

## REPUBLIC OF THE PHILIPPINES GGM Case Study

### A. SUMMARY

The Philippines is one of the four pilot countries for the GMM program in 2004. At the same time, the government through the Department of Health (DOH) was trying to improve access to cheaper and quality medicines, and the government-wide anti-corruption programs were starting. The program has analogous goals with the 2005-2010 Medium-Term Philippine Development Plan's anti-corruption program, and the health sector reform agenda on better medicine access and regulatory systems and good governance (National Objectives for Health, Philippines, 2005-2010). It was essential then to harmonize it with these parallel efforts, thus was included in the on-going reforms on procurement and health regulation, and the DOH Integrity Development Action Plan.

From the assessment until its current implementation, there is an active participation of civil society, academe anti-corruption bodies, concerned professionals, development partners and representatives from the pharmaceutical sector. Commitments were made to institutionalize transparency and good governance in the medicine supply chain.

The Philippine GGM program was conceptualized to address both the individual and more critically also build systems of governance that will reduce vulnerabilities to corruption, with acceptable structures and mechanisms, and processes, and good practices. It is a disciplined-based and value-based strategy and takes on health systems approaches in consonance to the country's health sector reform agenda, political structures and Filipino culture.

With existing similar activities and ongoing systems improvement, the implementation focused in two specific activities that will address the two main components: accountable system - the GGM awards, and for accountable individuals – the GGM manuals on registration, selection and procurement in addition to the integrity development activities on norms of behavior or code of conduct, gift giving policy, public disclosure, whistle blowing and reporting, anti-red tape, moral recovery, etc. The manuals describe risks and manifestations of corrupt practices across the pharmaceutical procurement cycle, registration and selection and identify measures and tools to manage these risks. The manuals are on their final draft and will be launched soon and disseminated.

The GGM awards was designed as an advocacy and a voluntary compliance mechanism with the primary goal to institutionalize transparency and good governance along the registration, regulation, selection and use, procurement and over-all management of medicines. Specifically, it intends to instill that transparency and good governance are essential in improving access to medicines. It recognizes and provides incentives to good practices in transparency and good governance for medicines in both the private and public sector and build models and duplicate them. The first awards was launched in August 2008 and the awarding was done last January 2010 from among 12 entries. The entries were assessed on their compliance to WHO and national standards on their over-all management of medicine and including access, and are enjoined to improve their systems and processes further. The criteria are on minimum structural and systems requirements; transparency and good governance structures and systems; medicine selection, procurement, management, financing, rational use and access. The 2<sup>nd</sup> awards may be launched on the 3<sup>rd</sup> quarter of this year with improved administration and mechanics after the presidential and local chief executives election.

The GGM program has been endorsed to the newly established National Center for Pharmaceutical Access and Management in the DOH in relation to the Universally Accessible Cheaper & Quality Medicines Act of 2008. After a stakeholder's consultation, it was agreed that a Phase IV is in order to review the implementation framework and further harmonize and integrate it with the good governance pillar of the pharmaceutical access and management. In the short term, a GGM Benchbook will be developed to provide a general framework and minimum standards and requirements for the local government units

and private health providers to ensure access, availability, affordable prices and sustained financing for essential medicines, acceptable selection and rational use, procurement, allocation and supply management.

## B. BACKGROUND INFORMATION

The Republic of the Philippines is an archipelago composed of 7,107 islands in Southeast Asia in the Eastern Pacific Ocean with an estimated population of 94 million (2010) making it world's 12<sup>th</sup> most populous country. The population is relatively young with median age of 22.5 years. The birth rate is 26.01/1,000 population and death rate of 5.15/1,000 population.

Filipino and English are the official languages which are both used in government, education, print, broadcast media, and business. Filipinos have a functional literacy rate of 84% and simple literacy rate of 92.3%. Filipinos are predominantly Christians (90%).

The economy is a capitalist market and is considered a newly industrialized emerging market economy. The GDP (2008) is \$320.6 billion, with an annual GDP growth rate (2008): 4.6%. And GDP per capita (2008) of \$3,300. Important economic sectors include agriculture (14%), industry (32%) and services (55%) which is beginning to dominate.

The Philippines is broadly divided into three main geographical divisions: Luzon, Visayas and Mindanao. Administratively, these are divided into 17 regions, 81 provinces, 136 cities, 1,495 municipalities, and 42,008 villages or called 'barangays'.



