

Extending Social Protection through Health Micro-Insurance  
Schemes to Women in the Informal Economy

(RAS/01/02/MNOR)



*Strategies and  
Tools against  
Exclusion and  
Poverty*



# Reference Guide and Tools on Health Micro-Insurance Schemes in the Philippines



International Labour Office





# **Reference Guide and Tools on Health Micro-Insurance Schemes in the Philippines**

**International Labour Office**

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First published 2005

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ILO  
*Reference Guide and Tools on  
Health Micro-Insurance Schemes in the Philippines*  
Manila, International Labour Office, 2004

ISBN 92-2-116745-3 (print)  
ISBN 92-2-116746-1 (cd-rom)

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Printed in the Philippines

# **Reference Guide and Tools on Health Micro-Insurance Schemes in the Philippines**

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The ILO Subregional Office for South-East Asia and the Pacific, located in Manila, serves Australia, Fiji, Indonesia, New Zealand, Papua New Guinea, the Philippines, Solomon Islands, Timor Leste and Vanuatu. It also works with other countries in the Pacific on their road to the ILO membership.

The Subregional Office promotes Decent Work in the above countries to provide opportunities for women and men to obtain decent and productive work in conditions of freedom, equity, security and human dignity. The Decent Work integrates ILO's four strategic objectives - rights at work, employment, social protection, and social dialogue. The Office works closely with its tripartite constituents in the subregion through Decent Work Country Programmes, which define national social development priorities within the overall framework of the Decent Work agenda.

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The global program "Strategies and Tools against Social Exclusion and Poverty" (STEP) of the International Labour Office (ILO) is an instrument for extending the coverage and effectiveness of social protection throughout the world.

Following the conclusions of the World Summit for Social Development in Copenhagen, STEP promotes the design and implementation of innovative systems of social protection for excluded populations. Based on the principles of equity, efficiency and solidarity, these systems contribute to social justice and cohesion.

In its work, STEP combines different types of activities: concrete actions in the field, research, production of methodological tools, reference documents and technical assistance for policy development and implementation.

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## Foreword

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

More than fifty percent (50%) of the Philippines' labour force is in the informal economy. They face high risks because of their hazardous working and living conditions. A very small percentage of these workers also do not have access to existing social security schemes making them less prepared for contingencies such as ill health and accidents.

Hence, a variety of actors like community-based groups, non-government organizations, and workers' groups responded to the needs of informal economy workers for social protection through risk-pooling schemes such as mutual organizations and health micro-insurance schemes. These interventions are based on the principles of solidarity, equity and good management.

The "Reference Guide and Tools on Health Micro-insurance Schemes in the Philippines" could serve as frameworks for ensuring the sustainability of these risk-pooling schemes. At the same time, we also hope that as organizations gain proficiency in managing their schemes, models of linkage with the National Health Insurance Program could be developed and replicated.

The development of these guides and tools was made possible through the project being implemented by the ILO Subregional Office for South-East Asia and the Pacific and ILO's global programme, Strategies and Tools against Social Exclusion and Poverty (STEP) in the Philippines, funded by the Government of Norway. It was undertaken in the framework of the National Plan Action for Decent Work in the Philippines. The tools benefitted from valuable comments from various government agencies such as the Department of Labor and Employment, Department of Agrarian Reform and Philippine Health Insurance Corporation, workers' groups from the informal economy and employers' organizations who participated during the consultation workshops and interviews.

We trust that these tools be a good reference for the development of an effective health insurance system in the Philippines.

Werner Konrad Blenk  
Subregional Director  
International Labour Organization  
Subregional Office for South-East Asia and the Pacific

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## Acknowledgement

The development of this Reference Guide and Tools on Health Micro-Insurance Schemes (HMIS) in the Philippines was spearheaded by ILO SRO Manila through its STEP Project as part of its overall plan to extend social protection to those in the informal economy.

The ILO SRO Manila is grateful for STEP which provided the template from which this project based the modules from. The ILO-SRO-Manila is most grateful to STEP-Africa for having gone ahead in producing a Manual on HMIS. Their final product served as the main reference in the development of this Reference Guide and Tools and became the pattern for customizing it to local needs and situation in the Philippines. Without this excellent initial work, the production of the Reference Guide and Tools would have taken much longer time and entailed more cost, notwithstanding the rigours of starting anew without a pattern or guide. Most invaluable in the STEP-AFRICA manual are the tried and tested tools and concrete examples that facilitate the understanding of HMIS management and operations. These paved way for the smooth adaptation of the material in the local context.

Enhancing the material to fit the Philippine's conditions would not have been possible without the invaluable contributions of national, sub-national and local stakeholders. The draft Reference Guide and Tools was subjected to review and validation by a total of 21 participants last April 15-16, 2004. In that validation workshop, the content of the guide was enhanced with the identification of key aspects of HMIS management and operations that require more focus and elaboration and the adjustments of terminologies and examples more fitting to the set-up of HMIS in the country.

The ILO SRO Manila would like to recognize the inputs of these representatives from the national offices of the Philippine Health Insurance Corporation (PHIC), Department of Labor and Employment (DOLE), Department of Agrarian Reform (DAR) and National Anti-Poverty Commission (NAPC), including the World Health Organization (WHO).

It is equally indebted to the sub-national and local stakeholders who spent their time in reviewing the whole Reference Guide and Tools and who so generously shared their on-the-ground experiences. These are the managers, bookkeepers and staff of community-based health insurance schemes from Bulacan, Isabela and Angono, Rizal in Luzon, from Bohol, Guimaras, Bacolod and Cebu in Visayas and Agusan del Sur, Campostela Valley and Davao del Norte in Mindanao. The list of the participants to the Validation Workshop is appended below.

Special interviews and visit were also undertaken among selected managers and implementers in the informal economy. These include the officials of Informal Sector Program (ISP) and the Organization and Resource Training – Health Plus Scheme (ORT-HPS) in San Fernando, La Union. The ORT-HPS management and staff shared their administrative and financial records to substantiate the discussion and provide illustrative examples in the guide. The ILO-SRO-Manila would like to express its heartfelt thanks to those who shared their ideas and experiences in the interview and the ORT-HPS Team.

Lastly, STEP Philippines would also like to thank the other ILO management, staff and consultants for their inputs and expert advice in the adaptation of this Reference Guide and Tools on HMIS in the Philippines.



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### HMIS Reference Guide and Tools Validation Workshop April 15-16, 2004, ILO Conference Room, RCBC Plaza

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#### ILOSRO-Manila

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3. Ms. Sylvia Fulgencio, Program Officer
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#### Consultants

1. Ms. Maria Luz Quesada Tiongson for inputs on Gender
2. Ms. Eireen B. Villa for facilitating the adaptation of this Manual

## List of Acronyms and Abbreviations

AB	Auditing Body	NAPC	National Anti-Poverty Commission
AIDS	Acquired Immuno-Deficiency Syndrome	NGO	Non-Government Organization
BARBD	Bureau of Agrarian Reform Beneficiaries Development	NHIP	National Health Insurance Program
BD	Board of Directors	ORT	Organizing Resources for Education and Training
DA	Cooperative Development Authority	OHPS	ORT Health Plus Scheme
CF	Client Feedback Form	PATAMABA	Pambansang Tagapag-ugnay ng mga Mangagawa sa Bahay (National Network of Homeworkers)
COE	Client-Oriented, Provider Efficient	PhilHealth/PHIC	Philippine Health Insurance Corporation
DAR	Department of Agrarian Reform	Php	Philippine Pesos
DLE	Department of Labor and Employment	POs	People's Organizations
DOLERW	Department of Labor and Employment- Bureau of Rural Workers	PSPs	Policies, Systems and Procedures
EB	Executive Body	SIE	Statement of Income and Expenditure
EC	Employees Compensation Commission	SEC	Securities and Exchange Commission
FGD	Focused Group Discussion	SMART	Specific, Measurable, Attainable, Realistic, Time-Bound
FRR	Financial Ratios Record	STEP	Strategies and Tools Against Social Exclusion and Poverty
GA	General Assembly	SSS	Social Security System
GSS	Government Service Insurance System	WHO	World Health Organization
HC	Health Center		
HIV	Human Immuno Deficiency Virus		
HMS	Health Micro-Insurance Scheme		
ILC	International Labor Conference		
IO	International Labour Office		
ILOSRO-Manila	International Labour Organization, Subregional Office for Southeast Asia and the Pacific - Manila		
IP	Indigent Program		
IIP	Individually Paying Program		
ISP	Informal Sector Program		
LGUs	Local Government Units		
MB	Membership Book		
MC	Management Chart		
MMR	Monthly Monitoring Report		
MOA	Memorandum of Agreement		

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(RAS/01/02/MNOR)

**User's Guide**



Reference Guide and Tools on Health  
Micro-Insurance Schemes in the Philippines

**User's Guide**



STRATEGIES & TOOLS  
AGAINST SOCIAL EXCLUSION  
& POVERTY



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



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## Why the Reference Guide and Tools on HMIS?

While the overall health status in the Philippines has steadily improved over the past two decades, large variations exist across regions and also within population groups. The health care delivery system was unable to adequately address the health concerns of the Filipinos, most particularly that of the poor and the marginalized. Quality of health care remains wanting in most areas, while the cost of health services continue to rise beyond the reach of individuals.

Health care in the Philippines consists of a strong private sector providing quality care, but is accessible only to those who can afford it. Though the delivery of health services was transferred to the local government units (LGUs) in 1991, most LGUs were unable to absorb the cost of health in their local budget, giving it the least priority in funding. Moreover, the health utilization practice by the general public is relatively poor and even worse among the poor and marginalized considering their limited resources and lack of appreciation of what is an appropriate care.

The labor sector, on the other hand, for the past two decades has shown a steady growth of people working in the informal economy. To date, more than 50%, approximately 19.0 million, of the labor force are in the informal economy. Since work in the informal sector tends to coincide with harsh and precarious working conditions, workers in the sector should benefit a lot from social protection measures. However, these workers are not covered by the institution-based social security systems or are unable to access their services due to a number of factors. As a result, many of those groups (civil society groups, people's organizations, trade unions, cooperatives, etc.) catering to workers in the informal economy have begun to venture into innovative schemes to create access to social protection for the workers. In the field of health, health micro-insurance schemes (HMIS) are considered promising alternatives to help the informal sector access better quality health care. Several studies have confirmed their potentials in ensuring access to health.

There has been a growing interest to put up HMIS in the country. Most micro-insurance schemes in the Philippines have been in existence for more than 10 years. However, they lack the information and the know-how in running these schemes efficiently and effectively. Others utilize crude tools and lack the rational basis in determining the members' premiums and defining the package of services to offer. Little is really known about these schemes and that there is not much local level expertise around to help those setting them up and operating them.

These innovative experiences and expertise in HMIS need to be developed within the community-based groups (cooperatives, micro-finance groups, people's organizations, etc.) and other organizations which could provide them with support. This is to ensure that the traditional forms of mutual aid and solidarity is taken into account, that sustainable community-based approach is considered and that genuine ownership of the scheme is recognized.

The project of ILO in the Philippines, tasked to develop strategies and tools to address exclusion of the men and women in the informal economy from social protection services, has undertaken bold steps in capacity building to address the needs of the informal sector for social protection, most especially in the area of health care.

Its major thrust is to develop the capacities of the community-based groups to set-up and manage HMIS for their members. One of its strategies is to provide them with a ready-reference material as guide. It is in this light that the development of this Reference Guide and Tools came into fruition.

## What Does the Reference Guide and Tools on HMIS Want to Achieve?

This Reference Guide and Tools on HMIS is intended to further upgrade the knowledge and appreciation of managers, administrators, initiators and promoters in setting up and managing HMIS in the Philippines. It aims to empower those working in the informal economy to make their HMIS fully operational, sustainable



and responsive to the health needs of the individual workers and their families. It hopes to develop the capabilities of community-based organizations, particularly on the following areas:

- foundations and features of HMIS
- setting - up HMIS
- organization, administrative and financial management of HMIS
- monitoring and evaluation of HMIS

This guide is prepared to meet the need for information and to provide access to basic techniques on the above aspects of HMIS operations. As such, it is to be used as a tool to support community-based organizations in setting up and operate their respective HMIS efficiently and effectively. This effort is expected to contribute ultimately to increased access of those in the informal economy to quality health care.

## **To Whom is the Reference Guide and Tools on HMIS Addressed?**

The Reference Guide and Tools on HMIS is intended primarily for individuals or organizations who are planning to establish, currently setting up or those who are already operating a health micro-insurance scheme. These can be the initiators, coordinators, administrators, managers or promoters of HMIS in any local setting in the Philippines.

The guide is designed for sub-national and local implementers of HMIS. It situates the local potential users of this guide with the rationale and context of social protection in health in general, within which the successive stages in setting up an HMIS and the details of its administration and management are drawn.

## **How Can National Policy-Makers and Decision Makers Benefit From the Modules?**

The Guide is also useful for promoters and advocates for HMIS, whether they operate at the national or local level. It provides basic information to anyone interested to know more about HMIS. Policy makers and decision-makers may benefit from the modules through the various situational experiences presented and the discussions on key operational difficulties that require national level action. An example of this will be the mainstreaming of the HMIS into the National Health Insurance Program.

## **What are the Elements of the Reference Guide and Tools on HMIS?**

The Reference Guide and Tools consists of 5 modules designed as separate modules and is introduced by this USERS' GUIDE. The USERS' GUIDE explains the rationale for the development of the Reference Guide and Tools, the objectives, the target users, the major content of each module and how it can be used to effect better understanding and application. Built-in to each of the 5 modules are annexes that further illustrate the main content of each module.

## **What Does Each Module of the Reference Guide and Tools on HMIS Deal With?**

The Reference Guide and Tools on HMIS has 5 modules and these deal with the following aspects of HMIS operations in the Philippines.

### **Module 1: Health Micro-Insurance in the Philippines**

The first module gives you an overview of social protection in the Philippines, in general

and introduces you to HMIS as a promising mechanism for extending health services and care to those working in the informal economy.

The first part of the module describes the different risks and vulnerabilities faced by individuals, particularly those in the informal economy and enumerates the different ways by which the individual workers and groups respond to these risks as they occur. It enumerates the existing social protection in health in the Philippines, those designed for the formal sector and the established non-conventional schemes, the services and benefits they offer including their limitations.

The second part of module 1 details to you the key features of an HMIS and provides you with information vital to its efficient and effective operation. It expounds the key principles and approaches that govern its formation and establishment and presents the basic elements that make it up as a whole system.

This module ends with a discussion of the various risks associated with putting up and operating an HMIS and the ways by which these risks can be minimized.

## **Module 2: Setting-Up A Health Micro-Insurance Scheme**

Module 2 deals with the overall process in setting up a HMIS. It outlines to you the following stages of establishing the scheme and clarifies the steps to be undertaken per stage. More importantly, it clarifies the significant factors that must be considered when undergoing each stage.

Stage 1: Awareness Raising and Decision to Set-up an HMIS

Stage 2: Situational Analysis

Stage 3: Defining the Mutual Benefit Formula

Stage 4: Launching of the HMIS and Start-up Activities

In addition, Module 2 provides you with information on the other activities that support and sustain the operations of your HMIS. These include the series of capability building activities which the HMIS management and members should undergo, the continuing information-dissemination-campaign among HMIS members, service providers and other concerned stakeholders as well as the conduct of regular monitoring and evaluation.

Module 2 ends with the discussion of the basic principles in managing your HMIS which highlights the need for transparency and confidence, preservation of resources and separation of management and then segue way to the significant factors that most likely determine the future of your HMIS.

Annexed to the main discussion in Module 2 are the detailed guides in calculating the members' contributions and an example of a situational analysis showing how data are analyzed and used as basis in designing an HMIS.

## **Module 3: Organization and Administrative Management of HMIS**

Module 3 provides you with a detailed guide on the organization and administrative management of your HMIS. It clarifies the organizational structures that must be created, the institutional links that must be established and the different administrative systems that

need to be put in place.

This module begins with the importance of putting in place organizational structures and management systems as it identifies the key aspects of your HMIS requiring focused and proper management.

Module 3 lists before you the organizational bodies that govern your HMIS and clarifies their respective roles and responsibilities. It describes their links with one another and expounds how to manage their relations with external partners. In this Module, focus is given to documents used as tools in organizing your HMIS which include your By-Laws, Policies, Systems and Procedures, minutes of meetings and the Memorandum of Agreement between your HMIS and your service providers.

In the administrative management of your HMIS, Module 3 orients you on the key elements to be properly administered. These include the enrolment of your members, the registry of their contributions, the mechanism in collecting their premiums and the different mechanisms or set-up in providing the health services and benefits.

Actual examples of documents discussed in this section are annexed for your further reference and guide.

#### **Module 4: Accounting and Financial Management of HMIS**

Sound financial management and control mechanisms anchored on sound auditing principles help ensure the viability of your HMIS and establish its credibility among your members and service providers.

Module 4 deals with the accounting and financial management of your HMIS. It lists the financial management systems to be established and provides you with the necessary tools to help you account and manage your financial resources on a daily basis. In more detail, Module 4 provides you with a set of guidelines in (a) planning your financial requirements, (b) day-to-day accounting of your cash flows and (c) in consolidating and reporting your financial status.

For financial planning, this Module walks you through the preparation of an action plan, the corresponding budget and forecast of your cash flow throughout the year.

For the day-to-day accounting of your financial transactions, you are provided with guides in recording your disbursements and cash receipts. It also presents tools in managing your financial resources, the cash-in-bank and cash-on-hand including petty cash.

For financial consolidation and reporting, you are provided with a guide in preparing the Statement of Income and Expenditures and the Balance Sheet.

In all these aspects of financial management and accounting, you are provided with templates of the documents that need to be prepared and accomplished with actual samples in the Annexes.

#### **Module 5: Monitoring and Evaluation of Your HMIS**

Monitoring and Evaluation is an essential management tool that helps you keep track of the progress in achieving your HMIS goals and the direction where your HMIS is going. By undertaking monitoring and evaluation regularly, you are able to act on issues and problems right away before they reach the critical stage. More importantly, you are

equipped with the necessary information that becomes your basis in formulating policies, making decisions and strategizing appropriate actions.

This module provides you with the set of guidelines and tools in monitoring and evaluating the operations and performance of your HMIS. It encourages you to establish the system to help you manage and operate efficiently and effectively your HMIS.

Module 5 begins with the differentiation between monitoring and evaluation and clarifies the different methods that can be applied when undertaking both. It also specifies aspects of your HMIS that require regular monitoring and periodic evaluation.

The module highlights the use of the Monthly Monitoring Record, the Management Chart and the Financial Ratios Chart as tools in monitoring and assessing the performance of your HMIS. Their contents and applications are discussed lengthily so you can apply them to your own HMIS operations. On the other hand, Module 5 equally highlights the need to monitor and assess regularly the quality of health care being provided to your members. Several options are presented and discussed for you to choose from.

Annexed to the main text of this Module are templates of the monitoring and evaluation tools as guide.

## How to Use the Reference Guide and Tools on HMIS?

This Reference Guide and Tools on HMIS is packaged into modules or modules, each designed as a stand alone reference material which you can access and use separately depending on your particular interest or needs.

In using this guide, you are advised to refer first to this USERS Guide, an introductory module to the whole reference material which describes briefly the content of each major module. You can scan what each module or module contains and then locate the particular module or module which could best respond to your particular interest or need.

Each module or module is provided with a Table of Contents that helps you find the key sections and major topics that you are interested or need to read. In addition, a cover page is prepared to briefly introduce the whole module and clarifies its purpose and content. Note that in the main text, the annexes found at the end of each module are indexed should you need to further refer to them.

For better understanding and maximum application of the guide, it is best that you consider the following:

- (1) While it has been advised that the modules are designed separately as stand-alone references, you will have a better appreciation and fuller grasp of the information if you begin to read the modules in a chronological order – meaning from Module 1 to Module 5.
- (2) Take note of the following links across modules and the required background reading necessary to better understand the concerned module.

### Module of Interest

Module 2: Setting up An HMIS

### Helpful Background Reading

Read Module 1, particularly the second part that discusses the rationale, features and principles of an HMIS.

Module 3: Organizing and

Refer first to Module 1, particularly on the section that

	discusses the Administrative Management of organizational structure and risks of an insurance scheme.
Module 4: Accounting and	Read Module 3, particularly the section on organizing and Financial Management of administrative management since these have bearing on the inflow- an HMIS outflow of your HMIS resources that need to be properly managed.
Module 5: Monitoring and	Read Modules 3 and 4 considering that the data source of your Evaluation of an HMIS monitoring and evaluation tools and indicators are discussed in these modules.

- (3) While the reference guide and tools can be used and referred to on an individual basis, you are encouraged to organize a group discussion or information-exchange where two or more people can share their understanding of the material and further explore the appropriate and potential application of the guide and examples to their respective HMIS.
- (4) In each module, you are encouraged to seek the advice of those who have had previous experiences in setting up and operating an HMIS, those whose HMIS are already in more advanced implementation phase or seek professional advice from external agencies or groups. This is particularly important in (a) Module 2 while choosing the type of organization you want to set-up and defining the mutual aid formula to apply; (b) in Module 4 where you need to establish the financial systems of your HMIS; and (c) in Module 5 where you need to design and undertake an in-depth evaluation of your HMIS performance and operations.
- (5) Consider the guide as prescriptive rather than mandatory. The guide does not dictate straight forward answers to meet your particular needs. Considering the wide range of your HMIS' organizational set-up, size, level of operations and administrative arrangements, you must view the guide as a reference of possible options from which you can choose actions that could best respond to your particular need or situation.
- (6) The reference guide and tools cannot be fully grasped in one reading. There is a need for you to read and reread the pertinent sections you are interested in. You should seep through the given examples and try to adopt or apply them in your own HMIS. As advised earlier, you may want to organize a group discussion where you can ask for necessary clarifications of those pertinent sections you cannot fully understand.

## What are the Limitations of the Reference Guide and Tools on HMIS?

The Reference Guide and Tools on HMIS as designed has certain limitations as a self-guide and as a reference material.

- (1) The Reference Guide and Tools does not provide all the information you need to improve your HMIS' performance and operations given your particular situations. It provides you with the detailed guides on how to set-up, operate, monitor and assess your scheme. However, it does not provide you with the step-by-step procedures for every particular situation you are in. It does provide you though with a generic guide and some illustrative examples but allows you flexibility to design your own measures to respond to your particular situation. For certain areas where you need more detailed instructions, you have to seek additional advice from

external groups or access a more specialized documents that further explain these procedures.

- (2) The Reference Guide and Tools does not pretend to develop your skills in managing your HMIS. It only introduces to you the vital management processes and tools (e.g. situational analysis, monitoring and evaluation, calculations of contributions and benefits, social marketing, etc.) in order for you to better appreciate their importance in running your HMIS. To develop your skills in the areas mentioned above, you need to undergo a special training or orientation on each particular management process or system.
- (3) The Reference Guide and Tools are designed particularly with HMIS managers, initiators and advocates in mind. Hence, in certain cases, you may find the guide too elementary or too technical depending on what you already know and the level of exposure you have had before.
- (4) The Reference Guide and Tools are developed in English. It assumes that you are able to read, write and calculate. There may be some of you who may not be well-versed or fluent in English or have difficulty in reading, writing and calculating. In this regard, you may need to seek the assistance of a resource person who can translate the guide as necessary.
- (5) The Reference Guide and Tools is not designed as a training module. Hence, it does not provide simulation exercises to promote better understanding of the guide and tools. It can only be used as a technical reference during training but not as a training guide. It has to be translated first into a facilitator's guide to become useful in training.
- (6) The reference guide and tools do not cover all the aspects in the management and operations of an HMIS. It may not be able to respond to all your management requirements and needs. In this case, do not hesitate to contact or seek help from the national agencies concerned, the donor community or non-government organizations for assistance.





Reference Guide and Tools on Health  
Micro-Insurance Schemes in the Philippines

# Health Micro-Insurance Schemes in the Philippines



STRATEGIES & TOOLS  
AGAINST SOCIAL EXCLUSION  
& POVERTY



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





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## Purpose

The purpose of this module is to provide you with an overview of social protection in the Philippines in general and of health micro-insurance scheme in particular.

The first part of this module hopes to help you understand better the rationale and importance of social protection in the Philippines as a response to the risks and vulnerabilities faced by individuals, particularly those working in the informal sector. It aims to clarify what social protection in health is and lists the different mechanisms that exist, the services and benefits they offer as well as their limitations.

Recognizing the limitations of the existing health protection schemes, the second part of this Module introduces you to health micro-insurance as a promising mechanism for extending health services and care to those working in the informal economy. It aims to improve your understanding of the key features of a health micro-insurance scheme and equip you with significant information vital to its efficient and effective operation. By reading this Module, it is hoped that you will be able to fully understand the rationale, principles and the basic features of a health micro-insurance scheme before setting up one as discussed in the next Module.

## Content

Module 1 starts with the discussion on the importance of social protection in health by presenting the risks that any individual faces, giving emphasis to sickness-risk and explaining why men and women working in the informal economy are more vulnerable to these risks. With this introduction, the Module then describes the various ways adopted by individuals in coping with these risks, the nationally designed institutions-based schemes and non-conventional mechanisms initiated by community groups and organizations. The Module describes their limitations and introduces health micro-insurance as a tool for extending social protection to men and women working in the informal economy.

The Module then segues way to defining what is a health micro-insurance scheme and expounds on the key principles and approaches that govern its formation and establishment. It presents the basic elements that make it up as a whole system. These elements include the organizational structures to be formed, the categories of beneficiaries that patronize its services, the types of services it offers and the mechanisms for membership application, payment of contributions, granting benefits and availing of these benefits. This module ends up with the presentation and discussion of various risks associated with health micro-insurance scheme and the ways by which these risks can be minimized.

## Sections

- Section 1.1: The Rationale of Social Protection
- Section 1.2: Responding to Health-Related Risks
- Section 1.3: Health Micro-Insurance Scheme As A Tool for Social Protection in Health
- Section 1.4: Components of HMIS

### 1.1.1 Various Risks An Individual Faces

As individuals, men and women alike, you are exposed to a range of risks. When these risks occur, you incur corresponding losses. These risks vary in degree or magnitude depending on the type of work you are engaged in, the setting where you work and the level of hazard attached to your work.

The term “risks” relate to the possible occurrence of a future event, usually an undesirable one, against which you must be protected. The exposure to risk is undoubtedly part of the human condition. Sources of risk are diverse, and all populations are susceptible to adverse shocks resulting from natural, health, social, economic, political, and environmental risks. Depending on the number of individuals or households that are simultaneously affected, risks are either idiosyncratic (individual) or covariate (aggregate). As the terms imply, idiosyncratic risks are those that occur when only one or a few individuals or households in a community suffer losses, whereas covariate shocks affect a large number of households, entire communities, regions within a country, or countries. Some of these risks may result from acts of nature, whereas others are caused by human activity. These risks are not evenly distributed among all men and women, hence people are equally exposed.

Certain individuals and groups have a much higher exposure to risk than others because of socio-demographic characteristics, economic status, physical or mental condition, age, lifestyle and so forth. Vulnerability is a state of high exposure to certain risks, combined with a reduced ability to protect or defend oneself against those risks and cope with their negative consequences.

Examples of risks occurring at the individual level include those associated with health, such as illness, disability, old age, death, or social shocks such as crime and domestic violence. Aggregate risks affecting large populations can include natural disasters (earthquakes, floods), health epidemics (HIV/AIDS), environmental calamities (pollution), political (Coup d’État) or economic (financial crisis) risks.

### 1.1.2 Sickness As A Risk

Sickness is a risk whose scope goes beyond health matters. An illness may imply a serious financial burden, it is not possible for you to know in advance the expenses you may need to pay or when you need to pay for such expenses. Sickness may cause lasting and sometimes irreversible damage to your health. It may incur major material losses. Sickness can lead to incapacity for work, either temporary or permanent, with consequent loss of earnings. Oftentimes, sickness also affects your significant others who will care for you. In Philippine society, it is usually women - mothers, grandmothers, sisters, daughters, daughters-in-law, aunts - who are expected to perform this role. Other than having additional responsibility, sometimes it also prevents them from performing their regular activities, including attending to their paid work.

(a) *Categories of Sickness Risk:* In financial terms, sickness risks are usually broken down into two categories:

- (a.1) *Major Risks:* These include the risks connected with serious illness and, more generally, complaints that require expensive care like hospitalization, surgery, and other specialist care. The probability that these events will occur is low but, when they do, the costs involved are beyond the means of most families. Few individuals are in a position to bear the full financial burden of such costly care, particularly if they have to seek the services of distant care providers.
- (a.2) *Minor Risks:* Minor risks relate to the lesser ailments that require less expensive care but which occur far more frequently than the major risks. This category includes, for example, nursing care and outpatient consultations.

You are well advised to protect yourself, in order to reduce this risk. In insurance, this risk associated with sickness is called the “sickness risk”. If you, as an individual are not insured, you may not be able to shoulder the expenses involved in your recovery, thus compounding the effect of the illness on your health.

(b) *Implications of Sickness:* Sickness implies financial costs or burden on your part and your family and it is usually the root cause of poverty. Sickness increases the financial burden of you and your family and its occurrence aggravates conditions of poverty. The financial as well as psychological burden of being sick or caring for a sick family member could further prevent you and your family from engaging in productive work.

(b.1) *Limited coverage:* The financial burden of your sickness is manifested by your capacity to access treatment. If you have limited means, your access to health care is reduced. Your non-coverage comes in different forms depending on the sources and level of your income as individual and your family.

(b.1.1) *Economic limitations:* This means your inability to afford health care expenses due to lack or insufficient income you have throughout the year.

(b.1.2) *Financial limitations:* This means that even if you have earned some income, it is not always regular, hence, you are limited due to this financial constraint:

- Temporary limitation occurs when your family does not immediately have the necessary means to pay sickness-related expenses, which consequently delays your seeking of care
- Partial limitation happens when you do not have enough means to pay for all the care and treatment required or prescribed
- Seasonal limitation exists when your income fluctuates over the year. For example, if you are in the rural area, your income is often concentrated only during one or several periods, corresponding to the time when you sell your crops. In this case, you encounter major difficulties during the rest of the year in paying health expenses, even for minor ailments. Men and women workers are not exempted from seasonal variations.

(b.2) *Poverty:* Sickness is frequently at the root of long-term poverty, particularly when:

- you or your spouse, who is the breadwinner dies or becomes disabled, for lack of care
- your family incurs a large debt to pay a substantial and urgent health care expense, usually to a moneylender, or sells an asset, notably a production tool, at a hugely reduced price

### 1.1.3 Vulnerabilities of men and women workers in the Informal Economy Workers to Risks

It has been mentioned that no one is exempt from risks, but those of you in the informal economy are most vulnerable to them given your unsuitable working conditions and poor situation.

(a) *Characteristics of Workers in the Informal Economy:* Given the very nature of your work as home-based workers, construction workers, market vendors, transportation workers, ambulant vendors, sari-sari store owners, small farmers, fisherfolks and forest dwellers, and

many others, it is understandable why you are more vulnerable to risks. As workers in the informal economy, you are generally economically poorer and are more frequently subjected to financial risk connected with illness. Majority of you frequently live “from hand to mouth” and cannot always devote part of your income to provident measures and actions for health and education. The non-regularity of your income and the seasonal fluctuations of your earning levels also limit your capacity to access health services on a regular basis.

- (b) *Working Conditions in the Informal Sector:* Your working conditions in the informal economy are generally characterized by poor welfare facilities, unsanitary and cluttered surroundings, lack of potable water supply and poor lighting. This is primarily true for you as home-based workers. Since your work is most often done near or within your homes, your entire family is also greatly exposed to the same risks of illness and accidents.

Those of you in the manufacturing and construction are exposed mainly to accidents. Fire or electric-related accidents were found highest among you who are working in restaurants, personal and household services as well as in food and beverage retailing. Machine-related accidents occur mainly in manufacturing, repair services, other trades and construction work. Accidents due to falls are mostly found in construction. In the agricultural sector, risks are often related to sudden changes in the season/climate and the threats of natural calamities and pests infestations.

For women like you in the informal economy, the working conditions aggravate your risks to illness or sickness. The type of work you are mostly engaged with (e.g. laundry washing and ironing, sewing, selling food or merchandize on the street and in the market) usually entails very long hours of work, thus exposing you more to suffer psychological and physical stress as you strive to balance your responsibilities both at work and at home (and in the community, such as volunteering as a barangay health worker or para-teacher).

Your working children on the other hand, are found in many work situations where they suffer working conditions similar to or even worse than you are exposed to as adults. These are characterized by long working hours, unhealthy environment and hazards in the workplace which stunt their growth and development.

#### 1.1.4 Increasing Magnitude of the Informal Economy

All over the world, there has been a significant increase in the number of people working in the informal economy while more formal enterprises have been subcontracting mostly their production and service requirements to you as external providers. Self-employment, casual or contractual arrangement or part-time jobs are now becoming the typical form of work arrangements, which is quite the opposite 15 or 20 years ago.

The trend towards flexibilisation of labour in response to competitive pressures on the global market has resulted in the growth of “atypical” or “non-standard” forms of employment such as part-time or home work. Home workers are vulnerable to exploitation and often excluded from the protection and benefits afforded by labour legislation.

In the Philippines, the proportion of people like you becoming self-employed, casualized and contracted for part-time or piece meal work is steadily growing for the past years. There are about 19.0 million workers like you now working in the informal economy, representing over 50% of total employment population. Women are highly represented among informal economy workers - especially in poorer segments, in worse conditions or at lower or no wages; they engage in such activities because of the need to combine

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family responsibility with jobs and because of the lack of other income-earning opportunities.

With this growing size of the informal economy, more and more people like you are being exposed to the above-mentioned risks. Hence, there is a need to parallel this increasing magnitude with the corresponding expansion and coverage of responsive social protection services.

### **1.1.5 Reasons for Social Protection Services**

There are significant reasons why social protection must be made available and accessible to those of you working in the informal economy and to the working population in general. Given the risks and vulnerabilities you face in your work, it is necessary that you should be covered with social protection schemes and have access to their services at the time you need them and at the cost you are able to afford.



## Section 1.2: Responding to Health-Related Risks

First, you must note that social protection is considered as your basic human right. It is a core need that must be made available to every worker like you in all society, whether you are working in the formal or informal sector. At the same time, the basic labor standards require that your welfare as workers must always be considered and that measures of protection should be made available to you regardless of the kind of work you are asked to do. If social protection is your basic human right and an integral component of the labor standards, then this must be provided for by the government and adhered to by the concerned enterprises you are working with.

Secondly, the absence of social protection makes you in the informal economy most vulnerable to any adverse condition that might occur in the course of your work. If as a worker, you are immobilized due to sickness, your productivity is reduced, resulting to a drop in your earnings, which in turn makes it more difficult for you to pay for health care and treatment. Social protection is essential to cushion you from the grave impact of these adverse conditions.

Third, the lack of social protection incurs higher cost on your part as workers. It has been shown that when you are not insured against illnesses or disasters, the cost you spent during this time of need is much higher than when you should have provided for these services in the first place. Social protection therefore is a cost-effective way of responding to your needs.

Lastly, the lack of social protection results to your reduced productivity, and thus delaying the overall economy of the country altogether. Providing social protection and ensuring your security as individuals are expected to bring about better productivity in the workplace and throughout the economy.

### 1.2.1 Social Protection in Health

There are different interpretations and definitions of the term “social protection.” Some define it to mean the sum of social security fund activities while others define it to be any activity of a social nature to constitute social protection.

This guide considers social protection to refer to the coverage provided by society or by an organization to its members, through a series of public measures for the following purposes:

- to compensate for loss or significant drop in earnings in a series of contingencies (examples are sickness, maternity, occupational accident or disease, invalidity, old age, death in the family breadwinner and unemployment)
- to provide health care
- to provide assistance to families with children

Social protection in health refers therefore to any coverage provided by any institution or organization to its members that addresses the health needs of its members and their families. This coverage may take various forms of health activities and services.

At this point, please take note that this guide is mainly concerned with the social protection in health and is focused to those in the informal economy.

### 1.2.2 Coping Mechanisms To Sickness Risks

It is known that you and your families cope with various risks differently. There are some of you who make use of traditional or usual mechanisms to cope with these risks. Others are engaged in pre-payment and insurance schemes when these events occur. You, as individuals and your families, have usually two alternatives for coping with sickness risks:

(1) You can either wait until a sickness occurs and then try to raise the necessary means to pay your health care expenses, or

(2) You can take steps to be ready to cope with such expenses before a sickness occurs

In the first one, you do not seek protection against the risk but simply deal with the financial repercussions at the time the sickness occurs. The uncertainty remains high whether you will be able to cope with the costs or not. Oftentimes, women who are tasked with taking care of the sick, are also burdened with borrowing money from creditors, because of the common perception that women are more likely to honour their promise of payment. In the second case, you anticipate the financial implications of sickness. It is possible for you to meet the costs of sickness more readily. It is a provident way of protecting yourself against the sickness risk.

In all societies, majority are averse to risk like you. It is for this reason that a number of people have developed provident mechanisms to protect themselves against risks. These mechanisms have been perfected over time, particularly with the development of insurance, which is the most effective instrument of protection against risks. The following shows you the different ways of coping with the sickness risks as individuals and as a group.

**Table 1.1: Different Ways of Coping with Sickness Risks**

Usual and Traditional Alternatives	Prepayment and Insurance Systems	Other Alternatives
<b>As Individual</b>		
<ul style="list-style-type: none"> <li>✓ Loan from a moneylender</li> <li>✓ Sale of assets (livestock, furniture, tools, jewellery,</li> <li>✓ Use of shop or workshop funds</li> <li>✓ Using credit not for its original purpose</li> <li>✓ House keeping – engage in laundry, ironing and other housekeeping services for other families or households</li> </ul>	<ul style="list-style-type: none"> <li>✓ Loan from a moneylender</li> <li>✓ Membership to prepayment mechanisms (without risk-pooling)               <ul style="list-style-type: none"> <li>• Saving/health credit</li> <li>• Health Subscription</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>✓ Traditional medicine</li> <li>✓ Self-medication, purchase of drugs from a shop or market</li> </ul>
<b>As A Group (collective)</b>		
<ul style="list-style-type: none"> <li>✓ Recourse to mutual aid and solidarity within the family or between friends/ neighbours: loans and/or gift</li> <li>✓ Participation in a mutual aid association</li> </ul>	<ul style="list-style-type: none"> <li>✓ Membership an insurance scheme               <ul style="list-style-type: none"> <li>• Social Security</li> <li>• Commercial Insurance</li> <li>• Not-for-profit Insurance</li> <li>• Health Micro Insurance</li> </ul> </li> </ul>	

### 1.2.3 Existing Schemes of Social Protection in Health

The Philippines has established national schemes on social protection designed for workers in the formal economy. Of these, two have programs that can cover health-related risks of the informal economy workers.

- (a) *Social Security System (SSS)*: This offers a comprehensive cash benefits as insurance for disability, maternity and sickness and provides benefits for retirement, old age and death. It



also offers low interest loans during calamity, emergency situation, housing and educational loans paid through salary deductions.

The SSS in 1995 has extended its membership to the informal sector under its self-employed and voluntary membership program. Under this scheme, the minimum monthly salary required to qualify as SSS member was lowered to Php 1,000. Definition of self-employed was expanded to include “all self-employed persons regardless of trade, business or occupation, with a monthly net income of at least Php 1,000.” It includes household help, individual farmers, fisherfolks and other small entrepreneurs wanting to join the scheme on a voluntary basis.

The monthly contribution to SSS is set at Php 84.00 and paying this amount regularly for at least 1 year entitles the member to sickness, maternity, disability, retirement and death benefits including service loans like salary, calamity, stock investment and special education loan. Enrolment to the self-employed scheme of SSS requires the submission of duly accomplished forms which include: (a) birth certificate, (b) business license/permit for single proprietor and professional regulations commission for professionals. These requirements are viewed to exclude those persons working with no clear employer-employee relationship and those self-employed with income less than Php 1,000 but whose businesses have not been registered with any government agencies.

- (b) *Philippine Health Insurance Corporation (PHIC or PhilHealth)*: The PHIC, established in 1995 is mandated to administer health care contributions and to develop a health insurance system that will ensure affordable, adequate and accessible health care services to all Filipinos. Medical services are obtained from accredited service providers and facilities and medical expenses are reimbursed using a ceiling of fees pegged according to the severity of illness suffered by members or qualified dependents.

PhilHealth, just like the SSS, has also created a mechanism to enrol the self-employed. This allows members in the informal economy to pay contributions in order to access health benefits. Two programs are found relevant to the informal sector: (a) the Individually Paying Program (IPP) and (b) the Indigent Program.

The IPP focuses on the self-employed and the informally employed. Individuals are required to pay Php 100.00 as monthly contribution regardless of income. This amount entitles them coverage for room and board, laboratory tests, medicines and doctor’s fees when confined in a hospital. The benefits though depend on the category or type of illness, type of hospitals and type of medical services received.

The Indigent Program (IP) on the other hand focuses on enrolling the poorest 25% of the population of each province or municipality. This program requires the consent and participation of the local government units (LGUs) who provide the counterpart contributions together with the national government. Aside from being entitled to the same benefits as members in the IPP, members can avail of the Out-Patient Benefit Package (OPB) from accredited Rural Health Units (RHUs).

Other agencies like the Employees Compensation Commission (ECC) or the Government Service Insurance System (GSIS) also offer social protection for health like insurance from accidents in the workplace for ECC and health benefits like maternity, disability and sickness for GSIS. However, both agencies do not have programs that would cover informal economy workers.

- (c) *Non-Conventional and Indigenous Mechanisms:* There are also other forms of social protection in health which consist of the non-formal, non-conventional and indigenous mechanisms that have evolved in communities, people's organizations, cooperatives and civil society groups. These schemes are rooted in the traditional forms of family and community support namely: the "bayanihan" and "damayan". In times of economic and social need, Filipinos traditionally seek help from their families, relatives, friends and community. Several efforts are being undertaken to institutionalize these schemes.

For health care, some schemes cover free check-ups and outpatient consultations. In some cooperatives, free medicines are given and partial reimbursements are also provided to help defray hospitalization, laboratory and surgical costs. There are some cooperatives with large base of members who maintain a small clinic and hire medical staff to render preventive and curative care. In a few cooperatives, dental care in the form of tooth extraction, oral prophylaxis and tooth filling are provided.

Under these schemes, more formal means of collecting premiums are established for a specific set of benefits. Examples of these are the Guimaras Insurance Program and the Organizing Resources for Education and Training (ORT) Health Plus Scheme (OHPS).

These non-conventional schemes have some advantages over the formal schemes. They offer more affordable premiums or contribution rates, they have more flexibility in the forms of payment, they have simple and straight forward procedures and benefit packages focused to what they really need.

### 1.2.4 Limitations of the Existing Schemes of Social Protection in Health

It must be noted that social protection in health emerged from the concern that majority of workers like you are beyond the scope and coverage of the institutional social security systems (e.g. PhilHealth, SSS, ECC, etc.). The large poor segment in the work force is unable to abide by the principle of contribution on a regular basis as required by these institutional-based security systems. There are more forms of limitations imposed by these formal schemes. The same is true for the non-conventional indigenous schemes. These limitations are discussed below:

- (a) *Limitations of Social Protection in Health in the Formal Economy:* The institution-based schemes have limited coverage. The SSS for example, excludes those workers with unclear employer-employee relationship and those self-employed earning less than Php 1,000. and those who have not registered their business with the appropriate government agencies. Secondly, SSS and Phil Health collection centers are found mostly in the cities. This is difficult for voluntary members who may have to go to distant locations to pay their contributions. In addition, these schemes are also weakened by the following factors:

- limited levels of security
- fragmented institutional framework
- lack of a comprehensive financial analysis
- low participation of workers in the informal economy due to:
  - absence of employer-employee relationship
  - low and unstable incomes
  - lack of awareness of social security rights
  - satisfaction with indigenous social schemes
  - complex policies and procedures
  - inappropriate and inadequate health benefits

- (b) *Limitations of Non-Conventional Indigenous Schemes:* The basic limitations of these schemes are the limited scope of support that can be provided by the families and friends and the unsustainable nature of the support. There is no assurance that help will always be available. Resources are also limited, inadequate and may not always be forthcoming. These informal schemes have certain advantages but they have also limitations. On the other hand, their limitations include the small size membership, their lack of technical expertise and lack of marketing and information dissemination activities.

In the Philippines, several groups have ventured into health micro-insurance scheme (HMIS) initiatives as a form of social protection in health. Because of the increasing cost of health care, the inaccessibility of health services, and the inability of individual workers to participate in the formal health insurance systems, many groups have begun to establish their own mechanisms to meet their health needs. HMIS are a promising alternative for overcoming barriers of access to health care in the informal economy.

## Section 1.3: Health Micro-Insurance Scheme As a Social Protection in Health

HMIS in the Philippines are viewed though as an interim arrangement in extending social protection to men and women in the informal economy until such time that they could be mainstreamed with that of the National Health Insurance Program (NHIP). Existing HMIS can be mainstreamed when they are made to function as an extension of the NHIP in terms of service provision, collection of fees or a complementation of services to be made available to the members. There is a great potential in the country for these local or community risk pooling schemes (e.g. HMIS) to be integrated with the national schemes into one system. Increasing therefore the capacity of HMIS helps to prepare them for this integrated set-up with the National Health Insurance Program (NHIP) which is managed by Phil Health.

### 1.3.1 Goal of Health Micro-Insurance Scheme

HMIS are aimed at women and men who are not reached by the formal health protection schemes or those set up by the government or offered by commercial companies. The goal of HMIS is to allow each member and their dependents to have access to quality health care. The HMIS are therefore intended above all to bring down financial and if necessary, geographical barriers hindering access to such care.

### 1.3.2 Forms of Health Micro-Insurance

HMIS cover a wide range of activities intended for the dis-advantaged groups not covered by mandatory health insurance and who do not have access to the usual commercial insurance. These are set-up to respond to different levels of risks and are operated by different actors like non-government organizations (NGOs), community organizations and other types of groups.

- (a) *Insurance supplied by care providers:* A health center or hospital may suggest that potential users pay a contribution entitling them to care, either free of charge or at a reduced cost. Usually the members of this scheme are not involved in managing the system.
- (b) *Health insurance schemes provided by micro-finance institutions:* This form offers their members supplementary services such as life insurance or an emergency health fund.
- (c) *Mutual Health Pharmacies:* These are managed by non-profit-making organizations that favour members who contribute to a mutual fund. In general they mainly deal in essential

generic medicines. In the Philippines, several groups have set up community-managed pharmacies or “*botika sa barangay*” to respond to the need for quality medicines at an affordable cost.

- (d) *Other forms of not-for-profit insurance:* This may involve, for example, a transportation insurance operated by a group which owns an ambulance. Membership is either voluntary or compulsory (the contribution in the latter case is collected in the form of a tax), and the funds collected ensure free or reduced-price service for emergency transportation. The purpose is to finance the operating cost of the vehicle.

