Philippine Institute for Development Studies

Case Study of Community Health Financing in Region XI

Institute of Primary Health Care

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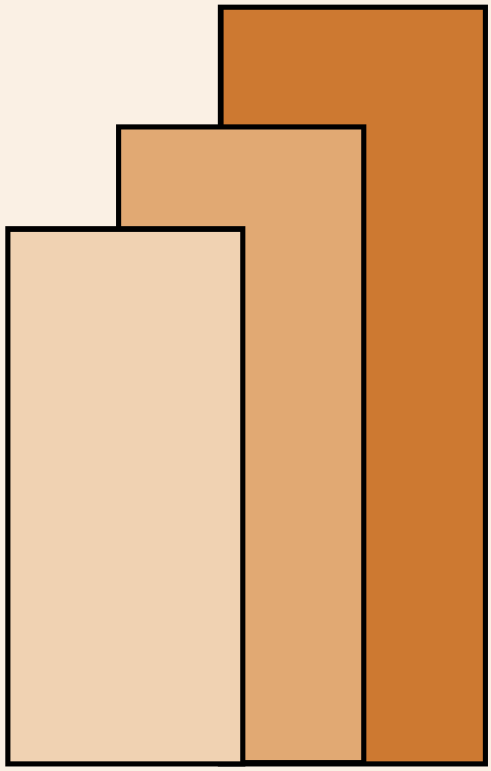

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CASE STUDY
OF
COMMUNITY HEALTH FINANCING
IN REGION XI

MAIN REPORT

Submitted to:

PHILIPPINE INSTITUTE FOR DEVELOPMENT STUDIES

Submitted by:

Institute of Primary Health Care-Davao Medical School Foundation

and the

Development Academy of the Philippines

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LIST OF ABBREVIATIONS

AADP	Accelerated Area Development Program
BHS	Barangay Health Station
BHWs	Barangay Health Workers
CBHP	Community Based Health Program
CBHS	Community Based Health Services
CDA	Cooperative Development Authority
CFDC	Cooperative Federation of Davao City
CHFA	Community Health Financing Association
CHF	Community Health Fund
CHILD	Community Health through Integrated Local Development
CHO	City Health Office
CRB	Cooperative Rural Bank
DMSF	Davao Medical School Foundation
DOH	Department of Health
FHSIS	Field Health Service Information System
GOs	Government Organizations
HFS	Health Financing Scheme
IPHC	Institute of Primary Health Care
IPHO	Integrated Provincial Health Office
KC	King Cooperative
KsK	Kapunungan sa Kasakit
LDAP	Local Development Assistance Program
LGUs	Local Government Units
MACHEVCC	Malalag Community Health Volunteers Credit Cooperative
MGLF	Medical Guaranty and Loan Fund
MHO	Municipal Health Office
MMGHHSC	Medical Mission Group Hospitals and Health Services Cooperative
NESAHHA	New Sambog Health and Hospitalization Assistance
NGOs	Non-Government Organizations
PBSP	Philippine Business for Social Progress
PHO	Provincial Health Office
PMCC	Philippine Medical Care Commission
QLC	Quality of Life Circle
RESPOND	Region Eleven Response to People's Organizations National Development
RHM	Rural Health Midwife
RHP	Rural Health Physician
RHU	Rural Health Unit
SDF	Social Development Fund
SHIELD	Sustained Health Improvement through Expanded Local Development
SNHH	Sto. Niño Helping Hands

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Non-HFS Communities

Lagao:

Tambobong:

EXECUTIVE SUMMARY

Two important policy developments in the Philippines provide a strong basis for focusing attention to self-initiated health endeavors. One is the implementation of the Local Government Code of 1991 which involves the devolution of a broader range of powers and responsibilities of the national government to the local government units and regional offices of national line agencies. The other is the current thrust of the Department of Health (DOH) in striving to attain its vision of **Health for All Filipinos by 2000 and Health in the Hands of the People by 2020**, a key strategy being espoused in the propagation of community-managed health care.

The Case Study of Community Health Financing in Region XI Project is intended primarily to look into the existing health financing schemes of communities in the region, particularly on the factors that enable them to set up a sustainable self-managed system whereby they can generate resources to finance the health services needed by their members.

While much debate has ensued over the viability of community-based health financing schemes as an alternative source of financing the ever-growing need for health care services, much has yet to be learned of it. This study attempts to provide baseline data on the factors and processes that enabled the setting up of these schemes, as well as, the initial outputs and impact they may have made.

MAJOR FINDINGS

The baseline survey conducted by the study revealed 48 organizations in Region XI are operating community-based health financing schemes. Four methods of fund sourcing were found: (1) personal pre-payment, (2) income generation, (3) *ad hoc* contribution /fund-raising and, (4) drug sales. Some of the organizations employ more than one method.

Personal pre-payment is an insurance type system wherein contributions from individuals and households are made in advance of service need. A scheme under this system may require one-time payment and/or regular contributions. The income-generating type of fund sourcing involves commercial activities which may be health-related and non-health related. These activities are conducted to help finance health care. Under some schemes, drug sales are used as a method of raising income. In general, drugs are sold with a mark-up, but the price is usually kept well below the market price. Other schemes employ *ad hoc* contributions. These contributions are made at the time of need.

Membership fees, one-time payment for the general fund, installments on capital share, regular weekly or monthly contributions, income from the village drugstore and even fines from members who fail to attend meetings make up the bulk of the organizations' funds.

Most of the schemes found operated at the barangay level with memberships mainly made up of the residents of the catchment area. Membership size range from 7 to over 1,000.

Groups with members over 100 are multi-purpose cooperatives which offer, among others, health benefits.

The schemes of 7 organizations were selected for further study from among those identified in the survey. These organization are: **Malalag Community Health Volunteers Credit Cooperative** or **MACHEVCC** (Income-generating scheme); Sto. Niño Helping Hands or **SNHH** (Pre-payment and Ad hoc contribution); **New Sambog Health and Hospitalization Assistance**, NESAHHA (Pre-payment and Ad hoc contribution); **Medical Mission Group Hospital and Health Services Cooperative** or **MMGHHSC** (Pre-payment); King Cooperative (Pre-payment); **Barangay Health Workers Federation of Tacul** (Drug sales and Income-generating); and **Kapunungan sa Kasakit** (Pre-payment).

Motivating Factors for Setting-up Schemes. Almost all of the work done in initiating the schemes are founded on the local residents' strong sense of volunteerism, cooperation and desire for self-help activities in the community. The initiative to set-up a scheme is especially heightened if a community structure or organization which facilitates the members' interaction is already present. More so if income-generating projects able to sustain such a scheme are already in place in the organization.

It was also observed that a scheme tended to work out and is sustained if at its inception, local officials were already actively involved in promoting it among local residents. The results are especially encouraging when non-government organizations (NGOs) join hands with the local officials in carrying out their programs.

It is also observed that schemes tend to take off among communities where BHWs take active role in the implementation of health-related activities and programs. It is noted that most of the BHWs are women.

Processes in Setting-up the Health Financing Scheme. Four of the organizations in the case study, namely: MACHEVCC, SNHH, NESAHHA, and the Barangay Health Workers Federation of Tacul, were all offshoots of projects of the Institute of Primary Health Care (IPHC). One of the requirements for IPHC-assisted communities was to apportion part of their social development funds (SDF) for health-related purposes. Two schemes opted to build up the SDF from profits derived from livelihood undertakings, while the other two created their own schemes with the help of LGU officials who took part in the organization of the community prior to setting up the scheme. In one case, it was the officials themselves who drafted the organization's constitution-and-by-laws.

The King Cooperative started out as an informal association among employees of a government office to put up a mortuary aid in 1967. Over the years it evolved into a multi-purpose cooperative which offers health assistance as part of its many services. The MMGHHSC was formed by a group of medical practitioners who initially put up a clinic which evolved into a cooperative hospital. The group now accepts non-medical professionals as member-cooperators. To generate income, it started a health insurance scheme called the Cooperative Helth Fund (CHF) in 1991 which extends free outpatient and inpatient services to subscribers.

The "Kapunungan sa Kasakit sa Barangay" was initiated by the residents headed by the Barangay Captain to build up a mortuary aid. Eventually, medical loans were made available to members using the general funds of the organization.

Health Service Structure. Unlike the scemes in IPHC-assisted communities, the MMGHHSC and the King Cooperative in Davao City have accredited medical professionals as providers of curative health care services. The MMGHHSC is a pioneer in setting up a cooperative hospital.

Similar to social insurance type of schemes, the King Coop has prime hospitals in the city accredited under its Medical Guarantee and Loan Fund (MGLF) where members are able to avail of accredited hospital services immediately without requiring any cash deposit. Another is that of a medical assistance of up to P2,000 but not more than the claimant's capital share where the latter either undergoes an operation or is treated due to an accident.

For the MMGHHSC, members can avail of free hospital services and medicine at the cooperative hospital for any illness as long as it is not pre-existing, much like that of any social insurance type of scheme.

In contrast, health funds in the rural communities are utilized only for cases which are emergency in nature or those which necessitate hospitalization. The difficulty of accessing hospital-based health care due to geographical constraints has encouraged both government and non-government health field workers to make use of inexpensive traditional medicine or self medication. The schemes, especially those run by BHWs, offer supplementary services like primary or preventive care which are aligned with government health programs and simple curative care like administering first aid.

Risk-pooling Among Members. The sharing of risk in terms of resources contributed by recipients is more pronounced in the CHF and the one-time pre-payment and ad hoc contributions of SNHH because of the wider scope or coverage of benefits compared with the other schemes.

Impact of the Health Financing Scheme

Health Status. Most of the respondents perceived an improvement on the health status of their families. The reasons behind this, however, are varied. Most of the respondents in the rural areas attributed the change to the adoption of preventive care measures taught by the BHWs which form part of the government's field health services. Others pointed out that the children in the family are past the stage when they are most susceptible to childhood diseases. Still others indicated the increase in the level of health services utilization brought about by the benefits derived from the financing scheme and/or from other health insurance policies they have enrolled in. Some, however, have indicated that they did not perceive any significant change in their health status with the presence of the scheme.

Health Service Utilization. For rural-based schemes, as in the case of most IPHC-assisted communities, the pooled resources has increased the opportunity for members to consult and to seek treatment from professional health practitioners about their illnesses. The financial assistance extended is rather limited though due to fund constraints. Other members would have to wait for the funds to be replenished before loans can again be granted.

Some officers and managers of the schemes observe that some members tend to be abusive in that they seek services repeatedly even for the slightest suspicion or symptom of illness.

One officer of the MMGHHSC even said the concept of free total health care seems to have a negative side to it in that its psychological impact on members is to 'over-use' their privileges. While the CHF has the largest resource base among all schemes covered, members are still encouraged to declare their Medicare so as not to deplete the fund.

Health-seeking Behavior. Most respondents say they have gained confidence to seek the services of professional medical practitioners and to have sick members confined at the hospital, if necessary, with the benefits derived from the scheme. With the joint efforts of both government and non-government personnel carrying out health and education programs in the communities, the members' consciousness on maintaining good health has improved. However, for the BHWs, it is rather difficult to isolate their responses from other influences since one of the incentives they receive is that of free hospitalization for the health services they render in their communities.

Access to Health Services. In general, all members have equal opportunity to avail of the services offered by the schemes. The limitations include having unpaid loan accounts or contributions (for IPHC-assisted communities) and the size of the funds so that there is not enough money for all members if they get sick at the same time. Contributions made are not pro-rated according to the income earned although for the CHF rates differ only in so far as the room preferred (private or ward) is concerned.

Where secondary and tertiary services are concerned, however, rural-based communities are still at the disadvantage due to geographical constraints with most facilities located in or near the urban centers.

Problems in Operationalizing the Schemes. Some critical issues affecting the success of the schemes include (1) the lack o self-help initiatives among members, (2) financial sustainability, and (3) the need to maintain a relatively high level of commitment from members in terms of effort and resource pooling.

Communities which are able to maintain the members' sense of commitment and spirit of volunteerism tended to be more successful in setting up the schemes. The involvement of local officials or acknowledged local leaders also reinforces the efforts pooled to set up the schemes.

Also, as most schemes are geared towards curative treatment, schemes tended to work out for the communities if members are able to contribute their share regularly. Needless to say,

the presence of successful income-generating activities that supplement the present means of earning income helps in sustaining the level of funds pooled.

LIMITATIONS

Suggested Model. While the study was originally intended to come up with a suggested model of an alternative community-based financing scheme, most schemes found appeared to be still in their 'evolutionary' stage where present approaches remain experimental and have been operationalized only for a very short period of time i.e. less than two years. Thus, it may be too early to make an accurate assessment on the efficiency and effectiveness of the schemes as they have yet to firm up and stabilize. This includes having clear targets, goals and policies, among others as well as clear and concrete data which can be used as evaluation measures.

Data. The retrieval of the necessary data for analysis and evaluation encountered problems even during the baseline survey due to the lack of absence of systematized recording and documentation. Primary data even were unreliable in some cases since no document could support them and some informants gave contradicting responses.

POLICY RECOMMENDATIONS

Community-based health financing schemes provide a critical service to the community. Accordingly, because of their capability to mobilize local resources and promote volunteerism, as well as, cooperation of households at the village level, their development should be nurtured by the government. Policies therefore that promote and enhance the effectivity and sustainability of community-based health financing schemes should be formulated and implemented. These policies may include, among others, the following:

1. Promotion of efficient/economic scale size community-based health financing schemes.

   Most of the schemes are located in rural-based barangays and comprise a minimum of twenty households. Unless these schemes increase in size or are organized to become federation(s), their sustainability and effectivity will be difficult to maintain. Local and national government therefore should provide support to enable these schemes to expand their coverage. This support may come in the form of subsidy and training.

2. Networking community-based health financing schemes with the existing health system.

   The community-based health financing schemes offer an effective mechanism for government health services and programs to reach a wider clientele. Linking the community-based health financing schemes therefore to existing health services and programs should be given top priority. This link-up may be more cost effective compared to providing health services under the present set-up. The fee for a service

system, for example, may be looked into as a means of supporting schemes as this can be a source for remunerating present health workers.

3. Capacity building requirements.

Promotion of technical support given by NGOs to Community-based health financing schemes should be integrated in the development plans of local government units. It is also recommended that the technical support given by external groups to these communities should go beyond capacity building and seed fund requirement. It should also focus on management i.e. pricing of services, marketing, facilities management, among others.

1.0 BRIEF DESCRIPTION OF THE PROJECT

1.1 Background of the Project

The Case Study of Community Health Financing in Region XI is a component of the Health Care Financing Reforms Project undertaken by the Philippine Institute for Development Studies (PIDS) for the Department of Health (DOH).

Jointly proposed by the DMSF-IPHC and the DAP, the study looked into existing community health financing scheme. Factors which led to the setting up of a sustainable self-managed system which resulted in generating resources to finance health services needed by community members, shall also be looked into.

Southern Mindanao pioneered many cooperative efforts in setting up a health fund for those who can least afford to pay for health services. One of the very active pioneering non-government in community health financing is DMSF-IPHC. To take advantage of the situation, communities assisted by the DMSF-IPHC through its various social interventions (e.g. community organizations, trainings, credit facilities/assistance, livelihood projects, among others) are included in the study. The project also covers the experience and evolution of a Brokenshire Integrated Health Ministries, Inc. and the largest Health Cooperative, the Medical Mission Group Hospital and Health Service Cooperative and the smaller health cooperatives.

1.2 Objectives of the Project

General Objective:

The overall objective of the study is to design or formulate a model of an alternative community-based health financing scheme.

Specific Objective:

1. To identify all the existing community-based health financing schemes;

2. To present a comprehensive description of each existing scheme as to the type of ownership, location, level of coverage, benefits provided and other identifiable characteristics;

3. To identify the processes, mechanisms and other factors that may influence a successful and sustainable community-based health financing scheme;

4. To determine success indicators for each type of health financing scheme in terms of health service utilization;

5. To identify the prospects for the growth and expansion of the present level of coverage of the existing schemes in terms of health service utilization;

6. To come up with alternative measures that would improve existing schemes and to simulate their impact on the financial resource base.

1.3 Significance of the Project

Very few case studies focused on the experiences of groups (non-government organizations, church, cooperatives, communities (barangays, sitios) on health care financing were conducted in Region XI. Because of lack of information, it is difficult to assess and develop a viable health care financing system.

By taking a closer look at the experiences of the IPHC project communities, as well as, cooperative groups in the region operationalizing community-based health financing schemes, useful references and other data are generated which can in turn provide basis for institutionalizing the community health care financing schemes.

The thrust of international organizations involved in health during the last few decade has manifested continued concern on bridging the gap between scarce resources and the group needs for health services. In recognition of this, many countries have committed to expand the coverage of health financing service to include PHC. This in turn, generated interest in identifying scheme to mobilize new financial resources to help support the operation of said health services. One scheme looked upon with great potential is community health care financing.

In the Philippines, several forms of health insurance exist. These include: 1) government sponsored health insurance i.e. Medicare; 2) private insurance i.e. Health Maintenance Organizations (HMOs); 3) employer provided health insurance; and 4) community or cooperative shared-risk schemes (Solon, et al. 1992). There are two known cases of a community-based HMO type of health insurance which were part of a pilot test. First is that of the San Antonio (SAHMO) which started in 1988 and had 400 members in June 1990 which dropped to 315 as of June 1992. Second is the case of University of the Philippines, Diliman (UPHMO) which began in 1989 starting with 89 members which steadily grew to 429 in June 1990 and stood at 814 as of mid-1992 (Gorra, 1992). It appears that despite evidence of its having rendered the promised medical benefits to its members, the SAHMO's financial viability was found to be unstable. The evidence presented in the study pointed to the reluctance of core leaders to follow formal organizational structure. This made adherence to a system of roles and responsibilities and therefore accountability, such as in the management of funds and resources difficult.

On the other hand, the UPHMO appeared to be more financially stable compared to SAHMO. Basically, this is because UPHMO members were fixed income earners and therefore less vulnerable to economic downswings experienced by SAHMO members who were mostly self-employed in small scale businesses. The salary deduction scheme adopted by the UPHMO may have significantly facilitated its growth in membership which is probably a plus factor in keeping the scheme financially viable.

Indications of the existence of a number of community-based health financing schemes or community-level health insurance have been found with the conduct of the Health and Management Information System (HAMIS) project. It was found out that various communities or groups of families have, through their own initiatives or upon the encouragement of community influentials, set up various schemes to finance health related activities. However, apart from a description of such schemes, no further systematic study has been done on their long-run financial viability, sustainability and impact on health of the community. With little data and information available and with the schemes apparently having been set-up fairly recently, documentation of those schemes will provide an excellent benchmark for their evaluation in the future.

1.4 Scope and Research Methodology

A. Locale of the Study

The study covered IPHC-assisted project communities in Region XI (see Figure 1 and 2). These communities are located in Davao del Norte, Davao del Sur, Surigao del Sur, South Cotabato and the city of Davao. Other areas within the provinces and cities in the region where other community-based health financing schemes exist were also included in the study.

For the communities without community based health financing schemes, one urban area and one rural area were chosen:

Urban – Barangay Lagao Gen. Santos City
Rural – Barangay Tambobong, Davao City

B. Definition of Terms

B.1 *Community Financing* – According to Russell and Reynolds (1985) community financing includes contributions made by beneficiary individuals and groups to support part of the cost of public health care services. These contributions may come in the form of cash, labor or in kind.

B.2 *Providers* – refer to medical and paramedical practitioners within a financing scheme who support and render services for the health

and medical needs of individual patients, i.e. doctors, nurses, midwives, barangay health workers (BHWs), Community Health Workers (CWs) and, other health volunteers.

B.3 *Managers* – refer to those who operate and administer the financing schemes i.e. officers of the federations, associations, QLCs and cooperatives.

B.4 *Recipients* – the expected beneficiaries of the health assistance rendered through the financing schemes who have actually received benefits from the schemes.

B.5 *Types of Community and Self-Financing Methods*

a. Prepayment

Prepayment/insurance schemes are usually contributions made by individual and households in advance of service need. Only the sick avail of services. Therefore in such financing schemes risks are shared between the healthy and the sick. Schemes may provide different levels of coverage for community and hospital care, varying from partial coverage to total coverage.

FIGURE 1. LOCATION MAP OF REGION XI

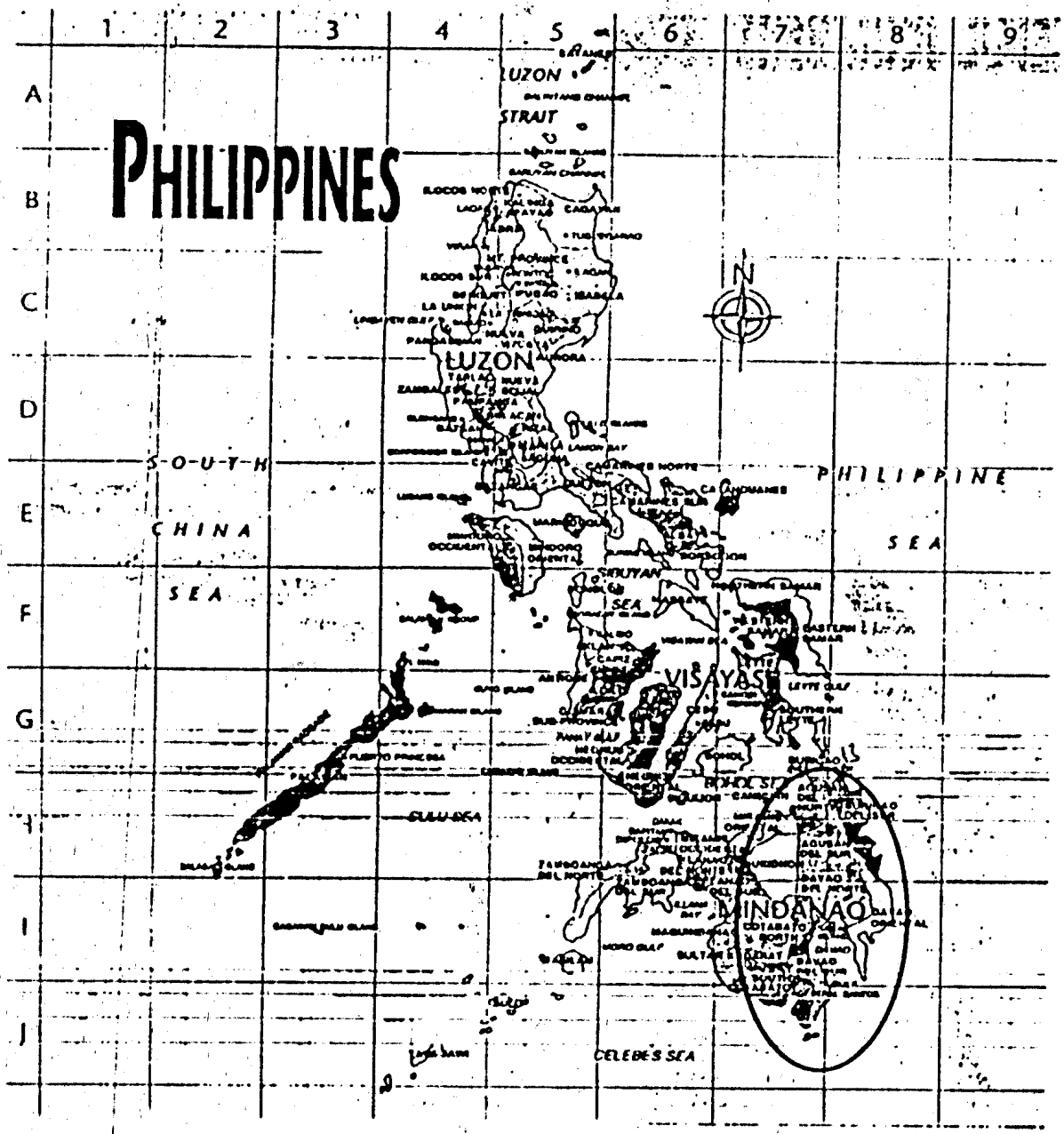
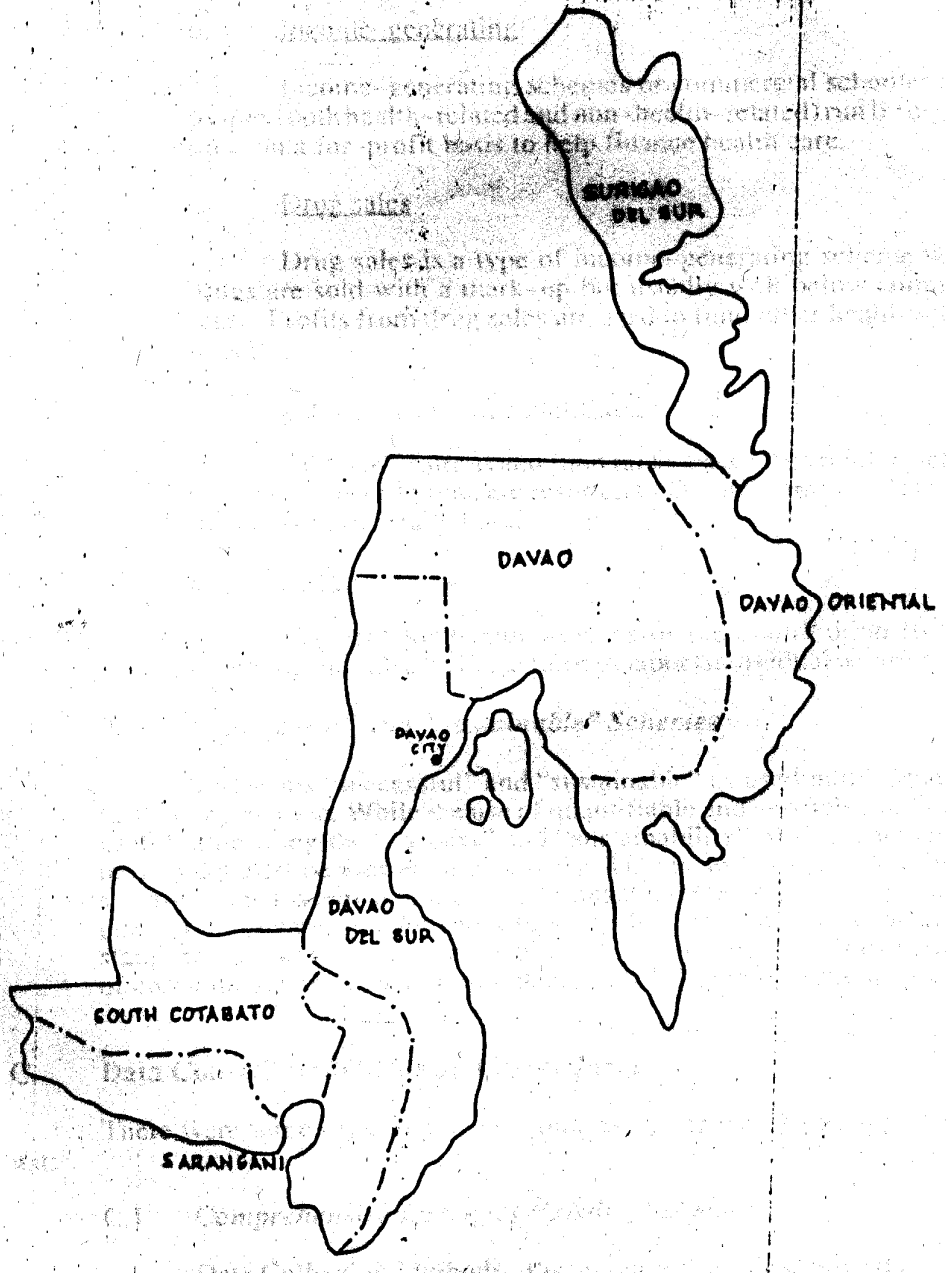


FIGURE 2. MAP OF REGION XI



Prepayment can be broken down into two types: community managed and purchase of pre-need.

Community managed prepayment schemes are those run by the beneficiaries themselves. Purchase of pre-need schemes refer to the subscription of an organization to another group operating and managing the prepayment scheme.

b. Income-generating

Income-generating schemes or commercial schemes are activities (both health-related and non-health-related) run by organizations on a for-profit basis to help finance health care.

c. Drug sales

Drug sales is a type of income-generating scheme wherein drugs are sold with a mark-up but usually well below commercial rates. Profits from drug sales are used to fund other health activities directly.

d. Ad hoc donations/Fund Raising

Ad hoc donations and fund raising activities refer to activities which from time to time are resorted to by a scheme to raise revenues to help finance health care.

e. Labor

Payment for health services or the contribution for health financing may also be in the form of labor (individual or community).

B.6 *"Successful" and "Sustainable" Schemes*

The terms "successful" and "sustainable" as used in this study need further explanation. While the use of quantifiable and verifiable indicators is useful in defining the "success" and "sustainability" of the schemes, these terms may also be viewed subjectively. This is so because even though a scheme would seem to have little impact or the scope of services and population covered would seem to show limited improvement in health status, the "success" and "sustainability" of the scheme is seen from the level of commitment and spirit of volunteerism that keeps the scheme going.

C. Data Collection Methods and Procedures

There were three (3) components comprising the data gathering phases, to wit:

C.1 *Comprehensive Listing of Existing Schemes*

Data Collection Methods. Preliminary activities showed a dearth of information on the health financing schemes in the region. For example, a complete listing of health financing schemes operating in the region is not available. To respond to this information gap and to make accessible an inventory of financing schemes and their description for future use, a *baseline survey* was carried out as a start – off point of the study. Results of the survey became the basis for the final selection of schemes covered by the study. Likewise, a *review of secondary data* relative to the description of the mechanics of the schemes was used to supplement other information.

Instrumentation. The baseline survey was done through a series of personal interviews using a structured interview guide.

Key Informants. To provide information on the existing schemes, respondents to the survey included the following:

1. Technical staff of the Department of Health (DOH)
2. Cooperative Development Specialists (CDS) of the Cooperative Development Authority (CDA)
3. Project Officers (POs)/Project Development Officers (PDOs) of the Institute of Primary Health Care (IPHC)
4. Officers of established cooperatives
5. Other referrals

Snowball approach was used to identify other respondents i.e. pre-identified respondents will provide referrals for the next respondents.

C.2 *Selection of Sample Financing Schemes*

Sampling Procedure. As soon as the roster of existing health financing schemes was established by the survey, an elimination process ensued to identify the schemes for the case study. Included in the sample were schemes which fit the following criteria:

Level 1:

1. have been in continuous operation for at least six (6) months;

2. presence of recipients who have actually availed of the services and benefits;
3. scheme is clearly defined (it has the consensus of the community that it is really in operation and accepted by the community);
4. availability of records/documents; and
5. unique (those whose manner of raising resources or whose services or benefits set them apart from the rest).

Level 2: (when there is more than one case for each type)

1. accessibility of area;
2. most number of members; and
3. willingness of respondent/community to be interviewed.

C.3 *Case Study of Selected Existing Schemes*

Data Collection Methods. In gathering detailed data and information for the case study and assessment of the existing schemes, *personal interviews* and/or *focus group discussions* (FGDs) were conducted among selected respondents. The conduct of FGDs was aided by a structured interview guide administered by a facilitator.

To generate information relative to policies, operations, management systems and mechanisms of the health financing schemes being studied, much effort were expended on the *review of secondary data* reported by various organizations engaged in health financing. Documents reviewed included financial and periodic progress reports. Likewise, the organizations' constitution and by-laws and project proposals were reviewed to provide a picture of the objectives and the past activities of those organizations.

Periodicals and other manuscripts documenting previous experiences of any of the existing financing schemes were likewise reviewed.

Key Informants. Respondents for the case study and assessment of the health financing schemes were the recipients, the managers and the providers who were involved with each type of scheme included in the sample selection. However, it was only in the case of the MMG that a provider (doctor) was interviewed.

Sampling Procedure. The respondents of the survey were limited to members who are paying periodic contribution and who have actually availed of benefits from the scheme. Furthermore, due to time constraints,

the number of recipient-respondents was limited using *quotas sampling* for each scheme, as follows:

Total Population	Sample Population
25 and below	3
26-45	5
46-65	7
66-85	9
86-105	12
106-125	15
126-145	18
146 and over	20

Purposive sampling was used for the managers and providers. For the managers, the key informants for the case study and assessment included the president or chairman, finance officer and other key officers managing the scheme. The health workers or other health providers who have directly provided services for the scheme were included.

C.4 *Case Study of Control Groups and Failed Schemes*

During the conduct of the baseline survey, cases of communities with no schemes (control groups) and of failed schemes were also looked into. Control groups provide a benchmark for practices and experiences of communities on financing health care. They were used to compare groups with and without the schemes in terms of health benefits and services.

The study and documentation of failure cases was also conducted to give a clearer picture of the factors, constraints and problems that are met in operating the schemes. Findings in this area could offer lessons in formulating viable alternative schemes.

In gathering the desired data and information, two (2) barangays were identified and studied as control groups. One barangay have at least a network of communication and transportation facilities, and complete social services (e.g. clinic, hospital, school). The other barangay, considered "depressed", have very minimal to almost non-existent infrastructures and social services. Selected members of the control barangays and former recipients, providers and managers of the failure cases were interviewed.

C.5 *Description of Other Recent Efforts*

In the course of doing the study, several schemes have been uncovered that have not met the required criteria for a case study. These are efforts which have yet to evolve into full-blown health financing schemes. Nevertheless, proper documentation of these schemes was conducted. Consequently, selected managers, providers and recipients of those schemes were also interviewed.

1.5 Proponents

A. The Institute of Primary Health Care (IPHC)

The IPHC is a department of the Davao Medical School Foundation. It was established in 1978. It implements projects, and conducts training, and research primarily on health. Its mission is to uphold total human development through partnerships with the community, and collaboration with government and non-government organizations.

B. The Development Academy of the Philippines (DAP)

DAP is a government corporation established in 1973 with the mission to build individual and institutional capacities for developmental change by addressing development problems of local, national and international significance. The Academy carries out its mission through the professional provision of services in training, management consultancy, research and publication.

2.0 BASELINE SURVEY RESULTS AND SELECTION OF SCHEMES FOR CASE STUDY

2.1 Results of the Baseline Survey

Official permission, as well as assistance was sought from every provincial and Municipal Chief Executives, Health Officers, Local Government Officers, and other heads of government agencies in the baseline survey. The baseline survey provided the identification of the Presidents or Contact Persons of different Non-Government Organizations (NGOs) and People's Organizations (POs) engaged in community health financing schemes.

The following tables present the number of groups which have implemented health and other health-related financing schemes in the various provinces of Region XI.

Table 1. Number of Groups Engaged in Health Financing Schemes, by Province

Province and City	Number
Davao del Sur	12
Davao City	9
Surigao del Sur	9
South Cotabato (including General Santos City)	8
Davao Province	4
Sarangani	4
Davao Oriental	2
TOTAL	**48**

Twenty-five (25) of these groups operate only in the barangays where they were organized. Six (6) cover two to three barangays in the same municipality, four (4) operate only in several puroks within one baranga, three (3) operate only in one purok, and three (3) others cover the whole municipality. The rest have the following as their areas of operation: the whole of Davao City (1), only one zone in General Santos City (1), the whole poblacion only in the municipality (1), province-wide (2), Davao City and provincial capital of Davao province (1) and one (1) covers Region X, XI, and XII.

Table 2. Number of Groups Engaged in Health Financing Scheme, by Type of Membership, Region XI

Characteristics	Number
Open to all residents in the area or areas of operation	32
Barangay Health Workers Only	7
Health Professionals Only	3
Church Members Only	3
Farmers Only	2
Elderly Citizens Only	1
TOTAL	**48**

Number of members range from six (6) to three hundred seventy one (371). The King Development Cooperation, Inc. which covers Region X, XI and XII has 6,056 members as of April 30, 1993.

Table 3. Number of Groups Engaged in Health Financing Scheme, by Nature of Grouping, Region XI

Nature of Grouping	Number
Association	18
Quality of Life Circle (QLC) Federation	10
Multi-Purpose Cooperative (CDA-registered)	6
Multi-Purpose Cooperative (non-CDA registered)	6
Federation of BHWs	2
Church-based group	2
People's Organization	1
Women's Club	1
Foundation	1
Informal group	1
TOTAL	**48**

Whether the groups are called associations or federations or are cooperatives, they have one common objective: the provision of any kind of assistance as well as primary health care services.

The table below presents the different benefits and services embodied in their objectives and purposes.

Table 4. Number of Groups Engaged in Health Financing Scheme, by Benefits and Purposes, Region XI

Benefits & Services	Number
Loan solely for medical purposes	7

Loan solely for medical purposes, Health Services and continuing education for QLC members	3
Health Services like deworming, feeding, weighing, immunization, dental, pre-and post-natal, circumcision, family planning	2
Health Services and Emergency Loan	2
Loan solely for medical purposes and micro-business loan	2
Emergency loan for medical needs and in times of calamities	2
Hospitalization grant or refund	2
Free total health services for members and free OPD services for members' dependents	2
Hospitalization support, feeding, deworming, Support to BHWs, and educational loan	2
Health Services, Emergency Loan and Mortuary Aid	2
Health Services, Mortuary Aid and Farm Production Loan	1
Health Services, Emergency Loan and Hospitalization Grant	1
Loan solely for medical purposes, Surgical and Dental Assistance and Livelihood Loan	1
Emergency Loan, Credit line on over-the-counter medicines and assistance for transportation expenses	1
Farm Production Loan, Educational Loan, Emergency Loan for hospitalization and subsistence	1
Maximum "Survival Assistance" of P500.00 per member	1
Hospitalization grant and 6 months Interest-free loan	1
Interest-free loan for livelihood purposes	1
Emergency Fund, Education Fund and Support to other Health Projects (e.g. potable water supply)	1
Free health care training assistance from health professionals and free medicines if available	1
Maternal and child care skills training	

and free medicines	1
Financial assistance for medical needs, Mortuary Aid and incentives for BHWs	1
Emergency Loan, Microbusiness Loan, Seminar counterpart for QLC continuing Education, Educational Loan and Support to exposure programs for farmers	1
Emergency Loan, emergency assistance for transportation and feeding and deworming	1
Emergency Loan, BHWs' continuing work and feeding	1
Health Services, Emergency Loan and calamity fund for flood victims	1
Health Services, Emergency Loan and support for service projects (e.g., water chlorination)	1
Health Services and Livelihood Loan	1
Livelihood Loan, Educational Loan and Emergency Loan for medicines	1
Loan solely for medical purposes and Mortuary Aid	1
30% of total contribution for health purposes	1
Benefits and services have not been firmed up yet	1
TOTAL	**48**

Eighteen (18) groups derive funds solely from the membership fees, weekly or monthly contributions, or payments to capital share from members. Thirteen (13) use the income or percentage of net income from existing projects to support their health projects without asking for any contributions from members. Three (3) groups depend on ad hoc contributions which are mostly done during an illness. The rest of the groups raise funds from a combination of two or more sources mentioned above, in addition to Drug Sales or their "Botika sa Barangay", as shown in Table 5.

Table 5. Sources of Funds of Health Financing Schemes, Region XI

Source of Funds	Number
Personal Pre-payment/Contributions from members	18
Income generated from existing projects	13
Personal Pre-payment/Contributions from members and Income generated from existing projects	7
Ad Hoc Contributions/Fund Raising	3
Income generated from existing projects and Ad Hoc Contributions/Fund Raising	2
One-Time Payment and Ad Hoc Contributions/ Fund Raising	2
Drug Sales and Personal Pre-payment/ Contributions from members	1
Drug Sales and Ad Hoc Contributions/Fund Raising	1
Income generated from existing projects Personal Pre-payment/Contributions from members and Drug Sales	1
TOTAL	**48**

Table 6. Starting Year of Health Financing Schemes, Region XI

Year	Number
1973	1
1981	1
1983	1
1987	1
1988	1
1989	2
1990	8
1991	9
1992	15
1993	7
Not specified	1
Has not started yet	1
TOTAL	**48**

Majority of the groups were organized in 1992. The most recently organized is the Bagumbayan Proper Fishermen's Health Cooperative which during the baseline survey has been in operation only for five months. The longest running organization is the "Kapunungan sa Kasakit sa Barangay" which started in 1973. These two groups operate in two Davao del Sur barangays.

2.2 Bases of Selection

Using the criteria discussed in C.2 section 1.4, seven health financing schemes were selected for case study. The selected community-based health financing schemes are presented in Table 7. Out of the seven, one, the Los Amigos Community Health Financing Association (LACHFA) was later dropped after the actual interviews were done. This was due to the following reasons:

a. The LACHFA was only organized in December 1992, and, although it passed the first two Level 1 criteria, the chairman of the Board and the Project Managers expressed that the group is still on the experimental stage and therefore cannot really shed light as far as effectivity of performance is concerned; and

b. The Secretary of the organization went on an indefinite vacation outside the country a few weeks before the actual data gathering. Although all the records are with the Project Manager, she has still to familiarize with everything before she can pass on some information.

An investigation into two communities without community based health financing schemes was also undertaken to find out their views on the scheme. One is Tambobong, Davao City which, by its socio-economic characteristics, is a rural community and the other is Barangay Lagao, an urban area in Gen. Santos City. These two barangays were chosen because they offer contrast in terms of availability and access to resources and services.

2.3 Other Schemes

Three other schemes were included as part of the other cases worth looking into. These are the Medicare II program in the Municipality of Cantilan, Surigao del Sur; the Coop Care of the Medical Specialist Health Services Cooperative (MSHSC), Digos, Davao del Sur; and the scheme of the Brokenshire Health Ministries, Inc. (BHMI) in Davao City. These schemes were organized through the efforts of health professionals who have banded themselves to provide health care services on a more affordable rate.

Table 7. Selected Cases of Community-Self-financing

Location (By Province/City/ Municipality/ Barangay)	Name of Organization	Types of Community Health Financing Schemes				
		Income Generating	Ad hoc Donations Fund Raising	Community-managed personal pre-payment	Purchase of pre-need	Drug sales
DAVAO CITY (Poblacion)	1. King DCI				X	
	2. .Medical Mission Group Hospital & Health Services Cooperative of Davao				X	
DAVAO New Corella (New Sambog)	3. New Sambog Health Assistance and Hospitaliza-tion Association (NESHAHA)		X	X		
(Sto. Niño)	4. Sto. Nino Helping Hands		X	X		
DAVAO DEL SUR Kiblawan (Balasiao)	5. Kapanungan sa Kasakit sa Barangay			X		
Magsaysay (Tacul)	6. BHW Federation	X				X
Malalag (Bolton, Ibo, Tagansul)	7. Malalag Com-Munity Health Volunteers Credit Cooperative (MACHEVCC)	X		X		X

3.0 PRESENTATION OF FINDINGS

3.1 Cases in IPHC-assisted Organizations

3.1.1 The Community Health and Finance Associations: A Historical Background

The organization of the Community Health and Finance Associations (CHFAs) is the Year V activity of the Sustained Health Improvement Through Expanded Local Development (SHIELD) project of the Davao Medical School Foundation-Institute of Primary Health Care (DMSF-IPHC). CHFAs are composed of the confederated Quality of Life Circles (QLCs). These QLCs are composed of community members who are the target beneficiaries of SHIELD. These SHIELD communities in turn, have been chosen from among those served by the CHILD (Community Health Through Integrated Local Development) project.

