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**HEALTH  
FINANCE  
DEVELOPMENT  
PROJECT**

HFDP Monograph No. 4  
April 1994



Department of Health  
Republic of the Philippines

United States Agency for  
International Development  
(USAID)

UPecon Foundation

# The Private Medical Sector in the Philippines

The Current Situation and  
Prospects for Change

Charles C. Griffin  
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*Design and Production*  
Beulah P. Taguiwalo

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## 1

# Executive Summary

This study assesses the current state of the private sector, develops a better understanding of the main constraints on expansion of the sector, and recommends changes in public policy to strengthen the private sector. This summary first outlines the framework used in the study, then it describes the distribution and main characteristics of the private sector, then it reviews the findings based on an application of the framework, and finally, it reviews recommendations for public policy.

## Framework

A conceptual framework for public-private interactions in the health sector is developed, which distinguishes between the demand and supply sides of the market. Several general hypotheses emerge from that framework:

**1. Output.** Governments affect the private sector on the *demand side* or its market environment, via financing policies, requirements for employment-based financing of medical care, and

*"Private medical services comprise a substantial portion of the Philippine health care market. In 1990, 66 percent of the hospitals and 49 percent of the beds were privately owned."*

competition from public sector services.

**2. Input.** A second part of the private sector's environment is *input markets, or the supply side*. Government regulations, taxes, or subsidies on inputs, such as duties on the importation of materials, transportation and communication infrastructures, and the training and licensing of personnel, affect the private sector through input markets.

**3. Structure and performance.** The *economic and medical organization* of the institutions delivering medical services is a response to the environment on the demand and supply sides of the market and is a determinant of their performance in delivering medical care.

## Findings

### Availability and Distribution of the Private Sector/Structure and Performance

There were about 650 people per hospital bed in the Philippines in the late 1980s, which put it at about the average for developing countries in Asia. Private medical services comprise a substantial portion of the Philippine health care market. In 1990, 66 percent of the hospitals and 49 percent of the beds were privately owned. The private hospital sector is dominated by small primary operations with 5 to 15 beds, providing basic levels of care. The average private hospital is 41 percent smaller than the average public hospital, which is due to the predominance of these small primary hospitals but also to the fact that private sector hospitals of all types tend to be smaller than their public sector counterparts. These small private

operations are widely dispersed across the country, with only 11 percent of them located in Metro Manila (which contains 14 percent of the population). Although no statistics are available on the number and distribution of private clinics, it is safe to assume (based on surveys of private physicians in the 1970s) that they exceed the number of hospitals by a large margin and are even more widely dispersed.

The stock of health care personnel seems to be adequate, again putting the Philippines at about the average for developing countries in Asia. However, official personnel counts of personnel probably understate their numbers because there is no formal tracking of private sector personnel once they have been licensed at the beginning of their careers. Estimates from the late 1980s indicate that professional personnel are found predominantly in the private sector and are widely dispersed all over the country. Midwives are the most numerous and dispersed group, and dentists are the least numerous and most concentrated in the major cities. The flow of new medical personnel seems to be more than adequate. The number of private medical, nursing, and midwifery schools expanded tremendously over the past two decades, and they produce a high volume of new professionals. Interviews with hospital operators indicate that they have little trouble hiring new physicians or nurses, although in the major cities there is considerably more turnover in these positions than in the countryside. There have been high emigration rates for physicians and nurses, but some of these international markets have contracted in recent years.

The 1970s saw the expansion and geographic equalization of private medical services. However, in the 1980s the number of private hospitals

actually declined slightly, while public hospitals continued to expand at about the same pace as before. Over the last decade, the public sector has not only caught up to, but has overtaken the private sector, as the number of government hospitals and beds has expanded while the number of private beds has contracted. It is unlikely that this public sector expansion has been targeted to areas not served by the private sector, and given the disease profile of the country and the relatively low level of fiscal effort by the government in health, it is probably not the best use of scarce public funds.

Private sector development is the product of many uncoordinated private decisions, and the sector has achieved impressive coverage and a vigorous service delivery system. If it lags at all, it is in improving the quality of care and the mix of services delivered. There is no strong effort by either the Department of Health or the Medicare system to monitor and evaluate private sector performance nor to assist in improving quality. The conduct and organization of the industry is problematic in that it is based on small, single practitioner clinic and hospital operations that are informally organized from both medical and economic perspectives. While evidence is scarce, this structure may be effective for outpatient and primary care, but it probably is weak in providing adequate preventive, diagnostic, and hospital services.

Evidence from interviews with hospital administrators and visits to hospitals indicate that primary hospitals in the public sector have probably been stronger than those in the private sector in terms of management, financial viability, and medical organization. This is true because these small hospitals were part of a larger organization that could supply services

such as standard record keeping, in-service training, and management information. This advantage fades at the secondary and tertiary levels, which are as well organized or better organized in the private sector. In addition, at these levels certain advantages of the private sector come into play, such as adequate financing for consumables and more efficient staffing. However, management and administrative systems in both the public and private sectors could be improved for secondary at all levels, and the private sector infrastructure is skewed toward the level at which it is relatively less effective: primary hospitals.

Lower level public sector hospitals have now been devolved to local governments, with the likely effect that whatever advantages existed in the public sector for operating smaller hospitals will be reduced. The public hospital sector is likely to take on many of the characteristics of its private sector counterparts and to be exposed to the same incentives created by Medicare and fee-for-service financing that have molded the private system. There may be a role for the center to play (both the Department of Health and Medicare) in supporting weaker hospitals through the development of standardized medical records, treatment protocols, financial and administrative systems, and in-service training for both public and private sector facilities.

#### Environment of the Private Sector - Output or Demand Side

We found evidence that demand side issues in the Philippines have a significant impact on the organization and development of private medical services. On the demand side, the government most directly affects the private sector through competition from government services for paying patients and through the Medicare system. The Medicare system is shown to have an impact on the organization of private medical services far out of proportion to the amount of financing it supplies to the system. We found evidence to support the following conclusions:

1. Government Competition. The government most directly affects the private sector through competition from government facilities for paying patients. There is evidence that government hospitals tend to be located in

the same cities and towns as private hospitals. In addition, household surveys indicate substantial mistargeting of government subsidies for medical care. High proportions of poorer households use private sector providers and pay out of pocket for their care. At the same time, although lower proportions of high income households use public facilities, substantial proportions of these households do use subsidized public facilities. These findings show that improving the targeting of public subsidies could reduce substantially the competition that exists for paying patients. In addition, the method of subsidizing medical care today depends on construction and operation of government facilities. A more flexible and potentially easier-to-target means for providing these subsidies would be through cash transfers, such as through vouchers or subsidized health insurance coverage, that would allow consumers to receive the subsidy whether they use public or private providers.

2. Medicare. The Medicare system is an important financial interface between the public and private sectors, as it is financed by a payroll tax, covers about half the population, and finances care from either the public or private sector. We find some important shortcomings of the Medicare system. It therefore merits emphasis in efforts to strengthen the private sector. These problems are summarized below:

a) Distorts provider incentives. Although Medicare reputedly pays only about half of inpatient hospital bills, it is an important source of revenue for private hospitals. There is evidence that reimbursement rules create incentives for smaller, less sophisticated hospitals and argue that Medicare is the primary reason for the proliferation of small primary-care hospitals, often side-by-side, throughout the country. Because it covers only inpatient care, the system gives providers incentives to build these small hospitals and to admit patients unnecessarily. The same observed behavior of hospital operators is consistent with dependence on out-of-pocket spending for half or more of their revenues. The combination of Medicare reimbursement and fee-for-service financing has created a private system that is poorly financed, with incentives to provide inpatient services

*"The Philippines is far ahead of most developing countries in establishing a reasonable legal and regulatory environment for the private sector."*

in small hospitals that are weak both medically and financially.

b) Raises transactions costs. Claims processing is split between two government agencies, the Government Service Insurance System (GSIS) and the Social Security System (SSS). The two funds do not follow the same claims processing policies. Hospitals must claim separately from each, must follow up problem claims in two different organizations, one of which is centralized in Manila and the other of which has recently been decentralized to the regional level. Claims are arbitrarily cut or dismissed; these must be appealed to the Medicare Board. Claims processing in both systems is slow.

c) Slow institutional development of Medicare. Between 1972 and 1986, Medicare (the Philippine Medical Care Commission or PMCC) weakened as an institution, with falling support values for claims, falling real income per worker because the payroll tax was rarely adjusted to inflation, little improvement in coverage of the population, and little or no change in benefit levels. The financing of benefits has been tied to the financial viability of SSS and GSIS, with the weaker of the two (GSIS) putting a ceiling on benefits available to the entire beneficiary base. This slow institutional development must be speeded up significantly to improve the financing of medical care from the private sector.

d) Crowding out of alternative forms of risk sharing. The Medicare system has been treated as the primary risk-sharing mechanism, with other insurers topping up its benefits. Administrative costs for private insurance thus remain high, and marketing is done primarily to individuals and large firms. In addition, Department of Labor requirements for direct delivery of health services by larger companies reduce the demand for insurance-type instruments. The result is slow development of the private health insurance industry and of managed care (such as Health Maintenance Organizations).

3. Direct Purchasing. Except for the purchase of drugs, the public sector has done little contracting for services from the private sector, such as management, laboratory, and training. Thus markets for these services have been relatively slow to develop in the private sector.

The three major elements of the

demand side that appear to be bottlenecks to further development of the private sector -- government competition for paying patients, development of the Medicare system and insurance, and direct purchasing from private suppliers -- are under the direct control of the government. Innovations in these areas hold great promise for development of the private sector, for helping families finance their demand for health services, and for increasing the ability of the government to target its resources effectively and in a cost-minimizing manner.

#### Environment of the Private Sector - Input or Supply Side

The bottlenecks created by government on the input side of the market are of varying importance, but the study concludes that they are not crucial impediments to development of the sector. Government interventions are listed from the least to the most problematic.

1. Duties and import restrictions. Private hospital owners complain bitterly about duties charged on medical equipment and drugs and believe they should be exempted from these taxes. Even donated equipment, they argue, is subject to duties. These duties are thought to put the private sector at a disadvantage relative to the public sector, which is exempt from duties yet competes with private hospitals. The law actually exempts donated essential machinery and equipment of private primary and secondary hospitals, although they are still subject to a 10 percent value added tax. Interviewers for this study found that in practice, no duties need be assessed on purchased or donated equipment for primary and secondary hospitals, as exemptions are routinely granted. Apparently, however, this exception is virtually unknown to the industry. None of these exemptions affect tertiary hospitals, which are clearly at a cost disadvantage relative to the smaller hospitals in terms of border taxes.

2. Training and licensing. Most training is accomplished in the private sector; there is a ready supply of well-trained physicians, nurses, and other professional personnel; and licensing of personnel is accomplished at the beginning of their professional careers. Licensing of medical facilities is also not a major issue, as requirements are not difficult to meet. However, be-

*"It is in a position to move forward in developing policies to positively affect the financing of the private sector and the mix and quality of services."*

cause both the Department of Health and the Medicare system accredit hospitals, there are some complaints about the lack of coordination between the systems and the required payment of multiple fees. Minimum staffing regulations are part of the DOH licensing requirements, and the lack of divisibility of staff requirements (such as the requirement for a full-time pharmacist rather than permitting a consulting part-time pharmacist) limits the ability of hospital operators to make cost-minimizing economic decisions. Such requirements probably unnecessarily raise the unit costs of small hospitals relative to larger ones.

3. Taxation. A major complaint of hospital owners is that private health facilities are taxed as if they were regular businesses. Owners argue that they are performing a social service that benefits the country beyond the income and profits of the proprietors and thus should be given special tax-free privileges. Education institutions are accorded this privilege; they are treated as non-profit institutions and thus enjoy tax- and duty-free privileges. The major impact of this provision on the hospital sector in the Philippines is that it gives for-profit private hospitals an incentive to open an affiliated medical, nursing, or midwifery school. Then, as part of a professional school, certain activities can be sheltered from taxes by transferring them to the educational part of the institution.

4. Infrastructure. Particularly in rural areas, lack of electricity, water systems, roads, and inexpensive communication limits the size of the market on which medical facilities can draw and increases the cost of constructing and operating medical facilities outside of major cities. This lack of infrastructure may contribute to the construction of smaller, less

sophisticated hospitals than would otherwise be built, especially in rural areas.

5. **Credit.** The availability of credit for hospital construction and operation may be an important bottleneck. Hospitals are typically financed personally by physicians or a group of physicians, rarely by investors or through bank loans. Thus they tend to be under-capitalized and many are persistently close to financial failure (Inter-care 1987). This method of financing is partially responsible for the proliferation of small single-proprietor hospitals in the private sector. There have been concessional credit instruments created for private hospitals and schools in the past (primarily in the 1970s, in response to the creation of the Medicare system) through the Government Service Insurance System, the Social Security System, and the Development Bank of the Philippines (DBP). The general experience with these loans was high failure rates and fund shortages at the subsidized interest rates limited the volume of loans. In general, therefore, hospitals are either financed internally or pay market rates for credit. Successful private hospitals may gain access to some subsidized loans, but it is unlikely that new hospitals are able to secure below-market rates on borrowed funds. Although these credit problems probably have serious consequences for the private medical sector, solving them is more linked to the demand side than to the supply side, as is discussed in greater detail below.

The government appears to have created a relatively open environment for the private sector in health. It can take additional positive actions by leveling the playing field through equal tax treatment of the education and health sectors, by encouraging development and fair pricing of support infrastructure (e.g. power, transport, communication, and credit), and the promotion of more organized means of paying for health care services. Credit problems can be reduced by opening up credit markets to more competition and by improving the financing of health service demand through greater involvement of third-party payers. The demand side is key, as problems in servicing loans arise from unpredictable revenue streams caused by dependence on individual out-of-pocket payments. In addition, the government and Medicare can

play a role in improving the quality of medical care in the private sector by developing and encouraging use of standardized treatment protocols, standardized medical record keeping, and standardized medical accounting practices in both the public and private sectors. In-service training is another positive contribution the government can make to improving medical care in both the public and private sectors.

## Recommendations

Listed below are major recommendations within each category -- demand side, structure and performance of the industry, and the supply side. Among these categories, the most important is the demand-side and Medicare part of the equation. The recommendations can be easily summarized. First, on the demand side, changes in financing for the end user through more effective and widely available insurance coverage can have a tremendous impact on the mix and quality of services available in the private sector as well as the organization and structure of the industry. These changes should be accompanied by reductions in subsidized competition from the public sector for higher income patients and increased demand for private sector services from public institutions. Second, the government can make positive -- as opposed to strict regulatory -- contributions to improving the quality of care from the private sector. Third, some changes on the supply side -- taxes and regulations -- could improve the environment of the private sector but would probably make a much more marginal contribution than action in the other two areas. Specific options for action include the following :

### Output/Demand Side

1. Reduce redundancy of government facilities; channel subsidies to households rather than facilities (allowing them choice among providers when receiving the subsidy).

2. Medicare :

a) Seek areas where privatization can occur, such as in determining benefits, in organizing new groups to become part of Medicare, in claims

processing, and other areas to strengthen risk sharing institutions and cut transactions costs for hospital operators.

b) Develop multiple benefits/ premium options for workers.

c) Reform reimbursement policies to speed up claims processing, encourage managed care, encourage larger private sector hospitals, encourage medically sound treatment, and reduce hospitalizations.

3. Increase contracting for private services by government in areas where the government continues to operate facilities.

### Distribution and Organization/Structure and Performance

Use the local government initiative as an opportunity to develop positive methods, as opposed to regulatory and legal approaches, to assist *both* local government and private suppliers of care in the following areas: standardizing medical record keeping, standardizing financial record keeping, developing standard treatment protocols, and developing effective and widely attended in-service training programs. Reimbursement and licensing rules by the Medicare system should provide incentives to providers to take advantage of these services.

### Supply or Input Side

1. Review labor requirements for licensing to allow hospital operators to make better economic choices (e.g. allow part-time pharmacists or small hospitals to contract for these services).

2. Improve rural infrastructure and the pricing of utility services, again equalizing these costs for public and private providers.

3. Equalize tax treatment across facilities : public versus private, educational versus health, and smaller versus larger. Formal rules should be widely disseminated so all can take advantage of exceptions provided in existing laws or regulations, such as in the assessment of duties for imported equipment.

The Philippines is far ahead of most developing countries in establishing a reasonable legal and regulatory environment for the private sector. It is in a position to move forward in developing policies to positively affect the financing of the private sector and the mix and quality of services. ■

# 2

## Introduction

### Issues

In general, studies of public-private interactions in the medical sector in developing countries -- which tend to be embedded in technical assistance reports rather than in published articles -- have concentrated only on the supply-side interface between the public and private sectors. This focus has resulted from a preoccupation with directly observable barriers to private sector development, such as government regulation, tax laws, and legal restrictions on location and staffing. Private physicians and hospitals have reinforced this focus because rules and regulations are the most tangible evidence of government involvement in their affairs and the ones they are most interested in shedding. However, Griffin (1989) argued that because of the element of catastrophic risk in medical markets and the related problems consumers have of paying for their care, a major impediment to development of the private sector

*"...good policy should be based on a conceptual framework that allows us to inventory... government-influenced barriers to private sector development, rank them, and develop appropriate policy responses."*

must be the development of instruments on the demand side of the market to finance the consumption of medical services.

The mix of barriers to private sector development and the effects they have on the observed institutional characteristics of medical providers are likely to vary from country to country, therefore good policy should be based on a conceptual framework that allows us to inventory all of the possible government-influenced barriers to private sector development, rank them, and develop appropriate policy responses.

This paper reports on an effort to develop such a framework and apply it to the Philippines. The discussion focuses on demand-side interventions through which government policy can affect the quantity, mix, and quality of services provided in the private sector. Evidence that has led to this demand-side focus is presented, and resulting follow-up analysis supporting possible policy changes in insurance and government expenditure policies is introduced.

### Conceptual Framework

#### Framework for Distinguishing the Roles of the Public and Private Sectors in Health

One point of confusion in policy debates is what the private health care sector will and will not do. One way to approach this topic is from a public finance perspective, in which we identify goods and services that have qualities that would merit public financing: which medical services are nonrival and/or nonexclusive in consumption? In Table 1, health care ac-

tivities are divided into three categories ranging from pure public health services (Category 1) to pure private health services (Category 3).

The private sector tends to produce Category 3 services almost exclusively, but it also participates to some degree in the provision of Category 2 services because people are willing to pay for the benefits they receive from these services (even though the services also provide community benefits). Under no circumstances would the private sector, without some public financing,

**Table 1** A Public Finance Approach to Government Activities in Health

#### Category 1

##### Public Health Activities

- Data collection
- Health education
- Regulation, licensing
- Environmental health
- Prevention of communicable diseases
- Decreasing cost utilities (water, sanitation)

#### Category 2

##### Mixed Public/Private Activities

Health intervention with both individual and community benefits:

- Family planning
- Maternal/child health
- Infant nutrition
- Immunizations
- Treatment of communicable diseases

#### Category 3

##### Private Activities

Acute care:

- Inpatient
- Outpatient

produce adequate amounts of Category 2 services. This statement applies doubly to Category 1 services. The reason is quite simple -- as one moves from the bottom to the top of the table, individuals lose the incentive to pay for the services. If no one will pay, there is no incentive for the private sector to provide the service. Some type of taxation or community payment is necessary to supply Categories 1 and 2 services in adequate amounts. Thus, without some public financing, the private sector will produce adequately only those services that do not require public subsidies.<sup>1</sup>

Yet health professionals and government officials often argue that the private health sector must begin to contribute more to public health activities (Category 1) rather than concentrating, as it does, on curative health services. Tools that are mentioned for achieving this goal are regulations requiring such services, general incantations about the need for a culture of public-spiritedness, and other formal and informal requirements to force the private sector to change the mix of outputs. These approaches may succeed partially but they do not represent effective ways to use the private sector to achieve public health goals. Similarly, the government may force employers to pay for public health services, but this approach is similar to taxing employers to pay for the services, yet only their employees (rather than the public at large) benefit from such an employment-based approach.

Within this framework, pushing the health system as a whole to achieve public health goals requires the opposite approach -- having the government exercise direct responsibility for the financing of public health activities. This option generally requires that limited public resources be removed from the financing of Category 3 services and reallocated to Category 1 and 2 services. The private sector may be called upon to *produce* these public health services, but the public sector must *take primary responsibility for financing* their provision. This conceptualization of the problem is the source of economists' advice for governments to prioritize spending to solve public health and environmental health problems with public money, financing curative services only after these activities are adequately funded.

The private sector plays two roles in

this approach. First, it takes primary responsibility for delivering curative (Category 3) services as the government allocates its spending to the other categories. Second, it can be called upon to deliver public health services which the government finances, either partially or fully. The government need not enter into service delivery in order to achieve its public health goals; rather, its role can be financial and regulatory. The decision to enter into service delivery is made outside of the framework proposed in ; it must be related to other distributional problems or other types of market failure in medical markets.

Of course the government will pay close attention to the equity impacts of private delivery of Category 3 services. However, equity problems that arise can be resolved, in principle, by carefully targeted subsidies or income transfers. In addition, because of peculiarities of medical markets, the government is likely to play a major role in arranging and regulating the institutions required to finance the private provision of health services (primarily insurance).

#### Framework for Analysis of Public/Private Interactions

Table 2 illustrates the conceptual framework used to organize this study. It looks at private sector producers of private medical services as an industry, sandwiched between demand side (output, left side of the table) and supply side (input, right side of the table) markets. The productive private sector units listed in the center column are hospitals, clinics, single practitioners, and part-time government personnel. At the bottom of this column is a list of organizational, structural, and performance issues that are outcomes of how economic agents in the sector are organized. The government holds policy tools that can affect these and other aspects of the sector's organization and performance.

On the demand side are listed the consumers and organizations that are sources of demand and revenues for the private sector: individuals paying out of their pockets for care; third party payments by government, private insurers, or employers; and direct purchases by government and employers. Between these sources of demand (or revenue to private prac-

*"One point of confusion in policy debates is what the private health care sector will and will not do. One way to approach this topic is from a public finance perspective, in which we identify goods and services that have qualities that would merit public financing: which medical services are nonrival and/or nonexclusive in consumption?"*

tioners) and the providers is a list of government interventions that can affect the demand for private services. For individuals' out-of-pocket payments, these include primarily public competition for paying patients on the negative side and subsidies to indigents to use private sector services on the positive side. Government also affects private insurer and employer behavior indirectly through regulation. However, by far the most important direct impact the government can have on revenues for the private sector are through the national medical insurance system Medicare in the Philippines and contracting for services.

To the far right are supply-side issues categorized according to types of inputs required by the private sector. The inputs are categorized according to typical economic groups, including capital and labor. Other categories that are specified are equipment and supplies, access to financial capital, and public infrastructure. Between the inputs and center column are listed possible governmental interventions that affect the cost and availability of each input. Virtually all government interventions on this side of the market affect the private sector indirectly, through regulations, licensing, taxes, credit rationing, and infrastructure development. ■

**Table 2** Schematic Diagram of Private Medical Sector and Points of Government Intervention

Demand Side		Producers	Supply Side	
Sources of financing	Possible Government Interventions	Production of Private Allopathic Services	Possible Government Interventions	Inputs Required for Private Practice
Individual demand and financing  (Private out-of-pocket spending)	Malpractice laws	Hospitals	Training and licensing	Labor
	Subsidies for indigents	Clinics	Employment and staffing regulations	
	Public sector competition	Single practitioner	Import restrictions	
	Assistance to create risk-sharing mechanisms	Part-time government providers	Import taxes (tariffs)	
Public sector insurance and risk-sharing  (Medicare)	Reimbursement rules	Issues in Structure and Performance	Certificate of need	Financial capital
	Beneficiary base	Medical	Credit rationing	
	Speed of payment	Economic (Prices and Quantities)	Barriers to foreign capital or investors	
Private sector insurance	Regulations	Service Quality	Facility licensing requirements	Physical plant
	Insurance industry regulation	Organization: simple or complex?		
Direct purchases by government	Tax treatment of premium payments	Potential for development of managed care	Location restrictions	Intrastructure (transport, power, water)
	Contracts for goods and services	Development of specialized support services		
Payments by employers	Employment-related coverage laws	Financial organization	Public investment decisions	

# 3

## The Philippines in the Asian Context

### Overall Performance of the Health Sector

Comparisons of health indicators and spending patterns are often made within countries across time. The Philippines has witnessed a substantial improvement in the infant mortality rate (IMR) from 72 in 1965 to 42 in 1989 and a corresponding improvement in female life expectancy at birth (LEB) from 57 years to 65 years (World Bank 1991). The share of this improve-

ment that took place during the last 15 years was achieved despite relatively low spending on health. Overall (government plus private) expenditures on health services appear to have been stuck at under 2 percent of GNP, and government health expenditures were, at best, flat through most of the 1980s (Solon et al. 1991). Thus one might conclude that the Philippines has performed surprisingly well -- substantial improvements in aggregate health indicators despite limited spending on health services.

With a few exceptions, however, aggregate indicators of health have im-

proved over time in all countries.

More useful information can therefore be derived about a country's performance by comparing current levels as well as rates of improvement in these indicators across countries. This section, which is adapted from Griffin (1992), compares the performance of the Philippines to selected developing countries in Asia on aggregate measures of health status, health expenditures, prices of medical services, and the role of the private sector.

