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**A STRATEGY TO INCREASE
PRIVATE COMMERCIAL
SECTOR INVOLVEMENT IN
THE PHILIPPINES FAMILY
PLANNING PROGRAM:
SITUATION ANALYSIS**

by

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TABLE OF CONTENTS

	<u>PAGE</u>
EXECUTIVE SUMMARY	2
I. BACKGROUND	3
A. Brief Overview of the Philippine Economy and the Social Reform Agenda	3
B. The Philippine Family Planning Program (PFPP)	5
C. The PROFIT Project	5
II. THE PRIVATE COMMERCIAL SECTOR (PCS) IN THE PFPP	7
A. The Present	7
B. The Goal	11
III. ISSUES AND CONCERNS RAISED BY PRIVATE COMMERCIAL SECTOR GROUPS	14
A. Department of Health (DOH) - PCS Communication Links	16
B. Training	17
C. Access to FP Information, Education, Communication (IEC) Materials	20
D. Access to FP Products and Services of the DOH	22
E. Market Segmentation	23
F. Government Incentives	24
G. Distribution of DOH FP Supplies	26

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INVOLVEMENT IN THE PHILIPPINE FAMILY PLANNING PROGRAM:
SITUATION ANALYSIS**

EXECUTIVE SUMMARY

PROFIT (PROmoting Financial Investments and Transfers) is a USAID-funded project which seeks to mobilize private sector participation in family planning (FP) - related activities in developing countries. As a collaborating agency under the Philippines' Department of Health (DOH) Integrated Family Planning Maternal Health Program (IFPMHP), PROFIT was requested to provide assistance to the DOH in developing a strategy to enhance the role of the private commercial sector in the PFPP.

To achieve this mandate, PROFIT conducted several interviews from June to August 1995 with representatives from private commercial sector groups (e.g. medical professional associations; private medical providers - HMOs, hospitals, and companies; pharmaceutical companies) whose resources could be tapped for the PFPP. Through these interviews, PROFIT was able to identify certain issues and concerns that constrain these private commercial sector groups from increasing their involvement in the PFPP.

In addition, PROFIT commissioned two studies on private medical providers and their clientele. The first study, entitled "*Attitudes and Practice Survey Among Health Professionals in the Private Sector*", aimed to identify private providers' attitudes and practices regarding FP and to explore their views on the barriers and incentives to offering private sector FP services. The second study, entitled "*Consumer Survey on Preferred Source of Basic Health Care and Family Planning Services*", aimed to augment the findings of the provider survey. The supply side information gathered from the providers could best be utilized if analyzed against meaningful demand side information from consumers.

This paper presents and discusses the issues raised by the private commercial sector groups during the interviews. It also includes relevant findings from the two commissioned studies. The paper is meant to be circulated among key people at the DOH, USAID Manila, collaborating agencies, private commercial sector representatives, and other Government of the Philippines (GOP) agencies (e.g. Population Commission (POPCOM), National Economic and Development Authority (NEDA), etc.) for their comments and suggestions, in order to solidify the issues. This process of consultation will serve to crystallize the action steps necessary to address the issues and thus be a basis for an overall strategy for increasing private commercial sector involvement in the PFPP. The paper can also be used as an input to the **National Family Planning Program Strategy** document presently being updated by the DOH with the assistance of the POLICY Project of USAID.

I. BACKGROUND

A. Brief Overview On The Philippine Economy And The Social Reform Agenda

In his year-end *Ulat sa Bayan (Report to the Nation)*, President Fidel V. Ramos heralded the sustained growth exhibited by the economy in 1995 as contributory to the **Social Reform Agenda** of his administration. Gross National Product (GNP) growth was 5.5 per cent in 1995, an improvement over the 5.3 per cent growth in 1994 and 2.8 per cent growth in 1993. During the same period, price levels were kept relatively stable as inflation averaged a moderate 8.2 per cent each year. *(The latest official report of the National Economic and Development Authority (NEDA) shows that GNP growth for the first quarter of 1996 accelerated even further to 6.2%.)*

Accompanying this growth was an improved employment situation as evidenced by the 9.5 per cent unemployment rate registered in 1995. Based on the latest **Labor Force Survey**, new jobs created in January 1996 exceeded the one million mark, leading to a lower unemployment rate of 8.3 per cent from 8.8 per cent in January 1995. Interest rates (as measured by the 91-day Treasury bill weighted average rate) declined during 1995 posting an average of 11.3 per cent during the first eleven months of the year versus the 13.7 per cent actual rate for the same period in 1994.

In the battle against poverty, the **Family Income and Expenditures Survey** revealed that poverty incidence has declined to 36 per cent in 1994 from 40 per cent in 1991. The **Social Reform Agenda** is government's main strategy to fight poverty. Interventions have been identified in three main areas: (1) ensuring access to quality basic services; (2) ensuring access to productive resources and economic opportunities; and (3) enabling ordinary Filipinos to actively participate in formulation and implementation of policies and programs which affect their welfare and interests. These interventions were specifically aimed at pre-identified beneficiaries, namely the marginalized sectors (indigenous peoples, urban poor, women, children, youth, senior citizens, landless farmers and rural workers, coastal fishermen, unskilled workers, etc.) and disadvantaged geographical areas (19 poorest provinces and pockets of poverty).

Among the quality basic services that receive priority are health, nutrition and housing as these immediately impact upon the welfare and income prospects of the poor. In 1995, the government through the DOH intensified the implementation of mass-based health and nutrition programs in order to sustain the gains achieved during the previous years. These programs included the National Immunization Day (*Oplan Alis Disis*), Micro-nutrient Day (*Araw ng Sangkap Pinoy*), Doctors to the Barrios Program, Promotion of Mother-Baby Friendly Hospitals, Micro-nutrient Supplementation and Food Fortification and the People's Health Day (*Araw ng Kalusugan*).

In the population front, the 1995 Census of Population conducted by the National Statistics Office (NSO) placed the country's population at 68,614,162 as of September 1, 1995 with an annual growth rate estimated at 2.32%. The Population Commission (POPCOM) revealed at a Senate hearing that the total number of Filipinos hit the 70 million mark in September 1996, making the Philippines the 13th most populous nation in the world. President Ramos recently re-affirmed his administration's commitment to pursue a population policy that will support, and not derail, economic development objectives. In his keynote address at the *Food Security Summit* last January 26, 1996, the President stated:

"The pressure of our high population growth rate and increasing household requirements are taking a big chunk of the government budget, leaving less for the improvement and development of our agriculture, such as support and training of farmers, improved agricultural and irrigation technology and research development -- all necessary to achieve improved agricultural outputs. Quite clearly, we cannot long afford the effects of this high population growth rate and the highly vulnerable condition of our natural resources and environment . . ."

