Social protection and health insurance in the Philippines

A short review of experiences between 1994 and 2009

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Ethno-linguistic regions of the Philippines

[Wikipedia]

The Philippines has a fast growing population of actually more than 90 million people. It is a multi-ethnic country with 171 different languages. English is lingua franca for many due to a long period of colonisation and due to the fact that the official Tagalog is native language of less people that those speaking Cebuano and similar languages. The map on the left shows the ethno-linguistic regions of the Philippines.

The Spaniards – occupying the Philippines before the Americans came – left behind Catholicism. One book on the history of the Philippines is entitled: 400 years of Spanish cloisters and 100 years of Hollywood. More than 80% of the people are Catholic, 5% are Muslims which were pushed down and away by systematic immigration from Cebuano settlers to Southern Mindanao and an unfair but legalised expropriation of Muslim settlers took place. In Mindanao 32% of the population is Muslim. The marginalization of the original population is a main source of political, cultural and military conflicts in the Philippines. More than 100.000 civilians died during the civil 'wars' since the 70s of last century.

[1] In memory of Emma Palazo, the first president of the HAMIS Winners Federation in the Philippines who died in a plane crash in Northern Luzon in 1999 when she was disseminating the ideas of a drug insurance – botica binhi – for the poor. Some of her colleagues are still active in a bottom-up battle "towards effectiveness, efficiency and equity in health care", especially the Mother Clubs in Surigao del Norte and Medical Ambassadors in Bukidnon. I dedicate this article to Zeny Aranas and Rene Sison, the guiding stars of these two projects. The author learnt a lot from them when working in the Philippines between 1989 and 1997. He thanks Arbeiterwohlfahrt International for a recent visit there on the occasion of evaluating a project in Mindanao.

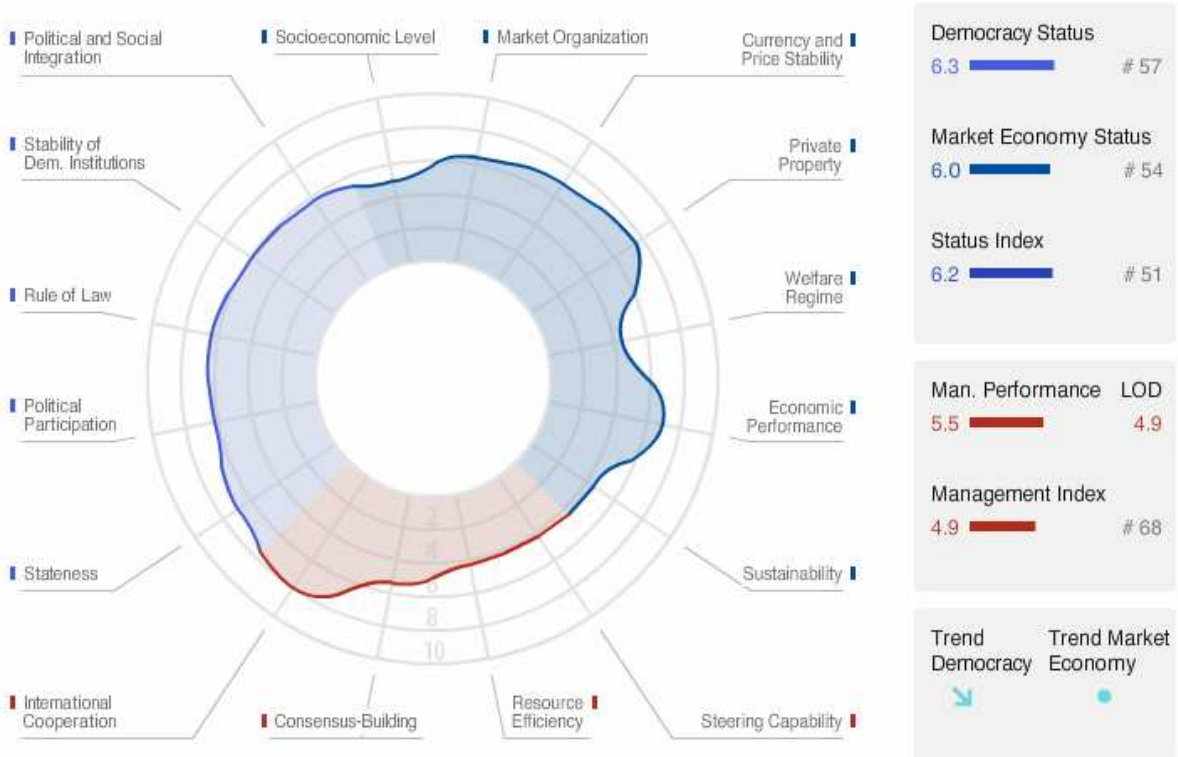
1. Governance

Economically the Philippines are considered to be a fast driver after several years with an economic growth of five and more percent. Remittances of the 8 to 11 million English speaking Filipinos working abroad contributed significantly to a rather good economic performance.

“Despite an average growth rate of 5% over the past five years, there were no significant inroads in job generation, poverty alleviation and hunger prevention. Historically rooted structural weaknesses continue to perpetuate poverty, impede long-term sustainable growth, and constrain the governance performance of political leaders. Corruption and an ineffective bureaucracy stymie reform efforts. Unabated population growth continues to put enormous strain on public financial resources and the government’s ability to both provide basic services and create economic opportunities. These factors contribute to the enduring sociopolitical conflicts in the country. On a positive note, however, the Philippines has a vibrant civil society with a tradition of civic engagement and a wellspring of social capital.” [07]

Bertelsmann Stiftung assesses the transformation process of countries according to various criteria which are given in the following figure.

Philippines transformation performance 2008



Status index is composed of 32 indicators for 12 criteria on 2 dimensions. The dimensions are democracy status and market economy status. The criteria for the democracy status are: stateness, political participation, rule of law, stability of democratic institutions, and political and social integration. The criteria for the market economy status are: level of socioeconomic development, organization of the market and competition, currency and price stability, private property, welfare regime, economic performance, and sustainability. Data were collected for 125 transition countries. The values range between 0 and 10, i.e. between extremely poor and excellent.

Management index has 5 criteria and 20 indicators. The criteria for management performance are: steering capability, resource efficiency, international cooperation. The respective indicator values are weighted according to a 6-indicator ‘level of difficulty’-criterion. Values range between 0 and 10, i.e. between very poor and excellent.

[08]

The scores on a scale from zero to ten are not that good regarding management. Bertelsmann specifies the main constraints: "Historically rooted structural weaknesses perpetuate poverty, impede long-term sustainable growth, and constrain the political governance capacities in the Philippines. With a system of government susceptible to political factionalism, reforms do not deliver maximum utility. One of the barriers to development and poverty alleviation is the inability of political leaders to complement economic reforms with social and political reforms. Economic and social policies become secondary priorities, for the political climate necessitates strategizing for political survival. Several governmental attempts at pushing social and political reforms meant to curtail the power of vested interests have been saddled by a lack of sustained political will, a legal and regulatory environment laden with corruption, and a politicized and ineffective bureaucracy. Poverty continues to be a predominantly rural phenomenon, with around three-quarters of the poor living in rural areas. Despite posting a 3% per capita growth for five continuous years, economic growth for the last twenty years has been at a pace that makes it difficult to lift the country out of poverty. Unabated population growth continues to place enormous strain on public financial resources and the government's ability to provide basic services and create economic opportunities." [07]

The human rights situation is not promising, either. In its 2008 report Human Rights Watch mentions especially four critical issues [26]:

- Extrajudicial killings and enforced disappearances
- Attacks against civilians by armed groups
- The Human Security Act of 2007, a counterterrorism law that violates constitutional rights
- Government blacklisting of critics

Bertelsmann explains: ""Driven by the logic of regime survival, President Arroyo actively mobilized government resources, dispensing funds in order to consolidate support among her congressional and local government allies. She also resorted to a series of controversial actions inconsistent with democratic principles. She persecuted dissenters and critical media, tolerated the extrajudicial killings of left-wing personalities, and attempted to unilaterally change the constitution to suit her own political objectives." [07]

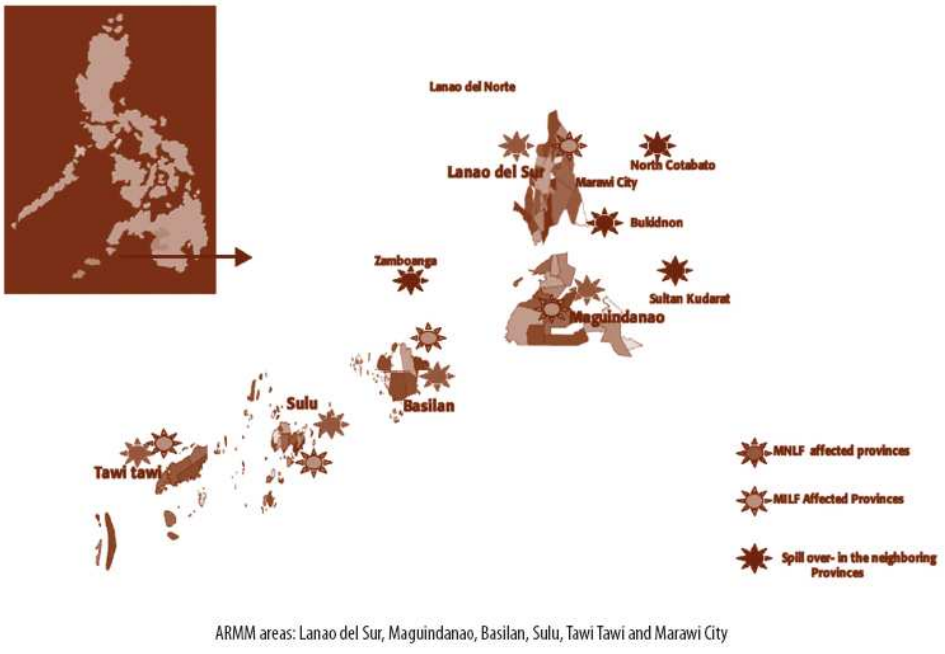
Governance in the Philippines		
Indicator	Value	Remarks
Government effectiveness	56	The World Bank governance indicators are measured in percentiles. Percentile 50, for example means, that 50% of the countries are better and 50% are worse. [World Bank Governance Indicators 2008] [31]
Regulatory quality	50	
Voice and accountability	53	
Rule of law	34	
Political stability and absence of violence	10	
Control of corruption	22	
Corruption rank measured as percentile	78	141 of 18 countries [58]
Bribery	>32	% of respondents reporting they paid a bribe to obtain a service. [31] Countries most affected by petty bribery include Albania, Cameroon, FYR Macedonia, Kosovo, Nigeria, Pakistan, Philippines, Romania and Senegal. [57]
Corruption perception in medical services	2,.5	2008 To which extend do you perceive the following sectors to be affected by corruption? (1: not all corrupt, 5: extremely corrupt) Average value in 60 countries: 3.2 [57]
	3,2	2004 [59]
	2,9	2006 [59]
Corruption prospects	78	% of respondents expecting corruption to increase in the next three years. [57]
Ease of doing business	14	Rank 155 of 180 countries, i.e. 86% of the countries are doing better. [68]

Governance in the Philippines		
Indicator	Value	Remarks
Measles immunization rate1990	85	% of children 1 year old immunized. "Measles immunization coverage provides a robust measure of public service performance as it reflects government's ability to perform a critical and basic health service. "[32] Measles immunization rates were obtained from [60]
1995	72	
2000	81	
2005	80	

The foregoing table compiles various indicators related to governance and its impact on poverty. The governance indicators of the World Bank seem to be quite different, even if all are low as compared to the economic possibilities. When seen in a time perspective, nevertheless, all indicators went down during the last years, as shown in Annex 1, but government effectiveness. This indicator remained stable at a lower level than expected according to the economic performance of the country. Doing business is not easy in the Philippines, according to the most recent World Bank ranking. It is getting even more difficult. [68] There seems not to be a development towards the better. Striking is especially the issue of corruption. The values given are averages and the value given for corruption in medical services seems not to be too bad – but – "in the Philippines perceptions of corruption in public health services discouraged use of public facilities, particularly in poor communities". [32]

Human insecurity is a serious problem in the Philippines. The Philippines' human development report 2005 of the United Nations Development Programme (UNDP) is dedicated entirely to these issues: armed encounters, costs of the conflict in terms of losses of human lives, terror, child soldiers, internal displacement, diaspora and discrimination, deprivation, minorization. The conflicts are increasing. Mindanao is most affected. Annex 3 describes a few historical roots of the Moro struggle in the area of Lanao. Annex 4 gives a provincial mapping of indicators on human insecurity in the Philippines. The day-to-day insecurity is but one issue. Armed conflicts affect quite some areas in Mindanao and have spillover effects as shown in the next map.

Conflict-affected areas and spillover areas in Mindanao



[59]

2. Poverty

The poor are hit especially. And the subjective feeling of corruption and poverty can be much higher than the 'real' values might suggest. Regular surveys of the Philippine Social Weather Station show that around 60% of the population consider themselves as poor – since years, whereas the officially measured poverty incidence according to the National Statistical Coordination Board is well below 40%. [70] 'Objective' poverty indicators speak a different language as can be depicted from the following table.