### 1.3.3 Advantages of HMIS

The advantages of an insurance system for its beneficiaries are:

- (a) *Greater security in the event of sickness for members and their dependents:* By paying an amount that is known in advance and on a planned basis (daily, weekly, etc.), your members will not have to assume exceptional expenses which may be very high when unforeseen situations arise.
- (b) *Better continuity of treatment:* The number of recourse to care during the period covered is not limited or confined to a single period of sickness, and your beneficiary enjoys greater facility of access to necessary care.
- (c) *Reduction of delay in seeking care:* Your members benefit from free care or with slightly reduced prices. Access to care is therefore not anymore or fairly less delayed while your affected member raises the necessary funds.
- (d) *Reduction of financial limitations:* The forms of limited coverage connected with lack of money at the time of sickness are reduced because the sums to be paid for care are small or non-existent. Your member is assured of access to health services even during periods of greatest financial hardship (low cash season, festivities and ceremonies, etc).
- (e) *Reduction of parallel practices:* Your member is informed of the share of the health care bill that they will eventually be required to pay to the health center or hospital. Consequently, relations with the health care provider are more transparent and there are fewer possibilities of parallel practices (unlawful receipt of money by health staff).

### 1.3.4 Characteristics of a HMIS

Majority of HMIS in the Philippines for the informal economy workers, are programs of existing cooperatives, people’s organizations (POs), mutual organizations and NGOs which have mobilized their group’s resources to set up a their own schemes. Most of these have included health services as part of the package of social protection benefits they provide to their members. The following are the basic features of an HMIS. You can verify if your HMIS possesses the following characteristics or if you are planning to set-up one, ensure that it should have the following features:

- (a) *The HMIS Has An “Insurance Function”:* One of the basic features of HMIS is it functions as an insurance. This means that your members obtain a guarantee from your HMIS that they will receive financial reimbursement, or that they will be covered, should the sickness risk occur.
- (b) *Financial Participation:* The members or beneficiaries of your HMIS pay their contributions,

at least in part to finance the benefits they get from your HMIS.

- (c) *Non-Compulsary Membership:* The beneficiaries of your HMIS are insured on a voluntary or automatic basis. This means that your members were not coerced to join. Their participation or membership is not compulsory. In some HMIS, the membership becomes automatic. This is true for example, for individuals working in an organization or is a member of an association that is already enrolled in an HMIS as a whole group.
- (d) *Non-Coverage From Social Security:* Your beneficiaries are in part or at least individuals who are excluded from the national social security system or whose earnings are below the poverty threshold that are fixed nationally. Though this should not limit your organization from accepting members who are also members of a national social security scheme.
- (e) *Involvement of Beneficiaries in the Management:* The members or beneficiaries of your HMIS are involved or participate in the management of your insurance scheme, or at least in the selection of health services to be covered.
- (f) *Complement to Formal Social Security Systems:* Some HMIS are established to complement the formal social protection schemes. It means that your HMIS are those not usually covered by these formal institution-based mechanisms. Note however that there are also some HMIS which have been established by some organizations in lieu of these schemes. For example, some organizations are still hesitant to participate in PhilHealth or SSS for a variety of reasons. In short, they cover and offer services which are also provided by the formal sector. Caution should be taken though in going to a similar path, reasons for not participating in the national schemes should be carefully evaluated and weighed.
- (g) *Legal Personality:* Your HMIS is usually operated by a non-profit voluntary association of people, operating on the basis of solidarity among all members. Through your members' contributions, and according to their decisions, your HMIS provides insurance, mutual aid and solidarity measures to insure them against the risk related to illness, bear the consequences and promote health. It is important however that your HMIS must have a legal personality. This means that it should either be registered in the Securities and Exchange Commission (SEC) or under the Cooperative Development Authority (CDA). Having a legal personality means that your HMIS is licensed to operate, allowed to enter into a Memorandum of Agreement (MOA) with concerned entities and that it can collect and accept financial contributions as an organization.

### 1.3.5 Basic Principles of a Health Micro-Insurance Scheme

The following are the basic principles which you must observe in establishing and operating your HMIS.

- (a) **Solidarity:** Your HMIS must be rooted on solidarity, or the spirit of “bayanihan” or “damayan”. Your membership is neither compulsory nor dependent on the state of health of your future members. Through solidarity, the members of your HMIS express their desire to deal with their problems themselves by assisting each other. Their contributions signify the principle of mutual assistance and solidarity within the organization. This means that your members who are in good health and accept that their contributions are used to cover the expenses of other members who are ill. It entails pooling of these risks among themselves. On the other hand, solidarity also means that your individual member who fails to give his/her regular contributions cannot receive benefits from the scheme. Solidarity means the willingness of your members to



contribute and that they allow their contributions to be pooled together in response to risks that anyone of them might encounter.

- (b) **Democratic and Participative Operation:** In your HMIS, everybody must be free to join without racial, ethnic, sexual, religious, social or political discrimination. All your members should have the same rights and duties. These include the right to participate, directly or indirectly in the decision-making process. Participative democracy in your HMIS is evidenced by your formation of organizational structures or bodies which allow your members to participate in decision-making and in controlling your HMIS operations. Your members therefore have to be made fully aware of their duties and responsibilities. This can be done through appropriate training, supported by clear, complete and readily understandable information.
- (c) **Autonomy and Freedom:** Autonomy as a principle in your HMIS means that any public authority or any other party (political or religious groups, service providers) should not interfere in your management and decision-making process as an organization. It does not mean though that your HMIS is not subject to laws and regulations. Your HMIS should comply with these national laws and regulations but it should not allow its decisions and programs to be dictated upon by politicians, businesses or other groups with strong influence. Freedom, on the other hand, means that your members are free to decide what services your HMIS should offer or that they have the flexibility to modify them according to what they most need. This right usually leads to more efficient use of your resources.
- (d) **Personal Fulfilment:** In addition, your HMIS must espouse respect for the dignity of your individual members regardless of gender, race, ethnic or social origin. As an HMIS, you must encourage your members to become truly socially committed to the sick and the most destitute.
- (e) **Service-Oriented:** Your HMIS should devote its time to serving your members and not in making profit. It does not mean though that covering for operating expenses is not allowed in your HMIS. The extra income that your HMIS earned over expenditure can be used to improve your existing services, or to meet the other needs of your members.
- (f) **Responsibility:** While your HMIS emphasizes solidarity, autonomy and participative democracy, it equally underscores the importance of responsibility. All the rest of principles will come to nothing if your members and leaders are not mindful on the way they use your HMIS resources or do not respect the decisions which you have collectively agreed-upon.
- (g) **Dynamics of a Social Movement:** Your members are characterized to be pro-active, not passive. They must become committed to an individual and collective development process and that your members are group of individuals who seek to defend the common good and common interests of all.
- (h) **Quality Preventive and Curative Health Services:** Your HMIS shall endeavour to provide both preventive and curative health services to your members. You must understand that enhancing preventive health services becomes more beneficial to your individual members and whole organization in the long run. Your HMIS must be able to balance the provision of this mix of services. Over and above this, your HMIS shall always strive to maintain high quality of these services.
- (i) **Sustainable Operations:** You must be mindful of ensuring not only the viability of your HMIS but also its sustainability over time. It is therefore necessary for your HMIS to put in place the appropriate management structure, develop capabilities of its leaders and members, institutionalize essential support systems, and generate the needed resources to continuously

run and adequately maintain its operations.

- (j) **Rights-Based Approach:** Your HMIS must always regard the need and right of your members. As mentioned earlier, your membership must be opened to anyone regardless of race, gender, age or state of health. Each and everyone has the right to participate. Your organizational structure must be set-up to allow all your members to have their opinions and voice heard and participate in deciding the affairs of your HMIS. They also have the right to correct information, hence the need for you to set up mechanisms that they are regularly updated and informed of the developments in your HMIS. Quality health care is a basic human right. You must ensure that your members receive the quality of care they deserve.
- (k) **Gender-Sensitivity:** Your HMIS must not discriminate anyone regardless of their gender and sexual orientation. It must adjust its services to meet both needs of men and women alike. Vulnerable groups like women and children as beneficiaries of your HMIS must be given due attention. Leadership must be equitably shared among male and female members in your groups. Opinions from male and female members must be considered equally and should be sought with the same degree.

As a scheme of social protection in health, your HMIS must have (a) the appropriate organizational structure, (b) the general membership who pool their resources to respond to their health needs, and (c) the right mix or package of services available to its members. More importantly, it should have the management systems well in place in support to these components.

## Section 1.4: Components of a HMIS

### 1.4.1 Organizational Structure

Your HMIS involves the tripartite partnership of your members, service providers and the managers/operators of the scheme. There are different organizational arrangements that can be set up but you must decide which structures are best suited to your particular situation or need.

Usually, an HMIS is structured into four essential bodies. You don't have to create all four structures. You may opt to combine duties and responsibilities into one unit only, if you think this is the best structure for your HMIS to be managed and ran.

- General Assembly (GA)
- Board of Directors (BD)
- Executive Body (EB)
- Auditing Body (AB)

In the Philippines where most cooperatives or mutual organization manage health micro-insurance schemes, additional responsibilities are usually given to existing committees in the organization to oversee the operations and management of the HMIS.

Note that these structures are discussed in more detail in the subsequent chapter. What is presented here are their general functions and competencies.

- (a) **General Assembly (GA) :** This is the highest decision-making body of your HMIS. It is the general membership of your HMIS. It determines the general policy of your whole HMIS and its decision is binding on all your members. It is usually convened at least once a year to approve annual accounts and the budget or new programs that will be undertaken or new benefits that will be given to all the members of the scheme or organization.

- (b) *Board of Directors (BD)*: The BD is the policy-making body and is responsible for the overall management of your HMIS. It exercises all the responsibilities apart from those explicitly assigned by the law or your own By-Laws or Constitution. Your BD constantly monitors the management of the organization. It may delegate part of its responsibilities to the chair or more administrators. But it generally proposes the admission and exclusion of your members to the GA.
- (c) *The Executive Body (EB)*: This is usually established by the BD and is responsible for implementing the decisions of the GA and the BD. It is in-charge of the day-to-day management of your HMIS. In certain cases, especially in smaller organizations, the EB may come from the BD itself. If your HMIS is large enough, the EB staff are hired and are salaried. The Chair usually becomes a member of the BD to be able to regularly update and inform them of what is happening to the organization. The EB are called differently in the Philippines. Some refer to it as the Project Management Staff. Others call it as the Executive Committee or the Management Committee.
- (d) *The Auditing Body (AB)*: The AB is usually elected by the GA. Its purpose is to monitor the implementation of the decisions of the GA. Based on the results of their monitoring, the AB can recommend ways to improve the operations and management of your HMIS to ensure more effective functioning and efficient operations. In cooperatives, the AB is called the Audit and Inventory Committee while others call it as the Monitoring and Evaluation Committee.

The following tables summarize the major functions and competencies of the above mentioned structures of your HMIS.

The overall structure of your HMIS depends largely on the size of your members and its geographical coverage. If your HMIS operates only within a given district or a city where your members reside, then your structure may be limited only to one level. Whereas if your membership extends region-wide or nation-wide, then it may be necessary for you to establish organizational structures at two levels or more.

A regional body, if it is formed, can provide several services to your HMIS like advisory support, technical assistance, financial services or a guarantee fund, representation services and promotion services.

You must take note that your HMIS may create additional committees to help carry out its programs and activities. Some HMIS may need to create separate structures like:

- Medical or Therapeutic Committee
- Grievance or Complaints Committee
- Quality in Health Committee

In determining the composition of these different structures, you should ensure that apart from their interest, commitment and competency, there should be a good mix of women and men that ensures substantive representation of the needs and interests according to gender, occupational groups, ethnic identities, age groups, and other similar categories.

### 1.4.2 Beneficiaries

(a) *Definitions*: A “beneficiary” refers to individuals who have the right to your HMIS benefits. Beneficiaries include both your members and their dependents. A “member” refers to the one who joins your HMIS, who pays the membership fees, undertakes to observe the rights and duties and pay contributions. He/she is sometimes called the “policy holder.” In your HMIS, anybody may join the



organization if he/she has attained the minimum required age, without discrimination of any kind by reason of state of health, sex, race, ethnic origin, religion, philosophical or political views, provided that they observe the By-Laws and the Policies, Systems and Procedures (PSPs) and regularly pay their contributions.

“*Dependents*,” on the other hand, refers to individuals who are directly dependent on your policy holder or member with whom the right of HMIS benefits are extended. The dependents may include the spouse, children up to certain age and orphans who have been officially fostered. Family members however may not be considered dependents unless they are indeed financially dependent upon the policy member. If a child becomes a wage earner herself/himself, then he/she is no longer considered a dependent but must become a policy holder himself/herself.

There are cases where it is difficult to determine the “dependents of a policy holder.” Examples are young unmarried persons who continue to live with the policy holder, the parents of the policy holders or the second wife in a polygamous relationship. This suggests that extra care must be exerted to define clearly the parameters that the HMIS considers as qualified “dependents.”

- (b) *Categories of Members:* Though in principle, membership to your HMIS is not conditional to the state of health of your individual members, your HMIS must take a conscious effort to consider memberships of the older persons, those who are chronically ill or sick individuals or HIV carriers, as they cause financial imbalance especially at the start of your HMIS operations.

Some HMIS have addressed the “older persons” issue by setting a certain age limit for participation, or requiring a higher amount of first time contribution from members enrolling for the first time over a given age. For those with chronic diseases, you must really need to strike a balance between supporting those who are most in need and the survival of your HMIS. Some ways for you to address the issue of your members with chronic diseases are:

- offer payment of drugs only
- set a ceiling of benefits to each beneficiary monthly or yearly
- cover hospitalization only in the acute phase
- set an annual flat rate for each type of disease
- establish an action fund separate from the main fund

- (c) *Membership Fees:* With regards to membership fees, ensure that your GA incorporates into your HMIS By- Laws a provision for the payment of membership fees upon registration of a member, and that the fees can be changed periodically. Note that the membership fee is used primarily to cover the cost of the registration process. Thus, it is supposed to be paid only once - at the time the individual joins your HMIS. It is therefore not payable in subsequent years. There are times though that your membership fees may be replaced by the sale of your membership card or book, which is usually more preferred by most members. There are only two possible occasions for more than one-time payment of membership fees. The first is when your membership fee is replaced by the sale of your membership card - the card is purchased at each renewal. The second opportunity is when the HMIS requires the membership fee to be paid again by those who have stopped paying their contributions after a period of over a year or so.

- (d) *Membership Contributions:* Your members’ contributions are the main source of income of your HMIS.

These should be sufficient to allow your organization to:

- (1) grant benefits to your members
- (2) finance its operations
- (3) build reserves in order to reinforce its financial soundness from one financial year to the next

There are also 4 possible systems for paying the contributions:

- (1) your policy holder and his/her dependents each pay the same contributions
- (2) dependents pay a lower contribution than your members
- (3) two contributions rates are applied with or without dependents
- (4) a single contribution is paid, regardless of the number of dependents

The payment system is the decision of your GA and is usually incorporated in the by-laws. The GA can also decide to add a special contribution (e.g. for AIDS), if it is so desires.

(e) *Membership Card*: The membership card serves two purposes: (a) to identify your member and the other beneficiaries; and (b) serves as evidence that your member and his/her dependents, listed on the card, are entitled to your HMIS benefits. This card may take different forms. It may be a family card, or an individual card (one card per person) or it may take the form of a health record which contains several blank pages on which the health care providers record their procedures and prescriptions. Each card, whatever form it may be, must contain the following information.

- the first name and the surname of each beneficiary (this means your member and his/her beneficiary/ies)

**Table 1.2: Model Organization Chart of an HMIS**

FUNCTIONS	HMIS BODIES
General Policy	General Assembly (GA)
Control and Audit	Auditing Body (AB)
Management	Board of Directors (BD)
Execution	Executive Body

**Table 1.3: Competencies of the HMIS Bodies**

Competences	GA	BD	EB	AB
1. Adopts and amends by laws	X			
2. Controls the accuracy of accounting and correct handling of financial operations				X
3. Fixes the amount of contributions and of any special payments	X			
4. Decides on criteria for acceptance or rejection of HMIS members	X			
5. Monitors compliance with the HMIS policies, systems and procedures				X
6. Coordinates the work of the different committees		X		
7. Deals with day-by-day HMIS administration			X	
8. Manages the HMIS assets and funds			X	
9. Draws up annual accounts and budget for the next accounting period		X		

- each beneficiary's date of birth
  - a family or individual code number which allows the possible tracking of each individual through health care billing or monitoring tools. This number is noted in the register of your members and the code may include other components like the village, group or region where your member belongs
  - an indication that the contribution has been paid, usually in a form of a stamp, to show that your member's contribution is up to date
- (f) *Membership Qualification and Application:* Anyone who has reached a minimum age established by the GA and who respects the By-Laws and the PSPs, may apply to become a member of your HMIS. In terms of joining, ensure that each applicant or enrollee undergoes the following:
- (f.1) *Membership Application:* Ask the individual to apply in writing by accomplishing the membership form containing the basic information about him/her and his/her dependents. This is submitted to the GA but is often delegated to the EB.
  - (f.2) *Payment of Membership Fee and Contribution:* Once his/her application is accepted, ask him/her to pay the membership fee and the contribution for the corresponding period.
  - (f.3) *Entry on the Registry of Members:* Ensure that you enter on the Register of Members every new member of your HMIS, and issue to them their membership cards indicating the date when they become eligible to the benefits.
  - (f.4) *Information to the Member on the Policies and Internal Rules:* Upon enrolment, give each applicant a full orientation about your HMIS, By-Laws and PSPs as well as their rights and duties as members. You can support or aid this orientation with flyers containing these rules and policies.
- (g) *Probationary Period:* The new member is usually asked to observe a probationary period established by your organization before becoming entitled to your HMIS benefits. This probationary period refers to the phase in which your new member pays contributions but is not yet entitled to your HMIS benefits. It is otherwise known as the observation period or the waiting stage. Its purpose is twofold: to ensure that people do not join only when they are ill, and to allow your HMIS to build up its financial reserves to cover the costs of benefits to your members. Your new member must respect a waiting period before receiving benefits.

### 1.4.3 Services

The services offered by your HMIS should correspond to the needs felt and expressed by your target membership. It is essential that the services you offer are matched with their needs, from the time you are still starting your HMIS and throughout its operations over time. You need to regularly evaluate though these services if they continue to be relevant and appropriate to your members' needs and if they are delivered in satisfactory manner.

- (a) *Choosing the Services to be Offered:* The services provided to your beneficiaries are the reason for the existence of your HMIS. It is important that your scheme meets the needs of your beneficiaries, taking into account their ability to contribute and the existence of an adequate supply of care. You must note however, that for each new service your HMIS offers, the contribution of your members may have to be increased. It is therefore advisable for you to strike a balance between the services that meet the needs of your members as closely as

possible, and on the other, the need to fix a contribution level which is accessible to your members.

There are two approaches in identifying the services which your HMIS can offer to your members.

*Option 1:* Take the available earnings of your HMIS as the basis and establish the corresponding services

*Option 2:* Identify the priority needs of your members and assess the level of contributions necessary to meet those needs.

If your HMIS is constrained more by the low income of your potential members, then it may be better for you to:

- (1) fix a contribution amount that is accessible to your target membership
- (2) estimate the number of your potential members and the expected annual income from them
- (3) determine the priority services that can be financed by the financial resources available in your HMIS

If on the other hand, the income constraint is less pressing in your HMIS, then it is advisable that you:

- (1) assess first the priority needs of your members;
- (2) calculate the volume of resources that are needed; and
- (3) fix the contribution at a level that will bring in the necessary amount

Note that whatever option your HMIS takes, this will entail a lengthy procedure. Hence, there is a need for you to come up with several scenarios. The ultimate decision should be taken by your GA. One important thing though that you have to bear in mind – is that it is always advisable for you to offer initially a limited number of services. Once your HMIS has gained some experience and that its management system is already in place and fully functioning, then you can expand the number of services to offer.

(b) *Type of Care That The HMIS May Cover:* Generally, it is not possible for your HMIS to cover all health care from the start-up activities. Only part of the care can be taken into consideration, such as primary healthcare, secondary or specialist care, medicines, transport or other social risks. The following gives you examples of health care that your HMIS can cover:

(b.1) *Basic Health Care:* This package of services is the most common type of care that is usually provided by the health centers or Rural Health Units (RHU), which is the first point of contact between the target membership and the health care system. This package includes:

- preventive and promotional care including pre-natal and post-natal consultations, monitoring of infants' health, vaccination, family planning, health education and counselling

- curative care which primarily includes consultations, nursing care, supply of drugs and some laboratory analysis; sometimes it also includes minor hospitalization in health centers or assisted childbirth
- coverage of chronic diseases like diabetes, high blood pressure, haemophilia, heart diseases, etc.
- coverage of treatment of children suffering from malnutrition and their recovery

(b.2) *Hospital Care*: This covers both accommodation in the hospital and medical, surgical and technical procedures and drugs consumed.

(b.3) *Specialized Care*: This includes consultations (gynaecology, obstetrics, surgery) and technical medical treatment such as radiology and clinical biology.

(b.4) *Dental Care*: Some HMIS reimburse dental expenses, usually tooth extraction, sealant and prophylaxis.

(b.5) *Spectacles*: There are some HMIS that reimburse the cost of spectacles if they are issued as part of the medical prescription. Most often, the coverage is confined to prescribed lenses and the frames are not covered.

(b.6) *Medicines*: As far as medicines are concerned, it is important that you list those that will be reimbursed by your HMIS. Given the disparity of prices between branded (proprietary) medicines and generic medicines, it is advisable that you only reimburse the generic medicines if they are available, or the corresponding proprietary medicines on the basis of the price of the generic medicines. You can base the list of proprietary medicines to be covered by your HMIS on those listed in the National Drugs Formulary produced by the Department of Health. Ideally, the medicines should be delivered by the health centers. If this is not possible, the medicines on your list may only be reimbursed if they have been prescribed. In this case, possible abuse is more difficult to counteract.

(b.7) *Transportation of Patients*: In addition to meeting the cost of healthcare, your HMIS may organize and take responsibility for transporting beneficiaries who are ill to a health center or for transferring them to the nearest hospital, in accordance with a referral system (patient transferred to hospital after consulting a health centre).

(b.8) *Other Social Risks*: Some HMIS also cover other social risks to which their beneficiaries are exposed. Your HMIS may grant lump sum allowances (indemnities) on the occurrence of certain events such as giving birth or marriage. Other social risks that your HMIS may cover include the following:

- incapacity to work following illness or accident (daily allowance)
- invalidity (periodic pension)
- old age (pension allowance)
- death (allowance and funeral services)

(c) *Partial Coverage of Health Expenses*: Your HMIS has the option to cover fully or in part the expenses incurred by your members. You may grant benefits in the form of flat rate, for example the transportation of patients. The following are options for applying partial coverage:

*Option 1: Percentage Co-Payment*: This means that you deduct part of the total health expense from the amount reimbursed to the member.

*Option 2: Flat Rate Co-Payment* – In this second option, your HMIS only covers the amount above the pre-determined amount. This is usually applied to certain types of services provided.

*Option 3: Ceiling of Benefits (or guarantee)*- In this option, your HMIS sets a limit/ceiling of its coverage to a maximum amount for a particular event. This means that the member will be the one to shoulder any cost beyond the set ceiling. This protects the HMIS from exceptionally high expensive cases.

**Example: Percentage Co-Payment**

If your HMIS shoulders 80% of total expenses in the amount of Php 20,000., or the equivalent amount of Php 16,000, then your member will pay the other 20% or the remaining Php 10,000. This means that the co-payment by your HMIS is 80%. It is expressed in terms of percentage.

Total Expenses Incurred	:	Php 20,000.
Set Percentage of 80%	:	Php 16,000. (to be paid by the HMIS)
Remaining Balance	:	Php 4,000 (to be paid by the member)

**Example: Flat Rate Co-Payment**

If a member incurred a total cost of Php 20,000. for his/her hospitalization and that the predetermined amount is set at Php 8,000., then the HMIS will only pay the amount above Php 8,000, which in this case is Php 12,000. If the member only incurred Php 6,000 for his/her hospitalization, then the HMIS will not pay anything because the pre-determined rate is still higher than the actual cost incurred.

Total Expenses Incurred	:	Php 20,000.
Pre-determined Amount	:	Php 8,000.
Amount Paid by the HMIS	:	Php 12,000.

**Example Ceiling Benefit of Guarantee**

For example, if the ceiling set to be paid by the HMIS is set at Php 12,000, and the member actually incurred a total amount of Php 20,000, then the member will have to pay the balance of Php 8,000.

Total Expenses Incurred	:	Php 20,000.
Ceiling Set by the HMIS	:	Php 12,000.
Balance to be paid by member:	:	Php 8,000.



(d) *Granting of Benefits to Members:* There are two ways by which you can grant the benefits to your members. This is either through the service provider or third party contracted by your HMIS or delivered by the health facility you established on your own.

(d.1) *Providers Based on a Contractual Agreement with the HMIS:* In this first scheme, there are three parties involved in the payment: your member, your HMIS, and the service provider or third party you contracted. Granting the benefits under this scheme works this way:

(d.1.1) *Payment by Members:* Your member pays in full the service provider and is subsequently reimbursed by your HMIS. In this case, your member pays according to the mechanism set by the service provider (e.g. fee-for service, case payment or flat rate payment) or arrangements agreed upon with the HMIS. This means that your member must obtain proofs of payment (receipts or invoice) from the provider and bring these to the HMIS for reimbursement.

This scheme is not so good for the members as they need to put up front the whole amount to be paid. Its advantage for the HMIS is that it discourages over consumption and abuse of the system for fraudulent billing. This however requires more paper work on the part of your HMIS, hence a higher administrative cost.

(d.1.2) *Direct Payment by the HMIS:* Your HMIS pays the provider directly. In this scheme, you require your member only to pay the co-payment to the provider. Your HMIS pays the remainder of the total bills to the provider directly upon presentation of invoice by the provider.

This scheme is more advantageous for your members since they do not have to make financial resources available and that they are spared from additional formalities and delays in receiving the reimbursement. Your HMIS may have less control through of the service consumed by the members, thus, it may result to over consumption of services and escalating costs.

Sometimes, the two schemes of granting benefits can be combined by having your member pay the third party for minor expenses while your HMIS pays the service provider for major expenses.

(d.1.3) *Capitation Scheme:* Another way of paying for health services rendered to your members is through the capitation scheme. This requires your HMIS to guarantee a fixed amount to your partner health care provider (e.g. hospital, clinic, etc.) in a given period, usually annually corresponding to the number of your eligible members. During the period, anyone of your eligible members could avail of the services from your partner service provider depending on the terms and conditions agreed upon in your HMIS. The costs of health care are charged to the capitation fee, hence your members do not shell out cash for the services they availed of (except of course for those services not covered by the HMIS). During the year, it is expected that the capitation fund is used up but at other times, it redounds to additional income for the service providers..

This scheme lessens administrative cost and at the same time reduces financial burden on your members.

This capitation scheme is currently practised by the ORT- Health Plus Scheme in San Fernando, La Union. The ORT-OHPS pays the partner hospital – the Ilocos Training and Regional Medical Center a certain amount at the start of the year corresponding to their eligible number of members. The list of eligible members is provided by the ORT-OHPS to the hospital at the time they release the capitation fee. When an eligible member gets sick and becomes hospitalized, the hospital confirms with the ORT-OHPS staff the eligibility of the member. If confirmed positive, the cost is charged to the capitation fund. At other times, the sick member goes to the ORT-HPS first and then is referred and endorsed direct to the health provider.

*(d.2) Services Provided by Health Infrastructure Established by the HMIS:*

The health facilities established by your HMIS provide the services to your members, including non-members alike. Members are given preferential rates over the non-members. It is always advisable that your HMIS observe separate accounting from its established health facility in the interest of good organization and transparency.

There are several means by which benefits are granted to your members through the health centers/RHUs or hospitals established by your own HMIS.

- Members are covered 100% once the probationary period has been completed. In this case, benefits are provided upon presentation of the membership card to the health facility
- Only consultation is free and care and drugs consumed must be paid for by the members
- A flat-rate co-payment is paid by your member for each consultation or procedure.
- Your HMIS applies a percentage co-payment, in which case the member pays a given percentage of the full cost of consultations, care and technical procedures.

In the dispensaries set up by your HMIS, the sale of generic drugs is encouraged. Only when there is no alternative that specialist drugs are provided. In this scheme, you give preferential rates to your members while the non-members may purchase drugs at the market price. A larger reduction may also be granted for generic drugs to encourage their consumption over that of brand name drugs. As additional information in the management or operation of a community pharmacy or “botika sa barangay”, you may coordinate with the regional offices of the Department of Health or through the Municipal Health Office of your Local Government Unit. Information on legalities of its operations, how to coordinate with other groups in purchasing medicines to get a more



affordable rate, management of inventory and the like should be gathered.

#### 1.4.4 Management of Major Risks Connected to Health Insurance

All HMIS are faced with certain risks. In this regard, you must take particular preventive measures so that the feasibility of your HMIS is not compromised. The following are the major risks facing any HMIS wishing to offer its services to their target membership as a whole without discrimination:

- the risk of ‘adverse selection’ or spontaneous pre- selection
- the moral hazard of over-consumption
- the moral hazard of over-prescription
- fraud and abuse
- the occurrence of ‘catastrophic’ cases

(a) *Risk of Adverse Selection:* Adverse selection relates to situations where people with a high risk connected to their state of health join your HMIS in large numbers, and when people in good health tend to refrain from joining. This may compromise the financial viability of your HMIS, since it involves too high a level of expenditure per beneficiary. Unlike a commercial private insurance scheme, your HMIS cannot select its beneficiaries or make each of them pay premiums corresponding to their personal risk. There are different ways to minimize this risk:

- (a.1) your HMIS demands that the **minimum unit** of admission should be the family
- (a.2) in setting up your HMIS, it is advisable for you to enrol all the members of a particular group simultaneously (e.g., members of a company, trade union, group, association or religious community)
- (a.3) You may also provide for a **waiting period** or a probationary period. This period is necessary to prevent certain people joining only when they need to, and then opting out afterwards (e.g. membership in anticipation of giving birth).

(b) *Moral Hazard of Over-Consumption:* The moral hazard is the situation often observed when your members or their dependents tend to abuse the services offered, or use them more than they normally would from the time they are insured. The fact that the contribution is independent of the amount of expenditure met, it encourages individuals to consume a maximum of care to make their contributions worthwhile. The following measures can be taken to reduce this risk:

- (b.1) *Patient’s Contribution:* You may establish a cost-sharing scheme between your HMIS and members (for example, the member to pay the remainder over the threshold set for reimbursable cost).
- (b.2) *Establishment of an obligatory reference system:* This entails your HMIS determining the conditions of access to a higher-level of care, which is often more costly. You may require your beneficiaries not to go to the hospital until they have

consulted a general practitioner in a health center, where services rendered are less costly.

- (b.3) *Establishment of an observation or probationary period:* You may demand, particularly in the case of monthly contributions, your members to contribute for a probationary period first (three or six months, for example) before being entitled to the benefits offered.

(c) *Moral Hazard of Over-Prescription:* Care providers may cause a sudden increase in healthcare costs by prescribing unnecessary treatment without objection from the member-patient simply because they are insured. The following measures may help to minimize this risk:

- (c.1) Payment on the basis of a **lump sum or flat rate** per person or per episode of illness
- (c.2) Standardization of treatment schemes and control by your HMIS' medical adviser
- (c.3) Obliging providers to prescribe **generic essential medicines** or limiting the reimbursement of certain medicines included in the list drawn up by your HMIS
- (c.4) Establishment of **benefit ceilings**. Your HMIS may, for example, decide only to cover a limited number of days in hospital, the remainder being your member's responsibility
- (c.5) Establishment of **non-reimbursable days or of flat-rate co-payment** for hospitalization (example, the first day of hospitalisation can be paid for by the patient to avoid non-essential hospitalization)
- (c.6) Requiring your members and their dependents to adhere to the available **preventive measures** like vaccination in order to reduce the risk

(d) *Fraud and Abuse:* Your HMIS is exposed to risks of fraud and abuse by your members, particularly when it reaches a significant size. Fraud and abuse are often a result of the pressure that can be exerted on a member by their family, circle of friends or neighbours. Your members may also make a selection within their family by not paying contributions for all their children. For example, when one in the family who is not covered falls ill, there will be a great temptation to pass them off to the service provider as one of those included on the membership card. The following measures can be taken to combat this risk:

- (d.1) *Ensure that a check is made before treatment is administered:* Before being attended for treatment, your beneficiary should appear first before the administrator of your HMIS, who provide a Certificate of Entitlement;
- (d.2) *Ensure that a check is made after treatment is administered:* You should check whether the members for whom the providers issue an invoice for treatment are really ill during the period concerned. Fraud is not avoided, but it can be remedied and punished

- 
- (d.3) *Affix an identity photograph of the member and their dependents on the membership card:* This solution is often costly however, and may limit membership.
  - (e) *Occurrence of ‘Catastrophic’ Cases:* This concerns HMIS that cover major risks, without setting a ceiling on meeting the cost. It occurs basically when your HMIS begins its activities: if exceptionally high health expenditure occurs at this time, your HMIS will very rapidly experience a financial crisis.
    - (e.1) The first response to this risk is to establish substantial financial reserves. Hence, the application of a waiting period before meeting the cost of health expenditure is very critical.
    - (e.2) Access to a guarantee fund or the possibility of reinsurance.





Reference Guide and Tools on Health  
Micro-Insurance Schemes in the Philippines

# Setting Up a Health Micro-Insurance Scheme



STRATEGIES & TOOLS  
AGAINST SOCIAL EXCLUSION  
& POVERTY



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



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## Purpose

This module aims to provide you with the basic guide in setting up your HMIS. It is hoped that it will give you a better understanding of the significant factors that must be considered in establishing your HMIS. If you have already set up one, this section may still be useful to you as a template against which you can check if your own HMIS scheme has indeed considered the important elements mentioned. This guide may not be able to provide you with all the details and steps you need in setting up the scheme but it will provide you with an overall flow of processes that must be undertaken and the important elements that must be considered when undertaking them.

## Content

This module begins with the presentation of the overall process in setting up an HMIS. It then presents each stage and discusses the detailed steps to be undertaken. The guide starts with the stage of exploration, awareness raising and dialogue with the target membership and concerned stakeholders. It then covers the subsequent stages until the formal launching of the scheme. Built-in to this discussion are the essential elements or factors that you must consider in each stage of setting up. At the end of this module, you will be presented with the basic principles to be observed in the management of your HMIS.

## Sections

- Section 2.1: Overall Process in Setting Up Your HMIS
- Section 2.2: Support Activities in Setting Up and Running Your HMIS
- Section 2.3: Basic Principles in Management

## Section 2.1: Overall Process In Setting Up a HMIS

### 2.1.1 Introduction

The establishment of a HMIS is often a slow and painstaking process. It involves several stages in which you will encounter a number of challenges. Every step that you take and every decision you make at each stage is critical to the success of your scheme. Any mistake you make in the choice of services, in defining the mode of your organization and in calculating contributions could be detrimental to the future viability of your HMIS. The smooth implementation therefore of your HMIS is largely dependent on the efforts you exert in setting it up.

Note that each HMIS is set up on its own way according to the particular needs expressed by the target community and the opportunities that you can master. However, there are generic steps or practices that are commonly followed in setting up most of the HMIS. Taking these practices into account can help ensure the success and sustainability of your scheme.

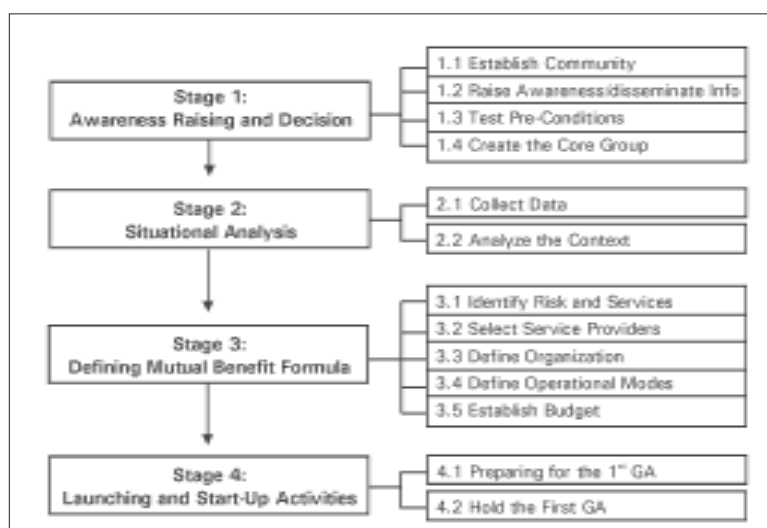
Overall, the setting-up process entails a growth period until you have reached break-even. This may take 6 months to a year period. This is to be followed by another 2-3 years long process of refining and modifying your scheme based on your initial experience. In general, the setting up of your HMIS follows four (4) major stages:

- |          |   |
|----------|---|
| Stage 1: | Awareness-Raising and Decision to Set-up A HMIS |
| Stage 2: | Situational Analysis                            |
| Stage 3: | Defining Your Mutual Benefit Formula            |
| Stage 4: | Launching Your HMIS and Start-Up Activities     |

### 2.1.2 Major Stages in Setting-Up Your HMIS

There are four major stages in setting up your HMIS as shown by the box below. The focus of each stage is described briefly.

**Box 2.1: Stages in Setting Up Your HMIS**



- Stage 1:** At this stage, potential members become aware of their common health-related difficulties and need and consequently decide to set up a joint solution in the form of a HMIS.
- Stage 2:** At this stage, you need to collect data and study the information necessary to decide the nature and characteristics of your future HMIS.
- Stage 3:** At this stage, you need to define the most appropriate mutual benefit formula which covers the services to be offered, the type of organization and mode of operation of your HMIS.
- Stage 4:** At this stage, you need to prepare for the holding of the initial meeting of the General Assembly or the so called formal launching and start with the initial activities of your HMIS.

### 2.1.3: The Steps in Setting up Your HMIS

#### (a) *Stage 1: Awareness Raising and Decision to Set-up a HMIS*

This stage revolves around the organization of meetings, dialogues and awareness-raising among your target membership regarding the setting up the HMIS. The overall purpose of these initial activities is for everyone concerned to reflect and determine their priority health need/s, make them appreciate the importance of joining their efforts and resources together to address their needs, and to get them express interest in forming a HMIS in response to these needs.

##### **Step 1.1: Establish Contact with the Target Membership**

In this step, you need to establish contact with the community and have a close dialogue with them to collect their points of view, identify their health needs and define the actions that need to be undertaken. You may have to pay special attention to existing local associations which have started establishing aid funds or other groups of women and men who have already bonded themselves together for a common cause or interest. You must also involve all concerned authorities from the administration, church and other traditional leaders in the area.

##### **Step 1.2: Raise Awareness and Disseminate Information**

This step revolves around the organization of awareness-raising meetings and activities. The purpose is for you to involve the target group in a process of reflection based on observation and analysis of health needs, as expressed by those directly concerned. Awareness-raising and activities are on-going and occur at every stage in your set up process. They will play an important role during the third stage when the target membership is required to participate actively in selecting the benefits to be offered and in fixing the corresponding contributions. In these dialogues and meetings, you must be conscious of the following concerns:

- that solidarity is an essential factor and the cornerstone of any HMIS; as such, you should be able to find and build on those solidarity links among groups or associations in the locality
- that potential members actually experience difficulties in accessing health care; therefore they should realize and be able to express the need to provide a

solution – this is the primary consideration in setting your HMIS

- that the target membership must become genuinely interested in setting up the scheme; this interest is not only based on the real need but one that they consider a priority or an important concern to be addressed
- that people who are likely to join the future scheme must have confidence in the initiators; it is necessary then that previous links between the targeted membership and the initiators in the past be cleared
- that the opinion and attitude of local authorities is important to be considered in setting up your HMIS
- that quality and accessibility of health services to be provided must be assured; it is important for the initiators to assess the capacities and attitudes of these health service providers

### Step 1.3: Test Pre-Conditions

It is at this step where you explore and discuss with the target membership and stakeholders the relevance in setting up an HMIS. You have to ascertain at this stage whether the conditions necessary for setting up the insurance scheme really exist and are valid. In addition, you must also generate other relevant information about the target membership – their principal needs, educational level, current practices, cultural barriers, etc. You must remember that the major pre-conditions that must exist for setting up your HMIS are:

- ä **solidarity links between members:** These links constitute the foundation of your HMIS. Without a genuine commitment to mutual aid to counter a shared risk, your members will be reluctant to become actively involved in establishing and running that scheme. The links of solidarity that must underpin the set up of a HMIS may manifest themselves in different situations: inhabitants of a village or neighbourhood, employees of an enterprise, members of a social movement, etc.
- ä **potential members experience financial difficulties in accessing health care:** The future HMIS will, first and foremost, provide a solution to the financial difficulties experienced in paying for health care. Such problems are the primary consideration in the set up of a HMIS. For the target population to become genuinely interested in the HMIS, it must not only meet a real need but this need must also be perceived as being a priority, or at least an important concern. This condition does not always exist at the outset of the project. It is necessary then to help communities to clarify and express their needs, without prompting them artificially.
- ä **quality health services in an environment close to the target groups:** It is important to note that the problems encountered by the targeted membership relate to the inaccessibility of health services both in financial and geographical terms. Health services must therefore be of good quality and are accessible to them. You may opt to establish health facilities, but this is a substantial project which is not always viable.

- ä **a climate of confidence between the members and the promoters of the system:** This is a decisive factor, particularly if your target group has previously experienced failure in similar endeavours (savings, credit funds, etc.) in the past. You need to ascertain the level of confidence the general membership has on the advocates and promoters of your health insurance.
- ä **a socio-economic development dynamics:** An existing development dynamics, particularly in rural areas, encourages the introduction of a mutual benefit funding for health services. Profitable economic activities provide communities with the financial resources to be able to pay contributions more readily. In other words, you have to determine economic activities or productive opportunities that exist in the locality which can help gauge the capacity of the targeted membership to pay their premiums.

Note that by the end of this stage, you may decide not to set up your HMIS as the best solution to address the need of your target population. It may happen, for example, that the needs identified by the local communities do not coincide with the services that can be offered. It may be also that mutual aid or solidarity does not exist. If this is the case, then the set up process ends here, and you may possibly shift to another provident system like an insurance managed by a health care provider.

#### Step 1.4: Creating the Core Group

Your contact with the community should result to organizing a core group that will be involved in data collection, planning and designing the insurance scheme. Since, for obvious reasons, it is not possible for all of the targeted membership to be involved in all aspects of establishing your HMIS, a good solution is for the targeted membership itself to designate a core group. The members of this group will carry out the preliminary work preceding the organization of a General Assembly. This core group should:

- participate in carrying out preparatory studies
- report to the targeted membership the outcome of their work and organize on-going activities and information
- collect the opinions of potential members and facilitate the process of reaching a collective decision on the choices to be made

It is advisable that this core group should have reached a certain level of schooling and must also have the confidence of the targeted membership. It is important for them to undergo training so they can become familiar with the basic principles and operational requirements and dynamics of an HMIS. This group should have the knowledge on:

- the basic principles of mutual benefit program
- the mode of operation and characteristics of an HMIS
- the type of services that the HMIS will provide
- modalities of organization and operation

This basic knowledge will be supplemented by the continuous learning that will occur by participating in the successive stages of setting up the HMIS.

*(b) Stage 2: Situational Analysis*

It is important that you become thoroughly familiar with the context in which your HMIS will operate. This can be achieved by conducting a feasibility study that will generate information on demographic, socio-economic (including gender relations), health, financial and legal matters relative to your HMIS. The feasibility study forms the basis for the functioning of your HMIS. It generates information that are essential in assessing the overall feasibility of your scheme and, more particularly, for identifying the specific needs of your target membership, making financial projections and determining the benefits to be offered. It provides you with sufficient information in designing the scheme and deciding on the critical elements and features which your HMIS must adopt.

**Step 2.1: Data Collection**

In this step, you need to collect all the data necessary for planning and designing your HMIS. These data should cover a solid information on the demographic aspects, socio-economic, cultural, medical, financial and legal information. You must note that you only need to collect the useful and relevant data. It is suggested that you access first the data that are already available or already being collected by other groups or organizations to shorten your time and lessen the burden of collecting these back from the primary sources. Specifically, the data collection may include the following components:

- ä demographic characteristics
- ä health care provision
- ä legal and institutional framework
- ä forms of solidarity and organization within the population
- ä family income and health expenses
- ä sanitary conditions and health-related needs
- ä gender relations
- ä health care financing
- ä others: available physical, human and other resources

Please refer to Annex 2.1 for the recommended list of data to be collected.

There are different methodologies that you can employ in collecting these data. It is for you to decide the appropriate mix or combination of collection activities that best generate your information requirements. In deciding which methodologies to apply, you need to consider the time allotted for you to complete the situational analysis, the amount of funds you can spare for these activities and the skills in undertaking these activities. The following section provides you with data collection options with their brief description and application.

- ä **Secondary Data Gathering:** This method refers to the collection and review of already existing data or information from various sources. Major sources are the existing reports or documentations in the local area or those outside with similar or relevant experiences. These may also include reports that are routinely accomplished or submitted or those updated data boards existing in the community. Reports or materials could be sourced from the local government offices (e.g. municipal/ city planning and development office,



schools, etc.), facilities (e.g. Rural Health Units or barangay health stations) or organizations (cooperatives or non-government organizations, local associations or federations). It is advisable that in collecting these data, you are guided by an outline of key information you need to collect. It is important that you only collect those that are relevant so that you will not be swarmed with voluminous materials. In reviewing these materials, it is important that you summarize the key information you have learned from each of the material. Be sure that the sources of these summaries are properly referenced.

- ä **Key Informants Interview:** There are certain data that are best gathered using this methodology. This involves an interview of selected stakeholders or people in authority who possess the relevant information you may need. In undertaking this method, it is important that you are guided with the written set of questions that you want to ask and a recording material where you can note down their responses. Ensure that your questions are logical and properly sequenced and specific. Note that you may have different sets of questions per official or individual that you will interview. This is a good way of getting the views and experiences of people (e.g., economically poor women and men who generally feel inferior because of their low educational attainment, or men and women who belong to the so-called “minority” groups) who find it hard to speak in group settings.
- ä **Focused Group Discussion (FGD):** This is an effective tool to obtain the opinions of your target group. This allows you a more thorough discussion of critical topics or concerns you need to focus on. The FGD as a methodology requires you to undertake this among a homogenous group of participants or members. For example, you may have to organize a group of adult women separate from the adolescent groups or from adult men. The homogenous grouping may be based on the type of work the members are engaged with. The ideal size of the group is from 8-10. In this mechanism, you need one person to facilitate the discussion and another one to record the discussions. It is a must that the facilitator and documentor are guided with a list of questions relevant to the topic to be discussed. The facilitator must have the skills to draw out the responses from each of the participants, focus the discussion on the topics at hand and facilitate the exchange of ideas, without one member dominating the discussion or one being left out in the exchange of ideas.
- ä **Ocular Observation:** There are many information which are best obtained through ocular observation. This methodology requires you to physically go around the community or area to be covered by your HMIS. Ocular observation is most appropriate if you want to know the existing facilities, their distance from the members’ residence, their physical set-up, who patronize them or how they deliver services. Ocular observation will also point out social and economic activities in the locality. You will be able to identify social clustering and economic productive activities. Arrangements of houses, sanitary conditions of the place, the mode of transportation and other socio-economic features. In conducting ocular observation, you must also have an Observation Checklist as guide and on which you will record your actual observations.
- ä **Survey:** A survey entails the collection of data from a sample of the target



membership. The sample is usually selected at random to ensure objectivity and the right group to represent the target membership. This means that not all the individuals in the community or all the target members need to be interviewed or become respondents. The survey also requires the development of a questionnaire or a checklist which will be used to interview the selected respondents.

