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

RULE I. GENERAL PROVISIONS

Section 1. Title.
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 Policy
These Rules shall enforce RA No. 11223 and its spirit in its entirety, embodying the following principles:

2.1. 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;

2.2. 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;

2.3. 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

2.4. A people-oriented and rights-based 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. Statement of Objectives
The objectives of these Rules are to:
3.1. 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

3.2. 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 this Act and RA No. 7875 entitled “National Health Insurance Act of 1995” as amended or their implementing rules and regulations, and is inimical to the public.

4.2. Amenities – Refer to features of health services 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, at the minimum, 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 health insurance plan, as defined in the Act.

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 (hereinafter referred to as PhilHealth), as defined in the Act.

4.6. Contracting – Refers to a process of engaging providers and networks to deliver quality health services at agreed cost and quantity, in compliance with prescribed standards.
4.7. **Coordinator** – Refers to a health care provider with the function of referring individuals to appropriate health care providers and overseeing transitions of care, including overall integrated case management when necessary.

4.8. **Dependent** – The following are the legal dependents of a member:

4.8.a. Legitimate spouse/s who is not an active member;

4.8.b. Unmarried and unemployed legitimate, legitimated, acknowledged, illegitimate children and legally adopted or stepchildren below twenty-one (21) years of age;

4.8.c. Foster child as defined in RA No. 10165 entitled “Foster Care Act of 2012”.

4.9. **Direct Contributors** – Refer to those who have the capacity to pay premium contributions, 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, as defined in the Act.

4.10. **Domestic Worker or “Kasambahay”** – Refers to any person engaged in domestic work within an employment relationship such as, but not limited to, the following: general househelp, nursemaid or “yaya”, cook, gardener, or laundry person, but shall exclude any person who performs domestic work only occasionally or sporadically and not on an occupational basis. The term shall not include children who are under foster family arrangement and are provided access to education and given an allowance incidental to education, i.e. “baon”, transportation, school projects and school activities as defined in RA No. 10361 entitled “Domestic Workers Act of 2013”.


4.11. **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.

4.12. **Entitlement** – Refers to any singular or package of health services provided to Filipinos for the purpose of improving health.

4.13. **Essential Health Benefit Package** – Refers to a set of individual-based entitlements covered by the National Health Insurance Program which includes primary care; medicines, diagnostics and laboratory; and preventive, curative, and rehabilitative services.

4.14. **Financial Integration** - Refers to the pooling of all health funds by the province-wide and city-wide health systems for exclusive and strategic use for health and health-related needs that demonstrate cost and resource sharing and employ a single planning and investment strategy.

4.15. **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.

4.16. **Health Care Providers** – Refer to any of the following:

   4.16.a. **Health care professional** – Doctor of medicine, nurse, midwife, dentist, or other skilled allied professional or practitioner duly licensed to practice in the Philippines;

   4.16.b. **Health facility** – Public or private facility or institution 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;

4.16.c. **Community-based health care organization** – Organizations or
associations of members of the community organized for the purpose
of improving the health status of that community;

4.16.d. **Pharmacies or drug outlets** – Any establishment which sells or offers
to sell any health product directly to the general public as defined in
RA No. 9711 entitled “Food and Drug Administration Act of 2009”;
and

4.16.e. **Laboratories and diagnostic clinics** – Any facility where tests are
done on specimens from the human body to obtain information about
the health status of a patient for the prevention, diagnosis and
treatment of diseases.

4.17. **Health Maintenance Organizations (HMOs)** – Refer to entities that provide,
offer, or cover designated health services for its plan holders or members for a
fixed prepaid premium.

4.18. **Health and Health-Related Data** – Refer to data and information that relate to
the physical or mental health and well-being of an individual or population; data
gathered as a matter of running a healthcare system, preventing illness and
promoting health, providing health services, registering births and deaths,
conducting health research, health insurance membership and claims processing
and others, and administrative and survey data and its related micro and meta
data as identified by the Department of Health (hereinafter referred to as DOH).
4.19. **Health-Related Entities** – Refer to health care providers, HMOs and private health insurance companies issued certificates of authority by the Insurance Commission, pharmacies and pharmaceutical companies licensed for operation by the Food and Drug Administration, all other agencies involved in the collection and processing of health and health-related data and/or providing health services, and those identified by the DOH.

4.20. **Health Technology** – Refers to the application of organized knowledge and skills in the form of devices, medicines, vaccines, procedures and systems developed to solve a health problem and improve quality of lives.

4.21. **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 clinical, social, economic, organizational, environmental, and ethical issues of a health intervention or health technology.

4.22. **Immediate Eligibility** – Refers to the ability to avail and access health services without the need for any documentary requirements for identification of citizenship, certification of indigency, PhilHealth membership and contribution, among others.

4.23. **Indirect Contributors** – Refer to all others not included as direct contributors, as well as their qualified dependents, including those who are subsidized as a result of special laws, whose premiums shall be subsidized by the national government,
4.24. **Individual-Based Health Services** – Refer to services that 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.

4.25. **Managerial Integration** – Refers to the consolidation of administrative and managerial functions of the province-wide and city-wide health systems over its resources such as health facilities, human resources for health, health information systems, health technologies and equipment, and supply chain management.

4.26. **National Health Insurance Program (NHIP)** – Refers to the compulsory health insurance program of the government as established in this Act, which shall provide universal health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all citizens of the Philippines.

4.27. **Navigator** – Refers to a health care provider with the function of directing the individual to obtain health services needed to manage a wide range of health needs and eliminating barriers for timely, cost-effective, and appropriate care or service.

4.28. **Population-Based Health Services** – Refer to interventions such as health promotion, disease surveillance, and vector control, which have population groups as recipients.

4.29. **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.
4.30. **Primary Care Provider** – Refers to a health care worker, with defined competencies, who has received certification in primary care as determined by the DOH or any health institution that is licensed and certified by the DOH.

4.31. **Private Health Insurance (PHI)** – Refers to coverage of a defined set of health services financed through private payments in the form of a premium to the insurer.

4.32. **Public Health Emergency** – Refers to any actual threat to public health or safety.

4.33. **Public Health Practice** – Refers to the development, implementation, management, and evaluation of a public health policy, program, or system, and the conduct of activities that prevent disease or injury, such as but not limited to population health assessment, disease surveillance, and outbreak investigation all of which are primarily intended to protect or improve the health of communities.

4.34. **Public Health Research** – Refers to the systematic collection and analysis of identifiable health data by a public health authority, practitioner, or designee for the purpose of generating knowledge to improve public health practice.

4.35. **Recidivist** – Refers to one who, at that time of hearing for an offense, shall have been previously found liable with finality by the Arbitration Office or by the Board of PhilHealth, for three (3) or more offenses under the same classification of offenses, under these Rules.

4.36. **Underserved and unserved areas** – Refer to any local government unit that has significantly high poverty incidence or magnitude and significantly insufficient health resources (in terms of human resources for health, facilities, or financing) to meet the health needs of its catchment population, as determined by the DOH; and
4.37. **Unethical Act** – Refers to any action, scheme or ploy against the NHIP, such as overbilling, upcasing, 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.

**RULE II. UNIVERSAL HEALTH CARE (UHC)**

**Section 5. Population Coverage**

5.1. Every Filipino citizen, as defined in the existing Philippine Constitution, is automatically included into the National Health Insurance Program, hereinafter referred to as the NHIP.

5.2. The Philippine Health Insurance Corporation, hereinafter referred to as PhilHealth, is required to include all Filipinos in the database of its members.

5.3. PhilHealth shall coordinate with other national agencies such as but not limited to the Department of Social Welfare and Development (hereinafter referred to as DSWD), Department of Foreign Affairs (hereinafter referred to as DFA), Department of Labor and Employment (hereinafter referred to as DOLE), Department of Trade and Industry (hereinafter referred to as DTI), Civil Service Commission (hereinafter referred to as CSC), Bureau of Internal Revenue (hereinafter referred to as BIR), Philippine Overseas Employment Administration (hereinafter referred to as POEA), Overseas Workers Welfare Administration (hereinafter referred to as OWWA), Philippine Statistics Authority (hereinafter referred to as PSA), Social Security System (hereinafter referred to as SSS), the Government Service Insurance System (hereinafter referred to as GSIS), and health care facilities towards the inclusion of all
Filipinos in its database. 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 is 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. However, a fair and transparent HTA process as defined in Section 34 of these Rules shall govern the inclusion of health goods and services to which every Filipino is eligible to access thru PhilHealth and DOH.

6.2. The DOH and PhilHealth shall define specific service packages for population-based and individual-based services in accordance with the provisions in Section 17 and 18, respectively.

Comprehensive Outpatient Benefits

6.3. Within two (2) years from the effectivity of this Act, PhilHealth shall implement a comprehensive outpatient benefit, including outpatient drug benefit and emergency medical services, subject to HTA recommendations as prescribed under Section 34 of these Rules. The benefits include but not limited to:

6.3.a. Services of health care professionals;

6.3.b. Diagnostic, laboratory, dental and other medical services;

6.3.c. Personal preventive services;

6.3.d. Prescription drugs and biologicals, subject to the limitations of the Act; and

6.3.e. Other services deemed appropriate
6.4. PhilHealth shall continue to implement existing or current packages for individual-based services unless reclassified by the DOH as population-based services.

**Provision of Primary Care Providers**

6.5. 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 of these Rules.

6.6. The primary care provider shall act as the navigator, initial and continuing point of contact in health care delivery system, and coordinator of access to higher levels of care, except in emergency or serious cases and when proximity of the facility or services is a concern, subject to the guidelines to be issued by PhilHealth and the DOH.

**Registration of Filipinos to Primary Care Provider Networks**

6.7. Every Filipino shall register with a public or private primary care provider of choice with due consideration, but not limited 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, provided that within the first year of implementation of this Act, PhilHealth shall register all Filipinos to the primary care providers taking into consideration geographic and spatial considerations.

6.8. The DOH, the Professional Regulation Commission (hereinafter referred to as PRC), PhilHealth shall promulgate the guidelines on the licensing of primary care providers and the registration of every Filipino to a primary care provider within 90 days from the effectivity of these Rules, provided that:
6.8.a. The DOH and PhilHealth shall define the standard processes, procedures, guidelines, form, and data, among others, in the registration of every Filipino to a primary care provider;

6.8.b. The DOH and PhilHealth shall use geographically-defined catchment, spatial area, and care service capacity, in determining the primary care provider to which Filipinos are registered to for the first year; and

6.8.c. PhilHealth shall establish, manage, and maintain the electronic submission of data pertinent to the registration of every Filipino to a primary care provider in accordance to Section 31 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, with PhilHealth, the Department of Budget and Management (hereinafter referred to as DBM) and the Department of Interior and Local Government (hereinafter referred to as DILG), in consultation with LGUs and health services and health care provider partners, shall identify the milestones for the transition of other sources of financing of health facilities to improve the prospective payment mechanism of PhilHealth as defined in Section 18.

7.1.b. Other National Government Agencies (hereinafter referred to as NGAs), LGUs, international development 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 services. Province-wide and city-wide health systems as defined in Section 19 of these Rules shall ensure funding for the effective 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.

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. To rationalize financing schemes, the DOH and PhilHealth, in consultation with private health insurance and HMOs, shall develop guidelines and monitoring schemes to ensure that there is complementation in the financing coverage of individual-based health services in accordance to Sections 18 and 28 of these Rules.

RULE III. NATIONAL HEALTH INSURANCE PROGRAM

Section 8. NHIP Membership

8.1. Membership into the NHIP shall be simplified into two (2) types, direct contributors and indirect contributors, as defined in Section 4 in the Act.

