Brazil: Comprehensive primary care, private hospital care[1]

Brazil went against the neoliberal trend in vogue in the rest of Latin America by creating the tax-funded *Sistema Único de Salud* (SUS, the Unified Health System) in 1986. The country's 1988 constitution also proclaimed the government's duty to provide **free health care for all**, despite strong opposition from a powerful and mobilized private health sector. This progressive stance was the culmination of decades of mobilization in favour of better health care that was part of the struggle to restore democracy in Brazil.

The creation of the SUS resulted in the roll out of an impressive primary care scheme, which now covers almost the entire country. But paradoxically, when in June 2013 millions came out to demonstrate on the streets of several Brazilian towns, one of the key concerns expressed was the lack of access to health care.

Costly private secondary and tertiary care

The problem is that while most primary health care is provided by a vast network of public providers and facilities, the state contracts out most of secondary and tertiary care services to the private sector. High-volume primary care clinics and emergency units remain largely public, whereas hospitals, outpatient clinics and other profitable services such as diagnostic and therapeutic services are in private hands.

This places several kinds of strains on the system. The private sector continues to ratchet up the cost of care it provides, and with **health expenditure** standing at 9% of GDP, Brazil now has one the most expensive health systems in the world. No less than 57% of public funding goes to private care (one of the highest in the Latin American region in terms of percentage of total health expenditure, even higher than in the United States). Such dominance of the private sector introduces **inequity in access** and is further reinforced by the fact that most Brazilians who can afford it (including an influential and growing middle class) purchase private insurance to 'top-up' services that they can access through the public system.

[1] Amit Sengupta (2013) Universal health coverage: Beyond rhetoric. MSP Occasional Paper No. 20. Cape Town: Municipal Services Project. http://www.municipalservicesproject.org/publication/universal-health-coverage-beyond-rhetoric

Chile and Costa Rica: Different Paths to Universal Health

A comparative study of health outcomes in Chile, where private and public insurance companies and providers co-exist in the healthcare sector as part of a national policy, and in Costa Rica, where the public sector is dominant, convincingly debunks the myth that the private sector is inherently more efficient than the public sector and should therefore participate in health services.

Access to health services

In terms of access to basic services, both Costa Rica and Chile have made major advances. Today, they have the lowest infant mortality and highest life expectancy in the Latin American region. However, availability of basic services is not the same as having access to comprehensive care to resolve most health problems, which may explain why, over the last decade, people in Costa Rica have consistently perceived their **access to health services** to be better than people in Chile have (66.4% vs 35.0%). This difference has been maintained even after 2005 when Chile sought to remedy the situation by imposing more stringent regulation of insurance companies (Plan AUGE).

Financial protection

With respect to **financial protection**, although the lack of access to health services for economic reasons has been reduced substantially in Chile since 2005 (from 11.7% to 4.2% in 2011), the figure remains much lower in Costa Rica (0.8%). And in comparison with Costa Rica, out-of-pocket expenditure by families and the proportion of households facing catastrophic health expenditure are all substantially higher in Chile. This situation is produced in part by the fact that Chileans pay for services or products that are not covered by their insurance (e.g. drugs or consultations).

Health system efficiency and affordability

The relative efficiency and affordability of the Costa Rican health system is all the more impressive given the fact that total **per capita health expenditure** is lower than in Chile (US$811 vs US$947). The higher cost of the Chilean health system can be attributed in part to the inefficiency of the private sector in that country, where the use of unjustified medical procedures is more frequent and administrative costs are higher.

Insurance drives costs up

Health insurance schemes are often promoted on the assumption that competition among different providers should produce higher levels of service quality at lower costs ("active purchasing" [WHO 2010] and "management competition" arguments [World Bank 1993]). To the contrary, the Chilean health system is an example of how segmentation produced by the coexistence of private and public insurances is detrimental to efficiency; **collusion** among private providers and **oligopolies** are realities that are ignored in these arguments.

