

University of the Philippines
Padre Faura, Manila

**The Impact of Privatization
On Government Hospitals**

A Thesis Submitted
In Partial Fulfillment of
the Course Requirements for
Development Studies 199.2

To
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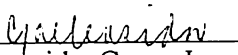
March 2000

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APPROVAL PAGE


This thesis entitled “The Impact of Privatization On Government Hospitals” was submitted and approved as partial fulfillment of the requirements for Development Studies 199.2.

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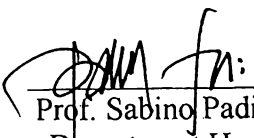
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ABSTRACT

This paper aims to probe deeper into the effects of privatization on government hospitals especially on its indigent patients and health workers.

This paper is divided into nine parts. The first part is the introduction which shows the presentation of the statement of objectives, review of related literature, research methodology as well as the significance of the study. The second part discusses the trends in the privatization of health services. Commercialization and privatization is discussed in the third part. The privatization background and rationale and the reasons for privatizing government hospitals are discussed in Chapters 5 and 6. The impact of privatization on government hospitals and its effects on health workers and indigent patients is discussed in Chapter 7. Chapter 8 shows the struggle against privatization. The final part is the conclusion.

The researcher was able to conclude that the privatization of government hospitals brings more death and disease instead of what it promised to be as “health in the hands of the people.” Privatization of government hospitals breed ill health and the health workers and the patients – especially the poor and the peasants – are always at the losing end.

Thank you...

To the Lord Almighty...for sharing with me wonderful people who have helped me in my work and for giving me the strength and the will to continue even in troubled times

To Mom and Dad... for always believing in me and supporting me in all the things that I do

To Sir Simbulan...for teaching me DS 199.2 and more and for generously sharing your knowledge with me

To Miss Amy Chavez of Health Alliance for Democracy, Ate Del and Ate Virgie of Alliance of Health Workers and to Dean Cecilia Laurente of the Network Opposed to Privatization for providing me with most, if not all, of the reference materials I need to support my thesis

for their willingness to
participate in my thesis

To Cats... who has kept me being insane, for being my "tour guide" into the jungle, that is, the world of computers

To Camille... for the sweet notes and kisses on my cheeks

To Tyn... for typing and editing some parts of my paper and for the times we stayed up late just to memorize a different version of "UP Naming Mahal"

To my brothers, Kuya Ino and Bok, and Yay..... wala lang

To Little Penny... for making the family happy and I very...soo-very happy

To Liz and Mari... for all those years of kabaliwan and kakikayan; for all the memorable trips: from Baguio to Banahaw; for the listening ear and pieces of advice; for all those sleep-overs and movie marathons; for the understanding and encouragement you give in times of crises; for all the shitty situations we've been through; for telling me that problems have a way of solving themselves; for teaching me to be good (but not all the time); for reminding me that we are always beautiful no matter what happens

To Plaza... for telling us (Liz, Mari and I) we can do it: "Kayo Pa!"; for not forgetting to keep in touch and telling your escapades in Japan

To Nine beth, Mike and Mary Ann - my lunch buddies... for sharing your ideas with me over lunch, for telling me always that I can finish my paper

To Glenn Bulacan... for giving me pieces of advice; for asking for my help when "life sucks"; for being "so slow"

To Russelle... for sharing with me your research materials; for never failing to ask "how's your thesis?"; for the Viva Angono! trip; for never losing hope that we can finish this thesis

To Theresa... for the quiet moments

To the Harry Houdini gang (Mitch, Helen, Hannah, Mia and Weng)... for the disappearing acts and for the fun times

To all of you guys (DS block 7 '96)... you're the best! I will miss you borrowing and photocopying my notes

To Dennis, Carlo, Al & Lea, Ana & Mike, Banj and JP... for being my new-found friends

To my Richard VAI... for sticking with me all those 4 years and 5 months; for the good and the bad memories; for being my constant source of inspiration; for always reminding me to keep working on my thesis; for lending me your Chant CD; for being concerned enough to wake me up in the wee hours of the morning just to finish my paper; for accepting my imperfections; for tolerating my weaknesses, for accepting and developing my strengths and for being there in times of pitfalls

To all the people who have helped me, in one way or another, to finish this paper

Carenjoy

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CHAPTER 1: INTRODUCTION

The era of globalization has spawned the commercialization of even the most basic social services including health. The IMF-WB has come to rescue the economies in crises and has imposed cost-cutting measures realized as cutbacks in government subsidies for social services, which has resulted to very poor quality and inavailability of these services. The government's lack of budgetary allocation has allowed the private business to take control over government corporation and assets, public utilities and the provision of the most basic social services or the phenomenon more popularly known as privatization.¹

Privatization is an economic policy reform embraced by many countries to achieve sustainable growth. It is appealing to governments of both developed and developing nations because it is fiscal in nature and offers a quick solution to persistent fiscal deficits brought about by the inability of revenues to grow as fast or faster than expenditures.²

Countries plagued with debt and budgetary crises have given in to privatize in order to raise revenues for the government even at the expense of its people. In dire needs for revenues, these governments find solution to privatize various assets to reduce government expenditures. Singapore Deputy Premier Lee Hsien-Loong had said: "With

¹ "Privatization. Turning Government Over to Transnational," IBON Special Release, July 1997, p. 1.

² Epictetus Patalinghug. Philippine Privatization: Experience, Issues and Lessons, UP Press, No. 13, 1996, p. 2.

privatization, more competition, innovation, efficiency and service will flow to consumers.”³ This further implies that privatizing will provide a more efficient economy aided by better, cheaper services and more tax revenues. Also, it would make the government earn more revenues instead of losing money. On the other hand, those against privatization argued that it is not solving the country’s debt problem but may further aggravate the crisis.

Privatizing government hospitals also means hiring contractual workers with contracts ranging from 3 to 12 months. Labor development within the health sector is fast deteriorating. Many government hospitals employ nurses as well as personnel through labor-only contracting. The placement of warm bodies to a principal or business contractor, where the contractor does not have sufficient capital and the deployed workers perform jobs which are favorable to the business contractor is labor-only contracting. Technically, the law does not allow labor- only-contracting but the practice flourishes in the system.

Because many are desperate to find jobs, many have become victims of labor-only contracting. A large chunk of jobs contracted are related to security services and maintenance of janitorial jobs. There are various reasons why many are demanding contractual workers. One, the strategy reduces their production cost and maximizes their profits. Two, doing so gives them convenience and practicality for it saves them money and time for advertising, training and screening of workers. For the contractual health

³ Tim Healy. “Asia’s Long March to Free Markets,” Asiaweek, 24 November 1995,p.58.

workers, contractualization denies them of their security of their career path, marginalizes them with their measly wages and most importantly, it threatens their right to unionize which is their only weapon against the excesses of the administration.

Although the complete privatization of the four specialty hospitals is being planned out, they are undergoing various forms of privatization. Many manifestations are being felt by its indigent patients. Though it has not yet been wholly privatized, it has already given way to contracting out some of the hospitals' functions – including administrative, collection, janitorial and security services – to the private sector. According to the Alliance of Health Workers, the utility workers, drivers, clerks and nursing attendants comprise the bulk of hospital staff and are often overworked but underpaid.⁴ In order for government to raise revenues, services previously free are now charged. Through the people's payment for health services, health has become a lucrative business and not a committed service to the people.

This thesis takes an encompassing look at the privatization thrust of the government especially on its effects on health workers and its indigent patients. This also aims to probe and criticize the privatization policy using the case of the Lung Center of the Philippines and its health workers in finding out its intended objectives and effects. The contractual health workers and the indigent patients will be the central focus of this study since they will be the ones immediately affected.

⁴ "Checking Up On Hospitals." IBON Facts and Figures. Vol.20, No.16, 31 August 1997,p.8.

Statement of Objectives

The general objective of the study is to probe deeper into the effects of privatization on health workers and on indigent patients. In so doing, the following specific objectives would function as guides in assessing the selected study:

1. To provide a clear background on the privatization of hospital services/functions such as administrative services which include computerization, collection, janitorial and security services;
2. To know the various schemes of privatization in the health sector;
3. To determine the faces of exploitation experienced by health workers;
4. To determine the adverse effects of privatization on patients, especially the poor;
5. To understand the role of the government and the International Monetary Fund-World Bank in the privatization drive; and
6. To evaluate the implications of privatization of hospital functions and services and its effects to national development.

Significance of the Study

Marginalized Filipino families, who compose the majority of the country's population, depend on public hospitals for their health needs since they cannot afford expensive private hospitals and clinics. The Lung Center of the Philippines is one of the specialty hospitals which has greatly benefited the poor who have availed themselves of

excellent medical care at minimal cost or at times, at no cost at all. With the hospitals undergoing various forms and stages of privatization, its ailing health workers and its indigent patients are the most badly hit. The practice of hiring contractual health workers has been detrimental to the hospital staff. Poor patients are now expected to pay hospital fees. This study will evaluate the government's current thrust of privatizing government hospitals. It would clear the issue of privatizing health services and hospital functions in government hospitals. It would also provide knowledge about the real motives for privatizing government hospitals.

This study will show the effects of commercialization of government hospitals, so that hopefully, the government will review its policies, for them to make "health in the hands of the people" a reality, to furnish the people with competent services and ponder on the alternative ways.

Review of Related Literature

One of the objectives of the study is to dig deeper into the impacts of privatization of the most basic social services including health.

In Antonio A. Tujan, Jr.'s *Crisis and Privatization* (Manila, Philippines: Institute of Political Economy, September 1998), privatization has not been limited to the selling of public assets through public bidding or direct sales. It has taken on a broader meaning, i.e., it includes the commercialization of government services, transfer of control of state

enterprises through various means including subcontracting and concessions of government management contracts, lease agreements of equipment and assets and even build-operate-transfer schemes. In the Philippines, privatization started “blandly” as a means of reducing debt through debt-equity swaps and disposing the non-performing assets. President Ramos was not only accountable for turning over the utilities and public assets to private enterprise. He also began the enforcement of privatization of social services like education, health, and housing among others. Partial privatization and commercialization have thrived, as these services had to cope up with slashed budgets. Little by little, hospitals are being sold in different ways. These include the four specialty hospitals like the Philippine Children’s Medical Center, the Heart Center, the Lung Center and the National Kidney and Transplant Institute as well as the Fabella Medical Center and the San Lazaro Hospital which have catered to rich and poor patients alike.

The Philippines is a good model to show that the scope of privatization has not been restricted to the sale of government assets. Private participation involves control and profit of different aspects economic and social development, social services and even some functions and responsibilities that are purely government. The outright sale of large state monopolies in utilities, power and telecommunications involve the more famous cases of privatization. Through this, TNCs are able to enlarge their business through assured profits with their share of monopoly control of the utilities. With privatization, it is the Filipino masses that bear the brunt through higher transportation, communication and utilities cost. Retrenchment became the trend of this era of privatization. The privatization of MWSS and NAPOCOR has left hundreds of thousands of workers

jobless. Taking over the basic social services, TNCs are assured of markets for their products in supplies, equipment or facilities aside from giving them the increased chances of reaping greater profits.

The debt and budgetary crises had laid the grounds for privatization. Countries enmeshed in debt crisis have resorted to privatization in order to generate funds for debt service. They find opportunity in commercializing and privatizing social services aside from the austerity measures and massive lay-off of workers in order to cut back government expenditures. The drive to privatize comes from the neo-liberal agenda that believes in the market efficiency where it is said that by adhering to the tenets of privatization, the bureaucracy can only become competent.

The *Asset Privatization: The Philippine Experience* (Philippines: Fiscal Administrative Foundation, Inc. 1989) written by Leonor M. Briones, gave a background on Philippine privatization. It was in the last days of the Marcos regime that the introduction of the administration's privatization policy was seen. But it was only during the Aquino presidency when actual realization of the policy began. Its emphasis was mainly on the government-owned and controlled corporation of the GOCCs. But its policy on privatization of assets went beyond the disposition of the GOCCs. The focus was shifted to the entire bureaucracy. Thus, the take over of private firms of government services like health, education and housing. Also, privatization was adhered upon by developing countries as a remedy to external pressures and plight not only to internal pressures like large fiscal deficits and slow down of economic growth.

Patricia Ronald, in her *The Context of Privatization and Neo-Liberal Policies*, (Philippines: Institute of Political Economy, September 1989) spelled out the forms of privatization. One form is the contracting and competitive tendering of services. According to her, these contracts are usually long-term ranging from 5-10 years to bring about labor and service delivery with a guarantee of an arbitrary level of savings of 20%. But studies proved it otherwise: savings are not realized as promised. Contracting bids down employment conditions, which often results to less paid hours or work, temporary and inadequately trained staff, which affects service quality. Furthermore, competitive tendering has shown job losses and reduced working conditions. Privatization has also its impacts on workers and unionization. De-unionization and breaking the power of the public sector unions was an explicit aim of the British privatization program. Also with privatization, there have been price rises and service quality failures. It has also its effects on public accountability. Privatization by sale or contract take essential services out of the realm of public accountability.

Interest in privatization efforts in the form of definitive studies have been lacking. Epictetus Patalinghug in his *Philippine Privatization: Experience, Issues & Lessons*, (Quezon City, Philippines: Center for Integrative and Development Studies, 1996) assessed the impact of privatization, explored related issues, discussed the order of events in Philippine efforts to privatization since 1986, the reasons for privatizing, its impact on the government budget as well as the internal efficiency of privatized firms. According to him, one of the lessons learned was that the push to privatize would have produced more sound results if it were accompanied by reforms to make the industries more

competitive or if free entry of other industries were encouraged. He stated that a privatization scheme that simply tries to maximize profit without changing the market structure geared towards a more competitive and market-oriented environment would be as satisfying. The appropriate institutional and regulatory structure is a necessary accompaniment to a successful privatization policy. Privatization in the Philippine experience has largely been an exercise in fulfilling the objective of revenue-generation as a solution to the persistent fiscal deficit problem. But it is significant to note that proceeds of privatization should not be handled by the government as fixed sources of revenues.

IBON Special Release entitled *Privatization: Turning Government Over to the Transnationals* (Manila: IBON, July 1997) defined that privatization is not so much of efficiency but it means the expansion of business for the transnational corporations and the local elite, a component of the neo-liberal program of restructuring economies and giving the upper hand to private monopoly enterprises in the name of free market. The government's lack of budget for the social services makes it inviting to private concerns. It means commercializing the whole concept of social services in the name of efficiency and funds maximization. The neo-liberals argued that with privatization increased competition results in wider access and cheaper public service. Truth to tell, it is profit rather than service that is the ultimate motive. Privatization has only added to increasing joblessness, depresses wages amidst high costs of living and has marginalized access to social services. Hiring contractual workers has become the norm for increased profits. Costs of the social services have shot up and thus deprived the poor.

Research Methodology

Theoretical Framework

Due to neo-liberal globalization, the imperialist crisis has further intensified. Through the privatization of hospitals, which reveal signs of neglect, public hospitals will now be funded by the private sector. Privatization is realized in the guise of correcting government inefficiencies. In the country, privatization is now being underway to attain service efficiency and to generate revenues for debt service. But privatization has its impacts on the health workers as well as its poor patients. The historical materialist framework will guide the presentation of the study.

Adam Smith, the main advocate of the classical theory of economics, argued that the market must be left free to find its own natural levels of prices and wages and profits and production; whatever interferes with the market does so only at the expense of the true wealth of nations. His doctrine of laissez-faire meant that the least government is certainly the best. Smith was against the meddling of government with the market mechanism. He was against government laws which shelter industry from competition and against government spending for unproductive ends.