3.1.2 The CHILD Project

To be able to have a clearer picture how CHFAs came about one has to start from the implementation of CHILD project. The following description was published in the "A Final Report on: The Community Health Through Integrated Local Development (CHILD) Project in Region XI" which was submitted by the Regional Steering and Technical Committee (RSTC) to the United States Agency for International Development (USAID).[1]

The CHILD project is at health delivery – community organizing type of project utilizing a combination of efforts and resources of private and public agencies. Its goal is to reduce infant and young child mortality in 280 communities of 5 provinces and 2 cities in Southern Mindanao. The attainment of this goal is dependent on the success of 4 component sub-projects, namely:

a. *Health Service Delivery Component*, where the principal implementing agency is the Department of Health (DOH). This component is designed to expand and upgrade the delivery of health and health-related services in the region;

b. *Local Development Component*, where the principal implementing agency is the National Economic and Development Authority in Region XI (NEDA XI). This component is designed to build the capability of provincial and municipal development councils in the region in the identification, planning and management of social development projects, especially Child Survival Action Programmes (CSAP);

[1] Submitted in February 1991. RSTC is composed of the Development of People's Foundation, Davao Medical School Foundation – Institute of Primary Health Care, National Economic and Development Authority, Department of Health XI, Population Commission XI, and the Development Academy of the Philippines – Mindanao Office.

c. *Community Participation Component*, where the principal implementing agency is the DMSF-IPHC. This component is designed to build the capability of the members of the project communities to effectively manage the planning, implementation, monitoring and evaluation (PIME) of community health projects particularly those related to child survival; and

d. *Project Management Component*, where partner agencies are involved in setting up an efficient and effective system for managing this intersectoral social development program with region-wide scope.

The project started in August 1986 and ended in August 1990. Funding of the CHILD project came from USAID. The Development of People's Foundation (DPF) has the over-all management responsibility and financial accountability for the program, while DMSF-IPHC took charge of the management of project operations.

There were 286 project communities (PCs) initially covered by CHILD, identified from among the 188 barangays of 30 chosen municipalities in the two cities and five provinces of Region XI. Each PC covers 150 households. The number of PCs were later narrowed to 255, when 31 were dropped because of inaccessibility and worsening peace and order situation. In its second year of operation, however, there were other barangays idenfified and organized, totaling the PCs to 400 before the year ended.

The major project activities implemented were:

a. Health Service Delivery Component (sub-project 1)

- Augmentation of the health supplies and equipment/instruments of the barangay health stations (BHS).
- Upgrading the knowledge and skills of the DOH personnel and barangay health workers (BHWs).

b. Local Development Component (sub-project 2)

- Training of regional/provincial/city/municipal development council and staff in social development planning.
- Encouraging municipal governments, development councils and staff to provide financial and technical support to 460 CSAPs developed by the project communities.
- Encouraging the 30 municipalities and two cities to increase budgetary allocation for social development programs/projects.

c. Community Participation Component (sub-project 3)

- CHILD project orientation.

- Training of BHWs and Barangay Secretaries on the Management Information System.
- Training of BHWs and other members of the cluster planning team on Community diagnosis.
- Training of BHWs and other members of the cluster planning team on PIME and project proposal writing.
- Community resource mobilization.
- Establishing linkage with at least two agencies during the entire project life.
- Project monitoring and community reflection.
- Evaluation of the health status of the community based on the results of quarterly and annual survey.
- Re-planning, implementation, monitoring and evaluation.
- Continuing education of BHWs and barangay leaders based on identified training needs.

There are two particular aspects in the entire duration of the CHILD project which are significant factors in the health status and health services utilization of the CHFAs finally selected for this case study. These are:

a. First is the installation of the Management Information System (MIS) as a result of the Community Participation Component (sub-project 3) which consists of the following major activities:

- Baseline and subsequent annual survey by the BHWs on demographic/health data of every cluster. A cluster comprises either a group of 10-20 families or a neighborhood of 10-15 families. It could also be one whole purok or one whole sitio.

- Data collation and analysis (community diagnosis) wherein the BHWs and some cluster members do a situational analysis from the data at hand, and from which vision-setting emerges.

- Quarterly collection of demographic or health data, monitor and evaluate the outcome/effects of their projects and be able to re-plan if deemed necessary.

- The outputs are: Baseline/annual health information report, Quarterly health information report. Under-six masterlist, and the Community Data Board.

b. The second aspect is the strengthened and sustained GO-NGO partnership at the regional/provincial and municipal levels. Not only moral but also financial support were extended by the government officials and by the health units. There was complementation of both technical expertise and logistical matters.

When CHILD project was on its second year of operation (1988), IPHC entered into an agreement with the Canadian International Development Agency (CIDA) to implement a health care financing scheme entitled Sustained Health Improvement through Expanded Local Development (SHIELD).

3.1.3 The SHIELD Project

The SHIELD was designed to sustain the health benefits brought about by the CHILD project by uplifting the economic well-being of selected 100 poor communities in the Region XI. The project was founded on the basis that the family's capacity to improve its health and to sustain the same was directly proportional to its income.

Selection of SHIELD Community-Beneficiaries. From among the 400 CHILD project communities located in four provinces and one city in Region XI, 100 were chosen to become SHIELD community-beneficiaries based on the following criteria:

a. The community was a CHILD community;

b. The community is at least two kilometers away from the main road, and is accessible either by foot or vehicle;

c. It has a relatively stable peace and order situation (no armed conflicts for the last three months);

d. It has existing CHILD or health projects;

e. It has potential projects for community-managed income generating activities; and

f. The barangay health workers and the community residents are willing to actively participate in project activities.

Project Activities

Quality of Life Circles. Organizing Quality of Life Circles was the major community activity in the early years of the project. Each QLC had 7-15 members belonging to one community and with a common goal. The QLC was the venue through which community members received instructions and support, undertook community analysis and initiatives, and receive training for livelihood projects. In the later stages of the Project, the QLCs were organized into federations. As of March 31, 1992, 617 WLCs and 19 federations had been formed.

Establishment of Social Development Funds. The SHIELD scheme called for percentage of interest earnings from loans to credit beneficiaries to be contributed to a community Social Development Fund (SDF). By the third year, two types of SDFs had evolved:

a. SDF for community health – includes the amount of collected as repayment by the beneficiaries for the cost of the water sealed toilets and rain collectors they received from the project, as well as interest earnings from loans.

b. SDF for capital build-up (CBU) – generated from membership fees to the associations, share capital raised by some CHFA members funds pooled together from the QLCs, and interest earnings from loans. Some CHFAs added their 10% commission to this development fund. The raising of share capital was done through various forms: loan retention scheme, daily contributions and monthly installments.

The SDF for community health is used for various specific purposes. It may cover expenses for the maintenance of the Barangay Data Boards, interbarangay visits by QLC members and BHWs, snacks for community guests like NGO representatives and doctors, maintenance of water pumps or reservoirs medication and hospitalization of sick QLC/BHW members, mortuary aid for QLC/BHW members, pocket money or travel allowance of BHW trainers, supplemental feeding of 0-6 year old malnourished children, and/or occasional incentives for BHWs.

Community Health and Finance Association. By Year V of the project, after consistent low credit repayment and unsuccessful livelihood projects led to the inactivity of QLCs, the workplan was revised. The QLCs were to be strengthened and maintained as an informal group to be able to enhance the members' ability to generate income, improve health and address gender, environmental and other community issues. *Community Health and Finance Associations* (CHFA) were developed to become viable and legal credit and savings entities able to pool the savings of the members, fund their livelihood projects and fund their community health projects. These CHFAs were to eventually serve as the base for Provincial level federations. The new CHFAs would remove credit extension from the QLCs. Thus, the emphasis on a community-managed-based approach was increased and resulted to improved repayment rates of the pilot federations.

3.1.4 AADP

The *Accelerated Area Development Program* is a three-year (May 9, 1988 to May 8, 1991) USAID-funded project committed to accelerate the improvement of the socio-economic conditions of 50 target barangays in region XI through the provision of technical and financial assistance to basic social services, livelihood projects and the provision of minimal infrastructure projects.

Potable water supply, health and nutrition projects are among the basic social services given said assistance.

It is jointly implemented by the Development of People's Foundation (DPF), the Institute of Primary Health Care – Davao Medical School Foundation (IPHC-DMSF), and the Kauswagan sa Timugang Mindanao Foundation, Inc. (KTMFI). The project coordinates with GOs and other NGOs for the socio-economic development of the Region.

3.1.5 LDAP

The *Local Development Assistance Program* of the Philippine Business for Social Progress (PBSP), through its NGO Support Grant Component, has implemented a project entitled "Partnership Mechanisms in the Management of Basic Health Care Programs and Services."

The project is jointly managed and implemented by the Basic Health Care Services Program of the Local Government Unites (LGUs), the Department of Health Region XI (DOH XI), DMSF-SPHC, and other people's organizations.

It covers ten (10) barangays each in the Municipality of New Corella, Davao Province, and Municipality of Magsaysay, Davao del Sur, its two pilot areas. The project's benefits, however, are expected to redound to nearby areas and other municipalities since health workers and volunteers from nearby municipalities and barangays will be incited to participate in the project.

The project seeks to:

a. Involve the private sector in health care delivery system;

b. raw a health profile of the areas and establish a health care monitoring system;

c. Conduct an information drive in health and sanitation;

d. Activate permanently the Barangay and Municipal Health Centers;

e. Strengthen the Local Health Board; and

f. Identify self-sustaining health care financing modes/schemes which would compliment LGU/DOH medical subsidies.

It started in May 1992 and is ongoing in the two municipalities mentioned earlier.

4.0 SUMMARY OF FINDINGS

4.1 Organization

Figure 3 shows a diagram for the assessment of a Community-based Health Financing Scheme. The assessment focuses on the three groups and their corresponding functions related to operationalizing the scheme. The three groups are: (1) the recipients, (2) the managers of the scheme, and (3) the providers of the benefits i.e. services, commodities and facilities provided to the members-recipients through the scheme.

Dimensions for Assessment

Health Service Structure. Deals with the type of health services that are to be produced.

Health Service Focus. Deals with service efficiency i.e. should the services that are produced be focused or targeted so as to maximize the health impact?

Health Service Utilization. Includes how the services produced are used i.e. greater efficiency can be achieved if (1) those with real health needs as medically defined do seek and get care; (2) those that do get health care do not demand or are not provided excessive or unnecessary services as medically defined; and (3) those that do seek and are provided with necessary services at the most appropriate health facility in the delivery structure.

Health Service Production. Includes how health services should be produced.

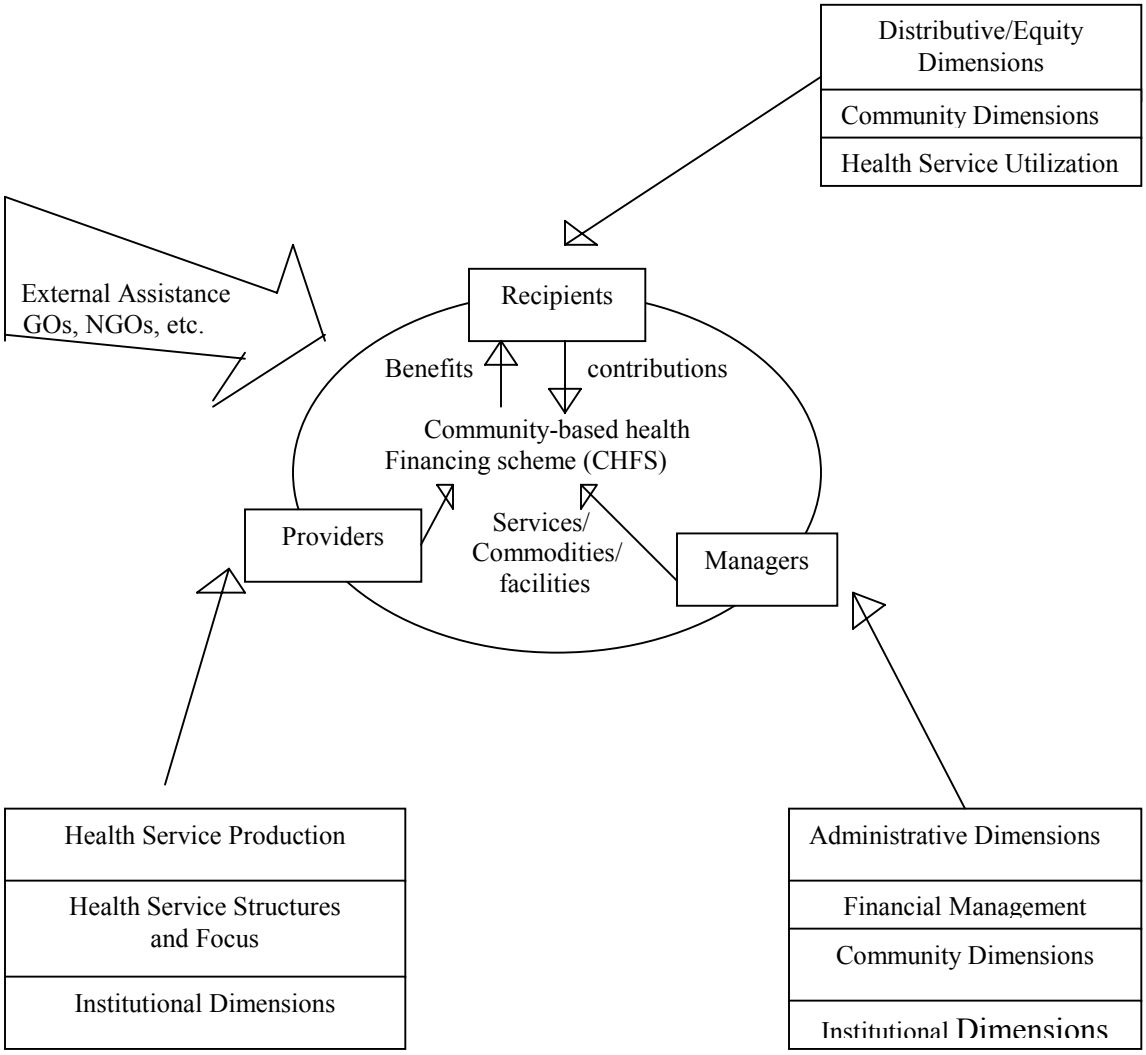
Administrative. Deals with the intricacies of the management and operations of the scheme or with how the delivery or provision of health services should be directed.

Community. Covers the degree of community awareness about the relevance of setting up the scheme, its benefits, and readiness and willingness of the community to contribute and to participate in the operationalization of the scheme.

Distributive or Equity. Includes the extent of community access to the services and facilities *vis-a-vis* their level of contribution.

Institutional. Includes the required number of staff to manage the scheme and their competence, trends in the development of community organizations, level of technical support received, linkages with resources outside of the scheme, etc.

Figure 3. Evaluation Framework for a CHFS



Financial Management. Focuses on how health services should be financed; looks into the levels and proportions of the contributions made by recipients as well as the efficiency of generating such resources. It may also look into the sustainability aspects of the schemes financial resource base.

Among the seven cases included in the study, four were organized through an intervention of an institution which came from outside of the barangay (village). These are the MACHEVCC, SNHH, SESAHHA, and the Magsaysay BHW Federation.

The KsK and the King Coop started as mutual self-help groups particularly in times of grief and sorrow. The CHF was organized through the efforts of health professionals.

4.2 Goals and Objectives

All these groups have a common Vision-Mission: support for life, be it through preventive or curative means, or through economic sustenance. The bottom line is health.

MACHEVCC aims to generate funds and extend credit to its members for productive and provident purposes. This is to be able to serve the interest of the members and to promote their general welfare.

Both SNHH and NESAHHA, having common take-off points, that of the IPHC-LDAP health partnership between the GOs and NGOs, primarily aim to give immediate assistance to members in times of medical emergencies. While SNHH's secondary objective is cooperation with the LGU to improve the health of the barangay populace, NESAHHA's is to cooperate with the LGU toward economic advancement.

King Coop's mission is to Improve the Quality of Life while the CHF-MMGHHSC aims at being able to offer total health coverage to the "Karaniwang Tao" (or the ordinary folk.)

The two failure cases, KsK and the BHW Federation (hereinafter referred to as BHWFed), have practically similar objectives as with the five cases earlier mentioned. KsK, which started as a self-help group for mortuary aid, has eventually aimed at extending loans for medical purposes. BHWFed endeavors to ensure good health for the barangay residents by implementing health-related activities and establishing the "Botika sa Barangay" or the village drugstore.

4.3 Membership

SNHH, NESAHHA, and KsK are open to all residents of their particular barangays, while MACHEVCC and BHWFed accept only health volunteers who reside in the area. SNHH collects P100.00 as membership fee, NESAHHA collects P20.00, and MACHEVCC P30.00. KsK collected P1.00 from 1973 to 1990. The amount was raised to P15.00 in January 1991.

CHF admits only those who are actual members of existing cooperatives in Davao City and Davao Province. It offers three health plans, and the amounts of P365.00, P1,200.00 and P1,800.00 are payable either in lump sum or in installment basis. While the P1,200.00 and P1,800.00 cover the principal member, the P365.00 covers one dependent.

King Coop requires from its prospective members the capacity to invest, thus accepting only permanent employees, professionals, businessmen, and farmers with adequate income and who can invest. The membership fee is P100.00 and the initial individual share is P500.00. The minimum share requirement of P10,000 is paid by the member through payroll deduction. The spouses, children and grandchildren of regular members are considered special members.

Table 44. Number of organization per composition of members

Composition of Members	Number
Open to all residents in catchments areas or areas of operation	30
Barangay Health Workers only	7
Health Professionals only	3
Church members only	3
Farmers only	2
Elderly citizens only	1
Open to all cooperative members only	1
Open to all employees, professionals, businessmen, and farmers who have capacity to invest	1
TOTAL	48

4.4 Fund Sourcing

SNHH and NESAHHA totally depend on the contributions from their present members. While SNHH raises the amount after a refund has been released. NESAHHA raises the amount immediately before its release to a member in need of medical attention.

KsK has been collecting a contribution of P1.00 monthly from 1973 to 1991. The amount was raised to P5.00 in January 1991. MACHEVCC collects P2.00 monthly contributions from its members. In addition, it received a grant through the AADP in

August 1991 as Social Credit Assistance for livelihood projects. From the interest payments on loans availed of 20% is allocated for emergency fund and 20% for health fund, the rest are allocated for education and reserve funds.

In December 1987, the DMSF loaned to the BHWFed an initial drug stocks worth P400.00 through the CHILD project. To augment its capital for a "Botika sa Barangay" it went on caroling in that same month. The newly assigned 27th Infantry Battalion to the area also assisted in the raising of additional capital by organizing a disco. Income from the drugstore was then allocated as follows: 40 percent for the honorarium of the aide/caretaker, 35 percent for Capital Build-Up, and 25 percent for Social Development Fund.

The CHF totally depends on the health plan subscription payments. However, unspent contributions are deposited with the Cooperative Bank to earn interest. The MMGHHSC, being a tertiary hospital, also earns income from user charges.

King Coop has several revenue sources in addition to the premium payments from its members. It earns income from interest on loans, service fees, interests from bank deposits, from rentals and from different investments which include pawnshops, among others.

Table 45. Number of Organization Per Type of Fund Sourcing

Source of Funds	Number
Personal pre-payment/contribution from members	18
Income generated from existing projects (through SHIELD proj. of the DMSF-IPHC	13
Personal pre-payment/contribution from members in addition to income generated from existing projects	7
Ad Hoc contributions/fund raising	3
Income generated from existing projects in addition to Ad Hoc contributions/fund raising	2
One-time payment and Ad Hoc contributions	2
Drug sales, personal pre-payment, and regular contributions	1
Drug sales, Ad Hoc contributions, fund raising	1
Income generated from existing projects, Personal pre-payment, drug sales	1
TOTAL	**48**

4.5 Benefits and Services

MACHEVCC grants medical loan of P500.00 taken from their Emergency Fund at an interest rate of 1 percent per month. There is no fixed maturity. Since the members are BHWs, they and members of their household also receive special privileges from the DOH, from free medicines to free hospitalization.

SNHH refunds hospital fees and medicines incurred during ACTUAL hospitalization. The maximum amount is equivalent to 20 percent of the total contributions at P100.00 per member multiplied by the present number of members. Replenishment of the amount refunded will be borne equally by all members excluding the recipient. Members of the household can avail of the same benefits.

From the contribution of P20.00 per member per episode of illness, an ailing or injured NESAHA member can avail of free medicines. Also, from the total amount collected, 50 percent is extended to the member as a medical grant and 40% as a loan. The loan is free of interest for the first six months, afterwhich, it will bear a 5 percent monthly interest. Payments on interests will be added to their general fund.

The BHW Fed served the barangay by selling drugs at much lower cost.

All these barangay-based schemes, being spearheaded by BHWs in cooperation with barangay officials, BHS, or RHU personnel, also accord the residents health-related services. These include continuous efforts at proper waste and sewerage disposal (e.g., building of water-sealed toilets and blind drainage), immunization, nutrition for children under six, maternal and child health care, and the maintenance of the Barangay Health Data Board, among others. The BHWs are almost always at the frontline doing health monitoring and follow-ups.

Health benefits offered by King Coop are the medical and dental assistance. There is the Special Medical Loan at a maximum amount of P2,000.00 per annum, interest free for one year. There is also the Medical Guaranty and Loan Fund (MGLF) which is a special arrangement between King Coop and its accredited hospitals that it will guaranty the payment of hospital expenses up to P20,000.00 and the hospital waives the pre-admission deposit requirements and attends immediately to the King Coop patient who is an MLGF card holder.

The King Coop has its own dentist who performs not only the usual extraction and filling services, but also dental prosthesis, oral prophylaxis, root canal therapy, minor oral surgery and wholistic reflexology. A 30 percent to 40 percent discount rate is offered to members. Members from outside of Davao City are allowed to claim reimbursements for dental expenses.

Members who undergo surgical operation or those who are treated due to injuries caused by accidents are entitled to a medical grant of up to P2,000.00. This amount can be availed of only once a year.

CHF benefits and services may be availed according to three plans to which the member is enrolled, depending on the amount of contributions. Plan A holders are given total health care benefits and are eligible for confinement at the hospital's ward section. Plan B is primarily for the dependents of Plan A holders. Benefits under this plan include free out-patient consultations and free hospitalization benefits of not more than P5,000.00 only per confinement. Plan C holders receive the same benefits as Plan A holders except that they are eligible for confinement in private rooms of the hospital.

For the failure cases, including the BHWFed of Tacul and the KsK of Balasiao, members have access to loans for health purposes from the association. In addition, the BHW Fed also had a drugstore in their barangay.

4.6 Access to Health Facilities and Services

Members of the barangay-based schemes have as their immediate and primary access the services of the Barangay Health Workers. From the BHWs, they are referred to the Barangay Health Stations if necessary. The next level of referral if the Rural Health Unit, for more advanced or difficult cases. More thorough examinations that require laboratory tests, as well as complicated to critical cases are brought to the tertiary hospital in the provincial capital or in the city.

There are a few members however, who can go directly to any private clinic in the municipality, or to the tertiary hospital in the province or in the city. The SNHH, KsK, NESAHHA, and MACHEVCC do not influence their members' choice as to whom do they consult. Only SNHH made it clear to its members that if possible, seek first the services of a government hospital because its charges for room, board, and laboratories are very much lower than private hospitals and therefore easily refundable.

The BHWFed members who are themselves health volunteers have direct access to any government hospital any time, as part of the incentives they receive.

King Coop members, salaried or with regular incomes, can go to any hospital of their choice any time, as they may also be MEDICARE, PHILAMCARE, CAP Health, Fortune Care, or Life Care members. But, as far as the use of MGLF is concerned, they can only go to four King Coop accredited hospitals, three in Davao City and one in the capital town of North Cotabato.

The CHF subscribers have direct access to MMGHHSC, which is a tertiary hospital now almost completely equipped with the latest medical equipment.

4.7 Payment Schemes

In the absence of contracted health professionals to provide medical services, recipients of schemes are free to disburse the loans availed in the manner they choose whether these be on transportation, food, medicines or doctor's fees.

For the King Cooperative, the guaranty loans make it possible for the accredited hospital – providers to waive deposits which are usually required from in-coming patients prior to treatment or confinement. Payments are advanced by the cooperatives to the providers and are later on repaid by the recipients to the coop.

However, in some cases, as when an accident occurs, recipients may pay directly for medical expenses and are reimbursed later on by the cooperative upon proof of receipts for actual medical expenses incurred.

4.8 Members' Assessment of the Benefits and Services: Extended and/or Availed of

At P20.00 per member multiplied by 29 members one can collect a total P580.00. Ten percent of this is P58.00. This amount, per illness-episode, is used to buy the over-the-counter drugs which the NESAHHA gives to its members for free, at no limit as to number of times, everytime somebody suffers from headache, stomachache, cough or colds.

Although fifty percent or P290.00 can cover consultation fee and start up dosages, it is insufficient for subsequent dosages. The remaining 40 percent or P232.00, which can only be availed of as medical loan, can hardly be enough to cover all other expenses especially if those were incurred during actual hospitalization.

But the recipients interviewed however, are still grateful for the help extended to them by the association. At least it saves them from unnecessary worry where to look for money with which to pay for private doctors (if the case cannot be attended by either the BHW or the RHM), as well as to buy a portion of the medicines prescribed.

The same sentiments are expressed by the recipients of the SNHH medical refund. The 20 percent of P100.00 x 58 members which is P1,160.00, could spell a lot of difference for those who were used to exhausting any means just to be able to bring a sick member to the hospital. Those interviewed said at least they are no longer afraid of borrowing from their neighbors and relatives because they can immediately pay once they are refunded. Although refund received covered only a minimal portion of the total hospitalization expenses incurred (2.9 percent of the mastectomy-chemotherapy patient) still the member-beneficiary was thankful this scheme was organized in their barangay.

The same is also true among the MACHEVCC recipients. The Hepatitis B patient had to sell a pig and spend part of her capital for the sari-sari store just so she can buy all the capsules she had to take for six months. The other respondent who has had appendectomy had to sell their lot located in the poblacion. Despite these, their gratitude is overwhelming.

There were only very few CHF and King Coop beneficiaries interviewed. As most of the member-subscribers are employees, interviewing them proved to be very

difficult as compared with interviewing the members in the barangay-based schemes. The CHF and King Coop members interviewed however, did not have the same reactions as with the earlier recipients presented.

The CHF patients complained of perfunctory attention given to them by the MMGHHSC doctors they were referred to for consultation. King Coop members expressed that those who have to undergo major surgical operation and who have bigger share capital should have been accorded proportionate medical assistance more than allowable maximum amount of P2,000.00. Special medical loans should not only be limited to P2,000.00. If a member is in good standing (MIGS), and who has at the time of application for special medical loan, deposited more than P5,000.00 should also be qualified to borrow a much bigger amount.

In general, however, the respondents claimed that these days when one's level of income cannot even guarantee it can meet all the basic necessities of a family, membership to these schemes has done them some good. At least, they say, the idea that there is a group to depend on, or a fund to borrow from, or a card that will guarantee not only entry to a hospital but also the attention of the doctors, has taken off a lot of unnecessary anxiety.

While the CHF and King Coop members have the financial capacity to switch options from among the different health insurance schemes being offered nowadays. SNHH, NESAHHA, and MACHEVCC members can only hang onto their commitment to continue with their membership, continue paying the contributions or replenishment, so that the funds of their associations will be sustained.

4.9 Impact of the Health Financing Scheme

Health Status. Most of the respondents perceived an improvement of the health status of their families. The reasons behind this, however, are varied. Most of the respondents in the rural areas attributed the change to the adoption of preventive care measures taught by the BHWs which form part of the government's field health services. Others pointed out that the children in the family are past the stage when they are most susceptible to diseases. Still others indicated the increase in the level of health services utilization brought about by the benefits derived from the financing scheme and/or from other health insurance policies they have enrolled in. Some, however, have indicated that they did not perceive any significant change in their health status with the presence of the scheme.

Health Service Utilization. For rural-based schemes, as in the case of most IPHC-assisted communities, the pooled resources has increased the opportunity for members to consult and seek treatment from professional health practitioners about their illnesses. The financial assistance extended is rather limited though due to fund constraints. In some cases members have to wait for the funds to be replenished before loans can again be granted.

Some officers and managers of the schemes think some members tend to be abusive in that they seek services repeatedly even for the slightest suspicion or symptom of illness. One officer of the MMGHHSC even said the concept of free total health care seems to have a negative side to it in that its psychological impact on members is to over-use their privileges. While the CHF has the largest resource base among all schemes covered, members are still encouraged to declare their Medicare so as not to deplete so much the fund.

Health-seeking Behavior. Most respondents say they have gained confidence to seek the services of professional medical practitioners and to have sick members confined at the hospital, if necessary, with the benefits derived from the scheme. With joint efforts of both government and non-government personnel carrying our health and education programs in the communities, the members consciousness on maintaining good health has improved. However, for the BHWs, it is rather difficult to isolate their responses from other influences since one of the incentives they receive is that of free hospitalization for the health services they render in their communities.

Access to Health Services. In general, all members have equal opportunity to avail of the services offered by the schemes. The limitations include having unpaid loan accounts or contributions (for IPHC-assisted communities) and the size of the funds so that there is not enough money for all members if they get sick at the same time. Contributions made are not prorated according to the income earned although for the CHF, rates differ only in so far as the room preferred (private or ward) is concerned.

Where secondary and tertiary services are concerned, however, rural-based communities are still disadvantage due to geographical constraints with most facilities located in or near the urban centers.

Table 48. Characteristics of the Seven Community-based Health Financing Schemes

Organization	Type of Scheme	Date the Scheme was Established	Health Services Provided	Fund Source (Methods of generating funds)	Level of Funds (In Pesos)	Membership Profile/ Number of Members	Number of Benefits Released Per Illness Episode (Up to the 3rd Qurter of 1995	Value of Benefits Extended (In Pesos)
1. Malalag Community Health Volunteers Credit Cooperative (MACHEVCC)	Income generating	July 1992	Medical loan (P500.00 per illness episode)	Financial grant thru the IPHC's AAD Project which was utilized as social credit for the buy and sell of farm or products extended by the association as livelihood loans to the members (P1,200.00 per member). The sources of funds for the financing scheme comes from the Social Development Fund (CDF) which is 20% of the 2% interest Collected from loan repayments. Out of the total CD Fund, 20% is allocated as Health Fund where 40% is allocated as Emergency Fund.	P2,584.27 (as of October 1993)	Women health Volunteers (31 members)	6	P1,500.00 (as of April 1992)
2. Sta. Niño Helping Hands (SNHH)	Personal One Time Payment and Ad Hoc Contributions	September 1, 1992	Medical grant (Maximum number of claim allowable per year is three: maximum amount that can be claimed is 20% of the total member-ship fee collected for the 1st claim, 10% for the second alaim and 5% for the 3rd claim).	Twenty percent of total member-ship fee (P3, 100 or P100 per member. This amount is replenished and borne equally by all members except the claimant upon use.	P1,100	Barangay Household members (51 members)	18	P15,037.40 (September 1992- October 1993)

Table 48 continued.

Organization	Type of Scheme	Date the Scheme was Established	Health Services Provided	Fund Source (Methods of generating funds)	Level of Funds (In Pesos)	Membership Profile/ Number of Members	Number of Benefits Released Per Illness Episode (Up to the 3rd Qurter of 1995	Value of Benefits Extended (In Pesos)
3. New Sambog Health and Hospital-Ization Assistance (NESAHHA)	One-time Pre-payment and Ad Hoc Contributions	July 1993	Medical loan Medical grant Free tablets	The total fund is P580.00 at P20.00 contribution per member. Fifty (50%) percent is allocated for medical grants. 40% is allocated for medical loans and 10% is allocated for the purchase of tablets which may be availed for free.	P530.00	Barangay household members (20 members)	7	P2,414.00 (P2,030.00 for Medical grants and P584.00 for Medical loans from July-December 1993)
4. Medical Mission Group Hospital & Health Services Cooperative (MMGHHSC)	Personal Pre-payment	1991	Cooperative Health Fund (CHF) which covers ltotl health care services such as: * Consultation during regular clinic hours * Medication * Dental care * Optometrical services * Obsterical-Gynecological Care *Surgery *Accommodation & food during confinement	Annual contributions which vary according to the Plan a member wants to enroll with: Plan A: P1,200 (or P112 a month for the ward section) Plan B: P365 for P1.00 a day for each dependent) Plan C: P1,800 (or P150 a month for private rooms) Share capital of cooperative members (No data on level of funds) Membership fee of P100.00 to the MMGHHSC (for those who are not yet members of any cooperative)	Initial amount coming from members' contributions was P6 million.	Coopertive members mostly salaried who may be working in government, non-government offices and private companies. Initial estimate: 5,000 members at an average of P1,300 annual contribution.	(No access to data)	(No access to data)

Table 48 continued.

Organization	Type of Scheme	Date the Scheme was Established	Health Services Provided	Fund Source (Methods of generating funds)	Level of Funds (In Pesos)	Membership Profile/ Number of Members	Number of Benefits Released Per Illness Episode (Up to the 3rd Qurter of 1995	Value of Benefits Extended (In Pesos)
			* Treatment of minor injuries such as lacer-ations, mild burns, sprain and the like * Laboratory examinations and diagnostic procedures * X-ray * Administration of vaccines (medicine not included *Referrals to instructions of specialists, as may be necessary * Health education, counseling on diets and exercise * Annual check-up on or before every anniversary date _____ of coop member's coverage					

Table 48 continued.

Organization	Type of Scheme	Date the Scheme was Established	Health Services Provided	Fund Source (Methods of generating funds)	Level of Funds (In Pesos)	Membership Profile/ Number of Members	Number of Benefits Released Per Illness Episode (Up to the 3rd Qurter of 1995	Value of Benefits Extended (In Pesos)
5. King Cooperative			* Free out-patient and hospitalization benefits of not more than P5,000 per confinement for dependents or planholders *Free dental and radiology consultation and 50% discount on extractions and billing for regular and special members residing in Davao City * 25% discount on other services * Medical assistance on expenses for operation and for treatment expenses due to accidents. Maximum amount of	Monthly premiums of at least P100 per member or lump sum minimum capital share of P10,000.00 Savings deposits of members	As of April 30, 1992. King Coop has about P20.8 million in equity. P48.2 million in assets and a loan portfolio of P30 MGLF stood at P1,547,534 with a total of 1.046 depositors for 1992	* Regular membership is open to employees of government and private agencies, professionals, established _____ farmers. * Special membership is open to the immediate ____ of regular _____ spouse, children and grand children. * Total number of members is 5,056 (as of April 30, 1993) * 992 regular members and 242 special members	16 50 155	* Dental services (P3,096.00) * Medical assistance (P102,276.00) * MGLF (P30,384.00)

Table 48 continued.

Organization	Type of Scheme	Date the Scheme was Established	Health Services Provided	Fund Source (Methods of generating funds)	Level of Funds (In Pesos)	Membership Profile/ Number of Members	Number of Benefits Released Per Illness Episode (Up to the 3rd Qurter of 1995	Value of Benefits Extended (In Pesos)
			assistance is P2,000 but not more than claimant's capital share * Medical Guaranty and Loan Fund (MGLF) (Hospital expenses in accredited hospital with corresponding amounts depending on the amount of deposits made (where P1,000 guarantees up to P5,000) * Special Medical Loan of P2,000 free of interest for one year			(govt. sector) and 178 regular and 27 special members (private sector) or a total of 1,441 in Davao City alone as of Oct. 31, 1992. * 2.504 members for Region XI (as of October 31, 1992).		

Table 48 continued.

Organization	Type of Scheme	Date the Scheme was Established	Health Services Provided	Fund Source (Methods of generating funds)	Level of Funds (In Pesos)	Membership Profile/ Number of Members	Number of Benefits Released Per Illness Episode (Up to the 3rd Qurter of 1995	Value of Benefits Extended (In Pesos)
6. BMW Association of Tacut	Drug Sales Income generating scheme (failure case)	December 1987	Emergency fund as medical loan	Income from Botica sa Purok Interest on loans repaid	P1,054.40 (as of April 18, 1992 for the drug sales funds which started from P400.00 in December 1987	BMW residents of Tacut (23 members)	(records not clear)	P4,000.00++
7. Kapunungan sa Kasakit (KsK) sa Barangay	Pre-payment (failure case)	1981	Medical loan of up to P300.00 at the start of 1981.	Membership fee of P15.00 for new members and a renewal fee of for old members Monthly contribution of P1.00 which was increased to P5.00 in 1981.	P1,024.00 (as of April 25, 1992)	Residents of Barangay Balasiao including household members (100+)	(records not clear al-though data indicate loans were extended from early 1981 up to May 1992)	(not data)

5.0 CONCLUSIONS AND RECOMMENDATIONS

The baseline survey revealed a number of community-based health financing schemes exist in the region. While there were commonalities in the means of setting up the said schemes, their sources of funding and management approaches provided contrasting picture.

The IPHC-assisted communities were mostly far-flung barangays with relatively difficult access to higher level medical services. In contrast, the MMGHHSC and the King Cooperative are based in the City of Davao where specialized professional medical services abound. Between the IPHC-assisted and non-IPHC assisted organizations surveyed, the following were observed:

The very first thing that was noticeable among communities studied (whether these were those with or without an HFS) was the active role of women in the implementation of health-related activities and programs. As housekeepers, these mothers and wives play a key role in looking after the health and general welfare of their respective households. Mothers are almost always therefore a vital link between promoters of health programs and activities and to target recipients or households. It may be noted that the role of the BHWs is more pronounced in rural and far-flung areas.

Almost all of the work done in initiating the scheme are founded on the local residents' strong sense of volunteerism, cooperation and desire for self-help initiatives in the community.

It was observed that the schemes initiated tended to work out and sustain if at its inception, local officials were already actively involved in promoting it among local residents, as well as, managing it as described in the experience of the Sto. Niño Helping Hands. In fact, it is only in Sto. Niño where it was observed that community participation and the level of awareness on the health financing scheme as most expressed and widespread.

Since the schemes were intended to provide a sort of buffer fund for residents from which they can seek help when in need specifically of professional medical help, a regular source of funds was indispensable. The amounts regularly contributed in IPHC-assisted communities were generally small and could be as low as P1.00 or P2.00 month per member, and would seem too insignificant to measure from an efficiency standpoint. However, the regularity with which each member gives is an important indicator of the communities' readiness and willingness to share the burden of providing for the health care needs of co-residents.

While some communities, on their own, have been able to manage their affairs quite well, part of the success of their health care scheme can be attributed to the strong support and mobilization efforts done by an external group such as a non-government organization, for example, the DMSF-IPHC. The results are especially encouraging when the NGO join hands with the local officials in carrying out their programs.

Most of the health care schemes documented are in their early stages of development. In fact, policies and operational guidelines in some are still being continually refined. It may be too early therefore and quite difficult to make categorical conclusions on the sustainability of the schemes surveyed.

For the relatively small-scale orgaizations, the schemes set up (usually only for cases termed as 'emergency' in nature as in accidents or necessitating confinement at a hospital) are there to make sure that when the need arises, the members have something to borrow money from. In short, the schemes are a form of a pre-need plan. The mobilization of savings is highly encouraged for future eventualities which may not expectd.

In contrast, the CHF essentially involves the purchase of a pre-need plan with a total coverage of health including the cost of prescribed medicines. However, applicants have to undergo a contemptibility period for pre-existing diseases. The MGLF on the other hand carries no restrictions on pre-existing illnesses and may also be availed at any given time. However, a ceiling on the loans that can be extended is imposed.

In terms of equity of access to services and to contributions made, the MMGHHSC and the King Coop tend to have a bias for individuals who have a regular income and who can afford to pay monthly premiums. Although they are open to practically anybody, the ordinary person who depends on an irregular source of income may not be able to afford the cost.

Furthermore on equity of access to services provided by the scheme, it is only in the CHF where one will find almost nil restrictions on the benefits availed. The experience of Sto. Niño recipients, although smaller in scale, is also interesting since the size and frequency of the assistance granted considers how big the actual costs are i.e., a recipient who spends more gets a bigger amount of money from the scheme.

On the other hand, the other schemes of IPHC-assisted communities and the King Coop put a ceiling on the funds extended and these are given as loans.

Risk-sharing in terms of resources contributed by recipients is more pronounced in the CHF and the one-time pre-payment and *ad hoc* contributions of SNHH because of the wider scope or coverage of benefits compared with the other schemes. Recipients of the benefits are generally appreciative of the schemes. While there is optimism that the schemes will work out, managers and recipients are still not that definite about their sustainability in the long-run. With the CHF though, the hospital is also Medicare accredited. This implies that even if the scheme is as big as the CHF, its managers still see the need for some short of external subsidy. This means the recipients' contributions, as in the case of other schemes, is not enough to keep the scheme financially sustainable.

Recommendations

Based on the framework presented in in Figure 3, the factors which may influence the success or failure of the financing schemes identified in the subject project communities and cooperative groups may depend on a number of elements. The initial factors identified are, to wit:

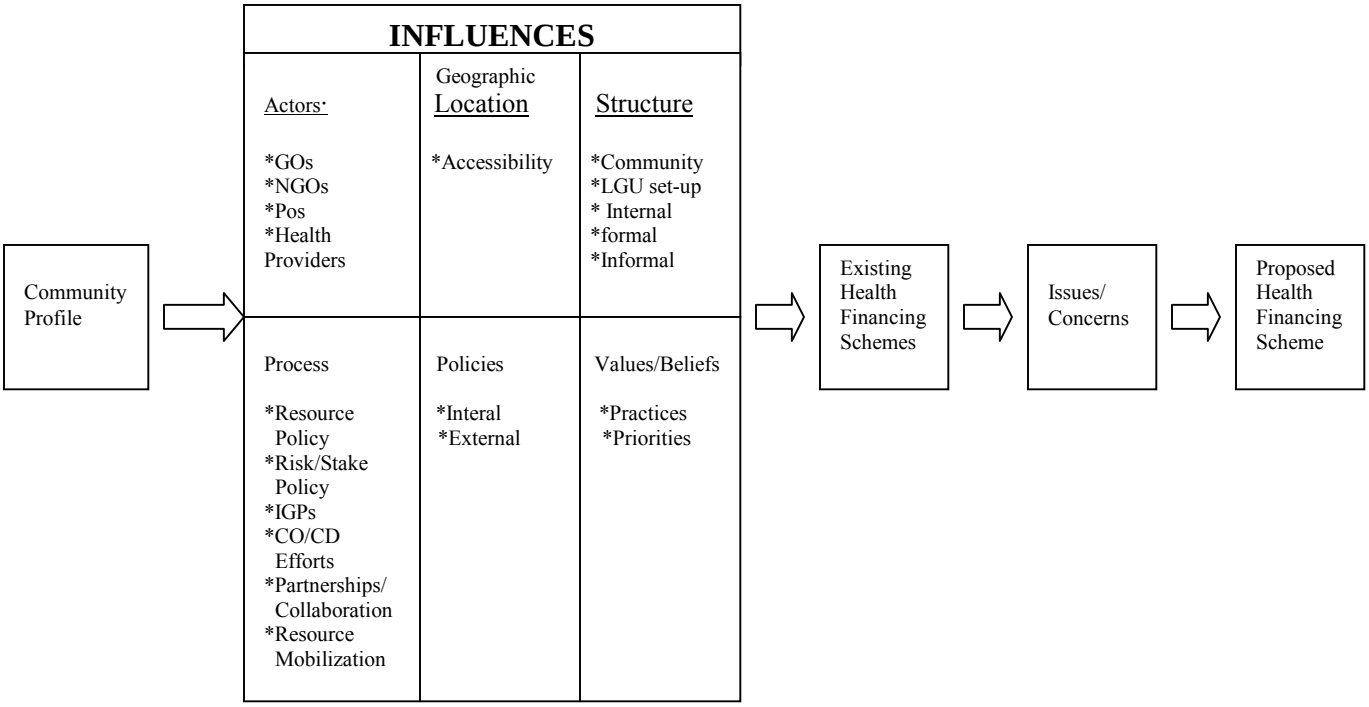
1. the presence of external groups/support (i.e. NGOs/GOs)
2. the presence of community structures or patterns of community organization;
3. practices or beliefs inherent to the community;
4. the level of awareness as well as readiness of the community to get involved;
5. the establishment of income-generating projects and other means of supporting the scheme;
6. the enforcement of policies (whether internal or external to the community) regarding the use of accumulated resources; and
7. linkages, partnerships and collaboration (intra and inter community);
8. resource generation and mobilization; and
9. geographic location.

