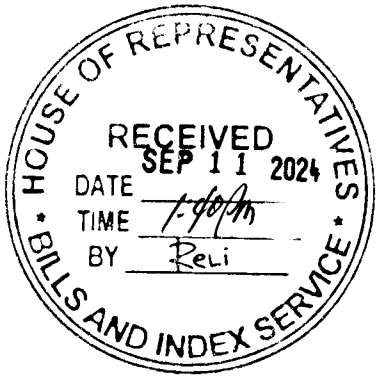
Republic of the Philippines
HOUSE OF REPRESENTATIVES
Quezon City, Metro Manila



NINETEENTH CONGRESS
Third Regular Session

HOUSE BILL NO. 10899

Introduced by **Representative Jaime R. Fresnedi**

EXPLANATORY NOTE

This proposed legislation aims to integrate palliative care into the Philippine health system through the creation of a National Palliative Care Policy. It seeks to establish a standard of quality palliative care services to patients suffering from life-threatening, complex and chronic illness.

Over the years, palliative care has become more of a luxury than it is a standard component of healthcare. This specialized type of care aims to alleviate symptoms, manage pain as well as physical and mental stress usually caused by their serious health conditions. Although global awareness of palliative care has increased, its implementation in our country has remained limited and inaccessible.

According to data from the World Health Organization (WHO), an estimated number of 56.8 million people, including 25.7 million in the last year of life, are in need of palliative care each year. Across the world, only 14% of those in need of palliative care actually receive it. In our country, hospice homes were first introduced in October 1991 by the late Dr. Mita Pardo de Tavera, then president of the Philipines Cancer Society, Inc. (PCSI). This effort led to the creation of various hospices throughout the country and the founding of the National Hospice and Palliative Care Council of the Philippines (NHPCCP), also known as Hospice Philippines in 2004. Since then, hospice care has been recognized as an essential component in the care for patients suffering with ESRD (end-stage renal disease), advanced heart, liver and respiratory diseases, dementia, and acquired immunodeficiency syndrome or AIDS. Despite this recognition, access to this type of healthcare has remained expensive due to the limited number of trained professionals in this field, the availability of resources like access to pain medications and the maintenance of specialized facilities.

Article XIII, Section 11 of the 1987 Constitution provides:

> *The State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost. There shall be priority for the needs of the underprivileged sick, elderly, disabled, women, and children. The State shall endeavor to provide free medical care to paupers.*

It is therefore the responsibility of the State to provide accessible and affordable healthcare services even for those with severe illnesses. Through this legislation we will be

It is therefore the responsibility of the State to provide accessible and affordable healthcare services even for those with severe illnesses. Through this legislation we will be able to assure these individuals that they will be able to receive the compassionate and comprehensive care they need and rightfully deserve in order to manage their symptoms and improve their quality of life. This initiative underscores our dedication to supporting all patients, regardless of their condition.

In view of the foregoing, the immediate passage of this bill is earnestly sought.

JAIME R. FRESNEDI
Representative
Lone District, Muntinlupa City

Republic of the Philippines
HOUSE OF REPRESENTATIVES
Quezon City, Metro Manila

NINETEENTH CONGRESS
Third Regular Session

HOUSE BILL NO. 10899

Introduced by **Rep. Jaime R. Fresnedi**

AN ACT
ESTABLISHING A NATIONAL PALLIATIVE CARE POLICY FOR THE PURPOSE OF ENHANCING THE DELIVERY OF INTEGRATED PALLIATIVE CARE SERVICES, PROMOTING AND PROTECTING THE RIGHTS OF PERSONS UTILIZING PALLIATIVE CARE SERVICES, APPROPRIATING FUNDS THEREFOR, AND FOR OTHER PURPOSES

Be it enacted by the Senate and the House of Representatives of the Philippines in Congress assembled:

SECTION 1. *Short Title.* – This Act shall be known as the "*National Palliative Care Act.*"

Sec. 2. *Declaration of Policy.* – The State affirms the basic right of all Filipinos to palliative and hospice care as well as the fundamental rights of people who require palliative and hospice care services. The State shall comply with its obligations under the United Nations Declaration of Human Rights, the Convention on the Rights of Persons with Disabilities, all other relevant international and regional human rights conventions and declarations, the Republic Act No. 7277, as amended, otherwise known as the "*Magna Carta for Disabled Persons*", Republic Act No. 11223 otherwise known as the "*Universal Health Care Act*" and Republic Act No. 11215 otherwise known as the "*National Integrated Cancer Control Act*".

Towards this end, it is the policy of the State to promote the well-being and quality of life of people by ensuring that palliative care is valued, promoted, and protected. Towards this end, the state shall adopt:

(a) An integrated and comprehensive approach to ensure that all conditions requiring palliative and hospice care are treated and palliated;

(b) A whole-of-system, whole-of-society, and whole-of-government approach in the development and implementation of essential, timely, affordable and high quality palliative care for the public; and

(c) A people-oriented approach for the delivery of palliative care assuring that palliative care services are free from coercion and accountable to persons with palliative care needs and further ensuring that persons needing palliative care are able to exercise the full range of human rights, to participate fully in society and at work free from stigmatization and discrimination.

