

PROFIT

Promoting Financial Investments and Transfers

- Private Health Care Providers
- Employer-Provided Services
- Innovative Investments and Transfers

- PN-ABR-655 ISA=88710

PROJECT PERFORMED FOR
**U.S. Agency for International
Development** *(Office of Population)*

**Deloitte &
Touche**



Deloitte Touche Tohmatsu International

In association with

Boston University Center for International Health

Multinational Strategies, Inc

Development Associates, Inc

Family Health International

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COUNTRY ASSESSMENT: PHILIPPINES, 1993



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June 24, 1993

Mr. Craig Carlson
U.S. Agency for International Development
Office of Population
Family Planning Services Division
Room 809, SA-18
Washington, D.C. 20523-1819

Dear Mr. Carlson:

Deloitte & Touche is pleased to submit the PROFIT (Promoting Financial Investments and Transfers) Country Assessment document for the Philippines to the Office of Population (R&D/POP) of the U.S. Agency for International Development.

This assessment document is the product of visits to the Philippines by PROFIT's core staff and contacts with Philippine private sector firms, cooperating agencies, and private voluntary organizations involved in family planning activities, as well as USAID/Manila. As such, it represents PROFIT's current strategy for developing private sector family planning initiatives in the Philippines.

PROFIT looks forward to implementing this strategy with your support and guidance. If you have any questions, or wish to discuss the document, please feel free to contact me at (703) 276-0220.

Very truly yours,



Donald R. Nicholson II
Project Director

DRN/cs

cc: Dr. Emmanuel Voulgaropoulos, Chief, OPHN, USAID/Manila

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I. INTRODUCTION

"Promoting Financial Investments and Transfers" (PROFIT) is a new and innovative family planning project sponsored by the Office of Population (R&D/POP) of the U.S. Agency for International Development (A.I.D.). The objective of the PROFIT project is to increase developing country resources for family planning -- funds, services and commodities -- by encouraging private sector involvement. PROFIT will achieve this by focusing on three routes of involvement:

- Private Health Care Providers
- Employer-provided Family Planning
- Innovative Investments.

This Country Assessment focuses on PROFIT's proposed project activities in the Philippines. The Country Assessment is designed to provide a summary of relevant demographic data, to identify feasible private sector interventions, to assess potential impact of these projects in terms of PROFIT objectives and to guide the design of PROFIT services for that country. The Country Assessments examine the private sector environment at a macro-level and focus on the areas where PROFIT initiatives may best succeed. The assessment develops initial project ideas, identifies areas that warrant further study, and helps direct specific projects towards investment.

PROFIT conducted three exploratory trips to the Philippines during Fiscal Year (FY) 1993 and has identified, together with A.I.D., some areas for possible PROFIT involvement. Some of these interventions were initially discussed in the trip report by Project Director Don Nicholson and team member Diana Escueta on their October 1992 trip, and in reports from follow-up trips by Family Planning Director Paul Burgess in December 1992 and March 1993.

The remainder of this document is structured as follows:

- Section II - provides an overview of the Philippines' demographics and a profile of the family planning environment. Elements of the macroeconomic, social and political environment which are relevant to the activities of PROFIT are identified for discussion.
- Section III - examines the areas of Private Health Care Providers, Employer-provided Family Planning and Innovative Investments, the mandated areas of PROFIT operation, within the context of the Philippines.
- Section IV - describes the potential interventions identified in the Philippines, outlines the relationship to PROFIT objectives, and the potential benefits of the activity.

II. COUNTRY BACKGROUND

The Philippines lies off the southeast coast of the Asian mainland -- an archipelago of over 7,000 islands covering nearly 300,000 square kilometers (115,000 square miles) of land area. There are three main island groups: Luzon (the largest), Visayas and Mindanao, further broken down into regions, provinces and municipalities at the local level. The capital Metro Manila area in Luzon still remains the predominant center of most economic activity.

A 1990 census estimated the country's total population at 62 million, making it one of the five most populous nations among A.I.D.-assisted countries. The growth rate of 2.3% per year also makes the Philippines one of the fastest growing countries in Asia. The eighties, marked by political upheaval and an increasingly influential Catholic Church, eradicated whatever gains were accomplished in family planning efforts during the early 1970s under the Marcos reign. Total fertility is considered high at 3.75, and is even higher in rural areas such as the Visayas at 6.0. Population density has soared in recent years, mostly due to urban emigration, and Metro Manila's density of 12,315 persons per km² is sixty times the national average of 202 per km².

The contraceptive prevalence rate (CPR) is officially estimated at 35%, though many believe it to be nearer 45%. (A Demographic and Health Survey is not expected until later this year). Only 22% of contraceptive prevalence is attributed to modern methods, a little over half of which is due to sterilization. Figure 1 shows the current modern method mix. Much needs to be done in family planning efforts to improve the modern method mix. Another important concern is the nationwide contraceptive dropout rate of 50%. This high dropout may be caused largely by women's fear of side effects and being "*hiyang*" which refers to the fit and comfort of a woman's body with the contraceptive used. Nevertheless, the 1988

CONTRACEPTIVE METHOD MIX	
<u>Method</u>	<u>Percentage Use*</u>
Vasectomy	1
Tubal Ligation	11
IUDs	2
Pills	6
Condoms	1
Traditional	14

TOTAL	35
* Of total MWRA	

Figure 1

Contraceptive Prevalence Survey estimated that 38% of the Married Women of Reproductive Age (MWRA) have an unmet need for family planning services. Induced abortion is illegal, yet is considered to be relatively high at 12%, and is even higher in the rural areas at 17%. Such a high rate of unwanted pregnancies serves as further indication of demand for contraceptive services.

These demographic trends have warranted increased action on the part of the government, and debate is heating up with the nation's Catholic Church over the issue of contraceptive use. Because of this, the Government argues for family planning mostly from the perspective of maternal and child health rather than birth control.

Specific factors which have an overall effect on family planning prospects, and on PROFIT's role in the Philippines are:

- **Government Policy and Commitment to Family Planning.** In 1988, the Department of Health (DOH) was designated as the lead agency in implementing the Philippine Family Planning Program (PFPP), while the Population Commission (POPCOM), which was a significant player in population program efforts in the 1970s, was assigned the role of policy coordination, advocacy and evaluation. With the recent lag in the government's program, NGOs have taken on an increased role in terms of service provision and in generating new acceptors.

The PFPP as well as past programs have been largely funded by external sources. Both USAID and UNFPA place a high priority on revitalizing the PFPP and have recently allocated \$40 million and \$25 million, respectively, to launch new programs. The PFPP has set several ambitious targets, which includes reducing the growth rate to 2% and increasing the CPR to 54.7% in 1994, through a range of concerted efforts in training, service provision and dissemination. During the Consultative Meeting for the PFPP held in 1990, there was wide consensus that based on experience, delivering family planning services exclusively was not the best approach towards an effective program.

The new administration under President Fidel Ramos and DOH Secretary Dr. Juan Flavio Velasco provides new hope for family planning programs through strong support for population management initiatives while acknowledging respect for individual choices and religious beliefs. This is evident in the DOH's recent creation of an Office for Special Concerns which reports directly to the Secretary to address priority issues such as family planning. Furthermore, Dr. Flavio Velasco has acknowledged that the DOH may not move fast enough to achieve the desired population targets and called on NGOs and other private agencies to fund most of the program.

- **Economic Environment.** The economy has continued to suffer enormous setbacks from both man and nature. In the last three years, the country has been devastated by a severe drought, followed by power shortages, a powerful earthquake, the Gulf War, a strong typhoon that killed nearly 8,000 people and, most recently, a volcanic eruption with its massive path of destruction, including the U.S. Clark Air base. These events have exacerbated the effects of political instabilities caused by repeated military coup attempts in the late 80s.