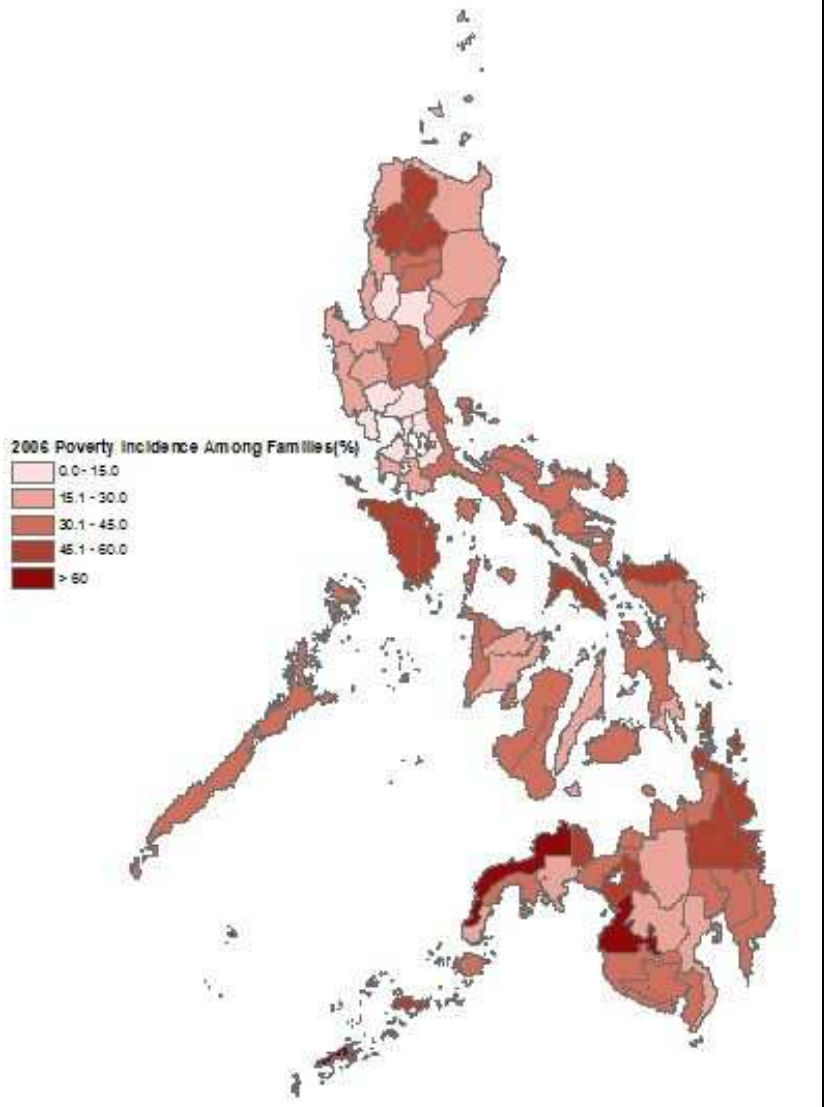
Poverty in the Philippines		
Self-rated poverty	62%	2003. Households who are 'mahirap'. [48]
Poverty incidence Philippines	32.9 %	2006 [17]
- Northern Mindanao	43,1 %	2006 [17]
- Muslim Mindanao	61,8 %	2006 [17]
Population below 1 US$ a day	15,5 %	1990-2004 [60]
Population below 2 US$ a day	47,5%	1990-2004 [60]
Share of poorest quintile in national consumption or income	5.4	1992-2005 [69]
Basic food needs deprivation	13,8 %	Only 13.8 percent of the population in 2003 do not have incomes sufficient to meet their basic food needs. This represents a 2- percentage point reduction from the 2000 level of 15.8 percent. [54]
Yearly income to meet minimum basic needs in Philippine Pesos (PP)	12.267	In terms of annual per capita poverty threshold a person needs a yearly income of PP12,267 in 2003 to meet the minimum basic needs. A family of five would therefore need an annual income of PP61,335 or a monthly income of PP5,111.25. [54]
Prevalence of child malnutrition 2000-7	20,7	% of children under 5, 2000-2007 [62]
Global hunger index - percentile	61	Value given as percentile. Rank 72 of 119 countries [01]
1992:	21.80	The Index varies between a minimum of 0 and a maximum of 100. However, the maximum value of 100 would only be reached if all children died before their fifth birthday, the whole population was food-energy deficient, and all children under five were underweight. Likewise, the minimum value of 0 does not occur, because this would mean that 0 percent of people were food-energy deficient, that no child under five was underweight, and that no child died before his or her fifth birthday. Even the most highly developed countries have under-five mortality rates greater than 0. [01]
1997:	19.63	
2003:	17.55	
Human development index	0.72	2003 [69]
Leading area	0.78	2003 [69]
Lagging area	0.50	2003 [69]
Human development index 1990	0.72	[60]
1995	0.75	[60]
2000	0.76	[60]
2005	0.77	[60]
Insurance intensity - percentile	7 %	2007. Rank 81 of 87 countries. 23.90 US$ per capita. 93% of the countries use more insurance.

There is quite a regional variation of poverty data in the Philippines. The human development index applied to leading and lagging areas according to the World Bank Development Report 2009 shows it quite clearly for the Philippines at a lower and for China at a higher level. [69]

The following map of the Philippines shows that poverty incidence in some provinces is very high, especially in Mindanao, Northern Luzon but also in areas in the middle of the Philippines. Anyway, 6 of the poorest 10 provinces are located in Mindanao. The map shows also, that very poor and better-off provinces are situated side by side, especially in Mindanao. The province of Misamis Oriental is in the poverty percentile 78 whereas the neighbouring province of Lanao del Norte ranges at percentile 32. Municipalities within Lanao del Norte range quite differently, too. Iligan City municipality has a poverty incidence of 28% whereas 74% of the population of the municipality of Magsaysay are measured to be poor. [36] A cooperation of World Bank with the National Statistics Board produced very revealing data on these issues by using quite diverse sources of poverty data. [36] In terms of the human development index 2003 of UNDP provinces are ranking quite differently, too. This index combines indicators of longevity, knowledge and standard of living. Some results [59]:

- 0.777 Metro Manila
- 0.717 Misamis Oriental in Mindanao – including Cagayan de Oro City, CLIMBS headquarter
- 0.702 Davao del Sur in Mindanao
- 0.673 Lanao del Norte in Mindanao – including Iligan City, MSU cooperative headquarter
- 0.601 Lanao del Sur in Mindanao
- 0.498 Maguindanao in Mindanao

Poverty incidence among families

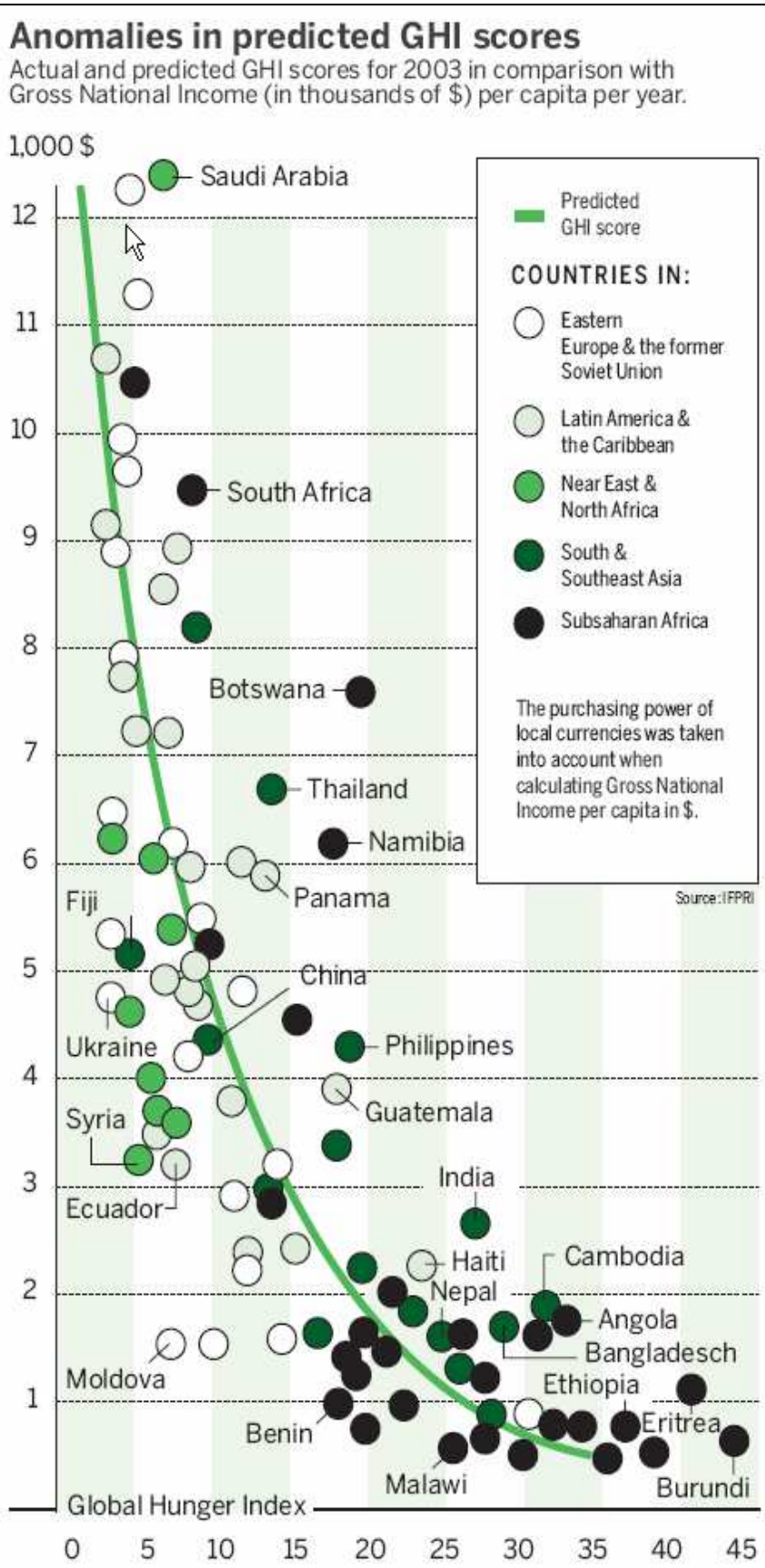


[37]

Regarding the human development index, there is a slight improvement over the years, as shown in the preceding table. But there is a clear trend of increasing poverty. Until 2006 the official poverty incidence increased by 2.5 percentage points to 26.9% from 24.4% in 2003. But despite increase in poverty, the income distribution continues to improve. [62]

Comparing the Philippines internationally in terms of economics and hunger there is a marked anomaly in predicted Global Hunger Index scores. Philippines is one of those countries in Southeast Asia where there is a coincidence of economic progress and hunger as shown in the next graph.

Economic progress and hunger in the Philippines



[67]

3. Health

"Catastrophic health care costs and loss of earnings due to ill-health are a leading cause of chronic poverty in the Philippines. Access to health services is inequitable, because of financial barriers to care for the poor and unequal distribution of health care capacity. There is substantial private financing (54.9%), most of which (44.9% of total health expenditure) is from out-of-pocket. Even for the insured, there is substantial extra-billing by private health care providers. A little over half of doctors have private practice and a little under half of hospitals are private. Though public healthcare facilities provide a more affordable service for the poor, in public hospitals, patients typically face additional costs due to lack of availability of drugs and supplies, and long waits and over-crowding in many public facilities." [18]

This statement summarises very well the problem of the Filipino people with health and health care.

3.1 Health policies

Decentralization of all public services including health services was a landmark of policy making in the Philippines since the 90s. Nowadays 79 provinces, 118 cities and 1,492 municipalities have administrative and financial autonomy. Not all agents

are sufficiently prepared and willing to use these powers for the benefit of the people. The power of national health policies is declining. “In 2005, under national leadership of the Department of Health (DOH), based on a deeper understanding of the requirements of implementation, and coordinated support from development partners, the Government formulated a new health reform implementation strategy, known as “Fourmula One for Health”. The strategy organizes the reforms into four implementation components, namely: Health Financing, Health Sector Regulation, Health Service Delivery (covering both public health and hospital reforms), and Health Sector Governance in Health (covering DOH’s internal management and its sector coordination and leadership role, of stewardship over the whole health system). The new implementation strategy emphasizes the role of Phil Health’s national social insurance program as the main lever to effect desired changes and outcomes in all four implementation components at national and local level.” [18]

Health financing gets priority one. Health financing involves the national health insurance system, especially. The national health financing strategy for 2008 was formulated accordingly:
“The Department of Health (DOH) shall:

- Promote and institutionalize the use of health accounts for monitoring of health expenditures and for policy making
- Allocate higher budget to enhance and upgrade health facilities
- Develop performance measures to ensure the attainment of health financing goals

The Philippine Health Insurance Corporation (PhilHealth) shall:

- Work towards universal coverage particularly the poor and informal sector and work with organized groups and other local-based schemes
- Introduce new packages including out patient through contracting arrangements with preferred providers like RHU or ILHZ (these are Inter-Local Health Zones, DS)
- Spearhead marketing efforts in collaboration with other partners in the health sector

The DOH hospitals / health facilities shall:

- Work towards claim maximization from PhilHealth
- Fully implement the policy on no co-payment for members of the Sponsored Program in DOH facilities
- Assist PhilHealth in its advocacy efforts

Local Government Units shall also be encouraged to continue advocating / sustaining the enrollment of their indigent population under the Sponsored Program and work for massive enrollment of informal workers.” [47]

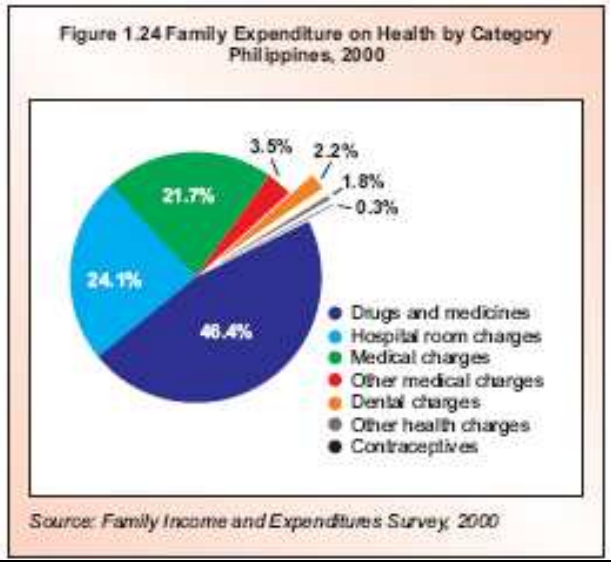
3.2 Health expenditures

The latest available national health accounts of the Philippines show the shares of the different agents for health and health care.

