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Health Care in Private Schools and Private Establishments in the Philippines

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ABSTRACT

In 2012, there were about 4.5 million Filipinos attending private schools and an estimated 21.6 million employed by private establishments in the Philippines. Private schools and private establishments are thus strategically positioned to contribute toward the protection, promotion, and maintenance of the health of a very large number of Filipinos. The roles that these institutional units can play in the health care of the population have in fact been strengthened by government policies on school health, and on occupational safety and health. This paper examined the provision of student health services in private schools and employer-provided health-care services and benefits in private establishments using data from two recent surveys. Some findings on private schools include the following: (1) about 28 percent employed the complete team of health personnel consisting of a doctor, nurse, and dentist (generally seen in schools with large enrollments); (2) about 18 percent had a nurse only (seen in schools with less than 1,000 students); and (3) about 10 percent had a doctor and a nurse (seen in all sizes of schools). Meanwhile, for private establishments, results show that (1) about 2 percent had clinics or health manpower on-site; (2) 69 percent offered PhilHealth coverage; (3) 5 percent provided private health insurance or health maintenance organization coverage; (4) 44 percent and 41 percent granted cash advance and loans, respectively, for medical purposes; and (5) about 7 percent gave medical allowance as employee benefits.

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INTRODUCTION

Schooling and working are two activities that take up most of people's lives. Filipinos may spend as much as 16 years in school and up to (or in some cases, even more than) 44 years at work. An estimated 25.4 million of the Philippine population were in school in 2012, of which about 4.5 million were attending private schools (PSA/NSCB 2013). Meanwhile, about 37.6 million Filipinos were employed in various occupations in 2012 (PSA/NSCB 2013), of which (excluding those in government or are self-employed) an estimated 21.6 million were employees of private establishments (based on the distribution of employed persons by worker class in the 2011 Annual Poverty Indicators Survey). Thus, schools (including private institutions) and workplaces (including private establishments) are strategically positioned to strongly influence and to contribute toward the protection, promotion, and maintenance of many Filipinos' health. The roles that these institutional units can play in the health care of the population have been strengthened by laws and by government policies on school health, and occupational safety and health.

This paper examines the provision of student health services in private schools and employer-provided health-care services and benefits in private establishments using data from two recent surveys. Unlike public schools and workplaces whose activities (including the provision of health care) are under the direct supervision of the government, private schools and private establishments decide individually how much and what types of health care to provide to their students and employees, respectively. It is expected, however, that these decisions are guided by government policies and standards.

The types and levels of services and benefits provided are analyzed by enrollment size in private schools and by industry group and employment size of private establishments. Policies and legal provisions for school health and occupational health are also reviewed and the surveys described.

Results presented in this paper are taken from Racelis (2014).

SCHOOL HEALTH POLICIES

The basis for student health services in private schools has a long history. A few of the laws, policies, and guidelines were intended specifically for private schools, while others were intended for all schools in general. Those intended specifically for private schools include Republic Act (RA) 124, RA 951, and Department of Education and Culture (DECS) Memorandum No. 87 Series 1984. The 1947 RA 124, which is the "Act to Provide for the Medical Inspections of Students Enrolled in Private Schools in the Philippines", requires that schools with 300 or more enrollments provide for the yearly inspection of its pupils by a physician. Such

was later amended in the same year by RA 951, or “An Act to Amend Republic Act Numbered One Hundred and Twenty-Four”, stipulating that private schools with 1,300 or more students provide a part-time or full-time physician and dentist, and that the Department of Health (then the Bureau of Health) is to regulate such medical and dental service provision. The title of RA 124 was also amended to “An Act to Require Certain Private Schools, Colleges and Universities in the Philippines to Provide Medical and Dental Service for Pupils and Students”.

