IBP Journal

Integrated Bar of the Philippines

Vol. 45, Issue No. 1 • August 2020

Special Issue on the Covid-19 Pandemic

Building a Resilient Judicial System: Preparing Legal Practice from Pandemics
by Jay Batongbacal, JJ Disini, Michelle Esquivias, Dante Gatmaytan, Oliver Xavier Reyes, and Theodore Te

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(August 2020)

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IBP Journal (ISSN 0118-9247) is an official publication of the Integrated Bar of the Philippines.

Subscription Rates (inclusive of postage):
Php 1,000.00 (local)
US $20.00 (foreign individual)
US $25.00 (foreign institution)

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The articles published in IBP Journal do not necessarily represent the views of the Board of Editors. The articles are representative of the views of the author/s alone and the author/s are responsible for the views expressed therein.

EDITOR'S NOTE

The COVID-19 pandemic brought massive disruptions to the Philippine legal and judicial system.

As the specter of the COVID-19 virus swept through cities and provinces, drastic lockdowns were enforced, leading to complete shutdowns of courtrooms, government agencies, law offices, and law schools. Almost the entire legal system slid into paralysis, as did the rest of society. It was unprecedented.

And even after the strict lockdowns were lifted, life has never been the same again. The imposition of new safety protocols—community quarantine, social distancing, occasional court lockdowns—shackled physical movements and face-to-face interactions, upsetting the ordinary course of business within the legal and judicial system and the academe.

With the upheaval also comes the birth of the so-called New Normal. Amid the gripping pandemic, various sectors of society, including the legal profession, soon learned to deal with new safety restrictions and reinvent work and lifestyle.

Thus, online court hearings, online classes, Zoom meetings and conferences, and work from home suddenly emerged as the new norms. The digital media has surfaced as the safest mode of communication in this COVID-19 era, upending over a century of reliance on physical documents and face-to-face encounters.

The solutions, however, also raise new problems. Lack of access to stable internet connection and available digital devices poses serious impediments to communication.

Remote working further slows court operations and government transactions. Law schools struggle to hold online classes as a lot of students and faculty find difficulties in adapting to online learning. Lawyers who are new to the digital world fumble over the use of software applications.

Indeed, the New Normal has brought new challenges. As the number of infections and death toll continue to climb worldwide, a definite end to the pandemic escapes the prediction of scientists and health experts. The dark cloud of uncertainty hovers over the horizon. And the New Normal may be here to stay.

To survive and stay relevant in a world gripped by a pandemic, every lawyer, just like the rest of society, must retool and adapt, and every legal institution must reinvent and reengineer. After all, amid all the public health uncertainties, the government must govern, the wheels of justice must turn, commerce must grind, private conflicts must be managed, legal learning and solutions must forge ahead.

This Special Issue tackles the impact of the Covid-19 pandemic on the legal profession and the judicial system. This edition also heralds the assumption of a new set of editorial team and editorial board, who are mostly incumbent deans of various law schools from Luzon, Visayas and Mindanao.

The first article explores how courts can better adapt to pandemics. Entitled *Building a Resilient Judicial System: Preparing Legal Practice from Pandemics*, it suggests short, medium, and long-term measures to make courts more resilient to public health emergencies. It also argues for a resilient judicial system that requires heavy coordination among courts, the IBP, the Philippine Judicial Academy, and

other legal institutions. The authors are noted professors and researchers from the University of the Philippines College of Law: Jay L. Batongbacal, JJ Disini, Michelle Esquivias, Dante Gatmaytan, Oliver Xavier A. Reyes, and Theodore Te.

The second article shows how public-private partnerships (PPP) can strengthen public health care. In *Before the Next Pandemic: Subnational PPPs in the Philippine Health Care System*, Michael Arthur C. Sagcal points out that various PPP models can help Philippine health care fund new hospitals and modernize existing ones. He discusses how, through private investments, public health care stands to gain benefits as experienced by the public in other services and industries.

The third article advances a legal framework for work-from-home arrangements. In *Telecommuting: A Review on Work from Home as a Viable Option*, Charles Janzen C. Chua explains the method of alternative work arrangements using online communications and file sharing tools. He discusses the concept of 'telecommuting' as defined under Philippine laws, which is roughly equivalent to 'home work' under the International Labor Organization and 'telework' under the European Union. He concludes employers must adapt to remote work arrangements for their businesses and employees.

The last article compares how Philippine schools transition to online learning. In *Tipping Point: Will this Pandemic Mainstream Online Learning in Philippine Legal Education?*, Justin D.J. Sucgang highlights the challenges law schools face in transitioning to synchronous and asynchronous distance-learning. He examines rules set by law schools to measure their students' academic performance. He concludes the Philippines cannot fully adapt

to online learning due to infrastructure and technology barriers faced by most law students.

In all, the articles are guides in these unprecedented times. No doubt the pandemic has receded the boundaries and disrupted the routines of courts and the legal profession. And the featured articles offer visions of transforming a crisis into an opportunity for growth.

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Building a Resilient Judicial System: Preparing Legal Practice from Pandemics[*]

Jay L. Batongbacal, JJ Disini, Michelle Esquivias, Dante Gatmaytan, Oliver Xavier A. Reyes, and Theodore Te

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College of Law[**]

I. BACKGROUND

The COVID-19 pandemic[1] stopped the world in its tracks. The deadly virus,[2] easily spread through casual

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[*] This Article is an expanded version of a discussion paper entitled "Building a Resilient Judicial System" which was drafted by the authors to suggest the ways by which the legal profession could reopen after an extended lockdown to prevent the spread of covid-19. *See* Jay L. Batongbacal, et. al, *Building a Resilient Judicial System*. (May 06, 2020), *available at* https://law.upd.edu.ph/building-a-resilient-judicial-system/?fbclid=IwAR3T0qUtqNne-t-cfcwsIBAMBdbhBtATuWEKmnqgwVLO7GP-u9Uvt1n_kO4.

[**] The authors would like to thank Samantha Mendiola and Kent Alonzo for their research and editing assistance.

[1] The World Health Organization (WHO) declared coronavirus disease 2019 (Covid-19) a public health emergency of international concern. As of February 25, 2020, a total of 81,109 laboratory-confirmed cases had been documented globally. Wei-jie Guan, Ph.D., Zheng-yi Ni, et.al, *Clinical Characteristics of Coronavirus Disease 2019 in China*, 382 N. ENGL. J. MED. 1708-1720 (2020), *available at* https://www.nejm.org/doi/full/10.1056/NEJMoa2002032.

[2] COVID-19 is infectious and is life-threatening. Within three months from the beginning of the outbreak (between December 2019 and 8 March

contact,[3] forced governments to institute lockdowns and enforce "social distancing" measures to prevent the further spread of the virus. As of June 10, 2020, there have more than 7 million cases of COVID-19 and over 400,000 deaths reported to the World Health Organization (WHO).[4] As of the same date, the Philippines has a total of 22,474 cases and 1,011 deaths.[5]

Philippine courts were forced to constrict their operations to stem the spread of the virus. All courts nationwide resumed full operation on June 1, 2020.[6] Furthermore, under a Supreme Court order, all hearings

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2020), the reported COVID-19 cases reached more than 100,000 with the reported deaths reaching 3,600. The figures are still rapidly increasing. *See* Chang-Fa Lo, The Missing Operational Components of the IHR (2005) from the Experience of Handling the Outbreak of COVID-19: *Precaution, Independence, Transparency and Universality*, 15 Asian J. Wto & Int'l Health L & Pol'y 1,3 (2020).

[3] The virus is "spread mainly from person to person," primarily "[t]hrough respiratory droplets produced when an infected person coughs, sneezes, or talks." Infected droplets can land in the mouth of another person, or they can land on a surface that another person touches with their hand before touching their nose or mouth, or another person can breathe in the virus from the air around them. *See* Robert Gatter & Seema Mohapatra, *COVID-19 and the Conundrum of Mask Requirements*, 77 WASH. & LEE L. REV. ONLINE 17, 20-21 (2020), *available at* https://scholarlycommons.law.wlu.edu/wlulr-online/vol77/iss1/2. SARS-CoV-2, the novel coronavirus that causes COVID-19 is detectable in aerosols for up to three hours, on copper for up to four hours, on cardboard for up to 24 hours, and on plastic and stainless-steel surfaces for up to two to three days. *See* Gabriel A. Fuentes, *Federal Detention and "Wild Facts" During the COVID-19 Pandemic*, 110 J. CRIM. L. & CRIMINOLOGY 441 (2020), *available at* https://scholarlycommons.law.northwestern.edu/jclc/vol110/iss3/2.

[4] World Health Organization, *Coronavirus disease (COVID-19) Situation Report – 141.* (June 09, 2020), *available at* https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200609-covid-19-sitrep-141.pdf?sfvrsn=72fa1b16_2.

[5] *Id.*

[6] A.M. No. 41-2020-SC, May 29, 2020. Night courts and Saturday courts remain suspended.

"shall be in-court, except in cases involving Persons Deprived of Liberty."[7] This is despite the fact that the available data regarding the spread of COVID-19 indicated that the Philippines has yet to flatten the curve.[8] The dangers posed to court personnel engaged in the frontlines of the delivery of justice, as well as litigants and their clients are real.

The COVID-19 pandemic has several negative impacts to the judicial system:

A. Courts—particularly the trial courts—cannot operate efficiently during the pandemic.

    1. All court participants will have concerns about becoming infected in the course of their work. Many of them are possibly senior citizens whose movements may be constrained even under general community quarantine rules. Some may refuse to work entirely, unwilling to risk their health.

    2. If the courts were to operate within the constraints of social distancing, court appearances will be few and far between to avoid infections between all litigants and lawyers. Docket processes will have to be modified to prevent the transmission of the virus through court submissions.[9] Documents may need

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[7] *Id.*

[8] Daphne Galvez, *NCR's shift to GCQ may expose dwellers to 'new wave' of virus transmission—senator*, PHIL. DAILY INQUIRER, May 29, 2020, *available at* https://newsinfo.inquirer.net/1282956/ncrs-shift-to-gcq-may-expose-dwellers-to-new-wave-of-virus-transmission-senator.

[9] The service and filing of pleadings must be done personally whenever practicable. *See* Musa v. Amor, G.R. No. 141396, April 9, 2002. "Personal service is preferred because it expedites the action or resolution on a pleading, motion or other paper…[I]t […] minimizes […] delays likely to be incurred if service is done by mail, and deters the pernicious practice of some lawyers who craftily try to catch their opposing counsel off-guard

to be stored at a secure location for a number of days to ensure that they are virus-free.

3. COVID-19-related problems are particularly pronounced at the trial court level, which relies extensively on face-to-face interactions. This is true because of the nature of the cases that are within their jurisdictions as well as the nature of the acts performed therein such as cross examination and the admission of evidence. Only trial courts receive evidence at first instance and are assigned the exclusive role of assessing the demeanor of witnesses and disqualifying objectionable questions and answers.[10]

4. Hence, appellate courts are less susceptible to external COVID-19 health hazards since they almost never interact face-to-face with litigants, save for the exceedingly rare occasions where oral arguments are called. As long as filing deadlines are resumed, and filing/service procedures are restored, appellate courts can return to their prior functions even during the health crisis without need for an extensive change in procedures or rules.

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or unduly procrastinate in claiming the parcel containing the pleading served." Victoriano v. Dominguez, G.R. No. 214794, July 23, 2018.

[10] "[T]rial court judges enjoy the unique opportunity of observing the deportment of witnesses on the stand, a vantage point denied appellate tribunals." The Supreme Court has also held that the assessment of the trial court of the credibility of witnesses is entitled to great respect and weight having had the opportunity to observe the conduct and demeanor of the witnesses while testifying. Ong Eng Kiam v. Ong, G.R. No. 153206, Oct. 23, 2006.

B. General impact on the rule of law:

1. A judicial system that cannot fully function puts Constitutional rights at risk and disturbs the balance of power among the branches of government. Citizens cannot go to court to question government conduct. Judicial review of executive actions would be impossible without functioning courts, especially suits that require reception of evidence—a function trial courts are specially equipped to perform.[11]

2. Private rights cannot be effectively vindicated without fully-functioning courts. Compliance with and enforcement of private obligations are already put in doubt due to quarantine measures. Parties to contracts who are injured as a result must have the courts opened to them to vindicate their rights; otherwise the stability of all commercial transactions will be jeopardized.

3. The rights of the accused are even more susceptible to violations. Without judicial oversight, abuses such as overstaying prisoners, denials of their entitlement to bail and preliminary investigation, and violations to right to a speedy trial may continue unabated. Access to counsel of choice during quarantine/lockdown is also impaired.

C. Private lawyers cannot practice or earn money. Lawyers practicing either by themselves or as part of a firm cannot ply their trade. Unable to render services, they cannot bill their clients and this puts them in dire

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[11] Gios–Samar, Inc. v. Department of Transportation and Communications, G.R. No. 217158, Mar. 12, 2019.

financial straits. This has spillover effects on their clients, employees, suppliers, and others with whom they transact. This further exacerbates the economic crisis brought by the pandemic and the lockdown.

D. The Constitutional guarantee of free access to the courts and quasi-judicial bodies under Article III, Section 11 is impaired, not simply by reason of poverty but also by reason of circumstance, *i.e.*, lawyers are not allowed to travel freely.

II. Objectives

This paper recommends an implementation framework for temporary alternative court procedures to facilitate the prompt resumption of court proceedings despite the health risks posed by the COVID-19 emergency. In the course of developing the framework, the paper shall identify gaps in current court procedures and practices that can be addressed by maximizing new technologies and best practices, as to enhance the efficiency and transparency of administration of justice by the trial courts. The paper also identifies potential longer-term reforms to the procedures and practices of Philippine trial courts. Finally, it offers some timelines within which to implement the strategy.

III. Policy Strategy

Short-term, medium-term, and long-term approaches must be formulated to address these concerns:

A. *Mixed approach.* Short-term approaches must accommodate the current paper-based system and

introduce technology-based measures to prevent or control the spread of the virus. The purpose of this is to address the urgency of controlling and preventing further spread of the virus but at the same time recognizing the existing court system. Portions of legal processes may use new technologies.

B. *Hybrid approach.* Medium-term approaches involving a transition period where some courts leave the paper-based system while others continue to use the same. This could ostensibly entail the use of hybrid systems. The whole value chains of certain legal processes are expected to be transitioned to online systems. During this period, some courts should be able to already shift away from paper-based systems, while some other courts continue to operate on that basis.

C. *Smart court approach.*[12] Long-term approaches may include overhauling the trial court system to make it more electronic, cloud-based, and more susceptible to participation from a distance. This may entail the review of laws and judicial administrative issuances for purposes of incorporating measures that prevent the spread of viruses.

IV. DISCUSSION

The following section identifies particular concerns that the proposed approaches must consider:

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[12] Mimi Zou, *Virtual Justice in the Time of COVID-19*, Mar. 16, 2020, *available at* https://www.law.ox.ac.uk/business-law-blog/2020/03/virtual-justice-time-covid-19. "Smart courts" is a policy approach first adopted by the Supreme People's Court, China's top court.

A. *What part of a function/rule/process has the potential to spread the virus or cause infection?*

1. Based on currently available information, the virus is able to survive on surfaces for a number of days.[13] Affected surfaces include paper documents and physical surfaces in courts. There is emerging evidence that the virus may be transmitted through airborne transmissions in certain closed quarters, leading to the recent mandatory rule for the wearing of masks. The opportunities for viral transmission on account of regular court practices and procedures should be definitively identified, so that appropriate mitigation measures can be adopted.

2. Paper-based processes need to have a period of storage to allow the virus to dissipate naturally before being transmitted to the courts.

3. Potential short-term solution: Allow online submission of pleadings to cloud providers coupled with hard copy submissions at a central point designated by the court where it will be received, stored for a number of days and then transmitted to the relevant branch for entry into the record. This process may be followed for pleadings, motions, submissions, and original evidence.

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[13] Richard Gray, *Covid-19: How long does the coronavirus last on surfaces?*, BBC, Mar. 17, 2020, *available at* https://www.bbc.com/future/article/20200317-covid-19-how-long-does-the-coronavirus-last-on-surfaces.

B. *What part of a function/rule/process can be remotely provided easily in the short term?*

1. Physical travel for the purpose of attending hearings, filing pleadings or serving processes creates health risks that can be mitigated through remote accomplishment of these tasks. The 2019 Amended Rules would implement such changes through limited online filing,[14] while conducting trials via video teleconferencing has been allowed for certain criminal cases.[15] Other opportunities exploiting remote accomplishment of tasks or functions should be identified and outlined.

2. As a potential short-term solution, videoconferencing equipment and services through commercially available services may be provided for free to the court, the jail and public attorneys by the private sector, *i.e.,* the local chapter of the Integrated Bar of the Philippines (IBP). If judges, private lawyers or any other participant can afford to procure their own technology and work from the safety of their own offices or homes, then they may do so. Perhaps it would be fair for the IBP to engage in price differentiation to allow more prosperous members of the bar to subsidize user costs to those starting out, with fewer resources or those providing free legal services such as law student clinics, NGOs, and human rights lawyers.

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[14] *See* 2019 Proposed Amendments to the 1997 Rules of Civil Procedure, A.M. No. 19-10-20-SC, Oct. 15, 2019.

[15] *See* Guidelines on the Use of Videoconferencing Technology for the Remote Appearance or Testimony of Certain Persons Deprived of Liberty in Jails and National Penitentiaries, A.M. 19-05-05-SC, June 25, 2019. .

C. *What controls are necessary to achieve the goals of a function/rule/process?*

1. Proposed procedural changes should be consistent with such constitutional rights as due process and the rights of the accused. Other virtues such as integrity and transparency must also be assured. Appropriate controls that safeguard concerns must be designed prior to implementation. These efforts should prevent abuse by litigants and lawyers such as coaching of witnesses, intercalation of documentary evidence, etc.

2. As a short-term solution, counsels (and in appropriate cases, their clients) can be bound by undertakings similar to the "signature" requirements in the new Rules. Such undertakings can stipulate that any appearance of a violation of ethical norms will be met with a suspension of the violating attorney's use of the system and/or the use of the same by his or her entire law firm. For abuses related to having a single camera, the system adopted may install at least 2 or more cameras to show the immediate surroundings of the participant or witness. All sessions will be recorded.

D. *What rule changes are absolutely necessary and how much of a solution can be provided by contract or binding rules?*

1. Some proposals may be inconsistent with the Rules of Court and would require amendments approved by the Court *en banc* for implementation. Certain changes though may fall within the discretion of individual trial courts to implement on a case by

case basis and hence would not require *en banc* approval.

2. As a short-term solution, private counsels (and in appropriate cases, their clients) can be bound by judicially-enforced contracts and/or undertakings to abide by the specialized rules to be enforced to facilitate the trial and court processes. In order to allow for the speedy implementation of such special measures, those solutions which can be implemented by mere court order will be identified, with their implementation preferably covered by court-enforced contract/undertakings rather than rules promulgated by the Supreme Court. Local IBP chapters can take the lead in finding their own solutions that fit their needs in their areas. A Circular from the Supreme Court will help especially one which allows for a feedback loop or sharing of best practices.

E. *What technology is appropriate (cost, ease of use, availability, security) to adopt with a view towards neutrality?*

1. Certain proposals, such as video teleconferencing, may be implemented using available general-use technologies that may be acquired for low rates. There may be proposed changes that would entail customized systems at greater cost but would also ensure that important concerns such as security and access rights would be addressed.

2. As a short-term solution, local IBP Chapters can be asked to determine their solutions based on the availability of infrastructure in their areas and the

ability of the users to learn the intricacies of the adopted technology.

F. *How will the technology (HW/SW/cloud services) be procured and how will operational expenses be paid?*

1. Fully automated courts and court procedures may be the ideal. However, the establishment of a fully functional electronic court system will take years to design. Deferring the implementation of technology solutions, especially during the COVID-19 crisis, may lead to litigants (particularly detention prisoners) having their fundamental rights violated or the administration of justice otherwise being unduly delayed.

2. A framework or an implementation plan for the implementation of the "smart court approach" should be developed immediately. Some systems may be procured by the Court already under the emergency procurement policies of the government. An implementation plan ensures that the systems that will be procured are consistent and compatible with the overall plan.

3. Another option is provision by private third parties. In this case, the local IBP chapter should be allowed to provide the infrastructure for free to the government agencies involved. Operational expenses can then be defrayed by the legal community, or by litigants, through reasonable access fees for the use of technology-enabled processes such as online hearings facilitated by the IBP or donations coursed through the IBP.

4. While the Offices of the Clerks of Court in the court stations can be eventually trained to operate or administer the new systems, outsourcing that role to the IBP or private sector employees may be more feasible as a short-term solution.

G. *How can we address concerns of those who may not be skilled in using the proposed technologies?*

1. Older practitioners who may be less adept at using technology as well as judges and court personnel who are used to paper-based processes may find it difficult to transition to an electronic platform.

2. As a short-term solution, the service provider, *i.e.,* the IBP Chapter, can provide technical support and training to the personnel concerned. For lawyers who are not familiar with electronic filings, a "service bureau" may be established by the IBP Chapter whereby paper-based documents are scanned and uploaded to the cloud according to the rules established. The cost for these services may be defrayed on a per-user basis.

3. The Philippine Judicial Academy (PhilJA) must also be harnessed and mobilized towards equipping judges with the necessary technical training, in the interim and short term, and expertise, in the medium and long term.

4. The Mandatory Continuing Legal Education (MCLE) Office must likewise be harnessed and mobilized towards equipping lawyers with the necessary technical training, in the interim and short term, and expertise, in the medium and long term.

H. *How can vulnerable litigants (detention prisoners, children, victims of violence against women and children (VAWC)) be accommodated?*

1. Current rules provide for protection for vulnerable litigants in the form of anonymity or shielding from direct confrontation. These rights have to be complied with in any solution proposed by the Court.

2. Current rules on perpetuation of testimony must be highly encouraged, if not made mandatory. These rules heighten the security of any witness as there would be no gain to threaten or kill witnesses who have already testified ahead of trial.

3. As a short-term solution, the rules adopted by the IBP, the Court, the litigants and all participants should adhere to statutory requirements protecting vulnerable parties. Video monitoring may, for example, be shielded or the video feed disabled to address privacy concerns.

V. Suggestions for Immediate Implementation (Short-Term Approaches)

The following short-term measures are proposed to allow courts and litigants to immediately implement health-friendly processes and measures that deploy available technology solutions without having to change the analog nature of litigation.

A. *Access to the Courts.*

The Concern: Due to the need to prevent spread of the COVID-19 virus, courts remain physically closed and are accessible only by appointment. A regime of physical appearance and paper filing imposes an undue burden on litigants, lawyers, judges, and court personnel that may detract from the urgency of the reliefs sought as well as undermine the guarantee of access to the courts.

The Proposal:
IBP Support for Online Remote Hearings. IBP local chapters will provide (at no cost to the Court) the IT infrastructure that permits courts to conduct hearings remotely. This is intended to sidestep the procurement issues faced by the courts as well as the Public Attorney's Office (PAO) and the Bureau of Jail Management and Penology (BJMP). The IT infrastructure includes the following minimum requirements:

- Laptop or desktop computer with a webcam, microphone and speakers;

- Internet connectivity, preferably broadband, if available; and

- Video conferencing service such as Zoom, with the IBP hosting of the session if the trial court judge is unable to do so. Alternatively, the Court can subscribe to video conferencing services through the emergency procurement provisions of the Government Procurement Reform Act (GPRA).[16]

[16] Rep. Act No. 9184 (2003).

The IBP shall ensure that the sufficient IT infrastructure is available in the following places:

- Courts - for judges and other court personnel;
- Jail - for detention prisoners; and
- IBP Office - for private litigants.

To defray the costs, the IBP will charge all private practitioners a user fee. Other users, such as public attorneys, non-profit legal aid organizations, student-practice clinics under Rule 138-A of the Rules of Court, court personnel, and detention prisoners will not be charged a fee. The costs associated with their use will be defrayed from the user fees paid by the private attorneys. This is equitable because private practitioners can recover those costs from their clients.

Cloud drive is necessary to store all the virtual proceedings. This may also be procured by the Court.

Administrative Concerns

1. Manual filings may still be accommodated. The courts can adopt a store-and-forward procedure where filings are kept in a secure area for a period of time to allow the viral threat to dissipate before the papers are physically transmitted to the court branches.

2. An e-filing system or electronic docket can mirror the paper docket to avoid spreading the disease through court filings. The Court can maintain a cloud solution where documents are deemed received when uploaded by the filer. Where manual filing takes place, the

document can be immediately scanned and uploaded by the receiving clerk, with the paper copy later forwarded to the branch once the viral threat dissipates.

B. *Notarization.*

The Concern: Many pleadings require notarization and as yet there are no rules that permit electronic notarization.[17] On this point, as an interim measure, Rules 3, 4, 5, and 6 of the Rules on Electronic Evidence[18] may be considered as instructive.

The Proposal: A potential solution can be composed of a process that results in a physically notarized document while avoiding physical contact between the signer and the notary public. Key elements to consider for such a process include:

- The assumption that both the signer and the notary public are located in the place where the latter holds a commission.

- The signer should be able to contact the notary public, directly or with the presence of counsel, via a teleconferencing application and show the notary that he or she is signing the document, or to deliver to the notary the signed document with a photocopy of the identification used. For these

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[17] "[U]nder Section 2 (b) of Rule IV of the Rules on Notarial Practice of 2004, a commissioned notary public is enjoined from performing a notarial act unless the affiant is: (1) in his presence at the time of the notarization; and (2) personally known to him or otherwise identified by him through competent evidence of identity as defined by these Rules." Mahilum v. Lezama, A.C. No. 10450 (Resolution), July 30, 2014.

[18] A.M. No. 01-7-01-SC, July 17, 2001.

purposes, email or photographic transmission of the document may be considered.

- The notary then initiates a teleconference with the signer, and possibly counsel, during which the notary confirms the authenticity of the signature by requiring the signer to sign on a blank sheet of paper and show it to the notary. The original ID can also be shown to the notary. The notary can then confirm through the teleconference the attestations contained in the verification or jurat.

- The notary may, if he or she wishes, amend the verification and jurat to reflect that he determined the identity of the signer, the authenticity of the signature, and all relevant information through a teleconference process.

- The notary can then affix his or her seal and signature on the physical document and then transmit the same to the signer. Copies of the document, identification information and the recordings of the teleconference can then be kept by the notary public to demonstrate, if necessary, the validity of the notarization process.

For simple oaths, a rule may be enacted to allow a judge to administer an oath via a teleconferencing platform. The Supreme Court may also consider enacting an interim rule that follows or is in the same spirit as the protocols above.

C. *Conduct of Trial.*

The Concern: Reception of evidence under current rules requiring physical appearance is no longer feasible. At the

same time, the right to due process—including presentation of witnesses and confrontation—needs to be safeguarded by the judge.[19] Finally, the judge must be in a position to appreciate the testimony of the witness and all the evidence.

The Proposal: The trial court, with the consent of the litigants, can adopt appropriate binding protocols for the reception, storage and appreciation of physical evidence, depending on the risk of viral infection they may face.

Technical concerns related to trials:

1. *Documentary Evidence.* Comparison of copies to originals for example may be done:

   a. In person via representatives;

   b. Electronically using videoconferencing facilities; or

   c. On the strength of the attorney's oath undertaking that upon pain of disbarment or suspension from use of the system, any evidence presented in

[19] Philippine law values face-to-face meetings of members of the legal profession. "[A]ll witnesses shall give their testimonies at the trial of the case in the presence of the judge. This is especially true in criminal cases in order that the accused may be afforded the opportunity to cross-examine the witnesses pursuant to his constitutional right to confront the witnesses face to face. It also gives the parties and their counsel the chance to propound such questions as they deem material and necessary to support their position or to test the credibility of said witnesses." Vda. de Manguerra v. Risos, G.R. No. 152643, Aug. 28, 2008. The right to confrontation is part of due process not only in criminal proceedings but also in civil proceedings as well as in proceedings in administrative tribunals with quasi-judicial powers. It has two purposes: (1) to afford the accused an opportunity to test the testimony of the witness by cross-examination; and (2) to allow the judge to observe the deportment of the witness. People v. Sergio, G.R. No. 240053, October 9, 2019.

electronic form is a faithful reproduction of the original.

2. *Presentation of Witnesses.* If there is a risk of a witness being coached, opposing counsel may ask a representative to be present but if virus concerns are relevant, the parties may agree to multiple cameras trained upon the witness so that a view of his or her immediate surroundings is visible. One can, for example, require a witness to face a wall and a camera can be positioned behind him to satisfy the other litigant that no coaching is being done.

3. *Ethical considerations*. To prevent litigants or lawyers from abusing the system for their own advantage, undertakings may be signed to enforce penalties such as disbarment or suspension from use of the system by the lawyer and his or her firm in case of suspicion of wrongdoing. This way the attorney is incentivized not only to act ethically but to avoid all appearances of impropriety.

4. *Criminal Cases*. Special attention must be brought to the rights of the accused. Given the limitations of a short-term solution, the written waiver (perhaps supplemented by a verbal waiver secured by the judge via teleconferencing) of the accused to a physical confrontation may be obtained.

The rationale for a consent-based voluntary system is based on the inherent difficulties faced by the formulation and implementation of a uniform solution for *all* courts—whose circumstances are so varied. This proposal allows the IBP to move quickly and basically preserve the paper-based system but with social distancing measures built in. It

requires no additional rules from the Court, although a confirmatory issuance will do well to tamp down any doubts.

VI. MEDIUM-TERM CONSIDERATIONS

While the short-term proposal is in place, the Court can then consider interim measures of rules to fine tune the system in place.

For example, the Court may enact a rule that makes the Continuous Trial Guidelines[20] and the Judicial Affidavit Rule[21] mandatory for this period to all cases, subject to the proposed interim rule on notarization in number 2. In the conduct of trial, the following modifications must be made to the Rules of Court:

1. *Rule 132, Section 1* (*Examination to be done in open court*): Insert "remotely, as provided by these Interim Rules" into the first sentence, as follows: "The examination of witnesses presented in a trial or hearing shall be done in open court, *or remotely*, and under oath or affirmation, *as provided in these Interim Rules.*";

2. *Rule 132, Section 4* (*Order in the examination of an individual witness*): Temporarily suspend item (a) "Direct examination by the proponent" in view of the mandatory application of the Judicial Affidavit Rule; and

3. *Section 2 of the Judicial Affidavit Rule*: Allow for the submission of judicial affidavits by email within a period of time provided by the judge but taking into

[20] A.M. No. 15-06-10-SC, Apr. 25, 2017.

[21] A.M. No. 12-8-8-SC, Apr. 7, 2015.

consideration the burden of proof and the burden of evidence requirements under the 2019 Rules on Evidence (Rule 131), and the accused's prerogative to submit a demurrer to the evidence. The prosecution can be required only to submit the judicial affidavits of its witnesses.