The survey questionnaire can cover several aspects relevant to your HMIS. Through the survey, the profile of the targeted membership can be obtained, their opinions surfaced and their knowledge and practices relative to the HMIS can be determined. Through the survey, you may also collect information on the expenditure patterns of the family and their current allocation for health care and other basic services. Their financial and economic capacity can also be determined. This methodology usually takes the longest to undertake and is resource-intensive.

### Step 2.2: Feasibility Analysis

The feasibility study is the foundation of your HMIS' functioning. It is important for you to have a clear understanding of the situation in which your HMIS will operate. This information is necessary in order for you to assess the viability of your scheme, make financial forecasts, determine the specific needs of your target membership and the benefits you will grant them.

On the basis of the feasibility study, your core group makes a financial calculation based on an estimated revenue and expenditure to assess whether it is a good time to set up your HMIS. A major challenge for you is to calculate the average cost of services and the appropriate rate of risk. In many cases, you will have to be content with the initial approximate figures.

The analysis of these data should yield information useful for determining the concrete needs of your target membership and confirming presence of the major pre-conditions in setting up a HMIS. Your analysis should yield first of all the information and recommendations whether setting up an HMIS is feasible or not.

Your analysis should also generate information as basis for identifying the services to be offered and calculating the potential contributions of your target members. The results of the analysis should become the basis for determining financial projections and the type of organization you need to set-up including the modalities of your operations.

#### (c) Stage 3: *Defining the Mutual Benefit Formula*

*(c.1) Purpose:* The purpose of the previous stage was to gather all the necessary information that would define the activities, organization and operation of your HMIS. In this stage of defining the mutual benefit formula, these information are now analyzed in order to identify the scheme that is best suited to meet the existing needs of your target membership considering local situation and customs.

*(c.2) Involvement of the Core Group:* The core group you created will be the one to undertake this analytical work with possible input by outside participants. Their analysis however should be regularly shared with your target membership.

For this purpose, you need to organize series of meetings among the targeted members for them to fully understand and internalize the significance of a HMIS. These meetings are also intended to further substantiate the initial data that were collected. These meetings can serve as a means to:

- gather the opinions of all potential beneficiaries
- gain a better understanding of the population's perception of its sanitary conditions, its problems, etc.
- prepare the ground among members for the choices that will result or emerge from the analysis
- prepare members in order to facilitate the decision-making during the first meeting of the General Assembly

### Step 3.1: Clarifying the Benefit Formula

You must remember that selecting the benefits to be offered and fixing the corresponding contributions is the central activity in setting up your HMIS. Several formulas for covering health expenses should be drawn up and compared in the light of the needs of your potential members and their financial capacity. Note also that the coverage to be offered by your HMIS must be:

- **relevant:** the types of care covered should correspond to the real health-related needs of your target population; this solution in the form of an insurance must genuinely improve in the situation
- **visible:** members must be able to rapidly perceive the advantages offered by your HMIS
- **accessible cost:** the sum of the contribution must be compatible with the financial capacity of the potential members

It is therefore important that you maximize the use of the information gathered and make an objective analysis of them.

### Step 3.2: Identifying the Risks and Services to be Offered

Given the collected information, your core group should be able to identify the health needs of the target membership and be able to identify the various risks involved. It must be able to identify the appropriate package of services that meets the needs of the target community. In this case, there could be different choices and options that will come out of the analysis.

In this regard, it is important for the core group to come up with the different scenarios and identify the major risks involved in each of these scenarios. The core group should appreciate these possibilities in terms of finances by making calculations based on estimates that include the average cost of services to be offered and the frequency the diseases.

### Step 3.3: Calculating the Contributions

Calculating contributions is the most difficult part in setting up your HMIS. It is also very important, since the sum of contributions determines the future viability of your scheme.

If the contribution is too low, your HMIS will accumulate a deficit with risk of bankruptcy at some stage in your operations if it cannot mobilize additional resources (e.g. exceptional contributions, subsidies, guarantee funds or other income from HMIS fund-raising events).

If the contribution is too expensive, your HMIS will not be financially accessible to a large number of your target members. The risks of adverse selection and over-consumption will be compounded.

Calculating contributions is based on an estimation of the frequency with which risks occur and the cost of care. Unfortunately, in most cases, there is lack of reliable information that can be used to arrive at accurate estimates. Consequently, the sum of the contribution to be estimated will not be very precise. It is essential, particularly during the early phase of your operation, that you carry out regular monitoring of the sum of contributions and the cost of the benefits, so that any necessary adjustments can be made.

The way in which contributions are calculated depends on the approach adopted in selecting the services you offer, either on the basis of your target members' available income, in a context characterized by poverty, or on the basis on needs expressed by your potential members, in situations where financial problems are less acute. The

**Table 2.1: Methods of Calculating Contributions**

Calculation: Available income		Calculation: Needs Expressed	
Method 1 contribution = risk premium + safety margin + operating costs	Method 2 contribution fixed in general assembly, without prior calculation	Method 3 contribution calculated on the basis of the operating budget of the health facilities	Method 4 contribution calculated on the basis of a HMIS budget forecast

following table presents the four most frequently used techniques for fixing contributions:

### Step 3.4: Selection of Service Providers

Once the services to be offered have been identified, the core group should be able to identify and come up with an inventory of the existing health institutions in the locality or nearby areas which they can tap later on to provide the services. The core group can contact these potential service providers and examine the possibilities for establishing agreements with them as a concrete expression to their co-operation. At this step, the core group must assess the possibility and rationale for setting up its own health facilities to provide the service.

### Step 3.5: Defining Your Internal Organization

Another aspect that must be defined at this stage is the type of organizational set-up that is most suited to meet the requirements of your HMIS. The analysis should be able to provide the core group with relevant information how the HMIS will be structured, what kind of governing bodies that need to be established and how simple or complex your organization should be.

### Step 3.6: Defining the Modalities of Your HMIS Operation

As previously stated, the core group needs to analyze and define how your HMIS should be ran and operated. In this step, you must be able to identify and determine among others your membership modalities, how the premiums will be collected, the mechanisms in providing the services, granting the benefits to your members and the options in payment scheme.

### Step 3.7: Preparation of Budget

There is also a need to formulate the program of action and the budget forecast which translates the choices you made into financial terms. You may need external technical assistance especially in the assessment and preparing the income statement.

In general, this step of defining the mutual health benefit will be summarized in the form of different scenarios which will be finally decided during the first GA. The extent and nature of HMIS activities will be reviewed according to your members' priorities.

#### (d) Stage 4: Launching Your HMIS and Start-up Activities

This stage concludes the previous stages and corresponds to the effective birth of your HMIS. This stage is categorized into two steps. The first step is all the necessary preparation before the first GA is held; and the second part is the holding of the first General Assembly or the formal launching of your HMIS.

### Step 4.1: Preparing for the Inaugural General Assembly (GA)

This step allows you to make all the necessary preparations in terms of logistics, systems, rules and guidelines prior to holding the first GA. In your preparation, you must give focus to the following four major areas of concern:

- formulating draft By-Laws
- preparing draft Policies, Systems and Procedures
- drawing up the agenda for the formal launching
- convening the first GA

#### (a.1) Development of By-Laws: In formulating the By-Laws, the following matters should be addressed:

- name and headquarters of your HMIS
- objectives
- services proposed

- conditions of the membership and coverage of dependents
- methods for fixing contributions and their amount
- mechanisms and procedure for the election of the board members
- rules governing the operation of the HMIS that are not provided for in law and in official regulations

The By-Laws lay down the rules regarding your HMIS objectives and operations, specifying the rights and duties of your members and your HMIS officials. It also provides for the modalities guaranteeing the democratic and solidarity operation of the whole organization. By-Laws are also collective contract between your members and the HMIS. They serve as reference in the relationships between your HMIS and the third parties. The working group is responsible for drafting these By-Laws.

*(a.2) Drafting the Policies, Systems and Procedures :* The By-Laws are complemented by formulating the policies, systems and procedures (PSPs) which specify certain provisions regarding the practical operations of your HMIS which are not covered in the law. This will also be submitted and presented to the first meeting of the GA.

*(a.3) Drawing up the First General Assembly Agenda:* Your core group needs to prepare the agenda of the first meeting of the GA or the formal launching of your HMIS. This first meeting usually has the following purposes:

- to inform the potential members about the proposed set of your HMIS
- to present and discuss the different options which your HMIS need to finally adopt
- to decide regarding the organization and operation of your HMIS

#### **Step 4.2: Holding the First General Assembly or the Formal Launching**

The first GA should be the venue to inform members about the proposed set-up of the organization, with emphasis on the following:

- its philosophy
- overall objectives
- advantages and disadvantages
- form of administration

The GA should also discuss the different options and decide on the organization and operation mechanisms of your HMIS.

In the actual launching of your HMIS, it is advisable to invite as many members and officials in the community. In this launching activity, the benefits of participating in the scheme must take focus and the principles of solidarity and mutual trust must be emphasized. Equally to be stressed are the expected contributions and other responsibilities of the members so that they will have a balance perspective when joining your HMIS.

In launching, extra effort must be exerted to make this a high profile activity. Target members are encouraged to join and enrol. Hence, there should be opportunities for members to enrol during the launching activity.

The organizational structure of your HMIS is agreed upon at this time, where

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management bodies responsible for ensuring its operations are decided upon. The organization chart of your HMIS must precisely determine the position of every official, define their functions and corresponding authority. Please refer to Annex 2.3 for a hypothetical example in setting up an HMIS.

## **Section 2.2 : Support Activities In Setting-up and Running Your HMIS**

There are other activities that you need to carry out in order to ensure the efficient and effective operation of your HMIS. Aside from establishing the management systems, there is a need to prepare your potential members and beneficiaries about the mechanisms and requirements of your HMIS. There is also a need to continuously remind them of the basic principles of your HMIS even during actual operations. More importantly is preparing the key leaders who have been assigned to manage your HMIS. All these entail a series of training, orientations and meetings.

### **2.2.1 Capability Building of Involved Persons and Staff**

The capability of persons assigned with responsibilities in managing your HMIS must be developed. They need to receive appropriate training to prepare and enable them to handle their tasks. These training programs must be packaged progressively in order to fully develop their competencies required in their jobs. Areas for training include:

- leadership and program management
- gender and development
- data processing, analysis and presentation
- advocacy and negotiation
- social marketing their products
- administrative and financial management
- monitoring and evaluation
- proposal development
- communication material development

It is therefore necessary that their competencies are defined for each role or function they are expected to perform.

These training must be followed up by periodic monitoring and regular supervision. Capabilities of staff and personnel may also be enhanced by providing them with the necessary tools in performing their tasks. In this regard, the checklist for monitoring and evaluation and templates of administrative and financial transactions must be provided. It is encouraged that staff or personnel assigned will be given the chance to participate in an observation tour which can demonstrate or model to them how a HMIS can be effectively and efficiently operated. In this regard, it is important that the authorities and responsibilities of each body/unit or assigned staff be clearly delineated and that their internal linkages and functioning arrangement be clearly defined and supported.



### 2.2.2 Continuous Information and Updating

A continuous effort to inform and update the members regarding the scheme must be exerted. The continuous information on the principles of their formation particularly solidarity, risk-pooling, precaution, etc. must be emphasized time and time again. It must be noted that the principles on which your HMIS was established cannot be learned and internalized at once. This requires series of orientation and open discussion.

Aside from constant reminders, you need to be abreast with the updated information and new technologies. This will expose you to new learning and methods which are helpful in making your operations and management more effective and efficient. This continuous learning must reach not only your key leaders but the general membership as well.

### 2.2.3 Continuous Campaign to Increase Membership

This must take precedence in your information drive. These campaigns must take on creativity and innovations of approaching and winning members to join the scheme, especially women and men who are in disadvantaged situations, or who tend to be excluded (e.g., residents in interior communities, indigenous peoples). Note that by increasing your membership, you are directly increasing the viability of your scheme through their additional premiums and contributions. Efforts must be taken to market your product and encourage others to join and enrol. Testimonials are effective methods of winning more members.

### 2.2.4 Continuous Promotion for Regular Contributions

In order to promote regular contributions and avoid abuse, you must ensure your members to continuously become aware of the principles underlying the purpose of your HMIS. Aside from continuous campaigning, there is a need for you to review and analyze the most appropriate collection system for your members. Note that one of the weaknesses in most HMIS is a weak collection system and the unavailability of staff to make these collections. Some HMIS have organized themselves to ensure constant, closer and more strict follow-up of the members' contributions. Others have dedicated staff or officers in their organization to perform this task.

### 2.2.5 Monitoring and Evaluation

Monitoring and evaluation is key to ensuring that your HMIS progresses the way your members and organizers planned it and for it to remain faithful to the agreements and covenants for which it was established. The need for a regular monitoring and periodic evaluation cannot be under estimated. Chapter 5 is dedicated for this topic.

Your HIMS is anchored on mutual assistance and solidarity. But as social protection in health, it is also looked upon as a financial tool that constitutes what could be called the 'social economy company'.



## Section 2.3 : Basic Principles of Management

The principal function your HMIS is to set up an insurance mechanism against certain health-related risks. The management of such an insurance scheme is relatively complex, since the coverage of risks involves a large component of uncertainty. Each HMIS therefore like yours should respect the basic principles of management. These include transparency and confidence, the preservation of resources and separation of management.

### 2.3.1 Transparency and Confidence

Transparency is one of the fundamental principles of management. It is necessary to earn the confidence of your members. Since the capacity to bring in contributions determines the income of your HMIS, ensuring the confidence of your members becomes the cornerstone of its lasting independent development. Your members contribute to your HMIS only if they believe that when they have health problems, they can call upon it for assistance.

Transparency can be demonstrated by recording information into the HMIS documents those that conform to the real situation. Nothing must be concealed, omitted or changed. All revenue and expenditure, for example, such as the purchase of consumables, payment of invoices, or recording of contributions, must be justified by an accounting record.

All these evidences must be retained, carefully filed and kept on hand. They must be available and accessible to all authorized persons. For practical reasons, management and accounting records must be centralized and kept at the HMIS office.

Note that confidence also of members in your manager/s or key officials is essential for your HMIS survival. Members joined your HMIS because they believe in the leadership and they are confident that the officials seated and assigned to run and manage their HMIS are trustworthy and competent.

Transparency must also be balanced with confidentiality. Your HMIS must be able to manage personal information concerning the beneficiaries (their contributions, sickness, treatment used, etc.). You must ensure therefore that the confidentiality of their personal information is respected.

### 2.3.2 Preservation of Resources

There are various resources held and maintained by your HMIS. These include the following:

- monetary resources: cash and liquid assets (cash on hand and/or at the bank);
- material resources: buildings, equipment, stock, etc;
- human resources: paid and voluntary staff, the know-how of the mutual health insurance scheme.

Your HMIS must ensure that consumable resources are renewed so as to sustain your operation. You may also have to seek to increase your resources to improve the services of your HMIS.

As HMIS, you can also develop your human resources. In particular, the importance of the work of unpaid volunteers or the abilities and know-how of personnel should be attended to.

### 2.3.3 Separation of Management

Your HMIS may have several activities, each of which involves its own cost and revenue. These activities may be managed by different structures which you established: credit activities, for example, may be managed by Structure 'A', while health insurance activities may be managed by Structure 'B'. In this case, each unit must be responsible for its own accounting.

It is also possible for your HMIS, being a single body, to manage several activities. In this case it may only have a single account department or unit. This single accounting, however, will not allow your HMIS to assess the performance of the different activities separately. There is a need to establish separate accounting for each activity, for a more effective management.

This principle of separation of management also includes the non-transfer of resources between different structures. A group which has an income-generating activity (collective fields, mutual savings and credit interest rates, etc.), for example, may decide to offer part of its profit to the HMIS to improve its ability to meet its beneficiaries' health costs. To ensure transparency in management, you must record inflows and outflows in two separate management systems. In this way, the separation of management will ensure clarity of the role/impact each activity has on the overall performance of your HMIS.

### 2.3.4 Key Parameters To Determine the Future Management of Your HMIS

Each HMIS arises out of a distinctive social situation. The management of each scheme should be conceived according to its particular features and needs. Several factors will play a decisive role in the management of each HMIS.

- (a) *Size of Your HMIS:* If your HMIS is small, it benefits from a social control that fosters confidence in the management and therefore, it is allowed to have certain flexibility in its procedures. On the other hand, if your HMIS is large, you may have to professionalize its management. In this context, the size of your HMIS becomes critical as it indicates the minimum number of beneficiaries that will allow it to function on a professional basis.
- (b) *Nature of Benefits of your HMIS:* The services offered by your HMIS must correspond to the needs of your target membership and their capacity to contribute. However, it will be in your interest, if at the initial stage, you only offer a limited number of services. You may increase these services later once you have gained experience and established adequate information about the trend or seasonality of your revenues and expenditures.  
The nature of services offered on the other hand also influences your management. Services with a high utilization rate (e.g. outpatient care) would require more intensive management of meeting the cost of benefits than the others (e.g. deliveries).
- (c) *Frequency of Contributions:* The feasibility study indicates the amount and frequency of contributions according to the income of your members. It is easier to check that contributions are paid regularly when they are on an annual basis. In the case of monthly contributions, for example, a well-developed system for collecting and monitoring these payment will be essential for the HMIS to succeed.
- (d) *Activities Associated With Your HMIS:* Your HMIS may benefit from synergies connected to supplementary activities carried out by your members. For example, if your HMIS is associated to a savings and credit bank, it may benefit from know-how acquired in management or the availability of equipment and premises, channels of communication.
- (e) *Your HMIS Relations With the Care Providers:* You may need to seek to involve the providers in your management so as to ensure better control and monitoring of care provision in favour of your beneficiaries.

## Annex 2.1 Checklist Data to be Gathered

Objectives	Indicators	Data Sources
<b>A. Demographic Characteristics</b>		
To know the target membership, in order to: (a) compute contributions (b) identify whether individual or family membership would be preferable (c) monitor the level of reach of the HMIS	<ul style="list-style-type: none"> <li>• population size and growth</li> <li>• distribution of the local population by age and by sex</li> <li>• average size, composition of families (men, women, children, other dependents)</li> <li>• migration movements</li> </ul>	<ul style="list-style-type: none"> <li>• national/regional census carried out by government offices (e.g. (National Statistics Office)</li> <li>• institutions reports (NGOs, POs, etc.)</li> <li>• local government offices Planning and Development Office, Social Welfare and Development )</li> <li>• household surveys</li> </ul>
<b>B. Health Care Provision</b>		
(a) To identify the type of health services that could be covered by the HMIS  (b) identify providers who could provide health care to HMIS Members	<ul style="list-style-type: none"> <li>• number and geographical distribution of health care providers</li> <li>• nature of health services (consultations, hospitalizations, maternity, etc.)</li> <li>• quality of health care</li> <li>• number and qualifications of health care staff</li> <li>• population's perception of providers</li> <li>• distances between health care providers and the target membership (area of operation of providers)</li> <li>• drug distribution circuits, availability of essential drugs and generic drugs</li> </ul>	<ul style="list-style-type: none"> <li>• Department of Health (national/regional)</li> <li>• provincial/ district and municipal/city health offices</li> <li>• hospital units</li> <li>• NGOs or other organizations working in the health-related field</li> <li>• household surveys</li> <li>• best-regarded health care providers</li> </ul>
<b>C. Legal and Institutional Framework</b>		
To gain an understanding of the legislative and institutional framework that will govern the operation of your HMIS	<ul style="list-style-type: none"> <li>• legal provisions whereby the HMIS can be given legal personality</li> <li>• regulations governing health policy: organization of health services, prevention, etc.</li> <li>• regulations dealing with medical drugs</li> </ul>	<ul style="list-style-type: none"> <li>• Public authorities.</li> <li>• NGOs, cooperatives and other local associations.</li> <li>• Department of Health (national and regional)               <ul style="list-style-type: none"> <li>- Bureau of Food and</li> <li>- Bureau of Health Facilities and Services</li> </ul> </li> </ul>

Objectives	Indicators	Data Sources
	<ul style="list-style-type: none"> <li>policy (including Acts and price-fixing regulations)</li> </ul>	- National Center for Health Facility and Development
The existence of a specific mutual benefit system's legislation or a code on mutual benefit system is not a prerequisite for establishing an HMIS. Your HMIS may take the legal personality of the cooperative, non-profit group, etc.		
<b>D. Forms of Solidarity and Organization within the Population</b>		
To identify the possibility of using local know-how in regard to organization and current mutual aid and solidarity practices	<ul style="list-style-type: none"> <li>current and past forms of organization within the population (community groups, cooperatives, district committees, etc.)</li> <li>organization and operation of local mutual aid bodies or associations</li> <li>modalities for collection of contributions, problems, experienced, etc.</li> <li>existing mutual aid and solidarity practices in regard to health</li> </ul>	<ul style="list-style-type: none"> <li>Associations, cooperatives, mutual aid funds, etc.</li> </ul> <b>Data Sources</b>
<b>E. Family Incomes and Health Expenses</b>		
(a) To identify the most favourable periods of the year for paying contributions (b) To ascertain an average amount that families could afford to pay as a contribution	<ul style="list-style-type: none"> <li>economic activities of the population</li> <li>type of agricultural production, share sold and share consumed</li> <li>level of earnings within the population</li> <li>distribution and evolution of purchasing power</li> <li>annual family budget and share of budget devoted to health</li> </ul>	<ul style="list-style-type: none"> <li>regional and/or national surveys</li> <li>NGOs and local projects.</li> <li>household surveys (difficult to carry out).</li> </ul>
<b>F. Sanitary Conditions and Health-Related Needs</b>		
(a) To identify priority risks to be covered	<ul style="list-style-type: none"> <li>health problems according to gender, age range/ life cycle occupational grouping</li> </ul>	<ul style="list-style-type: none"> <li>regional Department of Health (or equivalent administrative institution)</li> </ul>

Objectives	Indicators	Data Sources
(b) To obtain parameters for calculating contributions	<ul style="list-style-type: none"> <li>• priority health needs</li> <li>• incidence of malnutrition</li> <li>• infant mortality</li> <li>• frequency of visits to health care providers (by services)</li> <li>• most common complaints</li> <li>• rate of mortality/morbidity (by infectious and parasitic diseases)</li> </ul>	<ul style="list-style-type: none"> <li>• health care providers:               <ul style="list-style-type: none"> <li>- records of consultations, hospitalization, maternity, etc.</li> </ul> </li> <li>• WHO standards</li> <li>• NGOs and other organizations working in the health field.</li> </ul>
<b>G. Health Care Financing</b>		
(a) To obtain parameters for calculating contributions (b) To select modalities for granting of benefits and remuneration of health care providers	<ul style="list-style-type: none"> <li>• modalities of operation and financing of health expenses</li> <li>• cost of health care initiatives in health care financing</li> </ul>	<ul style="list-style-type: none"> <li>• Household surveys and surveys of health service users</li> <li>• FGDs or Key informant interviews of PO representatives and barangay leaders</li> </ul>
<b>H. Gender Relations</b>		
<p>To establish gender division of roles and responsibilities in family and community in relation to health</p> <p>To determine differential access of women and men vis-à-vis health programs, services and facilities</p> <p>To determine who makes decisions around health concerns in the family and community (e.g., budget, which facility to access, application of practices such as use of contraception)</p>	<ul style="list-style-type: none"> <li>• Which group would currently have greater interest in such scheme</li> <li>• Which group would need to be convinced on the benefits of such scheme?</li> <li>• Which group would have wider gaps in terms of access to these?</li> <li>• Which group would need to be especially convinced about the need for such scheme? (and therefore would be willing to allocate financial resources)</li> </ul>	<ul style="list-style-type: none"> <li>• FGDs or Key informant interviews</li> <li>• Household surveys</li> <li>• Local government unit and health unit</li> <li>• FGDs or Key informant interviews</li> </ul>
<b>Other Elements:</b> Identification of material resources (premises, etc.) human resources (local expertise, etc.) and others (banking institutions, providers of goods and services (printing businesses, etc.).		

## Annex 2.2: Calculation of Contributions

The following shows how the four methodologies in calculating contributions is done.

### Method 1: Contribution = Risk Premium + Safety Margin + Operating Costs

In order to understand this first, most precise, method of calculation, you must give consideration first to the purpose served by contributions, namely:

- % to reimburse health-related expenses (minus co-payment) relating to care covered by your HMIS
- % to build up reserves in order to place your HMIS on a sound financial footing, year by year
- % fund your HMIS operating costs

There are three stages in setting the premium:

1. Defining the benefit package – based on the needs identified in your feasibility study
2. Calculation of the premium
3. Establishing scenarios – determining the premium that is most acceptable to your target population

This first method breaks down the calculation of contributions into three elements:

Individual Contribution by Types of Health Care Covered = Risk Premium + Safety Margin + Unit Operating Cost

- (a) Risk Premium = frequency x (average cost of the service – co-payment payable by the patient)

*Frequency* is defined as the number of clinic consultations or hospital confinement divided by the total population of an area

- (b) Safety Margin = frequently fixed at 10% of the risk premium.

This is linked to uncertainty in the calculation of the risk premium.

- (c) Unit Operating Cost = estimate of total operating costs divided by the number of expected beneficiaries. It may also be fixed in the first instance at +/- 10% of the sum: risk premium plus safety margin. This second alternative is considerably less precise.

Added to these three elements is a factor E corresponding to the surplus to be set aside to generate financial reserves.

You may use the table on the following page to facilitate computation of the premium for a defined benefit package.

Health Services	Risk Premium		Rate of Coverage	Risk Premiums per year per person	Safety Margin	Operating Cost	Net Premiums per year per Person
	Frequency	Cost of Services					
	A	B	C	$A \times B \times C = D$	$D \times 10\% = E$	$(D + E) \times 10\% = F$	$D + E + F = G$
Out-patient care	1.53	1280	100%	195.84	1.95	1.97	199.76
Consultations		50		76.50	0.76	0.77	
Diagnostics		150		229.50	2.29	2.31	
Medicines		1000		1,530.00	15.30	15.45	
Transportation		80		122.40	1.22	1.23	
Maternity Service	0.57	580	100%	33.06	0.33	0.33	33.72
Pre-natal		300		171.00	1.71	1.72	
Post-natal		200		114.00	1.14	1.15	
Transportation		80		45.60	0.45	0.46	
Minor Surgery	0.28	1530	100%	428.40	4.28	4.32	470.72
Consultations		300		84.00	0.84	0.85	
Diagnostics		150		42.00	0.42	0.42	
Medicines		1000		288.00	2.88	2.90	
Transportation		80		22.40	0.22	0.23	
Hospitalization	0.08	4000	100%	320.00	3.20	3.52	326.72
Consultations		300		24.00	0.24	0.24	
Diagnostics		500		40.00	0.40	0.40	
Medicines		3000		240.00	2.40	2.42	
Transportation		200		16.00	0.16	0.16	
<b>Total Premium Per Person Per Year</b>							<b>1030.92</b>

Steps in using the above table:

1. Determine the needed health services of your community based on the feasibility study. You may further break down services into components like consultation, diagnostics and medicines for out-patient consultations.
2. Determine the frequency or the rate that a certain health event occurs by getting the number of consultations or number of hospitalization in one health facility divided by the total population of an area. You may get this information from the yearly census of the health center or the hospital in your area.  
As an example, Bicao, Carmen, Bohol has a population of 52,000 in year 2003; the rural health unit in Bicao had a total consultation of 80,000; there were 30,000 maternity consultations; and 15,000 minor surgery procedures done. The district hospital had 20,000 confinements for the year but it services a population of 250,000 which includes all the *baranggays* in Carmen. The frequency of out-patient consultations for year 2003 is 1.53; maternity service is 0.57; and minor surgery is 0.28. Hospitalization has a frequency of 0.08.
3. Estimate the cost of each health event. You may get information from the health centers, hospitals, pharmacy and laboratory or diagnostic centers.
4. At the point, it is assumed that the rate of coverage for each health service is 100% meaning the HMIS intends to pay for the total average cost per health service.
5. Risk Premiums Per Person Per Year is equal to the (frequency x cost of service) x rate of coverage.
6. A safety margin of 10% of the Risk Premium is usually set.
7. Operating Cost = estimate of total operating costs divided by the number of expected beneficiaries. It may also be fixed in the first instance at +/-10% of the sum: risk premium plus safety margin. This second alternative is considerably less precise.
8. The net premium per person per year for all the identified health services is equal to the Risk Premium + Safety Margin + Operating Cost.

Note that if several types of health care are covered, the total individual contribution is equal to the sum of contributions calculated for each type of care. The family contribution is equal to the total individual



contribution multiplied by the average number of family members.

These calculations will produce an estimate of the annual contribution. It may then be broken down by day, month, etc., depending on the periodicity of payment of contributions that is best adapted to the mode of income of the target membership.

The process whereby a final decision is reached regarding the contribution to be charged to members takes place in three stages:

- (a) An estimate is made of the target membership financial capacity, i.e. the average sum that each individual or family could afford to pay as a contribution;

In the above example, each member needs to pay Php 1,030.92 per year to cover all benefits identified. However if the target population said that they could only pay Php 400.00 per year per person, this premium-benefit package will be good but nobody could afford it.

- (b) Several scenarios are developed to cover health-related expenses according to your target members' capacity to pay. You may choose from the following options: (1) Limit the services, (2) Ask for subsidies, (3) Reduce the rate of coverage, (4) Negotiate with health care providers to reduce price of service and (5) Reduce the frequency of illness.

Limiting the health services that the HMIS would cover may enable the scheme to develop a package that is more affordable. However, preventive health care activities should be undertaken to prevent occurrence of such illnesses in the community. Subsidies should only be used for the operating costs and not for the payment of health care benefits. Reducing the rate of coverage is an acceptable practice to reduce the cost of premiums. Negotiating with health care providers is one of the best alternatives that the HMIS could do to offer better coverage to its members. Reducing the frequency of illness cannot be done on the first year of operation because your HMIS may not have the actual data. Conducting preventive health care activities could also reduce the frequency of illness.

The total sum of the contribution corresponding to each scenario must be compatible with the contribution that the target membership is in a position to pay.

- (c) These different scenarios are presented to your target membership who also participate in making a final choice of your HMIS activities and the care it will provide. One of these scenarios will ultimately be decided upon, in the light of which the promoters of your HMIS will be able to fine-tune, the mechanisms and tools to be employed and draw up a budget forecast for the mutual organisation.

### **Method 2: Contribution Fixed in General Assembly Without Prior Calculation**

The second "method" is probably the most widespread, despite the fact that it is not very scientific. Members meet and estimate how much they would be able to pay on a regular basis and then decide on the services to be covered by their HMIS.

If no particular expertise or prior studies are used as a basis (attendance, costs of health services, etc.), this approach is extremely random. Mistakes may easily be made and it is quite likely that financial difficulties will arise.

This approach must be combined with the following measures, in order to limit the possibility of bankruptcy:

- % a lengthy period of observation in order to accumulate substantial financial reserves
- % a ceiling must be placed on expenditure
- % members must be fully informed of the difficulties to be expected

This approach is mentioned here because it is one that has frequently been adopted in the past, and in order to highlight the dangers. It is not, however, recommended.

**Method 3: Contribution Calculated on the Basis of the Operating Budget of the Health Facilities** This mode of calculation is appropriate primarily in the context of an insurance system set up by a health care provider (non-profit insurance managed by a provider). The latter estimates its operating budget, taking into account that the insurance will probably attract increased attendance. This budget is then distributed over the entire target group (population covered by the provider, for example), to arrive at an individual premium.

Some HMIS also use this method, although it is appropriate only for those who run their own health facilities.

#### Method 4: Contribution Calculated on the Basis of an HMIS Budget Forecast

This technique involves: (a) assessing the health needs of the target membership; (b) estimating the expenses incurred in covering these needs; (c) estimating revenues necessary to cover these expenses; and (d) fixing the level of contribution necessary to achieve these revenues.

Therefore, to calculate the contribution, it is necessary to draw up a budget forecast establishing, first, a forecast of expenditure by the HMIS to cover health expenses, operational costs and training and, second, the revenues needed to cover these expenses.

While calculation of the contribution resides on the same elements as under the first method, they are presented in a different manner. A model budget is drawn up on the following page.

Expenditure		Income	
Items	Sum	Items	Sum
<u>Health Benefits:</u>		Membership Fees or	
service 1			
service 2			
service n		Sale of membership cards	
<u>Safety Margin</u> (10% of health benefits)		Contributions	
<u>Operating Costs</u>		(Donations or subsidies)	
– wages or compensation			
– travel cost			
– supplies			
– others			
<u>Training Costs</u>			
(Surplus)			
Total Expenditure		Total Income	

- 
- (1) Total Anticipated Expenditure=Frequency of Illness x (ave. cost minus co-payment) x expected number of members.
  - (2) Membership Fees are generally intended to defray administrative costs relating to membership (formalities, printing of membership cards, etc.), which are part of the operating costs in the "expenditure" column.
  - (3) Total Contributions = Total Expenditure - Membership Fees. The contribution per member is arrived at by dividing this total of contributions by the number of expected members.
  - (4) Possible donations and/or subsidies are not taken into account in calculating contributions. Indeed, in the interest of ensuring the sustainability of your HMIS, such as donations or subsidies must not be used to reduce the sum of the contribution. They may instead be used to cover specific investment or operating costs, in which case a corresponding entry will appear in the expenditure column, but will be excluded from the total of expenditure for calculating contributions.

They may alternatively be used to boost the financial soundness of your HMIS, in which case the corresponding item will appear under the surpluses item in the expenditure column which will likewise not be included when calculating contributions.

## An Example of Setting Up an HMIS

Cooperative X has decided to set up an HMIS. The core group made up of designated members of the cooperative has carried out a situational analysis. The results of this assessment are summarized below:

### A. Results of the Situational Analysis

#### (1) Demographic Characteristics

The municipality and surrounding areas have a population of 10,000 individuals (NSO Projected Population for 2000 based on 1995 Census), with a 50-50 male and female ratio. Families have six members on average (two adults and four children). The cooperative has 500 members who live in the municipality and nearby barangays.

#### (2) Health Care Provisions

The municipality has a health center which is administered by the municipal government. The health center provides the following services:

- outpatient consultations
- minor surgery (bandaging, stitches, etc.)
- maternity check-up
- vaccinations

The health center has a “botika” or pharmacy which sells only essential and generic drugs.

Initial meetings reveal that the members are happy with the health center, although they are less happy that the doctor is frequently absent and complain that the “botika” is selling medicines and not giving them for free.

It is also noted that a retired nurse lives in the municipality, carrying out home consultations and selling some drugs and medical consumer items. She charges fees higher than when availed of from the health center, but she accepts payment in instalment basis and gives a lot of vaccinations.

Thirty kilometres from the poblacion where the health center is located is a District Hospital which provides secondary health care of excellent quality.

- hospitalization
- surgery
- non-spontaneous deliveries
- laboratory and radiology
- others

The health center does not have an ambulance. Patients referred by the health center to the District Hospital are transported by tricycles or a passenger jeepney with an estimated amount of Php 20 per day). The fare between the poblacion and the district hospital is about Php 100.00, but many drivers do not hesitate to demand up to Php 300.00 when asked to transport a gravely-ill or emergency patient.

#### (3) Legal and Institutional Framework

The cooperative has its own by-laws and policies, systems and procedures. National legislation does not provide specifically for the mutual benefit system, but the cooperative is registered under the Cooperative Development Authority. The cooperative management is aware of the formalities required to obtain recognition as an association.

#### (4) Forms of Solidarity and Organization of Members

In addition to the cooperative, a number of formal and informal groups exist in the municipality and surrounding areas. These are primarily the women's associations (mutual aid for agricultural tasks, ceremonies, catering, etc.). Men also have their groups, primarily for the purpose of organizing mutual aid in carrying out agricultural tasks and building homes.

It is estimated that all families have access to these mutual aid activities, either through the woman or the man (most often both members of a couple belong to a group). The cooperative is a mutual aid fund intended to provide financial support during marriages, births, deaths, illnesses, etc. It operates along the same lines as traditional groups. The financial mutual aid activities are organized basically as follows:

- the members of a group pay a contribution of approximately Php 25.00 per week, plus a contribution of Php 500.00 per month during the period when crops are sold
- aid is granted to members requesting it in the following form:
  - gifts for sums of under Php 1,000
  - loans for sums of over Php 1,000 up to Php 5,000

All groups and associations experience the same problem. Their mutual aid fund is insufficient to meet the requirements of members, especially during low cash periods.

#### (5) Family Income and Health Expenses

A study carried out by the Department of Agriculture – Regional Office for the support of peasant farmers reveals that families average an annual income of Php 80,000. Income fluctuates over the year. Most money is available between December and February (sale of harvests, agricultural credits, etc.) and less between June and August (low cash period). Families spend an annual average of Php 6,000 on health.

#### (6) Sanitary Conditions and Health-Related Needs

The health center has carried out a survey of 100 families from the municipality, revealing the following percentages of the utilization of health care by source:

- |                                  |       |
|----------------------------------|-------|
| (1) no service taken             | : 15% |
| (2) self – medication            | : 15% |
| (3) traditional health providers | : 20% |
| (4) private nurse                | : 18% |
| (5) health center                | : 31% |
| (6) district hospital            | : 1%  |
| (7) others                       | : 4%  |
- Purchase of drugs at the market or from shops
  - Health care outside the district area (illness while traveling, etc.).

Families using the first four alternatives gave the following reasons for doing so:

- in 80% of cases, lack of money at the time of illness,
- in 20% of cases the illness was not serious or traditional treatment was used.

In regard to hospitalization, families stated that, on average, one gravely-ill patient out of every two could not be sent to the district hospital for financial reasons. When patients cannot be hospitalized, other forms of care are used, but many patients do not survive.

### Risk Rate

Based on the information from the health center and with the assistance of the hospital doctors, the HMIS core group calculated the following risks rates (in the light of local morbidity figures and hypotheses regarding the uptake of health services with the HMIS set-up):

Data/Information	Risk Rate
<u>Health Centre</u>	
outpatient consultation	150%
hospitalisation	6%
minor surgery	10%
maternity (rate spread over the entire population)	4,5%
<u>Hospital</u>	2%
hospitalisation (including surgery and non-spontaneous deliveries)	

### (7) Costs and Financing of Health Care

	Consultation	Hospitalization	Minor Surgery	Maternity Benefits	Drugs	Total Cost
<b>Consultations</b>	200				900	1,100
<b>Hospitalization</b>	200	500			2,000	2,700
<b>Minor Surgery</b>	200		300		500	1,000
<b>Maternity Benefits</b>	1,000			1,500	3,000	5,500

In order to acquire all the necessary information and given that the information available from the health center is not very reliable, the core group carried out two surveys:

- one survey among 100 patients seeking consultation, 50 hospitalized patients and 50 women delivering at the HC,
- another among 100 patients hospitalized at the hospital (all services included)

The objective of the survey carried out among patients attending the health center was to ascertain the average cost of the different services. The results were as follows:

## Survey Among Health Center Users: Average Cost of HC Services

- (1) No consultation charge for women who have undergone regular pre-natal check-ups.
- (2) The total maternity cost includes delivery, stay and initial care of the infant.

## Survey Among The District Hospital Patients: Average Cost of Services

Hospital services are paid as a flat rate and include the various procedures involved (hospitalization, surgery, non-spontaneous delivery, radiology, etc.) together with drugs supplied by the hospital pharmacy. The latter is always well stocked and carries all medical devices and drugs prescribed by doctors. An additional charge is payable for some specialist procedures, to be added to the flat rate charged. Upon arrival at the hospital, the patient undergoes an initial consultation at the cost of Php 150.00. which is not included in the flat rate. The average cost of a hospital visit is about Php 7,500.00 broken down as follows:

- consultation : Php 150.

Means of Payment	Attendance at Health Center	Attendance at Hospital
<b>Money Available at Home</b>	60%	30%
<b>Debt</b>		
– family	6%	10%
– friends/neighbours	2%	5%
– association		6%
– money lender (average interest rate: 50%)		15%
<b>Gift</b>		
– family	4%	2%
– friends/neighbours	–	–
– association		
<b>Sale</b>		
– crops grown or livestock – reared	10%	–
	15%	25%
– others	3%	7%
<b>Total</b>	100%	100%

- Hospitalization: Php 5,000.
- Specialist Procedure: 2,350.

It includes all the cost of procedures and drugs. It should be noted that patients arriving with a referral voucher from a health center do not pay the initial consultation at the hospital.

In the survey, families stated that they use the following means to pay for health center and hospital services: During the course of the survey and consultation meetings, the members, particularly the women, demonstrated considerable interest in the idea of an HMIS. A large majority said they would be ready to pay a weekly family contribution of Php 25, together with a sizeable contribution at the time of sale of their



main crops. A rapid survey in the municipality and surrounding areas revealed that 500 families are already prepared to join the HMIS to be established.

### **(8) Other Considerations**

The cooperative has premises that could be lent to the HMIS. In addition, the cooperative manager is ready to work with those running the HMIS to ensure efficient management. (However, the HMIS should ideally be independent from the cooperative, so that membership can be open to all and not confined to the members of the cooperative only).

A saving/credit fund has operated during the last five years in the municipality and has won the confidence of the people of all surrounding areas. It costs Php 1,000 to open an account.

Estimates from the stores and printing shops in the poblacion show that the following costs can be expected:

Ledger	: Php 50.00
Pen	: Php 10.00
Printing of Membership Card	: Php 150.00
Management Register	: Php 500.00
Calculator	: Php 300.00.

Lastly, the cooperative, which has had positive financial results over the last few years, proposes to make available to the HMIS a supporting fund of Php 50,000.00, the modalities of use for which will be laid down in consultation with the persons running the future HMIS.

## **B. Organization and Operation of the HMIS**

The HMIS could be organized in two ways.

(1) The HMIS is a new association open to all families in the municipality. Its office is at the poblacion and anybody wishing to join must go there to carry out the membership modalities then pay regular contributions at intervals specified by the HMIS. However, since people or groups are scattered and many are located far from the poblacion, this mode of organization might be considered to deter people from joining.

(2) Another solution, which is more suited to the lay-out of the municipality (several distant barangays, but accounting for 60 per cent of the population), would be to link the HMIS with the existing mutual aid associations. Tasks relating to the processing of membership, collection of contributions and control are shared between the mutual aid associations and the HMIS.

(2.1) Each association designates HMIS officers who meet on a regular basis (e.g. once per month) at the poblacion headquarters, constituting a Board of Directors.

(2.2) Each association is free to set up its own mutual aid and solidarity activities in order to facilitate HMIS membership for families, particularly the most disadvantaged.

(2.3) The General Assembly convenes once per year with the participation of all HMIS members. This event may provide an occasion for a major municipal celebration.

(2.4) The HMIS will open an account at the Poblacion Savings/ Credit Fund, but will also have a petty cash fund to meet current expenses, thereby avoiding the necessity of frequent trips from their area to the poblacion to withdraw.

**Activities of the HMIS:** The nature of the situation outlined suggests the following two activities but there are still others.

- coverage of health care costs (to be defined in the scenarios)
- financial assistance for transportation of patients to the hospital (and negotiation of prices with jeepney or tricycle drivers)

### Example of Coverage:

The level of interest demonstrated by families suggests that a relatively high number of members can be expected to join during the first year. However, it is prudent to work on the assumption of a maximum of 25 per cent membership rate. It is preferable to offer family membership, in the interests of limiting adverse selection.

Working with these hypotheses, the HMIS would have some 2,500 beneficiaries during the first year, distributed among approximately 420 families.

Families state that they are prepared to pay a contribution of Php 25.00 per week, plus an additional contribution when they sell their harvest (on average Php 300.00 in associations). This would produce an anticipated annual sum of Php 2,200 in contributions, distributed as follows:

Weekly Contribution : Php 25.00 or Php 1,300 per year  
 Additional Contributions : Php 300.00 x 3 months  
 (December to February), that is  
 Php 900.00

### Coverage Hypothesis

The HMIS assumes the objective of covering a combination of major risks and costs of minor hospitalization, maternity and minor surgery at the health center. There is no co-payment, covering 100 per cent of costs. The contribution is broken down as follows:

**Risk Premium:** (expected rate of attendance x average cost)

Hospitalization at the District Hospital :  $0.02 \times 12,500 = 250$   
 Minor Observation at health center :  $0.06 \times 2,700 = 162$   
 Minor surgery at health center :  $0.1 \times 1,000 = 100$   
 Maternity at health center :  $0.045 \times 4,500 = 203$   
 Risk Premium : Php 715.00/year/  
 person

### Safety Margin

Safety Margin = (10 % of of Risk Premium)  
 =  $\text{Php } 715 \times 0.1 = 72$  /year/person

### Unit operating Cost

Since the various costs can be estimated, it is possible, in this case, to ascertain unit cost, on the basis of a budget forecast. On the assumption that the HMIS works with two associations in each area and with five associations in the municipality, the annual operating costs of **Php 74,400.** would be distributed as follows:

450 membership cards : Php 67,500 (family cards),  
 2 ledgers/association :  $\text{Php } 50 \times 2 \times 5 \text{ associations} = \text{Php } 500.$   
 (record of members and of contributions)  
 20 pens :  $20 \times \text{Php } 10 = \text{Php } 200.$

Management Tools :  $5 \times \text{Php } 500 = \text{Php } 2,500$   
 (1 petty cash book, 1 bank book, 5 books of health care  
 receipt slips, 2 books of invoices)  
 calculator :  $\text{Php } 1,500.$   
 trips to Poblacion :  $\text{Php } 1,200.$   
 (1 return per month  $2 \times 50 \times 12$ )  
 charge for opening an account:  $\text{Php } 1,000$

Part of these costs can be covered through the sale of membership cards at  $\text{Php } 150$ :  $420 \times 150 = \text{Php } 63,000$

The other part is added to contributions:

$$(74,400 - 63,000) / 420 = \text{Php } 27.14 \text{ member/year} \\ = \text{Php } 28.00 \text{ member/year}$$

The total contribution will therefore be:

Per person and per year:  $715 + 72 + 28 = \text{Php } 815.00$

Per family and per year:  $\text{Php } 815 \times 6 = \text{Php } 4,890$  or  
 rounded off to  
 $\text{Php } 4,900.$

The coverage offered is attractive and gives the HMIS a high profile, but requires a contribution that is lower than the estimated contribution capacity. However, the HMIS must regularly monitor its benefits. Agreements may be made, for example, between the nurse and members to record outpatient consultations as minor surgery or minor hospitalization, which can then be charged to the HMIS. It would be wise to apply a percentage co-payment for these two types of health care.

In the interest of strengthening its financial sustainability, the HMIS could ask the cooperative to use the  $\text{Php } 50,000.00$  that it has offered to make available to set up a reserve fund, to be paid into a separate account at the savings/credit fund.

## (8) Gender Relations

According to focus groups discussions and informant interviews with representatives of people's organizations and barangay officials, women in most or all cases attend to the health needs of sick family members. Majority of those who volunteer in community health projects are women, with minimal participation of men. Health is seen in the community as a women's concern.

