Strengthening Good Health Care Management

The HAMIS Contests and the Federation of the HAMIS Winners in the Philippines

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1. Problem and procedure

The quality of health care is a matter of recurrent debate. Quality assurance programs try to improve the quality of medical procedures in the operation theatre or in the wards. Morbidity and mortality conferences are a kind of auditing by supervisors or peers. Whatever it is, quality of health care transcends the operation theatres and wards. What is the quality of health projects like the building of a chain of hospitals? What is the quality of health programs, like immunization and health education campaigns? What is the quality of health policies, like cost containment reforms of a national health insurance?

Aspects of the technical quality of performing operations or prescribing drugs or building operation theatres and hospitals according to the state of the art and avoiding nosocomial infections or other negative side effects, are very important aspects of the meaning of quality but certainly not sufficiently comprehensive. Aspects of “macro-quality” have to be considered among those of “micro-quality”.
A content analysis of more than a hundred articles in journals like Social Science and Medicine that deal with such ambitious words like "quality" of health care shows quite clearly what the connotations of quality are:

- importance, relevancy, significance, i.e. the meaning of something in terms of a strategical aim, e.g., to improve the living conditions of the poor majority of populations
- appropriateness, i.e. the meaning of something to avoid and or to ameliorate (avoidable) suffering, e.g., by means of primary prevention, early detection or proper treatment
- effectivity, i.e. the meaning of something for the achievement of goals. Nota bene: many projects have many different goals, in some cases more than 100 were counted
- efficiency, i.e. the costs to achieve goals, whereby costs do refer to monetary and material resources, and even time
- need, i.e. - as compared with demand - a justified demand, may it be from the point of view of the people (felt need, expressed need), of the professionals (professionally defined need), of science (normative need) or in terms of equity (comparative need)
- coverage, affordability, accessibility, equity, i.e. the meaning of something for those who need it most in spite of social, financial, temporal, geographical, organizational, institutional and other constraints
- completeness, i.e. the balances between preventive, curative and rehabilitative services, horizontal and vertical programes, out- and in-patient care as well as self-care
- coordination, intersectorality, multidisciplinarity, i.e. completeness also in terms of coordination with other sectors, disciplines, etc.
- quality and safety, i.e. the technical soundness of facilities and equipment and procedures, e.g., as assessed by peer-review
- acceptability, acceptancy, i.e. the meaning according to verbal reactions of more or less affected sections of the population in terms of complaints or assessed by analysing behaviour of people and of suppliers
- compliance, i.e. the correspondence between professional prescriptions, treatment plans or advices and patients' behaviour in case of prevention or treatment to the individual patient
- participation, i.e. the involvement of the community in planning and organization, e.g., for democratizing health care as well as a device for improving feasibility and reducing unnecessary costs
- planning and evaluation in a sense to build in self-reinforcing mechanisms to adjust and to sustain

Most of these criteria hint at factors of failure or success of health projects, programs or policies. These criteria constitute what can be called the n-dimensional property space of quality. Good health care management would try to meet as many as possible.

Choices and basic principle

Some years ago we started to help to improve health care management in the Philippines by building up a health and management information system. To be able to improve health care management one should know what good health care management is; this was our first concern.

- One source of information is to take the above mentioned criteria and to try actively to get them reaTized in a health project, program or policy. This could be seen as a prospective way to achieve quality. It is the usual way health projects are being implemented.
- Another source of information is to discover, describe and disseminate examples of a management that is to be considered "good" management from a common sense point of view of "good" managers. This can be seen as a retrospective way of assessing quality and learning from it.

This is the way we chose. We were guided by a Russian saying: "stupid people teach, smart people learn". We knew that there are good health care managers in the Philippines. We just did not know where to find them and how to avail of their knowledge and sharing. A contest for discovering good health care management was our choice.

Knowledge on management at the local level is usually not spread much beyond its immediate environment. The Contest, which is the method we used to bring forth such knowledge is based on a classical paradigm: "panem et circenses", i.e., bread and circus. A double incentive was used: an economic one in the sense of monetary awards for the winners and a moral incentive stemming from public recognition of achievement and performance.

Discovering good health care management is often the neglected other side of Health and Management Information Systems (HAMIS). They usually limit themselves to medical informatics only. Seldomly they explicitly deal with questions of information economics. Very rarely information sociology is added, i.e. the discovery, analysis and dissemination of knowledge on good management in practice.

Announcement and information campaign

In 1990 and 1993 HAMIS, i.e. a Philippine-German Partnership to strengthen the Health and Management Information System of the Philippine Department of Health issued this message: "We are looking for innovative improvements in health care which contribute to increase

* **E**ffectiveness meaning better outcomes from delivery of health care
* **E**fficiency meaning better management of resources for health
* **E**quity meaning improved access to health care for the poor."

Details regarding background, scope and purpose, participants, awards, deadline, format of the applications, selection committee members were given in posters and flyers. The flyers used during the second contest contained the lessons of all winners of the first contest so to disseminate them and link the reading of them with the financial incentive to win, eventually.

Extensive launching campaigns were undertaken. A general briefing during the August 1990 National Staff Conference of the Department of Health opened the first launching campaign. The Secretary of Health launched the program very actively himself. Department Orders, signed by the Secretary of Health reinforced the campaigns within the public health care system. Thousands of posters were distributed through the pyramidal network of the Department of Health, i.e. to hospitals, health centers, health stations. This network was used also to inform other public and private social services groups. All known non-governmental organizations in the field of health care were informed directly and were provided with contest flyers and posters. Announcements in the major newspapers in English, a number of radio announcements and many television spots promoted the campaign in three local languages: Tagalog, Cebuano and Ilocano. A prominent actor was promoting the television campaign for the first contest, the very popular health secretary did it himself for the second one. The deadline for the first contest was extended twice due to a heavy earthquake and due to communication bottlenecks. Deadlines were not taken too seriously to allow for many applications.

Applications, peer reviews and site visits

A total of 102 applications were received for the first contest of which 58 came from non-governmental organizations, 30 from services of the Department of Health, 9 from local governments, one from the labor sector and the rest from combinations thereof. The second contest produced 158 applications. Applications were received from all regions of the Philippines and from most of its 77 provinces. The main focuses of the first round of applications were as follows: 22 on primary health care and community development, 28 on public health services, 14 on personal health care, 17 on health financing, 11 on supportive services for health and 9 for strengthening institutions for health. A similar pattern emerged during the second contest. A number of projects submitted were considered as proposals rather than ongoing and "established" projects that stood already the test of self-sustainability. Short one-page "executive summaries" were prepared by HAMIS staff or HAMIS winners to describe in a comparative way the essence of all such applications.

All applications were submitted to a standardized three- or even four-fold peer review. Peer reviewers were:

- the incumbent service directors in the Department of Health
- outstanding specialists in the respective fields of expertise from academe or non-governmental organisations
- members of the HAMIS team and
- HAMIS winners (during the second contest).

They scored the written applications according to six criteria: quality, innovativeness, effectiveness, efficiency, equity and sustainability. Many peer reviewers justified their yes/no scores with lengthy explanations which were used to develop screening criteria for site visits.

Some of the project proponents seemed to be rich in merits but inadequate in documentation and vice versa. To correct for this bias, as many high score projects as possible were visited by a team composed of at least one DOH and one HAMIS staff member. During the second contest, winners of the first contest joined the team, too. A total of 186 projects were screened in detail. There were three cases where the projects were inaccessible for the screening team; we asked the proponents to come to Manila to present and explain their projects. Based on observations, interviews and validity checks of the information found in the submitted applications, the screening teams were to describe the project in terms of "facts and figures": benefits, beneficiaries, services, personnel, equipment, facilities, income and expenditure. A checklist of 59 binarily worded criteria looked into details of management: quality, innovativeness, effectiveness, equity, efficiency and sustainability. After the first contest these criteria were discussed, revised, expanded and approved by the first batch of HAMIS winners. During the second contest this checklist contained 73 criteria. Examples of the criteria are:

[] has clear objectives
[] acceptable standards are maintained
[] uses no routine procedure, predominantly
[] utilizes resources and capacity available in the area not fully considered before
[] includes aspects of quality of life
[] does not provide incentive for curative services alone
[] deals with underprivileged or marginal population
[] improves accessibility of health care
[] implies willingness of beneficiaries to participate and share
[] introduces concept of risk sharing
[] promotes improved productivity of services
[] involves minimal overhead only
[] drives at cost containment
[] is initiated from own resources
[] is appropriate and responsive to local social and economic conditions
[] seems to be easily replicable
[] is not dependent on outside financial support

Members of the site visit teams had to find a consensus on the applicability of each criterion on the project reviewed. The screening teams and the representatives of the projects were asked to find a consensus on the criteria.

Pre-selection and selection of the HAMIS winners

Based on the peer reviews and site visits, 49 projects of the first contest and 68 of the second contest were considered to have enough merits to deserve recognition and support. Twentyfour of them - quite fairly balanced in

terms of regional and topical aspects - were considered outstanding by the screening teams. Each of these outstanding projects was documented by a 10 to 15 minutes video coverage, by an extended three to five pages summary on the project and a one-page summary on facts and figures.