The judge may, after appreciation of the judicial affidavits, schedule as many trial dates as appropriate, for the defense to cross-examine the witnesses of the prosecution, who shall be presented remotely under item (a). Upon offer and objection to the prosecution's evidence, as provided by the Continuous Trial Guidelines, the defense would then be required to provide the judicial affidavit of its witnesses unless it manifests the intention to demur to the evidence. The procedure provided in the 2019 Rules on Evidence, supplemented by the Continuous Trial Guidelines, would then apply.

The Supreme Court may also begin to develop a framework for implementing a "smart court" approach and identify which part of the court value chains can be fully transformed into e-systems using new technologies.

VII. LONG-TERM CONSIDERATIONS

The enhanced community quarantine (ECQ), the potential for recurrence of the current pandemic as well as possibility of other pandemics in the future, add impetus to the need to overhaul the judicial process, from litigation in the trial courts to disposition of appeals in the higher courts. In the medium term and long term, the court should seriously consider new technologies to improve the efficiency, accessibility and transparency of the court system. New

technologies can make the court system resilient to disasters and pandemics in the long run:

A. Declogging the court docket, including physically reducing the number of people who have to be present and waiting in the courtroom at any given time or day, may improve system efficiency.

    1. The trial process must be revised extensively to reduce unnecessary time spent in tedious court appearances. More time should be spent outside of the courtroom in pre-trial stipulation of facts, gathering and validation of object or documentary evidence, and identification and distillation of issues. Ideally, judges should be immediately focused on weighing stipulations, admissions, and object/documentary evidence without having to spend excessive amounts of time in essentially facilitating and moderating an adversarial process.

    2. Civil cases involving contracts, commercial transactions, and other written transactions, are often unnecessarily prolonged by tedious procedures for the introduction and admission of evidence, both written and testimonial. These procedures still reflect the older, original processes for introduction and admission of evidence which were devised at a time when courts were not as congested.

    3. Reforms introduced by the Court, such as the Judicial Affidavit Rule, have shortened the time it takes to present testimonial and documentary evidence by reducing the time taken up by direct testimony, but have not optimized the potential reduction in time because the process simply puts into written form pre-existing processes for presentation of evidence.

a. For example, the required verbal forms for the identification and marking of documents, signatures, etc. are often still stated in the affidavit as if it were a transcription of an oral testimony in court. Written formal offers or evidence and objections thereto in separate pleadings await the prior conclusion of presentation of judicial affidavits and oral cross-examination before they can be submitted. These take up unnecessary space and time that continue to prolong the litigation process.

b. Judicial affidavits are still subject to the application of rules of evidence, including objections, that were appropriate for oral testimony but are of no relevance to prepared written affidavits. An example is the objection based on leading questions, which was intended to prevent coaching on the witness stand, but has no relevance to an affidavit prepared out of court.

c. Judges should be encouraged to render judgment on the pleadings where the reception of testimonial evidence through judicial affidavits will essentially work to prolong litigation. To a certain extent, they should be allowed to be actively inquisitorial rather than just passively receptive. The former will enable the judge to speed up the process of adjudication; in the latter case, which is how the court system is currently set up, it is the parties who can control the pace.

4. The digitization of documents presents new challenges and opportunities in terms of ascertaining authenticity and originality. Current requirements and modes of

authentication of documents are tedious and premised on manual transactions and record- keeping. Digital documentation using barcodes and QR codes will soon make these old modes and requirements superfluous. An over-reliance on testimonial evidence results in longer trials. The Rules on Evidence provide that the most reliable pieces of evidence are those that the judges can see and appreciate for themselves. Judges who are trained to analyze for themselves scientific or object evidence without the need for witnesses could help speed up the process.

5. The pre-trial process for both civil and criminal cases needs to be overhauled and modified substantially, with an emphasis on discovery and disclosure as well as a strong push towards depositions which are considered admissible if presented on trial. This leads litigants to take the process seriously and, in the event of a possible plea-bargain, to consider it instead of spending an inordinate amount of time in trial. Current mandatory alternative dispute resolution (ADR) diversions do sufficiently incentivize the settlement of cases, which would be more greatly prompted by the emergence of evidence through discovery that leads parties to more realistically assess their chances at trial and the costs they would have to incur should they pursue litigation to the end.

6. In other jurisdictions such as the United Kingdom and the United States, the bulk of civil litigation takes place outside of the trial process, through depositions, preparation of case folders, and pre-trial case management. The emphasis of these procedures is to facilitate the determination of facts even before trial, with the issues in dispute then already reduced to the most essential ones. Shifting the action away from trial

would have short-term benefits in light of the COVID-19 pandemic, but also long-term benefit as it reduces the role of the courts and facilitates a much speedier trial with only the most essential issues remaining for litigation.

7. A review of legislation and rules for possible amendment to integrate social distancing and other responses to pandemics such as but not limited to:

   a. Republic Act No. 7438 (Rights of Persons Arrested, Detained or Under Custodial Investigation, April 27, 1992);

   b. Republic Act No. 8493 (Speedy Trial Act of 1998, February 12, 1998);

   c. Batas Pambansa Bilang 129 (Judiciary Reorganization Act);

   d. Rules on Electronic Evidence (A.M. No. 01-7-01-SC, July 17, 2001);

   e. The Revised Rules on Evidence (A.M. No. 19-08-15-SC, May 1, 2020); and

   f. The Revised Rules of Civil Procedure (A.M. No. 19-10-20-SC, May 1, 2020).

8. Work with Congress to review penal provisions for minor infractions. The continued insistence on using penal provisions to exact accountability or demonstrate an eagerness to resort to imprisonment for even minor infractions leads to overcrowding of

dockets and congestion of jails.[22] This "overload" on the administration of justice exacerbates the health risks of the COVID-19 pandemic and similar outbreaks. Congress should consider decriminalizing certain offenses and making them "civil wrongs," with a clear system of exacting accountability through pecuniary rather than penal means.

9. Reform the determination of probable cause and preliminary investigation procedures. The Court should likewise examine and recommend to the Department of Justice (DOJ) the review of these procedures. If the investigating prosecutor were, as a rule, the prosecutor assigned to the case for trial, the preliminary investigation would be more rigorous as there would be greater assurance that only cases supported by sufficient evidence to convict would be filed in court. The effects of the current "two prosecutor" system warrants study, as this may be an area of reform that would weed out unnecessary criminal cases before the courts.

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[22] Occupancy of Philippine jails is at 463.6%. In 2000, the prison population was at 79,299. This figure increased steadily to 188,278 in 2018. *See* Institute for Crime & Justice Policy Research, *World Prison Brief: Philippines,* https://www.prisonstudies.org/country/philippines. When Rodrigo Duterte assumed office as President on June 30, 2016, the Bureau of Jail Management and Penology population stood at 96,000 inmates or Persons Deprived of Liberties. two years later ,the BJMP population stands at 160,000 or a staggering growth of 64 percent in two years. That figure does not include the 30-percent increase in BuCor prisons, and the unquantifiable growth in PNP detention cells and provincial jails where data are scantly collected and tallied. This makes the Philippines "officially the most overcrowded correctional facilities in the whole world" The country's 605-percent congestion rate is far ahead of Haiti's 320 percent, the second most crowded. *See* Dr. Raymund Narag, *State of the PH in 2018: Our jails are now world's most congested.* (July 23, 2018), https://pcij.org/article/923/state-of-the-ph-in-2018-our-jails-are-now-worlds-most-congested.

10. Adoption of new technologies including artificial intelligence (AI) tools and blockchains. In countries like China, AI tools are used to improve the efficiency and transparency of the court system.

    a. Mobile phone applications can be used in filing of cases, submission of evidence and communication between the parties and the judge. Pre-trial mediation, including e-signing of mediation settlement, and delivery of judgement are all done through the app.[23]

    b. AI tools are used to assist with non-complex court procedures like real-time recording and transcription of trial proceedings and provision of legal information.[24]

    c. Mobile courts utilizing new technologies should be explored further.

VIII. OVERSIGHT AND RULE-MAKING

A. *Form a Primary Committee to Address the Issues.* A primary committee should be formed in order to govern the process by which all particular issues are addressed. This will include supervision over the formation of and actions taken by the subcommittees. Preferably, this Committee should be headed by the Chief Justice with the Senior Associate Justice as the Working Chair and the Chairs of the Three Supreme Court Divisions as Members.

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[23] Mimi Zou, *supra*, note 12.

[24] *Id.*

B. *Form Subcommittees to Tackle Particular Challenges.*

1. *Trial Concerns.* This subcommittee should examine which trial procedures can be enhanced by technology. Documentary exhibits, for example, may be uploaded into a common database and the electronic copy presented to the witness. Electronic copies of stenographic notes and key case documents such as initiatory pleadings and pre-trial orders may likewise be stored in the database. A review of all statutes and relevant rules may be appropriate in this regard.

2. *Evidentiary Concerns.* This subcommittee should study the Rules on Evidence and the Rules on Electronic Evidence to see how the presentation of evidence by a party may be facilitated during online remote hearings.

3. *Criminal Cases.* This subcommittee should study special concerns affecting criminal cases. These include guaranteeing the rights of the accused notwithstanding the modified procedures. This subcommittee shall likewise address the concerns of specially protected victims (*e.g.,* victims of VAWC and child abuse) as well as those particular to drugs courts.

4. *Administrative Concerns.* Each branch of a court performs many administrative tasks. Each strand should be studied and adapted to an electronically facilitated court process. The roles of the members of the plantilla branch staff (*e.g.,* docket clerks, stenographers, interpreters and process servers or sheriffs), as well as that of the Office of the Clerk of Court should be re-examined or redefined in light of new changes.

5. *Technology Assessment.* This subcommittee should assess available technologies along a slew of vectors relevant to the courts from security, ease of use, availability, reliability, and cost. Ideally, a solution that best serves the goals of electronically enabled courts should be pursued. An examination of open source software, open standards and other technologies that promote the free flow of information should be undertaken to prevent vendor lock-ins.

6. *Ethical Concerns.* This subcommittee can examine the Code of Professional Responsibility to see their effectiveness against potential abuses from members of the bar who may want to take advantage of the gaps in processes to win their cases. Reevaluation of the Canons on Judicial Ethics may be warranted as well. Renewed enforcement of ethical rules or even amendments to the canons may be appropriate.

C. *Role of the IBP and Practitioners.* As the national and local organization of all lawyers, the IBP has a role to play in making sure that all their members act ethically as well as to provide a sounding board for feedback on the procedures adopted by the electronically enabled courts.

D. *Coordination with Congress and other actors in the Justice System.*

1. There needs to be a realization that the justice system is not just the courts; it includes the DOJ and the Department of Interior and Local Government (DILG) and their attached agencies. Any change to the processes must consider these agencies (*e.g.,* Rule 112 on Preliminary Investigation and Inquest are strictly with the DOJ, yet they are in the Rules of Court; the

conduct of preliminary investigation during this time is one of the processes that needs to be streamlined).

2. Many reforms will require congressional action. There needs to be a coordinated effort with Congress to address these reforms.

3. An economic analysis of the court system should be conducted. A serious, credible, and independent study of the economic aspects of litigation and court access must be made. This is the only way to ensure that the constitutional guarantee of free access to the courts is not diluted.[25] The costs of bail, filing suit, and hiring

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[25] CONST. 1987, art. III, §14. The aforementioned section provides:

> SECTION 14. (1) No person shall be held to answer for a criminal offense without due process of law.
>
> (2) In all criminal prosecutions, the accused shall be presumed innocent until the contrary is proved, and shall enjoy the right to be heard by himself and counsel, to be informed of the nature and cause of the accusation against him, to have a speedy, impartial, and public trial, to meet the witnesses face to face, and to have compulsory process to secure the attendance of witnesses and the production of evidence in his behalf. However, after arraignment, trial may proceed notwithstanding the absence of the accused provided that he has been duly notified and his failure to appear is unjustifiable.

For comparison, the Sixth Amendment to the United States Constitution provides, in part, that "[i]n all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial." The right to a public trial is not absolute, however, as some closures are permissible. In Waller v. Georgia, 467 U.S. 39, (1984), the Supreme Court set the test trial courts should apply to determine whether a courtroom closure is appropriate:

1. the party seeking to close the [proceeding] must advance an overriding interest that is likely to be prejudiced;
2. the closure must be no broader than necessary to protect that interest,
3. the trial court must consider reasonable alternatives to closing the proceeding, and
4. it must make findings adequate to support the closure.

See also Stephen E. Smith, *The Right to a Public Trial in the Time of COVID-19*, 77 WASH. & LEE L. REV. ONLINE 1, 5 (2020), *available at* https://scholarlycommons.law.wlu.edu/wlulr-online/vol77/iss1/1 .

lawyers are stumbling blocks towards "free" and meaningful access to the courts.

IX. Timelines

A. *Short Term* (May 15, 2020 – June 15, 2020). For the short term, the Supreme Court can leave the IBP and its chapters to work out solutions that are acceptable and permissible within their own areas. The large variances between the chapters in terms of the number of lawyers, litigants, case load, quality and reliability of internet connections, and availability of technically skilled support staff will make it extremely difficult to specify a single solution. Instead, the problem-solving can be delegated to the IBP chapters, with space and leeway to enter into arrangements with local participants to suit their needs.

1. *IBP*. Because the short-term proposals outlined in this paper are sketches of a possible solution, it is incumbent upon the IBP to convene various committees to tackle the concerns mentioned in Part IV of this paper. Several documents need to be drafted such as binding system agreements and waivers, procedures, contracts with the Courts and other recipients of equipment and services. Ideally, the National IBP should strive to issue a starting manual that can be used as a guide by chapters to get the system running as soon as possible.

   a. Expected Output:
      1) Manual of Operations for IBP Chapters;
      2) Governance documents; and
      3) Study of all relevant Rules that pertain to trial level.

2. *Supreme Court*.

   a. *Support for Short-Term Solutions.* The Court can aid the IBP's efforts by providing supportive measures that permit the chapters to problem-solve and innovate. Interim rules or guidance in the form of memorandum circulars on various topics including notarization would be helpful.

      1) Expected Output:
         a) Interim Rules on Notarization; and
         b) An expression of support for the IBP and its efforts to transform the paper-based process into one that considers social distancing.

   b. *Begin the work for Long-Term Solutions.* The Court can convene the committees outlined above to begin the work of addressing medium term issues and the more permanent long-term issues.

      1) Expected Output:
         a) Appointment of Chairmen and Members for the Primary Committee and Subcommittees in Part VIII; and
         b) Formulation of a work plan with timelines for Medium-Term Solutions.

B. *Medium Term* (June 15, 2020 – September 15, 2020). In this phase, the Supreme Court can consider the issues raised in Part VI above and enact an Interim Rule to further impart validity and stability to the hybrid electronic-analog process put in place by the IBP. Meanwhile, the IBP can, with the Court's encouragement, continue to fine-tune short-term solutions by allowing chapters to share experience and best practices. The

PhilJA can also begin to provide support to judges in the form of training and other resources.

1. Expected Output:
   a. *Supreme Court.* Interim Rule of procedure to support the short-term solution;
   b. *PhilJA.* Training sessions, technical support and training materials for judges; and
   c. *IBP.* Feedback loops and platform for chapters to share best practices.

C. *Long Term* (September 15, 2020 – December, 2021). During this phase, the Supreme Court's Primary Committee and the various Subcommittees will commence their work through consultations and research, after which they will submit their reports. From this, deliberations shall be done for the formulation of their recommendations to the Supreme Court.

1. Expected Output:
   a. *Subcommittees.* Final Reports for submission to the Primary Committee; and
   b. *Primary Committee.* Approval of Final Report duly submitted to the Supreme Court *en banc.*

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Before the Next Pandemic: Subnational PPPs in the Philippine Health Care System

Michael Arthur C. Sagcal[*]

INTRODUCTION

"*[Our] health care system is neither healthy, caring, nor a system.*"
– Walter Kronkite

This paper is a COVID-19[1] baby. It was conceived in the days following the declaration of an enhanced community quarantine (ECQ)[2] over Luzon including the National Capital

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[1] Coronavirus Disease 2019 is the disease caused by the spread of the severe acute respiratory syndrome coronavirus 2 or SARS-CoV-2.

[2] Memorandum from the Executive Secretary entitled "Stringent Social Distancing Measures and Further Guidelines for the Management of the Coronavirus Disease 2019 (COVID-19) Situation" (March 13, 2020).

Region (NCR), during the early stages of the country's fight against the disease.

The ECQ was announced on March 16, 2020, and was to be implemented from March 17 to April 13.[3] Earlier that day, the Department of Health (DOH) reported that the Philippines had a running total of 142 confirmed cases of COVID-19, out of which twelve had died.

Many other countries had it worse. For the first time since the disease began, the total number of cases and deaths outside China eclipsed those inside it, according to a World Health Organization (WHO) report.[4] Wuhan and the rest of the country was still the disease's epicenter with 81,077 cases and 3,218 deaths, but Italy's numbers were rising alarmingly fast with 24,747 cases and 1,809 deaths. Iran, where an outbreak occurred in mid-February, was still the third-worst hit country, reporting 14,991 cases and 853 deaths.

The whole of Italy had been placed under lockdown on March 9, and quarantined Italians started what would later become an international trend: neighbors and erstwhile strangers partaking in communal musical and athletic activities from their balconies. On March 11, WHO declared COVID-19 a pandemic in a press briefing in Geneva, and the United States banned all travel to and from 26 European countries. Two days later, the United States declared a state of national emergency.

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[3] Memorandum from the Executive Secretary entitled "Community Quarantine Over the Entire Luzon and Further Guidelines for the Management of the Coronavirus Disease 2019 (COVID-19) Situation" [hereafter referred to as "ECQ Guidelines"], (March 16, 2020).

[4] World Health Organization (WHO), *Coronavirus disease 2019 (COVID-19) Situation Report - 56*, *available at* https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200316-sitrep-56-covid-19.pdf?sfvrsn=9fda7db2_6 (March 16, 2020).

Back in the Philippines, as the second half of March was starting, an outpouring of donations came in many different forms—from as high as nine-digit financial pledges to government by the country's largest conglomerates, to as simple as packed meals provided to hospital workers by small- and medium-sized restaurant enterprises.

Several celebrities initiated fundraisers to buy medical equipment for hospital workers and relief goods for the poor, and artists organized online concerts with the same objective. One Senator facilitated a donation of hundreds of thousands of face masks for frontliners, and another Senator was the first high-profile Filipino official to have tested positive for the disease.

Local government units (LGUs) in NCR responded to the crisis in a handful of ways and were thrust into the national spotlight. Cities like Pasig, Marikina, and Valenzuela garnered praise for their preparedness and quick action. Some of the measures adopted were the house-to-house distribution of food packs, grocery vouchers, vitamins, and disinfection kits, deployment of mobile kitchens and shuttle services, provision of temporary housing for hospital workers in hotels and shelter for the homeless in public gymnasiums, and installation of disinfection tents in public spaces.

Mobility was the major issue on the first day of ECQ. At the stroke of midnight, scores of commuters who failed to make it past either side of the NCR-Bulacan Province boundary between Valenzuela City and Meycauayan were corralled for hours before being allowed to cross over and head home. As dawn broke a few hours later, essential workers who did not own private vehicles, including medical

staff, were left with no choice but to walk for up to several hours to get to their places of work.

An emotional television interview of taxi driver Reynaldo Alcala, who was accosted by authorities for violating the public transport ban, went viral. His breaking voice and trembling hand serving as a portent of what society would perhaps become more conscious of in the coming weeks: "*Magugutom talaga kami 'pag hindi kami bumiyahe dahil wala kaming pera… Mahirap 'pag mahirap. Walang pagkukunan.*" (We will really starve if we don't drive because we have no money… It is difficult to be poor. We have nothing.)

That brings us to this paper. The genesis of this work was set against the chaotic backdrop illustrated above. Though written during a time of uncertainty when no end was yet in sight, at least four initial lessons from the unprecedented COVID-19 crisis were already clear as day within the second half of March 2020—

A. *Public policy must always pay extra attention to the most vulnerable members of society. Two embodiments of this lesson are discussed below:*

   1. Social or physical distancing was one of the recommended measures to limit the spread of the coronavirus from inception, and there was no doubt as to its effectivity. When combined with the "stay at home" directive under ECQ, however, social disparities suddenly become more apparent.

      Among the upper and middle classes, staying at home meant enjoying luxuries such as online entertainment and air conditioning, while keeping away from others. Among the lower classes especially

in highly-urbanized areas, however, this meant being cramped into dense communities with little comfort, and worse, higher exposure to possible carriers.

There may have been little else that government could have done considering the emergency, but in a broader sense this showed how the poor have been substantially excluded from policy formulation over the decades.

2. The sudden declaration of ECQ with only a few hours before effectivity was drastic and may well have been necessary. Most citizens managed to comply despite the short notice, still, not a few workers were stranded at NCR's boundaries with neighboring provinces. By and large, it is lower income wage earners who reside in the provinces, and they rely on public transportation to commute to and from their workplaces.

   More than this, the ECQ guidelines guaranteed that establishments providing basic necessities would remain open during the quarantine period in one breath, and suspended mass public transport in the next.[5]

   It was but a natural if not foreseeable consequence the next day, therefore, that many workers did not make it to their establishments, and those who did were suffered to walk for hours to and from work. This had the same impact on hospital staff and non-medical workers—except for those with their own private vehicles.

[5] *Supra* note 4, par. 5-6.

By the following day, March 18, the national government and some donor-volunteers managed to deploy some buses to serve hospital staff, and this was augmented further in the weeks that followed. Nevertheless, it was evident that not much consideration was paid to the working class when ECQ was declared.

The impact that these policies had cannot be understated. According to estimates of the Philippine Statistics Authority (PSA), NCR's population at the time of the ECQ was between 13.6 to 13.8 million,[6] while the World Population Review reports that actual population was at 13.9 million.[7] Poverty incidence among families was around 1.5%[8] to 1.8%,[9] translating to around 48,400 poor families.[10]

Those most immediately affected by the ECQ were daily wage earners, especially those under "no work-no pay" arrangements, many of whom are paid the

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[6] Philippine Statistics Authority (PSA), *Updated Population Projections Based on the Results of 2015 POPCEN*, *available at* https://psa.gov.ph/sites/default/files/attachments/hsd/pressrelease/Updated%20Population%20Projections%20based%20on%202015%20POPCEN.pdf (October 4, 2019).

[7] World Population Review, Manila 2020, *available at* https://worldpopulationreview.com/world-cities/manila-population/.

[8] PSA, *2018 Full Year Poverty Statistics Table 1a*, *available at* https://psa.gov.ph/poverty-press-releases/data.

[9] PSA, *PSA shares latest poverty statistics*, *available at* https://pia.gov.ph/news/articles/1033382 (January 30, 2020).

[10] PSA, *2018 Full Year Poverty Statistics Table 1a*, *available at* https://psa.gov.ph/poverty-press-releases/data

minimum NCR daily wage of only P 537.00.[11] These workers ordinarily spend their earnings on a day-to-day basis, and they instantly lost their sources of income without any cushion. While the PSA and the Department of Labor and Employment (DOLE) do not appear to have data on the number of no work-no pay workers, the Trade Union Congress of the Philippines (TUCP) approximates that there are around five million in NCR,[12] which is one-third of the region's 15 million daytime population estimate.[13]

B. *LGUs are first responders in times of disaster, and are indispensable actors in delivering basic services to the people.*

As we have seen in this particular pandemic, it was the LGUs that first mobilized on the ground to deliver—quite literally—the basic needs of their constituents. From going house-to-house to distribute provisions, to disinfecting public and even private spaces, to providing shelter for medical staff and the homeless, to ensuring intra-city mobility: LGUs filled the entire government role while national agencies focused on the macro-level requirements of organizing and strategizing the country's overall disaster response.

This was neither by chance nor an aberration. It was by design, and specifically provided for in the Philippine

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[11] DOLE-NWPC-RTWPB Wage Order No. NCR-22, *available at* https://nwpc.dole.gov.ph/wp-content/uploads/2018/06/reg-ncr-wo-22.pdf (2018).

[12] Philippine Star, *DOLE to assist thousands of workers out of jobs, available at* https://www.philstar.com/headlines/2020/03/17/2001506/dole-assist-thousands-workers-out-jobs (March 17, 2020).

[13] *Supra* note 8.

Disaster Risk Reduction and Management Act,[14] which states that Local Disaster Risk Reduction and Management Offices (LDRRMOs) "shall take the lead in preparing for, responding to, and recovering from the effects of disaster."[15] LDRRMOs are under the offices of local chief executives on the provincial, city, and municipal levels.[16]

The LGU's role as a frontliner is but a consequence of the devolution of powers expressed in the Local Government Code (LGC),[17] which mandated the establishment of organizational structures and operating mechanisms in every LGU that would meet the priority needs and service requirements of their communities.[18] Thus, LGUs were authorized to exercise such powers and discharge such functions and responsibilities as are necessary, appropriate, or incidental to the efficient and effective provision of basic services and facilities.[19]

C. *The country's health services sector still has much room for improvement, especially in terms of infrastructure and quality of care.*

As of March 31, the Philippines reported 1,546 confirmed cases of COVID-19 and 78 deaths.[20] We

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[14] Rep. Act No. 10121, Philippine Disaster Risk Reduction and Management Act of 2010.

[15] *Id.*, §15.

[16] *Id.*, §12.

[17] Rep. Act No. 7160, Local Government Code of 1991.

[18] *Id.*, §3(b).

[19] *Id.*, §17.

[20] WHO, Coronavirus disease 2019 (COVID-19) Situation Report - 71, *available at* https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200331-sitrep-71-covid-19.pdf?sfvrsn=4360e92b_4

compare this below with same-date statistics in five of the consensus top managers of the pandemic at the time: Singapore, Taiwan, South Korea, Vietnam, and Germany.

Singapore reported a total of 879 confirmed cases and only three deaths. Its success was attributed to its meticulous planning and preparedness, a world-class health care system, strong epidemiological surveillance and contact-tracing capacity, and strict travel and quarantine policies.[21]

Taiwan recorded 322 confirmed cases and five deaths.[22] It was credited for swift action on travel bans and extensive screening, robust policymaking, intensive health monitoring through big data and repeat testing, and its progressive national health insurance system.[23]

South Korea had 9,786 confirmed cases and 162 deaths. The heart of its strategy was aggressive testing—it even implemented drive-thru testing from the early stages—and its whole-of-government approach, where

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(March 31, 2020). This is also the source for other countries' statistics cited in this chapter.

[21] Philip J. Heijmans and Bloomberg, *Singapore's coronavirus response has contained the outbreak – but its strategy is hard to replicate*, *available at* https://fortune.com/2020/02/28/singapore-coronavirus-contained-response/ (February 28, 2020)

[22] Taiwan CDC, *Cumulative total of 322 COVID-19 cases confirmed in Taiwan, 39 patients released from isolation*, *available at* https://www.cdc.gov.tw/En/Bulletin/Detail/7XTz1qzNqDYE1yL6TT9D3w?typeid=158 (March 31, 2020)

[23] Isaac Scher, *Taiwan has only 77 coronavirus cases. Its response to the crisis shows that swift action and widespread healthcare can prevent an outbreak*, *available at* https://www.businessinsider.com/coronavirus-taiwan-case-study-rapid-response-containment-2020-3 (March 18, 2020).

regions shared hospital beds and medical professionals with each other.[24]

Vietnam reported only 203 confirmed cases and no deaths, though this was considered underreported,[25] because Vietnam did not have mass testing capability.[26] In any case, the country was recognized for its organization and culture of surveillance.[27] It also halted flights to China and imposed strict quarantine measures early on.[28]

In Europe, Germany stood out with 61,913 confirmed cases and only 583 deaths as of March 31. Its success was attributed to its high number of hospital beds and quick rollout of testing, which was partly due to the absence of a centralized diagnostic system.[29]

In contrast, the Philippines witnessed many of its top NCR private hospitals reaching full capacity for COVID-19 patients within the month, as a result of which in several cases, suspected carriers queued in emergency rooms and

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[24] Sean Fleming, *South Korea's Foreign Minister explains how the country contained COVID-19*, *available at* https://www.weforum.org/agenda/2020/03/south-korea-covid-19-containment-testing/ (March 31, 2020).

[25] Amy Searight and Brian Harding, *Southeast Asian Responses to COVID-19: Diversity in the Face of Adversity*, *available at* https://www.csis.org/analysis/southeast-asian-responses-covid-19-diversity-face-adversity (March 27, 2020).

[26] Sean Fleming, *Viet Nam shows how you can contain COVID-19 with limited resources*, *available at* https://www.weforum.org/agenda/2020/03/vietnam-contain-covid-19-limited-resources (March 30, 2020).

[27] *Id.*

[28] *Supra* note 26.

[29] Don Reisinger, *Germany has remarkably few COVID-19 deaths. Its healthcare system shows how Germany prevented a runaway death toll*, *available at* https://www.businessinsider.com/why-germany-has-a-low-covid-19-mortality-rate-2020-4 (April 3, 2020).

waiting areas to wait for their turn. Doctors and hospital staff were extremely overworked, and worse, were being quarantined in groups due to exposure to carriers. Personal protective equipment (PPE) supply was so sorely lacking that frontliners had to improvise with ill-advised materials in the better scenarios, while some had to forego their own protection altogether in the worst cases.

According to the 2019 Global Health Security Index (GHS Index), the Philippines ranked 53rd out of 195 countries in terms of health security capabilities.[30] Its regional peers placed as follows: Thailand – 6th, Malaysia – 18th, Singapore – 24th, Indonesia – 30th, Vietnam – 50th, Myanmar – 72nd, Laos – 73rd, Cambodia – 89th, and Brunei – 128th.

The GHS Index measured each country in six categories, and the Philippines' lowest rank was in Risk, where it placed only 124th in the world. Out of the five subcategories under Risk, the country placed in the lower half of the world in terms of Political and Security Risk (159th), Public Health Vulnerabilities (128t), and Infrastructure Adequacy (124th).

The Philippines performed worse on the health index of the World Economic Forum's Global Competitiveness Report 2019, where it ranked only 102nd out of 141 countries.[31] In contrast, Singapore ranked 1st, Thailand was 38th, Brunei placed 62nd, Malaysia ranked 66th, Vietnam was

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[30] Global Health Security (GHS) Index, *available at* https://www.ghsindex.org (2019).

[31] World Economic Forum, *The Global Competitiveness Report*, p. 464, *available at* http://www3.weforum.org/docs/WEF_TheGlobalCompetitivenessReport2019.pdf (2019).

71st, Indonesia placed 96th, Cambodia was 105th, and Laos ranked 109th. Myanmar was not part of the study.

From the data above, we see that the Philippines does not even land in the top half of the Southeast Asian region. While its national health insurance program called the Philippine Health Insurance Corporation (PhilHealth) achieved 98% coverage of its population in 2018[32]—a significant milestone in itself—the country still has much work to do in order to improve on its delivery of health services.

