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# Evaluation of the Medicines Transparency Alliance Phase 1 2009-2010

## Philippines Country Report

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## Ph - Executive summary

MeTA's Philippines group (M-Ph) has made great progress towards its objectives. A National Council was established at the end of 2007. Since then it has continued to expand, with good representation of all three sectors, and has helped launch a thriving CSO coalition. M-Ph has also shown itself capable of producing good quality studies, maintaining a useful website and running three Forums that are sources of substantial debate on transparency issues.

M-Ph benefits from the supportive participation of three multilateral entities – the WHO, the World Bank and the EU. But its core consists of dedicated figures with current or past public sector experience, who have been joined successively by private sector and now CSO representatives exhibiting equal levels of commitment. The organisation is moving forward in its extensive work plan, even though at the time of this study, many policymakers were distracted by a forthcoming national election. Despite the campaigning, medicines issues retain a prominent place on the national political agenda, with widespread recognition of problems of access in particular, and price- and quality-related legislation having been passed in 2009.

M-Ph's Executive Committee (EC) has been in place since the start, though it is now due for replacement according to its own internal rules. There are 25 members of the full Council, in which the EC is fully integrated. The Council has met monthly since establishment, almost always quorate. The most recent development has been the entry of three CSO representatives.

The Secretariat is well resourced (five fulltime staff), and is about to move to new premises provided by WHO. In particular, the Secretariat Technical Consultant worked previously in the pharmaceutical industry and has capacity to contribute to studies, while there is also someone dedicated to the website and IT issues.

The CSOs formed their own coalition, CHAT, in early 2009. CHAT has held its own Forums, had its work plan accepted by MeTA-International (MIS) and is in receipt of its own separate funds (£30k in 2009).

M-Ph's own activities already include several completed projects, notably the Pharmaceutical Benchbook (which sets quality standards for medicines distribution and retail), the Data Disclosure document and a WHO-sponsored annual award for Good Governance in Medicines (GGM). A number of other projects are underway or almost completed: household and facility surveys as part of the benchmarking exercise, two studies on procurement, the Pharmaceutical Sector Scan and a study on medicines promotion and advertising. A study on the financing of medicines for the poor also began in January 2010.

But a combination of rapid disbursement of funds from MIS, a slow initial start in M-Ph's workplan, generous funding from partners and careful operational cost control has meant that funds are still largely underspent (less than 50% in January 2010). Expenditure should rise relatively quickly given the number of activities now in train. WHO has served as a competent fund-holder. Financial reporting takes place quarterly as per the MoU, and in the first quarter of 2010 M-Ph made these reports more

comprehensive, introducing an expense breakdown per work plan activity and projected expenditure through until September.

The quality of the activities carried out to date has been generally high. This includes the Data Disclosure document (largely compiled by the M-Ph Secretariat), the Benchbook and the Sector Scan (by contractors). A useful capacity to learn from initial mistakes was demonstrated (e.g. verification of the Scan was more thorough than that of the Data Disclosure document). The national and CSO forums have also been successful, with the most recent attracting over 200 and 50 attendees respectively. Debate (observed by a consultant team member) was lively and well-informed at both, with the main forum achieving coverage in the national media.

The private and public sectors both cooperated and disclosed data to these studies to a reasonable (if not perfect) degree. Some activities are planned to specific target audiences (e.g. the benchbook, the fora), others less so. M-Ph has shown some skill (and useful contacts) in achieving publicity and its website records increasing usage. But undoubtedly there is more to be done to boost communication across the country, especially poorer regions.

It is difficult to ascertain to what extent M-Ph has influenced policy so far. Certainly at least somewhat, as several important policymakers are either involved in the Council or (like the health minister) attended the forum. But the debate leading to the medicine price limit law of 2009 also showed that the disparate interests of M-Ph could not be welded into a single lobbying force. So there was no substantial effect that MeTA had on this important medicines policy debate. If M-Ph enacts an effective policy of analysis and dissemination of the projects they now have underway, then there will be a good chance of influencing future policy and business practice.

M-Ph has been fortunate in the positive attitude of the local offices of the WHO and World Bank (and the EC, a major health sector development partner in the Philippines). All have contributed material and human resources to the MeTA project. The WHO commendably viewed its GGM as complementary, rather than an alternative to MeTA. But there is scope to extend cooperation to other donors, such as USAID, who are active on the same issues but with whom no link has yet been forged.

M-Ph does face uncertainties: the effect of May's national election, the need to renew its Executive Committee and finding the best way to make use of the current broad crop of studies. But the strengths, human resources and confidence it has already developed augur well for the future.

## Summary of Recommendations and Conclusions

- **Expand Council membership to include local government representatives, reflecting the decentralised nature of the Philippines health sector. Potential organisations that might be approached include the Association of Provincial Health Officers; Association of Municipal Health Officers; League of Mayors; League of Governors – though conveniently all have a joint umbrella group, ULAP. A balance would need to be struck between technical/academic representation and that of geo-political interest groups.**
  - **Another part of the private sector for M-Ph to consider reaching out to would be the IT industry, which would have useful expertises and a practical role in increasing transparency.**
- **All Council members should appoint alternates in case they are unable to attend a meeting or change jobs. This would act to ensure more institutional continuity. A similar system works well in Peru. A position of (rotating?) sector leader might also create a figure who would act as champion to the sector and encourage attendance.**
- **Revise the current internal rules, as well as hold the required elections for Council Executive Committee. Examine the possibility of some form of ‘general membership’, which does not confer a Council seat but allows institutions and individuals to feel included in MeTA; the media might be good candidates for this. Establish some criteria on which to base further invitations to join the Council. Consider establishment of legal personality (incorporation) for M-Ph, which would also make fundholding more straightforward.**
- **Try to ensure a balance of technical/policy content with the necessary administrative discussions in Council meetings. This should help check the decline in attendance that occurred over 2009.**
- **Plan to expand MeTA’s field of interest to include OTC/‘food supplement’ products, which are marketed with apparent medical claims and account for substantial expenditure in the Philippines. [may form part of MeTA II, but is a policy priority for the country].**
- **Consider at least technical engagement with other donors active in the fields of medicines and governance in the Philippines (e.g. USAID, GF, Ausaid/UN agencies), and perhaps also request funding.**
- **Clarify with the WHO what MeTA’s GGM obligation will be. The need for visits to assess candidates across the country is very human resource-intensive. Also, there is a possible conflict of interest given that DoH is involved in assessing its own institutions. More thought is needed on determining the objective of GGM, and the most cost-effective way of**

- achieving this. If the awards are continued with, one possibility is contracting evaluation to a more specialist organisation, such as the Galing Pook foundation, which promotes good local governance but is led by an ex-hospital director (<http://www.galingpook.org/main/>)
- Consider seeking financial support from DoH and relevant Congressional committees, both of which have funds and need of information, as well as additional international institutions.
  - M-Ph could select a specific community (municipality/ies or perhaps province) and get involved in assisting on medicines transparency issues in practical ways. This would serve as a good balance to theoretical and national analyses, and seems appropriate in so decentralised a health system. It would show what can be done, and the exemplary effect could be very powerful. M-Ph would itself undoubtedly learn a lot too.
  - Do more to propagate best practices. Some could be via the website (e.g. using the planned pharmacy 'benchbook', or putting up the evidence tables drawn up by UP for the FDA). M-Ph's good academic contacts could also be used to get MeTA on professional and academic syllabuses. All of this would help increase website access.
  - Seek to ensure Council attendance and engagement remains attractive to government entities. This may involve seemingly minor measures such as ensuring that invitations to meet are sufficiently formal (rather than just by email). Planned situation within the WHO compound in DoH may help with this. Also ensure they are not always 'pilloried'.
  - Seek to ensure Council attendance and engagement remains attractive to academia. A shift in Council discussion from administrative to technical/policy issues may help with this. There may also be already extant academic resources which could usefully add to MeTA's offering, e.g. University of Philippines Medical College's community drug quality studies and national evidence tables (used for justification of the national formulary) on the MeTA website.