8.2. Direct contributors, including their qualified dependents as defined in Section 4 of these Rules, shall be composed but not limited to the following:

8.2.a. Employees with formal employment characterized by the existence of an employer-employee relationship including workers in the government and private sector, whether regular, casual, or contractual, is occupying either an elective or appointive position, regardless of
status of appointment, whose premium contribution payments are equally shared by the employee and the employer;

8.2.b. Domestic worker or Kasambahays;

8.2.c. All other workers who are not covered by formal contracts or agreements or no employee-employer relationship, 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 Filipinos, such as:
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 with or without Dual Citizenship; and
8.2.f. Lifetime Members.

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

8.4. Indirect contributors, including their qualified dependents as defined in Section 4, shall be composed of the following, but not limited to:

8.4.a. Indigents identified by the DSWD;
8.4.b. Pantawid Pamilyang Pilipino Program/Modified Conditional Cash Transfer (4Ps/MCCT);
8.4.c. Senior Citizens;
8.4.d. Persons with Disability;
8.4.e. Sangguniang Kabataan (SK) barangay officers; and
Those previously identified as point of service (POS) and are financially incapable to pay premiums, subject to the guidelines to be issued by PhilHealth.

Section 9. Entitlement to Benefits

Benefit Availment

9.1. Every member is granted immediate eligibility for health benefit packages under the NHIP.

9.2. The PhilHealth Identification Card shall not be required in the availment of any health service. However, those who are not in the PhilHealth database shall be duly registered by health care facilities, subject to the guidelines to be developed by PhilHealth.

9.3. Failure to pay premiums shall not prevent the enjoyment of any NHIP benefits. However, employers and self-employed direct contributors are required to pay all missed contributions with an interest, compounded monthly:

9.3.a. At least three percent (3%) for employers of:

9.3.a.i. Private and government sector;

9.3.a.ii. Sea-based migrant workers; and

9.3.a.iii. Kasambahays;

9.3.b. Not exceeding one and one-half percent (1.5%) for:

9.3.b.i. Self-earning individuals;

9.3.b.ii. Professional practitioners;

9.3.b.iii. Land-based migrant workers; and

9.3.b.iv. Other overseas Filipinos with or without dual citizenship.
No Co-payment Policy

9.4. No other fees or expenses, including professional fees, shall be charged to all Filipinos admitted in any basic or ward accommodations.

9.5. Filipinos who opt for basic or ward accommodations must 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, Filipinos who opt for basic/ward accommodation but admitted in non-basic accommodation must be entitled to no co-payment for services, professional fees, and amenities.

9.7. In the event of change in level of care, Filipinos who opt for basic or ward accommodation shall be treated with the same unless otherwise chosen by the patient or legal next of kin.

9.8. Filipinos who opt for admissions in non-basic or non-ward accommodations may be charged co-payments for services, professional fees, and amenities.

9.9. PhilHealth shall issue guidelines operationalizing this provision within 90 days from the effectivity of these Rules.

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 within 90 days from the effectivity of these Rules.

9.11. The DOH, PhilHealth, and health facilities are required to regularly inform all Filipinos of the co-payment or co-insurance scheme as prescribed by DOH and PhilHealth.
PhilHealth for public health care providers and public-led health care provider networks, and 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 PHIs are required to regularly inform all Filipinos of the complementation and co-insurance policies as prescribed in Section 28 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:

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<tr>
<th>Year</th>
<th>Premium Rate</th>
<th>Income Floor</th>
<th>Income Ceiling</th>
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<tbody>
<tr>
<td>2019</td>
<td>2.75 %</td>
<td>Php 10,000.00</td>
<td>Php 50,000.00</td>
</tr>
<tr>
<td>2020</td>
<td>3.00 %</td>
<td>Php 10,000.00</td>
<td>Php 60,000.00</td>
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<td>2021</td>
<td>3.50 %</td>
<td>Php 10,000.00</td>
<td>Php 70,000.00</td>
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<td>4.00 %</td>
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<td>Php 80,000.00</td>
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<tr>
<td>2023</td>
<td>4.50 %</td>
<td>Php 10,000.00</td>
<td>Php 90,000.00</td>
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<td>2024</td>
<td>5.00 %</td>
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<td>2025</td>
<td>5.00 %</td>
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10.2. The following special provisions shall apply to the following:

10.2.a. **Self-earning Individuals and Practicing Professionals** – The premium contribution rate 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 within 90 days from the effectivity of these Rules.

10.2.b. **Domestic Workers or Kasambahays** - Premium payments or contributions of Kasambahays shall be shouldered by the employer. However, if the domestic worker is receiving a wage of Five thousand pesos (P5,000.00) and above per month, the domestic worker shall pay the proportionate share in the premium payments or contributions, as provided by RA No. 10361.

10.2.c. **Overseas Filipinos** - The premium contribution rate 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.

10.2.d. **Persons with Disability** – Premium payments or contributions of formally employed PWDs must be shared equally by their employers and the national government as provided by RA No. 11228 entitled “An Act Providing for the Mandatory PhilHealth Coverage for All Persons with Disability (PWDs)”. 

10.2.e. **Students and previously declared dependents who turn 21 years old**

– Students and previously declared dependents who turn 21 years old and have the capacity to pay premiums but are not formally employed shall pay their premiums based on the income floor.

**Indirect Contributors**

10.3. The premium subsidy for indirect contributors shall be gradually adjusted and included annually in the General Appropriations Act (hereinafter referred to as the 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.

**Section 11. Program Reserve Funds**

11.1. PhilHealth must 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 above-mentioned 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 may 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 investments 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 institutions created or existing under the laws of the Philippines listed in the stock exchange with high growth opportunities and earning 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 paragraphs (a) to (e) hereof, 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. 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.

11.8. As part of its investment 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 is required to submit an annual report on investment performance to PhilHealth.

11.9. The PhilHealth shall set up the following funds:

11.9.a. A fund to secure benefit payouts to member prior to their becoming lifetime members;

11.9.b. A fund to secure payouts to lifetime members; and

11.9.c. A fund for optional supplemental benefits that are subject to additional contributions.

11.10. A portion of each of the above funds shall be identified as current and kept in liquid instruments. In no care shall said portion be considered part of invested assets.

11.11. PhilHealth shall allocate a portion of all contributions to the 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.

11.12. PhilHealth is required to manage the supplemental benefits and the lifetime members’ funds in an actuarially sound manner.
11.13. PhilHealth is required to manage the supplemental benefits fund to the
minimum required to ensure that the supplemental benefit payments are secure.

Section 12. Administrative Expense

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 must 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:
   13.1.a.i. Secretary of Health;
   13.1.a.ii. Secretary of Social Welfare and Development;
   13.1.a.iii. Secretary of Budget and Management;
   13.1.a.iv. Secretary of Finance; and,
   13.1.a.v. 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 following:
   13.1.c.i. Direct contributors;
   13.1.c.ii. Indirect contributors;
   13.1.c.iii. Employers group;
13.1.c.iv. Health care providers to be endorsed by their national associations of health care institutions and health care professionals; and

13.1.c.v. 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 must be 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 the ex officio non-voting Chairperson of the Board.

13.6. All appointive members of the Board are required to undergo training on health care financing, health systems, costing health services and health technology assessment, among others, prior to the start of their term and shall be conducted by PhilHealth. Non-compliance to this clause constitutes grounds for dismissal.
For this purpose, PhilHealth must develop and implement a training program to ensure that members of the Board of Directors possess the basic competencies they need to be effective and responsive.

13.7. Within thirty (30) days following the effectivity of this Act, the Governance Commission for Government-Owned or -Controlled Corporations (GCG) shall, in accordance with the provisions of RA No. 10149, promulgate the nomination and selection process for appointive members of the Board with a clear set of qualifications, credentials, and recommendations 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. 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 fields of expertise.

Section 15. PhilHealth Personnel as Public Health Workers

15.1. All PhilHealth personnel are classified as public health workers in accordance with the pertinent provisions under RA No. 7305 entitled “Magna Carta for Public Health Workers”.

15.2. In line with RA 7305 and Section 23 of these Rules, PhilHealth shall endeavor to offer permanent employment to all currently employed job order and project-based personnel and shall offer competitive salaries to all regular employees.

15.3. PhilHealth shall allocate in their Corporate Operating Budget the necessary annual budgetary requirements for this purpose.
Section 16. Additional Powers and Functions of the Philippine Health Insurance Commission

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 its positions, including its President and Chief Executive Officer, 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 that 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, subject to the approval of the President of the Philippines, 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;

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 authorize such capital and operating expenditures and disbursements as may be necessary and proper for the effective management and operation of PhilHealth, provided that:

16.1.d.i. This provision shall be subject to the budgetary limitations stated under Section 12 of the Act; and

16.1.d.ii. The submission of the corporate budget to the Department of Budget and Management (DBM) shall be for information purposes only.

RULE IV. HEALTH SERVICE DELIVERY

Section 17. Population-based Health Services

17.1. The Department of Health shall endeavor to contract province-wide and city-wide health systems as defined in Section 19 of these Rules, including BARMM, for the delivery of population-based health services through a legal instrument to ensure shared responsibilities and accountabilities among members of health systems.

17.2. Health services shall be classified as population-based health services if they fulfill any of the following criteria:

17.2.a. Intended to benefit populations or identified groups of people, of which outcomes contribute to general public health, safety and protection; or,
17.2.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; or,

17.2.c. Intended to impact social determinants of health or underlying causes of illness.

17.3. International, national, and local investments to operationalize province-wide and city-wide health systems shall be incorporated into the province- and city-wide investment plans for health, also known as the local investment plans for health. Local investment plans for health shall serve as the basis for grants from national government. The Department of Health shall develop the necessary annual guidelines on the provision of these grants.

17.4. Province-wide and city-wide health systems shall have the following minimum population-based health service components:

17.4.a. A Primary Care Provider Network (hereinafter referred to as PCPN), which refers to a coordinated group of health workers and/or facilities, whether public, private, or a mix of both, that provides primary care services as described in Section 4 of this Act and enables patient records to be accessible throughout the health system.

17.4.a.i. The PCPN shall:

17.4.a.i.(1) 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;
17.4.a.i.(2) Ensure patient records are securely stored and accessible throughout the health care provider network to which it belongs. Government health facilities shall lead in the collection and management of shared patient records, while private primary care provider facilities shall be encouraged to participate actively in the existing health system; and

17.4.a.i.(3) Coordinate with PhilHealth and the DOH to establish a mechanism in accessing and sharing patient records and data, including patient’s medical and health information throughout the health system, in accordance RA No. 10173 entitled “Data Privacy Act of 2012” and other statutory laws.

17.4.a.ii. To facilitate these services, a primary care unit shall be established in all hospitals. These units shall be linked with primary care provider facilities within their network;

17.4.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 to Sections 31 and 36 of these Rules; and

17.4.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.

17.5. In addition, province-wide and city-wide health systems may include the following population-based health components:

17.5.a. Effective and efficient environmental health management, including vector control and water sanitation;

17.5.b. Timely, effective, and efficient preparedness and response to public health emergencies and disasters, which refer to a public health emergency in which local authorities cannot cope; and

17.5.c. Such other means to ensure delivery of population-based health services.

17.6. The DOH, within one (1) year from the effectivity of these Rules, shall develop guidelines for contracting province-wide and city-wide health systems for the delivery of population-based health services, ensuring that the abovementioned components are met.

Section 18. Individual-based Health Services

18.1. PhilHealth shall endeavor to contract public, private, or mixed health care provider networks (hereinafter referred to as HCPNs) for the delivery of individual-based health services, provided that:

18.1.a. Member access to services shall not be compromised:

18.1.b. Networks agree to service quality, co-payment/ co-insurance, and data submission standards:
During the transition, PhilHealth and DOH shall incentivize health care providers that form networks:

Apex or end-referral hospitals, as determined by the DOH, may be contracted as stand-alone health care providers by PhilHealth.