This comparative study demonstrates widespread and consistent financial and health outcome advantages of a strong, single public system rather than a fragmented public-private, insurance-driven model. Insurance schemes are neither the only, nor the best policy option.

Ghana's NHIS: What success story?

Ghana launched the National Health Insurance Scheme (NHIS) in 2003. It materialized the 2000 electoral promise of the New Patriot Party, whose manifesto had proposed the abolition of user fees. This outcome was the crowning achievement of decades of citizen mobilization against what was popularly known as the "Cash and Carry" system.

In theory, a NHIS pools risks of ill health and facilitates cross-subsidization among large populations, drawing on epidemiological and actuarial trends. While usually they are partly supported by government budgetary subsidies, the mandatory contributions from members and employers are the main source of funding. However in the example of the Ghana NHIS, only 5% of income drew from direct subscription from registered members.

This is why, in practice, critics argue that it is misleading to think of Ghana's NHIS as a "health insurance" because it is tax-funded at roughly 70%, while only 24% come from social security contributions from formal sector workers and 5% from mutual health insurance schemes. The remaining 1% accrues from donations and returns on investments. As such, it would be more akin to a national health care system.

Within two years, the scheme was said to cover one third of the population, and roughly two-thirds by 2009. The policy was held up as a success story by international agencies such as the World Bank and World Health Organization.

However, a broad-based coalition came together in 2009 to denounce the inefficiency of the system and documented gross inequalities existing in the scheme. Through the Essential Services Platform hosted by ISODEC, a 'universal access to healthcare campaign' was launched using various advocacy tools, such as research, roundtable meetings with sector policy makers, alliance with international health movements as well as local and international media to denounce the largely anti-poor outcomes of the NHIS.

That year a new president was elected with a promise to make it a truly universal system by extending access to all and downsizing the health insurance bureaucracy. When this promise went unfulfilled, civil society organizations active in the campaign published a report that revealed that enrolment could be as low as 18% due to unaffordable annual premium payments and other barriers to access (even though all citizens pay for the scheme through VAT taxes). While acknowledging some advances such as the comprehensiveness of the services package offered and improvements on access and quality, they denounced low national health expenditure levels, stark social inequality (64% of richest registered while only 29% for poorest stratum), high out-of-pocket payments for those falling outside of the scheme, misappropriation of public funds, shortage of human resources, and skyrocketing costs for medicines, among others.

The paper received mixed reactions locally and internationally because it contradicted the careful portrayal of the Ghana NHIS case as a successful model by the World Bank and the Government of Ghana. The foremost critique of the report was the National Health Insurance Authority who felt embarrassed by the report's evaluation of enrolment at 18% as opposed to their own figure of about 68%. Their strategy then was to deflate the report by attacking its credibility; the criticism focused on the methodology used to reach this lower figure and on the motivations of the international partners of the campaign who were accused of a neo-colonial agenda. Despite the attempts to shoot down the report the shocking statistical reality of the discriminatory nature of the NHIS

succeeded in inviting curious minds, both nationally and internationally to find out what the actual situation was. In 2012 the National Health Insurance Authority had to revise their coverage figure to about 32% in their annual report.

The campaign in Ghana is currently demanding the scrapping of annual subscriptions to enroll in the scheme (the premium ranges from $2.25 and $15 while minimum wage is roughly $1.87 per day), which prevents mostly the poor from access even if a small sum. The campaign is also developing and sharing alternative policy and administrative practices that will enable cost savings to extend access.

India: Public financing for whom?[2]

Health financing.

In the past six years there has been an impressive roll out of **government-funded insurance schemes** in India that are meant to improve the country's public health system. In theory, treatment covered under these schemes can be provided by any accredited facility. But in practice the majority of providers are found in the largely unregulated private sector which already accounts for 80% of outpatient and 60% of in-patient care according to the National Sample Survey Organisation (NSSO), making India one of the most privatized systems in the world and one with an infamous track record of expensive private health services and unethical practices.

