**Philippine National Health Accounts (PNHA)**

**Data Sources & Estimation Procedures**

This section describes data sources and estimation procedures used in the compilation of the 1991 to 2002 Philippine National Health Accounts (PNHA) matrices. It also discusses the significant revisions/changes made since the first publication covering the 1991 to 1997 PNHA. It also describes how inadequacies in the data (with respect to PNHA needs) were handled, i.e. specific estimation rules applied, so that users can take these limitations into account when interpreting the PNHA statistics.

**National Government**

**.:: DOH and Other National Government Agencies**

• Data Sources

The following documents/data were used, namely: (a) COA’s 1991-1999 and 2002 Annual Financial Report of National Government which reports total actual expenditure per agency; (b) COA’s special tabulation of 2000-2001 actual expenditure per agency excluding FAPs for agencies covered in the PNHA; (c) DBM’s 1991-1994 General Appropriations Act (GAA) containing appropriation per program/project/activity (PPA) per agency; and (d) DBM’s 1995-2002 National Expenditure Program (NEP) files containing obligations incurred per PPA per agency.

• Coverage and Estimation

Expenditures included in the PNHA are those for national government agencies with health-related activities. For PNHA purposes, national government agencies were broadly classified into two, namely: (a) agencies whose mandates are all health-related (i.e., “health-related” agencies); and (b) agencies also providing non-health services (i.e., “partial budget” agencies).

The entire budget/expenditures of “health-related” agencies are included in the PNHA. These are as follows: DOH-OSEC, DDB, PHC, LCP, NKTI, PCMC, PVAO-VMMC, FNRI, NMIC, AFP-Medical Center, NNC, POPCOM, PCHRD, NCWDP.

“Partial-budget” agencies, on the other hand, are those agencies in which only a portion of their expenditures are for health care. These are: AFP-GHQ, AFP-PN, AFP-PA, AFP-PAF, NBI, BFP, BCOR, DECS-OSEC, OP-Proper, UP System, DOLE-OSEC, PNP and NAPOLCOM.

Since COA does not report expenditures with the required PNHA breakdown (i.e. by agency and by program/project/activity or PPA), expenditures per PPA were estimated.

For the years 1992-1994, national government expenditures with the required PNHA breakdown (i.e. by agency and by program/project/activity or PPA) were estimated based on (a) appropriation per PPA by agency as reported in the 1992-1994 GAA of the DBM; and (b) agency actual expenditure-to-appropriations ratios or "utilization rates" computed from agency-level data reported in the 1992-1994 Annual Financial Report of National Government of COA. For the 1995 to 2002 series, the estimates were based on: (a) obligations incurred per PPA by agency as obtained from the NEP files of the DBM and (b) agency actual expenditure-to-obligations incurred ratios or “utilization rates” computed from agency level data reported in the 1995-1999 and 2002 Annual Financial Report of National Government of COA and the 2000-2001 special tabulation of actual expenditure (excluding FAPs) per agency also provided by COA.

The 2002 Annual Financial Report (AFR) of the National Government of the COA is the first report based on the New Government Accounting System (NGAS). The NGAS is a simplified set of accounting concepts, guidelines and procedures adopted by COA to ensure correct, complete and timely recording of government financial transactions and production of accurate and relevant financial reports. One implication of the new accounting system is the non-comparabilty of data on expenses by object, that is, by Personal Services (PS), Maintenance and Other Operating Expenses (MOOE) and Capital Outlay (CO). The new summary reports from COA now include expenses according to: PS, MOOE, Financial Expenses and Subsidy. Thus, expenses for CO are estimated using previous proportions of CO to total.

Expenditures of GOCCs like National Kidney and Transplant Institute, Philippine Heart Center, Philippine Children's Medical Center and Lung Center are funded by budgetary support coming from the national government as well as by revenues from agency operations and other sources of corporate funds.

