

**LINKAGES BETWEEN STATUTORY SOCIAL SECURITY
SCHEMES AND
COMMUNITY-BASED SOCIAL PROTECTION MECHANISMS**

PHILIPPINES

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ACRONYMS	
BHS	Baranggay Health Stations
CBHCO	Community-Based Health Care Organizations
CBO	Community-Based Organizations
DAR	Department of Agrarian Reform
DoH	Department of Health
DOLE	Department of Labor and Employment
ECC	Employees Compensation Commission
ECP	Employees Compensation Plan
GSIS	Government Service Insurance System
GTZ	German Technical Cooperation
GTZ-SHI	German Technical Cooperation, Social Health Insurance Project
HAMIS	Health Management and Information System
ILO	International Labour Office
ILO STEP	International Labour Office-Strategies and Tools against Social Exclusion and Poverty
IPP	Individually Paying Program
KaSAPI	Kalusugang Sigurado at Abot-Kaya sa PhilHealth Insurance
LGU	Local Government Unit
Medicare	Philippine Medical Care Program
NHIP	National Health Insurance Program
NSCB	National Statistical Coordinating Board
NSD	Normal Spontaneous Delivery
NSO	National Statistical Office
OFW	Overseas Filipino Worker
OG	Organized Group
PhilHealth	Philippine Health Insurance Corporation
PMCC	Philippine Medical Care Commission
POGI	PhilHealth Organized Group Interface
RHU	Rural Health Unit
SP	Sponsored Program (formerly Indigent Program)
SSS	Social Security System
WHO	World Health Organization

1 Introduction

1.1 Background on the Study

1.1.1 Rationale

Statutory social security schemes have often been successful in covering civil servants and formal sector workers. They provide comprehensive benefits and through their compulsory nature have big and geographically diversified risk pools. However, limitations in relation to their capacity to cover informal sector workers have become more and more apparent. These are mainly due to the nature of informal employment that make the identification and registration of workers difficult and contribution collection expensive, to low contributory capacities of informal sector workers that do not match the requirements of formal sector schemes and to a lack of focus on the specific needs of informal sector workers. These problems have been exacerbated by a poor understanding by target groups of insurance principles and difficulties to provide quality services in all rural and urban areas of a country. A lack of solidarity between better-off formal and often poor informal sector workers has also limited the capacity to extend statutory social security. While many initiatives are under way to overcome these problems, reality dictates that immediate ambitions for the expansion of coverage in many developing countries require innovative approaches.

Community-based social protection mechanisms, given their small-scale decentralized and/or participatory nature, have the potential to focus on specific interests and needs of small populations such as creating solidarity among its members who are often excluded from statutory social protection schemes. They can be connected to existing institutions or organizations such as cooperatives, micro-finance institutions, workers' groups which can facilitate registration, collection and service provision. Experience however shows that many of these mechanisms face problems relating to financial sustainability due to a small risk pools. At the same time, difficulties in expanding to geographic and socio-occupational areas and in increasing membership are often linked to poor management skills and information systems.

Given the respective strengths and weaknesses of statutory social security schemes and community-based social protection mechanisms, there is value in learning from existing linkages between the two types of schemes and understanding its merits and contributions to extending social protection particularly to the informal sector workers. The results of this study will contribute to the development of an integrated social protection strategy.

1.1.2 Objectives

The study shall:

- Develop an inventory of potential linkages between statutory social security and community-based social protection schemes;
- Review factors that supported or hindered the success of these linkages in terms of extending coverage; and
- Identify measures that could be taken to improve and strengthen these linkages.

1.1.3 Methodology and Scope

For purposes of the study, statutory social security schemes are compulsory social health insurance as well as tax-financed schemes administered by national or local authorities. Community-based social protection mechanisms are defined as institutions that directly administer or facilitate the implementation of social protection schemes. These may be microinsurance schemes, cooperatives, microfinance institutions, workers' associations or trade unions. Linkages may be in the form of but not limited to, subsidies and redistribution, financial consolidation such as reinsurance, technical advice, sharing of management functions, assistance in registration and contribution collection, exchange of information and good practice, regulation and control, co-contracting with health care providers, access to health service delivery networks, and joint participation in the design and implementation of national social protection extension strategies.

This study is focused on linkages that cover the risks of maternity and ill-health, which includes medical care, cash sickness and maternity benefits. Linkages related

to other risks such as retirement and death are also identified but were not purposively explored.

Most linkages between statutory schemes and community based social protection mechanisms are in an experimentation stage. Information on existing linkages came from discussions and interviews with different implementers such as project managers, leaders of community-based groups and donor agencies, project reports including assessment reports and experiences of the author while working with some of the schemes in one way or another. Limited information could be gathered on some forms of linkages especially those that are initiated by community-based groups and local government units. Analysis and assessment of the different schemes are enriched by discussions with managers of PhilHealth and the different community-based organizations, policy makers, and other stakeholders such as health economists and donor agencies.

1.1.4 Organization of the Study

The rest of section 1 gives a background on the Philippines describing its demography, government and economy, the present health care system and the labour force and the informal economy.

Section 2 discusses the different statutory and community-based social protection schemes describing their membership coverage, financing mechanisms, benefit packages and developments over the last decade.

Section 3 describes the existing linkages between statutory and community-based schemes focusing on experiences during implementation and on its strengths and weaknesses.

And section 4 focuses on the findings of identified schemes from which most of the recommendations and suggestions for improvements are based on.

1.2 Background on the Philippines

1.2.1 Demographics, Government and Economy

The Philippines, an archipelago of 7,100 islands in Southeast Asia, had a total population of 76.4 million in year 2000 approximately 49.6% of whom are women. With an annual growth rate of 2.32%, one of the highest in Asia, the population was expected to reach 85.2 million in 2005. The rate of growth over the past decade is attributed to the slow pace of decline in the country's Total Fertility Rate, from 6.0 lifetime births per woman in 1970, to 4.1 in 1993 to 3.5 in 2003. However the poorest quintile has a total fertility rate of 6.5 children per woman compared to only 2.1 children per woman for the richer group. For the past three decades, fertility rates have outpaced economic growth which makes progress in improving health and other human development indicators more difficult.

Under the Constitution, the Philippines is a democratic and republican state with three branches of government – the executive, legislative and judicial branches. The executive power is vested in the President and appointed Cabinet members (Secretaries). The lawmaking power, on the other hand, is vested in a bicameral congress composed of the Senate and the House of Representatives. Judicial power is vested on the Supreme Court and a system of several lower courts.

The Philippines is divided into 17 administrative regions, which are politically subdivided into Local Government Units (LGUs). There are 79 provinces headed by governors, 117 cities and 1,500 municipalities headed by mayors and 42,000 barangays or villages headed by barangay chairpersons. LGUs are guaranteed local autonomy under the Philippine Constitution. LGUs such as provinces, cities and municipalities are classified according to its income, which serves as a basis for determining financial capability of a local government unit to provide in full or in part the funding requirements of developmental projects and other priority needs of the locality. The income class of LGUs is used as a factor in the allocation of national or other financial grants for projects.

The long-run performance of the Philippine economy is characterized by slow and uneven economic growth. In 2005, per capita gross domestic product (GDP PPP US\$)

was US \$ 5,300. The poor, based on government's estimates, comprise 30% of the population or roughly about 25.56 million people.

Coupled with the slow economic growth is the slow structural transformation of the economy. The proportion of labour force in industry has remained stagnant at around 10% since the 1970s. The decline in the share of labour force in agriculture was absorbed in the services sector, often in unskilled and low paying categories e.g. personal services. The slow structural transformation of the economy makes it harder to expand coverage of social insurance schemes beyond the formal employed sector.

1.2.2 Labour Force and the Informal Sector

The labor market absorbs approximately 1.5 million new entrants yearly. Of the 35.2 million workers, 2.8 million or 8.1% are unemployed and 6.9 million or 21.3% are underemployed.¹ High unemployment and underemployment rate has compelled millions to work abroad. More than 1 million workers leave to find work overseas annually. The government has set up programs to extend assistance to Overseas Filipino Workers or OFWs including social health insurance and other social security coverage for OFWs and their dependents.

Continuous high unemployment and underemployment brought about by policies like trade liberalization and import substitution also saw the growth of the informal economy. Recognizing the issues confronting the informal sector like invisibility, lack of access to productive resources and lack of social protection, the government through Department of Labor and Employment (DOLE) started institutionalizing programs and policies for the informal sector. One of its initial accomplishments was the adoption of an official definition by the National Statistics and Coordination Board (NSCB) which would facilitate tracking of informal sector workers through regular surveys done by the National Statistics Office (NSO). Informal sector is defined as:

“The informal sector consists of “units” engaged in the production of goods and services with the primary objective of

¹ Based on Labour Force Survey (LFS) January 2006, National Statistics Office.

generating employment and incomes to the persons concerned in order to earn a living.”

These units typically operate at a low level of organization, with little or no division between labour and capital as factors of production. It consists of household unincorporated enterprises that are market and non-market producers of goods as well as market producers of services. Labour relations, where they exist, are based on casual employment, kinship or personal and social relations rather than formal or contractual arrangements.”

For statistical purposes, the informal sector shall refer to household unincorporated enterprises which consist of both informal own-account enterprises and enterprises of informal employers. (NSCB Board Resolution No. 15, 2002)

However, in spite of adopting an official definition, the National Statistical Office (NSO) has not done a national survey that would estimate the number of informal sector workers in the country due to administrative and financial constraints. The number of own-account workers and unpaid family workers which are included in the quarterly Labour Force Surveys serve as a tentative estimate of informal sector workers which is roughly 50% of the labour force or approximately 17.6 million based on January 2006 Labor Force Survey. However, this process does not present an accurate estimate of informal sector workers in the country.

The International Labor Organization (ILO) - United Nations Development Programme (UNDP) Project on the “Development of Policy, Legislative and Institutional Reforms for the Promotion and Protection of Workers in the Informal Sector” proposed a process to estimate the size of the informal economy. Using data from Survey of Establishments and the Labour Force Survey, it estimated the population of informal sector workers to be 70%, approximately 19.5 million workers, of the employed population in year 2000.² Using the same estimation

² Number of informal economy workers is estimated by: total number of employed workers minus number of workers employed in establishments minus number of workers employed in government plus number of workers employed in small enterprises. Data on the number of workers employed in small enterprises is not always available hence its exclusion from the present estimation.

procedure and the latest available data, the informal sector grew to 76% of the employed population by year 2003 which is approximately 28.5 million workers.

1.2.3 Philippines Health Sector

The Department of Health (DOH) is the principal government agency that formulates national health policies and programs, and guides the development of local health systems, programs, and services. In 1991, by virtue of a landmark legislation known as the Local Government Code, health services were devolved to the LGUs. In the past, the delivery of preventive and curative health services were solely under the responsibility of the DOH, after 1992, the public health and preventive health programs were delivered by the LGUs. Municipal governments maintain rural health units (RHU) and barangay health stations (BHS), which are primary health-care facilities; provincial governments maintain the provincial and district hospitals. The DOH on the other hand, still directly operates a few large-scale health programs, such as those relating to HIV/AIDS and tuberculosis; maintains national health facilities; and administers a limited number of sub-national medical facilities that issue referrals to local health agencies. There is a regional Department of Health office in each of the 17 administrative regions of the country.

About 40% of all hospitals are public; these contribute 42,070 beds, or 52% of all bed capacity in the country. The private sector plays a significant role in the delivery of health care, especially within the devolution framework. There are approximately 1,068 private hospitals, providing almost half of the country's hospital beds.

The single largest source of health financing is the households, contributing 43% of total health expenditures in 2001. Households in turn finance these expenditures, especially large and unanticipated expenditures, in a variety of ways—from savings, contributions from extended family, borrowings, sale of assets, and from reduction in current consumption of human capital formation such as nutrition and basic education that may affect children more than adults. Lower-income groups are likely to bear a disproportionate burden of these expenditures.

2 Social Protection in Health

2.1 Statutory Social Protection Schemes

The Philippines has four (4) programmes that provide social protection in health: (a) the National Health Insurance Programme (NHIP); (b) Employees Compensation Programme (ECP); (c) Social Security Programme; and (d) Commonwealth Act. The NHIP provides access to health care through social health insurance. The ECP is designed to provide employees and their dependents with income and other benefits in the event of a work-related injury, accident or illness while the Social Security Program and the Commonwealth Act ensure social security benefits to private sector and government sector employees, respectively.³

Three (3) national agencies administer these programmes, namely, the Philippine Health Insurance Corporation (PhilHealth), which manages the NHIP; the Social Security System (SSS), which administers the Social Security Program and the ECP for private sector workers; and the Government Service Insurance System (GSIS), which manages the Commonwealth Act and the ECP for government sector workers. As of December 2005, PhilHealth has covered 41.5% of workers while SSS and GSIS have covered 85.4% of workers. Statistically defining the informal sector as the total number of own account workers and unpaid family workers, approximately only 30.5% of informal sector workers are covered by PhilHealth and 33.33% are covered by the SSS. However, if estimates by the ILO-UNDP Project were used, coverage of informal sector by PhilHealth would be 25% while SSS would cover 28%. The absence of an employer-employee relationship, low and unstable incomes, and lack of awareness of social security rights, satisfaction with indigenous social security schemes, complex policies and procedures of statutory schemes and inappropriate and inadequate benefits and services are some of the factors that influence low participation of informal sector workers in the formal social security schemes.

³ Aside from these programmes, the Labour Code also prescribes a minimum set of medical, dental, and occupational safety obligations for employers. The requirements vary, depending on the hazards in the work place and on the number of workers employed. As a minimum standard, the Labour Code requires that first-aid treatment must be available within the premises. Larger companies on the other hand must provide a company clinic with a full-time doctor, nurse and dentist. Collective Bargaining Agreements (CBA) also specify the medical benefits that companies must provide their employees and the employees' dependents.

