HARVARD MEDICAL SCHOOL
BRIGHAM AND WOMEN'S HOSPITAL

CASES IN GLOBAL HEALTH DELIVERY

GHD-030
OCTOBER 2015

"Sin Taxes" and Health Financing in the Philippines

In April 2015, Dr. Enrique Ona stood before a diverse group of finance ministers from low- and middle-income countries at a finance leadership forum. The forum organizers had invited him to serve as an "expert resource" during a session on the health and economic benefits of tobacco control. Ona had worked as a physician and seen the health effects of tobacco consumption before becoming health secretary of the Philippines, which had a very high smoking prevalence. Ona detailed to the ministers how the country had raised tobacco taxes after decades of opposition from the tobacco industry and allied politicians. The new legislation earmarked a majority of the revenues for health, enabling him to extend subsidized coverage under the government's health insurance plan to all poor and near-poor Filipinos and invest in health facility upgrades.

Although Ona had resigned from his post in late 2014, he remained concerned about the impact of the "sin tax" reforms on smoking prevalence and health care access. Could the initial decline in smoking be sustained long-term? Could the new revenues have the impact on national health that he hoped?

Overview of the Philippines

From the 16th until the late 19th century, the Philippines was under Spanish rule. During this time, Roman Catholic missionaries converted a majority of the population to Christianity, introduced tobacco farming, and built universities and hospitals.[1] In 1898, Spain lost the Spanish-American War and ceded the islands to the United States (US; see **Appendix** for commonly used acronyms).[2]

In 1941, the US entered World War II, and Japan invaded the Philippines. More than 1 million Filipinos were killed by the time Japan surrendered in 1945.[3] In 1946, the country gained independence from the US and became the Republic of the Philippines.

In 1965, Filipinos elected Ferdinand Marcos as president. Under his leadership, corruption and civil rights abuses were common. In 1986, Marcos fled the country during a popular revolution, and new national elections installed Corazon Aquino—the widow of Marcos's political rival—as president.[4]

The 1990s and 2000s were politically tumultuous, with repeated allegations of election fraud and several coup attempts. The economic growth of the 1990s halted with the Asian financial crisis in 1997. Vice

Amy Madore, Julie Rosenberg, and Rebecca Weintraub prepared this teaching case for the purpose of classroom discussion rather than to illustrate either effective or ineffective health care delivery practice.

President Gloria Macapagal-Arroyo became president in 2001, and the economy rebounded. But poverty, inflation, income inequality, and the budget deficit increased during her presidency, and legislators filed impeachment complaints for election fraud and corruption.[5] A 2008 national poll declared Arroyo the most unpopular leader since Marcos.[6]

When former president Corazon Aquino died in 2009, Filipinos called for her son, Liberal Party member Senator Benigno Aquino III, to run for president.[7] Aquino accepted and ran on a platform of government reform and poverty reduction. Unlike previous presidents, he did not accept campaign contributions from the tobacco industry. In 2010, he became the 15th president of the Philippines. Filipinos affectionately called him *NoyNoy*, a nickname derived from *Pinoy*, the slang word for Filipino.

In response to pressure from Philippine tobacco control groups to quit smoking, Aquino said, "When I ran for president, the public knew I smoked. At the appropriate time, I'll stop. […] This is one of the few remaining freedoms I have."[8]

Geography, Demographics, and Economy

The Republic of the Philippines (the Philippines) is an archipelago of 7,107 islands in the Western Pacific Ocean in Southeast Asia (see **Exhibit 1** for a country map). The islands—about 2,000 of which are inhabited—comprise three geographical regions: Luzon, home to the capital city of Manila; Visayas; and Mindanao.[9] In 2014, the Philippines was organized into 81 provinces headed by governors, 144 cities and 1,490 municipalities headed by mayors, and 42,029 *barangays* (villages) headed by barangay captains.[10] An estimated 80% of the population was Roman Catholic.[11] Average household size was 4.6 people in 2010, down from 5 in 2000.[12]

The Philippines was a lower-middle-income country and the 39th-largest economy in the world.[13] It was one of the leading rice producers.[14] Other agricultural products included sugar, corn, coconuts, pineapple, and rubber.[15]

In 2009, average annual household income was PhP 206,000 (Philippine pesos), or USD 4,605 (US dollars).[*] Families in the poorest decile earned PhP 41,000 (USD 917) annually, on average.[16] In 2010, underemployment and unemployment were 20% and 7.3%, respectively.[17] Approximately 75% of workers were employed in the informal sector; 10–15% of the population was considered part of the "underground economy"—part of the informal sector that did not qualify as poor. Fifty-three percent of the population worked in the services industry, and 32% worked in agriculture. Foreign remittances comprised 8.5–10.5% of GDP from 2010 to 2013.[18]

Basic Socioeconomic and Demographic Indicators[†]

INDICATOR		YEAR
UN Human Development Index ranking	117 (out of 187)	2013
Population (thousands)	100,096	2014
Urban population (%)	44.5	2014
Access to an improved water source (% of total population)	92	2015
Poverty (% living on less than USD 1.25 per day, 2005 international prices)	19.0	2012

[*] All currency calculations were performed using the prevailing exchange rate on March 24, 2015 of 1 USD = 44.7350 Philippine pesos (PhP). The average exchange rate from January 1, 2008 – March 24, 2015 was 1 USD = 44 PhP.

[†] Compiled by case writers using data from the United Nations, UNICEF, World Bank, and UNESCO.

INDICATOR		YEAR
Gini index	43.0	2012
GDP per capita in PPP (current international dollars)	6,915.6	2014
GDP per capita (current USD)	2,843.1	2014
Literacy (total/female/male)	95.4/95.8/95	2008

Health in the Philippines

The Philippines began reporting national morbidity and mortality data in the late 1970s. There was limited integration of local and national data collection systems, and the DOH relied on vertical surveillance systems for disease estimates.[19] The Philippine Cancer Society, a nongovernmental organization (NGO), managed the national cancer registry.

In 2009, the main causes of death included heart disease, vascular disease, malignant neoplasms, pneumonia, accidents, and tuberculosis.[20] The primary causes of morbidity were acute respiratory infection, acute lower respiratory tract infection and pneumonia, bronchitis, hypertension, watery diarrhea, and influenza.[21] Approximately 22% of adults were overweight and 6% of adults were obese in 2011.[22]

While tuberculosis treatment rates had improved, the Philippines was still on the World Health Organization's (WHO's) list of high-burden countries in 2010.[23] The country was not on track to achieve the Millennium Development Goals (MDGs) for maternal and reproductive health.[24] Maternal mortality had risen from 162 deaths per 100,000 live births in 2006 to 221 deaths per 100,000 live births in 2011.[25]

Health System

The Philippines' public health system consisted of national and regional tertiary hospitals; provincial and district hospitals; city and municipal health centers; and *barangay* (village) health centers and rural health units. Since 1991, the health system had been decentralized. Local government units, or LGUs (provinces, cities, municipalities, and *barangays*), administered and financed health services locally and were the main providers of primary health care. They were expected to dedicate 30% of their budgets to health.

Rural health units and *barangay* health centers frequently were understaffed and undersupplied. Patients regularly bypassed local facilities to visit regional hospitals or private facilities. The Department of Health (DOH) managed 72 regional and tertiary hospitals and provided oversight, targeted funding, and technical guidance to LGUs.[19] Public hospitals were also overcrowded and underequipped; as of 2010, no new national hospitals had been built since the early 1980s, and only a few provincial and district hospitals had expanded. Weak national logistics and procurement systems led to regular drug and supply stockouts.

Most hospitals were private, and about 30% of Filipinos obtained health care from the private sector. Some estimates suggested closer to 40% were relying on the private sector.[19] Data on the quality of health care were limited; however, surveys indicated that Filipinos often preferred private providers to public providers because they perceived them to offer higher-quality care.[19]

In 2010, approximately 63% of total health spending was private.[26,27] Household out-of-pocket health spending made up 83.6% of total private health spending; private health insurance financed the remainder.[28] Those who wanted but could not afford to use private health services typically borrowed money or sought financial assistance from the national lottery to pay for care. A 2003 study estimated that 14% of households became impoverished due to catastrophic health expenses.[29]

The Philippine Statistics Authority conducted a national demographic and health survey once every five years. According to 2008 survey results, average travel time to a health facility was 45 minutes for people in rural areas and 32 minutes for those in urban areas.[30]

The Philippines was the largest exporter of nurses and one of the largest exporters of doctors globally.[31,32] Health professionals migrated primarily because of economic need, professional and career development opportunities, and the attraction of better living standards, including higher wages.[19] One Filipino physician observed, "We're good at recruiting and training health professionals, but we're bad at retaining them. There are hundreds of *barangays* without doctors in the Philippines."

Health System and Epidemiologic Indicators[‡]

INDICATOR		YEAR
Average life expectancy at birth (total/female/male)	72.5/75.6/69.5	2014
Maternal mortality ratio (per 100,000 live births)	221	2011
Under–five mortality rate (per 1,000 live births)	30	2013
Infant mortality rate (per 1,000 live births)	18	2014
Vaccination rates (% of DTP3 coverage)	86	2012
Undernourished (%)	16.2	2013
Adult (15–49 years) HIV prevalence (per 100,000)	<1	2013
HIV antiretroviral therapy coverage (%)	60	2009
Tuberculosis prevalence (per 100,000)	292	2013
DOTS coverage (%)	100	2010
Malaria cases (per 1,000)	<1	2013
Government expenditure on health as % of total government expenditure	8.5	2013
Government expenditure on health per capita (PPP international dollars/USD)	91/38	2013
Total health expenditure per capita (current USD)	122	2013
Physician density (per 10,000)	12	2009
Nursing and midwifery density (per 10,000)	61	2009
Number of hospital beds (per 10,000)	10	2011

National Health Insurance

The Philippine government established the Philippine Medical Care Plan in 1969 to provide mandatory health insurance coverage for formal-sector employees. Informal-sector workers and unemployed Filipinos could voluntarily join and pay into the plan, purchase private insurance, or pay out-of-pocket for services. To address low participation and high out-of-pocket expenses among poor Filipinos, the government replaced the Philippine Medical Care Plan with the National Health Insurance Program in 1995 and formed the Philippine Health Insurance Corporation (PhilHealth) to manage it. The government promised to extend

[‡] Compiled by case writers using data from the United Nations, UNICEF, the World Health Organization, and World Bank.

coverage to the poor and achieve universal PhilHealth coverage by 2010. Initially PhilHealth covered only catastrophic health care costs. Approximately 23% of the population was covered in 1995.[33]

Households that could not afford the minimum premium contributions (PhP 1,200 or USD 27 annually) could receive financial assistance through PhilHealth's Sponsored Program. LGUs determined who qualified for assistance; there were no standardized eligibility criteria for the Sponsored Program. LGUs covered half the cost of Sponsored Program members' annual premiums, and the national government covered the other half. It was not uncommon for *barangay* captains and mayors to enroll family members, friends, and neighbors whose incomes exceeded the national poverty threshold in the Sponsored Program. Many LGUs ran out of funding for premium costs and denied coverage to poor families.

