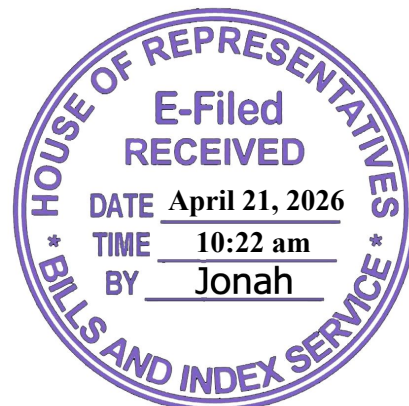




Republic of the Philippines
House of Representatives
Quezon City, Metro Manila

Twentieth Congress
First Regular Session

HOUSE BILL NO. 8903



Introduced by Representatives Ferdinand Martin G. Romualdez, Yedda Marie K. Romualdez, Andrew Julian K. Romualdez and Jude A. Acidre

AN ACT
INSTITUTIONALIZING A NATIONAL PALLIATIVE AND HOSPICE
CARE PROGRAM, ENSURING ACCESS TO INTEGRATED, EQUITABLE,
AND RIGHTS-BASED PALLIATIVE CARE SERVICES, AND
APPROPRIATING FUNDS THEREFOR

EXPLANATORY NOTE

This proposed bill seeks to institutionalize a national Palliative and Hospice Care Program, establish the rights of palliative care patients and other stakeholders, outline the different palliative care services and essential medicines, promote palliative care in educational institutions and workplaces, provide capacity-building to providers of palliative care, conduct research towards the improvement of the Program, and evaluate the implementation of such. The proposed bill likewise ensures that efforts of different national government agencies involved and local government units are harmonized.

Palliative and hospice care plays a vital role in improving the quality of life of patients with life-limiting illnesses by relieving pain, alleviating symptoms, and addressing emotional, social, and spiritual needs. However, despite its recognition as a human right and an essential component of universal health, access to palliative and hospice care in the Philippines remains limited.

According to a study in 2020, only about 10% of hospitals nationwide have dedicated palliative and hospice units. This leaves the majority of Filipinos without access to such services. Many institutions lack the facilities and essential medicines needed to provide adequate care.

The lack of trained professionals further worsens this gap as palliative and hospice care are barely integrated into medical education. Thus, only a handful of specialists serve the country's large and growing population. Many healthcare professionals also hesitate to refer patients to palliative care, perceiving it as "giving up."

At the same time, cultural values that emphasize family caregiving, while rooted in compassion, often prevent patients and families from seeking formal palliative care services. Moreover, there are misconceptions among families that equate palliative care services with euthanasia or exclusively end-of-life care.

Therefore, this bill responds to these urgent challenges by institutionalizing a National Palliative and Hospice Care Program to ensure equitable, rights-based, and culturally sensitive access to services. It establishes the Philippine Council for Palliative Care to coordinate national efforts, strengthens training and education for healthcare providers, allocates dedicated resources to expand facilities and access to essential medicines, and embeds palliative care within the continuum of healthcare delivery. It also promotes public awareness campaigns to dispel misconceptions, encourage acceptance, and empower families to make informed choices.

By passing this proposed measure, the State does not just fulfill its commitment to national and international laws to promote the health, wellbeing, and the overall quality of life of its citizens. It likewise asserts and affirms that every Filipino has the right to live and die with dignity, free from unnecessary pain and suffering.

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



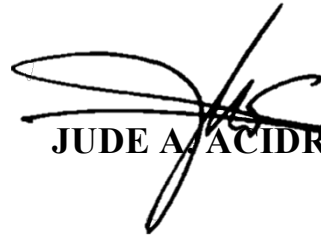
FERDINAND MARTIN G. ROMUALDEZ



YEDDA MARIE K. ROMUALDEZ

A stylized handwritten signature in black ink, consisting of a large 'A' followed by 'JR'.

ANDREW JULIAN K. ROMUALDEZ

A stylized handwritten signature in black ink, featuring a large 'J' and 'A' followed by 'ACIDRE'.

JUDE A. ACIDRE



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

CHAPTER I
General Provisions

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

SECTION 2. *Declaration of Policy.* – The State affirms the right of every Filipino to receive palliative and hospice care services that uphold dignity, autonomy, and

compassion. In line with the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), and other international conventions ratified by the Republic of the Philippines, the State commits to ensuring equitable access to quality palliative care for all, particularly those with chronic life-limiting illness (CLLI), recognizing such access as a fundamental human right.

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

To achieve this, the State shall pursue the following principles:

- a. An integrated and comprehensive approach that ensures continuity of care and addresses the diverse needs of individuals across all age groups and health conditions who require palliative and hospice services throughout the full continuum of care;
- b. A whole-of-system, whole-of-society, and whole-of-government approach in the development and implementation of essential palliative and hospice care programs made available to the public
- c. A model of care that respects and responds to the unique needs, values, and preferences of individuals and their families, ensuring that services are timely, affordable, culturally appropriate, and aligned with the person's dignity and goals of care;
- d. A legal and service framework that upholds the dignity and choices of individuals receiving palliative care by ensuring their freedom from coercion

and discrimination, protecting their autonomy, and supporting their active role in family, community, and civic life.

SECTION 3. *Objectives.* – The objectives of this Act are as follows:

- a. Promote and protect the rights and freedoms of persons with palliative and hospice care needs, consistent with international human rights obligations;
- b. Establish a comprehensive, integrated, and responsive national palliative and hospice care system that addresses the needs of all population groups;
- c. Strengthen leadership, governance, and institutional coordination in the planning, delivery, and evaluation of palliative care programs and services;
- d. Build the capacity of the health workforce and community partners through sustained training, education, and support;
- e. Advance research, data systems, and evidence-informed practices in palliative and hospice care, including indigenous and community-based models;
- f. Embed palliative care within the basic health services, public health strategies, and educational, community, and workplace settings across all levels of government.

SECTION 4. *Definition of Terms.* – For the purposes of this Act, the following terms are hereby defined:

- a. ***Allied health professional*** refers to trained non-palliative specialist health professionals such as physicians, social workers, nurses, occupational therapists, recreational therapists, dietitians, among others;
- b. ***Carer*** refers to a person who provides regular support to a palliative patient, whether voluntarily or as part of a paid or professional role. A carer may be a family member, friend, or an individual formally designated by the patient or

their family, regardless of whether a prior close personal relationship exists between them and the carer.

- c. ***Chronic Life-Limiting Illness*** refers to any health condition that is inevitably fatal or which significantly shortens a person's life expectancy, and/or causes serious health-related suffering. This includes advanced or metastatic cancers, endstage organ failures (such as end-stage renal, cardiac or liver disease), chronic progressive illnesses (such as late-stage chronic obstructive pulmonary disease or neurological disorders), AIDS with severe complications, degenerative conditions, congenital disorders, and other similar diseases or injuries where curative treatment is no longer effective or feasible.
- d. ***Confidentiality*** refers to the obligation of all healthcare providers, institutions, and personnel involved in the delivery of palliative care services to protect the personal and medical information of patients from unauthorized access, use, or disclosure. This duty shall be exercised in accordance with the Data Privacy Act of 2012 (RA 10173), its Implementing Rules and Regulations, and other relevant issuances by the National Privacy Commission.
- e. ***Continuum of Care*** is the coordinated and comprehensive delivery of health services that accompany a person's health journey—health promotion, disease prevention, diagnosis, treatment, rehabilitation, supportive care, palliation, survivorship, end of life care, and bereavement support—ensuring continuity, responsiveness, and dignity at every stage.
- f. ***Hospice Care*** refers to a component of palliative care which deals with persons who are not expected to survive more than six months. It focuses on ensuring peace, comfort, dignity, and holistic support—including medical, psychological, and spiritual care—delivered in accordance with the patient's

values, rights, and preferences.