Table 1. Members of Statutory Social Security Schemes

Labour force as of January 2006: 32.38 million	Members (as of December 2005)
PhilHealth	13.43
Employed	8.3
Individually Paying	2.44
Sponsored	2.49
Non-Paying	0.2
SSS	26.23
Employed	20.84
Self-employed	5.39
GSIS	1.42

Table 2. Employed Persons by Class of Worker, January 2006

	Jan-06	
	Number	Percent
Philippines	32.38	100
Wage and Salary Workers	16.21	50.1
Private Household	1.58	4.9
Private Establishment	12.05	37.2
Gov't/Gov't Corporation	2.48	7.7
With pay (Family owned Business	0.10	0.3
Own Account	12.09	37.3
Self Employed	10.61	32.8
Employer	1.48	4.6
Unpaid Family Workers	4.09	12.6

Following is a description of the different statutory social protection programmes.

2.1.1 National Health Insurance Programme

2.1.1.1 Medicare Programme

Social health insurance has been an integral part of social security program in the Philippines since the 1960s. The Medicare Programme launched in 1969 made health insurance mandatory for salaried workers in the private and government sectors. It was established by Republic Act 6111 in August 1969 and implemented on 01 January 1972, with the creation of the Philippine Medical Care Commission (PMCC). The PMCC, as a government agency, was the regulatory body for the implementation of the Medicare Programme. It was supervised administratively by the Department of Health (DOH).

Medicare had two (2) programmes: Programme I, which covered only public and private sector employees and their dependents, and Programme II which was intended to cover the informal sector but its implementation was impeded by financial and administrative difficulties. Medicare was implemented (premium collection and benefit reimbursement) by the GSIS for government employees and by the SSS for private employees.

By 1990, Medicare covered 38% of the total population (members and dependents) or 23.5 million Filipinos, 16.8 million of whom were under SSS and 6.7 million were under the GSIS. Premium contribution was equally shared by the employer and the employee at 2.5% of the salary base credit. Medicare provided only inpatient benefits. However Medicare support values, defined as the portion of hospitalization paid by the programme, fell short of the targeted 70%, averaging only from 32% to 49% since its implementation in 1972. National Health Accounts data show health insurance remained a small contributor to health care financing in spite of its 20 years in existence. There were high cases of fraud in the fee-for-service payment of accredited providers. This finding spurred the Department of Health (DOH) and Congress to consider a new legislation designed to expand the role of social health insurance in making health care affordable to the people.

2.1.1.2 PhilHealth's Mandate

Congress passed the National Health Insurance Act (Republic Act 7875), in 1995 which instituted the National Health Insurance Program (NHIP) that shall provide

health insurance coverage for all citizens by year 2010. The National Health Insurance Act also established the Philippine Health Insurance Corporation (PhilHealth) to administer the NHIP. PhilHealth also assumed the responsibility of administering the former Medicare Programme for government employees managed by the GSIS on October 1997 and for private sector employees managed by the SSS on April 1998. Republic Act 7875 was amended in 2003 through Republic Act 9241. One of the provisions amended is the coverage of up to the fourth (4th) normal obstetrical deliveries, which was not covered at all in RA 7875.

2.1.1.3 Membership

PhilHealth's membership programmes namely Employed Sector, Individually Paying Program (IPP), Non-paying Program, and Sponsored Program covers the following types of members:

Employed members – all those employed in the government and private sector including household help and sea-based Overseas Filipino Workers (OFWs) who are compulsory members of the NHIP;

Individually paying members – self-employed, personnel of international organizations based in the Philippines, individuals separated from employment, unemployed persons who are not qualified as indigents, parents who are not qualified as legal dependents, and OFWs.⁴

Non-paying members – members entitled to lifetime coverage that include retirees and pensioners of the GSIS and SSS prior to the implementation of the NHI Act of 1995, and those who have reached the age of retirement, which is 60 year old, and have paid at least 120 monthly contributions, and;

Indigent members – members classified as indigent under the NHIP who are entitled to subsidized premium. Target members of the Programme are those belonging to the lowest 25% of the population identified through a survey called Community-based Information System, Minimum Basic Needs (CBIS-MBN), using the Family Data Survey Form (FDSF), conducted by the local Social Welfare Development Office.

⁴ The Omnibus Guidelines of PhilHealth defines OFWs as Filipinos who are residing in other countries, is engaged, to be engaged or has been engaged in a remunerated activity in a state of which the worker is not a legal resident. The term is used interchangeably with migrant worker.

Also covered under the NHIP as dependents without additional premium are the legitimate spouse of the member who is not a member of any of the above categories; the children (legitimate, illegitimate, adopted and step-child) below 21 years old, unmarried and unemployed; and parents and/or step parents of members. There are no limits to the number of dependents for each member.

As of December 2005, there are 13.42 million members approximately covering 54.60 million beneficiaries or 64% of the Philippines' total population. Private sector workers comprise 48% of PhilHealth's total membership. Members from the Individually Paying Program and the Sponsored Program, where most of the informal sector workers are found, comprise 36.8%. Approximately 22% of the Individually Paying Members are OFWs. On the average, there are 4.1 beneficiary per member of PhilHealth. Because of Plan 5 million⁵, which was launched in 2004 to cover the poorest families, there were more than 31 million indigent members covered by NHIP. At the end of 2005, there are only 2.44 million indigent beneficiaries covered by NHIP indicating a need to study sustainability of such programmes.

Table 3. NHIP Active Members as of December 2005

	Members, millions		Beneficiaries, millions	
	Number	Percentage	Number	Percentage
Employed	8.3	61.8%	30.68	56.2%
<i>Government Sector</i>	<i>1.85</i>	<i>13.8%</i>	<i>7.49</i>	<i>13.7%</i>
<i>Private Sector</i>	<i>6.45</i>	<i>48.1%</i>	<i>23.19</i>	<i>42.5%</i>
Individually Paying Members*	2.44	18.2%	11.14	20.4%
<i>OFWs</i>	<i>0.55</i>		<i>2.67</i>	
Sponsored Members	2.49	18.6%	12.44	22.8%
Non-paying Members	0.2	1.5%	0.33	0.6%
Total	13.42		54.6	
*includes OFWs				

Source: Stats and Charts 2005, PhilHealth

2.1.1.4 Benefits

A major portion of NHIP coverage is for in-patient care. PhilHealth has a unified benefit package for all members since 1999. Private sector and government sector workers used to receive different benefit packages under the Medicare Programme.

⁵ Plan 5 Million is a project of President Arroyo's government to cover 5 million poor families through a subsidy from the national government. Local government units were not expected to put up their counterpart for families covered under Plan 5 Million.

Employed Sector and Individually Paying members including OFWs are entitled to benefits when they have paid at least three (3) monthly premium contributions within the immediate six (6) months prior to the month of confinement. Sponsored members are entitled to avail of NHIP benefits on the date of validity as stated in the PhilHealth card while non-paying members or retirees can avail of benefits upon reaching the age of retirement.

This package of benefits with the corresponding ceiling in pesos according to hospital category is shown in the following table. Benefit ceilings are periodically adjusted to cover for inflationary cost of medical care. It should be noted, however, that providers are allowed to bill patients for cost above the benefit ceilings. The support value typically declines as the cost of health care goes up.

2.1.1.4.1 Enhancements to the Benefit Package

Aside from regularly reviewing and adjusting the benefit ceilings of NHIP, enhancements in the benefit packages are done to respond to needs of members.

2.1.1.4.1.1 Maternity Care

The NHIP, RA 7875, and the Medicare Programme excluded the coverage of normal spontaneous deliveries (NSD) unless its inclusion in the benefit package could be supported by actuarial study. On 1 May 2003, PhilHealth started to reimburse Normal Spontaneous Deliveries (NSD) done in lying-in clinics, midwife-managed clinics, birthing homes, and rural health units (RHUs). The Maternity Care Package is applicable only to the first two NSDs which are expanded to cover up to the first three NSDs effective on 1 October 2006. The package which is paid with a case payment rate of PHP 4,500⁶ (US\$ 89) covers prenatal care, delivery care, newborn care and postpartum care to PhilHealth members and beneficiaries. All medically necessary care for the newborn, including professional services, medicines and laboratory examinations, is reimbursable and classified as an ordinary medical case type. Therefore the claim for newborn care is different from maternity care claim of mothers.

⁶ 1US\$ = 50.50 PHP, based on September average exchange rate.

A member or a dependent should show sufficient regularity of premium contributions and should have at least nine (9) months or three (3) quarters of premium payments in the immediate twelve (12) months prior to the normal spontaneous delivery to be eligible for the Maternity Care Package. However, IPP members enrolled as a group need not satisfy the sufficient regularity rule. Also, the first prenatal visit of the member or qualified dependent must not exceed the four (4) months age of gestation (AOG) of the current pregnancy.

2.1.1.4.1.2 TB DOTS

The Philippines has one of the highest incidences of tuberculosis in the world. In response to this, PhilHealth developed the TB-defined package which was made available starting 1 April 2003. The package follows the anti-TB treatment known as Directly-Observed Treatment Short-Course or DOTS. For 6 to 8 months of therapy, a DOTS facility shall be paid an amount of PHP4,000/US\$ 79 and this shall cover expenses for diagnostic work-up, consultation services and anti-TB drugs that the patient requires. The DOTS Benefits Package is limited to new cases of pulmonary and extra pulmonary tuberculosis of children and adults.

2.1.1.4.1.3 Out-Patient Benefit Package

Sponsored Programme members, in addition to the above benefits, are entitled to avail of the following services from accredited Rural Health Units or Health centres: free primary consultation with the physician, and free laboratory examinations for complete blood count, chest x-ray, stool exam, urinalysis and sputum microscopy as well as preventive health services such as: visual acetic acid screening for cervical cancer, regular blood pressure measurements, annual digital rectal exam, body measurements, periodic clinical breast examination, counselling for cessation of smoking and lifestyle modification counselling.

This benefit package is administered and delivered by the accredited rural health units (RHUs) through the capitation payment scheme. PhilHealth shall pay the amount of PHP 300 /US\$ 5.94 per member per year to the LGUs, being government entities managing RHUs, as capitation payment to cover such services.

At present, private clinics and out-patient clinic services in hospitals are not accredited to provide OPB Package.

2.1.1.4.1.4 Others

PhilHealth had limited the reimbursement for dialysis treatments to hospital facilities but on 1 April 2003, it started to cover dialysis treatments in free-standing dialysis centres.

The Philippines, like the rest of Asia, is threatened by new diseases of the century such as Severe Acute Respiratory Syndrome (SARS) and the Avian Flu. PhilHealth designed a package worth Php100,000.00 (US\$1,980) for government health care workers who might contract the disease, while entitling members and their dependents to a similar package worth PHP 50,000.00 (US\$990). However, these benefit packages are limited to DOH-designated SARS or Avian Flu hospitals. Payment to health care providers covers room and board, drugs and medicine, radiographic and laboratory examinations, supplies, transfer services and professional fees.

Table 4. Benefits for Members and Dependents of the NHIP

UNIFIED MEDICARE BENEFITS				
For all Members and Dependents under the National Health Insurance Program				
BENEFITS	HOSPITAL CATEGORY			
1 US\$= 50.50 Php				
as of September 2006	PRIMARY	SECONDARY	TERTIARY	
ROOM AND BOARD				
Not exceeding 45 days for each member & another 45 days to be shared by his dependents	PHP 200	PHP 300	PHP 400	
	\$3.96	\$5.94	\$7.92	
DRUGS & MEDICINES				
Per single period of confinement shall not exceed: A single period of confinement refers to a series of confinements/procedures for the same illness with the interval between such confinements not exceeding 90 calendar days within the calendar year. A member shall only be entitled for the remainder of the benefit ceilings set by PhilHealth for that period for drugs and medicines, x-rays, laboratories and others.				
a. Ordinary	PHP 1,500	PHP 1,700	PHP 3,000	Catastrophic illness refers to cancer cases with metastases requiring chemotherapy or radiotherapy, meningitis, encephalitis, cirrhosis of the liver, mycocardial infarction, cerebrovascular attack, rheumatic heart disease, renal failure, other conditions requiring dialysis or transplant, other conditons with massive hemorrhage, shock of any cause; and surgical procedures with an RVS of 20 and above.
	\$30	\$34	\$59	
b. Intensive	PHP 2,500	PHP 4,000	PHP 9,000	
	\$50	\$79	\$178	
c. Catastrophic	PHP 0	PHP 8,000	PHP 16,000	
	\$0.00	\$158	\$317	
X-RAY, LAB, ETC.				
Per single period of confinement				
a. Ordinary	PHP 350	PHP 850	PHP 1,700	Intensive illness refers to all confinementsrequiring services in an intensive care unit and other similar serious illnesses or injuries; and surgical procedure with an RVS of not more than 9.9.
	\$7	\$17	\$34	
b. Intensive	PHP 700	PHP 2,000	PHP 4,000	
	\$14	\$40	\$79	
c. Catastrophic	PHP 0	PHP 4,000	PHP 14,000	
	\$0	\$79	\$277	
PROFESSIONAL FEES				
Per single period of confinement shall not exceed:	PHP 150/day or \$3/day for General Practitioner			Ordinary illness refers to illnesses/injuries other than those specified as intensive or catastrophic.
	PHP 250/day or \$5/day for Specialist			
a. Ordinary				
General Practitioner	PHP 600	PHP 600	PHP 600	
	\$12	\$12	\$12	
Specialist	PHP 1,000	PHP 1,000	PHP 1,000	
	\$20	\$20	\$20	
b. Intensive				
General Practitioner	PHP 900	PHP 900	PHP 900	
	\$18	\$18	\$18	
Specialist	PHP 1,500	PHP 1,500	PHP 1,500	
	\$30	\$30	\$30	
b. Catastrophic				
General Practitioner	PHP 900	PHP 900	PHP 900	
	\$18	\$18	\$18	
Specialist	PHP 1,500	PHP 1,500	PHP 2,500	
	\$30	\$30	\$50	
OTHERS				
Operating Room				
a. RVU of 30 and below	PHP 385	PHP 670	PHP 1,060	
	\$8	\$13	\$21	
b. RVU of 31 to 80	PHP 0	PHP 1,140	PHP 1,350	
	\$0	\$23	\$27	
c. RVU of 81 and above	PHP 0	PHP 2,160	PHP 3,490	
	\$0	\$43	\$69	
Surgeon	Maximum of PHP 16,000/\$317			
Anesthesiologist	Maximum of PHP 5,000/\$99			
Compensable Outpatient Services:				
Ambulatory surgeries and procedures including dialysis, radiotherapy and chemotherapy				
TB DOTs				

Source: PhilHealth (Last Update: February 21, 2005)

2.1.1.5 Financing

PhilHealth has a contributory scheme. Each membership program has a defined contribution schedule.

