PUBLIC–PRIVATE PARTNERSHIP (PPP):
A CASE STUDY OF THE
PHILIPPINE HEART CENTER FOR ASIA (PHCA)

An Undergraduate Thesis

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ABSTRACT

Health is defined by the World Health Organization as a state of complete physical, mental and social well-being and not just the absence of disease. At present, the plight of our country hinders us to achieve the right to health, a basic social service that has to be available and accessible for all, and more importantly, provided by the national government. That being said, it is clearly blatant on how huge the role of the government has in order to fulfill this right.

However, it has been the current trend of the national government to pass the burden of providing health care to the private corporations rather than them who should be bearing it.

Social services are the only means by which the government can offer a semblance of wealth redistribution – by taxing the haves to deliver services to the have-nots in society. As it pushes its responsibility of providing public utilities and social services to the back, it eventually loses the capacity to provide these. Health is starting to be for sale, commodified, and the worst effect would be to the indigent.
CHAPTER I – INTRODUCTION

Health, as we know of, is “a state of complete physical, mental and social well-being and not just the absence of disease,” as defined by the World Health Organization (WHO). However, this doesn’t mean that whatever we know is easily translated into actions. At present, the plight of our country hinders us to achieve the right to health, which has been in the very first place, a basic social service that has to be available and accessible for all, and more importantly, provided by the national government.

Several legal writings had already been placed in order to emphasize how important it is that everyone has the right to health. Our constitution, for example, explicitly says that “the State shall protect and promote the right to health of the people” (Article II, Section 15). Under the portion of Social Justice and Human Rights, it also says that “the State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all people at affordable costs” (Article XIII, Section 11). It further explained the priority that should be given to indigent patients, the elderly, the persons with disabilities (PWDs), women and children.

On the other hand, the International Covenant on Economic, Social and Cultural Rights has provided specific obligations that should be carried out by the state to achieve the “…right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (Article 12, Section 1).
That being said, it is clearly blatant on how huge the role of the government has in order to fulfill the people's right to health. However, it has been the current trend of the national government to pass the burden of providing health care to the private corporations rather than them who should be bearing it. This is firstly done through the government’s increasing dependency on the development assistance the country receives overseas or even from non-government sources. The second, which is more glaring, is through the Health Sector Reform Agenda (HSRA) of 1999. This officially commodified health through user fees and other charges being asked to be paid for, even by the public hospitals. This was done, despite the obvious fact that those who prefer the public hospitals are those who have lesser in life. And yet, this act was still pushed in order for the public hospitals, they believe, to be self-sustaining in the future.

One blatant example is the recently built Faculty Medical Arts Building (FMAB) inside the University of the Philippines Manila–Philippine General Hospital (UPM–PGH). Some call it ‘a hospital within a hospital.’ It is an opportunity for the doctors to be able to hold their private clinics while still being available for consultation in PGH. This project boasts not only the best doctors, as we know of, but also the latest technology it can offer. However, critics have already stated their sentiments especially because of the fact that there is an issue regarding the privatization of services because of this project. The latest equipments and facilities that the PGH couldn’t offer, its FMAB can give. It will result to the patients having the need to go there. And we all know that it is a government hospital, thus, most patients wouldn’t be provided with their deserved health care if they couldn’t pay for it. Therefore, most of the critics think that the administration should have rather opted for the development of the facilities in the hospital itself.
An early project is still too much to study on. We haven’t seen its full implications on everyone that might get involved, especially the indigent patients who rely on PGH itself. Taking into account this consideration, a case study on one of our government hospitals which also has a Medical Arts Building could serve as a substitute. This may give us a hint on whatever path the UPM–PGH FMAB might take in the near future.

At present, the government has slashed the allocated budget for the health sector by P1.4 billion. This would greatly affect the hospital’s services because they wouldn’t have enough funds to maintain their facilities and equipments. This would then result to passing the burden through user fees and other charges to the patients. The Philippine Heart Center for Asia (PHCA), being one of the government–owned and controlled corporations (GOCCs) specialty hospitals, is also experiencing the same condition. Along with other tertiary hospitals, the budget allotted for them has been cut by P970.6 million.

This would, then, lead us to asking how effective has been the Philippine Heart Center for Asia? Were there significant changes as the country changed leaders? And how did it affect the national government, the private sector, the hospital itself and most importantly, the patients and to–be patients that would be of most concern in this issue?

A. Statement of the Objectives

The overall objective of this research is to be able to evaluate the effectiveness of the Medical Arts Building of the Philippine Heart Center for Asia. This shall be done by fulfilling the specific objectives provided below.
1. To be able to present a background study on the said institution and the program of public–private partnership itself.

   A background study on the institution would include not only its history (when, how and on what conditions was the institution built, including its main proponents), but also the main functions provided and performed by the hospital, especially its Medical Arts Building.

   Meanwhile, a background study on the program would entail laying down the history of the program since the previous presidents, including its differences and similarities with each other, and how it evolved through time.

2. To be able to identify several factors that could influence the hospital’s effectiveness.

   These determining factors would be the basis on whether the hospital operates effectively not only for its patients, but even for its employees and the masses in general.

3. To be able to determine the role of the government, private corporation and the hospital in its public-private partnership relationship with each other.

   Determining the roles played by the private corporation and the hospital may extend further than being the contractor and contracted and the government as their connector. These would also determine what their main goal in pursuing such program is.

4. To be able to know the implications brought upon by the said roles on each stakeholder and even the patients.
Implications brought upon by the program would be the judging factor if the said program is still to be pursued further, or just left to the ground and replaced by a better or possibly, even a worse alternative.

5. To be able to provide recommendations for the hospital to become more effective in its role, especially to the indigent patients.

The patients would be the most affected, positively or negatively. Hospitals were and are built because health is a basic need. Therefore, an effective hospital, especially the national hospitals, would be best most especially to the indigent patients.

**B. Review of Related Literature**

The objective of this study is to evaluate the effectiveness of the Philippine Heart Center for Asia's Medical Arts Building through viewing several factors that could have influenced it. With the help of several books and journals, the researcher hopes to be able to capture the intended objectives by looking at different perspectives.

Globalization is being widely recognized but there have been no systematic analysis on its impact on human health. Its impacts on diverse, encompassing global economic, political, socio-cultural, technological and environmental changes are what Kelley Lee's *Globalization and Health: An Introduction* (New York, USA: Palgrave Macmillan, 2003) presented by using a framework for understanding these varied impacts, focused on temporal and cognitive dimensions of global change. The term globalization itself has said to be one of the words most abused and misused in popular usage. However, no matter how
different kinds of people look at it, the more important challenge are the contenations surrounding it. This surprisingly involves whether globalization is happening or not, and if it does, the causative explanations of how it occurs. Several other writers have been keen to point out that globalization is, in fact, happening right now. Causative explanations on how it occurs, on the other hand, vary from being driven by the invisible hand to being guided by rationalism and not by vested interests only. The book, though, chose to focus globalization as being human–induced – the form it takes, how its effects are assessed and responded to, and how it is controlled and unequally distributed.

It was demonstrated that globalization, in its present form, create patterns of health and disease in population groups across the world. Not to mention that it produces both positive and negative consequences, such as worsening inequalities within and across countries versus the trickling down effect it may offer to the poor. These changes are posing fundamental challenges to the way we think about the determinants of health and health outcomes. Also, the importance of the relationship of globalization, inequality and health to the overlapping spheres of the state, market and civil society has been demonstrated in the book. While others see that the whole globalization project should be aborted, others would opt to rebalance the existing asymmetries through new forms of governance. More attention, then, is needed to ensure that current forms of globalization become more equitable, sustainable and guided by appropriate forms of governance.

While the previous book viewed health privatization globally, the next one specifically focuses in Asia. In William Newbrander's *Private Health Sector in Asia: Issues and Implications* (New York, USA: Wiley, 1997), issues related to both public and private sector
interaction in the provision of health services are taken into account. The general
development contexts in which these issues will be addressed are considered, along with
the implications for national health care priorities and policies. It explored the range of
policy options currently being implemented as part of health care reform efforts. According
to the book, simply applying national policies for economic development to health may fail
to recognize the special characteristics of the sector or to address the strategic priorities
that public health policies need to address. In addition to that, priorities given to the health
sector must also be balanced with other national priorities in the context of overall
economic development.

More often than not, it is said that privatization is the issue to be addressed because in most
countries throughout the world, the private sector already accounts for the majority of
shares of the services they have utilized and have accounted for. The book mentions that it
is the policy–making aspect that has to be probed deeper. Actual and potential roles that
the private provisions of services within these policy options are further discussed and
suggestions for the directions for policies that can reinforce the potential synergy of public
and private efforts to improve the effectiveness of health services were also given.
Balancing efficiency and equity considerations, for the private and public sector
respectively, is not simple at all. The expansion of private production of services will
inevitably increase the resources flowing into the sector but it may not increase the
resources for the most cost-effective public health priorities. Thus, it is important to aim for
realistic goals and having appropriate priorities for the use of public funds.
A certain chapter in the book was also specifically allotted for the private health sector performance and regulation in our country. The said cause of the slow growth of the private health sector is the slow economic growth. The government decided to stimulate the private sector by encouraging the production of health providers and special financing for private hospital construction, by mandating employers to provide for health benefits to their employees and by initiating social insurance. Private sector has then developed a number of government regulations were implemented to assure the people that these private sectors would still continue to provide quality health care services and would therefore have an impact on both private and public hospitals. However, it is said that it is still early to determine the effects of these laws.

