Mapping the Landscape of Physician Professional Fees: A Comparative Country Analysis

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Preliminary Analysis

Why discuss Physician Professional Fees now?

BACKGROUND

UHC Law changed PhilHealth's mandate

National Strategic Purchaser

Shift to DRG-GB payment system

Physician fees are part of total health expenditure

41.2%

of total health expenditures are **out-of-pocket**
(CHE, 2025)

Evidence shows that there is no system to setting Physician Fees

No guidance → No one teaches physicians how to set a fee

No shared floor → No agreed baseline to price against

No institutional backing → No payer stands behind what physicians charge

Source: Lasco, Lim, and Mendoza (2026). *Final Report: A Qualitative Study on Professional Fee Setting Among Medical Practitioners in the Philippines. Philippine Institute for Development Studies. PhilHealth-PIDS 2025-2027 RISE Mission Research Project. [Unpublished]*

The questions we set out to answer

Does it function?

We ask whether the **current system** that is used for setting physician fees **work**

What would a functioning one need?

As **provider-payment reforms roll out** (DRG–GB), we want to know what a **working system would require**

Will doctors stay?

We want people to **still choose this profession** and **stay in it**. We want medicine to remain **worth pursuing here**

Methods

1 Initial Scoping Review

Determined the **factors** that shape professional fees and produced the **domains** and **subdomains** used for analysis

2 Selection of Countries

Chose **seven comparator countries** spanning income levels and health system structures

3 Literature Search

Reviewed policies, published articles, government reports, and grey literature across each domain and country

2 Synthesis

Assigned each country a **status per subdomain with evidence**, then compared the Philippines against comparators to locate the gaps

Limitations

- Purposive literature search was done
- Measures are not always comparable across countries

Country Profiles

We selected countries with mature health systems across income levels and varied health system designs

Country	Income Classification	Health System Characteristics			
		% Public Facilities	% Private Facilities	Centralized / Decentralized	Health Financing System
Philippines	Upper middle-income	33.8%	66.2%	Decentralized	Social health insurance system
Germany	High-income	28.7%	71.30%	Centralized	Social health insurance system
Indonesia	Upper middle-income	35%	65%	Decentralized	Social health insurance system
Australia	High-income	52%	48%	Decentralized	Hybrid public–private system
Japan	High-income	14.7%	85.3%*	Centralized	Social insurance-based universal system
Poland	High-income	58%	43%	Centralized	Social health insurance system
South Korea	High-income	<10%	>90%	Centralized	Social health insurance system

Sources: World Bank (2024–2026). *Country and Lending Groups FY2026–27; Income Classifications 2024–2025, 2025–2026;* Dayrit MM et al. (2018). *The Philippines Health System Review;* Philippine Statistics Authority (2024). *Philippine National Health Accounts;* Republic of the Philippines (2019). *Universal Health Care Act (RA 11223);* BPJS Kesehatan (2024). *Jaminan Kesehatan Nasional (JKN) Program;* Alberta Medical Association (2025). *Dual Practice Models in Select Countries: Environmental Scan Report;* International Monetary Fund. *Health Care Reform in Japan (IMF eLibrary);* Commonwealth Fund (2025). *International Health Care System Profiles: Japan;* World Health Systems Facts (2024). *South Korea Health System Overview; Germany Health System: Physical Resources;* Fraser Institute (2023). *How Germany Embraces the Private Sector to Deliver Universal Health Care;* European Observatory on Health Systems and Policies (2019). *Poland: Health System Review (HiT);* OECD (2023). *Health at a Glance 2023;* OECD/The Health Foundation (2025). *How Do Health System Features Influence Health System Performance?;* World Health Organization (2024). *Governance of Dual Practice in the Public and Private Health Sectors.*

Professional Fee Domains and Sub-Domains

01 Governance & Regulation

- Legal and Statutory Basis
- Regulatory Authority / Body
- Interagency Coordination