D. *The private sector is able and willing to contribute significantly to public health requirements when needed.*

In various scales and levels, the private sector provided aid to government agencies, hospital frontliners, essential workers, and the underprivileged members of society. From the largest of the country's conglomerates, several of which donated hundreds of millions' worth of cash and goods, to smaller companies that provided their products to those in need, to different groups that spearheaded fundraising drives and distribution efforts, down to volunteers who designed and shared materials and implements for everyone's use, made improvised PPEs for frontliners, and packed and distributed goods to the poor.

The private sector has a long history of playing a prominent role in Philippine development, which has traditionally been a private enterprise economy in both

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[32] PhilHealth, *Primed for Change, Grounded in Our Vision 2018 Annual Report*, p. 11, *available at* https://www.philhealth.gov.ph/about_us/annual_report/ar2018.pdf (2018).

policy and practice.[33] It provides 96% of the country's total Gross Domestic Product (GDP), employing 92% of the workforce.[34] In real numbers, it generates most formal jobs in the Philippines at close to 40 million.[35]

Specifically in the Philippine health industry, the private sector role is also invaluable in augmenting the inadequacies of government.[36] For example, 790 hospitals are privately-owned, while only 430 are owned by government.[37] Private sector participation in health is generally fragmented though, comprising thousands of for-profit and not-for-profit service providers, and is largely market-driven, where health services are paid for through user fees at the point of service.[38]

These four lessons from the early stages of the ECQ form the underlying idea of this article, which seeks to propose a policy that would empower LGUs and the private sector to consolidate their resources through public-private partnership (PPP) projects in order to deliver better quality health care to the people, especially the underprivileged.

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[33] U.S. Library of Congress Federal Research Division, *Economic Planning and Policy*, *available at* http://countrystudies.us/philippines/59.htm.

[34] Cayetano W. Paderanga, Private Sector Assessment Philippines (2011), p. 47, *available at* https://www.adb.org/sites/default/files/institutional-document/32479/files/psa-philippines-2011.pdf.

[35] IFC, Creating Markets in the Philippines (2019), pp. 1-5, *available at* https://www.ifc.org/wps/wcm/connect/211167eb-02ec-4c99-94da-e834f9859582/202003-CPSD-Philippines.pdf?MOD=AJPERES&CVID=n4TirgZ.

[36] Manuel Dayrit *et al.*, The Philippines Health System Review (2018), p. 21, *available at* https://apps.searo.who.int/PDS_DOCS/B5438.pdf.

[37] *Id*, p. 127.

[38] *Id*, p. 21.

In Part I, we will survey the Philippines' policy framework on health, based on its Constitution,[39] key legislation, and administrative programs. In Part II, we will have an overview of the country's health care system, focusing more on the public sector side of the industry. Part III will be a brief discussion of the development of PPPs on the LGU level in the Philippines, and Part IV will be a summary of how different countries have utilized PPPs in their health sectors. Lastly, Part V will elaborate on possible transaction structures for subnational health sector PPPs, before we summarize this work in the Conclusion.

I. THE POLICY FRAMEWORK

"*[T]he care of the public health is the first duty of a statesman.*"
– Benjamin Disraeli

Ten days into the ECQ, on March 27, China continued to have the highest number of reported cases at 82,078, but slipped to only third highest when it came to deaths at 3,298.[40] Italy, which had 80,539 cases, topped the list of deaths with 8,165. By that time, Cuba's "army of white robes" was already on Italian soil to help combat the disease.

Spain, which reported 56,188 cases, jumped to second in terms of deaths with 4,089. The United States, meanwhile,

[39] 1987 CONSTITUTION OF THE REPUBLIC OF THE PHILIPPINES [CONST.].

[40] WHO, Coronavirus disease 2019 (COVID-19) Situation Report - 67, *available at* https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200327-sitrep-67-covid-19.pdf?sfvrsn=b65f68eb_4 (March 27, 2020). This is also the source for other countries' statistics cited in this chapter.

became the country with the third-highest number of cases at 68,334, though it only reported 991 deaths.

The Philippines only had 707 confirmed cases and a death toll of 45 at the time. Earlier that week, on March 23, Congress passed the Bayanihan to Heal as One Act,[41] which declared the existence of a national emergency and granted emergency powers to the President. The next day, the National Task Force-COVID-19 was created to operationalize the National Action Plan. The Secretaries of Defense and of Interior and Local Government were appointed as Chairman and Vice Chairman of the Task Force, respectively, while the Presidential Adviser on the Peace Process was named its Chief Implementer.[42]

That week had its share of inspiring stories, such as a university in Manila and a popsicle shop in Quezon City opening their doors to provide temporary shelter to the homeless. Meanwhile, pictures of an apparently pollution-free Metro Manila began circulating online, showcasing clear skies and vistas of distant mountains.

On the other hand, it also saw widespread condemnation of preferential treatment given to prominent individuals in the form of VIP testing, and extreme indignation with regard to one Senator's breach of quarantine protocols which potentially exposed hospital staff, grocery shoppers, and political party mates.

The medical field was especially poignant: 10 doctors, including prominent physicians Raul Jara and Gregorio Macasaet, died after contracting the disease in the line of

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[41] Rep. Act No. 11469, Bayanihan to Heal as One Act of 2020.

[42] Memorandum from the Executive Secretary entitled "Designation of the Philippines' Chief Implementer Against COVID-19" (March 24, 2020).

duty. Some of the country's top hospitals, namely The Medical Center, Makati Medical Center, and St. Luke's Medical Center, announced that they could no longer accommodate COVID-19 patients. Meanwhile, the Philippine General Hospital (PGH) accepted the challenge of converting into an end-referral COVID-19-only facility, a daunting task that it said was in line with its tradition of service.

At that point, we could see NCR's health system quickly approaching, if not breaching, capacity. Hospitals were plagued with a lack of beds, healthy personnel, and PPEs, and government began preparing for the likelihood that larger facilities, whether medical or not, would need to be converted into COVID-19-only centers. Quite possibly for the first time since Philippine independence, all State concerns took a back seat to public health, and its health policy framework came to the fore.

The Constitution

If only words unfailingly yielded their desired results, then the Constitution would have sufficed in ensuring the good health of its citizens. Known to be one of the more robust organic laws in the world, it does its share in recognizing health as a primary concern of government.

The Constitution establishes the people's right to health, the protection and promotion of which is declared as a State policy, and it obligates the State to instill health consciousness among the people.[43] It recognizes health as an element of social justice, and accordingly mandates the State to "adopt an integrated and comprehensive approach to health development which shall endeavor to make essential

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[43] CONST., art. II, § 15.

goods, health, and other social services available to all the people at affordable cost."[44] Free medical care for indigents is also expressly made a goal.[45] Finally, the State is charged with the obligation to maintain an effective food and drug regulatory system, and to undertake research and manpower development to address the country's health requirements.[46]

These mandates and guiding principles have been given life in the form of various laws, which largely focus on consumer protection, price regulation and management, and revenue generation to fuel the national health insurance coverage.

Legislative Policies

Over the span of the past three decades, Congress has passed several significant pieces of legislation which help meet the Charter's health mandates. These laws include the following:

A. The Generics Act,[47] which required the use of generic terminology in the entire drugs supply chain and aims to ensure the supply of generic drugs at the lowest possible cost and to make them available for free to indigent patients;

B. The PhilHealth Law,[48] which created the National Health Insurance Program and established the Philippine Health Insurance Corporation, with the aim

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[44] CONST., art. XIII, § 11.

[45] *Id.*

[46] *Id.*, §12.

[47] Rep. Act No. 6675, Generics Act of 1988.

[48] Rep. Act No. 7875, National Health Insurance Act of 1995 (As Amended).

of providing all Filipinos with financial access to health services;

C. The Cheaper Medicines Act,[49] which allowed the parallel importation of drugs, promoted competition in the pharmaceutical industry, and set a price control and monitoring mechanism;

D. The Sin Tax Reform Law,[50] which simplified the excise tax system and imposed additional excise taxes on alcohol and tobacco products in order to finance the Universal Health Care program; and

E. The Reproductive Health Law,[51] which provided for the hiring of additional skilled health workers and upgrading of facilities specific to maternal health care, and the procurement and distribution of family planning supplies.

Of note is that these statutes focus on increasing financial access to health care by: (a) lowering the price of drugs, (b) increasing their availability to the public, and (c) broadening the national health insurance coverage, partly through excise taxes—but they do not incentivize either public or private investment in physical infrastructure such as hospitals, equipment, and other medical facilities. Instead, infrastructure development has been treated by Congress as an executive function, which is subject to limited budgetary appropriations.

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[49] Rep. Act No. 9502, Universally Accessible Cheaper and Quality Medicines Act of 2008.

[50] Rep. Act No. 10351, as amended.

[51] Rep. Act No. 10354, Reproductive Health Law of 2012.

A review of the general appropriations acts (GAA) of the past three fiscal years supports this observation.

A. In the 2020 GAA,[52] the health sector was given a total budgetary allocation of ₱175.9 billion, ₱100.6 billion of which went to the DOH. The rest were distributed to the National Nutrition Council (NNC), PhilHealth, and specialty hospitals such as the Philippine Heart Center and the Lung Center of the Philippines.

   Only ₱8.4 billion or 4.7% was allocated for the Health Facilities Enhancement Program (HFEP), which was supposed to be utilized for the purchase of hospital equipment and for government health care facilities to be constructed, upgraded, or expanded.[53] This amount was smaller than allocations for Assistance to Indigent Patients, at ₱10.5 billion,[54] and the Human Resources for Health Deployment Program, at ₱10.0 billion.[55]

B. In the 2019 GAA,[56] the health sector was given a total budgetary allocation of ₱168.9 billion, with ₱97.7 billion going to the DOH. The rest were distributed among the NNC, PhilHealth, the Commission on Population, and specialty hospitals.

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[52] Rep. Act No. 11465, General Appropriations Act for Fiscal Year 2012.

[53] *Id*, Vol. 1-A, Part XIII.A., Special Provision 6.

[54] *Id*, Special Provision 7.

[55] Department of Budget & Management (DBM), 2020 National Budget, *available a*t https://www.dbm.gov.ph/images/pdffiles/2020_Quick_Glance_FINAL_v1.pdf.

[56] Rep. Act No. 11260, General Appropriations Act for Fiscal Year 2019.

Only ₱15.9 billion or 9.4% was allocated for the HFEP, which was utilized for: (1) the completion, repair, rehabilitation, relocation, and equipping of 1,523 Barangay Health Stations (BHSs) and 794 Rural Health Units (RHUs), Urban Health Centers (UHCs), and City Health Offices (CHOs), as well as (2) the construction of 173 new BHSs.[57] This amount was less than half of that allocated for the Health Facilities Operations Program, at ₱32.5 billion, and was only slightly higher than that allocated for the Purchase of Drugs, Medicines, Vaccines, and Medical and Dental Supplies, at ₱15.4 billion.[58]

C. In the 2018 GAA,[59] the health sector was given a total budgetary allocation of ₱179.4 billion, from which ₱106.1 billion directed to the DOH. The rest was distributed to the same agencies and hospitals as in the 2019 GAA.

₱30.3 billion or 16.9% was allocated for the HFEP.[60] Out of this amount, ₱23.2 billion was allocated for the construction, upgrading, expansion, rehabilitation and/or repair of, and land acquisition for, BHSs, RHUs, LGU hospitals, specialized hospitals, regional medical centers, dangerous drugs abuse treatment and rehabilitation centers, and other health care facilities.[61] Meanwhile, ₱6.3 billion was allocated

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[57] DBM, 2019 People's Budget, p. 26, *available a*t https://www.dbm.gov.ph/images/pdffiles/2019-Peoples-Budget.pdf.

[58] *Id.*

[59] Rep. Act No. 10964, General Appropriations Act for Fiscal Year 2018.

[60] DBM, 2018 People's Budget, p. 21, *available a*t https://www.dbm.gov.ph/wp-content/uploads/Our%20Budget/2018/2018-People%27s-Budget-for-posting.pdf.

[61] *Supra* note 60, Vol. 1-A, Part XIII.A., Special Provision 6.

for the purchase of hospital equipment for government health care facilities to be constructed, upgraded, or expanded, and the balance of ₱795 million was allocated for the purchase of ambulances and mobile dental vans.[62]

While less and less fiscal attention has been given to facility upgrading over the years, government has nevertheless continued to pursue its health targets that have more or less been unchanged for the better part of two decades. These include the provision of universal health care coverage to Filipinos and the reduction of financial risk for patients.

Administrative Programs

Since the 1990s, every administration has defined its vision and action plans for the health sector through the Health Sector Reform Agenda (HSRA). Under the Philippine Health Agenda (PHA) 2016-2022, government is committed to meeting the following goals:[63]

A. *Financial Protection,* through which Filipinos, especially the underprivileged, are protected against the high cost of health care,

B. *Better Health Outcomes*, as a result of which Filipinos attain the best possible health outcomes with no disparity, and

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[62] *Id.*

[63] DOH, *All for Health Towards Health for All*, *available at* https://www.doh.gov.ph/sites/default/files/basic-page/Philippine%20 Health%20Agenda_Dec1_1.pdf.

C. *Responsiveness*, due to which Filipinos feel respected, valued, and empowered in all interactions with the health system.

At the forefront of these goals is the DOH, which is primarily in charge of ensuring that the following Guarantees under PHA 2016-2022 are fulfilled:[64]

Guarantee	*Description*
Guarantee #1: All Stages of Life and Triple Burden of Disease	This guarantees medical services from the "first 1,000 days" of life to geriatric health, as well as for the "triple burden" of communicable diseases, non-communicable diseases, and diseases of rapid urbanization and industrialization.
Guarantee #2: Service Delivery Network	This guarantees services delivery through a network of health facilities that are fully functional, compliant with clinical practice guidelines, available 24/7, in the practice of gatekeeping, located close to the people, and enhanced by telemedicine.
Guarantee #3: Universal Health Insurance	This guarantees that services for 100% of Filipinos are financed predominantly by PhilHealth, which will have simplified rules and will be the main revenue source for public health care providers.

In order to fulfill its obligations, the DOH mapped out a seven-point strategy under PHA 2016-2022, out of which

[64] *Id.*

only one relates to capital investment in facility upgrading: specifically, subtask number three of the first strategy point reads “Transform select DOH hospitals into mega-hospitals with capabilities for multi-specialty training and teaching and reference laboratory.”[65] But even the declaration of this strategy does not guarantee that the DOH will deploy resources into constructing, rehabilitating, or modernizing hospitals and medical facilities.

First, the subtask limits its scope to “select” DOH hospitals only, which means that there is no plan for an across-the-board upgrading of all or even most hospitals. Further, there is no declared strategy for improving other medical facilities whatsoever.

Second, the subtask may be satisfied without actual investment in hard infrastructure: it is possible for the transformation of hospitals into mega-hospitals to be done only through equipment or technology upgrades, or worse, by simply reconfiguring hospital space and facilities to accommodate other specialties.

At least two underlying factors may contribute to the relatively lesser attention placed on the need for facility upgrading.

The first is rather blunt and is the most obvious explanation: funding prioritization. With a limited amount of financing options available to the government, not only within the health sector but also across all components of government, both the legislative and executive departments have had to prioritize the allocation of their resources. With evidence indicating that the areas which more urgently need

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[65] *Id.*

funding are financial access, operations including supplies, and improvement of the workforce, infrastructure investment has become a second-tier priority only.

The second has to do with results prioritization. With the end-goal of every public health agenda being the welfare of individuals, the metrics used to measure success is not based on the tools dedicated towards achieving them, but the results thereof. Thus, between having the highest-level facilities and equipment on the one hand, and having the lowest mortality rate and disease incidence on the other, for example, success is measured based on the latter.

This second factor is best exemplified by United Nation's Sustainable Development Goals (SDG), specifically SDG 3, which defines the global indicator framework for health.[66] Examples of metrics under SDG 3, entitled "Ensure Healthy Lives and Promote Well-Being for All at All Ages," are the reduction of global maternal mortality to less than 70 per 100,000 live births by 2030 and halving the number of global deaths and injuries from road traffic accidents by 2020.[67] The Philippines has adopted SDG 3 and sets its health targets in accordance with such metrics.

In any case, government has the ability to enhance the country's health infrastructure without revisiting its priority areas. This may be done by shifting the burden of capital and even operating expenditure to the private sector, as well as by supporting LGUs in developing their own high-quality health and medical facilities. These possibilities are further examined in the succeeding chapters.

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[66] *Id.*

[67] UN, Sustainable Development Goal 3, *available at* https://sustainabledevelopment.un.org/sdg3.

Synthesis

Without detracting from the complexity of delivering quality health services in a developing country or from government's efforts to do so thus far, it is clear from Philippine health policies that the development of hospital infrastructure and of other medical facilities has been relegated by decisionmakers as secondary to ensuring financial access to health services.

Health-specific legislation passed in the three decades since the effectivity of the Constitution have been virtually silent on providing for capital investments in physical infrastructure, and plans and programs of the executive have similarly been relatively indifferent to such need.

Perhaps the most revealing facts in support of this observation are the budgetary allocations for infrastructure development in the health sector: from P 30.3 billion in 2018, it was reduced by almost half to P 15.9 billion in 2019, and then further reduced by almost half again to only P 8.4 billion in 2020. The budgetary numbers tell us that the national government has shifted focus away from infrastructure investment in favor of operational expenditures and the purchase of drugs in 2019, and towards medical assistance and human capital investment in 2020.

While this article does not question the soundness of such policy decisions especially considering economic limitations, they do leave a gap in the continuing need for facility upgrading across the country. To zero-in on the specific areas where more attention may be needed, the next chapter examines the state of the Philippine health care system.

II. The Health Care System

"*The health care system is a chain. [If] it breaks anywhere, it breaks everywhere.*"
– Gov. Andrew Cuomo

April 2 marked two undesirable milestones in the pandemic: the total number of confirmed cases in the world breached one million, and the global death tally surpassed 50,000 people. On that day, the United States had the highest number of cases at 187,302, and the third highest number of deaths at 3,846.[68]

Meanwhile, Italy had the highest number of deaths at 13,157 and the second highest number of reported cases at 110,574. Spain had the second highest number of deaths at 9,053, and the third highest number of cases at 102,136. By this time, China was reporting only the fourth highest number of cases at 82,724, and the fifth highest death count at 3,327.

In fact, China had just announced on March 28 that it was about to begin the gradual lifting of the lockdown on Wuhan. On that day, the Philippines' DOH apologized for allotting a mere ₱500.00 daily allowance for volunteer health professionals, and announced that only 40% of China's donated test kits were reliable.

[68] WHO, *Coronavirus disease 2019 (COVID-19) Situation Report - 73, available at* https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200402-sitrep-73-covid-19.pdf?sfvrsn=5ae25bc7_2 (April 2, 2020). This is also the source for other countries' statistics cited in this chapter.

On March 29, the DOH retracted its statement on China's test kits, and tragedy struck in the evening when a Lionair airplane conducting a medevac mission crashed at the Ninoy Aquino International Airport, killing all eight passengers including a doctor, a nurse, a medic, and a patient.

A few days later, the new month got off on a chaotic note. April 1 saw some 21 residents of a depressed community in Barangay San Roque, Quezon City take to the streets to demand food and basic necessities from government, but the gathering was dispersed and its participants arrested by the police.

Conflicts within government began to surface. First, the National Bureau of Investigation (NBI) wrote the Mayor of Pasig City, informing him that he was being investigated for a possible violation of the Bayanihan to Heal as One Act. The next day, a Commissioner of the Presidential Anti-Corruption Commission (PACC) requested the NBI to investigate the Vice President as well for allegedly competing with the administration's relief efforts.

One of the many lessons that may be distilled from these gaps between different levels of government is that policymakers should craft sound organizational structures that optimize and institutionalize service delivery to the public, and ensure their continued operating efficiency. In this chapter, we examine how the Philippine health system in particular is organized.

Government Structure

Under the Administrative Code that was enacted soon after the adoption of the Constitution, the DOH was mandated to be "primarily responsible for the formulation,

planning, implementation, and coordination of policies and programs in the field of health."[69] Its primary function was defined as "the promotion, protection, preservation, or restoration of the health of the people through the provision and delivery of health services and through the regulation and encouragement of providers of health goods and services."[70] It was just a matter of a few years, however, before the DOH's mandate was considerably altered by the LGC. The LGC devolved the delivery of health services to LGUs, including the following:

A. Cities were made responsible for hospitals and other tertiary health services, the implementation of programs and projects on primary health care, maternal and child care, and communicable and non-communicable disease control services, access to secondary and tertiary health services, and the purchase of medicines, medical supplier, and equipment;[71]

B. Provinces were made responsible for hospitals and other tertiary health services;[72]

C. Municipalities were made responsible for the implementation of programs and projects on primary health care, maternal and child care, and communicable and non-communicable disease control services, access to secondary and tertiary health

[69] Exec. Order No. 292, Administrative Code of 1987, Title IX, Chapter 1, §2.

[70] *Id.*

[71] *Supra* note 18, §17(b)(4).

[72] *Id.*, §17(b)(3)(iv).

services, and the purchase of medicines, medical supplier, and equipment;[73] and

D. Barangays were made responsible for the maintenance of barangay health centers.[74]

These mandates have led to Cities managing city hospitals, city or urban health centers, and BHSs, Provinces managing provincial, district, and municipal hospitals, Municipalities managing RHUs, municipal health centers (MHCs), and BHSs, and Barangays managing BHSs.[75]

Local health boards were also created for Cities, Provinces, and Municipalities to: (1) propose budgetary allocations to the local legislative body for the operation and maintenance of health facilities, (2) advise the local legislative body on health matters, and (3) create committees which advise local health agencies on technical and administrative matters.[76] The health boards are headed by the local chief executive as Chairman, the local health officer as Vice Chairman, and its members are the chairman of the local legislative body's committee on health, a representative from either the private sector or a non-government organization (NGO) involved in health services, and a DOH representative in the city, province, or municipality as the case may be.[77]

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[73] *Id.*, §17(b)(2)(iii).

[74] *Id.*, §17(b)(1)(ii).

[75] Janet S. Cuenca, *Health Devolution in the Philippines: Lessons and Insights* (Dec. 2018), p. 15, *available at* https://pidswebs.pids.gov.ph/CDN/PUBLICATIONS/pidsdps1836.pdf.

[76] *Supra* note 72, §102(b).

[77] *Id.*, §102(a).

With this change, the DOH's role was redefined. By way of Executive Order (EO), it was designated as the lead agency in: (a) articulating national objectives for health, (b) health emergency preparedness and response services, (c) ensuring equity, access, and quality of health care services, and (d) health and medical research.[78]

Among other responsibilities, it was also assigned to serve as: (a) the direct service provider for specific programs that affect large segments of the population, (b) the technical authority in disease control and prevention, (c) technical oversight agency in charge of monitoring and evaluating the implementation of health policies, and (d) innovator of new strategies for responding to emerging health needs.[79]

Of particular relevance to this article are these three roles that follow, which were also assigned to the DOH in the same EO:

A. Administrator of selected health facilities at subnational levels that act as referral centers for local health systems, including tertiary and special hospitals;

B. Capacity-builder of LGUs, the private sector, and other institutions in implementing health programs and services through technical collaborations, logistical support, and other partnership mechanisms; and

C. Facilitator of the development of health industrial complexes in partnership with the private sector.[80]

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[78] Exec. Order No. 102 (1999), §2.

[79] *Id.*

[80] *Id.*

In sum, LGUs presently act as the health system's first line of service providers, while the DOH acts as policymaker and technical authority, although the DOH may temporarily assume direct supervision and control over any LGU's health operations during any widespread public health danger such as epidemics and pestilence.[81]

It should be noted that the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM) has its own Ministry of Health, and its health system is excluded from the scope of this article owing to its recent transition from the former Autonomous Region in Muslim Mindanao (ARMM) through Republic Act No. 11054[82] and its relative independence from the national health system.

Private Sector Participation

The private sector's collective role in the country's health system in enormous, consisting of clinics, infirmaries, laboratories, hospitals, drugstores, pharmaceutical and medical suppliers, health insurers, academic and research institutions, and other service providers including traditional healers or "herbolarios" and traditional birth attendants or "hilots."[83] For-profit health enterprises are mostly operated by self-employed health professionals and family-owned companies, while not-for-profit health enterprises are commonly run by charitable institutions, faith-based organizations, civil society organizations, and community-

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[81] *Supra* note 72, §105.

[82] The Organic Law for the Bangsamoro Autonomous Region in Muslim Mindanao, which took effect in 2018.

[83] Manuel Dayrit *et al.*, The Philippines Health System Review (2018), p. 21, *available at* https://apps.searo.who.int/PDS_DOCS/B5438.pdf.

based volunteer groups.[84] While the private sector's participation in the health industry is extensive, it is nevertheless fragmented and largely market-driven.[85]

Operationalization at the Local Level

A revolutionary development in the way health care systems are organized around the world is rooted in what is known as the Declaration of Alma-Ata,[86] which was unanimously adopted by all World Health Organization (WHO) member-countries present at the International Conference on Primary Health Care held in the Kazakh Soviet Republic in September 1978.

The Declaration strongly reaffirmed health as a fundamental human right, and that governments have a responsibility for the health of their people.[87] It identified primary health care (PHC) as key to the attainment of health for all.[88] In the years following the Declaration, the District Health System (DHS) model was formulated as an organizational framework for the delivery of PHC through the seamless integration of community-based, primary level and Level 1 Hospital services within a clearly-demarcated geographical area.[89]

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[84] *Id.*

[85] *Id.*, p. 24.

[86] WHO, *Declaration of Alma-Ata*, *available at* https://www.who.int/publications/almaata_declaration_en.pdf.

[87] *Id.,* Declarations I and V.

[88] Audrey R. Chapman, *ALMA-ATA at 40: Revisiting the Declaration*, *available at* https://www.hhrjournal.org/2018/09/alma-ata-at-40-revisiting-the-declaration/#_edn8 (September 10, 2018).

[89] People's Health Movement, *et al.*, Global Health Watch 2005-2006, p. 58 (2005).

In the Philippines, the decentralization of health services delivery in 1991 was partly based on the goal of making PHC accessible at the community level. This devolution of health services has been described by the World Bank as "the most ambitious health decentralization initiative ever undertaken in Asia."[90] It involved the devolution of: (a) more than half of health personnel, or 46,080 individuals out of 78,080, (b) all 12,580 RHUs, MHCs, and BHSs, and (c) almost all hospitals, or 595 out of 639.[91]

The devolved budget was less than half of the total budget, however, at only ₱4.215 billion out of ₱10.227 billion.[92] Nevertheless, this may be correlated with Local Government Code provisions which authorize the national government or the next higher-level LGU to augment or provide the basic services and facilities of an LGU when they are unavailable or inadequate,[93] and which exempt from the devolution mandate such public works and infrastructure projects and other facilities, programs, and services funded by the national government.[94]

In the 20 years that followed the massive devolution of health services, two mechanisms were created by the national government to operationalize the delivery of quality health care at the local level: Inter-Local Health Zones (ILHZs), which were created in 2000, and Service Delivery Networks (SDNS), which were mandated in 2012. The ILHZ system is considered

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[90] Janet S. Cuenca, *Health Devolution in the Philippines: Lessons and Insights*, p. 5, https://pidswebs.pids.gov.ph/CDN/PUBLICATIONS/pidsdps1836.pdf (December 2018).

[91] *Id.*, p. 4.

[92] *Id.*

[93] *Id.*, §17(f).

[94] *Id.*, §17(c).

as an adaptation of the DHS concept to the devolved setting in the Philippines,[95] and SDNs may be similarly considered such.

A. *Inter-Local Health Zones*

Partly in order to address the country's fragmented health services following devolution, the DOH launched the HSRA in 1999, with ILHZs as the basic framework.[96] ILHZs were formally established by way of Executive Order No. 205, s. 2000, for the effective delivery of integrated health care and to ensure smooth coordination among LGUs.[97] They comprise a well-defined population in a rural or urban area, and all institutions and sectors whose activities contribute to improved health care delivery in that zone.[98]

The DOH defines ILHZs as "[a]ny form of organized arrangement for coordinating the operations of an array and hierarchy of health providers and facilities serving a common population within a local geographic area under the jurisdictions of more than one local government."[99] Their key operating elements are supposed to be: (a) primary

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[95] *Supra* note 91, p. 16.

[96] Jhpiego Philippines, Guide in Establishing a Functional Service Delivery Network (SDN) for MNCHN-FP Services, p. 13, *available at* https://www.doh.gov.ph/sites/default/files/basic-page/Updated_SDN Guide_final.pdf (2016).

[97] *Id*, §5.

[98] *Id.*

[99] DOH Adm. Order No. 2006-0017, Part V.2 (2006).

health care providers, (b) core referral hospitals, and (c) end referral hospitals.[100]

Described otherwise, an ILHZ is a clustering of contiguous LGUs with a core referral hospital wherein preventive primary public health care is integrated with hospital care.[101] It is a district health system in a devolved set-up in which the component LGUs cooperate in health operations to better protect the collective health of the catchment community, assure access of individuals in the catchment community to a range of services necessary to meet their health care needs, and to manage more efficiently and equitably the cooperating LGUs' health resources.[102]

In practice, an ILHZ is usually composed of one core referral hospital, catchment RHUs, and BHSs.[103] There is no readily-available recent data on how ILHZs have performed to this point, but as of February 2010, the DOH counted only 312 ILHZs in the entire Philippines.[104] One likely explanation of why there is a low number of ILHZs is that they are voluntary in nature,[105] whereby DOH merely encourages LGUs to be part of one or more ILHZs.[106]

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[100] *Id.*

[101] DOH, *What is an ILSZ?*, *available at* https://www.doh.gov.ph/faqs/What-is-an-ILHZ.

[102] *Id.*

[103] *Supra* note 97.

[104] DOH, *What is the number of ILHZs/Province?*, *available at* https://www.doh.gov.ph/faqs/What-is-the-number-of-ILHZs/province

[105] DOH Adm. Order No. 2006-0017, Part VI.B.1 (2006).

[106] *Id.*, Part VI.F.

B. *Service Delivery Networks*

SDNs were first defined by the DOH in 2010 as health service delivery structures composed of a network of health service providers at different levels of care, which may be as small as an ILHZ or as large as a regional SDN where the regional hospital serves as the end referral hospital.[107]

Following the adoption of the Implementing Rules and Regulations (IRRs) of the Sin Tax Law and of the Reproductive Health Law in 2013, both of which required the operation of SDNs, the DOH issued Administrative Order (AO) No. 2014-0046 in 2014, describing SDNs as "the network of health facilities and providers within the province or city-wide health systems, offering a core package of health care services in an integrated and coordinated manner similar to the local health referral system."[108]

SDNs may be initiated or composed of public and private hospitals and health facilities, and should ensure access to quality health care for every family within its area for: (a) population health interventions, PHC, and primary care, (b) emergency and medical/surgical intervention in general hospitals, and (c) referral links to specialty hospitals and other health facilities.[109]

In the Philippine Health Agenda 2016-2022, SDNs were affirmed as one of the three guarantees of the

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[107] DOH Adm. Order No. 2010-0036, Part IV.13 (2010).

[108] *Id.*, Part V.A.1.