The Philippines has a dual health system, composed of the public and a very strong private sector. The public sector is composed of the Department of Health (DOH), Local Government Units (LGUs) and other government agencies providing health services. The public health services are devolved since 1991. The DOH is the over-all technical authority on health. It regulates health services, providers and products; develops health policies and standard and provides technical assistance to other health providers specially the LGUs. It also provides special and tertiary care through 71 hospitals including 11 special and 4 specialty Hospitals. It has 16 Centers for Health Development that coordinates and provides technical assistance and monitors health program implementation at sub-national levels. Each LGU (municipality, city, province) has exclusive responsibility over their own local health authorities. The province manages a provincial and at least 3 district hospitals; provides hospital and population development services, and acts as technical supervisor for health of province. Each Municipality and City manages at least one rural health unit/health center depending the size of population and several barangay health stations (BHSs); provides primary health care, maternal and child care, communicable and non-communicable disease control, FP services, general medicine, etc. There is a local health board in every LGU that develops local health policies and chaired by the local chief executive. Each of the LGU has its own medicine supply chain.

The GGM was introduced at a time that the country was determined to ensure better access to cheaper and quality medicine based on the National Objectives for Health (NOH), 2005-2010. It was also the start of anti-corruption initiatives under the Medium-term Philippine Development Plan, 2005-2011.

The health regulation reform in the NOH which includes better access to quality and cheaper medicines and system improvement in drug regulation<sup>1</sup> was based on the following circumstances. The pharmaceutical market was estimated to be more than 70 billion pesos. The per capita consumption was 40 to 50% of per capita health spending. Medicine was the largest out-of pocket household expenditure (46.4%). The pharmaceutical market is segmented due to asymmetric information, income disparities and inadequate regulatory system. Multinationals controls 70% of market shares and prices are 3.4 to 184 times the international reference index.<sup>2</sup> A branded drug cost 4 to 6 times more than its generic equivalent produced by the same manufacturer. Cheaper generics products had only a market share of 4%. There were promotion of more expensive products and claim of better quality in comparison to more affordable and what is perceived as more inferior products with given inadequate capacity to ascertain drug quality. The decentralized set-up also multiplied inefficiencies in supply management and procurement leading to stock outs and very high prices differential across regions (1-1048%). Procurement cycle is between two to 18 months, making essential medicines unavailable most of the time. Further, availability of core essential medicines is only around 10-12%.<sup>3</sup> Irrational drug prescribing, dispensing and use contributed to the problem. Preferences of certain products by health professionals in the guise of quality and convenience gave limited choices and bringing about inability of patient to complete courses, and eventually requiring more expensive drugs later to address. Registration was also very long.

<sup>1</sup> DOH(2005), National Objectives for Health, 2005-2010

<sup>2</sup> Batangan, D., The Prices people have to pay for medicines in the Philippines, WHO/HAI, 2006

<sup>3</sup> Study on the Impact of Decentralization on the Access of Essential Medicines, Social Development Research Center, De La Salle University as commissioned by WHO/PHL, 2006

Given, these challenges, lowering of drug prices and widening access have been spiritedly pursued using a various means such parallel drug importation, widening and strengthening Botika ng Barangay networks and making over the counter drugs in national food authorities rolling stores and supermarkets, improving supply management and procurement systems, mechanisms for pooled procurement among health facilities and across LGUs to realize economies of scale. Then Cheaper Quality Medicine Act of 2008 and the Food and Drugs Administration Act of 2009 were then in the drawing board.

Also, strategies for good governance for health include establishing inter-LGU coordination mechanisms; developing performance assessment systems; institutionalizing professional track mechanisms and improving management support systems to enhance delivery of health goods and services; including improving public finance and procurement and logistics and warehousing capacity system.<sup>4</sup> It likewise consisted of setting up the policies and systems for transparency and accountability, mustering the political will to enforce the rules and providing the right incentives to ensure positive behaviors of players.

The integrity development program (IDP) had 22 “must” activities.<sup>5</sup> An integrity development review (IDR)<sup>6</sup> and corruption vulnerability assessment was conducted in 2006 by the Office of Ombudsman which included procurement and drug regulation. Also, an agency procurement performance assessment had also been undertaken with civil society (Transparency Accountability Network) and the Government Procurement Policy Board (GPPB).