In 2010, PhilHealth data indicated that only 53% of the population was enrolled in PhilHealth, and only 42% of members used their benefits. PhilHealth and the DOH attributed low utilization to the limited benefits for hospitalization and minimal coverage for outpatient care. On average, PhilHealth covered 34% of the total cost of members' inpatient health care bills. The cumulative likelihood that any Filipino was eligible to file a PhilHealth claim (i.e., registered and paying contributions), aware of his or her benefits and able to use health services at accredited providers, and fully reimbursed by PhilHealth for total health care expenditures was 8%.[34] Participation in PhilHealth was optional for informal-sector workers but required for formal-sector workers, who shared premium costs with employers through payroll deductions. Most of the poor were not covered. (In contrast, the government required Filipinos to carry insurance for other types of purchases, such as third-party-liability auto insurance. Less than 50% of households owned a car, however, making the Philippines the fifth-lowest-ranking country in terms of car ownership.[35])

Rural health facilities, which served 55% of the population in 2010,[36] were less likely to meet PhilHealth standards for accreditation, which included infrastructure (e.g., ventilation, cleanliness), equipment and supplies, human resources, and record-keeping requirements. Rural Filipinos with insurance often had to pay out of pocket or travel long distances to use their benefits at an accredited facility.

PhilHealth had the largest clinical database in the country but managed claims manually and on paper, making it more cumbersome for providers and patients to request reimbursement and increasing the time and costs of processing claims for hospitals and PhilHealth staff.[19]

Tobacco

In 2011, tobacco use was the leading cause of preventable death globally, killing 6 million people every year and contributing significantly to the incidence of noncommunicable diseases.[37] Approximately 80% of deaths attributable to tobacco use occurred in low- and middle-income countries in 2011.[38]

In recognition of the global threat posed by tobacco use, WHO had established the Framework Convention on Tobacco Control (FCTC) in 2003. The WHO FCTC provided countries with evidence-based guidelines, international accountability, and technical assistance for tobacco control implementation.[38] The recommendation to impose a high tax on tobacco products was backed by a growing body of research demonstrating the effectiveness of higher tobacco taxes and prices in reducing consumption of cigarettes and other tobacco products.[39–41] Estimates of the price elasticity of demand for cigarettes varied but typically suggested higher price sensitivity in low- and middle-income countries than in high-income countries (see **Exhibit 2** for a glossary of tax and related terminology).[42] WHO suggested a single, or unitary, tax rate for tobacco products and recommended that excise taxes account for at least 70% of retail price.[40]

Despite widespread adoption of the WHO FCTC,[43] the tobacco industry remained one of the most profitable industries in the world. In 2010, global tobacco industry revenues were estimated at USD 500

billion.[44] When sales and consumption fell in developed markets with strong tobacco control policies, tobacco companies focused on expanding sales in emerging markets with less-developed regulatory environments such as the Middle East, Africa, and the Asia-Pacific region.

The tobacco industry became increasingly consolidated during the 2000s. In 2013, Philip Morris International held 14% of the global market share.[45]

Tobacco and the Philippines

Tobacco was grown in 27 Philippine provinces but most concentrated in 5 northern provinces. Following a peak in 1992, tobacco-growing declined as agricultural lands were converted for residential use, repurposed to grow more profitable crops, or diversified.[42] Most tobacco farmers planted multiple crops in addition to tobacco.[46] In 2010, tobacco farming accounted for 0.4% of total agricultural employment, and farmers produced more than 70 million kilograms of tobacco leaf valued at PhP 4.85 billion (USD 108.4 million).[47] Approximately 40 million kilograms were exported.[48] The National Tobacco Administration regulated and provided technical support to the industry.

Cigarettes were the most popular tobacco product in the Philippines. In 2010, the largest local cigarette manufacturer, Fortune Tobacco, merged with Philip Morris International's local subsidiary to form Philip Morris Fortune Tobacco Corporation (PMFTC).[49] PMFTC produced cigarette brands representing more than 75% of cigarettes consumed in-country.[42] In 2012, it controlled approximately 85% of the domestic market.[50]

Smoking and Tobacco Control

The Philippines' first tobacco control advocacy organization, FCTC Alliance, Philippines (FCAP), formed in 2001 (see **Exhibit 3** for a timeline of tobacco industry and policy events). In 2003, Congress passed landmark legislation tightening restrictions on tobacco marketing and prohibiting smoking in public places and sales to minors.[51] In 2005, the Philippines joined 167 other WHO member states in signing the WHO FCTC.[52]

In 2008, 31% of adults age 20 or older smoked.[30] A 2009 survey showed 94% of Filipinos age 15 or older agreed that smoking caused serious illness, and 60% of smokers were interested in quitting.[53] Smoking prevalence was increasing among youth and was most common among males and in rural areas. More than one-quarter (27.3%) of 13- to 15-year-olds smoked in 2007, up from 19.6% in 2003.[54] More than half (53.2%) of men and 12.5% of women age 20 or older smoked in 2008.[30] In rural and urban areas, 33.1% and 28.9% of adults smoked, respectively.

On average, smokers spent PhP 326.40 (USD 7.30) on cigarettes monthly;[53] the average monthly income was PhP 17,200 (USD 384) in 2009.[16] Thirty-one percent of adults in the first (lowest) income quintile and 26% of adults in the second quintile were smokers.[55] By contrast, 21% of adults in the three wealthiest quintiles were smokers. Poor households spent a larger proportion of their income on tobacco than wealthier households.[56]

In 2010, there were no public smoking cessation clinics in the Philippines. PhilHealth benefits included lung disease diagnosis and treatment, but did not cover smoking cessation treatment.

Taxation

Historically low tax rates on tobacco products made cigarette prices in the Philippines among the lowest in the world. As part of its periodic tax policy review, in 1997 and 2004 the Department of Finance

(DOF), backed by a few civil society groups and legislators, attempted to raise tobacco and alcohol taxes to increase government revenues. Taxes on tobacco products and alcohol products—commonly referred to as "sin taxes"—were legislated together in the Philippines. The proposals aimed to increase taxes by indexing rates to inflation and eliminating preferential taxes for cheap and older brands.

The tobacco industry and the "Northern Alliance" of legislators with ties to tobacco-growing provinces repeatedly defeated or weakened these proposals. As a result, the excise tax base eroded over time, costing the government billions of pesos (see **Exhibit 4a** for comparison of nominal and real tobacco tax revenues and **Exhibit 4b** for tobacco excise taxes as a percentage of total governmental revenue, 1999–2009).[57]

From 2003 to 2008, the government collected approximately PhP 25 billion (USD 559 million) in taxes from tobacco companies. Revenue generated from tobacco accounted for 1.3% of GDP in 2008.[58] A portion of the revenue was allocated for economic development and alternative livelihood programs in the tobacco-growing areas to mitigate any potential negative impact of tobacco taxation.

In 2011, a popular brand of cigarettes sold for PhP 12–25 (USD 0.27–0.56) while some brands were as inexpensive as PhP 8 (USD 0.18) per 20-pack.[59] Excise taxes averaged 24.1% of cigarette retail prices.[42]

Aquino's Presidency

President Aquino developed a 16-point agenda for reform, which he called his "Social Contract with the Filipino People" (see **Exhibit 5** for the agenda).[60] He aimed to strengthen the country's fiscal capacity without levying new taxes. Instead, he would focus on improving tax administration through the DOF's Bureau of Internal Revenue (BIR) and the Bureau of Customs. "With the gradual movement toward reducing tariff rates and duties through international agreements, revenues from the Bureau of Customs are not as plentiful as they once were," a former secretary of finance noted. "There will be more and more reliance on the BIR, so the BIR has to be more efficient and find ways to generate additional revenues without discouraging business. It's a very difficult balance."

Aquino's social contract promised to transform health from "just another area for political patronage" to a "key measure[] of good governance."[60] When he took office, Aquino was alarmed to learn that about 30% of Filipinos died without any treatment for the disease that killed them. Although the source of the statistic was unverified, it became a widely accepted estimate of the percentage of people needing but unable to access life-saving health care. Aquino appointed Dr. Enrique Ona as secretary of the Department of Health and charged him with resolving the problem by extending PhilHealth coverage to all Filipinos.

Enrique Ona

Ona was regarded as a top surgeon in the country. After completing his medical residency at a public hospital in 1962, he spent several years training and doing research in the US and the UK. He returned to the Philippines in the early 1970s to establish a vascular and transplant surgery program at the University of Philippines' College of Medicine and practiced surgery in the private sector. His patients included high-profile congressmen, government officials, and their families. He observed:

> When I came back from the US, I was performing complex surgeries and operations, but there were very few people who could afford them. And what was the reason? There was no health insurance. That's why a good number of Filipinos who are well trained eventually go to the US. You are trained to do these things but can hardly live off of your craft because not enough Filipinos can afford to pay.

In addition to being a clinician and an instructor, Ona had been the president of the Transplantation Society of the Philippines since 1989 and executive director of the National Kidney and Transplant Institute

since 1998. "Making our specialty hospital nationally and regionally renowned was probably what prompted the search committee to consider and recommend me as health secretary," Ona reflected. He had also launched the Philippines' first generic drug company and organized its first health maintenance organization (HMO).

Ona felt strongly that the state of public health facilities—especially those outside of Manila—and the financing arrangement between LGUs and the national government were largely to blame for low utilization of PhilHealth benefits. The "dilapidated" public health infrastructure contributed significantly to the shortage of health care professionals in poor and rural communities, Ona observed, noting, "We train around 3,000 new doctors every year, so there is really no shortage of doctors. What we have to do is to make it attractive for them to stay in the community." During his speech at the United Nations' 2010 World Population Day celebration, Ona noted that 70% of health professionals worked in the private sector to serve 30% of the population, while the remaining 30% of health workers served a majority of Filipinos in the public health sector.[61]

Ona observed that PhilHealth coverage was low due to the unclear Sponsored Program eligibility guidelines and LGUs' limited capacity to pay their share of subsidized premiums. Expanding PhilHealth coverage and addressing weaknesses in public health infrastructure required additional funds. Given Aquino's promise not to introduce new tax measures, Ona knew that he needed to leverage existing government revenue streams to increase his health budget. With a new legislative session convening and new leadership in the DOF and Department of Budget and Management (DBM), tobacco and alcohol taxes would likely be reviewed. FCAP knew this and requested a meeting with Ona to advocate that the DOH support dramatic sin tax reform. Ona was receptive; he had seen many patients with tobacco-related diseases over the years. He agreed to advocate for an increase in taxes on tobacco products, though he was unsure how best to design the tax policy to ensure sufficient revenue.

In the fall of 2010, FCAP invited Action for Economic Reforms, a Philippine NGO experienced in advocacy and economic policy research, to work together to promote sin tax reform. "We had a new president, so there was a breath of fresh air—the possibilities seemed endless," one advocate reflected. "It was an opportune time for groups to re-strategize the approach to passing sin tax reforms." Action for Economic Reforms received a grant from the US-based foundation, Bloomberg Philanthropies, to unite tobacco control, health care, and economic reform groups, including WomanHealth Philippines, Foundation for Economic Freedom, the Philippine Society of General Internal Medicine, the Philippine College of Physicians, and New Vois Association of the Philippine. They called their collaboration a coalition. Representatives from the groups met to establish a shared goal: to improve public health by reducing smoking and, secondarily, to generate revenues for health by raising taxes on cigarettes and alcohol.