On the other hand, Marx believed that under capitalism, the life of the working men and women could only be one of the steadily increasing miseries. He conceived the idea that the workers needed a fighting theory to unite them in their struggle for a better life and for a better society. Under the capitalist system, two basic classes oppose each

other: the owner of the means of production and the workers. With its development, the class struggle takes an acute form. The introduction of machinery is profitable to the individual capitalist because it enables him to produce more goods at a lower cost. The outlay for machinery grows faster than the outlay for wages. Since only labor can produce the surplus value from which profit is derived, this means that the capitalist's rate of profit tends to decline. Along with the declining rate of profit goes an increase in unemployment. Crisis shake it at regular intervals, preludes to the general crisis that will sweep it away. This instability is increased by the formation of a reserved army whose pauperization keeps increasing. The exploitation of the workers by the owners will bring into being the class that will encompass its overthrow. Workers are taught to organize, to bargain collectively for their greater share of income and to build cooperatives devoted to these ends. Everything that is used in producing goods should be owned by the community- by the "people" – not by few individuals.

Conceptual Framework

It may be true that through privatization, hospitals will be funded sufficiently by the private enterprises. And with enough resources, they may be able to hire more hospital staff, acquire state-of-the-art equipment and render the services of the best Filipino and foreign specialists. But we should not put aside that the health workers and the poor clients would be the ones paying the cost of privatization. The "greed for profit" rule maneuvers these private firms to incur maximum profits at the expense of the health workers as well as its indigent patients. Health is indeed expensive but still it is every

people's right. The government should not abandon its responsibility and duty to its citizens. It should protect the welfare of the health workers and make health services accessible and affordable to the ordinary Filipino. The government should reconsider its plans of wholly privatizing our government hospitals which deliver essential services especially to the most deprived.

CONTRACTUALIZATION

- A kind of employment where workers are employed temporarily ranging from 3-12 months; with this kind of employment, their right to organize and unionize is denied; workers are also denied of rights and privileges regular employees enjoy; denied the right of security of tenure

HEALTH SERVICES

- can be classified into (a) preventive services for community groups at risk, e.g., immunization for infants; (b) curative services for acute and chronic illnesses; and (c) hospital services

HEALTH WORKERS

- not only professional health care providers like doctors, nurses, medical technicians but also pertain to the hospital staff who take care of the daily operations of the facility: utility workers, drivers, clerks, janitors, security and maintenance workers

HOSPITALS

- an institution whose function is to provide complete health care to the populace; where the sick or injured are given medical or surgical attention; “centers of wellness”

SPECIALTY/TERTIARY HOSPITAL

- a type of hospital with sophisticated diagnostic and therapeutic facilities for a specified medical problem or illness

Research Design

Impacts of privatization are carefully analyzed through this study. Its impacts on health workers and its clientele would be the focus of the study. With this, it attempts to expose how the government’s push to privatize hospitals depresses the health workers as well as its patrons. It assesses the implications of privatization and the contractualization of services and its influence to national development.

In conducting this research, the methodologies which will be used are library works and in-depth interviews with health workers, indigent patients and hospital administrators from the specialty hospital. The researcher will also interview key persons from Alliance of Health Workers and other similar agencies.

The conclusion that will be drawn out from this research would be exclusively limited and dependent on the materials available and in-depth interviews from the affected sectors especially the health workers.

CHAPTER 2: TRENDS IN THE PRIVATIZATION OF THE HEALTH SECTOR

The country's social services have traditionally been privatized and commercialized as a result of government default. The lack of budgetary allocation for socialized services has resulted in very poor quality and inavailability of public education, health, housing, welfare, community development and other social services. Budget for health care as a percentage of GNP has averaged only 0.16% from 1990-1998. The government's budget for education, touted to be a substantial share of the budget pie, receives only 10.9% while debt servicing gets 33.8%.⁵

The Philippines health sector has long been in the process of commercialization. The Philippines, compared to other Asian countries, ranks second (after Korea) in the penetration of the private sector in hospital ownership.

The devolution or transfer of health services from the national government to the local government in 1993 (as defined in the Local Government Code of 1991) was also a salient part of reducing health spending. The national government has effectively passed the bucket to the local government units (LGUs) who have neither the resources nor finances to absorb all the devolved functions and personnel.

Devolution has only conformed to the cost-cutting measures and the revenue-enhancement programs of the government. It paved the way for the eventual

⁵ "How Sick Are the Filipinos?," Council for Health and Development Situationer, 27 July 1999.

privatization of the government's health services. Privatization does not only mean the outright sale of hospitals but also revenue-enhancement programs wherein patients are made to pay for services such as blood pressure taking, room and linen use, hospital food and even immunization.

Republic Act 7160 or the Local government Code of 1991 opened doors and windows to the private sector as far as government hospitals are concerned. The law allows local government units (LGUs) to involve private corporations in the maintenance and operation of local hospitals which were once run by the Department of Health. The people who can pour out capital for the maintenance of these hospitals are less civic, religious or cause-oriented groups. They are more likely to be from the business sector.

The Ramos regime mouthed NIC-hood for "growth and development." It opened the economy to globalization by attracting foreign investments, encouraging the entry of foreign goods and pushing export production to ensure mega-profits to foreign investors.

Former President Fidel V. Ramos has this ambitious plan to make the Philippines a medical center in East Asia, "known for high quality medical and health services including traditional methods of healing." The Ramos regime sees the country as East Asia's financial market, food basket, shopping paradise and Medical center.⁶

⁶ "Checking Up On Hospitals." IBON Facts and Figures, Vol.20, No. 16, 31 August 1997, p. 5.

Part of his “Polevaulting into the 21st Century” strategy was to privatize the specialty hospitals. Also, an Alternative Medical Research and Development Center, a National Center for Disease Control and a Modern Medical Complex was to be put up.

Privatization was the focus of his projected reforms. A strategy for empowerment hinged on private sector-led development, it relies on nongovernment initiatives, i.e., people’s organizations, NGOs, cooperatives, the private business sector, etc.⁷ It considers reliance on market forces as ways of achieving efficiency and competitiveness, maximizing limited resources and improving delivery of services.

Privatization refers to the transfer of functions rendered traditionally by the government to the private sector. The financing, production and distribution of health care would now come from the private firms.

Medical transnational corporations (TNCs) are currently eyeing the country for possible business opportunities. The Hospital Corporation of America has invested in the Canlubang Medical Center, the first private hospital to be operated by a foreign company. The Malaysian Landmarks Berhad also engaged in a built-operate-transfer scheme with the Medical City in Mandaluyong and the Lung Center of the Philippines.

The main targets of the privatization drive are the four government-owned and controlled hospitals namely: The Lung Center of the Philippines, Philippine Children’s

⁷ NEDA, Medium Term Philippine Development Plan 1993-1998.

Medical Center, Philippine Heart Center and the National Kidney and Transplant Institute. The Association of Philippine Physicians in America have inquired about the selling terms of the Philippine Heart Center while the MCA Holdings and Management Corporation, a Filipino company with Canadian links has shown interest in all four.

Government hospitals are being modernized through funding coming mostly from big foreign investors. Higher fees are then charged to avail of these state-of-the-art facilities. An Austrian company has invested at Dr. Jose Reyes Memorial Medical Center and four banks with the Jose Fabella Memorial Hospital. The Philippine General Modernization Act of 1997 promises to improve the situation by “streamlining” the bureaucracy by returning fiscal and administrative autonomy to the PGH and providing a nest egg of Php 1 billion.⁸

The Fabella Medical Center, a Philippine government-run maternity and children’s hospital, is already undergoing various stages of privatization. Fabella provides free maternity and pediatric care and caters to families belonging to the lowest income brackets. It is just one of the few hospitals specializing in maternal and pediatric care for the economically disadvantaged. In the few cases that the hospital charges its patients, the highest will be depend on the income status of the patient - at least 10% of the total fees collected in private hospitals are charged to users.⁹

⁸ “People’s Right to Health Care.” Philippine Daily Inquirer, 10 February 1998, p.10.

⁹ “Privatization: Turning Government Over to Transnationals.” IBON Special Release, July 1997, p.33.

The Tala Leprosarium is undergoing phase-out of leprosy services through conversion to a tertiary general hospital to generate income. The same goes with the land where the National Center for Mental Health stands. It is being sold to give way to a commercial-industrial-residential-recreational facility while a much smaller hospital will be built in the outskirts of Metro Manila. Patients in both hospitals are discharged regardless of their illness.

Public hospitals did not escape the free market ideology prevalent today. The price of medication and hospitalization has risen. This is true not only in private hospitals but in public hospitals as well.

Public hospitals are pushed by the government to embark in austerity programs. It is raising revenues through people's payment for health services through various means. Hospitals such as the Philippine Orthopedic Center and The Tondo Medical Center, which, in the past, provided free services to charity or indigent patients, now require payment for all laboratory tests, supplies and medications incurred during hospitalization. They are also reduced to issuing prescriptions to patients instead of free medicines. In many hospitals, charity cases have to hand in cash "donations." Laboratory/radiologic examination fees have increased and hospital room rates have become unaffordable. Increasing health expenses are being felt by indigent patients of PGH – the premier government hospital. Since 1996, there has been a 60% increase of hospital lab fees.¹⁰

¹⁰ Jacqui Mercado. "The Government Health care system: Unhealthy!" Medical Observer, October 1999, p.13.

Commercialization is also synonymous to hiring contractual health workers with contracts ranging from 3-12 months. Since July 1, 1996, PGH has hired 228 contractual workers like nurses, pharmacists, medical technicians, physical therapists, x-ray technicians, clerks and utility workers.¹¹ Labor-flexibility measures are being implemented even in hospitals. These are in the form of contractualization and “on-the-job” training of health workers in the hospitals. This is the government’s strategy to reduce their costs and maximize their profits. With contractualization, no matter how skilled, productive or proficient the health worker is, he or she stops working in the hospital or enter into another contract, after the expiration of the contract. Other forms such as right-sizing, down-sizing and early retirement programs are being implemented by the hospitals to cut down their number of workers.

Health workers have no security to their career path under these schemes. These are also instruments to effectively deprive health workers of their democratic rights. These also ensure the decline in the quality of services. With the imposition of labor flexibility measures, the health workers’ commitment to their work is jeopardized, since job tenure is not secure. These anti-worker policies also contribute to the commodification of health services.

The government passed the National Health Insurance Policy (NHIP). NHIP is a compulsory health insurance for every citizen, which he has to pay from his own pocket. Without such, a patient may be denied of services at a hospital.

¹¹ “The Primary Health Care: A Post-Mortem.” IBON Facts and Figures, Vol.21, No. 19, 15 October 1998, p. 6.

The government also encourages the entry of private and US-styled and owned health maintenance organizations (HMOs). Premiums are voluntary and more expensive that favor more commercialization and elite provision of health services to the few who can afford it.¹² When the government fails to provide people with basic services, they are left with no choice but to look for private service firms like the HMOs.

Another form of privatization of the health sector is the collectivization of local hospitals. The ownership and management of hospitals are given to cooperatives. Some local hospitals in Davao have this already implemented.

The Estrada administration in fact, implements its official policy that promotes “privatization of health services among hospitals, clinics, research centers and research and documentation facilities.”¹³ The policy enables big business to have a primary role in the production and provision of economic goods and services. At the same time, privatization diminishes the role of the government from being a main provider of health care services to that of a mere health regulator.

Though government hospitals are not wholly sold, privatization of government hospitals is, in fact, being realized insiduously and neatly through various modes.

In accordance with the RP-Austrian Agreement in Industrial Corporation in the Health Sector signed on September 1997 and agreements reached during the 2nd meeting

¹² “Health is Wealth: At Least for the HMOs.” IBON Facts and Figures, Vol 22, No.20, 31 Oct 1999,p.5.

¹³ “Erap’s To-Do List.” Today, 30 June 1998.

of the RP-US Austria joint committee on September 26, 1998, a soft loan of ATS 800 M (about 2.5 Billion Php) is being provided for the Philippine Lung Center Redevelopment Project.¹⁴ The foreign capital is being used under the build-operate-transfer scheme.

Corporatization of government hospitals/medical centers is claimed to be a “key strategy for reform... which allows hospitals to collect user-fees so they can reduce their dependence on direct subsidies from the Department of Health.”¹⁵ The four specialty hospitals and the general hospital East Avenue Medical Center will be integrated through the National Center for Specialized Health Services. Integration will mean increased fees for service under a standardized system and the displacement of health workers.

The corporatization policy continues to regional medical centers, devolved hospitals in the province up to the district and municipal level. Corporatization will encourage subcontracting of services like pharmacy and laboratory to business entrepreneurs.

Another case is co-location. The provincial government of Cavite solicited \$6.394 M from the Korean Industrial Corporation Agency (KOICA) to build a new 100-bed hospital in a one-hectare vacant lot within Andres Bonifacio Memorial Compound located at Trece Martires City. Korean funds will be used to build a new and modern hospital without necessarily updating the adjacent old and antiquated government

¹⁴ “Estrada administration fast-tracks anti-people health policies.” Pulso ng Bayan, Educational Series No.98-99, Jan-Sep 1999, p.18.

¹⁵ “DOH set to privatize 5 government hospitals.” Philippine Star, 1 January 2000, p.16.

hospitals.¹⁶ Co-location means giving red carpet treatment to foreign investors who run hospitals for profits while neglecting the already dilapidated government facilities.

In general, government hospitals have resorted to revenue enhancement programs that include charging fees for laboratory and diagnostic procedures already at par or at times higher than private hospitals, charging patients for supplies like cotton balls and syringes, that used to be free and charging a fee for parking space.

Executive Order 102 (Redirecting Functions and Operations of the DOH) and House Bill No. 5125 (Health Care Delivery Modernization Act) as proposed by Rep. Emilio Macias II are believed to be anchored towards “devolution part two.”¹⁷

EO 102 is meant to restructure and reprogram the central DOH to suit its new role. It reflects the changing function of the DOH, which was once the actual health care provider and is now supposed to serve as the regulator, coordinator and policy maker.

Incorporated in the EO 102 is the Rationalization and Streamlining Plan (RSP) which eventually leads to massive retrenchment of rank-and-file employees whose positions are considered “inappropriate” in the reorganization of the DOH. It is responsible for the lay-off of more than 70 per cent of 2900 DOH employees.¹⁸ It is in line with the policy dictate of the IMF-WB to re-orient the bureaucracy towards

¹⁶ Op cit., p.18.

¹⁷ “Retooling the bureaucracy.” *Medical Observer*, October 1999, p.13.

¹⁸ “Starvation salaries, and benefits, job insecurity and mass lay-off for health workers.” *Pulso Ng Bayan*, Educational series No. 98-99, Jan-Sep 1999, p.15.

privatization and to implement austerity programs to ensure foreign debt servicing. In the RP memorandum of intent for IMF loan Structural reforms Sec. 27 states that “ We will endeavor to move forward the Government Re-engineering Program which was initiated in 1994... “Reengineering the Bureaucracy” bill in order to obtain full authority to restructure the executive branch of the government. We expect the reduction in staffing will result from the merger or abolition of redundant agencies, the devolution of activities and programs of local governments and the further privatization of public services...”¹⁹

The Macias bill seeks to transform devolved hospitals into self-governing components. Also featured in his bill is the private sector participation in managing district health units, regional medical center and specialty hospital health boards.²⁰

Whatever name is used – modernization or privatization – , whatever schemes are implemented , the results are the same: commercialization of health services, big business for investors, more poverty, hunger, disease and death for the Filipino people.

¹⁹ Memorandum of Economic and Financial Policies of the Philippine Government, March 11, 1998.

²⁰ Rep. Emilio Macias II. House Bill No. 5125.

CHAPTER 3: COMMERCIALIZATION and PRIVATIZATION

Privatization is a very big issue and a major government policy. It is not only happening in the country but also in New Zealand, Canada and Malaysia. Airports in Wellington and Oakland were privatized but protect actions from its citizens nearly put the country in near constitutional crisis. Especially in New Zealand, their fire department is already privatized. There is a strong opposition against the privatization of health services.