The Selection Committee included the Secretary of Health, some of his Undersecretaries, one Congressman, one Senator, one NGO-representative, university professors and the manager of the HAMIS project. Representatives of those Local Governments with many outstanding projects during the first contest joined the selection committee in 1994. The gold winners of the first contest were appointed to be in the selection committee, too. In its meetings the roles and responsibilities of the Selection Committee and the Technical Committee were clarified and policy matters discussed. One additional screening for the top running projects was done. Members of the Selection Committee joined the final site visit screening of most of the top ranking projects. During the second and final Selection Committee meetings, the most outstanding projects were presented by video, explained and ranked and policy issues discussed. During the first contest, one project was unanimously chosen as the best by all Selection Committee members, two others with only one dissenting vote each. These three were considered to be gold awardees. The remaining 8 of the top 12 were considered silver awardees and one project which did not get a vote from the Selection Committee - was dropped from the top twelve list and included in the bronze winners. During the second, contest the selection committee found easily a consensus on whom to award gold and silver among the highest ranking projects.

Reassessment of the First HAMIS Winners

All “old” winners of 1991 were reassessed in 1994 through site visits of the screening teams. The same procedure and the same criteria were applied that were used for the “new” applicants. Additionally the “old” winners were checked according to

- impact, i.e. in terms of strengthening and/or replicating the project and getting local, provincial or even national repercussions and impacts
- use of the award money that they received in 1991, i.e. how carefully the money was spend, how this was based on consultative processes and internal auditing and control and if the expenditure was justifiable for strengthening or replicating the project
- summary assessment scores given by the screening team on scales for macro-quality (i.e. all our criteria), money spending, replication, expansion, participation in the activities of the associations of the winners, help given to other winners, impact on local and national policies.

The screening team was asked to give an overall field assessment in terms of upgrading the project or retaining or downgrading it. Taking into consideration such scores and assessments the selection committee decided to upgrade and give new awards to

- all gold winners to diamond winners,
- four of the former silver winners to gold winners,
- one bronze winner into gold and
- eight bronze winners to silver winners.

One of the silver winners of 1991 was downgraded to bronze. Two ceased to exist in the meantime; their project managers, nevertheless, are still members of the HAMIS Associations and Federation.

Awarding and support

During the site visits and based on discussions with the applicants, the "absorptive capacity" of the projects for award money was estimated. Absorptive capacity took into account a reasonable spending of money which would be realistically undertaken by the project and which would safeguard its basic character as a smaller scale self-help initiative. The award levels for the winners were to reflect grosso modo these capacities with the assumption that the winners might best know how to spend the prize money. This assumption was validated through our assessement of the expenditures of the first batch of winners. Nevertheless, official contracts with the awardees were to try to guarantee that the award is being spent as asked for in the posters, i.e. for strengthening the project or for replicating it elsewhere, and not for anything else.

The prizes ranged between 250.000 Pesos and 50.000 Pesos, i.e. between 3.000 and 10.000 US$. Most were given from GTZ funds, i.e. German tax money granted to the Philippine Government through the German Ministry for Economic Cooperation and Development (BMZ) and its German Agency for Technical Cooperation (GTZ). In 1991, some bronze award winners were given an award through funds of the Philippine Department of Health. Three additional projects were granted special recognition awards from private sponsors. In 1994 the College of Public Health of the University of the Philippines sponsored 22 of the new winners with GTZ borne funds; these winners are working in the catchment areas for the College´s community training efforts.

In ceremonies held in the Presidential Malacañan Palace on June 25, 1991 and June 29, 1994, the gold and silver awards were given to the winners by the President of the Philippines, the Secretary of Health and the HAMIS Project Manager. This national recognition of the projects was considered most important by the winners. The top finalist of 1991 got additional strengthening by building a HAMIS, i.e. a Health and Management Information System around it and in the catchment area. This was first undertaken in Quezon Province and later in Surigao del Norte City. Taking into consideration both peer review scores and site-visit scores, the projects submitted from Quezon province received the highest total score for a non-metropolitan province and the surrounding Region IV had the highest score of all regions of the Philippines. The HAMIS modules which were implemented in Quezon are: diabetes survey, public health and hospital information systems, material and money information systems, representative household survey on health behavior and expenditure, studies on costs and financing of health institutions, intensive briefing on information for decision makers in local governments and health care, regular information-based quality assurance conferences. Starting 1995, a number of other HAMIS winners got the HAMIS information tools to give the best available infostructure to the best health care managers in the Philippines.

Altogether, there are five awards the winners get at the same time:

- national recognition as outstanding showcase of good health care management
- prize money for strengthening and/or replicating the project
- membership in the Federation of the HAMIS Winners, a recognized consultative body for health policy and management
- sharing budgets from the Department of Health allocated for the Federation for replication, dissemination and promotion of good health care management, and
- the use of the HAMIS Federation´s Reassurance Fund in case of emergencies.

Indirect support to the winners is being given by establishing what we call "HAMIS Clubs", i.e. groups of similar projects which might learn from each other, e.g., through newsletters and visits and conferences or lobbying. These Clubs dealt with herbal medicine, community health workers, drug cooperatives, community health care financing and local health insurances. They were strong and smart enough to influence local and even national health policies. They influenced the national agenda on herbal medicine, and the shaping of national bills regarding incentives for community health workers and the national health insurance law. HAMIS Clubs organize already their own meetings, fora and conferences. New HAMIS Clubs are emerging: on water supply, for IECM (information, education, communication and motivation) campaigns, community economics, womens health and so on. All winners were invited to give their training offers and training needs into a databank that helps composing HAMIS Clubs. It will also help to identify trainors and trainees for specific topics. An Academy of the HAMIS Winners of the Philippines is under study.

Mutual bilateral visits among winners already had their impacts in several projects: replicable elements of some are being implemented now in others as e.g. a cooperative extends into health insurance and herbal medicine. The number of HAMIS winners involved in herbal medicine increased from four during the screening of the applications to 20 just 20 months thereafter. This is what we cultivate as "healthy epidemics of infectious good ideas", sometimes even “crazy” ideas. Most of the first batch of HAMIS winners is actually replicating elements of other winners. Some of the winning health management components are being replicated now as national programs: databoards, incentives for volunteer health workers, community drug insurances and water for life projects.

The most powerful networking was initiated by the winners themselves. Winners located in Mindanao, Visayas and the Bicol Region formed a Southern HAMIS Winners Association for Regional Progress and Development (SHARP Dev) while winners in Luzon and the National Capital Region formed the Regional Unification of Northern Winners (RUN-WIN). Both federated in 1993 into the Federation of HAMIS Winners in the Philippines, Inc. with the aim of networking and reinforcing the members, replicating achievements, and disseminating the message of good health care management. The Federation serves as a network for strengthening local centers of managerial excellence and for disseminating the messages on good health care management.

The Department of Health commissioned the Federation of the HAMIS winners to

- draft policy papers on local health care financing, especially regarding the winner´s experiences on community drug insurances, cooperatives, credits and loans, incentives for volunteer health workers, financial indicators in databoards, financial issues of women´s health, etc
- design licensing standards for private hospitals based on the winners experiences with computerized hospital information systems developed by HAMIS
- test a strategy for expanding the HAMIS information tools in two provinces of Luzon to prepare a national strategy for the 19 poorest provinces.

The budgets from the Department of Health were given to make sure that the HAMIS winners can share their knowledge and experiences with other health care managers. In addition to the special project funds mentioned, a regular line item in the budget of the Department of Health includes funds for the operational expenses of the Federation, already. Additionally, a GTZ sponsored Reassurance Fund was build up to maintain, strengthen and/or replicate the projects that were awarded by the HAMIS Contests; for the time being this fund is used solely as reassurance fund for emergencies, since other funds are available for operational expenses.

Performance monitoring of the winners and their award money spending is being supported through a kind of peer review, i.e. through the sharing of experiences with other winners. The diamond winners are now entitled to audit other winners; this power will be expanded to the gold winners, soon. The Northern and the Southern Winners and the Federation convene regularly to get updates on project achievements. Bilateral visits of the winners thereafter transfer monitoring from the HAMIS team to a social control within the winners networks. Economic incentives are in sight: the upgrading of the best of the winners during the next contests and the sharing of a revolving reassurance fund as long as they are accepted to be members of their corporate networks. The existing 120 projects will participate in the selection of the next winners and in a mutual monitoring, which seems to get stricter as time goes by.

Case studies and dissemination of learnings

After the fist contest, in depth analyses of 28 winners and three losers were done by five research groups from universities, i.e. by experts of health economics, health education, sociology, anthropology and social work. The terms of reference of the case studies included

> to explore and analyze factors contributing to a good health care management at local level

> to investigate the role that data and information play for good health care management

> to disseminate the study's findings to health care managers in order to improve health care management elsewhere.

All studies were participatory researches. It helped the winners to understand themselves and it helped to bring the lessons of the winners into colleges and universities. A number of research projects is being carried out under the wings of some winners. The winners are very open for this cooperation with the academe because it can spread the word about good management.

Such insights will be used for spreading the virus of good management as well as for shaping future strategies towards expanding and strengthening good health care management. Health care managers and the public should know about such innovative endeavors to improve health care. The videos and summaries prepared during the selection stage were intensively used for dissemination of the basic ideas. During the second contest campaign the lessons of the gold winners were presented in all posters and flyers. The lessons of all 52 winners were sent by mail to each and every Barangay Health Station in the Philippines, together with the message on the second contest. The willingness to win served as an incentive to use and digest the messages of good health care management - so to disseminate them and to improve health care management. Other means are added, e.g., conferences, visits, newsletters, articles and booklets.

Summary

The launching of a next HAMIS Contests is not scheduled before 1997. The first batch of winners needed three years to get consolidated into networks of good health care managers. Integrating 68 new winners into the southern, the northern and the national networks will take time.

Consolidation will be given priority over expansion. Handling carefully the awarded health policy contracts and participating actively in the national health care agenda is the priority chosen now. Step by step the network of previous and new winners will shape its own future and that of health policy and health law making in the Philippines.