As indicated, some conditions inherent in the communities may contribute towards the success of a community-based health financing scheme, for example, the adherence to certain traditional beliefs and practices such as following authority structures and placing high value on local self sufficiency. In addition, the presence of community structures and organizations which will reinforce the system established to operationalize the scheme may contribute significantly to its success. Other conditions such as the level and certainty of income and other economic means may also be crucial concerns if communities were to depend highly on their own resources to support the schemes.

Some communalities on the causes of the success of some schemes may be observed. On the other hand, the diversity of the communities and cooperative groups which operationalized the community health financing schemes provided a rich ground for individuality and uniqueness to prosper.

It is not enough, however, to stop at determining the distinctive characteristics of each scheme. Given the schemes and the issues and and concerns related to them, the next vital step is to generate alternative measures to improve or to complement the present schemes. One of these complementary measures is the improvement of their financial resource base.

Figure 4. Conceptual Framework in Setting Up a Suggested Model of a Community-Based Health Financing Scheme



Given the relatively short span of time that the said schemes have existed, the community-based helth financing schemes in Southern Mindanao (at least especially for the numerous IPHC-assisted communities) may have not yet reached the stage where they can be evaluated in terms of effectiveness, efficiency and equity as well as sustainability. In fact, many of the recently IPHC-assisted communities still need to be helped. In some areas, community residents have not even heard yet of the term 'health insurance'. This raises the issue on the degree of technical capability needed to manage the scheme especially with regards to expanding its coverage.

Some of the factors that may contribute towards the improvement of the existing health financing schemes is to provide an opportunity for them to dialogue with other groups with similar experiences. This may offer them an opportunity to look at alternative schemes and to make their own options as to what kind of scheme would work out for them.

While the documentation of these efforts was originally intended to come up with a suggested model of an alternative community based health financing scheme, most of the efforts expended in doing this study border on a descriptive rather than evaluative approach. In the first place, with the absence of preliminary data and the difficulty in

sourcing concrete information either due to poor or the lack of documentation, there was not much to go on with. It is apparent however that to get more substantial data on these schemes an in-depth study over a longer period of time is needed.

The most vital observation we could offer in this study is that the community-based health financing scheme provide a critical service to the community. Accordingly, because of their capability to mobilize local resources and promote volunteerism as well as cooperation of households at the village level their development should be nurtured by the government. Policies therefore that promote and enhance the effectivity and sustainability of community-based health financing schemes should be formulated and implemented. These policies may include, among others, the following:

1. *Promotion of efficient/economic scale size community-based health financing schemes*. Most of the schemes are located in rural-based barangays and comprise a minimum of twenty households. Unless these schemes increase in size or organize to become federation(s) their sustainability and effectives will be difficult to maintain. Local and national government therefore should provide support to enable these schemes to expand their coverage. This support may come in the form of subsidy and training.

2. *Networking community-based health financing schemes with the existing health system*. The community-based health financing schemes offer an effective mechanism for government health services and programs to reach a wider clientele. Linking community-based health financing schemes therefore to existing health services and programs should be given top priority. This link-up may be more cost effective compared to providing health services under the present set-up. The fee for a service system, for example, may be looked into as a means of supporting schemes as this can be a source for remunerating present health workers.

3. *Capacity building requirements*. Promotion of technical support given by NGOs to CHFS should be integrated in the development plans of local government units. It is also recommended that the technical support given by external groups to these communities should go beyond capacity building and seed fund requirement. It should also focus on management i.e. pricing of services, marketing, facilities management, among others

4. *Support on the role of housewives/women in health care*. Housewives/ women play a critical role in family health care. A recognition and enhancement of the said role through appropriate policy9ies) to optimize its impact should be given top priority.

Case Study No. 1. AN INCOME-GENERATING SCHEME: THE MALALAG COMMUNITY HEALTH VOLUNTEERS CREDIT COOPERATIVE (MACHEVCC)
Malalag, Davao del Sur

7.0 PERCEPTIONS AND ATTITUDES TOWARDS COMMUNITY HEALTH FINANCING

7.1 On the Membership Process
7.2 Initial Reactions to the Concept of Setting Up the Scheme

8.0 HEALTH STATUS, BENEFITS AND SERVICES UTILIZATION AFTER SCHEME:

8.1 Utilization of Health Benefits and Services
8.2 Perceived Changes in Health Status and Health-Seeking Behavior
8.3 AFTER Scheme
8.4 On the Sufficiency of Funds

9.0 IMPROVING AND SUSTAINING THE SCHEME

Case Study No. 1 AN INCOME-GENERATING SCHEME: THE MALALAG COMMUNITY HEALTH VOLUNTEERS CREDIT COOPERATIVE (MACHEVCC)
Malalag, Davao del Sur

1.0 INTRODUCTION

When the Community Health through Integrated Local Development (CHILD) project was implemented in Malalag, Davao del Sur (See Fig. 5 for location map of Malalag) in 1989, the health workers of Barangays Ibo, Tagansule and Bolton were tapped as primary recipients and local project implementors.

The project was primarily aimed at the reduction of the mortality rate of children in 400 barangays of 38 municipalities in Region XI with the purpose of expanding the scope of health services through the collective effort of both private and government agencies together with the communities.

Through the CHILD project, the health workers were organized by the Institute of Primary Health Care (IPHC) and the Department of Health (DOH). The Malalag Community Health Volunteers Development Association (MACHEVDA) was then formed and later registered with the Security and Exchange Commission (SEC).

In August 1991, MACHEVDA received a financial grant from the IPHC through the latter's Accelerated Area Development (AAD) Program – a partnership project with other non-government organizations to address the lack or delay of funds or non-response to community needs in the implementation of development projets.

The project aimed to make technical and financial assistance available to the target barangays at the shortest possible period of time. An example of such assistance was the grant to MACHEVDA which was utilized as social credit for the buy and sell of farmer products extended by the association as livelihood loans to its members.

In the course of its operation, the MACHEVDA was able to set up a financing scheme for health, with the earnings on the interest on the repayments on the loans extended.

FIGURE 5. LOCATION MAP OF MALALAG, DIGOS, KIBLAWAN & MAGSAYSAY

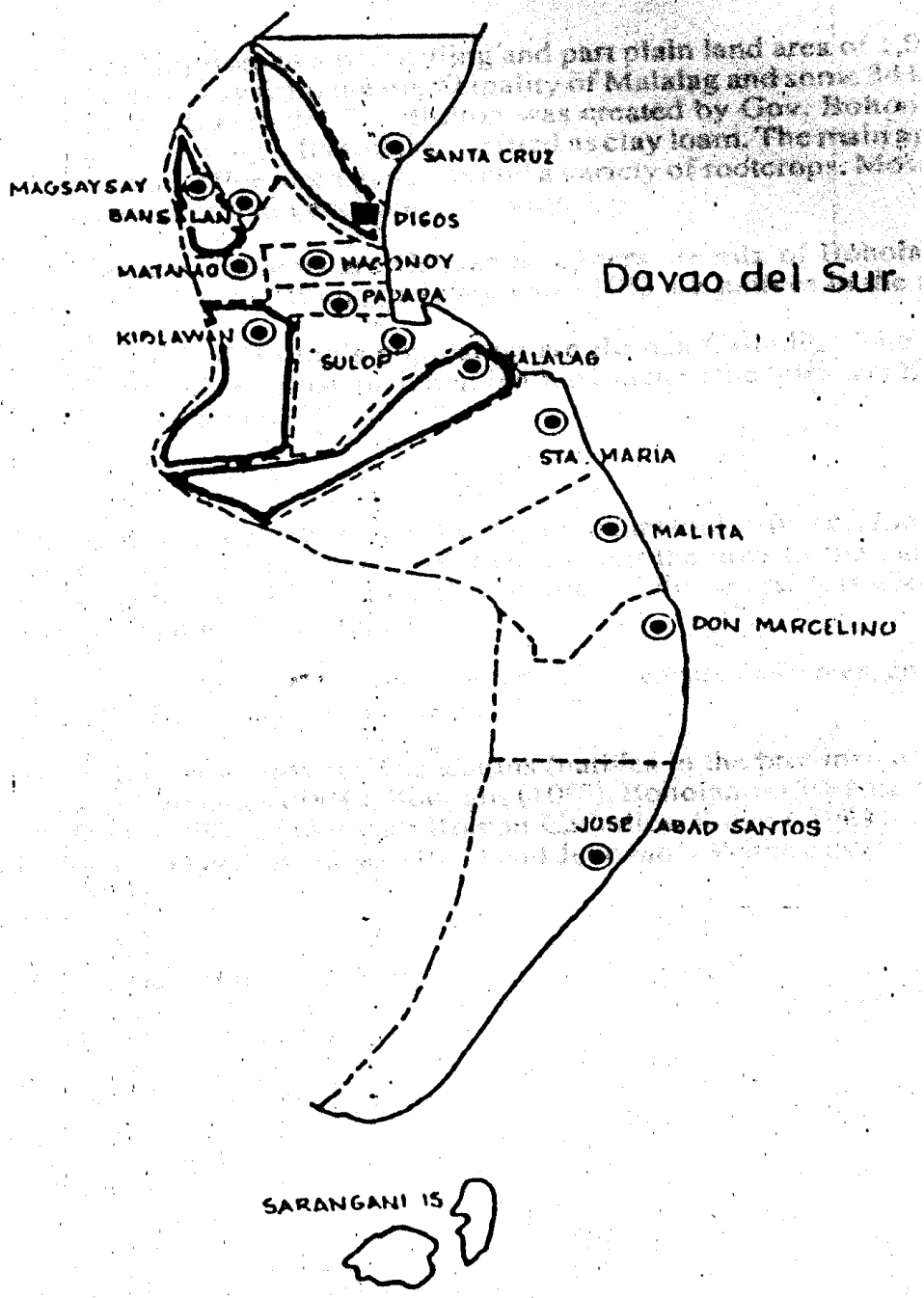
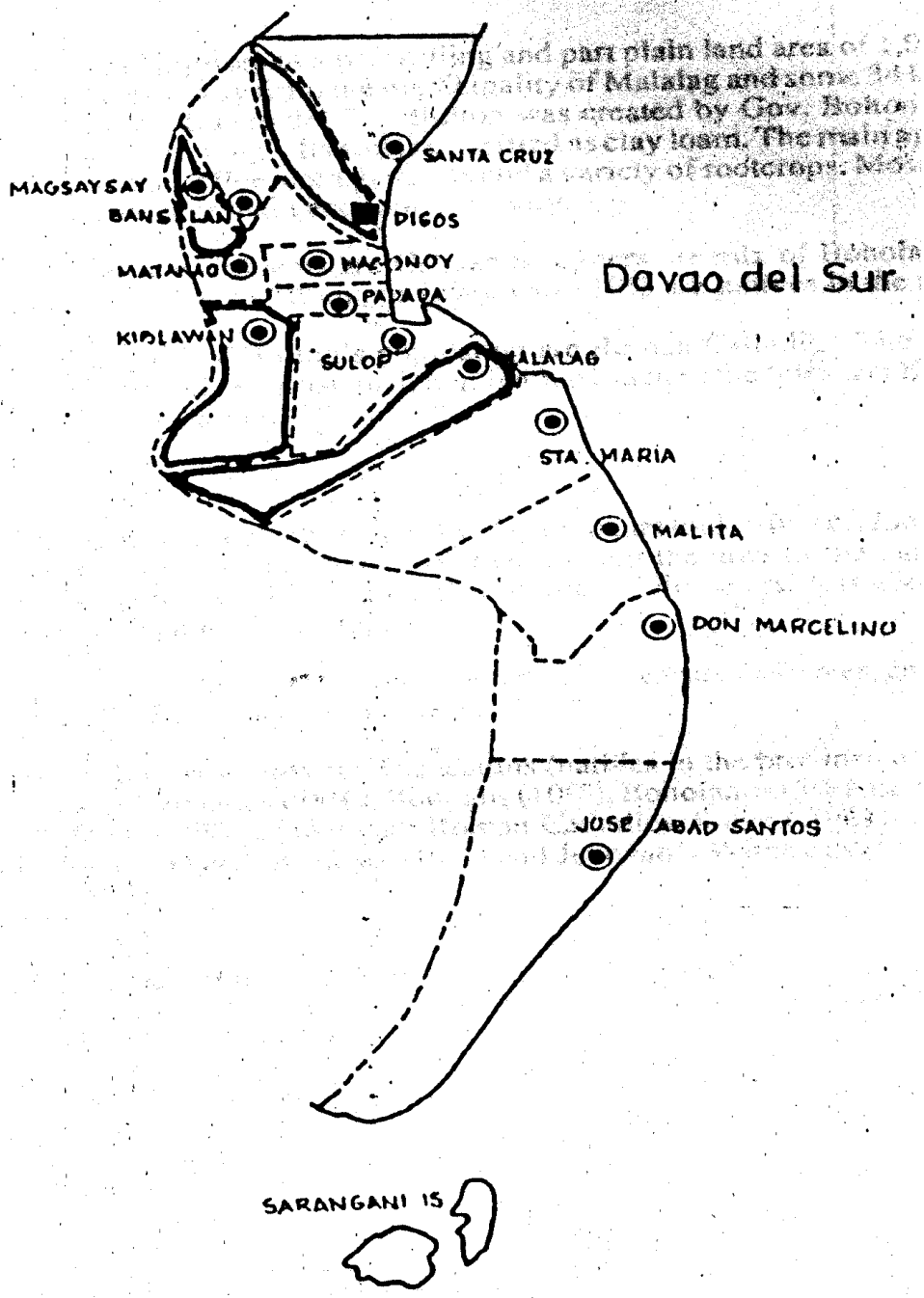


FIGURE 5. LOCATION MAP OF MALALAG, DIGOS, KIBLAWAN & MAGSAYSAY



2.0 AREA PROFILE[2]

2.1 Barangay Background

Bolton

Bolton's terrains comprises of a part rolling and part plain land area of 1,055 square kilometers. It is 6 kolometers away from the municipality of Malalag and some 34 kilometers from the province of Digos, Davao del Sur. Bolton was created by Gov. Bolton and Datu Magulawin from the word "Butong". Its soil is classified as clay loam. The main agricultural products are coconut, cacao, coffee, com, bananas and a variety of rootcrops. Most residents are engaged in farming as their economic activity.

Majority (75%) of the residents are Cebuanos. Others are mix of Boholanos (5%), Leyteños (5%), Ilocanos (3%), and Ilonggos (2%). Only 10% are natives in the area.

Nnety (90%) percent of Bolton's population are Roman Catholics. The remaining ten (10%) percent belong to other Christian denominations such as the Iglesia ni Kristo (5%) and the Foursquare Gospel Church (5%).

Ibo

Ibo was created into a regular barangay by RA 3590 that took effect on June 22, 1963. Its name was derived from a tree called "Ibo" that abound the area in the early days. It comprises of 6 puroks with a total land area of 891 square kilometers. It is about 6.5 to 8 kilometers from the poblacion of Malalag.

The main produce of the area are coco products, com, cacao, fruit trees, coffee, castor beans (tangan-tangan), bananas and vegetables.

Half (50%) of Ibo's residents are Tagacaolos (natives in the province of Davao del Sur). The rest are mix of Cebuanos (28%), Ilonggos (10%), Boholanos (5%), Leyteños (5%) and Ilocanos (2%). Most (65%) of them are Roman Catholics. Some (10%) are Moslems, while the rest are Seventh Day Adventists (10%) and Jehovah's Witnesses (15%).

Tagansule

Tagansule's name originated from the Tagacaolo words "Tagad" and "Sule", meaning wait and return. It was created under Executive No. 596 dated May 26, 1953.

Its topography comprises of rolling hills with a total land area of 678 hectares. It is 7 to 10 kilometers away from the poblacion of Malalag and is adjacent to Barangay Bolton.

[2] Sources Records Division, National Hospital, Davao del Sur.

Similarly, the products from its clay loam soil are coconut, corn, mangoes and vegetables.

A good number (70%) of the residents are Cebuanos. A few (15%) are natives in the area while the rest are a mix of Boholanos (5%), Leyteños (5%), and Ilocanos (2%). Majority (75%) are Roman Catholics. The others belong to the Philippine Benevolent Missionary Association – PBMA (15%), the Iglesia ni Kristo (5%), and the Foursquare Gospel Church (5%).

2.2 Socio-Economic Factors

A. Environmental Indices

Water Resources

In 1991, a total of 94 households in Bolton were served by Level 1 sources varying from deep wells, artesian wells, shallow/open wells and rain water. A total of 101 households were also served by an unimproved spring/river while 70 others were served by an improved spring.

In Ibo, 4 units of Level 11 sources served 279 households while in Tagansule, deep well and artesian well sources served 23 households while shallow/open well and rain water sources served 189 households. Twenty two (22) households, in tum, in the latter barangay were served by improved spring.

Toes of Toilet

On one hand, majority of the households in all three barangays are served by sanitary toilets such as flush/water sealed and "antipolo" or pit program, to wit: Bolton – 103, Ibo – 128, Ibo – 48 and Tagansule – 121.

On the other hand, a good number still use unsanitary toilets such as the overhang and cat-hole: Bolton – 63, Ibo – 48 and Tagansule – 35. (See Table 9.)

Table 8. Potable Water Supply, By Source/Barangay

WATER SUPPLY SOURCE	B A R A N G A Y					
	BOLTON		IBO		TAGANSULE	
	No. of Units	HH Served	No. of Units	HH Served	No. of Units	HH Served
	Level I		Level II		Level I	
Deep well		94	4	279		\ 23 /
Artesian well Shallow well Rain water						\ 189 /
Improved Spring		70				\ 22
Unimproved Spring		101				/

Source: DOH XI (aso f 1991)

Table 9. Number of Household Served by Types of Toilet

Types of Toilet/Barangay	Bolton	Ibo	Tagansule
Sanitary Toilets	103	128	121
Flush Toilets Water Sealed Toilets Antipolo/pit program			
Unsanitary Toilets	63	48	35
Over-hang Cat-hole Others			

Garbage and Sewage Disposal

In 1991, some methods of garbage disposal employed were those of compost pits and dumping. A good number of households also burned their garbage. Relative to sewage disposal, there was a total of 128 households served in Ibo by open drainage while 133 households were served by blind drainage. No data was available for Bolton and Tagansule. (See Table 10.)

Table 10. Garbage and Sewage Disposals, By Method Employed

METHODS/BARANGAY	BOLTON		IBO		TAGANSULE	
	HH Served	Pop. Served	HH Served	Pop. Served	HH Served	Pop. Served
Garbage Disposal	-	-	18	100	18	-
Compost Pit	25	-	-	-	-	-
Dumping	240	-	261	1,345	216	-
Burning						
Sewage Disposal						
Open Drainage	-	-	128	768	-	-
Blin	-	-	133	677	-	-

Source: DOH XI

B. Social Indices

Education

The number of students was inversely proportional to the level of education. The higher the educational level, the fewer the number of students (see Table 11). Each barangay had one elementary school with the following number of teachers: Bolton – 5, Ibo – 7, and Tagansule – 6. Only Ibo had one Day Care school with 7 teachers.

Table 11. Distribution of Students, By Barangay/Education Level

EDUCATION LEVEL	BARANGAY		
	Bolton	Ibo	Tagansule
Postgraduate	15	45	25
Graduate	10	75	12
High School	32	400	75
Elementary	250	808	200

Communication

Ibo's accessibility to transportation made it relatively better-off than Bolton and Tagansule as practically all media of communications was available in the area. Eighty (80%) percent of its households had radios while four (4%) percent had television sets. However, as in the two other barangays, it had no commercial source of electrical power. Majority (90%) of Bolton and Tagansule's households owned radios as the man medium of communication. Only a few (Bolton – 2% and Tagansule – 5%) had televisions. The usual source of power were batteries including automobile batteries.

Table 12. Communication, By Type Available

TYPE AVAILABLE BARANGAY	Bolton		Ibo		Tagansule	
	Yes	No	Yes	No	Yes	No
Newspaper		/	/			/
Magazine		/	/			/
Radio	/		/		/	
Television	/		/		/	
Telephone		/	/			/
Telegram		/	/			/
Postal Office		/	/			/
Others (special)						

Transportation

The areas are accessible by land transporation. The common means include jeeps, motorcycles, bicycles, pedicabs and horses. Of the three, however, Bolton is the least accessible being so only with motorcycles and pedicabs. However, access to interior portions especially the hilly portios are only possible on foot.

Table 13. Type of Transportation Available, By Barangay

Type Available	BARANGAY		
	Bolton	Ibo	Tagansule
Bus	15	45	25
Jeep	10	75	12
Motorcycle	32	400	75
Others	250	808	200
Bicycle			
Pedicab			
Horse			

Source of Income Livelihood

Majority of the residents are engaged in farming (Bolton – 85%m Ubi – 70% and Tagansule – 90%). Others were either employed or engaged in business.

Table 14. Sources of Income/Livelihood

Source/Barangay	Bolton		Ibo		Tagansule	
	No.	%	No.	%	No.	%
Farming	130	85	279	70	172	
Employment	43	10	30	20	35	5
Business	30	15	10	10	15	5

2.3 Health Status

A. Trends in Morbidity and Mortality: 1990 and June 1991

Data culled from the DOH XI shows the following trends of Morbidity and Mortality in the three barangays for the period January 1990 to June 1991. The records showed a high incidence of cough and fever among the three barangays. Parasitism was also one of the more common illnesses reported. In fact, it particularly became the top leading cause of morbidity in Ibo in mid-1991.

There were few cases of mortality reported for the period. Common causes in the three barangays for 1990 were broncho-pneumonia and PTB. Other cases included accidents, myocardial infraction, ischemic heart disease, septicemia, asphyxia/hanging depressure psychosis, leprosy, and typhoid fever with only one incidence each.

In mid-1991, the leading causes included PTB (1), for Bolton, myocardial infraction (1), ischemic heart disease (2) for Ibo, epilepsy/malnutrition (1), senility (1) and cerebral memorrhage (1) for Tagansule. (See Tables 16 and 17 on next page.)

2.4 Health Resources

A. Manpower (1991)[a/]

Table 15. Distribution of Available Health Manpower

Particulars	BARANGAY		
	Bolton	Ibo	Tagansule
Midwife	1[b/]	1	-
BHW	10	8	10
Trained Hilot	6	5	4
Untrained Hilot	2	-	2
Barangay Nutrition Specialist	1	1	1

a/ Latest data available.
b/ Serves both Bolton and Tagansule.

The local health manpower in the areas include one midwife for each BHS and a handful of BHWs numbering 8-10 for each barangay. With the DOH focus on primary health care, health workers are trained to carry-out preventive and promotive health care among the cluster of households assigned to them. Some of the BHWs are trained 'hilots' (traditional birth attendants). Others are trained as nutrition specialist. Each BHW is provided by the DOH with a first aid kit. But they are trained and highly encouraged to practice the use of herbal medicines and other alternative indigenous forms of medical treatment.

B. Health Facilities

Barangay Bolton and Tagansule share one Barangay Health Station (BHS) Barangay Ibo has a different BHS which it shares with Pitu, an adjacent barangay complemented by a similar number of manpower.

Cases that are beyond the midwives or BHWs are referred to the RHU located in the poblacion of Malalag. Referrals from the RHU are brought to the National Hospital in Digos, Davao del Sur. While private clinics exist in the area, no data on the actual count is available.

Table 16. Ten Leading Causes of Morbidity in Bolton, Ibo and Tagansule, Malalag (as of end of June 1991 and December 1990)

BOLTON				IBO				TAGANSULE			
1991 (Jan – June)		1990 (Jan – Dec)		1991 (Jan – June)		1990 (Jan – Dec)		1991 (Jan – June)		1990 (Jan – Dec)	
Illness	No.	Illness	No.	Illness	No.	Illness	No.	Illness	No.	Illness	No.
Cough	173	Cough	157	Parasitism	130	Cough	300	Cough	90	Cough	175
Cough/fever	47	Fever	50	Cough	48	Cough/fever	100	Parasitism	30	Fever	74
Fever	36	Cough/fever	35	Hyperacidity	48	Fever	100	Cough, fever	29	Cough, fever	63
Parasitism	29	Parasitism	39	Blood pressure	60	Parasitism	91	Fever	23	Parasitism	30
Skin allergy	15	Headache	25	Cough, fever	40	Hyperacidity	60	Epigastric pain	14	Headache	30
Colds	14	Diarrhea	21	Infected would	38	Pale	35	Wound	12	Diarrhea	30
Wound	11	Abdominal pain	13	Skin allergy	30	Wound	46	Dizziness	6	Abdominal pain	18
Epigastric pain	6	Dizziness	13	Pale	22	Skin disease	39	Pador	6	Dizziness	13
Pador	5	Bronchitis	3	Body weak	10	Diarrhea	27	Body malaise	5	Bronchitis	6
Abdominal pain	4	Pador	2	Chicken pox	3	Headache	21	Offs meofa	2	Pador	5

Table 17. Causes of Mortality Bolton, Ibo and Tagansule, Malalag (as of end of June 1991 and December 1990)

BOLTON				IBO				TAGANSULE			
1991 (Jan – June)		1990 (Jan – Dec)		1991 (Jan – June)		1990 (Jan – Dec)		1991 (Jan – June)		1990 (Jan – Dec)	
Causes	No.	Causes	No.	Causes	No.	Causes	No.	Causes	No.	Causes	No.
PTB	1	Bronchopneumonia	1	Myocardal Infraction	1	Bronchopneumonia	2	Epilepsy, mal-Nutrition	1	Bronchopneumonia	1
		PTB	1	Eschemic heart Disease	2	Eschemic heart disease	2	Sanity	1	PTB	1
		Accident	1			PTB	1	Cerebral hemorrhage	1	Accident	1
		Myocardal infraction	1			Sepcemia	1			Leprosy	1
		Hypertension	1			Asphyxia, hanging depressure psychosis	1			Typhoid fever	1

The DMSF-IPHC Projects

3.1 The CHILD Project

The MACHEVDA, a non-stock, non-profit organization, was organized by the IPHC and the DOH XI through the CHILD project way back in the late 80's. This was primarily concerned with material and child health care in depressed communities.

By virtue of their being BHWS, most of their activities were health-related. Even without the IPHC, they have conducted regular monitoring of environment sanitation and health education to barangay residents.

During the CHILD project, the volunteer workers were trained on how to conduct planning, implementation, monitoring and evaluation (PIME) of projects. Every quarter, the BHWs together with their Barangay Officials work hand in hand in monitoring and making follow-up of their health activities.

3.2 The AADP

With farming as their main source of income, the availability of transport and oher farm-to-market support facilities and services to market their produce was vital, but starkly wanting in the areas.

While the areas are accessible by any land vehicle, the only means of public transportation that ply the route regularly from the poblacion are regular-sized tricycles which do not take off unless fully loaded. 'Tri-sikads' (bicycles fitted with sidecars that could carry 2-3 passengers) are also a common means of getting around. It seems no passenger jeepneys ply the route because the tricycle drivers have taken on the said areas as their 'balwarte' (self-proclaimed territory).

With the difficulty in transporting goods to the interior areas from the urban center and vice versa, residents are therefore forced to go to the Poblacion to buy goods for household consumption.

For those who can afford to do so, owning a bicycle or motorcycle and even a horse is very useful to get around.

It is largely due to these difficulties that the residents of the communities mentioned above became recipients of a social credit assistance from the IPHC through the AADP.

4.0 THE ORGANIZATION

Upon the approval of its registration with the Cooperative Development Authority (CDA) last October 14, 1993, the association has since then been called Malalag Community Health Volunteers Credit Cooperative (MACHEVCC).

4.1 Organizational Structure

The MACHEVCC, being primarily a credit cooperative, intends to generate funds and extend credit to its members for productive and provident purposes. Its broad objectives includes the serving of the interest of the members in promoting general welfare.

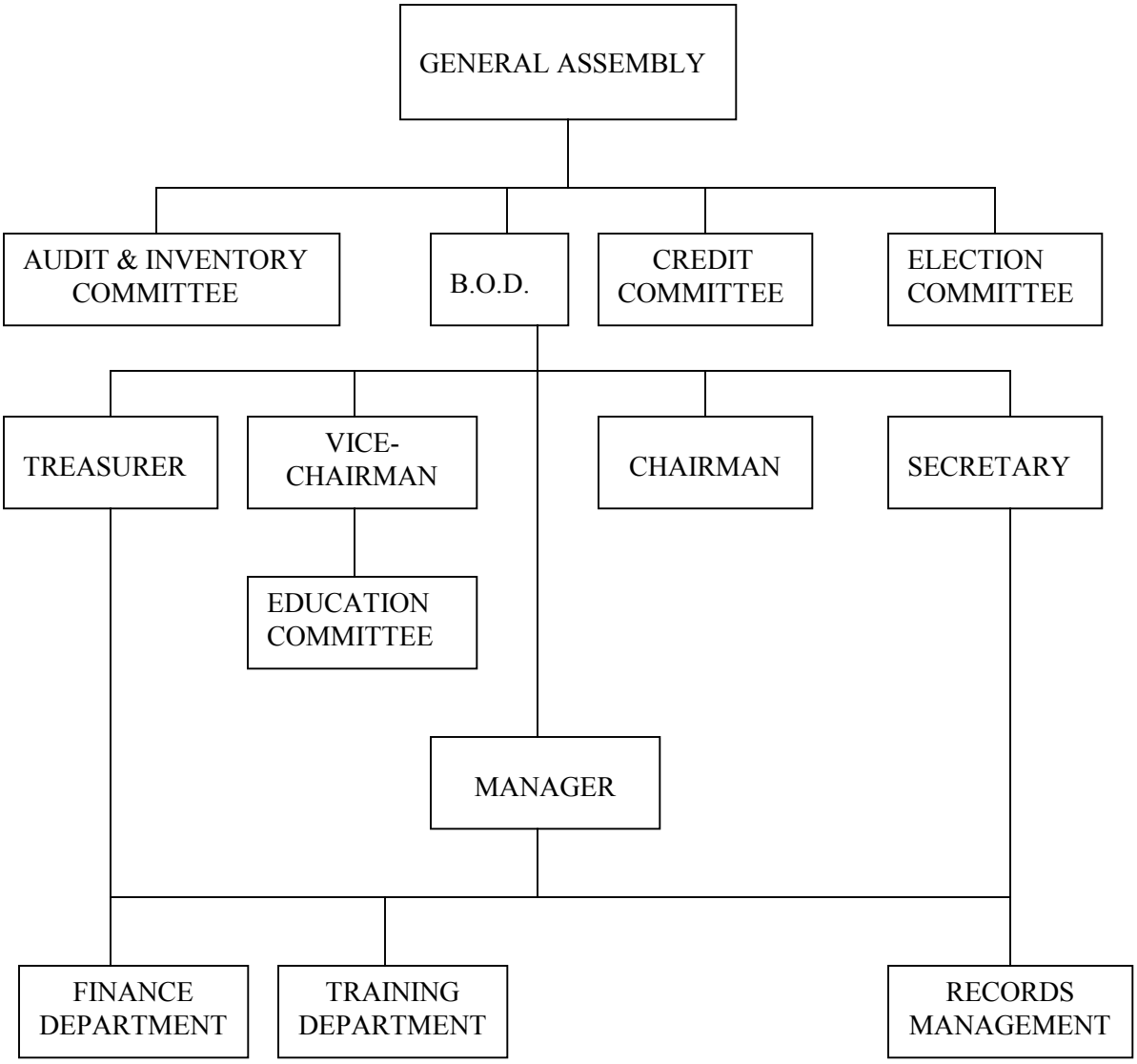
All members are barangay health workers (BHWs). Therefore, they are also actively involved in the implementation and monitoring of health-related programs and activities in their respective areas.

4.3 Membership

The organization is open to all women who are health volunteers in their respective barangays. At present, the cooperative has thirty one (31) members.

When it was just starting out, the organization had one (1) male member. He eventually left participation in the activities to his wife who also became a BHW as all other members were female.

Figure 6. Organizational Structure of MACHEVCC



4.4 Benefits and Services

Being a credit cooperative, the main service extended to members is that of loan assistance. This has been extended since October 1992. Each member can borrow up to P1,200.00 to be repaid with an interest rate of two (2%) percent per month.

Members also receive patronage refunds at the end of the calendar year.

Regular members are able to avail of a medical loan up to P500.00. While this is primarily intended only for bonafide members, the immediate family members are able to enjoy this as well.

4.5 Sources of General Funds

The MACHEVDA was a recipient of a financial grant from the AADP in August 1991 for its Social Credit Assistance Project. Out of the total project cost of P88,132.00, the AADP gave a total grant of P51,130.00 leaving P37,002.00 as the association's counterpart. The grant was extended as loan in the amount of no more than P1,250.00 to each member. (The Projected Income Statement and Porposed Budget are shown in Appendices A and B.)

When the association became a cooperative, there was a total of 31 members each with a total value of at least 5 shares at P100 per share. This translates into an Authorized Common share capital of the cooperative is a total of P62,000.00 for 155 shares. Out of this, 25% or P15,000.00 has been subscribed of which a total of P4,000.00 has been paid. Nine (9) members have paid up two (2) shares while the rest (22) have paid up one (1) share. The members do not depend on a regular income therefore contributions are based on their capacity to earn.

Aside from the initial share, each member has also paid P30.00 each (or total of P930.00) as membership fee.

The following are sources of funds for operations:

a) payment of monthly contribution of P2.00 per member
b) payment of a 2% interest on loans
c) collection of a fine of P10.00 for each member who is absent from the monthly meeting (scheduled on each last Sunday of the month).

The organization sometimes accepts 'special projects' which enable them to earn other income. An example was when they were sub-contracted by the IPHC to oversee the construction of a school building for fisheries in Bagumbayan, Malalag. This was donated by the Office of the President during the term of then President Corazon Aquino.

From this undertaking, the association was able to earn an unspecified amount which they added to their general fund.

4.6 Operating Expenses

In the review of secondary data, the only financial records found were that of the accounts on Interest/Reflows Distribution from July 1992 to April 1993.

In July 1992, the Reflows were distributed accordingly: CBU – 40%, 20% - SDF and Administrative Expenses – 40%. However, in November 1992, an additional expense was added – the monthly honoraria received by the Project Manager, Project Officer and Bookkeeper which amounts to P200.00 each.

The distribution of Reflows was modified to: CBU – 10%, SDF – 20%, Honoraria – 30% and Administrative Expenses – 40%. Another administrative expense added recently was the monthly rental of P150.00 for an office space. The space was acquired sometime September 1993.

Table 18. Interest/Reflows Distribution

%age Distribution (7/30/92)			40%	20%	0%	40%
	(11/30/92)		10%	20%	30%	40%
Date	Ref.	Cash in Bank	CBU	SDF	Honoraria	Admin.
7-30-92	CRB	P 3,720.00	1,488.00	744.00		1,488.00
8-30-92	CRB	780.00	312.00	156.00		312.00
9-30-92	CRB	228.00	91.20	45.60		91.20
10-30-92	CRB	878.07	351.23	175.61		351.23
11-30-92	CRB	620.00	62.00	124.00	186.00	248.00
12-30-92	CRB	790.00	79.00	158.00	237.00	316.00
		P 7,016.00	2,383.43	1,403.21	423.00	2,806.43
1-30-93	CRB	510.00	51.00	102.00	153.00	204.00
2-28-93	CRB	805.32	80.53	161.06	241.60	322.13
3-30-93	CRB	230.00	23.00	46.00	69.00	92.00
4-3—93	CRB	480.00	96.00	-	384.00	-

** CRB – Cash Receipt Book*

The sub-components of the distribution are as follows:

a. Capital Build-Up (CBU - 10%

b. Admin. Distribution - 40%

	7-30-92 to 12-30-92	1-30-93 and up
Supplies -	10%	20%
Rental -	10%	20%
Transportation -	15%	20%
Honorarium -	65%	40%
	100%	100%

c. Social Development Fund (SDF) 20%

Health Fund	- 20%
Education Fund	- 20%
Reserve Fund	- 20%
Emergency Fund	- 40%

d. Honorarium 30%

TOTAL 100%

5.0 HEALTH CARE PRACTICES

5.1 Health Service Utilization Before Scheme

When asked about their common practices in attending to the sick members of the family prior to their membership with the MACHEVDA, the respondents said relief was sought from alternative health care practices.

Within 24 hours upons experiencing common illnesses such as headaches, stomachaches, cough, colds and fever, respondents sometimes made use of herbal medicines, a massage or Oriental medicine such as acupuncture, acupressure, reflexology, pranic healing, etc. to relieve the sick members of their families. In some cases, they also take self-prescribed medicines.

If the sick person does not get well after 3 days, he or she is then brought to a doctor for a consultation. The local midwife was also cited as consultant.

While there were not many recurring illnesses, a particular case cited was that of recurring pains in the lower back experienced since 1982 by the husband of a BHW respondent. According to the respondent, her husband was hit in the lower back by a log in motion as he was working. He was brought to a local 'hilot' after which the pain eventually subsided.

Of late, however, the patient has felt the pain coming back. When asked why they had never sought a doctor for this problem, the respondent said it was all they could afford.

The experience of not being able to see a doctor at one time or another was common among the respondents. The reasons varied from not being able to afford the cost to the fear of learning about the nature of the ailment which in the words of the resondent 'mao ra unyay iyang kamatyan' (might only cause his death).

In the case of the patient with the recurring back pains, the respondent said their not having gone to the doctor just boiled down to her husband's 'ka-tapul' (laziness).

5.2 Access to Health Services

Much of the health-related activities carried out in the areas are tied-up with the health programs and services under the Department of Health (DOH). In the case of Bolton, Ibo and Tagansule, much of the activities pursued in community organizing efforts of the IPHC borders along the lines of the Primary Health Care (PHC) and the Maternal and Child Health (MCH) Programs.

A large part of the capability-building efforts undertaken by the DOH and the DMSF-IPHC puts emphasis on the use of the local health workers being at the forefront of the delivery of basic health services in the communities as well as on the use of indigenous medicines. With the concentration of medical services in the urban and urbanizing centersl, BHWs are instrumental in closing in on the gap between the demand for and supply of health care services in the areas.

To maximize them as principal health resources, some BHWs are trained as 'hilots' (traditional birth attendants). They are also a big help in the implementation of the primary health care program as well as other disease control and immunization programs.

The practice in Bolton, Ibo and Tagansule per the experience related by one midwife is not unlike those of other typical farflung barangays. BHWs are provided with first aid kits to treat their patients. They are responsible in monitoring the health status of a cluster of households assigned to them. With the distance of the – RHU and other health facilities, the use of indigenous medicines is highly encouraged especially with the focus on PHC. In line with this, a Mothers' Class is also held at least once every quarter to provide health-related education.

When the treatment of patients is beyond the capacity of BHWS, they are then referred to the RHU. For more complicated cases as in those requiring minor surgery and operation, the next level of referral is the National Hospital located in the provincial capitol – Digos.

As was observed, the higher levels of health facilities are not that accessible especially to residents who live in the hilly portions of Bolton and Tagansule. In emergency cases, patients are brought either to the RHU or the National Hospital by hiring public utility vehicles on a 'pakyaw' (full rent or paying the equivalent amount of the jeepney's full capacity) basis. This proves to be expensive given the difficulty in transportation means especially when the patient needs to be brought down at night.

When asked what their problems were in implementing the health programs, one midwife answered that since certain functions of the DOH were devolved to the municipal government in April 1993, there were less supplies of medicines for common illnesses like cough and fever. The use of alternatives (e.g. herbal medicines) have therefore been intensified.

Another significant problem for them was the lack of logistics support. For example, the health workers were left to spend for the reproduction of various forms of reports (on the status of health) which were required of them for submission.

6.0 THE HEALTH FINANCING SCHEME

6.1 How the Concept Began

The practice of setting aside some amount of the organization's funds for some kind of buffer fund in case of health-related emergencies is emphasized by the IPHC in the course of community organizing efforts.

Even in the project proposal preparation stage when organized groups in the project community make their request for financial assistance, one of the components that an organization is expected to set-up when their income-generating projects earn is the Social Development Fund (SDF) part of which is allotted to the emergency fund for health. In some cases, IPHC-organized associations call this the SDF for health. With MACHEVCC, this is called 'emergency fund'.

The emergency fund started in July 1992. The concept was made known to the body through a special meeting (General Assembly) called by the officers.

6.2 The Emergency Fund

The emergency fund thrives on the profits (if any) made by the members out of their livelihood projects which involves the buy and sell of their agri-products. It is essentially a medical loan. When last interviewed in October, the officers revealed that

their fund stood at P2,584.97. Accumulated funds may be borrowed by members in need of assistance relative to health concerns as when they fall ill or meet accidents. The maximum amount a member in need may borrow is P500.00.

6.3 Coverage

In terms of geographical area, the scheme covers the member-residents of Barangays Bolton, Ibo and Tagansule. In terms of the choice of health services, there are no restrictions imposed. The members may make use of the loan on any expense as long as it is health-related. Furthermore, the members can also avail of the loan for a sick member of their respective immediate families.

6.4 Membership Processes and Fees

The emergency fund is a component of the services extended by the MACHEVCC to its members. As such, a member is only eligible for a medical loan upon becoming a member of the organization.

At the start, applicants attended a seminar after which they paid a registration fee of P15.00. In the current year, the body agreed to set an annual membership fee of P30.00. The said amount was agreed upon by officers and members as most affordable considering the operating expenses borne by the organization.

With the organization converted into a cooperative, the members are expected to put up a minimum capital share of P500.00 each. Other than this the members also pay a monthly contribution of P2.00.

