HealthCLIR Pilot Diagnostic: THE PHILIPPINES

Health Business Climate Legal and Institutional Reform

This publication was produced for review by the United States Agency for International Development by Booz Allen Hamilton under the Business Climate Legal and Institutional Reform (BizCLIR) project.

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AGENDA FOR ACTION

November 2009

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INTRODUCTION

This report addresses the legal and institutional constraints faced by the health system in the Philippines, with an emphasis on the issues impacting private sector participation within the health system. This pilot assessment activity applied an established commercial legal and institutional reform analytical methodology using a health sector lens to identify how laws and institutions impact the participation of the private sector within the overall health system framework. This HealthCLIR assessment was conducted on behalf of the U.S. Agency for International Development in the Philippines to help validate the tool's design, while at the same time providing a new approach for understanding the legal and institutional issues impacting health service providers and medical goods distribution.

The findings observed in this report are intended to help inform the U.S. Agency for International Development and other donors' assistance programs, as well as provide a potential framework for guided reforms for government officials, private sector representatives, and other interested stakeholders. The findings and recommendations are solely the opinions of the authors, and are not the opinions of the U.S. Agency for International Development. A list of targeted reforms is included as an appendix to this report.

THE PHILIPPINES CROSSROADS

The health system of the Philippines is at a crossroads. For over 30 years, the healthcare industry has developed along two separate tracks: fostering the best and brightest doctors and nurses for export, while at the same time attempting to balance remaining resources to develop a strong public health system, with the introduction of world-class tertiary hospitals. However, outside of the Manila capital area and other urban centers the population remains underserved by either the private or public sectors of the health system. This dual-track, urban versus rural health system development is a widening gap, resulting in a perverse outcome where an estimated 100,000 nurses remain unemployed in the country. Anecdotal evidence shows that nurses are willing to pay to work for two years to gain experience in the best hospitals, yet clinics and medical facilities in rural areas of the country are closing down due to a lack of human resources.

Exacerbating this resource imbalance, the decentralization of health policy, procurement, and health system implementation to the municipal local government units (LGUs) has resulted in a disconnect between the more sophisticated LGUs with greater resources, and those LGUs with less capacity to address health issues in a holistic manner.[1] The theoretical benefits of a decentralized system, such as speedier response to local health issues and greater individual accountability, can also have detrimental legal and institutional effects for private and public healthcare providers at the community level. For example, disparate local health codes, regulatory procedures, and increased opportunities for graft affect market entry and expansion decisions by both private and public sector healthcare entities.

While the causes of and solutions to this major gap in the health system are numerous, the Government of the Philippines (GOP) does

1 Local Governance Act of 1991.

recognize this problem, and appears to be taking some first steps toward alleviating the effects of this system-wide imbalance.[2] The GOP must now choose which path to follow: whether to continue to reactively treat the effects of this imbalance, or whether to diagnose and address the underlying legal and institutional causes of this imbalance.

This report examines the environment for providing healthcare services in the Philippines and identifies opportunities to strengthen the laws and institutions that support participation of both the public and private components of the health system to provide guidance to policymakers as they choose whether to balm the effects, or address the underlying issues facing the health system. The specific areas of the health system under review are "Delivering Goods," which is a review of the supply chain for pharmaceuticals and medical devices; "Developing Human Capacity," which looks at issues of training, certification, and the balance of supply of and demand for trained medical staff within the Philippines; "Providing and Maintaining Facilities," which looks at facility start-up, operations, licensing and certification; and "Governing the System," which focuses on the distribution of decision-making authority within the health system, the budget process, and public/private participation within the health system. For each of these subject areas, this report looks at the legal framework, public and private institutions, and the social dynamics shaping the system and the foundations for reforms.

This diagnostic was undertaken from February 9 to February 20, 2009. A six-person team of consultants, whose backgrounds range from commercial legal reform and public health to organizational strategy and design, traveled to the Philippines to conduct interviews with individuals from the public sector policymakers, public sector facilities and administrators, private sector facilities and administrators, non-governmental organizations, members of the international donor community, public insurance corporation employees, and other stakeholders for a broad-based set of interview data. Interviews were conducted throughout the greater Manila metropolitan region, as well as on the islands of Cebu and Bohol. The report attempts to focus especially on those barriers to the private sector, although issues facing both public and private components of the health sector were identified. Initial findings were presented to the U.S. Agency for International Development/Philippines mission on February 20, 2009. This report provides additional context to the observations and recommendations provided to USAID/Philippines.

SUMMARY OF FINDINGS

Health system sustainability ultimately requires the most efficient provider to supply services. As health is a public good, opportunities for market failure are ripe. Ultimately, this report seeks to identify whether the existing laws and institutions support a system that allows for competition and collaboration among private and public sector market participants.

DELIVERING GOODS

The legal framework for delivery of medical goods and devices is largely sound, with the exception of an effective competition policy. However, capacity and resources constrain implementation of these laws and regulations. The pharmaceuticals market, at every step along the supply chain, has a single dominant market participant, resulting in a substantial increase in drug prices. No competition agency exists with a primary mandate to enforce competition within the private sector. Further, enforcement of existing laws against the restraint of trade does not appear to be a governmental priority, reinforcing anti-competitive market behaviour. Government procurement agencies exist that provide rules and regulations in favor of competitive sourcing, however private sector for-profit and non-profit providers have no protections from anti-competitive behaviours of market participants, increasing costs associated with doing

2 The government has sponsored the "Doctors to the Barrios" program that encourages recent medical school graduates to provide services in underserved rural regions. A similar program for nursing school graduates has been announced as well.

business. Further, the decentralization of the health system has led to a highly decentralized drug procurement system, resulting in very low relative negotiating power for pharmaceutical consumers, and limited opportunities for bulk drug purchasing. Each separate LGU and each private facility seemingly has its own procurement procedures, such as supplier accreditation. PITC Pharma has the sole legal authority to engage in parallel imports, but issues of capacity, resources, and supply keep PITC Pharma from expanding beyond existing levels of import. Further, the local generic drug production industry remains small, as consumers have a high level of distrust of the quality of generic products.

DEVELOPING HUMAN CAPACITY

For over 30 years, the Philippines has institutionalized the export of highly skilled medical labor to the United States, Canada, the UK, the United Arab Emirates, and other regions with high demand, especially for qualified nurses. This strategy has resulted in a substantial amount of remittances to the Philippines, now an estimated 10 percent of gross domestic product (GDP). In response to this high demand, the private sector has opened many new nursing schools in the Philippines, but the standards of training are not perceived to be high, resulting in a glut of unemployed nurses with insufficient experience to work abroad. Indeed, beyond statistics showing low board passage rates of schools over the past five years, physicians, surgeons, and health facility human resources specialists all voiced concerns over the lack of clinical experience obvious in nurses who graduated from certain institutions. Although there is an estimated 100,000 unemployed, trained nurses in the urban areas of the Philippines, there is also a crisis-level lack of medical staff in certain rural municipalities. Current laws on professional workers allow only Filipino citizens to practice, including medical professionals, which restricts opportunities for other trained medical staff to replace those lost to export. While the legal framework for training and certification of licensed medical professionals is largely sound, there are a few areas of concern. Specifically, certain laws such as those regulating the midwifery profession do not reflect current international "best practices" in midwifery standards. Additionally, while implementing agencies have the legal mandate to regulate certification of staff, there is reluctance to enforce curriculum standards on non-compliant schools, which reinforces the cycle of perceptions of low-quality education in some training facilities.

PROVIDING AND MAINTAINING FACILITIES

The legal framework pertaining to the start-up and licensing of healthcare facilities is largely clear, and made widely available in English via the Department of Health (DOH) website. However, implementation of facility licensing procedures tends to vary considerably based upon whether the facility is private or publicly owned and operated, and whether the facility is located in a region with insufficient medical service providers. Most interviewees found that private sector facilities and facilities in urban areas with greater medical coverage were held to a higher standard than public facilities located in underserved regions. Further, ownership of hospitals and most healthcare organizations is largely unconstrained. Foreign (i.e., non-Filipino) ownership of hospitals, pharmacies, and other healthcare practices that exist in a corporate form are constitutionally limited to a 40 percent equity stake in the corporation. However, under Filipino law, the doctors, pharmacists, and other professionals who practice within the facilities must be Filipino. Each of these issues serve to increase the cost of maintaining a facility and, on the margin, likely limit market entry.

GOVERNING THE SYSTEM

The health system's governance model is one of almost complete devolution of implementation authority to the LGUs. While the DOH retains competencies and a mandate to develop strategic national policies to guide the system, capture and manage data flows that inform the system, develop regulations for medical facilities,

pharmaceuticals and medical devices, and collaborate for professional standards, much of the implementation and operational decision-making within the system is handled at the LGU level. While a devolved system can create opportunities for private sector participation in the health system, such as a potential for an increased number of service tenders, some barriers may arise from the devolved nature of information, disparate client bases, and differing procurement systems that can lead to higher administrative costs in procurements. Trends in LGU collaboration, such as inter-local health zones,[3] are positive, and should receive continued support from donors and the DOH.

By most accounts, the legal framework for the system of governance is largely sound, and the institutions largely have adequate capacity to manage the system. However, it is notable that most stakeholders have not yet received any information regarding the next phase in strategic policy development, so all strategy documents naturally expire in 2010. Interviewees were interested in both learning about next strategic steps, and listed interest in participating in development of the next strategic policy.

CROSSCUTTING THEMES

Although this report focuses on the application of a standardized analytical framework to four discrete indicators for effective private and public sector participation in the health system, certain themes were so prevalent across all sections, or so significant to more than one section, that they warrant special notice.

REGIONAL HARMONIZATION

Perhaps the single largest exogenous factor that could significantly reshape the Philippine health system is The Association of Southeast Asian Nations (ASEAN) harmonization in the healthcare sector. With the health sector listed as one of 11 top priority sectors for harmonization, ASEAN harmonization would, in the words of one interviewee, "set a new path and maybe reshape healthcare in the Philippines." While health sector harmonization generally could have significant effects across the Philippines health system, of special importance is the ASEAN Consultative Committee for Standards and Quality Pharmaceutical Product Working Group, which has been working to harmonize pharmaceutical regulatory processes and standards and minimize technical barriers to trade within inter-ASEAN trade.

While harmonization is viewed favorably within the international pharmaceutical industry represented in the Philippines, it could also lead to considerable hardship initially for smaller-scale local pharmaceutical producers that will have to comply with revisions to the existing Bureau of Food and Drugs (BFAD) regulatory scheme. However, in the long term ASEAN harmonization should support increased regional competition among pharmaceutical producers as regulatory burdens decrease administrative costs for market entry. Indeed, as suggested by one official, ASEAN harmonization could logically lead to increased collaboration among ASEAN countries in regional drug price negotiations with international pharmaceutical companies, and even a potential region-wide drug procurement system for certain classes of pharmaceuticals.

DONOR COORDINATION

International donor agency coordination within the health sector has made great strides at the central government level. While areas for improvement exist, most donors expressed a generally high level of satisfaction regarding coordination. Clear assistance provided in policy formulation, especially regarding the development of the Fourmula One for Health strategy, has provided a sound basis for central government donor assistance.

However, at the LGU level, little donor coordination seems to exist beyond sharing best practices in an *ad hoc* manner. The devolution of health system implementation and budget authority to the LGU level has resulted in a greater need to engage and collaborate among donors, with substantial GOP interface.

3 Inter-local health zones are similar to a district health system in which individuals, communities and all other health care providers in a well-defined geographical area participate together in providing quality, equitable and accessible health care with Inter-LGU partnership as the basic framework. See: http://www.doh.gov.ph/blhd/lhsdp.

Significant variance in regulatory standards among LGUs can cause a barrier to expansion and market entry for successful private healthcare providers. One interviewee cited an example of an NGO seeking to replicate its successful maternal health model in a new municipality, but finding differing regulatory code standards among LGUs to prohibit entry. Horizontal coordination (i.e., coordination among donors providing advice to various LGUs) and vertical donor coordination (i.e., coordination among donors providing assistance among varying levels of government) for policy and programming assistance could assist by promoting similar policy and program standards among LGUs to reduce policy and regulatory variance.

CONSUMER ADVOCACY AND BEHAVIOR

Currently, no entity has the legal mandate for, nor serves as a *de facto* consumer advocate. Nowhere is this lack of advocacy felt more than the supply of pharmaceuticals. Specific examples of a failure in consumer advocacy throughout this report include:

- At all levels of the drug supply chain, individual market participants have captured significant market share. Without a strong competition policy and the absence of a dedicated competition policy enforcement agency, there is little safeguard to protect pharmaceutical consumers from abuse of market dominant positions along the supply chain.
- Currently, no entity with measurable market power represents the consumer in pharmaceutical transactions.
- The existing Filipino health system emphasizes curative services rather than preventive care. Existing insurance schemes, public and private, focus on reimbursement of curative services rather than providing incentives for annual check-ups and healthy lifestyle choices.

As a market participant covering approximately 80 percent of the population, a logical consumer advocate could be the Philippine Health Insurance Corporation (PhilHealth). PhilHealth has an opportunity to leverage significant market power to negotiate drug prices with local and international pharmaceutical providers. Currently, PhilHealth reimburses drug prices without negotiating best deals or bulk member discounts. Additionally, as an entity whose reimbursement policies significantly shapes consumer behavior, it should focus on encouraging generic drug purchases, and providing reimbursement levels emphasizing a less costly preventive healthcare structure.

PUBLIC PRIVATE COLLABORATION

The DOH increasingly views the private sector as a potential partner, especially in formulation of laws and policies. Yet at the municipal and provincial levels, oftentimes private sector providers are still seen as competition rather than a potential partner. Further, no system-wide process or policy exists to support private sector participation and collaboration in the development of health policy, regulations, and the budget-making process.

By many accounts, both within government and within the private sector, the level of public/private interaction in development of the Universally Accessible Cheaper and Quality Medicine Act of 2008 ("Cheaper Medicines Law") was the most inclusive process yet for private sector comment. Despite the non-existence of formal guidelines for public notice and comment procedures, members of the government and representatives of the private sector separately praised the result of stakeholder participation at an early stage, and separately suggested that this could serve as a model for future stakeholder participation. According to one interviewee, other government ministries have inquired into the process as a potentially useful tool for their own regulatory measures. This development, if memorialized into official guidelines, could represent a significant step in stakeholder participation at the central government level, and also serve as an example for public-private collaboration at the LGU level.

INFORMATION ASSURANCE

Information-based decision-making at the central government level is stymied by disaggregated information, poor reporting standards, and limited utilization of off-the-shelf database software. Budgeting, policy, and procurement decisions made with outdated or erroneous data can have significant impact on the availability of life-saving drugs. Incorrect data on levels of morbidity and mortality could shift limited resources into less-productive uses. Information-based decision-making requires assurance of the quality and sufficient quantity of data collected.

While the overall Field Health Support Information System applied by the Department of Health is deemed to be generally suitable, the quality of data input into the system significantly impacts the quality of analysis enabled by information systems. The disparity of resources and collection methodologies among LGUs in data capture impact the quality of data. In one instance, an interviewee recounted an example of data gathered by the mayor of a municipality reporting on incidence rates of a chronic disease. The mayor reported on incidence rates of the chronic disease over a one-year period based purely upon recall of which of his citizens had mentioned their illness to him. Without focusing on significant systems overhaul, even basic retraining on simple survey methodologies and best practices in records management could provide a marked improvement in data quality.

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DELIVERING GOODS

The Philippine pharmaceutical sector is unusual in several respects. It is beset by weak regulatory implementation, ineffective institutions, and a lack of competition. As a result, pharmaceutical prices are higher than among similarly situated countries within the region. The distinctive characteristics of the sector include the following:

First, it shows a very high level of concentration at all levels of the supply chain. Manufacturing is dominated by two firms, each capturing approximately 30 percent of the market for production. Distribution is dominated by a single firm that has captured over 60 percent of the market. At the retail level, one pharmacy chain accounts for almost 70 percent of retail sales. There is also significant vertical integration, with, for instance, the largest distributor owning the second-largest manufacturer and also about 25 percent of the retail outlets.

Second, the Philippines does not produce the raw materials for most of its drugs. The Philippines has never had a large chemical industry, so it has a very limited capacity to produce active pharmaceutical ingredients (APIs). Thus, most raw materials—salts, esters, binders, among others—have always been imported.

Third, prices for drugs and other medical supplies are quite high by regional standards.[4] Most branded drugs are sold at prices similar to those in developed countries, and higher—sometimes much higher—than in neighboring countries such as Indonesia and Malaysia. The high prices apply not only to patented drugs but also to many off-patent originator brands, and while prices are highest in retail pharmacies, they are also quite high in clinics and in public and private hospitals.

Fourth, the level of generic penetration is quite low. Generic prescription drugs account for only about 11 percent of gross sales in the Philippines, in sharp contrast to neighboring countries such as Indonesia (where they are about 45 percent) or Singapore (about 60 percent). Cheap and high-quality drugs by local manufacturers do exist, but they are not promoted effectively and are not widely consumed.

COMPARISON OF SELECTED DRUG PRICES (2008)

Product	Manufacturer	Price in Philippines	Price in India	Price in Pakistan
Norvasc	Pfizer	45	5	n/a
Ventolin	GSK	315	123	62
Imodium	Jansen	10	3	1.8

Prices in peso equivalents.
Source: Business Meridian International

Fifth, an unusually high percentage of drugs are sold at retail. Roughly 85 percent of the money spent on drugs in the Philippines is spent at retail pharmacies. Only about 15 percent is spent by hospitals or clinics.[5]

The overall size of the market is approximately US$2.6 billion per annum. This works out to about 2 percent of GDP, or an annual drug expenditure of around US$30 per capita. As of 2007, this broke down roughly as follows:[6]

DRUG	US$
Branded	1.6 billion
Generics	290 million
Over the counter	730 million

The market for medical supplies is much smaller—about US$80 million per year.

The country relies heavily upon imports of both raw materials and finished drugs. Philippine drug manufacturers do not produce anything for

4 The last comprehensive survey of drug prices in the Philippines was conducted in 2005; it is available online at http://www.haiweb.org/medicinepricessurveys/200502PH/sdocs/PhilippinesSummaryReportFINAL.pdf. However, there have been numerous comparisons of individual drugs since then by a variety of interested parties—donors, NGOs, PITC Pharma, and others. The general pattern of high drug prices continues to hold true.