This theme was reiterated by the President during his address at the opening ceremony of the *National Anti-Poverty Summit* on March 19, 1996:

". . . I told you a while ago we can win the war against poverty, but we can still lose it . . . The task will not be easy. There are many constraints -- including the country's 69 million strong population, which grows by 2.3 per cent every year. If population is improperly managed, we could have 120 million Filipinos in about 24 years. This will stretch to unsustainable limits the carrying capacity of our natural resource base and our system of social services"

And lastly, in his **1995 Socio-Economic Report** (March 1996), the President unequivocally states :

". . . The Administration also implemented public investments in primary health care, women and child health, and responsible parenthood. These health investments lead to productivity gains through the reduction in morbidity, absenteeism, and the lengthening of life expectancy. Reduced uncertainty about life-time is an incentive to individuals and households to invest in human capital. The family planning program pursued by the Administration matters greatly for private human-capital decisions"

B. The Philippine Family Planning Program (PFPP)

The Philippine Family Planning Program (PFPP) is a Philippine government initiative designed to contribute to the country's population management objectives within the overall context of national development. The lead agency in the implementation of the PFPP is the Department of Health (DOH). The DOH views family planning (FP) from the public health perspective, in particular as it relates to improving the maternal and child health of the general populace.

On August 1, 1994, the DOH approved the Integrated Family Planning and Maternal Health Program (IFPMHP), the centerpiece program of the PFPP up to the year 2000. The IFPMHP has been granted financial and technical support from the United States Agency for International Development (USAID) and the United Nations Fund for Population Activities (UNFPA). There are three main components of the IFPMHP:

- *National Services Component* -- This component supports on-going FP-related efforts performed by the DOH on a nation-wide scale (e.g. IEC, Procurement and Logistics, Training, Operations Research, etc.).
- *Local Government Units Performance Program Component* -- Under the recently passed Local Government Code, local government units (LGUs) are now responsible for the delivery of public health services, including FP. This component is designed to develop/enhance the abilities of selected LGUs to plan and implement their own FP programs.
- *Private Sector/Non-Government Organizations Component* -- While non-government organizations (NGOs) have long been partners of the government in FP, the private commercial sector (e.g. pharmaceutical companies, private hospitals, HMOs, private medical professionals) has a promising potential to increase its role in the delivery of FP services. This component aims to further strengthen the capabilities of the NGO sector to sustain their FP activities as well as to promote a larger private commercial sector involvement in the PFPP.

C. The PROFIT Project

PROFIT is a USAID-funded project which seeks to mobilize private sector participation in FP-related activities in developing countries. As a collaborating agency under the IFPMHP, PROFIT was requested to provide assistance to the DOH in developing a strategy to enhance the role of the private commercial sector in the PFPP.

To achieve this mandate, PROFIT conducted several interviews from June to August 1995 with representatives from private commercial sector groups (e.g. medical professional associations; private medical providers - HMOs, hospitals, and companies; pharmaceutical companies) whose resources could be tapped for the PFPP. Through these interviews, PROFIT was able to identify certain issues and

concerns that constrain these private commercial sector groups from increasing their involvement in the PFPP.

In addition, PROFIT commissioned two studies on private medical providers and their clientele. The first study was done in collaboration with the Social Marketing for Change (SOMARC) Project, another USAID-funded project which aims to increase private commercial sector involvement in FP through innovative social marketing schemes. The study, entitled "*Attitudes and Practice Survey Among Health Professionals in the Private Sector*" (January 24, 1996), aimed to identify private providers' attitudes and practices regarding FP and to explore their views on the barriers and incentives to offering private sector FP services. Structured interviews were held with 600 private providers -- 200 obstetrician-gynecologists, 200 general practitioners, and 200 midwives in key urban centers.

The second study, entitled "*Consumer Survey on Preferred Source of Basic Health Care and Family Planning Services*" (March 11, 1996), aimed to augment the findings of the provider survey. The supply side information gathered from the providers could best be utilized if analyzed against meaningful demand side information from consumers. PROFIT asked the PULSE Research Group, the market research firm contracted for both studies, to include nine questions in its quarterly omnibus survey which covers key urban centers in the Philippines. PULSE reached 1,627 respondents aged 15 - 49, almost equally split between males and females, and from all economic classes.

This paper presents and discusses the issues raised by the private commercial sector groups during the interviews. It also includes relevant findings from the two commissioned studies. The paper is meant to be circulated among key people at the DOH, USAID Manila, collaborating agencies, private commercial sector representatives, and other Government of the Philippines (GOP) agencies (e.g. Population Commission (POPCOM), National Economic and Development Authority (NEDA), etc.) for their comments and suggestions, in order to solidify the issues. This process of consultation will serve to crystallize the action steps necessary to address the issues and thus be a basis for an overall strategy for increasing private commercial sector involvement in the PFPP. The paper can also be used as an input to the **National Family Planning Program Strategy** document presently being updated by the DOH with the assistance of the POLICY Project of USAID.

II. THE PRIVATE COMMERCIAL SECTOR IN THE PFPP

A. The Present

As in any strategic planning exercise, it is necessary to first define the existing situation. In this case, the appropriate question to pose is: “*What is the present level of involvement of the private commercial sector in the PFPP?*” A quick answer to this question is provided in the Philippines: National Demographic Survey 1993. Table 4.11 (entitled *Source of supply for modern contraceptive methods*) of this report provides a snap shot of the public - private sector mix as of 1993. A table summarizing Table 4.11 of NDS 1993 is reproduced below:

Table 4.11 Source of supply for modern contraceptive methods (Summarized)

Percent distribution of current users of modern contraceptive methods by most recent source of supply, Philippines 1993

Source of supply	All methods
Public sector	71.4
Private sector	27.7
Private hospital/clinic	16.4
Pharmacy	7.3
Private doctor	2.6
Other private	1.4
Other/Don't know/Missing	0.9
TOTAL	100.0

Source: National Demographic Survey 1993: Philippines

The table above reveals that the FP “market” in the Philippines is largely dominated by the public sector where seven out of every ten FP clients obtain their modern contraceptive method from a public sector source. Government hospitals, *barangay* health stations, *barangay* supply offices, and puericulture centers are indeed the traditional sources of supply for a large part of the married women of reproductive age (MWRA) as the PFPP has always utilized the government network (POPCOM before 1989 and the DOH after 1989) to distribute FP products and services. It must also be noted that FP products (i.e. pills, condoms, IUDs, injectables [DMPA]) are provided by the government for free. FP services (i.e. IUD insertion, female sterilization, male sterilization), on the other hand, are provided by government medical personnel either for free or at subsidized rates. While the provision of free FP products and services is in keeping with the notion adopted in the Philippines that family planning is a “public” good which must be provided by government, this practice effectively reduces the role that the private sector can play.