The HAMIS Contests show that there are quite a number of innovative ways of improving effectiveness and efficiency of health care for those in need. They validated our basic idea that a smart competition is a good strategy to discover excellent management. They did not deny our basic instinct that a smooth follow up of such a contest might be helpful to induce social processes of networking towards mutual control, cooperation and achievement. The discovery and networking of so many good health managers is helpful for improving the management of health services in the Philippines.

2. Description of selected HAMIS winners

Looking into some details of the winners may show what good health care management can be under the constraints of every-day work and life in the Philippines and very often quite far away from the center. The projects might give us examples of what to do and hint at further ideas of how to improve effectiveness, efficiency and equity of health care (management) at the grassroots. The winners of the first HAMIS contest give us examples of good health care management and tell us some lessons.

Gold winners of 1991 that received diamond awards in 1994

Manila: Stimulated by an enlightened group of medical students, urban poor in a community of garbage collectors in Manila realized cost sharing through donation of some seed money. This enabled voluntary community health workers to provide some preventive and medical care that was complemented by services of volunteer doctors. Additionally, they collect contributions from families so that they can avail of a 50% discount of the factory prices of drugs when buying prescribed drugs in the cooperative store. Others in the catchment get drugs at prices below retailers price. The contributions are according to family income but not according to family size thus having a progressive risk sharing component. The lesson of this project is that self-organization and cooperation can save money for all in the catchment, not just for the members of the cooperative. Under the name “community drug insurances” this project is now being replicated as a national program in 1.000 local areas all over the Philippines.

Quezon: A voluntary association of diabetic patients in Quezon Province reduces public costs by early discovery (and prevention) of complications through monthly testing and training. It reduces private costs by having reduced drug and consultation fees due to economies of scale and managed care. At the same time social and mental suffering is alleviated through banding together and consoling each other. Membership fees and donations are collected. The lesson of this project is that cooperation brings about private and public savings.

Surigao: A network of mother clubs initiated a comprehensive blend of activities to develop skills among mothers, their families and other individuals in the community to allow them to achieve an acceptable level of health and well-being in a self-reliant way: health care, health education and training in nutrition and food production, environmental sanitation, building of infrastructure, livelihood projects, day care centers, weekly radio program, bargain incentives for mother club members in city stores including drug stores, emergency credit arrangements, scholarships, regular self-evaluation and awarding of good performance, and last not least: diversified fund raising. The lesson of this project is that good health care management should be comprehensive and comprehensiveness, sustainability and expansion is achieved if people understand and share it. One of the components of this project - a databoard in the hands of volunteer health workers - was proclaimed a national program and is being replicated now all over the Philippines by the Department of Health.

Silver winners of 1991 that received gold awards in 1994

Cebu: In and around a small hospital serving mountain areas, a local school of medicine gives medical students field exposure and serves the needs of underserved areas through a diversified program of health care, training of basic health workers, community organization, and income generating activities. By merging university training and health services both get value added.

Hinterlands: In ethnic communities in the hinterlands not reached by government health services, community based child survival and maternal health care is built up during a three year term so to empower the communities and their new health committees to demand basic services even beyond health. Small-scale food and income generating projects are initiated as well. Experience, knowledge and empowerment are thus productive forces in the fight for health.

Laguna: At a university institute, herbal medicine is studied, tested and finally produced and promoted to create an awareness of the importance of easily available plants in the treatment of common ailments, to help establish a scientific basis for the use of plants in medicine, to help provide adequate health care to the poorer sectors of the population and to disseminate information on the proper utilization of medicinal plants. Widely available cheap resources are quality-tested and the knowledge and information thereof disseminated by this project.

Samar: Local herbal medicine is produced and promoted to support primary health care in poor communities and to provide an alternative and sustainable source of complimentary medicine in a difficult to access area. Innovative ways of fund raising, like running a canteen and selling herbal medicine to the better off as well as practice and training in acupressure complement the program. Herewith locally available medical resources - plants for symptomatic cure - are brought to end users and reduce their health expenditure.

Silver Winners in 1991 and 1994

Iloilo: Social work students of a university assist in the empowerment of individuals, groups, and rural communities to participate in their own development via community organization and leadership skills training, cooperative development, community-based health development, women's integrated development program, entrepreneurship development, family wellness. Here again, both get value added.

Manila: Sisters set up a western and oriental medical clinic for depressed urban poor in a squatter area. The tuberculosis program asks participants for copayment and gives them a share in livelihood projects (soap, lanterns, herbal medicine, and candle making) if their health behavior is good. The nutrition program asks mothers to contribute one peso (five cent) per week per child for food and her time for organizing this program and for participating in income-generating projects. There is sewing training and production for jobless adolescents and a consumers cooperative for all. A rather comprehensive social and health care program exemplifies cost and benefit sharing in actual detail and not just in theory.

Pasay: Maternal and child health is a major program component of this health and social center, the service of which starts primarily when a child is still in the mother's womb. The program does not concentrate on curative health care but provides also a broad array of primary and secondary prevention including nutrition, training and empowerment of women. The community development program embraces community organization and housing, livelihood program, small loans through a tie-up with a bank and education. The program centers around the empowerment of mothers as agents of production and change.

Examples of other winners of 1991

Agusan: feeding and maintaining a nutrition center through income generating activities like renting a tricycle
Antique: promotion of entrepreneurship through varied income generating projects and low interest loans from the cooperative to sustain the health program
Bataan: maximizing cultural similarities and social/experiential identification in providing mental health services to Indo-Chinese refugees
Batangas: diversified fund-raising for beautification and improvement of health facilities to attract more patients and to give them better services
Batangas: premium collection for members that can avail of an interest free loan and managed referral in case of illness
Camarines: organizing the community members into teams to tackle the various aspects of malaria control
Cebu: empowering community members to implement and manage own health programs through the training and transfer of skills and technology
Cebu: maintaining a disaster brigade and emergency rescue unit through private and voluntary contributions and linkages with private and professional organizations like radio operators, medical practitioners, etc
Cebu: training and development of competencies of community leaders in health care, supported by income-generating projects to prepare the community for self-sufficiency
Cotabato: training of families, particularly the mothers, in curative health care and "housing" the patients in "community hospitals" manned by volunteers from the community itself
Davao: providing livelihood opportunities to participating families to improve their health, nutrition and socioeconomic status
Iligan: networking and linking with existing organizations already involved in health care delivery, particularly in the systematic and joint use of data and other resources to widen coverage of health care delivery
Iloilo: manufacturing of herbal medicine to provide cheaper alternative sources of medicine for the community
Isabela: socializing health care delivery by identifying indigent families
Isabela: using radio as a means of disseminating information on health issues
La Union: establishment of strong linkage between the Regional Health Office and the community for an effective transfer of management of the barangay water supply
Ilocos: diversified livelihood projects to provide supplemental income to families of members of Family Planning and Mother's Club
Leyte: information drive and data gathering on schistosomiasis by a youth club to support health authorities in the disease's control
Laguna and National Capital Region: case-testing the use of a community-based health maintenance organization as a means of financing community health care
Marinduque: intensification of tuberculosis sweeping operation by community participation
Misamis: maximizing the use of barangay health workers in the implementation of programs of the Department of Health
Mountain Province: undertaking agro-livelihood projects to support delivery of health care
National Capital Region: training and empowerment of women in the provision of health care services to the community, with emphasis on nutrition
National Capital Region: preparing and transforming worker-members to be health care givers among their co-workers by training them on health care and the medical opportunities available to them
Negros: providing training and monetary incentives to barangay health workers to augment inadequate health manpower and to obtain better data and information through them
Negros: training and mobilization of mothers in cross-stitch embroidery to enable them to earn supplemental income during and after rehabilitation of their undernourished children
Pampanga: pooling of resources of private individuals (mostly "cabalen") in establishing funds to provide medical-dental and nutrition services to indigent and the under-served public sector
Quezon: establishment of barangay health station and "paluwagan" among community members for interest-free loans for medical emergencies
Quezon: organizing a health cooperative which will provide for low-interest loans for livelihood projects and medical emergencies to the members
Quezon: outreach medical care in far-flung areas for small consultation fees that are deposited on a savings account in the name of the patients family so that they avail of a loan after surpassing the ceiling allowing them to be members of a nearby cooperative
Romblon: upgrading of the rural health unit to a mini-hospital to provide medical services otherwise not available due to geographical bottlenecks
Samar: developing and directing communities to plan a unified action and wholistic approach on their health care needs and capabilities given available resources in the community and possible linkages

with government and non-government organizations
Samar: buying and ripening of green bananas providing seed money for income generating projects and for basic health workers
Samar: developing community-based programs by linking with professionals and auxiliary professionals for health work support
Sorsogon: improving earning capacity of the community through various income generating projects, the proceeds of which go to a Barangay Health Account that provides for assistance to the health needs of the members
Sorsogon: using a cooperative mill's proceeds to strengthen primary health care
Tacloban: developing community health workers through a community-based and initiated health program heavily underlined by principles of moral commitment
Tawi Tawi: stepping-up the drive against malaria through the introduction of additional and/or alternative technologies

Some features of all HAMIS winners

Good health care management can be found in quite diverse situations:

- in small scale self-help groups as well as in larger scale national programs
- with volunteer health workers as well with governors and regional health directors
- in preventive as well as curative health care
- in horizontal as well as vertical health programs
- in religious as well as in civilian, military or rebel settings
- in governmental as well as in non-governmental organisations
- in City centers as well as in small islands

i.e. everywhere. The common practice of assigning a higher quality to some positions on the scales mentiond seem to be premature. Good health care management is ubiquitous and not that rare.