As a result, economic growth continues to be sluggish. After an average growth of 4.6% in 1986-1990, GDP grew by roughly 1% in 1991 and 1992, which was below the target

of 2-3%. Inflation dropped to 9% in 1992 compared to the average rate of 15% in the 1980s. These trends imply that per capita income has not improved in recent years, and the Ramos Administration remains concerned that any gains in economic growth will be wiped out by the accompanying growth in population. Unemployment still averages 9% and, along with underemployment, continue to be major problems. It should be noted that a significant part of the economy is made up of the informal or underground sector, unaccounted for in most economic and employment statistics. Though the rise in emigration has offset the effects of unemployment, the recent closure of the two military bases had an adverse impact. These bases directly employed an estimated 67,000 Filipinos in 1989, making the bases the second largest employer after the government.

In the meantime, a deteriorating fiscal situation, along with a wide current account deficit, has put increasing pressure on infrastructure and services, resulting in the breakdowns seen in transportation and energy. With the energy shortage producing daily "brownouts" that are forecasted until 1994, inconvenience has become a way of life. Power rates are due to increase again, making them one of the most expensive in the region. Aside from the impact on business operations, the power shortage also serves as a major deterrent to foreign investors. The World Bank estimates that the energy crisis cost the economy up to \$1 billion in 1992, with up to 400,000 jobs lost. The current rash of kidnappings which first started with the affluent Chinese community, also had a debilitating effect on Philippine economic recovery efforts. The Chinese community is a well-known and established source of capital, but the continuous dilemma posed by the kidnappings has and may continue to drive precious capital resources and much needed investment away from the country.

Throughout these difficulties, the business sector has proven to be quite resilient. With the Ramos government remaining committed on implementing the private sector support policies begun under former President Aquino, recent economic reforms instituted by the government have provided further encouragement.

- **Social Environment.** The alleviation of poverty continues to be the government's greatest challenge. The World Bank estimated that 50% of the population lived below the poverty line in 1988, though other surveys cite 80%, earning between 3,000 to 5,000 Pesos (\$120 to \$200) per month. Past trends have shown that income distribution has not improved over the last twenty-five years and remains highly uneven, with the lowest 20% of income earners holding only a 3% share of total income, while the top 20% hold at least a 60% share of total income. As mentioned above, income has remained somewhat stagnant. The average annual income for a family of six was 40,458 Pesos (\$1,618) in 1988. Of this, less than 2% went to medical care.

Many will agree that the tragedy in the economy lies with the failure to utilize the talented work force. The Philippines has one of the higher literacy rates in the region: 88% of those over 15 are literate and 97% are literate in the Metro Manila area. Female literacy is as high, if not slightly higher than the national average at 89%. Furthermore, the nation suffers from the massive "brain drain" phenomenon due to the increasing rates of emigration abroad, especially felt in the areas of medicine and health care.

Approximately 80% of the nation is Roman Catholic, representing a strong voice of opposition to any form of artificial contraception. Cardinal Sin, the Archbishop of Manila, is a leading national figure and greatly influences public opinion on family planning program efforts. Another challenge is the fast-growing and influential Opus Dei movement, many of its members being leaders in the business community.

- **Investment and Financial Environment.** While the Philippine financial environment is a challenging one, there are improved opportunities for investment activities. Prime lending rates have recently gone down to 18%, still one of the highest in the region, while inflation has fallen to 9%. The Philippine Peso remains on float against the U.S. Dollar and has in recent years gradually depreciated to its current level of 25 Pesos per \$1. Foreign investment has been liberalized with the Philippine Foreign Investments Act of 1991 to allow increasing rates of foreign participation. Special incentives are extended to priority industries and to projects that support major government development programs. In 1992, restrictions on holding and repatriating foreign currencies were overhauled, allowing full and immediate repatriation of foreign capital and profits. Import controls have also been continuously relaxed over recent years, but a minimum tariff of 10% across-the-board levy still exists over imports in addition to a value-added tax of 10% on goods and services. A mutual preferential trading agreement exists with other members from the Association of South-East Asian Nations (ASEAN) which includes Indonesia, another PROFIT country, on which a 50% discount on imported tariffs are granted.

USAID/Manila's Private Enterprise Support Office (PESO) is involved in numerous activities to aid financial market reform. In July 1992, a special desk was opened at the Philippine Board of Investments (BOI), funded by USAID/Manila, to serve the needs of potential U.S. investors to the Philippines. The two rival stock exchanges in the country (Manila and Makati) have agreed to merge into the new Philippine Stock Exchange as part of the government's efforts to reform markets and attract foreign investors, and as a precondition to loans from both the Asian Development Bank (ADB) and USAID to assist in the reform of capital markets. Private investment is expected to grow with the reforms instituted by the new administration. The outstanding success of a recent \$150 Million Eurobond issue in the international bond market is highly indicative of increasing investor confidence in the Philippine economy.

With a total debt of \$29.2 billion and a debt service/exports ratio of 26% at the end of 1992, the Philippines is one of the world's most heavily indebted countries. The total composition of debt is shown in Figure 2. Debt negotiations with commercial banks are proceeding, while the Central Bank's debt-equity conversion program (for external liabilities) resumed with an auction held in January 1993, tenders of which were reported at \$185 million.

The basic institutions for investment credit exist, though are not fully developed. Any weakness in the banking system is attributed more to the huge losses by the Central Bank rather than the

private commercial banks which have proven to be quite competitive and profitable. Furthermore, Manila is known for its strong cadre of bankers and financiers. As in most developing countries, the challenge in the Philippines lies in serving the credit needs of underserved areas which have little access to capital.

- **Summary.** Indicators show a vast need for improved family planning and contraceptive services. Though government programs have lagged behind in the past decade, the new administration provides much needed support for family planning efforts. Private sector initiatives will be constrained by a difficult business/economic environment and consumers' ability to pay for commodities and services.

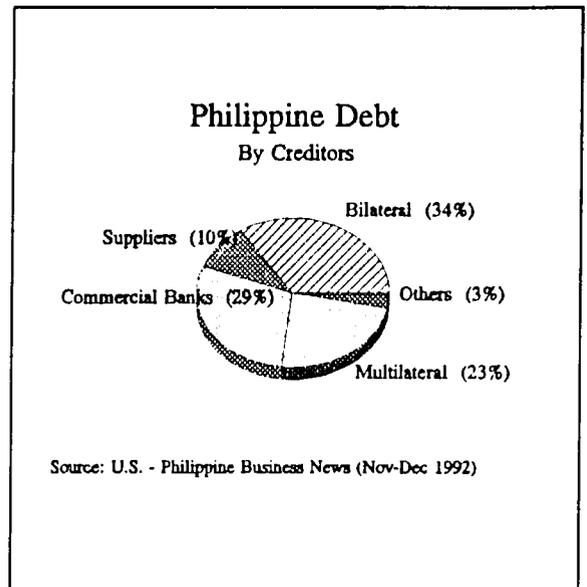


Figure 2

III. SCENARIO FOR PROFIT INVESTMENT

The PROFIT Project is mandated to operate in the areas of Private Health Care Providers, Employer-provided Family Planning and Innovative Investments. These areas are analyzed below in the Philippine context.

A. PRIVATE MARKET-BASED PROVIDERS

PROFIT seeks to work with health care personnel, insurers, group practices, hospitals, pharmacists and professional associations towards the goal of expanding existing family planning service delivery and increasing the availability, quality and method mix of contraceptive commodities.

The Philippines ranks low within the region in terms of health care expenditures, with only 2.4% of GDP spent on health care. (The breakdown of these health care expenditures is shown in Figure 3.) The bulk of health care financing is borne by the private sector, comprising 64% of total health care expenditures. Private expenditures are mostly out-of-pocket, emphasizing curative rather than preventive care. The high proportion of private expenditures confirm that most Filipinos prefer to obtain outpatient care in the private sector, even in rural areas.

Private Practitioners

The Philippine private health care sector consists of thousands of clinics, small hospitals, small drugstores and large drugstore chains. The private sector also includes traditional healers and birth attendants. It is also where the training of most medical personnel including pharmacists, physicians and nurses, occur.