The DECS Memorandum No. 87 Series 1984 entitled “Organization of School Health Units in Private Schools” provides guidelines for the establishment of school health units and comprehensive school health programs in private schools “for the promotion, protection and maintenance of the health of the schooling population” (cited in PSA/NSCB1998). Basic provisions required by the memorandum include: (1) school health unit housed in a space not less than 65 sq m (i.e., for schools with 3,000 or more students), which should be divided into separate rooms to ensure privacy: waiting room, examining room, dental evaluation area, office rooms, and toilet with lavatory facilities; and (2) the following manpower required based on enrollment size of a school:

Enrollment Size	*Required Manpower*
1–299	1 full-time nurse
300–4,999	1 part-time medical officer 1 part-time dental officer 1 full-time nurse
5,000 or more	1 full-time medical officer 1 full-time dental officer 1 full-time nurse – one set of these officers for every 5,000 students

Other key legal instruments with provisions on school health services in both private and public schools include the Sanitation Code, the Department of Education (DepED) school health manual, and the DepED educational facilities manual. The 1975 Presidential Decree 856, or the “Code on Sanitation of the Philippines”, specifies the health facilities required in schools in Chapter VI School Sanitation and Health Services, Section 43. It states that trained health personnel and adequate facilities should be available so that students may be accorded the following health services:

1) Periodic physical and medical examination;
2) Periodic immunization;
3) Medical and dental treatment;
4) Treatment for common emergencies; and
5) Counseling and guidance.

The Department of Health (DOH) is the agency in-charge of implementing and enforcing the Sanitation Code.

The *1997 DepED School Health Manual* includes details on school health services, particularly preventive health care rendered by the school nurse, and the location, equipment, and supplies of a standard school clinic. The *2010 DepED Educational Facilities Manual* also provides specifications (for location, size, space allocation, and basic equipment and furniture) for the school health clinic in Chapter IV, Section R (Facilities for Ancillary Services). The manual also stipulates that a duly trained first aider and teacher should be in charge of the school clinic if no health professional is employed by the school.

All the abovementioned instruments serve as the bases for organizing student health services and health-related activities in private schools in four areas: manpower for emergency curative health care; specifications on school clinics; preventive health activities in schools; and sanitation and safety in the school environment.

At present, the DepED and the Commission on Higher Education (CHED) are responsible for ensuring compliance and for monitoring student health services and activities in private schools up to the secondary level and private higher education institutions (HEIs), respectively. For schools to be granted the permit to open and to operate, both the CHED and DepED had included availability of student health services as requisites (DepED 2010; CHED 2006, 2008, 2013). The permit to operate is renewed yearly to ensure continuing compliance with the requirements.

In the DepED Memorandum Order No. 88 Series 2010 entitled "2010 Revised Manual of Regulations for Private Schools", the requirement simply states that health facilities and services are available, and does not go further into the specifics. Meanwhile, both CHED Memorandum Order No. 21 Series 2000 ("Guidelines on Student Affairs and Services") and Memorandum Order No. 09 Series 2013 ("Enhanced Policies and Guidelines on Student Affairs and Services") stipulate that student health services be included among the Student Welfare Programs and Services of HEIs. Guidelines apply to both public and private HEIs.

Details of the stipulations on the required health services are the following (CHED 2013):

Section 27. Health Services – refers to the provision of primary health-care and wellness program.

27.1 The Higher Education Institution shall provide primary health-care services administered by licensed medical, dental, and allied professionals to all students.

27.2 There shall be adequate facilities for health care and updated health records, including disability records for students with disabilities, that are kept and maintained as required by the Department of Health and other related agencies.

27.3 There shall be mechanisms to promote a healthy lifestyle such as, but not limited to, healthy diet, physical activities, and no smoking and drinking of alcoholic beverages and substance abuse, and to provide a healthy environment not only inside the campus but also outside the school premises.

27.4 The school shall provide policies and an environment that will enable the practice of healthy lifestyle.

Private HEIs must have health personnel as part of the nonteaching staff and a school clinic under Support Services. The health personnel may be part-time or on an on-call basis. Student health services could alternatively be outsourced and the school needs to show a memorandum of agreement with a health provider as proof.

In contrast to the detailed standards specified in the 1984 DECS Memorandum No. 87, the CHED and DepED memorandum orders currently in effect do not prescribe any number, type of health personnel, nor clinic specifications. It thus becomes the decision of each individual school what and how much health services to provide.