**Definition of Individual-based Health Services**

18.2. Services shall be classified as individual-based, whether accessed remotely or through a facility, if they fulfill the following criteria:

18.2.a. Intended to benefit a single recipient;

18.2.b. Service intends to treat the illness, and/or the immediate or intermediate causes of illness, with limited effect at a population; and,

18.2.c. Does not alter the underlying cause of illness.

18.3. Services that meet either both population-based and individual-based criteria, or neither of the criteria, shall be classified under population-based services and shall retain its current financing mechanism, provided that these services shall be subject to assessments by the DOH to determine the most efficient financing mechanism.

18.4. All individual-based health services, including those services transitioned from population-based services, shall be covered by PhilHealth. All current benefit packages of PhilHealth shall continue to be covered as individual-based services unless reclassified by the DOH as population-based services.

**Network Contracting**

18.5. Contracted HCPNs must be composed of primary to tertiary care providers that are public, private, or a mix of both, wherein the primary care provider acts as the navigator and coordinator of health care within the network, and with each provider having the following minimum components:
18.5.a. Assurance of member access to all levels of the Health Care Provider Network; and,

18.5.b. A service level agreement with PhilHealth for maintaining service quality, co-payment and co-insurance, and data submission standards that include the following:

18.6. In addition, all Health Care Provider Networks shall include, but not be limited to, the following components:

18.6.a. A primary care provider network as described in Section 17 of these Rules, linked to secondary and/or tertiary care providers; and

18.6.b. Available individual-based health services from the initial point of contact to higher or lower levels of care.

18.6.c. A patient navigation and coordination system that ensures a continuum of coordinated care from primary to tertiary services, as well as custodial care, mental health in accordance to RA No. 11036 entitled “Mental Health Act”, and transitions of care, which shall refer to the various points where, for the purposes of receiving health care, a patient moves to or returns from a physical location or contacts a health care professional. This includes transitions between home, hospital, residential care settings, and consultations with different health care providers in out-patient facilities.

18.6.d. A back referral system that ensures patients are referred back to their assigned primary care providers, once transition back is possible, and that their primary care providers are informed of the following: clinical diagnosis or clinical impression; diagnostics administered;
medications and treatments provided; referrals made to other facilities; and, management plans;

18.6.e. Patient records management system that ensures records are accessible by all facilities or providers within the health care provider network or among other facilities as necessary; and,

18.6.f. Provider payment mechanism based on the guidelines of PhilHealth, as appropriate, provided that these networks shall ensure adequate and sustainable funding to complement shortages and/or stock outs of drugs and supplies, among others, within the network.

18.7. The DOH, in coordination with PhilHealth, shall determine the service quality standards and data submission standards.

18.8. PhilHealth shall contract with health care provider networks, provided that:

18.8.a. All facilities within the network are licensed or certified by the Department of Health, as applicable;

18.8.b. All facilities within the network shall execute or sign a performance commitment with PhilHealth whereby networks shall abide by the standards on service quality, co-payment/co-insurance and data submission as prescribed by PhilHealth;

18.8.c. The network must have a juridical personality and can either be:

18.8.c.i. A group of public providers, subject to the provisions on the organization of local health systems as defined in Sections 19, 20, and 21 of these Rules;

18.8.c.ii. A group of licensed private providers with different levels of care from primary to tertiary and specialized levels of care; or,
18.8.c.iii. A network of mixed private and public providers with different levels of care, bound by a contract, subject to the guidelines of multiple participation in networks as prescribed by the Department of Health and PhilHealth.

18.8.d. Contracted networks and their health care provider members shall be subjected to the quasi-judicial powers of PhilHealth; and,

18.8.e. Networks exhibit clinical, management, and financial integration.

18.9. PhilHealth and DOH shall incentivize health care providers that form networks through the development of guidelines for the selection and payment of health care provider networks based on Section 41(f) of the Act.

**Apex Hospitals**

18.10. Apex or end-referral hospitals, as determined by the DOH, may be contracted as stand-alone health care providers by PhilHealth, provided that the apex or end-referral hospital:

18.10.a. Is classified as a specialty or a tertiary-level hospital based on the classification of DOH and can provide curative, rehabilitative, and palliative care;

18.10.b. Endeavors to contract with multiple health care provider networks;

18.10.c. Navigates and coordinates patients to other facilities as needed; and,

18.10.d. Has all the components of a Health Care Provider Network.

18.11. The Department of Health shall provide PhilHealth an updated list of public and private apex or end-referral hospitals within the last quarter of every year.

**Financing of Individual-based Health Services**

18.12. PhilHealth shall:
18.12.a. Continue to finance individual-based services utilizing current payment mechanisms while preparing to shift to paying providers using performance driven, closed-end, prospective payments based on diagnosis-related groupings and validated costing methodologies and without differentiating facility and professional fees;

18.12.b. Develop differential payment schemes that give due consideration to service quality, efficiency, and equity; and

18.12.c. Institute strong surveillance and audit mechanisms to ensure networks’ compliance to contractual obligations.

18.13. Transitory guidelines for this purpose shall be developed by the DOH, DBM, DILG, in consultation with LGUs and health care providers within 90 days from the effectivity of these Rules.

18.14. For contracted networks and apex hospitals, PhilHealth shall endeavor to shift to paying providers based on disease or diagnosis related groupings and validated costing methodologies and without differentiating facility and professional fees.

18.15. 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 mechanisms that may be determined by PhilHealth. PhilHealth shall issue guidelines implementing this provision within 180 days from the effectivity of these Rules.

18.16. PhilHealth shall develop differential payment schemes that give due consideration to service quality, efficiency, and equity.
18.17. In the event of insufficient funds of providers and networks due to calamities, emergencies, disasters, epidemics and emerging disease, PhilHealth shall consider adjustments in provider payment.

18.18. PhilHealth shall develop information technology-based solutions in support of the institutionalization of regular costing and DRG implementation and shall likewise facilitate capacity building of health care providers for the prospective provider payment mechanism that is required under this Act.

18.19. PhilHealth, through the Department of Science and Technology- Philippine Council for Health Research and Development (hereinafter referred to as DOST-PCHRD), may recognize centers of excellence in qualified academic institutions and research institutions, and provide long-term grants thereof to inform the continuous improvement and updating of the following areas:

18.19.a. Costing and strategic purchasing;

18.19.b. Diagnosis related groups;

18.19.c. Coding standards for diagnosis and procedures, and;

18.19.d. Others that may be deemed necessary, pertinent to provider payment mechanism and benefits development.

18.20. Strong surveillance and audit mechanisms shall be instituted to ensure networks’ compliance to contractual obligations.

RULE V. ORGANIZATION OF LOCAL HEALTH SYSTEMS

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

Roles and Responsibilities in the Integration of Local Health Systems

19.1. The DOH, DILG, PhilHealth, and LGUs shall endeavor to integrate local health systems into province-wide health systems and highly urbanized city (HUC)
and independent component city (ICC)-wide health systems, hereinafter referred to as HUC/ICC-wide health systems or city-wide health systems.

19.2. The local health systems refer to health offices, facilities and services, human resources, and other operations relating to health under the management of the local government units. Community-based mental health care facilities administered or operated by LGUs in accordance to RA No. 11036 are considered to form part of the local health systems.

19.3. Private providers shall also be encouraged to join the integrated health systems through a contractual arrangement with the Province, HUC, or ICC Health Board.

19.4. In the case of the Bangsamoro Autonomous Region in Muslim Mindanao, the adaption of the integrated province- and city-wide health systems shall be specified in their Local Government Code and other related issuances, in reference to RA No. 11054 entitled “Bangsamoro Organic Law”.

19.5. The DOH, through the Centers for Health Development and the DOH Hospitals, 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 HUC/ICC-wide health systems that are resilient, sustainable, and responsive to the needs of the population. The assistance may include, but are not limited to, health systems management and service delivery. Furthermore, the DOH shall provide an environment that shall promote the exchange of knowledge and good practices among the levels of the health care delivery system.

19.6. The DILG shall ensure the integration of LGUs into province-wide and HUC/ICC-wide health systems by a system of coordination and cooperation.
among the local chief executives to ensure the effective and efficient delivery
of health services.

19.7. PhilHealth shall develop and provide incentives to health care providers that
shall form networks, whether public, private, or mixed.

19.8. The component local government units of the provinces and HUCs/ICCs shall
integrate all government-delivered health services, encompassing the
continuum of care, for the entire province and HUC/ICC, respectively. Likewise,
they shall ensure that needed resources and support mechanisms are available
to make the integration possible and sustainable.

19.9. Province-, HUC- and ICC-wide health systems shall deliver both population-
and individual-based services as specified in Sections 18 and 19 of these Rules.

19.10. Pursuant to Section 41(d) of this Act, LGUs that will commit to province-wide
and HUC/ICC-wide integration shall ensure managerial integration for the first
three years and financial integration for the next three years thereafter. The
DOH, in consultation with PhilHealth, DBM, DILG and LGUs, shall develop
the necessary implementing guidelines within 60 days from the effectivity of
these Rules.

**Provincial Integration**

19.11. The Municipal Health Offices, Component City Health Offices, Municipal
Hospitals, Component City Hospitals, and LGU-managed health care providers
in the municipalities and component cities shall be managerially and financially
integrated with the Provincial Health Office, Provincial Hospital(s), and District
Hospitals of the province to constitute the province-wide health system. 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. This health system shall be linked to at least one (1) Apex Hospital.

19.12. The Provincial Health Office is headed by a Provincial Health Officer II (PHO II). Each PHO II shall have one (1) Assistant Provincial Health Officer acting as the Health Service Delivery Manager (HSDM) and another provincial officer of similar level acting as the Health Systems Manager (HSM).

19.12.a. The HSDM shall manage the health service delivery operations of the primary care health facilities and hospitals, and public health programs operations in the province-wide health system, including the implementation of the clinical practice guidelines and referral protocols.

19.12.b. The HSM shall focus on health system financing, information system, logistics and supply chain management, regulation, and procurement of health commodities and products, among others, in close coordination with the concerned offices of the provincial government.

19.13. In consideration of the size, population, and geography of the province, several municipalities and component cities may opt to group themselves to form sub-provincial health systems for effective delivery and management of health services. A sub-provincial health system may overlap with congressional districts within a province, based on contiguity of cooperating municipalities and component cities.

**City Integration**

19.14. The LGU-managed health care providers and City Hospital(s) within each city shall be integrated with the City Health Office of the HUC or ICC to constitute the HUC/ICC-wide health system. The HUC/ICC-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. This health system shall be linked to at least one (1) Apex Hospital.

19.15. The HUC/ICC Health Office is headed by a City Health Officer. Each City Health Officer shall have one (1) Assistant City Health Officer acting as the Health Service Delivery Manager (HSDM) and another city officer of similar level acting as the Health Systems Manager (HSM).

19.15.a. The HSDM shall manage the health service delivery operations of the primary care health facilities and hospitals, and public health programs operations in the HUC/ICC-wide health system, including the implementation of the clinical practice guidelines and referral protocols.

19.15.b. The HSM shall focus on health system financing, information system, logistics and supply chain management, regulation, and procurement of health commodities/products, among others in close coordination with the concerned offices of the city government.

Provincial and HUC/ICC Health Boards

19.16. The Provincial Health Board is headed by the Provincial Governor as Chairperson, and the Provincial Health Officer as Vice Chairperson. The members include the Chairperson of the Committee on Health of the Sanggunian Panlalawigan; a representative of the DOH in the province; a representative of PhilHealth in the province; a representative from accredited people’s organizations, non-governmental organizations or private sector involved in health; a representative from the League of Municipalities/Cities of
the Philippines (LMP/LCP) in the province; a representative from the
Association of Municipal Health Officers of the Philippines (AMHOP) in the
province; and as applicable, a representative of the indigenous cultural
communities or indigenous peoples. The Board may opt to expand its
membership as deemed necessary.

