



International Labour Office



Case Studies of Community - Based Health Insurance Schemes in the Philippines

Extending Social Protection through Health Micro-Insurance Schemes
to Women in the informal Economy
(RAS/01/02/MNOR)



*Strategies and
Tools against social
Exclusion and
Poverty*

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ILO Subregional Office for South-East Asia and the Pacific

19th Floor, Yuchengco Tower, RCBC Plaza

6819 Ayala Avenue, Makati City 1200

P.O. Box 4959 Makati City, Philippines

Tel. No.: (+632) 580-9900

Fax. No.: (+632) 580-9999

E-mail: manila@ilomnl.org.ph

Website: www.ilo.org/manila

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STEP Global Programme

ILO Social Security Policy and Development Branch

4 Route des Morillons

CH-1211 Geneve 22 - Switzerland

Tel. No.: (+41 22) 799 - 6544

Fax. No.: (+41 22) 799 - 6644

E-mail: step@ilo.org

Website: www.ilo.org/step

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contents

Foreword	
INTRODUCTION	1
CHAPTER 1. BICAO Investment Care Administration Organization	5 - 30
1.1. Context	8
1.2. Implementation	13
1.3. Characteristics	19
1.4. The Actors' Point of View	26
1.5. Summary and Conclusions	27
CHAPTER 2. NOVADECI Health Care Program	31 - 78
2.1. Context	34
2.2. Implementation	38
2.3. Characteristics	47
2.4. Indicators	68
2.5. The Actors' Point of View	70
2.6. Summary and Conclusions	75
CHAPTER 3. ORT Health Plus Scheme	79 - 142
3.1. Context	82
3.2. Implementation	87
3.3. Characteristics	99
3.4. Indicators	129
3.5. The Actors' Point of View	130
3.6. Summary and Conclusions	139
REFERENCES	143 - 144

contents

APPENDICES		145 - 164
A	Health Insurance Policy, BICAO	146
B	Memorandum of Agreement, BICAO	149
C	Accreditation Agreement, NOVADECI	153
D	Collaboration Agreement, ORTHPS	157
TABLES		
Table 1.1	Top ten causes of mortality in Carmen	10
Table 1.2	Top ten causes of morbidity in Carmen	11
Table 1.3	Services covered by BICAO during its first term	17
Table 1.4	Resources used to finance BICAO's the first term	18
Table 2.1	Services covered by the NHCP during its First Term	43
Table 2.2	Resources used to finance the NHCP creation in the first term	44
Table 2.3	Salaried staff employed by the NHCP	45
Table 2.4	Current number of members and membership growth	49
Table 2.5	NHCP membership growth compared with Novadeci	50
Table 2.6	New services provided by the NHCP	51
Table 2.7a	Contributions and benefits schedule of NHCP	55
Table 2.7b	The Growth of NHCP	57

contents

TABLES

Table 2.8	Personnel employed by the NHCP	59
Table 2.9	Real role distribution	64
Table 3.1	Services covered by OHPS	94
Table 3.2	Resources used to finance OHPS creation on its first term	96
Table 3.3	Salaried staff employed by OHPS	98
Table 3.4	Technical assistance summary (creation phase and first year of operation)	98
Table 3.5	Current number of members and beneficiaries	102
Table 3.6	Total amount of budgeted contributions	110
Table 3.7	OHPS contribution rates	111
Table 3.8	Costs incurred by OHPS	112
Table 3.9	OHPS authorized providers	115
Table 3.10	Personnel (salaried and unsalaried) employed by OHPS	120
Table 3.11	Other salaried staff not employed by OHPS	121
Table 3.12	Real role distribution	124
Table 3.13	Main training of officials and personnel	126
Table 3.14	Space used for OHPS clinics	127
Table 3.15	Indicators of OHPS operations	129

list of abbreviations

ARB	Agrarian Reform Beneficiary
ARC	Agrarian Reform Community
BHS	Barangay Health Station
BHW	Barangay Health Worker
BIARSP	Belgian Integrated Agrarian Reform Support Programme
BICAO	Bicao Investment Care Administration Organization
BoD	Board of Directors
BSFMPC	Bicao Small Farmers Multipurpose Cooperative
BUA	Blood Uric Acid
BUN	Blood Urea Nitrogen
CBC	Complete Blood Count
CBR	Crude Birth Rate
CDA	Cooperatives Development Authority
CDR	Crude Death Rate
DAR	Department of Agrarian Reform
DAR-AP	DAR Agraryong Pangkalusugan (Agrarian Health)
DBM	Department of Budget and Management
DILG	Department of the Interior and Local Government
DOH	Department of Health
ECC	Employment Compensation Commission
ECG	Electro-cardiogram
FBS	Fasting Blood Sugar
GSIS	Government Social Insurance System
HSRA	Health Sector Reform Agenda

list of abbreviations

ILO	International Labour Organization
ITRMC	Ilocos Training and Regional Medical Center
LGU	Local Government Unit
MARO	Municipal Agrarian Reform Officer
MCC	Mother and Child Care Project
MMR	Maternal Mortality Rate
NATCCO	National Confederation of Cooperatives
NHCP	Novadeci Health Care Program
NHIP	National Health Insurance Program
NOVADECI	Novaliches Development Cooperative Incorporated
OCMC	ORT Community Multi-purpose Cooperative
OHPS	ORT Health Plus Scheme
ORT	Organizing for educational Resources and Training
ORT MCC	ORT Mother and Child Care Project
PCSO	Philippine Charity Sweepstakes Office
Ph.P.	Philippine Pesos
PHIC	Philippine Health Insurance Corporation
PhilHealth	Philippine Health Insurance Corporation
PTCA	Parent-Teacher Community Association
RHU	Rural Health Unit
SHINE	Social Health Insurance Networking and Empowerment
SSS	Social Security System
STEP	Strategies and Tools against social Exclusion and Poverty
WHO	World Health Organization

foreword

The Philippines has a great challenge on providing social protection coverage for all. Globally, only one in five of the world's population has adequate social security coverage while half of the world's population is without any social security protection. Those without coverage tend to work in the informal economy where women are more likely to be working, and are disproportionately found in the developing world.

Extending social security coverage to excluded populations is one of the chief priorities of the ILO in the framework of its global strategy aimed at ensuring that all people - both men and women - have decent work. Existing formal social security schemes are designed and focused on workers in formal employment. Although the appropriate legislation has been enacted in some cases to ensure that these benefits also reach workers in the informal economy, evidence suggests that only a very small percentage of these workers are able to access social protection through these structures.

The 89th session of the International Labour Conference in 2001 reached a new consensus on social security. It was agreed that the highest priority be given to "policies and initiatives, which can bring social security to those who are not covered by existing systems." New strategies for the extension of traditional social security mechanisms and the development of decentralized systems are being encouraged and developed. At the same time, the ILO promotes the design of sustainable linkages and bridges between decentralized and statutory systems.

This collection of case studies on three health micro-insurance schemes in the Philippines aims to show how communities developed their own mechanisms to provide members with social protection particularly health care. The hope is that this effort to document decentralized systems of social protection may be useful in contributing in developing linkages between these schemes and that of the national government and help make health care more accessible to the poor and the excluded.

These case studies were made possible through the project being implemented by the ILO Subregional Office for Southeast Asia and the Pacific and ILO's global programme, Strategies and Tools against Social Exclusion and Poverty (STEP) in the Philippines funded by the Government of Norway. This work was undertaken in the framework of the National Plan of Action for Decent Work in the Philippines. This report was prepared by Dr. Alexander G. Flor and his University of the Philippines Open University knowledge management team in September 2004 in collaboration with Mr. Kenichi Hirose, Social Protection Specialist; Ms. Naomi Cassirer, Gender Senior Specialist; Ms. Ginette Forgues,

foreword

Local Development Senior Specialist and Dr. Annie A. Asanza, National Project Coordinator of STEP.

We appreciate the following collaborators for their cooperation and valuable contribution to the case studies: Managers and staff of Bicao Investment Care Administration Organization, NOVADECI Health Care Program and ORT Health Plus Scheme; officials from the Department of Agrarian Reform and the Philippine Health Insurance Corporation; Dr. Aviva Ron and Mr. Avi Kupferman who lent the authors all the available documents on OHPS; and Ms. Marife Yap for providing invaluable comments as well as Ms. Evy Messell of the ILO. Appreciation is also extended to Ms. Eloisa Raymundo for secretarial support and assistance in finalizing the document.

We trust that this book will be a valuable reference for the development of an effective social security policy in the Philippines.

December 2004, Manila

Werner Konrad Blenk
Director
ILO Subregional Office for South-East Asia and the Pacific

Introduction



What determines the rational provision of health care?

Health care services are dependent not only on health care system supply factors but also on continued access to a balanced spectrum of health care for each member of the community, from the removal of financial barriers to seeking care. In many developing countries, government budgets for health have been significantly reduced leading to the implementation of mechanisms where government health care providers and institutions are allowed to apply user charges to all but the indigent population. In many of these developing countries, these services in public hospitals were the only source of care provided free of charge for the majority of the population. Moreover, in many countries the private health provider sector is to a large extent for-profit initiatives.

A system of user charges is currently being implemented in many developing countries as the mechanism to recover costs and augment decreasing government appropriations. However, the use of such a system has, over time, manifested some serious limitations. Poor families tend to delay seeking health care due to limited resources. Others tend to give low priority to health care over other necessary needs of the household. When charges cannot be avoided, payment for hospital care can force the sale of household assets,

including the source of household income. It is now recognized that the burden of having to pay for health care themselves at the time of illness can bring families below the poverty line. User charges are generally a fixed amount for a specific service, and are therefore by nature not progressive. This amount may be an insignificant expense for some families but presents an excessive burden for others.

Many countries, like the Philippines, have also introduced social health insurance as part of a package of social protection measures to be provided for its citizens. The implementation of this program is usually done in phases, starting with the formally employed and salaried workers. However, a huge majority of its labor force does not fit into this category. In the Philippines, it is recognized that more than 50 percent of the labor force belong to the informal economy or the so-called “underground economy”. These are the self-employed or small home-based enterprises in agriculture, services and marketing. These workers and their dependants have been generally excluded from the national and compulsory social security systems. Public and private sector providers of different social security mechanisms are reluctant to cover the informal sector because of difficulties in tracing and monitoring member contributions and benefits provision. Since such workers generally do not belong to any organized labor association or union, there has been little pressure to extend health insurance coverage to them.

In response to the increasing need for access to health care services, a sizable number of communities and associations in the Philippines have implemented community-based initiatives to provide some social security for its members. Most of these schemes are small and aim to generate health care financing through voluntary prepayment schemes or contributions. These usually start with very simple policies and procedures so as not to alienate and inhibit members from joining.

Attempts have been made to describe the different features of these programs in the Philippines. A minor subset of this cluster of community-based initiatives recognizes the operation of a voluntary pre-paid mechanism to access a package of out-patient and in-patient health care services for its members.

Such is the general environment within which micro-insurance schemes in the Philippines operate. The case studies being presented are examples of such initiatives. The document presents studies on three health micro-insurance schemes, namely, ORT Health Plus Program in San Fernando, La Union; the NOVADECI Health Care Program in Novaliches, Quezon City and BICAO Investment Care & Administration Organization in Carmen, Bohol. The first two case studies are updates on the previous case studies done by STEP in year 2000. It deals more on the impact of the health micro-insurance schemes to the communities and lessons learned. BICAO is a very young scheme established by a cooperative of agrarian reform beneficiaries.

The case studies were prepared using the Methodological Guide for Undertaking Case Studies: Health Micro-Insurance Schemes developed by the Strategies and Tools against Social Exclusion and Poverty (STEP) in year 2000.

Chapter 1

*BICAO Investment Care
Administration Organization
Carmen, Bohol*

SYNTHETIC DESCRIPTION

Name of the insurance system (IS)	<i>DAR Agraryong Pangkalusugan Program/ Bicao Investment Care Administration Organization</i>
Name of the IS' parent company or company, which owns it	<i>Bicao Small Farmers Multi-Purpose Cooperative</i>
Address of the IS' headquarters	<i>Bicao, Carmen, Bohol</i>
Date IS was created (conception)	<i>October 2002</i>
Date IS launched operation (payment of first benefits)	<i>April 4, 2003</i>
Date IS' parent company was created	<i>February 1997</i>
Nature of IS' parent company	<i>Co-operative</i>
Legal recognition of the IS	<i>Accredited and registered under Philippine laws</i>
Other activities of the IS' parent company	<i>Savings/ credit Other activities – consumer store</i>
Types of members	<i>Individuals, families</i>
Other beneficiaries	<i>Family, other dependants</i>
Acquisition of beneficiary status	<i>Voluntary</i>
Current number of IS staff members	<i>No regular fulltime staff</i>
Current number of IS beneficiaries	<i>Total: 69; 31 males; 38 females</i>
Total current number of members of the IS' parent company	<i>Variable</i>
Residential location of members	<i>Rural area; 100%</i>
Relationship between members (other than membership to the IS)	<i>members of the same village; members of the same cooperative</i>
Economic situation of members	<i>95 % of members work in the informal sector (including subsistence agriculture); 5 % of members work in the formal sector Income under the poverty line: 100 % of members (60 % women) Extreme poverty income: 80 % of members</i>
Restrictions on membership	<i>Age Health risks Place of residence</i>
Geographic area of IS' operation	<i>District/village</i>

Type of health services covered by the IS	<i>Hospital care Preventive and promotional care Medicines</i>
Total amount of benefits paid during the last term (default year)	<i>PhP. 2,086.00 (US \$ 36.61). Only two members have availed themselves of benefits during the current year (October 2003to September 2004)</i>
Method of financing the health insurance	<i>Members' contributions; Subsidizing of health care providers linked to the IS; Contributions and subsidies from other organizations involved; Financial returns on the reserves; Other: donation from politician</i>
Type of contributions	<i>Fixed fee without member differentiation by category</i>
Average annual amount of contributions paid by members during the operating year	<i>PhP 28,980 (US \$ 517.50)</i>
Health care providers offering services covered by the IS	<i>Public sector Private sector</i>
Degree of members' participation in management	<i>Democratic management by members (general assembly)</i>
Who is responsible for the management of current operations	<i>No salaried staff</i>
Technical assistance	<i>Benefits from periodic technical assistance: since 2002 (conceptual/formative stages).</i>
Membership to a reinsurance system	<i>No</i>
Has guarantee funds	<i>No</i>
Other key actors and their roles in the operation of the IS	<i>Rural Health Unit – Health care provider Private Hospitals – Health care provider DAR – Coordinating agency ILO – Provision of technical assistance</i>

1.1

THE CONTEXT



The province of Bohol in the Visayas region of the Philippines is known for two things: more than 1,200 Hershey Kisses shaped geological formations known as the *chocolate hills*; and the smallest monkey in the world called the Tarsier. The municipality of Carmen is located within the clusters of chocolate hills in central Bohol. Bicao, one of Carmen's villages or *barangays*, is home to a recently established but health microinsurance scheme that is fast becoming one of the most progressive in the Philippines, the Bicao Investment Care Administration Organization or, simply, BICAO.

BICAO evolved as a social services scheme for an agrarian reform community in the Philippines. This case study describes its evolution, its objectives, how it operates and who are the actors involved in its management and organization. Additionally, it provides a set of lessons learned and best practices that may provide guidance to other similar schemes in the future. Although still in its infancy, the BICAO case was included in this series because of its unique developmental circumstances. An added feature of this case study is its treatment of the gender dimension of health microinsurance.

The case study was developed and written using the *Methodological Guide for undertaking case studies of health microinsurance schemes* developed by the ILO Global Program, Strategies and Tools against social Exclusion and Poverty (STEP). However, due to the infancy of BICAO some prescribed sections cannot be completed

because of the lack of organizational and program maturity compared with the more developed health microinsurance schemes.

1.1.1. Demographic aspects

Bicao is the largest barangay or village in the municipality of Carmen in the province of Bohol, Philippines. It has a total land area of 1472.25 hectares. Carmen itself, classified as a second class municipality in terms of internal revenue, is strategically located in the central part of Bohol. Its scenic natural features notably the well-known chocolate hills and the Loboc River has become among the focal points in the province's tourism industry. It has a population of 51,451 (as of 2003) residing in 29 barangays. Bicao's population density is quite low at 1.8 and a total of 2606 inhabitants.

1.1.2. Economic aspects

The province of Bohol in the Philippines is one of the most economically depressed areas in the Visayas region. Agricultural production is the main source of livelihood making it the lifeblood of Bicao's economy. The average value of crop production in Carmen is PhP2.5 million per year while the average value of livestock production is pegged at PhP2.2 million per year. However, a substantial amount of local revenue is derived from tourism. The annual income of Carmen is estimated at PhP 5.5 million.

The modes of transportation include passenger buses, vans for hire, motor service and tricycles. Communication facilities available are landline phones, mobile phones, public calling offices, and handheld radios. Ninety eight percent of households in Carmen are served with electricity.

1.1.3. Social aspects

There are 30 public primary educational institutions and five public secondary educational institutions in Carmen. There is also one private primary school, one private secondary school, and one private postsecondary school in the municipality. The average classroom to student ration is 1:40. Only twenty percent of the total primary education student cohort is enrolled. Hence, literacy in Bicao may be lower than provincial or national figures.

1.1.4. Health and Sanitation indicators

Heart diseases, respiratory diseases, hypertension, are the leading causes of mortality in Bicao and in Carmen, in general. Poor environmental sanitation, lack of potable water, inadequate support infrastructure, lower accessibility to basic health care, lack of education and health awareness, inadequate supply of medicine and poverty are common problems in such rural communities. These are the primary reasons for the aforementioned diseases

to thrive and the main constraints to the improvement and development of the health sector of the Municipality..

1.1.5. Supply of health care

The municipality of Carmen currently employs one physician, two nurses, one dentist, one medical technologist, eleven midwives and four sanitary inspectors. Carmen has one hospital, the Simeon G. Toribio Memorial Hospital; one municipal health center; and 29 barangay health centers. Carmen is the center of what is known as the Carmen Health District, a bcatchment of local government units covering the municipalities of Batual, Bilar, Carmen, Dagahoy, Danao, Loboc, Pilar, Sierra Bullunes, and Sevilla of the provincial government of Bohol. In collaboration with the Belgian Integrated Agrarian Reform Support Program (BIARSP), the Department of Agrarian Reform, and the Department of Health, the Simeon G. Toribio Memorial Hospital has been identified as the health district hospital, which along with other district facilities, will be recipients of equipment support, technical assistance and capacity building assistance.

Table 1.1 gives the top ten causes of mortality from 1990 to 1994 while **Table 1.2** gives the leading causes of morbidity from 1993 to 1995.

TABLE 1.1 TOP TEN CAUSES OF MORTALITY IN CARMEN (MHO)					
CAUSES	Number of Cases				
	1990	1991	1992	1993	1994
Ischemic Heart Diseases	12	13	13	15	28
Bronchopneumonia	31	0	15	10	14
Chronic Bronchitis	27	11	9	10	12
Hemorrhage (stab, gunshot wounds)	10	10	6	8	0
Respiratory Distress syndrome	17	15	6	0	0
Nephritic Syndrome	14	0	5	0	0
Septicemia	12	0	0	0	11
Malignancy/Cancer	9	0	0	0	6
CVA	8	17	0	0	0
Congestive Heart Failure	0	11	22	0	0

1.1.6. National and local health policy

The Philippine health sector needs much improvement, especially in meeting the health care needs of the lower-income groups of the population. Although real and per capita expenditures for health have been increasing in the past years, the cost of health care remains exorbitant. This is partly because most of the funding goes into government hospitals which focus mainly on curative rather than preventive health care. Also, the coverage of public and private health insurance systems still excludes most of the poorer sectors of Philippine society.

TABLE 1.2 TOP TEN CAUSES OF MORBIDITY IN CARMEN (MHO)

CAUSES	Number of Cases		
	1993	1994	1995
Diarrhea	3,070	2,370	1,890
Pneumonia	2,732	1,470	483
Bronchitis	1,035	522	0
URTI	208	141	2,569
Abscess	194	121	0
Gastritis	178	115	140
Pulmonary Tuberculosis	169	265	0
Infected Wound	150	131	331
Hypertension	120	173	174
Neuritis	77	0	0
Influenza	0	140	0
UTI	0	0	167
Scabies	0	0	113
Boil	0	0	103
Neuritis	0	0	70

During the five year period 1999 to 2004, a five-point health sector agenda program was implemented. This includes: providing fiscal autonomy to government hospitals, securing funding for priority health programs, strengthening the capacity of health regulatory agencies, support for the formation and effective performance of the district health system and the expansion of coverage and benefit expenditure of the National Health Insurance Program.

Health insurance is a vital element for expanding the coverage of public and private health care to the more indigent sectors of Philippine society. In 1997, nearly 50 per cent of the country's total health expenditure was paid directly by individual families, while only 7 per cent was provided by the government's social insurance programs. In view of this, the national government intends to strengthen its NHIP by increasing benefits, expanding the membership base, and improving the quality of health care services.

Specific reform strategies towards this goal have been proposed. These include: increasing benefits to make the NHIP more attractive, enhancing the institutional and organizational capacity of the Philippine Health Insurance Corporation (PHIC) in order to expand coverage, increasing public investment for health insurance and enacting legislation to achieve the necessary reforms. These are programs that have yet to be fully implemented and will not have an immediate impact on the country's health sector.

1.1.7. Social protection in health

The present situation is that poorer sectors of Philippine society are often excluded from formal social protection programs, including social protection in health. This is attributed mainly to the limited capacity of the formal social security system to respond to the actual needs and conditions of informal sector participants.

The Philippines basically follows the principle of contributory social insurance, under which

social security members pay a regular contribution that is usually deducted from wages or salaries. Responsibility for implementing the country's social security programs, which includes health insurance lies with SSS, the Government Service Insurance System (GSIS), Philippine Health Insurance Corporation, and the Employment Compensation Commission. However, these institutions and their programs usually cover workers in the formal sector. Thus, coverage of those working in the informal sector, which has been described as the "poor mans' economy," has so far, been very limited. Occasionally, a program is implemented specifically addressing the needs of the informal sector.

PHIC or Phil Health has three health microinsurance programs: the formal program; the self-paying program; and the indigent program. Phil Health's Plan 5 Million is an off-shoot of its indigent or sponsored program. Informally known as the enhanced PCSO GMA Program, it was officially launched on February 2004. The program was a collaboration of the Philippine Charity Sweepstakes Office, the



Department of Budget and Management and the Philippine Health Insurance Corporation for the coverage of an additional 5 million indigent families nationwide in 2004 the coverage having a validity of one year. For the implementation of the program, PCSO allocated P 1.5 billion as assistance for the payment of the local government unit premium counterpart to PhilHealth, initially utilizing the one billion peso (PhP1.0 B) stand by fund approved by the PCSO Board.

Under the scheme, DBM assured the release of P 1.5 B to PhilHealth for the national government premium counterpart. The program would provide the regular in-patient and outpatient benefits. Identification of qualified indigent families was barangay-based. PhilHealth requested the participation of other national government agencies and sector groups, namely DOH, DILG and DAR.

In Carmen, 4,478 indigent households were targeted for 2004 and 300 of them considered actively enrolled as of November 2003. Prior to the 2004 presidential elections, free PhilHealth cards were distributed to barangays all over the Philippines under the program, Bicao being one of these. The PhilHealth cards have a validity of one year.

In the absence of long-term formal social protection in health for low-income groups, Filipinos began innovating and implementing their own informal social security schemes. The more traditional forms of social protection still exist, and among the more popular are family support, patron-client support, the *bayanihan* (or collective mutual support), and the *damayan* (solidarity). In situations of difficulty and adversity, Filipinos often find economic and social support from individuals, the family, and/or the community. The Bicao Investment Care Administration Organization was launched within these conditions and circumstances.

1.2

IMPLEMENTATION



1.2.1. The Launching of the Program

As implied in the previous section, most Filipinos who are poor and who work in the informal sector are excluded from health insurance. Formal health financing systems have acknowledged this fact but are still unprepared to integrate the characteristics and dynamics that exist in these sectors, which represent people who have the most need for and who stand to gain most from vital health services.

Institutions with responsibility for providing social security in health are the SSS, the Government Service Insurance System (GSIS), the Philippine Health Insurance Corporation (PHIC), and the Employment Compensation Commission (ECC). The programs of these institutions are basically founded on the principle of contributory social insurance; i.e. individual members pay for the cost of health care through collective mobilization of funds.

These public social-insurance programs, however, cater mostly to those employed in the formal sector, who have some capacity to pay for the cost of health care. Those who are unemployed or informally employed are generally excluded from health finance coverage. The state of health financing in Bicao is very similar to that in the country in general. Because of widespread poverty and the informal employment arrangements that persist in the area, many people are not covered by any health financial system, and thus find it hard to access health care services.

1.2.2. The phases of program implementation

(a) *Historical Context*

The Bicao Investment Care Administration Organization owes its existence to a number of agencies, particularly its parent institution, the Bicao Small Farmers' Multipurpose Cooperative. BSFMC was established in 26 May 1990 under CDA Registration Number CEB-A-095. BSFMPC was envisioned as a farmers' organization that would offer the following services to its members:

- Rice production assistance
- Corn production assistance
- Pineapple production assistance
- Hog dispersal
- Provision of Carabao loan
- *Palay* trading assistance
- Tractor services
- Lending or microfinance
- Savings account
- Consumer store

Like most health microinsurance schemes in the country, the program was conceptualized within the framework of the Local Government Code of 1991. This law mandated the devolution or decentralization of health services. Previously, the public health care delivery structure was a centralized organization emanating from a central office of the Department of Health headed by a Secretary of Health. After the devolution, the responsibility of delivering health services to communities was delegated to local chief executives. In the BICAO case, the major initiative came from a nontraditional stakeholder in the health sector, the Department of Agrarian Reform. Prior to the establishment of the BSFMPC, Bicao has been identified as one of five barangays in Carmen comprising an agrarian reform community or ARC. The other barangays in this community are Buenavista, Katipunan, Poblacion Norte and Guadalupe. In 1992, the Belgian Integrated Agrarian Reform Support Program or BIARSP under the guidance of the Department of Agrarian Reform identified the Carmen Health District as a program beneficiary. The ARC being part of the Health District was targeted for technical assistance. Thus the BSFMPC, being an active farmers' cooperative, became a logical choice as a BIARSP beneficiary.

BSFMPC was envisioned to become a health microinsurance provider under the Department of Agrarian Reform's *Agraryong Pangkalusugan* or Agrarian Health program. The cooperative began receiving technical assistance from DAR. The Municipal Agrarian Reform Officer of Carmen and the Senior Agrarian Reform Provincial Technician were assigned to BSFMPC to serve as development facilitators. From the mid-nineties to 2001,

the cooperative slowly but surely moved towards establishing a health full-blown microinsurance scheme. In one of their regular meetings during that year, the scheme was presented to the general membership of the BSFMPC. It was approved by majority vote. However, it only became operational a year later, October 2002. The formal launching had to wait another six months with the availability of benefits in April 2003.

(b) Defining objectives

The general objective of the Bicao Investment Care Administration Organization is to provide an affordable and suitable health care system that makes medical expenses more affordable for the its members.

The specific objectives of BICAO are:

- to ensure that medical expenses become more economical for members of the health care system; and
- to provide health education and awareness on community based-health insurance.

(c) The target group

Initially, the target group was limited to members of the Bicao Small Farmers Multipurpose Cooperative, who are all agrarian reform beneficiaries or ARBs. BICAO is now considering extending its services to ARBs from other multipurpose cooperatives based in other barangays within the ARC.



(d) Leadership and decision-making

Although the BSFMPC has been around for a decade and a half, BICAO is still in its infancy. Leadership and decision-making for the latter rest with the officers and staff of the former. In other words, there is neither a separate board of directors nor a set of officers for the health microinsurance scheme. Furthermore, the scheme is still very much dependent on the guidance of the agrarian reform provincial technician.

1.2.3. Operation during the first term

(a) Members and other beneficiaries

The health microinsurance scheme is currently limited to agrarian reform beneficiaries, members of the cooperative and their immediate family. During its first year of business operation, October 1, 2002 to September 30, 2003, forty two (42) members signed up, composed of twenty five (25) males and seventeen (17) females. Two members availed

themselves of insurance benefits, one male and one female. There were no drop-outs for the initial year. However, one regular member died.

(b) Benefits

In-patients are treated in the Simeon Toribio Memorial Hospital, which is the district hospital for the Carmen Health District. A cost ceiling of P3,000.00 per head each year is imposed. A breakdown of the ceiling amount is provided below:

Accommodation	P	210.00
Medicine		1,190.00
Professional Fee		300.00
Laboratory		600.00
Ambulance		200.00
Sundries		750.00
TOTAL		3,000.00

However, the following pre-existing ailments were not covered: tuberculosis; uncomplicated gastric ulcer; diabetes mellitus; tumors of different organs; optometric services; organ transplant; suicidal injuries; illness attributed to the member's misconduct; gross negligence; abuse of drugs and alcohol; and meliorate service injuries sustained from armed conflicts such as rebellion and insurrection. Maternity related treatments and services were also excluded.

Table 1.3 gives a schedule of benefits offered during the initial year.

(c) Financing

During its first year of operation, BICAO relied heavily on BSFMPC subsidies and technical assistance from the Department of Agrarian Reform. There were very little expenses. Apart from the benefits paid out to two members who availed of these, the insurance contributions were mainly retained. A sum of PhP 10,000 was donated by Senator Juan Flavio Elorde used mainly for microinsurance seminars for members.

Table 1.4 summarizes the financial support received by BICAO.

(d) Health care providers

The main health care provider for BICAO members is the Simeon Toribio Memorial Hospital and its medical staff. Members may also go to the Bicao Barangay Health Center and the Carmen Municipal Health Center, whose services are essentially free. However, they may purchase medicine from these health centers that would be reimbursed by the scheme.

TABLE 1.3 SERVICES COVERED BY BICAO DURING ITS FIRST TERM

Services	Persons Covered	Co-payment	Maximum coverage limit	Waiting period	Compulsory Reference
Unprogrammed Surgical Intervention All types except resulting from: <input type="checkbox"/> Attempt suicide <input type="checkbox"/> Excessive self-induced intoxication <input type="checkbox"/> Accident from committing crime <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Abortion	NA	NA	NA	NA	NA
Gynecological-obstetrical Intervention <input type="checkbox"/> Caesarian Section <input type="checkbox"/> Normal delivery	NA	NA	NA	NA	NA
Medical Hospitalization <input type="checkbox"/> Hearth by-pass <input checked="" type="checkbox"/> Appendectomy <input checked="" type="checkbox"/> Mastectomy <input checked="" type="checkbox"/> Rehydration <input checked="" type="checkbox"/> H-fever <input checked="" type="checkbox"/> Broncho-pneumonia	M	Maximum coverage	PhP 3,000 for members	Six months	C
Programmed Surgical Intervention <input checked="" type="checkbox"/> Excision of cyst <input checked="" type="checkbox"/> Haemorrhoidectomy <input checked="" type="checkbox"/> D & C	M	Maximum coverage	PhP. 3,000 for members;	Six months	C
Programmed Ambulatory Care <input checked="" type="checkbox"/> Consultation <input checked="" type="checkbox"/> Baby check-up <input checked="" type="checkbox"/> Pre-natal check-up <input checked="" type="checkbox"/> Physical examination	M	Maximum coverage	PhP300	Six months	C
Preventive Care <input type="checkbox"/> Immunization					
Unprogrammed ambulatory <input checked="" type="checkbox"/> Medicines/Drugs	M	Maximum coverage	PhP 1190	Six months	C
Laboratory/Radiology	M	Maximum coverage	PhP 600	Six months	C

M = members only, B = other beneficiaries as well, C = reference is compulsory

TABLE 1.4		RESOURCES USED TO FINANCE BICAO'S FIRST TERM	
Source	Amount	Aim	Kind
Technical Assistance		To set up the books and accounting system	Provided by the Department of Agrarian Reform
Staff		To add trained personnel to manage the scheme.	Staff time provided by BSFMPC and DAR
Infrastructure and Equipment	NA	NA	NA

(e) Administration and management

Appendix A gives the statutes and regulations of BICAO.