#### **'Climate change', or shifting perceptions between stakeholders**

The Philippines experience seems to support the idea that partnerships can be forged through dialogue. Representatives from all three sectors reported changes in their perceptions of other stakeholders through experience with MeTA.

Dr Romualdez, ex-Secretary of Health and now M-Ph Chair, says "*Previously there was an adversarial relationship, especially between those wanting to reform the sector and the multinational companies. Now the climate has changed.*" Certainly relations had been strained in the past. Industry association PHAP has sued the DoH and the PITC alleging illegal parallel importation, while Pfizer and the FDA have faced each other in court over patent infringement.

But while there will always be differences of opinion; many M-Ph Council members say they value the chance to hear these views. Dr Robert So, who leads medicines policy formulation at the DoH describes MeTA as “*our conscience*”, recognising the usefulness of independent view and data disclosure. FDA head Nancy Tacandong describes MeTA as “*a mirror*”.

Some of the feedback Dr So and Nancy Tacandong receive is from CHAT, a consortium of 24 civil society organisations with interests in medicines. Most of the groups in CHAT didn't know of each other. Cecilia Sison, of Health Watch, believes since entering MeTA they are more tolerant of differing opinions and can see policy options from a more objective viewpoint.

Dialogue can lead to unlikely couplings. Dr Reiner Gloor, PHAP's representative says “*Before MeTA there were only minimal discussions with CSOs or NGOs. But we've found areas of common ground, especially health financing. Price cuts don't help if there are not even the funds to buy reduced price medicines!*” PHAP and alternative industry association PCPI are both now meeting separately with CHAT regarding advocacy for universal health care.

Beyond the monthly MeTA meeting, there is also discovery of different situations at the annual Forum. Many who had previously seen public sector as a single coordinated actor were shocked to hear of judges pressurising the FDA to stop its bioequivalence testing.

M-Ph Secretary Dr Kenneth Hartigan-Go sums up: “*There was never any venue for the different interests to come together. Now there is.*”

## **Ph1 MeTA in country**

### **Ph1.1 Commitment to the META pilot**

Many elements of the government show commitment to MeTA. A large number of public sector bodies are represented directly in the National Council: the two key DoH units – NCPAM and FDA; Phil health; the Department of Budget and Management; the Commission on Audit; and also several parliamentarians (Rep. Rey Pinggoy, Rep. Risa Hontiveros-Baraquel and Sen. Mar Roxas – currently a candidate for the national vice presidency). However, it should be noted that attendance has waned recently from some of these (more below).

There are also a number of prominent Council members with government experience and good contacts, making government linkage greater than is apparent via current positions alone. The Chair is an ex-Secretary of Health, for example, and the Vice-Chair an ex-provincial Governor. The current Secretary of Health showed her good will towards MeTA by addressing the Forum in January 2010.

There is also generally a commitment to disclose data, for example on the part of FDA and (with somewhat more reticence) manufacturers for the Data Disclosure document. Future studies, such as that on advertising and promotion, will test this commitment further.

### **Ph1.2 Establishment of the MeTA Council**

MeTA-Philippines (M-Ph) was established in November 2007, making it the first country pilot and pre-dating MeTA International Secretariat (MIS). Prior to this Loraine Hawkins and Guiitelle Baghdadi Sabetti had carried out a scoping report (April 2007) and the WHO had launched their Good Governance in Medicine project (2004).

Establishment was led, soon after DFID's initial approach, by WHO, World Bank and EU staff together with senior public sector contacts. Industry and CSOs followed later (during 2008-9). Among industry, the local association PCPI joined first (probably because they had better relationships with the public sector). The relatively swift launch is testament to the fact that there were not any particular obstacles to this initial phase.

### **Ph1.3 Governance arrangements**

M-Ph is governed by two documents. The first is the MoU with the MeTA International Secretariat (MIS) (signed December 2008 and amended May 2009). This states the basic MeTA objectives and strategy, as well as detailing how quarterly financial reports should be made. The second is the Internal Rules set at M-Ph's establishment. In some respects these are obsolete – for example, they confer all decision-making power on M-Ph's Secretariat, rather than the Council. M-Ph does not have legal personality, though this possibility is being considered. Organisational structure and rules are to be reviewed by a working group of the Council.

Some institutions enjoy automatic membership - DoH; FDA; Phil Health; WHO; World Bank; and EU. The Rules also mandate invitation to membership to several other bodies – Departments of Budget & Management, Trade & Industry; Foreign Affairs; and the Commission on Audit – and to representatives from NGOs/foundations; academe; the Philippine Medical Association; the Philippine Pharmaceutical Association; and LGU Leagues. It should be noted that not all of these invitees sit on the Council yet.

The Rules also mandate re-election of officers (Chairman, Vice-Chairman and Secretary) every two years. This is overdue, but discussion is underway regarding new elections – though it may be sensible to delay these until after the May 2010 national elections. Working groups are appointed on an ad hoc basis as needs arise.

Four disbursements were received from the MIS in 2009, totalling £130k, whereas £48k was spent. CHAT funds are disbursed from the M-Ph account, under the same signatories, and £30k of the funds in 2009 were for CHAT. Following a 2009 amendment to its MoU with DFID, M-Ph’s total budget up until September 2010 is £200k. Non-DFID partner organisation financial contributions to this are significant and currently total over US\$220k. Resources disbursed by the WB and WHO largely or completely are funded from DFID’s grants to these organisations. This generous funding from partners has contributed to the difficulty in quickly spending MIS provided funds.

**Table 1: Partner financial contributions**

Partner	Contribution (US\$)	Purpose
WHO	90,000	Facility and household surveys, Benchbook, GGM awards, office space
World Bank	67,000	Procurement assessment, e-procurement design
DoH	15,000	EDPMS
FDA	5,000	‘Labs in a suitcase’, FDA website
Unidentified/other	45,000	LGU courses, Roundtable discussions, CSO support, travel, Forum
<b>Total</b>	<b>222,000</b>	

Note: as of 5 March, 2010 Source: MeTA-Philippines (see Appendices)

Funds are held in a WHO bank account to which the Chairman and WHO Country Rep are signatories. This arrangement has been fine so far, but may need to be revised if funding increases. Essentially it operates like a personal joint bank account. Change would be tied to the question of creating a legal personality for M-Ph.

M-Ph’s Secretariat reports monthly to the Council on financial activity in advance of the submission of quarterly reports to MeTA-International (MIS). In the first quarter of 2010, reporting was enhanced, giving expenditure by work plan item and projections through to September 2010.

All Council members stated that they consulted on MeTA activities with the organisation that they represent. CHAT representatives consulted with and were accountable to all of the CSOs within CHAT, as is mandated by the CHAT constitution. The representatives

of the two industry associations acted similarly. However, it is evident that interest in MeTA varies within the bodies represented on the Council.

## **Ph1.4 Operation of the Council**

M-Ph is a functional coalition of many (if not all) elements of government, civil society, the private sector, academia, professional associations and donors. Monthly meetings have been held since December 2007, which are usually if not always quorate (e.g. not in June 2009). Proceedings are well minuted and actions appear to be generally followed up.

Operation seems to take place in the spirit of M-Ph's Internal Rules. Where there are contraventions (see above), these do not seem unreasonable, are acknowledged and discussion is underway of revision of the Rules to bring them into line with sensible practice.

