.

Licensing for Primary Care Facilities and Stand-Alone Health Facilities

- 27.4. The DOH shall institute a responsive licensing and regulatory system for stand-alone health facilities, including those providing ambulatory and primary care services, and other modes of health service provision such as, but not limited to, mobile health services and digital technologies for health, subject to the appropriate regulatory instruments.
- 27.5. The DOH shall issue a License to Operate and Certificate of Accreditation, as appropriate, to these facilities that shall be valid for at least three (3) years, unless otherwise provided by laws and issuances and shall be independent of permits, registrations, and accreditations issued by other government offices.
- 27.6. The mandate and enforcement mechanisms of DOH to regulate health facilities and services shall be expanded and strengthened. For this purpose, the DOH shall establish line regulatory units up to the regional level to harmonize and enforce licensing standards; and shall allocate funds and resources to support such regulatory mandate.

Clinical Practice Guidelines

- 27.7. The DOH, in cooperation with professional societies and the academe, shall set standards for clinical care through the development, appraisal, and use of clinical practice guidelines (CPGs) based on best evidence, to assist practitioners in clinical decision-making.
- 27.8. The DOH shall establish a mechanism for the development, adoption and dissemination of CPGs; *Provided*, That DOH and Philhealth shall monitor compliance to such CPGs.

Section 28. Affordability

National Price Reference Indices for Drugs, Medical Devices and Supplies

- 28.1. The DOH shall expand the current drug price reference index (DPRI) implemented in DOH-owned health facilities and develop price reference indices before mark ups for drugs, medical devices and supplies.
- 28.2. In establishing the price reference indices for drugs, medical devices and supplies, the DOH shall consider all factors relevant to their costs.
- 28.3. The procurement price for innovative, proprietary, patented, and single-sourced drugs, medical devices and supplies shall be centrally negotiated by a price negotiation board at the lowest price that is most advantageous to the government in accordance with RA 9184 (Government Procurement Reform Act) and other Government Procurement Policy Board (GPPB) issuances.
- 28.4. The DOH shall update the price reference indices at least every year and make them public through various platforms, including web-based databases, price booklets, and publication in major newspapers.
- 28.5. All DOH-owned health care facilities shall procure drugs, medical devices and supplies guided by the price reference indices in accordance with relevant laws, such as, RA 9184 (Government Procurement Reform Act) and RA 9502 (Cheaper Medicines Act of 2008).
- 28.6. Noncompliance by the DOH-owned health facilities with the published price reference indices shall be subject to existing rules and administrative sanctions as stipulated in these Rules and other relevant laws such as RA 9184 (Government Procurement Reform Act), RA 9502 (Cheaper Medicines Act of 2008), and RA 7394 (Consumer Act of the Philippines), among others.
- 28.7. The published price reference indices shall guide PhilHealth in setting payment rates for drugs, medical devices and supplies for its contracted healthcare providers.

Prescribed Mark-ups for Drugs, Medical Devices and Supplies

- 28.8. The DOH shall prescribe uniform rules and structures in setting mark-ups for drugs, medical devices and supplies that shall be applied by DOH-owned health facilities on top of the price reference indices to protect patients from excessive and unnecessary charges.
- 28.9. All DOH-owned health care facilities shall submit to the DOH all relevant costs and information necessary for the creation of a mark-up structure for drugs, medical devices and supplies.
- 28.10. All DOH-owned health care facilities shall adhere to the price structure and shall not go beyond the prescribed mark-ups for drugs, medical devices and supplies.
- 28.11. PhilHealth shall adopt the prescribed mark-ups issued by the DOH in setting payment mechanisms for drugs, medical devices and supplies among its contracted DOH-owned health care facilities.
- 28.12. Noncompliance to the prescribed mark-up structure shall be subject to existing rules and administrative sanctions as stipulated in these Rules and other relevant laws such as RA 9184 (Government Procurement Reform Act), RA 9502 (Cheaper Medicines Act of 2008), and RA 7394 (Consumer Act of the Philippines), among others.

Central Price Negotiation for Health Technologies

- 28.13. An independent price negotiation board, composed of representatives from the DOH, PhilHealth and the DTI, among others, shall be constituted to negotiate prices on behalf of the DOH and PhilHealth, guided by certain parameters including new health technology, innovator drugs, and sourced from a single supplier; *Provided*, That DOH shall issue guidelines as to the structure and constitution of such board; *Provided, further*, That the negotiated price in the framework contract shall be applicable for all healthcare providers under DOH; *Provided, finally*, That the board shall adhere to the guidelines issued by the GPPB.

Framework Contracting of Drugs, Medical Devices and Supplies

- 28.14. The DOH shall promulgate guidelines and procedures in implementing framework contracting on drugs, medical devices and supplies.
- 28.15. Multi-year framework contracts may be implemented by the DOH in accordance with RA 9184 (Government Procurement Reform Act) and other GPPB issuances to ensure

the continuous availability of drugs, medical devices and supplies centrally negotiated by the price negotiation board at affordable prices, which shall be applicable throughout the term of the contracts.

Submission of Price Information by All Healthcare Providers

- 28.16. Healthcare providers and facilities shall be required to make readily accessible to the public and patients and submit to DOH and PhilHealth, all pertinent, relevant, and up-to-date information regarding the prices of health services, and all goods and services being offered.
- 28.17. The DOH and PhilHealth shall issue the guidelines on submission of information and public access to said information regarding the prices and charges for all goods and services, including professional fees being offered by health care providers and health care provider networks.
- 28.18. The DOH and PhilHealth shall issue policies and procedures, as well as establish systems to undertake the following functions:
- 28.18.a. Monitor the prices of health services, which include among others, laboratory fees, cost of procedures, cost of amenities, professional fees, and other health services provided by hospitals and other health care providers; *Provided*, That the collection, submission, and publication of price data as required by law shall form part of data submission to PhilHealth; and,
- 28.18.b. Monitor the prices of all health goods such as drugs and medicines, health and medical devices, and laboratory and medical supplies.

Mandatory Provision of Fairly Priced Generics

- 28.19. Drug outlets shall be required at all times to make available and offer fairly priced generic equivalent of all drugs in the DOH Primary Care Formulary (PCF) based on the local needs and prevailing disease patterns in the community.
- 28.20. No retailer or drug outlet shall withhold from sale or refuse to sell to consumers fairly priced generic equivalents of drugs in the PCF.
- 28.21. The DOH shall issue a list of generic drugs in the PCF with their corresponding fair prices.
- 28.22. Noncompliance to this specific provision shall be subject to administrative sanctions under these Rules and relevant laws such as the RA 9711 (Food and Drug Administration Act of 2009), RA 9502 (Cheaper Medicines Act of 2008), and RA 7394 (Consumer Act of the Philippines).