Table 3 lists the countries included in the comparison and divides them into groups based on the level of

**Table 3** Per Capita GDP, Female Life Expectancy, and Infant Mortality Rates, Selected Developing Countries of Asia, 1989 and 1965

	Per Capita GDP 1989 in US\$	Female LEB 1989	Female LEB 1965	Change in Female LEB	IMR 1989	IMR 1965	Change in IMR
<b>Below 60 years</b>							
Bangladesh	180	51	44	7	106	153	-47
Nepal	180	51	40	11	124	184	-60
Papua New Guinea	890	55	44	11	59	140	-81
India	340	59	44	15	95	151	-56
<b>Between 60 and 69 years</b>							
Indonesia	500	63	45	18	64	136	-72
Myanmar		63	49	14	66	122	-56
<b>Philippines</b>	<b>710</b>	<b>66</b>	<b>57</b>	<b>9</b>	<b>42</b>	<b>72</b>	<b>-30</b>
Thailand	1220	68	58	10	28	88	-60
<b>Over 70 years</b>							
China	350	71	59	12	30	90	-60
Malaysia	2160	72	60	12	22	55	-33
Korea	4400	73	58	15	23	63	-40
Sri Lanka	430	73	64	9	20	63	-43
<b>Summary</b>							
Average	1033	64	52	12	57	110	-53
Median	500	64.5	53	11.5	50.5	106	-58
Range	4220	22	24	11	104	129	-51

Note: LEB = Life Expectancy at Birth, in years.

IMR = Infant Mortality Rate, infant deaths per thousand live births.

SOURCE: WORLD BANK 1991

female life expectancy in 1989. The range in female life expectancy in 1989 was 22 years, from 51 years in Bangladesh and Nepal to 73 years in Korea. Median life expectancy was about 65 years, which put the Philippines (66 years) at the middle of the list. For infant mortality, the range was 104 deaths per thousand live births, from 20 in Sri Lanka to 124 in Nepal. The Philippines' rankings on both measures are almost identical.

If the list were sorted according to female life expectancy in 1965, the Philippines would also be in the middle of the table. However, the rankings do not tell the whole story, because country performance was quite variable over the period. If we look at the absolute number of years of life expectancy added over the 24 year period, the Philippines (with a 9 year improvement) ranks among the bottom fourth of the countries, along with Bangladesh and Sri Lanka. Had the Philippines kept up with the average for the sample, life expectancy for women would have stood at 69 years in 1989 instead of 66 years. For absolute improvement in infant mortality, the Philippines ranks last, with a

reduction in 30 deaths per thousand over the period. By 1989, for every infant dying in Malaysia, 2.1 die in the Philippines. The country's IMR was 82 percent of Thailand's in 1965; by 1989, it was 150 percent of Thailand's.

Are the differences related to income? The short answer is yes. Figure 1 shows infant mortality for the sample in 1986 arrayed by per capita GNP in that year, showing a very strong inverse relationship between the two variables, especially at the lowest levels of per capita GNP.<sup>2</sup>

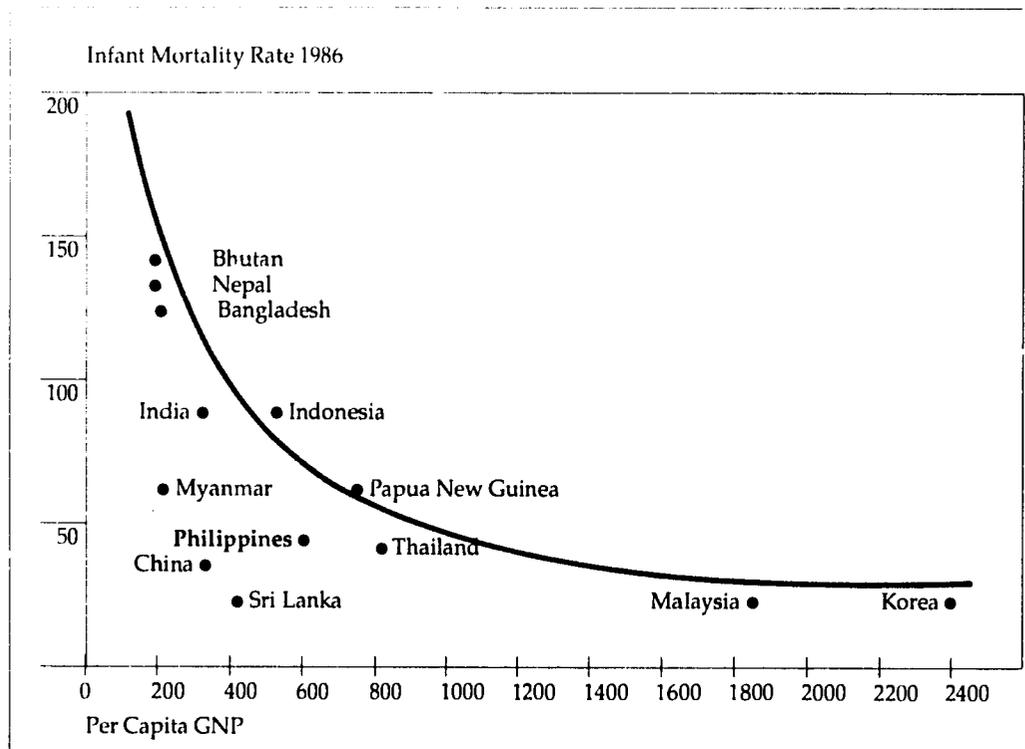
However, there are so many outliers that low income cannot be much of a barrier to good performance. China and Sri Lanka are examples of countries that have achieved tremendous improvements in health indicators at extremely low levels of per capita income. With 49 percent of the Philippines' per capita income, China has achieved a level of female life expectancy that is 113 percent of the level achieved by the Philippines. Sri Lanka has less than 10 percent of Korea's per capita income but has achieved a lower infant mortality rate. Growth in income may also be important, but again there are many exceptions.

India's per capita income grew just a little bit faster than the Philippines (1.8 versus 1.6 percent per year since 1965) but performed substantially better in improving these measures of health status. There is little question that differences in health spending and health policy can affect these outcome measures, the impact can be large indeed.

## Public and Private Financing of Health Services

Given the public/private framework described above, two simple hypotheses for policy can be derived. First, there is no fixed public/private expenditure ratio that would flow from the framework; rather, this ratio would be a function of disease patterns and other characteristics of each national system. Second, whatever the ratio of public to private spending, public spending should be, in a norma-

Figure 1 Infant Mortality Rate and Per Capita GNP, Asian Countries with World Trend 1986



tive sense, directed to services with a greater public content -- those characterized by broad externalities -- and not to curative services. Governments that have relatively low spending should have a higher ratio of Categories 1 and 2 spending to Category 3 spending because Category 3 spending is something of a public luxury to be consumed after Categories 1 and 2 are adequately funded.

Where does the Philippines stand relative to other Asian countries in terms of spending on health services? Figure 2 displays relevant information for the late 1980s. It shows first, using the bars on the left, the percent of GNP devoted to health care for a sample of Asian countries. Second, these same

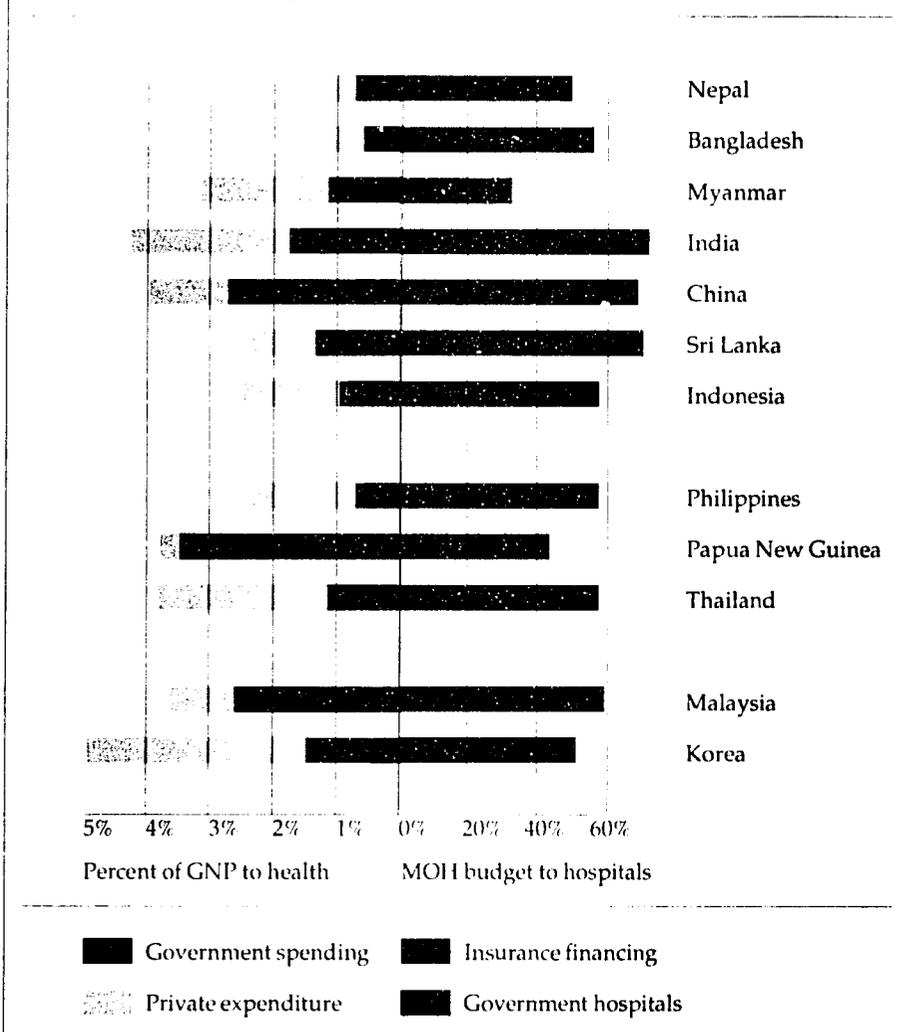
bars show how expenditure is divided among government, insurance (third party), and private out-of-pocket spending. Third, the right side of the graph shows the percentage of government spending, allocated to public hospitals, expenditure that is primarily for Category 3 services. The countries are arranged in order of increasing income per capita, with the breaks occurring between the low-income and middle-income countries, with an additional break separating Korea and Malaysia from the other middle-income countries. Each new group of countries in the figure represents about double the GNP per capita of the middle country of the group above it.

Health expenditures vary from 1.4

percent of GNP to 5.1 percent, with a regional mean of 3.1 percent.<sup>3</sup> The Philippines is well below the mean, at 2.4 percent of GDP. The public sector is estimated to account for roughly 30 percent of total spending, which is at the low end for this sample.

Total spending in the Philippines was about \$14 per capita using the 1987 exchange rate, with about \$3.75 (27 percent) contributed out of government tax revenue (Table 4). About \$9.75 (69 percent) came from private spending, and \$0.50 (4 percent) was contributed by insurance.<sup>4,5</sup> These estimates place the Philippines first in terms of dependence on private out-of-pocket spending to finance health care. However, Thailand, Korea, Myanmar, and Bangladesh are close behind.<sup>6</sup>

**Figure 2** Total Health Expenditures by Source as a Percent of GNP, and Public Spending on Hospitals, 1986-87



Given its level of per capita income, how much might we expect the Philippines to spend on health care, and where does it stand relative to that expectation? Figure 3 and Figure 4 show per capita health expenditures for the sample arrayed against per capita GNP, with trend lines drawn through the points.<sup>7</sup> The trend lines can be interpreted as showing the predicted level of per capita health spending at each level of GNP. The Philippines falls well below the level of spending that would be predicted for it based on the experience of this sample of Asian countries. Predicted spending is about 32 percent higher than actual spending.

Thus spending on health is relatively low in the Philippines both in comparison to its neighbors and in relation to its per capita GNP. Spending by the government is particularly low relative to other Asian countries. Does the government ameliorate this problem by spending its resources in a different way from other countries in the sample? For example, it might spend its limited resources almost exclusively on public health, environmental health, and preventive health interventions (Categories 1 and 2 in Table 1), leaving curative care to be paid for and delivered in the private sector. Alternatively, it might complement spend-

ing on public health activities with targeted curative care subsidies to basic health services for the poor. If the Philippines pursued either of these types of policies, it would behave quite differently from other Asian countries.

The only way to examine this issue across countries, given the inadequate state of financial data for the health sector, is a combination of statistics on the ownership of facilities and a rough-and-ready financial statistic, the share of government spending going to hospitals. Table 5 shows the population per bed and share of all beds owned by the government in 1986-87, sorted by population per bed. With about half its hospital beds in the private sector, the Philippines ranks second after Korea in the penetration of the private sector in hospital ownership. Thus the government does behave differently by apparently allowing the private sector to supply a relatively large share of the beds.<sup>8</sup>

However, Figure 2 above indicates that the government mimics other countries in the sample by devoting about 60 percent of public spending to hospital-based services. Thus it appears that the low absolute level of public spending leads to a greater share of hospitals in the private sector

but that, of the meager resources available to the government, the share going to hospitals is high. The problem of low levels of public spending is probably exacerbated by allocation decisions that channel well over half of that money through hospitals (despite a vigorous private sector).

## Major Issues for the Philippines in a Comparative Context

These findings present several clear policy options that merit attention at the highest levels of policy:

1. The low level of spending highlights the importance of possibly raising public spending but also of carefully allocating the relatively meager public funds now available.

2. The public sector devotes a large share of its funds to Category 3 activities. The appropriate policy-level action is not cajolery of the private sector to provide Category 1 and 2 services but reallocations of the public budget to finance those services.

3. In the light of such a high proportion of health spending originating from individuals in the form of out-of-pocket payments, it is surprising to observe such a low share of spending from Medicare or private insurance. However, the *institutions* for insurance coverage are relatively well developed. Medicare covers about 40 percent of the population and reimburses care in nearly all hospitals in the country. The system is somewhat anemic only in terms of the share of *financing* that it administers.

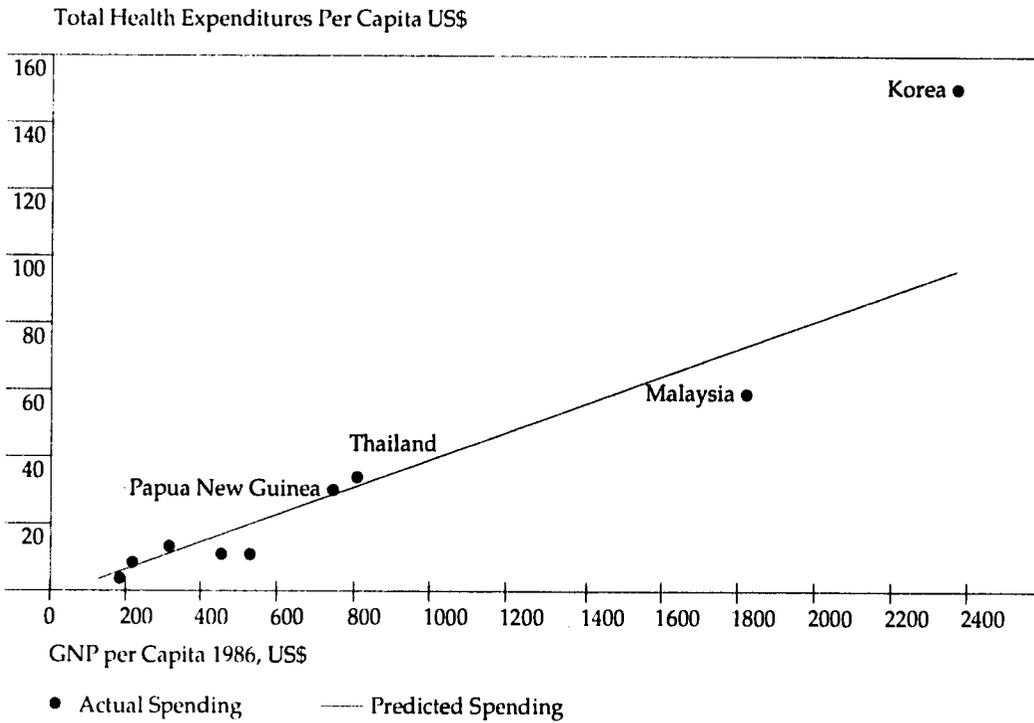
The relatively large size of the private sector in the Philippines creates options for the government as it searches for additional public resources for health and improved allocation of existing resources. ■

**Table 4** Health Expenditures in U.S. Dollars and Percent of Spending by Government, Most Recent Year

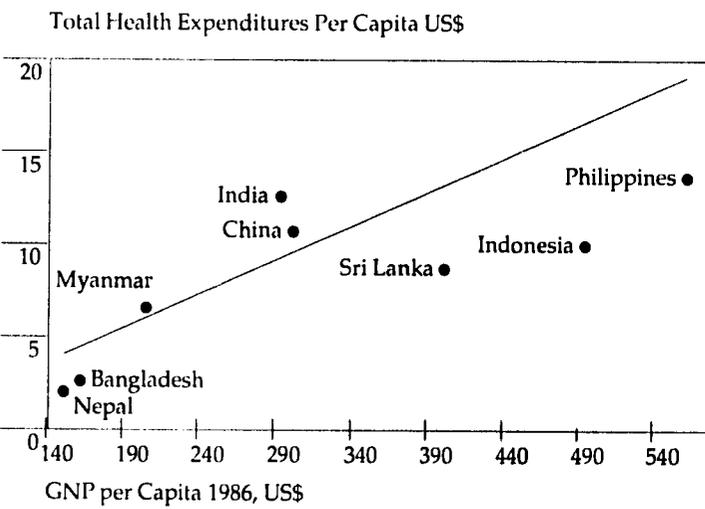
	U.S. dollars per capita	Government Percent of all Health Expenditures	Year
Nepal	2.1	61	1987
Bangladesh	2.8	40	1987
Myanmar	6.4	36	1986
Sri Lanka	9.2	58	1986
Indonesia	10.4	37	1986
China	11.0	19	1987
India	12.5	37	1987
<b>Philippines</b>	<b>14.1</b>	<b>27</b>	<b>1987</b>
Papua New Guinea	26.2	91	1987
Thailand	32.8	30	1987
Malaysia	58.5	77	1987
Korea	148.4	12	1987
Mean	27.9	45	
Median	11.0	37	

SOURCE: GRIFFIN 1991, TABLE A 15

**Figure 3** Relationship Between Per Capita Income and Total Health Expenditures



**Figure 4** Detail of the Lower Tail in Figure 3



**Table 5** Population per Hospital Bed and Share Owned by Government, Latest Year

	Population per bed	Percent Government
Nepal	4,511	86
Bangladesh	3,589	85
Indonesia	1,743	69
India	1,489	74
Myanmar	1,484	100
Papua New Guinea	772	100
Thailand	665	90
<b>Philippines</b>	<b>647</b>	<b>53</b>
Korea	558	18
China	465	100
Malaysia	435	86
Sri Lanka	368	91
Mean	1394	79
Median	719	86

SOURCE: GRIFFIN 1991, TABLE A-15

# 4

## Availability and Distribution of the Private Sector

The private health sector in the Philippines is composed of thousands of single-proprietor clinics; over a thousand hospitals of all sizes and types ranging from 5 to 1000 beds; thousands of stores selling drugs, several large chains of drug stores; and uncounted thousands of traditional healers and birth attendants.

Real output of private medical services, measured by gross value added, was 1.3 billion pesos in 1989. Between 1986 and 1989, the average annual rate of growth of real output in private medical services was 6.6 percent. Following the difficult years of 1984-1985, during which negative growth rates were experienced by the economy as a whole, private medical services registered an annual rate of change of 2.12 percent in 1986 and 10.86 percent in 1989. Private medical output was concentrated (40.5 percent) in the National Capital region, but faster rates of growth were registered for several other regions.

### Facilities and Infrastructure

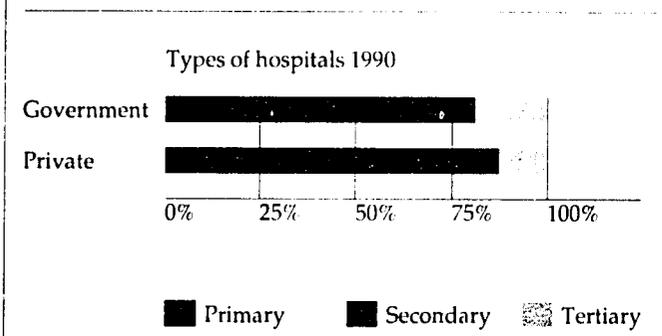
Official figures of the Department of Health showed that in 1990, there were 1,696 hospitals, of which 33 percent were government and 67 percent private. Hospitals in the Philippines are classified as either primary, secondary, or tertiary, depending on service capabilities.<sup>9</sup> Primary hospitals offer a basic level of care, supporting only minor surgery and a few basic laboratory tests. More than 50 percent of private hospitals are considered primary, with an average of 16 beds. Government however offers more secondary hospital services, with average bed capacity of 43. District hospitals fall largely in this category.

For 1990, the distribution of Philippine hospitals under these classifications is shown in Figure 5. It is apparent that there is a wide variation in service orientations between the public and private hospital systems, as the average private hospital is 41 percent

smaller than the average public hospital, due partially to the preponderance of small primary hospitals in the private sector. However, the average private tertiary hospital is 46 percent smaller than the average public tertiary hospital.

Private hospitals are widely dispersed across the country, with only 11 percent located in Metro Manila. A third of these private Metro Manila hospitals are tertiary hospitals (see Table 6). Metro Manila hospitals, both public and private, account for only 10 percent of the total number of hospitals, but they comprise 34 percent of country's total bed capacity. Forty-six percent of Metro Manila hospital beds are provided by the private tertiary hospital sector. Primary hospital beds are largely located outside Metro Manila. While only 24 percent of Metro Manila hospitals are public, they account for 64 percent of total bed capacity in the area. Government hospitals in Metro Manila, comprising 7.2 percent of the total public system, are large teaching and specialized institutions.

**Figure 5** Composition of Public and Private Hospital Sectors



**Table 6** Distribution of Hospitals and Beds in the Private Sector, 1990

	National Capital Region	Other Regions	Total
<b>Hospitals</b>			
Primary	4.8	95.2	100.0
Secondary	15.5	84.5	100.0
Tertiary	31.0	69.0	100.0
<b>Beds</b>			
Primary	4.5	95.5	100.0
Secondary	16.6	83.4	100.0
Tertiary	46.0	54.0	100.0

## Personnel

In general, the Philippines is well covered by medical personnel with the exception of dentists (Table 7). The poorer regions of the country, Bicol, Eastern Visayas and Mindanao provinces, are underserved. A 1987 estimate of employed health manpower in the country showed that of the 18,293 physicians, 58 percent were in private hospitals,<sup>10</sup> 38 percent were with the Department of Health and the rest were distributed across other government agencies like the armed forces and schools. A majority of the estimated 8,500 dentists were in private practice. The pattern for nurses and midwives showed a reverse trend, where majority, 53 percent and 73 percent respectively, were with government service (Reyes and Picazo, 1988). The authors estimates for nurses (22,413) showed a large disparity with estimates by the Philippine Nurses Association, which reported 50,000 nursing practitioners. A large number of nurses may have shunned the practice of their profession due to low salaries, especially in private clinics, while others may have waited for jobs abroad. This observation is consistent with reported shortages of nurses in cities by hospital administrators interviewed for this study.

A third of physicians and nurses

and two-thirds of dentists were found to be practicing in Metro Manila and the nearby provinces in Southern Tagalog (Table 8), areas which account for about one-fourth of the country's population. The various estimates also show that there has not been much movement in the distribution of manpower over the years, except for a slightly increasing concentration of dentists in the national capital area.

The same study looked into the determinants of locational decisions by health manpower, particularly physicians and dentists. The strongest correlate with physician location was observed to be the number of hospital beds. Physicians tend to locate in provinces which are more urbanized, with more people and with higher incomes; however, they are widely dispersed around the country.

Health manpower in the country and those exported abroad are produced by the country's network of medical schools, which grew by 150 percent between 1975 and 1988. The government had a policy of establishing at least one medical school for each of the country's 13 regions. While this was not fully realized, the private sector more than made up for this remiss. The 1987 figures showed 25 medical schools, 126 nursing schools, 16 dental schools and 113 midwifery schools.

Average cohort survival rates for medical, nursing and dental students

were 98.4 percent, 94.7 percent and 53.7 percent respectively. This may be high volume production, it is apparently of low quality as average passing rates in the licensure exams were 75.6 percent for medicine, 70.5 percent for nursing, 65.3 percent for midwifery and 54.9 percent for dentistry. The passing rates have been declining through the years.

The high cost of medical education may account for the strong inclination of graduates to go into private practice to recoup investments. Tuition in private medical schools is twice as expensive as in government schools. Nursing education in private schools is four times more expensive than in government schools. The policy of requiring all medical graduates to render two years service in the rural areas have been discontinued since 1986.

## Determinants of Private Sector Development

The development of the private health care sector is a product of various factors. Our framework discussed the role of the regulatory environment, and the availability of various inputs, like labor, financial capital, etc. The role of other factors are cited here to provide a more complete picture.