5 Business Meridian International (BMI), Q4 2008 report on the Philippine pharmaceutical sector.

6 Ibid.

export except for a handful of herbal products and food supplements. The balance of trade in pharmaceuticals is strongly negative and has been so for decades.

Finally, much of the country's population has little or no access to prescription drugs. Approximately 40 percent of the Philippines' population lives on US$2 per day or less and cannot afford pharmaceuticals. (The World Health Organization (WHO) classifies the Philippines as a country where a significant minority of the population entirely lacks access to drugs or primary health care.) Some of the Philippines' poor have coverage under PhilHealth, the national health insurance corporation, but this only covers hospitalization and not outpatient care or pharmacy visits.

LEGAL FRAMEWORK

On paper, the country has a very solid legal framework for the delivery of medical goods. Laws and regulations are clearly drafted and widely available to stakeholders. The Department of Health (DOH) is given overall responsibility for delivering health care, while the Bureau of Food and Drugs (BFAD) is charged with regulating the import, production, distribution and sale of drugs and medicines. The laws and regulations give these agencies fairly clear responsibilities and powers, and establish a framework of penalties for violations. The result, on paper, is a mixture of public and market responsibility for the delivery of medical supplies and pharmaceuticals, similar to the structures found in many advanced countries. Overall, the legal framework appears consistent with international standards and best practices.

In practice, the situation is more complex. Resources are limited, so the laws are not always implemented or enforced. The domination of the sector by a handful of large actors encourages activities that are technically legal but tend to stifle competition and drive up prices.

CHEAPER MEDICINES LAW

One major change to the legal framework occurred in 2008: the passage of the "Universally Accessible Cheaper and Quality Medicines Act of 2008," generally known as the "Cheaper Medicines Law." Passed in June 2008, this law has a number of interesting provisions. Among other things, it

- prohibits government hospitals and clinics from purchasing branded or innovator products if cheaper generics are available instead;
- gives new powers and responsibilities to the Bureau of Food and Drugs (BFAD), including the power to keep and spend its fees;
- carves out several exceptions to the existing patent laws, including a ban on patenting new uses of existing molecules;
- enjoins PhilHealth to enter into cost containment measures;
- allows the punishment of "price manipulation," "profiteering" and "cartels"
- allows for compulsory licensing;
- legalizes parallel importing;[7]
- sets up a price monitoring and regulation system, run by BFAD; and
- gives the DOH the power to set maximum retail prices for selected drugs.

While the Cheaper Medicines Law may seem at first review to be a mélange of diverse issues, some of the provisions may have a real and significant impact.

WTO

The Philippines is a member of the World Trade Organization (WTO) and is responsible for enforcing foreign intellectual property rights. It is possible that some of the provisions in the Cheaper Medicines Law, if implemented, could bring the Philippines into conflict with its WTO obligations. For example, the law allows compulsory licensing at the discretion of the government, without necessarily fulfilling all the requirements of Article 31 of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement.[8] Where a certain determination is made within the discretion of the Secretary of Health about the availability of a drug or medicine, there is no requirement that a petitioner seek to negotiate commercial terms with the patent holder.[9] This

7 Parallel importing by PITC Pharma is affirmed and encouraged. Private entities are also allowed to engage in parallel importing, provided that they first register with BFAD. The details of the registration process are not yet made clear.

8 A simple explanation of a WTO signatory's obligations under TRIPS can be found here: http://www.wto.org/english/tratop_e/TRIPs_e/public_health_faq_e.htm. Further discussion can be found at http://www.wto.org/english/tratop_e/TRIPs_e/healthdeclexpln_e.htm

9 Rule 12 Section 8 (d) of the Final IRRs of the Cheaper Medicines Law changed the existing provisions to expressly remove an obligation that a compulsory license petitioner first seek to negotiate commercial terms with a patent holder where the Department of Health, within its discretion, determines that the "demand for patented drugs or medicines is not being met to an adequate extent and on reasonable terms." This broad authority seems to extend beyond the limited exceptions within the TRIPS agreement requiring compulsory license petitioners to seek to negotiate with patent holders for commercially reasonable terms over a reasonable period of time before the compulsory license may be issued. Rule 12 Section 8(d) expressly removes this obligation, thus likely creating non-conformity with the TRIPS agreement.

would be legal under the Cheaper Medicines Law, but would likely be a violation of the Philippines' international obligations.

ASEAN

The Association of Southeast Asian Nations (ASEAN) is encouraging gradual harmonization of laws and regulations across various sectors. In the health sector, this includes developing common technical documents and harmonizing drug registration. This will result in, among other things, a single uniform application form for registering new drugs and new uses of drugs across all ASEAN countries, and also enhanced information sharing among ASEAN member state regulators.

Harmonization was originally scheduled for completion by early 2009, but it is running behind. This is partly because the government has moved slowly and partly because of resistance by private actors.[10] However, it is expected that harmonization will be substantially complete by the end of 2010.

IMPLEMENTING INSTITUTIONS

THE DEPARTMENT OF HEALTH

The Philippine Department of Health (DOH) has primary authority for regulating the health sector. The DOH is also itself a health provider, as it owns and administers certain hospitals within the public health system. For purposes of this chapter, the DOH is of interest as a major purchaser of medical supplies and drugs.

DOH procurement is decentralized. The department conducts large procurements of drugs for the entire country, but individual public hospitals also set out bid proposals on an ad hoc basis. In fact, procurement across the entire system—public and private hospitals, rural health units (RHUs), clinics—is not only decentralized but almost completely uncoordinated; individual actors rarely pool bids or cooperate.[11]

KEY IMPLEMENTING INSTITUTIONS

- Department of Health (DOH)
- Bureau of Food and Drugs (BFAD)
- Philippine Health Insurance Corporation (PhilHealth)
- PITC Pharma (PPI)
- Drug importers and manufacturers
- Drug distributors

There are many problems with DOH procurement. The bid process is inefficient and requires bidders to submit the same information multiple times. There is no centralized accreditation for suppliers, so each hospital, province and RHU may demand a complete set of documents before allowing a bid. Although in theory bids cannot take place without a certification that funds are available, in practice funds are often diverted or delayed; this discourages smaller and less well-funded bidders, often reducing the number of bids to just one or two.[12]

Prices are high, shortages and waste are not unusual, and there is a widespread perception that corruption is a problem.[13] The system as a whole is not considered either transparent or efficient. The DOH has not conducted a review of procurement policies since decentralization; there is an interest in doing so, but it has been blocked by a lack of resources.

The DOH is also trying to subsidize some key medicines. The "P100 project" is a DOH initiative to provide a complete course of treatment in a single package for 100 pesos (about US$2.25). P100 packages of several different drugs are being distributed to local clinics across the archipelago. However, the initiative is limited by a lack of funding.[14]

BFAD

The Bureau of Food and Drugs (BFAD), is responsible for licensing and regulating the delivery of pharmaceuticals in the Philippines.[15] BFAD is responsible for testing all drugs—including bioavailability and bioequivalence

10 Smaller importers and manufacturers are unhappy with the change, because it will require them to learn a new system. While this will be beneficial in the long run, there is a perception that the larger actors (i.e., the multis) will benefit more, and in any event the burden of making the change will be smaller for them in proportion.

11 Certain municipalities have started to collaborate, with mixed results, as inter-local health zones (ILHZs). These ILHZs could provide a useful function if collaboration is successful, and resources are pooled effectively.

12 Many government contracts go to a small group of medium-sized distributors and wholesalers. The largest pharmaceutical distributors appear to be relatively uninterested in government contracts, finding distribution to retailers to be less troublesome and more profitable.

13 Complaints about corruption take several forms. Two of the most common are that the mayors of individual RGUs ask for kickbacks from drug distributors, and that the distributors collude on keeping prices high. There are also allegations that poor IT and weak inventory control allow drugs to be paid for and not delivered, or to leak out of the system.

14 In theory, it should be possible to have a private sector actor pick up the P100 program. At the moment, though, it is entirely a government program. This might be worth examination by an interested donor; there are some barriers to privatizing this program (i.e., low profit margins on individual packets, the need for assurance that the program will continue) that a donor could perhaps help overcome.

15 BFAD was originally responsible for testing and regulating medical goods as well. However, in 2007 this responsibility was given to a new agency, the Bureau of Health Devices and Technology (BHDT) which was spun off from BFAD. BHDT seems to be struggling with many of the same problems as BFAD, but unlike BFAD, BHDT has not been given the right to keep its fees under the Cheaper Medicines Law.

testing[16]—and for pharmacovigilance, including post-sale surveillance and monitoring of adverse reactions. BFAD is also responsible for food and cosmetic safety.[17]

Most actors in the sector perceive BFAD as honest and reasonably competent, but badly underfunded and understaffed.[18] BFAD lacks, among other things, dedicated IT personnel. BFAD also lacks a library, though one has been in the planning stage for years. BFAD does receive significant donor aid, especially from WHO and the Japanese International Cooperation Agency (JICA), but it still lacks adequate resources.

At this time BFAD has only one laboratory serving the entire country, at the main office in Manila. A satellite laboratory has been partially assembled in Cebu, but its opening has been delayed for lack of funding. The satellite office would be useful, as Cebu is a major port. Approximately half of all pharmaceutical imports pass through Cebu, and the country's second largest concentration of drug formulators and manufacturers is located in and around the city.

The Cheaper Medicines Law allows BFAD, for the first time, to keep the fees that it charges. These will not be enough to render BFAD self-financing, but they should allow a significant increase in available resources. However, the law also gives BFAD new responsibilities; in particular, it is now tasked with monitoring drug prices.

PhilHEALTH

The Philippine Health Insurance Corporation (PhilHealth) is a state-owned enterprise responsible for offering health insurance to the entire country's population. PhilHealth estimates that roughly 80 percent of the Philippine population is enrolled, although anecdotal evidence suggests that participation levels are lower.

PhilHealth has considerable financial resources. It has been running at a profit for years, and has substantial reserves. This is in part because PhilHealth's coverage is limited: it only covers hospitalization, not outpatient care or prescriptions. PhilHealth sees itself primarily as a service organization, not as delivering products or intervening in the market. Most of its operations are restricted to a simple buy-

THE MAXIMUM RETAIL PRICE ISSUE

The Cheaper Medicines Law allows the DOH to impose maximum retail prices (MRPs) on selected drugs. This is supposed to be a last resort, undertaken only after other avenues have been exhausted. However, the DOH is looking into possible MRPs on several important drugs, all branded multi products. The criteria for consideration include:

- The drug is a dominant, branded innovator product;
- The drug is much more expensive than in neighboring countries;
- The drug has few competitors or none; and,
- There is a significant public health concern

The DOH will try to negotiate with the multis first, but if they cannot reach agreement, the DOH will impose the MRPs.

If MRPs are imposed, the multis may back down. On the other hand, they may refuse to produce or import the drug at the new price. If this happens, the drug may quickly vanish off the shelves.

The DOH plans, in this case, to use PITC Pharma to bring in massive parallel imports. However, this plan is problematic. PITC Pharma probably does not have the institutional capacity to bring in massive amounts of parallel imports on short notice. It may be able to adapt in the long term, but meanwhile crucial drugs may become unavailable for weeks or months.

16 These tests are quite expensive, averaging about P1.2 million or US$25,000 per new formulation. At this time, only two labs in the country can do them. This is a minor but noticeable deterrent to the introduction of new formulations.

17 Food safety lies outside the scope of this report, but it should be noted that USAID's A to Z project has worked with BFAD on food issues.

18 There is a widespread perception that BFAD suffers from internal brain drain: as soon as a BFAD technician or manager gains some experience and shows signs of competence, the perception is that he or she is hired away by the private sector at a much higher salary. In the words of one interviewee, "BFAD is like a sushi bar for the multis' HR departments."

claim-reimburse system. Perhaps because of this, PhilHealth is not strongly engaged with cost control of pharmaceutical purchases. The Cheaper Medicines Law enjoins PhilHealth to begin doing so, but it is quite short on specifics.

PhilHealth is relatively well run, but it has distinct weaknesses in IT, data management, and staff training. There is a political will to expand coverage, but PhilHealth is probably at or near its maximum capacity; it just barely has the human and institutional resources to manage its current workload. A significant expansion of coverage would require a serious commitment of resources, and probably outside technical assistance as well.

PITC PHARMA

PITC Pharma Incorporated (PPI) is a state-owned enterprise for importing pharmaceuticals. It is jointly owned by PITC, the Philippine International Trading Corporation (PITC), and the National Development Corporation (NDC), a state development agency. However, it acts under the supervision of the DOH, and the Secretary of Health is chairman of its board. PPI has been in existence since 2004; it was created with a P185 million(US$4 million) loan from NDC, plus another P35 million of investment capital.

PITC Pharma's purpose is to provide cheap drugs for distribution to government hospitals and clinics.[19] It does so by a combination of local purchases and parallel imports.

Most of PPI's parallel imports are from India; it acquires some drugs from Pakistan and southeast Asia as well. As of early 2009, it was importing 45 different products, though some of these were the same molecule in different packages or dosages. The total volume of parallel imports is not large: about 300 million pesos, or US$7 million. This is about one quarter of 1 percent of the Philippines' US$2.6 billion drug market. However, because of the Cheaper Medicines Law, PPI anticipates an expansion to about 1 billion pesos ($22 million). PPI would like to have about 75 percent of this money go

to the hospitals, and 25 percent to the Botika ng Bayan systems.

BOTIKA NG BAYAN AND BOTIKA NG BARANGAY

Most of PPI's drugs are distributed through the Botika ng Bayan system—almost exactly the opposite of PPI's goal. This is a franchise system that aims to provide cheap drugs across the archipelago, especially in smaller towns and rural areas. Botikas sell a list of essential products—antibiotics, multivitamins, and the like—at very low prices. The Botika ng Bayan system can either create new drugstores or work through existing ones—mostly individual stores, but sometimes some of the smaller chains as well. The Botika ng Bayan has two variants: Botika ng Bayan Express (which provides a single cabinet of selected medicines for sale in general and convenience stores) and Botika ng Barangay (which is targeted at isolated and rural areas).

PITC Pharma faces a number of challenges. It is funded by the DOH; since it is not supposed to turn a profit, its expansion is limited by the availability of DOH funds. It has severe shortcomings in IT and inventory management, so that it will be challenged to manage

19 Outside of the mixed public/private Botika ng Bayan system, PITC Pharma does not supply the private sector. They do not have a mandate to do so, and in any event they lack the capacity.

the distribution of drugs even if the funding is found.[20] It has not been able to send a purchasing agent abroad to Southeast Asia or India; instead, it is forced to rely on local interlocutors, contacted by phone and e-mail. It is currently receiving technical assistance from the EU, but this consists of a single embedded technical expert. There is a need for much more assistance, especially since the Cheaper Medicines Law envisions a much more ambitious role for PITC Pharma.

DRUG IMPORTERS AND MANUFACTURERS

The Philippines has a vibrant pharmaceutical importation and manufacturing subsector. Because only a few active ingredients are manufactured locally, most manufacturers are primarily formulators. The sector is dominated by a relatively small group of actors, largely the multinational pharmaceutical companies (multis), United Laboratories (Unilab) and InterPhil.

The multis include most of the world's large multinational pharmaceutical companies: Pfizer, Novarits, Glaxo SmithKline, Merck, among others. They engage in a mixture of importing complete drugs, formulating in their own local laboratories, and licensing to local formulators—mostly InterPhil, since Unilab primarily produces generics and its own local brands, and most other formulators are too small or unable to assure quality control.

Unilab and InterPhil have roughly one third of the market each. Approximately one half-dozen medium-sized producers account for another 15 percent–20 percent of the market, while the rest of the market is divided among more than 200 small producers. Very few local firms hold patents, although Unilab does have several, including a popular food supplement. Investment in R&D is quite low by international standards.

Imports are significant: accounting for nearly half the market by volume, and more than half of the market when measured by value. The import business is relatively fragmented, since there are about a dozen multinationals with local subsidiaries, and each may do its own importing. There are also a number of independent importers, some of them acting as local agents for multis that do not have a large enough presence to have a subsidiary.

There is some importing of generics, but this is a very small portion of the generics market. Unilab is by far the largest generic manufacturer, but this is not immediately obvious, because Unilab splits its generic sales and marketing among a number of differently named subsidiaries. There is some parallel importing, but it is quite small—approximately one half of 1 percent of the total market.[21] PITC Pharma accounts for most of the parallel imports, although there seem to be some private parallel importers as well.

DISTRIBUTORS

Distributors move drugs from manufacturers to retail pharmacies and hospitals; in between, they handle warehousing, invoicing, transport, collection, and demand management—though usually not marketing, which is handled by the multis and individual manufacturers.

Distribution of pharmaceuticals in the Philippines is dominated by a single firm, Zuellig Pharma. Zuellig is a Philippine company, founded in 1916, that has since grown to be a major distributor across Southeast Asia.[22] Zuellig controls between 50 percent and 60 percent of the distribution market;[23] Metro, another firm owned by Zuellig, controls another 10 percent. It is difficult to distribute drugs widely across the country without using either Zuellig or Metro; there are a number of other distributors, but several are tightly linked to Unilab,[24] while others have difficulty distributing consistently to Mercury, the largest retail drugstore.[25] Thus Zuellig, while not a monopolist, enjoys substantial market power.

Smaller distributors and wholesalers face a number of challenges. In addition to competing with Zuellig and Metro, they suffer from limited access

20 As one interviewee said, "It's 1980 at PPI. There are computers, but they're used as typewriters. There are spreadsheets, but no database. Information is all entered by hand, and nothing connects to anything else."

21 PITC Pharma's parallel imports have attracted attention far out of proportion to its actual impact, including a great deal of media coverage—both positive and negative—and at least one lawsuit, filed by Pfizer.

22 Zuellig was founded by a Swiss emigrant to the Philippines in 1916. It is currently a major distributor in Hong Kong, Taiwan, Thailand and China as well as the Philippines.

23 Zuellig is also vertically integrated. It owns InterPhil, the second largest drug manufacturer, and has majority shares in three medium-sized drug chains accounting for about 25% of the retail pharmacy market. This gives Zuellig considerable leverage at all levels of the supply chain.

24 Unilab is believed to control about 15–20% of the distribution market. It does not actually own any distributors, but it has a cadre of several small distributors that are very closely linked to it, doing all their business with Unilab and little or none with any other producer.