If one further disaggregates the data provided in Table 4.11, it will be noted that the pharmacies play a significant role in providing pills and condoms, accounting for

about 17.4 per cent of the market for pills and 40.6 per cent of the market for condoms. Private hospitals and clinics, on the other hand, have a significant share of the market for the female sterilization method and IUDs, claiming 26.8 per cent and 12.8 per cent respectively of these markets. The data also shows that private doctors are most active in the IUD market, accounting for a 6.7 per cent share of this market.

Table 4.11 is not clear about the extent of the role played by FP NGOs. By their very name (i.e. non-government), FP NGOs should be classified as private sector and therefore may fall under the private clinic category. On the other hand, several FP NGOs are located within puericulture centers which are classified as public sector in this table. Also, FP NGOs act in a private sector manner when they charge their customers a small professional fee for the FP services they render (e.g. IUD insertion, pills prescription, etc.). However, FP NGOs become public sector adjuncts when they do not charge (as a general rule) for the cost of the FP products which they also obtain from the DOH. For purposes of this discussion, NGOs are not subsumed under the private commercial sector category.

Table 4.11 was recently updated through Table 11 of the 1995 Family Planning Survey conducted also by the National Statistics Office. A summarized version of Table 11 of the 1995 FPS is shown below:

Table 11. Source of supply for modern contraceptive methods currently used (Summarized)

Percent distribution of current users of modern contraceptive methods by most recent source of supply according to specific methods, 1995 FPS

Source of supply	All methods
Public sector	78.3
Private sector	19.0
Private hospital/clinic	9.8
Pharmacy	6.0
Private doctor	1.5
Other private	1.7
Other/Don't know/Missing	2.7
TOTAL	100.0

Source: *Family Planning Survey 1995*

The updated figures reveal that the private sector has dramatically reduced its share in the overall family planning "market" from 27.7% in 1993 to only 19.0% in 1995. The decline was most seen at the private hospital / clinic category where a reduction by 6.6 percentage points (from 16.4% in 1993 to 9.8% in 1995) occurred.

To derive an indication of the size (in terms of volume and value) of the government "share" of the market for FP products, it is useful to ask the question: "How much does the DOH import (since there is no local manufacturing of FP products) each year?" In 1995, the DOH (through the Family Planning Logistics Management Project) imported around US\$4.5 million (₱120 million) worth of contraceptives, broken down as follows:

FP Product	Volume imported in 1995	Units	Cost per unit (US\$)	Total cost (US\$)
Condoms	19 million	pieces	US\$ 0.05	US\$ 950,000
Pills	14 million	cycles	0.20	2,800,000
IUDs	200,000	pieces	1.14	228,000
Injectables (DMPA)	660,000	vials	0.85	561,000
TOTAL				US\$4,539,000

(₱118,014,000)
at US\$1:PHP26

Note: These costs are based on worldwide bulk purchases and do not reflect the price of commercially available products.

Another snapshot of the present role of the private commercial sector in the PFPP is provided in the 1995 Family Planning / Maternal Child Health Status Report:

Couple Years of Protection Provided
By Type of Method, By Source
1994-1995

Type of Method	1994			1995		
	DOH-supplied	Social Marketing	Other Comm'l Sector	DOH-supplied	Social Marketing	Other Comm'l Sector
Pills	770,630	25,103	68,473	801,632	32,660	71,300
Injectables (2 mos & 3 mos)	13,253	4,991	875	77,790	3,472	1,520
Condoms	165,227	99,976	20,862	167,644	110,948	16,258
IUDs	663,936	0	NA	590,244	0	NA
TOTAL	1,613,046	130,070	90,210	1,637,310	147,080	89,078

The table shows that for the four types of methods (i.e. pills, injectables, condoms, and IUDs), the DOH is the dominant player in these "markets" accounting for 88% and 87% of CYPs in 1994 and 1995 respectively. The share of the private commercial sector (i.e. social marketing and other commercial sector) in these "markets" was only 12% in 1994 and 13% in 1995.

At present, the DOH through the efforts of collaborating agencies under USAID encourages a private sector role in the PFPP. The **NGO Strengthening Project** funds the operations of non-government organizations (NGOs) which provide FP services and products. At present, there are 19 NGOs with 110 clinics and 102 health posts nationwide participating in this project. Some of the larger NGOs are the Institute of Maternal and Child Health (IMCH), the Institute of Maternal Child Care Services Development, Inc. (IMCCSDI), the Associated Council for Coordinated Development in Negros Occidental (ACCORD), and the Davao Medical School Foundation (DMSF).

The **Social Marketing for Change (SOMARC) Project** encourages pharmaceutical companies to make the prices of their contraceptives more affordable in exchange for inclusion in an overall social marketing campaign (i.e. *Couples' Choice*). Another social marketing project run by **DKT** is also providing below - cost contraceptives (e.g. Trust condoms) in commercial outlets. DKT receives condoms from donor agencies for free and sells these commodities below actual cost. Soon to be launched by DKT are low cost pills.

The **Responsible Parenthood / Maternal Child Health (RP/MCH) Program for Industry Project** allots funds for the establishment of FP programs in private companies with large labor forces. The Philippine Center for Population and Development (PCPD), the NGO administering this project, has recently included in their program industrial clinics which service private companies with small labor forces. The **PROFIT Project** is engaged in two experimental pilot projects designed to promote the involvement of young private doctors and a private health maintenance organization (HMO) in the family planning program. And only recently, the assistance of the **POLICY Project** was sought to review / study FP policy matters, a number of which will impact upon the private commercial sector.

B. The Goal

Having described the prevailing situation regarding private sector involvement in the PFPP, the next steps in the strategic planning process are to answer the *questions: Where do we want to go? and How do we get there?* DOH Undersecretary-designate Dr. Antonio Lopez, who is also concurrently the IFPMHP Project Director-designate, provided an overview of the DOH position on the matter of private sector involvement in the PFPP during an interview with PROFIT. Dr. Lopez said that the private commercial sector, if tapped properly by the DOH, will be a *"tremendous help"* in achieving the objectives of the family planning program as well as those of the 23 other public health programs (e.g. communicable diseases, non-communicable diseases, maternal and child health, environmental sanitation, STD/AIDS, women's health and safe motherhood, and early child development). He categorically stated that the DOH cannot provide for the FP and other public health needs of the entire country, and that the DOH in fact *"needs"* the private sector.

