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Challenges in Health Services Trade: Philippine Case

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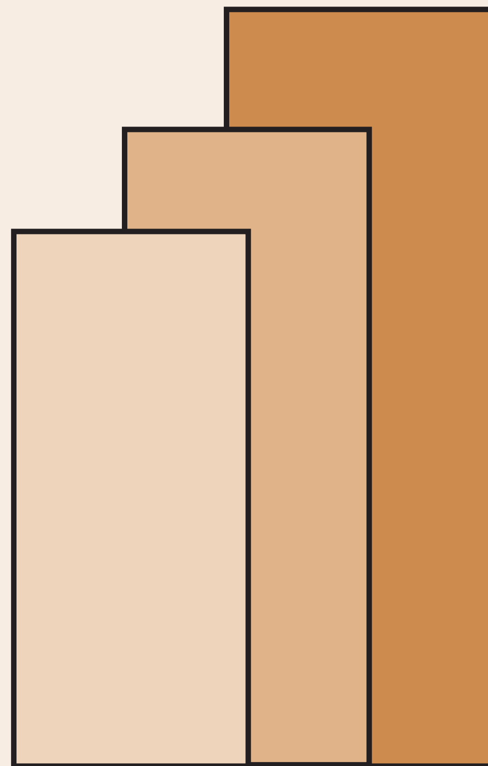

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CHALLENGES IN HEALTH SERVICES TRADE: PHILIPPINE CASE

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ABSTRACT

There is a growing emphasis on the role of trade in health services (telehealth, health tourism and retirement, investments and deployment of medical professionals) in easing fiscal constraints, generating jobs and income, improving infrastructure and financing, and upgrading the capacities of health professionals. This paper seeks to identify the opportunities, barriers, and risks for the Philippines in participating in global trade in health services. It examines the country's capabilities in engaging in trade and identifies strategic directions that the Philippines can pursue. It also presents the different market niches that can be tapped relative to the opportunities, namely: the aging populations of the Organisation for Economic Co-operation and Development (OECD) nations; the shortage of medical professionals in those countries; the long waiting lines in hospital facilities; the Health Insurance Portability and Accountability Act of the United States; and the poor healthcare systems in other countries. It also addresses the weaknesses in the supply capabilities of the country—the lack of a policy framework to develop the healthcare services sector in a globalized environment, the lack of human resources planning, and the lack of alignment in the initiatives of the government and private sector.

INTRODUCTION

The Philippines has been a major supplier of healthcare workers, particularly nurses to the world. The growth in the demand for nurses and the economic incentives offered by developed countries have triggered rapid migration in recent years. There are fears of the local healthcare system collapsing due to a number of reasons: migration of doctors to work as nurses abroad; closure of private hospitals due to lack of patients and manpower; decline in enrollment in medicine and allied courses (except nursing); and meager budget for public healthcare. The sustainability of the local healthcare industry will depend to a great extent on how migration is managed and how healthcare delivery and financing are improved.

There is a growing interest among developing countries on the role of exportable health services in easing fiscal constraints, generating jobs and income, improving infrastructure (number and quality of health facilities) and financing, and upgrading the capacities of health professionals. Countries like Thailand, Chile, Singapore, and Malaysia are embarking on aggressive health tourism programs. For India and Pakistan, business process outsourcing (e.g., medical transcription, backroom operations) is proving to be another growth area. For developed countries, investments in health facilities abroad tend to expand income streams. The United States (US) and Singapore are aggressive in establishing their presence in foreign shores through their healthcare brands (e.g., John Hopkins and Mayo Clinic for the US and the Gleneagles International for Singapore). On the other hand, developed countries are importing healthcare professionals in order to sustain their own healthcare systems. Indeed, these evidences reveal that trade is being used to enhance a country's strengths and make weaknesses irrelevant in the field of healthcare services.

Given this background, this paper is an initial attempt to map out the issues related to tradable health services for the Philippines. It will:

1. assess the trends, market opportunities and challenges in global healthcare services trade
2. examine the current state of healthcare delivery and financing (e.g., strengths and weaknesses) in the Philippines that will affect the ability to explore the market opportunities; and
3. explore strategic directions to enhance competitiveness in healthcare services.

The following section maps out the changes in global healthcare that are driving the trends in tradable health services. The barriers and risks to strategic directions are likewise discussed. Then another section defines the health services industry and examines the current healthcare situation in the country. The paper concludes with some next steps for further research and the actions that may be considered by the public and private stakeholders.

GLOBAL TRENDS AND TRADE IN HEALTH SERVICES

This section maps out the opportunities in the global healthcare market that can be tapped to manage migration and sustain the local healthcare delivery and financing.

Healthcare Spending on the Rise

In 2000, global healthcare spending reached US$3 trillion—a 14 percent growth from the 1990 level. Asia's healthcare market accounts for US$390 billion. Japan's per capita healthcare spending alone is US$1,314-US$2,400 annually, comprising 77 percent of the regional market. By 2010, the Asian healthcare market is expected to be valued at US$600 billion, with Japan spending US$422 billion. Other Asian countries are projected to spend at least US$190 billion by 2013. The Centers for Medicare and Medicaid Services report that in the US, the overall cost of healthcare—from hospital and doctor bills to the cost of pharmaceuticals, medical equipment, insurance and nursing home—doubled from 1993 to 2004. In 2004, the US spent almost US$140 billion more for healthcare than in the previous year.

From the demand side, the growth is driven by the aging populations, expanded reach of mandatory insurance schemes, emergence and/or discovery of new diseases, and lack of incentives for patients to economize since healthcare is covered by most insurance schemes. From the supply side, the growth is driven by the lack of incentives to relate the cost of treatment with benefits, introduction of more expensive technologies, shortage of health professionals, insufficient healthcare planning, and unfocused treatment by doctors (WTO 1998). These factors have contributed to the high cost of healthcare delivery and have forced governments to consider reforming their financing schemes and explore ways to reduce the costs and/or increase the revenue streams by engaging in health services trade.

At least four major trends impact either positively or negatively on the healthcare system of a developing country that has a relatively abundant supply of human resources such as the Philippines.

Aging populations

The number of persons aged 60 years and older is projected to grow to almost 2 billion by 2050 in which the population of older persons will be larger than the population of children for the first time in history. Today, the majority of the world's older persons reside in Asia (54%) while Europe has the next share (24%). Japan is the only developed country that is aging at a very fast rate. In 2025, the proportion of the population aged 65 years and above will be highest in Japan, followed by Italy and Hong Kong. Although the US is also aging, in relative terms, its population will be much younger than Japan's.

The OECD countries are increasing healthcare spending allocation for elderly people—from one-third to one-half. Japan spends the largest proportion (47%), while Germany spends the least (34%). The US is near the middle (38%). In looking at the ratio of per capita spending for people 65 years and older compared with those under 65 years, Japan spends proportionally the most (4.8 times), while Germany spends the least (2.7 times).

In most OECD countries, the aging population is forcing them to open their doors to healthcare workers particularly from developing countries. In some cases like Japan, the government has been encouraging their citizens to consider retirement in foreign shores.

Shortage of healthcare professionals and long waiting times

More people are living longer but the number of healthcare workers available to take care of the aging populations is declining in countries such as the US, Canada, and the United Kingdom (UK) due to low birth rates and the decline in interest in the healthcare profession (particularly nursing and caregiving). In developing countries, health professionals are needed not just to take care of the elderly but also to provide healthcare services for the general population. In 14 sub-Saharan countries in South Africa, for instance, there are no radiologists. Rural areas hardly have access to doctors. In addition, the waiting times for treatment are quite long. In the United Kingdom (UK), for instance, the average waiting time for kidney transplantation is eight months to three years. In Canada, there are 352 patients waiting for organ transplants. Table 1 presents the waiting time in British Columbia, Canada.

Table 1. Median wait time and waitlists for British Columbia

Median Wait Times and Waitlists for BC (March 31, 2005)		
Surgical Specialty	**Median Wait Time in Weeks**	**Waitlisted Patients**
Dental Surgery	7.1	1,673
Ear, Nose & Throat Surgery	5.4	5,111
Eye Surgery	8.6	13,836
General Surgery	3.4	12,314
Gynecology	4.3	5,860
Neurosurgery	4.0	1,293
Orthopedic Surgery	9.3	20,101
Plastic Surgery	6.6	4,541
Urology	4.7	5,689
Vascular Surgery	2.7	932
Cardiac Surgery	8.6	301
Corneal Transplant	17.6	603
Cancer Services (Radiotherapy)	0.6	268
Organ Transplants	N/A	352
Total		72,784
Specific Procedures (included in totals above)		
Endarterectomy Head/Neck	3.0	121
Cataract Surgery	9.4	12,850
Gall Bladder	5.1	1,571
Hip Replacement	21.8	3,044
Knee Replacement	28.3	5,464

Source: www.health.gov.bc.ca/cpa/mediasite/waitlist/median.html

High cost of medical services in OECD countries

People are moving abroad to seek treatment at lower costs. Table 2 gives some indicative figures on certain treatments in countries like Thailand, Singapore and Malaysia that are aggressively positioning themselves as medical hubs.

Table 2. Comparative costs of treatment (in US$)

Treatment	USA	Singapore	Malaysia	Thailand	Philippines
Cataract Surgery	2,500-3,500	1,749	1,014	950	1,424
Total Knee replacement	5,000	6,207	4,342	5,500	5,639
Liposuction	2,800 –5,700	3,221	1,711	1,365	1,400

Poor access to healthcare facilities and services

Apart from lack of healthcare workers, developing countries do not have sufficient facilities to provide quality healthcare to their local population. There are only 140,000 hospitals in Asia that are currently serving a population of 3.5 billion. The wealthy and the middle class of Asia are willing to pay for quality healthcare services. It is estimated that at least 130 million Asians can afford private services.

These trends have changed the landscape of health services delivery. The high cost of medical services, for instance, has stimulated the application of technology to reduce transaction costs and address the shortage of professionals through telemedicine. Thus, there are increasing discussions on the use of telehealth as an effective way of providing healthcare access. The high cost of healthcare and the long waiting times have also been driving consumers to seek these services in other countries.

The next section explores how countries use trade to take advantage of these opportunities and threats.

How Countries Export Health-Related Services

There are four possible ways based on the General Agreement on Trade in Services (GATS) by which the Philippines can explore these opportunities (Table 3).

Table 3. GATS modes of supply

Modes	Description	Examples in the healthcare services
1 CROSS-BORDER TRADE IN SERVICES	The possibility for non-resident service suppliers to supply services cross-border into the Member's territory.	Telehealth (e-health) o All forms of telemedicine o For nonclinical purposes: o shared medical services (medical transcription), laboratory services or claims processing; (b) hospital management functions; data collection for statistical or educational purposes, back-up advisory facilities for local staff abroad.
2 CONSUMPTION OF HEALTH SERVICES ABROAD	The freedom for the Member's residents to purchase services in the territory of another Member.	o Consumers who travel abroad for medical care o Tourists who incidentally need medical care abroad; o Retirees abroad o Temporary or migrant workers o Cross-border commuters who may have multinational coverage options; o Residents of multinational areas with integrated health systems.
		o Medical and health sciences education provided to foreign students
3 ESTABLISHMENT TRADE OR COMMERCIAL PRESENCE	The opportunities for foreign service suppliers to establish, operate or expand a commercial presence in the Member's territory, such as a branch, agency, or wholly owned subsidiary.	o Investments in hospitals o Investments in health insurance companies o On ad-hoc basis (under short-term contract as an organization)
4 MOVEMENT OF HEALTH PROFESSIONALS.	The possibilities offered for the entry and temporary stay in the Member's territory of foreign individuals in order to supply a service.	o Two forms for the international trade in health services are existing: (a) temporary movement of health personnel to provide services abroad; and, (b) short-term health consulting assignments.