As a result, **health insurance schemes mostly channel public monies for private profit**. For example, from 2007 to 2013 the state of Andhra Pradesh allocated a total Rs.47.23 billion to facilities accredited under the Arogyasri scheme, of which Rs.36.52 billion went to private facilities.

Limited coverage

What the majority of Indians lack is comprehensive primary care, but current health insurance "packages" only insure beneficiaries for ailments that require hospitalization. They **cover a very small portion of the burden of disease**, excluding out-patient treatments for tuberculosis, diabetes, hypertension, heart conditions, and cancer among others. Evidence from the first such scheme in India – Arogyasri – suggests that it consumed 25% of the state's health budget but addressed only 2% of the burden of disease.

Limited availability and quality of health services

This situation ends up distorting the very structure of the health system by **starving primary care facilities** to the benefit of more profitable secondary and tertiary care. In 2009-2010, direct national government expenditure on tertiary care was slightly over 20% of total health expenditure, but if one adds spending on the insurance schemes the total would be closer to 37%. In Andhra Pradesh, following the implementation of Arogyasri, the proportion of funds allocated for primary care fell by 14%.

Current public health services are marked by poor access, low quality and limited choice. Besides rampant corruption, poor management results in mismatches between demand and supply of services: facilities aren't distributed optimally; equipment and funds fall short of requirements and don't flow efficiently. Labour shortages can be partly explained by disinvestment in medical education and flawed deployment mechanisms. Although programs such as the National Rural Health Mission have made some inroads to improve services, much remains to be done. The problem is largely one of unresponsiveness to citizens coupled with unreliable technical estimates of costs and disease burden, leading to ill-informed prioritization.

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[2] Amit Sengupta (2013) Universal healthcare in India: Making it public, making it a reality. MSP Occasional Paper No. 19. Cape Town: Municipal Services Project. http://www.municipalservicesproject.org/publication/universal-health-care-india-making-it-public-making-it-reality

The ambiguity of public and private: Malaysia's corporatized health system

Since decolonization in the 1950s, Malaysian citizens have become accustomed to a *de facto* entitlement to publicly provided and highly subsidized health care. The country's primary health care system is one of the most accessible in the world, reportedly second after Cuba.

To address geographical barriers to access, the Health Ministry's Rural Health Service began in 1953 and expanded rapidly to provide extensive primary care coverage. As of 1993, 93 per cent of the population of Peninsular Malaysia lived within five kilometers of a permanent primary care facility.

Malaysia was notable in achieving much of Alma Ata's Primary Health Care goals via an institutionalized formal health care delivery system with minimal resort to health auxiliaries and community health workers, as generally envisaged for resource-constrained settings. In addition to vaccination, pre-and post-natal care, maternal and child health programs, primary medical care with referral backup, health education and promotion, and vector control of communicable diseases, the Rural Health Service also addressed social and environmental determinants of health such as potable water supply, sanitary latrines, environmental hygiene, village midwifery practices, and nutrition.

Exodus of public health workers

Remarkably, this was achieved with public sector health expenditures that seldom exceeded 2.5 per cent of the gross domestic product (GDP). These modest expenditures, however, also impose limits on the level, timeliness and (perceived) quality of care that can be delivered, and furthermore translates into lower salaries for healthcare professionals than in the private sector. This situation sustains a continuing exodus of experienced staff from the public sector (one third of specialists currently practise in the private sector, attending to a quarter of total hospital beds).

Meanwhile, the unrelenting promotion of medical tourism adds to the lure of private practice, which increasingly services a clientele that is regional in scope (Chee 2010). Many health professionals decide to emigrate too.

By 2008, government health facilities accounted for 74 per cent of hospital admissions and only 38 per cent of outpatient visits (Ministry of Health 2010a). Privatization was gaining ground thanks to complex health sector reforms.

Corporatizing public health care

In 1999, the Malaysian government announced plans to corporatize its hospitals and other healthcare facilities, in part to try and stem the outflow of health professionals, and in part due to this growing trend elsewhere in the world. The corporatized institutions would continue to be publicly owned but vested with more operational and financial autonomy outside the purview of civil service rules.