Ona worked with his health undersecretaries to develop a framework for accomplishing the DOH's goals. He was inspired by the health financing systems he had observed in other countries, including Singapore and the UK, as well as the international movement toward universal health care (UHC). During the fall of 2010, Ona made a series of speeches at medical universities and hospitals announcing universal health care as the centerpiece of the Aquino health agenda. Its three "strategic pillars" were (1) financial risk protection through expansion in PhilHealth enrollment and benefit delivery; (2) improved access to and quality of hospitals and other health care facilities; and (3) attainment of the health-related MDGs.[62] The goal of UHC was to "address inequities in health outcomes by ensuring that all Filipinos, especially those belonging to the lowest two income quintiles, have equitable access to quality health care."[34]

Sin Tax Reform

Despite being a smoker himself, Aquino supported raising taxes on tobacco products to discourage smoking and raise revenues to expand health care access. In August 2011, he announced his official legislative agenda, which included increasing sin taxes. He directed all of his cabinet secretaries to join Ona in prioritizing sin tax legislation reform.

Civil society coalition members requested meetings with legislators allied with the Aquino administration to ask if they would "champion" a sin tax reform measure. They focused initially on members of the Ways and Means Committee in the House of Representatives, where fiscal bills were filed first. Legislators with known connections to the tobacco industry typically dominated the Committee.

Government and civil society proponents of sin tax reform agreed the new tobacco tax system must align with the WHO's two recommendations. Adopting these standards would mean simplifying the Philippines' multi-tiered tobacco tax structure, removing preferential tax rates enjoyed by older brands, and increasing taxes annually to keep pace with inflation.

Proponents anticipated strong opposition from PMFTC and local cigarette manufacturing companies, the Northern Alliance, tobacco farmers, and cigarette factory workers. They decided to emphasize the sin tax reform's health objectives: to discourage Filipinos from smoking and generate revenues specifically for health care. To be consistent with existing sin tax legislation and mitigate opposition, proponents also proposed allocating a portion of incremental revenues for economic development projects in tobacco-growing provinces.

International organizations and national governments—including WHO, World Bank, the International Monetary Fund, Bloomberg Philanthropies, AusAid, The Asia Foundation, Campaign for Tobacco-Free Kids, and the Union (formerly the International Union Against Tuberculosis and Lung Disease)—contributed funding and/or technical assistance to support the Philippines in achieving WHO FCTC recommendations.

Civil society groups reached out to local chronic disease experts to gather data on the impact of smoking. Dr. Antonio Dans, a Filipino epidemiologist, had been studying the economic and health costs of tobacco for more than a decade. His work had never been used for advocacy. One advocate explained: "It had worked for the tobacco industry that nobody could connect these things. All of these data existed, so the work in 2011 was to connect the dots." Dans updated his previous study using current data and found the cost of death and disease resulting from four tobacco-related illnesses (lung cancer, chronic obstructive pulmonary disease, coronary artery disease, and cerebro-vascular disease) to be PhP 188.8 billion (USD 4.22 billion)—nearly 2% of GDP.[63] Costs included health care, productivity losses, and premature death losses (see **Exhibit 6** for the estimated costs of smoking compared with tobacco excise tax collections, 2000–2008).

Before speaking publicly about sin tax reform, Ona, DOF Secretary Cesar Purisima, and DBM Secretary Florencio Abad met to align their messaging. The DOF convened meetings, inviting point persons from other government agencies and civil society to share updates and concerns and to coordinate actions in support of the reform. The meetings took place at the DOF offices and were led by either the DOF or the DOH. Undersecretary of Finance Jeremias Paul emphasized the value of a "whole of government approach," noting that, "If you're not united, powerful opposing lobbies will capitalize on that."

Traditionally, the DOF took the lead on submitting tax proposals to Congress. For the sin tax legislation, Paul reflected, "What differentiated this from past efforts was that health and finance were working together." Ona and Purisima entrusted day-to-day coordination and communications to their undersecretaries, Paul for finance and Ted Herbosa for health. Paul and his team helped Ona determine

how much revenue the DOH required to achieve its goals, while Herbosa worked with the DOF and civil society coalition to emphasize the legislation's health objectives.

Ona also consulted with the Department of Agriculture's National Tobacco Administration to understand how reform might impact tobacco farmers and cigarette manufacturing workers. Because of this, some were concerned he would favor more conservative tax increases. He countered, "I was aware that five of our provinces depend on tobacco for major industry," Ona explained. "I wanted to ask them what their concerns were and to convince them that this was a health issue."

Research and Data

The DOF began modeling how consumers in the Philippines would respond to different tax rates given various elasticity scenarios and how their response would impact revenue generation. Paul discussed his simulations with World Bank and WHO economists and studied their analyses of elasticity in other countries. Studies varied based on different assumptions about how a new tax system would influence (1) consumer substitution across different cigarette tax and price tiers and (2) industry decisions about the volume and timing of cigarette production and removals.

Paul also consulted with Dr. Frank Chaloupka, an economist and tobacco control researcher from the University of Illinois at Chicago. Chaloupka had received a grant from US-based Bloomberg Philanthropies to study tobacco taxation in six different countries, including the Philippines. During one of his in-country visits, Chaloupka spent a day at the DOF comparing models and exchanging feedback with Paul's team. In some cases, the DOF was able to contribute data on the local tobacco industry that strengthened Chaloupka's models. After he left the Philippines, he commented, "Paul, the World Bank and WHO consultants, and I would talk to one another and share the inner workings of the models until we got to the point that we were more or less on the same page. Usually countries don't want to sit down and look at the model, but Undersecretary Paul really wanted to understand our model and what the other models were, and try to come up with the best combination of them."

The DOF calculated the price elasticity of demand for cigarettes to be –0.5, meaning that a 10% increase in cigarette prices would yield, on average, a 5% reduction in cigarette consumption. Tobacco industry stakeholders argued that elasticity was closer to –0.8, suggesting that a tax increase would discourage smoking so much that the revenue-generating goals of the bill would be undermined. Lower consumption would have a negative economic impact, they warned, stifling business for local tobacco farmers and cigarette manufacturing companies. Some also cautioned that a tax increase would disproportionately burden poor Filipinos.

Proponents of the tax increase cited studies showing that job and economic losses owing to higher tobacco taxes were usually more than offset by increased spending and employment in other sectors. Studies suggested money previously spent on tobacco was diverted to other goods and services.[64,65] Tobacco-related employment was declining globally as the industry shifted to new production mechanisms. In response to arguments that higher tobacco taxes would be regressive, the DOF countered that poor Filipinos had the most to gain because they would not otherwise be able to afford care. "The net effect is actually progressive," Paul said.

Dans modeled how many premature deaths could be prevented with every 1% increase in the tax rate. He created a table showing how various tax proposals would affect smoking prevalence and revenue generation (see **Exhibit 7** for the table).

Drawing from the DOF's recommendations and Chaloupka's final report,[42] the DOH and coalition members decided to advocate for the highest tax rate possible. The DOF and DBM typically preferred not to

earmark legislation because it restricted the government's flexibility. In this case, all government parties agreed that the new revenue should go directly to the DOH.

Unlike tobacco consumption, there were limited data on the health and economic costs of alcohol consumption.[66] The World Trade Organization was pressuring the Philippines to bring its distilled spirits tax structure into compliance with international standards,[67,68] since the existing structure made it cost-prohibitive for foreign companies to compete with domestic manufacturers. Proponents appreciated that alcohol and tobacco taxes were legislated jointly—as they had been historically—because they could focus on supporting one bill instead of two.

Next Steps

Ona worked with his team to standardize membership criteria for the PhilHealth Sponsored Program. He hoped this would ensure greater enrollment of the poor and near poor. They decided to use the Department of Social Welfare's conditional cash transfer (CCT) program to identify qualifying families and enroll CCT households automatically. LGUs would notify families and encourage them to use their benefits.

The DOH quickly realized that the national CCT listing did not capture every family that met the criteria. Many poor Filipinos were mobile and difficult to track. Furthermore, the CCT program enrolled households, and it was common for multiple families to live in one household to share living expenses. As a result, the DOH underestimated the number families in need of Sponsored Program enrollment.

In 2012, PhilHealth began covering annual checkup visits and basic preventive services to complement catastrophic care coverage. The new primary care benefits package would be available initially only to a subset of PhilHealth beneficiaries, including Sponsored Program members. PhilHealth planned to extend coverage to other members over time.

Health economists at the University of the Philippines observed that PhilHealth participation among informal-sector workers who were not automatically enrolled via an employer or through the Sponsored Program was consistently low and wanted to understand why. They learned that assistance with enrollment paperwork had a more significant effect on enrollment than lowering prices. One researcher explained, "The transaction costs are a key deterrent. I think it's partly because insurance literacy, in general, is pretty low among Filipinos ... As long as members are able to get something out of PhilHealth, they're okay. There's really no clamor for a more effective PhilHealth."

Ona hoped that improving the quality of public sector facilities would attract people to the public sector and eventually increase the willingness of formal-sector workers to pay higher premiums and a copay for health services. PhilHealth could then use these additional revenues to expand benefit coverage and to subsidize coverage for poor Filipinos.

The DOH aimed to identify infrastructure needs, with an emphasis on modernizing primary and secondary facilities. Ona began designing a public-private partnership program to accelerate modernization of public hospitals through private sector investment, modeled after successful public-private models in the US and UK.

To address the shortage of PhilHealth-accredited public health facilities, especially in poor, remote areas, the DOH established the Health Facilities Enhancement Program (HFEP) to finance public facility upgrades upon request. The DOH did not have a mechanism for ensuring facility requests aligned with the health needs and priorities in their communities but believed reforming rural health units to become "poly clinics" would support universal health care.

The DOH funded an ultrasound pilot program at a large hospital to train rural general practitioners to operate and read results from a basic ultrasound machine. Each trainee received a small ultrasound machine to install and use in a rural health unit. The program goal was to reduce maternal mortality by detecting potential pregnancy complications early and referring patients to appropriate facilities. "By giving funds to a rural health unit to purchase an x-ray machine or an ultrasound machine to diagnose diseases early, you are helping prevent the more complicated and therefore more expensive diseases," Ona explained. "They really are interrelated."

Ona also believed shoring up public health programs such as the national immunization campaign was an important step to achieving universal health care. He worked with his team to identify ways to expand immunization of children under five for vaccine-preventable diseases (85% coverage of measles in 2012) during the 2014 mass immunization campaign.

Getting the Law Passed

The tobacco industry mobilized farmers and factory workers to protest and slow the bill. Northern Alliance members proposed a phased transition to a unitary tax instead of an immediate one. The bill's authors had to make some compromises and agreed to the phased transition on the condition that they could replace the existing four-tiered system with a two-tiered system (see **Exhibit 8** for a detailed summary of the law's provisions). In exchange for the support of San Miguel Brewery, legislators adjusted the lower of the two price tiers for fermented liquor brands to include its popular premium beer brand (see **Exhibit 9** for a comparison of the old and new tobacco and alcohol tax rates). San Miguel Brewery commanded 90% of the beer market in the Philippines;[69] the total revenues of its parent company, San Miguel Corporation, were equivalent to 5.4% of the country's GDP in 2010.[70]

An organization representing local government leaders appealed to a nationally known, former governor from a tobacco-growing province to endorse the legislation by publicly denouncing the notion that higher sin taxes would lead to the demise of the Philippines' tobacco industry—a popular argument among opponents. The governor supported the local government leaders and argued the tax would "level the playing field" for smaller domestic companies trying to compete with PMFTC. Ona believed the governor's public support of the bill convinced several politicians from the north to support it.