Source: WTO (1998).

The following discussion explores each of these modes and identifies the opportunities and threats that exist and how to make the four modes work for the Philippines' advantage.

Mode 1: Telehealth

Under Mode 1, trade in health services is aided by telecommunications (so-called "telehealth"). Trade is aided by the use of computer-assisted telecommunications to support the functions for clinical (e.g, telemedicine) and nonclinical purposes (e.g., medical

transcription, business process outsourcing, management, surveillance, literature and access to knowledge). Two market niches to be considered are telemedicine and medical transcription.

Telemedicine. There is a relatively wide spectrum of telemedicine services such as teleconsultations, telepathology, teleradiology, telepsychiatry, teledermatology, and telecardiology. The European Commission's Healthcare Telematics Program in 1996 defines telemedicine ("medicine at a distance") as the rapid access to shared and remote medical expertise by means of telecommunications and information technologies (e.g., telephones, fax machines, personal computers, and other forms of multimedia) no matter where the patient or relevant information is located. Information exchange takes the form of data, audio and/or visual communication between physician and patient or between physicians and healthcare professionals in geographically separate locations to facilitate the exchange of information on medical, healthcare, research, and/or educational purposes. Although the applications are mostly within the national systems, there are evidences of cross-border trade especially in the areas of radiology and pathology. Globally, the major factor driving telemedicine is the high cost of medical services particularly for the aging populations. The flows of telemedicine exports, however, are still largely from developed to developing countries where there is poor access to healthcare.

Telemedicine will be needed as the Philippines positions itself for medical tourism and retirement. A patient seeking treatment in the Philippines can consult with a Filipino doctor online and send the latter his records before actually coming to the Philippines and after his treatment. Furthermore, foreign retirees living in retirement communities in the provinces can access doctors from medical zones or city hospitals via telemedicine. Tele-education is another area where the Philippines has comparative advantage given its expertise in the study of tropical diseases. At this stage, the country can provide radiological and other medical diagnostic support to these countries through second opinion or standard reading of results in health screening programs or tests for patients.

The major obstacles include the recognition of licenses and the liability issue. The practice of cross-border telemedicine, for instance, requires Filipino physicians to be licensed in the markets being served. A healthcare facility can have a pool of foreign-certified physicians working with a bigger pool of locally licensed physicians or healthcare

professionals (similar to the strategy of India). There are existing disparities in standards and technology to achieve accuracy in the transmission of images, data, and electronic records.

The costs can be prohibitive if the provider has other priorities in terms of equipment upgrading. On the other hand, the use of store-forward technology requires less investment costs compared to real-time telemedicine practice which is not yet integrated in everyday use of hospitals or healthcare providers. Most patients still prefer to see their physicians so the trust on the accuracy of findings generated through telemedicine needs to be built up. Partnering between a local healthcare provider and a reputable institution in the target market may help overcome this barrier. Another barrier is the lack of privacy and security regulations. In other countries, the lack of interest on the part of the providers is the main barrier. This can be due to the absence of viable business models or cases. There is a need therefore to study how telemedicine can be integrated in everyday practice and how payment schemes can be facilitated.

Telemedicine can also provide opportunities for the Philippines in tapping the expertise of foreign-based institutions without its citizens having to leave the country. For instance, some Filipino patients from well-to-do families have started to secure medical services in local hospitals that have tie-ups with foreign hospitals, such as the Makati Medical Center which is affiliated with the Stanford Hospital in California, USA.

Cross-border telemedicine can impose risks and imbalances on the local healthcare system. A dichotomy in healthcare delivery can exist if cross-border telemedicine develops while local access to healthcare through telemedicine lags behind. There are minimal evidences on telemedicine application even in the national health system. Engaging in cross-border practice requires some success stories or models that the private sector can use as reference to make the business case for investing in the telemedicine business. Furthermore, there is a need to articulate a national policy and strategic framework on the practice of telemedicine for the local and foreign healthcare markets. The key to a successful telemedicine initiative is to have a champion who will mobilize ready providers. This champion will be the one to start defining the product or service that the country is capable of delivering. What is needed is a pool of Filipino doctors who have licenses to practice in the US market. They will form part of a larger pool of practitioners who will conduct the diagnosis but the certification will be done by the licensed practitioners. The government

through the Department of Health (DOH) and the University of the Philippines-Philippine General Hospital's National Telehealth Center—having initiated a national telemedicine project on teledermatology and tele-education for regional hospitals—can be tapped to work with the private sector in developing the national framework for the practice of telemedicine (including cross-border). This framework should be able to address the logistics of telemedicine applications—from the products to be offered up to the payment or reimbursement coverage. The equity issue should likewise be articulated in the national framework.

Medical transcription. Another exportable health-related service includes business process outsourced activities such as medical transcription and backroom operations (e.g., insurance claims and bills processing). In medical transcription, a doctor in another country, say the US, sends his recording via the Internet to a transcriptionist in the Philippines. The transcription is then sent back to the doctor within 3 to 24 hours depending on the urgency of the need.

The major driver for the growth of the medical transcription industry in developed countries is the need by healthcare professionals to document patients' records (e.g., diagnosis, treatment procedures, findings) to facilitate processing of claims and avoid malpractice suits. In the US, healthcare providers need to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Also, the need of hospitals to restructure their operations and costs has increased the demand for business process outsourcing in the form of insurance claims and bills processing. This offshore medical transcription industry is estimated at US$17 billion for the US alone. Based on the Department of Trade and Industry - Information and Communication Technology (DTI-ICT) Report, about 6,700 US hospitals have yet to convert their medical records into electronic format. This is in compliance with the Federal Certification, a US law requiring all medical records to be computerized. The figure represents about 42 percent of US demand that requires outsourcing. India has already captured 80 percent of the market while the rest are being shared by Pakistan, Philippines, Sri Lanka, and Australia. To meet the demand, the US market alone needs about 230,000 medical transcriptionists. The Philippines has tapped only around 1 percent of the outsourcing demand of the US. The bigger portion of the demand is being served by India, which is recognized as the market leader today. Its outsourcing industry has around 200,000 employees. India has the first mover advantage.

On market access, the lack of a data protection and privacy law is a major concern of the industry. As experienced by India in the early 1990s, companies could easily lose customers due to lack of data protection. US clients require that their providers are HIPAA compliant. Ceferino Rodolfo elaborated on these issues in his paper on business process outsourcing.

Mode 2: Consumption abroad

One way to manage the migration of healthcare workers and generate economic contributions for the country is by bringing the consumers of healthcare and related services (tourists, patients, students) to the Philippines.

Health tourism. The categories of consumers moving abroad include (Table 4):

- Consumers who travel abroad for wellness purposes and medical care;
- Tourists who incidentally need medical care abroad;
- Retirees abroad;
- Temporary or migrant workers;
- Cross-border commuters who may have multinational coverage options; and
- Residents of multinational areas with integrated health systems.

Health tourists are usually motivated by factors such as higher quality, lower cost, reduced waiting time in the availment of treatments, and availability of services that are either unavailable or illegal in their country of residence (Blouin et al 2005). For a long time, the US has been a major health hub given its established expertise in medical care through its well-known brand names such as Mayo Clinic, John Hopkins, and Stanford Hospital. Recently, however, a growing number of countries such as Thailand, Malaysia, Jordan, Singapore and India have started to offer medical services at relatively lower costs and sometimes bundled with leisure or tourism-related services (Appendix 1). Table 5 presents a profile of the health tourism activities in these destinations.

Table 4. Categories of consumers moving abroad

	Categories/ products	Health tourism market	Sample	Client group	Capacity requirements	Target markets for the Philippines	Importance of insurance coverage	Major players
Health Tourism	Spa Wellness	Those who travel to specific places to benefit from natural endowments such as hot springs and spas.	Spas Lifestyle/Healthy vacations Nature tourism Ecotourism Community Resorts Herbal Complementary	Upper middle to high income Healthy Low health risk All ages	Good facilities Skilled manpower (i.e. therapists, tour operators)	All tourists who visit the Philippines	No	United States Canada Germany Thailand Singapore Indonesia Austria
	Medical Wellness	those who travel abroad for leisure but incorporate consultations for second opinion or diagnostics	Diagnostic	Upper middle to high income Healthy enough to travel All ages Potential market for repeat visits to seek further medical attention	Specialist skills Skilled support groups (e.g. tour operators) Language and cultural affinities	Overseas Filipinos USA China South Korea Australia	Yes (currently consultations are not covered by insurance and patients are willing to pay in cash)	Singapore Thailand India US Malaysia Australia

		those who travel for medical, dental, cosmetic, eye and other related outpatient treatment (non-invasive procedures), similar quality to that they can receive at home, but less expensive or for specific services not available in the country of origin. Emigrants living abroad and border patients are important groups of clients. Usually pursuit for aesthetic purposes rather than for recuperation	Elective surgery Cosmetic surgery Joint replacement Cardiothoracic Eye surgery Cancer treatment	Upper middle to high income Healthy enough to travel Specific surgical or medical requirements Variable health risk All ages	Specialist skills Broad range needed for intervention and backup Higher level of Technology Skilled manpower (e.g. nurses, therapists, etc.) Language and cultural affinities		Yes (Cosmetic treatments are not covered by insurance and patients tend to be willing to pay on their own as long as the costs are competitive relative to those in their country of residence)	Singapore India Thailand Cuba Malaysia
		those who travel abroad looking for specialized (invasive) surgical treatments that employ advanced technology which may not be available at home or from prestigious health institutions;		Upper middle to high income Healthy enough to travel Specific surgical or medical requirements Variable health risk Middle age to elderly	Specialist skills Broad range needed forintervention and backup Higher level ofTechnology Skilled manpower (e.g. nurses, therapists, etc.)	Guam Micronesian	Yes (non-portability of public and private insurance is a major barrier but some private insurance companies are starting to accredit some facilities that meet their standards)	United States Singapore Great Britain Australia India

	Rehabilitation/ Long Stay	those who travel for convalescence and not necessarily retirees;	Recuperation from cancer treatment Theraphy Dialysis Addiction programs Elderly care programs	Higher income Specific needs Other health conditions Low to medium health risk Elderlysubstance abusers	More ention rather than Language and cultural		Yes	Thailand Malaysia Florida Carribbean economies
Retirement	Long Stay/ Migrant Retirees	Retirees who travel abroad to spend long holidays (at least 6 months) or escape from the cold winter months and may seek medical attention during their stay.		Higher income Variable health risks Potential market for retirement	Skilled manpower (e.g., nurses, therapists, etc.) Language and cultural affinities	Japan USA	Yes	Thailand Malaysia Carribbean economies

	Immigrants	Those who travel abroad to retire permanently in countries where the costs of living are lower or where the climate is favorable among other things. They can live in three different types of retirement communities: (a) independent living; (b) assisted living, and (c) continuing care.		Upper middle to higher income Specific needs Middle to elderly age	Skilled manpower (e.g., nurses, therapists, etc.) Specialist skills Language and cultural affinities	Overseas Filipinos	Yes	Florida, Panama, Spain Canada Australia Thailand, Caribbean economies

(a) there are three segments of the retiree market: retiring individuals, retired and the retired elderly. The retiring individuals can be the potential market for long stay. Retired and retired elderly for retirement industry.

