PUBLIC-PRIVATE PARTNERSHIPS IN HEALTH IN THE PHILIPPINES
AN EQUITY PERSPECTIVE

Policy report

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This document reflects solely the views of the author.
1. SUMMARY

Public-private partnerships in the health sector have gained ground worldwide. Also in the Philippines, partnership arrangements between the public and the private sector are adopted as a health policy strategy under the current Aquino administration. In the Philippine health context, which is characterized by glaring health disparities among social groups, the implementation of such partnerships is contested. This research approaches the issue on public-private partnerships in health from an equity perspective. The overall objective of the research is to find out whether the public-private partnership strategy in the current health policy is leading toward or away from greater health equity.

The research was designed as a qualitative research, in which data was collected by semi-structured interviews. A total of sixteen informants was interviewed. The results of the research show that the health system will not perform better by using the public-private partnership strategy. Public-private partnerships are not responsive to the priorities of the Philippine health system, and could even have counterproductive effects. As a result, public-private partnerships are not responsive to the interests and needs of the Philippine population, in particular the most vulnerable groups.

In conclusion, the research found no signs to indicate that using the public-private partnership strategy will lead toward greater health equity.
SAMENVATTING

Publiek-private partnerschappen in de gezondheidssector worden wereldwijd toegepast. Ook in de Filippijnen worden partnerschappen tussen de publieke en private sector gebruikt als een strategie van het gezondheidsbeleid onder de Aquino administratie. In de Filippijnse gezondheidscontext, die gekenmerkt wordt door grote ongelijkheden in gezondheidsstatus tussen sociale groepen, wordt de implementatie van dergelijke partnerschappen in vraag gesteld.

Dit onderzoek benadert de kwestie rond publiek-private partnerschappen op het gebied van gezondheid vanuit een equity perspectief. De algemene doelstelling van het onderzoek is om uit te zoeken of de strategie van publiek-private partnerschappen in het huidig gezondheidsbeleid al dan niet naar een grotere equity in gezondheid zal leiden.

Het onderzoek werd opgezet als een kwalitatief onderzoek, waarbij data verzameld werd via semi-gestructureerde interviews. Een totaal van zestien informanten werd geïnterviewd.

De resultaten van het onderzoek tonen aan dat het gezondheidssysteem niet beter zal functioneren bij aanname van de strategie van publiek-private partnerschappen. Publiek-private partnerschappen bieden geen antwoord op de prioriteiten van het Filippijns gezondheidssysteem, en zou zelfs contra-productieve effecten kunnen inhouden. Als gevolg bieden publiek-private partnerschappen ook geen antwoord op de belangen en noden van de Filippijnse populatie, in het bijzonder de meest kwetsbare groepen.

Het onderzoek vond dus geen tekens die erop wijzen dat het gebruik van publiek-private partnerschappen naar een grotere equity in gezondheid zal leiden.
2. **INTRODUCTION**

2.1 **IBON FOUNDATION**

This policy report is the product of a research conducted in consultation and in cooperation with IBON Foundation. IBON Foundation is a Philippine non-stock non-profit development organization (http://www.ibon.org/ibon_institution.php). The purpose of this report is to provide insight on the topic of public-private partnerships (PPPs) in health in the current Philippine context, and thereby contribute to the policy of the organization on PPPs.

IBON Foundation functions as an alternative research, information and education center. It was founded in 1978 in Manila, The Philippines. It has spread since, and currently IBON has several chapters worldwide. It is part of an international network with – among partners in other countries – partners in Belgium, specifically Third World Health Aid and intal. Their mission is to provide materials to grassroots organizations and peoples movements through producing own research and through making other publications accessible, in order for these organizations to make their advocacy work well-founded and to strengthen their position and demands. Among these organizations are progressive health organizations who advocate for the human right to health.

The strategy of IBON is based on three principles: research, information and education. In terms of research, IBON commits to multidisciplinary and independent research on political, social and economic topics that affect the current situation of the Philippines. These issues are approached from a local perspective, while taking into account the international influences under which these issues take shape. Thus connecting struggles of the Philippine people with global issues of development. In terms of information, IBON commits in communicating this generated research to a broad audience in various sectors. They try to explain issues in an understandable manner. In terms of education, they publish and distribute educational materials and have an increasing presence in the formal education sector through textbooks, journals and seminars (http://www.ibon.org/ibon_institution.php).

2.2 **PHILIPPINE HEALTH CONTEXT**

Before embarking on the issue of public-private partnerships in health, an overview of the context in which this phenomenon is taking place is in order. In this section, an overview of the Philippine health context is presented.

The health sector in the Philippines exists in a context of persistent poverty. In 2012, The Philippines had a poverty headcount ratio of 25.2% of the population, while the GNI per capita was $3,270 in 2013 (http://data.worldbank.org/country/philippines).

Basic demographic indicators show that more than half of the Philippine population is younger than twenty-five years, and the population of 92.2 million people is still increasing at a total fertility rate of 3.03 and a rate of natural increase of 17.92 (the crude death rate subtracted from the crude birth rate provides the rate of natural increase (http://data.worldbank.org/indicator/SP.DYN.CBRT.IN).
Demographic indicators for The Philippines

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
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<tbody>
<tr>
<td>Population</td>
<td>92.3 million&lt;sup&gt;(a)&lt;/sup&gt;</td>
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<tr>
<td>Population &lt; 25 years</td>
<td>53.2 %&lt;sup&gt;(b)&lt;/sup&gt;</td>
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<tr>
<td>Population ≥ 65 years</td>
<td>4 %&lt;sup&gt;(a)&lt;/sup&gt;</td>
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<tr>
<td>Total fertility rate&lt;sup&gt;1&lt;/sup&gt;</td>
<td>3.0&lt;sup&gt;(c)&lt;/sup&gt;</td>
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<tr>
<td>Birth rate, crude&lt;sup&gt;2&lt;/sup&gt;</td>
<td>18.9&lt;sup&gt;(d)&lt;/sup&gt;</td>
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<tr>
<td>Death rate, crude&lt;sup&gt;3&lt;/sup&gt;</td>
<td>5.3&lt;sup&gt;(d)&lt;/sup&gt;</td>
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</table>

Table 1: Basic demographic indicators for The Philippines

(a) Available data for 2010, based on NSO (2014)
(b) Available data for 2013, based on PSA & ICF International (2014)
(c) Available data for 2010, based on PSA & ICF International (2014)
(d) Available data for 2009, based on NSO (2014)

Health indicators for The Philippines

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<thead>
<tr>
<th>Indicator</th>
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<tr>
<td>Life expectancy at birth&lt;sup&gt;4&lt;/sup&gt;</td>
<td>69&lt;sup&gt;(a)&lt;/sup&gt;</td>
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<tr>
<td>Under-five mortality rate&lt;sup&gt;5&lt;/sup&gt;</td>
<td>17.8&lt;sup&gt;(b)&lt;/sup&gt;</td>
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<td>Infant mortality rate&lt;sup&gt;6&lt;/sup&gt;</td>
<td>12.6&lt;sup&gt;(b)&lt;/sup&gt;</td>
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<tr>
<td>Maternal mortality ratio&lt;sup&gt;7&lt;/sup&gt;</td>
<td>96.4&lt;sup&gt;(b)&lt;/sup&gt;</td>
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Table 2: Conventional health status indicators for The Philippines

(a) Available data for 2012, based on http://data.worldbank.org/country/philippines
(b) Available data for 2010, based on NSO (2014)

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1 The total fertility rate represents the number of children that a woman would give birth to, in accordance with age-specific fertility rates in a certain year (http://data.worldbank.org/indicator/SP.DYN.TFRT.IN).
2 The crude birth rate represents the number of live births per 1,000 population in a certain year (http://data.worldbank.org/indicator/SP.DYN.CBRT.IN).
3 The crude death rate represents the number of deaths per 1,000 population in a certain year (http://data.worldbank.org/indicator/SP.DYN.CDRT.IN/countries).
4 Life expectancy at birth summarizes the mortality pattern that prevails across all age groups of a certain population – including children, adolescents, adults and elderly – in a certain year, and thereby reflects the overall mortality level of that population (http://www.who.int/gho/mortality_burden_disease/life_tables/situation_trends_text/en/).
5 The under-five mortality rate is the risk of a child dying before completing the age of five years per 1000 live births (http://www.who.int/gho/child_health/mortality/mortality_under_five_text/en/).
6 The infant mortality rate is the risk of a child dying before completing the age of one year per 1000 live births (http://www.who.int/gho/child_health/mortality/neonatal_infant_text/en/).
7 The maternal mortality ratio is the risk of a woman dying while pregnant or within forty-two days of termination of pregnancy per 100 000 live births (http://www.who.int/healthinfo/statistics/indmaternalmortality/en/).
In the area of health, conventional health indicators (see Table 2) show slow improvements over the years, despite the advances of scientific medicine and modern public health methods (Acuin, Lim, & Lasco, 2010). Still seven out of ten Filipinos die without medical attention (Lorenzo, Galvez-Tan, Icamina, & Javier, 2007). Widely spread infectious diseases like tuberculosis (TB) pose continuing challenges. Malaria and dengue fever still claim the lives of many, particularly indigents (Herrera, Roman, & Alarilla, 2010). In addition, new challenges are facing the system, like the increasing prevalence of HIV/AIDS in the country and the incidence of non-communicable diseases (Herrera et al., 2010).

Yet, these critical health and medical issues are not distributed evenly over the various social groups in Philippines society. The Universal Health Care Study Group\(^8\) points out the disparities in health status among regions and income groups within the country. “The great disparity in access to and use of health care has resulted in differences in health status between the rich minority and the poor majority of Filipinos constituting a great violation of this right [the right to health] for most Filipinos” (Acuin et al., 2010, p. 9). The health status indicators shown in Table 3 indicate considerable variation when disaggregated according to income group and geographic location. It is obvious that there are very wide differences between health outcomes of the wealthiest quintile and the poorest quintile, and between outcomes of urban and rural residents. The disparities highlight inequitable health outcomes in The Philippines.

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<tr>
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<th>Neonatal mortality(^9)</th>
<th>Postneonatal mortality(^10)</th>
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**Table 3: Inequitable health outcomes in The Philippines by wealth and by residence (HEAD, 2011)**

Rich urban communities who have access to modern facilities like those in Metro Manila, Cebu and Davao, have outcomes comparable to those of developed countries (i.e. life

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\(^{8}\) The Universal Health Care Study Group was erected under the aegis of the National Institutes of Health in University of Philippines Manila to strive for universal health care. The Group exists since 2008. Communicating and advocacy on UHC is the main goal (http://www.universalhealthcare.ph/).

\(^{9}\) The neonatal mortality rate indicates the deaths occurred during the neonatal period – the first twenty-eight days of life per 1000 live births (http://www.who.int/gho/child_health/mortality/neonatal_text/en/).

\(^{10}\) The postneonatal mortality rate indicates the number of newborns dying between 28 and 364 days of age per 1000 live births (http://www.naphsis.org/about/Documents/Postneonatal_Mortality_Rate.pdf).

\(^{11}\) A quintile is a fifth of the population. The wealth quintiles represent the population according to wealth; the fifth representing the wealthiest fifth of the country, the first representing the poorest fifth of the country.
expectancy at birth of over 80 years, infant mortality rate of less than 10 and maternal mortality rate of less than 15). In contrast, poor rural communities like those in Bicol, the Samar provinces and Autonomous Region in Muslim Mindanao (ARMM), have outcomes that approach those of least developed countries (i.e. life expectancy at birth of under 60 years, infant mortality rate of over 90 and maternal mortality rate of over 150) (Acuin et al., 2010).

These disparities result from the inequities in society in general and inequities within the health system in specific (Acuin et al., 2010). These inequities in the Philippine health system, are the result of deficiencies in the health system which is characterized by “inappropriate governance within the health system, an antiquated and inadequate health information system, ineffective regulation of health goods and services, fragmentation of health service delivery, a dysfunctional health workforce, and unfair, unjust and inadequate health care financing” (Acuin et al., 2010, p. 9).

### 2.2.1 Dichotomy and fragmentation of health service delivery

According to the World Health Organization (WHO), health systems are made up of six building blocks (http://www.wpro.who.int/health_services/health_systems_framework/en/). The first building block discussed here, is ‘service delivery’.