Complementation of Private Health Insurance and Health Maintenance Organizations

- 28.23. The DOH, PhilHealth, HMOs, and life and non-life PHIs, in consultation with the Insurance Commission, shall establish a coordination mechanism, and develop standards, policies and plans that complement the NHIP's benefit schedule, with the following as minimum requirements:
- 28.23.a. HMOs and life and non-life PHIs shall cover the cost of amenities and other healthcare goods and services that are not covered by PhilHealth subject to the contractual obligations entered into by the member with HMOs and life and non-life private health insurance; and,
- 28.23.b. HMOs, life and non-life PHIs shall duly submit health and health-related data, as prescribed in Section 31.1 of these Rules, in aid of developing policies, standards, and plans.

Section 29. Equity

Preferential Licensing of Health Facilities

- 29.1. The DOH shall develop the framework and guidelines on appropriate service capability in underserved and unserved areas, considering complementary infrastructure, equipment and bed capacity, and number of health care professionals for purposes of preferential licensing of health facilities and contracting of health services.
- 29.2. The DOH shall develop the guidelines for identifying GIDA barangays and update the list of underserved and unserved areas annually.
- 29.3. The DOH shall develop a system to prioritize the processing of applications and issuance of License to Operate and Certificate of Accreditation for health facilities in these areas. PhilHealth shall establish an incentive scheme in contracting DOH-licensed health facilities and services located in underserved and unserved areas that shall ensure sustainability of provision of safe and quality health services.
- 29.4. The DOH, PhilHealth and LGUs shall prioritize GIDAs in the provision of assistance and support, such as but not limited to, health human resources, infrastructure, medical equipment and supplies to ensure equitable distribution of health services and benefits.

Bed Capacity of Hospitals

- 29.5. Government general hospitals, regardless of size and level, are required to operate not less than ninety percent (90%) of their authorized bed capacity as basic or ward accommodation. h

- 29.6. Specialty hospitals, either single-specialty or multi-specialty government hospitals as designated by the DOH, are required to operate not less than seventy percent (70%) of their authorized bed capacity as basic or ward accommodation.
- 29.7. Private hospitals are required to operate not less than ten percent (10%) of their authorized bed capacity as basic or ward accommodation.
- 29.8. Currently licensed hospitals shall fully comply with the required allocation of beds for basic or ward accommodation subject to the guidelines that will be issued by the DOH; *Provided*, That the required allocation of beds for basic or ward accommodation shall be immediately applicable to new hospitals applying for License to Operate.
- 29.9. All government general hospitals, specialty hospitals, and private hospitals are required to annually submit a report, through a DOH online reporting system, on the allotment and actual utilization of the authorized beds for basic or ward accommodation, in compliance to licensing requirements.

RULE VIII. GOVERNANCE AND ACCOUNTABILITY

Section 30. Health Promotion

- 30.1. The DOH, being the overall steward for health care, shall strengthen national efforts in providing a comprehensive and coordinated approach to health development with emphasis on scaling up health promotion and preventive care to ensure that every Filipino has access to information to build personal skills, opportunity to engage in strengthening of community action, and enable participation in creation of supportive environments as fundamental component of UHC.
- 30.2. The Health Promotion Bureau shall be established in the DOH from the existing Health Promotion and Communication Service. The Health Promotion Bureau shall:
- 30.2.a. Be responsible for healthy public policy and reorient health systems to prioritize health promotion and prevention, and increase health literacy;
 - 30.2.b. Lead the formulation of a Health Promotion Framework Strategy which shall serve as the national health promotion roadmap and the basis of all health promotion policies and programs;
 - 30.2.c. Implement population-wide health promotion policies and programs across social determinants of health and behavioral risk factors;
 - 30.2.d. Promote and provide technical, logistical and financial support to local research and development of local policies and programs based on the Health Promotion Framework Strategy and the local investment plans for health; and,
 - 30.2.e. Exercise multisectoral policy coordination and enter into partnerships with national government agencies, LGUs, the private sector, civil society organizations, professional societies and academe, among others to ensure the attainment of the Health Promotion Framework Strategy and its policies and programs.
- 30.3. The DOH, together with DBM and other relevant agencies, shall identify and ensure appropriate organizational structure with corresponding human resource complement to support the mandate of the Health Promotion Bureau; *Provided*, That health promotion capabilities, financial capacities, and human resources to support the implementation of the Health Promotion Framework Strategy at the regional level shall be strengthened and expanded.
- 30.4. Within two (2) years from the effectivity of these Rules, the DOH shall allocate at least one percent (1%) of its total budget appropriations to the Health Promotion Bureau to implement health promotion programs; *Provided*, That the succeeding budget appropriations shall be in accordance with the Health Promotion Framework Strategy.
- 30.5. Province-wide and city-wide health systems are mandated to provide proactive and effective health promotion programs and campaigns in accordance with the requirement of Section 17 of these Rules; *Provided*, That a Health Promotion Unit with appropriate

human resource complement shall be established within the province-wide and city-wide health systems to ensure sustainable implementation of health promotion and improve health literacy.

- 30.6. The DepEd shall hereby designate schools as healthy settings based on the standards set by the DepEd and DOH, where all members of the school community work together to provide students, teachers, and staff, including those from alternative learning systems, with integrated and positive experiences and structures which promote and protect their health. Designation of schools as healthy settings shall be based on the following minimum components: healthy school policies, physical school environment, social school environment, health skills and education, links with parents and community, and access to health services.
- 30.7. The DepEd, in coordination with the DOH, shall address public health problems through the school systems by:
 - 30.7.a. Intensifying the fight against the spread of communicable diseases through promotive and preventive programs that include among others, personal hygiene, oral health, access to safe water and sanitation, environmental measures to prevent vectors-borne diseases, and vaccinations;
 - 30.7.b. Enforcing measures to ban sale of, and prevent access to, tobacco products, alcohol and illicit drugs in schools and immediate vicinity in coordination with LGUs;
 - 30.7.c. Promoting healthy lifestyle through physical activity, proper nutrition, injury prevention and mental health programs, among others;
 - 30.7.d. Ensuring the promotion of health of children with special needs, learning disabilities or other developmental conditions to provide opportunities for them to live productive lives;
 - 30.7.e. Cultivating a healthy school environment and community;
 - 30.7.f. Formulating and implementing school health and nutrition policies, programs, and services; and,
 - 30.7.g. Mobilizing community action on health promotion.
- 30.8. The DepEd shall formulate programs and modules on health literacy and health rights that shall be integrated in formal and informal curricula, programs, and co-curricular activities.
- 30.9. DepEd and DOH shall submit an integrated annual report on health promotion and health literacy programs that they have respectively implemented including an assessment of the impact thereof, to the President of the Philippines, the Senate President, and the Speaker of the House of Representatives; *Provided*, That regular data sharing on health promotion programs, projects, and activities between DepEd and DOH shall be established, in accordance with Section 31 of these Rules, relevant provisions of RA 10173 (Data Privacy Act), and other relevant laws and policies.