6.5 Resourcing

Funds are generated mainly through collections on the interest on loans repaid by members. The principal amount loaned is a maximum of P1,200.00 per member. After four (4) months, the recipients pay back the principal with an interest of two (2%) percent. The interest is then apportioned as follows:

	Particulars	Percentage (%)
a.	Capital Build-Up (CBU)	10
b.	Social Development Fund (SDF)	20
c.	Administrative Expenses	40
d.	Honorarium	30
	TOTAL	100

6.5.1 Apportionment of the Interest on Loans

Twenty percent (20%) of the cooperative's loan payment interest is allocated to the Social Development Fund (SDF). The SDF distribution is as follows:

	Particulars	Percentage (%)
a.	Educational Fund	20
b.	Reserve Fund	20
c.	Emergency Fund	40
d.	Health Fund	20
	TOTAL	100

On the other hand, the Administrative Expenses which is apportionment is as follows:

	Particulars	Percentage (%)	
		(1992)	(1993)
a.	Supplies	10	20
b.	Rental	10	20
c.	Transportation	15	20
d.	Honorarium	65	40
	TOTAL	100	100

Another source of funds is a one (1%) percent interest on the loans from the Emergency Fund. One respondent was quoted as saying that this amount is already deducted upon the release of the loan. Others say the interest is collected if the repayment is made after two (2) months have lapsed.

While the sources of funds are generally irregular in that collections are made based on the frequency of loans availed, which is in turn dependent on the availability of funds, the organization seems to have been able to manage its finances well.

7.0 PERCEPTIONS AND ATTITUDES TOWARDS COMMUNITY HEALTH FINANCING

7.1 On the Membership Process

In general, the members are satisfied with the membership process because it is relatively easy there being not too many requirements. Applicants are no longer subject to physical examinations.

The members agree that there is no need for a rigid screening process since they already know one another being residents of adjacent barangays and having undertaken various activities together as health workers.

7.2 Initial Reactions to the Concept of Setting Up the Scheme

When asked what their initial reaction was towards the concept of setting-up the emergency fund, the members claimed they were glad that such a scheme was thought of. They said the fund was a big help to them especially in emergency cases. They added it was necessary and important to set it up and that it was better to borrow from their organization (or cooperative) than from the usual usurers who charge higher interest rates on loans.

8.0 HEALTH STATUS, BENEFITS AND SERVICES UTILIZATION AFTER SCHEME

8.1 Utilization of Health Benefits and Services

Based on the memory recall of the respondents, complaints of illnesses amng members themselves or their households were minor cases, which included muscle pains, cough and fever or plain fever. In all cases except for one, the patients merely took selfprescribed medicines. The one who experienced muscle pains underwent a session on acupressure.

It can be noted that the respondents do not make use of the health financing scheme (HFS) for all episodes of illnesses (whether it be personal or that of a family member). In the case of one respondent, when her two-year old daughter got sick with cough and fever, the latter was brought to a hospital in a neighboring municipality (Padada Hospital). The expenses incurred were borne by the respondent without borrowing from the HFS. However, when another child got sick with the same complaint, the respondent borrowed P300.00 from the HFS to buy medicines.

There were six members who have availed of loans from the Emergency Fund. Only two of them were direct recipients.

The first one, Evelyn, was afflicted with Hepatitis B and sought treatment from the Digos Provincial Hospital more popularly known as the 'National Hospital' or simply the 'National' among local residents. The treatment was OPD. Being a BHW, Evelyn did not have to pay for consultation fees at the government-run hospital.

However, the prescribed medicine, *Escetiale* (which cost P10.75 each) posed a problem for the patient especially since it had to be maintained over a six-month period. For the first prescription, the dosage was one capsule three times a day for two (2) months (March to April). This yielded a total of 183 capsules for the period.

Then, in the next four months (May to August), the dosage was reduced to one capsule a day or 123 capsules. This brought the total expenses to P3,289.50 for medicines alone.

Upon borrowing from the MACHEVCC emergency fund, Evelyn was able to purchase P483.75 worth of *Escetiale* (or 45 capsules). For the succeeding dosages, however, she had resorted to other means to raise money which included: (1) asking help from her parents for which she was given P200.00; (2) selling a pig (50 kilos at P18.00/kilo) for which she yielded P900.00; (3) selling peanuts from which she netted an income of P1,000.00 and, (4) selling basic commodities ('sari-sari' store) the net income of which she could not be definite since it varied from day to day.

Evelyn was able to borrow twice from the fund, the second occasion having been able to borrow P300.00.

In the case of the other direct recipient, Alfreda, her complaint was appendicitis. She was operated on at the Davao Medical Center (DMC) in Davao City as she was referred here from the National.

Alfreda was confined for four days. The total hospital bill was P5,067.00 out of which she only paid P60.00 as 'donation' being a BHW and having declared herself as an indigent.

Aside from the hospital bill, however, Alfreda still had to purchase worth P3,000.00 of medicines. The large part of the money used to purchase this came from her own pocket having raised it by selling a 15 x 20 square meter lot she owned for P3,000.00. She was able to borrow P500.00 from the emergency fund.

In the case of Marissa, it was her husband and two children who fell ill with fever and cough and got confined at the National Hospital. She borrowed P200.00 from the fund and used this to pay for their transportation expenses. The hospital expenses, however, were covered by Medicare through her husband's contributions.

Table 19. Loans Sourced from the Emergency Fund [a/]

Amount of Loan	Date Availed
P 200.00	8-20-92
500.00	1-18-93
300.00	2-11-93
300.00	2-28-93
300.00	3-01-93
300.00	3-04-93
Total: P1,900.00	

[a/] As of October 1993. (Last entry made was April 1993).

8.2 Perceived Changes in Health Status and Health-Seeking Behavior AFTER Scheme

The respondents were asked to compare their present health status with how it was five years ago when they did not yet have a health financing scheme. It can be noted that while they perceived their health condition to be much better at present than before, it is difficult to establish a direct relation between change in health status and the presence of the scheme. When asked why they said their health was better, the respondents gave the following reasons:

(1) There are BHWs who can advise about nutrition, hygiene as well as on the use of herbal medicines as a cheaper but effective alternative in the treatment of illness;

(2) The members have become aware of their responsibilities to their selves, to their community as well as to the environment with the knowledge of proper nutrition, drainage system, water-sealed toilets and putting up a herbal garden; and

(3) The members find it easier to seek health services now than before.

However, one member expressed that there was no change in her family's health status over the past 5 years.

When asked how they would feel if a member of their respective families need to be brought to the hospital, the members expressed that they would readily do so first, because of benefits extended to BHWs and sometimes, even members of their immediate

families and second, since they are covered by benefits from the organization's emergency fund.

While one member said, she would readily go to the hospital and look for money to pay for the expenses later, another said that she would not bring her sick kin to the hospital immediately because of difficulty in sourcing money to pay for medical services as well as for food and transportation for whoever tends to the sick.

When asked further if the scheme has given them confidence that their health needs will be responded to, one member said yes because in addition to the free hospitalization and medicines accorded BHWs in any government hospital, they could still look forward to the extended by the organization. Other members expressed optimism having been benefited from the scheme and being able to seek help for an immediate need. However, other members' views were echoed by one respondent's answer which said that P500.00 cannot suffice for an illness that requires confinement at a hospital.

The money has to be returned after two months which boil down to postponing the burden of having to look for additional resources for the purpose.

8.3 On the Sufficiency of Funds

While the setting up of the scheme is a commendable effort especially especially in preparing the community members for health-related eventualities, the members recognize that the present level of their funds ((which stood at P2,584.97) is insufficient.

First, if there would be more than five members who will need to borrow the maximum allowable amount of P500.00 each from the fund, there would not be enough funds to lend. Second, even if there is only one case of a member who falls ill and needs to be confined in a hospital, the present scheme is unable to shoulder the total cost of health care services needed.

Members say that the amount loaned is only enough for transportation, start-up dosage of medicines and other related expenses incurred by whoever takes care of the patient in the hospital. This is especially true if the patient-cannot be attended by local hospitals in Davao del Sur and would need to be brought to the Davao Medical Center in Davao City.

To support additional costs of medical treatment, their standard practice is to use their BHW Card to obtain health privileges such as free or minimal consultation or hospitalization cost.

One recipient has actually sold some pieces of property, while the others have personally borne part of the cost or solicited some money from relatives or friends. In view of this inadequacy, the cooperative has come up with suggestions and plans on how

to spawn more income to increase funds, e.g. herbal plants production and Botica sa Barangay.

Recognizing the insufficiency of the present level of funds, the members are generally willing to increase the amount of their contribution if it is within their means and if so agreed by the majority of the members. No definite amount or ceiling was given, however.

9.0 IMPROVING AND SUSTAINING THE SCHEME

When posed with the question what can you suggest to make the scheme more capable of responding to the health needs of its members? Some members did not have definite ideas. Some felt that the organization was functioning well enough save for the problem of some who are not able to attend meetings since they are not allowed by their husbands to do so. Other feel it is too early to give their opinion since the scheme is still on an experimental stage.

However, some suggestions given included pursuing a drug store (botica sa barangay) project and increasing the monthly dues (the present level of which is P2.00). The second suggestion was supported by many of the members for as long as the amount of contribution is within their means and is agreed upon by majority of the members.

When asked whether they thought the scheme would be sustainable given the present number of members and the present amount of funds it is able to generate from each member, the members had diverse opinions.

One member thought the scheme is sustainable since the members are granted privileges of free hospitalization and other health services. The emergency assistance can be used to purchase medicines not available in the hospitals. Another thought the scheme would be sustainable if loans are repaid since this is their primary means of generating funds.

Other members thought otherwise. One said it would be difficult for them to sustain the scheme along with their other activities as BHWs since her own husband along with several other husbands of other members keep discouraging them from joining meetings and activities.

Another member said that the present number of members (32) and level of fudns would not yet make the scheme sustainable especially if a lot of the members get sick at the same time.

When asked to identify what kind of support and from whom would the scheme need in order to sustain it, most pointed to the government (DOH) and the DMSF-IPHC as providers of financial support and supply of medicines. However, others merely said that they could not think of anyone else.■

Case Study No. 2 PERSONAL ONE-TIME PAYMENT AND AD HOC CONTRIBUTION: The STO. NIÑO HELPING HANDS (SNHH), Sto. Niño, New Corella, Davao Province

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Case Study No. 2 PERSONAL ONE-TIME PAYMENT AND AD HOC CONTRIBUTION: The STO. NIÑO HELPING HANDS (SNHH), Sto. Niño, New Corella, Davao Province

1.0 BARANGAY PROFILE

1.1 Creation

Sto Niño became a regular barangay by virtue of the Provincial Board Resolution No. 595, dated September 20, 1972. It is one of the 20 barangays of New Corella, a municipality in the province of Davao (see Figure 7 for location of New Corella. It comprises of six (6) Puroks.

1.2 Location

The barangay is located in the northern portion of the municipality. It is eight kilometers away from the municipal hall, and 27 kilometers away from the provincial capitol.

1.3 Topograhical Characteristics

The barangay has a total estimated area of 800 hectares. Its terrain consists of flat and rolling areas evenly distributed throughout the whole barangay.

1.4 Accessibility from the Provincial Capitol

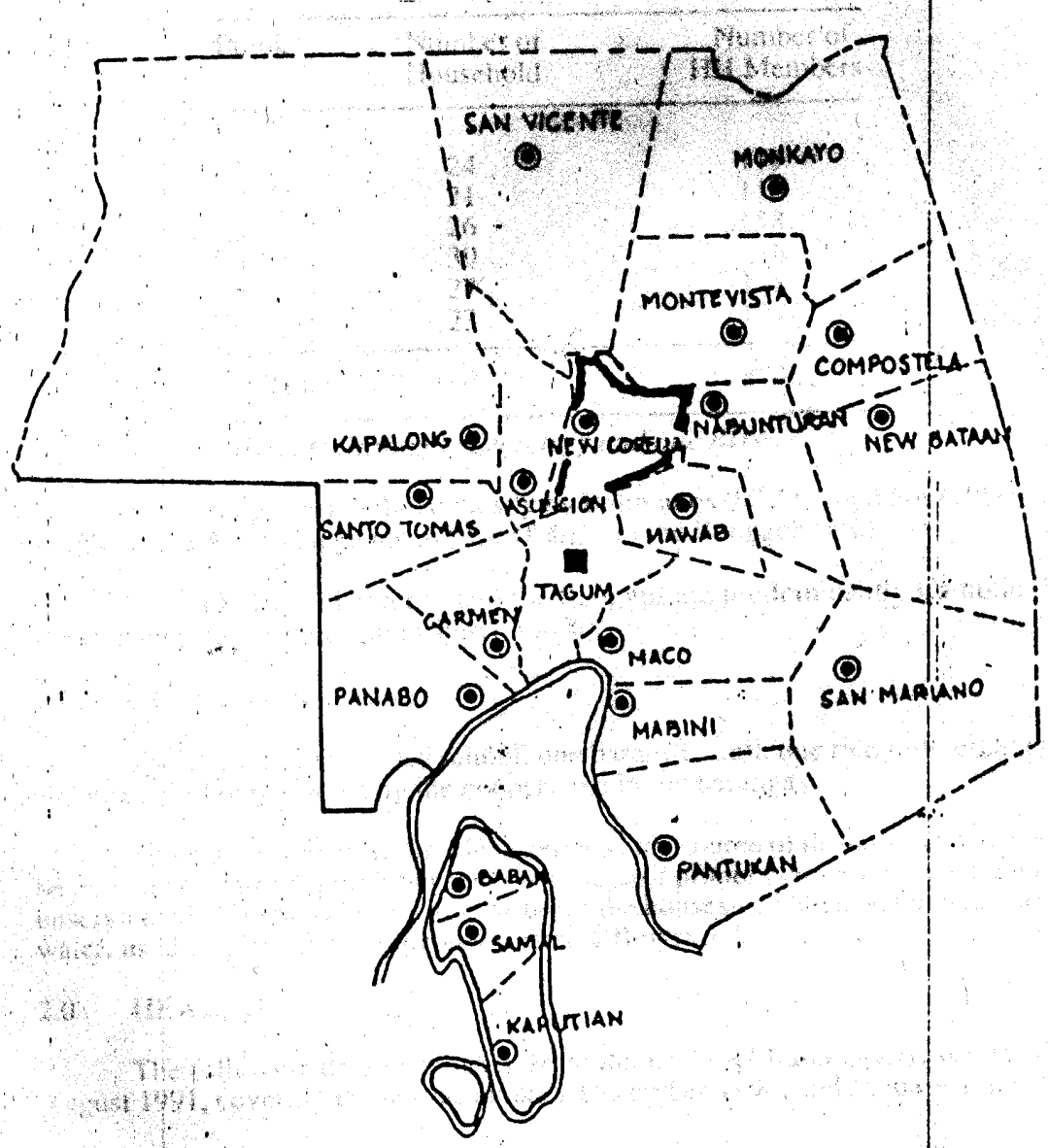
Poblacion New Corella is accessible by any means of transportation and there are regular passenger jeepneys traveling on compact municipal roads. Although the jeepney leaves only the terminal when full, but the average number of trip is one every 20 minutes.

The barangay too is accessible by any means of transportation, but the most common mode of public transport is the motorcycle which may carry as many as five to six passengers per trip. The minimum number of passengers however, is four. These motorcycles are parked at the terminal within the vicinity of the poblacion's public market.

1.5 Primary and Secondary Sources of Livelihood

Primary source of livelihood is farming (85%), with rice as the major crop grown. But the land is also planted to coconut, corn, coffee, peanuts, fruit trees, and bananas. Secondary sources of livelihood is through employment (5%), duck raising (5%), sari-sari store (3%) and carpentry (2%).

FIGURE 7. LOCATION MAP OF NEW CORELLA



DAVAO PROVINCE

1.6 Household and Population Composition

There are, as of March 1993, 160 households, and a total population of 879, distributed as follows:

Table 20. Distribution of Household and Household Population by Purok

Purok	Number of Household	Number of HH Members
1	24	119
2	21	110
3	26	158
4	39	216
5	27	148
6	23	128
Total	160	879

Sources: Barangay Secretary and one BHW

The barangay is inhabited mostly by Boholanos (80%), Leyteños (10%), indigenous people of the Ata-Mangguangan tribe (8%), and the Ilonggos (2%).

The Boholanos, Leyteños and Ilonggos are predominantly Catholic (90%), and a few belong to the Protestant Church (10%).

1.7 Other Characteristics

There is one elementary school, one barangay hall, one rice mill, eight chapelettes, and one storehouse owned by the cooperative in the barangay.

There are six open wells which serve as the source of drinking water. There used to be jetmatic pumps per purok but because of lack of proper maintenance, these have become unserviceable for several years now. Most of the houses still have water tanks to collect rain water, used largely for washing and watering flowerbeds.

2.0 HEALTH

The following data were taken from the DOH XI Barangay Health Profile done in August 1991, covering the period January-December 1990, and January-June 1991.

			Jan-Jun 1991	Jan-Dec 1990
2.1	**Health Status**			
2.1.1	Total Birth	Male	14	9
		Female	13	11
2.1.2	By Location at Birth			
		Home	24	18
		Hospital (Govt)	3	2
2.1.3	Attendance at Birth			
		Physician (Govt)	2	2
		Midwife (Govt)	1	3
		Trained Hilot	22	11
		Untrained Hilot	2	4
2.1.4	Leading Causes of Morbidity/Illness			
		Cough	68	62
		Fever	42	35
		Epigastric pain	15	16
2.1.5	Leading Causes of Infant Morbidity			
		Cough	20	15
		Fever	15	12
		Epigastric pain	9	7
2.1.6	Leading Causes of Mortality/Death			
		Stab wound	(none)	1
2.1.7	Leading Cause of Infant Mortality		(none)	(none)
2.1.8	Number of Perinatal Deaths		(none)	(none)
2.1.9	Causes of Maternal Deaths		(none)	(none)
2.2	**Health Resources**			
2.2.1	Manpower			
		Physician	0	0
		Dentist	0	0
		Nurse	0	0
		Medical Technologist	0	0

Sanitary Inspector	0	0
Midwife	2	2
Barangay Health Worker	12	12
Trained Hilot	1	1
Untrained Hilot	1	1

2.2.2 Health Facilities

Rural Health Center	0	0
Barangay Health Station	0	0

3.0 SOCIO-ECONOMIC FACTORS (Mid-Year, 1991)

	No.	Total HH served	Total Pop'n served
3.1 Environmental Indices			
Shallow/Open well	6	89	n.d.
Rain water	10	10	n.d.
3.2 Types of Toilet			
Flush	0	-	-
Water sealed	69	69	414
Antipolo/pit privy	43	43	258
Over-hang	20	20	20
3.3 Garbage Disposal			
Compost pit	52	52	n.d.
Dumping	20	20	-
Burning	40	40	-
Thrown anywhere	20	20	-
3.4 Communication			
Radio	85	85	-
Television	1	1	-

4.0 PREVIOUS DMSF-IPHC PROJECTS

4.1 The CHILD Project

Sto Niño was one of the 188 barangays included in the 283 CHILD project communities in 1986. When the project ended in 1990, the barangay was able to accomplish the following:

1. Trained 12 BHWs
2. Built 69 water sealed and 43 antipolo type toilets
3. Encouraged 52 households to dig compost pits for their garbage

4.2 The AADP Project

Although it was not chosen to become one of the SHIELD recipients, the AADP was implemented in the area during the last quarter of 1990. This project made it possible for the establishment of the Sto. Niño Multi-Purpose Cooperative, receiving a grant of P114,371.00 for the construction of a warehouse. The community's counterpart, with a peso value equivalent of P90,823.00, were the 67 square meter-lot, and the labor provided by the members. The warehouse was completed in the last quarter of 1991, which can store a minimum capacity of 2,000 cavans of palay.

4.3 LDAP-IPHC Project

Then in May 1992, the municipality of New Corella was chosen to become one of the two pilot projects of the Local Development Assistance Program (LDAP) of the Philippine Business for Social Progess (PBSP). The project entitled "Partnership Mechanisms in the Management of Basic Health Care Programs and Services" is implemented by the IPHC in collaboration with the NGOs and LGUs, especially the Municipal Health Office (MHO).

The project's general objective is to improve the health delivery system especially in marginalized communities.

With the implementation of RA 7160, or the Local Development Code of 1991, IPHC gained official recognition from the Municipal Government of New Corella as one of the NGOs working toward development. In a regular session held on July 13, 1992, the Sangguniang Bayan of the Municipality of New Corella passed Resolution No. 102, series of 1992, accrediting the IPHC as one of the LGU partners.

On October 22-24, 1992, 54 participants from the Municipality of New Corella, attended the "New Corella Municipal Consultation on Health Service Delivery and Planning" held at the Mindanao Training and Resource Center in Davao City. Composed of municipal and barangay officials, MHO personnel, BHS personnel and BHWs, the participants were able to come up with each respective Barangay Health Plans.

Other LDAP activities carried out to date are the LDAP Orientation, Management Information System 1 and System 2, Barangay Health Plan, Municipal Health Plan, Health Skills 1 to 3, Environmental Training, Micro-Business Enterprise, Process Documentation, and Monitoring and Evaluation.

Support to these trainings, consultations and seminar-workshop, either in cash or in kind or a combination of both, came from the barangay councils, the muniCiDal government, the DOH and the barangay residents.

On February 23, 1993, Mayor Daniel B. Turan of the Municipality of New Corella signed Memorandum Circular No. 93, informing the Sangguniang Bayan and the Local Health Board (LHB) that the duly authorized representative of the DMSF-IPHC is an additional member to the Local Health Board.

It is largely through this project that the community health financing scheme in the Municipality of New Corella was initiated, and the health care and health delivery concerns of the municipality was further strengthened.

5.0 CULTURAL AND ATTITUDINAL CONSIDERATIONS

Long before these projects were implemented in Sto. Niño, the residents have already banded themselves in order to give support, in cash or in kind, to any one who gets married or to the family whose member dies. Being "Bol-anons" (80% of the residents come from Bohol or of Boholano lineage), they claim the "idja-idja, aho-aho" (which literally means "they on their own, us on our own") nomenclature must have some truth in it because they always have that tendency to band together almost to the exclusion of other groups. However, they also claim, they are ready to help anybody who is in need, regardless of whatever ethnicity or religion he or she belongs.

For every Bol-anon male offspring, the parents are to contribute P200.00 everytime a male member of the Boholano Community gets married. Thus, if one have three sons, and one's neighbor's son gets married, he is bound to contribute P600.00. And this is not all there is to it. Every member household also gives 6 gantas of rice, - and firewood.

The same self-help practice holds true when a household member dies. All the other households contribute P20.00 in cash, and donate any of the following: rice, firewood, mung beans, coffee and what else's. They take turns in the preparation of snacks or meals the entire duration of the vigil. Male members also take care of the tomb construction or in graveyard digging.

However, loose and informal, these forms of cooperation did serve its primary purpose. Although there were neither elected nor appointed leaders, no official by-laws, no clearly drawn tasks and functions, yet each practice was dutifully observed and carried out.

Cooperation did not end with these practices. It also found its way to school projects, community undertakings and even family problems. The school's fence, although a PTA project, would not have been made possible if non-PTA members refused to donate some amount and willingly volunteered their labor. Purok structures were built from materials and labor ungrudgingly extended. Anybody who got sick received either solicitous advice, a andful of medicinal roots and leaves, a few pieces of eggs each morning, and even some tablets or half-

emptied bottles of medicine from someone else who suffered from the same illness few months before.

In general, they are welcoming people. Even strangers who come to their place armed only with a short introductory note from the Mayor can be assured of a bed and board for the night. And if he or she has established goodwill, he may stay for as long as he likes.

The people, their culture, and their sense of oneness and selflessness paved the way for the CHILD, the AADP and the LDAP projects and laid the foundation of a community-based health financing scheme.

6.0 THE STO. NIÑO HELPING HANDS: ITS BEGINNINGS

6.1 The Organization

In the morning of May 3, 1992, the Barangay Council of Sto. Niño passed Resolution No. 8, series of 1992, accrediting the DMSF-IPHC as partner in development work of the LGU in Barangay Sto. Niño, New Corella, Davao.

After the regular session was adjourned, the barangay officials who were present, the Purok leaders, the BHWs and all other residents who opted to stay behind, continued with their discussions with the LDAP Project Officer (PO). The agenda at hand was how best to carry out an effective basic health care program and services.

Among other things discussed, the PO floated the idea of a scheme, specifically to give financial assistance to anybody who gets sick and is in need of professional medical attention, and even hospitalization. Citing the residents' cooperation when somebody gets married, or dies, the challenge was posed why not also extend help to the sick. Why not give minimal contribution to a fund from which can be drawn amounts to pay for whatever medical expenses which can be incurred.

Since the scheme is a complementation to the LGU/DOH medical subsidies, LDAP-IPHC's role is solely to assist in terms of technical expertise, and not in the provision of funds. The funds for emergency hospitalization should, therefore, come from the health association organized for the purpose.

On that same day, after thorough deliberation, the Sto. Niño Helping Hands was organized.

6.2 Membership

1. It is open to all residents of the barangay who are willing to join.

2. Those who are willing to join pay a membership fee of P100.00.

3. Upon payment of membership fee, a list of the complete household members should be submitted to any of the BHWs in his/her purok who will submit the list to the Treasurer upon his/her election.

4. All the present members of the household are also considered as members. However, any member of the nuclear family who has been living separately will only be considered member if he/she pays the membership fee. Any additional household member will also have to pay the membership fee.

6.3 Drafting and Approval of the Constitution and By-Laws

From May to June, 11 BHWS, 5 barangay officals, and 6 purok leaders sat down and drafted the SNHH Constitution and By-Laws.

On July 8, 1992, the Sto. Niño Helping Hands Constitution and By-Laws was ratified. Election of officers followed. The elected treasurer asked for the initial list of those who signified their membership.

There were 36 members. (Constitution and By-Laws, July 1992)

6.4 Other Concurrent Activities

Simultaneously done was the collection of P100.00 membership fee from those who were willing to join by the BHW who resides in each purok. Deadline of membership fee payment was set on August 31, 1992.

The barangay officials, purok leaders, and anybody who has signified willingness to join the scheme lost no time in informing the others about SNHH.

6.5 Initial Reactions to SNHH

According to the President and Treasurer as well as the BHW-informant interviewed, there were more "cynics and skeptics rather than believers" even during the inception of this scheme.

Others opted for the "wait-and-see" attitude, and said they will only join when the scheme has carried out its objectives of giving assistance in times of emergencies.

A few others waived their membership at a much later time when they are able to raise the P100.00 membership fee.

7.0 PERFORMANCE RESULTS: SEPTEMBER 1992-OCTOBER 1993

Since the deadline for membership was set on August 31, 1992, actual operation started on the first day of September.

7.1 The First SNHH Meeting

On its first quarterly meeting on September 1,1992, the number of members grew to 51. The treasurer duly reported a total collection of P5,100.00, as per the August 31, 1992 deadline set in Article V, Section 3 of their Constitution. With this amount on hand, one resolution was carried out, and was later incorporated in the By-Laws, that only those who were actually hospitalized were to be the priority recipients of the 20% of the total fund. This was agreed upon so that what little fund they had would not be readily consumed.

7.2 Data on Membership

In October, membership reached 60, but 2 dropped during the December General meeting. Thus, at the end of December 1992, there were only 58 members. On its June 5, 1993 quarterly meeting, one of the members formally informed the officers and members that he be officially dropped from the roll because he cannot as yet pay all the cash replenishment. Thus, by June 5 till October 31, 1993 there were only 57 members.

7.3 The First Assessment

On January 2, 1993 a special meeting was called. There were four agenda:

1. Evaluation of SNHH after four months of operation;
2. Limitation as to the number of times a patient can avail of the assistance within one year;
3. Exemptions from claims; and
4. If expenses incurred having been confined in a private hospital should be refunded.

Agenda 1. Results of their evaluation showed that the association has really been of help, except for some mattes which need review and revision and be subsequently incorporated in the By-Laws during any of the succeeding quarterly meetings. Per three other agenda above, the following were approved and duly recognized as amendments:

Agenda 2. Any member, including each of his beneficiaries, is entitled to three maximum allowable number of claims per year, subject to the following stipulations:

1st claim = 20%
2nd claim = 10%
3rd claim = 5%

Table 21. Data on Availment of Hospitalization Assistane from Sto. Niño Helping Hand (September 1992 – October 1993)

Date of Acceptance Release	Position in the Household	Reason for Confinement	Where Confined (Name and Addresses of Clinic/Hospital	Total Amt. Incurred by Family	Total Amt. Released by	Remarks
9/4/92	Head of Family	Amoebiasis	Regional Hospital Tagum, Davao	P 404.50	P 404.50	
10/2/92	Wife	Dysentery	Tagum Doctors Hosp. Tagum, Davao	1,062.00	1,062.00	
11/28/92	Head of Family	Broncho-pneumonia	Regional Hospital Tagum, Davao	527.18	527.18	
10/8/92	Daughter (1st availment)	Heart ailment plus other com-placations	Regional Hospital Tagum, Davao	All in all more than P5,000.00	1,300.00	Patient died Sometime in March 1993
12/-/92	(2nd availment)	- do -	- do -	-	478.65	
6/24/92	(3rd availment)	- do -	- do -		300.00	
12/-/92	Daughter	Fractured right __	- do -	932.00	932.00	
1/01/93	Wife	Mastectomy: Chemotherapy from Jan. to June	- do - MMGI, then Davao Doctors Hospital Davao City	More than P40,000.00	1,100.00	
1/01/93	Wife	Dysentery	Regional Hospital Tagum, Davao	494.00	494.00	
1/28/93	Son (1st availment)	(Records only indi-cated: complicated ailment)	- do -	All in all more than P4,000.00	1,100.00	Died in June 1993
2/14/93	(2nd availment)		- do -		417.00	
2/27/93	Wife	Dysentery	Nocilla Clinic, New Correla, Davao	351.00	241.00	Excess of Medicare
4/01/93	Son	Broncho-pneumonia; Asthma	Regional Hospital Tagum, Davao	2,000.00+	1,140.00	
5/25/93	Daughter	Appendicitis	Tagbilaran General Hospital, Tagbilaran City, Bohol	5,000.00+	1,140.00	She wired some of the receipts to her parents in Sta. MLA.

6/10/93	Daughter	Typhoid fever	MMGI. Davao City	2,295.00	1,120.00	
6/14/93	Head of the Family	Cyst operation	Regional Hospital Tagum, Davao	285.35	285.35	
8/04/93	Head of the Family	Dysentery	Tagum Doctors Hosp. Tagum, Davao	760.00	760.00	
10/04/93	Daughter	Broncho-pneumonia–	Regional Hospital Tagum, Davao	2.000.00+	878.75	
10/04/94	Daughter	Malaria	MMGI-Erum Clinic Tagum, Davao	554.40	554.40	Excess of Medicare
(not included)	Son	____ operation	MMGI Davao City	297.20	297.20	Excess of Medicare
				Total Released to Date:	**P 15,037.40**	

*Some of the data were supplied by the BHW contact person.

Agenda 3. The following are exemptions (or are not allowed for any claim or refund) –

b) Suicide
c) Vehicular accident
d) Accidents which are directly caused by:
   - being drunk
   - acts of violence 'amok'
   - any kind of brawl or altercations

Agenda 4. Should a member be confined, in a private hospital, only expenses incurred for medicines will be refunded. Bills for room and board will be excluded.

8.0 THE INTERVIEW AND THE FOCUS GROUP DISCUSSION RESULTS

8.1 Members' Evaluation as to Benefits

From among the key informants interviewed, and those who participated in the focus groups discussion, it was teamed that the SNHH has generally been of help. Specifically, it has given the members a feeling of security that it is always there ready to refund hospitalization expenses.

When asked as to whether they are satisfied with the amount granted, majority of those who have actually made claims said that inasmuch as the financing scheme has only been in actual operation for a year, it has even exceeded their expectations.

Even the member who has spent more than P40,000.00 for mastectomy and subsequent chemotherapy treatments said that the P1,160.00 she claimed from SNHH after her hospitalization covered almost half of her first chemotherapy treatment. Her husband who was nearby during the interview, opened that it is not so much as to the amount actually given, but what mattered most was the thought that there are people, each willing to share, behind every peso given.

One mother-respondent, whose three sons are asthmatic, and whose youngest daughter was born with a congenital heart defect said that the financing scheme has benefited her family very much. But although each of her nine children are each entitled to the three maximum allowable number of claims, she availed only once each for the two of her children who were confined for more than three times within the period. She said if she would have claimed the maximum allowable number for both, she would have felt she has abused the association's help. Although, she said, the members would not think of it that way. It was, for her, simply a matter of discretion, because the association is just starting and the funds are dependent only on members' contribution.

8.2 Plans and Projections for the Next Year\

According to the President and the Treasurer, next year's plans will be discussed in the association's general assembly scheduled on the first Saturday of December, 1993. A general assessment on the SNHH's overall performance for the past 14 months will also be done.

Per their last quarterly meeting, it was decided that all those with unsettled "hulipans" should pay the total unpaid amount of contributions due to date, within the grace period September 1 to November 30, 1993. Those who cannot still settle their dues up to the third "hulipan" by the end of November, and without any word or advice to any of the officers as to intention of settling them beyond the deadline set, will be automatically crossed off from the list of members. This includes the whole household.

Within this period also, until the first Saturday of December, all the other members will be actively campaigning for the others to join the association. According to the President, if they can convince all the households to join by the end of 1994, this will really make a difference as to total amount of grant or refund that can be released in any given time.

As of October 31, 1993, the proportion of actual SNHH members to the present number of households per purok is as follows:

Table 22. Percentage of Actual SNHH Members to Present Households, by Purok

Purok	Present No. Of Households	Actual Number of SNHH Members	%
1	24	11	45.8
2	21	5	23.8
3	26	8	30.8
4	39	12	30.8
5	27	13	48.1
6	23	7	30.4
TOTAL	160	56	35.0

Also included among their plans, which the officers hope will be approved in the general assembly and which will become effective at the start of 1994, are the following:

8.2.1 In case of hospitalization of either wife or husband, or of any of the household members wherein it is necessary for any or both parents to stay with the patient, all the SNHH members will agree to follow a schedule of work to be done, prepared by a committee tasked for the purpose, which may be any or all of the following:

a) look after the children, if any, who will be left on their own as well as attend to all other household chores;

b) feed the animas raised by the couple including the pasture of carabao and cow, if any; and

c) carry out all farm activities being done or will have to be done by the couple until such time as the patient is seen fit to go back to work, e.g., plowing, irrigating, spraying pesticides, fertilizer application, weeding, harvesting, threshing, and if need be, even marketing.

8.2.2 Refund of all expenses incurred for consultation fees, laboratory tests and medicines which are less than or equivalent to the 20% of the total fund, by any member treated on an outpatient or ambulatory basis.

8.2.3 Their Constitution and By-Laws, including all the amendments, will have to be finalized before the year ends so that the association can already be registered with the Securities and Exchange Commission.

Although both officers interviewed were not able to give definite percentage projection as to increase in membership, they expressed confidence that those who opted

for the "wait-and-see" attitude for the past 14 months, may join the association by January 1994.

9.0 AVAILMENT OF BARANGAY HEALTH STATION (BHS) SERVICES *BEFORE* AND *AFTER* SCHEME

A look into BHS health services utilization of the Sto. Niño residents, which is under the supervision of the BHS located at Barangay Limbaan was also done. Bgy. Limbaan is located halfway between Sto. Niño and the poblacion.

Each household has a separate file, and in each of these files are recorded the dates, names, and nature of complaints, and the corresponding diagnosis as well as treatment dispensed by either the rural health midwife (RHM) or the rural health physician (RP). All in all, there are 66 file-folders, each with recorded treatments from as far back as September 1989 to October 14, 1993, the latest recorded consultation prior to interview date. Each of the residents supplied the BHS a folder.

From the 66 files (or 66 households), there are total of 93 patients attended to. The following tables show further pertinent data.

Table 23. Number of Households by Number of Household Members Treated at the BHS

Particulars	Number of Households	Total No. of HH Members Treated
Only one member per HH	42	42
Two members per HH	11	22
Three members per HH	5	15
Four members per HH	1	4
Five members per HH	2	10
No member treated / No data recorded on file	5	-
TOTAL	66	93

Majority of the households (42) only had one member who has availed of the services of the BHS. Among those who had more than two household members who went to the BHS for consultation and/or treatment, the children were involved in almost 90% of these cases, complaining of suffering from cough, colds and fever.

Table 24. Number of Consultations and/or Treatment per Individual Patient (September 1989 – October 1993)

Frequency of Consultation/ Treatment Per Patient	No. of Patients	%	Total No. Consultations or Treatment Per Frequency	%
Once	67	72.0	67	48.6
Twice	15	16.1	30	21.7
Thrice	6	6.5	18	13.0
Four times	4	4.3	16	11.6
Seven times	1	1.1	7	5.1
TOTAL	93	100.0	138	100.0

Close to three-fourths of the patients (72.0%) went only once for consultation and/or treatment. One patient who has had seven consultations, had six of these from May to November 1990 for cough, fever and skin problems, and the last one in March 1991 for cough and ear problems.

Table 25. Number of Consultations and/or Treatment by Year (September 1989 – October 1993)

Year	Number	%
1989[a]	3	[b]
1990	58	43.20
1991	33	24.60
1992	23	17.20
1993	16	12.00
Date not specified/ unrecorded	4	3.00
TOTAL	137	100.00

[a] There were less number of consultations/treatments in 1989 because the residents from barangays went directly to the Municipal Health Center. In December 1989, a particular directive came from the MHO that by January 1990, residents should first seek diagnosis of treatment from the BHS to which their barangay belongs. The Rural Health Unit (or the Municipal Health Center) will only attend to cases referred to them by the BHW or by the Rural Health Midwife assigned in the particular BHS, or cases diagnosed to be complicated or in advanced stages.

[b] Not included in the computation or percentages. N=134.

Table 26. Percentage of Household as to SNHH Membership as of October 31, 1993

Particular	No.	%
Number of Household which have become SNHH members	49	74.2
Still Non-SNHH members by October 1993	17	25.8
TOTAL	66	100.0

The 49 households make up 87.5% of the present number of SNHH members, and comprise 30.6% of the total number of households (Table 22). Although it would seem right to say that the Helping Hands had, for it s early willing members, those who have had cases of illnesses (which in this particular study was limited to as early as 1990), but such an observation would have been as reliable had an equal representative of households who never went to BHS for treatment and/or who did not join the SNHH upon its inception in July 1992 was also included in this study.

As such, we can only conclude that majority of those who have availed of the health services offered by the BHS make up the greater number of those who openly showed ready acceptance of the objectives of the Helping Hands.

10.0 CONCLUSIONS

The Sto. Niño Helpig Hands, as with the other self-help financing schemes in the region, has only been in actual operation for fourteen months. It is still periodically adjusting its policies and procedures based on what the members observe, and decide, as necessary.

Even the experiences of the 18 beneficiaries, which constitute only 5.8% of the 310 total SNHH household member-beneficiaries, and only 2% of the total barangay population, cannot be considered reliable basis to determine whether the benefits granted by the SNHH has really made an impact to the community or not.

To say that the SNHH has been of help can only be taken as true from the point of view of each individual beneficiary relative to the particular need and the reciprocal financial capability to respond to that need.

Financial equity cannot as yet be established because there are no data as to each member's net monthly income. Inasmuch as these 56 members are dependent on rice farming as their primary means of livelihood their produce for the last five years (or equivalent to ten harvests) would have to be studied to be able to get a reliable average yield per harvest. The five-year period could adequately cover the years with average rainfall, the pre-and the post-El Niño period, and the 1992-1993 months when the northeast monsoon rains ravaged the area.

This association does not receive financial allocation from the barangay's cooperative. It did not receive any grant from either the LDAP and RESPOND projects. Resources come directly from the members' one-time membership contribution, and from the cash replenishment they give after medical refunds have been made.

STO. NIÑO HELPING HANDS
Sto. Niño, New Corella, Davao

BATAKANG BALAOD

Alang sa kasayuran sa tanang makabasa niini:

Kami nga mga motimaan sa among ngalan sa ubos mga miebro sa Sto. Niño Helping Hands ug mga lumulupyo sa Sto. Niño, New Corella, Davao nagkauyon sa pagmugna niining mosunod nga kodigo sa Batakang Balaod alang sa Sto. Niño Helping Hands Organization.

ARTIKULO I
PANGALAN SA KAPUNUNGAN

Seksyon 1. Ang pangalan sa kapunungan mao ang Sto. Niño, New Corella, Davao.

ARTIKULO II
DAPIT NGA NAHIMUTANGAN

Seksyon 1. Ang buhatan sa maong kapunungan nahimotang sa Sto. Niño, New Corella, Davao.

ARTIKULO III
TUMONG UG KATUYOAN

Seksyon 1. Aron matabangan ang adunay balatian nga mga miembro sa Sto. Niño Helping Hands Organization.

Seksyon 2. Aron adunay pondo nga makuhaan panahon sa dinalian nga panginahanglan sa mga Miembro nga adunay balatian.

Seksyon 3. Aron pagtambayayong sa local nga paggamhanan sa pagpalambo sa maayong panglawas.

ARTIKULO IV
MGA MAMAHIMONG SAKOP

Seksyon 1. Bukas alang sa mga pamilya nga lumulupyo sa Sto. Niño, New Corella, Davao.

Seksyon 2. Panahon sa magmugna sa maong organization/LDAP Project kadtong lumulopyo nga wala pa magpamiembro pede pang moapilapan bayaran ang membership fee ug ang mga hulip.

Seksyon 3. Ang pamilya nga gikan sa laing lugar nga nia na manimuyo mo-apil apan bayaran ang membership fee.

ARTIKULO V
MGA TULOMANON UG GIMBUHATON

Seksyon 1. Isipon siya nga usa ka miembro kung makahatag siya ug membership fee sa kantidad Nga usa ka gatos ka pesos (P100.00).

Seksyon 2. Kinahangalan ang miembro motambong ug tigum, seminar, training nga Pagasiugdan sa LDAP Project.

Seksyon 3. Dedline sa paghatag sa membership fee karong Agosto 30, 1992.

ARTIKULO VI
MGA OPISYALES

Seksyon 1. Mga opisyales ug ilang boluhaton:

Presidente	-	modumalasa tigum - motimaan sa mga papeles ug momatuod sa mga salapi nga mosulod ug mogawas sa panudlanan sa kapunungan - motawag ug dinalian nga tigum pinaagi sa sugyot sa usa katulo (1/3) ka bahin sa mga miembro kon adunay mga mahinungdanong butang nga pagahisgutan, pagatukion.
V – Presidente	-	maoy mopuli sa katungdanan ug mga bulahaton sa mga Presidente Kalihim mohimog mga minutos sa tigum - motipig sa talaan sa mga miembro ur sa mga mahinugdanong papeles
Mamahandi	-	maoy tinugyanan sa panalapi sa kapunungan - motipig sa mga record sa salapi nga mosulod ug mogawes sa panudlanan sa kapunungan
Tigsusi	-	mosusi sa bahandi sa kapungan

ARTIKULO VII
MGA BENEPISYO

Seksyon 1. Ang mabinipesyohan mao lang ang sakop sa pamilya.