In the Philippines, there are no hospitals sold outrightly, but the rallying point of anti-privatization campaign is hinged on the budget issue and government's buck passing health services to the private sector. The common excuse for subsidy cuts is the huge external debt of about \$50 million.

With the government's repeated claims of no budget, government hospitals are placed in a "helpless situation" and there is falsely no recourse but to enter into contracts with private businesses. Contractualization of labor and services follow. The World Bank refrains from using privatization to mean outright sale or transfer of ownership, but loosely as mechanisms where there is effective control by the private sector of government utilities or functions.

Privatization is the effective control by the private sector and is geared towards more commercialization and making more profit. Commercialization of health services,

per se, is NOT privatization, BUT is a step towards eventual privatization. Commercialization of health services means providing health services in the context of profit.

Social services, including health, are basic necessities and as such are basic demands. In terms of commerce, the private sector command a big market. Once they secure these as their markets, they are guaranteed superprofits. Privatization means big business. Hospitals and supplies are big businesses. To secure them as markets is the need to buy them, to own them.

CHAPTER 4: BACKGROUND OF THE LUNG CENTER OF THE PHILIPPINES

History

In the early part of 1978, the former First Lady Imelda Marcos suggested the establishment of a Lung Center of the Philippines, a project that was estimated to cost Php 300.0 million. This staggering amount was beyond a financially-strapped government to undertake. It thus tapped the Philippine Charity and Sweepstakes Office (PCSO) as the primary funding source for the project.

The Lung Center Project became concrete with the issuance of Presidential Decree No. 1823 on January 16, 1981 creating the Lung Center of the Philippines. The government appropriated Php 25.0 million as initial contribution to its 1981 operation. The decree further confirmed PCSO as one of the GOCCs that shall grant financial assistance.

According to the PCSO, it was already having cash flow problems and did not have the financial resources to honor the obligations exacted upon it by the government to finance the Lung Center.

The PCSO Board of Directors authorized the agency to borrow Php 300.0 million from any domestic or foreign financial institution to build the building. Aside from, this, PCSO was also tasked to provide funding for the medical equipment for the LCP to be imported from the Netherlands.

Nature of Clientele

The services of the Lung Center of the Philippines are essential. It provides services to patients with respiratory diseases, a leading cause of death that has accounted for more than 45% of annual deaths from all causes.

Lung Center's clientele (patients) are mostly those who have least in life in terms of financial concern. Admitted cases are mostly chronic and long term in nature hence plans and assistance are extensive and expensive. They come from all places in the country. Majority are from the rural areas who have come after resources in the province were drained and have little chances for recovery. Some are from the squatters area in the city who have nothing even for daily subsistence. Most often than not, it is the agency who provides for their medical needs though some were able to mobilize community resources to augment little help from the government.

Anybody who presents himself in need is qualified for the social service assistance. The LCP Social Worker then does the assessment and the evaluation and assistance varies depending on her independent assessment of data and facts given. The patient may immediately get the needed assistance or maybe referred to other agencies when necessary. When admitted, the patient's relatives must secure the following and submit before the day of discharge:

1. Recent Resident Certificate

2. Certificate of Residency from the Barangay captain
3. Social case study report from the local social worker
4. Certificate of property ownership/assets/liabilities from the municipal treasurer
5. Certificate of employment including those of children and/or siblings
6. Latest income tax return of all employed members of the family
7. Blood donors especially those who are for blood transfusion

Miss Nimfa Joy T. Sapiera, Social Worker Officer 3 of the LCP, explained that, “Proper information should be given to the public that NOT all charity patients can be given free hospital service and medicines. The extent of “FREE SERVICE” would depend on the classification made by the Social Worker based on its independent assessment criteria on charity patients.”²¹ According to her, “a standard computation of 20% discount is allowed to all out-patient department patients needing assistance with regards to procedures required.” But when and if the discount given is beyond payment, assessment and evaluation is made on the following criteria:²²

<i>CATEGORY</i>	<i>HOSPITAL SHARE</i>	<i>PATIENT SHARE</i>
<u>Class A-SIA</u> - family head is the sole support - slum dwellers - no support from relatives	free accommodation, board and linen, all procedures and examinations including medicines and supplies	donation only

²¹ Nimfa Joy T. Sapiera, Chief, Medical Social Service, an interview held at the Lung Center of the Philippines, Quezon City, 7 February 2000.

²² Official data from the Medical Social Service of the Lung Center of the Philippines.

<u>Class A SIA/MOBS</u> (Medicines, Oxygen, Blood Transfusion, Supplies) <ul style="list-style-type: none"> - family head and wife are both employed and earning the minimum wage - other relatives are extending minimal support 	free accommodation, board and linen, all procedures	100% cost of medicine, blood transfusion , cost of OR procedures Medicare benefits
<u>Class B</u> <ul style="list-style-type: none"> - 2 or more family members are employed - with minimal support from relatives 	Free accommodation 50% on total hospital bill	Medicare benefits 50% on total bill
<u>Class C</u> <ul style="list-style-type: none"> - 2 or more family members are employed - with minimal support from relatives 	Free accommodation 50% cost of procedures	Medicare benefits 50% cost of procedures 100% cost of MOBS
<u>Class D</u> <ul style="list-style-type: none"> - these patients are those who do not likely to complain with Social Service requirements but wish to avail of free accommodation 	- free accommodation only	-100% cost of hospitalization

Official data also showed the decline in charity cases in the out-patient department. In 1995, it has 24,106 patients while in 1999, it dropped to only 10,122.

Financial Condition

The 1997 third quarter subsidy of LCP amounting to about Php 25 million has been withheld by the Bureau of Treasury.²³ Without government subsidy, the hospital cannot go on with its services. The hospital is threatened to be closed or sold.

The LCP has been in a financial difficulty since 1996. The Bureau of the Treasury ordered on withholding and applying LCP subsidy for offsetting the loan contracted by the PCSO for the establishment of the hospital.

Of its annual budget of about Php 68 million, 30% or more than Php 20 million has been deducted by the Bureau of Treasury.²⁴

As a result, LCP incurred payables from four to six months which were carried over to 1997. It has outstanding debts amounting to more than Php 23 million.

The Lung Center has been operating on savings and collected fees for its services. Admissions of charity patients have been limited to 40% with the rest allotted to pay patients. Rates have gone up.

The financial problem faced by the LCP may be the much needed excuse to sell the hospital to private investors to save the hospital. Its solution has been focused on

²³ Alliance of Health Workers. Lung Center of the Philippines' Fact sheet.

²⁴ Ibid.

recuperating its losses due to unpaid PCSO loans and on increasing rates passed on to service users instead of working out the LCP budget.

The LCP Aftermath: The Philippines as Medical Center for East Asia

In the midst of raging controversies over the future of the Lung Center of the Philippines following the 20-hour fire that killed 25 patients and practically destroyed the entire hospital, the government has not made any statement regarding the immediate rebuilding of LCP. The fire also affected the nearby National Kidney and Transplant Institute's emergency room, radiology department and service or charity wards.

Before the fire, the LCP has a bed capacity of 272 (142 for charity and 130 for pay patients). The outpatient department (OPD) and Emergency room service about 30,000 patients per year. LCP is just one of the few hospitals doing laser therapy and cobalt for pulmonary patients. The fire gutted down almost all facilities and equipment.

At present, the Emergency room and OPD is already operational. Patients needing hospitalization are referred to other hospitals.

Former President Ramos in his visit to LCP after the fire stated his future plans for LCP as follows: estimate the cost of the damages, convert the hospital into a general medical center and not a specialty hospital anymore; and effective land use similar to that of Philippine Veterans' Hospital.

These statements reflect the government's plan to privatize the four GOCC hospitals as stated in the National Development Summit document dated June 8-9, 1997 to make the PHILIPPINES A MEDICAL CENTER FOR EASTASIA. Under the privatization plan, the main responsibility for either financing health care and the supply of goods and services relies on the private sector.

It is not by any chance that a draft Memorandum on Agreement between the Malaysian Landmarks Berhad and the Department of Health has been prepared last December 22, 1997. The MOA speaks of “ the government's recognition for massive capital resources and technical know how to develop the capabilities of the government hospitals to make them globally competitive and at par with international standards.”

It also speaks of the concept of “co-location” which is in coherence with the Department of Health concept of privatization.

The Memorandum of Agreement restrict the Lung Center of the Philippines with the following conditions:

1. Landmarks will have the exclusive right for a period of six months to make a study of the records and operations of LCP and have exclusive access to all information, data, documents , manuals, projections and resource person to determine the feasibility of the private sector profitability entering into partnership with LCP in certain areas of operations.

2. Acknowledge that the proponent has exclusive right to the co-location concept.

Under this co-location scheme, the private sector operator would enter into a long term lease arrangement with the government to develop a private hospital which would be co-located with a major public hospital.

As defined in Annex A of the MOA, co-location has three advantages:

- a. Additional income is generated to the public hospital from a number of direct sources:
 - lease of land or vacant hospital space
 - the purchase of an agreed range of services from the public hospital which would potentially include: food service, maintenance, fuel, light and power and cleaning services
- b. The retention of key medical staff in the public hospital, due to the availability of a private hospital located on site to supplement their income; and
- c. The private operator's capacity to provide some additional services to the public hospital, such as onsite consulting, room developments and upgrading computing systems.

After the fire, it may not be denied that the government would mercilessly pursue its plan to privatize the LCP.

With the government's austerity measures, it is hard to believe that it will spend for the rebuilding of the LCP and portion of the NKTI. It won't take long before it sound off calls of assistance to those most financially capable, whether that be Landmarks Berhad or any other foreign investors.

Privatization Schemes in LCP

Dr. Fernando A. Melendres, Executive Director of the Lung Center of the Philippines explained, "There is no such animal (privatization). It is a long dead issue. What we have now is corporatization and they are a world of difference. Privatization is selling the hospital to a private entity while corporatization is turning it to a public corporation."²⁵

Although there is no outright sale of the hospital, there are various schemes akin to privatization: contractualization and fee-for-service.

After the fire, majority of the 535 employees of LCP were temporary deployed to different hospitals. A Memorandum of Agreement was entered into the LCP management and the management of the hospitals where the LCP employees were temporarily deployed. There were 142 employees retained at LCP, more than 100 employees were assigned at the East Avenue Medical Center, 50 at the Philippine Heart

²⁵ Dr. Fernando A. Melendres, Executive Director, an interview held at the Lung Center of the Philippines, 7 February 2000.

Center, about 100 at the Quezon Institute while the others were at the Jose Reyes Medical Center, Research Institute for Tropical Medicine, DoH and other hospitals and offices.²⁶

Not only doctors and nurses are the common people we see in hospitals. Maintenance people and security guards also comprise the bulk of hospital staff.

Lung Center of the Philippines employs more than 60 security guards before the fire gutted almost the entire building last may 1998. At present, only forty (40) guards are employed by Star Force Agency, a private agency hired by the hospital since 1994. Guards undergo training and seminars for fifteen (15) days before they are deployed to their respective places. The forty (40) retained guards were then chosen by security officers of LCP on the basis of who are, “subservient to the administration and those who have committed less offenses.”

Security guards are minimum wage earners ranging from Php 5,000 to 6,000 a month. Though they receive their salaries on time through automated teller machines or ATMs every 7th and 22nd of the month, it is still not enough to sustain their living. *“Natatakot nga akong mag-asawa dahil sa liit ng kinikita namin sa araw-araw. Kung binata ka, makakasupporta yun, eh, paano kung may pamilya ka nang pakakainin? (I fear of having my own family because of the meager wages that we receive each day. For a bachelor, it may be enough. But what if you a family to feed?).”*²⁷ Also, they receive

²⁶ Alliance Of Health Workers. Status of Government Hospitals. 10 November 1998.

²⁷ Manuel Ramores, Security Supervisor, an interview held at the Lung Center of the Philippines, 5 February 2000

benefits such as 13th month pay, SSS and bonuses. However, they are not allowed to form unions. “*Bawal ‘yan sa agency,*” explained Mr. Manuel Ramores, LCP’s security guards’ supervisor. When asked why, he was quick to add, “*Kasi contractual nga lang kami.*”

Although, unions are prohibited to be formed, Star Force Agency is recognized as the Best Private Security Agency for the years 1997-1999.

The same goes with the maintenance people who are handled by Fast Manpower for twelve (12) years now. Now, the LCP has twenty-two (22) janitors as compared to the sixty-nine (69) janitors hired before the fire. They, too, receive very low wages ranging from Php 4,500 to 5,000. Twenty are contractuels while the other two are casuals. Not all receive benefits such as SSS, Medicare, overtime pays and day-offs. Some workers described their jobs as “*pwede na rin*” while others as “*mahirap.*” There are some cases wherein they get infected by the patients.

No unions are formed. “*Kapag nagtayo kami ng unyon, masisira sa management ng LCP ang aming agency. Kapag nangyari ‘yan, matatanggal sila, kasami na rin kami doon* (If we form unions, our agency may be put in a bad light. If that happens they maybe pulled out from the LCP, that includes us also.),” explained Nestor Eboña, OIC Supervisor and has been with the hospital for twelve years now.²⁸

²⁸ Nestor Eboña, an interview held at the Lung Center of the Philippines, 7 February 2000.

According to LCP-Alliance of Health Workers President, Miss Glenda Picardal, “Whatever name is used - privatization or corporatization – it means the same thing – profit for business enterprise. Since government hospital budgets are slashed, they resort to hiring contractual workers. In so doing, they reduce costs and maximize profits. Contractual health workers are denied of their security of tenure, thus, they hardly improve their living conditions. Contractualization is being implemented for practicality and convenience. Patients are also charged with fees to compensate for the lack of funds.”²⁹

One of the most common problems in LCP is the lack of medicine and supplies. Government health workers end up giving prescriptions instead, leaving the burden of buying medicines to the patients. One patient complained, “We bring and buy even the most basic supplies such as cotton and alcohol. Syringes, gloves, gauze are bought at the CSR. Medicines available here are the common ones although they are much cheaper to the ones bought outside. We still need to buy from nearby commercialized drugstores antibiotics, pain relievers and other medicines at skyrocketing prices. *Mabigat talaga sa balsa.*”

An x-ray cost from Php 84 to Php 300. CBC costs Php 800, oxygen is paid for Php 211.25 and medicine bottles at Php 19.45 each. However, facilities/equipment such as CT scan and bone scan are not yet available for patients.

²⁹ Glenda Picardal, President, AHW-LCP, an interview held at the Lung Center of the Philippines, 8 February 2000.

Hospital bills are discounted through the Social service but are subject to approval if requirements are properly met and completed. Senior citizens are given 20% discount. Other bills are shouldered by private insurance companies and health maintenance organizations.

With the Lung Center of the Philippines undergoing various privatization schemes, health services become unobtainable and unaffordable for its indigent patients. The proposed integration of the four specialty hospitals through the National Centers for Specialized Health Services will mean increased fees and the displacement of workers.

CHAPTER 5: PRIVATIZATION DRIVE: BACKGROUND AND DOH RATIONALE

Privatization in the country has taken on various forms but the logic stays the same. Echoing IMF-WB's oft-repeated homily, the *raison d'être* for privatizing state assets and companies and development undertakings are: (1) focus government energies and resources to provision of basic public goods and services; (2) create favorable investment climate; (3) broaden ownership base and develop capital market; and (4) generate revenues for priority government expenditures.³⁰

Privatization as a government policy was introduced through Presidential Decree 2030 under Marcos but it was only under Cory Aquino that it was finally executed. It was instituted on December 6, 1986 pursuant to Proclamation No. 50.³¹ It created the Committee on Privatization and the Asset Privatization Trust. COP is an executive office under the Office of the president tasked to oversee the Philippine government's privatization program. It also handles policy matters and approves private transactions as to price and buyer.

Under the Cory Aquino administration, the focus of the privatization program was the sale of white elephants – assets and/or corporations owned by former Marcos cronies whose foreign indebtedness was guaranteed and assumed by foreign banks.³²

³⁰ "Privatization: Turning Government Over to Transnationals." *IBON Special Release*, July 1997, p.2.