- 30.10. To implement the Health Promotion Framework Strategy, the CHED and TESDA are enjoined to designate educational and training institutions as healthy settings based on the standards set by DOH.
- 30.11. LGUs, guided by the Health Promotion Framework Strategy, shall issue and implement effective health promotion policies and programs that promote health literacy and healthy lifestyle among their constituents, prevent and control diseases and their risk factors to advance population health and individual wellbeing.
- 30.12. The laws to the contrary notwithstanding, LGUs are directed to enact stricter ordinances that strengthen and broaden existing health promotion policies and programs; *Provided*, That LGUs shall prioritize the following: the reduction of the prevalence of tobacco use, the reduction of the burden of alcohol use, the reduction of incidence of communicable diseases and prevalence of non-communicable diseases, addressing mental health issues, and the improvement of health indicators.
- 30.13. To ensure compliance, the DOH and DILG shall formulate a joint administrative issuance to implement, monitor, and evaluate health promotion policies and programs in LGUs. An annual report on the policies adopted and programs undertaken, and an assessment of the impact thereof, shall be submitted by the LGUs to the DILG, copy furnished the DOH.

Section 31. Evidence-Informed Sectoral Policy and Planning for UHC

Submission of Health- and Health-related Data

- 31.1. For the purpose of these Rules, health and health-related data collectively refer to a set of specific variables or parameters that relates to individual and population health and well-being, including, but not limited to, administrative, public health, medical, pharmaceutical and health financing data. Such data shall be submitted to PhilHealth by all health-related entities through a National Health Data Repository, in compliance with guidelines that shall be jointly developed by DOH and PhilHealth, in consultation with the Department of Information and Communications Technology (DICT) and the National Privacy Commission (NPC); *Provided*, That submission of data by health-related entities shall be a requirement in the licensing and contracting arrangements; *Provided, further*, That health-related entities shall include, but not limited to, health care facilities, national and local government agencies involved in the provision of health services, and agencies involved in the collection of health data; *Provided, finally*, That PhilHealth shall provide the DOH access to the National Health Data Repository.
- 31.2. All health-related entities shall issue a proper notice to their clients that any collected data or information shall be submitted to the National Health Data Repository, in lieu of informed consent. Such notice shall state that these data or information shall be used consistently with the objectives of this law, and in compliance with RA 10173 (Data Privacy Act).

Strengthening Health Policy and Systems Research

- 31.3. The DOH, PhilHealth, LGUs, and other DOH-attached agencies shall establish mechanisms that integrate explicit use of evidence into the policy and decision-making process, strengthen health policy and systems research, and support the growth of research consortia in line with the vision of the Philippine National Health Research System as stipulated in RA 10532 (Philippine National Health Research System Act of 2013).
- 31.4. The DOH shall allocate and manage funds for training grants to develop a pool of health policy and systems researchers, technical experts, and health systems managers; *Provided*, That DOH and Department of Science and Technology (DOST) shall establish the systems and procedures on the provision of such training grants.
- 31.5. The DOH, together with the DOST, shall identify academic or training institutions, whether in the Philippines or abroad, that are globally benchmarked and with relevant curricula that are aligned with the health needs of the Philippines.
- 31.6. Recipients of training grants shall be required to serve for at least three (3) full years, under supervision and with compensation, in DOH, PhilHealth and other relevant government agencies; *Provided*, That those who will serve for additional two (2) years, shall be provided with additional incentives as determined by the agency concerned.
- 31.7. A training registry shall be shared between the DOH and DOST for purposes of tracking recipients of training grants, and monitoring compliance to return service obligations.

Access to Public Health and Health-Related Data

- 31.8. All health, nutrition and demographic-related administrative and survey data generated using public funds shall be considered public records and be made accessible to the public unless otherwise prohibited by law.
- 31.9. The Interagency Committee on Health and Nutrition Statistics (IACHNS), through the PSA and DOH, shall formulate policies and guidelines on data access relative to the covered public data.
- 31.10. All agencies responsible for the generation of covered administrative and survey data shall make available to the general public, the government, and entities commissioned by government all microdata and metadata in public use files (PUF), and in either electronic format, or hard copies, subject to guidelines to be issued by DOH; *Provided*, That any person who requests hard copies may be required to pay the actual costs of reproduction and copying.

Participatory Action Researches

- 31.11. Participatory action researches on cost-effective, high-impact interventions for health promotion and social mobilization shall form part of the national health research agenda of the Philippine National Health Research System which shall also be mandated to provide adequate funding support for the conduct of these researches.

Section. 32. Monitoring and Evaluation.

Conduct of Surveys in Support of UHC

- 32.1. The PSA shall design and conduct relevant modules of annual household surveys in close coordination with the DOH, consistent with overall monitoring and evaluation plan, during the first ten (10) years of the implementation, and thereafter follow its regular schedule.
- 32.2. The PSA shall include the costs of implementing the relevant modules of the household surveys in its annual budgetary proposal under the GAA. The DOH may provide supplementary funding, as deemed appropriate.

Burden of Disease Estimates

- 32.3. The DOH shall publish annual provincial burden of disease (BOD) estimates using internationally validated estimation methods and biennially using actual public and private sector data from electronic records and disease registries, to support LGUs in tracking progress of health outcomes; *Provided*, That the DOH, in consultation with relevant stakeholders, shall issue guidelines that specify procedures for BOD estimation. For this purpose, BOD estimates shall refer to quantitative health information concerning the distribution of and health loss attributable to diseases, injuries, and risk factors.
- 32.4. The DOH, in coordination with PhilHealth, academic and research organizations, and development partners, shall:
- 32.4.a. Produce annual BOD estimates through a systematic and transparent manner;
 - 32.4.b. Build institutional and sectoral capacity for BOD research and analysis;
 - 32.4.c. Promote the use of BOD estimates for policy and planning at national and local levels; and,
 - 32.4.d. Inform the improvement of existing disease-specific information systems.
- 32.5. All BOD estimates must be made accessible in public use format (PUF) and accessible by the general public, in accordance to RA 10173 (Data Privacy Act) and existing laws.