2.1.1.5.1 Employed Sector

Contributions of the Employed Sector are equally shared by the employer and the employee equivalent to 2.5 percent of the monthly salary base. The minimum monthly salary range is PHP 4,000.00/US\$79.29 and with a maximum of PHP 25,000/US\$ 495 and above beginning 01 January 2006. The salary range has been revised at least twice since 2003. The salary ceiling will again be increased to PHP 30,000 (US\$ 594) starting January 2007. Salary ceiling is periodically raised to allow a more equitable share in contributions.

2.1.1.5.2 Individually Paying Programme (IPP)

Premium contribution for the IPP including all existing self-employed, voluntary, and overseas worker members of SSS is fixed at PHP 100 or approximately US\$ 2 per month. This can be paid on a quarterly, semi-annual or annual basis. According to PhilHealth, the premium contribution is fixed generally because there is no regular monthly compensation for which to base the contribution upon. The IPP is made under a voluntary scheme therefore they face the problem of high adverse selection. Majority of the target clientele of the programme falls under the less privileged sectors. Member shoulders the total amount of the premium contribution.

2.1.1.5.3 Sponsored Programme

The LGU and National Government through PhilHealth share the premium payments for the indigent population to be enrolled. Other government agencies and officials as well as private entities may also participate in the Sponsored Programme by paying the LGU counterpart. Donations to the Programme are fully deductible from taxation income.

The premium is discounted in accordance with the income classification of the LGU where the indigent enrollees reside. The premium discount is then paid for by the National Government. For LGUs that have difficulty in enrolling their indigent constituents due to budgetary constraints, they may tap other national government agencies (i.e. Philippine Charity Sweepstakes Office, Department of Agrarian Reform, etc.), legislative (i.e. congressmen, senators) and private entities in seeking financial assistance to pay for its annual premium counterpart.

The table below presents the schedule of premium contributions to the Sponsored Programme:

Table 5. Premium Contribution of Sponsored Programme

Schedule of Premium Contribution					
LGU Income Classification	YEAR	National Government Share		Local Government Unit Share	
		%	Php	%	Php
1 st to 6 th city and 1 st to 3 rd municipality	1st onward	50	600.00	50	600.00
4 th to 6 th municipality	1st and 2nd	90	1,080.00	10	120.00
	3rd	85	1,020.00	15	180.00
	4th	80	960.00	20	240.00
	5th	75	900.00	25	300.00
	6th	70	840.00	30	360.00
	7th	65	780.00	35	420.00
	8th	60	720.00	40	480.00
	9th	55	660.00	45	540.00
	10th onward	50	600.00	50	600.00
Source: IRR 2004, NHIP					

2.1.1.6 Provider Payment System

The National Health Insurance Act of 1995 allows fee for service, capitation, or a combination of both subject to a global budget as provider payment mechanisms. Payment of health care providers as of now is mostly on a fee-for-service basis particularly those services for in-patient care and ambulatory surgeries. Health care providers, professionals and institutions alike, go through a process of accreditation adhering to certain quality standards before they could participate in the NHIP.

As of December 2005, there are 1,574 accredited hospitals, 40% of which are government hospitals. To date, there are 20,843 accredited health care professionals, 38% of whom are in the National Capital Region. It is worth noting that more facilities are accredited to provide out-patient or ambulatory care. Almost 40% of

RHUs in the country are accredited to provide OPB Package including some that are capable of giving maternity care and administer TB-DOTS.

Table 6. Number of Accredited Health Care Providers

Professional Health Care Provider	
Doctors	20,843
General Practitioners	10,864
Specialists	10,357
Dentists	218
Midwives	87
Institutional Health Care Provider	
Hospitals	1,574
Government	607
Private	967
Ambulatory Surgical Clinics	27
Out-Patient Facilities	
Rural Health Units	919
TB DOTS Centers	108
Maternity Care Clinics	103
Free standing dialysis clinics	19

Source: PhilHealth Stats and Charts, December 2005.

The introduction of enhancements in the benefit package paved the way for the accreditation of other health care providers, professionals and institutions, such as midwives and lying-in clinics, midwife-managed clinics, birthing homes and RHUs for the Maternity Care Package; TB-DOTS centers and free-standing dialysis centers. The OPB Package for members of the Sponsored Programme ushered in the accreditation of RHUs as service providers which were later on expanded to cover other benefits like the TB-DOTS and Maternity Care Package.

The enhancements of the benefit package also allowed PhilHealth to test and move towards other forms of provider payment systems like case payments for TB-DOTS, Maternity Package, SARS & Avian Flu Benefit Package and capitation payments of RHUs through the LGUs for OPB Package.

2.1.2 Employees Compensation Programme (ECP)

2.1.2.1 Mandate

The Employees' Compensation (EC) program aims to assist public and private sector workers who suffer work-connected sickness or injury resulting in disability or death. It was created under Presidential Decree 626 and became effective on January 1975. It assures workers of total protection through the provision of a comprehensive benefit package encompassing preventive occupational safety and health aspects, curative or medical and compensatory grant, and rehabilitation of occupational disabled workers.

There are three agencies involved in the implementation of the Employees Compensation Program. These are: The Employees' Compensation Commission (ECC) which is mandated to initiate, rationalize and coordinate policies of the ECP and to review appealed cases from the GSIS and the SSS, the administering agencies of the ECP. GSIS and SSS are tasked to: evaluate all employees' compensation claims and pay the corresponding benefits; collect premiums remitted by employers; and manage the State Insurance Fund. Both agencies invest the funds in profitable ventures to generate earnings which will form part of the State Insurance Fund from where payments for employees' compensation claims are sourced.

2.1.2.2 Membership

All public sector employees covered by GSIS and all private sector employees covered by SSS are covered by the Employees Compensation Programme. They are entitled to benefits on their first day of employment. ECP benefits are granted only to members with employers other than themselves so self-employed and voluntary members of SSS are not eligible. This effectively renders the ECP inaccessible to informal sector workers.

The spouse, children not gainfully employed or parents can be beneficiaries of members upon his/her death.

2.1.2.3 Benefits

GSIS and SSS members receive the same benefits under the ECP. Benefits include: Medical services, appliances and supplies provided to the afflicted member beginning

on the first day of injury or sickness, during the subsequent period of his disability, and as the progress of his recovery may require. These benefits, however, are limited to the ward services only of an accredited hospital and physician. Rehabilitation services, consisting of medical, surgical and hospital treatment are also covered. The SSS and GSIS also provide a balanced program of remedial treatment for handicapped members.

Members are also entitled to income cash benefit for temporary total or partial disability or sickness, and death - a monthly pension is provided to the deceased member's primary beneficiaries, plus 10 per cent of such benefit for each of five dependent children.

Members could avail of ECP benefits together with other benefits of the SSS and the GSIS.

2.1.2.4 Financing

Only the employer is required to remit monthly ECP contributions on behalf of his employees. For the private sector, it is equivalent to one per cent of the employee's monthly salary credit. The required contribution ranges from PHP 0.25/US\$ 0.001 to PHP 10/US\$ 0.20 depending on the employee's salary with a maximum salary credit of PHP 1,000. The Government sector pay PHP 100 or US\$ 2 per member per month. No written justification can be found on the disparity of premium payment between private and government sector.

2.1.3 Social Security Program

2.1.3.1 Mandate

The Social Security Act (Republic Act 1161) was passed in 1954 that provided for a social security system for wage earners and low-salaried workers, which was finally implemented in 1957 after some amendments to the law. With the implementation of the Social Security Law, the government also adopted a social insurance approach to social security covering the employed segment of the labour force in the private sector.

On 1 May 1997, Pres. Fidel V. Ramos signed RA 8282, known as the Social Security Act of 1997, amending RA 1161. RA 8282 provided for better benefit packages, expansion of coverage, flexibility of investments, stiffer penalties for violators of the law, pardon of penalties of delinquent employers and the establishment of a voluntary provident fund for members.

The Social Security System (SSS) administer the Social Security Program. It basically provides financial benefits to qualified members to cover real life contingencies such as retirement, disability, death, maternity, sickness and employment-related injury that may result in income loss or financial burden.

2.1.3.2 Membership

All employees of private enterprises or establishments including Filipino sea farers are covered by the Social Security Program. Domestic helpers, self-employed persons such as professionals, entrepreneurs, actors, actresses, professional athletes, small farmers and fisher folks and those in the informal sector such as cigarette vendors, and watch-your-car boys, earning at least PHP 1000/US\$ 19.80 a month are also compulsorily covered.

Under a voluntary membership program, workers who are separated from work or ceased to be self-employed, OFWs, and non-working spouses of SSS members can also be members of the SSS.

The primary beneficiaries of a member are his or her dependent spouse, the dependent children. Validity of membership starts on the first day of employment for employed members or upon payment of first contribution for self-employed and

voluntary members. As a protection for employed members, they are still entitled to benefits even if their employers refuse to remit their contributions to SSS.

Of the 26.2 million SSS members as of December 2005, some 20.5% or 5.4 million are self-employed and voluntary members. It is in this group where workers of the informal economy are found. The top five categories of these informal sector workers are odd-job workers, market and sidewalk vendors, hand and pedal vehicle drivers, stall and market sales persons, and street ambulant vendors.

2.1.3.3 Benefits

Members are entitled to a package of benefits under the Social Security Program in the event of retirement, death, disability, maternity, sickness, old age, death and work-related injuries. The SSS provides for a replacement of income lost on account of the aforementioned contingencies.

The *maternity benefit* is a daily cash allowance granted to a female member who is unable to work due to childbirth or miscarriage. The maternity allowance is equivalent to 100 per cent of the member's average daily salary credit multiplied by 60 days for normal delivery or miscarriage, and 78 days for caesarean cases. Maternity benefits are available only to female members, up to four pregnancies. The main qualifying condition for eligibility to claim maternity benefits is at least 3 monthly contributions during the 12-month period prior to the semester of contingency.

The *sickness benefit* is a daily cash allowance paid to a member who is unable to work due to sickness or injury. The amount of an employee's sickness benefit is computed as a daily sickness allowance times the approved number of days. A member is eligible to receive sickness benefit if the following conditions are met: (1) the member has at least 3 monthly contribution within the 12-month period prior to the semester of contingency, (2) the member has been confined in the hospital or at home for at least 4 days, (3) the SSS has been notified, and (4) all sick leaves have been used up.

The *disability benefit* is a cash benefit paid to a member who becomes permanently disabled, either partially or totally. An SSS member is eligible to receive a monthly

pension if he has contributed at least 36 monthly contributions. If the member has less than the required number of contributions, he will receive a one-time lump sum payment equivalent to the monthly pension multiplied by the number of monthly contributions paid to SSS or the monthly pension times 12, whichever is higher. The minimum disability pension is set at PHP1,000/US\$19.80.

A summary of benefits from the SSS is presented in Table 7.

Special loan packages are also offered during calamity and emergency situations. SSS also offers housing and educational loans which are paid through salary deductions. Self-employed and voluntary members get the same benefits as employed members except those benefits under the EC program.

2.1.3.4 Financing

A Social Security Programme is a contributory scheme that has a contribution rate of 9.4% of a member's average monthly compensation not exceeding PHP 15,000 and payable by both employers (6.07%) and employees (3.33%). The minimum monthly salary credit is PHP1,000/US\$19.80 and the maximum is PHP15,000/US\$297 beginning January 2002.

For the self-employed and the voluntary member, the premium monthly contribution is fully shouldered by the worker and is based on the declared monthly compensation. However, the declared earnings should not be lower than PHP 1,000/US\$ 19.80 per month except for the OFWs whose lowest monthly salary credit is pegged at PHP 3,000/US\$59.40.