The data provided in the previous section and earlier studies, particularly in Griffin and Paqueo (1987) showed huge improvements in the availability and distribution of Philippine medical resources between 1972 and the early 1980s. The expansion and geographic equalization in the 70s is seen largely as a private sector-led growth. Figure 6 shows the number of hospitals in the public and private sectors over a twenty year period. The 1970s were characterized by steady growth in the number of public hospitals and tremendous growth in the number of private hospitals after the Medicare system and related incentives to develop private hospitals became effective in 1972. However, in the 1980s, the number of private hospitals actually declined, while public hospitals continued to expand at about the same pace as before.

The same phenomenon is reflected

**Table 7** Population to Medical Personnel, by Region, 1987

Region	Physician	Nurse	Midwife	Dentist
Region 1: Ilocos	2806	1907	3222	15088
Region 2: Cagayan Valley	4703	2959	3408	19241
Region 3: Central Luzon	3812	3092	4093	10718
Region 4: S. Tagalog	3833	3655	4977	13495
Region 5: Bicol	5005	3437	4183	31096
Region 6: W. Visayas	4673	2902	4526	39413
Region 7: C. Visayas	2747	2508	3991	32941
Region 8: E. Visayas	5674	3169	3060	33433
Region 9: W. Mindanao	8703	5725	4371	28877
Region 10: N. Mindanao	3764	2575	3175	47096
Region 11: S. Mindanao	4098	2829	4267	24743
Region 12: C. Mindanao	4244	3071	2939	40029
NCR: Metro Manila	1256	1319	4167	2533
<b>Philippines</b>	<b>3135</b>	<b>2559</b>	<b>3926</b>	<b>10799</b>

Note: Health manpower includes public and private health personnel affiliated with hospitals and health centers.

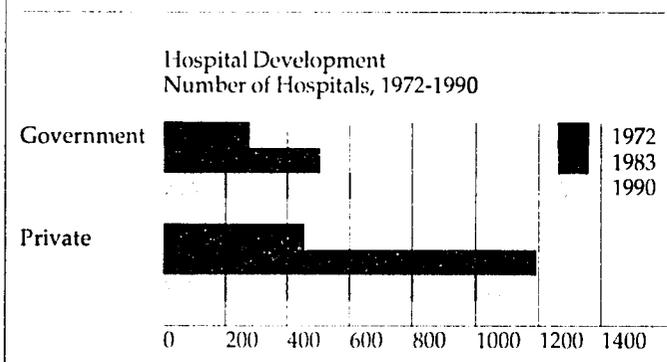
SOURCE: REYES AND PICAZO 1989, TABLE 3

**Table 8** Distribution of Selected Manpower in Metro Manila and Southern Tagalog Relative to the Rest of the Country, Various Years

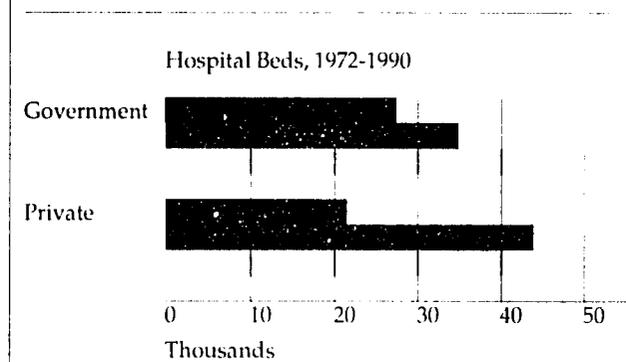
Study	Percent of the Population		Percent of Health Manpower	
	Manila and Southern Tagalog	Elsewhere	Manila and Southern Tagalog	Elsewhere
<b>Physicians</b>				
Association of Philippine Medical Colleges Survey, 1970		77.0	45.9	54.1
National Economic & Development Authority, 1974	23.0	75.8	40.1	59.9
National Economic & Development Authority, 1977	24.2	75.4	39.2	60.8
Philippine Institute of Development Studies, 1987	24.6	74.1	32.0	68.0
	25.9			
<b>Nurses</b>				
Association of Philippine Medical Colleges Survey, 1970		77.0	51.7	48.3
Philippine Nurses Association, 1980	23.0	74.9	42.7	57.3
Philippine Nurses Association, 1987	25.1	74.1	40.3	59.7
Philippine Institute of Development Studies, 1987	25.9	74.1	34.0	66.0
	25.9			
<b>Midwives</b>				
National Manpower Survey, 1973		76.3	25.6	74.4
Philippine Institute of Development Studies, 1987	23.7	74.1	22.4	77.6
	25.9			
<b>Dentists</b>				
National Manpower Survey, 1973		76.3	35.9	64.1
Philippine Dental Association, 1988	23.7	74.0	65.4	34.6

SOURCE: REYES AND PICAZO (1989)

**Figure 6** Number of Hospitals in the Philippines; Three Observations from the Past Two Decades



**Figure 7** Expansion in Public and Private Hospital Bed Capacity Since 1972



in the distribution of beds between the two sectors over these two decades. As Figure 7 shows, the public sector has not only caught up but has overtaken the private sector, as the number of government beds has expanded while the number of private beds has contracted. Thus the public sector has targeted its funds in a manner that is the reverse of what would be expected on public finance grounds -- rather than moving scarce public money out of hospitals, the public hospital sector has grown while the private hospital

sector has begun to contract. Table 9 shows for the 74 provinces (including Metro Manila) how the public and private sectors fared from 1983 to 1990. Twenty nine percent of the provinces experienced growth in the number of private beds; 56 percent experienced growth in the number of public beds. In 36 percent of the provinces, the number of private beds fell as the number of public beds rose. The opposite occurred in only 9 percent of the provinces. It is unlikely that the increase in public and decrease in

private hospital beds has better targeted hospital resources geographically, as a previous study indicated that private hospitals in 1983 were at least as evenly distributed around the country as were public hospitals (Griffin and Paqueo 1987). The current state of our data base do not allow us to rigorously analyze the determinants of this situation. From the experience of other countries and insights from other studies in this project, we can provide some useful leads towards an explanation of

private sector development.

Low incomes and the disorganized nature of employment are seen as barriers to private health care sector development, particularly risk sharing or insurance schemes. Economic growth in the 1980s averaged at about two percent, way below the 4-6% growth registered in earlier years. Population growth has slowed down the growth of the economy. Formal sector employment is largely based in the highly disorganized service sector. A much larger proportion of the population are in agriculture. Employment in manufacturing has remained stagnant at around 20% for the last three decades. This limits the potential for risk sharing to a small, formally employed sector. Schemes that can cover the less formal sectors are not only costlier to administer but also cover higher risks.

Private medical services, especially physician practice, often locate in densely populated areas where costs of inputs are lower. Health manpower locate in areas where other medical services, like hospitals and laboratories, are easily accessible. The dispersal of private medical facilities across the country has historical precedents. By the 1950s, a substantial public and private hospital infrastructure was already in place. But the growth in public infrastructure has been slow, contributing to the clustering of facilities in certain areas, and limiting the expansion of services outside. Earlier public sector efforts to reduce the concentration of facilities and manpower by locating more health centers outside and staffing them with midwives contributed to the dispersal of medical services. The vast network of medical schools, largely as a result of

unequal tax treatment between schools and hospitals, contributed to increased manpower supply.

Budgetary constraints and the devolution are likely to cut the public sector's investments in hospital facilities. A favorable financing environment can be expected to enhance private sector investments in health care.

## Structure and Organization of the Industry

The Department of Health issues all licenses for hospitals to operate, provides the technical and administrative standards for their operation, and enforces regulations. Public hospitals, until the changes arising from decentralization,<sup>11</sup> have been operated by the Department of Health. The public hospital system is organized in a tiered system, with the regional hospital network serving as the apex of a structure built from the base provided by the primary levels. The hospital system is linked to an integrated public health network which is anchored by numerous village-level health stations coordinated at the regional levels. General policies emanate from the central Department of Health office in Metro Manila. However, public hospital chiefs have flexibility in day-to-day operations. Planning and budgeting done at the hospital level feeds into central planning processes at the Department of Health and the National Economic

Development Authority. Key appointments in the organization are made at the central level. Capital investments and service expansion are cleared at the central level. Salaries, training, supplies and equipment, are provided by the central office. Decisions to open or expand public hospitals are made at the national legislative level. Eighty-six (86) new hospitals, mostly 10-bed size, were mandated for 1990, and only 70 percent of these were recommended by the Department of Health. The rest were upon the recommendation of politicians.

The private hospital system is largely operated as single proprietorship, family-owned, non-profit enterprises; while a few are ran as stockholder-type corporations or corporate foundations. Most hospitals begin as part of a private practice of a physician-owner. This operation expands with a few beds from an outpatient clinic, usually situated in a residence, until a hospital license is sought. Primary hospital standards for licensing are easily met by husband and wife teams, with both providing full-time services as medical staff, nurse and/or pharmacist. Decisions are reached simply in family-run businesses, with authority solely vested with the physician-owners. Family income and assets often mesh with hospital business operations that separating the two is difficult. Secondary hospitals develop from successful primary operations as they staff, add beds and expand departments. Private tertiary hospitals, managed by outside professional managers, have more complex decision structures, with consultations across departments. There is clearer delineation and independence between the administrative/ management services and medical services.

**Table 9** Comparison of Changes by Province in Public and Private Beds, 1974-1990 (Percent of 74 Provinces)

	Increase in Private Beds	Decrease in Private Beds
Increase in Public Beds	20	36
Decrease in Public Beds	9	14

**Table 10** Hypotheses About Organization and Structure of Hospitals

Hospital Type	Medical Organization	Financial Organization	Economic Scale
Primary	Poor	Poor	Too small
Secondary	Reasonable	Varies	Better/varies
Tertiary	Excellent	Good	Good/some too large

Most private hospitals are operated for profit. The few non-profit hospitals are operated by parishes/churches, unions, cooperatives, physician groups, foundations with corporate or international tie-ups. There are few church-owned hospitals now; but religious orders can be found managing a number of private foundation-based hospitals. The advantage for non-profit hospitals lies mainly in the tax shelter provided, i.e. non-taxable incomes and land. Unfortunately, there is no estimate at present of the number of these private hospitals classified by type of ownership.

Table 10 provides some of the hypothesis we hoped to test regarding public/private differences in organization and structure. As part of the overall project, a preliminary, qualitative interview instrument was developed to investigate the medical and economic structure and problems experienced by hospitals. This instrument was applied to administrators or owners of public, non-profit/charitable, and private hospitals. At least one hospital within each ownership classification was chosen among primary, secondary and tertiary levels. We would like to caution against drawing broad generalizations from this small sample which was largely drawn to provide a qualitative overview of the sector.

Several issues emerged from these interviews. They provide insights into the importance of quantifying differences across ownership and size of hospitals and in understanding the role of government and third party payers in influencing the organization of the sector.

First, the advantage with small operations in the private sector is that they make for a more dispersed system. However, its viability becomes tenuous in the face of strong competition in a fee-for-service, pay-as-you-go financing environment. The study team observed nine primary hospitals coexisting in one poor area, four primary and one 25-bed hospitals operating in another (Blakney and Gamboa, 1991). Private secondary hospitals are just slightly enhanced versions of primary hospitals and are weak. They retain the single proprietorship/owner management style, although the hospital often grows well beyond the effectiveness of such a management approach, both medically and economically. They have neither the management flexibility offered

primary hospitals because of its size, nor adequate financial resources to meet the demands of an expanded service.

Second, inadequate administrative systems limit the private sector's ability to monitor the quality of its operations and its viability. The ability to separate the physician-owner's practice income from the income of the hospital enterprise requires adequate accounting systems. As the demand of hospital management and operating systems becomes more complex as one moves from primary to tertiary levels, the demand for effective management and administrative support services becomes increasingly important. The private tertiary sector on the other hand competes on the basis of the prestige lent by its physician staff and consultants, but its administrative and support services remain weak. Computerization of medical records and billing systems is still uncommon in the private sector, even at the tertiary level.

Third, there is an advantage enjoyed by the public sector in small operations as public primary hospitals, especially those located in under-served areas, form part of a larger organization with training, record-keeping, and standard pieces of equipment. However, it is precisely in the direct competition they present to the already-*numerous* private primary hospital sector that this view is not likely to be popular. Moreover, the transfer of these primary hospitals to the local government units breaks up this advantage. Central government can take on a stronger monitoring and standard-setting presence in these local operations, and probably provide these to the private sector as well.

Fourth, at the secondary and tertiary levels, the medical and economic advantages of the public sector disappear quickly and the disadvantages of inadequate public budgets weaken public institutions in medical terms relative to their private counterparts. This is most serious in the secondary level, where the ratios of inpatients to health manpower are wholly inadequate. The public tertiary level, probably due to the prestige it must maintain, have better ratios of inpatients to physicians and nurses. There could also be some resource misallocations as the public secondary hospital in the sample showed more than adequate inpatient to administrative and other

◆ "...small operations in the private sector... make for a more dispersed system.

◆ "...inadequate administrative systems limit the private sector's ability to monitor the quality of its operations and its viability.

◆ "...there is an advantage enjoyed by the public sector in small operations as public primary hospitals... form part of a larger organization...

◆ "...at the secondary and tertiary levels... the disadvantages of inadequate public budgets weaken public institutions...

◆ "...within private hospitals, the tax shelter provided for non-profit or non-government (NGOs) hospitals contributes to viable operations."

support services staff ratios. Patient load is heaviest in the public sector, with the public tertiary sector showing occupancy rates 58 percent higher than in the private sector. Estimates of cost per patient per day are almost the same for public tertiary and secondary hospitals. Costs per patient per day for private tertiary hospitals is five times higher than public tertiary hospitals; but private secondary hospitals enjoy some advantage in cost per patient per day over government secondary hospitals.

The overall weakness of the public secondary hospital sector will be glaringly emphasized once decentralization is completed. Local government units are taking over all of the secon-

dary and primary public hospitals. Doubts are raised as to these units' ability to raise funds for and improve management of these hospitals, in the short run. But decentralization presents opportunities for the central health department to improve training, standards-setting and monitoring and make these central services and functions responsive to private sector needs as well.

Fifth, within private hospitals, the tax shelter provided for non-profit or non-government (NGOs) hospitals contributes to viable operations. For-profit private hospitals often have to create a nursing or medical school in order to qualify as an educational institution and therefore enjoy tax-free importations and land ownership. This only stretches limited resources, both financial and human, and may

compromise quality of education and hospital service. Most schools subsidize their hospital operations. Favorable inpatient to health manpower ratios were consistently shown by these NGO hospitals. Primary-level NGO hospitals, with definite service philosophies, are strong as they are guided by the zeal of their visionary founders. Tertiary NGO hospitals often have international donor support. NGO secondary hospitals are just as weak as their other counterparts.

These observations are summarized in Table 11 and should be taken as hypotheses that deserve testing through rigorous quantitative data collection and analysis from a much larger sample. However, the relative strength of the public sector in operating smaller hospitals and the relative strength of the private sector in operating larger hospitals should be kept in mind below when data are displayed on the relative size of public and private hospitals, and the direction the two sectors have taken. ■

**Table 11** Preliminary Findings about Public/Private Differences in Organization and Structure of Hospitals by Ownership

Hospital Type	Medical Organization	Financial Organization	Economic Scale
Primary	Public stronger	Both weak	Both too small
Secondary	Differences narrow	Private stronger but undercapitalized	Private still relatively small
Tertiary	Very similar	Both improved, persistent problems	Good/public tends to be too large

## 5

# Environment of the Private Sector - Supply Side

## Legal and Regulatory Framework

The government regulatory framework for private sector participation in the health care sector is shaped by the following forms of legislation. A more extensive discussion of each is made in Appendix 1.

1. Executive Order 119 vests regulatory functions in the Department of Health. It mandates the DOH to regulate the operation of and issue licenses and permits to government and private hospitals, clinics and dispensaries, laboratories, blood banks, drugstores and such other establishments which by the nature of their functions are required to be regulated by the Department.

2. The requirements of the Hospital Licensure Act as well as Medicare accreditation set down parameters for health care providers. As a requirement to licensing, all hospitals are required to demonstrate compliance with technical standards on personnel and staffing, equipment and instruments, and physical facilities. Accreditation to the Medicare program is done separately. The latter requires further compliance with regards to membership in a national hospital association, and 12 months prior operation.

3. Professional regulations are applied to all health personnel. Republic Act 2382 deals with the standardization and regulation of medical education, the examination for registration of physicians, and the supervision, control and regulation of the practice of medicine in the Philippines. Pharmacists, dentists, nurses, medical technologists, and allied professionals

are also guided by various regulatory laws.

4. The Generics Law requires all physicians to prescribe in generic names and manufacturers to label drugs and medicines accordingly.

5. Import restrictions affect the entry of inputs of the health care industry into the country. Importations of medical equipment and supplies and pharmaceuticals are subject to a set of tariffs and duties. The law grants tax exemptions to some categories of health care institutions, especially donated equipment of private primary and secondary hospitals.

6. The Omnibus Investments Code of 1987 limits the entry of foreign investments to 40 percent of the stock of a company engaged in an industrial activity not listed in areas covered by the Investment Priorities Plan. Areas listed in the plan are for government promotion and therefore certain rules may be waived. Production of herbal medicines, parenteral therapy systems and other pharmaceutical are favored by the Priorities Plan.

7. The Local Government Code of 1991, while directly affecting the organization of public services, is expected to alter the organization of regulatory bodies of the DOH. It also presents an opportunity for these regulations to be reviewed.

## Government-Private Interactions

This component of the study gathered information on all of the possible government interventions listed on the supply side in Table 2, and the findings are briefly reviewed here. At the outset, it should be stated that all repre-

sentatives of the industry interviewed - private physicians and hospital owners - cited problems on the supply side as the most important issues facing them. However, the bottlenecks created by government on the input side of the market seem to be of varying importance.

### Personnel and Facility Licensing

Most training is accomplished in the private sector; there is a ready supply of well-trained physicians, nurses, and other professional personnel; licensing of personnel is accomplished at the beginning of their professional careers. Licensing of medical facilities is also not a major issue as requirements are not very difficult to meet. However, because both the Department of Health (DOH) and the Medicare system accredit hospitals, there are some complaints about the lack of coordination between the systems and the required payment of multiple fees. Minimum staffing regulations are part of the DOH licensing requirements, and the lack of divisibility of staff requirements (such as the requirement for a full-time pharmacist rather than permitting a consulting part-time pharmacist) limits the ability of hospital operators to make cost-minimizing economic decisions. In particular, these requirements are claimed to raise the unit costs of small hospitals relative to larger ones.

### Domestic and International Taxation of Inputs

Imports of the health care sector may be classified into two broad categories:

- Medical equipment and supplies;
- Pharmaceuticals.

Most items in the first category are classifiable under Tariff Heading 90.18 of the Tariff & Customs Code of the

Philippines with a rate of duty of 10 percent ad valorem. A 10 percent value added tax is also levied, based on the landed cost.

Table 12 shows the value of imports under this category for the years 1980-88. The trend shows a sharp decline in the years 1984 and 1985. This period was characterized by a critical shortage of foreign exchange, thereby bringing about its rationing. Negative real GNP growth was also experienced during these years (see Table 13).

Imports of pharmaceuticals, on the other hand, were also significantly affected although medicines were

among those given priority in the rationing of foreign exchange during the crisis years. Table 14 shows the value of pharmaceutical imports for the years 1980-88.

Imports of the industry are subject to the following levies:

1. 10 percent duty on raw materials. However, some raw materials are subject to as high as 50 percent duty (e.g. colors, flavors).
2. 20 percent duty on finished goods.
3. 10 percent value added tax.
4. import duties on packaging materials, e.g., bottle caps - 40 percent,

plastics - 30 percent, aluminum foil - 30 percent, etc.

Although over 90 percent of drugs sold in the country are locally manufactured, almost all active substances and auxiliaries are imported. Refined sugar, glycerine, alcohol and starch are the only raw materials obtainable locally.<sup>12</sup> In addition to all these, the government imposed early in 1991 a 9 percent levy on all importations. Several items were subsequently exempted from the levy but imports of the health sector were not among those included.

The law grants import tax exemp-

**Table 12** Top Imports of Medical Equipment and Supplies, by Commodity, 1984-1988, in Thousands of U.S. Dollars (CIF)

Commodity	1984	1985	1986	1987	1988
Other surgical, medical, veterinary instruments	6,656.9	4,167.6	5,070.4	8,560.7	10,273.2
X-ray apparatus	1,025.2	1,225.9	460.5	2,273.5	3,178.8
Gauze and bandage, unmedicated	843.5	374.3	739.3	1,376.7	1,134.5
Lab, Medical, Surgical, dental, hygienic glassware	624.3	533.7	785.9	1,026.2	1,155.4
Wadding gauze, bandages medicated	426.0	515.0	810.6	909.3	913.2
Sterile surgical catgut	788.6	464.7	443.3	920.6	944.5
Optical examination and diagnostic equipment	19.5	12.6	46.5	6.2	1.8
Other hygienic medical and surgical articles, n.e.s.	250.2	253.7	466.9	512.3	503.1
Electromedical apparatus	389.3	225.8	165.6	313.0	2,504.2
Breathing appliances	259.2	270.8	235.5	253.1	64.5
Medical, dental, surgical, veterinary furniture	6.9	67.6	36.2	500.1	98.0
Clinical thermometers	125.4	205.3	133.6	252.8	198.5
Ampoules	140.8	122.8	184.1	276.5	271.0
Parts of surgical, medical instruments and appliances, not electric	209.8	41.9	46.5	133.5	191.8
Bottle nipples or unhardened rubber	28.8	67.3	86.0	250.6	242.2
<b>Composite</b>	<b>11,794.4</b>	<b>8,549.0</b>	<b>9,710.9</b>	<b>17,565.1</b>	<b>21,674.7</b>
<b>Growth Rate</b>	<b>-50%</b>	<b>-28%</b>	<b>14%</b>	<b>81%</b>	<b>23%</b>

**Table 13** Gross National Product, 1980-1988, in Million Pesos at Constant Prices

Year	GNP	Growth Rate
1980	92,532	
1981	95,722	3%
1982	97,539	2%
1983	98,620	1%
1984	91,644	-7%
1985	87,867	-4%
1986	89,611	2%
1987	94,680	6%
1988	101,186	7%

SOURCE: PHILIPPINE HEALTH CARE FACTBOOK, 1990

**Table 14** Imports of Pharmaceuticals, 1980-1988 (in U.S. Dollars, FOB)

Year	Import Value	Growth Rate
1980	64,850,226	
1981	66,997,912	3%
1982	76,745,991	15%
1983	70,337,643	-8%
1984	58,911,791	-16%
1985	49,116,034	-17%
1986	67,285,036	37%
1987	98,826,609	47%
1988	107,506,536	9%

SOURCE: PHILIPPINE HEALTH CARE FACTBOOK, 1990 - SOURCE OF BASIC DATA: FOREIGN TRADE STATISTICS OF THE PHILIPPINES

tions to some categories of health care institutions. Under the rules and regulations of the National Economic and Development Authority (NEDA), donated essential machinery and equipment of private primary and secondary hospitals may be imported free of duty. They are, however, still subject to the 10 percent value added tax and the 9 percent levy just mentioned.

Although only donated items are exempted under this provision, interviews with customs brokers reveal that in practice, all imports of primary and secondary hospitals, whether they are donated or not, are granted duty free privileges.

Unfortunately this duty free privilege may not be known by all those envisioned to be benefitted. The owner of a provincial hospital in Cavite (one of those interviewed) had no inkling at all of this privilege. He was so elated at learning about it that he immediately made plans to import badly needed x-ray equipment. Department of Finance Order no. 137-87, on the other hand, grants duty free entry to imports of educational institutions, including imports of tertiary teaching hospitals.

In summary, private hospital owners complain bitterly about duties charged on medical equipment and drugs and believe they should be exempted from these taxes. Even donated equipment, they argue, is subject to duties. These duties are thought to put the private sector at a disadvantage relative to the public sector, which is exempt from duties yet competes with private hospitals. The law actually exempts donated essential machinery and equipment of private primary and secondary hospitals, although they are still subject to a 10 percent value added tax and a temporary 9 percent across-the-board levy on all imports. Interviewers found for this study that in practice, customs agents do not charge duties on purchased or donated equipment for primary and secondary hospitals. Apparently, however, this informal exception is virtually unknown to the industry. None of these exemptions affect tertiary hospitals, which are clearly at a cost disadvantage relative to the smaller hospitals in terms of border taxes.

A major complaint of hospital owners is that private health facilities are taxed as if they were regular businesses. Owners argue that they are

performing a social service that benefits the country beyond the income and profits of the proprietors and thus should be given special tax-free privileges. Education institutions are accorded this privilege; they are treated as non-profit institutions and thus enjoy tax- and duty-free privileges. The major impact of this provision on the hospital sector in the Philippines is that it gives for-profit private hospitals an incentive to open an affiliated medical, nursing, or mid-wifery school. Then, as part of a professional school, the hospital becomes a teaching hospital and enjoys non-profit status as an educational institution.