Through the IDP, the DOH issued the following policies: “norms of behavior (code of conduct) for employees and officials, policy and rules on gift giving, rules on internal whistle blowing and reporting, rules on public disclosure, reproduction and dissemination of the compilation of anti-corruption laws, rules and regulations. The GPPB also issued blacklisting guidelines and has been publishing blacklisted companies and individuals. All employees were made to acknowledge receipt and to certify that they have read and fully understood the provisions of above six issuances.

This case study shows the experience of the Philippines in implementing the GGM and how it has been harmonizing it with existing initiatives. A mechanism of advocating the program in the form of awarding and recognizing good practices and innovative programs is discussed. The awards espouses a minimum standard requirements essential for a good medicine supply chain. A complying facility merits recognition and given an incentive to further make their health facility compliant.

## **C. GGM IMPLEMENTATION**

### **1. OBJECTIVES AND STRATEGY**

Government with civil society support was determined and passionate to improve access to cheaper and quality medicines especially the poor and vulnerable. The GGM was an addition to what were being undertaken. Since the program is has analogous goals with the government’s anti-corruption initiatives, and the health sector reform agenda on better medicine access, regulatory systems and good governance for health, accepting was easy but integrating and/or harmonizing it with current initiatives to avoid redundancy and confusion was a challenge. In 2008, programs with similar intentions, were plotted and a decision was made to ride on or harmonize these to the extent practicable.

The over-all goal of the program is to institutionalize transparency and good governance along the registration, regulation, selection and use, procurement and management of medicines. Based on the GGM and parallel activities, the problems were not just attributed to individual motivation and also because it is systemic. Thus, the framework for implementation identified two key components: accountable individuals and accountable systems. The former include promotion ethical code of conduct, compliance to civil

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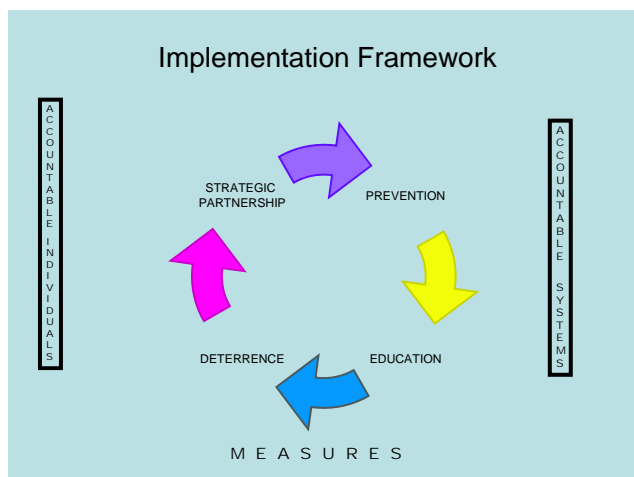
<sup>4</sup> DOH(2005), National Objectives for Health, 2005-2010

<sup>5</sup> Integrity Development Committee (2005), ‘Twenty (22) Doables,’ Manila: Presidential Anti-Graft Commission

<sup>6</sup> The IDR is a preventive measure against corruption and systems improvement tool used by the Office of the Ombudsman

service rules for government and disciplinary actions under existing laws <sup>7</sup> and putting up of ethical committees in both public and private sector among others. The approaches that will be used are: influencing organizational culture, fostering acceptable leadership values, establishing incentive mechanisms or merit system for good behaviour and compliance to rules and standards and disciplinary measures to those who do not. Accountable systems means transparency, evidenced-based decision making and good governance which means implementation of standards and protocols for medicine registration, selection, procurement, management and use.

Thus, it is a disciplined-based and value-based strategy and takes on health systems approaches in consonance to the country's health sector reform agenda, political structures and Filipino culture.



Approaches and methods <sup>8</sup> for having these key components implemented are grouped into four, namely: education, deterrence and enforcement, prevention, and strategic partnership with civil society, industry, professional organization and other stakeholders. Education is in the form of advocacy to fight against graft and corruption, and values formation. Deterrence and Enforcement, means making corruption a high-risk and low-reward undertaking. Prevention is focussing in reforming and making systems efficient and transparent. Strategic Partnership is enjoining public support will provide check and balance and enhanced systems.