Out-of pocket spending by families and households is the main source of income for the health sector. This is especially spent for drugs and medicines. Private expenditure for health is well above 50% if the private premium payment is not allocated to the category of ‘social health insurance’ but taken seriously as private expenditure to be paid by people, families and households. Recent estimates in the Department of Health (DoH) assume that private expenditure is above 60% of all health expenditure. [13]

Next table shows the historical development of the private/public share in health spending and confronts it with the share of social health insurance spending. In 2005 the share of social health insurance to the total health expenditure increased to 11%, whereas private expenditure was at 59.1%. Per capita health expenditure (in pesos, at current prices) in 2005 amounted to 2,120 pesos. [35]

Philippine health expenditure by source of funds and expenditure targets, 2003



[16]

World Health organization reports this data on national health account estimates for the Philippines:

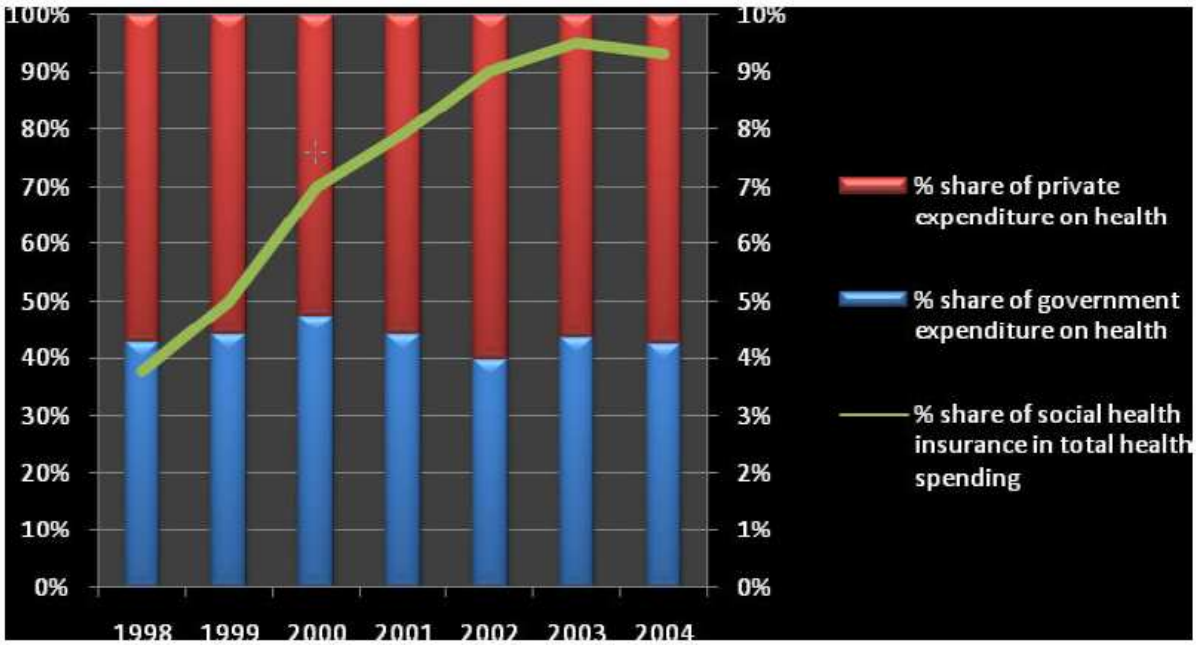
Philippines national health accounts according to WHO, 2000 and 2005

	2000	2005
Total expenditure on health as % of gross domestic product	3.5	3.2
General government expenditure on health as % of total expenditure on health	47.6	36.6
Private expenditure on health as % of total expenditure on health	52.4	63.4
General government expenditure on health as % of total government health expenditure	7.0	5.5
External resources for health as % of total expenditure on health	3.5	5.1
Social security expenditure on health as % of general government expenditure on health	14.7	31.6
Out-of-pocket expenditure as % pf private expenditure on health	77.2	80.3
Private prepaid plans as % of private expenditure on health	11.1	10.5
Per capita total expenditure on health at average exchange rate (US$)	34	37
Per capita total expenditure on health (PPP int $)	170	199
Per capita government expenditure on health at average exchange rate (US$)	16	14
Per capita government expenditure on health (PPP int $)	81	73

[71]

The data do not tally with the data from the Philippine health accounts. All this and the following data is to be taken cautiously indicating estimates more than facts and reliable and valid figures. The pharmaceutical industry in the Philippines compiled the following data.

Private, public and social health insurance expenditure for health



[43]

Out-of pocket expenditure of households is quite different according to income quintiles [64]:

- Quintile 1: 26,82 US$
- Quintile 2: 54,21 US$
- Quintile 3: 81,20 US$
- Quintile 4: 118,67 US$
- Quintile 5: 270,23 US$

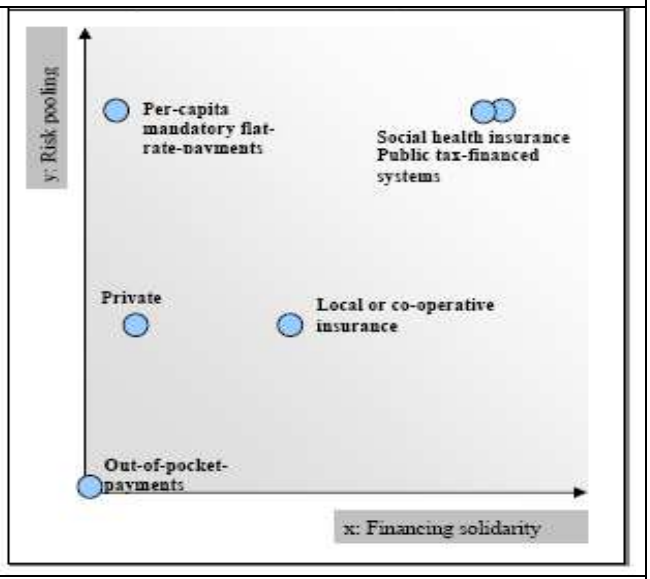
Even relatively small expenses for the poor are catastrophic expenses. There is no much difference in the share of out-of-pocket spending according to the Philippine regions, except that region 8 – Eastern Visayas – has a higher than expected share [45], probably due to the availability of many private health care providers.

3.3 Health insurance

Out-of-pocket spending is typically irrational and uninformed spending. There is an argument, that public agents could better allocate the money and could bargain to get the best for least money. This is the case for a tax-based health care provision or for social health insurance. The next figure supports the idea that both systems are better than out-of-pocket payments in terms of risk pooling and financing solidarity.

The Philippines opted for a social health insurance system. The hitherto separated health insurance systems for formal sector employees in the government and the private employment sectors were merged in 1995 and a national health insurance system was set up, called PhilHealth. PhilHealth shall cover all Philippine population by the year 2010.

Fair health financing systems



[19]

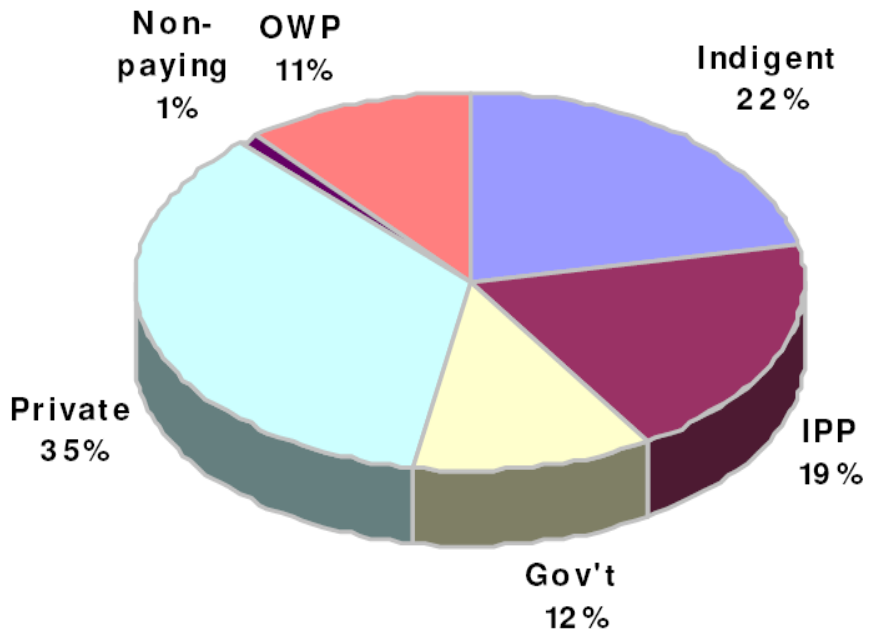
- "In addition to the principal members, PhilHealth provides coverage to the spouse, children below 21 years of age (and those 21 and above but with congenital conditions) and the parents 60 years old and above. Currently, PhilHealth covers about two-thirds of the country's population." [06]

- "PhilHealth provides a set of inpatient benefits and several outpatient packages which include minor and day surgeries, normal deliveries, treatment of tuberculosis through DOTS, dialysis, cataract extraction, among others. For inpatient care, PhilHealth reimburses expenses for drugs and medicines, professional fees of doctors, room and board, and x-ray and laboratories." [06]

Annex 5 gives details for the Individually Paying Program, i.e. for the self-employed.

Currently PhilHealth covers 73% of the Philippine population. The traditional sectors of private and government employees represent 47% of the members. Employer and employee contribute 1,25% of the employee's salary and they share by 50/50%. Pensioners do not have to pay after 120 months of contribution payments. There are special contracts for overseas workers. They comprise 11% of the members. There were quite some fluctuations in the published membership pattern of PhilHealth [42], especially regarding the indigents, i.e. those families that do not have to pay contributions after a means-testing verified that they are poor. In this case national and local governments share the contributions of 1.200 Philippine Pesos (PP) per year according to a rather complicated but politically bargained algorithm that takes into account the years of membership and the income classification of the local government. The following figure presents the coverage trends of social health insurance since 1973.

PhilHealth insurance coverage



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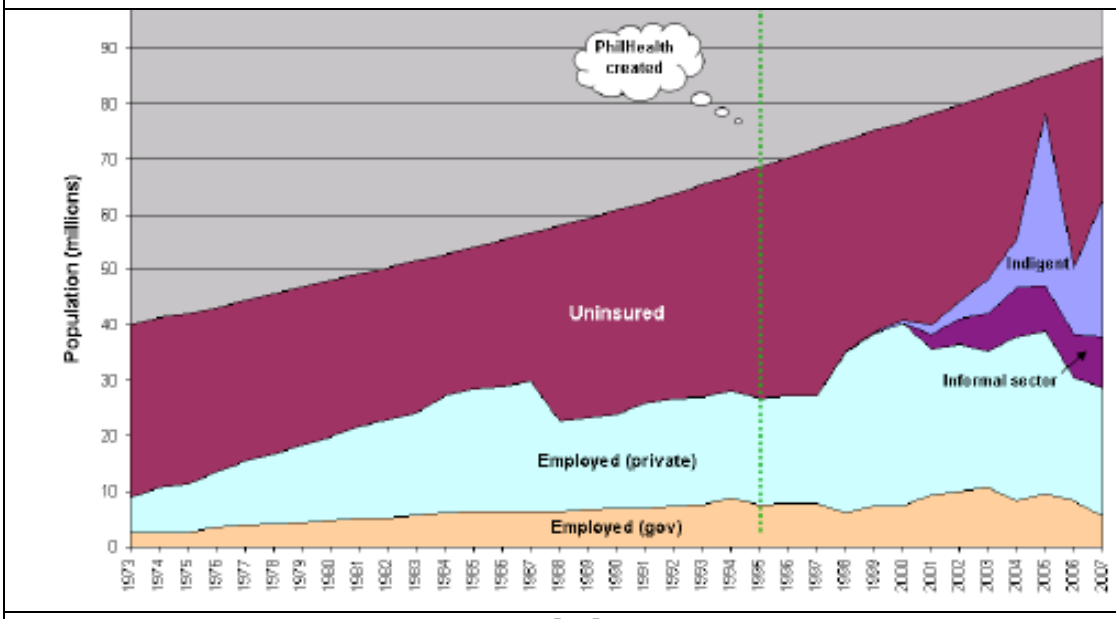
PhilHealth coverage trends, 1973-2007

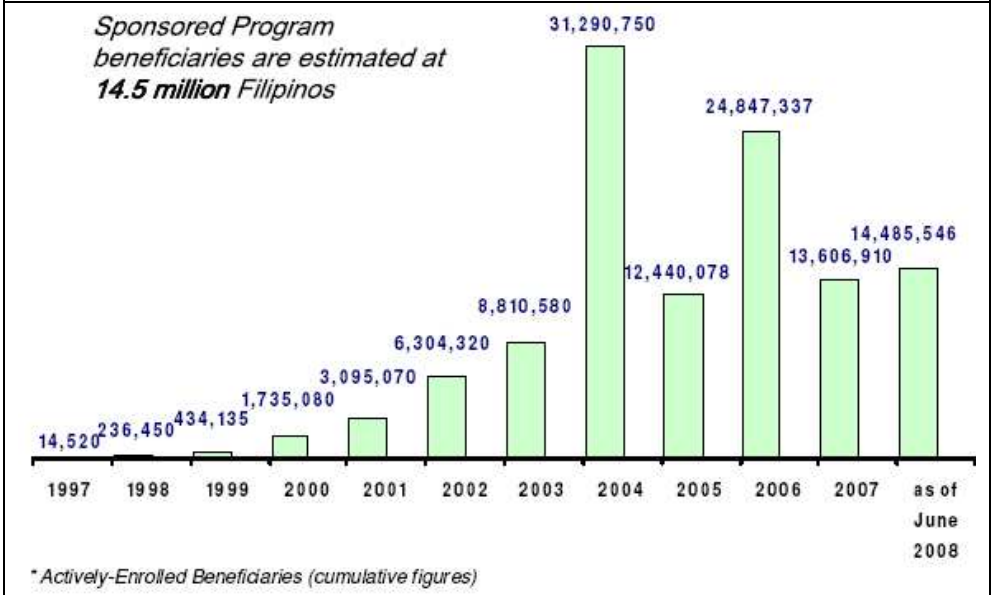


[29]

During the last years PhilHealth spent between 60 and 100% of the collections for health benefits, currently fund utilization amounted to 80% in the first semester of 2008. [43][40]. According to the processed claims 35% goes for drugs and medicines, 21% each for professional fees and diagnostics – x-rays, lab, etc. – and 17% for room and board. Finally 7% was spent for operation room fees. [40] Current providers are 1.536 accredited hospitals (39% government, 61% private), 1.226 accredited rural health units, 20.961 professionals. There are "cross subsidies from government-employed sector (78% of benefit payment to collection) and especially the private employment sector (56%) to the sponsored (159%) and individually paying sector (171%)." [40]

The trend of including indigent beneficiaries in Phil-Health hints at a problem of including the informal sector. The graph shows that in the year of the presidential election 2004 there was a strong coverage increase. The same happened during the campaigning for the next presidential election in 2007. Since 60% of the Filipinos consider themselves as poor they rather expect that sooner or later they will be included in the so-called

PhilHealth coverage trend for the indigents



[40]

'sponsored program' for which national and local governments have to pay. PhilHealth and the health insurance bill had limited the coverage of the indigents at 25% of the members. This does not tally with the poverty data in the Philippines. The result was a very tedious process of the so-called individually-paying programme, which should have attracted better-off and poorer families belonging to the self-employed sector. In view of the difficulties the national aim of covering all Filipinos by 2010 is being delayed. According to the national health policy just 80% of the informal sector shall have been included by the year 2010 – altogether 85% of the entire population. [16] The slow membership growth was accompanied by an adverse selection of those better-off self-employed with previous health conditions and a low persistency rate when they dropped out after having availed of some benefits. These problems induced PhilHealth to test the first of the following programmes with low success and then switch to a new programme, called KaSAPI, acronym of "Kalusugan Sigurado at Abot-Kaya sa PhilHealth Insurance": [06]

- The Organized Groups Initiative (POGI) was tried since 2003. POGI was pilot tested in two (2) regions – Cavite and Southern Leyte – with a total of 11 Organized Groups (OGs) joining the pilot program. The annual premium per member remained at P1,200. Phil Health's benefit payments covered about 40% of the total medical expenses of the members. A very high dropout rate was reported
- Larger scale organizations were addressed thereafter. They should have at least 1,000 members; 70% of whom must be enrolled into the program. When KaSAPI was launched, Memoranda of Agreement (MOA) were signed with two of the largest micro-finance institutions in the country linked to the Grameen Bank initiative.