OCCUPATIONAL HEALTH POLICIES

Under the Philippine Constitution of 1987, occupational safety and health is a constitutional objective described as "just and humane terms and conditions of work". The Philippine Labor Code accordingly devotes an entire book (Book IV) to prevention of work-related health problems, enforcement of occupational safety and health standards, compensation of work-related injuries and illnesses, and details on the provision of emergency health care (DOLE 2006). Additionally, the provision of health insurance coverage for workers is governed by the National Health Insurance Act. Thus, based on these various legal stipulations, it is the duty of establishments or employers to provide their workers with medical and dental health care, preventive/safety measures in the workplace, and health insurance (specifically, PhilHealth) and employee compensation (EC) coverage.

Requirements on emergency health-care services for workers as stated in the Labor Code (Book IV, Title 1, Chapter 1) include (1) first aid medicines and equipment in the workplace; and (2) the following manpower and facilities based on establishments' employment size and type of workplace (i.e., hazardous versus nonhazardous):

Employment Size	*Required Health Manpower/Facilities at Workplace*
less than 51	depends on the type of workplace or industry
51–200	1 full-time nurse (for hazardous workplace) or 1 graduate first aider (nonhazardous)
201–300	1 full-time nurse 1 part-time physician 1 part-time dentist (part-time manpower has to be present for a minimum of two hours for hazardous workplaces; and on-retainer basis for nonhazardous workplaces) emergency clinic
301 or more	1 full-time nurse 1 full-time physician 1 full-time dentist dental clinic emergency hospital (1 bed per 100 employees)

For their emergency clinic, dental clinic, and emergency hospital, establishments may use nearby facilities on-retainer basis. Other provisions for medical and other health services require that employers (1) train a sufficient number of employees on first aid; (2) develop and implement a comprehensive occupational health program through the physician engaged by the employer; and (3) provide all necessary assistance to ensure adequate and immediate medical and dental treatment to an injured or sick employee in case of emergency.

The provisions on the protection and prevention of work-related injuries and illnesses among workers are articulated in the Labor Code under Article 162, Occupational Health Standards. The enforcement of the provisions is the responsibility of the Department of Labor and Employment (DOLE) and is carried out through the DOLE's Administrative Code on Enforcement of Safety and Health Standards (DOLE 2006).

DATA SOURCES

Two surveys on health-care provision and health expenditures of private schools and private establishments were conducted in 2013–2014 under the PIDS-DOH Health Systems Research Management Program. They included 163 sample units from private schools and 439 sample units from business entities in three areas: the National Capital Region, Davao City, and the province of Rizal. The survey of private schools collected data on student health services, health facilities, and size of student enrollment for the year 2012. The survey of business establishments collected data on employer-provided health care and health benefits as well as on their economic activities and number of employees for the year 2012.

Private schools in the sample were categorized into six enrollment sizes. The sample overrepresented large schools (enrollment of over 3,000 students) to be able to compute for percentages and averages at each enrollment size category. The distribution of all private schools under the supervision of the DepED and CHED in 2012 by enrollment size is shown in Table 1 as a point of reference (DepED, n.d; CHED, n.d.).

Meanwhile, Tables 2 and 3 show the 2012's actual distributions of all establishments in the country as well as this study's sample by industry group and by employment size (PSA/NSO, n.d.). Note that the distribution of the sampled private establishments based on the modified four-industry grouping is similar to the distribution of all establishments in the country. The distribution according to employment size categories as shown in Table 3, however, overrepresented the larger establishments.

The computation of percentages and averages by enrollment size (for private schools) and by industry group and employment size (for establishments) were done directly using survey data. Overall percentages across the total samples in the two surveys, however, were computed in two ways, i.e., either unweighted or weighted. The unweighted values are uncorrected computations done directly on sample survey data. The weighted values are computations where 2012 actual numbers on private schools (by enrollment size) and on establishments (by industry group and employment size) are applied to the private schools and private establishments' survey data, respectively, as sample weights. Sample weights are used to correct for the overrepresentation of large private schools and large private establishments in the two surveys.