The strategic objectives for 2007-2009 focussed on putting up the needed structure, to manage policy concerns and operations. The working group on ethical framework should bring forth a GGM Committee to finalize and seek approval of management in promoting the unified core values and GGM program framework. Coordination aspect is the harmonization of same or parallel activities such as the development and implementation of a code of conduct, gift-giving policy, whistle blowing and public disclosure; and harmonization with existing systems reforms or improvements. For promotion and socialization, it is to develop advocacy tools and materials, development of a training program, and GGM manuals and provision of assistance in the dissemination of SOPs and collection and dissemination of best practices on good governance in medicine among health facilities.<sup>9</sup>

## 2. KEY MILESTONES

| Key Milestones  | Dates                      |
|---|----------------------------|
| Phase I: National Assessment of transparency and potential vulnerability to corruption  |                            |
| • Official letter DOH Supporting transparency assessment                                | November 2004              |
| • Conduct of Assessment   | January – February 2005    |
| Phase II: Development of national GGM framework   |                            |
| • 1 <sup>st</sup> national GGM workshop and adoption of transparency assessment results | 31 August-2 September 2005 |

<sup>7</sup> 1987 Constitution of the Philippines Article XI – Accountability of Public Officers; RA 6713: Code of Conduct and Ethical Standards for Public Officials and Employees; PD 46: Making it Punishable for Public Officials and Employees to Receive Gift and for Private Persons to give, Gifts on any Occasion including Christmas; RA 7305: Magna Carta for Public Health Workers, etc.; Executive Order on the Institutionalization of Code of Conduct for Public Procurement initiated by the Office of Ombudsman (national effort)

<sup>8</sup> Modified from the Integrity Development Plan, Implementation Framework (Presidential Ant-Graft Commission).

<sup>9</sup> DOH 'GGM Program Framework,' for 2007-2009' as revised in December 2009

| Key Milestones   | Dates                         |
|--|-------------------------------|
| • Harmonization with the Integrity Development Program   | January - December 2006, 2007 |
| • Consensus Building Workshop on Promoting Ethical Practices (Harmonization Workshop)  | November 9-10, 2006           |
| • 1 <sup>st</sup> draft national ethical infrastructure  | November 2006                 |
| • Official publication of national transparency assessment report  | 2006 (done by WHO)            |
| Phase III: Implementation of the GGM program   |                               |
| • Creation of Committee to implement GGM   | April 2007                    |
| • Stakeholders (LGU, academe, DOH, pharmacist association, Anti-corruption Bodies, civil society, etc) Orientation on the GGM and Launching of the GGM award and Pledging of Support to GGM including a press conference | August 2008                   |
| • Presentation and Solicitation of Pledge of Support from the National Health Sector Meeting   | August, 2008                  |
| • GGM Awards   |                               |
| • Official Publication in newspapers and website posting   | October-December 2008         |
| • Deadline in the submission of Expression of participation  | January 2009                  |
| • Assessment of Entries  | April-October 2009            |
| • Awarding ceremonies  | January 2010                  |
| • Post awards review   | February 2010                 |
| • Endorsement of the program to National Center for Pharmaceutical Access and Management   | March 2010                    |
| • Stakeholders meeting to review GGM Framework and Implementation  | March 2010                    |
| • GGM manual   |                               |
| • Engagement of consultant   | January 2009                  |
| • 1 <sup>st</sup> Draft  | August 2009                   |
| • 2 <sup>nd</sup> Draft  | January 2010                  |
| • 3 <sup>rd</sup> Draft  | April 2010                    |

### 3. MAIN ACTIVITIES

#### a. Transparency Assessment

Being one of the pilot countries, the assessment was limited to registration, selection and procurement. The assessment was undertaken by two consultants from the University of the Philippines and Procurement Watch Inc. Thirty key informants (KI) or 10 KIs for each decision point were initially selected. However, 35 KIs representing a multi-sectoral group of government officials and technical staff involved in the three areas, and representatives from non-government organizations, pharmaceutical industry and hospitals were interviewed initially and consulted in succeeding group validations which were undertaken for two months.

The final result showed the following:<sup>10</sup>

| Registration          | Selection             | Procurement          |
|-----------------------|-----------------------|----------------------|
| 6.8                   | 6.1                   | 8.5                  |
| Marginally Vulnerable | Marginally Vulnerable | Minimally Vulnerable |

The following are the noted weaknesses and strengths:

<sup>10</sup> WHO (2006), "Measuring transparency in medicines: registration, selection and procurement, four country assessment studies," Geneva: WHO

## **Registration**

Registration of pharmaceutical products is undertaken by the Bureau of Food and Drugs or the now the Food and Drug Authority.

