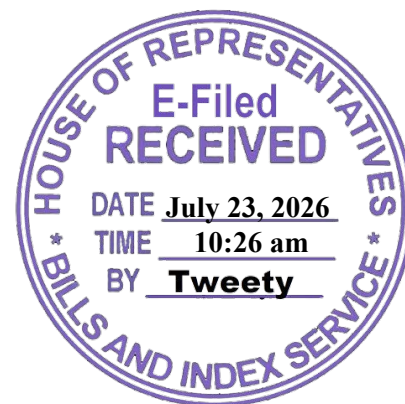


Republic of the Philippines
HOUSE OF REPRESENTATIVES
Quezon City
TWENTIETH CONGRESS
Second Regular Session



HOUSE BILL NO. 10205

Introduced by: **REP. TOBIAS “TOBY” M. TIANGCO**

EXPLANATORY NOTE

Access to essential medicines is a basic component of the right to health and a necessary condition for the effective implementation of Universal Health Care in the Philippines. *Republic Act No. 11223*, or *the Universal Health Care Act*, declares the policy of ensuring that all Filipinos are guaranteed equitable access to quality and affordable health care goods and services and are protected against financial risk. However, this promise becomes difficult to realize when public health facilities are unable to provide the essential medicines that patients need.

In the Philippines, medicine stockouts are not merely supply or inventory problems. They directly affect patients, especially the poor, elderly, persons with chronic illnesses, and those living in geographically isolated or disadvantaged areas. When essential medicines are unavailable in public hospitals, rural health units, city health offices, or government pharmacies, patients are often forced to delay treatment, interrupt maintenance therapy, travel to another facility, or purchase medicines from private drugstores using their own money.

Studies and government data show that the problem of medicine availability remains persistent. The *2017 Health Facility and Household Survey on Access to and Use of Medicines* found that key essential medicines were only partially available in public health facilities at 69%, in public-sector warehouses at 74%, and in private pharmacies at 63%. The same study reported long stockout durations: 69 days at public procurement level and 63 days in the public sector, indicating that essential medicines are not continuously available.

The *Philippine Institute for Development Studies (PIDS)* likewise noted that only two in every ten hospitals had the complete set of sixteen (16) essential medicines examined in its service capacity and readiness study. PIDS emphasized that lack of availability forces patients to buy medicines outside health facilities, increasing out-of-pocket expenses. This is especially burdensome in a country where household out-of-pocket payments still accounted for 44.4% of *Current Health Expenditure* in 2023, the highest share among health financing schemes for that year.

The *Philippine National Formulary (PNF)* already identifies medicines that satisfy the priority health needs of the population based on evidence of efficacy, safety, and comparative cost-effectiveness. Recent PhilHealth guidance also states that health care providers should ensure that PNF drugs are available for their usual case-mix, as these are used for claims reimbursement and performance monitoring. Yet despite the existence of the PNF, patients and policymakers often do not have timely, facility-level information on whether these medicines are actually available, low in stock, or already stocked out.

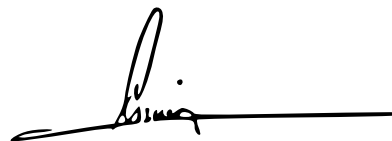
For these reasons, this bill seeks to establish an *Essential Medicines Stockout Transparency System* requiring public health facilities, government hospitals, local government health units, public pharmacies, and government medicine warehouses to regularly report the availability, low-stock status, and stockout status of essential medicines. The proposed measure shall require the Department of Health (DOH), in coordination with PhilHealth, the Department of the Interior and Local Government (DILG), local government units, and other concerned agencies, to maintain a public and regularly updated dashboard showing medicine availability by facility, generic name, dosage form, and expected replenishment date.

This Act shall also require every covered facility to prepare and implement a Stockout Response Plan whenever an essential medicine becomes unavailable or reaches critical stock level. Such plan may include emergency procurement, inter-facility redistribution, referral to nearby facilities with available stock, and written notice to patients. The bill further mandates periodic audits, public reporting, and accountability mechanisms while protecting patient privacy and confidential procurement information.

This proposed legislation does not seek to punish honest reporting of stockouts. Rather, it seeks to prevent hidden stockouts, late responses, and avoidable treatment interruptions. By making stockout information visible, government can identify recurring supply gaps, support LGUs with weaker procurement capacity, improve forecasting, and protect patients from unnecessary out-of-pocket spending.

Transparency in essential medicines is transparency in health care itself. A medicine listed as essential must not only exist in policy; it must be available when and where patients need it.

In view of the foregoing, the immediate passage of this bill is earnestly sought.

A handwritten signature in black ink, appearing to read 'Toby', followed by a long horizontal line.