Sec. 3. *Objectives.* — The objectives of this Act are as follows:

(a) Strengthen effective leadership and governance for palliative care by, among others, formulating, developing, and implementing national policies, strategies, programs, and regulations relating to palliative care;

(b) Develop and establish a comprehensive, integrated, effective, and efficient national palliative care program responsive to the needs of the Filipino people;

(c) Protect the rights and freedoms of persons with palliative care needs;

(d) Strengthen information systems, evidence, and research for palliative care;

(e) Integrate palliative care in the basic health services; and

(f) Integrate strategies promoting palliative care in educational institutions, the workplace, and in communities.

Sec. 4. *Definitions.* — As used in this Act, the following terms are defined as follows:

(a) *Allied Healthcare Professional* refers to non-palliative trained health professionals such as physicians, social workers, nurses, physical therapists, counselors, nutritionists, among others;

(b) *Carer* refers to the person, who may or may not be the patient's next-of-kin or relative, who maintains a close personal relationship and manifests concern for the welfare of the patient;

(c) *Confidentiality* refers to ensuring that all relevant information related to persons with palliative and hospice care needs is kept safe from access or use by, or disclosure to, persona or entities who are not authorized to access, use, or possess such information;

(d) *Continuum of Care* refers to delivery of comprehensive health care services, which includes risk assessment, primary prevention, screening, diagnosis, treatment, survivorship, rehabilitation and end-of-life care;

(e) *Transitional Care* refers to the support given to persons moving from care settings, such as from hospital care to home care, and levels of healthcare, such as a shift in goals of care or in age groups;

(f) *Discrimination* refers to any distinction, exclusion or restriction which has the purpose or effect of nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation. Special measures solely to protect, the rights or secure the advancement of persons with decision-making impairment capacity shall not be deemed to be discriminatory;

(g) *Hospice Care* refers to a component of palliative care which deals with persons who are not expected to survive more than six months, otherwise known as end-of-life care, wherein the main goals are provision of peace, comfort, and dignity through holistic support which includes medical psychological and spiritual support;

(h) *Impairment or Temporary Loss of Decision-Making Capacity* refers to a medically-determined inability on the part of a palliative patient or any other person affected by a mental health condition, to provide informed consent. A palliative patient has an impairment or temporary loss of

decision-making capacity when the palliative patient as assessed by a mental health professional is unable to do the following:

(i) Understand information concerning the nature of an advanced life-limiting health condition;
(ii) Understand the consequences of one's decisions and actions on one's life or health, or the life or health of others;
(iii) Understand information about the nature of the treatment proposed, including methodology, direct effects, and possible side effects; and
(iv) Effectively communicate consent to treatment or hospitalization, or information regarding one's own condition;

(i) *Informed Consent* refers to content voluntarily given by a palliative patient to a plan for management, after a full disclosure communicated in plain language by the attending palliative care provider, of the nature, consequences, benefits, and risks of the proposed management, as well as available alternatives;

(j) Involuntary Treatment refers to a type of medical treatment that is undertaken without the consent of the person being treated.

(k) *Mental Health* refers to a state of well-being in which the individual realizes one's own abilities and potentials, copes adequately with the normal stresses of life, displays resilience in the face of extreme life events, works productively and fruitfully, and is able to make a positive contribution to the community;

(l) *Mental Health Condition* refers to a neurologic or psychiatric condition characterized by the existence of a recognizable, clinically-significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a genetic or acquired dysfunction in the neurobiological, psychosocial, or developmental processes underlying mental functioning. The determination of neurologic and psychiatric conditions shall be based on scientifically-accepted medical nomenclature and best available scientific and medical evidence;

(m) *Palliative Care* refers to an approach of care that improves the quality of life of patients and their families facing problems with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual;

(n) *Palliative Care Health Facility* refers to any establishment, or any unit of an establishment, which has, as its primary function, the provision of palliative care services;

(o) *Palliative Care Professional* refers to a medical doctor, psychologist, nurse, social worker or any other appropriately-trained and qualified person with specific skills relevant to the provision of palliative care services;

(p) *Palliative Care Specialist* refers to a medical doctor who received formal fellowship training in palliative and hospice medicine and who has passed the subspecialty board examination for the same;

(q) *Palliative Care Service Provider* refers to an entity or individual providing palliative care services as defined in this Act, whether public or private, including, but not limited to, palliative care professionals, specialists and workers, social workers and counselors, peer counselors, informal community caregivers, palliative care advocates and their organizations, personal ombudsmen, and persona or entities offering nonmedical alternative therapies;