Strengths:

- Existence of a list of all registered pharmaceutical products and an information system for the registration these products;
- With written procedure on the submission and assessment of application; standard application form including required level of detail of information;
- Formally established and operational registration committee with technically capable members; and mechanism of providing written information of all decisions on application with explanation for rejection as the case maybe; and
- Known appeals process

Weaknesses:

- No guideline for committees composition and terms of reference of members;
- No declaration of conflict of interest for the committee members and involved public officials.
- Need to review and improve the decision-making process of various groups/ committees involved from application to actual approval or disapproval of application

## **Selection**

Selection at national level for the EDML, is done by national committee of experts and health practitioners. In each hospital, there is a Therapeutic Committee.

Strengths:

- Availability of a national essential medicines list (Philippine National Drug Formulary) with the DOH as primary responsible body;
- Publicly available documented selection process for including and deleting medicines from the EML and criteria for inclusion of new products;
- Procedures for selection process is transparent and in-line with WHO recommended procedures such as listing by generic name and based on national standard treatment guidelines;
- Available terms of reference for selection committee with description of roles and responsibilities

Weaknesses:

- No conflict of interest form for the selection committee and ensure obligatory completion;
- No specific regulation prohibiting committee members to accept gifts from pharmaceutical companies although general principles are present;
- Terms of membership are not in public domain;
- Decision making process indicated in SOPs have different levels of clarity and transparency
- Decisions are not widely disseminated but publicly available

## **Procurement**

Procurement is done by the DOH central office only for all vaccines, drugs for TB and for diseases for elimination, each DOH hospital, province, city and municipality

#### Strengths:

- Procurement of pharmaceutical products are competitive as prescribed by the Procurement Reform Act requiring use of competitive bidding as default mode of procurement and the use of standard bidding documents in all government agencies;
- Bulk procurement done in some cases;
- Use of transparent procurement procedures as these are written and publicly available and include specific requirements such as use of generic names, based on the Philippine National Drug Formulary;
- Use of an objective quantification methods for purchases;
- Clear procedure to ensure delivery and payment link;
- Monitoring system and reporting of suppliers performance and existence of a suppliers blacklisting mechanism.

#### Weaknesses:

- Need to strengthen formal appeals process for bid rejection;
- Need regular audit of procurement offices

### **Key recommendations and Status of Implementation**

Some of the recommendations are confirmation of various assessments previously undertaken. Actions undertaken are part of the over-all reforms in health regulation and good governance as stipulated in NOH.

#### Drug Registration

1. Review and implement the proposal to reorganize the BFAD to meet needs of drug registration. It shall be done with the passage of the Food and Drugs Administration Act of 2009 which included a separate Center for Drug Regulation and Research
2. Acquire technical assistance to help review and set up ethical practices and systems. This is one intention of the GGM manual. Also in 2007, BFAD was part of an Integrity Development Review conducted by the Office of the Ombudsman and regular monitoring of action taken.
3. Train officials and staff on good governance and ethical practices in drug management. Several orientations on value formation, anti-red tape and moral recovery programs have been so far undertaken. The GGM Manual should also address this.
4. Develop and maintain an efficient data management system. The computerization of FDA is ongoing including upgrading of their website.
5. Strengthen post market surveillance. Strengthening is ongoing. BFAD has been pursuing a risk-based approach in selecting products for analysis especially newly marketed products, providing capacity building to promote compliance with cGMP to conform to international standards and implementation. Last year, even started implementing an online public ADR reporting. Also, there is ongoing improvement to bring to operation two satellite BFAD laboratories in the Visayas and Mindanao
6. Clarify powers and responsibilities of the evaluation committee for drug registration under the Product Registration Division relative to current process with an external advisory committee and the BFAD management committee. Have been undertaken.
7. Develop and enforce the standard form for conflict of interest. The GGM manual includes a COI
8. Assess the period and duration of drug registration and decision-making. Being undertaken and additional personnel had been hired to facilitate the process. In compliance to the Anti-Red tape Act, the BFAD/FDA has posted in their website and in conspicuous place in their compound its Citizen's Charter providing the step by step process of drug registration including fees, location of office and duration of activity.

#### Drug Selection

1. Facilitate the update the 2000 Philippine National Drug Formulary (PNDF) and it widely disseminated. This had been revised and published and the next edition is upcoming

2. Assess the demand among hospital pharmacies for drugs listed in the PNDF and requests for inclusion for new drugs. New guidelines for request inclusion in the PNDF and policy on procuring and using drugs not in the PNDF have been released
3. Identify best practices and models in drugs selection. One intention of GGM awards.
4. Develop and enforce standards form for COI and guidelines on how the drug selection committee and pharmaceutical should relate to each other. COI form and mechanics is in the GGM manual.