Service delivery in The Philippines is designed as a referral network: Barangay Health Stations, manned by Barangay Health Workers, serve as the base. They report to City Health Offices (located in a city) or Rural Health Units (located a town) that are usually staffed by a physician, nurses, a sanitary inspector, trained midwives or affiliated traditional birth attendants and Barangay Health Workers. City Health Offices or Rural Health Units refer patients to primary hospitals, with a capacity of around twenty-five beds. These ‘Level 1’ hospitals provide primary care as well as initial clinical care to patients requiring immediate treatment. Large provinces have secondary hospitals, composed of provincial and city hospitals. These ‘Level 2’ hospitals are non-departmentalized hospitals that provide clinical care on prevalent diseases in the locality. At the end of the line there are final referral hospitals, which encompass medical centers, regional hospitals and specialty care hospitals. Referral hospitals can be ‘Level 3’ or ‘Level 4’ hospitals. Level 3 hospitals are departmentalized and capable of managing particular forms of treatment, surgical procedures and intensive care. Level 4 hospitals are teaching and training hospitals providing the same clinical services as provided in a Level 3 hospital. They offer sub-specialty clinical care as well (Lavado, Sanglay-Dunleavy, Jimenez, & Matsuda, 2010).

In terms of geographical presence, most hospitals and health professionals are based in urban areas. Health care facilities in rural areas are limited to Barangay Health Stations, and the health workforce typically consists of social workers and midwives (Herrera et al., 2010).

One problem burdening health care delivery in The Philippines is the existing dichotomy between public and private hospitals, which traces back its roots to the American colonial model (Acuin et al., 2010).

Public hospitals on the one hand, are classified into two kinds based on their source of funds and management structure: hospitals retained by the national Department of Health (DOH),

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12 A barangay is the smallest political unit in the Philippines (Lavado, Sanglay-Dunleavy, Jimenez, & Matsuda, 2010).
the so-called ‘DOH hospitals’, and hospitals retained by Local Government Units (LGUs), the so-called ‘LGU hospitals’ (Herrera et al., 2010). There are currently seventy-two hospitals under the DOH. All DOH hospitals fall under either Level 3 or Level 4 (Lavado et al., 2010). The Philippine Heart Center (http://www.phc.gov.ph/), the Philippine Lung Center (http://www.lcp.gov.ph/), the Philippine Orthopedic Center (http://www.doh.gov.ph/node/1448.html) and the National Kidney and Transplant Institute (http://www.nkti.gov.ph/) are examples of such hospitals. Yet, of the 1578 registered hospitals, public hospitals – both DOH and LGU hospitals – account for only thirty-nine percent of the total number of hospitals. But because they are usually larger than private hospitals, in terms of number of beds the gap between public and private hospitals is minimal. Though, in the poorer regions, there are more public hospitals than private ones; while private hospitals greatly outnumber public hospitals in highly urban regions (Lavado et al., 2010). Overall, private sector participation in Philippine health care delivery is strong. In total, the private sector currently provides more than half of all services (Herrera et al., 2010).

Another problem with the delivery of health services is the fragmentation of service delivery. This fragmentation manifests in several ways. For starters, the department of
health has no direct link with local government service providers. In addition, the provincial health system has no direct link with the city and municipal health systems that are within its geographic area. Also, government links with the private sector are limited to licensure by the DOH and accreditation by PhilHealth. Lastly, the referral system operates largely on a personal level, depending on who one knows at the next level (Acuin et al., 2010). Now where does this fragmentation come from? As touched upon earlier, public health facilities are divided into DOH hospitals and LGU hospitals. This division actually goes beyond hospitals, and comprises almost all health services and responsibilities. This fragmentation stems from the enactment of the Local Government Code of 1991 (RA 7160), when the powers and responsibilities of the central government were passed on to Local Government Units. The DOH turned its hospitals, provincial and district offices – together with the staff of these offices – over to the provinces, cities and municipalities. They were given the responsibility of providing basic health services through Barangay Health Stations, Rural Health Units and City Health Offices. In theory, primary care was devolved to the local level; in practice, the referral network failed to work as envisioned due to the absence of a cohesive and logically organized referral system (Acuin et al., 2010; Lavado et al., 2010). For instance, there are more secondary hospitals than primary hospitals, and tertiary hospitals usually attend to all the cases, even primary ones. This has led to the current situation where hospitals serve as the locus of health care delivery: most households go directly to hospitals for medical treatment (Lavado et al., 2010). Yet, reliance on formal health care services remains low for Filipinos. Only five percent received in-patient care in a hospital or clinic in 2012 (PSA & ICF International, 2014).

These problems are further compounded by the lack of quality of these health facilities (Acuin et al., 2010). There is a generally perceived difference in quality between services from public health providers on the one hand, and private health providers on the other hand. Public providers offer free medical services and are usually governed and regulated by the government through the DOH or LGUs. Private providers generally charge fees for services. People at the lower wealth quintiles use public health facilities such as rural health units and village health stations more than those at the upper quintiles. Such facilities are generally perceived to provide services of low quality. Diagnosis is poor, medicine supplies are unavailable or inferior, staff members are often absent (especially in rural areas), waiting times are long, and facilities are rundown (Herrera et al., 2010).

2.2.2 Unfair, unjust and inadequate health care financing

A second building block, is ‘health care financing’ (http://www.wpro.who.int/health_services/health_systems_framework/en/). There are essentially three sources of financing: taxes, health insurance and out-of-pocket spending (Acuin et al., 2010).

The problem with health care financing is that it is unfair, unjust and inadequate. Concretely, Philippines health care faces financing issues related to chronic underfunding, high out-of-pocket spending, and inefficiency (Acuin et al., 2010).

In terms of chronic underfunding, insufficient financial resources are directed towards the health sector. Total health expenditure is 467.8 billion pesos, merely 4.4 percent of GDP (Philippine National Health Accounts, 2012). The recommended level by WHO is five to six percent of GDP for low and middle income countries (WHO, 2010).
High out-of-pocket spending is the result of this low public spending on health (Acuin et al., 2010). Many poor spend out-of-pocket for health care, which limits financial access to health and impoverishes thousands of Filipino families (Herrera et al., 2010). The cost of care is more than twice as high in private facilities as in public facilities (PSA & ICF International, 2014). Utilization is therefore mainly determined by capacity to pay (Acuin et al., 2010).

![Figure 2: Source of funds for health in 2012, based on WHO (2012)](image)

Figure 2 shows that out-of-pocket expenses are the primary source of health expenditure, and renders the sourcing of funding for health care in The Philippines highly inequitable. To rectify the situation, the Philippine government has instituted the National Health Insurance Program (NHIP) (RA 7875) in 1995 to make health care more accessible, through the provision of universal health coverage. The Philippine Health Insurance Corporation (PhilHealth) is the government-owned and -controlled corporation that is mandated to administer the NHIP and to promote the membership of every Filipino in the health care program, particularly indigents. In the indigent program of PhilHealth, the government transfers funds to PhilHealth as contributions for their coverage. Covered individuals are able to avail free services up to the benefit limits. But as of today, studies show that PhilHealth coverage has not yet reached half of the total population. Only twenty-two percent of covered Filipinos are indigents (Herrera et al., 2010).

“The combined weight of the uncoordinated spending for health by the national government and local governments, with our national social health insurance program’s spending being is so low and so weak, has driven the health system into a debilitating dependence on out-of-pocket payments by patients. Also, it leads to the commercial dominance of our health care system. The Philippines’ health sector is dominated by commercial interests of a segment of the system that is driven less by health outcomes and primarily by bottom-line profits” (Acuin et al., 2010, p. 10).
Health financing is plagued with efficiency issues in terms of allocation of limited financial resources and payment mechanisms as well, in turn leading to higher health care costs (Acuin et al., 2010).

Many challenges undermine the efficiency of the health system. First, with a disfunctioning referral network, tertiary hospitals – which are designed to cater to more serious diseases – are also accommodating cases that can be handled by facilities at a lower level. Therefore, tertiary hospitals require more financial resources to be able to attend to its patients. The DOH spends more than half of its annual budget for its hospitals. Second, aside from being more expensive, the current arrangement leads to overcrowding of tertiary facilities (Lavado et al., 2010). “This mismatch in the capability of tertiary facilities and the severity of cases they cater to make costs of seeking health care higher not only for the facilities but for the patients as well” (Lavado et al., 2010, p. 12). Thirdly, the fragmentation and overlap of health financing institutions by the lack of an articulated national health policy contributes to the inefficiency (Acuin et al., 2010).

### 2.2.3 Dysfunctional Health Workforce

The third building block being discussed is ‘health workforce’ (http://www.wpro.who.int/health_services/health_systems_framework/en/).

The Philippine health care system deals with a dysfunctional health workforce. The country “suffers from the paradox of lacking health care professionals, especially in economically depressed regions, while at the same time enjoying an oversupply of the said professionals” (Acuin et al., 2010, p. 10). On the one hand, there is a shortage in human resources for health. The Philippines has a policy to export human resources for health to richer countries as a mechanism to generate income (Chongsuvivatwong et al., 2011; Lorenzo et al., 2007; Yeates, 2009). The number of government health practitioners is declining. In 1990, the estimate was 1.22 doctors for every 10 000 Filipinos. By 2007, this figure dropped to 0.33. In 1990, there were 0.17 nurses for every 10 000 Filipinos, the number was down to 0.05 in 2007 (Herrera et al., 2010). The fact that eighty percent of government doctors and ninety percent of Municipal Health Officers are taking up nursing and/or are about to leave for work abroad is a big reason for this decline (HEAD, 2011).

On the other hand, this leads to a situation where there is an ‘oversupply’ of nurses. In 2008 there were 400 000 nurses added to the health workforce, as opposed to 1500 doctors (HEAD, 2011). This creates a detrimental health situation in The Philippines: due to the mass migration of Filipino health professionals, many hospitals have fully or partially closed down due to a shortage of highly skilled nurses and the massive retraining of physicians to become nurses elsewhere (Lorenzo et al., 2007). International trade in health services and workforce migration creates equity issues on national health systems, especially in widening disparities between rural and urban distribution, and between public and private providers (Chongsuvivatwong et al., 2011).

The distribution of health personnel is a problem as well. As is the case with hospitals, most doctors and nurses are concentrated in the private sector and in urban areas. Seventy percent of all health professionals are working in the private sector addressing the needs of about thirty percent of the population, while the government employs thirty percent of health workers, who are serving the health needs of seventy percent of Filipinos (HEAD, 2011; Herrera et al., 2010). In particular the supply of midwives, who provide the basic health care for the poor, is inadequate to meet the demands of the rural health centers...
In terms of concentration of health practitioners, more than six out of ten doctors, nurses, and dentists work in the National Capital Region (NCR), while the remaining professionals are spread over the rest of the country (Herrera et al., 2010). Acuin et al. (2010) traces these problems back to three factors: unregulated market forces, quotas determined by capacity rather than sustainability, and the absence of an emphasis on public service and common good.

### 2.2.4 Inappropriate Governance Within the Health System

A fourth building block to be handled, is ‘leadership/governance’ (http://www.wpro.who.int/health_services/health_systems_framework/en/). In the Philippines, the Department of Health (DOH) serves as the government’s overall policy formulation and implementation agency in health (Acuin et al., 2010). Although, since devolution (see 2.2.1) Local Government Units (LGUs) have been given responsibilities, especially with regards to primary care, in their locality.

The most glaring governance problem in the Philippine health system, is the lack of an encompassing policy of health service provision that explicitly addresses the issues of health inequity and its social implications. Governance is inappropriate, not focused, nor directed. The top-down approach of the DOH is firmly entrenched and stifles attempts at introducing participatory processes in decision making in health and policy formulation through the primary health care approach (Acuin et al., 2010).

### 2.2.5 Ineffective Regulation of Health Goods and Services

A fifth building block to be discussed, is ‘medical products, technologies’ (http://www.wpro.who.int/health_services/health_systems_framework/en/). Medical products, drugs, services, facilities, practitioners, providers, ... need to be regulated.

The importance of health regulation stems from the government’s responsibility to ensure that the people, especially the underprivileged, have adequate and equitable access to health products, facilities and services. A regulatory system aims to provide a set of methods to influence behavior of public and private providers of health care, and protect buyers from their own inability to judge quality. Regulation must improve access, advance moral principles and counteract monopoly (Acuin et al., 2010).

The Philippine regulatory authority in health struggles with scarce resources, inadequate staff and capability, inefficient use of available technology, and lack of progressive technological development. There is a shortage of functioning diagnostic imaging technologies, such as computed tomography (CT) and magnetic resonance imaging (MRI) scans. If these technologies are available, they are generally only available in highly urban regions (Acuin et al., 2010; Herrera et al., 2010). Because of the lack of funding, manpower, technical capacity, compounded with the problem of legal constraints, health policies and regulations are inadequately enforced. As a result, health facilities are – if not absent – substandard and dilapidated, uncoordinated and fragmented (Acuin et al., 2010).
2.2.6 Antiquated and Inadequate Health Information System

The sixth and last building block to be discussed, is ‘information and research’ (http://www.wpro.who.int/health_services/health_systems_framework/en/).