- g. ***Impairment or Temporary Loss of Decision-Making Capacity*** - A condition, as determined and documented by a licensed physician or mental health professional, in which an individual is unable to understand, deliberate, or communicate informed decisions about their care. For legal purposes, such assessment must be recorded in the patient's medical record and, when applicable, must conform to relevant laws and institutional protocols governing substitute decision-making.
- h. ***Informed Consent*** - A process in which a patient, who has decision-making capacity, voluntarily submits to a proposed treatment or intervention after receiving clear, comprehensible information on the nature and purpose of the intervention, its expected benefits and potential risks, and available alternatives (including the option of no treatment). Documentation of the patient's voluntary decision shall be maintained in their medical record.
- i. ***Life-sustaining Treatment*** refers to any medical intervention that serves to prolong life without curing the underlying condition, including but not limited to mechanical ventilation, dialysis, resuscitation, and artificial nutrition or hydration. Such treatment may be withheld or withdrawn in accordance with the patient's wishes, advance directives, or applicable law and ethical standards.
- j. ***Palliative Care*** is an approach that improves the quality of life of patients (adults and children) and their families facing problems associated with a life-threatening illness. It prevents and relieves serious health-related suffering through the early identification and impeccable assessment and treatment of pain and other issues—physical, psychosocial, or spiritual.
- k. ***Palliative Care Health Facility*** is any establishment primarily engaged in

delivering palliative care services, whether standalone or as part of a larger health institution, that is duly licensed or accredited by the Department of Health (DOH) or other regulatory bodies authorized by law.

- l. ***Palliative Care Specialist*** is a physician who has completed formal fellowship training in Palliative and Hospice Medicine conducted or accredited by the Philippine Society of Hospice and Palliative Medicine (PSHPM) and has received certification in accordance with applicable rules and guidelines set by the Professional Regulation Commission (PRC) or its duly authorized agency.
- m. ***Palliative Care Service Provider*** refers to a person, organization, or legally registered entity that is authorized to deliver palliative care services, including but not limited to licensed professionals, certified palliative care specialists, palliative care facilities, and accredited community-based service groups.
- n. ***Palliative Care Services*** refers to a comprehensive range of evidence-based and rights-centered health interventions—including physical, psychosocial, and spiritual support—delivered across the continuum of care for individuals with chronic life-limiting illness.
- o. ***Palliative Health Aide*** refers to a volunteer, advocate, or community-based worker duly certified to provide basic palliative and hospice care in the home/community-based or hospital/facility-based setting.
- p. ***Palliative Patient*** refers to any person of any age diagnosed by a qualified health professional with a chronic life-limiting illness and who requires, is receiving, or has been referred for palliative or hospice care services.
- q. ***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

- r. ***Pediatric Palliative Care*** refers to palliative care that is specifically adapted and provided to infants, children, and adolescents with life-limiting or life-threatening conditions. It addresses the unique medical, developmental, psychosocial, and spiritual needs of both the child and their family through a comprehensive, interdisciplinary approach. Care begins at diagnosis and continues throughout the illness trajectory, regardless of whether disease-directed treatment is ongoing. It is provided across all levels and settings of care and includes support for family caregivers and bereavement services.
- s. ***Psychosocial support*** refers to the range of interventions, services, and assistance—beyond direct medical care—aimed at addressing the emotional, social, economic, cultural, and spiritual well-being of palliative patients and their families. It includes, but is not limited to, financial aid, counseling, grief and bereavement support, peer and family support, access to transient housing, transportation assistance, food and nutritional services, livelihood support, and spiritual care. Psychosocial support is designed to reduce distress, promote resilience, and maintain the dignity and quality of life for individuals with CLLI.
- t. ***Serious Health-Related Suffering*** refers to suffering or distress associated with illness or injury of any kind and cannot be relieved without professional intervention and that compromises physical, social, spiritual, and/or emotional functioning.
- u. ***Supportive Care*** refers to a set of services provided alongside curative or life-prolonging treatment to help patients manage the physical, emotional, and practical side effects of their illness or therapy. It includes symptom control, psychosocial support, nutritional care, rehabilitation, and interventions that

promote comfort, well-being, and daily functioning throughout the illness trajectory

- v. ***Surrogate Decision Maker or Healthcare Proxy*** refers to a person legally designated to make care-related decisions on behalf of a palliative patient, either through a written advance directive made by the patient, a legal appointment by a court, or assignment under applicable law when the patient is no longer able to decide for themselves
- w. ***Transition care*** refers to the set of time-bound services and coordinated support provided to patients and their families when transferring between care settings (e.g., hospital to home), shifting approach to care (e.g. pediatric to adult), or shifting care goals (e.g., curative to palliative). These services aim to ensure safe, continuous, and well-informed care. They are delivered by the referring and receiving healthcare teams, in coordination with the patient, family, community providers, and Patient Navigators who help guide and support the transition process.

CHAPTER II

Rights of Palliative Patients and Other Stakeholders

SECTION 5. *Rights of Palliative Patients* – All persons receiving palliative or hospice care services shall enjoy, on an equal and non-discriminatory basis, the rights guaranteed under the 1987 Philippine Constitution, the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the

Universal Health Care Act (RA 11223), the National Integrated Cancer Control Act (RA 11215), relevant Department of Health issuances, and other international conventions ratified by the Republic of the Philippines. These rights shall include, but shall not be limited to, the following:

- a. **Right to Non-Discrimination.** The right to be free from all forms of discrimination, stigma, or marginalization based on age, sex, gender, health status, socioeconomic status, ethnicity, religion, disability, or any other personal condition;
- b. **Right to Full Enjoyment of Civil, Political, Economic, Social, and Cultural Rights.** The right to exercise inherent civil, political, economic, social, and cultural rights, including religious and educational rights, without discrimination, and with full respect for individual dignity, preferences, and values;
- c. **Right to Palliative and Hospice Care Services.** The right to receive palliative and hospice care services that respect dignity, autonomy, culture, and values, and to be provided with humane and compassionate care, especially at the end of life;
- d. **Right to Quality and Equitable Care.** The right to access quality, safe, affordable, and evidence-based palliative and hospice care, consistent with the highest attainable standard of health, across all levels of the health care system;
- e. **Right to Coordinated and Comprehensive Services.** The right to coordinated, comprehensive, and patient-centered services that include prevention, promotion, diagnosis, treatment, rehabilitation, palliation, and end-of-life care, under a multidisciplinary plan of care;

- f. **Right to Appropriate Care Setting.** The right to receive care in the least restrictive, most appropriate, and dignified setting, whether in a health facility, hospice, or the community;
- g. **Right to Information.** The right to receive adequate, clear, and timely information regarding available palliative and hospice services, including options, risks, benefits, and the nature of care to be provided;
- h. **Right to Informed Consent.** The right to informed consent, including the right to freely accept or refuse any proposed diagnostic or medical treatment procedure, and the right to withdraw consent at any time. Such consent or refusal shall be appropriately documented in the patient's medical record.
- i. **Right to Participate in Care.** The right to participate in the formulation, development, and periodic review of their individualized plan of care, and to designate a person of legal age to act as their representative for decision-making purposes when necessary;
- j. **Right to Appoint a Proxy.** The right to appoint a surrogate decision-maker or legal representative by applicable law, in the event of impairment or loss of decision-making capacity;
- k. **Right to Privacy and Confidentiality.** The right to confidentiality and privacy of all personal, medical, and health-related information, by the Data Privacy Act of 2012 and other applicable laws. Information shall not be disclosed without prior consent, except in cases authorized by law.
- l. **Right to Psychosocial and Spiritual Support.** The right to psychosocial, emotional, and spiritual support for themselves and their families throughout care and in the bereavement period;
- m. **Right to Participate in Policy-Making.** The right to participate in palliative care policy-making, planning, service delivery, monitoring, and evaluation,

subject to their voluntary capacity and interest;

- n. **Right to Legal Assistance.** The right to receive prompt legal support and representation. In cases where the patient cannot afford legal services, free legal assistance shall be provided by the Public Attorney's Office or accredited legal aid institutions.
- o. **Right to Know Rights and Responsibilities.** The right to be informed of their rights and responsibilities under this Act within twenty-four (24) hours of admission to a health facility, in a manner and language that is comprehensible to the patient and family.