Section 33. Health Impact Assessment (HIA)

- 33.1. The DOH, in coordination with the NEDA, DILG, DENR, relevant LGUs and other executive agencies, shall ensure that Health Impact Assessment (HIA) is conducted, public health mitigation and management plans are implemented for all development initiatives, and members of potentially affected communities are well-represented in the process. *Provided*, That this is without prejudice to future amendments to the guidelines that will be carried out in response to evolving needs and practices. For this purpose:
- 33.1.a. *Health impact assessment (HIA)* shall refer to a means of assessing the health impacts of policies, programs, and projects in diverse economic sectors before, during, and after implementation. It provides practical and alternative recommendations to increase positive health effects and minimize negative health effects;
 - 33.1.b. *Public health mitigation and management plans (PHMMP)* shall refer to a set of actions necessary to routine operations that seeks to prevent or limit negative public health impacts and losses associated with the risks involved in the implementation of development initiatives; and
 - 33.1.c. *Development initiatives* shall refer to all proposed and existing policies, programs, and projects emanating from government and private sectors.
 - 33.1.d. *Health sensitive projects* shall refer to projects whose raw materials, by products, intermediate products, finished products, and other components and processes during its construction, operation, and decommissioning phases have potential to pose significant health risks to workers and potentially affected communities;
 - 33.1.e. *Projects in health sensitive areas* shall refer to projects located in areas delineated as critical for health, such that significant health impacts can be expected and vulnerable populations adversely affected due to implementation of certain types of projects, or to any sudden changes to the natural and community resources in which livelihood and health are also closely dependent;
 - 33.1.f. *Non-health sensitive projects* shall refer to projects that have low potential to pose significant risks or impacts to the health of workers and potentially affected communities, or to any of its determinants; and,
 - 33.1.g. *Potentially affected communities* shall refer to groups of people who are on the receiving end of the intended and unintended effects of the development initiatives, and whose lives will be affected by the development initiative being assessed.
- 33.2. For development initiatives classified as projects, the DOH shall convene a review committee, and issue health impact clearance for projects upon positive recommendation of the committee.
- 33.3. For development initiatives classified as policies and programs, findings from the assessment and recommendations shall be appraised by relevant DOH offices and formally endorsed to appropriate national government agencies.

Section 34. Health Technology Assessment (HTA)

- 34.1. The DOH shall lead the health sector in the institutionalization of the HTA process as a fair and transparent priority setting mechanism that shall be recommendatory to the DOH and PhilHealth for the development of policies and programs, regulation, and the determination of a range of entitlements such as drugs, medicines, pharmaceutical products, and other devices, procedures and services as provided for under these Rules.
- 34.2. Investments on any health technology or development of any benefit package by the DOH and PhilHealth shall be based on the positive recommendations of the HTA; *Provided, That:*
- 34.2.a. Despite having undergone the HTA process, all health technology, intervention or benefit package shall still be subjected to periodic review;
- 34.2.b. HTA may be conducted as new evidence emerges which may have substantial impact on the initial coverage decision by the DOH or PhilHealth; and,
- 34.2.c. HTA process shall adhere to the principles of ethical soundness, inclusiveness and preferential regard for the underserved, evidence-based and scientific defensibility, transparency and accountability, efficiency, enforceability and availability of remedies, and due process.

Criteria in the conduct of HTA

- 34.3. *Responsiveness to Magnitude, Severity, and Equity* - The health interventions must address the top medical conditions that place the heaviest burden on the population, including dimensions of magnitude or the number of people affected by a health problem, and severity or health loss by an individual as a result of disease, such as death, handicap, disability or pain, and conditions of the poorest and most vulnerable population;
- 34.4. *Safety and Effectiveness* – Each intervention, especially drugs and medicines, shall undergo Phase IV clinical trial, and systematic review and meta-analysis must be readily available, as deemed necessary. For long term safety data, other sources of clinical evidence may be used in the HTA process, such as reports of adverse drugs events to the FDA, case reports, case series and real-world data; *Provided, That* for non-drug interventions and technologies where clinical trials are not possible or practical to conduct (e.g., surgical and medical procedures, medical device), the Health Technology Assessment Council (HTAC) shall make use of the best available source of objective evidence, including, but not limited to, observational studies and real world evidence. The interventions must also not pose any harm to the users and health care providers that would outweigh the benefits they provide.
- 34.5. *Household Financial Impact* - The interventions must reduce out-of-pocket expenses. Interventions must have economic studies and cost-of-illness studies to satisfy this criterion.

- 34.6. *Cost-effectiveness* - The interventions must provide overall health gain to the health system and outweigh the opportunity costs of funding drug and technology.
- 34.7. *Affordability and Viability* - The interventions must be affordable, and the cost thereof must be viable to the financing agents.

Health Technology Assessment Council (HTAC)

- 34.8. The HTAC, to be composed of health experts, shall be created within the DOH and supported by a Secretariat and a Technical Unit for Policy, Planning and Evaluation with evidence generation and validation capacity. DOH and DOST shall issue joint guidelines on the implementation of this provision.
- 34.9. A HTAC shall be constituted within the DOH with the following functions:
- 34.9.a. Facilitate provision of financing and coverage recommendations on health technologies to be financed by DOH and PhilHealth;
 - 34.9.b. Oversee and coordinate the HTA process within DOH and PhilHealth; and,
 - 34.9.c. Review and assess existing health technologies financed by DOH and benefit packages of PhilHealth.
- 34.10. The HTAC shall consist of a core committee and subcommittees.
- 34.10.a. The core committee is composed of nine (9) voting members, which shall elect from among themselves its Chairperson, namely: a public health epidemiologist; a health economist; an ethicist; a citizen's representative; a sociologist or anthropologist; a clinical trial or research methods expert; a clinical epidemiologist or evidence-based medicine expert; a medico-legal expert; and a public health expert.
 - 34.10.b. The subcommittees to be constituted may include, among others: Drugs, Vaccines, Clinical Equipment and Devices, Medical and Surgical Procedures, Preventive and Promotive Health Services, and Traditional Medicine. All subcommittees shall have a minimum of one (1) and maximum of three (3) non-voting members for each subcommittee. Qualifications of the subcommittee shall be determined by the DOH and DOST.
- 34.11. The HTAC may call upon technical resource persons from the PhilHealth, Food and Drug Administration (FDA), patient groups and clinical medicine experts as regular resource persons; and representatives from the private sector and health care providers as by-invitation resource persons.

Appointment and Remuneration of HTAC

- 34.12. The HTAC's core committee and subcommittee members shall be appointed by the Secretary of Health for a term of three (3) years, except for the medico-legal expert,

ethicist, and the sociologist or anthropologist, who shall serve for a term of four (4) years. No member shall serve for more than three (3) consecutive terms.

34.13. Members of the HTAC shall receive an honorarium in accordance with existing policies.

34.14. The DOH, together with DOST, shall promulgate the nomination process for all HTAC members with a clear set of qualifications, credentials, and recommendations from the sectors concerned. Conflict of interest shall be managed by the HTA Office in accordance with Section 35 of these Rules.

34.15. The Secretary of the DOST shall appoint the members of the HTAC upon its transition into an attached agency under DOST, based on the established criteria and demonstrated competencies by the DOH and DOST.

HTA Process

34.16. The HTA Technical Unit for Policy, Planning and Evaluation, in coordination with the HTAC and other stakeholders, shall establish the process and methods to guide the HTA implementation. This shall be published and shall be reviewed periodically.