The coalition organized press conferences, testified before Congress, and worked closely with media outlets to broadcast data on the negative effects of smoking and the legislative process. Former secretaries of finance and health who had participated in past sin tax reform efforts spoke publicly in favor of the bill. When Ona spoke publicly, he emphasized the bill's health aims. He noted, this "… was probably the most important role I played: to make it very clear to everybody to forget about it being a tax measure and focus instead on it being a health measure." Dans and other coalition members presented the table showing how different tax rates would impact smoking and revenue generation during legislative hearings. Proponents began calling the sin tax reform bill an "anti-cancer tax" and rallied more than 50 medical associations to sign a petition for it. A government official observed, "Anything coming from government is considered propaganda, and anything coming from legislators and other politicians is meant to enhance their political careers." To put additional pressure on Congress, the coalition created a public webpage that tracked which legislators supported the bill and which opposed it. "Elections were scheduled for May 2013, and people were checking how senators had voted," one advocate explained. "We made it an election issue."

International credit rating agencies were also watching the bill's trajectory carefully. They recognized its potential to broaden the Philippines' fiscal base for higher spending on infrastructure, health, and education. In October 2013, Moody's Investors Service joined Fitch Ratings and Standard & Poor's Ratings Services in upgrading its assessment of the country's debt quality to the level below investment grade.[71] The

DOF hoped to achieve an investment grade rating—which would reduce some borrowing costs and attract more investment funds—by 2014.

In November, a small group of representatives and senators selected by their peers convened a committee to reconcile the Senate and House versions of the bill. They debated how exactly the incremental tax revenues—i.e., the difference between the total revenues generated by the new tax structure and the total revenues that would have been generated by the previous tax structure—should be spent to achieve the law's goals. Members of the Philippine College of Physicians lobbied to include a specific allocation for human resources. They advocated that issues of health access and quality stemmed primarily from poor incentives for general practitioners to provide primary care in poor, remote areas.

Ona preferred less specificity: "I said that we should leave it to the Department of Health to allocate the funds. We are talking about a long-term revenue stream here, so you don't want to be boxed in." The bicameral committee pushed back. Members believed specifying how the revenues should be allocated would increase the DOH's accountability for achieving the UHC objectives and protect the funds from being misappropriated by future leaders. There was high turnover within the DOH; since 1987, there had been 12 health secretaries under 5 presidents.

The bill ultimately passed, with 10 votes for and 9 votes against the measure. Aquino signed the bill (Republic Act 10351, more commonly referred to as "the sin tax reform act") into law on December 19, 2012, with the higher tax rates taking effect on January 1, 2013. More than 300 people attended, and Aquino gifted the pen he used to sign the bill into law to Action for Economic Reforms.

The law differed from historical tobacco and alcohol tax policy. For the first time, it pegged (i.e., indexed) tobacco and alcohol taxes to the inflation rate (4%). It also simplified the existing four-tier tobacco tax system to a two-tier system and removed preferential tax rates for older brands. As a result, cigarette taxes increased by up to 340%,[72] and the average price per cigarette pack increased from PhP 21.12 in 2012 to PhP 31.26 in 2013 (see **Exhibit 10** for a price comparison of cigarettes and other commodities).[73] In 2017, the two-tier system would transition to a unitary tax rate for all tobacco products and fermented liquor brands, regardless of price. Distilled spirits would be taxed at a uniform rate beginning in 2013.

Eighty-five percent of incremental tobacco tax revenues and 100% of incremental alcohol tax revenues were earmarked for health. Of these combined revenues, 80% would be used to finance PhilHealth, attainment of the Millennium Development Goals, and health awareness programs. The remaining 20% would be used for health infrastructure improvements and support for indigent patients. Incremental tobacco tax revenues not supporting health (15%) would fund economic development projects in tobacco-growing provinces. In 2016—the same year presidential and congressional elections were scheduled to take place—the Congressional Oversight Committee would conduct an official review the legislation's impact.

Health Policy Changes

In 2013, the DOH and PhilHealth adjusted a number of policies and programs designed to reduce out-of-pocket expenditures and increase PhilHealth utilization. PhilHealth increased minimum premium contributions to PhP 2,400 (USD 54) annually and expanded benefits, including the primary care package. Ona worked to change the structure of the financing agreement between LGUs and the national government by advocating for and implementing the National Health Insurance Act of 2013. The law made PhilHealth enrollment compulsory for all Filipinos.

The new law also shifted the responsibility for subsidizing PhilHealth premiums for Sponsored Program families to the DOH. Revenues from the sin tax law would finance expanding the Sponsored

Program to include informal-sector workers in the second income quintile. Newly gained revenues from the reformed sin tax would finance the expansion.

PhilHealth also introduced a policy prohibiting PhilHealth-accredited government facilities from billing Sponsored Program members for any health expenses. If a member's benefits did not pay the full cost of a covered procedure, the hospital could not charge the member for the balance. PhilHealth would deduct a penalty from hospitals' reimbursement claims for noncompliance with the policy or for prescribing medication not available at the hospital pharmacy.

PhilHealth launched Point of Care enrollment to ensure that qualifying patients who were not on the CCT list would not be denied coverage at public facilities. Social workers conducted a means test onsite and enrolled eligible patients immediately. "These were the tweaks that Secretary Ona and I tried to implement to ensure the health system would become financeable and self-sustaining," said Health Undersecretary Herbosa.

Initial Results

Total sin tax revenue collections (i.e., incremental revenues plus the taxes that would have been collected from tobacco and alcohol products in the absence of any reform) for tobacco and alcohol reached PhP 70.4 billion (USD 1.57 billion) and PhP 33.0 billion (USD 737.7 million), respectively, during 2013 (the first year of implementation). Incremental tobacco tax revenues were 179% of the BIR's projections; incremental revenues from alcohol were under goal by approximately 12% (see **Exhibit 11** for a comparison of target and actual excise tax revenues). The total tobacco excise tax collection in 2013 represented a 114% increase over 2012 collections, while total alcohol tax collections grew by 38%.[74] Excise taxes comprised 53% of cigarette retail prices on average, a marked increase but still lower than the WHO target (70%).[75]

The sin tax reform act resulted in an unprecedented year-over-year increase in the DOH's budget of 57% (see **Exhibit 12** for annual budget growth). Ona petitioned the DBM to allocate the surplus incremental revenues to its 2015 budget; however, the DBM declined.[76] "It's really a challenge to spend the money," DBM Secretary Abad observed. "Their budget has tripled in about four years, but their operational capacity may not have caught up accordingly. Our argument was, 'Let's see to what extent you can really absorb the budget you have right now.'" The DOH's overall disbursement rate was around 65% in 2014, meaning the DOH returned, on average, 35% of its budgeted resources to the DBM annually because it was unable to spend the funds during the fiscal year.

PhilHealth Enrollment and Utilization

The DOH budgeted a majority of the incremental revenues for PhilHealth premiums. PhilHealth used the funds to increase Sponsored Program enrollment to 45.1 million poor Filipinos, representing 14.7 million members and 30.4 million dependents (see **Exhibit 13** for allocations of incremental revenues in the 2014 budget). In doing so, it effectively enrolled 100% of the poor and near-poor in PhilHealth.[76]

Despite the introduction of Point of Care enrollment at government hospitals, many Filipinos who had been automatically enrolled in the Sponsored Program were unaware of their PhilHealth benefits.[77] Utilization and reimbursement remained low, and out-of-pocket spending continued to be high. PhilHealth estimated that 11% of members used their benefits in 2014. Only 3% of members in the Sponsored Program used their benefits. "Enrollment is the first step," one health economist explained. "Once you enroll people you have to make it known that they're covered and you have to teach them how to use their benefits."

Several in-country health economists questioned the sustainability of PhilHealth if more members became aware of and began using their benefits. One economist predicted, "If people were effectively informed of their benefits, the buffer that PhilHealth has now in terms of resources would run out in a year and a half." He believed the DOH should stop creating new benefit packages and focus on educating members and expanding the number of accredited providers. Despite the addition of several new benefit packages, the government had only increased premiums once since the passage of the sin tax reform act.

Infrastructure Enhancement

In 2014, civil society groups and legislators began to question how the DOH was using incremental sin tax revenues and their impact on the health system. LGU executives asked how the funds were being spent and when they would begin to see the promised improvements in their local facilities. A former cabinet secretary explained:

> The local government executives are not feeling the favorable effects of the law because conditions in the hospitals are not significantly different from two years ago. So they're asking me, 'Can you check on what's happening?' This is where the DOH will have to be more proactive in saying, 'We received this much, and we gave this amount to Hospital A,' and then Hospital A will have to certify that they have received that amount. This kind of information has not been made available.

Ona struggled to convey the rationale and impact of health infrastructure spending. People criticized him for being "a hospital man" who favored health facilities and equipment over primary care and public health. Ona retorted that modernizing *barangay* health centers and rural health units was an investment in primary health care. Ona spoke with national newspapers while his team used the DOH website, web-based newsletter, and social media accounts to provide updates on the number of public facilities that had been upgraded and to explain that health facility spending would help address the health workforce shortage in the provinces (see **Exhibit 14** for an example of a DOH social media press release related to health facilities enhancement). Ona believed that part of the problem was that those expenditures fell within the "Facilities" category of the DOH budget, so it was not obvious that they were investments in primary care. "I realized the importance of having a strategy for educating the president and the public about the purpose and goals of your investments in health," he said.

The ultrasound pilot program yielded promising results. Ona used it as an example of his effective spending on equipment and reported that one participating health center reported zero maternal deaths. Ona planned to scale up the program over the next two years.

The DOH also struggled to purchase and deliver new supplies and drug stock for LGUs, and new procurement laws—designed by the Aquino administration to increase transparency and reduce corruption—lengthened the bidding process for government agencies. A health economist who consulted for the DOH summarized the challenge facing Ona and his team:

> The weaknesses of the health system became apparent when money was made available. No matter how inefficient the logistics system was, we did not notice because we did not have the money—we didn't have any use for it. Suddenly, the Department had money and it was procuring goods, equipment, drugs, and medicines to be distributed down the line, and then you realize that the whole supply chain isn't there. So things weren't moving; warehouses got filled up, the wrong things went to the wrong places. You have lots of money for meds, but then you still have stockouts.

Smoking

As soon as the law passed, tobacco industry stakeholders asked the BIR and DOH for evidence that the tax increase was meeting revenue generation and smoking reduction objectives. The DOH did not have

national data. In November 2013, it worked with civil society groups to conduct and publicize local impact studies.[78] Survey and focus group results were promising, showing that fewer Filipinos were smoking.

National survey data became available in 2014 and suggested a reduction in smoking. According to the National Nutrition Survey, smoking prevalence among adults age 20 or older fell from 31% in 2008 to 25.4% in 2013.[79] A separate national poll found that smoking prevalence among adults age 18 or older fell from 29% to 26% between December 2012 and March 2014.[55] The most dramatic declines were in the lowest income quintile (from 38% to 25%) and among adults 18–24 years of age (from 35% to 18%). There was a slight or no reduction in smoking within older age groups, and smoking increased by one percentage point among 45–54 year olds. Proponents of the sin tax believed the reduction in smoking was largely the result of fewer Filipinos starting the habit. Dans, who had presented the costs of tobacco-related diseases during the sin tax reform debates and whose epidemiologic research spanned a variety of lifestyle-related diseases, attributed the change to the sin tax reform effort:

> Studies show that people don't exercise in the Philippines because there are no facilities for nonmotorized traffic. There's no place to walk or to bike. Filipinos don't eat vegetables because they're too expensive, and they smoke because tobacco is so cheap. So we used this logic, and whereas for 30 years we were unable to reduce smoking by telling people it was bad for them, with just a small tax measure the prevalence went down from 31% to less than 26%. This seems small, but it's the equivalent of 3 million fewer smokers in 2013. Our estimate is that about 32,000 premature deaths were averted.