3. Some findings

The winners of the HAMIS contests reveal some interesting features to be taken care of when trying to understand good management in health care.

First impressions: winners handle resources very carefully

When we started we did not expect to discover many outstanding, interesting and committed projects of good health care management all over the Philippines. This is why each winners idea was very intensively, even emotionally taken into account. Based on this “intake” of their deeds and ideas we somehow thought to discover the “gestalt” of their unique diversity. This is how we understood it, then.

Good management in the way the HAMIS winners show us does not content itself with improving health care with resources that are already on hand and obvious. Good health care management does the right things despite scarcity of resources and immobility of institutions and people, or better: it does not accept the notions of scarcity and immobility but discovers untapped resources and forces to move ahead. It

1 discovers untapped resources in the sense of financial, material, moral and time resources, as for example through innovative ways of fund raising or using herbal plants or converting charity into economics or using the time of mothers of malnourished children,
2 mobilizes human and intellectual resources, as for example via empowerment of mothers and health workers and through better use of knowledge and information,
3 combines existing resource patterns resulting in multiplicative effects, as for example university training and health services or private and public health services or radio stations,
4 reconfirms productivity gains through self-organization and banding together, as for example through patient associations and drug cooperatives.

Good health care management in this sense is the more productive use of otherwise overlooked resources for the benefit of those in need.

This theoretical conclusion stems from another conclusion that is more operational. It is that there are excellent examples for improving health care management just or even in constrained situations of poverty and dependence. We only have to look for them and discover them and give them a chance to come to the fore. And when this is done, social processes and economic incentives might serve as catalysts for disseminating the theoretical findings and for improving health care management in terms of effectiveness, efficiency and equity.

First case studies: some factors of success

Extended case studies on HAMIS winners by four research groups from universities of the Philippines reveal a bit of the processes that turn health care management into quality. We think the findings can be synthesized in the following way.

Good management can be found within a challenging or a supporting context. It can originate within an especially poor array of resources or with good resources at hand. It can start alone and from scratch, or might be reinforced by a wider and broader program, i.e. an institutional network or a comprehensive health and livelihood approach. Community organizations and volunteers can provide a proper back up. Such reinforcement, we see, can stem from many different realities. Nevertheless, the context seems to be not the decisive factor to predict good management. It is rather the human factor. It is the proper personality traits and leadership qualifications of the managers. Leadership means empowerment of partners, staff and target groups. One who excels in clarifying or even simplifying goals and objectives, especially at the earlier stages of a project. One who keeps the processes going on through smooth follow up and motivation. In the Philippines it is women that often play this role of a "guiding star" or "moving spirit" behind good health care management. This - in a nutshell - are the findings of the extended case studies on some of the winners.

What about the role of data and information for good management? Here again, as we saw it also in our analyses on felt needs for information with health care managers it was not the pinpointing at individual data or information requests that we found, or long listings of indicators. Our findings hint at something that deals with realities way beyond data. Yes, data are being needed for good management. And good managers have essential data on population, health status, health care, and its natural and socioeconomic environment. Usually not in computers or on paper, but “at their fingertips”. Insiders like them know already what outsiders have to get through formal or even computerized information systems. This refers especially to smaller projects or catchments. Good managers do not look so much into individual data but into their relationships and into the linkages with concepts behind such data. Such linkages between data,

information, understanding, knowledge and even values and wisdom is a key for good management.

Actual policy issues: community health care financing

Community health care financing is a topic of concern in poor countries. Out of pocket payments of the overwhelmingly poor population and meager national as well as local government budgets are not sufficient to pay for a qualitatively sound basic health care - at least at the commonly experienced levels of handling the available resources. This is why health systems management deserves some priority. This is why the topic of local health care financing is getting political cloud. The Department of Health of the Philippines was very much interested, when the HAMIS Winners formed a HAMIS Winners Club on Health Care Financing. According to our first impressions - as mentioned above - we decided that this is not a closed shop for just some of the winners. All are handling ressources when being involved in the many m´s of management: manpower, material, minutes, markets, motivation, monitoring et cetera. And that money is not the most important, either. Based on the experiences of the winners a handbook and resourcebook on local health care financing are in preparation.

Challenging issues relate for example to the practices of fundraising. There are many sources of funds that can be raised. The HAMIS Contest discovered the following:

- contributions from existing organizations in kind: regular DOH supply, lot provided from local government, materials from private industry, free supply of various materials from different existing organizations
- contributions from existing organizations in cash: grant from foreign donor, local government funds, contribution from PAGCOR, contributions from government agencies, PHC funds, loan from various sources
- contributions in kind: donation of blood, voluntary labour, supply of materials
- special fund raising activities: fund raising for specific projects, town fiesta proceeds, raffles, beauty contest, popularity contest, bingo game, Christmas caroling, benefit dance, cockfighting, collection of empty bottles, collections, paluwagan
- income from entrepreneurial activities: sale of proceeds from the backyard, sale of piglets, sale of fish powder, sale of herbal medicines, lending of assets, patient fees, fee for services, tuition fees, excess of sale over purchases, provident fund, botica fund, interest income of various funds
- income from charity: benefactors contributions, donations from private individuals, voluntary contributions
- income from self-organization: membership fees, cooperative income

The projects tell us the many ways funds can be raised, i.e. possibilities for a diversified cost sharing. This is not only cost sharing by those in need. Our first fact findings hint at the importance of raising other funds wherever available so to be able to spend them for those in need. The lessons we can learn from the field is that there are many sources of funds for a fair cost sharing.

Fund raising is just one topic related to local health care financing. The Department of Health commissioned the Federation of the HAMIS Winners to go into a deeper search of community health care financing and gave us a special budget to prepare policy papers on

- Community Drug Insurances
- Community Cooperatives
- Credits and Loans for Health
- Community Health Fund Raising
- Financial Indicators for Community Health Databoards
- Incentives for Barangay Health Workers
- Women´s Health

A series of clarification and consensus conferences and meetings and gatherings at local, regional and national levels were conducted. In the spirit of trying to discover the pillars of the strength of the winners and in the pride of being able to share insights to other winners inspite of doubts, policy papers were prepared and revised and rewritten. They tried to condense the experiences of some or of a cluster or even all HAMIS Winners in these areas. More than 70 % of the Winners shared their experiences and agreed to the following recommendations all of which are based on extensive and intensive justifications given forward in the policy papers. We mention just the recommendations.

Community health fund raising

- The government should recognize and accredit community-managed health organizaitons as health care providers.
- The purok should be developed as the unit of community-managed health care.
- Fund-raising activities for health should be gender- and culture-sensitive, should be socially acceptable, and should enhance value formation.
- It is recommended that local government units support and include community health programs in their development plans and provide them regular annual budgetary support.
- It is recommended that Congress should allocate funds for community health programs from their Countryside Devlopment Funds.
- A multi-level (from barangay to national) reassurance fund should be made available to community health organizations, so as to ensure their viability and the sustainability.
- Health programs should expand their membership to include, not just mothers and children, but also fathers and the youth.

Community drug insurance

- Community drug insurances (CDI) should be integrated into the National Health Insurance System, instead of dismantlying community-managed programs through bureaucratic corporations.
- The dispensing of essential drugs, including antibiotics, by properly trained and accredited community health workers (CHWs) should be legalized.
- A multi-level reassurance fund should be maintained to ensure the viability and sustainability of CDIs.
- There should be support for a reasonable expansion of the program into other benefit packages beyond essential drugs.
- There should be legislation for a comprehensive and multi-multi-aspect training of CHWs nationwide.
- CDI should be included as one of the services of multi-purpose cooperatives.
- Community savings could be increased by at least three strategies that will be incorporated into the set-up of CDIs:
- A Family Health Program in which at least one member is trained to be responsible for the health of the family would ensure that the use of drugs would be prevented or minimized altogether.
- CHWs should be given the information, knowledge, and understanding for handling the most common diseases in that require antibiotics, like ARI.

- CDIs could contract with healthcare institutions or physicians to provide health care for its members at a reasonable cost.

Community cooperatives

- The people's access to health information and health care financing (HCF) is a prime responsibility of the state.
- The state recognizes, protects, and promotes cooperativism in the mainstream of society as a vehicle towards social and economic progress.
- In the issue of implementing social health insurance, the state shall recognize cooperatives as an implementing arm of the current National Health Insurance Bill.
- Options must be set for alternative systems of monitoring and evaluation of HCF.
- Community-organizing should focus on cooperative principles and other reelevant provisions relative to the policies of the Cooperative Development Authority.
- A trainors' pool among NGOs should be organized and accredited with CDA to enrich their experiences.
- Authorization should be given to community cooperatives to collect premium contributions of the community to the National Health Insurance Program.

Healthy credits and loans

- The prioritization of the prevention of diseases and the promotion of health should obviate the need for credits and loans.
- Credits and loans should be linked to health-promoting behavior, e.g., immunization, and to discourage unhealthy behavior, e.g., smoking.
- A reassurance fund needs to be created to backstop HCF organizations whose members experience epidemics, disasters or catastropic illnesses.
- Soft credits and loans should be provided for health emergencies, using improved future health behavior as collateral.
- Credits and loans should be provided for the income-generation projects of people's organizations' with health agendas.
- Both the government and the community should share in the funding of credits and loans.