In the case of the Bureau of Corrections, health expenditures are measured only in terms of the salaries of its medical officers and chiefs of hospitals. Other operating costs of its facilities could not be estimated from the current format of expenditure reporting.

Administration cost of health services in agencies also providing non-health services (i.e. "partial budget" agencies) are estimated by multiplying (a) total general administration and support services expenditures with (b) percentage share of health-related expenses to total expenses of the agency net of general administration expense.

• Classification by PNHA Use

Expenditures for mixed services/facilities (e.g., payment for hospital, medical and other professional health care by NAPOLCOM) which could not be disaggregated by component are classified according to the most expensive component or that which is expected to account for most of the total. In the example cited, the mixed-uses expenditures of NAPOLCOM are classified under government hospital care. This general rule on classification is applied repeatedly on various types of expenditure mixes as described in some of the succeeding items below.

Expenditures of DOH's Dental Services are classified under personal health care since most of its budget are for dental commodities provided to RHUs through the Community Health Care Agreement (CHCA).

RHU expenditures for dental services are included under public health care because no detail on RHU/BHS budget is available. Based on service statistics reports for RHUs and BHS, however, dental cases account for about 2.14 percent of all cases seen at RHUs and BHSs. For a rough estimate of dental cost, the percentage may be applied to total DOH budget for Field Health Services, for pre-devolution years, or to total LGU budget for Health Services, for post-devolution years.

Due to data limitations, expenditures for dental clinic services of the following agencies are lumped under either the government hospital health care or clinic care categories: AFP/General Headquarters, AFP-PAF, AFP-PA, AFP-PN, DECS-OSEC and OP-Proper.

Expenditures of the DOH for its Traditional Medicine Program and Herbal Processing Plants are classified under (personal) traditional health care.

All activities of government hospitals including those for general administration and support services are classified under government hospital care.

Terminal Leave Benefits, Personnel Economic Relief Allowance and other similar (non-salary or non-wage) personnel compensation/benefits, which were reported lump-sum under General Administration and Support from 1992-1993, were all assigned under the PNHA uses category Other-General Administration. This rule must particularly be taken into account when comparing levels of central government administration expenditures to expenditures for other PNHA uses. It should be noted that these benefits are paid not only to personnel performing administrative functions but also to those performing health care provision functions.

Starting 1994, with the reclassification of national government expenditure items, only Medicare, EC and PAGIBIG premium payments were retained lump-sum under General Administration. All other types of personnel benefits or non-salary compensation (90 percent of all benefits) were already reported as part of Personal Services for each program or activity of the agencies, i.e. transferred out of General Administration. With this new way of reporting, majority of personnel benefits have then been classified according to the program or activity to which they have been transferred, i.e. no longer General Administration. This change should be taken into account when comparing General Administration cost between the years 1993 and 1994.

**.:: Foreign-Assisted Projects**

• Data Sources

Data on health expenditures by foreign-assisted projects (FAPs) came from three basic sources (listed in the order of preference): (a) DBM's BESF; (b) DOH-Foreign Assistance Coordination Service reports and DOH Annual Reports; and (c) NEDA Project Management Staff reports. BESF is preferred because it is the source that provides actual fund utilization by projects. The other two sources, however, are also necessary because not all FAPs are reported in the BESF.

• Coverage and Estimation

All FAPs undertaken by the DOH (or those in which DOH is one of the implementors) are included in the PNHA. Similarly, all FAPs of other national government agencies whose mandates are entirely health-related (e.g., National Nutrition Council, Food and Nutrition Research Institute, Philippine Council for Health Research and Development, etc.) are also included.

Actual availment for the year are reported only for projects listed in the BESF and, when available, availment figures are used directly in the PNHA. For projects with multiple implementing agencies, only the availment of the DOH and the health-related agencies are included in the PNHA.