When asked what role the DOH envisioned for the private commercial sector in the PFPP, the Undersecretary - designate first cited two principles contained in the DOH's **National Health Plan** (a DOH Internal Planning document), namely the principles of *"bias for the poor"* and *"self-reliance or no dole-outs"*. Under the first principle, the DOH commits itself to *"concentrate its resources on the marginalized sector of society"*. The second principle stresses that whenever possible, the DOH will not provide dole-outs or free products and services as it would like to promote self-reliance (in terms of health) among the populace.

In the context of the family planning program, these two principles translate into a need within the DOH to *"prioritize its beneficiaries"* for FP services. Only those belonging to the marginalized sector of society should receive free FP supplies and services. Those who can afford FP supplies and services should be encouraged to be self-reliant and thus pay. In Dr. Lopez's view, under the present situation, the DOH's *"act of giving (free FP supplies and products) has become indiscriminate"*. Thus there is a need to rationalize the DOH system of giving free FP supplies and products. The need for such a rationalization becomes even more urgent in view of the present reality of *"dwindling donor funds"* upon which the PFPP is totally reliant. *[Note: DOH Secretary Carmencita N. Reodica, in enunciating her vision for the DOH, espoused a strategy of " . . . (utilizing) alternative financing mechanisms enhancing public / private partnership (to ensure) sustainability of (DOH) programs -- (in light of) the gradual phasing out of foreign support . . .]* Dr. Lopez cautioned, however, that the rationalization process can prove to be tricky since *"even those who can afford to pay for FP products will continue to demand free contraceptives on the grounds that they also pay their taxes."*

Dr. Lopez then stated that the DOH could use some assistance to learn how to deal with the private commercial sector to achieve the DOH ends through a meaningful win-win partnership between public and private sectors. PROFIT advised Dr. Lopez then that even within its own sphere of influence, the DOH can

initiate innovative public-private cost-sharing schemes for FP services. The DOH is represented in the Boards of the two health insurance agencies of the government, the newly created **Philippine Health Insurance Corporation (PHIC)** and the **Employees' Compensation Commission (ECC)**. The DOH representatives in the Boards of these two agencies can explore the viability of including FP services and even the purchase of FP products in the benefit packages for the members of these health insurance programs.

The PHIC was created by virtue of Republic Act 7878 signed on February 13, 1995. It is a tax-exempt government corporation attached to the DOH for policy coordination and guidance. The Secretary of Health is the *ex-officio* Chairperson of the corporation. The principal task of the PHIC is to administer the National Health Insurance Program which seeks to eventually cover all citizens of the country. The intention of the law creating the PHIC is to provide its members and their dependents with a health benefit package consisting of specific inpatient, outpatient, emergency, and such *other health care services that the PHIC determines to be appropriate and cost-effective*. The DOH, through the Secretary, can surely appeal for the inclusion of FP services in the health benefit package, either for inpatient or outpatient service. (*Note: In the past, the Philippine Medical Care Commission, the precursor of the PHIC, paid for a portion of the cost of surgical contraception procedures. Based on the Schedule of Benefits for Medicare beneficiaries under E.O. 441 as of January 1, 1991, PHP250.00 is paid by Medicare for a vasectomy procedure and PHP400.00 for a tubal ligation.*)

The Employees' Compensation Commission (ECC), on the other hand, was created on December 27, 1974 through Presidential Decree No. 626. The ECC is the body which formulates the policies of the Employees' Compensation Program which aims to help workers and their dependents - in the event of employment-connected injury, sickness, disability or death - promptly receive meaningful and adequate income benefits, medical or related services, and rehabilitation services. The chairperson of the PHIC (thus the Secretary of Health) sits as an *ex-officio* member of the seven-person Board. The DOH can convince the ECC that while pregnancy is not an injury or sickness, its proper spacing surely contributes to the productivity of any work force. In 1995, the ECC established twelve industrial clinics to serve preventive occupational health service needs of workers in small- and medium-size industries. A case may be made to include family planning in this outpatient benefit package.

Undersecretary - designate Lopez also sought assistance to help the DOH rationalize its "*act of giving*". USAID Manila has in fact responded to this expressed need. An assessment team from the POLICY Project visited the Philippines in January 1996 and has proposed to conduct an *Intercept Survey of Users of DOH Family Planning Services* in order to derive a better "picture" of DOH clientele. This will provide the DOH with better insight on how to target their desired market.

The DOH can indeed benefit from advice on how to tap the resources of the private commercial sector. A review of the principal PFPP descriptive documents [namely *The Philippine Family Planning Program: An Update and Status Report, 1994*; *Primer: Philippine Family Planning Program (Department of Health, March 1993)*; and *The Philippine Family Planning Program (1990-1994)*] which outline the DOH's goals, objectives, policies and strategies for the PFPP, will reveal that with the exception of the social marketing project, there are no other strategies designed to involve the private commercial sector. While the documents speak of "enhancing public - private sector partnerships", it is evident that the private sector referred to is the NGO sector and not the private commercial sector. The POLICY Project, a USAID-funded project designed to study policy issues related to population and family planning, is presently assisting the DOH in developing an updated *National Family Planning Program Strategy*. This new document, which will be finished by November 1996, will replace the existing PFPP descriptive documents mentioned above.

An indication of where the DOH would like to go insofar as private sector involvement in the PFPP is concerned can be gathered from the IFPMHP end-of-project indicator adopted for the **Private Sector/NGO Component**. By the year 2000, the DOH would like to see "the percent of family planning services provided by the private sector increase to 34%" from the 27% figure in 1993. The challenge to promote more private sector involvement has become even more daunting in light of the results of the 1995 Family Planning Survey which showed that the percentage of MWRA who source their modern contraceptive method from the private sector has decreased to 19.0%.

The main increases in the private sector are envisioned to come from the following sources:

- (1) *private hospitals and clinics* which are expected to account for half of the total 7% increase expected from the whole private sector; and
- (2) *pharmacies* which are expected to contribute a 2.7% gain in their share of the "market" during the period.