25 Because of its size, Mercury can negotiate very favorable supply and payment terms against small distributors. Zuellig is the only distributor that can negotiate with Mercury as an equal. For example, Mercury pays Zuellig's invoices in 30 days, but all other distributors' after 60 days.

to credit, weak inventory systems, and an inability to bargain as equals with the largest retail pharmacy, Mercury. There is also a widespread perception that some smaller distributors are corrupt, unreliable, or both.

In addition to distributors, there are a limited number of drug wholesalers. These do business mostly with the smaller "Mom and Pop" pharmacies.

RETAIL PHARMACIES

The retail pharmacy market is dominated by a single chain, Mercury. However, Mercury's dominance is qualified by several factors. First, while Mercury is found across the entire archipelago, it is concentrated in Luzon. In Metro Manila, Mercury's market share is over 60 percent, but in Cebu it is less than 30 percent. Second, Mercury is facing a number of challenges to its long-established dominance. Watsons, a large Hong Kong beauty and health care retailer, has opened more than fifty stores in the last two years. A local Filipino firm—Generic Pharmacy—has set up a low-margin, low-cost franchise operation that has grown with explosive speed. There are over 200 Generic Pharmacies already, and this number is expected to double within a year. Meanwhile, MedExpress, a mobile pharmacy developed in Indonesia, has recently entered the Philippine market in force.

That said, Mercury is still the dominant market entity. Mercury is able to negotiate deep discounts with distributors,[26] and to buy drugs on credit or even on consignment. Mercury also has the most advanced IT systems, the best-trained personnel, the easiest access to credit, and one of the Philippines' strongest brands. While its dominance may be challenged, Mercury is likely to remain the largest and most powerful retail entity for many years to come.

Meanwhile, Mercury and the other chains are putting significant pressure on the small and medium-sized family-owned drugstores across the archipelago. With their smaller inventories and limited access to finance, these stores are vulnerable to competition from the chains, especially in towns and cities. The retail sector appears to be entering a period of consolidation as the chains buy up or drive out many of these smaller stores.

SUPPORTING INSTITUTIONS

COMPETITION AUTHORITY

There is no Competition Agency in the Philippines. While this matter is a recurring theme within a prior assessment of the business enabling environment sponsored by USAID in 2006,[27] a thorough review of the laws and institutions impacting the private health sector in the Philippines requires a review of the impact of this gap in international best practices in the legal framework for private sector regulation.

The Philippines does have some laws relating to the regulation of competition: Article 186 of the Revised Penal Code defines and bans combinations in restraint of trade, while the Price Act bans cartels and "abusive" price increases. The Corporation Code of 1980 and Revised Securities Act of 1982 have both been used to block the creation of interlocking directorates. The Cheaper Medicines Law gives vague but broad powers to the DOH to investigate and move against restraint of trade in medical services. Thus far, the DOH has not attempted to apply this authority to any anti-competitive behaviors.

The Philippines lacks a unified competition authority charged with enforcement of the existing laws.[28] There is a Bureau of Trade Regulation and Consumer Protection, but it is weak, understaffed, does not seem to coordinate well with other government agencies, and in any event has no power to bring cases against restraint of trade.[29] As a result, the legal framework gives rise to ad hoc legal actions—some successful, most not. For instance, the Philippine Supreme Court blocked an attempt by the owner of Asia Brewery to join the board of San Miguel Beer. Later, in 1997, the Court blocked an attempt by Petron, Caltex and Shell to cartelize the gasoline market. But these actions

26 Distributors say that, when dealing with distributors other than Zuellig, Mercury may demand discounts of up to 30%. Smaller chains cannot demand more than half this much, and "Mom and Pop" stores only 5% or less. Also, the drug law requires that senior citizens get a 20% discount; Mercury can in some instances require the distributor to take on a large share of that discount.

27 The U.S. Agency for International Development published an assessment of the business enabling environment for the private sector in July 2007. A copy of this report can be accessed online at http://www.bizclir.com/galleries/country-assessments/philippines.pdf.

28 A discussion of the current state of the Philippine competition law and enforcement can be found at http://www.jftc.go.jp/eacpf/06/6_01_02.pdf.

29 See http://www.apeccp.org.tw/doc/Philippines/Organization/phorg4.html. The Bureau is part of the Department of Trade and Industry. It does not keep a very high profile, and is rarely mentioned in the media.

are isolated and intermittent, and almost never affect the health sector. There have been discussions of creating a central competition authority, but nothing has ever come of them.[30] There is a Philippine Fair Trade Forum (PFTF), which is an umbrella organization for a variety of trade-related NGOs, but it seems to have had little impact so far, and none in the pharmaceutical or medical supply fields.[31]

HMOs

There are several HMOs in the Philippines, but so far their impact has been very limited. They serve only a very small sector of the population, and they do not appear to be growing rapidly.

DISPENSING DOCTORS

In theory, most doctors are not allowed to dispense most drugs. The law states that doctors who practice within five kilometers of a pharmacy cannot dispense any drugs except for a short list that includes vaccinations, injections, topical antibiotics and antiseptics, and the like. In practice, this law is often interpreted very narrowly, or simply ignored. Many doctors have formed close associations with local pharmacies; many others simply sell drugs direct to their patients. Legality aside, this is a fairly widespread practice, and one that shapes doctors' attitudes on, for instance, the issue of international brands versus generics.

PHAP

The Philippine Healthcare and Pharmaceutical Association (PHAP) is a trade association that includes all the larger drug importers and manufacturers. PHAP is dominated by the multis and is generally a conservative body, but it did introduce the Philippines' first Code of Pharmaceutical Marketing Practices in 2003. This requires, among other things, that promotional material must include clear, accurate and specific information; that doctors should not accept kickbacks; and that drug company representatives should not seek to trade favors to doctors for overt commitments to prescribe particular products.

PCPI

The Philippine Chamber of the Pharmaceutical Industry (PCPI) is a counterpart to PHAP, but its membership is made up of smaller importers and manufacturers. PCPI encourages training, information sharing, public awareness, and CGMP compliance; however, it is handicapped by a lack of resources.

PHARMACISTS ASSOCIATIONS

Two pharmacists associations exist with the Philippines, with distinct yet overlapping memberships. The Drugstore Association of the Philippines (DSAP), supports pharmacists, while the Philippine Pharmacists Association (PPHA) serves pharmacists. However, since many small drugstores are owned by a dispensing pharmacist there is a great deal of overlap between them. DSAP has tried to challenge some of the business practices of Zuellig, though without much success; both DSAP and PPHA are involved in the "Safe Medicines Network" (see below), though it is unclear whether anything is actually being done. Neither DSAP nor PPHA has been very effective at improving access to medicines, though they might be able to do more with assistance.

SOCIAL DYNAMICS

INCOME INEQUALITY

The Philippines suffers from significant inequalities of wealth and income,[32] and this has had a significant impact on the delivery of goods in the health sector.

Poverty is a major issue in the demand for pharmaceuticals. Approximately 40 percent of the Philippines' population lives on less than US$2 per day. These people are often unable to afford most drugs; even very basic and cheap generics may be out of reach. The poor are also exquisitely sensitive to pricing; raising the cost of a drug by just a few pesos may cause a dramatic drop in demand from low-income buyers.[33]

This is in sharp contrast to the country's wealthy, who are not price sensitive at all. As one drug

30 Most recently HB 116, "An Act Creating the Philippine Competition Commission," filed by Representative Joey Sarte Salceda in 2005. It did not pass either house of the legislature.

31 The PFTF was created in 2002 with the assistance of Oxfam International. Member organizations include Alter Trade Corporation (ATC), Southern Partners for Fair Trade Corporation (SPFTC), Panay Fair Trade Corporation (PFTC), People's Global Exchange (PGX), and the Advocate of Philippine Fair Trade, Inc. (APFTI). It is unclear whether PFTF's non-engagement in the medical sector reflects a lack of interest or a lack of capacity.

32 According to the UN, the Philippines' Gini coefficient is 44.5—high, but not unusual for a developing country at the Philippines' level of income.

33 It can also have a dramatic effect on patterns of drug consumption. Poor patients often want to purchase drugs one pill or one dose at a time when possible, and are very likely to drop a course of treatment before it is complete in order to save money.

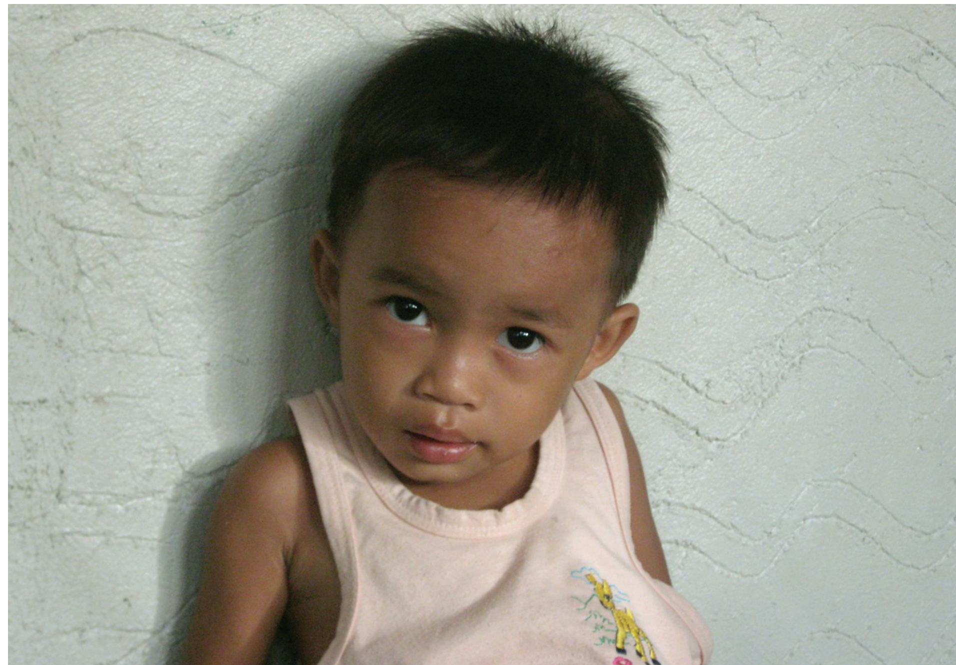
importer candidly acknowledged, one reason for high drug prices has been that "most drugs were always purchased by the rich, and the rich don't care about price." However, this is changing. During the 1980s, 5 percent of the population accounted for over 80 percent of the drug market; that same top 5 percent now accounts for just over 50 percent of the market.[34] The difference is largely due to the expansion of the Philippines' middle class, and their rise as important purchasers of drugs and medical services is a major reason the price of drugs has become a political issue in the last several years.

Low elasticity of demand among the wealthy, the largest consumers of drugs, is also a contributing factor in the slow adoption of generics. Popular international brands have name recognition; for the wealthy, their higher cost is not a deterrent.

FEAR OF COUNTERFEIT DRUGS

Fear of counterfeit drugs is a major issue in the Philippines. While there is no formal study assessing the impact[35] of counterfeit drugs, there is a widespread perception that it is a serious problem, especially outside of Metro Manila and in smaller, non-chain drugstores. There is a widespread belief that non-chain drugstores sometimes sell expired, adulterated, or entirely counterfeit drugs.

Whether this is true or not, it definitely affects the behavior of both sellers and consumers. The large chain drugstores all emphasize their honesty and reliability and the high quality of their products.[36] Zuellig notes that its superior inventory and IT systems enable it to deliver more reliable products faster than other distributors. The multis have invested in advertising campaigns touting the purity and reliability of their drugs. Doctors cited concern about counterfeits as a reason for prescribing brands instead of generics, and for steering patients towards particular pharmacies. And wealthy and middle-class consumers are willing to pay a price premium for safety. Fear of counterfeits encourages them to shop at chains instead of small and medium-sized family-owned drugstores, and to accept prescriptions for branded drugs instead of generics.



BFAD is responsible for combating counterfeit drugs, with the assistance of police, prosecutors and the Philippine Drug Enforcement Agency (PDEA). However, BFAD has a very limited ability to educate the public. In November 2008 several industry associations joined together to create a "Safe Medicines Network" under the sponsorship of PHAP, but it is unclear whether this has actually accomplished anything yet.[37]

ADVERTISING

Advertising for drugs is ubiquitous in the Philippines; there are billboards in all major cities, print ads in newspapers and magazines, and commercials on television. However, advertising for prescription products is almost entirely dominated by Unilab (which has a number of local brands of post-patent molecules, and also a great many popular food supplements) and by the multis for their branded products. There is very little advertising for local generics by anyone other than Unilab. Advertising tends to be pitched at the upper and middle classes; very

34 BMI international, Q4 2008 report on the Philippine pharmaceutical sector.

35 Multiple interviewees gave anecdotal reports of counterfeiting incidents, but none of them—including BFAD—were able to point to numerical analysis or hard data. The Philippine Drug Enforcement Agency (PDEA) has estimated that the counterfeit drug market is around P8 billion or US$140 million, but it has not been possible to find the basis for this estimate. PDEA's definition of "counterfeit" is very broad, and includes drugs that have not been properly registered or that have been imported without a license.

36 This reputation seems to be deserved. No interviewer could recall a single example of a Mercury drugstore being found selling expired or counterfeit drugs, and representatives of the major drugstores all emphasized their clean records.

37 See http://www.phap.org.ph/anticounterfeit.aspx

few advertisements make cost comparisons or even mention a product's price.

Aggressive drug industry marketing and promotions can be seen in many health facilities, both government and private. While this is legal, such actions must still be closely monitored by the national drug authorities. Aggressive marketing affects prescribing behaviors and has an impact on drug pricing.[38] Hence, there is a need to develop a pharmaceutical benefit scheme beyond the rather sketchy code of ethics promulgated by PHAC. The DOH has been taking such a measure under consideration, but nothing seems to be happening yet.

PRESCRIPTIONS

In theory, all prescription drugs require a prescription for purchase. In practice, if products are not regulated by the Dangerous Drug Board (i.e., narcotics or CNS active), they are available over the counter. It is possible to walk into a drugstore anywhere in the Philippines and simply order Lipitor or Norvasc. Putting aside the health concerns of laypersons self-prescribing, this practice tends to amplify the power of advertisement: nobody walks into a drugstore and demands an obscure generic.

CONSUMER PROTECTION

There is not a strong culture of consumer protection in the Philippines, especially in the medical field. Few NGOs deal with consumer problems in this area. Ordinary consumers tend to defer to the authority of doctors and pharmacists. BFAD handles consumer complaints about pharmaceuticals and medical supplies, but it cannot respond effectively even to the limited number of complaints it receives.

38 Windmeijer, F. et.al., 2006. *Pharmaceutical Promotion and GP Prescribing Behavior* (Health Economics), Vol. 15, Issue no. 1.

DEVELOPING HUMAN CAPACITY

The quality of a country's health services is significantly impacted by the development and distribution of health professionals. As a net exporter of skilled medical professionals, the Philippines has benefited from remittances, but has suffered from shortages of key skilled health human resources as a result of this "brain drain." In addition to comparatively low compensation for medical professionals in the Philippines, non-wage factors dissuading participation of trained medical employees in the local health sector include poor working conditions, insufficient resources, and limited career opportunities. The country has also experienced an internal brain drain as health workers who remain in the Philippines are often lured from the public to the private sector, which is concentrated in urban centers.

The Philippine Government has struggled to harmonize labor export policies with programs to address the poor distribution of health workers in the country. While some health professionals are in demand, others such as nurses have been over-supplied. At the same time, an uneven distribution of health workers exist, with some geographic regions unattended by medical personnel. While the private sector increasingly complements the public health care system, most private facilities also tend to cluster in urban centers and remain inaccessible for many Filipinos.

In the absence of an over-arching policy to guide the planning and development of health human resources, the retention of skilled professionals and the staffing of medical facilities across the country, particularly in rural and disadvantaged areas, will almost certainly continue to be a critical challenge. The following section proposes several recommendations to address this challenge, including the encouragement of the private sector as a complement to public sector health care.

LEGAL FRAMEWORK

ACCREDITING ACADEMIC MEDICAL INSTITUTIONS

The government oversees the production of health professionals through the Commission on Higher Education (CHED), which governs public and private higher education institutions and degree-granting programs in all Philippine tertiary educational institutions. The CHED, established through Republic Act 7722: The Higher Education Act of 1994, is responsible for setting the standards for academic medical institutions and granting the authority to offer services. The CHED's charter gives it the power to "monitor and evaluate the performance of programs and institutions of higher learning for appropriate incentives as well as the imposition of sanctions such as, but not limited to…recommendation on the downgrading or withdrawal of accreditation, program termination or school closure." However, the Commission has historically not invoked the power to recommend the closing of non-performing institutions, which in some instances has compromised the quality of education, particularly in nursing schools, which have been able to flourish without sufficient quality control by the government.

LICENSING AND REGULATING MEDICAL PROFESSIONALS

Once students have completed their respective medical training programs, they take a licensure exam prepared and administered by the governmental Professional Regulation Commission (PRC).

Each medical profession is governed by relevant medical legislation that outlines education and licensing requirements and establishes a relevant specialty professional regulatory board under the PRC. There are ongoing debates about specific legislation such as the Philippine Midwifery Act of 1992 (RA 7392) which is inconsistent with international standards regarding the active management of the third stage of labor. Midwives can therefore choose to follow the law that is inconsistent with industry standards and may ultimately contribute to the country's poor maternal mortality statistics. Alternatively if midwives choose to practice according to international standards, they are non-compliant with the Philippine law and therefore would be without legal protection should something go wrong. Debate also continues about the Medical Act of 1959, which its critics maintain is inconsistent with modern curriculum requirements for medical students.

LICENSING FOREIGN MEDICAL PERSONNEL

While the laws governing the various medical professionals apply explicitly to Filipino citizens, in most cases, there is an allowance for reciprocity agreements with countries offering the same working conditions to Filipinos and where the requirements or licensing in that country are substantially the same as those prescribed under the relevant Philippine law. The PRC is ultimately responsible for issuing a certificate of registration/professional license to foreign individuals who meet these two conditions. A more liberal law with regards to foreign medical professionals would encourage freedom of movement and may help optimize the right skill mix and distribution of medical personnel in the Philippines.