Table 7. Summary of SSS Benefits

MATERNITY	
Description	The maternity benefit is a daily cash allowance granted to a female member who was unable to work due to childbirth or miscarriage.
Eligible Members	<ol style="list-style-type: none"> 1. She has paid at least three monthly contributions within the 12-month period immediately preceding the semester of her childbirth or miscarriage. 2. She has given the required notification of her pregnancy through her employer if employed or to the SSS if separated, voluntary and self-employed member. 3. The maternity benefit may be given to a separated female employee provided that the female member was pregnant and has given the required notification prior to the date of separation from her employer. <p>A voluntary or self-employed female member is entitled to the maternity benefit, provided that she meets the qualifying contributions.</p>
Benefits	The maternity allowance is equivalent to 100 per cent of the member's average daily salary credit multiplied by 60 for normal delivery or miscarriage, 78 days for cesarean cases.
SICKNESS	
Description	The sickness benefit is a daily cash allowance paid for the number of days a member is unable to work due to sickness or injury.
Eligible Members	<p>A member is qualified to avail himself of this benefit if he or she:</p> <ol style="list-style-type: none"> 1. is unable to work due to sickness or injury and is thus confined either in the hospital or at home for at least four days; 2. has paid at least three monthly contributions within the 12-month period immediately before the semester of sickness; 3. has used up all current company sick leaves with pay for the current year; and 4. has notified his employer or the SSS, if he is a separated, voluntary or self-employed member. <p>A member can be granted sickness benefit for a maximum of 120 days in one calendar year.</p>
Benefits	The amount of an employee's sickness benefit is computed as: the daily sickness allowance times the approved number of days.
DISABILITY	
Description	It is a cash benefit paid to a member who becomes permanently disabled, either partially or totally.
Eligible Members/Beneficiaries	A member who suffers partial or total permanent disability, with at least one contribution paid to the SSS prior to the semester of contingency, is qualified.
Benefits	<p>Monthly pension: Cash benefit paid to a disabled member who has paid at least 36 monthly contributions to the SSS prior to the semester of disability. The pension will be suspended if the pensioner recovers from his illness, resumes employment or fails to report for physical examination when notified by the SSS. The monthly pension of a partially disabled member is limited to a certain number of months according to the degree of his disability.</p> <p>Lump sum: Amount granted to those who have not paid the required 36 monthly contributions.</p>
RETIREMENT	
Description	Cash benefit paid to a member who can no longer work due to old age
Eligible Members	<ol style="list-style-type: none"> 1. A member who is 60 years old and unemployed and has paid at least 120 monthly contributions prior to the semester of retirement. 2. A member who is 65 years old, whether employed or not. If employed he should have paid 120 monthly contributions prior to the semester of retirement, whether employed or not.
Benefits	<p>Monthly pension: Lifetime cash benefit paid to a retiree who has paid at least 120 monthly contributions to the SSS prior to the semester of retirement.</p> <p>Lump sum amount: Granted to a retiree who has not paid the required 120 monthly contributions.</p>
DEATH BENEFIT	
Description	Cash paid to the beneficiaries of a deceased member.
Eligible Members/Beneficiaries	The primary beneficiaries are the legitimate dependent spouse until he or she remarries and legitimate, legitimated, legally adopted or illegitimate dependent children of the member. In the absence of primary beneficiaries, the secondary beneficiaries are the dependent parents of the member. In their absence, the person designated by the member as beneficiary in his member's record will be the recipient.
Benefits	<p>Monthly pension: Granted only to the primary beneficiaries of a deceased member who had paid 36 monthly contributions before the semester of death.</p> <p>Lump sum: Amount granted to the primary beneficiaries of a deceased member who had paid less than 36 monthly contributions before the semester of death.</p>
FUNERAL GRANT	
Description	A funeral grant of PHP 20,000 is given to whoever pays the burial expenses of the deceased member or pensioner.

2.1.4 Commonwealth Act

2.1.4.1 Mandate

The Commonwealth Act No. 186 passed on November 14, 1936 provided social security benefits such as compulsory life insurance, optional life insurance, retirement benefits, and disability benefits for work-related contingencies and death benefits for government employees. The Government Service Insurance System (GSIS) was created and mandated by the same Act to administer the program. Various amendments have been passed, liberalizing the life, retirement, health and disability benefits schemes for government workers. Most recently, RA 8291 enacted on 24 June 1997, expanded and increased the coverage and benefits of the GSIS and provided for pre-need insurance, unemployment and separation benefits. Aside from increasing and expanding the social security protection of the government workers, it also enhanced the powers and functions of the GSIS to better respond to the needs of its membership.

2.1.4.2 Membership

The GSIS covers all government workers irrespective of their employment status – permanent, substitute, and temporary, casual or contractual – as long as they have an employer-employee relationship with the agencies they serve. It has an estimated 1.4 million members coming from the government's national and local agencies and offices. The GSIS also services the members' dependents and beneficiaries, the retirees and pensioners, and the survivors of the deceased members or pensioners.

Employees of the Armed Forces of the Philippines and Philippine National Police are not covered by the GSIS. These government workers are covered by the Armed Forces of the Philippines' Retirement and Separation Benefit System.

2.1.4.3 Benefits

The principal benefit package of the GSIS consists of compulsory and optional life insurance, retirement, separation and employee's compensation benefits. Life insurance benefits include disability, accidental death, burial assistance, death benefits and sickness income. Retirement and other social security benefits include unemployment insurance, separation benefits, pensions and survivorship allowance,

and disability. Similar to SSS, benefits of the Employees Compensation Program (ECP) are given to GSIS members who incur a work-related injury/accident or illness. Active GSIS members are entitled to the following loan privileges: salary, policy, emergency and housing loans.

GSIS does not cover absence from work due to pregnancy and delivery. But government through its agencies provides maternity benefits, as stipulated in the Labor Code, to government workers.

At present the GSIS has a Hospitalization Support Program launched in June 2004 that offers members and pensioners and dependents discounts on costs of hospitalization, medical procedures, professional fees and consultations from partner hospitals. These discounts are given after benefits from PhilHealth are deducted from the members' hospital expenses.

2.1.4.4 Financing

The employer and employee share in paying contributions to GSIS broken down as follows:

Table 8. Premium Contribution of GSIS members

Employee's Share	Employer's Share
9% of the Basic Monthly Salary for the first P16,000	12% of the employees' basic monthly salary
Additional 2% in excess of P16,000	12% of the employee's basic monthly salary

2.2 Community-based Social Protection Schemes

Community-based social protection schemes are defined as institutions that directly administer or facilitate the implementation of social protection mechanisms. These may be micro-insurance schemes, trade union-based schemes that directly administer schemes or civil society groups, trade organizations such as cooperatives, microfinance institutions or associations of workers that play intermediary roles between social security schemes and their members. In a study by Health Management Information System (HAMIS) project in the 1990s, these schemes are usually established to respond to unmet health care needs in the community which results from under-provision or under-utilization of health services. Under-provision occurs when there are not enough local health care providers in the community and transport to the nearest facilities is difficult. Underutilization may occur when section of the community cannot afford to pay for health care, do not know that health care is available and affordable, and do not recognize health conditions that require medical attention.

2.2.1 Typology of Community-based Social Protection Schemes

A number of community-based social protection schemes exist in the country. The German Technical Cooperation-Social Health Insurance (GTZ-SHI) project maintains a database of 35 community-based health care organizations (CBHCOs) which function either as or a combination of the following: health care service providers, administrative intermediaries with strong information, education and communication activities and health care financing schemes which have risk pooling and risk sharing arrangements. In 2004, the International Labour Office's Strategies and Tools against Social Exclusion and Poverty (ILO-STEP) developed an inventory of 41 micro-insurance schemes. Most of the results of the Inventory of Micro-insurance Schemes in the Philippines by ILO-STEP will be used, unless otherwise indicated, in the succeeding discussion on community-based social protection schemes. Table 9 provides the list of micro-insurance schemes from the ILO-STEP study.

2.2.1.1 Institutions Managing the Schemes

A community-based organization is the foundation of most micro-insurance schemes, whether as 'initiator' or as 'owner' once the scheme has been established.

Cooperatives and mutual benefit associations (MBAs) comprise more than half (59%) of the documented schemes in the ILO-STEP study. The study also found that while many of the schemes had their origins through other types of associations (micro finance projects, health care projects, NGOs), considerations of institutional sustainability and ‘critical mass’ (achieving sufficient numbers of members to ensure financial stability and continuity of operations) led many of the groups to adopt a cooperative-type of model of organizational structure and governance. The cooperative model supports the principle of community ownership and management, and community pooling of risk.

Schemes initiated by health-sector organizations (health management organizations (HMOs), health service providers, etc) seem to be smaller in size and more project-dependent than community-based initiatives. Schemes in the GTZ-SHI which had health sector initiated schemes, on the average would have 2,000 members but almost half (47%) of the schemes in the ILO-STEP study cover more than 5,000 members.

2.2.1.2 Level of Experience

Nearly half (41%) of schemes have been operating for more than 10 years, and 56% operating for more than seven years. Many of the documented schemes had their origins in micro finance projects being promoted by various NGOs and development agencies. As the micro lending activities of small community groups expand, a natural supplementary financial service frequently requested by members is insurance. Through the practices of the micro lending programs, members are familiar with regular savings and money management principles, and group discipline ensures regular collection of loan repayments and insurance premiums.

The Micro finance Council of the Philippines, an umbrella group of micro finance institutions, commented that programs on micro-insurance attracted the highest level of interest and participation by Council members. Grameen Bank replicators (such as CARD-MBA) have experienced increased rapid growth in membership once micro-insurance services are introduced to the micro-finance programs, as the network established through the micro finance programs facilitates easy affiliation by members (usually women borrowers). Officers of NOVADECI, a cooperative offering several social protection benefits, also reported that members are attracted into the cooperative because of the social protection benefits that they offer.

Although only a small portion of documented schemes are micro-finance institutions (MFIs), most of the cooperative groups are also engaged in micro-finance-type savings and lending programs.

2.2.2 Membership

The aggregate number of individual members / contributors currently active in the documented schemes totals 935,612. Number of beneficiaries cannot be accurately determined as policies were widely diverse between groups of schemes.

The members of micro-insurance schemes come from various backgrounds and occupational pursuits. One-third (33%) of the respondent schemes in the study covered members in the agricultural sector (farmers) while informal economy employment represented the next largest group (20%).

Among the informal sector respondents, the largest group was the retail sector, representing market vendors, food stall operators, and small sari-sari convenience-type retail stores. Not all organizations in the survey considered the informal sector as a target group – although there were members from the informal sector, many of the groups (particularly cooperatives) served members as members, regardless of occupation or economic activity.

2.2.3 Benefits

Micro-insurance schemes tend to limit their risk coverage to those identified needs of their members. This is supported by a finding of the GTZ-SHI study that 28% of the schemes changed their packages based on members' requests. Among schemes covered by the ILO-STEP study, many cover more than one risk, with various product options and premium plans; majority (36%) limited their risk coverage to not more than 2 risks (usually hospitalization and primary health care or life insurance).

Most of the schemes (66%) covered hospitalization, followed by life insurance (56%), maternal health care benefits (46%), and primary health care (34% of schemes). Maternal health care benefits cover expenses incurred during delivery only but none of the schemes offer cash payment for being absent from work due to pregnancy and delivery.

It is worth noting though that CBCHOs tend to provide health care services in areas where hospitals or clinics are not available. (GTZ-SHI)

2.2.4 Financing Mechanisms

Premiums range from ‘free’ (as in one case – Baao Community Cooperative, for their active members only) to a high of Php15,000 per annum for two of the larger cooperative groups (Cooperative Insurance System of the Philippines (CISP), and Cooperative Union of the Philippines). The majority of the schemes assess premiums of less than Php500 per year (less than USD\$10).

Popular assessment options include ‘Peso-per-day’ and schemes collecting premiums of Php20.00 per week (Php1,000 per year). In most cases, the premium option has a marketing appeal or is tied directly to a membership obligation in a savings-and-credit or solidarity group.

The larger and more developed schemes (MBAs, cooperatives) tend to have more options, and provide products that were available at fixed multiples of the ‘regular’ premium (e.g. CISP offers policy holders the option of purchasing up to 3 ‘units’ of coverage at an annual premium of Php.15,000 per unit).

Table 9. List of Documented Micro-insurance Schemes in the Philippines

Co-operatives		Mutual Benefit Association	
1	Angono Credit and Development Co-operative (ACDECO)	22	Philippine Public School Teachers Association (PPSTA)
2	Apalit Small Christian Communities Foundation	23	Praxis Fides Mutual Benefit Association, Inc
3	Asscom Multi-Purpose Cooperative, Inc	Microfinance Institutions	
4	Baao Parish Multi-Purpose Cooperative	24	ABS-CBN Bayan Foundation, Inc
5	Cavite Farmers' Credit Cooperative	25	Agricultural and Rural Development for Catanduanes, Inc (ARDCI)
6	Cooperative Insurance System of the Philippines, Inc (CISP)	26	Milamdec Foundation, Inc- Tibod
7	Claveria Agri-Based Multi-Purpose Cooperative	27	Negros Women for Tomorrow Foundation, Inc
8	Cooperative Union of the Philippines	28	Alalay Sa Kauswagan Sa Gitnang Luzon, Inc (ASKI)
9	Federation of Free Farmers Cooperatives, Inc (FFFCI)	29	Cebu Micro-Enterprise Development Foundation, Inc
10	First Community Cooperative (FICCO)	30	Community Economic Ventures, Inc
11	GMA Multi-Purpose Cooperative	31	FCB Foundation, Inc
12	Imus Vendors Development Cooperative	32	Jaime V Ongpin Foundation, Inc
13	Medical Mission Group Hospitals and Health Services Cooperative (MMGHHS)	Other	
14	Novaliches Development Cooperative, Inc (NOVADECI)	33	Bustos LGU – PhilHealth Project
15	ORT Community Multipurpose Cooperative	34	DAR Employees Association – DAREA Foundation, Inc
16	St Jude Multi-Purpose Cooperative (SJMPCC)	35	Provincial Government of Guimaras
17	Tarlac Health Maintenance Co-Operative (THMP)	36	Medicare Program II Scheme
18	Valenzuela Development Cooperative	37	Mercy Community Hospital
Mutual Benefit Associations (MBAs)		38	Norfil Foundation, Inc
19	Center for Agriculture and Rural Development-Mutual Benefit Association, Inc (CARD - MBA)	39	Notre Dame Business Resource Center Foundation, Inc
		40	Peso for Health Program
20	Coop Life Mutual Benefit Services Association, Inc (CLIMBS)	41	UP Diliman Health Maintenance Organization, Inc
21	Pambansang Kilusan Ng Mga Samahang Magsasaka (PAKISAMA)		

Source: Inventory of Micro-insurance Schemes in the Philippines, ILO-STEP

3 Linkages

Universal coverage is a common goal of both PhilHealth and SSS hence they have existing membership programs that would cover those that are not traditionally covered by statutory social security schemes. PhilHealth has the Individually Paying and the Sponsored Programmes while the SSS has mandatory coverage of domestic helpers, OFWs and the self-employed. Yet in spite of these programmes, there is a low coverage of workers particularly those in the informal economy.