All three main sectors are reasonably well represented on the Council. The pharmaceutical industry has two seats, while CSOs have three. There is more extensive representation of the public sector and donors. Review of minutes and observation of January 2010's meeting also indicated that representatives from all three sectors contributed constructively to discussions. Academia and professional associations also have seats.

There is potential for improvement in the representativeness of the Council membership. In particular, LGUs are absent yet an important player in pharmaceutical procurement and usage. This is something that needs to be remedied. From the private sector, there is little involvement from distributors or the less reform-minded of local manufacturers (even though both are to an extent represented within PHAP and PCPI, who sit on the Council). Yet, the two existing representatives seem committed to MeTA principles (and to wider health sector reform) and may have the skills to widen the effective private sector involvement. Already, they have helped engineer discussions between some of the industry and CSOs outside of MeTA to explore how they can lobby together in favour of universal coverage - a positive development, (and one that raises the question of MeTA's involvement in health sector reform more widely). It should also be noted that though manufacturers dominate PHAP numerically, PHAP's Executive Director, who sits on the Council, previously worked for a distributor (Zuellig).

The CSOs and their representatives are numerous, impressive and eager to play an increasing role (e.g. more Council seats). Several expressed recognition of their current limited technical knowledge, but also that they wish to remedy this. EU consultant Klara Tisocki is helping here, and HAI is apparently preparing a course for this purpose.

A query could still be raised as to how representative CHAT is of 'grass roots' CSOs, even if the trend is positive. Health Watch plays the lead role, but according to some is staffed mainly by ex-employees of PITC (and hence might have its credibility questioned if analysing PITC). In many ways, Health Watch is effective and committed, however. Another influential CSO is dedicated to minimising the role of government in Philippine society. Procurement Watch gained a Council seat but only attended once in 2009.

Government is clearly engaged, in terms of institutions represented (see above). But there has been a problem of declining attendance by Council members over the course of 2009, and the public sector is the worst of the three main sectors in this respect (parliamentarians, Commission on Audit, Department of Budget and Management), followed by academia, professional organisations.

## **Ph1.5 Achievements of the Council**

The successes of M-Ph's Council are important and undeniable. It represents the multi-stakeholder process in action. Senior representatives of all three sectors have met every month for more than two years. These meetings appear to enjoy a constructive atmosphere (even if one public sector representative complained they are too often '*picked upon*'). M-Ph's Chair is experienced and appears reasonably even-handed between the sectors. The membership profile is also still evolving, greater CSO and private sector representation added in 2009 and an openness to further expansion.

The Council has also overseen a successful strengthening of the Secretariat, which has itself delivered an excellent website, several good study documents and three lively Forums (more below). Moreover, the M-Ph Council seems a good member of the 'MeTA family', contributing to the IAG, offering case studies to other pilot countries as well as hosting their representatives.

## **Ph1.6 Barriers and issues faced by the Council**

The Council still does not fully reflect the stakeholders active in medicines transparency issues in the Philippines. In particular, LGU representation is missing, though more could also be done to engage private sector distributors, 'non-reform minded' manufacturers and truly grass roots CSOs. However, to an extent (especially regarding LGUs) this issue is recognised. And the trend is in the right direction, with the entry of PHAP followed by PCPI and the advent and growth of CHAT all demonstrating a determination to widen the Council's franchise.

Funds have been chronically underspent, with around £50k still untouched. However, there are here legitimate reasons for this. It took time to organise the Secretariat after personnel changes (see below), and careful consideration was devoted to finding the right human resources to undertake workplan activities (also below). Also, a cautious approach was taken to accommodation costs. The Forums have certainly been adequately funded, with good results. And again, the trend is in the right direction, with a range of workplan activities now underway or soon to start, which will absorb much of the underspend.

As with any organisation, there have also been personnel issues. The departure of Dr Socorro Escalante (WHO and Filipina national) in early 2009, who had done a great deal to establish both the Secretariat and the Council, left a capacity gap which it took time to address. There were also poor relations between the previous Programme Coordinator[?] Dennis Quiambao and the international consultant— now better with the revised Secretariat.

Declining Council attendance is a worrying symptom, though it is recognised as a problem and at least being monitored. It may be due in part to a tendency of Council meetings to focus on administrative, rather than technical/policy issues. The admirable breadth of public sector representation may also have led some such representatives to feel superfluous. A linked concern is that MeTA membership is still seen too much as an individual, rather than institutional, characteristic. So if a committed representative cannot make it or changes job, no substitute steps in. This raises doubts regarding sustainability.

As stated above, M-Ph's Internal Rules need revision, and elections are technically overdue – though delaying until after the May national elections could make political sense, given the political links of some potential candidates for M-Ph office.

The Council also recognises that better use could be made of the media usage. Nevertheless, it should be stated that the Chairman Dr Romualdez shows skills in relations with the national press, writing columns himself and managing the Forum press conference with skill.

## **Ph1.7 Relationship with IAG**

Links between the IAG and M-Ph have worked primarily through M-Ph Secretary Kenneth Hartigan-Go and PHAP representative Reiner Gloor. The former is an exceptionally committed Council member and the latter both committed and a useful link with pharmaceutical manufacturers internationally as well as in the Philippines. However, few others involved with M-Ph seemed aware of any specific benefits flowing from the connection with the IAG. Any visits from IAG or MIS members with technical expertise or senior positions are likely to be very welcome and well utilised.

## **Ph3 Secretariat**

### **Ph3.1 Structure and capacity**

The Secretariat was the only one established before the global pilot phase began in December 2007, and has been functioning ever since. It has undergone a complete change in personnel, however, with Dr Suzette Lazo joining as Secretariat Technical Consultant in May 2009, and Dr Erwin Abueya as Programme Coordinator. Initially the WHO had provided Secretariat capacity.

There are an additional two research assistants and one person in charge of the website – all are full time. Despite initially struggling, Dr Abueya now seems capable of producing good financial reports, in addition to his other duties. Council members, especially the WHO and EU, also provide technical support when needed.

Given Dr Lazo's expertise (she previously worked at a local pharmaceutical manufacturer), the Secretariat has greater technical capacity and was largely responsible for the Data Disclosure document – though with guidance from Klara Tisocki (EU). A Research Committee oversees studies, led by Dr Madeleine Valera (Phil Health). An external event organiser was contracted for the 2010 Forum, though the Secretariat also contributed substantially to what was a well-organised gathering.

### **Ph3.2 Location**

Until now, the Secretariat has worked from temporary space within a university in Manila (Pamanantasan ng Lungsodng Maynila, PLM), where M-Ph Chair Dr Romualdez is Dean at the Graduate School for Health Sciences. Apparently Dr Escalante rejected offers from DoH and the Zuellig Foundation to host the Secretariat, in case objectivity was threatened. It is now due to move to more spacious and permanent premises at the WHO building within the DoH compound. Holding Council meetings there may encourage DoH participation. M-Ph members seem pleased about the move, without concern that the WHO (or DoH) may become too influential.

### **Ph3.3 Procedures and systems**

A quarterly progress report, including narrative and financial status, is sent to MIS in what M-Ph believes is the prescribed format.

M-Ph's website was launched in April 2009. This has information about MeTA, its objectives and its national workplan; updated relevant articles and video material; laws, policies and regulations linked with other sites, such as WHO, DoH, DFA, PHAP, academe and professional groups; 'Chairman's Corner' (regular original articles from Dr Romualdez) and a comments box. It is a fine resource, with growing usage (see below).

The relationship with the MIS Secretariat is described as good, with frequent contact, especially in order to clarify things that are unclear.