Table 1. Distribution of sample private schools by enrollment size

	Percent Distributions	
Enrollment Size Group	Sample	CHED, DepED Tabulations
1–199	21.5	61.6
200–999	49.7	26.0
1,000–2,999	16.0	11.2
3,000–4,999	6.1	0.5
5,000–7,999	2.5	0.5
8,000 and over	4.3	0.2
Total percent	100.0	100.0
Total number	163	18,926

Sources: Racelis (2014) for Sample; Department of Education (DepED), n.d., and Commission on Higher Education (CHED), n.d. for CHED, DepED Tabulations

Table 2. Distribution of sample establishments by industry group

	Percent Distributions	
Industry Group(1)	**Sample (n)**	**PSA/NSO Tabulation**
1 AFFMN	1.1	1.1
2 MEGW	9.3	12.8
3 CWRTTC	48.5	51.6
4 FIRE and AFS and others	41.1	34.5
Total percent	100.0	100.0
Total number	439	944,897

(1) AFFMN-agriculture, forestry and fishing, and mining and quarrying
(2) MEGW-manufacturing, electricity, and gas and water
(3) CWRTTC-construction, wholesale/retail trade, and transportation and communication
(4) FIRE and AFS and others - financial and insurance and real estate; and accommodation and food service, entertainment, health, education, professional and other service activities
Sources: Racelis (2014) for Sample; Philippine Statistics Authority/National Statistics Office (PSA/NSO), n.d., for PSA/NSO Tabulations

Table 3. Distribution of sample establishments by employment size

	Percent Distributions	
Employment Size	**Sample**	**PSA/NSO Tabulation**
1–4	13.9	75.6
5–9	32.6	13.8
10–19	26.0	5.8
20–49	11.8	3.0
50–99	4.8	0.9
100–199	4.1	0.4
200–499	3.0	0.3
500–999	1.4	0.1
1,000 and over	2.5	0.1
Total percent	100.0	100.0
Total number	439	944,897

Sources: Racelis (2014) for Sample; PSA/NSO (n.d.) for PSA/NSO Tabulations

HEALTH-CARE SERVICES IN PRIVATE SCHOOL

The provision of student health services in private schools requires employing the services of health professionals (mainly doctors, nurses, dentists, and, occasionally, trained medical officers), setting up a clinic, and having medicines and medical supplies for emergency care. A few schools interviewed, particularly those with low enrollment, reported zero health personnel employed for pay, but they have

alternative arrangements for providing health services to students. One such arrangement involved using a health facility such as a nearby hospital. Another option meant tapping the voluntary services of, among others, school alumni and parents of students who are health professionals and who provide health services to students at no cost to the school. Some schools have personnel who have been employed primarily as administrators or teachers but are also qualified health professionals—e.g., a school principal who is a licensed physician or a teacher who is a registered nurse. In such cases, these personnel can function in their medical capacity as needed.

Health personnel

Private schools may employ health personnel on full-time basis, part-time basis, or a combination of both. Table 4 shows that in 2012, nearly half—or about 43 percent—of schools with less than 200 students reported had no paid health personnel. Overall, only 30 percent of schools, mainly in the two smallest categories, had no paid health personnel. About 34 percent, mostly schools with less than 1,000 students, hired part-time health workers only. About 26 percent of schools—mostly those with over 1,000 students enrolled—engaged the services of both part-time and full-time health personnel.

Table 5 shows the types and combination of health professionals employed by private schools. Nearly one-third (about 28 percent) of schools employ the complete set of health personnel consisting of a doctor, nurse, and dentist, and this combination is more likely to be seen in institutions with larger enrollment sizes and in nearly 100 percent of the country's very large schools. Other likely combinations include having a nurse only, or a doctor-and-nurse team, which

Table 4. Percent of private schools with available health personnel by type of employment arrangement: Philippines, 2012

		Type of Employment Arrangement (percent)			
Enrollment Size	Sample (n)	None	Part Time Only	Full Time only	Full Time and Part Time
1–199	35	43	37	9	11
200–999	81	14	38	16	32
1,000–2,999	26		8	4	88
3,000–4,999	10				100
5,000–7,999	4				100
8,000 and over	7			43	57
Overall (unweighted)	163	16	28	12	44
Overall (weighted)		30	34	10	26

Source: Racelis (2014)

Table 5. Percent of private schools with combinations of health personnel by type of health professionals: Philippines, 2012

		Combination of Health Personnel (percent)				
Enrollment Size	Total	None	Nurse Only	Doctor and Nurse	Doctor, Nurse, Dentist, and More	Other (e.g., medical officer)
1–199	100	39	21	9	12	18
200–999	100	18	19	13	40	10
1,000–2,999	100		4	12	77	8
3,000–4,999	100			14	86	
5,000–7,999	100			0	100	
8,000 and over	100			14	86	
Overall (unweighted)	100	17	15	12	46	10
Overall (weighted)		29	18	10	28	15

Source: Racelis (2014)

respectively exist in about 18 percent (seen in schools with less than 1,000 students) and 10 percent (seen in schools of various enrollment sizes) of the study's sample.