TOBIAS “TOBY” M. TIANGCO
Representative
Lone District, Navotas City

Republic of the Philippines
HOUSE OF REPRESENTATIVES
Quezon City

TWENTIETH CONGRESS
Second Regular Session

HOUSE BILL NO. 10205

Introduced by: **REP. TOBIAS “TOBY” M. TIANGCO**

**AN ACT REQUIRING PUBLIC HEALTH FACILITIES TO DISCLOSE ESSENTIAL
MEDICINES AVAILABILITY, LOW-STOCK STATUS, STOCKOUTS, RESTOCKING
TIMELINES, AND PROCUREMENT STATUS, CREATING A NATIONAL
ESSENTIAL MEDICINES AVAILABILITY DASHBOARD, AND PROVIDING
PENALTIES FOR NON-COMPLIANCE**

SECTION 1. *Short Title.*—This Act shall be known as the “Essential Medicines Stockout Transparency Act.”

SEC. 2. *Declaration of Policy.*—It is hereby declared the policy of the State to protect and promote the right to health of the Filipino people by ensuring timely, equitable, and affordable access to essential medicines in public health facilities.

Consistent with Universal Health Care, the State shall promote transparency, accountability, and timely public access to information on the availability of essential medicines in government hospitals, local health facilities, public pharmacies, and medicine warehouses.

The State recognizes that the unavailability of essential medicines in public health facilities causes treatment delays, treatment interruption, unnecessary referrals, and additional out-of-pocket expenses for patients. Therefore, the government shall establish a mandatory reporting and disclosure system for medicine availability, stockouts, restocking timelines, and procurement status.

SEC. 3. *Coverage.*—This Act shall apply to the following:

- a. Department of Health-retained hospitals;
- b. Specialty hospitals and medical centers owned or controlled by the National Government;
- c. Provincial, city, municipal, and district hospitals;
- d. Rural Health Units, City Health Offices, Municipal Health Offices, barangay health stations, and other primary care facilities operated by local government units;
- e. Public pharmacies, Botika ng Bayan outlets, or government medicine dispensing points;
- f. Central, regional, provincial, city, or municipal medicine warehouses and storage facilities;
- g. PhilHealth-accredited public primary care providers and public health facilities dispensing medicines reimbursable or covered under government health benefit packages; and

h. Other public health facilities or government medicine access points as may be identified by the Department of Health.

SEC. 4. *Definition of Terms.*—For purposes of this Act:

a. *Essential Medicines* refer to medicines included in the Philippine National Formulary, Essential Medicines List, and other priority medicine lists officially adopted by the Department of Health for public health programs, primary care, hospitals, emergency care, maternal and child health, communicable diseases, non-communicable diseases, and other priority health needs.

b. *Priority Essential Medicines* refer to a subset of essential medicines identified by the Department of Health for mandatory and more frequent reporting due to high demand, public health importance, chronic disease use, emergency use, or recurring stockout risk. These shall include, at minimum, medicines for hypertension, diabetes, asthma, infections, tuberculosis, maternal care, child health, mental health, emergency care, and other priority conditions.

c. *Stockout* refers to the complete unavailability of a covered medicine in a public health facility, pharmacy, dispensing point, or warehouse where such medicine is required to be normally available based on the facility's service capacity, usual case mix, approved medicine list, or public health program mandate.

d. *Low-stock status* refers to a condition where the remaining stock of a covered medicine is equal to or less than fourteen days of average consumption, or below the minimum buffer stock level prescribed by the Department of Health, whichever is stricter.

e. *Medicine Availability Status* refers to the classification of each covered medicine as available, low-stock, out-of-stock, not applicable to the facility's service capacity, or temporarily unavailable due to recall, quality concern, emergency restriction, or other lawful cause.

f. *Restocking Timeline* refers to the expected date or period when a stockout or low-stock medicine will be replenished, based on purchase order, delivery schedule, inter-facility transfer, emergency procurement, or other authorized supply action.

g. *Procurement Status* refers to the current stage of procurement or supply action for a covered medicine, including procurement planning, purchase request preparation, posting, bidding, evaluation, award, purchase order issuance, delivery, inspection, acceptance, payment, emergency procurement, or inter-facility transfer.

h. *Dashboard* refers to an online public information system maintained by the Department of Health showing the availability, low-stock status, stockouts, restocking timelines, and procurement status of essential medicines in covered public health facilities.

SEC. 5. *Mandatory Reporting of Medicine Availability.*—All covered facilities shall submit regular medicine availability reports to the Department of Health through an electronic reporting system.

The report shall contain the following information for each covered medicine:

a. Generic name;

b. Dosage form;

- c. Strength or concentration;
- d. Unit of measure;
- e. Quantity on hand;
- f. Average monthly consumption or average weekly consumption, when available;
- g. Current status: available, low-stock, stockout, or not applicable;
- h. Date when low-stock or stockout status began;
- i. Cause of low-stock or stockout, if known;
- j. Procurement or replenishment status;
- k. Expected restocking date;
- l. Alternative source or nearest public facility with available stock, if known; and
- m. Name or designation of the reporting officer.

