

# ORT Health Plus Scheme in the Province of La Union, Philippines

- A case study of a community-based health micro-insurance scheme •

2002

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## Abbreviations

BHS	Barangay Health Station
BHW	Barangay Health Worker
CBR	Crude Birth Rate
CDR	Crude Death Rate
DOH	Department of Health
GSIS	Government Social Insurance System
HSRA	Health Sector Reform Agenda
ILO	International Labour Organization
ITRMC	Ilocos Training and Regional Medical Center
LGU	Local Government Unit
MCC	Mother and Child Care Project
MMR	Maternal Mortality Rate
NATCCO	National Confederation of Cooperatives
OCMC	ORT Community Multi-purpose Cooperative
OHPS	ORT Health Plus Scheme
ORT	Organizing for educational Resources and Training
ORT MCC	ORT Mother and Child Care Project
PhilHealth	Philippine Health Insurance Corporation
PTCA	Parent-Teacher Community Association
RHU	Rural Health Unit
SHINE	Social Health Insurance Networking and Empowerment
SSS	Social Security System
STEP	Strategies and Tools against social Exclusion and Poverty
WHO	World Health Organization

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## Foreword

Over the past twenty years, governments around the world have not provided free health services except to their poorest citizens. In many developing countries like the Philippines, the poor comprise more than 50 per cent of the population, and most of them are not able to access basic health services even from the public sector.

As a consequence many non-governmental organizations and social development agencies have developed various forms of innovative community based health care programmes in order to make health care services more accessible to communities where government health services have been found wanting. Through the years, these programmes have branched out to include the implementation of health financing mechanisms such as health microinsurance.

This case study documents one such initiative. The experiences of the past seven years of the ORT Health Plus Scheme in the province of La Union in Northern Philippines is a rich source of lessons and best practices that can be used to help refine and replicate this effort to similar communities all over the Philippines.

The case study was developed and written by using the *Methodological Guide for undertaking case studies of health microinsurance schemes* developed by the ILO Global Programme called Strategies and Tools against social Exclusion and Poverty (STEP).

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Finally, the authors are also very grateful to Dr. Aviva Ron and Mr. Avi Kupferman who lent them all the available documents they had on OHPS and who answered all the questions. The hope is that this effort to document OHPS may be useful in contributing to replicate this model and help make health care more accessible to the poor and the excluded.

## 1. Introduction

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

A system of user charges is currently being implemented in many developing countries as the mechanism to recover costs and augment decreasing government appropriations. However, the use of such a system has, over time, manifested some serious limitations. Poor families tend to delay seeking health care due to limited resources. Others tend to give low priority to health care over other necessary needs of the household. When charges cannot be avoided, payment for hospital care can force the sale of household assets, including the source of household income. It is now recognized that the burden of having to pay for health care themselves and at the time of illness can bring families below the poverty line. User charges are generally a fixed amount for a specific service, and are therefore by nature not progressive. This amount may be an insignificant expense for some families but presents an excessive burden for others.

Many countries, like the Philippines, have also introduced social health insurance as part of a package of social protection measures to be provided for its citizens. The implementation of this programme is usually done in phases, starting with the formally employed and salaried workers. However, a huge majority of its labour force does not fit into this category. In the Philippines, it is recognized that 45 per cent of the labour force belong to the informal sector or the so-called “underground economy”. These are the self-employed or small home-based enterprises in agriculture, services and marketing. These workers and their dependants have been generally excluded from the national and compulsory social security systems. Public and private sector providers of different social security mechanisms are reluctant to cover the informal sector because of difficulties in tracing and monitoring member contributions and benefits provision. Since such workers generally do not belong to any organized labour association or union, there has been little pressure to extend health insurance coverage to them.

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

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



The case study being presented is an example of such a scheme. This community health microinsurance scheme known as the ORT Health Plus Scheme<sup>1</sup> was developed by ORT, an international non-governmental organization operating largely in several villages in the province of La Union. This province is located in the northern section of the Luzon islands in the Philippines.

## 2. The Context in which OHPS Operates

### 2.1 Demographic aspects of the zone of operation of OHPS

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

In 1998, the total population of La Union stood at 628,827 persons. Population in the province is unevenly distributed across municipalities. The top three most populated municipalities are San Fernando City (96,399 or 15.33 per cent), Bauang (59,156 or 9.41 per cent) and Agoo (51,015 or 8.1 per cent). Many OHPS members come from these municipalities and the central unit and main service provider of the scheme is located in the City of San Fernando.

The province has a declining population growth rate. From a 1.94 per cent growth rate from 1980-1990, it has decreased to 1.72 per cent for the 1990-1995 period. In 1998 the population density of the province was pegged at 421 persons/sq. km. Based on the total population in 1995 (597,442), 28.73 per cent or 171,664 reside in the urban areas whilst 71.27 per cent live in the rural areas of the province. It is predicted that the population residing in the urban area will increase to 30.92 per cent by the year 2002.

Half of the population are females with the sex ratio placed at 101 females to 100 males. Around 59.14 per cent of the total population belong to the 15-64 age group. Over one-third (35.42 per cent) of the population are in the 0-14 year old group and 5.44 per cent are 65 years old and above.

In 1998, there were 126,962 households in occupied dwelling units with an average household size of five persons. Some municipalities however register household sizes larger than the provincial average.

The number of in-migrants to the province increased at a rate of 8.48 per cent over the past ten years. By the year 2000, it was estimated that 41,560 in-migrants will reside in the province. It is recognized that this increase will definitely have an impact on the provision of services such as education, health, social welfare, housing and infrastructure.

### 2.2 Economic aspects

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

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<sup>1</sup> Commonly referred to as OHPS

work. This will then lead to an increase in the population of the urban centers and the coastal areas of the province.

Males dominate the labour force with 186,000 (59.62 per cent) potential workers while the female labour participation rate is recorded at 57.53 per cent. As of April 2000, the province registered a labour force participation rate of 73 per cent and an unemployment rate of 10.9 per cent. The visible underemployment rate is 15.9 per cent. In 1998, the employment rate was 93.8 per cent decreasing by 0.8 per cent from the 1995 figure. Under-employment during this period was recorded at 7.6 per cent increasing by 0.7 per cent from 1995. Urban and rural employment rate in 1998 was 89.9 per cent and 94.8 per cent respectively. In the urban areas, a greater number of males are unemployed whilst in the rural areas there are more unemployed females.

Based on 1994 prices, the average annual family income of the La Union is Ph.P. 81,239 (US \$ 1625)<sup>2</sup>. Average annual family expenditures (at 1994 prices) on the other hand is Ph.P. 63,397 (US \$ 1268). As of 1997, preliminary data show that overall poverty incidence in La Union province is 37.6 per cent.

There is no data from the province regarding the percentage of employment in the informal sector. Also, it is difficult to describe the mobility between the informal and formal sectors. However, based on national figures, it is assumed that about 45 per cent of the labour force of the province are engaged in informal sector activities.