Health information systems are crucial for decision-making and policy formulation (Acuin et al., 2010).

The Philippine health system suffers from an antiquated, rudimentary and inadequate health information system, that is not useable for health policy formulation. The development of information and communication technology (ICT) to facilitate health insurance access has lagged behind (Acuin et al., 2010; Herrera et al., 2010). The data that are being gathered, are gathered and recorded as a matter of duty, and not for their usefulness for the health care system. Due to these deficiencies, higher offices are deprived of timely information which are crucial to effective and dynamic national policy formulation. But this applies the other way around as well: the lack of effective leadership for the implementation of health information standards has caused stagnation in the improvement of the data gathering system (Acuin et al., 2010).

2.3 Philippine Health Policy

To address these deficiencies, radical reforms in all components of the Philippine health system are required (http://www.universalhealthcare.ph/executive-summary/). Such reforms must be aimed at achieving universal health care (UHC) in the country over a reasonable period of time – ten to fifteen years. Universal health care must be implemented to address the inequities in the health system and is defined in the Philippine context as “the provision to every Filipino of the highest possible quality of care that is accessible, efficient, equitably distributed, adequately funded, fairly financed and appropriately used by an informed and empowered public. UHC will ensure health as a right to all Filipinos regardless of ability to pay” (http://www.universalhealthcare.ph/executive-summary/). The philosophy is that access to social services must be based on need and not on the capacity to pay.

Overarching reforms have been introduced to this end.

In 1999, the Health Sector Reform Agenda (HSRA) (1999-2004) was launched (http://www.doh.gov.ph/milestones.html). The operations of the DOH were directed to create a comprehensive approach to manage the health sector. The objectives were, firstly, the expansion of social health insurance. Secondly, the corporatization of government hospitals was set as a goal. Thirdly, HSRA aimed to strengthen local health systems. Fourthly, improved health regulation and drug management was envisioned. And lastly, public health services were to be improved (Herrera et al., 2010).

In 2005, FOURmula One (F1) for Health (2005-2010) was adopted as the HSRA’s implementation framework. F1 functioned as the blue print for the implementation of reforms. Investment Plans for Health were developed in sixteen provinces as the basis of F1 implementation (http://www.doh.gov.ph/milestones.html). Concretely, F1 sought to implement income retention programs and economic enterprise reforms for public hospitals. Local governing boards for public hospitals were to improve the fiscal autonomy of public hospitals and lessen dependency. In addition, the reforms also sought to enhance the networking capability of public hospitals through public-private partnerships (Herrera et al., 2010).
2.3.1 AQUINO HEALTH AGENDA

The health policy of the current administration under the presidency of Benigno Aquino III follows in the steps of the comprehensive reforms HSRA and F1.

“To address persisting challenges, the Aquino Health Agenda (AHA) is being launched to improve, streamline and scale up reform interventions espoused in the HSRA and implemented under F1” (Ona, 2010b, p. 2).

The health policy of Aquino is referred to as the ‘Aquino Health Agenda’ (AHA) (2010-2016), and envisions to achieve universal health care for all Filipinos (http://www.doh.gov.ph/milestones.html).

The AHA lays out three strategic routes to achieve universal health care:

1. universal health coverage through a rapidly expanding and refocused (with regards to using national subsidies for the poorest families) PhilHealth;
2. attention to the accelerated construction and rehabilitation of public hospitals and health care facilities;
3. attainment of the health-related Millennium Development Goals by applying additional effort and resources in localities in need (Ona, 2010b).

2.3.2 PUBLIC-PRIVATE PARTNERSHIPS

Public-private partnerships play an important role in the AHA. The AHA explicitly pushes PPPs forward as a strategy to achieve the health policy aims. “UHC shall harness the strength of revitalized public-private partnership especially in services needing heavy capital investments.” (Ona, 2010b, p. 5) Therefore, policy directions aim to “facilitate private-public sector partnership in the provision of health care and promote corporate practices that will sustain provision of quality and affordable health care” (Ona, 2010b, p. 9).

PPPs are seen as an integral part of one of the three strategic routes of the AHA, namely ‘the accelerated construction and rehabilitation of public hospitals and health care facilities’ (see 2.3.1). The DOH will primarily employ the PPP strategy to improve public health facilities (Ona, 2010a).

This follows the line that has been set out by the Aquino administration in general. PPPs are considered the cornerstone strategy for national development and infrastructure investments (NEDA, 2011). The Aquino administration is also keen to attract foreign PPP partners. In some circumstances guarantees are offered to the private sector to this end (EIU & ADB, 2011).

In the area of health, President Aquino signed Executive Order 8 in 2010. The order set aside a 300 million pesos working fund to support studies and activities of selected PPP projects (ADB, 2012; Edep & Dedace, 2010).

Proposed PPP projects comprise:

- An ITC system for DOH and PhilHealth
- The modernization of the Philippine Orthopedic Center
- An airambulanceproject
- A research institute for tropical medicine, for the commercial production of vaccines
- The establishment of San Lazaro Hospital as a Center for Infectious Diseases
- The commercial utilization of vacant hospital land assets
- The establishment of multi-specialty centers in selected regions
- The construction of patient and hospital staff’s lodging facilities (Ona, 2010a)
2.3.3 CONCERNS

Progressive health organizations and the media have voiced concerns on the PPP strategy as the cornerstone of development and health facilities enhancement. Questions are raised on how involving the private sector in the delivery of public health services will improve the poor functioning of the Philippine health system – as described above –, and in the end, improve health outcomes for all Filipinos (see for instance Gonzales, 2012). Also IBON Foundation struggles with these questions. In the light of the mission of IBON to provide materials to grassroots organizations in the health sector – in order for these organizations to advocate for the human right to health in a well-founded manner and thereby strengthen their position and demands – the objectives of this research is to augment the knowledge and understanding on how PPPs manifest in the Aquino administration. To this end, this policy report tries to provide an insight on the issue of PPPs and a deeper understanding of the potential implications of PPPs – as a priority strategy of the current administration – on the health of the Philippine population. This is considered a precondition for developing strategies which can achieve some coherence between immediate local issues and the broader societal and health reforms that are needed.

In the section that follows, the research perspective and objectives will be explained. Next, in the theoretical framework, a literature review on PPPs will shed light on the debate that surrounds the issue. This is followed by a description of the research methodology and an exposition of the findings. The results of the research show that the health system will not perform better by using the PPP strategy. PPPs are not responsive to the priorities of the Philippine health system, and could even have counterproductive effects. As a result, PPPs are not responsive to the interests and needs of the Philippine population, in particular the most vulnerable groups.
3. OBJECTIVES

3.1 RESEARCH APPROACH: AN EQUITY PERSPECTIVE

As touched upon in the end of the previous section, the ultimate question regarding PPPs in health in The Philippines is which implications the PPP strategy of the current administration will have on the Philippine health system, and in the end, on health outcomes of the Philippine population. Will the health system perform better through the use of PPPs and will it lead to better health outcomes for all groups in society? Therefore, the ultimate aim of any research on PPPs in a health context that is plagued with glaring disparities in health outcomes, should be to find out what impact PPPs will have on closing these disparities, so that everyone – opposed to only a small portion of the population – can enjoy his or her right to health.

Assessing the impact of PPPs on a certain health system begs the question: by which criteria might PPPs be assessed (Barr, 2007; Boardman & Vining, 2012)? Boardman and Vining (2012) state that the evaluation of the impact of PPPs requires a normative perspective against which to judge them. According to Boardman and Vining (2012) PPPs should normatively serve the public interest, and this means that the relevant criterion for government decision making should be the expected change in social welfare. Therefore, they propose social welfare as the appropriate normative criterion to evaluate the social value of PPPs.

In some policy contexts, distribution of social welfare – as opposed to the overarching social welfare status of the country – is highly relevant. This is especially the case in developing countries, because of the challenges they face in terms of disparities in social welfare among the wealthiest and the poorest of society (Weimer and Vining, 2009 in Boardman & Vining, 2012). That is why an equity perspective is of paramount importance in these contexts, including the Philippine context.

Equity in health can be defined as “the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage – that is, wealth, power, or prestige. Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health” (Braveman & Gruskin, 2003, p. 254).

Social determinants of health in the definition refer to household living conditions, conditions in workplaces and health care (meaning the utilization of health services, as well as the allocation of health care resources and the quality of health care services), along with the policies affecting these factors. Underlying social advantage or disadvantage refers to the attributes that define how people are grouped in social hierarchies: income, economic assets, occupational class, educational level, ethnicity, religion, gender, geography, age, disability, sexual orientation, etcetera (Braveman & Gruskin, 2003). Systematically refers to the fact that a health disparity must be systematically associated with social disadvantage, meaning that the associations between the disparity and the socially disadvantaged group “must be significant and frequent or persistent, not just occasional or random” (Braveman & Gruskin, 2003, p. 255)

Furthermore, equity is an “ethical value, inherently normative, grounded in the ethical principle of distributive justice and consonant with human rights principles” (Braveman & Gruskin, 2003, p. 256). It refers to social justice and fairness.
Equity is also closely related to human rights principles. The right to health – as explicated in international human rights treaties – is the right to the highest attainable standard of health (OHCHR & WHO, 2008). Braveman & Gruskin (2003) believe their proposed definition of equity is useful in the operationalization of the right to health. Indeed, the highest attainable standard of health can be understood to be indicated by the level of health enjoyed by the most socially advantaged group within a society. At the least, this reflects a level of health that is biologically attainable in practice, and therefore sets a minimum standard for what should be possible for everyone in that particular society (Braveman & Gruskin, 2003). It is considered the responsibility of governments to take the necessary measures to ensure the right to health of its citizens, irrespective of which kind of health care delivery mechanism is in place (Maru & Farmer, 2012). Human rights are considered interrelated and indivisible as well, thus, the right to health cannot be separated from other human rights and social determinants of health. Therefore, being healthy does not only require addressing defaults in the health system, social determinants of health in the overall society which badly affects health need to be addressed too (Braveman & Gruskin, 2003).

According to the equity framework of Braveman and Gruskin (2003), assessing health equity requires comparing health status and its social determinants between more and less advantaged groups in society. These comparisons are deemed to be essential in assessing whether national (and international) policies are leading toward or away from greater social justice in health. Without such comparisons, it will not be known who is benefiting most or least from health policies, and therefore it will not be known how best to target interventions or redistribute resources either (Braveman & Gruskin, 2003).

### 3.2 Overall objective

The overall objective of the research is to find out whether the public-private partnership strategy in the current health policy – the Aquino Health Agenda – is leading toward or away from greater health equity.

This leads to following general research question:

*Which implications do public-private partnerships in health in The Philippines have for improving health equity in the country?*

There is no completed case of a PPP in health under the current administration yet. This renders assessing health equity in terms of comparing health status between more and less advantaged groups (Braveman & Gruskin, 2003) in a particular case of PPP difficult. Yet, studying the overall effects and implications of PPPs on the functioning of the Philippine health system – which according to the Universal Health Care Study group underlies the disparities and inequities in health – should enable to point out in which direction the developments are heading.

### 3.3 Specific objectives

To get a well-founded idea of the potential contributions or aggravations of PPPs to the Philippine health situation, one needs to get a view on how PPPs are interpreted and implemented by the current administration. This leads to following specific research objectives:
(1) The first specific objective is to understand the rationale behind public-private partnerships in the Philippine health sector under the current administration.

(2) The second specific objective is to grasp the status of implementation of public-private partnerships in the Philippine health sector under the current administration.

3.4 FOCUS QUESTIONS

Information on following questions regarding the first specific objective needs to be gathered:
- (1.1) Who are the main actors involved in PPPs in health?
- (1.2) Who are the proponents of PPPs in health and what is their rationale?
- (1.3) Who are the opponents of PPPs in health and what is their rationale?

Information on following questions regarding the second specific objective needs to be gathered:
- (2.1) In what building blocks of the health system are PPPs found?
- (2.2) In what geographic areas are PPPs found?
- (2.3) Which PPP projects are being initiated and which are in the pipeline?
4. THEORETICAL FRAMEWORK

In this section, a review of academic literature on public-private partnerships is presented to shed light on the debate surrounding the PPP issue. Before taking a closer look at the selected international publications, it is worth noting that The Philippines has a history with public-private partnerships that date back long before the presidency of Benigno Aquino III. As in many developing countries at that time, PPPs have been utilized as a development strategy in the Philippine water sector since the late eighties of the previous century, as well as in the energy sector, roads and airports (Bello, Docena, de Guzman, & Malig, 2009). The BOT Law (Republic Act 6957) was adopted in 1990 to provide guidance for PPP infrastructure projects (EIU & ADB, 2011). Since the Aquino administration, PPPs is also promoted in social services such as health and education. In 2011 the “Aquino Administration has allocated P8 billion to support public-private partnerships (PPP) that will enable the government to close the resource gaps in key education and healthcare services” (http://www.gov.ph/2011/08/08/aquino-government-allocates-p8-billion-for-ppp-in-social-services/).