(r) *Palliative Care Health Services* refer to physical, psychosocial or spiritual activities and programs along the whole range of the palliative care support services including promotion, prevention, treatment, and aftercare, which are provided by palliative care facilities and palliative care professionals;

(s) *Palliative Care Health Worker* refers to a trained person, volunteer or advocate engaged in palliative care health promotion, providing support services under the supervision of a palliative care professional or specialist;

(t) *Palliative Emergency* refers to a condition presenting a serious and immediate threat to the health and well-being of a palliative patient or any other person affected by advanced life-limiting health condition, or to the health and well-being of others, requiring immediate medical intervention;

(u) *Palliative Patient* refers to a person diagnosed with any advanced life-limiting health condition including persons who require, or are undergoing palliative, hospice or psychosocial care;

(v) *Partial Hospital Care* refers to a type of intensive, structured mental health treatment that falls between in-patient (full hospitalization) and outpatient care. It is designed for individuals who require a higher level of care than traditional outpatient therapy but do not need 24-hour supervision provided in an inpatient setting.

(w) *Patient Navigation* refers to the provision of individualized assistance to patients and families to help them overcome healthcare system barriers and facilitate timely access to quality medical and psychosocial care from pre-diagnosis through all phases of the illness experience;

(x) *Psychosocial Support* refers to the assistance on nonmedical costs such as financial assistance, transient housing, transportation, food and nutrition and the like;

(y) *Restrictive Care* refers to any intervention that restricts the rights and freedom of movement of a person with disability.

(z) *Support* refers to the spectrum of informal and formal arrangements or services of varying types and intensities, provided by the State, private entities, or communities, aimed at assisting a palliative patient in the exercise of his or her legal capacity or rights, including: community services; personal assistants and ombudsmen; powers of attorney and other legal and personal planning tools; peer support; support for self-advocacy; nonformal community caregiver networks; dialogue systems; alternate communication methods, such as nonverbal, sign, augmentative, and manual communication; and the use of assistive devices and technology;

(aa) *Supported Decision Making* refers to the act of assisting a palliative patient who is affected by an impairment or loss of decision-making capacity, in expressing a palliative care-related preference, intention or decision. It includes all the necessary support, safeguards and measures to ensure protection from undue influence, coercion or abuse;

(bb) *Supportive Care* refers to prevention and management of the adverse effects of advanced life-limiting conditions and its treatment which includes management of physical and psychological symptoms and side effects across the continuum of the disease experience; and

(cc) *Surrogate Decision Maker or Healthcare Proxy* refers to a person designated by the palliative patient, appointed by a court of competent jurisdiction, or authorized by this Act or any other applicable law, to act on the palliative patient's behalf. The legal representative may also be a person appointed in writing by the palliative patient to act on his or her behalf through an advance directive.

CHAPTER II
RIGHTS OF PALLIATIVE PATIENTS AND OTHER STAKEHOLDERS

Sec. 5. *Rights of Palliative Patients.* - Service users shall enjoy, on an equal and non-discriminatory basis, all rights guaranteed by the Constitution as well as those recognized under the United Nations Universal Declaration of Human Rights and the Convention on the Rights of Persons with Disabilities and all other relevant international and regional human rights conventions and declarations, including the right to:

(a) Freedom from social, economic, and political discrimination and stigmatization, whether committed by public or private actors;

(b) Exercise all their inherent civil, political, economic, social, religious, educational, and cultural rights respecting individual qualities, abilities, and diversity of background, without discrimination on the basis of physical disability, age, gender, sexual orientation, race, color, language, religion or nationality, ethnic, or social origin;

Respect for their dignity, culture, and values at all times. Likewise, hospice care patients shall be entitled to humane medical care to make end of life as dignified and comfortable as possible;

(c) Access to evidence-based treatment of the same standard and quality, regardless of age, see, socioeconomic status, race, ethnicity or sexual orientation;

(d) Access to affordable essential health and social services for the purpose of achieving the highest attainable standard of palliative care;

(e) Access to good-quality palliative care services and humane at all levels of the national health care system within the limits of the resources, manpower, and competences available for medical care;

(f) Access to comprehensive and coordinated treatment integrating holistic prevention, promotion, rehabilitation, palliation, care and support, aimed at addressing palliative care needs through a multidisciplinary, patient-centered management plan;

(g) Access to palliative and hospice care in the least restrictive environment and manner;

(h) Access to aftercare and rehabilitation, when possible, in the community for the purpose of social reintegration and inclusion;

(i) Access to adequate information regarding available multidisciplinary palliative care services;

(j) Participate in palliative care advocacy, policy planning, legislation, service provision, monitoring, research and evaluation;

(k) Confidentiality of all information, communications, and records, in whatever form or medium stored, regarding the patient, any aspect of the patient's health condition, or any treatment or care received by the patient, which information, communications, and records shall not be disclosed to third parties without the written consent of the patient concerned or the patient's legal representative, except in the following circumstances:

(i) Disclosure is required by law or pursuant to an order issued by a court of competent jurisdiction;