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Most of the health projects involve maternal and child health care, and occasional sanitation and cleanliness drives. Child-bearing women complain that the reproductive health and family planning services of the local health unit have deteriorated.

Most respondents reported that the men still generate the bigger income within the household, even as women help out in farm activities and generate occasional earnings from selling goods. Men get to decide on major expenditures. Local associations are mostly dominated by men in terms of membership and leadership, with the exception of a lone women's group that was initially set up for accessing micro-finance for livelihood projects.



Reference Guide and Tools on Health  
Micro-Insurance Schemes in the Philippines

# The Organization and Administrative Management of a Health Micro-Insurance Scheme



STRATEGIES & TOOLS  
AGAINST SOCIAL EXCLUSION  
& POVERTY



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



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## Purpose

Chapter 3 aims to provide you with a guide in organizing and running your HMIS. It covers the organizational structure and linkages of entities involved in your HMIS and the necessary administrative functions that must be undertaken. It is hoped that after going through this chapter, you will be equipped with the necessary information on the organizational arrangements and administrative systems considered most critical in running an efficient and effective scheme. Hopefully, you will be able to translate and apply these in running your respective HMIS.

## Content

In this chapter, you will be introduced to the importance of management systems in your HMIS. First, it outlines the organizational structures that you need to set-up to govern your HMIS together with the corresponding roles and responsibilities. It will also provide you with details on the by-laws as well as policies, systems and procedures (PSPs) that guide your operations. Secondly, you will be oriented on the administrative arrangements that your HMIS must undertake. In particular, these include the enrolment of your members, the registry of their contributions, the mechanism in collecting their premiums and approaches in providing the services.

## Sections

- Section 3.1 : HMIS Management Systems and Tools
- Section 3.2 : Organization and Operation of a HMIS
- Section 3.3 : Managing Relations With External Partners
- Section 3.4 : Administrative Management of a HMIS

## Section 3.1: HMIS Management and Tools

### 3.1.1 Importance of Establishing HMIS Management System

Health micro-insurance schemes in the Philippines are established primarily to make quality health care more accessible to those of you in the informal economy until such time that the National Health Insurance Program being managed by PhilHealth could integrate these community risk-pooling schemes. Though HMIS are established with a social objective and are rooted to the principles of mutual aid and solidarity, they are not exempted from other organization required to provide services of high quality and to operate effectively. HMIS, like yours, are built and maintained through the hard-earned contributions of each of your members. It is important therefore that your HMIS operations are properly managed and your resources utilized rationally to fully benefit your members. The management of your own HMIS largely determines the success of its activities and the achievement of its objectives.

- (a) *Building Confidence*: For one, good management boosts your members' confidence. This is particularly important if your HMIS requires your members to pay regular contributions without receiving any immediate benefit. Remember that your members benefit from the contributions they pay, only when a contingency occurs, that is, often several months after they have begun to pay contributions. They must have confidence in your HMIS that it is able to help them when they are in need.

Effective management also boosts the confidence of your health care providers towards your HMIS. They need to be reassured that your HMIS will always be in a position to pay the invoices for care they dispensed to your members.

- (b) *Viability of the Scheme*: Note that your HMIS is an insurance system against a “sickness risk,” which is relatively complex to manage. It is compounded by its very nature of uncertainty due to this risk. It is imperative that your scheme remains viable. This means that you need to put in place management systems of forecasting and accounting and financial control to counter any possibility of adverse events and maintain the viability of your HMIS against such diverse situations.

- (c) *Minimize Dysfunctions*: The type of management system you will establish is vital to the operations of your HMIS. It is important that you define this management system at the very beginning - the same time when you are defining your HMIS' organizational structure and operational arrangements. Experience has shown that if the management system is not well defined prior to the initiation of activities, your HMIS is very likely to experience major dysfunctions that lead to uncontrollable operational issues and concerns. Ultimately, it will result to an irreversible loss of credibility in the eyes of your potential members and service providers.

You are provided in this Module simple and effective management guide and tools in managing your respective HMIS. In particular, Module 3 discusses the organization and operation of your HMIS and provides guides and tools on administrative management. Module 4 deals more with the accounting and financial management of your HMIS. Note that the documents presented here are only examples to optimize your understanding. They do not pretend to meet all your management needs.

### 3.1.2 Various Aspects of HMIS Management

Managing an HMIS involves mobilizing and using as effectively as possible a series of resources to carry out activities intended to meet its objectives. Any organization like your HMIS has three types of resources to mobilize and manage. These include: (a) human resources, (b) material resources, and (c) financial resources.

- (a) *Human Resource*: Human resources are frequently the most valuable resource but also the most complex to manage. Your management involves very diverse aspects, but resides first and foremost on motivating your individual staff or volunteers. The available human resources in your HMIS depend largely on the size of your organization and the amount of contributions that you ask your members to pay.

If your HMIS has few members, the operation of your HMIS may reside primarily on voluntary work, notwithstanding the fact that administrative and management functions are often demanding and time consuming. In this case, your HMIS must encourage volunteers, distribute the tasks and responsibilities and set up simple administrative and financial procedures. It must also offer opportunities for self-development and learning to be truly motivating. If your HMIS has large membership, you entrust a substantial proportion of your activities to paid staff. You must therefore establish an adequate recruitment, hiring, management and assessment procedures of your staff.

- (b) *Material Resources*: Unlike a production enterprise which must purchase necessary machines and instruments, your HMIS does not require a lot of equipment to operate. Since it is a service enterprise, it would primarily manage financial flows and information flows. You must have therefore the appropriate resources to carry out this function. Equipment may be necessary if you establish your own clinics or centers to provide the health services to your members.
- (c) *Financial Resources*: If you want your HMIS to be operational and financially viable, you must set in place management tools and procedures. You should also allocate functions to the different bodies you have created. These management tools should encompass the effective collection of your members' contributions, safe-keeping of your funds, forecasting of your income and expenditure, keeping your management documents up to date, monitoring and regularly analyzing the invoices you received, the expenditures you incurred and the overall financial status of your HMIS.

There are basically three areas which you need to focus on in managing your HMIS. These are:

- **Organization and Operation**: This area of management is determined by the organizational structures that you set-up and the By-Laws as well as the Policies, Systems and Procedures (PSPs) that you establish, the meetings your organization undertakes and the relationship you have with your service providers or external partners.
- **Administrative Management**: Administrative management involves your tasks on membership registration and monitoring, collection of contributions, their entry on the books as well as monitoring and payment or benefits. These tasks are particularly important because contributions and benefits are the main source of income and expenditure of your HMIS. The tools used for administrative management also make it possible for you to have all the information necessary to carry out monitoring and analysis of your overall HMIS performance.
- **Accounting and Financial Management**: The purpose of accounting management is to record the various transactions of your HMIS in the form of inflows and outflows of resources, and to file and process them. Accounting management follows the different stages of your HMIS activities in a given period (usually 1 year), known as a financial year (start-up, operation and closure). The purpose of financial management is to ensure long-term financial viability of your HMIS. It aims to forecast and control your revenue and expenditure, analyze your financial situation and manage your financial

investments.

Your accomplishment of the above documents are expected to give you information in keeping track the progress of your HMIS operations, and as basis for developing your monitoring tools themselves. Monitoring of your HMIS is the focus of discussion in the Module 5.

### 3.1.3 Main Management Aids and Tools

There are various tools and records that will help you set-up the management system in your HMIS. These are summarized as follows. Note that the details of each are described in the subsequent sections of this module and in Module 4.

- **Administrative Management:**
  - The Membership Card
  - The Register of Members
  - The Certificate of Entitlement
  - The Invoice
- **Accounting Management:**
  - The Cash Journal
  - The Cash-in-Bank Journal
  - The Cash Receipt Book
  - The Cash Disbursement Book
  - The Petty Cash Form
  - The General Ledger
  - The Statement of Income and Expenditure
  - The Balance Sheet
- **Financial Management**
  - The Action Plan
  - The Budget
  - The Cash Flow Forecast
  - The Statement of Income and Expenditure
  - The Balance Sheet
  - The Financial Ratios Record

## Section 3.2: Organization and Operation of a Health Micro-Insurance Scheme

This section concerns the organization and operation of your HMIS. It deals first with the management structures to be set up and the By-Laws as well as Policies, Systems and Procedures (PSPs) to be established. While the structural bodies to be formed have been introduced briefly in Module 1, there is a need to know their expected responsibilities and understand how they link-up with one another. In addition, the By-Laws that govern the operations of your HMIS are presented together with the PSPs. The minutes of meetings as a vital tool in managing the operations of your HMIS is also presented and discussed. Lastly, the section summarizes the different external partners your HMIS may have to deal with and therefore, it gave you some options to consider in granting benefits. Lastly, it looks into the Memorandum of Agreement (MOA) you may enter into with your potential external partners.

### 3.2.1 The Management Structures

The type of management structure is a very important aspect in the operation of your HMIS. You must think about this management structure up-front, specifically during the stage when you are defining the organization and operation of your HMIS. You must have a precise definition of the authorities and responsibilities of your management bodies to ensure that your HMIS function effectively. Your organizational chart must precisely determine the place of each structure/unit and define each of their functions and responsibilities and attribute their corresponding authority.

The HMIS may consist of the following management bodies:

- General Assembly
- Board of Directors
- Executive Body
- Auditing Body

Most of the cooperatives running HMIS in the Philippines usually require only two management bodies, the General Assembly and the Board of Directors. In more complex or advanced associations or groups, an Executive Body is also formed, and in some instances, these are composed of salaried staff. Other committees may also be formed depending on the size and complexity of the needs and activities of your HMIS:

- Medical Committee
- Committee of Experts
- Monitoring and Evaluation Committee (in some cases, this function is merged with the Auditing Body)
- Grievance Committee

This Guide deals with the management bodies found in most HMIS in the Philippines, namely: the General Assembly (GA), the Board of Directors (BD), the Executive Body (EB) and the Auditing Body.

#### (a) *The General Assembly (GA)*

*(a.1) Overall Function:* The General Assembly (GA) is the most important and highest decision-making body in your HMIS. It determines your By-Laws, its decisions bind all its members and all the other management units. During the first General Assembly meeting or the so-called formal launching of your HMIS, your members determine and establish the By-Laws as well as the PSPs of your HMIS.

*(a.2) Frequency of Meeting:* The GA is normally convened at least once a year to approve the annual accounts and budget. In most cases, it also convenes upon the request of at least one fifth of the members of your HMIS. This is called the Special General Assembly. According to



the By-Laws or the PSPs, the GA may also be convened at the request of the Board of Directors, the Executive Body or even the Auditing Body.

*(a.3) Duties and Responsibilities:*

- define the mission of the HMIS and formulate its By-Laws
- approve and alter the By-Laws
- examine and approve the activity reports of the various bodies, including the Auditing Body
- examine and approve the annual accounts and budget
- establish the amount of contributions and any special contributions
- elect the members of the Board of Directors
- elect the members of the Auditing Body
- define the new directions of the HMIS
- decide on mergers with another HMIS, or wind-up the HMIS
- decide on the admission or exclusion of members of the scheme (more common in small health micro-insurance schemes or those with annual contributions)
- decide on any other matters provided for by the By-Laws
- decide on the benefits offered by the HMIS

As far as adjustments in contributions are concerned, the GA may delegate its powers to the Board of Directors for a definite period - often one year, renewable after approving the decisions taken the previous year. This allows decisions to be taken rapidly if the financial situation makes it necessary, like for example, the changes in the cost of medicines or inflation).

*(b) The Board of Directors (BD)*

*(b.1) Overall Function:* The Board of Directors (BD) is the body responsible for managing the HMIS. It exercises all the responsibilities not specifically entrusted by law or the HMIS By-Laws to the GA or the Auditing Body. The members of the BD are all volunteers who agree to make their skills and part of their time available to others.

The BD asks the GA to consider its decisions to admit and exclude members. Once these decisions have been adopted, these are enforced by the BD. While awaiting the GA's decision on such proposals, members may be provisionally admitted or suspended. This may be difficult to apply in large-scale HMIS. It is possible though to delegate responsibility for admitting or excluding members to the BD or the Executive Board. In this case an appeal to another managing body, such as the Auditing Body or the GA itself, is also possible.

*(b.2) Delegation of Powers:* The BD may delegate part of its powers to the Chairperson or to one or more directors. As far as the daily management and specific implementation of decisions is concerned, the BD may delegate certain powers to the Executive Board.

*(b.3) Duties and Responsibilities:*

- ensure respect for the By-Laws with a view to attaining the objectives of the HMIS
- propose the admission or expulsion of members and apply the disciplinary penalties provided for, if necessary
- nominate the responsible members of the Executive Body



- draw up the annual accounts and budget for the following financial year
- coordinate the work of the various committees
- draw up the activity reports of the HMIS on an annual basis
- represent the HMIS in its relations with the third parties and establish relations with other associations, particularly other social movements which are also founded on solidarity
- sign agreements/conventions, specially with care providers
- establish staff pay
- recruit the director/manager (if are paid and not elected)
- fulfil all other missions entrusted by the By-Laws or the GA

The BD must permanently monitor the management of the HMIS and address the problems it faces.

*(c ) The Executive Body (EB)*

*(c.1) Overall Function:* The principal executing body is generally the Executive Body (EB). It is also called the Executive Committee, Management Committee or Management Board. In many HMIS, the management-related functions are ensured by voluntary members of the Executive Board. This involves day-to-day tasks, organizing activities, supplies or the maintenance of premises. The EB is responsible for the day-to-day administration of the HMIS:

*(c.2) Duties and Responsibilities:*

- prepare budget BD and ensure proper implementation once approved
- present to BD the annual accounts and execute the budget
- make any proposal to BD to achieve HMIS objectives more thoroughly
- negotiate conventions/agreements after submission to BD
- manage the HMIS assets and funds
- recruit/supervise personnel (except the director/manager)
- ensure liaison between members and the management
- negotiate with providers and protect members' health interests
- exercise functions indicated in the By-Laws or endorsed by BD and GA

*(c.3) Composition:* Above a certain size, an HMIS may become professional and recruit permanent staff. In general, paid staff do not form part of the management bodies but are entrusted with technical and administrative tasks linked to daily management including accounting and office work. The Executive Body is often made up of members of the BD, such as the Chairperson, the Secretary or the Treasurer. The following are the responsibilities of the members of the EB.

**Box No. 3.1: Responsibilities of the Executive Board Members**

Titles	Functions
Chairperson	<ul style="list-style-type: none"> <li>• coordinates the HMIS activities</li> <li>• chairs meetings of the Executive Body</li> <li>• leads the team of permanent staff</li> <li>• orders expenditure</li> <li>• fixes the agenda of meetings</li> <li>• co-signs cheques</li> </ul>
Secretary	<ul style="list-style-type: none"> <li>• manages the administration of the HMIS</li> <li>• proposes agenda and draws up minutes of meetings</li> <li>• ensures the HMIS correspondence</li> <li>• keeps and files documents</li> </ul>
Asst Secretary	<ul style="list-style-type: none"> <li>• supports secretary in his or her work</li> </ul>
Treasurer	<ul style="list-style-type: none"> <li>• manages the HMIS funds</li> <li>• keeps accounting records</li> <li>• draws up financial reports</li> <li>• deals with collections</li> <li>• carries out expenditure and co-signs cheque</li> <li>• ensures respect for budgets</li> </ul>
Asst. Treasurer	<ul style="list-style-type: none"> <li>• supports treasurer in his or her work</li> </ul>

(d) *The Auditing Body (AB)*

(d.1) *Composition:* Elected by the GA, the Auditing Body (AB) verifies the implementation of the GA's decisions, proposes improvements and guarantees that the HMIS management bodies function efficiently. Even in relatively small or recently created HMIS, it is essential to designate a person who, after appropriate training, will closely examine receipts and accounting records. This requires special skills and cannot be carried out by the GA. Sometimes this Auditing Body is also tasked to do the monitoring and evaluation, hence they become the Monitoring Committee.

(d.2) *Duties and Responsibilities:*

- ensure that minutes of the management bodies conform to the By-Laws as well as the PSPs and do not contravene laws and regulations in force in the country
- control the accuracy of the accounts and regularity of financial transactions
- control the execution of decisions of the GA
- draw the attention of the responsible management bodies to irregularities committed and propose measures or procedures to avoid repetition
- ensure respect for the HMIS By Laws and PSPs
- receive complaints from members concerning the services offered and ask the competent body/person to correct them;
- require the competent person or body to carry out a task which has not been performed or which has been poorly performed, and ask for necessary procedures to be applied

- examine and check the conditions of eligibility of members taking part in the GA
- exercise all the functions assigned to it by the By-Laws and the PSPs

### 3.2.2 The By-Laws and Policies, Systems and Procedures

The documents concerning organization and internal operation of your HMIS define the framework for its management and lists down the responsibilities of each player, specifically who does what and how. At the start, these documents need not be that rigid. They need to be reviewed and adjusted regularly as new situations present themselves. The principal organization and functioning documents include :

- The By-Laws
- The Policies, Systems and Procedures
- The Minutes of Meetings
- The Memorandum of Agreement

#### 3.2.a The By-Laws

##### a.1 What are the By-Laws for?

The HMIS is incorporated by means of By-Laws. An inaugural or first meeting of the GA officially precedes the creation of the HMIS by providing it with legal personality.

In the Philippines, the operation of the HMIS is regulated according to the needs of the community and is derived from legislative laws on cooperatives and non-profit making associations, mutual savings and credit banks. The rules relating to the objectives and functions of your HMIS are defined by the By-Laws, which determine the rights and duties of the members and the role of the different management bodies. They establish the means, guaranteeing that the HMIS functions democratically and jointly.

##### a.2 What information does the By-Laws contain?

Despite the lack of regulation, the By-Laws of many HMIS in the Philippines have the same logical structure. This Guide suggests the basic information found in most By-Laws. There are basically five sections of the By-Laws that highlight each set of pertinent information:

<b>Title 1 :</b>	The General Provisions
<b>Title II:</b>	Administration of the Health Micro- Insurance Scheme: composition, election and powers of the management bodies.
<b>Title III :</b>	Financial Provisions
<b>Title IV :</b>	Obligations of the Health Micro-Insurance Scheme and its Members (may be specified in the internal rules of procedure)
<b>Title V :</b>	Rules of Application, Amendments, Membership of Unions, Federation, Merger, Winding-up and Liquidation

The following outlines in more detail the contents of each section of the By-Laws.

<b>Title I :</b>	<b>General Provisions</b>
<b>Chapter 1 :</b>	<b>Incorporation and Object of the Health Micro-Insurance Scheme</b>

Article 1	:	Incorporation
Article 2	:	Object
Article 3	:	Field of Action/Prohibitions

**Chapter 2 : Conditions of Admission, Withdrawal, Suspension, Deregistration and Exclusion**

<u>Section 2.1</u>	:	<u>Conditions of Admission</u>
Article 4	:	Conditions
Article 5	:	Capacity of Member (ordinary/honorary member)
Article 6	:	Common Premises
Article 7	:	Terms of Membership
<u>Section 2.2</u>	:	<u>Conditions of Withdrawal, Suspension, Exclusion, and Deregistration</u>
Article 8	:	Withdrawal
Article 9	:	Suspension
Article 10	:	Exclusion
Article 11	:	Deregistration
Article 12	:	Special Provisions

**Title II : Administration/Functioning of the Health Micro-Insurance Scheme: Composition, Election and Powers of the Management Bodies**

**Chapter 1 : The General Assembly (GA)**

Article 13	:	Composition
Article 14	:	Election
Article 15	:	Powers

**Chapter 2 : The Board of Directors (BD)**

Article 16	:	Composition
Article 17	:	Election
Article 18	:	Powers

**Chapter 3 : The Auditing Body (AB)**

Article 19	:	Composition
Article 20	:	Election
Article 21	:	Powers

**Chapter 4 : The Executive Body (EB)**

Article 22	:	Composition
Article 23	:	Election
Article 24	:	Powers

**Title III : Financial Provisions**

**Chapter 1 : Revenue and Expenditure**

Article 25	:	The Revenue of the Health Micro-Insurance Scheme
Article 26	:	The Expenditure of the Health Micro-Insurance Scheme

<b>Chapter 2</b>	:	<b>Methods of Investing and Withdrawing Funds</b>
<b>Article 27</b>	:	<b>Legal Reserves</b>
<b>Article 28</b>	:	<b>Methods of Investing</b>
<b>Title IV and its and</b>	:	<b>Obligations of the Health Micro-Insurance Scheme Members (may be specified in the Policies, Systems and Procedures)</b>
<b>Chapter 1</b>	:	<b>Obligations of Members</b>
<b>Article 29</b>	:	<b>Membership Fees</b>
<b>Article 30</b>	:	<b>Contributions</b>
<b>Article 31</b>	:	<b>Conditions of Access to Benefits</b>
<b>Chapter 2</b>	:	<b>Obligations of the Health Micro-Insurance Scheme</b>
<b>Article 32</b>	:	<b>Benefits of the Health Micro-Insurance Scheme</b>
<b>Article 33</b>	:	<b>Information on Members</b>
<b>Title V</b>	:	<b>Rules of Application, Amendments, Membership of Unions, Federation Merger, Winding-up and Liquidation</b>
<b>Chapter 1</b>	:	<b>Rules of application and amendments</b>
<b>Article 32</b>	:	<b>The Policies, Systems and Procedures</b>
<b>Article 33</b>	:	<b>Amendments and Alterations</b>
<b>Chapter 2</b>	:	<b>Membership of Unions, Merger and Demerger</b>
<b>Article 34</b>	:	<b>Unions</b>
<b>Article 35</b>	:	<b>Merger</b>
<b>Article 36</b>	:	<b>Demerger</b>
<b>Chapter 3</b>	:	<b>Winding-up and Liquidation</b>
<b>Article 37</b>	:	<b>Winding-up</b>
<b>Article 38</b>	:	<b>Liquidation</b>

### a.3 How are the By-Laws used?

The By-Laws are a collective contract between your HMIS and the members. They are a reference document regarding the following:

- its name and registered office
- the objectives pursued
- the services offered
- the conditions of admission and coverage of dependents
- the methods of establishing contributions
- the methods and procedure regarding the election of members of the Board of Directors
- the rules of operation of the health micro-insurance scheme not provided for by law or other official texts

**Table 3.1: Preparation and Use of HMIS's By-Laws**

Health Micro-Insurance Scheme Internal Organisation				External Partners	
General Assembly	Executive Body	Board of Directors	Auditing Body	Adm Authorities	Other Partners
(2) Adopts By-Laws	(3) Carries out activities according to terms set down in the By-Laws	(1) Prepares By-Laws  (1.a) Prepares simplified version of By-Laws	(4.a) Controls monitoring and respect for By-Laws	(4.b) Checks conformity with regulations and recording	(4.c) May consult By-laws

The above table summarizes the different responsibilities of those involved in relation to the By-Laws.

- (1) The By-Laws are generally drafted by the Executive Body or the Board of Directors.
- (2) The General Assembly is responsible for approving them.
- (3) When the By-Laws have been adopted the Executive Body administers the activities according to the methods described.
- (4) Given the rather inaccessible nature of the regulatory texts supplied to members during the first GA meeting, a simplified version of the By-laws adapted to their level of understanding may be necessary to improve transparency and participative democracy in your HMIS.
- (5) Only the GA may alter the provisions laid down in the By-Laws. The By-Laws will be sent to the administrative authorities to be recorded, in accordance with the regulations in force.

**a.4 Example of By-Laws:** Please refer to Annex 3.1 for the actual sample of the HMIS' By-Laws.

### Document 3.2.2.b: The Policies, Systems and Procedures

#### b.1 What are the Policies, Systems and Procedures for?

Provisions concerning the practical operation of your HMIS but not articulated in the By-

Laws are defined in the Policies, Systems and Procedures (PSPs). These are usually practical methods such as:

- documents for members contributing for the first time
- the content of membership records
- the conditions required to be considered a beneficiary or dependent
- the amount and details of membership fees and contributions
- the detailed functioning of structures
- conditions of access to the benefits detailed

## **b.2 What information does the Policies, Systems and Procedures Contain?**

The PSPs complete and clarify the By-Laws of your HMIS. They therefore require the same information as the By-Laws:

<b>Title I</b>	:	<b>General Provisions</b>
Chapter 1	:	Incorporation and Object of the Health Micro-Insurance Scheme
Chapter 2	:	Conditions of Admission, Withdrawal, Suspension, Deregistration and Exclusion
<b>Title II</b>	:	<b>Administration/Functioning of the Health Micro-Insurance Scheme: Composition, Election and Powers of the Management Bodies</b>
Chapter 1	:	The General Assembly (GA)
Chapter 2	:	The Board of Directors (BD)
Chapter 3	:	The Auditing Body (AB)
Chapter 4	:	The Executive Body (EB)
<b>Title III</b>	:	<b>Financial Provisions</b>
<b>Title IV</b>	:	<b>Obligations of the Health Insurance Scheme and Its Members</b>
Chapter 1	:	Obligations of Members
Chapter 2	:	Obligations of the Health Micro-Insurance Scheme
<b>Title V</b>	:	<b>Rules of Application, Amendments, Membership of Unions, Federation, Merger, Winding-up and Liquidation</b>
Chapter 1	:	Rules of Application and Amendments
Chapter 2	:	Membership of Unions, Merger and Demerger
Chapter 3	:	Winding-up and Liquidation

## **b.3 How are the Policies, Systems and Procedures used?**

All members must comply with the PSPs in the same way as the By-Laws.



**Table 3.2: Preparation and Use of the Policies, Systems and Procedures**

Health Micro-Insurance Scheme Internal Organisation				External Partners	
General Assembly	Executive Body	Board of Directors	Auditing Body	Admin. Authorities	Other Partners
(2) Adopts or ratifies PSPs	(3) Executes activities according to terms indicated in the PSPs	(1) Prepares PSPs and may alter them	(4a) Controls monitoring and respect for PSPs	(4b) Verifies conformity with regulations and recording	(4c) May consult PSPs
		(1a) Prepares simplified version of PSPs			

Table 3.2 summarises the responsibilities of those involved in preparing the organization and functioning documents.

- (1) the PSPs are generally prepared by the Executive Body or the Board of Directors.
- (2) the GA is responsible for approving the PSPs.
- (3) once these are approved during the first meeting of the GA, the PSPs constitute a collective contract between the HMIS and its members. The scope of the PSPs is defined by the By-Laws.
- (4) in general, the By-Laws show that the Board of Directors is entitled to make immediately enforceable alterations to the PSPs. The GA may then ratify such alterations.
- (5) the Executive Body administers the activities according to the methods described in the PSPs. Like the By-Laws, they will be used as a reference document for the health micro-insurance scheme and can be adapted to the education level and communication

tradition of its members.

- (6) A copy of the PSPs, together with the By-Laws, will be sent to the administrative authorities to be recorded, in accordance with the regulations in force.

**b.4 Example of Policies, Systems and Procedures:** Please refer to Annex 3.2 for the actual example of PSPs.

### **Document 3.2.2.c: The Minutes of Meetings**

#### **c.1 What are the Minutes of Meetings for?**

The Minutes of Meetings are important documents for the strategic management of your HMIS. They record the decisions you have taken during your management meetings and in your interaction with external partners. Minutes are recorded for meetings of the General Assembly, Board of Directors or the Executive Body. They constitute the history of the collective decisions of your HMIS.

#### **c.2 What information do the Minutes of Meetings contain?**

The Minutes of Meetings usually contain the following:

- date of meeting
- place or venue of meeting
- body convening (General Assembly, Executive Body, Board of Directors, Auditing Body)
- agenda
- excused absentees
- absentees not excused
- decisions taken
- end of meeting (time)
- signature of the chairperson and secretary of sessions

This Guide presents an example of Minutes of Meeting which contains the principal information to be recorded during a meeting and the attendance list, possibly with the signatures of those present.

#### **c.3 How are the Minutes of Meetings used?**

The Minutes are drafted by the secretary of the session (also called the ‘rapporteur’). After each meeting, the body or committee draws up the minutes, including the information indicated above. The minutes are submitted to the members for approval at the following meeting.

**Table 3.3: Preparation and Use of the Minutes of Meetings**

The minutes make it possible to ensure respect for decisions taken and can be used as evidence in the event of litigation and for justification that meetings have been properly held. The secretary of the health micro-insurance scheme files the minutes according to the date or characteristics of the meeting.

The example presented is adapted for internal meetings (BD, EB, GA, AB). If, on the other hand, it is a meeting with external partners, it is important for the institutions and persons present to be mentioned.

**c.4 Example of Minutes of Meeting:** Please refer to Annex 3.3 for the format of a Minutes of Meetings.

**Table 3.3: Preparation and Use of the Minutes of Meetings**

Health Micro-Insurance Scheme Internal Organisation				External Partners	
General Assembly	Executive Body	Board of Directors	Auditing Body	Admin. Authorities	Other Partners
Minutes per General Assembly	Minutes per EB meeting  filing of Minutes of other management bodies	Minutes per BD meeting	Minutes per AB meeting		

## Section 3.3: Managing Relations with External Partners

### 3.3.1 External Partners of Your HMIS

The internal management bodies of your HMIS should work with the external relevant actors. These include, among others, the care providers, suppliers of services and equipment, beneficiaries and members, banking, legal and government institutions and supporting structures. Your relations with each one of them is essential for a smooth operations of your HMIS. You must therefore manage those relations very well.

- (a) *The care providers* are your special partners in operating your HMIS. This may be the barangay health station (BHS), a barangay health and nutrition post, a Rural Health Unit (RHU) or a health center, an infirmary or a hospital, but also a pharmacy, individual providers such as a doctor or radiologist, or a health transport company. The quality of relations between your beneficiaries and your providers will partly determine the effectiveness of your HMIS. Cooperation between your HMIS and your health service providers is embodied by signing a Memorandum of Agreement (MOA). The HMIS may be supported by a consultant doctor to manage better this relationship.

Communication between members and beneficiaries is important for your HMIS viability. You must engage in transparent management to win and retain the confidence of your members. You must also ensure that your members are satisfied with the quality of the benefits and services offered by your HMIS. Your members though and their dependents, must respect the terms laid down in the By-Laws and the PSPs.

- (b) *Legal or Public Authorities:* In the event of disputes, theft, fraud or other matters, your

#### Box 3.2 Micro-Finance Systems and Health Micro-Insurance Schemes

Experience has shown that HMIS and micro-finance systems can be complementary.

Many **micro-finance systems** have characteristics that foster the success of implementing an HMIS. They are deemed to manage money in a proper way and already have a reflex of results, profitability and viability. The experience of management bodies in the area of financial and administrative management may also benefit the HMIS. More than that, the existence of a legal and organizational framework and channels for promotion, awareness-raising and information favour the natural implementation of an HMIS. Certain micro-finance systems already have a much more integrated view of development and have developed 'education' and 'health' dimensions to their activities. Others have a relief fund for social risks.

In return, the **HMIS** as a health micro-insurance system may establish loyalty and reinforce the social image of the micro-finance system. The HMIS meets a specific need and reinforces responsibility and foresight. It may also reduce the risk of non-repayment or over-indebtedness. Following an epidemic, for example, it may reduce the risk of a massive withdrawal of savings. (Source: *ILO/STEP Africa, 2000, p.37*). Cooperatives and mutual benefit groups in the Philippines also serve the same purpose. Cooperatives provide a variety of services for their members such as micro-finance or access to credit and social services like health micro-insurance,

HMIS must be supported by these legal or public authorities. In this context, your HMIS should therefore play the role of a legal body. More than that, certain national agencies (with administrative authority) and decentralized services may provide activities or services in favour of your HMIS.

- (c) *Financial Structures*: The management of your HMIS is based largely on its financial structures such as savings banks, or savings and credit co-operatives from which your HMIS may secure its funds. Invoices may be paid through bank transfer.

In the Philippines, HMIS have been legislated as part of the programs or services provided by the cooperatives or community-based organizations. You must therefore in all cases, let your HMIS act in compliance with the existing regulations. You may also contact other health micro-insurance schemes, unions or federations. You may also benefit from the backing of support structures at technical, financial or organizational level.

### 3.3.2 Granting Benefits

Generally, the cost of health services is shared between your beneficiary and your HMIS. A tripartite relationship is established among you, the manager or operator of your HMIS, your beneficiary and your care provider.

Two possibilities must be considered for granting benefits to your beneficiaries. This may involve care delivered by providers who have signed an agreement with your HMIS, or care provided by the facilities which you established yourself. You have two options on how pay the cost of the health care:

Option 1: Indirect Third Party Payment

Either your beneficiary pays the total amount of the services they have used and are reimbursed subsequently by your HMIS

Option 2: Direct Payment Third Party Payment

Your HMIS pays the provider directly.

(a) *Payment of Care by the Beneficiary: Indirect Payment or Third Party Payment*

In this option, you ask your beneficiaries to pay the costs of the services provided before you reimburse them. In this case, your beneficiary pays according to the methods adopted by the care provider (payment at the time, by episode of illness or by outpatient care), and according to the rates you have agreed upon with your service provider.

Your beneficiary will therefore request the care provider you contracted for a proof of payment, usually a receipt or invoice, that must include at least:

- the identification of the care provider
- the identification of the beneficiary
- the nature, cost and date of the benefit

Equipped with his/her Membership Book and proof of payment, the beneficiary goes to your HMIS office to be reimbursed.

The disadvantages of this form of payment for your beneficiary are: they are obliged to have the total amount necessary to pay for the care and, on the other, the need for additional formalities and to wait for reimbursement. The disadvantages of this option for your HMIS are

the additional procedures which imply greater administration costs on your part.

The advantage of this system for your HMIS on the other hand is that it limits over-consumption, a tendency to abuse of the system and fraudulent invoicing.

*(b) Direct Payment by the Health Micro-Insurance Scheme (Third Party) Payment*

This second option is called the direct (third party) payment because it is not your beneficiary who pays but your HMIS - the third party in addition to the provider and the beneficiary. This option is often adopted for ‘major risks’ involving substantial costs which your beneficiary cannot meet (e.g. hospitalization or surgery). In certain cases, your beneficiary also pays a patient’s contribution to the provider. Your HMIS pays the service provider directly, upon presentation of an invoice.

You may negotiate with the provider and make a deposit available to them. This deposit will assure the care provider of your HMIS ability to pay. After this gesture of confidence, the care provider may issue invoices for care over a longer period and therefore in turn, adopt longer payment times. If this is convenient, you may negotiate with the provider to use the deposit as working capital for supplying stocks of medicines. .

The direct payment system is more advantageous for the beneficiary, since there are no cash problems, no formalities and no waiting for costs to be reimbursed. Administratively, the system may be less costly (reclassification of payments by provider rather than by beneficiary), but there is less potential for controlling the real situation of the care provided, and risks of over-consumption and mounting costs in particular are greater. Different discounts may also be granted, according to whether essential generic or proprietary medicines are involved, so as to favour the use of the former.

Some HMISs combine the two options in carrying out the payment of the cost of health care. According to the nature of the care, you may combine these two methods. For example, you may reimburse your beneficiary for minor expenses (e.g. outpatient care) and pay your care providers directly for more significant expenditures like hospitalization.

There is another scheme which some HMIS used to pay for the health services rendered to the members. This is the “capitation” scheme whereby the HMIS guarantees a fixed amount to the partner service provider (e.g. hospital) every year corresponding to the number of its subscribers or members.

One example of this scheme in the Philippines is the ORT-HPS in San Fernando, La Union. The ORT-HPS partnered with the Ilocos Regional Training and Regional Medical Center to provide health care to its members through a capitation contract. The ORT-HPS pays a yearly fixed income to the hospital depending on the number of its enrolled and qualified members during the year.

This scheme is less cumbersome on the part of the HMIS in terms of paying for health services since they only need to monitor if the members availing the services are qualified or entitled or not in coordination with their partner hospital. The health services are then charged to the capitation fund released earlier to the service provider.

**Box 3.3: Services of Health Facilities Established by HMIS**

The services of health facilities established by your HMIS may be proposed to members and non-members, with preferential rates for the former. For reasons of sound organization and transparency and in order to be able to evaluate the performance of the different facilities separately, the accounts of your HMIS and the health facilities must always be kept separately, even where non-members will not have access to the services offered.

**Health Centers and Hospitals Established by the Scheme:**

Several options can be considered:

- the costs of members and their dependents are met 100% once the waiting period has been concluded: they are then provided with care upon presentation of their membership card;
- only the consultation is free of charge, while care and medicines are paid for according to the products used;
- an excess (participation in costs) is accepted by the member for each consultation or act carried out;
- a patient's contribution is established by the HMIS: the patient supports a certain percentage of all the costs of consultations, care and various technical acts.

**Pharmaceutical Stores of the HMIS:**

The HMIS favours the sale of generic medicines and only delivers proprietary medicines if it is essential. Members will benefit from a preferential rate, while non-members may purchase medicines at the market price.

*Source: ILO-STEP/WSM-ANMC, 2000, 'Mutuelles de santé en Afrique: caractéristiques et mise en place. Manuel de formateurs', pages 158-159*

**3.3.3 Tool for Managing External Relations**

Your HMIS relations with its external partners must be very well documented through a memorandum of agreement. Note that the main objective of your HMIS is to provide your beneficiaries with better access to quality health care. Your relationship with care providers will be your cornerstone of better service for your beneficiaries. The establishment of a memorandum of agreement (MOA) between you and the care provider may ensure that this external relationship functions better.

**Document 3.3.3a The Memorandum of Agreement****4.a What is the Memorandum of Agreement for?:**

The MOA is otherwise known as co-operation agreement. You, being in-charge of your HMIS, sign an agreement with the service or care providers to formalize your partnership and how to operationalize it. Your MOA should establish, among others, the benefits and means of meeting the cost of treatment. It must ensure that your beneficiaries receive quality care at a reasonable pre-established cost.

Your MOA can include: the methods of paying invoices (such as reimbursement, direct payment or indirect payment), the system of granting benefits and the payment of invoices. It consolidates relations with your service provider and is a tool for arbitration in the event of disputes.

The MOA may also include the procedure for meeting costs and the membership procedure for your beneficiaries. These procedures and documents will be discussed in the following sections.



## a.2 What information does the Memorandum of Agreement contain ?

The MOA is generally structured as follows:

Preamble:	Presentation of the Two Parties
Article 1	: Object: Objective of the Cooperation, Type of Services Covered (must be described as accurately as possible)
Article 2	: Commitments a. Health Micro-Insurance Scheme b. Care Provider: Conditions for Meeting Beneficiaries' costs
Article 3	: Duration of the Agreement
Article 4	: Arbitration: Procedure in the Event of Dispute
Article 5	: Revision: Possibility to Alter the Terms of the MOA
Article 6	: Termination: End of the MOA
Signature of the Two Parties	
Signature of the Arbitration Authority	
Annexes: List of Benefits Offered Plus Costs	

## a.3 How is the Memorandum of Agreement used?

**Table 3.4: Formulation and Signing of the MOA**

Health Micro-Insurance Scheme Internal Organisation				External Partners	
General Assembly	Executive Body	Board of Directors	Auditing Body	Providers	Arbitration Authority
	(1) Examine possibilities and prepare MOA: provisional version	(2) Examine possibilities and prepare MOA: final version			
		(3a) Negotiate and sign MOA	Control/ monitoring of terms set down in MOA	(3b) Negotiate and sign MOA	(3c) Co-sign reference in event of arbitration

Table 3.4 shows the involvement of the different management bodies in the preparation and signing of the MOA.

- (1) The EB examines the possibilities for signing MOA with providers including the conditions and possibilities for reductions or demand for a deposit.
- (2) The BD then negotiates the terms of the MOA with providers and signs it with the provider in two copies.

The MOA is a reference document and working tool for your HMIS and the care provider. It may also have a legal value, particularly if it bears the stamp of an arbitration authority. The

MOA may be signed by the Chairperson of the Board of Directors of your HMIS or by any other authorized person. The care provider may be bound by the signature of the director, the senior doctor or any other authorized person.

It is important that the provisions contained in your PSPs concerning the conditions for meeting beneficiaries' costs are consistent with the terms of the MOA. In view of the complexity of health-related activities, your MOA may not foresee all potential cases and may leave room for interpretation. In the event of a dispute, your HMIS and the service provider must try to settle their differences amicably. If necessary, the competent authorities will be contacted.

The terms of the MOA may be revised if necessary. The example given in Annex 3.4 describes the partnership and cooperation between a Health Center and the HMIS for meeting the cost of outpatient care, hospitalizations, deliveries and transports.

**a.4 Example of a Memorandum of Agreement :** Please refer to Annex 3.4 for the actual sample of an HMIS MOA.

For efficient and effective management of your HMIS, you must give particular attention to two administrative concerns in operating your HMIS. These have regard to your members in general and the provision of health services or benefits.

On membership, you need to properly identify them, manage their participation and enrolment by completing and updating your membership registry including their dependents, the collection of their premiums and the recording of these contributions.

On benefits, vital areas to be administered will include the benefit entitlements of your members, their actual availment of services and recording the services provided.

For each of the above operational concerns, there are corresponding administrative documents that could help you manage them well. These documents make it possible for you to record information essential to the administrative management of your HMIS and to the control, monitoring and evaluation of its activities.

These documents present a system of recording pertinent administrative information. Care must be taken at all times to ensure that you and your staff sufficiently understand and master them. However, you need to adapt these documents according to your needs and skills including the characteristics and context of your HMIS.

The principal documents for recording administrative information are:

- For membership:
  - The Membership Book
  - The Register of Beneficiaries
  - The Register of Contributions
- For benefits:
  - The Certificate of Entitlement
  - The invoice
- The Register of Benefits

There are also other supplementary documents such as the contribution deposit slip, the individual or family monitoring form or statements of expenditure of local sections which you can use.

## Section 3.4: Administrative Management of a Health Micro-Insurance Scheme

### 3.4.1 Identifying and Recording Your Membership

After setting up your HMIS or after holding the first GA meeting and at the end of the waiting period, your HMIS must begin to process membership records.

In this regard, you must be able to systematically enlist your members and register the beneficiaries properly. This section examines the key documents useful for processing your new members. These include:

- The Membership Book
- The Register of Beneficiaries

#### a.1 What is the Membership Book for?

The Membership Book (MB) is an evidence of membership of individuals to your HMIS. Other HMISs call this the Membership Pass Book. Some refer to it as a Membership Card. The Membership Book may take different forms. It may be a family card, in which case it will display all information to precisely identify the member of the family and each of his/her dependents. Other organizations prefer an individual card (one for each beneficiary), while giving priority to family membership. In other HMIS, the Membership Book also serves as a health record. It includes several blank pages for use by health care providers to record their services and prescriptions.

Note that the principal objective of your Membership Book is to identify your members and beneficiaries and to check that their contributions are paid regularly. It shows the logical succession of contributions paid and the benefits used by each of your members.

The MB serves as a “passport” of your members. This confirms to the health care provider that your members are covered by your HMIS. It also helps you check the accuracy of the records on the Register of Contributions and the Register of Beneficiaries at any time. It also serves as a monitoring tool. However, if it is to be effective as such, the MB should bear a photograph of each beneficiary. This however is difficult to achieve given the cost that hampers the poor families from accessing your HMIS. You must bear in mind that there are costs associated in printing the MBs, thus they should be kept as simple as possible. They should not also be renewed too frequently.

#### a.2 What information does the Membership Book contain?

Your MB should contain the following information:

- Identification of members and their dependents
- Monitoring of contributions

The MB may also include a brief description of your PSPs on:

- methods of meeting costs
- benefits covered/not covered
- illustrations or flowchart to visualise the procedure for meeting costs

For confidentiality reasons, it is not advisable for you to include the diagnosis of medical consultations in your MB. The monitoring of the beneficiaries’ medical conditions may be encouraged by using instead a simple reference to any document issued by the service provider. The following information details of an MB are presented below:

**Cover Page:**

- Details of the HMIS such as address, telephone, etc.
- Logo, if any
- Name of the Member

**First Page:** identification of member with the following info:

- First name
- Surname
- Sex
- Address
- Telephone Number
- Identity Card Number
- Date of Birth
- Place of Birth
- Beneficiary Code
- Blood Type
- Date of Joining (time of payment of membership fee).

**Following Pages:** Identification of Dependents

- First Name and Surname
- Identity Card Number
- Connection with Member: relation, under guardianship
- Date and Place of Birth
- Beneficiary Code
- Blood Type
- Photograph
- Date of First contribution

It is advisable that you provide several beneficiary identification pages in order to record new dependents. You may have the photograph replaced by other evidence, such as the fingerprint. You may include the blood type of your member to facilitate medical intervention in the event of an accident.

The summary of the PSPs gives the beneficiaries and providers a better understanding of the methods of meeting costs and fosters transparency of your HMIS to your members, partners and providers including beneficiaries. This helps avoid pointless arguments in the event of disagreement.

Your MB may also show the following among other things:

- the aim of your HMIS
- HMIS structure
- conditions of membership
- conditions of entitlement to benefits

Note that you will be the one to make the final decision regarding the draft, number of pages of your MB and the information it must contain. Remember that the MB can be used as a reference material or a reminder but it also entails cost.

**a.3 How is the Membership Book used?**

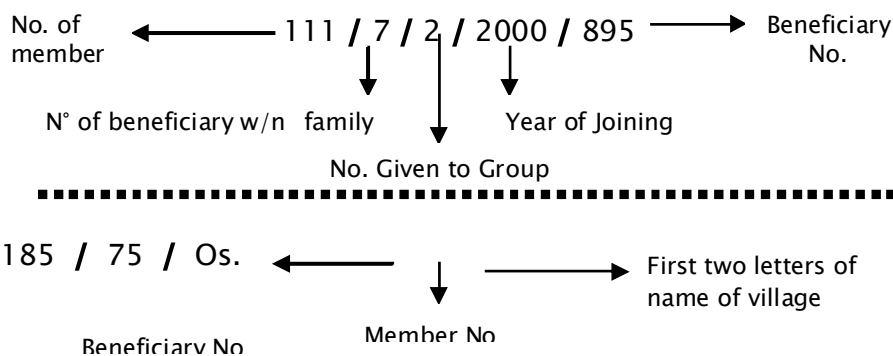
In the By-Laws, the GA stipulates the payment of a membership fee corresponding to the issuance of the MB.

- (1) First, you request the applicant to complete the information form. You may request for photographs of his/her beneficiaries. although this is not fully recommended, it may represent a substantial burden to your members. You may, for example, accept that the photograph is not obligatory, provided that the beneficiary furnishes you with an identification card with photograph. Since these are references, in the event of a check, you may have therefore to refer to the identity card.
- (2) You attribute a code to each beneficiary, in the knowledge that the member is both a member and a beneficiary. The code may be constructed as follows:
- (3) After each contribution is paid, the person responsible for collecting contributions puts a stamp or signature on the space provided in the MB and indicates the total amount of contributions paid. This helps your:
  - members to check if their contributions are up-to-date
  - care providers to know whether the person concerned meets your HMIS conditions for meeting the cost, together with the certificate of entitlement
  - HMIS to have a means of control (comparison with register of contributions - membership book, see following page).

The monitoring of contributions also makes it possible - after joining to keep track of your beneficiary's waiting period.