Using PPPs in the health sector is not a national phenomenon, since the nineties, and more vigorously since the turn of the century, PPPs in health have been promoted and implemented worldwide. During the eighties, political and economic disruptions led to a reassessment of reliance on the public sector for maintaining health systems. “Movement toward privatization and increased reliance on market forces became increasingly widespread” (Barr, 2007, p. 19). During the late nineties many PPPs were created which were focused on specific diseases such as HIV/AIDS, tuberculosis, and malaria. Nowadays, it has become a common approach to a variety of welfare services and health care problems extending beyond eradication of communicable diseases, especially in developing countries (Barr, 2007). “Through the emerging new paradigm of public-private partnerships (...) the challenges of the myriad unmet health needs of developing nations can begin to be fulfilled” (Barr, 2007, p. 20). There are documented experiences of PPPs in health in countries worldwide, and The Philippines is but one case.

Although promotion and implementation of PPPs is widely spread, the success of PPPs in the health sector appears to be mixed and there is a lack of firm evidence of the circumstances under which a PPP model is preferable to more traditional models of procurement and service delivery (Barr, 2007). As will become apparent in the following sections, the academic debate on the issue is ongoing.

4.1 WHAT ARE PPPS? TERMINOLOGY AND WORKING DEFINITION

The PPP model comprises a diversity of arrangements: “The term public-private partnerships covers a wide variety of ventures involving a diversity of arrangements, varying with regard to participants, legal status, governance, management, policy-setting prerogatives, contributions and operational roles” (http://www.who.int/trade/glossary/story077/en/). The literature on public-private partnerships is characterized by what Brinkerhoff & Brinkerhoff (2011) call “analytic cacophony” (Brinkerhoff & Brinkerhoff, 2011, p. 3). The concept has been addressed from a variety of perspectives: some studies are empirical, others are promoting PPPs based on a normative agenda. Because the use of PPPs in public infrastructure has the longest history, a dominant thread in the definition of PPPs concerns infrastructure financing (Brinkerhoff & Brinkerhoff, 2011; Hodge & Greve, 2007).

Thus, before discussing the debate on the subject of PPPs, it is important to define what is meant by ‘public’, ‘private’ and ‘partnership’, and explicate which definition of public-private partnerships this report adheres to.
Following Nishtar (2004), ‘public’ refers to the public sector and encompasses all government – national, provincial and district – and inter-governmental agencies with the mandate of delivering public goods.

‘Private’ refers to two possible sets of structures: the for-profit and non-profit private sector, the former denoting commercial companies and the latter denoting non-profit organizations like Non-Governmental Organizations (NGOs) and philanthropies (Barr, 2007; Mitchell, 2008; Nishtar, 2004).

‘Partnership’ refers to a commitment to a common goal that is determined from the outset of the partnership, through the provision of complementary resources and expertise of the partners involved (these can entail the hard resources, such as money and materials, as well as soft resources, such as managerial and technical skills, contacts, and credibility) (Brinkerhoff & Brinkerhoff, 2011), and where there is a sharing of the risks and benefits of the joint venture (Barr, 2007; Brinkerhoff & Brinkerhoff, 2011). Mitchell (2008) adds that the formal agreement between the two (or more) parties, specifies the mutual rights and responsibilities of each party and how the partnership will be managed. These elements differentiate partnerships from privatization. “Privatization involves permanent transfer of control through transfer of ownership right or an arrangement in which the public sector shareholder has waived its right to subscribe” (Nishtar, 2004, p. 2). There is also a distinction between partnerships and mere contractual arrangements. The mutual commitments that are made in partnerships go beyond the principal-agent dynamic of a contractual relationship. There is a shared dedication to achieve the predetermined outcomes (Brinkerhoff & Brinkerhoff, 2011; Nishtar, 2004).

Based on these features, this report adheres to following working definition of a public-private partnership:

A public-private partnership is a cross-sectorial collaboration between the public sector and the private sector, where the parties involved agree to a mutual commitment – in terms of mutual rights and responsibilities, shared objectives and shared accountability – , and where the parties involved bring competence – in terms of resources and expertise – to the table.

4.2 Types

Public-private partnerships in health can take many forms. Mitchell (2008) proposes four dimensions by which we can categorize these partnerships: scope, partners, level of commitment and type of objective.

4.2.1 Scope

The first dimension that helps define the partnership is scope. In general terms a partnership will be at the local, national or global level (Mitchell, 2008; Nishtar, 2004).

At the local or regional level individual public and private units will work together to achieve a shared goal. A contract between a local food company and a public hospital to provide food to the patients is an example of a local PPP. These local partnerships are typically less complex than national or international ones (Mitchell, 2008).
At the national or country level national governments can form partnerships with the for-profit or non-profit private sector (Nishtar, 2004). These arrangements are more varied in nature. They can take the shape of national contracts between the government and NGOs for provision of health services in underserved areas, or between the government and pharmaceutical distributors for the distribution of essential medicines. One type of national partnership that is having a major impact on national health systems globally is the establishment of a social health insurance system in which private providers participate in an insurance scheme at negotiated rates that is financed jointly by employers, individuals, and the government (Mitchell, 2008).

At the global level, partnerships are typically between multinational companies and multilateral donors. The most common form of this type of partnership is a drug donation program between a drug company and a donor or research organization, in which drugs for a specific purpose are donated or given at reduced price to international organizations, who for their part can ensure the drugs are used for the specified purpose. The majority of these global PPPs are dedicated to infectious disease prevention and control, such as HIV/AIDS, tuberculosis and malaria. Although there are also global PPPs on other health issues such as reproductive health or nutrition (Mitchell, 2008; Nishtar, 2007). The database of the Initiative on Public-Private Partnerships for Health lists ninety-one international public-private partnership arrangements in the health sector. An example is the Stop TB partnership. These global partnerships are often quite complex in nature because there are often multiple partners involved (they can bring together several governments, NGOs, research institutions and United Nations agencies) (Barr, 2007; Mitchell, 2008; Nishtar, 2007), complex financial arrangements are made, and particular institutional objectives are involved (for instance: working with respected organizations to gain legitimacy or enhance the corporate image; or drug research that will be used for future product development) (Mitchell, 2008).

4.2.2 Partners

The second dimension by which partnerships vary is the nature of partner organizations. There are many different types of partners. In the public sector these comprise national and local governments, and public organizations such as medical associations or nursing colleges. In the private sector these include for-profit organizations and non-profit organizations. For-profit organizations can be of the local, national or multinational kind. Non-profit organizations can be community or civil society groups. Some of which are formed for the purpose of community development, and some of which are formed to generate income such as cooperatives. They can have a religious base or be secular. Some may take the form of multilateral (such as the Asian Development Bank) or bilateral donor organizations (such as USAID); while others are private donors (such as The Bill and Melinda Gates Foundation) (Mitchell, 2008).

The type of partnership that has been most discussed is that between the public sector and a for-profit enterprise. There are partnerships in which the private sector provides financing, while the public provides health services; and the opposite in which the public sector finances and the private sector provides health services. In the latter, (part of) the services are delivered by the private sector in the belief that the quality and efficiency of these services will be better than if they were provided by the government directly. The two most common models of these types of partnerships are contracting and insurance programs.
Contracting is being used widely for a large array of services, ranging from ancillary services such as food, maintenance, and logistics to the direct delivery of patient care. It is worth noting that the effectiveness of this type of contracting in terms of improved quality and reduced cost are still inconclusive (Mitchell, 2008).

4.2.3 LEVEL OF COMMITMENT

A third dimension of partnership is the level of commitment of the partners. Some partnerships involve a minimal level of commitment from each partner, for example an agreement to provide a piece of equipment to a public facility. At the other extreme is a partnership in which two organizations agree to pool all their resources in a particular area, share all decision making, and jointly market and provide their services. Between these two extremes lie a wide range of commitment levels between partners. In any case, the level of commitment does not necessarily relate to the size or level of the organization at which the partnership is formed; rather it is a measure of the sharing of resources in terms of funds, people, information and expertise.

Concretely, partnerships can occur at the governance level, at the managerial level or at the operational level. A PPP where a joint board oversees strategic decisions, is an example of a partnership at the governance level. A partnership at the managerial level occurs when for example an international NGO partners with the government to develop a disease control program using government personnel for the day to day operations. At the operational level tasks are shared, but not strategies. For instance, an international drug company may agree to procure pharmaceuticals at reduced prices on behalf of a country (Mitchell, 2008).

4.2.4 TYPE OF OBJECTIVE

The fourth dimension is the type of objective that is to be achieved through PPPs in health. The first type of objectives are financial objectives. Many partnerships are formed on the basis of financial goals, and in general the objective in these instances is to reduce the total cost of the production of health services or products through improvements in efficiency. For example, if a hospital purchases food services from a private firm at a lower cost than producing the food itself, both the hospital and the food company can benefit through a negotiated price which is set between the cost of the hospital producing food itself and the cost of production of food by the company (Mitchell, 2008).

The second type of objectives are disease specific objectives. Many of the global PPPs are formed with disease specific objectives, as mentioned earlier. In each of these cases, the objective is the control or eradication of a particular disease. Disease specific objectives are interesting for partners who are interested in the public relations advantages of partnerships, since it is easy to present in the humanitarian benefit of the endeavor in a few words (Mitchell, 2008).

The third type of objectives are objectives related to the expansion of access to services in a country. An example is a PPP that often takes place: a partnership between a religious NGO hospital and the government, in which the government subsidizes the NGO hospital that provides services in an area where there are no government facilities (Mitchell, 2008).

The fourth type of objective that can be reached through a partnership in health is the development of innovative approaches to address public health issues. This may for instance take the form of new drugs or vaccines. Innovation may also be in the form of new approaches to service delivery, like in the case of social marketing of condoms (Mitchell, 2008).
4.3 Debate on PPPs

As mentioned earlier, PPPs are a global phenomenon. PPPs in health have been promoted and implemented in countries worldwide. Despite of this PPP enthusiasm, the success of PPPs in the health sector appears to be mixed (Barr, 2007). Depending on the perspective from which PPPs is approached, some literature puts forth opportunities and advantages of PPPs in health, while other literature strands focus on the challenges and disadvantages of using the PPP model in a health context.

The next sections give a brief overview of the academic debate on the issue of health PPPs.

4.3.1 Opportunities and Advantages of PPPs

“Development and health actors have highlighted the need to harness the potential that exists in collaborating with the private sector to advance public health goals. This is also becoming increasingly essential as both the public and the private sector recognize their individual inabilities to address emerging public health issues that continue to be tabled on the international and within country policy agendas. Public-private partnerships therefore seem both, unavoidable and imperative” (Nishtar, 2004, p. 5). As Nishtar (2004) points out, public and private participants engage in PPPs because – like in any partnership – there is a perceived win-win situation. Participants hope to move from a situation where they seperately do not gain ground in reaching their goals, to a collaboration where every party moves forward (Brinkerhoff & Brinkerhoff, 2011).

There are many different ways that participants can benefit from partnerships. Brinkerhoff & Brinkerhoff (2011) refer to the different reasons why parties engage in PPPs as ‘partnership rationales’. The different reasons and arguments which are put forth, shape the different rationales that exist on why PPPs in the health sector are preferred. Overall, the most common motivation is financial, but as partnerships grow more complex, the benefits may include many other incentives such as prestige, publicity and coverage, which are not directly related to financial gain (Mitchell, 2008). In any case, the benefits of the partnership are often a function of the type of partner involved (Buse and Walt in Mitchell, 2008).

- Reasons why public sector participants choose to partner

Governments may choose to partner with the non-profit private sector for specific reasons. Firstly, PPPs with NGOs provide comparative advantages in trust building and outreach for the government (Brinkerhoff & Brinkerhoff, 2011). Services to underserved population groups can be expanded through the outreach related competence of NGOs (Mitchell, 2008; Nishtar, 2004). For this reason, a lot of governments have long experience with partnerships with religious groups to provide health services in rural areas (Mitchell, 2008).

Another consideration that provides the incentive to partner with each other is the transfer of technical knowledge between participants. The public sector and NGOs are both considered to have knowledge and skills that are useful to the other, and that creates a situation where they are able to learn from each other (Mitchell, 2008).