A system of discounts is considered to be attractive for these organisations. The maximum discount would be 10% of the annual premium of 1.200 Pesos. The discount should benefit the organised groups and their members. By this a 'triple win outcome' is expected. [51] At present, there are 22 organizations such as Microfinance Institutions, cooperatives and rural banks that have signed up with PhilHealth to participate in KaSAPI to expand PhilHealth membership into the informal sector.

3.4 Social health insurance?

Philippine health insurance is mandatory for all and universal coverage is to be realized in 2010 according to the law. Benefits are portable and permanent and many other characteristics underscore that it is considered to drive towards a social health insurance system. Is this the fact? Will it be achieved? Many issues can be raised with regard to the above mentioned initiatives and processes regarding PhilHealth. The following is rather a random review of striking issues. A systematic review is overdue.

Underfinancing

- PhilHealth contribution rates for the formal sector are 1.25% each for employer and employee. This is less than a maximum of 3% that was stipulated by the law. In international comparison this rate is extremely low. The contribution rate of 1.200 PP per year for the self-employed is below 1% of the income of 50% of the population but it hits relatively those in the first income deciles who are not enrolled with the health insurance program for the poor.

Benefits

- PhilHealth deals mainly with inpatient care. Only for the poor and for the overseas workers outpatient benefits are paid for.
- Benefit package ceilings and packages are differentiated according to the level of the hospital – primary, secondary, and tertiary – and according to the complexity of cases, i.e. normal, intensive, catastrophic and super-catastrophic cases.

- PhilHealth is a learning body. In 2007 the inpatient benefit package was extended to cover so-called super-catastrophic cases like SARS and AIDS. This year outpatient benefit packages are pilot-tested for hypertension and diabetes patients.
- Benefit ceilings are quite low. Low financial protection "constitutes an important barrier to accessing health care, especially for indigents who require hospital services. In many cases, the current benefit package does not provide adequate coverage for catastrophic medical expenses, as a result of the low benefit ceiling. The absence of fee regulation, coupled with the fee-for-service approach to paying providers, often results in excessive financial costs falling to the patient. Social health risk pooling is still far from being reached and the patient, not PhilHealth, ends up bearing the risk associated with increased fees and volume when providers are able to extract profit out of insurance benefits." [09]
- Outpatient care package particularly for consultation and routine diagnostic tests is given currently only for overseas workers and within the 'sponsored program' for the poor. Out-patient services such as selected day surgeries, chemotherapy and radiotherapy, haemodialysis are covered as well. Packages such as TB DOTS and maternal care are available to all members and beneficiaries of PhilHealth.
- Drugs are often not available in public facilities when insured people expect them. This is communicated quite widely in poor communities, where the cost of drugs and their availability is a major issue. "Access to essential medicines to treat the major causes of acute and chronic illness is still a major problem in many countries, especially among the poor. Failure to use medicines when they are needed can lead to preventable morbidity and mortality, catastrophic episodes of illness that increase impoverishment, and large-scale losses to health systems and employers. Frequently, economic factors are the most important barriers to access. Insurance programs that cover medicines can play a key role in extending access to high risk populations and in encouraging more economical and effective use of medicines." [63]
- Rational drug use can best be supported by a good health insurance system that controls quality and safety. In private drug outlets about 30% of the drugs sold are fake drugs. [60]
- Transport costs to the next health care provider, especially in cases of emergencies, hit mainly the poor population living in far-flung areas. In many cases these are indirect health care costs that can amount to a third of the total expenditure. Transportation costs in the Philippines increased by 58% from 2003 to 2006 in the Philippines. [62]

Indigents

- Voluntary health insurance leads to adverse selection and moral hazard. "The enrollment of indigents by government is NOT mandatory. The decision to enroll its poor constituents is entirely left to the local government and they may decide to prioritize other activities. Although, the Indigent Program is gaining popularity amongst Local Governments, PhilHealth still devotes much time and resources to marketing and administering the program, which in turn results in high transaction costs. Indigents are not necessarily enrolled in a continuous manner i.e. the priority of local government may change or there may be administrative delays which break the terms of the agreement between PhilHealth and the Local Government." [09] The same applies to the informal sector which is not included in the sponsored program of PhilHealth.
- For the means-testing to identify the poor there are competing methodologies and questionnaires developed by different international sponsors. It is said that a two-page questionnaire with proxy-indicators proposed by the World Bank will win the race. In many cases means-testing is influenced 'politically'.
- Since in Northern Mindanao – for example – more than 30% of the population is given the free PhilHealth membership for one year, it is difficult to market the same insurance to the informal sector. Many of them expect to be covered sooner or later by the free-contribution part of the NHIP.

- An important problem for expanding the PhilHealth membership to the poor informal sector is the fact that the free health insurance card given to the poor (the so-called 'sponsored' program) is often politically abused and expanded or reduced according to political circumstances. This makes a decision to join the informal-sector program doubtful because sometimes the enrolees could have a chance joining the sponsored program (for one year) without paying contributions.

Informal sector

- The marketing of PhilHealth was originally oriented on individual members and not on larger groups with a potential of joint memberships. This strategy failed to achieve a clear increase in coverage.
- Contribution payment difficulties are well known among the self-employed. They often can pay only after harvest, after a contract done but not regularly like government employees.
- Mistrust "of programs sponsored by the central government" [21] is a rational behaviour of poor people in view of the governance situation at all levels of governments and institutions.
- "The fixed annual premium of P 1.200 is relatively cheap for self-employed professionals, but prohibitively expensive for many farmers and other workers in the informal economy." [38]
- Diversity of the target group: The sector of the self-employed includes well-off business(wo)men as well as farmers and fisherfolk belonging to the poorest members of society lacking security and safety nets. A flat contribution rate is quite unfair.
- Difficulties in assessing the income as a basis for contribution payments. This should not lead to the ironing out of vast economical and cultural differences within the informal sector by applying flat rate contributions.
- Self-employed are employers and employees at the same time. There are no tax subsidies for the self-employed to compensate this double role.
- For the PhilHealth program for the self-employed in 2009 a social grading of contributions is started after long preparations. A contribution of 2.400 PP should be applied in the first year and a 3.600 PP contribution thereafter for 'professionals' according to a detailed listing of such professions.
- A draft of a new health financing strategy of the Department of Health (DoH) will propose that the health insurance of the poor should be financed by the national government and the health insurance of the informal sector by the local government. This uncertainty adds to the hesitance of the informal economy to enrol.

Formal sector

- The public and the private formal employment sector are the main pillars of the health insurance system in the Philippines. They are getting most of the benefits of the system. They get additional benefits, too.
- There are hospital income benefits for the government employees. They are handled by GSIS – the Government System of Social Security – for government workers and SSS – the Social Security System for privately-employed workers but not by PhilHealth. The same applies to other such cash benefits within the social security package of private and government employees and workers in the formal employment sector. Additional premia have to be paid for availing of such benefit packages. It is mandatory for privately employed workers and government sector workers. The SSS has a venue for informal sector workers to avail of its services and products.

Generalities

- PhilHealth is good for the highways, as some people say, i.e. for urban populations but it is quite weak for remote areas, far away from accredited PhilHealth providers.

- The Local Government Code of the Philippines fostered decentralization considerably. This does not apply to PhilHealth organization. Regional and provincial offices can only give recommendations which very seldom are followed.
- There is an adverse selection due to a rather short waiting period after which the first benefits can be availed of.

Providers

- Excessive billing by providers: Solon could show empirically that PhilHealth "fails to expand insurance coverage or shift the burden to the private sector because providers capture SI (social insurance - DS) benefits as rent by raising price-cost margins to insured patients. As a result the out-of-pocket costs to the insured patient are the same as to the uninsured. Our empirical results from the Philippines indicate that hospitals extract 86 percent of SI benefits through price discrimination. We also show that expanding SI actually increased the burden on the public sector rather than relieving it." [22]

Average hospital costs and bills for uninsured and insured patients

Table 3. **Predicted Bills and Costs for a Standard Package of Services (in Pesos)**

	Private Hospital	Public Hospital	Difference
Predicted Price Charged to			
Charity Patient	4,590	838	3,752
Uninsured Patient	6,663	1,539	5,124
Insured Patient	8,359	2,777	5,582
Cost Per Patient			
Marginal Cost	2,909	2,611	
Average Fixed Cost	1,398	3,270	
Marginal + Average Fixed Cost	4,307	5,881	

Source: *Solon, et. al.*

[14]

- Partial cost-coverage by PhilHealth: "Under the Philippines National Health Insurance scheme, the purchaser pays only a portion of hospital costs. When the scheme raised payments to reduce out-of-pocket costs and make scheme benefits more accessible for the poor, hospitals raised their prices and continued to collect the difference directly from the insured patients." [24]
- A very conservative calculation of hospitals regarding reimbursement by PhilHealth is being observed widely.
- The provider payment method "for outpatient and inpatient care (is) based on the conventional fee-for-service and case payment reimbursement model, resulting in cost escalation, overcharging, excessive admissions, and irrational use of drugs and investigations. The package for inpatient care is limited. Co-payment is very high especially with private providers, with average support ranging from 30- 70% of billing." [70]
- Provider selection "is currently an issue in the Philippines, where the national health insurance system must accept all accredited providers, thus limiting its ability to negotiate more favorable rates in return for greater patient volume." [24]
- Private hospitals organize drug provision for the PhilHealth members. Government hospitals are less supportive. This is an incentive of PhilHealth members to prefer private hospitals.

Administration

- "There is an enormous workload on claim reviews, resulting in high administration costs (12% of total spending) and ineffective filtering of frauds." [70]

Partners

- There is a clear distinction of the roles of Insurance and Government: the Government is responsible for prevention and promotion and for outpatient care in government facilities whereas health insurance caters for hospital care.
- Local governments are allowed to introduce own health policies, e.g. for health insurance. Some of them are trying it, some have failed to be successful :
  - North Cotabato has added to the PhilHealth benefit packages [02]
  - Negros Oriental tries to set up a system apart from PhilHealth by enrolling indigents to its own local health insurance system with government health providers as partners [04]
  - Bukidnon uses all funds of the sponsored program to enrol all population that is not yet covered with health insurance
  - Guimaras had abolished its health insurance program
  - Tarlac tried health insurance without success
  - Isabella is said to try an own health insurance project, too.

Surplus

- "The awareness and utilization rates are low, resulting in a funds surplus." [70]
- A 1.2 billion US$ reserve – some calculate 1.5 billion US$ – has been accumulated by PhilHealth. This is said to be due to the lack of educating the public to avail of their benefits and to present the proper documentation when they claim to be reimbursed. This lack leads to a severe under-utilization of the health insurance benefits.

Conclusion

Recently PhilHealth is reported to have been criticised by assessments of the World Bank and UNICEF & UNFPA. The respective reports had not been endorsed by the Philippine Government and they are therefore confidential. A systematic review is overdue. The InfoSure methodology would help not to overlook essential components. [25][54a][54b]

3.5 Social health protection

This is indeed a long listing of difficulties that still have to be overcome. Some of them are of a general nature and others very specific for the informal sector of the economy. After studying in depth social health insurance in the Philippines Flavier, Soriano, and Nicolay "conclude that one strategy toward implementing universal coverage under the National Health Insurance Program could be to have community groups play a predominant role in health insurance coverage of the informal sector". [21]

Indeed, one of the most difficult tasks of social health insurances is the integration of families belonging to the informal sector or to the self-employed. In Germany it took nearly 100 years to get them – e.g. the farmers – integrated. Costa Rica, Japan and Korea achieved it much faster – but quite late when compared to the other groups of society. Many developing and transition countries have faced these problems and can learn from the lessons learned and from best practices. Annex 2 presents three good and well reputed reviews on these issues. The Philippines should not disregard such knowledge and PhilHealth would be well advised to take such issues into consideration.

Best practices exist in the Philippines, especially. “The Philippines has a vibrant civil society with a tradition of civic engagement and a wellspring of social capital.” [07] Especially during times of hardship and oppression self-help organizations were sprouting in the Philippines. In the early 90s many of such community endeavours were discovered. A national contest of the Department of Health supported by German Agency for technical Cooperation (GTZ) was searching for best practices for achieving effectiveness, efficiency and equity in health care management. Three rounds of national contests were launched and the more than 150 winners were awarded by the Philippine presidents. Examples of their approaches are given in Annex 7. Some of them were dealing with small-scale health insurances, as for example:

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

> 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.

> 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 ecommendations 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, ecommendations 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 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 channelled 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 catchment.” [52]

These projects from all over the Philippines associated into one federation and started to influence health policy making.

Those projects dealing with community cooperatives, community loans and community insurances wrote a policy paper on social health insurance as a response to the draft bill of the Philippine Government of 1994. [52] They listed 17 problems and they recommended 10 steps to contribute to their solution in partnership with policy makers and the incoming national bureaucracy for health insurance. These problems were addressed:

1. The problem of overuse
2. The problem of misuse
3. The problem of abuse
4. The problem of fake and ghost patient
5. The problem of non-representation
6. The problem of inaccessibility
7. The problem of the rights of the consumers
8. The red tape problem
9. The problem of lack of check and balances
10. The problem of indigents
11. The problem of disabled and mental health patients
12. The problem of the chronically ill and the elderly
13. The problem of self-employed and the unemployed
14. The problem of ceilings and severe illness
15. The problem of profits
16. The problem of investments
17. The problem of corporational omnipotence

Annex 6 gives the details, including the 10-step roadmap to overcome them. But all these problems still exist with PhilHealth. Community health organizations could have contributed a bit to solve them, since the beginning. They were disregarded by PhilHealth. What was achieved was only that in the bill and in the implementing rules and regulations community organizations were mentioned in the following way: “It must be cognizant of the appropriate roles and respective strengths of the public and private sectors in health care, including people’s organizations and community-based health care organizations”. [46] “The NHIP shall build on existing community initiatives for its organization and human resource requirements Instead of listening to the pleas of community based organizations.” [39]

PhilHealth concentrated on other issues and disregarded a mutual co-operation at eye level. They were convinced that small scale community organizations could not contribute significantly to a national health financing scheme. They did not use the vast reservoir of local managers knowledgeable in community motivation and management for building up an organisation based on the trust of the people. It was only in the first years of this millennium that PhilHealth rediscovered community health organizations due to difficulties encountered in the Individually Paying Program.