[109] DOH Adm. Order No. 2014-0046, Parts V.A. 3 and V.A.2 (2014).

health system, under the title "Access to health interventions through functional Service Delivery Networks (SDNs)."[110] The DOH also issued Administrative Order No. 2017-0004, which provided a framework to redefine SDNs as well as guidelines to organize them.

There is no policy direction towards replacing ILHZs with SDNs – in fact, as recently as June 2017, city and municipal officials from the Province of Cebu expressed their intention to revive their ILHZs[111] – but considering that SDNs are mandated by the IRRs of two major statutes while ILHZs are voluntary in nature, it may be reasonable to expect that SDNs will be more prevalent in the coming years. At any rate, the successful experiences of functional ILHZs were seen to benefit SDNs which were still to be established.[112]

The success of SDNs is reliant on functioning referral systems.[113] In a 2015 study of SDNs across 21 provinces within Luzon, however, it was determined that only 20% had written referral agreements and arrangements among the service delivery facilities involved, while 80% had none at

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[110] DOH Adm. Order No. 2016-0038, Part IV.C.2 (2016).

[111] Metro Cebu News, *LGU Execs Support Revival of Inter-Local Health Zones (ILHZ)*, *available at* https://metrocebu.news/2017/06/lgu-execs-support-revival-of-inter-local-health-zones-ilhz/ (June 7, 2017).

[112] Jhpiego Philippines, Guide in Establishing a Functional Service Delivery Network (SDN) for MNCHN-FP Services, p. 13, https://www.doh.gov.ph/sites/default/files/basic-page/Updated_SDN Guide_final.pdf (2016).

[113] RTI International, Strengthening the Referral Mechanism in a Service Delivery Network, p. 2, https://www.doh.gov.ph/sites/default/files/basic-page/Strengthening%20the%20Referral%20Mechanism%20in%20a%20Service%20Delivery%20Network.pdf (2018).

all.[114] In the next section, we examine how referral systems work and how they may be improved.

The Referral System

Referral is a process in which a health worker at one level of the health system, having insufficient resources to manage a clinical condition, seeks the assistance of a better-resourced facility at the same or higher level to assist in or take over the management of the patient's case.[115] In order to optimize the process, relationships between health service providers within a network should be formalized and referral procedures should be agreed upon.[116] It goes without saying that all levels of the health system should function appropriately, and should have suitable means of communication and transportation between each other.[117]

These levels of the modern health system are universally organized into primary, secondary, and tertiary care. These classifications are rooted in the so-called "Lord Dawson Report," which was a seminal British Ministry of Health report prepared by Sir Bertrand Dawson in 1920 entitled "Interim Report on the Future Provision of Medical and Allied Services."[118] Though medical science has advanced by leaps and bounds since the Lord Dawson Report was

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[114] *Id.*

[115] WHO, *Referral Systems - A summary of key processes to guide health service managers*, p.2, *available at* https://www.who.int/management/facility/referral/en/

[116] *Id.*, p. 3.

[117] *Id.*

[118] Bertrand Dawson, *Interim Report on the Future Provision of Medical and Allied Services*, *available at* http://www.nhshistory.net/Dawson%20report.html (1920).

presented to the British Parliament a full century ago, its recommendations have withstood the test of time, as seen in the comparative table below:

Lord Dawson Report Recommendations	*Contemporary Health Systems*
Creation of Primary Health Centres, staffed mainly by general practitioners, to provide domiciliary services per district.	Primary care is the first level of contact of individuals and families with the national health system, bringing health care as close as possible to where people live and work.[119]
Towns to have adequately-equipped Secondary Health Centres, staffed mainly by consultants and specialists, to which cases of difficulty or cases requiring special treatment would be referred by Primary Health Centres.	Secondary care is made up of specialized ambulatory and hospital services involving procedures of medium-level complexity between primary and tertiary care, and includes specialized medical services, diagnostic or therapeutic support services, and emergency services.[120]

[119] R. Thomas-MacLean, *et al.*, "*No Cookie Cutter Response" Conceptualizing Primary Health Care*, p. 2, *available at* https://www.uwo.ca/fammed/csfm/tutor-phc/documentation/training papers/TUTOR_Definitio_%20of_primar_%20health_care.pdf (2002).

[120] Alacoque Lorenzini Erdmann, *et al.*, *Secondary Health Care: best practices in the health services network,* 21 Rev. Latino-Am. de Enfermagem, *available at* http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-11692013000700017 (2013).

Lord Dawson Report Recommendations	*Contemporary Health Systems*
Secondary Health Centres to be merged with Teaching Hospitals in towns where the latter existed, and specially-staffed Supplementary Services to be established across wide areas to treat patients suffering from conditions such as tuberculosis and certain infectious diseases.	Tertiary care, which has long been in practice but was only integrated into the US National Library of Medicine's Medical Subject Headings Thesaurus in 2013, is defined there as "care of a highly technical and specialized nature, provided in a medical center, usually one affiliated with a university, for patients with unusually severe, complex, or uncommon health problems."[121]

In the Philippines, access to the three levels of quality health care is secured through health facilities as classified below:[122]

Primary Care	*Secondary Care*	*Tertiary Care*
• BHSs • RHUs	• Municipal Hospitals	• Provincial Hospitals

[121] Ken Flegel, *Tertiary hospitals must provide general care*, 187(4) CMAJ, *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4347764/ (2015).

[122] Albert Francis E. Domingo, *Medical Governance, Health Policy, and Health Sector Reform in the Philippines: An Overview of Key Concepts and Present Trends*, *available at* https://www.slideshare.net/aedomingo/medical-governance-and-health-policy-in-the-philippines (2013), and Paolo Victor Medina, *The District Health System in the Philippines*, *available at* https://www.slideshare.net/lopaoMD/the-district-health-system-in-the-philippines (2015).

Primary Care	*Secondary Care*	*Tertiary Care*
• MHCs • UHCs • Lying-In Clinics/ Birthing Homes	• City Hospitals • District Hospitals • Comprehensive Emergency Obstetric and Neonatal Care Centers	• Regional Hospitals

As will be observed, primary care facilities exclude hospitals, which provide secondary and tertiary health care under this system.

Hospital Hierarchies

Hospitals and other health facilities in the Philippines are classified by the DOH, and the current classifications are set forth in its AO No. 2012-0012, s. 2012, as amended by AO No. 2012-0012-A, s. 2015. Under the AO, hospitals may be distinguished by ownership, i.e. government or private, and by scope of services, i.e. general or specialty.

Briefly, a government hospital is created by law, while a private hospital is owned, established, and operated with private funds.[123] Meanwhile, a general hospital provides services for all kinds of illnesses, diseases, injuries, or deformities, in the form of medical and surgical care to the sick and injured, maternity care, newborn care, and child care, and a specialty hospital specializes in a particular disease or condition or in one type of patient only.[124] This

[123] *Id.*, §V.B.1.a.

[124] *Id.*, §V.B.1.b.

article's primary interest is in privately-owned general hospitals.

At the minimum, all general hospitals must be equipped with the service capabilities needed to support board certified/eligible medical specialists and other licenses physicians rendering services in:

A. Clinical Services (family medicine, pediatrics, internal medicine, obstetrics and gynecology, and surgery);

B. Emergency Services;

C. Out-Patient Services; and

D. Ancillary and Support Services (e.g. clinical laboratory, imaging facility, and pharmacy).[125]

General hospitals are classified as either Level 1, Level 2, or Level 3, based on the following minimum requirements:[126]

A. Level 1 Hospitals must have:

    1. A staff of qualified medical, allied medical, and administrative personnel headed by a licensed physician,
    2. Bed space for its authorized bed capacity in accordance with DOH guidelines,
    3. An operating room with standard equipment and provision for sterilization of equipment and supplies in accordance with DOH requirements,
    4. A post-operative recovery room,

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[125] *Id.*, §V.B.1.b.1.

[126] *Id.*, §V.B.1.c.1.

5. Maternity facilities, consisting of ward(s), room(s), a delivery room, exclusively for maternity patients and newborns,
6. Isolation facilities with proper procedures for the care and control of infectious and communicable diseases as well as for the prevention of cross-infections,
7. A separate dental section/clinic,
8. Provision for blood station,
9. A DOH-licensed secondary clinical laboratory with the services of a consulting pathologist,
10. A DOH-licensed level 1 imaging facility with the services of a consulting radiologist, and
11. A DOH-licensed pharmacy.

B. Level 2 Hospitals must have:

1. All of a Level 1 Hospital's requirements,
2. An organized staff of qualified and competent personnel with Chief of Hospital/Medical Director and appropriate board-certified Clinical Department Heads,
3. Departmentalized clinical services equipped with the service capabilities needed to support board-certified/eligible medical specialists and other licenses physicians rendering services in the specialties of medicine, pediatrics, obstetrics and gynecology, surgery, their subspecialties, and ancillary services,
4. Provision for general Intensive Care Unit (ICU) for critically-ill patients,
5. Provision for Neonatal ICU (NICU),
6. Provision for High-Risk Pregnancy Unit (HRPU),
7. Provision for respiratory therapy services,
8. A DOH-licensed tertiary clinical laboratory, and
9. A DOH-licensed level 2 imaging facility with mobile x-ray inside the institution with capability for contrast examinations.

C. Level 3 Hospitals must have:

a. All of a Level 1 and a Level 2 Hospital's requirements,
b. Teaching and/or training hospital services with at least any two accredited residency training programs for physicians in any medical/surgical specialty and/or subspecialty,
c. Provision for Physical Medicine and Rehabilitation Unit,
d. Provision for ambulatory surgical clinic (ASC), and
e. Provision for either a hemodialysis facility, a peritoneal facility, or both,
f. Provision for blood bank,
g. A DOH-licensed tertiary clinical laboratory with standard equipment/reagents/supplies necessary for the performance of histopathology examinations, and
h. A DOH-licensed level 3 imaging facility with interventional radiology.

As of 2018, 64% of the 1,224 DOH-licensed hospitals were Level 1 hospitals with an average bed size of 41, 26% were Level 2 hospitals with an average bed size of 97 beds, and only 10% were Level 3 hospitals with an average bed size of 318 beds.[127]

Synthesis

The massive devolution of health services in the Philippines in the early 1990s was intended to ensure the delivery of PHC at the community level in line with the Declaration of Alma-Ata, but the manner in which it was implemented broke down the referral system that was in

[127] Manuel Dayrit *et al.*, *The Philippines Health System Review*, p. 134, *available at* https://apps.searo.who.int/PDS_DOCS/B5438.pdf (2018).

place prior to the pre-devolution period,[128] and it unwittingly fragmented public health service delivery in the country.[129]

In that sense, devolution broke the chain of the health care system: because administrative control over primary care (mainly through municipalities and barangays) was made separate from administrative control over secondary and tertiary care (mainly through provinces and cities), the limited jurisdiction between LGUs deterred the operation of the referral system.[130]

We see how government has attempted to address this fragmentation through the establishment of ILHZs and SDNs, wherein LGUs are sought to consolidate their health service providers into functioning networks that provide all levels of care to their respective catchment populations, but there appears to be a long way to go before these efforts reach fruition. This is partly because ILHZs[131] and SDNs[132] are required to have end-referral or Level 3 hospitals, and data shows that there are only around 125 Level 3 hospitals in the entire Philippines—equivalent to a dismal ratio of one Level 3 hospital to every 880,000 Filipinos.

Fortunately, this lack of apex hospitals in an archipelagic country—whose geographical terrain presents inland logistical challenges as well—may be directly addressed by LGUs pursuant to the devolution principle. In

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[128] Janet S. Cuenca, *Health Devolution in the Philippines: Lessons and Insights*, p. 15, *available at* https://pidswebs.pids.gov.ph/CDN/PUBLICATIONS/pidsdps1836.pdf (December 2018)

[129] *Id.*, p. 16.

[130] *Id.*, p. 15.

[131] DOH Adm. Order No. 2006-0017, Part V.2 (2006).

[132] DOH Adm. Order No. 2014-0046, Part V.A.2 (2014).

the next chapter, we look at mechanisms through which LGUs may establish their own Level 3 hospitals, despite the lack of resources.

III. SUBNATIONAL PPPS IN THE PHILIPPINES

"*It is at the local…level where we are most likely to innovate and implement new health care delivery solutions.*"
– Clinton Foundation

Midway through the 2020 Holy Week, on April 8, the United States reported 363,321 confirmed COVID-19 cases—much more than the combined total of Spain and Italy, which had the second and third highest number of cases at 140,510 and 135,586, respectively.[133] Germany had surged to fourth highest with 103,228 cases, passing fifth-place China which reported only 83,157.

In terms of deaths, Italy still topped the list with 17,129, followed by Spain with 13,798, the United States with 10,845, China with 3,342, and Germany with the impressively low number of 1,861.

A bevy of developments unfolded in the days leading up to Holy Wednesday. On April 3, the Philippine Food and Drug Administration (FDA) announced its approval of the first locally-manufactured COVID-19 test kits developed by

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[133] WHO, Coronavirus disease 2019 (COVID-19) Situation Report – 79, *available at* https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200408-sitrep-79-covid-19.pdf?sfvrsn=4796b143_6 (April 8, 2020). This is also the source for other countries' statistics cited in this chapter.

Manila HealthTek, Inc., President Lee Hsien Loong announced that schools and places of work in Singapore would be closed beginning the following week, and President Rodrigo Duterte defended Vice President Leni Robredo's relief efforts, in the process firing the PACC Commissioner who sought her to be investigated by the NBI.

A 12-person team of medical experts from China arrived in Manila on Palm Sunday to assist the Philippine government in fighting the disease. The following day, April 6th, United Kingdom (UK) Prime Minister Boris Johnson was moved to the ICU of St. Thomas' Hospital in Central London as his COVID-19 infection took a turn for the worse, while DOH Secretary Francisco Duque III gave the green light to the Philippine International Convention Center, the World Trade Center, and the Rizal Memorial Coliseum, all of which had just been converted into COVID-19 facilities, cumulatively increasing Metro Manila's bed capacity by 908.

On April 7, Singapore's offices were closed one day before its schools would be shut down, Cabinet Secretary Karlo Nograles confirmed that the Luzon ECQ had been extended to April 30 after President Duterte raised the possibility in a late night address to the nation the evening before, and Manila HealthTek transferred one of its polymerase chain reaction (PCR) machines to Marikina City's COVID-19 testing center.

This cooperation between Manila HealthTek and Marikina captures the essence of this chapter. In the previous months, Manila HealthTek developed the innovative GenAmplify COVID-19 rRT PCR Detection Kit in partnership with two national government offices: the National Institute of Health (UP-NIH) and the Philippine Genome Center, both under the University of the Philippines. This time, it was teaming up with an LGU: Marikina provided space for mass

production of the GenAmplify test kits, and Manila HealthTek transferred some laboratory equipment to the site to manufacture test kits that the City would use for its constituents for free.

In this chapter, we briefly discuss the subnational PPP industry in the Philippines, including the types of projects that LGUs may pursue under this mechanism.

Legal Framework for Subnational PPPs

The contemporary iteration of PPPs was first infused into the Philippines in October 1990, when the BOT Law[134] took effect. This early piece of PPP legislation allowed infrastructure agencies, including government owned- and controlled-corporations (GOCCs) and LGUs, to implement infrastructure projects, and permitted only two types of contractual arrangements: the build-operate-and-transfer (BOT) and build-transfer (BT) schemes.

Four years later, in the midst of a legal controversy concerning the build-lease-transfer (BLT) arrangement used for what would eventually become the Metro Rail Transit Line 3 (MRT-3) system on EDSA, the BOT Law was revised[135] to include seven additional schemes including the BLT arrangement, plus any other variant of the BOT scheme approved by the President. The revision also introduced the unsolicited proposal process, and expanded the scope to include development projects in addition to infrastructure projects.

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[134] Rep. Act No. 6957, Built Operate Transfer Law of 1990.

[135] Rep. Act No. 7718, An Act Amending Built Operate Transfer Law of 1990.

The BOT Law's Implementing Rules and Regulations (IRR) requires LGU projects to be approved by the following bodies: (a) the municipal development council, for projects costing ₱20 million and below, (b) the provincial development council, for projects costing more than ₱20 million up to ₱50 million, (c) the city development council, for projects costing ₱50 million and below, (d) the regional development council, for projects costing more than ₱50 million up to ₱200 million, and (e) the National Economic and Development Authority's (NEDA) Investment Coordination Committee (ICC), for projects costing more than ₱200 million.[136]

Only one subnational or LGU PPP project was implemented under the BOT Law prior to its revision in May of 1994: a seven-story combined public market and shopping mall-type commercial complex in Mandaluyong City using a BT scheme for the public market component, which was later transferred to the LGU at no cost to the latter, and a 40-year BOT scheme for the commercial component, from which the private investor would recover its investment in the entire project.[137]

Apart from the BOT Law, the other option available to LGUs to implement PPPs is the enactment of a PPP or a Joint Venture (JV) Code in the form of a local ordinance. This may be done in the furtherance of an LGU's power to enter into contracts under the Local Government Code,[138] specifically including its right to enter into: (a) contracts for the financing, construction, operation, and maintenance of any

[136] *Id.*, 2.6.b.

[137] Asian Development Bank (ADB), Philippines: Public-Private Partnerships by Local Government Units, p. 4, *available at* https://www.adb.org/sites/default/files/publication/213606/philippines-ppp-lgus.pdf (2016).

[138] *Supra* note 136, §22(a)(5).

financially-viable infrastructure facility under BOT arrangements,[139] and (b) joint ventures with people's and non-government organizations,[140] as well as the private sector,[141] and to make them active partners in the delivery of basic services and the enhancement of the economic and social well-being of the people. LGUs also enjoy full autonomy in the exercise of their proprietary functions and in the management of their economic enterprises, subject to limitations in applicable laws.[142]

Affirming this authority of LGUs, the Department of Justice (DOJ) issued Opinion No. 18, s. 2012, wherein it stated that LGUs may enact their own PPP Codes. The Department of Interior and Local Government (DILG) later reinforced this view of the DOJ through Legal Opinion No. 10, s. 2014. In September 2016, the DILG circulated a draft PPP Code among LGUs,[143] versions of which have since then been adopted by many provinces, cities, and municipalities across the country. Recently, in December 2019, the DILG and the PPP Center jointly circulated a draft JV Code to LGUs.[144]

Much earlier than when the draft PPP and JV Codes were circulated, however, several LGUs already had functioning Codes. Cebu City enacted its JV Ordinance in September 2008[145] and has used it for projects such as real estate development, while Manila passed its JV Code in May

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[139] *Id.*, §302.

[140] *Id.*, §35.

[141] Adm. Order No. 270, Rule XIII, sec. 62. This order is the Implementing Rules and Regulations of the Local Government Code.

[142] *Supra* note 18, §22(d).

[143] DILG Mem. Circular No. 2016-120 (2016).

[144] DILG-PPPC Joint Mem. Circular No. 2019-01 (2019).

[145] Cebu City Ordinance No. 2154 (Sept. 17, 2008).

2014[146] and has availed of it for projects such as public market upgrading and management. The Province of Cavite adopted its PPP Code in 2012,[147] while Makati City,[148] Quezon City,[149] and Pasay City[150] adopted their PPP Codes in 2014.

Typically, these LGU PPP and JV Codes contain features similar to the BOT Law and the 2013 NEDA JV Guidelines, such as risk allocation between the public and private parties, investment recovery mechanisms, procurement procedures, and the acceptance of unsolicited proposals. For as long as they do not violate statutes such as the BOT Law and the Procurement Law,[151] LGUs are free to adopt their own PPP and JV ordinances.

LGU PPP Projects

The BOT Law and the typical PPP or JV Code allow the government instrumentalities concerned to pursue a comprehensive set of infrastructure and development projects.

Both the BOT Law[152] and the draft JV Code[153] have the same non-exclusive enumeration of eligible projects, including the following:

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[146] City of Manila Ordinance No. 8346 (May 6, 2014).

[147] Province of Cavite Ordinance No. 002-s-2012 (2012)

[148] Makati City Ordinance No. 2014-051, as amended (2014)

[149] Quezon City Ordinance No. SP-2336, s. 2014 (Aug. 11, 2014)

[150] Pasay City Ordinance No. 5611, s. 2014, as amended (Jan. 13, 2014)

[151] Rep. Act No 9184, Government Procurement Act of 2003.

[152] *Id.*, §2(a).

[153] *Id.*, §6.

Industry	*Eligible projects*
Energy	Power plants, hydropower
Transportation	Highways, ports, airports, railroads, railways, transport systems
Water	Water supply, sewerage
Technology	Telecommunications, information technology (IT) networks, database infrastructure
Land/Property Development	Land reclamation, industrial estates, townships, markets, slaughterhouses, warehouses
Tourism	Tourism projects
Social and Civic	Housing, education facilities, health facilities
Agricultural	Irrigation
Environmental	Solid waste management
Public Works	Highways, canals, dams, government buildings, drainage, dredging

The draft PPP Code,[154] on the other hand, lists its eligible projects in an open-ended and yet unnecessarily detailed fashion:

Industry	*Eligible projects*
Energy	Energy and power, renewable energy, waste-to-energy, hydropower

[154] *Id.*, §8.

Industry	*Eligible projects*
Transportation	Ports, wharfs, terminals, airports, community airports, railroad and railways, short-haul transit services such as monorail, guided bus, bus services and trams, intermodal and multi-modal transit systems, transport systems, traffic control and management, parking facilities
Water	Water supply and distribution, sewerage
Technology	Telecommunications, information technology networks and database infrastructure
Land/Property Development	Reclamation, platform settlements, industrial estates or townships, central business and industrial park development, hotels and resorts, residential subdivisions, commercial buildings, storage buildings, public markets, slaughterhouses, warehouses
Tourism	Tourism such as eco-tourism, wellness tourism, and agri/ agro-tourism
Social and Civic	Socialized housing, non-conventional low-cost housing, settlement/resettlement and relocation facilities, parks and open space development/ redevelopment, pocket parks, public art, libraries, heritage conservation, sports facilities, wellness establishments, meeting and convention centers, education-related, classrooms, health facilities, hospitals, social services-related, prisons

Industry	*Eligible projects*
Agricultural	Irrigation, cold storage, agriculture-related, post-harvest facilities
Environmental	Water conservation such as impoundment areas and rainwater harvesting, sustainable/ green public buildings, solid waste management, sanitary landfills, environmental management and protection, climate change adaption, disaster risk reduction
Public Works	Roads, bridges, causeways, waterways, highways, canals, dams, desilting, dredging, drainage, government buildings
Natural Resources	Mining and exploration

Subnational PPP projects have grown significantly in number, sector, and ticket size since 1991, when Mandaluyong City started with its relatively modest seven-story commercial building. A selection of more recent subnational PPPs is provided below, to briefly illustrate the variety of projects that have since become possible because of the foregoing developments:

Project	*LGU*	*Est. Project Cost*	*Legal Basis*	*Scheme*
Sangley Point International Airport	Province	₱550 B	PPP Code	JV
Pasay City 265-Ha. Reclamation	City	₱60 B	PPP Code	JV

Project	*LGU*	*Est. Project Cost*	*Legal Basis*	*Scheme*
Cebu-Cordova Link Expressway	City and Municipality	₱27 B	JV Code and PPP Code	JV
Quezon City Integrated Solid Waste Management Facility	City	₱22 B	PPP Code	JV
Tanauan City Public Market Redevelopment	City	₱400 M	BOT Law	DBTO
Primark Town Center – Rosario, Cavite	Municipality	₱220 M	PPP Code	Lease
Baggao Water Supply	Municipality	₱84 M	BOT Law	BOT
Pampanga GIS Center	Province	₱49.99 M	BOT Law	BTO

From the eight selected projects above, a diverse portfolio may be seen: there are three land/property development projects (reclamation, town center, and public market), two transportation projects (toll bridge and airport), an environmental project (solid waste management), a technology project (database infrastructure), and a water project (water supply). Provinces, cities, and municipalities are all represented, and contractual arrangements include

BOT/BOT Variants, JVs, and a Lease. In terms of ticket size, the project costs range from as low as ₱49.99 million to as high as ₱550 billion.

Synthesis

For almost 30 years, LGUs have had sufficient bases in law in order to fulfill their infrastructure and development responsibilities to their constituents via PPP arrangements. The BOT Law is one avenue, and local legislation in the form of a PPP and/or JV Code pursuant to the Local Government Code is another.

Although data on subnational PPP contracts is grossly deficient, two notable observations may be drawn from available information. The first is that the original wave of subnational PPPs from the 1990s to the early 2000s were mostly for smaller-scale projects under the BOT Law. But once local legislative bodies began enacting PPP and JV Codes from 2008 to present, LGUs have clearly shifted towards JV arrangements and have diversified into more capital-intensive sectors with ticket sizes well into the billions of pesos, rivalling infrastructure projects of the national government.

The second point is that no LGU, so far as available resources reveal, has implemented a health sector PPP project. There was a proposed ₱60-million Bicol Regional Training and Teaching Hospital-Oncology Center BOT project in Albay in 2011, but it appears to have never been awarded.[155]

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[155] ADB, Philippines: Public-Private Partnerships by Local Government Units, p. 39, *available at* https://www.adb.org/sites/default/files/publication/213606/philippines-ppp-lgus.pdf (2016).

Considering that LGUs currently have the appetite for big-ticket PPP projects, and that public health has been thrust to the top of the country's priorities as of this writing, it appears timely for subnational hospital PPPs to be seriously considered by LGUs. For context, the disparity in the distribution of hospitals in the country is troubling: 13.3% are located in NCR, and 51.2% are in the balance of Luzon.[156] Together, that is almost two-thirds of all hospitals in the country. Only 21.8% are situated in Mindanao, and a measly 13.6% are scattered across the Visayas—almost the same number as in contiguous NCR.[157]

If there is any area where subnational PPPs are needed right now, it would be in the health care sector. In the next chapter, we study the experiences that various countries have had in pursuing PPPs in health.

IV. PPPs in Health Around the World

"*Hospitals are… never intended at all even to take in the whole sick population.*"
– Florence Nightingale

During his April 13 address to the nation, President Duterte brought nationwide attention to the death of a 65-year old man from Nueva Ecija who reportedly passed away at home after no less than six hospitals had refused to admit him despite his breathing difficulties. The President warned

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[156] Manuel Dayrit *et al.*, The Philippines Health System Review, p. 127, *available at* https://apps.searo.who.int/PDS_DOCS/B5438.pdf (2018).

[157] *Id.*

officers of those hospitals that they would be prosecuted by the DOJ if the report would turn out to be true.

Earlier that day, a news article quoted Presidential Adviser for Flagship Programs and Projects Vince Dizon, saying that the administration would have to "reassess available sources of financing toward the COVID-19 response as well as long-term health care infrastructure"[158] since the disease would persist for some time. Indeed, as the global COVID-19 crisis drew longer, the need to finance and improve hospitals became more and more apparent.

On April 10, the world's COVID-19 death count had breached the 100,000 mark. By April 14, the United States was atop COVID-19 lists, reporting 553,822 confirmed cases and 21,972 deaths respectively.[159] For second through fourth places: Spain, Italy, and Germany placed in that order in terms of number of cases, while Italy, Spain, and France was the order insofar as fatalities were concerned. China's reported statistics had barely changed, remaining in the 83,000 and 3,00 ranges respectively.

On the same date, Taiwan reported no new cases for the first time in over a month, India and France announced that their lockdown measures would extend into May, Italy reopened shops selling books, children's clothing, and stationery, and it was the second consecutive day that around

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[158] Philippine Daily Inquirer, *Gov't to revamp 'Build, Build, Build', available at* https://business.inquirer.net/294578/govt-to-revamp-build-build-build (Apr. 13, 2020).

[159] WHO, Coronavirus disease 2019 (COVID-19) Situation Report - 85, *available at* https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200414-sitrep-85-covid-19.pdf?sfvrsn=7b8629bb_2 (Apr. 14, 2020). This is also the source for other countries' statistics cited in this chapter.

300,000 non-essential workers in Spain's Madrid region were allowed to report for work since their lockdown began.

In the Philippines, the tail-end of the Holy Week brought concerning incidents. On Good Friday, a model LGU had its almost two-week spotless streak broken: Baguio had recorded its first new COVID-19 case since March 28. On the same day, five Caloocan City barangay officials engaged in illegal cockfighting operations inside the Manila North Cemetery. They surrendered the next day, after both Mayors of Caloocan and Manila threatened to initiate manhunt operations against them.

Positive developments followed, bringing a glimmer of hope. One after the other, LGUs that had garnered much praise in their handling of the crisis began announcing that they were ready to do mass testing within their jurisdictions. Valenzuela City did so on April 11, Pasig City and the Province of Cavite made their announcements on April 12, and the City of Manila followed suit on April 13.

While LGUs had taken charge of these frontline operations against the disease, the national government was mapping out the longer-term plans for the country. In this chapter, we study various health sector PPP projects from around the world to determine how LGUs may continue playing a significant role in the long-term, specifically by developing their own health care infrastructure.

PPPs in Health

In a very broad sense, PPPs in the health sector may be classified into two types: hospital PPPs and health program

PPPs.[160] Hospital PPPs have been used to address the public sector's need for infrastructure, facilities, and equipment, while health-program PPPs exist in activities such as research and development, public advocacy, and quality assurance.[161] This article focuses on the first category, as the latter activities are better suited for partnerships with multilateral and donor organizations.

Hospital PPPs are also generally classified into two types of contractual arrangements:

A. The Private Finance Initiative or PFI model, which is a design-build-finance-operate (DBFO) arrangement. Under this structure, the private partner (1) constructs, rehabilitates, or expands the facility, (2) maintains the facility, and (3) provides non-core (clinical support and/or non-clinical) services, in exchange for fixed annual availability payments from government. Core (clinical) services are not transferred to the private partner, as they are retained by the public sector. This is also sometimes referred to as a DBFO, DBFM, or PPP structure; and

B. The Concession model, whereby all components are transferred by government to the private partner, including construction, financing, management, operation, maintenance, and the provision of core and non-core services. The private partner recoups its investment directly from patients and customers by

[160] Geoffrey Hamilton, *et al.*, Draft Discussion Paper, A Preliminary Reflection on the Best Practice in PPP in Healthcare Sector: A Review of Different PPP Case Studies and Experiences, p. 7, *available at* https://www.unece.org/fileadmin/DAM/ceci/images/ICoE/PPPHealthcareSector_DiscPaper.pdf (2012).

[161] *Id.*

imposing user fees and other charges, and engaging in commercial services. This is also sometimes referred to as a Franchising structure.

All hospital PPPs would fall under one category or other, but there are many different permutations around the world. Australia alone, which pioneered the PFI model,[162] has a diverse range with differing versions in several of its states.[163]

Some are clear where they fall, such as Canada's DBFM model, which has earned a reputation for on-time on-budget project delivery, good value-for-money (VfM) results, and innovation due to its output-based specifications.[164] Others are more ambiguous, such as in Andhra Pradesh, India, where the private partner provides clinical services directly to patients in 11 hemodialysis centers that it established,[165] but its revenue stream is in the form of payments from the state government for each performed dialysis.[166]

It may be noted that India also has Concession model PPPs, which is more of a private hospital on public land, where a certain number of beds are allocated for publicly-funded patients and the rest may be utilized for private patients.[167]

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[162] World Bank PPP Legal Resource Center, PPP in Health, *available at* https://ppp.worldbank.org/public-private-partnership/ppp-health.