This was intended to allow for more flexibility in salary scales, patient fees, procurements, and timely response to shifts in market demand and client preferences. Coming in the wake of the outsourcing of hospital support services and pharmaceutical supplies, however, it aggravated public anxieties about a future privatization of clinical and hospital services. This quickly became a contentious issue in the run up to general elections in November of that year, and the blueprint was quietly shelved.

Eight years passed before the issue re-emerged on a pilot scale in the form of opportunities for limited private practice in government hospitals. Effective August 1, 2007, Putrajaya Hospital and Selayang Hospital, two of the newer public hospitals with advanced treatment facilities, began to offer to "full-paying patients" preferential access to consultation and treatment by specialists of their choice, in an 'executive' or 'first-class' facility – to be charged accordingly.

The state as entrepreneur

In recent years, Malaysian government agencies have acquired controlling stakes in major for-profit healthcare enterprises. The Johor state government, for instance, controls a large diversified healthcare conglomerate which includes the largest chain of private hospitals in the country. Its diversified portfolio of services includes hospital management, training for nurses and allied health professionals, laboratory and pathology services, central procurement and retailing of pharmaceutical products, healthcare informatics, and laundry and sterilization services.

Meanwhile, the Malaysian federal government's sovereign wealth fund (Khazanah) controls the second largest listed private healthcare provider in the world. Government-linked companies now account for more than 40 per cent of 'private' hospital beds in Malaysia.

Domestically, these developments mean that the Malaysian government, in concert with government-linked companies at both federal and state levels, effectively own or operate three parallel systems of healthcare providers in Malaysia:

1. the regular Health Ministry facilities;
2. corporatized hospitals (National Heart Institute and the university teaching hospitals of Universiti Malaya, Universiti Kebangsaan Malaysia and Universiti Sains Malaysia);
3. commercial hospital chains that account for more than 40 per cent of private hospital beds.

How are conflicts of interests playing out, as the state juggles its multiple roles as funder and provider of public sector health care, as regulator of the healthcare system, and as prime investor in the for-profit health services industry?

Targeting policies

Policies of targeting (as opposed to universalism) are an illustration of the public/private tension in the Malaysian healthcare system (Chan 2006). With the devolution of social services to private enterprise, entrepreneurs in search of investment prospects are primarily interested in the "market-capable" segments of society.

As government-linked entities built up their stakes in the commercial healthcare sector in Malaysia, a succession of health ministers have argued that Malaysians who could afford it should avail themselves of private healthcare services (suitably encouraged thus with income tax rebates). This would allow the government to target its limited healthcare resources on the 'really deserving poorer citizens'.

This intuitively appealing logic ignores the consequential poaching of staff from the public sector, which exacerbates the already burdensome workload of its remaining staff, thus feeding into a vicious downward spiral. Identifying and tracking the "targeted eligibles" (means testing, etc.) would furthermore entail administrative and

transactional costs that are unnecessary with a policy of universal entitlements. Most importantly, a policy of selective targeting would detach a politically vocal, well-connected and influential middle class from any remaining interest in public sector health care, hastening the arrival of a rump, underfunded, decrepit public sector for the marginalized poorer classes.

Indeed, government expenditures on health care, amounting to 2.3 per cent of GDP in 2011 are far from extravagant. Whether this is tantamount to an implicit policy of benign neglect of the public sector – to encourage a migration of the "market-capable" to the private sector – is debatable. While health expenditures in the private sector have increased more than four-fold between 1997 and 2009 (Ministry of Health 2011), there has been a parallel increase in government health expenditures so that the private sector share has remained steady at about 45 per cent of total health expenditures (see Table 1).