If the public sector partners with the for-profit private sector, by far the most common benefit that drives these partnerships is financial gain, through the expectation of efficiency
gains as a result of the partnership (Mitchell, 2008; Nishtar, 2004). “The for-profit private sectors’ immense resources make it an irresistible partner for public health initiatives” (Nishtar, 2004, p. 5). This enables governments to tap into additional resources in order to fulfill their mandate (Nishtar, 2004).

This financial benefit can be direct, with simple financial mechanisms, like increasing resources through direct payments for service delivery or like cost reductions through contracting for food or cleaning services in a public hospital. The expectation is that the contracted service can be done cheaper by a private contractor than doing it with government employees. The savings in this case come about from greater efficiency of the private cleaning company which is not bound by government policies on hiring and firing, and thus have a cheaper labor pool to do the job (Mitchell, 2008; Nishtar, 2004; UNECE, 2007).

The financial benefit can also be indirect. Indirect gains may come to a donor government who is willing to support partnerships between their national private companies and foreign host governments in the interest of opening new markets for its national industries. In this case, the financial benefit of the donor government is indirect, in the form of new investment opportunities (Holden, 2009; Mitchell, 2008).

In any case, direct or indirect, each of the partners sees a long or short term financial advantage resulting from the partnership (Mitchell, 2008; Nishtar, 2004).

Though, financial gains are not the only incentive, another incentive for the development of a partnership is improving “efficiency and effectiveness by importing ‘businesslike’ practice and thinking, including bottom-line enforcement mechanisms and competition” (Brinkerhoff & Brinkerhoff, 2011, p. 5). Efficiency is generally seen as more common in private enterprises than in government bureaucracies. It is felt that the private sector, as a result of the competitive environment, is more responsive to change and pushing down prices. Thus, as cost pressures and the need for change have been increasingly felt by the public health sector, they have looked at private sector business models of how to deliver services more efficiently (Mitchell, 2008). Effectiveness is appropriated to the private sector as well. Therefore, partnerships have been promoted as a means to enhance governance effectiveness of the public sector, for example by the New Public Management paradigm (Brinkerhoff & Brinkerhoff, 2011; UNECE, 2007).

In addition, increase of quality of health care is one of the hopes for partnerships. Traditionally, government health services in developing countries have been known for their poor quality, in terms of availability of services as in terms of training and motivation of government health workers. Government services, especially in poor rural areas, do not provide the level of quality as in wealthy urban areas. Many reasons underlie this problem, including the lack of accountability, inadequate staff supervision, inadequate equipment, inadequate procurement of drugs, and inefficient bureaucratic management. In contrast, the private sector is renowned for the excellent quality of its hospitals in urban centers that cater for the rich (Mitchell, 2008).

In the case of multilateral public organizations such as the WHO or the World Bank, other reasons for developing PPPs can play a part. The private corporate sponsors may provide knowledge and skills. Or partnerships with non-profit private organizations may provide legitimacy for technical and moral leadership in a certain technical area or country program (Mitchell, 2008).

In the case of national public agencies, other benefits may comprise: access to products they otherwise could not afford, improved infrastructure, technical knowledge and expertise from the private partner, access to established business networks of the private partner,
etcetera (Brinkerhoff & Brinkerhoff, 2011; Mitchell, 2008).

➢ Reasons why private sector participants choose to partner

In the case of non-profit private participants, the benefit may be enhanced opportunities to work in a country, national and international legitimacy, or the ability to learn from larger players how to expand their programs (Mitchell, 2008).

In the case of for-profit private participants the main motivation is also financial. Indeed, most partnerships are built on the basis of mutual financial gain (Mitchell, 2008). These financial benefits are mostly obvious and direct. However, it can also be indirect, with complex financial arrangements. This is often the case in international drug donations.

“An example is the program by Pfizer to donate Zithromax® for use in trachoma prevention programs. In this case, a very expensive drug is donated free of charge to an international trachoma control program that serves a very large number of people who would not otherwise be able to afford the treatment. The financial benefit to the program, government, and populations is clear. The benefit to Pfizer is more subtle. In this arrangement, they donate the drug at market value to a US based charitable organization, and are therefore able to deduct the price of the drug from their tax obligations to the US government. Through this mechanism, the US Government is subsidizing the distribution of Zithromax® for use in Trachoma prevention program, and are thus an inadvertent partner in this activity” (Mitchell, 2008, p. 8).

In addition, product research conducted during the term of the partnership can later be used for other product development. Another example of an indirect benefit is when a private company enters into a partnership with a national government in order to ease the regulatory control over the industry concerned. For instance, a pharmaceutical company will postulate to streamline the government approval process of a certain drug, while in turn the company will make all industry information on these drugs available to the government (Mitchell, 2008).

Another incentive for the commercial private sector is that it can fulfill its social responsibility – for which private companies are increasingly being challenged – through the partnership (Nishtar, 2004). It offers the opportunity for publicity in philanthropy, or legitimacy in terms of working with respected organizations, or enhancement of the overall corporate image and name recognition (Mitchell, 2008).

4.3.2 Challenges and disadvantages of PPPs

Many global health PPPs have positively contributed to health outcomes: technologies for tropical diseases were developed, surveillance and screening strategies were established, etcetera. Yet, health PPPs that go beyond disease specific objectives into health service delivery to patients have not been without skepticism and opposition. “These partnerships should be regarded as social experiments; they show promise but are not a panacea” (Barr, 2007, p. 21)

Especially when PPPs involve the for-profit private sector, they bring many concerns in their wake. The motivation to engage in or promote these kinds of PPPs are questioned. Western countries like the UK, Canada and Australia have already accumulated significant experience in such PPPs in health. And the proclaimed advantages in PPP rationales have been contested by evidence of concrete PPP practices.

Different types of public-private arrangements package complex ethical and operational challenges, since they bring together a variety of actors with different – and sometimes conflicting – interests and objectives, and with different governance structures (Nishtar, 2004). While PPPs contain the potential to provide improvements in health services and the
enhancement of the health status of the population, this potential is not necessarily realized. There is also the risk for abuse through corruption, for neglect of the poor, and for quality deterioration (Mitchell, 2008).

➢ Ethical challenges

Ethical challenges are in PPPs relate to several dimensions. Firstly, there are no global norms and principles to set a framework within health goals can be pursued in a PPP setup. Secondly, there is a risk that PPPs will reorient the mission of the public sector and redirect national health policies. This shift can ignore the poor and marginalized and can therefore conflict with equity in health (Nishtar, 2004). The for-profit private sector, which aims to maximize profit, is generally less concerned with poverty or equity issues. Their attention is focused on the wealthy instead of the poor, who are not capable of paying the full cost of services. Also, some parts of health care are more profitable than others, and private firms may want to direct their attention to these parts and leave non-profitable parts to be provided by the government, both to wealthy and poor (Mitchell, 2008).

“An example of this is chemotherapy which is a very expensive service to deliver, but has very low profit potential in most countries. As disease patterns change and the demand for chemotherapy has increased, governments are finding themselves spending a very high percentage of their budgets on this type of treatment with less and less money available for other primary health services that would preferentially benefit the poor. Further, since chemotherapy is more often used by wealthier urban populations, this type of service may preferentially benefit the wealthy rather than the poor. The result is that even those with private insurance and who use private care for more health care may use the government safety net for these very expensive services, further draining the ability of the government to provide a safety net of basic services to the poor. In this instance, the private partner benefits while the government has all the financial risk. If partnerships are to help address this issue of equity and delivery of services to rich and poor alike, better mechanisms for risk sharing between the partners will need to be developed as well as a strict regulatory environment to ensure the quality and access of services promotes equity in the population” (Mitchell, 2008, p. 20).

Thirdly, PPPs provide the state the opportunity to renounce their responsibilities as a health care provider and regulator. Failure to commit to their role in public health, partnerships may lead to withdrawal of the state and the breakdown of social safety nets on which the most vulnerable groups in society rely. Fourthly, the organizational objectives and interests of the public and for-profit private sector can be regarded as conflicting: the basic motive that drives the for-profit private sector demands a return on investment. (And this is why it is important to make a distinction between the for-profit and non-profit private health sector, which adheres to public health goals. Yet, in complex PPP arrangements, generally assumed organizational objectives of both non-profit and for-profit organizations can be distorted by unclear agendas. For-profit organizations can use the partnership to improve the corporate image by engaging in cause-related marketing. While NGOs are sometimes not more than lobby groups with an interest which may not be aligned with public health goals) (Brinkerhoff & Brinkerhoff, 2011; Nishtar, 2004).

Fifthly, the national health system runs the risk of getting (further) fragmented by PPPs. PPPs generally “tend to pick the lowest lying fruits” (Nishtar, 2004, p. 4) and look for high profile goals that can be achieved in a short term, which do not necessarily fit into the structure and needs of the health system that adopts them. Partnerships tend to set up independent vertical programs. Therefore, if PPPs are instituted in countries with weak health systems they have the potential to fragment the health care system (Nishtar, 2004).

Lastly, while PPPs are presented as an effort to improve quality, efficiency and effectiveness of the public sector, such an assumption is partly based on a normative belief that the
management model of the private sector is inherently better than that of the public sector. Such normative beliefs have led to an under appreciation of the unique role governments play in health care delivery and can hold dramatic consequences for the public health sector (Brinkerhoff & Brinkerhoff, 2011).

➤ Operational challenges

Operational challenges relate to the processes by which partnerships take shape. These comprise several dimensions as well. Firstly, developing countries are often contended with a lack of legislation to interact with the private sector, which in turn makes it difficult to have a sound overarching legislation to deal with PPPs. Due to this legislative weakness, partnerships are often developed on an ad hoc and opportunistic manner (Nishtar, 2004). As a result, a lot of PPP cases deal with governance and regulatory failures (Brinkerhoff & Brinkerhoff, 2011). Partnerships only work to their fullest potential if they are properly regulated, and when there is a robust legal framework in place that can enforce these regulations. Regulation in health is not effective if it cannot be enforced by the legal system (Mitchell, 2008).

Secondly, participatory decision-making is often an ideal that is not accomplished. While this is not a problem that only troubles partnerships, it is a common hurdle in PPPs. Beneficiaries often don not play a part in the decision-making process. In addition, decision-making in a PPP may also be skewed because of the influence of stronger partners. The danger is that the financially stronger partner will affect the public sector’s health policies, regulation and legislation to coincide with their profit motives (Nishtar, 2004).

Thirdly, the selection criteria can raise questions on competence and appropriateness of the chosen partners. In many instances the public sector remains vague about how potential private partners are screened and selected (Nishtar, 2004).

Fourthly, partnerships only function optimally when the rights and responsibilities of the different partners involved are clarified (Mitchell, 2008). Yet, many partnerships do not explicate the accountability of partners for the efficient, effective and equitable delivery of health care (Nishtar, 2004).

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13 Regulation in health aims to (1) protect the individual (for instance by controlling the quality of health facilities, products and practitioners); (2) control costs (for instance the government places a cap on fees private health providers can charge); and (3) ensure access (for instance by directing the location of new health facilities to underserved areas) (Mitchell, 2008).
5. **Methodology**

The overall objective of the research is to find out whether the public-private partnership strategy in the Aquino Health Agenda is leading toward or away from greater health equity. Two specific objectives were determined: (1) understand the rationale behind health PPPs as interpreted by the Aquino administration, (2) grasp the status of implementation of health PPPs since the Aquino administration. These objectives give rise to particular data needs. With regard to the first objective, the main actors involved in health PPPs need to be identified, proponents and opponents need to be identified, and their argumentation needs to be clarified. With regard to the second objective, specific PPP projects under the Aquino administration need to be identified, and the geographic and speciality areas need to be sought out. In order to address these data needs, the research was designed as an empirical qualitative research that incorporates different perspectives and approaches to PPPs. An as wide as possible array of informants were interviewed in the available timeframe to get a variety of interpretations on how health PPPs currently manifest in The Philippines. By triangulating these perspectives and interpretations, a comprehensive and objective understanding of the social reality is pursued (Holloway, 1997).

The specifics of the research methodology will be described in the following sections.

5.1 **Sampling Method**

A qualitative research was conducted in order to gain an understanding of the profile and status of PPPs in health in the Philippines. A maximum variation sampling method was used to sample for heterogeneity, since the aim of the research is to understand how the phenomenon of health PPPs in The Philippines is seen by different actors. “When using a maximum variation sampling method, the researcher selects a small number of units or cases that maximize the diversity relevant to the research question” (http://www.qualres.org/HomeMaxi-3803.html).