Private practitioners are maldistributed among regions and are located primarily in urban areas. In addition, emigration has resulted in a shortage of trained service providers. It is estimated that 4,000 doctors and 28,000 nurses graduate yearly, from which 68% of doctors and 88% of nurses go and practice abroad. Doctorless rural areas is a continuous issue to contend with on the part of the public and private health sector. The combination of these factors accounts for the worsening ratio of patient to physician. Despite the large number of personnel trained in the country, the ratio of the population to physician, declined from 6,570 in 1984 to 8,825 in 1989. Meetings with officials from the Philippine Medical Association (PMA) further confirmed this dilemma.

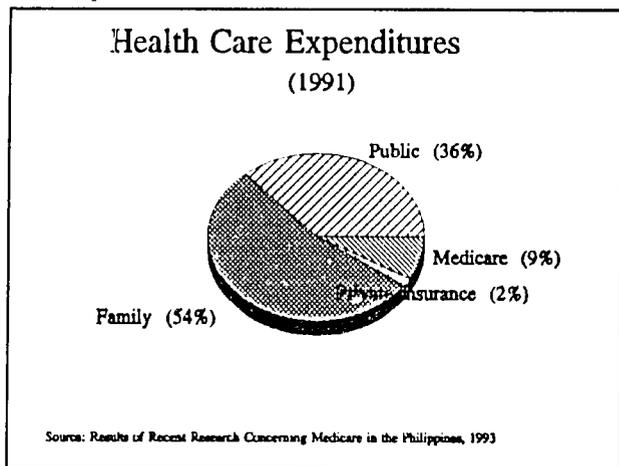


Figure 3

The PMA estimates that there are 30,000 practicing doctors in the country, and another 30,000 Filipino physicians practicing abroad.

Opportunities exist to encourage physicians to remain in the Philippines and practice in underserved areas. In addition, there are opportunities to provide incentives for service providers in all sectors to more aggressively promote family planning.

Health Care Facilities

There are roughly 1,700 hospitals in the Philippines, 66% of which are private. Many are either family-owned, run by a group of doctors, or by religious organizations. Most private facilities are located in the urban areas, especially in Metro Manila. Total hospital bed capacity is considered low at 15.9 per 10,000 population, and greatly disadvantages rural areas.

Both the A.I.D. centrally-funded OPTIONS and Health Financing & Sustainability (HFS) Projects have conducted comprehensive studies on the Philippine hospital system. The impact of health financing on service delivery facilities was observable after Medicare came into effect in 1972 when the number of private hospitals increased. Medicare, the national medical insurance plan which is a compulsory insurance scheme, reimburses inpatient services in nearly all hospitals in both the private and public sectors. Medicare encouraged the growth of small private hospitals over the last two decades, paralleling the growth of public hospitals during the same time period. But recent financial constraints have started to reverse this trend as more hospitals are plagued by a high failure rate, estimated at 50%. This failure rate resulted from the over-supply of hospitals, under-capitalization and the high interest rates on existing debt. Hospitals are taxed as regular businesses, unless they are teaching hospitals which enjoy non-profit status.

There are opportunities for PROFIT to work with Philippine hospitals by providing needed capital and improved service delivery options, such as family planning, to build usage rates. However, we need to keep in mind that hospitals comprise a small portion of family planning service providers. Moreover, we must assess whether this is an efficient mechanism for service delivery.

Health Care Insurance

Medicare covers roughly 45% of the population, yet finances less than 9% of total health care expenditures. Less than 2% of total health care spending is attributed to private health insurance, indicating room for further expansion in risk-sharing mechanisms. But the private health insurance sector is deemed to be unprofitable due to several reasons, among them is the lack of public awareness on the benefits of prepaid insurance, as well as the lack of regulation.

Nonetheless, Health Maintenance Organizations (HMOs) represent a small but growing segment of private providers. There are 19 HMOs enrolling an estimated 500,000 persons in 1992, covering 1% of the population, mostly from upper middle income to high income classes. Rapid enrollment growth in the last two years may have raised this to 2%. Recent studies such as the "PMCC-HMO tie-up experiment"¹ attest to the huge potential offered by HMOs in offering preventive health benefits and services. An interview with PhilamCare, the leading HMO with 50% share of the market, further indicated that opportunities exist, primarily in new segments of the market. While health insurance may still be underdeveloped, it has the potential to improve private sector financing of health care.²

Non-Governmental Organizations

The proliferation and significance of the NGO community in the Philippines warrants recognition, especially since NGOs play a major role in providing health services and family planning. The Philippine NGO Council on Population, Health and Welfare (PNGOC) reports that there are at least 126 NGOs currently involved in family planning and population activities. Some 545 NGO clinics comprise 15% of total family planning clinics and yield one-third of all new family planning acceptors.

NGOs are mostly reliant on government funding and therefore have been widely affected by the government's budget reductions. Some NGOs are undertaking a variety of income-generating activities to supplement their funding. These efforts range from providing a wider array of health care services, to operating a shoe factory. Current regulations state that NGOs risk losing their non-profit status if more than 25% of their income is derived from commercial activities. However, this regulation is being reevaluated in light of the need for increased access to financial resources. Some NGOs that wish to pursue this self-sufficient route are located in low-income areas, and therefore are concerned with the clientele's ability to pay. Furthermore, some also feel that pursuing income-generating activities goes against their social mandate.

USAID/Manila, through John Snow, Inc. (JSI), currently assists NGOs through PNGOC and by strengthening management and increasing income-generating opportunities through

¹ In 1987, the Philippine Medical Care Commission (PMCC), which manages the Medicare program, launched an experimental project designed to provide increased Medicare benefits at the existing contribution levels by utilizing services provided by health insurance companies and HMOs. Two HMOs participated in the experiment -- HealthKard International and Pamana, Inc..

² USAID/Manila's Health Finance Development Project (HFDP) is looking at the question of improving the efficiency of health care financing. The HFDP Project includes three components: (1) to develop the government's capacity for private/public sector health finance policy; (2) to improve efficiency and expanded coverage of the national health care financing programs and develop options for other health financing schemes; and (3) to focus on hospital sector restructuring and institutional reform.

clinic franchising projects. PROFIT has similar experience in this area and is willing to provide complementary technical assistance or subsequent investments in ongoing efforts to increase NGO sustainability.

B. EMPLOYER-PROVIDED SERVICES

PROFIT seeks to assist firms with large employer populations in offering family planning as an employee benefit. PROFIT can assist by providing technical assistance, cost/benefit analyses, investment in on-site clinics and collaboration with providers seeking to serve employee populations.

Regulatory environment. The Labor Code requires contributions to the Employees Compensation (EC) Fund (similar to Workmen's compensation) and further requires minimum medical, dental and occupational-safety obligations of employers. Some of the large companies provide this benefit in the form of subsidies. In addition, companies with over 200 employees are required to provide on-site family planning. However, the Department of Labor and Employment has been weak in enforcing this requirement.

In addition, the work force is covered by Medicare, which currently provides no outpatient reimbursement for any primary health care or family planning services. A large number of private firms offer health benefits in addition to those provided by Medicare, though only a few cover maternity costs. Medicare does not provide any maternity benefits but nevertheless accrues significant inpatient pregnancy-related expenses. Medicare coverage of sterilizations as part of Caesarian sections and complications from birth have accounted for the bias towards sterilization. The reform of Medicare itself, as an effective national health insurance scheme, is an important component of the HFDP, while OPTIONS is assessing the feasibility of an outpatient package that includes family planning in Medicare benefits.