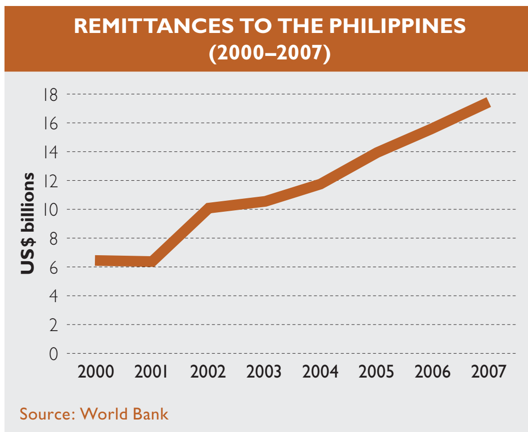
MEDICAL MALPRACTICE

Despite several attempts, including House Bill 4955, Medical Malpractice Act of 2002, to ensure greater quality medical care for patients and provide penalties for medical professionals for gross negligence, there are no formal laws regarding medical malpractice. Several organizations, including the Philippine Medical Association, the Philippine College of Physicians, health organizations, and others have fought medical malpractice legislation, arguing that medical malpractice insurance would increase the high cost of health care, engender mistrust between physicians and patients, and deter medical tourism. They have also argued that the revised Penal Code and Medical Act of 1959, as well as penalties embedded in the PRC and hospital rules and regulations, are sufficient to regulate and monitor medical personnel. Furthermore, according to several sources, there is at present no legal basis, beyond standard negligence causes of action, that provides a consumer protection function for patients through which they may seek compensation for professional medical negligence.

REGULATING THE MOVEMENT OF MEDICAL PROFESSIONALS

The flow of health workers is primarily outward from the Philippines. While the Philippines Immigration Act of 1940 encourages the inflow of tourists and business people, the various laws regulating medical professions provide barriers to foreigners practicing in the Philippines.

The legal framework is firmly in place, however, to support the outward flow of medical professionals. In the1970s under President



Marcos, the government began to encourage Filipino workers to work overseas in order to send remittances back to the Philippines as an engine for economic growth. Article 22 of the Labor Law: Mandatory Remittance of Foreign Exchange Earnings mandates that Filipino workers abroad "remit a portion of their foreign exchange earnings to their families, dependents, and/or beneficiaries in the country." The prevalence of remittances has grown steadily over the past several years, with the Philippines representing the fourth largest country recipient of remittances in real value terms worldwide. In 2007 alone, Overseas Filipino Workers (OFWs) sent US $17 billion in remittances, nearly tripling the amount of remittances in 2000.[39]

Representing approximately 10 percent of the country's GDP, remittances have become a critical part of the Philippine economy. To safeguard this important economic input, the government established formal policies to ensure that OFWs were supported while working overseas and when returning to the Philippines. To implement what has been called "managed migration," the government also established a specialized agency, the Philippine Overseas Employment Administration (POEA), to formulate and oversee labor migration policy. The government is also working with international partners to establish several ethical recruitment initiatives to ensure mutual benefits to both supplying and receiving countries.

In 1995, the Migrant Workers and Overseas Filipinos Act was established to protect OFWs overseas. The Act requires that the government provide OFWs legal support, consular services, and other support services to ensure that OFWs have adequate working conditions and are not mistreated while working abroad. The Citizenship Retention and Reacquisition Act of 2003 and the Balikbayan Act, P.D. both assist OFWs who return to the Philippines in reacquiring citizenship, if necessary, and facilitating the purchase of property.

MANAGING PUBLIC SECTOR MEDICAL PROFESSIONALS

All government employees, including public health workers, are subject to the policies regarding hiring, firing, professional development, performance evaluation, and disciplinary procedures that are outlined in the Civil Service Act of 1959. Further guidelines for health workers are outlined in the Magna Carta of Public Health Workers which was passed to provide for higher compensation and benefits to persons engaged in health and health-related work. In practice, the law is implemented unevenly across the country, partially because of the devolution of the health system. The Department of Budget and Management sets the salary schedule for all government employees, including rural health physicians, nurses, and midwives and is ultimately responsible for approving the number of public health-related positions.

While the DOH maintains responsibility for regional hospitals, the responsibility for local health services was devolved to LGUs under the Local Government Code of 1991 (RA 7160). While the Local Government Code states that all municipalities should have a doctor, some LGUs cannot afford or do not prioritize ensuring the employment of a doctor.

The government has taken efforts to engage in "task shifting," a global trend to respond to health worker shortages by shifting tasks typically performed by doctors and nurses to others in the community. The government has encouraged

39 See http://siteresources.worldbank.org/INTPROSPECTS/Resources/334934-1199807908806/World.pdf

the development of community health workers through the Barangay Health Workers Benefits and Incentives Acts of 1995 which provides for the training of volunteer workers and the provision of incentives to join *barangay*[40] health stations. While these volunteers may be unable to respond to the most pressing health needs of the community, they can attend to clerical tasks and perform minor health procedures.

ENCOURAGING PRIVATE PRACTICE

The private sector is increasingly seen as a complement to public sector health care. A strong private sector enables those who are able to pay to receive rapid, quality medical services, while alleviating the volume in government facilities and enabling the public sector to focus on less affluent citizens. The government has begun to engage the private sector to achieve its health care goals.

KEY LAWS

- Corporation Code of the Philippines
- Local Government Code of 1991 RA 7160
- Philippine Immigration Act of 1940
- Presidential Decree 442—Labor Code
- Republic Act 2260—Civil Service Act of 1959
- Republic Act 2382—The Medical Act of 1959
- Republic Act 5921—Regulating the Practice of Pharmacy
- Republic Act 7305—Magna Carta of Public Health Workers
- Republic Act 7392—Philippine Midwifery Act of 1992
- Republic Act 7883—Barangay Health Workers Benefits and Incentives Acts of 1995
- Republic Act 8042—Migrant Workers and Overseas Filipinos Act of 1995
- Republic Act 8423—Traditional and Alternative Medicine Act of 1997
- Republic Act 9173—Philippine Nursing Act of 2002
- Republic Act 9225—Citizenship Retention and Reacquisition Act of 2003
- Republic Act 9484—Dental Act of 2007

The prevalence of private medical professionals, albeit concentrated in the national capital region, is testament to the ease of going into private practice in the Philippines. In addition to a license to practice medicine from the Professional Regulatory Commission, physicians wishing to go into private practice also require a license from the Department of Trade and Industry and a professional tax receipt for practice in a community. For insurance purposes, further accreditation by PhilHealth and/or Health Maintenance Organization (HMO)s is also needed. Once established, there is no regulation as to the fees private sector physicians are able to charge patients for specific services, allowing the market to establish sustainable income rates for private physicians.

MEDICAL TOURISM

With skilled medical professionals, world-class tertiary hospitals, natural beauty, and a developing tourism infrastructure, the Philippines has many of the ingredients for a robust medical tourism industry. In 2004, President Arroyo made a commitment to the development of the medical tourism industry through the issuance of Executive Order 372: Creating a Public-Private Sector Task Force for the Development of Globally Competitive Philippine Service Industries which created the Philippine Medical Tourism Program (PMTP). PMTP is a private-public sector partnership led by the Departments of Health, Tourism, and Trade and Industry. The program is comprised of private and government medical facilities and businesses from the retail, wellness, spa, health, and tourism industries. Its critics have argued that while medical tourism caters to wealthy foreigners and contributes to the Philippine economy, in the absence of a deliberate effort, it largely does not enhance the healthcare of the majority of Filipinos who cannot afford private services. In counterpoint to this argument, supporters emphasize the retention of world-class trained medical staff that otherwise might seek employment in higher-value medical markets

40 The barangay is the smallest government unit in the Philippines, and each municipality or city is sub-divided into barangays. It is the primary planning and action unit for government programs and projects.

overseas. Additionally, other positive effects could cascade from high-value specialty medical services, including increased private investment into commonly-shared infrastructure, such as national laboratory facilities, medical schools, and domestic pharmaceutical industries.

IMPLEMENTING INSTITUTIONS

ACADEMIC MEDICAL INSTITUTIONS

Academic medical institutions in the Philippines are largely modeled on the American system. In the case of medical school, for example, students complete four years of medical school and a year of clinical internship, followed by the PRC-administered licensure exam. Most students then specialize during a post-graduate residency, followed in some cases by a sub-specialty. This orientation toward "over specialization" draws talent disproportionately toward overseas medical practice as opposed to primary care facilities where doctors are most needed in the Philippines.

Most schools place a strong emphasis on clinical experience and in some instances, hospitals have set up satellite clinics where graduate students can get additional hands-on experience. Medical curricula, elaborated by the Commission for Higher Education (CHED), tend to be dynamic and incorporate international standards. In the case of the public health curriculum, the program at the University of the Philippines (UP) has been the benchmark for other Southeast Asian countries interested in establishing public health schools.

RETURN SERVICE AGREEMENTS (RSAs)

Medical institutions have begun to address the issue of medical brain drain by encouraging students to remain in country to practice medicine. The University of the Philippines Medical School, for example, a public institution subsidized by the government, has announced that beginning with the 2009–2010 school year, all students will be required to sign a return service agreement (RSA) requiring them to spend three years working in the Philippines within the first five years of graduation. Failure to do so will result in a double repayment of the portion of their tuition that was subsidized by the government. This program complements UP's ongoing "Regionalization Program" which recruits students from the provinces who must then serve in their home provinces for five years after graduation. The 20 to 30 regionalization students each year (per class of 160), all of whom speak the language of their locality, benefit from a full scholarship to study at UP in exchange for their public service.

The model exists for private schools as well. The private University of Santo Tomas has also established a program where students who are on financial scholarship must sign a contract requiring them to remain in the Philippines for three years after graduation. Non-compliance results in a repayment of their scholarship money to the university. As these RSAs begin to take effect, the Philippines will begin to see hundreds more doctors remaining in country after graduation, fulfilling at least their minimum time commitment.

TEACHING HOSPITALS AND RESEARCH INSTITUTIONS

Most health sciences schools are either attached or affiliated with a teaching hospital, a critical relationship to ensure clinical training for medical and nursing students. Many teaching hospitals also conduct research and several independent research institutions exist, often working in collaboration with the government in priority health areas. In an effort to influence the health research agenda further, the Health Policy Development and Planning Bureau (HPDPB) at the DOH partnered with the umbrella organization, the Philippine National Health Research System (PNHRS), to launch the National Unified Health Research Agenda (NURA). The NURA is a three year plan that gives guidelines on the research priorities of the DOH.

DEPARTMENT OF HEALTH (DOH)

While human resource management has been largely devolved to the LGUs, the DOH still plays a critical role in the development, distribution, and retention of medical personnel in public institutions across the Philippines. In an effort to lay out a strategic direction for the country's health human resources, the DOH actively participated in the development of a 25 year health human resources plan (Philippine Human Resources for Health Master Plan 2005-2030). A multi-sector effort which included participation from the private sector, the plan's development was led by UP's Institute for Health Policy with active participation from public health professionals, the DOH, the Philippine Overseas Employment Agency, and the Department of Budget and Management.

Challenging the meaningful application of the plan is the desegregation of relevant statistics regarding the numbers, distribution, and movements of health workers. With multiple agencies involved in the development, licensing, distribution, and migration of health workers, there is no aggregated database giving a complete picture of health human resources upon which the DOH and others can engage in meaningful human capital planning. For example, the National Office of Statistics captures data on demographics, while the Philippine Overseas Employment Administration holds data regarding outgoing medical professionals, and the Bureau of Immigration holds data on returning medical professionals, etc.

Despite ongoing challenges to effective human capital planning, the DOH has sponsored and supported several initiatives to augment the country's health human resource capacity and to address the uneven distribution of health workers. The Pinoy MD Medical Scholarship Program, for example, pays for individuals to go to medical school and is partially funded by the Philippine Charity Sweepstakes; 82 scholars were enrolled in various medical schools for the academic year 2007–2008.

The Doctors to the Barrios Program, another successful initiative with the goal of ensuring regional medical coverage, assigns doctors to government hospitals in under-served communities. The doctors receive an enhanced government salary and benefits package to serve in the Barrios for a minimum of two years. Recipients of semi-annual training, the doctors are meant to improve the overall community health system, enhancing community involvement at the health centers. They partner with local NGOs and the local chief executive to improve the health outcomes for the community.

KEY IMPLEMENTING INSTITUTIONS

- Academic Medical Institutions
- Teaching Hospitals
- Research Institutes
- Department of Health (DOH)
- Department of Labor and Employment (DOLE)
- Local Government Units (LGUs)
- Medical Facilities

CENTERS FOR HEALTH DEVELOPMENT (CHDs)

As a result of the Philippines' devolved health system, DOH regional offices, called Centers for Health Development (CHDs), liaise directly with the LGUs and are on the front lines of implementation. CHDs offer direct technical assist to support the human resources of the LGUs, providing training and logistical assistance where needed. The human resource development unit within the CHD coordinates with the LGUs to develop a training plan for health personnel. CHDs also play a key role in the development of the LGUs' Province-Wide Plan for Health (PIPH), which includes investment regarding health human resources.

DEPARTMENT OF LABOR AND EMPLOYMENT (DOLE)

The Department of Labor and Employment (DOLE) has partnered with the DOH on programs targeting unemployed medical practitioners. DOLE has taken the lead for example, on

a new program to employ some of the 100,000 unemployed nurses currently in the Philippines. The program, Nurses Assigned to Rural Service (NARS) engages nurses to go to rural areas for periods of six months to a year. The nurses receive a stipend, gain clinical experience, and provide health services for communities that typically do not receive adequate health care as a result of a lack of health professionals.

SUPPORTING FAMILY/ MATERNAL HEALTH

The DOH has also taken an approach to improving family/maternal health through the issuance of an administrative order: Department of Health (DOH) Partnership with Department of Labor and Employment (DOLE) for Strengthening Support for Workplace Health Programs which identified areas for public-private collaboration regarding family health programming. Through the program, DOLE is partnering with CHDs to implement a family welfare program to ensure that workers have access to family health services.

REINTEGRATING OFWs

DOLE also runs a Reintegration Center that helps OFWs re-join the local economy upon their return to the Philippines. Through the Philippine Job Exchange Network managed by DOLE's Bureau of Local Employment, returned OFWs can access kiosks all over the country to identify job openings in the Filipino economy, in both the public and private sectors. While the Reintegration Center is particularly helpful for contract workers (e.g., domestic help, engineers), those in the medical community avail themselves of the services less frequently largely because doctors and nurses, once they have left for overseas positions, rarely return to the Philippines before retirement.

LOCAL GOVERNMENT UNITS

Through the devolution of the health sector in 1992, LGUs gained additional responsibility for recruiting, developing, and managing their own health workers. While the DOH remains responsible for specialty and regional hospitals, medical centers and regional field offices, provincial governments are responsible for provincial and district hospitals, and municipal governments are responsibile for municipal and barangay health units. Facing tight budgets and multiple pressing priorities, some LGUs have found additional flexibility by signing six-month contracts with health workers who can be hired and fired more easily. While this provides LGUs with budgetary flexibility, the practice does not ensure full benefits and protection for health workers.

While the DOH renewed job descriptions for Central Office positions during the development of the Human Resources Master Plan in 2005, consistent job descriptions and competencies are currently lacking across other levels of the DOH and at the LGU/facility level. Current job descriptions and competencies of hired staff are not aligned, and some positions are not included in the plantilla.

While devolution of the health sector has had some positive effects, the impact on public health workers has been mixed. The financing of health personnel followed the devolution as LGUs received the authority to decide to what degree health care would be prioritized and how much financing to put toward health professionals. With limited funding, in many instances, LGUs are able to pay lower salaries than medical professionals received in the centralized system. There is additional variation in the management of human resources across LGUs.

PRIVATE MEDICAL FACILITIES

Private sector facilities have more flexibility in the management of their human resources. While there appears to be variation across private sector facilities, large tertiary hospitals generally provide job descriptions for each position and ensure training, career development, and continuing medical education for practitioners.

Private facilities remain an attractive employer for medical professionals because of the

compensation and working conditions as well as the experience of working in a private tertiary hospital. Many medical professionals, particularly nurses, use private medical facilities as a "stepping stone" for deployment to overseas positions that require two to three years of nursing experience.

Increasingly, medical professionals are establishing their own health facilities. While physicians have typically dominated private practice, many midwives have also set up private practice, taking advantage of a liberalized process that allows them to achieve both facility and insurance accreditation through PhilHealth, as opposed to the former process that required DOH accreditation. The Philippine Nurses Association (PNA) and others have begun to discuss the advantages of encouraging entrepreneurial nurses to set up private practice as a complement to midwifery clinics.

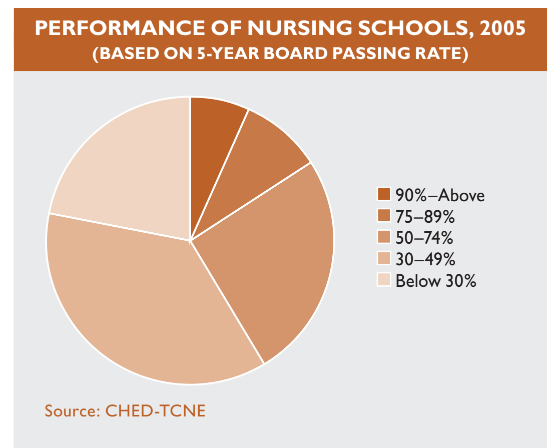
In all cases, the majority of private practice clusters around urban centers, and primarily in the national capital region. With many health needs in the provinces, additional incentives are likely needed to encourage private practice in these areas. Creative financing schemes that include government loan programs featuring favorable loan terms, or micro-credit programs for entrepreneurial medical professionals may encourage the private sector to develop further in rural areas.

SUPPORTING INSTITUTIONS

REGULATORY INSTITUTIONS

The Commission on Higher Education (CHED) is responsible for accrediting academic medical institutions. It relies on specialized committees of a pool of experts responsible for developing curricula, setting policies and standards, and conducting monitoring and evaluation. The CHED grants the authority to offer services according to standard minimum requirements that address facilities, faculty, administration, and curricula.

PERFORMANCE OF NURSING SCHOOLS, 2005
(BASED ON 5-YEAR BOARD PASSING RATE)



Source: CHED-TCNE

While the CHED is empowered to approve medical academic institutions to offer services, it has not executed the power to close sub-standard schools. This has compromised academic quality, particularly in private nursing schools that have proliferated in response to the overseas demand for experienced nurses. The performance of the more than 450 nursing schools currently functioning in the Philippines is mixed, with some schools providing poor educational services and exhibiting low passage rates on the nursing licensure exam. A study in 2005, for example, identified that 21.7 percent of nursing schools exhibited "very low performance," defined as below 30 percent exam passage rate.