#### Drug Procurement

1. Document all formal appeals made by the bidder on the BAC action. The revised implementing rules and regulations of the Government Procurement Reform Act 2009 has stipulated filing of motion for reconsideration and appeals mechanism for every BAC action.
2. Bar poor performing suppliers from participation in future biddings. A simplified supplier registration system is in place, and there is a blacklisting mechanism but need strengthening.
3. Strengthen the Management Information System to better track the procurement process. The World Bank currently is funding the development of Procurement Operation and Management Information System including Supply Management System. Also, the Phil. Government Electronic Procurement System provides a means of tracking the procurement since it requires posting of invitation to bid and awards
4. Monitor modes of alternative procurement and default mode of drug procurement (competitive bidding). Procurement office have undertaken regular monitoring of procurement of DOH hospitals since 2009.

#### **b. Development of the GGM framework or strategy**

After the assessment, the assessors were paired with government officials from the BFAD and the Procurement Office to define the ethical infrastructure. An advocacy brochure was designed to promote the core values through Procurement Watch. A national workshop was undertaken to develop the ethical framework. With similar and related of anti-corruption efforts done by government especially in the DOH, it was agreed to harmonize it with the integrity development programs whose components are similar. A discussion also ensued with regards to whether to just concentrate on the disciplined-based and value-based strategy given the on-going health systems reform. It was agreed to address both the individual level and systems by building "accountable systems" by which and through which "accountable individuals" can work. A personnel order was also made to name members on the ethical framework, develop advocacy mechanism and training program to socialize the framework.

A technical assistance from EC was provided to hold a consensus workshop on the core values and framework and what to do next. An accord was made on the unified core values which was made certain that it is similar with existing. Most of the components of the framework, are also part of the 22 'doubles' of the Integrity Development Plan mandated by the Presidential Anti-Graft Commission such as the norms of behavior (code of conduct), whistle blowing mechanism, gift policy, public disclosure. These may be customized for medicine registration, selection and procurement if necessary. There are also already very specific anti-corruption laws such as the code of conduct and ethical standards for public officials and employees, anti-red tape act, moral recovery program, procurement reform act and regulatory system reform.

With all these, coordination and matching were undertaken. So, programs with similar intentions, were plotted and a decision was made to ride on or ensure that activities complement each other.



## Harmonization with other Anti-Corruption & Integrity Development Programs

|  | 2004   | 2005   | 2006  | 2007  | 2008  |
|--|--|--|---|---|---|
| <b>Good Governance For Medicines</b>       | Assessment   | 1 <sup>st</sup> National GGM Workshop Presenting results to key stakeholders and Development of Action Plan  | 2 <sup>nd</sup> 1 <sup>st</sup> National GGM Workshop developing GGM NEI  | <ul style="list-style-type: none"> <li>• Draft NEI</li> <li>• GGM committee creation</li> <li>• TOR for GGM Manual</li> </ul>   | <ul style="list-style-type: none"> <li>• Technical assistance on development of National GGM Manual &amp; Communication Plan</li> <li>• Orientation on the GGM and soft launch of National GGM &amp; Awards &amp; consultation workshop</li> <li>• Presentation of the GGM &amp; Awards to the National Health Sector Meeting</li> <li>• Pledge of Commitment</li> </ul>  |
| <b>HSRA Good Governance Pillar</b>         | <ul style="list-style-type: none"> <li>• Medium Term Philippine Development Plan 2004-2010, Anti-corruption Thrust agenda</li> <li>• Launching of "Countering Corruption through Integrity Development"</li> <li>• DOH Integrity Development Action Plan</li> <li>• Procurement law full implementation</li> </ul> | <ul style="list-style-type: none"> <li>• National Objectives for Health, good governance Pillar</li> <li>• Medicine Monitoring Project with NAMFREL (CS)</li> <li>• Review of workflows and flowcharts</li> <li>• DOH Integrity Development Committee (IDC) with CS and resident Ombudsman as members</li> <li>• Regional IDCs</li> <li>• Start of the Aham! Aha! Training</li> <li>• Suppliers Blacklisting guidelines</li> </ul> | <ul style="list-style-type: none"> <li>• Alliance with Transparency Accountability Network</li> <li>• Integrity Development Review</li> </ul> | <ul style="list-style-type: none"> <li>• Presentation of the IDR results</li> <li>• Norms of behavior /code of conduct</li> <li>• Rules on gift giving</li> <li>• DOH customized procurement manuals</li> </ul> | <ul style="list-style-type: none"> <li>• Reproduction and dissemination of updated compilation of anti-corruption laws, rules &amp; regulations</li> <li>• Retiteration of Guidelines on Blacklisting &amp; publication of blacklisted suppliers</li> <li>• Rules on Public Disclosure</li> <li>• Rules on internal whistle blowing and reporting</li> <li>• Anti-corruption and Integrity Development Action plan, 2008-2010</li> <li>• Start of advocacy for policies on norms of behavior, gift giving, public disclosure, whistle blowing, etc</li> </ul> |
| CONTINUOUS SYSTEMS AND PROCESS IMPROVEMENT |  |  |   |   |   |