Nurses are most likely to be employed on a full-time basis in schools with 1,000 or more students (Table 6). The mean number of full-time nurse increases from about 1.5 per school for schools of 100–299 enrollment size to five per school of 8,000 or more students. Doctors, dentists, and other health personnel are less likely to be employed on a full-time basis except in schools with 8,000 or more students. Schools in the largest category have on average nearly two full-time doctors, five full-time nurses, and one full-time dentist.

Unlike the case with nurses, the doctors and dentists are more likely to be employed on a part-time basis (Table 7). The mean number of part-time doctors increases from about 1.1 per school with 1,000–2,999 students to about 2.6 per school of 8,000 or more pupils. The mean number of dentists similarly increases from about 0.8 per school of 1,000–2,999 students to about 1.6 per school of 8,000 or more pupils.

Clinic and medical supplies

About 70 percent of private schools reported having clinics while about 84 percent have medicines and medical supplies (Table 8). However, note that 100 percent of schools with 3,000 or more students have both clinics and medical supplies. Also, it may be observed that the percentage of schools reported to have no medical supplies (about 16%) is much lower than the percentage of institutes with no clinics (about 30%). This means that even without a clinic, emergency care such

Table 6. Percent of private schools with full-time health personnel and average number per type of health professional: Philippines, 2012

Enrollment Size	Type of Full-time Health Professional			
	Doctor	Nurse	Dentist	Other
	Percent with the full-time personnel			
1–199		17		3
200–999	4	48	2	
1,000–2,999	12	92	15	8
3,000–4,999	30	100	20	10
5,000–7,999	25	100	50	
8,000 and over	57	100	57	14
Overall (unweighted)	9	55	9	3
Overall (weighted)	3	35	3	3
	Average number of personnel per school			
1–199		0.2		0.03
200–999	0.05	0.6	0.04	
1,000–2,999	0.1	1.5	0.2	0.1
3,000–4,999	0.4	2.4	0.3	0.2
5,000–7,999	0.3	2.0	0.5	
8,000 and over	1.6	5.0	1.3	0.6

Source: Racelis (2014)

as treatment of cuts and wounds can still be rendered because of the availability of medical supplies.

Preventive health care

Table 9 lists the top 12 types of preventive health activities of private schools as reported in the surveys. These activities may be classified into:

1) Personal preventive (e.g., annual physical examination – rank 1; dental check-up – rank 3; immunization – rank 8; health assessment, health screening, and record keeping – rank 11; and fitness activities – rank 12);
2) Health orientation and seminars (e.g., general health information dissemination – rank 3; seminar/dissemination on personal hygiene – rank 6; seminar/dissemination on nutrition – rank 7; health posters and health fair – rank 9); and
3) School facilities-related activities (e.g., keeping school premises clean and safe – rank 5; food safety – canteen-related measures – rank 10).

There are other preventive activities that some schools had identified but did not rank high in the survey, such as training on first aid; seminar

Table 7. Percent of private schools with part-time health personnel and average number per type of health professional: Philippines, 2012

Enrollment Size	Type of Part-time Health Professional			
	Doctor	Nurse	Dentist	Other
	Percent with the part-time personnel			
1–199	29	26	29	
200–999	62	37	46	
1,000–2,999	92	12	81	8
3,000–4,999	100	10	50	
5,000–7,999	100	25	100	
8,000 and over	57	14	43	
Overall (unweighted)	63	28	49	1
Overall (weighted)	45	27	39	
	Average number of personnel per school			
1–199	0.3	0.3	0.3	
200–999	0.7	0.4	0.5	
1,000–2,999	1.1	0.2	0.8	0.1
3,000–4,999	1.8	0.2	0.8	
5,000–7,999	1.8	0.3	1.3	
8,000 and over	2.6	0.1	1.0	

Source: Racelis (2014)

on drugs and smoking; proper disposal of garbage; home visitation; keeping school staff healthy; and integrating more health topics into the regular school curriculum.