Legal Protection

34.17. All official actions of the HTAC shall be supported by appropriate legal staff as deemed necessary.

Transition of HTAC from DOH to DOST

34.18 The HTAC, supported by its Secretariat and a Technical Unit for Policy, Planning and Evaluation as created in Section 34.8 of this Rule, shall transition into an independent entity separate from the DOH as an attached agency of the DOST within five (5) years after its establishment and operation subject to the joint guidelines for its implementation.

Section 35. Ethics in Public Health Policy and Practice

Conflict of Interest Management

35.1. All stakeholders involved in policy-determining activities at all levels of policy-making are required to act in a manner that shall serve the public's best interest, and thus are required to disclose and manage any real or perceived conflicts of interest. For the purposes of these Rules:

- 35.1.a. Conflict of Interest (COI) shall refer to acts or omissions constituting a conflict of interest under existing laws and civil service rules, including international treaties where the Philippines is a signatory. This definition shall be applicable to reportable financial and non-financial interests of all public and private stakeholders involved in policy-determining activities.
- 35.1.b. Policy-determining activities shall refer to actions taken in aid of public policy development leading to impartial decisions in adopting and implementing a policy option or policy recommendation using the best available evidence.
- 35.2. Decision makers, policymakers, staff members, and consultants shall disclose all actual and potential conflicts of interest to their heads of office, as applicable.
- 35.3. The DOH shall issue guidelines that specify standards for receipt, assessment, and management of declared COI, in consultation with the CSC and other relevant public and private stakeholders.

Tracking Financial Relationships between Health and Health-Related Commodity Manufacturers, Healthcare Providers, and Health Professionals

- 35.4. All manufacturers of drugs, medical devices, biological and medical supplies registered by the FDA shall document, maintain records, and make publicly available the information on all financial relationships directly or indirectly made with health care professionals and healthcare providers in accordance with existing laws. For the purposes of these Rules:
 - 35.4.a. Financial relationship shall refer to any form of emolument that may be contractual or non-contractual in nature, such as but not limited to cash, cash equivalent, in kind, stock, stock option or any ownership interest, dividend, profit or other return of investment, and transfers of value.
 - 35.4.a.i Transfer of value shall refer to the direct or indirect transfer of benefits or gains, whether in cash, in kind or otherwise, made, whether for promotional purposes or otherwise, in connection with the development or sale of drugs, medical device, and biological and medical supplies.
 - 35.4.b. Financial relationships shall cover the following:
 - 35.4.b.i. For health care professionals: donations, educational grants, research funding, sponsorships related to events, travel, and accommodation, registration fees, honoraria, support for continuing professional development (CPD), royalties, current or prospective ownership or investment interest, consultancy/speakership fees, or other contractual arrangements for health care provider services, either given in cash or benefits in kind.
 - 35.4.b.ii. For health care providers: sponsorship of events, research and educational grants, payment of services, space rentals or facility fees, and donations for patients, whether given in cash or in kind.



- 35.5. All manufacturers of drugs, medical devices, biological and medical supplies covered by these Rules shall submit reports of disclosures to the DOH subject to existing laws and issuance of a guideline.

Public Health Ethics Committee

- 35.6. A Public Health Ethics Committee shall be constituted as an advisory body to the Secretary of Health to assess the ethical soundness of public health practice, through monitoring and management of conflict of interest declaration and collecting and tracking of financial relationships of manufacturers of drugs, medical devices, and biological and medical supplies with healthcare professionals and providers.
- 35.7. The DOH shall issue guidelines on the composition and tenure of the members of the Public Health Ethics Committee as well as the procedures for review and recommendations for the development of policies and programs.

Section 36. Health Information System

- 36.1. All health service providers and insurers are required to maintain a health information system on enterprise resource planning, human resource information system, electronic health records, and electronic prescription log, including electronic health commodities logistics management information, which shall be electronically uploaded on a regular basis through interoperable systems consistent with standards set by the DOH and PhilHealth and in consultation with the DICT and NPC; *Provided*, That the applicable standards shall be set depending on variables such as type and level of health care providers.
- 36.2. The DOH and PhilHealth, in consultation with the DICT and NPC, shall issue detailed guidelines on the scope and standards of electronic health records, enterprise resource planning, human resource information system, electronic health records, and electronic prescription log including electronic health commodities logistics management information and maintenance of said health information system; *Provided*, That the same shall be without prejudice to future amendments in response to evolving needs and practices.
- 36.3. The DOH and PhilHealth shall fund and engage providers, through appropriate mechanisms, to develop and upgrade information systems, which may be availed at no cost by health care providers and insurers.
- 36.4. The DOH, PhilHealth, health service providers and insurers, shall ensure patient privacy and confidentiality in the maintenance of health information systems, in compliance with RA 10173 (Data Privacy Act).

- 36.5. PhilHealth shall use its contracts to incentivize the incorporation of health information systems, automation of clinical information, improvement of data quality, integration and use of telemedicine, and participation in regional or national health information networks.
- 36.6. The DOH and PhilHealth shall adopt efficient approaches to the best advantage of both agencies in the development and implementation of health information systems based on the result of feasibility studies.
- 36.7. The DOH and PhilHealth shall issue guidelines for the maintenance of the information systems and access of healthcare providers and insurers.

RULE IX. APPROPRIATIONS

Section 37. Appropriations

- 37.1. The amount necessary to implement these Rules shall be sourced from the following:
- 37.1.a. Total incremental sin tax collections as provided for in RA 10351 (Sin Tax Reform Law); *Provided*, That the mandated earmarks, as provided for in RA 7171 (An Act To Promote the Development of the Farmers in the Virginia Tobacco-Producing Provinces) and RA 8240 (An Act Amending Sections 138, 140, and 142 of the National Internal Revenue Code, as amended, and for other purposes), shall be retained;
 - 37.1.b. Fifty-percent (50%) of the national government share from the income of the Philippine Amusement Gaming Corporation (PAGCOR), as provided for in Presidential Decree No. 1869, as amended; *Provided*, That the funds raised for the Act shall be transferred to PhilHealth at the end of each quarter subject to the usual budgeting, accounting and auditing rules and regulations; *Provided, further*, That such funds shall be used by PhilHealth to improve its benefit packages;
 - 37.1.c. Forty percent (40%) of the Charity Fund, net of Documentary Stamp Tax Payments, and mandatory contributions of the Philippine Charity Sweepstakes Office (PCSO), as provided for in RA 1169 (An Act Providing for Charity Sweepstakes Horse Races and Lotteries), as amended; *Provided*, That the funds raised for this purpose shall be transferred to PhilHealth at the end of each quarter subject to the usual budgeting, accounting, and auditing rules and regulations; *Provided, further*, That the funds shall be used by PhilHealth to improve its benefit packages; *Provided, finally*, That the funds shall also be attributed as part of PCSO's Gender Equality, Diversity, and Social Inclusion (GEDSI) Program, subject to applicable rules and regulations of RA 9710 (Magna Carta of Women).
 - 37.1.d. Premium contribution of members;
 - 37.1.e. Annual appropriations of the DOH included in the GAA; and,
 - 37.1.f. National government subsidy to PhilHealth included in the GAA.
- 37.2. A joint guideline shall be issued by concerned national government agencies to ensure that the funds from PCSO and PAGCOR, as provided under the Act, are accurately assessed and timely transferred to PhilHealth in accordance with existing laws, rules, and regulations.
- 37.3. The amount necessary to implement the provisions of the Act shall be included in the GAA and shall be appropriated under the DOH and national government subsidy to PhilHealth. In addition, the DOH, in coordination with PhilHealth may request Congress to appropriate supplemental funding to meet targeted milestones of the Act.

