Review of the Cheaper Medicines Program of the Philippines

Executive Summary

I. Botika ng Barangay (BnB)

The BnB program has rapidly grown in terms of number but the systems requirements to make them effective, efficient and sustainable have lagged behind.

- BnBs were revived in a Presidential pledge in mid-2005 and the program has since registered impressive growth, reaching 16,000 pharmacies in 2010, serving about 8 million people. About 62 percent of BnBs serve 2 barangays while 38 percent serve 1 barangay, indicating that program target has been exceeded by 30 percent.

- However, their geographic spread remains problematic. Regions worst served with BnB also tend to be the poorest (ARMM, Soccsksargen, and Mimaropa). Provinces worst served also tend to be the poorest (Basilan, Sulu, Lanao del Sur, Tawi-tawi, Compostela Valley, Suquijor, Batanes, and Marinduque).

- Drug supply replenishment after the initial stock has run out remains challenging. While BnBs were conceived as drug revolving funds (DRF), this format has not evolved, weakening the reflow of funds to buy stocks. Moreover, each BnB has been left to locate its source of drugs, some buying from costlier private distributors or retailers.

- About 35 percent of BnBs had expired medicines at the day of the EU survey in 2009. The lack of control and information on prescribing behavior arising from the lack of supervising pharmacists (and the lack of up-to-date prescription registers) poses serious health risk due to potential overuse of antibiotics.

Available data comparing the selling prices of selected drugs among BnBs and a range of private suppliers (generic, branded generic, innovator drug equivalent, and discounted innovator drug equivalent) show that BnBs are not the cheapest suppliers.

- Of the four drugs considered in one study, BnBs can claim to have the lowest selling price only for one drug (metformin 500 mg, selling at Php 1.62 per tablet), and even their price advantage over the lowest generic (Php 1.70) is very small. In the other three drugs for which comparable data are available, the BnBs were outpriced by the lowest generic supplier. Indeed, the innovator drug discount price is even lower than the BnB price for felodipine and amlodipine.

- BnB prices are not the lowest in the market for comparable drugs because they have some of the highest mark-ups (25-355 percent) even though they are supposed to have a regulated 30 percent markup. High mark-ups result from BnBs' having a minimum selling price of Php 1 per tablet/capsule – thus the high markups on medicines costing much less than this – while others increased their price of fast-moving items to recover losses due to expiry of slow-moving drugs. BnB operators complain that the 30 percent markup does not take into account the actual transport costs between the supplier and the BnB.

- The wide variation in BnB prices means that some of them are pricing way above the competition. The EU survey shows that for amoxicillin, although the median price is Php 3.00, 70 percent of the BnBs surveyed sold it at a price higher than Php 3.00; indeed, 10 percent of them sold it as high as Php 7.00 or more. Similar patterns of pricing occurred for cotrimoxazole and metropolol.

The BnBs' (and Botika ng Bayans') role in increasing the contestability of the local (especially rural) drug market is an important role that the government plays, even if BnBs/BNBs have prices that maybe a bit higher than alternative private suppliers.

- The prices of innovator medicines have gone down through their generic counterparts in BnB/BNB, or sold by the private drugstores throughout the country. The BnBs/BNBs and private pharmacies selling generics have brought down the once-dominant sellers of innovator drugs, causing them to lower their prices dramatically. Now, the table is being turned, with discounted innovator drugs outpricing the BnB/BNBs.

- If BnBs/BNBs withdraw completely from supplying the local market, private suppliers may raise their prices again to "pre-contested" levels. This is a strategic consideration that should be taken into account in deciding about the future of the BnBs.

The sustainability of BnBs remain precarious due to management weaknesses, skill deficits among proponents, and their uneconomical size.

- About 87 percent of the 302 BnBs actually visited in the EU survey were still functional. The 34 BnBs closed due to poor demand for products; resupply problems; and financial difficulties in keeping the business up.

- The typical BnB is just struggling along. Out of the 240 BnBs with financial data, 54 percent are deemed acceptable or desirable, i.e., with sales of at least Php 24,000 per annum. However, almost half (46 percent) have annual sales figures lower than Php 24,000 which is deemed undesirable.