#### Access to Foreign and Domestic Financial Capital

**Foreign Capital.** Book II of the Omnibus Investments Code of 1987 (Executive Order 226) limits the entry of foreign investments to 40 percent of the stock of a company engaged in an industrial activity not being promoted by the government. However, the Board of Investments (BOI) upon application, may waive this requirement under the following conditions:

- the firm's activities are not inconsistent with the Investment Priorities Plan;
- it will contribute to the sound and balanced development of the economy on a self-sustaining basis;
- the business does not conflict with the Philippine Constitution and various laws of other countries;
- the business activity is not one which is already adequately exploited by Filipinos;
- the business does not promote monopolies or combinations in restraint of trade.

Enterprises in preferred "pioneer" areas listed under the Investments Priorities Plan (IPP) may be owned 100 percent by foreign nationals, subject likewise to constitutional and statutory limitations. Such foreign-owned enterprises may avail of incentives under Book I of the Code, among which are a six year income tax holiday, tax and duty exemption of imported capital equipment and tax deduction for labor expense. They are, however, required to subsequently accept Filipino investment so that within thirty years or within such longer periods as the BOI may determine, 60

percent of the voting equity would be Filipino.

The health products and services listed in the 1991 IPP are the following:

1. Parenteral therapy systems and components thereof (non-pioneer)
2. Herbal medicines (pioneer/non-pioneer)
3. Other Pharmaceuticals (pioneer/non-pioneer)

**Domestic Credit Supply.** Four institutions were interviewed in an effort to establish the credit environment which hospitals face: Government Service Insurance System (GSIS), Development Bank of the Philippines (DBP), Social Security System (SSS) and a commercial bank. Of the four only SSS has a loan window granting concessional loans to hospitals. Although GSIS helped finance the construction of some government specialty hospitals in the seventies, it has not seen it fit to set aside funds for private hospital financing since it neither has the mandate nor the capability to function as a credit institution.

Although the DBP does not have a concessional loan window devoted to hospitals at present, it has always been in the forefront of hospital financing. It would therefore be instructive to look at DBP's experience in this area in order to better appreciate the present state of credit supply to hospitals.

The period 1966 to 1969 saw DBP embark on a substantial lending program for hospitals. Guarantee and direct loans were granted on a selective basis for the establishment of new and improvement of existing hospitals and medical clinics. Financing was selective in the sense that loan accommodations were granted only to members of the medical profession or to corporations organized predominantly by medical practitioners. However, in December 1969, the funding of hospitals and other special projects was curtailed indefinitely in line with a presidential directive suspending the grant of substantial commercial loans.

The loan window was subsequently reopened in response to the Philippine Medical Care Act of 1969 (Republic Act 6111) which provides, among others, that "hospitals be given priority by government financing institutions, especially in the rural areas where there are no existing government or private hospitals, at a maximum rate of six percent (6 percent) per

annum on a long term basis".<sup>13</sup>

However, its cost of funds did not allow the bank to charge interest at the mandated rate. The loans offered therefore carried an interest rate of 12 percent which was still lower than the commercial bank rate. Priority was given to loan applications for the establishment of field station hospitals in the rural areas where there were no existing government or private hospitals as determined by the Philippine Medical Care Commission.

In October 1978, this was supplemented by a special financing program for hospitals which was set up specifically to provide financing for the establishment of hospitals with bed capacities of 100 beds and below in areas which had been identified as bed deficient.

The loans had a maximum term of twenty years, inclusive of a 5-year grace period on principal repayment at the rates of 12 percent and 14 percent per annum (12 percent interest was charged on the portion of the loan secured by real estate collateral while 14 percent was charged on the portion secured by collateral other than land).

Hospitals located in areas other than those listed as bed deficient were also eligible to apply for financing but only for the renovation or expansion of their existing facilities or the purchase of additional machinery and equipment. These loans had a repayment period of 13 years inclusive of a 3-year grace period at an interest rate of 19

percent per annum.

However, the bank experienced a 50 percent failure rate among those who availed of this credit line. A study commissioned by DBP in 1982 to assess the factors underlying these failures enumerated three main causes:

- Under-utilization of services. The eight hospitals studied failed to generate utilization required to fund operations and retire debt.
- Failure to build effective organizations. The distressed hospitals studied failed to build organizations that could generate patients (e.g., medical staff members who could bring in patients) or the requisite support staff who could professionally operate the facilities thereby enhancing service.
- Relative overborrowing. All the eight hospitals studied had outstanding debts ranging from one million pesos to more than 12 million pesos. All were adjudged to have overborrowed "relative to either their current or short term potentials, relative to what (was) necessary to service patients and remain competitive, and relative to the financial mix of their equity and debt".

The window was closed in 1985 due to a severe fund shortage. The School and Hospital Development Projects Department of the DBP, which was primarily tasked to manage the school and hospital loan windows was itself

subsequently abolished when the bank was reorganized in 1986. At present, hospitals have to compete for DBP financing just like any other industrial enterprise under terms which cannot be considered concessional. Table 15 shows the current status of DBP's hospital accounts.

- The same thing is true with commercial banks. Inquiries with the Central Bank indicate that there is no requirement for commercial banks to open special loan windows for hospitals. An interview with a commercial bank officer confirmed this. Loan applications from hospitals undergo the same evaluation process as any other commercial loan application.

This therefore leaves SSS as the only institution which offers a financing program for hospitals. Under the guidelines of this program, loans shall be available to eligible borrowers for any of the following purposes:

- Construction of new hospital buildings
- Completion or improvement of existing buildings
- Acquisition or repair/upgrading of hospital equipment and machinery.

However, in practice, loans are granted only for the purpose of expanding or improving existing facilities and for the procurement or repair of machinery. The loan evaluation officers interviewed consider lend-

**Table 15** Current Status of Development Bank of the Philippines Hospital Accounts, May 1991.

Organization	Type	Purpose	Rate Status
Afable Medical Center	Corp.	Mach. & Equip.	26% new under RAMM
Alidio Nestor (restructured acct.)	Sole Prop.	Const. of Bldg., Mach. & Equip.	14%/16% old acct.
Perpetual Succer	Corp.	Const. of Bldg., Mach. & Equip.	14%/16% old acct.
Cruz, Robe E.	Sole Prop.	Mach. & Equip.	16% old acct.
Miraculous Medal Hospital	Corp.	SCR Acct.	21% old acct.
Pamana Inc. (Laguna Polymedic)	Corp.	SCR Acct.	21% old acct.
Mariame Doctors Hospital	Corp.	Const. of Bldg.	26% new under RAMM
Capitol Medical Center (restructured)	Corp.	Const. of Bldg.	10/9% old acct.
Angeles University Foundation	Corp.	Mach. & Equip.	29% new under RAMM
University of Sto. Tomas	Corp.	Mach. & Equip.	17% new under RAMM*
Manila Medical Services	Corp.	Bldg. / Mach. &	
Computed Technology Center	Corp.	Mach. & Equip.	25% new under RAMM

Note : SCR Account : Foreclosed asset subsequently acquired by another private entity.

RAMM : Risk Asset Management

Two interest rates : Rate application depends on purpose; rate is usually lower for building construction than machinery & equipment acquisition.

\*Rate fixed for two years, repricing 8/91.

ing money to newly established health care institutions as too risky.

The loan window is open to all categories of hospitals who have demonstrated viability and who are not delinquent with respect to their SSS, Medicare and ECC contributions. The amount of the loan is limited to 50 percent of the total project cost or 80 percent of the appraised value of the property offered as a collateral, whichever is lower.

Where the loan is for the purchase of machinery and equipment, the amount shall not be more than 60 percent of the value of the machinery and equipment.

All loans under the program carry an interest rate of 18 percent (the rate was increased from 16 percent in April 1991), with the SSS reserving the right to review the rate at the end of the tenth year. The projected cash flow of the project determines the tenor of the loan but this shall not be more than twenty years, including a grace period of three years on principal from the first release on the loan.

Although the revolving fund allocated for this program is pegged at 300 million pesos, Table 16 indicates that the fund is replenished whenever it registers a deficit. The ceiling imposed on the program appears just to signal the need for a decision of the SSS board to allocate funds for replenishment. Table 17 shows the current status of accounts under the hospital financing program.

- In 1984, the Employment Compensation Commission (ECC) opened a loan window to finance the purchase of medicines and equipment as well as the repair and expansion of existing facilities. A revolving fund of 100 million pesos was set aside for this program and loans were offered at an interest rate of 19 percent with a payback period of 18 months. Fifty-one hospitals availed of this fund using up less than 20 million pesos. The loan window was closed in 1986 and the management of existing accounts was taken over by the SSS.

This brief review of hospital financing sources reveals a long standing recognition by government - particularly the government financing institutions -- of the need to provide development financing for private hospitals in order to enhance the growth of the health care industry and to encourage the dispersal of services to the provinces. However, the deep recession that was experienced in the mid-eighties not only led to severe fund scarcities on the part of financing institutions but also to wholesale business failures. Many heavily indebted and poorly managed hospitals went under, thereby reinforcing decisions to close down loan windows on the industry.

The subsequent recovery after 1986 did not see the resumption of these financing programs, leaving only the SSS with a concessional loan window devoted to hospital development. But not everybody knows about this program. The primary and secondary hospitals interviewed indicated that they were not previously aware of the SSS loan window. Considering that

**Table 16** Status of SSS Hospital Financing, May 24, 1991

<b>Initial Revolving Fund</b>			300,000,000
Less Approved Loans :			
Angeles Univ. Foundation Medical Center	Angeles City, Pampanga	25,000,000	
AUF Medical Center (additional)	Angeles City, Pampanga	10,000,000	
Makati Medical Center	Makati, Metro Manila	30,000,000	
Makati Medical Center (additional)	Makati, Metro Manila	20,000,000	
De La Salle University Medical Center	Dasmariñas, Cavite	15,000,000	
Riverside Medical Center	Bacolod City	13,000,000	
Medical City General Hospital	Mandaluyong, Metro Manila	40,000,000	
Capitol Medical Center	Quezon City	28,000,000	
Manila Doctors Hospital	Manila	50,000,000	
Perpetual Help Medical Center	Las Pinas, Metro Manila	20,000,000	
Davao Doctors Hospital	Davao City	21,378,000	272,378,000
Balance			27,622,000
Less Pending Loan Applications :			
F.M. Cruz Orthopedic & General Hospital	Valenzuela, Metro Manila	5,000,000	
St. Luke's Medical Center	Quezon City	20,000,000	
Dr. Jesus C. Delgado Memorial Hospital	Quezon City	5,000,000	
Medical Center Manila	Ermita, Manila	50,000,000	
Holy Child Medical City	Midsayap, Cotabato	2,500,000	
Cotabato Med. Specialist & Emergency Ctr.	Cotabato City	7,700,000	
The Doctor's Clinic & Hospital	Koronadal, South Cotabato	5,000,000	95,200,000
Deficit under Initial Revolving Fund			-67,578,000
Additional allocation under SSS Res. No. 107			200,000,000
Unallocated Fund			132,422,000

**Table 17** Status of Accounts under the SSS Hospital Financing Program, April 30, 1991

Year / Borrower	Amount in Million Pesos		Bed Capacity		Gross Revenues in Million Pesos		Profit in Million Pesos		Project to be financed
	Approved	Released	Before Loan	After Loan	Before Loan	After Loan	Before Loan	After Loan	
1987 / Angeles University Foundation Medical Center	25.000	25.000	0	125	43.500	48.400	7.400	8.200	Building construction and equipment acquisition.*
1988 / Makati Medical Center	30.000	30.000	500	586	273.800	306.300	6.400	7.200	Building construction and equipment acquisition.*
1989 / Angeles University Foundation Medical Center	10.000	10.000							Additional loan was due to project cost overrun.
1989 / Makati Medical Center	20.000	18.000	586	613	306.300	329.700	7.200	16.300	Building expansion and acquisition of polydiagnostic cardiovascular equipment.
1989 / De La Salle University Medical Center	15.000	15.000	140	240	24.600	32.600	2.900	4.100	Hospital annex construction and equipment acquisition.*
1990 / Riverside Medical Center	13.000	7.900	200	247	43.428	Expansion	0.542	Expansion	Building construction and equipment acquisition.*
1990 / Medical City General Hospital	40.000	21.450	257	350	87.678	Expansion	3.656	Expansion	Building construction and equipment acquisition.*
1990 / Capitol Medical Center	28.000	16.114	178	227	68.736	Expansion	2.685	Expansion	Building renovation and equipment acquisition.*
1990 / Manila Doctors Hospital	50.000	40.500	200	400	93.146	Expansion	1.753	Expansion	Hospital annex construction and equipment acquisition.*
1990 / Perpetual Help Medical Center	20.000	13.950	1	190	17.154	Expansion	0.772	Expansion	Building construction and equipment acquisition.*
1990 / Davao Doctors Hospital	21.378	—	150	200	53.900	Expansion	2.300	Expansion	Hospital expansion and acquisition of CT scanner.

\*Equipment acquired subject to verification.

the secondary hospital is in Metro Manila while the primary hospital is only fifty kilometers south of the city, it would therefore not be surprising to find many of those situated farther away to be just as uninformed.

Thus the credit environment faced by private hospitals appears to be one which is characterized by fund scarcity and relatively high interest rates as hospitals are mostly left to compete with other industries in the commercial loan market. The scarcity becomes more acute in the provinces where financing facilities are meager and where information on financing programs by government financial institutions is slow to trickle down.

**The Demand for Credit.** An effort to establish a picture of hospital demand for credit was made in the course of the interviews with hospital owners and administrators. As mentioned earlier, four hospitals were interviewed: a tertiary hospital in Metro Manila, a tertiary teaching hospital in Laguna, a secondary hospital in Metro Manila and a primary hospital in Cavite. Of the four, three availed of loans from financial institutions to a significant extent. The credit experience of each will be discussed in turn to give a sense of the demand profile of the industry.

The tertiary hospital in Manila has 48.1 million pesos in long-term debt: 40 million pesos from the SSS hospital financing program and 8.1 million pesos in mortgage loans from the GSIS. The loans were used to finance the construction of an additional wing and the purchase of new equipment. They also availed of lease purchase financing schemes offered by bank-affiliated financing companies for the acquisition of equipment considered to have high potential for revenue generation such as the 2D echocardiogram, ultra sound machine, etc. These schemes were availed of at a time when the hospital was not yet generating enough revenue to fully finance acquisition. There are no plans to finance present acquisitions through this line because of the relatively high interest rate charged (up to 30 percent).

The tertiary teaching hospital in Binan, Laguna is part of a satellite system of hospitals controlled by a family of doctors and hospital administrators. The conglomerate consists of a hospital each in Manila, Pangasinan, Las Pinas and Laguna. The hospital in Binan was purposely established to ser-

*"...the credit environment faced by private hospitals... is characterized by fund scarcity and relatively high interest rates... hospitals are mostly left to compete with other industries in the commercial loan market. The scarcity becomes more acute in the provinces where financing facilities are meager and where information on financing programs by government financial institutions is slow to trickle down."*

vice the adjacent medical and nursing schools which the family also owns. As a teaching hospital, it is registered as a non-profit institution as required by law. This allows the said entities to enjoy tax and duty free privileges.

The hospital was established in 1977. Although a significant amount of the start-up capital consisted of advances from the stockholders (the land was owned by the family) as well as loans from other hospitals in the conglomerate, the greater portion was financed out of a 4 million pesos DBP loan at 12 percent interest. Since the medical and nursing schools generated enough funds to subsidize the operations of the hospital, there was no need for subsequent financing until 1986 when 100 million pesos had to be raised for the rehabilitation of equipment. The owners were able to generate the amount through loans from private banks and the ECC. School revenues and improved management practices introduced by a son who finished graduate studies in hospital management abroad have since then kept the hospital and school system relatively profitable and liquid.

The secondary hospital in Metro Manila is owned by a religious order. They also used to run it until losses prompted them to turn over management to a private management group (MG). The management contract required MG to put up 15 million pesos

for operating capital in addition to paying a fixed rental fee. The contract is good for 10 years, renewable for another 10 years, at which time MG is supposed to bring in another 15 million pesos.

However, MG subsequently found it necessary to put up an additional 45 million pesos for the renovation and expansion of doctors' offices. All of these were recorded as advances by MG whose owners had other lines of business which generated surplus funds and allowed access to financing sources. The share of MG in the expected profits was not revealed.

To further reduce costs, MG applied for a change in category from tertiary to secondary, citing the inadequacy of their facilities in certain areas. The recent approval of their application now allows them duty-free import of their equipment and supplies.

The primary hospital in Cavite is owned by a medical practitioner (single proprietor). He put up the hospital in 1985 using savings generated from his private practice in addition to revenues generated from the sale of family-owned farm land. This was augmented by an agricultural loan of 70,000 pesos from a rural bank (at 15 percent interest). Although the recorded project cost was 500,000 pesos, the owner estimates the actual cost to be much more since labor was provided almost free by former patients and some equipment was acquired free or for a pittance from more established colleagues.

He has not availed of financing since then. Subsequent equipment acquisitions were financed through savings or were donated by relatives and friends abroad as well as by grateful patients. In fact he is extremely reluctant to borrow even for much needed equipment because of the very uneven income stream of the hospital. He cites this as the greatest deterrent to upgrading his facilities.

These hospital owners, having been survivors of the recessionary years in the middle eighties appear to display a great degree of sensitivity to economic indicators that may affect their bottom line performance. For instance, both provincial hospital owners expressed concern about the price of oil being sticky upwards as this not only increases their input costs but it also dampens demand for health care services as increased transport costs make hospital visits less affordable.

They were unanimous in saying that high financing costs and the scarcity of credit lines have had a significant negative effect on their willingness as well as on their ability to expand. It also appears that the high failure rate of debt-laden hospitals in the eighties have taught these survivors to be wary of the risks involved in assuming a heavy debt burden.

Only one hospital availed of the lease-purchase schemes on equipment acquisition offered by some financing companies. Others worry about making the mortgage payments on these schemes because of the high interest rate. Even the hospital which availed did so only to acquire those pieces of equipment with an expected high revenue yield, at a time when money for them was tight. However, all except one expressed interest in a more affordable leasing or lease-purchasing scheme especially if accompanied by a servicing agreement. The sole exception was the primary hospital owner who seemed overly concerned about his unsteady income stream.

None of those interviewed appeared to have perceived any geographical

*"The picture of the health care industry that emerges is one wherein government has a large presence in terms of service delivery, and there is a complete and modern set of laws regulating private practice. With... decentralization... it is expected that [the government's role] will alter substantially and that [the government]... can provide more meaningful regulation when its role in service provision is greatly reduced."*

bias in the credit conditions imposed by financial institutions. Those situated in the provinces lamented the lack of incentives for locating outside the Metro Manila area. The primary hospital owner in particular decried the lack of information on available credit lines and the inaccessibility of credit facilities to small hospital owners in the provinces.

In summary, the availability of credit for hospital construction and operation may be an important bottleneck in several ways. First, hospitals are typically financed personally by physicians. Thus they tend to be undercapitalized and many are persistently close to financial failure (Inter-care 1987). Second, inadequate or expensive capital may be partially responsible for the proliferation of small single-proprietor hospitals in the private sector. Investigation by the study team indicates that there have been concessional credit instruments created for private hospitals and schools in the past (primarily in the 1970s, in response to the creation of the Medicare system) through the Government Service Insurance System, the Social Security System, and the Development Bank of the Philippines (DBP). The general experience with these loans was negative, and fund shortages at the subsidized interest rates limited the volume of loans. DBP construction loans, for example, carried nominal interest rates of 12 percent with a 20-year term and a 5-year grace period on repayment of principal. Equipment loans had a 19 percent rate, and a 13-year term that included a 3-year grace period. The failure rate among hospitals using this concessional window was 50 percent. Of the institutions offering concessional loans in the past, only the Social Security System still does, although it limits loans to existing institutions with an established history. In 1984, the Employment Compensation Commission (the worker's compensation system) opened a similar facility. Hospitals are also subject to standard provisions limiting foreign investment to 40 percent. In general, therefore, hospitals are either financed internally or pay market rates for credit. Successful private hospitals may gain access to some subsidized loans, but it is very unlikely that new hospitals are able to secure below-market rates on borrowed funds.

### Public Infrastructure

Particularly in rural areas, lack of electricity, water systems, roads, and inexpensive communication limits the size of the market on which medical facilities can draw and increases the cost of constructing and operating medical facilities outside of major cities. The lack of infrastructure may thus contribute to the construction of smaller, less sophisticated hospitals than would otherwise be built, especially in rural areas.

Utility services in the country leave a lot to be desired. In many areas including Metro Manila, water supply comes infrequently while power brownouts come often and unannounced. Hospitals are not exempt. In fact, they are not given preferential treatment even in terms of rates and priority. There are, however, a few notable exceptions.

The telephone system does not give hospitals any special rates. Government entities however are exempt from subscribed investment plans.

For power support, private hospitals are classified by the Manila Electric Company (MERALCO) as non-industrial service. As such, they are billed at the same level as industrial service for generation charge (applicable generation charge per KWH for the billing month) and demand distribution charge (25.00 pesos per kw for each kw of billing demand). However, they are billed higher than industrial service in terms of energy distribution charge, but they enjoy a 12 percent discount on the combined demand and energy charge so long as they are duly registered by the Bureau of Medical Services and provided the metered services serve solely the energy requirements of the educational institution and/or private hospital. Government hospitals enjoy preferential rates below those charged to private hospitals.

### Conclusions

The picture of the health care industry that emerges is one wherein government has a large presence in terms of service delivery, and there is a complete and modern set of laws regulating private practice. Private hospital operators are concerned about the ef-

fects of the government's competition for potentially paying patients on the development of the industry. In addition, a number of those interviewed question the wisdom of some of the government edicts particularly those dealing with minimum standards for hospital facilities and personnel. They view some of the requirements as unreasonable and generally deter plans for expansion as these are required to be made in terms of defined quantum jumps instead of more manageable and affordable increments. Its effectiveness as a regulator is stymied by its own involvement in service delivery. With the decentralization process, it is expected that its role will alter substantially and that it can provide more meaningful regulation when its role in service provision is greatly reduced.

With its reduced service delivery role, the competition it poses with the private delivery sector is also reduced. Public sector role can now be focused on providing for more public goods, particularly planning, information and communication services, standards and regulations, research and development, logistics support and resource mobilization, etc.

The industry presently faces relatively tight credit as the absence of sufficient concessional loan windows forces hospitals to compete with other industrial enterprises for financing. They also will have to make do with the terms offered in the market. A single practice or a hospital's ability to play in the market is determined by a steady supply of clients which in turn is largely a result of the quality and price of the services it offers. The practice which is well-managed will have an edge. The problems faced by large and small firms in the industry are similar. The ability of the private sector to improve management and make capital investments, in terms of medical equipment, for example, can be enhanced by a financial and regulatory environment supportive of such initiatives (see Box 1). The demand side of the market is not well-developed to support the numerous and varied services offered by the market. On the other hand, there is a case for cooperation and networking among private sector providers, if a more organized system in financing is in place.

Yet, while there is a clear case for a re-examination of the current government regulatory framework not much is known regarding the current and

#### **Box 1 A Recent Example of Cooperation Between Public and Private Hospitals in Manila**

The DOH's recognition of the shared role that public and private hospitals play in the system is expressed in the hospital network concept it launched in 1986. Sharing of facilities, exchange of manpower, including consultants, and pooling of resources are encouraged to further achieve economies and efficiencies in hospital operations.

In the Policy Framework for the National Hospital Development Plan framed in late 1989, the shared role is underscored. The document states that "the Department of Health recognizes the vital role of private sectors in the provision of comprehensive health care of high quality to all Filipinos."

Thus, it will first rationalize the development of public and private hospital facilities responsive to the needs of the population. It will encourage the establishment or expansion of private hospitals in areas where the bed-population ratio is below ideal levels. The DOH will have as its primary population the indigents and the underserved.

Second, it will promote and maintain a symbiotic relationship between the public and private hospitals, characterized by cooperative and coordinated efforts. The networking efforts will continue. At the same time, government regulations for hospitals will be simplified, integrated, and maintained at a necessary minimum. Regulatory and licensing agencies will be coordinated; integrated service centers for regulation and licensure set up, and licensure standards developed to assure quality medical care based on safety of the patient, appropriateness, and effectiveness.

Third, the DOH and the private sector will cooperate towards the enhancement of the viability of hospitals. A cost and price information bank will be developed and disseminated to hospitals as a guide for fair and just pricing of hospital services. Innovative financing schemes will be set up to enhance cost recovery, such as third party payment schemes. Also, government incentives will be provided to private hospitals, including the reduction and removal of taxes on hospital equipment, parts, and supplies.

The shared role also becomes operative through the Philippine Hospitals Association (PHA) which draws membership from both the public and private sector operators. While its primary focus is on the private hospitals, it also coordinates the interests of the public hospitals as well. It takes an active interest in standards and is concerned with matters of operational efficiency. The PHA lobbies for incentive schemes to support the private hospitals by way of tax concessions, favorable loans for capital work and exemptions from some inhibiting labor laws. ■

potential role for self-regulation among professional societies and provider groups in the health sector. The response to the government's regulatory role and the perception of an uneven playing field in government-private transactions arise from monitoring loopholes that enables one group or individual to shirk or circumvent the rules. While the government can only respond slowly and inadequately, self-regulation can provide the needed impetus for market discipline. Groups actively participating in public decision-making bodies can enhance and nurture this penultimate private-public linkage with stronger programs in self-regulation.