Seksyon 2. Sulod sa tulo ka hulipan ang miembro dili makahatag pagatakakon isip miembro Sa maong kapunungan ug dili niya makuha ang iyang membership fee.

Seksyon 3. Ang manganak nga dili normal puede siyang makakuhasa pondo.

ARTIKULO VIII
KATUNGOD UG PRIBILIHIYO

Seksyon 1. Ang mga miembro may katungod sa:

a) pagpili sa mga opisyales
b) pagpili sa bisan unsang posisyong sa pangatungdanan

Seksyon 2. Ang miembro makakuha sa kantidad nga biente porsento (20%) sa kinatibukang kantidad diha sa pondo ug kini pagahulipan sa tanang miembro.

Seksyon 3. Ang angayan nga gastohan sa maong kantidad mao lang ang hospital bill, Medisina ug doctor's fee ug kini suportada sa mga resibo.

Seksyon 4. Kon adunay sobra 20% nga iyang gikuha kinahangalan nga iyang iuli sa pondo.

Seksyon 5. Kon ang iyang panghinahanglan moubos sa kuatro centos (400.00) pesos dili siya makakuhasa pondo.

ARTIKULO IX
TIGUM

Seksyon 1. Ang tigum pagahimuon usa kasemana human makuha ang kuwarta dala na ang hulip.

Seksyon 2. Ang tigum makausa suold sa kada tulo ka bulan nga pagahimoon sa kada unang Sabado sa ala una (1:00 p.m.) and takna sa hapon.

Seksyon 3. Ang tinuig nga tigum pagahimoon sa unanag sabado sa Energo.

ARTIKULO X
AMMENDMENT

Seksyon 1. Kining batakang balaod mahimo nga amenduhan sa regular nga tigum sa Sto. Niño Helping Hands sa may gidaghanan nga 2/3 votes.

ARTIKULO XI

Kini nga batakang balaod maga-epekto pinaagi sa pag-uyon sa tanang miembro sa Sto. Niño Helping Hands niing bulan sa Setyembre 1, 1992.

Case Study No. 3 **ONE-TIME PREPAYMENT AND AD HOC CONTRIBUTIONS FOR MEDICAL GRANT, MEDICAL LOAN AND FREE TABLETS: NEW SAMBOG HEALTH AND HOSITALIZATION ASSISTANCE (NESAHRA)**
New Sambog, New Corella, Davao Province

1.0 BARANGAY PROFILE

- 1.1 Background Information
- 1.2 Socio-Economic Indices
  - 1.2.1 Water Resources
  - 1.2.2 Types of Toilet
  - 1.2.3 Garbage and Sewage Disposal
- 1.3 Health Resources
- 1.4 Health Status

2.0 HEALTH CARE PRACTICES AND HEALTH SERVICES UTILIZATION *BEFORE* SCHEME

- 2.1 Health Care Practices
- 2.2 Health Services Utilization

3.0 THE NEW SAMBOG HEALTH AND HOSPITALIZATION ASSISTANCE (NESAHA)

- 3.1 The Organization
- 3.2 Objectives
- 3.3 Who are Qualified to Become Members
- 3.4 Membership Process
- 3.5 Benefits
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4.0 PERCEPTIONS AND ATTITUDES TOWARD THE NESAHHA

- 4.1 Initial Reactions to the Setting-up of the Scheme
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- 4.3 Perception as to Sustainability

5.0 PLANS AND PROJECTIONS FOR 1994

Case Study No. 3 ONE-TIME PREPAYMENT AND AD HOC CONTRIBUTIONS FOR MEDICAL GRANT, MEDICAL LOAN AND FREE TABLETS: NEW SAMBOG HEALTH AND HOSITALIZATION ASSISTANCE (NESAHRA)
New Sambog, New Corella, Davao Province

1.0 BARANGAY PROFILE

1.1 Background Information

New Sambog is one of the 20 barangays in the Municipality of New Corella, Davao Province (see Figure 5 for Location Map), with an area of 874 square kilometers. It is 3.5 kilometers away from the municipal hall, and 24 kilometers away from the provincial capitol. Access to the barangay is through motorcycles. As of December 1992, there are 104 households. Total population is 563.

Residents are composed of Boholanos (90%). Cebuanos (6%), Leyteños (2%), and Ilonggos (2%). Majority belong to the Roman Catholic church.

Ninety four percent (94%) are engaged in farming, and 6% earn their livelihood from employment. Rice is the major crop grown, along with corn, soybeans, coffee, banana, cassava, rootcrops and vegetables.

1.2 Socio-Economic Indices

1.2.1 Water Resources

There are five (5) artesian wells serving all the residents. The water has been found to be potable after the IPHC and the RHU examined them. There are also several shallow and open wells in the area.

1.2.2 Types of Toilet

According to the August 1991 Barangay Health Survey of the DOH XI, there are 63 water-sealed toilets and 29 antipolo/pit privy used by the residents. Eight households (there were 100 in August 1991), did not have their own toilets yet.

1.2.3 Garbage and Sewage Disposal

Per Health Plan Assessment done in October 1992 at the Mindanao Training and Resource Center (MTRC) in Bajada, Davao City, attended by the municipal and barangay officials, the RHU personnel, as well as BHWs coming from the different barangays, 69 households have already built their own blind

drainage. Of these, 60 have also dug compost pits with covers. The rest of the households neither blind drainage nor compost pits. Garbage are either burned in their backyard, or thrown anywhere.

1.3 Health Resources

The barangay is under the direct supervision of the Del Pilar, Barangay Health Station (BHS), which is about three kilometers away from the poblacion. There are no private clinics, and no private health practitioners in the area. There are however, six (6) BHWs.

Because of its proximity to the poblacion, residents have fairly easy access to the Rural Health Unit and other private clinics found in the poblacion center.

1.4 Health Status

The DOH XI Survey cited in 1.2.2 earlier also reported the following data:

1.4.1 All the four (4) reported births as of June 1991 were delivered at home, with a trained hilot (traditional birth attendant) in attendance.

1.4.2 Cough and cold are the leading causes of morbidity, all ages.

1.4.3 The two reported deaths, all ages, were due to vehicular accidents.

1.4.4 There were no data as to leading causes of infant mortality, and no reported cases of perinatal as well as maternal deaths.

2.0 HEALTH CARE PRACTICES AND HEALTH SERVICES UTILIZATION *BEFORE* SCHEME

2.1 Health Care Practices

The key informants interviewed, aside from being NESAHHA members, are either BHWs or close relatives of BHWS. Their experiences BEFORE the scheme therefore, would still cover the years they have been trained (for BHWS) or oriented to health and other health-related practices (for non-BHWs). As they are relatively young (28-32) -- they would either have to be unmarried and still living with their parents, or newly married and would still have to be strongly influenced by their parents – when the CHILD project was implemented in their barangay. Health care practices therefore, which are non-CHILD influenced, cannot be fairly established by system of recall alone.

Thus, when the informants mentioned the use of herbal remedies, it could either be attributed to having learned these from their training as BHWS, or having teamed these from their parents.

"Hilot" or massaging the head, or the stomach, or the back when there is pain felt, is very commonly done, especially at the onset of pain. After 24 hours, however, when the pain persists, the informants said that in most cases, they let the suffering household member take self-prescribed medicines. These are usually the over-the-counter drugs. Not unless the patient cries or writhes in pain would they bring him to the nearest doctor, or directly to the hospital in the provincial capital.

Even injuries like sprains, fractures, gashes or would are applied with homemade poultices. Serious cases of fractures are brought to the attention of the local masseuse (manghihilot), whose hands are believed to have healing powers.

2.2 Health Services Utilization

Prenatal check ups, immunizations and follow-up check up/consultations for either malnourishment or tuberculosis have been due to the performance of the BHWs of their functions, from as far back as 1986 to the present.

Before there were BHWS, only very few pregnant women have had regular prenatal check up. One informant even chided, "maestra lang man seguro and kahibalo mopaprenatal" (it seems only a teacher would know what prenatal is). What was practiced then was to be seen by the "mananabang" (traditional birth attendant) and through the beat of the mother's pulse, the position of the fetus can already be discerned. If the mananabang presses and pushes her abdomen in a clockwise motion.

Immunizations were also limited to the implemented immunizations, and, in most cases, only the children who were of school age were immunized. Most mothers did not even know what a DPT or a booster is. They only learned of this when the BHWs have become active.

Most parents only bring their children to the Rural Health Unit (RHU) when these are suffering from cough and cold for more than three days, when their fever have been on and off for almost a week, and when they seem to be lethargic and have lost their appetite. They almost always go to the RHU because they know there is always a medical personnel ready to attend to them, aside from not having to pay anything.

3.0 THE NEW SAMBOG HEALTH AND HOSPITALIZATION ASSISTANCE (NESAHHA)

3.1 The Organization

Its organization was the result of the implementation of the LDAP-IPHC project in the municipality of New Corella. One of the specific objectives of this project is to devise self-sustaining health financing schemes that can complement the LGU/MHO medical subsidies.

NESAHHA was officially organized in June 1992. A committee, composed of 11 members, was tasked to draft the Constitution and By-Laws. Composing the committee were three (3) Purok leaders, two (2) Sangguniang Panglungsod members, and six (6) BHWS.

3.2 Objectives

1. To establish a self-help group among the residents of Barangay New Sambog to be able to give assistance to any member or any member of the household who needs hospitalization; and

2. To cooperate with the local government unit in the pursuit of economic development

3.3 Who are Qualified to Become Members

1. Open to all families residing in Barangay New Sambog, New Corella, Davao who are willing to abide by and cooperate with the activities of the LDAP project;

2. Those who are willing to contribute, from his personal resources, in order to attain the aims and objectives of this association; and

3. Those who will observe and respect this Constitution and By-Laws, and who will wholeheartedly accept any responsibility or task given to him as a member of this association.

3.4 Membership Process

At the very start, when the officers were not yet elected, anybody who was interested had only to approach any of the BHWs and pay the membership fee of P20.00. Upon payment, he/she also submits a list containing all names and birthdates of the present members of the household. The total membership fees collected constitutes the general fund.

When the officers were elected upon the approval of the Constitution and By-Laws, membership fee was paid to the Treasurer, and the list of household members was submitted to the Secretary.

3.5 Benefits

All the members, including his or her household, can avail of free tablets, and is entitled to 50% of the total fund as medical grant. A member may also apply for medical loan without interest for the first six months. The loan bears a 5% monthly interest on the seventh month.

The association does not have any accredited medical practitioner. The member may choose to which clinic or hospital he may bring his patient.

3.6 Availment of Benefits and Fund Regeneration

Everytime a member or any of his household gets sick, he informs the nearest BHW, or his cluster leader who will in turn inform the BHW assigned to their area. One cluster is composed of five households. There are two BHWs per purok.

The BHW will make an initial diagnosis if the member will really need the attention of the doctor. After which, she will inform the President. The President will approve the BHWs recommendation and will notify the Treasurer for the release of medical grant.

As there are, at present, 29 members, the total fund amounts to P580.00 at P20.00 per member. The 10% is set aside for the purchase of tablets, 40% will be added to the general fund, and the 50% to be immediately released to the member who is sick.

The P20.00 per member is collected every time somebody gets sick. When one or two members cannot pay at once, the corresponding amount will be temporarily borrowed from the general fund. This will be replenished as soon as the members can pay their dues.

If the patient (or his family) wishes to apply for medical loan, the maximum loanable amount is P232.00 or 40% of the P580.00. There are no service charges. It bears no interest if to be paid within six (6) months. If still unpaid, or there is a remaining balance, the amount will bear a 5% interest per month. Interest payments will directly go to the general fund.

Tablets are dispensed for free so long as there are available supply. Purchases can only be made when a member gets sick, because that will be the only time the 10% allotment can be acquired. The P58.00 is used to purchase the commonly-needed tablets: Medicol, Biogesic, Aspilet, Neozep, Bentyl, and Serugan.

4. PERCEPTIONS AND ATITTUDES TOWARD THE NESAHHA

4.1 Initial Reactions to the Setting-up of the Scheme

As with the experiences shared by the respondents in Barangay Sto. Niño, the residents too of New Sambog had ambivalent reactions toward the setting-up of this scheme. Some were immediately sold to the idea, others accepted the objectives but opted to wait until after a year, and still others evidenced lukewarm reception as they have yet to see its actual operation.

Actual operation of the scheme started in July 1993, upon the approval of the Constitution and By-Laws. There were 35 members who signed in. According to two of the earliest members, they saw the merit of the scheme, that it can give immediate assistance in times of emergencies, however minimal that assistance is. In addition, the interest-free loan of P200.00 is much better than borrowing P100.00 at 8% or even 10% interest per month from the usual money lenders as is common in countrysides.

4.2 On the Sufficiency of Funds

The total general fund stands at P580.00. If a member is allowed a loanable amount of P232.00 (40% of the present number of members x P20.00) per illness episode, only two members can avail of the full loanable amount, and one can borrow only half the amount. Definitely, the respondents claimed, the funds are very limited.

As to the 50% portion of the P580.00 collection per illness episode, this cannot cover all expenses incurred by the family who sought medical attention. Table 27 shows that, on the average, the P290.00 covered only about 49% of the total expenses incurred in payment for consultation and hospitalization fees and medicines. These expenses do not include the transportation expenses in going to the health facility and coming back home, as well as expenses for food of the family member tending the sick.

In general, however, the respondents expressed that the P290.00 has given them enough courage to seek professional help, because the amount can already pay for doctor's fees (if on an outpatient basis) and buy the start up dosages. But they are optimistic that there will be an increase in these amounts.

4.3 Perception as to Sustainability of the Scheme

The officers and members who took part in the focus group discussion agreed on one point: that the success and the continuous existence of NESAHHA is totally dependent upon members' cooperation. This could be through payment of their contributions on time, prompt payment of their loans, and maintaining their membership with the association.

The members are also encouraged to convince other households to join the association to increase the funds collected per illness episode.

As far as the possibility of increasing the amount of contribution, the respondents said they are quite willing because this would mean an equal increase in the amount of medical grant or loan they can avail of. However, since they are only dependent on their income from farming, prompt payment of contribution cannot be assured within those months in-between harvest.

5.0 PLANS AND PROJECTIONS FOR 1994

The officers interviewed commonly expressed that the plans for next year specifically on resourcing and benefits will largely depend on the results of the assessment/evaluation which will be conducted during the NESAHHA's general assembly on the first Saturday of December 1993.

As to the projection in terms of a possible increase in membership, respondents refused to even make a conservative estimate. One respondent commented, that for a barrio folk used to "dole out" from GOs from way back they could no longer remember, and from the NGOs for the past seven years or so, the idea of a health assistance to all individuals, wherein funds are sourced from among themselves, will have to be proven first if workable.■

Table 27. Members who have Availed of Medical Grant and Medical Loan

Position in the Household	Nature of Ailment/ Illness	Name and Address of Clinic / Hospital	Govern-ment or Private	If In-patient or Outpatient	Total Expenses Incurred	Medical Grant	Medical Loan	Payment of Loan to Date
Son	Edema	Medical Mission Tagum, Davao	P	Inpatient	P1,500.00	P 290.00	-	-
Head of Family	Dysentery	Pay of Clinic New Correla, Davao	P	Outpatient	300.00	290.00	-	-
Wife	Malaria	Regional Hospital Tagum, Davao	G	Inpatient	500.00	290.00	-	-
Son	Dengue Fever	Regional Hospital Tagum, Davao	G	Inpatient	2,000.00	290.00	P 292.00	none
Daughter	1st Degree Burn	Bongcalan Clinic New Corella, Davao	P	Outpatient	500.00	290.00	-	-
Head of Family	Malaria	Regional Hospital Tagum, Davao	G	Inpatient	700.00	290.00	292.00	None
Daughter	Dysentery	Regional Hospital Tagum, Davao	G	Inpatient	500.00	290.00	-	-

Case Study No. 4 **PERSONAL PREPAYMENT: THE COOPERATIVE HEALTH FUND OF THE MEDICAL MISSION GROUP HOSPITALS AND HEALTH SERVICES, COOPERATIVE, COOPERATIVE FEDERATION OF DAVAO CITY, AND THE COOPERATIVE BANK OF DAVAO CITY**

Case Study No. 4 PERSONAL PREPAYMENT: THE COOPERATIVE HEALTH FUND OF THE MEDICAL MISSION GROUP HOSPITALS AND HEALTH SERVICES, COOPERATIVE, COOPERATIVE FEDERATION OF DAVAO CITY, AND THE COOPERATIVE BANK OF DAVAO CITY

1.0 INTRODUCTION

In an article entitled "The Cooperative Health Fund: Total Health Coverage of the Karaniwang Tao" Dr. Jose M. Tiongco (1992)[4], the General Manager of the Medical Mission Group Hospitals and Health Services Cooperative, wrote that eighty percent (80%) of the Filipinos live below the poverty level, earning only between P3,000 to P5,000 per month. The Filipino's average health expenditure per year is P1,200 or 2-3% of his income. The average cost of hospitalization is about P5,000.

Tiongco pointed out that in a community of 100 people, statistics show that five persons will need hospitalization annually. He further illustrated that not one of the 100 can afford this with his/her yearly budget. If, however, the 100 people contribute P1,200 each annually P120,000 would be raised. This can cover the P25,000 for the hospitalization of 5 individuals per year and leaves P95,000 for our-patient services and medications of the remaining 95 people. Moreover, since the members of the community do not get sick at the same time, the money deposited in the cooperative bank earns interest. The interest could be invested in the hospital to earn income. This income would then increase the fund.

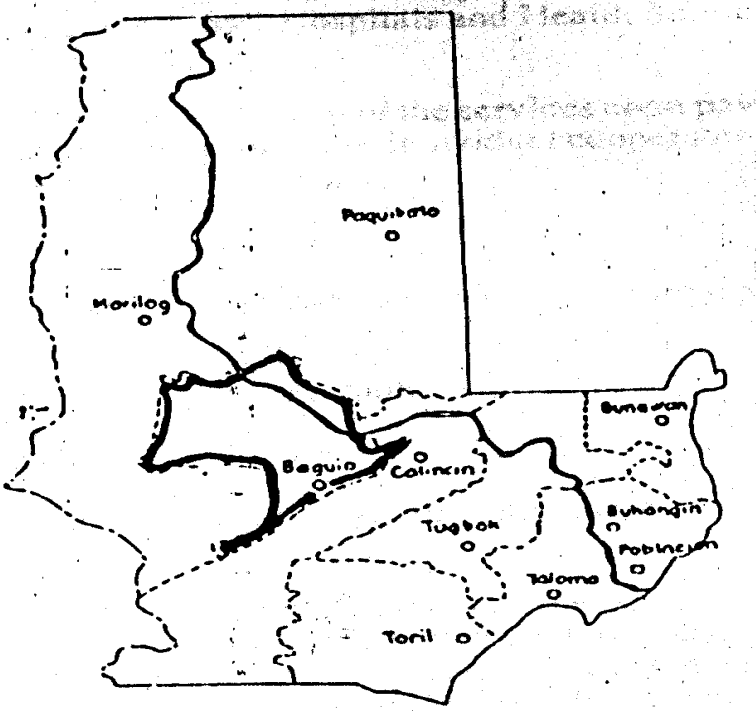
Given the preceding bases the Cooperative Health Fund (CHF) was initiated. Although the Medical Mission Group, Incorporated had long existed as a clinic in 1982, and eventually turned into a cooperative hospital in 1989, the scheme itself was established only in 1991.

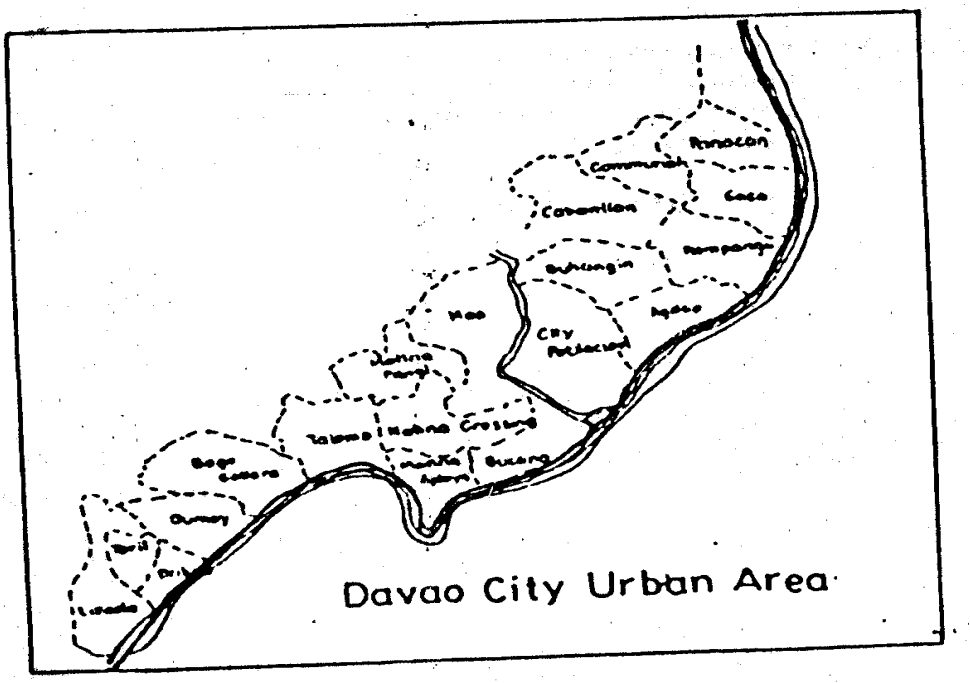
2.0 THE MECHANISM OF THE COOPERATIVE HEALTH FUND

The CHF is a mutual self-help program among cooperatives aimed to provide its member cooperators total health benefits at very affordable costs. The CHF is one of the projects of the Cooperative Federation of Davao City (CFDC).

[4] Tiongco, Dr. Jose M. "The CHF: Total Health Coverage for the Karaniwang Tao", Pag-asa (Vol. 1, No. 2), April 22-28, 1992, pp. 18-19.

FIGURE 8. MAP OF DAVAO CITY





2.1 Access to Benefits and Services

The CHF benefits may be availed by any member of any cooperative registered with the Cooperative Development Authority (CDA) and are coop-members of the CFDC. Prospective applicants are asked to fill up an application form. Before forwarding the application papers, the applicants undergo a medical and physical check-up conducted by the duly accredited medical doctor of the MMG Hospital and Health Services Cooperative of Davao (MMGHHSCD).

Non-cooperative members may also avail of the services upon paying a membership fee of P100.00. In effect, the applicant becomes an individual cooperator of the MMGHS Cooperative.

2.2 Contributions

The amount of annual contributions vary according to the Plan a member wants to enroll with:

Plan A - P1,200 (or P112 per month)
Plan B - P365
Plan C - P1,800

Payments are usually made in cash although these may also be paid in kind as in sacks of palay.

Payments are made in full upon the submission of the application form. However, installment can be granted when the Coop with which a CHF member belongs, pledges to undertake the monthly installment payments as co-obligator for and in his/her behalf. All payment of contributions shall be made within five (5) days after receipt of the statement of accounts. The member may also borrow the amount from the bank and then pay monthly.

If membership in the CHF should lapse for non-payment of contributions, his/her CHF membership may be revived by way of reinstatement. A membership shall be considered reinstated when the entire contributions in arrears including penalties thereof are paid within three (3) months from the date the last contributions were made.

The initial amount coming from members' contributions was P6 million.

3.0 THE TOTAL COVERAGE HEALTH FUND

Managers of the CHF are quick to distinguish the scheme from other preneed plans. According to them, the CHF is different because it covers practically all kinds of health care needs and services. However, a look at how it operates reveals its similarity to other prepayment

schemes in that recipients pay a health premium first before being able to avail of the benefits and services.

There are three kinds of CHF plans available to cooperators:

3.1 Plan A

The member shall have total health care benefits under this plan. Plan holders are eligible for confinement at the hospital's ward section.

An enrolled cooperative member who has paid the coverage amount and his application has been endorsed by his primary cooperative and approved by a Board of Trustees and issued or holds a CHF card can avail of the following benefits:[5]

1. Consultation during regular clinic hours
2. Medication
3. Dental care
4. Optometrical services
5. Obstetrical-Gynecological care
6. Surgery
7. Accommodation and food during confinement
8. Treatment of minor injuries such as lacerations, mild bums, sprain and the like
9. Laboratory examinations and diagnostic procedures
10. X-ray
11. Administration of vaccines (medicine not included)
12. Referrals to institutions or specialists, as may be necessary
13. Health education, counseling on diets and exercise
14. Annual check-up on or before every anniversary date or enrollement of coop member's coverage

The following services are not covered:

1. Cosmetic and plastic surgery
2. Organ transplant like kidney, heart, liver, etc. and to include other corrective appliance and artificial aids
3. Corrective and rehabilitative surgery for congenital defects
4. Preexisting chronic diseases/conditions of coop member with less than two (2) years of active membership in the CHF
5. Suicidal injuries/illness attributable to the covered individual coop member's own misconduct, gross negligence, intemperate use of drugs or alcohol, vicious or immoral habits
6. Injuries or illness resulting from war or any combat related activities while in military service, and infuries in armed conflicts such as rebellion, insurrection or mutinees

[5] Culled from the CHF application form.

7. Injuries or illness incurred in the participation of the commission of a crime, violation of law or ordinances and including dangerous drug addiction or abuse and unnecessary exposure to imminent danger and hazards to health
8. Acquired Immune Deficiency Syndrome (AIDS)
9. AIDS-related diseases and sexually related diseases actively acquired
10. Confinement purely for executive check-up, rest, and recuperation, speech therapy, ratio therapy, chemotherapy and renal dialysis
11. Mass injuries or illness caused by natural catastrophes like earthquakes, fire, volcanic eruption, floods, typhoons, etc., including epidemics
12. Mass screening programs for industrial or community related studies, except when subsidized by the company or community

3.2 Plan B

Plan B is primarily for the dependents of Plan A holders the benefits of which can be availed at a cost of P1.00 a day (or P365.00) a year for each dependent. These may include the immediate family of Plan A holders and even their household helpers. However, their benefits are limited to free outpatient consultations and free hospitalization benefits of not more than P5,000 only per confinement.

3.3 Plan C

Members under this plan shall have total health care benefits as in Plan A. The only difference is that these plan holders are eligible for confinement in private rooms of the hospital.

4.0 MANAGEMENT

The management of the scheme is two-pronged. First, the funds are managed by the Cooperative Federation of Davao City (CFDC) Board of Directors through the CFDC General Manager. The MMGHHSC, on the other hand, concentrates on its role as providers of the health care services.

4.1 The CHF Council of Trustees

The CHF Council of Trustees acts as the advisors to the CFDC Board of Directors. It is composed of representatives from the following cooperatives involved in its development, promotion and implementation: Three (3) members from the Cooperative Federation of Davao City (CFDC) as the one who manages the CHF; two (2) members from the Cooperative Bank of Davao City (CBDC) as official depository bank of the CHF; and two (2) members from the Medical Mission Group Hospital and Health Services Cooperative of Davao (MMGHHSCD) as the health servicing arm of the CHF.

4.2 The Cooperative Federation of Davao City

The Cooperative Federation of Davao City sends a Statement of Accounts to the individual cooperator-member and the cooperative where he/she belongs of any unpaid monthly or annual contributions, issues an official receipt (OR) for all contributions received, advises members at least three months in advance before such membership shall lapse, advises CHF members stoppage of his/her CHF membership in the event of his/her failure to renew his/her CHF membership, and informs everyone any amendment of the plans and programs of the CHF.

4.3 The Medical Mission Group Hospitals and Health Services Cooperative of Davao (MMGHHSC)

Starting as Medical Mission Clinic in 1982, MMGHHSC has grown to be a three storey 60 bed hospital in December 1991. It is equipped with modern facilities and fully airconditioned ward rooms. A 100-bed Medical Mission Hospital is under construction iin Tagum, Davao del Norte.

The hospital fees are patterned after Medicare rates. (Refer to Tables 28 to 32.) If the hospital sees that a non-CHF patient is financially hard up services are performed without fee as in one instance when a patient requested for a free OPD consultation.

4.4 The Cooperative Bank of Davao City

The Cooperative Bank of Davao City guarantees proper care and handling of all CHF fund-contributions entrusted to it for safekeeping by the CFDC, and will furnish, when so required by any competent cooperator deputized by the CFDC, the status of CHF funds in its depository.

5. INTERVIEW RESULTS

In general, it was more difficult to pursue data-gathering activities among the CHF recipients, providers and managers. All are based in Davao City where interviewees were most of the time busy with work. The providers proved to be the most difficult as doctors were most of the time making their rounds hopping from one hospital to another.

5.1 Socio-Economic Status

The recipients interviewed are employees of two government regional line agencies and one government corporation. Others are employees of a credit cooperative subscribing to the CHF.

The respondents' ages range from 25 to 46 belonging to a household with an average size of five.

All but one are college graduates.

Their estimated family monthly income range from P1,922.00 to P13,710.50 of which medical expenditures account for 0.38 to 7.29% or P40 to P1,000. With this group, it was observed that medical monthly expenditures did not necessarily rise or decrease with gross monthly income or with total monthly expenditures.

5.2 Health Status and Health Services Utilization BEFORE Scheme

The most reported recurring illnesses are cough, colds and fever among children of respondents. The usual remedy adopted was either to take self-prescribed medicines, to use herbal medicine, or to take plenty of water and rest. Others consult a doctor immediately.

When illness or symptoms of it persist after three days despite having tried other indigenous practices, all but one respondent finally consulted a doctor.

Table 28. MMGHSHC Complete History and Physical Examination Package Deal

PACKAGE DEAL*	USUAL RATE	PACKAGE RATE
Private aircon room for two (2) days	P 900.00	800.00
Complete History and Physical Examination plus P.S. of attending physician	900.00	400.00
LABORATORY EXAMINATIONS:		
Complete Blood Cound	72.00	64.80
Blood Typing	60.00	54.00
Urinalysis	42.00	37.80
Stool Examination	42.00	37.80
F B S (Fasting Blood Sugar)	126.00	113.40
Serum Creatinine	180.00	162.00
Serum Uric Acid	162.00	145.00
Serum Cholesterol	180.00	162.00
Hepatitis Screening (HBSAG)	216.00	194.00
X- RAY EXAMINATIONS:		
Chest X – ray	156.00	140.40
Ultrasound exam of the gallblader, liver, pancreas and kidneys	1,000.00	900.00
Upper Gastro-intestinal Series	606.00	545.40
Barium Enema	696.00	626.40
E C G	204.00	183.60
Total for Males	4,642.00	4,847.80
Add: For Females		
Pelvic examination with papa smear	360.00	280.00
Total for Females	5,002.00	4,847.80
OPTIONAL EXAMINATIONS:		
Oral Cholecystography		
Intravenous Pyelography		367.20
E E N T		505.80
Dental Check-up		85.00
Proctosigmoidoscopy (including PS of P250)		70.00
		490.00

* Examinations, procedures and use of special instruments not included in the above list will be charged accordingly at discounted rates. Effective September 13, 1993.

Table 29. MMGHHSC X–ray Examination Charges/Fees

	OPD	WARD	SEMI-PRIVATE	PRIVATE	SUITE
SKULL:					
Skull Series	P 225.00	266.00	300.00	365.00	402.00
Mastoids	210.00	246.00	285.00	360.00	385.00
Paranasal Sinuses	215.00	266.00	293.00	342.00	376.00
Internal Auditory Meat	300.00	348.00	395.00	454.00	499.00
Mandible	190.00	191.00	214.00	267.00	294.00
CHEST:					
Chest P.A.	P 110.00	158.00	178.00	216.00	238.00
Chest P.A. Lateral	180.00	219.00	250.00	305.00	336.00
Chest Pedia	100.00	137.00	157.00	194.00	213.00
Chest Pedia Lateral	170.00	171.00	200.00	253.00	278.00
Apico Lordotic View	100.00	116.00	130.00	171.00	188.00
Thoracic Bony Cage	150.00	171.00	200.00	253.00	278.00
Thoracic Bony Cage w/ Oblique	210.00	233.00	264.00	305.00	336.00
SPINES:					
Cervical Spine	P 185.00	191.00	214.00	267.00	294.00
Cervical Spine APL/Both Oblique	255.00	294.00	163.00	394.00	433.00
Dorsal Spine	220.00				
Lumbo Sacral Spine APL	220.00	231.00	264.00	305.00	366.00
Lumbo Sacral APL w/ Bone Obuque	380.00	437.00	464.00	491.00	540.00
Thoracio Lumbar Spine	350.00	410.00	464.00	535.00	589.00
ABDOMEN:	P 150.00	171.00	200.00	238.00	262.00
Kub	240.00	253.00	293.00	342.00	376.00
Abdomen (Spine Upright)	165.00	266.00	314.00	366.00	392.00
Pelvimetry					
PELVIS:	P 145.00	158.00	171.00	216.00	238.00
Hips	190.00	205.00	228.00	283.00	311.00
Hips with one Obuque Lateral					
UPPER EXTREMITIES:	P 130.00	158.00	171.00	208.00	229.00
Clavicle	180.00	219.00	243.00	297.00	327.00
Shoulder (Left & Right)	130.00	158.00	178.00	230.00	253.00
Humerous, Elbow, Wrist, Forearm					
LOWER EXTREMITIES:	P 180.00	105.00	228.00	283.00	311.00
Femur	180.00	219.00	243.00	297.00	327.00
Leg	130.00	158.00	178.00	230.00	253.00
Knee-Ankle-Foot Oscalsis					
SPECIAL PROCEDURES:	P 530.00	724.00	820.00	891.00	980.00
Barium enema	630.00	704.00	806.00	877.00	985.00
Chole Q I	510.00	587.00	671.00	751.00	826.00
IVP	450.00	457.00	513.00	687.00	646.00
G.I Series	485.00	253.00	278.00	326.00	359.00
Esophagogram	320.00	369.00	414.00	475.00	523.00
Cholecystogram	280.00	253.00	278.00	326.00	359.00

Rate Adjustment Effective September 13, 1993.

Table 30. MMGHHSC Laboratory Rates

	OPD	WARD	SEMI-PRIVATE	PRIVATE	SUITE
CHEMISTRY :					
FBR/RBS	P 85.00	115.00	126.00	149.00	164.00
SUA	115.00	150.00	164.00	210.00	231.00
BUN	150.00	180.00	192.00	226.00	249.00
CREATININE	130.00	156.00	168.00	205.00	226.00
CHOLESTEROL	130.00	165.00	179.00	226.00	249.00
SGPT	170.00	204.00	216.00	226.00	226.00
SGOT	190.00	228.00	240.00	252.00	249.00
ALKALINE PHOSPHATASE	190.00	228.00	240.00	252.00	250.00
ACID PHOSPHATASE	210.00	252.00	264.00	276.00	278.00
BILLIRUBIN	210.00	252.00	264.00	276.00	304.00
TOTAL PROTEIN	130.00	156.00	168.00	180.00	304.00
ALBUMIN	120.00	144.00	156.00	195.00	198.00
TP A/G	210.00	252.00	277.00	325.80	215.00
SERUM CALCIUM	240.00	288.00	300.00	312.00	359.00
SERUM CHOLORIDE	265.00	318.00	330.00	342.00	343.00
SERUM SODIUM	250.00	300.00	312.00	342.00	356.00
SERUM POTASSIUM	270.00	324.00	336.00	348.00	383.00
AMYLASE	270.00	324.00	336.00	348.00	383.00
LDH	300.00	360.00	372.00	348.00	422.00
PROTIME	230.00	276.00	288.00	300.00	330.00
LIPID PROFILE	500.00	621.00	656.00	715.00	787.00
TRIGLYCERIDE	230.00	285.00	304.00	364.00	400.00
LDL	500.00	621.00	656.00	715.00	787.00
HDL	200.00	240.00	252.00	264.00	290.00
T3T4	430.00	480.00	492.00	504.00	554.00
2 HR. POST PRANDIAL BLOOD SUGAR	100.00	120.00	132.00	150.00	165.00
URINE CREATININE	150.00	180.00	192.00	210.00	231.00
CREATININE CLEARANCE (Serum Crea & Urine Crea)	250.00	300.00	328.00	420.00	482.00
ALPHAFETOPROTEIN	510.00	612.00	624.00	636.00	700.00
HERMATOLOGY:					
CBC	40.00	68.00	77.00	88.00	97.00
HEMATOCTRIT	35.00	42.00	54.00	76.00	84.00
HEMOGLOBIN	35.00	42.00	54.00	76.00	84.00
WBC	20.00	36.00	44.00	76.00	84.00
RBC	20.00	34.00	44.00	76.00	84.00
BSMP	50.00	60.00	72.00	94.00	103.00
PLATELET	70.00	84.00	96.00	112.00	123.00
BLOOD TYPING	32.00	50.00	60.00	88.00	95.00
BLEEDING TIME (BT)	18.00	29.00	36.00	65.00	72.00
CLOTTING TIME (CT)	18.00	29.00	36.00	65.00	72.00
ESR	60.00	72.00	84.00	112.00	123.00
OSMOTIC FRAGILITY TEST	150.00	188.00	206.00	242.00	266.00

URINALYSIS/PARASITOLOGY:					
URINALYSIS	P 15.00	30.00	36.00	46.00	51.00
EXAM	15.00	30.00	36.00	46.00	51.00
OCCULT BLOOD	60.00	72.00	84.00	96.00	106.00
URINE ACETNE	25.00	41.00	46.00	70.00	77.00
URINE SUGAR	25.00	30.00	42.00	47.00	52.00
URINE ALBUMIN	25.00	30.00	42.00	47.00	52.00
URINE BILIRUBIN	25.00	30.00	42.00	47.00	52.00
URINE UROBILINOGEN	25.00	52.00	62.00	94.00	52.00
URINE PH	25.00	30.00	42.00	60.00	103.00
URINE SPECIFIC GRAVITY	25.00	30.00	42.00	60.00	66.00
24 Hr. URINE ALBUMIN	30.00	36.00	48.00	60.00	66.00
SEROLOGY:					
CROSMATCHING (per Bag)	70.00	94.00	106.00	140.00	154.00
WIDAL TEST	185.00	222.00	241.00	270.00	297.00
Ph TYPING	40.00	48.00	60.00	72.00	79.00
ASO ITTER	230.00	245.00	304.00	364.00	400.00
Hbs ANTIGEN	160.00	192.00	204.00	233.00	256.00
RHEUMATOID FACTOR	230.00	276.00	288.00	300.00	330.00
VDRL	95.00	122.00	135.00	177.00	195.00
ANTI-HBs	190.00	228.00	240.00	252.00	277.00
BACTEROLOGY:					
GRAM STAIN	95.00	112.00	135.00	168.00	185.00
AFM STAIN	100.00	150.00	205.00	205.00	226.00
KOH	60.00	77.00	122.00	122.00	134.00
URINE C/S	320.00	384.00	408.00	408.00	449.00
STOOL C/S	320.00	384.00	408.00	408.00	449.00
PLEURAL	320.00	384.00	408.00	408.00	449.00
SYNOVIAL	320.00	384.00	408.00	408.00	449.00
CSF	320.00	384.00	408.00	408.00	449.00
DISCHARGES C/S	320.00	384.00	408.00	408.00	449.00
SPUTUM (d/p P100.00)	320.00	384.00	408.00	408.00	449.00
BLOOD	320.00	384.00	408.00	408.00	449.00
HISTOPATH/CYTOLOGY:					
BIOPSY (Small) (P300.00 Path.)	330.00	396.00	408.00	420.00	462.00
BIOPSY (Big) (P450.00 Path.)	480.00	576.00	588.00	600.00	660.00
BIOPSY (Bigger) (P550.00 Path)	580.00	696.00	708.00	720.00	792.00
BIOPSY, ENDOCERVICAL & ENDOMENTRIAL SCRAPPINGS (P350.00 Path.)	380.00	456.00	468.00	480.00	528.00
CELL BLOCK (P300.00 Path.)	330.00	396.00	408.00	420.00	528.00
PAP SMEAR (P100.00 Path.P)	130.00	156.00	168.00	180.00	198.00
PERIPHERAL SMEAR (P100.00 Path.)	150.00	180.00	192.00	204.00	224.00
SPUTUM, PLEURAL/ PERITONEAL (CYTOLOGY (P150.00 Path.)	180.00	216.00	228.00	240.00	284.00
BONE MARROW INTER-PRETATION (P200.00 Path.)	250.00	300.00	312.00	324.00	356.00

BONE MARROW ASPIRATION WITH INTER-PRETATION (P500.00 Path.)	550.00	660.00	672.00	684.00	752.00
LE CELL (P300.00 Path.)	330.00	396.00	408.00	420.00	462.00
FROZEN SECTION (P1,000.00 Path.)	1,050.00	1,260.00	1,272.00	1,284.00	1,412.00
OTHERS:					
SEMENALYSIS	130.00	145.00	154.00	194.00	213.00
SPERM COUNT	90.00	108.00	120.00	132.00	145.00
CSF ROUTINE	150.00	180.00	192.00	204.00	224.00
ECG	180.00	214.00	241.00	270.00	297.00
MASTER'S ECG	200.00	240.00	252.00	264.00	290.00
PREGNANCY TEST (Fertilitex/Gravindex)	110.00	132.00	144.00	179.00	197.00
PREGNANCY TEST (Abbot/Hexagon)	150.00	155.00	162.00	174.00	191.00
QUNTI, PREGNANCY TEST	190.00	228.00	240.00	252.00	277.00

NOTE: There shall be additional 30% for all examinations performed during:

a> Holidays & Sundays;
b> 7:00 P.M. to 7:00 A.M.; and
c> All STAT procedures.

Rates Adjustment Effective September 13, 1993.

