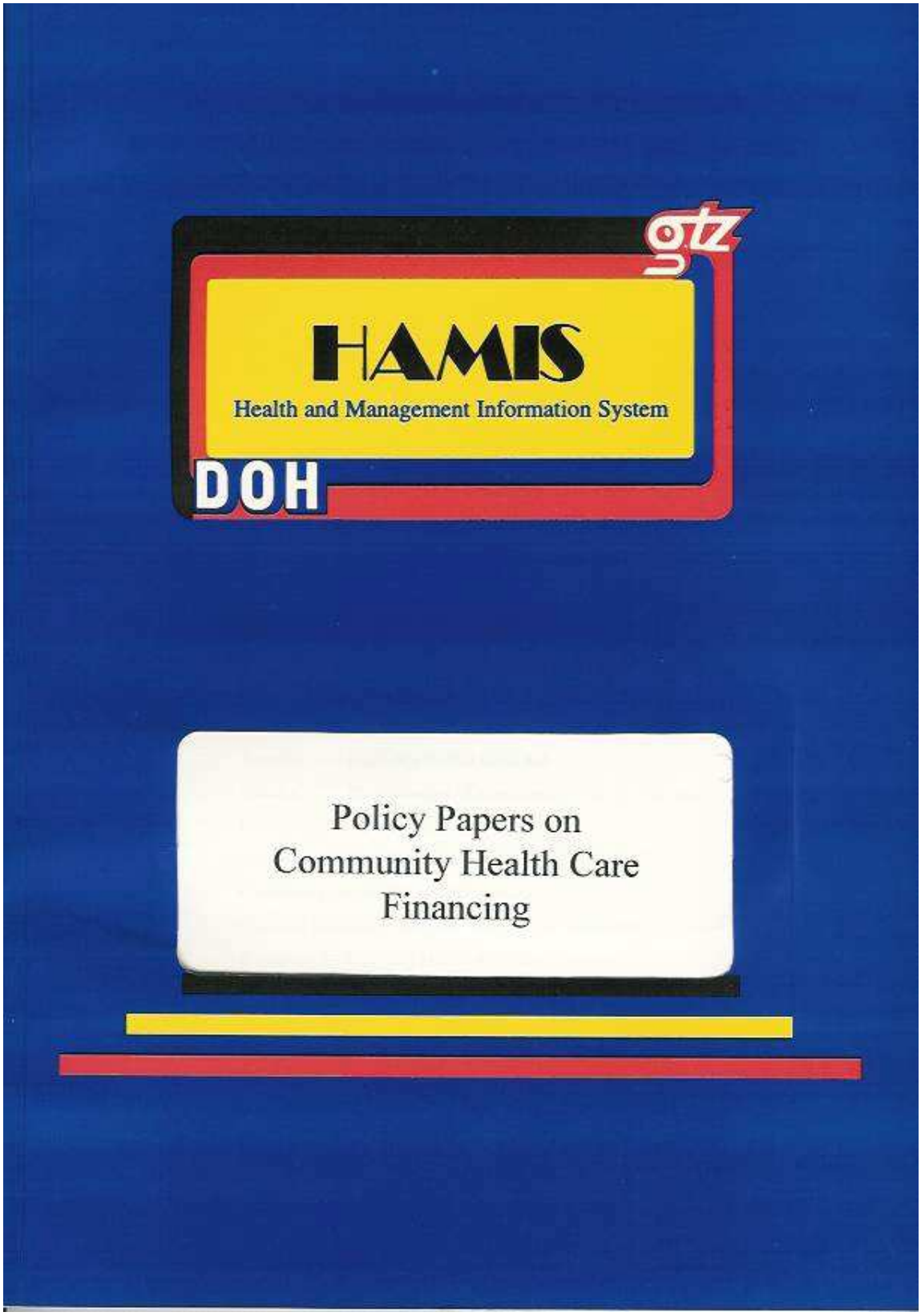
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HAMIS
Health and Management Information System
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Policy Papers on
Community Health Care
Financing

DOH **Department of Health of the Republic of the Philippines** **gtz**
Deutsche Gesellschaft für Technische Zusammenarbeit

Health and Management Information System

HAMIS

Federation of HAMIS Winners in the Philippines, Inc.

Policy Papers on Community Health Care Financing

Manila 1995

Philippine-German Cooperation
between the
Department of health (DOH) of the Republic of the Philippines
German Agency for Technical Cooperation (GTZ)
German Federal Ministry for Economic Cooperation and Development (BMZ
to Strengthen the
Health and Management Information System
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Policy Papers on Community Health Financing

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Key Words: Quality of Health Care, Health Care Management
Health and Management Information System, Philippines

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Preface

Since 1989 the German Ministry for Economic Cooperation and Development (BMZ) has supported the strengthening of the Health and Management Information System (HAMIS) of the Department of Health (DOH) through the German Agency for Technical Cooperation (GTZ).

One of the information systems developed by HAMIS has been especially innovative, and answers the question "What are the examples of good management in the country?" The HAMIS Contest is a "discovery module" on good health care management. Through the HAMIS Contests, a variety of outstanding community programs for those in need have been identified and integrated into an extended national networking. Several of the programs developed or discovered by HAMIS have received national recognition for their valuable contributions to health and social development.

The 120 winners of the HAMIS Contests have organized themselves into a nationwide Federation of the HAMIS Winners in the Philippines, Inc. This HAMIS Federation is recognized by the Department of Health as an outstanding consultative group for health policy formulation. We welcome policy advise from this group of accredited good health care managers. The Department of Health commissioned the Federation of the HAMIS Winners to draft policy papers on community health care financing. We were happy to provide a 3 Million Pesos budget for this undertaking. This book contains the policy papers. They will guide us in our fight to bring back health into the hands of the people.

This publication is one of the many achievements of the Federation of the HAMIS Winners in the Philippines. We welcome this contribution to the performance of the Department of Health. We see it as a fruitful result of a good Philippine-German Partnership.

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Department of Health

Policy Papers on Community Health Care Financing

Acknowledgements

The Policy Papers of the Federation of the HAMIS Winners in the Philippines are the product of a team rather than of individuals even if individuals were the driving forces. Drafts were widely circulated among all HAMIS Winners and discussed and revised in many local, regional and a national convention of the HAMIS Winners. Intensive consultation processes with the Department of Health enriched the paper. We would like to mention the fruitful cooperation with the Health Policy Development Staff of the Department of Health. The authors of the policy papers are the members of the Federation of the HAMIS Winners in the Philippines, i.e. all the following 120 projects.

HAMIS Diamond Winners

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

HAMIS Gold Winners

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

HAMIS Silver Winners

1-018Kapitbahayan, Midsayap, Cotabato
1-042Water For Life, La Union
1-051Community-based Health Care Program, Iloilo
1-061Canossa Health and Social Action Center, Tondo
1-064Malaria Surveillance and Vector Control Project, Camarines Norte
1-065Pahinog Costa Project, Northern Samar
1-076Emergency Disaster Brigade, Cebu City

1-080LGU Indigency Program, San Mateo
1-092Improved Rural Health Unit, Romblon
1-084Bukas Palad, Pasay
1-100Camatagan Ladies Association, Mt. Province
2-031Leprosy Control Project, Nueva Vizcaya
2-101Tagbitan-ag Women's Organization, Davao del Norte
2-102Hilongos' Integrated Nutrition Program, Leyte
2-133The Calatrava Municipal Health Board, Romblon
2-148Stop AIDS Campaign, Manila
2-149Child to Child Health Education Program, Lucena City
2-151Kalusugan Pamayanang Programa ng Katiwala at Katuwang, Cavite

HAMIS Bronze Winners

1-001HEWSPECS' Community-based HMO, Diliman and Binan
1-004Health Resource Distribution, Cebu
1-005Manufacture of Herbal Medicine, Iloilo
1-006Family Care Program for Patients with Long-term Illness, Bulacan
1-007MAKAPAWA Community Health Program, Tacloban
1-009Provincial Nutrition Village, Agusan del Sur
1-012Improvement of Sta. Fe RHU, Romblon
1-014BHW Masterlister, Negros Oriental
1-020Cottage Industry for Mothers of Malnourished Children, San Carlos City
1-025Public-private Health, Negros Occidental
1-027Health Promotion for the Urban Poor, Iligan City
1-028Health Banking & Development, Sorsogon
1-029Alternative Malaria Control Project, Tawi-Tawi
1-030Operasyong Tulungan Pamilya, Batangas
1-031HERB, Samar
1-034MASIKAP - Workers' Health Program, NCR/General Santos City
1-041People's Adoption to Total Health Sufficiency, Lucena
1-043Archdiocesan Nutrition Program on MCH, Davao City
1-044Medical-Dental Nutrition Assistance Project, Pampanga
1-046Health Care Campaign on the Air, Isabela
1-048Health Financing by Cooperative
1-052BHW Health Stations, Tagkawayan Quezon
1-053TB Sweeping Operation, Marinduque
1-055NORFIL's Basic Health Care Service, Cebu
1-063Family Welfare Program, Antique
1-067Puericulture Center Family Planning & Mothers' Club, Pagudpod, Ilocos Norte
1-070Cooperative Health Emergency Assistance Program, Lucena
1-072Information Nutrition Action Program, NCR
1-077FRB's Radio for Health, Q.C.
1-078Kadang Youth Group and Health, Leyte
1-085Refugees Mental Health, Bataan
1-099Community-based Health Program, Samar

1-101BHW Mobilization, Cagayan de Oro City
2-002Holistic Development of Talispungo, Marugundon, Cavite
2-007Community Primary Hospital, Dumaguete City
2-008SAMAPA for Mt. Pinatubo Victims and Pioneer Settlers, Occidental Mindoro
2-015Yakan Integrated Resources Development Program, Basilan
2-016Silago Multi-purpose Cooperative, Southern Leyte
2-017Primary Health Care (PHC) Mothers' Club of Mainit, Surigao del Norte
2-018Institute of Community Health Development Project, Quezon City
2-019Purok Health Care Management and Delivery System, Bohol
2-024Health Care Opportunities for Economic Success Program, Lucena City
2-028Health Scouts, Bontoc
2-029Kalahan Health Program, Nueva Vizcaya
2-032OSF Assistance Community Center
2-034Village Health Workers' Training Program, Sultan Kudarat
2-041Community Health Education and Promotion, Zamboanga del Norte
2-042Partnership Mechanism on Basic Health Care Program, Davao
2-045Intensive Rehabilitation of Severely Malnourished Children, Quezon City
2-046Kapatirang Tulungan ng mga Diabetiko sa Malolos, Bulacan
2-049Eastern Besao Deanery Episcopal Church Women Federation, Mountain Province
2-050Day Care Service, Lucena City
2-055Kapatiran ng mga may Kapansanan sa Buhay, Inc., Lucena
2-057Urban Family Development Program, Quezon City
2-058Two Peso A-Day Hospitalization Plan, Iligan City
2-061TB Control Program, Davao City
2-062Capalangan Kiddie Care, Pampanga
2-063Mobile Surgery, Tagum, Davao del Norte
2-064Communal Garden, Capiz
2-065Integrated Community Development, Abra
2-070PHC Delivery Program, General Santos City
2-071Drop-In Center for the Mentally-Ill and the Drug Dependent, Agusan del Norte
2-072Pediatric Dentistry Division, Quezon City
2-073Handog sa Mahihirap, Butuan
2-074Mass Immunization of Hepatitis B Vaccine for Indigent Newborns, LapuLapu City
2-080Linabo Parish, Bukidnon
2-081Community Participation in the TB Control Program, Albay
2-084Medical Outreach Mission Foundation, Inc., Baguio City
2-085Tribal Women's Health Project, Lake Sebu, South Cotabato
2-089Comprehensive Health Development Project, Magallanes, Cavite
2-093Philippine Band of Mercy, Inc. Northern Mindanao
2-094Siuton PHC Project, Sorsogon
2-103Purok Health Data Board, Bukidnon
2-105Botika Kooperatiba Kang Antique
2-106Federation of BHW's, Surigao del Norte
2-108Lying-In Clinic, Negros Occidental
2-110Community Health Financing Project, Catanduanes
2-111Damayan Social Fund, Lucena

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

We would like to express our special acknowledgments and thanks for the strong support given to us by Dr Juan Flavier, Secretary of Health 1992 - 1995.

The compilation and editing of this book was done by Detlef Schwefel and Emma Palazo. Good assistance was provided by Edeliza Salem and Limerly Hernandez.

Policy Papers on Community Health Care Financing

Recurrent Abbreviations

AMDA	Asia Medical Doctors' Association
ARI	Acute Respiratory Infection
BHW	Barangay Health Worker
BPHCC	Barangay Primary Health Care Committees
BMZ	German Ministry for Economic Cooperation and Development
BNS	Barangay Nutrition Scholar
CDA	Cooperative Development Authority
CDI	Community Drug Insurance
CDIP	Community Drug Insurance Program
CHF	Community Health Financing
CHS	Community Health Service
CHW	Community Health Worker
DOH	Department of Health
FHSIS	Field Health Services Information System
GO	Government Organization
GTZ	German Agency for Technical Cooperation
HAMIS	Health and Management Information System
IGP	Income Generating Project
LGU	Local Government Unit
MMP	Mission Ministry of the Philippines
NGO	Non Government Organization
NORMA	Norwegian Missionary Alliance
NTMPI	Tribes Mission of the Philippines
OMF	Overseas Missionary Fellowship
P	Philippine Peso
PAGCOR	Philippine Amusement and Gaming Corporation
PAMS	Philippines Alliance of Medical Students
PCHD	Partnership for Community Health Development
PHC	Primary Health Care
PO	People's Organization
SFPHC	Surigao City Federated Primary Health Care
SMBK	Samahan ng Manggagawa ng Binhing Kalusugan
UMMTAI	United Mandaya Mansaka Tribal Assn., Inc.
ZOPP	Goal Oriented Project Planning

Policy Papers on Community Health Care Financing

Context

1. General Context

Valid and reliable information is an essential prerequisite for a more effective, efficient, and equitable health care system. On request of the Philippine Government the Federal Republic of Germany supports such endeavours through a grant channeled through the German Agency for Technical Cooperation (GTZ) on behalf of the Federal Ministry for Economic Cooperation and Development (BMZ), 1989- 1998.

Through the Goal Oriented Project Planning (ZOPP) methodology, which is mandatory for all German official development aid, repeatedly it was discovered that a core problem in health care management is an inefficient and ineffective health and management information system. Six major causes were identified:

> information gaps = lack of supply
> underutilization of data = lack of demand
> excessive generation of data = oversupply
> poor reliability and validity of data = poor product quality
> lack of skills in information management = poor production processes and
> lack of cost-effectiveness of health management.

Following ZOPP methodology, these problems were translated into objectives and operationalized by identifying the activities to achieve them.

The interaction between planning, exploration, implementation and replanning showed clearly that developing or strengthening health and management information systems is not just a technical matter of data handling and informatics. It is a joint task for medical, economic and social sciences. It has at least four dimensions:

> **information on management** means discovering good management practices in the field, thus understanding from reality and not just from textbooks what good management is and the role data and information play in it

> **information for management** means improving management of health care through data and information and thus enhancing an informa-tion culture for key areas of concern; for example, decentralized health care and assured health care for the poor

> **information management** asks for information economics, i.e. efficiency in informatics and information collection as well as using need-responsiveness and cost-effectiveness concepts

> **project management** means addressing this broad focus pragmatically in view of constraints.

These four dimensions of HAMIS deny a predominantly technical notion of health and management information systems. Rather, it is an incremental but nevertheless systematic approach to use data and information and understanding to strengthen a knowledge-based, i.e. rational decision making towards effectiveness, efficiency and equity in health care.

2. Specific context

Increased decentralization of health care tries to strengthen self-control and management at a level closer to the communities. The following approaches were used to justify and develop the first steps of a need-responsive and cost-effective Health and Management Information System (HAMIS) to support decentralized health care management.

2.1 Information needs

Five approaches were used to design a need-responsive Health and Management Information System (HAMIS).

> **felt information needs** of health managers were identified via a survey with 192 health managers in two provinces of Northern Mindanao

> **implicit normative information needs** according to the state of the art of public health were elaborated by an outstanding expert

> **explicit normative information needs** were drafted according to an economic decision making framework for the health sector

> **expressed information needs** are being analyzed by case studies of good health care management schemes that were discovered in 50 provinces of the Philippines

> **comparative information needs** were assessed via a review of health reporting abroad

2.2 Information demand and supply

The health and management indicators that emerged from these steps were reviewed and validated by health managers at local, regional and national level. After further technical review this list of indicators was provided through a survey to more than 10 different groups of health professionals and decision makers to identify a cost-effective shortlist of key indicators for management at the decentralized levels of health care. Existing as well as potential sources for all indicators were identified and compared according to criteria of availability and cost.

2.3 Information systems of HAMIS

These steps allow us to propose need-responsive and cost-effective information systems. Based on this HAMIS is working actually on the following lines of production and marketing.

2.3.1. Public health information systems

The Field Health Services Information System (FHSIS) of the Department of Health contains very important data on health services that is being brought back to the lower levels of health care management in a way understandable to the grassroot health workers; we propose the use of our BLACKBOX Information

System which is based on the FHSIS data. A menu driven software is ready for application by any interested province, district, municipality or even barangay health station. As of now it contains data on 14 health programs and on population, morbidity and mortality.

2.3.2. Hospital information systems

In this area HAMIS operates at two levels, at the level of handling the existing routine data available in the Department of Health and at the level of setting up information systems proper at the hospital level.

> Routine data on hospitals: Data compiled with the Department's Hospital Operations and Management Service (HOMS) form contain important data on hospital services. HAMIS developed a computerized encoding and retrieval system for this data on public hospitals (HOMSBOX) as well as on data given by private hospitals licensed by the Department of Health (LEILA).