The management of BICAO is the responsibility of the Bicao Small Farmers' Multipurpose Cooperative Manager, Mr. Edgar Barloso, and its Chairman of the Board of Directors, Mr. Bienvenido Ceroy. Mr. Barloso runs the day-to-day affairs of BICAO while Mr. Ceroy heads the board that determines the schemes policies and procedures. Up till July 2004, Mr. Barloso was Chairman of the BoD. He relinquished this position to take a more active part in the operations of BICAO. Under his supervision are: a collector; a petty cash custodian; a guest relations officer; and a bookkeeper, all of whom assume these responsibilities as members of the coop and hence, are unsalaried.

For the past two years, the Department of Agrarian Reform has provided technical assistance to BICAO in terms of financial and program management. Ms. Olive Galleto, an agrarian reform provincial technician, has been assigned by the provincial agrarian reform office to act as development facilitator, plan and implement financial and program management systems, and train coop members to assume these responsibilities. Ms. Galleto is supported by the Municipal Agrarian Reform Officer, Mr. Arnold Baguio, and Ms. Joyce Palgan of the provincial office.

1.3

CHARACTERISTICS



1.3.1. The target group and the beneficiaries

(a) Target group

As mentioned earlier, the original target group of the Bicao Investment Care Administration Organization consisted of agrarian reform beneficiaries who are members of the Bicao Small Farmers' Multipurpose Cooperative. The emphasis on ARBs was made since the health microinsurance scheme was initiated as part of the DAR *Agraryong Pangkalusugan* or DAR-AP. As a matter of fact, until now BICAO is still known to many of its members as DAR-AP. *Agraryong Pangkalusugan* is a health care finance system under the health component of the integrated social service package that the DAR has envisioned for agrarian reform communities.

Membership was eventually extended to non-ARBs who were members of BSFMPC and the family of BICAO enrollees. As of August 2004, the BICAO BoD is seriously considering extending the coverage to coop members from other barangays within the agrarian reform community. These barangays include Buenavista, Katipunan, Poblacion Norte, and Guadalupe. However, prospective enrollees need to be members of existing multipurpose cooperatives in these villages. This move is deemed necessary for financial sustainability of the health microinsurance scheme.

(b) Beneficiaries

To apply for membership, applicants must fulfill certain conditions. There is no age limit to pioneer and old coop members as of the implementation of BICAO. However, an age limit applies to new members, at least 15 years old up to 65 years old only. An applicant with existing chronic diseases may be accepted but with limited benefits on health care services.

Members are classified as follows: individual members and family members. The latter may include dependents or merely the married couple (husband-wife category). An incentive of 10 percent in premiums paid if the entire family covered is within the age bracket. Married couples pay a premium of P 420 with regular benefits up to P 2.500 per year. Only one spouse may avail of these benefits per calendar year. Regular members are those who have passed all the qualifications for membership and none of the disqualifications. An applicant will be accepted as member upon payment of an enrollment fee in the amount of fifty pesos only (P50.00). An applicant must attend a two (2) day orientation seminar on Health Care Financing System.



New enrollees have a waiting period of six months (180 days), meaning six monthly premium contributions need to be completed before a member can avail himself/ herself of health care services under the BICAO Program. A member should regularly pay his/her monthly premium as required by the BICAO Program. He is automatically dropped as a registered enrollee of the BICAO program if he/she cannot comply with the requirements, systems, policies and procedures.

The growth rate of BICAO for its second year was 50 percent. By the second year, membership increased to sixty-nine (69). Out of this total, thirty seven (37) or sixty percent are females and thirty one (31) or forty percent are males. Note the increase in female membership. This trend may continue if female members remain more active in organizational responsibilities and in attending meetings than the male members.

For the past two years of operations, there were only two cases of members losing their status. One was due to death and the other to disability.

1.3.2. Financial aspects

BICAO members are each required to pay the scheme a one-time PhP 50 enrollment fee. Renewal of membership for succeeding years will cost each member an additional PhP 20 per year. Entire families who will enroll enjoy a ten percent discount as previously stated. Additionally, the members pay monthly contributions of PhP 35 as insurance premium per individual. The latter is usually collected during the coop's monthly meetings.

The overhead costs of BICAO are shouldered by the BSFMPC. The only costs that are reflected in BICAO's records are the ones incurred for benefits.

1.3.3. Health Care Providers

The main health care provider for BICAO is the Congressman Simeon Toribio Memorial Hospital in the municipality of Carmen. As previously discussed, this facility is the Carmen Health District hospital. In the past ten years, the hospital has been a beneficiary of the BIARSP. It has received funding for equipment, facilities renovation, training and Belgian technical assistance. Hence, its equipment, facilities and trained manpower is one of the best in the province. Other health care providers that are linked with BICAO are the Carmen Municipal Health Center and the Bicao Barangay Health Center, wherein medicine may be purchased at discounted prices and reimbursed with BICAO provided supporting receipts are submitted with the claim.

1.3.4. Administration and management

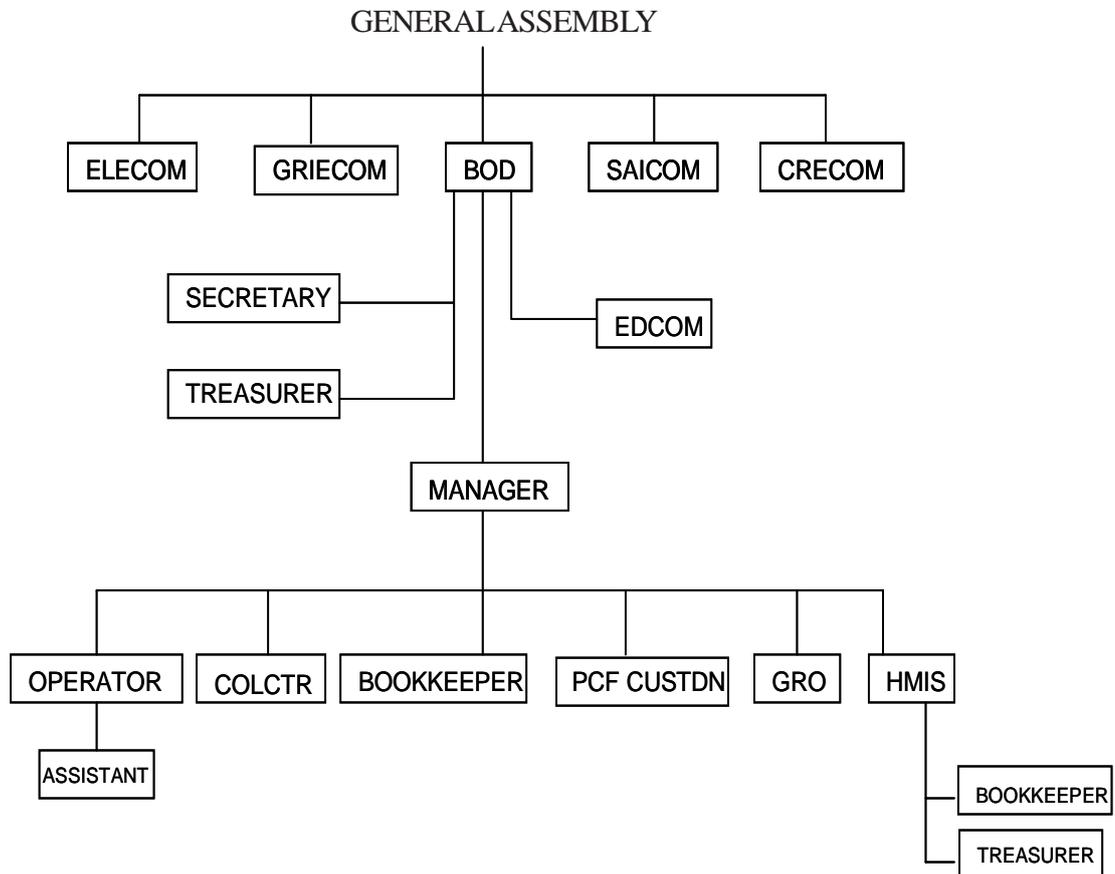
(a) Organizational Structure

The health microinsurance scheme operates within the organizational structure of the multi-purpose cooperative. The organizational structure of this cooperative is given in the following figure. From the cooperative's General Assembly, five committees were formed central of which is the Board of Directors. The Manager of the coop is answerable to the BoD. Under the Manager are coop members who are voted as Operator, Collector, Bookkeeper, Petty Cash Fund Custodian, and Guest Relations Officer. Each of these officers receive a token allowance for their services to the coop. Only the Manager is male.

(b) The democratic and cooperative character of the management system

Being based within a cooperative, the Bicao Investment Care Administration Organization is clearly democratic in its procedures and its decision making. The case writer has witnessed these first hand in two separate General Assembly meetings that he attended. As in all active cooperatives, the membership of the BSFMPC are also divided into factions some of which are political. Differences of ideas are reflected in the deliberations of regular meetings. All ideas are respected and decisions are adhered to by the membership irrespective of their original views.

**ORGANIZATIONAL STRUCTURE
BICAO SMALL FARMERS MULTI-PURPOSE COOPERATIVE (BSFMPC)**



1.3.5. Other Stakeholders

(a) The Local Government Unit

The municipal government of Carmen headed by Mayor Pedro E. Budiongan Jr. clearly puts health care as one of the priorities for his platform. He has actively lobbied for the PhilHealth benefits to be distributed in his barangays. He has linked up with the Home Reach Foundation, an association of Bohol natives in the United States who, in collaboration with the First Consolidated Bank Foundation of Bohol, has donated modern health equipment and medicine to the Carmen Health Center.

The BICAO initiative lends well the Carmen local government health care platform. Once the program develops into a robust health microinsurance scheme covering barangays beyond Bicao, a synergy is expected to develop between the local government’s agenda and the coop’s health care initiative. BICAO’s current manager is a member of the municipal council of Carmen.

(b) The Department of Agrarian Reform

The Department of Agrarian Reform is the line agency mandated to guide the national government's land reform program. Health care is farthest from its technical scope. Its interest in BICAO is due to the recognition that land reform programs can only succeed if the appropriate social protection mechanisms are in place in agrarian reform communities. And it has been part of BICAO from the very beginning. Its Agraryong Pangkalusugan program certainly finds support in the success of BICAO.

On the other hand, the technical assistance that it has been providing the scheme is perhaps the single most important external intervention that is keeping BICAO healthy in its formative years. Yet, DAR's primary contribution to social protection vis a vis health care provision is the institutional network that it has championed, the health districts composed of local governments, Department of Health facilities, and agrarian reform communities. The evolution of BICAO, with its holistic approach to development and attendant inter-agency collaboration, is a developmental model for health microinsurance schemes that may be followed by other communities.

(c) The Department of Health

The Department of Health provides the technical expertise and the policy instruments that keep the network of provincial hospitals, municipal health centers, and barangay health centers intact. However, access to these expertise as well as to the network of facilities need to be supported. The BICAO case provides a model of how access can be enhanced.

1.4

THE ACTORS' POINT OF VIEW



1.4.1. Evaluation process

The Bicao Small Farmers' Multipurpose Cooperative meets every month to update its members, discuss issues and determine courses of action. Since the cooperative's health microinsurance scheme is merely in its second year, it is primarily through these monthly exchanges that a formative evaluation of BICAO is conducted through the feedback from its members.

One of the members who have availed herself of health care benefits is Mrs. Roberta Rafols, a 65 year old housewife. She visited a physician to consult an eye problem. The professional fees she paid and the medicine that she purchased were immediately reimbursed by BICAO. "Dali ra sa DAR-AP!" she exclaimed, intimating that the processing of her benefits was so fast. She felt that the benefits should be extended to the rest of her family. And it was because of such feedback that BICAO considered extending the scheme beyond regular members of the coop to their immediate families with a ten percent discount.

Another member, Mrs. Adelina Oludin, 50, feels that an incidental benefit of the program is the confidence that it gives to its members when seeking medical assistance. Membership assures them that they can afford medical services and hence, cannot be disenfranchised from seeking these. In fact, Mrs. Myrna Galcio, 44, considers BICAO as a *dangapan* (something that you can turn to in times of trouble).

1.4.2. The management's viewpoint

Management is encouraged by this informal feedback from the membership. Health care is such a pressing need that people relate to it personally. BICAO's manager, Edgar Barloso, cannot help but regard the program's success as a personal crusade. Whenever he gets the opportunity, he promotes the program in whatever venue.

Barloso was once given a Model Farmer Award by the Philippine Business for Social Progress, a nongovernmental organization established by business leaders in the Philippines. He has served as Chairman of the BSFMPC Board twice, in 2001 and 2004. Yet he relinquished the chairmanship to ensure that he can work actively for BICAO's progress. He feels that the biggest challenge facing the microinsurance scheme to date is the recruitment of more members. He is aware that the insurance business can only work if premiums are reinvested elsewhere to earn profit, which in turn may be plowed back into members' benefits. However, members' contributions need to reach a respectable amount in order to earn premium investment rates. In other words, the economies of scale have not yet been achieved in BICAO's current membership.

1.5

SUMMARY AND CONCLUSIONS



1.5.1. Best Practices

In the BICAO case, we find four best practices to be emulated by other health microinsurance schemes.

(a) Health microinsurance schemes should be considered as part of an integrated package of services

Health microinsurance cannot be offered as a stand alone service. It should be part and parcel of an integrated package of services that support the informal economy and provide social protection to the disadvantaged. In the BICAO case, health microinsurance is offered along with microfinance, agricultural production services, marketing services, and banking.

(b) Health microinsurance should evolve organically from existing cooperatives

Related to the practice given above, health microinsurance should evolve organically from existing cooperatives. The chances of a new establishment succeeding in providing health microinsurance are far less than that of an existing cooperative which would venture into it. In the case of BICAO, the BSFMPC assumes the overhead of health microinsurance operations. In other words, the overhead cost of providing this new service is basically nil. Furthermore, the microinsurance scheme was generally well-accepted because the

cooperative already had a well-established track record of service to the community. However, the need for separate financial accounting between the mother establishment and the health microinsurance scheme cannot be over-emphasized.

(c) Health microinsurance should tap existing networks

The best practice that best represents the BICAO case is the tapping of existing networks in health microinsurance schemes. The barangay of Bicao is part of an Agrarian Reform Community or ARC. The ARC is supported by the Department of Agrarian Reform, which in turn is being assisted by the Belgian Integrated Agrarian Reform Support Program. BIARSP, among other things, has provided medical facilities and technical assistance to the main Carmen Health District medical service provider, the Simeon Toribio Memorial Hospital. The latter logically becomes BICAO's primary health service provider.

(d) Health microinsurance should be a product of inter-agency collaboration

Related to the previous best practice is an inter-agency collaboration strategy for the provision of health microinsurance. As stated in a previous section, the Department of Health provides the medical expertise and local government units provide the infrastructure of provincial, municipal and barangay health centers. However, in the BICAO case, it was primarily the Department of Agrarian Reform which provided access to this expertise and infrastructure.

1.5.2. Lessons Learned

Additionally, the BICAO case presents us with three lessons learned.

(a) Women are more active exponents of health microinsurance

In the case of BICAO, women outnumber men during meetings. The more outspoken testimonials on the program come from women. Even the coop officers are made up mostly of women. Such is the situation in spite of the fact that the scheme does not respond to a very critical need, maternity benefits.

Perhaps, health care and subsequently, health microinsurance, may be considered as a domestic concern in rural families. Thus the female gender may be the logical person responsible for them in the household. This should provide the argument for health microinsurance schemes to be more sensitive to the needs of rural women since they are the critical decision makers in this situation. Additionally, health microinsurance information campaigns should be directed at rural women's organizations such as mothers' clubs. Furthermore, more efforts should be undertaken to make the menfolk more involved to generate equal participation between man and women in rural health care.

(b) There is a need to extend membership of health microinsurance schemes to members of the immediate family

Considering the security dimension of health microinsurance, extending membership to family members would make it more appealing.

(c) There is a need for wider geographical coverage

Economies of scale need to be achieved in health microinsurance. In the case of BICAO, the manager feels that membership should be expanded. He is aware that the insurance business can only work if premiums are reinvested elsewhere to earn profit, which in turn may be plowed back into members' benefits. However, members' contributions need to reach a respectable amount in order to earn premium investment rates.

(d) There is a need to collaborate/ integrate with Phil Health

The Bicao case has shown that the Phil Health indigent program, particularly the ones fully subsidized by the national government, may become a hindrance in attracting new members. Collaborative arrangements with Phil health such as linking up both government and microinsurance schemes should be seriously studied and considered.

Chapter 2

NOVADECI Health Care Program

Novaliches, Quezon City

SYNTHETIC DESCRIPTION

Name of the insurance system (IS)	<i>Novadeci Health Care Program (NHCP)</i>
Name of the IS' parent company or company, which owns it	<i>Novaliches Development Cooperative (NOVADECI)</i>
Address of the IS' headquarters	<i>Sarmiento corner Buenmar Sts. Novaliches, Quezon City</i>
Date IS was created (conception)	<i>September 1993</i>
Date IS launched operation (payment of first benefits)	<i>1994</i>
Date IS' parent company was created	<i>1976</i>
Nature of IS' parent company	<i>Co-operative</i>
Legal recognition of the IS	<i>Accredited and registered under Philippine laws</i>
Other activities of the IS' parent company	<i>Death insurance Prevention, health education Disability insurance Savings/ credit Education/literacy Other activities – consumer store Other social services – training center programme</i>
Types of members	<i>Individuals, families</i>
Other beneficiaries	<i>Family</i>
Acquisition of beneficiary status	<i>Automatic</i>
Current number of IS staff members	<i>Total: 9; 5 males; 4 females</i>
Current number of IS beneficiaries	<i>5,732 members (as of October 2004)</i>
Total current number of members of the IS' parent company	<i>7,936 (as of 2003)</i>
Residential location of members	<i>Urban and rural area</i>
Relationship between members (other than membership to the IS)	<i>members of the same village, district, or geographic community; members of the same cooperative</i>
Economic situation of members	<i>Mixed: sari-sari vendors, teachers, doctors, businesspersons</i>
Restrictions on membership	<i>Age Place of residence</i>

Geographic area of IS' operation	<i>Municipality</i>
Type of health services covered by the IS	<i>Hospital care; Specialized medicine; Preventive and promotional care; Medicines; Gynae-obstetrical care; Laboratory examinations; Radiology; Vaccinations; Dental and optometric (for old members only)</i>
Total amount of benefits paid during the last term (default year)	<i>PhP1,987,177.12 (US\$25,463.16) for the period 2003 (PhP1 = US\$56)</i>
Method of financing the health insurance	<i>Members' contributions Subsidizing of health care providers linked to the IS and staff of IS</i>
Type of contributions	<i>Fixed fee without member differentiation by category</i>
Average annual amount of contributions paid by members during the operating year	<i>PhP4,732,781.50 (US\$84,513.96) (PhP1 = US\$56)</i>
Health care providers offering services covered by the IS	<i>Private sector Health care providers of IS</i>
Degree of members' participation in management	<i>Management by parent company with members' participation; general assembly has decision-making capacity in terms of benefit package, health care providers</i>
Who is responsible for the management of current operations	<i>Management exclusively by salaried employees of the IS</i>
Technical assistance	<i>Benefits from regular technical assistance from parent company</i>
Membership to a reinsurance system	<i>No</i>
Has guarantee funds	<i>Yes</i>
Other key actors and their roles in the operation of the IS	<i>Accredited clinics and hospitals – medical services</i>

2.1

THE CONTEXT



In one of the busiest corners of Novaliches located within the northern fringes of Metro Manila stands a six-storey concrete building fully owned and occupied by a multi-purpose cooperative. The Novaliches Development Cooperative Inc, known to the community as Novadeci, takes pride in this edifice as one of its most significant asset. Three of its floors house medical facilities and offices of the Novadeci Health Care Program or NHCP.

The Novadeci Health Care Program is a health micro-financing scheme availed of by the members of the Novaliches Development Cooperative, Inc. (Novadeci). This case study describes the objectives of this scheme, how it operates and who are the actors involved in its management and organization. It assesses the impact of scheme to the community. Additionally, it provides a set of lessons learned and best practices that may provide guidance to other similar schemes in the future.

2.1.1. Demographic aspects

NHCP is based in Novaliches, an urban area situated in the northern portion of Quezon City, which is the largest city in Metropolitan Manila in terms of land size. Novaliches

measures 2,275 hectares, or roughly 15 per cent of the total land size of Quezon City. It is divided into 15 barangays: Bagbag, Capri, Greater Lagro, Gulod, Kaligayahan, Nagkaisang Nayan, North Fairview, Novaliches Proper, Pasong Putik, San Agustin, San Bartolome, Santa Lucia, Santa Monica, Sauyo, and Talipapa.

Novaliches accounts for 16 per cent of Quezon City's total area. The population density is estimated at 145 persons per hectare, which is the same as the City's average population density. The average household size is five, with two household members engaged in economic and income generating activities. The latest census indicates that there are 328,880 people (or around 67,269 households) living in Novaliches.

2.1.2. Economic aspects

In recent years, business growth has been mostly confined to the service sector, particularly wholesale and retail trading. Unfortunately, the employment generating capacity of trading activities is very limited. As a result of slow enterprise development and job creation, unemployment and underemployment have become a problem. In 1998, for example, unemployment was recorded at 11.6 per cent. In 1999, this figure increased to 12.3.5.3 percent. Compounding the employment problem is the existence of a large labor force in the city. Nearly 64.8 percent of the population (or roughly 1.39 million) fall within the working age of 15 years and above. Despite the high unemployment rate and flat enterprise growth, the average family income in Quezon City (recorded in 2000 at Ph.P32757 or US\$585) is about average for Metro Manila.

2.1.3. Social aspects

The Philippines has a 96 percent literacy rate (National Statistics Office, 2003) one of the highest in Asia. Quezon City is the nation's capital and is thus expected to approximate the national average. Local government expects the literacy rate in the City to further improve in the coming years as more children enroll in schools. Statistics show that the enrolment rate has steadily increased in the last six years. From 1997 to 2002, the average increase in enrolment at the elementary and secondary levels was 3.63 percent. For school year 2001-2002, almost 240,000 and 120,000 students enrolled in the elementary and secondary levels, respectively. The current classroom-student and teacher-student ratio in the city is 1:50, which is at par with the national level. For the school year 1999-2000, Quezon City had 3,479 classrooms and 8,438 teachers.

2.1.4. Health and Sanitation indicators

In 2001, the mortality rate in Quezon City was registered at 3.81 or 8,442 cases. The leading cause of death was pneumonia, which was responsible for 1047. This was followed by ischemic heart disease/ myocardial infarction (1,005 cases) and cancer (827 cases). Meanwhile, the leading causes of death for infants were broncho-pneumonia (129 deaths),

immaturity, and respiratory distress. Maternal mortality rate was estimated at 0.5 for every 100,000.

2.1.5. Supply of health care

Currently, Quezon City has a total of 55 health centers, 56 sub-health centers including four maternity clinics distributed in four districts. These health centers offer an array of services which included medical and dental services, maternal and child health care, communicable disease control, nutrition programs, family planning, etc. Aside from the health centers, the city also has a total of 64 hospitals, 18 of which are government-owned. Low-income families which number 158, 237 based on 2002 statistics, generally attend government hospitals which offer lower health care rates, thus representing a bed-population ratio for public hospitals at 1:2,670.

2.1.6. National and local health policy

The Philippine health sector needs much improvement, especially in meeting the health care needs of the lower-income groups of the population. Although real and per capita expenditures for health have been increasing in the past years, the cost of health care remains exorbitant. This is partly because most of the funding goes into government hospitals which focus mainly on curative rather than preventive health care. Also, the coverage of public and private health insurance systems still excludes most of the poorer sectors of Philippine society.

During the five year period 1999 to 2004, a five-point health sector agenda program was implemented. This included: providing fiscal autonomy to government hospitals, securing funding for priority health programs, strengthening the capacity of health regulatory agencies, support for the formation and effective performance of the district health system and the expansion of coverage and benefit expenditure of the National Health Insurance Program.

Health insurance is a vital element for expanding the coverage of public and private health care to the more indigent sectors of Philippine society. According to the WHO Statistical Information System on core health indicators, 54.8 percent of total health expenditures in 2001 were made by the private sector. Only 17.2 percent of health expenditures attributed to the public sector were charged to social security. In view of this, the national government intends to strengthen its NHIP by increasing benefits, expanding the membership base, and improving the quality of health care services.

Specific reform strategies towards this goal have been proposed. These include: increasing benefits to make the NHIP more attractive, enhancing the institutional and organizational capacity of the Philippine Health Insurance Corporation (PHIC) in order to expand coverage, increasing public investment for health insurance and enacting legislation to achieve the necessary reforms.

These are programs that have yet to be fully implemented and will not have an immediate impact on the country's health sector. Meanwhile, at the local level, the Quezon City government has initiated various health care programs (which are mostly implemented by the local government's health centers) to attend primarily to the health care needs of indigent groups. Among these programs is the MEDICAP program of the Office of the Mayor, which provides poor families the opportunity to access Ph.P.5,000 (US\$ 89) worth of

treatment and medicine costs from the Quezon City General Hospital. This is the only local government program that approximates to a health care financing scheme.

2.1.7. Social protection in health

The present situation is that poorer sectors of Philippine society are often excluded from formal social protection programs, including social protection in health. This is attributed mainly to the limited capacity of the formal social security system to respond to the actual needs and conditions of informal economy workers.

The Philippines basically follows the principle of contributory social insurance, under which social security members pay a regular contribution that is usually deducted from wages or salaries. Responsibility for implementing the country's social security programs, which includes health insurance lies with SSS, the Government Service Insurance System (GSIS), Philippine Health Insurance Corporation, and the Employment Compensation Commission. However, these institutions and their programs usually cover workers in the formal economy. Thus, coverage of those working in the informal economy, which has been described as the "poor mans' economy", has so far, been very limited.

In the absence of formal social protection in health for low-income groups, Filipinos began innovating and implementing their own informal social security schemes. Traditional forms of social protection still exist, and among the more popular are family support, patron-client support, the *bayanihan* (or collective mutual support), and the *damayan* (solidarity). In situations of difficulty and adversity, Filipinos often find economic and social support from individuals, the family, and/or the community. The Novadeci Health Care Program was launched within these conditions and circumstances.

2.2

IMPLEMENTATION



2.2.1. The Launching of the Program

As implied in the previous section, most Filipinos who are poor and who work in the informal economy are excluded from health insurance. Formal health financing systems have failed to acknowledge and integrate the characteristics and dynamics that exist in these sectors, which represent people who have more need for and who stand to gain more from vital health services.

Institutions with responsibility for providing social security in health are the SSS, the Government Service Insurance System (GSIS), the Philippine Health Insurance Corporation (PHIC), and the Employment Compensation Commission (ECC). The programs of these institutions are basically founded on the principle of contributory social insurance; i.e. individual members pay for the cost of health care through collective mobilization of funds.

These public social-insurance programs, however, cater mostly to those employed in the formal economy, who have some capacity to pay for the cost of health care. Those who are unemployed or informally employed are generally excluded from health finance coverage. The state of health financing in the Novaliches area is very similar to that in the country in general. Because of widespread poverty and the informal employment arrangements that persist in the area, many people are not covered by any health financial system, and thus find it hard to access health care services.

2.2.2. Health care in Novaliches prior to the launching of the Novadeci Health Care Program

In 1993 (prior to the launching of the NHCP), there were 14 health establishments operating in the Novaliches area which offered various health care services. Six of these establishments were privately-owned hospitals while the remaining eight were government-run health centers. The majority of the population in Novaliches, because of their poverty, relied mostly on the government run health centers for their health care needs. However, despite offering free or inexpensive services, these lacked important infrastructure and equipment such as clinical laboratories and X-ray facilities. This greatly limited the type and quality of services offered.

Similarly, most people were also effectively excluded from private and state-led health financing systems, which in turn was a major cause for inability to afford the cost of health care. Despite the existence and availability of health institutions in the area, a large segment of the Novaliches population were not able to effectively access the services these institutions had to offer. Instead, as indicated by a report prepared by the Quezon City Government, many of the people relied on traditional healers such as the *hilot* to cure their illnesses. Members of the Novaliches Development Cooperative, Inc. or Novadeci were no exception. The majority of members (or nearly 85 per cent) of the cooperative were informally employed women engaged in micro-enterprise activities, mostly wholesale and retail trading. The members fall within the category of “self-employed” and “entrepreneurial” poor whose ages range from 21 to 40 years (47 per cent) and 41 to 60 years (50 per cent). Again, because of their informal employment status, health care coverage for these people was not ideal. In fact, many were not covered by any health insurance system at all.

Although the multi-purpose cooperative maintained a medical clinic and a pharmacy to serve the health care needs of its members, they continued to express a need for better health services. Clinic patients were frustrated at not being able to find and afford the types of health services they needed, particularly for laboratory tests and analysis. To fund most of their medical and hospitalization expenses, members borrowed money from the cooperative which offered a special emergency loan package.

2.2.3. The phases of the Novadeci Health Care Program implementation

(a) Identifying needs

To follow up on the apparent need of Novadeci members for better health care services, the management held an informal survey that was conducted by the clinic nurse. Walk-in patients were interviewed and asked what types of medical and health care services they needed, and how much they were willing to pay for such services. To help validate the findings of the survey, an analysis was made by Novadeci’s Credit Services Department on how Novadeci members utilized their emergency loans. The survey results showed that respondents wanted a “one-stop-shop” clinic where patients could have their laboratory tests and analysis done and where they could easily purchase medicines. The respondents also wanted a system that would free them from the complicated financial procedures involved in health financing.

(b) Context, feasibility studies, and defining objectives

With the results of the survey, the clinic nurse made a formal recommendation to the management and the Board of Directors (BOD) for the cooperative to establish a health insurance program. After close evaluation, the BOD agreed that the proposed health insurance scheme was financially feasible and would greatly increase the cooperative's capability to handle the health and medical needs of its members. Consequently, the proposed health insurance program was approved.

Although no formal and external actuarial study was organized, an internal financial study was performed with the help of the credit services and accounting departments of the cooperative. In designing the NHCP, various sources relating to health financing were consulted and schemes employed by existing health insurance systems were adopted.

From the outset, the specific objectives of the program were to:

- Provide health care services to Novadeci members by creating a relevant health program.
- Extend health care services to families/dependants of Novadeci members.
- Extend the health care services to the community.
- Create and mobilize funds for the Novadeci Health Care Fund, specifically by having the cooperative's own medical laboratory, lying-in clinic, pharmacy, medial clinic, and hospital.

(c) The target group

Only a few of the cooperative's members (who were the target of the program) have had any experience with health insurance schemes. Most of them were either formally employed or had sufficient funds to get a private insurance plan. Thus, the concept behind the NHCP was totally new for the majority of the cooperative's members.

On 3rd September 1993, Novadeci members were formally introduced to the NHCP during the cooperative's anniversary. On this occasion members were initially oriented with the programs goals, objectives, and policies. If the number of NHCP recruits indicated the level of interest in the program, it would seem that the NHCP failed to attract the interests of Novadeci members. Only 198 out of the cooperative's 3,277 members initially signed on with the program: a 6 per cent coverage rate. This may be attributed to the lack of social marketing of the program prior to its launching.

(d) Leadership and decision-making

From the very beginning, the BOD was responsible for the policies that governed the NHCP. However, the BOD relied heavily on the other actors involved; specifically on the Medical Coordinator and the General Manager. The Medical Coordinator's attention to the day-to-day operations of the program, and the General Manager's close supervision of the finances involved with the NHCP, made their opinion much valued.

External technical assistance was not deemed necessary in making and evaluating decisions concerning the NHCP, although some technical assistance was provided by the cooperative's in-house financial staff. The cooperative's finance department helped set up the books and accounting format of the NHCP (based closely on the cooperative's own accounting system). So far, this has been the only technical assistance received by the NHCP.

Basically, the leadership and decision-making structure of the NHCP was also based on and integrated with that of Novadeci. Trained professionals took care of the day-to-day management and operations, and were given considerable freedom in making daily decisions. But at the policy level, it was the BOD and the general assembly that had the final say.

2.2.4. Operation during the first term

(a) Members and other beneficiaries

Only Novadeci members with at least Ph.P.1,000 (US\$21) in fixed deposits were allowed to join the NHCP. Unlike the other insurance programs of Novadeci, membership into the NHCP was purely voluntary. Members paid in full a one-time membership fee of Ph.P.200 (US\$4) in addition to the fixed annual contribution fee of Ph.P.300 (US\$6). Each member had an average of three dependents, all of whom were directly related to the members. This included the member's spouse and two children or the member's parents. Although the participation rate was perceived as relatively good, it failed to meet the expected target of 1,000 new members. By the end of 1994, around 670 Novadeci members had signed up for the NHCP.