EMPLOYEE HEALTH CARE AND BENEFITS IN PRIVATE ESTABLISHMENTS

Employees' health care and benefits refer broadly to their employers' various arrangements to facilitate or directly provide their employees with funding and access to health-care goods and services. There is a wide range of arrangements, including:

- direct provision of health care to employees through health facilities or health professionals (doctor, nurse, or medical officer) that are either based within or outside (on retainer) the workplace plus provision for medicines and medical supplies in the workplace;
- direct provision of preventive health care through company programs;
- payment schemes for employees' health-care cost through either direct reimbursement by the employer or through employer-supported health

Table 8. Percent of private schools with clinic and medical supplies: Philippines, 2012

Enrollment Size	Sample (n)	Percent with Clinic	Percent with Medical Supplies
1–199	33	63	83
200–999	84	74	90
1,000–2,999	26	100	73
3,000–4,999	7	100	100
5,000–7,999	6	100	100
8,000 and over	7	100	100
Overall (unweighted)	163	79	87
Overall (weighted)		70	84

Source: Racelis (2014)

Table 9. Top 12 preventive health-care programs/activities/policies in private schools: Philippines, 2012

Rank	Description
1	annual physical examination
2	general health information dissemination
3	dental check-up
4	keeping school premises clean/safe
5	seminars/dissemination - disease prevention
6	seminars/dissemination - hygiene
7	seminars/dissemination - nutrition
8	immunization
9	health posters; health fair
10	food safety - canteen-related activities
11	assessment and record keeping
12	fitness activities

Source: Racelis (2014)

insurance coverage (e.g., PhilHealth, private health insurance, and health maintenance organization or HMO); and

- availability of funds through cash advances, medical loans, medical allowances, and sick leaves with pay.

It is expected that the types of health benefits provided in establishments vary depending on their employment size and, possibly, type of industry.

Direct health-care provision

Tables 10 and 11 list the different ways health-care goods and services are provided directly by employers to employees. It may be noted from Table 10 that about 30 percent provide medicines and medical supplies in the workplace, 2 percent have clinics or health manpower in the workplace, 5 percent have health facilities or health professionals on retainer, and 18 percent have company-sponsored health programs. Except for the very small establishments (1–4 employees), the percentage of those offering medicines in the workplace is generally similar across establishments of different employment sizes. The provision of the other three health services or benefits, on the other hand, is observed to increase along with the establishments' employment size.

Direct provision of health care is observed to be generally higher for industry groups 1 and 2 compared to the other industry groups (Table 11). The difference is most notable in the provision of company clinic/health professionals (company based or on retainer) and company health programs. Such difference may be explained by the fact that industry groups differ in terms of their work location and nature of work.

Agricultural plantations and mining operations are generally located farther from urban centers compared to other businesses; thus, such availability of health facilities on-site allows emergency care to be rendered more quickly. The nature of work in agricultural, mining, and manufacturing industries also generally involves more potential hazards than in other industries. Thus, firms in these industry groups expectedly provide more emergency health care and carry out more preventive measures and activities as part of their health programs.

Preventive health care

The top 12 types of preventive health activities reported in the survey are listed in Table 12. These activities may generally be classified as follows:

- Personal preventive activities (e.g., annual physical examination – rank 4; and fitness program – rank 2);
- Occupational health and safety (e.g., providing protective gear – rank 7; regular safety inspection – rank 10; and training on safe handling of equipment – rank 12);
- Health information dissemination (rank 6);
- Healthy workplace environment (e.g., keeping workplace clean – rank 1; no smoking policy – rank 3; proper disposal of garbage – rank 8; and proper ventilation or workplace – rank 11); and
- Other activities that respondents view as promoting good health of employees (e.g., serving nutritious food in workplace – rank 6; and hiring nonsmokers – rank 9).