(ii) The patient has expressed consent to the disclosure;

(iii) A life-threatening emergency exists and such disclosure is necessary to prevent harm or injury to the patient or to other persons;

(iv) The patient is a minor and the attending palliative care provider reasonably believes that the patient is a victim of child abuse; or

(v) Disclosure is required in connection with an administrative, civil, or criminal case against a palliative care provider or specialist for negligence or a breach of professional ethics, to the extent necessary to completely adjudicate, settle, or resolve any issue or controversy involved therein;

(l) Give informed consent before receiving treatment or care, including the right to withdraw such consent. Such consent shall be recorded in the patient's clinical record;

(m) To refuse diagnostic and medical treatment procedures provided that the refusal releases those involved in the care from any obligation, does not jeopardize public health and safety, and is from a person or surrogate decision maker who is:

(i) Of legal age and sound decision-making capacity;

(ii) Informed of the risks, benefits, and consequences of the refusal.

(n) Participate in the development and formulation of the palliative care plan to be implemented;

(o) Designate or appoint a person of legal age to act as his or her legal representative in accordance with this Act, except in case a of impairment or temporary loss of decision-making capacity;

(p) Legal services, through competent counsel of the patient's choice. In case the patient cannot afford the services of a counsel, the Public Attorney's Office, or a legal aid institution of the patient or representative's choice, shall assist the patient; and

(q) Information, within twenty-four (24) hours of admission to a health facility, of the patient's rights including those enumerated in this section in a form and language understood by the patient.

Sec. 6. *Rights of Family Members, Carers and Legal Representatives.* — Family members, carers and duly designated or appointed legal representative of the patient shall have the right to:

(a) Receive appropriate psychosocial and spiritual support from the relevant government agencies;

(b) With the consent of the concerned patient, participate in the formulation, development, and implementation of the patient's individualized management plan;

(c) Apply for release and transfer of the patient to home or an appropriate health facility provided that:

(i) They are informed of the risks, benefits, and consequences of their decision;

(ii) They release from any obligation those involved in the care relevant to the consequences of their decision;

(iii) Their decision will not jeopardize public health and safety; and

(d) Participate in palliative care advocacy.

Sec. 7. *Additional Leave Benefits.* – Immediate family members or relatives who are employed, whether in the public or private sector and are assigned by the family to provide palliative care to a critically-ill relative shall be granted an additional leave of fifteen (15) days aside from all existing leave benefits granted by their employers, subject to the guidelines on the use of the said benefits.

Sec. 8. *PhilHealth Benefit Package.* – Pursuant to this Act, the PhilHealth shall increase its present benefit package to include palliative care.

CHAPTER III
PALLIATIVE CARE SERVICES

Sec. 9. *Quality of Palliative Care Services.* — Palliative Care services provided pursuant to this Act shall be:

(a) Based on best medical practices, clinical standards of care, and scientific research findings;

(b) Responsive to the clinical, gender, cultural and ethnic and other special needs of the individuals being served;

(c) Most appropriate and least restrictive setting;

(d) Age appropriate; and

(e) Provided by palliative care providers, specialists and workers in a manner that ensures accountability and is aligned with the Department of Health Manual of Operations, Procedures, and Standards for the National Palliative and Hospice Care Program.

Sec. 10. *Palliative Care Services at the Community Level.* - Responsive primary palliative care services shall be developed and integrated as part of the basic health services at the appropriate level of care, particularly at the city, municipal, and barangay level. The standards of palliative care services shall be aligned with the DHOH Manual of Operations, Procedures, and Standards for the National Palliative Care Program.

Every local government unit (LGU) and academic institution shall create its own program in accordance with the general guidelines set by the Philippine Council for Palliative Care, created under this Act. LGUs and academic institutions shall coordinate with all concerned government agencies and the private sector for the implementation of the program, aligned with the Department of Health Manual of Operations, Procedures, and Standards for the National Palliative Care Program.

Sec. 11. *Community- based Palliative Care Facilities.* — The national government through the DOH shall fund the establishment and assist in the operation of community-based palliative care facilities in the province, cities and cluster of municipalities in the entire country based on the needs of the population, to provide appropriate palliative care services, and enhance the rights-based approach to palliative care.

Each community-based palliative care facility shall have a complement of palliative care specialist, palliative care providers, allied professionals, support staff, trained barangay health workers (BHWs), volunteer family members of patients or service users, basic equipment and supplies, and adequate stock of medicines appropriate at that level, aligned with the Department of Health Manual of Operations, Procedures, and Standards for the National Palliative Care Program.

Sec. 12. *Reportorial Requirements.* - LGUs through their health offices shall make a quarterly report to the Philippine Council for Palliative Care through the DOH. The report shall include, among

others, the following data: number of palliative patients attended to and/or served, the respective kinds of illness or disability, duration and result of the management, and patient's age, gender, educational attainment and employment without disclosing the identities of such palliative patients for confidentiality.