(b) Benefits

The NHCP offered only one benefits package scheme which included free clinic services (e.g. consultation, check-up, etc), discounts on medicines and laboratory work, and hospitalization benefits. In determining the choices of what types of services to offer, the BOD and management mainly used the results of the informal survey. Other factors considered were the availability of health care services and facilities of the cooperative, capacity of the target group to pay for the cost of the program, and the cooperative's financial stability. The Medical Coordinator, General Manager, and the BOD were aware that the cooperative had definite limitations in terms of professional staffing, logistics, and financial resources. These limitations were taken into account in choosing which types of services and benefits the NHCP could afford. Table 2.1 shows the summary of services and benefits covered by the NHCP.

Basically, the cooperative played the twin-role of insurance system and health care provider. The Novadeci Medical Clinic handled most of the members' medical needs. Members had to register their names in the clinic's logbook and their expenses were taken care of by the cooperative. Because of this twin-role, the cooperative exercised control over how the NHCP was designed, managed and operated.

However, Novadeci did not run its own hospital, nor did it have any formal arrangements with external health care providers. Members with more complicated medical needs were

then referred to accredited hospitals. A “reimbursement” scheme was used to finance hospitalization treatments (i.e., members advanced the payment for hospital bills and were later reimbursed).

To ensure that NHCP policies were correctly implemented and followed, the Novadeci and NHCP management regularly prepared and produced simple monthly reports which featured contributions collections, benefit expenses, number of beneficiaries, types of services used, etc. These reports helped to monitor the operations of the program.

(c) Financing

During its first year of operation, the NHCP relied heavily on Novadeci subsidies. The cooperative shouldered most of the NHCP expenses, mainly because the latter lacked the necessary funds to set up the facilities required for the new clinic. The subsidies were deemed necessary given the low collection and target coverage rate suffered by the NHCP in its first year, which in turn resulted in the program’s net loss of Ph.P.79,790 (US\$1,425). The annual fixed fee of Ph.P.300 (US\$5) proved to be too small to help finance the NHCP. (Eventually, in 1995, the fixed annual fee was raised to Ph.P.600 (US\$11) to help stem the NHCP’s financial losses.) Table 2.2 summarizes the financial support given by Novadeci.

(d) Health care providers

As mentioned earlier, except for hospitalization benefits, Novadeci through its medical clinic was the direct provider of health care services for NHCP members. A large investment was made to improve the facilities of the clinic in an effort to upgrade the services offered. Also, Novadeci took much of the initiative in lending some of its professional staff to develop the management and operations systems of the NHCP. To a large extent, the NHCP was dependent on Novadeci funding and logistics which in turn affected the price of services the NHCP offered. Without these subsidies, the NHCP would have had to set higher prices for its services to avoid financial difficulties.

(e) Administration and management

i. Statutes and regulations

From the onset, the NHCP followed a set of statutes and regulations that guided the administration and management of the program. These were all found in the *Alituntunin sa Lingap-Pangkalusugan* - the NHCP Policy Guideline divided into eight sections. Section 1 dealt with the goals and objectives of the program. Basically, the objective was to expand the services of the cooperative for its members through the provision of health care services, with the ultimate goal of improving the economic, social and spiritual well-being of members.

Section 2 enumerated the application requirements and procedures which were as follows:

TABLE 2.1 SERVICES COVERED BY NHCP DURING ITS FIRST TERM

Services	Persons Covered	Co-payment	Maximum coverage limit	Waiting period	Compulsory Reference
Unprogrammed Surgical Intervention All types except resulting from: <input type="checkbox"/> Attempt suicide <input type="checkbox"/> Excessive self-induced intoxication <input type="checkbox"/> Accident resulting from committing crime <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Abortion	B	Maximum coverage	Ph.P. 10,000 for members; Ph.P. 5,000 for dependants	6 months	C
Gynecological-obstetrical Intervention <input type="checkbox"/> Caesarian Section <input type="checkbox"/> Normal delivery	M	Maximum coverage	Ph.P.5, 000 for C- section; Ph.P.2,500 for normal deliv	12 months	C
Medical Hospitalization <input type="checkbox"/> Hearth by-pass <input type="checkbox"/> Appendectomy <input type="checkbox"/> Mastectomy <input type="checkbox"/> Rehydration <input type="checkbox"/> H-fever <input type="checkbox"/> Broncho-pneumonia	B	Maximum coverage	Ph.P. 10,000 for members; Ph.P. 5,000 for dependants Ph.P.5, 000 for members; Ph.P.2,500 for dependants	6 months	C
Programmed Surgical Intervention <input type="checkbox"/> Excision of cyst <input type="checkbox"/> Haemorrhoidectomy <input type="checkbox"/> D & C	B M	Maximum coverage	Ph.P. 5,000 for members; for dependants Ph.P.2,500	0	C
Programmed Ambulatory care <input type="checkbox"/> Consultation <input type="checkbox"/> Baby check-up <input type="checkbox"/> Pre-natal check-up <input type="checkbox"/> Physical examination	B M	Maximum coverage		0	C
Preventive Care <input type="checkbox"/> Immunization	B	Maximum coverage	Depends on discounts for medicines	0	C
Unprogrammed ambulatory <input type="checkbox"/> Medicines/Drugs	B	Maximum coverage	Depends on amount of discounts for medicines	0	C
Laboratory/Radiology	B	Maximum coverage	Depends on the amount of discounts for medicines; X-ray: with minimal fee: regular built = 130; big built = 150	0	C

¹² The NHCP did not reimburse the full amount of hospitalization cost, but only up to the limit allowed (which is a maximum of Ph.P.10,000 for members and Ph.P.5,000 for dependants).

TABLE 2.2 RESOURCES USED TO FINANCE NHCP'S CREATION IN ITS FIRST TERM

Source	Amount	Aim	Kind
Technical Assistance	PhP 0.00	To set up the books and accounting system	Incorporated in the existing operation of Novadeci; no need for additional funds
Staff	PhP 0.00	To add trained personnel to handle the medical clinic and the pharmacy	Fixed salary for: <input type="checkbox"/> Medical Coordinator <input type="checkbox"/> Medical Technologist <input type="checkbox"/> Pharmacist <input type="checkbox"/> Nurse <input type="checkbox"/> Midwives <input type="checkbox"/> Attendants Retainer's fee for: <input type="checkbox"/> Doctor <input type="checkbox"/> Pathologist <input type="checkbox"/> Cardiologist <input type="checkbox"/> Dentist
Infrastructure and Equipment	Ph.P. 672,906 (US \$12,016)	To set up the clinic and its facilities	Subsidy from Novadeci; internally generated and financed by the cooperative.

·The applicant must be a member of the cooperative and must have at least Ph.P.1,000 (US\$17.80) in fixed deposit.

·A formal application had to be submitted to the NHCP management.

·Payment of a one-time membership fee of Ph.P.200 (US\$4) and an annual contribution fee of Ph.P. 300 (US\$5) was necessary.

Sections 3 and 4 listed the role of NHCP members, once they were accepted into the program. This section highlighted the financial obligations of the members, and in return benefits that were gained by them (e.g. health care services offered and amount of benefits).

ii.Management organization

The program was managed and operated solely by the employees and staff of Novadeci,

and it utilized the existing organization and management structure, as well as the logistical and human resources available to the cooperative. Specifically, the NHCP was initially run by the Novadeci Medical Clinic Staff. The work primarily involved attending to walk-in patients of the clinic, producing daily accounting records, and updating the clinic inventory.

Meanwhile, the overall responsibility for coordinating and supervising the NHCP staff was assigned to the Medical Coordinator and the General Manager. Apart from their supervisory role, the two officials were also assigned responsibility for collating and analyzing monthly financial reports and giving feedback to the BOD, which in turn, was responsible for policy recommendations. A special committee called the Medical Services Committee, (composed of BOD members), was formed specifically to handle issues and problems relating to the NHCP. Table 2.3 lists the actors involved with the NHCP while diagram 1 illustrates the organizational structure of the NHCP.

Table 2.3		SALARIED STAFF EMPLOYED BY THE NHCP	
Category	Number	Employer	Percentage of time dedicated to NHCP
Medical Coordinator	1	Novadeci	Full time
Doctors	3	Retainer	56 hours a week
Nurse	1	Also as Coordinator	Full time
Midwife	2	Novadeci	Full time
Medical Technologist	2	Novadeci	Full time
Pharmacist	1	Novadeci	Full time
Bookkeeper	1	Novadeci	Full time
Utility/Attendant	1	Novadeci	Full time
Pathologist	1	Retainer	
Cardiologist	1	Retainer	
Dentist	1	Retainer	
X-Ray Technician	1	Novadeci	Full time

iii. Information System

To help the various actors in managing and operating the NHCP, an array of documents were used to systematize information and data on finance and member's profiles. This included members' application/ registration forms, membership cards, contributions register, benefits records and accounting documents. The application form held most of the information about the member: demographic and economic data and the names of the member's dependants/ beneficiaries.

iv. Technical assistance

As mentioned earlier, technical assistance was provided solely by in-house staff, and mostly concerning financial matters only. Accounting personnel of the cooperative helped in setting up the books and accounting formats of the NHCP. Eventually, one of the accountants of the cooperative became the NHCP's part-time bookkeeper.

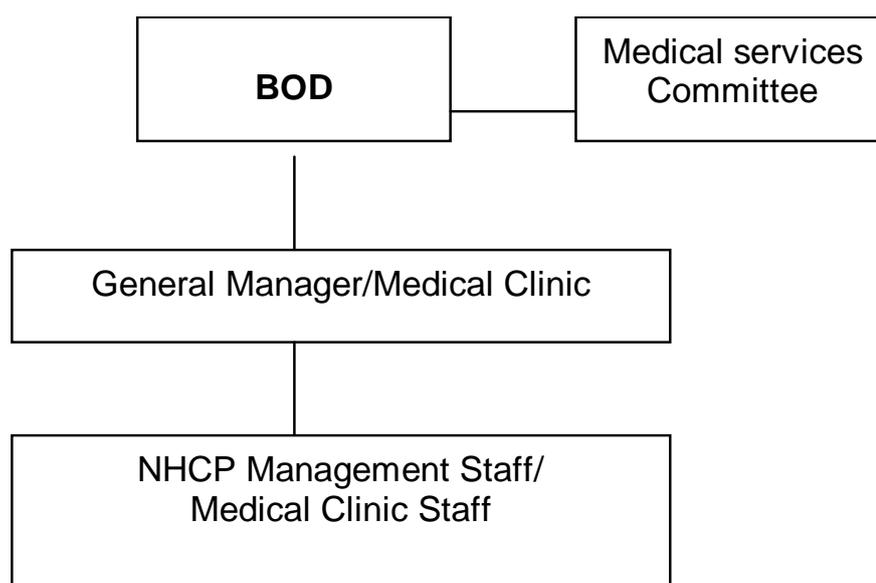


Diagram 1: Organizational Structure of NHCP

2.3

CHARACTERISTICS



2.3.1. The target group and the beneficiaries

(a) Target group

Members of the cooperative continue to be the target group of the NHCP. However, changes have been made in the screening program for potential recruits. For instance, an age requirement was introduced. Members, their spouse and/or parents who are above 55 years old are now excluded from the NHCP as well as the children of NHCP members over the age of 21 years. Also excluded from the NHCP are those already receiving assistance from Novadeci's old-age and disability pension program.

(b) Various categories of beneficiaries

Only Novadeci members and their dependants are qualified to join the NHCP. Previously, NHSP membership became an automatic provision when a member applies for a lone. Beginning 2001, however, participation in the NHCP has been made compulsory for all Novadeci members. New recruits of the cooperative are required to sign-on with the NHCP and current members, as before, are obliged to join the NHCP as soon as they avail themselves of the credit services of the cooperative. This initiative was undertaken to increase the membership and funds of the program.

The annual contribution fee has been raised to Ph.P.600 (US\$11) to make the program more financially viable. Although it was initially feared that the increase might exclude some members from participating in the program, it soon became clear that the increase did not prove to be a deterrent. After the increase was initiated in 1995, membership into the NHCP continued to grow (although at a very slow rate).

Another major change in NHCP policy was the abandoning of the required pre-membership physical examination. According to the NHCP Medical Clerk, some members expressed their interest in joining the NHCP, but were inhibited from doing so because they did not have the time to visit the Novadeci clinic to take the required physical examination. To solve this problem, the examination was waived and, instead, a 2-year waiting period for specific types of illnesses was put in place. These were: tuberculosis, cardiovascular diseases, diabetes mellitus, asthma, arthritis, hyperthyroidism, cataract, glaucoma, epilepsy, and renal failure or kidney disease.

However, the general conditions and policies governing the NHCP remain the same. The changes introduced were focused mainly on refining the procedures and requirements thus making the program more efficient and effective.

Application procedure

To apply for NHCP coverage, applicants must fulfill certain conditions:

- The applicant must be a member of Novadeci with an existing Ph.P.1,000 (US\$18) fixed deposit with the cooperative.
- The applicant should not be over 55 years old.
- The applicant must not yet be covered by the cooperative's old-age and disability pension program.

Suitable applicants must then file and submit an application form to the Medical Clerk, who forwards the application to the Medical Services Department Head (initially known as the Medical Coordinator) for evaluation. After the evaluation, the application is sent to the General Manager for approval. As soon as the application is approved, the new member and their dependants are registered into the NHCP files and are provided with membership identification cards. These cards are used to facilitate transactions and expedite benefits entitlement. Applications may be submitted at anytime during the year.

(c) The number of beneficiaries and its evolution

Since it began operations in 1993, the number of NHCP members and beneficiaries have failed to increase significantly, mostly due to lack of social marketing on the part of the management. Although membership greatly improved from 1998 to 1999, this growth spurt was short-lived. In fact, membership fell by 3 per cent from 817 in 1999 to 790 in 2000. Table 2.4 shows the evolution of the NHCP and Novadeci membership in the last three years.

TABLE 2.4 CURRENT NUMBER OF MEMBERS AND MEMBERSHIP GROWTH RATE											
	1998	1999	2000	2001	2002	2003	Growth Rates				
							1998 - 1999	1999 - 2000	2000 - 2001	2001 - 2002	2002 - 2003
No. of NHCP members	663	817	790 156 m, 634 f	3,533	4,908	4,935	23%	-3%	347%	39%	1%
No. of NOVADECI members	5,985	6,034	6,057	6,435	6,727	7,936	1%	0%	6%	5%	18%

Reasons for loss of membership status

There are basically three reasons for exclusion from or loss of NHCP membership status:

- Attainment of age 52.3.5.
- Non-renewal of NHCP membership resulting from the expiry of cover age.
- Withdrawal of membership from Novadeci.

The age limit was introduced to prevent abuse of the scheme. It was perceived that those who reached age 55 are high-risk members, and therefore represent a danger to the financial stability of the NHCP. Besides, Novadeci provides an old-age and disability pension program for its members and therefore those 55 years of age and above benefit from some form of social protection.

(d) Target group's coverage

During its first seven years of operation, the coverage rate of the NHCP averaged only 11 per cent annually. However, policy changes were introduced in 1999 and 2001 that significantly increased coverage. In 1999, the pre-membership physical examination requirement was waived. In 2001, the new policy on compulsory membership into the NHCP took effect increasing the coverage by 40 percent. **Table 2.5** shows the evolution of the target coverage rate for the last seven years. Although, membership has been made compulsory, the number of NHSP enrollees still does not equal the number of coop members since not all of the old members have availed of credit services since 2001.

2.3.2. Benefits and other services offered by Novadeci Health Care Program

Initially, the choice of services was based on the health care needs of Novadeci members as evidenced by their use of emergency loans and clinic services. However, since the program started, an array of new services has been introduced. Dental, optical, and childbirth as well as more types of laboratory services were finally made available. These new clinical services were meant to increase the incentive for Novadeci members to join the NHCP

TABLE 2.5 NHCP MEMBERSHIP GROWTH COMPARED TO THAT OF NOVADeci

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
No. of NHCP members	418	492	535	589	663	817	790	3,533	4,908	4935
No. of Novadeci members	4,280	5,018	5,332	5,962	5,985	6,034	6,057	6,435	6,727	7,936
Target coverage rate	10%	10%	10%	10%	11%	14%	13%	55%	73%	62%

and they also provided an additional source of revenue for the Medical Clinic. **Table 2.6** lists the services covered by the NHCP.

During 2000, the five services most commonly used were: the annual physical examination (which included ECG, CBC, Urinalysis, FBS, BUN, BUACHolesterol Screening, Hepatitis-B Screening, Pap Smear, and dental check-up), pulmonary aide, ECG, immunization, and minor surgery. Most of those using these services were women. NHCP members are informed about the types of services available to them through the distribution of newsletters, flyers, and leaflets. Complementing this promotional action are orientation seminars and refresher courses regularly given to NHCP members. Yet, according to the NHCP medical clerk, only a few of the NHCP members are genuinely interested in learning more about the program. The majority take only an interest in the NHCP when they need to avail of its services.

NHCP members are also provided with information on policies and updates concerning program costs and the need for risk management. It is considered necessary for members to understand how the program is financed and how risk-management affects its financial stability. To do this, the management makes it clear that the program is not meant to pay for the full cost of their health care but merely to provide some financial assistance to meet medical and health emergencies. Thus, it is made clear that co-payments play a vital and integral role in the program's finances; otherwise funding for medical and health care services would be insufficient. Similarly, it is explained to members that the prescribed waiting periods for certain types of services are necessary to allow their contributions to "age" so that there are no liquidity problems. **Table 2.6** summarizes the required co-payments and waiting periods for the new services offered by the NHCP and should be read in conjunction with **Table 2.1**.

The management is strict when it comes to these two policies: no one is exempted from paying his/her required participation fee or from observing the waiting period. To ensure that these two important policies are observed, the Medical Clerk is required to screen all benefit claims and to verify the coverage limits of claimants.

TABLE 2.6 NEW SERVICES PROVIDED BY THE NHCP

Services	Persons Covered	Co-payment	Maximum coverage limit	Waiting period	Compulsory Reference
Dental Care <input type="checkbox"/> Tooth Extraction <input type="checkbox"/> Prophylaxis <input type="checkbox"/> Temporary tooth filling <input type="checkbox"/> Check-up and consultation	B	Maximum coverage	0	0	C
Laboratory/Radiology	B	Maximum coverage	Depends on amount of discounts medicines	0	C
Others <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Cardiovascular diseases <input type="checkbox"/> Diabetes Mellitus	B	Maximum coverage	Ph.P.10,000 for members; Ph.P. 5,000 for dependants	2 years	C
<input type="checkbox"/> Asthma <input type="checkbox"/> Arthritis <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Cataract <input type="checkbox"/> Glaucoma <input type="checkbox"/> Epilepsy <input type="checkbox"/> Renal Failure or Kidney disease			(if with operation) Ph.P. 5,000 for members; Ph.P.2, 500 for dependants (if operation not required)	0	C

M = members only, B = other beneficiaries as well, C = reference is compulsory

(a) Benefits payment

When the service provided is in-house, that is if the medical or health care procedures are conducted in the Novadeci Medical Clinic, the NHCP member need only sign his/her name in the clinic's logbook. Unless the cost exceeds the coverage limit, the member does not need to pay for anything.

However, if the medical or health care procedure is obtained outside the clinic (i.e. external health care provider), the member is obliged to advance the cost of the procedure. Only upon the submission of relevant documents (i.e.,

medical certificate, hospital bill, laboratory results, official receipt of hospital and drugstore, operative report, NHCP membership card) by the member will be reimbursed. No cash advances are allowed or provided. No particular sub-group has a significant share in benefits paid, although there are more female beneficiaries than male largely due to the high female membership rate found in Novadeci and NHCP.

Reimbursement procedure

To claim for reimbursements, the NHCP member first submits to the Medical Clerk a reimbursement application form accompanied by relevant documents. The Medical Clerk checks the application form and documents to verify their authenticity. The reimbursement claim is then forwarded to the Medical Services Department Head for evaluation, and then submitted to the General Manager for approval. If the claim is approved, a check signed by the General Manager is then provided to the claimant. On average, the whole procedure takes three to five days. All approved claims are filed and recorded by the Medical Services Department, and reported in the NHCP monthly and annual summary. These summary reports contain basic information on the number of patients served during the month, the members who used the medical, hospitalization and annual physical examination services, the cost of these services, and an update on the Health Care Fund. The report also includes updates and issues about the NHCP.



According to management, there have been very few cases where a reimbursement claim has not been approved. These were mostly cases where the types of medical or health care services used by the NHCP client were not distinctly or specifically covered by the NHCP policy or where fraud was committed.

(b) Other services provided for members

i. Other financial health services

Apart from the NHCP, members have access to emergency medical loans provided by Novadeci. Members can borrow up to Ph. P.20,000 (US\$357) payable within 3 years, with a monthly interest rate of 1.5 per cent. This loan facility, however, is handled by the Credit Services Department which operates separately from the Medical Services Department. However, since the NHCP was introduced, the need for emergency loans has significantly declined.

ii. Health supply

Novadeci provided direct medical and health care services for its members through its in-house Medical Clinic, pharmacy and laboratory facilities. Although the clinic was open to the public, NHCP members could obtain free services from the clinic, while Novadeci members could use the services at discounted rates. Non-members were charged the full amount. Novadeci employs three persons (medical clerk, staff nurse, and utility worker) to directly manage and operate the Medical Clinic and its facilities. The salaries of the rest are financed through the income of the Medical Services Programs (e.g. clinic and laboratory fees).

iii. Prevention and health education

Novadeci, through its Medical Services Department, hosts a variety of health care and medical activities not only for Novadeci and NHCP members, but also for non-members in the community. These programs include monthly medical field trips to deprived areas. Through sponsorship from pharmaceutical companies and other concerned civic groups, Novadeci is able to finance such medical field trips, which not only form part of the cooperative's social and civic goals, but also provide opportunities for promotion and recruitment.

iv. Other services

The NHCP is only one of the services and social security programs offered by Novadeci. Apart from the NHCP, there are five other major programs which serve the needs of its members. They are:

- The savings and credit program began in 1976 and under this members are provided the opportunity to access financial services such as deposit savings and credit. In 1997, Novadeci mobilized a total of Ph.P.93 million (US\$1,660,714) in savings deposits. It also disbursed over Ph.P.277 million (US\$4,946,429) in loans, mostly in the form of business credit. This savings and credit facility is the most popular program offered by the cooperative.

- Assistance with education, literacy, and scholarship. This was introduced by the cooperative in 1982, and has since helped many of the members' children to finish schooling.

- The *Damayan*—a social insurance program covering contingencies such as death, old-age, and disability. In 1997, the *Damayan* maintained a reserve fund of over Ph.P.6 million (US\$107,143), and was able to disburse over Ph.P.2.9 million (US\$51,786) in benefit claims.

- A consumer store program, which began in 1990, tries to increase the economic potential of members who are engaged in or were interested in starting their own small businesses. The program is basically credit-based.

- The Training Center Program, which like the previous one, is intended to enhance and develop the economic capabilities of its members.

2.3.3. Financial aspects of the Novadeci Health Care Program operations

(a) The Novadeci Health Care Program's sources of finance

i. Contributions

In 1993 during its first year, the NHCP charged members Ph.P.300 (US\$2.3.5.35) a year for its services. However, in 1995, the fee was raised to Ph.P.600 (US\$10.70) to ensure financial viability.

Although some income is generated by Novadeci's clinic, laboratory and pharmacy, members' contributions remain the primary source of funding for the NHCP. As a result, the Medical Services Department is very strict in pursuing outstanding payments. It is up to the Medical Clerk to constantly follow-up non-payment by members and to secure payment.

Members may pay their contributions either by lump sum or in monthly installments according to their income and capacity. An official receipt is always issued and payments are also recorded into members' passbooks. This helps both members and NHCP staff to monitor payments and balances.

Recently, the average monthly contribution collected grew significantly from Ph.P.158,961 (US\$2838) in 2003 to Ph.P.281,064 (US\$5019) in 2004. This is noteworthy because collection has outpaced benefits expenditure. During the same period, the average monthly expenditure was actually reduced from Ph.P.165,598 (US\$2957) in 2003 to Ph.P.28,122 (US\$673) in 2004 (as of October).

In its early years, the average monthly expenditure always surpassed the average monthly collection, but this changed after the requirement for a pre-membership physical examination was abandoned in 1999. This policy increased the incentive and opportunity for interested parties to join the NHCP, and as a consequence, led to increased revenues for the program. As in the case of coverage, revenues were further bolstered by compulsory membership of coop members.

ii. Membership fees and their capacity to pay

A new NHCP member pays a one-time Ph.P.200 (US\$4) membership fee plus an annual contribution of Ph.P.600 (US\$11). Payments can be made either direct to Novadeci or through Novadeci-accredited banks and may be made on a staggered basis and according to the capacity of the member to pay. What is considered important is that the member is able to complete his/her scheduled payments for the year. If payments for the year are less than the required Ph.P.600 (US\$11), only a certain per cent of the benefit will be provided to the member. This is intended to encourage members to pay their contributions on time in order to fully utilize the services of the NHCP. A member, for instance, who is only able to pay less than half of the required annual fee of Ph.P.600 (US\$11) for the year is entitled to only half of whatever benefits that would otherwise be due to him/her. Incomplete payment of contributions for the year means the member is entitled to only a corresponding percentage of his/her full benefit. Table 2.7a shows how the benefits were computed as per contributions paid for the year.

During 2001, it was planned to further expand the range of services available to NHCP members in order to make the program more attractive, and thereby increase the incentive for prompt payment of contributions. This led to the provision of additional services such as X-ray services. A plan to reinsure members of the NHCP with another insurance system (possibly with the state-led Philippine Health Insurance Corporation) to help defray the cost of claims was also proposed and is still being actively considered.

TABLE 2.7a CONTRIBUTIONS AND BENEFITS SCHEDULE OF THE NHCP	
Payment made for the year	Corresponding benefit
Zero payment	No benefits
Ph.P. 150 (US\$3) to Ph.P.29 9 (US\$5)	25% benefits
Ph.P. 300 (US\$5) to Ph.P.499 (US\$9)	50% benefits
Ph.P. 500 (US\$9) to Ph.P.59 9 (US\$11)	75% benefits
Ph.P. 600 (US\$11)	100% benefits

iii. Donations and subsidies from other sources

Because the Novadeci pharmacy is registered as a dispensing unit of the Department of Health, it is able to purchase and retail medicines at cheaper prices. Also, a number of pharmaceutical companies regularly donate medicines and laboratory supplies to Novadeci for use in the cooperative's Medical Clinic and in the monthly medical field trips.

However, the primary donor of the NHCP is Novadeci itself which has channeled into it large amounts of human, logistical, and financial resources. In addition, every year the cooperative allocates a budget for the Medical Services Department (which handles the NHCP and the Medical Clinic). The money is used to cover the cost of operation of the Department, particularly personnel costs.

Even though considerable financial support has been provided to the NHCP, the program is still far from being financially sound. According to management, there is a definite need for new laboratory equipment such as ultrasound equipment and an x-ray machine, but apparently there are insufficient funds available for this.

(b) Costs

In its first year of operation, the NHCP disbursed nearly Ph.P.262,000 (US\$4,679) in benefits claims. The following year, disbursements amounted close to Ph.P.499,000 (US\$8,911). Since then, the annual disbursement fluctuated between Ph.P.400,000 (US\$7,143) to Ph.P.1.33 million (US\$29,792). In 2003, more than Ph.P. 1,987,177 (US\$35,485) in benefits was spent by the NHCP making it the scheme's largest financial exposure to date. This figure excluded operations and management costs.

(c) Surplus allocation and reserve funds

Surplus funds of the NHCP are kept in a contingency or reserve fund aptly called the Health Care Fund. Although surplus income is generated yearly from the sale of medicines and collection of clinic and laboratory fees, this is not enough to make any impact on the financial status of the program. In fact, the Health Care Fund has been slowly diminishing in value. For 2000, the Health Care Fund covered only two months of program operation. There is a need to develop and augment the fund in order to make it more financially secure. Table 7b highlights the evolution of the Health Care Fund.

2.3.4. Health Care Providers

(a) Health care providers linked to the Novadeci Health Care Program

The Novadeci Medical Clinic is the primary health care provider of the NHCP. However, the clinic is quite limited in staff and facilities, and thus is not able to totally respond to the members' growing health care needs.

Accredited clinics and hospitals serve as secondary health care providers of the NHCP. The NHCP-accredited hospitals include: Bernardino General Hospital, Legaspi General Hospital, Casaul General Hospital, Chinese General Hospital, Quezon City General

TABLE 2.7b THE GROWTH OF NHCP

Year	No. of Clients	No. of Beneficiaries	Expenses	Balance After Expenses
1993	326	HBC – 71 APE – 10	-	Php 163,000.00
1994	670	HBC – 139 APE – 122	Php 261,945.67	Php 183,224.33
1995	810	HBC – 139 APE – 122	Php 498,816.98	Php 312,182.59
1996	870	HBC – 133 APE – 188	Php 472,280.94	Php 295,345.09
1997	715	HBC – 116 APE – 137	Php 393,576.61	Php 297,701.02
1998	668	HBC – 113 APE – 204	Php 441,694.00	Php 213,946.02
1999	783	HBC – 96 APE – 247	Php 475,389.35	Php 167,066.67
2000	813	HBC – 98 APE – 272	Php 452,290.00 Php 144,900.00	Php 185,197.22
2001	3533	HBC – 125 APE – 372	Php 439,096.00 Php 196,210.00	Php 1,561,905.50
2002	4908	HBC – 268 APE – 420	Php 900,832.02 Php 431,520.00	Php 3,017,331.11
2003	4935	HBC – 439 APE – 1168	Php 1,425,937.00 Php 561,240.00	Php 3,998,809.47

HBC- Hospital Benefit Claim
APE- Annual Physical Examination

Hospital, MCU Hospital, UST Hospital, St. Luke’s Hospital, and Philippine Heart Center Hospital. Among the hospitals mentioned, the Novaliches General Hospital is the most accessible because of its proximity to NHCP members.

However, there have been no formal arrangements with the hospitals mentioned which greatly affects the effectiveness of the NHCP as a health insurance provider. For instance, direct payments for hospital expenses are not made and members have to advance the payment for hospital bills, and then claim reimbursement from the NHCP. Members consider this procedure highly tedious and a financial burden.

(b) Payment of health care providers

Most of the staff working for the Medical Clinic are employees of Novadeci, while the rest are employed on a retainer or part-time basis. The clinic’s doctors, apart from receiving a retainer fee, also receive a percentage of the income from clinic fees (see Table 3).

2.3.5. The Novadeci Health Care Program administration and management

(a) Statutes and regulations

As mentioned in Part C of this case study, the statutes of the NHCP are defined clearly by the NHCP Policy Guideline, which over the years, has undergone some revisions. Although the general theme and elements of the NHCP remain the same, changes were made

regarding the program's procedures, requirements, and limitations in order to make it more responsive, transparent, and balanced.

A major policy change has been the imposition of an age requirement. Applicants who are over 55 years old are automatically disqualified from joining the program. Other changes have been the increase in the fixed annual contribution fee from Ph.P.300 (US\$6) to Ph.P.600 (US\$13), and the abandoning of the required pre-membership physical examination.

Changes in operation procedures have also been made. This includes new procedures for NHCP members who have been disqualified for non-payment of contributions to enable them to reapply for membership. More stringent application requirements and procedures have been set up for these members.

The latest version of the NHCP Policy Guideline came out in 1999.