[163] Martin McKee, *et al.*, *Public-private partnerships for hospitals*, 84 (11) Bulletin of the World Health Organization, p. 891, *available at* https://www.who.int/bulletin/volumes/84/11/06-030015.pdf (2006).

[164] *Supra* note 161, p. 9-10.

[165] *Supra* note 163.

[166] *Supra* note 164.

[167] *Supra* note 163.

Case Studies

In this section, we examine three countries with pioneering hospital PPP experience as case studies to dissect the details of various arrangements that have been tested in their jurisdictions.

A. *United Kingdom*

Model	*PFI*
Private Side	Design, build, finance, operate, non-core services
Public Side	Payment of annual fee, core services
Revenue Stream	Unitary charge
Contract Period	25 to 30 years, in general

Background

There can be no serious discussion about hospital PPPs without mention of the UK. Although both Australia and the UK had been developing the PFI model since the early 1990s, it was the latter that took the model in 1997[168] and launched it in its health sector in a sweeping manner: in a span of 12 years, approximately 100 new hospitals were built.[169] So revolutionary was the country's use of this

[168] EU, Health and Economics Analysis for an Evaluation of the Public Private Partnerships in Health Care Delivery across EU, p. 29, *available at* https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/ppp_finalreport_annexes_en.pdf (2013).

[169] *Supra* note 180, at 12.

new contractual arrangement that the term "PFI model" is universally understood to refer to the UK structure.

PFIs were first announced in the UK through the country's November 1992 budget statement, referring them as "ways to increase the scope for private financing of capital projects," and they rapidly expanded beginning in 1997.[170] The model was particularly popular for hospitals since, on the one hand, the UK had vastly underinvested in its National Health Service (NHS) hospitals, many of which were built in the late 1800s,[171] and on the other hand, the government had a target for public sector borrowing[172] which effectively capped its access to financing for capital intensive projects.

A PFI's defining characteristic is the use of project finance by tapping private sector debt and equity, underwritten by government.[173] PFIs thus enabled the UK government to do off-balance sheet financing, as these investments did not appear in government books as new borrowings.[174]

Project Structure

UK's typical hospital PFI model involves a 25- to 30-year contract awarded by a local body, wherein private funding is tapped to design, build, and operate the structure, as well as to provide non-core services such as

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[170] *Supra* note 169.

[171] *Supra* note 170.

[172] *Supra* note 170.

[173] *Supra* note 169.

[174] *Supra* note 164.

cleaning and catering.[175] The NHS would provide the core medical, clinical, and nursing services, as well as doctors and nurses.[176] As compensation, the private partner would receive an annual "unitary charge," comprising: (a) an availability charge for the provision and management of the structure and equipment, and (b) a service charge for the provision of facilities management and non-core services.[177]

The private partner, usually a special purpose vehicle (SPV) created by a construction company, would have three subcontracts: (a) with banks to finance the project, (b) with a construction company to build the structure, and (c) with a facilities management company to manage it over the lifetime of the contract.[178]

Issues

While this PFI model has been described as a huge success considering that it would have been otherwise impossible for the UK to build an impressive number of new hospitals when they were badly needed,[179] many issues eventually surfaced, and public backlash ultimately led to a revamp of the PFI model into the PF2 model in late 2012.

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[175] *Supra* note 170,

[176] *Id.*, p. 7.

[177] *Id.*

[178] Martin McKee, *et al.*, *Public-private partnerships for hospitals*, 84 (11) Bulletin of the World Health Organization (2006), p. 891, *available at* https://www.who.int/bulletin/volumes/84/11/06-030015.pdf.

[179] *Supra* note 170.

The first issue had to do with costs. The initially-promoted benefits of risk transfer and VfM were later largely discounted by authoritative reports, and the strategy of taking capital spending off of government's balance sheet—instead of improving health sector efficiency—was criticized for being the wrong incentive for entering into PFIs.[180]

Some of the factors that made PFI hospitals more costly than non-PFI hospitals were the following:[181]

A. Corporate bonds used to finance PFI deals were typically awarded BBB+ status only, while government bonds are considered less risky and therefore attracted AAA ratings. Hence, cost of borrowing was higher for PFIs.

B. Construction risk was often bundled with operations risk in PFIs, even if the latter carry a much lower risk profile. Many of the early PFIs benefitted exclusively from post-construction refinancing, until government belatedly required profit-sharing in such cases.

C. Because a PFI was structured to deliver a single project, there was an incentive to integrate as many components as possible into a PFI since additional capital may not be available in the future. In the process, schemes became more complex, carried more risk, and became less financially viable.

D. Availability charges may have been higher than the cost for the same services under non-PFI models. While

[180] *Supra* note 169, at 36.

[181] *Supra* note 179, at 891-892.

PFIs set aside money for the proper maintenance of buildings, government would usually reallocate part of its maintenance budget to provide services.

E. Profit margins for the private partner.

The second issue had to do with quality, as many PFI hospitals experienced significant design and structural problems.[182] Although such problems were not exclusive to PFI hospitals and may have been also due to government's inadequate architecture and planning departments,[183] the model nevertheless incentivized private partners to minimize their costs and risks in constructing the buildings.

The last issue had to do with flexibility. While health service delivery and medical technology evolve rapidly, PFIs have been rigidly crafted in great detail in order to minimize risk.[184] Thus, making adjustments during the contract's lifetime is extremely difficult. In fact, private partners consistently refuse to accept the risks of changes in volumes, clinical risks, quality of care, and changes in functional needs.[185]

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[182] *Id.*, at 892.

[183] *Id.*

[184] *Id.*, at 893.

[185] U, Health and Economics Analysis for an Evaluation of the Public Private Partnerships in Health Care Delivery across EU, p. 35, *available at* https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/ppp_finalreport_annexes_en.pdf (2013).

Impact

Over 90% of all major hospital infrastructure investment projects in the UK are PFIs.[186] As opposed to traditional methods, PFIs were normally delivered on-time and on-budget:[187] for example, 76% of PFIs were delivered on-time and 79% were on-budget in 2001, compared to only 30% and 27% respectively under conventional procurement.[188]

Nevertheless, in light of widespread public concerns about VfM, PFIs were practically ruled out for more hospital projects after: (a) the 2008 credit crisis led banks to become more risk-averse and monoline insurers to collapse, and (b) a government report revealed that the high unitary charges in PFIs compared to non-PFI hospitals had led to perverse impacts on quality of care and the financial stability of hospitals.[189]

The PFI structure was thus replaced with Project Finance 2 or PF2 in 2012. The changes introduced included: (a) government becoming a minority shareholder in the projects, (b) government retaining non-core services, (c) bidders being required to develop long-term financing solutions not solely reliant on bank debt, and (d) a greater retention and management of risks by government.[190]

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[186] *Id.*, p. 31.

[187] Martin McKee, *et al.*, *Public-private partnerships for hospitals*, 84 (11) Bulletin of the World Health Organization, p. 894, *available at* https://www.who.int/bulletin/volumes/84/11/06-030015.pdf (2006).

[188] *Id.*, p. 892.

[189] *Supra* note 186, pp. 36-37.

[190] Based on an email from Her Majesty's (HM) Treasury officials to the author on February 5, 2013.

The PF2 model was used six times, comprising around 0.5% of public investment until 2018, when government announced that it would no longer use PF2 contracts.[191]

B. *Italy*

Model	*PFI*
Private Side	Design, build, finance, operate, non-core services
Public Side	Payment of annual fee, core services
Revenue Stream	Unitary charge, commercial revenues
Contract Period	20 to 30 years, in general

Italy is considered the second market for hospital PPPs in Europe next to the UK,[192] having launched the first of its many projects in 2001 after it experienced a deep financial crisis in the 1990s. There is no clear country-wide framework for PPPs and each deal is different from others, but almost all follow the PFI model.[193] There are only four experimental operations where core services were transferred to the private partner.[194]

[191] HM Treasury, Private Finance Initiative and Private Finance 2 projects: 2018 summary data, *available at* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/805117/PFI_and_PF2_FINAL_PDF1.pdf (2019).

[192] *Supra* note 186, p. 183.

[193] *Id*, p. 185.

[194] *Id*.

Background

Italy has a long history with PPPs, having passed its first concession law in 1923.[195] Currently, there are three ways in which PPPs may be awarded: (a) concessions under public initiative, which are solicited projects, (b) concessions under private initiative, which are projects proposed by the private sector, or (c) concessions of service contracts, which do not involve major facility construction and relate mainly to service provision.[196] With the way PPPs have been legislated, it appears that they are regarded primarily as a way to provide goods and services, rather than as funding mechanisms.[197]

Project Structure

PPPs are delivered through DBFO or DBFM arrangements, whereby the private partner designs, builds, and maintains the facility, and provides non-core services during the contract period.[198] In some cases, the private partner provides initial equipment or clinical support services such as imaging and laboratory analysis.[199] The private partner may also provide commercial services such as canteens, carparks, accommodations, and shopping areas.[200]

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[195] *Supra* note 180, p. 13.

[196] *Id.*, p. 12.

[197] *Supra* note 186, p. 183.

[198] *Supra* note 196.

[199] *Id.*

[200] EU, Health and Economics Analysis for an Evaluation of the Public Private Partnerships in Health Care Delivery across EU, p. 185, *available at* https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/ppp_finalreport_annexes_en.pdf (2013).

During the contract period, government retains ownership of the estate, and both estate and management are handed back to government at the end of the contract.[201] 60% of Italy's hospital PPP contracts have 20- to 30-year periods, 22% are anywhere from 10 to 20 years, 9% are between six to 10 years, and 9% are longer than 30 years.[202]

In addition to any commercial revenues and, in some cases, public funding for some capital costs,[203] the private partner receives a unitary charge comprising: (a) an availability-based fee for providing the facility, housekeeping, and maintenance, and (b) a volume-based fee for on-demand services like catering and parking.[204] In case of excessive returns, contracts usually provide for a profit-sharing scheme with government.[205]

Issues

The PPP scheme has not resulted in a lower cost of capital for Italian hospitals, especially considering the relatively high amount of public contributions to the projects.[206] Nevertheless, these public contributions significantly reduce the actual amounts of the considerable risks assumed by the private partner, specifically demand risks associated with non-core services, which are compensated based on services

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[201] *Supra* note 196.

[202] *Supra* note 201.

[203] *Id.*, p. 186.

[204] *Supra* note 196, p. 14.

[205] *Id.*, p. 15.

[206] *Supra* note 201, p. 188.

actually rendered rather than on an availability basis, as well as commercial services.[207]

Impact

At the end of the day, despite the fact that its hospital PPPs have not been cost-effective, Italy has benefitted from the greater involvement of private capital up to 60% of the mobilized amounts, reduced claims and disputes during construction, and on-time on-budget project delivery.[208]

C. *Spain*

Model	*Concession*
Private Side	Design, build, finance, operate, core, non-core services
Public Side	Payment of annual fees
Revenue Stream	Capitation fee, rental fee
Contract Period	15 to 30 years

Spain has an almost equal number of PFI-model hospitals as it does Concessions—out of 20 such PPPs in 2011, nine were PFIs and 11 were Concessions.[209] Yet literature on the matter consistently cites the country for one thing: its innovative Alzira model, named after the place where Spain's first Concession hospital PPP was

[207] *Id.*, p. 187.

[208] *Supra* note 180, at 14.

[209] *Supra* note 201, at 99.

devised at a time when other countries were working on PFI models.

Background

There are several types of health sector PPPs in Spain: (1) conciertos, which include the outsourcing of testing, diagnostic, and therapeutic services, (2) contracts between the regional health services and private providers, (3) mutual health organizations, and (4) administrative concessions with or without the provision of core services.[210] Administrative concessions were established by a 1997 law as a means of allowing private capital to go into public infrastructure.[211]

With no centralized PPP agency and no standard contractual structure,[212] each local authority could structure its own projects, which is precisely what the autonomous community of Valencia did when it granted an administrative concession for what would be the new Hospital de la Ribera in Alzira in 1997.[213]

In that project, the private partner was ultimately dependent for corporate financing on regional savings banks, which were also controlled by the government of Valencia.[214] Soon after it became clear in 2002 that the

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[210] *Id.*

[211] *Id.*, p. 97.

[212] *Id.*, p. 98.

[213] *Id.*

[214] *Id.*

project was financially unsustainable[215] because of the low fees it was receiving from government, Valencia terminated the contract with a hefty payment made to the private partner.[216] The contract was retendered in 2003 with a wider scope of services, a longer period, and higher fees.[217]

Project Structure

The Alzira model is more than the typical Concession encompassing DBFO plus both core and non-core services. What makes it unique is that, in addition to those obligations, the private partner also manages all primary care centers in the hospital's surrounding health area.[218] A health area provides specialist care and comprises health zones, which in turn contain a hospital and primary health centers.[219]

The Alzira contract was for a 15-year period, extendible for another five years,[220] though the Valencia government decided not to extend it beyond March 31,

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[215] Martin McKee, et al., *Public-private partnerships for hospitals*, 84 (11) Bulletin of the World Health Organization, p. 892, *available at* https://www.who.int/bulletin/volumes/84/11/06-030015.pdf (2006).

[216] EU, Health and Economics Analysis for an Evaluation of the Public Private Partnerships in Health Care Delivery across EU, p. 98, *available at* https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/ppp_finalreport_annexes_en.pdf (2013).

[217] *Id.*

[218] *Id.*

[219] Anne Stafford, *The Alzira model*, *available at* https://www.sochealth.co.uk/2018/01/02/the-alzira-model/ (Jan. 2, 2018)

[220] *Supra* note 209, p.23.

2018.[221] As compensation for core services, government paid the private partner a capitation fee, which was a pre-established annual amount per capita of the population under coverage.[222] Meanwhile, infrastructure and non-core services were remunerated through rental payments.[223] The private partner's profits were capped at 7.5% of turnover, with yields above this being turned over to the government partner.[224]

Issues

Based on regular research done by Hospital de la Ribera, it ranked high in terms of customer satisfaction and appeared to be satisfactory among employees.[225] At the same time, there were several issues that we can learn from, especially from the original terms prior to retender.

First, the original contract did not truly transfer financing risk since Valencia was obligated to pay a fixed annual capitation fee to the private partner on the one hand, but the private partner's lenders for capital investment were banks controlled by Valencia on the other. In fact, the project has been described as an "in-

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[221] Micaela Comendeiro-Maaløe, *et al.*, Public-private partnerships in the Spanish National Health System: The reversion of the Alzira model, 123(4) Health Policy, pp. 408-411, *available at* https://www.sciencedirect.com/science/article/pii/S0168851019300223 (Apr. 2019).

[222] Alberto de Rosa Torner, Lessons from Spain: The Alzira Model, presentation, *available at* https://www.kingsfund.org.uk/sites/default/files/alberto-roso-torner-integrated-care-spain-alzira-model-kings-fund-may12.pdf (2012).

[223] *Supra* note 217, p.100.

[224] *Id.*

[225] *Id.*, p. 109.

house transaction,"[226] and since financing was not project-based, the risk fell back to the government.[227] Valencia was thus exposed to a high payout risk, which materialized when it had to pay the private partner a termination sum of 69.3 million euros in 2002 for written-down assets and lost profits.[228]

Second, the capitation fee worked in such a way that, if the private partner could provide health services for the average citizen on a full-life basis cheaper than the fee, it would make a profit.[229] The best practice that arose from this experience is to use a capitation fee only when there is full health provision,[230] such as in the second contract where the entire health area, and not just the hospital, was conceded to the private partner. In addition, the capitation fee was revised from being indexed to inflation in the original contract to being indexed to government's budgeted per capita health spending in the second contract, since health expenditures typically rise on top of inflation.[231] Such indexation yielded 25% lower average costs than in the rest of Valencia.[232]

Third, since the private sector was incentivized to minimize its costs, there was a tendency to reduce medical staff in hospital PPPs. While public health personnel had the option to retain their government

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[226] *Id.*, p. 98.

[227] *Id.*, p. 101.

[228] *Id.*, p. 107.

[229] *Id.*, p. 105.

[230] *Id.*, p. 98.

[231] *Id.*, p. 107.

[232] *Id.*, p. 100.

employment, about 70% accepted private employment.[233] This transfer of labor-related risks to the private partner was a critical success factor in the Alzira model.[234]

Impact

The successful turnaround of Alzira confirmed the model's viability and has been replicated in at least five other hospitals in Spain and in other countries.[235] According to one study, privately-run hospitals—which include both Concessions and consortia—save 39% on supplies and report 37% higher activity levels against production costs 27% lower than that of hospitals under public management.[236]

Specific to Hospital de la Ribera, the Concession contract was not renewed due to a variety of reasons. Mainly, social and political pressure raised questions on the lack of competition in the health area, possible regulatory capture, lack of transparency with respect to its financial achievements, and the dubious role of the regional savings banks in the project.[237]

There are other countries with notable hospital PPP experience, though they have not been as impactful as the UK, Italy, and Spain. Briefly, these are:

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[233] *Id.*, p. 97.

[234] *Id.*, p. 100.

[235] *Id.*, p. 98.

[236] *Id.*, p. 101.

[237] Micaela Comendeiro-Maaløe, *et al.*, Public-private partnerships in the Spanish National Health System: The reversion of the Alzira model, 123(4) Health Policy, pp. 408-411, *available at* https://www.sciencedirect.com/science/article/pii/S0168851019300223 (April 2019).

A. *Portugal*, which had a unique bundled "twin-SPV" Concession model. Under this set-up, government tendered two contracts together: an "InfraCo" for construction and maintenance of the hospital infrastructure, and a "CliniCo" for the provision of core services.[238]

The InfraCo contract was a 30-year DBFO agreement, paid according to availability of facilities and equipment, while the CliniCo contract was a 10-year agreement, renewable up to 30 years, for the provision of core services and was remunerated on a diagnostic related group (DRG) basis.[239] Private partners usually expected to generate more VfM savings on the CliniCo side rather than on the InfraCo side.[240]

Considering that personnel expenses amount to 50% to 70% of clinical operating costs, profitability depends largely on its management of such expenses.[241] It should be noted that the transfer of labor relations risk to the private partner is always a critical issue in health care,[242] and the transition of staff from public to private management combined with

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[238] EU, Health and Economics Analysis for an Evaluation of the Public Private Partnerships in Health Care Delivery across EU, p. 71, *available at* https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/ppp_finalreport_annexes_en.pdf (2013).

[239] *Id*, p. 72.

[240] *Id*, p. 73.

[241] *Id*.

[242] *Id*, p. 76.

managing newly-hired staff poses a special challenge.[243]

Clinical risk was a major issue for bank creditors, which resulted in an exhaustion of underwriting capacity after four hospitals, and along with delays in closing the Concession contracts, this led to the template's replacement with the PFI model in 2005.[244]

B. *Germany*, which has several unique features: the government-controlled hospital plan makes it difficult for an existing hospital to be removed and for a new one to be included,[245] the decision to shift to a PPP is up to hospital owners, which are usually municipalities,[246] all hospitals regardless of status receive the same DRG price for services performed and annual lump sum grants for medical equipment,[247] and all hospitals may apply for PPP funding out of governmental investment subsidies.[248]

There are several hospital PPP models,[249] the prominent ones of which are: (a) "Accommodation and Service," a five- to 25-year arrangement which follows the PFI model and only occasionally includes non-clinical and clinical support services such as laboratory services, and (b) "Franchising," which follows the

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[243] *Id.*

[244] *Id.*, p. 74.

[245] *Id.*, p. 162.

[246] *Id.*, p. 156.

[247] *Id.*, p. 155.

[248] *Id.*, p. 156.

[249] *Id.*, pp. 154-155.

Concession model and has a 25-year period, extendible by another five.[250]

Contracts must state that services provided are for public authorities in order to keep the services eligible for financing through investment subsidies, which implies that revenues are insufficient to repay private debt.[251]

In sum, hospital PPPs tend to ensure higher efficiency of construction and faster implementation[252] as well as provide higher quality of care,[253] but despite being able to generate significantly higher revenues per case on average compared to non-PPP hospitals,[254] returns are not very exciting.[255]

C. *France*, where the term "PPP" is associated with the PFI model and the term "concession" or "delegations de service public" refer to the Concession model.[256] Most contracts involve the provision of infrastructure, electronic medical records, hospital management, and logistics, while there have also been some leasing and partnership contracts.[257]

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[250] *Id.*, p. 160.

[251] *Id.*

[252] *Id.*, p.161.

[253] *Id.*, p. 162.

[254] *Id.*, p. 163.

[255] *Id.*, p. 161.

[256] *Id.*, p. 112.

[257] *Id.*

PFI-model contracts range between 20 and 35 years, during which time the private partner retains property rights over the facility, receives rental payments, and in some cases, a guaranteed minimum service charge.[258] Concession-model contracts have the same duration and treatment of property rights, but payment is in the form of free exploitation and operation rights.[259] There are also energy and logistical supply hospital PPP contracts, which usually have 15-year periods.[260]

Lastly, Finland and Sweden both have operating Concession-model hospital PPPs, while Turkey, Romania, Czechia, and the Philippines have all attempted to launch their own hospital PPP projects.

Philippine PPPs in Health

Though limited, the Philippines has some experience with PPPs in its health sector. We discuss them briefly below:

A. National *Kidney and Transplant Institute (NKTI) Hemodialysis Center Project*

This completed project consisted of a five-year contract in 2003, followed by a similar five-year contract in 2010, both awarded under the BOT Law for the lease of hemodialysis equipment from the private partner to the NKTI.[261]

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[258] *Id.*, p. 113.

[259] *Id.*

[260] *Id.*

[261] NKTI, *The NKTI Hemodialysis Project as Featured in the PPIAF's Publication Entitled "Emerging Partnerships: Top PPP's in Emerging Markets*," *available at* https://www.nkti.gov.ph/index.php/news/

Before the project, hemodialysis slots were filled quickly, with at least one to two patients turned away daily, and emergency cases that could not be immediately attended to due to a lack of machines.[262] With old technology, aging equipment, long downtime, and rising cost of repairs, patient services declined.[263] This led NKTI to pursue a PPP arrangement with the following responsibilities between the parties:

1. NKTI would provide the space, staff, and utility requirements, maintain quality performance in accordance with international standards, ensure compliance with government regulatory policies, and pay the private partner promptly, and

2. The private partner would supply all hemodialysis equipment, including state-of-the-art water treatment and dialyzer reprocessing machines, provide maintenance and service technicians at all times, ensure availability of hemodialysis supplies at all times, provide regular staff training, and maintain and upgrade technology.

The project resulted in a 22% increase in the hemodialysis center's income from 2002 to 2009, and a 38% increase therein between 2010 and 2011 alone.[264]

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newsroom/533-the-nkti-hemodialysis-project-as-featured-in-the-ppiaf-s-publication-entitled-emerging-partnerships-top-ppp-s-in-emerging-markets.

[262] NKTI, National Kidney and Transplant Institute Hemodialysis Project: A Model for Health of the Public-Private Partnership, presentation, *available at* https://www.scribd.com/document/121923270/NKTI-s-Presentation-to-ADB-on-Hemodialysis-Project-Public-Private-Partnership (Jan. 2013).

[263] *Id.*

[264] *Id.*

More importantly, it enabled the NKTI to provide the highest quality and most advanced type of hemodialysis therapy to all Filipinos at one-third of the cost of the same treatment in other hospitals.[265]

B. *Philippine Orthopedic Hospital (POC) Modernization PPP Project*

This project was set to be the country's pathfinder hospital PPP project when it was bid out by the DOH pursuant to the BOT Law in 2012. It was awarded in 2013, financial close was reached in 2014, yet it was terminated by the private partner in 2015 after the DOH failed to hand over possession of the project site, which was a condition precedent under the contract.

Structured using the Concession model, this P 5.69-billion 25-year project involved the design, construction, financing, equipping, operation, maintenance, and transfer of the hospital, and had the following terms:[266]

1. The DOH would deliver possession of the project site, which was an 8,000-sqm. area of the NKTI property in Quezon City, to the private partner,

2. The private partner would construct a new 700-bed super-specialty tertiary care orthopedic hospital on the site,

3. The private partner would supply, install, operate, and manage modern diagnostics equipment,

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[265] *Id.*

[266] Based on original project documents available with the author.

4. The private partner would supply, install, operate, and manage IT facilities,

5. The private partner would operate and maintain the entire new hospital facility, including the diagnostic center, out-patient and in-patient departments, and all other activities related to the operation of the hospital based on the Minimum Performance Standards and Specifications (MPSS),

6. The private partner would be entitled to collect all hospital revenues, such as medical fees, diagnostic fees, laboratory fees, surgery charges, and bed charges during the life of the contract, as well as commercial revenues such as those from leasing, advertising, use of support amenities, and training,

7. 30% of the beds equivalent to 210 units would be pay beds, on which the private partner could impose charges in its discretion,

8. 70% of the beds equivalent to 490 units would be charity beds, out of which 420 would have been exclusively for PhilHealth-sponsored patients and 70 would have been for indigent or "service" patients,

9. If necessary and agreed upon, the DOH could provide annual operations and maintenance (O&M) support to the private partner as Viability Gap Funding (VGF),

10. In case actual total revenues exceed those projected in the private partner's financial model during any

year of operation, 50% of the excess revenues would be given to the DOH, and

11. At the end of the contract, the private partner would hand over the project and all project assets to the DOH free of any costs.

Under the structure, the DOH would have permitted its 927 personnel at the existing POC to seek employment with the private partner, which would have been responsible for filling the 1,575 staffing requirement and which had discretion on whom to hire. The DOH would have formulated a staffing rationalization plan to allow any of its remaining employees to be utilized at the new hospital, to be deployed to other DOH hospitals, or to otherwise remain in employment.

Apart from these projects, NKTI appears to have also implemented its Radiology-Oncology Center project in the same manner as the Hemodialysis Center, i.e. an equipment lease arrangement under the BOT Law,[267] but details of the transaction are not immediately available.

In 2011, the DOH initiated its Vaccine Self Sufficiency Project that would have established facilities for local production of vaccines to save 20-30% of the annual vaccine procurement budget,[268] but the project seems to not have

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[267] NKTI, National Kidney and Transplant Institute Hemodialysis Project: A Model for Health of the Public-Private Partnership, presentation, *available at* https://www.scribd.com/document/121923270/NKTI-s-Presentation-to-ADB-on-Hemodialysis-Project-Public-Private-Partnership (Jan. 2013).

[268] PPP Center, *DOH Vaccine Project Prioritized Under PPP Program*, *available at* https://ppp.gov.ph/press_releases/doh-vaccine-project-prioritized-under-ppp-program/ (Aug. 31, 2011).

been pursued. Nevertheless, the Research Institute for Tropical Medicine (RITM) Biological Manufacturing Division's Vaccine Self-Reliance Project (VSRP) is part of the DOH's PPP Project for Universal Health Care, which was launched in July 2019 in partnership with UP, International Finance Corporation, Singapore Cooperation Enterprise, and Temasek Foundation.[269]

Meanwhile, the PPP Center lists four projects under development:[270]

A. The *Philippine General Hospital* (PGH) in Diliman Project, which is intended to establish a multi-storey tertiary hospital with medical research center, ancillary facilities, and commercial areas in the University of the Philippines (UP) – Diliman. It is planned to be a hybrid project, with government funding to be used for design and construction, and PPP funding for O&M;

B. The *UP PGH Manila Cancer Center Project*, which is intended to deliver the design, construction, financing, equipping, operation, and maintenance of the country's first comprehensive cancer care center at PGH;

C. The *Baguio General Hospital and Medical Center Renal Care Center Building Project*, which is planned to deliver the design and construction of a renal care center building along with the provision of sufficient hemodialysis machines; and

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[269] RITM, *DOH embarks on first Public-Private Partnership project for UHC*, *available at* http://ritm.gov.ph/doh-embarks-on-first-public-private-partnership-project-for-uhc/ (Jul. 30, 2019).

[270] The PPP Center's project database, *available at* https://ppp.gov.ph/list-of-projects/

D. The *Cagayan Valley Medical Center Hemodialysis Unit Project*, which is intended to deliver the design, construction, financing, operation, and maintenance of a three-storey hemodialysis center with 100 additional hemodialysis machines.

It appears that the PPP Center is also developing a hemodialysis center project for the Quezon City General Hospital, as it was part of the agency's market sounding activity held in October 2019.[271]

Previously, the DOH identified an extensive PPP pipeline of infrastructure projects for hospitals across the country,[272] including the Vicente Sotto Memorial Medical Center, Rizal Medical Center, Jose Reyes Memorial Hospital, Jose Fabella Hospital, San Lazaro Hospital, and Quirino Hospital. No developments appear to have been made, however, with respect to this pipeline.

Synthesis

PPPs have played a prominent role in the health sector for almost a quarter of a century, especially in Europe. Over that time, we have seen two contractual arrangements for hospitals—the PFI model and the Concession model—emerge as the primary schemes that may be adopted or tweaked for new projects.

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[271] PPP Center, *Hemodialysis Center PPPs: Project Structures and Terms*, *available at* https://ppp.gov.ph/wp-content/uploads/2019/10/PPPC_Market-Sounding-Hemodialysis-Projects.pdf (Oct. 25, 2019).

[272] Teodoro Herbosa, *The Philippines Public-Private Partnership Program in Health*, *available at* https://www.unece.org/fileadmin/DAM/ceci/documents/2012/ppp/ppp_days/Day1/Herbosa.pdf.

A general observation may be made that hospital PPPs have not delivered on the value-for-money propositions they originally offered: in fact, they have been shown to be more expensive than conventional procurement, and have been accused of being mere accounting tools to effectively take public borrowing off of government balance sheets. On the other hand, it has also been widely acknowledged that PPPs enabled governments to increase their capital stock of hospital infrastructure on-time and on-budget, which would not have been possible otherwise. Results have also shown that hospital PPPs were effective in improving health care delivery, albeit at a price.

In the Philippines, there have been far more attempts than successes, but prospects are promising. First, it appears that there is clear market for equipment-based health PPPs, specifically the provision and maintenance of machines for hemodialysis and similar centers. Based on the NKTI experience, equipment-based PPPs could vastly improve a hospital's ability to treat its patients and at the same time generate more revenues.

Second, there appears to be a growing interest on the part of medium-sized and LGU-owned hospitals to utilize PPP schemes in order to improve their facilities. This could lead to models where only a specific wing or department of an existing hospital is modernized and equipped by a private partner, thereby minimizing construction risk but at the same time enhancing services.

Third, despite the unfortunate conclusion of the POC Modernization Project, it nevertheless gives policymakers a good base structure for the rehabilitation or establishment of large or other national government-owned hospitals. The fact that it was successfully tendered, awarded, and reached

financial close is proof that the Concession model for hospital PPPs is bankable in the Philippine market.