## Ph4 Building capacity in country

CSO development has progressed well with M-Ph. A CSO mapping conference was held in January 2009, attended by more than 60 multi-stakeholders. This led to the formation of CHAT in February, primarily for the purpose of representation in the M-Ph Council but also as a platform for capacity building. The next month, CHAT's General Assembly met and

- ratified its Charter, with constitution and a set of by-laws and officers;
- agreed a draft work plan, with a focus on technical education about the pharmaceutical sector (well costed, at £50k, if fairly broad);
- identified coordinators for five interest groups; and
- elected a lead coordinator to link between CHAT, M-Ph and MIS.

Further activities have included Fora on Access to Information and Drug Pricing (both in July), and a meeting with a Thai medicines activist. Also (as mentioned above), there have been dialogues with PHAP on health sector reform.

Currently 24 organisations are members of CHAT, but more are interested in joining. There is plenty of scope for further growth, with an estimated 2,000 health sector CSOs in the Philippines. Cecilia Sison, of Health Watch, believes CHAT is the only coalition of CSOs in the sector.

In late 2009, Carolyn Green, who had played a helpful role in all of this, switched from general consultant to M-Ph to become coordinator of MeTA's CSO involvement across all pilot countries. But the January 2010 CHAT Forum, which followed the MeTA Forum and manifested a good attendance (50) and lively debate, indicated that CHAT was progressing even without dedicated attention from Carolyn.

Technical training in medicines is the most common capacity building request from CHAT members, among whom there are no pharmacists (see section 2, above). This will be important if CSOs are to develop some form of M&E role in future.

Beyond capacity building, the key wish is for more seats on the M-Ph Council: CHAT has asked officially for five, though several members want more. Some feel that the public and private sector (and donors) have more power than they do, without it being clear why. At the same time, some seem reluctant to speak out too loudly given that the Council's Vice-chair also runs Health Watch. There is also a wish for more control over their own funds.

It should also be noted that all CHAT activities have been in Manila. But CHAT seems to be furthering MeTA principles both in terms of medicines policy goals and in terms of multi-stakeholder process. Separate control of funds seems to have made a difference in how independent CSOs feel, and their profile is beginning to shift from international NGO-linked to more local grass roots entities. Debate is vigorous and relations are cordial even between organisations with quite different views (e.g. HAIN and Minimal Government Thinkers).

## Ph5 MeTA country Workplan

M-Ph's ambitious draft work plan was initially drafted by Dr Escalante. It was then gradually revised by a working group chaired by the Phil Health representative, and through feedback from MIS, before a final version was agreed. It remains broad in scope, with 'something for everyone', but certainly seems related to need, given the current national context and MIS requirements. It also goes well beyond government policies. Dr Romualdez sees it as '*a work in progress*' and expects further revision over 2010 in the light of baseline data. MIS have apparently indicated the sequencing of activities.

However, pricing is not being explicitly addressed by any of the activities, though WHO and HAI have conducted pricing studies outside of MeTA. One interviewee indicated there was indeed a 'low hanging fruit' avoidance of controversy in not including pricing research within the work plan, while another thought it was more because price cut legislation was passed anyway in 2009.

The current (reduced) version of the plan is considered realistic by stakeholders. There is an agreed budget of £200k, of which £150k was received by January 2010. This is probably realistic, given M-Ph has considerable (and increasing) experience in commissioning work and activities are mainly of the 'study' type, and thus less likely to suffer cost over-runs.

Operational activities (Hypothesis 1) got underway relatively quickly and effectively, though the multi-stakeholder assessment has not been carried out to verify this. There was delay in starting many of the Hypothesis 2-related studies, hence the budget underspend, explained largely as the difficulty of lining up adequate contractors. Apparently, in May 2009, it was also reported that M-Ph had exceeded its then budget by \$50,000, prompting a call both to restrict spending and to use other sources of funds (e.g. WHO, World Bank, HAI). Over the past year the pace has been increasing, and expenditure should soon rise significantly. Beyond Council, Secretariat and CHAT activities, the current status is:

### Completed activities

- Pharmaceutical benchbook – guideline on minimum standards for LGUs and facilities (and potentially the private sector). WHO-funded, collaboration with Phil health (which already has a version, covering inpatient medicines). Cost: \$20k.
- GGM's first annual award – with WHO and some DoH funds, but M-Ph human resources in the assessment team. Had been suggested as 'low hanging fruit'. Cost: \$40k.
- Data Disclosure document (not in work plan) – a first version completed, but needs revision, and validation. While imperfect, it was completed under significant time pressure, and remains a useful and impressive achievement.
- Significant material prepared for MIS for case studies.
- Three National Fora – 2010's had 201 attendees, with an estimated 30 members

of the press. Cost: \$50k.

#### Activities underway

- Household and facility surveys, - not completed (despite marked as so in 18-11-09 MIS overview of progress of baseline assessments), four of the six regions still require their data to be encoded; managed by WHO, who estimate April 2010 completion. M-Ph just get occasional updates from WHO. Budget: \$35k.
- Two related procurement studies managed by the World Bank, one to design an e-procurement system. As with the surveys, M-Ph just receives occasional updates from the Bank. Budget: \$67,000.
- Pharmaceutical sector scan (not in work plan) – near complete draft seen, currently undergoing verification; a comprehensive survey of current data from both Filipino and national sources (more below).
- A study on health financing for the poor was begun in January 2010;
- A range of activities including a medicines promotion and advertising study; analysis of existing pharmaceutical data; medicine quality survey, using ‘FDA in a suitcase’ approach; assistance to FDA on their website; assistance to DoH with their EDPMS.

#### Planned activities expected to get underway soon

- Pharmaceutical management course for LGUs;
- Strengthening Drug Therapeutic Committees at regional and provincial levels; and
- Multi-stakeholder assessment (not due any time soon).

Some Council members see the work plan as still too general, and in need of greater focus on practicality. Certainly the breadth of the work plan risks spreading Council attention very thinly, though it should generate a lot of discussion as studies are released.

It will take some time to complete the entire baseline series of studies. The tool kit is praised in general terms, but there is little familiarity with it: *“The only item used so far has been the communication guide and the finance guide will be used by an accountant due to audit M-Ph’s accounts”*. Consultant Carolyn Green considered the RAAKS approach to capacity building good, but very time-consuming.

All three sectors seem engaged in oversight of the work plan, though the lack of experience (and hence confidence) of CSOs other than HAI and Health Watch is visible. The public sector played the leading role in setting the work plan, due to its early MeTA involvement. Council interviewees said they see the work plan as something that will always be a ‘work in progress’. The WHO- and World Bank-managed projects are to an extent merely activities ‘in MeTA’ rather than ‘by MeTA’.

There is perhaps an issue regarding the background of contractors hired for work plan activities, and the potential trade-off between relevant experience and perceived objectivity. An example is the medicines promotion and advertising study, which will be carried out by a consultant who had mainly worked in the past for industry - knowledgeable, but perhaps biased in their favour? Would this also mean that a consultant who had always worked for public sector clients might be biased in favour of public sector perspectives? Should Council members be allowed to carry out M-Ph-financed studies?

## **Ph6 Access to Data**

Between them, the M-Ph Council and Secretariat appear to have a good idea of both private and public data availability and reliability. This is not to imply that any single person has the complete picture, and public sector, private sector and CSO representatives all expressed that they had learnt from each other on data issues.

The Data Disclosure document, the Pharmaceutical Sector Scan, the Household and Facility Surveys, the procurement studies and the advertising and promotion project are all extensive studies which provide or soon will provide specific data sets. The formats of the first three activities have been agreed both by the M-Ph Council and MIS. A number of data sources cooperated, including the FDA, DoH and PHAP. Prior to these, lighter disclosure documents were produced, such as the Situational Analysis (on the website), and all relevant legislation and regulations were compiled electronically. The government's attitude to data provision is described as sometimes irritated (e.g. the procurement studies) but so far always eventually compliant.