In IBON Facts and Figures Special Release's Vol.32 No.22, *Health for Sale: The Privatization of Health Systems* (Quezon City, Philippines: IBON Foundation, Inc., October 2009), it was narrated how health has becoming more and more inaccessible to those without the means to pay for it. The journal has described privatization as the government’s scapegoat on its responsibility on ensuring the people’s right to health. In the guise of greater efficiency, less strain on government finances, more effective and better quality services, wider coverage of the poor and improved accountability through competition and privatization of one of the basic service sectors in the society has been pushed through. However, it never failed to mention that there were also studies that show how privatization didn't result to the said assumptions, instead it lead to worse conditions – soaring of price of health services and deteriorating services of the hospitals. Due to lack of funds combined with market reforms, public clinics and hospitals were forced to increase the price of their medications or procedures to recuperate costs. Preventive health care was also neglected due to the
commercialization. Immunization which is supposed to be given free becomes available for a certain price. The same story happens for vaccines for the prevalence of tuberculosis, measles and polio. Shrinking budget for public hospitals was also stated in the journal. A special mention was given to the corporatized hospitals, now government–owned and controlled corporations (GOCCs), whose budget went down by 39%, with the biggest cutback at the Philippine Heart Center for Asia. The government’s dismal budget allocation creates a vicious cycle of low quality of health, poor equipment and facilities, poor diagnosis and real and perceived lack of medical skills that also affects the usage of the health system. Ironically, these are also the said reasons why there is a need for privatization.

As a result, the country has been experiencing several cases of inequitable access to health facilities, goods and services, low quality and inappropriate health care and technology, displacement of health workers and closure of public health units, and a health system that increasingly caters only those with the ability to pay. Not to mention the worsening poverty and diminishing access of the poorest to other basic social services such as food, water, sanitation and housing. In addition to that, Filipinos have been increasing their out-of-the-pocket expenditures in the health sector to be able to avail the needed services. For the past years, the Filipinos have been shelling out more than what the government provides. To add to their expenditures, user–fees or fees for service in public hospital and other health facilities also undermines the Filipinos’ access to the health system. Dissolution of government units and hospitals were also products of privatization policies. People living in poor areas far from urban centers were the ones most affected by the closure of district hospitals and Rural Health Units (RHUs). Unfortunately, there was little discussion on what role does each sector must take in order to provide the basic service of health.
In another Special Release of IBON Facts and Figures, Vol. 32 Nos. 17 & 18, entitled *PPP: Private Gains, Public Costs* (Quezon City, Philippines: IBON Foundation, Inc., September 2010), PNoy’s centerpiece of economic development, which is the public–private partnership, was highlighted. There are said to be three reasons why governments enter into PPP. First, is to attract private capital investment, often to either supplement public resources or release them for other public needs. Second, is to increase efficiency and use available resources more effectively. And lastly, is to reform sectors through a reallocation of roles, incentives and accountability. Hospitals are just one of the sectors covered by PPP. Other sectors include power generation and distribution, water and sanitation, school buildings and teaching facilities, housing, among others. PPP is one of those under delegation which is a form of privatization. This strategy requires a continuing active role for government, which retains responsibility for the function while delegating the actual production activity to the private sector. Despite the contradiction on the similarity between PPP and private sector participation (PSP), the journal has said otherwise. In the very least, both still possess privatization as its core.

According to the journal, the Asian Development Bank (ADB), as the major proponent of the PPP, didn’t hesitate to point out that private sectors participate in this with their clear-cut goal of making and maximizing profits. The only job left for the national government is to ensure that the needs of the people as well as the economy will be met to ensure the favorability to the private sector. The richest and most influential families who hold huge businesses in the country would have the control over several of the largest infrastructures. Multilateral institutions will play a huge part by providing loans. When they’re quite satisfied with how everything turned out, the people who are burdened by user-fees and
debt servicing are the only ones discontented. As stated in the journal, the heavy focus on profitability that is inherent in any private enterprise instead of social gains makes projects pursued through PPP anti-development and anti-people. It is very well true that in most cases of PPP, it is only the side of the ‘private’ who benefits from the ‘partnership’, while the ‘public’ is either neglected or burdened.

C. Research Methodology

1. Research Design

This case study gives a special focus on how effective the Medical Arts Building of the Philippine Heart Center for Asia is. This will assess several factors involved in the said focus. These factors would include both the hospitals' technical and systemic efficiency.

The systemic and technical efficiency of the institution may vary from the technicalities or inputs used in the hospital, as well as other factors such as the patients’ perspective. The hospital would not be limited with its connection with these factors alone. The current administration's public-private partnership may as well affect the effectiveness of this hospital.

In order to fulfill these, collection of data from several books and journals from different health-related institutions and organizations was accomplished. In addition to that, interviews were also conducted by the researcher for other needed information.

Finally, the neo–liberal theory was used by the researcher as it was heavily linked to privatization, in order to evaluate and assess the research.
2. **Framework of the Research**

a. **Theoretical Framework**

Several theories that would make the issue of privatization in health services float have already been around for the longest time. One of which is neo-liberalism. Neo-liberalism is a market-driven approach to economic and social policy based on neo-classical theories of economics that stresses the efficiency of private enterprise, liberalized trade and relatively open markets. It therefore seeks to maximize the role of the private sector in determining the political and economic priorities of the state.

With privatization as one of its dominant ideas, neo-liberalism seeks to transfer control of the economy from public to the private sector, under the belief that it will produce a more efficient government and improve the economic aspect of the country. Liberalization and Privatization of state enterprises are just some of the policy recommendations of this theory.

While critics thinks that this theory is biased only to the upper class and the business sector, the theory otherwise argues that state-shrinking will lead to a significant decrease in taxation. This decrease in taxation, in return, would enable the lower class to have more money to spend, thus being consumers in the free market.

Therefore, by promoting market provision of goods and services which the government cannot provide effectively and/or efficiently (in our case, I personally think the
government just refuses to do so), it is said that it would promote choice and competition.

However, with such a strong emphasis on the free market under neoliberal economic theory, privatization leads to large corporations owning the rights to utilities, natural resources and even basic services. A major goal of the free market economy is to increase competition, which in turn should decrease costs. But, it is not uncommon in a neoliberal economy for single corporations to obtain monopolies on these resources. And when a monopoly is reached, the profit-oriented corporations are free to inflate their prices, as their consumers have no other method available to attain the resource in question.

Globally, the principles of neo–liberal economics that have redefined the role of the state and the market have been directly evident in health sector reforms, even by other countries around the world. Several policies has been achieved through national governments, bilateral aid agencies and multilateral institutions searching for effective ways of addressing the changing health needs of both industrialized and the developing world. Importantly, the uptake of these ideas was not only the result of coercion, although it is clear that policy conditionalities were imposed on many low and middle-income countries.

The neo–liberal theory further argues that competitive markets yield the greatest economic growth which, in turn, eventually leads to a ‘trickling down’ of benefits to other social classes including the poor. Another theory that, on the other hand, claims
that if the top income earners invest more, it will in turn lead to more goods at lower prices, and create more jobs for middle and lower class individuals. The proponents of the Trickle-down Theory argue that economic growth flows down from the top to the bottom, indirectly benefiting those who do not directly benefit from the policy changes. If this fails to happen, they argue that this is due to the failure of some governments to sufficiently embrace appropriate economic reforms, hence not allowing market forces to work their magic (Lee, 2003).

The World Bank remains true to the promise of poverty reduction through economic growth achieved by trade liberalization, market forces and global economic integration. And our country, being tied to global financial institutions, has followed the lead on this trend. There still remains a clear theoretical difference about how the importance of health development should be achieved.

b. Conceptual Framework

This study focuses on the relationship between the institution’s technical and systemic efficiencies which will act as the independent variable, and the hospital’s effectiveness
in delivering health care, which will be the dependent variable. Systemic and technical
efficiencies of the institution could include the patients’ satisfaction on the health care
that they have received, competence of the personnel, technicalities like the supplies,
equipments and facilities used, and even the allotted expenditure for their social service
patients.

However, the current administration’s public-private partnership may serve as an
intervening variable in this study. It may possibly have positive or negative effects that
might influence on how the institution would be ran by its administration and provide
health care.

c. Definition of Variables

Several concepts that are important in the study have emerged from the research. The
effectiveness of the Philippine Heart Center for Asia that would serve as the dependent
variable in the study would be defined by the factors influencing it such as, both the
hospital’s systemic and technical efficiency, which would serve as the independent
variables.

Systemic or scale efficiency would refer to the overall organization of the health
services delivery system and whether the produced services are offered at lower cost.
This also includes the patients’ satisfaction in the given health service. The patients’
satisfaction, especially the indigent patients, may also include the hospital's expenditure
for social service patients. This is the allotted budget of the hospital to be given to those
who are in most need of financial expenses.
Intervening variables that may be included in this consideration would be the public-private partnership program of the country.

Public-private partnership is defined by the Asian Development Bank (ADB) as a range of possible relationships among public entities such as ministries, departments, municipalities, state-owned enterprises and private local or foreign businesses or investors in the context of infrastructure and other services. Contributions of the public partner in a PPP may take the form of capital for investment, a transfer of assets, or other commitments or in-kind contributions.