#### Box 3.4 Examples of Coding of Beneficiaries

##### Member:



**a.4 Example of Membership Book:** Please refer to Annex 3.5 for the actual sample of an HMIS Membership Book.

#### Document 3.4.1b: The Register of Beneficiaries

##### b.1 What is the Register of Beneficiaries for?

The Register of Beneficiaries is an important administrative management tool. It is designed to allow you ascertain the following on a regular basis:

- the number of beneficiaries (members and dependents)

- new memberships and withdrawals during an accounting period
- payments of membership fees and contributions,
- renewal of contributions in order to be able to track, from one accounting to the next, the growth in number of members and, where relevant, of cancellations of membership

The Register of Beneficiaries enables your HMIS to record information relating to your beneficiaries and makes it possible for you to monitor the number of beneficiaries of your HMIS at all times, particularly your members and their dependents.

This register also serves to record any changes within a member's family (birth, death, etc). Lastly, it is intended to reflect payment of contributions and identify any arrears.

### **b.2 What information does the Register of Beneficiaries contain?**

The Register of Beneficiaries makes it possible for you to record the following data:

- beneficiary code: indicating the number of the beneficiary and their status (member or simple beneficiary)
- surname and first name
- sex
- address
- date of birth
- status: member or dependant
- date of joining: first contribution
- date of leaving
- comments: reasons for leaving, other relevant information

### **b.3 How is the Register of Beneficiaries used?**

You must record any beneficiary into the Register of Beneficiaries for whom a contribution is paid to your HMIS. You must also assign them with a beneficiary code.

You can use the Register of Beneficiaries at any time to find information on your beneficiaries. You can also find the details of all your members. For example, those who attended the GA.

It can also be used for:

- monitoring the number of members/beneficiaries by means of the coding system
- assessing reasons for leaving your HMIS: for example, members who have not paid their contributions for the last six months
- identifying the number of men/women members of your HMIS, their age group, their location (e.g. if they are near the care provider)

The admission procedure is as follows:

- (1) The person goes to your HMIS office and gets information on the conditions of membership and pays for membership.
- (2) The Executive Body examines the application and accepts the money, records the membership with a reference in the Register of Beneficiaries to the name of the people whose costs will be met, and completes the membership book with the details of the member and the other beneficiaries.
- (3) In the event of doubt as regards acceptance or rejection of the application for admission, the

**Table 3.5: The Recording of Members**

Health Micro-Insurance Scheme Internal Organisation				External Partners	
Member	Executive Body	Board of Directors	Auditing Body	Providers	Bank
(1) Demand and pay membership fees	(2) Record new members: update Register of Beneficiaries	(3) Accept or refuse applications to join			
(5) Receive MB	(4) Prepare MB		Control		(7) Collection and recording in HMIS account
	(6) Pay money into bank account				

EB may ask for guidance from the BD.

**b.4 Example of a Register of Beneficiaries:** Please refer to Annex 3.6 for the actual sample of an HMIS Register of Beneficiaries.

### 3.4.2 Collection and Recording of Contributions

Another aspect that you need to manage properly regarding your members is the regular collection of their contributions. You must be able to set up a mechanism that enables you to collect and record appropriately these contributions. Note that one of the weaknesses in an HMIS is the difficulty of collecting premiums on a regular basis.

Various reasons have been cited on this regard. For one, your HMIS office or collection center may be located far from your members' area of residence, which could discourage them from going to your office frequently given the extra transport cost. Secondly, with low income and seasonality of their earning, your members are unable to put up the amount of premiums in a lump sum or on quarterly basis so as to reduce the frequency of payments. Thirdly, gender dynamics at the household level oftentimes lead to conflict in allocation of financial resources (e.g., spending on vices such as gambling and alcohol versus investments on health), thus leading to defaults in contributions. On the other hand, small-sized HMIS have no dedicated staff to make these collections. It is critical therefore that your HMIS sets up a mechanism to encourage regular collection of premiums from your members.

You may learn from the practices of several HMIS with regard to the collection of their members' contributions.

- (1) Accountability and Collection by Peers: The Mangloy, MPC -Tagum, Davao Norte in Mindanao has organized their structure in such a way that for every 5 members, there is one assigned



member to collect premiums daily. These daily collections are submitted to the HMIS office base weekly. The peer strategy requires the collector in-charge to remain in the area until all the premiums are collected from the group. The peer strategy also demands that the payment of premium of one is the responsibility of all the 5 members. Hence, peer pressure is employed if there is one who is unable to pay regularly. On the other hand, the peers also became a source of assistance and guidance for the rest, thus building up solidarity among the group and sense of responsibility for one another.

- (2) **Automatic Deduction:** The SAKAHA group's decision to include social protection for health among their groups required the automatic deduction of Php 30.00 from their savings in case an immediate member of the family dies or falls sick. The SAKAHA as a credit organization collects loan payment daily through their organized cell groups and module structures. Included in the loan payment by each member is a contribution for their savings in the amount of Php 50.00. It is from these savings collected daily where the Php 30.00 for health services are automatically withdrawn.
- (3) **SEA K Project:** Another project where the SSS premium was collected as part of the regular collection of loan payment. Since the SSS enrolment is optional to their members, those who opted to pay SSS premiums were incorporated in the regular collection. At this time, the credit organization only charges Php .50 of their each monthly collection for administrative fee, part of which is for transmitting these collections to the SSS.
- (4) **In ORT-OHPS in La Union,** they set up 13 satellites which provide education and health services to their members. It is through these satellites that the contributions of their members are collected. The ORT-OHPS staff in these satellites receive the contributions of the members by issuing provisional receipts to the paying membes. At the end of the week, these collections are remitted to their home office where the official receipts are issued.

Given these various mechanisms of collecting contributions, it is equally important that you record these collections properly and keep track of your member's continuous participation. You must note that your members' contributions are the very source of finances to meet the cost of health care your HMIS provide to your members. It is therefore necessary that they are collected regularly, recorded appropriately and are completely accounted for. For this purpose, the Register of Contributions is one document recommended for your HMIS to establish.

### **Document 3.4.2.a: The Register of Contributions**

#### **a.1 What is the Register of Contributions for?**

The Register of Contributions makes it possible for you to monitor the situation of contributions of your members on a daily basis. Its principal function is to show whether the beneficiary is entitled to your HMIS benefits. You may establish a waiting period during which your member regularly pays their contributions without being entitled to use the HMIS services. This waiting period may be for one year, for example, for covering deliveries.

#### **a.2 What information does the Register of Contributions contain ?**

The Register of Contributions contains the following information. These information make it possible for you to monitor the payment of your members' contributions:

- member's code: member's beneficiary code-responsible for paying the household's contributions to the HMIS
- surname and first names
- number of beneficiaries: member and dependents
- total amount of monthly contributions
- possible arrears from previous year
- amount of contributions paid: (e.g. by month January, February, March, April, etc.)
- years: 2002, 2003, 2004
- possible end-of-year arrears

### a.3 How is the Register of Contributions used?

Your member pays a contribution to your HMIS according to the agreed-upon frequency (monthly, quarterly, yearly) in your By-Laws. After recording the contribution in the Membership Book, you record the amount of the contribution again in the Register of Contributions. When your beneficiary appears, you verify whether his/her contributions are up-to-date before issuing the Certificate of Entitlement. The Register of Contributions allows you to examine the number of beneficiaries who are entitled to your HMIS' benefits.

**a.4 Example of Register of Contributions:** Please refer to Annex 3.7 for the actual sample of an HMIS' Register of Contributions.

**Table 3.6 The Recording of Contributions**

Health Micro-Insurance Scheme Internal Organisation				External Partners	
Member	Executive Body	Board of Directors	Auditing Body	Providers	Bank
(1) Pay contributions	(2) Verify Membership in the Register of Beneficiaries (3) Record contributions in register of contributions. Update membership book (4) Pay money into bank account		(5) Control		(5) Collect and record in HMIS account

### 3.4.3 Recording of Benefits

The procedure for meeting the cost of health care between your HMIS and your care provider is described in the MOA as discussed earlier. For day-to-day management, you are encouraged to record your HMIS' benefits based on three reference key documents:

- The Certificate of Entitlement
- The Register of Benefits
- the invoice

#### Document 3.4.3a. The Certificate of Entitlement

##### a.1 What is the Certificate of Entitlement for?

The Certificate of Entitlement assures your service provider that the contributions of the beneficiary concerned are up-to-date and confirms that their costs will be met according to the terms defined in the MOA between you and your service provider.

The use of the Certificate of Entitlement should be considered according to the size of your HMIS, the level of care (cost and frequency) you provide and the level of management. In some cases though, the Certificate of Entitlement may no longer be useful if there is a significant social control among the beneficiaries of your HMIS. If and when you use a Certificate of Entitlement, it is advisable that involve your care provider in preparing the format.

##### a.2 What information does the Certificate of Entitlement contain?

The Certificate of Entitlement is composed of three parts:

- ä Beneficiary Profile Section: This part contains the particulars on the beneficiary.
  - member's name
  - member's code
  - beneficiary name
  - beneficiary code
  - address
  - sex
  - date of application
  
- ä Guarantee Section: This part, which contains the following information, is referred to by the service provider before administering the service. This indicates that your HMIS is guaranteeing the payment of the cost of services to be provided to your beneficiaries.
  - number of certificate of entitlement
  - beneficiary code number
  - beneficiary name
  - name of provider
  - application to meet the cost
  - signature of a person in charge of your HMIS
  - with a reference to the date
  
- ä Certificate of Care Section: This part, which contains the following information, is detached

by the service provider upon providing care or treatment and send it to your HMIS.

- number of certificate of entitlement
- beneficiary name
- beneficiary code number
- type of benefits
- certificate of care form
- amount paid by the beneficiary and HMIS
- date and signature of provider

### a.3 How is the Certificate of Entitlement used?

The proposed Certificate of Entitlement has several functions. When your members fall ill, you draft and issue a Certificate of Entitlement to that particular member. Before issuing this certificate, you keep the Beneficiary Profile which serves as your key reference.

The sick member use the Guarantee and Service Provider Certificate sections of the Certificate of Entitlement and present these to the service provider whom you have contracted to provide

**Table 3.7: The Recording of Benefits**

Health Micro-Insurance Scheme Internal Organisation				External Partners	
Beneficiary	Executive Body	Board of Directors	Auditing Body	Providers	Bank
(1) Apply to meet the cost	(2) Verify whether member's contributions are up-to-date (3) Draft certificate of entitlement (4a) File Beneficiary Profile Section of the certificate of entitlement			(5) Receive member and provide care (6) receive payment of patient's contribution from the beneficiary (7) File Guarantee Section and forward Certificate of Care with invoice to HMIS	
(4b) Receive certificate of entitlement and visit to provider with certificate of entitlement and MB	(8) Check Beneficiary Profile Section, Certificate of Care and receipts				
	(9) Pay service provider	Monitor benefits	Control		(10) Release money

the service. The Guarantee Section acts as confirmation (a guarantee) by your HMIS that the beneficiary's costs will be met by your HMIS according to the conditions provided for in the MOA. The Certificate of Care Section certifies that care has been provided. This is detached and filled-in by your provider and returned with the invoice to your HMIS.

To account for emergencies (e.g. transport during the night, for example), you may recommend the possibility of presenting the Certificate of Entitlement within 24 hours of the first aid as part of your agreement with the provider. The quality and correct use of this Certificate of Entitlement influences the quality of cooperation between you and your care providers. The management of the Certificate of Entitlement in meeting the beneficiary's costs is summarized in the following table.

Table 3.7 outlines the processing and use of the Certificate of Entitlement:

- (1) When your beneficiary falls ill, he/she goes to your HMIS with his or her Membership Book. Your HMIS checks the MB and the Register of Contributions to confirm that the beneficiary's contributions are up-to-date.
- (2) Your HMIS then hands over a Certificate of Entitlement to your member and retains the Beneficiary Profile Section.
- (3) After receiving the Certificate of Entitlement, the beneficiary goes to the care provider and presents his/ her MB and the Certificate of Entitlement.
- (4) The provider verifies whether it is the same person indicated in the Certificate of Entitlement and may carry out a second check on the Membership Book for his/her contributions. After providing the care, the provider files the Guarantee Section of the Certificate of Entitlement and sends the Certificate of Care Section with the invoice to the HMIS.
- (5) Your HMIS manager in turn compares the Beneficiary Profile Section with the Certificate of Care Section and verifies whether the cost of the benefits invoiced are met by your HMIS. The manager then pays the invoice.

In some HMIS, it is possible for a reference person (e.g. medical secretary or consultant doctor) working in the health center to support the procedure for meeting beneficiaries' costs by facilitating the letters of guarantee. He/she may also record the benefits in a Register of Benefits, while respecting the principal of separation of management.

**a.4 Example of Certificate of Entitlement:** Please refer to Annex 3.8 for the actual sample of an HMIS' Certificate of Entitlement.

### Document 3.4.3.b: The Invoice

#### b.1 What is an Invoice for?

The Invoice is the aid used by the care provider contracted by your HMIS for obtaining reimbursement of the cost of care they delivered to your beneficiaries. It allows the provider to add up all the care delivered to your members and the respective amounts over a given period. The Invoice, once accomplished is sent to your HMIS, which knows exactly how much it must reimburse. For your HMIS, the Invoice is an accounting record that justifies the outflow of your HMIS money on a given date from the cash you have on hand or from your bank

account. It also fosters appropriate monitoring of your activities as HMIS, since it summarizes the number and type of transactions and the expenditure your HMIS incurred with a given provider over a given period – usually, a month.

## **b.2 What does an Invoice contain?**

Since the methods of payment of care providers may vary according to the nature of the provider and its agreement with your HMIS, the Invoice also functions in different ways:

### **For the health center:**

- An amount per bout of illness: the center receives an amount that covers outpatient care, medicines and laboratory analyzes per case of illness. The advantage of this system is that patients' ongoing treatment is not interrupted due to lack of funds.
- An amount per consultation: this includes the cost of medicines and laboratory analyzes. The first consultation is often costlier than subsequent ones.
- A lump sum per person registered in the center: after registration, the center undertakes care for the beneficiary for a given period (generally one year) for a lump sum, irrespective of the care required.

### **For the hospital:**

- A lump sum per day's hospitalization: this sum includes both accommodation and medical, surgical and nursing care, technical treatments and medicines.
- A lump sum covering all the time in hospital: a single amount calculated on the basis of an estimation of the average duration of hospitalization.
- A payment per benefit or per treatment: all accommodation medical treatment, and medicines are invoiced separately
- A payment per grouped benefit: all medical treatment, accommodation and medicines are grouped in the invoice for outpatient care, hospitalization, deliveries, transports.

In order to fulfil its different functions, the invoice must contain the following information:

### **Information on the Provider:**

- details of the care provider
- number of the invoice
- period concerned/covered
- date when the invoice is issued
- who the invoice is to be sent to

### **Information on the Care Invoiced (per benefit):**

- date of treatment
- identification of beneficiary: beneficiary code

- number of certificate of entitlement
- nature and cost of benefits: hospitalization, medicines analyzes, external care, with breakdown as to beneficiary

**Other information:**

- total amount of invoice in figures and words
- signature of provider: competent person of the health structure (senior doctor, duty nurse, competent administrative staff member).

Note that the HMIS does not always meet all the medical costs. A co-payment in the form of a patient's contribution, excess, lump sum or other amount is generally the beneficiary's responsibility. This co-payment will not be charged to the HMIS account because it has been paid by the beneficiary, and should therefore not be included in the amount to be reimbursed by the HMIS. To foster sound monitoring of the HMIS, this co-payment should appear on the Invoice for each beneficiary. This allows the HMIS to keep track of the whole cost of the care rather than only the part it pays.

### **b.3 How is the Invoice used?**

The Invoice is an important reference document for you. In the MOA, it is important that you specify the provider's obligation to detail the costs to be met. A sample Invoice should be discussed with the care provider when drawing up the MOA. Your HMIS therefore should constantly possess the information necessary to monitor the benefits given, which would not be possible if the provider altered the way of completing the invoice every month.

The Invoice is generally drawn up on a monthly basis. In the MOA, however, certain providers may opt to establish the Invoice according to the number of times care is provided (one Invoice every 100 treatments, for example), or the amounts to be reimbursed (one invoice as soon as the total amounts to be reimbursed reach Php 50,000, for example).

The Invoice is drawn up in two copies: one is sent to your HMIS while the other is retained by the provider. When you reimburse the care provider, you need to mark the reference indicating the date and methods of payment (cash, by transport or by cheque) on both copies of the Invoice.

The example presented below makes it possible for you to sum up the number of times costs are met and the monthly expenditure covered - direct payment system - by your HMIS with a care provider. The Invoice is based on the existence of Certificate of Entitlement - Certificate of Care Section which provides more accurate details of costs by type of treatment provided (e.g. hospitalization, examinations, etc.). If the system set up does not include Certificate of Care Section, the Invoice must be more detailed to show the expenditure covered per treatment. You then need to file these Invoices.

In the given example, the service provider (Health Center) sends an Invoice (per grouped benefit) with the following information, according to the MOA:

- outpatient care: 50% paid for by the HMIS
- transports: 50% paid for by the HMIS



- simple delivery: 80% paid for by the HMIS
- hospitalization: 80% paid for by the HMIS

As agreed, no later than the tenth of each month the Health Center submits Invoices for the different benefits provided, indicating: the date of treatment, the beneficiary code, the number of the Certificate of Entitlement, the nature of benefits and their cost for the HMIS and for beneficiaries. It also grants the HMIS a 10% reduction in the overall amount of the benefits.

**b.4 Example of Invoice (Direct Payment System with Patient's Contribution):** Please refer to Annex 3.9 for the actual sample of an HMIS Invoice.

### Document 3.4.3.c: The Register of Benefits

#### c.1 What is the Register of Benefits for?

The Register of Benefits makes it possible for you to keep track of all benefits received by the beneficiaries of your HMIS. It is also called the 'register of health expenditure or 'benefit records.' This register makes it possible to know the following:

- the most frequent benefits
- the monthly/annual amount of benefits: periods of epidemics or other
- the average cost of benefits
- the utilization rate of health services
- respect for the agreement with the health facility
- the most frequently visited health facility
- the age, sex, occupation, geographic location of the highest-risk beneficiaries

Certain HMIS also work with Benefit Records. Each record contains the beneficiary's details and the monitoring of benefits consumed. This Guide recommends the use of a register.

#### c.2 What information does the Register of Benefits contain?

The Register of Benefits contains the following information:

- date
- number of certificate of entitlement
- beneficiary code
- invoice number
- origin of invoice: name of care provider
- amount payable: MHIS/beneficiary/total
- observations

You may organize the details of the register of benefits so that each new page of the register

represents another type of service. If it is convenient, your HMIS and the service provider may also code the benefits. Depending on your needs, you may also organize the benefit information according to the care provider or according to beneficiary sub-groups (e.g. by *barangay*, by sub-office, by age group or others).

### c.3 How is the Register of Benefits used?

After receiving the Invoice from your care provider, your HMIS must record the expenditure in the Register of Benefits. You need to verify the number of the Certificate of Entitlement (Beneficiary Profile Section and the Certificate of Care Section) and the nature of the benefits before paying the invoices.

c.4 **Example of Register of Benefits:** Please refer to Annex 3.10 for the actual sample of an HMIS' Register of Benefits.

**Table 3.8: The Recording of Benefits (The Register of Benefits)**

Health Micro-Insurance Scheme Internal Organisation				External partners	
Beneficiary	Executive Body	Board of Directors	Auditing Body	Providers	Savings Bank
	(1) Pay invoice ↓ (2) Record in Register of Benefits		(3) Control accuracy of information		

**Annex 3.1: An Example of HMIS By-Laws***DRAFT BY-LAWS***TABLE OF CONTENTS**

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## TITLE I: GENERAL PROVISIONS

### CHAPTER 1 : INCORPORATION AND OBJECT OF THE HEALTH MICRO-INSURANCE SCHEME

- Article 1 : At the level of the \_\_\_\_\_ Federation of Women, a structure called a Health Micro-Insurance Scheme is \_\_\_\_\_ hereby established as a non-profit making group of people whose primary object is solidarity and mutual assistance between its members.  
(1) It shall be known as '\_\_\_\_\_HMIS';  
(2) Its duration is unlimited;  
(3) The registered office is in front of the town council. This may be transferred to any other place by a decision of the General Assembly.
- Article 2 : The object of the health micro-insurance scheme is to pursue the business of foresight, solidarity and mutual assistance in favour of its members, particularly by means of action relating to:  
(1) information, awareness-raising and risk prevention;  
(2) assistance in terms of health;  
(3) training.
- Article 3 : The \_\_\_\_\_ Health Micro-Insurance Scheme undertakes not to participate in any religious, political \_\_\_\_\_ or ethnic issue. It may, however, maintain co-operative relations with any group, organization, association or trade union in pursuit of its objectives.

### CHAPTER 2 : ADMISSION, WITHDRAWAL, SUSPENSION, DEREGISTRATION AND EXCLUSION

#### SECTION 1 : ADMISSION

- Article 4 : The \_\_\_\_\_ health micro-insurance scheme consists of honorary members and ordinary members (or adherents).
- Article 5 : The title of honorary member may be granted by the General Assembly on the proposal of the Board of Directors to people who have provided exceptional services to the \_\_\_\_\_ health micro-insurance scheme or to the cause of mutuality, or at international level. Honorary members are not subject to any conditions regarding age, residence, profession or nationality. The number of honorary members may not exceed 50.
- Article 6 : Ordinary members or adherents are people who have been granted the right to join and who, by regular payment of their contributions, allow the \_\_\_\_\_ health micro-insurance scheme to carry out its obligations towards its members.
- Article 7 : The health micro-insurance scheme may not use paid intermediaries to recruit members or award remuneration according to the number of members or contributions paid.
- Article 8 : Members of the health micro-insurance scheme and their families may benefit from the services of the health micro-insurance scheme. Admission is individual and voluntary and is obtained by applying in writing to the Board of Directors.

#### SECTION 2 : WITHDRAWAL, SUSPENSION, DEREGISTRATION, EXCLUSION

- Article 9 : Any member may leave the health micro-insurance scheme by sending notice of their withdrawal in writing to the Board of Directors, though any members who withdraw may not re-join the health micro-insurance scheme.
- Article 10 : The Board of Directors may at any time suspend any members whose conduct is detrimental to the proper functioning of the health micro-insurance scheme. Only the General Assembly is authorized to announce such suspensions.
- Article 11 : Members who no longer comply with the conditions to which these statutes subject their admission shall be deregistered. Their deregistration shall be declared by the Board of Directors and shall be ratified by the General Assembly. Members who have not paid their contributions for six months shall be deregistered. Such deregistration shall come into effect following notification in writing of a warning in the third (3rd) month, followed by a letter explaining the reasons from the sixth ( 6 t h ) month.
- Article 12 : Members who have voluntarily caused duly ascertained damage to the interests of the health micro-insurance scheme (such as fraud or embezzlement) may be excluded.
- Article 13 : Withdrawal, deregistration and exclusion shall not grant any entitlement to payment.
- TITLE II : ADMINISTRATION OF THE HEALTH MICRO-INSURANCE SCHEME: COMPOSITION, ELECTION AND POWERS OF THE MANAGEMENT BODIES**
- CHAPTER 1 : THE GENERAL ASSEMBLY (GA)
- Article 14 : The management bodies forming the health micro-insurance scheme are:  
(1) The General Assembly  
(2) The Board of Directors;  
(3) The Auditing Body;  
(4) The Executive Body.
- Article 15 : The GA shall be made up of members delegated from basic groups. They shall be elected for one (1) year, in accordance with the normal procedure of the \_\_\_\_\_ Federation of Women.
- Article 16 : Each basic group elects delegates who shall be chosen from the members of the functional management bodies of the health micro-insurance scheme (BD, AB or EB). Each delegate shall have one vote.
- Article 17 : The GA is the highest authority of the health micro- insurance scheme. It shall meet once per year in ordinary session and extraordinarily whenever necessary, on the proposal of the Executive Body, the AB or 2/3 of its members.
- Article 18 : Convening notices shall set out the agenda, the date and venue of the GA and shall reach addressees two weeks in advance.
- Article 19 : The GA of the \_\_\_\_\_ health insurance scheme may not validly deliberate unless half its members are present or represented. If this condition is not fulfilled a second GA shall be convened fifteen (15) days later in the same conditions as the first. It shall deliberate validly, irrespective of the number of members present.
- Article 20 : Decisions shall be taken by a simple majority of votes cast for important matters: alterations to the statutes, exclusion of a member, winding the health micro-insurance scheme up. They are pre-eminent and not subject to appeal. Any decision taken during a GA which has not been properly convened shall be null and void. Minutes of each session of the GA shall be drawn up.

- Article 21 : The GA shall define the mission of the health micro-insurance scheme and shall formulate its general policy. It shall:
- (1) Approve and alter the By-Laws;
  - (2) Examine and approve the activity reports of the various management bodies;
  - (3) Elect the members of the management bodies;
  - (4) Establish the membership fees and monthly contributions;
  - (5) Study the balance sheet submitted by the Board of Directors and approve the new programme of action.
- CHAPTER 2 : THE BOARD OF DIRECTORS (BD)
- Article 22 : The GA may delegate part of its powers to the BD.
- Article 23 : The \_\_\_\_\_ health micro insurance scheme shall be run by a BD composed of 15 people who shall be elected for three years.
- Article 24 : Eligible members must be up-to-date with their contributions. Outgoing members may be re-elected.
- Article 25 : The BD shall meet when convened by the Chairperson and at least once per month. It shall be convened obligatorily when so requested by half the members of the Board.
- Article 26 : The BD may not validly deliberate unless at least half its members are present. No member of the Board may have more than one vote. Decisions shall be taken by a majority. In the event of equality the Chairperson shall have the casting vote. Each meeting shall be ratified by minutes approved by the BD at the following session.
- Article 27 : The BD shall enjoy all the powers not expressly set aside for the GA by these By-Laws. It shall ensure the management of the health micro-insurance scheme and the implementation of its programmes and budget. Its activities shall be recorded in a report submitted to the GA.
- Article 28 : The BD may delegate part of its powers under its responsibility and control.
- Article 29 : The functions of members of the BD are unpaid. Certain representation expenses may be reimbursed.
- CHAPTER 3 : THE AUDITING BODY (AB)
- Article 30 : The AB shall be composed of four (4) members, one of whom shall be a coordinator and one a secretary. They shall be elected by the GM for three years.
- Article 31 : The AB shall meet every month and shall draw up duly signed and dated minutes and shall verify the accuracy of the information recorded on the monthly monitoring record of the health micro-insurance scheme. It shall report to the GA.
- Article 32 : The AB is responsible for ensuring that the acts of the health micro-insurance scheme comply with the regulations, verifying the accuracy of the accounts and the regularity of financial transactions. In exercising its functions it may call upon other internal or external abilities.
- Article 33 : The AB may if necessary convene a Special GM.
- CHAPTER 4 : THE EXECUTIVE BODY (EB)
- Article 34 : The Executive Body is composed of:
- (1) A Chairperson;
  - (2) A Vice-Chairperson;
  - (3) A Secretary and Deputy;
  - (4) A Treasurer and Deputy;
  - (5) A person responsible for education and promotion;

- (6) Coordinators.
- Article 35 : The Chairperson of the health micro-insurance scheme shall convene and chair meetings of the GA, BD and EB. He or she shall manage relations with the health centers to which the health micro-insurance scheme is connected by agreement, and with other providers who work with the latter. The Vice-Chairperson shall support and replace the Chairperson if the latter is unexpectedly prevented from acting, with the same powers.
- Article 36 : Under his/her responsibility and control and with the authorization of the BD, the Chairperson may delegate some of his/her tasks.
- Article 37 : The Secretary, in co-operation with her or his deputy, shall draft the minutes of the different meetings held within the health micro-insurance scheme. He or she shall ensure the ordinary correspondence of the health micro-insurance scheme, file and keep records, and issue the different documents relating to the health micro insurance scheme's operation.
- Article 38 : In co-operation with his/her deputy the Treasurer shall ensure that the cash flow of the health micro-insurance scheme is recorded and shall participate in seeking ways to increase resources. The Treasurer shall draw up and present the financial reports and shall sign the accounts with the Chairperson or his/her replacement.
- Article 39 : The person responsible for education and promotion shall ensure the education and training of members, and shall organize activities to promote the health micro-insurance scheme, in cooperation with the coordinators.
- Article 40 : The coordinators are responsible for assisting the EB, particularly the person responsible for education and promotion, in their coordination, awareness-raising, education and guidance work.
- Article 41 : The Manager is responsible for attending the meetings of all management bodies and for co-operating with them in executing their respective tasks. He/she shall, however, work under the control and supervision of the BD.
- Article 42 : The EB shall keep a Cash Journal and a Cash-in-Bank Journal and shall ensure that the financial tools and statements are presented at the beginning and end of each financial year.
- Article 43 : Meetings of the EB shall be held every month or when expressly convened by the Chairperson or two-thirds (2/3) of the members.

### **TITLE III : FINANCIAL PROVISIONS**

#### **CHAPTER 1: REVENUE AND EXPENDITURE**

- Article 44 : The revenue of the health micro-insurance scheme comprises:
- (1) Members' admission fees and contributions;
  - (2) Donations and legacies;
  - (3) Subsidies granted by the government, local authorities or individuals;
  - (4) Interest on funds invested or disposed of;
  - (5) Revenue from events or voluntary contributions organized for the benefit of the health micro-insurance scheme;
  - (6) Any other revenue not prohibited by law.
- Article 45 : Expenditure comprises:
- (1) Meeting the cost of the healthcare described in the annex to the Policies, Systems and Procedures;
  - (2) Operating expenses;



- (3) Contributions paid to unions;
- (4) Any other expenditure not prohibited by law.

**CHAPTER 2 : METHODS OF INVESTING AND WITHDRAWING FUNDS**

- Article 46 : The BD shall decide on investments and withdrawals of the health micro-insurance scheme funds, bearing the guidelines established by the GA in mind.
- Article 47 : Expenditure shall be ordered by the Chairperson or their replacement and shall be made by the Treasurer or their deputy.
- Article 48 : 30% of the surpluses of the financial year shall be allocated to reserves. Withdrawals from these reserves shall no longer be obligatory when the amount of the reserve fund reaches three-quarters of the total benefits actually given over to the health micro-insurance scheme during the preceding financial year.

**TITLE IV: OBLIGATIONS OF THE HEALTH MICRO-INSURANCE SCHEME AND ITS MEMBERS**

**CHAPTER 1 : OBLIGATIONS OF MEMBERS**

- Article 49 : Members shall pay a non-returnable membership fee of Php1000.
- Article 50 : Members undertake to pay a monthly contribution of Php 200.  
This amount may be reviewed by the GA. Special contributions whose amount and types are established by the GA shall be added to the contribution.
- Article 51 : Any unjustified delay of three (3) months in the payment of contributions shall give rise to a 25% increase in the amount owed.
- Article 52 : In order to enjoy the benefits of the health micro- insurance scheme, members must be up-to-date in the payment of their contributions on the date of delivery of the care.
- Article 53 : Entitlement to benefits takes effect from the end of the waiting period of three (3) months.

**CHAPTER 2 : OBLIGATIONS OF THE HEALTH MICRO-INSURANCE SCHEME**

- Article 54 : The Policies, Systems and Procedures specify the methods of meeting beneficiaries' costs.
- Article 55 : The benefits granted by the health micro-insurance scheme are agreed every year by the BD in agreement with the care providers. They shall be set down in a document available to everyone.

**TITLE V : RULES OF APPLICATION, AMENDMENTS, MEMBERSHIP OF UNIONS, FEDERATION, MERGER, WINDING-UP AND LIQUIDATION**

**CHAPTER 1 : RULES OF APPLICATION AND AMENDMENTS**

- Article 56 : The Policies, Systems and Procedures established by the BD and approved by the GA determine the conditions of application of these By-Laws. All members shall comply with them in the same way as the By-Laws. The BD may make alterations to the Policies, Systems and Procedures which shall apply immediately. They shall be submitted for application at the next GA.
- Article 57 : Only the GA may alter the By-Laws, on the proposal of the BD or two-thirds of the GA.

**CHAPTER 2 : MEMBERSHIP OF UNIONS AND MERGER**

- Article 58 : The health micro-insurance scheme may join one or more unions on the decision of the GA. The unions may form into a federation of health micro-insurance schemes with a

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Article 59 : view to pursuing the same ends.  
The merger of the health micro-insurance scheme with one or more health micro-insurance schemes shall be decided by the GA. This decision shall be ratified at a Special GA convened specifically for this purpose.

CHAPTER 3 : WINDING-UP AND LIQUIDATION

Article 60 : The voluntary winding-up of the health micro-insurance scheme may be decided only by a Special GA convened for this purpose by means of a notice indicating the object of the meeting. A 2/3 majority of the members must be present.

Article 61 : In the event of winding up, the GA shall decide on the use to be made of the funds and assess the health micro-insurance scheme, in compliance with the HMIS spirit.

## Annex 3.2: An Example of HMIS Policies, Systems and Procedures

### \_\_\_\_\_HEALTH MICRO-INSURANCE SCHEME POLICIES, SYSTEMS AND PROCEDURES

#### TABLE OF CONTENTS

TITLE 1	:	GENERAL PROVISIONS
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SECTION 1	:	ADMISSION
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TITLE II	:	ADMINISTRATION/FUNCTIONING OF THE HEALTH MICRO-INSURANCE SCHEME: COMPOSITION, ELECTION AND POWERS OF MANAGEMENT BODIES
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ANNEX	:	SERVICES COVERED BY THE HEALTH MICRO INSURANCE SCHEME
<b>TITLE I</b>	<b>:</b>	<b>GENERAL PROVISIONS</b>
CHAPTER 1	:	INCORPORATION AND OBJECT OF THE HEALTH MICRO-INSURANCE SCHEME
Article 1	:	These Policies, Systems and Procedures complete the By-Laws of the _____ HMIS. All ordinary members shall comply with them in the same way as the By-Laws.
Article 2	:	The object of the health micro-insurance scheme is to promote mutual assistance and solidarity towards its members, insurance, healthcare and health education.
Article 3	:	The health micro-insurance scheme includes members and their dependents as beneficiaries. The latter category of member may not participate in but may attend voting.
Article 4	:	A Membership Book is issued to each member and an honorary membership book is issued to all honorary members.

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- CHAPTER 2 : ADMISSION, WITHDRAWAL, SUSPENSION, DEREGISTRATION AND EXCLUSION
- SECTION 1 : ADMISSION
- Article 5 : Persons meeting the following conditions may join the health micro-insurance scheme:
- (1) People who enjoy all civic and civil rights.
  - (2) People who enjoy all mental and physical faculties.
  - (3) People who pay the membership fees of Php 1,000.
- SECTION 2 : WITHDRAWAL, SUSPENSION, DEREGISTRATION, EXCLUSION
- Article 6 : Withdrawal is free and voluntary. It shall be sent in writing to the Board of Directors, who shall take formal note of it, but it will be examined by the GA.
- Article 7 : A member shall be suspended in the event of committing an offense or if their conduct does not conform to the rules. Suspension may be declared by the Board of Directors or the General Assembly.
- Article 8 : Members who no longer comply with the conditions to which their membership is subject shall be deregistered. They shall be notified of the deregistration by the Board of Directors. Ordinary members who have not paid their contributions for the last six (6) months shall also be deregistered.
- Article 9 : Members who have voluntarily caused duly ascertained damage to the interests of the HMIS (such as fraud or embezzlement) may be excluded. Members are given notice to appear before the Board of Directors to have the facts they are accused of considered. If they fail to appear on the day indicated, new notice is sent to them. If they again decline to attend, the Board of Directors may declare their exclusion and they will be notified accordingly in writing.
- Article 10 : Dismissal, deregistration and exclusion do not entitle the persons concerned to any repayment of contributions or membership fees.
- TITLE II : ADMINISTRATION/FUNCTIONING OF THE HEALTH MICRO-INSURANCE SCHEME: COMPOSITION, ELECTION AND POWERS OF THE MANAGEMENT BODIES**
- CHAPTER 1 : MANAGEMENT BODIES OF THE HEALTH MICRO- INSURANCE SCHEME
- Article 11 : The management bodies of the health micro-insurance scheme are:
- (1) The General Assembly (GA).
  - (2) The Board of Directors (BD).
  - (3) The Auditing Body (AB).
  - (4) The Executive Body (EB)
- Article 12 : An optional management body may be created if deemed necessary.
- Article 13 : The members of the BD and the AB come from the GA, while those of the EB are chosen from among the directors.
- CHAPTER 2 : OPERATIONS
- Article 14 : The delivery of a certificate of entitlement by the health micro-insurance scheme shall be subject to the following conditions:
- (1) All the people recorded in the family record must be up-to-date with their contributions.
  - (2) The waiting period must have concluded.
  - (3) For hospitalizations, a hospitalization ticket provided by the doctor from the approved center or any other qualified medical authority must be presented.

(4) If deemed necessary by the EB, the letter of commitment must be signed.

In the event of an emergency the beneficiary shall present their Membership Book showing that their contributions are up-to-date and shall deposit the certificate of entitlement duly signed by the health micro- insurance scheme within 24 hours of the first contact.

- Article 15 : The beneficiary shall comply with the commitments set down in the letter of commitment, failing which legal action may be brought against them.
- Article 16 : Failure to respect the undertakings laid down in Article 15 shall involve the immediate suspension of the member from entitlement to benefits prior to any other action that may be initiated.
- Article 17 : The decisions of the management bodies are pre-eminent and shall be approved by the GA. The EB is, however, under the control of the BD.
- Article 18 : The Chairperson of the BD, the Treasurer and the manager may not be relatives or relatives by marriage in the first degree.
- Article 19 : The management bodies of the health micro-insurance scheme shall function according to the procedures set down in the By-Laws.
- Article 20 : The members of the various management bodies composing the \_\_\_\_\_ HMIS shall comply with their duties, subject to the penalties established for this purpose (see the By-Laws).
- Article 21 : For the first five years after the incorporation of the health micro-insurance scheme, the \_\_\_\_\_ Women's Federation is guaranteed that the management bodies of the \_\_\_\_\_ health micro-insurance scheme will function regularly and normally. The federation is qualified to take protective measures, if necessary, in accordance with the regulations governing mutual health insurance schemes.

### CHAPTER 3: ELECTION

- Article 22 : Elections of members of the management bodies shall take place democratically and transparently, and in accordance with the normal rules of the \_\_\_\_\_ Women's Federation.
- Article 23 : Voting by proxy is authorized only in exceptional cases (authorized absence, illness, justified incapacity, etc). One person may not receive more than one proxy.

### TITLE III : FINANCIAL PROVISIONS

#### CHAPTER 1 : REVENUE AND EXPENDITURE

- Article 24 : The membership fees are set at Php 1,000.
- Article 25 : The amount of the monthly contribution is set uniformly at Php 200. Members are, however, encouraged to pay the total amount of their contribution for several months or one year in a single lump sum.
- Article 26 : Contributions are paid in exchange for a receipt or supporting document no later than five (5) days after the meeting of the group.
- Article 27 : Any members responsible for arrears of one month in the payment of contributions may not use the benefits for a period of 30 days after settling all the sums owed. Any member with arrears of six months in their contribution shall be deemed to have withdrawn.

#### CHAPTER 2 : METHODS OF INVESTING AND WITHDRAWING FUNDS

- Article 28 : Funds may be withdrawn subject to the joint signature of two of the following four people: the Chairperson, the Treasurer, the Vice-Chairperson or the Deputy Treasurer

- of the BD of the health micro-insurance scheme.
- Article 29 : The execution of certain expenditure may be delegated by the Chairperson or the Treasurer to the manager or his/her assistant.

**TITLE IV : OBLIGATIONS OF THE HEALTH MICRO-INSURANCE SCHEME AND ITS MEMBERS**

**CHAPTER 1 : OBLIGATIONS OF MEMBERS**

- Article 30 : Members shall pay a non-returnable membership fee Of Php1,000 and shall provide identification photo-graphs of all beneficiaries to be in the Membership Book. The personal details of each beneficiary are set down in this Membership Book.
- Article 31 : Members undertake to pay a monthly contribution, set at Php 200 per beneficiary, before the 10th of each month. The number of dependents is limited to 18 per member.

**CHAPTER 2 : OBLIGATIONS OF THE HEALTH MICRO-INSURANCE SCHEME**

- Article 32 : Any ordinary member may benefit from the ff services:  
 (1) The benefits offered by the HMIS;  
 (2) Joint benefits to a deceased member's beneficiaries, the amount of which shall be determined by the BD according to existing financial resources.
- Article 33 : The people set down on the register of beneficiaries whose contributions are up-to-date are entitled to the benefits of the HMIS. Contributions are monitored by means of the Register of Contributions and MB.
- Article 34 : A form summing up the services covered by the HMIS is annexed to these Policies, Systems and Procedures.
- Article 35 : The HMIS shall ensure the quality of the care provided and shall ensure good relations with the Health Center.
- Article 36 : Any matter not covered in the By-Laws or the Policies, Systems and Procedures shall be examined by the BD.

**TITLE V. AMENDMENTS**

- Article 37 : Only the GA may make alterations to these Policies, Systems and Procedures. The BD may, however, make alterations which shall apply immediately but which shall be submitted for ratification at the following GA.

**ANNEX : THE SERVICES COVERED BY THE HEALTH IMICRO-INSURANCE SCHEME**

By means of its agreement with the Health Center, the health micro- insurance scheme has obtained:

- a 10% reduction in the overall monthly benefits;
- the undertaking of \_\_\_\_\_ Health Center to ensure that any beneficiary of the health micro-insurance scheme is welcomed.

The health micro-insurance scheme undertakes to meet the costs of any beneficiary provided with:

- a numbered Certificate of Entitlement completed and signed by the Chairperson of the health micro-insurance scheme;
- a Membership Book in which he/she is included, with an initialled photograph and up-to-date contributions.

The following benefits are granted by the Health Center:

### Annex 3.3: An Example of HMIS Minutes of Meeting

- outpatient care: 50% paid for by the health micro- insurance scheme;
- transport: 50% paid for by the health micro-insurance scheme;
- simple delivery: 80% paid for by the health micro-insurance scheme;
- hospitalizations: 80% paid for by the health micro-insurance scheme.

### Annex 3.3: An Example of HMIS Minutes of Meeting

#### Health Micro-Insurance Scheme

Minutes N° : .....

#### MINUTES OF MEETING

In the year.....on....., the meeting of the .....of  
the.....of the Health Micro-Insurance Scheme was held  
at.....

The agenda was as follows:

1. ....
2. ....
3. ....
4. ....

Number Attending : .....  
Absentees Excused : .....  
Absentees Not Excused : .....

The following decisions were taken:

- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....

Opened at .....hours .....minutes. The session was closed at ....hours.....  
minutes on the above day, month and year

The Secretary:

Chairperson



## Annex 3.4: An Example of HMIS Memorandum of Agreement

\_\_\_\_\_ Health Micro-Insurance Scheme  
Republic of the Philippines

\_\_\_\_\_  
\_\_\_\_\_

### Agreement

Between the \_\_\_\_\_ Health Micro-Insurance Scheme and \_\_\_\_\_ Health Center

On 2 October 2002 the following is hereby established

Between

The \_\_\_\_\_ Health Micro-Insurance Scheme, represented by the Chairperson of the Board of Directors, Madame \_\_\_\_\_, and: \_\_\_\_\_ Health Center, represented by Dr. \_\_\_\_\_.

### Article 1: Object

The object of this Agreement is to define the conditions according to which care benefits are supplied by \_\_\_\_\_ Health Center to the beneficiaries of the \_\_\_\_\_ Health Micro-Insurance Scheme.

### Article 2: Commitments

2.1. The \_\_\_\_\_ Health Center commits itself to:

Welcome any beneficiary provided with a numbered Certificate of Entitlement, completed and signed by the Chairperson of the health micro-insurance scheme, and a Membership Book in which he/she is included with an initialled photograph, and showing that their contributions are up-to-date.

- Ensure that in the event of an emergency the beneficiary presents their Membership Book indicating that their contributions are up-to-date and files the Certificate of Entitlement duly signed by the health micro-insurance scheme within 24 hours of the first contact.
- Complete the Certificate of Care Section of the Certificate of Entitlement after treating the beneficiary.
- Provide quality health care to any beneficiary whose contributions are up-to-date, in accordance with the risks covered by the health micro-insurance scheme:
  - outpatient care: 50% paid for by the HMIS;
  - transports: 50% paid for by the HMIS;
  - simple deliveries: 80% paid for by the HMIS;
  - hospitalizations: 80% paid for by the HMIS.
- Prescribe medicines in generic form for beneficiaries in the first instance.
- Submit by the tenth of each month at the latest, the invoices for the different benefits provided, bearing: the date of treatment, the code of the beneficiary, the number of the Certificate of Entitlement, the nature of the benefits and their cost for the HMIS and the beneficiaries.
- Grant the HMIS a 10% reduction from the overall monthly benefits by means of a deposit of Php. 200,000.

2.2. The \_\_\_\_\_ Health Micro-Insurance Scheme undertakes to:

- Honour invoices presented by the care provider within no more than 15 days of their receipt. Payment shall be made by bank transfer, cheque or cash.
- Deliver a Certificate of to beneficiaries whose contributions are up-to-date, to be presented to the care provider.
- Participate with and support the care provider in organizing information and disease-prevention activities.

### Article 3: Duration

This Agreement shall have a duration of two years and may be tacitly renewed.

#### Article 4: Arbitration

Any dispute between the two parties shall be settled amicably, failing which it shall be submitted to the competent health and legal authorities.

#### Article 5: Termination

The agreement may be terminated at any time, providing the party which has taken the initiative to do so informs the other party three (3) months in advance in writing.

#### Article 6: Revision

This Agreement may be revised whenever necessary.

#### Article 7: Signature

This Agreement shall come into effect on the date of its signature by the two parties.

For the Health Center.    For the Health Micro-Insurance Scheme

The senior doctor

The Chairperson of the BD

Dr. \_\_\_\_\_

Mme \_\_\_\_\_

For the \_\_\_\_\_

**ANNEX: COST OF BENEFITS OFFERED  
PRICE OF TREATMENT**

Description of Treatment	Price (in Php)
Adult consultation	150
Child consultation	100
Pre-natal consultation	100
Post-natal consultation	150
Family planning	50
Care with dressing/stitches	250
Injection	100
Vaccination	100
Vaccination record	100
Accommodation of patient per night	750
Simple delivery	4 000
Maternity record	50
Health transport with ambulance HC:	
- inside the catchment area	500
- up to 10 km outside	1 000

The overall cost of the treatment will depend on the duration and cost of the medicines used.

The \_\_\_\_\_ Health Micro Insurance Scheme benefits from a reduction of 10% of the overall cost (which includes the above rates in force and all costs of supplementary medicines), in accordance with the agreement.

## Annex 3.5: An Example of HMIS Membership Book

(1) The first example is a recommended format that contains the basic information in a membership Book.

Cover Page

Health Insurance Scheme

# Membership Book

Name of Member: \_\_\_\_\_

Inside Cover Page

Monitoring Contributions						Monitoring Contributions						
Year	Jan.	Feb.	Mar.	April	May	June	July	Aug	Sept	Oct.	Nov.	Dec.

### First Page: Identification of Member

Photo	<b>Member</b>
	Beneficiary Code: .....
First name: ..... Surname: ..... Identity Card N° : ..... Sex: ..... Address: ..... Telephone: ..... Date of Birth: ..... Place of Birth: ..... Blood Group: ..... Date of Joining: .....	