19.17. The HUC/ICC Health Board is headed by the City Mayor as Chairperson, and
the City Health Officer as Vice Chairperson. The members include the
Chairperson of the Committee on Health of the Sanggunian Panglungsod; a
representative of the DOH in the city; a representative of the PhilHealth in the
city; a representative from accredited people’s organizations, non-governmental
organizations or private sector involved in health; and as applicable, a
representative of the indigenous cultural communities or indigenous peoples.
The Board may opt to expand its membership as deemed necessary.

19.18. The Provincial and HUC/ICC Health Boards shall:

19.18.a. Set the overall health policy directions and strategic thrusts;

19.18.b. Propose to the sanggunian concerned, in accordance with the
standards and criteria set by the DOH, DBM, and DILG, annual
budgetary allocations for the operation and maintenance of health
facilities and services within the province, HUC, or ICC, as the case
may be;

19.18.c. Serve as an advisory committee to the sanggunian concerned on
health matters such as, but not limited to, the necessity for and
application of local appropriations for health operations;

19.18.d. Create committees, as necessary, to assist the health board on the
execution of its roles and responsibilities, such as but not limited to,
19.18.e. Oversee and coordinate the integration and delivery of health services across the health care continuum for province-wide and HUC/ICC-wide health systems;

19.18.f. Manage the Special Health Fund; and

19.18.g. Exercise administrative and technical supervision over health facilities and health human resources within their respective territorial jurisdiction.

19.19. In reference to the additional functions of the health board, it may create its own management support unit to assist in its operations, particularly in the management of the Special Health Fund.

19.20. The Provincial, HUC, and ICC Health Boards shall meet at least once a month or as often as may be necessary.

19.21. A majority of the members of the board constitutes a quorum for the purposes of conducting ordinary business of the Provincial, HUC, and ICC Health Boards, but the chairperson or the vice chairperson must be present during meetings where budgetary proposals are being prepared or considered. The affirmative vote of a majority of the members present is necessary to approve proposals relating to ordinary business; however, the affirmative vote of a majority of all of the members of the board is necessary to approve budgetary proposals.

19.22. The chairperson, vice chairperson and members of the health boards shall perform their duties as such 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 Special Health Fund, subject to existing budgeting, accounting, and auditing rules and regulations.

Section 20. Special Health Fund

20.1. A Special Health Fund, hereinafter referred to as the SHF, must be maintained in every province, HUC, and ICC, wherein the province-, HUC-, and ICC-wide health system must pool and manage all resources intended for health services to be provided by the government. The creation of a SHF is a requirement in contracting province-, HUC- and ICC-wide health systems.

20.2. Sources for the SHF shall include financial grants and subsidy from National Government Agencies such as the Department of Health; income from PhilHealth payments; and all LGU budgets for health. An appropriation ordinance must be passed to determine the provincial, city or municipal budget for health, in accordance with existing rules and regulations. Other sources may include, but not limited to, financial grants and donations from Non-Government Organizations, Faith-Based Organizations, and Official Development Assistance. Sub-ledgers shall be created for each source of fund. OR

20.3. As determined and approved by the Provincial, HUC, or ICC Health Board, the SHF shall be allocated for:

20.3.a. Population-based and individual-based health services;

20.3.b. Capital investment such as, but not limited to, infrastructure, equipment, and information technology;

20.3.c. Health research;

20.3.d. Health system operating costs;
20.3.e. Remuneration of additional health workers; and

20.3.f. Incentives for all health workers, including volunteer health workers, in accordance to RA No. 7305 and RA No. 7883, entitled “Barangay Health Workers’ Benefits and Incentives Act of 1995”.

20.4. The allocation of the financial grants from DOH and income from PhilHealth payments shall be based on the contractual obligation of the Province, HUC, or ICC Health Board with the DOH and PhilHealth for population-based services and individual-based services, respectively.

20.5. The Provincial, HUC, or ICC Health Board shall assume full responsibility for the management of the Special Health Fund.

20.6. For this purpose, the DOH, in consultation with the DBM, DILG, Department of Finance, and the LGUs, shall develop guidelines for the allocation and utilization of the Special Health Fund within 180 days from the effectivity of this IRR.

Section 21. Income Derived from PhilHealth Payments

21.1. All income derived from PhilHealth payments shall accrue to the Special Health Fund to be allocated by the LGUs exclusively for the improvement of the province-, HUC- and ICC-wide health systems.

21.2. PhilHealth payments shall be credited to the annual regular income (ARI) of the LGU through a mechanism that shall be determined by DOH, DILG, DOF, and DBM.

21.3. Any efficiency gains or remaining budget from the income derived from PhilHealth payments after completion of target services as provided for in the contract shall be retained by the province-, HUC-, or ICC-wide health system.
as incentive for its health workers or for further improvement of health facilities
and services, subject to the SHF guidelines.

21.4. PhilHealth shall develop and maintain an LGU Health Expenditure and
Utilization System that shall allow real-time submission of data to track LGU
health budgets and expenditures. Required data for this system shall be
considered health and health-related data as defined in Section 4 of these Rules.

Section 22. Incentives for Improving the 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-, HUC- and ICC-wide health systems.

22.2. Underserved and unserved areas as defined in Section 4 of these Rules shall be
given priority in the allocation of grants.

22.3. The province-, HUC-, and ICC-wide investment plans for health, also known
as the local investment plans for health (LIPH), 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.

22.4. The DOH shall develop the annual guidelines on the provision of these grants.

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 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 human resources for health, which include standards for human resources for health requirements, appropriate generation, recruitment, retraining, regulation, retention, productivity mechanisms, and reassessment of the health workforce that shall be updated to accommodate changing population health needs. As such, the Plan shall adopt a comprehensive health labor market and whole of society approach and shall be implemented at national and local levels by both government and private sectors, which shall be developed within one (1) year from the effectivity of these Rules.

23.2. The DOH, in consultation with the DBM and the CSC, shall develop mechanisms to progressively increase the number of permanent positions, and create new positions as necessary, 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 qualified health workers required for continuity of health services and implementation of health programs in priority areas shall be hired in permanent positions under province- and HUC/ICC-wide health systems, provided that recipients of national or local scholarships and grants are prioritized in the selection process.

23.4. All private and non-government health facilities, including laboratories, pharmacies, and other such facilities licensed by the DOH, shall endeavor to meet the minimum required health care professionals and health care workers, with competitive salaries, as set by the DOH. These shall be incorporated into PhilHealth’s contracts for health facilities.
23. Relevant national government agencies, local government units, and the private sector, shall ensure that sufficient resources are available to implement the National Health Human Resource Master Plan. Local investment plans for health shall align its investment needs with the National Health Human Resource Master Plan.

Section 24. National Health Workforce Support System

24.1. For purposes of these Rules, the National Health Workforce support system is a mechanism that shall support equity in local public health systems, such as but not limited to: management systems; policies; system operation expenses; and, salaries, benefits, incentives, capacity development, and occupational health and safety of deployed health care professionals or health care workers.

24.2. To augment health workforce needs of local public health systems, the DOH shall secure positions from a pool of 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 Geographically Isolated and Disadvantaged Areas as defined by this Act, provided that graduates of allied and health-related courses who are recipients of government-funded scholarship programs as defined in Section 25 of this Act 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 wage rates.

24.5. Private entities are encouraged to augment the national pool of positions.

24.6. LGUs shall endeavor to hire health care professionals and health care workers under permanent positions or increase its plantilla positions to meet the required
health care professional and health care worker standards, as determined by the
DOH. LGUs that are unable to achieve these standards are be eligible to receive
deployment augmentation from the National Health Workforce support system.

24.7. National government shall provide support to local government units until such
time the SHF of province- or city-wide health systems is deemed sustainable
and viable by the DOH, provided that a portion of the SHF of province- or city-
wide health systems shall be earmarked for additional personnel services cost
needed to standardize salaries and benefits for all health workers, subject to the
SHF guidelines.

24.8. The DOH shall assess the performance of the National Health Workforce
support system and LGUs’ health workforce complement within five (5) years
from the effectivity of these Rules.

Section 25. Scholarship and Training Program

Expansion of Degree and Non-Degree Training Programs

25.1. The National Health Human Resource Master Plan shall be 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, together with its recognized organizations or societies, 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 a
sufficient number of medical specialists and sub-specialists based on
the health needs of the population and priorities identified by the
DOH, especially those in underserved and unserved areas; and,

25.2.c. Assist national and local government in the establishment of
accredited medical residency and sub-specialty training, and
specialization tracks for allied health professions programs, where
feasible, in provinces where specialists or sub-specialists are in
shortage.

25.3. The Commission on Higher Education (hereinafter referred to as CHED) and
the Technical Education and Skills Development Authority (hereinafter referred
to as TESDA) shall:

25.3.a. Review and update, if 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
HCPNs 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
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 technology vocational training providers and take necessary actions to enforce quality standards.

25.4. The DOH shall:

25.4.a. Assist its hospitals and LGUs in the establishment of medical residency and sub-specialty training and specialization tracks for allied health professions programs 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.

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-

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funded scholarship programs that shall 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 is given by the DOH or CHED through its
government-funded scholarship programs, to eligible individuals, which
include full or supplementary payment for subsidies to complete tuition fees and
other school fees; living, book and uniform allowances; and a corresponding
return service obligation to national or local government as described in Section
26 of this Act, from national government, local government, non-government
or private entities, and international bodies, provided that bona fide residents of
underserved and unserved areas or members of indigenous peoples shall be
prioritized for scholarship grants, and that grantees shall be subject to a return
service agreement under the supervision of the DOH as described in Section 26
of these Rules.

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:

25.8.a. determine the human resources for health data required for the
national health workforce registry;

25.8.b. act as a repository and manager of data collected; and

25.8.c. manage the registry.
25.9. The PRC, together with duly registered medical and allied health professional societies, 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 non-government and 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. Coordinate to produce health care professionals and health care workers capable of providing primary care services as defined in this Act;

25.10.b. Reorient health sciences education towards public health and health promotion;

25.10.c. Determine recommended areas of study in public health to be incorporated in the curriculum of all health sciences education; and,

25.10.d. Determine educational outcomes focusing on primary care to respond to the needs of the country. These shall be incorporated in the program and/or course outcomes of all medical and allied health professional education programs; the scope of licensure examinations, where applicable, for health professions; continuing professional development programs for health professionals; and, certification programs for health workers.

25.11. The DOH and the PRC shall, within three (3) years from the effectivity of these Rules, develop guidelines for the eligibility requirements, standard
competencies, training mechanisms, and certification process for primary care providers. This is without prejudice to any transitory process that may be adopted to implement Section 6(c) of this Act.

Section 26. Return Service Agreement

26.1. All graduates of allied and health-related courses who are recipients of government-funded scholarship programs, as defined 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 locations and facilities 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. Graduates may extend the return service for an additional two (2) years with incentives.

26.2. Scholarship grant recipients shall not be admitted to enter into a program course leading to another profession or career path unless the return service agreement has been fulfilled. Recipients of government-funded scholarship programs shall report to the DOH every six (6) months until such time their return service obligations have been completed.

26.3. Graduates of allied and health-related courses who are recipients of government-funded scholarship programs shall be prioritized for government employment, which includes 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, together with the academic or training institutions, shall set up a monitoring system to track scholarship recipients and graduates and monitor compliance to return service and assess effectivity of the return service agreement.

26.5. The DOH shall source and administer funds for their compensation, incentives, and benefits and issue operational guidelines for the return service monitoring, placement, employment and incentives within 180 days from the effectivity of these Rules.

26.6. 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 of the public sector.

26.7. The DOH, CHED, and PRC shall develop guidelines 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 Ratings 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 measures on:

27.2.a. Provision of complete and appropriate care;

27.2.b. Health outcomes;

27.2.c. Patient satisfaction;

27.2.d. Fund utilization and allocation of resources across providers and different levels of care;
27.2.e. Compliance to standards of clinical practice;

27.2.f. Compliance to guidelines and standards as prescribed by DOH and PhilHealth and other applicable laws; and

27.2.g. 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 providers to be identified by PhilHealth.