SECTION 6. *Rights of Family Members, Carers and Legal Representatives.* – Family members, carers, and duly designated or appointed legal representatives of palliative and hospice care patients shall enjoy the following rights, in accordance with the provisions of this Act, the Universal Health Care Act (RA 11223), and other applicable laws and issuances. These rights shall be exercised with full respect for the patient's autonomy and informed consent:

- a. **Right to Participate in Care Planning.** With the patient's consent, the right to participate in the development and implementation of the patient's individualized care plan.
- b. **Right to Psychosocial and Spiritual Support.** The right to receive psychosocial and spiritual support from health care providers, the DSWD, and other relevant agencies during caregiving and bereavement.
- c. **Right to Caregiver Education and Respite Support.** The right to receive caregiver training, guidance in home care, and access to respite services, where available.
- d. **Right to Compassionate Workplace Accommodation.** The right to use

available leave benefits for caregiving, and to receive reasonable flexibility from employers. The State shall explore a dedicated Compassionate Care Leave.

- e. **Right to Request for Discharge or Transfer.** Family members, carers, or legal representatives may request the discharge or transfer of a patient to home or a more suitable health facility. This right may be exercised provided that:
 - i. They are fully informed by the care team of the risks, benefits, and implications of such decision;
 - ii. They execute a written waiver releasing the health care provider and facility from liability for foreseeable consequences;
 - iii. The decision does not endanger public health and safety, as determined by the attending team and applicable public health guidelines.
- f. **Right to Participate in Palliative Policy and System Development.** The right to engage, on a voluntary basis, in palliative care policy-making, program planning, and system evaluation.
- g. **Right to Bereavement Support.** The right to receive basic bereavement services, including counseling referrals and support group access, and to be informed of where to seek help.

CHAPTER III

National Palliative and Hospice Care Program

SECTION 7. *National Palliative and Hospice Care Program.* – There is hereby established a National Palliative and Hospice Care Program which shall serve as the framework for all palliative care-related activities of the government. The program

shall have the following objectives:

- a. Decrease the overall burden of serious health-related suffering of all adult and children with CLLI;
- b. Uphold the rights, preferences, dignity, and comfort of palliative patients and their families;
- c. Develop national standards for palliative and hospice care services;
- d. Improve the capacity to provide quality palliative services throughout the country;
- e. Provide timely access to optimal and cost-effective palliative care services and medication;
- f. Make palliative, hospice, and grief and bereavement care more affordable and accessible to all Filipinos;
- g. Improve the experience of palliative care of patients and families and support their inclusion and/or reintegration to society.

SECTION 8. *The Philippine Council for Palliative Care* – There is hereby established the Philippine Council for Palliative Care, hereinafter referred to as the Council, as the principal policy-making, planning, coordinating, and advisory body attached to the Department of Health (DOH). The Council, as a part of the DOH, shall:

- a. Oversee the implementation of this Act and the National Palliative and Hospice Care Program;
- b. Uphold the rights and freedoms of persons with palliative, hospice, and psychosocial care needs; and
- c. Promote a rational, unified, and integrated service delivery network for

palliative and hospice care responsive to Filipino health and cultural contexts.

SECTION 9. *Composition.* – The Council shall be composed of the following:

- a. Secretary of Health as the Chairperson in an *ex officio* capacity;
- b. A vice chairperson who shall be elected by the non-*ex officio* members, from among themselves and who shall serve for a term of three (3) years;
- c. *Ex officio* members consist of the following:
 - i. Secretary of DepED;
 - ii. Secretary of DOLE;
 - iii. Secretary of DSWD;
 - iv. Secretary of the Department of the Interior and Local Government (DILG);
 - v. President and Chief Executive Officer of PhilHealth;
 - vi. Chairperson of CHR;
 - vii. Chairperson of CHED;
- d. One (1) representative from the academe/research involved in palliative and hospice care;
- e. Two (2) palliative care specialists; and
- f. Three (3) representatives from palliative care-focused nongovernment organizations (NGOs), patient organizations, and/or advocacy networks

The *ex officio* members of the Council may designate their permanent authorized representatives. The Secretary of Health's designated representative must have a rank not lower than Undersecretary.

The *non-ex officio* members of the council must be citizens and residents of the Philippines, of good moral character, of recognized probity and independence, and

have distinguished themselves professionally in public, private, civic, or academic service in the field of palliative care. They shall be chosen from at least five (5) persons recommended by the Secretary of Health, to be appointed by the President 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.

SECTION 10. *Powers and Functions.* – The Council shall exercise the following powers and functions:

- a. Formulate, in coordination with the DOH and relevant stakeholders, a National Strategic Plan for Palliative Care that shall be periodically updated and shall include:
 - i. National goals and measurable targets for protecting the rights and dignity of patients with palliative and hospice care needs;
 - ii. A roadmap for developing and sustaining an integrated, rights-based palliative care service delivery network, including the development of human resources, infrastructure, and health information systems;
 - iii. A multi-year investment and resource mobilization plan with identified funding sources to support the implementation of this Act;
- b. Monitor and evaluate the implementation of this Act, the Strategic Plan, and the corresponding Rules and Regulations, including mid-term reviews and end-line impact assessments;
- c. Ensure effective inter-agency coordination and policy harmonization, and issue resolutions or recommendations to concerned government offices to guide program implementation, providing clear and comprehensive guidance to all involved.

- d. Strengthen collaboration among national agencies, local government units (LGUs), civil society, the private sector, and development partners in the promotion of equitable and high-quality palliative care, ensuring that all stakeholders are included and part of a larger, collective effort.
- e. Engage in technical cooperation with international agencies and institutions in the areas of policy, training, research, and innovation for palliative and hospice care;
- f. Facilitate joint planning and budget alignment across agencies to guarantee that appropriate allocations for palliative care are reflected in national and local budget proposals;
- g. Require the submission of relevant data and reports from government and private stakeholders to inform evidence-based policies and programs;
- h. Institutionalize and oversee a National Palliative Care Registry and monitoring system, in coordination with the DOH, for purposes of planning, policy-making, and quality assurance;
- i. Exercise such other functions as may be necessary to carry out the objectives of this Act.

SECTION 11. *Creation of the DOH Palliative Care Division.* – A Palliative Care Division shall be established within the Disease Prevention and Control Bureau of the Department of Health. This division, staffed by qualified palliative care specialists, program managers, and support personnel with permanent appointments, will be responsible for the technical and operational aspects of the National Palliative and Hospice Care Program.