### c. Implementation of the GGM program

Given other existing efforts and ongoing systems improvement, the implementation focused in two specific activities that will address the two main components: for accountable system - the GGM awards, and for accountable individuals – the GGM manuals on registration, selection and procurement supplementing integrity development activities in the bureaucracy on norms of behavior or code of conduct, gift giving, public disclosure, whistle blowing and reporting, anti-red tape, moral recovery, etc.

#### ***NATIONAL AWARDS ON GOOD GOVERNANCE IN MEDICINES***

The GGM awards was designed as an advocacy and a compliance mechanism with the primary goal to institutionalize transparency and good governance along the registration, regulation, selection and use, procurement and over-all management of medicines in the public and private sector. Specifically, it intends to instill that transparency and good governance are essential in improving access to medicines; recognize practices in transparency and good governance for medicines in both the private and public sector; and provide incentives for these good practices and build models and duplicate them.

A major consideration in the launching the awards is the challenge for good governance within the context of a decentralized health system. The Local Government Code has devolved health services to LGUs, with each level procuring medicines on their own. There are concerns in transparency, high transaction cost, accountability in selection, rational use, allocation and financing, compromising access of medicines in the local level.<sup>11 12</sup> There are however good practices and innovative programs to improve access to medicines at the local level.

The first awards was launched in August 2008 which included an orientation of the program and pledging of support. The awarding was done last January 2010 among 12 entries. The entries were assessed on their compliance to WHO and national standards for their over-all management of medicine and including access, and enjoined to further improve their systems and processes. The criteria are on minimum structural and systems requirements; transparency and good governance structures and systems; medicine

<sup>11</sup> Study on the Impact of Decentralization on the Access of Essential Medicines, Social Development Research Center, De La Salle university as commissioned by WHO/PHL, 2006; Batangan, D., The Prices people have to pay for medicines in the Philippines, WHO/HAI, 2006

<sup>12</sup> DOH, WHO (2008) 'GGM Awards Primer'

selection, procurement, management, financing, rational use and access. Example of the criteria are: presence of a functional drugs and therapeutic committee, use of the Philippine National Drug Formulary as basis during selection, an annual procurement plan and Certificate of Product Registration during procurement and inspection, compliance to the procurement law, First Expiry, First Out and maintaining required temperature and stock levels, use of standard clinical practice guidelines, availability of essential medicines and rationality of procurement and retail prices, among others.<sup>13</sup> The 2<sup>nd</sup> awards may be launched on the 3<sup>rd</sup> quarter of this year with improved administration and mechanics.



The Awards are given in three categories namely for local government units, national health facilities and the private sector. A total of twelve (12) that took the challenge: eight were (8) Local Government Units (LGUs), three (3) national health facilities or DOH hospitals and one (1) from the private sector. Three special awards be given to those who have satisfactorily conformed to a number of the WHO and national standards to be used to improve their systems. The 12 are expected to pledge to comply with all the criteria and thus, shall vie for the next awards.

### GGM Manuals

The development of Manuals of Good Governance in Medicines is another specific endeavor to translate into more practical strategies the values and principles espoused. The manuals describes possibilities, expressions and symptoms of corrupt practices across the pharmaceutical procurement cycle, registration and selection and identifies measures and tools to manage these risks. The manuals are in its semi-final form (version 3). The manuals have to be simplified and made very specific on medicines.