02 Payment & Fee-Setting

- Fee Negotiation
- Payer Configuration
- Fee-Setting Mechanism
- Payment Method

03 Workforce & Market Structure

- Physician Practice
- GP vs Specialists
- Geographic Location Differentiation
- Bargaining Power
- Training and Entry Governance

04 Monitoring & Accountability

- Fee Transparency
- Patient Protection Mechanisms
- Compliance, Monitoring & Enforcement

Country	Subdomains		
	Legal and Statutory Basis	Regulatory Authority / Body	Interagency Coordination
Philippines	None / Unclear	Market-based / None	AdHoc / Consultative
Germany	Dedicated Law	Shared (Provider-Payer)	Institutionalized
Indonesia	General Regulation	State Agency	Institutionalized
Australia	Dedicated Law	State Agency	Institutionalized
Japan	Dedicated Law	Shared (State Agency and Professional Associations)	Institutionalized
Poland	Dedicated Law	State Agency	AdHoc / Consultative
South Korea	Dedicated Law	State Agency	Institutionalized

DOMAIN 1: Captures the foundational mandate: the presence, specificity, and coordination of involved agencies' roles in fee governance and regulation

Preliminary Analysis

01 Governance & Regulation

Country	Subdomains		
	Legal and Statutory Basis	Regulatory Authority / Body	Interagency Coordination
Philippines	None / Unclear	Market-b	sultative
Germany	Dedicated Law	Shared (Provider-Payer)	Institutionalized
Indonesia	General Regulation	State	alized
Australia	Dedicated Law	State	alized
Japan	Dedicated Law	Shared (Sta Professional Associations)	alized
Poland	Dedicated Law	State Agency	AdHoc / Consultative
South Korea	Dedicated Law	State Agency	Institutionalized

No dedicated statute governs physician professional fees

Proposed Standard Medical Professional Fees Act (HB 6715) (April 2026) proposes baseline ranges set by DOH with PRC, PhilHealth and physician organizations

Legal and Statutory Basis: Captures the specificity and strength of the underlying legal foundation

Other countries **anchor PF setting in legislation** so it has legal force and survives political cycles

Country	Subdomains		
	Legal and Statutory Basis	Regulatory A	
Philippines	None / Unclear	Market-b	Ad Hoc / Consultative
Germany	Dedicated Law	Shared (Pr	
Indonesia	General Regulation	State	
Australia	Dedicated Law	State Agency	Institutionalized
Japan	Dedicated Law	Shared (Sta Professiona	
Poland	Dedicated Law	State	
South Korea	Dedicated Law	State	

A specific statute directly establishes and regulates physician fee-setting

Single social insurance statute sets up the whole fee system for publicly insured patients and creates an avenue for discussions to take place

2017 Act on the method of determining the lowest basic salary of employees performing medical professions in medical entities sets minimum basic salaries for medical staff

Legal and Statutory Basis: Captures the specificity and strength of the underlying legal foundation

Country	Subdomains		
	Legal and Statutory Basis	Regulatory Authority / Body	Interagency Coordination
Philippines	None / Unclear	None / Market-based	AdHoc / Consultative
Germany	Dedicated Law	Shared (Provider-Payer)	Institutionalized
Indonesia	General Regulation	State Agency	Institutionalized
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No regulatory body

Regulatory Authority / Body: Captures the power to set, negotiate, or regulate physician fees

Preliminary Analysis

Other countries **designate a body with real rate-setting scope**

Country	Subdomains		
	Legal and Statutory Basi		nteragency Coordination
Philippines	None / Unclear		AdHoc / Consultative
Germany			Institutionalized
Indonesia		State Agency	Institutionalized
Australia		State Agency	Institutionalized
Japan		Shared (State Agency and Professional Associations)	Institutionalized
Poland		State Agency	AdHoc / Consultative
South Korea		State Agency	Institutionalized