The Division shall:

- a. Serve as the lead technical and operational arm for the implementation of the National Palliative and Hospice Care Program and provide secretariat support to the Council;
- b. Coordinate with regional health offices, local governments, and stakeholders for effective service delivery. This coordination will involve regular communication, joint planning, and monitoring of service delivery to ensure that palliative and hospice care services are effectively reaching those in need;
- c. Ensure policy consistency and alignment with the Universal Health Care (UHC) Act, the DOH Manual of Operations for Palliative and Hospice Care, and international health commitments, including the UDHR, ICCPR, ICESCR, and WHO guidelines.

CHAPTER IV

Palliative Care Services

SECTION 12. *Quality of Palliative Care Services.* – Palliative Care services provided pursuant to this Act shall be:

- a. Evidence-based and aligned with internationally accepted clinical standards, including those of the World Health Organization and the Department of Health;
- b. Responsive to the clinical, gender, cultural, ethnic, and other specific needs of patients and their families;
- c. Delivered in the most appropriate and least restrictive setting possible;
- d. Age-appropriate and consistent with the principles of dignity and comfort across the lifespan;

- e. Provided by duly trained and accredited palliative care professionals, specialists, health aides, and workers, in a manner that ensures transparency, accountability, and adherence to the Department of Health's Manual of Operations, Procedures, and Standards for the National Palliative and Hospice Care Program.

SECTION 13. *Minimum Scope of Palliative and Hospice Care Services.* – Palliative and hospice care services provided pursuant to this Act shall, at a minimum, include the following core components:

- a. **Pain and Symptom Management** - Relief from pain and other distressing symptoms through evidence-based pharmacologic and non-pharmacologic interventions. Patients shall have timely access to essential palliative medicines, including opioids, as listed in the Philippine National Formulary. The DOH, FDA, and PDEA shall ensure safe, legal, and appropriate availability and use at all levels of care.
- b. **Psychosocial Support** - Services to address emotional, social, and psychological needs of patients and families, including counseling, peer support, and social work assistance. Support for children, such as child life services, shall be provided when applicable.
- c. **Spiritual Care** - Spiritual support shall be offered in line with the patient's beliefs, with access to faith leaders or spiritual advisers. Facilities shall accommodate spiritual practices when requested.
- d. **Multidisciplinary Care** - An interdisciplinary team shall deliver coordinated care that addresses medical, nursing, psychosocial, and spiritual needs. Palliative health aides and trained volunteers may support care delivery, especially at home.

- e. **Patient and Family Education** - Patients and families shall be informed about the illness, care expectations, and basic caregiving skills. Education shall include medication use, comfort care, and recognizing signs of deterioration or death.
- f. **End-of-Life Care** - Care during the terminal phase shall focus on comfort and dignity, avoid non-beneficial interventions, and respect patient wishes. Providers shall support families before, during, and after death, including postmortem guidance and bereavement initiation.
- g. **Respite Care** - Short-term care shall be available, when feasible, to relieve family caregivers. Public hospitals, hospices, and community-based palliative care programs are encouraged to offer this when resources allow.
- h. **Advance Care Planning** - Patients shall be supported in documenting their care preferences, including advance directives and appointment of proxies. Discussions shall be part of routine care.
- i. **Transition Care** - Support shall be provided during transitions in care settings, phases, or populations to ensure continuity and safety for patients and families.
- j. **Home-Based Care** - When appropriate, care may be provided at home through coordinated home visits, medication access, and caregiver support.
- k. **Grief and Bereavement Support** - Families shall have access to basic bereavement support, including counseling referrals and information on grief resources.
- l. **Patient Navigation and Case Management** - Navigators or case managers shall assist patients and families with service coordination, referrals, resource access, and continuity of care.

SECTION 14. *Withholding or Withdrawing Life-Sustaining Treatment.* – Any person of legal age and sound mind may execute a directive directing the withholding or withdrawal of life-sustaining treatment in a terminal condition or permanent unconscious condition, given:

- a. Prior to withholding or withdrawing life-sustaining treatment, the diagnosis of a terminal condition by the attending physician or the diagnosis of a permanent unconscious state by two (2) physicians shall be entered in writing and made a permanent part of the patient's medical records.
- b. The directive shall be signed by the declarer in the presence of two witnesses who:
 - i. Are not related to the declarer by blood or marriage;
 - ii. Would not be entitled to any portion of the estate of the declarer upon declarer's death under any will of the declarer or codicil thereto then existing or, at the time of the directive, by operation of law then existing;
 - iii. Shall not be the attending physician;
 - iv. Shall not be an employee of the attending physician or a health facility in which the declarer is a patient; or
 - v. Have no claim against any portion of the estate of the declarer upon declarer's death at the time of the execution of the directive
- c. The directive shall be duly notarized.
- d. The directive, or a copy thereof, shall be made part of the patient's medical records retained by the attending physician, a copy of which shall be forwarded by the custodian of the records to the health facility when the withholding or withdrawal of life-support treatment is contemplated.

- e. A directive may be revoked at any time by the declarer, without regard to declarer's mental state or competency, by any of the following methods:
 - i. By being canceled, defaced, obliterated, burned, torn, or otherwise destroyed by the declarer or by some person in the declarer's presence and by the declarer's direction.
 - ii. By a written revocation of the declarer expressing the declarer's intent to revoke, signed, and dated by the declarer. Such revocation shall become effective only upon communication to the attending physician by the declarer or by a person acting on behalf of the declarer. The attending physician shall record in the patient's medical record the time and date when said physician received notification of the written revocation.
 - iii. By a verbal expression by the declarer of the declarer's intent to revoke the directive. Such revocation shall become effective only upon communication to the attending physician by the declarer or by a person acting on behalf of the declarer. The attending physician shall record in the patient's medical record the time, date, and place of the revocation and the time, date, and place, if different, of when said physician received notification of the revocation.
- f. If the declarer becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarer's condition renders declarer able to communicate with the attending physician.
- g. Any physician or health care provider acting under the direction of a physician, or health facility and its personnel who participate in good faith in the withholding or withdrawal of life-sustaining treatment from a qualified

patient in accordance with the requirements of this chapter, shall be immune from legal liability, including civil, criminal, or professional conduct sanctions, unless otherwise negligent.

- h. Any person who willfully conceals, cancels, defaces, obliterates, or damages the directive of another without such declarer's consent is guilty of a gross misdemeanor.
- i. Any patient may appoint a surrogate decision maker or healthcare proxy through a written notarized document voluntarily signed by the patient in the presence of witnesses. Surrogate decision makers or healthcare proxies can make medical decisions on behalf of the individual in instances of inability to communicate, loss of decision-making capacity, or unconsciousness.
- j. If a qualified patient capable of making health care decisions indicates that he or she wishes to die at home, the patient shall be discharged as soon as reasonably possible. The health care provider or facility has an obligation to explain the medical risks of an immediate discharge to the qualified patient. If the provider or facility complies with the obligation to explain the medical risks of an immediate discharge to a qualified patient, there shall be no civil or criminal liability for claims arising from such discharge.
- k. Nothing in this Act shall be construed to condone, authorize, or approve mercy killing or physician-assisted suicide, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

SECTION 15. *Community-Based Palliative Care Services* – Primary-level palliative care services shall be integrated into the basic health services at the city, municipal, and barangay levels. Standards of care shall conform to the National Palliative and Hospice Care Program, the Department of Health's Manual of

Operations, Procedures, and Standards for the National Palliative and Hospice Care Program, and relevant issuances.

SECTION 16. *Role of Local Government Units (LGUs).* – Each LGU, in partnership with other institutions and community stakeholders, shall develop and implement a community-responsive palliative care program that is inclusive and considerate of all individuals, in accordance with the national guidelines set by the Philippine Council for Palliative Care. This inclusive approach ensures that all individuals, regardless of their background or circumstances, are considered in the development and implementation of the palliative care program. LGUs shall coordinate with relevant government agencies, private healthcare institutions, and civil society to support this inclusive and culturally appropriate implementation.