## 5. Funding

The implementation is both funded by the WHO and the regular budget of government. Funding has not been a problem in the implementation. Major events such the GGM awards and the development of the GGM manuals are at this time purely funded by WHO. Other activities which are not purely GGM specific but are part of good governance reforms and integrity development initiatives are funded by government. Improvements in procurement and drug management, rational use and access are funded separately by government with support from development partners such as the World Bank and European Commission.

At this stage of implementation, and the establishment of the National Center for Pharmaceutical Access and Management which is taking the technical secretariat work for the program, majority of the funding will be borne by this office with support major events such as the GGM awards from WHO and MeTA.

<sup>13</sup> DOH,WHO/Phi (2008) 'GGM Awards Assessment Tool'

## D. LESSONS LEARNT

The assessment results further emphasized previous systems improvements needed. Because the program is in line with the country's anti-corruption initiatives and the health sector reform agenda on medicine access and management and in public finance management, it elicited great interest and has been adopted right away by the DOH. The challenge is how to integrate this initiative with the existing efforts given different players and priorities, and to broaden the perspective of good governance in medicine within the country's medicine access and management reforms. It requires health systems approaches in addition to disciplined-based and the value-based strategies. Thus, the program has to be coordinated with various stakeholders and have to carefully consider the existing initiatives and plans to ensure that these do not duplicate or contradict each other but contribute to the over-all goal.

Another, push factor is the active participation of the private sector and academe and civil society such as the Procurement Watch, NAMFREL as part of their Medicine Monitoring Project, academe, pharmaceutical industry, MeTA, professional organization and the anti-corruption bodies. The WHO country office and the regional office relentlessly provided technical assistance and funding support. The adoption of specific offices of the program in the assessment and implementation such as the BFAD then Procurement Office that acted as the technical and administrative secretariat in specific phases is also critical. Later, a committee on the ethical infrastructure development and implementation was organized ensuring key players in pushing the program forward. High ranking champions among stakeholders in the assessment, definition of the ethical infrastructure in the GGM awards administration and implementation are also necessary. A critical mass of GGM advocates must be engaged to guarantee adoption and sustainability.

The form of implementing the program must also be culturally acceptable given myriad of similar initiatives especially on anti-graft and corruption that people have become skeptical. Thus, the GGM awards was conceptualized.

Post-awards review emphasized that the process, criteria, categories and prizes or incentives and the mechanisms and administrative arrangement within which the awards was undertaken must be reviewed. The contest must be made sustainable and prestigious for more buy in. This first contest showed that most of the good practices are on medicine procurement. Advocacy and capacity building on other aspects in coordination with concerned offices must be done with the health facilities and service providers to comply with at least with the minimum standards.

### **Future Directions**

The Program has been formally endorsed to the newly created National Center for Medicine Access and Management based on the Cheaper Quality Medicine Act of 2008. This is to ensure that it is institutionalized within the DOH and ensure its integration with the over-all efforts on medicine access and management, implementation of the Cheaper Quality Medicine Act and the New Food and Drugs Administration Act of 2009. A stakeholders meeting was undertaken last March and it was agreed to have a Phase IV to review the GGM implementation framework and identify what can be achieved in 3 years.

In the short term, from the experience of the GGM Awards, a Pharmaceutical Benchbook will be developed to provide a general framework and minimum standards and requirements to ensure quality systems and processes, transparency and good governance, medicine access, availability, affordable prices and sustained financing for essential medicines, acceptable selection and rational use, procurement, allocation and supply management.

In the short term, a pharmaceutical bench book identifying minimum criteria or standard based on the GGM awards criteria will be developed. The benchbook will:

- a. Provide minimum requirements and indicators for local government units and private health providers in ensuring access, availability, affordable prices and sustainable financing for essential medicines.

- b. Ensure the proper selection, quantification and quality and safety of medicines at all levels
- c. Provide indicators and benchmarks for good governance and transparency in medicines selection a rational use, procurement, allocation and re-imburement.
- d. Provide a mechanism for ensuring quality systems and processes in medicines management.
- e. and later provide benchmark for the accreditation of facilities for medicines re-imburement.

Criteria for both the public and private sector will be developed. Standards above the minimum criteria will also be identified. The LGUs will capacitated on the minimum standards and maybe given awards for the compliance to criteria above the minimum or for innovations. The awards should in the long term give also incentives to good performing physicians, pharmaceutical industry and pharmacy. The coordination structures and key strategies will be reviewed including the new implementation framework.