ECONOMIC TRANSFORMATION PROGRAMME

Total Health Expenditure by Source of Financing by Public and Private Sectors, 1997-2009

Year	Public	%	Private	%	Total
1997	4,540	56.4	3,504	43.6	8,044
1998	4,879	55.8	3,873	44.2	8,752
1999	5,424	55.9	4,288	44.1	9,712
2000	6,479	55.7	5,156	44.3	11,635
2001	7,669	58.2	5,513	41.8	13,182
2002	8,310	60.0	6,278	40.0	14,588
2003	10,856	59.0	7,543	41.0	18,399
2004	11,092	55.7	8,820	44.3	19,912
2005	10,227	50.8	9,904	49.2	20,131
2006	13,216	54.6	11,012	45.4	24,228
2007	14,098	53.4	12,291	46.6	26,389
2008	16,524	54.0	14,077	46.0	30,601
2009	18,401	54.6	15,291	45.4	33,692

Source: MNHA: Health Expenditure Report: Revised Time Series (1997-2008) & Health Expenditure Report (2009)

PEMANDU

Source: Putrajaya: PEMANDU, Prime Minister's Dept (2009)

In any case, an alternative scenario that would rely on more progressive taxation regimes to improve universal access to quality care on the basis of need, which dispenses with much of the administrative and transactional costs of managing a proposed national health insurance scheme, is notably absent from the options under consideration.

Today, the issue regulatory conflicts of interest remains unaddressed. There is little evidence that the state is exercising its ownership prerogatives in commercial healthcare enterprises to pursue a balance of social versus pecuniary objectives (e.g.

through cross-subsidies or a price-restraining role) beyond cosmetic corporate social responsibility initiatives.

The conclusion that emerges from this investigation is that public ownership (or control) of commercial healthcare enterprises in Malaysia may not work in favour of the equitable provision of health care on the basis of need.

Philippines: Universal Health Care through Public Private Partnerships?

Health outcomes

The Philippines is a lower middle income country with a total population of about 100 million people spread over 7107 islands. Life expectancy at birth is 69 years, which is lower than the regional average. The under five mortality rate with 30 deaths/1000 live births is higher than the regional average (WHO Philippines country health profile, 2015). Worryingly, maternal mortality has actually increased from 110 (in 1990) to 120 maternal deaths per 100000 live births in 2013 (ibid).[3]

Lack of access to health services

Filipinos suffer from dismal access to health services. Today, 8 people out of 10 in the country report never having had a medical check-up or physical examination in their life. This glaring lack of access to health services is also illustrated by the fact that 28% of all Filipino women do not enjoy skilled birth attendance.[4] Health care utilization rates in the Philippines show worse access to health than the regional average.[5]

The primary reason for the low coverage is a lack of financial means. Free health services are very limited and the poorest cannot afford medicines and treatment. This is not a surprise given that average costs of hospital admission are equivalent to 167.5% of the monthly salary of a minimum wage earner. Due to poverty, 6 out of 10 people die without ever having seen a doctor.

There are large disparities in access to health services between different socio-economic groups in society. Coverage of health services in the Philippines is much lower among people living in poverty or who did not enjoy an education.[6] The poorest two-thirds of the population use public facilities, especially Rural Health Units and village (*barangay*) health centers; in comparison only 10.6% of the richest quintile use these facilities, favouring private hospitals and clinics. However, the availability of public health services remains very poor in the Philippines, with large urban-rural disparities. In the Philippines there is only 1 hospital bed available per 1000 people, while in Europe this amounts to 63 hospital beds per 1000 people. There are only 1 doctor, 3 nurses and 7 midwives available per 100,000 people, while the WHO recommends 228 health workers per 100,000 population.

Health policy in the Philippines

President Benigno S. Aquino III is implementing the country's Philippine Development Plan (2011-2016). Within this framework, his government embarked upon two major strategies to supposedly rescue the ailing health system:

1. Expansion of the National Health Insurance Program called Philhealth
2. Corporatization and public-private partnerships in the health sector

Aquino's Health Agenda claims to bring “equity and access to critical health services to poor Filipinos”. It is a continuation and intensification of previous policies: the ‘Health Sector Reform Agenda’ (Estrada) and ‘Fourmula One for Health’ (Arroyo). The 3 policies advance a smaller government role and privatization of health services with hospital corporatization, medical tourism and opening up for local and foreign corporations in

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3 IBON, 2013c. *State of Maternal Health*.