SECTION 17. *The Role of the Department of Health (DOH).* – The DOH, in close coordination with LGUs and other stakeholders, plays a crucial role in establishing and supporting the operation of community-based palliative care facilities in provinces, cities, and clusters of municipalities. This is based on population health needs and service accessibility, demonstrating the government's commitment to providing accessible care.

Each community-based palliative care facility shall have:

- a. An adequate physical infrastructure, including patient care rooms and administrative offices;
- b. A core team composed of a palliative care specialist, palliative care providers, palliative health aides, allied professionals, support staff, and community

volunteers;

- c. A substantial amount of essential medical supplies, equipment, and medications appropriate for the facility's service level; and
- d. A system that adheres to the Department.

LGUs, through their health offices, are required to submit quarterly reports to the DOH and the Philippine Council for Palliative Care in accordance with the requirements of the Palliative Care Registry and in compliance with the Data Privacy Act of 2012.

SECTION 18. *Palliative and Hospice Services in Regional, Provincial, and Tertiary Hospitals.* – All public and private regional, provincial, and tertiary hospitals shall integrate the following palliative and hospice services to be provided by a multidisciplinary team under the supervision of a palliative medicine specialist:

- a. Inpatient care in designated palliative or hospice wards for patients experiencing acute symptoms;
- b. Partial hospital care for those with moderate symptoms or psychosocial challenges;
- c. Outpatient services coordinated with community-based programs;
- d. Transition or home-based care for patients with special or long-term needs;
- e. Coordination with relevant programs addressing comorbidities, including substance use disorders and mental health conditions;
- f. An integrated referral system to public and private providers of palliative and hospice care;
- g. Hospital-based Palliative Care Registry that must record the personal identification of palliative patients, type of CLLI, 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 providing palliative and hospice care services.

SECTION 19. *Referral Networks and Continuity.* – Each province or region shall establish a referral network for palliative and hospice care, ensuring coordinated transitions across providers, facilities, and care settings. The DOH shall integrate palliative care into Service Delivery Networks under the Universal Health Care framework, with each network designating at least one palliative care specialist to accept referrals and support other facilities. Continuity of essential medicines, particularly for pain management, shall be ensured upon discharge through adequate supply or valid prescriptions redeemable at community pharmacies.

SECTION 20. *Duties and Responsibilities of Palliative Care Facilities.* – Palliative Care facilities shall:

- a. Ensure compliance with existing standards for licensure by the DOH and other relevant agencies;
- b. Establish internal policies to minimize involuntary and restrictive care practices;
- c. Provide all patients with accessible information regarding their rights under this Act;
- d. Ensure transparent communication of each patient’s individualized care plan;

- e. Obtain informed consent prior to any procedure, except in emergencies or when the patient has impaired decision-making capacity;
- f. Maintain detailed clinical records of treatments administered;
- g. Ensure legal representatives are designated in accordance with this Act, honoring patient preferences and safeguarding autonomy.

SECTION 21. *Pediatric Palliative and Hospice Care.* – The State shall ensure access to age-appropriate palliative care for infants, children, and adolescents with life-limiting or life-threatening conditions. In addition to the general provisions of this Act, the following shall apply:

- a. Tertiary hospitals with pediatric services shall establish or designate pediatric palliative care teams to provide coordinated, family-centered care from diagnosis.
- b. The DOH, with relevant professional societies, shall develop pediatric-specific standards covering pain assessment, medication dosing, communication, and family support.
- c. LGUs and the DOH shall integrate pediatric palliative care into home and community programs and ensure access to child-appropriate medicines and educational continuity.
- d. Parents, guardians, and siblings shall receive counseling, decision-making guidance, and bereavement support as part of routine care.
- e. Providers shall prioritize pain relief, use age-appropriate tools, and ensure access to pediatric formulations, including opioids, with proper safeguards.
- f. Palliative care training shall be included in pediatric medical education and supported through continuing professional development programs.
- g. Hospice care for children shall be responsive and family-centered, with

facilities staffed and equipped to meet pediatric needs.

- h. In cases of neglect or refusal of essential care, the DOH and Department of Social Welfare and Development (DSWD) shall act to uphold the child's best interests and right to relief from serious health-related suffering.

CHAPTER V

Education and Promotion of Palliative Care in Educational Institutions and in the Workplace

SECTION 22. *Public Awareness.* – The DOH, in partnership with LGUs, other institutions, media, and civil society, shall implement a nationwide information campaign promoting awareness and understanding of palliative and hospice care. The campaign shall include:

- a. Health education on the components and benefits of palliative care;
- b. Information on patient rights, advance care planning, and available services;
and
- c. Promotion of community support, spiritual care, and psychosocial well-being.

SECTION 23. *Encouraging the Integration of Palliative Care into the Educational System.* – The State shall recognize the importance of building palliative care awareness, promoting the values of compassion, and imparting knowledge of supportive care among students and health professionals. To this end:

- a. The Department of Education (DepEd), Commission on Higher Education

(CHED), and Technical Education and Skills Development Authority (TESDA) shall incorporate age-appropriate and culturally sensitive content related to palliative and hospice care into relevant curricula and training programs, consistent with their institutional mandates and subject to existing education standards and development processes.

- b. Institutions offering medical and allied health courses shall include palliative and hospice care as essential components of undergraduate and postgraduate training, in coordination with the Department of Health (DOH) and professional societies.

SECTION 24. *Promotion of Palliative Care in Educational Institutions.* – Educational institutions, such as schools, colleges, universities, and technical and vocational institutions shall:

- a. Develop programs and information campaigns to raise awareness on palliative care, reduce stigma associated with life-limiting conditions, and promote supportive care values among students, teachers, and staff;
- b. Facilitate linkages with local health offices, professional associations, and palliative care organizations to provide appropriate support, referrals, and services for students and staff in need of palliative care or psychosocial support; and
- c. Adopt anti-discrimination measures to ensure safe, inclusive, and compassionate environments for people with CLLI.

SECTION 25. *Palliative Care Promotion and Policies in the Workplace.* – The Department of Labor and Employment (DOLE), the Civil Service Commission (CSC), and TESDA, in coordination with the Department of Health (DOH), shall

develop guidelines and provide technical support to employers, workers' organizations, and unions to:

- a. Promote awareness of palliative care and related health conditions through workplace communication initiatives, health and wellness programs, and continuing education;
- b. Encourage employers to mainstream supportive care and psychosocial assistance for workers living with CLLI and their families;
- c. Integrate, where feasible, appropriate palliative care services into workplace clinics or referral arrangements with accredited providers;
- d. Establish mechanisms that reduce stigma and discrimination in the workplace related to life-limiting conditions and promote compassion-based inclusion;
- e. Encourage employers to develop and implement internal policies that support workers and their families affected by CLLI, in collaboration with the DOLE, CSC, or other applicable regulatory agencies; and
- f. Promote meaningful family involvement in palliative and end-of-life care by encouraging the provision of short-term compassionate leave for immediate family members, without risk to their employment or benefits.

SECTION 26. *Community-Based Palliative Care Education and Promotion.* –

The Department of the Interior and Local Government (DILG), in partnership with the DOH, LGUs, palliative care networks, and patient support organizations, shall lead public awareness campaigns at the community level to:

- a. Promote understanding of palliative and hospice care, including the value of compassion, advance care planning, spiritual care, and family-centered care;
- b. Provide age-appropriate, gender-sensitive, and culturally relevant education

on palliative care, especially for community leaders, barangay health workers, and out-of-school youth; and

- c. Develop Information, Education, and Communication (IEC) materials and conduct training workshops to strengthen local understanding and participation in palliative care.