RULE X. PENAL PROVISIONS

Section 38. Penal Provisions

38.1. Any violation of the provisions of these Rules, after due notice and hearing, shall suffer the corresponding penalties as herein provided:

Offenses of Health Care Providers of Population-based Health Services

38.2. Any health care provider contracted for the provision of population-based health services, who violates any of the provision in their respective contracts, shall be subject to sanctions and penalties under each respective contract without prejudice to the right of the government to institute any criminal or civil action before the proper judicial body; *Provided*, That individuals or corporate personalities may file complaints to the DOH regarding any violation of said contract; *Provided, further*, That the DOH may pursue complaints as necessary.

Offenses of Health Care Providers of Individual-based Health Services

Classification of Offenses

38.3. Offenses committed by the health care provider for the provisions of individual-based health services are classified as fraudulent acts, unethical acts, and abuse of authority.

Penalties

38.4. Offenses committed by a health care provider for unethical acts, abuse of authority vested upon the health care provider, or performance of a fraudulent act, shall be penalized a fine of Two hundred thousand pesos (Php 200,000.00) for each count, or suspension of contract up to three (3) months or the remaining period of its contract or accreditation, whichever is shorter, or both, at the discretion of PhilHealth, taking into consideration the gravity of the offense.

38.5. If the health care provider is a juridical person, its officers and employees or other representatives found to be responsible, who acted negligently or with intent, or have directly or indirectly caused the commission of the violation shall be liable.

38.6. Recidivists may no longer be contracted as participants of the Program.

Definition of Offenses

- 38.7. PhilHealth shall prescribe the definitions of specific offenses of health care providers and members, rules on administrative cases, and the period to resolve from investigation to the resolution of the cases including Rules on Preventive Suspension, Withdrawal of Contract or Accreditation, and Temporary Suspension of Payment of claims pending investigation; *Provided*, That non-compliance with the policy on no co-payment, co-payment and co-insurance shall likewise be penalized.

Criminal Case

Violation of RA 7875 (National Health Insurance Act of 1995) and RA 11223 (Universal Healthcare Act)

- 38.8. A criminal complaint shall be filed against the health care provider, and, if a juridical person, the officers, employees or other representatives of the health facility, community-based health care organization, pharmacy/laboratory and diagnostic clinic, and health care provider network found to be responsible, who acted negligently or with intent, or have directly or indirectly caused the commission of the violation referred to in Section 38 (b) of the Act. A criminal violation is punishable by imprisonment of six (6) months and one (1) day up to six (6) years, upon discretion of the court without prejudice to criminal liability defined under the Revised Penal Code.

Civil Case

Filing of Civil Action

- 38.9. The filing of an administrative or criminal action does not preclude PhilHealth from filing a separate civil action against the health care provider before the appropriate court

Offenses of Members

- 38.10. A member who commits any violation of the Act; fails to pay all missed contributions with an interest, compounded monthly, as provided in Section 9 of the Act; or, knowingly and deliberately cooperates or agrees, whether explicitly or implicitly, to the commission of a violation by a contracted health care provider or employer, as defined in this provision, including the filing of a fraudulent claim for benefits or entitlement under the Act, shall be punished, after due notice and hearing, by a fine of Fifty thousand pesos (Php 50,000.00) for each count or suspension from availment of the benefits of the Program for not less than three (3) months but not more than six (6) months, or both, at the discretion of PhilHealth.

Offenses of Employers

Failure or Refusal to Register Employees

38.11. Any employer, officer, or responsible employee who deliberately or through inexcusable negligence fails or refuses to register employees regardless of their employment status shall be punished, after due notice and hearing, with a fine of Fifty thousand pesos (P50,000.00) for every violation per affected employee, or imprisonment of not less than six (6) months but not more than one (1) year, or both such fine and imprisonment, at the discretion of the court.

Failure or Refusal to Deduct Contributions

38.12. Any employer, officer, or responsible employee who deliberately or through inexcusable negligence fails or refuses to accurately and timely deduct contributions from the employee's compensation shall be punished, after due notice and hearing, with a fine of Fifty thousand pesos (Php 50,000.00) for every violation per affected employee, or imprisonment of not less than six (6) months but not more than one (1) year, or both such fine and imprisonment, at the discretion of the court.

Failure or Refusal to Accurately and Timely Remit Contributions

38.13. Any employer, officer, or responsible employee who deliberately or through inexcusable negligence fails or refuses to accurately and timely remit contributions from the employee's compensation shall be punished, after due notice and hearing, with a fine of Fifty thousand pesos (Php 50,000.00) for every violation per affected employee, or imprisonment of not less than six (6) months but not more than one (1) year, or both such fine and imprisonment, at the discretion of the court.

Failure to Refusal to Submit Report

38.14. Any employer, officer, or responsible employee who deliberately or through inexcusable negligence fails or refuses to submit the report of the contributions to PhilHealth shall be punished, after due notice and hearing, with a fine of Fifty thousand pesos (Php 50,000.00) for every violation per affected employee, or imprisonment of not less than six (6) months but not more than one (1) year, or both such fine and imprisonment, at the discretion of the court.

Presumption of Misappropriation

38.15. Any employer, officer, or employee authorized to collect contributions under these Rules who, after collecting or deducting the monthly contributions from the employee's

compensation, fails or refuses for whatever reason to accurately and timely remit the contributions to PhilHealth within thirty (30) days from due date shall be presumed prima facie to have misappropriated the same and to have been obligated to hold the same in trust for and in behalf of the employees and PhilHealth, and shall be immediately obligated to return or remit the amount.

- 38.16. If the employer is a juridical person, its directors, trustees, president, general manager, partners, and other officers and employees or other representatives found to be responsible, whether they acted negligently or with intent, or have directly or indirectly caused the commission of the violation, shall be liable.