### Other Inside Pages: Identification of Beneficiaries

Photo	<b>Beneficiary</b>
	Beneficiary Code: .....
First name and surname: ..... Relation with member (parent, under ..... guardianship, other) Identity Card N° : ..... Date and Place of Birth: ..... Blood Group: ..... Date of First Contribution: .....	
Photo	<b>Beneficiary</b>
	Beneficiary code: .....
Relation with member (parent, : ..... under guardianship, other) Identity Card N ..... Date and Place of Birth: ..... Blood Group: ..... Date of first contribution: .....	

Other Pages (Optional) : Summary of Internal Rules of Procedures

**Page 1:**

**Useful Information on the Health Micro-Insurance Scheme**

Goal of the Scheme : The goal of the scheme is to improve access to healthcare by means of mutual assistance and solidarity among members.

The scheme makes a distinction between members and their dependents.

Conditions of Membership : People who meet the following conditions may join the scheme

- those who comply with the HMIS legislative and regulations;
- those who pay the membership fees;
- those who undertake to contribute regularly to the HMIS

**Page 2:**

**How can I obtain the services of the health micro- insurance scheme?**

To obtain the benefits of the HMIS, I must:

- be up-to-date with my contributions;
- have concluded the waiting period;
- go to the HMIS with my Membership Book to obtain the Certificate of Entitlement, duly numbered, completed and signed by the person authorized by the HMIS.

Go to the provider with:

- the Membership Book;
- the Certificate of Entitlement

**Page 3:**

**Benefits Offered:**

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**Providers:**

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In the event of fraud, or delay of contributions, the HMIS refers to the penalties provided for in the Policies, Systems and Procedures.

(2) The following shows an example of a membership card used by the ORT-OHPS in San Fernando, La Union.

The ORT-OHPS Membership Card is a three-fold 3" x 11" card which contains the following information

Code  
No.: \_\_\_\_\_  
Family No.: \_\_\_\_\_

**MEMBERSHIP CARD**

ORT Health  
Plus Scheme  
LOGO  
Partnership

O  
H  
P  
S

*"Paglaanan ang Kalusugan  
Para sa Magandang Kinabukasan"*

Page 1

NAME OF MEMBER(PM)			<input type="checkbox"/> PHIC <input type="checkbox"/> NPHIC	
Last	First	M		
NAME OF SPOUSE			<input type="checkbox"/> PHIC <input type="checkbox"/> NPHIC	
Last	First	M		
FAMILY MEMBERS	AGE	BIRTHDATE	RELATIONSHIP	SIGNATURE

Untitled Dependents : (1) children 17 years old and above  
 (2) legally adopted children  
 (3) disabled children  
 (4) parents of PM 60 years old an above



Page 2 - 3

[illegible]

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DATE OF REGISTRATION

1. \_\_\_\_\_ 3. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_

**ENTRY STATUS** ☐ NEW ☐ OLD ☐ RE-ENTER

YEAR:		YEAR:	
JAN	JUL	JAN	JUL
FEB	AUG	FEB	AUG
MAR	SEP	MAR	SEP
APR	OCT	APR	OCT
MAY	NOV	MAY	NOV
JUN	DEC	JUN	DEC

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**ORT HEALTH PLUS SCHEME  
OHPS-ITRMC PARTNERSHIP**  
Guerrero Road, San Fernando City  
Telefax: (072) 242-51-58  
Clinic: 700-30-82    TIN: 003-983-068-NV

**----- OHPS-----  
MEMBERSHIP CARE**

- This card is exclusive use of the member and beneficiaries.
- ALWAYS PRESENT THIS CARD PLUS ANY VALID ID FOR BENEFICIARIES WHEN AVAILING OF THE SERVICES COVERED BY THE AGREEMENT
- To avail of your benefits, pay your contribution on time.
- Report loss of this card immediately.

\_\_\_\_\_  
Signature of Principal Member

## Annex 3.6: An Example of HMIS Register of Beneficiaries

(1) The following are information about members of an HMIS to illustrate how the Register of Beneficiaries is accomplished.

### Member 1: Juan de la Cruz

The manager records the membership of Juan de la Cruz by giving him a Beneficiary Code:

1/1/0s : first beneficiary

first member from Barangay San Nicolas)

The manager then records the following information on Juan dela Cruz in the Register of Beneficiaries and Membership Book:

- surname and first name
- sex
- address
- date of birth.

### Member 2: Sandra de la Cruz

The manager then records Sandra de la Cruz as a dependant of Juan de la Cruz, giving her the Beneficiary Code:

2/1/0s - second beneficiary

- person dependant on first member, from Barangay San Nicolas

The manager also records all the information concerning them: sex, address and date of birth.

### Member 3: Antonio Corpuz

He joined the HMIS on 2/10/00, is the third beneficiary of the HMIS, the second member and comes from Barangay an Felix (Beneficiary Code: 3/2/K).

2) Register of Beneficiaries: The informatiom are entered into the following registry.

Beneficiary Code	First Names and Surname	Sex	Address	Date of Birth	Status Member Dependancy	Date of Joining	Date of Leaving	Reason/ Observations
1/1/0s	Juan de la Cruz	M	Brgy. San Nicolas	22/10/67	X	1/10/00		
2/1/0s	Sandra de la Cruz	F	Idem	1/7/86	X	1/10/00		
3/2/K	Antonio Corpuz	M	Brgy. San Felix	2/10/72	X	2/10/00		
4/2/K	Sally Fernandez	F	Idem	28/2/72	X	2/10/00		

3) The following is an actual example of Registry of Beneficiaries being used by ORT-OHPS in San Fernando, La Union, March 2004

ID No	Name	Satellite	Registration Date	Category	No.	Initial	Med	Last Payment	Amt	Reference	Mem
102289301	Esguerra, Fe	CU	07/10/2002	2	3	<input type="checkbox"/>	<input type="checkbox"/>	March 4	120	P	A
13210201	Eslaya, Jacinto	Nadsaag	07/07/1994	2	4	<input type="checkbox"/>	<input type="checkbox"/>	Feb 4	240	P	A
1712909121	Espejo, Estelita	Bariquir	07/21/2003	1	1	<input type="checkbox"/>	<input type="checkbox"/>	Jan 4	210	P	W
1722109171	Espejo, Rodolf	Bariquir	07/12/2003	2	3	<input type="checkbox"/>	<input type="checkbox"/>	Jan 4	360	P	W
15210601	Esperon, Lolita	Bulala	08/01/1994	2	3	<input type="checkbox"/>	<input type="checkbox"/>	Feb 4	240	P	W
1722109201	Espino, Irma	Bariquir	08/06/2001	2	3	<input type="checkbox"/>	<input type="checkbox"/>	Feb 4	240	P	W
1722109071	Spino, Jennie	Bariquir	07/08/1994	2	5	<input type="checkbox"/>	<input type="checkbox"/>	Jun4		P	A
						<input type="checkbox"/>	<input type="checkbox"/>				
						<input type="checkbox"/>	<input type="checkbox"/>				
						<input type="checkbox"/>	<input type="checkbox"/>				
12210801	Fontanilla, Elisa	San Francisco	07/17/2003	2	6	<input type="checkbox"/>	<input type="checkbox"/>	March 4	120	P	A

### Register of Benefits

Type of Service: Delivery

Date of Treatment	N° Certificate of entitlement	Beneficiary Code	Invoice: N°	Invoice source	Amount Payable (in Php.)			Observations
					HMIS	Beneficiary	Total	
5/1/02	5/2002	24/6/K	16	RHU San Nicolas	5 000	1 250	6 250	
2/2/02	27/2002	207/85/Os	17	RHU San Nicolas	3 000	3 000	6 000	
17/2/02	31/2002	150/68/K	17	RHU San Felix	5 000	5 000	10 000	
21/2/02	35/2002	131/60/Os	17	RHU San felix	4 000	4 000	8 000	
....								
Total					...	...	...	

# Module 3

Reference Guide and Tools on Health Micro-Insurance Schemes in the Philippines

### Annex 3.8. An Example of HMIS' Certificate of Entitlement

<p style="text-align: center;"><b>HEALTH MICRO-INSURANCE SCHEME</b></p> <p style="text-align: center;"><b>CERTIFICATE OF ENTITLEMENT NO. _____</b></p> <p><b>BENEFICIARY PROFILE SECTION</b></p> <p>Place: _____</p> <p>Name of Member: _____</p> <p>Code No.: _____</p> <p>Date of Birth: _____</p> <p>Sex: _____</p> <p>Address: _____</p> <p>_____</p> <p>Beneficiary Code No.: _____</p> <p>The _____</p> <p>For the HMIS _____</p>
---

<p style="text-align: center;"><b>HEALTH MICRO-INSURANCE SCHEME</b></p> <p style="text-align: center;"><b>CERTIFICATE OF ENTITLEMENT NO. _____</b></p> <p><b>GUARANTEE SECTION</b></p> <p>_____</p> <p>According to the agreement signed between you and the HMIS, please meet the costs of the Beneficiary identified below and send us the Invoice accompanied by the Certificate of Care Section.</p> <p>The _____</p> <p>Chairperson for the HMIS</p>
---

---

**HEALTH MICRO-INSURANCE SCHEME**  
**CERTIFICATE OF ENTITLEMENT NO. \_\_\_\_\_**  
**CERTIFICATE OF CARE SECTION**

Name of Beneficiary: \_\_\_\_\_

Code No.: \_\_\_\_\_

Beneficiary Code: \_\_\_\_\_

Name of Beneficiary: \_\_\_\_\_

Care Provided: \_\_\_\_\_

Name of Beneficiary: \_\_\_\_\_

- Total Cost Care \_\_\_\_\_

- Amount paid per beneficiary \_\_\_\_\_

- Amount payable to HMIS \_\_\_\_\_

The \_\_\_\_\_

For the Provider

### Annex 3.9. An Example of HMIS Invoice (Direct Payment System with Patient's Contribution)

<b>Health Center</b>		Date: 10/11/2002	
Number: 25			
To the _____ Health Insurance Scheme			
<b>INVOICE</b>			
Period covered: 1/10-1/11/2002			

Date of Treatment	Beneficiary Code	N° Certificate of Entitlement	Nature of Benefits	Cost of Benefits (after reduction of 10%, in Php)		
				HMIS to Pay	Benefits Paid	Total
2/10/02	167/76/K.	120/2002	Hospitalisation	6 000	1 500	7 500
5/10/02	180/80/Os.	121/2002	Outpatient care	1 500	1 500	3 000
7/10/02	23/12/K.	123/2002	Outpatient care	500	500	1 000
7/4/02	12/5/Os.	122/2002	Outpatient care	1 000	1 000	2 000
8/4/02	50/20/K.	124/2002	Delivery	5 000	1 250	6 250
9/4/02	61/23/K	125/2002	Transport	3 000	3 000	6 000
10/4/02	220/91/S	127/2002	Outpatient care	1 200	1 200	2 400
11/4/02	210/86/K	126/2002	Outpatient care	1 000	1 000	2 000
12/4/02	4/1/Os	128/2002	Outpatient care	500	500	1 000
14/4/02	12/5/0s	129/2002	Outpatient care	1 500	1 500	3 000
17/4/02	19/6/K	130/2002	Outpatient care	1 000	1 000	2 000
21/4/02	182/80/0s	132/2002	Outpatient care	1 800	1 800	3 600
25/4/02	120/60/K	131/2002	Outpatient care	2 000	2 000	4 000
<b>Total</b>				<b>26 000</b>	<b>17 750</b>	<b>43 750</b>

This invoice is issued for the sum of: *Twenty Six Thousand Pesos.*

Signature of Provider: \_\_\_\_\_

The Invoice presents the sum of Php 26,000 to be paid by the HMIS for meeting the cost of 10 benefits of outpatient care, one delivery, one transport and one hospitalization. By means of the members' contribution system, the beneficiaries have participated in meeting the cost for an amount of Php 17,750.



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### Annex 3.10: An Example of HMIS Register of Benefits

In the example given below, the HMIS records the information from the monthly Invoices in the Register of Benefits. The page summarizes meeting the cost of deliveries with:

- a reference to the date,
- the number of the Certificate of Entitlement,
- the beneficiary code,
- the invoice number,
- the origin of the invoice (name of care provider),
- and the amount payable by the HMIS and the beneficiary, and the total

A column is provided for comments. These information correspond to the information on the invoice and on the Certificate of Entitlement-Certificate of Care Section.

At the end of the page (or at the end of the year), your HMIS must add up the expenditure connected to meeting the cost of deliveries by your HMIS and by the beneficiary respectively.





Reference Guide and Tools on Health  
Micro-Insurance Schemes in the Philippines

# Accounting and Financial Management of a Health Micro-Insurance Scheme



STRATEGIES & TOOLS  
AGAINST SOCIAL EXCLUSION  
& POVERTY



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



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## Purpose

This Module hopes that you will be guided in establishing sound financial management and control of your HMIS to ensure its viability and credibility among your members and service providers. It aims to enhance your knowledge in preparing your HMIS for the new financial year, in accounting its day-to-day financial transactions and in generating financial statements and reports. It is designed to make you appreciate better the financial management systems and tools which your HMIS needs to efficiently and effectively run its operations.

## Content

This Module begins with the accounting principles in operating an HMIS. It walks you through the systems and tools in financial planning, day-to-day accounting and financial reporting. It describes to you the development of an action plan, the preparation of budget and the forecasting of cash flow as your HMIS approaches a new financial period. It presents tools how to account for the daily transactions of your HMIS and describes how financial statements and reports are generated and consolidated at the end of each financial period. In all these phases, the Chapter provides you with templates of financial documents to be accomplished and maintained by your HMIS.

## Sections

- Section 4.1 : Financial Management System and Tools
- Section 4.2 : Preparing for a New Financial Year
- Section 4.2 : Day-To-Day Accounting and Financial Management
- Section 4.3 : Generation of Financial Statements and Reports



## Section 4.1 Financial Management Systems and Tools

### 4.1.1 Significance of Financial Management to Your HMIS

Accounting and financial management is a critical system that your HMIS needs to establish and maintain. It covers the preparation phase for the new financial period, the day-to-day accounting and management of resources and the generation of financial statements and reports at the end of a financial period.

Preparing for the new financial year entails action planning, budget preparation and forecasting cash flows. These enable you to make critical decisions as to your HMIS' overall activities and program for a given period and help you estimate the revenues you expect to generate and the amount you will spend for the same period. Cash Flow Forecast ensures that your HMIS is in a position to finance the expected expenditure for a given time.

Day-to-day financial management allows you to record the inflow and outflow of your resources and helps you generate the financial statements. The recording of cash flow enables information on expenditure, revenue and income within the different accounts to be filed, making it possible for you to determine the results and financial situation of your HMIS. In the same way as for commercial companies, the function of accounting management for HMIS is to describe, among other things the following:

- the financial structure of your HMIS, specifying the source and application of funds
- changes in the criteria and value between the beginning and end of a particular period

The consolidation and generation of financial statements and reports is essential in managing your HMIS. They give you information as to the cash standing of your HMIS and assess its viability. It helps you to focus on critical items in your revenue and disbursements. You must note that all the information concerning the functioning of your HMIS must be clearly and precisely recorded to enable you to produce these documents.

### 4.1.2 The Accounting System As Applied in the Philippines

The accounting and financial management system must be tailored to the specific needs of your HMIS. It must also comply with the accounting system requirements in force in the Philippines. Your HMIS is a non-profit-making organization which offers insurance, solidarity and mutual assistance services by means of your member's contributions. Through these contributions, your HMIS guarantees that all or part of the cost of your members' health care will be paid for or reimbursed. The care is supplied by providers with whom you have actually contracted to deliver the service, covered by signed MOA stipulating the pricing and quality of care among others. The viability of your HMIS is determined by the benefits you offer and the contributions you receive.

HMIS in the Philippines are often small or medium-sized and usually operate in the informal sector. Because of lack of resources, they often function on a voluntary basis and do not have the funds to ensure professionalized management. Your accounting management tools and administrative operating system should adapt to these characteristics. Another specific feature common to your HMIS is its financial vulnerability following unexpected risks such as epidemics, adverse events (due to their small size) and abuse. You must therefore take preventive measures and ensure sound financial monitoring of activities to preserve the viability of your scheme.

In the Philippines, there are no specific regulations for managing HMIS. With respect to accounting and tax regulations, your HMIS naturally falls within the regulations covering non-profit organizations or cooperatives. Apart from the specific features referred below, the accounting and financial management of your HMIS does not differ from classical accounting principles and mechanisms common to all social economy companies.

The non-profit principle involves a series of specific accounting features such as:

- **The Distribution of Profits:** While in the commercial sector the goal is to seek distributable profit, this does not apply for organizations in the non-profit-making sector. Where there are positive results, for example, the term 'surplus' is used rather than 'profits'.

- **Income Tax (surpluses):** Non-profit-making organizations are not generally subject to income tax.
- **Voluntary Service:** The voluntary contribution of members is a feature specific to certain non-profit-making bodies such as your HMIS. The different voluntary acts are contributions in terms of work, goods or other services. Your HMIS may record such voluntary contributions in the accounts to give a value to such contributions in work.

This Guide does not deal with all aspects of accounting and financial management of your HMIS. Neither does it tell you step-by-step what need to be done. If you are interested to know more how to set-up these systems, you should consult other HMIS with advanced experiences on this regard, refer to special publications or materials or seek advice from national or subnational government agencies, NGOs or from the concerned donor agencies.

### 4.1.3 Accounting and Financial Management Tools

The accounting and financial management documents include:

Preparing for a New Financial Year

- the Action Plan
- the Budget
- the Cash Flow Forecast

For Day-to-Day Accounting and Management

- the Cash Journal
- the Cash-in-Bank Journal
- the Cash Receipt Book
- the Cash Disbursement Book
- the Petty Cash Form
- the General Ledger

For Generation of Financial Reports

- the Statement of Income and Expenditure
- the Balance Sheet

## Section 4.2 Preparing for a New Financial Period

This Guide distinguishes between the recording of cash flow and the preparation of financial tools and statements. Cash flow should be recorded by all HMIS while the production of financial tools and statements may require the support of external agencies or groups such as unions or specialist firms. The classical accounting notions of 'debit' and 'credit' is also replaced by 'inflows', 'outflows' and 'balance'. The balance is defined as the difference between inflows and outflows.

### 4.2.1 Process in Preparing for the New Financial Period

There are basically three activities that must be done in preparing for the new financial period, which is usually a year. These are the development of an Action Plan, the preparation of the Budget and establishing the Cash Flow Forecast. These activities are essential to fully prepare your HMIS for the next financial period. The following table shows the overall process in preparing for the financial year.

**Table 4.1: Preparation of a New Financial Year**

Internal Organization				External Partners	
General Assembly	Executive Body	Board of Directors	Auditing Body	Providers	Savings Bank
	(1) Prepare action plan, budget and cash flow forecast: first proposal	(2) Review and/or revise action plan, budget and cash flow forecast: second proposal			
(3) Adopt action plan, budget and cash flow forecast during annual GA	(4) Execute action plan, budget and cash flow forecast	(5a) Monitor action plan, budget and cash flow forecast	(5b) Control implement action plan, budget and cash flow forecast		

Table 4.1 illustrates the preparation for the new financial year.

- (1) The Executive Body develops the Action Plan, prepares the Budget and the Cash Flow Forecast and submits these to the Board of Directors for review. These are still considered drafts or first version.
- (2) The Board of Directors review these drafts and make the necessary adjustments, if needed. These are called the second versions. Once the BD approves these documents, these are submitted to the annual General Assembly for final approval and adoption.
- (3) When the GA has given its approval, the Executive Body carries out the activities provided for, supervised by the Board of Directors.
- (4) The Auditing Body verifies if the action plan is carried out as intended, the budget is executed as approved and the cash flow forecasts are reviewed.

### 4.2.2 Tools in Preparing for the New Financial Year

To ensure that your HMIS is effectively managed, you must know where your HMIS is going and where it stands in terms of its financial health status. To know where your HMIS is going, is to define first the objectives and programmes of your HMIS with an accompanying Action Plan, Budget and Cash Flow Forecast. As mentioned earlier, there are three outputs or documents that need to be prepared. These are the Action Plan, Budget and Cash Flow Forecast. The purpose, information and use of these documents or tools are described in the following section. Formats and examples of these tools are provided in the Annexes.

#### Document 4.2.2.a The Action Plan

##### a.1 What is the Action Plan for?

Within a given financial period (usually a financial year), the achievement of activities of your HMIS will be compared regularly with your budget estimates in order to identify deviations or differences. This review enables you to take measures so that you can realize the objectives and activities you have laid down at the beginning of the financial year.

In this regard, you need to develop an Action Plan which reflects the key programs and activities that you intend to do within the financial period. This Action Plan must be consistent with your estimated budget for the same financial period.

##### a.2 What information does the Action Plan contain?

The Action Plan contains the objectives, activities, people-in-charge of these activities, the targets of each activity and the means to achieve these activities.

*Objectives:* These are statements of what your HMIS wants to accomplish at the end of the financial period. The objectives of your Action Plan must be S.M.A.R.T. (Specific, Measurable, Attainable, Realistic and Time-Bound). They should also be quantifiable in terms of the indicators for easier monitoring and assessment.

*Activities:* These are actions that you need to undertake in order to realize your objectives. Each objective therefore will have a set of activities to accomplish it. For these activities to be carried out, they should be clear, precise and well-defined to help attain your objectives.

*Staff Responsible:* This refers to the people in your HMIS who are in-charge of the activity. Note that these people or individuals are assigned with the responsibility of making the activities happen. They are to ensure that the actions envisaged are executed soundly.

The targets are the people whom the activities are aimed at. A distinction can be made between the direct and indirect beneficiaries of the activity. You should be able to define which activities are for BOTH women and men, and which activities are specifically intended for men or women.

The means consists of what the activities to be carried out require. These should be quantifiable and must be consistent with the budget.

The schedule of implementation should cover the whole year (or the specified financial period). This can be broken down into months or quarters. Each activity in the plan must have an identified date or schedule when it should be carried out.

### a.3 How will the Action Plan be used?

The Action Plan that is drafted by the Executive Body will be reviewed by the Board of Directors and then submitted to the GA for final approval and adoption. The Action Plan reminds you of the key activities that your HMIS should undertake and when you should carry them out.

The Action Plan is also used as a reference to validate the budget that you have prepared, whether the budget is consistent and is enough to support the planned activities or not. On the other hand, it helps you assess which actions need not be pursued considering the status of your finances or other interim events during the financial period. The action plan guides you in preparing your Cash Flow Forecast. Since activities are programmed according to schedule, this will help you plot out when cash are mostly needed. It is also a basis for monitoring the status of implementation by your HMIS.

### a.4 Format of an Action Plan: Please refer to Annex 4.1 for the format of the Action Plan.

## Document 4.2.2.b The Budget

### b.1 What is the Budget for?

The budget is the financial reflection of your HMIS action of programme for each new financial year. It is a forecast of the revenue and expenditure necessary to carry out your activities and attain your objectives. The budget should be balanced with regard to revenue and expenditure. The preparation of budget involves the choices concerning the benefits to be given, the corresponding contributions to be collected and the respect according to these decisions during the financial year. Your HMIS must be aware of the limits not to exceed its expenditure, taking the forecast revenue into account.

### b.2 What information does the budget contain?

The budget presents the financial forecasts of your HMIS, grouped into two major categories:

- ä estimated expenditure
  - health benefits or the reimbursement of the cost of beneficiaries' care
  - operating costs which include staff allowances, travel expenses, supplies, etc.
  - training expenses and other expenditures
- ä estimated revenue
  - membership fees
  - contributions
  - additional resources: income from other activities, interest on investments and other revenues

It will be useful to present these information using sex-disaggregated data, where appropriate, in order to come up with more nuanced analysis.

The special feature of your budget as an HMIS is that it is easier to estimate your revenue than your expenditure since the amount of contributions is known, but the number of members and beneficiaries expected for the new financial year still needs to be assessed. Your

expenditure, in fact, depends on several external factors which your HMIS does not have a great deal of control over: For example, these are:

- the state of health of the population
- the behaviour of care providers as regards prescribing medicines, tests, etc.
- the outbreak of epidemics

After operating for more than a year, your HMIS would have gained experience and collected information which allow you to improve your estimates for the next financial year. You will be now in a better position to estimate certain parameters such as:

- the development of the number of members
- the cost of health services
- rates of risk (expected use by beneficiaries of the different health services covered)
- operating costs
- inflation

Those of you who are just beginning, you may have to draw up your first budget according to assumptions you made in your situational analysis.

### b.3 How is the Budget used?

The Budget is prepared from the information of the past and assumptions about the future. The first Budget will be based on information collected during the situational analysis.

During the financial year concerned, the achievement your activities will be compared regularly with your budget estimates so as to identify possible differences and take measures in order that the objectives you laid down at the beginning of the financial year will be achieved.

- (1) The Budget is prepared by the Executive Body and the Board of Directors and then submitted to the General Assembly.
- (2) The GA approves the budget or may amend it, particularly by adjusting the forecast activities proposed by the BD.
- (3) The budget thus adopted by the General Assembly must comply with the By-Laws of your HMIS and with the legal provisions. It must be balanced and must foresee the reservations imposed by the regulations and required in all cases for sound management.

The interest in using the Budget lies above all in monitoring its execution. Execution is the act in which the HMIS carries out the activities planned and implements the revenue and expenditure programmed in its Budget. The decision makers of your HMIS play an important role in executing the Budget. For example, an expense cannot be incurred without the agreement of the Chairperson and unless it complies with the Budget.

Monitoring the execution of the budget is particularly important: like any company, your HMIS must be able to adjust its forecasts periodically according to interim achievements. For example, a quarterly comparison of budget forecasts and achievements would enable essential measures



to be taken, if necessary, to re-establish a balance between revenue and expenditure. Having a sex-disaggregated budget will help in analysing sex-based patterns in health expenditures towards formulating promotive and preventive measures.

b.4 Example of Budget: Please refer to Annex 4.2 for the actual sample of an HMIS budget.

### **Document 4.2.2.c: The Cash Flow Forecast**

#### **c.1 What is the Cash Flow Forecast for?**

You should pay attention to your cash flow. You must ensure all the time that your HMIS have sufficient money on hand or in the bank to be able to meet your expenditure. The management of your cash flow is even more important when your HMIS is subject to seasonal variations connected in particular to:

- seasonal peaks of the disease; For example, the prevalence of malaria, one of the main causes of disease, increases in the rainy season and declines in the dry season.
- seasonal or irregular income of members. In rural environments, for example, they are dependent on the sales periods of crops

In managing your cash flow therefore, you need to take these variations into account during planning to ensure that you have sufficient cash flow to honour your commitments to your members and care providers. The Cash Flow Forecast is a tool for planning, monitoring and control of your resources.

#### **c.2 What information does the Cash Flow Forecast contain?**

The Cash Flow Forecast covers the principal information on your HMIS budget. It divides the forecasts for cash flow on a monthly basis, taking into account the seasonal variations.

##### **ä estimated expenditure**

- health benefits: reimbursement of beneficiaries' care expenditure
- operating costs: staff allowances, travel costs, supplies;
- training costs
- other expenditures such as investments, loan repayment

##### **ä estimated income**

- membership fees
- contributions
- additional resources: revenue from other activities (investment interest, loans)

#### **c.3 How is the Cash Flow Forecast used?**

The Cash Flow Forecast enables your HMIS to ensure that it has enough liquid assets to meet its obligations at any time. It also allows you to avoid keeping too high a level of liquid assets on hand in a period of low expenditure. During such periods, you may have to decide to make

the liquid assets pay by investing them in interest-bearing accounts.

- (1) In order to establish the Cash Flow Forecast, you need to assess all your expenditure and income items monthly.
- (2) Obtain monthly cash balances by drawing up the balance of these monthly receipts and disbursements.
  - (2.1) When a balance is positive, it means that your receipts are greater than your disbursements and that there will be no liquid asset problem. If the surplus is significant, you can invest part of your HMIS' liquid assets in an interest-bearing bank account.
  - (2.2) If the balance is negative, it means that your disbursements are greater than your receipts and that there will be liquidity problems. In this case, you must choose from the following solutions how to meet your commitments:
    - withdraw the amount necessary from your savings account
    - negotiate for a loan
    - defer certain expenses by obtaining longer payment periods
    - take action to obtain revenue from members whose contributions are in arrears

Note that establishing an accurate Cash Flow Forecast is particularly difficult for the first, or even the second or third year of operation of your HMIS. This is due to limited information that would accurately measure the seasonal variations in your health benefit expenditure. Only after several financial years will you be able to see trends every month to be able to work out the pattern of seasonal variations.

- c.4 Example of Cash Flow Forecast: Please refer to Annex 4.3 for the actual sample of an HMIS Cash Flow Forecast.



## Section 4.3: Day-to-Day Accounting and Financial Management

### 4.3.1 Paramount Considerations in Accounting and Managing Your HMIS' Financial Resources

Day-to-day transactions of your HMIS involve the movement of assets, services or money. Movements of money are also called 'cash flow'. As managers of your HMIS, you have a daily task in managing inflows and outflows of your cash and bank accounts.

What is paramount in the accounting and management of your day-to-day transactions is first, your ability to record these transactions appropriately, correctly and immediately as they occur. Second, your recording must enable you to keep track of the cash you have on hand and your cash in-bank on a daily basis. These records must be able to provide you with information that leads you to assess readily your financial status and take immediate actions as needed.

It is also important that your financial management system considers the accounting principle of control and balance. Ensure that person/staff assigned are competent and above board with clear delineation of their respective tasks. Staff assigned to receive and record cash (Bookkeeper) must be different from the one who will deposit and withdraw (Treasurer) from the Bank and from the one who issues checks or handles payments or cash releases (Cashier). Above all, you must ensure that your financial recordings are transparent and stand the scrutiny of your Auditing Body and members of the general assembly.

### 4.3.2 Common Day-to-Day Accounting and Financial Management Practices of HMIS

There exist a lot of variations in the way HMIS manage and account their day-to-day financial transactions. It usually depends on the size of members, their organizational set-up, existing agreements with their external partners (e.g. the service providers), their access to bank institutions, the nature/classification of revenue and expenditures and the availability of staff to manage such financial transactions.

HMIS in the Philippines use different terms for their financial records even though these have similar functions and provide the same information. They adopt different formats and levels of detail. Some have their Cash Receipt and Cash Disbursement Books more detailed than others to reflect specific classifications of disbursements (e.g. supplies, training, etc.) and receipts (contributions, donations, membership fees, etc).

In some HMIS, cash receipts and cash disbursements are recorded in one document. Others record them separately. In smaller-sized HMIS where transactions are only few, no Cash Disbursement and Receipt Books are maintained. Transactions are recorded directly to the General Ledger. In more advanced HMIS like the ORT-OHPS in La Union, all their disbursements are done through checks, hence their Cash Disbursement Book reflects movements only of their cash in bank and none from their cash-on-hand, except the petty cash.

Almost all HMIS maintain a petty cash, in varying amounts and different recording formats. Most HMIS use "Credit" and "Debit" for in-flow and out-flow respectively. Regardless of these variations, your HMIS must be able to properly account your financial resources and transactions.

### 4.3.3 Tools for the Day-To-day Accounting and Financial Management

Given the differences in the financial terminologies, recording format and practices, you must be able to use appropriately the following tools to record and keep track of the movements of your financial resources. The following are the most common:

- Cash Journal : This is to record your daily transactions involving your cash on hand

- **Cash-in Bank Journal** : This is to record your daily transaction involving your cash-in-bank
- **Cash Receipt Book** : This records the day-to-day amount of received by your HMIS
- **Cash Disbursement Book**: This records the day-to-day disbursements made by your HMIS
- **Petty Cash Form** : This records disbursements out of your petty cash
- **General Ledger** : This is to record at the end of each month your day-to-day transactions according to the classification or nature of your transactions

Before discussing each tool in detail, take note that the Cash Journal and Cash-in-Bank Journal are quite similar with the Cash Receipt Book and Cash Disbursement Book respectively. In this case, you may need to select which of these tools you want to use and maintain in your HMIS.

Note that the Cash Journal and the Cash-in-Bank Journal are tools to record the daily movements of your cash-on-hand and cash-in-bank accounts respectively. In the Cash Journal, you record both the amount of cash received (in-flow) by your HMIS and how much it is disbursing (out-flow). Your Cash-in-Bank Journal records the same thing. Both give you a rundown of how much cash you have on hand and in the bank on a daily basis.

The Cash Receipt Book and the Cash Disbursement Book are also tools to record the daily movements of your finances. However, the Cash Receipt Book records the in-flow of cash (receipts) in both your cash-on-hand and cash-in-bank while the Cash Disbursement Book records the out-flow of cash (disbursements) also from both cash accounts. These two records provide you a rundown how much cash you have received and how much you have disbursed on a daily basis.

The following section discusses the purpose, use and information provided by the each of the above-listed tools.

### **Document 4.3.3.a : The Cash Journal**

#### **a.1 What is the Cash Journal for?**

The Cash Journal is otherwise called as the Cash Record or Cash Book. The Cash Journal records on a daily basis the cash transactions carried out by your HMIS. It allows the movements of your funds in cash to be recorded chronologically and serves as a "continuous memory." It makes it possible for you to find all the details about the cash transactions which your HMIS made and verify at any time the accuracy of your cash in hand. It is therefore an essential tool for you in managing your HMIS.

#### **a.2 What information does the Cash Journal contain?**

The Cash Journal generally includes the following information:

- date
- reference of supporting document: invoice number, receipt, cash certificate, etc.
- object: the nature or name of the cash transaction carried out (other name: description)
- inflows: the amount coming into your cash-on-hand account if the transaction involves cash coming in
- outflows: the amount going out of the cash-on-hand account, if the transaction involves

- cash going out
- balance: the difference between the amount of inflows and outflows which can be calculated at the end of the day

### a.3 How is the Cash Journal used?

The following outlines to you how to accomplish the Cash Journal:

- (1) any transaction carried out by your HMIS involving cash should :
  - be recorded in the Cash Journal exactly at the time when you carried out the transaction
  - specify the reference of the supporting document corresponding to the transaction
- (2) You should previously identify each page of the Cash Journal you used according to the month concerned
- (3) At the end of each day and after recording the last transaction of the day in the Cash Journal, you need to calculate the new balance
- (4) Record the amount identified for the close-of-day balance under the Balance Column on the last line of the day. You will carry the same amount forward to the beginning of the following day.
- (5) At the end of each month and after recording the last transaction of the month, you need to close the Cash Journal for the month. To close the Cash Journal, it is necessary for you to:
  - (5.1) Calculate and record the last balance, after the last transaction at the end of the last day of the month.
  - (5.2) Check the accuracy of this final balance. You can check the final balance by:
    - (5.2.1) adding up all the sums coming in during the month under the "In-Flow Column."
    - (5.2.2) adding up all the sums going out during the month under the "Out-Flow Column."
    - (5.2.3) by carrying out the following calculation:
 

new end		start of month balance	
of month	=	+	total inflows during month
balance		-	total outflows during month

The amount identified after this check should be equal to the balance you calculated after the last transaction at the end of the month.
- (6) At the end of the month, use a new page of the Cash Journal to record your transactions relative to the following month by carrying forward the previous balance. Identify this by the new month beginning and carrying forward the previous end of month balance to the top of the new page, specifically on the line marked 'carry forward'. Your preceeding end of month balance becomes your new start of month balance for the

month beginning.

(7) The Cash Journal is usually managed by your HMIS Treasurer.

**Table 4.2: The Recording of Cash Flow –The Cash Journal**

Health Micro-Insurance Scheme Internal Organisation				External Partners	
Beneficiaries	Executive Body	Board of Directors	Auditing Body	Providers	Savings Bank
	(1) Pay invoice ↓ (2) Record expenditure in Cash Journal	(3) Monitor and assess	(3) Monitor and control		

Table 4.2 describes the daily management of expenditure, particularly cash payments. After receiving the invoice from the service provider, the HMIS pays it from cash on hand and records the transaction in the Cash Journal (outflows).

**a.4 Example of Cash Journal:** Please refer to Annex 4.4 for the actual sample of an HMIS Cash Journal.

### Document 4.3.3.b: The Cash-in Bank Journal

#### b.1 What is the Cash-in-Bank Journal for?

The Cash-in-Bank Journal is otherwise called as the Bank Record or the Bank Book. In a day-to-day basis, the Cash-in-Bank Journal records all transactions carried out by your HMIS through your bank account. It presents the chronological succession of all bank transactions and constitutes its continuous 'memory'. It makes it possible for you to find all the details relative to your HMIS bank transactions. It also enables you to check the accuracy of the amount available in your HMIS bank accounts at any time. This tool is therefore essential in managing your HMIS.

In certain cases also, the Savings and Credit Passbook may replace the Cash-in-Bank Journal. These usually contain the same information. In most remote areas, the HMIS may be far or too distant from the existing bank, hence they may not have opened a Bank Account.

#### b.2 What information does the Cash-in-Bank Journal contain?

The Cash-in-Bank Journal allows you to record chronologically the movements of your HMIS funds in the bank. It allows you to carry out the bank reconciliation of your assets. The Cash-in-Bank Journal generally includes the same information as the Cash Journal.

- date

- reference of supporting document
- object: nature or name of the transaction (also called description)
- In-flows: the amount coming into the bank account
- outflows: the amount going out of the bank account
- balance: the difference between the amount of inflows and outflows can be calculated at the end of each day

### b.3 How is the Cash-in-Bank Journal used?

Your HMIS must have as many Cash-in-Bank Journals as it has separate bank accounts. Separating accounts may help your HMIS to manage its different budgets better. It is therefore possible for your HMIS to develop separate accounts for your reserves, for budgeted operating costs and the management of a pharmaceutical store, if you operate one. The following outlines to you how the Cash-in-Bank Journal should be accomplished:

- (1) any transaction carried out by your HMIS through your bank should:
  - (1.a) be recorded in the Cash-in-Bank Journal at the time you
    - carry out the transaction (For example: withdrawal), or at the time you have been informed about it (For example: advice of bank charges).
    - (1.b) specify the reference number of the supporting document corresponding to the transaction.
- (2) Identify each page of the Cash-in-Bank Journal that is being used according to the month concerned.
- (3) Calculate the new bank balance at the end of each month and after recording the final transaction of the month in the Cash-in-Bank Journal. Carry out a bank reconciliation based on the bank statements. You should record the amount identified as the end of month balance under the "Balance Column" on the last line of the day.
- (4) You carry the same amount forward to the start of the following month.
- (5) You need to close the Cash-in-Bank Journal at the end of the month. To close the Cash-in-Bank Journal, you need to:
  - (5.1) calculate and record the final balance after the last transaction at the end of the month.
  - (5.2) check the accuracy of the final balance by:
    - (5.2.1) adding up all sums coming in to the bank during the month under the "Inflow Column"
    - (5.2.2) adding up all sums going out of the bank during the month under

the "Outflow Column"

(5.2.3) carrying out the following calculation:

$$\begin{aligned} &\text{new end} && \text{start of month balance} \\ &\text{of month} = &+ &\text{total 'inflows' of the month} \\ &\text{balance} &- &\text{total 'out-flows' of the month} \end{aligned}$$

The last amount identified after this check must be equal to the balance you calculated after the last transaction at the end of the month.

(6) At the end of the month, use a new page of the Cash-in-Bank Journal to record transactions relating to the following month and carry the previous balance forward. Identify it with the new month beginning. Carry the previous end of month balance forward to the top of the new page on the line marked 'carry forward'. The preceding end of month balance becomes the new start of month balance for the month beginning.

(7) The Cash-in-Bank Journal is usually managed by your Bookkeeper.

Table 4.3 describes the movement of your cash in-bank transactions as recorded in the Cash-in-Bank Journal.

**Table 4.3: The Recording of Cash Flow – The Cash-in-Bank Journal**

Beneficiaries	HMIS: internal Organisation			External Partners	
	Executive Body	Board of Directors	Auditing Body	Providers	Savings/ Credit bank
	(1) Pay invoice				(2) Bank withdrawal
	(3) Record expenditure in Cash-in-Bank Journal				
		(4) Monitor and assess	(4) Control		

(1) The service provider sends in the invoice.

(2) The Executive Body checks the invoice and orders payment by withdrawing cash from the bank.

(3) The HMIS records the withdrawal in the Cash-in-Bank Journal with the reference document. It also notes the date, the number of the supporting document and the amount paid out in the 'outflows' column. The balance is then calculated.

(4) A similar procedure is used for payments by cheque.

**b.4 Example of Cash-in-Bank Journal:** Please refer to Annex 4.5 for the actual sample of an HMIS Cash-in-Bank Journal.

### Document 4.3.3.c: The Cash Receipt Book

#### c.1 What is the Cash Receipt Book for?

Most community-based organizations (e.g. cooperatives, etc.) in the Philippines commonly use the Cash Receipt Book to record the amount of cash their HMIS receives day-to-day. This cash either flows into your cash-on-hand or cash-in-bank account. Together with the Cash Disbursement Book, they provide another way of recording day-to-day transactions of your HMIS just like the Cash Journal and the Cash-in-Bank Journal. Their purpose though is the same, which is to help you keep track your cash flow on a daily basis and to keep a record of these in chronological manner.

#### c.2 What information does the Cash Receipt Book contain?

The Cash Receipt Book contains the following information:

- date
- particulars
- Reference Document
- Amount of Cash received under Cash-on-Hand
- Amount of Cash received under Cash-in-Bank
- Classifications of the received cash: (e.g. contributions or premiums of members, donations or grants, etc.)
- total amount received for the month and by classification
- cumulative amount of cash received from previous months

Where appropriate, it is helpful if data is sex-disaggregated to help in forming analysis.

#### c.3 How is the Cash Receipt Book Used?

The Receipt Book is used to record cash received by your HMIS on a day-to-day basis. This means that every time that cash is remitted to your HMIS or donated/granted, these should be recorded appropriately under the Cash Receipt Book. For each cash received, the above information should be recorded. The cash received is further classified either under "contributions" or "premiums" received from members, "grants" given by other agencies, "subsidies" from the HMIS other fund-raising activities or "donations" from other groups. At the end of each month, all the cash you received under your cash-on-hand and cash-in-bank accounts are summed up. This gives you an overall picture of how much cash you have received for the month. You can add then these amounts to the cash you received the previous months to give you a running account of all your cash receipts. You apply the same procedures for the incoming month.

#### c.4 Example of a Cash Receipt Book.: Please refer to Annex 4.6 for the actual sample of a Cash Receipt Book.



### Document 4.3.3.d: The Cash Disbursement Book

#### d.1 What is the Cash Disbursement Book for?

On a daily basis, disbursements made by your HMIS must be recorded in your Cash Disbursement Book. Cash disbursed may either come from your cash-on-hand or your cash-in-bank account. The Cash Disbursement Book records in a chronological order these disbursements, classifies them by the nature or category of the disbursements and serves as the "memory" source of cash outflows day-to-day. This tool makes it possible for you to find all the details relative to your HMIS cash-out flow transactions. It also enables you to check the accuracy of the amount available in your HMIS bank accounts and cash-on-hand at any time.

#### d.2 What information does the Cash Disbursement contain?

The Cash Disbursement Book records all daily cash-out-flows of your HMIS. Specifically, it provides you information on the amount of financial resources disbursed by your HMIS out of your HMIS cash-on-hand and cash-in-bank accounts. Specifically, it contains the following information:

- date
- particulars
- amount of cash disbursed from cash-on-hand
- amount of cash disbursed from cash-in-bank account
- classification of the disbursement (e.g. supplies, training, communications, health service payment, etc.)
- total amount disbursed for the month and by classification
- cumulative amount disbursed from previous months

Similar to cash receipts, it is helpful if data is sex-disaggregated, were appropriate, to help in forming analysis.

#### d.3 How is the Cash Disbursement Book used?

The Cash Disbursement Book is used to record cash outflows of your HMIS on a day-to-day basis. This means that every time your HMIS uses or disburses money, these should be recorded appropriately, whether they are taken from your cash-on-hand or cash-in-bank account. You need to further classify the nature or purpose of your disbursement (e.g. supplies, training, communications, payment to your service provider for health services offered, etc.) At the end of each month, all cash disbursed are summed up. This gives you an overall picture how much cash you disbursed for the month. These amounts are then added to the disbursements from the previous months. The recorded information allows you to keep track of the amount and nature of cash disbursed by your HMIS on a daily and monthly basis including the purpose for which they were used. Information on your daily and monthly disbursements becomes your basis for establishing trends of your monthly expenditure, thus enabling you to make a better forecast of your cash requirements over the financial period.



**d.4 Example of a Cash Disbursement Book:** Please refer to Annex 4.7 for the actual sample of a Cash Disbursement Book.

### **Document 4.3.3.e: The Petty Cash Form Ledger**

#### **e.1 What is the Petty Cash Form for?**

The use of petty cash is a common practice in the day-to-day transactions of all HMIS. As the term "petty" indicates, these are small amounts of cash that you keep as a ready source for small amount transactions of your organization. Though these are small in amounts, it is still necessary and a sound financial management practice to record the disbursements from your petty cash. Each HMIS has its own format and structure in recording the utilization of their petty cash. Regardless of these variations, your Petty Cash Form must be able to record on a daily basis the amounts used and the purpose or nature of your disbursement. It should enable you to make timely remittance before your petty cash become completely utilized.

#### **e.2 What information does the Petty Cash Form contain?**

The Petty Cash Form contains the following information:

- Total amount of Petty Cash
- Date
- Particulars: describes briefly for what purpose the petty cash was used for (e.g. for supplies, transportation, etc.)
- Reference Document
- Amount released/disbursed
- Balance

#### **e.3 How is the Petty Cash Form used?**

Indicate at the beginning of your Petty Cash Form the total amount of petty cash you are allowed to maintain. You must also be clear on the minimum balance you can maintain at which point you can request for replenishment.

Every transaction paid from your petty cash must be recorded into the Petty Cash Form as they occur. You must indicate the particulars of the transaction, the reference document and amount. At the end of the day, you sum up the amount disbursed and determine the balance. The balance should be consistent with the actual amount of money you have in your petty cash. Once you have reached the minimum balance, you can request for replenishment with the accompanying supporting documents.

**e.4 Example of a Petty Cash Form:** Please refer to Annex 4.8 for the format of a Petty Cash Form.

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## Document 4.3.3.f      The General Ledger

### f.1 What is the General Ledger for?

The General Ledger summarizes the daily transactions of your HMIS during the month according to the classification or nature of your activities or transactions. It summarizes debit transactions (inflows) and the credit transactions (outflows) for each account, in accordance with your HMIS accounting plan.

The General Ledger reduces the number of entries to be made and gives an overall view of the transactions in the accounting plan. It allows all transactions to be recorded in chronological order, while indicating the accounts to be credited ('inflow') or debited ('outflow'). It also makes it possible for you to find all the details relating to all transactions carried out for each account and to know the balance used by your HMIS at any time. By comparing the different accounts used, it also makes it possible for you to rapidly calculate the provisional results of your HMIS activities.

By accomplishing the General Ledger, it makes it easier for you to draw up the Statement of Income and Expenditure at the end of the financial year, and to calculate the different indicators of activities and useful statistics.