SEC. 6. *Reporting Frequency.*—Covered facilities shall comply with the following reporting periods:

- a. *Weekly reporting* for all covered essential medicines;
- b. *Daily reporting* for Priority Essential Medicines identified by the Department of Health;
- c. *Within twenty-four hours* from discovery of any stockout of a Priority Essential Medicine;
- d. *Within forty-eight hours* from discovery of any stockout of other covered essential medicines; and
- e. *Within twenty-four hours* from replenishment of any previously stocked-out medicine.

The Department of Health may require more frequent reporting during public health emergencies, disasters, disease outbreaks, supply disruptions, or other urgent health situations.

SEC. 7. *National Essential Medicines Availability Dashboard.*—The Department of Health shall establish and maintain a *National Essential Medicines Availability Dashboard* accessible to the public.

The Dashboard shall show, at minimum:

- a. Name and location of the public health facility;
- b. List of covered medicines by generic name, dosage form, and strength;
- c. Medicine availability status;
- d. Date of reported stockout or low-stock status;
- e. Expected restocking date;

- f. Procurement or replenishment status;
- g. Alternative public facility or source where the medicine may be available;
- h. Facility contact information for verification; and
- i. Date and time when the information was last updated.

The Dashboard shall be searchable by province, city, municipality, facility name, medicine name, and medicine status.

SEC. 8. *Patient Notice Requirement.*—Whenever a covered medicine is stocked out or under low-stock status, the public health facility shall post a visible notice at the pharmacy window, outpatient department, admitting area, or other relevant patient service area.

The notice shall indicate:

- a. Name of the unavailable or low-stock medicine;
- b. Date when the stockout or low-stock status began;
- c. Expected restocking date, if available;
- d. Whether an equivalent or alternative medicine is available;
- e. Nearest public facility or government medicine access point where the medicine may be available; and
- f. Contact details of the facility officer responsible for medicine availability concerns.

No patient shall be merely advised to purchase from a private pharmacy without first being informed of available public-sector alternatives, substitute medicines, or referral options.

SEC. 9. *Stockout Response Plan.*—Each covered facility shall prepare and implement a Stockout Response Plan whenever a medicine reaches low-stock or stockout status.

The plan shall include:

- a. Immediate verification of inventory records;
- b. Identification of the cause of stockout or low-stock status;
- c. Emergency request for replenishment;
- d. Inter-facility transfer or redistribution, when available;
- e. Referral of patients to the nearest public facility with available stock;
- f. Use of therapeutically equivalent alternatives, subject to clinical guidelines;
- g. Emergency procurement, when allowed by law;

- h. Written documentation of all actions taken; and
- i. Submission of the plan to the Department of Health within three working days from stockout confirmation.

SEC. 10. *Facility Medicine Availability Officer.*—Every covered facility shall designate a *Medicine Availability Officer*, who shall be responsible for:

- a. Submitting medicine availability reports;
- b. Updating stockout and restocking information;
- c. Coordinating with procurement, pharmacy, warehouse, and clinical units;
- d. Ensuring that patient notices are posted;
- e. Preparing stockout response reports; and
- f. Certifying the accuracy of submitted data.

For hospitals, the Medicine Availability Officer shall preferably be the chief pharmacist, supply officer, or other qualified personnel designated by the head of facility.

For RHUs, health centers, and barangay health stations, the officer may be the pharmacist, nurse, midwife, supply officer, or other qualified health personnel designated by the local health officer.

SEC. 11. *Procurement Status Disclosure.*—For medicines that are stocked out or under low-stock status, the concerned facility or procuring entity shall disclose the procurement or replenishment status, including:

- a. Whether procurement has already been initiated;
- b. Procurement mode or replenishment method;
- c. Date of purchase request or procurement request;
- d. Date of posting or bidding, if applicable;
- e. Date of award, purchase order, or contract issuance, if applicable;
- f. Supplier or source of supply after award;
- g. Expected delivery date;
- h. Reason for delay, if known; and
- i. Whether emergency procurement, direct contracting, repeat order, framework agreement, inter-facility transfer, or other lawful supply method is being used.

Disclosure under this section shall be consistent with procurement laws, data privacy laws, and lawful exceptions on confidential information.

SEC. 12. *Data Validation and Audit.*—The Department of Health shall conduct periodic validation of submitted medicine availability reports.

Validation may include:

- a. Comparison of reported stock levels with inventory records;
- b. Review of dispensing logs and prescription records;
- c. Review of delivery receipts, inspection reports, and stock cards;
- d. Random physical inventory inspection;
- e. Patient feedback verification;
- f. Coordination with local government units and hospital management; and
- g. Referral to the Commission on Audit, Civil Service Commission, or other appropriate body when warranted.