Sec. 13. *Palliative Care Services in Regional, Provincial, and Tertiary Hospitals.* - All regional, provincial, and tertiary hospitals, including private hospitals shall provide the following palliative care services:

(a) Short-term, in-patient hospital care in a palliative care ward for patients exhibiting acute pain and non-pain symptoms needing palliative care;

(b) Partial hospital care for those exhibiting pain and non-pain symptoms or experiencing difficulties vis-à-vis their personal and family circumstances;

(c) Out-patient services in close collaboration with existing palliative care programs at primary health care centers in the same area;

(d) Home care services for palliative patients with special needs as a result of, among others, long-term hospitalization, non-compliance with or inadequacy of treatment, and absence of immediate family;

(e) Coordination with drug rehabilitation centers vis-à-vis the care, treatment, and rehabilitation of persons suffering from addiction and other substance-induced mental health conditions;

(f) A referral system involving other public and private health and social welfare service providers, for the purpose of expanding access to programs aimed at providing palliative and hospice care to patients with advanced life-limiting conditions; and

(g) Hospital-based Palliative Care Registry that must record the personal identification of palliative patients, type of advanced life-limiting condition, management received and its results and other data that the DOH may prescribe. The information shall be treated with utmost confidentiality and shall not be released to third parties, in accordance with Republic Act No. 10173 or the "*Data Privacy Act of 2012.*" Submission of the Palliative Care registry data to the DOH shall be a requirement for the renewal of a license to operate of a hospital.

Sec. 14. *Duties and Responsibilities of Palliative Care facilities.* — Palliative Care facilities shall:

(a) Establish policies, guidelines, and protocols for minimizing the use of restrictive care and involuntary treatment;

(b) Inform palliative patients of their rights under this Act and all other pertinent laws and regulations;

(c) Provide every palliative patient, whether admitted for voluntary treatment or not, with complete information regarding the management plan to be implemented;

(d) Ensure that informed consent is obtained from palliative patients prior to the implementation of any medical procedure or plan of treatment or care, except during palliative emergencies or when the palliative patient has impairment or temporary loss of decision-making capacity;

(e) Maintain a register containing information on all medical treatments and procedures administered to service users; and

(f) Ensure that legal representatives are designated or appointed in accordance with the provisions of this Act.

Sec. 15. *Public Awareness.* - The DOH and the LGUs shall initiate and sustain a heightened nationwide multi-media campaign to raise the level of public awareness on the protection and promotion of palliative care and rights including, but not limited to, palliative care and nutrition, stress handling, counselling, spiritual care and other elements of palliative care.

CHAPTER IV
EDUCATION, PROMOTION OF PALLIATIVE CARE IN EDUCATIONAL INSTITUTIONS AND IN THE WORKPLACE

Sec. 16. *Integration of Palliative Care into the Educational System.* - The State shall ensure the integration of palliative care into the educational system, as follows:

(a) Age-appropriate content pertaining to palliative care shall be integrated into the curriculum at all educational levels; and

(b) Palliative and hospice care shall be required subjects in all medical and allied health courses, including post-graduate courses in health.

Sec. 17. *Palliative Care Promotion in Educational Institutions.* — Educational institutions, such as schools, colleges, universities, and technical schools, shall develop policies and programs for students, educators, and other employees. Such policies and programs shall be designed to raise awareness on palliative care issues, identify and provide support and services for patients, facilitate access, including referral mechanisms of individuals needing palliative care to medical and psychosocial support, and adopt initiatives that minimize or eliminate stigma and discrimination in schools, colleges, and universities that are experienced by people with advanced life-limiting conditions.

All public and private educational institutions shall be required to have a complement of palliative care providers.

Sec. 18. *Palliative Care Promotion and Policies in the Workplace.* — The Department of Labor and Employment (DOLE), Civil Service Commission, and Technical Education and Skills Development Authority, in coordination with the DOH, shall develop policies and provide technical guidance to employers, employees associations and unions to:

(a) Promote and facilitate integration of gender sensitive messages on cancer and/or chronic disease risk factors, early signs and symptoms of cancer and chronic disease, prevention and control, adoption of health lifestyles and healthy diets, in their communication initiatives, health and wellness programs and employee development programs;

(b) Undertake mainstreaming of practical supportive care and psychosocial support programs for people living advance life-limiting conditions and their family members;

(c) Integrate appropriate palliative care services in their health services and clinics; and

(d) Develop programs, initiatives or mechanisms that shall minimize or eliminate stigma and discrimination in the workplace that is experienced by people living with advanced life-limiting conditions and their families.

Employers shall develop appropriate policies and programs on palliative care in the workplace These shall be designed to raise awareness on palliative care issues, correct the stigma and

discrimination associated with advanced life-limiting conditions, identify and provide support to palliative patients and their families, and facilitate access of individuals with advanced life-limiting conditions and their families to medical and psychosocial support.