CHAPTER VI

Capacity Building, Research, and Development

SECTION 27. *Capacity Building and Training of Palliative Care Specialists.* –

The Department of Health, to ensure the delivery of quality, evidence-based palliative care services, in coordination with the Professional Regulation Commission (PRC) and recognized specialty societies in palliative care accredited by the Professional Regulation Commission (PRC) shall:

- a. Establish and institutionalize national standards for palliative care specialists, including qualifications, scopes of practice, certification process, and continuing professional development in accordance with Republic Act No. 10912 or the Continuing Professional Development Act of 2016;
- b. Designate a single national accrediting body for palliative medicine training programs and certification of palliative care specialists, based on defined criteria including nationwide representation, expertise, and alignment with DOH policies;
- c. Promote the recognition of palliative medicine as a medical and allied health subspecialty, and support the development of accredited training programs

- through partnerships with academic institutions and specialty boards;
- d. Ensure that palliative care specialists are equitably deployed across various levels of care, including regional hospitals, cancer centers, and community settings, especially in underserved areas; and
 - e. Maintain a national registry of certified palliative care specialists to support workforce planning and resource distribution

SECTION 28. *Capacity Building and Training of Palliative Care Providers.* – The DOH, as the leading authority in healthcare, in collaboration with other government or private institutions, health facilities, professional societies, and other relevant stakeholders, shall take the lead in developing and implementing standardized, evidence-based training programs for palliative care providers, specialists, health aides, and workers. These programs shall emphasize community- and public health-oriented palliative care, promoting gender-sensitive, culturally appropriate, and human rights-based approaches to care delivery.

The DOH shall ensure that all service providers engaged in the provision of palliative and hospice care undergo continuing education, professional reorientation, and periodic competency assessments.

SECTION 29. *Capacity Building of Barangay Health Workers (BHWs) and Palliative Health Aides (PHA).* – The DOH and the TESDA shall lead the charge in developing training modules and disseminating relevant information to LGUs. This collaborative effort aims to educate and empower BHWs and community-based volunteers, underscoring the shared responsibility in delivering community-based palliative care.

The LGUs, with technical assistance from the DOH, the TESDA, and accredited

palliative and hospice care organizations, shall be primarily responsible for training and continuing the development of BHWs and volunteers in community-based palliative care delivery. The DOH shall likewise provide necessary assistance in the form of supplies, equipment, and resource materials.

SECTION 30. Research and Development on Palliative and Hospice Care. – The DOH, in partnership with research institutions, academic organizations, medical and allied health associations, and civil society organizations, shall promote and support research on palliative and hospice care.

Such research aims to generate evidence-based, culturally relevant, and inclusive models of palliative care delivery, including the documentation of indigenous and traditional practices that align with palliative care goals.

All research shall observe the highest ethical standards, including but not limited to:

- a. Securing free and informed consent from participants;
- b. Prohibiting undue inducement or coercion in participant recruitment;
- c. Avoiding research activities that are harmful or pose undue risks; and
- d. Requiring approval from an accredited institutional review board or independent ethics committee, in accordance with national regulations.

SECTION 31. National Center in Palliative Care. – There shall be established a National Center in Palliative Care under the control and supervision of the DOH, to be headed by an Executive Director. Other comprehensive specialty palliative centers shall be designated in strategic locations across the country. The National Center in Palliative Care shall have the following purposes and objectives:

- a. Promote, encourage, and engage in scientific research on palliative care;
- b. Encourage and undertake the training of palliative care service providers, palliative health aides, allied health professionals, patients, and families on palliative care and related activities;
- c. Assist communities, universities, hospitals, and research institutions in training, research, and capacity-building in palliative care and related activities;
- d. House the National Palliative Care Registry and its Registry Committee; and
- e. Publish annual reports from the National Palliative Care Registry including an evaluation of the state of palliative and hospice care in the country. These reports shall be submitted to the Council, the Department of Health, the Global Atlas of Palliative Care and other similar international bodies reporting on global palliative care services.

SECTION 32. *National Palliative Care Registry.* – The DOH in collaboration with relevant stakeholders shall establish a national palliative care registry and monitoring system. The registry shall 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 VII

Duties and Responsibilities of Government Agencies

SECTION 33. *Duties and Responsibilities of the Department of Health (DOH).* – To achieve the policy and objectives of this Act, the DOH shall:

- a. Formulate and implement a comprehensive National Palliative and Hospice Care Program, in coordination with relevant government agencies and stakeholders. This pivotal role includes a public awareness campaign on palliative care, its components, services, and rights-based approaches to reduce stigma and misinformation. The DOH will be responsible for developing service delivery models, capacity-building guidelines, a national formulary for essential medicines, and performance benchmarks.
- b. Ensure that all palliative care facilities meet standards of safety, sanitation, privacy, and therapeutic support, and shall exercise regulatory authority through licensing, monitoring, and evaluation mechanisms aligned with the DOH Manual of Operations;
- c. Integrate palliative care indicators into the National Health Information System;
- d. Promote and support research and innovation, including partnerships with academic institutions and research centers for culturally appropriate palliative care models, consistent with ethical and scientific standards;
- e. Uphold the rights of patients in all facilities, particularly protection from cruel, degrading, or inhumane treatment, in accordance with the Constitution, RA No. 9439, and applicable international conventions;
- f. Coordinate with the PhilHealth to develop and expand insurance packages that cover palliative and hospice care, commensurate with the burden of illness and aligned with UHC principles;
- g. Prohibit any form of coerced or unpaid labor within palliative care settings, unless part of a documented and consent-based therapeutic or rehabilitative intervention;
- h. Provide psychosocial, spiritual, and practical support services to families,

caregivers, providers, and affected communities;

- i. Promote community-based palliative care models, including home-based care and transitional services, that respect autonomy, cultural values, and the dignity of the patient;
- j. Require all health facilities to establish Internal Ethics Review Boards. These boards will be responsible for reviewing treatment decisions that involve ethical dilemmas, consent issues, and disputes regarding the rights of patients receiving palliative care.
- k. Ensure a balanced network of palliative care services across all levels of care, from barangays to regional hospitals, and promote access for marginalized and geographically isolated populations;
- l. Facilitate human rights and palliative care training for health professionals in partnership with academic and civil society institutions; and
- m. Guarantee the availability and affordability of essential medicines for palliative care, especially for pain and symptom management, with strict oversight of storage, prescription, and administration procedures.

SECTION 34. *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 specialists, providers, and health aides. The focal commissioner shall, upon a finding that a palliative care health facility, palliative care specialist, palliative care provider or palliative care health aide 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.

SECTION 35. *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;

- d. Develop modules for basic community-based palliative care training and integrate into existing frameworks and mechanisms; and
- e. Develop policies that support the palliative care needs of students and/or trainees.

SECTION 36. *Duties and Responsibilities of the Department of Labor and Employment (DOLE) and the Civil Service Commission (CSC).* – The DOLE and the CSC shall:

- a. Develop guidelines and standards on appropriate and evidenced-based palliative care programs for the workplace as described in this Act;
- b. Develop policies that promote palliative care in the workplace and address stigma and discrimination suffered by people with CLLI;
- c. Develop policies that promote the well-being of family and caregivers of palliative care patients; and
- d. Develop policies that support the grief and bereavement process of family and caregivers of palliative care patients.