> Hospital information system: On the other hand side, a consultant of HAMIS has successfully adapted his computerized Private Hospital Information System to be used in a Public Provincial Hospital. This LUCENA system basically is a menu driven software for admissions and medical records and contains data on patients, physicians, sociodemographics and on morbidity and mortality. Actually it is being replicated in more than 40 hospitals with quite different sizes and locations. An outpatient module is being prepared. Other modules are under study.

2.3.3. Material and money management information systems

According to our analyses on information needs and demands data on logistics, procurement and financing in the sectors of field health services and of hospitals are missing, especially.

> Logistics information system: For the management of drugs, medical and laboratory supply we propose our HAMIS Logistics Information System as a starting point. It was pilot tested, first in the MARAMAG district hospital in Mindanao and so we call it. Its base is a software of the National Computer Center. It is ready for a broad band replication.

> Money management information system: A MONEY management information system for use in public hospitals was developed, too. It follows the flow of monies and takes as starting points the cashier and the accountant in the hospitals. Such information systems will be merged eventually and linked to the payroll, billing and other information systems in the hospitals and similar institutions of health care.

2.3.4. Health financing and insurance information systems

Institutional money and material management information systems will be linked eventually with broader information systems on health care financing. In this area, HAMIS presently works at three levels.

> Provincewide institutional studies on costs and financing for health (PISCO) look into the details of

financial management of provincial, district, and municipal hospitals as well as of smaller health care institutions.

> The household level of health care financing was studied through a representative household survey of more than 1.728 households in Quezon province and dealt with health seeking behavior and private health expenditure (QUESEX); direct and indirect costs and sources of financing were the main topics of this survey.

> Intermediary levels of health care financing for communities through cooperatives, mother clubs, local health insurances, loan arrangements and the like are being studied and strengthened via a special string of sub-projects of HAMIS related to the discovery of good health care management through nationwide contests (DISCO).

2.3.5. Socio-economic information systems

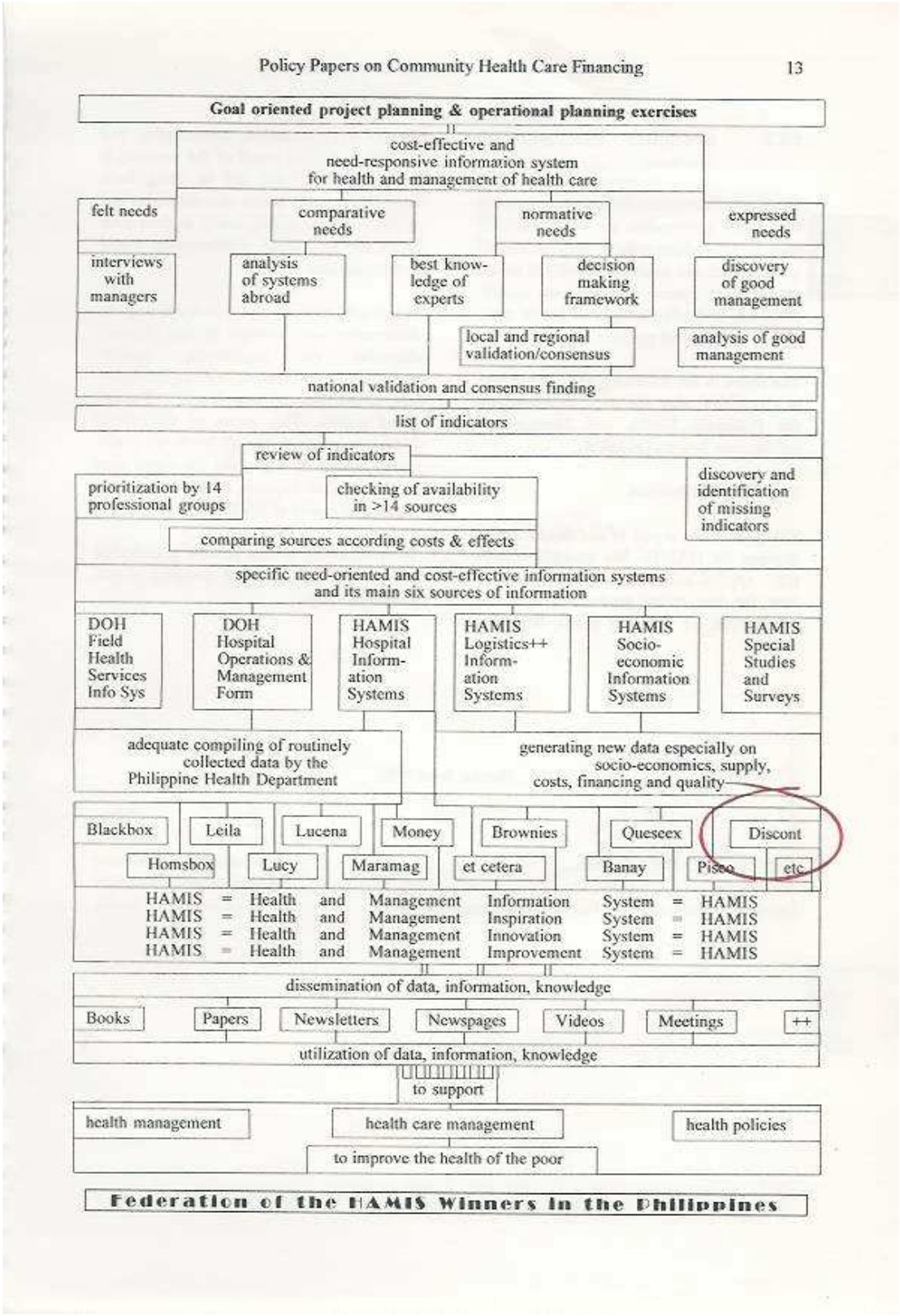
Here we support one system on barangays that is in the hands of the midwives and one system on the puroks in the hands of the barangay health workers.

> Barangay information system: The missing link between socio-economics and health care can be filled by using the HAMIS Barangay Socio-economic Profile that contains in addition to socio-economic data, data on culture and provision of and access to health care at the local levels. A menu driven software is available with all such data for the barangays in Bukidnon Province; we call it BROWNIES and it can be linked with Blackbox. It is being used now in four provinces.

> Purok information system: This system includes data on an autochtonous information system that is in the hands of community health workers. Household information on a few basic indicators, e.g., immunization, family planning, sanitation, is put on spot maps and is a means of community health awareness and empowerment. We call it BANAY, the Visayan word for groupings of households. It is now a national program, already.

2.3.6. Information systems on good health care management

Last not least, one important step for obtaining knowledge on the data and information needed for good management is the discovery of good management. HAMIS discovered more than 250 such schemes through national contests and supports and learns from the best hundred-twenty. The factors of success were analysed and the role that data/information played as a production factor for such “good” management. Support is given to the self-organization of the winners into networks of excellency in health care management. The Federation of the HAMIS Winners in the Philippines, Inc., emerged as a consultative body for the Department of Health and is influencing already health policy and law making.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Goal oriented project planning & operational planning exercises
cost-effective and need-responsive information system for health and management of health care
felt needs
comparative needs
normative needs
expressed needs
interviews with managers
analysis of systems abroad
best know-ledge of experts
decision making framework
discovery of good management
local and regional validation/consensus
analysis of good management
national validation and consensus finding
list of indicators
review of indicators
prioritization by 14 professional groups
checking of availability in >14 sources
discovery and identification of missing indicators
comparing sources according costs & effects
specific need-oriented and cost-effective information systems and its main six sources of information
DOH Field Health Services Info Sys
DOH Hospital Operations & Management Form
HAMIS Hospital Inform-ation Systems
HAMIS Logistics++ Inform-ation Systems
HAMIS Socio-economic Information Systems
HAMIS Special Studies and Surveys
adequate compiling of routinely collected data by the Philippine Health Department
generating new data especially on socio-economics, supply, costs, financing and quality
Blackbox
Leila
Lucena
Money
Brownies
Queseex
Discont
Homsbox
Lucy
Maramag
et cetera
Banay
Pisco
etc
HAMIS = Health and Management Information System = HAMIS
HAMIS = Health and Management Inspiration System = HAMIS
HAMIS = Health and Management Innovation System = HAMIS
HAMIS = Health and Management Improvement System = HAMIS
dissemination of data, information, knowledge
Books
Papers
Newsletters
Newspages
Videos
Meetings
++
utilization of data, information, knowledge
to support
health management
health care management
health policies
to improve the health of the poor
Federation of the HAMIS Winners in the Philippines

2.3.7. Conclusion and graphical summary

When data/information/knowledge obtained with these instruments are being recycled back in an understandable way to (local) governments and health workers, the health management system will increase equity, efficiency and effectiveness of health care. This is our aim and purpose.

The figure in the following page expresses in a graphical way our steps to strengthen the Philippine Health and Management Information System (HAMIS).

3. This publication

This publication is part of our dissemination strategy for HAMIS. We strongly believe that applied information economics must care for the entire production cycle of information, i.e. bridging needs, demands, (factors of) production, consumption and reproduction. The proof of the pudding is in its eating. If we fail to bring back information to the health care managers and to the populace taking health in their own hands, the production of information would be meaningless.

This is why now we try to find our ways to disseminate our findings to the different clienteles via workshops, (quality assurance) conferences, videos, newsletters, newspages, popular books and occasional papers. This series of Occasional Papers is intended for all levels of health (care) managers, especially for those who are working to improve effectiveness, efficiency and equity of health care.

The positioning of this volume is encircled in the foregoing cognitive mapping of our project strategy.

Manila, June 1995

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Department of Health

Policy Papers

on

Community Health Care Financing

Executive Summaries

TOWARDS A SOCIAL HEALTH INSURANCE

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.

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 HAMIS winners in Batangas, Butuan, Bukidnon, Cebu, Lucena, Quezon, Surigao, Tawi-Tawi, Tondo. They offer us three valid starting points that could be used as strong pillars for a social health insurances: community loans, community cooperatives and community insurances. 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. Jokingly we speak about Medicare 10.

According to the draft of the proposed bill on a national health insurance 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.

Endeavors of health insurances in the Philippines thus far have been examples of lack of concern for 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. These are some of the problems: overuse, misuse, abuse, non-representation, inaccessibility red tape, check and balances, exclusion of the indigents, disabled, mental and chronic patients, the problem of the elderly, of the self-employed and the uemployed, the problem of ceilings and severe illnesses, the problem of profits and investments of insurances.

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

We recommend a step-by-step approach to build up a social health insurance system for al Filipinos. 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. The achievements of the HAMIS winners have undergone a long process of trial and error. We are willing to share our experiences to build up a social health insurance that is not just for the officials and the workers but for all Filipinos, i.e., for the self-employed, the unemployed, the fishermen in the remote islands, the farmers in far-flung areas, the chronically ill and mentally retarded. This is why we choose to call it social health insurance and not just health insurance. These are the steps:

- public hearings, consultations
- understanding shortcomings of Medicare
- orientation of Local Governments
- accreditation standards
- consultations on benefits, premiums, definitions
- pilot testing of different models
- improvement of public and private health services

- phasing and review of implementation
- assessment of organizational alternatives

COMMUNITY DRUG INSURANCES

The Filipino nation has a wealth of experiences in mobilizing resources in the community to improve the health situation of the people. This was proven by the Department of Health (DOH), when its Health and Management Information System (HAMIS) started to conduct national contests that were looking after effective, efficient and equity oriented health care projects in the Philippines that were excellent, innovative and sustainable at the same time.

One of the gold winners of the 1991 HAMIS contest was a drug insurance program that started in Smokey Mountain, Balut Tondo, Metro Manila. In 1994 it was upgraded to a diamond winner after it emerged from an unknown program among garbage scavengers into a national program; that was due to intensive dissemination of the ideas of the HAMIS winners. At present, there are about two hundred health workers managing Botika Binhis in one hundred twenty communities all over the Philippines. The Community Health Service (CHS) of the Department of Health, together with the Samahan ng Manggagawa ng Binhing Kalusugan (SMBK) started replicating the community drug insurance program nationwide in October 1993.

Wherever in the Philippines midwives and barangay health workers are being asked what the most pressing public health problem is, they will say: lack of medicine, unaffordable drugs, lack of money for buying a full regimen of drugs when needed. This is the basic problem to be addressed by the community drug insurance. The Botika Binhi is designed to be a community based and organized drug insurance scheme premised on the principle of saving for one's health through collective efforts. Botika Binhi is a community drug insurance program (CDIP) that aims to make essential drugs affordable, accessible and available to the people in the barangays, especially to the people in depressed and marginalized communities. Botika Binhi is a kind of "public pharmacy", i.e. a pharmacy not making profit for the benefit of the one having the capital. To establish such pharmacies for the benefit of the poor and the vulnerable, is the first objective of Botica Binhi.

Botica Binhis are the result of a continuous process of learning from the people and building on what

they have. The main features are: people's consultation, 1 percent savings of family income for health, participatory management, filipino-based fund raising initiatives, promotion of Philippine medicine. The paper addresses some of the economical and financial issues of the Botika Binhis as well, specifically the ways and means of saving the profit transfers to private pharmacies and of spending the "earnings" wisely. The policy agenda for supporting community drug insurances is being spelled out in the paper as well: recognition, legalization, reassurance, cooperation, and support.

The HAMIS Winners recommend

1. CDIs should be integrated into the National Health Insurance System, instead of being dismantled through bureaucratic corporations.

2. The dispensing of essential drugs, including antibiotics, by properly trained and accredited community health workers (CHWs) should be legalized.

3. A multi-level reassurance fund should be maintained to ensure the viability and sustainability of the CDIs.

4. There should be support for a reasonable expansion of the program into other benefit packages beyond essential drugs.

5. There should be legislation for a comprehensive and multi-aspect training of community health workers nationwide.

6. CDIs should be included as one of the services of multi-purpose cooperatives.

7. Community savings could be increased by at least three strategies that will be incorporated into the set-up of CDIs.

   a. A Family Health Program in which at least one member is trained to be responsible for the health of the family would ensure that the use of drugs would be minimized or prevented altogether.

   b. CHWs should be given the information, knowledge, and understanding for handling the most common diseases that require antibiotics, like ARI.

   c. CDIs should contract with health care institutions or physicians to provide health care for its members at a reasonable cost.

COMMUNITY COOPERATIVES

The prevalence of poverty, the lack of health services, and the inacessibility of health providers and hospitals have prompted the people to bind themselves into organizations like cooperatives. This act of solidarity gives the community access to economic facilities and health services that help alleviate their miserable conditions. This people's initiative to identify resources and innovations for health also enables them to find means for improving their economic condition. Genuine cooperatives are bound by the cooperative spirit and a mutual consideration for the common good of every member not the gratification or self-interest of the few.

Based on the HAMIS Winners' experiences, livelihood loans have helped members of the community support the economic needs of poor families. Cooperatives have tried to develop alternative schemes for health financing because of the felt health needs among its members. Through participatory processes, members have been involved in making key decisions: the amount of contributions they can afford and the kind and quanitity of benefits they can avail of.

This conclusion stems from valid observations and experiences of the HAMIS Winners, e.g., in Antique, Batangas, Bulaca, Cavite, Cebu, Cotabato, Iligan, Leyte, Lucena, Negros and Tondo. These experiences can be grouped into voluntary non-withdrawable savings schemes and cooperative hospital health financing scheme

Voluntary Non-Withdrawable Savings Schemes: Here we have to distinguish

- income-generating projects, i.e. collective efforts of savings mobilization with a return of investment to members in the form of dividends and patronage refunds.
- payments and collections through personal remittances, the use of collectors, or salary deductions.

  Health Financing and Mortuary to cover expenses during illness and after death.

Cooperative Hospitals Health Financing Scheme: Cooperative hospitals are accredited with the Bureau of Medical Services; these hospitals are open for membership to all members of the community, as is the case with some of the HAMIS

Winners. Members are willing to contribute at least P500 as share capital for the cooperative hospital (Siaton) and a P2/day for a hospitalization plan (SH Iligan).

The HAMIS Winners recommend:

1. The people's access to health information and community health financing (CHF) is a prime responsibility of the state.
2. The state recognizes, protects, and promotes cooperativism in the mainstream of society as vehicle towards social and economic progress.
3. Accreditation should be given to community cooperatives to collect premium contributions of and to deliver health services to the community to the National Health Insurance Program. It is one way of ensuring and protecting the right of the citizens and of minimizing red tape.
4. Options must be available for alternative systems of monitoring and evaluating CHF.
5. Community organizing should focus on cooperative principles and other relevant provisions relative to Cooperative Development Authority (CDA) policies.
6. A trainors' pool from both government and non-government organizations should be organized and accredited with CDA.
7. Authorization be given to community cooperatives to collect premium contributions of the community to the National Health Insurance Program.

CREDITS AND LOANS FOR HEALTH

In situations of widespread poverty, the relationship between spending and saving money is of crucial importance. Money management at the household level has an enormous impact on health and social life. This has to bee seen in the wider context of saving and what is being called "negative saving." In situations of poverty, as among the poor in the Philippines, the usual economic concept of positive saving is not an option. The poor frequently do not have a choice between consuming or saving. Often, they are forced to go into negative saving (indebtedness to money-lenders) in the present, in order to avert an existing crisis, like a catastrophic illness that is not covered by Medicare. Not to loan and spend in such a situation would worsen the crisis. Thus, we have to look at credits and loans for health from a different perspective. On the one hand, real saving, as we know it, if practiced by the poor may worsen their health and may not even be possible to achieve. On the other hand, negative saving, or loans from money lenders, though a depressing fact of the poor's lives, can be life-saving.

In this policy paper, we will attempt to show how alternative forms of credits and loans can wean the poor away from having to incur negative saving. It presents the notion that credits and loans do not have to lead to a situation of worsening health and deepening poverty. In individual cases, the health risks may easily exceed the level of affordability when catastrophic illnesses are involved. Processes of increasing pauperization may result from this. This is an area of concern where many HAMIS Winners have stepped into with programs to alleviate the situations of families in need. We find examples in Antique, Batangas, Butuan, Quezon, Surigao, Tawi-Tawi and Tondo.