Table 31. MMGHHSC Hospital Accommodation Rates

Emergency Room Use		P 390.00
Room Rate:		
Ward		120.00
Semi-private		400.00
Private Room		450.00
Suite Room (Small)		600.00
Suite Room (Big)		600.00
CP Clearance:		
Ward		250.00
Semi-private		325.00
Cardiac Monitoring:		
Private		380.00
Suite Room		500.00
Electron Microscope		P 300.00
Professional Fee/Service:		
Paracentesis		580.00
Thoracentesis		520.00
Bone Marrow Puncture		520.00
OPD Consultation		70.00
Package deal for surgery:		
Major	11.2 – 16.8	
Medium	8.4 – 11.2	
Minor	5.6 – 6.4	
Anesthesiologist:		
Ward – 1/3 of Surgeon's fee		
Private & Semi-private – 40% of surgeon's fee		
P.S. Pedia and Internist:		
Attendant should write his/her P.S.		
If he/she does not want to fllow the standard		
P.S. base on the room rate. P.S. may also depend		
On the severity of the case		
Standard P.S.:		
Ward		P120.00/130.00 per day
Semi-private		P300.00/310.00 per day
Private		P350.00/360.00 per day
Suite Room		P520.00/530.00 per day
P.S. Calling for surgeons:		
OPD Minor Surgery		P 1,000.00
Operating Room:		
Minor Surgery		4,000.00
Medium Surgery		6.000.00
Major		8,000.00
Major - major		1,500.00

Table 32. MMGHHSC Nursing Procedures Charges/Fees

Nursing Procedure	Fee
Plain 1.V. Insertion	P 40.00
I.V. Insertion with spliant	50.00
Catheterization (2/out cath)	60.00
Soap buds enema	70.00
Steram inhalation with rhea solution	15.00
Dressing: Minor	35.00
Medium	65.00
Major	115.00
Pre-op skin prep	50.00
Pre-op vaginal prep	50.00
Vaginal Douche	40.00
Plain Hot Sitzbath	12.00
Gastric Lavage without NGT	75.00
Hot sitz with bedadine 25.00	
Newborn care (including cord clamp, eye	115.00
Umbcinth, Vit.k. 0..alcohol OS etc.)	70.00
Umbilical cord dressing	35.00
Thoracentesis (Anesthesia excluded)	225.00
Thoracostomy	250.00
Paracentesis	225.00
Tracheostomy without trachea	210.00
Cut-down NGR Fr. not included	250.00
Oxygen inhalation with cath per 1 min.	0.35
Oxygen tank	600.00
Gastric Lavage (including NGT)	75.00
Perilite	15.00
Warm compress	5.00

5.3 How They Became CHF Members

Some respondents became members of the Cooperative Health Fund because this is part of the benefit package provided by the company where they worked.

Representatives of the MMGH went to the respondents' offices to orient the employees abut the program. The membership process includes the filling up of registration forms, paying the total annual premium, and undergoing physical exam to determine if there are preexisting illnesses. All respondents liked the process except for one who said that she was only interviewed and not given thorough medical check-up.

6.0 EXPERIENCES OF CHF MEMBERS WHO WERE DIAGNOSED AND TREATED BY THE CF PROVIDERS

This portion relates the comments of CHF recipients who have already sought treatment from the MMG Hospital. Although it does not give a comprehensive description, much more a thorough assessment of the quality of services given by CHF providers, the comments related here are the candid views of actual recipients.

In general, most CHF recipients were at the start appreciative of the hospital's services and benefits. The provision of free medicines was a particular come-on to most members especially for those who need to take relatively expensive drugs or for those who need to do so for a longer period of time. In fact, there have been cases where the recipients gave up other social health insurance in favor of the CHF.

Furthermore, the CHF Plan B for dependents was also an interesting attraction especially for those who have children who are prone to and high-risk to illness.

When asked whether they were satisfied with services accorded them whenever they consult or seek treatment from CHF doctors, a number of recipients from a group of employees of one government agency said they thought the way the MMG doctors diagnosed their complaints was perfunctory.

There is the case of one employee who was in her mid-twenties and married with two children aged two and one year respectively. She accompanied her husband who complained of cough, colds and fever to MMHG. She said the attending physician did the diagnosis too hurriedly and was not thorough not even bothering to ask the patient's medical history before prescribing medicines.

The case does not seem to be isolated because there were similar complaints from other recipients coming from the same office. One CHF recipient had become particularly vulnerable to several illnesses ranging from high blood pressure (since June 1992) for which she maintains taking Betaloc (50 mg) once a day and PTB (since July 1993) for which she was prescribed a maintenance dosage of 2 tablets a day of Remactacyd. All medicines are supplied by the MMGH.

The respondents has also complained of not being thoroughly informed of the details on the actual benefits during the orientation given. She only found out at the time of availment that eyeglasses were not for free as the hospital advertised them to be. Eye patients with prescribed eyeglasses will have to pay the amount in excess of P450.00.

One other patient, however, got here eyeglasses for free. Some cardholders are therefore confused over the extent of the benefits extended.

The second case may be extreme given the number and frequency of illnesses afflicting her rather unexpectedly. Due to the frequency of visits to the hospital for consultation, the resident doctor had gotten to the point of telling her that she was just imagining her ailments – even if she were indeed feeling dizzy and all – and that she should instead strive to simply 'think of beautiful things' to rid of her illnesses. The patient felt it was not how she should have been treated considering the veracity of the symptoms she was experiencing. In her subsequent visits, she requested that another doctor attend to her instead.

While the patient felt that she was not very satisfied with the way the CHF doctors did their diagnosis, she said she was grateful just the same because the scheme was still able to provide the maintenance dosages she needed which, otherwise, would have cost her additional financial burden. The help was especially valuable since the recipient served as sole breadwinner to her jobless husband and two young children, the latter of whom had to maintain periodic consultations and in-take of medicines for primary complex.

The same patient comments on the practice of the MMGH to ask their recipients to declare their (the latter) Medicare when the CHF itself is supposed to offer free services. The sentiment was echoed by her other officemates who were CHF cardholders as well.

Two other respondents who were employees of a credit cooperative subscribing to the CHF also said they were not satisfied with the kind of services they were receiving from doctors. One of them said that sometimes CHF patients are taken for granted. Once she was not given medicines upon check-out after two days of confinement. She acquired an infection and was admitted in another hospital.

One respondent would not agree to give additional contribution because of poor quality of services from the health providers. Another would also not agree to it because the initial package including the set contribution was what made it attractive in the first place and, therefore, should not be changed.

6.1 What CHF Managers and Providers Can Say

However, on the part of the providers and managers of the CHF benefits and services, the common problem that the MMGH have experienced is the irrational use of benefits by CHF members especially those who were salaried or had regular income. According to them that it was the group of those who were more able to afford the costs of health care that would directly seek the services of the hospital for very minor cases like a cough or a cold that had just started and which could be remedied at home. There

are also a few members who keep coming back complaining of pain here and there, when they have earlier been advised, after thorough medical examination, that nothing is wrong with them.

Within the past year, two memberships were terminated. One involved a 65-year old individual who apparently wanted to avail of CHF services badly that he falsified his birthdate. The other had a pre-existing heart ailment and was able to get around the physical examination. Their membership fees and initial contribution were refunded in full after having been fund out.

7.0 ON IMPROVING AND SUSTAINING THE SCHEME

Two respondents said that the scheme is not sustainable because the benefits are too extensive, that the scheme may not be able to afford the total cost should several members get sick at the same time.

One cannot say because there are not enough information given to members on the financial status of the CHF.

The rest opined that the scheme is already sustainable.

On the part of the CHF managers, there is a strong appeal to CHF cardholders to help sustain the scheme's funds by declaring their Medicare (if any) so as not to deplete the limited resources of the hospital. They would also like to see their recipients make a rational use of the hospital's benefits and services; that is, to consult or to seek treatment for cases which really require professional medical help.

8.0 CONCLUSIONS

Among all the schemes studied, the CHF shows it has the most formal operational structures. The CHF is essentially a health insurance scheme managed by a cooperative. What makes it unique over other health insurance companies is that it offers "Total Health Coverage" and that a cooperative hospital provides the health services. Beneficiaries can avail of services like free hospitalization as well as room (ward or private) accommodations and free medicines which are absent in other schemes.

Although the target beneficiaries are those who cannot readily afford health care, members to the CHF are dominantly employed individuals receiving regular monthly compensation.

On the whole, the CHF still needs help to keep it financially sustainable given the extent of the health services it covers. Like its present practice, the need to tie up with other health insurance schemes e.g., the Medicare may be worthwhile to enable the scheme to share in the risks of maintaining the benefit it has envisioned to continue to offer.

Case Study No. 5 PERSONAL PREPAYMENT: KING COOPERATIVE

1.0 COOPERATIVE BACKGROUND

2.0 MEMBERSHIP QUALIFICATION AND REQUIREMENTS

3.0 CONTRIBUTION

4.0 HEALTH BENEFITS AND ASSISTANCE

- 4.1 Dental Assistance
- 4.2 Medical Assistance
- 4.3 Medical Guaranty and Loan Fund
- 4.4 Special Medical Loan

5.0 MANAGEMENT

6.0 AVAILMENT OF BENEFITS AND SERVICES

7.0 SELECTION OF RESPONDENTS

8.0 INTERVIEW RESULTS

- 8.1 Respondents' Socio-Economic Characteristics
- 8.2 Health Practices and Health Services Utilization
- 8.3 Benefits Received by the Respondents
- 8.4 Perceived Satisfaction with the Benefits
- 8.5 Improving the Scheme

9.0 CONCLUSIONS AND RECOMMENDATIONS

Case Study No. 5 PERSONAL PREPAYMENT: KING COOPERATIVE

1.0 COOPERATIVE BACKGROUND[6]

In 1967 an informal association was started among employees of the defunct Bureau of Agricultural Extension in Region XI, with the purpose of helping one another financially when a co-worker or a member of his family dies. It was eventually registered with the Securities and Exchange Commission as Bureau of Agricultural Extension Employees Association (BAEEA) with SEC Registration No. 88366 dated September 10, 1969.

The association was converted into the Ministry of Agriculture Cooperative Inc. (MACI) and was registered with the Bureau of Cooperative Development on April 15, 1981 under RXI-041 – R.

In order to serve employees of other government and private offices, the cooperative decided to change its name and amend its by-laws. On February 15, 1983, it became the King Development Cooperative, Inc. (King DCI). King DCI was issued Reconfirmation of Registration No. 074 by the Cooperative Development Authority on January 4, 1991. In conformity with the Cooperative Code of the Philippines, King DCI changed its name to King Cooperative on January 24, 1993.

As of April 30, 1993 after 12 years of operations, King Cooperative has about P20.9 million in equity, P48.2 million in assets, a membership of 6,056, a loan portfolio of P30 million and 15 vital services which includes insurance services, loans, pawnshop, lending, time deposit, saving deposit, and health services.

There are 94 chapters located in Cagayan de Oro City, Butuan City, Surigao City, Agusan del Sur in Region X; Lanao del Norte, North Cotabato and Cotabato City in Region XII; Surigao del Sur, Davao Oriental, Davao, Davao del Sur, Gen. Santos City, South Cotabato and Davao City, in Region XI. Its main office is located in Davao City (see Figure 8).

2.0 MEMBERSHIP QUALIFICATIONS AND REQUIREMENTS

2.1 Membership is open to all health persons not yet sixty (60) years old with the capability to invest. It is further classified into:

2.1.1 Regular membership which is open to those who are employees of government and private agencies, to professionals, established businessmen and farmers and health person with income and can invest.

2.1.2 Special membership which is open to the immediate members of the family of regular members such as spouse, children and grandchildren.

[6] Culled from the King Cooperative Primer, 1993.

2.2 To apply for membership, the requirements are:

A. For regular membership:

A.1 Fill up application form

i. employee – copy of appointment and salary adjustment notice and special power of attorney

ii. businessman – business license, BIR forma and income tax

iii. farmers, professionals – BIR form and income tax

A.2 Information sheet with current 2 x 2 inches picture
A.3 Must have undergone briefing
A.4 Payment of P100.00 membership fee plus an initial share capital of P500.00

B. For special membership:

B.1 Fill up application form
B.2 Current picture 2 x 2 inches
B.3 Payment of P100.00 membership fee plus an initial share capital of P500.00

2.3 The King Cooperative membership is composed dominantly of employed or salaried individuals. The cooperative recruits members, by going to offices and orienting the employees about the program.

2.4 As of October 31, 1992 there were 992 regular members and 243 special members with the government sector, and 179 regular and 27 special members with the private sector or a total of 1,441 members in Davao City alone. Region XI had a total of 2,504 *members.

2.5 A one-day briefing for incoming members is held every Saturday in the main office or branch starting 9:00 in the morning. Briefings can also be held at offices or other places by appointment.

2.6 A member who wishes to resign as member of the King Coop shall pay a withdrawal fee of P100.00, the insurance premiums, loan balance if he has any, and penalty if he is delayed or past due. His share balance is returned.

3.0 CONTRIBUTION

3.1 The share capital may be paid in cash or in 'quincena' (every 15-day period) installments. The minimum share requirements is P10,000.00. The minimum initial share capital is P500.00 and the membership fee is P100.00.

3.2 Contributions may be coursed to the cooperative through payroll deduction, or may be directly paid by the member to either its main office or to any of its branches.

4.0 HEALTH BENEFITS AND SERVICES

The cooperative members can avail of dental assistance, medical assistance, Medical Guaranty Loan Fund and the Special Medical Loan. Only a member in good standing (MIGS), one who has a minimum of P10,000.00 share capital or who continuously builds up capital until it reaches the minimum and pays his loan on time, can fully enjoy the services of King Coop.

4.1 Dental Assistance

4.1.1 Regular and special members in good standing in Davao City can only avail of the dental assistance at the King Cooperative clinic. Members can enjoy free dental and iridology consultation and 50% discount on extraction and filling.

4.1.2 Recipients outside Davao City can only avail of 50% extraction and filling cost reimbursement.

4.1.3 Other dental services offered to members on 25% discount are:

a. Dental prosthesis (denture)

a.1 Full upper and lower denture
a.2 Plastic and porcelain jacket crown
a.3 Crown and bridges
a.4 Partial and removable denture

b. Oral prophylaxis
c. Root canal therapy
d. Minor oral surgery
e. Wholistic reflexology

4.2 Medical Assistance

4.2.1 Only regular and special members in good standing with membership of 6 months or more are entitled to medical assistance from King Coop. The assistance covers expenses for operations and for treatment expenses due

to accidents. The maximum amount of assistance in one year is P2,000 but not more than the claimant's share capital, reckoned on the date prior to operation or treatment.

4.2.2 The medical assistance shall be applied to the Medical Guarantee and Loan Fund (MGLF) loan of a member if he or she has any.

4.3 Medical Guaranty and Loan Fund

4.3.1 The Medical Guaranty and Loan Fund provides loan assistance to members to cover part or all of their hospital expenses in King Coop accredited hospitals. The accredited hospitals are:

a. San Pedro Hospital, Davao City
b. Ricardo Limso Medical Center, Davao City
c. Davao Doctors Hospital, Davao City
d. Kidapawan Medical Specialist Center, Inc., Kidapawan, North Cotabato

4.3.2 Regular and special members in good standing are qualified to join the MGLF program. A deposit of P1,000.00, P2,000.00 or P3,000.00 will entitle a member to a guaranty amount of P5,000.00, P10,000.00 and P20,000.00 respectively. The deposit may be given in a lump sum or in ten monthly installments. The deposit may come from his share capital provided however that his MIGS status will not be affected.

4.3.3 The hospital expenses of the MGLF member shall be paid by the King Coop direct to the accredited hospital and such payment shall be considered a loan of the MGLF member with the King Coop. This loan shall bear no interest for the first two months. If such loan, however, remains outstanding after two months grace period, the loans shall bear interest of one half percent per month in the next three months. Payments beyond three months shall bear penalty and –the regular interest.

4.4 Special Medical Loan

This loan can be availed of by regular and special members in good standing whose health are in very critical condition. The maximum amount of loan is P2,000 free of interest for one year. If the member dies within one year, his family is not obliged to pay the loan. After one year, if still alive, the member shall pay the principal plus the second year interest.

5.0 MANAGEMENT

5.1 The members belonging to one agency/institution constitute a chapter. A chapter has at least 15 members and a management committee.

5.2 The management committee in the chapter level is composed of the chairman, secretary and treasurer to be selected from among the regular chapter members in good standing. This committee is responsible for screening applicants for membership and for credit and collection management of the chapter. It also acts as linkage between the chapter members and that of the king Coop Management.

5.3 The main office management staff includes the General Manager, Asst. Manager, Accountant, Cashier, Secretary, Insurance-in-Charge, Bookkeeper, Appraiser/Loans Officer, Loans/Accounts Officer, and a Collector.

6.0 AVAILMENT OF BENEFITS AND SERVICES

6.1 Within January – December 1992, 16 members have availed of P3,098.00 dental services and 59 were beneficiaries of P102,276.00 medical assistance.

6.2 As to the Medical Guaranty and Loan Fund, of the 1,068 total depositors for 1992 with an average of P1,449.00 deposit for the year to date or a total of P1,547,534.00, 158 or about 15 percent (14.8%) have availed of the service in the amount of P630,354.00.

Table 33. Number of MGLF Depositors and Total Amount Deposited, 1989 – 1992

Year	Number	Amount
1992	1,068	1,547,534.00
1991	1,155	1,489,134.00
1990	1,206	1,368,185.00
1989	804	622,975.00

Source: King Cooperative Primer, 1993

Table 34. Availments of Dental Assistance, Medical Assistance and MGLF, 1989-1992

Benefit/Assistance	1992	1991	1990	1989
Dental				
Number	16	33	44	41
Amount (P)	3,098.00	5,164.00	8,785.00	5,955.00
Medical				
Number	59	69	74	80
Amount	102,276.00	107,070.00	108,177.00	114,264.00
MGLF				
Number	158	523	132	21
Amount	630,354.00	699,876.00	431,448.00	38,800.00

Source: King Cooperative Primer, 1993

7.0 SELECTION OF RESPONDENTS

7.1 Beneficiaries taken from a Davao City partial list of medical assistance, dental assistance and MGLF availments drawn up by the King Coop management and who were readily available were interviewed. (The cooperative had no updated comprehensive listing of beneficiaries per kind of assistance. Thus, names were perfunctorily extracted from vouchers' and the corresponding assistance noted down).

7.2 The respondents in this study are all employees from three government corporations with membrship to the cooperative dating from 1979 to 1989.

7.3 Seven received medical assistance while one availed of the MGLF. One respondent was also a recipient of dental assistance.

8.0 INTERVIEW RESULTS

8.1 Respondents' Socio-Economic Characteristics

Seven wives and one household head were interviewed. Their ages range from 37 to 51 years old. The average family size is 4.375.

All respondents are college graduates with one of them a masteral degree holder. All have schooled or schooling children.

Estimated family income ranges from P6,507 to P22,100 while the estimated total monthly expenditure ranges from P5,165.00 to P24,795.35. The monthly medical expenditure is from P42 to P700 or from 0.17% to 5.8% of the monthly total expenditure.

8.2 Health Practices and Health Services Utilization

When illnesses like headache, stomachache, cough, cold and fever occur in the respondents' families they take self-prescribed medicines, herbal medicines, take a rest or apply oils or salves to treat the sick member within 24 hours. When the illness or its symptoms persist after three days all but one said that they would then consult a doctor.

The respondents usually go to doctors who were reliable or are known to be specialists of the illness they are suffering from.

8.3 Benefits Received by the Respondents

One respondent had an ectopic pregnancy and was confined for three days in the hospital nearest to her residence. The bill amounted to P19,000.00. Two thousand pesos (P2,000.00) was refunded by the King Cooperative one month after her discharge. Six thousand pesos (P6,000.00) was borne by Medicare and the rest the family's own savings.

One respondent had a minor operation to remove a skin overgrowth on his elbow. He went to a cooperative hospital as advised by friends. King Coop refunded the total bill of P1,800.00. He had also availed of a couple of discounted dental operations at the cooperative clinic. He cannot recall the actual amount discounted, however. He said that he was refunded right on the day he presented the receipts and the doctor's certificate of operation.

Two respondents had a beat cyst removed. One was treated at a private clinic while the other was hospitalized. Both were reimbursed with P2,000.00. They cannot recall the total operation and treatment cost.

Another recipient of the medical assistance of P2,000.00 had a Caesarian delivery. The rest of the P16,950 bill was paid for from her personal savings. The respondent's mother who was treated for hypertension also benefited from her (the respondent's) membership to the MGLF.

The last respondent had a goiter removed. She also received the medical assistance to pay part of P10,500 total cost. The rest was shouldered by a church group which was then conducting a goiter operation program. She was also hospitalized to give birth by Caesarian. Unfortunately, the baby died upon delivery. The amount expended was applied as her loan with MGLF.

8.4 Perceived Satisfaction with the Benefits

All respondents are financially able to bring themselves or other members of the household to a doctor or to the hospital. It is important to note, however, that this is not solely because of the benefits they are able to derive from the King Cooperative but also because of health coverage they enjoy from Medicare, from other cooperatives, and other health insurance they may have enrolled with. One respondent has, in fact, withdrawn her deposit from the Medical Guaranty Loan Fund with her application to another Health Fund she finds more beneficial. Another respondent uses her benefits from CAP Health for the treatment of minor illnesses occurring in her family because King Coop only covers operations involving surgery. All respondents are confident, however, that the King Cooperative takes a load off their health financing needs with the kind and amount of benefits and services it already offers.

As to the delivery of benefits they have received, the respondents have no complaint whatsoever. They were satisfied with the services of the MGLF accredited providers. They also found that the process in securing the reimbursement or the P2,000 medical assistance was easy. As one respondent disclosed, the member has only to show the receipts and the medical certificate to get the refund 'no questions asked.'

8.5 Improving the Scheme

In the course of the interviews, the respondents were asked to give suggestions on how the King Cooperative can further help its members and how to ensure its sustainability. The suggestions brought up were for the cooperative to choose investments wisely, to extend loan payment terms, to increase its assistance by covering consultation and treatment for illnesses not requiring surgery, and to formulate a program with the health needs and financial capability of low-income groups in mind. One respondent further expounded that the King Coop should look into a possibility of creating health insurance scheme that will provide total health care services.

One respondent commented that financial support from the government can be sought but most saw that the members' financial support was the most important.

Respondents shared that the personal contributions they can give to the cooperative are: punctual contribution and loan payment, increase in the member's contribution, and simply maintaining good membership standing.

All agreed to an increase in the amount of contribution because it would mean additional benefits and it is also in keeping with the escalating trend in medical costs.

9.0 CONCLUSIONS AND RECOMMENDATIONS

In its twelve (12) years of operation, King Cooperative has extended members with an increasing number of innovative services. In effect, it has also enjoyed a good following which first and foremost ensures its sustainability. Its mission is "to improve the quality of life", economically and socially, of its members. The program turned out, however, to cater primarily to employed or salaried individuals or established businessmen especially in the urban centers. Low-income groups would find it difficult to meet the minimum contribution requirement.

One of its long range projects is to give complete medical services. It may begin carrying out this plan by improving all its existing health services by increasing the amount of its medical assistance as suggested by the respondents. It should also consider treatment of minor illnesses as part of its coverage. A separate health service package can be made to accommodate lower income groups.

It can also be noted that the availment of dental services is relatively low. In 1992, when membership in Davao City was 1,441 only 16 have availed of the dental services at the King Cooperative clinic meaning members have not made full use of the benefits. The reasons may be that dental care is of low priority among the members' health concerns or the members have their personal choice of dentists other than the cooperative's dentist. To expand its services, King Cooperative may consider allowing members to choose their dentist in the future and a reimbursement policy may then be applied.■

Case Study No. 6 FAILURE CASES OF THE DRUG SALES AND THE INCOME GENERATING SCHEMES: BHW ASSOCIATION OF TACUL Tacul, Magsaysay, Davao del Sur

Case Study No. 6 FAILURE CASES OF THE DRUG SALES AND THE INCOME-GENERATING SCHEMES: BHW ASSOCIATION OF TACUL
Tacul, Magsaysay, Davao del Sur

1.0 BARANGAY PROFILE

1.1 Geographical Accessibility and Socio-Economic Traits

Barangay Tacul is an upland community situated about fourteen (14) kilometers from the Poblacion with an estimated population of 2,525. The area is accessible by public utility jeepneys (PUJS) which are usually scarce. In going to the area, sometimes, one has to wait for several hours before getting a ride. In going back to the poblacion, PUJs are usually only available up to one or two o'clock in the afternoon. Otherwise, it would be very difficult to go down. Other residents usually own either horses or carabaos as a means of moving around.

The main source of livelihood is farming. The present crops planted include corn, rice and variety of rootcrops and fruits such as bananas and durian. The area is also into the production of copra and other coconut products. For these, the residents have expressed the need for farm support facilities such as solar dryer and 'bodegas' (warehouse) to store rice and corn as well as the need for a mechanical dryer for copra. Of late, however, residents say there has been an increasing trend in the demand for rubber.

1.2 Health Profile

With the difficulty in pinning down the local midwife, who was the only one who had access to the complete health records of the barangay, the data gathered was mostly partial and incomplete.

The most common reported illnesses in Tacul for the last two years are cough and colds and skin diseases. In 1992, there was an outbreak of measles. Informal interviews among BHWs also revealed that malaria was a common case in the area. In fact, Barangay Tacul along with Barangay Talusob had the highest rate of malaria cases.

Of the leading causes of *mortality* in Magsaysay in 1992, two cases of Bronchopneumonia and one case of a gunshot wound were reported in Tacul. In 1993, there were three cases of cancer, two of poisoning/dehydration, and one each of congestive heart failure, cardiac failure, and gunshot wound.

Table 35. Leading Causes of mortality, 1992 and 1993: Tacul, Magsaysay

Cause	Number (1992)	(1993*)
Broncho-pneumonia	3	-
Gunshot Wound	1	1
Cancer	-	3
Poisoning /Dehydration	-	2
Congestive Heart Failure	-	1
Cardiac Failure	-	1
Gunshot Wound	-	1
TOTAL	3	9

** As of October 1993.*

1.3 Health Resources

1.3.1 Health Manpower and Facilities

There is one midwife assigned in Tacul with catchment aras in Maybo and Malungon. Her schedule in manning the local BHS is every Tuesday, Wednesday and Friday.

Cases beyond the BHS are referred to the RHU in the poblacion which is manned by one doctor, one dentist, two nurses and twelve midwives. Other complicated cases are brought to hospitals in the neighboring municipalities or at the National Hospital in Digos.

One Barangay Nutrition Scholar (BNS) is also assigned per barangay. The primary duties of the BNS are to monitor health activities of mandated agencies like D, DOH, DECS, DSWD and to conduct the program 'Operation Timbang' (weighing) among 0-18 month-old children to monitor malnourishment.

The association also has 18 BHWs helping in the implementation of the various health programs of the DOH.

1.4 Health Practices

Residents in Barangay Tacul are much like other barangays in a rural setting. Practices in treating illnesses lean quite strongly on the use of indigenous medicines such

as herbs. This makes sense not only because it is a cheaper alternative but also because of the place's distance from the urban centers in the area where there is professional medical help. Even the visits of professional medical practitioners from the DOH usually come only once a month.

If a sick person needs to be brought to the hospital, the usual practice is to hire a jeepney on a 'pakyaw' (paying for the full capacity of the jeep as when taking a regular fare). The money used in paying for the fare as well as the doctor's fees and other hospital expenses is usually borrowed from middlemen or traders who buy the residents agri-produce such as rice and corn.

2.0 THE ENTRY OF THE DMSF-IPHC PROJECTS

In the early eighties, there were no known programs or projects in the area. The locality was prone to armed conflicts then. In fact, in later years, the area served as a 'camp' to military occupation at the height of anti-insurgency operations in the area.

Barangay Health Workers (BHWS) were then already existent. They were trained by the local midwife designated by the Department of Health. The number of BHWs was not enough and their services were limited. Most of the health programs (e.g. immunization and family planning) introduced did not seem to have an impact on the residents.

2.1 The CHILD Project

Sometime in 1986, the DMSF-IPHC conducted a survey among depressed barangays in Region XI. Considering the high rates of malnutrition and the need for maternal and child health care and environment sanitation programs in the areas, the DMSF-IPHC held a series of consultations among local officials and residents wherein the concept of the CHILD project was introduced.

When the communities such as Tacul signified their interest in the project, the DMSF-IPHC recruited local residents and gave them a series of seminars and trainings as Community Health Volunteers (CHVs). These health volunteers went through a few changes in names- from being called a CHV to a CHO to a BHW – with the progress of programs implemented by the DOH. At present, they remain being called BHWS.

With the CHILD project, the group set-up a communal farm planted to corn. Another project was a 'botica sa barangay' (barangay drugstore) which began in January 1987. The group, which by then, had already formed an association, was extended a loan in the form of an initial one-month supply of drug stock the estimated value of which was no more than P400.00. To augment its capital, the association went caroling at Christmas.

Then, when the 27th Infantry Battallion of the Philippine Army was assigned to the area, they sponsored a 'disco' (dance) to increase the association's capital.

Out of the proceeds from drug sales, the group was able to set up a Social Development Fund (SDF).

2.2 The SHIELD Project

In 1988, the BHW association of Tacul was granted financial assistance to start a soap-making enterprise. However, the project failed when the mix in the soap solution was inappropriate so that the users found the soaps produced to be harsh on the skin. The association undertook the project twice and was able to set aside some amount for an emergency fund.

With the entry of the SHIELD project in 1988, the Federation was able to loan from DMSF the amount of P58,980.00. This loan was used for a soap-making project. Eventually, the interest from loans added to the drug sales was used to put up a Social Development Fund as an emergency fund mostly for health purposes.

2.3 The AAD Project

After the SHIELD project, the community also became a recipient of a grant from the IPHC through the AADP. This involved a spring development project.

3.0 THE ORGANIZATION

3.1 How It Began

The BHW Association of Tacul was formally organized in July 1987. Its catchment area consists of the 15 puroks in Barangay Tacul: Siogan, Mansanitas, Blasting, Bamba, Blocon, Ugsing, Kawagan, Talisay, Centro A, Centro B, Kalubihan, Gomahan, Umahan, Durian and Bankerohan.

It was organized by the DMSF-IPHC after a consultation with the local officials and residents.

3.2 General Objective and Benefits

The primary aim of the association was to ensure the resident's good health by implementing health-related activities and monitoring the households' health status.

Among the health benefits accorded the community through the efforts of the association were the provision of water-sealed toilets, improved drainage systems and other health sanitation projects. Also provided were health education seminars among households.

3.3 Membership

The association is open only to BHWs who are residents of Tacul. At the time of the study, there were 23 members but only 18 were active. As in other BHW associations of IPHC-assisted communities, most members were women although some of those who served as project officers were men.

4.0 THE SCHEMES

4.1 The Botica sa Purok

In December 1987, the DMSF loaned an initial drug stock worth P400.00 to the BHW Association of Tacul through the CHILD project. The group then raised additional funds by carolling in December. Then the 27th Infantry Battalion assigned in the area organized a disco in the barrio to raise additional capital for the drug store.

The Botica was widely acknowledged as having benefited the residents in enabling them to buy drugs at a lower cost without having to go down to the poblacion. The income from the 'botica' was allocated as follows:

25% - Social Development Fund (SDF)
35% - Capital Build Up (CBU)
40% - 'Botica'aide honorarium

The drug store is located across the house of the botica aide. When it acquired its initial drug stock, the composition of drugs were as follows:

1. Paracetamol liquid
2. Glycerol liquid
3. Bromhexine capsule
4. Remedoil
5. Ampicillin suspension
6. Ampicillin capsule
7. Bromhexine suspension
8. Ferrous sulfate
9. Multivitamins
10. Aspilet
11. Anacin tablet
12. Biogesic tablet
13. Gardan
14. Neozep tablet
15. Ponstan capsule
16. Sumapen
17. Kremil-S
18. Asmasalon
22. Enervon C liquid
23. Bank Aid
24. Tuseran capsule
25. Enervon C liquid
26. Revicon forte
27. Luiscol
28. Toilet paper
29. Cotton
30. Vicks vaporub
31. rubbing alcohol
32. Erythromycin suspension
33. Erymicin tablet
34. Trisonit
35. Muscosan
36. Decolgen tablet
37. White flower
38. Allerin tablet
39. Myracof T

19.	Penicillin tablet	40.	Diclomine liquid
20.	Bugayana	41.	Paracetamol tablet
21.	Neozep liquid	42.	Diatabs

4.1.1 Problems in the Operations

The 'Botica sa Barangay' was eventually renamed to 'Botica sa Purok' because of some problems experienced involving the choice of drugs to stock. According to the botica aide, the main health center personnel used to insist on what drugs to purchase even if those from the areas did not feel these drugs were needed (drugs were not those needed for commonly experienced illnesses.)

The Botica was temporarily closed down since December 1992. This was because the botica aide who used to tend to the store became busy with other concerns. When she suggested that other members take over the task she has shouldered for the past years alone, all the other members refused saying they were too busy with other things and unwilling to rotate the responsibility of tending the store; not even with the incentive of getting forty percent of the store's proceeds as honorarium.

At the time of study, the botica aide said her coworkers asked if she could open the store only on Saturdays. She could not, however, since she practiced the faith of Seventh Day Adventists where Saturdays are devoted to attending church service.

Aside from giving alibis on why they could not tend to the store, a number of members said they did not want to to do so because they thought it was too much trouble to keep track of the stock cards and recording mechanisms needed to maintain the store especially as they had difficulty in a accomplishing it. Some expressed lack of confidence to take over the responsibility due to poor education.

Another problem being considered in maintaining the Botica was its location since there were indications that is present location may come in the way of a road soon to be constructed in the area. Should the Botica be moved, the aide thought it would be difficult for her to tend to the store unlike when it was just in front of her house.

An interesting problem experienced by the BHWs in running the Botica is the lack of awareness on the part of some residents on generic drugs. Some members go to the length of saying that the generic drugs sold at the Botica are no good and ineffective having been used to using drugs with specific brand names.

4.1.2 Management of Funds

Nang Sario (short of Rosario), the botica aide, who was trained in Basic Bookkeeping and Accounting Procedures by the IPHC religiously kept a record of

all transactions related to the buy and sell of drugs for the botica. The stocks bought were properly recorded and quantified. An inventory and auditing by an IPHC staff was made every quarter. The sales grossed and the apportionment of the net income among the SDF, CBU and botica aide honoraria were delineated although there remained some minor data gaps. (See Table 36)

From a beginning stock of P400.00 in December 1987, the drug sales funds stood at P1,054.40 as of April 16, 1993, when Nang Sario was no longer able t purchase additional stocks and tend to the drugstore.

For the period first quarter of 1988 up to April 1993, a total of P2,2497.33 (or some 25% of the net income) had been generated from the net income for the SDF.

However, the loans extended to members from the emergency funds (which is coursed from the SDF) had low repayment rate. It was observed that the system of recording was crude. The loans were just listed down with a name and the corresponding amount of loan. When the loans were paid, the pre-listed name are marked paid the corresponding amount of loan on the same list. There was no effort to draw up a separate list of accounts receivables every so often for easier reference. Also, no notice of collection were sent to debtors. Repayments were mostly left to the conscience of the borrowers. Finally, when a new treasurer took over the job, she refused to accept the record of loans and it was difficult to isolate the paid up amounts from those unpaid.

Another factor which strongly negated efforts to repay/collect loan repayments was the fact that even the past president of the association did not bother to pay his own loan. Other members would therefore retort/Nganong magbayad man ko nga wala man gani magbayad ang presidente? (Why should I pay my account when the president himself has not paid his?) One member quipped she would only pay if the president pays his own account first.

4.2 The SDF for Emergency

The drug sales is in itself a source of funds from the group's SDF. Part of this is allocated as an emergency fund from which members can borrow during illness episodes.

Each member is entitled to maximum of P200.00 as medical loan on the condition that it is repaid with a 5% interest.

Members felt the credit ceiling was too limited. As of the time of interview, there had been a total of over P4,000 worth of loans extended. However, most of these were unpaid. Since the finance officers could no longer keep track of unpaid accounts much less collect given the unwillingness of some member to pay, loans were stopped.

Table 36. Quarterly Inventory & Net Income Apportionment of the Botika sa Purok

	1st qtr. 1988	2nd qtr 1988	3rd qtr. 1988	4th qtr. 1988
Sales	P 2,524.40	P 3,734.80	P 2,399.60	P 3,028.55
Remaining Stocks	-	333.65	1,117.05	975.20
CBU	1,026.50	-	-	-
Operating Expensen	295.50	400.00	208.50	199.30
Purchase	-	-	2,470.35	2,209.80
BSB Loan	-	-	250.00	-
Net Income:	1,202.30	1,265.19	587.50	619.35
Aide (40%)	480.92	506.08	235.12	244.74
SDF (35%)	420.81	442.80	205.75	216.77
CBU (25%)	300.57	316.29	146.95	154.83
	1st qtr. 1989	2nd qtr 1989	3rd qtr. 1989	4th qtr. 1989
Sales	2,731.40	-	2,421.35	-
Remaining Stocks	1,835.30	-	1,675.00	-
CBU	-	-	235.00	-
Operating Expenses	362.30	-	-	-
Purchase	3,108.20	-	2,642.90	-
Net Income	1,096.20	-	1,218.95	-
Aide (40%)	383.67	-	487.58	-
CBU (35%)	338.48	-	426.63	-
SDF (25%)	274.05	-	304.73	-
	1st qtr. 1990	2nd qtr 1990	3rd qtr. 1990	4th qtr. 1990
Sales	1,900.35	1,847.35	2,082.40	2,693.55
Remaining Stocks	-	-	-	311.30
Operating Expenses	-	-	-	-
Purchase	1,094.83	1,543.66	1,832.90	2,077.02
Net Income	805.52	303.69	561.30	615.79
Aide (40%)	322.20	121.48	224.30	246.66
CBU (35%)	282.93	106.29	196.45	215.00
SDF (25%)	201.38	75.92	140.32	154.13
	1st qtr. 1991	2nd qtr 1991	3rd qtr. 1991	4th qtr. 1991
Sales	-	-	-	2,523.10
Purchase	-	-	-	2,267.60
Net Income	-	-	-	255.50
Aide (40%)	-	-	-	102.20
CBU (35%)	-	-	-	89.42
SDF (25%)	-	-	-	63.87
	1st qtr. 1992	2nd qtr 1992	3rd qtr. 1992	4th qtr. 1992
Sales	3,061.55	-	-	-
Operating Expenses	2,451.69	-	-	-
Net Income	610.86	-	-	-
Aide (40%)	244.34	-	-	-
CBU (35%)	213.80	-	-	-
SDF (25%)	152.71	-	-	-

Note: Figures may not tally. Auditing, inventory and stock purchases became irregular in the long run.

5.0 NEXT STEPS TO REVIVE THE SCHEME

5.1 What the Residents Think

The steps identified by the manager herself were at best only "stop gap" measures. These included the possibility of letting her own daughter do the lending if the group cannot hire an aid to man the botica.

Talks among the town folk had it that the store's location (which is in front of the house of Nang Sario) would be in the way of the road to be constructed soon. Part of the recommendations, therefore, included looking for an alternative site for the store and a regular aid to watch it.

Members also said that there should be a policy that loans be paid within one week as agreed.

Also, to help boost the botica's sales, community members must be educated on the use of generic drugs especially as many of them criticized it as being ineffective compared to drugs with brand names.

5.2 Some Recommendations

Given the seeming lack of awareness of community members, BHWS should play a more active role in giving out health education orientation seminars to the community.

Likewise, the organization managing the scheme evidently needs to be strengthened in terms of know-how and capability in the financial and management aspects.■

Case Study No. 7. A FAILURE CASE OF A PREPAYMENT SCHEME: "KAPUNUNGAN SA KASAKIT (KsK) SA BARANGAY" Barangay Balasiao, Kiblawan, Davao del Sur

1.0 BARANGAY PROFILE

2.0 HEALTH PRACTICES, SERVICES AND UTILIZATION

- 2.1 Health Status
- 2.2 Health Practices BEFORE the Scheme

3.0 FINDINGS ON THE ORGANIZATION

- 3.1 How the Association was Organized
- 3.2 Membership Qualifications and Processes
- 3.3 The Kasakit sa Barangay: A Scheme for Mutual Aid (Mortuary) and for Health Financing
- 3.4 Management

4.0 THE KASAKIT SA BARANGAY AS MEDICAL LOAN

- 4.1 Processing of Loans

5.0 PERCEIVED CHANGES IN HEALTH STATUS AND HEALTH-SEEKING BEHAVIOR AFTER SCHEME

6.0 PERCEPTIONS ON REVIVING AND SUSTAINING THE SCHEME

- 6.1 Some Problems in Operationalizing the Scheme
- 6.2 Perceived Sustainability Mechanism

Case Study No. 7. A FAILURE CASE OF A PREPAYMENT SCHEME: "KAPUNUNGAN SA KASAKIT (KsK) SA BARANGAY" Barangay Balasiao, Kiblawan, Davao del Sur

1.0 BARANGAY PROFILE

Balasiao is one of the 30 barangays of Kiblawan, a municipality in the province of Davao del Sur (See Fig. 5 for location map of Kiblawan). It is located 20 kilometers from the municipal hall. Trucks of corn, sugar and ricefields line the main partially-cemented road winding through a sloping landscape. The climate gets cooler upon nearing the area as it is almost surrounded by verdant green hills lined with terraces of agri-crops.

The main mode of transportation are public utility jeepneys and motorcycles. The barangay roads are not paved and walking around on foot can be difficult when heavy rains cme. Horses are therefore not an uncommon means of going around.

Farming is the major means of livelihood. The total population was estimated at 1,937 in December 1992.

Dialects commonly spoken are Cebuano and Ilnggo.

The peace and order situation still makes the residents apprehensive at times because of occasional armed encounter between the New People's Army (NPA) rebels and military forces.

2.0 HEALTH PRACTICES, SERVICES AND UTILIZATION

2.1 Health Status

A look at Tables 37 and 38 reveals that the most common illnesses afflicting children aged below one year include Acute Respiratory Infection or ARI (199 and 133 for 1992 and 1993, respectively), Influenza (218, 112) and Pulmonary Tuberculosis or PTB (136, 131). The same illnesses also had high rates of occurrence reported for children aged one (1) to four (4) years old: ARI (162,93), Influenza (116,81) and PTB (6,750) although there was a marked decrease from 1992 to 1993 except for the latter. PTB was also the top cause of morbidity and in facts showed an increasing trend for the age group fifteen (15) to forty nine (49) years old (237,305).

The health status is observed to have improved because of the services given by BHWs and the increasing number of government programs like family planning and immunization.

Table 37. Case of Morbidity Per Age Group in Balasiao, Kiblawan, Davao del Sur, 1993

AGES	ANEMIA	OTHER NUT'L VITAMIN DE-FICIENCIES	ACUTE RESPIRATORY INFECTION	INFLUENZA	PNEUMONIA	BRONCHITIS	HEART DISEASE	PARASITES	SKIN PROBLEM	GASTRO-INTESTINAL DISORDER	MUSCULO SKELETAL DISORDER	PTS	OTHERS
0-1	4	8	133	112	-	-	-	-	7	13	-	131	-
1–4	7	12	83	81	-	-	-	18	4	16	-	50	-
5-14	8	3	28	24	-	-	-	12	8	16	-	6	-
15–49	14	-	86	152	-	-	-	1	8	10	-	305	-
50-64	0	-	24	19	-	-	-	-	1	1	-	81	-
65 Up	5	-	8	2	-	-	-	-	-	-	-	26	-

Table 38. Case of Morbidity Per Age Group in Balasiao, Kiblawan, Davao del Sur, 1992

AGES	ANEMIA	OTHER NUT'L VITAMIN DE-FICIENCIES	ACUTE RESPIRATORY INFECTION	INFLUENZA	PNEUMONIA	BRONCHITIS	HEART DISEASE	PARASITES	SKIN PROBLEM	GASTRO-INTESTINAL DISORDER	MUSCULO SKELETAL DISORDER	PTS	OTHERS
0-1	1	7	199	218	1	-	-	-	48	34	-	134	2
1-4	28	15	162	118	-	-	-	57	8	40	-	67	3
5-14	4	13	50	77	-	-	-	28	13	22	-	42	7
15-49	55	12	67	67	-	-	-	16	6	14	-	237	2
50-64	5	-	50	33	-	-	-	1	-	6	-	57	-
65 Up	-	-	20	21	-	-	-	-	-	1	-	22	-

Health Practices BEFORE the Scheme

When the sick cannot immediately pay for the health services, the family usually seeks assistance from big store owners, relatives, friends, government insurance, DSWD, from the church-based Gagmay'ng Kristohanong Katilingban (GKK) or the Basic Christian Communities (BCC), and from the Kapunungan sa Kasakit (KsK) when the medical loan was still operational.