## **2.3 Social aspects**

In 1998, the province had a total projected school age population of 249,834 or annual growth rate of 1.73 per cent. With this growth, it is estimated that by the year 2000, the school age population will reach 258,799. For the school year 1998-1999, La Union province had a total of 464 public and private schools. There was a total of 3,791 classrooms in the elementary public schools with a classroom to pupil ratio of 1.22. For the public secondary schools, there were 764 classrooms.

There were 2,978 public elementary school teachers for the school year 1998-999 with a teacher to pupil ratio of 1:30. There is no significance in the number of teachers in proportion to enrollment. In secondary public schools, there were 764 teachers with a ratio of 1.31.

Projected data indicated that the literacy rate of La Union was 97.93 per cent in 1998. In terms of numbers, data from a survey conducted revealed that there are a total of 22,622 illiterate persons who have not received any formal education. In the school year 1995-1996 there was a drop out rate of 0.28 per cent while the overall drop out rate in all levels has significantly decreased in the province.

The most common traditional organizations in the communities are the different village organizations usually formed by the incumbent political leader or village head. Other popular organizations are the church-related groups organized around church activities. There are also 79 non-governmental organizations registered in the province involved in a variety of social development activities.

## **2.4 Sanitation indicators**

In 1998, the Crude Birth Rate (CBR) in the province of La Union was 23.16 per 1000 population representing an increase of 1.43 from the previous 21.57 CBR in 1997. About 35 per cent of

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<sup>2</sup> US \$1=Ph.P. 50.00 (This conversion rate will be used in the entire case study when figures in Philippine Pesos are indicated.)

births were administered by physicians, 51 per cent by midwives and the remaining 12 per cent by nurses, trained and untrained traditional birth attendants and others.

The average life expectancy at birth increased from 61.6 years in 1980 to 65.7 years in 1991. The life expectancy of females (68.4 years) is higher compared to male life expectancy (63.1 years). In 1995 the average life expectancy for both sexes increased to 67.4 years.

The Crude Death Rate (CDR) in the province was 5.64 per 1000 population in 1998. A changing pattern in the causes of mortality in the general population of La Union has been observed. Whilst in the 1980s, communicable diseases were among the leading causes of death, these are gradually being replaced by non-communicable diseases. Cardiovascular diseases, senility and cancer are among the leading causes of mortality. There is also a notable rise in the proportion of deaths from accidents and chronic obstructive pulmonary diseases.

A decline in Infant Mortality Rate (IMR) from 14.40 per 1000 live births in 1997, to 8.58 per 1000 live births in 1998 has been observed. Among the leading causes of infant mortality were pneumonia, premature births, congenital abnormalities and septicemia.

Maternal Mortality Rate (MMR) posted a decrease by 0.01 per cent from 0.36 per 1000 live births in 1997 to 0.14 in 1998. Retained placentas and postpartum hemorrhage are the reported leading causes of maternal mortality.

The leading causes of morbidity showed a decreasing trend based on their five year average. Acute Urinary Tract Infection was the most common cause of morbidity followed by diarrhea. Pneumonia remains the leading cause of infant morbidity followed by premature birth. Of the 105,720 households in the province of La Union in 1998, 74 per cent had access to Level I water supply while 15 per cent and 11 per cent had access to Level II and Level III water supply, respectively. A total of 1619 jetmatic pumps were also provided by the Health in Every Home Programme from 1995 to 1999. About 93,780 or 89 per cent households had satisfactory garbage disposal, in 1998 and 85 per cent of households had complete sanitary facilities. The province does not have aggregate figures and data on the frequency rate of visits to health establishments of the population.

## **2.5 National health policy**

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

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

- ❑ **Health financing:** To expand Social Health Insurance by improving benefits, expanding coverage, strengthening payment systems, improving management capacity and understanding and possibly accrediting alternative financing schemes such as community based health insurance schemes.
- ❑ **Local health systems:** To strengthen Local Health Systems by forging cooperation among adjacent Local Government Units (LGUs), cost-sharing and establishing technical linkages among facilities and providers in the health district.
- ❑ **Public health:** To build centers of disease control and prevention as an instrument for technical leadership and to sustain public health programmes through multi-year budgets.
- ❑ **Public hospitals:** To introduce fiscal management autonomy in government hospital facilities and critically upgrade capacities for greater competitiveness.

- ❑ **Regulatory agencies:** To strengthen capacities and adopt a new regulatory framework that will promote better quality and greater competition in health care markets.

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

OHPS is one of the health microinsurance schemes currently being studied and analyzed by the Philippine Health Insurance Corporation<sup>3</sup>. It is obvious that this scheme is very relevant and instrumental in accomplishing one of the major policy areas in the HSRA.

Since the devolution of health services in 1991, the roles and functions of the National and Local Government Units in relation to health care still need to be defined clearly. Thus it has proved very difficult to regulate and control the quality of health care delivered at local level. There is no existing regulatory mechanism or structure that performs the function of quality assurance at the local level in the Department of Health.

## **2.6 Supply of health care**

In terms of access to health care services, La Union Province in 1998 had seven public hospitals and 11 private hospitals. These hospitals have a total bed capacity of 769. The public hospitals accounted for 415 beds while the private hospitals had a total of 354 beds.

There are also 184 Barangay (village) Health Stations (BHS) that are responsible for delivering public health care to the communities. The BHS population ratio was pegged at 1:3,743. Apart from these, there are 20 Rural Health Units (RHU) with at least one per municipality. Each RHU has a full personnel complement comprising of a physician, public health nurse, sanitary inspector, institutional worker, public health worker, dentist, medical technologist and several midwives. The RHU physician to population ratio in La Union in 1998 was 1:28,583. The nurse to population ratio was 1:23,290 while the rural health midwife to population ratio was 1:3,635. There is no readily available information on the aggregate number of physicians and other health professionals in the private sector as there is no requirement for them to register their own practice at a local government level.

Private clinics and diagnostic centers are also present in the urban areas of the municipalities. These provide health services to the upper and middle segments of society.

Intensifying the preventive and promotional aspects of health is now the main thrust of the health sector in the province through its Health in every Home Programme.

Although there are no formal surveys to prove this, many informal surveys of the province indicate that a significant majority (around 80 per cent) of the population do not have access to health care, especially drugs and medicines.

## **2.7 Social protection in health**

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

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<sup>3</sup> The agency of government under the Department of Health entrusted with the implementation of the national health insurance law or social health insurance programme.

The network of support also extends to neighbors and village associations. In La Union, a traditional form of solidarity called *saranay* exists. This term describes the practice of family and friends contributing an amount of money as assistance to a relative or neighbour whose family member had died or was sick and required treatment. This practice is also harnessed in times of natural calamities such as typhoons, floods and fires that may have unexpectedly destroyed lives and property in the community.