Technical efficiency, on the other hand, includes the mix of inputs which would result to the health services. This consists of the personnel (specifically their competence), supplies, equipment and facilities in the hospital.

Staff competence could be defined by the minimum standard requirements accomplished by those involved to function appropriately in their respective roles.

Supplies, on the other hand, are the daily expendable items that are used in the said institutions that are smaller than equipments and machines and are readily available to the consumers.
Equipments may be defined as physical articles or utilities that are fixed assets besides owned land and infrastructures that are used to function in a specific operation required by the institution.

And lastly, facilities are infrastructures installed, established or built in order to ease and improve performance to be able to carry out specific actions.

All of these would be maximized if for a given set of resources, the highest output possible is achieved. Also, given a set level of output or services desired, it is maximized when the fewest possible inputs are used.

d. Instruments Used and Data Gathering Plan

In able to attain the efficiency of data gathering the researcher reviewed several literatures, which included published books and journals, about privatization in the health sector in various libraries. Research using the internet was also done as a guide to the study.

Journals from the institution being studied also provided the researcher with some of the needed information. Reviewing some journals from the Department of Health was also done to gather additional data.

People who were and are involved in the negotiation process of a public–private partnership program would also be interviewed regarding their views on the said program and other questions that would suffice the objectives of the research.
e. Data Analysis Plan

This research would mainly focus on the current administration’s thrust towards its recent program, which is the public–private partnership along with one of the country’s specialty hospital, which is the Philippine Heart Center for Asia. The study aims to be able to show the institution effectiveness in its duties, not only how it delivers, but also its impact to the people.

Specific aims of the study could are provided in the earlier part of this chapter. This would include data from health–related institutions and organizations and also from other key persons.

All of these would be possible through archival research, as well as by doing several interviews on regarding the main topic. In this way, the researcher hopes to be able to acquire quality information.

The researcher mainly used the neo-liberal theory to be able to evaluate and to explain how the issue on the privatization of health care came into being. With the help of globalization, neo-liberal policies were pushed that would further strengthen the increasing power of the private sector, not to mention the increasing inequality it would offshoot between classes.

f. Scope and Limitations

The scope of the study is the effectiveness of the aforementioned hospital, through analyzing several factors that would contribute to it. Internal and external factors
involved in the process of the hospital being a government hospital yet acting like a private one. Through the mentioned methodologies, the researcher hopes to be able to accomplish the objectives laid down at the beginning of this proposal.

The limitations of the study, first and foremost would be the institution itself. The Philippine Heart Center for Asia would be the main focus of the research. On the other hand, measuring the effectiveness of the said hospital would only be done through the variables the researcher deems to be important in the study – systemic and technical efficiency along with the public-private partnership project of the government. Interviews that would be done would only be limited to the people holding significant information regarding the PHCA and the PPP program itself.

**g. Significance of the Study**

This study was made with the aforementioned objectives within the capacity of the set limitations. Health is foremost a basic requirement to live included in the physiological needs, ranking first in Maslow’s theory. With the privatization of the said necessity, what comes to mind is the further lack of resources for those who are badly in need in our country, which then results to the domino effect that starts with the deterioration of health itself within the masses, who cannot afford the services that they call for, to the lower productivity rates and higher mortality rates among the population.

For the existing patients who are now in need of the services provided by the health sector, to help them further understand the costs they are paying for and where it goes, the efficiency in which their treatment may progress and how successful their ailments
have been managed accordingly to their needs. To further heighten their knowledge with the public services that should be unreservedly available to those who need it.

The future patients of the said institution, in order for them to expect what kind of services the government is offering to them in times of need and how they can benefit professional and topnotch assistance within the health department. To broaden their knowledge on how privatization may affect their prognosis in terms of providing care fit to their treatment. How their future health complaint would be handled by the privatized health sectors and public hospitals that they would consult for their necessities.

This study can also be a learning paradigm to enhance the knowledge, not only the students themselves, but for anyone who might be interested in the same topic. The output of this study is may be used as a source material by professors that can be assimilated and disseminated for the knowledge to be acquired by the students.

This study is made for every one of us who may be in potential of needing the services of the institution that will serve as the subject of research. It would help us acknowledge the facts and the differences between the private health sector and the public health sector regarding how proficient and effective the services they provide and how they maintain the expectations from the aforementioned hospital.

Moreover, the research's objectives was designed not only to be able to hand out additional knowledge but also to provide recommendations on how the hospital will be
more effective on its performance of providing the needed and deserved health care of everyone, especially the poor.

h. Scheduled Time of Research

The proposal for this research was done during the earlier part of this academic year. After it has gone some revisions, the proposal has been approved before the semester ended. This was the signal for the research to start.

The body itself of the research was done during the latter part of the academic year. Writing the body of this research included scheduling trips to several libraries and institutions and also scheduling interviews.

The researcher, then, has more or less half a year to be able to accomplish the objectives and be able to produce a research of quality.
CHAPTER II – BACKGROUND OF THE STUDY

A. Public-Private Partnership

A Public-Private Partnership (PPP) may be defined as “a cooperative venture between the public and private sector, built on the expertise of each partner that best meets and clearly defines public needs through the appropriate allocation of resources, risks and rewards” (DOH, 2010).

PPP is a form of privatization that is being implemented globally. It is a term used to refer to various relationships, usually in infrastructure and services, which involve the private (businesses) and the public (government and parastatals) sectors. PPP also includes government partnership with non-governmental organizations (NGOs) and/or community-based organizations that represent stakeholders directly affected by the project (Guzman, 2011).

In shorter terms, a private company provides a certain service or services to the government through a contract, such as infrastructure construction or operating an existing facility or providing a service directly to the target population. In exchange, the private sector receives payments from the users of the services primarily through user-fees.

PPP and other forms of privatization are one of the policies to implement neoliberal globalization policy, the other main two policies being economic liberalization and state deregulation.
Privatization has been used as a means by several countries since the 1970s, to be able to be their solution against falling profits. Though it had brought advancement in their technology and further production, it also brought them increase in oil prices, which came as a shock for them. The blame was then pointed to the state for intervening in the market forces.

Meanwhile, Third World governments were obtaining loans from International Finance Institutions (IFIs) such as the International Monetary Fund (IMF), World Bank (WB), African Development Bank, Asian Development Bank (ADB), etc. to build dams, buy weaponry, nuclear power plants and large factories. When their debts piled up and repayment was brewing into a debt crisis, the IFIs implemented a string of structural reforms known as Structural Adjustment Programs (SAPs) as conditionalities attached to the loan and debt servicing. The rationale was made clear – governments had to earn foreign exchange and limit spending. In order to do this, export-oriented was promoted, imports and foreign investments were liberalized, key-economic sectors were deregulated, and state-owned enterprises were privatized (Guzman, 2011).

The term PPP first appeared in World Bank publications in the late 1980s and early 1990s. The WB advanced the idea of privatization as a replacement to the Keynesian principle of giving the State a bigger role in the economy. Starting in the 1990s, however, when the term privatization has been discredited because of its negative impacts, especially in the Third World, the term PPP has been presented as a more sanitized version.
According to the ADB, PPPs have different features as opposed to simple “private sector participation” or divestment. First, there is a contractual agreement of defining the roles and responsibilities of the private and public sectors. Second, there is a sensible risk-sharing among the public and the private sector partners. And finally, there are financial rewards to the private party commensurate with the achievement of prescribed outputs.

The ADB, IMF, WB and other apologists of privatization differentiate PPP from privatization, yet advance it with the same objective and framework and with a greater scope to include education, health, housing and other social services (Guzman, 2011).

The concept of PPP assumes that the government isn’t capable in providing and delivering public utilities and services to its citizens. While the private sector brings in the capital, the government is expected to bring out capital outlays.

In the Philippines, it was President Corazon Aquino who first implemented privatization via Presidential Proclamation 50 in 1986 which created the Committee on Privatization to identify assets to be sold, and an agency, the Asset Privatization Trust (APT), to sell the assets.

The first batch was composed of the foreclosed private enterprise owned by the cronies of the former dictator Ferdinand Marcos. President Corazon Aquino released Executive Order 15 which resulted in 20 power generation projects by TNCs and local corporations. She also signed the Build–Operate–Transfer (BOT) Law or the Republic Act 6957 which contained
various schemes where private corporations took over the function of the government in implementing infrastructure projects (Guzman, 2011).

President Ramos amended the BOT Law (RA 7718) in 1993. The table below provides the similarities and differences between the RA 6957 and RA 7718.

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<thead>
<tr>
<th>Comparison of RA 6957 and RA 7718</th>
<th>RA 6957</th>
<th>RA 7718</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declaration of Policy</td>
<td>Recognizes the indispensable role of the private sector for national growth and development. Provides incentives to mobilize private resources for the purpose of financing the construction, operation and maintenance of infrastructure and development projects normally financed and undertaken by the Government.</td>
<td>Recognizes the indispensable role of the private sector for national growth and development. Clarifies the provision of incentives in mobilizing private resources with the inclusion of minimum government regulations, procedures and specific government undertakings for the private sector as the need arises.</td>
</tr>
<tr>
<td>Private Initiative in Infrastructure</td>
<td>Emphasizes the solicitation of expertise from a duly prequalified private contractor through build–operate–and–transfer or build–and–transfer scheme.</td>
<td>Emphasizes the solicitation of expertise of individuals, groups or corporations in the private sector who have extensive experience in undertaking infrastructure or development project.</td>
</tr>
<tr>
<td>Priority Projects</td>
<td>Provides that local projects funded and implemented by the local government units</td>
<td>Enhances the provision of RA 6957 by citing all concerned government agencies, Government–Owned</td>
</tr>
</tbody>
</table>
Controlled Corporations (GOCCs) and LGUs shall identify priority development programs for PPP. Provides that local projects shall follow the approval process for different cost ceilings, to wit: (a) Three hundred million pesos (Php 300,000,000) for approval of the Investment Coordination Committee (ICC) of National Economic and Development Authority (NEDA); and (b) more than Php 300,000,000 for the approval of the NEDA Board. Clarifies the acceptance of ‘unsolicited’ proposals provided that such comply with the provision of Implementing Rules and Regulations (IRR).