Residents usually take self-prescribed medicines and apply oriental medicine like the use of soothing salves or oils, massage and herbal medicines to treat minor illnesses. When the symptoms persist after three days, some would seek the services of doctors while others would still resort to oriental medicine.

Whenever medical or dental services are to be conducted in the area by the RHU personnel, an advance party has to inform the community (which usually entails a lot of legwork) so that there is a sizable number of patients during the actual schedule.

3.0 FINDINGS ON THE ORGANIZATION

3.1 How the Association was Organized

An informal group called the "Kapunungan sa Kasakit sa Barangay" (which means an "association of those in grief and sorrow") was started in 1973 by residents of Barangay Balasiao headed by the then barangay captain, Mr. Estanislao Cabarlo. This came about when the child of one community member died and the residents decided to pool resources to pay for the expenses. Since then members have been turning to the organization for mortuary aid.

However, the members thought it would be better and more beneficial if the members did not have to wait until a family member or kin died before they could be given help. Eventually, a medical loan was made available to members using the general funds of the organization.

The organization has been able to accord the residents with mortuary aid. But the medical loan assistance has been in a standstill for more than a year now because of low repayment rate. The members have decided during a general assembly that no new loans be released unless all collectibles are paid.

3.2 Membership Qualifications and Processes

The KsK sa Barangay is open to all residents in Barangay Balasiao and the neighboring Barangay Pasig. Those who are entitled to enlist are usually the heads of the family and their spouses. Upon enlisting, all members of their immediate families are covered by the benefits. To date, there are over 100 members.

The only requirements to membership are to enlist, and pay the membership fee. The fee was initially P1.00. It was raised to P15.00 in 1991 and the amount of P10.00 was levied for renewal of membership for old members.

Farmers (of sugarcane, rice and corn), teachers and housewives constitute the greater bulk of the membership.

3.3 The Kasakit sa Barangay: A Scheme for Mutual Aid (Mortuary) and for Health Financing

When the Kapunungan was organized in 1973, the members agreed to pay a monthly contribution of P1.00 each. The said amount was paid by each member until 1990 afterwhich (at the start of 1991), it was increased to P5.00. Aside from this, when a family member or kin died, each member family contributed the amount of P20.00.

Most members were able to give their contributions at the time of collection. Delinquents to the collection of P20.00 per death episode, however, were given three warnings before being subjected to sanctions decided upon during the general assembly. The sanctions usually came in the form of reduced amount of benefit availed.

Other funds mobilized by the organization (e.g. the monthly contributions) were utilized as loans extended to members or their kin who fall sick and would need cash to defray expenses related to seeking professional medical help.

As of April 25, 1992, total funds stood at P1,024.

3.4 Management

The KsK, though an informal organization not having been formally registered in any government accrediting institution, has some nuances of a formal organizational structure. In fact, the leader (President) of the group was the wife of the then acting Barangay Captain at the time of interview. However, the top officers save for the secretary and the treasurer were not available for interview at the time.

Elections of officers are supposed to be conducted at the start of every year. They are to serve a one-year term. But the 1990-elected officers were still the same officers at the time of interview.

Likewise, meetings are supposed to be held quarterly but there have been no regular meetings from January 1991 up to the general assembly in May 1992.

The officers render voluntary work. They neither receive any compensations nor enjoy special privileges. As far as decision-making is concerned, they can decide on ‘light matters’ even without quorum. The respondent interviewed, however, did not shed light as what these ‘light matters’ are.

While the organization is informal, it has some nuances of a formal structure there having been elected a set of officers. Although there is no regular constitution and bylaws, the group's operations are guided by decisions made by the general assembly (which is composed of all the members).

4.0 THE KASAKIT SA BARANGAY AS MEDICAL LOAN

At the start of 1991, a medical loan of up to P300.00 was made available to members or their dependents. The loan bears no interest and is payable in three months. If the borrower is unable to pay back the loan after the grace period, the general assembly is supposed to impose a sanction (i.e. limiting the amount that can be loaned by the delinquent member in the future). However, the sanction has not been implemented. Some members say that the interest on the repayments should be foregone. Some argue that if the borrowers find it difficult to repay the principal, how much more when an interest is imposed?

4.1 Processing of Loans

The only expenditures considered in extending a medical loan are those directly related to medical treatment. The process involves the following procedures: (1) the president approves the loan upon request and, (2) is released by the treasurer.

There are no paper requirements when applying for a loan. It is released immediately as long as there are available funds. The borrower can re-loan only if he/she has paid his/her past accounts. This was especially manifested in the case of one member who was refused a loan because of his reputation of not paying on time.

In their general assembly in May 1992, it was decided that no new loans will be released because borrowers were not able to pay up and the funds have been depleted. It will only be revived if all the collectibles have been settled.

5.0 PERCEIVED CHANGES IN HEALTH STATUS AND HEALTH-SEEKING BEHAVIOR AFTER SCHEME

When asked how they thought their health status was at present compared to how it was five years back, one respondent replied it was just about the same. If they needed to bring a sick member of the family to the hospital they would readily do so provided it is low-cost (as in the National Hospital).

Another member said they would immediately bring their sick to a hospital and worry about finding money later on since the loan is too inadequate to be depended on.

On the other hand, one member thought their family health status was much better now compared with five years ago. This is so due to the presence of more BHWs who actively

implement the DOH health programs. Also, a clinic day is held at the BHS every first Wednesday of the month.

With regards health practices, residents still tend to exhaust all traditional means of treatment before thinking of seeking professional medical help. In fact, a very common practice among residents is the use of 'tuob' (steam inhalation). When all other means do not work, this is usually the last resort. It involves determining the particular food or drink which caused 'pasmo' (getting sick with fever and experiencing body weakness as when one takes cold drinks with an empty stomach).

Upon bringing the patient inside the house, all openings (doors and windows) that allow the wind to enter are closed. The particular element suspected to cause the 'pasmo' is boiled and the patient, usually covered under a blanket inhales the steam of the broth. The steam is believed to be an effective cure.

These practices are very widely practiced because Balasiao is very far from the RHU in the poblacion and from the hospitals in the locality. Cases requiring services of a hospital are usually brought to the National Hospital.

6.0 PERCEPTIONS ON REVIVING AND SUSTAINING THE SCHEME

6.1 Some Problems in Operationalizing the Scheme

When asked whether the scheme would become sustainable if ever it will be revived, the respondents expressed doubts. According to some, the scheme worked smoothly during the early years because there was only one objective: to help the bereaved family, and that was all. But when the benefits to be availed of expanded to helping the sick, and extending loans, the expectations of the members grew, but the level of contributions moreso, the capacity to contribute, remained the same.

Therefore, a key factor which disrupted the smooth operation of the scheme is the lack of funds.

Funds were insufficient first because the amount contributed by each member is so little and almost insignificant compared to the actual cost of seeking professional medical care. Second, of those who have been able to borrow from the funds there has been a low rate of repayment in general so that the used funds are not readily replenished. Third, a number of members do not pay their monthly contributions on time.

Given these, not all members in need are able to avail of the medical loan. In fact, because of these reasons, the general assembly decided to stop extending the loans.

Other negative but mostly isolated comments from the members included the playing of 'favoritism' by offices on the recipients of the loans. One respondent claimed only those who were close to the officers were able to avail of the loan.

However, from one officer's point of view, a number of members have been a problem to the organization since they readily mutter around complaints when they are not able to get a loan immediately. Some find it difficult to understand that the funds are not readily available at all times due to the problems cited above. Other members have allegedly abused the benefits extended by wanting to avail of a loan even for the mildest complaint. She further said that anybody could borrow from the fund for as long as the funds are available.

Other problems cited included the lack of cooperation among members as well as the members' unstable source of income being mostly upland farmers in the area.

In effect, many are not confident that the scheme would be able to extend help at the time of need.

Records pertaining to the organization were kept by the secretary. These included records of the loans extended. However, it was difficult to make use of the data available as the health financing scheme had already been at a standstill for sometime. The conduct of the study was rather difficult because the schedule had gone through a lot of time that the present officers were not very definite on the exact details of its organization much more tracking down and following-up the collections. The present set of officers could not even impose the sanctions decided upon by the general assembly.

6.2 Perceived Sustainability Mechanisms

The residents had mixed reactions and opinions on reviving the scheme. Some were not keen on reviving the medical loan arguing that the original intention in putting up the KsK was for mutual (mortuary) aid.

However, when asked what would make the scheme more sustainable, one respondent suggested that the association be reorganized and should be registered with either the Securities and Exchange Commission or the Cooperative Development Authority so that financial support from the government can be pursued.

When asked whose support and what kind of support should be sought, another respondent suggested that the barangay council should make arrangements with the municipal council that a vehicle be made available in the barangay especially in times of emergencies as it is difficult to bring the patient down from Balasiao to the poblacion.

A proposal to increase the monthly contribution was made, but it should not be over P25.00 because the members could no longer afford to contribute any amount beyond this.■

NON-HFS COMMUNITY: THE CASE OF BARANGAY LAGAO
(An Urban Setting)

1.0 BARANGAY PROFILE

2.0 HEALTH RESOURCES

- 2.1 Health Facilities
- 2.2 Health Manpower and Services Rendered

3.0 HEALTH STATUS

4.0 PROFILE OF PUROKS 2, 5 AND 6

5.0 EXPERIENCES AND PRACTICES IN HEALTH CARE

6.0 VIEWS ON HEALTH FINANCING SCHEME

7.0 CONCLUSIONS AND RECOMMENDATIONS

NON-HFS COMMUNITY: THE CASE OF BARANGAY LAGAO
(An Urban Setting)

1.0 BARANGAY PROFILE

Barangay Lagao is one of the eighteen barangays comprising General Santos City (see Fig. 9 for the location map), in the province of South Cotabato. It has a population of about 89,000 or 33.75% of the 263,660 population of the entire city. The total land area is 18.47 square kilometers or 4.6 percent of that of Gen. Santos City (GSC). The barangay has a complete transport and communication network and has residential, commercial and industrial areas. It also has a trade school and an elementary school. The city's main public market is also located in the area.

Its populace is made up of families with varied income-levels and sources of livelihood. The primary source of livelihood of the residents is employment in the non-agricultural sector, particularly in the service sector.

The barangay has six (6) puroks and for the purpose of this study, interviews were conducted in Puroks 2, 5 and 6. These puroks were chosen since they were perceived to have different economic status. This provides a comparison on the health care and financing practices among different economic settings.

2.0 HEALTH RESOURCES

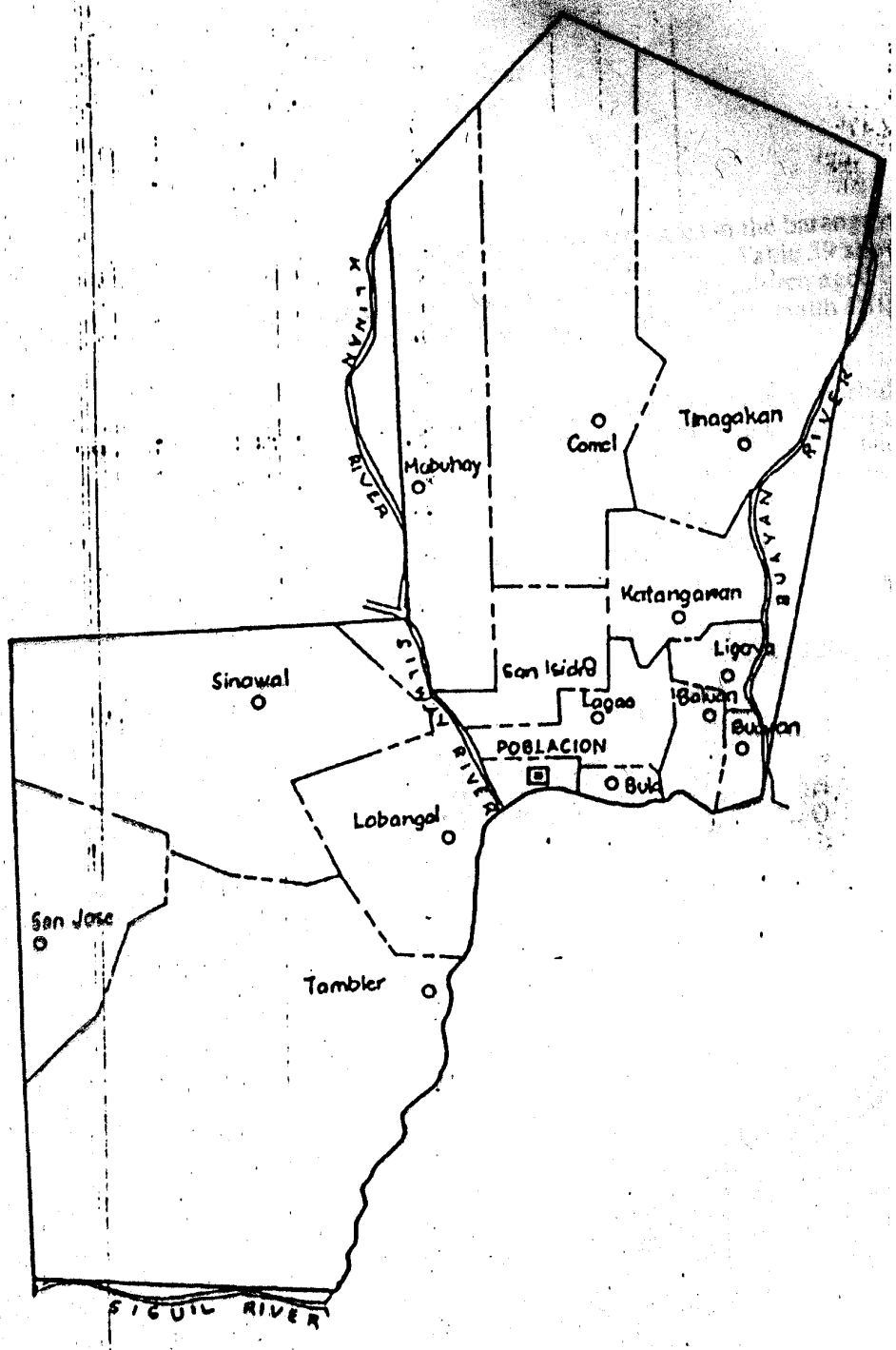
2.1 Health Facilities

Several health institutions are located in the barangay: two barangay health centers, Peñamante Clinic, Canda School of Midwifery and Clinic, Cagape Clinic, Gen. Santos Doctors Hospital, Mindanao Baptist Hospital, Gen. Santos District Hospital and the City Health Office and several others small private clinics in Lagao. Outside the barangay, and still very much accessible, is still another larger institution, the St. Elizabeth Hospital.

2.2 Health Manpower and Services Rendered

The Lagao Main Health Center has one doctor, one nurse, one dentist, five midwives, three sanitary inspectors, five government Volunteer Barangay Health Workers (BHWs), and about fifteen barangay hilots or traditional birth attendants. People coming to the health center are usually from the squatter areas of Purok 5 and Balite. During consultations the doctor attends to an average of eighty (80) patients per day, ten to fifteen of whom are referral cases from midwives.

FIGURE 9. MAP OF GEN. SANTOS CITY



Free medicines are given only for start up dosage. The patient purchases other medicines prescribed him. The health center admittedly lacks medicines and is understaffed. The physician holds office at Lagao while serving nine other barangays.

The existence of the Volunteer BHWs has given valuable support to the Health Center's service delivery. Among the functions performed by BHWs are the conduct of 'operation timbang', facilitation of feeding program, information dissemination, sputum collection, maternal and child care monitoring, application of herbal and traditional medicine, assisting the midwives regular barangay clinics in their respective area of assignment and other DOH-National sponsored activities like the National Immunization Day, the Araw ng Sangkap Pinoy and the like.

The schedule of services at the Main Health Center of Lagao is as follows:

Monday	-	Consultation
Tuesday	-	Field Work
Wednesday	-	Immunization
Thursday	-	Education/Seminar
Friday	-	Prenatal check-up

3.0 HEALTH STATUS

According to the health center physician, the most attended cases in the barangay is Acute Respiratory Infection followed by bronchitis, anemia, and diarrhea. Table 39 shows the leading causes of morbidity for all ages, 1991-1992, and Table 40 for children aged 0-5 years old, also for both years. These data are culled from records at the City Health Office (CHO) of Gen. Santos City.

Acute Respiratory Infection (ARI) has been the consistent leading cause of morbidity for both age groups in the past two years. Diarrhea has also been high in all ages in 1991 and 1992.

Table 39. Leading Causes of Morbidity, All Ages, 1991-1992

Leading Causes	1992	1991
Acute Respiratory Infection	612	492
Bronchitis	355	6
Anemia	257	259
Diarrhea	194	316
Gastrointestinal Tract Disorder	96	5
Skin problem	89	30
Other Nutritional Deficiency	52	17
Parasitism	35	41

Injuries	28	27
Pneumonia	23	22
Influenza	20	29

Table 40. Leading Causes of Morbidity, 0-5 Age Group, 1991-1992

Leading Causes	1992	1991
Acute Respiratory Infection (ARI)	456	289
Bronchitis	258	1
Diarrhea	98	177
Gastrointestinal Tract Disorder	67	3
Skin problems	56	22
Other Nut. & Vit. Deficiency	22	10
Parasitism	20	22
Pneumonia	14	9
Anemia	12	22
Influenza	8	9
Injuries	6	9

There is a sharp upsurge of bronchitis in all ages (from 6 to 355) and children aged 0-5 (1 to 258) from 1991 to 1992. The Lagao main health center physician attributed this as well as the escalating trend in the number of ARI cases to the worsening pollution in Lagao although the barangay is mainly a residential rather than an industrial area.

4.0 PROFILE OF PUROKS 2, 5 AND 6

There were three puroks chosen: Puroks 2, 5 and 6.

Purok 5 is a squatters' area which is thickly populated with low-income families. Residents earn their living as tricycle drivers, laborers, stevedores, and peddlers of fish, vegetables and other foodstuff. Houses are of frail materials, majority with earthen floors. As one respondent described the families living in Purok 5: "60% of the populace belong to the survival level, 20% to the subsistence level, and only 8% are self-sufficient,' without venturing further how she arrived at those classfication. Only 2% of them belongs to the middle class composed of store owners and about 2 or 3 DOLE Plantation employees including the Purok Leader.

Purok 2 and 6 are both residential subdivisions. Purok 6, however, is characterized by wider lots and larger houses.

5.0 EXPERIENCES AND PRACTICES IN HEALTH CARE

The key informants randomly chosen from the three puroks have incomes as contrastingly different as the place they are residing in. Their gross monthly income ranges from P2,600.00 to P17,920.00.

Whenever a family member gets sick, the residents in Purok 5 usually resort to the health center's services. When major or complicated cases occur, they are usually referred to the GSC District Hospital.

The health unit can only give medicines for start-up dosage. The follow-up medicines are shouldered by the patients or their families. If the patient is referred for further treatment at the district hospital, not all the medicines a patient may need can be given to him for free considering the number of patients served by the hospital. In cases where there are neither medicines available nor further treatment can be availed of by the patient, he ends up going home and leaving the situation in God's hands. According to one respondent, some members of her community can hardly even eat three times a day. Thus, medical needs are not exactly among their primary concerns.

Some residents make use of cheaper alternatives instead. In the case of one respondent, she put off bringing her feverish child to the hospital. Instead, she treated her child with what a neighbor recommended: boiled 'malunggay' leaves, the broth of which was to be drunk by the patient. The child fortunately got well. In another case where a neighbor of the respondent put off seeking professional medical help for a sick member of the family, the sick member died.

The use of herbal medicines and taking of self-prescribed medicines or medicines previously recommended by doctors for treatment of minor ailments within 24 hours are quite commonly done among Purok 2 and 5 respondents. They would consult the doctor only if the illness persists after three days.

One Purok 6 respondent revealed that his family immediately seeks the advice of a private family doctor at the first sign of any illness. Last year alone, his family spent P20,000 for the treatment of his two small grand-children suffering from recurring cough, colds, and fever, one of whom was confined at St. Elizabeth Hospital.

Lagao had no health center physician for 6-7 months before the present physician took office in 1992. There was lack of information dissemination about her consultation schedule thus there were fewer patients when she first started. She commented that the number of patients coming to the health center for consultation or treatment is significantly increasing. She also noted the growing confidence, especially among Purok 5 residents, in seeking medical attention from health professionals.

6.0 VIEWS ON HEALTH FINANCING SCHEME

One respondent in Purok 6 said a scheme would be helpful but he himself does not believe in insurance. Another respondent from Purok 2 did not see the need for a community-based health financing scheme for his family since they are enjoying benefits from Philam Care. This is the health care program under Philam Life Insurance where the respondent is an underwriter. He also noted that majority of the residents are covered by Medicare.

However, he has had experience in soliciting donations to help out the poorer members of the other puroks. He finds this difficult and inconvenient. It is in this respect that health financing can be organized in order to address these needs. He further said that, as the purok president, he is quite willing to organize a scheme within their purok shuld there be a directive from the barangay captain to do so.

The respondent further proposed that the program should be established in the whole barangay but that each purok should manage its own scheme for it to become more efficient and effective. He said that those who are experienced on this kind of project should manage the program. He even suggested that the Gagmay'ng Kristohanong Kanlingban (GKK) or the church based Basic Christian Communities (BCC), or perhaps the Sangguniang Kabataan (SK) can help in the implementation. The respondent from Purok 5 also suggested that their purok leader can organize the scheme.

The identified possible constraints in the setting-up of the scheme are the financing and the office site.

The respondents do not only welcome the idea of a health financing scheme. They even proposed the following as possible benefits it should offer: free consultation, free medicines, and financial assistance to pay for hospitalization including food and room. One respondent was even willing to contribute P100.00 per month, if only to be able to avail of the benefits mentioned above.

The barangay captain also expressed the need for a health financing scheme and commented that the scheme of the Medical Mission and Group Hospital and Services Cooperative in Davao City was a good example to follow.

The Rural Health Physician also agreed that a community based financing is helpful especially for the poor members of the community but noted that there might be difficulty in the organizing. She noticed that a cooperative office in the barangay had closed down only after a few months of operation. She could not supply other details, however.

7.0 CONCLUSIONS AND RECOMMENDATIONS

Lagao, being an urban center, has a relative edge in terms of being endowed with health facilities and services from both the government and private sector. Access to these facilities and services however, is limited. Reasons range from without having enough financial capacity to pay for health services, to not seeing the need for such services at all.

Employed individuals and middle-class families who are health insurance subscribers may avail of the services not so much because they really need to, but moreso because they would like to make use of that which they have been paying for regularly.

For the respondents, the health financing scheme is not only practical, it is a worthy cause. Especially among the resident of Purok 5 who would welcome anything that may ease their sufferings without having to spend so much.

In the meantime, the following concerns are worth looking into:

1. Compensation of the Community Health Volunteers/Barangay Health Workers. Although they will no longer be called volunteers once compensated for their services, but any form or amount to recompense them of their work should be given consideration. Current incentive provides only for free hospitalization of BHWs and an easy access to medicines for their family members.

2. The need to systematize DOH/Barangay Health Centers data banking system for easier access to information.

3. The need to conduct education/orientation classes, especially among the low-income group, on the value of savings for health care.■

NON-HFS COMMUNITY: THE CASE OF BARANGAY TAMBOBONG (A Rural Setting)

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NON-HFS COMMUNITY: THE CASE OF BARANGAY TAMBOBONG
(A Rural Setting)

1.0 BARANGAY PROFILE

1.1 General Physical Characteristics

Barangay Tambobong, by political subdivision, is part of Davao City. It is one of the eight barangays under the jurisdiction of Baguio District (see Figure 8 for location map). It is 41 kilometers away from the City Hall.

There are no data as to its exact total land area (please read portion in problems met). Classified as highland, the area is planted to coconut, com (both the traditional and the high-yielding yellow corn variety), rice which is largely rainfed, coffee, cacao, banana, cassava, sweet potato, lanzones and vegetables. As to volume per crop per harvest, neither the Barangay District Hall nor the Davao City Planning and Development Office has the data.

1.2 Household and Population Composition

There are 609 households according to the data supplied by the Barangay Secretary, 21% of which are converged in the central area where the public elementary school, the barangay hall, and the barangay health station are located. The other 79% is widely dispersed among the 11 sitios which are accessible only by foot or on horseback. Total population as of December 1992 is 3087.

The whole barangay is inhabited by the Bagobo tribes and the Visayan settlers. There has been no known conflict between these groups. Those who have resided in the area for some times peaks fluently the Visayan (either Cebuano or Ilonggo) and the "Diangan" dialects.

1.3 Access to the Area

From Davao City poblacion, there are public utility jeepneys regularly plying the 28-kilometer route to the poblacion area of Calinan District. From Calinan poblacion to Tambobong, there are two access routes: the Calinan-Maligatong-Tambobong Route, and the Calinan-Tamugan-Tambobong route.

1.3.1 <u>The Calinan-Maligatong-Tambobong route</u>

There are trips going to Maligatong which leave very after two hours, or when all seats have been occupied. Maligatong, asitio of Barangay Carmen which is also under the jurisdiction of Baguio District, is ten kilometers away. The trip takes about 40 minutes.

From Maligatong, the four-kilometer wal to Tambobong begins. It starts with a downhill trek for about a kilometer. Then one crosses Tamugan river three times. When it doesn't rain or about two weeks, the river is knee-high and the current manageable. One has to be very careful though with stones and boulders as these are quite slippery. When it happened to rain the night before, depth could be from waist to breast level, and the current could become dangerously strong. When this happens there are two options: pass through the hanging bridge which is about half a kilometer away, then only cross Tamugan river once. But this option would take one quite farther away from the road to Tambobong. The second option is simply to look for portions in the river where there are big boulders strongly buried in the bed and can be used as natural foot bridges. However, one has to be very sure of his foothold that he doesn't slip.

Having crossed the river the third time, the final leg to Tambobong begins. There are two routes to choose from: the shorter but steeper route, and the easy uphill walk but longer route. The former requires agility and strong grip on whatever available roots or stems of trees to hold onto to be able to literally haul oneself up. The second route is a steady uphill climb, skirting loose stones along the way. Either way is difficult and would make one breathless, moreso for first timers. It would take about 40 minutes to reach Tambobong through the first route, and about an hour to an hour and 15 minutes through the second.

1.3.2 The Calinan-Tamugan-Tambobong route

During dry months, there are jeepneys that travel directly from Calinan to Tambobong. The schedule is one trip every three hours, unless it is a Sunday when residents come to Calinan to sell their produce or buy food items, or a Monday when workers in the pineapple farms go up for their Monday-Friday work and teachers assigned in the highlands report for duty. On these days, trips could be as frequent as one every hours.

For about four kilometers, the jeepney passes through the asphalted Davao City-Bukidnon national highway. It turns right at the crossing beyond Marilog District and the barangay road to Lower Tamugan begins. The jeep sways alarmingly everytime it passes through a rut. The road is very dusty when dry, and muddy when rainy. Since the terrain is part plain and part hilly, the Calinan Tambobong trip takes about an hour and a half.

On rainy days however, the jeepney stops at Sitio Cogon in Tamugan. Tamugan, a barangay under Marilog District, is 10 kilometers away from Calinan and 9 kilometers away from Tambobong. The 5-kilometer distance from Cogon to Tambobong will have to be completed on foot.

Whether the jeepney ride goes directly to Tambobong or stops at Sitio Cogon, the ride is not an easy one. The jeep does not leave the terminal unless

filled to capacity. And full capacity means passengers on top, sitting on the hood, holding on to sides of the jeepney, or barely holding on to whatever bars are sticking out at the back. The only space left free is the portion of the hood in front of the driver. The Calinan-Cogon trip takes about 45 minutes.

1.4 Types and Number of Toilet

As of the March 1993 report of the BHWs submitted to the City Health Office, of the 609 households, 249 have built antipolo-type toilets, 115 built the open pit type, and four own the water-sealed with manual flush type. The rest either use the overhang type, or none at all.

1.5 Water Resources

The barangay has one reservoir built under the Water Supply Level I project of Davao City Engineering District of the Department of Public Works and Highways in 1991. This reservoir, however, being spring-sourced, is able to supply water only during rainy season. Some houses have water tanks to store rain water for drinking.

Primary source of water for all other purposes is the Tamugan river.

1.6 Other Characteristics

The barangay does not have electricity. All households use kerosene lamps. There are three sari-sari stores selling basic condiments and limited food items. There are fish and bread peddlers who come to the place at least once a week when the weather is fine.

2.0 HEALTH STATUS AND HEALTH SERVICES UTILIZATION

2.1 Health Status

The following are based on the data supplied by the Tambobong Rural Health Midwife (RHM) covering the period January-December 1992:

2.1.1 Characteristics of Children Weighed

Ages: 0-6

Total Number weighed	=	677
Normal	=	357
Mildly malnourished	=	207
Moderately malnourished	=	95
Severely malnourished	=	8
Overweight	=	10

2.1.2 Number of Malnourished Children who Died

Moderately malnourished	=	4
Severely malnourished	=	1

2.1.3 Top 10 Complaint/Ailment Treated at the BHS

Urinary Tract Infection (UTI)
Diarrhea
Antipartum
Parasitism
Anemia
Penumonia
Influenza
Tuberculosis
Skin Problems
Abcess/Infected Wounds

2.2 Health Manpower and Resources

There is only one Rural Health Physician (RP) serving the whole district. Baguio has eight barangays, including the district proper. Since most of these barangays are not accessible by land transport, clinic day schedules have to be planned in advance. Schedules have to be closely coordinated with the BHWs or with the elementary teachers in the area for proper dissemination to parents.

One RHM serves three barangays, with a catchment radius of seven kilometers. One BHW oversees two barangays for monitoring and follow-up. The BHWs submit monthly reports to the RHM.

The top ten illness or ailments residents of Tambobong suffer from, per actual record, are: Acute Respiratory Infection, gastro-intestinal disease, parasitism, nutritional and vitamin deficiency, influenza, bronchitis, pneumonia, muculo intestinal disease, skin problems and anemia. These are based on the reports submitted by the Rural Health Midwife (RHM) based in Tambobong covering the last quarter of 1992, and the first three quarters of 1993 (please see Table 41.).

2.3 Health Services Utilization

Minor aliments are diagnosed and treated at the barangay level. Patients either see the Barangay Health Worker (BHW) based in their sitios for initial diagnosis and for referral to the Barangay Health Station (BHS), or they go directly to the RHM for treatment. If medicines are available, these are dispensed to the patients for free. The Department of Health has issued paracetamol, ferrous sulfate, ORS, cotrimoxazole, amoxycillin, chloramphenicol, and Mefenamic Acid, through the District Health Station. These medicines are in turn distributed equally among the barangays under the district.

Complicated ailments are referred to and are treated at the District Health Station. Should patients need further examination, they are referred to and are treated at the City Health Office, or to the Davao Medical Center, where they can be given adequate medical attention of treatment.

The data on general services and treatment culled from the Field Health Service Information System are shown on Table 42.

As can be gleaned from the table, only about eight percent, on the average, have been given or have availed of these services. According to one BHW-informant, the primary reason is that majority of the residents suffering from these ailments would rather spend their time in their farms, rather than walk for an hour to three hours going to the BHS for treatment, and then walk the same length back. In addition, if there are no available medicines for their ailments and are prescribed medicines to be bought at the district proper or in the city, heir next problem would be where to get the money with which to buy them.

2.4 Common Health Practices

Folk medicine have long been practiced by the indigenous people. The very common medication when somebody in the family has cough, colds, fever, or even wounds, is to drink and/or rub concoctions of herbs grown for the purpose. Herbs or plants known to have medicinal value which grow in the area are buyo (betel leaf pepper), panyawan (Scientific Name: Tinospora rumphii Boerl; known as Makabuhay in Tagalog)' bayabas (guava), tanglad (lemon grass), mayana (Coeus blumei Benth; also known as mayana in Tagalog), and gabon (Elumea or Ngaicampor). Other herbs which neither their Scientific names nor Engligh and Tagalog equivalents were not found are the "sangig", "hilbas", and "manguntani".

Table 41. Top Ten Illnesses/Ailments Tambobong Residents Suffer From

Ailment/Complaint	Dec 1992	Mar 1993	June 1993	Sept 1993
1. Acute Respiratory Infection	102	194	353	217
2. Gastro-intestinal disease	46	69	100	136
3. Parasitism	25	45	47	112
4. Nutritional and Vitamin Deficiency	20	15	85	56
5. Influenza	18	4	27	5
6. Brochitis	17	69	85	12
7. Pneumonia	15	32	21	19
8. Musculo Intestinal Diseases	11	13	12	23
9. Skin problems	9	7	4	3
10. Anemia	3	1	1	5

Submitted by the Tambobong RHM to the Office of the Barangay Health Worker Coordinator, City Health Office, September 1993

Table 42. Report for General Medical Services and Treatment
Brgy. Tambobong, Baguio District

Services and Treatment	January 1993		March 1993		June 1993		August 1993	
	Brgy. Total	Dist. Total.	Brgy. Total	Dist. Total	Brgy. Total	Dist. Total	Brgy. Total	Dist. Total
Total number of services given	184	231	254	318	380	776	255	493
ARI (cold, coryza, cough)	20	20	38	56	172	276	68	142
Gastrointestinal disease	40	50	15	26	29	40	28	52
Parasitism	18	18	53	62	31	65	3	21
Other nutritional and vitamin deficiency	4	8	12	19	34	43	0	3
Bronchitis	4	7	0	0	8	56	10	22
Influenza	1	1	7	7	47	56	8	35
Pneumonia	4	4	1	3	8	35	47	88
Skin problems	9	11	13	21	0	35	0	14
Anemia	0	2	0	2	0	19	0	3
Injuries	6	6	0	0	1	1	10	10
Musculo intestinal Disease	1	1	5	5	0	1	0	2
Chicken pox	0	4	9	10	8	19	3	8
Heart disease	64	76	93	99	5	25	63	68
Physical examination check up	13	13	8	8	37	108	15	24
Others	0	0	0	0	0	2	0	1

FHSIS, DOH; Davao City

Childbirths are attended to by a "mananabang", a traditional birth attendant. It was only when a fll time RHM was assigned in the area in the mid-80s that pregnant women learned to avail of their services.

The "manghihilot" or local masseuse is always consulted for treatment of sprains and fractures.

2.5 The Barangay Health Workers (BHW)

There are, at present, six BHWs in Barangay Tambobong. The earliest training received was in 1979, and the latest in 1989. They undergo further training from time to time. One of these six is a trained hilot (local midwife), and she either assists the midwife in child delivery, or she performs it herself. She does the latter most of the time especially when the RHM is visiting the other barangays or attending meeting in the

district or submitting reports to the city. She has a complete kit supplied to her bh the City Health Office. These BHWs make constant follow-up and monitoring especially of cases under doctor's observation.

Other health-related activities which BHWs directly assist with are those related to immunization, sanitation, hygiene, nutrition, maternal and child care. In cooperation with the barangay officials, they conduct information campaigns on proper sewage and garbage disposal, and in encouraging the residents to build toilets. The remaining 46 have yet to build their own toilets. They mobilized the barangay's participation in the National Immunization Day (NID) and the Araw ng Sangkap Pinoy (ASAP).

3.0 HEALTH EXPERIENCES: PROBLEMS AND SOLUTIONS

3.1 The Focus Group Discussion: The Discussants and the Topic

There were three BHWS, four mothers, two husbands, along with the principal of the elementary school in the area who formed the focus group. The topics discussed ranged from what common illnesses do residents in Tambobong suffer from and what are usually done about these, to what do they fear most when a family members gets seriously ill. Also discussed were the BHWs' experiences in carrying out their tasks. If those who get sick would seek professional medical help, and what are the usual reasons if they do or don't. Should a family member gets to be hospitalized, how is the family able to pay for all the medical expenses incurred.

Taking off from the BHW's experiences, and from what husbands and wives shared about their families' and the community's health situations, the latter part of the discussion focused on what do they think or feel about organizing themselves to be able to support each other's health needs. And from whom, or what group, would outside support come from, and in what form or manner.

3.2 Health Care Experiences and Practices

One of the discussants is a mother of five, and is on her seventh-month pregnancy. All her five children have been born at home with the assistance of the mananabang (traditional birth attendant). She thinks that for her sixth child she will be giving birth in the same manner.

The other mother, who has just turned 20, also gave birth at home with the same mananabang in attendance. When asked as to why they opted to give birth at home, they said there was no need to go to the health center or the private clinic in Calinan proper. The mananabang has been following them up on their condition and has assured them everything is normal and that there would be no cause for alarm. In addition, almost all the mothers in Tambobong, from as far back as they can remember, had given birth that way.

An "if-question" was posed: what if the birth giving would be difficult that even the most experienced mananabang can no longer handle?

Should this happen, the BHW in the area would have to accompany the expectant mother to the nearest hospital, which is about eight kilometers away (the first four either on foot or on houseback). This is the Tamugan river-Maligatong-Baguio-Calinan route. As there is no lying-in clinic in the Baguio proper, the patient will have to be brought to Calinan where there is a general hospital and one lying-in clinic. If birth giving would be too complicated for either he general hospital or clinic to handle, the patient will be referred to any of the hospitals in the city proper. First option, however, would have to be the Davao Medical Center, a government-owned hospital.

As to illnesses common among the residents within the past year, the top five are acute respiratory infection, gastro-intestinal diseases, parasitism, influenza, and pneumonia. Children as young as two months old and adults as old as 65 are equally victimized by these.

3.3 Access to Health Manpower and Resources and the Problems Common to the Residents

The Barangay Health Station (BHS), their only source of free medicines (cotrimoxazole, novotossil, chloramphenicol, amoxycillin, and paracetamol) has long since ran out of these supplies. Since going down to the district proper would take sometime and entail transportation expense, majority of those suffering from cough, colds, fever and other common but recurring illnesses would have to resort to herbal medicines, as they were won't to do.

Long before the very first BHW learned how to diagnose and what herbal medicine to prescribe, the residents have been practicing oriental medicine, or "folk" medicine as they call it. These they have learned from their forebears. Belonging to ICCs (indigenous cultural communities), the Diangans, Tagabawa, Ubo and Plata (the four sub-tribes of the Bagobo in the area), have learned that plants have medicinal values.

Leaves of tanglad (lemon grass) or guava are boiled, the decoctions of which are drank by patients suffering from diarrhea. Mayana leaves are pounded and the poultice directly applied to boils, wounds, and even sprains. Children, who lose weight and whose abdomen bulge, are told to eat the green ipil-ipil seeds. These are very effective in getting rid of all kinds of parasitic worms. Poultice or decoction from tobacco leaves are used for treatment of skin lesions or infections. Betel leaf pepper leaves are also pounded and applied to boils and wounds.

A mother who has just given birth is given soup from tender chicken, papaya, and coconut milk. This will not only make her regain her strength, it will also encourage the production of more milk.

One of the husbands shared that the time he suffered from stomachache which he didn't think was appendicitis, was relieved when he drank decoction from boiled star apple leaves.

When the principal fell down from the horse and suffered sprain in his left elbow, he sought treatment from the "manghihilot" in the area, and poultice of mayana and tubatuba leaves was applied, tightly wrapped in cloth, and let it stayed there for about a week. Subsequent application was done every week until he was able to stretch his elbows without pain.

Aside from having learned these treatments from their forebears and making these an integral part of their lives and their culture, poverty is the next reason why most of them do not seek medical professional help when they feel they should. Expenses for transportation, food and more so for medical fees would be too heavy a burden for them.

3.4 Income Status and Financial Sources to Respond to Medical Needs

Per 1989 barangay profile, 67% of the families have gross monthly income of P2,000.00 and below. Food is the priority expenditure item which may include corn grits if it is in-between harvest and the stored corn has long been consumed or sold, fish from time to time, dried fish mot of the time. It is followed by basic household needs such as matches, kerosene (for their lamps), salt, sugar, oil and the like.

Farm-related expenses comprise their third expenditure item, especially for those who are growing rice and corn. With an average household member of six, only a meager amount can be set aside for medical emergencies.

Thus, when a household member gets seriously ill, and which the BHS cannot possibly treat, the family would have no other recourse but to borrow some amount from neighbors and relatives to be slowly paid back every after harvest. The amount they can borrow, however, would barely cover transportation and food for both the patients and whoever accompanies him. Medical services are therefore almost always limited to government hospital in the city.

The trained hilot who was also present, even had this to share. Sometime in September she had attended to a mother who gave birth, by herself, because the RHM was attending a one-week seminar in the city. There were no snags, no problems. Both the mother and the baby did beautifully well. But when she asked the husband to prepare some hot soup for his wife to sip when she wakes up, the husband only mumbled some unintelligible sound and then left the house. The hilot learned from the oldest child, barely seven, that they only had either boiled sweet potato (camote) or cassava for their meals for almost a week to that day.

The hilot went home, but was able to return to her patient only the day after. She cannot determine the distance by kilometers, she can only judge the distance by the change in the sun's position from the time she left the house to the time she arrived. She left when the sun was about to rise in the horizon and she arrived when it was halfway through the zenith.

She brought with her a chupa of rice (equivalent to ¼ of a kilo) for porridge. Since a handful of rice is equivalent to a bowl of porridge, she was assured of a least six meals of hot porridge. This was supplemented by whatever vegetable can be asked from neighbors, the nearest of whom is half a kilometer away.

This is what the residents fear most. Where to look for help in times of emergencies. Some of the residents are used to asking for help from the barangay captain, from cash assistance when they will bring a patient to the district health station, to wood or nails for their houses.

Lately, however, the barangay captain has been staying in the city more often, because of (according to the discussants) fear of his life from rebels who are slowly coming back to the area. The captain has allegedly received several death threats for asking military protection. According to the principal and teachers however, while it is true that there are strange-looking persons that would pass by the vicinity of the school from time to time, the situation in Tambobong, at least in the barangay prope, has been peaceful.

3.5 BHWs' Additional Responsibilities

It becomes therefore the responsibility of the BHWs to muster help when needed. Every BHW whose assistance is sought when a child or an adult has been coughing for more than one week, or whose fever has been and on and off for almost two weeks, had to personally accompany the patient to the District Health Station.

If these patients are fortunate enough to be personally attended by the RHD, the next problem to contend with is where to get money to buy for the medicines prescribed. What a BHW usually does is approach the district's Deputy Mayor and ask for assistance, showing him the prescription. That is if the Deputy Mayor is there, and if, he can extend some cash. If he cannot extend help, all the members of the Barangay Council are approached. If help extended is still lacking, the City Mayor is almost always the last recourse.