What are the lessons?

> Granting of soft loans in cases of very high expenditures of individual families is a way not a few community organizations have used for alleviating the economic impact of diseases in individual families. HAMIS winners provide good examples.

> Individual illnesses can have a wide impact on the health and social life of entire families. There have to be ways of alleviating such situations, especially where vulnerable

groups like women and children are concerned. Again, some HAMIS winners have gone into comprehensive health care arrangements with heavy emphasis on prevention and promotion, changing the lifestyles of families towards more rational health behavior.

> With what community organizations have done, how can the government respond? One way would be to establish a national reassurance fund for life-threatening illnesses that affect entire families, for example, cholera epidemics. This is not a health insurance for all. This is an assurance against catastrophic illnesses of a few families.

The HAMIS Winners recommend:

1 The prioritization of the prevention of diseases and the promotion of health should obviate the need for credits and loans.

2 Credits and loans should be used to encourage health-promoting behavior, e.g., immunization, and to discourage unhealthy behavior, e.g., smoking and eating junk food.

3 Reassurance funds needs to be created at local, provincial and national levels to backstop CHF programs whose members experience catastrophic illnesses, epidemics or disasters.

4 Soft credits and loans should be provided for health emergencies, using health behavior as collateral. The funds might come from community fund raising for health.

5 Credits and loans should be provided for income-generation projects of people's organizations with health agendas, as well as for food-generation projects and health-generation projects.

6 Both the government and the community should share in the funding of soft credits and loans.

COMMUNITY HEALTH FUND RAISING

This paper is concerned with resource mobilization, with particular emphasis on community participation. The objective of the paper is to help policy makers fit community financing into the overall health financing plan and to suggest ways in which community schemes, based on HAMIS winners' experiences, can be implemented.

The winners of the first HAMIS Contest in 1991 discovered that there are many sources of funds in implementing and strengthening community health programs. These sources are:

1. contributions in kind from existing organizations -- regular DOH supply, lots provided from local government, materials from private industry, free supply of various materials from different existing organizations.
2. contributions from existing organizations in cash-grants from foreign donors, local government funds, contributions from PAGCOR, city government agencies, PHC funds, loans from various sources.
3. voluntary contributions in kind - donations of blood, voluntary labor, voluntary supply of materials.
4. special fund-raising activities--fund-raising for specific projects, townfiesta proceeds, raffles, beauty contests, popularity contests, bingo games, Christmas caroling, benefit dances, cockfighting, collection of empty bottles, collections, paluwagan
5. income from entrepreneurial activities--sale of vegetables and livestock from the backyard, sale of piglets, fish powder, and herbal medicines, lending of assets, patient fees, fee for services, tuition fees, provident fund, botika fund, interest income of various funds
6. income from charity-benefactors' contributions, donations from private individuals, voluntary contributions
7. income from self-generation--membership fees, cooperative income

The contest discovered possibilities of diversified cost-sharing. This is not only cost- sharing by those in need. The poor already pay quite a lot for health care in terms of hidden direct and indirect costs. It is important to raise funds wherever available to be able to spend them for those in need. One important lesson of the contest is that there are many sources of funds with fair cost-sharing.

The HAMIS Winners recommend:

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

FINANCIAL INDICATORS FOR COMMUNITY HEALTH DATABOARDS

The Department of Health in one of its policy papers for the year 1993 delineated its commitment to peoples' empowerment by committing to develop the Purok Health Databoards - one of the ´23 programs in ´93. It was a HAMIS contest winner in Surigao City that maintained the health databoard when DOH leaders saw it while visiting the communities, the start of a national program.

People's empowerment is in practice in Community Health Databoards as the household health status is being measured by the households themselves and the data is analyzed and interpreted by the community during assemblies. The capability of the communities to handle and monitor health status data shows the potential of the databoards as one of the very effective tools for households to manage their own health status. Health status indicators measured by the health databoards comprise the household's: immunization, nutrition, prenatal care, family planning, water, garbage disposal, toilets and other indicators, eventually.

The abovementioned potentials of the databoards show how the databoard develops community awareness for health and how it ensures an appropriate behaviour related to health and well-being by every household. With the Department of Health's commitment to develop the capability of the communities to finance their health care, the databoard becomes one of the arenas of action. The HAMIS Winners' experiences in health care financing range from community credits, innovative income-generating projects, community drug insurances, and community health insurance. The databoard may be used as a monitoring tool for the communities to determine the household's capacity to finance its own health care needs.

The HAMIS Winners recommend:

A. All existing community health databoards should include financial indicators.
B. The content and mixture of these financial indicators should be determined by the community itself, with guidance from a national databoard trainors' pool.

C. Aside from health and financial indicators, other social indicators that constitute the most basic needs (MBN), e.g., community participation, housing, sustainable livelihood, literacy and psycho-social development, peace and order, and disability, can be included.

INCENTIVES FOR BARANGAY HEALTH WORKERS

The concept of primary health care in the Philippines calls attention to the tenet: participation of the people, especially among men and women who volunteered to be Barangay Health Workers. Such enthusiasm brought to the attention and the consciousness of the community the importance of their participation in the total delivery of health care services. This is exemplified by experiences gleaned from NGOs and GOs. In the family of HAMIS Winners, unique and innovative approaches were developed to train BHWs for the DOH and the LGUs.

Community spirit and community support are vital in sustaining the continuing activity of the BHWs. But sooner or later, such continuity of support must be expressed in more definite terms. It must rely on the mutual commitment of BHWs to their communities and of communities to their BHWs. Community commitment is a vital factor for BHW viability and productivity . When this is not spelled out in specific terms BHWs will soon find themselves:

1. losing morale and interest
2. losing their original love for service
3. without direction
4. without any links with GOs and NGOs

All resulting to significant number of drop-outs. While "incentives" is too narrow a term to accomodate the spirit and substance of community commitment to the BHWs, it can nevertheless be a vehicle to convey the concrete expressions of such commitments.

There is quite a number of experiences among the HAMIS Winners, e.g., in Misamis Oriental and in Negros Oriental where quite a complex pattern of monetary and non-monetary incentives were developed and successfully used and embedded into structures and organizations as, e.g., Barangay Primary Health Care Committees (BHPCC) or Federations of BHW

The HAMIS Winners recommend budgetary and technical support

a. Community Support: Community-initiated fund-

raising activities in support for BHW incentives shall be encouraged. These may include: discounts from drugstores and other establishments, community health insurance, and out-of-pocket donations.

b. Government support: DOH shall formulate a policy that gives support to BHWs. Support from the DOH may include sickness benefits. Support form other government organizations may include access to soft loans, IGPs, field exposures, and skills development. Support from LGUs may consist of honoraria, health insurance, free legal service, logistics, recognition, scholarship program, counterpart funding for IGPs, and transportation expenses.

c. Technical support: While all BHW's are independent on their structures and schedules, BHW's still have to be guided by DOH standards for their duties and responsibilities. Additionally, the updating of skills and technical knowledge are still DOH responsibilities.

Policy Papers

towards

Community Health Care Financing

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 thePhilippines, Inc.

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 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 1. 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 1

Good Health Care Management

Lessons from the Winners of the First HAMIS Contest

To be able to improve health care management one should know what good health care management is. One source of information is to discover, describe and analyze examples of such a management. At the level of local health services a contest for discovering innovations was undertaken by the Department of Health (DOH) together with the German Agency for Technical Cooperation (GTZ) in 1990/91 through the Health and Management Information System (HAMIS) Project.

More than 100 applications for the HAMIS Contest were received from all regions of the Philippines and from 52 of the 75 provinces. All applications were submitted to a standardized fourfold peer review. Additionally, a total of 70 projects from 50 provinces were screened in detail through site visits. A checklist of 59 binarily worded criteria looked into quality, innovativeness, effectiveness, equity, efficiency and sustainability. One project was unanimously chosen as the best by all Selection Committee members, two others with only one dissenting vote each. In a ceremony held in Malacañan Palace, the three gold and the eight silver winners were given their awards by the President of the Philippines, the German Ambassador and the Secretary of Health.

Good health care management

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

1 discovers untapped resources in the sense of financial, material, moral and time resources, as for example through innovative ways of fund raising or using herbal plants or converting charity into economics or using the time of mothers of malnourished children,

2 mobilizes human and intellectual resources, as for example via empowerment of mothers and health workers and through better use of knowledge and information,

3 combines existing resource patterns resulting in multiplicative effects, as for example university training and health services or private and public health services or radio stations,

4 reconfirms productivity gains through self-organization and banding together, as for example through patient associations and drug cooperatives.

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

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

The HAMIS Gold Winners

The three gold winners of the HAMIS contest give us examples of good health care management and tell us some lessons.

Quezon

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

Manila

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

Surigao

A network of mother clubs initiated a comprehensive blend of activities to develop skills among mothers, their families and other individuals in the community to allow them to achieve an acceptable level of health and well-being in a self-reliant way: health care, health education and training in nutrition and food production, environmental sanitation, building of infrastructure, livelihood projects, day care centers, weekly radio program, bargain incentives for mother club members in city stores including drug stores, emergency credit arrangements, scholarships, regular self-evaluation and awarding of good performance, and last

not least: diversified fund raising. The lesson of this project is that good health care management should be comprehensive and comprehensiveness, sustainability and expansion is achieved if people understand and share it.

The HAMIS Silver Winners

The eight silver winners of the HAMIS contest give us the following messages based on what they do and achieve.

Cebu

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

Hinterlands

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

Iloilo

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

Laguna

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

Manila

Sisters set up a western and oriental medical clinic for depressed urban poor in a squatter area. The tuberculosis program asks participants for copayment and gives them a share in livelihood projects (soap, lanterns, herbal medicine, and candle making) if their health behavior is good. The nutrition program asks mothers to contribute one peso (five cent) per week per child for food and her time for organizing this program and for participating in income-generating projects. There is sewing training and production for jobless adolescents and a consumers cooperative for all. A rather comprehensive social and health care

program exemplifies cost and benefit sharing in actual detail and not just in theory.

Nationwide

Health oriented radio broadcasting was strengthened to reinforce the information, education and communication activities of the Department of Health and other health agencies through regional networks and broadcaster-members throughout the country including very small radio stations, altogether more than 150. Health messages interface with lessons on agriculture, fisheries, and other concerns of the poor and country folks, especially. This program links formal and informal resources, including those of radio aficionados, to serve health and wealth promotion for the poor.

Pasay

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

Samar

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

All Other HAMIS Winners
of the First Contest

Further aspects of good management are according to other winners of our contest.

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: active solicitation and mobilization of the whole community in the betterment of health infrastructures like the health centers, health stations and "Botica sa Barangay"

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

Bulacan: tapping family members of patients with long-term illness to participate in the management of psychosocial problems

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: organizing private companies health assistance to be extended into the underserved public sector

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

More detailed findings and insights are included in our extended case studies that had been commissioned to five research groups from different Universities and disciplines.

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COMMUNITY DRUG INSURANCES

Botika Binhi

Policy Paper of the Federation of HAMIS Winners in the Philippines, Inc.[1]

I Justification and Rationale

To attain health for all by the year 2000 for developing countries like the Philippines, it is imperative that health care financing schemes be developed. However, these financing schemes should consider the socio-economic, cultural and political situation of the country. In the Philippines, several commercial health care financing schemes have been established, but only a very small percentage of the population benefit from them. Most of the financing programs are replications of projects in other countries that do not have the same socio-economic situation as the Philippines.

Comprehensive health development in depressed and marginalised communities is a challenging task for governmental as well as non-governmental organizations in developing and underdeveloped countries. The challenge is to maximize the available meager resources in the community and to assure the sustainability of the program.

This policy paper hopes to inform the government and the law-makers of our society that community health financing has an integral and potential part in expanding the economic support for health for all. Thus, policies and legislation should be established that will support, facilitate, and strengthen the implementation of community health financing programs.

Filipinos are known to be creative and innovative in developing programs inspite of the limited resources. The key leaders of the country just have to explore these programs by consulting the people. It is also important to realize that health problems can not be solved only by providing external funding. **Maximizing indigenous resources** utilization is a better alternative to develop community health financing activities. It is essential to facilitate the involvement of untapped resources of marginal communities in the process of urban development. It is to this end that the Community Drug Insurances, more popularly known as CDI, is hereby submitted as a solution to the ever

1 The first draft of this policy paper was written by Dr. Emma Palazo and Dr. Detlef Schwefel. It transcends the experiences of Botika Binhi into a community drug insurance program. This paper acknowledges the fruitful contributions of most of the HAMIS Winners in the Philippines and the DOH consultants during the intensive consultation processes.

worsening drug distribution scheme of the country.

The Filipino nation has a wealth of experiences in mobilizing resources in the community to improve the health situation of the people. These experiences can be expanded, replicated, and institutionalized to hasten the attainment of health for all. This is not just a statement, it was proven by the Department of Health itself, when its Health and Management Information System (HAMIS) started to conduct national contests that searched for effective, efficient, and equity-oriented health care projects in the Philippines that were innovative and, at the same time, sustainable.

In 1990 and 1994, the Health and Management Information System (HAMIS) of the Department of Health in cooperation with the German government spearheaded a contest that discovered innovative good health care management programs that increase the efficiency, effectiveness and equity of the health care delivery system. The HAMIS contest revealed that good health care management: discovers untapped financial, material, moral, and time resources; mobilizes human and intellectual resources; combines existing resource patterns resulting in multiplicative effects; and reconfirms productivity gains through self-organization and banding together (Pons and Schwefel, 1993). At present there are one hundred (120) programs that have won after the standardized peer review, site visits, and through discussions of the selection committees composed of key leaders from the government, congress, senate, academe, NGO, and HAMIS.

Wherever in the Philippines midwives and barangay health workers are being asked what the most pressing public health problem is, they will say: lack of medicine, unaffordable drugs, and lack of money for buying a full regimen of drugs when needed. This is the basic problem to be addressed by the community drug insurance.

II The HAMIS Winners Experience in Smokey Mountain

After the 6th Asian Medical Students Conference in the Philippines in 1985, the Philippines Alliance of Medical Students (PAMS) adopted a garbage community of 20,000 people in Manila more known as Smokey Mountain. PAMS implemented a five-year comprehensive health development program that addresses the problems of malnutrition, prevalence of infectious diseases, lack of local health workers, unavailable doctors and medicines, and no health center.

After four years of implementing the program all activities were successful except for the provision of drugs. PAMS (which later became the Asia Medical Doctors' Association (AMDA)) realized that the practice of giving free drugs would not ultimately help the people after the program. Together with the health workers and the people of Smokey Mountain, CDI started in June 1990. When AMDA left Smokey Mountain in November of 1990 a people's group was organized--the SMBK. The Samahang Manggagawa ng Binhi ng Kalusugan (SMBK) is a people's organization of health workers who manage the first CDI in the barangay. SMBK started in Smokey Mountain Tondo, Manila in March 1991 with ten health workers.

The program has for its precursor the Seed of Health Drug Insurance Program in

Smokey Mountain which was among those that garnered the highest honors in the DOH-Health Management and Information System (HAMIS) Competition in 1991. Under this project, a drug insurance was established in the marginalized and destitute Smokey Mountain community to provide low-cost medicines to its members. At the start of 1990, members of the health center were asked to donate some amounts for medicines they acquired from the community primary health care clinic. Within six months, they were able to collect twelve thousand four hundred and sixty pesos (P12,460). With this seed money, medicines were bought medicines at wholesale prices and sold them to members at a fifty percent discount. Families earning less than P1,000.00 per month paid a monthly due of P10.00 to avail of the fifty percent discount. Members who earn more paid P25.00 on a monthly basis. Non-members were charged the full amount of the medicine at prices still lower than prevailing market rates. The profits reverted to the drug insurance together with the monthly dues and the sales of the medicines which served as revolving fund for the program.

At present, there are about three hundred health workers managing CDIs in one hundred fifty communities all over the Philippines. The Department of Health National Primary Health Care Strategies, together with the Samahan ng Manggagawa ng Binhing Kalusugan started replicating the CDIP nationwide in October 1993. The status of the dissemination is shown in the Annex.

III. Policy Content

A. Definition

1. The community drug insurances (CDI) is designed to be a community-based and organized drug insurance scheme premised on the principle of saving for one's health through collective efforts.

2. Community drug insurance programs (CDIP) aim to make essential drugs affordable, accessible, and available to the people in the barangays, especially to the people in depressed far-flung and marginalized communities.

3. CDI are a kind of "public pharmacy", i.e., a pharmacy not making profit for the benefit of the one having the capital. To establish such pharmacies for the benefit of the poor and the vulnerable, is the first objective of CDIs.

B. Basic Considerations

1. As a revolutionary approach to the perennial problem of providing drugs at affordable prices, stiff opposition is to be expected from established commercial drug distributors. It, therefore, becomes imperative that the policy formulation and ensuing legislation on the matter be water tight so as to avert any and all reprisals from this influential sector.

2. The basic idea is that a daily forty centavos (P0.40) savings of a member entitles her/him to savings when buying medicine.

3. The revolving fund of the program will be sufficient to meet expenses beyond the monthly contributions of the members and that the savings are used for preventive and public health endeavours in the community, as managed by the community itself. This idea incorporates several principles.