<table>
<thead>
<tr>
<th>Eligible Projects</th>
<th>Infrastructure</th>
<th>Cites infrastructure or development projects, and emphasizes the inclusion of non-traditional infrastructure sectors such as education, health and agriculture.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation Schemes</td>
<td>BOT and BTO</td>
<td>Includes other variants – BOT, BT, BOO, BLT, BTO, CAO, DOT, ROT, ROO and other variants as may be approved by the President.</td>
</tr>
</tbody>
</table>

Source: (PPP Center, 2012)
This was to allow the full participation of private corporations through, in addition to BOT, Build–Transfer (BT), Build–Lease–Transfer (BLT), Build–Operate–Own (BOO), Build–Transfer–Operate (BTO), Contract–Add–And–Operate (CAO), Develop–Operate–Transfer (DOT), Rehabilitate–Operate–Transfer (ROT), and the inclusion of unsolicited proposals.

<table>
<thead>
<tr>
<th>PPP Modality</th>
<th>Role of the Private Proponent</th>
<th>Role of the Government</th>
<th>Notes / Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Build–Operate–and–Transfer (BOT)</td>
<td>Finances and constructs; operates and maintains facility for a fixed term; collects fees and charges to recover investments plus profit; transfers facility at the end of cooperation period (maximum of 50 years)</td>
<td>Provides franchise (if required) and regulates activities of BOT contractor; acquires ownership of facilities at the end of cooperation period</td>
<td>Includes a supply–and–operate scheme, a contractual arrangement whereby the supplier of equipment and machinery for a given infrastructure facility, if the interest of the Government so requires, operated the facility</td>
</tr>
<tr>
<td>Build–and–Transfer (BT)</td>
<td>Finances and constructs; turns over ownership of the facility to government after project completion.</td>
<td>Acquires ownership of facility after construction; compensates proponent at agreed amortization schedule</td>
<td>May be employed in any project, including critical facilities which, for security or strategic reasons, must be operated by the Government</td>
</tr>
<tr>
<td>Build–Own–and–Operate</td>
<td>Finances, constructs and owns facility;</td>
<td>Provides authorization and assistance in</td>
<td>All BOO projects upon recommendation of the</td>
</tr>
<tr>
<td>(BOO)</td>
<td>operates and maintains facility in perpetuity (facility operator may be assigned); collects fees and charges to recover investments and profits</td>
<td>securing approval of BOO contract; possesses the option to buy the output / service provided by the BOO operator.</td>
<td>NEDA–ICC shall be approved by the President of the Philippines</td>
</tr>
<tr>
<td>Build–Lease–and–Transfer (BLT)</td>
<td>Finances and constructs; turns over project after completion; transfers ownership of facility after cooperation or lease period</td>
<td>Compensates proponent by way of lease of facility at agreed term and schedule; owns facility after cooperation or lease period.</td>
<td>Akin to Lease–to–Own</td>
</tr>
<tr>
<td>Build–Transfer–and–Operate (BTO)</td>
<td>Finances and constructs a turn–key basis; transfers title of facility after commissioning; operates the facility under an agreement</td>
<td>Owns facility after commissioning</td>
<td>Minimizes construction risk delays</td>
</tr>
<tr>
<td>Contract–Add–and–Operate (CAO)</td>
<td>Adds to an existing facility; operates expanded project for an agreed franchise period</td>
<td>Collects rental payment under agreed terms and schedule; regains control at the end of lease term</td>
<td>There may or may not be a transfer arrangement with regard to the added facility provided by the Project Proponent</td>
</tr>
<tr>
<td>Develop–Operate–</td>
<td>Builds and operates a new infrastructure;</td>
<td>Regains possession of property turned over</td>
<td>Project proponent enjoys some benefits the</td>
</tr>
</tbody>
</table>
It was also under Ramos that the Philippine implemented subsequent SAPs through the 1991 to 1993 Economic Stabilization Program and 1994 to 1997 IMF Exit Program. The Ramos government undertook a massive privatization program, to include the sale of the Philippine National Bank (PNB), Manila Hotel, Petron, Fort Bonifacio, and Manila Waterworks and Sewerage System (MWSS). Under Estrada, the 1998–2000 Standby Agreement from the IMF consisted of a US$500 million loan package from the WB and the US$280 million standby facility from the IMF. The conditionalities included fiscal reforms.
Arroyo being the staunchest advocate of globalization rendered the coup de grace by completing the privatization of Napocor through the passage of the Electric Power Industry Reform Act (EPIRA) (Guzman, 2011).

On the other hand, in the health sector during the ‘60s, ‘70s and ‘80s, according to Dr. Teodoro Herbosa, current Undersecretary of Health, the country was struggling in terms of health budget which is less than 2% of the GDP. The government then decided to outsource parts of the hospitals to the private sector. For example, during that time, linen and security was outsourced. These outsourced contracts or privatized portions, especially services, of the hospital were called the unbundling of services. In later time, there was a shift from outsourcing linen and security to diagnostics.

An example would be the Dialysis Center in the National Kidney Transplant Institute (NKTI). All of the forty machines were provided by the private sector and not a single centavo was shelled out by the government (Usec. Herbosa, 2012). What technically happened in simple terms was that the government chose to be partners with a private company that makes the machine, and then it was the government who supplied the area and in the end, they shared the profits.

**B. Philippine Heart Center for Asia**

In the Philippines, statistics show that cardiovascular disease is number three among all leading causes of morbidity and mortality. Some data, though, places it in the number two position. Of all the cardiovascular diseases, hospital records reveal that rheumatic fever-rheumatic heart disease is the number one as far as morbidity and mortality is concerned
Heart-related diseases never get out of the leading causes of morbidity and mortality in the country.

In the concluded conference of the World Health Organization, Western Pacific Region, on the epidemiology of cardiovascular diseases, it was noted that epidemiological study of this group of malady is wanting in some member countries, specifically in the Philippines. Rational, economical and feasible national health programs for the control and prevention of cardiovascular disease in these countries cannot be planned nor implemented due to lack of understanding of the extent of the problem and natural history of the disease. (PHCA, 1975)

The Philippine Heart Center for Asia is a non-profit, semi-private, semi-government organization, devoted to the care of patients with cardiovascular diseases. It is a referral center for heart patients requiring special diagnostic tests and treatment.

With their mission-vision-goals that aims at quality patient, research, education and training, public information, the hospital has a long history too.

Because of one heart patient who approached then First Lady Imelda Marcos, everything started. This particular heart patient could not afford the high price of medical attention he or she needs. After helping the said patient, many other heart patients decided to appeal to the First Lady. It was then that she decided to organize the Heart Foundation of the Philippines (HFP) which would spearhead the fight against heart diseases, being the third killer disease during that time (Committee on Publicity, 1975).
During one of their organizational meetings, the doctors have brought out the fact that most of those who were affected by heart disease came from low-income groups. Not to mention those who also currently have the disease, which also comes from the same income bracket. Besides, the heart diseases that many of them had already cost their lives with, could have been cured if only they were provided with the needed medical care.

The HFP then became a private non-stock, non-profit organization, with the principal goal to provide for the hospitalization and treatment (free operation, medication, hospitalization and rehabilitation) of deserving heart patients. Some of the country’s prominent heart specialists served as the Foundation’s Medical Advisory Board to help in the evaluation of heart cases to determine whether they are truly deserving of assistance, both material and professional (Committee on Publicity, 1975).

At the same time, the Foundation will bark on a massive information drive on how to avoid heart complications. Many of the patients who die of heart disease are ignorant of its symptoms and the proper health routine with which to avoid them. Lay instruction on heart disease is therefore a vital part of the continuing health education of the masses. The HFP, in collaboration with the Department of Health (DOH) and the Philippine Heart Association (PHA), petitioned for a presidential proclamation that will set one month of every year for cardiology education.

Such an effort bore fruit when late President Ferdinand E. Marcos signed Presidential Proclamation 1096 declaring February of each year as Philippine Heart Month to be
devoted to the task of “effecting the highest possible degree of health care among our people thru encouragement of research on the heart and its afflictions and thru community involvement.” With the cooperation of various existing heart groups, HFP organized a coordinated program of education and service for the Philippine Heart Month in 1973 (Committee on Publicity, 1975).

To provide a home for the Foundation’s program, Mrs. Marcos envisioned the Philippine Heart Center for Asia. The Center would be the nerve center of all activities geared toward achieving the Foundation’s goals. Although priority attention is given to heart cases, the main thrust of its program would be the education of the public, which is still included in its goals up to the present.