Although this case happened only twice the last six months, and very seldom the past years since the start of the BHWs existence, still they feel this should be given attention by the barangay officials.

4.0 ATTITUDES AND PERCEPTION TOWARD HEALTH FINANCING SCHEME

4.1 The Possibility of a Community Health Financing

This was the opening seen to follow-up with the question: "What do you think or feel about organizing yourself into some sort of self-help group to be able to extend assistance in times of emergencies?"

The community has had the mortuary self-help from long since they can remember. But the help extended is from P5.00 to P10.00 for those who can afford to give cash. The others bring in firewood, any quantity of rice or corn grits, a milkcan of mung beans, bamboo poles, or pieces of lumber. Several other males are tasked to dig the ground (where the dead is to be buried). But this practice has never been formalized. It simply evolved through the years.

Another "if-question" was again posed: What if the practice of helping when somebody dies can also be extended when somebody gets sick?

There were mixed reactions. From as basic as how will they start with the whole undertaking, to the more complicated how will the whole thing be managed. Foremost among the questions expressed was, will they be extending financial help everytime somebody gets sick. What if more than one will get sick every month? Will their P5.00 or P10.00 be enough?

From what has been earlier gathered from the discussants, as well as from what learned from the teachers the night before, harvests from rice, corn, cassava, coffee, coconut, and cacao have never been good the past five years. The El Niño phenomena did not spare their barangay. The strong rains during the last quarter of 1992 also brought more harm than good to their crops. Being totally dependent on these crops for their survival, or on agriculture (farming, sharecropping, farmworking) as their primary means of livelihood, their fears are not therefore unbounded.

However, the discussants never totally shirked the idea. They understood its importance, should it be given impetus.

4.2 Possible Sources and Manner of Support

Because of barangay's distance from the city proper, the almost close to inaccessible routes, and the once-believed-to-be description that it was once one of the strongholds of the NPA rebels, no non-government organization (NGO) has ever started any project here. The discussants can therefore only think of the government as the only source of support. From the barangay to the city officials, to other government entities such as the Department of Health, and the Department of Social Welfare and Development. Form and manner of support ranges from food assistance to livelihood programs (through loans) to road improvement.

Only the BHWs have heard of the Davao Medical School Foundation (DMSF) having been the recipients of several health trainings DMSF-IPHC have conducted.

5.0 PROBLEMS MET IN THE DATA GATHERING

In addition to transportation difficulty, the other major problem met was in the gathering of secondary data. The file-folder on Barangay Tambobong is noticeably absent from among all the 180 barangay files at the City Plannng and Development Office (CPDO). One staff searched for this but to no avail. The profile on Tambobong available at the Barangay Secretariat was still the 1989 data. There has been no updates submitted for 1990 to 1993.

Hoping the Department of Interior and Local Government (DILG) Office at the district where Tambobong belongs would have pertinent files, this was next visited. Result: no files in Tambobong. According to the DILG staff, the barangay captain has been uncooperative. He has not even been attending meetings at the district hall for several months now.

Enlisting the help of the school principal, the barangay secretary was asked some data, which he supplied. However, as per his information, the total land area is 70,000 hectares (or 114.64 sq km). With the total area of Davao City which is 2,443.61 sq km, then Tambobong already constitutes 4, 69% of Davao City. And yet Tambobong is only one of the 180 barangays.

Since neither the CPDO nor the Barangay Secretariat has the data, the next office sought was that of the City Assessor's. Since they do not have the total area, all the areas in square meters for every titled or surveyed lot as per tax mapping done were added to arrive at the total, whch is 1,340.28 hectares or 5.174 square kilometers.

6.0 CONCLUSIONS AND RECOMMENDATIONS

From what has been gathered, heard, and observed, the barangay sorely needs health services and facilities which are accessible to the residents seven days a week. Although the performance of the BHWs are noteworthy, it cannot be denied they can only attend to primary health care activities.

In addition, roads, bridges, and a year-round source of potable water are sadly lacking in the area. Lack of electricity does not pose much of a problem as the residents are wont to using kerosene lamps.

It is therefore strongly recommended, that before any attempt at organizing a community health financing scheme is done, the Government of the City of Davao should first make a thorough assessment of the needs of the barangay, if possible from each resident, be he a Bagobo, a Cebuano, an Ilongo, a Catholic, a protestant. More importantly still, the needs analysis should also be made based on the inhabitant's primary source of livelihood, which is farming.

The indigenous people's time-tested health practices should be taken in the context of their cultural beliefs and practices.

As it might turn out, their two priorities would be first, improve the two access routes to Barangay Tambobong; and second, production loan assistance that will enable them to increase their yield, along with a crop insurance program that will protect the farmers should there be long dry spells or incessant rains.

With increased yield, which they can very well market to the district centers or even directly to the city because of improved roads, incomes will likely increase. With increased income and better roads, health services will more likely be accessible.■

THE MEDICARE PROGRAM II
Cantilan, Surigao del Sur

THE MEDICARE PROGRAM II
Cantilan, Surigao del Sur

1.0 MUNICIPALITY PROFILE

Cantilan is the second northernmost municipality of Surigao del Sur (see Figure 10) for the Location Map of Cantilan) and has a population of about 70,000. It has a total land area of 240.10 square kilometers which is about 5.58% of the total land area of Surigao del Sur. It is composed of seventeen (17) barangays. The main industries in the area include agro-forestry and fishing. The populace is characterized by mixed ethnic groups of Boholanos, native Surigaonons and Moslems. The major dialects are Cebuano, Cantilangnon and Surigaonon.

2.0 SETTING UP THE MEDICARE PROGRAM II

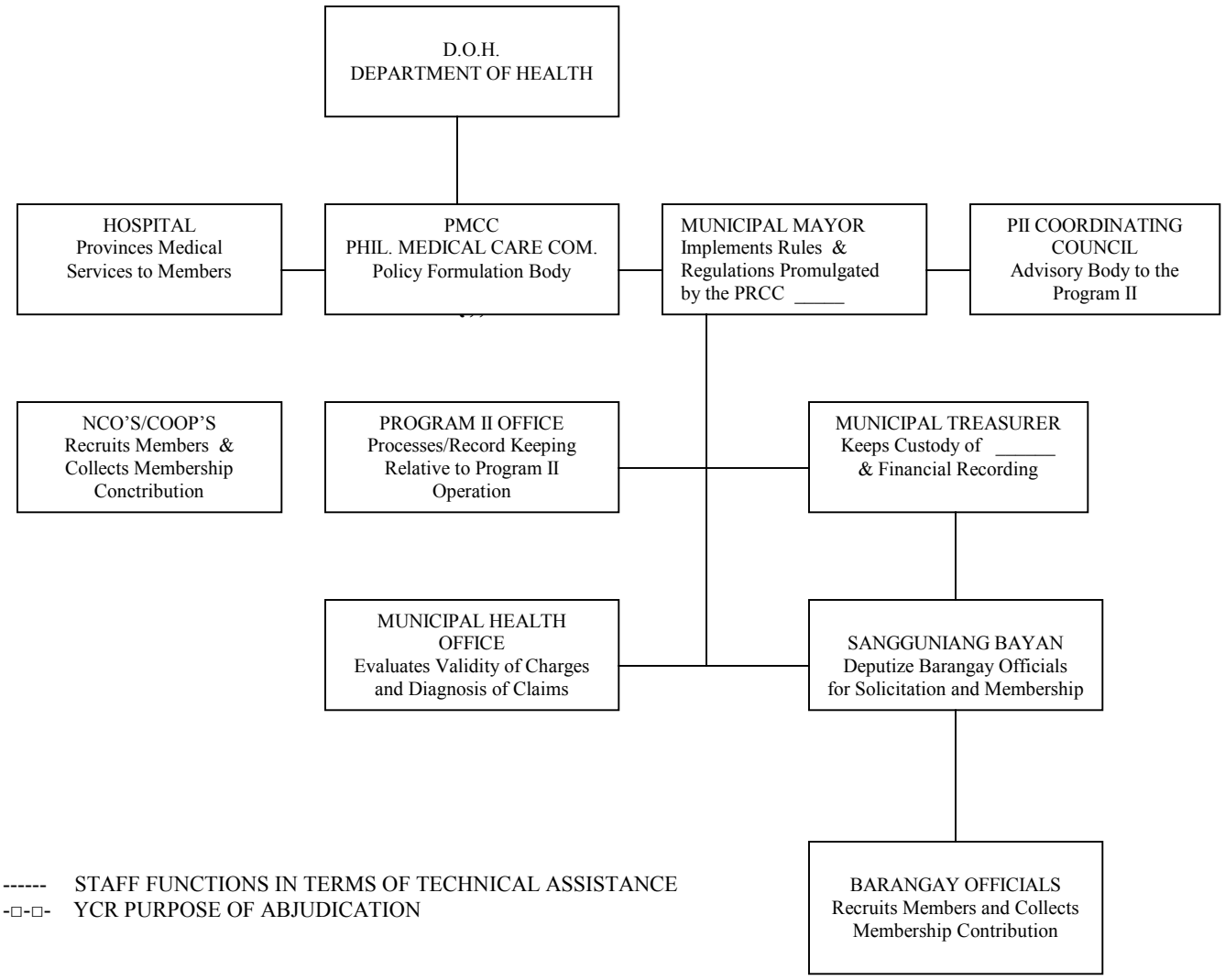
Efforts to organize a localized health financing program was started in May 1993 in the hope that the health financing needs of low income families may be addressed. The local officials headed by Mayor Live Azarcon sought the assistance of the Philippine Medical Care Commission (PMCC) on the setting-up of the scheme. Dr. Sodusta of the Cantilan Polymedic Hospital and who was formerly employed with PMCC was instrumental to the scheme's conception. The setting up took about three months.

The planning stage involved PMCC Central Office representatives, seventeen (17) barangay captains, ten (10) Sanguniang Bayan members, ten (10) Coordinating/Advisory council members, the Mayor and the Vice-Mayor. Five thousand pesos (P5,000.00) was granted by the municipal government for expenses incurred during the setting-up. Materials such as membership forms and other forms needed for reports submission to PMCC were supplied by the PMCC. Thus, the Medicare Program II in Cantilan, a first in Mindanao, was launched July 17, 1993.

Although the financing scheme is a government program, it has been included in this report since the financial resources solely come from members' contributions. As can be gleaned from the organization set-up (Fig. 11), the PMCC only acts as the policy-formulating body. The program is implemented by the Municipal Mayor and managed by the Coordinating Council which is based in the Municipal Hall. Also, with only a minimal start-up assistance of P5,000.00, the scheme was able to take off. Within three months, the scheme has had over one hundred beneficiaries.

FIGURE 10. LOCATION MAP OF CANTILAN

Figure 11. Organizational/Functional Set-Up of Program II in Cantilan, Surigao del Sur



3.0 THE PROGRAM

3.1 Program Objectives

Medicare Program II is a component of the Philippine Medical Care Plan (Medicare), the only national health insurance program in the Philippines which was established in 1969 under Republic Act No. 6111 but was only implemented in 1972.

Medicare Program II was established to provide medical care benefits mainly to those not covered under Medicare Program I (or the SSS/GSIS members), specifically, the low income and the non-salaried individuals.

3.2 Management

The program is temporarily managed by the Coordinating Council 11 whose members were appointed by the mayor. These members will serve a one-year term without compensation or privileges from the Medicare program. The Medicare 11 program holds office at the Municipal Hall and is manned by one coordinator who is actually the Municipal PIO and one clerk whom the DILG lent to the program.

3.3 Participating Hospital

The recognized accredited medical facility for this project as of October 20, 1993 is the Cantilan Polymedic Hospital. Accreditation with Madrid District Hospital of the adjacent municipality is still under negotiation. The program, however, is still open to accredit other hospitals which may be recommended by the members.

The Cantilan Polymedic Hospital is a private hospital owned by fifty six individuals. It has operated for five years and has been accredited with Medicare I for three years now. It is a primary hospital with a 15-bed capacity. There are two regular resident doctors and one contractual. At the moment, the hospital still has limited equipments/facilities to service the patients.

A. Access to Services

The hospital serves an average of eight in-patients and seven out-patients a day. About 30% of the total patients are Medicare 11 members.

The top five cases attended at the hospital are diarrhea, pneumonia, Urinary Tract Infection, injuries/wounds, and acute bronchitis. A separate statistics on Medicare II members has not been accomplished since the hospital has not yet seen the need for it.

B. Payment Scheme

The hospital admittedly does not give services for free because it already has collectibles amounting to P250,000 from Medicare I. Members of Medicare II secure a form or claim for payment at the hospital and fill up Part I of this form. Part II is accomplished by the hospital. The bill is processed and the patient pays excess of program benefits. The hospital bills the Medicare II office monthly. The office pays the hospital within three to four weeks.

Monthly reports on Medicare II program beneficiaries are also sent by the hospital to the Municipal Health Officer for validation of charges and diagnosis of claims.

4.0 MEMBERSHIP

The reception of Cantilan residents to the program is noteworthy. The barangay captains, NGOs and cooperatives were tasked to recruit members and collect membership contribution. The initial membership numbered 200. In three months the membership grew to 466. Members practically come from all walks of life including farmers and fishermen.

4.1 Contribution

The yearly contribution was set at P300 per member. The contribution is payable either in full upon enrollment, or a 50% down payment the balance of which will be paid within 60 days from date of enrollment. The participating hospital receives P76 from each contribution to augment funds for the purchase of medicines. Members' contributions has totaled to one hundred eight thousand pesos (P108,000). The unpaid balance from members who had only paid half of the contribution upon enrollment amount to P38,000.00. The scheme has already expended P31,000.00 in benefits.

4.2 Requirements and Entitlement to Benefits

Membership to the program is voluntary and open to all residents of Cantilan, Surigao del Sur and its neighboring municipalities as well as Program I members who want to enroll in this Program. Interested parties may enroll to the Program through the Program II Office in the Municipality of Cantilan or through Barangay Officials, or in any of the participating Cooperatives and NGOs. During enrollment, any member is free to choose among participating hospitals where he shall avail the benefits during his one year membership. The name of the hospital must be clearly stated in the Registration Form.

Members can avail of the benefits only at a participating hospital of their choice. Their dependents can also avail of the benefits. Each member shall be entitled to benefits if he meets the following conditions:

A. For outpatient benefits

A member who has registered with the program, and who has either fully paid or paid at feast 50% of the annual contribution is entitled to the following benefits on an outpatient basis):

- Free consultation
- Discounted laboratory services
- Discounted other special diagnostic services

B. For inpatient benefits

A member who has registered with the program , and who has fully paid or paid at least 50% provided the balance will be paid within 60 days from date of first payment. Confinement shall also be after 7 days from date of full payment to be able to avail of the following:

- Free Ward Room accommodation for a maximum of 10 days for members and another 10 days for dependents per year;
- Free laboratory service
- Free consultation fee
- Free essential medicines with the following ceiling:
  P500 for ordinary/non surgical cases
  P800 for intensive orsurgical cases
- Discounted X-ray and other special diagnostic services

In the availment of outpatient and inpatient benefits, a member/patient shall present to the selected participating hospital his Membership Identification (ID) Card or Official Receipt of membership payment in case no ID card has been issued yet.

4.3 Membership Disqualification

A member who has failed to pay in full the required yearly contribution within the 60 days grace period after the first payment shall be automatically dropped from the Program 11 membership but may avail of the outpatient benefits from Cantilan Polymedic Hospital within 6 months after the first payment.

Any member or his dependent who allows himself to be misrepresented by another person shall be automatically dropped and disqualified for future membership to the Program.

4.4 The Medicare II Benefit Package

Benefits	Benefit Limit	Patient Counterpart
1. Out-Patient:		
Consultation	P 30	
Laboratory, X-ray & Other Special Diagnostic Services		Special Rate (see Schedule A)
Medicines	10% of hosp. price	90% of hosp. price
2. In-Patient:		
Ward room accommodation (10 days for member and 10 days shared by dependents per year)	Free	BYOP
Lab Services	Free	-
Professional fee	Free	-
Medicines (Essential)	Free	-
Ordinary (maximum)	500	Pay excess
Intensive	800	
X-ray & other Special Diagnostic Services		Special Rate (see Schedule A)
3. Surgical Services:		
Anesthesiologists and Surgeon's Fees	Free	
(Selected cases on In-patient or Out-patient Services, see schedule B)		
Operating Room	100	P400

SCHEDULE A

	Services	Regular Rate	Program II Rate
1.	LABORATORY SERVICES		
	• Urinalysis	P 40	P 27
	• Fecalysis	30	27
	• CBC	60	45
	• Widal Test	95	81
	• Pregnancy Test	100	81
	• Hemoglobin	30	27
	• Blood Typing	40	27
	• X – Matching	30	27
	• FBS	120	81
	• BSMP	50	45
	• Urine Sugar	10	9
	• Creatinine	20	9
2.	X-RAY SERVICES		
	• Chest	160	120
	• Skull series	240	120
	• Abdomen	170	125
	• Upper Extremities	160	120
	• Lower Extremities	160	120
	• Lumbosacral	210	170
	• Cervical	160	120
	• Mandible	160	120
	• Water's View	160	120
3.	ULTRASOUND		
	• Pelvis	350	220
	• Kidneys	300	200
	• Gall Bladder	300	200
	• Liver	300	200
	• Gall Bladder/Liver	400	250
	• Abdomen	850	500
4.	EKG	150	130

SCHEDULE B
Selected Surgical Cases
(Free Anesthesiologist & Surgical Fees)

1. Appendictome (adult)
2. Caesarian Section
3. Suturing of Wounds
4. Incision of Cyst
5. Close Reduction
6. Disarticulation of Joints
7. Amputation
8. Removal of Foreign Bodies
9. Lepomas Excision
10. Hydro-coelectomy
11. Hernias

4.5 Confinement in Another Hospital on Referral or Emergency Case

When the beneficiary during emergency or referral case is confined in another hospital, the member/patient shall pay the total hospital bill and may seek reimbursement from Program II Office through Cantilan Polymedic Hospital (CPH) of benefits not to exceed P20.00/day for room accommodation, P30.00/day for professional fee on nonsurgical cases, P500.00 for surgeon's fee on surgical cases and P500.00 on medicines. Payment for room accommodation, professional and surgical fees shall be refunded by the CPH while payment on medicines shall be refunded by the Program II Office upon submission of the following documents:

a) Official Receipts
b) Hospital Bill or Statement of Account
c) Certificate of Emergency Confinement; and
d) Referral Slip (if referred)

Reimbursement for emergency case is allowed only once a year.

In case of referral by the CPH physician to another hospital, patient shall be reimbursed only for the unused balance in benefits consumed at Cantilan Polymedic Hospital.

4.6 Availment of Selected Surgical Cases on Emergency or Elective Case (see Schedule B)

Selected surgical cases can be availed anytime on emergency case provided the member has fully paid the required yearly contribution while elective selected surgical cases can be availed after 3 months of membership.

In the availment of selected surgical cases on elective or emergency case, members are required an advance premium payment of ne year for minor surgical operations and two years for higher cases.

5.0 ACTUAL AVAILMENT OF SERVICES

As of September 30, 1993, there were ninety three (93) outpatient beneficiaries and eight (8) inpatient beneficiaries who have already been served by the Cantilan Polymedic Hospital (Tables 43 and 44). Note, however, that on the outpatient schedule only partial reports (as requested) were provided.

Based on the survey results, it was noted that about 75% of the 466 membership are salaried individuals and at the same time are Medicare I members. Only 25% are non-salaried which can be broken down as follows:

- 15% Farm owners
- 10% comprises the tenant-farmers, fishermen and market vendors

Table 45. Distribution of Composition of Medicare II Members

Type of Members	Numbers (n—466)	Percentage (%)
Salaried	350	75
Non-salaried		
Farm owners	70	15
Tenant farmers, fishermen and market vendors	46	10

5.1 Problems Encountered by:

A. Management

While it is true that the scheme was purposively designed for the nonsalaried-low income individuals of Cantila, very few from the targeted groups had actually subscribed the program thus, Medicare II had a quota shortage of 534 members.

Also the campaign for membership and other organizational needs of the program were not given ample time considering that the assigned staff are just lent from other municipal offices and they cannot render full-time services. On the other hand, the local PMCC cuncil has only met once in three-mnthstme, which means that their regular monthly meetings was not yet followed.

B. Beneficiaries

The problems encountered so far has been complaints of lack of hospital facilities as well as lack of medicines, of computerized systems, and of specialized doctors. Also, the seminar on the program details was conducted only once and that was during the launching. Therefore, not all members had a clear understanding of the benefits and the processes.

C. Program Sustainability

Due to the short span of time that the program has been operationalized, there is not enough basis to comment on its financial sustainability. Some beneficiaries themselves are uncertain since the funds are still low.

6.0 PLANS

Per result of the local PMCC council during their first meeting, the following were their plans:

1. Expansion of membership to reach the quota of 1,000 members by reaching out the nearby municipalities of Carrascal, Madrid, Cortes, Carmen and Lanuza but side by side will look into the possibilities of increasing membership from the non salaried-low income groups by adjusting the mode and amount of payment to suit to their needs and capacity to contribute.

2. Finalization of the accreditation of the Madrid District Hospital and possibility of accrediting other clinics of the members' choice.

3. An evaluation of the program is to be made every six months (the first schedule will be on December 1993).

Table 43. Cantilan Medicare II Outpatient Services for the month of September, 1993

Date	Name of Patient	Name of Member	Diagnosis	Diagnostic Services Rendered	Actual Cost (P)	Amount Paid (P)	Amount Discounted (P)	Date Paid
9/2/93	Elizar, Maria Fe	Elizar, Maria Fe	Lipoma	-	-	-	-	-
	Cantiveros, Thomas	Cantiveros, Destrella	Fructured wound, L, Foot	-	72.00	64.00	7.20	9/2/93
	Gamot, Danzel	Gamot, Rodolfo	Follow-up check up	-	-	-	-	-
	Urbiztondo, Ronnel	Urbiztondo, Juan	Soft mass at R. Scrotal area (Hernia)	-	-	-	-	-
			Acute Pneumonia	-	-	-	-	-
9/6/93	Urquia, Herculano	Urquia, Herculano	Acute Pharyngitis	-	208.50	187.00	20.85	9/6/93
	Urquia, Eustella	Urquia, Herculano	Acute Rhinitis	-	-	-	-	-
	Sering, Noli	Sering, Marilyn	Pneumonia I	-	-	-	-	-
9/8/93	Sering, Noli	Sering, Marilyn	Flu Syndrome	-	-	-	-	-
	Arrubio, Romeo	Arrubio, Romeo	Follow-up Check up	X-ray	180.00	120.00	40.00	9/10/93
9/10/93	Urquia, Herculano	Urquia, Herculano	Diarrhea	-	10.00	8.00	40.00	9/14/93
9/14/93	Castente, Prudencio	Castente, Prudencio	Flu Syndrome	-	187.00	177.30	18.70	9/15/93
9/15/93	Duero, Joel	Duero, Joel	Acute Bronchitis	-	57.50	78.75	5.75	9/15/93
	Loren, Augusto	Loren, Leoncio	Breast Mass	-	147.50	132.75	14.75	9/15/93
	Castro, Victoria	Castro, Victoria	Closed Fracture,					
	Espura, Primo	Espura, Primo	R tumor	-	147.50	132.75	14.75	9/15/93
			Pneumonia, PUD	-	128.00	115.20	14.75	9/17/93
9/17/93	Urbiztondo, Rosalia	Urbiztondo, Juan	R/O Acute					
	Milan, Mark	Milan, Ramon	Sinusitis/Otitis Media - Bilateral	-	-	-	-	-
	Buniel, Arlyn	Buniel, Valentin	Parasitism R/O Amoebiasis	-	-	-	-	-

Table 43 continued.

Date	Name of Patient	Name of Member	Diagnosis	Diagnostic Services Rendered	Actual Cost (P)	Amount Paid (P)	Amount Discounted (P)	Date Paid
9/19/93	Ganancias, Catherine	Ganancias, Efren	Primary Complex	-	145.80	134.15	14.00	9/19/93
	Brillantes, Neria	Brillantes, Eduardo	Tonsilitis / Hypertension	-	75.80	68.20	7.00	9/19/93
9/20/93	Azarcon, Mark Lester	Azarcon, Tomas	Pneumonia	-	-	-	-	-
	Urbiztondo, Rosalia	Urbiztondo, Juan	Crabios, Left Lunf field	Chest X-ray	402.00	238.40	64.40	9/20/93
	Loren, Augusto	Loren, Leoncio	Follow-up Check up	-	142.45	128.30	14.25	9/20/93
9/21/93	Gamot, Danzel	Gamot, Rodolfo	Eczema	-	-	-	-	-
9/22/93	Rueza, Betheluz	Rueza, Teogenes	Primary Complex	Chest X-ray	232.80	186.15	47.25	9/22/93
	Yparraguirre, Feliciana	Yparraguirre, Feliciana	Lymph Node Axillary R/O Metastatic spread Breast Cancer	-	245.00	220.50	24.50	9/22/93
	Millan Mark Francis	Millan Ramon	Follow-up Check up	-	-	-	-	-
9/27/93	Grume, Virgilio Jr.	Grume, Virgilio Jr.	_____ Dermatitis Secondary to Bacterial Infection	-	-	-	-	-
	Urbiztondo, Eustaquia	Urbiztondo, Eustaquia	Acute Bronchitis/ _____	-	175.50	156.85	17.65	9/27/93
9/28/93	Orcinada, Panfilo	Orcinada, Panfilo	-	-	-	-	-	-
9/30/93	Ganancias, Aldren	Ganancias, Efren	Parasitism	-	-	-	-	-
	Urbiztondo, Eustaquia	Urbiztondo, Eustaquia	Follow-up Check up	-	27.00	24.30	2.70	9/30/93
				Total	P2,611.35	P 2,275.20	P 22.25	

Source: Cantilan Medical Program II Office

Table 44. Cantilan Medicare II Inpatient Services as of September 30, 1993

I.D. No.	Name of Member	Name of Patient	Confinement Period	Illness	Amount of Claim in Medicines Cantilan Polymedic Hospital (P)
00223	Roy, Niconstancio	Roy,Francis Junico	July 24-26, 1993	Bronchial Asthma	500.00
00083	Azarcon, Mendrado	Azarcon, Mendrado	July 29-31, 1993	Koch's	500.00
00101	Omba, Amado	Omba, Menia	Sept. 3-4, 1993	Diabetic KRTO Acidosis	500.00
00219	Cuartero, Orsina	Cuartero, Antonio	Sept. 15-16, 1993	URTI	500.00
00081	Pingol, Rosita	Pingol, Reynante	Sept. 17-18, 1993	Parasitism R/I Amoebiasis	396.00
00096	Seladores, Jenny	Seladores, Christy	Sept. 19-22, 1993	Infectious Diarrhea w/ Moderate Dehaydration	500.00
00288	Tabin, Ceriaco	Tabin, Ceriaco	Sept. 23-26, 1993	Koch's Pneumonia, CHF	500.00
00030	Arizobal, Maria	Arizobal, Maria	Sept. 27-28, 1993	Lacerated Wound Occiput 2 cm long secondary to vehicular accident Closed fracture M/3 clavicle left, secondary to vehicular accident	226.75
				Total	P 3,622.75

Source: Cantilan Meidcare Program II Office.

THE COMMON HEALTH FUND FOR DIAGNOSTIC AND HEALTH CARE SERVICES OF THE BROKENSHIRE INTEGRATED HEALTH MINISTRIES, INC. (BIHMI)

THE COMMON HEALTH FUND FOR DIAGNOSTIC AND HEALTH CARE SERVICES OF THE BROKENSHIRE INTEGRATED HEALTH MINISTRIES, INC. (BIHMI)

1.0 INTRODUCTION

One of the efforts uncovered in setting-up community-based health financing schemes was a scheme beng organized by the Brokenshire Integrated Health Ministries, Inc. (BIHMI) among tricycle drivers plying a route within the institution's vicinity. In so doing, a more interesting effort was disclosed by the institution's administrator who served as interviewee. This report has been included in the study as part of a documentation of the noteworthy efforts of other groups or institutions pursuing cooperative efforts in making health care services accessible to the common tao.

2.0 THE BIHMI: A HISTORICAL BACKGROUND

Brokenshire Integrated Health Ministries, Inc., formerly Brokenshire Memorial Hospital was named after Dr. Herbert Brokenshire, a former administrator of the United Church Board for World Ministries (UCBWM) who was reported missing in action during the World War II. It started in 1908 when the American missionaries came to Davao with the American occupation forces involved in the pacification campaign durng the Philippines-American War. It opened a small outreach clinic along the banks of the Davao river. This evolved into a 34-bed Davao Mission Hospital, fully supported by the UCBWM based in New York. As a mission hospital, it rendered free, partly free, and full pay hospital services depending on the patient's potential capacity to pay.

In 1951, the UCBWM transferred supervision of the hospital to the United Church of Christ in the Philippines (UCCP) with increased bed capacity of 75 from an original of 34 beds and began departmentalizing its services. In 1954, the Brokenshire School of Nursing was established and in 1969 the hospital transferred to a 14 hectare-lot which is now its present site. While its budgetary needs became the main responsibility of UCCP, BMH continued to receive occasional gifts and grants from abroad.

In the early years of the 80's, operational costs mounted as a result of the country's economic crisis. Rising medical costs resulted to fewer and fewer patients. The 250-bed capacity tertiary hospital was not admitting only 80 patients daily.

The employees union demanded for back wages hounding the administration to release hospital operation funds. On March 1, 1985 the BHM closed down after 77 years of service. It was the 58th hospital in the country to close down within a period of one year.

It took seven long years from 1985-1992 for the Board of Trustees representatives of the General Assembly of UCCP and friends to tackle the need for redirecting BMH, until it has

finally reopened with its new name the Brokeshire Integrated Health Ministries, Inc., in March 1992. It has reopened to renew its commitments to the healing ministry of the UCCP and to holistically serve the health needs of the general public in the most accessible, acceptable and affordable manner especially to the poor and the marginalized sector of the community.

3.0 PROGRAM THRUSTS

As a health care service institution, the BIHMI has major program thrusts, to wit: (1) the Integrated Health Program and, (2) the Resource and Development Program.

3.1 Integrated Health Program

This program has two components, the first of which is the Rural and Urban Community Based Health Program (CBHP) and the second, the Health Care Referral Unit (HCRU).

3.1.1 Rural and Urban CBP

This program aims to build an alternate "essential health care" based on practical, scientifically sound and socially acceptable methods and technology made accessible to families and individuals in the community through their own participation and at a cost that the community can afford in the spirit of self-reliance and self-determination.

The target population are individuals in the rural communities, labor secotr, church workers and members, and the urban poor.

3.1.2 Health Care Referral Unit (HCRU)

This program exists to provide the population with affordable, effective and essential health care services which are curative, preventive, promotive and rehabilitative. It provides support to the CBHP in the urban and rural communities as a first level referral. It provides diagnostic and direct health care services to both inpatients and outpatients.

3.2 Resource and Development Program

3.2.1 The Training, Information & Education Program has the following purposes:

(a) To develop and train human resources for health;

(b) To respond to the training needs of the communities and churches involved in the health program; and

(c) To develop information, education and communication materials for publication and dissemination.

3.2.2 Provision of Clinical Pastoral Education and care-community approach.

3.2.3 Development of a Resource Center that should become a "Grace Center" where lives are touched, transformed and renewed.

3.2.4 Development of strategies to generate funds for self reliance.

3.2.5 To establish health care financing scheme which would make health care services affordable to the majority of the population.

4.0 BIHMI'S EFFORTS AT SETTING UP OF A COMMUNITY-BASED HEALTH FINANCING SCHEME

Sometime September 1992, initial efforts were started by the BIHMI staff among the Bankerohan Triccle Drivers' Association (BATRIODA). With the support of the association's president for 1992, the concept of pooling together P2.00 per day or P60.00 per month contributions into a common health fund in exchange for medical services at BIHMI was introduced.

The idea was accepted by the group seeing the need for it when two of their colleagues met an accident. Strapped for some cash and unable to raise enough amount to settle their bills, the patients signed promissory notes just so they can be discharged. However, this was with the condition that part of their daily earnings should go to the hospital for payment.

The then president of the association (BATRIODA) was not only very supportive of the program, he also actively involved himself in marketing the program. Even then, the BIHMI found it had to exert a lot of effort in 'winning over' the members to subscribe to the idea. There were 37 tricycle drivers who readily expressed willingness to join the program, but to date, only 10 are religiously paying their daily contributions.

With the change of officers in 1993, the common health fund drive reached an impasse. The new president's priority is for the drivers to becme SSS and Medicare members. BIHMI thus found it difficult to pursue the common health fund when the officers' interest focused on SSS and Medicare coverage. Nevertheless, the BIHMI continues to assist the said group in pursuing their goals e.g., in setting up their own cooperatives as well as supporting them in their efforts of availing SSS membership.

Even the BIHMI's vision of a common health fund however, persists. Efforts are no longer limited to the association of tricycle drivers. Sometime in April, the BIHMI expanded its community coverage. Target pilot communities are Puroks Mother Ignacia and San Nicholas of Madapo Hill in Bankerohan, Davao City, both of which are situated near the vicinity of BIHMI.

During the third quarter of this year, the BIHMI Administrative and Program Management has drawn initial plans to convert the institution into a Cooperative Hospital.

In this, a local chapter of the National Federation of Labor has taken particular interest. It was learned that the present members of the NFL, most of which are working in large companies involved in the banana industry of Davao, had been subscribing to the MMGHHSC paying P100.00 a month (or P1,200.00 a year) in exchange for health insurance for a priod of one (1) year. Feeling that they stood to gain nothing if they were not able to make use of the insurance within the period subscribed, they transferred to another scheme which provided for a monthly salary deduction of P300.00 in exchange for medical services at the Davao Doctors' Hospital. But again, the laborers feel their resources are pinched to the last centavo they are able to give.

When the NFL got wind of BIHMI's intent to put up a cooperative hospital, they readily expressed interest. It seems a health financing scheme was attractive to this laborers group because it allowed them to gain something from their contributions (i.e. patronage refunds or dividends) if they ae given the chance to become part owners of the hospital. The BIHMI, however, is presently studying how to implement this concept with the institution's vision and mission statement kept in tact.■

THE COOP CARE OF THE MEDICAL SPECIALISTS AND HEALTH SERVICES COOPERATIVE

THE COOP CARE OF THE MEDICAL SPECIALIST AND HEALTH SERVICES COOPERATIVE

1.0 THE ORGANIZATION

1.1 Background

The Medical Specialist and Health Services Cooperative (MSHSC) was organized on September 20, 1991. It was registered on April 8, 1992 with the Cooperative Development Authority (CDA). It holds office in Digos, Davao del Sur (See Fig. 2).

Basically, the cooperative was formed to alleviate the disparity in the distribution of medical specialists as well as to help the poor cooperative members help themselves healthwise. Although it was basically started by a group of mostly health professionals, the vision is to provide affordable health care services to marginalized sectors especially the farmer groups in Davao del Sur.

1.2 Objectives

The objectives of MSHSC are:

1. To establish and affordable pre need health and hospitalization plan geared towards the cooperative members of Davao del Sur

2. To establish a progressive clinic, blood bank and diagnostic center facility in Davao del Sur

3. To establish an industrial health retainer plan for private companies in the area of operation

4. In the long term – to establish tertiary medical center owned by the cooperatives of Davao del Sur

1.3 Membership

Membership is open to members of all types of cooperatives and other cooperative oriented groups including civic, professional or fraternal organizations based in Davao del Sur. The requirements are: the payment of membership fee of P1,000.00, and subscription to and payment of shares of stock with a par value of P100.00 per share.

There is no age limit to membership.

Health workers from 70% of the membership. Other members include teachers, bank employees and farmers. There are presently 35 member-cooperators. In the current

year, the MSHSC has been 'marketing' the concept of Coop Care among farmer cooperatives in Davao del Sur.

2.0 THE MEDICAL SPECIALIST AND HEALTH SERVICES COOPERATIVE CLINIC AND LABORATORY

2.1 Personnel

The MSHSC clinic has the following personnel: one X-ray tecnician, on receptionist/secretary, one resident doctor, and one medical technologist. There are also twenty (20) other doctors, two (2) nurses, and one (1) auditor serving the MSHSC. Not all doctors, however, render full-time services to the clinic.

2.3 Services

The clinic's services include X-ray, complete laboratory tests, medical, and dental consultation.

Specifically, the clinic has consultants specializing on these areas: Urology, Internal Medicine, OB-Gyne, Orthopedic, Neuro surgery, EENT/Opthalmology, Radiology, Family Medicine, Pediatrics, General Surgery, Anesthesiology, Dental Medicine, Nursing Services and Pathology.

Laboratory tests on the following are available:

1. Routine

CBC	Urinalysis
Platelet Count	Fecalysis
BSMP	Occult Blood
Blood Typing	

2. Blood Chemistry

Basic 5	Lipid Profile
Lipid Profile	Electrolytes

3. Immunology

Hepatitis B Profile
Hepatitis A Screening
Thyroid Profile
Cancer Tests
AIDS Test

4. Special Tests

Peripheral Smear/Bone Marrow
Pap Smear/Gram Staining
Serology
Prothrombim Time
Widal Test
LE Tests
ASO Titer/RF Factor
Pregnancy Test
Histopathologic Exams

The X-ray charge is P100 per view. The average number of X-ray patient per day is 10-12. The most attended cases in the clinic are PTB, Pneumonia and Hepatitis B.

3.0 THE COOP CARE (COOPERATIVE CARE)

Five Types of health plans are envisioned. It should be noted though that these plans are still subject to a lot of discussion and refinement as the member-cooperators are very much interested in teaming from the experiences of other groups who have started similar efforts.

3.1 Coop Care Services Features

A. Coop Care I (Cooperative Health Retainer Plan)

Features:

1. Offers free OPD consultation to members of the enrolled cooperative from the generalists to the specialists.
2. Offers annual compulsory P.E. to members (including laboratory services).
3. Provides 10% discount to members on pharmacy, laboratory and other diagnostic services available in the cooperative clinic and facility.
4. Doctors from the MSHSC will serve as the attending physician on the hospitalized patients.
5. MSHSC pays the deposit requirements of the admitted accredited patients from the enrolled coops.
6. MSHSC pays for the hospitalization (medical and surgical) bill of an accredited cooperative members in designated MSHSC hospital up to P20,000.00 in excess of Medicare per hospitalization.
7. Offers patronage refund every two (2) years to enrolled cooperative member.
8. Covers complicated first delivery cases.
9. Covers chronic diseases after 2 years of membership.

Exclusions:

1. Diseases or injury sustained by assault, by design, gross negligence, alcoholic intoxication, military or police service, or insurgency related injuries or force majeure.
2. Rehabilitative, cosmetic and reconstructive aspect of medical and surgical care, including dental prosthesis.
3. Failure to undergo annual P.E.
4. Members and dependents below 10 years old and above 60 years.

B. Coop Care 11 (OPD care only

Features:

1. Offers free OPD consultation to members of the enrolled cooperative members from the generalists to the specialist.
2. Offers annual compulsory P.E. to members (including basic laboratory services like CBC, stool and urine).
3. Provides 10% discount to members on pharmacy, laboratory and other diagnostic services available in the cooperative clinic facility.
4. Doctors from MSHSC will serve as the attending physician on hospitalized patients.

All exclusions in Coop. Care I are also applicable.

C. Coop Care III (Dependents' In-patient Plan)

Features:

1. Offers free OPD consultation to dependents of the enrolled cooperative members from the generalists to the specialist.
2. Offers annual compulsory P.E. to members and applicants (including basic services).
3 Provides discount to members on pharmacy, laboratory and other diagnostic services available in the cooperative clinic facility.
5. MSHSC pays the hospitalization (medical and surgical) bill of accredited dependents in a designated MSHSC hospital up to P20,000.00 in excess of Medicare per hospitalization.

All exclusions in Coop Care I are also applicable.

6. Coop Care IV. (Dependents' OPD Plan)

Features:

a. Offers free OPD consultation to dependents of the enrolled cooperative members from the generalists to the specialist.
b. Offers annual compulsory P.E. to members and applicants (including laboratory services).
c. Provides 10% discount to members on pharmacy, laboratory and other diagnostic services available in the cooperative clinic facility.
d. Doctors from the MSHSC will serve as the attending physician to hospitalized dependents.

All exclusions in Coop Care I are also applicable.

7. Coop Care Special

Features:

a. Offers four (4) OPD free consultation to enrolled members within a five month period from the generalists to the specialist.
b. Offers annual compulsory P.E. to members and applicants (including basic laboratory services like CBC, stool and urine).
c. Provides 10% discount to members on pharmacy, laboratory and other diagnostic laboratory services available in the cooperative facility.

3.2 Subscription

To date, the MSHSC accepts only cash subscriptions. The cooperative also has plans to accept marketable farm products from cooperative members, the worth of which will be computed at current market value, less 10% discount on total price.

The cash subscription rate for Coop Care I (Coop Health Retainer Plan) is P125.00 per month per member, for Coop Care II (OPD), P50.00 per month; Coop Care III (Dependent's In-patient Plan), P400.00 per quarter per member; Coop Care IV (Dependents' OPD Plan), P225.00 per quarter per member; and for Coop Care Special, P100.00 per 5-month period/per member.

3.3 Availment

There are only 12 current subscribers for Coop Care II. There has been no subscription yet with other Coop Care Plans. The services and benefits were extended starting only last July 1993.

There are already ten (10) recipients of Coop Care II for treatment of illnesses like Hepatitis B, Hypertension, skin diseases, cough and colds.

4.0 ACCESS TO SERVICES

Most of the medical practitioners on the clinic's medical directory are based in Digos, Davao del Sur.

A few are based in Davao City. In fact, the chairman of the cooperative board is a consultant of at least two prime hospitals in the city and spends part of his time as company doctor of a softdrinks corporation.

The cooperative has also been negotiating with some hospitals in Digos as well as the Brokenshire Integrated Health Ministries, Incorporated (BIHMI) in Davao City to provide health services within the Coop Care. While these efforts are still under negotiation, it will be noted that the doctors of other cooperative groups (i.e. Dr. Jack Estuart-Community Based Health Program) initiating similar efforts are already on the roster of the BIHMI consultants per a recent visit to the hospital.

The clinic in Digos continues to entertain OPD caes. However, there have been few beneficiaries of the Coop Care but these are mostly in the form of discounts granted on clinic services such as consultation fees as well as laboratory fees.

On the whole, the Coop Care has been put almost on hold pending the finalization of agreement with farmer cooperatives in Davao del Sur. Officers say they are aiming to recruit at least 100 members before going full blast. Without a larger membership base, the cooperative is not so keen on forging ahead its operations due to financial considerations.

5.0 CONCLUSIONS

The MSHSC Coop Care plan is still in its infantile stage. Promoters of the concept are still very much into the process of honing their own lans and approaches while taking into consideration the experiences of other existing cooperative health care programs and assimilating these into their own scheme.

While the scheme is still relatively recent, it will be interesting to follow its progress especially since it has a particular bias in making health care services affordable to those who are least able to afford it, particularly the farmer groups in Davao del Sur.■