4. The Botica Binhi rests on some fundamental principles such as :

a. **People's Consultation**: The program starts by consulting the people about their perceived health problems and possible solutions to the problems. The participatory methods used to determine the problems are family surveys, focus group discussions, community assemblies, or group dynamics. If the community health problems are expensive drugs, unavailable drugs during emergencies, and inaccessible drugstores or health centers, the trained health workers suggests the CDIP as a solution.

b. One Percent Savings of Family Income for Health: Every month, families are encouraged to save for health no matter how little. The monthly contribution ranges from P2 to P10. This component of the program instills the feeling of ownership of the program by the people. The relationship of the people in thecommunity is enhanced and strengthened because the common drug fund of the community makes the prices of drugs cheaper. Fathers are encouraged to lessen the number of cigarette sticks they smoke per day and instead to save the money for medicines.

c. Participatory Management: The people in the community organize themselves to plan for the program. They choose their leaders and set-up guidelines for the operation of the CDI.

d. Pilipino-Based Fund-Raising Initiatives: It is important that the initial seed capital should come from the community. Examples of fund-raising activities are newspaper handicraft, social dancing, charcoal-making, and garage sale.

e. Promotion of Philippine Medicine: There are ten herbal drugs in the Philippines that are proven to be effective supported with clinical trials and voluminous researches. However, these are not yet widely promoted. Thru CDIs, the herbal drugs in tablet form are promoted and made available to the community. Other Philippine-made products pormoted by CDIs are iodized salt and anti-mosquito bars. These products are safe, effective, and cheap.

5. The Botica Binhi has three essential components in the implementation of the program:

a. Participatory Community Organization: As the experience of Smokey Mountain has shown, the people's potential for improving their own health conditions is remarkable. When the community is actively involved, collaborative efforts between different sectors are successfully integrated. It is manifest that

community involvement is essential for health development.

b. Community Financing: One factor that sets the CDI apart is its revolutionary approach at community-financing. The members themselves contribute the initial and operational funds of the insurance scheme. It is not a dole-out on the part of the government as is usually the case in health programs. Value formation is essential here as the program would have to work against the inertia of relying on dole-outs. A conviction would have to be made that no matter how poor they are, collectively, they have the capacity to be responsible for their health.

c. Wholistic Development of Health Workers: The health workers provide health services, and promote health in the community. In the provision health services, basic training on health should be provided. For the promotion of health in the community, they should be trained on community organizing, leadership skills, basic accounting and economics, counseling, teaching and value formation. It is important that the health workers are honest, sincere, committed, respected, and trusted by the people.

6. The Smokey Mountain experience shows us that when working in depressed communities we do not have to look at what things the people do (not) have but we have to look at their lives and their heart as their major resources to start a participatory developmental program. These are some basic questions to raise:

- Where do we start in helping the poor and the needy?
- How can we motivate people who are just surviving from garbage to help themselves?
- How do we respond to the needs of people who lost their houses, clothes and everything because of war, lahar or mudflow, flood and/or fire?

7. The three aspects that can support this drive towards better prices of drugs are:

a. The quantity of participants in the CDI Movement is a decisive factor for getting good prices. This refers to the quantity of the members of the individual CDIs as well as to the number of CDIs. The more members and CDIs, the better is the bargaining power for getting better prices. If many members of many CDIs band together and have a joint procurement, then there will be substantial savings. The best situation would be if all households in a barrio would participate. We can not oblige them. But we might give incentives for them to join when we give them drugs cheaper when compared to the retail prices but still higher than a member would have to pay. For a longer sustainability

of the program, we have to overcome the difficulties that health economists call the voluntarism trap of community insurances. They argue that mandatory membership is important for sustainability.

b. **Continuity** of purchasing essential drugs is being given when the CDI has regular members that will promise to buy the drugs at the CDI whenever they need them. This continuity is best achieved through a membership relationship between people and the CDI, e.g., through a kind of community drug insurance system. To reinforce the membership, the members have to get better prices than anybody else. They have to feel that membership brings greater savings.

c. **The spectrum** of drugs to be purchased is another important factor. Through the drive of the Department of Health towards the use of generic drugs and through the World Health Organization we know that there is just a small number of essential drugs that are needed for reasonable health care. When we take into account what the most common illnesses are in the barrios and what Volunteer Health Workers can reasonably manage after appropriate training, then we can develop a short list of the most essential drugs for CDIs. The smaller the spectrum, the better again is our power in the negotiations with providers. And the easier it is to handle by the Volunteer Health Workers.

8. As compared to market prices, there is a saving when CDIs are established. This saving can be used for many purposes:

- **a.** it can be given back entirely to the members of CDI
- **b.** it can be used to expand health services to the members of CDI, e.g., X-ray or hospital insurance
- **c.** it can be used for community actions to prevent diseases and to strengthen the community
- **d.** it can be used for safeguarding the sustainability of the program
- **e.** it has to be used, in a very small fraction, for running the overhead costs of the program.

The best balance of these spendings will have to be discussed by the members themselves. There will be quite some differences in how the individual CDIs will come up with the best mix of using the savings. Other CDIs should listen to them and try to understand them and develop step-by-step the best options.

9. It is the strength of the CDI idea that it was sustainable by itself in the Smokey Mountains experience. In this sense, it is a self-sustained and self-financed health program for the poor. Nevertheless, when the program is being replicated now and might be expanding into other areas of basic health care, problems of financing arise. We were very much enlightened when we saw that there

are many sources of ideas and of money. When we replicated CDI in other areas we received contributions from mayors, other NGOs, barangay councils, and others. This was not just a token of to keep the program in their own hands appreciation. It was showing the way to go in the f uture, i.e., to untap sources of financing for the program that are available to us. We know, nevertheless, that we will have to face a dilemma. The more financing sources we get the more the donors will try to have a say on the way to go. We will support any drive of the communities

10. There are many more economic aspects and impacts of the community drug insurances, as for example the better use of underutilized manpower; in some instances we saw that unemployed midwives and nurses are happy to collaborate. The relationships of the people in the community are strengthened because of "damayan"--other members are helping members who need drugs. Many more of such aspects will be discovered along our way when replicating and disseminating the CDIs. We will be very open for such experiences and we will carefully monitor them all.

11. One of the factors of success of the CDIs was its relative "simplicity" in a very positive sense. It was dealing just with essential drugs and its prices. The casestudies conducted on the HAMIS winners show that it is very important for success that very clear objectives are set at the beginning. Management has to be easy at the beginning in terms of the many aspects of management:

a. **Masterplan** It should be a clear strategy that is gets more complex only slowly. In this sense, some of the CDIs are already branching out into insuring X-rays and hospitalizations. It will be monitored very carefully by the HAMIS Federation.

b. **Motivation** The motivation behind the CDIs is the pride of poor people that they are in a position to take health into their own hands. This is why the CDI should not be complicated by any means. Its beauty is in its simplicity that can be shared with all strata of the population.

c. **Manpower** The volunteer health workers are dedicated women and a few men from the urban poor, rural poor, and mountainous and hard-to-reach communities. Most of them are elementary or high school graduates and a few have reached first or second year college. Most of the health workers find it very fulfilling to help their neighbors inspite of their poor living conditions. Their being health workers provide good models for their children to hopefully live a better life in the future. Five years ago, a daughter of one health worker from Smokey Mountain wanted to be a scavenger in the future. But now, she has

changed her mind and wants to be a health worker like her mother. Volunteer or Barangay Health Workers are the leading agents behind the CDI Movement. They have to gain and maintain the leadership for this community managed program. The administration and management of the CDIs should not be taken away from them.

d. **Money** CDIs are a self-sustained effort of the people. Whatever the future will be, this principle has to be a leading one.

e. **Material** The spectrum of materials to be handled should be kept at a very narrow range. It will concentrate on the following: **f**irst aid material, **a**ffordable essential drugs, **m**edicinal plants, **u**nderstandable information, **s**afe motherhood and family planning. We call this combination "FAMUS".

f. **Mobilization** Our sharing with other HAMIS winners showed us the ways to strengthen the mobilization of communities to share with us the fruitful experiences of the CDI. One essential aspect is another discovery of the HAMIS Contest, i.e., the databoards that were turned into a national program of the Department of Health, too. These databoards are very valuable for a proper coordination between communities, health workers, and local leaders for the benefit of all families in the catchment.

g. **Monitoring** Actually the Smokey Mountain Health Care Program, including the Botika is monitored weekly by means of progress reports submitted during monitoring conferences. This is supported by regular sessions of assessment of needs and problems encountered. The monitoring needs quite some attention in the future to avoid the problems of too fast an extension and expansion of the CDIs. This problem is real since so many communities are requesting CDIs. We will use some of the HAMIS information tools for monitoring and measurement, notably the logistics information system. On the other hand: simplified bookkeeping, accounting, and auditing procedures will have to be applied in all CDIs.

h. **Makability** It has been noted that government collaboration with communities may be hampered by excessively technical approaches, inadequate mechanisms for social planning, an insistence on technical standards that are unrealistic and unnecessarily high, inappropriate legislation, administrative red tape, and an inability of officials to communicate with the community and to understand the dynamism of the local

community.[2] These are the factors that the CDI would have to guard against if it desires to adequately and successfully address the issue of distribution of basic drug services.

Managing all these aspects of the Botica Binhis in a proper way is a herculean responsibility that will need quite some sensitivity, understanding, training, and experiencing. It will incorporate trials and errors, mistakes and messages to learn. We need an open-minded flexibility for a back-up of such endeavours. We need the strong political support of the leaders of the Department of Health. We need the support of well-minded politicians. This is why we address this policy paper to them!

The most important means of disseminating the program are trainings. These are given by the barangay health workers of the first Botica Binhi, themselves. They best can show their fellow workers what CDI is. They can best discuss all aspects of the program. And as a return, they will get advise through good questions of the trainees. On the other hand, orientation-training was given to primary health care regional coordinators and CDI regional coordinators of the Department of Health.

IV Policy Recommendations

1. CDIs should be integrated into the National Health Insurance System, instead of being dismantled through bureaucratic corporations.

2. The dispensing of ssential drugs, including antibiotics, by properly trained and accredited community health workers (CHWs) should be legalized.

3. A multi-level reassurance fund should be maintained to ensure the viability and sustainability of the CDIs.

4. There should be support for a reasonable expansion of the program into other benefit packages beyond essential drugs.

5. There should be legislation for a comprehensive and multi-aspect training of community health workers nationwide.

6. CDIs should be included as one of the services of multi-purpose cooperatives.

7. Community savings could be increased by at least three strategies that will be incorporated into the set-up of CDIs.

a. A Family Health Program in which at least one member is trained to be responsible for the health of the family would ensure that the use of drugs would be minimized or prevented altogether.

b. CHWs should be given the information, knowledge, and understanding for handling the most common diseases that require antibiotics, like ARI.

2 Rossi-Espagnet, Spotlight on the Cities: Improving Urban Health in Developing Countries (1989).

c. CDIs should contract with health care institutions or physicians to provide health care for its members at a reasonable cost

Annex A

A Discussion on the Legal Implications Attendant to the Nationwide Implementation of CDI

Written by : Atty. Eloisa Palazo for the Senate Health Committee 1993

A. Constitutional Mandate

The 1987 Constitution is replete with provisions which protect and promote the right of every Filipino to health.

Article XIII section 11 provides,

> "The State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost. There shall be priority for the needs of the underprivileged, sick, elderly, disabled, women and children. The State shall endeavor to provide free medical care to paupers."

It has been opined, and rightly so, that the phrase "an integrated and comprehensive approach to health development" sums up two principles premised on the understanding that the high level of health of the people and of the country can be attained only through a combination of social, economic, political and cultural conditions.[3]

Integration connotes a unified health delivery system, a combination of private and public sectors, and a blend of western medicine and traditional health care modalities. **Comprehensiveness** includes health promotion, disease prevention, education, and planning. And all of these are a recognition of the Filipino's right to health.[4]

Other Constitutional provisions worthy for consideration in conceptualizing the master plan for the nationwide implementation of the CDI are the following:

1. Article II, section 9.

> "The State shall promote a just and dynamic social order that will ensure the prosperity and independence of the nation and free the people from poverty through policies that provide

3 Bernas, The 1987 Philippine Constitution 315-352 (1987).
4 Id.

adequate social services, promote full employment, a rising standard of living, and an improved quality of life for all."

2. Article II, section 15.

"The state shall protect and promote the right to health of the people and instill health consciousness among them."

3. Article II, section 23.

"The State shall encourage non-governmental, community-based, or sectoral organizations that promote the welfare of the nation."

4. Article XIII, section 12.

"The State shall establish and maintain an effective food and drug regulatory system and undertake appropriate health manpower development and research, responsive to the country's health needs and problems."

5. Article XV, section 3(4).

"The State shall defend the right of families or family associations to participate in the planning and implementation of policies and programs that affect them."

6. Article XVI, section 9.

"The State shall protect consumerism from trade malpractice and from substandard or hazardous products."

On all counts the nationwide implementation of the Botika Binhi is consistent with the mandates of the primary law of the land.

B. Overlapping of Functions Issue

One prevalent problem in the country's political system is the overlapping of function of various governmental agencies. Confusion arises as to which unit is legitimately accountable and responsible, that in many instances the function is left unperformed. This situation is true for the health sector.

The Revised Administrative Code provides as follows:

> "The Department of Health shall be primarily responsible for the formulation, planning, implementation, and coordination of policies and programs in the field of health."[5]

Specifically, the Department shall:

> "1) Define the national health policy and formulate and implement a national health plan within the framework of the government's general policies and plans xxx
>
> 2) Provide for health programs, services, facilities and other requirements as may be needed xxx"[6]

The Local Government Code of 1991, on the other hand provides as follows:

> "Consistent with local autonomy and decentralization, the provision for the delivery of basic services and facilities shall be devolved from the national government to provinces, cities, municipalities and barangays so that each LGU shall be responsible for a minimum set of services and facilities in accordance with established national policies, guidelines and standards."[7]

Specifically,

> "The LGU shall, in addition to their existing functions and responsibilities, provide basic services and facilities devolved to them covering, but not limited to the following:
>
> Barangay
>
> xxx
>
> (b) Health and social welfare services, through maintenance of barangay health and day care centers;
>
> xxx
>
> Municipality

5 The Revised Administrative Code of 1987, Title IX, Chapter I, section 2.
6 Id, section 3(1)&(2).
7 The Local Government Code of 1991, Rule V, article 24.

xxx

(c) Subject to the provisions on local health boards and in accordance with the standards and criteria of the Department of Health, provision of health services through:

(1) implementation of programs and projects on primary health care, xxx

(3) purchase of medicines, medical supplies, and equipment needed to carry out the devolved health services."[8]

In this issue, the Local Government Code prevails over the Revised Administrative Code as it is the later law. This means that the distribution of health services to the communities is now within the jurisdiction of the local government unit concerned. The power of the Department of Health has been limited to policy formulation and coordination of activities.

This notwithstanding, there is no legal impediment for the consensual sharing of responsibilities between the two agencies. It will take the local government sometime to acquire the expertise that is within the grasp of the Department of Health, whereas the latter will greatly benefit from the decentralized nature by which the former can efficiently distribute health services. It is herein suggested that a Memorandum of Agreement between the two agencies be executed to delineate their areas of cooperation and coordination in the task of providing health for all.

C. Privatization Issue

It is a basic principle of Philippine law that the powers expressly vested in any branch of the Government shall not be exercised by, nor delegated to, any other branch of the Government, except to the extent authorized by the Constitution.[9]

A corollary principle is that, except for instances specifically provided for by law, governmental powers shall not be exercised by, nor delegated to the private sector. Pursuant to this principle, the private sector is prohibited from exercising and assuming the powers and functions of the Regional Trial Courts nor of the Philippine National Police Force.

There are, however, instances when the participation of the private sector is allowed by law. This includes the construction of infrastructure projects, and the operation of selected government facilities, to name a few. In these instances, Republic Act No. 6957, otherwise known as the Act Authorizing the Financing, Construction, Operation and Maintenance of

8 Id, article 25.
9 The Revised Administrative Code, Book 2, Chapter 1, Section 1(8).

Infrastructure Projects by the Private Sector (The Build-Operate and Transfer Law), provides the step by step mechanism as well as the criteria by which the privatization of governmental services may take place.

In the case of the nationwide implementation of the CDI, which basically involves the harnessing of community potentials for the dissemination of drugs and related services at affordable costs, however, it is herein submitted that the same does not contemplate a situation of privatizing governmental services which necessitate compliance of and/or concurrence with R.A. 6957 and other related laws.

It is worth emphasizing that while the CDI is a private community-based-and-organized entity, it is not in any way designed to perform or trespass the functions of the Department of Health and the local government units. In fact, it complies with the law as it responds to the challenge of the Constitution to promote the welfare of the nation.[10]

In reality, as far as the "private" nature of the CDI is concerned, it is no different from privately owned hospitals and drugstores. The latter, similar to the CDI, are perfectly legitimate private enterprises engaged in the business of rendering of health services. It is of no moment that the Departments of Health, and Internal and Local Governments are mandated to provide and coordinate the same services. There is no legal impediment for private enterprises to engage in the activities related to health provided they comply with regulations set forth by the aforementioned agencies, or the legislature.

It is hereby submitted that the CDI, a community-initiated-and-maintained entity, is not subject to privatization procedures. Policies would have to be formulated, however, so as to ensure the efficient and adequate regulation and supervision of the same by the Department of Health and/or the concerned local government units. Nonetheless, these policies must perforce be more lenient than those for commercially owned drugstores. This is in keeping with the Constitutional mandate of encouraging and promoting community initiatives.

D. Fund Disbursement Issue

The issue on governmental fund disbursements in support of the CDI is more problematic.

It is a fundamental principle of law that government funds or property shall be spent or used solely for public purposes.[11] There is no question that the dissemination of drugs at affordable costs is a public purpose. The "private" nature of the CDI, however, potentially negates the "public purpose" character of this objective. As much as the government is constrained by law from disbursing funds to Mercury Drug or Unilab, private entities, so is it problematic to justify the disbursement of funds to the CDI.

10 The 1987 Philippine Constitution, Article II, Section 23.
11 Presidential Decree No. 1445, Ordaining and Instituting a Government Auditing Code of the Philippines, section 4(2).

It is worth asking whether the primary objective of the community-initiated-and-maintained CDI to provide medicines to the marginalized sectors of society at very low prices, and its quasi-governmental function of assisting the government in fulfilling its mandate to ensure the provision of health for all, is sufficient to support the argument that it is a "public purpose" for which the disbursement of governmental funds is justifiable (i.e., whether the objective of the program is sufficient for the law to ignore the private ownership of the same.)