³¹ Crisanta Legaspi. "The Philippine Privatization Program." Paper presented at the DOH Policy Forum, 20 February 1997.

³² Epictetus Patalinghug. *Philippine Privatization: Experience, Issues, and Lessons*. No. 13, 1996, p.4.

Later, she broadened the scope of privatization to include private-sector participation in infrastructure and energy projects including water and irrigation. The Build Operate Transfer Law or RA 6957 was enacted to legalize the entry of private firms in important government development undertakings and operations.

It was during the Ramos administration that privatization was intensified by seriously following the IMF-WB dictates. He considered shaping partnerships with the private sector in the provision of basic services through Executive Order No. 37. This also widened the coverage of privatization and these include properties and functions of line agencies such as social services and health. The third wave of privatization also includes health.

During the Ramos regime, the concept of outright privatization of the country's specialty hospitals was ruled out. Instead, they pushed for a private-public partnership which would explore private sector participation in the various services offered by hospitals which are all located in Quezon City. Public-private partnership is just one mode of privatization being pursued by the government for better efficiency and effectiveness in the delivery of social services.³³

Semi-privatization, as it was called, would allow more portions of the hospitals' funds provided by the by the national government to subsidize "expenses incurred by the

³³ DOH Policy Forum Report. "Charting the Course of a Public-Private Partnership in Managing Health Facilities and Services." 1st Discussion Series, 20 Feb. 1997, p. 1.

indigent patients.” Hospital management would also be contracted out to the private sector. “We welcome foreign partners but as a policy, we prioritize local investors,” former health chief Carmencita Reodica explained.³⁴

The Estrada administration has a clear policy on the framework on privatization of health services. In a paper entitled, “A Presidency for the People,” it stated that the program for health under the Estrada administration is one of commitment to completion of the devolution process, more privatization of hospitals, health centers and institutions and propagation of managed care.³⁵ This was also included in his 10-point action program for his first 100 days, i.e., promote the privatization of health services among hospitals.

The Health Sector Reform Agenda reported that the “burden of disease is heaviest on the poor,” or the constituency that President Estrada has promised to provide with quality life by the end of his term in 2004.

The DOH staff has put together a package of reform proposals to deal with, among other problems, the inequity in health resources and delivery of services.

It is embarking on the privatization program to enable the chosen government hospitals to provide better health services and earn revenues at the same time. The

³⁴ Aldwin Fajardo. “Specialty hospitals face semi-privatization – DOH.” Manila Standard, 16 October 1996, p.3

³⁵ Antonio Tujan, Jr. “Privatization and Globalization in the Estrada Administration.” Paper presented at the NO to privatization meeting, 22 August 1998.

government has started the groundwork for the conversion of the four specialty hospitals into private corporations to promote their fiscal autonomy.³⁶ Among the government-run hospitals are The Lung Center of the Philippines, Philippine Children's Medical Center, National Kidney and Transplant Institute and the Philippine Heart Center.

To upgrade their critical capacities, like diagnostic equipment and laboratories as well as admit more indigent patients, the DOH is advocating that government hospitals be allowed to collect socialized user fees so as to lessen dependence on state subsidies. Or, they should be converted to public corporations.³⁷

A Task Force on Hospital Corporatization was created pursuant to Department Order No. 92. It was put up primarily to keep in line with the policy thrusts of the Department of Health towards developing and upgrading health facilities.

Under corporatization, the President of the Board will be the DOH Secretary. The rest of the Board will come from the private sector. The government will not provide the budget. But instead, poor or indigent cases will be paid for by income from gambling – through the PAGCOR (Philippine Amusement and Gaming Corporation) and the Philippine Charity Sweepstakes Office and private institutions.³⁸

³⁶ "DOH sustains Philippines' improved health status." Philippine Daily Inquirer, 27 December 1999.

³⁷ "DOH set to privatize 5 government hospitals." Philippine Star, 1 January 2000, p.16.

³⁸ "Hospital Workers in the Philippines Brace Against Corporatization." Solidarity Partnerships, Winter 1999.

According to the Department of Health, there is no privatization because there are no hospitals sold outrightly. Privatization meant that hospital services such as computerization, laundry, janitorial and security services will be contracted out to the private sector.³⁹

Privatization, for the DOH, meant the following: (1) partial sale, i.e., shares of stocks are sold until the hospital management is restructure or if majority of the stocks belong to foreign or local investors; (2) “lease agreements,” “joint ventures,” or “co-location” and (3) build-operate-transfer schemes.

Privatization, as the DOH reported, is done through the different disposition methods such as:

Sale of shares through public offerings;

Sale of assets through public biddings;

Negotiated sale, if bidding fails; and

Lease, management contract, B-O-T schemes and joint ventures

It also has options for privatization:

Complete transfer of institutions to private sector;

³⁹ Dave Gomez “Sale of hospitals defended.” The Philippine Star, 7 December 1995, p.21.

Mixed ownership: Government as majority stakeholder then private sector as minority stakeholder

Franchising to the private sector of components component or support services

In a DOH briefing paper, a three-step procedure is followed in the disposition of the four GOCCs hospitals:

- ✿ A Memorandum of Agreement between the interested party and the hospital will be signed whereby the interested party will have an exclusive right to have to review for six months the track record of the hospital, its operations, its clientele, profitability and so on. If the party continues to be interested, the next step is taken.
- ✿ Joint venture contract. There are two (2) options. First, the private party will construct a separate building for private patients. Second, the interested party will use a vacant underutilized space in the existing government hospital building. (The entire unit for private patients will be for PROFIT and the party will allow the doctors of the existing government hospital to admit private patients in the new building or unutilized space.)
- ✿ Build-operate-transfer

These are in accordance with the principles the Department of Health follows:

- ✿ Government initiates provision of health services/facilities in areas where the private sector does not want to come in or unusable to establish such services.
- ✿ Government ultimately withdraws and relegate the health service facilities to the capable private sector.

The Department of Health, with its drive to privatize, has intentionally altered its role from a health care provider to that a mere broker for investors.

CHAPTER 6: WHY PRIVATIZE?

Government Cuts Expenditure for Health

Over the years, the national budget for the Department of Health has been constantly reduced.

The Department of Health has admitted that the health budget is not enough for the delivery of health services. The allocation for health has been consistently low. From 1980-1985, an average of 3.45% of the national budget was received by the health sector while for the period 1986-1989, it has decreased to 3.2%.⁴⁰

In 1992, it was 5.46% proportionate to the national budget. In 1996, less than 3% of the national budget was given to health while \$4.9 billion was spent for debt service.

In 1999, it is only 2.4% (Table 1).⁴¹

Table 1. Department of Health Appropriations: 1992-1999

	1992	1993	1994	1995	1996	1997	1998	1999
Total Health Budget (in millions pesos)	10.628	7.262	7.418	8.647	9.301	11.020	11.507	11.275
% Relative to National Budget	5.46	2.35	2.30	2.30	2.23	2.54	2.18	2.40
% to GNP (current prices)	0.78	0.48	0.42	0.45	0.41	0.43	No data	No data
Nominal Per Capita Budget (current prices)	164	110	108	123	129	150	No data	No data
Real Per Capita Budget at constant 1985 Prices	87	55	49	54	50	54	No data	No data

Source: 1992-1997 DOH Annual Report; 1998-1999 General Appropriations Act used as reference since DOH data is not available.

⁴⁰ "Public Health Under the Knife." *IBON Facts and Figures*, 31 May 1995, p. 7.

⁴¹ *Pulso ng Bayan*, Educational Series No.98-99, Jan-Sep 1999, p.18.

The expenditure for defense and interest payments on foreign debt are much bigger than the health budget (Table 2).

Table 2. Sectoral Distribution of Public Resource Budget (1998) (in billions)

Sectors	Total Budget
Economic Expenditures	P 341
Social Services	201
Education, Culture and Manpower Development	109
Health	26
Social Security, Welfare and Employment	14
Housing and Community Development	18
Land Distribution	0
Other Social Services	5
Defense	47
General Public Expenditures	121
Total Productive Expenditures	711
Debt Interest Payments	76
Financial Expenditures	1,528
GRAND TOTAL	P 2,314
Source: Budget of Expenditures and Sources of Financing (Fiscal Year, 1998)	

Allocations for health have been reduced even further despite the admitted poor performance of the health sector. While the country is increasing the budget of the military yearly, the allotment for health was slashed by more than Php 1.5 billion between 1998-1999.⁴²

Because the government decided to cut spending in all their agencies, public spending on health, education and social services was curtailed even further.

⁴² "Retooling the Bureaucracy." *Medical Observer*, October 1999, p. 12.

Such budget constraints in the health sector meant lower allocation for the delivery of health services in terms of hospitals, facilities, equipment and medical personnel, toilet facilities, etc.

Because the government's low health budget is unable to preserve public hospitals, private companies are allowed to "co-own and co-maintain" these services.

A Filipino received only Php 367 for a year's health supposing that 70 million Filipinos got equal shares of a 26 billion budget. But not all of the health budget was consumed for the primary health care of the people. Official data showed that out of the Php 26 billion health budget, Php 5 billion was spent for the expenses of the DOH personnel, i.e., bonuses and incentives, employee compensations, training of personnel, etc.⁴³

The Department's sustenance and other operating costs, e.g., supplies and materials, rents, travelling expenses, etc., were given another Php 5 billion.⁴⁴

An insignificant Php 16 billion budget for health was left. It is not extraordinary that selected items for health have been decreasing. (Table 3)⁴⁵

⁴³ "Health is Wealth: At Least for the HMOs." 31 October 1999, p.6.

⁴⁴ Ibid., p.6.

⁴⁵ Ibid., p 7.

Table 3. Details on Health Allocation (in million pesos 1996-1998)

	1996	1997	1998
Subsistence Allowance for Barangay Health Workers	-	150	-
Magna Carta for Public Health Workers Devolved to local government units	166	-	-
National Nutrition Council	42	97	51
Philippine Heart Center	113	122	120
Source: Budget for Expenditures and Sources of Financing (Fiscal Year, 1998)			

The government's solution to budget constraints is to seek private or foreign funding for its programs.

As a result, health expenditures have been shouldered by the people mainly through out-of-pocket payments. In 1991, out-of-pocket payments was 45.82%. It reached a high 49.36% in 1995 (Table 4).

Table 4. Health Expenditures by Sources of Funds: 1991-1997

SOURCE OF FUNDS	Amount (in billion pesos)							% Share to Total Health Expenditure						
	1991	1992	1993	1994	1995	1996	1997	1991	1992	1993	1994	1995	1996	1997
Government	13.61	14.24	15.98	19.14	22.19	27.73	34.12	36.46	34.12	33.85	34.56	33.31	35.67	38.59
National	12.23	12.51	10.05	10.41	11.76	15.26	18.64	32.76	29.97	21.28	18.80	17.65	19.62	21.08
Local	1.38	1.73	5.93	8.73	10.43	12.48	15.48	3.70	4.14	12.57	15.76	15.66	16.05	17.51
Social Insurance	3.39	3.97	4.64	5.57	6.10	6.59	6.37	9.09	9.52	9.82	10.06	9.16	8.47	7.20
Medicare	3.00	3.62	4.23	5.13	5.70	6.23	6.09	8.03	8.67	8.95	9.27	8.56	8.02	8.89
Employees Compensation	0.39	0.35	0.40	0.42	0.39	0.33	0.26	1.05	0.83	0.85	0.76	0.58	0.42	0.29
Health Insurance Plan	0.01	0.01	0.01	0.01	0.01	0.03	0.02	0.01	0.02	0.02	0.02	0.02	0.04	0.02
Private Source	20.32	23.52	26.60	30.66	38.32	42.43	47.93	54.45	56.36	56.33	55.38	57.63	55.86	54.21
Out-of-pocket	17.10	19.63	22.62	25.92	32.88	37.12	40.96	45.82	77.04	47.89	46.81	49.36	47.74	46.32
Private Insurance	1.25	1.53	1.42	1.46	1.47	1.63	1.99	3.34	3.68	3.01	2.63	2.20	2.10	2.25
Health Maintenance Organizations	0.46	0.54	0.70	0.92	1.30	1.73	2.04	1.23	1.29	1.47	1.65	1.96	2.22	2.31
Employer-based plans	1.22	1.44	1.44	1.84	2.04	2.26	2.18	3.28	3.45	3.04	3.33	3.06	2.90	2.46
Private Schools	0.30	0.36	0.43	0.53	0.64	0.69	0.77	0.79	0.91	0.92	0.96	0.95	0.89	0.87
ALL SOURCES	37.32	41.73	47.23	55.37	66.62	77.75	88.42	100	100	100	100	100	100	100

Source: UP Econ (1991-1994); NSCB (1995-1997)

Because public health care system is deficient, health care delivery is being captured by the business sector.

With the health budget for 2000 was slashed anew, “DOH will be lowering its target spending per citizen due to steady population... The government will only spend Php 145 per citizen on health services.”⁴⁶

Health budget cuts arise to insufficiency of funds earmarked to indispensable medical supplies, imposing fee-for-service schemes, commercialization of hospital fees, wage freeze and nonpayment of benefits and massive lay-off of health workers.

Imperialist Crisis and Privatization

Technological revolution in the 1970s was actually an apparatus of monopoly capital which intensified the global crisis of overproduction. Advancement in technology pressed for the production of new products to increasingly over saturated markets.

Over consumption and overproduction was made possible because of huge borrowings brought about by corporations, governments and consumers and provides profits for the financial oligarchy. Debt and budgetary crises have perpetuated and have become more stubborn.

⁴⁶ Volt Contreras. “Health budget for 2000 cut.” Philippine Daily Inquirer, 13 August 1999.

As a consequence, markets were obviously needed where surplus products and surplus capital could be dumped.

Capital was no longer in the form of technology but in gargantuan speculative portfolios which pushed for neo-liberal tenets of privatization, deregulation and privatization. Through multilateral institutions like the IMF-WB, ailing economies were revived by the new lending.⁴⁷

Dishonest governments push for the entry of financial capital. In so doing providing capitalists with markets to dump their surplus products and obtain super profits.

Privatization meant nothing but the plunder and exploitation of the population especially the most deprived, marginalization and power of the ruling elite under the auspices of monopoly capitalism led by the G7 nations.

Role of the IMF-WB

The International Monetary Fund, undeviating with its role as fiscal protector, has utilized its structural adjustment programs to enforce privatization.

⁴⁷ "Crisis." IBON Facts and Figures, Vol. 21, No. 15-16, 15-31 August 1998, p.11.

The IMF-WB conditionalities have been the basis for government policies which pushed for the sale or lease of public lands, corporations, and even hospitals at give-away terms. It is also the reason why workers' wages are kept low, workers' rights and privileges are denied, cause mass lay-offs and contractualization.

Government officials claim that privatizing health services is meant to improve the quality of care. But the real purpose is to "save money" – to pay for unjust interest on unjust loans and for programs which enrich the ruling elite and foreign monopoly capitalists.

The Philippine government has pursued programs in accordance to the dictates of the IMF-WB and structural adjustment programs or SAPs. SAPs are burdened on developing countries to restructure their economies so they can better save foreign exchange for debt service and to change their basic macroeconomic and eventually social policies of the Third World countries to be coherent with the long term requirements of the imperialists.

Privatization is one of the provisions of the structural adjustment program (SAP) of the International Monetary Fund and the World Bank. SAPs demand currency devaluation, high interest rates, removal of trade and exchange controls and higher taxes. It also orders cuts in government spending, particularly in health, education and social services.

SAPs made sure that the indebted country would be able to repay its debts through tight fiscal management reducing government spending through cost-cutting and privatization, including raising government revenues through taxation and sales receipts from privatization and opening the country to foreign investments.