When actual availment data are not available, as in the case for FAPS reported only in DOH-FACS or NEDA-PMS documents, an alternative estimation method is used. Three pieces of information are required: (a) total project cost, (b) project duration and (c) number/types of implementing agencies. Annual availment is then estimated as follows: divide total project cost by the duration of the project and then calculate for the share of the health agencies out of the total estimated availment assuming that each implementing agency is assumed to take equal share out of total availment. If even one piece of information is missing, annual availment was not estimated.

• Classification by PNHA Use

Expenditures by FAPS for mixed services/facilities (e.g., Philippine Health Development Project's payments for hospital equipment, vector control, training of public health personnel, improvement of provincial health office planning and programming and more) which could not easily be disaggregated by component are classified according to the most expensive component or that which is expected to account for most of the total. In the case of the PHDP, most of the expenditures are for providing public health care.

**.:: Local Government**

• Data Sources

Health care expenditures of the Provincial, Municipal and City Governments are reported, along with all other local government expenditures, in the Commission on Audit's (COA) 1991-2001 Annual Financial Reports of Local Government.

• Coverage and Estimation

Health expenditures of LGUs are reported under two (COA-defined) expense categories: Health, Nutrition and Population Control (Population Control was reported together with health services in 1991. Starting 1992, the program was renamed Family Planning Service and assigned under Social Welfare Services) and Education Subsidiary Services (a subcategory under Education Services).

General administration cost for health services provision was estimated by applying (a) the proportion accounted for by health services out of total cost for all LGU services (i.e., total include health, education, labor and employment, housing, economic and others) to (b) total general administration cost of LGUs. Administration cost includes those for the following: Executive, Planning and Coordination, Accounting, Auditing, Treasury, Budgeting, Administrative and General Services.

The data for education subsidiary services (under item on Non-Hospital MD Facilities) is not available from the 2002 COA AFR. Current data were therefore estimated using regression of the proportion to total local government health expenditure.

• Classification by PNHA Use

LGU health expenditures were generally classified under four uses: Hospital Services under personal (hospital) care; Education Subsidiary Services under personal (non-hospital) care; Health Services, Chest Clinic, Population Control, Development Funds and Miscellaneous Health Services under public health care; and Administration Expenditures under "others".

**Social Insurance**

• Data Sources

Most of the required data were taken from the 1992-1997 Annual Reports of the GSIS and SSS. Starting 1998, expenditures from Medicare program were obtained from PhilHealth’s Statement of Revenues and Applications.

Expenditures of PMCC (1992 to 1995) and PhilHealth (1996-1997) were obtained from COA’s Annual Financial Report of National Government and DBM’s General Appropriations Act and National Expenditure Program (NEP) files.

For OFWs’ Medicare program, expenditures were obtained from the 1995-2002 Annual Statement of Income and Expenses and Fund Balance of OWWA-Medicare Assistance Unit.

Data on EC benefit payments by type (to be able to segregate medical benefits) were obtained from reports of the ECC's Policy, Programs and Systems Management Division. For the 1995 to 2002 EC-SSS data, information were obtained directly from SSS.

Tabulations for the 1992 and 1993 Medicare claims by type of hospital paid were generated by PMCC (Health Data Systems). Tabulations for the later years were generated directly by GSIS/SSS/PhilHealth.

• Coverage and Estimation

Included are benefit payments from the Medicare Fund (SSS and GSIS for 1992 to 1997; PhilHealth for 1998 to 2002; OWWA-Medicare for OFWs from 1995 to 2002), EC Fund of SSS and GSIS (medical components only) plus operating expenses of these institutions attributable to the management of the said fund.

Included also are the entire expenditure of PMCC, the forerunner of PhilHealth, from 1992 to 1995.

General administration cost for the medical component of EC are estimated by applying the proportion accounted for by EC-medical benefit payments (out of the total benefit payments for EC) to the total general administration cost of EC.

Insurance expenditures of the GSIS were excluded to avoid double counting. Payments by re-insurers are accounted for in the "private insurance" column of the PNHA.