Unlawful Deduction

- 38.17. Any employer or its officers or employees who deducts, directly or indirectly, from the compensation of the covered employees or otherwise recover from them the employer's own contribution on behalf of such employees shall be punished, after due notice and hearing, with a fine of Five thousand pesos (P5,000.00) multiplied by the total number of affected employees or imprisonment of not less than six (6) months but not more than one (1) year, or both such fine and imprisonment, at the discretion of the court.
- 38.18. If the unlawful deduction is committed by an association, partnership, corporation or any other institution, its managing directors or partners or president or general manager, or other persons responsible for the commission of the act shall be liable for the penalties provided for in the Act.

Offenses of Directors, Officers, or Employees of PhilHealth

- 38.19. Any director, officer or employee of PhilHealth who:
- 38.19.a. Without prior authority or contrary to the provisions of the Act or these Rules, wrongfully receives or keeps funds or property payable or deliverable to PhilHealth, and who appropriates and applies such fund or property for personal use; or shall willingly or negligently consents either expressly or implicitly to the misappropriation of funds or property without objecting to the same and promptly reporting the matter to proper authority shall be liable for misappropriation of funds under these Rules and shall be punished, after due notice and hearing, with a fine equivalent to triple the amount misappropriated per count and suspension for three (3) months without pay;
 - 38.19.b. Commits an unethical act, abuse of authority, or performs a fraudulent act shall be administratively liable, after due notice and hearing, to pay a fine of Two hundred thousand pesos (Php 200,000.00) or suspension for three (3) months without pay, or both, at the discretion of PhilHealth, taking into consideration the gravity of the offense. The same shall also constitute a criminal violation punishable by imprisonment for six (6) months and one (1) day up to six (6) years, upon discretion of the court without prejudice to criminal liability defined under the Revised Penal Code.

Other Violations

- 38.20. Failure to submit health and health-related data to PhilHealth by health-related entities shall be penalized, after due notice and hearing, with a fine of not less than Five thousand pesos (Php 5,000.00) but not more than Twenty thousand pesos (Php 20,000.00), per count.
- 38.21. Other violations of the provisions of the Act or of the rules and regulations promulgated by PhilHealth shall be punished, after due notice and hearing, with a fine of not less than Five thousand pesos (Php 5,000.00) but not more than Twenty thousand pesos (Php 20,000.00).
- 38.22. All other violations involving funds of PhilHealth shall be governed by the applicable provisions of the Revised Penal Code or other laws, taking into consideration the rules on collection, remittances, and investment of funds as may be promulgated by PhilHealth.

Circumstances Affecting Penalties

- 38.23. PhilHealth shall prescribe and enumerate circumstances that shall mitigate or aggravate the liability of the offender or erring health care provider, member or employer.
- 38.24. Individuals or corporate personalities may file complaints to the DOH or PhilHealth regarding any violation; *Provided*, That the DOH or PhilHealth may pursue complaints as necessary.

Effects of Cessation of Operation

- 38.25. Despite the cessation of operation by a health care provider or termination of practice of an independent health care professional, while the complaint is being heard, the proceeding shall continue until the resolution of the case.

RULE XI. MISCELLANEOUS PROVISIONS

Section 39. Oversight Provision

- 39.1. A Joint Congressional Oversight Committee on UHC shall be created to conduct a regular review, of the implementation of the Act which shall entail a systematic evaluation of the performance, impact or accomplishments of these Rules and the performance of the various agencies, such as but not limited to, DOH, PhilHealth, LGUs, and the private healthcare providers involved in realizing UHC, particularly with respect to their roles and functions.
- 39.2. The Joint Congressional Oversight Committee shall be jointly chaired by the Chairpersons of the Senate Committee on Health and Demography and the House of Representatives Committee on Health. It shall be composed of five (5) members from the Senate and five (5) members from the House of Representatives, to be appointed by the Senate President and the Speaker of the House of Representatives, respectively.
- 39.3. The National Economic and Development Authority, in coordination with the PSA, National Institutes of Health, and other academic institutions shall undertake studies to validate and evaluate the accomplishments of these Rules. These validation studies and annual reports, on the performance of the DOH and PhilHealth shall be submitted to the Joint Congressional Oversight Committee.
- 39.4. The DOH and PhilHealth shall allocate an adequate funding for the purpose of conducting the studies provided under Section 39.3 of these Rules.
- 39.5. The Joint Congressional Oversight Committee shall commission an independent study to evaluate the implementation of the Act.

Section 40. Performance Monitoring Division

- 40.1. The DOH shall establish a Performance Monitoring Division (PMD) which shall be responsible for:
- 40.1.a. Developing an inclusive and effective platform for monitoring and evaluating the performance of the health sector in the context of the implementation of these Rules;
 - 40.1.b. Facilitating the engagement of third-party providers, as may be deemed necessary, to ensure unbiased conduct of monitoring and evaluation activities;
 - 40.1.c. Coordinating with other DOH offices, other national government agencies and LGUs, development partners, civil society organizations and sectoral

stakeholders, to ensure co-ownership of targets and complementation of activities; and,

40.1.d. Operationalizing an assistance and feedback mechanism among various stakeholders and particularly for patients, to ensure that implementation is patient centered.

40.2. The DOH shall establish performance monitoring units up to the regional level and in all DOH hospitals to assist in the implementation of these Rules.

Section 41. Transitory Provision

41.1 Within thirty (30) days from the effectivity of the Act, the President of the Philippines shall appoint the new members of the Board and the President of PhilHealth. The existing board of directors shall serve in a hold-over capacity until a full and permanent board of directors of PhilHealth is constituted and functioning.

41.2 All officers and personnel of PhilHealth, except members of the Board who shall be governed by Section 41.1 of these Rules, shall continue to perform their duties and responsibilities and receive their corresponding salaries and benefits; *Provided*, That the approval of the Act and these Rules shall not cause any demotion in rank or diminution of salary, benefits and other privileges of the incumbent personnel of PhilHealth; *Provided, further*, That qualified officers and personnel may voluntarily elect for retirement or separation from service and shall be entitled to the benefits under existing laws; *Provided, finally*, That PhilHealth shall submit for approval the compensation framework to the Office of the President, and the organizational structure and early retirement program to the PhilHealth Board of Directors, within one (1) year from the effectivity of these Rules.

41.3. All affected officers and personnel of the PCSO shall be absorbed by the agency without demotion in rank or diminution of salary, benefits and other privileges; *Provided*, That qualified officers and personnel of the agency may voluntarily elect for retirement or separation from service based on PCSO Board-approved Early Retirement Incentive Program (ERIP), utilizing internally-generated funds, or savings from its operating fund or the Office of the President approved existing ERIP of the Agency; *Provided, finally*, That the retirement benefit package shall be reasonable and within the bounds of existing laws.

41.4. In the first six (6) years from the enactment of these Rules, the national government, through the DOH, DILG and PhilHealth, shall provide technical and financial support, in addition to support regularly provided, to selected LGUs that commit to province-wide and city-wide integration, subject to further review after the lapse of six (6) years.