- BnB management and institutional weaknesses are serious. Only 7 percent of the BnBs had available management tools (sales book, inventory register, and prescription register), and only 2 percent were up to date in their business data.

- The discount given to senior citizens affects the financial condition of BnBs. Senior customers are entitled to a 20 percent discount, but the markup enjoyed by BnB outlets is only 7-8 percent of the catalogue price of PITC. Thus, for each senior customer purchase, the BnB suffers an outright loss of 12-13 percent.

- The smallness of the BnB works against efforts to make it sustainable. It has been suggested that non-economical BnBs should be allowed to fold up. The rural drug distribution strategy should be re-strategized to tap already-existing sari-sari stores, which can then sell over-the-counter drugs on the side. Along this thrust, a pooling or aggregator mechanism can be more easily employed to join together the resupply mechanisms of a group of sari-sari stores.

The DOH has placed a moratorium on additional BnBs being established since January 2011 until the systems problems are fixed. Three problem areas need particular attention:

- To stabilize the supply and prices of drugs in BnBs, the DOH is considering alternative options to pool procurements, impose order, and monitor drug quality.

- New location strategies need to be formulated on account of emerging competition from the private sector. The BnBs should focus on really poor areas.

- The Administrative Order establishing the BnB program is being revamped.

Despite its current problems, the BnB program provides a strong signal from government of its commitment to pursue affordable and quality drugs. The role of BnBs (and BNBs) in reducing prices through competition is an important consideration. These outlets have helped ease the contestability of the local drug market. The drastic reduction, if not complete stoppage, of the BnB program could signal the private sector sources to resume their high-price regimes.

II. Botika ng Bayan (BNB)

BNBs are a network of private sector pharmacies operated as a franchise, with PITC Pharma as the franchisor. Since the program started in 2005, the cumulative number of BNBs has continued to rise, peaking at 2,256 in 2010. However, the annual addition to BNBs has declined from a peak of 347 in 2007 to only 61 in 2010.

BNBs are concentrated in the National Capital Region and the surrounding areas of Central Luzon, Calabarzon, Ilocos, Cagayan Valley, Mimaropa, Bicol, and Central Visayas. The poorest regions (all of Mindanao and Eastern Visayas) have the least concentration of BNBs. The BNB target is to have 1 BNB for each city or municipality; around 1,000 municipalities are not yet served by a BNB by 2010.

The BNB format (franchise) is far more structured than BnB. Its outright for-profit nature has built-in incentive for the owner to perform better. The owner can also sell the business. The BNB urban market is also more stable and assured than BnB rural market. Out of the 2,149 BNBs that have been established so far, 137 have folded up, indicating a six percent mortality rate. Some BNBs have been advertised for sale in Bulacan and Davao.

BNB drug replenishment is less of a problem than in BnB; the franchise arrangement provides for an automatic reflow of resources and goods.

III. P100 Treatment Pack Program

DOH initially funded the P100 treatment pack program with Php 50 million, with additional technical support provided by WHO, EU and GTZ. The systems support for the initial phase of this program was weak. The current M&E system does not provide unified and up-to-date information on the use of the initial Php 50 million that seeded the program. Only about Php 19 million have been remitted by participating hospitals after three years, and the Commission on audit is going after the recipient hospitals.

Available price comparison shows that the P100 yields savings to the consumer:

- The DOH 2009 price comparison shows that the savings range from Php 64.00 to Php 1,829. The 2009 price comparison for Oriental Mindoro, where the program was pilot-tested, shows that the savings range from Php 158.85 to Php 995.50.

- Since the P100 program was initiated, the market for generics drugs in the Philippines has boomed, with the rapid growth of the private-for-profit The Generics Pharmacy as well as similar generic compliance-pack initiatives of the private pharmacy chain Watson (using Pharex products) and Rite-Med branded generics (using Unilab products). Thus, price comparison of the P100 treatment pack should also be made with these newer initiatives.