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

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

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

### 3. The Implementation of the ORT Health Plus Scheme

#### 3.1. The launch

At the time of the launch<sup>4</sup> of OHPS in La Union, access to health care in poor rural communities in the Philippines was very severely limited. This was largely due to inadequate supply, through sparsely distributed government health centers and hospitals. During this time, the Local Government Code of 1991 had just been implemented in full. This law mandated the devolution or decentralization of health services. Previously, the public health care delivery structure was a centralized organization emanating from a central office of the Department of Health headed by a Secretary of Health. After the devolution, the responsibility of delivering health services to communities was delegated to local chief executives. Thus in the La Union Province, the Governor was the primary leader responsible for the delivery of the different social services including health. Lower in the bureaucracy, the different cities and municipalities also ran their health facilities independently with the mayor as the local chief executive in charge. Thus, at the time of the launch of OHPS the public health care sector was still going through a difficult transition under a new leadership at various levels. In addition, some municipalities in the province had been severely affected and devastated by the strong earthquake that rocked the Philippines in 1990.

During this period, the province of La Union had a total of sixteen hospitals, nine of which were privately owned with the other seven being public institutions. The total bed capacity was 744. Government hospitals accounted for 415 beds with the Ilocos Regional Hospital having the largest bed capacity of 150 beds. Private hospitals had a total of 329 beds. At that time each of the twenty municipalities had a Rural Health Unit with a Family Planning Centre. In addition,

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<sup>4</sup> July 1994 to December 1995

there were a total of 190 Barangay Health Stations located in the different villages of the province.

In 1995, there were 1,179 medical, dental and health personnel in the province. Of these 466 were employed by the public sector whilst 713 were privately employed. The doctor to population ratio at that time was 1.3,522 whilst the nurse to population ratio was 1.1,966.

Among the leading causes of morbidity at that time were Acute Respiratory Infection, Bronchitis, Pneumonia, Diarrhea and Urinary Tract Infection. The leading causes of mortality, on the other hand were Cardiovascular Diseases, Pneumonia, Pulmonary Tuberculosis and Cancer.

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

At the national level, there were already some proposals recommending that tertiary level health centres under the Department of Health (DOH) Central Office should start to collect user charges as a cost recovery measure due to increasingly limited funds in government. At the local level, this was not fully implemented as the local chief executives felt that it would not be politically correct for them to implement user charges when many of their constituencies frequently came to them to ask for financial support for illnesses and hospitalization costs. Thus it can be said that at that time only the Ilocos Regional Hospital had begun to impose some user charges, while the different Rural Health Units were still providing free services and medicines when these were available.

At the time of launching of OHPS, the scheme was targeted towards the families of the children enrolled in the Mother and Child Community Project implemented by ORT. The daycare centres that ORT had supported and helped to build were then located in 14 villages in different municipalities in La Union. The daycare centres were called satellites. The following are the locations of the 14 satellites:

- ❑ Bariquir, Naguilan Municipality
- ❑ Baroro, Bacnotan Municipality
- ❑ Bulala, Bacnotan Municipality
- ❑ Carcarmay, Bacnotan Municipality
- ❑ Gonzales, Tubao Municipality
- ❑ Lloren, Tubao Municipality
- ❑ Macalva, Agoo Municipality
- ❑ Nadsaag, San Juan Municipality
- ❑ Pangao-aoan, Aringay Municipality
- ❑ Pudoc, Bauang Municipality
- ❑ San Francisco, San Fernando Municipality (now a city)

- ❑ San Juan, Agoo Municipality
- ❑ Sta. Rita, Aringay Municipality
- ❑ Santiago Norte, San Fernando Municipality

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

The identified target population of OHPS at the time of the launch was representative of the lower income bracket of society. The selected villages had an average of 100 households per village with a male to female ratio of 1:1. The target population had an average family size of four. There was an estimated unemployment rate of 20 per cent. The estimate average monthly income among the target households was Ph.P.1000 to 2000 : most were poor. Among their most common economic activities were farming as well as engaging in small economic enterprises. A small percentage also relied on remittances from relatives who worked as overseas contract workers. There was a 95 per cent literacy rate among the target groups.

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

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

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

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

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

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<sup>5</sup> Barangay Health Workers' Association (BHW)

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

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

## **3.2 The phases of implementation of OHPS**

### **3.2.1 *Identifying needs and defining objectives***

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

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

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

Only the identified target group of parents and community members in the day care centres were consulted. Local Government officials and public health sector institutions were not consulted. However courtesy visits were made to all relevant public sector institutions to inform them of OHPS and its proposed objectives and activities. Such visits were done in the hope that endorsements and support could be generated towards the scheme. With the support and endorsement from local officials, recruitment of members to OHPS was facilitated as doubts and suspicions were dispelled.

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



### **3.2.2 Context and financial feasibility studies**

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

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

### **3.2.3 Information on the target group**

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

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

### **3.2.4 The launch of activities**

When OHPS began in 1994, there was no special or landmark event held to start operations. It did not have any independent legal status as it was considered to be just one of the service programmes under the cooperative. The first members began registering in July 1994. This was also the time when the first contributions were paid. The first capitation payment made to the private hospital provider was in September 1994.

### **3.2.5 Leadership and decision-making**

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

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

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

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

### **3.3 Operation during the first term**

#### **3.3.1 *Members and other beneficiaries***

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

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

Membership was on a family basis. No restrictions were set in relation to the beneficiaries of the scheme. This meant that the spouse and all the children of the member could equally avail themselves of the same set of benefits. There were no exclusions imposed on any member or beneficiary with regard to pre-existing conditions or illnesses.

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

### 3.3.2 Benefits

Table no.1: Services covered by OHPS

Services	Persons Covered	Co-payment	Maximum coverage limits	Waiting period	Compulsory Reference
<b>Unprogrammed Surgical Interventions</b>					
All (depending on capability of the provider hospital)*	M & B	NA	45 days	2 months	C
<b>Gynae-obstetrical Interventions</b>					
All*	M & B	NA	45 days	2 months	C
<b>Hospitalization</b>					
All*	M & B	NA	45 days	2 months	C
<b>Programmed Surgical Interventions</b>					
All*	M & B	NA	45 days	2 months	C
<b>Programmed Ambulatory Care</b>					
General Outpatient Consultation	M & B	NA	NA	1 month	N
<b>Preventative Care</b>					
All*	M & B	NA	NA	1 month	N
<b>Unprogrammed Ambulatory Care</b>					
All*	M & B	NA	NA	1 month	N
<b>Medicines</b>					
Only Essential Drugs (National Drug Formulary)	M & B	NA	NA	1 month	C
<b>Transportation/Evacuation</b>					
Not applicable		NA	NA	NA	NA
<b>Specialized Medicines</b>					
Not applicable		NA	NA	NA	NA
<b>Laboratory/Radiology</b>					

Services	Persons Covered	Co-payment	Maximum coverage limits	Waiting period	Compulsory Reference
Basic Lab and Radiology Procedures (if available in provider hospital)	M & B	NA	NA	NA	C

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

**\*All** here indicates services available at the provider hospital (ITRMC) that are delivered to the majority of the population and excludes special cases and procedures like organ transplantation, dialysis, cardiovascular intervention and other highly specialized procedures.