Enterprise's experience. The A.I.D.-funded Enterprise Program conducted work place-based programs with two large Filipino companies: Benguet Gold Operations and Matling Industrial & Commercial Corporation. Both were successful in convincing management of the economic benefits that can be derived from investing in family planning services, and both programs have continued after Enterprise concluded its involvement. The Enterprise Program also worked with umbrella NGOs such as the Philippine Center for Population and Development, Inc. (PCPD, formerly PCF) to develop responsible parenthood programs in a multitude of industrial companies. Despite initial delays, the program has been largely successful and continues to attract new companies to sign on to what is now the third phase of the industrial-based program, funded by the USAID/Manila Mission.

The Enterprise Program was relatively successful in stimulating participation by the industrial sector in employer-based family planning programs, and various cost-benefit studies conducted under Enterprise provides encouragement for further interventions. In addition, employer-based programs are considered to be an important element in A.I.D.'s overall population assistance strategy. Efforts to strengthen employer-based family planning provides an important area for PROFIT to provide assistance. For instance, though the Labor Code requires large employers to have outpatient clinics, compliance is weak. PROFIT can assist in determining alternatives for employers in delivering cost effective health and family planning services.

Industrial Estates. An area of growing interest is that of Industrial Estates and export processing zones (EPZs). The stimulation of the manufacturing sector in the 70s created EPZs where companies are granted special tax incentives. The first zone was set-up in Mariveles (Bataan) and there are currently other zones in such areas as Cebu, Baguio and Cavite. Recent changes in foreign investment laws have also encouraged growth in these facilities -- there are 50 new EPZs and Industrial Estates in various stages of planning and development. These sites present unique opportunities due to their large female worker populations and resulting need for appropriate health facilities.

While industrial estates and export zones provide opportunities for PROFIT involvement, we need to be mindful of the restriction posed by Section 599 of the Foreign Assistance Act which prohibits the use of U.S. appropriated funds in providing "assistance for the purpose of establishing or developing in a foreign country any export processing zone or designated area...in part or in whole, to activities carried out within that zone or area". In assessing potential ventures, PROFIT would need to consider the impact of the proposed activity on U.S. jobs and whether industrial estates fall within the same tax-privileged status as export zones.

C. INNOVATIVE INVESTMENTS

PROFIT is mandated to invest in projects that promote contraceptive production and distribution. PROFIT can also work with local groups towards privatization of services, the reduction of trade barriers if they have an adverse impact on the family planning environment or availability of contraceptives, and in leveraging funds through innovative financial transfer mechanisms.

Local Production of Contraceptives

Most, if not all, the large players in the pharmaceutical arena are well represented in the Philippines and 90% of all pharmaceutical products are domestically produced. However, supply of contraceptives has been inconsistent. Of the contraceptives that are available, the oral contraceptive pill is the most widely used, accounting for 6% of the method mix (see Figure 1). Wyeth, Schering and Organon all manufacture and market oral contraceptives. In addition, Pascual Labs produces the pill at half the price of the

multinationals. SOMARC recently launched their oral contraceptive campaign, with the "Couple's Choice" (generic) brand with the participation of Wyeth, Schering and Organon.

Condoms are not very popular since they have been traditionally associated with illicit sex. Condoms, though not classified as pharmaceuticals, are distributed in local pharmacies. Condoms are not produced locally. Condoms are commercially distributed through Philusa, a sister company to the large Mercury Drug store chain -- both are dominant players in the distribution field. Ansell is the most prevalent condom supplier in the market, with at least nine different brands. The total commercial market size is unknown but Philusa has estimated an annual sales volume of 2 million condoms. The SOMARC Condom Social Marketing Campaign, launched in late 1992, markets the "Sensation" brand (using a condom made by Ansell) and has conducted successful campaigns in the urban centers of Metro Manila, Cebu and Davao. PSI's local affiliate, DKT International also has their "Trust" brand in the market. Recent developments also include the possible construction of London Rubber's condom manufacturing plant in the Philippines and the opening of an Ansell plant in Sri Lanka aimed at exporting to the Philippines and other countries within the region. In addition, a large number of condoms are donated by USAID. Total annual demand is estimated at 22 million units. In FY 1991, USAID distributed nearly 10 million units.

Contraceptives are donated by donors such as USAID, UNFPA and IPPF, and are distributed free through the public sector and through NGOs. However, there are problems with frequent shortfalls due to the erratic supply. Other contraceptives available include the Lorophyn brand suppository and small quantities of spermicides and IUDs (Lippes Loop). Norplant is not widely available, and did not fare well in clinical trials. Depo-Provera was recently re-approved for local distribution after being banned over a year ago. In addition, small quantities of the injectable Noristerat are also available from Berlimed (Schering). It is widely felt that injectables have enormous market potential since they are popular with Filipino women.

With the government retraction in contraceptive provision over recent years, commercial sector activity is expected to increase, but has done so slowly. SOMARC estimated that the demand for contraceptive services is expected to grow at roughly 10% per year. Recognizing the successful efforts of SOMARC in launching recent contraceptive campaigns, additional inducements may not be needed at the current time for condoms and oral contraceptives. It has yet to be determined whether a public sector, social marketing or fully commercial approach would be most feasible for redistributing Depo-Provera. Nonetheless, given the huge potential for injectable use and feasible prospects for collaboration with the Upjohn Company, the manufacturer of Depo-Provera, PROFIT can provide assistance towards facilitating the distribution and marketing of Depo-Provera in whatever way necessary.

Trade Barriers & Regulatory Reform

The issue of exemption of contraceptives from import duties/taxes is being evaluated in light of the new administration's policies since a 10% value added tax (VAT) still applies to contraceptives. Donated essential machinery and medical equipment of private primary and secondary hospitals are exempted by law from duties though this remains relatively unknown in the industry.

Drug distribution is controlled through prescription requirements, including prescriptions for the pill. Though enforcement by pharmacists has been weak, the practice may slowly change due to recent regulation -- particularly the Generics Act. The Generics Act was passed in 1988 and became effective in 1990, to encourage the use of generic names in all aspects of drug manufacturing and dispensation in order to ensure adequate supply at the "lowest cost possible". This law requires all single formulation drugs to have the generic name printed as large as the brand name on the packaging. Although the law is not yet fully enforced, it has already impacted the medical and drug community and most are in compliance.

Finally, the Local Government Code (LGC) which will devolve the responsibilities and functions of the central government through the various Departments down to the local government unit level, was passed in late 1991. However, controversy and debate still surrounds the devolution in health, which includes family planning services. All the parties that PROFIT spoke to in recent trips have voiced their concerns or expectations regarding the potential effects of devolution on family planning service delivery efforts. A team was requested by USAID/Manila to specifically address the repercussions of the devolution program on the health sector. The team was generally optimistic about the program's success and recommended financial and technical assistance to boost the structures that are already in place. A.I.D.'s RAPID Project is pursuing follow-up activities by establishing pilot projects to assist various local government units (LGUs), initially in Region XI, the province of Pangasinan and the city of Iloilo, to strengthen their population programs.

PROFIT is cognizant of local regulation and its potential effect on local ventures, as well as the ongoing activities of other A.I.D. funded projects in the area of policy reform such as HFDP, OPTIONS, and RAPID. PROFIT is willing to assist, if an appropriate role is determined, towards the reform of any regulatory barriers to private sector activity, and as part of USAID/Manila's strategies for achieving family planning program goals.

Financial Transfer Mechanisms

As part of the Central Bank's debt equity conversion program, a category of "high social impact" programs has been established that would include most projects by NGOs. Debt-for-Development Coalition has estimated a yield of 30-35% increase in local currency for project funds. No taxes are applied to debt conversions. Other USAID projects have

shown relative success in utilizing the debt conversion mechanisms available to finance local projects, including USAID's Child Survival project and the establishment of a green fund utilizing a debt-for-nature swap to finance a local environmental undertaking. PROFIT seeks to utilize this mechanism alongside a project intervention to assist in leveraging funds.

As mentioned earlier, the credit market is considered tight, capital is inadequate and expensive especially for hospitals which are financed mostly by doctors. These conditions warrant the consideration of financial mechanisms such as revolving funds or loan financing for doctors and other practitioners given the poor condition of infrastructures in health facilities and the shortage of capital.