The first release of the PNHA (i.e., 1991-97 PNHA) included net income and additions to reserves among the “others” use of fund. These two items were later excluded from the PNHA concept of health expenditure as these do not represent actual expenditure. Instead, information regarding these are placed as memo items under the PNHA annual matrices. For the medicare, “net revenue” (of SSS and PhilHealth), “net income before increase in reserves” (of GSIS) and “excess of receipts over expenses” (of OWWA-Medicare) refers to total revenue of the medicare fund net of benefit payments, administrative and operating and other expenses. For the EC-medical component, net revenue (for SSS) and net income before increase in reserves (for GSIS) were estimated by applying the proportion accounted for by EC-medical benefit payments (out of the total benefit payments for EC) to the total net revenue/net income before increase in reserves of EC.

Breakdown of GSIS and SSS Medicare benefit payments by type of hospital was available only for selected years. Information on the breakdown was obtained from special tabulations made by PMCC, GSIS and SSS. For the years for which no tabulations were obtained, the breakdown was estimated based on data from the nearest year(s).

No breakdown by type of hospital was derived for the 1998 Medicare benefit payments since PhilHealth’s computer system was still in the process of enhancement and was not yet capable of extracting such data at that time. Starting 1999, however, PhilHealth was able to provide such breakdown in terms of percentage shares.

In the same manner, no breakdown by type of hospital was derived for OWWA-Medicare benefit payments due to lack of data.

• Classification by PNHA Use

For Medicare, benefit payments cover only hospitalization cost and are therefore classified under PNHA use category personal (hospital) care.

EC medical benefits cover hospitalization as well as rehabilitative care and should therefore be classified under four subcategories of personal care, i.e. government hospital, private hospital, non-hospital medical clinics and other professional care, if data were available.

**Private Sources**

**.:: Out-of-Pocket**

• Data Sources

Data on household expenditure for health are taken from the National Statistics Office's (NSO) Family Income and Expenditure Survey (FIES) conducted every three years. The 1991, 1994, 1997and 2000 FIES results were used directly in the PNHA estimation.

Other data/parameters used include: (a) 1992-2002 Personal Consumption Expenditures (PCE as estimated in the National Income Accounts); (b) proportion of PCE spent by non-household entities (1990 Social Accounting Matrix of NSCB); and (c) proportion of household health care expenditures truly paid for by household funds (PNHA Rider to the 1994 FIES.)

• Coverage and Estimation

For the FIES years 1991, 1994, 1997 and 2000, household health care expenditures were estimated directly by multiplying the ratio of health care to total household expenditures (computed from the FIES) by the PCE for the current year.

During non-FIES years, household health care expenditures were estimated by multiplying (a) the ratio of health care to total household expenditures (computed from the FIES) for the closest FIES year(s) with (b) PCE for the current year.

If estimation year falls between two FIES years, the ratio used is derived by linear interpolation of the: (a) computed ratio from the FIES conducted prior to the estimation year; and (b) the computed ratio from the FIES conducted after the estimation year.

If estimation year comes after an FIES year and no FIES has been conducted after the estimation year, then the ratio computed from the most recent FIES is used and assumed to remain the same in the current year.

The 1998, 1999 and 2000 PNHA estimates of out-of-pocket were updated/revised as results of the 2000 FIES.

The PNHA Rider to the 1994 FIES provides an estimate of the percent of health care expenditures which are truly paid for by household funds, that is, excluding the value of free medical goods and services from government hospitals/clinics and value of medical goods and services paid for by employers, medicare, private health insurance and charitable or philanthropic organization.

In all the calculation involving the use of the PCE, the proportion of spending by non-profit institutions serving households (NPISH) was netted out of PCE to make PCE comparable to the composition of FIES expenditures.