Survey data also suggested almost half (45%) of smokers, especially older smokers, smokers in rural areas, and poor smokers, "downshifted" to less expensive brands since the tax increase. Despite the tax increases, cigarette prices in the Philippines were still among the lowest in Southeast Asia and the world (see **Exhibit 15** for a comparison of prices in Southeast Asian countries).[80] The DOH and civil society hoped that moving to a unitary tax rate in 2017 would force inexpensive brands to increase their prices and eliminate the option of downshifting.

In 2014 some government facilities began offering free smoking cessation services. Most were located in Manila. PhilHealth did not cover the cost of drug abuse or dependency treatments (e.g., smoking cessation counseling or drugs, alcoholism treatment, etc.).[81]

Industry Response

Cigarette and fermented liquor production decreased following the sin tax reform, while distilled spirit production increased (see **Exhibit 16** for production pre– and post–sin tax reforms). The government saw the decline in factory removals as further evidence that tax increases had discouraged consumption of cigarettes and fermented liquor products. The BIR also believed it was the result of manufacturers over-producing at the end of 2012 to reduce the number of cigarettes they had to manufacture at the beginning of 2013. This practice was known as frontloading. Cigarettes removed from factories prior to January 1, 2013, would not be subject to the higher tax rates, allowing companies to save money.

Contrary to industry claims that tobacco farmers would face an immediate decline in revenues due to lower cigarette demand, tobacco farming remained strong. Production increased by 4.5% in 2013, and exports expanded by 35%.[82] Local cigarette manufacturing company Mighty Corporation reportedly saw its domestic market share grow from 3% in 2012 to more than 20% in 2013. Meanwhile, the largest domestic manufacturer, PMFTC, reported that its market share fell from 90% in 2012 to 70% in 2013.[83]

Mighty's increasing competitiveness with PMFTC suggested that the tax reforms had begun to level the playing field. PMFTC accused Mighty of underreporting sales to avoid taxes and suggested the government lost billions due to illicit trade (see **Exhibit 17** for PMFTC ad denouncing Mighty).[84] The BIR investigated the claims but found no evidence of tax evasion.

In late 2014 the BIR issued new regulations requiring companies to affix government-printed tax stamps to cigarette packs produced in the country before they could be sold to consumers, effective in March 2015. The stamp system would make it easier to identify tax evasion and eliminate incentives for frontloading. The BIR announced similar plans for alcohol products, set to roll out in mid-2015.[85] NGOs were exploring research options for estimating the prevalence of illicit trade. It would be difficult to understand the full extent of tax evasion without industry cooperation.

Looking Ahead

In October 2014, President Aquino asked Secretary Ona to take a leave of absence while the government investigated a procurement decision the DOH had made in 2012: Ona had approved purchasing a different anti-pneumonia vaccine for children than the one recommended by the DOH pharmaceutical access and management center. When President Aquino's office received complaints from unnamed stakeholders regarding the decision, Aquino ordered an official investigation. In December, while the investigation was ongoing, Ona resigned from his position. Aquino appointed DOH undersecretary and former congresswoman Janette Garin to the health secretary role.

Garin's goals for the remainder of Aquino's term were to improve collaboration between LGUs and the DOH, strengthen the country's public health infrastructure, and identify options for improving and growing PhilHealth benefits. "One gap that I noticed was that the [DOH] plan was limited to the central office," she said. "People in the *barangays* do not know what the road map is. Even if you have a very good road map at the national level, if the people on the ground—your generals and your soldiers—do not know what it is, it will be difficult for you to achieve what you want."

Garin prioritized the 48 poorest, most geographically isolated and disaster-prone provinces for health facility investments. She aimed to increase PhilHealth utilization by ensuring each province had at least one PhilHealth-accredited facility offering basic maternity, checkup, and TB services by mid-2016. In early 2015, her team began inventorying equipment in public health facilities nationwide to help them evaluate LGU funding and supply requests.

In early 2015, the BIR released 2014 tax collection totals. Incremental tobacco and alcohol tax revenues were PhP 50.18 billion (USD 1.12 billion) for the year, surpassing the government's target by 17%.[86] Around the same time, PMFTC laid off more than 10% of its 6,000 workers in the Philippines, citing a need to cut costs due to unfair competition from Mighty.[83] The BIR was investigating Mighty's alleged tax evasion.

In March, Bloomberg Philanthropies recognized the DOH and DOF as co-recipients of the 2015 Global Tobacco Control Awards.[87] Other countries looked to the Philippines' tobacco tax reform story as an example, asking Paul or Ona to present at international conferences and workshops. In February, PhilHealth expanded the primary care package to include smoking cessation counseling and "lifestyle modification" at accredited primary health care providers.[88]

Ona and other proponents of sin tax reform worried the tobacco industry would cite the limited improvements in PhilHealth utilization and out-of-pocket spending to advocate for reversing the tax increase. In 2016, they hoped to advocate for increasing the tax rate and adding an ad valorem tax on sugary beverages.

Ona believed sin tax reform was one of his greatest accomplishments as health secretary. As he explored options for remaining involved in tobacco control advocacy efforts, he wondered how he would be remembered. Had the health system policy changes and investments he had chosen to leverage the increased sin tax revenues been the right ones? Could those changes be sustained under new leadership?

Appendix *Commonly Used Abbreviations*

BIR	Bureau of Internal Revenue
DBM	Department of Budget and Management
DOF	Department of Finance
DOH	Department of Health
FCAP	FCTC Alliance, Philippines
LGU	Local Government Unit
MDG	Millennium Development Goal
NGO	Nongovernmental Organization
NRP	Net Retail Price
PhP	Philippine Pesos
PMFTC	Philip Morris Fortune Tobacco Corporation
RA	Republic Act
UK	United Kingdom
US	United States
USD	United States Dollars
WHO	World Health Organization
WHO FCTC	WHO Framework Convention on Tobacco Control

Exhibit 1 *Map of the Republic of the Philippines*

Source: U.S. Central Intelligence Agency, 2014.

Exhibit 2 *Glossary of Tax and Related Terminology*

Types of Taxes

Ad Valorem Tax: A tax on goods or property expressed as a percentage of the sales price or assessed value, not the size, quantity, weight, or other characteristic of the taxed item.

- A **value-added tax (VAT)** is a type of ad valorem tax that is levied at each stage in the production and distribution process for a specific good. Although VAT ultimately bears on individual consumption of goods or services, liability for VAT is on the supplier of goods or services. VAT normally utilizes a system of tax credits to place the ultimate and real burden of the tax on the final consumer and to relieve the intermediaries of any final tax cost.

Excise Tax: A tax imposed on a specific act, occupation, or good. Excise taxes are often included in the price of the taxed product.

- Excise taxes on socially proscribed luxury goods and services such as alcohol, tobacco, soft drinks, and gambling are often referred to as "**sin taxes**."

Tax Policy Tools and Related Terms

Indexation: Over time, inflation can diminish or erode the value of taxes unless they are increased to keep pace with the rate of inflation. Indexing is a method of tying taxes to an index of inflation or other indices to preserve the public's purchasing power and maintain the government's tax base during periods of inflation. For example, a government could index its tobacco tax to inflation by increasing the tobacco tax rate annually by the same percentage as the country's average inflation rate.

Net Retail Price (NRP): The price of a product excluding the excise tax and value-added tax.

Tax Capacity: The predicted tax-to-GDP (gross domestic product) ratio that can be estimated empirically, taking into account a country's macroeconomic, demographic, and institutional features. It is an estimate of how much tax revenue a country can expect to collect given these factors.

Tax Effort: An index of the ratio between a country's actual tax collections, expressed as a share of its GDP, and the country's **taxable capacity**. It is a measure of how well a country is doing in terms of tax collection relative to what could be reasonably expected given a variety of factors—i.e., given its tax capacity.

Multi-Tier Tax System: The taxed entity (e.g., cigarettes) is divided into different categories based on a particular characteristic or characteristics of the product (e.g., net retail price, size, weight, packaging type, etc.), and each category is assigned a different tax rate.

Price Elasticity of Demand: The percentage change in consumption of a good or service that results from a 1% change in the price of that good or service. Elasticity estimates can be used to predict how consumers will respond to an increase or decrease in the price of a good or service. If price elasticity of demand for cigarettes is highly inelastic, smoking prevalence will remain high. If price elasticity of demand for cigarettes is highly elastic, a higher tax rate should dissuade consumers from smoking.

Source: Compiled by case writers using data from the World Bank and the Organisation for Economic Co-operation and Development (OECD) Centre for Tax Policy and Administration.

Exhibit 3 *Tobacco in the Philippines: Timeline of Key Policy and Industry Events*

Year	Event
1987	The **National Tobacco Administration** (NTA) is established as the government agency responsible for improving the economic conditions and quality of life of tobacco farmers and promoting development of the tobacco industry to strengthen agriculture in the Philippines. It manages the Tobacco Growers Assistance Program, aimed at supporting tobacco farmers who voluntarily stop planting tobacco or who are displaced as a result of government regulation of the industry.[89]
1997	Republic Act 8424, or the **Tax Reform Act of 1997**, is passed, converting tobacco taxes from ad valorem to excise, instituting a one-time 12% increase in cigarette tax rates, and introducing a multi-tiered system wherein expensive brands are taxed at higher rates than cheaper brands.[90]
2001	The Philippines' lead tobacco control advocacy organization, **FCTC Alliance, Philippines** (FCAP), is created.[59]
2003	Republic Act 9211, or the **Tobacco Regulation Act of 2003**, is passed—the first comprehensive tobacco control legislation in the Philippines. It prohibits smoking in public places and sales to minors; places new restrictions on tobacco product packaging and labeling; increases regulation of promotion and sponsorship activities of tobacco companies; and establishes the Inter-Agency Committee for Tobacco (IAC-T), one of the first government-mandated inter-agencies charged with implementing tobacco control policies. The law bans most tobacco product advertising, with the notable exception of advertising at point-of-sale. WHO launches the **Framework Convention on Tobacco Control** (FCTC), the first WHO-stewarded international treaty.[91] The treaty commits Parties to reduce tobacco consumption by implementing a variety of supply- and demand-reduction measures.
2004	Republic Act 9334, or the **Sin Tax Law of 2004**, is passed. It maintains the multi-tiered taxation structure introduced in 1997, increases excise taxes for high-priced cigarettes, lowers taxes for low-priced cigarettes, and introduces a price classification freeze privileging existing tobacco and alcohol brands by pegging their tax rates to their 1996 net retail prices.[91]
2005	The **WHO FCTC** enters full force. The Philippines joins 167 other WHO member states in signing the treaty.[91]
2007	The first **Global Youth Tobacco Survey** (GYTS) is conducted in the Philippines. The school-based survey is designed by WHO and implemented nationally by countries.
2009	The first **Global Adult Tobacco Survey** (GATS) is conducted in the Philippines. The household survey is designed by WHO and implemented nationally by countries.
2010	In February, Philip Morris Philippines Manufacturing Inc. and Fortune Tobacco merge, forming the **Philip Morris Fortune Tobacco Corporation** (PMFTC).[92] In June, **President Benigno Aquino III** is elected the 15th President of the Republic of the