A government body holds primary authority

The government's **MBS Review Task Force** ran ~60 clinical committees and 1,400+ recommendations

Authority is jointly exercised by a state body and the profession

Has a **Central Social Insurance Medical Council** with representatives from the payer side, the provider side and the public interest and this council decides and negotiates the rates

Regulatory Authority / Body: Captures the power to set, negotiate, or regulate physician fees

Country	Subdomains		
	Legal	rity / Body	Interagency Coordination
Philippines		/ None	AdHoc / Consultative
Germany	Dedicated Law	Shared (Provider-Payer)	Institutionalized
Indonesia	G	ncy	Institutionalized
Australia		ncy	Institutionalized
Japan	Dedicated Law	Shared (State Agency and Professional Associations)	Institutionalized
Poland	Dedicated Law	State Agency	AdHoc / Consultative
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Coordination runs through temporary or consultative arrangements, with no permanent institutional home

DOH PF technical working group was established in April 2026 but it is in its infancy stage

Interagency Coordination: Captures durability and formality of coordination among responsible actors

Preliminary Analysis

Other countries have **set processes** with a **defined payer counterparty**

Country	Subdomains		
	Legal and Statutory Basis	Regulatory Authority / Body	Interagency Coordination
Philippines	None / Unclear	Market-based / None	AdHoc / Consultative
Germany	Dedicated Law	Shared (Provider-Payer)	Institutionalized
Indonesia		State Agency	Institutionalized
Australia		State Agency	Institutionalized
Japan		d (State Agency and sional Associations)	Institutionalized
Poland	Dedicated Law	State Agency	AdHoc / Consultative
South Korea	Dedicated Law	State Agency	Institutionalized

Coordination runs through a permanent, mandated mechanism with defined membership and recurring output (e.g., a standing council with fixed revision cycles)

Interagency Coordination: Captures durability and formality of coordination among responsible actors

02 Payment & Fee-Setting

Country	Subdomains			
	Fee Negotiation	Payer Configuration	Fee-setting Mechanism	Payment Method
Philippines	None	Multipayer, Fragmented	Regulated schedule + Market segment	Blended / Mixed
Germany	Collective / National Negotiation	Multipayer, Regulated	Negotiated within a regulated frame	Blended / Mixed
Indonesia	Payer-Provider Bilateral	Single Payer	Regulated schedule + Market segment	Blended / Mixed
Australia	Individual / Facility-level	Multipayer, Regulated	Regulated schedule + Market segment	Blended / Mixed
Japan	Collective / National Negotiation	Multipayer, Regulated	Fully administered	Blended / Mixed
Poland	Individual / Facility-level	Single Payer	Regulated schedule + Market segment	Blended / Mixed
South Korea	Collective / National Negotiation	Single Payer	Fully administered	Blended / Mixed

DOMAIN 2: Captures how prices actually get set: whether fees are negotiated, how the payer side is configured, the fee-setting mechanism, and the payment method translating services into payment

Preliminary Analysis

Country	Subdomains			
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Australia	Individual / Facility-level	Multipayer, Regulated	Regulated schedule + Market segment	Blended / Mixed
Japan	Collective / National Negotiation	Multipayer, Regulated	Fully administered	Blended / Mixed
Poland	Individual / Facility-level	Single Payer	Regulated schedule + Market segment	Blended / Mixed
South Korea	Collective / National Negotiation	Single Payer	Fully administered	Blended / Mixed

No formal collective physician bargaining mechanism

No formal mechanism for PhilHealth; Collective negotiation occurs in the private HMO sector

Fee Negotiation: Captures the level at which physicians negotiate the rate governing most of their income