These observations give rise to a num-

ber of issues which could be the subject of further study:

- How effective are present regulations in setting standards of quality and ensuring equity in the delivery of health care services?
  - How can various professional societies and provider groups improve self-regulatory mechanisms? What complementarities can be explored with government regulations?
  - Should government intervene in the credit market to promote equity? In what manner? To what degree?
- One could approach the first issue by examining the adequacy of the regulatory provisions and enforcement measures. Is coverage of regulatory provisions comprehensive enough?

Are loopholes minimized? Do enforcement measures or efforts ensure sufficient compliance?

Beyond regulations, the government can take more positive actions towards leveling the playing field through equal tax treatment to education and health sectors, the provision and fair pricing of support infrastructure (esp. power, credit) and the promotion of greater public-private sector collaboration through more organized means of

paying for health care services. To summarize the supply-side problems, most appear either not to be major bottlenecks to private sector development or to be perceived as much more serious than they really are. The two that are serious for rural facilities and most hospitals are problems with infrastructure and access to credit. Solving infrastructure problems takes positive action by government that benefits all sectors, not just private

hospitals. Credit problems may be more effectively solved on the revenue (or demand) side than on the supply side. Hospitals currently qualify for credit at market rates; problems they have in servicing loans are related to the difficulty in paying off loans when much of their income depends on individual out-of-pocket payments rather than more predictable third party payments. ■

## 6

# Environment of the Private Sector - Demand Side

The remainder of this discussion of findings is devoted to a more detailed look at the interface between the government and the private sector on the demand side of Table 2. We conclude from the study that while there are problems to be fixed on the supply side and changes to be made in incentives and regulations that affect the structure of the industry, many of the desired changes (e.g., improved access to credit and helping the private sector move a primary hospital model to a secondary or tertiary model) require attention to demand-side issues. On the demand side, the government most directly affects the private sector through competition from government services for paying patients and through the Medicare system, as will become clear in this section.

## Demand by Individuals

### Coverage of and Subsidies to Indigents

The most recent spending figures indicate that 43 percent of all health care spending is out-of-pocket spending on private goods and services. How do government interventions affect this part of the market? First, through protection of consumers by regulating the services that are delivered, by assisting people unable to pay for private services, and by giving consumers recourse against malpractice. Government intervention in these areas is minimal.

As for indigents, they are protected primarily by direct service delivery by the government. By law, public hospitals are expected to allocate 70 percent of their authorized bed capacity for

charity patients, 20 percent for Medicare patients, and 10 percent for pay patients. Private hospitals, on the other hand, are expected to allot at least 10 percent of their authorized bed capacity for charity patients, 20 percent for Medicare patients, and 70 percent for pay patients.

To enable private hospitals to serve charity patients, there is a legal provision allowing them to claim income tax deductions for services rendered to emergency patients who are unable to pay their medical bills. However, this provision has never been implemented by the Bureau of Internal Revenue. As a safeguard, private hospitals typically demand a deposit before extending the needed services to emergency patients. In addition, a small allocation is provided in the public budget to pay for charity patients in private hospitals who do not have access to a public hospital at the time they need care. Interviews with private hospital owners suggest that it is so difficult to obtain this money that it is rarely requested or distributed.

### Competition from Government

Thus the major role the government plays in reducing costs to indigents is through free provision of its own services. However, to what extent does this approach target subsidies well, or is its main effect to create competition with the private sector for patients who could pay for their care? Figure 8 shows use of two types of government facilities, hospitals and rural health units (clinics), along with combined use of private hospitals and clinics by income group. Because these income groups are not of equal sizes, the proportion of the population in each is shown by the bars at the bottom of the graph. The graph shows the percentage of households in each income

group that reported using the specific type of facility in the previous year.

One way to look at the graph is to note that the percentage using private facilities rises as incomes rises, while use of public facilities decreases. However, for our purposes there is clearly considerable leakage of public spending, especially public hospital spending, to households in the upper income brackets. In the top bracket alone, about 20 percent used free government clinic services from rural health units, and 30 percent used public hospital services. Hospital services are less likely to be completely free of charges (for example, the high-income groups are more likely to use Medicare or private wing services), but they are heavily subsidized for all. Private hospital owners complain that the public sector competes unfairly for the higher income patients by subsidizing services for them.

## Public Sector Financing and Demand -- Medicare

The single largest health financing mechanism in the country other than the DOH is the Medicare Program. Through it, public financing through a payroll tax is linked with private provision of health care, both goods and services.

The Medicare program is a compulsory health insurance scheme that was established by Republic Act (RA) 6111 in August 1969. The Medicare Program was implemented starting January 1, 1972 with the creation of the Philippine Medical Care Commission (PMCC).

PMCC serves as the policy-formulating and coordinating body for the program while the Social Security System (SSS) and the Government Service Insurance System (GSIS) are mandated to collect and remit payments for private company employees and estate employees, respectively. Currently, PMCC is under the supervision of DOH.

As of 1990, Medicare covered 23.5 million Filipinos, or 38 percent of the total population. Of this, about 16.8 million were served by SSS while the balance of 6.7 million were under GSIS. There were a total of 4.6 million Medicare members (i.e., excluding dependents and retirees) as of 1989, or about 20 percent of the estimated 21.8 million people employed for the year.

Currently, Medicare provides for in-patient benefits utilizing a vast network of public and accredited private hospitals. From 1972 to 1990, the rate of availment (i.e. beneficiaries served / total coverage x 100) for the total Medicare program averaged 6-45

percent: SSS at 5.36 percent and GSIS at 10.36 percent.

In 1990, benefits paid by SSS and GSIS totalled 710 million pesos and 442 million pesos respectively. Medicare support values (i.e. proportion of total hospitalization expenses paid for by Medicare) have failed to reach the targeted 70 percent. It is estimated that average support values have ranged from 32 to 49 percent, the latter experienced in 1989 and the highest recorded support value so far (1991 benefit increases have not yet been analyzed in terms of support value provided).

In the health care sector, Medicare provides an opportunity for risk-sharing. It has helped widen the access to health services by giving its members the necessary funding support for hospitalization needs.

The Medicare system reimburses in-patient services in both the public and the private sectors. Judging from the information in the previous two figures, Medicare had a tremendous

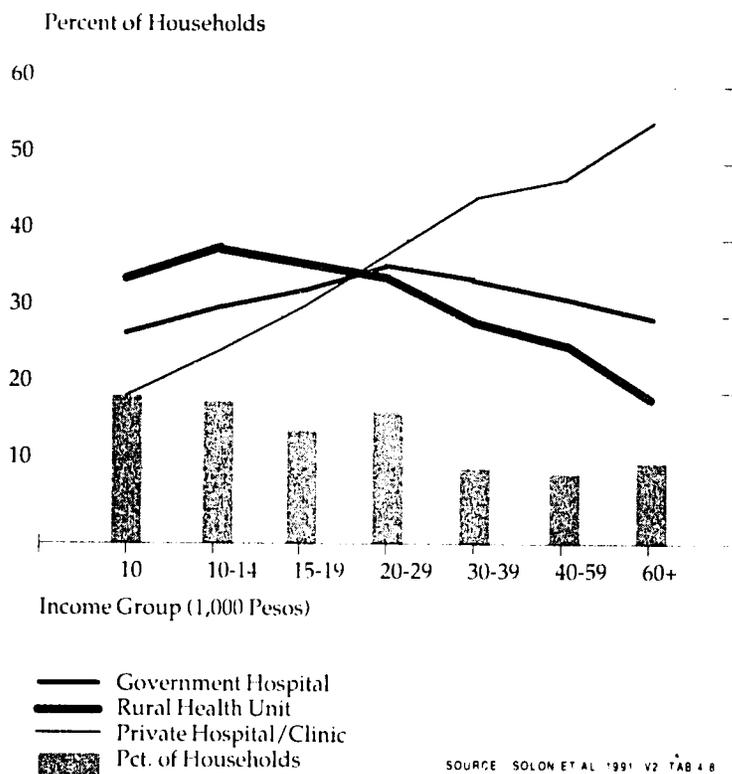
impact in facilitating the expansion of the private hospital sector after 1972, but the expansion has not continued. Between the late 1970s and the mid 1980s, Medicare's reimbursement levels were allowed to fall to an average of considerably less than 40 percent of a typical hospital bill, and membership growth stagnated. After 1986, efforts to reverse these trends may now begin to foster growth in the private hospital sector again.

To investigate the impact of Medicare on the economic signals received by hospitals, Medicare claims data for 1990 from the Social Security System were matched to a list of public and private hospitals obtained from the Hospital Licensing Bureau of the Department of Health. This matching has never been done before. It indicates some strange geographical and hospital-specific patterns of disbursements that suggest extreme distortions in economic and medical behavior for some physicians. Such distortions aside, the data also reveal systematic economic incentives created by reimbursement rules that appear in practice to favor small primary care hospitals.

The list of hospitals contain the entire population of accredited public and private hospitals in 1990, and the claims provided by the Social Security System are supposed to include all payments made, by hospital, in 1990, on behalf of all private sector employees who were eligible for the Medicare benefit. It does not include public sector employees, whose claims are administered by a separate agency. There are 1,765 hospitals in the database, including 1,168 private and 597 public. Bed capacity ranges from 5 to 2000. 1,304 of the hospitals had claims with the Social Security System in 1990. The average number of claims per hospital was 458, ranging from no claims up to 11,201 claims for one hospital. The average value of claims per facility for the year was 270,372 pesos (about \$10,399 @26 pesos/U.S. dollar), ranging from 110 pesos to 8,549,604 pesos. To standardize on the size of the hospital, a more useful statistic is the number and value of claims per bed. Hospitals had an average of 15 claims per bed, with an average value of 6,703 pesos per bed. The number of claims ranges up to 622 claims per bed; the value of claims ranges up to 109,563 pesos per bed.

The distribution of these two statis-

**Figure 8** Use of Public and Private Medical Facilities, 1987 National Health Survey

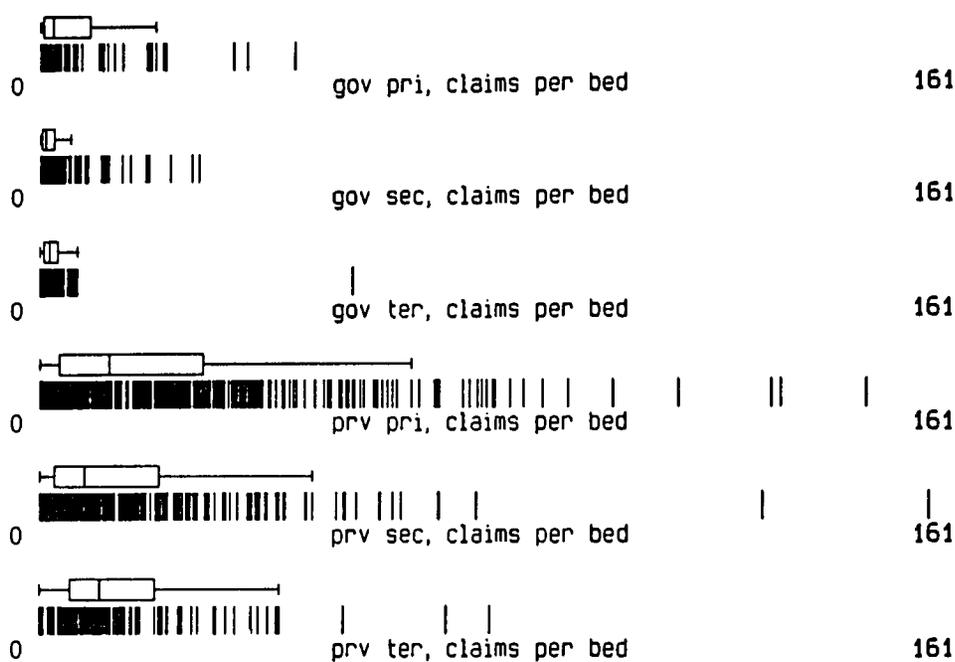


tics across hospital types provides an indication of the incentives faced by hospital owners. Figure 9 and Table 18 display descriptive information on claims per bed (the graph eliminates the outliers above 161 claims per bed to make the graph more readable).

There are six rows in the graph. The top three rows refer to government primary, secondary, and tertiary hospitals, respectively. The bottom three refer to private primary, secondary, and tertiary hospitals. Each row is composed of a scatter plot, in which

each vertical slash represents one observation or hospital. Above the scatter plot is a syringe-like box-and-whiskers graph that displays the distribution. The line inside the box shows the 50th percentile of the distribution -- the halfway point. The left and right sides

**Figure 9** SSS Medicare Claims per Bed in Government and Private Hospitals; by Primary, Secondary, and Tertiary Classification, in Pesos, 1990



**Table 18** Statistics Characterizing the Distribution of SSS Medicare Claims per Bed, 1990.

		SSS Medicare Claims per Bed, 1990				
Type		Number	Mean	25th Percentile	50th Percentile	75th Percentile
Government	Primary	81	9	1	3	11
	Secondary	216	2	0	1	3
	Tertiary	99	3	1	2	3
Private	Primary	482	23	4	13	30
	Secondary	298	16	3	8	22
	Tertiary	119	15	6	11	21

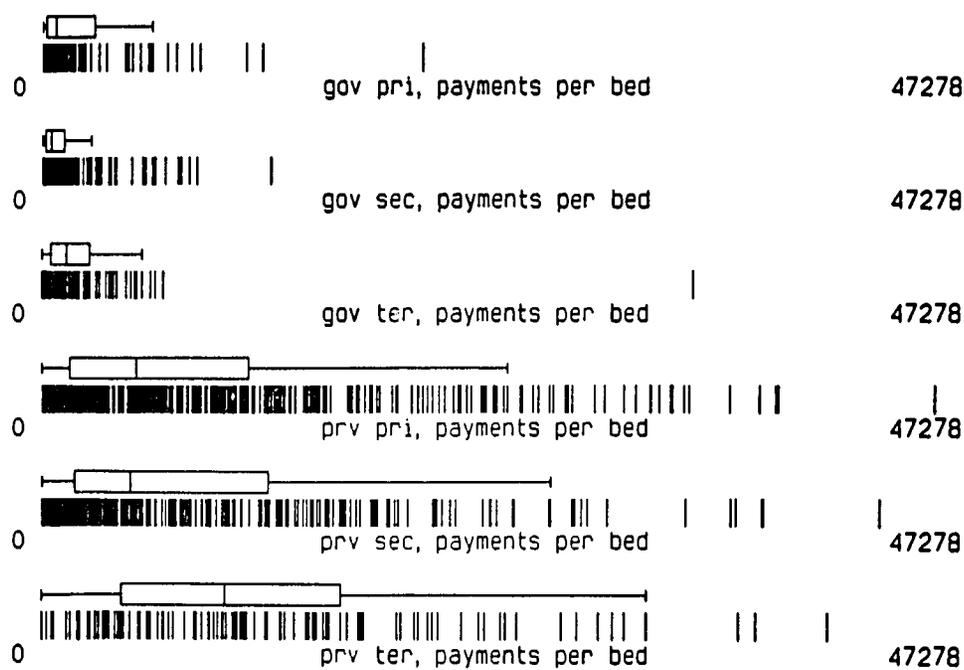
of the box show the 25th and 75th percentiles (see Table 18 for the exact numbers using the whole sample), so the width of the box accounts for 50 percent of the observations in the center of the distribution. The lines emerging from the box are 1.5 times

the width of the box. Observations beyond these lines, or whiskers, are considered to be outliers.

The first piece of information shown in Figure 9 is the relatively low level of claims activity in government hospitals despite the fact that personnel are

allowed to keep the professional fee portion of the Medicare reimbursement. The low claims may reflect that relatively few Medicare beneficiaries use government hospitals. On average, however, government primary hospitals tend to make more

**Figure 10** Value of SSS Medicare Claims per Bed in Government and Private Hospitals; by Primary, Secondary, and Tertiary Classification, in Pesos, 1990



**Table 19** Statistics Characterizing the Distribution of SSS Medicare Claims per Bed, 1990.

SSS Medicare Claims per Bed in Dollars (P26=\$1), 1990

Type		Number	Mean	25th Percentile	50th Percentile	75th Percentile
Government	Primary	81	\$111	\$9	\$28	\$115
	Secondary	216	\$55	\$18	\$44	\$110
	Tertiary	99	\$81	\$18	\$49	\$96
Private	Primary	482	\$316	\$57	\$194	\$429
	Secondary	298	\$331	\$66	\$181	\$464
	Tertiary	119	\$455	\$160	\$375	\$623

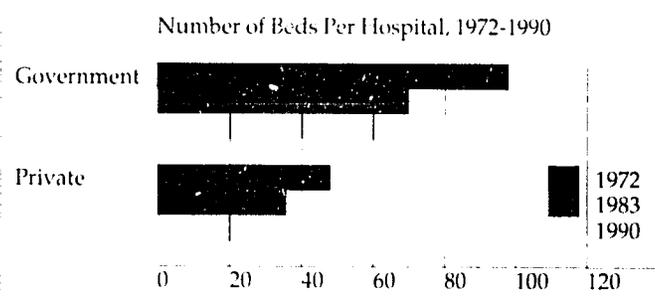
claims per bed than do secondary or tertiary hospitals. As is shown in the bottom three rows, the private sector makes many more claims per bed on average at every level, but primary hospitals again exceed both secondary and tertiary hospitals in the number of claims per bed. Primary hospitals tend to have lower occupancy rates in both the public (Solon et al. 1991) and private (Intericare 1987) sectors, so the high average claims rates for these smaller hospitals are the reverse of what might be expected based on occupancy rates alone.

Figure 10 and Table 19 show the peso value of claims per bed for 1990. The upper limit is fixed at 47,278 for readability, although this limit eliminates the extreme outliers. The figure provides information that is consistent with the Figure 9. Government hospitals treat relatively few Medicare patients (or are not careful to process claims for them) and the value of these claims is relatively low. The mean value of claims for the three types of government hospitals is very similar. The average claim in private hospitals is much higher, and the range is wide at each level of hospital. The average value of claims for private primary and secondary hospitals is similar, with almost the same range. The average claim in tertiary hospitals is much higher, but the range is very similar to that for the smaller hospitals.

The Medicare reimbursement system explicitly provides for higher rates of reimbursement for secondary and tertiary hospitals relative to primary hospitals. It also distinguishes between regular and catastrophic cases. Thus one would expect to see that the revenue per bed would be substantially higher in secondary and tertiary hospitals relative to primary care hospitals, but it is not. It appears that primary hospital owners are able to achieve almost any level of revenue per bed that they desire, despite rules that provide them with lower reimbursement prices.

•The Medicare system thus creates an important economic incentive. A proprietor of a hospital seems to be better off as a claimant against Medicare to own a small, relatively inexpensive primary hospital rather than investing in a more capital-intensive and sophisticated secondary or tertiary level hospital. Does this incentive help to explain the commonly observed proliferation of small single-proprietor

**Figure 11** Average Size of Public and Private Hospitals, 1972 to 1990



private hospitals, often in the same neighborhood, all over the country? Many observers have wondered why these small hospitals do not combine into larger secondary or tertiary hospitals that can offer more sophisticated services. Obviously we have a possible explanation, although it will be only one of a number of possible causative factors and requires more sophisticated analysis before strong statements about it can be made.

A possible reflection of this incentive is the smaller average size of private hospitals relative to public hospitals, as shown in Figure 11. The size of private hospitals has also been decreasing since 1972 despite higher incomes, vast changes in hospital technology, improved credit markets, improved transport and communication, urbanization, and the fact that Medicare reimburses using cost-based formulae. All of these factors would be more consistent with consolidation of private hospitals than with disintegration of them. The fact that we observe the opposite is further circumstantial evidence that the Medicare reimbursement system creates extreme incentives of the types suggested in this section.

#### Findings of the HMO Tie-Up

In 1989, the PMCC embarked on an experimental HMO-Medicare tie-up aimed at providing HMO-type benefits (outpatient and higher inpatient benefits) to Medicare members at the prevailing Medicare premium rates. Under the program, the two social security systems (SSS & GSIS) continue to collect the participating members' premiums, but remit these to the participating HMOs after deducting for administrative costs.

The HMO will arrange for and/or render services directly to these beneficiary-members. Membership was voluntary but limited to Metro Manila. Catastrophic cases are reverted back to the regular Medicare program. PMCC enters into the agreement with the private company, monitors service performance and render assistance as requested, while the participating HMOs are responsible for program marketing.

The program was offered to the industry. Only two HMOs joined the program. They both offered similar packages with some variations in benefit ceilings and co-payments. By August 1990, there were 173,469 member-participants, excluding their dependents. After a February 1991 evaluation, membership was frozen as administrative problems were ironed out. After a second evaluation in 1992, the program was terminated. Program resistance was strongly felt from the two systems. Administrative bottlenecks, from the confirmation of membership status to the remittance of premiums to the HMOs, proved unwieldy. While there were no claims processing involved between the two systems and providers, the confirmation of membership status took just as long. While the benefits offered were clearly more than the regular program, and support values were higher, utilization by members was lower than that of the regular program and marketing efforts were considered inadequate. HMOs were seen to attract only the low risk groups, thus, contributing to perceptions of windfall profits for the participating HMOs.

The difficulties encountered by the HMO-Medicare tie-up project highlight the nature of the problems likely to be encountered in programs that

**Table 20** Sales of Pharmaceuticals in Current Prices 1981-1990 (in Million Pesos)

	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	Growth 85-90
<b>Hospitals</b>											
Private	558.4	643.8	573.4	643.6	725.3	645.3	855.6	1040.9	1229.8	1634.5	125.4%
Government	213.5	247.2	234.5	218.0	262.0	215.8	360.4	470.8	698.5	858.9	227.8%
Total	771.9	891.0	807.9	861.6	987.3	861.1	1216.0	1511.7	1928.3	2493.4	152.5%
<b>Drugstores</b>											
Manila	1248.2	1450.0	1675.7	2101.6	2772.5	3122.5	3819.5	4504.2	4636.9	5479.3	97.6%
Luzon	549.1	590.1	801.9	1088.3	1515.9	1762.1	2182.5	2348.0	2241.5	3064.8	102.2%
Visayas	444.6	509.0	528.3	556.5	805.7	930.9	1160.8	1449.9	1657.6	1821.6	126.1%
Mindanao	303.1	311.1	362.1	505.1	589.3	724.5	945.7	1074.5	1051.9	1369.5	132.4%
Total	2545.0	2860.2	3368.0	4251.5	5683.4	6540.0	8108.5	9376.6	9587.9	11735.0	106.5%
<b>Grand Total</b>	3317.0	3751.0	4176.0	5113.0	6671.0	7401.0	9325.0	10888.0	11516.0	14229.0	113.3%

**Table 21** Government Purchases as a Percentage of Hospitals and Total Pharmaceutical Sales

	Percent of Hospital Sales	Percent of Total Pharmaceutical Sales
1981	27.7	6.4
1982	27.7	6.6
1983	30.1	5.8
1984	25.3	4.3
1985	26.5	3.9
1986	25.0	2.9
1987	32.3	3.9
1988	31.1	4.3
1989	36.2	6.0
1990	34.4	6.0

use public financing mechanisms for private delivery of services. Moreover, the program showed the potentials for expanded Medicare benefits, at present costs, and further public-private sector collaboration. Before its termination, more companies expressed their interest to participate in the program.

**Non-Medicare Sources of Demand**

In many countries, the public sector has little experience contracting for services from the private sector. However, in the Department of Health, there is considerable experience tendering for pharmaceuticals from the private sector, and hospitals have experience contracting for a variety of

services from the private sector, including specialist physician services.

There is probably scope for increasing the use of this mechanism. Yet, while there is experience with many forms of contracting for private services, the extent of the practice, its scope, and the forms it takes have not been quantified.

The more obvious linkage of the public sector with the private health sector is the purchase of services, supplies and pharmaceuticals from private firms. Government demand for goods from the private health sector is indicated by government purchases of pharmaceuticals as shown in Table 20. Sales to government increased by around three hundred percent in nominal terms over the past decade: from 213.5 million pesos in 1981 to 858.9 million pesos in 1990. It makes up from 25 percent to 35 percent of total hospital sales and from 3 percent to 6.6 percent of total pharmaceutical sales. Table 21 shows how the share of government sales has fluctuated within these ranges over the past ten years.

**Private Insurance and Employer-Based Plans**

Except for Medicare, third party payment is not well-developed as a financing mechanism. Private health insurance (including HMOs) payment is estimated to account for less than one

percent of health care expenditures. But the health insurance industry is one sector where private development prevails. On the supply side, its development is shaped by the financing and regulatory climate. From the demand side, its growth and prospects are largely functions of the development of employer-provided benefits and its interface with Medicare and other health care providers, particularly hospitals.

**The Private Health Insurance Market and Regulatory Environment**

The private sector in the health insurance market is currently composed of commercial indemnity health insurance (HI) and health maintenance organizations (HMOs).

**Commercial Indemnity Health Insurance.**

Data for 1987 showed that there were 103 companies involved in offering health and accident insurance in the country (Table 22). This latest figure is less than the number of companies operating in 1975. Health insurance is offered by both life and non-life companies. The industry is dominated by domestic non-life insurance companies. Group health insurance is the most common offering and the value of insurance sold in 1988 is 2.5 times that of the value for individual health insurance. There is no data on enrollment. But data submitted to the Insurance Commission showed that nominal gross premiums grew at an average of 20 percent between 1974 to 1988. Gross risks, representing the potential amount in benefit payments

that companies are committed to their clients, grew at an annual average rate of 24 percent during the same period. In 1988, for every one peso earned in premiums, 51 percent or 0.51 pesos were paid out as benefits.