In the next chapter, we wrap this article up by integrating the lessons we have learned to this point into an actionable proposal that would hopefully mobilize LGUs and private investors towards availing of PPP options to improve health service delivery.

V. TRANSACTION STRUCTURES FOR SUBNATIONAL HOSPITAL PPPS

"*I want to ensure that preserving and protecting our finances will also improve the health of the population.*"
– Robin Kilfeather-Mackey

On April 18, the Inter-Agency Task Force for the Management of Emerging Infectious Diseases (IATF) announced that it had calibrated its approach to battling the pandemic by adopting a "national government-enabled, local government-led, and people-centered response." Having been officially placed in the head role, LGUs were "enjoined to pursue regional cooperation in leading the fight."

This announcement came soon after the April 16 Resolution signed by more than half of the Senate calling for Secretary Duque to resign due to his alleged "failure of leadership," a call that was immediately nixed by Malacañang and unceremoniously followed the next day by the resignation of another Cabinet member, NEDA Secretary Ernesto Pernia, due to policy differences with other officials.

Before those political developments took place, April 15 marked two public health milestones. On the bleak side, the number of COVID-19 cases worldwide breached two million, on the positive side, the running count of recoveries in the Philippines finally outnumbered fatalities, 353 to 349. At that time, the Philippines was in the midst of a streak of having only 200-plus new cases per day, until April 19 saw that number go below 200 for the first time since April 10, with only 172 reports.

Meanwhile, as for the global tally on April 20, country rankings appear to have stabilized: the United States still topped both lists of cases and deaths at 723,605 and 34,203, respectively.[273] Spain, Italy, and Germany again placed in that order as far as cases were concerned, and it was still Italy, Spain, then France ranking below the United States in terms of fatalities. China, for its part, reported 84,237 cases and 4,642 deaths.

April 20 was also the day that the first batch of the locally-made Manila HealthTek test kits was delivered for actual use to the UP-NIH. At the same time, Manila HealthTek's LGU partner Marikina City was preparing to open its testing center, which was set to be accredited on April 22 according to DOH's update of April 17.

The previous chapter must have made it clear that the Marikina testing center's partnership with Manila HealthTek for the production of the GenAmplify test kits is in itself a PPP. In fact, it bears similar features to the NKTI Hemodialysis Center Project—in the sense that the

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[273] WHO, Coronavirus disease 2019 (COVID-19) Situation Report - 91, *available at* https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200420-sitrep-91-covid-19.pdf?sfvrsn=fcf0670b_4 (Apr. 20, 2020). This is also the source for other countries' statistics cited in this chapter.

government partner provides real estate space for the private partner to use in delivering better health services to the people. It also possesses similarities with RITM's Vaccine Self-Reliance Project, in the sense that local production of medical supplies is made possible through the provision of facilities, in the process reducing procurement expenditures.

In this chapter, we propose three main transaction structures for hospital-related subnational PPP projects, each one intended to match various market profiles: from developing, middle-income cities, to LGUs that serve as economic centers in their regions, to the most progressive, upper-quintile provinces and highly-urbanized cities.

Industry Notes

In formulating possible transaction structures, we take the following industry trends and developments into consideration:

A. Health sector PPPs in the Philippines have been structured in line with the Concession, rather than PFI, model. In the NKTI Hemodialysis Center project, the private partner is remunerated directly through charges imposed on patients for use of the equipment. In the POC Modernization project, the private partner would have generated revenues from user fees on all facilities, subject only to the 70% bed requirement for sponsored and service patients.

   The Philippine market is considered uncommon in the global PPP industry as most of the country's projects across all sectors are Concession-model PPPs, whereas most other countries are primarily PFI-model markets. Considering the success that the Concession model has had in the Philippines, and the familiarity with this

model on the one hand versus the limited exposure to the PFI model on the other, this article will propose Concession-model PPP structures.

B. The basic financial model for hospital PPPs may be simplified into the following categories: (a) capital expenditure: number of beds, gross area per bed, construction costs, and equipment costs, (b) operating expenditure: salary costs, maintenance costs, supplies, and utilities, and (c) revenue drivers: estimated demand, public funding, co-payments, and other private revenue opportunities.[274]

C. An emerging trend in the global health industry is made possible by technological advancements: an increasing use of out-patient day operations not involving in-patient stay.[275] This means that there seems to be a shift from dependency on large general hospitals to more focus on specialist out-patient facilities or clinics.[276] This factor, along with the need for flexibility due to rapidly-changing health technology, is considered in our proposals.

D. Labor resistance has historically been a major concern for hospital PPPs.[277] It is important to analyze, as we have done below, whether it will be more advantageous to transfer full control over labor to the private partner or to allow government to retain its existing personnel who will work alongside the private partner's own

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[274] PPP Knowledge Lab, *Health*, *available at* https://pppknowledgelab.org/sectors/health.

[275] World Bank PPP Legal Resource Center, *PPP in Health*, *available at* https://ppp.worldbank.org/public-private-partnership/ppp-health.

[276] *Id.*

[277] *Supra* note 180, at 43.

employees, especially when a Concession model is used.

Equipment-Based Transaction Structure

Following the success of the NKTI PPP projects, it will make sense for certain health facilities to replicate the equipment-based structure. As we have seen, this arrangement worked well to improve services, specifically for specialized care, it generated savings by minimizing rental, maintenance, and associated costs, it required almost negligible resources to be utilized by government, and it was not capital-intensive to the private partner, since no construction requirement was involved. The general terms may be summarized as follows:

Term	*Summary*
Description	An arrangement whereby government provides suitable space in an existing hospital or health facility to the private partner, and the private partner provides medical equipment and renders services to the hospital's or health facility's patients.
Public Side	Government provides the space to the private partner.
Private Side	The private partner provides the equipment as well as maintenance thereof. It replaces any equipment whenever necessary, as well as trains government staff on the proper use of the equipment.
Revenues	Generated from user fees collected from patients who avail of the service. Discounted rates may be offered to residents of the host LGU.

Term	*Summary*
Period	Short- to medium-term, based on the number of years necessary for the private partner to recoup its investment with a reasonable return.
Labor	Parties may agree on which side will provide the necessary personnel, but the default choice should be government.
Termination	The private partner will hand the provided space back to government and will retain ownership over the equipment upon termination.

This transaction would be suitable for secondary or tertiary care providers: Level 1, 2, or 3 hospitals, as well as specialized care out-patient facilities. Since it would require relatively low capital expenditure, it may be utilized in middle- and possibly even lower-income LGUs, depending on the equipment required, which in turn will be based on the health needs of a catchment area.

In order to make this transaction available to lower-income areas, financial viability may be enhanced by bundling non-core services together with the equipment-based component, similar to the PFI model. For example, the private partner may be allowed to provide: (a) clinical support services such as testing, diagnostic, and laboratory services, and/or (b) non-clinical services such as cleaning and catering, in case an equipment-based PPP would not be feasible on its own within a particular catchment area.

The transaction may be structured in a number of ways. One follows the NKTI project, which availed of the BOT Law. Pursuant to this option, the project may be implemented

under a supply-and-operate arrangement.[278] Another option is a JV, whereby government contributes the use of its space and the private partner contributes the use of its equipment to the venture, and they share proportionately in the profits. Lastly, the project may also be implemented as a lease PPP, which in itself requires further consideration: it could be a lease of space by the government to the private partner inasmuch as a lease of equipment by the private partner to the government.

Facilities-Based Transaction Structure

Higher-income LGUs may pursue their own hospital PPP projects in a similar vein to the POC Modernization project. Under this structure, a new hospital would be built or an existing one rehabilitated, and high-quality services would be provided to the public. The Concession model would be more suitable for such an undertaking considering the high capital expenditure involved, and the insufficiency of local government funds for a build-transfer arrangement. The general terms may be summarized as follows:

Term	*Summary*
Description	An arrangement whereby government provides a suitable site with or without facilities to the private partner, and the private partner constructs/rehabilitates, operates, and maintains a hospital, or a portion thereof.
Public Side	Government provides a site to the private partner.

[278] *Supra* note 136, §2(b).

Term	*Summary*
Private Side	The private partner designs, constructs and/or rehabilitates, finances, equips, operates, maintains, and manages a hospital, or a portion thereof such as a department or an expansion wing or building for specific health services.
Revenues	Generated from user fees collected for the provision of facilities and services, subject to a bed allocation requirement where, for example, 70% of beds will be dedicated to sponsored and service patients. The project may involve commercial activities, such as pharmacy, restaurant, and shopping operations. Discounted rates may be offered to residents of the host LGU.
Period	Long-term, based on the number of years necessary for the private partner to recoup its investment with a reasonable return.
Labor	The private partner will provide all personnel, although the private partner may opt to allow existing government hospital staff to work alongside its own personnel.
Termination	The private partner will hand the hospital and the site back to government upon termination.

This structure will be available to tertiary care providers primarily, but possibly to secondary care providers as well. It will best meet the needs of larger Level 2 or 3 hospitals. Due to the need for a high level of capital expenditure and, concomitantly, high demand, this arrangement will be best suited to highly-urbanized cities as

well as higher-income provinces which serve as economic centers in their respective areas.

In order to broaden the scope of delivery of improved health services, a page may be taken from Valencia's Alzira model, where health facilities outside of the hospital were bundled into the project. Thus, if feasibility so requires or if desirable to an LGU, it may integrate the construction and O&M components of new or existing primary care facilities, specialized care facilities, polyclinics, mobile clinics, ambulatory services, and the like with the hospital PPP project, with or without some form of remuneration such as availability payments. Doing so may even optimize the area's service delivery network as well as enhance cost-efficiency for the private partner.

The transaction may be structured as a BOT Variant under the BOT Law, depending on the particular components needed. It may also be implemented as a lease PPP, although careful attention should be given to how the infrastructure component is characterized. Lastly, perhaps the most advisable structure is a JV, where government contributes the site and the private partner contributes the infrastructure, equipment, and other services to the venture. In any case, it should be endeavored to ensure that resulting health expenses for patients are kept at the minimum, and margins should instead be derived by the private partner mainly from commercial activities, and secondarily from non-core services.

Tourism-Based Transaction Structure

LGUs may also implement hospital and other health-related PPPs as part of a broader medical tourism initiative. Medical tourism is a fast-growing global industry, registering a compound annual growth rate (CAGR) of 12.9% from 2018

to 2025.[279] One study pegged its value at US$ 53.768 million as of 2017, and projected it to reach US$ 143,461 million by 2025.[280]

Among the most commonly-availed of treatments under medical tourism programs are: cosmetic, bariatric, orthopedic, dental, alternative medicine, cardiovascular, infertility, ophthalmology, cancer, and neurological disease.[281] The three biggest medical tourism markets in 2019 were Thailand, India, and Mexico in that order, distantly trailed by Singapore and Brazil in fourth and fifth, respectively.[282] These top five countries are forecasted to retain their places through to 2027, leading other players such as Costa Rica, Malaysia, Colombia, Turkey, Taiwan, South Korea, Czechia, and Spain.[283]

The market's growth drivers are: (a) affordability and accessibility of good quality health care services, usually in cases where a patient can save at least 30% of the cost in his/her home country—for example, patients from the United States can usually save 30% to 50% on treatments for common ailments such as heart issues if they travel to Asia or Latin America, (b) support from tourism departments and

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[279] Allied Market Research, Global Medical Tourism Market Opportunities and Forecasts, 2018-2025, *available at* https://www.alliedmarket research.com/medical-tourism-market (Jan. 2019).

[280] *Id.*

[281] Grand View Research, Medical Tourism Market Size, Share & Trends Analysis Report by Country (Thailand, India, Costa Rica, Mexico, Malaysia, Singapore, Brazil, Colombia, Turkey, Taiwan, South Korea, Spain, Czech Republic), And Segment Forecasts, 2020-2027, *available at* https://www.grandviewresearch.com/industry-analysis/medical-tourism-market (Mar. 2020).

[282] *Id.*

[283] *Id.*

local governments, and (c) availability of latest medical technologies in medical tourism hubs.[284]

In the Philippines, the Tourism Infrastructure and Enterprise Zone Authority (TIEZA) promotes the development of medical tourism through fiscal and non-fiscal incentives made available to tourism enterprise zones (TEZs), which include Health and Wellness Tourism Zones.[285] This classification includes establishments such as medical and allied services, spas, health farms, counselling and rehabilitation services, and traditional Filipino touch therapy.[286]

A Mixed-Use TEZ is one that combines features of different classifications.[287] Apart from Health and Wellness, there are: (a) Cultural Heritage Tourism Zones,[288] which cover historical sites and museums, for example, (b) Eco-Tourism Zones,[289] which include sites of scenic natural beauty, areas for observing wildlife, and the like, and (c) General Leisure Tourism Zones,[290] featuring facilities such as golf resorts and theme parks, among others. In addition, retirement communities and facilities accredited by the Philippine

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[284] *Supra* note 280.

[285] Guidelines for the Designation and Supervision of Tourism Enterprise Zones and the Administration of Incentives under RA 9593, Rule II, Sec. 3(b), *available at* http://tieza.gov.ph/wp-content/uploads/2015/11/TIEZA_Amended_Guidelines.pdf.

[286] *Id.*

[287] *Id.*, §3(e).

[288] *Id.*, §3(a).

[289] *Id.*, §3(c).

[290] *Id.*, §3(d).

Retirement Authority may be located in Mixed-Use, Health and Wellness, and General Leisure Tourism Zones.[291]

TEZs must be one contiguous territory, they must have a strategic location and strategic access, and must be at least five hectares and sufficient in size, among other requirements.[292] In order to avail of incentives, the minimum investment amount is US$ 5 million, exclusive of land and acquisition costs.[293] The fiscal incentives offered are substantial, as shown in the table below:[294]

Incentive	*Description*
Income Tax Holiday (ITH)	6-year ITH, with possible renewal of up to another 6 years in case of substantial expansion
Gross Income Taxation (GIT)	In lieu of all taxes, imposts, assessments, fees, and licenses, except for real property taxes and any fees imposed by TIEZA, registered tourism enterprises pay a tax of 5% on gross income earned from registered activities
Importation of Capital Investment and Equipment	100% exemption from all taxes and customs duties, subject to certain conditions
Transportation Equipment and Spare Parts	Exemption from customs duties and national taxes, subject to certain conditions

[291] *Id.*, §3.

[292] *Id.*, §2.

[293] *Id.*, §4.

[294] *Id.*, Rule XI, §§1 to 6.

Incentive	*Description*
Goods Consumed and Services Rendered	100% exemption from all taxes and customs duties, and a tax credit equivalent to all national internal revenue taxes paid on all locally-sourced goods and services, subject to certain conditions
Social Responsibility Incentive	Tax deduction equivalent to 50% of the cost of environmental protection and similar activities

LGUs, certain government instrumentalities, duly-incorporated Philippine entities,[295] and any joint venture between the public and private sectors[296] may apply with TIEZA for the designation of an area as a TEZ.

This transaction structure would, in reality, be more of a property development project with a focus on health rather than a pure hospital- or health-based PPP. While it would require high capital expenditure, it would also potentially generate more than commensurate returns, establish a hospital of the highest level for the catchment area, and deliver quality health services to the public. Beyond health sector benefits, it would be an economic driver by stimulating the local tourism industry, which would translate into more business activity, jobs, and livelihood opportunities especially in the service sector. The general terms may be summarized as follows:

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[295] *Id.*, Rule II, §5.

[296] TIEZA, TEZ Investment Forum, *available at* http://tieza.gov.ph/wp-content/uploads/2015/11/TEZ-Presentation-Davao-27-April-2017.pdf (Apr. 27, 2017).

Incentive	*Description*
Description	An arrangement whereby government provides a suitable site to the private partner, and the private partner develops and operates a health-focused TEZ.
Public Side	Government provides a site to the private partner, and applies for TEZ designation whether in its own capacity or as part of a JV.
Private Side	The private partner designs, develops, constructs, finances, operates, maintains, and manages the TEZ, and ensures the establishment of a hospital therein.
Revenues	Generated from rental fees, user fees, and commercial charges collected from locators and other establishments in the TEZ. It may design, construct, finance, equip, operate, maintain, and manage the hospital directly in the same manner as a facilities-based hospital PPP, or it may contract these functions out to third parties. Discounted rates may be offered to residents of the host LGU.
Period	Long-term, based on agreement of the parties.
Labor	Each locator will be responsible for its own staffing needs.
Termination	Based on agreement of the parties.

This transaction structure would best fit LGUs that, regardless of economic standing, already have existing tourist attractions in the vicinity. These may be beaches, heritage sites, natural sceneries, and the like, since medical

tourism zones usually offer tourist activities outside of the zone itself.

The international trend in medical tourism is to have a teaching or training hospital at the heart of the development.[297] It is therefore advisable that the hospital will be a university hospital or a hospital having a training partnership with a teaching institution, either of which would be Level 3 types. Considering the type of development, the hospital should be able to cater to higher-income patients and paying foreign tourists, but at the same time deliver affordable health services to ordinary and underprivileged citizens. Thus, just as in the POC Modernization project example, the hospital may have pay wards for the upmarket clientele, and charity wards for sponsored and service patients. In fact, even PGH is aiming to have a 60:40 to 70:30 charity-to-pay ward ratio.[298]

Meanwhile, apart from the hospital, the menu of prospective locators that would serve a health and wellness zone is quite diverse, more so in the case of a mixed-use TEZ. This includes specialized outpatient clinics, wellness centers, golf courses, retirement homes, shopping malls, sports facilities, and many types of consumer-oriented establishments. Further, following the RITM Vaccine Self-Reliance Project as well as the Marikina City-Manila HealthTek partnership, the TEZ may also host research and development (R&D) and manufacturing facilities for medical and pharmaceutical purposes.

Depending on how the transaction is structured, this project may be implemented as a BOT Variant under the BOT

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[297] As stated by PGH Director Dr. Gerardo Legaspi on ANC program "The Boss," which aired on Sept. 7, 2017.

[298] *Id.*

Law, in which case it is the LGU that will apply for TEZ designation. The LGU should also have the capability to prepare a satisfactory project study to determine project and economic internal rates or return. A slightly more efficient option would be a lease PPP arrangement, whereby government may lease its property out to the private partner for a fee, and in addition, require some share in the project's proceeds. In such case, the planning and preparation for the TEZ business will be up to the private partner, and the LGU will simply collect rental fees and its share in the revenues.

Finally, a JV arrangement may be the most suitable relationship for this project, primarily since its nature is revenue-generation. Under a JV, government would contribute the site and resources for TEZ designation, while the private partner would contribute all development and associated works to the venture. Again, health expenses at the hospital may be kept at the minimum—especially for the underprivileged—since profits may be derived from the swath of commercial activities available to the JV.

Project Preparation

As a final section before closing this chapter, we briefly discuss some of the factors to consider in preparing a hospital project as a PPP, based on guidelines prepared for the PPP Center.[299] The items below should be made part of the feasibility study to be undertaken for such a project.

A. *Project Identification*. At the project inception stage, the following should be assessed: (a) functional features, such as the range of health services involved

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[299] GHD Pty. Ltd., Sector Guidelines Health, *available at* https://ppp.gov.ph/wp-content/uploads/2015/01/Final-Draft-of-Sector-Guidelines-for-Health.pdf (Dec. 23, 2013).

and the level of services required, (b) basic data, such as the number of patients in the catchment area and of those who pay full cost, partial cost, or not at all, and (c) technical features, such as the layout of the building and internal areas and the standard gross area per bed.

B. *Demand Analysis*. In this exercise, current and forecasted demand for the project's services should be identified, as well as the precise services to be offered and *operational* requirements. A thorough market assessment will be advisable; thus a market survey should be conducted to find out critical information like prevalence statistics of illnesses in the catchment area, affordability issues, and competing health facilities.

C. *Technical Analysis*. This activity entails the study of engineering and operational aspects of the project, such as: site selection including its soil and geological profile, size, location, and compliance with local planning ordinances, technical design including suitability for services to be offered, provision of utilities, and compliance with standards for medical facilities, and construction plans including project cost, timeline, quality, and risks.

D. *Economic Analysis.* An assessment of the benefits of the investment should be derived primarily from morbidity and mortality improvements, and from "added quality of life years" efficiency gains. This should consider future savings in health costs, the number of deaths prevented, and efficiency measures, among others. The human-capital approach and the willingness-to-pay techniques should be used to evaluate statistical life value.

E. *Financial Analysis*. This exercise should identify project inflows and outflows, specifically: (a) inflows from room rates, fees for diagnoses, fees for treatment, revenues from ancillary services and commercial activities, and transfer from government budget, and (b) outflows from investment costs such as civil works and equipment, O&M costs such as personnel, maintenance and supplies, and costs for utilities.

F. *Risk Analysis.* This activity involves a review of the risks attached to a hospital project: (a) site risk, including site conditions and permitting requirements, (b) design, construction, and commissioning risk, (c) sponsor and financial risk, including financing and refinancing aspects, (d) operating risk, such as technical obsolescence and multi-year appropriation risk, and (e) demand risk. Political risk is also always prominent in LGU projects.

G. *MPSS Preparation*. In this process, the service products, deliverables, or outputs of the project should be specified and aligned with the needs of government. It will focus on the use of equipment, assets, infrastructure, and other resources, setting out functionality and volume of use required for each output. For example, it should identify the number of beds to be provided, the requisite equipment needed for specific treatments, and the hospital's operating hours.

H. *Payment Mechanism Identification*. The revenue sources for the parties should be assessed through this exercise. In general, the options are: (a) user charges received directly from users, (b) VGF as a capital grant from government, (c) usage payments from government based on volume of use, (d) availability

payments from government for making the facility or services available, and (e) service performance payments from government based on quality of service.

Other analyses to conduct are on the PPP structure, environmental and social aspects, institutional and stakeholder aspects, the implementation plan, and contract management.

Synthesis

In its limited experience with health sector PPPs, the Philippines has favored versions of the Concession model rather than a PFI, consistent with its general preference in other sectors. The NKTI Hemodialysis Center is essentially a lease arrangement financed through user fees, and the POC Modernization project was a concession that would have generated income from a combination of user fees and commercial revenues. Following this approach, this article proposed three transaction structures.

The first is an equipment-based project similar to the NKTI example, where the private partner provides a hospital's required equipment, as well as maintenance thereof, and the government provides space in the hospital for such equipment to be operated. As remuneration, the private partner collects charges directly from users of the equipment. The viability of this model may be enhanced with the bundling of PFI-type non-core services into the contract.

The second is a facilities-based project similar to the POC Modernization project example, where government provides the site for a greenfield or brownfield hospital, and the private partner designs, constructs or rehabilitates, finances, equips, operates, maintains, and manages the

hospital facility. To recoup its investment, the private partner imposes applicable fees and charges on all users, as well as engages in suitable commercial activities. To improve viability, the provision of other health care services within the host LGU's territory may be integrated into the project.

The third is a tourism-based project, which has more of a property development character rather than that of a pure health sector PPP. In such a structure, government provides a site for the development of a health and wellness or mixed-use TEZ and takes the lead in obtaining TEZ designation, while the private partner handles all aspects of development and operations, from which it generates revenues. Such a project would be centered on a teaching or training Level 3 hospital, complemented by other health, wellness, leisure, entertainment, retirement, and allied medical facilities.

For all three transaction structures, three contractual arrangements were identified as possible options. One is a BOT or a variant thereof under the BOT Law, which was the case for the NKTI and POC Modernization projects, another is a lease PPP which may be provided in an LGU's PPP Code, and the last is a JV, which may also be provided in an LGU's PPP or JV Code. Each option has its pros and cons, and they should be sufficiently studied in order to arrive at the most suitable arrangement for any given project.

Finally, this chapter also provided a brief summary of the factors to be reviewed as part of project development, and which should be thoroughly addressed in the corresponding feasibility study, before a PPP project is pursued.

CONCLUSION

"He who has health has hope, and he who has hope has everything."
– Arabian Proverb

Although the world has not stood witness to a disease of COVID-19's proportions since the so-called Spanish Flu about a century before, pandemics are much more common than we think. In this 21st century alone, there have already been five:[300] COVID-19, the Middle East Respiratory Syndrome or MERS, the Ebola Virus, the H1N1 Flu or Swine Flu, and the Severe Acute Respiratory Syndrome or SARS.[301]

Factors such as increasing population density, urbanization, and international travel have contributed to the ease of human-to-human transmission of new viruses, thereby facilitating the spread of associated diseases worldwide. Thus, whereas pandemics used to take place decades apart, at present times, outbreaks occur within a few years of each other. In fact, as of this writing, we are in the midst of up to three ongoing pandemics: COVID-19, MERS, and Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome or HIV/AIDS.[302]

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[300] This is based on the classical definition of a pandemic rather than official declarations. The classical definition according to A Dictionary of Epidemiology, 4th ed. is "an epidemic occurring worldwide, or over a very wide area, crossing international boundaries, and usually affecting a large number of people." (2001)

[301] Nicolas LePan, *A visual history of pandemics*, *available at* https://www.weforum.org/agenda/2020/03/a-visual-history-of-pandemics (Mar. 15, 2020).

[302] *Id.*

The threat of a "large and lethal, modern-day pandemic occurring in our lifetimes" has been famously raised to public attention by no less than Bill Gates over the course of the past several years.[303] He repeatedly gave this warning on account of the "continual emergence of new pathogens, the increasing risk of a bioterror attack, and how connected our world is through air travel," noting that we would not be prepared to handle such a crisis: supply chains would break down, systems would be overloaded, and there would be a lot of panic.[304]

Indeed, such warnings have proven to be prophetic. The COVID-19 crisis exposed how health care systems across the world are ill-prepared to manage such a pandemic. From shortages in hospital beds, to overworked hospital staff, to the lack of PPEs and ventilators, to poor logistics and coordination, to slow government responses—the global health system has been utterly overwhelmed by a coronavirus.

This article proposes a means through which subnational PPPs may contribute, albeit in a relatively modest way, to the country's efforts in improving its delivery of health services to the public. More than simply establishing new and modernized hospital infrastructures, health sector PPPs could be instrumental drivers in the broader public health strategy.

For one, government funds that would have been allocated for health infrastructure development may be

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[303] Natacha Larnaud, *Bill Gates warned of a deadly pandemic for years – and said we wouldn't be ready to handle it*, *available at* https://www.cbsnews.com/news/coronavirus-bill-gates-epidemic-warning-readiness/ (Mar. 19, 2020).

[304] *Id.*

redirected to R&D, vaccine production, the procurement of medicines, improving compensation packages for the health workforce, and the like. Moreover, by improving access to health facilities and services as well as the quality of health care, the country would have better morbidity and mortality rates and Filipinos would be less vulnerable to various diseases. Finally, these subnational PPPs may themselves directly engage in R&D, in the development and manufacturing of vaccines and medicines, and in hospital teaching and training, among other related activities.

As this article's writing comes to a close in the last few days of April 2020, the world remained in a state of flux. The global number of confirmed COVID-19 cases was nearing three million, with 2.878 million reported, and the death count was approaching 200,000, with 198,668 reported,[305] as of April 27. The United States' numbers were still increasing rapidly[306] as states were poised to reopen in accordance with testing guidelines issued by President Donald Trump,[307] while New Zealand declared that it had successfully stopped community transmission.[308]

On the same date, countries like Australia, Iran, and Spain began to ease their lockdowns, and Italy announced

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[305] WHO, Coronavirus disease 2019 (COVID-19) Situation Report - 98, *available at* https://www.who.int/docs/defaultsource/coronaviruse/situation-reports/20200427-sitrep-98-covid-19.pdf?sfvrsn=90323472_4 (Apr. 27, 2020).

[306] *Id.*

[307] Dartunorro Clark, *Trump lays out new coronavirus testing 'blueprint' as states weigh reopening*, *available at* https://www.nbcnews.com/politics/politics-news/trump-lays-out-new-coronavirus-testing-blueprint-states-weigh-reopening-n1193771 (Apr. 28, 2020).

[308] BBC, *Coronavirus: New Zealand claims no community cases as lockdown eases*, *available at* https://www.bbc.com/news/world-asia-52436658 (Apr. 27, 2020).

that it would relax its two-month quarantine restrictions beginning on May 4.[309] For their part, Germany and France were still set to loosen their restrictions on May 3 and May 11, respectively. Taiwan, which was widely acknowledged as the best responder to the crisis despite still being refused membership by WHO, was on its 15th consecutive day of having no local transmissions.[310]

The day before, on April 26, Wuhan declared that it had no remaining COVID-19 infections in its hospitals, with all patients having been discharged.[311] Vietnam was reporting no new cases at all from April 18 to 27, except for April 25 when it had two, and South Korea was reporting only 10 or less new cases per day from April 23 to 27.[312]

Meanwhile, Singapore, which had been regarded as one of the best managers of the crisis early on, was reporting daily new cases in the range of around 700 to 1,000 in its second wave of the disease.[313] UK Prime Minister Boris Johnson's first day at work since recovering from COVID-19 was also on April 27th, when he declared that his country's lockdown would continue to avoid its own second wave.[314]

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[309] Al Jazeera, *Timeline: How the new coronavirus spread*, *available at* https://www.aljazeera.com/news/2020/01/timeline-china-coronavirus-spread-200126061554884.html (Apr. 27, 2020).

[310] Focus Taiwan, *Taiwan confirms no new COVID-19 cases for 5th time in April*, *available at* https://focustaiwan.tw/society/202004270008 (Apr. 27, 2020).

[311] *Id.*

[312] WHO's database of its daily COVID-2019 situation reports, *available at* https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports.

[313] CNA, *2 more COVID-19 deaths as Singapore reports 799 new cases*, *available at* https://www.channelnewsasia.com/news/singapore/covid-19-singapore-799-new-cases-past-14000-12679140 (Apr. 27, 2020).

[314] Zamira Rahim, *Boris Johnson warns against relaxing UK lockdown as he returns to work after battle with coronavirus*, *available at*

In the Philippines, a glimmer of hope was surfacing. On April 24, President Duterte announced that the ECQ over NCR and certain provinces would once again be extended, this time until May 15, but in some areas, restrictions would be downgraded to a general community quarantine (GCQ). On April 27, the Philippine leader disclosed that modifications to the ECQ were in the works, such that a partial reopening of certain sectors would allow some workers to return to work.

Amid the prevailing uncertainty all over the world, the human race pinned its hopes on the discovery of a vaccine that would bring normalcy back to society, a process that some were saying would take one to two years to complete. In the meantime, governments were preparing for the "new normal" that would greet their citizens once lockdowns would be lifted. It is this article's hope that, as we collectively navigate through these untested waters, we pursue the necessary reforms that we have identified through this experience, before the next pandemic.

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https://edition.cnn.com/2020/04/27/uk/boris-johnson-downing-street-speech-return-intl-gbr/index.html (Apr. 27, 2020).