IV. POSSIBLE AREAS FOR PROFIT INTERVENTION

The previous section provided an overview of the Philippine health and family planning environment in the sectors relevant to PROFIT's mandate. The overall conditions in the Philippines, provide timely and effective arguments for increased private sector interventions. These conditions are:

- A large unmet need for family planning/contraceptive services
- The lack of resources in the public sector to meet these needs, and strong political support to expand overall family planning program efforts, and
- A positive business climate, despite difficult economic conditions.

Previous sections also discussed areas of related activity by other USAID/Manila or A.I.D.-sponsored initiatives. Given these conditions, the PROFIT Project serves as a complement to these other activities, in assisting the Mission and the GOP achieve their family planning goals. PROFIT's participation is one additional component in what could be viewed as a wide-reaching and comprehensive strategy to attack the country's overpopulation crisis from all possible fronts.

PROFIT's mandate is to increase the resources for family planning by encouraging greater private sector involvement. PROFIT seeks to utilize a flexible, innovative approach to investing in sustainable commercial family planning ventures that will have a positive impact on family planning.

PROFIT serves a rather specific target market, a market that is willing to pay for family planning services in the private sector, and by so doing allows the public sector to devote already scarce resources to those who need them the most. However, PROFIT recognizes that the prevalence of poverty, an adverse economic environment, and the opposition that exists from the Catholic Church, requires that we take a creative and flexible approach if, in fact, we are to achieve our challenging mandate.

Based on trips made by PROFIT's core staff to the Philippines, and numerous meetings with various groups from both the public and private sector, PROFIT proposes to undertake the interventions listed below. Concept papers are attached for each proposed activity.

A. TEST MARKETING A LOW COST HEALTH CARE PLAN TO PROVIDE FAMILY PLANNING SERVICES

PROFIT proposes to undertake a joint venture activity with PhilamCare to test market a low cost health care plan. PROFIT will share in the risk, thus acting as a "social" investor along with PhilamCare, a commercial operation that would not normally undertake such a venture alone. Further realizing that family planning is politically controversial, and thus commercially difficult to sustain, family planning services will be provided within the context of a wider array of maternal and child health (MCH) services, a strategy not unlike those of other service providers. Furthermore, the provision of basic health care services addresses the perceived needs of the lower income groups, the target market of this health plan.

B. FUND FOR FAMILY PLANNING PROVIDERS IN UNDERSERVED AREAS

PROFIT proposes to establish a fund that would allow private health and family planning providers to gain access to low cost capital. Financial and other incentives will be specifically geared towards: (1) practitioners who would like to establish their practice in underserved areas and offer family planning services (2) practitioners already practicing who would like to expand their practice and add family planning services.

The fund would encompass a wide array of incentives and support mechanisms including information dissemination, training, and access to equipment and commodities. PROFIT proposes to establish pilot projects with one or two local organizations, and has already initiated discussions in this regard with the Philippine Medical Association.

C. ASSISTANCE IN EMPLOYER-BASED ACTIVITIES

PROFIT proposes to assist in expanding or building upon current efforts in industry-based family planning programs, with a view to ensuring the program's commercial and family planning sustainability. While Section 599 of the Foreign Assistance Act temporarily prohibits the use of A.I.D. funds to assist Export Processing Zones, PROFIT seeks to expand assistance through Industrial Estates and other large employers that are yet to be targeted. Programs would be carried out in collaboration with PCPD.

PROFIT also proposes to assist where necessary current ongoing family planning program efforts including:

- technical or financial assistance in improving NGO sustainability activities; and
- financial assistance to Upjohn or SOMARC in the marketing and distribution of the injectable Depo Provera.

Appendix A
CONCEPT PAPERS

CONCEPT PAPER

Test Marketing a Low Cost Health Care Plan to Provide Family Planning Services

I. INTRODUCTION

The political, social and economic circumstances prevailing in the Philippines over the last decade have caused a setback to the effective provision of health services, especially family planning services. Meeting the growing unmet needs for family planning services has now become an urgent priority of the current administration. However, public officials recognize that the public sector alone cannot meet all these needs. It is therefore timely and necessary for increased private sector intervention in the delivery of family planning services in the Philippines. Private sector intervention will likely include the NGO sector, large employers, private providers, commodity suppliers and private health insurance. Given that private health insurance currently finances a small portion of health expenditures, there is much room for the expansion of risk-sharing mechanisms, and low cost health insurance in particular.

II. HEALTH INSURANCE IN THE PHILIPPINES

Recent studies note the high proportion of private expenditures (64%) to total health care expenditures. A great majority of these expenditures are out-of-pocket expenses. Medicare, the compulsory health insurance system, covers 40% of the population (both public and private formal sector workers) yet finances only 7% of total health care spending. Part of this is explained by the limited coverage that Medicare provides -- benefits cover inpatient care only, does not include drugs, and are not indexed to price increases.

Private insurance comprises a mere 2% of total health care spending, which provides much room for expanding risk-sharing mechanisms. Current health care financing is particularly difficult for the lower income groups and members of the informal economy who are not covered by Medicare. While HMOs are still new in the Philippines and cover no more than 2% of the population, the market is expected to grow. However, the public still lacks knowledge on the benefits of managed health care plans.

A recent paper written under the HFDP noted that "many HMOs still complain of the lack of knowledge of the public concerning insurance" and that "private health care institutions can benefit from Medicare if it provides the population with a demonstration of the benefits of being insured".³ These conditions underscore the need for private sector intervention to help inform and educate the public on the advantages of pre-paid health insurance.

³ Results of Recent Research Concerning Medicare in the Philippines, HFDP (1993)

III. THE ENTERPRISE PROGRAM'S FEASIBILITY STUDY

The concept of a low cost health care plan was evaluated in a feasibility study done in 1991 by Arthur Andersen (Phils.) for John Snow, Inc. (JSI) under the Enterprise Program.⁴ The study assessed various proposed schemes for providing health services to underserved areas. The low cost health care scheme involves the expansion of services by an existing health maintenance organization. For purposes of the study, the Pasay Metro Manila Fish Dealers and Vendor's Association (PMMFDVA) was identified as the target market, representing a small market with 280 members and 1,050 dependents. The product used was PhilamCare's (low-end) Pearl Plan, which offers both outpatient and inpatient benefits and can be used in any of the clinics and hospitals affiliated with PhilamCare. PMMFDVA would coordinate with PhilamCare in offering the Pearl Plan to its members and dependents.

Though financial feasibility was not encouraging, the market was deemed "too attractive to abandon". The study suggested that an HMO actually enter the market through a test marketing activity. To do so, two alternatives were presented: (1) create a lower cost HMO package to limit the financial risks of the HMO and make it more affordable to the potential target market, and (2) utilize existing products such as PhilamCare's Pearl Plan.

Other findings:

- A new low cost health care plan may incur higher costs due to the higher risk classifications of the target market and non-coverage by Medicare. Premium rates will therefore have to be adjusted upwards, at rates which may prove difficult for the target group.
- Financial analysis projected a US\$50,000 (1.3 million Pesos) revenue shortfall for the three year test-market period.

IV. THE PROPOSED PROJECT ACTIVITY : LOW COST HEALTH CARE PLAN

Based on the above-mentioned study and extended discussion with PhilamCare, PROFIT proposes to undertake the test marketing activity as a joint venture with PhilamCare. In particular, the test activity will devise and assess a new low cost health care plan, that will differ from existing plans such as PhilamCare's Pearl Plan. The test marketing activity will build on the assumptions raised in the Enterprise study, but further proposes to:

- (1) increase and widen marketing efforts to include members of both the formal and informal sector;

⁴ "Feasibility of Moving Health Manpower and Family Planning Services to Underserved Areas through Private Sector Initiatives" (John Snow, Inc., 1991)

- (2) broaden the size of the trial, both in volume and in location;
- (3) assess various methods for cost containment and reimbursement, possibly through increased public-private sector collaboration to help maintain reasonable rates; and
- (4) include family planning as an important feature of the plan.