Sec 19. *Palliative Care Health Education and Promotion in Communities.* – The Department of Interior and Local Government (DILG) and LGUs, in collaboration with the DOH central and regional offices, palliative care patient support organizations and professional societies, shall lead the health education and promotion campaign in local communities, including out-of-school youth. The DILG, in coordination with the Department of Social Welfare and Development (DSWD), shall conduct and promote age appropriate and gender sensitive palliative-focused health education.

CHAPTER V
CAPACITY BUILDING, RESEARCH AND DEVELOPMENT

Sec. 20. *Capacity Building, Reorientations, and Training.* — In close coordination with health facilities, academic institutions, and other stake holders, palliative care providers, specialists, and other service providers shall undergo capacity building, reorientation, and training to develop their ability to deliver evidence-based, gender-sensitive, culturally-appropriate and human rights-oriented palliative care services, with emphasis on the community and public health aspects of palliative care.

Sec. 21. *Capacity Building of Barangay Health Workers (BHWs).* - The DOH shall be responsible for disseminating information and providing training programs on palliative care to LGUs. The LGUs, with technical assistance from the DOH, shall be responsible for the training of BHWs and other barangay volunteers on the promotion of palliative care. The DOH shall provide assistance to LGUs with medical supplies and equipment needed by BHWs to carry out their functions effectively.

Sec. 22. *Research and Development.* - Research and development shall be undertaken, in collaboration with academic institutions, palliative, hospice, and related associations, and non-government organizations, to produce the information, data, and evidence necessary to formulate and develop a culturally-relevant national palliative care program incorporating indigenous concepts and practices related to palliative care.

High ethical standards in palliative care research shall be considered to ensure that:

(a) research is conducted only with the free and informed consent of the persons involved;

(b) researchers do not receive any privileges, compensation or remuneration in exchange for encouraging or recruiting participants;

(c) potentially harmful or dangerous research is not undertaken; and

(d) all research is approved by an independent ethics committee, in accordance with applicable law.

Research and development shall also be undertaken vis-à-vis non-medical, traditional or alternative practices.

Sec. 23. *National Palliative Care Registry.* – The Department of Health in collaboration with relevant stakeholders shall establish a national palliative care registry and monitoring system. The registry must cover all forms of palliative care illnesses among adults and children and serve as a guide in policy development of the National Palliative and Hospice Care Program.

CHAPTER VI
DUTIES AND RESPONSIBILITIES OF GOVERNMENT AGENCIES

Sec. 24. *Duties and Responsibilities of the Department of Health (DOH).* – In pursuit of the policies and objectives declared in this Act, the DOH shall:

(a) Formulate, develop, and implement a national palliative care program. In coordination with relevant government agencies, create a framework for Palliative Care Awareness Program to promote elective strategies regarding palliative care, its components, and services, as well as to improve awareness on stigmatized medical conditions;

(b) Ensure that a safe, therapeutic, and hygienic environment with sufficient privacy exists in all palliative care health facilities and, for this purpose, shall be responsible for the regulation, licensing, monitoring, and assessment of all palliative care facilities;

(c) Integrate palliative care into the routine health information system and identify, collate, routinely report and use core palliative care health data disaggregated by sex and age, and health outcomes, including data on hospice and bereavement care, in order to improve palliative care service delivery, and promotion strategies;

(d) Improve research capacity and academic collaboration on national priorities for research in palliative care, particularly operational research with direct relevance to service development, implementation, and the exercise of human rights by persons with advanced life-limiting conditions, including the establishment of centers of excellence;

(e) Ensure that all public and private palliative care health institutions uphold the right of patients to be protected against torture or cruel, inhumane, and degrading treatment;

(f) Coordinate with the Philippine Health Insurance Corporation to ensure that insurance packages equivalent to those covering physical disorders of comparable impact to the patient, as measured by Disability-Adjusted Life Year or other methodologies, are available to patients affected by advanced life-limiting conditions;

(g) Prohibit forced or inadequately remunerated labor within palliative care health facilities, unless such labor is justified as part of an accepted therapeutic treatment program;

(h) Provide support services for families and co-workers of palliative patients, palliative care providers, specialists, workers, and other service providers;

(i) Develop alternatives to institutionalization, particularly community-based approaches aimed at receiving patients discharged from hospitals, meeting the needs expressed by persons with advanced life-limiting health conditions, and respecting their autonomy, decisions, dignity, and privacy;

(j) Ensure that all health facilities shall establish their respective internal review boards. In consultation with stakeholders, the DOH shall promulgate the rules and regulations necessary for the efficient disposition of all proceedings, matters, and cases referred to, or reviewed by, the internal review board;

(k) Establish a balanced system of community-based and hospital-based palliative care services at all levels of the public health care system from the barangay, municipal, city, provincial, regional to the national level;

(l) Ensure that all health workers shall undergo human rights trainings in coordination with appropriate agencies or organizations; and

(m) Ensure sufficient supply of medicines for palliative care that are available at affordable prices. Further, the DOH shall formulate a monitoring system to check that pain medications are safe and administered in correct dosages.