The catch phrases of free competition, free markets and free trade – the forces behind “globalization” exert efforts to cover-up the workings of monopoly capitalism. Worse conditions of neo-colonial dependence and subservience to imperialist dictates are imposed on the oppressed people and nations. SAPs demands on liberalization, deregulation and privatization have come to mean economic genocide. Governments have implemented oppressive provisions which include the following:

- ✿ Cutbacks in government spending
- ✿ Privatization of government services
- ✿ Freezing of wages
- ✿ Tariff reduction
- ✿ Retrenchment of workers
- ✿ Deregulation of the economy
- ✿ Trade liberalization
- ✿ Abolition of price controls

SAPs have accelerated the integration of all countries into the global system of capitalist relations. SAPs benefit big businesses instead of serving the people.

People from more than 90 countries in the Third World, Eastern Europe and former Soviet Union have been deprived after implementing SAPs. ⁴⁸

SAPs and its neo-liberal mantra of deregulation, privatization, and liberalization have globalized poverty and deteriorated health conditions.

Privatization of health has worsened worldwide crisis. Monopoly capital is controlling key areas of public sector and social services to exploit people under the guise of state-sanctioned policies. The already impoverished people have been further denied of even the most basic health services. Millions of health workers are also robbed of their income and pushed into the brink of unemployment, making sacrifice their commitment to serve the people.

The World Bank has also dictated health care policies to the Third World. The Bank group stimulates private sector development for it “stimulates economic growth and creates jobs and privatization created the fiscal space that allows government to allocate greater resources to the social sector.”⁴⁹

It also encourages and bolsters the expanded role of the private sector through its various financial instruments, advisory services, training and the nurturing of business partnerships.⁵⁰

⁴⁸ Michel Chossudovsky. The Globalisation of Poverty. 1997.

⁴⁹ World Bank Annual Report, 1996, p. 61.

⁵⁰ Ibid., p.61.

The Bank aids countries in privatization and enterprise reform by providing direct advice and analysis, making loans for technical assistance to facilitate transactions, designing adjustment projects to help governments face the onetime costs that may associated with privatization, making investment loans to help privatized companies restructure and providing guarantees to cover risks to private investors.⁵¹

Translated into real terms, the Bank's policies include cutbacks in the government spending on health, thus leaving the responsibility of health care to the person who needs the service and privatization of medical and health care services by transferring government services, which in the past, are subsidized, to big businesses.

The World Bank estimates an expenditure of only \$8 per person per year as adequate to meet the acceptable standards of clinical service.⁵² The Bank's solution lies in the imposition of fee-for-service schemes, commercialization of fees and the massive lay-off of doctors and health workers.

Private providers as an important source of care in many countries are recognized: the private involvement in supplying service providers with drugs and equipment are welcomed and increased public and private investments in generating new drugs and equipment are also encouraged.⁵³

⁵¹ Ibid., p.62.

⁵² "Investing in Health." World Bank World Development Report., 1993.

⁵³ "Making A Difference." World health Organization Report 1999, p.33.

The Memorandum of Economic and Financial Policies of the Philippine Government on March 11, 1998 included the following reforms:

Structural Reforms Sec.27 --- Government Re-engineering Program... “We expect the reduction in staffing from the merger or abolition of redundant agencies, the devolution of activities and programs to local governments and the **further privatization of public services** to improve the effectiveness of efficiency of government.

Structural Reforms Sec 29 --- Strengthening the Corporate Sector... “our structural reform agenda will increase the resiliency of the corporate sector mainly by imposing the enabling framework, continuing trade and investment liberalization, developing the domestic capital market, **additional privatization** and further strengthening debt management.

Section 33 --- The government remains committed to carrying forward its privatization plans in the coming years...

CHAPTER 7: IMPACT OF PRIVATIZATION OF GOVERNMENT HOSPITALS

On indigent patients

Cutbacks in government spending and privatization have caused the further decline of people's health. So-called health policies and programs have not improved the lives of the Filipinos.

Although the outright sale of the four GOCC hospitals namely the Lung Center of the Philippines, The Philippine Heart Center, Philippine Children's Medical Center, and the National Kidney and Transplant Institute, was not pushed through, because of the very low subsidy from the government, hospital charges in these hospitals are already at par or even higher than private hospital fees. Even patients categorized as indigents have to pay expensive medical treatment and procedures.

According to the management of the National Kidney and Transplant Institute, "the rest of the needed funds, the NKTII has to earn primarily from pay patients. Given the current national and regional economic difficulties worsened by the Lung Center fire, it is everyone's concern to undertake survival measures."⁵⁴ Improved collection of receivables, frugality and prioritization are supervised. A flexi-trade center was opened, selling directly to patients the hospital and pharmaceuticals supplies they need. The hospital no longer provide free medicines and other supplies for indigent patients.

⁵⁴ National Kidney and Transplant Institute's Administration response to the letter of NKTII-Employees Association.

Hospital fees greatly increased: room rates, laboratory, x-ray and 25% marked-up for medicines plus 10% VAT was set. A fee of Php 200 is being charged for the first 2 hours stay at the emergency room while waiting for room accommodation. The rate can reach up to Php 400 if waiting exceeds two hours. New rates were charged for other procedures: water heater - Php 70 per use; use of monitor - Php 210; fee for the insertion of IV is also charged to patients. Patients need to deposit Php 150,000 for kidney operation.

According to Dean Cecilia Laurente, “At the Philippine Heart Center, patients undergo very strict screening process. They are being assessed not in terms of indigency but in terms of survival rate and accessibility of hospitals in the region or province that can render follow-up services. No operation is also done without the presence of “sponsors.” Thus, many patients are turned down.”⁵⁵

The Philippine Children’s Medical Center considered as the “premiere tertiary center for pediatric and prenatal care” is currently implementing revenue-enhancement program.

The Dr. Jose Fabella Memorial Medical Hospital is part of the 12.8-hectare lot which includes the Old Bilibid prisons, central market and part of the San Lazaro Hospital. These structures will be affected by the Php 14 billion commercial and transport complex that will be built. The commercial complex includes an MRT station,

⁵⁵ Dean Cecilia M. Laurente, an interview held at the College of Nursing, UP Manila, 22 February 2000.

9 condominium towers, student dormitories, jeepney and bus terminals and “upgrading” of the Fabella Hospital.⁵⁶

The “modernization” of the hospital will ultimately lead to further commercialization of services.

At the National Center for Mental Health, patients were charged on medicines and other services. The subsidy for medicines was greatly reduced (from 30 Thorazine tablets to 10), medicines were substituted for cheaper ones. It is also being planned to be relocated in a much smaller place in Pillila, Rizal.

The Tala Leprosarium is to be converted into a general hospital. To phase-out leprosy services, the government handed out Php 10,000 for every patient. In exchange, they will stop receiving medicines and other subsidies from the hospital and the government has no more obligation to them. There is also no more admission of lepers despite valid reasons for hospitalization. The multi-drug therapy subsidy per patient was diminished. Fees for hospital services are pegged: Php 7 for the issuance of out patient ID, a fine of Php 50.00 is charged for lost ID card, and the laboratory personnel were conditioned to demand payments from patients for every laboratory procedure.⁵⁷

⁵⁶ Jerry Esplanada. “ Prime Manila Property: 4th Palace Land deal questioned.” Philippine Daily Inquirer, 30 March 1998, p.1.

⁵⁷ “Elimination of Leprosy or Elimination of Lepers?” Tambalan, July-December 1997, p.1.

*“Masyadong mabigat para sa mga pasyente ng Tala at Mental ang pagrelocate sa kanila. (It will be very hard for Tala and Mental Hospital patients if they will be relocated.) They are special patients and thus they need special care. They still need a hospital which will specifically take care of their needs. If ever they will be in far-flung communities, are they willing to accept mental and leprosy patients? Add to that the health workers who are not skilled in taking care of them.”*⁵⁸

Other special hospitals under the Department of Health can hardly provide basic services to the patients this year but in the proposed budget for 1999, the budget allocations for these hospitals were again reduced:⁵⁹

Rizal Medical Center:	from Php 196,126,000 for 1998 to Php 179,449,000 in 1999
East Avenue Medical Center:	312,097,000 to 259,151,000
Quirino Memorial Medical Center:	228,894,000 to 164,504,000
Amang Rodriguez Medical Center:	139,277,000 to 97,358,000
Saint Anthony Mother and Child Hospital:	30,689,000 to 17,465,000

In regional hospitals, commercialization through revenue enhancement programs and pay for service schemes are now in place. All laboratory procedures and even emergency room services have to be paid.

⁵⁸ Dean C.M. Laurente, Manila, 22 Feb.

⁵⁹ Alliance of Health Workers. Status of Government Hospitals. 10 November 1998.

Regional hospitals are swamped with patients coming from devolved provincial and district hospitals because these hospitals are under great financial and human power constraints.

The Veterans Memorial Medical Center and RSBS (AFP Retirement, Separation and Benefit System) has drawn up a Memorandum of Agreement in October, 1997 to undertake a feasibility study on the modernization of the VMHC.

An Australian contractor will be hired to demolish the present hospital. A twin tower (condotel with hospital), a convention center and commercial center will be built. A golf course will also be upgraded.

On health workers

For the majority of the health workers, life remains a day-to-day struggle for survival against the steadily rising prices of the most basic necessities such as food, water, house rental, fuel, electricity and medicines.

The aggravating health condition is a direct manifestation of the socio-economic and political crisis affecting the people. This condition is further exacerbated by the implementation of government's policies such as: devolution of health services and privatization.

Project Cocoon is a continuum process for the Local Government Code.

According to the concept of the Project which the DOH adheres:

“This is in line with the directives of the Secretary of Health to make devolution work and to provide full support to decentralization of health services, a period of transition and metamorphosis is proposed to enable the organization to shed its old roles, assume new ones and transform itself into relevant and efficient agency that can truly respond to the health needs of the country. Project Cocoon seeks to create an environment for strategic thinking and organizational development toward a strong and responsive Department of Health in a devolved set-up.”⁶⁰

Project Cocoon, in essence, meant nothing but the widespread streamlining and massive lay-off of health workers.

The government’s subservience to IMF-WB dictates has resulted to starvation salaries and benefits, job insecurity and mass lay-off for health workers.

At the Jose Reyes Memorial Medical Center, there is an influx of patients but no additional staff was hired. Hospital employees are overworked. The same is also true at the Tondo Medical Center, where no additional staff was hired for extra loads such as laundry work, which was previously awarded to an agency is now added to the functions of the linen department.

⁶⁰ Alliance of Health Workers. “Pagsusuri sa Project Cocoon ng Sentral na Kagawaran ng Kalusugan.” 1 March 1999.

Lack of budget further exposed health workers at the San Lazaro Hospital to hazardous conditions due to lack of safety equipment and supplies. They remained doubly overworked because of the freeze hiring policy. Their salaries were hardly enough to make both ends meet and no additional benefits were given to them.⁶¹

The hazard pay for health workers at the Tala Leprosarium was not given since January 1998. The patient's assistants' working hours were reduced from 8 hours to 4 hours a day. The organizational structure of the hospital was changed and was patterned after to that of a general hospital.

At the start of the new millenium, the much publicized 10% salary increase is still unsure; only 5% of the basic pay was given as hazard pay contrary to the 25% specified under the law. The additional subsistence allowance and agency incentive allowance of Php 7,200 were wantonly rejected by the government. These are in addition to other economic benefits which were denied, although legally due to Republic Act 7305 or the Magna Carta for Health Workers, such as overtime pay, night shift differential, housing allowance and holiday pay.

The hazard pay prescribed by law, which is equivalent to 25% of the basic pay was never given. Instead, only Php 600 monthly hazard pay was given to all hospital workers for the past years. In 1998, hazard pay was given cautiously to only four hospitals handling infectious diseases and laboratory and x-ray personnel in other

⁶¹ "Working Conditions of Hospital Workers and Patients in San Lazaro Hospital." People's Health Watch, Series No. 3, 26 October 1998.

hospitals. Late last year, only 5% of the basic pay were given for hazard pay. If the Php 600 hazard pay already fell short of the 25% of the basic pay specified by law, the latest hazard pay scheme of 5% of the basic pay is even worse. It is not only lower than the previous hazard pay, it is also divisive for it favors those few who are already receiving high salaries while for the majority receiving measly wages, it was a major blow. For example, with this scheme, those receiving Php 4,000 per month will receive only Php 220 while those at the management level getting Php 25,000 will receive Php 1,250 per month.⁶² The present scheme widens the compensation gap among health workers.

Due to insufficient salaries and health benefits, health workers have no choice but to resort to borrowing money or engaging in sidelines in order to survive.

The practice of hiring contractuales is putting hospital employees at a loss. Contractualization deprives them of their security of tenure and also jeopardizes hard-won unionism, their weapon against the excesses of the administration and labor abuse.

⁶² Alliance of Health Workers. "Start the New Millenium Right, Stand for our Rights: Demand for the Payment of Hazard Pay and other Benefits!" 11 January 2000.

CHAPTER 8: STRUGGLE AGAINST PRIVATIZATION

Long before Makati executives gave new meaning to the term “Parliament of the Streets” in the 1980s, health activism was alive and well in the Philippines, and struggling for reforms.

True health activism though, as advocated by groups like the Health Alliance for Democracy (HEAD), goes beyond the interests of the rallyists. “HEAD has served as a think tank and information resource for issues involving health of the Filipinos, ranging from the use of nuclear energy to essential drugs and privatization as a national health policy.”⁶³

Another organization which has united opposition against privatization is the Network Opposed to Privatization. It is a loose network of concerned individuals, community health programs, hospital unions and associations, health professionals, community health workers, student councils and organizations, medical social workers associations, patient groups and people’s organization.

“NO to Privatization believes that it is every Filipino’s right to have access to health services and that should be provided by the State. No one should be deprived of it

⁶³ Amy Chavez, an interview held at the UERMMMC, Quezon City, 18 February 2000.

because of cost. Privatization means the abandonment of the State of its responsibility to its citizens. The IMF-WB is behind the push to privatize to ensure that there is enough money to pay our debts. What we need is the concerted efforts of the people and the direct involvement in mass actions to curb privatization and other foreign impositions.”

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The combination of militant struggle by the Alliance of Health Workers, the Health Alliance for Democracy (HEAD) and other similar health NGOs, and coalition-building in the form of the broad coalition named Network Opposed to Privatization or NO to Privatization has forced the Estrada government to verbally declare, contrary to their official written policy, that government hospitals would not be privatized. **This is a very significant triumph in the people’s fight against the privatization of health care services.** But oppositionists have continued to be attentive and keep in the struggle including issues on budget cuts, commercialization of health care services and unmasking other modes of privatization that the government has resorted to.

Health activists in the Philippines are banded in the belief that the nation is always headed towards worse times as far as the health of the Filipino people is concerned. For as long as freedom of expression is sustained, there will always be people protesting to what its leaders are doing. There are more and more people from all walks of life, up in arms, wishing and hoping to make a difference in the health status of the Filipinos.

⁶⁴ Dean C.M. Laurente, Manila, 22 February 2000.

CHAPTER 9: CONCLUSION

In general, the National Government's subsidy for the government-owned and controlled corporation hospitals and other government hospital is decreasing. For GOCCs, the support is only meant for the maintenance and operating expenses. No support is intended for personnel services and capital outlays.

All government hospitals are implementing revenue-enhancement programs or fee-for-service schemes at different levels to cover shortage in their budget. For GOCCs, bulk of the patients who are pay patients reign supreme in terms of surgical operations and other procedures than the "service" patients. Service patients suffer rigid screening procedures before they are categorized as service patients. Though service patients, they still have to cash-in "donations or contributions" or are still obliged to pay depending on their category.

The four GOCC hospitals are now operating on a very low subsidy from the government. With insufficient subsidy, the management are compelled to raise funds thus, they manage the hospitals as businesses not as service institutions. They charge very high fees to their patients. As a result, they prefer those who can pay and only few poor patients can avail of the services they provide.