(b) The Novadeci Health Care Program management organization

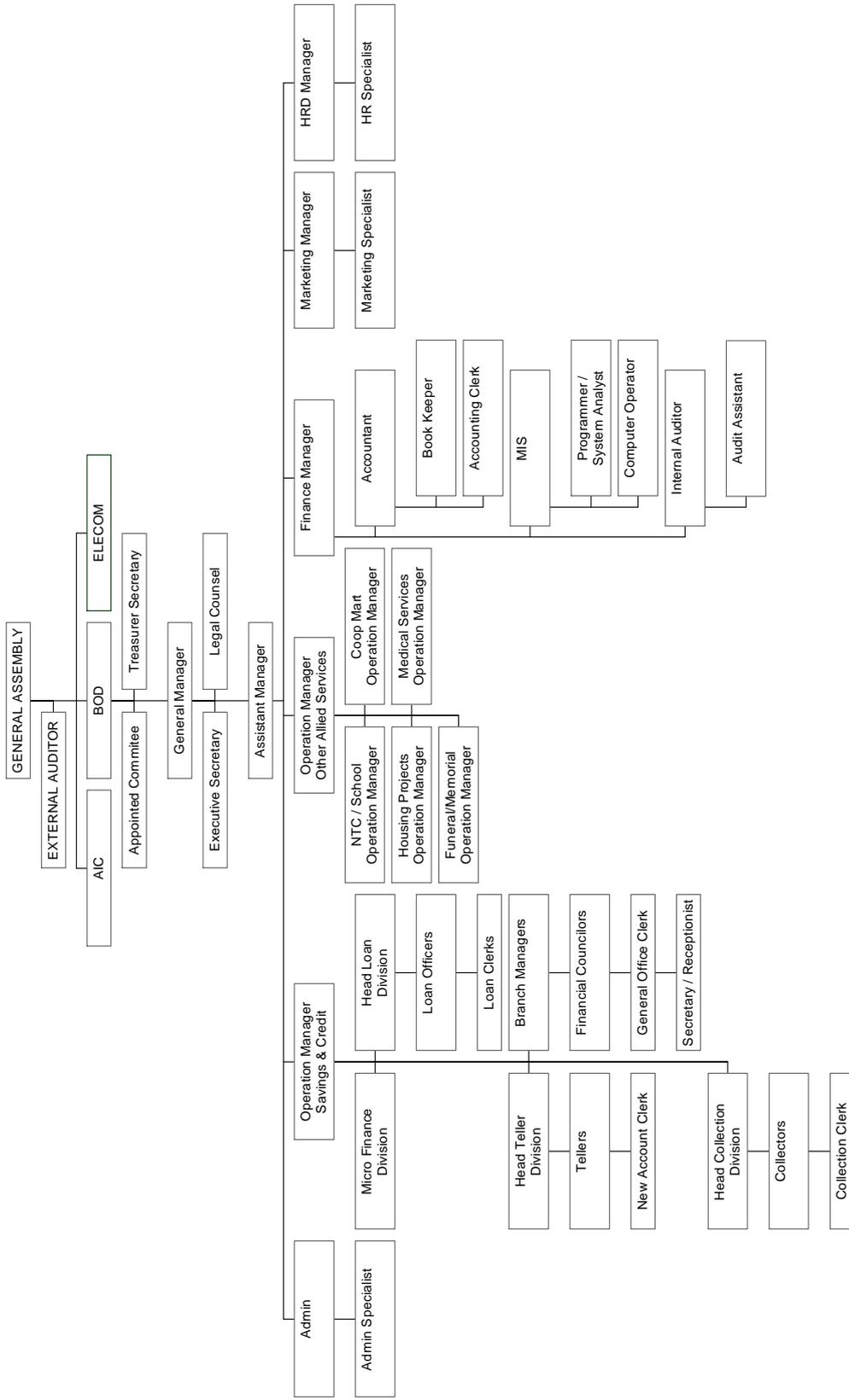
The management and organizational structure of the NHCP remain basically the same, except for one significant modification: the creation of the Medical Services Department which replaced the Medical Services Committee. Previously, the Cooperative's Marketing Department handled the NHCP and the Medical Clinic. However, after realizing the need to institutionalize the NHCP and the Medical Clinic as distinct programs for the cooperative, the BOD and management created another department to specifically handle the affairs of the NHCP, the Medical Clinic, and the other health care projects of the cooperative (including the medical field trips). With the creation of the new department, the Medical Coordinator became the head of the Medical Services Department.

The BOD is directly accountable to the general membership, and its officers are elected by the members. However, the management staff of Novadeci and NHCP, although members also of the cooperative, are professional people hired as full-time employees of the cooperative. They are not elected by the general membership and this arrangement is important because it helps prevent management transactions from being influenced by the membership. **Table 2.8** lists the employees of the NHCP, while Diagram 2 illustrates the revised organizational structure of the NHCP.

TABLE 2.8 PERSONNEL (SALARIED OR UNSALARIED) EMPLOYED BY THE NHCP

Job Title	Mode of payment	Creation of post	Qualifications	Main tasks
Medical Coordinator/department Head	Salaried	1993	4 year medical course plus background in accounting	Supervision of daily operations
Retainer Doctor	Allowance/ Retainer Fee	1993	BSc. Medicine	Attends to patients; helps in giving of medical seminars
Staff Nurse	Salary	1993	BSc. Nursing	Assist patients; acts as petty cash custodian
Medical Clerk	Salary	1993	Midwifery	Acts as NHCP Clerk; assists patients
Medical Technologist	Salary	1993	BSc. Medical Technology	Takes samples for laboratory testing; and reads results
X-Ray Technician	Salary	2003	Licensed	Operates the x-ray machine
Pharmacist	Salary	1993	BSc. Pharmacy	Acts as purchaser and cashier of Novadeci pharmacy
Pharmacy Aide	Salary	1993	Midwifery	Assists customer in the pharmacy
Utility	Salary	1993	High School Graduate	Maintains cleanliness of whole medical area; serves as messenger; assists patients

NOVADECI ORGANIZATIONAL CHART



(c) The democratic and cooperative character of the management system

The management practices a high degree of democratic ethic. Although the BOD and management assume a great deal of responsibility in running the cooperative and its programs (including the NHCP), they are also accountable to the individual members of the cooperative.

Apart from electing the people who will compose the BOD, the members also have some control over the annual budget of the Medical Services Department. If the general membership is not satisfied with the effectiveness, impact and outreach of the Medical Services Department, it is most likely that the department will get a small budget. In the past this department received the smallest budget allocation among the different departments of the cooperative.

Members are informed and consulted by the management on how medical services and the NHCP could be improved. This is done through feedback and appraisal, which is usually conducted through the annual survey during the General Assembly meeting and through informal interaction between clinic patients and staff.

Comments and suggestions are analyzed and included in the recommendations that are regularly submitted to the BOD.

The General Manager and the Medical Services Department provide advice to the BOD, as well as take responsibility for implementing program policies.

(d) Financial management

The General Assembly and the Novadeci management prepare the annual budget of the Medical Services Department, while the Department Head and the General Manager see that the budget is followed, and expenses do not exceed budget allocations. For its daily cash transactions, the Medical Clerk assumes the role of treasurer and is responsible for handling the program's petty cash.

To help in the handling of the NHCP financial accounts, the services of a bookkeeper (an employee of the cooperative) is enlisted. Together with the Medical Services Department Head and the General Manager, the book-keeper prepares monthly and annual NHCP financial reports which are posted publicly.

(e) The information system and management tools

i. Accounting framework

The Medical Services Department Head supervises the daily operations of the NHCP and the Medical Clinic, including the posting of transactions and the preparation of financial statements at the end of each month. The bookkeeper handles the preparation and filing of these records. All NHCP financial reports follow a strict accounting format which includes the publication of all income and expenses of the program and a breakdown of all financial transactions.

ii. Information about members, contributions, and benefits

Information about NHCP members, contributions, and benefits used are regularly updated by the NHCP management staff through the use of the available documentation. Among these are the registry and membership cards which record particular information such as types of benefits and services used by the member, the cost of the service, balance of premium and benefits, and the expiration date of the member's plan. These records are systematically kept by the NHCP management staff, but computerization of the records and documents, would facilitate faster retrieval and monitoring of information concerning members, contributions and benefits.

iii. Management tools

Every month, the Medical Services Department Head and the NHCP book-keeper prepare the NHCP's financial reports, which consolidates the daily recorded transactions of the NHCP and Medical Clinic. The financial reports (which are basically a breakdown of the program's income and expenses for the month) together with the monthly NHCP summary report, are submitted to the General Manager for approval.

The monthly NHCP reports contain the program's financial statement for the past month, and also feature information on the number of patients the Medical Clinic has served, the number of persons who have made use of hospitalization and physical examination benefits, and the status of the Health care fund. Included in the monthly reports are updates of news concerning the NHCP (e.g. policy changes, reminders, promotions, etc.). At the end of every fiscal year, the monthly reports are consolidated to form the NHCP annual report which helps in preparing the proposed budget of the Medical Services Department for the following year.

iv. Formalizing management procedures

The NHCP uses a variety of formal procedures and documentary materials for its operation and management activities. The first is the NHCP application form which performs two functions: it provides the NHCP management background information on the applicant and it formalizes the insurance provider-user arrangement between Novadeci (which is the principal operator of the NHCP) and the applicant. Official receipts and vouchers are used to make financial transactions of the program and other documentation such as the membership cards and registry forms facilitate transactions between the management and members.

In the processing of benefits, the NHCP also employs a variety of procedures and documents. Members claiming reimbursements for hospital treatment need to submit a completed reimbursement application form together with relevant documents for the claims to be considered.

(f) Financial control

Control over finance and claims disbursements is maintained by the Medical Clerk, the Medical Services Department Head, and the General Manager. These three persons are considered to be the "gate keepers" of the NHCP. They regularly screen applicants and

members, monitor benefit disbursements, and analyzing program income and expenses. The use of formal management procedures and tools (e.g. preparation of monthly reports, use of waiting periods and referral systems, strict pre-membership requirements and application and reimbursement procedures) help in accomplishing such tasks. The monthly reports (e.g. financial statement and bank reconciliation) represent the most important control mechanism of the program.

(g) Role distribution

The management and operation of the NHCP can be divided into six different functions:

- Benefits management.
- Membership management and contribution collection.
- Management of relationship with NHCP.
- Accounting and financial management.
- Control.
- Management of relationship with the beneficiaries and target groups.

TABLE 2.9 REAL ROLE DISTRIBUTION

	Members	Salaried Staff	Health Care Provider	Technical Assistance	External HealthCare Provider	Board of Directors
Benefits management						
Who decides the services covered?	*	*				
Who makes decisions about coverage?	*	*				
Who decides patient referral to a more complex level?			Clinic's Doctor			
Who process benefits claims?		*				
Who monitors benefits?		*				
Membership management and contributions collection						
Who receives membership requests?		*				
Who updates the members' register?		*				
Who initiates membership cards?	*					*
Who decides the exclusion of members?	*					*
Who calculates the contributions amount?	*					*
Who decides the contribution amount?		*				
Who collects contributions?		*				
Who carries out contributions recovery?		*				
Who keeps the contributions register?		*				
Accounting and Financial Management						
Who implement the accounting framework?	*	*				
Who prepares the budget?		*				
Who implements the treasury plan?		*				
Who works out the income expenditure account?		*				
Who prepares the balance sheet?		*				
Who calculates the financial ratios?		*				
Who proposes surplus allocation?	*					
Who determines surplus allocation?	*	*				
Who monitor deposits?		*				

TABLE 2.9 REAL ROLE DISTRIBUTION (continuation)

	Members	Salaried Staff	Health Care Provider	Technical Assistance	External HealthCare Provider	Board of Directors
Who recovers debts?		*				
Who determines the financial investments?		*				
Who authorizes expenditure?		*				
Who manages the petty cash?	*	*				
Control						
Who controls the petty cash?		*				
Who implements accounting & financial controls?		*				
Who controls the beneficiaries' status?		*				
Who controls contributions payments?		*				
Who controls beneficiaries' right to benefit?		*				
Who carries out the medical control?	*					
Who prevents fraud?						
Who intervenes in embezzlement cases?	*					
Relationship with the beneficiaries and target group						
Who decides to call a general assembly?	*					
Who organizes the general assembly?		*				
Who designates the officials?	*	*				
Who informs the beneficiaries of services covered?	*	*				
Who organizes information campaigns for the target group?	*	*				
Who organizes prevention and health education activities?	*	*				
Who carries out prevention and health education activities?	*	*				

(h) Equipment and infrastructure

Novadeci's office is in its own six-story building located in Sarmiento corner Buenamar Streets, in Novaliches Proper, Quezon City. The building also houses the Medical Clinic, the pharmacy, the NHCP office, a consumer cooperative store and a number of other offices. Novadeci also owns various vehicles and communication facilities including telephones, faxes and e-mail, computers, photocopying machines, and video equipment. This equipment is also available for NHCP use.

2.3.6. Actors in Relation to the Novadeci Health Care Program

(a) Reinsurance and guarantee funds schemes

The NHCP is a self-help program utilizing internal funds generated by the cooperative and itself. It is not linked to any external insurance institution or agency, although there are plans to reinsure the program with the Philippine Health Insurance Corporation. This, however, has yet to go beyond the planning and discussion stage. Although PHIC, as of yet, is not actively considering going into reinsurance, the NHCP remains hopeful that it will in the future.



Although the NHCP maintains a Health Care Fund, which is basically the reserve fund of the program, this should not be considered as a guarantee fund. There is a disclaimer clause in the NHCP policy guidelines which states that in the event of "mass hospitalization", only the available funds of the NHCP will be disbursed as benefits to members.

(b) Technical assistance

The only technical assistance received by the NHCP has come from the in-house financial staff of the cooperative. Accounting support is provided by the cooperative to keep the books and records of the NHCP in order and one of the accountants of the cooperative is assigned as a part-time bookkeeper of the NHCP.

(c) Social movement and social economy organization

Although the cooperative itself is a member of the National Cooperative Council (NATCCO), one of the largest organizations of cooperatives in the Philippines, the NHCP is not affiliated or linked to any other external organizations. The disadvantage of this policy is that the NHCP is limited in what it can realistically offer its members in terms of benefits and services. Linking it with external organizations, especially those with rich resources and experience, can provide valuable inputs for the NHCP.

There are advantages however, in being detached from other organizations in that the NHCP is insulated from external politics, and bureaucracy. Likewise, it can continue at its own pace, without being pressured by outside influences.

(d) Other actors

The NHCP is an informal micro-insurance scheme, and beyond the scope of existing formal social security arrangements. It therefore operates independently of the government's social security systems.

The NHCP is able to maintain a good rapport with the community through its medical clinic services and monthly medical field trips, and is able to reach out to a wider population.

2.4

INDICATORS OF OPERATION



2.4.1. The membership dynamic

Major policy changes, especially those which have increased incentives for program participation, have had a tremendous effect on membership. For instance, the 1999 policy which abandoned the required pre-membership physical examination enhanced the attraction and accessibility of the NHCP for potential recruits. As a result, from 1998 to 1999, membership increased by 23 per cent from 663 to 817. Similarly, the target coverage rate increased from 11 per cent to 14 per cent during the same period.

However, according to management, the lingering economic contraction brought about by the Asian Financial Crisis reduced members' capacity to contribute in 2000. Thus, many NHCP members failed to renew their NHCP plans for the year, leading to a 3 per cent drop in membership.

The number of NHCP members as of the end of 2000 was only 790, only 14 per cent of the target group. Given that each member had three dependants, the total number of people covered by the NHCP at the time was 3,160. With the effectivity of the new policy in 2001, which required Novadeci members to participate in the NHCP, membership growth for the year 2001 was again spurred. The twin goals of expanding the coverage and scope of the program, and also enhancing its financial standing were both met.

2.4.2. Service use

The clinic services of the NHCP are the most popular. In 2000, a total of 2,811 members and their dependants used the clinic's services; representing an 89 per cent consumption rate. This includes those who took advantage of the free annual physical check-up, which registered a consumption rate of only 9 per cent. Hospitalization service, meanwhile, registered only a 3 percent consumption rate. During the year only 98 persons used the NHCP's hospitalization benefits. However, the cost of providing such benefits to the members and their dependants amounted to over Ph.P.331,000 (US\$5,911) or roughly 73 per cent of the year's total benefit disbursements.

2.4.3. Financing issues

The surplus income of the NHCP goes into a reserve fund called the Health Care Fund, which has grown in recent years to almost PhP 4.7 million. Thirty percent of this fund is placed in high-earning time deposits.

Although staff salaries are still subsidized by the coop, contributions collected are now starting to effectively cover the cost of operations of the NHCP. Along with sound financial management, the program has become a viable concern and will soon be independent from Novadeci subsidy.

2.4.4. Members' participation

Novadeci conducts an annual general assembly which is attended by most of the cooperative's members. On this occasion, a feedback and assessment survey is conducted to see how Novadeci members perceive and value the services offered by the cooperative.

2.5

THE ACTORS' POINT OF VIEW



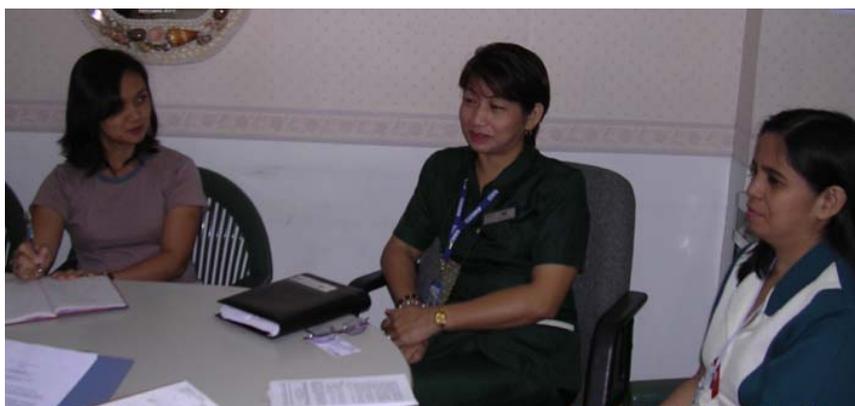
2.5.1. Evaluation process

The annual general assembly held by the cooperative is the venue where members' opinions and ideas are expressed, and where the management is given the opportunity to obtain a feedback from members concerning the services and activities of the cooperative. During this event in 2000, the management conducted surveys among members as regards their evaluation of the services offered by the cooperative. Among those included in the surveys were the NHCP. The annual surveys were able to get at least 30 per cent of NHCP members as respondents. In the most recent survey conducted in 2003, it was found that NHCP members demanded more health services to be included but without a corresponding increase in their annual contributions.

Apart from the annual surveys, a more frequent assessment of the NHCP was completed through an analysis of the programs financial operations. The Head of the Medical Services Department and the General Manager were responsible for monitoring the financial status of the program. They did this by producing monthly and annual financial and operation reports, which were then reviewed by the other department heads and Board of Directors.

The analysis of the finances and operations of the NHCP was used to identify trends in membership growth and contributions, and benefits expenditure. These were considered

to be the most vital indicators in assessing the soundness of the program. In 2000, membership dropped by 3 per cent, which indicated a reduction in interest in NHCP membership. But despite the fall in membership, the average monthly collection increased substantially from Ph.P.35,704 (US\$638) in 1999 to Ph.P.44,069 (US\$787) in 2000. By 2004, the average monthly collection has reached PhP 281, 064 (US\$5019).



2.5.2. The management's viewpoint

(a) Insurance system implementation

The management saw two principal factors for the NHCP's relative success:

- Affordable rates.
- Accessibility to the Novadeci clinic.

Apart from being more affordable, the Medical Clinic (which was the NHCP's primary health care provider) was also very accessible to the members. It was located on the second floor of the Novadeci Building, which is found in the heart of Novaliches' business district. Members could easily take a short ride or walk to get to the clinic.

However, Novadeci members were beginning to demand more specific medical and health care needs, which were not covered by the program or were beyond the limitations and competence of the clinic and its staff. The emerging problem was that the NHCP had no formal arrangements with tertiary hospitals which could provide services not available in the clinic. This has resulted in two solutions to the problem which were instituted by the Novadeci management. One solution, as previously stated, was to increase revenue by requiring new cooperative members to sign-on with the program. The revenue collected helped the clinic acquire new equipment such as an X-ray facility. The other solution was to formalize arrangements with tertiary hospitals such as the Novaliches General Hospital. A memorandum of agreement between the NGH and the NHCP was eventually signed and now enforced (See Appendix).

(b) Membership dynamic

Despite the fact that most of the members appreciated the free annual physical check-up and free medical consultation offered by the NHCP, many of them felt that the benefits and services offered by the program were insufficient although Novadeci operated a very good clinic.

In an effort to retain the interest of current members and attract new ones, the management hired medical specialists such as a pediatrician, an internist, and an optometrist. In addition, a delivery room was constructed within the clinic in order to accommodate the growing demand for child-birth services. In addition, the management increased the budget for promotional activities for the NHCP as part of a strategy to attract new members and create interest in the program.

(c) Access to health services and relationship with the health care provider

According to the Medical Clerk, there has been no firm evidence that the health condition of the members has improved. Prior to the NHCP, members always had access to medical and health care funds through the emergency loan facility of the cooperative. However, with the commencement of the NHCP, access to such funds became more convenient and affordable and there has been a considerable drop in the use of emergency loans for medical and health care services. This indicates that the financial situation of the members has improved.

In the near future, the Medical Services Department envisaged more types of medical and health care services to be covered by the NHCP. This would include the hiring of more medical specialists and the formalization of arrangements with a nearby general hospital. This would enhance the accessibility — in terms of geographical location, affordability and availability — of the health care services offered.

Such initiatives, however, depend on the financing capability of the program and the cooperative in raising revenue. Late payment of contributions was considered a big problem. To solve this, the Medical Services Department holds free medical and health care seminars beginning in 2001 to encourage interest in health care and health care financing.

(d) Contribution payment

In anticipation of the influx of new recruits in 2001, the management has arranged with the cooperative's Credit Services Department to automatically deduct NHCP payments from loans taken out by coop members. The deductions would then be deposited into the Health Care Fund for use by the NHCP.

(e) Determining the contributions and benefits relationship

Although average monthly contributions collected have steadily increased in the nineties, the level of incremental increases were not enough to fully cover program costs. Previously, the program relied heavily on subsidies provided by Novadeci, and the Health Care Fund slowly diminished. The management did not raise the annual contribution fee but opted instead to make membership into the NHCP compulsory for Novadeci members. This effectively generated more revenue.

(f) Insurance risk-management

Initially, NHCP applicants had to undergo a pre-membership physical examination to enable them to join the NHCP. This policy ended in September 1999 and a new policy was begun, which introduced a two-year waiting period for ten specified diseases. This was viewed as necessary to provide enough time for the member's contribution to "age" and to prevent liquidity problems.

The management is considering reinsuring members through an external health insurance provider, possibly the state-led Philippine Health Insurance Corporation. If the plan goes through, the NHCP will not have to shoulder the total cost of health care, and more health care services would be available.

(g) Fraud

The incidence of fraud is very small and in the few instances where it did occur, the cases mostly concerned the falsifying of hospital and pharmacy receipts. These acts of fraud were easily detected because of NHCP's strict screening procedure for evaluating claims. Once fraud was detected, the management's response was immediate: disallowance of benefits claims plus filing of legal cases against the members involved.

(h) Administration and management

Because much of the operations of the cooperative were handled by professional managers, the level and form of activity generated in the Novadeci and NHCP office is very efficient; with responsible and hard-working staff. The employment of professionals however, made the cost of operations high.

Computerization of the NHCP information system is ongoing to help reduce the need for more professional people handling the program. Although the manual system used is satisfactory, the influx of new NHCP members in 2001 necessitated the need to computerize the database and information system of the NHCP.

More volunteer workers (e.g. college student doing practical work) for the program may also have reduced the cost of operations. The disadvantage of such a move is that there would be a high turn-over of people involved in the program. This may create problems for the NHCP in certain aspects of its operations.

(i) Relationship with the State and local authorities

As previously mentioned, the NHCP has not yet been formally linked with any state or local government agency since its inception. However, plans are underway to link the NHCP with the state-led Philippine Health Insurance Corporation. Informal discussions have been held on how to align the systems of the two health insurance providers. However, no firm arrangements and models have been proposed.

(j) General operation

The NHCP is very much dependent on the financial and logistical support provided by Novadeci and is far from being self-sustaining. However, management expects to be more forthright with its marketing, reaching out to current and new members to explain and sell the NHCP, expanding the services it has to offer to make it more attractive, and holding health education and awareness campaigns to encourage interest in health issues.

2.5.3. The health provider's point of view

According to the Medical Clerk, there had been no significant change in the health conditions of the members. What has changed, though, is members' accessibility to more affordable health care services, without asking for an emergency loan. According to the Medical Clerk, there is much to be done in terms of generating interest among Novadeci members to join the NHCP. Although many of the cooperative's members visit the Medical Clinic for treatment, they still need to be sensitized about joining the scheme.

2.6

SUMMARY AND CONCLUSIONS



2.6.1. Best Practices

(a) Health microinsurance can best be offered by an organization that is trusted and respected by its members and the community

Novadeci has been operating in the area since 1976, and has been able to create and maintain a good rapport with its members and the community. More than this, it has earned the respect of the community as an organization with financial expertise and integrity. This is important given that most of its clients come from poor families. It is important for these clients to be assured that their hard-earned money will not be wasted.

The organization is vital since it gives institutional legitimacy to the health care scheme which assures continuity and some degree of permanence to the programs. They also provide the leaders, the behavioral norms and expectations, and organizational structure required for the operation of a credible social security program.

(b) Health microinsurance should have an operating fund-management system and network

Much of the work involves fund management, which is why organizations that have this background such as Novadeci are more likely to succeed with their social security programs. They already have the system and network set-up, which makes the task of collecting and disbursing funds easy. The problems associated with setting up a financial system is greatly reduced, thereby allowing more time and energy to be focused on improving the design and implementation of the micro-insurance scheme.

(c) The organization should offer a more affordable and responsive alternative.

The organization must not only offer something new, it must offer something that is more affordable and responsive. Traditional and commercial social security schemes continue to prosper and compete for social security benefits offered by cooperatives and other organizations. This organization must be able to provide a better alternative to such schemes.

(d) The scheme should not depend fully on subsidies which reduce the incentive to innovate

It has taken the management a long time to make radical changes in the policies and design of the NHCP. For many years, the NHCP depended on the generosity of Novadeci to provide badly needed funds and logistical support. Although changes have been introduced into the program to help make it more financially viable, they have fallen short of their expected impact. The subsidies obtained from Novadeci reduced the incentive for management to make innovative and radical changes in the design and policies of the NHCP to improve it financially.

The NHCP began with the use of subsidies coming from Novadeci which were deemed necessary to fund the construction of badly needed infrastructure and the purchase of vital medical equipment. This has become a problem however because it continues to operate while still depending on Novadeci subsidies.

Present plans to make participation in the NHCP compulsory for Novadeci members and to link the NHCP with external insurance providers are some of the steps being taken towards finding alternative solutions to the funding problem of NHCP.

2.6.2. Lessons Learned

(a) Importance of social marketing

The concept and the mechanics of health micro-insurance schemes are a relatively new subject for most people including the poor working in the informal sector. Thus, it is imperative that members first realize the importance of health insurance, and how it can directly and indirectly help raise their standard of living. It is therefore recommended that Novadeci assess the reliability and relevance of its marketing and feedback efforts, and find other ways to further educate members on the rewards and responsibilities that come with health insurance programs. The objective should be to align what the actual and specific needs of the clients are, with what the NHCP can offer.

(b) Necessity of actuarial evaluation

Social marketing, however, is not the only problem faced by the NHCP. Because of the lack of any reliable actuarial valuation of the program, it is possible that the NHCP may not be financially viable or sustainable. Decisions on financial matters, specifically social insurance, must be based on precise and concrete risk assessment procedures. Therefore, the use of formal actuarial valuation methods is highly recommended.

(c) Increase in volume of members

It is vital that the membership of the NHCP be increased to a much higher level, otherwise, the program may soon find itself in deep financial crisis. The essence of any risk-pooling scheme lies in its ability to attract and mobilize a large volume of people who have the ability and willingness to invest their resources for a common purpose. In the case of the NHCP, it has failed to gain the interest of members of the cooperative, primarily due to unsatisfactory social marketing.

(d) The importance of inculcating a sense of ownership among members

The Novadeci case has underscored the importance of inculcating a sense of ownership. To NHCP members, the program is neither the government's nor of the private health care providers. It is their own. To a large part, this sense of ownership has sustained NHCP's growth.

(e) Microinsurance schemes increase the community's knowledge on health care

The average NHCP member knows more about medical laboratory tests, types of antibiotics, dreaded diseases, and health practices than the non-member. In fact, his stock knowledge on health care is above average. Health microinsurance increases the community's awareness and knowledge.

2.6.3. Conclusion

Health micro-insurance schemes managed by community based organizations are beginning to make their presence felt in the Philippines. Yet, there is still a lack of information on how these schemes can complement the more formal health insurance systems in the country. It is hoped that through more in-depth research, such information will eventually enable both community based organizations and the Government to find ways of improving access to health care for poor and informal sector workers.

The experience of the NHCP illustrates that self-help and informal health financing schemes are feasible, and represent viable ways of providing valuable health services to the poor. The NHCP described in this study has provided one model of a health micro-insurance scheme and, in addition, has been able to provide observers with a glimpse of areas of concern and opportunities.

Chapter 3

ORT Health Plus Scheme

San Fernando, La Union

SYNTHETIC DESCRIPTION

Name of the insurance system (IS)	<i>ORT Health Plus Scheme (OHPS)</i>
Name of the IS' parent company or company, which owns it	<i>Organization for Educational Resources and Technological Training (ORT) Community Multipurpose Cooperative</i>
Address of the IS' headquarters	<i>Guerrero Road, San Fernando City La Union, Philippines</i>
Date IS was created (conception)	<i>July 1994 to December 1995</i>
Date IS launched operation (payment of first benefits)	<i>September 1994</i>
Date IS' parent company was created	<i>1992</i>
Nature of IS' parent company	<i>Co-operative</i>
Legal recognition of the IS	<i>Accredited and registered under Philippine laws</i>
Other activities of the IS' parent company	<i>Prevention, health education Savings/ credit Education/literacy (Mother and Child Care Project) Other activities – Livelihood Projects</i>
Types of members	<i>Individuals, families</i>
Other beneficiaries	<i>Family</i>
Acquisition of beneficiary status	<i>Voluntary</i>
Current number of IS staff members	<i>Total: 7; 1 male, 6 females</i>
Current number of IS beneficiaries	<i>Total: 2,277; 1126 males, 1151 females</i>
Total current number of members of the IS' parent company	<i>631</i>
Residential location of members	<i>62.6% rural area; 37.4% urban area</i>
Relationship between members (other than membership to the IS)	<i>members of the same village, district, or geographic community; members of the same cooperative</i>
<i>Economic situation of members (from ages 19-65 years only)</i>	<i>32.8% members work in the informal sector 13.3% work in the informal sector</i>
<i>Restrictions on membership</i>	<i>Age Place of residence</i>
<i>Geographic area of IS' operation</i>	<i>Province/region</i>
<i>Type of health services covered by the IS</i>	<i>Ambulatory care Hospital care Preventive and promotional care Medicines Gynae-obstetrical care Laboratory examinations Radiology</i>

Total amount of benefits paid during the last term (default year)	<i>PhP. 830,731.10 (US \$14,834.48) for the year 2003 (Exchange Rate: US\$1 = PhP56)</i>
Method of financing the health insurance	<i>Members' contributions State contribution to the IS (Provincial Government of La Union) Contributions and subsidies from other organizations involved Others: Yearly raffle projects and sales of medicines</i>
Type of contributions	<i>Fixed fee using member differentiation by category (age, sex, etc.)</i>
Average annual amount of contributions paid by members during the operating year	<i>PhP690,976.34 (US\$12,338.86) for the year 2003</i>
Health care providers offering services covered by the IS	<i>Public sector (1)</i>
Degree of members' participation in management	<i>Management by parent company with members' participation – general assembly</i>
Who is responsible for the management of current operations	<i>Management exclusively by salaried employee of the IS</i>
Technical assistance	<i>Benefits from regular technical assistance: since 1994</i>
Membership to a reinsurance system	<i>No</i>
Has guarantee funds	<i>None</i>
Other key actors and their roles in the operation of the IS	<i>OHPS Authorized Healthcare Providers: Ilocos Training and Regional Medical Hospital – provides tertiary hospital care, lab and ancillary OHPS Doctors – provide primary health care and regular consultations OHPS Nurses – provide health care and referral services Financing Source/Agencies: Australian Embassy – provided donation grant during OHPS' first term Provincial Government of La Union Project – provides continuation of support for Mother & Child Care World ORT Union – provided donation grant during OHPS' first term Members of OHPS members - continually guarding the integrity of the IS and recruitment of new members</i>

3.1

THE CONTEXT



The Capitol of the Province of La Union in Northern Philippines is located on top of a hill overlooking the City of San Fernando. A complex of buildings surrounds the Capitol itself. In one of these buildings, the entrance is draped with a streamer announcing that its occupant agency has received a 2003 Philippine Senate Award as the best cooperative in the land. The Organization for Educational Resources and Technological Training (ORT)

Community Multipurpose Cooperative (OCMC) has been in La Union since the early nineties. It boasts of services that cover the entire spectrum of human needs, “from womb to tomb.” Central to this package of services is its health microinsurance scheme, the ORT Health Plus.