The environment that facilitates linkages between statutory and community-based social protection mechanisms exists in the Philippines. The National Health Insurance Act and the Social Security Law specifically identify community-based organizations as partners in attaining universal coverage. There are also a number of community-based organizations that are organizationally mature and capable of delivering or facilitating insurance services.

At least eight (8) linkages are documented in this study. Variations may be present in schemes particularly those initiated by community organizations and/or local government units but it is assumed that they approximate those that are discussed in the study.

3.1 Linkage with PhilHealth

The National Health Insurance Act of 1995 provides for forging of cooperative arrangements with organized groups or community-based organizations to expand the coverage of social health insurance to all Filipinos⁷. It recognizes the role of CBHCOs as health care providers⁸, and as partners in expanding enrolment⁹ including premium collection and other activities¹⁰. PhilHealth has pilot tested at least two

⁷ Article 1, Section 2: It must be cognizant of the appropriate roles and respective strengths of the public and private sectors in health care, including people's organizations and community-based health care organizations

⁸ Article 2, Section 4: community-based health care organization, which is an association of indigenous members of the community organized for the purpose of improving the health status of that community through preventive, promotive and curative health services

⁹ Article 3, Section 7: all persons eligible for benefits as members of other government-initiated health insurance programs, community-based health care organizations, cooperatives, or private non-profit health insurance plans shall be enrolled in the Program upon accreditation by the Corporation which shall devise and provide incentives to ensure that such accredited organizations will benefit from their participation in the program

¹⁰ Article 5, Section 23: to supervise the conduct of means testing which shall be based on the criteria set by the Corporation and undertaken by the Barangay Captain in coordination with the social welfare officer and community-based health care organizations to determine the economic status of all households and individuals, including those who are indigent; and to tap community-based volunteer health workers and barangay officials, if necessary, for member recruitment, premium collection

models of partnerships with community-based organizations or organized groups¹¹ in the informal economy namely POGI and KaSAPI. These two schemes are the first of PhilHealth's initiatives to extend health insurance coverage to the informal sector through organized groups.

Other models of linkages initiated by community organizations, LGUs and other national agencies or non-government organizations also exist such as voluntary membership of community-based organizations, partial subsidy schemes or approaches to assist Sponsored Programme members become Individually Paying Members.

In addition to the above linkages, a representative of the Basic Sector of the National Anti-poverty Commission sits in as a member of the Board of Directors for the Philippine Health Insurance Corporation. The Basic Sector represents and works for the interests of the informal economy workers.

3.1.1 Organized Group Initiatives

As a commitment to a partnership with community organizations, PhilHealth has set up a Management Committee that shall oversee developments of schemes to effectively reach out to organized groups. They have pilot tested two schemes since 2003, POGI and KaSAPI.

3.1.1.1 PhilHealth Organized Group Interface (POGI)

PhilHealth Board of Directors approved the Board Resolution No. 569 (PBR 569) in June 2003 which allowed partnerships with organized groups on a pilot basis. The partnership, called PhilHealth Organized Group Interface (POGI), is seen as an innovative approach to reach out to workers in the informal economy through micro-credit cooperatives. POGI aims to institutionalize the partnership between PhilHealth and organized groups for the implementation of the NHIP by allowing cooperatives to act as marketing and premium collection agents of PhilHealth. Through this partnership, informal economy workers would have financial protection from illness

and similar activities, and to grant such workers incentives according to the guidelines set by the Corporation and in accordance with the applicable laws.

¹¹ Organized Group (OG) is the term used by PhilHealth to refer to any legally registered organization of informal sector with an authorized government regulatory body, with the aim of promoting social protection/social health insurance to its members such as a micro finance institution, a cooperative, a non-government organization and credit union, among others.

as well as access to quality health care services. The initiative was tested with six (6) cooperatives in Cavite province and five (5) cooperatives in Southern Leyte province.

POGI and similar initiatives with organized groups falls under the Individually Paying Program of PhilHealth.

3.1.1.1.1 Institutions Involved

A total of eleven (11) multipurpose cooperatives participated in the pilot implementation of POGI. Most of the cooperatives offer credit facilities to their members but not many offer any social protection benefits. Collectively, cooperatives that participated in POGI have a total membership of 17,037, 8,317 of whom come from Cavite and 8,720 are from Southern Leyte. On the average, the cooperatives have 1,500 members each with a low of 500 and a high of 3,456. Approximately 30% to 50% of the members are in the employed sector or are dependents of formally employed workers. Those in the informal economy are farmers, vendors, transport operators, traders and small entrepreneurs.

PhilHealth's central office was the overall administrator while the PhilHealth Regional Offices together with its Services Offices in the municipalities oversee operations at the field level.

The provincial LGU of Cavite was involved in POGI during the initial negotiations with the cooperatives but unsettled differences prompted the LGU to withdraw its support. However in spite of the absence of the LGU in the project, cooperatives opted to continue its partnership with PhilHealth. Municipal LGUs' participation in POGI is limited to being health care providers through the RHU of the Out-Patient Benefit Package.

The project in Southern Leyte is supported by the Social Health Insurance component of the Unified German Support to the Philippine Health Sector (GTZ-SHI)¹². Aside from providing assistance in the pilot's implementation, GTZ SHI conducted a market study in April 2003 among five municipalities in Sogod, Southern Leyte to understand and gather the profile the informal economy in a rural area of the Philippines which became the basis for the marketing plan of the project. The United

¹² The Social Health Insurance component is commonly referred to as 'GTZ-SHI'.

States Assistance for International Development (USAID) extended its support to the cooperatives in Cavite and PhilHealth Regional Office for Region IV-A during its initial implementation phase.

3.1.1.1.2 Mechanics of the Partnership

Cooperatives were assessed based on the Performance Standards for Philippine Credit Cooperatives and Other types of Cooperatives¹³ (COOP-PESOS) which provided information on the cooperatives' governance, management and organizational structure as well as their financial performance. Cooperatives were categorized based on an overall rating (Group A, Group B, and Group C) that determined the activities which they could perform for PhilHealth; premium payment schedule by members, and the type of benefits that members could avail of. Cooperatives have the prerogative to determine the collection system from its members. Aside from 2 cooperatives that got funds to pay for premiums from members' cash dividends or savings, all of the cooperatives that participated in the pilot study offered a loan facility to pay for the premium payment especially those from Category A. As a result, a POGI member can be charged with an interest rate of 1.5% to 2.0% per month (18% to 24% per year) and a service fee for the special PhilHealth premium loan.

Groups A and B cooperatives can perform marketing and premium collection on behalf of PhilHealth while Group C cooperatives are only required to perform marketing functions. Incentives are given to the cooperatives based on the number of new members enrolled to the NHIP and amount of premium payment remitted to PhilHealth.

Table 10. Categories of Cooperatives under POGI

	Group A	Group B	Group C
COOP-PESOS Rating	70 - 100%	45 - 69%	20 - 44%
Activities	Marketing Enrollment Premium Collection	Marketing Enrollment Premium Collection	Marketing
Benefits	All PhilHealth benefits plus OPB Package	All PhilHealth benefits	All PhilHealth benefits

¹³ Developed by the Technical Working Group comprising of representatives from the Department of Finance, National Credit Council, Credit Policy Improvement Project, Cooperative Development Authority, Bangko Sentral ng Pilipinas, Philippine Deposit Insurance Corporation, Land Bank, National Confederation of Cooperatives, Philippine Federation of Credit Cooperatives, Cooperative Union of the Philippines, National Market Vendors Confederation of Cooperatives, Federation of Peoples' Sustainable Development Cooperatives and the Credit Union Strengthening Project in Davao and National Cooperative Movement.

Premium Payment Schedule	Annual Only	Annual Semi-annual Quarterly	Annual Semi-annual Quarterly
Incentives	Marketing: PHP 10 per new member enrolled Collection: 3% of total annual premiums remitted or 2% of total semi-annual or 1.5% of total quarterly premiums remitted	Marketing: PHP 10 per new member enrolled Collection: 3% of total annual premiums remitted or 2% of total semi-annual or 1.5% of total quarterly premiums remitted	Marketing: PHP 10 per new member enrolled

Source: POGI Guidelines

Members enrolled under POGI are entitled to all the benefits accorded to any PhilHealth member. Members from Group A cooperatives are also entitled to the OPB Package on condition that they pay their premiums on an annual basis. The cooperative has the option to choose a PhilHealth accredited private or public provider for the OPB Package.

Table 11. Information on POGI Cooperatives and Members Covered in the Pilot Study, as of June 2005.

<i>Cooperative</i>	<i>Location</i>	<i>Category</i>	<i>POGI Members</i>	<i>Total Membership</i>	<i>Enrollment Rate</i>
CAFFMACO	Cavite	A	191	1008	19%
CAFFCO	Cavite	B	64	1000	6%
GMAMPC	Cavite	A	62	1000	6%
SAJOWASEDEC O	Cavite	B	58	3456	2%
IMCC	Cavite	A	79	1340	6%
IVEDECO	Cavite	B	62	513	12%
SUBTOTAL Cavite			516	8317	6%
BONTOC MPC	S. Leyte	A	367	2819	13%
HCMPC	S. Leyte	A	117	2665	4%
SPPMPC	S. Leyte	A	75	1553	5%
LAMP	S. Leyte	B	94	724	13%
SILAMPCO	S. Leyte	C	92	959	10%
SUBTOTAL S. Leyte			745	8720	9%
TOTAL			1261	17037	7%
Assumption: 50% are non-NHIP beneficiaries				8518.5	15%

3.1.1.1.3 Experiences in the Scheme's Implementation

3.1.1.1.3.1 Members

According to most leaders of the cooperatives participating in POGI, members are motivated to join the program because of the Out-Patient Benefit Package; a fact that is confirmed by one of managers even after almost three years of implementation.

However, POGI was only able to cover at most 15% of the cooperatives' total membership and there was also a low re-enrolment rate. Low turnout could be due to (1) the lack of awareness of the benefits of social protection particularly health insurance, (2) inflexibility of payment schedule, (3) low financial protection, and (4) the presence of another program, Plan 5 Million, that directly competed with POGI for members.

Low awareness on PhilHealth's program and benefits of the NHIP simply due to the lack of proper information. In a study by GTZ, a farmer said that he had heard of the program but did not understand it since it was never explained to him. Not knowing their rights as members may also be a reason for low awareness on the programme.

Inflexibility of payment schedule was also cited as a reason for a low turn out especially among Groups A and B cooperatives. It seems that income and savings patterns do not match PhilHealth's payment schedule. Cooperatives had to resort to a premium loan to facilitate membership to POGI which resulted to an increased burden for members. Cooperatives charged 1.5% to 2.0% per month as interests in addition to service fees which effectively increased premium to PHP 1,416 to PHP 1,448 per year. There was a high delinquency rate among those who availed of the premium loan facility. Financing premiums through savings or through members' dividends would have been more effective as shown by two (2) cooperatives in Cavite and Southern Leyte. A flexible payment schedule like a monthly or quarterly basis prove to be easier for members.

Financial protection for POGI members is quite low due to high out-of-pocket payments with a considerable portion spent on medicines. High out-of-pocket payments were also aggravated by unregulated pricing practice of health care providers. With a low financial protection, members are less satisfied making it more difficult to encourage members to enrol and retain their membership in PhilHealth through POGI.

However since membership through POGI is voluntary, the scheme is very prone to adverse selection. Based on the data from PhilHealth Regional Office IV-A for the year 2004, utilization rate for in-patient care among POGI members in Cavite was

eight percent (8%), a rate higher than the national average of 3.9% among IPP members.

Another factor that could have affected membership is the massive campaign for Plan 5 million which was launched a few months after POGI was offered to cooperatives in the provinces. Plan 5 million was meant to cover the poorest families through a complete subsidy from the national government. Cooperatives had to compete with Plan 5 million which offered health insurance coverage for free.

3.1.1.1.3.2 Cooperatives

The cooperatives are keen to provide their members with health insurance coverage because they understand that (1) illness is a risk in the members' lives and leaders would want to offer these members some protection during unexpected times of need, and (2) healthy members could mean lower delinquency in payment of members' obligations thereby improving the business performance of the cooperatives. However all of the cooperatives expressed the need for more assistance from PhilHealth in promoting the program to their members by scheduling information campaigns during assemblies and meetings. They need to receive a lot of assistance especially in promoting the NHIP during the initial years of partnership.

The partnership also increased administrative cost for the cooperatives which had to set up a different system to facilitate registration, collection and payment of premiums. The need to study and incorporate additional functions as a PhilHealth partner into existing cooperative management systems is apparently needed. It is recommended that a more efficient marketing strategy, registration of members, collection of payments and other administrative tasks should be explored. An effective and efficient management information system could reduce administrative cost both for the organized groups and PhilHealth and at the same time improve policy decision making.