**Licensing for Primary Care Facilities and Stand-Alone Health Facilities**

27.4. The DOH shall institute a licensing and regulatory system for stand-alone health facilities, including those providing ambulatory and primary care services, and other modes of health service provision.

27.5. The DOH shall adopt a responsive policy framework to regulate all types of health facilities and services. The DOH shall adopt a risk-based approach in identifying the appropriate regulatory instrument to be used for each type of health facility and service.

27.6. The DOH License to Operate (LTO) shall be valid for at least three (3) years, unless otherwise provided by special laws or regulations. The issuance of DOH LTO shall be independent of permits, registrations, and accreditations issued by other government offices.

27.7. The mandate and enforcement mechanisms to regulate health facilities, products, and services shall be expanded and strengthened. The DOH shall allocate funds and resources to support the expansion of its regulatory mandate.

27.8. The Health Facilities and Services Regulatory Bureau (HFSRB) shall establish line offices at the DOH regional level to strengthen and harmonize the implementation of licensing standards.
Clinical Practice Guidelines

27.9. 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 (hereinafter referred to as CPGs), which refer to systematically developed guideline summaries, based on best evidence, intended to assist practitioners in clinical decision-making on appropriate management of specific clinical conditions or diseases.

27.10. A national program on the development of CPGs is hereby established in the DOH, which shall standardize CPG development in the Philippines. The DOH shall issue guidelines for the operationalization of this provision within 30 days from the effectivity of these Rules.

27.11. PhilHealth shall monitor indicators for efficiency and quality of care. Possible indicators include bed occupancy rate, readmission rate, length of stay, frequency of complications, and compliance to CPGs.

27.12. The CPGs shall be disseminated to relevant stakeholders through various effective channels identified by the DOH. The DOH shall ensure that there is a dissemination plan for DOH-endorsed CPGs or National Guidelines.

Section 28. Affordability

Procurement by DOH-owned Health Care Providers

National Price Reference Indices for Drugs, Medical Devices and Medical 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 medical devices and supplies within one (1) year from the effectivity of these Rules.
28.2. In establishing the price reference indices for drugs and 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 and medical devices shall be centrally negotiated by a Price Negotiation Board at the lowest price that is most advantageous to the government in accordance with RA No. 9184 entitled “Government Procurement Reform Act” and other Government Procurement Policy Board (hereinafter referred to as 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 providers must adhere to the price reference indices in all forms of procurement, in accordance with RA No. 9184 and other GPPB issuances, or consignment in accordance with RA No. 9502 entitled “Cheaper Medicines Act of 2008”.

28.6. Noncompliance to the published price reference indices shall be subject to existing rules and administrative sanctions as stipulated in this Act and other relevant laws such as RA No. 9184, RA No. 9502, and RA No. 7394 entitled “Consumer Act of the Philippines”, among others.

28.7. PhilHealth must adopt the price reference indices issued by the DOH in setting reimbursement prices for drugs and medical devices or global budgets among its contracted health care providers, both public and private.

28.8. The DOH shall prescribe uniform rules and structures in setting mark-ups for drugs and medical devices that shall be applied by DOH-owned health facilities
on top of the price reference indices within one (1) year from the effectivity of
these Rules to protect patients from excessive and unnecessary charges.

28.9. All DOH-owned health care providers must submit to the DOH all relevant
costs and information necessary for the creation of a mark-up structure for drugs
and medical devices.

28.10. All DOH-owned health care providers must adhere to the price structure and
shall not go beyond the prescribed mark-ups for drugs and medical devices.

28.11. PhilHealth must adopt the prescribed mark-ups issued by the DOH in setting
reimbursement prices for drugs and medical devices or global budgets among
its contracted health care providers.

28.12. Noncompliance to the prescribed mark-up structure shall be subject to existing
rules and administrative sanctions as stipulated in this Act and other relevant
laws such as RA No. 9184, RA No. 9502, and RA No. 7394, among others.

28.13. Private health care providers that have availed of centrally negotiated prices
shall adhere to the prescribed mark-ups on health technologies to be issued by
the DOH. This shall be stipulated by PhilHealth in their contractual
arrangements with health care providers, both public and private.

Central Price Negotiation for Health Technologies

28.14. An independent price negotiation board (hereinafter referred to as the PNB),
composed of representatives from the DOH, PhilHealth and the Department of
Trade and Industry (hereinafter referred to as the DTI), among others, is hereby
constituted to negotiate prices on behalf of the DOH and PhilHealth, guided by
certain parameters including health technologies sourced from a single supplier.
The negotiated price in the framework contract shall be applicable for all
healthcare providers under the DOH.
28.15. Other members of the price negotiation board shall be appointed by the Secretary of Health and are composed of the following:

28.15.a. Economist;  
28.15.b. Citizen’s representative or patient representative;  
28.15.c. Procurement specialist;  
28.15.d. Clinician;  
28.15.e. Health facility representative; and  
28.15.f. LGU Representative (PHOs or CHOs)

28.16. The PNB shall be chaired by the DOH representative and co-chaired by the DTI representative. Members of the Board shall have a term of three (3) years each, renewable for a maximum of two (2) terms. They shall hold office until their successors shall have been appointed and qualified. Any vacancy in the Board shall be filled in the manner in which the original appointment was made, and the appointee shall serve only the unexpired term of his predecessor. Each member shall receive appropriate remuneration based on existing rules and regulations.

28.17. The PNB shall promulgate guidelines and procedures, in compliance with existing rules and regulations, in carrying out its mandate to negotiate prices for purposes of government procurement and contracting of PhilHealth. The unit assigned to pricing and affordability under the office in charge of health technology access and management shall serve as the secretariat of the PNB. The funds required for its operations shall likewise be sourced through the said office.

28.18. Other government agencies and health facilities may procure using the negotiated price of the PNB. Direct central price negotiation shall conform to
conditions set under Section 50 of the IRR of RA No. 9184 for the procurement
of medicines and medical devices. Private health facilities may also use the
negotiated price, subject to applicable rules and regulations.

*Pooled Procurement and Framework Contracting of Drugs and Medical Devices*

28.19. The DOH, through the Philippine Pharma Procurement, Inc., shall expand the
current scope of pooled procurement and framework contracting to include
medical devices negotiated by the PNB.

28.20. Within one (1) year from the effectivity of these Rules, the DOH shall
promulgate rules and procedures in the performance of its mandate as the
common procurement ordering facility for drugs and medical devices and
modernize its systems by developing online platforms for ordering, e-
procurement, inventory monitoring, and management and payment mechanisms.

28.21. Multi-year framework contracts may be implemented by the DOH in
accordance with RA No. 9184 and other GPPB issuances to ensure the
continuous availability of drugs and medical devices centrally negotiated by the
PNB at affordable prices, which shall be applicable throughout the term of the
contracts.

28.22. Other government and private health care facilities accredited by PhilHealth
shall be encouraged to participate in the framework contracts entered into by
the DOH to achieve affordable prices for medicines and medical devices.

*Submission of Price Information*

28.23. In implementing the price monitoring and regulation system for health products,
goods, and services, the DOH is hereby tasked to create policies, systems, and
procedures to undertake such functions as required by law within one (1) year
from the effectivity of these Rules:
28.23.a. Take the lead in the price monitoring and regulation of health services, which include laboratory fees, cost of procedures, cost of amenities, professional fees, and other health services provided by hospitals and other health care providers. The collection, submission, and publication of price data as required by law shall be a requirement in the granting of license to operate (LTO) or contracting of health facilities; and

28.23.b. Expand its mandate to monitor and regulate the prices of medicines as stipulated in RA No. 9502 to cover other health goods such as medical devices and laboratory/medical supplies. A Medical Devices Division shall be created for this purpose. The DOH shall deputize the Food and Drug Administration (hereinafter referred to as FDA) in ensuring the compliance of all drug and medical device establishments in submitting the required information regarding the prices of health products.

28.24. Within 180 days from the effectivity of these Rules, all health care providers and facilities shall be required to make readily accessible to the public and patients a menu containing the price list of health services and goods being offered in their facilities.

28.25. The price list shall be posted or made available in conspicuous areas within their premises and using various channels, and regularly updated with the changes in services and their prices.

28.26. The DOH, PhilHealth, and FDA shall develop the guidelines on public access to, and submission of, said information regarding the prices and charges for all goods and services, including professional fees being offered by health care
providers and provider networks, within 90 days from the effectivity of these Rules. Furthermore, the DOH, PhilHealth, and FDA shall utilize all possible platforms to disseminate price information.

**Creation of an Institutional Office for Price Monitoring and Regulation**

28.27. In view of the expansion of regulation and price monitoring to other health technologies, the DOH, in consultation with the DBM, shall create an institutional office that shall have the following functions, among others:

28.27.a. Manage and implement the health technology access and management policy;

28.27.b. Undertake policy studies and make appropriate recommendations to contribute to improved access to health technologies;

28.27.c. Provide technical and secretariat support to the PNB and the Health Technology Assessment Council as described in Section 35 of this Act;

28.27.d. Monitor the prices of drugs and medical devices and supplies; and

28.27.e. Coordinate the entire process of health technology assessment, pricing, and management at all levels of the health system, guaranteeing their effectiveness, cost-effective and rational use, affordability, and optimal performance.

28.28. The said office shall be adequately provided with requisite personnel complement based on identified relevant competencies, budgetary support, and, where necessary, sufficient capital outlay.
**Mandatory Carriage of Fairly Priced Generics**

28.29. Drug outlets are 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.

28.30. No retailer or drug outlet shall withhold from sale or refuse to sell to consumers fairly priced generic equivalents of drugs in the PCF.

28.31. The DOH shall issue a list of generic drugs in the PCF with their corresponding fair prices within 90 days of the effectivity of this IRR.

28.32. Noncompliance to this specific provision is subject to rules and administrative sanctions under this Act and relevant laws such as the RA No 9711 entitled “Food and Drug Administration (FDA) Act of 2009”, RA No. 9502, and RA No. 7394.

**Complementation of Private Health Insurance and Health Maintenance Organizations**

28.33. The DOH, PhilHealth, HMOs, and life and non-life private health insurance (PHIs) shall issue a joint agreement led by PhilHealth, establish a coordination mechanism, and develop standard policies and plans that complement the NHIP’s benefit schedule within one (1) year from the effectivity of these Rules, with the following as minimum requirements:

28.33.a. HMOs and life and non-life private health insurance shall cover the cost of amenities and other healthcare goods and services that are not covered by PhilHealth; and

28.33.b. HMOs, life and non-life PHIs shall duly submit health and health-related data, as prescribed in Section 31 of these Rules, in aid of developing the standard policies and plans.
Section 29. Equity

Preferential Licensing of Health Facilities

29.1. The DOH must develop a system to prioritize the processing of applications and issuance of License to Operate (LTO) for health facilities in underserved and unserved areas.

29.2. PhilHealth shall develop an incentive scheme for DOH-licensed health facilities and services located in underserved and unserved areas that shall ensure sustainability of provision of safe and quality health services and retention of health human resources.

29.3. The DOH shall develop the framework and guidelines to determine the appropriate service capability with complementary infrastructure and equipment, number of health care professionals, bed capacity and equitable distribution of public health facilities across the continuum of care.

29.4. The DOH shall lead in ensuring that the distribution of health services and benefits provided for in this Act shall be equitable by prioritizing geographically isolated and disadvantaged areas (hereinafter referred to as GIDAs) in the provision of assistance and support.

29.5. 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 a physical factor and a socio-economic factor must be present.

29.5.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.
29.5.b. Socio-Economic factors are social, cultural, and economic characteristics of the community that limit access to and utilization of health services.