About seven years later, when PhilHealth recognised the slow expansion of social health insurance into the informal sector, community organizations were called upon to support. German cooperation partners – especially GTZ and Arbeiterwohlfahrt – contributed to this issue, since it is a key for the social protection of the poor. There is a growing awareness internationally about the importance of the involvement of the communities. Community based health insurances, i.e. “CBHIs often complement Government health care financing efforts. They generally provide supplementary insurance, over and above that which is covered by universal health care systems or social health insurance.” [56]

“Universal health systems pool risks across the population as a whole, although rising health care costs may limit their scope and quality because they are based on tax-financing. Social health insurance allows the pooling of risks across different groups, often with sliding premium scales for different categories of employees. But these schemes require the development of an administrative capacity to collect and manage large scale insurance funds — a capacity that is in short supply in developing countries. They are also normally limited to urban, formal sector workers, although governments sometimes provide default options for the unemployed or destitute that may cover a small segment of the informal work force. For example, in the case of the social insurance programs in the Philippines (PhilHealth), special provisions were made to provide subsidized social insurance coverage for the indigent using a combination of local

government targeting, central government subsidies, and capitation payments to providers. But whether providing subsidies to extend social health insurance to the poor actually improves their access to and usage of effective healthcare services appears uncertain (Schneider and Racelis 2004)." [56]

Philippines has a good knowledge base and experienced (local) managers in this field. The above mentioned directory of community organisations could be used to find partners. Quite a number of other inventories of local and community projects as well as micro-insurances in the Philippines were written in the 90s, e.g. by the International Labour Office [27][28][50][72]. Altogether it is estimated that there are about 29.000 non-governmental organizations in the Philippines and many more small-scale and informal groups. This is a good reservoir for a support of PhilHealth into a national health insurance system which could be labelled 'social' health insurance. Several types of linkages between statutory social security schemes such as PhilHealth and community based social protection mechanisms have been identified in a study by the ILO in 2006. [03]

Strengths and weaknesses of community based health insurance

Strengths	Weaknesses
• CBHI schemes are typically community-run, not-for-profit, pre-payment plans with voluntary membership and quite heterogeneous in terms of populations covered, benefits, regulation, and management. • CBHI can play a role in mobilizing additional resources, providing access and financial protection in LICs, where high levels of out-of-pocket payments, uncertainty concerning financial flows from donors, large rural and informal sector populations, and weak tax capacity result in limited levels of formal medical protection. • Risk sharing is usually from the well to the sick but if premiums are based on income, there can also be risk sharing from the better off to the poor.	• The impacts of CBHI in terms of providing access and financial protection are limited due to the small size of most schemes. • The financial sustainability of most schemes is questionable. • CBHI schemes generally do not reach the very poor. • Their impacts on care delivery are quite limited. • Their development should be favored by governments and donors only in contexts where more comprehensive and sophisticated health financing systems cannot be implemented on a large scale. • CBHI schemes should always be regarded as a complement to and not as a substitute for NHS or SHI systems.

[49]

4. Some conclusions

The poor majority of the population in the Philippines still lacks good and fair social protection measures and a social health insurance system that addresses their specific needs.

- With very low contribution rates PhilHealth is extremely under-financed. It is demonstrated by the rather small benefit package, by the exclusion of outpatient care benefits for the majority of the enrolees, by the ceilings of the benefit package that bring the risk of high expenditures back to the 'insured' patient, who is not 'assured' that s/he can afford being admitted in a hospital. This situation is reflected in the very high out-of-pocket payments for health care. A throughout study on the health insurance system is urgently needed and a drastic modification of quite some of its traits.

- The most pressing needs of the needy are not taken care of sufficiently. This refers to catastrophic expenses beyond the low reimbursement ceilings of PhilHealth, to the high expenses for drugs and medicines in outpatient care or self-medication and to the high transportation costs to health facilities facing especially the poor and self-employed in remote rural areas.

- Visible benefits of PhilHealth are quite few, since hospitalisation is (or should be through prevention and promotion that is not supported by PhilHealth) a rather rare case in families. This issue refers to outpatient care and especially to the availability and affordability of drugs, not only in the case of chronic conditions like hypertension and diabetes.

- PhilHealth was not responding to the demands for accommodating bottom-up initiatives for local and community health insurance and cooperative insurance endeavours. It is still a bureaucratic national government program with no real decentralization and networking initiatives. It is a top-down approach of governance.

- PhilHealth accumulated in the meantime a surplus of considerably more than one billion Euros. In view of low ceilings, omitted benefits and a disregard of the pressing needs of the poor this can be considered to be the bankruptcy of a 'social' health insurance system that was considered to be built up since 1995.

An independent professional systematic review of the social protection and social health insurance system in the Philippines is overdue.

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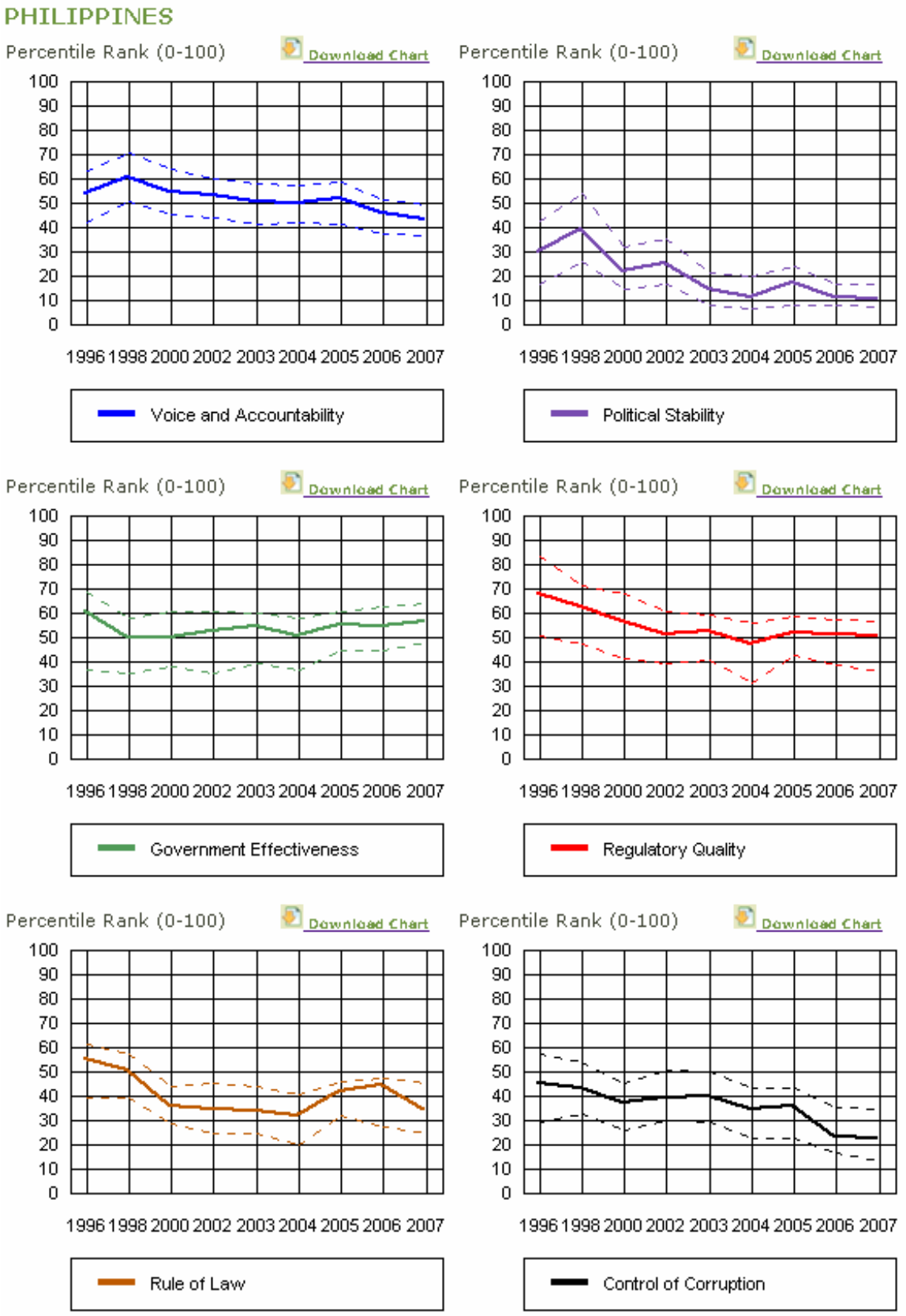
72 Yap, Maria E. and Editha Aldaba: ORT Health Plus Scheme in the Province of La Union, Philippines • A case study of a community based health micro-insurance Scheme. Geneva (ILO, Social Security Policy and Development Branch) 2002

Annex 1 Good governance time series in the Philippines



Source: World Bank: Governance matters. 2007. [31]

Annex 2 Health insurance for disadvantaged

Mills, Anne:
Strategies to achieve universal coverage: are there lessons from middle income countries?
A literature review commissioned by the Health Systems Knowledge Network.
London (London School of Hygiene and Tropical Medicine) 2007
[34]

The issue of financing coverage for disadvantaged groups is a major concern of systems which rely heavily on mandatory insurance funding, since insurance premiums can be collected most easily in the formal sector. Commonly, it takes a considerable amount of time before social health insurance arrangements are extended to cover those outside the formal sector and universal coverage is reached. However. Carrin and James (2004) argued that the speed of change is increasing: the transition period in Germany was 127 years, Austria 69 years, and Belgium 118 years, but for Costa Rica it was 20 years, and Korea 26 years. However, the FSU and especially Africa still lag behind, particularly for reasons to do with the structure of employment (Ensor 1999). In some regions this problem is getting worse because of increased informalisation of the workforce including sub-contracting arrangements. Gideon, for example, finds that in Chile, it is low income women who are often most at risk of exclusion from formal insurance arrangements (Gideon 2007).

Extension of SHI cover to self-employed and low income workers has been financed in a number of ways (Mills 1998), with support from general tax often being key. The cost of insurance premiums can be kept low by providing highly subsidised public hospital care to such members (Singapore); social insurance funds can be used to cross-subsidise care for low income workers (Mexico, Costa Rica) or for formal sector employees of private firms as planned in Tanzania (McIntyre et al, 2005); all compulsory health insurance premiums can be subsidised by public funds (Thailand), or only those of the low income employed and self-employed, identified through some form of a means test (Philippines (Obermann, Jowett, Alcantara et al 2006), Korea, Turkey); innovative ways can be found of incorporating farmers, who usually make up the bulk of the self-employed (payment at the time of harvest; payment related to assets as well as or in place of income: Korea); the government can encourage and subsidise voluntary insurance or prepayment schemes which in time might become compulsory (Philippines, Ghana: McIntyre et al, 2005).

A related issue is how to finance the extension of cover to those without a steady income, namely many of the aged, the unemployed, and the disabled. A considerable number of the elderly, as well as children, can be covered as the dependants of those in formal sector employment: this, for example, has been frequently recommended as the next stage in the extension of the Thai social health insurance scheme, was done in Costa Rica in 1956 (Carrin and James 2004), and has been planned in Kenya (McIntyre et al, 2005). A few countries have introduced insurance specifically for children – for example school children in Egypt (Nandakumar et al, 2000). Free care funded through general tax can be given to especially vulnerable groups (e.g. in many countries including Moldova and Burundi, pregnant women and children under five receive free care). In Europe, rights to health care have often been added to cash benefits given within social security schemes (for example for those who become unemployed), and those on social assistance may have their contributions paid for them (Mills 1998).

A key issue in this extension of cover is whether separate arrangements are made for the various population groups not in formal employment: for example a separate and self-contained arrangement created for the self-employed with tax subsidies; or whether government funding is used to bring them under the umbrella of the compulsory insurance scheme. The experience of countries in Asia suggests that the former is the preferred or most feasible option in the first instance: for example Japan, Korea and

Taiwan all have had historical experience of separate arrangements for different population groups. Over time the different schemes were standardised and made more compatible, one of the key issues being at what point it is affordable to the government to bring the benefits for lower income groups up to the level of those in formal employment. Thailand also created a separate general tax-funded arrangement for the uninsured (the 30B scheme), and over time is intending to harmonise benefits across schemes.

Mexico has also taken the route of a specific programme for the uninsured. A major programme of voluntary insurance has been launched, to eventually protect 12m uninsured families and to guarantee them an explicit package of benefits (Frenk 2006). Financial transfers to states to cover the cost are linked to enrolment numbers, and over time the package is increasing in depth of coverage. The poorest two deciles are not required to contribute financially (Frenk, Knaul, Gonzalez-Pier et al 2005) and are intended to receive priority in the expansion of enrolment. In the early years of the scheme, 90% of enrolees were from the poorest quintile and over 70% were femaleheaded households, in part because of the predominance of single mothers amongst non salaried workers, though a recent study has found that only 43% are in the poorest quintile (Scott 2006). Women may be more likely to appreciate the benefits of enrolment: evidence from a community based health insurance scheme in West Africa suggests that women favour enrolment, since they can obtain care for their children without needing to find money (Arhin 1994). The challenge, as now faced in Colombia, will be to achieve high coverage of the target population: Colombia had anticipated achieving full coverage and phasing out all supply side subsidies in favour of transfers to those insured in the subsidised scheme. However this has proved neither feasible or affordable (Gaviria, Medina and Mejia in Wagstaff 2006).

Services for the general public do not necessarily reached disadvantaged groups. When fees are charged, exemptions are required for disadvantaged groups, though they rarely work well. A more promising approach is an equity fund, which compensates the facility for the less of fee revenue (Hanson et al in press). Where care is free, the problem of reaching disadvantaged groups is not inherently one, as it is for insurance, of contribution being tied to benefit, but rather one of service availability and quality. A financing solution increasingly being discussed is that of introducing subsidies or incentives in the form of direct payments to users, either untied or conditional on use of services. This is being tried out, for example, in order to encourage pregnant women to deliver in facilities in Nepal (Borghi et al 2006). While experience of such conditional cash transfers is reported to be highly positive in several Latin American countries, there is virtually no evaluation evidence from low income settings (Palmer et al 2004).

Despite the enthusiasm for a greater degree of targeting of general tax funding – whether through cash transfers to individuals as an incentive to use publicly funded services, or though providing insurance coverage in a subsidised scheme as in Colombia and Mexico, or through funding a local purchaser such as a contracting unit for primary care in Thailand, there is little evidence on how well these arrangements work in efficiency or equity terms, and whether the increased transactions costs outweigh the benefits. A recent study in Bogota has found that for first level services, hierarchical arrangements have been replaced by a bilateral monopoly, and referrals to higher levels of care are complicated by disputes between insurers and providers (Castano-Yepes personal communication). More broadly, the advantages of demand-side funding, and a purchaser provider split, have yet to be conclusively established (Mills et al 2006).

Wagstaff, Adam:
Social health insurance re-examined.
Washington (World Bank, World Bank Policy Research Working Paper 4111) 2007
[66]

"Many countries have succeeded in setting up a scheme for poor, financing their SHI membership out of general revenues. Most, however, typically commit large errors of exclusion, largely because poor households fail to apply. In Colombia in 2003 (ten years after the reform), less than 50% of the principal target group (households in categories 1 and 2 of the 'SISBEN' meanstesting instrument) is actually enrolled in the non-contributory scheme (Gaviria, Medina and Mejía 2006). In Vietnam, about 40% of those who ought to have received health insurance coverage (or a free health care card) by virtue of being poor actually had done so in 2004 (Wagstaff 2007). Errors of inclusion are also common. In Colombia, over one quarter of households in SISBEN category 4 are enrolled in the non-contributory (subsidized) program but ought not to be covered under the rules (only categories 1 and 2 are universally covered; some municipalities also cover some households in SISBEN category 3) (Gaviria, Medina and Mejía 2006). In Mexico, only 43% of those covered at the taxpayer's expense in *Seguro Popular7* are actually in the poorest 20% of the population—the official cutoff point (Scott 2006).