It is submitted that the question is answerable in the affirmative. For indeed even the United States Supreme Court stated that "there is no known definition of public purpose that will fill all cases, for the question 'What public purpose is?' is not one of exclusive logic. It has to be resolved as one involving more or less policy and wisdom, properly determinable in the light of public welfare, present and future."[12]

Public purpose contemplates that which affects the inhabitants of the state as a community, and not merely as individuals.[13] This does not mean, however, that a tax is not for a public purpose unless the benefits from the funds to be raised are to be spread equally over the whole community or a large portion thereof. A use may be public although it is of benefit primarily to the inhabitants of a small and restricted locality.[14] Any direct public benefit, no matter how slight, as distinguished from merely incidental benefits, will sustain public purpose.[15]

Some purpose which American courts have held as public are: the establishment and maintenance of hospitals; construction and maintenance of transportation facilities and means; improvement of rivers and harbors; erection of buildings to carry on governmental or strictly public functions; construction and maintenance of memorial buildings, public auditoriums or public stadiums; erection of monuments and statutes in the streets and in public places; observance of a historical event by celebration; and holding of agricultural fairs and industrial expositions.[16]

Philippine courts have had occasion to adjudge similar cases as follows: eradication of dreaded disease,[17] and the establishment of experimental stations for increasing efficiency in sugar production, utilization of by-products and solution of allied problems, as well as the improvement of living and working conditions in sugar mills and plantations.[18] But a legislative appropriation for the construction of feeder roads inside a private subdivision is illegal since it is for a private purpose.[19]

Pursuant to the foregoing discussion, it is herein submitted that it is legally tenable to sustain fund disbursements in support of the CDI program. As a legal precaution, however, it

12 State ex rel. Reclamation Bd. v. Clausen, 110 Wash. 525, 14 Alr 1133.
13 Union Ice & Coal Co. v. Ruston, 135 La. 898.
14 Milheim v. Moffat Tunnel Improv. Dist., 262 U.S 710.
15 Cunningham v. Northwestern Improvement Co., 119 P. 554.
16 71 America Jurisprudence 381-384.
17 Gomez v. Palomar (1969).
18 Lutz v. Araneta, 98 Phil. 148 (1955).
19 Pascual v. Secretary of Public Works, et al., 110 Phil. 331 (1960).

is suggested that disbursements be made by way of a trust fund created for this purpose. The creation of this fund will adequately address inherent problems that may still potentially arise from the "public purpose" issue.

"Trust funds" refer to funds which have come officially in to the possession of any agency of the government or of a public officer as trustee, agent or administrator, or which have been received for the fulfillment of some obligation.[20] Include in these funds are those which by virtue of various restrictions applying to them, are not the outright property of the particular government which holds them to use as it pleases (as differentiated from general funds).

Trust funds are held in trust as endowment or to be expended, either as to principal or income or both, for certain special purposes, or to be retained until certain objects or requirements are accomplished and then returned. The chief sources of trust funds are: (1) gifts; (2) deposits held as security for the performance of contracts or other purposes; (3) contributions, such as credits to pension and insurance funds; and (4) funds received and held by the government as agent for other government agencies or for individuals. Each fund has a special purpose which must be carefully understood and followed. In many cases, it is for the benefit of certain individuals rather than the public in general.

Under this arrangement funding support from the national government including the Department of Health as well as other national agencies, and the local government units will be coursed to the CDI through this special trust fund. It is further suggested that every municipality have this trust fund so as to ensure the efficient distribution of support to the CDI programs.

It is noteworthy that this arrangement will likewise prevent the operation of traditional politics to the detriment of the program, inasmuch as the funds are not at the free disposal of the concerned municipal official.

E. Regulatory Issues

As discussed above, governmental supervision of the CDI program is essential to the success and efficiency of the program. It was likewise raised that the rules and regulations to be promulgated must be less stringent than existing rules due to the non-traditional nature of the CDI.

One notable aspect of regulation is that which is required by the Pharmacy Act of 1969. Section 25 of which provides that,

> "No medicine, pharmaceutical, or drug of whatever nature and kind or device shall be compounded, dispensed, sold or resold, or otherwise be made available to the consuming public except

20 Presidential Decree No. 1445, supra, section 3(4).

> through a prescription drugstore or hospital pharmacy, duly established in accordance with the provisions of this Act."

Moreover, section 27 of the same act provides that,

> "Every pharmacy, drugstore or hospital pharmacy whether owned by the government or a private person or firm shall at all times when open for business be under the personal and immediate supervision of a registered pharmacist: Provided, that no pharmacist shall have personal supervision of more than one such establishment. In cases where a drug establishment operates more than one shift, each shift must be under the supervision and control of a registered pharmacist."

There is an urgent need to amend these provisions. Present day realities have seen the mushrooming of drug outlets in supermarkets, sari-sari stores, department stores minus the "registered pharmacist" required by the above-quoted provisions. And given the low pharmacy-population ratio, it is highly improbable that each and every CDI will be ably supervised by "registered pharmacists."

Proof to this reality is the concession made by the Generic Act of 1988 in defining drug outlets as that which includes the "drugstores, hospital and non-hospital pharmacies and non-traditional outlets such as supermarkets and stores".[21]

It should be noted, however that the Generic Act did not repeal sections 25 and 27 of the Pharmacy Act in requiring the full-time supervision of duly licensed pharmacists. This is pursuant to the rule of Statutory Construction that an express repeal is necessary to obliterate the conditions of a previously set rule, inasmuch as implied repeals are not favored by law. The need to amend the Pharmacy Act therefore remains.

A possible suggestion is to provide for the inclusion of pharmacy skills in the training of community health workers. There is no reason why they can not be entrusted with basic pharmacy skills when oftentimes they are made to assume the role of medical practitioners in their localities.

III. Conclusion

It is most encouraging that the congressional Commission on Health is looking into the feasibility of including the nationwide implementation of the CDI in its legislative agenda.

While the Department of Health may always adopt the program as its own, its institutionalization be means of national legislation will ensure the continuity and viability of

21 Republic Act No. 6675, An act to Promote, Require and Ensure the Production of an Adequate Supply, Distribution, Use and Acceptance of Drugs and Medicines Identified by Their Generic Names (1988), section 6(d).

the project inspite of the changes in guards that may attend the Department. National legislation is likewise impereativein ensuring that local government officials will not take undue advantage in using to further their political agendas.

Annex B

Draft of a Botica Binhi Bill

Ninth Congress of the Philippines)
Third Regular Session)

SENATE

S.B. No. _____

Introduced by Senator .....

AN ACT
INSTITUTING A COMMUNITY BASED COOPERATIVE
IN EVERY BARANGAY OF THE PHILIPPINES,
TO BE KNOWN AS THE BOTIKA SA BARANGAY,
AND APPROPRIATING FUNDS THEREFOR AND FOR OTHER PURPOSES

Be it enacted by the Senate and the House of Representatives of the Philippines in Congress assembled:

SECTION 1. Short Title

This Act shall be known as the "Botika sa Barangay Act of 1994".

SECTION 2. Declaration of Policies and Principles

It is a clear mandate of The 1987 Philippine Constitution to protect and promote the right of every Filipino to health. Section 11 of Article XIII provides that the State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost.

Moreover, section 12 of the same article provides that the State shall establish and maintain an effective drug regulatory system and undertake appropriate health manpower development and research, responsive to the country's health needs and problems.

Pursuant to this mandate, this Act adopts the following guiding principles:

1. **Community Involvement**

Community involvement is essential for health development. People's potential for improving their own health condition is remarkable. When the community is actively involved, collaborative efforts between different sectors are successfully integrated.

It is imperative that the sentiments of the communities are adequately represented. Their active participation in the planning and implementation processes ensure the continued success of the program.

2. **Key Role of Community Health Workers**

The training, accreditation and deployment of community health workers is essential for the achievement of health for all. Community health workers have two distinct yet non-mutually exclusive roles: the provision of cost-effective health services and the promotion of health in communities where the services of medical practitioners are usually not available and if so present are cost-prohibitive.

3. **Community Financing**

While the state endeavors to provide free health services for the needy, there is a growing realization that Filipino communities, no matter how poor, have the capacity to be collectively responsible for their health. The Botika sa Barangay is designed to raise the community's level of responsibility in being accountable for their health at their own expense in partnership with the government.

In encouraging community members to give meager contributions in accordance with their financial capability, there arises a realization of the limitless potential of what they can do to promote and protect not only their own health, but that of their community in general.

4. **Government Participation and Cooperation**

The vision of health in the hands of the people brings the government closest to the people. The successful implementation of the Botika sa Barangay is dependent on the establishment of a mutually beneficial partnership between the government and the community. This partnership entails the recognition of what self-help, respect for the individual and the community, and willingness on the part of government authorities to support community initiatives, can do.

SECTION 3. Establishment and Purpose

There shall be instituted a Botika sa Barangay in every barangay of the Philippines. The Botika will be a community based and organized drug insurance scheme which will be

initiated by the different barangays with the assistance of the Department of Health and the Department of Interior and Local Government. The Botika will provide needed drugs and medicines to the Barangay members at costs significantly lower than the factory price of the said drugs.

Under the scheme, family members of the barangay will make minimal monthly contributions in accordance with their financial capabilities. The collected contribution, together with that of relevant government agencies, will be used to purchase medicines at wholesale prices. The purchased medicines will then be sold to the members at a significantly discounted price.

The Department of Health in consultation with the Department of Local Government shall designate priority areas/barangays for the immediate implementation of this Act.

SECTION 4. The National Botika sa Barangay Council

There is hereby created a National Botika sa Barangay Council composed of representatives from the Department of Health, Department of Local Government and duly accredited people's organizations.

SECTION 5. Powers and Functions

The Council shall have the following powers and functions:

1. To administer the nationwide implementation of the Botika sa Barangay.

2. To formulate and promulgate implementing rules and regulations for the Botika sa Barangay in consultation with local communities.

3. To hold and administer as trustor for barangay beneficiaries the Botika sa Barangay Trust Fund.

4. To formulate and implement guidelines on contributions, payment schemes, pricing, quality assurance, training, accreditation and deployment of community health workers, evaluation procedures, periodical reviews and other issues pertinent to the implementation of this Act, always in consultation with local communities.

5. To perform such other acts as it may deem appropriate for the attainment of the objectives as well as the proper enforcement of the provisions of this Act.

SECTION 6. Board of Directors

The Council shall be governed by a Board of Directors hereinafter referred to as the Board, as follows:

The Secretary of Health;
The Secretary of Local Government;

The President of the League of Governors;
The Commissioner of the Food and Drug Authority;
Three representatives of duly accredited peoples organizations specializing on the provision of health services.

The Board may otherwise agree on the inclusion of other directors as it deems necessary.

SECTION 7. Botika sa Barangay Trust Fund

There is hereby created a Botika sa Barangay Trust Fund which the Council will hold in trust for the Botika sa Barangays. These funds shall be used for the mobilization and education of local communities with regard to the Botika sa Barangay program, the training and accreditation of community health workers who will be the responsible officers to supervise the sale and prescription of medicines in the Botika, and other expenses incidental to the implementation of this Act. This trust fund will be the financial

Under this arrangement funding support from the national government including the Department of Health as well as other national agencies and local government units will be coursed to the Botika sa Barangay through this special trust fund.

SECTION 8. Accreditation of Community Health Workers

The Council shall train and accredit community health workers in selling and dispensing drugs and medicines in the Botika sa Barangay. This expressly repeals section 27 of Republic Act No. 5921 which requires the supervision of licensed pharmacists in all drug stores.

The Council shall ensure that the community health workers are well trained in the sale and dispensation of drugs. No Botika sa Barangay will operate without the direct supervision of a community health worker duly trained and accredited by the Council. The Botika shall at all times display the qualification and accreditation documents of its community health workers. Provided that the said community health workers may supervise the dispensation of drugs only in the Botika sa Barangay.

SECTION 9. Appropriations

For the purpose of establishing the Council, the Trust Fund and initiating its operations, there is hereby appropriated the sum of Five Million Pesos to be sourced from the Philippines Games and Amusement Corporation.

SECTION 10. Appointment of Board of Directors.

Within forty five (45) days from the date of effectivity of this Act, the Secretary of Health and Secretary of Local Government shall appoint the members of the Board of Directors of the Council.9

SECTION 11. Implementing Rules and Regulations.

Within forty five days from the completion of such appointments, the Council shall convene to formulate the necessary rules and regulations to implement this Act.

SECTION 12. Within sixty (60) days from its initial meeting, the Board shall promulgate the aforementioned rules and regulations in at least two (2) national newspapers of general circulation.

SECTION 13. Repealing Clause

All laws, decrees, rules and regulations contrary to and/or inconsistent with the provisions of this Act are hereby repealed or modified accordingly.

SECTION 14. Separability Clause

If any part or section of this Act is declared unconstitutional for any reason whatsoever, such declaration shall not in any way affect the other parts or sections of this Act.

SECTION 15. Government Guarantee

The Government of the Philippines guarantees the financial viability of the Botika sa Barangay.

SECTION 16. Effectivity Clause

This Act shall take effect fifteen (15) days upon its approval and completion of its publication in at least two (2) national newspapers of general circulation.

APPROVED.

Annex C
Actual Dissemination of Community Drug Insurances

as of May 1994

Established Community Drug Insurance Projects by
SAMAHANG MANGGAGAWA NG BINHING KALUSUGAN (SMBK),
P.O. Box 4532, Manila

REGION/ PROVINCE	*CITY/TOWN*	*DISTRICT*	*BARANGAY Sitio*	*DATE Started*	*SMBK PARTNER*
1. NCR	1. Manila	1. Balut, Tondo	1. Smokey Mountain	July 1990	Community
		2. Sampaloc	2. Balic-Balic	October 1993	International Team
	2. Paranaque		3. Freedom Island	April 1992	Church
	3. Quezon City	3. Diliman	4. Luzon	February 1993	Community, Church
			5. Fort Santiago	January 1993	Mission Ministry of the Phil. (MMP)
			6. Manggahan	January 1993	Overseas Missionary Fellowship (OMF)
			7. Litex Common wealth	February 1994	Community, MMP
			8. Sto. Nino, Fairview	February 1993	MMP Community
			9. Laurel Comm-onwealth	July 1993	Church, MMP
			10. Ruby, Fairview	April	Community
			11. Kapatiran Common wealth	March 1993	MMP Community
			12. Grp I Ph B Payatas	July 19944	Community
		4. Congressional	13. Mendez, Baesa	November 1993	Church
			14. Militar	March 1994	Servants Inc.
	4. Caloocan	5. Bagong silang	15. Phase 7-B	March 1993	Servants
			16. Phase 5	November 1993	Community
	5. San Juan		17. Little Baguio	February 1993	Norwegian Missionary Alliance (NORMA)
	6. Mandaluyong		18. Welfare Ville	July 1994	Community

REGION/ PROVINCE	*CITY/TOWN*	*DISTRICT*	*BARANGAY Sitio*	*DATE Started*	*SMBK PARTNER*
2. Pangasinan (Reg. I)	7. Alaminos		19. San Jose	March 1993	Community
			20. San Antonio	July 1994	Community
3. Benquet/CAR	8. Kapangan			December 1992	Tribes Mission of the Phil. (NTMPI)
	9. Kibungan		22. Poblacion	March 1993	NTMPI
	10. Taloy Sur		23.	August 1993	NTMPI
4. Bulacan (Reg. 3)	11. Bustos		24. Sampaguita	December 1991	Church
	12. Angat		25.	April 1994	NTMPI
5. Cavite (Reg. IV)	13. Dasmarinas		26. Bulihan	March 1993	NORMA
Rizal	15. Taytay		27. Muzon	June 1993	NORMA
6. Misamis Oriental (Reg. 10)	16. Opol		28. Kauyunan	April 1994	NTMI
Agusan Sur (Reg. 10)	17.	6. Ulanganan	29. Kalakala	May 1994	NTMI
			30. Kababaan	May 1994	NTMI
			31. Nimbulan	May 1994	NTMI
			32. Manlay^-ungan	May 1994	NTMI
			33. Manungnung	May 1994	NTMI
	18.Gingoog City	Eureka	34. Baliguihan	April 1994	NTMI
	19. Surigao City		35. Punta Pilar Sur	May 1994	SFPHC, Mothers Club
			36. Anomar	May 1994	SFPHC, Mothers Club
			37. San Juan	May 1994	SFPHC, Mothers Club
			38. Zaragoza	May 19944	SFPHC, Mothres Club
			39. San Jose	May 1994	SFPHC, Mother Club
			40. Sukailang	May 1994	SFPHC, Mothers Club

REGION/ PROVINCE	*CITY/TOWN*	*DISTRICT*	*BARANGAY Sitio*	*DATE Started*	*SMBK PARTNER*
			41. Lipata	May 1994	SFPHC, Mothers Club
			42. Mat-i	May 1994	SFPHC, Mothers Club
			43. Libuac	May 1994	SFPHC, Mothers Club
			44. San Jose	May 1994	SFPHC, Mothers Club
7. Davao del Norte (Reg. 10)	20. New Bataan		45. Manurigao	May 1994	United Mandaya Mansaka Tribal Assn. Inc. (UMMTAI)
			46. Andap	March 19944	UMMTAI
			47. Boston	March 1994	UMMTAI
			48. Taytayan	March 1994	UMMTAI
			49. Upper Andap	March 1994	UMMTAI
			50. Poblacion	March 1994	UMMTAI
			51. Cogonon	March 1994	UMMTAI
			52. Libuton	March 1994	UMMTAI
			53. Pagsabangan	March 1994	UMMTAI
			54. Camaren	April 1994	UMMTAI
	21. Mabini		55. Libudon	March 1994	UMMTAI
	22. Monkayo		56.	April 1994	UMMTAI
Davao Oriental	23. Cateel		57. Mampi	April 1994	UMMTAI
Davao del Sur	24. Jose Abad Santos		58. San Isidro	March 1994	UMMTAI
	25. Saranggani		59. Small Margus	March 1994	UMMTAI

COMMUNITY COOPERATIVES

Policy Paper of the Federation of HAMIS Winners in the Philippines, Inc.[22]

I Justification and Rationale

A. The prevalence of poverty, the lack of health services, and the inacessibility of health providers and hospitals have prompted the people to bind themselves into organizations like cooperatives. This act of solidarity gives the community access to economic facilities and health services that help alleviate their miserable conditions.