Sources: Adapted from Gonzales et al (2001); Kaiser (2005); Dacanay and Rodolfo (2005).

Table 5. Major health tourism destinations in Asia

Country	Est. Market Size		Current Markets	Target Markets for Expansion	Target Revenues
	Volume	**Value**			
Singapore	150,000 – 200,000	US$915 M	Indonesians and Malaysians account for 70-85%	Affluent Asian market - residents and expatriates - (including Philippines) to increase its less than 1% share to 2%	1 million international patients per year contributing US$3B by 2012
Thailand	1.1 million	US$470 M	Japanese 130,000 Americans 59,000 Britons 14,000	Japan Rest of Southeast Asia	US$2B (2010)
Malaysia	122,000	US$94 M	60% of foreigners who seek treatment are from Indonesia, another 10% are from Brunei, Vietnam, Singapore and Thailand. The rest are from West Asia, South Asia (Bangladesh and India) and Japan.	Middle East and China Vietnam, Myanmar, Cambodia and Brunei.	US$1 B by 2010
India	150,000	US$333 M	Middle East (Kuwait, Qatar, Saudi Arabia) and South Asian (particularly Bangladesh)	Southeast Asia, West Asia, Africa, UK and USA	US $2.2 B (2012)
Philippines	?:	?:	Micronesia, Indonesia, USA (primarily Overseas Filipinos), South Korea	USA, Japan, South Korea, China, Micronesian States (all markets for spa wellness)	?

Retirement. Retirees move to another country because of the high costs of retirement in their own country, which their pension money may not sustain. Their governments' fiscal resources are not sufficient to support their needs. They move to destinations such as Florida, the Caribbean, Panama, and emerging ones such as Dubai, Malaysia, and Thailand that offer a wide range of incentives (e.g. political, financial, health and social security) and choices of care (e.g. independent living, assisted living and continuing care). These countries generate employment and income in a number of

service-oriented industries (e.g. private and personal, community, manufacturing, tourism) outside of healthcare services. Some governments encourage their citizens to travel and consider retirement (long stay and/or permanent) abroad. In Japan, for instance, the government has encouraged its citizens to seek retirement in other countries such as Costa del Sol in Spain during the 1980s under the Columbia Plan. Because of Japan's increasing silver market, it has become a major target of countries positioning themselves in the retirement business. As of 2003, a total of 911,000 Japanese are living abroad either as long stayers or permanent residents (Table 6). A number of those living in the Philippines are married to locals. The development of the retirement industry is closely tied to with tourism which serves as a pull factor for attracting retirees to consider destinations. For the Philippines, the natural markets are the US and Northeast Asia and some European countries such as Germany and the UK (overseas Filipinos).

Table 6. Long Stayers and Permanent Retirees

Country/Region	Long-Term Stayers	Permanent Residents	TOTAL
Asia	199,122	7,399	206,521
Asean	83,231	5,076	88,307
Brunei	73	8	81
Cambodia	727	6	733
Indonesia	10,867	741	11,608
Laos	384	2	386
Malaysia	9,959	810	10,769
Myanmar	606	34	640
Philippines	8,981	1,669	10,650
Singapore	19,987	1,117	21,104
Thailand	28,181	595	28,776
Vietnam	3,466	94	3,560
China (incl. Hong Kong, Macau)	76,168	1,016	77,184
Oceania	35,152	27,866	63,018
North America	240,033	129,606	369,639
Central America, Caribbean	5,056	2,528	7,584
South America	5,491	88,819	94,310
West Europe	119,293	33,540	152,833
Central and East Europe, NIS	5,260	455	5,715
Middle East	4,749	1,108	5,857
Africa	5,069	472	5,541
South Pole	44	0	44
World	619,269	291,793	911,062

Source: Ministry of Foreign Affairs website.
Note: Figures as of April 2004
(1) Total: Total of Long-Term Stayers and Permanent Residents
(2) Long-Term Stayers: Japanese nationals staying overseas for more than 3 months with no permanent resident status

(3) Permanent Residents: Japanese nationals with permanent residence status of the country of residence

At this stage, there is still a need to define the health tourism and retirement products of the Philippines. There are bits and pieces of initiatives being undertaken but there is no concrete program for positioning the country as a whole. The product or service offering should translate into a brand of Philippine health services (e.g. similar to Singapore Medicine). By virtue of Executive Order No. 1037 of 1985, the Philippine Retirement Authority (PRA) was mandated to develop and promote the country as a retirement haven. To date, however, the industry has not yet taken off due to several barriers.

The major barrier to movement of consumers for health tourism and retirement is the lack of insurance portability, particularly public insurance. US citizens who wish to seek medical treatment or even retire in the Philippines cannot use their Medicare insurance in the country (Table 7). To some extent, private insurance is already portable as long as the healthcare provider in another country is accredited by the insurance company or the health maintenance organization (HMO). In the case of the Japanese market, patients can seek partial reimbursement of their medical cost outside Japan. However, long-term care insurance, which is more relevant in the movement of retirees, is not yet portable.

Table 7. Summary of how US health plans treat healthcare received abroad

Plan	**US Population covered in Year 2004**	**Healthcare received overseas covered?**	
		Emergency Care	*Non-emergency Care*
Medicare and Medicaid	26% of US population (mainly retirees, low income families and disabled families)	Not covered, except when beneficiary is a border resident, and lives closer to the foreign provider than the US provider.	Not covered
Tricare	3.5% of US population (active duty and retired US military personnel and their families)	Covered, with overseas network provider handling the claim filing.	Covered, if beneficiary is stationed or retired overseas, until the age of 65
HMO plans	25% of all employees in the US with employer-sponsored health insurance	Covered but as an out of network benefit requiring higher consumer cost-sharing. Initially beneficiary pays entire cost out of pocket qualifies	Not covered

		for reimbursement only when claim form and itemized bill are submitted to insurer upon return to the US	
Point of Service Plan (POS)	15% of all employees in the US with employer-sponsored health insurance	Same as HMO	Not covered
Preferred Provider Organizations (PPOs)	55% of all employees in the US with employer sponsored health insurance	Same as HMO. However, some plans have a network of overseas providers who accept US insurance (e.g. Blue Cross Blue Shield) and would handle claim filing on consumer's behalf.	Not covered by most plans. When covered (e.g., World Bank employee health plan) it is treated as an out-of-network benefit requiring higher consumer cost sharing.

Source: Adapted from Mattoo and Rathindran (2005).

Emotional insecurities can also slow down the movement of patients or retirees. Language and cultural barriers may hinder them from seeking treatment abroad. This is particularly true for the Japanese market. Even if a retiree has already been staying for some time in the Philippines, he still goes back to Japan to seek medical treatment because of language concerns and the issue of cultural differences (Rodolfo and Padojinog 2004).

Beginning 2005, the government embarked on a bold move to position the Philippines as a medical services hub in Asia (Mode 2). The Arroyo administration issued Executive Order (EO) No. 372 that created the Public-Private Partnership Task Force on Export Competitiveness. The Task Force is mandated to pursue strategic directions for three sectors—health and wellness, IT enabled services, and logistics. It designated the Department of Health's Office of Undersecretary for Special Concerns to mobilize hospitals and clinics. This program is likewise intended to encourage local healthcare workers to stay in the country. The DTI's Board of Investments (BOI) identified health and wellness (including retirement villages) as a priority sector in the 2005 Investments Priorities Plan (IPP) and incorporated incentive schemes for pioneer and nonpioneer investment projects (Mode 3). To date, the Philippine Economic Zone Authority (PEZA) is working with the Department of Tourism (DOT) and the DOH in defining the incentives for health tourism and retirement villages. However, the policy framework on the

development of health tourism and retirement in relation to the local healthcare situation has yet to be developed. In the meantime, hospitals, clinics and physicians are steadily attracting foreign patients while some real estate projects are serving as hosts to foreign retirees.

There are still unresolved issues related to health tourism and retirement. These include the following:

- How will foreign direct investments (FDIs) affect equity to healthcare services?
- How will the government address the incentives structure for FDIs and for local healthcare providers that are starting to export health services?
- Will the entry of foreign healthcare professionals matter in the country's bid to become a medical services hub? If yes, to what extent will the Philippines allow foreign healthcare professionals to practice in its soil?
- To what extent will the government give incentives to foreign retirees to consider the Philippines for their retirement?
- To what extent will public healthcare workers be given incentives to participate in medical tourism and retirement without causing brain drain?
- How will the Philippines sustain these export initiatives given the weaknesses in the local healthcare delivery and financing?

Table 7. Summary of how US health plans treat healthcare received abroad

Plan	**US Population covered in Year 2004**	**Healthcare received overseas covered?**	
		Emergency Care	*Non-emergency Care*
Medicare and Medicaid	26% of US population (mainly retirees, low income families and disabled families)	Not covered, except when beneficiary is a border resident, and lives closer to the foreign provider than the US provider.	Not covered
Tricare	3.5% of US population (active duty and retired US military personnel and their families)	Covered, with overseas network provider handling the claim filing.	Covered, if beneficiary is stationed or retired overseas, until the age of 65
HMO plans	25% of all employees in the United States with employer-sponsored health insurance	Covered but as an out of network benefit requiring higher consumer cost-sharing. Initially beneficiary pays entire cost out	Not covered

		of pocket qualifies for reimbursement only when claim form and itemized bill are submitted to insurer upon return to the United States	
Point of Service Plan (POS)	15% of all employees in the United States with employer-sponsored health insurance	Same as HMO	Not covered
Preferred Provider Organizations (PPOs)	55% of all employees in the United States with employer sponsored health insurance	Same as HMO. However, some plans have a network of overseas providers who accept US insurance (e.g. Blue Cross Blue Shield) and would handle claim filing on consumer's behalf.	Not covered by most plans. When covered (e.g., World Bank employee health plan) it is treated as an out-of-network benefit requiring higher consumer cost sharing.

Source: Adapted from Mattoo and Rathindran (2005).

Movement of students. Students are another group moving abroad to consume health-related services. There are incentives for students to pursue undergraduate and postgraduate medical education (e.g., traditional and nontraditional) abroad. First, specific programs may not be available in their home country. Second, scholarships on medical education require students to pursue the program in another country and not in their home country. Third, foreign institutions have a good reputation in their desired fields of specialization. Among the medical education hubs are the US, Australia, and Singapore (and China for traditional Chinese medicine). Fourth, due to cost considerations, students from more developed countries go to lesser developed ones with a good reputation in medical education. The establishment of satellite or affiliate schools by developed countries in developing ones through joint venture agreements has encouraged medical students to study in their home country. Some universities in the Philippines have started to strengthen their marketing efforts to attract foreign students in order to address the decline in enrollment and encourage investments in their educational system. For instance, St. Paul University of Tuguegarao has partnered with the Yan Jing Overseas Chinese University of the Peoples Republic of China for the delivery of a Bachelor of Science in Nursing program. There are also hospitals (e.g., St. Luke's Medical Center, Capitol Medical Center, University of Santo Tomas and Cebu Doctors Hospital) that provide postgraduate training to foreign doctors for specialization.

Some barriers that schools and hospitals face in their drive to develop this niche market are the 10 percent cap (e.g., share to total student population) on the number of foreign students allowed and the lack of government guidelines on the scope of responsibilities of foreign doctors who are training in the Philippines. Santiago (this volume) discusses further the issues related to the movement of students.

The major barriers faced by foreign students when they move to another country for their education are the lack of mutual recognition of diplomas or certificates between countries and the visa regulation and processing. The possibility of these students not returning to their home country is another major concern among developing countries. The application of new technologies in education delivery via teleconferencing could encourage students to pursue their degrees in their home country since it could give them access to expert education without having to go abroad.