	Philippines. He appoints **Dr. Enrique Ona** as secretary of the Department of Health.[93,94] In November, civil society representatives from over 100 countries presented the **Dirty Ashtray Award** to the Philippine delegation to the fourth session of the WHO FCTC Conference of Parties. The Philippines was selected because of its alleged collusion with tobacco industry interests to challenge draft guidelines that would regulate tobacco product contents and require disclosure of those contents.[95]
2012	Republic Act 10351, or the **sin tax reform act**, is passed. Key provisions include removal of the price classification freeze; indexation of tax rates to inflation; bringing the tax structure for distilled spirits into compliance with World Trade Organization international trade rules; earmarking of revenues for health and tobacco-growing regions, and a timeline for transitioning alcohol and cigarette taxes to unitary, or uniform, tax rates.[96]
2014	Republic Act 10643, or **the Graphic Health Warnings Law**, is passed in July. Beginning in 2016, the law requires cigarette manufacturers to place graphic health warnings on 50% of each of the principal display areas of cigarette packs.[97] In December, Enrique Ona resigns as health secretary; **Health Undersecretary Janette Garin** becomes acting secretary of health.[98]
2015	In March, President Aquino appoints **Acting Secretary Janette Garin** as health secretary.[98] Bloomberg Philanthropies announces the Philippines as one of the winners of its **Awards for Global Tobacco Control**, honoring the Department of Health and the Department of Finance for their work to raise the price of tobacco.[87]
2016	**General elections** are scheduled to take place in May. Filipinos will elect a new president, 12 senators, and all seats in the House of Representatives. They also will determine the seats of governors (if applicable), mayors, and other local elected officials. In the third quarter of 2016, the **Congressional Oversight Committee** will review the impact of the increased tax rates enacted by the sin ta reform act.[96]

Source: Compiled by case writers from various sources.

Exhibit 4a *Nominal vs. Real Tobacco Tax Revenues in the Philippines, 1999–2009*

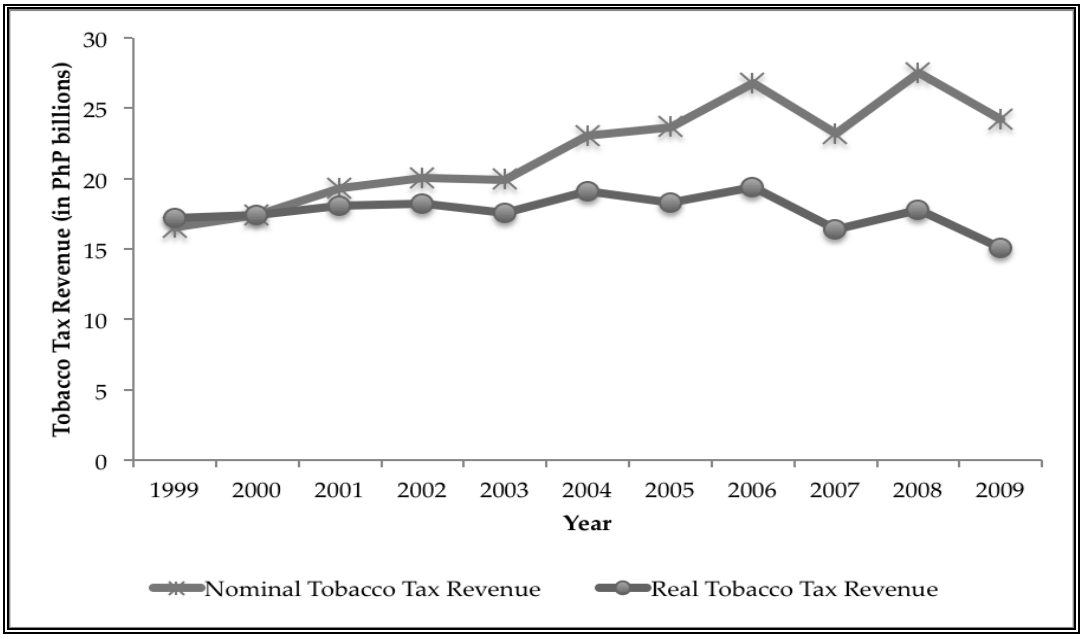
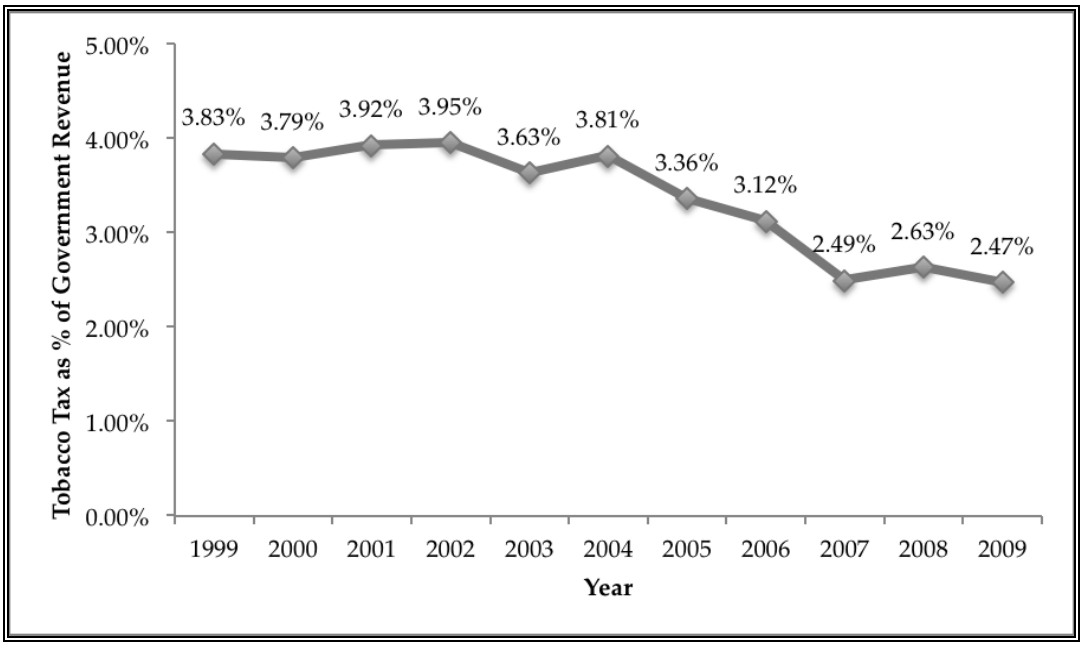


Exhibit 4b *Tobacco Excise Taxes in Relation to Government Revenues in the Philippines, 1990–2009*



Source: Bureau of Internal Revenue; Filomeno St. Ana III and Jo-Ann Latuja (2010).

Exhibit 5 *President Aquino's Social Contract with the Filipino People, 2010*

A Commitment to Transformational Leadership:

1. From a President who tolerates corruption to a President who is the nation's first and most determined fighter of corruption.
2. From a government that merely conjures economic growth statistics that our people know to be unreal to a government that prioritizes jobs that empower the people and provide them with opportunities to rise above poverty.
3. From relegating education to just one of many concerns to making education the central strategy for investing in our people, reducing poverty and building national competitiveness.
4. **From treating health as just another area for political patronage to recognizing the advancement and protection of public health, which includes responsible parenthood, as key measures of good governance.**
5. From justice that money and connections can buy to a truly impartial system of institutions that deliver equal justice to rich or poor.
6. From government policies influenced by well-connected private interests to a leadership that executes all the laws of the land with impartiality and decisiveness.
7. From treating the rural economy as just a source of problems to recognizing farms and rural enterprises as vital to achieving food security and more equitable economic growth, worthy of re-investment of sustained productivity.
8. From government anti-poverty programs that instill a dole-out mentality to well-considered programs that build capacity and create opportunity among the poor and the marginalized in the country.
9. From a government that dampens private initiative and enterprise to a government that creates conditions conducive to growth and competitiveness of private businesses, big, medium and small.
10. From a government that treats its people as an export commodity and a means to earn foreign exchange, disregarding the social cost to Filipino families to a government that creates jobs at home, so that working abroad will be a choice rather than a necessity; and when its citizens do choose to become [overseas foreign workers], their welfare and protection will still be the government's priority.
11. From Presidential appointees chosen mainly out of political accommodation to discerning selection based on integrity, competence and performance in serving the public good.
12. From demoralized but dedicated civil servants, military and police personnel destined for failure and frustration due to inadequate operational support to professional, motivated and energized bureaucracies with adequate means to perform their public service missions.
13. From a lack of concern for gender disparities and shortfalls, to the promotion of equal gender opportunity in all spheres of public policies and programs.
14. From a disjointed, short-sighted Mindanao policy that merely reacts to events and incidents to one that seeks a broadly-supported just peace and will redress decades of neglect of the Moro and other peoples of Mindanao.
15. From allowing environmental blight to spoil our cities, where both the rich and the poor bear with congestion and urban decay to planning alternative, inclusive urban developments where people of varying income levels are integrated in productive, healthy and safe communities.
16. From a government obsessed with exploiting the country for immediate gains to the detriment of its environment to a government that will encourage sustainable use of resources to benefit the present and future generations.

Source: Official Gazette, Republic of the Philippines: http://www.gov.ph/about/gov/exec/bsaiii/platform-of-government/

Exhibit 6 *Tobacco Excise Tax Collection Compared with the Health Care and Economic Costs of Smoking in the Philippines, 2000–2008*

Year	Tobacco Excise Tax (PhP billions)	Health Care and Economic Costs of Smoking (PhP billions)
2000	17.4	46.0
2001	19.4	46.0
2002	19.9	46.0
2003	19.7	148.5
2004	23.1	148.5
2005	23.3	148.5
2006	26.2	148.5
2007	23.2	445.5
2008	27.4	445.5
TOTAL	**199.6**	**1,620.0**

Note: Costs were estimated by Dr. Antonio Dans, University of the Philippines (2000–2002 data); WHO (2003–2006 data); and *Newsbreak* (2007–2008 data).

Source: National Tobacco Administration, Department of Health, WHO, and Dans AL http://www.tobacco-facts.net/2009/06/rp-loses-p148b-a-year-to-smoking-related-diseases

Exhibit 7 *Estimated Impact of Tobacco Tax Increases on Smoking Prevalence and Excise Tax Revenues (excise tax revenues in PhP billions)*

		PTI			Abaya	Santiago		
% Increase in Excise Tax	**0%**	**13%**	**100%**	**200%**	**225%**	**267%**	**300%**	**400%**
Average retail price (PhP)	19.05	19.86	25.26	31.47	33.02	35.63	37.68	43.89
Elasticity = –0.4 (least price sensitive)								
Excise Tax Revenue	25.4	28.2	45.4	62.6	66.5	73.1	78.0	92.4
Smoking Prevalence (%)	31.0	30.7	29.3	28.0	27.7	27.2	26.9	26.1
Elasticity = –0.5 (less price sensitive)								
Excise Tax Revenue	25.4	28.1	44.1	59.5	63.0	68.7	72.9	85.1
Smoking Prevalence (%)	31.0	30.7	28.8	27.2	26.8	26.3	25.9	24.9
Elasticity = –0.6								
Excise Tax Revenue	25.4	28.0	42.9	56.6	59.7	64.5	68.2	78.4
Smoking Prevalence (%)	31.0	30.6	28.4	26.4	26.0	25.4	24.9	23.7
Elasticity = –0.7 (more price sensitive)								
Excise Tax Revenue	25.4	27.9	41.7	53.8	56.4	60.6	63.6	72.0
Smoking Prevalence (%)	31.0	30.5	28.0	25.7	25.2	24.4	23.9	22.4
Elasticity = –0.8 (most price sensitive)								
Excise Tax Revenue	25.4	27.8	40.6	51.2	53.4	56.8	59.3	66.1
Smoking Prevalence (%)	31.0	30.5	27.5	24.9	24.3	23.5	22.9	21.2

Note: PTI stands for the Philippine Tobacco Institute and refers to the version of the sin tax reform bill PTI proposed to Congress. Representative Emilio Abaya was the lead author of the House of Representatives version of the reform bill, and Senator Miriam Defensor-Santiago was the lead author of the Senate version. The bold rectangle represents the elasticity (–0.5) that the government and civil society coalition recommended, and the smaller box within the rectangle indicates the tax revenue and smoking prevalence estimates that the government and coalition believed a 200% tax increase would generate.