While the CHED has officially issued a moratorium on the opening of nursing schools, those schools in existence continue to attract Filipinos who dream of working overseas for much higher salaries, including many doctors who have retrained as nurses to go abroad. The over-production of nurses has led to unemployment, underemployment, and mismatching of skills and has put downward pressure on nursing salaries in both the public and private sectors.

Professional Regulatory Commission (PRC). The Professional Regulatory Commission (PRC), responsible for licensing medical professionals, was reinforced through the PRC Modernization Act of 2000 (RA 8981). The modernization was meant to equip the PRC to better handle such challenges as licensure

fraud. The PRC has suspended requirements for continuing medical education credits for license renewal. Many have called for the reinstatement of continuing education requirements, an important step toward ensuring quality among medical professionals.

MEDICAL ASSOCIATIONS

Associations have been established to represent each medical profession, with one association officially accredited by the PRC to represent each industry. Associations represent the industry's interests and engage in such actions as policy advocacy, continuing medical education, and assistance for the renewal of licenses. They generally have a positive working relationship with government agencies such as the DOH and the PRC. For example, the Association of Philippine Medical Colleges recently submitted sample questions to the PRC for a new board exam for medicine. In another case, the Philippine Nurses Association (PNA) has been invited by the CHED to help draft nursing curricula to be implemented in public and private schools.

COMMUNICATION OF PUBLIC HEALTH ISSUES

Several implementing institutions from both the public and private sectors contribute to the dissemination of health information to the public. NGOs, which have proliferated and are working closely with Philippine government agencies, have mobilized to help communicate health messages and have played an important role in several national campaigns.

While to a certain extent the devolution of the health system fractured the health information system, the National Center for Health Promotion is responsible at the national level for communication of all DOH programs, including advocacy, social mobilization, and mass media. The Center uses celebrities to endorse health messages and publishes an annual calendar of health events. Many messages are disseminated through the CHDs and LGUs which all have professionals focusing on the communication of health information.

The Philippines has two official languages, Filipino (based on Tagalog) and English, and eight major dialects exist. The DOH has made efforts to address language barriers and the CHDs translate public health information into the local language when necessary. Each CHD has a communication officer who ensures that messages are delivered to the targeted audiences.

KEY SUPPORTING INSTITUTIONS

- Commission on Higher Education (CHED)
- Professional Regulatory Commission (PRC)
- Medical Associations
- Department of Education
- Non-Governmental Organizations (NGOs)
- Private Sector Partners

DEPARTMENT OF EDUCATION (DepEd)

The Department of Education (DepEd), with strong networks at the local level, is a natural partner for the dissemination of health information to vulnerable groups. DepEd employs 513,000 teachers, who are highly respected community members and are well-positioned to deliver health messages to children during their formative years. DOH has collaborated with DepEd through a health-related task force and has led successful education/awareness campaigns on topics such as breast feeding, de-worming, dental health, personal hygiene and drug addiction. Initial work has also begun to incorporate a health focus into the early education curriculum. Additional opportunities for partnerships exist between these two departments.

PRIVATE SECTOR PARTNERS

While the Government of the Philippines currently has no over-arching policy to engage the private sector, there are several instances where partnerships with the private sector have successfully contributed to the development of health professionals.

Public-private partnerships, such as the involvement of TIMEX in developing community midwives and the sponsorship by Pfizer of

components of the Doctors to the Barrios Program, have proven to add value to the government's ongoing efforts. Partnerships with municipal chambers of commerce have also proven to be successful in involving businesses in health priorities. In several instances, businesses have partnered with the government to ensure that medical clinics are available onsite. The Philippine Business for Social Practice (PBSP) is a non-profit organization that promotes the business sector's involvement with social development goals and can be further leveraged for the health agenda.

SOCIAL DYNAMICS

Medicine remains a prestigious and respected field in the Philippines. While Filipinos choose the field of medicine for many reasons, a common motivator is a desire to move overseas to higher salaries. International demand for health workers, particularly nurses, has reinforced this path for Filipinos. As a result of international demand and a consequent proliferation of nursing schools in the Philippines, the country has seen an overproduction of nurses. While the number of Filipinos enrolling in medical schools experienced a recent dip due to an overwhelming interest in pursuing nursing, enrollment has recently rebounded. The majority of doctors who remain in the Philippines practice in urban centers despite government programs to encourage them to practice in rural communities.

Midwives, a growing group of practitioners, represent the most accessible primary care providers for many and are critical in the country's efforts to improve maternal mortality rates. While public midwives are intended to be located in every barangay, some Filipinos must travel to other barangays for service. In some instances, this perpetuates a reliance on traditional healers, many of who are not trained and consequently contribute to the country's high maternal mortality rates. However opportunities increasingly exist for midwives to find creative means to finance their private practice in the regions. A public private partnership in Bohol, for example, has enabled private sector midwives to practice in a public facility, thereby encouraging private midwifery clinics while lessening their financial burden.

WORKING IN THE HEALTH SECTOR

The Magna Carta of Public Health Workers was established to "promote and improve the social and economic well-being of the health workers, their living and working conditions and terms of employment." It also lays out guidelines around the development of skills and capabilities so that health workers are able to best deliver in their jobs. In practice, the Magna Carta is not equally applied across the country. In many instances, the devolution of the health system has had a negative impact on health professionals in the public sector who are disconnected from a centralized system, receive less information, and have fewer career options. As a result of insufficient resources, fragmented human resources systems, and inconsistencies across LGUs, many people working in the health sector experience low salaries, poor working conditions, and limited career opportunities.

In an effort to supplement their income, many public sector health professionals also engage in private practice, particularly in urban centers. While the Civil Service Commission requires public medical professionals to work 40 hours a week, the DOH has formally allowed public medical professionals to work in the private sector after hours. While dual practice can lead to conflict of interest in some instances, it generally appears to encourage medical professionals to remain in the public sector, while enhancing their salaries with private practice.

MEDICAL BRAIN DRAIN

Admission to medical programs generally appears to be merit-based, though biased toward the upper middle class which can afford tuition. At the public University of the Philippines, however, where tuition is subsidized by the government, medical training is more accessible to a wider social-economic group, though admission remains very competitive.

Medical students in the nation's top universities express a near universal intention to travel abroad for their residency programs, citing higher compensation, advanced technology, and research opportunities as their primary motivators. Some students have recognized that while their university may encourage them to stay in the country to practice medicine, their education has prepared them for specialized practice in a tertiary hospital, rather than as a general practitioner in a primary care facility. Most medical students do not aspire to work in the provinces where the compensation is low and the technology is limited.

ACCESSING HEALTH CARE

The Philippine health system is intended to guarantee access to health care for all citizens, regardless of socio-economic status, gender, region, ethnic or other reasons. In reality, class is the most significant indicator. Many indigents have poor access to quality health care as a result of limited health personnel in some government facilities as well as policies that assign elective power to LGUs regarding the enrollment in an indigent health care program. In addition, while private sector health care providers have flourished, they remain clustered in urban centers and so have largely not provided additional health options in the regions. Many people also feel a greater distance between doctors and patients, particularly as doctors become increasingly specialized and focused on technology, which in turn drives up the cost of health care.

Further complicating access to health care for many is an over-whelming tendency for Filipinos to take a curative rather than preventive approach to their health care. This perpetuates a reliance on tertiary hospitals and drives up the cost of health care, often putting it out of reach for many Filipinos. Information about preventive medicine and the importance of taking care of oneself and one's family before illness strikes would be beneficial to the general public. While the DOH focuses on communications about specific government programs and health campaigns, more focus is also needed regarding over-arching approaches to health care. These messages should also be delivered by health workers who themselves sometimes orient away from primary care medicine.

Coexisting with modern facilities and specialized health personnel are traditional medicinal practices. Recognizing the importance of integrating and regulating the practice of traditional medicine, the DOH established the Philippine Institute of Traditional and Alternative Health Care in 1997. The Institute's primary purpose is to conduct research and development in the areas of traditional and alternative health care with the goal of integration into the health care system. The industry has also begun to organize itself with the establishment of professional associations such as the Philippine Association of Medical Acupuncturists.

INTERAGENCY COMMUNICATION

There are many strong examples of multi-partner collaboration and ongoing communications among the multiple stakeholders, from both the public and private sectors, which are implicated in the production, development, and management of health human resources in the Philippines. For example, there is regular contact between the DOH and medical universities regarding medical research. The development of the Philippine Human Resources for Health Master Plan 2005-2030 provides another strong example of inter-agency collaboration where stakeholders from both the public and private sectors agreed on a strategic way forward regarding human health resources.

To the extent possible, these collaborative efforts should increasingly include the private sector, which should be seen as a government partner and a legitimate stakeholder in the health system. In addition, the processes of planning, budgeting, and deployment of health human resources need to be further integrated and relationships need to be formalized in places where informal ties currently exist. The development and distribution of health workers will require deliberate collaboration and collective action in order to reach the country's desired health outcomes.

PROVIDING AND MAINTAINING FACILITIES

Private health delivery in the Philippines is active and in some cases thriving. Many facilities make up the private health system in the Philippines—such as hospitals, doctors clinics and midwifery facilities. They are all part of a system that also includes public facilities, such as the extensive network of public hospitals.

LEGAL FRAMEWORK

Companies in the health field are started in the same fashion as other businesses. A corporation involved in the medical field is incorporated under the Corporation Code of the Philippines, which was approved on May 1, 1980.[41] In general incorporation is rather easy and inexpensive (P 5,000 or US $100).

As to the medical profession itself, the practice of all professions in the Philippines, including medical professions, is limited to Filipino citizens, except in cases prescribed by law (Article 12, Section 14 of the Constitution). The 1987 Constitution of the Republic of the Philippines provides:

> *The Congress shall, upon recommendation of the economic and planning agency, when the national interest dictates, reserve to citizens of the Philippines or to corporations or associations at least sixty per centum of whose capital is owned by such citizens, or such higher percentage as Congress may prescribe, certain areas of investments. The Congress shall enact measures that will encourage the formation and operation of enterprises whose capital is wholly owned by Filipinos. In the grant of rights, privileges, and concessions covering the national economy and patrimony, the State shall give preference to qualified Filipinos. The State shall regulate and exercise authority over foreign investments within its national jurisdiction and in accordance with its national goals and priorities.*

FOREIGN OWNERSHIP AND INVESTMENT

Foreign equity ownership of a medical facility is not enjoined by the Constitution or existing foreign investment laws generally, though foreign citizens may not provide services as a medical provider. However, if any of these professionals wished to have a practice in a corporate form, then foreign ownership of that corporation would have to be limited to 40 percent.

Under R.A. 7042, Entitled Foreign Investments Act of 1991, foreign investment is limited in certain cases. The Fifth Foreign Investment Negative List A restricts the practice of professions, including medicine and allied professions, to Filipino citizens. It also contains a list of industries to which foreign ownership can be limited. The legal counsel for the health care provider was also of the view that since a private hospital is not mentioned on the list, it can therefore be owned by non-Filipinos (as is apparently the case with one major hospital in Metro Manila).

LICENSING FACILITIES

The process for licensing medical facilities has become substantially streamlined and efficient over the past two years. The framework for licensing facilities is clearly established, concise, and fairly simple. R.A. 4226 (1964), entitled "An Act Requiring the Licensure of all Hospitals in the Philippines and Authorizing the Bureau of Medical Services to serve as the Licensing Agency" ("Licensure Act"), provides

41 The Corporation Code provides that it shall not be applicable to Educational Corporations (Sections 106-108) and it has special provisions governing Religious Corporations (Sections 109-116). It does not single out corporations in the medical area as not being subject to the Corporation Code, or as being subject to the Code but under special provisions. Additionally, a detailed discussion of the evolution and present state of the law can be found in the BizCLIR publication entitled "Southeast Asia Commercial Law and Trade Diagnostics—Final Report" (July 2007), found at http://www.bizclir.com/galleries/country-assessments/Philippines.pdf

the legal framework for establishing certain medical facilities. It covers government and private hospitals, but it also covers medical facilities in other forms, specifically "any clinic or dispensary where there is more than at least six (6) beds or cribs or bassinets installed for twenty-four hour use by patients shall be construed to fall within the definition of a hospital as described in [the Licensure Act]."[42]

The Licensure Act covers such matters as:

- Construction permits
- Registration and operating licenses
- Minimum standards and construction (e.g. standards for matters such as sufficient bed space for hospital bed capacity, a laboratory room, an operating room)
- Inspections
- Revocation of licenses and hearing

A recent Administrative Order issued by the Department of Health (Administrative Order No. 2007-0021, June 6, 2007), entitled Harmonization and Streamlining of the Licensure System for Hospitals, attempts to streamline the licensure system for hospitals). It establishes a "One-Stop Shop" for licensure. Prior to this order, a hospital with ancillary facilities or services, such as a "clinical laboratory, x-ray facility and pharmacy," required separate permits from separate regulatory units within the DOH. To ease the regulatory burden, the Order provides that a single license cover all hospital services. A team of DOH regulators with the mandate to represent each of the regulatory authorities is empowered to conduct all necessary inspections at one time. The "One-Stop Shop" was mentioned by a number of hospital-affiliated persons as an excellent step toward streamlining the licensure process.

Notably, while private health facilities are required to obtain a business license from their LGU to operate a facility, there is no obligation that a private sector facility obtain a health facility license from the DOH. Most facility operators do not seek out DOH licensing to operate their facilities, and thus remain largely unregulated regarding facility standards.

ACCREDITATION

All facilities, even private facilities seeking to be designated as an accredited institution duly authorized for services covered by the Philippines Health Insurance Corporation (PhilHealth), must receive a DOH license to operate. To be eligible for PhilHealth accreditation, a health facility must provide a list of its equipment, personnel, service charges, rates, information on a therapeutics committee, Infection Control Committee manual, and the facility's Quality Assurance program. In addition, the health facility must provide its accreditation fee, evidence of a current DOH license and a notarized form indicating the health facility's compliance with laws, standards, and other requirements. Of the approximately 1,500 hospitals accredited by PhilHealth as of March 2009, nearly 61 percent of the hospitals belong to the private sector, while 39 percent are owned and operated by the government.[43]

CERTIFICATION

Separate from the DOH's regulatory process for licensing institutions, and separate from PhilHealth's accreditation process, the DOH has also created a process for certifying quality assurance standards within health facilities. The Sentrong Sigla Movement seeks to promote better health outcomes while providing health facilities with a publicly recognized seal of quality assurance based upon objective quality assurance indicators. Though a recognizable brand,(an image of the sun with eight rays protruding) the certification process commences with a self-evaluation and technical assistance provided by the DOH. Sentrong Sigla certification comprises three graduated levels of increasing performance to provide an organized framework for continuous quality improvement for health facilities.

Administrative Order No. 2007-0041 (November 7, 2007), on the subject of

42 Section 2 (A)(c) of the Licensure Act.

43 See: http://www.hsph.harvard.edu/phcf/publications/Hsiao.Shaw.2007.SHI.developing.countries.pdf.

Guidelines on the Mandatory Allocation of a Certain Percentage of the Authorized Bed Capacity as Charity Beds in Private Hospitals, requires that all *private* hospitals shall allocate not less than 10 percent of its authorized bed capacity as charity beds, for indigent patients (or other low income patients as provided in the administrative order). In the "rationale section" for this requirement, the administrative order points out that one policy to improve affordability of hospital services is to allot a certain percentage of their authorized bed capacities solely for charity beds. Under Republic Act 1939, "government hospitals are already mandated to allot a certain number or percentage of their authorized beds as free or charity beds," but there was no similar requirement for private hospitals. Complying with this requirement has put new financial obligations on private hospitals.

KEY LAWS

- The Constitution of the Philippines
- The Corporation Code of the Philippines
- R.A. 7042 (Foreign Investments Act of 1991 and Foreign Investments Negative List
- R.A. 4226 (An Act Requiring the Licensure of all Hospitals in the Philippines and Authorizing the Bureau of Medical Services to serve as the Licensing Agency)
- R.A. 7875 (National Health Insurance Act of 1995)
- Administrative Order No. 2007-0021 (Harmonization and Streamlining of the Licensure System for Hospitals)
- Administrative Order No. 2007-0041 (Guidelines on the Mandatory Allocation of a Certain Percentage of the Authorized Bed Capacity as Charity Beds in Private Hospitals)
- Administrative Order No. 2008-0001 (Implementing Rules and Regulations of R.A. 9439, An Act Prohibiting the Detention of Patients in Hospitals and Medical Clinics on Grounds of Nonpayment of Hospital Bills or Medical Expenses)

ENFORCEMENT OF CONTRACTS AND PROMISSORY NOTES

The second recent change is contained in Administrative Order No. 2008-0001 (January 7, 2008), on the subject of Implementing Rules and Regulations of Republic Act No. 9439, known as "An Act Prohibiting the Detention of Patients in Hospitals and Medical Clinics on Grounds of Nonpayment of Hospital Bills or Medical Expenses." The administrative order applies to patients in both government and private hospitals and medical clinics (other than those who stay in private rooms). The general policy enunciated is that patients who are partially and fully recovered and who wish to leave the hospital but are unable to pay shall be allowed to leave the hospital or clinic. They should be given their medical certificate and other documents upon executing a promissory note secured by a mortgage or a guarantee of a co-maker, who shall be jointly and severally liable for the unpaid obligations. Hospitals, both government and private, have found themselves with unpaid promissory notes totaling very substantial amounts, causing them economic difficulties. The rules against detention and requiring the taking of a promissory note in the event of inability to pay upon discharge does not apply to indigents only. Thus, one private hospital said it now requires a credit card (of the patient and/or others, if the credit limit on one card is not sufficient) to be presented prior to or on admission to the hospital, to guarantee payment and not to have to resort to having to back a promissory note. It has also instituted "progress payments" so as not to allow an unpaid hospital bill to get too high.

While detention of patients is an unnecessarily extreme enforcement mechanism for payment of a hospital bill, this administrative order does bring to light a critical issue regarding income streams and operational funding for hospitals, public and private alike. Several sources have noted the difficulty in obtaining and enforcing civil judgments. Assuming that the promissory notes held by hospitals are enforceable as written,

several interviewees indicated a very long time-frame for scheduling a civil trial, and obtaining a judgment as a significant factor in failing to bring legitimate claims to court. Further, no small claims court exists in the Philippines at present, and arbitration for promissory note dispute settlement has not been effective. Even in instances where patients could afford to pay in installments, the system allows patients to avoid their repayment obligations. Interviewees indicated that this risk of non-payment is indeed factored into hospital service charges, raising the cost for consumers.