Preliminary Analysis

Other countries have **collective negotiations at the national level**

Country	Subdomains			
	Fee Negotiation	Payer Config		t Method
Philippines	None	Multipayer, Fra	Market segment	/ Mixed
Germany	Collective / National Negotiation	Multipayer, R		/ Mixed
Indonesia	Payer-Provider Bilateral	Single Pa		/ Mixed
Australia	Individual / Facility-level	Multipayer, Regulated	Regulated schedule + Market segment	Blended / Mixed
Japan	Collective / National Negotiation	Multipayer, R		/ Mixed
Poland	Individual / Facility-level	Single Pa		/ Mixed
South Korea	Collective / National Negotiation	Single Pa		/ Mixed

Physicians **negotiate fees collectively** with the **state** through their **associations** or a **body speaking for the profession**

The **KBV** and **GKV-Spitzenverband** jointly set the federal EBM framework, while **regional KVen** negotiate aggregate ambulatory remuneration with sickness funds

Physician fees are set through a**nnual collective negotiations between the NHIS and each provider association** over the conversion factor, with unresolved talks decided by vote in the **Health Insurance Policy Deliberation Committee (HIPDC)**

Fee Negotiation: Captures the level at which physicians negotiate the rate governing most of their income

Preliminary Analysis

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Poland	Individual / Facility-level	Single Payer	Regulated schedule + Market segment	Blended / Mixed
South Korea	Collective / National Negotiation	Single Payer	Fully administered	Blended / Mixed

No strategic purchaser and all are fragmented

Payer Configuration: captures how concentrated the purchasing side is and this shapes how much leverage exists to anchor prices across the system

Preliminary Analysis

Country	Subdomains			
	Fee Negotiation	Payer Configuration	Fee-settin	
Philippines	None	Multipayer, Fragmented	Regulated Market	Blended / Mixed
Germany	Collective / National Negotiation	Multipayer Regulated	Negotiat regula	
Indonesia	Payer-Provider Bilateral	Single Payer	Regulated Market	
Australia	Individual / Facility-level	Multipayer, Regulated	Regulated schedule + Market segment	Blended / Mixed
Japan	Collective / National Negotiation	Multipayer, Regulated	Fully ad	
Poland	Individual / Facility-level	Single Payer	Regulated Market	
South Korea	Collective / National Negotiation	Single Payer	Fully administered	Blended / Mixed

Multiple payers coexist but operate under a common government-set framework

Has a **dominant public payer (Medicare) plus private insurers** bound by community-rated premiums, risk equalization, and government tax incentives

Has **3,000+ insurers**, but all offer **standardized coverage** and pay providers under the **set fee schedule**

Payer Configuration: captures how concentrated the purchasing side is and this shapes how much leverage exists to anchor prices across the system

Preliminary Analysis

Country	Subdomains			
	Fee Negotiation	Payer Configuration	Fee-setting Mechanism	Payment Method
Philippines	None	Mult	+	Blended / Mixed
Germany	Collective / National Negotiation	Multipayer, Regulated	regulated frame	Blended / Mixed
Indonesia	Payer-Provider Bilateral		+	Blended / Mixed
Australia	Individual / Facility-level	Mul	+ Market segment	Blended / Mixed
Japan	Collective / National Negotiation	Multipayer, Regulated	Fully administered	Blended / Mixed
Poland	Individual / Facility-level	Single Payer	Regulated schedule + Market segment	Blended / Mixed
South Korea	Collective / National Negotiation	Single Payer	Fully administered	Blended / Mixed

Providers are paid through a combination of methods to balance the incentives

Nearly every system is blended; whether it works depends on what providers will tolerate and what holds up in practice

Payment Method: Captures the mechanism used to pay providers, which shapes the incentives they face