Source: Antonio Dans, 2012.

Exhibit 8 *Key Provisions of Republic Act 10351, the Sin Tax Reform Law of 2012*

Removal of price classification freeze and transition to a two-tiered system: Taxes for all cigarette and alcohol brands are based on their current prices; "legacy" brands no longer enjoy a tax advantage over new market entrants. Taxes for cigarettes and fermented liquor are determined based on a two-tiered system as opposed to a four-tiered system. On January 1, 2017, a **unitary tax rate** will take effect, requiring all cigarette and fermented liquor brands to pay the same tax rate regardless of price. For distilled spirits, the excise tax rate will be calculated as a percentage of net retail price (NPR) and applied uniformly to all brands.

Increase in the tax rate: Cigarette tax rates increase to PhP 12 (USD 0.26) per pack for cigarette brands in the lower price bracket and PhP 25 (USD 0.56) per pack for cigarette brands in the higher price bracket. Cigarette taxes will increase annually by between 1 and 5 pesos (USD 0.02 to USD 0.11) until 2017, when the unitary rate of PhP 30 (USD 0.67) takes effect. Taxes on distilled spirits and fermented liquor also increase but to a lesser degree.

Indexation to inflation: Beginning January 1, 2018, taxes on cigarettes and fermented liquor will increase annually by 4%, the average rate of inflation in the Philippines. For distilled spirits, the ad valorem tax will increase by 4% annually beginning in 2016, whereas the excise tax will remain at 20% of NPR per proof. Indexing the taxes to inflation will preserve the value of the tax over time.

Earmarking incremental revenues for universal health care and alternative livelihood programs: Fifteen percent of incremental revenues generated from the tobacco tax increase are earmarked to help tobacco farmers and workers pursue economically viable alternatives to tobacco production or manufacturing. In addition, these revenues can be used to develop the tourism potential and basic infrastructure (roads, schools, hospitals, rural health facilities) of tobacco-growing provinces. The remaining incremental revenues (85% of the incremental tobacco tax revenues and 100% of the incremental alcohol tax revenues) are dedicated to spending on health care: 80% are for universal health care under the National Health Insurance Program (mainly for insurance premium subsidies), attainment of the Millennium Development Goals, and health awareness programs. The remaining 20% will support medical assistance for indigent patients and health infrastructure improvements through the Department of Health's Medical Assistance Program and the Health Facilities Enhancement Program.

Oversight: The Department of Budget and Management, the Department of Agriculture, the Department of Health, and the Philippine National Insurance Corporation (PhilHealth) are required to submit to the Congressional Oversight Committee detailed annual reports on the expenditure of earmarked revenues. In the third quarter of 2016 the Committee will conduct a review of the legislation's impact.

Source: Republic of the Philippines, Republic Act 10351, 2012.

Exhibit 9 *Cigarette and Alcohol Tax Rates Pre- and Post-Republic Act 10351*[§]

Cigarette Taxes (PhP per pack), 2011–2012

Net Retail Price (PhP per pack)	Price Tier	Tax
Below 5.00	Low	2.72
Between 5.00 and 6.50	Medium	7.56
Between 6.50 and 10.00	High	12.00
Over 10.00	Premium	28.30

Cigarette Taxes (PhP per pack) Effective January 1, 2013

NRP* (PhP per pack)	2013	2014	2015	2016	2017	2018
11.50 and below	12.00	17.00	21.00	25.00	30.00	4% annual increase thereafter
Above 11.50	25.00	27.00	28.00	29.00		

*Net retail price.

Distilled Spirit Taxes (PhP per proof liter), 2011–2012

Local Products	Tax
All products taxed at uniform rate, regardless of price	14.68
Imported Products (NRP, in PhP)	**Tax**
Below 250.00	158.72
Between 250.00 and 575.00	317.45
Over 575.00	634.89

Distilled Spirit Taxes (PhP per proof liter) Effective January 1, 2013

	2013	2015	2016
Ad Valorem Tax (PhP)	20.00	20.00	4% annual increase thereafter
Specific Tax	15% of NRP	20% of NRP	20% of NRP

[§] Approximate USD-to-PhP currency conversion rate: 1 USD = 44.7350 PhP.

Fermented Liquor Taxes, 2011–2012

Net Retail Price (PhP per liter)	Tax (PhP per liter)
Below 14.50	10.42
Between 14.50 and 22.00	15.49
Over 22.00	20.57

Fermented Liquor Taxes (PhP per liter) Effective January 1, 2013

Net Retail Price (PhP)	2013	2014	2015	2016	2017	2018
50.60 and below	15.00	17.00	19.00	21.00	23.50	4% annual increase thereafter
Over 50.60	20.00	21.00	22.00	23.00		

Source: Republic Act 9334, Republic Act 10351; formatting adapted from Action for Economic Reforms' *Primer on the Sin Tax Law*.

Exhibit 10 *Prices of Cigarettes and Other Commodities in the Philippines*

Product	Average Price in 2012 (PhP)	Average Price in 2013 (PhP)
2 lb. bag of regular milled rice	27.00	27.00
5 lb. bag of refined sugar	113.00	101.70
1 pound of pork belly	81.00	81.00
1 head of cabbage	40.00	40.00
100 mg aspirin (tablet)	2.25	1.25–4.50
250 mg amoxicillin (capsule)	4.25–8.50	2.25–9.00
100 ml insulin	755.00–1,350.00	720.00–2,516.00
1 gallon unleaded gas (prevailing price in Metro Manila)	11.75–13.72	12.69–14.57
20-pack of Marlboro cigarettes (most popular foreign brand)	41.81[a]	49.24[b]
20-pack of Fortune cigarettes (most popular local brand)	19.85[a]	24.62[b]
Average price of a 20-pack of cigarettes, all brands	21.12[c]	31.26[c]

Note: Cigarette prices were reported in USD; the authors converted them to PhP using the average exchange rates for 2012 (USD 1 = PhP 42.23) and 2013 (USD 1 = 42.45), provided by the Philippines' National Statistical Coordination Board. Case writers converted food product quantities to units of measurement commonly used by US consumers.

Source: (a) Southeast Asia Tobacco Control Alliance; (b) *Philippine Daily Inquirer*; (c) Campaign for Tobacco-Free Kids; all other price data were obtained from the Presidential Communications Development and Strategic Planning Office, Republic of the Philippines.

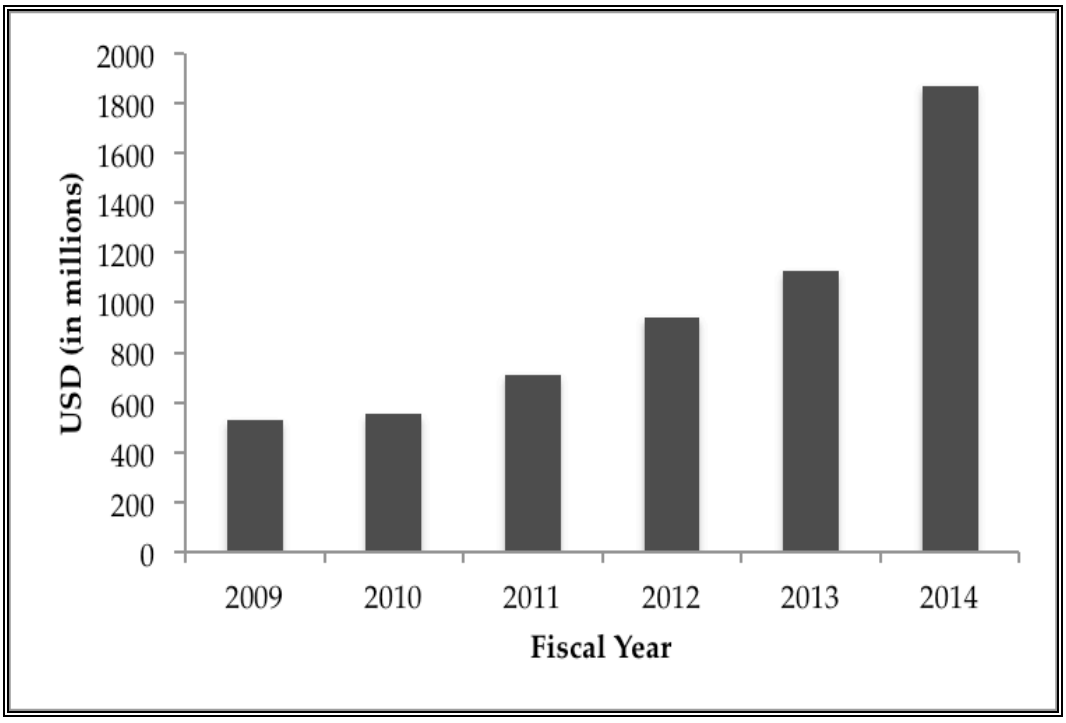
Exhibit 11 *Comparison of Excise Tax Targets and Actual Collections (PhP billions)*

Year	Product	Projected Incremental Revenue (goal)	Actual Incremental Revenue	Percentage of Projected Incremental Revenue Attained	Excise Tax Revenues Collected Based on Preexisting Tax Structure	Total Excise Tax Collection (including incremental revenues)
2012	Tobacco and Alcohol					**32.9**
2013	Tobacco	23.41	41.82	179%	26.12	**67.94**
	Alcohol	10.55	9.29	88%	23.69	**32.98**
	Total	**33.96**	**51.11**	**151%**	**49.81**	**100.92**
2014	Tobacco	29.56	40.41	137%	33.83	**74.33**
	Alcohol	13.30	12.23	92%	25.01	**37.29**
	Total	**42.86**	**52.64**	**123%**	**58.84**	**111.62**

Note: Total excise tax collection for 2013 was PhP 118.86 billion; the goal was PhP 102.37. Total tobacco and alcohol excise tax revenues accounted for 93.3% of total excise taxes collected in 2013.

Source: Bureau of Internal Revenue, Republic of the Philippines.

Exhibit 12 *Department of Health Budget, Republic of the Philippines, 2009–2014*



Note: The DOH's 2014 budget was the sum of its 2013 budget and the DOH's share of projected incremental tobacco and alcohol tax revenue collections for 2013, or PhP 30.5 billion (USD 681.4 million).

Source: Department of Health, Republic of the Philippines.