Telecommuting: A Review on Remote Work as a Viable Option

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INTRODUCTION

"*Working-from-home,*" "*remote working*, "*teleworking,*" or "*telecommuting,*" often used interchangeably in industry practice, refer to an alternative work arrangement that has become a more relevant discussion in the country today in light of the COVID-19 community quarantine, compared to what it was in 2018 when it was first introduced in law via Republic Act No. 11165, otherwise known as the Telecommuting Act (the Telecommuting Act or the law).[1]

The law defines "*telecommuting*" as "a work arrangement that allows an employee in the private sector to work from an alternative workplace with the use of telecommunications and/or computer technologies."[2] Although lauded as a pioneer in legislation of its kind, the Telecommuting Act is not the first to introduce the idea of remote working, yet it effectively formalized the government's initiative as a first step towards achieving its objectives. Thus, in line with the constitutional state policy of "affirming labor as a primary social economic force and

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[1] An Act Institutionalizing Telecommuting as An Alternative Work Arrangement for Employees in the Private Sector.

[2] Rep. Act No. 11165 (2018), §3.

protecting the rights of workers and promoting their welfare,"[3] the law specifically declares that the State does so "in light of technological development that has opened up new and alternative avenues for employees to carry out their work such as telecommuting, and other flexible work arrangements."[4] Clearly, legislators have recognized that breakthroughs in the field of telecommunication have not only made the world smaller, but have the potential of making work "easier" as well.

The advent of the internet, faster wi-fi connection, and prevalence of effective online communication and file sharing tools such as email, Zoom, Skype, Whatsapp, Messenger, Viber, Google Drive, to name a few, have made it possible and significantly more convenient to communicate and perform work in real time, locally and abroad. Moreover, certain online job portals such as Upwork (formerly Elance-Odesk), onlinejobs.ph, virtualstaff.ph, and the like, offer "work-from-home" or freelancing opportunities. Jobseekers may be hired as regular or part-time employees, freelancers, and independent contractors.

Although not all jobs can be performed remotely, business process outsourcing (BPO), legal process outsourcing (LPO), e-commerce, and information technology (IT) are prime examples of industries in which telecommuting is possible. In fact, several positions have proven to be effective despite performing work remotely, and employers not only recognized, but capitalized on this. Examples are "Youtubers," graphic artists, data encoders, web developers, online writers and editors, online language tutors, mystery shoppers, schedule planners, contact center agents, and to

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[3] CONST. art. II, §18.

[4] Rep. Act No. 11165 (2018), §2.

some extent, even lawyers (acting as consultants and contract managers in LPOs).

"*Telecommuters*" or remote workers that perform telecommuting work as defined under the Telecommuting Act are also often referred to as "*digital nomads*." However, the Telecommuting Act only covers employees in the private sector. For purposes of this discussion, "*telecommuters*" shall only cover employees as defined under the Philippine Labor Code and jurisprudence, and not "*digital nomads*" in general as to include independent contractors, or freelancers. This is not to say that any relevant discussion that may be applicable to "*digital nomads*" in general is exclusively for employees alone.

For purposes of this discussion, remote work does not include field work and is limited to the common understanding of remote work as "*work-from-home*," "*telework*," or "*telecommuting.*" Remote working falls under the category of flexible or alternative work arrangement such as the compressed work week, flexible time-ins and outs, and the like. Employers have explored optional flexible work arrangements either as a program incentive for their employees, or as an actual alternative to traditional work schedules often formalized in the company policy, collective bargaining agreement (CBA), or in the employment contract itself. Remote working is far from a new concept as employers and employees have agreed to such arrangements in the past which steadily progressed from a matter of mere contract between parties, to internationally-recognized "soft law."

I. DEVELOPMENTS ABROAD

On June 4, 1996, the International Labor Organization (ILO) convened a general session specifically addressing "*working-from-home*" as an alternative work arrangement that was adopted as Home Work Convention, 1996 (the Convention).[5] The Convention defines "*home work*" as:

> "(a) the term *home work* means work carried out by a person, to be referred to as a homeworker,
> (i) in his or her home or in other premises of his or her choice, other than the workplace of the employer;
> (ii) for remuneration;
> (iii) which results in a product or service as specified by the employer, irrespective of who provides the equipment, materials or other inputs used, unless this person has the degree of autonomy and of economic independence necessary to be considered an independent worker under national laws, regulations or court decisions;"[6]

"*Home work,*" as defined under the Convention, is more or less similar to "*telecommuting"* under the law save for the technological factor which was not specifically included as an element of the definition (as developments in the field were still in their infancy) but nonetheless taken into consideration under more general terms under the Convention. In fact, the difference in technology which would allow a worker to perform "*home work*" or to

[5] ILO Convention No. 177.

[6] Article 1, ILO Convention No. 177.

"*telecommute*" is not as significant as the fact that such remote work is being performed and the worker is deserving of ample protection of his/her rights. One of the most common features of both the Convention and the law is the call for equal treatment and non-discrimination. This is despite the fact the Philippines has never ratified Home Work Convention 1996.

According to the Convention, member states that ratify the same shall adopt a national policy that promotes equality in treatment of workers, regardless of whether they are performing work in the usual workplace of the employer, at home, or in any other location. Thus:

> "1. The national policy on *homework* shall promote, as far as possible, equality of treatment between homeworkers and other wage earners, taking into account the special characteristics of home work and, where appropriate, conditions applicable to the same or a similar type of work carried out in an enterprise.
>
> 2. Equality of treatment shall be promoted, in particular, in relation to:
> (a) the homeworkers' right to establish or join organizations of their own choosing and to participate in the activities of such organizations;
> (b) protection against discrimination in employment and occupation;
> (c) protection in the field of occupational safety and health;
> (d) remuneration;
> (e) statutory social security protection;
> (f) access to training;

(g) minimum age for admission to employment or work; and
(h) maternity protection."[7]

Similarly, the Telecommuting Act also mandates equality in the form of fair treatment for similarly situated employees working in the employer's work premises and goes further by requiring measures to prevent telecommuting employees from being isolated from the rest of the employer's workforce.

> *"Fair Treatment.* - The employer shall ensure that the telecommuting employee are given the same treatment as that of comparable employees are given the same treatment as that of comparable employees working at the time employer's premises. All telecommuting employee shall:
> (a) Receive a rate of pay, including overtime and night shift differential, and other similar monetary benefits not lower than those provided in applicable laws, and collective bargaining agreements.
> (b) Have the right to rest periods, regular holidays, and special nonworking days.
> (c) Have the same or equivalent workload and performance standards as those of comparable worker at the employer's premises.
> (d) Have the same access to training and career development opportunities as those of comparable workers at the employer's premises and be subject to the same appraisal policies covering these workers.

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[7] Article 4, ILO Convention No. 177.

> (e) Receive appropriate training on the technical equipment at their disposal, and the characteristics and conditions of telecommuting.
> (f) Have the same collectible rights as the workers at the employer's premises and shall not be barred from communicating with workers' representatives.
>
> The employer shall also ensure that measures are taken to prevent the telecommuting employee from being isolated from the rest of the working community in the company by giving the telecommuting employee the opportunity to meet with colleagues on a regular basis, and opportunity to meet with colleagues on a regular basis, and allowing access to company information."[8]

Another noteworthy international development is the treatment of "*telework*" in the European Union (EU) as a recognized tool for modernization. In July 16, 2002, partner organizations in the EU (social partners) negotiated and concluded the European Framework Agreement on Telework of 2002 (the Framework Agreement). The aim of the Framework Agreement was to promote "telework" as a new form of work while protecting employee rights and employer interests. A significant consideration was work-life balance for the workers.

Under the Framework Agreement, "[t]elework is a form of organising and/or performing work, using information technology, in the context of an employment

[8] Rep. Act No. 11165 (2018), § 3.

contract/relationship, where work, which could also be performed at the employer's premises, is carried out away from those premises on a regular basis."[9] The definition of "*telework*" was intentionally left broad to cover the different kinds of relevant remote work, yet it is specific enough bearing a great deal of similarity to the definition of "*telecommuting*" under the Telecommuting Act.

The implementation of the Framework Agreement was done in accordance with national practices of the respective agreeing partner states. "The tools and procedures of implementation chosen by social partners varied in accordance with national practices. They include, for example, social partner agreements in Spain or collective agreements in France, other joint texts negotiated by the social partners such as the joint recommendation prepared in the Dutch Labour Foundation. In some cases, implementation involved public authorities as was the case for the guidelines prepared in the United Kingdom. In other cases, the agreement leads to changes in national legislation, for example to clarify the extent to which labour law covers the situation of telework."[10]

A broader definition of "*telework*" is found in a piece of legislation in the United States (US) called the "Telework Enhancement Act of 2010" (the Telework Act). Enacted on January 5, 2010, the latter defines "*telework*" accordingly: "The term 'telework' or 'teleworking' refers to a work flexibility arrangement under which an employee performs the duties and responsibilities of such employee's position, and other authorized activities, from an approved worksite

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[9] The European Framework Agreement on Telework (2002), art. 2.

[10] Pages 7-14, Implementation of the European Agreement on Telework – Report by the European Social Partners, September 2006.

other than the location from which the employee would otherwise work."[11]

It is worth noting that in comparing all the above definitions, the Telework Act specifically provides that the alternative location where work will be performed should be approved (by the employer), whereas the Convention specifically mentions that the work may be performed at the premises of the employee's choice, while the Framework Agreement and Telecommuting Act are silent on such approval requirement. It is implicit from the reading of the two that the choice of alternative work location rests upon the employee. However, the Implementing Rules and Regulations of the Telecommuting Act (the Implementing Rules) specifically provides that for the effective implementation of a telecommuting program among what needs to be stipulated in any telecommuting policy or agreement are the appropriate alternative workplace/s.[12] Moreover, the national programs and policies that may be implemented pursuant to the Framework Agreement may also have such a stipulation on approved alternative workplaces.

Another point worth considering is that while the Telecommuting Act was established exclusively for employees in the private sector, and both the Framework Agreement and the Convention are broad enough to include both public and private workforces, the Telework Act was specifically enacted to further enable the US Federal Government to manage its employees with a greater degree of flexibly while ensuring better work-life balance for said

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[11] The Telework Enhancement Act (2010), §6501 (3).

[12] Section 3(c), Department Order No. 202, Series of 2019, Implementing Rules and Regulations of Republic Act No. 11165, otherwise known as the "Telecommuting Act".

employees. The Telework Act applies to all Federal Executive agencies and all Federal employees as defined under Section 2105.[13]

One of the most notable points in the Telework Act that distinguishes it from the other legal enactments mentioned herein is the requirement for interactive "*telework*" training for both employees and managers as a condition precedent prior to engaging in "*telework,*" with the exception of those already engaged in the same prior to the enactment as approved by the head of the agency.[14]

These are some examples of measures initiated by governments and organizations to provide formal guidance in the treatment of remote work to ensure the protection of employee rights and welfare while supporting employer convenience, business continuity, and effectivity. Not all nations have made such enactments or have adhered to such international agreements. Some have adopted national policies and programs short of a national law in the treatment of remote work, while other jurisdictions leave wider leeway to employers in adopting remote work through more traditional private devices such as company policies, employment contracts or CBAs.

Considering the COVID-19 pandemic, discussions on the viability and effectiveness of remote work has once again been thrust into serious consideration as governments have recommended, if not required, employers to adopt remote working as an alternative to traditional work arrangements given the present circumstances. Employers and employees that are not accustomed to remote work are put in a "sink-

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[13] Telework Enhancement Act (2010), §6501(1) and (2).

[14] *Id.*, §6503.

or-swim" scenario where they are forced to adapt to the quarantine and lockdown measures that make physically reporting to the office impossible.

With the backing of the government, formalized arrangements with the employees, approval from employers, and IT solutions to address technological and communication issues, it appears that remote work would not only be a viable long-term alternative to traditional work post pandemic, but it may be a "new normal" for businesses and workers alike. After all, the pros and cons of remote work may be subject to considerable debate where ultimately, with enough resources and creative measures to address concerns, the pros may outweigh the cons.

However undeniable are the advantages of remote work, and as the trend moving forward is for more and more employers to adopt remote work arrangements, aside from practical concerns, certain emerging legal issues are worthy of consideration. For purposes of this discussion, significant consideration shall be given to some of the legal issues that are pertinent to the Telecommuting Act and its Implementing Rules.

II. LEGAL CONSIDERATIONS

Contractual Matters

Like almost all work engagements, remote work has always been a purely contractual matter. It is voluntary and almost always optional, as an alternative to working in the usual place of business of an employer. Remote work may be set-up through a specific program, policy, or agreement whereby the option to perform work in a location other than

the usual place of business of the employer is stipulated and agreed to.

So far, there appears to be no legislative enactment, whether locally or abroad, that categorically mandates remote work arrangements as the new norm for select if not all industries. The most that has been required, as evident from the Convention and the Framework Agreement, is the adoption of national policies or programs to foster remote work as a viable alternative while protecting worker rights. As such, who will engage in remote work, where they will work, and what arrangements are to be made for the performance of such remote work is left entirely to the employer and employee as contractual parties. In fact, the Telecommuting Act specifically provides that private sector employers may offer a "*telecommuting program*" as a matter of policy or as per a CBA, such mutually agreeable terms and conditions should not be inconsistent with the requirements of the said law, and that the employee should be informed in writing of such terms and conditions.[15]

An issue that comes to mind is the matter of breach of contract. In practice, most employment contracts, appointment letters, and job descriptions (work engagement documents) specifically provide that an employee will report to a specific location which is usually the principal place of business of the employer without a specific mention of remote work as an alternative. Moreover, it is also commonplace and industry practice that remote work arrangements are adopted as a matter of company policy either as a privilege or as an added benefit only.

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[15] Rep. Act No. 11165 (2018), §4.

Even if a specific program for remote work is adopted by the employer, employee consent is seldom documented, and a general memorandum is just issued for guidance and information. Sometimes, this policy is not even reduced in writing but is merely common knowledge or established practice in a company. The Telecommuting Act will hopefully address this lack of formalization, but the fact remains that an employee who engages in remote work even with the employer's verbal or implicit approval may not be adequately protected by his/her work engagement documents absent a specific written stipulation allowing such remote work.

Lack of a formal agreement allowing the performance of remote work, or any inconsistencies between the work engagement documents of an employee and the employer's programs or policies allowing remote work will most likely lead to misunderstanding and misconstruction of what the employee is permitted to do with respect to remote work, where such remote work may be performed, how often, and other such matters. The employee may run the risk of exposure to accusations of misconduct, being absent without leave (AWOL), unauthorized brining home of company equipment, or even breaches of IT security if he/she fails to perform his/her work in accordance with approved policy.

To address this, it would be prudent to ensure that any approval of remote work, or stipulation allowing remote work as an option be set forth in writing either in the work engagement documents or in a subsequent agreement. The work engagement documents may also be amended to reflect remote work as an alternative to the previously stipulated work location. The Implementing Rules refers to such writing as a "*telecommuting agreement*" and defines the same as "the mutual consent of the employer and the employee in the implementation of a telecommuting work arrangement based on the telecommuting program of the company, Collective

Bargaining Agreement (CBA), if any, and other company rules and regulations."[16]

Another issue worth considering is the supposed optional nature of remote work. It has been established that remote work is seen as an option and alternative to performing work in the usual place of business. In fact, the Implementing Rules specifically highlights the optional nature of "*telecommuting*" by providing and "opt-out" for both employer and employee, stating thus: "The employer or employee may terminate or change the telecommuting work arrangement, in accordance with the telecommuting policy or agreement, without prejudice to employment relationship and working conditions of the employee, at no cost to the latter."[17]

First point to consider with respect to the above issue is that there are instances where the permissibility of remote working is "part-and-parcel" to the work agreement such that performing remote work either as an alternative or as a pre-agreed standard is a material consideration to the giving of consent. An employer may offer the option of performing remote work as a perk of the job or may specifically stipulate that the work may be performed at a location of the employee's choosing. Further, an employee whose place of residence is at a location as to present a challenge to report to the office on a regular basis may consider the option of performing remote work as a material condition to accepting a job offer. In such instances, it is humbly submitted that basic contract law principles take precedence.

[16] Dep't of Lab. & Employment (DOLE) Dep't Order No. 202 (2019), §2 (c). Rules Implementing Rep. Act. No. 11165.

[17] *Id.,* §3.

A second point worth considering is that the supposed optional nature of remote work may also be limited by basic labor law principles. According to the Implementing Rules, existing voluntary remote work arrangements entered prior to the enactment of the Telecommuting Act and the Implementing Rules shall not be impaired provided substantially similar or higher benefits are offered and the Department of Labor and Employment (DOLE) is notified.[18] Despite the "opt-out" provided by the Implementing Rules, and absent a specific agreement by the employee that the benefit of performing remote work may be withdrawn, if the employer has provided the option of performing remote work as a benefit which has already ripened into an established company practice, then the employer cannot terminate the same. Otherwise, this would amount to a diminution of the employee's benefits.

The Supreme Court had on occasion ruled on non-diminution of benefits as being founded on the constitutional protection of labor such that any benefit given by an employer cannot be unilaterally withdrawn or reduced when the giving of such benefit has ripened into company practice.[19] Once it is already a company practice, the said benefit is demandable by the employee as a matter of right. To establish company practice, the following elements must be present: (1) the giving of such benefit has been done for a considerable long period of time; (2) it has been consistently and intentionally done; and (3) it was not the result of an erroneous interpretation or construction of a doubtful or difficult question of law.[20] What constitutes "a considerable

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[18] *Id.*, §9.

[19] Arco Metal Products Co. Inc. *v.* SAMARM-NAFLU, G.R. No. 170734, May 14, 2008.

[20] Vergara *v.* Coca Cola Bottlers Philippines, G.R. No. 176985, April 1, 2013.

long period of time" differs in jurisprudence and is on a case-to-case basis. As such, it would be prudent to make sure that any attempt to change or terminate remote work arrangements would not constitute a diminution of benefits.

To address such contractual concerns, unless the contrary is intended by the parties, perhaps a pre-agreed stipulation that the option to perform remote work is not a material consideration for the parties, and that it is by no means permanent and is rather conditioned upon certain factors (e.g., remote work is feasible for the company or the employee is qualified by merit or seniority) should be formalized in the "*telecommuting agreement*" or in the work engagement documents accordingly. In short, the employer's policy of program should be specific as to the intent and details of allowing remote work, and this should be clearly communicated to the employee.

Occupational Safety and Health Standards

Another issue that comes to mind with respect to remote work is how occupational safety and health standards fit into the equation. A work location alternative to the principal place of business of the employer may be considered appropriate based on the employer's approval or by leaving the choice entirely to the employee's discretion. As such, remote work may be performed at the employee's home, a coffee shop, a shared office space, the park, or any other location.

To better address the need for health and safety standards in the workplace, the Philippines enacted in 2017 an Act Strengthening Compliance with Occupational Safety and Health Standards and Providing Penalties for Violations

Therefor (the OSHA),[21] and its Implementing Rules in 2018 (the OSHA Implementing Rules).[22] According to the OSHA, the same applies to "all establishments, projects, sites… and all other places where work is being undertaken in all branches of economic activity, except in the public sector."[23]

The relevant questions are: "Does the coverage for OSHA standards include remote work locations?" "If so, who should be responsible in ensuring such standards are met?" The Telecommuting Act and the Implementing Rules may be silent as to such standards but they do provide for non-discrimination and equal treatment such that "*telecommuting employees*" shall enjoy the same rights, benefits, treatment and protection as those of similarly situated employees who report to work in the employer's principal place of work.

Although remote work locations are not specifically mentioned or contemplated as being covered by the OSHA, the interpretation that it is would be consistent with resolving doubts in favor of labor and the protection of workers by ensuring "a safe and healthful workplace for all working people by affording them full protection against all hazards in their work environment…"[24]

Moreover, the OSHA also defines "*covered workplaces*" as to include "all other places where work is being undertaken wherein the number of employees, nature of operations, and risk or hazard involved in the business, as

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[21] Rep. Act No. 11058 (2017).

[22] Dep't of Lab. & Employment (DOLE) Dep't Order No. 198 (2018). Rules Implementing Rep. Act. No. 11058.

[23] *Supra* note 21, §2.

[24] *Id.*, §1.

determined by the Secretary of Labor and Employment require compliance with the provisions of this Act."[25] In turn, the OSHA also defines "*workplace*" as "any site or location where workers need to be or to go by reason of their work, and which are under the direct or indirect control of the employer."[26] In this context, subject to further determination by the Secretary of Labor, it is humbly submitted that however a work location is deemed appropriate for remote work, provided that the same is consistent with the "*telecommuting agreement*," or the employer's program or policy, OSHA standards are necessary and it is the employer's responsibility to ensure that health and safety standards in the remote work location are met.

Employers have a reasonably limited expectation of control over the remote work location. In fact, the OSHA does provide for shared responsibility between employer and worker in ensuring compliance with OSHA standards. Among others, they have respective duties such as the employer providing the employee with a hazard-free place of work;[27] the employer giving complete job safety instruction and orientation;[28] the employer informing the employee of work hazards, work-related health risks, preventive and emergency measures;[29] the worker participating in ensuring compliance with OSHA standards, following safety instructions, preventive and emergency measures and making proper use of all safeguards and safety devices, and the worker reporting any discovered work hazards.[30]

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[25] Rep. Act No. 11058 (2017), § 3(c).

[26] *Id.,* §3(p).

[27] *Id.,* §4(a)(1).

[28] *Id.,* §4(a)(2).

[29] *Id.,* §4(a)(3).

[30] *Id.,* §4(b).

Despite such shared responsibility, the ultimate party liable for compliance with the OSHA and the OSHA Implementing Rules would be the employer as the latter has joint and solidary liability with the project owner, general contractor, contractor, sub-contractor, or any person exercising supervision, management or control over the work.[31] Moreover, the OSHA also provides for prohibited acts and penalties for which such the employer and such persons would be liable for.

Thus, until a clear declaration that OSHA standards do not apply to remote work locations, it may be prudent for such matters be given enough consideration when adopting or approving remote work arrangements. As such, with a "*telecommuting employee*" "*working-from-home*" or from a coffee shop, certain things like improper lighting, ventilation, or room temperature, overcharging of laptops, tripping over wires and cables, bad posture, spillage of food and drink on the laptop, and a whole slew of other seemingly unnoticeable issues become more relevant as occupational safety and health risks are worth considering.

Tort Liability

As the coverage of the Telecommuting Act and the focus of this discussion are employees who will perform "*telecommuting*" or remote work in general, another issue worth considering is liability for tort. Torts are civil wrongs and as the Civil Code of the Philippines (the Civil Code) provides: "Whoever by act or omission causes damages to another, there being fault or negligence, is obliged to pay for

[31] Rep. Act No. 11058 (2017), §21.

the damage done..."[32] In the context of employees performing remote work, in reference to such obligation to pay for damages, the principle of employer's vicarious liability comes to mind. Thus, "The obligation imposed by Article 2176 is demandable not only for one's own acts or omissions, but also for those persons for whom one is responsible… Employers shall be liable for the damages caused by their employees… acting within the scope of their assigned tasks…"[33]

The essential element relevant to this issue is the presence of an employer-employee relationship. The burden of proving the presence of such element lies with the Plaintiff and it is enough for the Defendant to deny the allegation without any need to prove such negative averment.[34] Assuming such element is established, and it was proven that the employee is indeed at fault or negligent, then the presumption of negligence on the part of employer or the latter's vicarious liability is also established.

The employer, however, is not without any recourse. The Civil Code further provides that: "The responsibility… shall cease when the (employer) prove(s) that they observed all the diligence of a good father of a family to prevent damage."[35] The Supreme Court interpreted such diligence to mean diligence in the selection and supervision of employees.[36] Thus, in order to rebut the above-mentioned presumption of negligence, the employer needs to prove two

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[32] New Civil Code of the Philippines, art. 2176.

[33] *Id.*, art. 2180.

[34] Spouses Jayme v. Apostol et al., G.R. No. 163609, November 27, 2008 citing Belen et al. v. Belen, G.R. No. 5002, March 18, 1909.

[35] *Supra* note 33.

[36] Yambao v. Zuniga, G.R. No. 146173, December 11, 2003.

things (1) diligence of a good father in selection of employees, and (2) diligence of a good father in the supervision of employees.[37] Without going into too much detail, suffice to say that what would constitute such diligence in selection and supervision of employees differ on a case-to-case basis and mere oral testimony may not be sufficient to establish it according to prevailing jurisprudence.

As such, in the context of remote working, an employer would have practical challenges in exercising such due diligence in the supervision of employees. However, it may be addressed by certain measures such as limiting the unpredictability of the remote work location, for example, by requiring pre-approval of the location or designating specific locations where remote work may be performed. The employer may also exercise supervision over the employee and his/her work by online tools to increase and improve face-time, in checking attendance and monitoring work activity of the employee. Although these are measures that serve only to mitigate the risk and establish such diligence, there is always a possibility of the employee committing tort such as causing someone to trip over laptop cables while working from a coffee shop or causing accidents by taking calls while driving or walking despite being hands-free. However, such measures may prove sufficient to mitigate risk and limit the probability of fault or negligence on the part of the employee, or to prove that enough action was taken by the employer to establish due diligence in supervision.

Immigration and Work Documentation

Yet another issue worthy of consideration because of remote working is compliance with local immigration and

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[37] Reyes et al. v. Doctolero et al., G.R. No. 185597, August 2, 2017.

work permit regulations. With continuous globalization and the prevalence of multinational companies, employers and manpower are no longer confined to a specific locality. For many industries, foreign nationals are perceived as an equally invaluable human resource as the local populace due to the skills, experience, and expertise that they may bring. Moreover, as technological advances make remote work more convenient, it has become more convenient as well to employ foreign nationals as remote workers.

The general rule, under Philippine law, is that foreign nationals who will engage in gainful employment locally, or who will be performing work in the country will have to secure the necessary work papers such as an Alien Employment Permit (AEP) from DOLE, and/or special working visa, provisional working visa, or 9g working visa, among others, as the case may be. As such, unless falling within the exceptions and exclusions under local regulations, potential foreign national employees who will be performing remote work even if located outside of the Philippines, but are under local payroll or are employed locally, or will be performing work that would yield effects locally under an employer-employee relationship, compliance with such work permit regulations are in order. Thus, it is prudent to check with the DOLE or Bureau of Immigration first if the foreign national to be employed to perform remote work would be covered by regulation or not.

On the other hand, assuming Filipino nationals will be performing remote work outside the Philippines, it is also worthy to note that compliance with local immigration and permit to work regulations are also met. Similarly, it is also prudent to verify local laws on the subject as different jurisdictions may have different requirements as some may allow remote work to be performed under a tourist visa while others require actual work authorization documents. For

example, in certain countries, it is illegal for a person to perform any sort of work in such countries even if the same is online work without securing the necessary work permit. The rationale for this regulation is that the remote worker would be earning income while in such countries. The ultimate measure to address this issue is to verify local legal requirements first prior to actual performance or allowing the performance of such remote work in such location.

Failure to comply with such immigration and work permit requirements for remote workers may not be strictly policed at present given the challenges in implementation of the law, however, as modernization has made the performance of remote work easier, it shall eventually make enforcement and monitoring activities of the government equally easier as well.

Taxation

Another emerging issue with remote work performance is with taxation. Basic tax principles state that income derived in a specific location will be subject to the taxes imposed in such location as the latter is the "*situs*" of taxation. There are, however, other considerations, as tax law and regulations at present were designed to address local and not online remote work operations. Thus, there is a need to determine if there would be any additional tax burdens to the employer or employees, respectively, for the performance of such remote work. This will vary based on tax jurisdictions, local laws, treaties, period remote workers remain in a particular location, and others matters.

In addition, it is also noteworthy to determine if expenses incurred for the implementation of the remote work program, included but not limited to Wi-Fi connection costs and other expenses for utilities, are subject to tax

deductions or exclusions, and whether these are for the employer or the employee as taxpayer.

Philippine Economic Zone Authority (PEZA)

Enterprises registered under PEZA such as some BPOs and IT companies enjoy certain privileges such as a more beneficial tax treatment but are also subject to strict conditions. One such condition is that all business to be conducted by such PEZA-registered enterprise should be within a PEZA economic zone, I.T. park or building (PEZA location). Another condition is that all assets and equipment to be used for such business shall remain within such PEZA location. Thus, any remote work arrangement is apparently not consistent with such legal requirements.

As such, before implementation of any remote work arrangement, prior PEZA approval in the form of a Letter of Authority (LOA) should first be secured. Similarly, any movement of assets such as the purchase of new equipment, replacement of previously registered equipment or simply the bringing out of such equipment to facilitate remote work arrangements need prior PEZA approval. For example, a PEZA-registered BPO company with a "*work-from-home*" program would need to report to PEZA and get approval prior to allowing its call center agents to perform work outside the PEZA location" and before they can even bring home the company-issued laptops and devices that were previously inventoried and registered with PEZA as the BPO's assets. Otherwise, any unapproved remote work or bringing out of such assets would be in violation of the conditions for PEZA registration and therefore illegal.

Recently, in response to the COVID-19 outbreak, PEZA recognized the same as a "large-scale emergency" and to address the request of PEZA-registered Ecozone IT

enterprises for assistance, PEZA has, in the interest of the health and welfare of employees, and in order for such enterprises to render continuous efficient service in this time of crisis, allowed such enterprises to immediately implement courses of action to respond to and/or preempt the pandemic without need for the LOA as generally required. Thus, "*work-from-home*" arrangements may immediately be adopted and implemented such that employees may bring home their company-issued laptops to perform the remote work under the condition, among others, that the employees, equipment and other assets are temporarily reassigned and shall be brought back to the PEZA-registered facility or base office after the resolving the COVID-19 situation.[38]

CONCLUSION

In summary, the point of this discussion is merely to provide some insights on remote work as an option made more available by technological developments and on the government's response to the same to officially and formally address what once was left entirely to consenting parties to work arrangement agreements. The government's ultimate objective is to provide ample protection to employees while recognizing and capitalizing on the positive effects of remote work arrangements on how future business will be conducted. Thus, the Telecommuting Act and the Implementing Rules were enacted specifically for this purpose.

From a practical and business operation standpoint, remote work, or more specifically "*telecommuting*," presents enough challenges which are being addressed by

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[38] PEZA Memorandum Circular No. 2020-011.

technological tools and logistic support. However, from the perspective of law, this discussion sought to identify some legal considerations that have or may emerge as a result of such "*telecommuting*" arrangements, which is by no means exhaustive. Rather, it merely presents ideas on potential issues deserving of significant consideration in the context of implementing "*telecommuting*" arrangements.

Remote work arrangements are traditionally, and presently, optional and purely voluntary in nature. Government programs, policies, and enactments have only provided minimum compliance standards for employers who will be adopting such work arrangements geared towards employee protection but have not made the adoption of remote work arrangements mandatory. Although in practice, remote work may become the "new normal" given their proven efficacy and the availability of infrastructure to make remote work feasible, especially after the seemingly positive results of the "acid test" whereby many employers were constrained to allow the performance of remote work for majority of, if not their entire workforce, some for the first time, due to the community lockdown.