B. This people's initiative to identify resources and innovations for health also enables them to find means for improving their economic condition.

C. Genuine cooperatives are bound by the cooperative spirit and a mutual consideration for the common good of every member not the gratification or self-interest of the few.

D. Based on the HAMIS Winners' experiences, livelihood loans have helped members of the community support the economic needs of poor families. Cooperatives have tried to develop alternative schemes for health financing because of the felt health needs among its members. Through participatory processes, members have been involved in making key decisions: the amount of contributions they can afford and the kind and quanitity of benefits they can avail of.

II HAMIS Winners Experiences

This theoretical conclusion stems from valid observations and experiences of the HAMIS Winners. These are examples of good health care management even in the most extreme situations of poverty and dependence. We have only to look for them, discover them, and give them the chance to be known. Let us give some examples and group them, thereafter

Antique

22 The first thought of this policy paper was drafted by Dr. Carl Salem and Ms. Liza Salem. We acknowledge the fruitful ideas of Dr. Emma Palazo, Mr. Ben Ravida, Dr. Detlef Schwefel, and Dr. Cely Turno. This paper owes very much to the rich experiences of HAMIS Winners in the Philippines, and prolific suggestions of the DOH consultants . Especially to the cooperative endeavor of Secretary Jaime Galvez-Tan for the setting up of a Community Health Cooperative Unit at the Department of Health.

Botika Kooperatiba mobilizing Antiquenos to build a responsive health system and to promote cooperativism as a way of life for the economic and social well-being of the people.

Batangas

Operasyon Tulungan Pamilya in Lian. By contributing one peso a month, a family can avail of a small interest-free loan for health emergencies. The fund is repayed on installment basis according to the members' capacity to pay.

Bulacan

An amount from loans to small-scale businesses is alloted to finance health activities. As a requirement for availment of health services, members should promote health practices such as increaseing the family budget for nutrition, having a deep-well, etc.

Cavite

Talipusngo-MPCI Farmers' Cooperative supports a health financing program by allocating 10% of its annual income to the provision of health-related projects and services.

Cebu

Kauswagan: Health Resource Distribution Program with Livelihood Support. The IGP of the barangay cooperatives support the community health program through an allotment from the coop income: 50% goes to community health fund. It has a unique criteria for the availment of loans that is truly promotive of health, e.g.: sanitary toilets, immunization of children, couples practice family planning, clean environment, and active participation in meetings or coop activities.

Cotabato

Kapitbahayan Clinic in Midsayap distributes ducks to school children who are responsible for their propagation. The children and their families make balut as additional income to augment the family's budget for health needs.

Iligan

Sacred Heart Hospital's P2-a-day hospitalization scheme enables its members to avail of hospitalization services such as free ward accomodations, 10-15% discounts on laboratory exams, and free routine nursing care. For major operations, the patient-member pays only P3,000.

Leyte

Silago Multipurpose Coop, enrolls members to in a medical coverage program upon the payment of P25 as a reserved contribution. A member is required to put up at least P200 share capital in order to join the health plan. The ceiling amount of availment of mdical services is P500 per year. The benefits can be extended to any member of the family only once.

Lucena

A drivers' cooperative (LJODA) provides livelihood loans with low interest rate and interest-free health emergency loans plus monthly blood sugar monitoring of diabetic members.

An institutionalized development cooperative (Mt. Carmel) grants small-scale loans and entrepreneurs' capital to members. It also provides assistance for health emergencies to hospitalized members (P50 contribution a year) and mortuary assistance (Damayan Social Fund, contribution of P50 a year) as part of its health financing benefits. Continuous education strengthens the viability of the organization.

A NGO, HOPES, establishes drugstores in the locality of Quezon Province that are owned by the people and also extends livelihood assistance through a multi-purpose cooperative.

Negros

Siaton District Hospital: The members contribute a minimum of P500/share as equity for a cooperative hospital. They are provided low-cost and affordable health care. Members are entitled to patronage refunds from the coop.

Tondo

Drug store insurance originated in Smokey Mountain. A family contributes P10 a month or 1% of the family income as capital build-up for the Community Drugstore. The member can avail of a 50% discount when buying medicines.

These experiences can be grouped into voluntary non-withdrawable savings schemes and cooperative hospitals health financing scheme

1. Voluntary Non-Withdrawable Savings Schemes

a Income-generating projects: This is a collective effort of savings mobilization in which all community or cooperative members commit an affordable amount to be deposited by the group, at specified time intervals (monthly or daily), to a common fund for health benefits. Most of the cooperatives practice counterpart sharing for healthcare financing by paying monthly dues or premiums for availment of benefits like hospitalization assistance, accomodations for in/or out patients, and discounts on medicines and livelihood loan. Return of investment to members are in the form of dividends and patronage refunds. Every coop member pays a share capital (the amount depends on the members' capacity to pay) which is the basis of the loanable amount. On the other hand, the members' participation, the existence of health facilities at home (e.g., toilets), the practice of immunization, vegetable gardening, and other health-related activities for the community (in projects like OTP and Kauswagan) are also considered as bases for the grant of loans. In some organizations, loans are extended in kind, e.g.: materials for the construction of toilet bowls and ducks for propagation.

b Payments and collections: The good management of funds is an important contributing factor to the successful operation of cooperatives because it establishes credibility, gains the trust and confidence of its members, and promotes linkages with other institutions. For payments and collections, the most common methods used are through personal remittances, the use of collectors, or salary deductions.

As experienced by a well-established cooperative, a small cooperative is easy to manage, particularly in the collection of delinquent accounts. As the cooperative grows, management problems become more complex, particularly in the collection of accounts. To minimize delinquency problems, several collection strategies are used:

1. the signing of promissory notes,
2. loan ceilings based on a members' credit rating,
3. the assignment of collateral for loans,
4. the designation of monitoring aides, committees, or staff,
5. the fulfillment of commitments to improve the family's health status.

Because a cooperative is bonded by the mutual understanding of its members, the usual legal requirements are not the only measures used by coops in granting credit. Humanitarian concern extended on a case-to-case and whatever is judged fair and acceptable to the majority form the basis the approval of credit.

The continuous values formation of members is important for augmenting collections and for strengthening the cooperative.

c Health Financing and Mortuary: It is interesting to note instances in which a member may not have the capacity to contribute or pay due to unexpected events; this, although previously, they have actively participated. This happens when a family member becomes totally ill and dies. Thus, death benefits need to beincluded in health financing scheme. Death is expensive. To ease the financial burden of death on the living as well as provide a decent burial, cooperative members pool their contributions in a mortuary assistance fund (Mt. Carmel project). Giving out of Damayan Benefits is also an incentive for members to remain in the cooperative till their death.

2. Cooperative Hospitals Health Financing Scheme

Cooperative hospitals are accredited with the Bureau of Medical Services; these hospitals are open for membership to all members of the community. Shares of stocks make families and communities co-owners of the hospital. The management of cooperative hospitals is shared by the community, the hospital personnel, and professionals. It can be linked with LGUs depending on the category of the hospital--private or public.

Basically, the HAMIS Winners have developed health financing schemes for cooperative hospitals by identifying the problems of communities: why are many of them unable to avail of the hospital services even when they need them so badly.

The problem was not only the unavailability, inaccessibility, and the unaffordability of health services, but also the situation in which families do not have a "budget for health." It was observed that patients would seek hospitalization only if there the illness is severe and death is near.

A consultative study, made by drawing on the people's ideas and concerns about their health, has revealed that members are willing to contribute at least P500 as share capital for the cooperative hospital (Siaton) and a P2/day for a hospitalization plan (SH Iligan). The amount of contributions vary according to the geographical area and the ability of the people to pay. This positive

attitude enabled them to developed schemes to finance their health needs: hospitalization, regular consultations, the purchase of medicines, and, at the same time, initiate fund-raising activities for health.

Hospital cooperatives similarly promote the HMO (San Antonio/UPLB) idea of health financing for both in- and out-patient hospitalization benefits, while Medicare I provides only in-patient benefits.

III Policy Content

A. Definitions

1. A community cooperative is a voluntary organization whose members pool their resources into a common fund for a common goal: the improvement of the health and the economic conditions of their community. The nature of this organization may vary according to the services it provides its members: transportation, consumer, agro-marketing, drugstore, livestock, or multi-purpose. A cooperative encourages the habits of thrift and savings in order to support its capital formation scheme. The amount and the kinds of benefits are determined by the members' contributions and share capital. In this kind of organization, the members have the right to participate in the process of decision-making.

2. Community health financing is the sum total of material, human, financial, and time resources that are discovered, tapped, and mobilized for the purpose of establishing efficient, effective, and equitable economics towards improved health.

B. Basic Considerations

1. A community cooperative achieves productivity gains through the self-organization and the bonding together of people. Good health management, in this sense, is merely the productive use of otherwise overlooked resources for the benefit of those who are in need.

2. Community cooperatives then, are vehicles in the development of the people, the promotion of self-reliance, and the harnessing of the people's power toward the attainment of improved economic and social conditions .

3. The common model of health care is through the Doctor-Patient/Provider - Recipient System. This relationship brings about two valid questions:

a. Who pays? (Can the payee afford?)
b. Can we keep costs down or, alternatively, can we increase the capacity of the beneficiaries to pay?

Notice that the variables for improved health financing are in the second question: can we increase the capacity of beneficiaries to pay ?

It follows that by shifting responsiblity for financing from the individual to the entire community, the chances for improved health financing are enhanced. Furthermore, the health provider is given the option to participate in the scheme and is, no longer an "outsider", but a part of the community health financing scheme.

The idea of delivering health financing services through cooperatives is a desireable goal because there is equal access of all to health services; it also ensures the efficient delivery of benefits.

Lastly, a democratic approach to management prevails.

It is important to consider scenarios in which credit cooperatives are dissolved due to mismanagement, corrupt practices, non-repayment of loans and failing members' participation. Based on experiences (Mt. Carmel project), continous coop education and value formation are necessary for members and officers of cooperatives. This is because cooperatives should keep pace with the development of social and economic principles and with changes in the health condition of the people.

IV Policy Recommendations

1. The people's access to health information and community health financing (CHF) is a prime responsibility of the state.

2. The state recognizes, protects, and promotes cooperativism in the mainstream of society as vehicle towards social and economic progress.

3. Accreditation should be given to community cooperatives to collect premium contributions of and to deliver health services to the community to the National Health Insurance Program. It is one way of ensuring and protecting the right of the citizens and of minimizing red tape.

4. Options must be available for alternative systems of monitoring and evaluating CHF.

5. Community organizing should focus on cooperative principles and other relevant provisions relative to Cooperative Development Authority (CDA) policies.

6. A trainors' pool from both government and non-government organizations should be organized and accredited with CDA.

7. Authorization be given to community cooperatives to collect premium contributions of the community to the National Health Insurance Program.

CREDITS AND LOANS FOR HEALTH

Policy Paper of the Federation of HAMIS Winners in the Philippines, Inc.[23]

I Justification and Rationale

In situations of widespread poverty, the relationship between spending and saving money is of crucial importance. Money management at the household level has an enormous impact on health and social life. This has to bee seen in the wider context of saving and what is being called "negative saving."

Saving has many faces. Webster defines "to save" as:

- to rescue or preserve from harm or danger,
- to preserve for future use,
- to prevent or lessen,
- to prevent loss or waste,
- to avoid expense, waste, etc.,
- to store up money or goods.

To pick but one of these definitions and to declare it the only valid one would be inappropriate and insufficient when considering saving, its determinants, and its effects. Much more, saving is a social concept, a social reality, and a social problem.

In situations of poverty, as among the poor in the Philippines, the usual economic concept of positive saving is not an option. The poor frequently do not have a choice between consuming or saving. Often, they forced to go into negative saving (indebtedness to money-lenders) in the present, in order to avert an existing crisis, like a catastrophic illness. Not to loan and spend in such a situation would worsen the crisis. Thus, we have to look at credits and loans for health from a different perspective. On the one hand, real saving, as we know it, if practiced by the poor may worsen their health and may not even be possible to achieve. On the other hand, negative saving, or loans from money lenders, though a depressing fact of the poor's lives, can be life-saving.

In this policy paper, we will attempt to show how alternative forms of credits and loans can wean the poor away from having to incur negative saving. It presents the

23 A first draft of this policy paper was written by a team composed of Dr. Detlef Schwefel, Dr. Emma Palazo, and Dr. Carl Salem. It integrated parts of the article; Detlef Schwefel, and Reiner Leidl: Remarks on the social meaning of savings of the poor. In: Development, 1987, No. 2/3, pp. 142-144. This final version of the policy paper owes very much to intensive clarification and consultation processes with most of the members of the Federation of the HAMIS Winners.

notion that credits and loans do not have to lead to a situation of worsening health and deepening poverty.

II HAMIS Winners' Experiences

In the Philippines, catastrophic illnesses are not covered by Medicare and public hospitals often are often not in a position to render all services free of charge. In such cases, poor families have to spend substantial amounts for health and health care. The HAMIS household survey on private health expenditure shows this very clearly:

> that there are a large number of cases in which families earning less that P1,000 a month have to spend more than P10,000 for a case of catastrophic illness
> that in such cases, very often, families, friends, and even employers help out with donations or cheap credits

There are also quite a large number of cases where private lenders have to be asked for credits and loans. These private lenders often request a pay-back according to the 5-6-rule, i.e., "I give you five pesos and you give back 6 pesos."

In individual cases, the health risks may easily exceed the level of affordability when catastrophic illnesses are involved. Processes of increasing pauperization may result from this. This is an area of concern where many HAMIS Winners have stepped into with programs to alleviate the situations of families in need. These are just some examples:

> **Antique**: Promotion of entrepreneurship through varied income-generating projects and low-interest loans from the cooperative to sustain the health program.

> **Batangas**: Premium collection from members who can avail of an interest-free loan and managed referral in case of illness. The premium is 10 pesos a month per family. (Local Health Insurance)

> **Butuan**: Loans with low interest are given to families with good health behavior, i.e., complete immunizations, safe family planning, school enrollment. (Social Credit Program)

> **Quezon**: Establishment of a barangay health worker station and a "paluwagan" among community members for interest-free loans for medical emergencies. The contributions are even less than 10 pesos. (Barangay Health Workers)

> **Quezon**: Granting of small-scale loans and entrepreneurs' capital and provision of assistance for health emergencies. (Mount Carmel)

> **Quezon**: Providing livelihood loans with low interest rate and health emergency loans not bearing any amount of interest. (Drivers' Association)

> **Quezon**: Outreach medical care is delivered to far-flung areas for small consultation fees. These fees are deposited in a savings account in the name of the patients' family so that they can avail of a loan. It also allows them to be members of a nearby cooperative. The consultation

fee is 10 pesos per case. (Medical Society)

> **Surigao**: 10% of the proceeds of income-generating projects are channeled into a health fund for covering emergency expenses in case of illness. The money is granted free or at least interest-free. (Federated Mothers' Clubs)

> **Tawi-Tawi**: Premium collection from members of a health club who have to use preventive care to be able to get free or at least interest-free managed curative health care. The premium is 10 pesos a month per family. (Comprehensive Health Program)

> **Tondo**: Premiums are collected from families in order for them to avail of a 50% discount for prescribed drugs (others in the catchment area benefit from factory prices). The premium is 10 pesos a month per family. (Community Drug Insurance)

What are the lessons? There seems to be a magic ceiling for "health insurances" or "loans for health" for the poor. Ten pesos a month is an affordable and acceptable level. It does not cover all expenses but only the essentials. It, at least, assures that poor families who need money for health emergencies do not fall into the hands of private pawnshops or profit-hungry money-lenders. It is basically a "cooperative" activity of concerned citizens for getting interest-free or soft loans.

These are some of the issues under discussion that bear some policy implications:

> Granting of soft loans in cases of very high expenditures of individual families is a way not a few community organizations have used for alleviating the economic impact of diseases in individual families. HAMIS winners provide good examples.

> Individual illnesses can have a wide impact on the health and social life of entire families. There have to be ways of alleviating such situations, especially where vulnerable groups like women and children are concerned. Again, some HAMIS winners have gone into comprehensive health care arrangements with heavy emphasis on prevention and promotion, changing the lifestyles of families towards more rational health behavior.

> With what community organizations have done, how can the government respond? One way would be to establish a national reassurance fund for life-threatening illnesses that affect entire families, for example, cholera epidemics. This is not a health insurance for all. This is an assurance against catastrophic illnesses of a few families.

The avoidance of such situations (catastrophic illnesses) may be possible in the future, if health promotion and prevention activities are given the importance they deserve. However, in the present time, credits and loans for health purposes is a necessity if the poor are to have some security during times of crisis. This security will allow them the "breathing space" they need build themselves a healthier future.

III Policy Content

Basic concerns

It often said that savings can avoid the negative impacts of credits and loans and that "saving" is a sign of a rational household budget that is conducive to a healthy lifestyle. However, the mobilization of savings among the poor is an intricate issue; in the Third World, saving cannot be dealt with as money saving alone.

In a rather narrow sense, saving is often defined as the preservation of real income for future consumption. In a world of poverty and starvation, such a definition has little real meaning. Therefore one has to explore the social meaning of savings. We have to explore the social meaning of savings, since negative savings, in terms of almost permanent indebtedness of the poor to local money-lenders, is as widespread as are real savings. These negative savings may be in kind and assets, be it dried food, ornaments, or carabaos. When poverty and under-consumption prevail, saving should not only mean a further postponement of consumption, which, paradoxically, may lead to an even deeper impoverishment.