This was complemented with the respondent-driven sampling method, which enabled to get access to a hidden population and to get an idea of the connections between people and networks (Salganik & Heckathorn, 2004). There were two departure points for the sampling. Firstly, there was IBON Foundation, which has connections with grassroots health organizations (see 2.1). They were able to identify some key informants, as well as arrange exposures to public health facilities and popular mobilizations for health. Secondly, the conference ‘PPP in Health Manila 2012’ (http://www.adb.org/news/events/ppp-health-manila-2012) was attended on 24 and 25 October 2012. The connections made at the conference provided a second departure point for identifying relevant informants. In addition, during the data collection, two meetings of the Universal Health Care Study Group were attended, which further expanded the research sample.

In any case, informants were ultimately selected based on their specific involvement in health PPPs or on their expertise on health issues.

The research sample included representatives from government agencies, private companies, civil society and academe. A total of sixteen informants were interviewed. Those informants who represented the public sector involved in health PPPs consisted of:

- the Undersecretary of the Department of Health who leads the Center of Excellence for PPP in Health
- the head of the Social Development Unit of the Development Bank of the Philippines (DBP) (the informant was also a co-operator of the technical assistance (TA) for PPP in Health of the Asian Development Bank (ADB))
The Deputy Executive Director of the PPP Center
the head of the PPP unit of PhilHealth

The informants who represented the private sector involved in PPPs in health comprised:
- of the national for-profit private sector: an pharmacy supervisor of Planet Drugstore Corp. which has PPPs in several LGUs
- of the international for-profit private sector: an employee of Healthscope Medical Solutions Corporation (part of Philips Electronics and Lighting, Inc.)
- of the international non-profit private sector: the Deputy Chief of USAID’s Office of Health

The informants who represented civil society organizations consisted of:
- the Vice Chair of the Health Alliance for Democracy (HEAD), a progressive health organization (this informant is also a member of academe at University of the Philippines Manila)
- the president of the National Orthopedic Hospital Workers Union-Alliance of Health Workers (NOHWU-AHW), a health workers union

The informants who were member of the health academia, comprised:
- a professor at Asian Institute of Management (AIM) with experience as a facilitator of public-private partnerships
- a professor at Asian Institute of Management (AIM) (the informant is also an ADB consultant and PPP researcher)
- the Chairman of the Social Medicine Unit of the UP College of Medicine (the informant was also a co-operator of the technical assistance (TA) for PPP in Health of the ADB)
- a public hospital researcher of the UP College of Public Health
- the head of the UHC Study Group (the informant is also a consultant for the DOH and a researcher on social health insurance)
- the director of the Health Policy Development Program at the National Institutes of Health, UP Manila
- a professor at the UP College of Public Health

Following people were contacted for an interview, but were not able to participate due to time constraints:
- an employee of the Council for Health and Development (CHD)
- a public hospital director
- a former DOH Secretary
- an employee of the World Bank

Following organizations were contacted for an interview, but did not react to the invitation:
- the National Economic and Development Authority (NEDA)
- the Zuellig Family Foundation (ZFF)
- the Metro Pacific Investments Corporation (MPIC)
- the Asian Development Bank (ADB)

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14 At the request of the informant, his position in the corporation is not further specified.
5.2 **DATA COLLECTION AND ANALYSIS**

Data was collected through semi-structured interviews conducted from December 2012 to January 2013. All the interviews took place in Manila, The Philippines. The interview questions were based on the focus questions of the research (see 3.4). Interview data was supplemented with existing documentation on PPPs in health in the Philippines gathered during the interview period. Intermediary results were discussed with the IBON research department and health academe during the data collection period.

In order to analyse the collected data, the recordings of the interviews were transcribed into transcripts. In the initial stage of analysis, the transcripts were reduced to only the parts of the text that was relevant with regard to the research objectives. In a next step, the remaining text was divided in meaning units. These meaning units were interpreted and coded with labels. Codes that shared meanings were bundled into categories. The focus questions of this research were answered using these categorized data (see 6.1 and 6.2).

5.3 **ETHICS AND TRUSTWORTHINESS**

With regard to ethics, brief information on the research was given before starting the interview. The information concerned the objectives of the research, topics to be discussed and confidentiality of information. The informants were aware of the fact that – with their approval – the interviews would be recorded. They were also aware that the presentation of findings in this report would treat informants anonymous.

The trustworthiness of the data was augmented by the triangulation of information from the interviews and the existing documentation that was collected. By this means, the accuracy of the data was checked. In addition, discussions with the IBON research department and members of health academe – who were not informants but who were knowledgeable about the PPP issue – were held during the data collection period to identify preliminary interpretations of intermediary results.
“Noynoy and Ona\textsuperscript{15} is bullish about, really pushing hard about this PPP. We are foreseeing that it might really happen. But we tell people that it is not enough reason to stop and do nothing. One of our health workers, one of our nurses here just said that: I cannot sleep in my bed, thinking that – even though the PPP happened – at least I fought the battle. That I am not at fault to every life that will perish because they do not have money to seek treatment. So that’s one of the emo-side of the struggle. That even though the chance of winning is bleak – we accept that – we continue this, because this is the right thing to do. This is not a question of whether we will win or not. But this is a question of right and wrong. We cannot just stand idly. We truly love Virchow, when he said that health workers are the natural counsels of the people and their patients. We are that. We are that hardcore. We are the counsel of the patients. We will not allow them to be on the road to perdition as what Ona and Noynoy envisioned it to be.” (informant)

\textsuperscript{15} Noynoy is a nickname for president Benigno Aquino III. Ona is the Secretary of Health in the Aquino administration.
6. FINDINGS

6.1 PROFILE OF PPPs IN HEALTH: ACTORS AND RATIONALES

6.1.1 MAIN ACTORS

The public sector and private sector represent the two main parties in a PPP. In PPPs in the Philippine health sector, there are national as well as international public agencies and private non-profit and for-profit corporations involved.

The data gathered identifies several public sector agencies at the international level which promote and/or support the development of health PPPs in The Philippines:
- the World Bank, which provides assistance on hospital based PPP initiatives;
- the United Nations Economic Commission for Europe (UNECE) Team of Specialists on PPPs, who supports the Philippine government to develop and manage PPP projects (for example with their PPP Training Toolkit);
- the British government, through the British Embassy in Manila, which is supporting the development of PPPs in the Philippine health sector.

At the national level, the public sector is represented by the Department of Health (DOH), the government ministry responsible for health. At the local level, the public sector is represented by the Local Government Units (LGUs), who became responsible for health in their localities after devolution (see 2.2.1). LGUs can refer to provinces, cities or municipalities. Both the DOH and LGUs can engage in PPPs.

The collected data also identifies various private sector organizations, at the international and national level, that are interested in or actively promoting PPPs in the Philippine health sector.

In terms of non-profit private organizations, several multilateral development organizations and bilateral donor organizations are promoting the PPP model in Philippine health care:
- the Asian Development Bank, which – in cooperation with the Development Bank of the Philippines and Philhealth – provides technical assistance (TA) for PPPs in health;
- the Australian Agency for International Development (AusAid), which is a financial contributor to the assistance program of the ADB for PPPs in health;
- the Canadian International Development Agency (CIDA), which is a financial contributor to the assistance program of the ADB for PPPs in health;
- the United States Agency for International Development (USAID), which has incorporated PPPs into its health projects in The Philippines.

Many of the countries represented by these international organizations have already been engaging in PPPs for years.

The private donor Zuellig Family Foundation is an example of a non-profit private organization at the national level. The Foundation is active in the health sector and health PPPs.

In the area of for-profit private organizations, interest from multinational corporations from the United Kingdom, Japan, China, the Middle East, Korea, Australia, India and the United States of America, The Netherlands and Germany has been noted (among which multinationals like Siemens, Philips, Macquarie and GE).

Philippine companies express interest in health PPPs as well. Especially the "big players" (informant) like Ayala Corporation, SM Investments Corporation, San Miguel Corporation and Metro Pacific Investments Corporation.
6.1.2 **Rationale of PPP proponents**

Public and private sector proponents of PPPs have developed a specific reasoning for entering in PPPs in the Philippine health sector. In accordance with the theoretical framework (see 4.3.1), the collected data show that PPPs are perceived as a potential win-win situation, with particular interests depending on the organization objectives of the specific partner. Overall, it is believed that “having a good profit on the one hand and achieving health aims can work hand in hand” (informant). The perceived benefits and advantages of a PPP agreement from the perspective of the different parties involved— as has been mentioned by informants during the interviews— will be described in the following paragraphs.

- **From the perspective of the public sector**

Representatives of government agencies see benefits in following PPP aspects:

- The private sector can infuse the much needed financial resources to provide health services, which the government is short of. Through PPPs, the government can get the funds to fast track bigger projects, like building hospitals or buying very expensive machines. This enables the government to catch up with the public infrastructure underspending and backlog of medical facilities, without the money being “taken away from other governmental concerns” (informant). “Basically PPPs are supposed to provide a service without any expense for the government” (informant).

  For instance: a private investor builds a hospital, and the government allows the private entity to operate the facility. During the operation period, the investor can win back their investment. After the concession period, the hospital is turned over to the government. So the government achieves the public infrastructure, while the private entity gains as well, “so how can you lose?” (informant).

- PPPs is considered to be a way of tapping into the efficiency of the private sector in managing business, which the public sector is not good at. Government procurement is bureaucratic, slow and corrupt. Private businesses have a sound management model which is fast and efficient. In that way, the private sector can deliver “proper performance of health care facilities” (informant).

- The private sector can deliver better quality of care and offer “value for money” (informant). They can deliver good quality equipment and renovate or expand dilapidated infrastructure. In this way, patients will not need to travel far to get the services, as is often the case at the moment due to the lack of specialized care and infrastructure in most regions.

- The private sector can offer innovation and innovative strategies on how to improve service delivery, whereas there is no real innovation in government agencies.

- Involving the private sector can expand coverage.

  For instance: PhilHealth is having trouble enrolling the informally employed, to make it easier to reach them, they engaged in a partnership with shopping
malls to set up PhilHealth ‘bayad centers’\textsuperscript{16} in their buildings. The employees would be hired by the malls, in return, they would get a percentage of the enrollment fee or a service fee. “It’s a win-win: the malls earn, PhilHealth doesn’t spend money, and the members benefit from the convenience of having a PhilHealth office in the mall” (informant).

- Compared to the traditional route of taking out loans (from private banks or from official development assistance (ODA)) to fund public infrastructure development, government ownership of the development is maintained. In taking loans or funds, ownership often gets lost.

Next to these advantages, public sector informants also recognize a few disadvantages or challenges of partnering with the private sector to deliver health services:

- “The private entity needs to earn, so they will have to charge accordingly” (informant). The concern coupled with that is the concern of rising medical fees.

To address this concern, it has been stated that the private party will be allowed a reasonable rate of return, and that this amount will be monitored by the government and tempered by social health insurance through PhilHealth. An example of government monitoring is that the government can direct the contractual agreements towards affordability by extending the concession period (so for instance, if the private party will only start making money in ten years, they can make the concession period twenty years or more, so that the private party will be assured of a return of investment, without spiking the fees for the patients). An example of tempered fees via PhilHealth is that the indigent program – the No Balance Billing package – of PhilHealth will cover portions of the hospital bill for indigents who are beneficiaries of the program. This program is supposed to be a guarantee for the private party that they will get paid, as well as a guarantee for the patient that they will still be able to afford medical care in a PPP setup.

\begin{itemize}
\item \textbf{From the perspective of the private sector}
\end{itemize}

Informants mention following advantage for the non-profit private sector:

- Donations of equipment, like dental chairs or X-ray machines, can improve the image and reputation of the non-profit organization, since it is often stated very obviously onto these pieces of equipment who donated them.

Yet, most advantages informants mention have to do with benefits or opportunities for the for-profit private sector when engaging in a health PPP. These comprise the following:

- All informants – public and private sector representatives, civil society and academe – agree on the fact that the profit objective of private corporations is clear: the bottom line is that they will have to earn money. If they will not get a return on investment, they will not be interested in a partnership. “Business is business, it’s the nature of the thing” (informant). “This never changes, it’s more transparent and predictable” (informant).

- Keeping their bottom line in mind, private investors are interested in partnering with government agencies because of the large scale and demand in the public sector: “The case of the NKTI [National Kidney Transplant Institute] is a successful case of PPPs. There are a lot of kidney cases in the

\footnote{\textsuperscript{16} ‘Bayad’ is Tagalog for ‘pay’, so a ‘bayad center’ refers to a center where social insurance contributions for PhilHealth can be paid.}
country. I think the next one [PPP] would be with regard to heart illness and also with diabetes, in terms of pharmaceuticals. Or PPP on vaccinations” (informant). Development opportunities are large, because the needs are large. In The Philippines, the public health sector serves the largest population, and public facilities and services are old or do not exist at all. So the potential for growth lies in public health care delivery – in terms of patient census as in terms of infrastructure need –, not in private health care delivery. “Private hospitals are already okay with one, two, three machines. But in the government, most of the time it’s the whole hospital that we’ll have to develop. (...) Almost all the DOH hospitals needs the services that we can offer. So it also means good business for us at the same time. Bigger opportunities, and a bigger chance to engage in a more profitable partnership” (informant).