Incentives for volunteer health workers

- Barangay Primary Health Care Committees (BPHCC) should be organized or re-activated in every barangay. This committee shall select qualified BHWs from nominees submitted by the households.
- BHWs shall be federated in all levels from the barangay to the national level.
- The presidents of the federated BHWs shall sit in their respective local health boards.
- BHWs shall be guided by DOH standards for their roles, responsibilities, and training. However, they shall remain independent with regard to their structure and schedules.
- Support packages for the BHWs can come from:
  - the community--discounts in stores, fund-raising activities, community health insurance, and out-of-pocket donations
  - the government
  - training and sickness benefits from the DOH
  - soft loans, IGPs, skills development from other GOs
  - honorarium, health insurance, free legal services, logistics, etc. from LGUs

Financial indicators for community health databoards

- All existing health databoards of communities should include financial indicators.
- The content and mixture of these indicators should be determined by the community itself, with guidance from trainors.
- Aside from health and financial indicators, other social indicators that constitute the most basic needs (MBN), e.g., community participation, housing, sustainable livelihood, literacy and psycho-social development, peace and order, and disability, can also be included.

Women's health

- A center for women should be established in every municipality. This center will address psychological physical, socio-economic, and moral concerns of women in crisis situations.
- Awareness and literacy training and information campaigns should be provided to the women themselves at all ages as well as to the community at large.
- Health financing schemes should provide for programs addressing to the specific health needs of women.
- Women's welfare should be expanded towards emotional and psychological health and well-being by preventive and rehabilitative interventions, not only by professionals but also by women peers.
- The real issues, the needs, and the problems of women today should be the basis for plans and proposals for women's programs and for legislation in the country.

For sure, some of these recommendations are nothing new for health policy makers. Others might sound very general and emphatic. Yet, there is some strength behind them. They are shared by managers from all Philippine regions, from many sectors of health care management; and all these winners will try to influence their local policy makers and their national representatives as well. Two of these sets of recommendations had already impact on the law making: the incentives for the volunteer health workers and the recommendations regarding to social health insurance.

A longer term concern: Towards social health insurance

At the end of 1993, a bill on a national health insurance program was tabled for final discussion in the Department of Health. Health insurance is one of the cornerstones of the present administrations social reform agenda. A HAMIS Winners Club on Social Health Insurance was organized to make sure that the National Health Insurance would turn into a Social Health Insurance. This seemed to be necessary since the first reading of the first draft of the bill was somehow shocking for the winners. It appeared as if a new gigantic bureaucratic corporation would dismantle all existing community organizations and that local governments and existing health services would take it over. The Federation wrote its first policy paper and hammered it through several consultations and senate hearings until some modifications were given to the law, based on the following arguments.

“For the time being,“ - this is how the Federation formulated it - “health insurances can not be built upon the Philippine´s existing health services and the existing local government units. They have to be based on community organizations from the basic community units nationwide for the very reasons that:

1. Local Governments are neither ready nor properly prepared to support a national health insurance scheme.
   a. On one hand, local governments are not yet people-oriented; they have few mechanisms to respond properly to the needs of the communities. On the other hand, people are still passive and not yet empowered to influence local governments in their policy making. Education and conscientization of the majority of the population have not been undertaken so far. Mechanisms are needed in order that people's expression of their needs for effective services may be heard and transferred into actions. They are not yet in place.
   b. A comprehensive health orientation of local governments is still lacking or not yet palpable. Local government executives are not yet supportive of the preventive and promotive aspects of health care. Health care is often equated only to the curative aspects of it. A genuine interest in Primary Health Care - people's participation and services being accessible, adequate, efficient, affordable, acceptable and sustainable - can not be assumed.
   c. Local governments very often have very low interest and regard for people and communities in the periphery. Their interests are concentrated onto the centers of power and population which is often in the capital towns or cities. It results in low or no access to communities in the same way that communities have low or no access to local governments. The same holds true for government personnel and programs. The national government health services are also often not visible in the periphery where health care is most needed.

   Therefore, presently, not all LGU's can provide the necessary mechanisms to build up local health insurance organizations. They lack the capability and functional infrastructure to do this. Many LGU's still need the necessary preparation to participate fully and effectively in this undertaking.

2. Health services at local levels are not yet effective, efficient and equitable nor are they appropriate and accessible. At present, they provide a very weak matrix for building up health insurance organizations for all Filipinos.

“The development of health organizations should start from already existing people's initiatives; it should not be imposed by government. Imposing health care policy such as the draft of this health insurance bill normally elicits people's participation out of fear rather than out of interest and genuine concern for the common good. Health care policies ought to be developed with the active participation of people's organizations and communities. Trust and credibility are important elements in developing health insurance organizations. Imposition of laws and bills and bureaucracies does not ensure its viability. Community organizations represent the interest of the people. LGU's and other formal organizations often do not. Too often, they are entrenched in bureaucracy and foster dependency rather than equity and sustainability.”

The HAMIS Winners Club on Social Health Insurance continued its first policy paper by alluding to existing examples of affordable and accessible health assurances or insurances at the community levels: “There are already quite a few existing community organizations that are providing health services in an integrated way, i.e. have developed preventive, promotive, curative (primary, secondary, tertiary) and rehabilitative services. Many of them have already incorporated health insurances, emergency health funds and loan arrangements for catastrophic emergencies. These can be found all over the Philippines. Some of the examples are:

- Batangas Province: Premium collection for members that can avail of an interest free loans and managed referral in case of illness. The premium is 12 Pesos a year per family.

- Bukidnon Province and in other areas: Medical ambassadors organize people to support their own primary health care clinic (manned by barangay health workers) and boticas sa barangay. A barangay health committee manages the program.

- Butuan City: Loans with low interests are given to families with good health behaviour, i.e., complete immunizations, safe family planning, school enrolment. Thus health behaviour is thus the collateral for being creditworthy and not the material wealth of a family.

- Cebu Province: Kauswagen Community Health and Social Development Center is a shool-based primary health care project including a strong livelihood support with the following components: community organizing, health services, students community exposure, training of volunteer health workers, income generating projects. Some support for health care is available for members of the Barangay Livelihood Association.

- Lucena City: A community based cooperative - Mount Carmel - offering low interest loans on livelihood and providential needs of members. Cooperative health emergency assistance program (CHEAP) is extended as hospitalization assistance upon paying 55 Pesos annual dues. Also provides continuous education to its membership on cooperatives.

- Lucena City: A voluntary association of diabetic patients provides and incorporates a health insurance scheme called "LDPA DAMAYAN" to help members shoulder some economic difficulties on their health. An annual premium of 100 Pesos covers the member for death, hospitalization and disability benefit. The association also provides services in the preventive, curative, informative and rehabilitative aspects of the disease - diabetes mellitus.

- Quezon Province: Establishment of barangay health worker station and "paluwagan" among community members for interest-free loans for medical emergencies. The contributions are even less than 10 Pesos.

- Quezon Province: Outreach medical care in far-flung areas for small consultation fees that are deposited on a savings account in the name of the patients family so that they avail of a loan after surpassing the ceiling that allows them to be members of a nearby cooperative. The consultation fee is 10 Pesos per case.

- Surigao City: 10% of the proceeds of income generating projects are channeled into a health fund for covering emergency expenses in case of illness free or at least interest free. This is just one component of a wide ranging set of preventive, promotive primary health care activities that are in the hands of a federation of mother clubs in the many island barangays and the mainland. Mortuary

funds are another component of this incarnation of the real meaning of community health.

> Tawi Tawi Province: Premium collection from members of a health club who have to use preventive care to be entitled to get free or at least interest free managed curative health care. The premium is 10 Pesos a month per family.

> Tondo in Manila: Stimulated by an enlightened group of medical students, urban poor in a community of garbage collectors in Manila realized cost sharing through donation of some seed money. This enabled voluntary community health workers to provide some preventive and medical care that was complemented by services of volunteer doctors. Additionally, they collect a contribution of 10 Pesos per month from families so that they can avail of a 50% discount of the factory prices when buying prescribed drugs in the cooperative store. Others in the catchment area get drugs at prices below retailers price. The contributions are according to family income but not according to family size thus having a progressive component of risk sharing. The lesson of this project is that self-organization and cooperation can save money for not just for the members of the cooperative but for all in the catch-ment."

What followed was a complete listing of the 52 HAMIS Winners of 1991. The policy paper concludes: "What are the preliminary lessons for health insurances? There should be distinguished three valid starting points that could be used as strong pillars for a social health insurances.

> Community Loans: Very often, the need for borrowing money starts with the event of severe illness, needing cash to purchase very expensive drugs, or spend it for travel expenses to transport a patient to the hospital. Community loans offer an alternative for the poor to avoid one of the most persistent evils of society: the continuous impoverishment of the poor resulting from loans provided by profit-hungry neighbors and pawn shops.

> Community Cooperatives: These are efforts to pool together community resources to serve the needs of the group rather than the individuals. These cooperatives could be for mothers, fathers, patients, children or any other group with a certain cohesiveness and social control over the use of their resources. They could also be cooperatives of barangay health workers together with the hospital staff and the communities they serve.

> Community Insurances: Communities have a feel of what affordability means for them. Benefit packages are tailored to their needs and therefore assuring their relevance and effectiveness. In one area this might mean P50.00 from each member for a family if the breadwinner dies; in another it might mean managed care and interest-free credits; still in another, it might mean cash money for the boat fare to the next hospital and back.

"There seems to be a magic ceiling for loans repayment and cooperative premiums and health insurances for the poor. Ten Pesos a month is an affordable and acceptable level. It does not cover all expenses but it covers essential needs. It assures the poor that they need not fall into the hands of private pawnshops or profit hungry usurers. It is basically a cooperative activity of concerned citizens for getting interest-free or at least very soft loans for their health care. Is this a model for Medicare 2? Let us call it Medicare 10 for short. The allegory is that there are many Medicares, not just one or two or three.