Also, the Center will have the most modern hospital facilities both for surgery and diagnostic heart care. At the same time, it will be the most equipped in this part of Asia with research and laboratory facilities to combat the high incidence of heart disease not only in the Philippines, but hopefully in the region. Thus on November 24, 1972, the First Lady presided over the groundbreaking ceremonies for the Philippine Heart Center for Asia (Committee on Publicity, 1975).

It was when the First Lady commissioned Architect Jorge Ramos to design the PHCA that the construction started. What Ramos has evolved is a four-storey hospital annex and an imposing eight-storey Medical Arts Building (MAB). The ICCU Hospital Building sits on a park-like setting amidst greenery and tropical trees. The taller L-shaped building known as
the Medical Arts Building acts like a shield that protects the lower ICCU Hospital Building from the strong pressures of the elements and from the noise and dust of the streets.

Both of the buildings have utilized three new concepts First would be maximizing the use of attention time needed for patient care (Committee on Publicity, 1975). Particular attention is even given to the positioning of hospital beds making sure the patients' face are visible to the nurse manning the station. This is particularly important to a hospital where a state of emergency is always present. Efficiency is the keyword employed in relating the spaces to one another without being monotonous and regimental in character.

Second is the adaptation of materials in their natural form in order to achieve the feeling of warmth and homeliness with respect to the human scale (Committee on Publicity, 1975). Nursing Service at the Heart center is warm, personalized care qualified with high-level training in cardiovascular nursing care.

And lastly, there is a straightforward ‘factory type’ layout for all service areas that includes all research laboratories, operating rooms and all mechanical cores (Committee on Publicity, 1975).

Through time, the hospital has undergone changes in its infrastructure. For example, currently, the Medical Arts Building of the hospital is already made up of a nine-storey building. This additional floor houses the gaming facilities of the institution, such as various courts, that could be used for leisure or even the rehabilitation of the patients. Other improvements done in the hospital are further discussed in the next chapter.
CHAPTER III – PRESENTATION OF DATA

A. Overview of the Contemporary Situation

Currently, the Aquino government is making PPP its centerpiece program, supposedly to save, earn and acquire needed infrastructure. Of course, the IFIs are at the forefront of the PPP financing, having committed to be the source of loans and grants to jumpstart the infrastructure fund. The main advocates of PPP have vowed to be the financers of the PPP either through bond releases, project guarantees or direct investments (Guzman, 2011).

At the national level, specific committees and agencies perform review and regulatory functions in the development and approval of local PPP projects subject to the provisions of the IRR of RA 7718. These are the Investment Coordination Committee (ICC), Infrastructure Committee (INFRACOM), Regional Development Councils (RDCs), the NEDA Secretariat and the PPP Center.

<table>
<thead>
<tr>
<th>National Agencies and Committees for PPP</th>
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</thead>
<tbody>
<tr>
<td>Bodies or Agencies</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>ICC</td>
</tr>
<tr>
<td>INFRACOM</td>
</tr>
<tr>
<td>RDC</td>
</tr>
<tr>
<td>NEDA Secretariat</td>
</tr>
</tbody>
</table>
Because the ICC recommends for the approval of the proposed projects, it means that it is the overall decision-making body for all the PPP projects. With this in mind, it has its representatives from, of course, NEDA and other financial-related institutions, such as the Department of Budget Management (DBM), Department of Finance (DoF) and Bangko Sentral ng Pilipinas (BSP). With the help of these financial institutions, ICC would be able to plan on how to finance future PPP projects.

The PPP approach permeates virtually every section of the Aquino government’s Philippine Development Plan (PDP) 2011-2016. In fact, among the first bureaucracy tasks that President Aquino implemented was the creation of the PPP Center (Guzman, 2011). Executive Order No. 8, signed in September 2010, changed the former BOT Center to the PPP Center and transferred it from the Department of Trade and Industry (DTI) to the National Economic and Development Authority (NEDA). Each agency was, then, asked to create one. The DOH was one of the first to actually establish an office for PPP, the Center for Excellence in Public-Private Partnerships for Health.

The existence of the PPP Center is hinged on two premises. First, the introduction of structural adjustments into the economy is to lessen or remove government role and
promote competition among private entities, and to level the playing field. The policy and institutional mechanisms put in place are to allow the unhampered flow of resources from the private sector to the government infrastructure program (Guzman, 2011).

The PPP Center does not only provide services and assistance in PPP project preparation and development, et cetera, but also outlines a single flow for the approval and bidding of the projects.

While PPP is the centerpiece program of the PDP 2011–2016, amending Republic Act 7718 or the Build–Operate–Transfer (BOT) Law is one of its priorities.

PPPs for infrastructure in the Philippines are implemented under the BOT Law which specifies a set of processes to ensure that the government and the private proponent meet their obligations and there is a fair sharing of risks, among other provisions. The BOT Law provides guidelines, primarily used for the financing of large infrastructure projects. Revisions are discussed to make the BOT Law and its implementing rules and projects, including the health sector (DOH, 2010). The proposed amendments are centered on three things.

The first is to expedite the whole process of applying, prequalifying, approving, bidding, awarding and implementation of PPP projects by shortening the timeframe of the process. For example, the number of days necessary for the determination of prequalification (30 days) and qualification of proponents (7 days) is shortened to 20 days and 5 days, respectively. Second, proposed revisions seek to expand the coverage of the law. One of the
proposed amendments to the BOT Law include joint ventures, concession and management contracts as types of contractual arrangements which are previously contained in other binding documents. Third, which is a vital insertion, is the provision that will allow the implementation of guarantees against regulatory risks to attract foreign and local investors to invest in PPP projects. This is one of the two ways in which the Aquino brand of PPPs is distinguished from that of its predecessor (Guzman, 2011).

The Super Regions project of the former president Gloria Macapagal-Arroyo is somewhat alike to the thrust of the current administration’s, with additional sectors included. Just like the previous president, PPP focuses on the transportation and communication networks, along with its infrastructure that would hopefully improve the said networks.

On the other hand, the Aquino brand of PPPs has its own version. The first, as already said, is the granting of regulatory risk guarantees, an innovation and vital development to the way privatization projects were handled in the past.

Regulatory risk guarantees ensure that the private partner recovers the amount stipulated under the contract or the corresponding formulae by which tolls, fees, rentals and other charges are computed in the event that a statutory regulatory intervenes and affects price or tariff-setting. This regulatory risk guarantee may be in the form of make-up payments from the government to the private partner and other guaranteed payments and adjustments to contract terms and will be offered in the negotiations for solicited projects. The amount will be footed by the government. In short, the regulatory risk guarantees make sure that the government would pay the private sector the total cost in the case
external problems arise, which include even the public or customers’ clamor to regulate (Guzman, 2011).

The second feature of the Aquino–brand of PPP is the inclusion of even the social services. Non-traditional sectors, such as agro–industries, agri–services and micro–insurance, education, housing and health are already included in the PPP. Each of these would still focus on infrastructure development; building of classrooms for education, implementing house development projects for housing and rehabilitating or constructing facilities for the health sector.

1. **PPP in the health sector**

In the health sector, with the broad definition suggested, a number of typical PPPs have emerged.

- Outsourcing of clinical, technical (ancillary) or support services to private enterprises or organizations,
- Contracting the direct provision of a health facility or certain health services with a private provider (such as tuberculosis treatment, health education, etc),
- Collaboration initiated by private companies or NGOs to develop or deliver health care services for specific diseases or to specific groups or areas (development of vaccine manufacturing, TB–DOTS, child health services, parasite control, etc),
- Contracting or integrating private insurance schemes to cover specific populations, especially low income or rural areas (DOH, 2010).
The most common form of current PPPs in the health sectors, both in the Philippines and in other countries is contracting-out of government health services to a private partner in order to enhance access, or to improve management efficiency, or the quality of the service (DOH, 2010).

There is also a variety of health PPPs in the Philippines. Some of the variants of PPPs in the health sector covers primary health care services, inter-local health zones (ILHZs) in different provinces, drug distribution on the Botika ng Bayan, and even education and training for doctors that may be sent to the provinces.

Not to mention, corporate partnerships, outsourcing of hospital services (case in point, the National Kidney and Transplant Institute and La Union Medical Center) and the support provided by the country’s health insurance arm, the Philippine Health Insurance Corporation, or more commonly known to everyone as PhilHealth.

PhilHealth is mandated to provide affordable, accessible and quality health care to all Filipinos, and continue to enhance its role in the health care sector and support the preventive and curative aspect of health (Ybañez, 2011).

The issuance of the recently launched card will enable the state-run insurance corporation to meet its goal of providing a Universal Health Care (UHC) coverage or Kalusugang Pangkalahatan by 2013 (Bicarme, 2011).
Kalusugan Pangkalahatan is the health reform agenda of the Department of Health. Its main aim is to provide financial risk protection for all Filipinos, especially the poor, by ensuring universal PhilHealth coverage and improving the benefits of PhilHealth (Philhealth launches public–private, 2011). The PPP initiatives are said to be designed to help PhilHealth encourage more and more people to become part of PhilHealth and to assist PhilHealth in improving its services for its members. All of these will be at no cost to the PhilHealth.

According to PhilHealth President and CEO Dr. Rey B. Aquino, this is in hope of further expanding their members to be able to achieve the government’s goal of Universal Health Care. The current administration thinks the same, even saying that it is important for us to exhaust all possible means to bring all Filipinos into the NHIP, especially now that we have less than two years to achieve it (PhilHealth launches new, 2011).