DISTRIBUTION OF URBAN AND RURAL FACILITIES

There is general agreement that there is a surplus of medical professionals in urban areas, and either sufficient or an excess of medical facilities, while rural and non-urban areas suffer from a lack of medical professionals and facilities. Human capacity issues are dealt with in other parts of this report, but without adequately trained medical personnel, medical care will suffer in these underserved areas. For example, one hospital administrator said that his research indicated that up to 90 percent of medical school graduates from the Philippines wanted to leave the country and work abroad.

Many of the persons we met had proposals to try and solve these issues, such as:

- Write off (in whole or in part) student loans of health-care professionals if they work in the underserved areas
- Require health-care students, as a condition of admission, to promise to work in underserved areas for a period of time after graduation
- Provide "soft-loans" to medical school graduates to allow them to open practices in underserved areas, which would allow them to open an office and buy equipment. The loans would be at favorable rates, with repayment forgiven or reduced depending on the length of time spent in the underserved area

- Provide tax incentives along with, or in lieu of, the soft loans mentioned above
- Make borrowing secured by medical equipment easier to effectuate

According to a survey conducted by a local hospital administrator, hospitals and doctors are increasingly becoming the targets of litigation. A medical facility administrator stated that malpractice insurance to protect the facility or doctor is not common; coverage has to be sourced from abroad and the cost is prohibitive. This situation is thus in need of attention so as to retain medical professionals and to encourage new entrants.

The National Health Insurance Act of 1995 (R.A. 7875) established a national health insurance program (PhilHealth). For most medical facilities, accreditation by PhilHealth is imperative because it is a precondition for coverage of services and reimbursement of claims from the facility. By its statutory mandate, PhilHealth provides the following coverage at accredited facilities:

"a) Inpatient hospital care:

1) room and board;
2) services of health care professionals;
3) diagnostic, laboratory, and other medical examination services;
4) use of surgical or medical equipment and facilities;
5) prescription drugs and biologicals; subject to the limitations stated in Section 37 of this Act;

6) inpatient education packages;

b) Outpatient care:

1) services of health care professionals;
2) diagnostic, laboratory, and other medical examination services;
3) personal preventive services; and
4) prescription drugs and biologicals subject to the limitations described in Section 37 of this Act;

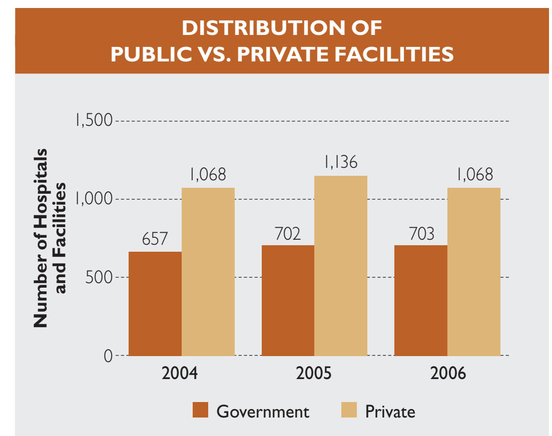
c) Emergency and transfer services; and

d) Such other health care services that the [Philippine Health Insurance] Corporation shall determine to be appropriate and cost-effective: Provided, That the Program, during its initial phase of implementation, which shall not be more than five (5) years, shall provide a basic minimum package of benefits which shall be defined according to the following guidelines:…"[44]

Notably, prescription drugs are covered when given as part of inpatient hospital care; however, PhilHealth does not cover prescription drugs when not given on an inpatient basis. Thus, there is an incentive for patients to seek admission to hospital facilities for relatively minor procedures that require pharmaceutical products.

The types of services for which reimbursement is made is quite broad, and these are provided by an accredited health care provider. A "health care provider" is defined as:

1) a health care institution, which is duly licensed and accredited and devoted primarily to the maintenance and operation of facilities for health promotion, prevention, diagnosis, treatment, and care of individuals suffering from illness, disease, injury, disability or deformity, or in need of obstetrical or other medical and nursing care. It shall also be construed as any institution, building, or place where there are installed beds, cribs, or bassinets for twenty-four hour use or longer by patients in the treatment of diseases, injuries, deformities, abnormal physical and mental states, maternity cases or sanitarium care; or infirmaries, nurseries, dispensaries, and such other similar names by which they may be designated; or
2) a health care professional, who is any doctor of medicine, nurse, midwife, dentist, or other health care professional or practitioner duly licensed to practice in the Philippines and accredited by the Corporation; or
3) a health maintenance organization, which is an entity that provides, offers, or arranges for coverage of designated health services needed by plan members for a fixed prepaid premium; or
4) a community-based health care organization, which is an association of indigenous members of the community organized for the purpose of improving the health status of that community through preventive, and curative health services.



IMPLEMENTING INSTITUTIONS

The key implementing institution in starting and maintaining facilities is the Department of Health (DOH). As discussed in the Legal Framework section above, the DOH deals with licensure of hospitals, as well as many other crucial institutions, facilities, and issues in the health field.

The DOH, through the Bureau of Health Facilities and Services (BHFS), in coordination with the Centers for Health Development

44 Article III, Section 10.

(CHDs), currently regulates the following types of health facilities and services (as of 2005)

- Ambulatory Surgical Clinic
- Blood Service Facility
- Clinical Laboratory
- Dental Laboratory
- Dialysis Clinic
- Drug Abuse Treatment and Rehabilitation Center
- Drug Testing Laboratory
- Health Maintenance Organization
- HIV Testing Laboratory
- Hospitals
- Kidney Transplant Facility
- Laboratory for Drinking Water Analysis
- Medical Facility for Overseas Workers and Seafarers
- Newborn Screening Center
- Psychiatric Facility

PhilHEALTH

As a result of its nationwide reach at all levels of society, accreditation by PhilHealth is critical for attracting clients. Many hospitals and other medical facilities with PhilHealth accreditation advertise PhilHealth accreditation status. PhilHealth's reimbursements are capped, so that in practice the patient is usually left to pay the majority of the medical bills. Estimates are that PhilHealth reimbursements cover only 15–20 percent of a patient's costs. There have been complaints that PhilHealth is also months behind in reimbursements. By law, all workers are to be covered, and indigents are to have their premiums paid for by the government.

KEY IMPLEMENTING INSTITUTIONS

- Department of Health (DOH) Bureau of Health Facilities and Services
- National Center for Health Facilities Development
- Philippines National Health Insurance (PhilHealth)
- Hospitals
- Local Government Units (LGUs)
- Clinics

Opinions among interviewees differed as to whether a dual "regulatory" environment, i.e., DOH licensing and PhilHealth accreditation, was burdensome. Some said that the two entities actually covered different matters—the DOH looks at facilities in the hospital, for example, and PhilHealth deals more with patient records and billing. Others described the difference as the DOH making sure the facility had certain equipment and/or personnel, while PhilHealth looks at how the equipment is used and what the results are. Still others said that there was duplication and overlap, although some of this group found that the duplication and overlap were not too burdensome since the facility would in any event have to comply with the more stringent requirement. This would in effect mean that it would comply with the other agency's weaker requirements. Finally, there is talk of coordinating the standards for licensing and accreditation, with the DOH looking at measures dealing with safety and PhilHealth looking at quality indicators.

Whether the overlap is duplicative, the rules and regulations governing licensing, registration and operation of healthcare facilities are generally well regarded. There are some who feel that strict observance of the rules and regulations varies based upon 1) the size of the facility; 2) whether the facility is publicly or privately owned; and 3) whether the facility is located in an urban or rural area (i.e., favoring small public facilities located in underserved regions). As rural areas may be underserved in terms of medical personnel and facilities, inspectors and others who enforce the rules and regulations in these regions also operate with insufficient resources and capacity. Quality assurance capacity development is critical for inspectors within the DOH Bureau of Health Facilities and Services.

HOSPITALS

In 2005, there were 359 government-licensed hospitals (including primary care, secondary

care and tertiary care) with 36,396 beds, and 343 other government-licensed facilities (infirmary/primary, birthing home, acute chronic psychiatric care, custodial psychiatric care) with 6163 beds, for a total of 702 government hospitals and other facilities with a total of 42,559 beds. With respect to private hospitals and facilities, there were 595 licensed private hospitals with 36,519 beds, and 541other private licensed facilities with 6878 beds, for a total of 1,136 private hospitals and facilities with a total of 43,397 beds. (Administrative Order 2007-0041 mentioned above, states that in 2006 there were 703 government hospitals with a total bed capacity of 47,774 beds (of which approximately 42,997 (90 percent) were charity beds) while there were 1,068 private hospitals with a total bed capacity of 44,296. It appears that the DOH, in this administrative order, may have been lumping together hospitals and other facilities.)[45]

As a result of devolution, LGUs maintain local public health centers. The Department of the Interior and Local Government supervises the LGUs and the implementation of national policy. The department focuses on five interagency initiatives with the DOH focusing on field health, HIV/AIDS, children, population and pandemics. The department engages in a number of formal and informal methods to encourage among LGUs behaviors consistent with national policy, such as a new performance based grant that rewards positive LGU behaviors with financing for health facilities. One issue that has been cited is the lack of oversight on how money sent to localities, for example to mayors, is not monitored.

There has been a growing trend toward private free-standing clinics. Although the government does offer free public sector clinics, service is said to be slow, with an inadequate number of doctors staffing the facilities. The DOH has issued guidelines for clinics that offer a great number of services. Some companies run a chain of clinics, with some branches in shopping malls. Clinics offer services not just to individuals "off-the-street," but larger ones (e.g. those which operate a chain of clinics) also have agreements to service HMO clients and employees of companies that engage the clinics. They may also run ancillary facilities, such as a medical laboratory. Clinics register with the Department of Trade and Industry as well as with the DOH. Unlike hospitals, they do not need a Certificate of Need.

When a doctor opens a "clinic" and only performs services that a physician normally offers, then all she or he needs is a medical license. If more services are offered, such as a laboratory or use of diagnostic equipment, then additional licenses would be required. However, no additional DOH registration or certification is required in this instance.

SUPPORTING INSTITUTIONS

Philippines Hospital Association (PHA) is comprised of hospitals and persons from both the public and private sector, and from all geographical areas of the Philippines. It also has "affiliate members," such as healthcare companies and other healthcare associations (such as the Association of Nursing Service Administrators

45 http://www.doh.gov.ph/files/ao2007-0041.pdf.

of the Philippines, the Philippine Society of Hospital Pharmacists, and the Philippine Society of Pathologists). The PHA is involved in advocacy, and asserts that amendments to the Hospital Licensure Law and issuance of DOH administrative orders can be credited to the efforts of the PHA, notably in the cause of primary hospitals, especially in rural areas. The PHA also has a Memorandum of Agreement with PhilHealth "defining the so called 'rules of engagement' in the inspection, investigation and monitoring of hospitals…"

Philippine Medical Association (PMA) carries on many activities as part of its vision "to have a fellowship of physicians united in the common goal of acquiring the highest levels of medical knowledge and skills through continuing education and research, and to promote the healing ministrations of the physicians in the delivery of health care of patients."

The PMA has many "component" associations (e.g. Abra Medical Society, Agusan del Norte Medical Society, Agusan del Sur Medical Society, Zamboanga del Norte Medical Society, Zamboanga del Sur Medical Society and Zamboanga Sibugay Medical Society). The PMA has "specialty divisions" such as the Philippine Academy of Family Physicians, the Philippine College of Physicians, the Philippine College of Radiology, the Philippine College of Surgeons, the Philippine Obstetrical and Gynecological Society, the Philippine Pediatric Society, the Philippine Society of Anesthesiologists and the Philippine Society of Pathologists.

The PMA is actively involved in advocacy and outreach, the scope and breadth of which is shown by its standing committees on food, drugs and cosmetics; hospital and laboratories; research, education and culture; emergency and disaster; indigency; environmental health and ecology; the Philippine Health Insurance Company; HMOs; nutrition; sports; political affairs; and medical tourism.

The Philippine League of Government and Private Midwives works on issues related to midwives, who are a crucial element in the health care system in the Philippines, especially in rural areas. As discussed in the Developing Human Capacity section, midwives serve a critical function in the Philippines, often serving as the primary caregiver for some women in rural populations and actively advocating on behalf of this segment of the health sector.

KEY SUPPORTING INSTITUTIONS

- Philippine Hospital Association (PHA)
- Philippine Medical Association (PMA)
- Philippine League of Government and Private Midwives

SOCIAL DYNAMICS

Professional associations are active in outreach and advocacy. The Philippines Hospital Association prides itself on having influenced amendments to the Hospital Licensure Law and issuance of DOH administrative orders, as well as having a Memorandum of Understanding with PhilHealth on inspections, investigations and monitoring of hospitals.

The Philippines Medical Association (PMA) has a Committee on Political Affairs. It also takes public stands on issues. According to the *Philippines Daily Inquirer*, the PMA warned in 2006 that "the country's health system risked complete collapse in a few years due to the large number of Filipino doctors and nurses who have found better-paying jobs abroad."[46]

The Philippines has a vibrant and vocal press that covers the news and openly voices its opinions. The Philippines Daily Inquirer not only quoted the PMA's warning, but also reported on the remarks of Health Secretary, Francisco Duque, who reported that there were 500 applications from Indian doctors to work in the Philippines, who could fill posts at various government hospitals due to the large number of Filipino medical professionals who seek work abroad. Secretary Duque stated that the Constitution forbade hiring them, and

46 Philippines Daily Inquirer, March 23, 2006, p. A9.

according to the article, he called for a review of the constitutional provision.

Although associations and other parties do work with the government, there is no formal process entitling the public to a hearing, or even authorizing notice and comment procedures on laws, regulations, and administrative orders. While notice and comment procedures have been conducted on an *ad hoc* basis, several interviewees, both in the public and private sectors, have supported the notion of providing formal guidelines for a notice and comment process for future policy and rule-making procedures.

GOVERNING THE SYSTEM

A well-organized, efficient governance system that is responsive to the needs of stakeholders and encourages public and private collaboration and competition is critical to a well-functioning health system. Of paramount importance is the degree to which public policies encourage private investments in the health sector and a satisfactory mix of sustainable public and private investments. Other key factors include health policy and budget development processes, the inclusion of medical groups and organizations into the national dialogue, and local, regional, national, and international variables that affect the health system. Health system performance hinges upon whether participation at all levels takes place in the development of health policies. In addition to the development of such policies, equitable and efficient implementation of health policies is highly significant.

The health system governance structure in the Philippines is unique in that it represents an almost wholesale devolution of health policy implementation, decision-making, and budgetary authority to the LGU level, while most regulatory enforcement is retained at the central level. While there are purported benefits of a devolved governance model for health systems, in the Philippines this has also led to institutional barriers to effective participation in policy development, disparity in policy implementation, and additional regulatory limitations that burden service providers, public and private alike. To support health system sustainability and harness the power of competition and cooperation among public and private sector service providers, policymakers must begin to address the flaws in the devolved governance system, and where sensible, support increased collaboration among LGUs to begin to rationalize the system.

LEGAL FRAMEWORK

The legal framework for the governance of the health system is clear, and easily accessible in hard copy as well as electronically. The legal mandate, both for the DOH as key central policymaker and regulatory body is clear. The mandate for implementation of health policies at the LGU level is also clearly established, and the basis for funding is clearly set. Furthermore, the basis for takeover of an LGU's authority by the DOH (primarily in the case of an epidemic) is also well-established.

The Department of Health (DOH) is the principal health agency in the Philippines. It is responsible for ensuring access to basic public health services to all Filipinos through the provision of quality health care and regulation of providers of health goods and services. Established by law in 1898 and subsequently modified several times to reflect modern demands, the DOH in the Philippines was historically the key policymaker as well as health policy implementation authority.

DEVOLUTION

The Local Government Code of 1991 also known as Republic Act (RA) 7160 devolved all structures, personnel, and budgetary allocations from the provincial level down to the barangays to the LGUs to facilitate health service delivery units. In addition to an entitlement to an Internal Revenue Allotment (IRA), which is a direct disbursement to the LGUs from the national treasury, LGUs are empowered to levy special taxes and establish fees

for the exclusive benefit of the LGU authority.[47] LGUs have great flexibility in the methods in which they may organize themselves to best achieve their public health goals. For example, LGUs are entitled to pool resources and collaborate with other LGUs for purposes of common gain, and also partner with NGOs and people's organizations (POs) to enhance provision of public services, including health services.[48] While in theory LGUs are able to pool resources and collaborate for mutual gain, in practice the perception is that few collaborative efforts have materialized, and fewer have been successful. Furthermore, according to one interviewee, no partnership between an LGU and an NGO has been sustained. Notably, the Development Bank of the Philippines is currently seeking to incentivize partnerships among LGUs and NGOs to roll out new medical facilities in underserved regions of the Philippines. Using the IRA disbursement as a source of future income, the Development Bank of the Philippines will be offering low-interest, low-risk loans as seed capital or expansion funding.

Title V of the Local Government Code also establishes the legal basis for the creation of local health boards that: 1) support local health budgetary advice; 2) provide technical advice for public health procurements; and 3) provide technical advice related to administrative matters such as personnel decisions, tenders, and other related administrative matters.[49] While the DOH is the primary policymaker, there is virtually no budgetary control over the LGUs in their implementation of health policy or personnel. The DOH, through CHDs, provides technical assistance directly to LGUs in performance of their health missions.

PHILIPPINES HEALTH INSURANCE CORPORATION

The laws establishing the Philippines Health Insurance Corporation (PhilHealth) provide a clear legal mandate to improve access, equity, and efficiency of the health system. For the most part, the laws regulating the existence of PhilHealth lay out its obligations and provide sufficient tools to accomplish its objectives. For example, the Health Insurance Act of 1995, also known as Republic Act 7875, creates a quality assurance obligation on the part of PhilHealth.[50] Further, to inform and enforce PhilHealth's quality assurance standards, the law establishes minimum requirements for facility and provider accreditations.