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

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

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

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

### 3.3.3 Financing

Table no. 2: Resources used to finance OHPS creation on its first term

Financing Source	Amount (Specify currency)	Aim	Type of financial support (subsidy, credit, contributions, etc.)
Australian Embassy	then Ph.P.10,000	To renovate satellite clinics and purchase equipment, an initial stock of medicines and 1 desktop computer	Donation grant
Provincial Government of La Union	Ph.P.36,000 per month	To pay for the salaries of 1 pediatrician (part-time), 1 nurse (full time), 1 project manager (part-time), 18 health promoters (part-time)  To pay for electricity, water and other utilities in the Central Unit and satellite clinics	Continuation of the support for the health care in the Mother and Child Project can be seen as partial subsidy.
World ORT Union	Ph.P.15,000 per month	To pay for the salary of 1 pediatrician (part-time), 1 marketing and promotion (part-time), 1 administrator (full time)	As above

US \$ to Ph.P. Exchange Rate: US \$1 = Ph.P. 25.00 in 1995

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

- A. Rate if Non-SSS/GSIS member
  - 1. Single (18 years old and above) – P50.00 per month
  - 2. Standard Family (6 members and below) – P100.00 per month
  - 3. Large Family (more than 6 members) – P130.00 per month
- B. Rate if SSS/GSIS member
  - 1. Single (18 years old and above) – P25.00 per month
  - 2. Standard Family (6 members and below) – P70.00 per month
  - 3. Large Family (more than 6 members) – P95.00 per month

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

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

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

### **3.3.4 Health care providers**

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

The doctors were chosen simply on the basis of their willingness to go to the satellite clinics and provide outpatient care. All of these doctors were personal friends and colleagues of the pediatrician who was also the assigned medical coordinator of the scheme. It should be noted that no formal criteria or evaluation process was made in the selection of these doctors. The choice was based more on willingness and convenience in terms of time and geographical location to the doctors.

The hospital provider on the other hand was chosen based on the perceived reputation that the services provided were of good quality. A contributory factor was the willingness of the hospital management to be paid on a capitation basis. Thus, an agreement with a private hospital in San Fernando City was reached. The important provisions of this agreement revolved around the mode of payment for the utilization of services by OHPS members. Also, the agreement emphasized that only the basic and most essential services were to be covered by the hospital. Thus, services like organ transplants, dialysis, orthopedic plates and aesthetic surgery among others were excluded from the benefit package. Another important provision was the hospital's responsibility for ensuring that their pharmacy should be well-stocked with medicines included in the Essential Drugs List. If the hospital was unable to provide a member with the drugs and medicines he/she required when hospitalized, the cost of purchasing these drugs by the member would be deducted from the next quarterly capitation payment to the hospital. Being a private hospital, no subsidies were provided by government and thus pricing was based on the hospital's actual costs.

### 3.3.5 Administration and management

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

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

*Table no. 3: Salaried staff employed by OHPS*

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

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

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

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

### 3.4. Technical assistance and training

Table no. 4: Technical assistance summary (creation phase and first year of operation)

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

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

## 4. The Characteristics of the ORT Health Plus Scheme

### 4.1. Target group and beneficiaries

#### 4.1.1 The target group

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

In 1997 the OHPS had an agreement with the Ilocos Training and Regional Medical Centre (ITRMC)<sup>6</sup> to become its authorized provider for in-patient hospital care and ancillary services. Since the hospital was located in San Fernando, the capital of the province of La Union, it became inevitable that the target population would include the residents of San Fernando and later that of the whole province of La Union to maximize the use of facilities. Individuals from nearby towns in San Fernando have likewise displayed interest in the scheme. (For a description and a general idea of the population of the province of La Union please see section I of this study.)

Despite this broader target group, the health microinsurance scheme still prioritizes and focuses its efforts in member recruitment and maintenance in the satellites. They are mostly the rural poor and were the original target group. However, the instability of their membership due to irregular and inadequate incomes as well as other financial burdens sometimes endangers the sustainability of the scheme. Broadening the target group, excluding no one, and including even those already enrolled with the Philippine Health Insurance Corporation or PhilHealth

<sup>6</sup> Formerly known as the Ilocos Regional Hospital



(formerly Medicare or the health insurance system of the Government Service and Insurance System (GSIS) for government employees and the Social Security System (SSS) for private employees), offers more prospects of increasing the membership and consequently the viability of the IS. The incentive for the latter groups to join was access to ambulatory health care, as the SSS and GSIS benefits are limited to hospital care.

#### **4.1.2 Various categories of beneficiaries**

The scheme allows membership at three levels: single member (over 18 years of age), standard family (up to and including six persons) and large family (more than six family members). All members of the family are entitled to health insurance benefits through a household contribution. Elderly parents over the age of 60 can also be claimed as dependants if they live in the same household as the principal member<sup>7</sup>.

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

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

If a new member pays three months contribution, or even six or 12 months – as the first payment, the member or his/her dependants can receive in-patient care only in the third month. This applies to all in-patient admissions, including what may be termed “elective surgery”. The only exclusion is maternity care (childbirth) which has a qualifying period of 12 months.

If the family stops paying the monthly contribution for two consecutive months, they have to be treated as new members when they opt to pay again and rejoin. When they rejoin, they have to complete a new qualifying period. Thus they have to pay an initial contribution covering a three month period, and wait two months if they need hospital care.

Ideally, the members of the ORT Multi-purpose Cooperative gain automatic membership to the OHPS. However this does not always follow since there is no mechanism that currently exists where the cooperative facilitates contribution payments of members to OHPS. Once the co-op member misses a monthly contribution he/she forfeits membership to the scheme. In effect, membership of a co-op member to OHPS then becomes voluntary. For the non-co-op members, membership to OHPS is voluntary. Many OHPS members are not able to afford membership to the cooperative because there is a required share capital of Ph.P. 4000 while membership to OHPS only requires payment of monthly contributions without membership fees nor capital shares.

To become an official member, one may register at the ORT Central Unit<sup>8</sup>, or at the outpatient clinic at the Ilocos Training and Regional Medical Center<sup>9</sup> or at any of the 13 ORT day-care centers/satellite clinics located in various villages in La Union Province. An initial three-month contribution is required upon registration. The new member has to fill up a registration form and submit with it the following:

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<sup>7</sup> Considered to be the person primarily responsible for contribution payment.

<sup>8</sup> Located at Guerrero Road, San Fernando City, La Union.

<sup>9</sup> Also located in San Fernando City, La Union.