The Department of Health shall publish a quarterly summary report identifying facilities with recurring stockouts, delayed reporting, non-reporting, or inaccurate reporting.

SEC. 13. *Prohibited Acts.*—The following acts are prohibited:

- a. Failure to submit required medicine availability reports without valid cause;
- b. Repeated late submission of reports;
- c. Concealment of stockouts;
- d. False reporting of medicine availability;
- e. Manipulation of inventory data;
- f. Failure to post patient notices during stockouts;
- g. Failure to prepare or implement a Stockout Response Plan;
- h. Refusal to provide stockout information to patients or authorized government agencies;
- i. Retaliation against personnel who report true stockout information; and
- j. Any act intended to hide, delay, or distort the actual availability of essential medicines in a public health facility.

SEC. 14. *Penalties and Administrative Sanctions.*—Any public officer or employee who violates this Act shall be subject to the following:

- a. For the first offense: written warning and mandatory submission of a corrective action plan within five working days;

- b. For the second offense: administrative reprimand, mandatory compliance audit, and inclusion in the facility's performance review;
- c. For the third offense: administrative charges for neglect of duty, misconduct, dishonesty, or other applicable offense under civil service rules;
- d. For willful concealment, falsification, or manipulation of data: referral for administrative, civil, or criminal action under applicable laws.

For private entities contracted by government to provide, store, deliver, or dispense essential medicines, non-compliance may be a ground for contract termination, blacklisting, disqualification from future government contracts, forfeiture of performance security, or other sanctions allowed by law.

SEC. 15. *Patient Feedback and Complaint Mechanism.*—The Department of Health shall establish a patient feedback and complaint mechanism through the Dashboard, hotline, email, or other accessible platforms.

Patients may report:

- a. Medicines listed as available but unavailable upon visit;
- b. Failure of a facility to post stockout notices;
- c. Repeated stockouts;
- d. Refusal to provide stockout information;
- e. Unreasonable referral to private pharmacies; or
- f. Other concerns involving access to essential medicines.

Complaints shall be acted upon within seven working days, unless urgent action is required due to life-threatening or emergency medical need.

SEC. 16. *Protection of Reporting Personnel.*—No public officer, employee, pharmacist, health worker, or facility personnel shall be punished, transferred, demoted, harassed, or retaliated against for truthfully reporting medicine stockouts, low-stock status, procurement delays, or inaccurate inventory data.

Any retaliatory act shall be subject to administrative sanctions.

SEC. 17. *Data Privacy and Confidentiality.*—The Dashboard and reporting system shall not disclose patient names, prescriptions linked to identifiable patients, medical records, or other personal information.

Only facility-level and medicine-level data necessary for public transparency shall be disclosed.

SEC. 18. *Implementing Rules and Regulations.*—Within ninety (90) days from the effectivity of this Act, the Department of Health, in coordination with the Department of the Interior and Local Government, PhilHealth, Department of Budget and Management, Government Procurement Policy

Board, Commission on Audit, and representatives of local government units and public health facilities, shall issue the implementing rules and regulations.

The IRR shall include:

- a. Standard reporting templates;
- b. List of Priority Essential Medicines;
- c. Reporting deadlines;
- d. Dashboard design and data fields;
- e. Validation and audit procedures;
- f. Stockout response protocols;
- g. Patient notice templates;
- h. Complaint handling procedures; and
- i. Administrative sanction procedures.

SEC. 19. *Phased Implementation.*—Implementation shall be phased as follows:

- a. Within six months from effectivity, the Department of Health shall pilot the Dashboard in DOH-retained hospitals and selected LGU hospitals;
- b. Within one year, all DOH-retained hospitals, specialty hospitals, provincial hospitals, and city hospitals shall comply;
- c. Within eighteen months, all municipal hospitals, RHUs, city health offices, municipal health offices, and public pharmacies shall comply; and
- d. Within two years, barangay health stations and other local medicine access points shall be integrated, subject to technical readiness and DOH support.

SEC. 20. *Appropriations.*—The amount necessary for the initial implementation of this Act shall be charged against the current appropriations of the DOH.

Thereafter, the necessary amount shall be included in the annual General Appropriations Act.

Local government units shall include in their annual budgets the necessary funding for medicine inventory reporting, facility compliance, personnel training, and information system integration.

SEC. 21. *Separability Clause.*—If any provision of this Act is declared unconstitutional or invalid, the remaining provisions not affected shall remain in full force and effect.

SEC. 22. *Repealing Clause.*—All laws, decrees, executive orders, rules, regulations, issuances, or parts thereof inconsistent with this Act are hereby repealed or modified accordingly.

SEC. 23. *Effectivity.*—This Act shall take effect fifteen days after its publication in the Official Gazette or in a newspaper of general circulation.

Approved,