Operating under the concept of Public-Private Partnership (PPP), the PhilHealth tapped corporate partners from the private sector to give the new ID card more value without requiring cardholders to be hospitalized (PhilHealth launches new, 2011). Special privileges that the card offers includes discounts when buying branded or unbranded generic medicines, vitamins and medical equipment and devices, as well as health services like eye exams, drug testing, or vaccination.

Other than this, there are still a number of PPP health projects that the Aquino administration has prepared.
<table>
<thead>
<tr>
<th>Project Name</th>
<th>Project Cost</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philippine Orthopedic Center as the Premier center for bone diseases, trauma, rehabilitation and commercial production of limb prosthesis</td>
<td>Php 1,500 million</td>
<td>The project will provide additional available resources for the center's modernization, rehabilitation and expansion, in pursuit of its thrust for quality health care services.</td>
</tr>
<tr>
<td>Air Ambulance Project</td>
<td>Php 500 million</td>
<td>Air Transport Service (aircraft which are ambulance-equipped and aircraft personnel) will be for the account of the private partner while the medical team and supplies will be for the account of DOH.</td>
</tr>
<tr>
<td>Research Institute for Tropical Medicines: Local production of equine rabies immunoglobulin (ERIC)</td>
<td>Php 150 million</td>
<td>This project will start with the establishment of an aseptic filing line at RITM for Pentavalent vaccine [diphtheria, pertussis and tetanus (DPT)], and Hepatitis B and Haemophilus influenza (HiB). This is seen to reduce the cost of the pentavalent vaccine by 25% to 30%. The project will also enhance the capacity of RITM to accelerate vaccine-self sufficiency targets.</td>
</tr>
<tr>
<td>Research Institute for Tropical Medicines: Local production of Pentavalent Vaccine (DPT, HepaB and HIB)</td>
<td>Php 500 million</td>
<td>This project will start with the establishment of an aseptic filing line at RITM for Pentavalent vaccine [diphtheria, pertussis and tetanus (DPT)], and Hepatitis B (HBV) and Haemophilus influenza (HiB) vaccine by 25% to 30%. Financially, this will reduce the cost of the pentavalent vaccine by 25% to 30%.</td>
</tr>
<tr>
<td>San Lazaro Hospital for Infectious Diseases</td>
<td>Php 1,000 million</td>
<td>As the national referral center for infectious and communicable diseases, it has an</td>
</tr>
</tbody>
</table>
abundance of materials in clinical cases in infectious diseases which can be used for research purposes, including the conduct of clinical trials for antibiotics and vaccines.

<table>
<thead>
<tr>
<th>Establishment</th>
<th>Cost</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eversley Childs Sanctuarium (Cebu) Open Land Area for Commercial Operations</td>
<td>no data available</td>
<td>The unused land can be utilized for commercial purposes to generate alternative funding sources that will help support the hospital's operations.</td>
</tr>
<tr>
<td>Western Visayas Sanitarium (Iloilo) Open Land for Commercial Operations</td>
<td>no data available</td>
<td>The unused land can be utilized for commercial purposes to generate alternative funding sources that will help support the hospital's operations.</td>
</tr>
<tr>
<td>Establishment of Multi-Specialty Centers in stem cell research, neurosciences and oncology in DOH retained hospitals</td>
<td>Php 400 million</td>
<td>Among the specialized services that could be provided through these specialty centers are: 1. stem cell therapy, which could allow patients with cancer to receive higher doses of chemotherapy; 2. neuroscience centers, to help improve treatment for the increasing number of neurologic disorders, such as Alzheimer's Parkinson's and Huntington's disease; 3. oncology/cancer centers that will offer a whole range of preventive, curative and rehabilitative services, in response to the alarming increase in cancer prevalence in the country.</td>
</tr>
<tr>
<td>Construction of Hospital Staff Housing Facilities</td>
<td>Php 500 million</td>
<td>State-of-the-art, eco-friendly hospital housing facilities should be constructed</td>
</tr>
<tr>
<td>Construction of PhilHealth Main Building</td>
<td>Php 2,400 million</td>
<td>Proposed building with an estimated gross floor area of 52,090 sq. m. composed of: 7</td>
</tr>
</tbody>
</table>
According to the National President of the Alliance of Health Workers, Jossel Ebesate, the Eversley Childs Sanctuarium in Cebu was a leprosy sanctuarium before it was turned to be a general hospital. To drive out the patients, they decided to give away 10,000 pesos to those who wants to be out of the institution already. What the government plans to do with it is to lease the huge land it has and just leave out a small portion for the general hospital.

According to Dr. Teodoro Herbosa, current Undersecretary of Health, PPP in the health sector right now is looking forward to modernizing about 32 to 35 of the biggest hospitals that the government has. These hospitals which usually have 500 beds would be improved to be able to double that number. This is mainly due to the reason that most of the hospitals were built sometime in the 1940s and 1950s, with the exception of the Lung Center of the Philippines (LCP), NKTI and PHCA which were built during the Marcos era, are not up to par with the current population we have. With this in mind, the government now wishes to rebuild and redesign these hospitals for the next 50 years.

In fact, there is a team for PPP under the DOH who goes around the country to study all the different hospitals and find out what they need to improve on.
At the end of the day, the support of the private sector is still called on by the government in able to fulfill this program – a critical factor in the pursuit of their objectives.

2. **Philippine Heart Center for Asia**

The two buildings of the Philippine Heart Center is composed of the hospital itself and the other building, which is the Medical Arts Building, that houses the doctors' offices and the offices of the director, assistant director, etc. It's basically a mix of private clinics and administrative offices.

The hospital, being a self-reliant institution means that the pay services are subsidizing the charity so it can generate its own income to propagate or promote services that are not so much income generating. According to Dr. Mejia, who have stayed in the hospital for more than 10 years, this means that, it has its own income-generating units that subsidize the charity patients. In fact, a very strong pay service of the institution subsidizes the charity clinic and charity admissions, whatever income they get from it.

Personnel competence is one the factors that the institution could actually boast about. The nursing services that they offer are probably one of the best in Metro Manila. This particular service follows a hierarchy in terms of seniority and experience in their practice. The institution is actually built where units that need more of the nursing service are stationed on the upper part of the building. The nurses with the said advantages are those who are assigned with the tougher jobs on the upper floors of the institution.
Specifically, the newly hired staff starts off with an organized orientation program which expands into professional staff development training on several levels: middle management group of head nurses and supervisors, aides, orderlies and ward clerks. There are also performance evaluation of all nursing units year round on maximum utilization of manpower, time and facilities (PHCA, 1984).

The competence and skill of its medical and surgical staff whose roster lists many of the country's top rate practitioners (PHCA, 1980). Besides patient service, one of the main aims of the hospital is to train physicians to be specialists in different subspecialties of cardiology. This training is also available for nurses and technicians (PHCA, 1984). The system of nursing and doctor activities has remained the same for about 10 years, but it does not mean that they are falling behind other hospitals.

The supplies, equipments and facilities in the institution have also been improved for the last years. The Center’s manpower strength is adequately backed up by modern technology enabling fast and more reliable diagnosis, treatment and rehabilitation of the patients. The Center is fully equipped with the most sophisticated cardiovascular apparatuses for its medical and surgical procedures (PHCA, 1975). Some of the advantages of some of their equipments include improved quality because of the selection of raw materials and minimal cost (PHCA, 1984).
Some of the institution's acquisitions could be found below.

<table>
<thead>
<tr>
<th>Acquisitions (2007)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Imaging Center and Nuclear Medicine Laboratory</strong></td>
</tr>
<tr>
<td>Ultrasound System</td>
</tr>
<tr>
<td>GamaWell Counter</td>
</tr>
<tr>
<td><strong>Cardiac Graphics Diagnostic Laboratory</strong></td>
</tr>
<tr>
<td>Ultrasound Systems (2)</td>
</tr>
<tr>
<td><strong>Radiology</strong></td>
</tr>
<tr>
<td>Fluoroscopic X–ray System</td>
</tr>
<tr>
<td><strong>Invasive Diagnostic Laboratory</strong></td>
</tr>
<tr>
<td>Intra–aortic Balloon Pumps (2)</td>
</tr>
<tr>
<td>Stretcher (2)</td>
</tr>
<tr>
<td><strong>Pulmonary</strong></td>
</tr>
<tr>
<td>Ventilators (10)</td>
</tr>
<tr>
<td>Videobronchoscope System</td>
</tr>
<tr>
<td><strong>Operating Room</strong></td>
</tr>
<tr>
<td>Operating Room Table</td>
</tr>
<tr>
<td>Heart–Lung Machine</td>
</tr>
<tr>
<td>Endoscope</td>
</tr>
<tr>
<td>Cautery Machines (2)</td>
</tr>
<tr>
<td><strong>Recovery Room / Intensive Care Units</strong></td>
</tr>
<tr>
<td>Cribs (2)</td>
</tr>
<tr>
<td>Neonatal Warmers (2)</td>
</tr>
<tr>
<td><strong>Other Hospital Units</strong></td>
</tr>
<tr>
<td>Hospital Beds (67)</td>
</tr>
<tr>
<td>Cardiac Monitors (12)</td>
</tr>
<tr>
<td>Centrifuge</td>
</tr>
<tr>
<td>Tissue Embedding System</td>
</tr>
<tr>
<td>Linen Trucks (23)</td>
</tr>
<tr>
<td>Food Serving Tray / Trolley (8)</td>
</tr>
</tbody>
</table>

Source: (PHCA, 2007)

If the question is about the changes that the hospital has gone through, these are mainly on its infrastructure, equipments and wards. There has been an expansion and renovation of some units, like the Intensive Care Units (ICUs) and the Dialysis Unit, and an expansion of some of the services such as the Magnetic Resonance Imaging (MRI), Computed
Tomography Scan (CT scan) and even the ultrasound. There are also new laboratories, like the vascular laboratories, located at the basement of the Medical Arts Building.