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

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

A membership card is issued for each household, listing all household members covered by the scheme and valid for 12 months. A member does not need to sign a contract. A household membership registration number is allocated to each contributing unit (household or individual) and individual numbers are assigned for each individual within the family. Each card contains 12 small squares in which monthly stickers<sup>10</sup> are attached. This indicates that the monthly contribution has been paid. The members have to present this card during medical consultations and whenever they want to access other services in the clinics or in the hospital. They also have to present it when paying their monthly contributions.

The only change in the condition for membership is that the qualifying period for maternity care was increased from an initial three months to a waiting period of 12 months. This came about following several cases of abuse through payment of contributions for three months prior to delivery and then dropping out of the scheme.

#### **4.1.3 The number of beneficiaries and their evolution**

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

**Table no.5: Current number of members and beneficiaries**

	<b>Total 1997</b>	<b>Total 1998</b>	<b>Total 1999</b>	<b>Total 2000</b>
Single	135	177	162	160
Standard Family	348	379	467	476
Large Family	30	28	39	38
Total Members	513	584	668	674
Total Individuals / Beneficiaries	2006	2045	2535	2447

<sup>10</sup>Stickers are different for each month. Only selected persons know what form these stickers take so as to avoid any fraud in payments.

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

#### **4.1.4 Reasons for losing membership status**

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

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

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

The extent of dropouts has gradually been reduced as more people in the community hear of real cases in which patients were covered for high health care expenditures. Such stories are spread by word of mouth and through an OHPS newsletter, which has played an important role in the development of the scheme. The scheme has also adopted a new policy whereby the membership cards are released to the new members only after they have attended an Orientation Seminar. The Orientation Seminar is held for three hours every last Friday of the month. Through this, the concepts, policies and procedures of social health insurance are explained more clearly to the members. These seminars also serve as venue for members to ask questions, provide feedback and seek clarification regarding some policies of the OHPS.

#### **4.1.5 Target group’s penetration**

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

The collection mechanism is perceived as being a hindrance to increasing membership. The OHPS encourages members to go to the Central Unit or to the satellites to pay their monthly contributions but for members residing in the communities where the centres are located, the community and health promoters act as collection agents when they do house visits. For the members of other cooperatives and staff of other offices however, the OHPS will only accept their application for membership if they either go to the Central unit or OHPS clinic at the Ilocos Training and Regional Medical Center (ITRMC) to pay, or if all the contributions of the employees are collected through the management payroll system of the employees and remitted to the OHPS as a lump sum. For example, if the staff of St. Louis College<sup>11</sup> wish to join, the College management should collect their contributions. The officers of the government agencies and cooperatives were not willing to do this as it was noted that they already had difficulties in their loan collections.

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

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<sup>11</sup> A private school located in San Fernando City

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

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

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

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

## **4.2 Benefits and other services offered by OHPS**

### **4.2.1 Health services**

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

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

upon presentation of a valid, updated OHPS membership card. In-patient hospital care is covered for up to 45 days per confinement.

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

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

*Table no.6: Services covered by OHPS*

Services	Covered persons	Co-payment	Maximum coverage limits	Waiting period	Compulsory reference
<b>Unprogrammed surgical Interventions</b>					
All (depending on capability of provider hospital)*	M & B**	NA	45 days	2 months	C
<b>Gynae-obstetrical Interventions</b>					
All*	M & B	NA	45 days	2 months	C
<b>Medical hospitalization</b>					
All*	M & B	NA	45 days	2 months	C
<b>Programmed surgical Interventions</b>					
All*	M & B	NA	45 days	2 months	C
<b>Programmed ambulatory care</b>					
General outpatient consultation	M & B	NA	NA	1 month	N
<b>Preventative care</b>					
All*	M & B	NA	NA	1 month	N
<b>Unprogrammed ambulatory care</b>					
All*	M & B	NA	NA	1 month	N
<b>Medicines</b>					
Only essential drugs (national drug formulary)	M & B	NA	NA	1 month	C

Services	Covered persons	Co-payment	Maximum coverage limits	Waiting period	Compulsory reference
<b>Transportation/evacuation</b>					
Not applicable		NA	NA	NA	NA
<b>Specialized medicines</b>					
Not applicable		NA	NA	NA	NA
<b>Laboratory/Radiology</b>					
Basic laboratory and radiology procedures (if available in provider hospital)	M & B	NA	NA	1 month	C

\***All** here indicates services available at the provider hospital (ITRMC) that are delivered to the majority of the population and excludes special cases and procedures like organ transplants, dialysis, cardiovascular intervention and other specialized procedures.

\*\*M = members B = beneficiaries

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

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

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

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

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

In 1999, a monthly average of 21 per cent of the members made use of the free medical consultation. Of this number 50 per cent were given free antibiotics, 11 per cent were referred for ancillary procedures and 6 per cent were referred for hospital care

There has been no major change in the benefit package. Minor changes have been updating the essential drug list. For example, in 1996, changes were made in drug benefits: anti-asthma drugs were covered and anti-hypertension drugs covered at 50 per cent of the OHPS charge.

#### **4.2.2 Benefits payments**

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

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

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

The OHPS capitation calculation is based on:

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

For the OHPS population, this calculation assumes the following:

##### **A In-patient care**

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

## B Out-patient care

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

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

The benefits provided can be indexed from the satellite log sheet, which lists the members having medical consultations. All consultations are entered, with the name, sex and age of patients, the reason for their visit and the referred services as well as the drugs prescribed. This log sheet becomes the basis for the monthly and yearly reports on the use of services by OHPS Members. As well as the number of consultations provided by the OHPS' doctors and nurses, the summary also includes how many of the consultations were referred to the hospital, how many were given antibiotics, and how many were referred to have ancillary procedures

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

### **4.2.3 Other services provided for members**

#### A. Other financial health services

In 1999, the OHPS began sponsoring a yearly raffle project to raise funds to sponsor indigent families in the insurance scheme. It allocates Ph.P.10,000.00 from the proceeds of the raffle to the *Sagip-OHPS*<sup>12</sup> project. The aim of the *Sagip-OHPS* is to grant loans to members in good standing who cannot pay their monthly contribution for a valid reason. The health promoter guarantees the loan of the member. This has helped in reducing the drop out rate among the members. For the year 2000, the OHPS decided to give a year's OHPS Membership as raffle prizes to 50 families.

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

#### B. Health supply

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

The health service in the satellites was created before the OHPS was implemented. It was created for the ORT Mother and Child Care (MCC) Project in 1991. The project has a Central Unit and 16 satellite day-care centers servicing 36 communities, providing pre-school education and basic health and nutrition services. These health services are provided by a team of one

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<sup>12</sup> Roughly translated as Save-OHPS



pediatrician and two nurses and the health promoters in each satellite. Services include prevention (vaccines and other immunization materials provided by the local government), growth and development monitoring, supplementary feeding and regular worming treatments for around the 1,000 children enrolled each year in the day-care centres.