Ultimately, remote work arrangements are here to stay, and the most prudent approach to this is to address issues, both operational and legal, that may arise by adopting responsive and preemptive measures for this purpose. Compliance with the Telecommuting Act and the Implementing Rules is mandatory but may not necessarily be enough as such enactments merely set the minimum standards and much like enactments abroad, were intentionally left vague enough to allow adequate response to changing circumstances. As such, it is up to the employers, with adequate consultation with, and participation of employees in the case of collective bargaining, whenever applicable, to adopt such measures.

Employers should determine both employee and work suitability for remote work. An adequate remote work program or policy should be developed with sufficient notice and information shared with the employees for purposes of formalizing the same in a clear, comprehensive, and detailed *"telecommuting agreement*" or remote work agreement.

In the development of such program or policy, a determination that there is adequate bandwidth, IT infrastructure, and logistic support is necessary to confirm operational feasibility of remote work. However, a determination of the legal issues as well as the capacity to address such legal issues should also be made. In this regard, it is evident the provisions of the Telecommuting Act and the Implementing Rules are not the only compliance matters that are relative to remote work as considerations related to taxation, OSHA, DOLE, PEZA, the Bureau of Immigration, among others, are also worth considering.

In conclusion, it is abundantly clear that adopting remote work arrangements are not a "run-of-the-mill" or "one-size-fits-all" type of situation as adequate legal consideration should also be made for remote work to be a viable alternative to traditional work arrangements.

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Tipping Point: Will this Pandemic Mainstream Online Learning in Philippine Legal Education?

*Justin D.J. Sucgang**

PROLOGUE

During the fall break of 2018, my Filipino friends and I decided to drop by Detroit. Ignorant of its contemporary history, I was surprised to see that unlike other big American cities, Detroit was homogenous—homogenously black.[378] I asked one of my friends what was so peculiar about Detroit, and he talked about the "white flight" phenomenon. I started reading about this. And one of the oft-cited explanation is the *Tipping Point* model posited by Nobel Prize winner Thomas Schelling.

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[378] According to the United States 1 July 2019 Census, Detroit has 78.6% black population. Compare this to the black populations of the states of Michigan (14.1%), Chicago (30.1%), New York City (24.3%) and Los Angeles (8.9%). *See* United States Census Bureau, Quick Facts: Detroit city, Michigan, *United States Census Bureau*, 27 June 2020, *available at* https://www.census.gov/quickfacts/fact/table/losangelescitycalifornia,chicagocityillinois,newyorkcitynewyork,detroitcitymichigan,MI/PST045219.

According to Schelling, white flight may have resulted when the tipping point is reached, *that is*, that moment in time when whites feel that they are in danger of achieving minority status.[379] Thus, even the most non-racist or tolerant white, who initially did not mind the presence of colored people or may even prefer integration,[380] would leave due to a chain reaction. Merriam-Webster Dictionary defines *tipping point* as "the critical *point* in a situation, process, or system beyond which a significant and often unstoppable effect or change takes place."[381] This model was soon applied in other phenomena, such as the #MeToo movement[382] and the Arab Spring.[383]

Could the same be said with the pandemic due to the Coronavirus disease (COVID-19) vis-à-vis online legal education? Is it the tipping point that may force even the most loyal adherents of the traditional methods to accept online learning as part of the mainstream law school pedagogy? If it is not, what may be its effect to Philippine legal education?

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[379] Thomas Schelling, *Dynamic Models of Segregation*, 1 JOURNAL OF MATHEMATICAL SOCIOLOGY 143-186 (1971).

[380] *Id.*, at 148.

[381] Merriam-Webster, *tipping point*, Merriam-Webster.Com, 27 June 2020, *available at* https://www.merriam-webster.com/dictionary/tipping%20 point.

[382] Julia Salasky, *Voices, The #MeToo campaign has reached the tipping point, and now we need to focus on the power of the law*, Independent.co.uk, 21 January 2018, *available at* https://www.independent.co.uk/voices/metoo-sexual-assault-harassment-gender-equality-john-worboys-law-justice-a8170546.html.

[383] Leila Hudson & Matt Flannes, *Opinion, The Arab Spring: Anatomy of a tipping point*, Aljazeera.com, 1 September 2011, *available at* https://www.aljazeera.com/indepth/opinion/2011/08/2011830814331 65611.html.

Précis

PART I of this essay argues that the pandemic is not and will not be the tipping point to the system-wide acceptance of online legal education. On the other hand, the aspect of legal education where online learning will most likely have significant effect is presented in PART II.

PART I

"The tipping point is that magic moment when an idea, trend, or social behavior crosses a threshold, tips, and spreads like wildfire."
-Malcolm Gladwell, The Tipping *Point*

Philippine legal education institutions (LEI)[384] never embraced online learning. This is unsurprising because only few higher education institutions (HEI), to which LEIs are attached, invested therein. So, too, because the Legal Education Board (LEB), as regulator of legal education, proscribes the use of distance learning.[385] As a result, LEIs

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[384] While §5(b) of LEB Mem. Order No. 1 (2011) used the term "law school", the Legal Education Board (LEB) started calling law schools as LEIs in LEB Mem. Order No. 9 (2017). This nomenclature was proposed by the author, when he was still a LEB Commissioner/Regular Member, to Rep. Rufus Rodriguez on 23 May 2014 as part of his suggested amendments to Rep. Act. No. 7662 (1993) or the "Legal Education Reform Act of 1993", as well as to the LEB *En Banc* on 28 January 2015 part of his recommendation to adopt a Legal Education Management Information System. Subsequent use by the LEB of this nomenclature vacillates; the term "LEI" was again employed in LEB Mem. Order No. 15 (2018).

[385] The limitations on the delivery of courses are provided under §18(a) of LEB Mem. Order No. 1 (2011), to wit: (a) all subjects in the curriculum must be taken within the entire semester; (b) their delivery cannot be

were caught unprepared to face the challenge brought about by the pandemic. Nonetheless, before I further discuss why the pandemic is not and will not be the tipping point to the mainstreaming of online legal education, a clarification on the nomenclatures used is in order.

When I use distance education, I partly adopt the definition used in Standard 306 of the American Bar Association Standards and Rules of Procedure for Approval of Law Schools 2019-2020. Distance education or learning is one in which students and the faculty member are separated from each other. Instruction is delivered using any technology to support regular and substantive interaction among students and between the students and the faculty member, either synchronously or asynchronously.

On the other hand, online education or learning, which traces its roots in distance education, is "learning that takes place partially or entirely over the Internet."[386] In other words, learning should have a significant Internet-based

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delivered in modular fashion (*i.e.*, completing the subject by a class held continuously for a number of days, although satisfying the required number of hours; and (c) distance education shall not be allowed, unless otherwise provided for by the LEB. In fact, it is my submission that this is the reason why the LEB, in the aforecited MCs, has to expressly permit LEIs to "formulate contingency plans in response to COVID-19 including the conduct of alternative modes of instruction and off-campus learning to ensure minimal disruption to studies." (*see* LEB Mem. Circ. No. 54 (2020), Item 4; and LEB Mem. Circ. No. 55 (2020), Item 3).

[386] Barbara Means, Yukie Toyama, Robert Murphy, Marianne Bakia & Karla Jones, *Evaluation of Evidence-Based Practices in Online Learning: A Meta-Analysis and Review of Online Learning Studies*, U.S. Department of Education Office of Planning, Evaluation, and Policy Development, *Sept., 2010*, *available at* https://www2.ed.gov/rschstat/eval/tech/evidence-based-practices/finalreport.pdf.

instructional component.[387] Online learning has two purposes:[388]

A. To serve as an alternative to the traditional onsite (or face-to-face) learning or education, thus, it is totally conducted online. Hence, pure online learning; or

B. To enhance the traditional onsite learning, thus, online learning components are combined or blended. This technology-enabled learning is called blended or hybrid learning.

Simply put, distance education refers to the situs of the instruction. Online learning refers to the platform of instruction.

Distance education may also be synchronous, which "refers to the teaching and learning activity happening at the same time, real time,"[389] and are used to "approximate face-to-face teaching strategies."[390] Examples of synchronous technologies are webcasting, chat rooms, desktop audio/video technology.[391] It may also be asynchronous where "interaction is not live or in real time. Messages are sent at one time and response from learner is given later."[392]

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[387] *Id.*

[388] *Id. See also* Christine Diane Lim, "Exploring Educational Platforms and Community Behavior to support DLSU Online Blended Learning Initiative," in *2016 DLSU Research Congress,* Manila, Mar. 7-9, 2016, *available at* http://xsite.dlsu.edu.ph/conferences/dlsu-research-congress-proceedings/2016/GRC/GRC-LLI-002.pdf.

[389] Lim, *supra* note 95, at 2.

[390] Means et al., *supra* note 93.

[391] *Id.*

[392] Lim, *supra* note 95.

When I talk about mainstreaming online legal education, I pertain to the second-order change (*i.e.*, transformation phase) following the SAMR Model for Technology Integration.[393] This is because, right now, a number of law instructors have already been using online tools for learning (*e.g.*, sending electronic copies of syllabus via electronic mail). However, it is not maximizing online learning but using online tools as mere substitute for some tasks or aspects. Below is a summary of the SAMR Model:

Change	*Phase*	*Definition*	*Illustration*
No Technology			
Enhancement	Substitution	Technology acts as direct tool with no functional change.	Send reading materials via email attachment; Online quiz via Google Forms
	Augmentation	Acts as direct tool substitute with functional improvement.	Send links to files; Online quiz with auto-grading
Transformation	Modification	Allows significant task redesign.	Create class webpage with files linked; Online quiz with automatic feedback for wrong answers
	Redefinition	Allows creation of new task previously unconceivable.	Online class; Individualized online quiz (with mastery path)

[393] Reuben Puentedeura, *Building Upon SAMR*, Hippasus.Com, 28 June 2020, *available at* http://hippasus.com/rrpweblog/archives/2012/09/03/BuildingUponSAMR.pdf. *Also see* Patrick Parsons, Talking Tech: TPACK & SAMR: Real Frameworks for Evaluating Instructional Technology, 24 AALL SPECTRUM 33 (2020).

With a common language, we proceed to the discussion why the pandemic is not the tipping point.

Fortunately or unfortunately, I submit the pandemic is not and will not be the tipping point to the mainstreaming of online legal education because of the following reasons: (a) internet access and reliability in the Philippines is substandard; (b) legal education is designed to approximate only the traditional aspect of legal practice; (c) the Socratic Method is still considered the gold standard in law school pedagogy; (d) a great majority of law instructors are adjunct; and (e) many LEIs do not have a learning management system (LMS).

The reality of poor internet connectivity

The LEB reported that 56% of law instructors respondents and 35% of law student respondents had stable internet. Meanwhile, a great portion of both groups had intermittent quality of internet access (44% for instructors and 64% for students).[394] Furthermore, 61% of law student respondents are living in areas where only 1% to 20% of households has an internet connection. And 38% of them are living in areas where 20% to 30% of households have internet connectivity. Ironically, an overwhelming majority of law students (89%) responded that they will be able to access in their own residence either using broadband or mobile data technologies.[395]

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[394] Aaron Dimaano, *Responding to a Pandemic: Refocusing on Welfare, Quality of Learning and Reducing Inequalities in Legal Education*, LEB, Apr. 17, 2020 *available at* http://leb.gov.ph/wp-content/uploads/2020/04/LEB-Policy-Paper-on-the-Pandemic-Response-1.pdf?fbclid=IwAR1lbPhd3g6eXvMwJWL_dDdPIOTiwF_3MqCl0g51DieGddmLvET6usbxePM (*hereinafter,* "LEB Policy Paper").

[395] *Id.*, at 5. According to the Policy Paper, this was based on the report of the Philippine Statistics Authority.

Indeed, even if we disregard the results of the LEB Policy Paper due to being non-representative,[396] the most recent National Telecommunications Commission (NTC) figures will point to the same conclusion. In 2016, individuals with access to the internet stand at 63.58%, while only 34% of households has internet connection. Also, mobile broadband penetration is only 41.58% while fixed broadband penetration stands at 8%.[397] These figures indicate problems with internet access. There is also a problem with internet speed reliability.[398] In the Q1 2017 State of the Internet Report, with an average of 5.5 megabytes per second, the Philippines placed 100 out of the 239 countries and regions surveyed. The country also placed last among the 15 Asia Pacific countries surveyed, and last among the six South East Asian countries surveyed. These figures alone attest to the fact that internet connectivity is a real problem. And this is not a problem exclusive to provinces. Although majority of the students (41%) and instructors (40%) are in the National

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[396] A note, however, on the LEB Policy Paper. As disclosed, it employed convenience sampling, a non-probability type of sampling, which is known for disadvantaged generalizability. Simply put, by using an online survey, the respondents are only those who have internet access, aware of the existence of the survey, and are interested in filling-up the survey regardless of whatever motivations they may have. Thus, at the onset, there is bias already – especially if we consider the pervasive negative student sentiment at the moment. Nonetheless, the Policy Paper admits that the results are not representative of the legal education community (*Id*, at 3). They do, however, provide insights.

[397] NTC, *Consolidated ICT Infrastructure Data,* Department of Information and Communications Technology, Dec. 2019, *available at* https://dict.gov.ph/ictstatistics/wp-content/uploads/2020/01/NTC-data-as-of-December-2019.pdf

[398] Akamai, *State of the Internet Q1 2017 Report* (David Belson, ed.), *available at* https://www.akamai.com/fr/fr/multimedia/documents/state-of-the-internet/q1-2017-state-of-the-internet-connectivity-report.pdf.

Capital Region (NCR), they still reported problems with internet connectivity.[399]

Substandard internet access and reliability are obviously not a conducive environment that will aid in the mainstreaming of online learning. In fact, there are anecdotal reports where students, gaming the system, pretended that their internet connection becomes unstable in order to escape from oral recitations. This leads me to my next point.

The untouchable fixation with the Socratic Method

Law instructors still consider the modified Socratic-Langdellian Method[400] (Socratic Method, for brevity) as the gold standard in law school pedagogy. Developed by Harvard Law School Dean Christopher Columbus Langdell, this "distinct legal pedagogy" uses an "approach to law teaching based on doctrines gleaned from cases published in books."[401] This was based on his belief that law is a pristine science, likening, therefore, a law library to a chemistry laboratory and court decisions to experiments.[402]

Notably, however, some legal educators started advocating for its total elimination or treating it as a mere supplementary strategy. And despite being criticized as

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[399] *Supra* note 17.

[400] I purposely termed it as modified Socratic Method because the Socratic Method, as defined, tests commonly held principles to determine their consistency with an individual's beliefs, while eliminating those contradictions. Most of the time, there are no right or wrong answers. This is different in practice, especially in the Philippines, where there are set answers.

[401] Larry Ribstein, *Practicing Theory: Legal Education for the Twenty-First Century*, 46 IOWA L.R. 1679 (2011).

[402] Paul Carrington, *Book Review: Law School: Legal Education in America from the 1850s to the 1980s*, 72 CALIF. L. REV. 477 (1984).

being utterly ineffective or grossly insufficient,[403] the Socratic Method remains untouchable because of its high correlation with the bar examination.[404]

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[403] There is sufficient literature claiming that the Socratic Method is now an impaired method. The philosophy behind it, borne out of the peculiar circumstances during the time of Dean Langdell, already "was dated by the 1920s. It was a relic by the 1960s. Law is now regarded as a means rather than an end, a tool for solving problems." (New York Times, *Editorial, Legal Education Reform*, The New York Times, Nov. 25, 2011, *available at* http://www.nytimes.com/2011/11/26/opinion/legal-education-reform.html?_r=0). And since the emphasis of the method is definitely the theoretical, the gap between legal education and practice of law is regrettably widening (Larry Ribstein, *Practicing Theory: Legal Education for the Twenty-First Century*, 46 IOWA L.R. 1679 [2011]). Recently, numerous empirical studies showed the ineffectiveness of this method to genuine learning due to the erroneous assumption that "all students will learn 'in a parallel fashion from any given exchange between student and instructor'" (Robin Boyle and Rita Dunn, *Article: Teaching Law Students through Individual Learning Styles*, 62 ALB. L. REV. 213 [1998]). This bias towards group learning forgets that each student has his or her own learning styles (*Id.*). And even if we consider it as an individualized (*not* group) method, it still does not improve learning because "...a Socratic dialogue's series of questions has no topic sentences, no conclusions, and no transitions to a new topic. It gives students few clues about the structure of the information they're trying to learn. Their natural focus is on answering the question we have just asked (the tree), not on recognizing how that question fits into a larger pattern (the forest) (Michael Gibson, *A Critique of Best Practices in Legal Education: Five Things All Law Professors Should Know*, 42 U. BALT. L. REV. 1 [2012]). There is also a plethora of empirical evidence showing that SM causes multiple psychological problems (Ruta Stropus, *Mend It, Bend It, and Extend It: The Fate of Traditional Law School Methodology in the 21st Century,* 27 LOY. U. CHI. L.J. 449 [1996]). Nonetheless, there are a number of legal academics who still believe in the pedagogical values of the modified Socratic-Langdellian method: (a) analytical; (b) intellectual; and (c) verbal attributes. These are all indispensable in the legal profession (*see* footnote 4 of Stropus, *supra* note 31, where she cited several journal articles defending this method). However, they conceded that it will not, when used alone in law school, adequately prepare law students to the future demands of the profession.

[404] This traditional teaching method is the only significant predictor in bar examination achievement. Most of the identified predictors (*e.g.*, student learning strategies, curriculum, institutional responses) have weak positive correlations (*see* Madelene Sta. Maria, Marshall Valencia, Christopher Cruz, Louie Montemar, Charisse Yap-Tan & Justin Sucgang, A baseline study on Philippine legal education [2010] [unpublished

That is why since the birth of American-style legal education system, through the establishment of the University of the Philippines (UP) College of Law, pedagogy among LEIs remained. Justice Ruth Flerida Romero aptly concluded that "[i]n the Philippines legal instruction in the classroom is done mainly through the case method developed by Dean…Langdell of the Harvard Law School and through lectures and recitations."[405] A survey conducted in the late 1970s found that more than 70% of law professors assigned cases, and 91.3% of NCR and 69.6% of non-NCR students answered that oral recitation was expected of them during class.[406] More than 40 years thereafter, its dominance remains unrivaled. In 2010, a system-wide empirical study commissioned by De La Salle University (DLSU) College of Law found that oral recitations and discussion were used more extensively than lectures.[407] And the same results appeared three years after in a follow-up study I conducted for my Juris Doctor thesis.[408]

What makes the Socratic Method effective in facilitating learning is immediacy of feedback—the subsequent question thrown by the instructor, the intonation, and even the other non-verbal cues and gestures.

Manuscript, University Research Coordination Office, De La Salle University]) (*hereinafter*, "Baseline Study on Philippine Legal Education").

[405] Flerida Ruth Romero, *Legal Education: Philippines,* 3 ASEAN COMPARATIVE LAW SERIES, Vol. 3, 41 (1980).

[406] Irene Cortes, *An Appraisal of the Law Curriculum and Prevailing Methods of Teaching Law*, 1 PHIL. YEARBOOK OF LEGAL EDUCATION 30 (1978).

[407] Baseline Study on Philippine Legal Education, *supra* note 27, at 32.

[408] Justin Sucgang, A Problem Bigger than Law Schools: Reforming Philippine Legal Education through an Institutional Approach (2014) (unpublished J.D. thesis, De La Salle University, on file with the De La Salle University College of Law).

And conducting recitations through online platforms may not approximate the benefits when conducted onsite. Obviously, with only the professor's face projected, the non-verbal cues are almost gone. Feedback is not as immediate as before. And couple this with substandard internet access and reliability, employment of this method certainly does not help the cause of online learning since synchronous learning is bandwidth-intensive.

The stagnant design of Philippine legal education

As discussed, the Socratic Method, which has for its objective equipping law students with analytical skills, is the prevalent teaching strategy among LEIs. It is through this that the proverbial *thinking like lawyers* is realized. The design behind it is the simulation of an adversarial court proceeding wherein the professor takes the role of a judge while the student being asked (*or* grilled) takes the role of a counsel.[409]

The method and the design behind it actually reflect the prevailing notion of legal practice, *that is*, litigation; both persisting notwithstanding the changing dynamics in the legal profession,[410] or even the promulgation of *Cayetano v. Monsod*.[411] Nonetheless, this obvious bias towards litigation

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[409] L. Penland, *The Hypothetical Lawyer: Warrior, Wiseman, or Hybrid?*, 6 APPALACHIAN J. L. 73 (2006).

[410] Nowadays, "lawyers do more non-litigious work than litigious ones and are highly involved in every aspect of business management." (Sedfrey Candelaria and Maria Christina Mundin, *A Review of Legal Education in the Philippines*, 55 ATENEO L.J. 582 [2010]) In fact, one could even say that a good lawyer could avoid going to courtrooms, *at all*. Lawyers are engaged as administrators and policy-makers, and may be involved in advocacy and lobbying. All of which are squarely within the definition of law practice in *Cayetano*, there being an application of legal knowledge or skill.

[411] G.R. No. 100113 (S.C., Sep. 3, 1991) (Phil.). The expanded definition of legal practice covers the mere giving out of legal information to laymen (*Ulep v. The Legal Clinic, Inc.*, B.M. No. 553 [S.C., Jun. 17, 1993] [Phil.]), and

makes it difficult for LEIs to adopt other teaching strategies, even though requiring other modes. To illustrate, the LEB was compelled to incorporate Alternative Dispute Resolution as one of the core courses in the Model Law Curriculum due to the gradual upstaging of litigation by arbitration not only in international but also in domestic disputes, as well as the adoption of its mechanics by government agencies.[412] However, the way its content is delivered is via the Socratic Method. Notably, the practical skills instilled by this method (*e.g.*, those needed in adversarial court proceedings) are in no way appropriate to those required by arbitration or mediation (*e.g.*, negotiation and writing skills).

How then would the innovative methods of online learning be adopted if the relatively newer legal fields, which call for different practical skills, are still taught traditionally?

The overwhelming dependence on adjunct instructors

In responding to the pandemic, big LEIs favored the asynchronous mode of distance learning because it addresses "inequality gaps and bring all students to a more or less level playing field."[413] A number of them made official that preference,[414] and some even prohibited synchronous

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even the teaching of law (*Re: Letter of the UP Law Faculty entitled "Restoring Integrity: A Statement by the Faculty of the University of the Philippines College of Law on the Allegations of Plagiarism and Misrepresentation in the Supreme Court*, A.M. No. 10-10-4-SC, [S.C., Mar. 8, 2011] [Phil.]).

[412] LEB Mem. Order No. 1 (2011), §55.

[413] Fides Cordero-Tan, Memorandum No. FCT-2020-026 (Mar. 30, 2020) (unpublished memorandum for faculty and students, on file with the UP College of Law).

[414] Ateneo Law School (ALS), DLSU College of Law, UP College of Law, and University of San Carlos (USC) School of Law and Governance.

learning outright.[415] The reasons are obvious. It enables "students to study at their own pace,"[416] allowing them to pursue other pressings matters: the student may be sick, or s/he is tending to a sick relative, or s/he doing errands because other housemates may have an underlying disease. It also "take[s] due consideration of the reality of poor internet connectivity"[417] in the country.

That asynchronous learning is effective has support in educational literature, such as in teaching library and information science,[418] agricultural education,[419] and pharmacy education.[420] So, too, in legal education.[421] However, in order to make it effective, asynchronous learning frontloads time and effort from the content delivery to the

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[415] ALS, UP, and USC.

[416] Jose Maria Hofileña, *Memorandum No. 2020-14-G*, ALS, Apr. 13, 2020, *available at* https://ateneo.edu/aps/law/news/memo-als-community.

[417] Joan Largo, *Advisory to our Law Students* (Mar. 27, 2020), *available at* https://www.facebook.com/lexcircle/photos/a.2141963253242 84/3078787895531765/?type=3&theater.

[418] Susan Stansberry, *Effective Assessment of Online Discourse in LIS Courses*, 47 JOURNAL OF EDUCATION FOR LIBRARY AND INFORMATION SCIENCE 28 (2006).

[419] Sara Brierton, Elizabeth Wilson, Mark Kistler, Jim Flowers & David Jones, *A Comparison of Higher Order Thinking Skills Demonstrated in Synchronous and Asynchronous Online College Discussion Posts*, 60 NACTA JOURNAL 20 (2016). Note, however, that "neither group demonstrated anything but small forays into higher order and critical thinking skills."

[420] Carol Motycka, Erin St. Onge & Jennifer Williams, *Asynchronous Versus Synchronous Learning in Pharmacy Education*, 2 JOURNAL OF CURRICULUM AND TEACHING 65 (2013).

[421] Yvonne Dutton, Margaret Ryznar, & Kayleigh Long, *Assessing Online Learning in Law Schools: Student Says Online Classes Deliver*, 96 DENVER LAW REVIEW 521 (2018-2019). For further readings on the current state of online education in American legal education, *see* Michele Pistone, *Law Schools and Technology: Where We Are and Where We Are Heading*, 64 JOURNAL OF LEGAL EDUCATION 586 (2015).

preparation phase. An instructor must do the pre-recording of teaching modules, uploading of the syllabus, reading packets and assignments, and creation of discussion boards, wikis, and other assessment tools beforehand. Otherwise, its purpose is defeated.

This, however, poses a challenge when we consider that more than half of the faculty members of LEIs have adjunct status (*i.e.*, engaged part-time).[422] More accurately, the LEB Policy Paper pegs it at 94%, with this majority status overwhelmingly maintained across the different major regional categories.[423] Law instructors in the Philippines, especially the veteran ones, do not extensively prepare for a course before a semester. Since majority are practitioners, the good ones simply come to the classroom with a textbook; the better (*or* cocky) ones with head knowledge. This is made more complicated when we follow recommendations from existing literature where online learning is made more effective when asynchronous is combined with synchronous (functioning as introductory or integrative part of the course) modes.

The total absence of LMS

Lastly, the effectiveness of asynchronous learning seems to be but a function of online tools—specifically, the use of an LMS.[424] If the tools are not integrated, then it would

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[422] Josefe Sorrera-Ty, "Law School Administration Cluster: Current State," in *2019 Legal Education Summit*, Manila, Jul. 31-Aug. 1, 2019, pp. 21, 23.

[423] LEB Policy Paper, *supra* note 18, at 2-3.

[424] An LMS is, from a technical standpoint, "a server-based software program that interfaces with a database containing information about users, courses and content." From a functional standpoint, it "provides a place for learning and teaching activities to occur within a seamless environment, one that is not dependent upon time and space boundaries… These systems allow educational institutions to manage a

be very difficult for instructors to see the mastery of students. Consider the following:

> "One of the things that I noticed when teaching online was that I had much greater access to students' work than I did in the face-to-face course. In the online course, I was able to see every post students made in the discussion board, and I was able to watch their preparation for negotiation, their performance in that negotiation, and their reflection on their performance. Since much of this interaction was conducted in writing, I was able to judge their attention to detail, their ability to think clearly, and the extent of their participation. In addition to assessing their assignment, the LMS allowed me to observe how often they accessed the material in the course and where they went within the course. While I can look at the classroom in a face-to-face environment and assess from body language whether or not students comprehend the material, I am never quite sure. The distance-learning environment allows me to more accurately gauge how students are processing the material."[425]

Imagine a professor conducting an asynchronous class, say a discussion board through Viber, sending of assignments through email, and holding online quizzes through Survey Monkey. In this case, I would daresay that asynchronous learning is no better than the traditional onsite class. The

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large number of fully online or blended (part online and part face-to-face) courses using a common interface and set of resources." *See* Anthony Piña, *An Overview of Learning Management Systems*, *in* LEARNING MANAGEMENT SYSTEM TECHNOLOGIES AND SOFTWARE SOLUTIONS FOR ONLINE TEACHIG: TOOLS AND APPLICATIONS 1-2 (Information Science Reference, Yefim Kats, ed., 2010).

[425] Sean Nolon, *Using Distance Learning to Teach Environmental Problem Solving Skills and Theory,* 28 JOURNAL OF ENVIRONMENTAL LAW AND LITIGATION STUDIES EDUCATION 225 (2013).

diverse and unintegrated tools will render it difficult for a professor to accurately monitor student progress, and, consequently, give useful feedback immediately. Without the necessary tools, the benefits of asynchronous learning are near absent.

Sometime in January 2019, DLSU rolled out its LMS via Canvas (called AnimoSpace),[426] with its College of Law undergoing training as early as November 2019. Remarkably, Canvas is used by more than 3,000 universities around the world; among the notable American law schools that adopted it are Harvard Law School, Yale Law School, Stanford Law School, University of Michigan Law School, Georgetown University Law Center, and University of Chicago Law School. While the Far Eastern University has Canvas as well, Ateneo de Manila University has Moodle, and UP the University Virtual Learning Environment, none of their constituent LEIs bothered to adopt an LMS. The USC recently adopted Schoology as a response to the pandemic.

PART II

Considering the foregoing reasons, the pandemic may not be the tipping point to the system-wide acceptance of online legal education. Although some aspects of teaching already utilize online tools, COVID-19 will not usher the mainstreaming of online legal education. However, with online learning being forced even to the most loyal adherents of Socratic Method, COVID-19 gives us a foretaste of its potential. And what I project right now are the following:

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[426] DLSU, *AnimoSpace: The Lasallian Learning Management System*, Medium, Dec. 3, 2018, *available at* https://medium.com/@DLSUManila/animo-space-the-lasallian-learning-management-system-ff836eb17970.

(a) utilitarian (*not* pedagogical) adoption of online legal education; and (b) adoption via its blended form.

First, online legal education may be adopted *not for its pedagogical value* but for a utilitarian purpose, enabling us to reach the augmentation phase of the SAMR Model. I predict that there may be a rise in its use as an alternative to make-up classes. In 2019, there are at least 21 suspended class days in Manila due to inclement weather, strikes and hosting of Southeast Asian games, on top of the national and local holidays. Moreover, make-up classes—be it synchronous or especially if asynchronous—may likewise be conducted online to compensate for the instructors' personal absences. And this may be used for all classes in all LEIs where he may be teaching.

Second, online education may be adopted in its blended form, pushing us further to the modification phase. For example, law instructors who may have been exposed thereto may use discussion boards, or pre-recorded video lectures or podcasts. They may also deploy electronic quizzes. These technology-assisted learning may act as a supplement to the onsite Socratic Method, to further enrich classroom discussion, and to free him from manually checking objective-type questions. They may even use electronic quizzes as a diagnostic tool deployed before beginning a new topic to give him a sense of aspects of the assignment that may need further expounding since results may be obtained in real-time.

EPILOGUE

COVID-19 disrupted the Philippine legal education system, forcing even the traditionalists to consider online learning. However, no amount of watering will make a plant grow in unfertile soil. In the same way, online learning will not be part of the mainstream Philippine law school pedagogy with the kind of system currently in place, with the kind of actors dominating the system, with the philosophy and focus pervading the system, and with the hard and soft infrastructure within the reach of the system—despite the pandemic. And it will not be a legitimate and effective alternative to the prevailing teaching strategies among Philippine LEIs, despite its potential.

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