Verification procedures have improved over time. In the rush to produce the Data Disclosure document, there was no check of data with the head of the FDA, Nancy Tacandong, for instance. Middle management at the FDA had assisted, but the first the head of the FDA heard of the finished product was when it was presented in London, from her perspective with errors. This suggests something of an MIS-driven, rather than country-led, process. With the Scan, however (perhaps as a result), a verification process is underway, involving checking draft data with all informants.

### **Ph6.1 Evidence of private sector and civil society involvement**

The private sector (PHAP) were involved in the provision of data for several data sets in the Data Disclosure document and the Scan. Both the private sector and CSOs have been involved in Council discussions on how these studies should be carried out, including on selection of contractors.

### **Ph6.2 Facilitating Factors**

The prestige of M-Ph's Council officers; the quality and breadth of representation across Council members; the more than two years that M-Ph has been operating (and building trust) have all facilitated data disclosure; and the experience of the contractors involved (e.g. with the Scan).

## **Ph6.3 Barriers**

A number of barriers have had to be (and are still being) overcome. There is a lack of a culture of data disclosure in the Philippines, in either the public or the private sector. Even where there is good will, data can be physically difficult to collect in the country, given extensive and recent devolution to often low levels of local government, great geographical obstacles and poor communications.

## **Ph 7 Communication of Data**

### **Ph7.1 Disclosure**

Apparently there is little dispute as to what is meant by disclosure in the Philippines. Debate within M-Ph has surrounded the process of study.

### **Ph7.2 Identification of target audiences**

There does not seem to have been any M-Ph-wide explicit consideration of target audiences, though PHAP recognises that safety issues relate to consumers and marketing issues relate more to taxpayers. Since M-Ph's beginning there has been clear courting of groups not already well-represented within the Council, e.g. through invitations to Forums and other events, as well as invitations to join the Council. This happened with the private sector, then CSOs and possibly now with LGUs.

### **Ph7.3 Means of communicating**

The Forum is increasing in importance as a means of communicating. Attendance is now broad – over 200 people in 2010, over two days, including CSOs, professional associations, LGUs, academics and the private sector. CHAT's CSO Forum (the following day) enhances the appeal to CSO attendees. Presentations were wide-ranging and impressive (see [http://metaphilippines.org.ph/index.php?option=com\\_content&view=article&id=174&Itemid=65](http://metaphilippines.org.ph/index.php?option=com_content&view=article&id=174&Itemid=65) for presentations). Discussions were lively, which should indicate attendees felt satisfied in making the effort to come. Demand (and costs) are such that M-Ph is considering levying a small attendance fee next year.

The National Forum also is marketable to the media as a news story, helped by high profile speakers such as the Secretary of Health. The press conference at the 2010 Forum, well timed for national newspaper deadlines, drew an estimated 30 media representatives (estimated by the number of press packs taken). M-Ph's message was

effectively put across, i.e. many quotes taken straight from the press pack and no negative comment. In contrast, though a table had been set aside for the media at the GGM awards presentation dinner (which included live music and fine dining), sadly no media representatives turned up. WHO did air a GGM video, however, which many dinner attendees thought highly of. Other events are organised by M-Phs and by CHAT on an occasional basis.

Generally, M-Ph has good media contacts (especially via Dr Romualdez), but interviewees complained that they suffered from a lack of materials to offer. As work plan activities are completed over the next few months, M-Ph will have the opportunity to remedy this. Interviewees recognised that discussion of the studies' findings could be a potentially beneficial process, and plans for a series of roundtable fora including study authors are being developed.

Another major communication channel is M-Ph's website, running since April 2009. Website content is regularly updated and at the time of writing this report included:

- background on MeTA concepts and Situational Analysis of the Philippines;
- copies of all presentations from the 2010 and 2009 Forums;
- links to all relevant legislation and regulations;
- PHAP's annual compilation of pharmaceutical data;
- a College of Physicians has a link where people can send in information on adverse drug reactions;
- FDA's list of manufacturers currently compliant with GMP; and
- a link to PhilGEPS, the government's electronic procurement system, though this is not fully operational.

The M-Ph Secretariat benefits from a dedicated full time member working on the website and communications issue. Of course there is always more that can be done. Despite growing site usage (see below) there is still a general public lack of awareness of MeTA, as well as a lack of internet access across a country containing more than 7,000 islands, and many areas of under-development.

Three studies have been completed and give an indication of M-Ph's analytic capabilities. The Pharmaceutical benchbook ('final' draft seen, 57 pages) is a basic, but practical document which should prove useful to those pharmacies looking to improve standards. When completed in mid-2009, it was presented in a conference apparently with good attendance from a range of stakeholders. It was field tested at draft stage in Manila and two other provinces to ensure usefulness.

GGM's first annual award presentation apparently involved careful review of candidates but did not offer much information on why the winning institutions and facilities had won their awards.

The Data Disclosure document ('final' version of January 2010 seen, 30 pages) is to the WHO template. It offers what seems a comprehensive review of the current data available, even though there are a small number of gaps (e.g. 3.1 - policies and practices regarding prices). Recommendations are briefly stated within the tables to which they apply. While the report itself is kept short, it contains links to an impressive array of appendices, containing quantitative data, supporting published

sources, etc. It appears that the verification process was flawed, with the FDA claiming mistakes were included.

While not yet completed, the Pharmaceutical Sector Scan is another impressive document ('near complete' draft of January 2010 seen). Its Harvard-developed 27-table format is apparently due to serve as standard for all other pilot countries. The draft is a comprehensive survey of current data from both Filipino and national sources. After a country profile, six medicines topics are addressed: policy and regulatory framework; market; financing; trade; supply system; access; and use. Each section has data tables (including many yes/no answers to questions), with sources given.

The Scan is currently undergoing a verification process which is apparently far more thorough than that of the Data Disclosure document. The report's lead author described the main difficulties as conflicting data and some sources being not yet committed to MeTA principles, but also commented that significant support from many Council members had helped a great deal. No draft was available of the household and facility surveys,

A question not yet answered is who should act on findings by studies of data being available but not being disclosed? One problem in the Philippines is that bureaucrats have personal legal liability if they are sued in the course of their work.

## **Ph7.4 Evidence of private sector and civil society involvement**

The private sector and CSOs are both well represented in M-Ph's communications efforts. Both sectors participated significantly at the Forums, both as attendees and as presenters. Private sector representatives also attended and presented at the CHAT Forum. Both sectors are also evident on the M-Ph website, for instance via the CHAT, PHAP and College of Physicians links. The private sector (PHAP) contributed to the Pharmaceutical Sector Scan.

## **PH7.5 Evidence of access**

As the table below shows, the number of visitors to the M-Ph website has grown quickly since it was launched. The ratio of pages viewed per visit has fallen, suggesting perhaps that visitors are less often new ones exploring the site and making more directed visits to specific parts of the site. New articles are regularly uploaded, keeping the content fresh.

**Table 2: Usage of MeTA Philippines's website**

	Hits	Visits	Pages	Articles uploaded
<b>April 2009</b>	103,045	269	5,881	11
<b>May 2009</b>	29,456	329	4,356	10
<b>June 2009</b>	8,968	357	1,654	36
<b>July 2009</b>	16,067	794	2,664	35
<b>August 2009</b>	9,805	946	3,054	22
<b>September 2009</b>	12,401	978	3,191	27
<b>October 2009</b>	13,365	1,063	3,239	28
<b>November 2009</b>	14,136	962	2,827	12
<b>December 2009</b>	11,243	1,639	4,122	11
<b>January 2010</b>	63,275	1,913	9,894	45

*Note: 'Hits' is the most commonly used measure of access, but is in fact a poor one, e.g. if a page containing 10 files is accessed it will record as 10 hits. Better measures are 'visits', which records how many distinct computers accessed the site, or 'pages', which records how many pages (distinct screen views) were seen by visitors.*

## Ph8 Policy and Business Practice Reform

Current policies are diagnosed and data analysed across the range of M-Ph studies listed in section 5 above, as well as in additional documents on the website and in presentations at the National and CSO fora.