03 Workforce & Market Structure

Dual practice is a consequence of the **fragmented compensation system**

Country	Subdomains				
	Physician Workforce Segmentation			Bargaining Power	Training and Entry Governance
	Practice: Private, Public, Dual	General Practitioners vs Specialists	Geographic Location Differentiation		
Philippines	Mixed with unregulated dual practice	Specialist-[illegible]			Profession-governed
Germany	Mixed with regulated dual practice	Balanced	Maldistributed	High	Profession-governed
Indonesia	Mixed with regulated dual practice	Balan[illegible]			State-governed
Australia	Mixed with regulated dual practice	Balan[illegible]			State-governed
Japan	Mixed with regulated dual practice	Specialist-[illegible]	(Urban > Rural)	Moderate	State-governed
Poland	Mixed with unregulated dual practice	Specialist-[illegible]			State-governed
South Korea	Mixed with regulated dual practice	Specialist-dominated	(Urban > Rural)	Moderate	State-governed

Physicians work across both sectors, but dual practice lacks a clear, enforceable definition of full-time service and location

- **Public physicians** → Salary Standardization Laws + RA 7305 (Magna Carta), but funded inconsistently by LGUs after devolution
- **Private physicians** → no equivalent law; governed only by the Labor Code, regional minimum wage, and DOLE D.O. 182-2017

Ulep et al. (PIDS DP 2025-15) documented **labour-standards violations** in the sector

Practice: how physician practice is distributed across sectors

Preliminary Analysis

Dual practice exists in most countries, but is regulated

Country	Subdomains				
	Physician Workfor				Training and Entry Governance
	Practice: Private, Public, Dual	Gene Practitio Specialists			
Philippines	Mixed with unregulated dual practice	Specialist-d			Profession-governed
Germany	Mixed with regulated dual practice	Balanced	(Urban > Rural)	High	Profession-governed
Indonesia	Mixed with regulated dual practice	Balanced	Maldistributed (Urban > Rural)	Low	State-governed
Australia	Mixed with regulated dual practice	Balanced	Maldistributed	Moderate	State-governed
Japan	Mixed with regulated dual practice	Specialist-d			State-governed
Poland	Mixed with unregulated dual practice	Specialist-d	(Urban > Rural)		State-governed
South Korea	Mixed with regulated dual practice	Specialist-dominated	Maldistributed (Urban > Rural)	Moderate	State-governed

Physicians work across public and private sectors, with dual practice governed by clear rules on time, location, and commitment

Under licensing rules, a doctor may practice at **up to three facilities** and each of these facilities has its own pay arrangement

Physician **shortages** drive widespread dual employment *(arubaito)* with **urban hospitals dispatching staff to rural areas**, now capped by **statutory working-hour limits** since April 2024

Practice: how physician practice is distributed across sectors

Preliminary Analysis

Country	Subdomains				
	Physician Workforce Segmentation				
	Practice: Private, Public, Dual	GP/PCP vs Specialists	Geographic Differentiation		
Philippines	Mixed with unregulated dual practice	Specialist-dominated	Maldis (Urbar		
Germany	Mixed with regulated dual practice	Balanced	Maldistributed (Urbar	High	Profession-governed
Indonesia	Mixed with regulated dual practice	Balanced	Maldis (Urbar		
Australia	Mixed with regulated dual practice	Balanced	Maldis (Urbar		
Japan	Mixed with regulated dual practice	Specialist-dominated	Maldis (Urban	Moderate	State-governed
Poland	Mixed with unregulated dual practice	Specialist-dominated	Maldis (Urbar		
South Korea	Mixed with regulated dual practice	Specialist-dominated	Maldis (Urbar		

Physician workforce is weighted toward specialists over generalists

Specialists outnumber GPs about two to one but most everyday care is still delivered by generalists in rural health units (RHUs)

- Most clinic "primary care" comes from ex-specialists without GP training (formal certification only since 2018)
- PCPs dominate the Japan Medical Association and out-earn specialists

Essential specialties (general surgery, OB/GYN, pediatrics, emergency medicine) **face chronic shortages** because low fees, heavy workloads, and legal risk push doctors toward better-paid procedural and cosmetic fields instead

General Practitioner / Primary Care Physicians vs Specialists: Captures the balance of the workforce between generalists and specialists, which shapes fee dynamics