Classifying the cooperatives and limiting their functions proved ineffective. In practice cooperatives perform functions that they were not supposed to under their category like collecting premiums on a quarterly or monthly basis for Groups A and B. It also caused confusion among accredited RHUs because they could not identify which members are eligible for the OPB and which are not.

3.1.1.1.3.3 Health Care Providers

As health care providers specifically for the Out-Patient Benefit Package, the LGUs are in favour of the program because of the capitation payment they would receive. However there is a need to monitor the flow of funds from the LGU to the RHU and analyze expenditure using the capitation funds. There were no documents that could track utilization of OPB package in both provinces but POGI members from Cavite reported that they did not avail of health care services from RHUs because of (1) the perception that RHUs provide poor quality service; (2) geographic locations of RHUs were very far from their areas of residences. At the same time, RHUs did not have any initiative to advocate for newly introduced program for POGI members.

Group A cooperatives have the option to negotiate with private clinics to provide the Out-Patient Benefit Package as long as these providers satisfy quality standards established by PhilHealth. Initial negotiations were done with the out-patient department of a private hospital but PhilHealth and the management of the hospital could not agree on the capitation payment for the set of services enumerated. There was apprehension on the part of the hospital management for over utilization of services putting their finances in jeopardy.

3.1.1.1.3.4 LGUs

The provincial LGU of Cavite was initially interested to participate in POGI. However, its involvement in the pilot study is highlighted by promises that could be not fulfilled such as a complete or partial subsidy of premiums, and arrangements that are not within the bounds of POGI. Hence the LGU of Cavite decided not to be involved at all. Its non-participation was somehow showed intentions of the cooperatives for social protection of its members. No cooperative from Cavite withdrew from the partnership in spite of the LGUs absence.

The role of LGUs as enforcer of the NHIP is not adequately explored in POGI. They could have been another avenue to expand coverage of informal sector workers by requiring all registered community-based organizations to enrol its members to PhilHealth.

3.1.1.1.3.5 PhilHealth

The partnership also brought to the fore the need to increase the capacity of PhilHealth staff to provide technical guidance and supervision to health care providers, LGUs, and cooperatives on the POGI initiative manifested as slow registration process, inability to adopt or modify existing procedures to accommodate the cooperatives' needs and requirements, inability to negotiate with private health care providers for the OPB and create a more effective marketing strategy to increase awareness of the NHIP. The ILO-GTZ-WHO consortium recommended that PhilHealth and its Regional Offices to (1) strengthen their administrative capacity by improving their knowledge on community-based organizations or organized groups, (2) consider existing social services being offered by the organized groups as entry points to promote the NHIP, and (3) strengthen their knowledge on the foundations of social health insurance.

3.1.1.1.4 Updates on the Scheme

PhilHealth's Executive Management Committee decided to terminate POGI on June 2005 based on the results of the ILO-GTZ-WHO evaluation and on the understanding of Board Resolutions that PhilHealth cannot implement two schemes reaching out to the informal economy simultaneously. The PhilHealth Circular terminating the scheme was only released in September 2006 which allowed the cooperatives to continue accepting members for POGI until the circular was issued.

KaSAPI, PhilHealth's new scheme to provide the informal sector access to the NHIP, targets community-based organizations which have at least 1,000 members who will be qualified as PhilHealth beneficiaries. This criterion prevents some cooperatives under POGI from participating in KaSAPI, due to their small membership size. Two options are presented to the cooperatives: (1) they could merge and register under one cooperative to reach the minimum number of eligible members or (2) they can enrol members through the IPP which does not entitle them to any incentive or premium discounts.

A cooperative in Southern Leyte decided to represent smaller cooperatives to be able to participate in KaSAPI. But other cooperatives which are faced with a challenge to finding other cooperatives with the same or similar goals, vision and mission have decided to continue its participation in the NHIP through the IPP.

The assessment of POGI is done better by comparing it with KaSAPI since the two models are closely related. Comparison of POGI and KaSAPI discussing their strengths, advantages, weaknesses and disadvantages will be discussed later in the document.

3.1.1.2 Kalusugang Sigurado at Abot-Kaya sa PhilHealth Insurance (KaSAPI)

Recognizing the need to improve on POGI that tried partnership with micro-credit cooperatives, PhilHealth passed Board Resolution no. 719 in September 2004 to explore collaboration with larger organizations such as micro-finance institutions and bigger cooperatives. The new model, called Kalusugang Abot Kaya sa PhilHealth Insurance or KaSAPI, offers a discounted premium, when a group of a minimum level is enrolled under a contract with PhilHealth. KaSAPI was launched in September 2005 and it is being pilot tested in seven (7) regions namely Regions I, III, IVA, VIII, X, XI and XIII. Activities such as marketing the program, recruitment and enrolment of members together with improvement of processes and systems within PhilHealth have been ongoing.

3.1.1.2.1 Institutions Involved

There are three (3) microfinance institutions, four (5) cooperatives and one (1) rural bank that currently participate in KaSAPI. All community-based organizations offer credit facilities to its clients with a strong foundation on micro-finance. Some organizations offer social protection benefits like life insurance, provident funds for retirees, funeral grants and loan protection plans.

Similar to the institutional arrangements of POGI, PhilHealth's Central Office is the overall administrator while the PhilHealth Regional Offices together with its Services Offices in the municipalities oversee operations at the field level.

The LGUs are not involved in the implementation of the project. The OPB Package is not included anymore among the benefits of KaSAPI.

GTZ-SHI is the only donor agency that supports the project. It has contributed to the development of marketing and promotional materials, development of information technology systems, refinements of the concepts and principle underlying the project

and capacity building of PhilHealth staff to understand and respond to the needs of the informal economy better. Most of its activities were geared towards responding to needs and weaknesses identified during POGI's implementation. Other donors like the European Commission, World Bank and the Asian Development Bank do not directly support the project but has endorsed or included KaSAPI as part of their programmes in the Philippines.

3.1.1.2.2 Mechanics of the Partnership

Community-based organizations or Organized Groups are assessed by PhilHealth in terms of the size of its membership; type of clientele – majority of their members should be from the informal sector; and organizational and financial stability. PhilHealth has simplified its evaluation criteria and has ceased on classifying organized groups.

An organized group should have at least 1,000 members who are qualified for enrolment under the Individually Paying Program. The group size is determined by subtracting from the total number of members the number of current beneficiaries of the NHIP. Currently, determining the group size is still the subject of much discussion; indigent population and dependents including retirees are inadvertently included in the target population. As a result, organized groups need to reach a higher enrollment to qualify for a premium discount and at the same time they would be competing with the LGUs which target the indigent population for the Sponsored Programme.

Qualified organized groups act as marketing and collecting agents of PhilHealth after they undergo training on the mechanics of partnership as well as on the National Health Insurance Program.

An organized group will qualify for the group premium rate if at least seventy percent (70%) of the group size is enrolled in PhilHealth. A lower premium rate will apply if an organized group enrolls eighty-five percent (85%) of its group size. Achieving majority coverage is aimed at minimizing adverse selection which is very prevalent in PhilHealth's IPP. It was also designed that the premium rate will vary depending on the payment schedule: annually, semi-annually or quarterly. However PhilHealth's Management Committee has required that all organized groups should pay an annual

premium to qualify for group premium rate which eventually made it difficult for groups to source financing for the premium. Realizing the difficulties that organized groups face in sourcing for financing the annual premium payment and with fewer organizations willing to participate under KaSAPI, PhilHealth's Management Committee allowed a more flexible premium schedule after almost nine (9) months of implementation.

Premium rates are determined through a group band which is a premium schedule based on the mode of payment, the group size and the percentage of members enrolled in PhilHealth.

Members of KaSAPI are considered under the Individually Paying Program and they are entitled to all benefits accorded to all members of the NHIP except the OPB Package which is a special benefit of Sponsored Program members. Learning from POGI, PhilHealth also made sure that there are accredited health care providers that are accessible to the target population. However, unlike POGI, there are no opportunities for KaSAPI members to avail of the Out-patient Benefit Package.

Table 12 shows the premium schedule of KaSAPI.

3.1.1.2.3 Experiences thus Far

3.1.1.2.3.1 Members and Organized Groups

Five (5) groups signed up as PhilHealth partners immediately after KaSAPI was launched, namely; CARD MBA which is a mutual benefit association of CARD Bank and has almost 150,000 members nationwide; TSKI is a microfinance institution operating in and around the Visayas Islands with a total membership of almost 50,000; and three cooperatives in Region VIII with a total membership of almost 20,000. Since KaSAPI is a pilot study, it is valid for organized groups to limit its initial implementation to contain any damage if there are any problems in the design or partnership.

All groups tried to limit its group size by concentrating on specific geographic locations or on specific member classifications such as length of membership, type of occupation and value of assets in the organization. However, even with a minimum group size of 2,000, most groups cannot reach 1,400 members. Reaching a minimum

of 70% of the determined group size is necessary before an organized group qualifies for a group premium discount.

Based on discussions with managers of the different organized groups, members do not register under the program because of (1) difficulty producing documentary

Table 12. Premium Schedule

Mode of Payment Annual					
Group Size	Percent of Members Enrolled	Band	Group Premium		
			One-Year	Annual Premium	3 Quarters Premium
4000 & up	85%	8A	1,083	1,083	816
	70%	7A	1,089	1,089	820
3000-3999	85%	6A	1,094	1,094	825
	70%	5A	1,100	1,100	829
2000-2999	85%	4A	1,106	1,106	834
	70%	3A	1,112	1,112	838
1000-1999	85%	2A	1,117	1,117	842
	70%	1A	1,123	1,123	847
Mode of Payment Semi-Annual					
Group Size	Percent of Members Enrolled	Band	Group Premium		
			One-Year	Semi-Annual Premium	
4000 & up	85%	8S	1,094	547	
	70%	7S	1,100	550	
3000-3999	85%	6S	1,106	553	
	70%	5S	1,112	556	
2000-2999	85%	4S	1,118	559	
	70%	3S	1,124	562	
1000-1999	85%	2S	1,130	565	
	70%	1S	1,134	567	
Mode of Payment Quarterly					
Group Size	Percent of Members Enrolled	Band	Group Premium		
			One-Year	Quarterly Premium	
4000 & up	85%	8Q	1,104	276	
	70%	7Q	1,112	278	
3000-3999	85%	6Q	1,116	279	
	70%	5Q	1,124	281	
2000-2999	85%	4Q	1,128	282	
	70%	3Q	1,136	284	
1000-1999	85%	2Q	1,140	285	
	70%	1Q	1,148	287	

requirements especially for beneficiaries or dependents of members, (2) the PHP 100 per month or PHP 25 per week for premiums is an added burden to members, (3) uncertainty on the type and quality of service that they will receive from PhilHealth

especially during utilization of benefits and (4) free membership in the NHIP through the LGUs or legislators. The second and third concerns, which could be related – members do not perceive the quality of service as commensurate to the premium that they pay - cannot be responded to directly or immediately by PhilHealth. The quality of service that accredited health care providers give cannot be directly controlled by PhilHealth. The possibility of free membership under the Sponsorship Programme has become a disincentive for members to pay. Aside from being influenced by politics, the Sponsored Programme does not distinguish between informal sector workers who fall within the indigent population and those who can afford to pay the full or partial premiums of the IPP. There is an inherent weakness in the means test¹⁴ being used by PhilHealth.

There is also a wait and see attitude that prevails among members. Experiences in the past of other PhilHealth members or the member himself or herself could also influence the decision to participate. Complex claims processes and slow reimbursements of expenses paid by members and low support value contribute to the uncertainty on the level of protection that PhilHealth could provide.

However in spite of relaxing rules on documentary requirements, all of the community-based organizations still cannot achieve majority coverage of the determined group size. Some of the organized groups like CARD MBA and TSKI enrolled members under the IPP which does not entitle them for any group discount. To assist groups further in reaching at least 70% of the group size, PhilHealth has assisted succeeding organized group partners in setting the group size at the minimum of 1,000 qualified members. Currently two (2) of the organized groups that recently joined KaSAPI has reached the minimum enrolment of 700 members which qualified them for a group premium rate.

The move to put the group size at a minimum to 1,000 and disregard how it was determined or how members are registered would definitely increase PhilHealth's enrolment of the informal sector but at the same time defeat the purpose of minimizing adverse selection. PhilHealth may also need to go back to organized groups that registered their members under IPP and discuss possible options to be

¹⁴ PhilHealth has plans to modify the existing means test tool in identifying the poor.

able to avail of a premium discount. This would create an environment of trust and transparency among partners.

3.1.1.2.3.2 PhilHealth

As an agency that is embarking on an initiative to expand coverage to the informal sector, PhilHealth has met unexpected as well as controlled challenges. The willingness to adopt its systems and rules to needs and standards of organized groups merits commendation. As an example, it has relaxed its documentary requirements to ease registration of informal sector members who most often do not have necessary civil registrations; it has even worked with organized groups to reach the minimum level of enrolment to qualify for a discount.

However there is a need to revisit management processes in order to facilitate timely decision making. Most of the modifications in the design of KaSAPI came too late to satisfy the needs of partners and even PhilHealth Regional Offices in the field.

3.1.1.3 Assessment of POGI and KaSAPI

3.1.1.3.1 Successes

POGI and KaSAPI have worthy accomplishments, among them are:

Political will to forge a partnership with organized groups. Even if it is written in the National Health Insurance Act, it took PhilHealth almost nine (9) years to forge a partnership with organized groups. It was fortunate that PhilHealth has leaders who have the fortitude to break away from its traditional ways of dealing with the informal economy. POGI, in spite of its many shortcomings, has paved the way for other forms of linkages with community-based social protection mechanisms. PhilHealth is now committed to continuously develop linkages until it can find the most appropriate measures to reach out to the informal sector.