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

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

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

### C. Prevention and health education

The OHPS team gives regular seminars to mothers in the communities on the following:

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

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

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

- ❑ Taking of vital signs (temperature, blood pressure, pulse rate, respiratory rate, weight and height);
- ❑ First aid treatment (wound dressing, burns, falls, insect bites, drowning, poisoning, and vehicular accident);
- ❑ Family planning;

- ❑ Pre and post natal care and nutrition;
- ❑ Dental care; and
- ❑ Environmental care and sanitation.

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

#### D. Other services

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

### 4.3 Financial aspects of the OHPS' operation

#### 4.3.1 Finance sources

##### A. Contributions

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

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

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

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

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

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

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

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

**Table no.7: Total amount of Budgeted Contributions**

Source of contribution	Amount		
	1997	1998	1999
Budgeted contributions: members/ beneficiaries	Ph.P.345 227.15	Ph.P.384 135.50	Ph.P.633 038.00
Budgeted contributions from sources other than members/ beneficiaries (Employers, etc.)	Ph.P. 14 00.00 (Sponsorship)	None	Ph.P. 33 447.00 (OHPS Raffle)

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

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

**Table no. 8: OHPS Contribution Rates**

	Before		Unified Rate effective March 1999
	SSS/GSIS	Non-SSS/GSIS	
Single	Ph.P. 25	Ph.P. 50	Ph.P. 70
Standard Family	Ph.P. 70	Ph.P. 100	Ph.P. 120
Large Family	Ph.P. 95	Ph.P. 130	Ph.P. 150

## B. Membership fees, social capital shares

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

## C. The financial contribution of the state and local collectives

The Provincial Government of La Union has made regular financial contributions to the IS in the form of support to the Mother and Child Care Project. The MCC project has been a joint undertaking between the Provincial Government and ORT. Since its inception in 1991, the government has given a subsidy the amount of which from 1997 to the present, is Ph.P.230,000 (US \$ 4,600<sup>13</sup>) for all the MCC Project Operations (mainly daycare centres). Of this amount, it is estimated that 20 per cent or Ph.P.46,000 (US \$ 920) for health services, now provided by the OHPS health team. This amount, however, is not reflected as a cash receipt nor as an expense under disbursements in the OHPS Cash Flow Statement but in the MCC project.

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

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

## D. Donations and subsidies from other sources

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

## E. Loan and credits

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

## F. Transfer of funds from the OHPS' parent company

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

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

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

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<sup>13</sup> US\$1= Philippine Peso 50.00

## G. Other sources

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

### 4.3.2 Costs

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

*Table 9: Costs Incurred by OHPS*

	1997	1998	1999
Capitation payment to ITRMC	76 546.40	131 936.47	169 172.75
ITRMC special services		11 005.15	46 609.15
Salaries of 2 OHPS doctors	116 400.00	127 283.33	141 292.46
Free medicines	127 817.63	137 826.63	170 296.27
Total	<b>320 764.03</b>	<b>408 051.58</b>	<b>527 370.63</b>

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

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

### 4.3.3 Surplus allocation

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

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

### 4.3.4 Reserve funds

As of 31 December 1999 the OHPS had a final cash balance of Ph.P. 133,821.94. If this is considered as the total reserve, it has a ratio of benefits coverage reserve of 3 months with the benefits excluding the portion subsidized by the government and other agencies. A portion of this reserve has been invested in the Cooperative to the amount of Ph.P. 50,000.00.

## 4.4. Health care providers

### 4.4.1 Health care providers linked to the OHPS

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

Table no. 10: OHPS' authorized providers

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

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

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

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

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

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

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

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

#### **4.4.2 The relationship between the health care providers and the OHPS**

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

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

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

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

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

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

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

#### **4.4.3 *Payment of health care providers***

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

### **4.5 Administration and management of OHPS**

#### **4.5.1 *Statutes and regulations***

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

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

The MCC was started in 1991. During this process, it appeared that the limited presence of the pediatrician and nurses constituted the only form of regular health care for several of the rural communities whose young children attended the day-care centres. The severity of illness



reflected the need for a regular source of primary health care in the community. At that time, basic health services were provided free of charge in the public health centres, operated at municipal and community level. However, access to these services was limited by the lack of regular primary health care staff, drugs and equipment.

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

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

The OHPS operation is based on the following principles:

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

#### **4.5.2 OHPS' management organization**

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

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

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

The Primary Health Care /Field Supervisor coordinates the OHPS nurses and health promoters while the Medical/Provider Coordinator controls the OHPS doctors and the Promotions and Marketing Supervisor, the community promoters. The community and health promoters are

volunteers and satellite based. The units comprising the Insurance Scheme management may also be divided according to function and location as follows:

#### 1. Central Unit – ORT MCC

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

ORT MCC Day-care/Satellite health functions:

- ❑ Training and monitoring
- ❑ Services in satellites

#### 2. ITRMC Primary Health Care Unit

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

**Table no. 11: Personnel (salaried and unsalaried) employed by OHPS**

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

**Table no. 12: Other salaried staff: not employed by OHPS**

Function	Number	Organization responsible	Percentage of working time dedicated to the Insurance Scheme	Main tasks
General Manager	1	OCMC	25	Policy implementation & general management
Promotions & Marketing Supervisor	1	OCMC	40	Membership promotion campaigns, member education, sponsorship and fund raising drives
Disbursement Officer	1	OCMC	20	Schedules payments & prepares cheques for OHPS' disbursements
Bookkeeper	1	OCMC	20	Recording of OHPS financial transactions

#### **4.5.3 The democratic and co-operative character of management**

The staff informs the new members of their rights and obligations through the orientation seminar and the OHPS-ITRMC partnership brochure as discussed earlier.

OHPS publishes a monthly newsletter distributed to all members through the health promoters in the satellites. Clarifications on OHPS policies and anecdotes of members when using the services are discussed here as well as health tips for preventative care.

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

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

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

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

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

#### **4.5.4 Financial management**

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

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

The OHPS maintains a petty cash fund of Ph.P. 5,000.00 for reimbursement to members of prescribed medicines not available in the OHPS clinic at ITRMC and emergency purchase of medical supplies. Replenishment is done almost every week. The petty cash custodian is the administrative clerk stationed at the OHPS clinic at ITRMC.

#### **4.5.5 Information system and management tools**

##### **A. The accounting framework**

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

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

##### **B. Information about members, contributions and benefits**

OHPS uses the following documents:

- ❑ Members' register
- ❑ Membership card
- ❑ Contributions register

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

- ❑ Benefits monitor register

#### C. Management tools

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

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

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

The monthly report on the number of member-families by satellite gives the information on the membership dynamic as well as growth trends per satellite.