Mode 3: Foreign commercial presence

This mode includes the establishment of a commercial presence in a foreign market to provide health-related services to clients. It is categorized as follows:

Hospital operation/management sector. Hospital management companies usually enter foreign markets through joint ventures with local partners or triad ventures with local and third country investors. Specifically, it concerns the acquisition of facilities, management contracts and licensing, and local partnerships to gain access to certified and qualified medical personnel as well as local markets.

The presence of foreigners in the industry is relatively strong in developing countries such as Indonesia and Thailand. A number of investments came at the height of the Asian crisis, when most hospitals either declared bankruptcy or failed to become profitable. Major investors in hospital services come from Australia and Singapore, some are from Malaysia and Japan. Even hospital management is a common practice in cities like Jakarta (where at least five hospitals are owned or managed by foreign firms and individuals), Surabaya, Java, and Bali. In Dubai, a medical zone was constructed to house the famous clinics of Mayo Clinic and Harvard Medical Center. These are currently patronized by the rich citizens of Arab countries. The Singapore-based Parkway Group Healthcare Pte. has developed the Gleneagles International as its brand in acquiring or investing in hospital facilities. It has

acquired so far 11 hospitals, 10 in Asia and one in Britain. A majority share in a dental surgery chain is operating throughout Southeast Asia.

Health insurance sector. Some countries have opened up their health insurance markets with some restrictions imposed on foreign insurance companies investing in hospitals. Managed care operations (a combination of managed care and insurance) have been used as a means to penetrate foreign markets to circumvent foreign equity and nationality restrictions. They are expected to reduce the total medical costs by requiring participating physicians to provide the lowest cost treatment. Patients have raised concerns over the discrimination by physicians between HMO patients and non-HMO patients.

Education sector. Some well-known medical schools are establishing themselves in foreign countries (as in the case of the John Hopkins School in Singapore), including developing countries, usually through joint ventures with local schools. This kind of foreign commercial presence is often accompanied by movement of providers (e.g., professors) and movement of consumers (e.g., students moving from headquarters to subsidiaries and vice-versa). The interest for the recipient country is to differentiate and upgrade the curricula available to its students or medical personnel. On the other hand, the interest for the exporting institution is to have access to new sources of revenue, spread its reputation abroad, and avoid overcrowding in its headquarters. This move encourages students in developing countries to pursue medical studies in their home country.

On an ad-hoc basis. To upgrade facilities, some companies expand abroad through contract-based activities under multilateral funding. Since it is time limited, the exporting country provides opportunities for its medical professionals without burdening the local healthcare system. Contracts can be renewed depending on the needs of the importing countries and the resources of multilateral agencies. The exporting companies can likewise develop a pool of personnel to be deployed thereby upgrading the quality of the healthcare workers.

In this context, health service providers can face government policies that discriminate against overseas entrants into the marketplace. These can include limits on foreign equity ownership (Table 8), discriminatory tax arrangements, restrictive competition policies (including the lack of competitive neutrality), clearance being required from the

health ministries, quantitative limits on the number, location, staffing and management of foreign establishments, and pre-emptory political decisions. Changes to these policies generally require high-level negotiations with the relevant foreign governments. The Philippines has not explored commercial presence of healthcare facilities abroad. What the government is pursuing is the establishment of foreign presence in the country in order to build the capabilities in modes 1 and 2.

Table 8. Investment rules on hospital and insurance companies

Countries	Rules/Policies
France, Italy, Luxembourg, the Netherlands, and Spain	The construction or expansion of hospital facilities is limited by a health services plan that identifies local needs.
Austria	Foreign commercial presence commitments affecting all 27 healthcare sectors require authorities to consider local interests before authorizing foreign persons or companies to acquire property and before allowing foreign concerns to invest in corporate entities.
Sweden	Maintains economic-need limitations on the number of private medical service practices that may be subsidized through its social security healthcare reimbursement system
Finland	Foreign commercial presence is allowed only through incorporation with a foreign equity ceiling of 51 per cent.
France	Foreign acquisitions of the stock of newly privatized companies may be limited if total foreign investment exceeds one third of total investment or 20 percent of total equity.
European Union	Some form of economic-need limitations on the establishment of new hospital facilities.
United States	the establishment of hospitals or other healthcare facilities may be subject to needs-based quantitative limits.
Japan	Limits ownership of hospitals and clinics to national-licensed physicians or groups of persons of whom at least one member is a Japanese-licensed doctor. Investor owned hospitals that are operated for profit are prohibited. Regulations are less strict in the nursing home sector where foreign companies are benefiting from a dramatic increase in the over-65-year-old population in Japan and a shortage of nursing homes and other long-term care facilities in that country.
Brazil	Foreign companies cannot own hospitals or clinics
India	foreign companies can establish themselves only through incorporation, with a foreign equity ceiling of 51 per cent
Mexico	Foreign investment is allowed up to 49 per cent of the registered capital of enterprises.
Malaysia	Economic needs tests. Foreign companies have to set up joint-venture corporations with Malaysian individuals or Malaysian controlled corporations or both.

Source: World Trade Organization.

Mode 4: Movement of natural persons

There are two types of movement defined under Mode 4 of the GATS. These are short-term consulting arrangements and intracorporate transfers.

As mentioned under Mode 2, the aging populations of the OECD countries present an opportunity to ease unemployment problems and augment income generation in developing countries through the deployment of medical workers. Among the health professions, the nurses have been in great demand in recent years. This is evidenced by the rapid movement of thousands of nurses from developing countries including the Philippines. The major importing countries so far are Saudi Arabia, US, UK, and Canada due to the shortage of nurses in these countries (Calma 2005).

Furthermore, there are new openings for nursing aides and caregivers for the elderly and those with disabilities. The major sources are the Caribbean nations, Philippines, and South African countries. There are many reasons why health professionals move out of their home country. Primarily, they are attracted to the more improved living and working conditions and the more lucrative remuneration that employers in other countries could offer, which is about five to six times more than they would receive locally. This is a tremendous help for their families back home. In addition, they want to upgrade their skills, which they could pursue by working in more advanced healthcare institutions. Cultural affinity and geographical proximity facilitate the movement of health personnel abroad.

From a national perspective, the remittances of these health workers will help finance the healthcare needs of the domestic population. In a way, migration also tends to ease the unemployment problems in the country. The temporary movement of health professionals is also beneficial at some point. The risk of brain drain starts to happen when these professionals get married and decide to live in other countries. It is aggravated when doctors leave their home country to work as nurses abroad.

The relevant barriers to the movement of healthcare professionals or workers include the economic needs test requirements, discriminatory licensing, difficulties with accreditation or recognition of foreign professional qualifications, and the nationality and residency requirements.

Other barriers include immigration regulations, examinations for completion of qualifications and foreign exchange controls affecting the repatriation of earning, and discriminatory regulation of fees and expenses. The movement of Filipino healthcare workers will continue with the globalization of healthcare. How can brain drain be addressed? One is to explore the export opportunities under Mode 1 (particularly business process outsourcing) and Mode 2. At the same time, the government (and even private institutions) can negotiate for equity or compensation for the costs of training or the provision of scholarships to sustain the local healthcare workforce.

ASSESSMENT OF CAPABILITIES

There are two areas that need to be examined in relation to the Philippine's capabilities to explore the opportunities presented earlier. These are infrastructure (facilities and services, cost structure, differentiated standards)and human resource pool (availability and quality). The presence of networks and business linkages enhance these two integral components of the healthcare delivery.

Infrastructure

The Philippines offers competitive prices in health-related services. One reason is the relatively low cost of labor in the country. In telemedicine, for example, a radiologist in the US is paid US$30-50 per plate read. Compare this to US$5-10 being paid to a radiologist in the Philippines per plate read. In medical transcription, the main advantages of the Philippines are its telecommunications infrastructure, labor, and reasonable office rental fees (see Rodolfo, this volume). These are the three main cost items that matter in the competitiveness of medical transcription companies. The Philippines also has a good track record—a minimum accuracy rate of 98 percent and a turnaround time of 24 hours. Emergency room (ER) cases can be turned around for three to six hours. The Philippines charges 10-12 cents per line—a rate that is competitive with India's. While labor cost in the Philippines is higher than in India, it is very competitive relative to the US. The average salary of a full-fledged transcriptionist in the Philippines is US$2,500-US$4,000 per year, depending on level of skills. In India, it is US$2,700 while in the US, the rate is US$25,000 to US$30,000. The costs of telecommunications lines are also lower by 30-50 percent in the Philippines than in India. Furthermore, procurement times are shorter (3 weeks as opposed to

3 months) and there is less transmission delay. The bandwidth cost has declined by 70 percent during the past four years, according to local IT service and contact center providers. Other major advantages include the benefits of the country's deregulated telecommunication sector (see Rodolfo, this volume). There are 29 medical transcription organizations and 10 medical transcription schools under the Medical Transcription Industry Association of the Philippines. Furthermore, the association has been working with the Technical Education Skills and Development Authority (TESDA) in developing a curriculum for medical transcription, which is currently being offered in some schools in the country.

As far as the retirement industry is concerned, the cost of living in the Philippines is lower than in developed countries. The Filipino-American community in the US is a major market that should be tapped. Another is Japan, although it is relatively more difficult to uproot the Japanese retirees from their homeland unless the government will strongly support and recommend the Philippines as a retirement destination. Japan has a dollar per capita income of over US$30,000—30 times more than the Philippines'. The daily cost of hospitalization in the Philippines is also 30 times lower than in Japan while medical charges in the Philippines are nine times lower (Padojinog and Rodolfo 2004).

The dwelling units in the Philippines also cost less. At the same time, they provide more living space for the household. At present, there is no need to construct new settlements just to serve the retirees. The soft property market currently prevailing in the Philippines has caught many developers of both subdivision and condominiums with large inventories of unsold units. With some adjustments in the standard of construction and amenities, many of these housing developments can be relaunched or remarketed as retirement villages or clusters or lifestyle communities. Active retirees prefer to still live in the metropolis and simply spend some activities in the countryside.

The Philippines takes pride in its archipelagic nature and relatively abundant tourism resources, including its network of hospitals, clinics, retirement facilities, and medical schools (Table 9). The major healthcare providers in the country consist of 1,723 licensed private and public hospitals that have a combined bed capacity of 85,040. The 1,069 private hospitals account for 47 percent of total bed capacity. Out of the 654 government owned and operated hospitals, the 72 retained Department of Health (DOH) hospitals have a total of

23,755 beds or 28 percent of the total beds of government hospitals. A profile of the hospital industry in the Philippines is given in Appendix 2.