POGI and KaSAPI made participation to the NHIP more accessible to informal sector workers. Organized groups are social institutions that have given informal sector workers access to financial services such as savings, credit and insurance, access to information and appropriate technology and the opportunity to participate in decision-making. By forging a partnership with organized groups, PhilHealth has brought the National Health Insurance Program to somewhere familiar to informal

sector workers. It became accessible to get information on the NHIP, register and pay contributions to PhilHealth.

Trust is built between partners. Organized groups exist for their members. Most, if not all, of their programs and projects have the best interests of their members or clients in mind. By signing in as a partner of PhilHealth, organized groups are sending signals to its members that the agency managing the National Health Insurance Program are trustworthy and sincere to extend their services. There is a consequent ownership of the program on the part of organized groups.

On PhilHealth's part, POGI and KaSAPI have somehow reduced apprehension among its managers on the inability of organized groups to promote and be partners in implementation of the NHIP. No organized group has abandoned the program in the middle of its implementation in spite of the many difficulties encountered.

A management information system for informal sector workers was developed. A difference in the implementation of POGI and KaSAPI is the presence of a management information system for members registered under KaSAPI which was not available in POGI. The KaSAPI Management Information System (KMIS) is supposed to facilitate registration and premium collection including tracking sustainability of membership, utilization of benefits and the like which would have eased administrative requirements for the organized groups. At present, the KMIS is undergoing enhancements to accommodate needs and other requirements of the organized groups as well as those of PhilHealth.

KaSAPI has gained support from other agencies. Appreciating the plan to expand coverage of the informal sector through the organized group and at the same time address the problem of adverse selection, KaSAPI has gained the support of other donor agencies like the World Bank, European Union and Asian Development Bank.

3.1.1.3.2 Challenges

The implementation of POGI and KaSAPI encountered many difficulties in the field. But these difficulties served as challenges to PhilHealth for them to improve further. The following are some of the complexities encountered in the field:

Low percentage coverage of the target population. POGI set the minimum number of new enrollees to 50 members per cooperative regardless of its membership size which resulted to at least 7% coverage of the cooperatives' total membership. KaSAPI has likewise experienced a low interest among members of organized groups to register in PhilHealth. Most of the organized groups especially those that signed in as partners during the earlier part of the project could not get the minimum 70% of a determined group size. Reasons such as complex registration requirements, premium that is too costly, uncertainty of the type of service that members could receive from PhilHealth and health care providers which may include the low financial protection offered by the programme, contributed to the low turn out of members. PhilHealth even has a problem dealing with programmes that competes for the same target population such as Sponsored Programme and KaSAPI or POGI.

Voluntary membership has exposed PhilHealth to high adverse selection. A voluntary social health insurance is prone to adverse selection, a problem that PhilHealth would soon has to face. Making membership to POGI and KaSAPI voluntary has exposed them further to high adverse selection. GTZ-SHI has started to look at how membership through organized group can be made compulsory under the organized group initiatives of PhilHealth.

Increased efficiency by collaborating with organized groups has not been realized. One of the reasons for collaborating with organized groups is to achieve administrative efficiency for PhilHealth. Instead of negotiating with almost 19 million informal sector workers, organized groups could serve as their representatives thereby reducing administrative cost and achieve efficiency. However due to the low turn out, there is not much difference between administration of the IPP and POGI or KaSAPI.

Table 13 shows a comparison of POGI and KaSAPI and summarizes some issues that have occurred or been responded to by changes in the design of the projects.

Table 13. Comparison of POGI and KaSAPI

	POGI	KaSAPI	Issues / Remarks
Objectives	Increase and sustain membership of informal sector through organized groups and expand informal sector's access to quality health care; develop innovative marketing strategies targeting the informal sector.	Boost enrollment and sustain membership in the informal sector; implement an alternative payment scheme to encourage OGs to partner with PhilHealth; limit adverse selection; strengthen solidarity and risk sharing.	
Target Organizations	Multipurpose Cooperatives	Bigger Community-based Organizations/Organized Groups such as microfinance institutions, cooperatives, mutual benefit associations with a minimum number of qualified members of 1,000.	KaSAPI expanded partnership to other organized groups. But limiting number of qualified members to 1,000 prevented smaller organized groups to participate in KaSAPI. The challenge of finding others that have the same goals and mission rest on the organized groups.
Institutions Involved	Health care providers – hospitals for in-patient care; RHUs for OPB Package LGUs – as managers of RHUs, initially as possible contributor to premiums of members from Cavite Donors: GTZ-SHI (Southern Leyte), USAID (Cavite)	Health Care providers – hospitals for in-patient care, RHUs, TB-DOTS Centers, Dialysis Centers for special benefit packages Donors: GTZ-SHI	The potential of working with LGUs to expand coverage of informal sector is not explored.
Mechanics of Partnership	Cooperatives are evaluated using the COOP-PESOS and limited functions of cooperatives based on this evaluation.	Organized groups are evaluated using simplified criteria. Classification of organized groups was disregarded.	New evaluation criteria are an improvement from POGI's evaluation criteria. It was also concluded that the COOP-PESOS is not a good basis to assess the cooperatives' capacity to act as financial intermediaries for PhilHealth.

	POGI	KaSAPI	Issues / Remarks
	Cooperatives get incentives for every new enrollee into NHIP and for premium collected.	Organized groups are entitled to a group premium discount based on a minimum number of enrollees, group size, and mode of payment.	Group premium discount seemed to be a better motivation than incentives for registration and premium collection under POGI. The group premium discount is also seen as an incentive that could increase re-enrollment rate which was very low with POGI.
	PhilHealth and Cooperatives negotiate with LGUs for OPB Package		
Benefits Package	All benefits accorded to IPP members plus OPB Package for those members who belong to a Class A or Class B (depending on mode of payment) cooperatives.	All benefits accorded to IPP members. OPB Package was removed as an incentive.	Removal of OPB Package runs counter to the findings of the ILO-GTZ-WHO Consortium. However, PhilHealth needs to justify the OPB Package's continued implementation since no appropriate evaluation of the programme was done yet. But during KaSAPI's implementation, there are more providers for maternity and TB-DOTS packages which also respond to health care needs of members particularly the poor.
Premium Schedule	Annually for Class A Cooperatives Annually or Semi-annually for Class B cooperatives Quarterly, Semi-annual, Annual for Class C cooperatives	Initially PhilHealth allowed only annual mode of payment but most organized groups could not enter into a partnership because of stiff financial requirements hence relaxing the rule of payment to quarterly, semi-annually and annually.	PhilHealth's willingness to reverse its original decision signified its sincere intentions to expand coverage to the informal sector.

3.1.2 Voluntary Membership of Community-based Organizations

PhilHealth's Individually Paying Programme opens the possibility of the self-employed and those not regularly covered by the NHIP to participate. Initially targeting individual enrollees, some cooperatives, people's organizations and workers' associations have begun paying their members' premium through the IPP. According to some PhilHealth staff, these organizations are usually market vendors and tricycle drivers' associations who might have heard of the NHIP from the information campaigns by PhilHealth in public markets and transportation stations. Unfortunately, PhilHealth has not documented such practice over the years so the names and number of organizations involved including the extent of coverage through this type of arrangement could not be determined. There are at least two (2) PhilHealth Regional Offices that can confirm the presence of such practice.

Recently, PhilHealth has recognized community-based organizations as collecting agents. NOVADECI, a cooperative of 28,000 members in Metro Manila, and CCT, an NGO with microfinance functions with 30,000 members nationwide, have signed up as partners. As partners, community-based organizations serve make enrolment and paying premiums as well as information on PhilHealth more accessible to members. Under the IPP, members can pay on a monthly, quarterly, semi-annual or annual basis. KaSAPI's database system for membership will also be used by these community-based organizations, which shall facilitate enrolment, premium payments, monitoring membership and utilization of benefits.

CCT became a partner of PhilHealth because they were interested to offer health insurance coverage to their members but could not afford the stiff requirement of annual premiums under KaSAPI. NOVADECI on the other hand could not participate in KaSAPI because the pilot study is limited to certain geographic locations. There is also an on-going debate among PhilHealth managers on the effectiveness of providing incentives or premium discounts to community-based organizations. Some believe that even without any incentives, community organizations are going to facilitate enrolment of their members because NHIP could improve their members' overall welfare.

Under this arrangement, the community-based organizations are not entitled to any incentives or premium discounts but they do not have any obligations to enrol majority of their members which exposes PhilHealth to adverse selection. However, members enjoy a more flexible payment schedule making the NHIHP more accessible and affordable to informal sector workers who do not have a regular source of income.

PhilHealth has only begun collecting data on this linkage by monitoring the number of community-based groups voluntarily enrolling their members and formally entering into a partnership with the community organizations. Eventually, PhilHealth needs to assess the different schemes extending coverage to the informal sector to find the most effective and efficient linkage with community-based social protection mechanisms.

3.1.3 Partial Subsidy

The Implementing Rules and Regulation of PhilHealth, 2004 Rule IV Section 29 allows a partial subsidy scheme that may be adopted for indigents who are proposed to be enrolled by the LGU or premium donor/s but do not qualify for full subsidy under the means test rules. The premium share of a partially subsidized member should be based on the ability to pay a portion of the annual NHIP premium as determined by PhilHealth. However PhilHealth has not issued any guidelines for the partial subsidy scheme and as a result several variations, though not labelled as partial subsidy, were developed by LGUs, other national agencies, community-based organizations and the private sector.

3.1.3.1 Partnership between LGUs and Community Members

LGUs like some municipalities in Laguna and Nueva Ecija require members of the Sponsored Programme to pay a portion of the LGU's premium counterpart for PhilHealth's Sponsored Programme. The share of community members in the premium is arbitrarily determined by the LGUs. The LGUs also identifies community members who can avail of the program making the scheme very prone to political influences or affiliations.

In this scheme, the poor or those who can pay a portion of the premium have access to the subsidized premium for the Sponsored Programme. According to some LGUs

that implement such a scheme, it gives the poor a sense of dignity and pride making them active participants in a government programme. It also allows the LGUs to support more indigents under their jurisdiction. In Nueva Ecija where the Municipal Mayor implemented such scheme, the LGU purposely improved health facilities such as the RHUs and BHS to show its constituents that their contributions go back to the community in the form of better service.

Similar to the voluntary membership of community-based organizations through the IPP, PhilHealth does not have any documentation of such practices in the field. They cannot account for the number of members who have benefited from such an arrangement, number and names of LGUs implementing such a scheme or how community members perceive this kind of program.

3.1.3.2 Partnership between LGUs and Community-based Organizations

Community-based organizations like cooperatives or workers' associations or people's organizations have collaborated with LGUs so they could participate in the NHIP through the Sponsored Programme of PhilHealth. These groups would usually negotiate with LGUs so they could pay for or a portion of the LGU's counterpart premium in the Sponsored Programme.

At present, there are two (2) documented or at least known cases of such an arrangement, the Mangloy Multipurpose Cooperative in Compostela Valley, Mindanao and Bigao Small Farmers' Cooperative in Carmen, Bohol which collectively have approximately 2,000 members. These community-based organizations are cooperatives that participated in the DAR-AP Program¹⁵ of the Department of Agrarian Reform. DAR-AP is a program of DAR that aims to provide agrarian reform beneficiaries access to quality and affordable health services through a health micro-insurance scheme. It is the intention of these cooperatives to expand health insurance coverage of their members through PhilHealth complemented by their own micro health insurance schemes.

¹⁵ The Department of Agrarian Reform (DAR) launched the "DAR Agraryong Pangkalusugan" (DAR-AP) to strengthen basic support mechanisms for Agrarian Reform Beneficiaries (ARBs) through the development and maintenance of community-based health insurance schemes in the agrarian reform communities (ARCs). This program aims to provide ARBs with access to quality and affordable health care services as one of the necessary support services towards improved productivity.

Members of micro-insurance schemes covering a variety of risks are more receptive to programs that could expand their protection against contingencies in life such as illness. Management systems like collection, payment premiums, and monitoring are also in place resulting to minimal additional administrative cost to the cooperative or health micro-insurance scheme. Indigent members or even those who are not qualified as indigents but are willing to pay a portion of the premium also have access to a lower premium through the an this arrangement with the LGU.

This linkage proves advantageous for LGUs as well. Since members are participating through the Sponsored Program, the LGU could avail of the Out-patient Benefit Package of PhilHealth entitling them to a capitation payment which the LGU in turn can use to improve health care services at the community level. Accreditation of RHUs could also mean an expanded benefit package for PhilHealth members such as the TB DOTS and maternity package. LGUs could also sponsor more indigent members in the community.

However this type of linkage still has to see its culmination. In one cooperative, the LGU of Carmen, Bohol has not agreed to the proposal. It seems that the LGU needs to understand PhilHealth's system better and appreciate its benefits to the LGU and its constituents. The LGU of Laak, Compostela Valley on the other hand was amenable to the proposal but did not deliver on its promise to improve its RHU for it to be accredited by PhilHealth as an Out-Patient Benefit Package provider. It also suffered from migration of health care workers to other countries; the Municipal Health Officer resigned from his post because of a more rewarding post outside of the country.

For both situations, the presence of another agency like DAR or PhilHealth's Regional Office that could serve as an intermediary in the negotiations could have helped in the finalizing the partnership. These agencies could explain better the NHIP to local executives and even to community-based organizations or health micro-insurance schemes.