"Indeed, they do have different coverages, benefit packages, target groups, philosophies and approaches. This reflects the creative ways of communities conceive innovative approaches to health care according to the prevailing circumstances and characteristics of the communities as well as the paying capability of the participating groups - reflecting the spirit of Alma Ata. This creative variety of innovative and responsive approaches has to be encouraged, strengthened, maintained and used as a backbone for a health insurance for all Filipinos. It is an authentic response to the needs of the Filipino people and not patterned after fashionable ideas abroad. It is conceived and developed in the Philippines.

"Community organizations as such have to be harnessed because government can not shoulder to do it alone. There is such a rich reservoir of creativity and talents in such organizations. Any other solutions will be less effective, less efficient and less equity-oriented. Significant number of needy populations are covered by such community organizations.

"According to the draft of the proposed bill such organizations at community levels will be dismantled for two reasons: first, local health insurance organizations will be set-up at the levels of local governments and will disrupt larger scale non-governmental and community organizations, e.g., Medical Ambassadors of the Philippines, community drug insurances, etc. The health insurance bill would split such organizations into non-viable units since it does not foresee national federations or associations of such types of insurances. Second, the proposed bill does not allow benefit packages that are limited to one aspect only, e.g., drugs, emergency cash, preventive activities, etc. These community initiatives will be taken over by larger, more powerful and profit-oriented systems."

Quite in detail some obstacles of and experiences with the existing health insurances in the Philippines where listed, especially those that deal with its prepayment character, its low ceilings for paying for hospital care and the exclusion of catastrophic illnesses. "Endeavors of health insurances in the Philippines thus far have been examples of lack of concern, effectiveness, efficiency and equity. They cater to the well-off and they are in favor of partial curative services. Thus, they have not improved the health status of the majority of population especially those in poverty. They often thrive on double payments through premiums and direct out-of-pockets payments. They are insurances for the providers rather than for those who are in need of the health service. There are many examples of inefficient management of the existing health insurances." This is just the listing of concerns:

- The problem of overuse
- The problem of misuse
- The problem of abuse
- The problem of fake and ghost patient
- The problem of non-representation
- The problem of inaccessibility
- The problem of the rights of the consumers
- The red tape problem
- The problem of lack of check and balances
- The problem of indigents
- The problem of disabled and mental health patients
- The problem of the chronically ill and the elderly
- The problem of self-employed and the unemployed
- The problem of ceilings and severe illness
- The problem of profits
- The problem of investments

- The problem of corporational omnipotence.

“These 17 points mentioned above revolve around bureaucratic inefficiencies that we see in existing organizations pretending to be health insurances for the people. Such inefficiencies have to be tackled before a new health insurance can be built up. We know that many of such insufficiencies would not occur if there is a competent and competitive cooperation between community organizations and other institutions that understand "social" health insurance as a social policy based on a newly found trust and credibility. It has to be a network of lean and clean organizations rather than one all-encompassing corporation.

“We recommend a step-by-step approach to build up a social health insurance system. This is not an effort to delay any kind of initiatives. It is an effort to make them stronger and to learn from our achievements. Our achievements have undergone a long process of trial and error. We are willing to share our experiences to build up a social health insurance that is not just for the officials and the workers but for all Filipinos, i.e., for the self-employed, the unemployed, the fishermen in the remote islands, the farmers in far-flung areas, the chronically ill and mentally retarded. This is why we choose to call it social health insurance and not just health insurance.” These are the steps:

- a series of public hearings, consultations, conferences
- a better understanding of the shortcoming of Medicare
- an orientation of Local Government Units
- the development of proper accreditation standards
- consultation processes on benefits, premiums, definitions
- pilot testing of different models
- review and improvement of existing public and private health services
- on-going phasing and review of implementation
- assessment of organizational alternatives

Many of these recommendations are being implemented now to prepare for a proper implemetation of the Health Insurances Bill that was signed into law on Valentines Day 1995. At the same day the Bukidnon Province Health Insurance Project turned two years old and the Community Drug Insurances Project turned six years old, i.e. the one that was discovered by the HAMIS Contest in 1991. These seem to be the three pillars of the future health insurance in the Philippines:

- a national corporation,
- provincial experiments and testings,
- community based projects and programs.

Consultations are going on now. The Implementing Rules and Regulations for the Law benefit from discussions among the different layers of social insurance. And the Law forsees, that it might take 15 years to cover the Philippines. The Federation of the HAMIS Winners will surely be in partnership with this development towards a more effective, efficient and equitable health care system.

4. Conclusion

Textbooks on health care management are full of parameters of quality. When we started to strengthen the Health and Management Information System in the Philippines we nevertheless decided not to teach such textbook lessons. We opted for listening first and discovering good health care management and to convert a few of such cases into showcases.

When we did our first national HAMIS Contest in 1991 we did not expect that we had to award 52 projects and programs from all over the Philippines and representing all subsectors of health care. We discovered them as untapped resources and then we learned from them to mobilize the available resources, to combine them and to get productivity gains through self-organization and banding together. The Federation of the HAMIS Winners learned these lessons from the individual winners and turned them into social processes. A second HAMIS Contest was done in 1994 and enlarged the network of the HAMIS Winners to 120 fighters for excellent health care management. This network gained productivity by banding together. Some of the winners ideas are now not only being replicated in the other winning projects but were already declared to be national programs, endorsed and supported by the Department of Health. The Federation is a consultative body of the Department and has its office in the Department and a budget from the Department. Grass-root managers turned to be advisors for national health policies and health law making in the name of the six basic HAMIS criteria: quality, innovativeness and sustainability to achieve effectiveness, efficiency, equity.

We conclude that good health care management is the more productive use of otherwise overlooked resources for the benefit of those in need. One of the most often overlooked resource are the good health care managers at the grass-roots or in far flung areas. To discover them and to bring them to the fore is a productive use of these resources. To combine them and to band them together and to give them the chance to influence health policies and law making is another way to use the available resources more productively and to sustain them. The health administration listens and learns from the winners. Thus, the real winners and beneficiaries are the Filipinos in need for improved health and health care.

This is a partial reprint of pages 24-75, 92-99 and 630-633 of the following book: Detlef Schwefel, Emma Palazo (Eds.): The Federation of the HAMIS Winners in the Philippines. Manila (HAMIS at the Department of Health: Popular Paper No. 3) 1995, 636 pages
In 1997 a further contest added 40 new winners to the HAMIS network of altogether 160 organizations.

The HAMIS Screening Criteria

Descriptive screening criteria (facts and figures)

[] services, programs, activities
[] beneficiaries
[] benefits, objectives, strategies
[] full-time personnel (paid by project)
[] part-time personnel (paid by project)
[] volunteers
[] facilities & equipment
[] sources of funds
[] total expenditure
[] total overhead (for administration)
[] total income
[] beneficiaries contributing
[] other aspects

Special screening criteria

Quality

[] has clear objectives
[] identifies target groups
[] identifies properly the needs for target groups
[] has clear focus
[] acceptable standards are maintained
[] is appropriate to peculiar economic character of the area
[] is appropriate to peculiar social character of the area
[] has clear program for implementation consistent with set objectives
[] has potential as an instrument for social change

Innovativeness / Uniqueness

[] uses no conventional, common and routine procedures
[] uses no conventional procedure vis-à-vis community mobilization
[] uses no conventional procedure vis-à-vis fund/resource generation
[] uses no conventional procedure vis-à-vis delivery of services
[] uses no conventional procedure vis-à-vis info dissemination/education
[] uses no conventional procedure vis-à-vis training
[] uses no conventional procedure vis-à-vis project evaluation
[] explores non-routinary means of supporting health services
[] utilizes resources or capacity available in the area but not fully considered before
[] introduces new initiatives for health and health care

Effectiveness

[] improves health status
[] improves health care delivery
[] produces better health attitudes
[] includes aspects of quality of life
[] achieves an acceptable goals achievement
[] mainly goal oriented activities undertaken
[] does not provide incentive for curative services alone

Equity

[] deals with those in need
[] deals with vulnerable population
[] deals with underprivileged or marginal population
[] gives services especially to target beneficiaries
[] considers felt need of population
[] improves accessibility of health care
[] implies willingness of beneficiaries to participate and share
[] stimulates risk and cost sharing across the sick and the healthy
[] introduces concept of risk sharing

[] encourages individual action for collective good
[] stimulates participatory behaviour
[] stimulates active participation of the poor

Efficiency

[] focuses on managerial practices beyond expectations
[] focuses explicitly on managing well financial issues
[] focuses explicitly on cooperating with local governments
[] promotes improved productivity of services
[] uses appropriate technology
[] uses appropriate management style
[] involves minimal overhead only
[] brings in resources hitherto not available for health (e.g., from university, other agencies)
[] raises funds from untapped sources
[] utilizes community resources
[] accepts flexibility in the use of resources raised
[] drives at cost containment

Sustainability

[] is initiated from own resources
[] is appropriate and responsive to local social and economic conditions
[] avoids dole-out mentality
[] promotes self reliance
[] increases community confidence to take active role
[] encourages greater community commitment to improved health status
[] discourages (complete) dependence on government
[] seems to be easily replicable
[] strong engagement of core group
[] has supportive leadership available
[] is not dependent on one personality as leader
[] is not dependent on outside financial support
[] had no foreign involvement yet
[] is supported by health services
[] has no need of continous outside support
[] exibits transsectoral character
[] combines public and private sector
[] is build around other concerns (religion, university, etc.)
[] implies continuity of resources generated
[] is not designed for raising funds for organization only
[] has committed leadership available
[] is taking into consideration value formation
[] is taking into consideration ecological aspects

Additional Screening Criteria for first HAMIS Winners

Impacts

[] Impressive changes of facts and figures?
[] Replication of project idea done? How often?
[] Expansion into new project components?
[] Learning lessons from other winners?
[] Impact on local policies?
[] Impact on national policies?
[] Improvement of quality and IEEES indicators, quantitatively?
[] Actively participating in HAMIS activities, quantitatively?