Sec. 25. *Duties and Responsibilities of the Commission on Human Rights (CHR).* — The CHR shall:

(a) Establish mechanisms to investigate, address, and act upon complaints of impropriety and abuse in the treatment and care received by palliative patients, particularly when such treatment or care is administered or implemented involuntarily;

(b) Inspect palliative care health facilities to ensure that palliative patients therein are not being subjected to cruel, inhumane, or degrading conditions or treatment;

(c) Investigate all cases involving involuntary treatment, confinement, or care of palliative patients, for the purpose of ensuring strict compliance with domestic and international standards respecting the legality, quality, and appropriateness of such treatment, confinement, or care; and

(d) Appoint a focal commissioner for palliative care tasked with protecting and promoting the rights of palliative patients and other persons utilizing palliative care services or confined in health facilities, as well as the rights of palliative care professional, specialists and workers. The focal commissioner shall, upon a finding that a palliative care health facility, palliative care provider, palliative care specialist or palliative care health worker has violated any of the rights provided for in this Act, take all necessary actions to rectify or remedy such violation, including recommending that an administrative, civil, or criminal case be filed by the appropriate government agency.

Sec. 26. *Duties and Responsibilities of the Department of Education (DepEd), Commission on Higher Education (CHED), and the Technical Education and Skills Development Authority (TESDA).* — The DepEd, CHED and TESDA shall:

(a) Integrate age-appropriate content pertaining to palliative care into the curriculum at all educational levels both in public and private institutions;

(b) Develop guidelines and standards on age-appropriate and evidenced-based palliative care programs both in public and private institutions;

(c) Pursue strategies that promote the realization of palliative care and well-being in educational institutions; and

(d) Ensure that palliative care promotions in public and private educational institutions shall be adequately complemented with qualified mental health professionals.

Sec. 27. *Duties and Responsibilities of the Department of Social Welfare and Development (DSWD).* - The DSWD shall:

(a) Refer palliative patients to palliative care health facilities, providers, specialists, workers, and other service providers for appropriate care;

(b) Provide or facilitate access to public or group housing facilities, counselling, therapy, and livelihood training and other available skills development programs; and

(c) In coordination with the LGUs and the DOH, formulate, develop, and implement psychosocial well-being training programs, including psychosocial and spiritual support services during and after natural disasters and other calamities.

Sec. 28. *Duties and Responsibilities of Local Government Units (LGUs).* - The LGUs shall:

(a) Review, formulate, and develop the regulations and guidelines necessary to implement an effective palliative care policy within its territorial jurisdiction, including the passage of a local ordinance on the subject of palliative care, consistent with existing relevant national policies and guidelines;

(b) Integrate palliative care services in the basic health care services, and ensure that palliative care services are provided in primary health care facilities and hospitals, within its territorial jurisdiction;

(c) Establish training programs necessary to enhance the capacity of palliative care service providers at the LGU level, in coordination with appropriate national government agencies and other stakeholders;

(d) Promote deinstitutionalization and other community-based approaches in the delivery of palliative care services;

(e) Establish, reorient, and modernize palliative care health facilities necessary to adequately provide palliative care services, within its territorial jurisdiction;

(f) Refer palliative patients to palliative care health facilities, providers, specialists, workers, and other service providers for appropriate care; and

(g) Establish a multi-sectoral stakeholder network for the identification, management, and prevention of advanced life-limiting health conditions.

Sec. 29. *Upgrading of Local Hospitals and Health Care Facilities.* - Each LGU, upon its determination of the necessity based on well-supported data provided by its local health office, shall establish or upgrade local hospitals and facilities with adequate and qualified personnel, equipment and supplier to be able to provide palliative care services and to address palliative emergencies: *Provided*, That people in geographically isolated and/or highly populated and depressed areas shall have the same level of access and shall not be neglected by providing other means such as home visits or mobile health care clinics, as needed: *Provided further*, That the national government shall provide additional funding and other necessary assistance for the effective implementation of this provision, if necessary.

CHAPTER VII
ESSENTIAL MEDICINES

Sec. 30. *Essential Palliative Medicines* – The DOH and other concerned government agencies shall implement reforms supporting early access to essential palliative medicines, innovative medicines and health technologies to ensure highest possible quality of life among all people with palliative and hospice care needs. The reforms include facilitating easy prescribing, dispensing and access to drugs for compassionate use and developing a more responsive system for effectively addressing urgent needs.

The DOH shall ensure a sufficient supply of medicines for palliative care that are available at affordable prices. PDEA and FDA shall create a dedicated and streamlined process for licensing, procurement, prescription, dispensing, and monitoring of these drugs.

CHAPTER VIII
THE PHILIPPINE COUNCIL FOR PALLIATIVE CARE

Sec. 31. *Mandate.* - The Philippine Council for Palliative Care, herein referred to as the Council, is hereby established as a policy-making, planning, coordinating and advisory body on palliative care.