The experiences of the past ten years of the ORT Health Plus Scheme in the province of La Union in Northern Philippines is a rich source of lessons and best practices that can be used to help refine and replicate this effort to similar communities all over the Philippines and the rest of Asia.

The case study being presented is an example of such a scheme. This community health microinsurance scheme known as the ORT Health Plus Scheme¹ was developed by ORT,

an international non-governmental organization operating largely in several villages in the province of La Union. This province is located in the northern section of the Luzon islands in the Philippines.

3.1.1. Demographic aspects of the zone of operation of OHPS

The province of La Union is located in the south-western part of the Ilocos Region in the northern part of the islands of Luzon in the Philippines. It has a land area of 149,309 hectares contributing 0.05 per cent of the entire land area of the country. La Union is predominantly hilly terrain with a coastal plain bounding its western border.

In 2000, the total population of La Union stood at 657,945. Population in the province is unevenly distributed across municipalities. The top three most populated municipalities are San Fernando City (102,082 or 15.52 percent), Bauang (63,373 or 9.63 percent) and Aringay (51,923 or 7.89 percent). Many OHPS members come from these municipalities and the central unit and main service provider of the scheme is located in the City of San Fernando.

For the past nine years, the province had an average population growth rate of 2.09 percent. Population density is pegged at 421 persons/sq. km. Population is evenly distributed between sexes with a ratio placed at 100 females to 102.13 males. Around 59.14 per cent of the total population belong to the 15-64 age group. Over one-third (35.42 per cent) of the population are in the 0-14 year old group and 5.44 per cent are 65 years old and above.

In 2000, there were 127,579 households in occupied dwelling units with an average household size of five persons. Some municipalities however register household sizes larger than the provincial average.

3.1.2. Economic aspects

The main sources of livelihood in the province are in the agriculture and service sectors. The province's potential labor force is the 15 years old and above age group. Of these, around 292,000 persons or 72.56 per cent are actually in the labor force. Due to rural under-employment, the labor force in the rural areas tend to migrate to the urban centers to look for work. This will then lead to an increase in the population of the urban centers and the coastal areas of the province.

Males dominate the labor force with 186,000 (59.62 per cent) potential workers. As of April 2000, the province registered a labor force participation rate of 73 per cent and an unemployment rate of 10.9 per cent. The visible underemployment rate is 15.9 per cent. There is no data from the province regarding the percentage of employment in the informal sector. Also, it is difficult to describe the mobility between the informal and formal sectors. However, based on national figures, it is assumed that about 45 per cent of the labor force of the province are engaged in informal sector activities.

3.1.3. Social aspects

Among the population aged five years old and over, 37.68 per cent had attended or completed elementary education; 31.47 per cent, high school; and 6.89 per cent, post secondary level. About 5 per cent were academic degree holders, 10.42 per cent were college undergraduates and less than one per cent (0.54) pursued post-baccalaureate studies. There were more males than females among those who had attended or finished elementary (50.22 per cent), high school (51.89 per cent) and post-secondary (55.38 per cent). On the other hand, there were more females who were college undergraduates (52.22 per cent), academic degree holders (60.52 per cent) and with post baccalaureate studies (63.57 per cent).

3.1.4. Health and Sanitation indicators

In 2000, the province of La Union had a total of 61,548 live births comprising of 31,630 males and 29,918 females. Of the total live births, 48,229 weigh within 2500 gms and greater, 11,947 weigh less than 2500 gms while the weights of the 1,372 babies were not known.

The Mortality Rate was 5.0 per 1000 population accounting for 20,939 individuals. Of which, 11,755 are males and 9,184 are females. There were 26 (rate: 0.3) maternal deaths, 1,068 (rate: 12.3) infant deaths, 239 (rate:2.8) still births and 5 (rate: 0.1) deaths due to neonatal tetanus. With the total deliveries of 86,513 in 2000, 27 per cent were attended by doctors, 0.9 per cent by nurses, 59.9 per cent by midwives, 11 per cent by trained hilot; 0.6 per cent by untrained hilot, another 0.6 per cent by others. Of the 659,919 households in the province of La Union in 2000, 524,427 (79.5 per cent) had access to safe water supply while 598,056 (90.6 per cent) had sanitary toilets.

The top three notifiable diseases were bronchitis/bronchiolitis covering 40,281 cases (Rate: 971.4), diarrheas with 38,165 cases (Rate: 920.4) and influenza with 31,865 cases (Rate: 768.4).

3.1.5. National health policy

During the period, 1998-2001, a Health Sector Reform Agenda (HSRA) was formulated. This document serves as the current master plan of the Department of Health, guiding all the activities and programs of the Department.

The Health Sector Reform Agenda has five main policy areas, namely:

- **Health financing:** To expand Social Health Insurance by improving benefits, expanding coverage, strengthening payment systems, improving management capacity and understanding and possibly accrediting alternative financing schemes such as community based health insurance schemes.

- **Local health systems:** To strengthen Local Health Systems by forging cooperation among adjacent Local Government Units (LGUs), cost-sharing and establishing technical linkages among facilities and providers in the health district.
- **Public health:** To build centers of disease control and prevention as an instrument for technical leadership and to sustain public health programs through multi-year budgets.
- **Public hospitals:** To introduce fiscal management autonomy in government hospital facilities and critically upgrade capacities for greater competitiveness.
- **Regulatory agencies:** To strengthen capacities and adopt a new regulatory framework that will promote better quality and greater competition in health care markets.

The HSRA is a relatively new policy document and the agenda is applicable to the present needs and conditions of most of the regions and provinces of the country, including La Union province.

Since the devolution of health services in 1991, the roles and functions of the National and Local Government Units in relation to health care still need to be defined clearly. Thus it has proved very difficult to regulate and control the quality of health care delivered at local level. There is no existing regulatory mechanism or structure that performs the function of quality assurance at the local level in the Department of Health. The HSRA was pilot tested in 2001/2002. Initial results, specifically in the establishment of centers of disease control and prevention, point towards the need for direct collaboration among local, regional and national agencies to ensure quality services. The LGU-based social hygiene clinic is a case in point. These may only conduct preliminary screening of ailments. Within the current structure, confirmatory testing may only be done in a national central laboratory.

3.1.6. Supply of health care

As of 2000, La Union Province has seven public hospitals and 11 private hospitals. These hospitals have a total bed capacity of 769. The public hospitals accounted for 415 beds while the private hospitals had a total of 354 beds. There are also 184 Barangay (village) Health Stations (BHS) that are responsible for delivering public health care to the communities. The BHS population ratio was pegged at 1:3,743. Apart from these, there are 20 Rural Health Units (RHU) with at least one per municipality. Each RHU has a full personnel complement comprising of a physician, public health nurse, sanitary inspector, institutional worker, public health worker, dentist, medical technologist and several midwives. The RHU physician to population ratio in La Union in 1998 was 1:28,583. The nurse to population ratio was 1:23,290 while the rural health midwife to population ratio was 1:3,635. The situation has worsened in 2004. Because of the migration of physicians to better paying jobs abroad, rural health units are only manned by midwives. The current ratio of rural doctors to people served is 1:32,000.

Private clinics and diagnostic centers are also present in the urban areas of the municipalities. These provide health services to the upper and middle segments of society. Intensifying the preventive and promotional aspects of health is now the main thrust of the health sector in

the province through its Health in every Home Program.

Insofar as access to these medical facilities and expertise are concerned, however, it remain low. Gloria Ordinario, ORT Health Plus Scheme Coordinator, bemoans that most rural health units in La Union lack medicine. Doctors are even harder to find. Although there are no formal surveys to prove this, many informal surveys of the province indicate that a significant majority (around 80 per cent) of the population do not have access to health care, especially drugs and medicines.

3.1.7. Social protection in health

In the province of La Union as in many provinces in the Philippines, there exists some traditional forms of solidarity that act as informal safety nets during times of crisis and difficulty. Typical Filipino families are characterized as closely-knit and consisting of a network of extended family members. This extended network is the first source of financial and emotional support of many families. When a family member is ill and is in need of care, most people would seek help and borrow money from relatives and occasionally friends. The network of support also extends to neighbors and village associations. In La Union, a traditional form of solidarity called *saranay* exists. This term describes the practice of family and friends



contributing an amount of money as assistance to a relative or neighbor whose family member had died or was sick and required treatment. This practice is also harnessed in times of natural calamities such as typhoons, floods and fires that may have unexpectedly destroyed lives and property in the community.

It is the philosophy behind *saranay* that has been used as the basis for the implementation of schemes like OHPS. There are also similar forms of solidarity existing in many, if not all of the villages and communities in the Philippines. They are observed to be increasing because of the continuing economic difficulties that many of the Filipino people experience.

Another form of social safety net that is widespread in many parts of the country, including La Union is the heavy reliance on assistance from local leaders particularly the governor and mayor of a province and town, respectively. This is a well-entrenched tradition and has in fact led to a culture of dependence and complacency among the people. Many politicians like to continue with this practice, as this is a form or assuring themselves of votes during elections.

This practice dates back from the time of the Spanish colonization where the feudal system was followed. At that time, many Filipinos were under the patronage of a rich landowner who took care of all their needs and continued to put them in eternal debt to him.

3.2

IMPLEMENTATION



3.2.1. The launch

At the time of the launch of OHPS in La Union, access to health care in poor rural communities in the Philippines was very severely limited. This was largely due to inadequate supply, through sparsely distributed government health centers and hospitals. During this time, the Local Government Code of 1991 had just been implemented in full. This law mandated the devolution or decentralization of health services. Previously, the public health care delivery structure was a centralized organization emanating from a central office of the Department of Health headed by a Secretary of Health. After the devolution, the responsibility of delivering health services to communities was delegated to local chief executives. Thus in the La Union Province, the Governor was the primary leader responsible for the delivery of the different social services including health. Lower in the bureaucracy, the different cities and municipalities also ran their health facilities independently with the mayor as the local chief executive in charge. Thus, at the time of the launch of OHPS the public health care sector was still going through a difficult transition under a new leadership at various levels. In addition, some municipalities in the province had been severely affected and devastated by the strong earthquake that rocked the Philippines in 1990.

During this period, the province of La Union had a total of sixteen hospitals, nine of which

were privately owned with the other seven being public institutions. The total bed capacity was 744. Government hospitals accounted for 415 beds with the Ilocos Regional Hospital having the largest bed capacity of 150 beds. Private hospitals had a total of 329 beds. At that time each of the twenty municipalities had a Rural Health Unit with a Family Planning Centre. In addition, there were a total of 190 Barangay Health Stations located in the different villages of the province.

Then, there were 1,179 medical, dental and health personnel in the province. Of these 466 were employed by the public sector whilst 713 were privately employed. The doctor to population ratio at that time was 1.3,522 whilst the nurse to population ratio was 1.1,966.

In many poor rural communities, access to health care was largely dependent on availability of facilities and people's capacity to pay for services. Most of the people preferred to consult private physicians and hospitals if they had the money to pay for the services. This was because public hospitals and health centers were perceived to be very congested, provided poor quality services and always lacked supplies and medicines. However at that time, about 40 per cent of the population were poor and had no recourse except to access health care services provided by public facilities.

At the national level, there were already some proposals recommending that tertiary level health centers under the Department of Health (DOH) Central Office should start to collect user charges as a cost recovery measure due to increasingly limited funds in government. At the local level, this was not fully implemented as the local chief executives felt that it would not be politically correct for them to implement user charges when many of their constituencies frequently came to them to ask for financial support for illnesses and hospitalization costs. Thus it can be said that only the Ilocos Regional Hospital had begun to impose some user charges, while the different Rural Health Units still provided free services and medicines when these were available. At the time of launching of OHPS, the scheme was targeted towards the families of the children enrolled in the Mother and Child Community Project implemented by ORT. The daycare centers that ORT had supported and helped to build were then located in 14 villages in different municipalities in La Union. The daycare centers were called satellites. The following are the locations of the 14 satellites:

- Bariquir, Naguilan Municipality
- Baroro, Bacnotan Municipality
- Bulala, Bacnotan Municipality
- Carcarmay, Bacnotan Municipality
- Gonzales, Tubao Municipality
- Lloren, Tubao Municipality
- Macalva, Agoo Municipality
- Nadsaag, San Juan Municipality
- Pangao-aonan, Aringay Municipality
- Pudoc, Bauang Municipality
- San Francisco, San Fernando Municipality (now a city)
- San Juan, Agoo Municipality
- Sta. Rita, Aringay Municipality
- Santiago Norte, San Fernando Municipality

Prior to full operationalization of the scheme, no formal survey on the socio-demographic characteristics of the target population was done. However during the early months of implementation, an informal, limited survey was done on some of the selected municipalities.

The identified target population of OHPS was representative of the lower income bracket of society. The selected villages had an average of 100 households per village with a male to female ratio of 1:1. The target population had an average family size of four. There was an estimated unemployment rate of 20 per cent. The estimate average monthly income among the target households was Ph.P.1000 to 2000: most were poor.

Among their most common economic activities were farming as well as engaging in small economic enterprises. A small percentage also relied on remittances from relatives who worked as overseas contract workers. There was a 95 per cent literacy rate among the target groups.

Among the identified obstacles to health care were geographical barriers to access. Many of the identified barangays where the satellites were located were in the more remote portions of the municipalities. Thus they were difficult to reach with public transportation being limited and usually expensive. Also, some of the public health stations in the village had no personnel and were not frequently visited by physicians.

As in most of the villages in the province at that time, ethnic and social ties were strong among neighbors and about 40 per cent of the population were members of different clubs and organizations. The identified political units at local level were active and conducted regular structured activities.

In general, it can be observed that the initial target population that was chosen for OHPS represented the poor and marginalized sectors of the province of La Union, who had little or no access to basic health care services due to geographic, economic and social factors. Also the existing national policy of the devolution of health services became an additional barrier for these people to access health care services at village level. The target group was not in any way involved in managing the supply of health care and in the overall functioning of the health sector in their villages and in the province.

In terms of access to social protection, the members of the target group were among the segment of the population who had little or no access to any of the social security benefits available from the public sector. Since most of them were self-employed or informal economy workers with no employer and not covered by any regulations, they were not able to access the Social Security System for social protection benefits.

At the time of OHPS's, coming into operation the Maternal and Child Community Project of ORT had not only been established but had in fact already been handed over to the responsibility of the local government unit. Thus, the Parent-Teacher Community Associations (PTCA) in each of the satellite clinics were already well established and were used as the vehicle by which OHPS was launched. In fact, some volunteers that came from this organization such as the community promoters, day care workers and health promoters eventually became the first members of the ORT Multi-purpose Cooperative.

The activities of OHPS were linked to the main activities within the Mother and Child Care Program. Thus the regular monthly Parent-Teacher Community Association meetings and skills training workshops became venues for recruitment and orientation into OHPS.

The idea of establishing a health microinsurance scheme came about as an offshoot of the visit of an expert in social security, then connected with the World Health Organization, Division of Intensified Cooperation with Countries. The expert, who was familiar with the ORT activities in La Union had been invited on a personal capacity to visit the project site. Thus, during one of her trips to the Philippines, she had the opportunity to see for herself the developments and accomplishments of ORT in the province. This led to suggestions by the expert on the possibility of implementing a health microinsurance scheme through the different daycare centers that had been established. It was observed that most of the essential factors that could create an enabling environment for the establishment of a social health insurance scheme could be found in the 14-day care centers already established. The same social security expert was then formally requested to serve as consultant, through the WHO Regional Office in Manila.

3.2.2. The phases of implementation of OHPS

(a) Identifying needs and defining objectives

Following the suggestion, the ORT Regional Director, the Project Manager of the ORT Multipurpose Cooperative, and the Pediatrician employed for the Mother and Child Community Project facilitated a meeting of parents from the different daycare centers. The idea of an insurance scheme was introduced and the general feedback received was that the proposed scheme was something that could indeed address some of the communities' problems of access to health care facilities. This informal process of consultation leading to the identification of needs and the definition of objectives was done over a five-month period prior to the launching of OHPS.

Through the various PTCA meetings, the target groups identified for the scheme were consulted on their various needs and concerns. Most of the targeted beneficiaries expressed the hope that government (both national and local) would be able to provide some subsidy and would participate in the scheme. Some of the community members felt that in schemes such as these, government should play a role.

Among the fears that were raised were the possibility of the accredited hospital provider not honoring membership and thus not providing the necessary service. Another fear expressed was on the sustainability of such a venture especially after ORT, the financially supporting NGO, came to the end of its project in the province. Some of the target group's other concerns were in relation to whether the contributions could be refunded if members did not avail themselves of any of the benefits over the year. Others expressed concern on how to select the organization that would handle and manage the funds.

Only the identified target group of parents and community members in the day care centers were consulted. Local Government officials and public health sector institutions were not

consulted. However courtesy visits were made to all relevant public sector institutions to inform them of OHPS and its proposed objectives and activities. Such visits were done in the hope that endorsements and support could be generated towards the scheme. With the support and endorsement from local officials, recruitment of members to OHPS was facilitated as doubts and suspicions were dispelled.

Among the local officials' hopes for the scheme was that it would eventually result in a decrease in charity support that the population usually expect from the Local Government Unit (LGU). On the other hand, fears were expressed in relation to the scheme's capacity to be sustainable especially when the external funding support was terminated.

(b) Context and financial feasibility studies

There was no feasibility or context study conducted prior to the launching of OHPS in the selected sites. However, reference was made to a survey conducted by the organization in 1991. This survey was done to obtain information on the socio-economic profile of beneficiaries at the time of implementation of the Mother and Child Community Project.

There was also no formal financial feasibility study undertaken. Instead the extensive experience and knowledge of the technical expert and consultant were used to aid in the formulation of the benefits/contributions relationship. Another basis was the current fees charged by the two leading private hospitals operating in the catchment area. Moreover, no other insurance system was visited or consulted prior to the development of the benefit and contribution package.

(c) Information on the target group

Since a very small percentage of the potential beneficiaries had previous experience with any insurance system, the implementers of the scheme organized several meetings, and village assemblies to introduce and discuss the concept of the health insurance scheme. Also during the annual general assembly of the ORT Multi-purpose Cooperative, the proposed OHPS was also introduced and discussed. During these meetings, information brochures were disseminated. In addition to these activities, the general manager of the cooperative was a guest on several radio talk shows where she had the chance to introduce and discuss the OHPS.

During these meetings and assemblies, it was found that a common attitude among most members regarding the creation and implementation of OHPS was to take a "wait-and-see" approach towards the scheme. Many wanted to see proof that such a proposal would be viable. Also, those who already had access to medical benefits as members of the SSS could not understand the rationale for another insurance scheme and why additional contributions had to be given. Among the most common obstacles were the financial obligations. During the initial months of implementation, the policy on having to pay contributions on a quarterly basis (a minimum requirement) became one of the most significant obstacles encountered. Some of the measures taken to respond to and overcome this were the introduction of raffles and efforts to elicit "sponsors" to support the membership of selected beneficiaries who were classified as the very poor. Through these sponsorship schemes, some very poor members of the target group had the chance of benefiting from

the health insurance scheme for at least one year. It was hoped that these members would realize the benefit of the scheme and would be motivated to continue their membership after the first year.

(d) Leadership and decision-making

The Project Manager of the cooperative with the support of the pediatrician and the nurse assigned to the Mother and Child Community Project assumed responsibility for the operation of OHPS. They were closely supervised and advised by the consultant from WHO who had provided the general framework and guidelines for the scheme. Regular updates and reports were sent to the consultant who in turn sent advice and suggestions.

The working group therefore consisted of the three key persons mentioned above. Many formal and informal discussions were held. Some roles and responsibilities were defined as follows:

- Issues and concerns relating to the delivery of health services were overseen and responded to by the doctor-pediatrician.
- Issues and concerns relating to the health promoters and satellite clinics were overseen and responded to by the nurse.
- Overall supervision, coordination and external links and networks were controlled by the project manager.

Most major decisions were taken by consensus and after discussion with the same consultant and the director of ORT. Among the areas suggested by the consultant were health care benefits, contributions, condition of membership and coverage of other beneficiaries. The project manager on the other hand was responsible for decision making regarding management methods, statutes and the internal organization. Decisions and policies on the health care providers was done by the pediatrician.

3.2.3. Operation during the first term

(a) Members and other beneficiaries

At the start of operations and even up to the present, the scheme has only three categories of members, namely, families of six members or less (standard family), families of seven members or more (large family) and single individuals (age 18 years and over). All memberships are voluntary and no membership fees are collected. There are also no prerequisites or conditions imposed prior to membership and anyone is free to join the scheme.

During its first term, members were largely the families of children enrolled at the day care centers of ORT as well as neighboring households surrounding the vicinity of the centers or satellite clinics. It was observed that most of the members were farmers and small entrepreneurs. Members of one satellite clinic would usually be residents of the same village. The first members were representative of the target group identified by the OHPS.

Membership was on a family basis. No restrictions were set in relation to the beneficiaries

of the scheme. This meant that the spouse and all the children of the member could equally avail themselves of the same set of benefits. There were no exclusions imposed on any member or beneficiary with regard to pre-existing conditions or illnesses.

At the end of the first term (December 1995), the scheme had enrolled close to 200 household heads, with about 800 individual insured persons. These largely belonged to the communities or villages where the different daycare and satellite clinics were located. Indeed these were the original targets of the scheme when it was first planned.

There was only one benefit package designed for both members and beneficiaries of the scheme. The reason for this was to emphasize that a health microinsurance scheme that targets the poor sectors should be simple, easy to understand, accessible and viable. The sample brochure describes the benefits that scheme provides for all its beneficiaries and members.

The single benefit package was designed based on an assessment of the most essential services that the majority would need.. The focus was on \ensuring that a basic and appropriate set of services could be offered, to ensure that members would in the first place, not develop the illness (primary care), and secondly, be able to provide solutions for his/her most common health needs (secondary and limited tertiary care).

The health care providers that were assigned to the different satellite clinics to provide outpatient services were salaried employees of the scheme. Thus, these providers were expected to be at their respective satellite posts on specified days of the week for at least three hours to offer medical consultations to those that came to seek care. The single hospital provider, on the other hand, was pre-paid quarterly through a previously agreed capitation rate.

At the outset there was no benefit monitoring introduced. Most of those who were involved in the management and administration of the scheme especially during the first term admitted that they were all “learning on the job”.

TABLE 3.1 SERVICES COVERED BY OHPS

Services	Persons Covered	Co-payment	Maximum coverage limit	Waiting period	Compulsory Reference
Unprogrammed Surgical Interventions					
All (depending on capability of the provider hospital)*	M & B	NA	45 days/year	2 months	C
Gynae-obstetrical Interventions					
All*	M & B	NA	45 days/year	2 months	C
Hospitalization					
All*	M & B	NA	45 days/year	2 months	C
Programmed Surgical Interventions					
All*	M & B	NA	45 days/year	12 months	C
Programmed Ambulatory Care					
General Outpatient Consultation	M & B	NA	NA	1 month	N
Preventive Care					
All*	M & B	NA	NA	1 month	N
Unprogrammed Ambulatory Care					
All*	M & B	NA	NA	1 month	N
Medicines					
Only Essential Drugs (National Drug Formulary)	M & B	NA	NA	1 month	C
Laboratory/Radiology					
Basic Lab and Radiology procedures (if available in provider hospital)	M & B	NA	NA	NA	C
Unprogrammed Surgical Interventions					
All (depending on capability of the provider hospital)*	M & B	NA	45 days/year	2 months	C
Gynae-obstetrical Interventions					
All*	M & B	NA	45 days/year	2 months	C

M & B = members and beneficiaries C = Compulsory N = not compulsory

(b) Financing

The required contribution to the OHPS during its first term depended on whether the member was enrolled with the social security scheme implemented by government or not. These schemes were known as the Social Security System for the privately employed and the Government Social Insurance Service for those employed in the public sector. Furthermore, the contribution scheme was subdivided according to the size of the family (single, standard or large). The following were the rates during the first term:

A. Rate if Non-SSS/GSIS member

1. Single (18 years old and above) – P50.00 per month
2. Standard Family (6 members and below) – P100.00 per month
3. Large Family (more than 6 members) – P130.00 per month

B. Rate if SSS/GSIS member

1. Single (18 years old and above) – P25.00 per month
2. Standard Family (6 members and below) – P70.00 per month
3. Large Family (more than 6 members) – P95.00 per month

The reduced rate for Group B, who had access to formal social security, compared to Group A may be construed as a situation wherein the “haves” support the “have nots.” However, there was less incentive for those already protected by social security to enroll in the program. Hence, a reduced rate was provided for. Additionally, it was assumed that members who already had protection were less likely to avail as much benefits as those who had no protection whatsoever.

In the first term, enrollment in the scheme was done every first week of the month. The first payment was to be done within one week of joining the scheme. Subsequent payments could be made as follows:

- Monthly – First week of every month.
- Quarterly – First week of every calendar quarter (March, June, September, and December).
- Semi-annually – First week of January and July of every year.

There were neither identified reserves nor preliminary funds during the first payment of benefits.

(c) Health care providers

During the first term, there were six doctors hired by the scheme to provide outpatient services in the different satellite clinics. All, except for the coordinator of the medical staff were hired on a part-time basis. These six individuals were private practitioners who also continued to hold their own private clinics. The hospital provider on the other hand, was a private for-profit institution operated by an organization affiliated with one of the Christian churches. Thus, it can also be said that perhaps the profit motives of this hospital were

slightly tempered by their religious affiliations and their prioritizing their services to their needy constituents. The doctors were chosen simply on the basis of their willingness to go to the satellite clinics and provide outpatient care. All of these doctors were personal friends and colleagues of the pediatrician who was also the assigned medical coordinator of the scheme. It should be noted that no formal criteria or evaluation process was made in the selection of these doctors. The choice was based more on willingness and convenience

TABLE 3.2 RESOURCES USED TO FINANCE OHPS CREATION IN ITS FIRST TERM			
Financing Source	Amount (Specify Currency)	Aim	Type of financial support (subsidy, credit, conditions, etc)
Australian Embassy	Then PhP 100,000	To renovate satellite clinics and purchase equipment, an initials stock of medicines and 1 desktop computer	Donation grant
Provincial Government of La Union	PhP. 36,000 per month	To pay for the salaries of 1 pediatrician (part-time), 1 nurse (fulltime), 1 project manager (part-time), 18 health promoters (part-time)	Continuation of the support for the health care in the Mother and Child project can be seen as partial subsidy.
World ORT Union	PhP. 15,000 per month (until June 2000 only)	To pay for the salary of 1 pediatrician (part-time), a marketing and promotion (part-time), 1 administrator (full time)	As above

NOTE: US \$ to PhP. Exchange Rate: US \$1= PhP 25.00 in 1995

in terms of time and geographical location to the doctors.

The hospital provider on the other hand was chosen based on the perceived reputation that the services provided were of good quality. A contributory factor was the willingness of the hospital management to be paid on a capitation basis. Thus, an agreement with a private hospital in San Fernando City was reached. The important provisions of this agreement revolved around the mode of payment for the utilization of services by OHPS members. Also, the agreement emphasized that only the basic and most essential services were to be covered by the hospital. Thus, services like organ transplants, dialysis, orthopedic plates and aesthetic surgery among others were excluded from the benefit package. Another important provision was the hospital's responsibility for ensuring that their pharmacy should be well-stocked with medicines included in the Essential Drugs List. If the hospital was unable to provide a member with the drugs and medicines he/she required when hospitalized,

the cost of purchasing these drugs by the member would be deducted from the next quarterly capitation payment to the hospital. Being a private hospital, no subsidies were provided by government and thus pricing was based on the hospital's actual costs.

(d) Administration and management

When OHPS was formulated and implemented, there were some guidelines and policies that were developed to assist the smooth operation of the scheme. Apart from this, there were no formal statutes and regulations that could serve as a guide, other than the guidelines presented in the brochure. This was because the scheme was not considered a separate entity from the cooperative, but rather as an extension of the services provided by the cooperative and the day care program.

It was run entirely by the management team of the ORT multi-purpose cooperative. The OHPS staff however were focused and assigned to attend to the insurance scheme only and were not involved in any of the cooperative's other activities.

From the inception of OHPS, the following documents were introduced:

- Members' register (computerized database system)
- Membership card
- Contributions register (included in the computerized database system)
- Accounting framework documents

Most of the information provided by these documents is consolidated in a database computer program, which includes an accounting system. However, because of the exploratory nature of the scheme, there was no indicative budget created and requests for funds were dealt with as they came and most of the initial costs were covered by the grants and donations as shown earlier.

Aside from the technical assistance received, there was no training conducted during the creation phase of the OHPS. Most of the members of the team underwent *on-the-job-training* on the various concerns and components of the scheme.

TABLE 3.3 SALARIED STAFF EMPLOYED BY OHPS

Category	Number	Employer	Percentage of time dedicated to the Insurance Scheme
Physician	1	ORT Multi-purpose Cooperative	100%
Coordinator	1	ORT Multi-purpose Cooperative	100%
Project Manager	1	ORT Multi-purpose Cooperative	30%

TABLE 3.4 TECHNICAL ASSISTANCE SUMMARY (CREATION PHASE AND FIRST YEAR OF OPERATION)

Organizations or persons providing technical assistance	Focus of support provided	Duration (period) of support	Direct beneficiaries of support
Social Security Expert from the WHO Division of Intensified Cooperation	Conceptualization and creation and operation of the scheme	1 year	OHPS management team

3.3 CHARACTERISTICS



3.3.1. Target group and beneficiaries

(a) The target group

The initial target population was defined as the family members of children attending the ORT day care centers as well as the general population of the communities in which the centers were located and the members of the ORT Multi-purpose Cooperative but the insurance scheme eventually broadened its target group.

After the first year, 1994, the OHPS terminated the contract with the first hospital provider, that it had entered into an agreement with. The withdrawal of the agreement was initiated by the hospital provider due to misunderstanding that developed from a single case. In 1997 the OHPS had an agreement with the Ilocos Training and Regional Medical Centre (ITRMC) to become its authorized provider for in-patient hospital care and ancillary services. Since the hospital was located in San Fernando, the capital of the province of La Union, it became inevitable that the target population would include the residents of San Fernando and later that of the whole province to maximize the use of facilities. Individuals from nearby towns in San Fernando have likewise displayed interest in the scheme.

Despite this broader target group, the health microinsurance scheme still prioritizes and focuses its efforts in member recruitment and maintenance in the satellites. They are mostly the rural poor and were the original target group. However, the instability of their membership due to irregular and inadequate incomes as well as other financial burdens sometimes endangers the sustainability of the scheme. Broadening the target group, excluding no one, and including even those already enrolled with the Philippine Health Insurance Corporation or PhilHealth offers more prospects of increasing the membership and consequently the viability of the IS. The incentive for the latter groups to join was access to ambulatory health care, as the SSS and GSIS benefits are limited to hospital care.

(b) Various categories of beneficiaries

The scheme allows membership at three levels: single member (over 18 years of age), standard family (up to and including six persons) and large family (more than six family members). All members of the family are entitled to health insurance benefits through a household contribution. Elderly parents over the age of 60 can also be claimed as dependants if they live in the same household as the principal member.

The primary concern for encouraging family membership is to avoid the adverse selection that occurs when voluntary membership is based on individual registration. In a system where membership of the insurance scheme is on an individual basis, it is to be expected that those who enroll will tend to include only members of their families or households who are more likely to be sick and to need hospitalization. This will then prove detrimental to the scheme's viability, as a huge majority of its enrolled members are likely to make use of the benefits.

The qualifying period (one month for out-patient care and two months for in-patient care) applies to the initial enrollment – the first time a family joins. The qualifying period is to prevent families from joining only when they are sick, or know they will need expensive treatment very soon. The concept of the qualifying period should not be confused with the contribution payment. A contribution payment gives entitlement, at any time.

If a new member pays three months contribution, or even six or 12 months – as the first payment, the member or his/her dependants can receive in-patient care only in the third month. This applies to all in-patient admissions, including what may be termed “elective surgery”. The only exclusion is maternity care (childbirth) which has a qualifying period of 12 months. If the family stops paying the monthly contribution for two consecutive months, they have to be treated as new members when they opt to pay again and rejoin. When they rejoin, they have to complete a new qualifying period. Thus they have to pay an initial contribution covering a three month period, and wait two months if they need hospital care.