The 2010 National and CSO Fora involved a series of debates about policy options, including reform of Phil health, procurement rules and the 'P100' and 'Botika ng Barangay' access improvement schemes, though there are no specific MeTA-endorsed proposals.

M-Ph Council members were involved in the national debates (and apparently quieter lobbying) over two pieces of legislation passed in 2009 – the Food and Drug Administration Act (9711) and the Medicines Act (9502), as well as Executive Order 821, which set maximum drug retail prices. Some M-Ph members (e.g. Dr Lazo) apparently helped draft 9502 and MeTA organised for academics to address hearings and bicameral negotiations on the law.

But it is difficult to know what effect M-Ph member activities had. There were no explicit M-Ph recommendations, and Council members may have lobbied in contrary directions. Certainly it wasn't a transparent process. Dr Romualdez believes that "*without MeTA there might have been no laws*", and in particular believes that MeTA helped face down the tobacco lobby in the FDA legislation and helped reach a compromise on generic prescribing for 9502. José Maria Ochave, Council member and vice president at UniLabs believes MeTA has "zero influence on policy", though he hopes that can change and believes the informal network of the Forum can be a powerful tool.

Some interviewees expressed disappointment that M-Ph did not use the debates around these laws to draw more attention to itself and present forthright views. Dr Romualdez admits that 9502 eventually has done almost nothing to improve access to medicines. But, especially with the issue of pricing, it is difficult for M-Ph to find consensus. Less controversially, Phil Health has reportedly adopted a M-Ph proposal of using a Pharmacy Benchbook-related accreditation-type tool.

Regarding business practice, PHAP's Code of Ethics predates the foundation of M-Ph, but Council member Renier Gloor is also head of PHAP's Ethics Committee and said that his MeTA involvement helped strengthen his position within PHAP. The Promotion and Advertisement study will be a test case of how a M-Ph activity directly affects business practice in the Philippines.

## **Ph9 Support to the MeTA process**

### **Ph9.1 Support by the International Secretariat**

MIS Secretariat has provided considerable assistance to M-Ph, including frequent contributions from Carolyn Green, Loraine Hawkins, Wilbert Bannenberg and Andrew Chetley. Visits have involved engagement with separate groups as well as M-Ph as a body. Interviewees expressed gratitude at how Elodie Brandamir was always available for required clarifications. Financial reporting requirements were seen as reasonable, and contrasted with those of the Global Fund, but there was some (mild) resentment given the perception that MIS pushes things into the work plan.

There was a request for international comparative studies, which always receive a lot of media and professional attention.

### **Ph9.2 Support from other pilot countries**

M-Ph members feel they more often have been helping other pilot countries than vice versa, though they are pleased to do this. Jacqueline Idusso, a representative of MeTA-Uganda addressed the 2010 M-Ph Forum (on GMP enforcement), and a good debate ensued. The link with Jacqueline dated from the 2009 London experience sharing meeting, which seemed to have a positive qualitative effect. Dr Lazo described that the meeting “*made us feel we were no longer orphans*”.

### **Ph9.3 Support by the IAG**

M-Ph’s representative on the IAG is Dr Kenneth Hartigan-Go. Dr Hartigan-Go (and others) feel the link is working well, with information flowing in both directions and M-Ph’s views fully articulated in the IAG. Other interviewees seemed satisfied with Dr Hartigan-Go’s role.

### **PH9.4 Support from WHO**

The Philippines office of the WHO (which is also the regional office for the Western Pacific) is a member of M-Ph’s Council, and was also instrumental in M-Ph’s birth (see above). Often more than one WHO representative will attend a Council meeting. The WHO additionally acts as fundholder for monies that arrive from DFID.

The WHO is also sponsoring and overseeing a range of activities within M-Ph’s work plan (see Annex 1), as well as other activities complementary to MeTA’s work, including HAI pricing studies. In addition, WHO contributions are made on an ad hoc basis when opportunities arise, such as facilitating the attendance of Jackie Idusso from MeTA-Uganda at the Forum. It is worth noting that the WHO saw their GGM programme as complementary rather than competing with MeTA – a positive and helpful decision.

Individually, WHO staff seemed enthusiastic about the MeTA project. The Country Representative stated that he wanted MeTA to become *"the main pharmaceutical sector programme in the Philippines"*.

## **PH9.5 Support from WB**

The World Bank is also a founder member of the M-Ph Council. Similarly, it is also sponsoring and overseeing two related studies within the M-Ph work plan: an assessment of public sector procurement, and design of an e-procurement system. To some extent, it seems that, as with the WHO, support of MeTA is rewarded with the right to nominate and manage projects in the M-Ph work plan.

While also enthusiastic about MeTA, the Bank feels it useful to maintain a deliberate low profile, as it is not always viewed as warmly or neutrally as the WHO.

## **Ph9.6 Support from EU**

The third multilateral lender that is a founding M-Ph Council member is the EU. In the Philippines the EU is closely involved with all aspects of health sector reform, including through budget support. EU consultants work within the FDA and the NCPTAM, as well with Phil Health and on health financing and with local government. As with the World Bank, the EU keeps a deliberate low profile.

While EU staffers (especially Klara Tisocki) seem committed to MeTA principles there is a conflict of interest perceived by some Council members due to representation of EU-based pharmaceutical manufacturers. The EU seems to value M-Ph as a potential source of studies in particular, given donor budget support in the Philippines health sector. There is not the same financial support from the EU as the WHO and World Bank provide, but the EU does provide international expertise and experience of commissioning studies.

## **Ph9.7 Other support mechanisms**

Two other supporting institutions are Health Action International (HAI) and the Pharmaceutical Inspection Cooperation Scheme (PICS). HAI carries out studies (such as one on the procurement prices of essential medicines in the Philippines), and provided an expert speaker for the Forum. The PICS, whose Secretariat is based in Geneva, is in the process of accepting membership by the Philippines FDA. Beyond a range of assistance to the FDA, PICS also provided a speaker for the MeTA Forum.

USAID (see section 1) has potential as a future supporting partner. The lead health sector person there knew nothing of MeTA but expressed a great deal of interest.