- In addition, private companies are keen on having PPP arrangements with the public sector because of the guaranteed income. “Their earnings will come in smaller chunks, but it’s guaranteed. In that sense there’s minimal risk” (informant).

- The financial gains also come indirectly.

One example has to do with maintenance products and costs: a company can supply a CT Scan at a lower cost or even for free, as to provide a service to the people. “But X-ray machines need reagents, dies, films, and a CT Scan needs air-conditioning. They will not function when those things are not there. So a lot of supplies are needed for the maintenance, and that will benefit the party who is supplying” (informant).

Another example of indirect financial benefits is the following: a well-known Filipino business conglomerate has engaged in a “buying spree of hospitals that are really falling down. The hospitals he has bought, he has renovated with all Indonesian products of a company that he is in association with. For example all the IV’s and all the plasters will be Indonesian. So the profits of the products that will be used and bought, will be for the partner of [the business conglomerate]. Even before the services start, they already have profits” (informant).

- In the case of these large business conglomerates, an informant also indicates that engaging in the health sector is the logical next step in terms of a company’s comprehensive business strategy: rehabilitating a number of hospitals in a specific region where they have other (industrial) activities as well, makes sense because the company has to provide its employees with good health services. “It makes sense businesswise to go into hospital care and services” (informant).

Some disadvantages of entering in a PPP are mentioned by private sector proponents as well:

- There is the issue of accountability. Past experiences when partnering with the public sector show that the contract is not always honored, especially when it is a long term contract and the people that hold public office change. “There should be legislative documents that would honor that the next major or governor will still pay you” (informant).

- The flaglaw17 is perceived by international private investors as a hurdle. The fact that more Filipino companies than foreign ones have engaged in PPPs is a

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17 The flaglaw refers to the fact that foreign investors cannot easily invest in The Philippines unless there is a 40%-60% sharing with a Philippine company, respectively.
result of this. “Because public bidding normally requires a corporation to have Philippine ownership. So if I’m a foreign corporation and I’d like to engage in a public bidding, I cannot. So I need to look for local partners, which is sometimes not seen as productive by foreigners” (informant).

➢ There are concerns about the consultation process as well: “From the conceptualization of the idea to the materialization of the actual project, they should always consult with investors” (informant), but they often do not. The government in The Philippines tends to work toward solicited projects\(^\text{18}\), wherein they will determine the rules and terms of the agreement at hand. But investors “investors are not that keen on solicited proposals, compared to unsolicited” (informant).

### 6.1.3 Rationale of PPP opponents

The concept of health PPPs has its proponents in The Philippines, as is clear from the data described in 6.1.1 and 6.1.2. Yet, there are people and organizations with a different perspective on the matter as well. Health PPPs meet a lot of opposition from civil society, especially from progressive health organization. The main actors are the Health Alliance for Democracy (HEAD), the Alliance of Health Workers (AHW) and the Council for Health and Development (CHD). Furthermore, in academia, there is quite some skepticism noticeable as well. The data described below show that both progressive health organizations and members of academe take the right to health as their departure point in approaching PPPs. Since their rationales are quite similar in conceptual terms, the rationale described in this section consists of interview data from representatives from the aforementioned progressive health organizations, as well as members of academe.

The right to health is the departure point of this alternative rationale on PPPs in the Philippine health sector. When health is considered a right, PPP opponents argue that

➢ (1) health care should be, if not free, affordable to all Filipinos.
➢ (2) the government – as representing the interest of the people – should be the primary provider of public goods, including health care. Public health is the obligation of the state and therefore the state is obliged to fund and/or provide it.
➢ (3) primary health care should be the focus of any health system.

That is why they raise following arguments against PPPs:

➢ (1) Health care that is affordable for all Filipinos cannot be equated with health care that is affordable via social health insurance. Because, firstly, packaging health care in insurance packages is a commodification of health care, which implies that health can be marketed and genuine intervention or subsidy by the government is not needed. “You can just avail this kind of package because you are in this kind of social strata, and not other kind of services, that’s limiting access to health care” (informant). Secondly, PhilHealth is pushed forward to solve the problems with regards to health PPPs, but PhilHealth people cannot provide a sensible answer. No Balance Billing is limited to only twenty-six diseases and the cost of treatment (like kidney dialysis, transplants and chemotherapy) has a ceiling. For instance: the cost of six sessions of

\(^\text{18}\) Solicited project are projects that are selected and proposed by government agencies.
chemotherapy, is about 1.5 million pesos. PhilHealth only covers up to 200,000 pesos.

“What we need instead of insurance is a genuine government subsidy, a free and comprehensive health care for Filipinos. Free because we are tax payers and it’s government obligation. Comprehensive because they should tend to the three facets of health: primary, secondary and tertiary; with major focus on primary health care” (informant).

(2) Health care is a government responsibility, and private involvement should be carefully handled and regulated. The public and private sector have a different goal and mandate: public health care is about treating people, not about their capacity to pay; so you cannot expect a return on investment in a public health care setup. In contrast, the private health sector is driven by profit. Capital is infused, and a return on investment is expected. The argument of the government that they do not have the financial resources to invest in health, is counteracted by the argument that the government does have money, but there is no political will to invest it in the health system. For instance, the government had a 47 million budget for the conditional cash transfer (CCT) program, of which the effectiveness is highly contested. “Why not give us a piece of that pie (...) to give to the maintenance of this hospital, and not rely of private investment. The only alternative action is for the government to have political will to put their wallet where their mouth is. They say universal health care, but they mean universal coverage. We are not totally against PhilHealth. But it should be the core of the health care delivery system” (informant).

The argument that PPPs will save the government money, is considered to be faulty by PPP opponents. In their opinion, evidence of PPPs in other, developed countries show that the government does not necessarily save money by engaging in a PPP model of health care delivery. A lot of PPP projects failed or the hosting government ended up spending a lot more than anticipated.

Another argument of PPP proponents is that the bureaucracy of government is delaying everything in health care and that public health care is inefficiently managed. Opponents argue that this has been disproven in practice, for instance: the government commissioned audit gave the Philippine Orthopedic Center an above average rating for management in 2012. They can discharge 80% of their patients without charge, even despite the low budget allocated to the facility.

The contention of opponents from progressive health organizations is that PPPs is part of privatization of health care. The idea is that if you hand over, even just a piece, of your role as a government to the private sector, that is privatization. PPPs can be called partial privatization or semi-privatization, it is still privatization and it is unacceptable.

(3) The health sector should be focused on primary health care, instead of business ventures like hospitals. “When you dismiss primary health care, you are declaring war against public health, because primary health care is public health” (informant). Yet, specialty care is highly estimated by policy makers. “They tend to believe that urban-based, hospital-based and doctor-centered treatment is thé policy” (informant). Current PPP projects tend to gravitate to large-scale hospital infrastructure projects, instead of concentrating on preventative care. The latter is very important in a health context where the
main causes of mortality and morbidity are preventable diseases and lifestyle diseases.

In this reasoning of PPP opponents, two groups in particular in the health sector will be badly affected:

- Firstly, poor patients will be affected. Prices of treatments and medicines would increase in a PPP setup. This would limit their access to health services and products even more. PPPs “would equal to a larger sum of money for the treatment, it would be deterrent for the poor to access (...) especially for chronic diseases. There is a man here who has been nineteen years on a respirator. Now his stay in the hospital is subsidized. If the management changes, he will be charged obviously a large amount of money per day. Which he cannot afford. He would die” (informant).

- Secondly, public health workers will be affected. PPPs and privatization brings with it a shift to contractualization. “The organic character of the employment would change, from a public employment to a private setup” (informant). This implies that tenured health workers would be replaced by contracted health workers, who can be fired at any time. In a business sense, contractualization saves a lot of money, because contracted workers do not have the benefits of tenured staff. “And they could dictate the amount of salary that they have. They would not be forced to give what is called the Magna Carta benefits of public health workers” (informant). This would lead to job losses or work displacement for current public health employees, and greater job insecurity for employees that will be working, or are already working, in a privately managed hospital.

### 6.2 Status of PPPs in health: Concrete PPP projects

The Philippines has experienced a lot of privatization and PPPs in the past. The implications of those projects has been the subject of a lot of debate (Bello et al., 2009). The NKTI Hemodialysis Center Project and the ‘Butika sa Barangay’ project have been mentioned during the interviews as cases of PPPs between the government and the for-profit private sector. The tuberculosis control program (supported by WHO and USAID), the leprosy treatment program and the anti-malaria treatment program (supported by the Global Fund) are cases of past PPPs between the national government and the non-profit sector. In addition, in many public hospitals, janitorial and food services have been outsourced for quite some time.

This situation has evolved further since PPPs have been proclaimed as the cornerstone of development by the Aquino administration (NEDA, 2011). Several supporting mechanisms have been put in place or reigned since the administration assumed office in 2010. Following interventions aimed at facilitating PPPs were mentioned by informants:

- a revision of the implementing rules and regulations of the Build-Operate-Transfer law (BOT Law), in order “to remove bottlenecks, to level the playing field and to make it more responsive and up to date” (informant);

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19 ‘Butika sa Barangay’ is a DOH program where village drugstores are being put up in order to provide and sell essential medicines. The agreement is that the private entity puts up the physical place and the personnel, while the DOH provides the training for the personnel.
the renaming of the previous BOT Center to the PPP Center, which got a fresh mandate along with the new name: the Center coordinates the PPP efforts of the implementing government agencies, provides funds for feasibility studies and ensures that the private sector and the public sector comply with the contractual arrangements;

- Executive Order 79 was issued, which mandates the inclusion of alternative dispute resolution provisions, to prevent that a project will get stuck in the judicial system for years (if the parties have a (potential) misunderstanding, they can talk about it in a forum which will not require judicial intervention);
- a memorandum issued by Department of the Interior and Local Government telling all government agencies and local governments units to put up a PPP desk;
- overall anti-corruption and transparency initiatives, in order to improve the business environment;

- specifically in the area of health, a PPP Specialist Center of Excellence on Health was established in Manila by the UNECE to promote and coordinate training, and knowledge-sharing in PPP best practices within health.

In this policy context, several PPP projects were proposed and initiated. The next two sections give a brief overview of the concrete projects.

### 6.2.1 Initiated PPP Projects in Health

Since the Aquino administration assumed office, following projects have been initiated on the national level:

- The Modernization of the Philippine Orthopedic Center (MPOC), a tertiary DOH-retained hospital. The private corporation engaged in the PPP project is to build and operate the hospital for an concession period of twenty-five years, after which it will be transferred back to the government.
- The Vaccine Self Sufficiency Project II. The project involves setting up a Research Institute for Tropical Medicine. It is aimed at making The Philippines self-sufficient in producing vaccines. The project is expected to reduce the annual cost for vaccine procurement in the country.
- National Kidney and Transplant Institute – Radio Oncology Center Project: the private sector will supply, deliver, and operate the new specialty Center for LINAC Facilities.

On the local level, in Local Government Units, PPPs are generally smaller yet numerous. Also on the local level hospital services are being targeted to put in a PPP setup. The technical assistance of the ADB in support of PPPs in health, is helping LGUs to frame the terms for outsourcing pharmacy services and hospital management.

### 6.2.2 Pipeline of PPP Projects in Health

The PPP Center has actively encouraged government agencies to propose ambitious projects. “If it’s a cheap project, the government can easily afford it. But if you’re talking about billions, then our resources are limited. (...) So because of that, necessarily only big ticket projects are being PPP-ed. And if there are small projects, the private proponents will not be very interested” (informant).
For the health sector, the Department of Health has come up with a list of priority PPP projects. It is essentially a list of DOH-retained hospitals they want to improve. Because these projects are proposed by a government agency, they can be classified as solicited projects. Therefore, if a hospital is on the list, the private sector cannot do an unsolicited proposal on the hospital concerned, and the terms of the engagement will be determined by the government.