Preliminary Analysis

Across countries, maldistribution is addressed through **incentives to the provider** (allowances, scholarships, deployment)

Country	Subdomains				
	Physician Workforce Segmentation			Bargaining Power	Training and Entry Governance
	Practice: Private, Public, Dual	General Practitioners vs Specialists	Geographic Location Differentiation		
Philippines	Mixed with unregulated dual practice	Specialist-dominated	Maldistributed (Urban > Rural)	Moderate	Profession-governed
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Indonesia	Mixed with regulated dual practice		Maldistributed		State-governed
Australia	Mixed with regulated dual practice				State-governed
Japan	Mixed with regulated dual practice	Spec			State-governed
Poland	Mixed with unregulated dual practice	Spec			State-governed
South Korea	Mixed with regulated dual practice	Specialist-dominated	Maldistributed (Urban > Rural)	Moderate	State-governed

- **RA 7305** provides hazard, subsistence and remote-assignment allowances for public health workers
- **RA 11509** gives medical scholarships with a return-service obligation prioritizing municipalities without government physicians

Geographic Location Differentiation: Captures the composition physicians in urban and rural areas

Preliminary Analysis

Physicians hold little leverage: fees set by state or facilities with minimal physician influence

Bargaining power is asymmetric: weak against PhilHealth but stronger in private/HMO

Country	Practice Public, Dual	Practitioners vs	Location Differentiation	Bargaining Power	Training and Entry Governance
Philippines	Mixe unregul pra		tributed > Rural)	Moderate	Profession-governed
Germany	Mixed with regulated dual practice	Balanced	Maldistributed (Urban > Rural)	High	Profession-governed
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Bargaining Power: Captures how much leverage physicians hold in setting or negotiating fees against payers and facilities

Preliminary Analysis

Country	Subdomains				
	Physician Workforce Segmentation			Bargaining Power	Training and Entry Governance
	Practice Publi		ic Location ntiation		
Philippines	Mixe unregulated dual pra	Specialist-dominated	tributed > Rural)	Moderate	Profession-governed
Germany	Mixed wit dual p		tributed > Rural)	High	Profession-governed
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Physicians hold strong, institutionalized leverage in fee-setting

Physicians exercise substantial institutionalized bargaining power through statutory self-governing organizations

Bargaining Power: Captures how much leverage physicians hold in setting or negotiating fees against payers and facilities

Preliminary Analysis

Country	Subdomains				
	Physicia			ning Power	Training and Entry Governance
	Practice: Private, Public, Dual				
Philippines	Mixed with unregulated dual practice		Maldistributed	oderate	Profession-governed
Germany	Mixed with regulated dual practice			High	Profession-governed
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Specialty formation and training are governed by the profession (societies/chambers) rather than the state, which does not steer training volume or specialty mix

- **PRC and Specialty Societies** accredit training, run exams, and quality-assure every physician and specialist in the country
- **PRC BOM Res. 25, s.2015** states that there is an *"absence of a government regulatory agency to supervise and monitor training"*
- **No government agency** plans the numbers, funds the pipeline, or aligns formation with need

Training and Entry Governance: Captures whether the state can align training numbers and specialty mix with population need, or whether that authority rests with the profession

Preliminary Analysis

Where the state governs training and entry, it holds the levers that matter: planning how many physicians to produce, funding the pipeline, and aligning that output with population need

03 Workforce & Market Structure

Country	Subdomains				
	Physician Workforce Segmentation			Bargaining Power	Training and Entry Governance
	Practice: Private, Public, Dual	General Practitioners vs Specialists	Geographic Location Differentiation		
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Poland	Mixed with unregulated d practice			oderate	State-governed
South Korea	Mixed with regulated dual practice	Specialist-dominated	Maldistributed (Urban > Rural)	Moderate	State-governed

The state aligns training and entry with population need by steering training numbers and specialty mix through admission quotas, funded training places, or government-appointed training authorities

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Training and Entry Governance: Captures whether the state can align training numbers and specialty mix with population need, or whether that authority rests with the profession

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Neither extreme works: the state planning without the profession fails, and the profession left to carry formation alone fails too. Alignment with need requires both.