4 World bank Data, 2013: Births attended by skilled health staff (% of total) in the Philippines. From: http://data.worldbank.org/indicator/SH.STA.BRTC.ZS/countries/PH?display=graph (last accessed on June 15th, 2015)

5 WHO Philippines Country health profile 2014

6 WHO Philippines equity profile, 2008

health service provision.

Philhealth social insurance

The National Health Insurance Act of 2013 mandates the state to provide comprehensive health care services to all Filipinos through a socialized health insurance program. The National Health Insurance Program was established in 1994. The Philippine Health Insurance Corporation (Philhealth) is a government-owned and controlled entity. The 1995 law expanding coverage of the National Health Insurance promises that "No one shall be denied access to basic health care services." In the 2013 budget, the government allocated P12.6 billion ($289 million) for PhilHealth. This is in line with the 2011-2016 Philippine Development Plan and Universal Health Care target to enroll the five million poorest families by the year 2015.

During his State of the Nation Address in 2012, Aquino trumpeted his administration's accomplishment on Universal Health Care for All under Philhealth. The Aquino administration boasted that there was an increase in the number of Philhealth beneficiaries, and that "nowadays, the poorest among our countrymen can simply walk inside any government hospital, show their Philhealth card, and receive the treatment they need free of charge." However, PhilHealth as a social health insurance has many limitations and restrictions.

Limited coverage

Despite high contributions for social insurance, access to health services and products is not enough and health care protection does not happen where it is needed most. More than 15 years after implementation the official population coverage is limited to 81%. On top of that, this claim of coverage is based on people with limited benefits. Dependent family members of Philhealth covered individuals are only entitled to coverage up to 45 days of hospital admission per year and this is shared among all dependents. In 2013, 6 out of 10 people covered by the scheme were dependents. This situation can exacerbate existing social exclusion and inequities, because the family might give preference to one dependent over another. In 2013, 6 out of 10 people covered were dependents.

There is economic inequity in coverage. Only 19.6% of the lowest income quintile and only 28.6% of the second quintile have adhered to Philhealth; others have no insurance at all. In contrast, 57% of the richest income quintile are enrolled in Philhealth.

High out-of-pocket payments

In addition, Philhealth covers a defined and limited service package; whatever needs to be paid for besides the covered costs, are out-of-pocket expenditures for medicines and medical treatment. User fees for health care persist, even if Philhealth is considered a mature social health insurance. In 2011 out-of-pocket expenditures in the Philippines accounted for 52.7% of total household health expenditures, over the WHO threshold for catastrophic expenditure leading to impoverishment.

Of all claims in 2012, Philhealth provided support for only 53%, while 47% of health care costs were paid out-of-pocket. Even the poor who claimed benefits only received a support value of 55%. In a nationwide survey by IBON, 8 out of 10 respondents said they used personal money for health spending while 4 out of 10 claimed they borrowed from family or friends. As much as 40% of Filipino households reported experiencing health shocks in the past three years and the majority were not able to cope with it.

Public-Private Partnerships' unkept promises

Corporate health policies

The Aquino government claims that public-private partnerships (PPP)[1] are the only alternative to meet health needs in the archipelago country. By outsourcing public hospitals to the commercial sector, the goal is to reduce government spending, while improving public health outcomes. Health Secretary Enrique Ona said that all 72 public hospitals in the Philippines would be eligible for corporatization.

This choice is cheered upon by the European Union. An example is its € 33-million financial support for the market-friendly health reform the Philippines. The latest Philippine-EU Strategy Paper (2007-2013)[7] stated that "further privatisation is critical and urgent" (p.18).