Notably, two significant holes exist in the law establishing PhilHealth. First, while rules governing PhilHealth's reimbursement for pharmaceutical prices and covered medical devices exist, no section in the law or implementing regulations establish a legal mandate for PhilHealth to negotiate drug prices on behalf of PhilHealth members. Second, while PhilHealth is charged with ensuring 100 percent coverage of the entire population by 2010 (i.e.,. 15 years from the date of the law), and while indigents are supposed to be covered by their LGUs, no single metric or standardized definition of the term "indigent" exists, and there is little guidance as to how to identify indigent versus non-indigent individuals.

"*FOUR*MULA" ONE FOR HEALTH REFORM AGENDA

The Philippines health strategy document "Fourmula One for Health Reform" (F1 plan) establishes the four-part priorities for a sector-

47 Local Government Code 1991 (RA 7160), §18.
48 *Id*, §19.
49 *Id, §102(b)(1) et seq.*
50 The Health Insurance Act of 1995 (RA 7875), §IX.

based reform effort for the Philippines. The FI plan and related administrative orders lay out a clear framework for health policy reform implementation, as well as short-, mid-, and long-term programmatic investments. Annual operational plans, linked to the Province-Wide Investment Plan for Health (PIPH) lay out clear funding priorities for programs at the provincial level, and serve as both an operational and strategic guide, as well as a sound basis for coordination of provincial level and central government level donor programmatic support. CHDs, which serve as the focal point for LGU PIPH Annual Operational Plan development pursuant to Administrative Order No. 2008-2003, play a critical, yet underutilized role in LGU collaboration and also potentially for donor coordination.

All current national policy programs naturally expire in 2010. Presently, no policy planning document provides guidance beyond 2010 (except for meeting the Millennium Development Goal challenge at 2015). It is not clear when the new strategy transitional documents will be available for preparation and dissemination. However, several key stakeholders interviewed had not yet provided feedback, and indeed had not yet been offered a review of the new strategy documents.

The National Objectives for Health 2004–2010 provides a "road map" of key ideas, targets, indicators and strategies to bring the health sector to its desired outcomes. It also defines the collective and individual roles that the various stakeholders—policy makers, program planners and managers, service providers, local government executives, development partners, the academe, and civil society—play in shaping the future of the Philippines' health system and in bringing better health outcomes. This document was developed for the purpose of health planning, policy and program development, implementation, and monitoring and evaluation.

The DOH implements health programs and, is able to modify the legal framework as the system requires. For example, Executive Order 102 modified the DOH's roles and functions to emphasize policy formulation, standard setting, and quality assurance, and shifted to technical leadership and resource assistance.

KEY LAWS

- RA 7875—The Health Insurance Act of 1995
- RA 7160—Local Government Code of 1991
- Executive Order No. 102 (May 21, 1999)
- Administrative Order No. 2008-0003
- Administrative Order No. 2008-0005
- Administrative Order No. 2007-0037
- Administrative Order No. 2007-0038
- Administrative Order No. 2007-0040
- Administrative Order No. 2005-0023
- Department Memorandum No. 2008-0078
- Department Memorandum No. 2008-0104

DEVELOPING THE BUDGET FOR THE DOH

The guidelines to develop the budget are very detailed and comprehensive. For example, in compliance with the annual submission of agency targets/budget proposals to the Department of Budget and management (DBM), the Health Policy Development and Planning Bureau (HPDPB) in coordination with the Finance Service (FS), facilitates the preparation of the CY 2009 DOH operational plan. These plans are then submitted to their respective undersecretaries/ assistant secretaries, CHD directors, chiefs of hospital, and heads of agencies for review and approval.

In addition, there are guidelines that establish a performance based budgeting system to measure the agency's performance in the implementation of programs, projects and activities with an emphasis on outcome.

IMPLEMENTING INSTITUTIONS

The Department of Health (DOH) is the principal health agency in the Philippines. It is the implementing institution, responsible for ensuring access to basic public health services to all Filipinos through the provision of quality

health care and regulation of providers of health goods and services towards "Health for all Filipinos."

The mandate of the DOH is to "provide assistance to LGUs, people's organizations (POs), and other members of civil society in effectively implementing programs, projects and services that promote the health and well being of every Filipino; prevent and control diseases among populations at risks; protect individuals, families and communities exposed to hazards and risks; and treat, manage, rehabilitate individuals affected by disease and disability."

"The health system shall be responsive to the needs of the population, especially the poor and shall strengthen the collaboration among the national and local governments, the private sector and non-government organizations to ensure accessibility of affordable quality health and health-related goods and services."[51]

To meet the health needs of the country, reforms in the country's health care system have been instituted over the past 30 years: the adoption of primary health care in 1979; the integration of public health and hospital services in 1983 (EO 851); the enactment of the Generics Act of 1988 (RA6675); the devolution of health services to LGUs as mandated by the Local Government Code of 1991 (RA 7160); and the enactment of the National Health Insurance Act of 1995 (RA 7875). In 1999, the DOH launched the Health Sector Reform Agenda (HSRA) as a major policy framework and strategy to improve the way health care is delivered, regulated and financed. The "Fourmula One for Health" approach was launched in August 2005 to set the directions and the implementation arrangements for strengthening the way health care is delivered, governed, regulated and financed.

Since the devolution of authority away from the DOH to LGUs for implementation of health programs at the local level, the DOH serves primarily as the national policy development unit and primary source for facility and medical product regulation. Additionally, the DOH provides technical assistance in policy implementation through CHDs, and also provides oversight for certain hospitals within the health system. The DOH is intended to also serve as the primary receptacle for country-level health data (i.e., mortality and morbidity rates, data on facilities, data on birth rates and other health-related statistics). The DOH also serves as the key implementing institution tracking disease epidemics and coordinating national vigilance efforts.

LOCAL GOVERNMENT UNITS

LGUs make up the political subdivisions of the Philippines. Administratively, these LGUs are grouped into 17 regions. LGUs are guaranteed local autonomy under the 1987 Constitution and the Local Government Code of 1991. As of 2004, the Philippines is divided into 79 provinces headed by governors, 117 cities and 1,500 municipalities headed by mayors, and 41,975 barangays or villages headed by barangay chairpersons (NSCB 2004). Legislative power at local levels is vested in their respective local legislative councils.

Under this complex health system, the public sector consists of the DOH, LGUs and other national government agencies providing health services. The DOH is the lead agency in health. Its primary mandate is to provide national policy direction and develop national plans, technical standards and guidelines on health. It has a regional field office in every region and maintains specialty hospitals, regional hospitals and medical centers. It also maintains provincial health teams made up of DOH representatives to the local health boards and personnel involved in communicable disease control.

With the devolution of health services under the 1991 Local Government Code, provision of direct health services, particularly at the primary and secondary levels of health care, is the mandate of LGUs. Provincial and district hospitals are the responsibility of the provincial

51 See http://www.doh.gov.ph/executive_order/eo102

government while the municipal government manages the rural health units (RHUs) and barangay health stations (BHSs). In every province, city, or municipality, there is a local health board chaired by the local chief executive. Its function is to serve as an advisory body to the local executive and the local legislative council on health-related matters.

The passage of the 1995 National Health Insurance Act expanded the coverage of the national health insurance program to include not only the formal sector but also the informal and indigent sectors of the population. The program is founded under the principle of social solidarity where the healthy subsidize the sick and those who can afford to pay subsidize those who cannot. The Philippine Insurance Health Corporation (PhilHealth), a government-owned and controlled corporation attached to the DOH, is the agency mandated to administer the national health insurance program and ensure that Filipinos will have financial access to health services (National Objectives for Health).

PHILIPPINES HEALTH INSURANCE CORPORATION (PHILHEALTH)

PhilHealth does not have systems in place to identify and select true indigents to provide free health care. As LGU politicians sponsor indigents to the program, some non-indigent constituents are offered sponsorship as political accommodation. There is a need to have a more "balanced" and "neutral" screening process where political accommodation is minimized. It is imperative for PhilHealth to develop a tool that will allow identification of the true poor. PhilHealth should utilize the Department of Social Welfare and Development (DSWD) system which provides services through the selection of poorest households based on a ranking system for households using the proxy means test (PMT) developed for their program. Once this household has been established as poor, PhilHealth should automatically enroll them in the health insurance for the indigents.

POLICY DEVELOPMENT PROCESS IN THE DOH

Administrative Order 182-2004 revised policies and guidelines on the Administrative Issuance System (AIS) in the DOH. This AO was prepared to "further systematize, harmonize, and effectively manage the DOH and provide instructions to execute and implement laws, programs, and perform mandated functions, the Secretary of Health shall formulate, and circulate policies and guidelines for everybody concerned." Standards, rules, regulations, announcements and declarations are documented and disseminated. All administrative issuances are filed and archived by the central record section, KMD-IMS. The KMD-IMS facilitates processing and administrative issuances that require publication in a leading newspaper for general circulation and will be responsible for filing them with the Office of the National Administrative Register, UP Law Center.

DECENTRALIZED BUDGET SYSTEM

The National Objectives for Health documents that in the Philippines, the primary fiscal vehicle supporting decentralization is the Internal Revenue Allotment (IRA), which transfers funds directly to LGUs from the national treasury. Most LGUs depend heavily on this source, as do devolved health services. The central DOH created the Local Government Assistance and Monitoring Service to manage transition budget shortfalls and to provide financial assistance to local governments unable to maintain health services or meet their obligations because of inadequate resources. The DOH also implemented a conditional matching grant program, the Comprehensive Health Care Agreements, intended to secure local funding for devolved functions and core public health programs. This reflected an important part of the country's strategy of using incentives and disincentives to achieve national objectives in a decentralized system. However, the relationship between service delivery and financing arrangements entailed significant weaknesses. For example, devolution of public

facilities led to fragmentation of the hospital referral system. Under the devolution, each hospital or clinic primarily serves the constituency of a local government. Several provinces therefore reduced budget appropriations to urban hospitals and channeled resources to less well-off municipalities, in the process raising the average cost of urban services. Instead of co-financing these facilities with the provinces, many cities opted to refurbish their own clinics or build enclave hospitals. Further, weak monitoring of local compliance with Comprehensive Health Care Agreements did not help ensure financing of the devolved services.

FIELD HEALTH SERVICE INFORMATION SYSTEM

The Field Health Service Information System (FHSIS) is the major Health Information System (HIS) of the Philippine health system. Data on health accomplishments, delivery of health services, and morbidity reports are regularly generated from the RHUs to municipalities, to provinces, to the Center for Health Development (CHD), and to the National Epidemiology Center (NEC) at the DOH central office.

The reporting system gathers information on diseases and other major public health programs. Data is submitted to the municipal health officer (MHO) as a tool for planning, decision-making and supervision at the municipal level. Information is collected on issues such as maternal and child health (MCH), family planning, and environmental health. Major players in the system are the midwife (data collector) and the public health nurse (consolidation at RHU level). However, only indicators for identified national vertical programs of the DOH are being reported to the provincial health office, CHDs, and the NEC.

There is inconsistency on generation of critical health indicators to establish trends. Information generated by the system is limited to government health facilities. Reports from the private sector and the LGUs are not submitted. Compliance and completeness of the submission from the LGUS are major factors affecting the quality of summarized information. In addition, there are delays in publishing and dissemination of the reports.

The main challenges are ensuring that data, information, researches, and best practices within the health sector are facilitated to reach provincial, regional and national policy makers, and how such information will be translated into use for policy making and program implementation. The Information Management Systems Bureau is preparing and developing a management information systems(MIS) strategy paper that will strengthen their systems.

HEALTH SERVICES

Since the inception of the HSRA in 1999, health reforms have made inroads in at least 30 provinces. In health governance, municipalities have joined together to form inter-local health zones (ILHZs) to optimize sharing of resources and maximize joint benefits from local health initiatives. In health regulation, LGUs have pooled their procurements to lower the price of essential drugs. In health service delivery, key local health facilities have been upgraded to meet accreditation requirements and be entitled for capitation or reimbursements from PhilHealth. In health financing, local governments have increased contributions needed to enroll indigents into the social health insurance program. Not only is the coverage of health services being improved in these localities, invaluable lessons are also being learned to bolster confidence in the implementation of these reforms nationwide.

Despite these achievements, the health care delivery system continues to address challenges such as policy and program planning, financing, management support, and networking. It was acknowledged during the interviews, specifically during an interview with a representative from the League of Governors, and in reviewing documentation that despite all the DOH efforts, the DOH and LGUs are

at times unclear on the operational definition of "devolved health services." Providing health services under this mechanism at times becomes the source of misunderstandings and conflicts among national, regional, provincial, and municipal health workers, affecting the over-all effectiveness and efficiency of the health care delivery system.

SUPPORTING INSTITUTIONS

The Bureau of International Health Cooperation (BIHC) ensures coordination among international donor organizations and the DOH. The BIHC develops standards, mechanisms, and procedures for international health cooperation; provides services related to mobilization, coordination, management, and assessment of externally supported health projects and initiatives; provides services related to promotion, coordination and mobilization of health sector support for international initiatives in health; and advises the Secretary and Undersecretary of Health on matters pertaining to international health programs, projects and initiatives, and externally supported national and local health projects.

BIHC Coordinates donor assistance through:

- Health partners meetings to discuss health sector policy issues and development issues including emerging infectious diseases.
- A sector development approach to health ("SDAH")
- A Joint Appraisal Committee to review and approve investment plan for the health sector
- A Joint Assessment and Planning Initiative to organize all the donors and meet twice a year to review the progress of the implementation plan. These include representatives from donors, NGOs, and private business sectors.

NGOs and People's Organizations (POs) have assumed a broad role in health service delivery through program development, management, policy advocacy and local service delivery.

KEY SUPPORTING INSTITUTIONS

- The Bureau of International Health Cooperation (BIHC)
- Bureau of Local Health Development (BLHD)
- Private Sector
- NGOs

NGOs in the country represent a great force and resource in terms of reaching underserved populations and extending coverage in high-risk areas. These groups have the capacity to organize and mobilize communities and therefore can serve as good advocates of health programs and direct providers of services, especially in areas where government personnel and services are inadequate.

PRIVATE SECTOR

The role of the private sector in public health service delivery became more evident with the mainstreaming of TB-DOTS among the private service providers as well as making family planning and maternal and child health services available in strategically located privately-managed clinics. The issuance of Executive Order 187 in 2003 providing for a comprehensive unified policy for DOTS has added value to the national thrust for more active involvement of the private sector. Inter-agency technical expert groups such as the National Immunization Committee and the National Infectious Disease Advisory Committee, which serve as technical advisory groups for the Secretary of Health, also have adequate private sector representation.

SOCIAL DYNAMICS

GOVERNMENT AND POLITICAL SYSTEM

The Philippines is a democratic state with three branches of government (executive, legislative and judicial). The Philippines has a unitary form of government and a multi-party political system. The Constitution guarantees direct election by the people for all elective positions

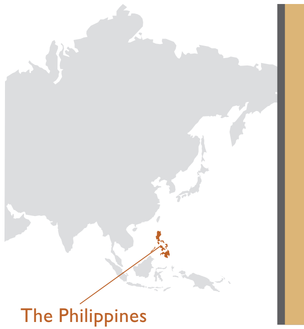
from the president down to the members of the barangay or village councils.

The executive power is vested in the president, who is the head of state and the commander-in-chief of the armed forces. The president appoints the cabinet members who assist the president in executing laws, policies and programs of the government. The lawmaking power is vested in a bicameral Congress, composed of the Senate and the House of Representatives. The Senate has 24 senators directly elected nationwide by the people. The House of Representatives has 250 members elected by congressional districts and by party list system. Judicial power is vested in the Supreme Court and a system of several lower courts. The Supreme Court is composed of the chief justice and 14 associate justices.

The Philippine Legislators' Committee on Population and Development Foundation, Inc. (PLCPD) is an example of the non-profit sector working well with the legislature system. The PLCPD provided education and information to the legislators in order to support and pass the Reproductive Health bill which is currently in Congress. The PLCPD was formally established in December 1989 as a non-profit foundation dedicated to developing policy champions and generating public policies on population and human development. The PLCPD is committed to working with and among legislative bodies at all levels.

The corruption and bureaucracy in the government are widely recognized by the interviewees we spoke to. Although they acknowledged that there is corruption in the government system, they expressed pride in their department's compliance with the Integrity Development Action Plan.

It is not clear whether there are mechanisms in place to protect the "whistleblower." Whistleblowers can sometimes be targeted and go through long court proceedings, which may deter them from coming forward and reporting corruption.



APPENDIX: LIST OF RECOMMENDATIONS

CROSSCUTTING THEMES	
No.	Recommendation
1	Donor Coordination—Undertake a 1-day facilitated donor coordination workshop with breakout groups for 1) Policy and program coordination at the provincial level; 2) Best practices capture; and 3) Coordination strategy discussion.
2	Donor Coordination—Formalize a bi-monthly donor committee meeting for information exchange for implementation best practices at the LGU level.
3	Donor Coordination—Through existing relationships with the DOH and the DOI, establish a committee of health representatives from each of the LGUs to serve as a coordination body for donor assistance at the LGU health policy implementation level. Ensure a proper legal mandate exists for coordination and outreach among donors.
4	Information Assurance—Create a simple training manual explaining proper data collection methodologies within the DOH, and data reporting obligations. Encourage best practices in data gathering through awards and grants programs.
5	Information Assurance—While the DOH has an office tasked with capturing and processing types of data, much of the relevant information related to prevalence, demographics, and budgeting, among other key statistical indicators are spread out across multiple statistical offices housed within several ministries, with little apparent coordination or central capture point. Work with the Bureau of Statistics, or some other relevant entity, to ensure a clear legal mandate and sufficient capacity that permits central capture, processing, and dissemination of all relevant health data.
6	Information Assurance—Conduct an inventory of information systems and tools available at all levels of government.
7	Consumer Advocacy and Behavior—Conduct a customer needs assessment to ascertain what critical consumer advocacy issues are not currently addressed by the existing institutional framework (especially PhilHealth). Ascertain whether PhilHealth is ultimately the proper entity to serve as the focal point for consumer advocacy, or whether a special consumer advocacy civil society organization would be better suited to this function.
8	Consumer Advocacy and Behavior—Provide training in negotiation skills, professionalism, management techniques, and other related skills development and capacity building for consumer advocacy group advocating on behalf of healthcare consumers for 1) drug pricing; 2) facility quality assurance; 3) healthcare finance and insurance coverage; and 4) information gathering and dissemination to address issues of information asymmetry.
9	Consumer Advocacy and Behavior—Provide services to support PhilHealth in business process reengineering to shift its mandate away from reactive inpatient drug expense reimbursement, and more toward dominant consumer advocate in line with traditional medical insurance benefits organization.