The health insurance component of life and non-life insurance companies is deemed least profitable in overall insurance operations. It is considered by most insurance companies as "sweetener" or "rider" to the life or accident insurance packages offered in the market. Industry sources cite the small market base, competition, pricing and high administrative costs as possible sources of the slow growth of the industry. Regulations are perceived to be non-responsive to the health insurance business per se, as these regulations are largely oriented to the life insurance business. There is a 5 percent premium tax on insurance companies. Those interviewed also cite that the regular 30-day grace period for premium payments is rather long considering that sickness may happen anytime. In addition, provisions on investments favor long-term commitments. But short-term liabilities are incurred for health insurance and therefore health insurance companies should be allowed to make short-term investments.

**Health Maintenance Organizations.** Health maintenance organizations or HMOs are relatively new in the Philippine health care market (Table 23). They do not only insure members against medical expenses but they are also committed to provide members with preventive or outpatient and inpatient medical services, from their own

facilities or with contracted facilities. The actual number of HMOs is in dispute right now, but the figures range from 12 - 16. The source of disparity largely lies in the many different types of HMOs currently operating. There are investor-based, community-based and employer-based HMOs. Investor-based HMOs largely spin from tradi-

**Table 22** Number of Companies Involved in Health and Accident Insurance 1975-1987

Year	Nonlife			Life			Total Number of Companies
	Domes- tic	82 Foreign	11 Total	Domes- tic	10 Foreign	0 Total	
1975							
1976	83	15	98	7	2	9	107
1977	76	13	89	6	0	6	95
1978	85	13	98	7	0	7	105
1979	86	13	99	7	0	7	106
1980	76	12	88	7	0	7	95
1981	81	13	94	7	0	7	101
1982	6	12	18	3	0	3	21
1983	78	13	91	7	0	7	98
1984	78	13	91	7	0	7	98
1985	79	13	92	6	0	6	98
1986	60	11	71	7	0	7	78
1987	82	12	94	8	0	8	102

SOURCE COMMISSION ON INSURANCE

**Table 23<sup>a</sup>** HMOs : Professionals and Facilities, 1989

HMO	Primary Physician	Total Accredited Doctors (MM only)	Hospitals in (out-side) MM	Clinics / MSUs in MM
Blue Cross*	Arrangements**			/ 8
Family Medicare			11 (18)	2 / 21
Family Health Care Plan*			21 (64)	
Fortune Care	10 clinic physicians	94		4 / 19
Health Care and Development	10	150	19 (8)	/ 10
Healthkard Int'l. Inc.	17	89	10 (2)	/ 14
Health Maintenance Inc.	26	app. 400	15 (1)	3 / 13
Health Plan Phils. Inc.	45	165	13 (2)	1 / 19
Caphealth (Intercare)	8	156	9 (14)	/ 7
Lifecare	32	232	10	/ 13
Maxicare	9	135	16 (12)	1 / 9
Medicard	19	235	9	8 satellite / 21
Pamana Golden Care			18 (9)	1 / 16
Philamcare	23	262	16 (12)	5 / 12
St. Patrick's	30 clinic physicians		17 (23)	/ 8
St. Vincent			8	1 / 8
Waterous Medical Corp.	12	92 consultants	8 (5)	7

\*As of 1991.

\*\*Arrangements are made through plan coordinators.

tional indemnity insurance companies and/or from hospitals. Employer-based HMOs are initiated by big companies and formed out of their industrial clinics. Community-based HMOs are largely experimental groups catering to low income groups. Investor-based HMOs dominate the market. The first quarter 1991 figures showed that the total HMO enrolment nationwide comprised roughly .97 percent of the population. The majority of companies and enrollees are based in Metro Manila. The provider network is limited as the common practice is for HMOs to contract with hospital providers (Table 23). Outpatient services are delivered by a smaller network of staff or salaried clinics. The number of accredited hospitals ranges from 8-19, and from 1-13 clinics/medical service units. HMO companies target corporate clients, although there are also benefit packages for individual or family enrollees.

Of the premiums received in 1988, between 55-60 percent of revenues of HMO companies went to medical services expense. High administrative costs of 20 percent, in addition to 15-20 percent brokers' commissions, are considered high and indicate certain market inefficiencies. However, the capital investment requirements, particularly those related to the establishment of outpatient clinics are steep. In 1991, it was estimated that to set up one clinic would require 3 million pesos. Operating through the extensive private provider network seems to be common sense. Industry sources however report difficulty in attracting provider participation. The reasons given range from the need to maintain independence in clinical decisions to the administrative burden involved in tracking down and getting reimbursements for HMO clients. Hence, HMOs work with existing hospitals and establish clinics only in strategic areas. As such, the influence of HMOs in the costs of medical services is minimal, considering that most HMOs hospitals and specialists are on fee-for-service discounted rates. Except for its outpatient benefit package, HMOs and insurance companies set rates at top-off Medicare rates. There is no standard on premium rates and HMOs do not normally explain to clients the assumptions used in the rates. They would normally just compare their prices with current market costs. There seems to be a considerable need for

greater rationalization of operations (marketing, claims processing, utilization review, etc.), and provider and consumer education for the industry to flourish.

Due to its relatively new entry in the health care market, HMOs do not fall under any government agency's regulatory sphere. While life insurance companies are under the jurisdiction of the Insurance Commission, the service delivery and financing components of HMO companies toss them between the Insurance Commission and the Department of Health. The leading HMOs are currently operating through self-regulation. At this stage, to enhance the growth of the industry, public-private sector collaboration can undertake information and education campaigns on risk and risk sharing concepts for providers and consumers. A regulatory framework can lead to the growth and development of the industry in a manner similar to the impact of HMO regulations in the U.S. However, such regulations need to take into account the current health financing environment in the country.

#### Legal Requirements on Employers

In addition to the Medicare program, the government also mandates employers to provide medical and disability benefits through the employee compensation program. In 1989, Medicare members in Metro Manila were offered an experimental HMO-Medicare tie-up program on a voluntary basis. In addition, supplemental health benefits may be provided through company self-insurance or through a private insurance company or HMO. Their provisions are largely offshoots of collective bargaining agreements or, in firms without

unions, through some owner-worker consensus.

Employee coverage is commonly noncontributory; while premiums for dependents are shared between employed and employer. The dominant practice, as identified by various collective bargaining agreement (CBA) surveys, is group hospitalization coverage. HMO-type benefits remain unaffordable to a large number of employers. Corporate arrangements with hospitals are popular as they do not entail admission deposit.

**The Employees Compensation (EC) Program.** The Employees Compensation Commission was established by Presidential Decree (PD) No. 626 which took effect on January 1, 1975. ECC replaced the old Workmen's Compensation Commission. ECC is a compulsory social insurance scheme that gives tax exempt benefits to employees (or their dependents) for work-related disability or death. ECC benefits come in the form of (a) cash income in the case of disability or death (b) medical and related services for injury and sickness and (c) rehabilitation service in case of permanent disability.

Administratively, ECC operates like the Medicare program. ECC is the policy formulating body and is supervised by Department of Labor and Employment (DOLE). SSS and GSIS serve as the collecting and claims processing/paying instrumentalities. Unlike PMCC which sources its institutional budget from the national government, ECC is dependent on SSS (60 percent) and GSIS (40 percent) for its institutional budget.

ECC coverage is compulsory for all employees who are not over 60 years old. An employee beyond 60 years old may also be covered if he had been paying contributions before 60 and has not been compulsorily retired.

As of 1987, ECC covered about 12.2 million workers, of which 10.9 million are SSS members. Total ECC coverage for 1987 represents about 21 percent of the Philippine population. ECC contributions are paid entirely by the employer unlike Medicare where the employee shares 50 percent of the premium. Private employers pay a maximum of 10.00 pesos a month, the government 30.00 pesos.

GSIS paid more benefits in absolute amounts than SSS in 1988: 177 million pesos versus 61 million. From 1975 to 1988, GSIS paid an average of 5461

*"On the demand side, the government most directly affects the private sector through competition from government services for paying patients and through the Medicare system...."*

pesos in benefits per claim, compared to 804 pesos.

**Labor Code Provisions.** Direct provision of medical services are also mandated on employers through the Labor Code. The Labor Code specifies the minimum medical, dental and occupational safety obligations of employers. Specific requirements are set accordingly to the number of employees and the nature of the work, i.e. hazardous or non-hazardous. Requirements range from first aid provisions for companies with less than 200 employees to provisions for a company clinic with full-time or part-time medical staff for hazardous work places with 200 or more employees. Mining companies and large agricultural plantations have set up hospitals for their work force. The Department of Labor monitors employer compliance and provides guidelines on occupational safety.

The major impetus for workers to press for supplemental benefits is the low support value from Medicare. Medicare was initially designed to cover 70 percent of actual costs incurred in a private hospital ward accommodation. However, support values hovered around 30-40 percent for the past decade. Beyond ward accommodations, the value is much more diminished. In addition, the low support value is perceived to be not worth the effort involved in the tedious filing and processing of claims.

#### **Potential for Wider Coverage of Employment-Based Plans**

Employers and employees have not focused much on the issue of health care. Organized labor emphasizes, instead, the basic issues of higher wages and tenure stability. Large companies

which have the resources go into direct service delivery, by setting up their own clinics or hospitals, often beyond that which is mandated. Most companies self-insure, providing for their employees' needs as they arise; or contracting with private providers for easy access for their employees but paying fee-for-service. Traditional indemnity coverage for hospitalization remains the least costly option to employers and employees.

The slow growth in manufacturing and the large agriculture and service sectors limit the potential for wider coverage of employment-based plans. Medicare covers only 20% of the employed. They are not likely to be reached, through their place of employment, by the formal system of Medicare. However, they represent a major pool of resources once tapped.

Employer-provided health benefits enable employees to have better financial access to health services. However, its provision, which are typically made in addition to Medicare and EC, makes for repeated coverage for a smaller group of formal sector workers. Over-insurance to a few and zero coverage for many highlight the inefficiencies of the country's health financing system. The basic coverage provided by Medicare suffices for many as they are constrained by low incomes. The growth of the private insurance sector is largely determined by its demand base.

The private industry can benefit from a consolidation of financial resources for health care. Household and firm resources are weak to play in the market. The single biggest payor is currently the Medicare program. In 1990, cumulative reserves of the Medicare program amounted to 5.2 billion pesos. Benefit payments made in

1990 was 1.1 billion pesos. The EC reserves managed by SSS was 3.9 billion pesos while GSIS had 0.3 billion of EC reserves. The financial performance of the two administering systems, SSS and GSIS, have not been the same for years and this contributes to a dual system of medical care financing. Given the proper mechanisms, private insurance/HMO delivery arrangements can provide greater value for money for the members, and may release resources towards the non-insured. A feasibility study can be made on the benefits of instituting Medicare funds into one health insurance fund and commonly administered by a government corporation. Medicare funds can also be combined with EC funds and the benefit package collapsed into one.

The integration of these health financing funds can provide the impetus for closer private-public sector collaboration in the health care sector. Private sector companies for example can competitively participate in claims processing and/or the provision of benefits. The heavy administrative burden of claims processing and review, and utilization controls can be done more efficiently in the private sector. The government can concentrate on category I type of goods, providing uniform standards of accounting and medical record keeping, promoting management techniques in health care through training and designing quality control mechanisms. Health care financing funds can be used to influence location decisions by physicians and or hospital investment decisions through the design of appropriate mechanisms. The movement towards managed care will be facilitated by an organized system of financing for health care. ■

# 7

## Conclusions and Recommendations

The tables at the end of this conclusion summarize in detail the following discussion. They follow precisely the structure presented by our analytical framework and present a short summary of the findings within each area. For each issue, the table includes the authors' evaluation of its relative importance as a bottleneck to private sector development, a tentative list of policy options, and a list of policy research needs. We develop these key points in this section.

### Major Impediments to Private Sector Development

In terms of the *supply side*, private sector development does not appear to be seriously impeded from an economic standpoint. The private sector in the health care industry was shown to develop from a complete and modern set of regulations providing minimum operating standards. A review of these regulations can be made to strengthen management structures and enhance quality of medical services. The lack of infrastructure and utilities support is conducive to the growth of small, less sophisticated hospital operations engendering an economic and medical organization that is surviving mainly on the wits of its single proprietor/physician owner.

Public sector competition, particularly intensified in the 1980s, posed considerable difficulties to private sector development. Public crowding-out was observed in some provinces. Secondary and tertiary facilities suffered as a result. In terms of *economic and medical organization* of the sector,

private primary and secondary facilities, mere extensions of primary operations, do not have adequate management support unlike the support services provided by the public sector to its facilities. Private tertiary services on the other hand compete through higher-end, high cost staffing patterns.

But the single, major source of instability in the growth of the private medical sector lies on the *demand, or revenue side*. While credit lines maybe available, the application of market rates deter small and big hospital owners alike from availing these loans. Loans servicing becomes a major problem when much of the income depends on individual out-of-pocket payments rather than the more predictable third party payments.

The spillover of indigent patients to the private sector poses considerable strain to private hospital operations. Not only do they create bad press to the private sector, but they also highlight the lack of appropriate mechanisms by which the private sector can access government funds to support activities that realize public goals.

Medicare reimbursement rules do not encourage the development of agglomeration or consolidation of small, low technology health care services into economically efficient and viable enterprises. The payment system favors these low-technology facilities that perform largely preventive services which can cost-effectively be performed outside these facilities. This abets the inefficient use of limited resources.

Low Medicare support value provides the impetus for employers and employees to top-off Medicare coverage with additional coverage from private insurance or health maintenance organizations. However, the

disorganized nature of employment does not provide a conducive environment to the growth of the industry. The market of the industry remains limited to the small, formally employed sector, a group already covered by Medicare and other legally-mandated health benefits. These many minimal coverage mechanisms do not create much impact on employee health seeking behavior nor enhance demand for insurance. Existing managed care organizations do not have the financial and economic sophistication to create an impact on the market.

### Policy Options

While supply side problems appear to be ranked relatively low in importance from an economic perspective, there appears to be a wide scope of indirect public support for the private sector. This type of support would be in general informational or public goods-type activities, such as management, medical, accounting protocols; quality assurance methods; and a labor clearinghouse. This is an unexplored territory. Regulations per se appear not to important stumbling blocks; however, updating is called for in the light of market developments (e.g. manpower) and government reorganization brought about by devolution.

Financial viability and more organized private delivery systems can be made possible through financial incentives and expanded third party payment mechanisms. Financial incentives can come in many forms: capital assistance programs in cooperation with financial institutions; and tax breaks and adequate information thereof, similar to the ones provided to the

educational sector. The organization of private delivery systems can be enhanced by third party mechanisms only in so far as the latter have access to large pooled funds like the Medicare. Efficient claims processing can lower risks of participation in managed care operations to the private sector.

The local government code offers opportunities for policy reforms in the delivery and financing of health services. The use of existing private support facilities can be explored particularly in the light of a short-term breakdown of centralized support from the DOH following the devolution. With its reduced delivery exposure, central public activities can be directed towards the development of geographical, income-based, health-based approaches for targeting government health subsidies in the local public units and in private facilities.

The demand side bears much emphasis. Medicare, despite its small size and problems, is key to financing private sector provision, regulation of quality, organization of the private sector economically and medically, and providing any goods through the private sector. Medicare can be opened up for private sector participation, especially managed care companies. Activities that can efficiently and effectively be handled by private groups include claims processing, provision of benefits (outpatients, rehabilitation/domiciliary, medical ancillary services, etc.) on capitation or other contractual arrangements, management information systems and other support services.

The use of the private sector, especially managed care organizations, in expanding Medicare and other public services can improve the beneficiary base of Medicare. Companies willing to take on under-served areas or beneficiaries can be provided with financial incentives to do so.

The growth of and the development of pluralistic ownership in managed care organizations can be promoted through appropriate regulations, incentives and sponsorships. A regulatory framework can be used to enhance the growth of HMOs as similarly done in the U.S. by the HMO acts.

Cost recovery programs in the public sector and systematic arrangements in contracting for private sector services can minimize public sector competition. There is scope for reduc-

tion of subsidies in the public sector for high income and Medicare patients.

The system of incentives called for in the paper can be made possible through the establishment of a large pooled fund for health care financing. The many small mandatory and employment-based coverage cannot effect much change in the delivery system, much less rationalize its organization and extend its coverage to other groups. The consolidation of mandatory health funds can enhance risk sharing mechanisms through the private sector. It provides a more promising alternative to the current Medicare set-up; one which offers greater possibilities of expanded beneficiary base and benefits.

## What More Must Be Known To Make Policy Decisions?

Much of the work reviewed in this paper can and should be extended in a more rigorous manner to quantify policy options in private sector development. There is much to be done from a cross country perspective and in within countries to move from the stage of talking about private sector development in the service of public health goals to doing something about it.

We only touched the tip of the iceberg. The last column of the tables for this section point to some of the research questions that need to be addressed to effect greater private sector participation, especially in health financing reforms. The issues range from strengthening public sector roles in category 1 and 2 activities to knowing more about private sector response to alternative incentives structure. There is a need to know more how the private sector will react to various changes in public sector performance. There is a need to know more about private sector operations and performance, its cost structures, and the efficiency of its management organization. The medical sector is one area of study which best highlights the nature of public-private interactions.

There has never been an opportune time to re-examine the role of the public sector vis-a-vis the private sec-

tor than now. The public sector in health care is no longer the monolith Department of Health, but a system of centralized and locally-funded institutions. Its role has been reduced in service delivery and enhanced in policy development, regulatory functions and supporting positive actions in health care.

The private sector, while expanding largely out of uncoordinated decisions, have performed a substantial role in medical services. It is a highly diverse group, ranging from hospitals to small community health plans. We don't know much about the operations of these groups, especially those operating from local levels. Its development has been largely affected by the Medicare program, and its future will be shaped by the development of improved payment mechanisms. Approached by clients in a nonsystematic fashion, largely without referrals and paid out of pocket, it is currently suffering from a weak client base and high cost of operations as a combined result of macroeconomic developments and lack of third party payment options.

This study is a modest attempt to bring to bear on policy decisions a conceptual framework on public and private roles and interactions in the medical sector. This conceptual framework was used to define and organize a short-term and inexpensive secondary data collection effort in the Philippines that does not answer the question of how the public sector can facilitate private sector development but does assemble enough information to make initial priorities among areas to consider for action.

As a direct result of this study, follow-up work is now proceeding on a feasibility study of providing outpatient benefits under the Medicare system. The expectation is that this policy change will reduce the distorting effects of the inpatient benefit on the structure of the private sector by discouraging the operation of small hospitals to qualify physicians to collect inpatient benefits for their clients. In addition, preventive and family planning services are included in the study to find out whether they would create a net cost savings for the system, to help the DOH better target its inadequate subsidies for those services to non-Medicare eligibles, and to elicit a supply response from the private sector in producing Category 2 services. ■

**Table 24** Summary of Findings, Options for Policy, and Research Matrix : Demand or Revenue Side of the Private Medical Care Sector

Possible Government Interventions / Importance	Findings	Policy Options	Research Issues
<b>Individual Demand and Out-of-pocket Financing of Health Care Purchases</b>			
<ul style="list-style-type: none"> <li>•Subsidies for indigents</li> <li>•Low importance</li> </ul>	<ul style="list-style-type: none"> <li>•Public hospitals: 70% of beds; private hospitals 10%; some extra compensation.</li> </ul>	<ul style="list-style-type: none"> <li>•All risk of losses for emergency patients is on private provider; consider sharing risk between government and private providers.</li> <li>•Consider converting current subsidies to patients through allocations to facilities (principally public facilities) into subsidies directly to patient.</li> <li>•Alternative public policies to improve the health of the poor.</li> </ul>	<ul style="list-style-type: none"> <li>•Quantify importance of nonpay regular and emergency patients; develop options for public-private cooperation that minimize moral hazard and cost escalation effects.</li> <li>•Investigate options for using insurance (MedicareII?) to solve this problem by subsidizing patients directly.</li> <li>•Investigate applicability of reforms in UK to Philippine public system. Investigate applicability of Korean and Thai approaches.</li> <li>•What are tradeoffs between investing in public health to reach poor and investing in curative services to reach poor?</li> </ul>
<ul style="list-style-type: none"> <li>•Public sector competition</li> <li>•High importance</li> </ul>	<ul style="list-style-type: none"> <li>•Large public and private systems overlap; 1989 hospital plan seeks cooperation between sectors; public crowding out in some provinces. Competition from public sector a particular problem for secondary and tertiary hospitals with high fixed costs.</li> </ul>	<ul style="list-style-type: none"> <li>•Focus government's curative spending to compensate for private market failure; develop geographical, income-based, health-based approaches to targeting government health subsidies. Consider options for reallocation of public budget out of curative services.</li> <li>•Reduction of subsidies in public sector for high income and Medicare patients to reduce subsidized public sector competition for these patients. (This does not mean that the private sector should face no price competition from the public sector, only that public subsidies be targeted to patients who would otherwise have difficulty paying).</li> </ul>	<ul style="list-style-type: none"> <li>•Development of data base for provincial-level targeting of DOH subsidies.</li> <li>•Development of cost-benefit rankings of alternative policies for given provincial health problems.</li> <li>•Investigation of political issues determining public sector subsidies and how to realign priorities.</li> <li>•Analysis of options for aggressive cost recovery in public hospitals. Determination of the current distribution of subsidies from the public sector and how it would change under cost recovery.</li> </ul>
<ul style="list-style-type: none"> <li>•Assistance to create risk-sharing mechanisms</li> <li>•High importance</li> </ul>	<ul style="list-style-type: none"> <li>•Poorly developed risk sharing despite well-institutionalized Medicare system and high out-of-pocket payments.</li> </ul>	<ul style="list-style-type: none"> <li>•The public sector is already heavily involved in risk sharing through its direct delivery system. By charging little or nothing, it is providing stop-loss insurance. Someone can always leave a private hospital for a free public ward. However, the insurance is tied to use of public facilities. Are there alternatives?</li> </ul>	<ul style="list-style-type: none"> <li>•Estimate alternative effects and costs of direct government services versus extending services through private sector and converting public direct-service subsidies into financially-based insurance.</li> </ul>
<b>Public Sector Insurance and Risk-Sharing (Medicare)</b>			
<ul style="list-style-type: none"> <li>•Reimbursement rules</li> <li>•High importance</li> </ul>	<ul style="list-style-type: none"> <li>•Support value extremely low, reimbursement rules distort private sector</li> </ul>	<ul style="list-style-type: none"> <li>•Reduce the copayment required of patients to relieve them of more of the risk.</li> <li>•Expand delivery of Medicare services</li> </ul>	<ul style="list-style-type: none"> <li>•Assess cost of changing the Medicare benefit schedule to reduce copayments, taking into account resulting cost escalation.</li> </ul>

**Table 24** Continuation

Possible Government Interventions / Importance	Findings	Policy Options	Research Issues
<ul style="list-style-type: none"> <li>• Beneficiary base</li> <li>• High importance</li> </ul>	<p>development and out/inpatient service choices.</p> <ul style="list-style-type: none"> <li>• Expansion to informal sectors and rural residents is the next step.</li> </ul>	<p>through HMOs and other managed care organizations.</p> <ul style="list-style-type: none"> <li>• Develop grouping mechanisms or public-subsidy approaches to expanding coverage of Medicare.</li> </ul>	<ul style="list-style-type: none"> <li>• Carefully evaluate the Medicare-HMO tie-up on medical and economic results.</li> <li>• Consider U.S. legal and policy approaches in early 1970s, plus current proposals, to creating incentives for prepaid care. Consider approaches in Canada, U.K. to solving similar problems.</li> </ul>
<ul style="list-style-type: none"> <li>• Speed of payment</li> <li>• High importance</li> </ul>	<ul style="list-style-type: none"> <li>• SSS : improving.</li> <li>• GSIS : troublesome.</li> </ul>	<ul style="list-style-type: none"> <li>• Options for consolidation and computerization.</li> <li>• Options for contracting data processing to private sector.</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluate coverage-expanding options (especially in rural areas), including costs, administrative requirements, source of revenues, effects on cost escalation, etc.</li> <li>• Cost-effectiveness of options.</li> <li>• Strategic plan for solving the problem.</li> </ul>
<ul style="list-style-type: none"> <li>• Regulations</li> <li>• Low importance</li> </ul>	<ul style="list-style-type: none"> <li>• Licensing by both DOH and Medicare is redundant.</li> </ul>	<ul style="list-style-type: none"> <li>• Consolidate.</li> </ul>	<ul style="list-style-type: none"> <li>• Action plan.</li> </ul>
<b>Private Sector Insurance</b>			
<ul style="list-style-type: none"> <li>• Insurance industry regulation</li> <li>• Medium importance</li> </ul>	<ul style="list-style-type: none"> <li>• Gamboa report.</li> <li>• HMOs tend to be for-profit, organized by insurance companies or providers.</li> </ul>	<ul style="list-style-type: none"> <li>• Gamboa report.</li> <li>• Sponsorship, incentives, regulations favoring more pluralistic ownership for managed and prepaid care organizations.</li> </ul>	<ul style="list-style-type: none"> <li>• Gamboa report.</li> <li>• Comparative information from other countries, investigation of how to create incentives for competition and varied forms of ownership of prepaid services.</li> </ul>
<ul style="list-style-type: none"> <li>• Tax treatment of premium payments</li> <li>• Low importance</li> </ul>	<ul style="list-style-type: none"> <li>• Gamboa report.</li> </ul>	<ul style="list-style-type: none"> <li>• Gamboa report.</li> </ul>	<ul style="list-style-type: none"> <li>• Gamboa report.</li> </ul>
<b>Direct Purchases by Government</b>			
<ul style="list-style-type: none"> <li>• Contracts for goods and services</li> <li>• Medium importance</li> </ul>	<ul style="list-style-type: none"> <li>• Pharmaceutical procurement, construction.</li> </ul>	<ul style="list-style-type: none"> <li>• Consider options for using private sector to deliver services, both curative and public health.</li> </ul>	<ul style="list-style-type: none"> <li>• Select a priority list of public activities that could be performed by the private sector; analyze costs of benefits (both short and long term) of contracting out.</li> <li>• Develop or adapt from existing practices in the Philippines and other countries approaches to contracting with private sector for services receiving high priority for contracting out.</li> </ul>