PROFIT would participate in the test activity as a joint venture partner with PhilamCare in ensuring the inclusion of a viable family planning component within the context of the proposed low cost health care plan and to provide additional funding for the proposed activity. PROFIT places emphasis on creating **sustainable** projects, both in terms of a project's commercial viability and its family planning impact. Though the proposed venture entails a substantial financial risk, should it succeed, it would present a unique opportunity to provide family planning and other health care services to the members of the population with the greatest need. The feasibility study states that PhilamCare is the most viable HMO to undertake this activity. As a market leader, PhilamCare's willingness to participate in this activity is important to the implementation of the proposed low cost health care plan.

Features of the Plan

The proposed scheme would feature the following:

- **Target market.** Low income groups with emphasis on the informal sector although it will be marketed also to people in the formal sector. Designation of two or three possible geographical areas to serve as the market base, to be determined according to high concentrations of the population.
- **Market Strategy.** Direct selling by trained agents who will earn a commission on sales. Barangay chairmen and leaders in low-income areas, officers of various associations, cooperatives and NGOs, and large employers within the locality will be approached as part of the sales effort. To make health insurance more available, PhilamCare will expand its efforts to create a larger insurance pool with a view to spreading the risk more broadly thereby lowering the cost of premiums.
- **Costs and Services.** Cost levels and premium rates need to be assessed further. PhilamCare has mentioned that no annual physical examination would be provided under the plan and that family planning coverage will include free, unlimited consultations, provision of family planning supplies at subsidized rates, insertion of IUDs etc.
- **Service Sites.** Policy holders will be restricted to receipt of services at designated local hospital site, where medical services will be capitated. Centralization of services, capitation and other managed care features are necessary to control costs. By managing the servicing hospital, the provider can install the control mechanisms for access and utilization of health services needed to stay within budget.

An essential component in instituting measures to contain costs is the availability of designated service delivery sites to the test marketing activity. PROFIT has met with a number of medical establishments and discussed possibilities for entering a lease-management relationship with PhilamCare to enable the provision of services through designated sites. Prospective sites include: (1) Manila Medical Center (Metro Manila); (2) Sacred Heart Hospital (Cebu); and (3) Brokenshire Hospital (Davao). As the trial progresses, PROFIT envisions the consideration and inclusion of other providers such as clinics and local health centers.

It is hoped that through the implementation of this test marketing activity, other considerations could be addressed such as: (1) possible expansion into other geographical areas, such as per-urban and rural areas; (2) additional means of increasing private sector participation in family planning through health insurance; and (3) increased collaboration with the public sector, through utilization of local government and other public hospitals or health facilities.

V. PROPOSED NEXT STEPS

Prior to carrying out the proposed test marketing of the low cost health care plan, the following next steps need to be completed:

1. Assess target population in terms of demographics, including ability and willingness to pay for low-cost health care plan.
2. Define the geographical areas, and the proposed market in each area. In particular, identify two to three geographic areas to serve as test sites, in consultation with MOH, AID, HFDP and PhilamCare. Areas should meet the following criteria:
 - Sufficiently large catchment area or target population
 - Access to an appropriate delivery site
 - Presence of organized groups (informal or wage-based).
3. Determine appropriate facilities for service delivery under the test program, including the potential for effective and cost-efficient delivery of family planning services.
4. Analyze PhilamCare's proposed health care plan for family planning impact, quality of care and service delivery through designated sites.
5. Analyze cost projections and actuarial assumptions of PhilamCare's proposed health care plan.
6. Define the roles and participation of each joint venture partner.
7. Develop and submit investment document for approval.

Staff and Timing Requirements:

Upon approval of the above concept, two consultants would be hired in a phased approach, to conduct the steps outlined above. A scope of work, along with projected level of effort and resumes of proposed consultants would be presented for approval.

CONCEPT PAPER

Fund for Family Planning Providers in Underserved Areas

I. INTRODUCTION

Much has been mentioned in recent years on the deteriorating health services delivery in the Philippines. Government expenditures on health has been described as historically low, even by developing country standards, averaging 2.5% of GNP. Even more disturbing is the access to health services. It is estimated that 68% of doctors and 88% of nurses leave annually to practice abroad. The continuous emigration of the country's doctors and nurses creates a huge gap in meeting the health services needs in the Philippines.

The problem gets worse when access is related to geographical distribution. An estimated half of all practicing doctors are in the Metro Manila area. There is little economic incentive for medical professionals to practice outside the big cities, or to deliver family planning services. This has resulted in an alarming shortage of private providers to help meet the needs of women seeking health and family planning services.

Furthermore, access to credit and low cost capital in the health sector is poor. The means for providing sufficient economic incentives to lure the unmet health and family planning needs, particularly in underserved areas, are a constant challenge.

II. PROPOSED ACTIVITY: FUND FOR FAMILY PLANNING PROVIDERS

PROFIT proposes to establish a fund that allows access to credit and low cost capital, particularly to private health and family planning providers. Financial and other incentives will be specifically geared to:

- (1) those who would like to establish their medical practice in underserved areas, and intend to practice in family medicine, including family planning; and
- (2) those who are currently practicing family medicine and would like to improve or expand their services in family planning.

Eligibility for financial support would emphasize the addition or expansion of family planning, and such support would include training as needed. The fund will be established in coordination with a local institution. Incentives would include:

- Access to credit, guarantees and leasing arrangements
- Favorable rates of interest, and flexible terms
- Access to equipment and supplies
- Technical assistance in clinics' business management
- Family planning training and IEC materials

Pilot Projects

PROFIT intends to identify and select at least two local organizations with which to develop this proposed activity. The Philippine Medical Association (PMA) has shown interest in collaborating with PROFIT on this venture (a concept paper from PMA is attached).

PROFIT also needs to consult with Nurses and Midwife associations for potential participation since nurses and midwives provide a significant portion of family planning services.

III. NEXT STEPS

The following are the proposed next steps, should there be agreement on this concept:

1. Define target group for financial assistance: Doctors, Nurses, Midwives, etc.
 - Evaluate available data on providers offering family planning services including private/public provider and client shares, access to credit, services currently provided.
 - Meet with appropriate institutions such as PMA, Nurses and Midwife Associations to evaluate their level interest and ability to reach providers, organize training and possibly administer program.
2. Define project financial parameters:
 - Determine credit needs of target providers.
 - Determine financial feasibility of re-payment terms, i.e. loan size, credit terms, re-payment schedule, collection process, collateral issues in addition to sustainability and financial risks.
 - Explore legal and taxation issues of setting up a local credit facility.
 - Identify the appropriate mechanism for administration of loans, i.e. is it handled directly through the institutions such as PMA or managed through a financial intermediary such as a bank.
3. Determine training needs of providers (business and family planning) and appropriate mechanism for providing training services.
4. Determine needs and identify sources for supplies and equipment.
5. Develop and submit investment document for approval.

Staff and Timing Requirements: Core Staff -- three months;
Consultant -- one month.