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Korea's government sets how many enter medicine each year. In 2024, they tried to raise that number unilaterally, over the profession's objections which resulted into mass walkouts, a broken training year, and a forced reversal

Training and Entry Governance: Captures whether the state can align training numbers and specialty mix with population need, or whether that authority rests with the profession

Preliminary Analysis

04 Monitoring & Accountability

Country	Subdomains		
	Fee Transparency	Patient Protection Mechanisms	Compliance Monitoring, Audit, and Enforcement
Philippines	Mandated Disclosure	Partial (limited protections)	Monitoring without Effecitve Enforcement
Germany	Partial / On-Request Disclosure	Comprehensive	Active with Sanctions
Indonesia	Mandated Disclosure	Partial (limited protections)	Monitoring without Effecitve Enforcement
Australia	Mandated Disclosure	Comprehensive	Active with Sanctions
Japan	Published Binding Schedule	Comprehensive	Active with Sanctions
Poland	None	Partial (limited protections)	Monitoring without Effecitve Enforcement
South Korea	Published Binding Schedule	Partial (limited protections)	Active with Sanctions

Domain 4: Captures whether the fee rules that exist on paper are made visible, enforced, and protective in practice

Preliminary Analysis

Country	Subdomains		
	Fee Transparency	Patient Prot	t,
Philippines	Mandated Disclosure	Partial (lim	
Germany	Partial / On-Request Disclosure	Com	
Indonesia	Mandated Disclosure	Partial (lim	
Australia	Mandated Disclosure	Com	
Japan	Published Binding Schedule	Com	
Poland	None	Partial (lim	
South Korea	Published Binding Schedule	Partial (lim	

Disclosure is legally mandated

Through AO 2021-0008 itemised price list and HFPA entry tied to license renewal, disclosing fees is required but gap lies in **implementation fidelity**

- Holds a professional standard of **Informed Financial Consent** → ensuring patients understand and agree to expected costs before treatment
- The Medical Board and AMA treat upfront cost discussion as part of **good medical practice** → embedded in a **Medical Specialist Professionalism Framework on ethical billing**

Fee Transparency: whether physician fees are disclosed to patients and the public before care

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Australia	Mandated Disclos		tive with Sanctions
Japan	Published Binding Sch		tive with Sanctions
Poland	None		onitoring without ecitve Enforcement
South Korea	Published Binding Schedule	Partial (limited protections)	Active with Sanctions

Some protection with significant gaps

- Protection is partial and attaches to the bed
- No Balance Billing covers only basic/ward accommodation, and private participation is capped at 10% of beds

Domain 4: Captures strength of patient's protection from unexpected charges

Preliminary Analysis

Country	Subdomains		
	Fee Transparency	Patient Protection Mechanisms	Compliance Monitoring, Audit, and Enforcement
Philippines	Mandated Disclosure	Partial (limited protections)	Monitoring without Effecitve Enforcement
Germany	Partial / On-Request Disclosure	Comprehensive	Active with Sanctions
Indonesia	Mandated Disclosure	Partial (limited protections)	Monitoring without Effecitve Enforcement
Australia			
Japan	Pu		
Poland			
South Korea	Pu		

Patients structurally protected from charges above expected/covered amounts

- Protects patients from balance-billing by setting ambulatory physician fees through the EBM/KV system
- Patient costs are limited to statutorily defined cost-sharing (mainly dental), with exemptions under SGB V
- Compulsory schemes finance over 90% of outpatient medical care costs