In the case of the poor, saving must mean a more efficient use of scarce resources in a substantial way, which is to secure the satisfaction of current and future basic needs. This might entail employing the economic activities of the informal sector: diversification of production, rehabilitation of subsistence economies in the form of gardening, establishment of fuel-saving stoves or the promotion of neighborhood kitchens, employment-creation, and real-income transfers in terms of health and nutrition. All these items are examples of more appropriate means of saving in the situation of poverty. From the above examples, it can be noted that saving means, not non-consumption, but, rather, wise consumption in the form of productive investments.

Saving should not be a setting aside of what are already meager surpluses for unknown and insecure uses in the future, but should help to widen the ways and strengthen the means that provide minimal security now and promise a future for the poor. This is the social meaning of "mobilization of savings". The concept of saving, if defined in purely monetary terms, entails nothing but the idea of the poor setting aside meager surpluses, for the benefit of the rich. This is quite evident in government housing programs, where compulsory deductions from the salaries of the working poor, ostensibly for housing purposes, lead to a situation where only the rich and the middle class can avail of these housing loans because of the high premiums and interest. The poor are subsidizing the rich.

To avoid this danger, we should always ask ourselves: what are the social effects of saving. For example, how do forced saving affect the state of health and nutrition of the women and children. Our plea, therefore, is for comprehensive approaches of qualitative and quantitative social science research in this field, which never forgets the key question of social research: who loses and who benefits?

1 First Concern: Widespread indebtedness as the starting point

In a situation of poverty, "negative saving", i.e., the widespread indebtedness of poor people, is the point of departure for any realistic analysis of savings. The poor produce deficits every month as can be seen from income and expenditure surveys and, more validly, from qualitative case studies. Borrowing is often used to satisfy consumption instead of investment needs, especially in the case of emergencies (necessary as opposed to excess). Everywhere, a tight hierarchical system of more or less informal mini-loans exists, which is based on trust and memory and which can exceed the loan conditions usually imposed in the formal sectors. This system penetrates families, friendships, businesses, and villages and is not restricted to the exchange of today's and tomorrow's money but includes goods, services, and social relationships as well. Implicit and explicit negative savings forced by high prices, e.g., of food, could be added to this picture. Sophisticated research on this topic is still very scarce. It would need promotion.

2 Second Concern: "Healthy" savings in cash and kind

Income statistics are especially poor for an economic analysis when applied to informal sectors linked with shadow, exchange, and subsistence economies. To regard only the monthly or yearly money left-overs as potential savings has a pragmatic appeal but some inconveniences as well. To mention only two points: *reserves in kind have to be added* and *debts have to be subtracted*. The first bias could not even be corrected by using family expenditure surveys; instead, non-standard research would have to be undertaken. These could show, e.g., a stock of mini-production factors, like a bicycle, or of durable consumer goods, like radios or TV sets, that could be sold when needed. Such sales are a first sign of a coming consumption crisis. Non-cash savings in kind are an important aspect of the problem under consideration.

Let us go further and be provocative: *child-rearing* may sometimes be considered a specific form of sacrifice of present family consumption, made in view of a future security for parental consumption. This, too, is a social facet of real savings. It implies that not only stored money or goods may be seen as savings, but also *behavior or activities aimed at securing future consumption.* Another example could be the construction of toilets in the present to avoid the expense of treating diarrheal diseases in the future.

Another aspect of saving may be *stored fitness* through good nutrition and health in order to be prepared for health crises, like infections, which are easier to overcome when well nourished. The reason behind this aspect of real savings is that activities to prevent possible crises in the future may be labeled as saving, because the expenditure that would have been required to cure and care later has been saved by preceding activities to prevent disease and to promote health.

Thus, to study the social meaning of saving in the informal sector in Third World countries, we have to look for real savings by applying a blend of social research designs, case studies, behavioral studies as well as health and nutrition surveys, and not only income and expenditure studies to operationalize nominal savings in terms of income minus expenditure.

3 Third Concern: Rational household economics and a healthy lifestyle

The latter two aspects of real savings introduce a normative concept of "rational" behavior: refraining from "bad" or "conspicuous" consumption in favor of "good" consumption is interpreted as saving as opposed to squandering. This is the case when future benefits can be expected from actual behavior. More generally, savings in the meaning of avoiding future consumption crises can be achieved by present consumption patterns, in the extreme case, even without any further reductions in the level of consumption. Hence, substantially "rational" consumptive behavior can be looked upon as an activity of saving, since it might help to enlarge human and environmental capital stocks for future consumption. Healthy life-styles or better education (as a precondition for a self-initiated improvement of the standard of living) are common examples for this type of saving. In short, saving can mean not only a reduction of consumption, but also a change of consumptive behavior towards healthier lifestyles.

One purpose of saving is to have a risk remedy at hand when needed. Not to spend all of one's money and to save some of it may be one instrument of fulfilling this purpose. It may be bad advice in times of inflation or in cases where social networks, friendship, good health, power, or love are the backbone of a minimal social security. To spend money for fiestas, where the gains may be intangible but desirable, may then be good advice to achieve the purpose of savings. This contradictory argument refers to the level of the individual.

Similar problems may arise when individual activities are linked with societal consequences. Individual saving, with the side effects of increased undernutrition or a diminished safety at work, may not only lead to later losses in production, but also to an increased use of public goods and services like hospitals. This is the situation of saving in the wrong places. Thus, individual saving may have social costs.

To overcome such dilemmas one has to avoid the naive definition of saving, i.e., to consider saving only as the difference between current income and current expenditure and forget about all the rest.

4 Fourth Concern: Health promotion as a rational saving behavior

Saving means to generate reserves to overcome future crises. To try and minimize the impact of crises could be one aspect of "preventive saving". There are more examples: spending money for good nutrition of the children, not spending money for excessive tobacco and alcohol consumption, and spending time for one's physical condition are examples of individual endeavors to strengthen health and to be fitter during ill health and consumption crises. At the social level, prior investment in projects like clean drinking water, environmental hygiene, and road safety may later save expenditures for cure and care. In short, the rational spending of individual time, energy, and money and of public funds is an effective and efficient kind of saving.

Let us imagine a family hit by a catastrophic illness following unemployment of the father. The following

income reduction may lead, via the distributive patterns of inter-family consumption, to undernutrition and disease of the socially weakest parts of the family, i.e., mostly younger girls and dependent older people. Let us now assume that, not unemployment, but gambling reduces food consumption for the family. Then, we would not speak of bad luck or misfortune, but of irresponsible behavior. This reasoning implies that nominal (irrational) saving in a situation of poverty may have unacceptable side-effects; an unthinking mobilization of the poor's savings may have, for example, unhealthy consequences for the weakest parts of society. The lack of rational saving, in the form of lack of health-promoting behavior (smoking or gambling), spells doom for the family in crisis.

5 Fifth Concern: The social meaning of mobilization of savings

Poverty is a widespread reality for our people. What is the social meaning of mobilization of savings in such a context? Let us take a rural electrification program as an example. Sixty-four percent of the electricity produced is spent for private lighting, 24% for television, 11% for public lighting, and 1% for radio. Current monthly expenditures are P10 for TV, P4 for light and P2 for radio. About 30% of the households with electricity bought a secondhand TV for about P1,000 that includes 45% import taxes and 10% other taxes; additionally, an average business profit of 30% can be assumed. These data imply that, in the wake of a rural electrification program, enormous savings were mobilized for the benefit of state and commerce and not for immediate productive use by the local population.

This example points to what the social meaning of mobilization of savings should be: to spend money, resources, and energy rationally to satisfy basic needs now or in the near future. In other words, the mobilization of the savings of the poor should be channeled into meeting basic needs, such as health. Not to do so would be to continue the present wasteful consumption in non-productive uses.

IV Policy Recommendations

1 The prioritization of the prevention of diseases and the promotion of health should obviate the need for credits and loans.

2 Credits and loans should be used to encourage health-promoting behavior, e.g., immunization, and to discourage unhealthy behavior, e.g., smoking and eating junk food.

3 Reassurance funds needs to be created at local, provincial and national levels to backstop CHF programs whose members experience catastrophic illnesses, epidemics or disasters.

4 Soft credits and loans should be provided for health emergencies, using health behavior as collateral. The funds might come from community fund raising for health.

5 Credits and loans should be provided for income-generation projects of people’s organizations with health agendas, as well as for food-generation projects and health-generation projects.

6 Both the government and the community should share in the funding of soft credits and loans.

COMMUNITY HEALTH FUND RAISING

Policy Paper of the Federation of HAMIS Winners in the Philippines, Inc.[24]

I. Justification and Rationale

The Alma Ata declaration of 1978 defined primary health care as "essential health care . . . made universally accessible at a cost that the community and country can afford." Such health care, it continued, "requires and promotes maximum community and individual self-reliance and participation . . . making fullest use of local, national, and other available resources." The declaration recognizes the necessity to exercise political will to mobilize resources and to use available external resources rationally. Since Alma Ata, "Health for All" has been following two complementary drives. One stresses mobilization and effective application of under-utilized local and national resources. The other emphasizes the development of affordable and culturally appropriate delivery systems so that basic health care can be universally accessible.

The Department of Health (DOH) redefined primary health care as health in the hands of the people. The DOH's policy statements mention that:

- Pesos for health is one of its priorities.
- Funds are needed to move the health programs in the community.
- Putting health in the hands of the people also means putting finances in the hands of the people.
- The more than 40,000 barangays will be the backbone and major source of health financing.

This paper is concerned with resource mobilization, with particular emphasis on community participation. The objective of the paper is to help policy makers fit community financing into the overall health financing plan and to suggest ways in which community schemes, based on HAMIS winners' experiences, can be implemented.

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24 The first version of this paper was drafted by Dr. Emma Palazo. This policy paper acknowledges the fruitful cooperation of the members of the Federation of HAMIS Winners in the Philippines, especially of the PHC Mothers Club in Surigao, and the consultants of the Department of Health in the process of intensive consultation and clarification. Ms Zeny Arana and Dr. Jocelyn Ilagan deserve special mention.

II. The HAMIS Winners' Experiences

The winners of the first HAMIS Contest in 1991 discovered that there are many sources of funds in implementing and strengthening community health programs. These sources are:

1. contributions in kind from existing organizations -- regular DOH supply, lots provided from local government, mmaterials from private industry, free supply of various materials from different existing organizations.

2. contributions from existing organizations in cash-grants from foreigndonors, local government funds, contributions from PAGCOR, city government agencies, PHC funds, loans from various sources. government funds, government agencies, PHC funds, loans from varioussource

3. voluntary contributions in kind - donations of blood, voluntary labor, voluntary supply of materials.

4. special fund-raising activities--fund-raising for specific projects, townfiesta proceeds, raffles, beauty contests, popularity contests, bingo games, Christmas caroling, benefit dances, cockfighting, collection of empty bottles, collections, paluwagan

5. income from entrepreneural activities--sale of vegetables and livestock from the backyard, sale of piglets, fish powder, and herbal medicines, lending of assets, patient fees, fee for services, tuition fees, provident fund, botika fund, interest income of various funds

6. income from charity-benefactors' contributions, donations from private individuals, voluntary contributions

7. income from self-generation--membership fees, cooperative income

The contest discovered possibilities of diversified cost-sharing. This is not only cost- sharing by those in need. The poor already pay quite a lot for health care in terms of hidden direct and indirect costs. It is important to raise funds wherever available to be able to spend them for those in need. One important lesson of the contest is that there are many sources of funds with fair cost-sharing.

In June of 1993, the winners of the HAMIS contest organized themselves into a Federation of HAMIS Winners in the Philippines and conducted a conference on Community Health Financing in Silang Cavite. This was attended by 36 representatives of 32 outstanding health projects nationwide.

One of the main topics discussed was on Innovative Fund Raising as exemplified by the activities of the Surigao City Primary Health Care (PHC) Federation Mother's Club. This organization is one of the Gold and Diamond winners of the HAMIS contests in 1991 and 1994, respectively, because of its self-help, comprehensive, and sustainable health programs.

The creativeness and innovativeness of the fund-raising activities of this Surigao Mother's Club is hereby submitted as a response to inquiries on how to bring “health in the hands of the people” to the community.

The Surigao City Federated Mothers' Club

The Surigao City Federated Mother's Club was organized in 1987 from the remains of a previously organized group that had its beginning in 1976. From a handful of mothers who have remained faithful to the ideals of the Mother's Club, the group has grown to its present size of 5,484 members, representing 22% of the total households in the city.

The Federation is composed of 176 chapters representing one or more sitios or puroks (a smaller political or community subdivision within a barangay) covering 53 barangays of the city. These groups are organized in a hierarchal structure. Each chapter selects a set of officers, including a representative to the Integrated Club at the barangay level. The Intergrated Clubs likewise choose their officers and representatives to the city-level Federated Club.

Although the federation has grown big through the years, its members have remained unaffected by their size, each flourishing on the self-esteem that comes from cooperating as a group. While the spirit of cooperation is strong among the members, the different clubs and chapters are also spurred into action by a helathy and lively competition to gain the recognition of their peers and the city health office.

The movement has also succeeded in mobilizing the male population or the husbands. They have been organized as an auxillary group called the Barangay Environmental Sanitation Implementation Group (BESIG). This group has 2,747 members city-wide. By involving the husbands in health-related projects, drop-outs from among the mothers have been drastically minimized, if not totally eradicated.

The youth or teenagers (12 to 21 years old) and the mini-youth (7 to 12 years old) were organized into clubs to involve them in neighborhood activities. At present there are 1,600 and 550 members of the youth and mini-youth clubs , respectively.

The involvement of the mothers, the fathers, and the youth in the community health programs ensures the social sustainability of the program. It makes health a family affair.

The Federation has also organized the barangay health workers (BHW), trained traditional birth attendants (hilot), and barangay nutrition scholars (BNS). There are now 240 BHWs, 154 trained hilots, and 60 BNS in the federation.

The members of the federation receive the following benefits:

a. priority access to health care and medication;
b. discounts (2 to 10%) from some commercial establishments in the city, i.e. department stores, bakeries, shoe stores, drugstores, school supply stores, and beauty parlors;
c. mortuary fund benefits;
d. health education;
e. trainings on health, IGPs, community development, and leadership training, and
f. services of community health workers, BNS and trained hilots.

The Federation uses several types of innovative fund-raising actvities to sustain

their numerous health programs. These activities are:

a. solicitation
   - to conduct workshops, seminars, and trainings for the members
   - to purchase awards for outstanding barangay chapters and community health volunteer workers

b. raffle draw
   - to fund the celebration of the annual convention

c. beauty and money contest
   - to search for Ms. PHC
   - for the Kuratcha Dance

d. tampohay (paluwagan)
   - to raise funds for districts' activities
   - for the construction of toilets

e. collect penalties
   - for being absent during meetings

f. member contribution
   - as agreed by the body

g. catering services to other organizations' activities

h. sale of herbal medicines produced by the Federation
   - to develop and maintain herbal laboratories in the puroks

i. collection of monthly dues (P1.00)
   - to avail of discounts in some commercial establishments

j. income from livelihood projects
   - to finance PHC activities, e.g., construction of data health boards, health centers, feeding centers, PHC headquarters

k. coordination with local governement to share in the salaries of the staff -
   - one PHC supervisor
   - one PHC secretary
   - one PHC BESIG secretary
   - one PHC caretaker
   - one PHC Federated president

l. mortuary fund dues of P20 annually
   - the excess money is diverted to the medical health insurance fund.

The objective of the Surigao Federation is to develop the skills of the 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. This policy paper will try to explain the factors that made the innovative fund-raising projects of the mothers successful.

For community health-oriented programs sponsored by NGOs, GOs, and POs, usually the challenge is how to ensure the financial sustainability of the program? This concern is more difficult when dealing with depressed and marginalized communities. But in these communities the most important thing are the people themselves-- they can be mobilized to generate resources beyond their individual capability. Organizing the mothers, the fathers, and the youth will result in multiplicative effects in the discovery of resources within and outside the community.

Innovative fund-raising activities motivate the people to consider their skills, talents

(dancing, singing), and capabilties collectively to solve their community health problems. In a developing country like the Philippines, mechanisms that would enhance maximal utilization of indigenous resources should be promoted, strengthened, and replicated to attain optimal health development in all communities.

It is therefore important that policies and legislations be formulated to institutionalize the support system of the government to community-initiated health programs. The institutionalization of the support by the government will hopefully minimize if not eradicate the ulterior interests of some politicians in supporting activities in the community.

III. Policy Content

Basic Considerations

According to the HAMIS winners in their conference on community health financing (CHF), any group that embarks on CHF needs to consider the presence of the following:

- a strong program staff that will support the community organization;
- a strong and committed community organiztion that will promote, develop and assist the group; and
- an appropriate enterprise development scheme that covers business assistance, savings and credit, and capital build up.

Establishing a CHF project means raising the necessary funds to keep the project going. The factors that can positively or negatively affect fund raising are:

1. Economic factors

In low-income communites, the capability to raise funds is limited. One alternative is to tap non-cash resources such as manpower and cooperation. In high-income communities, it may be difficult to motivate people to join a CHF project because they have money for their health needs. The rich people may still be tapped to support the CHF project and share what they have with the poorer members of their community. An alternative option to motivate solicitors is through an incentive mechanism.

2. Political factors

Political biases may become a problem in the decentralization of health services. The concept of health financing needs the support and endorsement of political leaders. The concept of CHF should be promoted among both traditional and political leaders through "social marketing."

3. Social and cultural factors

Conservative views and cultural practices may work in positive and negative ways. Some negative factors include the lack of trust between and among GOs and NGOs, especially those connected with politicians, the people's dependency on dole-outs, apathy or passive attitudes, and the people's low- prioritization of health.

4. Educational factors

There is a need for adequate information and continous advocacy and efforts to adopt appropriate information for community and political leaders.