Since no budget is available for personnel services, they are pushed to raise funds to pay for the employees and other expenses. They are also instituting strict rules for

personnel absences (like in NKTI) to reduce the expenses through salary deductions or to have reasons in firing employees. In this situation, the employees' job security is always at risk.

With the implementation of privatization and commercialization of health services, the health workers right to organize and unionize is in danger. Retrenchment, streamlining and contractualization have become the norm. Contractuals and casuals resulting from the contracting out of services lose their benefits and tenure. They further agonize from the worsening conditions of labor. Health workers find it more difficult to render quality health services due to reduced number of employees. They find the work conditions inhumane.

As these hospitals continue to implement cost recovery measures and revenue enhancement programs and yet still incur deficits, they will be ultimately opened up or be given up to big businesses and corporations. In business, superprofits should be guaranteed. In this case, state hospitals will be leaving its responsibility to its citizens and ultimately serve the interests of the big capitalists.

Privatization of government hospitals serves as an instrument for monopoly capitalists to further exploit the broad masses of the Filipino people and the people in different parts of the world. It is also government's admission of its own inadequacies.

Health becomes a commodity to earn super profits, not service to the people. Profits then become the sole measure of how efficient and effective one's economic policies are. We see how greedy imperialists rake in huge profits at the expense of the people's welfare.

Privatization, where the IMF-WB are key players in this serious problem, is a strategy of imperialist domination. In this scheme, public health care becomes a private commodity making its price well out of reach for the poorest 60% of the world population. Privatization is often implemented under the guise of making delivery of health services more efficient. But the current status of government hospitals show this is not true.

The heavy-handed structural adjustment programs have tied the country to a "profit before people" market system. The World Health Organization has now been replaced by the World Bank as the agency most influencing health policy. The government's subservience to IMF-WB impositions has generated a moribund economy and chronic ill health.

As the government willfully abandons its responsibility of basic health and social services delivery, more and more people are marginalized from the health care system.

Obviously, privatization of government hospitals breed ill health. Where health services have been commercialized, especially health workers, the poor and the peasants

are always at the losing end. It is evident that without enough support from the government, health services would suffer, to the detriment of the poor people in need of basic services.

Privatization is the refusal of the government of its responsibility to its people. Privatization of health services brings more death and disease instead of what it promised as “health in the hands of the people.” Once privatized, “health for all” becomes another illusion.

Health care is, indeed, expensive but it is our right. It is wrong to say that health is everybody’s business because it should be the State’s. The government is duty-bound to provide certain necessities to its citizens, whether they can afford it or not. It is the primary responsibility of this government to guarantee accessible and affordable health care for all, especially for the majority of the Filipinos who live in deep poverty.

The government should pour out more funds into these hospitals to enable them to rehabilitate their physical plant, upgrade their equipment and hire more specialists and experts. The Department of Health must provide and promote public health. The answer does not lie in deserting its obligations. It also do not rest in the hands of foreign medical corporations.

Our responsibility is clear. Good health has to be fought for. We must all unite and struggle against the evils of imperialist-imposed policy of privatization of health

services. We must strengthen the people's participation in all issues that affect their lives. We must all unite and fight for accessible and affordable health care because health is our right as citizens.

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Features
of House Bill No. 5125

80
APPENDIX A

1. Devolved Health Care Delivery System.
2. Cost of devolved functions fully remitted to LGU's together with funds coming from IRA, PAGCOR and Estate Authority.
3. Integrated health care delivery system (Public health and hospital care) under the province.
4. Abolition of the Local Health Boards in the Local Government Code (LGC).
5. Delineation of functions between the DOH and the provincial government so that there will be no duplication and overlapping of their respective responsibilities.
6. Further decentralized devolved functions by the formation of District Health Boards to assist the Governor.
7. Members of the House of Representatives are members of District Health Boards.
8. The Barangay Health Worker (BHW) with minimum honorarium together with the identification of a Family Health Worker for each family or home.
9. The dismantling of both the Regional offices and Hospitals.
10. "Beefing-up" of Regional Medical Centers with state of the art equipment together with the employment of adequately trained consultants capable of delivering level II to III Tertiary Hospital Care.
11. As much as practicable the Medical Centers will not routinely entertain primary and secondary hospital care cases.
12. The establishment of Organ or Disease Specific Specialty Hospitals with adequate sophisticated equipment and highly trained consultants capable of level IV Tertiary Hospital Care.
13. The presence of Medical Center and Specialty Hospital Health Boards.
14. Senators are members of Medical Center and Specialty Health Boards.
15. RDC Chairmen or Mayors of LGU's where Regional medical Centers are located are chairmen of Regional Medical Center Health Boards.
16. Members of the Private Sector are participants in managing District Health Units, Regional Medical Center and Specialty Hospital Health Boards.
17. Institutionalization of a Two-way Referral System between a lower level health care facility to a higher level and vice-versa.
18. **Putting up of Residency Training Program at the Provincial Hospital.**

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Republic of the Philippines
HOUSE OF REPRESENTATIVES
Quezon City

ELEVENTH CONGRESS
First Regular Session

HOUSE BILL NO. 5125

Introduced By: HON. EMILIO C. MACIAS II

EXPLANATORY NOTE

The health of the nation determines its own level of energy and vigor and therefore, ultimately, its performance in social and economic development. Implicit in the development process is the existence of a reasonably healthy citizenry capable of carrying out development goals. It is thus, clear that the promotion of health is always an urgent business of society not only because it is the very foundation of an active and useful life but also the right of every Filipino.

Cognizant of this reality, the Constitution explicitly provides that the State shall promote and protect the right to health of the people and instill health consciousness among them. In pursuance of this mandate, Republic Act No. 7160 otherwise known as the Local Government Code of 1991 was enacted devolving among others the functions of managing public health and district hospitals to local government units.

However, inspite of the time that has elapsed since the effectivity of the Code, there is still confusion and duplication of functions among public health care deliverers - the Department of Health still involves itself with the day to day public health work and hospital care (primary, secondary and level I tertiary) when these functions have long been devolved to local government units.

This situation clearly defeats the noble objectives of the Local Government Code. Besides, it drains the Department of Health of essential funds to provide for higher tertiary capability for its hospitals in the different regions which should be their primary concern. Moreover, local government units are still denied the funds for the cost of devolved functions. Numerous district hospitals had been renationalized in contravention of the policy on local government autonomy embodied in the Local Government Code.

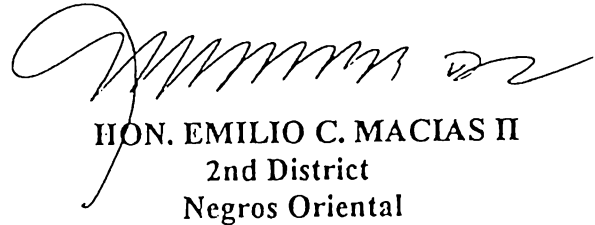
There is an urgent need therefore, to pass a curative and comprehensive legislation that will effectively address these health issues and concern in order to rationalize the health care delivery system in our country. Thus, this bill is filed.

This piece of legislation seeks to institute the modernization of the health care delivery system in the Philippines. This modernization program consists of several components that will ultimately phase out the antiquated system of health care delivery to complement the state-of-the-art equipment and technology. It includes strong advocacy that leans towards the realization of a genuine local autonomy by transforming devolved hospitals, together with their respective catchment rural health units into self-governing components with the establishment of district health boards in every district; health boards in regional medical centers, and in specialty hospitals.

These district health boards shall be separate and distinct from the local health boards embodied in the Local Government Code. It is also the intention of this bill to introduce among others, the active participation of the members of Congress in different district and hospital health boards; the private sector participation in the management of their own health care program; the delineation of specialized functions to enable the Department of Health to concentrate in establishing and maintaining fully equipped medical centers; the institutionalization of a dependable two-way referral system from the public health units at the grassroots level up to specialty hospitals and vice versa; and encourage partnership among local government units and between local government units and the DOH in establishing modern health care delivery facilities.

All these things are geared toward the promotion and protection of the general health of the Filipino people, which shall ultimately enhance the socio-economic conditions of the country.

In view of the foregoing reasons, the immediate passage of this important piece of legislation is earnestly sought.



HON. EMILIO C. MACIAS II
2nd District
Negros Oriental

MALACATAN
MANILAPRESIDENTIAL DECREE NO. 1823

CREATING THE LUNG CENTER OF THE PHILIPPINES

WHEREAS, for decades, respiratory diseases have been a priority concern, having been the leading cause of illness and death in the Philippines, comprising more than 45% of the total annual deaths from all causes, thus exacting a tremendous toll on human resources, which ailments are likely to increase and degenerate into serious lung diseases on account of unabated pollution, industrialization and unchecked cigarette smoking in the country;


WHEREAS, the more common lung diseases are, to a great extent, preventable, and curable with early and adequate medical care, immunization and through prompt and intensive prevention and health education programs;

WHEREAS, there is an urgent need to consolidate and reinforce existing programs, strategies and efforts at preventing, treating and rehabilitating people affected by lung diseases, and to undertake research and training on the cure and prevention of lung diseases, through a Lung Center which will house and nurture the above and related activities and provide tertiary-level care for more difficult and problematical cases;

WHEREAS, to achieve this purpose the Government intends to provide material and financial support towards the establishment and maintenance of a Lung Center for the welfare and benefit of the Filipino people.

NOW, THEREFORE, I, FERDINAND E. MARCOS, President and Prime Minister of the Philippines, by virtue of the powers vested in me by the Constitution, do hereby order and decree:

SECTION 1. CREATION OF THE LUNG CENTER OF THE PHILIPPINES. There is hereby created a trust, under the name and style of Lung Center of the Philippines, which, subject to the provisions of this Decree, shall be administered,



according to the Articles of Incorporation, By-Laws and Objectives of the Lung Center of the Philippines, Inc., duly registered (reg. No. 85886) with the Securities and Exchange Commission of the Republic of the Philippines, by the Office of the President, in coordination with the Ministry of Human Settlements and the Ministry of Health.

SECTION 2. TAX EXEMPTIONS AND PRIVILEGES.

Being a non-profit, non-stock corporation organized primarily to help combat the high incidence of lung and pulmonary diseases in the Philippines; all donations, contributions, endowments and equipment and supplies to be imported by authorized entities or persons and by the Board of Trustees of the Lung Center of the Philippines, Inc., for the actual use and benefit of the Lung Center, shall be exempt from income and gift taxes, the same further deductible in full for the purpose of determining the maximum deductible amount under Section 30, paragraph (h), of the National Internal Revenue Code, as amended.


The Lung Center of the Philippines shall be exempt from the payment of taxes, charges and fees imposed by the Government or any political subdivision or instrumentality thereof with respect to equipment purchases made by, or for, the Lung Center.

SECTION 3. ASSISTANCE FROM GOVERNMENT OFFICES.

The Lung Center of the Philippines, Inc., may call upon any Ministry, Bureau, Office, agency or instrumentality of the government, including government-owned or controlled corporations, particularly the Philippine Charity Sweepstakes Office, for such assistance it may need in the pursuit of its purposes and objectives.

SECTION 4. GOVERNMENT SUBSIDY AND CONTRIBUTIONS.

The amount of Twenty-Five Million Pesos (P25,000,000) is hereby appropriated as contribution of the National Government for the initial operations and maintenance of the Lung Center of the Philippines in the year 1981. Thereafter, the amount necessary to ensure the continued operations and maintenance of the Lung Center of the Philippines shall be duly provided for, appropriated and released from the National Budget, subject to the approval of the President and Prime Minister of the Republic of the Philippines. The funds therefrom shall be administered by the Board of the Lung Center of the Philippines, Inc., in behalf of the Lung Center.



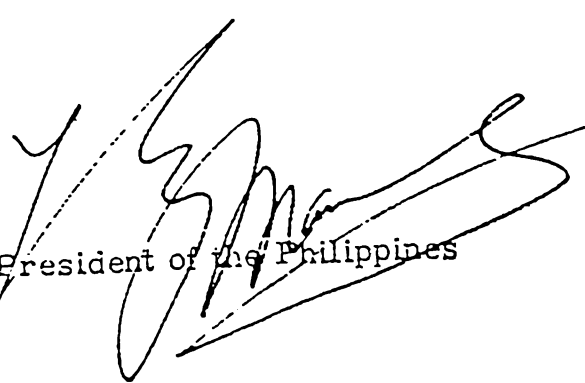
SECTION 5. AUDITING. The books of accounts of the Lung Center of the Philippines shall be under the charge and safekeeping of the Treasurer of the Lung Center of the Philippines, Inc., and of its CHAIRMAN but such books of account shall be subject to periodic auditing by the Chairman of the Commission on Audit, or by his duly authorized representative.

SECTION 6. ANNUAL REPORT. The Lung Center of the Philippines shall render to the President of the Philippines, the Minister of Human Settlements and the Minister of Health an annual report of its activities, accomplishments and recommendations.

SECTION 7. EFFECT OF DISSOLUTION OF THE CENTER. If for any reason, the Lung Center of the Philippines is dissolved, its assets and properties remaining at the time of dissolution, shall revert to the Philippine Government for disposition in accordance with law.

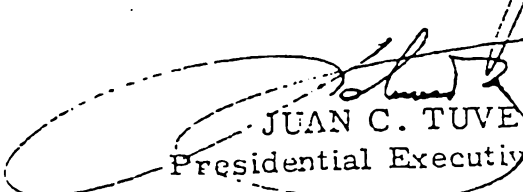
SECTION 8. EFFECTIVITY. This Decree shall take effect immediately.

DONE in Metro Manila, this 16th day of January, in the year of Our Lord, nineteen hundred and eighty-one.