Table 9. Average number of beds in private hospitals

REGION	Primary			Secondary			Tertiary			TOTAL		
	1997	1999	2003	1997	1999	2003	1997	1999	2003	1997	1999	2003
RP TOTAL	15	14	14	30	29	33	130	128	127	34	35	38
I	11	12	12	26	27	31	94	86	78	22	22	22
II	12	11	11	20	30	33	100	50	50	17	18	19
III	10	11	12	21	22	22	72	75	78	22	24	27
IV	12	12	4	25	25	48	84	84	87	28	29	29
V	13	13	20	27	28	27	61	65	62	20	21	28
VI	16	16	75	36	38	33	160	174	184	69	71	95
VII	16	17	16	39	40	40	127	126	165	56	56	73
VIII	14	14	14	26	31	28	113	113	113	25	26	26
IX	14	13	14	31	32	28	70	87	87	21	23	24
X	16	15	15	40	41	38	99	92	89	27	27	29
XI	20	19	19	50	44	36	115	110	110	31	31	32
XII	16	14	14	37	33	34	73	73	71	25	23	25
NCR	17	15	16	34	31	36	216	211	199	84	86	87
CAR	15	16	17	36	32	31	160	160	160	28	27	32
ARMM	16	17	20		15					16	17	20
CARAGA	16	17	12	32	32	42	75	82	67	24	26	22

Source: Department of Health.
Note: Shaded regions are those with an average number of hospital beds which is greater than the national average

Additionally, there are government specialty hospitals that have become known for providing quality medical care. These are the National Kidney and Transplant Institute, Philippine Heart Center, and the Lung Center of the Philippines. There are private clinics (e.g. Asian Eye Institute, American Eye Center, Makati Laser Eye Center, Eye Republic, Belo Medical Clinic, and Calayan Center) and individual practitioners who have gained expertise and reputation in their field (Dacanay and Rodolfo 2005).

The network has its own weaknesses that can affect the country's ability to service the demand of the health tourism and retirement markets. First, there are only about three destination spas in the Philippines compared to Thailand and Indonesia that have more. This can limit the economic opportunities for the industry.

Second, there are no clear directions yet on the accreditation system for the health tourism and retirement programs. International accreditation has been cited as an important requirement for insurance portability. To date, only St. Luke's Hospital is accredited by the Joint Commission International, an accrediting body based in the US. Nevertheless, there are already some ISO-accredited hospitals and this accreditation is what matters to the European and Asian markets (particularly Japan). Some providers are already able to attract markets in Guam and other Micronesian states, the US, Australia, and India, even without international accreditation at this point. Needless to say, international accreditation is needed to expand the market base. In the short term, while providers are beefing up their financial resources, a high quality local accreditation scheme can be applied.

Third, the network lags behind in terms of health information infrastructure and management systems (e.g. information documentation, processing and dissemination). This is one reason why most facilities are not yet ready for international accreditation and the integration of telemedicine in their everyday practice.

Fourth, there is a maldistribution of bed capacity (Dacanay and Rodolfo 2005). In the National Capital Region (NCR), the ratio is 371 patients per bed while in the Autonomous Region of Muslim Mindanao, the ratio is 3,872 patients per bed.

Fifth, private hospitals are closing down due to lack of patients and fast turnover of healthcare workers. The social healthcare financing has not significantly improved based on the Health Sector Reform Agenda (Appendix 3). Healthcare delivery and financing are interdependent. Healthcare financing does not only reduce the cost of healthcare, it also increases the ability of individuals to secure health services. The benefits and services offered by the healthcare financiers also impact on the providers. With the additional financial support from healthcare financing, people have greater access to healthcare providers. Moreover, because one is dependent on the other, policies that are directed to one part of the system also affects the other in terms of costs and benefits.

Lastly, there is still a lot of work to be done—from the airport infrastructure side to providing ease of entry and exit to consumers from abroad.

Human Resources

The Philippines' greatest strength is people. Its healthcare professionals have earned the global reputation of providing competent and compassionate care to patients. Two important questions have to be considered, however. Does it have the manpower to serve its own people as well as the foreign markets? How can it sustain the quality of care?

Data from the Professional Regulatory Commission (PRC) reveal that there are almost 100,000 licensed physicians in the country (Table 10). This is supported by a network of schools that produce medical and health sciences graduates—a total of 30,000 per year.

Table 10. Supply of health professionals

PROFESSION	AS OF FEB. 10, 2006
DENTISTS	*47,758*
MIDWIVES	*146,296*
NURSES	*390,059*
NUTRI DIETITIANS	*12,374*
OPTOMETRISTS	*9,636*
OCCUPATIONAL THERAPISTS	*2,286*
PHYSICAL THERAPISTS	*19,454*
PHYSICIANS	*98,240*

The Philippines has the pool of health professionals but as mentioned earlier, there is maldistribution (Galvez-Tan 2005; Rodolfo, this volume). For instance, around half of the surgeons are highly concentrated in the NCR. Enrollment in medicine and allied courses, except for nursing, has declined in the previous years (Table 11). Thus, lesser number of medical graduates is expected in three to four years' time. The number of National Medical Admission Test examinees has also dipped from 6,245 in 2000 to 2,912 in 2005. Doctors are leaving the country to work as nurses abroad primarily for economic reasons. Registered nurses earn an average of US$150 per month in the Philippines (Galvez-Tan 2005) whereas nurses in the US earn about US$4,000 per month and has the opportunity to bring their families. Any move to increase the salary scale of registered nurses by at least three to four times its current level may help abate the increasing migration. A government subsidy or grant could encourage trained nurses to stay. A fourfold salary increase equates to human capital investment that would convey huge marginal benefits for the smooth functioning of the healthcare system. There is also a concentration of medical and health science schools in

the NCR, Southern Luzon, Ilocos Region, and Western and Central Visayas. Mindanao suffers not only from the lack of access to healthcare facilities but also from the lack of medical schools.

Table 11. Enrollment in Medical Schools

Schools	Quota	2001-02	2004-05	Percentage Increase
Angeles University Foundation	150	72	30	-58.3%
Bicol Christian College of Medicine	160	25	19	-24.0%
Cebu Doctors College of Medicine	200	120	99	-17.5%
Cebu Institute of Medicine	260	115	77	-33.0%
Cagayan State University	80	33	19	-42.4%
Davao Medical School Foundation	160	88	100	13.6%
De La Salle University - EAC	200	257	117	-54.5%
Far Eastern University	360	379	248	-34.6%
Iloilo Doctors College of Medicine	160	78	20	-74.4%
Lyceum Northwestern	160	57	19	-66.7%
Manila Central University	210	148	54	-63.5%
Mindanao State University	80	42	54	28.6%
Pamantasan ng Lungsod ng Maynila	160	160	135	-15.6%
Remedios Romuladez Memorial Foundation	80	73	30	-58.9%
Saitn Louis University	160	112	64	-42.9%
St. Luke's College of Medicine	120	128	76	-40.6%
South Western university	210	138	78	-43.5%
UERM-MMC	360	309	200	-35.3%
University of Sto. Tomas	410	421	440	4.5%
University of the Philippines		167	160	-4.2%
university of Visayas	160	80	40	-50.0%
Virgen Milagrosa University Foundation	160	68	24	-64.7%
West Visayas State University	160	99	100	1.0%
Xavier University	100	55	63	14.5%
Zamboanga Medical School Foundation	80	30	33	10.0%

Source: Association of Philippine Medical Colleges

In medical transcription, a major concern faced by the industry is the lack of workers to service the demand. According to the MT Academy report, there were merely 5,000 professional medical transcribers in the Philippines from only 40 medical transcription firms, a small number compared with the 100,000 workers in the call center industry. A deterrent to the entry of graduates from the nonmedical allied courses is the opportunity cost of additional training that is usually conducted for six months.[1] Some find it more worthwhile, however, to

[1] The training basically consists of three modules and costs P20,000 per module or a total of P60,000–P75,000 for all modules. The cost is borne by the prospective applicants. The lack of English skills also makes companies spend on English language modules. Graduates of medical and allied courses can cut short the training to three months or even lessand focus on two modules only—mostly on the Medical Style and Grammar and Medical Transcription Technology.

spend on caregiving training as caregiving is an entry point to work abroad and seems to have better opportunities for their families.

Even if the Philippines has the available manpower, the deteriorating quality is an issue. Seemingly, low passing marks in the board exams is becoming a trend. A number of established nursing schools are enjoying high enrollment rates but the number of graduates and board passers continue to decrease each year. There is indeed a need to improve the curriculum of these schools in order to improve the quality of nursing graduates. An alternative career path can be pursued for those who do not take and/or pass the board exams. This would improve the future pool of human resources.

As the Philippines positions itself in health tourism and retirement, the industry must address the tension related to the entry of foreign medical professionals in medical and retirement facilities. Again, a strategic framework is needed as guide to this venture. In what specialty areas can foreign doctors be allowed to practice? Under what arrangements can they be allowed to practice? What is the spectrum of services or participation for their entry? Some conditions regarding practice can be explored such as allowing foreign doctors to stay in the country within a specific period of time only. This can be done together with a team of Filipino doctors who will be trained to specialize in relevant fields.

The Philippines has experience in setting up foreign presence abroad given the franchising models in retail store operations. Locally, franchising has been done in services such as spas and clinics like the Belo Medical Clinic. Models for expanding the presence of hospitals and other clinics are needed. These overseas franchises can start in communities with relatively large Filipino population. This is the same strategy pursued by the Apollo Clinic of India.

As regards attracting investments to the Philippines, there is a network of medical schools that can be positioned for joint ventures to encourage foreign students. There is also a network of hospitals, particularly tertiary hospitals, that can be upgraded to service the health tourism and retirement markets.

There is no doubt that markets exist. Demand is already high relative to the supply capabilities of the OECD countries and the developing countries in Asia. For years, the

markets have been the US and the UK for the deployment of healthcare workers. But the result has been the permanent migration of health professionals along with their families, which translates to the disintegration of the local healthcare system. It is therefore critical to develop, devise, and set up a health service enterprise that takes into consideration the brain drain risks.

This is where Mode 2 comes in. It is the point where citizens of OECD countries come, visit, spend time, and eventually retire in the Philippines. It would be very significant in the sense that their consumption and medical care expenditures in the country will create multiplier effects on the local economy. Tourism, for instance, has the capability to generate direct and indirect effects of around PhP2.25 for every PhP1.00 spent by a tourist. This goes with the existing tourist attractions already in place like holiday spots, malls, among others. However, it is not yet very clear which markets to tap in the short, medium, and long terms for medical tourism and retirement.

The Philippines can also enhance telehealth-related products and services (Mode 1) and commercial presence (Mode 3). Telehealth is an unexplored service that can be provided to neighboring Asian countries. It can be in the form of tele-education between top hospitals and schools. Telediagnosis is also part of prehealth and posthealth tourism. Perhaps in the medium term, the top facilities in the country can consider expanding their presence abroad, set up satellite clinics or offices, and contribute to revenue generation. Such mode can be linked to telehealth of Mode 1 when these satellite offices send their diagnosis via telemedicine to their main facilities here in the Philippines. Such arrangement can likewise serve to prepare patients for health tourism. Post telediagnosis can therefore serve as another revenue source when these patients return to their country of residence.

Encouraging foreign investments would help local hospitals upgrade their health facilities and services. Partnerships with healthcare providers in other countries would also provide the opportunity for technology transfer and improvement of human resource capability. Asian Hospital, for instance, has partnered with Bumrungrad International.

The Philippines should also consider the strategy of Australia in medical education. To facilitate the flow of foreign patients to public and private clinics, Australia established a medical visa. Australian medical schools also created specialized international departments,

set up joint ventures with foreign universities, and opened medical schools in the target markets. Incomes earned from overseas training activities have contributed up to 20 percent to the budget of Australian universities. The Philippines can explore this mode in order to increase the scholarships for Filipinos and improve the human infrastructure.

China's strategy of forming health teams to work abroad on contract—both in the framework of aid programs or strictly on a commercial basis—may be worth pursuing as well. Under this scheme, Chinese institutions enter into agreements with foreign governments or directly with medical institutions. Furthermore, it has opened access to more than a dozen traditional Chinese medicine and medical facilities in more than 20 countries. This is the same strategy being pursued by India's Apollo Clinic which is also looking at the Philippines for its expansion program. This strategy requires developing a brand of services to be exported abroad. Singapore's Parkway Health Group developed the Gleneagles International brand as part of its strategy. The Raffles Medical Group is building up strategic alliances overseas by partnering with healthcare organizations from developed countries.