### f.2 What information does the General Ledger contain?

The General Ledger summarizes the daily transactions of each of your accounts that can be sourced from your Cash Journal and Cash-in-Bank Journal or from your Cash Receipt Book and the Cash Disbursement Book. In general, it contains the following information:

- date
- subject
- in-flow, out-flow, balance in your cash-in-bank
- in-flow, outflow, balance in your cash-on-hand
- sundry activities: the other asset accounts that it has not been possible to open:
  - fixed assets: buildings, land, transport equipment (e.g. vehicles);
  - significant investments: amount of purchase;
  - stocks: balance of stocks of consumables, such as health books, medicines or registers;
  - realizable assets: credits, time investments, deposit accounts;
- credits:
  - when members owe arrears in contributions;
  - when they must reimburse the cost of benefits;
  - when a subsidy is granted without being received;
  - different undertakings/debts;
- deposit: the amount demanded by a service provider in relation to a guarantee -non-payment, reductions- for                      example;
- sundry liabilities (other liabilities accounts it has not been possible to open in the journal):

- reserves;
- short, medium and long-term debts
- income: new members, contributions, sundry (sale of medicines, subsidies, other);
- expenditure: benefits, functioning, sundry.

Sex disaggregated information in the statement of income and expenditure.

### f.3. How is the General Ledger used?

(1) On a daily basis, you must administer the accounts used in connection with the HMIS activities. You have to record each transaction in the balance sheet headings:

- In the Cash-in-Bank Column: if it concerns an activity involving inflows or outflows of money to or from the bank account (Refer to your Bank Book)
- In the Cash-on-Hand Column: if it is an activity concerning cash in hand. This column corresponds to the Cash Journal and therefore follows the same rules
- In the Sundry Assets Column: when it involves activities concerning fixed assets, the guarantee or the deposit
- In the Sundry Liabilities Column: when it involves reserves and short, medium or long-term debts

(2) The same amount is simultaneously recorded to the Statement of Income and Expenditure Column, specifying whether it concerns a charge or an income:

a charge:

- Operating costs: transport, training, etc
- Benefit costs: consultations, medicines, other income: contributions, benefits, others (such as subsidies or income from events)

(3) After you have recorded each transaction in a balance sheet account, you must recalculate the balance of that account.

(4) At the end of each month and after recording the last transaction of the month, you must close the General Ledger for the month ending. To close the General Ledger at the end of a month, it is necessary for you to:

- (4.1) calculate and record the last balance of each account, after the last transaction of the month
- (4.2) carry forward the previous balance
- (4.3) add up each column in total (total month + carry forward)

(5) You can check your recording by:

(5.1) In the inflows column, by adding up all the amounts that have gone into the account during the month + total income.

(5.2) In the outflows column, by adding up all the amounts that have gone out of the account during the month + total expenditure.

(5.3) Making a comparison between these two totals and having the balance equal to zero by carrying out the following calculation:

$$\begin{aligned} &\text{New End Start of Month Balance} \\ &\text{of Month} = + \text{Total Inflows and Income of the Month} \\ &\text{Balance} - \text{Total Out-Flows and Expenditures of the Month} \end{aligned}$$

(5.4) Verify if the amount identified after this check should be equal to the last balance calculated after the last transaction of the month.

(6) You must open a new page of the General Ledger and identify it by the new month beginning, and carrying forward the balance of the end of the previous month to the top of the new page on the line marked 'carry forward'. The previous end of month balance becomes the new start of month balance for the month beginning.

(7) You must record each transaction in the General Ledger. This makes it possible for you to follow the development of the balance sheet and statement of Income and Expenditure information of your HMIS at any time.

**f.4 Example of a General Ledger:** Please refer to Annex 4.9 for the format of a General Ledger.

## Section 4.4 Generation of Financial Statements and Reports

### 4.4.1 Importance of Financial Statements and Reports

This section deals with the production of financial tools and statements. In many small-scale HMIS in the Philippines, they only record cash flow. Such recording is necessary but not sufficient. Accounting and financial documents make it possible to have a better knowledge of and to analyze the financial situation of your HMIS.

Your HMIS should try to improve and professionalize its accounting and financial management. This reinforces the transparency of management, the confidence of your members and partners, and better decision-making by your management and staff. It should be noted that if your HMIS lacks certain abilities, it may also opt to seek external support provided by unions, accounting companies or specialist support structures.

### 4.4.2 Application and Limitations

As stated in the introduction of this Chapter, the accounting used should be adapted to the special needs of your HMIS but should also comply with the requirements of the accounting system in force. This Guide does not offer a complete explanation of the preparation, use and analysis of financial tools and statements. Where the accounting work is more complete, the preparation of financial statements is preceded by recording the accounting events of the day in the book or rough book, followed by chronological recording in the journal. The information is finally recorded in the different journals and is filed in the General Ledger or accounting record.

This section of the Guide is limited to a summary description of the principal accounting and financial tools and will therefore not deal with the accounting stages that precede the establishment of these tools. Readers interested in this topic should consult a more specialized publication or material or consult national or sub-national government agencies, NGOs or concerned donor agencies.

### 4.4.3 Tools in Generating Financial Statements and Reports

Note that the accounts of your HMIS usually are grouped into two major categories:

- the Balance Sheet accounts which track the development of resources (liabilities) and their use (assets);
- the Income and Expenditure accounts which record the resources generated by activities (contributions, membership fees, others) and the consumption of goods and services necessary for those activities (benefits, functioning) respectively.

The documents and tools described below are used for a given period, called the financial year. The profit and loss account and the balance sheet, for example, are often drawn up at the end of a period of one year.

The HMIS will work mainly with the following documents:

- Statement of Income and Expenditure
- Balance Sheet

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## Document 4.4.3.a The Statement of Income and Expenditure

### a.1 What is the Statement of Income and Expenditure for?

The Statement of Income and Expenditure (SIE) is otherwise known as the Operating Account or Profit and Loss Account. As managers of HMIS, you must keep your income always greater than your expenditure. Your HMIS must seek to produce a surplus (refers to the positive result of the HMIS and not refer to it as a profit). A surplus is sought not to make a profit but to reinforce the financial solidity of your HMIS by enabling financial reserves to build up.

The SIE is the summary of the expenditure and income of your HMIS during a given period called the 'financial year' (generally one year). It compares the expenditure and income of your HMIS and allows you to calculate the result for the year.

### a.2 What information does the Statement of Income and Expenditure contain?

The SIE is presented in a summary table with two columns:

- the left-hand column presents the expenditure, and
- the right-hand column presents income

In each column the expenditure and income are categorized according to a standardized classification.

The accounting principle of balance between the two parts of an account (the Statement of Income and Expenditure in this case) involves a comparison between total expenditure and total income. The difference is recorded in either of the two columns of the table in order to obtain the same total for both columns. This difference corresponds to the result for the financial year. It is called a deficit when total expenditure exceeds total income and a surplus, if the inverse is true. Take note of the different information that are recorded or derived from your SIE:

- (1) Expenditure: It refers to the consumption of goods and services necessary to implement the activities of your HMIS during a given period. The expenditure affects the result of the HMIS negatively. For the HMIS, these involve, among other things: the reimbursement of care expenditure, operating costs (wages, premises, bank charges), training costs and depreciation allowances.
- (2) Income: It is composed of financial resources generated by the activities of your HMIS in a given period. Income affects the results of your HMIS positively. Sources of income for your HMIS may include: membership fees, contributions, operating subsidies, financial incomes (interest) and other incomes following promotional activities and other income-generating benefits or services. The costs paid by your members to

replace passbooks and penalties for arrears are also to be recorded as sundry incomes.

- (3) Operating Subsidy: This is a subsidy that allows your HMIS to meet certain expenditure such as operations, benefit or training costs.
- (4) Capital Subsidies: These allow your HMIS to acquire investments in the form of tangible fixed assets(e.g. building, furniture, land or vehicles.
- (5) Depreciation Allowance: This is an example of a charge which is not an expense. The durable property of your HMIS for example like buildings, office furniture or equipment deteriorate over the years and suffer wear and tear that will require them to be replaced at a given time. This depreciation, is a loss that your HMIS must write off, should be recorded.
- (6) Depreciation: It is an accounting operation that consists of recording the depreciation suffered by various fixed assets. This depreciation may be caused by daily use or technical progress. Depreciation is calculated on the basis of the historical cost of the assets and their estimated working life. The method proposed, straight-line depreciation, is established as follows:

$$\frac{\text{historical cost}}{\text{working life (in years)}} = \text{annual amount of depreciation charge}$$

Example:

The HMIS purchased an office equipment for Php 500,000 on 1/1/2000. In accordance with the laws in force, it decides to write it off over a period of five years. The amount of annual depreciation is computed at :

$$\frac{\text{Php 500,000}}{5 \text{ years}} = 100,000$$

At the end of the 5th year, the HMIS will have written off Php 500,000.

The most common straight-line rates of depreciation are: buildings: 5 to 10%; furniture, office equipment and movable equipment:20-33%.



**Table 4.4: Principal Information on the HMIS's Statement of Income and Expenditure**

STATEMENT OF INCOME AND EXPENDITURE			
Period:			
EXPENDITURE		INCOME	
<ul style="list-style-type: none"> <li>• Benefits               <ul style="list-style-type: none"> <li>- deliveries</li> <li>- outpatient care</li> <li>- transports</li> <li>- hospitalizations</li> <li>- others</li> </ul> </li> <li>• Operating costs               <ul style="list-style-type: none"> <li>- leasing</li> <li>- transport</li> <li>- water and electricity</li> <li>- telephone</li> </ul> </li> <li>• Training costs</li> <li>• Provisions for depreciation</li> <li>• Financial expenditure</li> <li>* Other expenditure</li> </ul>		<ul style="list-style-type: none"> <li>• Membership fees</li> <li>• Contributions</li> <li>• Operating subsidies</li> <li>• Financial income (interest)</li> <li>• Other income               <ul style="list-style-type: none"> <li>- Promotional activities</li> <li>- Benefits</li> <li>- Other services</li> </ul> </li> </ul>	
<b>Result (surplus)</b>		<b>Result (deficit)</b>	
<b>TOTAL</b>		<b>TOTAL</b>	

### a.3 How is the Statement of Income and Expenditure used?

The SIE makes it possible for you to calculate the result and gives you a preliminary indication of the financial health of your HMIS. You must accompany this calculation though with other tools, particularly the Balance Sheet, the financial indicators and ratios that will make it possible to interpret this result. It is important to measure, for example, whether a surplus is too high or too low, or to identify the origin of a deficit.

Having sex-disaggregated income and expenditure data may also initially suggest patterns or trends that need to be addressed by management or by the organization as a whole.

**a.4 Example of a Statement of Income and Expenditure:** Please refer to Annex 4.9 for the actual sample of an HMIS' Statement of Income and Expenditure.

## Document 4.4.3.b: The Balance Sheet

### b.1 What is a Balance Sheet for?

The Balance Sheet is a summary table that presents the assets of your HMIS on a given date. The preparation of the Balance Sheet at the end of each financial year is just like producing a precise inventory or photograph of your HMIS resources for the whole year. The Balance Sheet summarizes these resources (reserves, loans or care providers' payment times) and their use, reflected in the acquisition of materials, stocks or the granting of extensions in the time for members to pay their contributions.

## b.2 What information does the Balance Sheet contain?

The Balance Sheet is presented in the form of a two-column table representing the assets and liabilities of your HMIS.

- (1) Assets: These represent how your HMIS resources are employed, namely, where its wealth is situated. They are broken down into two major headings:
  - fixed assets: the permanent assets which form the working tools (premises, equipment, vehicles, financial deposit with care provider, etc);
  - current assets: assets connected to current activities which are rapidly transformed or renewed several times during the year (stocks, bank accounts, financial debts, etc).
- (2) Liabilities: These correspond to the source of your assets, which consist of the resources that have been made available to your HMIS. They include:
  - equity capital: the resources that belong to your HMIS, such as reserves (established in particular by surpluses achieved at the end of previous financial years) or investment subsidies and other capital contributed by third parties (NGOs, government, etc);
  - outside capital or debts: everything your HMIS owes to other structures, such as care providers' invoices payable, loans obtained or other

Since the Balance Sheet provides information on increases or decreases in wealth during the financial year, the result of the financial year, calculated through the SIE, is also recorded in your HMIS annual Balance Sheet. If there is a positive result (surplus), this leads to an increase in the HMIS assets. A negative result (deficit) on the other hand leads to a decrease in these assets.

Since your HMIS is a non-profit-making organization, the surplus or deficit may result in an increase or reduction in your reserves respectively. You may also use part of your surplus to carry out actions in favour of your members.

The assets and liabilities clearly distinguish the expenditure and income that appear in the Statement of Income and Expenditure. For example, if your HMIS purchases or builds premises for its activities, these form part of your assets (the purchase or construction cost appears in the Assets Column of the Balance Sheet). On the other hand, current maintenance electricity costs relating to the use of the premises for example are expenditures that appear in the Statement of Income and Expenditure. The income earned from leasing the premises to third parties would constitute income.

**Table 4.5 : Principal Information of the Balance Sheet**

HMIS BALANCE SHEET			
ASSETS Use of Resources		LIABILITIES and EQUITY Origin of Resources	
Current Assets		Outside Capital	
- Cash on hand		- Invoices payable to providers	
- Cash in Bank		- Other short-term debts	
- Stocks (medicines or membership records)		- Long-term Debts	
- Contributions Receivable			
Deferred Expenditure Fixed Assets		Equity Capital	
- Office equipment		- Reserves	
- Vehicles		- Donations, legacies	
- Building		- Capital subsidies	
- Land		- Result of financial year (Surplus)	
TOTAL ASSETS		TOTAL LIABILITIES	

### b.3 How is the Balance Sheet used?

Your total assets should always be equal to your total liabilities. This equality arises from the fact that the Balance Sheet presents the source and application of funds: your HMIS (like a company) cannot use either more or less funds than it possesses. The Balance Sheet also provides a preliminary interpretation of the financial situation of your HMIS, indicating the use it has made of its assets. Like the Statement of Income and Expenditure, the Balance Sheet is a rough representation that must be interpreted to assess the performance of your HMIS.

**Table 4.6: Production of Financial Statements– Closure of the Financial Year**

Health Micro-Insurance Scheme Internal Organisation				External Partners	
General Meeting	Executive Body	Board of Directors	Auditing Body	Providers	Savings Bank
	(1) Close accounts ↓				
	(2) Prepare Statement of Income and Expenditure and Balance Sheet →				
		(3) Convene General Assembly ←			
(4) Present Activity Report and Financial Report for approval →			(5) Control accounts and regularity of financial transactions		

---

At the time of closing the financial year, your HMIS must close the accounts and draw up the SIE and Balance Sheet. The Executive Body then submits these documents to the Board of Directors. If the EB accepts them, they present these to the GA with the activity report. The Auditing Body ensures that the accounts are reliable and that the financial transactions have been carried out correctly.

**b.4 Example of a Balance Sheet:** Please refer to Annex 4.10 for the actual sample of an HMIS Balance Sheet.

[illegible]

## Annex 4.2: An Example of HMIS Budget

- (1) You are given here a description of what usually transpire in financial planning for a given financial period in order for you to visualize how an annual Budget is prepared. The following describes the conditions considered in the preparation of the HMIS Budget for the Year 2003 in a selected HMIS.

For Expenditure: The HMIS forecasts the following benefits for 2003.

Female: 20 deliveries at an average cost of Php 4,000.

Female and Male

- 190 services of outpatient care at an average cost of 2000
- 10 transports at an average cost of Php 3,000
- 20 hospitalizations at an average cost of Php 5,000.

(2) The HMIS also estimates the following operating costs:

- 12 months' rent at a monthly cost of Php 10,000
- transport at an estimated cost of Php 24,000
- water and electricity for a sum of Php 42,000 estimate based on 2002 expenditure)
- Php. 24,000 for telephone costs

(3) The HMIS training costs are estimated at Php 50,000. broken down as for Male: Php 20,000. Female: Php 30,000.

(4) The HMIS estimates unforeseen costs - a safety margin corresponding to 10% of the amount of expected contributions (Php 750,000).

For Revenue: As far as revenue is concerned, the HMIS forecasts 50 new members (Female:30; Male:20) (Php 1,000 per member). It estimates that members will pay Php 200 in(including themselves). A donation of Php 125,000 has been promised by the municipal council.

(2) The table below shows how the conditions above are reflected in the HMIS Budget for Year 2003.

-----Health Micro-Insurance Scheme Budget, 2003					
Expenditure	Amount (in Php)			Revenue	Amount (in Php.)
	M	F	Total		
• Benefits			<u>590 000</u>	• Members	
– deliveries		/	80 000	hip fees	<u>50 000</u>
– outpatient care	/	/	380 000	–Male	–20,000
– transports	/	/	30 000	–	–30,000
– hospitali-	/	/	100 000	Female	<u>750 000</u>
organizations			<u>210 000</u>	• Contribut	
				ions	<u>125 000</u>
• Operating Costs				• Subsidies	
– leasing			120 000	/donatio	0
– transport			24 000	ns	
– water and electricity			42 000	• Interest/i	0
– telephone			24 000	nvestmen	0
	20,000	30,000	<u>50 000</u>	ts	
• Training costs			<u>75 000</u>	• Loans	
Unforeseen costs				• Additiona	
(safety margin)				l resources	
<b>Total:</b>			925 000		925 000
Legend: M – Male F – Female; M/F – Male and Female, on a need basis					



### Annex 4.3: An Example of HMIS Cash Flow Forecast

- (1) You are given here a description of what usually transpire in a financial planning for a given financial period in order for you to visualize how cash flow forecast is prepared. The following are the conditions considered in making a Cash Flow Forecast for the first quarter of 2003 in a selected HMIS.

Cash Flow Forecast	
The expenditure for the first three months of the year 2002 is estimated.	
(1) Available cash flow (cash in hand) carried forward from the preceding month (Dec, 2001) is Php 384,300 (money at the bank is not directly available).	
(2) The benefits forecast cost Php 50,000 per month on average (Php 590,000 out of the annual budget).	
(3) The HMIS estimates the following operating costs:	
- rent at a monthly cost of Php 10,000	
- transport cost estimated at Php 2,000 per month	
- water and electricity for a sum of Php 3,500 per month	
- Php 2,000 per month for telephone costs	
(4) HMIS forecasts training in February to cost Php 16,000.	
As far as revenue is concerned, the HMIS estimates 6 new members per month (Php1,000 per membership) and 312 people who will actually contribute Php 200 per month. Part of a donation amounting to Php. 100,000 has been promised for February by the local council.	

- (2) The above examples are recorded in the following Cash Flow Forecast.

HEALTH MICRO-INSURANCE SCHEME Cash Flow Forecast for the First Quarter 2003				
DESCRIPTION	January (in Php)		February (in Php)	
	Male	Fmale	Male	Fmale
<b>A. Inflows</b>				
Carry forward from previous month	384 300		385 200	470 100
Membership fees	6 000		6 000	6 000
Contributions	62 400		62 400	62 400
Donations	0		100 000	0
Withdrawal of investments	0		0	0
Loan	0		0	0
<b>Total A</b>	<b>452 700</b>		<b>553 600</b>	<b>538 500</b>
<b>B. Outflows</b>				
Health benefits				
Operating costs	50 000		50 000	50 000
- leasing				
- transport	10 000		10 000	10 000
- water and electricity	2 000		2 000	2 000
- telephone	3 500		3 500	3 500
Training	2 000		2 000	2 000
Investments	0		16 000	0
Repayment of loans	0		0	0
<b>Total B</b>	<b>0</b>		<b>0</b>	<b>0</b>
<b>Balance A-B</b>	<b>67 500</b>		<b>83 500</b>	<b>67 500</b>
	<b>385 200</b>		<b>470 100</b>	<b>471 000</b>

## Annex 4.4: An Example of HMIS Cash Journal

(1) To give you an idea how the Cash Journal is accomplished and used based on the steps outlined in Section 4.3.3, you are provided here with examples of transactions that were carried out in a sample HMIS. Based on this exercise, you may try applying this to your own transactions.

### Cash Transactions

During the Month of March, 2003

- On 3/2/03: HMIS carries forward the balance in the amount of Php 340,000 at end of February
- On 3/5/03: HMIS receives contributions totalling to Php 52,000 with reference No 34
- On 3/9/03: HMIS makes payment of benefits in the amount of Php. 92,000 from cash in hand to the health centre with reference Invoice No: 22-03-CSK)
- On 3/10/03: HMIS buys consumables amounting to Php 10,000 with supporting document No. 444)
- On 3/22/03: HMIS pays Php 100,000 from cash in the HMIS Bank Account (with ref. 02-340-12)
- On 3/29/03: HMIS receives total contributions in the amount of Php 22,000, with reference No 35

The HMIS closes the cash book at the end of the month, and calculates and records the final balance after the last transaction of the month. HMIS checks if this final balance is accurate. This check is done as follows:

Start of month balance	:	Php. 340,000
+ total inflows in month	:	Php 74,000
- total outflows in month	:	Php. 202,000
= new balance for month	:	Php 212,000

Note that the amount identified at the end of this check, Php. 212,000, is equal to the balance calculated after the last transaction at the end of the last day of March, 2003. This check may be accompanied by a physical check/verification of the cash available in your HMIS cash on-hand.

(2) The following illustrates how the above transactions are to be recorded in the Cash Journal.

### Month: March 2003 Cash Journal

Date	Record N°	Subject	Inflows (in Php.)	Outflows (in Php.)	Balance (in Php)
2/3/03	Carry fwd	Carry forward February balance			340 000
5/3/03	34	Contributions	52,000		392 000
9/3/03	22-03-CSK	February benefits to health center		92 000	300 000
10/3/03	444	Purchase of consumables		10 000	290 000
22/3/03	02-340-12	Deposit to the bank		100 000	190 000
29/3/03	35	Contributions	22,000		212 000
3/31/03		Totals	74 000	202 000	
3/31/03	Balance	Balance to carry forward			212 000

## Annex 4.5 : An Example of HMIS Cash-in-Bank Journal

- (1) To give you an idea how the Cash-in-Bank Journal is accomplished and used based on the steps outlined earlier, you are provided with examples of transactions that were carried out in a sample HMIS. Based on this exercise, you may try applying this to your own transactions.

### Bank Transactions During the Month of March, 2003

The manager carries forward the sum of Php. 1,400,000 for February 2003 to March 2003.

- (1) On 3/9/03: HMIS pays the invoice to the health center for benefits in the amount of Php 400,000, with reference 815-02
- (2) On 3/20/03: HMIS records a deposit of Php 100,000 from cash on hand to the bank account;
- (3) On 4/29/03: HMIS pays by cheque for a table and chairs for a sum of Php 80,000.
- (4) HMIS closes the Cash-in-Bank Journal at the end of a month and calculates and records the last balance after the last transaction of the month. He then checks that this last balance is accurate. This check is carried out as follows:

Start of month balance	:	Php 1,400,000
+ total 'inflows' of the month	:	Php 100,000
- total 'outflows' of the month	:	Php 480,000
= new end of month balance	:	Php 1,020,000

The amount identified after this check, Php. 1,020,000, is equal to the balance calculated after the last transaction in March 2003. This cheque should be accompanied by a verification on the money available at the bank.

- (2) The above examples are recorded into the sample of Cash-in-Bank Journal below.

### Cash-in-Bank Journal Month: March 2003

Date	Record N°	Subject	Inflows (in Php)	Outflows (in Php.)	Balance (in Php)
3/1/03	Carry fwd.	Carry forward previous page			1,400,000.
3/9/03	815-02	Bank withdrawal to pay health center invoice		400,000.	1,000,000.
3/20/03	921-02	Deposit of money from cash on hand	100,000.		1,100,000.
3/29/03	825-432-02	Cheque for payment of table and chairs		80,000.	1,020,000.
		Totals	100,000.	480,000.	
3/30/03	Balance	March balance to carry forward			1,020,000.

## Annex 4.6: An Example of a Cash Receipt Book

(1) The following is an example of a Cash Receipt Book used by the \_\_\_\_\_ HMIS in \_\_\_\_\_

Date	Particulars	Reference Document	Cash-on-Hand	Cash-in-Bank	Membership Fee	Premiums	Grants
Cash received in January 2003			1,930.00		525.00	1,405.00	
Feb 2003							
Feb 2	Luz Endencio – 3 months (March-May)	OR No. 23	100.00		25.00	75.00	
Feb 04	Mario Endencio- 3 months (March-May)	OR No. 24	100.00		25.00	75.00	
Feb 06	Elias Tagulalap 3 months (March-May)	OR No. 25	100.00		25.00	75.00	
Feb 16	Ofelia Alfaras – 3 months (March-May)	OR No. 26	100.00		25.00	75.00	
Feb 18	Elisa Meterio – 3 months (March-May)	OR No. 27	100.00		25.00	75.00	
	Rudelyn Elanzar- 3 months (Mar-May)	OR No. 28	100.00		25.00	75.00	
	Donato Pordilla- 3months (March-May)	OR No. 29	100.00		25.00	75.00	
Feb 19	Belen Estelloro 2 months (March-Apr)	OR No. 30	50.00			50.00	
Total Cash received for February			750.00		175.00	575.00	

(2) The following table is a example of a Cash Receipt Book used and maintained by ORT-OHPS in San Fernando, La Union for January-March, 2003

Month/Received From	Ref Doc (OR #)	Cash-on-Hand	Cash-in-Bank	Loan Payable	1 <sup>st</sup> 6 Mos Finl Asst	Cash Advance	IEC	Donation	Cash on Hand (Debit)	Cash-in-Bank (Credit)
January, 2003										
ORT-Initial Deposit	106951	5,000.		5,000.					631,900	631,900.
ORT 6-months budget	106952	626,900.			626,900.					
Total		631,900.		5,000.	626,900.					
February, 2003										
Brigette Castillo	106953	450.				450.				
Eva Palaruan	106954	500.				500.				
Total		950.				950.				
March, 2003										
Salino Abuan	106955	500.				500.				
Zenaida Baroro	106955	500.				500.				
Christina Evangelista	106956	500.				500.				
Eva Palaruan	106957	500.					500.			
Myrna Ducusin	106958	90.				90.				
Total		2,090				1,590.	500.		2,090.	2,090.

## Annex 4.7: An Example of a Cash Disbursement Book

(1) The following is an example of a Cash Disbursement Book used by the \_\_\_\_\_ HMIS in \_\_\_\_\_

Date	Particulars	Ref Doc	Cash-on-hand	Cash-in-Bank	Transpo	Supply	Meals/snacks	Registration	Equipt
Total Cash disbursed in January, 2003			1475.00		475.00	350.00	395.00	255.00	
Feb2003									
Feb 10	3 members of SHI payee to GHIP	CV 03	255.00					255.00	
Feb 14	Assessment of PhilHealth	CV 04	558.00				558.00		
Feb 16	Attend cluster assessment conference	CV 05	300.00		300.00				
Feb 18	Purchase 1 unit computer	CV 06	1,150.00		150.00				1,000.00
Total for February			2,263.00		450.00		558.00	255.00	1,000.00

(2) The following table is a example of a Cash Disbursement Book used and maintained by ORT-OHPS in San Fernando, La Union for January-March, 2003

Date	Particulars	Ref Doc (Petty Cash Voucher)	Check Number	Cash-in-Bank	Presentation	Cap Bld/Trng	Office Supply	Service Delivery	Personnel Cost
March 25	Ruben Agsanlie-ACDZ	5451	080951	31,345.00	31,345.				
	La Union Morning Star	5452	080952	5,492.25		1,580.	1,316.25	2,596.	
March 26	La Union Morning Star	5453	080953	737.00				737.	
March 31	ORT-Cris, Flo and Mavic	5454	080954	20,500.					20,500.
	Ma. Cristina Evangelista	5455	080955	5,000.					5,000.
Total for the Month of March				63,074.25	31,345.	1,580.	1,316.25	3,333.	25,500.

## Annex 4.8: Petty Cash Form

-----HMIS

### Petty Cash Form

Date	Particulars	Ref. Doc	Amount	Balance
<b>Beginning Amount</b>				<b>2,000.</b>
March 3	Jeepney fare for monitors	Petty Cash Voucher 44	25.00	
	Snacks for visitors	OR No. 003	175.00	
	Pens/papers	OR No. 345	55.00	
Subtotal			255.00	<b>1,745.</b>
March 4				
March 15	Printing/xerox	OR No. 546	65.00	
	gasoline	OR No. 467	250.00	
Subtotal			315.00	<b>1,430.</b>
March 16	Snacks/food for meeting	OR No. 435	345.00	
	Cell card	PCV No. 45	150.00	
Subtotal			495.00	<b>935.</b>
March 19	Payment for carpentry repair	PCV No. 46	220.00	
Subtotal				<b>715.</b>
March 22	Reproduction of flyers	OR. No. 509	350.00	
	transportation	PCV No. 47	135.00	
Subtotal			435.00	<b>280.</b>
<b>March 28</b>	<b>Petty cash replenishment</b>		<b>+ 1,720</b>	<b>2,000.</b>
March 29	supplies	OR No. 567	67.00	<b>1,933.</b>

## Annex 4.9: An Example of a General Ledger

(1) The following is a more comprehensive example of a General Ledger usually used by advanced and larger-sized HMIS.

(2) A simple General Ledger is shown in the following table. This is a portion of the General Ledger being maintained by the ORT-OHPS in San Fernando, La Union.

Date	Subject/ Particulars	Balance Sheet – Assets									Balance Sheet - Liabilities			Statement of Income and Expenditure						
		Bank			Cash in hand			Sundry assets			Sundry liabilities (reserves or ST, MT and LT debts)			Income			Expenditure			
		Inflow	Outflow	Balance	Inflow	Outflow	Balance	Inflow	Outflow	Balance	Inflow	Outflow	Balance	New mem bers M F	Subs cript s. M F	Others	Ben efits M F	Functioning	Others	

### 2.2 Cash on Hand

## 2.2 Cash-in-Bank

Date		Ref. Page	Debit	Date	Ref. Page	Credit
March		Page 1	631,900.	March	Page 1	631,900.
April		Page 1	950.	April	Page 1	0.
May		Page 1	2,090.	May	Page 1	2,090.
June		Page 1	61,500.	June	Page 1	61,500.
	balance		950.			
July		Page 1	260.	July		0.
August		Page 1	15,000.	August	Page 1	15,000.
September		Page 1	321,645.	September	Page 1	321,645.
	balance		1,210.			

## 2.3 Recording Specific Transactions by Category / Classification in the General Ledger

### 2.3.1 Financial Assistance from the Cash Receipt Book

Date		Ref. Page	Debit	Date		Ref. Page	Credit
				Sept, 2003		Page 1	626,900.
						Page 1	285,300.

### 2.3.2 Reservations from the Cash Disbursement Book

Date		Ref. Page	Debit	Date		Ref. Page	Credit
March		Page 1	31,345.00				



## Annex 4. 10: An Example of HMIS Statement of Income and Expenditure

You are given below a description of a situation of a sample HMIS which you can base your calculation of the expenditure and income. This is a situation at the end of a given year 2001.

### A Situation in a Selected HMIS By End of 2001

- The following benefits were offered in 2001:
  - 21 deliveries at a total cost of Php. 81,000
  - 250 benefits of outpatient care at a total cost of Php 381,500; (Male: 200,000 Female: 181,500.
  - 13 transports at a total cost of Php 31,000
  - 16 hospitalisations at a total cost of Php. 102,000
- The HMIS incurred the following expenditure in order for it to function:
  - 12 months' rent at a monthly cost of Php. 10,000;
  - transport costs amounting to a total of Php. 20,000;
  - water and electricity amounting to Php. 35,500;
  - Php. 14,000 in telephone costs;
- expenditure relating to training activities amounted to Php 66,000; (Male: 26,000 Female: 40,000.)
- the HMIS depreciated its office equipment at a historical cost of Php 500,000 over five years (see example above). The equipment was purchased on 1/1/2000;
- other expenditure (bank charges) amounting to Php15,000 were paid by the mutual health insurance scheme
- the HMIS also received Php 27,000 for the sale of membership records representing membership fees; (Male: 15,000 Female: 12,000)
- the HMIS members paid contributions amounting to Php 735,200; (Male: 390,000 Female: 345,200)
- the HMIS benefits from an operating subsidy
- supplementary income of Php 30,000 (following promotional activity) were recorded.

The above transactions are translated into the following Statement of Income and Expenditure.

-----HEALTH MICRO INSURANCE SCHEME STATEMENT OF INCOME AND EXPENDITURE					
Period: 31/12/2002 - 31/12/2003					
EXPENDITURE (in Php.)				INCOME (in Php.)	
	M	F	Total		
• Benefits			595 500	• Membership fees	27 000
- deliveries		/	81 000	- Male	15,000
- outpatient care	200,000	181,500	381 500	- Female	12,000
- transports	/	/	31 000		
- hospital sations	/	/	102 000	• Contributions	735 200
				- male	390,000
				- female	345,200
• Operating costs	/	/	189 500		
- leasing			120 000	• Operating subsidies	240 000
- transport			20 000		
- water and electricity			35 500	• Other income: promotional activities	30 000
- telephone			14 000		
• Training costs	26,000	40,000	66 000		
• Provisions for depreciation of office equipment	/	/	100 000		
• Other expenditure	/	/	15 000		
<b>Result (surplus)</b>			66 200		
<b>TOTAL</b>			1 032 200	<b>TOTAL</b>	1 032 200

## Annex 4.11: An Example of HMIS Balance Sheet

Below is a given sample of a situation in a selected HMIS to help you figure out how to accomplish and prepare the Balance Sheet.

### Example Situation in a Selected HMIS

as of 12/31/2002

- the inventory shows that the HMIS has office equipment for a net book value (after depreciation) of Php 200,000:

Depreciation Schedule:

Date	Historical Cost (Php)	Rate	Annual Charge (Php)	Net Book Value (Php)
12/31/00	500 000	20%	100 000	400 000
12/31/01	500 000	20%	100 000	300 000
12/31/02	500 000	20%	100 000	200 000

- the bank book and cash book indicate a balance of Php 468,500 and Php 250,500 respectively
- five members still owe a total of Php. 4,200 to the HMIS for contributions payable
- the HMIS has reserves of Php 668,500 and capital subsidies for a value of Php 200,000;
- the statement of income and expenditure shows a surplus of Php. 66,200;
- the HMIS must pay supplementary invoices to care providers amounting to Php 65,000 and to suppliers amounting to Php 123,500.
- the HMIS made a deposit of Php 200,000. to the health center

The above transactions are translated or recorded into the following Balance Sheet.

<p style="text-align: center;">----- Health Micro-Insurance Scheme BALANCE SHEET as of 12/31/2003</p>			
ASSETS (in Php.)		LIABILITIES (in Php.)	
Fixed Assets		Equity Capital	
- Office equipment	200 000	- Reserves	668 500
- Health Center deposit	200 000	- Capital subsidies	200 000
		- Result of financial year	66 200
Current Assets			65 000
- Cash in hand	250 500	Outside Capital	123 500
- Bank	468 500	- Invoices payable to providers	
- Contributions owing	4 200	- Suppliers to be paid	
<b>TOTAL ASSETS:</b>	<b>1 123 200</b>	<b>TOTAL LIABILITIES:</b>	<b>1 123 200</b>





Reference Guide and Tools on Health  
Micro-Insurance Schemes in the Philippines

# Monitoring and Evaluation of a Health Micro-Insurance Scheme



STRATEGIES & TOOLS  
AGAINST SOCIAL EXCLUSION  
& POVERTY



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



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### Table:

<u>Number</u>	<u>Title</u>
Table 5.1	Aspects of HMIS to be Monitored and Evaluated With the Corresponding Methodologies and Tools

### **Box:**

<u>Number</u>	<u>Title</u>
Box 5.1	Monitoring, Evaluation of the Feasibility Study and Calculation of Contributions/ Benefits

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<u>Number</u>	<u>Title</u>
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## **Purpose**

Chapter 5 aims to provide you with the set of guidelines and tools in monitoring and evaluating the operations and performance of your HMIS. It encourages you to establish a monitoring and evaluation system by emphasizing its importance to the success of your HMIS and the value of indicators being measured. It also helps you understand the major aspects of your HMIS that must be given priority for monitoring and evaluation. It is hoped that after reading this Chapter, your understanding will be enhanced particularly on the critical indicators to be monitored and evaluated. More importantly, it is hoped that you will be able to modify and apply the guide in monitoring and evaluating your own HMIS.

## **Content**

This Chapter begins with the differentiation between monitoring and evaluation. It then introduces you to the three aspects of your HMIS operations that need to be monitored and evaluated including the indicators to be measured and the tools to be used. These include basically the monthly monitoring record, the management chart and the financial ratios chart. At the end of this chapter, you are also provided with different guides on how you can assess the quality of health services that are being provided by your service providers to your members.

## **Sections**

Section 5.1:	Importance and Scope of HMIS Monitoring and Evaluation
Section 5.2:	Monitoring and Evaluation of HMIS Operations
Section 5.3:	Assessing Quality of Health Care



# Section 5.1 Importance and Scope of HMIS

## Monitoring and Evaluation

### 5.1.1 Relevance of Monitoring and Evaluation to Your HMIS

In the previous chapter, you were presented with the methods and tools for recording, classifying and processing activities and resources of your HMIS. These tools make it possible for you to adapt and ensure the operation of your HMIS, but not to analyze whether it is functioning well or badly. It is necessary that you install in your HMIS a set of rules, techniques and tools that would allow you to monitor and evaluate your HMIS planned performance, its management, the results and conformity of its actions with your set of objectives.

Monitoring and Evaluation is an essential management tool that helps you keep track of the progress in achieving your goals and to validate if you are in the right direction. Since monitoring and evaluation is to be undertaken regularly and continuously, It enables you to act on issues and problems right away before they become worse or unsolvable. Monitoring and evaluation generates information as your basis for policy formulation and in making critical decisions. Definitely, it will tell you ahead of time if your HMIS is financially viable or in financial crisis. As a result, monitoring aims to make the operations of your HMIS more efficient and more effective. It enables you to make sound decision and apply more responsive measures which have been tried and tested (evidence-based). It also fosters transparency among your members and partners. If results of monitoring and evaluation are used appropriately, it is expected that the insurance risks mentioned in Chapter 1 will be minimized and that the quality of health care will be greatly improved.

The following box explains to you the importance of monitoring and evaluating certain variables during the initial phase of operation of your HMIS so that you can make the necessary adjustments in your services or contributions of your members.

#### **Box 5.1: Monitoring, Evaluation of the Situational Analysis And Calculation of Contributions/Benefits**

Monitoring and evaluation allows your HMIS to recalculate and possibly modify information you obtained during the situational analysis stage, particularly with regards to the relationship between contributions and benefits.

To gain a better understanding of the importance of managing the operations of your HMIS, you need to study the different stages which your HMIS goes through before becoming fully operational - meaning your HMIS' performance has reached stability with the contributions well adjusted to your members' revenue, the services meeting their needs, in sound financial health, and a large number of members. In brief, these stages are:

1. **During** a situational analysis, you have to evaluate an initial situation on the basis of little and often no very accurate information. You draw up a HMIS formula that proposes benefits and estimates the amounts of contributions necessary.
2. **During** its first 6 months of operations, your HMIS should verify the accuracy of the initial estimates you made and evaluate their impact on your members' demand for care, their behavior in terms of use of care or benefits, and that of providers. Note that your HMIS may in fact modify the habits of your members, who will take advantage of care more often than before and you may also change the prescription habits of providers who are initially faced with a lot of demands.
3. **On** the basis of these observations, you should gradually refine the benefits of your HMIS and the contributions of your members. Then, you can improve the functioning of your HMIS after being confronted with actual situations you did not initially anticipate.

### 5.1.2 Monitoring and Evaluation As A Management Tool

Before presenting the scope of monitoring and evaluation your HMIS needs to undertake, it is important that you will have a clear understanding of the definition and application of the monitoring and evaluation system.

Monitoring is a continuous activity that consists of ensuring your HMIS program to develop and progress according to what you originally planned and designed. It is based on a set of indicators which allow you to decide and take actions on to ensure that your HMIS is operating in the most effective and efficient way.

Evaluation is a periodic assessment (every one or two years) of your HMIS regarding its social, economic and financial performance level. It aims to check whether your HMIS is achieving the objectives you have established and identify the reasons for the differences observed. Evaluation involves the following mechanisms:

- **External Evaluation:** This is an evaluation of your HMIS in relation to its performance and environment. This involves in particular measuring whether there are differences in terms of risk perception, accessibility to care and utilization among members and non-members. The impact on the supply of care is also studied in terms of use and funding. At certain times, external evaluation requires more substantial resources than in monitoring. Hence, it entails the conduct of surveys and usually requires the intervention of an external resource (e.g. local NGOs, cooperation agencies, consultancies, etc).
- **Self-Evaluation:** This evaluation makes use of a participative technique allowing all your HMIS members to participate in measuring the accomplishment of your HMIS against its set objectives, and assess the soundness of the actions undertaken vis-à-vis the planned activities. It totally involves the beneficiaries in the processes of analysis and decision-making. It is a favoured instrument for coordination and training. Self-evaluation can be done through quarterly, semi-annual or year-end program review. It requires significant preparation on your part. These include the development of coordination tools, evaluation scales and may even require you to seek external technical support and assistance.

### 5.1.3 Aspects of HMIS to be Monitored and Evaluated

There are critical aspects in your HMIS operations that you need to track on a regular basis to ensure that it will run efficiently and effectively. There are also essential factors that you need to assess and evaluate periodically to fully ascertain the efficiency and effectiveness of your HMIS operations.

The monitoring and evaluation indicators vary according to your size as an organization and with the activities and objectives set by your HMIS. The basic principle, however, remains the same for any size or kind of HMIS: monitoring and evaluation must focus on the significant aspects of your operations. You need to study the development of indicators and should compare them with available standards established in your sector.

For monitoring purposes, some aspects of your HMIS operations that would require regular monitoring include among others (a) the organization and operation of your HMIS, (b) the increase in your membership, (c) the amount and regularity of your members' contributions, (d) the financial status of your organization and (e) the implementation status of programs/activities you intended to carry out.

Indicators concerning your HMIS that need to be evaluated cover the following but not limited to: (a) overall performance of your HMIS in terms of membership and the factors affecting their participation and

utilization of benefits, (b) the impact of services on the knowledge, behaviour and practices of your beneficiaries and on the health status of the whole community, (c) the adequacy and appropriateness of key processes and strategies that were employed by your HMIS, (d) the cost-efficiency and cost-effectiveness of interventions that were adopted, (e) the quality of health services being provided by your service providers, and (f) the effects of national policies/local policies and legislations to the overall operations of your HMIS.

These aspects that need to be monitored and evaluated must be translated into specific and measurable indicators. Indicators that are broadly stated are quite difficult to measure and therefore will not be able to generate the needed information for decision making and action planning. In more advanced HMIS, these indicators can be categorized into input, output, outcome and impact including process indicators. These are usually organized into a logical framework which becomes the basis for monitoring and evaluation of your whole organization. If you are interested to know more about this, you have to seek technical assistance from more advanced HMIS or from the national or regional government and NGOs to help you design and apply this to your HMIS.

#### 5.1.4 Monitoring and Evaluation Tools and Schemes

The following summarizes the key aspects of your HMIS to be monitored and evaluated with the recommended tools or methodologies to be applied:

**Table 5.1 Aspects of HMIS to be Monitored and Evaluated  
With the Corresponding Methodologies and Tools**

HMIS Operations/Performance	Tools/Methodology
<b>Monitoring</b>	
• Organization and Functioning (meetings, activities done)	Monthly Monitoring Report (MMR) Management Chart (MC)
• Membership and Benefits	MMR, MC
• Financial Status	Financial Ratios Record (FFR)
• Activities Undertaken	Program Review Based on Action Plan
<b>Evaluation</b>	
• ? Quality of Health Services	Quality Health Care Checklist; Client Feedback Form; Client Satisfaction Questionnaire
• overall performance on membership, contributions and benefits	Program Review; Time/Trend Analysis making use of the MMR, MC and FRR
• impact evaluation of services on the beneficiaries Knowledge. Attitudes Practices and community's health status	Household Survey
• effectiveness and efficiency of interventions	Pre-Post Evaluation; Cost-Efficiency and Cost-Effectiveness Study
• impact of policies on HMIS operations and performance	Policy Review and Assessment
• Capacity of Service Facility and Providers	Facility-Based Survey with Household Survey

### 5.1.5 Locus of Monitoring and Evaluation

It must be understood that monitoring and evaluation is the least aspect in the management of an HMIS that is given the least priority. Considering that most HMIS are only operated by volunteer staff/personnel, limited staff-time or none at all is allocated to take charge of this responsibility.

In the overall organization of your HMIS, the Auditing Body is tasked to monitor compliance to the HMIS By-Laws and Policies, Systems and Procedures. However, it has been observed that their main focus is the tracking only of financial-related matters. In a larger-sized HMIS, a separate Monitoring Committee is established to undertake this task in addition to the Auditing Body. In other cases, monitoring and evaluation is already incorporated in the responsibility of the Auditing Body.

Your HMIS has to decide the set-up for monitoring and evaluation, whether it be joined with the Auditing Body or a separate one. What is important is that this task is clearly lodged to a specific unit, committee or staff.

The monitoring task is rather more an internal affair, so that this can be undertaken by your own staff. The same is true for the internal evaluation, For external evaluation however, specially those that will employ impact studies or household surveys, an external group may be commissioned to undertake them, depending on the available resources of your HMIS.

The MMR and MC as well as the FRR can be accomplished by your Administrative Officer. The administration of the Quality of Health Care schemes can be assigned to 1-2 of your staff or volunteer members of your HMIS. These anyway are to be administered jointly with the service providers. Results of monitoring and evaluation must be reported to the Executive Body up to the level of the Board of Directors. Results should also be shared to the rest of the General Assembly and the partners concerned (e.g. service providers).

## Section 5.2: Monitoring and Evaluating HMIS Operations and Performance

### 5.2.1 Introduction

This section presents the principal activities of your HMIS to be monitored and evaluated regularly. In particular, these activities pertain to: (a) the organization and operation of your HMIS; (b) the membership and benefits; and (c) financial status of your HMIS. In addition, the quality of services being provided by your service providers need to be evaluated. Simplified documents and tools which you can use to monitor and evaluate are also presented, with focus to their uses, the information they measure and guide how they can be used. Templates of these tools are provided for in the annexes.

Once again, it has to be underscored that where appropriate, sex-disaggregation of data is important in order to help you in analysing the patterns and trends.

The monitoring suggested in this section is based on two principal tools: the Monthly Monitoring Record (MMR) and the Management Chart (MC). An evaluation can also be used based on your Management Chart and the Financial Ratios Record.

Aspects of HMIS operations that would require comprehensive or more in-depth evaluation have to be specifically designed and conducted with external help. In this regard, it is advisable that you consult another HMIS which have an advanced experience on this regard or you may seek technical assistance and advice from national or regional government agencies, the donor agencies or NGOs near your area.

### 5.2.2 Monitoring and Evaluation Tools

For each month, the Monitoring Record sums up the principal information. This information is repeated and completed in the Management Chart, which allows you to keep track and assess the progress of your HMIS over a longer period. If your HMIS has the capacity to ensure more advanced monthly monitoring, it may use the Management Chart directly.

The Monthly Monitoring Record and Management Chart have been selected as the tools to be presented in this section because of their simplicity and ability to provide the key information needed. These are designed in particular for HMIS who are not that well-versed yet on accounting and financial management, or in recording cash flow (cash book/bank book), and who are used to a monthly, uniform contribution system.