President of the Philippines

By the President:



JUAN C. TUVERA
Presidential Executive Assistant

EMERGENCY ROOM - OUTPATIENT CHARGES

	Rate	SC (20% Discount)	10% Discount
I. EMERGENCY ROOM FEE (Consultation Fee)	P200.00	(- 32)	(Rate -16) P184.00
II. FEES FOR PROCEDURES (Includes Use of Instruments But Does Not Include Supplies Used)	Rate	SC (20% Discount)	10% Discount
ASPIRATION OF CYST	P400.00	(- 64)	P336.00 (R -32) P368.00
BLOOD PRESSURE DETERMINATION	50.00	(- 8)	42.00 (R -4) 46.00
CERVICAL NODE BIOPSY (CNB)	1,050.00	(-168)	882.00 (R -84) 966.00
CODE 82	1,000.00	(- 160)	840.00 (R -80) 920.00
CUTDOWN	1,000.00	(- 160)	840.00 (R -80) 920.00
FIBEROPTIC BRONCHOSCOPY (FOB)	1,045.00	(- 167.20)	877.80 (R -83.60) 961.40
FOLEY CATHETER INSERTION / CHANGE	100.00	(- 16)	84.00 (R -8) 92.00
INCISION AND DRAINAGE	600.00	(- 96)	504.00 (R -48) 552.00
INJECTION FEE	50.00	(- 8)	42.00 (R -4) 46.00
INJECTION FEE WITH SKIN TEST	60.00	(- 9.50)	50.50 (R -4.75) 55.25
NGT INSERTION / CHANGE	100.00	(- 16)	84.00 (R -8) 92.00
PARACENTESIS	600.00	(- 96)	504.00 (R -48) 552.00
PLEURAL BIOPSY	400.00	(- 64)	336.00 (R -32) 368.00
PLEURODESIS (Chemical)	600.00	(- 96)	504.00 (R -48) 552.00
PNLB	1,050.00	(-168)	882.00 (R -84) 966.00
SUTURING	600.00	(- 96)	504.00 (R -48) 552.00
THORACENTESIS	600.00	(- 96)	504.00 (R -48) 552.00
TRACHEOSTOMY	1,000.00	(- 160)	840.00 (R -80) 920.00
TRACHEOSTOMY CHANGE	400.00	(- 64)	336.00 (R -32) 368.00
TUBE THORACOSTOMY (Including Change of Tube)	1,000.00	(- 160)	840.00 (R -80) 920.00
TUBERCULIN TEST / SCLAVO TEST/ SKIN TEST	50.00	(- 8)	42.00 (R -4) 46.00
WOUND DRESSING (Big)	200.00	(-32)	168.00 (R -16) 184.00
WOUND DRESSING (Small)	100.00	(- 16)	84.00 (R -8) 92.00

III. USE OF EQUIPMENT	Rate	SC (20% Discount)	10% Discount
CARDIAC MONITOR (<i>per day</i>)	500.00	(- 80)	(Rate - 40) 460.00
DEFIBRILLATOR	500.00	(- 80)	(R - 40) 460.00
NEBULIZER (<i>Excluding Medicines</i>)	100.00	(- 16)	(R - 8) 92.00
OXYGEN USE (<i>per liter per min per hour</i>)	18.00	(- 2.75)	(R - 1.40) 16.60
PULSE OXIMETER:			
<i>Single determination</i>	100.00	(- 16)	(R - 8) 92.00
<i>Continuous use (per day)</i>	500.00	(- 80)	(R - 40) 560.00
SUCTION MACHINE	50.00	(- 8)	(R - 4) 46.00
VENTILATOR (<i>Portable</i>)	550.00	(- 88)	(R - 44) 506.00

Formula for Senior Citizen (SC) Discount:

$$\text{Actual Price} \times 20\% = \text{Amount to be deducted from the Actual Price}$$



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

APPENDIX D

SAN LAZARO COMPOUND
RIZAL AVENUE, STA. CRUZ
MANILA, PHILIPPINES
TEL. NO. 711-60-80

December 22, 1997

MEMORANDUM

FOR: CARMENCITA N. REODICA, MD, MPIL, CESO II
Secretary of Health

Melchor R. Lucas, Jr.
FROM: DR. MELCHOR R. LUCAS, JR. MD, MHSA, MPH
Director III
Hospital Operations and Management Service

RE: Proposed Memorandum of Agreement between the Lung Center of the Philippines (LCP) and Landmarks Berhad.

The attached documents contain the Memorandum of Agreement and the opinion of the Office of the Government Corporate Counsel (OGCC) vis a vis the MOA.

The following comments were given:

1. The proposed agreement is in line with the government policy to privatize the specialty medical centers.
2. The MOA speaks of the concept of "co-location" which is in consonance with the Department of Health concept of privatization.
3. The MOA binds the Lung Center of the Philippines on the following conditions:
 - a) Landmarks will have exclusive right for a period of six (6) months to make a study of the records and operations of LCP and have exclusive access to all information, data, documents, manuals, projections and resource person to determine the feasibility of the private sector profitability entering into partnership with LCP in certain areas of operations.

4. Once the MOA is signed and its agreements are executed, a more detailed Joint Venture Agreement may be developed if both parties agree to enter into this mode.
5. The OGCC recommends that the procedural requirements for the award of the project shall be similar to a Build Operate and Transfer transactions. They are also proposing that the proposed joint venture need not be bidded out.

Recommendations:

On the whole, the Hospital Operations and Management Service (HOMS) concurs with the provisions of the proposed MOA. However, for item #5 of this memorandum, we need to consult with OLA if indeed the MOA contains the procedural requirements of a BOT transaction and further if COA rules and regulations allow the non-bidding of the proposed joint ventures. Once this is cleared in both offices, we recommend the signing of the MOA.

Attached are letter of referrals for both offices for your consideration.

We also suggest that a committee be joined to provide the appropriate advice regarding the privatization of the LCP. Its composition must be composed of representatives from

Each party shall co-operate with the other in
date of such termination. This memorandum for a period of five (5) years from the
this Section shall survive the termination of this
the projects. This obligation of the parties under
containing non-sensitive information in connection with

MEMORANDUM OF AGREEMENT
For the Upgrading and Modernization of
the Lung Center of the Philippines

THIS MEMORANDUM OF AGREEMENT is made and entered into this
day of 1997, by and between:
LUNG CENTER OF THE PHILIPPINES, a government owned and
controlled corporation attached to the DEPARTMENT OF
HEALTH, organized and existing under the laws of the
Philippines with principal office at the San Lazaro
Hospital Compound, Rizal Avenue, Sta. Cruz Manila and
herein represented by the Chairman/Secretary, Hon.
Carmencita Reodica and hereinafter referred to as the
"Center";

LANDMARKS BERHAD, a publicly listed company duly
organized and existing under the laws of Malaysia, with
principal office at 5th Floor, President House, Jalan
Sultan Ismail, 50250 Kuala Lumpur, Malaysia, and herein
represented by its Managing Director, Mohammad Abdul
Halim Bin Ahmad, and hereinafter referred to as
"Landmarks";

Landmarks shall submit studies to the Center
WITNESSETH this of a joint venture

WHEREAS, the Philippine Government has embarked on a
strategy to harness the country's competitive advantage in
providing health care services by making Manila a leading
health center in Asia;

WHEREAS, the country is rich with medical practitioners,
doctors to other professionals in the allied medical
professions;

WHEREAS, the Government has, however, recognized the need
for massive capital resources and technical know-how to
fully develop the capabilities of the Government hospitals,
to make them globally competitive and meet
international standards;

containing non-sensitive information in connection with the Projects. This obligation of the parties under this Section shall survive the termination of this Memorandum for a period of five (5) years, from the date of such termination.

6. Each party shall co-operate with the other in fulfilling the objectives and purpose of this Memorandum of Agreement and shall exercise its best efforts to accommodate the other party's requests, so long as the same are reasonably necessary for the implementation of the activities envisioned in this MOA and within its capacity to fulfill.
7. An Executive Committee composed of representatives from the Lung Center of the Philippines, the Department of Health, Landmarks, and Lead Corporation shall be constituted to oversee the conduct of studies.
8. If proven feasible, Landmarks shall retain its exclusive right to the co-location project concept and shall submit a formal proposal for the project.
9. Procedural Requirements for the Award of the Project - the following procedural steps shall be observed in the award of the project:
 - 9.1 The Center shall, at the expense of Landmarks, publish the proposal three (3) times in two (2) newspapers of general circulation over a period of two (2) weeks.
 - 9.2 The publication shall state the nature of the proposal, such as the scope of the works, the facility/services to be put up, proposed location site of the project, sharing scheme, among others, and shall invite interested parties to submit comparative or counter proposals which shall not be more than sixty (60) days reckoned from the date of last publication.
 - 9.3 In the event that another qualified party submits a proposal favorable to the Center than that submitted by Landmarks, the latter shall have the right to match said favorable proposal within thirty (30) working days from notice.
 - 9.4 Should Landmarks fail to match the favorable proposal within the prescribed period, the tenderer thereof shall be considered for the

award, and shall reimburse Landmarks for all costs incurred.

9.5 If Landmarks matches the favorable proposal within the specified period or if no comparative or counter proposal is received by the Center, Landmarks shall be considered for the award.

9.6 Documents to record Parties' Undertaking - Within three (3) months from the date of matching of Landmarks of the favorable proposal or from the date of expiration for the submission of comparative proposal and no such proposal is received, the parties shall execute a Joint Venture Agreement. These agreements shall become effective only after the same is approved by the Lung Center Board of Directors, reviewed and recommended by the Government Corporate Monitoring and Coordinating Committee (GCMCC) Technical Board and duly confirmed by the President of the Republic of the Philippines.

10. This MOA shall be governed by the laws, rules and regulations of the Republic of the Philippines.

IN WITNESS WHEREOF, the Parties, through their authorized representatives, have hereunto affixed their signatures on the date and at the place first mentioned above.

LUNG CENTER OF THE PHILIPPINES

LANDMARKS BERHAD

SECP CARMENCITA REODICA

MIA HALIM BIN AHMAD

Chairman

Managing Director

ANNEX A

Co-location Of a Private Hospital Within the Grounds of a Major Public Hospital

Under this option, the private operator would enter into a long term lease arrangement with the Government to develop a private hospital which would be co-located with a major public hospital. This could either be the construction of a purpose built facility with direct access to the public hospital through a linkway, or the conversion of currently unutilised bed capacity in the public hospital.

The advantages of these co-location are as follows:

- Additional income is generated to the public hospital from a number of direct sources:
 - * lease of land or vacant hospital space
 - * the purchase of an agreed range of services from the public hospital which would potentially include:
 - > food service
 - > maintenance
 - > fuel, light and power
 - > cleaning services
- The retention of key medical staff in the public hospital, due to the availability of a private hospital located on site to supplement their income, and
- The private operator's capacity to provide some additional services to the public hospital, such as onsite consulting, rooms developments and upgraded computing systems.

Doctors employed at the public hospital would need to have an agreed allocation of time per week in order to treat their private patients in the private hospitals. This concept of restricted rights of private practice for salaried full-time medical staff has worked well in Australia, and has worked to retain and attract doctors to work in the public hospital sector. It also appears to have been a success in the Philippines.

proposing a concept of "co-location" for the Lung Center, as defined in Annex A of the MOA. For this purpose, Landmarks is willing to finance and undertake the preparation of a full and detailed study at no cost to the Government, for submission to and consideration by the Government of the Republic of the Philippines.

2. The Center shall not entertain any proponent, for a period of six (6) months, while the study is being conducted, to determine the viability of the approach.
3. Landmarks shall submit said studies to the Center. These studies shall form the basis of a joint venture proposal with the Lung Center of the Philippines.
4. The Center shall commit to co-operate in the preparation of the studies, by providing all information, data, documents, manuals, projections, resource persons, and other pertinent information in the course of study, sixty (60) days, reckoned from the date of last publication.
5. All information, data and documents (whether financial, technical or otherwise) obtained by any party to this MOA or by their respective agents or employees from the other party or its agents or employees, which are not generally available to the public, shall be kept strictly confidential and shall not be disclosed to any other person or entity without the prior written approval of the other party except as required by law. Provided that each party may, with the consent of the other, issue from time to time, press releases.

APPENDIX E

**LUNG CENTER OF THE PHILIPPINES
SUMMARY REPORT OF ACCOUNTS PAYABLE
SUBSIDY FUND
AS OF AUGUST 31, 1997**

NAME OF PAYEE	PARTICULARS	AMOUNT
PLDT	TELEPHONE	385,920.65
VARIOUS CREDITORS	REPAIR OF FACILITIES AND MEDICAL /OFFICE EQPT.	2,200,045.20
VARIOUS CREDITORS	MEDICAL /OFFICE SUPPLIES	5,538,973.25
MERALCO	ELECTRICITY	3,946,267.75
MWSS	WATER	994,364.58
SANITARY STEAM LAUNDRY	LAUNDRY SERVICES	130,855.25
FAST MANPOWER SERVICES	JANITORIAL	821,004.36
CEEMM CONSTRUCTION	ENGINEERING SERVICES	668,954.80
STARFORCE SECURITY	SECURITY SERVICES	723,000.00
LTC STAFFING CENTER	OFFICE CONTRACTUALS	794,174.55
CIGI	OXYGEN	465,121.93
VARIOUS CREDITORS	DIETARY SUPPLIES	718,011.36
COA	AUDITING SERVICES	500,000.00
VARIOUS CREDITORS	COMPUTER RENTALS,LCP PROGRAMS,PREVENTIVE MAINTENANCE	5,259,159.93
	TOTAL	23,145,853.61

Certified Correct: .


 ANGELINE A. ROJAS
 Division Chief I



Republic of the Philippines
 Department of Health
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March 12, 1999

Department Order
 No. 92 s., 1999

SUBJECT: Creation of Task Force on Hospital Corporatization

In line with the current policy thrusts of the Department of Health towards developing and upgrading health facilities, a Task Force on Corporatization of Hospitals is hereby created. The Task Force shall be composed of the following:

A. Composition:

Chairperson:	Usec. Margarita Galon, OHFS
Vice-Chairperson:	Atty. Nicolas Lutero, BLR
Member:	OSR representative
	Dir. Crispinita Valdez, MAS
	Ms. Melanie Balane, HOMS
	Dr. Carmencita Banatin, OHFS
	Dr. Romeo Cruz/ Dr. Ruben Flores
	Ms. Maylene Beltran, HPDS
	Mr. Rolando Benitez, OMS
Secretariat:	Ms. Naomi Simon, HOMS
	OHFS representative

B. Functions:

The Task Force shall be responsible for undertaking a study on hospital corporatization. It shall perform the following tasks:

1. Identification and selection of pilot hospitals to consist following: 1 National, 1 Regional, 1 Provincial and 1 District hospitals.
2. Study issues and concerns relative to the proposed hospital corporatization, specifically on:
 - a. management and organization options
 - b. basic legal form of organization
3. Submit study reports and recommendations to the Secretary of Health.

The Task Force is expected to implement before the end of 1999 the activities once pilot hospitals for corporatization have been identified and selected.

The task force shall be assisted by a Consultant under the Office of the Secretary of Health.

This Order shall take effect immediately.



ANTONIO S. LOPEZ, M.D., M.P.H.
Officer-in-Charge, Office of the Secretary
(Undersecretary and Chief of Staff)

KP memorandum of intent for IMF loan

First of two parts

The following is the full text of a memorandum of economic and financial policies of the government of the Philippines.

The document, released by the International Monetary Fund on Wednesday, outlines the reforms the government plans to introduce during the course of a \$1.4-billion loan program agreed with the Fund. The government has said it does not intend to draw on the money.

March 11, 1998

Memorandum of economic and financial policies of the Philippine Government

I. Background

In recent years, the Philippine economy has made impressive progress, reflecting the implementation of prudent macroeconomic policies and sound structural reforms, as well as a favorable external environment. By 1996 GNP growth had accelerated to nearly 7 percent led by exports and investment; inflation had fallen to well within single digits; and the external position had strengthened with rapid export growth, increasing reserves and a steady reduction of the debt burden.

In 1997 economic conditions became markedly more difficult with the onset of the regional currency crisis. Particularly since the floating of the Thai baht last July, financial markets have been under severe pressure. Economic and financial policies have been adjusted to manage these pressures, contain their impact on the real economy and prepare for an early return of confidence. In particular, the peso has been allowed to float, accompanied by a tightening of fiscal and monetary policies, while we have moved forward with our structural reform agenda notwithstanding the difficult economic environment.

Our efforts, which were supported by an extension and augmentation of the Philippines' extended arrangement with the Fund, have met with considerable success. In particular, economic growth held up well in 1997 (real gross national product grew by nearly 6 percent), inflation (5-percent average) was contained below the target and the depreciation of the peso, although substantial, has been less than that of some other currencies in the region. Critical in this respect has been the limited damage so far to our financial and corporate sectors, which, although facing strains, have weathered the crisis relatively well. While much of the resilience of the economy is rooted in the successful reform policies of the 1980s, the pragmatic and flexible policy response in recent months has contributed as well.

The economy is now at a delicate juncture. While the regional crisis has not cut as deep as in some countries, some risks remain and we must guard against further shocks in the months to come. The economic environment remains challenging and further shifts in confidence are possible. While the priority is to manage the present crisis effectively and restore confidence as soon as possible, we also recog-

nize that recent developments have exposed certain vulnerabilities of our economy. Our goal is to contain these risks through an economic program that involves a tightening of fiscal and monetary policies; continuation of the floating exchange-rate regime; bolstering our proactive strategy to strengthen the banking sector and pursuing other structural reforms.

Beyond the immediate concerns of crisis management, economic policies are being focused to address the remaining barriers to sustained rapid growth and poverty reduction. Key medium-term requirements in this respect are to raise domestic saving, strengthen the financial system, reduce external vulnerability, and ensure fiscal sustainability. In order to support our economic program and bolster market confidence in these uncertain times, we wish to support our efforts through a precautionary arrangement in the form of a two-year stand-by arrangement with the Fund.