"Enrolling nonpoor informal sector workers and their families in SHI has proved even harder. This undoubtedly reflects the lack of attractiveness of the terms on which informal sector households enroll. Often the contribution is flat-rate, and therefore represents a burden for the near-poor. The enrolled often end up using the same public facilities they would use if they were not enrolled, and while they may end up with lower out-of-pocket payments, they typically do not fall to zero upon enrollment. Furthermore, people who do not enroll typically pay a price in public facilities that is subsidized, often heavily so. In many countries, people would probably prefer to use private providers, including drug vendors, and these are typically not covered by the scheme. People perceive the drugs that are covered by the insurance scheme as lower quality than those they can purchase—often without a prescription—at a pharmacy. And finally, in some countries, informal payments are rife, and these are also not covered; in fact, the providers may expect more generous informal payments of the insured, using insurance status as a signal of ability to pay.

"Vietnam is one of the many countries where many—if not all—of these factors help explain why voluntary SHI enrollment among informal sector workers and the families of formal sector workers has got stuck at around 20% of the target group (Nguyen 2006). As much as 13 percentage points of this is due to enrollment by schoolchildren, who are enrolled en bloc with a good deal of arm-twisting by the authorities. In the Philippines, only 14% of the target group is voluntarily enrolled with PhilHealth, ten years after its inception (Nguyen 2006). In Colombia, where enrolment by nonpoor informal sector workers is compulsory, enrolment in the contributory scheme among the richest 60% of the population—*including formal sector workers*—is only 52%, ten years after the reform that made insurance compulsory for nonpoor informal sector workers (Tono 2006). In Tanzania, total enrollment in the new SHI scheme is just 3% of the population, five years after the scheme's establishment (Nguyen 2006). In the Kyrgyz Republic, attempts to enroll the informal sector have largely failed. In Ghana, one year after the scheme's start, enrollment stood at 21% of the population, but only 5 percentage points of the 21 represented enrollment by contributing informal sector workers. Efforts in some countries are being made to enroll the informal sector through group associations (e.g. microcredit organizations), but the progress is painfully slow. One developing country that has succeeded—at least for the moment—where others so far have failed is China, where enrollment in its new subsidized and voluntary rural health insurance scheme is around 80% in pilot counties (Wagstaff et al. 2007). However, such high enrollment rates appear to have been the result of pressure being exerted by local government officials eager to hit their enrollment targets; some have been so keen in fact that they have waived the household's contribution and have financed it out of local government revenues. And coverage is so shallow that insured households still pay the vast majority of health care costs out-of-pocket. The sustainability of such an approach even in China seems questionable, and it is one that is ill suited to the most other developing countries. Where people

are enrolling in SHI schemes, there is some evidence that it is the worst risks that are enrolling. Such adverse selection appears to exist in the Philippines, for example, and is argued to pose challenges for the financial sustainability of PhilHealth (Jowett 2006). It appears to be present in China's rural scheme (Wagstaff et al. 2007). It would, in fact, be surprising if it wasn't a problem in all schemes that are voluntary in nature if not in name, given the evidence on the subject from the around the world. Furthermore, among informal sector workers who *do* enroll the contributions forthcoming are often less than they ought to have been, according to the contribution rules. In the Philippines, where contributions by individual paying members are flat-rate, only 75% of revenues have actually been collected (Obermann et al. 2006). In Mexico's *Seguro Popular* program, where contributions are linked to assessed income, only 8% of enrollees in the richest 60% of the population actually contributed (all should have done so according to the rules), and those who did contributed on average less than half of what they ought to have done (Scott 2006). And, as has already been noted, the costs associated with collecting these less-thanexpected contributions are often considerable.

"The difficulties that developing countries today are experiencing in extending coverage to nonpoor informal sector workers and in raising contributions from them point towards a long and frustrating road to universal coverage under SHI. The European SHI countries studied by Carrin and James (2004) (Austria, Belgium, Germany and Luxembourg) took close to 100 years to achieve universal health insurance (UHI). Costa Rica, Japan and Korea, which achieved UHI in 1991, 1958 and 1989 respectively took considerably less time, though Costa Rica's coverage rate in 1991 was still only 85%, and Japan and Korea were both at an advanced stage of economic development when they reached UHI (Japan's per capita income was $7876 in 1961 in 2000 prices, while Korea's was $6133 in 1989) (Carrin and James 2004; Wagstaff 2006). In the early 1980s, when Korea was extending coverage to the informal sector, it experienced similar problems collecting contributions to those being experienced now by developing countries: the health insurance societies had difficulty identifying the income level of informal sector workers, collecting the payment and determining the number of family members (there was an incentive for people to declare others as family members to receive benefits without paying); they also faced the problem that some households were genuinely unable to pay their contributions (Anderson 1989). Even today, the Korean government subsidizes about half of the contribution of the self-employed. In Japan, the role of tax finance is even larger: nearly 20% of total health spending compared to Korea's 10% (O'Donnell et al. 2005).

"Clearly, the chances of SHI leading to universal coverage in economies containing large numbers of informal sector workers are slim: the bigger the informal sector, the bigger the likely coverage gap. In such economies, SHI would not seem an especially promising route to achieving universal coverage, whether for a package that contains just 'basic' cost-effective interventions, or for one that contains these plus a few 'catastrophic' interventions. This conclusion helps explain why Thailand, which is strongly committed to UHI, relies on payroll contributions for only 12% of its population (those working in private businesses), and covers most of the rest of the population through taxation.8 It also explains why China is contemplating using tax revenues to finance a universal package of 'basic' services

Coheur, Alain et alii:
Linkages between statutory social security schemes
and community-based social protection mechanisms:
A promising new approach.
Geneva (International Social Security Association) 2007
[11]

Table 1. *Strengths and weaknesses of SSS schemes and CBSP mechanisms*

	Statutory social security	Community-based social protection
	Potential for population coverage	
Ability to cover	Strongest potential for civil servants and workers in employment relationships of a certain level of formality	Strongest potential for informal economy workers clustering around certain common characteristics (either regional or occupational, e.g. agricultural workers)
	Financial aspects and scope of benefits	
Levels of contribution	Relatively high and shared between employers and employees - often not affordable for informal economy and self-employed workers	Low levels usually affordable to all members of the scheme
Scope of benefits	Comprehensive and relatively standardized benefit packages	Limited scope and levels of benefits but well-adapted to needs of target population
Redistribution	Contributions according to ability to pay	Flat rate contributions (no redistribution)
Risk pool and financial consolidation	Big and geographically diversified risk pools. Steady contribution income flow	Small and varying (voluntary membership) size of risk pool. Income difficult to predict
	Operations / administration	
Management	Sophisticated computerization and management processes. Trained staff	Low level of management training and low levels of computerization and management system sophistication
Administrative procedures	High standardization and statutory contribution payments. Difficulties to adapt to non-standard groups	Flexible according to needs and capacities of target group. Low transaction costs and strong capacity to reduce fraud and moral hazard
	Governance	
Participatory nature	Representation of workers and employers in centralized decision-making	Direct participation of members in decentralized decision-making
	Health service provision	
Contracting	High market power and contracting capacity - agreements at a national / regional scope	Contracting power and agreements at the local level
	Policy planning	
Advocacy	Top-down policy approach	Bottom-up with/without policy support

Table 2. *Typology of potential linkages*

Financial linkages	• Tax subsidies • Redistribution between statutory and community-based schemes • Financial consolidation (risk transfers, re-insurance, guarantee fund) • Joint pooling to broaden risk pool
Operational/administrative linkages	• Technical advice • Exchange of information/good practice • Sharing of management functions: - Marketing/registration - Contribution collection - Claims processing/procedures - Fraud prevention and control • Information system linkages • Regulation and/or control
Governance linkages	Representation on boards or other institutional decision-making bodies
Linkages in health service provision	• Contracting linkages: - Definition of benefit package - Prevention and health education / promotion - Provider payment mechanisms (type of mechanism and prices) - Co-contracting with providers - Improvement and assurance of the quality of care • Access to health services delivery networks / providers
Policy planning linkages	• Joint participation in the design and implementation of national social protection strategies • Similarity in core policy design principles • Policy coherence to avoid unintended by-effects through imbalanced incentive structures

"Examples for financial linkages can be found in a number of countries. Colombia's subsidized health insurance scheme, for example, combines tax subsidies and the transfer of contributions from statutory schemes to stabilize the financing of health care for the poor and for vulnerable groups (Box 1).

Box 1

As a part of the reform of the health care system in Colombia in 1993, a special subsidized scheme was introduced to finance health care for the poor and vulnerable groups (including their families) who are unable to pay contributions to the general insurance scheme. The funds for this special scheme are raised through taxes (national and regional transfers - 69 per cent of the funding) and a solidarity contribution collected under the contributory social insurance scheme (24 per cent of the funding). These funds are then channelled to several institutions, including 7 mutual benefit associations federated in a national organization Gestarsalud, which now covers 60 per cent of the market, compensation funds (*cajas de compensación* - 20 per cent of the market), and several private commercial insurance companies that also cover 20 per cent of the market. Today this successful subsidized scheme covers 19.5 million people.

Box 2

In 2003, Philhealth, which is administering social health insurance for the private-sector in the Philippines, begun to work with CBSP mechanisms in order to extend its voluntary scheme to more informal economy workers under a project called POGI. Around 15 per cent of the target population newly joined the Philhealth scheme under this project. Building on some of the lessons learnt during this project, it was replaced by a new scheme under the name of KaSAPI that targeted community-based organizations with at least 1,000 members in 2005/2006. Under this new programme, these organizations market the Philhealth scheme, register workers and collect contributions on behalf of Philhealth. The programme offers a discounted premium when a group of a minimum level is enrolled under a contract with PhilHealth. An organized group qualifies for the group premium rate if at least 70 per cent of the group size is enrolled in Philhealth and an even more preferential rate applies if at least 85 per cent become members. At the same time Philhealth tried to adopt its systems and processes to the realities of the informal economy, e.g. it relaxed its documentary requirements to ease registration and made its payment schedule more flexible.

“A potentially even more effective procedure to ensure affiliation of informal economy and agricultural workers can be automatic affiliation of all members of an organized group (trade union, cooperative, etc.) to a scheme. The contributions can be deducted from the production sales or the taxes paid by workers instead of being deducted from individualized payrolls. These procedures have many advantages: automatic affiliation facilitates the coverage of a large percentage of the target population; it also leads to little adverse selection problems and low drop out levels; expensive marketing campaigns can also be avoided. Automatic deduction of the premium avoids having to collect premiums among the members. Moreover, since contributions are linked to sales figures or turnover, some redistribution is introduced into the scheme.

Annex 3 Lanao and the Moro struggle - history

Box 2.1 Historical roots of the Moro struggle: The Lanao perspective[1]

Scholars of Philippine history are unanimous in their account of the Moro people being the most dominant and advanced groups all over the Philippine archipelago before the arrival of the Spanish colonizers. They dominated both local and international economy, particularly trade, and possessed the most advanced technology of that period, which enabled them to produce surplus and engage in foreign trade. In politics, they had the most organized and centralized form of government, albeit feudal. The Sultanates as a political organization already existed in 1450 A.D.

Furthermore, two Bangsamoro "nation-states" existed before colonizers arrived in the archipelago. The Sulu and the Maguindanao Sultanates had, by the time of Spaniard's arrival, already perfected the requisites of nationhood, namely, territory, people, government, and sovereignty. And in the history of the Bangsamoro Sultanate, citizens included the non-Moro.

The Maranaos of Lanao del Sur and Marawi City share the same collective psyche with the rest of the Moros in Mindanao in their view of the historical injustice or holocaust inflicted by the Spanish and American colonialists and the Philippine Republic.

Spanish Colonial Period (1567-1898) The Spanish invasion of the Lanao region started with a recollect mission at Bayug, near present-day Iligan City in 1637. From this location they launched an invasion of the lake basin in 1639 but when they failed to subjugate the Moros, they retreated and built a fort to block Muslim fighters to the bay of Panguil (now Iligan Bay) (Majul, 1973:140-142). Because the Spaniards were aided by their Christian Filipino (Indio) allies, the campaign solidified a deadly Muslim-Christian antagonism in the region, and established the Christian "indios" as representatives of the colonial invaders.

For 200 years, the Lanao Muslim kept on resisting the Spaniards even as Muslim power disintegrated elsewhere in Mindanao. There was little interaction across the boundary between Muslim and Christian groups, and the small number of transactions that took place were usually facilitated by third parties, normally by the Chinese. The Spaniards finally succeeded in building and holding a fort in the lake area only after heavy campaigning in 1851-1895. Still the Muslims kept the fort under constant desultory siege [Majul, 1973:312-14].

American Colonial Period (1898-1946) According to Peter Gowing [1977:84], the initial American policies in Lanao closely paralleled those of the late Spanish regime, although American officials were more concerned with impressing the Maranao with their concern for the "personal welfare and material prosperity' of the indigenes. The American policies reflected both objectives of military control and pacification. Along with the military subjugation of the area, roads were opened on the coast to entice Maranao contact with the pacified Christian population (Philippine Commission, 1901:36). While administrative separation of the Muslim and Christian spheres was maintained, the territorial boundary between the two groups was breached.

Commonwealth Period and the Philippine Republic (1946 -) Among the Muslims in the Philippines, the Maranaos were the most critical of the commonwealth government. They criticized of the government's emphasis to develop Mindanao for the benefit of the country, the assignment to the province of officials with no experience or little knowledge of Maranao culture, the Military Training Act which required a quota of young men to undergo military training outside of their province, especially if they had to serve under Christian Filipino officers. Moreover, they were hostile to government tax collection campaigns, and indifferent to the incentives given in order to increase school attendance. The increasing number of Christian settlers who farmed traditional lands, held offices, and dominated the educational system infuriated the Maranao who felt their ancient legacies were being undermined. The dissatisfaction sparked several confrontations with government forces occurred [Dansalan Quarterly Vol. III/3 (1982); Vol. VI, 1984].