The Council shall be attached to the DOH to oversee the implementation of this Act particularly on the protection of the rights and freedom of persons with palliative care, hospice care and psychosocial needs and the delivery of a rational, unified and integrated palliative care services responsive to the needs of the Filipino people.

Sec. 32. *Composition of The Council.* - The Council shall be composed of the following:

(a) Secretary of DOH as Chairperson;

(b) Secretary of DepEd;

(c) Secretary of DOLE;

(d) Secretary of DSWD;

(e) Secretary of the Department of the Interior and Local Government (DILG);

(f) President and Chief Executive Officer of PhilHealth;

(g) Chairperson of CHR;

(h) Chairperson of CHED;

(i) One (1) representative from the academe/research involved in palliative and hospice care;

(j) Two (2) representatives from palliative care-focused medical professional organizations; and

(k) Three (3) representatives from palliative care-focused nongovernment organizations (NGOs) and advocacy networks.

The members of the Council from the government may designate their permanent authorized representatives.

Within thirty (30) days from the effectivity of this Act, the members of the Council from the academe/research, private sector and NGOs shall be appointed by the President of the Philippines from a list of three (3) nominees submitted by the organizations, as endorsed by the Council.

Members representing the academe/research, private sector and NGOs of the Council shall serve for a term of three (3) years. In case a vacancy occurs in the Council, any person chosen to fill the position vacated by a member of the Council shall only serve the unexpired term of said member.

Sec. 33. *Duties and Functions.* - The Council shall exercise the following duties:

(a) Develop and periodically update, in coordination with the DOH, a national multi-sectoral strategic plan for palliative care that further operationalizes the objectives of this Act which shall include the following:

(i) The country's targets and strategies in protecting the rights of Filipinos with palliative care needs and in promoting palliative care and the well-being of Filipinos, as provided in this Act;

(ii) The government's plan in establishing a rational, unified and integrated service delivery network for palliative care services including the development of health human resources and information system for palliative care; and

(iii) The budgetary requirements and a corollary investment plan that shall identify the sources of funds for its implementation;

(b) Monitor the implementation of the rules and regulations of this Act and the strategic plan for palliative care, undertake mid-term assessments and evaluations of the impact of the interventions in achieving the objectives of this Act;

(c) Ensure the implementation of the policies provided in this Act, and issue or cause issuance of orders, or make recommendations to the implementing agencies as the Council considers appropriate;

(d) Coordinate the activities and strengthen working relationships among national government agencies, LGUs, and nongovernment agencies involved in palliative care promotion;

(e) Coordinate with foreign and international organizations regarding data collection, research and treatment modalities for persons with advanced life-limiting health conditions;

(f) Coordinate joint planning and budgeting of relevant agencies to ensure funds for programs and projects indicated in the strategic medium-term plan are included in the agency's annual budget;

(g) Call upon other government agencies and stakeholders to provide data and information in formulating policies and programs, and to assist the Council in the performance of its functions;

(h) Establish a National Palliative Care Registry and monitoring system that cover all advanced life-limiting conditions among adults and children and serve as guide in the policy development of the Council; and

(i) Perform other duties and functions necessary to carry out the purposes of this Act.

Sec. 34. *Creation of the DOH Palliative Care Division.* — There shall be created in the DOH, a Palliative Care Division, under the Disease Prevention and Control Bureau, staffed by qualified palliative care specialists and support staff with permanent appointments and supported with an adequate yearly budget. It shall implement the National Palliative Care Program and, in addition, shall also serve as the Secretariat of the Council.

CHAPTER IX
MISCELLANEOUS PROVISIONS

Sec. 35. *Appropriations.* — The amount needed for the initial implementation of this Act shall be charged against the 2024 appropriations of the DOH. Thereafter, such amounts necessary shall be include in the annual appropriations of the LGUs and other implementing agencies.

Sec. 36. *Implementing Rules and Regulations (IRR).* - The Secretary of Health, in coordination with the CHR, DSWD, DILG, DepEd, CHED, TESDA, DOLE, CSC and together with associations or organizations representing palliative patients and palliative care providers, specialists, workers, and other service providers, shall issue the IRR necessary for the effective implementation of this Act within one hundred twenty (120) days from the effectivity thereof.

Sec. 37. *Separability Clause.* — If any provision of this Act is declared unconstitutional or invalid by a court of competent jurisdiction, the remaining provisions not affected thereby shall continue to be in full force and effect.

Sec. 38. *Repealing Clause.* - All laws, decrees, executive orders, department or memorandum orders and other administrative issuances or parts thereof which are inconsistent with the provisions of this Act are hereby modified, superseded or repealed accordingly.

Sec. 39. *Effectivity*. - This Act shall take effect fifteen (15) days after its publication in the Official Gazette or in at least two (2) newspapers of general circulation.

Approved,