Philippine Medical Association

Member: World Medical Association (WMA); Co-Founder Confederation of Medical Association in Asia and Oceania (CMAAO); Co-Founder: Medical Association of Southeast Asian Nations (MAS)
Address: PMA Bldg, North Avenue, Quezon City P.O. Box 4039, Manila Cable Address: PHILMEDAS Quezon City Telephone Nos.: 97-35-14; 99-21-32 FAX No.: 97-49-74

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CONCEPT PAPER

I. IDENTIFYING INFORMATION

Project Title : PMA Doctors in Family Planning Service Delivery Towards Self-Reliance

Proponent : Philippine Medical Association

Target Area : Nationwide

Project Duration : Two Years

Project Components : FP/MCH Service Delivery, Self-Reliance

Funding Request : P3,276,000.00 or US\$136,500.00

Contact Persons : Dr. Iva C. Anastacio
Chairperson
Committee on Family Planning
Responsible Parenthood
Tel. Residence - 818-10-37
Office - 87-39-34

Dr. Primitivo D. Chua
President, PMA
Tel. Residence - 801-61-95
Office - 97-35-14; 99-21-

II. EXECUTIVE SUMMARY

This is a multi-pronged project that fulfills various dimensions of the Philippine Family Planning Program. First, project aims to widen the service delivery network of the prog by co-opting new medical graduates interested to pursue a care in ob-gyne and family medicine. They will be the direct beneficiaries of the project. This will be achieved by offering t a package of benefits and technical assistance that will enabl them to practice their profession. The package will consist o a loan on an easy term to start a clinic with basic clinical equipment, training, technical assistance and provision of Family Planning materials. In return, an agreement will be fo between the direct beneficiaries and the PMA so that the forme will render family planning and MCH services.

This scheme is expected to help fill the gap in personnel requirements needed to service the more than 2.3 million married women of reproductive age who want to avail of family planning services.

In the process of recruiting and training physicians who will participate in the FP service delivery network, the project will also help professionalize and upgrade the skills of medical practitioners in the field. The net effect is improved quality of care and services.

Second, this will contribute to the attainment of self-reliance goals of the proponent in family planning endeavors. The returns from assistance provided to the direct beneficiaries will form part of the seed fund that will be used by PMA to replicate the project in other areas. The minimal interest that will be generated is expected to boost the seed money and provide similar assistance to more qualified beneficiaries. This scheme will enable PMA to help new graduates start their careers and at the same time attract more practitioners in family planning service delivery.

The performance of the project will be monitored by the Chairman of the Committee on Family Planning and Responsible Parenthood of the PMA. A set of quantifiable service goals and financial indicators will be established to serve as basis for measuring performance of the beneficiaries. Quarterly reports using prescribed forms will be collected and consolidated by the proponent to determine whether the project is on track or not.

A primer explaining the goals of this project as well as the mechanism for availing of assistance will be developed to serve as a promotional material and guide for beneficiaries.

The project is slated for two years during which the first batch of beneficiaries are expected to complete the payment of their loans.

III. OBJECTIVES

General : To contribute to the goals of Philippine Family Planning Program in providing family planning and maternal and child health services to married couples of reproductive ages as a means of improving their social, physical, and economic lives.

Specific :

At the end of the project period, the following should have been accomplished -

1. Recruitment of at least 45 physicians nationwide who will render family planning and MCH services;

2. Provision of capital investment assistance to at least 45 physicians;
3. Provision of technical and training assistance to at least 45 physicians;
4. Full recovery of loans granted and at least 10% return on this investment;
5. Management of the project according to standards and guidelines of PMA and the funding donor.

IV. STRATEGIES AND METHODOLOGIES

The management of this project will be the direct responsibility of the Chairperson of PMA Committee on Family Planning and Responsible Parenthood. She will work with the office of the PMA president who will act as consultant to the project. Program operation and administration will be handled by the said chairperson who will serve as Project Director.

The scheme will be promoted among selected medical colleges and universities nationwide. An English primer will be developed to explain the goal of the project and how to avail of the assistance. The salient operational mechanisms will also be explained in this primer. This promotional material will be sent to the secretariat of medical schools together with the invitation to participate in the project. PMA will also conduct a survey/inventory of its new members and invite them to this program. Promotion will also be done during professional gatherings.

To be chosen as beneficiaries are new graduates or doctors who are just starting their careers and who wish to specialize in obstetrics-gynecology and/or family medicine.

An application form which will serve as an improvised project proposal will be filled-up by interested physicians. Basic information such as clinic location and type of clientele, basic demographic information in his/her area (if available), level of skills and experience in family planning, career goals, and financial capacity will be included in the application form. The clinic space will be the beneficiary's counterpart.

Applicants who pass the criteria will undergo orientation of the project. Afterwards, they will receive basic clinical equipment worth P50,000 that will help them start up and render family planning and MCH services. These equipment will be given as a soft loan. Payment will be stretched in eighteen months with minimal interest. The proponent will seek professional advice of the donor in developing the repayment scheme of the project. It is expected that the first payment will be made six months after the delivery



of equipment and every three months thereafter. A set of policies for incidence of default, breakage of equipment, etc. will be developed in consultation with the donor.

Apart from capital assistance, the project will also lend training opportunities to beneficiaries by sending them to the Department of Health (DOH)-accredited family planning training courses. Part of the training cost will be assumed by the project as a grant to the beneficiaries. The proponent will also access international training program related to family planning. Resources for international training will be tapped from other donors. Other technical assistance such as accreditation assistance, financial management, etc. will also form part of the loan package.

IEC materials that will be given to beneficiaries will be taken from the DOH. Loan beneficiaries will be referred to local DOH offices for their family planning requirements.

A total of 45 rural and urban physicians will benefit from this project. Fifteen (15) beneficiaries will be chosen from the three major islands of the country. A screening committee will be formed to determine the list of qualified applicants.

V. PLAN OF ACTION

Activity	Timeframe	Person Responsible	Expected Output
1. Hire project personnel	Month 1	Project Director (PD)	Qualified applicants screened and employed
2. Establish grant/loan mechanism	Month 2	PD, PMA President	Policies and loan procedures formulated and finalized
3. Develop primer	Month 2	PD, Consultant	Draft of primer ready for printing
4. Print primer	Month 2	Administrative Assistant (AA)	200 copies of primer printed
5. Promote project	Month 3	PD, PMA Pres.	200 persons given information about the project

6. Screen applications	Months 4-5	Screening Committee	Applications processed and selected
7. Make grants	Months 6-7	PD, Project Staff	45 beneficiaries given loan package
8. Monitor project	Months 2-23	PD	Project strengths and weaknesses identified and acted upon
9. Prepare reports	Quarterly	PD	Quarterly reports ready for submission
10. Evaluate project	Months 12 and 24	PD, Project Staff, PMA President, Donor Representative, Selected Beneficiaries	Evaluation report

BEST AVAILABLE COPY

1. PROJECT BUDGET

Particulars	Rate/Month	Year I	Year II	Total
I. PERSONNEL				
Project Director (P.T.)	5,000.00	55,000.00	71,500.00	126,500.00
Accountant (P.T.)	3,000.00	39,000.00	42,900.00	81,900.00
Adm. Assistant (F.T.)	4,000.00	52,000.00	57,200.00	109,200.00
Fringe Benefits		12,000.00	12,000.00	24,000.00
Sub-Total				351,500.00
II. TRANSPORTATION				
Local Travel and Per Diem		60,000.00	72,000.00	132,000.00
III. SUB-GRANTS				
		2,250,000.00		2,250,000.00
IV. EQUIPMENT/FURNITURE				
Office Equipment		50,000.00		50,000.00
V. MATERIALS & SUPPLIES				
Office Supplies		14,400.00	18,000.00	32,400.00
VI. OTHER DIRECT COSTS				
Primer		15,000.00		15,000.00
Communication	2,500.00	30,000.00	30,000.00	60,000.00
Auditing		30,000.00	40,000.00	70,000.00
Training		315,000.00		315,000.00
Sub-Total				460,000.00
GRAND TOTAL				3,276,000.00

U.S.\$ 136,500.00

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VII. MONITORING AND EVALUATION

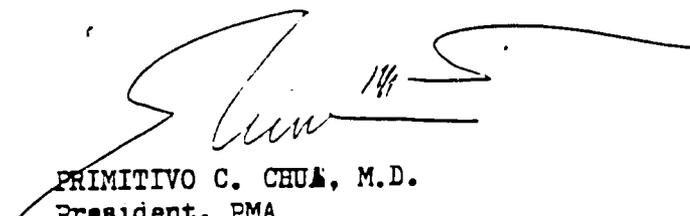
The following will be used as monitoring tools/instruments :

- o review of reports
- o field visit
- o assessment activities

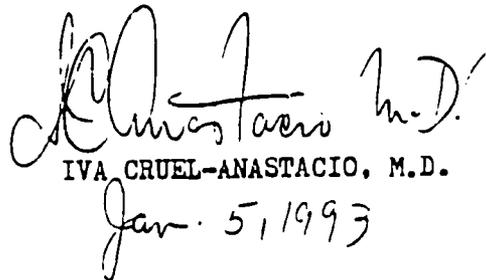
Performance of the project will be measured through the following indicators :

1. achievement of project objectives
2. number of FP/MCH services rendered by direct beneficiaries
3. number of FP clients serviced by direct beneficiaries
4. percent of returns vis-a-vis timeframe

The Project Director will be responsible for monitoring operations of the project. Annual evaluation will be conducted to establish the impact of the project and determine future directions/plans. The evaluation will be participated in by the project staff, donor representatives, PMA officials, selected beneficiaries, and outside facilitator.