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## Annex 2: Interviewees and Informants

Surname	Initial	Position	Organisation
Abueva	E	Country Programme Coordinator	MeTA Philippines
Aquino	S	Executive Director	Senate Quality Affordable Medicines Oversight Committee
Banzon	E	Senior Health Specialist	World Bank, Philippines
Bauer	A	Task Manager, Health Operations	EU Health Sector Support Programme
Dauphin	C	Programme Officer, Pharmaceuticals	WHO, Philippines
De la Paz	E	Coordinator	Health Action Information Network
Domingo	S	Group Vice President, Quality Assurance	Phil Health
Hartigan-Go	K	Secretary	MeTA Philippines Council
Hernandez	E		Cut the Cost Cut the Pain Network (3CPNet)
Hirschey	A	Chief, Office of Health	USAID Philippines
Gloor	R	Executive Director	Pharmaceutical and Healthcare Association of the Philippines (PHAP)
Green	C	Consultant	MeTA International
Hawkins	L	Consultant	MeTA International
Lazo	S	Technical Consultant to the Secretariat	MeTA Philippines, Secretariat
Legaspi	N	Provincial Health Officer	Mindoro Oriental Province

Mangkaya		City Health Officer	Tagaytay City Health Office, Cavite Province
Mendoza	A	Execom member	Coalition for Health Advocacy and Transparency (CHAT)
Nyunt-U	S	Representative	WHO, Philippines
Ochave	J	Representative Corporate Vice-President	Philippine Chamber of Pharmaceutical Industry (PCPI) United Laboratories
Pagdanganan	R	Vice Chairman President	MeTA Philippines Council Philippine Health Watch Initiatives
Roble		Emergency Doctor	Tagaytay City Hospital, Cavite Province
Romualdez	A	Chairman	MeTA Philippines Council
Santos	R	President	Philippine Medical Association
Shetty	P	Health Development Officer	USAID Philippines
Sia	S	Director	National Drug Information Center UP Manila
Sison	C	Coordinator	Coalition for Health Advocacy and Transparency (CHAT)
So	R	Program Manager	NCPAM, Department of Health
Tacandong	N	Acting Director	Food and Drug Administration
Tisocki	K	Drug Regulation Specialist	EU Health Sector Support Programme

## Annex 3: Brief situational analysis

The Philippines' 2007 national health accounts show 3.9% of GDP devoted to health, of which 35% is through the public sector and 2.9% (2006) from external sources. Calculated at purchasing power parity, \$132 was spent per capita on health, while 84% of the private spend is out-of pocket (i.e. \$72 at ppp). Some 23% of public spending was via social security. Social Insurer Phil Health claimed to cover 76% of the population in 2009, though this figure is disputed. Within medicines, the private share of spending is estimated at over 80%.

There is a National Drug Formulary of 627 active substances. But decentralisation has created some duplication, as hospitals draw up their own formularies. Legislation was passed in 2009 to strengthen regulation of the 20,000 products currently registered nationally. GMP is not yet compulsory. One current pharmacovigilance initiative is 'lab in a suitcase' testing.

The mere 1.3% of GDP that is publicly spent on health care ensures significant problems of access to medicines, given poverty levels among Filipinos. One expression of this is the fact that Phil Health still does not cover outpatient care for most members. A policy attempting to mitigate this problem is 'Botika ng Barangay' – a chain of around 15,000 private community pharmacies carrying a range of essential drugs, accredited and supplied (at low prices) by PITC and other suppliers.

There are a number of concerns about rational use of medicines. One is that between a third and a half of all pharmaceutical spending is on OTC products, with much on heavily advertised 'nutraceuticals' with no proven therapeutic value. Another issue is high drug resistance due to the practice of sales, of single pills. Counterfeit products are also widely sold. This problem is fuelled by the Philippines' high prices. These make it profitable even to produce and sell falsified versions of paracetamol. Some manufacturers/importers have signed an ethical code of practice, but others are uninterested.

There is a problem of availability, both through lack of outlets across the country's 7,100 islands (partly eased by the Botika ng Barangay policy) and through stockouts at facilities. A WHO/HAI 2006 study found an average of only 11% of the formulary available at public facilities. Trained professionals are also in short supply.

Medicine prices in the Philippines are estimated to be the second highest in Asia, after Japan, despite the country's low income levels. Policies have been launched to combat this. Both the 'Botika ng Barangay' and 'P100' schemes offer low prices on selected medicines. Maximum prices were also established for 21 drugs in 2009, though these reductions will mainly benefit higher income consumers. The DoH has an Essential Drug Price Monitoring system.

The swift and relatively comprehensive decentralisation of health care in the Philippines (through Law 7160) has brought a range of challenges. These include great variety of approach to procurement by LGUs and hospitals. In some cases it is done professionally, in many others less so, sometimes by local mayors (or family members)

with political ends. Corruption occurs, through bribing purchasers or through suppliers rigging their bids, as does other unethical supplier influence, such as unjustified criticism of generic alternatives.

Corruption may also occur at the national level, but there is also greater professionalism of procurement and distribution, including the PITC's parallel imports. A 2009 WHO/HAI study found that on average, originator brands were procured at 15 times and generics at three times the international reference price, but with great variation around these averages (LGUs highest, PITC lowest). Inappropriate behaviour has also been an issue for the Global Fund, which demanded repayment in 2009 of \$1m misspent by one of its principal recipients, Tropical Disease Foundation. The World Bank (via its Governance Matters programme) views 'regulatory quality' and 'control of corruption' as having declined in the Philippines over the past 15 years.

In January 2010, there were 276 registered local manufacturers, of which only 10% met GMP, and about twice that number of importers. Both figures have grown steadily since the passing of legislation liberalising generics in 1988. The leading local company is UniLab, which plays an active role in policy debates. The FDA is improving its ability to inspect for GMP, but there still seem many manufacturers uninterested in achieving compliance.

An estimated 80% of medicines are distributed via pharmacies, with hospitals accounting for 10% and the remainder through other outlets. Two private companies dominate wholesale, and operate effectively, while chains (led by Mercury) increasingly dominant retail. The taxes payable on medicines are 0-5% import duty and 12% sales tax.

There is widespread recognition of problems, and the Secretary of Health declared (at the MeTA 2010 Forum) "*quality health care remains a distant dream*". But the policy debate is currently overshadowed by national elections, due in May.

### **Key players and their strengths**

Despite significant decentralisation since 1991, the Department of Health (DoH) remains an important policy-making and regulatory body, as well as operating several national disease programmes and overseeing more than 70 national hospitals. Within DoH, medicines policy is driven by the National Centre for Pharmaceutical Access and Management (NCPAM – previously PMU), which is responsible for the national formulary. The Food and Drugs Administration (FDA – previously BFAD) oversees registration, production standards and post-market pharmacovigilance. Though under-resourced, legislation was passed in 2009 to fortify the FDA, which may triple its 400 strong workforce. All three bodies are generally supportive of reforms in favour of expanding access to medicines.

The country's 80 provinces, 137 cities and 1,494 municipalities (local government units, LGUs) have responsibility for health care in their areas since 1992. LGUs carry out most of their own procurement, with varying results, but a certain degree of democratic responsiveness. The Philippines International Trading Corporation (PITC), was established in 2004 to effect parallel medicine imports, which it has successfully been doing at low prices by local standards. The Philippines Health Insurance Corporation (known as Phil Health) is a state-owned social health insurer, without its own provider

facilities. Currently it only covers inpatient benefits for most members – other than some indigents enrolled by LGUs in rural facilities. But an expansion to outpatient care for all is under discussion.

Foreign pharmaceutical manufacturers account for around 70% of sales by value. Most of them sit within the Pharmaceutical and Healthcare Association of the Philippines (PHAP), together with the local main wholesalers and retailers. PHAP members have signed an ethical code of practice. Most local manufacturers are within the Philippine Chamber of the Pharmaceutical Industry (PCPI), including the country's largest firm by sales, UniLab. These two organisations effectively consolidate most relevant private sector interests and increasingly participate in policy debate. The leading wholesaler, Zuellig, also has a foundation that sponsors health-related causes.

The most relevant professional associations are the Philippines Public Health Association (PPHA) - the largest organisation of health workers – and the Philippine Medical Association (PMA). Interested academic institutions include the University of the Philippines (UP), Pamanantasan ng Lungsodng Maynila university (PLM) and the Asian Institute of Management (AIM). All have shown commitment to relevant policy debate – UP with most consistency.

Civil society is relatively strong, with two governments having been toppled by civil resistance since the 1980s. Most of the groups relevant to medicines were effectively organised by MeTA in 2009 into the Coalition for Health Advocacy and Transparency (CHAT), on which more below.