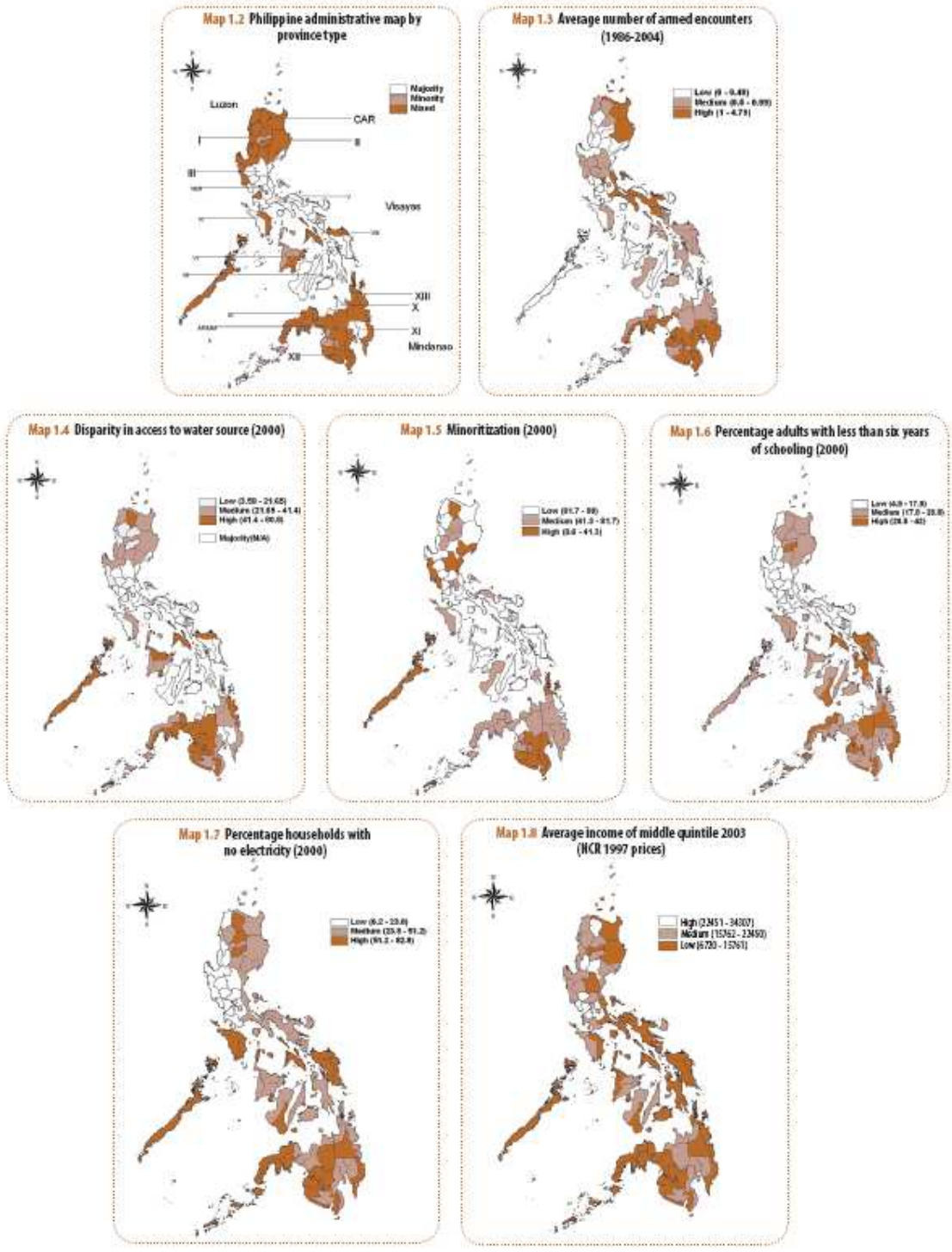
This period marked the dramatic political and economic dislocation of the Muslims. During the commonwealth, but more so during the post-war decades, the influx of thousands of migrant families affected large parts of Muslim areas especially in Cotabato and Lanao. In the Kapatagan basin in the western part of what is today Lanao del Norte, for instance, the number of Christian families increased to 8,000 in 1941. By 1960 there were some 93, 0000 Christians. This greatly outnumbered the 7,000 Maranaos still living in the area, resulting in 1959 in the political division of the Lanao Province into two—Lanao del Norte dominated by Christians, and Lanao del Sur by Muslims. The Maranao found themselves a minority in areas they once dominated.

The Muslims resented the loss of their lands, including those idle but which formed part of their traditional community. This resentment grew as Muslims witnessed the usurpation by Christian settlers of vast tract of prime lands. This ignited disputes between them and the Christian settlers. The question on land ownership and land disputes between Muslims and Christians was crucial during the post-war period. Journalist T.J.S George describes the intensity of such disputes, thus:

"...Virtually every incident sprouted from land disputes, religions only lending intensity to them. After migration gained momentum, the disputes multiplied in thousands. In one month in 1962, the Commission on National Integration listed cases involving 20,000 hectares valued at P20 million…More often than not, these cases went against Muslims as they were decided under Philippine laws [Dansalan Quarterly Vol. III/3 (1982); Vol. VI, 1984].

[1] Taken from Busran-Lao, 2005. See references for Chapter 1

Annex 4 Human insecurity mapping in the Philippines



Annex 5 PhilHealth Individually Paying Program Details

PhilHealth Individually Paying Program Details

Source: PhilHealth Website http://www.philhealth.gov.ph/members/individually_paying/index.htm

Welcome to the Individually Paying Program!

Established in 1999, the Individually Paying Program is open to self-practicing professionals, freelance writers and photographers, artists, employees of religious and civic organizations and Philippine-based international organizations.
The program also welcomes self-employed individuals, farmers and fisherfolks, and even daily wage earners such as vendors and transport drivers and operators.
Your health insurance premiums are remitted voluntarily at any accredited payments centers on a quarterly, semi-annual or annual basis.
Navigate this page to know more!

Qualified Dependents

The following also enjoy PhilHealth coverage without additional premiums for each qualified dependent:

- Legal spouse *(non-member or membership is inactive)*
- Child/ren - legitimate, legitimated, acknowledged and illegitimate *(as appearing in birth certificate)* adopted or step below 21 years of age, unmarried and unemployed. Also covered are child/ren 21 years old or above but suffering from congenital disability, either physical or mental, or any disability acquired that renders them totally dependent on the member for support.
- Parents *(non-members or membership is inactive)* who are 60 years old, including stepparents *(biological parents already deceased)* and adoptive parents *(with adoption papers)*.

All of your qualified dependents shall be entitled to a separate coverage for up to 45 days per calendar year. However, their 45 days allowance will be shared among them.

Benefits

Inpatient coverage:

PhilHealth provides subsidy for room and board, drugs and medicines, laboratories, operating room and professional fees for confinements of not less than 24 hours. Please refer to the table of rate ceilings/maximum allowances for inpatient coverage.

Outpatient coverage:

Day surgeries, dialysis and cancer treatment procedures such as chemotheraphy and radiotheraphy in accredited hospitals and free-standing clinics.

Special benefit packages:

- Coverage for up to the third normal delivery!
- Newborn Care Package
- TB treatment through DOTS
- SARS and Avian Influenza Package
- Exclusions/non-compensables

Table of rate ceilings/maximum allowances for inpatient coverage

The following are the maximum allowances or ceilings to be applied per single period of confinement**.

LEVELS 3 & 4 HOSPITALS (TERTIARY)				
Benefit Item	**Case Type**			
	A	**B**	**C**	**D**
Room & Board *	400/day	400/day	400/day	1,035/day
Drugs & Medicines	3,000	9,000	16,000	35,655
X-ray, Lab & Others	1,700	4,000	14,000	29,430
Operating Room	RVU 30 & below = 1,060 RVU 31 to 80 = 1,350	RVU 81 to 200 = 3,490	RVU 201 to 500 = 3,490	RVU 501 & above = 10,470
Professional Fees:				
General Practitioner	150/day Max. of 600	150/day Max. of 900	150/day Max. of 900	315/day Max. of 2,430
Specialist	250/day Max. of 1,000	250/day Max. of 1,500	250/day Max. of 2,500	450/day Max. of 4,050
Surgeon	40/Relative Value Unit (RVU) Maximum of 16,000			120/RVU Max. of 47,790
Anesthesiologist	30% of Surgeon's fee Maximum of 5,000			30% Surgeon's fee Max. of 14,355

LEVEL 2 HOSPITALS (SECONDARY)				
Benefit Item	**Case Type**			
	A	**B**	**C**	**D**
Room & Board *	300/day	300/day	300/day	660/day
Drugs & Medicines	1,700	4,000	8,000	19,725
X-ray, Lab & Others	850	2,000	4,000	10,215
Operating Room	RVU 30 & below = 670 RVU 31 to 80 = 1,140	RVU 81 to 200 = P2,160	RVU 201 to 500 = 2,160	RVU 501 & above = 6,480
Professional Fees:				
General Practitioner	150/day Max. of 600	150/day Max. of 900	150/day Max. of 900	315/day Max. of 2,430
Specialist	250/day Max. of 1,000	250/day Max. of 1,500	250/day Max. of 2,500	450/day Max. of 4,050
Surgeon	40/Relative Value Unit (RVU) Maximum of 16,000			120/RVU Max. of 47,790
Anesthesiologist	30% of Surgeon's fee Maximum of 5,000			30% Surgeon's fee Max. of 14,355

LEVEL 1 HOSPITALS (PRIMARY)		
Benefit Item	**Case Type**	
	A	**B**
Room & Board *	200/day	200/day
Drugs & Medicines	1,500	2,500
X-ray, Lab & Others	350	700
Professional Fees:		
General Practitioner	150/day Max. of 600	150/day Max. of 900
Specialist	250/day Max. of 1,000	250/day Max. of 1,500
Minor surgical operations are covered up to 1,200 for Professional Fees and 385 for Operating Room		

** Not to exceed 45 days for each calendar year*
*** Refers to a confinement or series of confinements of the same illness not separated from each other by 90 days within a calendar year. In this case, a member or beneficiary is not entitled to another set of benefits until after 90 days. They can only avail of the unused portion of the benefits and the room and board fees until the 45 days allowance is exhausted.*
However, a member can avail of new set of benefits if succeding confinements are of different illness.

Exclusions
The following are not being compensated yet except when, after actuarial studies, PhilHealth recommends their inclusion subject to approval of its Board of Directors:

- Fourth and subsequent normal obstetrical deliveries
- Non-prescription drugs and devices
- Alcohol abuse or dependency treatment
- Cosmetic surgery
- Optometric services
- Other cost-ineffective procedures as defined by PhilHealth

Availment conditions and procedures

Availment conditions
The following must first be met to avail of your PhilHealth benefits:

- Payment of at least three monthly premiums within the immediate six months prior to confinement.
  For pregnancy-related cases and availment of the new born care package, dialysis *(except those undergoing emergency dialysis service during confinement)*, chemotherapy, radiotherapy and selected surgical procedures, **payment of nine (9) monthly premium contributions within the last 12 months shall be required except for those enrolled under the KaSAPI program.**
- Confinement in an accredited hospital for at least 24 hours *(except when availing of outpatient care and special packages)* due to an illness or disease requiring hospitalization. Attending physicians must also be PhilHealth-accredited.
- Availment is within the 45 days allowance for room and board.

Benefit availment procedures
For outright/automatic deduction of benefits:

- Submit to the billing section the following prior to discharge from the hospital:
  - Duly accomplished PhilHealth Claim Form 1 (original)
  - Proof of applicable premium payments.
  - Clear copy of Member Data Record (MDR).
    - If patient is a qualified dependent but not listed in the MDR, submit applicable proof of dependency.
  - Agree with your attending physicians on how much is left to be paid for their services over the professional fee (PF) benefit.
  - Upon submission of all applicable documents, the billing section will compute and deduct your benefits from your total hospital bill.

For direct filing/reimbursement:
Submit the following to PhilHealth or through the hospital in addition to the documents mentioned earlier within **60 calendar days after discharge**:

- PhilHealth Claim Form 2 (to be filled up by the hospital and attending physicians)
- Official receipts or hospital and doctor's waiver
- Operative record for surgical procedures performed

For confinements abroad:
Submit the following **within 180 days after discharge.** Overseas confinements shall be paid based on Level 3 hospital benefit rates.

- PhilHealth Claim Form 1
- MDR or supporting documents
- Proof of applicable premium payments
- Original official receipt or detailed statement of account (written in English)
- Medical certificate (written in English) indicating the final diagnosis, confinement period and services rendered.

Post availment reminders:
After the automatic deduction or reimbursement of your benefits, PhilHealth will send you *(to the address you have indicated in your claim form)* a benefit payment notice or BPN. The BPN is a report of actual payments made by PhilHealth relative to your confinement/availment.
Should there be discrepancies or if you have other concerns pertaining to your benefit availments, you may contact PhilHealth or your health care providers and bring the BPN as reference document.

Frequently Asked Questions

Membership and premium concerns

1. **I just missed a quarter's payment due to an unforeseen event. Is there a chance that I can still pay for the missed quarter?**
Retroactive payments are not allowed except when a member can show proof of sufficient regularity of premium contributions or payment of at least nine (9) months within the last 12 months prior to the missed quarter. If you meet this condition, you shall be allowed to pay the missed quarter within the month immediately following the missed period.
For newly enrolled members (with less than 12 months reckoned from date of enrollment), retroactive payment shall also be allowed within the month immediately following the missed period.
This privilege is granted only once every 12 months.

2. **Can I still refund my contribution if I mistakenly paid twice for the same period?**
Overpayments shall be adjusted to cover underpayments (if there's any) or shall be considered as advance payments.

3. **I am a new member. When will I become eligible to avail of PhilHealth benefits?**
For one to become eligible for the benefits, payment of at least three (3) months within the immediate six (6) months prior to the month of confinement shall be required. However, payment of at least nine months within the last 12 months shall be asked of Individually Paying Members availing of the following procedures/packages:

- Pregnancy-related cases
- Newborn care package
- Dialysis (except those undergoing emergency dialysis service during confinement)
- Chemotherapy
- Radiotherapy
- Selected surgical procedures

4. **My spouse is also a PhilHealth member. Are we allowed to declare our only child so that we can both apply our separate coverage in the event she gets sick?**
PhilHealth does not allow multiple declaration and application of PhilHealth entitlements of both spouses. We advise you to decide who among you will declare and provide for the PhilHealth coverage of your only child as a dependent.

Benefits and availment concerns

1. **Are there substitute documents that I can submit for my dependent's confinement if my MDR is not readily available or is not yet updated?**
You can still proceed with your benefit claim with the following as substitute documents:
- Spouse - marriage contract/certificate
- Children - birth certificate
- Parents - birth certificate of member and patient

2. **Will PhilHealth reimburse my hospitalization in a foreign country even if the hospital is not accredited by PhilHealth?**
Overseas confinements of PhilHealth members, regardless of their membership category, and their dependents are still covered and shall be paid based on Level 3 Hospital benefit rates.

3. **What is a *single period of confinement*?**
It refers to a confinement or series of confinements for the same illness with intervals of not more than 90 days. In such cases, members are not entitled to another set of benefits/allowances until after 90 days. They can only avail of the unused portion of the benefits and room and board allowance until the 45 days allowance is exhausted.
However, members can avail themselves of a new set of benefits if succeeding confinements are of different illnesses or conditions.