PRIMITIVO C. CHUA, M.D.
President, PMA



IVA CRUEL-ANASTACIO, M.D.

Jan. 5, 1993

CONCEPT PAPER

PROFIT Assistance in Employer-Based Family Planning Programs

I. INTRODUCTION

Employer-based family planning services are often cited as an effective strategy for increasing the private sector's participation in the delivery of family planning services. This has proven particularly true in the case of the Philippines, where there is a well-developed industrial sector. More than half of the Philippine economy is based in the formal sector and a significant portion of the labor force is employed by large employers.

Since the mid-1970s, large employers were required by law to operate clinics or infirmaries for their workers, and were further required to offer family planning services. Though compliance among companies is weak, many companies are open to initiatives that assist in the promotion of family planning services on-site. Previous initiatives by A.I.D.'s Office of Population, namely the Enterprise Program and TIRPS, have found the Philippines to be an ideal setting within which assistance for work-based family planning programs might be beneficial.

II. A.I.D. AND WORK-BASED FAMILY PLANNING IN THE PHILIPPINES

The Enterprise Program developed employer-based projects with large employers such as Benguet Gold Operations, a mining company with local mine sites, and Matling Industrial & Commercial Corporation, a privately owned agricultural plantation. In these cases, Enterprise found that "plantation-type" companies with resident work forces, and therefore more expensive benefit programs, recognize the financial advantages of family planning programs most readily.

The concept of partnership between NGOs and industry was also found to be positive.⁵ In addition to a project with the Cebu chapter of the Personnel Management Association of the Philippines (PMAP), one of the endeavors under the Enterprise Program was a work-based family planning project with PCPD, then known as PCF, a respected family planning NGO. PCPD began with an Industry-based family planning project in 1985 with a first-round of 30 companies in the Metro Manila area. Enterprise funded a second round of "Responsible Parenthood" programs, and the program is now on its "third round" with a buy-in from USAID/Manila through 1994.

Pursuing health and family planning objectives through employer-based activities constitutes an important element of private sector health financing mechanisms, consistent with A.I.D. strategy and objectives, as well as those of USAID, as expressed through HFDP objectives.

- "Enterprise in the Philippines" (John Snow, Inc. 1990)

III. PROPOSED ACTIVITY : EXPANSION OF EMPLOYER-BASED FAMILY PLANNING PROGRAMS

The above mentioned industry-based program has been recently cited by A.I.D. as "one of the Philippines's most impressive family planning programs". Nevertheless, suggestions were made on ways to strengthen the current program. In particular, a geographical expansion was suggested which might include the growing Export Processing Zones. HFDP also includes employer-based health financial mechanisms in private sector interventions as an area for further study as well as possible demonstration activity.

Given that employer based programs are included as one of PROFIT's areas of focus, PROFIT proposes to build on the successes of the current programs by assessing opportunities for expansion. While Section 599 of the Foreign Assistance Act temporarily prohibits the use of A.I.D. funds to assist Export Processing Zones, PROFIT seeks to expand assistance through Industrial Estates and other large employers as yet to be targeted, possibly through collaborative efforts with PCPD.

PROFIT is also considering a proposal from PhilamCare to open an outpatient clinic at the Laguna Light Industry & Science Park, located outside Manila. The park's clinic is expected to serve a total work force of approximately 40,000 people and their dependents.

In exploring these opportunities, PROFIT can offer a wide range of assistance to ongoing as well as new work-based programs. This may include technical assistance, cost benefit analyses, investment in on-site facilities, and collaboration with providers seeking to serve employee populations.

IV. PROPOSED NEXT STEPS

1. Meet with PCPD and discuss opportunities for collaboration and project expansion.
2. Determine feasibility and timing of an employee-based program at Laguna Industrial Park.
3. Assess other possible mechanisms for program expansion.

Staff and Timing Requirements: Core staff -- one month.

Appendix B
SELECTED BIBLIOGRAPHY

- Country Opportunity Series: The Philippines (Debt for Development)
- Doing Business in the Philippines (Price-Waterhouse Information Guide)
- Enterprise program (trip and final project reports)
- Family Planning and Child Survival Programs (1991) The Population Council
- Feasibility of Moving Health Manpower and FP Services to Underserved Areas Through Private Sector Initiatives (SGV & Co., Manila, Philippines)
- Far Eastern Economic Review (various issues)
- HFS Project - trip reports and papers
- Insurance and Development of the Private Medical Sector in the Philippines: History and Prospects for Change (Griffin, et.al. 1992)
- Investment in the Philippines (KPMG Peat Marwick Guide)
- OPTIONS Project - Briefing Packet and trip reports
- RAPID Project - trip reports
- Results of Recent Research Concerning Medicare in the Philippines (HFDP, 1993)
- SOMARC Project - Philippine Country Assessment and trip reports

Appendix C GLOSSARY

Contraceptive prevalence rate (CPR) - percentage of married or in-union women of reproductive age (15-44) who are using (or husbands are using) any form of contraception.

Contraception - conscious effort of couples to avoid conception through rhythm, withdrawals, abstinence, male or female sterilization, or use of contraceptives: intrauterine device (IUD), oral contraceptives; injectables; condoms; spermicides; and diaphragm.

Unmet need - refers to the need for contraception by women who would like to space or to limit births, who are not using contraception and who are exposed to the risk of pregnancy.

Barrier methods - condoms, diaphragms, spermicides

All methods - include modern and traditional methods

Modern methods - includes clinic and supply methods such as pills, condoms, IUDs and sterilization

Traditional methods - do not depend on the use of products or devices, such as periodic abstinence, rhythm or withdrawal.

Total demand for family planning - sum of contraceptive prevalence and unmet need

Appendix D
DEMOGRAPHIC STATISTICS

Population (000)	Total		62,413
	Male		31,365
	Female		31,048
	Urban		26,602
	Rural		35,811
	Percent urban		42.6
Population/year 2000			77,473
Functional age groups (%)	Child	(0-4)	14.7
		(5-14)	25.4
	Youth	(15-24)	19.8
	Elderly	(60+)	5.3
		(65+)	3.4
	Women	(15-49)	24.6
Median age (years)			19.7
Dependency ratios (%)	Total		77.0
	Age	0-14	71.0
	Age	65+	6.0
Agricultural population density (hectare of arable land)			3.5
Population density (/km ²)			208
Average annual change (000)	Population increment		1,504
	Births		2,011
	Deaths		467
	Net migration		-39
Annual growth (%)	Total		2.3
	Urban		3.6
	Rural		1.2
Crude birth rate			30.4
Crude death rate			7.1
Net migration rate (/1000)			-0.6
Total fertility rate (/woman)			3.9
Gross reproduction rate (/woman)			1.9
Net reproduction rate (/woman)			1.7
Infant mortality (/1000 births)			40
Life expectancy at birth (years)	Males		63.1
	Females		67.0
	Both sexes		65.0
GNP per capita (\$ US, 1989)			710

Source: UNFPA, *Inventory of Population Projects in Developing Countries Around the World, Options Database*