Table 10. Health benefits in establishments: direct provision of health care by type, Philippines, 2012

Employment Size	Sample (n)	Percent of Establishments Providing the Benefit: Medicines and Medical Supplies at Workplace	Company Clinic and/or Health Professional	Health Facility and/or Professional on Retainer	Company Health Programs
1–4	61	23	2	5	13
5–9	142	50	1	2	27
10–19	114	53	4	6	49
20–49	52	50	4	6	37
50–99	22	67	38	10	24
100–199	17	89	39	33	39
200–499	13	92	62	8	69
500–999	7	50	50	17	67
1,000 and over	11	100	73	18	82
Overall (unweighted)	439	52	10	6	36
Overall (weighted)		30	2	5	18

Source: Racelis (2014)

Table 11. Health benefits in establishments by industry group: direct provision of health care by type, Philippines, 2012

Industry Group	Sample (n)	Percent of Establishments Providing the Benefit: Medicines and Medical Supplies at Workplace	Company Clinic and/or Health Professional	Health Facility and/or Professional on Retainer	Company Health Programs
1 AFFMQ	5	60	40	20	60
2 MEGW	41	76	34	10	49
3 CWRTTC	213	46	6	6	30
4 FIRE and AFS and others	180	53	8	6	39
Overall (unweighted)	439	52	10	6	36

*See Table 2 for the full labels of industry groups.
Source: Racelis (2014)

Examples of other programs, activities, and policies identified by establishments but which did not rank high include the following: random drug testing; health counseling; putting up of safety signages/posters; various seminars on prevention/ managing injuries, smoking, personal hygiene; health bulletin; and observing proper work and rest hours.

Table 12. Top 12 preventive health-care programs/activities/policies in establishments, Philippines, 2012

Rank	Description
1	keeping workplace clean
2	physical fitness program
3	no smoking in workplace
4	annual physical examination
5	serving nutritious food to employees
6	health information dissemination
7	providing protective gear
8	proper disposal of garbage
9	hiring nonsmokers
10	regular safety inspection
11	ensuring proper ventilation of workplace
12	training on safety and proper handling of equipment

Source: Racelis (2014)

Reimbursement and insurance

Aside from directly offering health-care goods and services, which may generally be sufficient for emergency care, establishments may also cover the cost of their employees' health care that are obtained from external health providers such as hospitals. How employers pay for such costs are listed in Tables 13 and 14.

About 69 percent of establishments provide PhilHealth coverage, 5 percent provide private health insurance or HMO coverage, and 24 percent had reimbursed employees for their hospitalization costs, doctor consultation fees, and medicine purchases. The proportion of establishments that reimburse employees' health expenditures seem to be about the same across all employment sizes (except for those with over 500 employees) and across industry groups. Meanwhile, the pattern of providing private health insurance is similar across industry groups but vary significantly across employment size. That is, the percentage of firms providing this benefit increases tremendously with employment size: very low percentages for those with less than 20 employees in contrast to the 73 percent among establishments with 1,000 employees or more.

The percentages of establishments providing PhilHealth coverage by industry group are generally similar, except for Group 1, but these vary by employment size. On the other hand, the percentage rises with employment size, reaching almost 100 percent for nearly all firms with 20 employees or more.

Table 13. Health benefits in establishments: Reimbursement and health insurance, Philippines, 2012

Employment Size	Sample (n)	Percent of Establishments Providing the Benefit: Reimbursement of Employee Health Cost by the Company	Private Health Insurance or HMO Coverage	PhilHealth Coverage
1–4	61	21	3	70
5–9	142	39	1	50
10–19	114	28	5	80
20–49	52	21	37	94
50–99	22	14	43	100
100–199	17	17	39	94
200–499	13	23	46	100
500–999	7		67	100
1,000 and over	11		73	100
Overall (unweighted)	439	28	14	74
Overall (weighted)		24	5	69

Source: Racelis (2014)

Table 14. Health benefits in establishments by industry group: Reimbursement and health insurance, Philippines, 2012

Industry Group*	Sample (n)	Percent of Establishments Providing the Benefit: Reimbursement of Employee Health Cost by the Company	Private Health Insurance or HMO Coverage	PhilHealth Coverage
1 AFFMQ	5		20	100
2 MEGW	41	22	20	80
3 CWRTTC	213	27	13	73
4 FIRE and AFS and others	180	31	14	72
Overall (unweighted)	439	28	14	74

*See Table 2 for the full labels of industry groups.
Source: Racelis (2014)

Cash transfers

Other arrangements involve cash transfers from employers when an employee has immediate need to finance his health care. These arrangements are listed in Tables 15 and 16. Cash advances and medical loans, which are offered in about 44 percent and 41 percent, respectively, of the firms surveyed, are common arrangements.