#### D. Formalizing management procedures

The list of forms used for OHPS' current operation are as follows:

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

#### **4.5.6 The function of control**

##### Petty cash control

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

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

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

- ❑ Control of health care providers billing

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

- ❑ Drugs management

Movements in the inventory are recorded in the prescribed forms both at the central and satellite levels. Distribution to the satellites is done every two weeks according to monthly allocation but may vary depending on the availability of stock from the Central Unit. The amount of drugs distributed per satellite is recorded in the monthly drug distribution form. Monthly allocation to satellites is calculated by reviewing the amount of each drug dispensed in a typical month for each satellite. The monthly allocation is then adjusted every six months according to actual use. A “Drug Card” for patients with chronic diseases is also prepared for proper monitoring of drug use.

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

#### 4.5.7 Role distribution

Table no. 13: Real role distribution

	The Insurance Scheme Organ (GA)	The Insurance Scheme salaried staff	Health care providers	Technical assistance staff	External health care providers	Other
<b>Benefits management</b>						
Who decides the services covered?				✓		
Who makes decisions about coverage?				✓		
Who decides patient referral to a more complex level?			✓			
Who processes benefits claims?		✓				
Who monitors benefits (frequency per covered service, average cost, etc.)?		✓				

	The Insurance Scheme Organ (GA)	The Insurance Scheme salaried staff	Health care providers	Technical assistance staff	External health care providers	Other
<b>Membership management and contributions collection</b>						
Who receives membership requests?	✓	✓	✓			
Who updates the members' register?		✓				
Who initiated membership cards?		✓				
Who decides the exclusion of members?		✓				
Who calculates the contributions amount?				✓		
Who collects contributions?		✓				
Who carries out contributions recovery?		✓				
Who keeps the contributions register?		✓				
<b>Management of relationships with health care providers</b>						
Who chooses the health care providers?		✓	✓			
Who negotiates agreements with the health care providers?		✓				
Who withdraws the agreement with a health care provider?		✓				
Who decides health care providers' payments?				✓		



	The Insurance Scheme Organ (GA)	The Insurance Scheme salaried staff	Health care providers	Technical assistance staff	External health care providers	Other
<b>Accounting and financial management</b>						
Who implements the accounting framework?		✓				
Who prepares the budget?		✓				
Who works out the income and expenditure account?		✓				
Who prepares the balance sheet?		✓				
Who calculates the financial ratios?		✓				
Who proposes surplus allocation?		✓		✓		
Who determines surplus allocation?		✓		✓		
Who monitors deposits		✓				
Who recovers debts?		✓	✓			
Who determines the financial investments?		✓		✓		
Who authorizes expenditure?		✓				
Who manages the petty cash?		✓				
<b>Control</b>						
Who controls the petty cash?		✓				
Who implements accounting and financial controls?		✓		✓		
Who controls the beneficiaries' status?		✓				

	The Insurance Scheme Organ (GA)	The Insurance Scheme salaried staff	Health care providers	Technical assistance staff	External health care providers	Other
beneficiaries' status?						
Who controls contributions payments?		✓				
Who controls beneficiaries' rights to benefits?		✓				
Who controls the health care providers' billing?		✓				
Who carries out the medical control?			✓	✓		
Who sanctions fraud?		✓				
Who intervenes in embezzlement cases?		✓		✓		
<b>Relationship with the beneficiaries and target group</b>						
Who decides to call a general assembly?	✓	✓				
Who organizes the general assembly?		✓				
Who designates officials?	✓					
Who informs beneficiaries of services covered?		✓	✓			
Who organizes information campaigns for the target group?		✓	✓			
Who organizes prevention and health education activities?		✓	✓			
Who carries out prevention and health education activities?			✓			

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

*Table no. 14: Main training of officials and personnel*

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

It is observed that the different training sessions mentioned in Table 14 have been designed and conducted in response to certain perceived needs and concerns that have been raised in relation to the implementation of OHPS. Very minimal professional assistance has been sought for these sessions and most are explanatory in nature.

#### **4.5.8 Equipment and infrastructure**

The MCC project has a Central Unit and 13 satellite day-care centres servicing 36 communities. These satellites, the Central Unit in the ORT Multi-purpose Cooperative Building and the Ilocos Training Regional Medical Center provide a specific area to serve as OHPS clinics cum offices.

*Table 15: Space Used for OHPS Clinics*

	<b>Total Area</b>	<b>OHPS office cum clinic</b>
Central Unit	474 square meters	22 square meters
13 Satellites	220 to 250 square meters	30 square meters
ITRMC		15 square meters

OHPS has one computer. The parent company has four computers, telephone fax, internet access, two vehicles, a photocopying machine and video. All of these can be used by OHPS when necessary.

#### **4.6 Actors in relation to OHPS**

##### **4.6.1 Reinsurance and guarantee funds schemes**

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

##### **4.6.2 Technical assistance**

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

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

##### **4.6.3 Social movements and Social economy organizations**

OHPS is an initiative that is supervised and managed by the ORT Multipurpose Cooperative. The cooperative is a member of a national federation (NATCCO) and is also registered under

the Cooperative Development Authority<sup>14</sup>. Thus the cooperative complies with the different regulations and laws stipulated by this body.

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

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

## 5. The Indicators of OHPS' operation

*Table 16: Indicators (see "The ORT Health Plus Scheme Indicators" for computation – Annex)*

	1997	1998	1999
<b>1.The membership dynamic</b>			
Target group's penetration rate	0.319	0.325	0.403
Number of members growth rate	21.56	13.84	14.38
Re-contribution rate	94.96	93.54	94.16
Average number of beneficiaries per member	4	4	4
<b>2. Service Use</b>			
Consumption rate of covered health services			
Consultation	18	21	21
Percentage of those consultations using the following:			
Referral to Hospitals	6	10	6
Antibiotics	5	48	50
Ancillary Services	7	8	11
	<b>1997</b>	<b>1998</b>	<b>1999</b>

<sup>14</sup> The governmental regulatory body for cooperatives.

Evolution of the average amount of benefits per beneficiary		24.79	4.26
<b>3. Financing and the Financial Situation</b>			
Surplus (deficits)	38 591.68	(82 875.15)	130 596.37
Total amount of benefits <i>This refers to the total amount of benefits provided by the Insurance Scheme to its beneficiaries during a term excluding subsidies.</i>	320 764.03	408 051.58	527 370.63
Contributions recovery rate	82.14	85.26	82.90
Percentage of members whose contributions are current	95.02	93.57	94.18
Budgeted contributions/ term expenditure ratio	0.58	0.57	0.70
[Budgeted contributions + regular contributions]/ term expenditure ratio	0.84	0.82	0.86
Ratio of benefits coverage by reserves	0.8	0.1	3.0
Benefits/ budgeted contributions ratio <i>- if benefits do not include subsidies</i>	0.93	1.06	0.83
Rate of Internal Financing (E.24)	0.40	0.36	0.55

## 6. The Actors' Points of View vis-à-vis OHPS

### 6.1 Evaluation process

The Promotions and Marketing Supervisor holds a quarterly OHPS “*pulong-pulong*” (meeting in local dialect) in each satellite to obtain information on beneficiaries’ opinions regarding the OHPS operation. All members are invited and the participation rate varies. In the OHPS *pulong-pulong* held in November 2000, the attendance rate was as follows:

**Table 17: Attendance at OHPS quarterly meetings**

<b>Satellites</b>	<b>Number of members</b>	<b>Number of members present</b>	<b>Attendance rate Percentage</b>
Bariquir	58	27	47
Carcarmay	27	12	44
Gonzales	67	35	52
Pudoc	105	20	19
San Simon	33	17	52
Sta. Rita	51	25	49
Total	341	136	40

These figures compare favourably with the participation rate of 29 per cent during the OHPS' Day 2000 where members had to go to the Central Unit.