Award money management

[] Date of receiving the award money
[] General objective and purposes to spend the award money
[] Itemized use of award money
[] All award money spent?
[] All official receipts & supporting documents available?
[] All expenditures reported to organization?
[] Expenditure was really done?
[] Is there internal auditing and control?
[] Regularity of financial reporting?
[] Timeliness of expenses?
[] Exemplary participation in decision making on spending?

[] Expenditures aimed at sustainability?
[] Expenditure justifiable for strengthening the project?
[] Expenditure justifiable for replicating the project?
[] Overall pattern of expenditure considered to be excellent?

Summary Assessment Scores of Old HAMIS Winners (1-7 scores)

[] Score on quality, etc
[] Score on award money spending
[] Active replication of project idea
[] Expansion of project components
[] Help given to other winners
[] Participation in HAMIS activities
[] Impact on local and national policies

WINNERS OF THE FIRST HAMIS CONTEST 1991

		Peer Score (0-24)	Visit Score (0-59)	Award Pesos
HAMIS Gold Winners				
1-054 Diabetic Patients Association, Lucena		23	51	250,000
1-050 Botika Binhi, Manila		23	56	250,000
1-069 Mothers Club for PHC, Surigao		15	58	250,000
HAMIS Silver Winners				
1-021 Medical Ambassadors, 21 Sites		23	54	100,000
1-051 University's Outreach, Iloilo		15	56	100,000
1-061 Health and Social Center, Manila		13	46	100,000
1-077 Radio for Health, Quezon City		13	48	100,000
1-081 Doctors' Community Health, Cebu		18	58	100,000
1-082 Herbal Medicine, Samar		19	43	100,000
1-084 Community Health as a Mission, Pasay		15	47	100,000
1-097 Medicinal Plants, Laguna		23	55	100,000
HAMIS Bronze Winners				
1-005 Herbal Medicines, Iloilo		14	44	50,000
1-007 Redemptorist Health, Tacloban		15	40	50,000
1-016 BHS Beautification, Batangas		15	48	50,000
1-020 Malnutrition and Embroidery, Negros		14	51	50,000
1-029 Alternative Malaria Control, Tawi-Tawi		19	43	50,000
1-030 Health Insurance, Batangas		21	53	50,000
1-070 Multipurpose Charity, Quezon		16	41	50,000
1-042 Water for PHC, La Union		17	51	50,000
1-044 Integrated Development, Pampanga	15	42	50,000	
1-052 BHW Health Stations, Quezon		13	45	50,000
1-053 TB Program, Marinduque		22	41	50,000
1-055 Basic Health Care, Cebu		21	50	50,000
1-063 Family Welfare Program, Antique		10	41	50,000
1-064 Malaria and Vector Control, Camarines		16	46	50,000
1-067 Motherclubs and PHC, Ilocos		14	42	50,000
1-076 Barangay Disaster Brigade, Cebu		21	45	50,000
1-078 Youth Group and Health, Leyte		7	46	50,000
1-101 Barangay Health Workers, Misamis	16	47	50,000	
DOH Recognition Winners	Peer	Visit Score	Award Score	Pesos
1-001 Health Insurance, Quezon City/ Laguna		23	26	50,000
1-004 Student Induced Self-Help, Cebu		14	25	50,000
1-012 Mini Hospital, Romblon		14	30	50,000
1-014 Masterlisting, Negros	13	35	50,000	
1-018 Neighborhood House Care, Cotabato		21	32	50,000
1-027 Hospital Networking, Iligan		12	40	50,000
1-028 Health Banking, Sorsogon		21	40	not replic.
1-031 Community Empowerment, Samar		22	38	50,000

1-034 Workers Health, Philippines		21	21	50,000
1-043 Nutrition and MCH, Davao		9	37	50,000
1-046 Health Campaign on the Air, Isabela		14	38	50,000
1-048 Health Financing Cooperative, Sorsogon		24	37	50,000
1-065 BHW Association for PHC, Samar		8	41	50,000
1-041 Saving for Health, Quezon		20	24	50,000
1-072 Nutrition Information, Manila		23	28	50,000
1-080 Indigency Program, Isabela		9	39	50,000
1-085 Refugees Mental Health, Bataan		21	34	50,000
1-092 Improved Rural Health Unit, Romblon		10	35	50,000
1-099 Community Health Program, Samar	19	35	50,000	
1-100 Ladies Association, Mountain Province		13	35	50,000

Other Recognition Awards	Sponsor	Peer Score	Visit Score	Award Pesos
1-006 PHC for Mental Health, Bulacan	Klein-Lange	16	31	31,000
1-009 Nutrition Village, Agusan	Schwartz	18	28	31,000
1-025 Private & Public Health, Negros	Schering	19	28	30,000

ALL HAMIS WINNERS (OF CONTESTS I AND II) ACCORDING TO AWARDS

HAMIS Diamond Winners

1-050 Botika Binhi, Manila
1-054 Lucena Diabetic Patients Association, Lucena City
1-069 Federated PHC Mothers' Club, Surigao City

HAMIS Gold Winners

1-016 Kumilos Para sa Kalusugan at Kaunlaran
1-021 Medical Ambassadors of the Philippines, Inc. + 21 sites
1-081 Cebu Kauswagan Health Resource Distribution Program
1-082 Community-based Herbal Medicine Project, Samar
1-097 Outreach Program - Medical Plants for PHC, Laguna
2-022 Barangay Balubal Health Station & Lying-in Center, Quezon
2-037 Re-orientation Program of the Holy Family Hospital, Tawi-Tawi
2-135 Balilihan Countryside Action Program (CAP), Bohol

HAMIS Silver Winners

1-018 Kapitbahayan, Midsayap, Cotabato
1-042 Water For Life, La Union
1-051 Community-based Health Care Program, Iloilo
1-061 Canossa Health and Social Action Center, Tondo
1-064 Malaria Surveillance and Vector Control Project, Camarines Norte
1-065 Pahinog Costa Project, Northern Samar
1-076 Emergency Disaster Brigade, Cebu City
1-080 LGU Indigency Program, San Mateo
1-092 Improved Rural Health Unit, Romblon
1-084 Bukas Palad, Pasay
1-100 Camatagan Ladies Association, Mt. Province
2-031 Leprosy Control Project, Nueva Vizcaya
2-101 Tagbitan-ag Women's Organization, Davao del Norte
2-102 Hilongos' Integrated Nutrition Program, Leyte
2-133 The Calatrava Municipal Health Board, Romblon
2-148 Stop AIDS Campaign, Manila
2-149 Child to Child Health Education Program, Lucena City
2-151 Kalusugan Pamayanang Programa ng Katiwala at Katuwang, Cavite

HAMIS Bronze Winners

1-001 HEWSPECS' Community-based HMO, Diliman and Binan
1-004 Health Resource Distribution, Cebu

1-005 Manufacture of Herbal Medicine, Iloilo
1-006 Family Care Program for Patients with Long-term Illness, Bulacan
1-007 MAKAPAWA Community Health Program, Tacloban
1-009 Provincial Nutrition Village, Agusan del Sur
1-012 Improvement of Sta. Fe RHU, Romblon
1-014 BHW Masterlister, Negros Oriental
1-020 Cottage Industry for Mothers of Malnourished Children, San Carlos City
1-025 Public-private Health, Negros Occidental
1-027 Health Promotion for the Urban Poor, Iligan City
1-028 Health Banking & Development, Sorsogon
1-029 Alternative Malaria Control Project, Tawi-Tawi
1-030 Operasyong Tulungan Pamilya, Batangas
1-031 Health Empowerment Rural Based Foundation (HERB), Samar
1-034 MASIKAP - Workers' Health Program, NCR/General Santos City
1-041 People's Adoption to Total Health Sufficiency, Lucena
1-043 Archdiocesan Nutrition Program on MCH, Davao City
1-044 Medical-Dental Nutrition Assistance Project, Pampanga
1-046 Health Care Campaign on the Air, Isabela
1-048 Health Financing by Cooperative
1-052 BHW Health Stations, Tagkawayan Quezon
1-053 TB Sweeping Operation, Marinduque
1-055 NORFIL's Basic Health Care Service, Cebu
1-063 Family Welfare Program, Antique
1-067 Puericulture Center Family Planning & Mothers' Club, Pagudpod, Ilocos Norte
1-070 Cooperative Health Emergency Assistance Program, Lucena
1-072 Information Nutrition Action Program, NCR
1-077 FRB's Radio for Health, Q.C.
1-078 Kadang Youth Group and Health, Leyte
1-085 Refugees Mental Health, Bataan
1-099 Community-based Health Program, Samar
1-101 BHW Mobilization, Cagayan de Oro City
2-002 Holistic Development of Talispungo, Marugundon, Cavite
2-007 Community Primary Hospital, Dumaguete City
2-008 SAMAPA for Mt. Pinatubo Victims and Pioneer Settlers, Occ. Mindoro
2-015 Yakan Integrated Resources Development Program, Basilan
2-016 Silago Multi-purpose Cooperative, Southern Leyte
2-017 Primary Health Care (PHC) Mothers' Club of Mainit, Surigao del Norte
2-018 Institute of Community Health Development Project, Quezon City
2-019 Purok Health Care Management and Delivery System, Bohol
2-024 Health Care Opportunities for Economic Success Program, Lucena City
2-028 Health Scouts, Bontoc
2-029 Kalahan Health Program, Nueva Vizcaya
2-032 OSF Assistance Community Center
2-034 Village Health Workers' Training Program, Sultan Kudarat
2-041 Community Health Education and Promotion, Zamboanga del Norte
2-042 Partnership Mechanism on Basic Health Care Program, Davao
2-045 Intensive Rehabilitation of Severely Malnourished Children, Quezon City
2-046 Kapatirang Tulungan ng mga Diabetiko sa Malolos, Bulacan
2-049 Eastern Besao Deanery Episcopal Church Women Federation, Inc., Mountain Province
2-050 Day Care Service, Lucena City
2-055 Kapatiran ng mga may Kapansanan sa Buhay, Inc., Lucena
2-057 Urban Family Development Program, Quezon City
2-058 2 Peso A-Day Hospitalization Plan, Iligan City
2-061 TB Control Program, Davao City
2-062 Capalangan Kiddie Care, Pampanga
2-063 Mobile Surgery, Tagum, Davao del Norte
2-064 Communal Garden, Capiz
2-065 Integrated Community Development, Abra
2-070 PHC Delivery Program, General Santos City
2-071 Drop-In Center for the Mentally-Ill and the Drug Dependent, Agusan del Norte
2-072 Pediatric Dentistry Division, Quezon City
2-073 Handog sa Mahihirap, Butuan
2-074 Mass Immunization of Hepatitis B Vaccine for Indigent Newborns, Lapu-Lapu City
2-080 Linabo Parish, Bukidnon
2-081 Community Participation in the TB Control Program, Albay
2-084 Medical Outreach Mission Foundation, Inc., Baguio City
2-085 Tribal Women's Health Project, Lake Sebu, South Cotabato
2-089 Comprehensive Health Development Project, Magallanes, Cavite
2-093 Philippine Band of Mercy, Inc. Northern Mindanao
2-094 Siuton PHC Project, Sorsogon
2-103 Purok Health Data Board, Bukidnon
2-105 Botika Kooperatiba Kang Antique
2-106 Federation of BHW's, Surigao del Norte
2-108 Lying-In Clinic, Negros Occidental