CROSSCUTTING THEMES (CONT'D)	
No.	Recommendation
10	Public/Private Participation—The DOH increasingly views the private sector as a potential partner, especially in formulation of laws and policies. By many accounts, the level of public/private interaction in development of the Cheaper Medicines law was the most inclusive process yet for private sector comment. Yet at the municipal and provincial levels, private sector providers are often still seen as competition rather than a potential partner. Using a very short-term, small value investment, (1) capture best practices from the notice and comment procedures for the Cheaper Medicines law and (2) systematize and memorialize the process to replicate for future legal and policy formulation. It is suggested that this recommendation be undertaken in a very short timeframe, as the positive experience of the DOH and the notice and comment style public hearings are still held in high regard at the DOH.

DELIVERING GOODS	
No.	Recommendation
1	Work with the DOH and provincial governments in integrating and improving procurement (for example, with a single procurement clearance system for drug distributors and importers). Assist the DOH in reviewing the success and impact of current procurement policies, especially at public hospitals, and then in developing and implementing new policies for better outcomes.
2	Consider working with the DOH and federal investigators to improve procurement-related anti-corruption efforts in areas such as bid collusion and kickbacks to Health officials. Additionally, work with investigatory unit regarding anti-corruption efforts such as bid collusion and anti-kickbacks to local officials as well.
3	Improve competition among generic drugs and branded pharmaceutical manufacturers by providing accurate information on bioequivalence of generics through public education and outreach to physicians. The public tends to perceive that generic drugs are not as high of a quality as branded equivalent drugs. GTZ and KFW have a program to support generics, but it is small, limited in scope, and will end in late 2009. No other donor is currently engaged with this, so there is a window of opportunity to build on KFW's work. Further, the high cost of bioequivalence testing Look into designing a funding mechanism to support bioequivalence testing for generic drugs. Without support for new alternate generics providers, the perceived high costs associated with market entry, such as the bioequivalence test, will likely keep competition among local generics manufacturers low. Finally, provide publicly recognizable quality seals of approval for generic drug producers implementing best manufacturing practices. Conduct a public education campaign to establish the value of a seal of quality for generic drugs produced using proven methods.
4	Work with the DOH, physicians and pharmacists to improve consumer access to information about drugs. Locate and encourage local NGOs with capacity to develop medical consumer advocacy.
5	Help PhilHealth improve IT, information retrieval systems, data management, and staff training. (The Cheaper Medicines Law gives PhilHealth a range of new powers to control costs, but PhilHealth currently lacks the capacity to take advantage of these.) If there is interest and political will, support a review of current policy with an eye towards expansion of coverage.
6	Help PhilHealth institute cost control measures on drug purchases. Currently, there is no cost control at all except for a general directive to purchase generics when possible. Much more advanced techniques exist and are available, and could lead to significant cost savings, but they will require training and technical assistance for startup.

DELIVERING GOODS (CONT'D)	
No.	Recommendation
7	Consider assistance to the DOH for actions against entities in restraint of trade. The Philippines lacks a competition policy enforcement agency, but the Cheaper Medicines Law gives the DOH vague but broad powers to take necessary actions to ensure access to drugs and medical care.
8	Consider assistance to the DOH on developing pricing analysis and policy. The Cheaper Medicines Law gives DOH the power to analyze drug prices and, if necessary, impose maximum retail prices; however, at this time there is no methodology beyond comparing prices across other national markets in the region.
9	Build technical capacity at BFAD for faster and more effective drug review and pharmacovigilance. BFAD is already receiving assistance from two different donors, but much work remains. The continued rapid growth of the pharmaceutical market, along with new developments such as parallel imports, will place increasing pressure on BFAD's limited resources, so there is an urgent need for capacity building right away.
10	Help BFAD open its long-delayed satellite office in Cebu.
11	Provide technical assistance to BFAD and the DOH in the process of regulatory harmonization with ASEAN. (This process was supposed to be complete for the pharmaceutical market by the end of 2009, but is well behind schedule and is almost certain to continue into 2010 or later.) Provide assistance to small and medium sized pharmaceutical manufacturers in understanding changes to accreditation processes necessitated by ASEAN regulatory harmonization.
12	Provide technical support to improve existing systems and staff to boost efficiency in PITC Pharma, especially with IT, inventory management, pricing policies, and management of parallel imports. PITC Pharma is currently receiving technical assistance from the EU, but this consists of a single embedded technical expert who will leave before the end of 2009. There is a need for much more assistance, especially if PITC Pharma is to fill the gap in the event of multinationals withdrawing from the market. There is also a dire need for upgraded computers, management information systems, and training of PITC staff.
13	Give administrative support to the Botika ng Bayan and Botika ng Barangay systems. This system provides a low-cost, sustainable distribution model for drugs. Consider assistance, as needed, to "train the trainer" programs for clerks and managers, especially in sales and inventory management.
14	Provide supply chain technical assistance at all levels to include forecasting, warehousing, inventory management, and freight movement. This may include outreach to private importers, distributors, wholesalers and retail drugstores, especially smaller and local entities with limited technical capacity. (Note that some of these are represented in business organizations that could serve to channel assistance.)
15	Consider assistance to manufacturers and formulators in improving access to raw materials, and to smaller actors at all levels—especially importers, distributors and retailers—in improving access to credit. Provide advocacy training to local pharmaceutical manufacturers, perhaps organized through the Philippine Chamber of the Pharmaceutical Industry to promote a reduction in tariffs on raw materials to encourage domestic competition in pharmaceutical production.
16	Offer training to pharmacists in modern best practices, not only in technical aspects but in pharmacy management as well. Increase accessibility of business management training to pharmacists and doctors, modeled on similar trainings provided to midwives. Further, look into expanding coursework to include an introduction to business management training as an elective to core curriculum for doctors, nurses, and pharmacists.

DEVELOPING HUMAN CAPACITY	
No.	Recommendation
1	Monitor existing donor programs currently working to integrate the multiple databases impacting health human resources planning. Include the multiple stakeholders (PRC, CHED, Immigration, DOH, LGUs, CHDs) who separately hold data regarding health human resources. Develop a process and system for collecting and using data to inform health human resources planning; include data from the private sector. Use the integrated database to reinforce inter-agency communication.
2	Using the data captured in the integrated database, support human capital planning for health professionals. Develop a forecasting method to predict the supply and demand of practitioners over time based on data which include demographics, migration and attrition patterns, training and education, etc. Assist the LGUs in making regional projections in order to help inform the human resource requirements that should be included in the LGUs' Province-wide Investment Plan for Health (PIPH).
3	Partner with universities to establish and sustain return service agreements (RSAs) with students studying medical sciences. Support the new program of the UP Medical School to establish return service agreements with incoming students. Assist the UP Medical School (Dean's office) in defining the details of the program and establishing the tracking mechanisms to ensure that graduated students remain compliant.
4	Set up support structures to enable the Medical School to manage and track the students by 2014, when the first class will graduate and begin looking for medical positions within the country. Support other UP medical science programs, including the School of Nursing which has expressed interest in establishing a similar program. Support the University of Santo Tomas, a private academic facility, which has also instituted a similar program for those students on financial scholarship.
5	Attempt to replicate the RSA model at other schools focusing on medical sciences.
6	In an effort to encourage more doctors to practice in rural areas, explore the possibility of supporting loan programs which enable doctors to set up their own private practice in rural areas. Consider negotiating favorable loan terms with private banks on their behalf. Identify potential risk avoidance issues, such as establishing a healthcare pooled guaranty fund. Explore partnerships with micro-finance organizations to facilitate loans for doctors who wish to open private practice in under-served areas.
7	Support LGUs in finding ways to provide incentives to doctors to improve retention. Also, identify key constraints to flexibility of employment relationships, especially municipal and national workers. Compile best practices to share with LGUs to encourage the strategic management of health care providers. Communicate successful incentive programs for doctors, including subsidized compensation schemes, flexible work schedules, part time positions, health work place programs, etc.
8	Consider supporting sustainable efforts such as a "Nurses to the Barrios" program which could provide nurses with additional salary and benefits in an effort to ensure medical coverage in rural areas. Partner with the DOH which has instituted the Doctors to the Barrios Program with success. Consider partnerships with universities, particularly UP Manila, to encourage public service schemes for nursing graduates.
9	Explore the possibility of supporting entrepreneurial "advanced practice" nurses who wish to open their own private clinics. Consider the added value of nurses who are able to provide general medical services which could complement those services provided by midwives. Consider the positive impact on the nursing career ladder and on the large (and growing) pool of unemployed nurses. Incorporate best practices from the PRISM program's approach with midwives including a strong partnership with the industry association, partnership with the LGUs, and an emphasis on achieving PhilHealth accreditation as a means to ensure financially viable businesses.

DEVELOPING HUMAN (CONT'D)	
No.	Recommendation
10	Consider partnering with the UP Nursing School which already offers a Masters Program that is designed to develop entrepreneurial nurses. Consider partnering with the Philippine Nurses Association (PNA), the PRC-recognized association for the nursing industry, which has been promoting the concept of entrepreneurial nurses and has been attempting to shift the societal perception of nurses solely as wage earners. Explore loan program options to support financing.
11	Consider expanding the support delivered through the PRISM program to focus on midwives in indigent communities. Conduct a municipal needs assessment to identify those communities most in need of midwives. Employ the lessons learned from the PRISM project; rely on previous participants in the program to build the capacity of existing midwives and develop additional midwives. Explore partnerships with the LGU whereby midwives are able to practice in public facilities or are partially supported through investment funds identified in the PIPH. Explore additional loan schemes including micro-credit and aggregated loans where USAID and/or the three midwifery associations guarantee loans on behalf of multiple midwives.
12	Build the capacity of the CHDs in the area of human resources management, in such areas as planning and managing the workforce, recruiting, developing training plans, and employing proficiency assessment tools. Establish a "train the trainer" system whereby CHDs pass along human resource management training to LGUs; ensure that training sessions focus on managerial training, (in addition to most of the current training which is generally clinical in nature). Support the CHDs in organizing local trainings across their regions in the Barangays. Leverage the public health professionals that have been deployed with the doctors in the Doctors to the Barrios program; target these individuals for training and local capacity building.
13	Increase the capacity and enforcement power of the Commission on Higher Education (CHED) to monitor and, if necessary, shut down poor-performing schools to ensure quality control across medical institutions. Support the development of performance requirements for medical institutions; enhance standards and ensure strong rationale for opening new schools. Review and amend the legal framework to ensure that the CHED has the legal capacity to monitor and close non-performing schools. Consider enforcement models including the establishment of a temporary Congressional Commission.
14	Reinforce public health education campaigns focusing on preventative health care. Partner with the DOH's National Center for Health Promotion to conduct a wide-reaching public education campaign about preventative health care and the importance of accessing general health care professionals. Emphasize health services at the primary and secondary level (disease prevention, health promotion, primary curative care.) Organize training for LGUs on preventative health benefits; ensure that they disseminate preventative health messages.
15	Partner with the Department of Education (DepEd) to ensure that critical health messages reach young students. Formalize working agreements between DepEd and DOH to support education and wellness programs leveraging the position, influence, and alignment of the DepEd networks at the local level. Expand ongoing efforts between DepEd and DOH to enhance age-appropriate health curricula in primary and secondary schools; leverage international standards and best practices. Develop materials for use in schools including written materials, videos, games, teaching guides, etc. Develop a system by which urgent health messages are delivered in schools on an ad hoc basis. Consider a pilot program in school districts with the most dire health statistics; implement national roll-out based on the pilot.
16	Develop and disseminate an HIV/AIDS public education campaign which targets call centers. Identify the ten largest call centers in the Philippines; approach them with statistics which have been collected by DOH and DOLE regarding sexual behaviors and resulting health outcomes as well as the economic burden of HIV/AIDS. Present models for public private partnerships where the calling centers invest in the health of their employees by providing health education, health services, etc. Work with the DOH's Center for Health Promotion to develop an HIV/AIDS awareness campaign, including social marketing materials, which can be rolled out to the largest call centers and eventually nation-wide.

DEVELOPING HUMAN (CONT'D)	
No.	Recommendation
17	Work with Chambers of Commerce to identify companies interested in engaging in partnerships to support positive health outcomes in their communities. Leverage lessons learned from the PRISM project regarding family health in the workplace programs. Prepare materials for companies including background information on the rationale and return on investment for such programs as family planning. Develop a toolkit of programmatic options and instruments for companies to engage with the health sector. Through partnership with CHDs/LGUs in the Province-wide Investment Plans (PIPHs), encourage private sector involvement.

PROVIDING AND MAINTAINING FACILITIES	
No.	Recommendation
1	DOH accreditation and certification standards are generally well-drafted, but implementation can be varied, depending upon size of organization and urban vs. rural location. Provide comprehensive training in quality assurance standards for DOH facilities inspectors. Provide training to inspectors in professionalism, standards enforcement, and legal obligations.
2	Redesign a midwife access to credit program targeting regions that are underserved by existing healthcare organizations. Through a pilot program, look into alternative forms of collateral, such as PhilHealth vouchers, or collateralization of medical equipment and devices, to help spur lending for medical facility startup and improvements.
3	Create a medical equipment registry for banks and other financial institutions willing to offer loans to healthcare organizations. Train financial institutions and banks on valuation techniques for medical equipment. Finally, monitor Philippine Development Bank's pilot credit facility program funding public-private partnership healthcare organization ventures to ascertain whether lenders could secure low-cost loans through LGU guaranty backed by IRA payouts.
4	Encourage trained healthcare professionals to establish healthcare facilities in rural and underserved areas by initiating and/or maintaining and expanding programs to "write off" or "forgive" student loans in exchange for the professional spending a minimum number of years in the rural and underserved areas.
5	Consider promoting tax incentives or "write-offs" to aid in establishing and equipping facilities and equipment.
6	Review the regional and municipal tax structure to identify appropriate tax incentives for heath care professionals to work in underserved areas.
7	Hospitals take promissory notes from clinical patients, but low repayment rates can drive up the costs of care. Without a time-effective and cost-effective contract enforcement mechanism, such as a small claims court, healthcare facilities are often forced to keep such notes on their books for a long time, if they are ever cleared, even if patients are able to pay for services under an installment plan. Support efforts of donors in creation of a small claims court to bolster contracts enforcement, and ultimately improve repayment rates. Additionally, for judgment-proof indigent patients, support funds against which healthcare organizations can submit claims for reimbursement (i.e., perhaps funded by PhilHealth capitation fees).
8	While no separate medical malpractice cause of action exists within the Philippines, patients can still sue doctors and medical facilities under a general negligence cause of action. Furthermore, individuals were often uncertain how the law treats public facilities, and doctors who work at public facilities under such claims, since the claims are typically brought against the person rather than the government. While negligence suits for medical practice are low at this point, it is advised that insurance providers be trained in medical malpractice risks, and begin developing standard, cost-effective products if such negligence claim rates begin to trend higher.

PROVIDING AND MAINTAINING FACILITIES (CONT'D)	
No.	Recommendation
9	The administrative rules that govern licensing, registration and operation of healthcare facilities are generally well-regarded, though perceptions exist that strict observance of regulations varies based upon 1) the size of the facility; 2) whether the facility is publicly or privately owned; and 3) whether the facility is located in an urban or rural area (i.e., favoring small public facilities serving under-served regions). Quality assurance capacity development is critical within the DOH Bureau of Health Facilities and Services inspectors. Training in standards enforcement and capacity is recommended.
10	The requirement to secure a Certificate of Need as part of the registration process for new healthcare facility permitting is a patent limitation on competition and market entry. A review of the Certificate of Need rules is advised to create a rebuttable presumption of need for the healthcare facility unless objective data supports a finding of no need to encourage market entry absent empirical data evidencing market saturation.

GOVERNING THE SYSTEM	
No.	Recommendation
1	The current health system is fragmented following devolution of authority to the LGUs; one example cited is that hospitals are under the jurisdiction of the governor while primary health care (PHC) systems are under the Mayor, creating issues of coordination among these types of healthcare providers. Coordinate with the DOH and donor community to undertake an extensive, system-wide analysis of the health system, at all levels, to ascertain fundamental weaknesses inherent in a fragmented system.
2	All current DOH strategic planning documents have an established end date in 2010. Certain policy planners in the DOH referenced a "Bridge Plan 2015" medium term strategy document, but others within the DOH, donor community, and local civil society had not heard of any mid-term strategy plan, and had not participated in any formative discussions. Support should be offered to the DOH both in preparation of a mid-term health system strategy document, if indeed mid-term strategy planning is ongoing, as well as in a long-term 10-year strategic framework. Also, the DOH should be encouraged to disseminate the plans for its next phase in the National Health Objectives.
3	Communication between the DOH and LGUs exists, but little communication and coordination exists among LGUs regarding best practice sharing, batch drug procurements, and health initiative implementation. While some LGUs have begun to engage with one another through Inter-Local Health Zones, much greater coordination can and should be taken to emphasize policy harmonization across LGUs.
4	The Management Information System (MIS) at the DOH does not capture all the necessary data to oversee the health programs. Upgrade current MIS to include data obtained by the Field Health Service Information System from the NEC. Create an access plan to ensure that all relevant stakeholders have access to the data.
5	The DOH does not have a consistent policy regarding partnerships with the private sector; there seem to be no systems in place to monitor private sector entities and there is little coordination or promotion for public private partnerships outside of specific programs. Work with local partners to prepare a Health Policy and Strategy paper on Public Private Partnerships.

GOVERNING THE SYSTEM (CONT'D)	
No.	Recommendation
6	The private sector has few, if any, compulsory data reporting obligations to DOH that are enforced. This is a crucial breakdown in public private partnership within the health system, and represents an important area for improvement of information-based policymaking and rulemaking. Engage a working group comprised of local civil society organizations, DOH representatives, and representatives of private sector health service providers, with participants from both small and large private sector companies, to look into proper data analysis and capture issues, reporting obligations, and suggest appropriate mechanisms for improved reporting systems. Further, FHSIS does not even have a section for data obtained from private sector sources. Look into a policy requiring LGUs to capture private sector services within their reporting requirements.
7	The DOH does not regularly engage in public education and stakeholder outreach advertising success stories of DOH initiatives. While a careful balance of self promotion is important, a small level of public education is necessary to build public support for successful initiatives. Look into options for strategic communications programs to enhance public support for DOH programs.

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