Ideally, the members of the ORT Multi-purpose Cooperative gain automatic membership to the OHPS. However this does not always follow since there is no mechanism that currently exists where the cooperative facilitates contribution payments of members to OHPS. Once the co-op member misses a monthly contribution he/she forfeits membership to the scheme. In effect, membership of a co-op member to OHPS then becomes voluntary. For the non-co-op members, membership to OHPS is voluntary. Many OHPS members

are not able to afford membership to the cooperative because there is a required share capital of PhP. 4000 while membership to OHPS only requires payment of monthly contributions without membership fees nor capital shares.

To become an official member, one may register at the ORT Central Unit⁸, or at the outpatient clinic at the Ilocos Training and Regional Medical Center⁹ or at any of the 13 ORT day-care centers/satellite clinics located in various villages in La Union Province. An initial three-month contribution is required upon registration. The new member has to fill up a registration form and submit with it the following:

- Birth certificate and /or Voter's ID;
- Senior Citizen ID, if senior citizen;
- Decree of adoption if child is adopted; and
- Marriage Certificate.

The members' register includes the following information: the family number, the name age, sex and civil status of the principal member together with his/her individual number; residence and office addresses, telephone number; spouse's name and beneficiaries' names, ages, birth dates, relationship to the principal member and their individual numbers.

A membership card is issued for each household, listing all household members covered by the scheme and valid for 12 months. A member does not need to sign a contract. A household membership registration number is allocated to each contributing unit (household or individual) and individual numbers are assigned for each individual within the family. Each card contains 12 small squares in which monthly stickers¹⁰ are attached. This indicates that the monthly contribution has been paid. The members have to present this card during medical consultations and whenever they want to access other services in the clinics or in the hospital. They also have to present it when paying their monthly contributions. The only change in the condition for membership is that the qualifying period for maternity care was increased from an initial three months to a waiting period of 12 months. This came about following several cases of abuse through payment of contributions for three months prior to delivery and then dropping out of the scheme.

(c) The number of beneficiaries and their evolution

Although the membership data includes the age and sex of members, the computerized system does not generate the number of members according to sex and age.

TABLE 3.5 CURRENT NUMBER OF MEMBERS AND BENEFICIARIES

	Total 1997	Total 1998	Total 1999	Total 2000	Total 2001	Total 2002	Total 2003
Single	135	177	162	160	186	202	160
Standard Family	348	379	467	476	564	526	526
Large Family	30	28	39	38	52	36	30
Total Members	513	584	668	674	802	764	716
Total Individuals/ Beneficiaries	2,006	2,045	2,535	2,447	2,883	2,630	2,485

The figures in the “standard” and “large family” include only the principal member of every family while the figures in the last row “Total Individuals/Beneficiaries” include all the family members in the standard and large family categories.

(d) Reasons for losing membership status

If a member fails to pay the monthly contribution for two consecutive months, the family loses membership status. The decision to delete membership is based solely on the inability to comply with the required monthly contributions. All members and program implementers are aware of this policy.

The drop out rate is relatively high due to the following reasons:

- The irregular or seasonal source of income of most members;
- A lack of understanding of health microinsurance concepts, policies and procedures despite extensive promotion and member education;
- Too high an expectation from members of the benefits provided such as full coverage of all medicines prescribed and daily presence of doctors in satellite clinics.

Calixta Patacsil, a longtime member of OHPS believes that there are dropouts because many are not open-minded about the scheme, particularly those who have not yet availed themselves of hospitalization benefits. The extent of dropouts has gradually been reduced as more people in the community hear of real cases in which patients were covered for high health care expenditures. Such stories are spread by word of mouth and through an OHPS newsletter, which has played an important role in the development of the scheme. The scheme has also adopted a new policy whereby the membership cards are released to the new members only after they have attended an Orientation Seminar. The Orientation

Seminar is held for three hours every last Friday of the month. Through this, the concepts, policies and procedures of social health insurance are explained more clearly to the members. These seminars also serve as venue for members to ask questions, provide feedback and seek clarification regarding some policies of the OHPS.

(e) Target group coverage

Expanding membership has always been a priority for the OHPS and it has organized house to-house campaigns in different communities as well as information drives among the other cooperatives and government agencies in the province. Many have shown interest but these were not translated into actual membership because of perceived difficulties in collection.

The collection mechanism is perceived as being a hindrance to increasing membership. The OHPS encourages members to go to the Central Unit or to the satellites to pay their monthly contributions but for members residing in the communities where the centers are located, the community and health promoters act as collection agents when they do house visits. For the members of other cooperatives and staff of other offices however, the OHPS will only accept their application for membership if they either go to the Central unit or OHPS clinic at the Ilocos Training and Regional Medical Center (ITRMC) to pay, or if all the contributions of the employees are collected through the management payroll system of the employees and remitted to the OHPS as a lump sum. For example, if the staff of St. Louis College wish to join, the College management should collect their contributions. The officers of the government agencies and cooperatives were not willing to do this as it was noted that they already had difficulties in their loan collections.

There was a plan to make an arrangement with a local bank or agent in San Fernando to accept members' monthly contributions into a designated bank account but this did not materialize.

For the year 2000, a promotion session was held this being to publicize and disseminate information about a new clinic opening the following week. The promotion lasted for three days between 10 a.m. and 2 p.m. Free blood pressure check-ups and medical consultations with OHPS nurses and two doctors who were present were offered. Staff members greeted the prospective clients, taking down their details, and answering questions about the concept of the scheme. Follow-up notes were made for people living in the town where the new clinic was to be located.

Further strengthening of an understanding of the concept of preventive and public health care needs and health micro insurance among the OHPS doctors is also constantly being addressed. The good performance of the doctors as well as opportunities for them to discuss with their patients the concept of social health insurance may attract prospective members.

Negotiations with the town mayors as well as the provincial Governor in La Union to cover indigent populations was also considered. In this scheme, the Local Government Unit would purchase cards through the OHPS at the same contribution rate and offering the same benefits. However, this did not develop through lack of support from the local

government units and line agencies and was even cited as one of the difficulties encountered in an evaluation report.

Non-essential drugs are sold to members at cost plus 20 per cent and to non-members at cost plus 50 per cent. The higher costs of drugs and medicines to non-members is also designed to serve as incentives for joining the scheme.

3.3.2. Benefits and other services offered by OHPS

(a) Health services

Since its launch in 1994, the OHPS has offered the same benefit package. The choice of services covered by the scheme was based on the consultant's knowledge and experience of the most common health care needs that affect a majority of people in a given poor population. At the outset, an informal survey was conducted and documents were also reviewed in relation to common health indicators. The benefit package was suggested by the consultant on that basis and include all of the following:

- **Primary health care / consultations** - Outpatient consultations are provided by doctors and nurses at the ORT day-care centers, the ORT Central Unit, and at the OHPS clinic at Ilocos Training and Regional Medical Centre on a regular weekday basis. On weekends and holidays, emergency consultations are provided at the Outpatient Department and/or Emergency Room
- **Prescribed essential drugs** – Dispensing of essential drugs prescribed by a doctor or nurse, are free of charge. Essential drugs prescribed for use following discharge from the hospital will be dispensed by the OHPS clinics. Over the counter or non-prescription drugs will be sold to members at reasonable prices.
- **Ancillary services** – Basic diagnostic tests are done at the ORT day-care centers. Other tests are done upon referral by ITRMC, free of charge.
- **Preventive care** - Immunization is provided by the ITRMC and in collaboration with the Rural Health Units, as well as prenatal and baby care.
- **Hospital care** – Outpatient services, including specialist consultation, laboratory tests and -rays, is provided to all members at ITRMC. In-patient services provided include: room and board (ward accommodation), doctors' services (resident physicians but not consultants/specialists), drugs (essential drugs), x-ray and laboratory tests. These are provided free of charge by the ITRMC only upon referral from the OHPS satellite clinics, and upon presentation of a valid, updated OHPS membership card. In-patient hospital care is covered for up to 45 days per confinement.

The OHPS does not cover services provided by ITRMC without proper referral or approval.

The above information is given out in a brochure to members as well as prospective members. The brochure also specifies the limitations of the insurance scheme. The following services are not covered: dental and optometrist care, cosmetic surgery, organ transplant, open heart surgery, dialysis, orthopedic pins/plates, special accommodation services in private room and specialist fees.

In addition to the brochure, the members are informed of the services covered by the OHPS through the orientation seminar held at the Central Unit every last Friday of the month for new members. Quarterly meetings are also held in the satellites where members can ask for clarifications regarding services.

The rationale for the waiting or qualifying period was explained earlier. The nurse or health worker who receives the patients at the satellite clinic decides whether the member or beneficiary is qualified to access services. In theory, no exceptions are made to this policy.

A written referral system is used when the OHPS' doctor refers a member-patient to a more complex level as in the case of referral to a specialist. In such cases, referral forms to, and reply letters from specialists are used to monitor and control referrals to specialists. The specialist's reply form should be completed and sent back to the OHPS doctor. These forms also become the supporting documents for the monitoring of utilization through referrals.

The scheme does not provide any form of support for indirect costs incurred by members and their dependants. Thus, clients who seek consultation at any of the clinics or at the ITRMC are expected to take responsibility for transportation, food and lodging for the patient's companions.

Since the benefit package has remained the same since the time of the launch of the health microinsurance scheme the only form of medical control occurs when the consultant is informed about benefit and service issues and concerns are raised. Other than this, there is no existing medical control mechanism. Management intervention has not occurred as yet although in theory, management is indeed consulted and allowed to make necessary changes when they are deemed appropriate.

(b) Benefits payments

The OHPS pays its hospital provider through a capitation payment which is a fixed amount paid to a health care provider per insured person for a defined set of health care benefits over a set period, regardless of actual utilization of any or all of the benefits.

The OHPS capitation is paid to ITRMC which provides defined in-patient services and selected out-patient services per insured person, for a 12 month period (based on quarterly payments, with adjustments for the number of insured persons during each quarter). No charge is made to OHPS or the patient for health services in the list of benefits rendered during the payment period. Currently, the list of benefits includes specialist consultation, laboratory tests, x-rays and in-patient services. There is no difference in the payment for

insured persons by age, sex, chronic conditions, need for surgery or reason for the need for care or in-patient admission (accident, illness, or pregnancy related conditions).

Initially, there was a differential payment for OHPS members with Medicare (SSS or GSIS) and those without. This was because insured members with Medicare had their in-patient care covered by Medicare. The capitation amount for OHPS members without Medicare was Ph.P.100 per person per year and OHPS members with Medicare was Ph.P.30 per person per year. From July 2000 however, the unified capitation amount (regardless of membership to Medicare) became Ph.P.120 per person per year.

The OHPS capitation calculation is based on:

- Expected utilization of the defined services by the insured population;
- The cost of the defined services as provided by the contract provider;
- An additional amount over and above the cost to serve as an incentive to the provider.

For the OHPS population, this calculation assumes the following:

A. In-patient care

- Assuming a total membership of 500 households (with an average household size of four or 2000 beneficiaries), the average expected utilization of in-patient care would be 0.2 days per person. 4 percent of the population for a four day admission would be 0.16 days per person, including deliveries. Thus assumed total in-patient days would be 400 days;
- The average cost of an in-patient day, including accommodation, services of a physician, drugs and medical supplies, diagnostic laboratory and X-ray services is Ph.P.350;
- Therefore, the assumed in-patient utilization would amount to Ph.P.140,000 (Ph.P.350 x 400) for one year;
- At 2000 members, the amount/per capita for in-patient care would then be Ph.P.70 (Ph.P.140,000 / 2000).

B. Out-patient care

- The average expected utilization of outpatient hospital services is 10 per cent of two visits per year per person at Ph.P.100 cost per visit: i.e. in a population of 100: 10 per cent of 200 visits at Ph.P.100 = Ph.P.20;
- The incentive payment would be Ph.P.10 per person per year.

If a member fails to pay the monthly contribution for two consecutive months he/she is considered as having dropped out. His/her name will be excluded from the quarterly list given to the hospital, of members who are entitled to hospital care and the total quarterly capitation payment is adjusted accordingly.

The benefits provided can be indexed from the satellite log sheet, which lists the members having medical consultations. All consultations are entered, with the name, sex and age of

patients, the reason for their visit and the referred services as well as the drugs prescribed. This log sheet becomes the basis for the monthly and yearly reports on the use of services by OHPS Members. As well as the number of consultations provided by the OHPS' doctors and nurses, the summary also includes how many of the consultations were referred to the hospital, how many were given antibiotics, and how many were referred to have ancillary procedures.

Since a separate log sheet is prepared for every satellite, the number of services provided among the 13 satellites can be compared. There are no significant differences noted among the various users of the service. This can possibly be attributed to the fact that most of the satellite clinics of the OHPS are located in rural areas and thus the persons who use the services are largely from there. A comparison between the services used from the ITRMC located in an urban area and from the satellites will not be useful because most of those going to the ITRMC are also the same members.

(c) Other services provided for members

Other financial health services. In 1999, the OHPS began sponsoring a yearly raffle project to raise funds to sponsor indigent families in the insurance scheme. It allocates Ph.P.10,000.00 from the proceeds of the raffle to the *Sagip-OHPS*12 project. The aim of the *Sagip-OHPS* is to grant loans to members in good standing who cannot pay their monthly contribution for a valid reason. Loans are solely for payment of premiums with a limit of 3 months and a repayment rate of 90 percent. The health promoter guarantees the loan of the member. This has helped in reducing the drop out rate among the members. For the year 2000, the OHPS decided to give a year's OHPS Membership as raffle prizes to 50 families.

At this point, initiatives like the raffle project are isolated mechanisms to help members. It is not clear if other types of financial services will be developed by the OHPS.

Health supply. The doctors and nurses at the satellite and outpatient clinics provide primary healthcare and initial consultations to the members. The doctors may refer patients to higher levels of consultation and services at the ITRMC when necessary.

The health service in the satellites was created before the OHPS was implemented. It was created for the ORT Mother and Child Care (MCC) Project in 1991. The project has a Central Unit and 16 satellite day-care centers servicing 36 communities, providing pre-school education and basic health and nutrition services. These health services are provided by a team of one pediatrician and two nurses and the health promoters in each satellite. Services include prevention (vaccines and other immunization materials provided by the local government), growth and development monitoring, supplementary feeding and regular worming treatments for around the 1,000 children enrolled each year in the day-care centers.

As shown above, some of the services are not intended exclusively for the insurance scheme's beneficiaries. The enrollees of the day care centers, however, have access only to the primary health care and medical consultation but not to the rest of the services. The people in the communities can also seek medical consultations for a minimal fee of PhP 50.

The establishment of the OHPS was originally financed by the Organization for Educational Resources and Training (ORT) which initiated the MCC Project with some health care for children in the day care centers. In 1994, the project was formally handed over to the Provincial Government. Thus, when the project was transferred to it, the local government unit took over financing of the children's health services as an integral part of the educational component of the project. At the same time, the health microinsurance scheme began to collect contributions from its members' for the general health care benefits under the scheme.



Two years after the launching of the MCC project, the ORT Multi-Purpose Cooperative was organized. This is the legally independent body that manages the supply of health services and the administration of the scheme along with its other projects. In particular, the OHPS team of the health unit of the Cooperative manages the health service and IS' members do not play any active role in the scheme's management.

Prevention and health education. The OHPS team gives regular seminars to mothers in the communities on the following:

- Basic course on early childhood care and development;
- Detecting and managing common illnesses;
- Personal care and hygiene;
- Primary health care; and
- Herbal medicines.

During the "Nutrition Month", nurses from the central office go to the satellites and speak to groups of around 25 to 50 parents and their children about the causes and symptoms of intestinal parasitism. After the talk, the health workers weigh the children and administer doses of anti-helminthic medicine for each child. The mothers are instructed to bring the children back for a second dose if they see any sign of worms. The medication is free to OHPS members but others are asked to pay five pesos.

The Health Promoters who assist the OHPS doctors and nurses in the satellites, are given the following training:

- Taking of vital signs (temperature, blood pressure, pulse rate, respiratory rate, weight and height);
- First aid treatment (wound dressing, burns, falls, insect bites, drowning, poisoning, and vehicular accident);
- Family planning;
- Pre and post natal care and nutrition;
- Dental care; and
- Environmental care and sanitation.

The preventive and health education activities conducted by OHPS are done in partnership

with the public health facilities. These are organized along various themes with the objective of helping the members and their dependants gain a better and more pro-active attitude towards health and seeking health care. In fact, one of the primary reasons for the creation of OHPS was to continuously promote and emphasize prevention and health care.

(d) Other services. The Cooperative which is the OHPS' parent company has offered its members savings, credit and death insurance since the start of its operations in 1994. The members of the Cooperative do not automatically become members of the health microinsurance scheme. Membership to OHPS is dependent on willingness and ability to pay the monthly contribution and thus, the cooperative services do not have much impact on the scheme or its members.

3.3.3. Financial aspects of the OHPS' operation

(a) Finance sources

Contributions. The monthly contribution rates effective from March 1999 are as follows:

1. Single (18 years old and above) PhP. 70.00
2. Standard family (up to six family members) PhP. 120.00
3. Large family (more than six family members) PhP. 150.00

Contributions can be paid on a monthly, quarterly, bi-annual or annual basis, according to the insured person's preference. A single set of premiums was set because SSS/GSIS members requested for it so that they can avail of the same benefits which non-SSS/GSIS members get. Contribution collections could therefore be adapted to income flow and capacity of members. The contribution rates are determined by the management with the guidance of the same consultant. All payments are made in cash. The contribution rates are determined after taking into consideration some observations, making certain conclusions from feedback and considering the financial situation of the health microinsurance scheme. The contributions may be paid at the ORT Central Unit at Guerrero Road, at the OHPS clinic at ITRMC or any day care centre/satellite clinic that the member is affiliated to. Collection of members' contributions may also be done during the house visits of the community and health promoters in each satellite of the ORT Project, and later transferred to a central fund at the Central Unit. The time of collection is not fixed and is flexible depending on when members are able to provide their contribution. However efforts are made to ensure that the scheme's rules and regulations are adhered to by setting regular schedules for payment and discouraging exceptions (e.g. weekly payments rather than monthly or quarterly).

A child enrolled in the ORT day-care centre from a non-member family is entitled to free consultation covered by the medical fee of Ph.P.25 per year in tuition. If the family joins OHPS, the Ph.P.25 annual medical fee will be deducted from the first OHPS payment for the family. All members are expected to pay contributions for their household.

The collection of payment is highly dependent on the motivation and persuasive skills of the community promoters. In areas where members are spread apart it is highly likely that one of the factors behind delayed payments is due to the collection mechanism.

When paid at the central unit, the members are given official receipts but when paid at the satellite, they are at first given provisional receipts. Once the collection has been transferred to the central unit, official receipts are issued.

The official receipt contains the following information: the official receipt number, the date of payment, the name of the member who has paid, the amount paid, for which particular month the contribution has been made and the signature of the authorized collector.

In case of late contribution payments, the member receives a collection letter written in local dialect. This letter reminds the member of the month/s he/she has failed to contribute and of the services he/she would no longer be able to use if non-payment is continued. The health promoter also pays a house visit to personally know the reason for non-payment.

The premium has been raised once by around 20 per cent since the beginning of the scheme, despite an almost 70 per cent devaluation of the local currency and a corresponding increase in the cost of drugs. The decision was taken through the ORT Multipurpose Cooperative Board that also serves as the Board.

Initially there was a difference in contribution rates between GSIS/SSS members and non- GSIS/SSS members. Since GSIS/SSS members already had in-patient hospitalization benefits, they had lower contribution rates to enable them to use only OHPS' medical consultations and out-patient services but later, they opted to use the in-patient services as well. The rates before and after the increase and unification are as follows:

TABLE 3.6 TOTAL AMOUNT OF BUDGETED CONTRIBUTIONS							
Source of contribution	Amount						
	1997	1998	1999	2000	2001	2002	2003
Budgeted contributions: members/beneficiaries	PhP. 345,227.15	PhP. 384,135.50	PhP. 633,038.00	PhP. 811,206	PhP. 855,409	PhP. 945,063	PhP. 862,755.75
Budgeted contributions from sources other than members/beneficiaries (Employers, etc.)	PhP. 1,400.00 Sponsorship	None	PhP. 33,447.00 (OHPS Raffle)	-----	PhP.3,580	PhP.26,000	PhP.25,000

Membership fees, social capital shares. The OHPS does not require members to pay any membership fee or social capital share to make the scheme more simple and affordable.

The financial contribution of the state and local collectives. The Provincial Government of La Union has made regular financial contributions to the IS in the form of support to the Mother and Child Care Project. The MCC project has been a joint undertaking between the Provincial Government and ORT. Since its inception in 1991, the government has given a subsidy totalling Ph.P.230,000 (US \$ 4,10713)for all the MCC

	OHPS CONTRIBUTION RATES		Unified rate effective March 1999
	SSS/GSIS	Non-SSS/GSIS	
Single	PhP. 25	PhP. 50	PhP. 70
Standard Family	PhP. 70	PhP. 100	PhP. 120
Large Family	PhP. 95	PhP. 130	PhP. 150

Project Operations (mainly daycare centers). Of this amount, it is estimated that 20 per cent or Ph.P.46,000 (US \$ 920)for health services, now provided by the OHPS health team. This amount, however, is not reflected as a cash receipt nor as an expense under disbursements in the OHPS Cash Flow Statement but in the MCC project.

The above regular contribution is covered in a Memorandum of Agreement dated 1991 together with the government’s permission to let ORT build its central office and day-care centers on government lots.

Since the change of the ownership of the ORT Building in 1994 to the Provincial Government, the latter has provided for its maintenance and security expenses.

Donations and subsidies from other sources. From January 1996 to January 2001, ORT, the international NGO that funds the MCC project, has subsidized the salaries of two doctors and an office clerk estimated at Ph.P.335,770 (US\$ 6,715) annually. This is the equivalent of the time they spend working for the OHPS. This has been given the same accounting treatment as that of the donation coming from the Provincial Government.

Loan and credits. The health microinsurance scheme has not received any medium-term loan during the past years to finance its operations. For purchase of drugs it enjoys a 30-day credit term from its regular suppliers. Funds for the purchase of drugs are recovered partly from the sales of nonprescribed medicines and partly from the member’s monthly contributions for the free medicines given to members.

Transfer of funds from the OHPS' parent company. Financing for the scheme is clearly distinctive from its parent company's other activities. The OHPS maintains its own accounting and treasury.

The bookkeeper and cashier of the ORT Community Multi-Purpose Cooperative (OCMC), the parent company, also perform their respective functions for OHPS operations. The value of the time they spend for OHPS is estimated at Ph.P.91,434 per year. As in the case of the subsidies from the government and ORT, these transactions are not included in the Cash Flow Statement since there is no actual turnover of cash.

For some months in 1997 and 1998 OHPS experienced deficits and had to borrow money from OCMC when expenses exceeded monthly contributions and other revenues. However, OHPS was able to pay this amount back in the succeeding months. Beginning in 1999, OHPS no longer experiences a deficit but now has a small investment in the Cooperative.

Other sources. Another significant finance source for OHPS is the sales of medicines. The proceeds of the gross sales amounted to PhP. 274,921.87, PhP. 256,736.70 and PhP. 356,743.83 for the years 1997,1998 and 1999 respectively. In 1999, another significant source was the raffle program, the net proceeds of which amounted to PhP. 33,447.00.

(b) Costs

The amount of benefits actually paid for by OHPS (excluding subsidies from the government, OCMC and ORT) during the last three terms can be computed by adding the following costs:

If the subsidies are considered, the amount of benefits would be higher. Total subsidies from take three donors amount to PhP. 979,200.00 per year. However, 35 to 40 per cent of this amount is spent on management costs as the OHPS does not have actual cash outlay for this purpose.

TABLE 3.8 COSTS INCURRED BY OHPS

	1997	1998	1999	2000	2001	2002	2003
Capitation payment to ITRMC	76,546.40	131,936.47	169,172.75	237,342.50	263,755.95	247,383.50	243,310.50
ITRMC special services		11,005.05	46,609.15	58,732.35	71,525.70	62,794.85	56,251.95
Salaries of 2 OHPS doctors	116,400.00	127,283.33	141,292.46	223,474.03	385,659.08	408,145.57	368,157.35
Free medicines	127,817.63	137,826.63	170,296.27	200,382.94	186,289.10	196,551.25	163,011.30
Total	320,764.03	408,051.58	527,370.63	719,931.82	907,229.83	914,876.17	830,731.10

Other operating costs include: printing, promotions, training, communications, office and clinic supplies and miscellaneous expenses. These costs do not include the cost of medicine for sale. Operation costs amounted to PhP. 19,806.90, PhP. 21,230.65 and PhP. 26,880.25 for the years 1997, 1998 and 1999 respectively.

FINANCIAL RATIOS RECORD	
Period: 2003	
A. Contributions/Expenditure Ratio:	
The Organization for Educational Resources and Technological Training (ORT) Health Plus Scheme had the following results in 2003:	
-	total revenue contributions: Php862,755.75
-	total expenditure: Php830,731.10
Ratio Contributions/Expenditure = $(862,755.75/830,731.10) = 1.04$	
Conclusion: The Organization for Educational Resources and Technological Training (ORT) Health Plus Scheme is capable of covering its expenditure with its contributions.	
B. Claims Ratio (Health Benefits/Contributions):	
The Organization for Educational Resources and Technological Training (ORT) Health Plus Scheme had the following results in 2003:	
-	total health benefits: Php299,562.45
-	total contributions: Php862,755.75
Health Benefits/Contributions Ratio = $299,562.45/862,755.75 = 0.35$	
Conclusion: The claims ratio shows that there is a good balance between health benefits and members' contributions.	

Surplus allocation

The health microinsurance scheme, following the nature of its parent company is legally defined as a non-profit organization. The surplus is allocated as an increase in contingent reserves.

The OHPS does not have an income statement. Based on the Cash Flow Statement the scheme experienced a deficit of PhP. 82,875.15 in 1998 but in 1997 and 1999, it generated surplus of PhP. 38,591.68 and PhP. 130,596.37, respectively.

Reserve funds

As of 31 December 1999 the OHPS had a final cash balance of PhP. 133,821.94. If this is considered as the total reserve, it has a ratio of benefits coverage reserve of 3 months

with the benefits excluding the portion subsidized by the government and other agencies. A portion of this reserve has been invested in the Cooperative to the amount of PhP. 50,000.00.

3.3.4. Health care providers

(a) Health care providers linked to the OHPS

All the members and beneficiaries of OHPS are allowed to seek consultation only at the different satellite clinics, the Central Unit Clinic and the designated outpatient clinic located at the partner hospital. For hospitalization needs and diagnostic services, there is only one accredited hospital that provides these services. All members and beneficiaries know about the authorized health care provider since all outpatient consultations are delivered at the satellite clinics and there are no other authorized or recognized providers of these services.

In the province of La Union there are seven public hospitals and 11 private hospitals. Though the total population of private physicians is not known it can be said however with some degree of certainty, that the health providers in the private sector outnumber those in the public sector by an estimated ratio of 3.1. In the province, no health care provider has a monopoly of the members of OHPS. However because ITRMC is the only accredited hospital provider of the scheme all beneficiaries that need hospitalization and other diagnostic services have no option but to go to this hospital to use these services.

Health care providers for the OHPS were chosen using three criteria. The most important of this is the providers' total support and agreement to the basic principles espoused by the scheme. The other two criteria include accessibility of the location of the hospital provider and people's general acceptance of the provider. Thus the chosen providers (both hospital and physicians) have to be easily accessible and well accepted by the scheme's beneficiaries. The health care providers were chosen by the management team, guided by the technical consultant.

Once the identified hospital provider agrees to the terms offered by OHPS, a Memorandum of Agreement is prepared and signed by both parties. This agreement is effective for a year and is renewable. No changes in capitation fee can be instituted during the contract year. Negotiations for a change in price are done only prior to the renewal of contract. Should the hospital provider decide to change its fees for the general public, they are not allowed to apply these changes to the scheme until such time that the contract has expired prior to its renewal.

The OHPS has difficulty in monitoring the quality of care given by the providers, as there are no agreed standards or guidelines used. The only mechanism used to monitor the quality of care is through taking note of the use of antibiotics and anti-tuberculosis medicines dispensed in the satellite clinics. In the ITRMC the control and monitoring of the quality of care is entrusted to the hospital authorities. This structure however has minimal interaction with the OHPS management. Thus it is only when complaints or cases are brought to the attention of the OHPS management that some monitoring occurs through the authorized department in the hospital.

TABLE 3.9 OHPS' AUTHORIZED PROVIDERS

Name/Health care provider's Identification	Location	Level	Type of services offered	Authorization date
Ilocos Training and Regional Medical Hospital (ITRMC)	San Fernando City, La Union	Public, tertiary, Hospital under the management of National Government	Tertiary hospital for in-patient care and laboratory and ancillary services	June 95
OHPS Doctors	San Fernando and 13 communities in La Union	Private	Primary health Care and regular medical consultations	July 94
OHPS Nurses (until 2000 only)	San Fernando and 13 communities in La Union	Private	Primary health care and referral services	July 94

Among the problems identified in relation to the availability of the services covered by the scheme are:

- Shortage of medicines and other supplies both at the hospital and satellite clinics;
- Unavailability of preferred doctors;
- Long waiting time at the hospital by the members; and
- Lack of space in the clinics for patients who are waiting to be examined.

The managers of the scheme are aware of the existence of these problems but as yet, no concrete measures have been undertaken to respond to them.

(b) The relationship between the health care providers and the OHPS

The accredited hospital provider of OHPS, the Ilocos Training and Regional Medical Center has a formal agreement with the scheme. A contract or Memorandum of Agreement is drafted and signed by the heads of the two organizations. However the primary care physicians do not have any formal agreement with the scheme. They have a verbal agreement with the OHPS and do not sign any contracts. The task of negotiating agreements with the hospitals is a joint effort between the cooperative's general manager and the coordinator of the medical staff of the OHPS. For the physicians, negotiations are the responsibility of the coordinator of the medical staff, occasionally assisted by the manager.

The major area of negotiation with the accredited hospital provider is the capitation fee to be paid for each beneficiary. The range or set of services that the hospital is expected to provide is also discussed. In turn the ITRMC has given some concessions to the OHPS. Among these are the use of space and utilities in the hospital for a separate consultation room/office for them as well as the assurance that OHPS beneficiaries will have a shortened waiting time when they avail themselves of services.

In 1994, the OHPS terminated the contract with the first hospital provider, the Bethany Hospital –a private church-based institution- that it had entered into an agreement with. As indicated earlier, the withdrawal of the agreement was initiated by the hospital provider due to misunderstanding that developed for a single case. The hospital had charged the scheme with an additional payment for the expenses incurred in doing the procedure, not understanding the concept of a capitation fee. Thus, because of this withdrawal in May 1995, the ITRMC was accredited and has remained the sole hospital provider for OHPS up to the present.

The different providers are able to control the beneficiaries' access to benefits by the issue of referrals. This means that no member or dependant can seek consultation or have diagnostic services performed by the hospital unless he/she has been referred by the authorized OHPS doctor from the satellite clinics. It is only in cases of emergency or during weekends that members are able to go directly to the hospital to seek care. However, such cases are also immediately verified and followed-up.

The management team regularly conducts informal group meetings and discussions in the various satellite clinics in the villages. These meetings serve as a venue for members to give their feedback on the quality and availability of services delivered both at the satellite clinic and hospital. These meetings are held on a quarterly basis.

There are no regular meetings with the different providers. Instead it is only when there is some issue or crisis that such meetings are conducted between the provider and the management team. It should be noted however that in the contract, it is stipulated that meetings be held regularly. In relation to the different primary physicians, regular quarterly meetings are called by the coordinator of the medical staff. Such meetings are held to discuss schedules of doctors and to respond to any problems or issues that may have surfaced in the past weeks or months.

In order to further improve their delivery of services, all OHPS primary care doctors are encouraged to attend Continuing Professional Education (CPE) activities. These are usually conducted by the different associations to which these doctors belong. Although the OHPS does not actively participate in conducting this training, all doctors are encouraged and allowed to attend seminars and conferences. Transportation costs and convention fees are subsidized by the OHPS.