In concrete figures, the number of Married Women of Reproductive Age (MWRA) Using Modern Methods [MCUMM] to be served by a private sector source by the end of the IFPMHP in year 2000 will be 1,341,561 -- almost a 110% increase from the estimated 642,208 MCUMM served by the private sector in 1993. The principal intervention mechanisms that will be relied upon to achieve this dramatic gain in the private sector are the various USAID- and UNFPA- funded projects. The USAID-funded cooperating agencies (namely the **NGO Strengthening Project**-John Snow, Inc., the **RP/MCH Program**-Philippine Center for Population and Development, and the **Social Marketing Project** - Futures Group) have estimated that their respective projects can account for only about one-fourth (1/4) [or

316,000] of the total MCUMM expected to be served by the private sector by year 2000.

Clearly there is a need to define more intervention mechanisms, most possibly in the policy arena, if the private sector/NGO indicator is to be met by the year 2000. It is within this purview that the issues and concerns raised by the private commercial sector groups should be addressed, where they have merit. It should be noted that some of the issues raised in this paper will be studied in depth by the **POLICY Project** in order to provide more guidance to the DOH in its strategy formulation process.

III. ISSUES AND CONCERNS RAISED BY PRIVATE COMMERCIAL SECTOR GROUPS

As mentioned earlier, PROFIT interviewed representatives from various private commercial sector groups whose resources could potentially be tapped for the PFPP. These groups can be classified as follows:

Medical Professional Associations --

- Philippine Medical Association (PMA)
- Philippine Obstetrical and Gynecological Society (POGS)
- Philippine Academy of Family Physicians (PAFP)
- Philippine Nurses Association (PNA)
- Maternal and Child Nurses Association of the Philippines (MCNAP)
- Integrated Midwives Association of the Philippines (IMAP)

Private Medical Providers (Groups) --

- Association of Health Maintenance Organizations in the Philippines (AHMOPI)
- Philippine Hospital Association (PHA)
- 19 company - participants in the RP/MCH Program for Industry Project

Pharmaceutical Companies --

- Upjohn
- Schering
- Organon
- Metro Pacific Pharma

The views of the DOH (Undersecretary-designate Lopez) and of the representatives from the two large USAID-funded projects (namely the Family Planning Logistics Management Project and the Population Communication Services Project) were also solicited.

The interview respondents were prompted into a discussion on the role of the private commercial sector in the PFPP with the following guide questions:

1. How do you perceive the role of the private commercial sector (PCS) in the PFPP to be at present?
2. What do you envision the role of the PCS to be in the future?
3. What regulatory and market-related issues hamper the participation of the PCS in the PFPP? How can these be resolved?
4. What additional measures can government take to "incentivize" or encourage more PCS involvement in the PFPP?
5. What can the PCS do on its own to increase its participation in the PFPP?

For the representatives from companies who have participated in the RP/MCH Program for Industry, the methodology utilized was a focus group discussion - nominal group technique wherein all 24 participants were asked to respond to the question: "What are the barriers to the sustainability of the RP/MCH Program?"

During the interviews, the representatives of the PCS groups themselves pointed out the tremendous potential of their involvement in what is essentially considered a government program such as the PFPP. The potential is brought about by sheer size and numbers alone -- the private sector will always be larger than the government. In the medical professional fields (doctors, nurses, midwives), the number of professionals belonging to the private sector is undoubtedly much larger than those employed by the government. The large number of private medical professionals, private hospitals, industrial clinics, and HMOs, and private pharmaceutical companies in itself makes it difficult and challenging for a government agency such as the DOH to develop a coherent program to harness their resources towards a public health objective. Fortunately, in the Philippines, the private sector has already organized itself into professional and industry associations.

To illustrate, the IMAP representative mentioned that there are around 114,000 registered midwives with the Professional Regulation Commission (PRC). To her knowledge, only the DOH-affiliated midwives (numbering about 17,000 or only 15% of the total number of registered midwives) are involved in the PFPP. If appropriate mechanisms can be instituted to reach the rest of the midwife population in the private sector and their support solicited, the contribution to national FP objectives can be great. As noted in the focus group discussions held by PROFIT in 1994 while designing its Loan Fund for Private Physicians project, private doctors and midwives are probably the better medical professional partners for the PFPP as the nurses (with the exception of the industrial clinic nurses) are limited to bed-side medical care.

In developing a strategy to make allies out of the large number of private medical care providers (both professionals and groups), the issues and concerns which their representatives raise constitute a good starting point.

A. DOH - PCS Communication Links

1. *Need for an integrated approach or strategy in tapping the PCS*

Almost all respondents indicated their respective organization's willingness to be involved not only in the PFPP, but in all public health programs of the DOH as well. The representative from the PAFP pointed out that when a patient sees a doctor, the chances are slim that the patient is visiting specifically for FP. Patients will be there for a myriad of other reasons but the physician can use this opportunity to educate the patient about the various public health programs, including FP, provided that the doctor is equipped with proper IEC materials. This opinion was shared by the representative of the AHMOPI. A similar sentiment was expressed by the representatives from company clinics. While they appreciated the efforts of the Philippine Center for Population and Development (PCPD) to involve them in the promotion of FP, they wanted to know whether the DOH could also involve them regularly in other public health campaigns. Such involvement can be merely in the form of information dissemination. Official DOH advisories on public health programs can be mailed directly to the company clinics so that they will not have to rely on the oftentimes inaccurate newspaper reports. After all, their concern is the total health of their employees and not just FP.

Notes / Comments :

- The current project design of the PCPD RP/MCH Program for Industry addresses the desire of participating companies to be involved in other public health programs aside from FP. These companies' clinics are expected to integrate the whole range of maternal and child health services in their benefit packages for employees.

2. *Need to formalize DOH - PCS communication links*

Upon analyzing the responses to the questions, a common sentiment became evident -- one which is related to the *existing communication structure between the DOH and the PCS*. The primary reason cited for the non-involvement of the PCS in the PFPP and other public health programs despite a sincere desire to do so is simply that the DOH has not actively sought their participation.

The AHMOPI representative related that there was only one instance he could recall when the DOH sought their organization's assistance. This was a plea by the DOH Secretary for financial assistance for the *Doctors to the Barrios Program*. The AHMOPI pledged their support to the DOH Secretary during the occasion; however, there was no follow-up after that. This incident was pointed out to highlight the possibility that *there may be no established mechanism within the DOH for seeking PCS participation in public health programs, including FP*. The AHMOPI representative said that it was in the best interest of their organization to promote public health programs, including FP, among their members since public health is

essentially preventive care in nature -- much in keeping with the concept of health maintenance which they espouse religiously. After all, less availments of inpatient care under HMO plans translates into better profitability for the HMO. In HMO plans which cover hundreds of thousands of individuals, inpatient care can be "minimized," so to speak, by encouraging plan members to avail of preventive care services.