41.4.a. In the first three (3) years from the enactment of these Rules, the province-wide and city-wide health systems shall exhibit managerial integration, including technical integration, while within the next three (3) years thereafter, the province-wide and city-wide health systems shall exhibit financial

integration. Technical integration refers to the functional and efficient linking of health service provision from primary to tertiary care, when appropriate, across different levels of facilities, care settings, across a comprehensive spectrum of care with primary care as the foundation and intersectoral participation as one of its key principles.

- 41.4.b. To effect a smooth and efficient transition without unduly prejudicing or disrupting the delivery of health services, the integration process shall proceed by phases. The implementation and completion of the minimum requirements of each phase may proceed ahead of the recommended timeline.
 - 41.4.b.i. *Phase I.* This shall include all the preparatory works needed to facilitate local health systems integration, such as operational guidelines, baseline studies, training needs assessment, development of local investment plan for health, and organization of local health board and its support unit. The SHF shall also be created.
 - 41.4.b.ii. *Phase II.* This shall include the DOH provision of technical assistance to the province-wide and city-wide health system in building their capabilities in managing the integrated health systems. Each province-wide and city-wide health system shall have organized its primary care provider network(s), an improved governance structure, and a functional health board managing the SHF. The health care provider networks shall be contracted by PhilHealth.
 - 41.4.b.iii. *Phase III.* This shall include the monitoring of the functionality of the integrated local health system.
- 41.4.c. The DOH, in consultation with other stakeholders, shall issue guidelines to determine managerial and financial integration in the province-wide and city-wide health systems. At the minimum, managerial integration, which includes technical integration, shall be characterized by the following:
 - 41.4.c.i. Local ordinance(s) issued on the:
 - 41.4.c.i.a. Integration of the municipalities' and component cities' local health systems to the province-wide health system;
 - 41.4.c.i.b. Implementation of the province-wide and city-wide health systems, in accordance with the Act and these Rules;
 - 41.4.c.ii. Unified governance of the local health system;
 - 41.4.c.iii. Integrated management system, consisting of financing, human resources for health management and development, strategic and investment planning, information management, procurement and supply chain management, and quality assurance/ improvement;
 - 41.4.c.iv. Functional referral system;
 - 41.4.c.v. Functional disaster risk reduction management for health system;
 - 41.4.c.vi. Functional epidemiologic surveillance system; and,
 - 41.4.c.vii. Proactive and effective health promotion programs or campaigns;
- 41.4.d. At the minimum, financial integration shall be characterized by the following:

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- 41.4.d.i. Creation of SHF;
 - 41.4.d.ii. Issuance of health board resolution on the utilization of the SHF, in strict adherence with the national guidelines; and,
 - 41.4.d.iii. Funds exclusively used for health services and health system development;
 - 41.4.e. Upon positive recommendation by an independent study commissioned by the Joint Congressional Oversight Committee on UHC of the overall benefit of province-wide integration and the positive recommendation of the Secretary of Health, all local health systems shall be integrated as prescribed by Section 19 of these Rules through the issuance of an Executive Order by the President.
- 41.5. In the first ten (10) years from the enactment of the Act, PhilHealth may outsource certain functions to ensure operational efficiency and towards the fulfillment of the Act; *Provided*, That any outsourcing shall comply with the provisions of RA 9184 (Government Procurement Reform Act), and its IRR.
- 41.6. In the first three (3) years from the enactment of these Rules, PhilHealth and DOH shall provide reasonable financial and licensing incentives to contracted health care facilities to form health care provider networks. Thereafter, these incentives shall be withdrawn and providers shall be fully subject to the provisions of Section 19 of these Rules. During the transition phase, PhilHealth may continue its accreditation process to ensure that primary care facilities can still be contracted; *Provided*, That accreditation by PhilHealth shall be applicable only in the following circumstances:
- 41.6.a. Absence of DOH licensing/certification process and/or standards for the type of facility in relation to Section 6 of these Rules. PhilHealth may develop the standards for accreditation of said facilities until such time that they are issued licenses and certification by the DOH; or,
 - 41.6.b. No contracted network is available or capable in the province or city to provide the health services.
- 41.7. The HTAC under the DOH shall be established within one (1) year from the effectivity of the Act; *Provided*, That the existing health benefit package shall be rationalized within two (2) years from the establishment of the HTAC.
- 41.8. Within three (3) years from the effectivity of these Rules, all private insurance companies and HMOs, together with DOH and PhilHealth, shall have developed a system of co-payment that complements PhilHealth benefit packages. HMOs and private insurance companies shall comply with guidelines prescribed by PhilHealth and DOH on the application of benefits and to cover for amenities and out of pocket expenses and services not covered by PhilHealth. PhilHealth shall coordinate with HMOs and PHIs on the transfer of benefit packages currently covered by HMOs and PHIs but are not covered by PhilHealth.

- 41.9. Within ten (10) years from the effectivity of the Act, only those who have been certified by the DOH and PRC to be capable of providing primary care will be eligible to be a primary care provider.
- 41.10. For the first two (2) years from the effectivity of the Act, the PCSO shall transfer at least fifty percent (50%) of the forty percent (40%) of the charity fund per year, in accordance with Section 37(c) of the Act, to enable the PCSO to conclude and liquidate its Individual Medical Assistance Program At-Source-ang-Processing (IMAP-ASAP) obligations.

Section 42. Interpretation

- 42.1. All doubts in the implementation and interpretation of the Act, including these Rules, shall be resolved in favor of upholding the rights and interests of every Filipino to quality, accessible and affordable health care
- 42.2. Nothing in these Rules shall be construed to eliminate or in any way diminish Program benefits being enjoyed at the time of promulgation of th Act.

Section 43. Separability Clause

- 43.1. If any part or provision of the Act and these Rules is held invalid or unconstitutional, the remaining parts or provisions not affected shall remain in full force and effect.

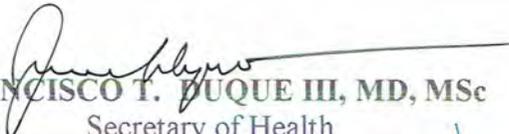
Section 44. Repealing Clause

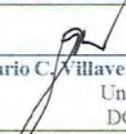
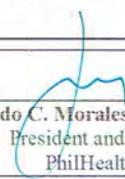
- 44.1. Except as otherwise expressly provided in the Act or these Rules, all other laws, decrees, executive orders, proclamations and administrative regulations or parts thereof inconsistent herewith are hereby repealed or modified accordingly.

Section 45. Effectivity

- 45.1. These Rules shall take effect fifteen (15) days after its publication in the Official Gazette or in any newspaper of general circulation.

Approved:


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

 Usec. Mario C. Villaverde, MD, MPH, MPM CESO I Undersecretary DOH HPSDT	 BGen. Ricardo C. Morales, AFP, (Ret) FICD President and CEO PhilHealth
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