Domain 4: Captures strength of patient's protection from unexpected charges

Preliminary Analysis

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Australia	Mandated Disclosure	Comprehensive	Active with Sanctions
Japan	Published Binding Schedule	Comprehensive	Active with Sanctions
Poland	None	Partial (limited protections)	Monitoring without Effecitve Enforcement
South Korea	Published Binding Schedule	Partial (limited protections)	Active with Sanctions

Monitoring bodies and sanctions exist on paper, but detection / investigation / sanction is weak or unevidenced in practice

Compliance Monitoring, Audit, and Enforcement: Captures whether violations are detected, investigated, and sanctioned

Preliminary Analysis

Country	Subdomains		
		echanisms	Compliance Monitoring, Audit, and Enforcement
Philippines		ections)	Monitoring without Effecitve Enforcement
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Japan	Published Binding Schedule	Comprehensive	Active with Sanctions
Poland		ections)	Monitoring without Effecitve Enforcement
South Korea	F	ections)	Active with Sanctions

Violations monitored, detected, and sanctioned with real consequences (e.g. audits, repayment orders, financial penalties)

A dedicated agency, the **Professional Services Review (PSR)**, protects the integrity of the MBS and safeguards patients and the community from inappropriate practice, publishing annual reports on reviewed cases

HIRA processes over 99% of claims electronically and uses IT-driven provider profiling to flag upcoding, unbundling, and abusive billing practices

Compliance Monitoring, Audit, and Enforcement: Captures whether violations are detected, investigated, and sanctioned

Preliminary Analysis

What is “Appropriate Compensation”?

A fee is “appropriate” if **enough physicians still enter and stay in each specialty and location to meet need** when it is set at that level across all providers and operationalized through provider response in aggregate (entry, retention, distribution)

Principle: Sustainability

Covers the resources, time, and training specialist practice requires across the workforce

Principle: Accessibility

Structure must keep essential care affordable regardless of a patient’s income

Principle: Quality

payment structure must reward high-quality care and the appropriate use of clinical expertise

Sustaining the Profession, the System, and the Patient

Physicians

Job Sustain a viable career; reproduce the pipeline

Pain Training debt, undercompensated time, maldistribution pressure

Gain A fee covering resources, time & training across the workforce

Government / Payer

Job Keep essential care affordable and available

Pain Fiscal exposure, access gaps, workforce shortages

Gain A fee that does not price care out of reach

Patients

Job Get high-quality care they can afford

Pain Cost burden; variable quality of care

Gain Rewarded expertise and appropriate use of it

Source: Zhang, Duckett, and Kemp (2026). *Australia’s Specialist Fee Failure: Three Principles for a Way Forward. Australian Economic Review 59 (1): 114-118.*

Preliminary Analysis

Summary of Key Insights

Ultimately, **professional fees are not set in isolation** but emerge as the **equilibrium of all the four domains** mentioned below; therefore, reforming any one domain shifts the others

Governance & Regulation	Payment & Fee-Setting	Health Workforce & Market Structure	Monitoring & Accountability
CURRENT SITUATION No dedicated law and no body empowered to set or enforce physician fees	**CURRENT SITUATION** PhilHealth rates are handed down administratively	**CURRENT SITUATION** No regulatory body matches supply (who enters and stays) to demand (what the country needs)	**CURRENT SITUATION** We mandate disclosure yet do not audit compliance
WHAT DO WE NEED A legal framework that gives PF a binding basis	**WHAT DO WE NEED** Structured, negotiated fee-setting mechanism with a built-in review cycle	**WHAT DO WE NEED** A framework that allows for standing state–profession conversation that plans the workforce to need	**WHAT DO WE NEED** Monitoring, reporting, and the data to set and update rates fairly

Next Steps

Questions to answer

What does the current landscape actually look like?

- ***We can't manage what we can't measure***
- We need to measure the landscape in order to effectively start negotiations

How will providers respond to payment and financing reforms?

- Government and societies need to understand **how political economy and physician dynamics operate across sectors** and find a way to integrate all of them

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