Some of the hospital's accomplished projects are cited in the table below.

<table>
<thead>
<tr>
<th>Major Engineering and Infrastructure Projects Accomplished (2007)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Construction of three–storey building with parking area and other hospital facilities</td>
</tr>
<tr>
<td>• Construction of Imaging Center (CT Scan / MRI / Ultrasound Laboratory)</td>
</tr>
<tr>
<td>• Construction of Basketball Court (9th floor) and Parking Area (near East Avenue Medical Center)</td>
</tr>
<tr>
<td>• Renovation of Pulmonary Department, Emergency Room, Recovery Room, Men's / Women's Wards, Ward I–A</td>
</tr>
<tr>
<td>• Repainting of Dietary Elevator, Neuro ICU Treatment Room, Main Cafeteria, Pacemaker Room, MAB Exterior, walls, doors, offices, lockers, comfort rooms</td>
</tr>
<tr>
<td>• Upgrading of basement elevator lobby (ceiling to floor)</td>
</tr>
</tbody>
</table>

Source: (PHCA, 2007)

The PHCA admits patients suffering from heart disease requiring special diagnostic tests and treatment. If the patient does not need special care, he or she may be referred to another hospital for treatment. This is to enable the Heart Center to concentrate its efforts and provide its facilities to patients who truly need them the most (PHCA, 1975).

Both paying and non-paying patients are admitted to the Heart Center. In the hospital, one is referred to as a “private patient” when he has the capacity to pay for his medical expenses, or as a “service patient” when he is unable to pay because of financial limitations.
If a patient is admitted a service patient, the hospital shoulders part of the expenses. It is however required that a service patient be certified either as indigent or semi-indigent (partially able to pay) by the Social Service of the Heart Center so that financial arrangements for payment of medical expenses could be made for the patient (PHCA, 1975).

Also, if a patient is admitted as pay, and wants to be transferred to service, it could be made possible, though in a very difficult process. This might happen if ever for example, a patient is admitted and decides that he or she is admitted to the pay service and is provided with a pay consultant. However, when the patient is already admitted in the private ward and realized that there are certain procedures or operations that he or she could not afford, that is when they will request for financial assistance. The financial assistance is basically transferring or referring the patient to social service so that the patient could be in the charity ward. However, this could be avoided if upon explanation of the procedures that the patient would undergo, and the patient doubts that he or she could afford such procedure, it is better for him or her to just be on the charity ward.

The difference in other institutions like the PGH, is that the personnel will see to it that you will be screened. Unlike in PGH, where if you are admitted as a pay patient and wishes to be transferred to the charity ward, the process that will be done is much easier. However the similarity of the two institutions is that the debt that you have not been able to pay in the pay ward is carried over to the charity ward because it will not be waived.

Dialysis patients in the PHCA also face a different case in regards to pay and charity ward. If a dialysis patient in the emergency room wishes to be admitted in the charity ward, he or
she could not be admitted. The dialysis has no charity ward in PHCA – it is never for free. What the institution will do is that it will refer the patient to NKTI. This particular case should be explained properly to the patient in order to avoid misunderstandings.

No patient in need care in the Heart Center, especially in case of emergency, will be turned away because of financial reasons. However, in case of lack of accommodation, some patients may be referred to neighboring hospitals for treatment (PHCA, 1975), just like the case for those who wish to be charity patients in the Dialysis Unit. As past Director Aventura summarily puts it, “PHCA is not just for the rich. Rather, it is also for the rich” (PHCA, 1980).

The health services delivery of the hospital is also doing well, yet the administration is still trying to improve it. And with the help of the other personnel in the institution, results should be in their favor.

The institution, also, has a huge expenditure for social service, which sometimes results to treating a larger number of service patients.

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Quantified Free Services</td>
<td>306, 123</td>
<td>314, 826</td>
<td>337, 296</td>
</tr>
<tr>
<td>Quantified Free Professional Services</td>
<td>153, 061</td>
<td>157, 413</td>
<td>168, 648</td>
</tr>
<tr>
<td>Total Expenses for Indigent Patients</td>
<td>459, 184</td>
<td>472, 239</td>
<td>505, 944</td>
</tr>
</tbody>
</table>

Source: (PHCA, 2007)
As Dr. Mejia said, this would also be to the credit of the doctors, especially the fellows, who, on their own, raise funds within the hospital (caroling in the Christmas season, movie premieres, etc.) for the charity patients.

The institution may have increased its prices but the bill or the cost is still lower compared to the Class A hospitals; which means the cost is still affordable. As a government hospital, the institution could not increase too much due to limits placed on them. However, if the government decides to raise the limit, the institution should still be reasonable regarding the price.

In general, the efficiency and effectiveness of the hospital is actually a good one. Yet, every institution has rooms for improvement, but the institution proves to be doing its best.

B. Possible Problems / Challenges Ahead

In general, the main issue faced by PPPs in the country is one of sustainability. This includes both funding and being dependent on the government for investments. A project funded by donations will always be in danger of being discontinued if the donors lose interest or are forced to withdraw their funding. The biggest problem facing the PPP projects are related to this, which in turn can be traced to the following weaknesses:

- A number of PPPs are fostered by international donors, NGOs and development agencies, with funding that lasts while the project is ongoing; no provisions or planning are made to ensure long term financing.
• Many PPPs are characterized by informality and personal leadership; while inspired by charismatic leadership which can be useful at start up, most initiatives are not “institutionalized” through long-term mechanisms

• Government has often a passive and weak role, and does not pick up the tab when international donors withdraw; changes in government seem to negatively affect the continuity of partnerships; government participation appears piecemeal, without any long-term strategy to decide why and when it should go into PPPs with private partners.

• Financial arrangements are generally weak and loose, with no link to performance, even though most PPP managers state the monitoring and evaluation is a routine activity, it does not seem to strongly impart decision-making (DOH, 2010).

The financing scheme of PPP projects entails the “raising of funds to finance a single indivisible large scale capital investment whose cash flows are the sole source to meet financial obligations and provide returns to investors”. Deals involving this financing scheme aim to shield private equity investors from the risks in financing and to decrease the financing cost for the project, through the use of debt instead of equity. This scheme requires a stringent borrowing program wherein the lenders are involved heavily in the project, or the payment for debt is ensured through clear policy formulations. PPP projects remain public in character and thus, being public, it is still the government which underwrites the debts incurred by PPP deals. This is called contingent liability (Guzman, 2011).
At the end of the day, the financers and the private sectors has only two ways to get back their profit – inflate prices and have the regulatory risk guarantees. Because guarantees will surely be borrowed, this would worsen the administration's condition of being slumped in a budget deficit.

However, for the private sector, the return of investments would surely be in their favor. But in the midst of all these, it would be the public who will be able to get the worse experience, especially when the prices would get high.

What is more alarming is how this guarantee undermines the remaining powers of the government itself to stop projects that are not beneficial to the Filipino people. For example, in the event that Philippine courts rule on cases filed before them or regulatory agencies exercise their quasi-judicial power to halt PPP projects or prevent the private proponent from being paid, the government is still bound to pay the private proponent the amount agreed on the contract (Guzman, 2011).

According to the Department of Health, there are yet stories of success or failure of current PPPs that have been systematically documented or assessed. Thus, it is difficult to pinpoint the key factor in the demise of the initiative. However, experience from the about 20 studied health PPPs in the Philippines show that others have lost steam or were all but suspended.
There is also no data that shows what population groups have benefitted from the PPPs. It would be desirable to establish whether the poor or other groups have benefitted from the PPPs, since the equity in access is an important objective of the HSRA.

However, the HSRA is a blueprint of health privatization that pushes for regional and national hospitals to shift to income-generating and financially viable health facilities primarily through corporatization. Revenue generation includes increased number of pay wards, private rooms and out-patient department (OPD) clinics, reviewing and implementing hospital fees and other charges, and expanding sources of revolving hospital funds, which may take the form of lease of assets and expanding hospital pharmacies. The HSRA recognizes the displacement of true indigent patients when the regional and national hospitals unload patients to give way to an increased number of pay and private rooms. Commercialization and privatization of health care and services has been ongoing for a while already through HSRA. Conversely, the budget for health in 2011 was slashed by Php1.4 billion. While the budget of hospitals, which are government-owned and controlled corporations (GOCCs) as well as specialty hospitals, were cut by Php970.6 million (Guzman, 2011).

“Cream skimming”, unwillingness to treat poor patients, are also possible problems. (DOH, 2010). Under commercialization and corporatization, user-fees in health services have become the norm. Increasing cost of services and use of facilities has been documented in public hospitals. The bottom line of all these is that poor people who cannot afford the increased user-fees are denied access to health services.
The institutionalization of user-fees for the most basic of services is the foremost critique on the PPP projects and something which proponents do not deny. The issue of user-fees and exorbitant tariffs instantly divides the recipient country and its population into those who have the means to pay for the privatized services, and those who do not and are left with no choice but to cough up the expenses through various means, including personal borrowing (Guzman, 2011).