OTHER STRATEGIC OPTIONS

There is a need for a roadmap that will address the sustainability of the health services sector under a globalized healthcare environment.[2] A common denominator among countries that are exploiting the global opportunities of the health services sector (such as Australia, Canada, Cuba, Jordan, India, Sweden, and UK) is the existence of a national structure to coordinate and promote participation in the global market. Their export strategies highlight the strong linkages between domestic production and external markets of healthcare services. A public-private mix is ideal for the Philippines since this will optimize scarce resources and create a forum for addressing political issues and other concerns.

Such a national structure is important to bring together all sectors and networks to develop a common vision and strategies. A key concern is to increase awareness on the capabilities of the various firms and the modes of health services the country can trade. A further interest is to identify barriers and obstacles that hinder market access to local and foreign clients. Fostering cooperation in an environment of competition is essential.

[2] The PPP Task Force main objective is to increase the export competitiveness of health and wellness and not the entire

Developing and maintaining a database of suppliers and clients is a tool to determine business strategies.

In the Philippines, related questions include the following: What is that national structure? Who is the authority behind this national structure? Is it the PPP Task Force on Export Competitiveness (E.O. 372) or the National Economic and Development Authority (NEDA)? At this stage, it is the Task Force that should align the initiatives for wellness, medical tourism, and retirement and even the entire health services sector. Such alignment will help provide a wholistic approach and strengthen the linkages between domestic production and external markets for healthcare services

The Philippines can consider the models of other countries:

- The London Medicine was created in 1993 with sponsorship and support from the national government as well as private medical and business communities. It has two main objectives: (1) to promote and develop business opportunities for London Medicine's affiliates so as to increase the flows of clinical, educational, and research work in London hospitals and medical schools, and (2) to attract research contracts and investment from British and international companies.

- Australia established the National Health Industry Development Forum in 1994 and set up a program of assistance to private firms. It is geared toward bringing various health industries together and developing a common focus. The Forum is jointly convened by the ministries of industry and health, with the support of Austrade. As part of its export strategy, Australia is focusing on the modes of cross-border trade and movement of consumers.
- Singapore also has its own Singapore Medicine that has consciously repositioned the country as a medical hub by focusing on more complicated procedures that do not directly compete with Thailand.

Based on the previous sections, there are four areas where strategies are needed.

Market Niching and Product Development

- *Strengthen domestic market base*. Word-of-mouth advertising and promotion can be an effective tool to convince and encourage the more affluent segment of the local population and subsequently the foreigners to consider the healthcare services in the country.
- *Define the product*. The private sector and the government (DOH, DTI, DFA, and DOT) should work together to define what the embassies and commercial posts can promote abroad.
- *Identify specific markets* for telemedicine, health tourism and retirement, and medical schools, and conduct a more detailed competitor analysis so the gaps can be identified and matched with existing strengths. Development and promotions of non-invasive procedures can spearhead the health tourism program. The retirement industry can focus more on the active retirees given that there are hardly any ready and fully integrated facilities that can be promoted to more discriminating markets such as Japan and the European countries.
- *Acquire market intelligence*. This is needed by private stakeholders. This is where the linkages with government can be exploited through the services provided by commercial and diplomatic offices abroad. Such service can reduce search costs on the part of the private sector.
- *Develop and strengthen global linkages*. To upgrade capabilities, increase the access to medical technology and expertise, and facilitate the entry of foreign clients (e.g. students, patients, retirees), local hospitals and schools should develop strategic alliances with foreign institutions (e.g., hospitals and schools). This initiative can be pursued by the Private Hospital Association of the Philippines or the Philippine Hospital Association, with support and guidance from the DOH, the Commission on Higher Education (CHED), and the Professional Regulatory Commission (PRC) in terms of rules and guidelines.

Human Resources Development

In the previous section, three main concerns related to human resource development were raised:

1. how to encourage healthcare workers to stay in the country;
2. how to provide economic opportunities to them via exportable health services; and
3. how to enable them to improve their services.

To address these, the following strategies are recommended:

- *Develop a national policy and a national plan on health human resources* (PMA 2005). This will include a national database on human resources development and local health professional registries. The policy should likewise address the maldistribution in human resources and medical schools.
- *Adopt interventions to increase the supply of healthcare workers*. One suggestion to increase the number of applicants in medical schools is to decrease the cost of medical education by tapping other sources of funds such as government (through subsidies or scholarship programs), business and philanthropic institutions, legislators through their countrywide development fund, and foreign students. Another is to actively recruit students through a coordinated marketing program with the C HED and the Department of Education.
- *Review the curricula for medicine and health sciences education* to properly prepare the graduates to the new healthcare environment. The curricula should be able to equip students with the proper knowledge, skills, and mindset to effectively serve both local and foreign patients and retirees. Schools that have zero or very low passing rates in the board exams should be phased out.
- *Strengthen the linkages between the academe and the hospitals and other healthcare providers* to address the mismatch between skills required by the industry and the graduates of medical and health sciences schools and to improve enrollment in health sciences courses.
- *Institutionalize continuing education programs for healthcare professionals*. This can be done through the PRC as requirement for license renewals. Associations and hospitals can likewise help support this program to keep the professionals up to date with the changes in economic, cultural, social and technological trends in healthcare delivery.
- *Manage migration of healthcare professionals* by: (a) negotiating with foreign governments or recruiting institutions for compensation schemes or equity; (b)

providing economic opportunities through health tourism, retirement and tele-health activities; (c) rationalizing distribution of schools and healthcare facilities; and (d) increasing coverage and health benefits for Filipinos. Any initiative of the national government to increase health benefits would certainly augment the incomes of healthcare professionals by at least 30 percent. A rise in healthcare spending due to additional benefits like health insurance would increase the demand for healthcare. As a whole, strengthening the capacity of PHILHEALTH as a health insurer is likely to achieve a strong ripple effect for the development of other sectors in the healthcare industry, particularly among its providers.[3]

- *Strengthen the initiatives of healthcare professionals to establish clinics or network of professionals for group practice.* This can provide economic opportunities and enhance development of clusters of providers. Some models are already observed in cosmetic surgery, eye care and dental treatment.

Industry Infrastructure

The main concern is the right infrastructure the industry needs to deliver quality services to domestic and foreign markets. The following strategies should be considered:

- *Do an inventory of facilities and capabilities of medical providers and allied industries* (e.g. schools, tourism providers, associations). This is needed to identify critical skills and gaps in healthcare services and facilitate the development of linkages and clusters of providers and expertise
- *Define incentive schemes for hospitals, clinics, retirement villages, wellness providers (e.g., spas), and schools* to encourage them to support the local and international healthcare service industries. There are no clear incentives systems for the health services sector as a whole. The investment environment must be clearly defined under the wings of the Board of Investments and the Philippine Economic Zone Authority (PEZA). Local hospitals that are starting with their

[3] The Thai government is aggressively making healthcare accessible for all starting 2002 This move is foreseen to increase the demand for healthcare services by public or private providers. The contingency fund of Baht 5.168 million for the development of hospitals facing deficits and another Baht 5.168 million for human resource development is expected to transform the healthcare sector in Thailand in two to three years to be at par with internationally accredited healthcare providers. The additional healthcare insurance benefit made available by the Thai government is meant to increase the utilization of existing facilities to promote medical tourism particularly for outpatient care (e.g., health promotion, primary care, and sickness prevention). This caters to both foreign and local markets.

medical tourism programs are concerned about the dual incentive structure that favor institutions with larger foreign patient base.

- *Map out initiatives and implementation schedule for accreditation of hospitals and retirement facilities* by local and/or international accrediting bodies to promote quality healthcare services for both local and foreign clients.
- *Map out clusters of services that can be promoted as well as clusters of facilities that can be linked up* to build an efficient referral system which is highly needed by the retirement industry.
- *Improve marketing infrastructure*. There is a need to increase the country's presence in the meetings, incentives, conferences and events (MICE) market by providing competitive bids for medical meetings or congresses. This is a way by which the Philippines can expose the capabilities of its health professionals and become a health hub. Travel, medical, and educational associations can hold symposia or meetings to discuss the latest issues and propose strategies to the government. The medical sector should also participate in talks regarding the liberalization of the health services sector. There is also a need for travel agencies, medical providers, and allied services to link up their core competencies in order to focus on delivering quality service.

Trade Negotiating Issues

In studying trade in health services, there are two important classification lists that should be used as reference—the UN Central Product Classification List and the GATS Classification List. The commitments of countries to liberalize the health sector are based on Section 8 of the GATS List. However, in discussing the four modes of supply defined above, there is a need to refer both to the UN CPC Division 93 and the GATS List. To illustrate, Table 12 reveals that under the GATS, health and social-related services are defined under Section 8. These include hospital services, other human health services, and social services. However, trade in health services also covers the export of medical professionals that are not covered in Section 8 but are in Section 1 (Professional Services) of the GATS List. As noted by the WTO Secretariat (1998), such delineation between Sections 1 and 8 tends to ignore the strong complementarities between medical services and hospital services.

Table 12. Health and social services in the GATS Scheduling Guidelines and the UN Central Product Classification (CPC) List

Sectoral Classification List under GATS	Relevant UN CPC No.	Definition/Coverage in provisional CPC
1. Business Services		
a. Professional Services		
h. Medical and dental services	9312	Services chiefly aimed at preventing, diagnosing and treating illness through consultation by individual patients without institutional nursing
i. Veterinary Services	932	Veterinary services for pet animals and animals other than pets (hospital and non-hospital, medical, surgical and dental services)
j. Services provided by midwives, nurses, physio-therapists and paramedical personnel	93191	Services such as supervision during pregnancy and childbirth… nursing without admission care, advice and prevention for patients at home
k. Other	n.a.	N.A.
8. Health Related and Social Services		
a. Hospital services	9311	Services delivered under the direction of medical doctors chiefly to inpatients aimed at curing, reactivating and maintaining the health status
b. Other Human Health Services	9319 (other than 93191)	Ambulance Services; Residential health facilities services other than hospital services
c. Social Services	933	Social Services with accommodation[(a)] ; social services without accommodation[(b)]

[a] Welfare services delivered through residential institutions to old persons and the handicapped (PPC 93311) and children and other patients (93312); other social services with accommodation (93319).
[b] Child daycare services including daycare services for the handicapped (93321); guidance and counseling services not elsewhere classified) related to children (93322);welfare services not delivered through residential institutions (93323); vocational rehabilitation services excluding services where the education component is predominant (93324); and other social services without accommodation (CPC 93329).

Sources: UN Statistical Classification System; World Trade Organization; Gonzales et al (2001).

There are other issues related to the sectoral classification list of the GATS on health services. Consider activities such as health tourism (spas, cosmetic surgery for aesthetic purposes, convalescent care, and rehabilitation of local health services by tourists) as defined

in Mode 2. Section 8 is not specific to activities aimed at providing specialized treatments to tourists. The use of spas can be categorized as professional services offered by midwives, nurses, physiotherapists, and paramedical personnel provided they involve some treatment with a medical doctor located in the premises as some wellness programs do (Gonzales et al. 2001). As far as health services are concerned, the export data are currently reflected in various accounts. In the case of medical transcription or outsourcing, the export figures are part of communication services. For health tourism, the data are part of travel and tourism. The revenues generated by medical professionals working abroad are reflected as overseas workers' remittances.