Notes / Comments:

- Under the IFPMHP, the DOH Family Planning Service has in fact designated a "component manager" to coordinate private sector (NGOs and private commercial sector) activities in the PFPP.
- Indeed it would seem that the DOH would like to involve the PCS more in public health campaigns while the PCS is more than willing to get themselves involved. Yet public-private cooperation, especially in FP, is minimal! A USAID official, when presented with the issues, observed that the PCS seemed to be waiting for the DOH to initiate PCS involvement and asked whether the PCS groups themselves could support public health programs, including FP, in their own ways even without prodding by the DOH. This is similar to the exhortation of former US President John F. Kennedy -- "*Ask not what your country can do for you but what you can do for your country*".

B. Training

1. *Need to develop FP training courses which are appropriate for the private sector*

Training for private practitioners

In order to provide FP services, it is assumed that a medical professional must have some amount of training on FP methods. In-service FP training is provided at the medical- and allied medical- schools in the country and this can be supplemented later on, but only at the volition of the individual medical professional. A USAID-funded program, the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO), has in fact been working with the Association of Philippine Schools of Midwifery (APSOM) and the Association of Deans of Philippine Colleges of Nursing (ADCPN) to incorporate FP topics in the in-service curricula for midwives and nurses. The study conducted by PROFIT and SOMARC on "*Attitudes and Practice Survey Among Health Professionals in the Private Sector*" showed that 89% of the doctors interviewed (base: 400) received FP training in their formal academic medical education. The JHPIEGO representative in the Philippines, however, says that the FP training of doctors in medical school is very limited and theoretical.

At present, supplemental FP training is offered by the DOH through agencies contracted by the foreign donor - assisted programs. Generally, the comment raised by the private medical professional sector about *the existing FP training courses of the DOH* was that they *are not suitable for private practitioners simply because they are too long*. The income of practicing professionals is directly commensurate to the time they spend rendering such medical service. Every hour spent on FP training can thus be translated into foregone income. On the other hand, government- or NGO- affiliated medical professionals who avail themselves of the DOH-sponsored FP training courses are able to allot the time for these courses since they are still paid their salaries (plus per diems in many cases) while attending the course.

The physicians interviewed said that shorter minilap and VSC training courses will be most welcome while refresher courses for the other FP methods will be adequate. The study on private providers which was commissioned by PROFIT and SOMARC indicated that natural family planning (NFP) was by far the most popular method among the providers. It is essential then that efforts must be increased in training and providing state-of-the-art knowledge of NFP (particularly the scientific methods such as the cervical mucus method, symptothermal method, and lactational amenorrhea method) to private providers to ensure that the use of these methods is effective.

According to the provider survey, few providers offered the full range of FP methods to their clientele. In particular, there seemed to be uneasiness with recommending injectables and IUDs. Future efforts need to focus on improving provider comfort with these methods through the distribution of updated information and training.

FP training can be offered by the professional medical associations to their members as the members need to earn Continuing Medical Education (CME) units before they can renew their respective licenses with the PRC. Assuming that such FP course offerings will be made available, regional train - the - trainers courses are considered most effective and sustainable. The regional or even provincial chapters of the professional medical associations can then offer these courses on their own to their members. At the initial stages, however, the support of a donor group will be helpful to move such an initiative forward. This is akin to venture capital being provided to enterprises who wish to engage in erstwhile unproven business endeavors. On their own, the professional medical associations do not have the resources to develop such training programs. The cost of developing the courses, however, can be redeemed slowly from the enrollment fees (which must not be too prohibitive).

Training for medical staff of private medical provider groups

HMOs, private hospitals, and private industrial clinics maintain medical staff as regular employees on their payroll. These staff undergo continuing medical training under the sponsorship of their employers and some of them may be interested in FP topics (i.e. surgical procedures, technical updates on FP methods). It appears, however, that the employers (executives of HMOs, private hospitals, and private

industrial clinics) do not know where to source such FP training. Also, assuming that their staff qualify for the DOH FP training programs, these courses are not suitable as they are too long. Private concerns, which monitor their costs tightly, cannot afford to "lose" a medical staff member for extended periods of time.

Notes / Comments:

- In reaction to the training issues presented, a USAID official commented that the new DOH training strategy should address the matter of training standards based on an honest assessment of training needs. Also, a determination of whether graduates of medical and allied medical schools in the country indeed receive adequate FP training in school must be pursued as there are conflicting findings regarding this.
- During a visit to clinic sites of physician borrowers from PROFIT's Loan Fund, a USAID official noted that private sector physicians will benefit from counseling training that will teach them how to direct patient consultations towards the topic of FP and/or birth spacing through the use of "entry questions". This counseling training was tried in a USAID-funded project in a Middle East country. This observation ties in with the comment of the representatives of the physicians' organizations that there is a small chance that private doctors' clients visit the clinic specifically for FP. In fact, the provider survey noted that most medical providers agree that they have numerous opportunities to promote FP, but they would rather wait for the client to initiate the discussion.
- PROFIT, with the Fertility Care Center, Inc., has recently developed a shorter (48 - hour) course on reproductive medicine for private physicians who borrow from its Loan Fund. This course has been granted 100 CME units by the Philippine Medical Association. The 24 doctors who have attended the training all expressed their satisfaction with the course. The actual and practical use of such knowledge, however, will still have to be evaluated by PROFIT in its final evaluation activity to be completed by year end.
- Under the IFPMHP National Services component, the DOH is currently working on a new FP training strategy that is competency-based. This new approach will appeal more to private medical providers as the training packages will be offered in modules.

2. *Need to streamline DOH accreditation of FP training programs*

The existing policy is not clear whether all FP training courses need accreditation from the DOH. Understandably, DOH accreditation is necessary for the DOH-sponsored FP training programs which are funded by foreign donors and which are offered to DOH- and NGO- affiliated medical professionals. If there is a private group which wishes to offer FP training to professional medical associations and their members, must this curriculum obtain a DOH accreditation?

Notes / Comments:

- Assistant Secretary - designate Rebecca Infantado (then the IFPMHP National Services Component manager and Chief of the Family Planning Service [FPS]) pointed out that the DOH has prepared guidelines regarding FP training accreditation. These guidelines were disseminated during the third quarter of 1995. Any private group which desires to offer an FP course should coordinate with FPS for accreditation purposes.