29.6. The DOH shall develop the guidelines for identifying GIDA barangays within 90 days from the effectivity of these Rules.

29.7. The DOH and LGUs must ensure provision of technical and logistical assistance for health human resources, infrastructure, medical equipment and supplies among others to GIDAs.

*Bed Capacity of Hospitals*

29.8. Government general hospitals, regardless of size and level, are required to operate not less than ninety percent (90%) of their authorized bed capacity across all units of the hospital as basic or ward accommodation.

29.9. 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 across all units of the hospital as basic or ward accommodation.

29.10. Private hospitals are required to operate not less than ten percent (10%) of their authorized bed capacity across all units of the hospital as basic or ward accommodation.

29.11. All government general hospitals, specialty hospitals, and private hospitals are required to annually submit a report on the allotment or percentage of their authorized bed capacity for basic or ward accommodation to the DOH. Compliance to the prescribed bed allotment for basic accommodation shall be a criterion for licensing.
29.12. Existing hospitals shall be given a transition period to fully comply with the required bed capacity for basic accommodation by the end of 2022.

29.13. The DOH Online Health Facility Statistical Report System (OHFSRS) shall include the report on the actual utilization of the hospital allotment or percentage of their authorized bed capacity for basic accommodation.

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.

30.2. The Health Promotion Bureau, hereinafter referred to as the HPB, shall be established in the DOH. The DOH, together with DBM and other relevant agencies, shall identify appropriate human resource requirements and shall create regular positions appertaining to the HPB’s mandates, functions, and scope, based on identified relevant competencies.

30.3. Concurrently, DOH Centers for Health Development (CHDs) shall strengthen and expand the health promotion capabilities, financial capacities, and human resources of CHD Health Promotion Units to support the implementation of health promotion based on the Health Promotion Framework Strategy.

30.4. Within two (2) years from the effectivity of these Rules, the cost of implementing health promotion programs under the HPB must be at least one percent (1%) of the DOH’s total budget appropriations, provided that the succeeding budget appropriations shall be in accordance to the Health Promotion Framework Strategy and its programs.

30.5. The HPB shall perform the following functions:
30.5.a. Lead the formulation of a periodic 10-year Health Promotion Framework Strategy. The Health Promotion Framework Strategy shall:

30.5.a.i. Be institutionalized through an administrative order within six (6) months from the effectivity of these Rules;

30.5.a.ii. Be anchored on the concepts, principles, and action areas set by health promotion charters, treaties, and conferences;

30.5.a.iii. Serve as the basis of all health promotion programs, projects, and activities in increasing health literacy and mainstreaming health promotion; and

30.5.a.iv. Be reviewed every three (3) years or as may be deemed necessary;

30.5.b. Implement population-wide health promotion programs, projects, and activities in reducing behavioral risk factors and non-communicable diseases using the social determinants of health framework as defined by the World Health Organization;

30.5.c. Exercise policy coordination with national government agencies and local government units to ensure the attainment of the Framework Strategy and its programs, projects, and activities. For this purpose, the HPB may enter into partnerships and agreements with these government instrumentalities and provide technical, research, and financial assistance, among others. To carry out a whole-of-government, whole-of-society, whole-of-system, and health-in-all-policies approach to health promotion, executive departments are
encouraged to designate a focal person to effectively coordinate the
implementation of the Health Promotion Framework Strategy with
the DOH and;

30.5.d. Promote and provide technical, logistical, and financial support to
local research and development programs, projects, and activities
based on the Framework Strategy. For this purpose, the DOH may
procure appropriate consultancy services, sub-allot funds through the
local investment plans for health and enter into joint administrative
issuances to support the initiatives of local health promotion
implementers, among others.

30.6. Province-wide and HUC/ICC-wide health systems are mandated to provide
proactive and effective health promotion programs and campaigns in
accordance to the requirements of Section 17 of these Rules. Likewise,
province-wide and HUC/ICC-wide health systems shall establish Health
Promotion Units with appropriate human resources to ensure sustainable
implementation of health promotion and improve health literacy.

30.7. The DepEd shall hereby designate schools as healthy settings, otherwise known
as Health Promoting Schools, based on the standards set by the DOH through
the Health Promotion Bureau. Health Promoting Schools shall be a place where
all members of the school community work together to provide students with
integrated and positive experiences and structures which promote and protect
their health. Health Promoting Schools shall cover the following key features:

30.7.a. Healthy school policies
30.7.b. Physical school environment
30.7.c. Social school environment
30.7.d. Health skills and education

30.7.e. Links with parents and community

30.7.f. Access to health services.

30.8. The Department of Education, in coordination with the DOH shall perform the following functions:

30.8.a. Intensify the fight against the spread of communicable diseases and increase in prevalence of non-communicable diseases through, among others, the effective promotion of healthy lifestyle, physical activity, proper nutrition, and prevention of smoking and alcohol consumption among students by cultivating a healthy school environment and community, formulating school policies, programs and services, and mobilizing community action;

30.8.b. Formulate programs and modules on health promotion and health rights based on the Framework Strategy that shall be integrated in formal and informal curricula, programs, and co-curricular activities;

30.8.c. Ensure regular data sharing with the DOH on health promotion programs, projects, and activities, subject to Section 31 of these Rules, relevant provisions of RA No. 10173, and other relevant laws and policies; and

30.8.d. Submit an integrated and comprehensive annual report with impact assessment on health promotion and literacy programs to the President of the Philippines, the Senate President, the Speaker of the House of Representatives, and the Secretary of Health.

30.9. Local government units shall develop and implement effective health promotion policies, programs, projects, and activities among their constituents to advance
population health and individual well-being, fight against the spread of communicable diseases, and reduce the prevalence of NCDs and their risk factors. The laws to the contrary notwithstanding, local government units are encouraged to enact stricter ordinances that strengthen and broaden existing health policies.

30.10. For this purpose and without prejudice to the power of local legislative councils to enact ordinances:

30.10.a. LGUs shall be guided by the Health Promotion Framework Strategy;

30.10.b. LGUs shall prioritize the development and enactment of local health ordinances for, but not limited to the following: a) the reduction of the prevalence of tobacco use, b) the reduction of the burden of alcohol use, c) the reduction of incidence of communicable diseases and prevalence of noncommunicable diseases, d) addressing mental health issues, and e) improve health indicators; and

30.10.c. The DOH shall provide technical assistance in developing stricter ordinances that strengthen and broaden existing health policies.

30.11. To ensure compliance, the DOH and DILG shall formulate a joint administrative issuance to design and implement the Health Promotion Framework Strategy in the 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 with a copy furnished to the DOH within a certain period of time.


**Section 31. Evidence-Informed Sectoral Policy and Planning**

**Submission of Health- and Health-related Data**

*Mandating Data Submission*

31.1. All health-related entities shall submit to PhilHealth all required health and health-related data through a central data repository, in compliance with data definition and submission guidelines jointly set by DOH and PhilHealth. The DOH and PhilHealth shall issue guidelines defining the scope of health and health-related data that shall be submitted.

31.2. All health-related entities collecting health and health-related data shall issue a proper notice to the public or their clients that the data collected will be:

31.2.a. Submitted to DOH and PhilHealth;

31.2.b. Subjected to security measures and protection mechanisms that will be developed in consultation with the Department of Information and Communications Technology and the National Privacy Commission to prevent unauthorized access to and use of data; and

31.2.c. Used consistent with the objective of this Act and these Rule

31.3. Compliance to the data submission policies shall be included in the DOH’s licensing and PhilHealth’s contracting requirements.

31.4. The DOH and PhilHealth shall create a joint unit responsible for:

31.4.a. Formulating and implementing policies, standards, and guidelines on health and health-related data management cycle in a manner that is consistent with existing policies, laws and regulations; and,

31.4.b. Establishing, maintaining, and sustaining the central data repository and health information systems.
31.5. Funds will be allocated to support such operations, subject to usual accounting rules.

**Establishing a Health and Health-Related Data Depository**

31.6. The DOH and PhilHealth shall allocate sufficient budget for personnel and operations to establish a system that shall serve as the central data repository of all submitted health and health-related data.

31.7. An annual external or independent system audit shall be conducted to evaluate and improve the effectiveness and performance of the system.

31.8. The offices in charge of research in the DOH and PhilHealth shall establish mechanisms integrating explicit use of the generated evidence into the internal decision-making process and linking policymakers with evidence through translation, communication, dissemination, training, and facilitation activities.

31.9. The DOH, PhilHealth shall issue guidelines on the organizational, physical, and technical standards to implement this provision within 180 days from the effectivity of these Rules, provided that this is without prejudice to future amendments to the guidelines in response to evolving needs and practices.

**Analyzing Data**

31.10. The DOH and its attached agencies shall:

31.10.a. Incorporate health policy and systems research in the competency framework for all its technical staff;

31.10.b. Develop programs in cooperation with local and international academic and research institutions to strengthen research capacities among its technical staff;

31.10.c. Make available access to scientific databases to its technical staff;
31.10.d. Mobilize financial and non-financial resources from within the DOH, attached agencies, other government agencies, development partners, and the private sector for conducting or contracting research;

31.10.e. Generate ethical, timely, and high-quality health policy and systems research to support systematic sectoral planning, monitoring and evaluation activities; and

31.10.f. Design and support activities that increase individual, institutional, and sectoral capacity in health policy and systems research, policy and data analysis, research methods innovation, research communication, policy entrepreneurship, and research management.

Disseminating and Translating Evidence to Policy

31.11. The DOH and PhilHealth shall develop mechanisms that integrate explicit use of evidence into existing decision-making processes, whether for program development, policy development, or planning, provided that this shall also cover other processes that shall be developed in the future.

31.12. The DOH shall develop mechanisms to disseminate results of analyses and other related outputs in aid of policy and planning support through various channels such as:

31.12.a. Developing an online repository of all relevant research project outputs including but not limited to manuscripts, policy briefs, infographics;

31.12.b. Developing a framework for research communication to guide in developing project-specific communication outputs; and
31.12.c. Investing in strategic, appropriate, and high-impact research communication activities, including but not limited to research fora, brown bag sessions, policy dialogues, and research and policy briefs.

31.13. The DOH shall develop and implement mechanisms that monitor research utilization and impact in policy and planning activities, including mechanisms for generating feedback from policymakers and decision-makers.

**Health Policy and Systems Research Cadre**

31.14. The DOH shall allocate and transfer funds for training grants to the DOST to finance formal degree programs, in order to develop a pool of health policy and systems researchers, technical experts, and health systems managers for the DOH and other agencies, the number and category of which shall be determined by the DOH.

31.15. 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.

31.16. Training grants shall be offered to individuals and shall be managed by the DOST, in accordance with its accounting rules and regulations, provided that recipients of training grants shall enter into a return service agreement with the DOH and DOST for at least three (3) years, to serve under supervision of the DOH in one of the DOH-identified offices or agencies, with compensation, benefits and incentives based on national wage rates. Recipients of training grants who wish to serve for an additional two (2) years shall be provided with additional incentives as determined by the agency to which return service is being served.
31.17. A training registry shall be shared between the DOH and DOST for purposes of monitoring and tracking recipients of training grants, their return service, and monitoring non-compliance obligations for failure to render return service. The DOH shall, within one (1) year from the effectivity of these Rules, develop guidelines for implementation and non-compliance.

Classification of Administrative and Survey Data as Public Use Data

31.18. 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) without further sub-setting or aggregation, in a manner consistent with existing policies, issuances, and regulations.

31.19. The Interagency Committee on Health Nutrition and Statistics shall approve, publish and update annually a list of all health, nutrition and demographic-related administrative and survey data covered under this provision.

31.20. The IACHNS shall formulate policies and guidelines on data access relative to the covered data, and monitor adherence of concerned agencies.