Most of the members have unbound commitments on Mode 1, which means they are free to introduce any new measure regulating foreign service provision in the domestic market— both in terms of market access and national treatment (Table 13). The Philippines has not made any commitments in the GATS (Table 14). To this end, the government and the private sector should work together to use trade to the country's advantage by considering the linkages across all modes of supply. For example, if infrastructure investments are needed and capital is lacking, then the Philippines can explore commercial presence through incentives to foreign providers. But what should be the conditions in the establishment of commercial presence? If 100 percent foreign ownership is allowed, how can the country ensure the transfer of technology and systems, and the capability building for research and development? How can these FDIs increase equity to healthcare services and sustain human resources for health? What are the monitoring mechanisms to ensure this access? The FDIs can serve as an entry point for foreign expertise but the country should set some conditions. For instance, the government may allow the entry of foreign experts for a specific period of time, or only require a certain percentage of the total workforce to be filled up by foreign experts. The specific fields of expertise needed can be determined by studying the critical skills required vis-à-vis current gaps.

The following strategies should be considered:

- *Develop a framework for linking trade* in international health services with the domestic healthcare system.

- *Pursue mutual recognition agreements (MRAs)* for the healthcare professionals on bilateral basis (or regional if possible). The proposed MRAs should be developed by the private sector, specifically associations, and the government.
- *Build the capacities of the health services stakeholders (e.g., government, private sector, civil society)* to understand the GATS and the opportunities its offers. Capacity building will enable the stakeholders to define a position on liberalization may lead to improvements in the local healthcare situation. There is a need to consolidate the position of the different stakeholders in order to strengthen the overall bargaining position of the country in the health services trade and address the imbalance due to the rapid migration under Mode 4.
- *Measure the economic contributions of tradable health services* for use in negotiations, policymaking, and industry and business planning. This can be initiated by the National Statistical Coordination Board and the National Statistics Office with from the DOH, Department of Tourism, Department of Trade and Industry, the National Economic and Development Authority, and various associations and private providers.

Table 13 . Overview of commitments for Modes 1, 2 and 3 on medical, health-related and social services

SECTOR	Number of members (Full commitment for Modes 1-3)[a]	Cross border supply			Consumption abroad			Commercial presence		
		Full	Limited	Unbound	Full	Limited	Unbound	Full	Limited	Unbound
Medical and dental services	49(12)[b]	17	6	26	38	7	4	19	24	6
Veterinary services	37 (10)[c]	17	2	18	33	1	3	19	14	4
Midwives, nurses etc.	26 (4)[d]	6	4	16	21	5	0	10	16	0
Others	3 (1)[e]	2	1	0	2	1	0	1	2	0
Hospital services	39 (9)[f]	11	1	27	31	5	3	18	17	4
Other human health services	13 (6)[g]	6	1	6	6	5	2	8	4	1
Social services	19(2)[h]	3	0	16	4	13	2	5	13	1
Other health and social services	3(2)[I]	2	1	0	2	1	0	2	1	0

[a] Full commitments for both market access and national treatment and no limitations in sectoral coverage.
[b] Brunei Darussalam, Burundi, Congo, Gambia (subject to horizontal limitations for Mode 3), Guinea, Hungary, Iceland (subject to language requirement), Malawi, Norway, Rwanda, South Africa, and Zambia.
[c] Australia, Burundi, Congo, Finland, Gambia, Lesotho, Singapore, Qatar, South Africa, Saudi Arabia, (subject to horizontal limitations for Mode 3).
[d] Gambia (subject to horizontal limitations for Mode 3).
[e] Iceland.
[f] Burundi, Ecuador, Gambia (subject to horizontal limitations for Mode 3), Hungary, Jamaica, Malawi, Saint Lucia, Sierra Leone, Zambia.
[g] Gambia (subject to horizontal limitations for Mode 3), Hungary, Malawi, Sierra Leone, Zambia.
[h] Hungary, Sienna Leone.

Sources: WTO (1998); ITC (2002).

Table 14. Summary of specific commitments in GATS

	Philippines	Thailand	Singapore	Malaysia	India	Indonesia
Accounting and finance		X	X	X		
Advertising		X	X	X		
Legal		X		X		
Architectural and engineering		X	X	X	X	X
Telecommunications	X	X	X	X	X	X
Audiovisual		X	X	X	X	
Construction/engineering		X	X	X	X	X
Distribution		X				
Education		X				
Health			X	X	X	
Travel and tourism	X	X	X	X	X	X
Recreation/culture/sports						
Transportation	X	X				
Courier			X			

Source: ITC (2002)

Appendix 1. Health tourism

USA

The United States is a major exporter of health services as evidenced by the relatively significant flows generated by institutions such as Mayo Clinic, Johns Hopkins Medical Center, and the Massachusetts General Hospital from Mexico, Argentina, and even Arab countries (WTO 1998). It has the first mover advantage in capturing the movement of patients across borders.

Cuba

The Servimed in Cuba has been tapped to generate foreign exchange earnings from the sale of health tourism packages and to establish joint ventures. Its competitive advantage lies in viable prices due to low labor costs, highly qualified health professionals, and certain exclusive treatments that are successfully drawing patients from Latin and North America. Its health tourism program is highly supported by the government.

Thailand

Singapore is facing stiff competition with the Bumrungrad Hospital (now Bumrungrad International) of Thailand. Today, the Private Hospital Association, which has more than 185 members, has been supporting this health tourism project. Available treatments include dentistry, ophthalmologic surgery, and plastic surgery, among others. Services in Bangkok can be 50-70 percent cheaper than the costs charged in Singapore. Around 800,000 foreign patients were treated in Thailand in 2003, generating US$470 million in revenues. The major markets of Thailand today are the Japanese, Americans, and British. The Bumrungrad Hospital treated 350,000 patients in the same year. The infrastructure and marketing investments of Bumrungrad helped increase the international patient volume by 57 percent between 1999 and 2001 while revenue contribution from international patients reached 37 percent . Bangkok's International Medical Centre also offers services in 26 languages, recognizes cultural and religious dietary restrictions, and has a special wing for Japanese patients.

Malaysia

Malaysia is another country whose stakeholders are convinced about the value of health tourism as a major growth engine. Under the 8th Malaysia Plan, the government identified health tourism as a growth driver in 1998 and created the National Committee for the Promotion of Health Tourism in Malaysia. The Committee is tasked to spearhead the development of the medical and long-stay programs, and to promote Malaysia as a "second home" for international tourists. The Committee is composed of airlines, hospitals, travel and tourism agencies, and the Malaysian Industrial Development Authority. Five subcommittees were created to address the issues of: (a) identification of markets; (b) tax incentives; (c) fee packaging; (d) advertisement; and (e) accreditation. In 2003, there were 100,000 health tourists, an increase of 18.2 percent from 2002. Of the total number, 60 percent were from Indonesia and 10 percent were from Brunei, Vietnam, Singapore, and Thailand. The rest were from West Asia, South Asia (Bangladesh and India), and Japan. Total revenue was estimated at US$10 million. Cardiology and general surgery services have the highest demand among foreign patients. The Middle East is a major target market given the large annual medical expenditures in these countries. The government aims to generate around US$1 billion in revenues from health tourism alone by 2010.

Singapore

Singapore is another aggressive player in the field serving its immediate regional markets. An estimated 150,000 foreign patients sought treatment in Singapore in 2000 and spent about S$345 million a year in healthcare. Based on figures from the Ministry of Health, most of the patients were from Malaysia and Indonesia (70-85%). Today, Singapore does not compete on the basis of price alone but is boosting its image as a destination with high standards of healthcare. Singapore is positioning itself as a center for health and wellbeing (e.g., health screening, aesthetic and antiageing therapies) and for the treatment of various illnesses. It also intends to establish one-stop centers in key regional markets to make it more convenient for foreign patients to come to Singapore. It aims for one million international patients per year by 2012 and total revenues worth US$2 billion.

Appendix 2. The private hospital industry in the Philippines

Private hospitals are classified according to levels of complexity or specialization. The hospital system in the Philippines basically follows a three-tier mode: primary, secondary, and tertiary. Each level has well-defined roles, functions, capabilities, facilities, organizational structure, and staffing standards. This categorization allows the provision of a hierarchy of services utilizing appropriate resources at each level. The following table shows the distribution of hospitals by category in 1997-2003.

Table A1. Average number of beds in private hospitals.

REGION	Primary			Secondary			Tertiary			TOTAL		
	1997	1999	2003	1997	1999	2003	1997	1999	2003	1997	1999	2003
RP TOTAL	15	14	14	30	29	33	130	128	127	34	35	38
I	11	12	12	26	27	31	94	86	78	22	22	22
II	12	11	11	20	30	33	100	50	50	17	18	19
III	10	11	12	21	22	22	72	75	78	22	24	27
IV	12	12	4	25	25	48	84	84	87	28	29	29
V	13	13	20	27	28	27	61	65	62	20	21	28
VI	16	16	75	36	38	33	160	174	184	69	71	95
VII	16	17	16	39	40	40	127	126	165	56	56	73
VIII	14	14	14	26	31	28	113	113	113	25	26	26
IX	14	13	14	31	32	28	70	87	87	21	23	24
X	16	15	15	40	41	38	99	92	89	27	27	29
XI	20	19	19	50	44	36	115	110	110	31	31	32
XII	16	14	14	37	33	34	73	73	71	25	23	25
NCR	17	15	16	34	31	36	216	211	199	84	86	87
CAR	15	16	17	36	32	31	160	160	160	28	27	32
ARMM	16	17	20		15					16	17	20
CARAGA	16	17	12	32	32	42	75	82	67	24	26	22

Source: Department of Health.
Note: Shaded regions are those with an average number of hospital beds which is greater than the national average

The DOH gives a more specific classification of the three levels. The tertiary level is composed of specialty centers, specialized hospitals, medical centers, regional hospitals, and provincial or general hospitals. Tertiary hospitals have capabilities and facilities for providing medical care to cases requiring sophisticated diagnostic and therapeutic equipment and the expertise of trained specialists in the subspecialties. In particular, specialty centers are equipped with expensive and sophisticated diagnostic and therapeutic facilities for a specific medical problem area. These are hospitals with fully departmentalized service capabilities and certified medical specialists and other licensed physicians in the field of medical science such as pediatrics, obstetrics and gynecology, surgery, and other subspecialties and ancillary services. These are large-scale hospitals with bed capacities ranging from 50 to over 700. Their medical equipment and facilities are usually the most advanced and are constantly upgraded. They are also considered as teaching and training hospitals.

The secondary level consists of district hospitals with capabilities and facilities for cases requiring hospitalization. It also has the expertise of trained specialists. Like tertiary hospitals, they have the support of licensed physicians in the medical sciences and operate as admitting medical centers. They have bed capacities ranging from 10 to 69. Occupancy rates range from 30 to 60 percent.

The primary level is composed of municipal and Medicare-affiliated hospitals that have facilities and capabilities for first-contact emergency care and hospitalization of simple cases. These are hospitals equipped with the service capabilities needed to support licensed physicians rendering services in medicine, pediatrics, obstetrics, and minor surgery. Bed capacity ranges from 6 to 25. Due to the limited number of beds and facilities, hospital operations are not centered on inpatient activities. Primary hospitals operate more as outpatient clinics than as admitting medical centers.

On average, medical personnel (doctors, nurses, midwives, and medical technicians) are present for every bed in a primary hospital. Doctors and nurses are employed as general practitioners or professionals. The average number of doctors for secondary hospitals is 14, mostly resident physicians. Especially in the rural areas, these hospitals experience difficulty in attracting doctors. On average, secondary hospitals maintain 1.06 medical personnel for every bed.