Similarly, in all calculations involving the ratio of health expenditures to total household expenditures, the proportion of the spending that went into taxes, gifts/donations and miscellaneous expenditures are netted out of the FIES household expenditures for comparability with the composition of the PCE (net of non-household final consumption expenditures).

• Classification by PNHA Use

Except for 1994 for which the PNHA Rider to that year's FIES provides household health expenditure breakdown by NHA use categories, no such breakdown are available for the other years.

**.:: Private Insurance**

• Data Sources

Data on health benefit payments and administrative plus other costs of private insurance companies were taken from the 1991-2002 Annual Reports of the Insurance Commission.

GSIS provided the data on benefit payments from the Hospitalization Insurance Plan (HIP) component of its Optional Life Insurance Fund (OLIF). The administrative and operating expenses of the OLIF were directly lifted from the Annual Reports of GSIS.

• Coverage and Estimation

Included are health benefit payments by both life and non-life insurance companies and the administrative costs attributable to the health insurance activities. Health benefits are reported in the Annual Report and these are used directly in the PNHA.

Included also are benefit payments from the Hospitalization Insurance Plan (HIP) under the Optional Life Insurance program of GSIS.

General administrative expenses and other costs of health and accident insurance activities were estimated using the assumption that for any company, the average cost per peso of any type of insurance benefit paid is the same. Thus, general administrative cost for health insurance was estimated by multiplying the proportion of health and accident benefit payments (to total benefit payments of a company) with the total general and other operating expenditures of the same company.

General administration cost for the HIP component of the Optional Life Insurance of GSIS are estimated by applying the proportion accounted for by HIP benefit payments (out of the total benefit payments for Optional Life Insurance) to the total general administration cost of Optional Life Insurance.

The first release of the PNHA (i.e., 1991-97 PNHA) included net income and additions to reserves among the “others” use of fund. These two items were later excluded from the PNHA concept of health expenditure as these do not represent actual expenditure. Instead, information regarding these is placed as memo items under the PNHA annual matrices. For private life and non-life insurance companies, net income of a company was estimated by multiplying the proportion of health and accident benefit payments (to total benefit payments from all insurance activities of a company) with the total net income from all insurance activities of the same company. Likewise, additions to reserves of a company was estimated by multiplying the proportion of health and accident benefit payments (to total benefit payments from all insurance activities of a company) with the additions to reserves from all insurance activities of the same company. Only life insurance companies reported additions to reserves. For HIP, net income before increase in reserves (for GSIS) was estimated by applying the proportion accounted for by HIP benefit payments (out of the total benefit payments for the Optional Life Insurance) to the total net income before increase in reserves of the Optional Life Insurance.

• Classification by PNHA Use

All health and accident benefit payments are classified under personal health care. Expenditures cannot further be classified according to the specific type of facility due to lack of data.

All other expenses are classified under the PNHA uses category "others" (i.e. general administration, additions to reserves and net income).

**.:: Health Maintenance Organizations (HMOs)**

• Data Sources

Data on health benefit payments and operating costs of HMOs are taken from Financial Statements (FS) submitted to the Securities and Exchange Commission. For those HMOs for which no FS were obtained from the SEC, the FS were obtained, as much as possible, directly from the HMOs themselves.

Consumer price index for medical goods and services for the years 1988 to 2002 were obtained from the NSO.

• Coverage and Estimation

Included in the PNHA are expenditures of entities that have been confirmed to be HMOs: (a) confirmed through brochures obtained from the organization; and (b) confirmed through the listing provided by the Bureau of Licensing and Regulations (BLR) of the DOH.

The first release of the PNHA (i.e., 1991-97 PNHA) included net income among the “others” use of fund. Net income was later excluded from the PNHA concept of health expenditure as it does not represent actual expenditure. Instead, information regarding net income earned by HMOs is placed as one of the memo items under the PNHA annual matrices. Net income of HMOs refers to total revenue net of benefit payments, administrative and operating and other expenses.