II. The program for 1998-99

A. Program Objectives

6. The main economic objectives for 1998-99 are to:

- contain the slowdown of real GNP growth to 3 percent in 1998, followed by 5 percent in 1999 and 6 percent thereafter;
- limit average inflation to around 3 percent in 1998, 6.7 percent in 1999 and 5 percent in subsequent years; and
- reduce the current-account deficit to 3.1 percent of GNP in 1998 and to 2.7 percent in 1999, and increase reserve cover to 1.9 months of imports in 1998 and to 2.3 in 1999.

In order to achieve these goals, we have formulated a comprehensive policy package centered on:

- prudent macroeconomic policies;
- accelerated banking sector reform; and
- other reforms to address the structural impediments to sustained high growth.

B. Fiscal policy

7. An immediate priority is to arrest the deterioration in the fiscal accounts that occurred in 1997, mainly as a result of worsening economic conditions and continuing weaknesses in tax administration. Although some deviation from the medium-term consolidation path envisaged earlier is unavoidable in current circumstances, the government remains committed to the longer-term goals of raising public sector saving and achieving overall fiscal surpluses. We consider these commitments as integral to our broader goals of rapid economic growth, external viability and successful poverty reduction.

8. After registering a deficit of P21.8 billion (0.9 percent of GNP) in 1997, the consolidated public sector position in 1998 will be limited to a deficit of P26.5 billion (0.9 percent of GNP) and balance in 1999. While these targets are somewhat less ambitious than envisaged earlier, they require a major effort in light of the recent deterioration in the fiscal accounts. Besides, they still imply sizable primary surpluses in both years (4.2 percent of GNP in 1998, and 4.7 percent of GNP in 1999). Consistent with the overall fiscal targets, the National Government budget seeks to attain a

small surplus in 1998 (P5 billion, including privatization receipts) and a P4 billion net income from the Bangko Sentral Board of Liquidators) and a significantly larger surplus of P22 billion (0.7 percent of GNP) in 1999. The fiscal plan for 1998-99 has been drawn up in line with our medium-term fiscal strategy (Paragraph 26).

9. Although the budget submitted to Congress for 1998 envisaged a surplus of P16 billion, the revenue assumptions underlying the budget have been undermined by the sharp deterioration in the economic environment and the lower-than-expected net revenue impact of the final version of the Comprehensive Tax Reform Program. Moreover, the tariff exemptions for agriculture and fisheries enterprises adopted by Congress recently risk reducing revenues further, although their implementation is expected only in the second half of 1998. Furthermore, the expenditure program has been burdened substantially by the impact of the depreciation of the peso and higher interest rates on interest payments. In the absence of corrective action the budget deficit for this year could reach P50 billion to 60 billion (1-1/2-2 percent of GNP). Faced with this prospect, and with Congress adjourned until after the May elections, the government has adopted the following emergency measures:

- a 25-percent mandatory reserve on all expenditures, including government-owned and -controlled corporations other than personnel and debt service (Paragraph 11);
- a 10-percent deferment in the internal revenue allocation for local government units;
- suspension of all tax subsidies of National Government agencies, government owned and controlled corporations and local government units;
- continuation of the selective ban on the creation of new civil service positions as well as restrictions on the filling of vacant positions (excepting health, education, and peace and order);
- suspension through Presidential Decree of P14.4 billion of new programs and projects from the 1998 budget; and
- a renewed effort to strengthen tax administration, following an action plan drawn up in collaboration with the Fund (Paragraph 12);

10. The above measures are sufficient to keep the fiscal program on track at least until midyear when the new government and Congress take office. However, to reach the targeted surplus of P5 billion for the year as a whole, and to complete the structural reforms in our budget, additional measures will be needed in the second half of the year.

These could include legislative revenue measures such as a restructuring of motor vehicle taxes and a rationalization of fiscal incentives with a view to making them more transparent and limited. In particular, the plan is to resubmit to Congress legislation to rationalize and limit the wide range of tax incentives for both public and private businesses.

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19. To improve the functioning of the foreign exchange market and to increase the flexibility of the exchange rate, the volatility band established by the Bankers' Association of the Philippines (BAP) will be reviewed by the BSP in consultation with BAP with a view to phasing it out as soon as possible, but not later than end-1998. In the meantime, measures will be taken to ensure that trading outside the band will not be stopped for more than an hour. Outstanding contracts under the nondeliverable forward (NDF) facility will be unwound gradually over the next 18 months and no new contracts (except rollovers) or similar schemes will be undertaken by the BSP. The BSP henceforth will channel all its spot foreign exchange transactions (except those with the government) through the Philippine Dealing System (PDS).

D. External Debt Management

20. Given the recent experience in a number of emerging market economies, strengthening external debt management is a particular focus under the program. This includes an enhanced effort both to improve the monitoring of debt flows and stocks, especially of short-term debt. Regarding debt statistics, the BSP is using a computerized debt management system to facilitate the compilation of statistics. We are also considering the use of survey methods to add a further dimension to our monitoring effort. In this context, ongoing technical assistance from the Fund in the area of balance of payments statistics will pay particular attention also to the debt statistics. To ensure that the private sector bears the full risks of its borrowing, the government will continue to refrain from providing any explicit or implicit guarantees on their external loans.

21. We are taking a number of steps to reduce short-term debt and encourage a better maturity structure of debt flows as well as higher nondebt creating flows. These include, in particular, several measures to diminish the disincentives to peso intermediation. In this regard, in addition to the measures described in paragraph 17, foreign currency deposits of residents have been made subject to a 1.5-percent tax on interest income, and a 1.5-percent liquid-asset cover requirement to be

has been introduced on foreign currency deposits. (This is in addition to the 100 percent cover requirement on foreign currency deposits.) New official external borrowing will be subject to quantitative ceilings under the program.

E. Financial Sector Reform

22. Notwithstanding the sharp deterioration of the economic environment, we are confident that the Philippine banking system can weather the resulting difficulties and emerge from the regional crisis in a healthier position. Nevertheless, to maintain the fundamental health of the system, and to guard against the risk that could arise from a further economic downturn, we are fully committed to accelerating ongoing efforts to improve our prudential and supervisory systems as well as to resolve without delay any problems that might emerge in individual institutions.

23. There are four main elements to our banking reform strategy. First, we are enhancing the banks' capacity to withstand shocks by raising their capital and encouraging some consolidation in the industry. Second, bank risks are being reduced by tightening provisioning requirements and strengthening regulatory oversight. Third, we are leveling the playing field between different types of instruments, especially with a view to reducing disincentives to peso intermediation. And fourth, our bank resolution strategy is geared to the twin objectives of dealing expeditiously with any problem banks while safeguarding the soundness of the banking system. To support implementation of this plan, we have requested an FSAL from the World Bank as well as follow-up technical assistance from the Fund/World Bank.

F. Structural Reforms

Medium-term fiscal sustainability

24. Our medium-term fiscal strategy envisages an increased revenue effort in order to achieve higher public savings while also allowing room for increased public investment in infrastructure and human capital. Accordingly, the medium-term framework provides for the overall public sector balance to gradually turn from a deficit of 0.9 in 1998 to a surplus of 0.9 in 2003. Over the same period, investment in infrastructure by the national government will increase from the 1998 level of 2 percent of GNP to 3.2 percent in 2003. Underlying this framework

ratio, as well as a reprioritization of expenditures through containing public sector personnel costs, and rationalizing the transfer of funds and responsibilities to local governments.

25. Major tax policy reform in all areas—income taxes, excises, tariffs and VAT—has taken place over the past four years, most recently with the passage in December 1997 of the final phase of the Comprehensive Tax Reform Package (CTRP), the income tax component of reform. This latter package will have a positive impact on revenues in the medium term, based on a more rational tax structure. Moreover, the adoption of revenue-enhancing measures such as the planned rationalization of fiscal incentives (paragraph 12) will have a significant revenue impact over the medium term. Overall, these measures should permit an increase in the tax revenue to GNP ratio of about 1.8 percentage points over the medium term.

26. Medium-term expenditure reforms to be initiated during the program period will include shifting to a medium-term budgeting framework under which appropriations will be defined within a three-year rolling macroeconomic framework. This will ensure that the future financial implications of new expenditure decisions in each budget are made in the context of the medium-term macroeconomic program. It will also help arrest key sources of expenditure drift, including the growth of personnel expenditures and of transfers to local governments. Implementation of this framework is being targeted for 1999 with the assistance of the World Bank in the context of the Public Sector Adjustment Loan (PSAL).

27. We will endeavor to move forward the Government Re-engineering Program which was initiated in 1994. We will resubmit to Congress before the end of 1998, the "Re-engineering the Bureaucracy" bill in order to obtain full authority to restructure the executive branch of government. We expect the reduction in staffing will result from the merger or abolition of redundant agencies, the devolution of activities and programs to local governments, and the further privatization of public service. To improve the effectiveness and efficiency of government, the passage of this bill, overall national government staffing will continue to be held down. Efficiency efforts have been undertaken to improve the compensation structure of government

private sector. With low- and mid-level salaries now broadly in line with the private sector, attention can be focused on the remaining issues of raising civil service executive compensation, de-compressing the salary structure, and improving overall personnel management.

26. Increased infrastructural investment is critical to our medium-term growth and development prospects. While part of the increase must come from the National Government (the medium-term fiscal plan provides for an increase of 0.5 percent of GNP), the private sector and local governments will need to play a more active role as well. We shall further strengthen the environment for investment in general, and for private sector investment in infrastructure in particular.

Strengthening the corporate sector

29. Our structural reform agenda will increase the resiliency of the corporate sector mainly by improving the enabling legal framework, continuing trade and investment liberalization, developing the domestic capital market, additional privatization, and further strengthening external debt management.

30. Significant liberalization of the trade regime has been achieved in recent years through continued tariff reform and steady elimination of non-tariff barriers. The average nominal tariff rate was reduced from 28 percent in 1990 to 13 percent in 1997, with the maximum tariff rate (which applies to a few agricultural products) lowered from 100 percent in 1996 (after WTO ratification) to 80 percent in 1997. Quantitative import restrictions were lifted on all agricultural imports (except rice) in March 1996, accompanied by their tariffication as agreed under the WTO.

31. Trade liberalization will continue in 1998-99 and beyond. The average nominal tariff rate has been reduced to 11.2 percent in 1998, and will be lowered to 10.2 percent in 1999 and to 9.1 percent in 2000. The maximum tariff rate (which applies to some agricultural imports) will be reduced to 65 percent in 1999. We are also taking measures to increase the transparency of quota allocation under the minimum access volumes arrangements. Furthermore, in the context of the WTO, we are committed to reviewing the restriction on rice imports in 2004.

32. We are continuing to make best efforts toward creating an at-

tractive environment and liberal regime for investment. To this end, further simplification and liberalization of registration requirements will be implemented during the program period. We intend to liberalize the retail-trade sector, particularly to investments in medium- and large-scale firms; draft legislation to this end will be submitted to Congress during the program period. Investment houses are being opened up further to foreign investment based on a law passed in late 1997 which raises the foreign equity participation from 49 percent to 60 percent voting shares.

33. The government remains committed to carrying forward its privatization plans in the coming years. In 1998 the privatization program is expected to generate P7 billion, most of which will come from the completion of the sale of the Fort Bonifacio property. Going forward, privatization efforts will focus on disposing of remaining major items which are strategically vital to industrial development particularly the National Power Corp. (paragraph 36). Other key assets remaining to be sold include the PNOC-Energy Development Corp. and the Food Terminal.

34. A comprehensive restructuring reform of the electric power sector has been pursued by the government, possibly with assistance from the World Bank and ADB. Under this restructuring reform, the government intends to pursue wholesale competition and produce implementation of retail competition through the following strategies, among others: (a) separating (unbundling) the transmission activities of NPC from its generation activities and establishing them as a separate legal corporate entity; (b) establishing generation companies, followed by incorporation and subsequent privatization of certain generation companies; (c) refocusing the role and functions of National Electrification Administration (NEA); (d) encouraging the consolidation/merger of distribution entities; (e) applying unbundled tariffs at generation, transmission, subtransmission, and distribution levels; and (f) strengthening the Energy Regulation Board's organizational and regulatory capacity.

35. To implement this restructuring program, the Omnibus Electricity Bill will be resubmitted to Congress before end-1998. Based on the new framework, and in close collaboration with the World Bank and the ADB, an ac-

tion plan to restructure and privatize the NPC will be launched.

Oil Deregulation

36. A key plank of our structural reform agenda has been the deregulation of the oil sector. The downstream oil industry was fully deregulated in February 1997, but, effective December 8, the Supreme Court ruled parts of the deregulation law unconstitutional. A new law was passed in February 1998, restoring most of the deregulation provisions of the original law while correcting its constitutional deficiencies. As part of the new regime, a transition period of up to five months was introduced during which prices of domestic petroleum products remain regulated and limited subsidies can be provided, at the discretion of the President, for the most socially sensitive products (liquefied petroleum gas, kerosene and regular gasoline). By March 15 the President will issue an Executive Order terminating the transition period for all products except for the most socially sensitive products. For these latter products, prices will remain regulated until July 1998, at which time they will also be freed. The cost of any price subsidies for socially-sensitive products will not exceed P2.9 billion during 1998. This amount will be accommodated within the revised fiscal program for 1998. Moreover, the outstanding balance under the Oil Price Stabilization Fund (OPSF) (P2.6 billion at end-1997) will be gradually repaid through the application of reimbursement certificates, following the provisions of RA 8479. The total amount used under the new buffer fund for socially sensitive products will not exceed P2.9 billion, as a performance criterion under the program.

37. In the current environment of regional uncertainty, close monitoring of developments under the program will be critical. We are also committed to consulting closely with the fund on progress with implementing the program. Accordingly, quarterly reviews are envisaged under the program. The first review, to be completed in May 1998, and subsequent reviews will focus on (i) implementing the financial program including interest and exchange rate policies, as well as on (ii) progress with banking reforms and (iii) tax administration. In addition, the second review, to be completed by August 1998, will provide an opportunity to discuss the new government's economic agenda, including the measures needed to meet the fiscal target for 1998.

EXCHANGE NOTES

Filinvest net

FILINVEST Development Corp. made a P2.5-billion net consolidated income for 1997, a company statement said.

Citing its report to the Securities and Exchange Commission, Filinvest said it posted P5.3 billion in gross revenue, down from P6.7 billion in 1996.

But it registered P67.3 billion in assets, up by 74 percent from P38.9 billion in 1996. Its shareholders' equity rose by 111 percent from P12.6 billion in 1996 to P26.5 billion.

BPI securities

THE Bank of the Philippine Islands (BPI) was named best government securities eligible dealer along with 11 other financial institutions.

In a letter to BPI executive vice president and treasurer Alberto Villarosa, Philippine treasurer Caridad Valdehueza said the bank excels in the securities market.

The Bureau of Treasury held a testimonial for BPI at the Palacio del Gobernador in Intramuros, Manila.

Meralco statement

THE Manila Electric Co. (Meralco) welcomes the ruling of the Department of Energy to repeal Energy Regulation 1-97, which allows customers to choose their power suppliers.

"We welcome the circular which allows customers like Meralco to have a power of choice. This will result in transparency in the true cost of electricity," it said in a statement.

It said that the circular will force the National Power Corp., its power supplier, to make its power rates competitive with those of other power producers.

"We estimate that our cost of purchased power could go down easily by 30 percent per kWh [reasonable us] to offer rates to industries at 77 centavos less," it said.

Rolls-Royce sold

LONDON—Vickers Plc. said it sealed an agreement to sell Rolls-Royce Motor Cars Ltd. to BMW for £740 million (\$560 million), leaving Volkswagen AG to appeal to the UK companies' shareholders with a promise of a high offer.

Vickers had been in exclusive talks for a sale to BMW at that price for more than a year.