SECTION 37. *Duties and Responsibilities of the Department of Social Welfare and Development (DSWD).* – The DSWD shall:

- a. Facilitate access to palliative care services for indigent or vulnerable patients, including referrals and coordination with care providers. This crucial role underscores the DSWD's commitment to ensuring no one is left behind in accessing palliative care.
- b. Offer counseling, shelter, livelihood, and other social protection programs to palliative patients and their families; and
- c. Lead post-disaster mental health and palliative response, in partnership with

DOH and LGUs, especially for bereaved families and those with chronic conditions.

SECTION 38. *Duties and Responsibilities of the Local Government Units (LGUs).* – The LGUs shall:

- a. Enact local ordinances and develop regulatory mechanisms aligned with national palliative care policies. This local leadership is crucial in ensuring the effective implementation of national policies at the grassroots level.
- b. Integrate palliative care into the primary health care network and ensure service provision in rural health units and barangay health stations;
- c. Lead training and capacity-building for local health workers, BHWs, and volunteers in collaboration with private organizations and civil society organizations;
- d. Promote home-based and community-oriented palliative care to reduce unnecessary hospitalization;
- e. Invest in the modernization of facilities and ensure geographic and financial accessibility;
- f. Provide access to housing, skills training, and livelihood programs for affected families;
- g. Build and support referral networks to connect patients to service providers;
- h. Convene multi-sectoral groups to coordinate prevention, early detection, and continuity of palliative care services across government and private sectors.

SECTION 39. *Duties and Responsibilities of the Philippine Health Insurance Corporation (PhilHealth).* – Philhealth shall:

- a. Develop and adopt benefit packages for palliative care and hospice services.

In coordination with DOH, PhilHealth shall establish a comprehensive benefit package that covers, at minimum, inpatient palliative care, outpatient hospice care, and home-based palliative care services.

- b. Consider coverage for essential palliative medicines (including pain medications), medical equipment rental (such as oxygen or hospital beds for home use), and relevant diagnostic or therapeutic procedures for symptom management;
- c. Shall conduct actuarial studies to determine appropriate payment rates and ensure sustainability of the benefit, and shall widely disseminate information to members about their palliative care benefits;
- d. Shall ensure that all Filipinos shall be immediately eligible for palliative care benefits as part of the basic benefit package under UHC.

SECTION 40. *Duties and Responsibilities of the Department of Science and Technology.* – Philippine Council for Health Research and Development (DOST-PCHRD). DOST-PCHRD shall:

- a. Prioritize and support research and development on palliative and hospice care.
- b. Facilitate studies on palliative care needs, outcomes, best practices, culture-specific approaches, and innovations in service delivery.
- c. Shall collaborate with the DOH, academic institutions, and professional organizations to build local evidence for improving palliative care policies and practices. The University of the Philippines National Institutes of Health, and other research bodies, may be tapped to conduct operational research to

identify gaps and effective interventions in palliative care, including in pain management, opioid access, and integration into primary care.

SECTION 41. *Duties and Responsibilities of Other Government Agencies.* – The following agencies shall support the implementation of this Act in accordance with their respective mandates:

- a. Department of the Interior and Local Government (DILG) - The DILG shall promote compliance of local government units with the provisions of this Act and may incorporate palliative and hospice care indicators into the Seal of Good Local Governance framework.
- b. Department of Justice (DOJ) and Bureau of Corrections. - The DOJ and Bureau of Corrections shall ensure that persons deprived of liberty with terminal or life-limiting conditions have access to appropriate palliative care services.
- c. Department of National Defense (DND) and Veterans Affairs Agencies. - The DND, in coordination with relevant veterans' agencies, shall strengthen palliative and hospice care services within military and veterans' hospitals and facilities.
- d. Department of Budget and Management (DBM) - The DBM shall ensure the inclusion of appropriate funding, positions, and programs required under this Act in the national budget and shall prioritize such allocations as necessary.
- e. Food and Drug Administration (FDA) and Philippine Drug Enforcement Agency (PDEA). The FDA and PDEA shall review and streamline regulatory processes to improve access to opioid analgesics and other controlled

medicines for legitimate medical use, in accordance with public health standards and international obligations.

SECTION 42. *Collaboration with Non-Government Organizations.* – The State recognizes the role of non-governmental, faith-based, and community organizations in delivering hospice and palliative care. The Department of Health and local government units are encouraged to partner with such organizations through memoranda of agreement, technical assistance, referrals, or fund sub-allotments where appropriate.

SECTION 43. *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 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.

CHAPTER VIII

Essential Medicines

SECTION 44. *Essential Palliative Medicines.* – The Department of Health (DOH), in coordination with the Philippine Drug Enforcement Agency (PDEA), the Food and Drug Administration (FDA), and other relevant agencies, shall ensure the availability, affordability, accessibility, and appropriate use of essential medicines for palliative and hospice care. These medicines shall be included in the Philippine National Formulary and made available at all levels of the public health system, especially in underserved and geographically isolated areas.

SECTION 45. *Implementation of Evidence-based Reforms.* – The DOH shall adopt and implement evidence-based reforms to:

- a. Facilitate early and uninterrupted access to essential palliative medicines, including opioids and controlled substances for pain and symptom management;
- b. Develop and promote compassionate use protocols, emergency dispensing mechanisms, and simplified documentation for patients with CLLI;
- c. Implement training programs for healthcare providers and pharmacists on the safe and ethical prescription and administration of palliative medicines;
- d. Strengthen the supply chain, inventory, and cold-chain management systems to prevent stockouts and wastage;
- e. Ensure that innovative medicines and emerging palliative health technologies are evaluated for inclusion into the formulary based on therapeutic value, cost-effectiveness, and ethical standards.

SECTION 46. *Establishment of a Rights-sensitive Regulatory Framework.* – The PDEA and FDA shall establish a dedicated, streamlined, and rights-sensitive regulatory framework for the licensing, procurement, prescription, distribution, and

post-marketing surveillance of essential palliative medicines, consistent with the UHC Act, the Dangerous Drugs Act (RA 9165), and international guidelines of the World Health Organization (WHO).

CHAPTER IX

Affordable Palliative and Hospice Care

SECTION 47. *Establishment of a Palliative Care Trust Fund.* – There is hereby established a Palliative Care Trust Fund. The DOH and the Council shall manage the Fund in accordance with existing budgeting, accounting, and auditing rules and regulations and shall make a quarterly report to the Office of the President and Congress on the disbursement of the Fund.

This fund is intended to ensure financial support for palliative care programs, services, and medications, particularly for the palliative and hospice care services provided to indigent and economically disadvantaged patients who may not be able to afford care or whose PhilHealth benefits are insufficient. The Palliative Care Trust Fund shall consist of:

- a. An annual appropriations from the national government as provided in the General Appropriations Act (an initial seed amount is to be appropriated under Section 13 of this Act);
- b. A portion of the sin tax revenues or universal health care funds, as may be determined by law or by the Department of Finance in consultation with DOH;
- c. Donations, grants, endowments, or contributions from domestic or foreign

donors; and

- d. Income or interest derived from the investment of the Palliative Care Trust Fund as permitted by law will accrue to the fund to be used for the same purposes.

SECTION 48. *Donations.* – The DOH may solicit and receive donations which shall form part of the Fund and such donations shall be exempt from income or donor's tax and all other taxes, fees, and charges imposed by the government. Likewise, fund raising activities may be conducted by the Council and the proceeds of which shall accrue to the Fund and shall be exempt from any and all taxes.