3.1.4 Savings for PhilHealth Premiums by Agrarian Reform Beneficiaries

The Department of Agrarian Reform (DAR) in partnership with PhilHealth has a program called “Greater Medicare Access sa Bayan Aniham” (Greater Medicare Access for Agricultural Communities) that aims to explore different strategies in extending health insurance coverage to agrarian reform beneficiaries. This program is studying four (4) models to determine the most appropriate scheme for agrarian communities: a health micro-insurance scheme or DAR-AP, a model linking PhilHealth and health micro-insurance scheme, PhilHealth’s Individually Paying Program and Sponsored Program. Among the four, linkage between health micro-insurance and PhilHealth is the only model that has not been designed yet. But negotiations and attempts at a partnership by cooperatives under DAR-AP and the LGUs towards access to the National Health Insurance Program could be considered as a starting point.

In the last two models, DAR serves as a facilitator for agrarian reform beneficiaries to become members of PhilHealth through its IPP and Sponsored Program. Propelled with a goal of building self-reliant communities, DAR is pilot testing a project wherein members in PhilHealth’s Sponsored Program are shifted to the Individually Paying Program through a saving scheme.

3.1.4.1 Institutions Involved

DAR got the assistance of Glaxo-Smith-Kline Pharmaceutical Company to sponsor premium payments of 1,000 agrarian reform beneficiaries from three (3) provinces, namely Pangasinan, Davao del Norte and Compostela Valley, in 2005. Members are enrolled under the Sponsored Programme of the LGUs. In turn, cooperatives where these beneficiaries belong to, set up a saving scheme for their premiums the following year. Under this scheme, the LGUs can also apply as Out-Patient Benefit Package Provider hence receives capitation payment for each indigent member enrolled.

3.1.4.2 Assessment of the Scheme

The project has not yet been assessed but the plan has attracted other cooperative members even if they are not sponsored by Glaxo-Smith-Kline to join the savings scheme. A savings scheme eases the burden of paying premiums as scheduled by

PhilHealth which do not necessarily coincide with members', particularly informal sector workers', income patterns. For example, agricultural workers earn minimally during planting seasons which limit their ability to pay for the monthly or quarterly contributions. This approach somehow verified the findings of POGI's evaluation that the better way to finance premium payments is through savings together with easy contribution schedule.

A subsidy sometimes becomes necessary for organized groups whose members do not have enough assets such as savings or a regular income source to pay for PhilHealth contributions. The subsidy could ensure that individuals still gain access to essential services without incurring additional expenses. Tax credits to private enterprises that support the Sponsored Programme certainly increased the capacity of LGUs to support more indigent population access to social health insurance.

Yet the approach of "Savings for Premiums" does not allow beneficiaries to be totally dependent on donors. Aside from savings, DAR supports enterprise development by providing access to capital, appropriate technology and information, physical infrastructures and markets; building social structures like community organizations that shall ensure participation and build local capacities; and establishment of community-based social services like health care, education, safe water supply and the like. DAR's development approach has looked at issues on land tenure, employment, social dialogue, social protection and access to basic services.

Private institutions or enterprises subsidizing premiums of indigent population to PhilHealth would certainly assist those municipalities that do not have fiscal space to cover increased expenditure on health care. It is often seen that lower class municipalities that have more indigent population could not finance membership of all indigent population to the NHIP because of limited finances. However, a more active partnership with the LGU should be explored. LGUs could enforce registration to the NHIP of members of organized groups. Their role as provider of health care being managers of RHUs should also be monitored with the purpose of improving quality of care.

3.2 Linkage with SSS

3.2.1 Easy Payment System

Aside from the private sector view that SSS contributions are additional costs for the employer and cuts on the take-home pay for employees, additional factors inhibit the participation of informal sector workers. A survey in the mid-1990s shows that among the reasons are: activities are too small, no need for coverage, lack of time, lack of information, lack of regular employment, and difficulty in contacting the SSS contribution collector. A more recent survey added the following: the perceived burden of a one-time monthly payment of the SSS contribution, and the transportation and opportunity costs incurred in the process of remitting.

To address the difficulty of the one-time monthly payment, the SSS launched a pilot payment scheme in coordination with the Philippine Savings Bank and the Development Bank of the Philippines. An informal sector worker opens a savings account with any of the said banks, and deposits small amount even on a daily basis that would accumulate into his/her monthly contribution. The pilot payment scheme was launched in May and June of 2002 in nine branches.

The project was implemented on a pilot basis in selected five cities of Metro Manila: Caloocan, Las Piñas, Manila, Muntinlupa, and Pasay. DOLE oversees the overall implementation of the project. To date, there are less than 3,000 workers in the informal economy registered as SSS members under the “easy - payment scheme”. When the project was launched, there was an on-going campaign by government to clear streets of sidewalk vendors that adversely affected their income contributing to the low turnout of enrollees. Uncertainty and irregularity of income is a reality that informal sector workers live with.

Sustaining the monthly contributions proved to be a difficult task for the informal sector as well. In the period from August 2002 to January 2003, the number of informal sector workers who accomplished remittance dropped from 67% to 33%. The main culprit, according to the workers themselves, was the amount of time they lost as they remitted the contributions.

To overcome problems of having each informal sector worker remit his/her payment to the bank everyday, some people's organizations such as PATAMABA¹⁶, Angono Rizal, took it upon themselves to collect contributions from members which they deposit to the individual accounts of each members everyday.

3.2.2 Cooperatives as Collecting Agents

The Social Security Act of 1997 empowers the SSS Commission to authorize duly registered cooperatives to act as collecting agents with respect to their members. Through this provision, concrete possibilities for different informal sector groups are made available for them to become members of the SSS.

Through the vigorous advocacy of the Trade Union Congress of the Philippines and its close collaboration with the SSS, guidelines have been drafted towards accrediting cooperatives as collecting agents.

Under such scheme, cooperatives can do the following:

- Facilitate membership registration with the SSS
- Collect and remit contributions and loan re-payments

These are roles normally played by employers on behalf of their employees. A role that the cooperatives may not want to perform, however, is to provide a counterpart similar to that which the employers provide.

¹⁶ PATAMABA is an association of home-based workers, most of whom are women.

Table 14. Table Guidelines on Accreditation of Cooperatives/Associations as Collecting Agents of the SSS

A. Requirements for Accreditation	
1.	Certificate of registration with the Cooperative Development Authority (CDA) or Securities and Exchange Commission (SEC)
2.	Certificate of updated remittances with the SSS contributions and loan amortizations
3.	Registry of members submitted to the CDA or SEC
4.	Articles of Cooperation for cooperatives or Articles of Incorporation for associations
5.	Audited financial statements for the past three years
6.	Annual report (duly filed with the CDA/SEC) about the cooperative/association's affairs for the past three years
7.	Secretary's Certificate on Board Resolution authorizing the cooperative/association to enter into agreement with the SSS and the authorized signature thereof
B. Criteria for Accreditation	
In order to be accredited, a cooperative/association must:	
1.	Be registered with the CDA/SEC
2.	Be an SSS member of good standing (both with respect to contributions and loan amortizations)
3.	Have a full-time manager and a duly bonded accountable officer
4.	Have conducted valid general assembly meetings for the past three years.
5.	Have its administrative, management, and financial records in order and audited for the past three years

Source: SSS Corporate Planning and Policy Office

While the SSS is committed to fulfilling this provision, negotiations have moved slowly. This is attributed to the apprehension that many cooperatives do not yet have the required stability and track record to guarantee the safety and regularity of contribution remittances. SSS officials would prefer that these cooperatives and associations also be subjected to strict guidelines approximating those required, for example, of rural banks which include a requirements of net assets of at least 5 million pesos and the absence of any past due obligation with the Bangko Sentral ng Pilipinas (Central Bank of the Philippines) or with any government financial institution.

Still this option presents a potentially workable mechanism to expand the coverage and reach of the SSS surmounting to some extent the problems of traceability and physical accessibility of the collecting agent. Both SSS and interested cooperatives are challenged to design a responsive mechanism that would make SSS accessible to the public while at the same time protecting members' contribution and continued viability of such a scheme.

4 Findings and Recommendations

The growing number of informal sector workers poses a challenge to SSS and PhilHealth in achieving their goal of universal coverage. Partnerships between community groups, private institutions and government social security agencies are considered as one of measures to extend social protection coverage to the informal sector.

There are at least eight (8) documented linkages between PhilHealth and SSS and community-based social protection mechanisms. Most of the schemes are tested and/or practiced by PhilHealth. The following are some suggestions to improve existing partnerships:

4.1.1 Assess all existing linkages

PhilHealth has at least six (6) types of linkages which are either initiated by PhilHealth, by organized groups or by other agencies or institutions. The number of linkages is indicative of the level of interest different institutions on social health insurance.

However PhilHealth has to start taking stock of all these approaches and assess the most effective, efficient, and equitable and appropriate ways to extend health insurance coverage to the informal sector. The assessment should also look at motivating factors for participating in the National Health Insurance Programme, access to quality care, as well as needs of PhilHealth, the institution and the staff, to be able to respond to intricacies and nuances of the informal sector better. Consolidating information and assessing these linkages together may be more effective than looking at each approach independent of one another.

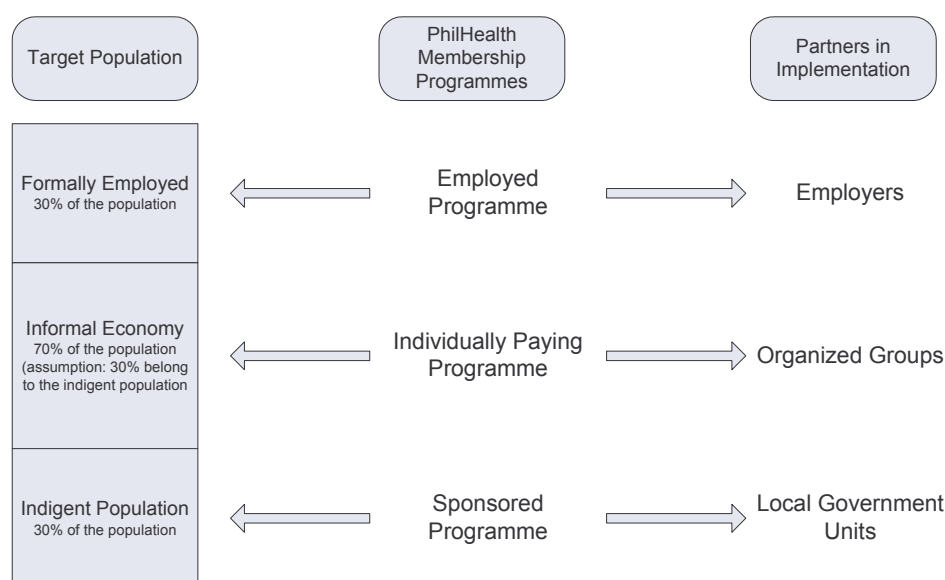
The SSS on the other hand can learn from the experiences of PhilHealth especially in establishing a partnership with community-based organizations.

4.1.2 Integrate approach for the informal sector and the indigent population

PhilHealth segments its target population into the employed sector, the self-employed where the informal sector falls, and the indigent population which consequently has three membership programmes namely: Employed Sector,

Individually Paying and Sponsored. Premiums are automatically deducted from the employed sector's salary by employers. The LGU is PhilHealth's partner in covering the indigent population through a premium subsidy shared with the national government while the organized groups on the other hand are slowly gaining trust as the partner in expanding coverage to the informal sector.

Figure 1: PhilHealth Membership Programmes



However based on experiences with schemes to expand health insurance coverage, the Sponsored Programme and initiatives with organized groups such as POGI and KaSAPI have always competed for the same target population. The means test tool is often mentioned as a very poor instrument in screening the poor. PhilHealth is now studying a better instrument to screen the poor. However the line dividing the informal sector and the poor are also vague. Most if not all of the informal sector workers slide in and out of poverty due to shocks experienced in their lifetime.

There are merits in letting the LGUs work with organized groups in extending coverage to the informal sector. Some of them are:

- a) It will reduce the possibility of including members of the community who are capable of paying for their premiums therefore allowing the LGUs to provide subsidy to the poorest of the poor;

- b) LGUs can enforce coverage of all members of organized groups by requiring that all members of organized groups participate in the NHIP before the organized group is duly registered with the LGU;
- c) There are indications showing the willingness to pay by some informal sector but they could not afford the full premium of PHP 1,200 of Individually Paying Members. The LGUs and the organized groups can identify members who would need partial subsidies which may be sourced from private organizations or government agencies. And since organized groups' main goal is to remove people from poverty through access to financial services and assistance to markets, LGUs and organized groups can agree on a gradual reduction of subsidy. Working closely with organized groups also provides the LGUs information on the needs of informal sector workers.

Incentives mechanisms for both LGUs and organized groups may have to be designed to encourage a more active participation to the National Health Insurance Program.

4.1.3 Continue working with organized groups

Organized groups or community-based organizations are social institutions where informal sector workers have access to support services that are necessary in improving households' productivity and income. Through these types of organizations, informal sector workers have access to credit, savings and insurance facilities.

Extending social health insurance and social security coverage through the organized groups is more efficient than individually targeting informal sector workers. Organized groups make these services more accessible and therefore also affordable because they reduce the time lost from work to register as members, pay for premiums and get information. PhilHealth has somehow refined screening criteria that identify stable and reliable organizations from which SSS could benefit from.

Social protection is a human right however workers in the informal economy are beyond the pale of statutory social security programs. Collaboration between the private sector specifically through community-base social protection mechanisms and

statutory social security schemes is imperative to extend coverage to the informal economy. Current initiatives have not reached majority of the informal sector workers which further supports the need to continue exploring better and more effective measures.

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