5. Other agencies

The presence of several agencies providing the same services in one area may either result in competition or collaboration. Inter- and intra-relationships among agencies may also affect CHF. On the other hand, there could be a lack of a health provider in or near the area where CHF is to operate. Thus, there is a need to address such a problem.

6. Leadership

Changes in leadership and turn-over of management affect CHF, as well as the willingness of current leaders to develop new ones who would eventually succeed them.

7. Calamities and Disasters

These consist of natural and man-made calamities, including financial and economic disasters. Is important that reassurance funds be established in the provincial and national levels.

Income-generating activities enhance and sustain improvements in the living conditions of community residents. They contribute to the stregthening of the community organization and its leadership, particularly in the areas of positive value formation and organizational and financial management. It is to be noted, however, that income-generating or fund-raising activities are not specific elements of PHC, rather, they are activities that generate resources.

Communities offer human resources as their counterparts in health care provision and in the management of CHF schemes. In starting the CHF, the community's contribution consists of the services of the barangay officials, other community leaders, as well as officers and members of organized groups and BHWs. They do part-time volunteer work without compensation.

Capital build-up schemes are of different categories:

a. Organizational category--membership fees, monthly dues, fixed deposits, share capital at P10 per year, interest from bank deposits, penalties.

b. Economic category--income-generating activities.

c. Health related category--sales of medicines and herbal drugs, consultation fees, laboratory fees, sale of toilet bowls, and low-cost food supplements.

d. Economic and health-related category--through pre-determined percentage of the project's use. An example is the BHW Association: 50% of daily income of the pedicab goes to the driver and the other half goes to the association which shoulders the expenses for repairs and maintenance.

e. Solicitations--held on a sporadic basis and for specific projects.

There are indeed myriad ways on how to generate resources in the community. The first step to recognize resources is to realize the potential of the people, no matter how poor or weak they are. In management, human power is the most important resource even if his individual capability is limited.

IV. Policy Recommendations

1. The government should recognize and accredit community-managed health organizations as health care providers.

2. The purok network should be developed as the unit of community-managed health care.

3. Fund-raising activities for health should be gender- and culture-sensitive, should be socially acceptable, and should enhance value formation.

4. It is recommended that local government units support and include community health programs in their development plans and provide them regular annual budgetary support.

5. It is recommeded that Congress should allocate funds for community health programs from their Countryside Development Funds.

6. A multi-level (barangay up to national) reassurance fund should be made available to community health organizations so as to ensure their viability and their sustainability.

7. Health programs should expand their membership to include, not just mothers and children, but also fathers and the youth

Financial Indicators for Community Health Databoards

Policy paper of the Federation of HAMIS Winners in the Philippines, Inc.[25]

I. Justification and Rationale

The Department of Health in one of its policy papers for the year 1993 delineated its commitment to peoples' empowerment by committing to develop the Purok Health Databoards.

The Purok Health Databoards, having been developed by a non-government project in Davao and further utilized by the Regional Health Office 10 in Cagayan de Oro City in 1991, is a concrete experience of a bottoms-up approach to technological development.

It was a HAMIS contest winner in Surigao City that maintained the health databoard when DOH leaders saw it while visiting the communities. It was also a HAMIS partner in a Barangay Health Station in Manlamonay, Don Carlos, Bukidnon that developed the databoard as a basis for health care management by the rural health midwife.

People's empowerment is in practice in Community Health Databoards as the household health status is being measured by the households themselves and the data is analyzed and interpreted by the community during assemblies.

The capability of the communities to handle and monitor health status data shows the potential of the databoards as one of the most effective tools for households to manage their own health status.

Health Status Indicators measured by the health databoards comprise the household's:

a Level of protection of its infants through immunization;
b Level of protection of its children through nutrition;
c Level of protection of its pregnant women through tetanus toxoid immunizations;

25 The first draft of this policy paper was written by Ms. Fe Remotigue. This policy paper recognizes the contribution of Ms. Zeny Arana, Ms. Rose David, and Dr. John Wong. The final version of this paper owes greatly to intensive clarification and consultation processes with most members of the Federation of HAMIS Winners and DOH consultants.

d Level of protection of the household through the use of an effective family planning method;
e Level of protection of the household through its sanitation level of water used;
f Level of protection of the household through sanitation level of garbage disposal;
g Level of protection of the household through sanitation level of human waste disposal or toilets.

II. The HAMIS Winners' and Partners Experiences

A. The Batangas Experience

Mothers' Classes in Lian, Batangas have started putting up databoards in health facilities. The Municipal Health Officer initiated the project after a HAMIS winners' forum in which the databoards were again discussed for only around four hours plus a demonstration of an actual health databoard.

All of the above experiences show that the databoard can mobilize the communities to develop their own set of indicators if they see the need to monitor these indicators and if they put weight on these indicators in measuring health status of the household and ultimately of the community.

B. The Bukidnon Experience

In Don Carlos, Bukidnon, implementation of the purok health databoard in the entire municipality has resulted in the addition of two indicators. These are:
a vegetable gardening and
b smoking.

C. The Mountain Province Experience

Camatagan, Mountain Province, the rural health midwife initiated the implementation of the health databoards after a four-hour discussion about the technology during a regular

D. The Surigao Experience

The HAMIS '91 Gold Winner and HAMIS '94 Diamond Winner, Surigao Primary Health Care Federated Women's Club, Inc., developed other indicators to be used in addition to the seven indicators that were identified by the Regional Health Director of RHO 10.

In different barangays, the communities have included dental programs as indicators that can be monitored through the databoard.

E. The Quezon Experience : HAMIS Partner

In Sampaloc, Quezon, the municipal mayor included the monitoring of herbal gardens, herbal medicines, and other programs of the municipality such as real estate tax payment, water dues, and public infrastructures.

F. The Benguet Experience : DOH-CHS partner

Tribal Communities of several Benguet municipalities, comprised of tribal communities, have started putting up their own databoards. Through a partnership with a non-government organization and

training support from HAMIS, databoards are now in operation.

HAMIS winners' forum. Matched by an actual showcase of a databoard, the midwife was able to replicate the databoards in her barangay health station.

III. Policy Content

Basic Concerns

A. Effectiveness Measures of the Community Health Databoards

The effectiveness of Community Health Databoards are measured not only through the installation of the boards in the communities, but also by the social processes that the databoard has generated in the community.

These processes are seen to be participatory, people-based, and community-managed. In effect, the databoard becomes a tool for education and awareness building.

In addition, the databoards also measure the behavioural changes that the household shall carry out as a consequence of utilizing the databoard information. This is seen in terms of a historical progression of the color changes in the households for every particular indicator.

Ultimately, the databoards shall be very effective when, by themselves, the communities shall evolve their own indicators according to what it see as important. At that stage, there shall be no more arguments as towho should maintain the board, who should provide what resources, and who should utilize what information. Once this happens, the essence of implementing a community health databoard will haave reached its desired effectiveness.

B. When is the Community Ready for a Health Databoard ?

The National Task Force on the Health Databoard made sure, during its policy meeting, that the implementation of the health databoard must not be done under an atmosphere of compliance. It must be so implemented only when the community sees the need.

In this light, a community is ready for a health databoard when at least one of its members sees the need. Once the need is there, then other groups can support the community to respond to this need.

A community member may be a local government official, e.g., the barangay captain or other elected or appointed officials. Other community members may be the health service providers paid or volunteers working and living in the community. An non-government organization may be one of the members of the community. Most importantly, any resident in the community may initiate the implementation of the health databoard.

The need for a Community Health Databoard may be developed by the Department of Health through promotional campaigns. The DOH may distribute the publication on the databoard (Guidebook for the National Implementation, HAMIS Manila 1994). Another form of generating need for databoard may be the holding of exhibits and the showcasing of databoard models. Even orientation workshops may

be done during health forums involving different types of audiences. This way, the need for a databoard shall be spread throughout the different communities.

Once this need is developed by the communities and the community transforms this need into demand, then databoard implementation starts.

C. Developing Financial Indicators for Databoards--Rationale

The abovementioned potentials of the databoards show how the databoard develops community awareness for health and how it ensures an appropriate behaviour related to health and well-being by every household.

With the Department of Health's commitment to develop the capability of the communities to finance their health care, the databoard becomes one of the arenas of action.

The HAMIS Winners' experiences in health care financing range from Community Credits, Innovative Income-Generating Projects, Community Drug Insurances, and Community Health Insurance.

The databoard may be used as a monitoring tool for the communities to determine the household's capacity to finance its own health care needs. The following conditions in the community may considered as financial indicators:

1. Membership of a household to a particular community organization that enables the household to avail of financing services in times of catastrophic illnesses.

2. Benefit packages of the community organization that provide these services that the household avails itself of. It must look into account the scope of coverage, the type of service, whether out-patient service or hospitalization, and the ceilings or the maximum amount or type of service that the organization can serve. Exclusions to the benefit packages and how they hamper availment of health services should also be considered.

3. Coverage of the health care financing organization. One must look into into how many members of the households are covered. Which particular members of the households are covered and who are the vulnerables and the breadwinners.

4. Conditions for coverage or availment of benefit. One must examine the conditions that a household must fulfill before the it may avail of the services of the community health financing scheme. For example, in Surigao City PHC Women's Club, the president of the chapter shall approve the loan package that a member shall avail of. Before the president signs, she has to check if the member is active in the organization.

From these, the communities can determine what conditions or combination of the above requirements would constitute a safe entry in the household with regard to its ability to finance its health care needs therefore earning a green color entry. Likewise, the community shall determine what constitutes a yellow entry (improving), and a red entry (unsafe).

D. Strategies in Developing Financial Indicators for Community Health Databoards

1. Inclusion by all existing databoards of the Community Health Care Financing Scheme Indicator in the household datacards. A guideline to this effect must be available to all networks, organizations and federations who are monitoring or supporting communities having databoards.

There is a significant difference in developing the financial indicators for the databoards. The existing seven indicators were previously DOH vertical programs, thus have standardized characteristics. The community health care financing schemes are local initiatives and, therefore, do not have a standard characteristics from community-to-community. This requires the community themselves to determine the indicators and their values for themselves. It has to be the community that decides the level of benefits, coverage, scope or whatever else should be taken into account in determining what constitutes the safe, improving, and unsafe entries.

2. Developing and sustaining a resource pool that will respond to any need for guided implementation from the communities. This resource pool must also be adept at the process of developing financial indicators for the databoard.

As of now, there are trainers' pools trained by the DOH. On the other hand, there are also practitioners of the databoards from the different communities who have seen the need and have themselves initiated.

Both the DOH trainer's pool and the practitioners' pool shall have to be accredited by the Department of Health as the databoard resource pool that will be tasked to guide the implementation of the financial indicators for health databoards.

3. Monitoring and utilization of the information generated from the community health databoards.

Full utilization of HAMIS' BANAY software--an application system that would capture, store, and process databoard information into community and health status indicators enables anyone to use the databoard information beyond the purok or the communities.

The information generated from the community health care financing information shall be used as input in the development of the Social Health Insurance Program of the country. It will also enable the Department of Health to detemine the extent of financial coverage of the households to community health care financing schemes.

4. Incentives and Rewards for Exemplary utilization of Health Databoards.

As shown by the HAMIS Contests, the Search for Outstanding BHWs, the Search for an outstanding Health Worker, and many other incentive systems, if done in a competitive manner, propels any undertaking to a better performance. Thus, a search for an outstanding Community Health Databoard becomes an exciting possibility.

Incentives and rewards may come in the form of exposure visits, training grants, other non-cash, yet educationally-intensive activities, or project funds or support for the communities.

In doing these rewards, it must be noted that the recipient is not only one single individual. It must also be enjoyed by the cross-section of the community. This way, the participatory character of the

databoard as an undertaking shall also be underscored.

5. Organization of databoard users' clubs

As shown in the HAMIS Forums and HAMIS Systems Users' Clubs, the sustainability of an initiative is carried out by organized action. The organization of users' clubs is based upon their interest. Users of health databoards may decide to form into natural groupings--either geographic affiliations, or by special interest groups, e.g., HAMIS Winners; PCHD Target Area for Development (TADs), Family Health programs, etc.

In addition, the local government units may also wish to form their own heirarchical users' club for the databoards for policy formulation or legislation, e.g., Association of Barangay Captains, League of Municipal Mayors, League of Municipal Planners, etc.

E. Responsibilities

By and large, the Department of Health places upon the hands of the National Task Force the implementation of the purok health databoards. Two DOH bodies are coordinating these: these are the Community Health Service (CHS) and the Health and Management Information System (HAMIS).

The Federation of HAMIS Winners, having shown the initiative and the willingness to develop the community health databoards ("3 of 23 in 93", SHARPDEV, Cebu, 1993), is one of the pillars in the implementation of the purok health databoards.

It is the local government units that are the silent partners at the onset of this undertaking. However, it is they themselves who shall have this tool in their hands in the long run.

Finally, it shall be the communities themselves who shall be owning this tool in the end. It shall be theirs as they put health management and health care into their hands.

III. Policy Recommendations

A. All existing community health databoards should include financial indicators.

B. The content and mixture of these financial indicators should be determined by the community itself, with guidance from a national databoard trainors' pool.

C. Aside from health and financial indicators, other social indicators that constitute the most basic needs (MBN), e.g., community participation, housing, sustainable livelihood, literacy and psycho-social development, peace and order, and disability, can be included.

INCENTIVES FOR BARANGAY HEALTH WORKERS

Policy Paper of the Federation of HAMIS Winners in the Philippines, Inc.[26]

I. Justification and Rationale

The concept of primary health care in the Philippines calls attention to the tenet: participation of the people, especially among men and women who volunteered to be Barangay Health Workers.

Such enthusiasm brought to the attention and the consciousness of the community the importance of their participation in the total delivery of health care services

This is exemplified by experiences gleaned from NGOs and GOs. In the NGO family of HAMIS Winners, unique and innovative approaches were developed to train BHWs for the DOH and the LGUs.

Community spirit and community support are vital in sustaining the continuing activity of the BHWs. But sooner or later, such continuity of support must be expressed in more definite terms. It must rely on the mutual commitment of BHWs to their communities and of communities to their BHWs.

Community commitment is a vital factor for BHW viability and productivity . When this is not spelled out in specific terms BHWs will soon find themselves:

1. losing morale and interest
2. losing their original love for service
3. without direction
4. without any links with GOs and NGOs

All resulting to significant number of drop-outs.

While "incentives" is too narrow a term to accomodate the spirit and substance of community commitment to the BHWs, it can nevertheless be a vehicle to convey the concrete expressions of such commitments.

26 The first draft of this police paper was written by Dr Bambi Marte. This policy paper recognizes the contributions of Ms Zeny Arana, Ms Jun Villarante, Dr Rene Sison, Dr Ding Aurelia, Mr Cesar Go. The final version of this paper owes greatly to intensive clarification and consultation processes with most members of the Federation of HAMIS Winners and DOH consultants.

I. HAMIS Winners Experiences

Misamis Oriental: Mobilizing barangay health workers in implementation of Doh programs by the Provincial Health Office

In the province of Misamis Oriental, the Barangay Health Workers are mobilized by the Department of Health to implement its various programs. The province has 2,323 BHWs who are trained by DOH as coordinators of different health programs like the control of diarrheal diseases, control of acute respiratory infections, rational tuberculosis program, nutrition, etc. These BWHs are responsible for case finding, referral of cases, and immediate treatment.

BHWs receive incentives from different sources and levels from the national, provincial, municipal and from the BHWs themselves. Incentives are monetary and non-monetary in form.

The national government through the DOH and the Community Health Services, has provided the financial assistance of BHWs a seed moeny of P100,00.00 for IGPs. This seed money is made available to BHWs as loans.

The Provincial Government provides accident health insurance to BHWs and recommends the BHW to obtain free hospital privileges at the Provincial Hospital. At the municipal level, the BHWs are given honoraria ranging from P50 to P300, depending on the income of the municipality. Non-monetary incentives provided are uniform and logistical support such as notebooks, pens, training updates, convention at the municipal and provincial level, and Recognition Awards.

Among themselves, the BHWs contribute P1.00 per month for the monetary fund and P1.00 per month for their fund to be given as loans to assist members.

Siaton District Hospital Masterlisting Project

In July, 1990 there were 36 BHWs recognized by DOH. At present, there are now 81 BHWs in Siaton. They are mobilized to undertake masterlisting and recording activities for the DOH. Among the incentives given to BHWs are hospitalization benefits.

III. Policy Recommendations

1. BHW Identification, Organization, and Structure

a. Barangay Primary Health Care Committees (BHPCC) or its equivalent should be created or activated in each barangay in order to set guidelines on BHW qualifications and identification, among other things. The independence of BHWs from political and partisan activities shall be ensured.

b. Qualified BHWs shall be selected by the BPHCC or its equivalent council from the nominees submitted by the households

c. The BHWs shall be federated in all levels from the barangay to the national level.

d. Presidents of Federated BHWs shall sit in their respective Local Health Boards for their concerns to be aptly represented in that Body, and consequently in the local Sangguniang Bayan (SB) or Sangguniang Panlungsod (SP), as the case may be.

2. Budgetary Support

a. Community Support--Community-initiated fund-raising activities in support for BHW incentives shall be encouraged. These may include: discounts from drugstores and other establishments, communityhealth insurance, and out-of-pocket donations.

b. Government support--DOH shall formulate a policy that gives support to BHWs, which shall be concurred with by the DILG. The latter shall mandate all LGUs to implement such policy. Monetary incentives should be determined by BPHCC and approved by the Local Health Board. Support from the DOH may include sickness benefits. Support form other government organizations may include access to soft loans, IGPs, field exposures, and skills development. Support from LGUs may consist of honoraria, health insurance, free legal service, logistics, recognition, scholarship program, counterpart funding for IGPs, and transportation expenses.

3. Technical Support

While all BHW's are independent on their structures and schedules, BHW's still have to be guided by DOH standards for their duties and responsibilities. Additionally, the updating of skills and technical knowledge are still DOH responsibilities.