Receipts from donations, whether in cash or in kind, shall be accounted for in the books of the donee government agency in accordance with accounting and auditing rules and regulations. The receipts from cash donations and proceeds from sale of donated commodities shall be deposited with the National Treasury and recorded as a special account in the General Fund and shall be available to the implementing agency. The cash value of the donation shall be deemed automatically appropriated for the purpose specified by the donor. Donations within a term not exceeding one (1) year shall be treated as trust receipts.

The donee-agency concerned shall submit the quarterly reports of all donations received, whether in cash or in kind, and expenditures or disbursements thereon with electronic signature to the DBM, through the Unified Reporting System, and to the Speaker of the House of Representatives, the President of the Senate of the Philippines, the House Committee on Appropriations, the Senate Committee on Finance and the Commission on Audit, by positing such reports on the donee-agency concerned websites for a period of three (3) years. The head of the donee-agency

concerned shall send written notice to the said offices when said reports have been posted on its website which shall be considered the date of submission.

SECTION 49. *PhilHealth Benefits for Palliative and Hospice Care.* – The Philippine Health Insurance Corporation shall expand its benefit packages to include palliative and hospice care in both adults and children and in all settings of care, including home-based care. It shall also develop innovative benefits such as support for community-based models of care. The development or expansion of any PhilHealth benefit shall go through a proper, transparent and standardized prioritization setting process, such as the Health Technology Assessment and actuarial feasibility study, to avoid inequitable allocation of funds for health care services.

The Palliative Care Trust Fund and PhilHealth benefits shall be made available in public and private DOH-licenced palliative care facilities. DOH, the Council, and PhilHealth shall prescribe, in consultation with stakeholders, the coverage rates and applicable rules on options to charge co-payment for services rendered. Processes to avail of such funding shall be streamlined to ensure timely provision of palliative and hospice care.

SECTION 50. *Social Protection Mechanisms.* – The DOH, in collaboration with the Social Security System (SSS), Government Service Insurance System (GSIS), Philippine Charity Sweepstakes Office (PCSO), DOLE, DSWD, PhilHealth, and LGUs, shall develop appropriate and easily accessible social protection mechanisms for palliative care patients, their families, and carers. It shall aim to encourage the underprivileged and marginalized palliative care patient to undergo the necessary care.

A Palliative Care Policy shall be established in every workplace. It shall form part of the employee benefits in the formal sector covering all palliative and hospice care services.

The Insurance Commission shall mandate the Health Maintenance Organizations (HMOs) to cover palliative and hospice care services for both adults and children, including home-based palliative care.

The palliative care-related absences from work of member employees and primary carers and voluntary members shall be covered and compensated by the Sickness Benefits of the SSS and Disability Benefits of the GSIS.

The employees in the informal sector shall be prioritized in the palliative and hospice care packages of PhilHealth while employees in the formal sector shall be offered cost-sharing PhilHealth benefit packages.

CHAPTER X

Monitoring, Participation, and Accountability

SECTION 51. *Monitoring and Evaluation Framework.* – The Department of Health (DOH), through the Philippine Council for Palliative Care, shall establish a comprehensive Monitoring and Evaluation (M&E) Framework. This framework, of utmost importance, will assess the implementation and impact of the National Palliative and Hospice Care Program. This task cannot be achieved without the active participation of all stakeholders.

The framework shall be based on evidence-based indicators covering access, equity, quality of care, financial protection, and patient and family satisfaction. It shall be aligned with the goals of the Universal Health Care Act, WHO guidelines, and international human rights instruments such as the UDHR, ICCPR, and ICESCR.

SECTION 52. *Multi-Stakeholder Engagement.* – The DOH shall develop a formal engagement mechanism that includes all stakeholders. This includes, but is not limited to, civil society organizations, patient and family groups, academic institutions, faith-based groups, health professionals, and private sector partners. Your involvement is crucial, and your perspectives are valued in the formulation of policies, delivery of services, training, research, and community-based initiatives.

Stakeholders shall be consulted in the formulation of policies through regular meetings, surveys, and public forums. Their input will be considered and integrated into the policy development process, ensuring that palliative care remains people-centered, inclusive, and culturally relevant.

SECTION 53. *Community Participation and Grievance Mechanism.* – LGUs, in coordination with DOH and community organizations, shall establish participatory platforms that allow palliative care beneficiaries and their families to provide feedback, raise concerns, and co-create solutions to improve services.

A grievance redress system shall be in place to ensure that all complaints related to access, quality, or abuse in palliative care services are addressed promptly and appropriately.

SECTION 54. *Transparency and Public Access.* – All reports, strategic plans, audit findings, and evaluation outcomes related to the implementation of this Act shall be published on the official DOH website and disseminated through public health information platforms. This commitment to transparency and citizen awareness is a testament to our dedication to keeping you informed about the progress and challenges in palliative care.

SECTION 55. *Legislative Oversight and Sunset Review.* – A Joint Congressional Oversight Committee on Palliative and Hospice Care shall be created to oversee the full and faithful implementation of this Act. This committee, composed of members from both houses of Congress, will be responsible for reviewing the progress of the Act's implementation, identifying any issues or challenges, and making recommendations for improvement.

Every five (5) years, the Act shall be subject to a legislative sunset review to determine its relevance, responsiveness, and effectiveness. The review shall be based on the findings of the M&E Framework and stakeholder consultations. Recommendations for policy refinements or amendments shall be submitted to Congress.

CHAPTER X

Miscellaneous Provisions

SECTION 56. *Appropriations.* – The amount necessary for the initial implementation of this Act shall be charged against the current appropriations of the Department of Health (DOH), specifically to cover:

- a. Maintenance and other operating expenses (MOOE) of the National Palliative and Hospice Care Program, a crucial component of this Act, including human resources, training, procurement of essential medicines, support for palliative care facilities, and public awareness campaigns.
- b. Capital outlay for the development of community-based and facility-based palliative care services in selected DOH-retained hospitals; and
- c. Formulation and operationalization of the National Strategic Plan for Palliative Care, as provided under this Act.

For subsequent years, funding requirements for implementing this Act shall be determined based on the Philippine Council for Palliative Care's multi-year investment plan. They shall be included in the annual budget proposal of the DOH and other implementing agencies. Such amounts shall be reflected in the National Expenditure Program (NEP) and incorporated into the General Appropriations Act (GAA).

SECTION 57. *Implementing Rules and Regulations (IRR).* – Within one hundred twenty (120) days from the effectivity of this Act, the Secretary of Health, as the key figure, in consultation with key implementing agencies, including the DSWD, DILG, and other relevant agencies and stakeholders representing palliative care patients, professionals, and service providers, shall promulgate the necessary Implementing Rules and Regulations (IRR) to carry out the provisions of this Act.

The DOH shall ensure that the IRR reflects the principles of universal healthcare,

participatory governance, gender responsiveness, cultural sensitivity, and the right to health and human dignity, in alignment with existing laws and the Philippines' international obligations under the UDHR, ICCPR, ICESCR, and the World Health Organization frameworks, underscoring our commitment to these principles.

SECTION 58. *Separability Clause.* – If any provision or part of this Act is declared unconstitutional or invalid by a court of competent jurisdiction, the remainder of the Act or any provision not affected thereby shall remain in full force and effect, and the court's decision shall not affect the validity of the Act as a whole.

SECTION 59. *Repealing Clause.* – All laws, decrees, executive orders, administrative regulations, or parts thereof that are inconsistent with the provisions of this Act are hereby repealed, amended, or modified accordingly.

SECTION 60. *Effectivity.* – All laws, decrees, executive orders, administrative regulations, or parts thereof that are inconsistent with the provisions of this Act are hereby repealed, amended, or modified accordingly.

Approved,