The Philippine Orthopedic Hospital (POC) is the first hospital to be corporatized as part of President Benigno Aquino III's PPP drive, through a P5.6 billion ($135 million) rehabilitation grant from the National Economic and Development Authority. The POC will be privatized under a build, operate, transfer (BOT) scheme. The winning bidder will operate it for 25 years with the option to renegotiate for another contract. So far, there are nine corporations that have expressed their interest in bidding for the project, among them national private companies and transnational ones such as Siemens, General Electric and Philips Electronics. The contract should be awarded in June 2015 and construction will then start and is planned to be completed in 2016.

According to the PPP Projects website, the "Modernization of POC" project consists in the construction of a 700-bed "super-specialty tertiary orthopedic hospital" and will be called the "Center for Bone and Joint Diseases, Trauma and Rehabilitation Medicine. This center will be integrated with other government owned and controlled hospitals, such as the Philippine Heart Center, Lung Center of the Philippines, National Kidney and Transplant Institute, and Philippine Children's Medical Center in Quezon City. The integration will become the Philippine Center for Specialized Care, a part of the medical tourism industry that is being developed by the government.

Unaffordable health services

According to the Philippine Department of Health, there are 1,796 hospitals in the country, of which 60% are privately owned. The WHO estimates that only 30% of the population can afford health services from the private sector. The Philippine public-private partnership approach does not resolve the problem of financial barriers to health care access for the majority of people. On the contrary, it results in higher user fees.

Together with increasing privatization of public health services, the government gradually reduces its allocation to health services. The budget for the health sector is now only 1.89% of Gross Domestic Product (GDP) (WHO Health system financing country profile, Philippines 2012).

There have been budget cuts for maintenance and other operating expenses of public hospitals and a zero budget for capital outlay for hospitals targeted for corporatization and public-private partnerships, such as the Philippine Orthopedic Center (POC) and the Research Institute for Tropical Medicine (RITM). Hospitals are then forced to become self-sufficient by charging user fees and imposing higher rates. Forced to survive with the limited budget and to demonstrate its financial viability to potential private investors, the Philippine Orthopedic Center and the Research Institute for Tropical

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[7] The EC EU-Philippines EU strategy paper (2007-2013). From: http://eeas.europa.eu/philippines/csp/07_13_en.pdf (last accessed on June 15th, 2015)

Medicine have, in the meantime, progressively increased their service fees.

According to local think-tank IBON Foundation, PhilHealth will not prevent costs of medical services from rising once a public hospital is privatized. If health care prices increase, PhilHealth coverage contributions will also grow: “For as long as the health care provision remains neglected, the expanded coverage of PhilHealth is useless. Social health insurance must be based on a strong health infrastructure and service delivery”. The PhilHealth card is not accepted in most private hospitals and is also of little help in poorly provisioned public hospitals, where the covered services are simply unavailable. In remote PhilHealth-accredited health facilities where there is a lack of medicines and health professionals, the insurance is “an ineffective and frustrating proposition,” said the Network Opposed to Privatization, a Philippine network of health workers, patients, health professionals and health advocates.

Health workers

The Philippines has among the highest densities of health workers; next to Japan and South Korea in the pharmaceutical industry, next to Cuba and Japan for dentists and next to Cuba and the US for nurses and midwives. The number of medical graduates has increased more than twofold from 60,655 in 2004-05 to 128,381 in 2008-09. Nursing is the program with the highest number of graduates, accounting for 76% in 2011-12, followed by midwifery with 5.3% of the total number of graduates. However, even with such as high health worker density, ironically in the public health sector health workers are sorely lacking.

First of all, the outsourcing of health care to commercial investors goes at the expense of the public sector; it is diverting resources away from the public sector. The private-for-profit sector entices health workers away from the public sector by offering better working conditions and higher salaries[3].The Philippines also train health workers en masse for export. Indeed, Export of health workers is promoted as a strategy to gain foreign exchange. Among the health workers that went abroad, the profession with the highest number was the nursing profession. So there is a net surplus of health workers, but through this "brain drain" the poor in urban and rural areas are left behind with a shortage of doctors and nurses (WHO country health profile Philippines 2014).