4. **What if I am not readily available to sign the PhilHealth Claim Form 1?**
The following are allowed to sign the said form on your behalf:

Member Status	**Authorized person *(in order of priority)***
Member is married	Legal spouse
	Child 18 years old and above in the absence of spouse.
	Parent (mother or father) in the absence of spouse and child.
Member is single	Parent (mother or father)
Member is orphaned	Brother/sister/guardian

Clearly state in the form the reason for signing on behalf of the member, or a certification (on a separate sheet of paper) may also may be issued to this effect, with the full name, complete address and contact number/s of the authorized signatory also indicated.
Provide a photocopy of the authorized signatory's identification card (ID) and/or proof establishing his/her relationship to the member.

5. **Are emergency cases covered?**
Emergency cases as defined by PhilHealth shall be paid.

6. **What if the hospital is not accredited? Will I still get paid?**
Claims of members confined in non-accredited hospitals shall not be compensated unless all of the following conditions are met:
- Case is emergency as determined by PhilHealth
- The hospital or facility has a current DOH license
- Physical transfer/referral to an accredited facility is impossible as determined by PhilHealth

7. **How will I know if I was deducted the correct amount of benefits?**
Members are sent a benefit payment notice or BPN to report the actual payments made by PhilHealth relative to their confinement/availment. The BPN is sent to the address indicated by the member in their claim form.
Should there be discrepancies in the payments and the actual benefits deducted from your hospital and doctors' bills, you may contact PhilHealth or your health care providers and bring the BPN as reference document.

8. **How long does it take to process a PhilHealth claim?**
All claims except those under investigation shall be processed and paid within 60 calendar days from receipt thereof.

Annex 6 A community based policy paper on social health insurance in the Philippines, 1994

TOWARDS A SOCIAL HEALTH INSURANCE

Response to the Draft of the Proposed Health Insurance Bill, as of 28 January 1994

First Policy Paper of the Federation of HAMIS Winners in the Philippines, Inc.[2]

1. Basic Concerns

For the time being, 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

[2] Federation of HAMIS Winners in the Philippines: Policy papers on community health care financing. Manila (Department of Health, Health and Management Information System, Occasional paper No. 14) 19995

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.

2. Integrated Health Care

The spirit of Alma Ata asks that primary health care (PHC) looks into community and personal health care in its entirety. Both services have to be provided in a complemented and coordinated way. Preventive and promotive community health services are primary functions of people's organizations and/or DOH, preferably in a way that these services complement each other. The draft of this Health Insurance Scheme will effectively sever this linkage and would tend to cover personal health care only. Lack of coordination would lead to limited prevention and overuse of curative services. It is imperative that DOH and/or community organizations develop an integrated approach for health care delivery.

Funds have to be made available especially for the community health services. This is so because people will not opt to pay for it. Therefore the income from personal health care (e.g., through Local Health Insurance Organizations) has to be used to support and sustain community health services and programs.

3. Community Health Insurances

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 catchment.

A complete listing of the 52 HAMIS Winners can be found in Annex 7. 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.

4. Bureaucratic Health Insurances

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.

1. **The problem of overuse**: The basic rules of Medicare encourage people to want to be hospitalized regardless of the fact that their illness could be well taken care of at an outpatient clinic. Hospitalization allows them to avail of Medicare benefits. This is the exact opposite of the idea that prevention, early detection and treatment are the best and least costly ways of primary health care. Medicare is espousing a health consciousness that is exactly the opposite of the spirit of the Alma Ata. Here is an example of a health insurance that is encouraging disease and disregarding the issue of health promotion and prevention of disease. We can not and should not share this philosophy.

2. **The problem of misuse**: All over the Philippines, stories with concrete evidences of the misuse of Medicare provisions and benefits are rampant. We, at the grassroots and in touch with community action and health care, see this daily. We are getting sick and tired of it. We are further intimidated when some providers and officials laugh about the stupidity of not having an effective misuse control, i.e., people making personal profits behind the back of the premium payer and at the expense of the patient. Until now, we have not noticed any serious and earnest endeavors to stop the misuse. We are still waiting for sanctions to have more teeth on violators and cheaters in the government and its institutions who pretend to provide health care but in reality are just self-service boutiques for too many.

3. **The problem of abuse**: Overcharging the patient and Medicare is one of the daily practices of several health care providers. Over-extending the length of stay of patients in hospitals is another example of abuse within a health insurance system that has gone out of control. The sad part is that this is common knowledge and yet we do not see any convincing efforts to remedy our concerns.

4. **The problem of fake and ghost patient**: Since hospitalization entitles a member to Medicare benefits, it is not uncommon that people fake being in a hospital or for doctors/hospitals to claim for benefits of non-existing patients. The money being used to pay for benefits of fake and ghost patients is coming from an institution that has already lost its credibility and trust of the people. Therefore, it is not even looked upon as an immoral act (stealing money and resources). Not only does it cover up the low occupancy rate of some hospitals, it also becomes important for their survival. We can not accept this. And we do not want to be integrated in organizations that condones and perpetuate such misdoings.

5. **The problem of non-representation**: Communities and people's organizations especially in the rural areas are not properly represented in nearly all formal organizations to make decisions that affect their lives. This is a disadvantage for both- the communities and the organizations. Such organizations could learn much from the creativity and ingenuity of the poor and of poor communities who have discovered/learned good management of meager resources and not affected by bureaucratic apathy. They can be best teachers of good management practice. The very fact of non-representation tends to strengthen the organizations which in turn are strengthening those who are already strong. This seems to hold true with Medicare and its recent modifications.

6. **The problem of inaccessibility**: Most health providers situate themselves in towns and cities. A large portion (70-80%) of the population lives in rural areas where the cost of transportation is prohibitive for a patient to reach the nearest hospital. This is true for those who might need health care but living in island municipalities and in hinterlands. This is geographic inaccessibility. Some ethnic groups are not used to avail of services that could alienating. In this particular instance, we have an experience of social inaccessibility.

7. **The problem of the rights of the consumers**: Health is a human right. Therefore, discussions on human rights should also be on the agenda of health providers and intermediaries like health insurances. It is good that one section of the bill specifically deals with this issue. There have been many complaints on the disregard of patients' rights. But they are not usually taken care of because of the position of power of the poor consumer viz-a-vis the position of power of the providers enshrined by the bureaucracy. the latter seem to be preoccupied with other things rather than dealing with this issue.

8. **The red tape problem**: Red tape is a chronic disease and an ugly sore of large organizations run by bureaucratic technocrats rather than human beings. While community organizations are relatively free of it, large corporations have to invent ingenious mechanisms to avoid it. The existing health insurances are plagued with red tape. This defeats the purpose of why they were created.

9. **The problem of lack of check and balances**: In a multi-cultural, multi-lingual and multi-island country like the Philippines there has always been a lack of effective communication. This has its advantages and also its disadvantages, especially when monitoring and control is the issue. This confounds the issue of overuse, misuse and abuse of Medicare provisions and benefits. HAMIS winners are suggesting that sanctions on corrupt cheaters should have more teeth.

10. **The problem of indigents**: There is no clear-cut definition of indigency. Those who are really indigent could not avail of the health services. By and large, those who could be considered indigents are found in the periphery. It is economically impossible for them to avail of health services that are usually found in town centers or cities. Indigency is also relative. One catastrophic illness could throw a middle class family in the brink of sustained indigency. This is issue has to be studied extensively. It is not only a matter of mean-tested income. Rather, it is a matter of compassionate health promotion and prevention on the part of any social organization.

11. **The problem of disabled and mental health patients**: Many insurances do not cater to the disabled or mentally ill. Such groups are most in need of health care services. When uncared

for, they would fill the ranks of the indigents and would have to be subsidized by another program of the same government.

12. **The problem of the chronically ill and the elderly**: The explanatory note of the draft of the proposed bill says: "Even as the Philippines continues to wrestle with pervasive communicable diseases, there is a gradual but visible aging of the population with the concomitant rise of chronic and degenerative diseases". But there is no provision of health services for this group of people in the proposed bill as home and rehabilitative care are excluded from personal health care services. In the experience in one of the HAMIS winners, some chronic patients have already organized themselves as in the case of the Lucena Diabetic Patients Association. Associations like that one show that grouping together chronically ill patients can bring about private and public savings.

13. **The problem of self-employed and the unemployed**: They represent a high percentage of the population in the Philippines. There is no clear health insurance policy that is affordable to them and to the whole enterprise. It needs careful study on how best their needs could be met. HAMIS-type community health insurances, cooperatives and community loan arrangements seem to be the most appropriate way to integrate these groups into a social network of social health assurance.

14. **The problem of ceilings and severe illness**: In reality as well as in the proposed bill benefits (services and drugs) are limited. Cost-effective highly-expensive procedures can be excluded. The patient has to pay for health care in case of severe illnesses as the expenses go beyond the imposed ceilings on benefits. If the ceiling would be patterned after Medicare provisions the proposed bill could not be called a "health insurance" since it would be more of an insurance for health providers. This is because pre-payments usually will not be paid back if not used. If they are used, then they cover expenses only up to a certain ceiling. A health insurance scheme has to avoid the mere shifting of the savings of the poor for the benefit of the providers.

15. **The problem of profits**: According to the draft of the proposed bill, Health Insurance Organizations subsidized by the government can choose to have any kind of organizational structure. It can either be an organization for-profit or non-profit. This might lead to the taking over of low-risk areas by for-profit organizations and high risk- areas will be left alone. In addition, the inclusion of for-profit insurances brings about an unwanted redistribution of non-profit premiums to the for-profit organizations and thus draining out community health endeavors.

16. **The problem of investments**: In the Philippines, for health insurances like Medicare there seems to be no limit of for-investment disbursements. It has turned an instrument of health care policy into an instrument of fiscal policy for the government. Health institutions turn into being investment agencies. Our solution would be to limit the profit from investment to a small margin of earnings and to keep a reserve earmarked just for health care.

17. **The problem of corporational omnipotence**: Creating a megalomanic corporation for more than 60 million Filipinos as planned by the proposed bill is drawing us back to the time before the devolution. It is taking over the responsibility for all Filipinos by one single institution as if it were realistic and practical. An association or federation of smaller institutions will be more reasonable. It would introduce the elements of reasonable choices, options, alternatives, healthy competition and compassionate bargaining and negotiation.

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.

5. Recommendations

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.

STEP 1 A series of public hearings, consultations, conferences dealing with the tabled proposal for a health insurance bill is very much needed. It will be useful to take this as a starting point for further discussions on health insurance, primary health care, prevention and promotion. Health insurance can not be dealt with in isolation. This will be even more useful if the unrepresented and the underrepresented groups would have access to these discussions. Taking health in our hands also means willingness to take health insurances into our hands.

STEP 2 Time is a very important resource needed for discussions to happen at all levels. We know that government officials, barangay captains, mayors, municipal health officers and different partners in health and health care are willing to participate in such discussion. We can learn much from their experiences. Clarifications and consensus meetings at such levels are mechanisms for empowering us and our partners, for enlightening them to understand that health is wealth and that small scale income-generating projects are more needed than additional hospital beds. Time for extensive discussions is not wasted time even if would take two or more years. It would be a good investment to learn from social realities and processes rather from academic studies and surveys.

STEP 3 The inefficiencies, bureaucratic rigidities and loopholes in our government insurance and/or Medicare need carefully to be studied. It would not be easy to get proper insight into this murky area. But if we would not understand all the ways and means how an existing health insurance organization is being abused and misused we will not be able to manage the future of a "social" health insurance for the benefit of the honest and humble people in need.

STEP 4 Especially essential is an orientation of Local Government Units on objectives, mechanisms of operation, coverages, etc... The Local Government will play an important role in health care in the future. The major focus of our endeavors will be to empower and enlighten them. Health care management is a biog concern for all Filipinos. The political representatives of the barangays, municipalities, cities and provinces will have to know what effective, efficient and equitable health care management really means. They should be elected on these grounds.

STEP 5 We are recommending the accreditation of HAMIS providers by the most appropriate level of DOH endorsed through the lowest possible level of the LGU. We also ask that approved accreditation standards. Priority should be given to providers that have comprehensive health care approaches based on empowered populations and using PHC standards. Standards would include all the criteria met by HAMIS winners that qualified them as excellent health care managers: quality, effectiveness, efficiency, equity, innovativeness and sustainability. We, HAMIS winners, have an approved set of 66 criteria for looking into the standards of good health care management. They could be used for building up a social health insurance.

STEP 6 Details of the health insurance will have to be discussed objectively: the advantages and disadvantages of different benefit packages and coverages the different premiums for the different target groups, the definition of terms, e.g. effectiveness, efficiency, equity, benefits, indigency. This is not just a technical step to be prepared by insurance specialist, economist, mathematicians, etc. A broader participation of concerned citizens and community organizations and non-governmental organizations should be included in this step.

STEP 7 The pilot testing of different models is an essential feature of a smooth development process towards a social health insurance. Demonstration projects and evaluation of on-going endeavors will be centers for pilot testing and evaluation. The many existing models of health assurance and health insurance and the many ways and means of formal and informal social security and safety nets will be reviewed. the same process was done with more than 30 HAMIS winners that underwent intensive case studies. There is not just one option for pilot testing, e.g., Medicare 2. There are many other options and alternatives that might be combined into a network of approaches rather than into one streamlined bureaucratic entity.

STEP 8 Such models work against a backdrop of real existing public and private health services which have to be reviewed at local levels in terms of effectiveness, efficiency and equity and in terms of the capacity and willingness of local governments to run them.

STEP 9 The lessons of these collective and social learning processes should not be applied nation-wide immediately. There should be an on-going phasing and review based on the principle: the best health benefits for the poor and for the needy through the best combination of existing and emerging organizations.

STEP 10 The assessment of organizational alternatives might result in the option that is in the form of Federations or Associations of Insurances at the most appropriate levels of organization. A possibility is that existing non-profit or social health insurance can be organized at regional or even at national levels as deemed appropriate by them. Then they will attach to the corresponding level of organization of the Department of Health or any kind of mother agency that cares for comprehensive primary, secondary, tertiary health care on the basis of an improvement of the socio-economic background (i.e., pre-primary health care). The members will be the ones to decide if they are to be integrated into the local, regional and even national level of organization.

The HAMIS WINNERS' CLUB on Health Insurance will start drafting a bill that is according to the principles stated. At the same time, we will incorporate as many elements as possible into the proposed "Angara Bill" on health insurance. And we are actually working on the finalization of our policy position paper on local health care financing.

More power!

Annex 7 Community health initiatives in the Philippines

Some winners of a national contest of good health care management
1991 and 1994
In:
Schwefel, Detlef and Emma Palazo (Eds.): The Federation of the HAMIS Winners in the Philippines. Manila (HAMIS at the Department of Health, Popular Paper No. 3) 1995, 635 pages
[53]

- Manila (diamond winner): 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 Province (diamond winner): 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 del Norte (diamond winner): 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.
- Cebu (gold winner): 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 (gold winner): 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 (silver winner): 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 (silver winner): 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.
- Iloilo (silver winner): 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 (silver winner): 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 (silver winner): 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.
- 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