For HMOs with missing financial statement, expenditures for that year may be estimated by one of three ways: (a) using CPI for the medical sector, deflate succeeding year's expenditures; (b) using CPI for the medical sector, inflate past year's expenditures; and (c) using a past year's and a succeeding year's expenditures, interpolate expenditures for the year that falls between the two years. Of the three, the third method is preferred if data permits. In any of these approaches, only benefit payments and operating expenses are estimated. No attempt was made to estimate additions to reserves and net income as these do not seem to follow distinct patterns of change over the period covered.

For the years 1992-2002, all three methods were invariably applied.

For HMOs that report premium collections in "net" format (i.e., net premium equals premium collected minus benefit payments) and for which benefit payments data are not available, benefit payments are estimated in one of two ways: (a) for all HMOs with complete data for the year, calculate industry average of the ratio of net premium to benefit payments and then apply the average industry ratio to the specific HMO's reported net premium; or (b) for HMOs with complete data for the year, calculate the industry average of administrative or operating cost per peso of benefits paid and then apply the industry average operating cost to the specific HMO's reported total operating cost.

• Classification by PNHA Use

All HMO benefit payments are classified under personal health care. Expenditures cannot further be classified according to the specific type of facility due to lack of data.

All other expenses are classified under the PNHA uses category "other" (i.e. commission expense, general operating expense, taxes paid and net income).

**.:: Employer-Based Plans**

• Data Sources

Average expenditure (excluding Medicare premium payments, EC premium payments, cash advances, premium payments to external private insurance or HMO) for the health care of employees per establishment, by employment size and by industry type, were estimated using results of the PNHA Rider to the 1994 Census of Establishments.

Number of establishments by employment size and by industry type for 1992-1994 were obtained from NSO's Yearbooks of Labor Statistics (various years). The 1995, 1996, 1999, 2000 and 2001 data were obtained directly from the Industry and Trade Statistics Department (ITSD) of NSO.

Consumer price index for medical goods and services for the years 1988 to 2002 were obtained from the NSO.

• Coverage and Estimation

Included in the PNHA are expenditures by establishments for the following: (a) health expenditure allowance/ reimbursements; (b) in-house provision of health care (personnel and other facility costs); (c) in-house provision of drugs and medicines; (d) pre-paid (retained) health care providers; and (e) fitness/health programs.

Total health care expenditures for all establishments in 1994 was estimated by multiplying (a) 1994 average health care expenditure per establishment by size of employment and type of industry (PNHA Rider to the 1994 CE) with (b) number of establishments for each size and industry type for 1994. For the other years, the 1994 average health cost per establishment were similarly multiplied by the number of establishments for the current year; and then the total expenditure obtained was adjusted for inflation using the CPI for medical goods and services.

Complete listing of establishments was conducted by the NSO in 1988 and 1996. During intervening years, the NSO generates the annual number of establishments (by employment size and by industry) by updating the previous year’s list only for sample areas. When a complete listing was conducted again in 1996, the total number compared to the previous year (1995) almost doubled. Therefore, it was assumed that data for intervening years are underestimated due to the fact that updating is conducted only in sample areas. To correct for underestimation/undercoverage, the 1992 to 1995 annual number of establishments (by employment size and by industry) were estimated by applying the straight line method to the 1991 and 1996 data (Ideally, it would have been better if the 1988 data was used instead of the 1991 data since 1988 was the year when a complete listing was also conducted. However, the 1988 data was no longer available from the NSO). Further, no updating activities were done in 1997 and 1998. Instead, the next updating was conducted in 1999 based again on sample areas. Thus, the 1997 and 1998 number of establishments were likewise estimated by applying the straight line method to the 1996 and 1999 data.

Data for 2002 were estimated using the consumer price index for medical goods and services.

Administration cost of providing health care was not estimated due to lack of data.

• Classification by PNHA Use

All expenditures for establishments (as estimated above) are classified under personal health care. No breakdowns by PNHA use categories are available.