C. **Access to DOH FP IEC materials**

1. *Need to provide FP IEC materials to the private sector*

For private medical professionals

Providing private medical professionals with government IEC materials for FP is considered important by the private providers themselves. These materials are considered very effective aids and time-saving tools when explaining FP methods. In particular, the desk-top flipchart on the different FP methods was mentioned as one which is most useful to the professionals. FP posters and leaflets can also be posted in the waiting areas of private clinics.

It was suggested that the distribution of these materials could be done through the associations themselves since they maintain their respective mailing lists.

Alternatively, the IEC materials could be distributed during the various national and regional conventions of the associations. Another area of interest was in on-going technical information on FP methods. It was also suggested that scientific or technical briefings on FP methods and procedures can be included in the newsletters and journals of these associations. These publications are produced and mailed out periodically (monthly for most newsletters and quarterly or annually for the journals). Any initiative in this regard will merely require coordination between the DOH-FPS / IFPMHP Private Sector Component Manager and the secretariat of the various associations.

For private medical provider groups

HMOs, private hospitals, and industrial clinics have outpatient clinics where FP can be promoted among the members who are waiting in the lounges for their turns to be seen by the physicians. HMO physicians and other medical personnel can also benefit from the IEC materials as FP counseling is almost always included in the

outpatient benefit package of HMOs. The IEC materials can encourage the members to seek actual FP service delivery from the HMO physician.

In addition, HMOs send newsletters to their members periodically where they discuss various health-related topics. For as long as articles on FP are written sensitively and present balanced views on the FP topic, HMO executives will be willing to give these articles space in the newsletters. It will also help though if the DOH can provide HMOs with articles on other public health programs so that FP is not over-emphasized.

Notes / Comments:

- Ideally, IEC materials for the PCS are to be provided through the SOMARC project. In addition to the limited resources of SOMARC, another option may be to ask pharmaceutical companies with contraceptive products to “sponsor” the publication of additional copies of IEC materials already developed by the DOH. The detailmen of these pharmaceutical companies can then distribute these materials to the physicians and outlets that they visit on a regular basis. Allowing the pharmaceutical companies to simply re-print DOH IEC materials saves them the cost of developing such materials.
- 2. *Need to develop “IEC materials” for top management of corporations regarding productivity gains because of FP program*

The representatives of the 19 corporations which have participated in the RP/MCH Program for Industry mentioned that the support of top management is the main factor that will ensure the sustainability of the FP program in their respective companies. Running an RP/MCH program in a company requires manpower resources (i.e. time spent by company clinic personnel and *kaakbays*, time spent by employees when they attend FP fora) and minimal financial resources. Top management has to determine whether the resources spent on the RP/MCH program produce benefits or gains which are measurable. Manpower productivity gains cannot be directly attributed to the RP/MCH program alone.

It was pointed out that numerous studies have already been conducted both in the Philippines and abroad regarding the benefits derived by individual corporations and industries from an FP program. A suggestion was made to compile all these studies and present them in business jargon as the audience will now be top management rather than development professionals. These “re-packaged” articles can then be printed/published in publications which top management reads. Alternatively, they can be circulated among the different management associations or chambers of commerce of which the Philippines has many.

Notes / Comments :

- A USAID official commented that this activity can best be pursued by PCPD since they have the direct first-hand experience with the companies.

D. Access to free contraceptives and FP services provided by the DOH

1. Need to improve the private to public sector referral system

The representative from the PAFP raised an interesting point regarding access by private physicians' clientele to the free DOH contraceptives. While she realized that the DOH contraceptives are ideally targeted to those who cannot afford to purchase them, she pointed out that it is quite common for a private physician to have her/his own share of indigent patients. To categorize all clientele of private physicians as belonging to that income class that can afford to purchase contraceptives is not accurate. She expressed the view that private physicians do not have to nor want to maintain a stock of DOH contraceptives (while acknowledging the nightmarish accountability problems that will arise under such a scenario); what they merely want is the ready information on where to refer their indigent patients for the free DOH contraceptives or even for the more affordable invasive or surgical FP service procedures (i.e. IUD insertions, VSC).

Notes / Comments :

- DOH Assistant Secretary - designate Rebecca Infantado acknowledged this need to further improve upon the FP referral system especially from the private sector to the public sector.
- The POLICY Project will develop a "map" of family planning sources which will consist of a Geographical Information System (GIS) map of public sector, NGO and private sector FP facilities. The dissemination of this valuable information to the private sector will help improve the private - public sector referral system.

2. Initial access to free contraceptives supplied by the DOH

The AHMOPI representative brought up this issue on gaining access to free contraceptives. At present, most HMO plans offered to the public include FP counseling as one of the out-patient services. To encourage all HMOs (except those whose executives do not support the FP program) to go one step further than counseling and provide either an FP product or service, the AHMOPI representative felt that the DOH should supply them with free products (IUDs, condoms, pills, injectables). In the first place, he noted that contraceptives were/ are provided for free to private corporations who are now contracting out to HMOs the provision of medical services of their employees. Since these employees (who are now HMO members) have been accustomed to free contraceptives from their clinics, the HMOs

feel that it is not good business sense for them to sell contraceptives or prescribe them as they (the HMOs) may be accused of selling products or services that are known to be free! Thus the HMOs request for an initial period of access to free DOH contraceptives, maybe for one year or such length of time it will take to wean their members out of the free contraceptives frame of mind.

Notes / Comments :

- USAID officials commented that providing free contraceptives to HMOs even for an initial period may not be feasible as there is in fact a move to terminate the current "free distribution to the private sector" policy. This policy seeks to shift that segment of the market which can afford to pay towards the SOMARC and other commercial brands of FP contraceptives.

E. Market Segmentation

The pharmaceutical companies view the DOH as a "competitor" and the largest player in the market for contraceptives. Since there is no economically sound way of competing with free goods, they have limited themselves to servicing that niche of the market that is willing to pay for their products. In an effort to reach another segment of the market, the pharmaceutical companies willingly participated in the *Couples' Choice* program wherein they reduce the price of some of their brands in exchange for inclusion in the social marketing campaign.

Given that they are cornering only a small segment of the market, the pharmaceutical companies appeal that a consistent market segmentation policy be followed by all players in the market (which they believe has not been the case to date). The DOH can concentrate on the "marginalized sector" of the market (income class D and E); the NGOs can service the middle income market (income class C); the pharmaceutical companies participating in *Couples' Choice* and the DKT group [another social marketing effort] can target the middle income class also (income class C); and the pharmaceutical companies can compete for the upper A and B markets.