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

There has been no formal or official evaluation of the scheme since its inception. Although there have been several international<sup>15</sup> and local agencies<sup>16</sup> who have visited and studied the scheme, most of them have come to gain information and knowledge. Occasionally, individuals and students have spent a few weeks learning about the scheme and some reports have been written.

There has also been no formal internal evaluation of the scheme. Reports are made and meetings conducted on a regular basis to analyze and understand some aspects of the scheme's operations. Apart from this there has been neither any formal evaluation process nor strategic planning exercise. One of the most significant findings is the lack of full understanding of the social health insurance concept, policies and procedures among the members and initially even among the staff. Concrete measures have been adopted to address this. A series of seminars were given to the volunteers and staff including the doctors. For members, meetings are held at the satellite level and more frequently, new members, who naturally would have the least understanding of the procedures, are required to attend the orientation seminar. It is only after they have attended the seminar that they are given their membership cards.

## **6.2. The Officials' point of view**

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

### **6.2.1 The Implementation of OHPS**

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<sup>15</sup> Examples of these agencies are: International Labour Organization (ILO), German Technical Cooperation Agency (GTZ) and World Health Organization (WHO).

<sup>16</sup> Examples of these are: Cooperative Development Authority, Shell Foundation, Philam Foundation and the Philippine Health Insurance Corporation.

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

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

In a paper entitled *"ORT Capacity in Community based Health Insurance Development"* dated September 2000, Mr. Avi Kupferman, ORT Regional Director-Asia together with Dr. Aviva Ron, wrote :

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

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

*...One lesson learned was that sponsorship of families by local politicians or donors for short period was not beneficial. If these were poor families, their income levels were no better at the end of the sponsorship period, after which they were again excluded from the social protection mechanism. In cases requiring social assistance, permanent funding is necessary and attempts are now being made to tap funds for the indigent population through local government funding for health insurance, as in fact mandated in the Philippine National Health Insurance Act (NHIA). OHPS provides benefits that are broader than those under the current national social health insurance, and at a lower expenditure per family through contribution. Delays in implementing this link are mainly due to delays in implementation of the indigent programme under the NHIA.*

Another difficulty encountered was the control of rights to benefits. It took at least two years to achieve strong control over the limitation of benefits only to those who were entitled on the basis of contribution payments. The tendency to make allowances for family members and acquaintances in small communities had to be overcome. A serious effort was made to address this by taking a closer look at the impact these problems have on the financial viability of the fund. This eventually led to better contribution collection and verification of entitlement before providing benefits.

### **6.2.2 Membership dynamics**

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



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

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

### **6.2.3 Access to health services and the relationship with health care providers**

The OHPS monthly meetings serve as a venue for clarifications, questions and sometimes complaints as well as an opportunity for management to gauge if the scheme has been able to improve access to health services for its beneficiaries. During meetings, members give both positive and negative feedback on the quality and type of health services. Members are especially grateful for the regular weekly visits of a doctor to their community. Before this, they relied mainly on the infrequent visits of the Barangay Health Workers<sup>17</sup> from the Rural Health Unit (RHU). The members also appreciate the availability of essential medicines in the OHPS satellite clinics. Prior to their membership of OHPS, members in need of medicines still had to go to the town centers or to the hospital to seek consultation and to purchase the drugs prescribed. However, there are always members who can only be satisfied if the doctors came more often and if the list of essential drugs was expanded.

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

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

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

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

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<sup>17</sup> Village health worker

hospital providers is an essential feature of OHPS. This method of compensating providers is hardly practiced or used in the insurance system in the Philippines. Because of this, the OHPS' non-negotiable stance in carrying out this arrangement becomes not only pioneering but allows the scheme greater influence and power.

#### **6.2.4. Contributions payment**

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

#### **6.2.5 Determining the contributions/benefits relationship**

The contribution/benefit relationship is quite difficult to apply in social health insurance because there is always the tendency for the benefits to outweigh the contributions. For purposes of ensuring financial viability however, the cash flow is used as one of the determining factors. Because the level of contributions is not yet adequate in relation to the benefits offered, OHPS still relies on subsidies. However, there was a move to lessen this dependence by increasing the contribution rates effective from March 1999.

#### **6.2.6 Insurance risk management**

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

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

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

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

Other than its own contingency reserve, the OHPS does not have any mechanism for financial protection. There is no reinsurance or guarantee fund system for any of the existing health microinsurance schemes in the Philippines. Lately however the OHPS Management has been

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<sup>18</sup> Translated to *Save OHPS*

approached and invited to participate in a study to explore the viability of a re-insurance scheme for social health insurance.

### **6.2.7 Fraud**

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

There were also some cases where members, whose parents were still below 60 years old, falsified the age of their parents in order to be able to register them as dependants. To minimize this, these parents are given free consultation although they are not entitled to the other health benefits.

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

### **6.2.8 Administration and management**

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

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

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

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

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

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

### **6.2.9 Relationship with the state and local collectives**

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

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

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

### **6.2.10 General operations**

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

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

Losing internal and external support will endanger the viability of the scheme. Funding through contributions is adequate if compliance with regular payment is high and cost control through provider payment are maintained.

The main strategy adopted to improve the operation and impact of OHPS is to seek more support from the Provincial Government. Aside from financial support, its endorsement of the scheme to the general population of the province will boost OHPS’ penetration rate of the target group.

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

## **6.3. The Beneficiaries’ points of view**

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

As can be seen from the minutes, discussions in September were focused on two health benefits: free medicines and medical consultations at the satellite clinics.

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

In relation to medical consultations, some members are unsatisfied because the OHPS doctors are not available at the satellite clinics on a daily basis but only come weekly. Sometimes the doctor's scheduled visit is late or is changed without the members being informed.

At the November meeting, similar sentiments were shared. In addition, members also observed that some stocks of medicines and supplies at the hospital pharmacy were inadequate and some hospital staff were not familiar with the benefits available to OHPS members.

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

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

#### **6.4 The health care providers' points of view**

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

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

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

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

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

## **6.5 Other actors' points of view**

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

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

## **7. Conclusion**

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

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

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

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

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

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

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

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

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

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### Interviews with

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Ms. Melrose Gomez, OCMC Administrative Staff

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## Annex