31.21. All administrative and survey data must be made available in electronic format downloadable through the applicable online portal at no cost to the requesting party except in cases where hardcopy is requested, in which case the cost of printing or copying shall be covered by the user.

31.22. The DOH shall issue detailed guidelines on the data format, procedures for access, and compensation arrangements within 120 days from the effectivity of these Rules, provided that this is without prejudice to future amendments to the guidelines that may be carried out in response to other sources of survey and administrative data that may emerge in the long-term.
31.23. The DOH shall take the lead in developing a program for supporting participatory action researches that encourages social mobilization, including for advocacy, dissemination, partnerships, and capacity building, provided that research focus is driven by communities, both in terms of need and eventual use, and priority is given to cost-effective, multisectoral, and high impact (health promotion) interventions. The program shall include capacity building for research design and management for potential researchers.

31.24. The Philippine National Health Research System, hereinafter referred to as the PNHRS, through its member agencies, shall ensure the adequacy of funding for PAR and shall include the costs of implementing the researches in their annual budgetary proposal under the General Appropriations Act, provided that PAR forms an integral component of the health promotion program as described in Section 30 of these Rules.

31.25. The DOST-PCHRD, as the PNHRS secretariat, shall manage the grants for such participatory action researches, provided that:

31.25.a. DOST-PCHRD updates relevant sections of its grants-in-aid guidelines to support the intent of this section;

31.25.b. Civil society organizations and local academe that do not have potential conflicts of interests with public health, or do not receive funding from those that do are encouraged to apply for PAR funding; and

31.25.c. Applications shall be assessed according to extent of alignment with the PAR agenda, demonstrated research capacity, declaration and management of conflicts of interests in accordance with existing
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.

32.2. The PSA shall include the costs of implementing the relevant modules of the household surveys in its annual budgetary proposal under the General Appropriations Act. The DOH may provide supplementary funding, as deemed appropriate.

Burden of Disease Estimates

32.3. The DOH, in coordination with PhilHealth, academic and research organizations, and development partners, shall:

32.3.a. Produce annual national and provincial burden of disease (hereinafter referred to as BOD) estimates, which refers to quantitative health information concerning the distribution of and health loss attributable to diseases, injuries, and risk factors, through a systematic and transparent manner;

32.3.b. Build local capacity for BOD research and analysis;

32.3.c. Promote the use of BOD estimates for policy and planning at national and local levels; and

32.3.d. Inform the improvement of existing disease-specific information systems.
32.4. The DOH shall enter into an agreement with global research institutes specializing in global health statistics and health metrics for assistance in consolidation of available data and production of estimates at the national and provincial levels with relevant equity-focused disaggregation, and support in capacity-building.

32.5. All BOD estimates must be made accessible in public use format (PUF) and accessible by the general public, in accordance to RA No. 10173 and existing laws.

32.6. The DOH shall develop guidelines that specify procedures for generating, validating, analyzing, publishing, and using estimates, including building institutional and sectoral capacity, in accordance with international benchmarks, within 60 days from the effectivity of these Rules.

Section 33. Health Impact Assessment (HIA)

33.1. The DOH, in coordination with the NEDA, relevant executive agencies, and relevant local government units, shall ensure that HIA is conducted and Public Health Mitigation and Management Plans implemented for all other development initiatives, including policies, projects, and programs outside of the scope of Presidential Decree No. 1586 and its succeeding implementing guidelines. 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 and/or 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 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 all government sectors.

33.2. For development initiatives broadly categorized or classified as ‘environmentally critical projects and areas’ per PD 1586 and its succeeding implementing guidelines, existing procedures of the DENR shall be applied and a DENR-DOH-DILG memorandum of agreement shall be instituted.

33.3. For development initiatives outside the scope of the DENR’s EIA mandate:

33.3.a. The DOH, NEDA, and DILG, in consultation with key stakeholders, shall develop thresholds to determine which development initiatives shall qualify under this provision;

33.3.b. All development initiatives that fall under this provision shall undergo the standard HIA process which shall follow specific guidelines and timelines set by the DOH, including report templates, provided that:

33.3.c. Members of potentially affected communities, refer to groups of people who are on the receiving end of the intended and unintended effects of the development initiatives, and whose lives shall be affected by the development initiative being assessed, and their inputs shall be well-represented in the HIA process;
33.3.d. DOH at its discretion may decide the type of HIA that shall be conducted (i.e., prospective, retrospective, concurrent), and may opt to enter into collaborative arrangements with academe (including local state universities and colleges), government research arms, communities, and civil society organizations with sufficient research capacity, in conducting HIA, provided that conflicts of interests are declared and managed in accordance to DOH guidelines; and

33.3.e. Findings and recommendations from HIA studies including the Public Health Mitigation and Management Plans, shall be endorsed to either the NEDA-Social Development Committee (SDC), SDC - Human Development and Poverty Reduction Council (HDPRC), NEDA-Investment Coordination Committee, relevant executive agencies, and local chief executives, for their appraisal and support.

33.4. The DOH office in charge of policy and planning shall be the focal office for the implementation of this provision. The DOH shall develop guidelines that specify the development initiatives that qualify for an HIA, the process of conducting HIA; roles and responsibilities of key actors and institutions involved in the HIA process; timelines, HIA report templates, and supplementary tools within 120 days of the approval of this IRR, in consultation with the DENR and NEDA and other relevant public and private stakeholders. This is without prejudice to future amendments to the guidelines that may be carried out in response to evolving needs and practices.

Section 34. Health Technology Assessment

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 this Act.

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. A health technology assessment 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. The HTA process shall adhere to the principles of ethical soundness,
inclusiveness and preferential regard for the underserved and
unserved, 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, must have undergone 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.

34.4.a. 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 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 other health technologies; and

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. A Health Technology Assessment Council, hereinafter referred to as the HTAC, is hereby constituted within the DOH with the following functions:
34.8. a. Facilitate provision of financing and coverage recommendations on health technologies to be financed by DOH and PhilHealth;

34.8. b. Oversee and coordinate the HTA process within DOH and PhilHealth, and

34.8. c. Review and assess existing health technologies financed by DOH and PhilHealth benefit packages.

34.9. The HTAC shall consist of a core committee and subcommittees.

34.9. a. The core committee is responsible for the development and submission of final recommendations to policy- and decision-makers, based on the evidence appraisal of the different subcommittees.

34.9. b. The core committee is composed of nine (9) voting members, which shall elect from among themselves its Chairperson, namely:

34.9. b.i. a public health epidemiologist;

34.9. b.ii. a health economist;

34.9. b.iii. an ethicist;

34.9. b.iv. a citizen’s representative;

34.9. b.v. a sociologist or anthropologist;

34.9. b.vi. a clinical trial or research methods expert;

34.9. b.vii. a clinical epidemiologist or evidence-based medicine expert;

34.9. b.viii. a medico-legal expert; and

34.9. b.ix. a public health expert.

34.9. c. 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.

34.10. The HTAC may call upon technical resource persons from PhilHealth, Food and Drug Administration (FDA), patient groups, and clinical specialists as regular resource persons, and representatives from the private sector and health care providers as by-invitation resource persons.

34.11. An institutional Health Technology Assessment Office is hereby created within the DOH to manage the HTA process until its transfer to the DOST as an independent entity in five years. It shall be composed of a Technical Secretariat and a Policy, Planning, and Evaluation Unit. This institutional office shall be adequately provided with the requisite personnel complement based on identified health economics, health technology assessment, and other relevant competencies, budgetary support, and, where necessary, sufficient capital outlay.

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. The members of the HTAC shall receive an honorarium in accordance with existing policies.
34.14. The DOH 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 to Section 35 of these Rules.

34.15. The Secretary of the Department of Science and Technology (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.

**HTA Process**

34.16. The Health Technology Assessment Office, in coordination with the HTAC and other stakeholders, shall develop the process and methods guide for the HTA implementation. This shall be published within 120 days from the effectivity of these Rules and shall be reviewed periodically.

**Legal Protection**

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

**Transition of HTAC from DOH to DOST**

34.18. Within five (5) years after the establishment and effective operation of the HTAC and the HTA Office, they shall transition into an independent entity separate from the DOH as an attached agency of the DOST.

34.19. Before transition, the DOH and DOST shall coordinate in the establishment and effective operations of the HTAC and the HTA office.

34.20. Upon transition, the independent HTA agency shall continue to engage with the DOH and respond to its policy needs.
Section 35. Ethics in Public Health Policy and Practice

Conflict of Interest Management

35.1. A Conflict of Interest (COI) shall refer to acts or omissions constituting conflict of interest under existing laws and civil service rules, including international treaties in which the Philippines is a signatory. For the purpose of these Rules, this definition is applicable to reportable financial and non-financial interests of all public and private stakeholders involved in policy-determining activities.

35.2. Conflict of Interest declaration and management for all policy-determining activities shall abide by the principles defined by the United Nations Convention against Corruption.

35.3. All stakeholders involved in policy-determining activities at all levels of policymaking 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.

35.4. All agencies involved in policy-determining activities, which shall refer to actions taken in aid of health policy development leading to impartial decisions in adopting and implementing a policy option or policy recommendation using the best available evidence, shall maintain an Integrity Management System that shall be responsible for the administration, interpretation, and application of this Section.

35.5. The DOH must establish, as part of its Integrity Management Program, a Checks and Balances Committee that shall be responsible for the administration, interpretation and application of this Section.

35.6. Decision makers, policymakers, and staff members are required to disclose all actual and possible conflicts of interest to their heads of office as they arise.
Heads of office are then required to refer all disclosed conflicts of interest to the Checks and Balances Committee. The Checks and Balances Committee must take charge to mitigate and resolve all conflicts of interest in the best interests of the DOH.

35.7. The DOH shall develop guidelines that specify standards for receipt, assessment, and management of declared COI within 60 days of the approval of this IRR, in consultation with the Civil Service Commission and other relevant public and private stakeholders.

Reportorial Requirements for Health and Health-Related Commodity Manufacturers

35.8. To meet the growing public expectation for transparency and a high level of integrity in the relationships and interactions between the industry, the government, the healthcare profession, patients and the larger society, requirements for the disclosure of payments and transfers of value amongst and between these stakeholders must be reported to the FDA.

35.9. All pharmaceutical and medical device companies have the obligation to document, maintain records, and make public the information on all financial relationships and transfers of value they directly or indirectly make to individual health care providers, health care facilities, patient groups and organizations, foundations, government agencies and academic institutions. For the purposes of these Rules:

35.9.a. Financial relationships 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
35.9.b. Transfer of Value refers 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.

35.10. Reports of disclosures shall be submitted January of every year by individual companies to the FDA using a standard template reflecting the required data, with the information to be made public through a searchable web platform or public database provided by the FDA. Each company shall also post the data in its own website available in the public domain for a minimum period of two years.

35.11. For payments and transfers of value to an individual health care provider, the reports shall cover 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.

35.12. Transfers of value to health care facilities, charitable foundations, patient organizations, academic institutions and government agencies shall also be disclosed to the FDA and may cover 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.
35.13. All information shall be made publicly available through an online platform that is searchable and is in a format that is clear and understandable, and consistent with RA No. 10173.

35.14. Until on or after the date on which the information is made available to the public, all information submitted by manufacturers shall be considered confidential and shall not be subject to disclosure.

35.15. The DOH through the FDA shall develop guidelines that specify additional information requirements, procedures, and timeline of submission and publication within 60 days from the effectivity of these Rules, in consultation with other relevant public and private stakeholders.

Public Health Ethics Committee

35.16. All public health policies, programs and activities must be founded upon a robust public health ethics framework.

35.17. All public health research are required to undergo ethical review guided by the policies of the Philippine Health Research Ethics Board, as elucidated in RA 10532; and all activities that constitute public health practice (or non-research activities) shall be reviewed by the Public Health Ethics Committee.