Civil society opposes Public-Private Partnership approach

According to local organizations - IBON, Gabriela, Council for Health and Development (CHD) and Advocates for Community Health – the current privatization policies of the Philippine government do not provide an answer to the enormous health needs. Despite the name of the Filipino “Universal Health Care” program that claims to “bring equity and access to critical health services to poor Filipinos”, commercialization of health services will do exactly the opposite and leave the poor behind. Civil society organizations in the Philippines insist that providing health services to the people, especially the poor and vulnerable is one of the fundamental functions of government. This function should not be subject to the profit motive and other influences but should remain a core public function. They insist that health services for Filipinos should be free. People should not be paying for health services because it is an obligation of the government to provide accessible and affordable health services. Instead of spending public money on health insurance, the government should provide government hospitals with budgets for capital outlay, maintenance and expand on key demands.

IBON, Gabriela, Advocates for Community Health and CHD are active members of the Network Opposed to Privatization of Health; a platform composed of groups and organizations of hospital workers, community health workers, students, professionals and individuals belonging to the health sector and from other sectors who oppose the

policy of privatization. Together with other progressive health groups: Alliance of Health Workers and the Health Alliance for Democracy, the network leads the forces opposed to privatization of health in nationally-coordinated mass campaigns and mobilizations. The Alliance of Health Workers (AHW) recalls: “it is the government, and not the private sector, that has the primordial constitutional mandate to deliver health services, to move toward social justice and equity. Our health system should be managed as a social service, and not as a business that focuses on the extraction of profit”, says a trade union representative of the AHW.

Because it is the first hospital to be corporatized, the campaign is focused on stopping the privatization of the POC. Following actions have been undertaken:

- A Mass walkout of health workers of the POC has been organized simultaneously with actions in 3 other government hospitals.
- Alternative media have been used to report on the campaign against the privatization of the POC.
- Education forums are organized in hospitals, health sciences schools and communities.
- Dialogue with the Secretary of the Department of Health regarding the POC privatization.
- There have been protest actions at the Department Of Health against the privatization with mass distribution of leaflets and reading materials.
- A petition has been organized to demand a prohibition of the privatization or a Temporary Restraining Order for the privatization of the POC.

In October 2014, the civil society campaign successfully managed to have a court ruling a Temporary Restraining Order for the privatization of the Philippine Orthopedic Center, on the basis of provisions in the constitution of the Philippines on the right to health, such as state responsibility in protecting and promoting the right to health and the adoption of an integrated and comprehensive approach to health development and access to essential goods, health and other social services, with priority for the needs of the under-privileged, sick, elderly, disabled, women, and children. Next to that, the campaign enabled to sensitize the health sector and the general public about the negative effects of privatization of public hospitals on universal access to health care.

Within the Philippine government Health secretary Enrique Ona is under fierce opposition for the privatization plan of 72 government hospitals, with Abakada party representative Jonathan de la Cruz filing a resolution asking Enrique Ona to attend the house inquiry. He said: “We have been giving the Department of Health huge amounts of money to improve the delivery of medical assistance through government hospitals and now Enrique Ona is coming out with statements on privatization, I don't think that is a responsible way of handling the budget his department receives.” Also representatives 'Gabriela' denounced the privatization plans, affirming that “it would make medical help more inaccessible to the majority of people” and filed a resolution compelling the Departments of Health, Finance, Budget and Management and the National Economic Development Authority to disclose the blueprint of the modernization plan for public hospitals.

Conclusion

The poor track record on access to health care in the Philippines is exacerbated by corporatization policies in the health sector. Although the policies officially aim to achieve universal health care, in reality they further decrease the availability and affordability of health care for all. Opening up the health sector for increased private-for-profit investments is exacerbating inequity in access to health care and thus inequity

in health outcomes, which raises serious concerns of social justice. A highly subsidized social health insurance alone cannot achieve universal access to health services if other health system aspects, such as financially unaffordable health services and insufficient availability of health workers, simultaneously undermine health outcomes.