**Table 24** Continuation

Possible Government Interventions / Importance	Findings	Policy Options	Research Issues
<b>Payments by Employers</b>			
<ul style="list-style-type: none"> <li>• Employment-related coverage law</li> <li>• High importance</li> </ul>	<ul style="list-style-type: none"> <li>• Many formal sector employers are topping up Medicare and EC coverage.</li> </ul>	<ul style="list-style-type: none"> <li>• Why is Medicare inadequate, define politically feasible options for improving it.</li> <li>• Consolidate health funds contributions from employers and employees (ECC, Medicare; SSS, GSIS) for expanded benefit options and private sector participation.</li> </ul>	<ul style="list-style-type: none"> <li>• Cost out impact on private employers of topping up Medicare coverage relative to adequate Medicare coverage.</li> <li>• Define policy options : improvement of Medicare, centralized administration of a portable premium, choice between Medicare and other plans, one health fund, etc. Costs and benefits of alternatives.</li> </ul>

PRC = Professional Regulation Commission  
 Gamboa Report = Rhais M. Gamboa (1991) Background Paper on Health Insurance in the Philippines USAID Contract 389-0249-C-00-1089-00 May

**Table 25** Summary of Findings, Options for Policy, and Research Matrix :  
Economic and Medical Organization of the Private Medical Care Sector

Issues in Structure and Performance / Importance	Findings	Policy Options	Research Issues
<ul style="list-style-type: none"> <li>• Medical care and service quality</li> <li>• High importance</li> </ul>	<ul style="list-style-type: none"> <li>• Private sector tertiary care services are sophisticated and well organized. Secondary services less formal and mixed quality. Some operate as extended primary hospitals. Primary hospitals are problematic. Public sector mimics private sector but has more organizational depth.</li> </ul>	<ul style="list-style-type: none"> <li>• This is an area for innovative public action to improve quality of low-level unsophisticated services : (a) development of financial procedures and accounting systems (possibly related to Medicare), (b) development of standard medical protocols (related to Medicare?), (c) training programs for private sector professionals, (d) possible bulk purchasing operations for inputs.</li> </ul>	<ul style="list-style-type: none"> <li>• These activities are new and exploratory. How have other countries handled the problem? Development of freely available protocols to facilitate standardization of medical records, financial records, treatment protocols for common procedures. Development of appropriate training programs. Evaluation of costs and benefits, on an experimental basis, of such activities to improve the quality of care in public and private sectors.</li> </ul>
<ul style="list-style-type: none"> <li>• Economic (prices and quantities)</li> <li>• Low importance</li> </ul>	<ul style="list-style-type: none"> <li>• Private sector <i>service</i> prices have risen more slowly than general price level. However, drug prices are relatively high and have increased faster than general prices.</li> </ul>	<ul style="list-style-type: none"> <li>• Any expansion of insurance, especially of Medicare as reimbursement is currently structured, will cause price escalation. Although inflation is not a serious problem today, this situation could easily change.</li> </ul>	<ul style="list-style-type: none"> <li>• Investigate components of prices -- nontraded labor inputs, drugs purchased from abroad, drugs produced locally, equipment and supplies, new technology, constructions costs, etc. What has changed over the last 20 years, how have policies affected prices, what policies indicated for the future? Where do the problems lie?</li> </ul>
<ul style="list-style-type: none"> <li>• Organization : simple or complex?</li> <li>• Low importance</li> </ul>	<ul style="list-style-type: none"> <li>• Larger hospitals are complex organizations, smaller secondary and all primary tend to be small proprietorships.</li> </ul>	<ul style="list-style-type: none"> <li>• Financial incentives for more sophisticated operation (e.g. four competing primary hospitals combine into a single secondary).</li> </ul>	<ul style="list-style-type: none"> <li>• Study costs of delivering services in small hospitals, potential sources of economies of scale and improved quality to larger operations. Policy options for encouraging more sophisticated services -- are there economies of scope and scale, especially for smaller operations? Implications may be for higher or lower costs.</li> </ul>
<ul style="list-style-type: none"> <li>• Potential for development of managed care</li> <li>• High importance</li> </ul>	<ul style="list-style-type: none"> <li>• Medicare-HMO tie-up indicates that even the top managed care organizations lack financial, contractual, and economic characteristics sophisticated managed care organizations.</li> </ul>	<ul style="list-style-type: none"> <li>• Medicare rules, e.g. requirements for binding contracts with providers, minimal accounting systems, etc. can force quick improvements in operation of HMOs.</li> </ul>	<ul style="list-style-type: none"> <li>• Investigation of how risk is being handled in HMOs currently and options for improving the management of risk. Are there Medicare options for reducing prepaid plans' exposure to risk through the Medicare system, allowing them to offer enhanced services? What quid pro quos could be exacted for improved service delivery?</li> </ul>
<ul style="list-style-type: none"> <li>• Development of specialized support services</li> <li>• Low importance</li> </ul>	<ul style="list-style-type: none"> <li>• Unclear the extent to which labs, radiology services have developed. Pharmaceutical industry well developed.</li> </ul>	<ul style="list-style-type: none"> <li>• Use of private laboratories and radiology services by the public sector, especially by local government facilities.</li> </ul>	<ul style="list-style-type: none"> <li>• Options, costs, benefits for contracting out such services.</li> </ul>
<ul style="list-style-type: none"> <li>• Financial organization</li> <li>• High importance</li> </ul>	<ul style="list-style-type: none"> <li>• Shaky finances.</li> </ul>	<ul style="list-style-type: none"> <li>• Development of insurance financing for catastrophic care, assistance as above for financial and medical management of private services.</li> </ul>	<ul style="list-style-type: none"> <li>• Financial analysis of sample of private clinics and hospitals to determine why they have problems -- episodic disasters due to inadequate working capital, constant problems due to unpaid bills, Medicare-related problems due to slow and inadequate payment, endemic problems due to weak management?</li> </ul>

**Table 26** Summary of Findings, Options for Policy, and Research Matrix :  
Supply Side Public-Private Interactions and the Private Medical Care Sector

Possible Government Interventions / Importance	Findings	Policy Options	Research Options
<b>Labor</b>			
<ul style="list-style-type: none"> <li>• Training and licensing</li> <li>• Low importance</li> </ul>	<ul style="list-style-type: none"> <li>• No constraints; tax incentive for hospitals to open professional schools. High staff turnover at tertiary level. Little or no in-service training. Licensing system cannot track professionals because it is issued only once in a lifetime. No knowledge of level, growth, or location of personnel except through PMCC reporting and DOH reporting, which are incomplete.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop methods to track personnel in order to understand distribution of services, redundancies between public and private sectors, high priority areas for public services.</li> <li>• Assist professional societies to develop in-service training programs for private sector personnel, consider requiring periodic renewal of license as a method to keep an up-to-date roster of personnel. No need to bring training into the public sector -- help to develop RFPs or contractual arrangements to provide a market for in-service medical training.</li> </ul>	<ul style="list-style-type: none"> <li>• Create inventory of professional personnel. Develop data base and methods to keep it up-to-date.</li> <li>• Develop training programs and licensing procedures. Investigate approaches used in other countries. Identify sources of private sector funding for such programs.</li> </ul>
<ul style="list-style-type: none"> <li>• Malpractice laws</li> <li>• Low importance</li> </ul>	<ul style="list-style-type: none"> <li>• PRC discipline, civil and possible criminal liability.</li> </ul>		<ul style="list-style-type: none"> <li>• Quantify importance, estimate trends, consider options for future.</li> </ul>
<ul style="list-style-type: none"> <li>• Employment and staffing regulations</li> <li>• Low importance</li> </ul>	<ul style="list-style-type: none"> <li>• Major issue is staffing requirements for licensing and Medicare approval. Ratios not economically efficient for small facilities</li> </ul>	<ul style="list-style-type: none"> <li>• Consider relaxing quantity requirements on labor; e.g., is a full pharmacist required or is the goal satisfied by the requirement that some amount of pharmacist's time be available for each bed-day?</li> </ul>	<ul style="list-style-type: none"> <li>• Investigate options for achieving desired regulatory goals using rules that allow operators to achieve economically efficient use of inputs.</li> </ul>
<b>Equipment and Supplies</b>			
<ul style="list-style-type: none"> <li>• Import restrictions</li> <li>• Low importance</li> </ul>	<ul style="list-style-type: none"> <li>• Appear to be no quantity restrictions on imports, but duties may be a problem (see next category).</li> </ul>		
<ul style="list-style-type: none"> <li>• Import taxes (tariffs)</li> <li>• Low importance</li> </ul>	<ul style="list-style-type: none"> <li>• Appears not be a problem, but it is an issue to private sector. Donated items to primary and secondary private hospitals are exempt from duties. In practice, all imports of these hospitals are granted duty free privileges. Tertiary teaching hospitals have duty free privileges. Apparently tertiary non-teaching hospitals must pay duty. 90% of pharmaceuticals are</li> </ul>	<ul style="list-style-type: none"> <li>• Develop options for reducing pharmaceutical costs and reducing distortions caused by possibly unequal duties on different types of medical institutions.</li> <li>• Develop public information for medical professionals about the regulations and border taxes for which they are liable. Reduce apparent discretion of customs agents.</li> </ul>	<ul style="list-style-type: none"> <li>• Investigate the tax paid on domestically produced pharmaceutical products whose ingredients (and possibly packaging) are taxed at the border.</li> <li>• Investigate the actual treatment of imports by different types of institutions (e.g. private tertiary teaching hospitals versus non-teaching hospitals). Effects on input decisions.</li> </ul>

**Table 26** Continuation

Possible Government Interventions / Importance	Findings	Policy Options	Research Options
<ul style="list-style-type: none"> <li>•Certificate of need</li> <li>•Low importance</li> </ul>	<p>domestically produced, but there are duties on ingredients.</p> <ul style="list-style-type: none"> <li>•Excess investment in capital seems not to be an issue; in fact, low investment is of greater concern. Note : in U.S. the impacts of the certificate of need approach have been criticized.</li> </ul>	<ul style="list-style-type: none"> <li>•Problems in over-investment in capital will result from improved third-party financing that rewards such investments. Design programs to prevent distortions of incentives rather than requiring future certificate-of-need legislation and the resultant quantity restrictions.</li> </ul>	<ul style="list-style-type: none"> <li>•Cross national investigation of approaches to capital investment decisions in the health sector.</li> </ul>
<b>Financial Capital</b>			
<ul style="list-style-type: none"> <li>•Credit rationing</li> <li>•Medium importance</li> </ul>	<ul style="list-style-type: none"> <li>•Some credit is available, but most investment seems to be self-financed. Public credit windows closed in mid-1980s. Compete with other sectors for credit at market rates. Result is slow expansion, inadequate working capital, investment in only the activities with the very highest rate of return.</li> </ul>	<ul style="list-style-type: none"> <li>•Credit problems are partially caused by demand-side financing problems and poor management of medical institutions. Develop demand side interventions first, then observe whether supply side financing problems disappear.</li> <li>•In rural areas, however, credit scarcity may be a serious problem. Targeted government assistance may be warranted.</li> </ul>	<ul style="list-style-type: none"> <li>•Investigate the effects of credit availability on investment in the private sector. Also investigate effects of credit availability on working capital in private hospitals.</li> <li>•Case studies of hospitals that have had financial problems or have gone out of business, and of hospitals that have few or no financial obligations. What is the role of credit conditions in determining failure and success? What assistance would be merited? What is the relative access to, and importance of, credit for urban and rural hospitals?</li> <li>•How do credit conditions affect the ability of prepaid plans to operate effectively? Again, a case study approach may be warranted.</li> </ul>
<ul style="list-style-type: none"> <li>•Barriers to foreign capital or investors</li> <li>•Low importance</li> </ul>	<ul style="list-style-type: none"> <li>•Some restrictions apply as to other sectors : 40% foreign ownership allowed except limited categories allowing 100% temporarily (parenteral therapy, herbal medicines, other pharmaceuticals).</li> </ul>	<ul style="list-style-type: none"> <li>•Possible foreign ownership allowed in areas where local competition, management, or organizational skills are problematic. Such areas might be managed care, insurance billing systems, actuarial services, medical reinsurance, benefit plan development.</li> </ul>	<ul style="list-style-type: none"> <li>•Examine cross national experience in using foreign investment to "jump start" new institutional or market activities. Assess need, if any, in the Philippines. Identify firms with specialized skills, especially those including Filipinos working overseas.</li> </ul>
<b>Physical Plant</b>			
<ul style="list-style-type: none"> <li>•Facility licensing requirements</li> </ul>	<ul style="list-style-type: none"> <li>•Well established licensing procedures in DOH. However, PMCC also</li> </ul>	<ul style="list-style-type: none"> <li>•Is some sort of rationalization of the two systems feasible and desirable?</li> </ul>	<ul style="list-style-type: none"> <li>•Costs and benefits of the separate licensing requirements.</li> </ul>

Table 26 Continuation

Possible Government Interventions / Importance	Findings	Policy Options	Research Options
<ul style="list-style-type: none"> <li>•Low importance</li> </ul>	<p>accredits hospitals for Medicare. Some redundancy.</p>	<ul style="list-style-type: none"> <li>•Use Medicare reimbursement or tie-up mechanisms for service delivery in these areas.</li> </ul>	<ul style="list-style-type: none"> <li>•Feasibility study for Medicare tie-up with private groups for capitation program in remote/unserved/under-served areas.</li> <li>•Development of location-based criteria for capitation program.</li> </ul>
<ul style="list-style-type: none"> <li>•Location restrictions</li> <li>•Low importance</li> </ul>	<ul style="list-style-type: none"> <li>•Potential for incentives to encourage service in under-served areas.</li> </ul>		

## Notes

- 1 This section is adapted from Griffin (1992).
- 2 The trend line reflects the experience for all countries in the world, not just this group.
- 3 A recent estimate for 1988 by the University of the Philippines / Research Triangle Institute team (Solon et al. 1991) suggests that overall spending in the Philippines was much lower than the 2.4 percent of GNP estimated in Griffin (1992) and lies somewhere between 1.7 and 1.9 percent of GNP.
- 4 Using Solon et al. (1991), these figures would be \$3.75 from government, plus between \$6.00 and \$7.40 from combined private and insurance expenditures.
- 5 Less than 7 percent of total spending in 1988 is estimated to be accounted for by insurance : 5 percent by Medicare and 2 percent by private insurance (Solon et al. 1991).
- 6 Solon et al.'s estimate of 50 percent private spending would put the Philippines about in the middle of the list.
- 7 The solid line is for the whole sample. The dashed line removes the high spenders (Korea and Malaysia). The dotted line removes the outliers at the lower end (Bangladesh and Nepal). The discussion in this section refers to predicted spending without Bangladesh and Nepal, which are much poorer than the other countries in the sample.
- 8 Of course this report will delve into this issue in more depth in subsequent chapters.
- 9 The technical and administrative standards for operations are provided by the Department of Health (See Appendix 1 for a discussion on government classification).
- 10 The figure includes those who are in private practice but affiliated with hospitals. There is no count of those who are in private practice with no hospital affiliation.
- 11 The Department of Health will transfer the majority of its hospitals to the local governments and will retain only the regional and specialty hospitals and medical centers by December 1992.
- 12 Drug Association of the Philippines, a position paper on the Pharmaceutical Industry, Jan. 1988, p. 10.
- 13 Program II, Sec. 27 (Second paragraph), Phil. Medicare Act of 1969.
- 14 Integrated Health Care Services, Inc. (Intercare) and PCI Management Consultants, Inc. Integrated Report : Eight DBP-Financed Hospitals, January 1982.
- 15 The discussion below on Medicare suggests that Medicare contributes to this situation.

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## Appendix 1

### Regulatory Framework

A discussion on the private sector in medical care cannot be complete without an understanding of the regulatory framework under which the sector operates. Data for the study of the regulatory environment in the private medical care sector were compiled from existing laws and statutes as well as pertinent government regulations. Interviews with government officials concerned and knowledgeable private individuals were conducted whenever further clarification was needed.

The government regulatory framework for private sector participation in the health care sector is shaped by the following forms of legislation.

1. Executive Order 119 vests regulatory functions in the Department of Health (DOH).
2. The requirements of the Hospital Licensure Act as well as Medicare accreditation set down parameters for health care providers.
3. Health care professionals are subject to professional regulations.
4. Malpractice Regulations.
5. Pharmaceutical firms have to follow the Generic Law.
6. Import restrictions affect the entry of inputs of the health care industry into the country, while the Omnibus Investments Code imposes a limit on foreign investments.

The recently enacted Local Government Code, while directly affecting the organization of the public health and hospitals delivery system alters the government regulatory framework and is seen to have far-reaching implications on the private sector, in so far as the latter are responsive to public sector reforms and local government health initiatives.

The discussion below provides an overview of the provisions of each of the pertaining laws and regulations.

#### 1. GOVERNMENT REGULATORY FRAMEWORK

##### A. Executive Order (EO) 119

Up until the finalization of the Department of Health's reorganization plan under the new administration and in the spirit of the Local Government Code of 1991, Executive Order (EO) 119 sets the regulatory role and functions of the Department of Health. Executive Order 119 reorganized the Department of Health and its attached agencies in 1987. It also vested in the DOH the following three functions pertinent to regulation:

- administer all laws, rules and regulations in the field of health, including

quarantine laws and food and drug safety laws;

- regulate the operation of and issue licenses and permits to government and private hospitals, clinics and dispensaries, laboratories, blood banks, drugstores and such other establishments which by the nature of their functions are required to be regulated by the Department;
- issue orders and regulations concerning the implementation of established health policies.

More specifically, the unit in the Department directly involved in regulation is the Office for Standards and Regulation. Per Section 13 of the EO, the Office for Standards and Regulation, headed by a Deputy Secretary and supported by an Assistant Secretary shall include three bureaus and one national office. It is responsible for the formulation of regulatory policies and standards over the various areas of concern in the health sector. Implementation remains the general responsibility of the Department's regional field offices.

The same bureaus are also responsible for providing the Secretary with current information on the status of these regulated areas of activity as well as a basis for preliminarily evaluating the efficiency of the Department's field offices in performing their regulatory functions. The same bureaus shall conduct studies and research pertinent to their areas of responsibility. In certain instances the bureaus may also perform consultative, training, and advisory services to the practitioners and institutions in the areas of regulated activity. These bureaus and national office follow.

##### Bureau of Research and Laboratories

(BRL). The Bureau of Research and Laboratories develops and formulates plans, standards, and policies for the establishment and accreditation and licensing of laboratories, blood banks and entities handling biological products. It also provides consultative, training and advisory services to public and private laboratories; and conducts studies and research related to laboratory procedures and operations.

**Bureau of Food and Drugs (BFAD).** The Bureau of Food and Drugs acts as the policy formulation sector and monitoring arm of the Secretary on matters pertaining to foods, drugs, traditional medicines, cosmetics and household products containing hazardous substances. It prescribes general stand-

ards and guidelines with respect to the veracity of nutritional and medicinal claims in the advertisement of food, drugs and cosmetics in the various media. It is also responsible for monitoring such advertisements and advising the Department's field offices about offenses.

The Bureau provides consultative, training and advisory services to all agencies and organizations involved in food and drug manufacturing and distribution with respect to assuring safety and efficacy of food and drug safety measures, and is mandated to maintain a corps of specially trained food and drugs inspectors for assignment to various field offices of the Department.

**Bureau of Licensing and Regulation.** The Bureau of Licensing and Regulation formulates policies and establishes the standards for the licensing and regulation of hospitals, clinics and other health facilities. It establishes standards that serve as the basis of inspections and licensure procedure of the Department's field offices. It also provides consultative, training and advisory services to field offices on the conduct of licensing and regulatory functions over hospitals, clinics and other health facilities.

**National Quarantine Office.** The National Quarantine Office formulates and implements quarantine laws and regulations. Its functions include supervision over rat-proof zones in designated international ports and airports, and over medical examination of aliens for immigration purposes.

#### B. The Hospital Licensure Act and Medicare Accreditation

The Hospital Licensure Act was passed on June 19, 1965. It required the licensure of all hospitals in the Philippines and authorized the Bureau of Medical Services to serve as the licensing agency.

The latest and current version of the act takes the form of an Administrative Order (AO), passed in 1989, entitled "Revised Rules and Regulations Governing the Registration, Licensure and Operation of Hospitals in the Philippines." Designed to be consistent with EO 119, the Reorganization Act of the Department of Health, the AO vests licensing and regulatory functions in the Office for Standards and Regulation of the Bureau of Licensing and Regulation.

No hospital, whether public or private, may operate without a proper

and valid license issued by the Bureau. A license is defined as a formal authorization issued by the DOH to a person, association, partnership, or corporation to operate and maintain a hospital including its ancillary medical services, such as pharmacy, laboratory, radiology, and other health services. It is renewed yearly.

As a requirement to licensing, all hospitals are required to demonstrate compliance with the following technical standards:

- Personnel - adequate staffing by qualified and trained personnel with physicians and professionals licensed in their respective fields and by trained non-professionals.
- Equipment/Instruments - necessary equipment/instruments to undertake the required services.
- Physical Facilities - well ventilated, lighted, clean and safe hospital building sufficient to accommodate its activities.

The AO requires a governing authority for each hospital organization. This authority is responsible for the conduct of the hospital as an institution. It also requires a well qualified administrator, director or chief of hospital designated to carry out its policies. Practicing physicians in the hospital are to be organized in order to provide quality patient care. Also, there must be a chief of medical service, or medical director, or an equivalent position to organize, coordinate, and supervise the hospital medical staff.

The AO provides a taxonomy of hospitals: whether government or private; general or special; and primary, secondary or tertiary according to service capabilities offered, and training or non-training. It then proceeds to identify the basic services for each category of hospital:

- Primary: Administrative, Clinical, and Nursing.
- Secondary: Administrative, Clinical, Medical Ancillary Service (Anesthesia, Clinical Laboratory, Radiology, Out-patient, Emergency, Dental, Pharmacy, Medical Records, Medical Social), and Nursing.
- Tertiary: Administrative, Clinical, Medical Ancillary (Anesthesia, Pathology, Radiology, Out-patient, Emergency, Dental, Pharmacy, Medical Records, Medical Social), and Nursing

The AO also translates the technical requirements for each category. Personnel are detailed in terms of administrative, clinical (medical), and nursing by qualification (e.g., percent professional, licensed, or registered) as well

as by bed capacity and ratio to number of beds. Equipment and instruments are identified according to required services of the category. Specific sections are given for the physical plant.

Procedures, with corresponding checklists, are given in the AO for the application to construct/expand/renovate a hospital, application for license to operate a new hospital, application for renewal of license to operate a hospital, application for change in category, application for an increase in bed capacity, and application for inspection of hospital prior to issuance of license to operate a new hospital.

**Medicare Accreditation.** Over and above licensure, hospitals, physicians and dentists are also subject to another mandated classification: accreditation by the Philippine Medical Care Commission (PMCC). Accreditation is an administrative process whereby PMCC grants the privilege to qualified hospitals, drugstores, physicians and dentists to participate in the delivery of adequate and standard medical care services under the Medicare program. Mandated by Presidential Decree (PD) 1519, accreditation not only serves as a seal of approval; it also ensures certain segments of the private health care delivery system access to a market that will pay for its services.

**Accreditation of Hospitals.** The three prerequisites for hospital accreditation are:

- it must be duly licensed by the DOH;
- it must be a member in good standing of a national association of government and privately-owned hospitals whose membership comprises the majority of licensed hospitals in the Philippines and with a continuing program for hospital administration and discipline of its members;
- it must have been in continuous operation for the past twelve (12) months prior to accreditation.

The requirements for accreditation generally build on the requirements of the licensure bureau, e.g., prescribed minimum personnel and equipment, and a copy of the current DOH license. To be accredited, the hospital must seek inspection and verification from the Assistant Provincial Health Officer and pay an accreditation fee. For new accreditation, the hospital must also submit its cash flow and audited financial statements for the past year. Accreditation is valid for two years and takes effect upon the date of approval by the Accreditation Committee of PMCC.