The P100 program currently has very few access points, with only DOH hospitals and some LGU hospitals dispensing them. The drug list is also very restricted. Expansion of the delivery network and expanding the list are being contemplated, but stock availability needs to be improved.

The P100 pilot project of Oriental Mindoro indicates that the treatment pack program can be sustainable. Data for the month of December 2008 alone show that sales at cost was Php 459,170 while sales at selling price was Php 530,610, yielding a net income of Php 71,440 (or an annualized net income of Php 857,280).

While the P100 program can be sustainable, it requires drug revolving funds (DRF) in health facilities for the program to be truly institutionalized. Without such DRFs and an accompanying fee-retention policy at the local level, health staff would not be incentivized to offer P100 treatment packs for sale. The problem is that not all LGU health facilities have established DRFs, and revenues for the P100 program are usually plowed back to the local treasury, reducing the incentive of health staff to collect payments.

Despite problems encountered in the initial phase of the program, the scheme is very innovative and has a large public health potential, as well as major impact in reducing out-of-pocket household spending on health especially on drugs dealing with chronic care. Thus, DOH is rebranding and relaunching the P100 program with the aim of making it the major drug supply program of the government, as the BnB is expected to slow down. The table below sketches the subprograms, types of recipients, initial funding, and subsequent funding to be required:

Classification of Households	Type of Recipients	Initial Funding for Treatment Packs	Subsequent Funding for Treatment Packs
Poor	4P/CCT recipients	DBM/DOH	DBM
	PhilHealth indigents and Sponsored Program members	DBM/DOH	PHIC capitation and/or Outpatient Benefit Package
Nonpoor	Public hospitals (DOH, LGUs)	DBM/DOH - Consignment	Drug revolving fund
	Private hospitals and clinics	DBM/DOH – Consignment	Drug revolving fund

Three separate sub-programs can be considered:

- Treatment packs to be provided for free to poor, Conditional Cash Transfer (CCT)-receiving families and families deemed indigent and enrolled under the PhilHealth Sponsored Program

(Sub-program 1). DOH and LGU facilities will be provided with the treatment packs as grants. Only facilities that have remitted the sales revenues from the original P100 treatment pack program will be eligible. DBM will be asked to fund the "pump-priming" program, but Philhealth should be asked to roll out its capitation scheme under the Sponsored Program for indigents.

- Treatment packs to be provided to nonpoor families in participating DOH and LGU hospitals, at allowed margins inclusive of all applicable discounts (Sub-program 2). DOH and LGU hospitals will be provided with treatment packs under consignment. The supply could similarly be contracted out to the private sector under a bidding arrangement (for non-Parallel Drug Importation). The initial year's requirements should be funded by DBM, with subsequent years' funding coming from PhilHealth's Outpatient Benefit Package.

- Treatment packs to be provided to patients in private retail outlets (Sub-program 3). Treatment pack drugs can be provided under a consignment basis.

The supply of treatment pack drugs will be open to bidders (private suppliers + PITC Pharma), since a healthy market for generic drugs has made this possible. Procurement of these treatment packs will be done centrally through open bidding (under COBAC), and not limited to PITC Pharma. DOH Materials Management Division can be the lead unit.

DOH has forecasted the annual needs of municipalities based on population and epidemiology. This should be reconciled with what would be made available by DBM as budget in 2012 and subsequent years. The availability of budget will also determine whether the program can expand to include other chronic diseases (asthma, chronic obstructive pulmonary diseases, and insulin for diabetes).

Under the new, rebranded treatment pack program, DOH plans to computerize the reporting and monitoring system from the rural health units by 2012. The RHU physicians will be required to submit quarterly reports to the Centers for Health Development on their distribution and utilization of treatment pack medicines, as well as their current inventory levels. A patient registry will be required.

IV. Performance of PITC Pharma

PITC Pharma outperforms DOH and LGUs in procuring medicines, according to an assessment of the public procurement prices of 50 medicines in six regions.

- DOH retained and LGU hospitals procure generic medicines at 2.9 times the international reference price. When originator brands are procured, they are on average 15.7 times more than the international reference prices.