About 11 percent of establishments offer sick leaves with pay, while about 7 percent provide medical allowances to employees. The study shows no systematic variation across industry groups regarding these four benefit types. Similarly, there is no trend seen regarding cash advances and medical loans when firms are analyzed according to employment sizes.

Medical allowance, however, has a higher percentage among establishments with 100–999 employees. Sick leave with pay is given increasingly as employment size becomes larger.

CONCLUSION

In private schools, the average numbers of health professionals per school computed from the survey are one part-time doctor, 1.5 full-time nurses, and 0.8 part-time dentist for schools with 1,000–3,000 students. For comparison, note that the 1984 DECS memorandum recommends one part-time medical officer, one full-time nurse, and one part-time dentist for schools with 300–5,000 students.

In institutes with 200–1,000 students, the average numbers of health personnel are 0.7 part-time doctor, 0.4 part-time nurse, 0.6 full-time nurse, and 0.5 part-time dentist. Schools with 5,000–8,000 students have computed average values of 1.8 part-time doctor, two full-time nurses, and 1.3 part-time dentist, whereas the recommendations in the 1984 DECS memorandum were one full-time medical officer, one full-time nurse, and one full-time dentist.

Based on these findings, private schools are in fact providing voluntarily the level of health-care service that is consistent with the standards set in the 1984 DECS Memorandum No. 87. The lack of details on health service provision in the DepED and CHED memorandum orders currently in effect may be the reason private schools seem to continue to use the 1984 DECS standards as the norm. However, these standards for student health services were set 30 years ago. Thus, this may be an area in the school health policy that can be improved. It may be time to conduct a review and, if necessary, to formulate an updated version of the standards more appropriate to the present situation of private schools.

In addition to providing emergency curative care, and PhilHealth and EC coverage—which constitute the minimum benefits consistent with provisions in the Labor Code and the National Health Insurance Act—private establishments support their employees' health care through other arrangements. These include providing medicines and medical supplies in the workplace; paying for employees' health-care cost through direct reimbursement; offering private health insurance or HMO coverage for employees; funding employees' medical needs through cash advances, loans, and allowances; and providing sick leaves with pay.

Table 15. Health benefits in establishments: Cash advance and similar benefits, Philippines, 2012

Employment Size	Sample (n)	Percent of Establishments Providing the Benefit			
		Cash Advance for Medical Purpose	Medical Loan	Medical Allowance	Sick Leave with Pay
1–4	61	41	38	7	8
5–9	142	61	62	8	8
10–19	114	51	39	10	26
20–49	52	40	29	4	42
50–99	22	57	19	14	62
100–199	17	50	22	28	72
200–499	13	38	46	15	77
500–999	7	50	33	33	83
1,000 and over	11	45	55	9	73
Overall (unweighted)	439	51	44	9	27
Overall (weighted)		44	41	7	11

Source: Racelis (2014)

Table 16. Health benefits in establishments by industry group: Cash advance and similar benefits, Philippines, 2012

Industry Group*	Sample (n)	Percent of Establishments Providing the Benefit			
		Cash Advance for Medical Purpose	Medical Loan	Medical Allowance	Sick Leave with Pay
1 AFFMQ	5	40	20	40	40
2 MEGW	41	61	54	15	37
3 CWRTTC	213	55	43	5	26
4 FIRE and AFS and others	180	45	43	13	25
Overall (unweighted)	439	51	44	9	27

*See Table 2 for the full labels of industry groups.
Source: Racelis (2014)

A number of these other arrangements are over and above the health benefits prescribed by law, although these are observed more in establishments with large employment sizes. Large establishments provide supplementary private health insurance or HMO coverage on top of the direct health-care services and PhilHealth coverage, thus allowing employees of such establishments to be well provided for in terms of health care.

On the other hand, most establishments with small employment size only offer alternative arrangements (e.g., medical supplies in the workplace,

cash advances, loans, and reimbursement) to employees. This thus raises a few questions: What employee health benefits should small establishments provide, taking into consideration the scale of their economic activity? What can be done to improve the health-care situation of employees in small establishments? Here, both the situation of small establishments and of their employees need to be taken into consideration and studied so as to arrive at the most feasible solution.

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