Tertiary hospitals have an average of 145 doctors. No difficulty is experienced in attracting doctors because of the perceived prestige attached to tertiary hospitals. Many tertiary hospital administrators believe that they have a greater responsibility in providing quality healthcare. The average medical personnel-to-bed ratio maintained by tertiary hospitals is 2.28. An interview with industry participants revealed that tertiary hospitals need an initial capital of about PhP5.6 million per hospital bed. Financial viability can only be achieved upon reaching 500 beds. Breakeven point happens on the tenth year of operation.

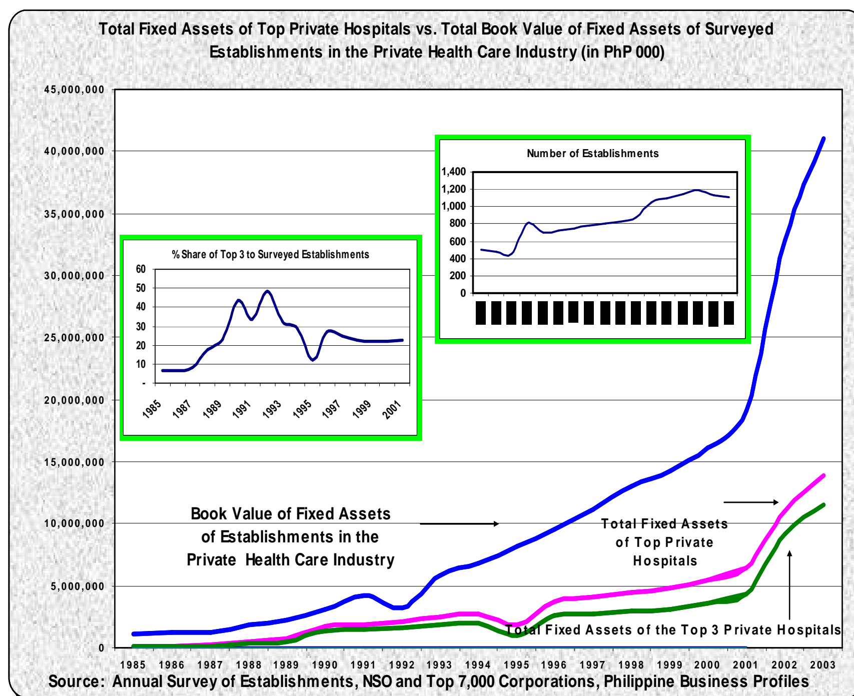
Each hospital is divided into several departments. Although the number of these departments varies according to specialization, eight departments can be distinguished: (1) cardiology department; (2) respiratory therapy; (3) laboratory; (4) surgery; (5) radiology; (6) emergency room; (7) coronary care unit; and (8) pulmonary care unit.

The distribution of private hospitals by category as of 1997 can be characterized by the clustering of hospitals in areas with relatively high income level such as the National Capital Region (NCR), and Regions 3 and 4. For instance, NCR has an average of 200 beds per tertiary hospital whereas Regions 3 and 4 have an average of 100 beds per tertiary hospital. The larger, more financially viable tertiary hospitals in the NCR have about 300 to 600 beds.

The financial viability of the private hospital sector is currently threatened, hampering its ability to engage in expansion programs and social services such as medical missions. This explains the marked decrease in the number of hospitals and beds from 1964 to 2003. Among the major problems besetting the sector include the increasing hospital operating expenses, high level of bad debts and uncollected accounts, increasing costs of capital expenditures (building expansion or equipment purchase), generally poor management skills and shortage in the supply of hospital management specialists, delayed reimbursements by Medicare, scarcity in long-term financing and high loan default rates, maldistribution of hospital facilities especially in urban areas, and low paying capacity for hospital services of the greater percentage of the population. Private hospitals may have improved their productivity in the past years but their capacity (in terms of number of beds per population) has not significantly increased.

Private hospitals account for the majority of fixed asset investments in the healthcare industry. From 2000 to 2003, the healthcare providers that had the biggest fixed asset investments were the top three hospitals in the NCR—St. Luke's Medical Center, Professional Services, Inc. (Medical City), and Medical Doctors, Inc. (Makati Medical Center). These hospitals accounted for 22 percent of total book value of fixed assets in the private healthcare sector. They invested a total of PhP8 billion in fixed assets from 2000 to 2003, which is equivalent to 33 percent of the total amount needed to modernize government hospitals and healthcare facilities (Figure A1)

Figure A1. Total fixed assets of top private hospitals vs. total book value of fixed assets of surveyed establishments in the private healthcare industry (in PhP '000)

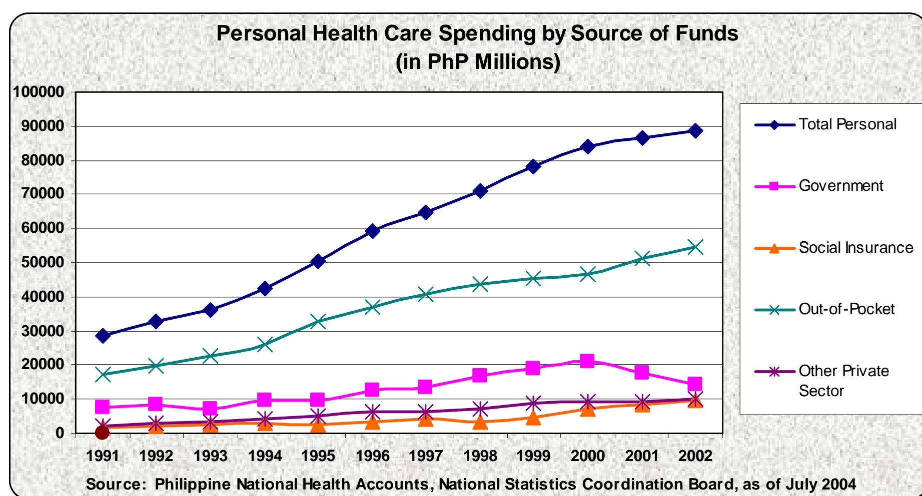


Appendix 3. Healthcare financing in the Philippines

The industry's contributions to the gross domestic product (GDP) reached 3.4 percent in 2004. Per capita spending was US$35.3—a 24 percent increase from its 2002 level. This can be explained by the low percentage share of healthcare expenditures to an average family's expenditures. This share amounts to only 2-3 percent of average income.

In recent years, the private sector has become the major provider of health financing (Figure A2). The government has been limited by its fiscal constraints. Moreover, there is an increasing availability of private healthcare companies. In private financing, a big portion is still financed by households as revealed by the proportion of out-of-pocket expenditures to total private sector financing. External financing, however, is quite limited to donations by international agencies.

Figure A2. Distribution of healthcare spending

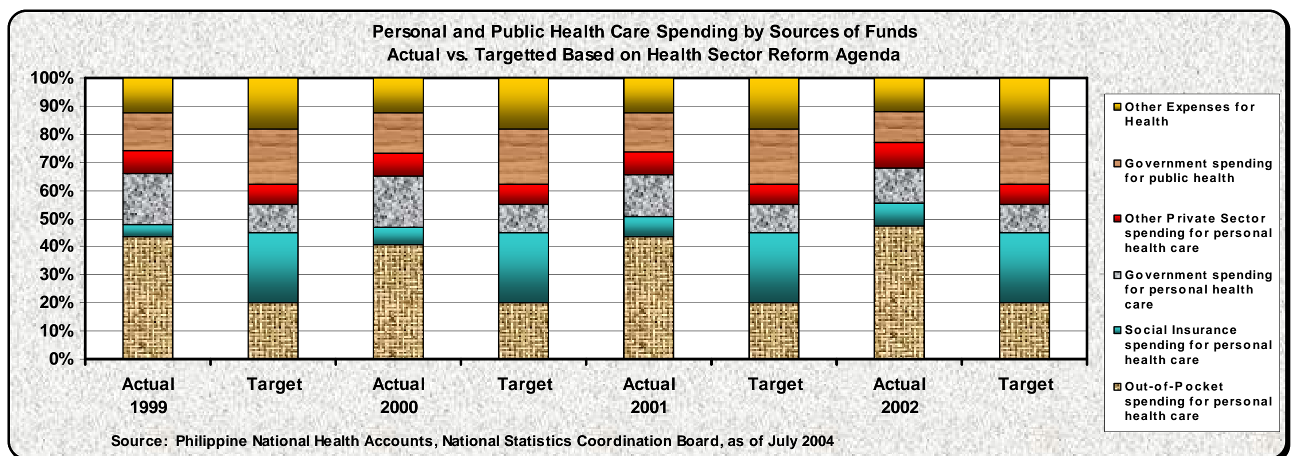


Looking at the total health expenditures in 2004, government spending, including social insurance, accounted for 40 percent. Private and other sources were 58.6 percent and 2.8 percent, respectively. In 2003, government expenditures increased to 43.7 percent while private sources declined to 54.9 percent. Health expenditures of the private sector came from private insurance companies (1.34%), health maintenance organizations (HMOs) (5.7%), and individual out-of-pocket expenditures (42.8%). Almost half of the healthcare expenditures were either financed without healthcare plans or insufficiently covered by these healthcare plans.

Traditionally, the healthcare industry of the Philippines has been principally financed by taxes and out-of-pocket payments of individuals. Nevertheless, various financing mechanisms, particularly insurance and prepayment schemes, are continuously increasing the contributions to health expenditures. Medicare, the compulsory health insurance, has been the most established of all insurance schemes. It has been in existence since 1972.

The actual percentage share of out-of-pocket spending, which falls significantly above the targeted percentage share from the healthcare reform agenda, manifests the dependence of the healthcare system on household personal disbursements. As could be gleaned from Figure A3, the healthcare system is expected to develop the capacity of social insurance to carry the burden of healthcare financing as indicated by the target share of social insurance.

Figure A3. Personal and public healthcare spending by sources of funds (actual vs targeted based on health sector)



There is a pressing need for the country to invest on education and healthcare to improve the quality of life and promote human development. If local financing is insufficient, the country can explore opportunities from tradable health services.

Additional spending on health will generate additional output and income for a number of sectors in the economy. The wide backward output and income linkages revealed in Table A2 imply that any increase in the spending for healthcare services and related industries by households, investors, or the government is beneficial to the development of the healthcare

sector as a whole, not only in terms of the output but also in terms of the incomes of healthcare professionals.

Most industries exhibiting high income multipliers are also typically labor intensive or belonging to the services industry. The entire medical and health-related industry itself ranked sixth among all other industries in the economy. For every one unit increase in final demand in the economy, there will be a P0.3387 increase in income of employees in the medical and health-related industry.

Table A2. Output and income coefficients of variation in the healthcare industry and health-related sectors

Industry description	Output linkages		Income linkages	
	Forward	Backward	Forward	Backward
Manufacturing				
Drugs and medicine	narrow	wide	Wide	wide
Surgical, dental, medical and orthopedic supplies	narrow	wide	Narrow	narrow
Ophthalmic goods	narrow	narrow	Narrow	narrow
Services				
Life and nonlife insurance	wide	narrow	Wide	narrow
Private hospitals, sanitaria and similar institutions	narrow	wide	Narrow	wide
Private medical, dental, veterinary and other health clinics and laboratories	narrow	wide	narrow	narrow
Other social and related community services	narrow	wide	narrow	narrow
Public health services	narrow	wide	narrow	narrow
Total medical and health-related services	narrow	narrow	narrow	narrow

Source: Authors' estimates based on NSCB 1994 Input-Output Table (NSCB 2003).

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