- For generic procurement, DOH retained hospitals (median price ration or MPR of 2.2) were generally more efficient than provincial hospitals (MPR 3.2), and provincial hospitals were more efficient than municipal hospitals (MPR 3.9).

- PITC Pharma was able to procure low-cost generic essential medicines using its current structures, procuring generics on average at levels similar to the international reference prices (MPR 1.0).

- PITC parallel imported originator brands are cheaper than locally available originator brand products and, in some cases, cheaper than publicly procured generic equivalents. However, PITC Pharma was able to procure generic captopril at prices lower than that for the parallel imported originator brand (unit costs Php 2.4 and 6.7, respectively).

While PITC outperforms other government procurers (DOH, LGUs) in terms of price, it does not beat the prices of a private pharmacy selling generics. In a study comparing four drugs (salbutamol 2 mg, salbutamol 5 mL syrup, glibenclamide 5 mg, and cotrimoxazole 400 mg):

- All four drugs were found cheaper in the generic private pharmacy compared to PITC Pharma. Sometimes, PITC Pharma is also beaten by pharmacies selling branded generics. Finally, in at least one of the sampled drugs, the difference between the PITC generic and the innovator (branded) drug is surprisingly quite close.

- These findings indicate that the private sector has a cost advantage (is more efficient) than PITC Pharma, especially for generic drugs.

An assessment done by BIZCLIR (2009) cites some of the reasons for PITC's cost disadvantage. These are the remaining challenges it needs to face:

- Sustainability: PITC Pharma is funded by the DOH. Since it is not supposed to turn a profit, its expansion is limited by the availability of DOH funds.

- Shortcomings in information technology (IT): PITC Pharma has severe weaknesses in IT and inventory management. It will be challenged to manage the distribution of drugs even if the money is found for large procurements.

- PITC Pharma has not been able to send a purchasing agent abroad to Southeast Asia or India. Instead, it is forced to rely on local interlocutors, contacted by phone and e-mail.

The future of PITC Pharma needs to be taken in the context of overall government strategy in lowering the price of drugs and reducing oligopolistic elements in the distribution and retail of drugs. Overall, there has been much progress over the past 4-5 years, mainly because of the push for PDI and generics drugs.

- However, there are serious capacity constraints all over the chain: PITC Pharma lacks more efficient procurement systems and skills training; BnBs remain fragile enterprises and need institutional support; BNB performance is unknown although they are growing and facing healthy competition from the private sector; and P100 remains very limited in reach, despite rapid expansion.

- A major part of the problem is the very small scale of government financing for pharmaceuticals, compared to the total size of drug sales. Despite this, it has been able to make a significant dent on the reduction of pharmaceutical prices. Given the structure of private pharmaceutical sector, what needs to be highlighted is the importance of the countervailing power of government in drug procurement and distribution.

- Existing opportunities to enlarge government financing of drugs must be exploited, including: increasing DOH appropriation (e.g., annual commitment to finance essential drugs); pooling LGU procurements; massively increasing PhilHealth pharmaceutical benefits; and strengthening BnB and P100 drug revolving funds so that reflows of funds are assured.

In terms of government drug procurement, the following options can be considered:

- Option 1: Contracting out procurement to international agencies (International Dispensary Association or IDA, UNICEF/Copenhagen, Crown Agents, and others). Any of these arrangements could be more expensive than the status quo, since they involve foreign exchange costs and expatriate management.

- Option 2: Contracting out procurement to local GMP-certified pharmaceutical firms. For generics, this is possible since the market has become competitive; local procurement would hasten the process and ensure an uninterrupted flow of supply.

- Option 3: Expand the drug consignment system now in place in certain government health facilities.

- Option 4: Central purchasing via a Public/Private Partnership "Service Access Program" of the Pharmaceutical Healthcare Association of the Philippines (PHAP).

- Option 5: Strengthen PITC Pharma. The capacity-building program should address the logistics, information technology, staff skills, and management gaps already identified earlier.

Note that the overall problem in this area is rooted in poor government financing of drugs and the fragmented drug procurements (arising from the devolution of health services) that need to be pooled through some mechanism. The procurement agency problem is secondary.