Accredited hospitals must warrant the following:

- its eligibility;
- its compliance with Medicare law, its implementing rules and regulations, and Medicare administrative orders;
- proper preparation and filing of Medicare claims;
- safe, adequate, appropriate and standard medical care delivery;
- maintenance of systematic and accurate records;
- cooperation in any hospital inspection/visitations/investigations.

Accreditation may be denied in two cases:

- new accreditation: where there is a saturation of accredited hospitals based on the national bed to population ratio or other standards as may be determined by the DOH; or the hospital does not satisfy the criteria for new accreditation.
- renewal of accreditation: where there is a prima facie evidence of violation of the law and Medicare rules and regulations.

On the other hand, it may be terminated due to:

- change of ownership or management of the hospital;
- change in location of the hospital;
- violation of Medicare rules and regulation or warranties, as recommended by the Hearing Committee of PMCC.

**Accreditation of Physicians and Dentists.**

The prerequisites for accreditation of physicians and dentists are:

- he/she must be duly licensed to practice in the Philippines;
- he/she must be a member in good standing of a national association of government and privately-employed physicians and dentists whose membership comprises the majority of licensed physicians and dentists in the Philippines and with a program of continuing medical education and discipline of its members.

The requirements consist of certifications that the prerequisites are met as well as payment of an accreditation fee. Specialists must also submit a xeroxed copy of certificate of training or membership in a specialty society. Accreditation is approved by PMCC's Accreditation Committee and is valid for a period of three years.

Warranties for medical and dental practitioners consists of:

- eligibility;
- compliance with Medicare law, its im-

plementing rules and regulations, and Medicare administrative orders;

- proper conduct in terms of adherence to the Code of Ethics of the Medical/Dental Profession in the Philippines and the Medical Act of 1959; promotion and protection of the Medicare Program; provision of safe, adequate, standard and appropriate medical care; and charging of reasonable professional fees;
- cooperation in any investigation/inspection/verification.

**C. The Local Government Code of 1991**

The Local Government Code, signed into law during the latter part of 1991, and fully implemented by December 1992, transfers substantial management and regulatory functions to local governments. In the health sector, the management, assets and personnel of all public hospitals, health centers and other basic health services are to be turned over to the provincial and municipal governments. The Department of Health domain is limited to a few retained hospitals, largely the regional medical centers and specialty hospitals. The Code transforms the Department of Health from a largely service delivery agency to a policy and standard setting body, providing technical support, administrative and financial support services to local units. The central office itself will undertake a reorganization. Initially, plans are for the merger of the Office of Standards and Regulation with the Office for Hospitals and Facility Services.

At the provincial and sub-provincial levels, local health boards will be convened to provide over-all guidance to the local units. The local health boards will be convened with public and private sectors.

The private medical sector is expected to be affected by the devolution in the following ways:

1. increased/decreased competition depending upon the extent to which local governments use their new powers to explore new ways of funding and managing their health systems, i.e. users charges, enter into management contracts with private groups, etc.;
2. expanded contracting opportunities for local firms as procurement is localized;
3. increased patient load, albeit largely non-paying, arising the initial breakdown in the public referral network;
4. higher taxes as local units are expected to introduce tax measures to augment local resources.

But the immediate, short-term confusion arising from public health sector reorganization is expected to be outweighed by a more efficient and responsive health delivery system engendered by decentralization. The strengthening of local government units is expected to redound to greater resources and power in the local levels which will benefit all.

**D. Professional Regulation**

The health professions in the Philippines consist of medicine and the allied fields of pharmacy, dentistry, nursing, midwifery, medical technology, nutrition/dietetics, occupational/physical therapy, and optometry. These professions require licensure from the Professional Regulation Commission (PRC) prior to practice. Specific laws and subsequent amendments, including Codes of Ethics, govern professional practice.

**Doctors.** Republic Act (RA) 2382, also known as the Medical Act of 1959, with its subsequent amendments, deal with the standardization and regulation of medical education, the examination for registration of physicians, and the supervision, control and regulation of the practice of medicine in the Philippines. Article III of the amended version states that one has to be at least 21 years of age to practice medicine in the Philippines, has satisfactorily passed the corresponding Board Examination, and is a holder of a valid Certificate of Registration duly issued him by the Board of Medical Examiners.

Doctors in the Philippines are bound by a Code of Medical Ethics that states that the primary objective of the practice of medicine is service to mankind irrespective of race, creed or political affiliation. In its practice, reward of financial gain should be a subordinate consideration. Physicians have duties towards their patients, the community, their colleagues and profession, and allied professionals. Rules and regulations governing the proper practice of medicine, and the conduct of administrative investigations were promulgated in 1968 by the Board of Medical Examiners.

**Pharmacists.** RA 5921 or the Pharmacy Act, and its subsequent amendments, provide for and govern: (a) the standardization and regulation of pharmaceutical education, (b) the examination for registration of graduates of schools of pharmacy, and (c) the supervision, control, and regulation of the

practice of pharmacy in the Philippines. A subsequent PD, PD 1863, contained an amendment designed to give all Filipinos equal opportunities in the pursuit of the pharmacy profession and in the sale of medicine and drugs.

**Dentists.** The dental profession is regulated by the Dental Law, RA 417 of 1949, as well as the Philippine Dental Act of 1965. The latter provides for the (a) regulation, control and supervision of the practice of dentistry in the Philippines, (b) giving of licensure examinations to graduates of recognized dental schools for registration, (c) regulation and standardization of dental education, (d) promotion and development of dental research in the country and (2) stipulation of penalties for infractions or violations.

Presidential decrees have also been providing for the registration and licensing of dental prosthetic laboratories, and requiring practitioners of dentistry to keep patient records. The dentistry profession practices a Code of Ethics which identifies, as the dentist's primary duty, professional service to the public.

**Nurses.** In 1953, the Philippine Nursing Law was passed, creating the Board of Examiners for Nurses, laying down provisions regarding nursing schools and colleges, and prescribing the examination and registration of nurses. Nurses also follow a Code of Ethics which states that the primary responsibility of nurses is to preserve health at all costs. This responsibility encompasses promotion of health, prevention of illness, alleviation of suffering, and restoration of health.

**Midwives.** Midwives are regulated by RA 2644, the Philippines Midwifery Law, which defines midwifery training and practice. Subsequently, the Board of Midwifery promulgated the Code of Ethics for midwives. This states that the primary objective of the midwifery profession is for its members to render service within the scope of their legitimate functions, having in mind that their patients, regardless of religion, social or economic status, deserve respect as human beings.

**Medical Technologists.** RA 5527 requires the registration of medical technologists and defines their practice. This act has been amended by several presidential decrees with respect to sections on the Council of Medical Technology Education, qualifications of examiners, definition of medical technologist, accreditation of schools, etc.

**Allied Professions.** Allied professions are also covered by their respective legislation: RA 768 for dental hygienists; RA 1364 for sanitary engineers; RA 1998 for optometrists; RA 2644 and PD 1286 for nutritionists and dieticians; and RA 5680 for physical and occupational therapists.

#### E. Malpractice

Medical malpractice is an act which violates the Hippocratic oath, the Code of Ethics and the rules and regulations of the Professional Regulation Commission (PRC) as well as existing laws and statutes.

A medical practitioner who commits an act of medical malpractice may be subject to disciplinary action by the PRC. Among the administrative sanctions that may be imposed are censure, warning, suspension from practice or cancellation of license. Decisions of the PRC are appealable before the Supreme Court.

If the act involves civil liability, then the New Civil Code applies. Among the operative articles in cases of malpractice are:

- Article 19 which provides that every person must, in the performance of his duties, act with justice, give everyone his due and act with honesty and good faith;
- Article 20 which provides that any person who willfully or negligently causes damages to another shall indemnify the latter for the same.
- Article 21 which provides that any person who willfully causes injury to another in a manner contrary to custom or morals shall indemnify the latter for the same.

Liability for damages is provided for under the following:

- Actual or compensatory damages. Article 2119 provides that one may be entitled for compensation only for actual loss or damages.
- Moral damages. Article 2217 defines moral damages to include physical suffering, mental anguish, fright, serious anxiety, besmirched reputation, wounded feelings, moral shock, social humiliation and similar injuries. Though incapable of pecuniary approximation, it may be imposed if it is a direct result of the defendant's action.
- Liquidated damages. Article 2226 defines this type of damages as those arising out of a violation of a contract between two parties (e.g., hospital and patient), with either party liable for damages to the other.
- Temperate or moderate damages.

Article 2224 defines this in terms of the situation wherein the loss is proven but the amount of loss is not.

• Exemplary damages are imposed under Article 2229 to serve as an example for the public good to deter further violations of the law.

When criminal liability is present, then the Revised Penal Code becomes operative. The Code applies generally in that it penalizes criminal acts regardless of the defendant's calling. The defendant may be meted a penalty of imprisonment or fine or both.

#### F. The Generic Act

RA 6675 is an act to promote, require and ensure the production of an adequate supply, distribution, use, and acceptance of drugs and medicines identified by their generic names. The law specifies the following users of generic terminology:

- Government health agencies and their personnel as well as other government agencies shall use generic terminology or generic names in all transactions related to purchasing, prescribing, dispensing, and administering of drugs and medicines.
- All medical, dental and veterinary practitioners, including private practitioners, shall write prescriptions using the generic name. The brand name may be included if so desired.
- Any organization or company involved in the manufacture, importation, repacking, marketing and/or distribution of drugs and medicines shall indicate prominently the generic name of the product. In the case of brand name products, the generic name shall appear prominently and immediately above the brand name in all product labels as well as in advertising and other promotional materials.
- Drug outlets, including drugstores, hospital and non-hospital pharmacies and non-traditional outlets such as supermarkets and stores, shall inform any buyer about any and all other drug products having the same generic name, together with their corresponding prices so that the buyer may adequately exercise his option.

The act took effect fifteen days after January 17, 1989 when it was first published in a major publication. The passage of the law was highly controversial, as it pitted the DOH with the private drug manufacturers and the Philippine Medical Association.

There has been no economic evaluation made on the effects on the law. The national survey conducted does

not provide enough material for economic analysis. This is an area for further work. It can examine the impact of the generics law on prices, prescribing behavior, consumer demand for drugs, industry practices, including differences in performance between foreign and domestic firms. Generic labelling was expected to spawn fly-by-night operators. The adequacy of the regulatory framework can be examined.

## 2. SELF-REGULATION AMONG MEDICAL SECTOR GROUPS

In addition to government regulations, hospitals, medical professionals and other health care organizations are subject to certain rules and guidelines set by professional societies and associations with which they are aligned. The channels for self-regulation may be formal or informal. Collegial bodies provide more formal mechanisms on affiliation, as strict entry criteria and testing requirements

are made. Professional societies and industry groups are comprised of members who meet certain minimum criteria and are guided by a code of ethic. Membership in these organizations is voluntary and these organizations operate from membership dues. Professional societies are known to provide continuing education to members.

Perhaps the more widely known organization which considers self-regulation as a serious policy option is the Association of HMOs in the Philippines, Incorporated (AHMOPD). Established in 1987, it attempts to unify all HMOs in the country and to promote operating and ethical standards in an industry which is not under the domain of any government regulatory body. HMOs do not have pure insurance features, therefore, they are not within the jurisdiction of the Office Of the Insurance Commission (OIC). They receive a license to operate from the Securities and Exchange Commission (SEC) only in so far as these firms are business entities. The AHMOPD's stance on self-regulation is limited by

the fact that not all HMOs are members of this organization.

There is a current effort at the legislative level to provide a more formal regulatory framework for HMOs. Government regulations must ensure financial soundness, accountability, and minimum operating practices to ensure quality, as well as look into accreditation mechanisms, practices related to enrolment and pre-existing conditions and grievance procedures.

The extent to which self-regulation can be made truly operational among a diverse group of health care organizations is unclear. But it is precisely in the inadequate response of government amidst this diversity that self-regulation becomes an imperative for an industry largely providing a public service. Self-regulation operating through a system of rewards and sanctions can be made more meaningful if organizations maintain up-to-date databases on their members and their practices, and linked with government information systems. ■

## Appendix 2

### Hospitals by Province

This appendix shows the estimated change in numbers of public and private hospital beds, by province, between 1983 and 1990. Because of difficulty comparing the numbers by hospital, it is not certain how reliable these estimates are. However, they are based on a comparison of the Bureau of Licensing's list for 1983 with that for 1990, so it is as accurate as that list. Overall, the public sector gained 108 hospitals and 7584 beds during the period. The private sector lost 24 hospitals and 2906 beds. Inspection of the table reveals that the loss of private beds and gain of public beds was widely distributed across the country. This situation is in contrast with the experience between 1972 and 1983, when

gains in the private sector far outstripped those in the public sector. This trend is somewhat disturbing in the context of the framework we have developed in the paper. Clearly the public sector has been substituting for private beds over the period.

The table also shows the percentage share of beds and population in each province in 1990. If the beds ratio is divided into the population ratio, we have an index of bed density relative to population, ranging from 0 for no beds to over 1 if the share of beds exceeds the share of population. Provinces with the lowest ratios might merit targeting with public hospital construction or incentives for private construction.

Province	Public Hospital Change 83-90	Private Hospital Change 83-90	Public Beds, Change 83-90	Private Beds, Change 83-90	Percent of Beds 1990	Percent of Population	Beds Relative to Population Ratio
Abra	1	3	-80	50	0.45	0.30	1.49
Agusan del Norte	-1	-3	-10	-162	0.95	0.77	1.24
Agusan del Sur	4	0	35	-30	0.42	0.69	0.61
Aklan	2	1	16	-10	0.41	0.63	0.66
Albay	2	-1	44	-179	1.57	1.49	1.06
Antique	2	1	20	25	0.31	0.67	0.46
Aurora	0	0	0	0	0.08	0.23	0.36
Basilan	2	-1	50	-355	0.20	0.40	0.51
Bataan	-2	1	30	-82	0.61	0.70	0.88
Batanes	0	0	0	0	0.12	0.02	4.84
Batangas	1	-2	32	-55	1.94	2.43	0.80
Benguet	1	-1	25	7	1.41	0.80	1.77
Bohol	3	2	50	154	1.49	1.56	0.95
Bukidnon	-2	12	-20	243	1.05	1.39	0.76
Bulacan	1	3	12	-33	1.64	2.48	0.66
Cagayan	3	-7	75	-140	1.02	1.37	0.75
Camarines Norte	0	-2	0	-45	0.42	0.64	0.65
Camarines Sur	3	-7	245	-187	1.47	2.15	0.68
Camiguin	0	0	25	0	0.17	0.11	1.58
Capiz	0	-2	-5	-66	0.57	0.96	0.59
Catanduanes	1	0	55	0	0.48	0.31	1.56
Cavite	2	2	-165	159	1.15	1.90	0.61
Cebu	9	-4	1257	-11	4.95	4.35	1.14
Davao del Norte	-2	2	-9	241	1.69	1.74	0.97
Davao del Sur	3	19	45	669	3.57	2.44	1.47
Davao Oriental	1	-2	15	-16	0.40	0.65	0.61
Eastern Samar	3	0	20	12	0.49	0.54	0.90
Ifugao	0	1	0	6	0.26	0.24	1.07
Ilocos Norte	0	-4	-25	-212	0.62	0.76	0.82
Ilocos Sur	1	5	-135	92	0.60	0.86	0.71
Iloilo	4	0	510	-155	2.32	2.90	0.80
Isabela	0	-5	0	-72	0.96	1.70	0.56
Kalinga-Apayao	1	-5	50	-59	0.60	0.35	1.71
La Union	0	1	-110	22	0.68	0.90	0.75
Laguna	-1	-4	-120	-130	1.62	2.25	0.72
Lanao del Norte	1	-8	25	-185	0.74	1.01	0.73

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Province	Public Hospital Change 83-90	Private Hospital Change 83-90	Public Beds, Change 83-90	Private Beds, Change 83-90	Percent of Beds 1990	Percent of Population	Beds Relative to Population Ratio
Lanao del Sur	3	3	55	79	0.5	20.99	0.52
Leyte	5	-1	460	-129	1.98	2.61	0.76
Maguindanao	1	4	-140	56	0.52	1.25	0.42
Marinduque	0	0	0	0	0.18	0.31	0.58
Masbate	2	0	25	53	0.62	0.99	0.63
Metro Manila	2	-49	2863	-2426	29.20	13.12	2.23
Misamis Occidental	-1	0	-75	73	1.38	0.70	1.97
Misamis Oriental	3	-4	140	-248	1.24	1.42	0.87
Mountain Province	1	-1	25	-6	0.35	0.19	1.81
Negros Occidental	1	-4	125	-523	2.13	3.71	0.57
Negros Oriental	0	-1	0	-147	0.85	1.52	0.56
North Cotabato	2	36	170	644	1.66	1.26	1.32
Northern Samar	1	0	25	10	0.46	0.63	0.73
Nueva Ecija	2	-3	105	-5	1.19	2.16	0.55
Nueva Vizcaya	1	-3	25	-54	0.38	0.50	0.77
Occidental Mindoro	1	-8	-65	-131	0.18	0.46	0.39
Oriental Mindoro	1	-3	20	-57	0.44	0.91	0.48
Palawan	2	0	-35	20	0.41	0.87	0.47
Pampanga	0	-1	-15	-29	1.90	2.52	0.76
Pangasinan	0	-8	-161	-237	1.77	3.32	0.53
Quezon	2	-3	0	-49	1.95	2.26	0.87
Quirino	1	-1	10	-25	0.19	0.19	1.02
Rizal	6	38	920	831	3.01	1.61	1.87
Romblon	2	0	20	0	0.32	0.37	0.86
Samar	0	-1	-5	-15	0.36	0.88	0.41
Siquijor	0	0	0	0	0.14	0.12	1.13
Sorsogon	1	-4	-15	-72	0.57	0.86	0.66
South Cotabato	3	-5	55	-60	1.03	1.76	0.58
Southern Leyte	0	0	-10	48	0.50	0.53	0.94
Sultan Kudarat	2	2	35	52	0.77	0.72	1.07
Sulu	8	-1	340	-40	0.53	0.77	0.68
Surigao del Norte	1	2	10	-42	0.70	0.70	1.00
Surigao del Sur	0	-2	-5	-12	0.76	0.74	1.03
Tarlac	0	-1	0	-19	0.74	1.41	0.52
Tawi-Tawi	3	0	85	2	0.15	0.38	0.39
Zambales	0	-1	25	-19	0.74	0.93	0.80
Zamboanga del Norte	1	1	-5	58	0.76	1.11	0.68
Zamboanga del Sur	8	0	620	17	1.97	2.54	0.78
Total	108	-24	7584	-2906	100.00	100.00	1.00

## Appendix 3

### SSS Claims By Province

This appendix shows the value of Social Security System (SSS) reimbursements to hospitals under the Medicare program in 1990. These data were supplied by SSS and represent only that share of total payments accounted for by SSS. Because GSIS records are not computerized, they could not be included in the total. The first column shows the number of claims per province and the second, the value of those claims (in pesos). The third column shows the average value of a claim. The last column

shows the ratio of claim value to population in each province and can be interpreted just like the similar ratio in Appendix 2. A ratio greater than 1 means that the province receives a greater proportion of payment than its proportion of the population.

Province	Number of SSS Claims 1990	Value of SSS Claims 1990	Value Per Claim	Percent of Value	Percent of Population	Value to Population Ratio
Abra	1,019	467,225	459	0.13%	0.30%	0.44
Agusan del Norte	15,378	6,846,906	445	1.94%	0.77%	2.54
Agusan del Sur	4,836	1,772,179	366	0.50%	0.69%	0.73
Aklan	992	523,491	528	0.15%	0.63%	0.24
Albay	12,078	5,677,954	470	1.61%	1.49%	1.08
Antique	779	384,342	493	0.11%	0.67%	0.16
Aurora	159	48,279	304	0.01%	0.23%	0.06
Basilan	4,933	2,286,939	464	0.65%	0.40%	1.62
Bataan	2,165	1,625,693	751	0.46%	0.70%	0.66
Batanes	13	5,788	445	0.00%	0.02%	0.07
Batangas	9,252	6,421,023	694	1.82%	2.43%	0.75
Benguet	3,295	2,368,917	719	0.67%	0.80%	0.84
Bohol	22,080	10,546,560	478	2.99%	1.56%	1.92
Bukidnon	37,659	16,197,076	430	4.59%	1.39%	3.31
Bulacan	3,792	2,353,726	621	0.67%	2.48%	0.27
Cagayan	562	291,727	519	0.08%	1.37%	0.06
Camarines Norte	3,246	2,344,120	722	0.66%	0.64%	1.03
Camarines Sur	5,385	2,823,820	524	0.80%	2.15%	0.37
Camiguin	116	56,507	487	0.02%	0.11%	0.15
Capiz	2,072	1,355,043	654	0.38%	0.96%	0.40
Catanduanes	269	173,677	646	0.05%	0.31%	0.16
Cavite	2,560	2,303,287	900	0.65%	1.90%	0.34
Cebu	23,272	20,860,557	896	5.92%	4.35%	1.36
Davao del Norte	34,510	15,112,180	438	4.29%	1.74%	2.47
Davao del Sur	79,068	40,048,358	507	11.36%	2.44%	4.66
Davao Oriental	2,144	906,952	423	0.26%	0.65%	0.40
Eastern Samar	2,129	1,215,017	571	0.34%	0.54%	0.64
Ifugao	26	14,094	542	0.00%	0.24%	0.02
Ilocos Norte	260	103,529	398	0.03%	0.76%	0.04
Ilocos Sur	978	417,104	426	0.12%	0.86%	0.14
Iloilo	6,024	5,646,993	937	1.60%	2.90%	0.55
Isabela	981	434,571	443	0.12%	1.70%	0.07
Kalinga-Apayao	348	146,878	422	0.04%	0.35%	0.12
La Union	1,112	698,542	628	0.20%	0.90%	0.22
Laguna	13,122	8,873,741	676	2.52%	2.25%	1.12
Lanao del Norte	11,020	6,961,757	632	1.97%	1.01%	1.95
Lanao del Sur	4,787	1,749,354	365	0.50%	0.99%	0.50
Leyte	3,615	2,294,760	635	0.65%	2.61%	0.25
Maguindanao	2,968	1,368,017	461	0.39%	1.25%	0.31
Marinduque	1,858	751,981	405	0.21%	0.31%	0.70

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Province	Number of SSS Claims 1990	Value of SSS Claims 1990	Value Per Claim	Percent of Value	Percent of Population	Value to Population Ratio
Masbate	4,643	2,400,752	517	0.68%	0.99%	0.69
Metro Manila	38,491	42,362,164	1101	12.02%	13.12%	0.92
Misamis Occidental	21,555	9,272,735	430	2.63%	0.70%	3.77
Misamis Oriental	11,526	7,043,005	611	2.00%	1.42%	1.40
Mountain Province	139	58,576	421	0.02%	0.19%	0.09
Negros Occidental	32,032	22,773,341	711	6.46%	3.71%	1.74
Negros Oriental	3,824	2,763,582	723	0.78%	1.52%	0.51
North Cotabato	11,652	5,414,825	465	1.54%	1.26%	1.22
Northern Samar	166	80,267	484	0.02%	0.63%	0.04
Nueva Ecija	1,170	1,167,727	998	0.33%	2.16%	0.15
Nueva Vizcaya	172	91,345	531	0.03%	0.50%	0.05
Occidental Mindoro	712	307,799	432	0.09%	0.46%	0.19
Oriental Mindoro	1,554	747,891	481	0.21%	0.91%	0.23
Palawan	203	84,990	419	0.02%	0.87%	0.03
Pampanga	8,093	7,890,698	975	2.24%	2.52%	0.89
Pangasinan	4,829	3,424,788	709	0.97%	3.32%	0.29
Quezon	34,336	21,233,919	618	6.02%	2.26%	2.67
Quirino	12	4,174	348	0.00%	0.19%	0.01
Rizal	15,295	10,364,977	678	2.94%	1.61%	1.82
Romblon	1	110	110	0.00%	0.37%	0.00
Samar	327	162,564	497	0.05%	0.88%	0.05
Siquijor	118	70,566	598	0.02%	0.12%	0.16
Sorsogon	2,042	968,839	474	0.27%	0.86%	0.32
South Cotabato	11,028	6,800,381	617	1.93%	1.76%	1.09
Southern Leyte	2,269	1,019,671	449	0.29%	0.53%	0.55
Sultan Kudarat	25,725	7,695,616	299	2.18%	0.72%	3.04
Sulu	18	7,218	401	0.00%	0.77%	0.00
Surigao del Norte	2,443	958,056	392	0.27%	0.70%	0.39
Surigao del Sur	18,251	8,421,217	461	2.39%	0.74%	3.21
Tarlac	5,472	4,629,958	846	1.31%	1.41%	0.93
Tawi-Tawi	11	3,464	315	0.00%	0.38%	0.00
Zambales	5,023	3,395,448	676	0.96%	0.93%	1.04
Zamboanga del Norte	3,245	1,443,611	445	0.41%	1.11%	0.37
Zamboanga del Sur	9,673	5,022,680	519	1.42%	2.54%	0.56
<b>Total</b>	<b>596,912</b>	<b>352,565,618</b>	<b>591</b>	<b>100.00%</b>	<b>100.00%</b>	<b>1.00</b>