(c) Payment of health care providers

There is only one method of compensation or payment to the providers. All primary care physicians who provide outpatient care in the satellite clinics are hired on a fixed salary basis (mostly part-time) by the scheme. The compensation package usually consists of the salary and other benefits as required by law, e.g. social security. The hospital provider on the other hand, is paid on a capitation basis that is agreed upon at the beginning of a new contract year. Through this arrangement, there is no need for any billing since all payments are made on a regular basis and no other subsidies are provided. The OHPS management oversees and controls the payments to all providers. The payment to the hospital provider is on a pre-paid basis. Because of this arrangement, payment to providers is simple and straightforward.

(b) OHPS' management organization

The ORT Community Multi-purpose Cooperative is responsible for the Insurance Scheme's general management. This cooperative had already experience in providing training and workshops, purchase of raw materials, marketing and transport of products, micro-lending as well as general administration and accounting.

The General Manager of the cooperative supervises the Health Management Team which oversees the delivery of primary health care in the satellites, negotiation, procurement of drugs and supplies, contracts and payments to external providers and the preparation of reports. The team is composed of the Primary Health Care/Field Supervisor, Medical/Provider Coordinator, Promotions and Marketing Supervisor and the General Manager. Among the four, they choose the over-all Health Coordinator on a quarterly basis.

The health professionals carrying out the primary health care and management of OHPS have become a permanent dedicated team, with almost no change. They are composed of four part time doctors and four nurses, with daily attendance at a central unit (now located in ITRMC, the partner medical center) and weekly or twice-weekly attendance at the satellite communities. The relatively high number of primary health care staff is necessitated by the widely dispersed location of the 14 communities.

The Primary Health Care /Field Supervisor coordinates the OHPS nurses and health promoters while the Medical/Provider Coordinator controls the OHPS doctors and the Promotions and Marketing Supervisor, the community promoters. The community and health promoters are volunteers and satellite based. The units comprising the Insurance Scheme management may also be divided according to function and location as follows:

1. Central Unit – ORT MCC

- OHPS administration
- Program planning, management and supervision
- Registration and membership management
- Personnel management
- Financial management
- Drug procurement and stocks
- Primary Health Care (for OHPS members in the area–registered at central unit and for children in the central unit classroom).

ORT MCC Day-care/Satellite health functions:

- Training and monitoring
- Services in satellites

2. ITRMC Primary Health Care Unit

- Primary health care of OHPS members in San Fernando
- Supply of drugs for OHPS members
- Liaison with hospital services for OHPS members (follow-up of out-patient referrals and inpatients)
- Referral of patients from satellites

(c) The democratic and co-operative character of management

The staff informs the new members of their rights and obligations through the orientation seminar and the OHPS-ITRMC partnership brochure as discussed earlier. OHPS publishes a monthly newsletter distributed to all members through the health promoters in the satellites. Clarifications on OHPS policies and anecdotes of members when using the services are discussed here as well as health tips for preventative care.

The members actually have a very limited role in the management of the scheme as they are not necessarily members of the Cooperative. Thus, not all of them can participate in the General Assembly and do not get to vote for the cooperative's officials. Furthermore, the choice of services covered and the amount of contributions are considered more as technical matters left to the decision of the OHPS Management Team. However, the members get to choose the contribution payment method at the time of their registration. They are also able to give their inputs in the evaluation of the IS' operation.

Although not all OHPS members can attend the General Assembly of the cooperative, every member is invited to attend the Annual OHPS' Day. During the OHPS Day 2000, the members were first convened in each satellite and then converged at the ORT Community Development Training Center where the Central Unit is also located. This became the venue to inform members, clarify policies and procedures, gather feedback from them and do an ocular visit of the ITRMC. A total of 195 members actively participated, which represented 29 per cent of the total number of members.

Aside from the Annual OHPS Day the members also have quarterly meetings with the Promotions and Marketing Supervisor or any OHPS representative and the community and health promoters in the satellite clinics. Discussions usually cover the following:

- Difficulties regarding the OHPS;
- Need for improvement;
- Problems encountered; and
- Requests and expectations.

Minutes of the meeting are documented and presented by the Promotions and Marketing Supervisor at the quarterly Management Committee meeting for information and appropriate action.

(d) Financial management

Current expenses are authorized by OCMC General Manager and the Primary Health Care / Field Supervisor who are also the signing authority for checks and withdrawals. They maintain only one account with a bank that is located close to the Central Unit.

For the year 1999, average monthly cash receipts amounted to PhP. 85,000.00 and average monthly cash disbursements amounted to PhP. 75, 000.00.

The OHPS maintains a petty cash fund of PhP. 5,000.00 for reimbursement to members of prescribed medicines not available in the OHPS clinic at ITRMC and emergency purchase

TABLE 3.10 PERSONNEL (SALARIED AND UNSALARIED) EMPLOYED BY OHPS

Job Title	Salaries (S) or Volunteer(V)	Salary paid or subsidized by	Current title holder's qualification	Main Tasks
Medical provider Coordinator	S	½ Provincial Government-MCC ½ OHPS	M.D.	Recruitment and supervision of OHPS team, liaison work with the hospital and specialist and review of programs to deal with the specific groups
Primary health Care/Field Supervisor	S	Provincial Government-MCC	Bachelor of Science in Nursing	Coordination of OHPS nurses and health promoters; drug and supplies management
OHPS nurses (up to 2000 only)	S	Provincial Government-MCC	Bachelor of Science in Nursing	Health care delivery in satellites; recording of drug distribution and other benefits/services to members; collection of contributions in satellites
	S	ORT		
OHPS doctors	S	OHPS	M.D.	Health care delivery
Admin. Staff/Clerk	S	OHPS		Registration of members, update on the status of members, contribution, collection, coalition and review of all medical/insurance forms
	S	Provincial Government-MCC		
Health Promoters	V	Honorarium provided by Provincial Government-MCC		Provision of preventive health care and basic health services such as first aid treatment, vital signs, family planning, pre and post natal care in satellites
Promotion Officers	V	Incentives (from collections)		Assistance in the recruitment of members in the satellites Payment collections

3.3.5. Administration and management of OHPS

(a) Statutes and regulations

The OHPS has a legal status through the ORT Community Multipurpose Cooperative (OCMC) which is governed by a Cooperative Board. The OCMC was created as a result of the organizing component of the ORT Mother and Child Care Community Based Integrated Project (MCC).

The main components in the ORT MCC Project are infrastructure, pre-school education and basic health services with local recruitment and training for the required pre-school day-care tasks, followed by community organizing and livelihood activities. The beneficiaries are residents of selected poor areas, with limited access to adequate education and health services, and to formal employment opportunities.

The MCC was started in 1991. During this process, it appeared that the limited presence of the pediatrician and nurses constituted the only form of regular health care for several of the rural communities whose young children attended the day-care centers. The severity of illness Case reflected the need for a regular source of primary health care in the community. At that time, basic health services were provided free of charge in the public health centers, operated at municipal and community level. However, access to these services was limited by the lack of regular primary health care staff, drugs and equipment.

Due to its overall concern with the health status and access to health care of the target population, ORT then considered ways to improve access to health care. The concept was proposed and adopted by the cooperative assembly in March 1994.

Because the insurance scheme is part of the cooperative, it may be subject to the tax and control provisions governing cooperatives. However, the Cooperative Development Authority, the regulatory government agency on cooperatives, when performing its annual audit of OCMC, disregards OHPS operations and considers it as one of the community development / social projects of OCMC.

The OHPS operation is based on the following principles:

- All members of the family are entitled to the health insurance benefits through a family contribution, which should be affordable for the majority of the target population.
- Administration of the scheme, including financial control with separate accounting, is the responsibility of a defined organization (such as a registered cooperative, community association or health care provider), with a defined community board to oversee and monitor the development of the scheme.
- Health care benefits include both ambulatory and in-patient care, with a strong primary care base, including prescribed drugs and preventive care components.
- Secondary health services are provided through a capitation allocation with the specific hospital serving the community.

of medical supplies. Replenishment is done almost every week. The petty cash custodian is the administrative clerk stationed at the OHPS clinic at ITRMC.

(e) Information system and management tools

The accounting framework. In its accounting framework, the OHPS uses official receipts for its cash receipt transactions and vouchers for cash disbursements. The official receipts and vouchers are pre-numbered and are recorded according to its number series. These are the basis for recording in the cash journals, posting to the ledger and finally the preparation of the Monthly Cash Flow Statement.

The cashier and the bookkeeper of the cooperative ensure that the documents are up-to-date. Both are graduates in commerce and have been trained by the accountant of the cooperative.

Information about members, contributions and benefits. OHPS uses the following documents:

- Members' register
- Membership card
- Contributions register

The monthly contribution of members is computerized and this generates quarterly lists at satellite level of the covered population and contribution payment status.

TABLE 3.11 OTHER SALARIED STAFF: NOT EMPLOYED BY OHPS

Function	Number	Organization responsible	Percentage of working time dedicated to the Insurance Scheme	Main Tasks
General Manager	1	OCCM	25	Policy implementation & general management
Disbursement Officer	1	OCCM	20	Schedules payment & prepares checks for OHPS' disbursements
Bookkeeper	1	OCCM	20	Recording of OHPS financial transactions

Management tools. The Monthly Cash Flow Statement is prepared and ready by the first week of the following month. This shows the financial condition of the scheme as well as the summary of income and expense accounts.

The OHPS also prepares the monthly projected members' contribution by category per satellite. This serves as the collection target per satellite for OHPS staff. Together with the Monthly Cash Flow Statement, it also becomes useful in limiting expenses within the projected available funds for the following month.

The membership (members' register) database is computerized. The recording of the use of services by the members done manually at satellite level but these satellite reports are collated and entered into the computer to come up with the monthly report on the total number of members who have used the different services. The monthly report on the number of member-families by satellite gives the information on the membership dynamic as well as growth trends per satellite.

Formalizing management procedures. The list of forms used for OHPS' current operation are as follows:

- Registration form
- Referral forms to and from Specialists
- Hospital in-patient form for all patients discharged from ITRMC
- Drug procurement, distribution and Inventory forms
- X-ray/Ultra Sound request
- Laboratory request
- OHPS-ITRMC In-Patient Summary Report
- Collection letter

(f) The function of control

Petty cash control. Every time the fund needs to be replenished, the person authorized to sign the checks reviews the expenditure and brings to the attention of the petty cash custodian any unauthorized expenses.

- Accounting control (Please refer to section 5.5 – a)
- Contributions payment control (Please refer to section 3.1 – a)
- Beneficiary status control

The Contributions Register enables the OHPS to produce a quarterly list of members whose contributions are up to date. This list is given to the ITRMC and satellites for beneficiary status control.

Control of health care providers billing. The capitation payment is based on the numbers included in the quarterly list of members whose contributions are up to date.



Drugs management. Movements in the inventory are recorded in the prescribed forms both at the central and satellite levels. Distribution to the satellites is done every two weeks according to monthly allocation but may vary depending on the availability of stock from the Central Unit. The amount of drugs distributed per satellite is recorded in the monthly drug distribution form. Monthly allocation to satellites is calculated by reviewing the amount of each drug

dispensed in a typical month for each satellite. The monthly allocation is then adjusted every six months according to actual use. A “Drug Card” for patients with chronic diseases is also prepared for proper monitoring of drug use.

An indicator for adequacy of stocks can be based on the absence of reimbursement for drugs purchased in private pharmacies for a given period. The satellite log sheet also contains the cost of all covered drugs prescribed and the revenue from the sale of non-essential/non-prescribed and non-covered drugs.

(g) Role distribution

The distribution of roles was determined by the technical expert who conceptualized and assisted in the launching of the scheme. Any changes and modifications however, are done through the management team, in consultation with the technical consultant. There have been no major changes in the distribution of roles since the launch of the scheme and at present no projected changes are being planned.

TABLE 3.12 REAL ROLE DISTRIBUTION

	The Insurance Scheme Organ (GA)	The Insurance Scheme salaried staff	Health care providers	Technical assistance staff	External health care providers	Others
Benefits management						
Who decides the services covered?				√		
Who makes decisions about coverage?				√		
Who decides patient referral to a more complex level?			√			
Who process benefits claims?		√				
Who monitors benefits (frequency per covered service, average cost, etc.)?		√				
Membership management and contributions collection						
Who receives membership requests?	√	√	√			
Who update the members' register?		√				
Who initiated membership cards?		√				
Who decides the exclusion of members?		√				
Who calculates the contributions amount?				√		
Who collects contributions?		√				
Who carries out contributions recovery?		√				
Who keeps the contributions register?		√				
Management of relationship with health care providers						
Who chooses the health care provider?		√	√			
Who negotiates agreements with the health care providers?		√				
Who withdraws the agreement with a health care provider		√				
Who decides health care provider's payments?				√		
Accounting and Financial Management						
Who implement the accounting framework?		√				
Who prepares the budget?		√				
Who works out the income and expenditure account?		√				
Who prepares the balance sheet?		√				
Who calculates the financial ratios?		√				

TABLE 3.12 REAL ROLE DISTRIBUTION (continuation)

	The Insurance Scheme Organ (GA)	The Insurance Scheme salaried staff	Health care providers	Technical assistance staff	External health care providers	Others
Who proposes surplus allocation?		√		√		
Who determines surplus allocation?		√		√		
Who monitor deposits?		√				
Who recovers debts?		√	√			
Who determines the financial investments?		√		√		
Who authorizes expenditure?		√				
Who manages the petty cash?		√				
Control						
Who controls the petty cash?		√				
Who implements accounting & financial controls?		√		√		
Who controls the beneficiaries' status?		√				
Who controls contributions payments?		√				
Who controls beneficiaries' rights to benefits?		√				
Who controls the health care providers' billing?		√				
Who carries out the medical control?			√	√		
Who sanctions fraud?		√				
Who intervenes in embezzlement cases?		√		√		
Relationship with the beneficiaries and target group						
Who decides to call a general assembly?	√	√				
Who organizes the general assembly?		√				
Who designates officials?	√					
Who informs beneficiaries of services covered?		√	√			
Who organizes information campaigns for the target group?		√	√			
Who organizes prevention and health education activities?		√	√			
Who carries out prevention and health education activities?			√			

TABLE 3.13 MAIN TRAINING OF OFFICIALS AND PERSONNEL

Direct beneficiaries of training	Training Objective	Duration (period) of training	Organizations or persons giving training	Financing
Medical and Administrative staff of ITRMC (hospital provider)	To orient the hospital personnel on the mechanics and principles of OHPS	One day	Technical Expert and Consultant of OHPS	OHPS
Volunteer staff health promoters and community promoters	To re-orient staff on OJPS and other concepts of preventive and promotive care	Two days	OHPS Management team	OHPS
OHPS Management Team	To gain knowledge about similar schemes in other areas of the Philippines	Five days	SHINE (a GTZ project) and the Bukidnon health Insurance project	SHINE
Community Leaders	To present OHPS to leaders of the community to motivate them to actively participate in the scheme	Two days	OHPS management Team	OHPS
Health promoters and Village Health Workers	To educate the health workers on basic principles of primary Health Care and the Use of Herbal medicines	Four days	Resource persons from NGO and DOH	OHPS

It is observed that the different training sessions mentioned in Table 13 have been designed and conducted in response to certain perceived needs and concerns that have been raised in relation to the implementation of OHPS. Very minimal professional assistance has been sought for these sessions and most are explanatory in nature.

(h) Equipment and infrastructure

The MCC project has a Central Unit and 13 satellite day-care centers servicing 36 communities. These satellites, the Central Unit in the ORT Multi-purpose Cooperative Building and the Ilocos Training Regional Medical Center provide a specific area to serve as OHPS clinics cum offices. OHPS has one computer. The parent company has four computers, telephone fax, internet access, two vehicles, a photocopying machine and video. All of these can be used by OHPS when necessary.

TABLE 3.14 SPACE USED FOR OHPS CLINICS		
	Total Area	OHPS office cum clinic
Central Unit	474 square meters	22 square meters
13 satellites	220 to 250 square meters	30 square meters
ITRMC		15 square meters

3.3.6 Actors in relation to OHPS

(a) Reinsurance and guarantee funds schemes

The OHPS is a scheme that is very limited in scope and geographical reach. It has not reached a stage in its organizational life that reinsurance or the setting-up of guarantee funds has been considered. Because the scheme is very limited, most of the present concerns deal only with how membership can be expanded and how services can be delivered more effectively and efficiently.

(b) Technical assistance

Through its entire existence, OHPS has received and continues to receive technical assistance from the same Social Security Expert. Up to the present, she continues to assist in the monitoring of the scheme and ensures that the scheme remains faithful to its primary objective of making basic, comprehensive and rational health care accessible to the poor and marginalized population. In addition, a national consultant was recruited to provide technical assistance, mainly to continuously adjust benefits and activities to deal with local morbidity and mortality, as well as local member and provider behavior.

Apart from this, OHPS has not really benefited from any other form of technical assistance. However, OHPS continues to be a regular showcase or model of a community based health insurance initiative that has demonstrated some level of success. Over the past years, several local and international groups have visited OHPS to learn more about the scheme and understand it better.

(c) Social movements and Social economy organizations

OHPS is an initiative that is supervised and managed by the ORT Multipurpose Cooperative. The cooperative is a member of a national federation (NATCCO) and is also registered under the Cooperative Development Authority¹⁴. Thus the cooperative complies with the different regulations and laws stipulated by this body.

There have not been links established by OHPS with any trade union since its target clientele are the farmers, fisher-folk and other informal sector workers in the province. Also because of the limited nature of its operations and capacity, OHPS has not made any moves to affiliate or establish links with any other associations or mutual societies within the province.

There is no relationship between OHPS and the Social Security System or the Philippine Health Insurance Corporation the two agencies which are the units of government tasked with the provision of social protection to all Filipinos.

3.4

INDICATORS OF OPERATION

TABLE 3.15 INDICATORS OF OHPS OPERATION				
	2000	2001	2002	2003
1. The membership dynamic				
Numbers of members growth rate	(3.47)	17.81	(8.78)	(5.51)
Average number of beneficiaries per member	3.63	3.59	3.44	3.47
2. Service Use				
Consumption rate of covered health services				
Consultation	21.5	17.1	15.7	13.7
Percentage of those consultations using the following:				
Referral to hospitals	6.31	2.66	0.3.73	8.98
Antibiotics	41.90	49.55	52.60	54.67
Ancillary Services	13.13	17.43	21.57	23.55
3. Financing and the Financial Situation				
Surplus (deficits)	91,272.18	(48,240.83)	56,187. 83	57,024.65
Total amount of benefits <i>This refers to the total amount of benefits provided by the Insurance Scheme to its beneficiaries during a term excluding subsidies.</i>	496,457.79	521,570.75	506,729.60	462,573.75
Budgeted contributions/term expenditure ratio	1.13	0.95	1.06	1.07
Budgeted contributions + regular contributions]/term expenditure ratio	0.61	0.61	0.52	0.52

3.5

THE ACTORS' POINT OF VIEW



3.5.1. Evaluation process

The Promotions and Marketing Supervisor holds a quarterly OHPS “*pulong-pulong*” (meeting in local dialect) in each satellite to obtain information on beneficiaries’ opinions regarding the OHPS operation. All members are invited and the participation rate varies.

During OHPS quarterly meetings, the problems and difficulties encountered in using of the different health services/benefits are discussed by the members. When difficulties arise from misunderstanding of policies and procedures, the OHPS representative clarifies the matter immediately. In case of suggestions to change or add services, the matter is referred to the OHPS management and the response is given at the next meeting.

There has been no formal or official evaluation of the scheme since its inception. Although there have been several international and local agencies who have visited and studied the scheme, most of them have come to gain information and knowledge. Occasionally, individuals and students have spent a few weeks learning about the scheme and some reports have been written.

There has also been no formal internal evaluation of the scheme. Reports are made and meetings conducted on a regular basis to analyze and understand some aspects of the scheme’s operations. Apart from this there has been neither any formal evaluation process nor strategic planning exercise. One of the most significant findings is the lack of full

understanding of the social health insurance concept, policies and procedures among the members and initially even among the staff. Concrete measures have been adopted to address this. A series of seminars were given to the volunteers and staff including the doctors. For members, meetings are held at the satellite level and more frequently, new members, who naturally would have the least understanding of the procedures, are required to attend the orientation seminar. It is only after they have attended the seminar that they are given their membership cards.

3.5.2. The Officials' point of view

The following are based on the officials' written reports and actual interviews.

(a) The Implementation of OHPS

The main factors that led to OHPS' success during its implementation process were:

- The existence of the ORT Community Multipurpose Cooperative administration which has served as an administrative framework to take on the responsibility of operating such a scheme.
- The availability of the Mother and Child Care Project doctors, nurses and volunteer health promoters to provide the primary health care and consultation benefits to the members.
- The partner-hospital's understanding of the nature of social health insurance and willingness to provide the secondary health service.

In a paper entitled "*ORT Capacity in Community based Health Insurance Development*" dated September 2000, Mr. Avi Kupferman, ORT Regional

Director-Asia together with Dr. Aviva Ron, wrote :

The major problem over the last five years has been a relatively high drop out rate. Dropouts are common for several reasons. First is the irregular or seasonal source of income of the covered population, which comprises mainly low-income families. Second, despite the extensive promotion of the scheme, there is a lack of full understanding of the social health insurance concept, policies and procedures in such populations. A third reason is related to high expectation of such population for donor funds and sponsorship, that is, a tendency to rely on others to dole out help in case of need.

The extent of dropouts has gradually been reduced, as more people in the community hear of real cases in which patients were covered for high health care expenditures. Such stories are spread by word of mouth and through an OHPS newsletter that has played an important role in the development of the

scheme over the last two years

One lesson learned was that sponsorship of families by local politicians or donors for short period was not beneficial. If these were poor families, their income levels were no better at the end of the sponsorship period, after which they were again excluded from the social protection mechanism. In cases requiring social assistance, permanent funding is necessary and attempts are now being made to tap funds for the indigent population through local government funding for health insurance, as in fact mandated in the Philippine National Health Insurance Act (NHIA).

(b) Membership dynamics

According to the Promotions and Marketing Supervisor the questions, clarifications and suggestions observed during the monthly satellite meetings could be an indication that the insurance mechanism is not yet well understood and accepted by some members. However, with the constant dialogue between management and members and the publication of the OHPS newsletter, this situation has improved.

The factors that limit membership could also be the same as the reasons for the high drop out rate. In addition to this, the OHPS limitation in its collection mechanism seems to hinder membership growth. Many officers and employees of other offices are interested in joining the scheme but the OHPS cannot accommodate them unless the payroll masters of the interested agencies are willing to be the collection agents.

The view of some members who consider OHPS as a savings and investment for health has contributed to some drop outs. If they have contributed for some months and do not make use of any of the services because they do not get sick, they feel that OHPS is not a worthy investment. Again, this can be attributed to a lack of understanding of the social health insurance concept.

(c) Access to health services and the relationship with health care providers

The OHPS monthly meetings serve as a venue for clarifications, questions and sometimes complaints as well as an opportunity for management to gauge if the scheme has been able to improve access to health services for its beneficiaries. During meetings, members give both positive and negative feedback on the quality and type of health services. Members are especially grateful for the regular weekly visits of a doctor to their community. Before this, they relied mainly on the infrequent visits of the Barangay Health Workers¹⁷ from the Rural Health Unit (RHU). The members also appreciate the availability of essential medicines in the OHPS satellite clinics. Prior to their membership of OHPS, members in need of medicines still had to go to the town centers or to the hospital to seek consultation and to purchase the drugs prescribed. However, there are always members who can only be satisfied if the doctors came more often and if the list of essential drugs was expanded.

The coverage or delivery of services to members whose contributions are not updated does not constitute a serious problem for OHPS operations. Once a member fails to pay his/her contribution for two consecutive months, the assigned record keeper automatically excludes him/her name from the list of current members furnished to the hospital. If this is not done these members will still be counted in the computation of the capitation payment to the hospital causing additional financial strain on its operations.

The various activities and seminars conducted and sponsored by OHPS on health promotion are indicators of its interest and priority to provide health education. The members confirm their interest and appreciation by their high attendance and participation rate. The OHPS can reinforce this by continuing its health program and coordinating these activities with other agencies, both government and private.

The utilization of all types of services has increased over time. Moreover, the referral mechanism from primary health care to hospital-based care is working satisfactorily. An increase in utilization is usually considered a positive outcome especially in a population that was previously under served.

The problem of accessing the benefits provided is sometimes observed in the satellite clinics because of the limited number of weekly visits by the doctors. The members and beneficiaries therefore are encouraged to seek consultations and take advantage of the days when the doctor is available. The presence of nurses and knowledgeable health promoters also alleviate this kind of problem. Furthermore, in cases of emergency, the members can always go to the Ilocos Training and Regional Medical Center even after OHPS satellite's regular clinic hours and during weekends, presenting their membership card. This arrangement with the hospital was facilitated by the capitation payment scheme. Because a fixed, previously agreed-upon rate is paid, personnel within the hospital do not have to keep extra records or prepare billing statements to the OHPS for services they have rendered. The capitation scheme of paying hospital providers is an essential feature of OHPS. This method of compensating providers is hardly practiced or used in the insurance system in the Philippines. Because of this, the OHPS' non-negotiable stance in carrying out this arrangement becomes not only pioneering but allows the scheme greater influence and power.

(d) Contributions payment

The delay in contribution payments may be attributed mainly to the members' seasonal / irregular source of income. To make it easier on the members, they can choose the terms of payment to adapt to their income flow. However this has not proved to be very helpful. For some farmer-members, all of their supposed income at harvest time is just enough to pay off their debts. Because of this, the Management Team of OHPS initiated the *Sagip OHPS 18* that aims (after careful screening) to offer loans to members to update their contributions.

(e) Determining the contributions/benefits relationship

The contribution/benefit relationship is quite difficult to apply in social health insurance because there is always the tendency for the benefits to outweigh the contributions. For

purposes of ensuring financial viability however, the cash flow is used as one of the determining factors. Because the level of contributions is not yet adequate in relation to the benefits offered, OHPS still relies on subsidies. However, there was a move to lessen this dependence by increasing the contribution rates effective from March 1999.

(f) Insurance risk management

The OHPS' decision to make the family as the unit of membership is a measure adopted to limit adverse selection. This feature is another key principle espoused by the scheme that has not been changed since the launch of activities. At present, when we consider the target group this seems to be the most appropriate method to be used.

The issue of moral hazard is addressed by the strict enforcement of the stipulated waiting time or qualifying period. It should be noted however that OHPS' policy on how long members and beneficiaries have to wait before making use of services is much shorter and less rigid than ordinary for-profit health insurance schemes. Another strategy employed to reduce moral hazard is the members' inability to directly access any specialty or diagnostic services in the hospital without a referral letter coming from the authorized primary care physicians or satellite clinic staff. Moreover, the presence of community and health promoters who live near or around the areas where most of the members come from uses the mechanism of social control to prevent the abuse or over-utilization of services. They are able to provide the staff or physicians concerned with some information regarding the members who may be using the services irrationally.

The newsletters as well as the monthly satellite meetings have greatly reduced moral hazard. Issues, misconceptions and clarifications are more often than not, settled by these two measures. They are also effective venues for positive feedback from members and for information on preventive health care.

Cost explosion has so far not been a serious problem for the OHPS mainly because of the capitation payment scheme to the health provider. By the end of 1999, OHPS was able to generate a contingency reserve unlike in previous years.

Other than its own contingency reserve, the OHPS does not have any mechanism for financial protection. There is no reinsurance or guarantee fund system for any of the existing health microinsurance schemes in the Philippines. Lately however the OHPS Management has been approached and invited to participate in a study to explore the viability of a re-insurance scheme for social health insurance.

(g) Fraud

In almost six years of existence, some minor cases of fraud have been encountered among the beneficiaries as well as the staff. Among these were instances when members got prescriptions for antibiotics from private doctors because the OHPS doctor was not available. These prescriptions were used by the members to get free antibiotics from the OHPS clinic. OHPS later found out that the member was not sick and the medicine had been sold to a neighbor. As a precautionary measure therefore, medicines for one day only are provided to the member if a private doctor and not an authorized OHPS doctor has

prescribed them. The rest of the medicine is only dispensed after the OHPS doctor has visited the member himself. There were also some cases where members, whose parents were still below 60 years old, falsified the age of their parents in order to be able to register them as dependants. To minimize this, these parents are given free consultation although they are not entitled to the other health benefits.

Among the staff, there were cases where they had not removed the names of their relatives from the list given to the hospital which was used as the basis for capitation payment, even if the said relatives had failed to pay two consecutive monthly contributions. It was explained to the staff concerned that this practice should not be done as it would greatly affect the financial viability of the scheme. Furthermore, the Manager now also checks the list of qualified members against their contribution payments.

(h) Administration and management

The status of OHPS as part of the ORT Community Multipurpose Cooperative has been very convenient and satisfactory and no problem has been encountered in relation to this situation. No changes in legal status are deemed as necessary.

With the cooperative as the body responsible for the general management of OHPS, there exists good cooperation between the latter and all the other units of the former. This may be due to the fact that some of the personnel involved in OHPS also have functions in other units of the cooperative. Although the scheme's financial management is autonomous, the payroll system of those involved with the Insurance Scheme is integrated and centralized with that of the Cooperative.

There have been some problems with personnel's competence in executing their tasks but these have been solved through training and seminars. The cooperative has been strong in its training component. This has also helped in reducing the difficulties of periodic renewal of officers and staff. Also, the officers and staff, like most other social development, are multiskilled, and used to job rotations or being called upon to perform other duties when different units need "reinforcements" or support.

In its information system, the only problem is that its present database program (Microsoft Access for its member database) does not seem adequate for the current needs of the insurance scheme. There have been attempts made to hire a computer programmer to install a customized system for social health insurance but the OHPS has not been able to get one with the necessary skills.

The level of member participation in management is very limited in the sense that not all of OHPS members are members of the cooperative. However, the members can always make suggestions during the satellite monthly meetings and the general assembly.

The level of operating costs is being kept to a minimum. This has been possible because of subsidies from the other units of the Cooperative, the funding agency ORT for its Mother and Child Care Project, the Provincial Government of La Union and free advisory services from the Social Security Expert.

(i) Relationship with the state and local collectives

At the municipal level, the relationship is limited to sponsorship of a few indigent families. However the experience here is that membership of these families is not sustainable because they remain dependent on the incumbent politician.

The Provincial Government, despite its monthly financial contribution, has not interfered with the operations of the insurance scheme. However, the Provincial Government may be studying the possibility of integrating the insurance scheme in its “Health in Every Home” program. If this is realized, the OHPS will have an advantage in terms of information dissemination and additional financial support.

At national level, the OHPS, like other health microinsurance schemes in the country, was envisioned as receiving technical and financial support from the Philippine Health Insurance Corporation. However, despite some initial attempts through a bilateral assistance program from Germany (GTZ), this has not yet materialized. Studies concerning this are still ongoing.

(j) General operations

The ORT Community Multipurpose Cooperative’s membership as well as the parents of the children enrolled at its Day Care Centers continue to be a source of prospective members for the insurance scheme. Any meeting at these two units of OCMC is an opportunity to promote the OHPS.

This internal advantage is coupled with the commitment of the staff. The favorable experiences of some members help neutralize the dissatisfaction felt by others. Externally, the OHPS’ main advantage is the continuing support from both the Ilocos Training and Regional Medical Center as its health care provider and the Provincial Government of La Union.

Losing internal and external support will endanger the viability of the scheme. Funding through contributions is adequate if compliance with regular payment is high and cost control through provider payment are maintained. The main strategy adopted to improve the operation and impact of OHPS is to seek more support from the Provincial Government. Aside from financial support, its endorsement of the scheme to the general population of the province will boost OHPS’ penetration rate of the target group.

It is felt that the development of a second level of deputies is also important to ensure that the OHPS operation will continue smoothly despite changes at management level. Among the staff, there is some job rotation so that no one becomes indispensable and among the officers, the scheme is managed as a team so that all of them are knowledgeable of the entire operation and not just the sub-units that they belong to.

3.5.3. The Beneficiaries' points of view

The following information is based on the minutes of monthly OHPS meetings held in September in eight satellites with a total attendance of 76 members and in November in six satellites with a total attendance of 136 members. These were informal meetings where the difficulties improvements, problems encountered and requests /expectations in regard to the OHPS were discussed.