Exhibit 13 *Department of Health Budget Allocations of Incremental Tobacco and Alcohol Tax Revenues for 2014 (USD thousands)*

Programs, Activities, and Projects	FY 2014 GAA (baseline)	Sin Tax Incremental Revenue Added to the 2014 DOH Budget	FY 2014 GAA Allocation of Relevant Programs, Activities, and Projects	% Increase
Enrollment Coverage (PhilHealth Premiums)	282,282	**507,651**	789,933	180%
Attainment of MDGs	155,071	**37,620**	192,691	24%
Noncommunicable Diseases	1,582	11,532	13,114	729%
TB Control and Assistance to Philippine Tuberculosis Society	23,110	924	24,034	4%
Other Infectious Diseases (HIV/AIDS, Dengue) and Operation of PNAC Secretariat	7,431	10,316	17,747	139%
Rabies Control Program	2,654	1,879	4,533	71%
Elimination of Diseases (Malaria, Schistosomiasis, Leprosy, and Filariasis)	12,752	5,741	18,492	45%
Expanded Program on Immunization	43,585	13,237	56,822	30%
Environmental and Occupational Health	1,159	35	1,194	3%
Health Awareness Program	3,632	**61**	3,693	2%
Implementation of Doctors to the Barrios	64,399	**1,989**	66,388	3%
Hospital Operations	244,722	**48,583**	293,305	20%
Health Policy and Regulations	136,667	**3,159**	140,199	3%
Quick Response Fund	—	**11,177**	11,177	n/a
Assistance to Indigent Patients Confined to Government Hospitals (MAP)	—	**71,397**	71,397	n/a
Total of Sin Tax Increment		**681,637**		**57%**

Note: GAA refers to the General Appropriations Act. It is the national budget for the Philippines and includes appropriations for each department.

Source: Department of Health, *Sin Tax Law Incremental Revenue for Health Report: Details on Expenditure of the Amounts Earmarked for Health*, 2014.

Exhibit 14 *Press Release Issued on DOH's Facebook Account, July 2014*

HEALTHCARE WORKFORCE: A PRIORITY OF KALUSUGAN PANGKALAHATAN
Press Release / 23 July 2014

The Department of Health (DOH) considers the Filipino healthcare workers as a priority of Kalusugan Pangkalahatan and continues to address the maldistribution of workers across the country.

"The welfare and advancement of Filipino healthcare workers was and still is among the priorities of the Aquino Health Agenda," Health Secretary Enrique T. Ona clarified. Understanding that achieving universal healthcare is not just about equipment and facilities, or funds to pay for services, the DOH is into the implementation of the Rationalization Plan that is seen to improve the status of government health workers, making it more competitive and attractive to be in government health service.

The Rationalization Plan was started in 2013 after it was approved in August. At present, all the 16 regional offices of the Department have received their Notice of Organization, Staffing and Compensation Action (NOSCA) from the Department of Budget and Management (DBM). This will help the health facility hire more health workers depending on their needs.

Among the reasons why health workers do not stay include lower salary or insufficient budgetary support from the local government, lack of medical equipment, and uncertainty for professional growth.

To complement the human resource needs and discrepancies in number, the DOH has deployed a total of 8,203 rural health midwives since its launch in 2010. Solely in 2013, the 2,738 midwives were deployed across the country. Similarly, there were a total of 324 doctors deployed through Doctors to the Barrio (DTTB) Program and 63,932 nurses deployed from 2010 to 2014.

With Local Government Unit hospitals, funding from PhilHealth capitation, it is now possible for LGUs to hire health workers which has already started for some cities and provinces. For the Registered Nurses for Health Enhancement and Local Service (RNHEALS) program, there were (20,801) nurses deployed in 2011, (10,000) nurses deployed in 2012, (21,929) for 2013, and (11,202) in 2014. For this year, the nurses are now deployed exclusively to rural health units where they are to lead Community Health Teams, participate in the Expanded Program of Immunization, perform pre-natal checkups, in addition to complementing regular clinical services.

"Improving our health facilities through the Health Facility Enhancement Program (HFEP) will definitely lead to increase health workers in the provinces. Since 2010, there were 3,846 LGU health facilities that have been upgraded (1,567 BHS, 2,027 RHUs/ city health centers and 252 LGU hospitals); 2,084 were completed in 2013 alone and an additional 60 infrastructure projects in the DOH retained hospitals; Heart-Lung-Kidney Centers were established in Luzon, Visayas, and Mindanao to improve accessibility to specialized care, decreasing the influx of patients to Metro Manila. Building a cancer center in Mindanao, for example, will encourage cancer specialists to practice there," Sec Ona said.

"Facilities improvement and health workforce augmentation go hand in hand. Doctors will not be happy if there are no laboratory test or equipment in the hospital/health center. With PhilHealth augmentation, doctors can potentially receive compensation by as much as Php 100,000 per month and use the same resources to continue modernization of their hospitals and rural health units that has already been started by the Health Facilities and Enhancement Program," the health chief explained.

In the noble quest for Kalusugan Pangkalahatan, getting competent health human resources whose welfare are taken care of will spell success.

Secretary Ona remains optimistic that although the salaries of our public health workers is less when compared to the financial rewards abroad, our noble Filipino doctors would choose to stay and serve their countrymen, as he added that DOH has been taking steps to increase the number of positions available and salaries of our public health workers. "Aside from salaries, DOH sees the role of private groups and medical schools in terms of the proper medical education and training to encourage our doctors. Private doctors and societies can encourage their colleagues to practice in the far-flung areas of the country. In line with the Doctor to the Barrios program, the DOH commends these nationalistic health workers for serving their countrymen most in need of medical care," the health chief concluded.

Source: Department of Health, https://www.facebook.com/OfficialDOHgov/posts/868529576491629

Exhibit 15 *Price Comparison of Popular Cigarette Brands in Southeast Asian Countries, 2014*

Country	Most Popular Local Brand		Most Popular Foreign Brand	
	Price (USD per pack)	Brand Name	Price (USD per pack)	Brand Name
Brunei Darussalam	N/A	N/A	6.47	Marlboro Gold
Cambodia	0.35	Ara	0.725–1.00	Alain Delon
Indonesia	1.20	A. Mild	1.30	Marlboro
Lao PDR	0.87	Adeng	1.62	Marlboro
Malaysia	2.12	John	3.70	Dunhill
Myanmar	0.72	Red Ruby	2.26 - 2.98	Marlboro
Philippines	0.96	Fortune	1.60	Marlboro
Singapore	N/A	N/A	9.60	Marlboro
Thailand	2.06	Krongthip	2.06	L&M
Vietnam	0.89	Vinataba	1.08	Craven A

Note: N/A signifies that the country had insignificant or no local cigarette production.

Source: Southeast Asia Tobacco Control Alliance, The ASEAN Tobacco Control Atlas, Second Edition, September 2014.

Exhibit 16 *Comparison of Factory Removals Pre- and Post-Sin Tax Reform*

Product	Volume of Removals (billions)		Change	Percent Change
	2012	2013		
Cigarettes (packs of 20)	5.76	4.87	–0.89	–15
Fermented Liquor (liters)	1.57	1.40	–0.17	–11
Distilled Spirits (proof liters)	0.29	0.37	0.08	28

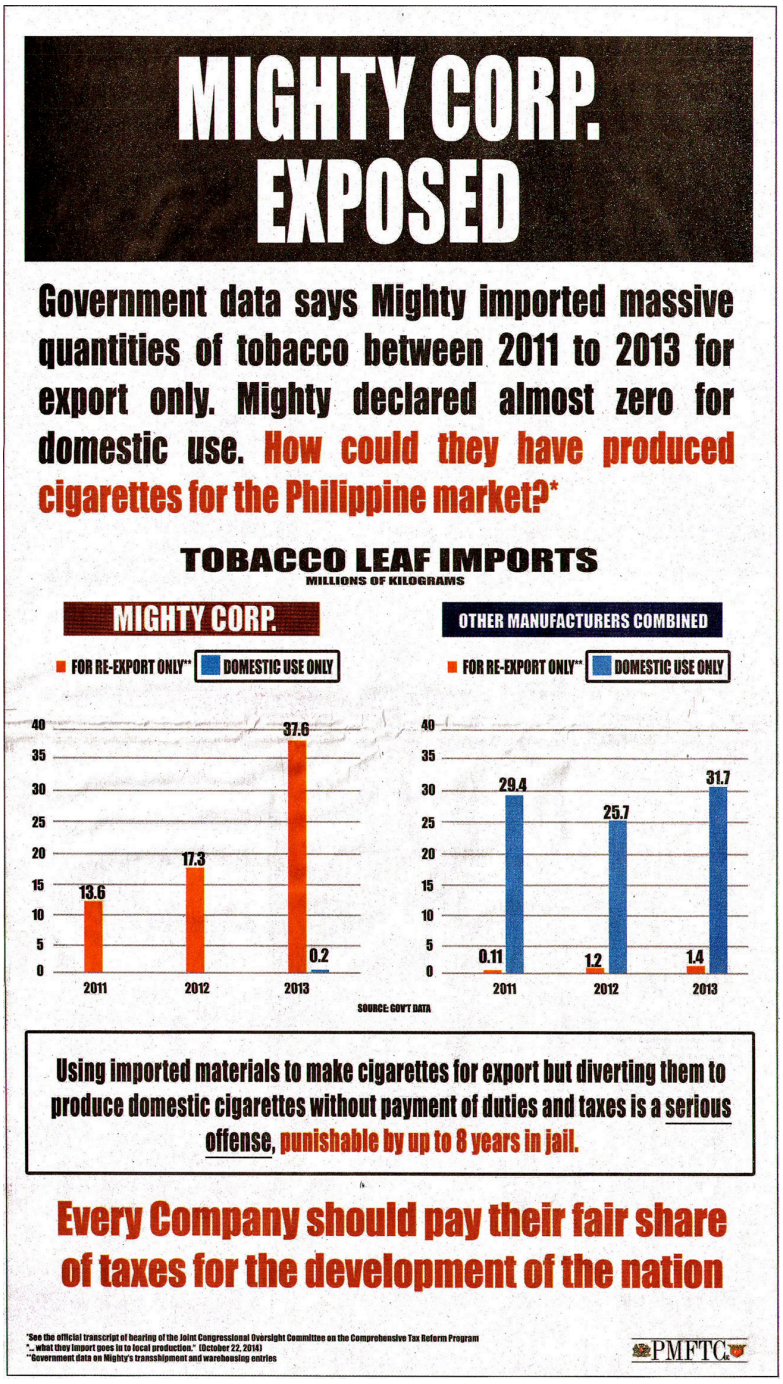
Note: Excise taxes were collected on products when manufacturers removed cigarettes from the factory to sell on the market. Companies could not withdraw products from the factory unless they had paid the tax on them.

The sin tax reform act changed the basis of taxation on distilled spirits from raw materials to the finished product. 2013 removals included local and imported raw materials, while removals in 2012 were based only on locally produced raw materials. The increase was due largely to the inclusion of imported raw materials in the tax base for domestic distilled spirits.

Cigarette and fermented liquor removals continued to fall in 2014; distilled spirit removals increased.

Source: Congressional Oversight Committee on the Comprehensive Tax Reform Program Hearing, Bureau of Internal Revenue, Republic of the Philippines, 2014.

Exhibit 17 *Philip Morris Fortune Tobacco Corporation Advertisement Accusing Rival Cigarette Manufacturing Company of Tax Evasion*



Source: Originally published in November 2014 in the Philippine newspapers *Philippine Star* and *Philippine Daily Inquirer*. Accessed via https://corruptionkillsinthephilippines.wordpress.com/.

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