#### Document 5.2.2.a: Monthly Monitoring Record

In the examples given, you will not only be able to monitor and evaluate the operation and membership/benefits of your HMIS better, but it will also make you understand the information you are collecting and recording in your Statement of Income and Expenditure, the monitoring of your budget through the Monthly Monitoring Records, and the periodic completion of the Management Chart.

##### a.1 What is the Monthly Monitoring Record for?

The Monthly Monitoring Record (MMR) enables you to analyze the basic data of your HMIS on a monthly basis. It provides you with a monthly snapshot of certain representative quantifiable aspects of your operation. It is a basic reference document for monitoring HMIS and allows members of your Board of Directors to obtain the information necessary to ensure better decision-making. It is also a reference point for controlling the management of your HMIS.

##### a.2 What information does the Monthly Monitoring Record contain?

The Monthly Monitoring Record is composed of three categories of indicators which conform to the three major aspects of HMIS operations to be monitored and evaluated. These include

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the organization and operation of your HMIS, the administrative, as well as accounting and financial management of your HMIS. You may have to modify this MMR according to the needs of your HMIS and the stage of development you are in.

a.2.1 Organization and Operation: Key indicators under Organization and operation include the number of meetings held, the activities undertaken and the number of participants who participated in these meetings or activities. The number and type of other activities undertaken like awareness raising, training, etc, are also included. The number of meetings convened by the following structures/ bodies is to be monitored and whether it takes place during the month or period concerned:

- the General Assembly
- the Board of Directors
- the Auditing Body
- the Executive Body
- awareness-raising
- training/teaching activities

## **a.2 .2 Membership and Benefits**

(a) Membership: The second set of indicators to be monitored concern the management of members and their contributions:

- number of members: number of men and women joining
- number of women joining: this number is important for assessing the involvement of women (and therefore also their needs) in the management and decision-making of your HMIS
- number of beneficiaries
- number of beneficiaries in arrears with their contributions
- number of beneficiaries enrolled who have not paid their contributions during the month or period

(b) Monitoring of Benefits: In monitoring benefits, it is necessary to indicate the number of benefits provided by each of the service provider as you agreed upon with them. In the example, this involves outpatient care, deliveries, hospitalizations, transports and others.

Part of the benefit monitoring is to also examine the total number of benefits per provider and the total cost of monthly benefits per provider. In the case of cost-sharing (sharing costs between the HMIS and beneficiaries), the part of the costs met by the HMIS and not by the member alone should be recorded. The number of times the beneficiaries visited the providers may be an indicator of interest including the opinion the beneficiaries have of the providers' services.

Monitoring the benefits availed according to sex can also tell you whether there is a pattern in terms of health problems that can be addressed in a more pro-active way, e.g., health education seminars that seek to prevent certain ailments from happening (for example, in an interior mountain community in Surigao Sur, a significant number of child-bearing women had goiter; the organisation then requested the local health unit to lecture on the causes of goiter, and preventative and curative measures to help curb it.)



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a.2.3 Financial Monitoring: Financial monitoring makes you summarize the total revenue and expenditure during the month.

(a) Revenue: This includes membership fees, contributions, subsidies and other inflows.

(b) Expenditure: This includes benefits, operating costs, training costs and other outflows. Monitoring expenditure enables you to establish your HMIS situation monthly. Comparing the amounts you forecast and the amounts achieved, allows you to monitor your cash flow and budget.

Monitoring revenue and expenditure also helps you examine the cash flow of your HMIS, by comparing the money on hand and at the bank at the beginning and end of the month respectively. Your Board of Directors can also verify whether the difference between revenue and expenditure is equal to the difference in total cash flow.

### a.3 How is the Monthly Monitoring Record used?

You need to complete the MMR in accordance with the required information. Most of the information is found in the following tools which are separately discussed in Chapters 3 and 4.

- organization and operation: minutes, By-Laws and Policies, Systems and Procedures
- management of admissions: Register of Beneficiaries, Register of Contributions, possibly Membership Books (in the event of doubt, the manager may always verify the information with the membership book)
- monitoring of benefits: Invoices, Register of Benefits, Guarantee and Certificate of Care of the Certificate of Entitlement
- financial monitoring: Record of Bank Transactions, Cash Book, supporting documents and Invoices

Your EB should prepare the MMR for the Auditing Body, which checks its content and approves it, if applicable. Your EB then presents the MMR to the Board of Directors. These reports or information are then discussed by the Board of Directors during their regular meetings.

Usually, your Board of Directors should compare the MMR data with the information from previous months. From hereon, the Board of Directors should draw conclusions for management and decision-making.

After the Board of Directors has validated the information, the data in the record will be introduced into the Management Chart. The manager or treasurer files the records.

a.4 Example of a Monthly Monitoring Record : Please refer to Annex 5.1 for the actual sample of an HMIS's Monthly Monitoring Record.

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## Document 5.2.2.b The Management Chart

### b.1 What is the Management Chart for?

The Management Chart (MC) is an important tool for monitoring HMIS activities. It is a powerful way of monitoring the dynamics and development of the principal indicators of your HMIS over a given period. It sums up the information in the MMR over a given period and completes it by utilization rate and average cost of benefits.

The monitoring of these two indicators is particularly important in the context of insurance, since it enables the contributions/ benefits relationship, which constitutes the basis of the operation of your HMIS to be updated. At this level, it also helps to control the demand for care and the practice of care providers and makes it possible to identify possible slippages so as to intervene rapidly.

The MC is a necessary tool for you in administering and managing your HMIS. You need it to evaluate and correct the weaknesses of your HMIS, and to reinforce its strengths, particularly in terms of operation, information and financial management.

### b.2 What does a Management Chart contain?

The MC proposed in this guide covers similar management aspects as the MMR but offers more information to allow activities to be compared over time:

#### b.2.1 Organization and Operation: The indicators include:

\* the number of meetings held and planned by the following bodies and whether these take place in the                      month or period concerned

- the General Assembly
- the Board of Directors
- the Auditing Body
- the Executive Body

\* the number of activities undertaken like:

- awareness-raising
- training/education activities

These indicators allow you to analyze the operations of your HMIS during a given period.

b.2.2 Membership and Benefits: The monitoring indicators of members reflect the vitality of your HMIS as a social movement and its impact on the target population.

(a) Membership: The next information concerns the management of new members and their contributions.

- (i) Number of New Members: number of male and female members of the scheme
- (ii) Number of Beneficiaries: number of members and dependents
- (iii) Number of Women Joining: an important indicator of gender that indicates the participation of women in the scheme
- (iv) Average Number of Beneficiaries per Member: number and sex of beneficiaries/ number of members



Example: Given the data as of May 2002,  
 Number of Members = 132 (Male: 52 Female:80)  
 Number of Beneficiaries = 354 (Male:150 Female: 204);  
 Ave. No. of Beneficiaries = Total No. of Members

- (v) Number of Contributions in Arrears: number and sex of beneficiaries enrolled whose contributions have not been paid
- (vi) Rate of Collection of Contributions: number of contributions received/number of contributions forecast (corresponds to number of beneficiaries) x 100. A rate of collection below 100% requires intervention so as to collect unpaid contributions or to withdraw the entitlements of members who are not up-to-date.

Example: In the same month of May 2002 there are 354 beneficiaries (Male: 104; Female:250), for whom 37 (Male/Female) have not had contributions paid on their behalf. What is the HMIS rate of collection

- No. of Beneficiaries (B) = 354 (M:104;F: 250)  
 - No. of Contributors w/arrears (C) = 37 (M:7; F= 20)  
 - No. members w/completed contributions = (B - C) (M:97; F: 230)

Rate of Collection:

$$= \frac{\text{No of Beneficiaries} - \text{No w/ Contribution in Arrears}}{\text{Number of Beneficiaries}} \times 100$$

$$= \frac{B - C}{354} \times 100 = \frac{(354 - 37)}{354} \times 100 = 89.5\%$$

Conclusion:

89.5% of beneficiaries (% M: 93.2 % F:92.0) are therefore up-to-date in paying their contributions, while 10.5% (% M: 34% F: 8%) are in arrears

- (vii) Rate of Coverage: no. of beneficiaries (Male, Female/target population (Male? Female?) x 100.

This makes it possible to measure interest of men and women in your HMIS, their perception of your HMIS capacity to meet their families' needs, and your HMIS' accessibility and potential growth. This rate generally increases during the first years of implementation. It is particularly worrying when it stagnates at a low level. Having a sex-disaggregated data will help you formulate your social marketing plan towards persuading new members to participate in the HMIS.

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Example: In May 2002 the HMIS has 354 beneficiaries (M: 104; F: 250) out of a target population of 2,500 potential beneficiaries (M: 1000; F: 1,500).

- Number of beneficiaries (B) = 354 M= 104; F = 250
- Number of target population = 2,500 M= 1000 ; F : 1,500

$$\begin{aligned}\text{Rate of Coverage} &= (354/2,500) \times 100 = 14.2\% \\ \text{Male} &= (104/1,000) \times 100 = 10.4\% \\ \text{Female} &= (250/1,500 \times 100) = 16.7\%\end{aligned}$$

#### (b) Monitoring of Benefits

The monitoring of benefits is essentially designed to observe your members' access to care and the conduct of care providers towards the HMIS. This is indicated by:

- (i) Annual Utilization Rate of Benefits Per Beneficiary defined as the number of treatments used by type of care over the total number of beneficiaries (Male/Female) who are actually entitled to benefits)  $\times 100$

In terms of monitoring, it makes it possible for you to measure the difference between the rates expected (and used in calculating contributions) and the rates observed when implementing the system. If the rates observed are largely and/or consistently greater than the rates expected, for different reasons (e.g. underestimation of rates expected, adverse selection, over-consumption, over-prescription), it means that the HMIS risks a financial crisis.

Example: The HMIS has 21 deliveries and an average of 355 beneficiaries in 2002. The average number of beneficiaries in arrears is 49.

The number of beneficiaries up-to-date in their contributions is therefore  $355 - 49 = 306$ .

The annual utilization rate of deliveries per beneficiary is = no. of deliveries/number of beneficiaries up-to-date  
 $= (21/306) \times 100 = 6.9\%$ .

- (ii) Average Cost of Benefits: is defined as Total Amount of Cost of Benefits over Total Number of Benefits

(Note: calculation only feasible if all contributions are the same for all beneficiaries)

This involves the part of costs met solely by the HMIS. In the case of the member's contribution system (sharing of costs between HMIS and beneficiary) with a participation of 50%, for example, the cost invoiced to the HMIS represents half the total cost of a benefit.

A more complete Management Chart includes in particular all the indicators of effectiveness to apply them to each care provider (where an HMIS would cover several headings and/or health centres and/or several hospitals, for example), which allows possible slippages to be identified at the level of one or other of these providers.

Example: The HMIS spent Php 81,000 on 21 deliveries in 2002.

$$\begin{aligned}\text{Average Cost/Delivery} &= \frac{\text{Total Amount of Cost of Delivery}}{\text{Number of Deliveries}} \\ &= \text{Php } 81,000 / 21 = \text{Php } 3,857\end{aligned}$$

- b.2.3 Financial Monitoring: This involves analyzing your annual summary of total expenditure incurred and revenue received during the month. For revenue, this involves the new members' contributions, subsidies and other inflows, while expenditure includes benefits, operating costs, training costs and other expenditures.

This chart helps you to appreciate certain information on the HMIS Statement of Income and Expenditure. In accordance with the Monthly Monitoring Record, this information also examines the cash flow of the scheme, namely the comparison of financial resources on hand and at the bank respectively at the beginning and end of the month. To validate this computation, compare the difference between expenditure over revenue and the difference in cash flow totals. These must be equal.

### b.3 How is the Management Chart used?

To be effective, you should not restrict your Management Chart merely to presenting figures and percentages. You must also allow it to be compared and have its development monitored and presented over time. The Management Chart may also be useful on a multi-year basis to compare annual results, new members, benefits and activities.

On a monthly basis, you need to update the Management Chart after the Monthly Monitoring Records are validated by the Board of Directors and Auditing Body. As shown in Annex 5.2, the example of the Annual Management Chart shows similar information as in your Monthly Monitoring Chart. As shown in the same annex, several indicators may be visualized in the form of curves and graphs. These provide a better understanding of the progress of the principal indicators of the operation of your HMIS, including rates of attendance of your beneficiaries and the average cost of your health services.

### b.4 An Example of a Management Chart : Please refer to Annex 5.2 for the actual sample of an HMIS Management Chart.

## Document 5.2.2.c: Financial Ratios Record

### c.1 What is the Financial Ratios Record for?

The Financial Ratios Record (FRR) includes the indicators that measure the financial health of your HMIS, namely its capacity to meet its obligations to your members and service providers at any time.

The financial monitoring and evaluation indicators are presented in the form of ratios, a ratio being the relationship between two countable numbers. According to the size, activities and objectives of your HMIS, the ratios may be different. In all cases, however, the basic principle is the same: the analysis must focus on a certain number of significant magnitudes, the ratios must be studied both in terms of their development over time, and their comparison with established standards or, if possible, with a set of similar schemes.

### c.2 What does the Financial Ratios Record contain?

The FRR generates a number of indicators as discussed below:

- (a) The Ratio of Contributions/Expenditures: When the ratio is equal to or preferably greater than 1, the contributions are sufficient to cover the expenditure of your HMIS. If not, it may be necessary to raise contributions, unless your HMIS does not benefit from other reliable and constant sources of funding. This ratio may be simplified by calculating the contributions to expenditure ratio.
- (b) The Claims Ratio - (health benefits/contributions): This measures the part of contributions you redistributed to your members in the form of health benefits. When the ratio is low, your members may feel that their contributions are too high in relation to the advantages they get from them. Conversely, if this ratio is too high, your HMIS will have difficulty financing its other expenditures. The optimum ratio is between 75 to 90%, approximately.
- (c) The Operating Cost/Income Ratio: This ratio is the reverse of the previous one since it measures the part of income you devoted to the other expenditures of your HMIS. It should preferably be situated between 5 and 15%. When it significantly exceeds this bracket, you need to rationalize the operations of your HMIS, which are too costly. A simplified ratio may compare operating costs with revenue.
- (d) The Liquidity Ratio (Balance Sheet Assets Available/Short-Term Debts): This ratio measures the capacity of your HMIS to meet its financial commitments immediately. The ratio should always be equal to or greater than 1, which indicates your HMIS capacity to pay its debts towards your care providers or other providers of services immediately.
- (e) The Solvency Ratio (Balance Sheet Assets/Debts): When this ratio is equal to or greater than 1, your HMIS can meet all its obligations towards third parties such as providers or banks with its own resources, without using external assistance or a loan. It indicates its financial autonomy and capacity.
- (f) The Ratio of Coverage of Expenditures (Reserves/Monthly Expenditures): This measures the number of months of normal operations that could be financed by your HMIS reserves. This ratio should be equal to at least 6 (six) months to ensure the stability of your system and to cope with exceptional circumstances such as epidemics. This ratio may be simplified by replacing monthly expenditure by monthly expenses (ratio of coverage of expenditure).

### c.3 How is the Financial Ratios Record used?

The Financial Ratios that form part of the record are generally calculated at the end of the financial year, after you draw up the statement of income and expenditure and balance sheet.

You as the manager or your treasurer must complete the data at the end of the year after drawing up the Statement of Income and Expenditure and Balance Sheet. The first three ratios may be calculated from your Management Chart (they do not concern the balance sheet). They either form part of the evaluation (when the latter is annual) so as to prepare the General Assembly, for example, or the monitoring. They may point to strategic guidelines to ensure that your HMIS is more financially viable.

### c.4 Example of Financial Ratios Record: Please refer to Annex 5.3 for the actual sample of an HMIS Financial Ratios Record.

## Section 5.3: Assessing the Quality of Health Care

### 5.3.1 HMIS and Quality of Health Care

There are several advantages of having an HMIS. First, it helps improve the health of your members. In allowing your members to choose priorities, benefits and contributions, your HMIS helps provide better information and a better analysis of health problems of the community or the coverage area.

The inadequate quality of healthcare, particularly in the public sector, is one of the main problems of health services in the Philippines. The poor quality of services offered by the public health structures is affected by other problems:

- inadequate number of personnel in relation to the volume or demand for services; or this is the low ratio of health service provider to serve the catchment population
- poor organization of the use of staff time: there may only be one nurse available at critical times, for example; some of the health staff are assigned with other tasks as decided upon by the LGUs
- possibility of breaching the privacy necessary for discussing personal issues such as fertility problems or lack of confidentiality
- Inadequate budget, resources and frequent-stock-outs of supplies and medicines
- Inadequacy of measures to prevent the spread of infections in structures

HMIS may help to improve the quality of existing services. By definition, the ultimate goal of your HMIS is to improve your beneficiaries' access to quality health services. They participate in improving the supply of care, particularly by means of their contribution to mobilizing resources, creating immediate demand for care and ensuring the quality of services. They cannot come into being, however, if there is no supply or if quality of service is poor.

As explained in Chapter 1, many HMIS are linked to a care provider by signing an agreement, which in one way or another, requires quality health care. In the absence of quality health care, the HMIS may create its own health facilities. In this case, keeping the management of the two activities separate (insurance and the supply of care) must contribute to greater efficiency. Your HMIS may contact care providers with a view to examining major problems as regards health service quality.

### 5.3.2 Tools in Assessing the Quality of Health Services

Regardless of your HMIS set-up with your service providers, it is important that you monitor and evaluate the quality of services being offered. There are several tools and methods for evaluating the quality of the health services, such as the Quality Assurance Project System of monitoring primary health services, the Client-Oriented, Provider Efficient (COPE), the use of Client Feedback Form or the Client Satisfaction Questionnaire. This chapter offers you a summary of the main components of a quality health service and a Checklist for Quality Health Care. This is based on the COPE approach, a self-evaluation technique adapted to health facilities for a more effective service in response to client needs.

It should be noted that the determination of the medical quality of health services offered is beyond the scope of this Guide.

#### Document 5.3.2.a: Quality of Health Care Checklist

##### a.1 What is the Checklist on Quality Health Care for?

A quality service is a service that meets the needs of beneficiaries. The quality of health care is determined by a range of criteria relating to the satisfaction expressed by a person or a group of

individuals in relation to resolving a health problem. To the extent that the HMIS may be considered to be an association or group of clients together, it is important for you to demand quality health care that meet your members' needs at all times.

Based on the principal rights of clients to quality health care and the duty of care providers to provide quality services, the Checklist on Quality Health Care enables your HMIS and care providers to identify the essential principles of quality care. This is designed to recognize and to exceed the needs and expectations of your members.

The recommended Checklist on Quality of Health Care is based largely on a selection and adaptation of the self-evaluation guides of the COPE method. By involving the HMIS in evaluating the quality of the health care offered, the exercise goes beyond mere self-evaluation. This checklist is an example, however, and should therefore be adjusted according to your own need and situation.

In addition to this checklist, there are other mechanisms that can be easily set up to monitor and evaluate the quality of care provided by your service provider. These include, as mentioned earlier the use of the Client Feedback Form and the Client Satisfaction Questionnaire.

#### a.2 What does the Checklist of Quality Health Care contain?

The COPE guide defines seven client rights and three provider needs that form the basis of quality health services.

Rights of the Members: The principal rights of clients are:

1. The right to information: This involves the availability of information by means of information activities, visits and teaching or promotional materials.
2. The right to access: This involves physical, cultural, financial or institutional barriers that hinder the members' access to services
3. The right to choice: This pertains to the service providers in the health facility allowing the members to choose the method of treatment.
4. The right to safety: This particularly involves tracking, the prevention of infections and the reporting of complications.
5. The right to privacy and confidentiality: These aspects are particularly important during consultancies and physical examinations. Privacy would require not only visual but also auditory privacy.
6. The right to dignity, opinions and comfort: it is also important to analyze the issue of interpersonal communication and the reception afforded to patients, and to ensure their physical comfort.
7. The right to continuity: the needs of your members to have continuity of services and to know that effective systems exist to ensure the continuity of care.

Service Providers' Needs: Care providers may often find it difficult to serve their members well. They in turn have certain needs, the three principal ones being:

- (a) Good quality material and infrastructures: Health facility staff need the tools and working environment necessary to offer quality services.



- 
- (b) Adequate management and supervision: This may determine whether the facility has a motivating working environment.
  - (c) Information, training and development of staff: This pertains whether staff are well-informed and trained according to the needs of proper functioning.

a.3. What is the Checklist of Quality Health Care for ?

You and your care provider may jointly evaluate the quality of services offered. Quality can always be improved, and this improvement should be continuous.

As stipulated in your MOA, you and the care provider are partners. It is therefore important to include problem solving in the 'process' of cooperation, rather than assigning blame. Employing a consultant doctor may make it possible to enhance exchanges of communication between the care provider and your HMIS. You may jointly organize meetings to identify problems or prepare questionnaires. If possible you may also design an action plan that includes the sources of problems, solutions, the people responsible and a period during which the solution will be implemented. You should adopt a participative approach to try to involve both parties in evaluating the quality of services. You must seek to avoid formal official meetings.

a.4. Example of a Quality of Health Services Checklist: Please refer to Annex 5.4 for the actual sample of Quality of Health Services Checklist.

### **Document 5.3.2.b: Client Feedback Form**

b.1 What is the Client Feedback Form for?

The Client Feedback Form is a simple tool that can be used to immediately obtain feedback from the clients regarding the quality of services they received from your care providers. While it is easy to administer, it has a number of limitations. First, the key elements to be assessed is very limited considering that this is supposed to be a self-accomplished form with the . Secondly, the client may not have the interest to fill the form. Third, given that the clients may be in a hurry to seek treatment, bothered by the condition that brought her/him in, he/she may not be able to provide the appropriate comment or rating.

b.2 What information does the Client Feedback Form contain?

The content of the feedback form can be largely varied and these can be changed or modified by your HMIS. Key information this form provides include: the level of satisfaction of the services provided in terms of the key elements that make health services high quality. The same set covered by the Checklist on Quality of Health Care may be included in the Client Feedback Form but usually in broader terms. As such, it can identify aspects of health services that require improvement or strengthening.

b.3 How is the Client Feedback Form used?

The Client Feedback Form (CFF) should be developed by your HMIS together with your service providers. This is to ensure that the process is participatory and that the results are transparent.

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This CFF can be administered on a monthly or quarterly basis, depending on the availability of your staff to administer them. Since this is a self-accomplished form, there is a need for you to proactively distribute these to clients before or immediately after they are attended to by the health providers. Clients may either be the members or non-members of your HMIS. These are collected back or dropped in a box in a prominent area in the health facility. The results are analyzed and discussed by both your HMIS and service providers. It may be helpful if results are sex-disaggregated to establish if there are significant differences in experiences, and to probe why.

b.4 Example of a Client Feedback Form: Please refer to Annex 5.5 for an example of the Client Feedback Form.

### **Document 5.3.2.c: Client Satisfaction Questionnaire**

#### **c.1 What is the Client Satisfaction Questionnaire for?**

The Client Satisfaction Questionnaire is very much similar with the Health Quality Care Checklist and the Client Feedback Form in terms of the information covered. The only difference is the method how it is administered and the specificity of the information being collected.

#### **c.2 What information does the Client Satisfaction Questionnaire contain?**

The Client Satisfaction Questionnaire collects and generates the same information as the previous tools. However, this allows you to become more specific with the elements of quality being measured. It also generates recommendations from the clients how the services can be further improved. The content of this questionnaire can be modified and enhanced, depending on the element of quality health care to be given emphasis.

#### **c.3 How is the Client Satisfaction Questionnaire Used?**

The questionnaire should be jointly developed by your HMIS and the service providers. Note that this scheme requires an exit interview of clients after they have been served by the health facility. In this regard, you need to dedicate 1-2 staff to administer this questionnaire on an agreed upon period. As explained in Annex 5.6, there is a need for you to spread out the interview at different times of the day and at different days in a week to avoid biases. If all interviews are done in the morning, the service providers may still not be tired compared when they are serving clients near noon or in the late afternoon. It is also possible that different health service providers are on duty everyday, hence, the need to get feedback from clients on different days. The number of clients in a day may be limited to 8 or 10, and if this is done for a week, there will be substantial responses or inputs that can already be looked into.

The questionnaire can be administered on a monthly, quarterly or semi-annual basis, depending on the staff time you can allot for this purpose. Note that data processing and analysis may take longer considering the number of items asked and the number of clients to be interviewed. Analysis should be done immediately and action planning responding to the findings should be given equal attention and priority.

Results of quality of care surveys or questionnaires should be discussed with health care providers.



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c.4 Example of a Client Satisfaction Questionnaire: Please refer to Annex 5.6 for the sample of a Client Satisfaction Questionnaire.

## Annex 5.1 An Example of HMIS Monthly Monitoring Record

----- HMIS

Date: ..... Period:.....  
 Person Responsible: ..... Board of Auditors Approval: .....

### 1. Organisation and Functioning

Activity	No. of Activities Done	No. of Part Male Female
Gen. Assembly		
Special GA		
BD		
Board of Auditors		
Executive Board		
Aware-Raising		
Training/Teaching activities		

### 2.A. Members

Indicator	Number Male Female
A. Members	
Beneficiaries	
C. Beneficiaries with Arrear Contributions	

### 2.B. Benefits

Benefits	Provider 1:.....		Provider 2:.....		Provider 3:.....	
	Number carried out	Total Cost Mo. Invoice	Number carried out	Total Cost Mo. Invoice	Number carried out	Total Cost Mo. Invoice
	M / F	M / F	M / F	M / F	M / F	M / F
Outpatient Care						
Deliveries						
Hospitalisation						
Transports						
Others						
<b>Total/Provider</b>						
<b>Total benefits</b>						

3. Financial Monitoring					
Revenue	Actual		Expenditure	Actual	
	M / F	M / F		M / F	M / F
Membership			Benefits		
Contribution			Functioning		
Subsidies/donations			Training		
Other revenue			Other Expenses		
<b>Total</b>			<b>Total</b>		
Balance Revenue/Expenditure:					
Cash Flow	Start Month	End Month	Difference	Comments	
Cash in Hand					
Cash at Bank					
<b>Total Cash Flow</b>					

## Annex 5.2: An Example of HMIS Management Chart

MANAGEMENT CHART  
 \_\_\_\_\_ Health Micro-Insurance Scheme  
 Year: \_\_\_\_\_

### 1. Organization and Functioning of the HMIS

	Number of Meetings Held/Activities Undertaken												Remarks
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
GA/EXTRA ORDINARY													
GA													
BD													
BA													
EB													
Awareness Raising													
Training/Teaching Activities													

**2. Administrative Management**  
**2.a. New Members**

	Attendance in Meetings																							
	Jan			Feb			Mar			Apr			May			Jun			Jul			Aug		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
A. No. of Members																								
B. No. of Beneficiaries																								
No. of Beneficiaries per New Member (B/A)																								
C. No. of Beneficiaries with Arrears in Contributions																								
Rate of Collection of Contributions (B-C/B) X 100																								
Rate of Coverage (B/Target Population) X 100																								

[illegible]

3.1 Revenues	REVENUES												
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
	New Members												
	Contributions												
	Subsidies												
	Other Revenues												
	Total												
3.2 Expenses													
Cash Flow Monitoring	ACTIVITIES UNDERTAKEN												
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
	Month												
	Benefits												
	Functioning												
	Training												
	Other Expenditures												
Total													
Money End of the Month	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
	On Hand												
	At Bank												
	Total Cash Flow												

B. An Analysis of the Management Chart Data							
Health Insurance-Scheme Management Chart							
Year 2002							
1. Organization and Functioning							
Month	GM	BD	EB	BA	Training	Awareness Raising	Total
January	1	1	3	1		1	7
February		2	2		2	1	7
March		1	4	2	1	4	12
April		1	5				6
May		1	3	1		1	6
June		1	2	1	1	1	6
July			1	2	1	1	5
August		1	2				3
September		2	3	1		2	8
October		1	2	1	1	1	6
November		1	4				5
December		1	1	1		1	4
Total	1	13	32	10	6	13	75

Month	No. of New Members				No. of Beneficiaries			No. of Contributions in Arrears	Size of beneficiaries/ New Members	Collection	Rate of Coverage
	M	F	Total		M	F	Total				
January											
February											
March											
April											
May											
June											
July											
August											
September											
October											
November											
December											



2.B. Monitoring of Benefits									
Month	Delivery		Consultation		Transport		Hospitalisation		Total Monthly Cost (Php)
	No	Cost (Php)	No	Cost (Php)	No	Cost (Php)	No	Cost (Php)	
January	1	5,000	29	40,000	1	3,000	1	8,000	56,000
February	3	12,000	14	31,000	1	2,000	1	5,000	50,000
March	2	8,000	39	57,000	1	1,000	1	9,000	75,000
April	3	11,000	12	20,000	1	3,000	1	8,000	42,000
May	2	7,000	19	35,000	1	2,000	1	6,000	50,000
June	1	3,000	23	43,000	1	3,000	1	4,000	53,000
July	1	5,000	20	39,000	1	3,000	2	15,000	62,000
August	1	4,000	14	25,000	2	5,000	1	6,000	40,000
September	3	11,000	19	21,500	1	2,000	1	5,000	39,500
October	1	5,000	10	12,000	1	3,000	1	6,000	26,000
November	2	6,000	17	17,000	1	2,000	2	12,000	37,000
December	1	4,000	42	41,000	1	2,000	3	18,000	65,000
<b>Total</b>	21	81,000	258	381,500	13	31,000	16	102,000	595,500
<b>Average cost</b>		3,857		1 479		2 385		6375	
<b>Utilisation rate</b>		6.9		84.2		4.2		5.2	

<b>3. Budget Monitoring</b>					
<b>3.A. Table of Expenditure</b>					
<b>Month</b>	<b>Functioning (Php)</b>	<b>Structures (Php)</b>	<b>Benefits (Php)</b>	<b>Other Exp (Php)</b>	<b>Total (Php)</b>
<b>January</b>	12,500	-	56,000	5,000	73,500
<b>February</b>	20,000	20,000	50,000	-	90,000
<b>March</b>	15,000	12,000	75,000	-	102,000
<b>April</b>	30,000	-	42,000	5,000	77,000
<b>May</b>	20,000	-	50,000	3,000	73,000
<b>June</b>	15,000	12,000	53,000	-	80,000
<b>July</b>	15,000	11,000	62,000	-	88,000
<b>August</b>	12,000	-	40,000	-	52,000
<b>September</b>	14,000	-	39,500	-	53,500
<b>October</b>	13,000	11,000	26,000	2,000	52,000
<b>November</b>	12,000	-	37,000	-	49,000
<b>December</b>	11,000	-	65,000	-	76,000
<b>Total</b>	<b>189,500</b>	<b>66,000</b>	<b>595,500</b>	<b>15,000</b>	<b>866,000</b>

3.B. Table of Revenue					
Month	New Members (Php)	Contributions (Php)	Subsidies (Php)	Other Revenues (Php)	Total (Php)
January	3,000	46,200	-	-	49,200
February	-	44,400	200,000	-	244,000
March	7,000	59,000	-	-	66,000
April	2,000	65,000	-	-	67,000
May	2,000	63,400	-	-	65,400
June	6,000	62,000	40,000	30,000	138,000
July	5,000	61,600	-	-	66,600
August	1,000	66,600	-	-	67,600
September	-	70,000	-	-	70,000
October	-	68,600	-	-	68,600
November	1,000	63,800	-	-	64,800
December	-	64,600	-	-	64,600
<b>Total</b>	<b>27,000</b>	<b>735,200</b>	<b>240,000</b>	<b>30,000</b>	<b>1,032,200</b>

4. Cash Flow Monitoring			
Month	Cash in hand (Php)	Bank (Php)	Monthly Balance (Php)
January	360,000	168,500	528,500
February	314,400	368,500	682,900
March	278,000	368,500	646,500
April	268,400	368,500	636,900
May	260,800	368,500	629,300
June	318,800	368,500	687,300
July	297,400	368,500	665,900
August	313,000	368,500	681,500
September	229,500	468,500	698,000
October	246,100	468,500	714,600
November	261,900	468,500	730,400
December	250,500	468,500	719,000

#### 5. Calculation of Financial Ratios

Ratio contributions/expenditure	84.90%
Claims ratio (benefits/contributions)	81.00%
Operating costs/revenue ratio	18.40%

## Health Insurance Scheme

### FINANCIAL RATIOS RECORD

Date: 31/12/2002

Period: 31/12/01-31/12/02

**A. Contributions/Expenditure Ratio:**

The \_\_\_\_\_ HIS had the following results in 2002:

- total revenue contributions: Php 735 200,
- total expenditure: Php 966 000,

$$\text{Ratio Contributions/Expenditure} = (735,200/966,000) = 0.76$$

**Conclusion:** The \_\_\_\_\_ Health Micro-Insurance Scheme is not capable of covering its expenditure with its contributions. To ensure the durability of its activities and autonomy vis-à-vis subsidies, an increase in contributions is necessary.

**B. Claims Ratio (Health Benefits/Contributions):**

The \_\_\_\_\_ HMIS had the following results in 2002:

- total health benefits: Php 595 500.
- total contributions: Php 735 200.

$$\text{Health Benefits/Contributions Ratio} = 595,500/735,200 = 0.81$$

**Conclusion:** The claims ratio shows that there is a good balance between health benefits and members' contributions.

### **C. Operating Costs/Income Ratio:**

The \_\_\_\_\_ HMIS had the following results in 2002:

- total operating costs: Php 189 500,
- total income: Php 1032 200.

Operating Costs/Income Ratio=Php189,500/Php1,032,200= .184

**Conclusion:** The operating costs are relatively high compared to the income (or revenue) of the \_\_\_\_\_ HMIS.

### **D. Liquidity Ratio** (Balance Sheet Assets Available/Short-Term debts)

The \_\_\_\_\_ HMIS had the following figures in 2002:

- \* balance sheet assets available: cash in hand: Php 250,500.
- \* we consider that money in the bank is not immediately available.
- \* short-term debts:
  - Invoices payable to Providers : Php 65,000.
  - Suppliers payable : Php123 500.
  - Total : Php188 500.

Liquidity Ratio = Balance sheet assets available/short-term  
Debts  
= 250 500 /188 500  
= 1.33.

**Conclusion:** The HMIS can pay its debts vis-à-vis its care providers or other service providers.

**E. Solvency Ratio:**(balance sheet assets/debts).

The \_\_\_\_\_HMIS had the following figures in 2002:

- Total Balance Sheet Assets : Php 1,123,200.
- Total Debts:
  - Invoices Payable to Providers : Php 65,000.
  - Suppliers Payable : Php 123,500.
  - Total : Php 188,500.

$$\begin{aligned}\text{Solvency Ratio} &= \text{balance sheet assets/debts} \\ &= 1,123,200 / 188,500 \\ &= 5.96\end{aligned}$$

**Conclusion:** The \_\_\_\_\_HMIS is solvent and can meet all its obligations towards third parties with its own resources.

**F. Ratio of Coverage of Expenditure** (reserves/monthly expenditure).

The \_\_\_\_\_HMIS had the following figures in 2002:

- Total reserves = Php 668 500
- The MHIS has Php 966 000 expenditure per year.  
It therefore spends on average per month:  
 $\text{Php } 966\,000 / 12 = \text{Php } 80\,500$

$$\text{Ratio of coverage of expenditure} = 668\,500 / 80\,500 = 8.3$$

**Conclusion:** more than eight months' financing can be funded by the HMIS reserves. The reserves should be able to ensure stability to meet exceptional situations such as epidemics.

## Annex 5.4: Checklist on the Quality of Health Care

### Checklist on the Quality of Health Services

Date : \_\_\_\_\_

Care Provider: \_\_\_\_\_

Rapporteur : \_\_\_\_\_

#### A. Rights of beneficiaries to quality health services

##### A.1 Information

- |  |     |   |    |   |
|--|-----|---|----|---|
| – Are boards showing the days and times of opening clearly visible everywhere in the health structure?   | Yes | O | No | O |
| – Are education and awareness-raising activities organised for the population, particularly with a view to protection against sexually transmitted diseases, including AIDS?                             | Yes | O | No | O |
| – Do staff ask beneficiaries whether they understand the information they receive or whether they have any questions to ask?   | Yes | O | No | O |
| – Do future at-risk patients of treatments (e.g. surgery, operations) receive information on the method with the type of operation, anaesthetics, the risks of the operation and possible complications? | Yes | O | No | O |

Comments or Suggestions:

.....

.....

##### A.2 Access to Health Care

- |  |     |   |    |   |
|--|-----|---|----|---|
| – Is the cost of health services accessible to patients?   | Yes | O | No | O |
| – Are the opening hours convenient for all beneficiaries, including those who work during the day? | Yes | O | No | O |
| – Can providers communicate with potential beneficiaries in all dialects of the region?            | Yes | O | No | O |
| – Do staff try to reduce the number of visits a patient has to make for each period?               | Yes | O | No | O |

Comments or Suggestions:

.....



### A.3 Right to Choice

- |   |     |                       |    |                       |
|---|-----|-----------------------|----|-----------------------|
| – Does the care provider offer a broad range of services adapted to patients' needs?  | Yes | <input type="radio"/> | No | <input type="radio"/> |
| – Are there services which are not available but which you think are essential?   | Yes | <input type="radio"/> | No | <input type="radio"/> |
| – Do all new patients receive advice that helps them to choose the method which is best adapted to their needs?                           | Yes | <input type="radio"/> | No | <input type="radio"/> |
| – If certain methods are not available in your premises, do staff know how to refer patients to obtain these services, and do they do so? | Yes | <input type="radio"/> | No | <input type="radio"/> |

Comments or Suggestions:

.....

### A.4 The Right to Safety

- |  |     |                       |    |                       |
|--|-----|-----------------------|----|-----------------------|
| – Are there breakdowns in stocks of medicines (generic, and bearing in mind the date of expiry)?                                     | Yes | <input type="radio"/> | No | <input type="radio"/> |
| – Is there a systematic monitoring programme for patients?   | Yes | <input type="radio"/> | No | <input type="radio"/> |
| – Are qualified staff always available for consultations in the event of possible complications?                                     | Yes | <input type="radio"/> | No | <input type="radio"/> |
| – Are single-use needles and syringes used? Is re-usable material appropriately sterilised?  | Yes | <input type="radio"/> | No | <input type="radio"/> |
| – Are sterile or well-disinfected gloves available when necessary?   | Yes | <input type="radio"/> | No | <input type="radio"/> |
| – Are soiled surfaces (such as examination beds or operating tables) cleaned with a 0.5% chlorine solution every time they are used? | Yes | <input type="radio"/> | No | <input type="radio"/> |

Comments or Suggestions:

.....

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#### A.5 Privacy and Confidentiality

- |   |     |                       |    |                       |
|---|-----|-----------------------|----|-----------------------|
| – Does your health structure have a private place where patients will not be seen, heard or disturbed during the consultation?                    | Yes | <input type="radio"/> | No | <input type="radio"/> |
| – Do all staff respect the patient's right to confidentiality by avoiding speaking about them unless it is to get advice from other clinic staff? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| – Is access to the patients' register strictly controlled?  | Yes | <input type="radio"/> | No | <input type="radio"/> |

Comments or Suggestions:

.....

A.6 Dignity, opinion and comfort

- |  |     |   |    |   |
|--|-----|---|----|---|
| – Are men and women who come to the health structure treated as you would like to be?                                | Yes | O | No | O |
| – Do staff use understandable language for patients?   | Yes | O | No | O |
| – Do staff encourage beneficiaries to ask questions?   | Yes | O | No | O |
| – Do you think the premises of the health structure are comfortable (clean, well-lit, well-ventilated and pleasant)? | Yes | O | No | O |
| – Is the health structure clean throughout?  | Yes | O | No | O |
| – Are sufficient numbers of staff available at times when the health structure is busiest?                           | Yes | O | No | O |
| – Do you think that waiting times for beneficiaries to use the services are reasonable?                              | Yes | O | No | O |
| – Are beneficiaries received in order of arrival?  | Yes | O | No | O |
| – Is the time beneficiaries spend in contact with health staff generally satisfactory?                               | Yes | O | No | O |

Comments or Suggestions:

.....

A.7 Right to Continuity

- |   |     |   |    |   |
|---|-----|---|----|---|
| – Is the health structure sufficiently well-stocked? (medicines, gloves, needles,...) | Yes | O | No | O |
| – Is all equipment well maintained?   | Yes | O | No | O |
| – Are beneficiaries given a follow-up meeting?  | Yes | O | No | O |

Comments or Suggestions:

.....

**B. The Needs of Care Providers**B.1 Staff needs as regards adequate supplies and infrastructures

- |  |     |   |    |   |
|--|-----|---|----|---|
| – Do the staff responsible for stocks of medicines always observe the 'first in – first out rule'?   | Yes | O | No | O |
| – Do staff have sufficient quantities of buckets, containers and bleach to be sure that they always have a disinfectant solution available whenever necessary? | Yes | O | No | O |

Comments or Suggestions:

---

*B.2 Need for staff to have good management and supervision*

- |  |     |   |    |   |
|--|-----|---|----|---|
| – Do staff find that supervision in the health structure is adequate?  | Yes | O | No | O |
| – Are there solid links between the different departments or services? | Yes | O | No | O |

Comments or Suggestions:

.....

*B.3 The need for staff to have information, training and development*

- |   |     |   |    |   |
|---|-----|---|----|---|
| – Is updating and continuous training provided for staff so that they are always well informed?                                       | Yes | O | No | O |
| – Does the health structure have enough staff with the necessary skills to advise beneficiaries, including groups with special needs? | Yes | O | No | O |
| – Have staff ever interviewed beneficiaries to measure their satisfaction vis-à-vis the services?                                     | Yes | O | No | O |

Comments or Suggestions:

.....

## Annex 5.5 Client Feedback Form

**Introduction:** This bravo card or feedback form is one mechanism of assessing quality of health services being provided by the health facility as reflected by the responses or feedback from clients who have just been served. You can easily administer this by distributing the forms to as many clients who enter the health facility on a specific period and collecting them back or by designating a certain place where they can drop their responses. Note that this is a self-accomplished form. You should have adequate pens for their ready use. It is suggested that the forms be proactively distributed and collected to ensure high response rate. This can be done for the whole straight week or in a day depending on the available time that you have. The use of this scheme should be decided jointly by your HMIS and the service providers concerned.

	Level of Satisfaction		
	Very satisfied	Satisfied	Not Satisfied
I am satisfied with:			
(1) the treatment and advice I received	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(2) the manner the staff served me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(3) the facilities' cleanliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(4) the facilities' assurance for privacy and confidentiality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(5) the waiting time before I was served	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Comments: _____			
Sex: ? Male ? Female	Age ____		
_____			

## Annex 5.6 Client Satisfaction Questionnaire

**Introduction:** This questionnaire is only a sample how to measure the level of satisfaction of clients with the quality of health services being provided or them by your service providers. You can change the questions according to your need or local situation. To make the application of this questionnaire more systematic and objective, follow the instructions below.

### Application of the Questionnaire:

- (1) You may administer the questionnaire on different days of the week and different times of the day. You may want to interview clients in the morning, near noon and in the afternoon. This is to cover the whole range of time the health facility is open in order to get a good representation of its services. You may want to administer the questionnaire at least on a quarterly basis to assess the consistency of services provided.
- (2) Ensure that when you apply this questionnaire, your service provider is aware of it and that jointly, you agree to look at the results and discuss what can be done about them.
- (3) Note that the overall purpose of this survey is to improve quality of health services and not to pinpoint blames to anyone. The analysis and discussion of results should be an empowering experience for every one concerned and that people involved are open to make these changes.

### Instructions in Administering the Questionnaire:

1. Randomly select clients who have just finished consultation with the health facility. Clients may be your HMIS members or anyone who patronizes the services of the health facility.
2. Interview clients privately and ensure confidentiality.
3. Note that there are 15 items in the questionnaire. For Item Nos. 4-13, read the statement and ask if the client agrees, disagrees or neither “agrees/disagrees”.  
“No response” will mean a “disagree” answer. Put a check (✓) mark opposite the given answer.
4. Count the number of “agree” answers per client interviewed and write this on the row below item No. 13.
5. If client provided at least six (6) agree responses, write “satisfactory” on the appropriate space and “unsatisfactory” if the number of agree responses is below six (6).
6. Each of respondent should be able to provide at least 6 agree answers to rate the facility with satisfactory rating.

## Client Satisfaction Questionnaire

Hello, my name is \_\_\_\_\_. I am helping to assess health services in this facility. I am interested in what you think about the health facility, the staff and services here. Could I ask you a few questions about your experience today?

Your answers will help us understand how to improve the provision of health services. Please be assured that your answers will remain confidential and you do not have to answer any question that will make you uncomfortable. The interview will last between 10-15 minutes.

Sex: ☐ Male ☐ Female Age: \_\_\_\_\_

Introduction				
No.	Question	Actual Responses		
		1st Client	2nd Client	3rd Client
1	What was the main reason for your visit or consultation today?			
2	How many minutes from your home is this place (indicate if by walking, by transportation, etc.)?			
3	Is this your first visit to the health facility?			

Quality of Care					
No.	Question	Possible Response	Actual Responses		
			1 <sup>st</sup> Client	2 <sup>nd</sup> Client	3 <sup>rd</sup> Client
Read Item Nos. 4-13 and ask client if he/she agrees, neither disagrees/agrees or					
4	The health facility is clean.	Agree			
		Neither Agree nor Disagree			
		Disagree / No Response			

No.	Question	Possible Response	Actual Responses		
			1 <sup>st</sup> Client	2 <sup>nd</sup> Client	3 <sup>rd</sup> Client
5	The facility has enough space to ensure privacy to clients, e.g. during physical/internal examination or counselling.	Agree			
		Neither Agree nor Disagree			
		Disagree/ No Response			
6	The facility has available medicines to give to clients.	Agree			
		Neither Agree nor Disagree			
		Disagree/ No Response			
7	The waiting time is reasonable.	Agree			
		Neither Agree nor Disagree			
		Disagree/ No Response			
8	The provider is friendly.	Agree			
		Neither Agree nor Disagree			
		Disagree/ No Response			
9	The provider seems knowledgeable.	Agree			
		Neither Agree nor Disagree			
		Disagree/ No Response			
10	The provider gave me the service that I came here for.	Agree			
		Neither Agree nor Disagree			
		Disagree/ No Response			
11	Overall, I am satisfied with the services I received at this facility today.	Agree			
		Neither Agree nor Disagree			
		Disagree/ No Response			



No.	Question	Possible Response	Actual Responses		
			1 <sup>st</sup> Client	2 <sup>nd</sup> Client	3 <sup>rd</sup> Client
12	Compared with other health facilities, the services here are acceptable.	Agree			
		Neither Agree nor Disagree			
		Disagree/ No Response			
13	I will come back to this facility.	Agree			
		Neither Agree nor Disagree			
		Disagree/ No Response			
Total Number of Agree Answers Item Nos. 4-13)					
RATING (Satisfactory or Unsatisfactory):					

No.	Question	Responses		
		1 <sup>st</sup> Client	2 <sup>nd</sup> Client	3 <sup>rd</sup> Client
Suggestions/Recommendation				
14	What do you like in this facility (ex: accessibility, facility-related, staff-related)? Be specific.			
15	What will you suggest this facility could do to improve its services (ex: in terms of facility/environment, equipment/supplies, manpower management)? Be specific.			

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ISBN 92-2-116745-3