As can be seen from the minutes, discussions in September were focused on two health benefits: free medicines and medical consultations at the satellite clinics. There are a number of requests from members to expand the current list of essential drugs which at the moment include only antibiotics, anti-asthma, and ant-arthritis drugs. Some members are content with the current list as long as they are readily available at the OHPS clinic to avoid buying them at higher prices and then claim reimbursement. Other members feel that an additional service that has been very convenient for many is the selling of medicines and drugs, not included in the essential list, at a reduced cost. This would be an added convenience because members are assured that these will be cheaper when compared to those sold in other establishments.

In relation to medical consultations, some members are unsatisfied because the OHPS doctors are not available at the satellite clinics on a daily basis but only come weekly. Sometimes the doctor's scheduled visit is late or is changed without the members being informed. At the November meeting, similar sentiments were shared. In addition, members also observed that some stocks of medicines and supplies at the hospital pharmacy were inadequate and some hospital staff were not familiar with the benefits available to OHPS members.

In relation to the contribution amount, some feedback from members was received. One complaint concerned an entire household which could not be covered as "one family". According to OHPS policies, this household of seven would involve three separate memberships. Although this is administratively necessary to reduce adverse selection, there is a need for incentives when an entire household wants to join as one membership unit. In the Philippines, the extended family system is common and culturally accepted. It has been noted that in the OHPS, many dropouts consist of households with multiple "families" who joined OHPS together.

While the OHPS meetings tended to focus more on the problems and issues, the OHPS-ITRMC Bulletin through its "OHPS Story of the Month" became the venue for positive feedback. This features actual testimonies from members on how OHPS has helped them.

3.5.4. The health care providers' points of view

So far, there has been no effort made to obtain in a systematic manner, the views and opinion of the health care providers on the OHPS. Most of the encounters with primary care physicians and the hospital partner are centered on solving problems as they are encountered.

No information is available on the impact of the scheme on the health status of its beneficiaries. There is also no data available to demonstrate that the health of the OHPS beneficiaries is significantly different from that of the rest of the population. It is very difficult to determine whether there have been changes in the perception and attitude of the beneficiaries to their health problems.

During informal encounters and discussions, most of the primary care physicians employed by OHPS realize that because of its equity-oriented nature, compensation and payment to the doctors and the hospital are not very financially rewarding. Moreover, the scheme is unable to provide any substantial professional support to the continuing medical education needs of the doctors. This is because of limited funds available for administrative and operational aspects of the scheme.

The different paradigm or framework around which the OHPS has been developed is still unfamiliar to the health care providers. Thus it has been an uphill climb for the organizers of the scheme to ensure that the health services delivered are preventive and promotive in nature as most of the health care providers are oriented towards a curative dimension of healing.

Nevertheless, it is felt that most doctors recognize the potential impact and value of the scheme and continue to work for the program despite the inconvenience and difficulty of traveling to the satellite clinics as well as the relatively low pay. They also encourage more people to become members of the scheme especially when they get the opportunity to see non-members who seek consultation.

3.5.5. Other actors' points of view

There has been no systematic or formal study that has been conducted to elicit the points of view of the other stakeholders of the scheme. Through the various activities and meetings held with different institutions, the OHPS is well known among the organizations in La Union. The Provincial Government also recognizes and accepts the value that OHPS provides. However, this acknowledgment and affirmation have not been translated into concrete support for the program by the Provincial Government structure. Over the past years, many attempts and efforts have been made to encourage the Local Chief Executive to ask employees of the local government offices to seek membership to the OHPS, but so far this has not proved to be successful.

However, on several occasions, different local authorities have recognized the OHPS contribution in providing quality health care to poor communities and members of the province and have asked OHPS training staff, to serve as resource persons in several province-wide workshops and training for village health workers.

3.6

SUMMARY AND CONCLUSIONS



In the Philippines, there are several traditional mechanisms that have evolved among low-income communities to provide some form of social protection to their members. Such traditional schemes have existed and in some cases have in fact become more important than formal social security systems.

In times of need, Filipinos look to their families, relatives, friends and community for economic and social support. This support is often limited in scope and unsustainable in nature. Resources are meager and inequitably shared, and there is no guarantee that they will be available every time need arises. Even so, these remain the only sources of support for many Filipinos in times of adversity.

The ORT Health Plus Scheme is an innovative health microinsurance scheme that was implemented to respond to the problem of inequity in access to health care for the poor and marginalized rural and suburban communities in La Union Province. The implementation of the scheme was a natural progression from what initially had been a Mother and Child Development Program that had been initiated by an international NGO in the province. Realizing that health care is a fundamental component of good mother and child care services were offered to focus on the health care needs of the beneficiaries of such programs.

3.6.1. Best Practices

(a) *Health microinsurance should tap existing organized groups in communities.*

The impact and gains achieved by OHPS over the past seven years have largely been facilitated by the existence of organized groups in these communities. Another contributory factor was the inability of the existing public health infrastructure to make available an adequate set of health care services to these communities. Thus, people who have participated in the scheme recognize that the benefits and health services being offered by OHPS do respond to their own health needs and concerns. If an alignment was not achieved between the community's needs and the services offered, the program would not be as successful as it is at present.

(b) *In order to succeed, the participation and active involvement of health care providers are absolutely essential in health microinsurance schemes.*

The participation and active involvement of the health care providers and hospital facility has also been a large contributory factor to the gains achieved by the OHPS. Without the agreement and cooperation of the Ilocos Training Regional Medical Center, the scheme would have had difficulty recruiting and sustaining members. In addition to this, the fact that procedures were kept as simple as possible was instrumental in helping members enroll and renew their membership in the scheme.

3.6.2. Lessons Learned

Many aspects of the scheme, however are still in need of strengthening and improvement.

(a) *The need for regular consultation.*

In relation to the members and beneficiaries, there is a need to consult them on a regular basis regarding the most appropriate packages offer. Experience shows that programs that have not encouraged participation and consultation among communities proved to be unsuccessful in making them relevant and acceptable. Moreover, the issue of the proper method and frequency of collection of contributions must be thoroughly explored among the members. It was realized that the OHPS always had problems of collection and many members dropped out because of their refusal or inability to continue payment.

(b) *Insurance is not synonymous to force savings.*

Health microinsurance schemes similar to OHPS should also ensure that these initiatives should not be marketed and projected as savings schemes. The idea that people are "saving for health" may convey the concept that during times of perceived need they may draw on these savings and are free to withdraw the contributions at the end of every contract year if they did not use any of the scheme's services. This wrong notion has led to many dropouts among OHPS members. Instead, what is to be highlighted is the solidarity component of the scheme which should be strong enough to motivate people to enroll in the scheme and to remain active members.

(c) *The need for social marketing.*

It is also important that OHPS and other similar schemes should embark on an extensive orientation and awareness campaign to first ensure that people in the communities are able to understand and value health in a correct and rational manner. The lack of access and poor health services have resulted in people whose beliefs are that good health care services are equated with sophisticated facilities and expensive medicines. This perception continues to exist among many existing and potential OHPS members so that it has been difficult to ensure a steadily increasing membership due to false expectations. What needs to be emphasized is that OHPS is NOT a traditional insurance program whose main objective is to earn a profit. OHPS is a health microinsurance scheme that is being implemented primarily to provide access to basic health care services to poor people. Such access is made available through the provision of curative care services through the outpatient or satellite clinics and the tertiary care public hospital. More importantly, preventive and promotive health care services are prioritized to ensure that they are viewed rationally and are truly appropriate and responsive to the needs of the people.

(d) *Initiatives like OHPS should be welcomed by the public sector.*

Many lessons and experiences can be learnt from the OHPS to contribute to the development of more appropriate packages and mechanisms that the government insurance corporation can adapt and replicate. Possible areas of expansion should be developed by government through its extensive infrastructure to replicate models and initiatives similar to OHPS. In doing so, the vision of achieving universal coverage of health insurance in the Philippines may become more attainable.

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Appendices

appendix A : Health Insurance Policy, Bicao

BICAO INVESTMENT CARE ADMINISTRATION ORGANIZATION PROGRAM Bicao, Carmen, Bohol

Health Insurance Policy

Bicao Investment Care Administration Organization Program (BICAO Program) Membership, Benefit Package, Financial Scheme system and procedure policy of community based social health insurance program.

1. Name of Organization Scheme:
The name of scheme is Bicao Investment Care Administration Organization Program (Bicao Program)
2. Address of Community Health Care System:
The address and area of coverage of BICAO is Bicao, Carmen, Bohol.
3. Ownership and Management:
The BICAO Program, a social health care system, is owned and managed by the officers and members of Bicao Small Farmers Multi-purpose Cooperative (BSFMPC), Bicao, Carmen, Bohol, Philippines.
4. Objective of the scheme:
The objective of the BICAO aims to provide an affordable and suitable health care system that makes medical expenses more affordable for the people who wish to join the system. This maybe said for both profit health care system as well as social health care system.
5. Statement of Policy on Membership:
The prospective members, the ARBs and non-ARBs of Bicao Small Farmers Multi-purpose Cooperative (BSMFPC) with the ARC and specifically registered coop members of BSFMPC.

conditions, to wit:

1. The COOPERATIVE shall only commit for admission to the HOSPITAL patient/member in accordance with the terms and conditions of the Bicao Investment care Administration Organization Program.
2. The HOSPITAL shall only admit patients with identification Cards indicating membership of the Bicao Investment Care Organization Program;
3. The health services shall include the following benefits: In patient benefits such as: accommodation, P210.00; medicines, P1,190.00; professional fee, P300; laboratory, P600.00; and ambulance, P200.00;
4. The following medical/health care services are not covered under this agreement:
 - a. Tuberculosis
 - b. Tumors
 - c. Uncomplicated Gastric Ulcer
 - d. Diabetes Mellitus
 - e. Organ Transplant
 - f. AIDS and its complications
 - g. Suicidal injuries-illness attributed to the members misconduct, gross negligence, abuse of drugs and alcohol, meliorate service injuries sustained from armed conflicts like rebellion, insurrection
 - h. Sterilization of either sex or reversal of such, artificial insemination and sex transformation
 - i. Normal deliveries
 - j. Cosmetic and Plastic Surgery
 - k. Optometric services
5. The COOPERATIVE shall only cover the hospital bills specified in the member's package, any excess of the bill shall be a personal responsibility of the member;
6. The HOSPITAL shall send the bill to the COOPERATIVE immediately upon discharge of the patient-member to facilitate early settlement of his/her hospital account;

12. Inactive Members/Dropouts:

- a) The member is automatically dropped as registered enrollee of the BICAO program if he/she cannot comply the requirements, systems, policies and procedures.
- b) The member will be accepted back, reinstated only if he/she can pay the required enrollment fee and undergo another two (2) days orientation course on Social Health Care System.

13. Membership Identification Cards (IDs):

- a) BICAO program will issue to each qualified members covered under the contract, an individual membership card that will be used by the member to identify himself/herself as the holder in case he/she is in need of health care services.
- b) The individual membership card does not constitute a contract, nor does it entitle the bearer to benefits unless the bearer is enrolled with the BICAO program of the BSFMPC. The individual membership card merely provides informative statement regarding the member and should be used by the member to identify himself/herself as a member in case he/she is in need of health care services.
- c) The membership card and the corresponding benefits are non-transferable.

14. Membership Participation in Activities and Decision Making:

- a) The enrollee/member of BICAO should attend all special meetings and activities called for a purpose.
- b) All comments, suggestions and recommendations from members can be accepted and treated only thru participatory approach based on the policy formulation by BICAO program.

15. Systems and Procedures:

I. a) Requirements

1. filling of application
2. general orientation (BICAO by-laws)
3. physical examination (doctors certificate as to chronic diseases)
4. ID pictures
5. enrollment fee

b) submission of requirements

c) approval of membership application

d) payment of dues

e) signing of contracts

f) issuance of Ids

II. Regular members

1. orientation on the policy
2. attendance of meeting

III. Documentations (Data Bank of Members)

1. List of active members
2. individual members/patients record
3. monthly updates

16. Benefit Package System:

- a) Benefit Ceiling – P3,000.00
- b) Amount Availment – P2,500.00
- c) Reserve for buffer – P500.00

Health Service	Other Financing	Co-payment	SHI	Total
Outpatient	BH midwife	Private practitioner	Free	
Consultation or outpatient	MHO			
Referral System	(other services	by BIARSP II	Health service	provider)
Hospitalization				
Accommodation	-	P100.00	P210.00	
Professional fee	-	P100.00	P300.00	
Medicines	-	P200.00	P1,190.00	
Ancillary H.S.	-	-	P600.00	
X-ray Laboratory CBC, Urinalysis, etc.				
Ambulance	-	P100.00	P200.00	

17. Financial Scheme

- a) Members Enrollment Fee ————— Php50.00/individual
- b) Entire Family enrollment fee ————— less 10% discount
- c) Renewal member enrollment fee ———— Php20.00
- d) Registration fee ————— Php20.00
- e) Premiums
 - 1) Monthly ————— Php30.00 + Php5.00 admin. Cost = Php35.00
 - 2) Quarterly ————— Php105.00
 - 3) Semi-annually ———— Php210.00
 - 4) Utilization rate ———— Php12%

Note: Policy is subject for any amendments by the BOD en banc.

appendix B:Memorandum of Agreement

MEMORANDUM OF AGREEMENT

KNOWN ALL MEN BY THESE PRESENTS:

This memorandum of Agreement, executed and entered into by and between:

The **BICAO MULTI PURPOSE COOPERATIVE**, a duly organized and registered cooperative existing under Philippine laws, with business and office address at Bicao, Carmen, Bohol, represented in this act by its chairman MR. MELQUIADES CANDA, and hereafter referred to as the **COOPERATIVE**;

AND

The **CONG. SIMEON G. TORIBIO MEMORIAL HOSPITAL**, previously known as the Carmen Hospital, Carmen, Bohol, represented in this act by the Chief of the Hospital, DR. AVELYN L. LANTACA, hereafter referred to as the **HOSPITAL**;

W I T N E S S E T H

WHEREAS, THE DEPARTMENT OF AGRARIAN REFORM (DAR); launched the DAR-Agraryong Pangkalusugan Program (DAR-AP) to ensure the delivery of the quality health services to Agrarian Reform Beneficiaries (ARBs);

WHEREAS, THE COOPERATIVE is desirous to develop and maintain a social health insurance system in accordance with the DAR-AP in order to make health services available, accessible and affordable to the cooperative members;

WHEREAS, THE COOPERATIVE has established the Bicao Investment Care Administration Organization Program as its health insurance arm and organized mainly to answer the health needs of the cooperative members within the framework of the DAR-AP;

WHEREAS, the CONG. SIMEON G. TORIBIO MENORIAL HOSPITAL is also desirous and can provide health services within the terms and conditions of the DAR-AP program of the DAR;

WHEREFORE, the COOPERATIVE and the HOSPITAL, hereby enter into this Memorandum of Agreement, subject to the following terms and

7. The COOPERATIVE, through its authorized representative, has the right to examine the hospital records of the patient-member's expenses including the billing charges of the Hospital pertaining to admission of the patient member;
8. This Memorandum of Agreement, notwithstanding the signatures of the parties herein, shall be in force and effect only upon approval by the Head of the Local Government Unit who has jurisdiction over the HOSPITAL.

IN WITNESS WHEREOF, the parties of this Memorandum of Agreement have hereunto set their hands this 4th day of April 2003 at Carmen, Bohol, Philippines.

MELQUIADES CANDA
Chairman

AVELYN L. LANTACA, M.D.
Chief of Hospital

APPROVED:

ERICO B. AUMENTADO
Governor

Signed in the presence of:

ACKNOWLEDGMENT

REPUBLIC OF THE PHILIPPINES)
PROVINCE OF BOHOL)S.S.
MUNICIPALITY OF CARMEN)

BEFORE ME, this 24th day June 2003 in the place above-written, personally appeared Melquiades Canda, representing to be the Chairman of the BICAO Multi-purpose Cooperative with his Community Tax Certificate No. _____. Issued on _____ at Bicao, Carmen, Bohol and Avelyn L. Lantaca, representing to be the Chief of the Hospital of the Cong. Simeon Toribio memorial Hospital with her Community Tax Certificate No. _____ issued on _____ at Carmen, Bohol, known to me to be same persons who executed the foregoing instrument for and in behalf of the Cooperative and Hospital, respectively, and they acknowledged to me that the same are their corporate act and deed.

WTNESS MY HAND AND SEAL this date, year and place above-written.

Doc. No. _____
Page No. _____
Book No. _____
Series of _____

Appendix C: Accreditation Agreement, NOVADECI

COMPANY-HOSPITAL MUTUAL ACCREDITATION AGREEMENT

THIS AGREEMENT, dated as of _____, by and between:

NOVALICHES DEVELOPMENT COOPERATIVE, a corporation organized and existing under Philippine laws, with principal office at NOVADECI Bldg., Buenamar cor Sarmiento Sts. Novaliches, Quezon City, represented in this act by its Chairman, _____, hereinafter referred to as the COMPANY”;

And

_____, a corporation organized and existing under Philippine laws, with principal office at _____, Novaliches, Quezon City, represented in this act by it, Hospital Administrator, _____, hereinafter referred to as the “HOSPITAL”.

WITNESSETH : That

WHEREAS, the COMPANY is the owner/operator of NOVADECI HEALTH a duly licensed managed care company providing out-patient, preventive, and in-patient health care services to its members; hereafter. “COMPANY” and “NHCP” shall refer to one and the same entity;

WHEREAS, NHCP requires a linkage with a duly-licensed and operating hospital, with adequate resources and facilities and competent personnel, to ensure quality service to its members;

WHEREAS, the HOSPITAL warrants and represents that it has and will continue to have during the term of its agreement the resources, facilities and competent personnel necessary to fulfill the requirements of the company.

WHEREAS, the parties have agreed to work together as partner institutions;

NOW, THEREFORE, for and in consideration of the foregoing premises and the mutual covenants and promises set forth below, the parties have agreed as follows:

I. MUTUAL ACCREDITATION

1. The COMPANY and the HOSPITAL hereby accredit each other as partner institutions. Henceforth, either party may use the name of the other in its brochures, publications and other advertising and information materials.

II. HOSPITAL PRESTATIONS

2. (a) The HOSPITAL shall admit members of NHCP who seek to avail themselves of its medical hospital services in accordance with their benefits package, subject to the policies and guidelines on hospital confinement which NHCP may issue as the need arises. The HOSPITAL shall not demand from the said members any deposit or up front payment as a condition for the admission, treatment or discharge if they present a valid membership identification card and authorization letter from an authorized NHCP representative.
- (b) In cases, patients need to be confined, he/she should present referral from NOVADECI Medical Physician. In case of a medical emergency, the HOSPITAL shall ensure that Emergency Room Physicians shall, without delay, attend to the NHCP member in need in accordance with existing hospital guidelines in cases of emergency. A “medical emergency” refers to a life threatening illness of accidental injury or a sudden and unexpected onset or as soon as the care may be made available generally within 24 hours from onset. Early in the morning in the next day it should be reported to NOVADECI Medical.
3. (a) The HOSPITAL shall allow physicians duly accredited by NHCP to treat its members confined in its hospital; provided, that said physicians are also accredited physicians or have valid visiting privilege in the HOSPITAL with the names of their duly accredited physicians.
- (b) Likewise, the HOSPITAL shall allow the medical staff of NHCP to use its facilities for the conduct of the preventive medical check-up and annual physical examination of the NHCP members; provided, that the composition of the medical staff is first approved by the Hospital. The Hospital shall be compensated by the NHCP for the use of these facilities based on rates agreed upon.

4. (a) The HOSPITAL shall be solely responsible for collecting from the patient- member of the following.

- (I) The incremental increase in room rate and the resulting adjustment in professional fees and charges for laboratory and other diagnostic tests should the patient-member upgrade his room accommodation to a level higher than that to which he is entitled under his membership package;
- (II) Bills for services of a private doctor or nurse;
- (III) Use of extra facilities not included in, or which are in excess of, the room rate, such as bed, food, electric fan, television set, toiletries, and which are not directly related to the medical treatment of the member-patient;
- (IV) Any amount in excess of the patient-members benefits package stated in the membership identification card or letter of authorization for coverage issued by the authorized representative of NHCP; and

The HOSPITAL shall have no recourse to any reimbursement from NHCP should it fail to charge and collect any of the above-listed expenses from the patient-member.

(b) The Hospital shall give NHCP a prompt payment discount of at least 5% percent on room rates and other hospital charges.

5. (a) The HOSPITAL shall provide the Physicians of NHCP or his duly designated representative complete information regarding health profile of a patient-member. It shall give the Physicians or his representative the right to visit the patient-members, and to monitor their health condition.

Where NHCP needs to obtain official copies of the patient's medical records, NHCP shall provide a conforme letter to be signed by the patient-member covering, among others, the release of his medical information to NHCP. This letter is an addition to the Authorization letter referred to in Section (a) of Paragraph 2 of this Agreement.

6. NHCP shall be solely liable for the payment of hospital and medical bills of patient-member, less deduction and discounts stated in paragraphs 4(b) and (c) of this Agreement within 30 days upon receipt of the Hospital's statement.

7. NHCP shall monthly furnish the HOSPITAL with an updated list of suspended or lapsed memberships. It shall be liable to the HOSPITAL for payment of the medical and hospitalization expenses of any patient-member not included in the list and all these covered by an authorization letter.

8. The HOSPITAL shall appoint a Plan Coordinator who will serve as an administrative link between NHCP and the HOSPITAL.

III. EFFECTIVITY AND TERMINATION

9. This agreement shall take effect as of _____ and be in force for a period of one (1) year. At the end of this period, it shall automatically be renewed on a yearly basis unless either party serves notice in writing to the other party of its intent to terminate this Agreement.

IV. MISCELLANEOUS

10. NHCP reserves the right to audit the billing of the HOSPITAL and make counterclaims or take exceptions in the event erroneous billing or entries have been made.

11. At any time during the effectivity of this Agreement, either party may propose changes or amendments to it. Any such proposed changes or amendments shall take effect as soon as possible and to the extent that both parties shall have expressed to them in writing unless a different date of effectivity is agreed upon.

12. The parties hereby undertake to exert their best efforts in settling amicably between themselves any dispute or differences arising from or relating to this Agreement.

13. This Agreement constitutes the entire agreement between the parties and supersedes any prior stipulation, agreement or understanding of the parties, whether oral or written, if any, with respect to the terms and conditions of the mutual accreditation.

I WITNESS WHEREOF, the parties hereto have caused their respective representatives to sign these presents on the date first written above in Novaliches, Quezon City, Philippines.

NOVADECI HEALTH CARE
PROGRAM

HOSPITAL

REYNALDO G. SAN ANDRES
Chairman

SIGNED IN PRESENCE OF:

appendix D: Collaboration Agreement, ORT HPS

COLLABORATION AGREEMENT

ORT HEALTH PLUS SCHEME – ILOCOS TRAINING AND REGIONAL MEDICAL CENTER COLLABORATION

This Collaboration Agreement is made between the **Ilocos Training and Regional Center (ITRMC)** and **ORT HEALTH PLUS SCHEME (OHPS)**.

ORT Health Plus Scheme represented herein by its Chairman of the Board, ORT Community Multipurpose Cooperative, **ROBERTO A.O. NEBRIDA** with postal address at San Fernando, La Union hereinafter called the **OHPS**:

-and-

Ilocos Training and Regional Medical Center represented herein by its Chief of Hospital, **FRANCISCO A. VALDEZ, MD, FPCP, MA, MPA, Ed.D, PhD** with postal address at San Fernando, La Union hereinafter called the **PROVIDER**:

In accordance with this Collaboration Agreement, OHPS members will be provided with specific health services under specified conditions by the Ilocos Training and Regional Medical Center. In recognition of the regular provision of these services to the beneficiaries according to their health care needs. OHPS will pay in cash to the Ilocos Training and Regional Medical Center, according to the number of beneficiaries covered.

1. COVERED PERSONS

The **PROVIDER** will provide defined health services included in the OHPS Health Care Benefits Package to the OHPS covered population. The Covered Persons are those members and their beneficiaries who have signed the membership form and has paid premium on regular basis.

2. HEALTH SERVICES BENEFITS

The **PROVIDER** shall provide:

2.1 OUT-PATIENT CARE including services provided by the physicians, nurses and other health care personnel after proper referral by OHPS physicians. Drugs shall be limited to the Philippine Essential Drug List and OHPS conditions, medical supplies, laboratory and ancillary services including imaging services as X-ray and ultrasound as necessary.

Drugs prescribed by the Provider's physicians for use following hospital discharge or following consultations in the Provider's Out-Patient Department will follow the Philippine Essential Drug List, the Generic Drug prescribing protocol and OHPS drug benefit limitations. The drugs prescribed on out-patient basis will be supplied OHPS.

With the exception of emergency Care, these services will only be provided following referral from the Primary Health Care Team of OHPS. Self-referral for emergency care will be monitored by OHPS and the Provider

2.1 IN-PATIENT CARE including room and board, professional services including services provided by physicians, nurses and other healthcare personnel. Drugs limited to the Philippine Essential Drug List, medical supplies, laboratory and ancillary services including imaging such as X-rays and ultrasound, and physiotherapy services.

The in-patient services will be provided to the insured persons in special patient rooms (according to conditions of care for Government workers), unless medical conditions require specific conditions such as intensive care, maternity and neonatal care.

Drugs prescribed during the in-patient care will follow the Philippine Essential Drug List. In the Event of drugs prescribed by the Provider to in-patients not being available in the Ilocos Training and Regional Medical Center, a generic prescription will be given to the patient by the attending physician and the required drugs will be bought by the hospital for the whole period of confinement, provided the prescription is marked "unserved" by the ITRMC Pharmacy.

In-patient admissions of OHPS members will be made only following referral by the OHPS physician. In case of emergencies, the OHPS physicians will be informed as soon as possible following admission and will coordinate discharge and medical follow-up.

The above in-patient and out-patient services will only be provided to OHPS members. Patient will not be charged for services as defined above when the referral condition has been followed. Maternity care will be provided only when the OHPS Prenatal Program and qualifying period has been followed.

3. ELIGIBILITY FOR SERVICES BY THE PROVIDER

The Provider will render the above services to the insured population according to the conditions of this Collaboration agreement following proof of eligibility, which is:

An OHPS Membership Card, bearing the name of the patient as a member or dependent, and showing proof of contribution payment (stamps on the card with the name of the patient):

3 months contribution for initial treatment and subsequent regular payment of contributions, as shown by stamps on the OHPS Membership Card, up to the last month.

For admission for delivery of maternity cases, the Provider will check the date of membership started at least 12 months prior to delivery date and the maternity report showing attendance at OHPS Pre-natal Program. The Pre-natal Care Program includes a minimum of six (6) prenatal visits, including the mandatory of at least three (3) visits to the OB-Gyne Clinic at the Ilocos Training and Regional Medical Center.

In the event of the patient not having proof of eligibility, the Provider will inform OHPS management. The Provider may charge the regular Hospital charges, or refer the patient to another hospital as necessary. OHPS will not be responsible for the costs of care to members whose eligibility has expired.

4. COLLABORATION WITH THE PROVIDER

In recognition of the provision of services to the beneficiaries of OHPS as medically required; OHPS will pay cash to the Provider on the basis of an **annual capitation calculation** to cover the total number of beneficiaries covered by OHPS. The payment will be made irrespective of the actual utilization of health services by the patient treated by the Provider.

The OHPS will submit to the Provider a monthly list of members and the total number of insured persons. The list and the number of insured persons will be adjusted every 3 months to adjust for the new covered persons, including new family members, and deletions due to death or cessation of eligibility.

At the time of adjustment, the amount spent by OHPS for drugs purchased for in-patients (when these drugs were not available during the hospital stay) will be deducted from the total capitation payment.

The **capitation calculation** beginning June 1, 2000 for each insured person will be:

PhP 120.00 per year (PhP 30.00 per quarter)

The remuneration will be made on a quarterly basis, with adjustment of the calculations based on the membership numbers every 3 months. Additions and deductions will be recognized in the new payment for the coming quarter.

Any request for re-negotiation of the collaboration agreement will be made no less than 6 months before termination of contract.

The review will take into account the actual utilization by the insured population.

5. UTILIZATION REVIEW AND QUALITY ASSURANCE

The above in-patient and out-patient health services will be provided to the covered population at the level of professional care and patient comfort which are at least those now provided by the Provider.

An annual meeting will be conducted between the representatives of the Provider and the OHPS Team for review and evaluation of the program.

To support the review of utilization and quality, the Provider will submit patient information on a regular basis, as follows:

- Individual in-patient discharge summary (as in Annex I. Information System Requirements) for purposes of patient follow-up in place of residence and for statistical analysis.
- Summary of out-patient services (number) provided to OHPS members.

Out-patient specialist consultations (for illness and accidents)

Emergency room visits

X-rays (including all imaging services carried out by the Provider)

Laboratory services, including all types of laboratory service carried out by the Provider

Following admissions of an OHPS insured person, the OHPS Primary Health Care Team will be notified as soon as possible. The Team may visit the hospitalized patient, to coordinate diagnosis, treatment and follow-up in the community.

6. EXCLUSIONS AND LIMITATIONS:

The Collaboration agreement will not cover the following services:

- Dental Care
- Cosmetic surgery and treatments
- Optometry and eyeglasses
- Neuro-surgery (major interventions)
- Organ transplant
- Open-heart surgery
- Dialysis
- Self-inflicted injuries, induced abortions, and drunkenness
- Blasting injuries (New Year's Eve)
- Out-patient Physical Therapy
- Orthopedics pins/plates and casting materials
- Special accommodation services in private room and Specialist Fee

Out-patient:

- Specialized x-ray and laboratory services:
- Special Instrumentation such as Endoscopy
- Small Intestinal Series
- Phacoemulsification
- Cardiac Series
- T-tube Cholangiography
- Intra-operative cholangiography
- Cystogram/Urethrogram/Hysterosalpingogram
- Cystourethrogram
- Sialogram
- Carotid Angiogram
- Arteriogram
- Skeletal Survey
- Ultrasound guided
- T3T4
- Free and Total PSA
- Trop T
- Typhidot
- ABG's
- Drug Tests
- All "send outs" tests

In-patient:

Medicines – maximum of Php15,000/confinement

Oxygen – maximum of Php30,000/confinement/90-day period

Laboratory and Ancillary Services – maximum of Php10,000/confinement

IN-PATIENT hospital care will be covered up to 45 days confinement per individual per year.

Referrals for tertiary services, which require further evaluation and treatment outside the Ilocos Training and Regional Medical Center will be coordinated with the OHPS Primary Health Care Team.

7. EARLY TERMINATION

The party who wishes to terminate the contract will notify the other party in writing 60 days prior to the termination of the contract.

8. EFFECTIVITY

The renewal of **COLLABORATION AGREEMENT** shall take effect on **August 1, 2004** and shall be effective for five (5) years.

CONTRACT

IN WITNESS WHEREOF, the parties have set their hand this _____ of August 2004 at City of San Fernando, La Union, Philippines.

FRANCISCO A. VALDEZ, MD. FPCP, MA, MPA, Ed.D, PhD
Chief of Hospital III
Ilocos Training and Regional Medical Center

ROBERTO A.O. NEBRIDA
Chairman of the Board
ORT Community Multipurpose Cooperative

SIGNED IN THE PRESENCE OF

DAISY GARCIA, MD, FPPS
PADERON
Chief Medical and Professional Staff

ENGR. MICHAEL JOSEPH I.
Managing Director
ORT Community Multipurpose Cooperative

ACKNOWLEDGEMENT

REPUBLIC OF THE PHILIPPINES)
PROVINCE OF LA UNION) S. S.
MUNICIPALITY OF SAN FERNANDO)

BEFORE ME, this _____ day of _____, 2004 in San Fernando City, La Union personally appeared:

	Persons	RC Nos.	Date/Place
Issued to:	Dir. Roberto A.O. Nebrida Dr. Francisco A. Valdez		

All known to me known to be the same persons who executed the foregoing instrument and acknowledge to me that the same is their free act and deed.

WITNESS MY HAND AND SEAL, on the day, place and year first above- written.

For more information, please contact:

International Labour Organization
Subregional Office for South East Asia and the Pacific

19th Floor, Yuchengco Tower
RCBC Plaza, 6819 Ayala Avenue
Makati City, 1259 Philippines
Tel. No.: (632) 580-9900
Fax No.: (632) 580-9999
<http://www.ilo.org/manila>

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