Key external multilateral donors in the health sector are the World Bank, the WHO, the European Union, the ADB and the Global Fund. The main bilateral donors are USAID, Ausaid and JAICA. KfW has been significant will be phasing out operations. Each agency currently contributes to increasing access to medicines in the Philippines in its own way.

### **Previous and other current initiatives in this field**

Complementary activities in the Philippines may be divided in two categories. The first involves those which are well known by M-Ph, and even substantially integrated into its work plan. All medicines transparency-related activities by the WHO fall into this category. One example is the WHO's Good Governance in Medicines programme, begun in 2004, which now covers 26 countries but with the Philippines as lead country. The first GGM annual national awards were presented in January 2010, as a M-Ph work plan activity. The WHO is also overseeing the household and facility surveys, which are part of M-Ph's baseline assessment.

The same is true of the World Bank, which is overseeing the procurement study, as part of M-Ph's work plan. Similarly to the WHO and the Bank, EU staff working on medicines-related projects sit on the M-Ph Council and ensure that the work of the two entities is harmonised and aligned. A fourth example is the international Pharmaceutical Inspection Cooperative Scheme, which is working to enhance the FDA's GMP inspection capability (a PICS representative addressed the 2010 MeTA Forum). Finally, there are a range of public sector-led activities such as FDA reform, and medicine price and availability policy changes (see section 1, above).

The second set of complementary activities in the Philippines appear to have been ignored by M-Ph so far. These include all of the other external donors mentioned above. USAID has six projects that overlap with MeTA issues, including work focused on health sector governance and on the private sector, with an overall five year budget of \$247m. As of February 2010 the Global Fund has contributed \$218m. There is cross-membership between their Fund's Country Coordinating Mechanism and the MeTA council (WHO's Dr So), and some awareness of corruption issues (see above). Ausaid activities include anti-corruption measures. The ADB supplies technical assistance on communicable diseases and governance issues.

## Annex 4: Work plan and budget as at 5 March, 2010

Activities	Unit	Budget (US\$)					(GBP)
		2 year workplan	Funded by MeTA Allotment	Country	Funded by other Donors partners	Funding Partner	
<b>MeTA PHILIPPINES</b>							<b>BUDGET USD-GBP = 0.66</b>
1.1. Analysis of existing pharmaceutical data	1	\$18,000.00	\$18,000.00		\$0.00		£11,880.00
Pharmaceutical Sector Scan							£4,000.00
1.2. Survey of the quality of medicines in the field using the BFAD in a suitcase strategy	1	\$20,000.00	\$10,000.00		\$10,000.00		£6,600.00
1.3. Conduct of Level II and III Survey on medicines	1	\$35,000.00	\$0.00		\$35,000.00	WHO	£0.00
1.4. a. Assessment of Public Sector Procurement ( including PITC) of drugs and medicines	1	\$25,000.00	\$0.00		\$25,000.00		£0.00
1.4.b. Design of e-procurement system for drugs and medicines	1	\$42,000.00	\$0.00		\$42,000.00		£0.00
1.4.c. Assessment/study on the current systems for financing medicines for the poor	1	\$10,000.00	\$10,000.00		\$0.00		£6,600.00

1.5. Study on medicines promotion and advertisement in the Philippines	1	\$10,000.00	\$10,000.00	\$0.00		£6,600.00
<b>Subtotal:</b>		<b>\$160,000.00</b>	<b>\$48,000.00</b>	<b>\$112,000.00</b>		<b>£35,680.00</b>
2.1. Improvement of the medicines registration and quality website of BFAD	1	\$5,000.00	\$0.00	\$5,000.00	FDA	N/A
2.2. Website for the Philippine National Drug formulary	1	\$5,000.00	\$5,000.00	\$0.00		£3,300.00
2.3. Support to the implementation of the EDPMS at the regional & provincial levels	1	\$20,000.00	\$5,000.00	\$15,000.00	DOH	£3,300.00
2.4. Development and testing of tools and feedback systems for monitoring and evaluation of ethical practices for industry and the medical profession	1	\$10,000.00	\$10,000.00	\$0.00		£6,600.00
2.5. Development and testing of monitoring tools for prescription audits.		\$10,000.00	\$10,000.00	\$0.00		£6,600.00
<b>Subtotal</b>		<b>\$50,000.00</b>	<b>\$30,000.00</b>	<b>\$20,000.00</b>		<b>£19,800.00</b>
<b>Key Outcome 3</b>						

3.1. Strengthening of Drug Therapeutic Committees at Regional and Provincial levels	1					
3.1.a. Technical capacity building for DTC's		\$10,000	\$10,000			£6,600.00
3.1.b. Development of tools for monitoring and evaluation of DTC's		\$10,000	\$10,000			£6,600.00
3.2. Pharmaceutical Management and Good Governance Course for LGU Health Managers and Local Chief Executives	1	\$20,000	\$5,000	\$15,000		£3,300.00
3.3. Piloting of the Pharmaceutical bench book	1	\$20,000	\$10,000	\$10,000	WHO/GGM	£6,600.00
3.4. Support to the Good Governance in Medicines Awards		\$20,000	\$20,000	\$40,000	WHO/GGM	£13,200.00
<b>Subtotal</b>		<b>\$80,000</b>	<b>\$55,000</b>	<b>\$65,000</b>		<b>£36,300.00</b>
<b>Key Outcome 4</b>						
4.1. MeTA Roundtable discussions	8	\$10,000.00	\$8,000.00	\$2,000.00		£6,600.00
4.2. Publications	20	\$3,000.00	\$3,000.00			£1,980.00
4.2.a. Publications, general						
4.2.b. Publication of Proceedings for MeTA Forum	2	\$3,000.00	\$3,000.00			£1,980.00

4.2.c. Publication of Baseline Assessments		\$5,000.00	\$5,000.00			£3,300.00
4.3. Development of the MeTA website	2	\$5,000.00	\$5,000.00			£3,300.00
4.43 Annual MeTA Forum	2	\$50,000.00	\$45,000.00	\$5,000.00	other sources	£29,700.00
<b>Subtotal</b>		<b>\$76,000.00</b>	<b>\$69,000.00</b>	<b>\$7,000.00</b>		<b>£46,860.00</b>
<b>Key Outcome 5</b>						
5.1.. MeTA Council and Secretariat Operations						
5.1.a. Salaries						
i. Project Coordinator	1	\$25,000.00	\$25,000.00			£16,500.00
ii. In House Research assistants	2	\$23,132.00	\$23,132.00			£15,267.12
iii. Website administrator	1	\$10,734.00	\$10,734.00			£7,084.44
5.1.b. Office rental and running costs / petty cash		\$13,566.00	\$8,500.00	\$5,066.00	WHO/other sources	£5,610.00
5.1.c. Communication		\$2,000.00	\$2,000.00			£1,320.00
5.1.d. Stationary and printing/Supplies		\$446.00	\$446.00			£294.36
5.1.e. Equipments	1	\$7,000.00	\$7,000.00			£4,620.00
i. laptop	1					
ii. LCD	1					
iii. Copier	1					

iv. Fax Machine						
v. Microphones						
5.1.f. Travel		\$10,000.00	\$5,000.00	\$5,000.00		£3,300.00
5.1.g. MeTA meetings		\$3,000.00	\$3,000.00			£1,980.00
5.2. CSO Support		\$20,000.00	\$12,000.00	\$8,000.00	other sources	£7,920.00
<b>Subtotal</b>		<b>\$114,878.00</b>	<b>\$96,812.00</b>	<b>\$18,066.00</b>		<b>£63,895.92</b>
<b>TOTAL</b>		<b>\$480,878.00</b>	<b>\$298,812.00</b>	<b>\$222,066.00</b>		<b>£202,535.92</b>

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