With all of these problems and issues, PPP would definitely result in projects that would greatly affect the public rather than being beneficial to them. The guise of efficiency and the private sector being able to offset high prices would not be enough. There is actually no need for such large infrastructure projects that wouldn't be beneficial to the people. Instead, the government should think of and provide alternatives that would be for the public.
CHAPTER IV – CONCLUSION / RECOMMENDATION

The Philippine Heart Center for Asia is really an efficient and effective hospital. As their technical and systemic efficiency seems to be working together with the effective healthcare that they provide their patients, especially those sorted for service patients.

It would be quite difficult to assume what might happen to UP–PGH’s FMAB in the future just by this study alone. For one, PHCA’s MAB is different from PGH’s because FMAB is overseen by its own Medical Ancillary Director. The executive offices that one will find on MAB are the administrative offices, including that of the director of the institution itself. Also, PHCA’s MAB was built the same time as the institution itself, not years after it just like what happened to FMAB. That is to say, I am not quite sure how governing the institution by one director, or two for that matter, and having their Medical Arts Building built in different periods, would affect the institutions’ efficiency, as that factor falls out of the variables presented earlier.

However, it would be a great deal of relief if PGH’s FMAB would turn out just like PHCA’s, with the exception of the current cost of healthcare. No matter how the doctors would say that the price is still affordable and lower than the cost of other hospitals, it would be a huge help, especially for the poor people, to be able to go to the hospital whenever they need to.

At the end of the day, it is the government who decides if it will enter into a PPP. The DOH should only consider entering into PPPs if the objective of the PPP will contribute in the
national objectives for health, if potential malpractice from the private sector can be reduced, and if PPP can be made effective and equitable (DOH, 2010). However, it is not the case.

A critical issue is to set the rules for user-fees for public health goods and services in order not to prevent access on part of the population to these services, particularly the poor (DOH, 2010). The private sector and the PPPs, particularly the PPPs created under the BOT Law, have user fees as their main source of revenue. Health facilities under the PPP modality operate under the principle of fee-for-service. To allow access for the poor, there should be mechanisms other than out-of-pocket to pay the fee, such as government or Local Government Units (LGU) subsidies, etc.

With the current provider payment scheme (i.e. fee-for-service), private health care providers can increase the price, volume, and intensity of profitable services and products, such as diagnostics and pharmaceuticals, even if they are not needed. Phil Health’s inability to regulate hospital and physician’s fees allows them to charge members with higher prices and thus, increase out-of-pocket payments. These results in patients, under stress and anxiety from diseases, being forced to pay for medical expenses above the benefit ceiling, which is sometimes above their capacity to pay, especially for the poor. Nevertheless, payment methods that force the service providers to treat all patients should be a priority for all health care projects.

In any partnership, according to Dr. Mejia, support must be given by the hospital but only within the limits of its mandate, mission and vision. For national hospitals, the mandate is
to serve the poor and those who are not capable of paying for their hospital and health needs – to serve the most underserved and indigent patients. Thus, the institution must not be a medical entrepreneurship where the hospital charges too much just to gain their Return of Investment (RoI), which is what happens in Class A hospitals – where everything rises at the expense of patients. The cost of care becomes too expensive because the target is return of investments. It also results to a lot of unnecessary things requested to promote RoI.

She further added that it’s not only the indigent, even the pay patients. Nonetheless, it should be very affordable. The national hospitals should remember that its costs should be contained, not for the rich alone, but for the majority of the people who need health care.

Another critical issue is the formulation and monitoring of service and quality indicators (DOH, 2010). The incentive of profit-making which is dominant in the private sector can be problematic for health care.

Economic tells that the reason why private health markets often fail is first, key preventive and public health services that produce external benefits will tend to be under-provided. Second, the patient’s lack of technical knowledge and the role of health providers directing the patient care, leaves the patient vulnerable to low quality treatment, excessive use of diagnostics and over-prescription (DOH, 2010).

Public–private partnership requires more accountability on the part of the implementing agencies. Monitoring requires vigilance over delivery by the private proponent of its
contractual obligations. The implementing agencies and the oversight agencies should observe transparency, from project identification to procurement to contract implementation.

Since it was said that there are no evaluations of current PPPs, a study should be done to assess the impact of the PPPs, particularly in relation to the effects of equity in access through evidences or statistics, practices in the country and analysis where there are gaps in the distribution of PPPs in the country. This would help the government not only for their monitoring, but also for their assessment.

This could be done through proper documentation of every files related into this partnership. There should not be a single document left that wouldn’t be properly filed. This way, the government wouldn’t be able to say that the lack of records yet prevents them to properly assess the projects.

In the same way, transparency is also ensured. Also, having an executive summary for these files that would be available to the public would be a great help to circulate the information.

Annual reports should also be conducted regarding the project to be able to continue its monitoring, evaluation and assessment. This would then give everyone the idea if it would still be intelligent to enter into another one of these projects.

The most important factor for the PPP projects are the contracts, specifically the demands they made of the private partner and how these are upheld. Most of the projects had specific performance indicators in order to determine what services the private partner
were obliged to provide according to the contract. The monitoring of these indicators is crucial in these projects and in some cases, a new unit is created to oversee the private partners’ performance. Several of the projects also include a unified information system which makes it easier to perform the monitoring and evaluation (DOH, 2010).

The enforcement of the contract, in the event one part did not meet the agreed upon conditions, is also an important factor. Thus, anything you do is bound by the terms of reference in that contract, which means that the regulatory power is the contract. To be fair to everyone, Dr. Herbosa said that the contract has to be clean, that is done properly and does not disadvantage government, or the public sector, or the service.

Even before entering into a PPP, the government should conduct feasibility studies. This would give them an idea of what might happen if they pursue the project. A feasibility study shouldn’t be biased on the advantages that we could gain. It should focus on weighing the pros and cons in entering such projects.

At present, I’m aware that the government is doing these kinds of studies. However, not most of us are. Thus, information dissemination should play a vital role.

Information dissemination is also another way to observe transparency. It would be one of the important factors in order for the public to be able to know what the project really is. It is one huge step that the government must be willing to take. The government should open its doors to the public so that the public could openly tell their thoughts for projects like these, because in the end, it is them that the government serves.
Here comes the issue of the truthfulness of the information given. The government should not only provide the public the advantages that both parties would gain in case these projects are implemented but also the disadvantages, just like in the feasibility studies. Whether the disadvantages outweigh the advantages, or the other way around, the public should know what’s really going on.

However, it still of great importance that the government has the capacity to oversee and regulate the health sector as a whole, including both public and private providers (DOH, 2010).

Control must, then, be issued when you come into PPP. There has to be control in not eventually ending up in patients spending too much and beyond reason just to return the investment given by the private institution. Also, especially on the part of the doctors, Dr. Mejia reminded that there has to be an ethical practice that only what is needed for the health of the patient is what should be done.

The government should remember that the prices are shouldered by the consumers – whether they may be high, low or just the right amount. And the consumers are also the public. If this kind of projects is to be implemented, the government should not forget that they are in their current position to be able to serve the public, that they are not a private sector whose primary motive is profit-making. Thus, they should impose regulatory measures that would prevent the private sector from pulling the prices up whenever they want to do so.
According to Dr. Herbosa, regulatory powers should be controlled because you cannot privatize public sector and allow the private sector to demand the price for their service. That means that price will be unreachable – that the product or the service will be unreachable to the general public, which is exactly what’s happening with oil.

A low budget on health provided by the government will be the main reason why the hospitals would think of entering into such projects. If the government would prioritize health as one of the basic needs of the public, there would be no need to enter in these projects. The continuous slashing of funds, especially to the government hospitals will also continue to cripple the institutions. It will only result to less facilities and equipments that the institution could provide for the ailing public and thus lower health care services are provided.

In turn, the public would continue to be sick. The prices would definitely rise because the hospitals would continue finding ways in order to provide better health care services for their patients. However, the public could not afford the frequent rising of the prices of these services.

Health is starting to be for sale – commodified. The indigent would be the one who would suffer the most in this never-ending cycle. Until the government straightens its back and accepts its responsibility to provide healthcare for its people, then the vicious cycle just goes on.
Phil Health is not always the answer to the problem. Yes, it provides benefits, especially to the poor. But it will be used by the government as a scapegoat to be able to provide the basic service of health. Blaming the Filipinos for paying a high price for health just because they do not possess a Phil Health card is just plain wrong; because in the first place, health is not a product, it should have never been paid for with a high price. It should have been available for everybody who needs it.

Even if the government boasts of more than a million Filipinos enrolled in Phil Health, they also admit that they could not still provide for the low-income families. And this is what should they be working on. They should have even thought of prioritizing those with low income rather than the middle income, just because it’s much easier.

Health interventions in service delivery according to the national objectives for health should improve the accessibility and availability of basic and essential health care for all, particularly the poor, through both public and private facilities and services (DOH, 2010).

Social services are the only means by which the State at this point can offer a semblance of wealth redistribution – by taxing the haves to deliver services to the have-nots in society. As government defaults on its responsibility of providing public utilities and social services, it eventually loses the capacity to provide these. (Guzman, 2011). On a worst case, this could lead to the government turning its back to its duties of providing the basic services everyone needs, and thinking and acting like the private corporations do – profit-motivated.
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