2-110	Community Health Financing Project, Catanduanes
2-111	Damayan Social Fund, Lucena
2-112	Sacsac PHC Project, Dumaguete
2-115	La Sallete PAMANA Foundation, Inc.
2-127	Integrated Community Family Welfare Program, Benguet
2-128	Health Education in Primary Health Care, Bulacan
2-131	Healthy Transport Cooperative (LJODA), Lucena City
2-134	Self-help Rehabilitation of Barangay Gaub Health Station, Iloilo
2-136	PHC Through Health Human Resources Development, Cagayan de Oro
2-139	Bayanihan sa Kaunlaran ng Sambayanan Cooperative, Caloocan City
2-142	Quezon Women's League, Inc., Lucena
2-146	Training Program for Diabetes Nurse Educators, Quezon City
2-150	VIBES, Inc., Manila
2-155	Siaton District Hospital Cooperative Health Care Project, Negros Oriental
2-157	Zero Waste Management, Bulacan
2-158	Kalumbayan Community Primary Hospital, Negros Oriental

Activities of the Federation of HAMIS Winners

June 1991 - June 1995

Venue	Date	Activities	Purpose / Output
Malacañan	June 24-26, 1991	First HAMIS Winners Convention	Awarding the First HAMIS Winners and sharing of experiences
Manila	March 15-17, 1992	Planning Workshop of the Northern HAMIS Winners	By-laws of the RUNWIN (Regional Unification of Northern HAMIS Winners)
Manila	June 19-20, 1992	Meeting of Northern HAMIS Winners	Follow-up of Winners by HAMIS, Sharing experiences, networking
Initao	June 19-20, 1992	First Meeting of the Southern Winners in Misamis Oriental	Follow-up of Winners by HAMIS, Sharing experiences, networking
Initao	August 3-7, 1992	LGOs Briefing on Health and Healthcare Management	LGOs commitment on quality healthcare and resources
Surigao	November 23-27, 1992	First HAMIS Winners Club Meeting	Herbal Medicine: Winners, DOH, Plant Managers
Cebu	January 15, 1993	SHARP Midway Conference	3 of “23 in 93”: herbal medicine, data board, incentives for BHWs
Tondo	March 3-5, 1993	BHW Club Meeting at Canossa, Tondo	Drafting of proposal for incentives of BHWs; commenting a bill
Cebu	March 24-28, 93	Herbal Medicine Training	Manual on Herbal Training
Manila	April 12, 1993	Meeting with IIRR	Winners Resource Book on Community Health Care Financing
Silang	June 23-26, 1993	Second National Convention, Launching of Second Contest, Conference on Community Health Financing at IIRR	Presentation of HAMIS Winners Projects with components of CHCF: community cooperatives, credits and loans, alternative fund raising, indigency program
Siaton	November 8-9, 1993	Halth in the Hands of the People, Negros Oriental	Health financing schemes and health insurance awareness
Santa Cruz	December 3, 1993	Health Care Financing Club	Comments of the Community Health Care Financing
Siaton	December 8 - 11, 1993	SHARPDEV Midway Conference	Concept of community health data board for national implementation
Santa Cruz	January 28, 1994	Health Care Financing Club	Deliveration of the first comments on NHI Bill
Santa Cruz	February 4, 1994	Health Care Financing Club	Position paper on the IRR-NHI
Manila	February 8, 1994	Health Care Financing Club	Presented position paper to the senate hearing with Sen. Webb
Manila	May 5, 1994	Consultative Meeting: Barangay Botika Act	Promotion of drug store cooperative, Gold winner in Tondo
Subic	June 7 - 10, 1995	Project Planning for Health Insurance	Feasibility of implementation of SHINE project
Malacañan Santa Mesa	June 29-30, 1994	Third Annual Convention / Second Contest Awarding	Policy proposals of the HAMIS clubs

Venue	Date	Activities	Purpose / Output
Manila	August 12, 1994	NHI Bill Discussion	Senate reading/hearing
Nasugbu	September 29 -30, 1994	Federation Board Meeting, Batangas	Review of policy proposals and discussion on contracts of service for DOH
Sorsogon	October 26 - 28, 1994	RUNWIN Mid Year convention, Sorsogon	RUNWIN on: drug insurance, elderly and chronically ill, women's health, child health, cooperatives, and fund raising.
Malaybalay	November 7 - 9, 1994	SHARPDEV Midyear Convention, in Bukidnon	SHARPDEV action plans on: Trad-med, community health data board, women's and child health, community health fundraising, cooperatives
Manila	November 14, 1994	RUNWIN Forum, DOH Manila	Comments on the presented revised NHI Bill
Santa Cruz	November 26, 1994	Meeting of the Committee on Policy Papers for the Department of Health	Drafting policy papers on cooperatives, credits and loans, fund raising, community drug insurance, women's health, BHW incentives, financial indiactors in data boards
Santa Cruz	December 3, 1994	Committee on Policy Papers	Submitted the first draft of seven policy papers
Balilihan	December 8, 1994	Federation Board Meeting in Bohol	Presented the first fraft of the policy papers for comments
Santa Cruz	December 19, 1994	Consultative meeting on Policy Papers	Comments of DOH consultants and directors on policy papers
Iloilo	January 19, 1995	SHARPDEV Forum	Policy papers on BHW
Villa Escudero	February 7-9, 1995	Federations Plenary and Consultative Meeting on Policy Papers	Discussion and revision of the policy papers; presentation to and discussion with the Secretary of Health and his staff
Surigao	February 19-22, 1995	Consultative Meeting on Social Health Insurances	Comments on the NHI Law. Recommendations for NHI-IRR
Butuan	February 23-24, 1995	Databoard Workshop; Networking in Region 10	Inclusion of financial indicators in community health data boards. Networking of LGUs, DOH, and HAMIS Fed.
Cebu	March 17-18, 1995	1st Visayas Forum on Social Health Insurances and the NHI Law, RHU 7	Condensed ideas on Means Testing, production of brochures, and the role of community health insurance initiatives.
Calatrava	March 23 - 25, 95	RUNWIN Annual Convention	Info campaign on NHI Law. Translation of NHI Law into Tagalog.
Cotabato	April 20, 1995	First drafting of the IRR for the NHI	Outline of the proposed IRR for the NHI
Baguio	April 21, 1995	RUNWIN Forum in Philex Mining	Suggestions on proposed outline for the NHI-IRR.
Cotabato	April 27-29, 95	NHI Consultation in Makilala	Additional input to the proposed IRR of the NHI
Cagayan	May 2, 1995	First Revision of the outline of the IRR for NHI	New draft of the IRR for NHI for comments of the Fed. BODs
Quezon City	May 12, 1995	Participation of the HAMIS FED at Strategic NHI Workshop	Format for NHI Primers Plan for Massive Info campaign for the NHI
Duma-guete	May 15-16, 1995	Meeting of Federation Board of Directors	Program for the HAMIS Convention, NHI Program, NHI-IRR, Means Testing
Diliman	May 22-23, 1995	WORKSHOP on Means Testing and Community Health Accounting	Contract for Means tersting ("Indigents') for NHI; Survey Instrument for community health accounting
Sablayan	May 25, 1995	RUNWIN Consultation meeting, Mindoro Or	Tagalog version of NHI
Manila	June 5-6, 1995	Means Testing Club Meeting	NHI Draft on Means Testing
Bulacan	June 9, 1995	NHI Forum Bulacan	Suggestions for the provisions and IRR of the NHI Program
Manila	June 25-29, 1995	Fourth National Convention of Federation	New set of elected officers, Federations Planning for the Coming years