The list of health PPPs in the pipeline:

- Imaging Facilities as Eligible PPP Projects (for the provision of X-Ray Digitization, CT Scans and MRI Machines)
- Modernization of hospitals:
  - Cagayan Valley Medical Center
  - Bicol Medical Center
  - Region I Medical Center
  - Vicente Sotto Memorial Medical Center
  - Rizal Medical Center
  - Baguio City General Hospital and Medical Center
  - Northern Mindanao Medical Center
  - Quirino Memorial Medical Center

The collected data shows that PPPs are mainly found in following in the health system building block of ‘service delivery’. Since PPP efforts tend to be anchored in hospital infrastructure improvement. Yet, PPPs projects are also found in the building blocks of ‘medical products, technologies’ (mainly drugs and specialized equipment) and ‘information and research’ (for instance the Vaccine Self Sufficiency Project, although this project also largely entails the establishment of new infrastructure).

In terms of geographic areas, PPP efforts are found nationwide, on the national (DOH) as well as on the local level (LGUs). The national projects are concentrated in wealthy urban centers “where there is a demand” (informant), not in remote rural areas. A lot of projects are located in Luzon and Metro Manila; “imperial Manila” (informant). The (international) for-profit private sector is primarily interested in these areas. DOH-retained specialty hospitals are targetted, by which they can also cater to neighbouring areas. “At the end of the day, the economics of the whole endeavour will speak out loudly” (informant)

On the local level, LGUs are mostly engaging in small-scale PPP efforts, for instance outsourcing the pharmacy services of a city hospital. Although they are small in size, they are becoming widely spread. Nonetheless, some projects have also been more ambitious, like the effort to contract out the management of a provincial hospital. In any case, also on a local level, the focus seems to be on hospital services. The international for-profit private sector shows reluctant or no interest in engaging with LGUs in PPP arrangements. LGU governments are not seen to be thrustworthy in terms of living up to the terms of the agreement or in terms of accountability.

6.3 **Potential implications for health equity**

The first specific objective of this research was to understand how PPPs in health under the current Aquino administration are understood by the different parties involved.

The collected data show that the rationale of participants in health PPPs is mainly based on the belief that the public sector is short on resources, lacks efficiency, quality and innovation – things the private sector can provide. Partnerships are perceived to be a win-win situation, both from the perspective of public proponents as from the perspective of private proponents. The view of proponents is congruent with an optimistic strand in PPP literature,
grounded in a normative belief in the potential of the private sector (see Brinkerhoff & Brinkerhoff, 2011). Opponents of PPPs in the Philippine health sector dismiss this rationale of PPP proponents. Although the arguments of the for-profit private sector are seen to be clear and part of the nature of business, they do not approve the private sector getting involved in the public health sector. In their view, the aim of for-profit private proponents to maximize profit does not coincide with the aim of the public health sector to provide service to the people, regardless of the ability to pay. With regard to the argumentation of the public sector, opponents strongly dismiss their arguments on the basis of a human rights approach to health. Health is the responsibility of the state and should be provided for free, or at least affordable, by the public health sector. The priority should be the needs of the people, and therefore primary health care should be the focus of the public health system.

The second specific objective was to find out to what extent the ‘talk’ of health PPPs has become a reality under the current administration. The status of nationally initiated health PPPs at the moment is small in number but large in scale. The ongoing and envisioned projects of the DOH are ambitious, big ticket projects. At the LGU level, PPP projects in health tend to be of smaller in size. In both cases, specialized hospital-based projects are predominant, be it in provision of specialized equipment or in modernization of hospital infrastructure. Furthermore, geographically, almost all PPP efforts concentrate in urban centers. Yet opponents question this focus of the current health policy on hospital improvement in urban areas. An comprehensive analysis of the building blocks of the Philippine health sector by the UHC Study Group indeed shows that the needs of the health system and the needs of the majority of Filipinos do not lie in specialized hospital-based health care in developed urban centers (Acuin et al., 2010).

In both cases, DOH- and LGU-level, partnerships with the for-profit sector prevail. In literature, partnerships between the national public sector and the for-profit private sector is widely debated, and evidence of effectiveness is inconclusive (see for instance Boardman & Vining, 2012 for a critical view). Also health PPP opponents in The Philippines contest this kind of partnership. The sentiment on partnerships of the government with the non-profit private sector is less intense. Notwithstanding that the role of the government could be more directive in those partnerships, opposition to partnerships with the for-profit sector is much stronger.

Now, how can these data be interpreted in the light of the ultimate question posed by health PPPs in developing countries: health equity? Indeed, the main objective of this research was to find out if the adoption of the PPP strategy is expected to lead toward greater equity in health?

In what follows (1) the implications of the PPP strategy of the Aquino administration on the Philippine health system will be discussed, and (2) the implications of the PPP strategy of the Aquino administration on health outcomes of the Philippine population will be discussed.

6.3.1 Implications of PPPs on the Health System

The deficiencies of the Philippine health system underlie the inequities in health, according to the UCH Study group (along with inequities in the broader society that underlie inequities in health) (Acuin et al., 2010). Considering the deficiencies described in section 2.2, the potential contributions of PPPs lie in the improvement of dilapidated health facilities and an increase of available technology
and equipment. Yet, as has been discussed in section 2.2 these do not address the greatest
defaults of the system and therefore should not be prioritized. Priorities do not lie in
specialized health care facilities in urban centers. A more effective referral system, with a
strong primary care basis, with rationalized health spending and an adequate workforce, are
the priorities.
Even worse than not contributing to the real needs of the health system, PPPs might hold
the risk of potential aggravation of the deficiencies that burden the system.
Firstly, preventive care should be prioritized on curative care. Spending on primary care will
eventually generate better returns than wasting on curative care. Yet, this is not where the
money lies and it hardly attracts the for-profit private sector. (Improved infrastructure on
the other hand, offers opportunities even before service delivery begins, remember the
example of Indonesian products.) PPPs are located on the end of the line of curative care;
the investments focus on highly specialized health care.
Furthermore, vertical programs instituted by PPPs (Nishtar, 2004) could aggravate the
already highly fragmented health care delivery system.
In addition, in terms of health financing, the money that the government spends (and could lose) on PPPs, represents an opportunity cost in areas of greater priority. Simply put, the
government puts their time and resources in one thing, it cannot put it in another thing. Also
the policy focus on universal health coverage, instead of genuine universal health care, can
be regarded as a faulty priority in achieving UHC. Informants mentioned several times that
supporting PhilHealth schemes – as a financial guarantee to investors and patients – goes
hand in hand with making PPPs attractive.
In the area of human resources for health, the possible contractualization that comes with
PPPs will make working in the public health sector even less attractive for doctors and
nurses, since it will further cut their benefits. The increased shortage of personnel could
have detrimental effects on an already precarious workforce situation.
In terms of health leadership and governance, it is considered the responsibility of
governments to take the necessary measures to ensure the right to health of its citizens,
irrespective of which kind of health care delivery mechanism is in place (Maru & Farmer,
“The destitute sick rely on governmental protection for their survival. If our goal is to reach
these most destitute, we must strengthen and support the public sector, rather than provide
parallel services. Patients may receive care, services, and goods from private companies or
organizations, but these institutions cannot themselves provide the basic social protections the
poor need to survive. Accompaniment, in a rights-base approach to public sector services, has
two elements: working with governments to build their capacity to deliver services, and
simultaneously working with communities to hold governments accountable for the quality,
equity, and effectiveness of those services.” (Maru & Farmer, 2012, p. 5)
Yet, in a PPP setup, the role of the DOH is pushed from being a health provider to a health
purchaser. And a much needed increase of capacity of the government is left hanging.

In conclusion, the data do not indicate that the health system will not perform better by
using the PPP strategy. PPPs are not responsive to the priorities of the Philippine health
system. PPPs do not scratch where it itches. And could even have counterproductive effects.

6.3.2 IMPLICATIONS OF PPPS ON HEALTH OUTCOMES

Keeping these tendencies and effects on the Philippine health system in mind, do the data
indicate that using a PPP strategy will lead to better health outcomes for all groups in
society?
In PPPs, the private sector is entering in the public health sector, which caters to 70% of the
Philippine population, including the most vulnerable groups in society (see 2.2). If they ever
do come in contact with the formal health system (still seven out of ten Filipinos die without medical attention (Lorenzo et al., 2007), it will be the public part of the system. The private health care sector is largely inaccessible to them. Informants working in the public health sector concur: the largest group of patients of public hospitals are indigent patients who rely on charity or free services in the hospital. For instance, the Philippine Orthopedic Center is the unofficial hospital for poor farmers and workers, since they treat a lot of cases related to work accidents and cases of tuberculosis of the bone (which is a poor man’s disease, because it is mitigated by poor living conditions).

It is presumed by PPP proponents that health outcomes will improve by putting the health care sector in a competition atmosphere. Yet, literature suggest that this is not necessarily the case (Boardman & Vining, 2012). And if it were to be true, the question remains: better health outcomes for who? Who are the beneficiaries of PPP efforts?

Contentions on rising medical fees due to PPP arrangements suggest that poor patients will not benefit from the enhanced infrastructure and services.

If they do not benefit, then who does? Informants push forward the medical tourism incentive. The “modern health picture” (informant) is important to attract wealthy clients from abroad and become competitive in the area of medical tourism. The National Kidney and Transplant Institute (NKTI) has been engaged in such efforts, even before this administration’s health policy has set its mind to PPPs. And again, the NKTI is in the pipeline for improvement via the PPP strategy. Although medical tourism can generate incremental income for the country, it is not necessarily benefiting the health budget.

Another contention, as well in literature (see Nishtar, 2004) as in the interview data gathered, is the lack of participation in the PPP process. For instance, there has been only one (forced) consultation of health workers during the initiated Modernization of the Philippine Orthopedic Center. The health workers union enforced a consultation through ongoing protests and mobilizations: “That was the first time and the last time when they consulted us. Not a dialogue, because he primarily just lectured me on the benefits of privatization. They just did it for photo ops, and for them to report that they had dialogue. We were just dismissed as an activist stand on the issue” (informant).

The ultimate beneficiaries of health care, the people, are not included in decision-making. Yet, they are the most important stakeholder of PPPs.

PPPs should normatively serve the public interest (Boardman & Vining, 2012). PPPs, as any other public sector endeavor, should benefit the people. Notwithstanding, the objectives of government officials is not always in the interest of the people. “The bottom line of the public sector should be the public good, but public sector’s definition of what the public good is not always transparent” (informant). “Sometimes the private entity offering the services has already been chosen for that particular hospital by the DOH” (informant). Informants relate this to an overarching problem in Philippine politics: the existence of political patronage and corruption. The ones in political power are also networked with business.

“We are now governed by networks, it’s all interlinked” (informant).

Boardman and Vining (2012) add that the motivation of politicians to put PPPs on the health agenda can benefit their political careers. Since PPPs can give the impression of dealing with limited government resources, and all the while providing efficient, good quality services as well. In a PPP setup, costs for the government can be pushed to the distant future, since concession periods usually span a lot of years. Leaving future administrations to deal with the problems that may occur (Boardman & Vining, 2012).

That is why a sound regulatory framework is needed in PPPs, and political opposition and mobilization is healthy (Maru & Farmer, 2012).
In conclusion, PPPs are not responsive to the interests and needs of the Philippine population, in particular the most vulnerable groups. Rather, the interest of medical tourists, politicians and business networks are being considered.
7. **Conclusions**

The conducted research provided an insight on the issue of PPPs in the Philippine health sector from a variety of positions and interpretations. When the findings are approached from a health equity perspective, pursuing PPPs as a health policy strategy can be questioned. This is especially the case in the health context of The Philippines, where health disparities among groups of different wealth status are prevalent. In this context, PPPs hold the potential to aggravate the existing deficiencies of the health system, and therefore does not provide an answer to the most pressing health problems. PPPs are not directed to the primary health needs of the majority of (poor) Filipinos. The implementation of the PPP model under the Aquino administration is primarily targeted to specialized care. Therefore, the collected data point to the conclusion that these PPPs will not contribute to greater health equity among Filipinos. There are no signs to be found that a reduction in preexisting inequities will take place through the PPP strategy.

This conclusion cannot firmly stand based on sixteen interviews. On this scale, evidence stays somewhat anecdotal. Yet the fact that all the interview data point in the same direction, suggests that there is a trend going on that cannot be ignored. The trend being that PPPs are not fit for the Philippine health context at the moment, and that the limited government resources should not be directed that way.

In order to confirm the findings and conclusion of this research, the issue of health PPPs in The Philippines should be studied further. It is recommended to perform case studies on initiated PPPs under the current administration. The research protocol described by Barr (2007) provides a good tool to conduct case study research on health PPPs.

In addition, studying PPPs from a health equity perspective, also requires taking into account social determinants of health that produce inequities in population health (Braveman & Gruskin, 2003). Compounded by the fact that disparities in health also run along the lines of political power of different social groups, it could be usefull to study health PPPs and their relation to power.
8. References


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