35.18. A Public Health Ethics Committee is hereby constituted to assess the ethical soundness of public health practice, recommend risk mitigation measures, and monitor compliance to recommendations, towards maximization of benefit and minimization of risk for all human subjects.

35.19. The Public Health Ethics Committee shall consist of seven (7) independent expert-members:

35.19.a. the Chairperson;

35.19.b. a public health expert;
35.19.c. an ethics advisor;
35.19.d. a lawyer who is not affiliated with DOH;
35.19.e. a social scientist;
35.19.f. a representative from patient groups; and
35.19.g. a lay person (non-scientific person).

35.20. The Chairperson of the Public Health Ethics Committee must be a recognized expert in health ethics and must have public health and health research experience.

35.21. The Chairperson and members shall be appointed by the Secretary of Health for a term of 3 years. In order to ensure continuity of functions, at least half of the PHEC shall be re-appointed for at least one (1) year before a new set shall be appointed.

35.22. The Chairperson and members shall receive honoraria subject to the usual accounting rules/regulations.

35.23. The DOH office in charge for policy is the designated secretariat of the Public Health Ethics Committee.

35.24. The DOH shall develop guidelines that specify procedures for review and recommendation and linkage to the policy and program clearinghouse function within 60 days from the effectivity of these Rules, in consultation with relevant public and private stakeholders.

**Section 36. Health Information Systems**

36.1. For the purposes of these Rules:

36.1.a. Electronic Health Record (EHR) refers to personal identifiable information being transferred across health care institutions in compliance with the provisions of RA 10173. EHRs can generate a
complete record of clinical patient encounters, as well as support other health sector activities such as evidence-based decision-support, quality management, and outcomes reporting;

36.1.b. Electronic Prescription refers to a system that allows health care providers to write and send prescriptions in an automated or electronic way to a pharmacy with capability to receive such; and

36.1.c. Enterprise Resource Planning (ERP) - Refers to an efficient system of managing and integrating the important parts of a business. It integrates planning, purchasing inventory, finance, and other resource management and operations.

36.2. All health care providers are required to maintain a health information system on enterprise resource planning, human resource information system, electronic health records, and electronic prescriptions compliant with the standards for interoperability set forth by the DOH in coordination with PhilHealth and in consultation with the DICT and data privacy in line with RA 10173, provided that the applicable standards shall be set depending on variables such as type and level of health care providers. Based on these data standards, data shall be regularly uploaded in interoperable systems.

36.3. The DOH and PhilHealth shall fund the development and upgrading of information system software, which may be availed by health care providers and insurers at no cost.

36.3.a. Health care providers and insurers who opt to avail of the developed and funded health information systems shall bear the cost of procurement and maintenance of hardware and comply with the other requirements set by DOH and PhilHealth.
36.3.b. Health care providers and insurers may opt not to avail of the developed and funded health information systems provided that they comply with interoperability and other standards.

36.4. The DOH and PhilHealth shall define the classification or category of health data to be collected to that shall enable analysis of the following domains, at the minimum, to support policy and planning, and compare performance of health care providers based on the following: (1) Quality of care (effectiveness) (2) Access to care (equity) (3) Costs and cost-effectiveness (efficiency) (4) Performance of providers (5) Effects of public health programs (6) Effects of policy changes on health (7) Disease surveillance (8) Rate and premium setting.

36.5. PhilHealth shall use its contracts to incentivize the incorporation of HIS, 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 and cost-effective approaches to the best advantage of both agencies in the development and implementation of health information systems such as public-private partnerships or outsourcing, based on the result of feasibility studies.

RULE VIII. APPROPRIATIONS

Section 37. Appropriations

37.1. The amount necessary to implement this Act shall be sourced from the following:

37.1.a. Total incremental sin tax collections as provided for in RA No. 10351, entitled “Sin Tax Reform Law”, provided that the mandated earmarks as provided for in RA Nos. 7171 and 8240 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:

37.1.b.i. 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; and

37.1.b.ii. The 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. No. 1169, as amended, provided that:

37.1.c.i. 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; and

37.1.c.ii. The funds shall be used by PhilHealth to improve its benefit packages;

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. The amount necessary to implement the provisions of this Act shall be included in the DOH and PhilHealth submissions to the National Expenditure Program
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 UHC Act.

37.3. PhilHealth, in coordination with DBM, shall determine the necessary requirements for the release of the funding sources from the national government, other than PCSO and PAGCOR, as identified in the Act. The requirements shall, in no case, disrupt the immediate transfer of sources of funds to effectively carry out the purposes of the Act.

37.4. After complying with all the requirements as agreed by both PhilHealth and DBM, all funding sources as identified in the Act, other than PCSO and PAGCOR, shall be immediately released to PhilHealth based in schedule to be determined and agreed upon by the said agencies, subject to the usual accounting rules and regulations.

37.5. Further, to oversee that the funds from PCSO and PAGCOR as provided for in this Act are accurately and timely transferred to PhilHealth, a Joint Order/Guidelines shall be created together with concerned National Government Agencies.

37.6. The Joint Order/Guideline shall cover the evaluations on the amount of funds from PCSO and PAGCOR to be transferred to PhilHealth, with due regard to applicable government rules and regulations and shall follow through actions to secure that funds are transferred to PhilHealth in a timely manner.
RULE IX. PENAL PROVISIONS

Section 38. Penal Provisions

Any violation of the provisions of the UHC Act, after due notice and hearing, shall suffer the corresponding penalties as herein provided:

38.1. Any health care provider contracted for the provision of population-based health services who violated any of the provision in their respective contract shall be subject to sanctions and penalties under their respective contracts without prejudice to the right of the government to institute any criminal or civil action before the proper judicial body. Individuals or corporate personalities may file complaints to the DOH regarding any provider violation for this section; the DOH may pursue complaints as necessary.

Offenses of Health Care Provider

Classification of Offenses

38.2. Offenses committed by health care provider for the provision of individual-based health services are classified as:

38.2.a. Fraudulent acts,

38.2.b. Unethical acts, and

38.2.c. Abuse of authority.

Penalties

38.3. Offenses committed by health care provider shall be penalized, for unethical act, abuses the authority vested upon the health care provider, or performs a fraudulent act, 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.
38.4. 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.

**Definition of Offenses**

38.5. PhilHealth shall prescribe the definitions of offenses of health care providers and the period to resolve administrative cases from investigation to the resolution of the case.

**Violation of RA No. 7875 and RA No. 11223**

38.6. In addition, 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 (b) of this Rule.

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

**Filing of Civil Action**

38.8. 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 by the Member**

38.9. A member who:
38.9.a. Commits any violation of this Act; or

38.9.b. 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 section, including the filing of a fraudulent claim for benefits or entitlement under this Act, shall be punished, after due notice and hearing, by a fine of Fifty thousand pesos (P50,000.00) 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**

38.10. 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**

38.11. 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 (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 Accurately and Timely Remit Contributions

38.12. 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 or Refusal to Submit Report

38.13. 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

38.14. Any employer, officer, or employee authorized to collect contributions under
the UHC Act 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 is
obligated to hold the same in trust for and in behalf of the employees and
PhilHealth, and is immediately obligated to return or remit the amount.
38.15. 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

38.16. 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.

38.17. 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 this Act.

Offenses by PhilHealth Director, Officer, or Employee

38.18. Any director, officer or employee of PhilHealth who:

38.18.a. Without prior authority or contrary to the provisions of this the UHC Act or its implementing rules and regulations:

38.18.b. 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
38.18.c. 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 this Act 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. 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. Other violations of the provisions of this 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).

38.21. 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.
38.22. 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; the DOH or PhilHealth may pursue complaints as necessary.

Effect 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 X. MISCELLANEOUS PROVISIONS

Section 39. Oversight Provision

39.1. 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 this Act. These validation studies and annual reports, on the performance of the DOH and PhilHealth shall be submitted to the Joint Congressional Oversight Committee established by Congress for this Act.

39.2. PhilHealth shall allocate funds equivalent to one-hundredth percent (0.01%) of its operating income for the previous year for the purpose of conducting these
Section 40. Performance Monitoring Division

40.1. The Performance Monitoring Division (PMD) is hereby created under the DOH to monitor and evaluate the performance of the health sector in the context of the implementation of Universal Health Care.

40.2. The PMD shall serve as the M&E oversight for UHC implementation in the health sector and shall coordinate with other DOH offices, other national government agencies and local government units, and sectoral stakeholders on UHC-related targets, deliverables, and commitments.

40.3. The PMD shall establish assistance and feedback mechanisms to ensure alignment of strategies and processes to health sector thrusts relevant to UHC implementation.

40.4. A Performance Monitoring Unit shall be established in all DOH Centers for Health Development and DOH hospitals, supervised by the PMD, to assist in the implementation of this Section.

Section 41. Transitory Provisions

41.1. Within thirty (30) days from the effectivity of this 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 the first paragraph of this Section, shall continue to
perform their duties and responsibilities and receive their corresponding salaries and benefits. The approval of this Act or these Rules shall not cause any demotion in rank or diminution of salary, benefits and other privileges of the incumbent personnel of PhilHealth, provided that qualified officers and personnel may voluntarily elect for retirement or separation from service and shall be entitled to the benefits under existing laws. PhilHealth shall submit the compensation framework and provident fund 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. However, qualified officers and personnel of the agency may voluntarily elect for retirement or separation from service based on the PCSO Board-approved Early Retirement Incentive Program (ERIP), utilizing internally-generated funds or savings from its operating fund. Such retirement benefit packages shall be reasonable and within the bounds of existing laws.

41.4. In the first six (6) years from the enactment of this Act, the National Government, through the DOH, DBM, 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 this Act, the province-wide and city-wide systems shall exhibit managerial integration, while within the next three (3) years thereafter, the
province-wide and city-wide systems shall exhibit financial integration.

41.4.b. The DOH, in consultation with other stakeholders, shall develop guidelines to determine managerial and financial integration in the province-wide and city-wide health systems. At the minimum, managerial integration shall be characterized by the following:

41.4.b.i. Unified governance of the local health system;

41.4.b.ii. Integrated management system, consisting of financing, strategic planning, information management and quality assurance/ improvement;

41.4.b.iii. Functional referral system;

41.4.b.iv. Functional disaster risk reduction management for health; and

41.4.b.v. Functional epidemiologic surveillance system.

41.4.c. At the minimum, financial integration shall be characterized by the following:

41.4.c.i. Creation of Special Health Fund;

41.4.c.ii. Funds exclusively used for health and health-related needs, as reported by the Commission on Audit; and

41.4.c.iii. Integrated planning and investment strategy

41.4.d. Upon positive recommendation by an independent study commissioned by the Joint Congressional Oversight Committee on Universal Health Care 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 this Act through the issuance of an Executive Order by the President.

41.5. In the first ten (10) years from the enactment of this Act, PhilHealth may outsource certain functions to ensure operational efficiency and towards the fulfillment of this Act, provide that any outsourcing shall comply with provisions of RA No. 9184 and its Implementing Rules and Regulations.

41.6. In the first three (3) years from the enactment of this Act, 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. 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 licensed 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 as outlined by Section 35 of these Rules from the effectivity of this Act. All existing health benefit packages offered by PhilHealth must be rationalized within two (2) years from the establishment of the HTAC.
41.8. Within three (3) years from the effectivity of this Act, 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 this Act, only those who have been certified by the DOH and PRC to be capable of providing primary care shall be eligible to be a primary care provider.

41.10. For the first two (2) years from the effectivity of this 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 of this Act, to enable the PCSO to conclude and liquidate its Individual Medical Assistance Program At-Source-Processing (IMAP-ASAP) obligations.

Section 42. Interpretation

42.1. All doubts in the implementation and interpretation of 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 this Act.
Section 43. Separability Clause

If any part or provision of 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

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

This Act shall take effect fifteen (15) days after its publication in the Official Gazette or in any newspaper of general circulation.