The consumer survey commissioned by PROFIT revealed that the public sector is still the preferred source of FP products for 7% of the income class AB group and 31% of the income class C group. This may be explained by several factors, not the least of which might be consumer attitudes that FP is a "public" good and therefore a service that should be provided free by government. Whether this is because of the prevalence of free services or other competing expenditure demands needs further exploration. It must be stressed also, however, that the private providers' capabilities to offer a full range of affordable FP services must be enhanced to encourage this significant percentage of income class AB and C members to shift back to a private sector source.

Crafting an FP market segmentation policy is one thing but implementing it can be difficult. There must be some form of agreement that the market segmentation policy will be adhered to by all players. One pharmaceutical company mentioned that a large FP NGO actively markets their commercial brand of pills, complete with detailmen, to private doctors at below market prices. The prices offered by the FP NGO can be significantly lower as the goods are given to them for free by an international donor. The NGO sells these free contraceptives at cheaper prices in line with their own self-sustainability drive.

Another inconsistency can arise in the market segmentation policy when the DOH itself supplies large companies with free contraceptives. The DOH has been doing this as they have an agreement with the Department of Labor and Employment (DOLE) to continue providing companies which participated in DOLE's own FP program with free FP goods. Some, if not all, of the employees of these large companies will surely fall within the market segment that is able to pay for FP commodities.

Notes / Comments :

- As a rule, USAID-donated contraceptives cannot be sold by any NGO. Other foreign donors may not have this same rule. The DOH should provide consistent guidance to donor agencies regarding this matter, while taking into consideration legal restrictions of the bilateral donors' home governments.
- The DOH recently received a KfW grant which will provide more oral pills and condoms. These contraceptives will be marketed by DKT through commercial outlets but at prices which are below cost. This situation will have to be taken into consideration when crafting the market segmentation policy.
- The POLICY Project will conduct an *FP Market Segmentation Study* which aims to: (1) define segments of the contraceptive market and to identify providers servicing each segment; (2) to ascertain the current status of FP service delivery in each segment; and (3) to project the potential of the private sector to be a source of FP services for each of the identified segments. This full-blown study will guide the DOH in crafting its policy on and implementing guidelines for FP market segmentation.

F. Government Incentives

Both the provider and consumer surveys commissioned by PROFIT point to the significant role played by price in the consumer's decision of where to obtain FP services / products. The consumer survey found that affordability of services far outweighed any other consideration in choosing a facility for FP services. Since affordable services and products are important to consumers

(70%), then efforts to reduce provider service charges will result in increased private sector FP service delivery. Private providers with access to affordably priced contraceptive products can fare better in the FP "market".

The pharmaceutical companies interviewed sought some government incentives which will result in a significant reduction in the price of their products. These are described below:

1. *Duties and taxes*

In order to keep their prices down, pharmaceutical companies avail of duty free privileges in their importation of contraceptives. To do so, they must first procure a waiver for each shipment from the Population Commission (POPCOM) - National Economic and Development Authority (NEDA). A representative of one of the companies interviewed by PROFIT would like the criteria for duty exemption to be clarified. According to him, his company's importation of a contraceptive implant was cleared through POPCOM and NEDA easily. However, a subsequent importation of IUDs was denied duty exemption for reasons not clear to him.

Another representative from another pharmaceutical company suggested that the 10% clearance cost on importations also be done away with gradually (10% to 5% to 3% over a specified period). The reduction in the cost of importation can translate into a 20 - 30% reduction in the retail cost of contraceptives. The reduced prices may encourage more use of commercial contraceptives.

Notes / Comments :

- The POLICY Project will conduct a Contraceptive Market Structure Study which will: (1) evaluate, among others, the components of the price of contraceptives; and (2) estimate the demand elasticity for contraceptives and analyze the potential for demand growth by income segment by simulating various price scenarios. This study can help policy makers in advocating additional incentives for pharmaceutical companies that will help bring prices of contraceptives down over the long run.

2. *Rationalization of the criteria for the inclusion of contraceptive methods / brands accredited by the PFPP*

Two of the pharmaceutical company-respondents inquired about the criteria for the inclusion of contraceptive methods / brands in the PFPP. One question was: "*Can there be more than one brand of pill carried by the DOH?*" Another one asked: "*How does the DOH decide which methods are included in the PFPP method mix?*" "*After all,*" both of them said, "*if the unmet need for contraception is still high, why doesn't the DOH procure different brands of pills or promote all modern contraceptive methods so that the people will have total freedom of choice?*"

PROFIT explained to them that the brands of contraceptives distributed by the DOH was also dependent on the source of funding for these contraceptives. Thus USAID funds have to be used to "buy American". The pharmaceutical companies understood such nuances but still requested that other brands (e.g. from Europe) that they have already registered with the DOH Bureau of Food and Drug (BFAD) also be "*endorsed by the Philippine Family Planning Program*". Such an endorsement by the PFPP will increase the marketability of their products over the long run. This is similar to the DOH endorsements presently given to certain bath / germicidal soap brands.

G. Distribution of DOH FP Supplies

Pharmaceutical companies either import finished drugs from abroad or manufacture / re-package drugs from imported active ingredients. To distribute their drugs down to the level of individual doctors, pharmaceutical companies utilize the services of a nation-wide drug distribution firm. During the interviews, PROFIT learned that these nation-wide drug distribution companies charge a commission of 10-12% of the value of the goods to be shipped. For such a fee, the distributor's services will include: (1) the actual distribution of the goods up to the retail level (i.e. drugstores, pharmacies, supermarkets, doctors); and (2) the provision of comprehensive computer-generated periodic reports on sales and stock levels.

The pharmaceutical companies interviewed expressed the view that the large distribution companies in the country would be willing to service the FP supplies distribution business. The DOH can compare the present cost of the existing FP supplies distribution system (via the FPLM project - CARE tie-up and the CDLMIS project) with the benchmark figure of 10-12% [of the value of goods shipped] charged by the private distribution companies in order to initially determine the viability of such an option. The distribution companies, however, would like to gain some assurance from the DOH that they will be paid promptly. Delay in payments is a primary reason why many reputable private firms refrain from servicing government accounts.

Notes / Comments:

- During the first quarter of 1996, the DOH assumed the responsibility for the freight forwarding and shipping activities previously carried out by CARE. Under the institutionalization plan for the FPLM Project, the DOH now pays for the shipping charges.