**.:: Private Schools**

• Data Sources

Average expenditure (1991-1993) for the health care of students per private school, by enrollment size, were estimated using results from the PNHA Survey conducted by the Commission on Higher Education (CHED) in 1995.

Total number of private schools by year was obtained from the Department of Education (DEpEd) and CHED. Distribution of private schools by enrollment size were obtained from: (a) NHA Survey by CHED (for higher education institutions 1991-1993) and from (b) DepEd (for pre-elementary, elementary and secondary schools 1991-1993, 1995-1996, 1996-1997, 1997-1998, 1998-1999, 1999-2000 and 2000-2001; (c) CHED (for higher education institutions 1995-1996, 1996-1997, 1997-1998, 1998-2000, 2000-2001.

Consumer price index for medical goods and services for the years 1988 to 2002 were obtained from the NSO.

• Coverage and Estimation

Included in the PNHA are expenditures by private schools for providing medical and dental care to students. Expenditures are basically for salaries and wages of health personnel and drugs and supplies.

Total health care expenditures for all private schools from 1991-1993 were estimated by multiplying (a) 1991-1993 average health care expenditure per school by size of enrollment (PNHA Survey by CHED) with (b) number of schools for each enrollment size for the years 1991-1993. For other years, the 1993 average costs were similarly multiplied by the number of schools for the current year; and then the total expenditure obtained was adjusted for inflation using the CPI for medical goods and services.

The 2002-2003 distributions of private tertiary schools by enrollment size were not yet available from CHED at the time of the compilation. Thus, the 2000-2001 distribution was applied to the 2002-2003 total number of private tertiary schools to estimate the 2002-2003 distribution. For the distributions of pres-school and elementary by enrollment size for SY 2002-2003, the 2001-2002 distribution was applied.

Due to unavailability of current data on actual distribution of private pre-school and tertiary schools for SY 2002-2003, the 2000-2001 actual distribution was applied to the total number of schools for 2002-2003. For the actual distribution of private elementary for SY 2002-2003, the 2001-2002 actual distribution was applied to the total number of schools for 2002-2003.

Administration cost of providing health care was not estimated due to lack of data.

• Classification by PNHA Use

All expenditures for establishments (as estimated above) are classified under personal health care. No breakdowns by PNHA use categories are available.

**Others**

• Data Sources

Data on health expenditures by “others” came from health care expenditures and sources of financing of all DSWD licensed/accredited NGOs. These are licensed accredited social welfare agencies of the DSWD who submitted their Annual Accomplishment Report with Annual Financial Statement.

• Coverage and Estimation

All processed annual financial statement submitted to DSWD by the NGOs are included in the PNHA.

The health expenditures of NGOs was based on a blowing up factor N/n.

Included in the PNHA are expenditures providing medical and dental care of NGOs. Expenditures are basically hospitalization, medication, drugs, supplies and other health programs.

• Classification by PNHA Use

Medical expenses; laboratory exams; medical assistance; medical equipment; doctor’s fee; hospitalization and medication are classified under personal health care.

All expenditure like Immunization; Pulmonary Tuberculosis (PTB) Treatment; Psychological Testing; Counseling Session: Blood Program; Free Consultation/Distribution of Medicines; Nutritional Assistance; Outside Medical Help Program; Hygiene Kit; Annual Medical Check-up; Special Medical Assistance; Community Health and Nursing Department; Health and Sanitation; Hepatitis Vaccination; Therapy Counseling; Safety Services; Medical and Health Mission; Health Program; Medical/Dental/Psychiatric and Social Hygiene; Rehabilitation Services for Person with Disabilities (PWD); Health and Physical Development; and Psychological Testing are classified under public health care.

Research activities; Health and Hygiene Education; Promotion and Health Issue; Health and Physical Development; Training of Health Workers; and Advancement and Promotion are classified under Others.