

The Novadeci Health Care Programme

• Case Study •

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Strategies and Tools against Social Exclusion and Poverty
Social Protection Sector,
International Labour Office
4, route des Morillons
CH-1211 Geneva 22,
Switzerland
Tel: +41.22.799.65.44
Fax: +41.22.799.66.44
E-mail: step@ilo.org
<http://www.ilo.org/step/publns>

ILO Manila
MCPO Box 4959
1289 Makati City
Manila
Philippines

Tel.: +63.2.815.2354/+63.2.819.3614
Fax : +63.2.761.1190
E-mail: manila@ilo.org

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Abbreviations

BoD	Board of Directors
BUA	Bilirubin Urea Analysis
BUN	Bilirubin Urea Number
CBC	Complete Blood Count
ECC	Employment Compensation Commission
ECG	Electro-cardiogram
FBS	Fasting Blood Sugar
GSIS	Government Service Insurance System
NATCCO	National Cooperative Council
NHCP	Novadeci Health Care Programme
NHIP	National Health Insurance Programme
PHIC	Phillipine Health Insurance Corporation
Ph.P.	Phillipine Pesos
SSS	Social Security System
STEP	Strategies and Tools against social Exclusion and Poverty

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Introduction

This paper looks at a self-help scheme for the poor: called the Novadeci Health Care Programme. This is a health micro-financing scheme employed by the members of the Novaliches Development Cooperative, Inc. (Novadeci). The paper describes the objectives of this scheme, how it operates and who are the actors involved in its management and organization.

The author, Reginald Indon, begins by giving a brief description of the Novadeci Health Care Programme and the socio-economic situation in which it operates with specific reference to the health situation at the local and national levels. The author then provides detailed descriptions of the NHCP during its initial and current year of operations. These two sections of the paper concentrate on the mechanics of the NHCP, the actors involved and the other specifics. In the last three sections of the paper, the author sets out brief but detailed performance indicators and statistics of the NHCP, insights of the different actors involved and his own observations, recommendations and conclusions.

This paper would not have been possible without the support provided by many people. The author, wishes to thank the staff of Novadeci, particularly Martha Bautista and Myrna Ramos for sharing their experiences and ideas on the NHCP, Evy Messell of ILO/STEP and Marife Yap for providing invaluable comments and insights on the production of this paper.

1. Analytical Summary of the Novadeci Health Care Programme

1.1 The context in which the health insurance system operates

Health financing virtually does not exist for people working in the informal sector in the Philippines. Yet these people have more need for and stand to gain more from vital health services. Even in the highly urbanized areas of the Philippines, where there is presumably greater accessibility to health services the majority of the population is far from being effectively covered.

In 1993, for example, only 342,000 out of nine million self-employed workers — a large portion of whom come from the informal sector — voluntarily registered with the Social Security System (SSS), the leading government agency responsible for providing social security in the country. This figure represents a meagre 3.8 per cent coverage (ILS 1995). Literature cites several factors for the low participation rate:

- ❑ Conventional social security programmes use the employer-employee relationship as a basis for coverage: this relationship virtually does not exist in the informal sector.
- ❑ Low and irregular income of informal sector workers reduce their capacity to make contributions.
- ❑ Ignorance of social security rights and obligations.
- ❑ Informal sector participants are already satisfied with indigenous social protection schemes offered by family, community, or self-help organizations.
- ❑ Legislative requirements, particularly those concerning employment status, exclude some informal sector workers from participation.
- ❑ Bureaucracy.
- ❑ Geographic accessibility (proximity) of social security institutions (e.g. SSS).

These factors point to the inability of formal social security institutions to respond to the condition and needs of the poor, specifically those in the informal sector. The system is simply not compatible with the conditions, dynamics and activities found in the informal sector. As in most of the country, poverty and informality is pervasive in Quezon City; the largest city in Metropolitan Manila. Statistics reveal that nearly 50 per cent of the population fall below the poverty threshold. This is attributed largely to the unequal distribution of wealth in the city.

In 1997, it was found that low-income families (which represent 50 per cent of the city's population) had an average monthly income of Ph.P.7,180 (US\$150) while the high-income group's average monthly income amounted to over Ph.P.123,000 (US\$2,562).¹

Compounding the problem of poverty are increasing levels of unemployment. In 1998, the unemployment rate in Quezon City was recorded as 11.6 per cent (considerably higher than the national average of 8 per cent). Lack of employment opportunities in the formal economy, compel people to work in the informal sector.

In the area of Novaliches, which is located in the northern section of Quezon City, and which accounts for 16 per cent of the city's population, similar economic and social conditions prevail. Poverty and employment problems persist and because of this, many of Novaliches' residents are not covered by any formal health insurance scheme.

1.2 The Novadeci Health Care Programme

In response to the need for health insurance services covering people not included in formal insurance schemes, a cooperative operating in Novaliches set up its own health insurance programme. The Novadeci Health Care Programme is a micro-insurance scheme operated by the Novaliches Development Cooperative (Novadeci).

Founded in 1976, Novadeci today is recognized as one of the premier cooperatives in the Philippines. 60 per cent of the members are small market vendors. The rest are micro-entrepreneurs (15 per cent), professionals (10 per cent), self-employed workers engaged in service sector activities (10 per cent) and students (5 per cent). Nearly 85 per cent of the members are women.

Novadeci is located in its own six-story building in Sarmiento Corner, Buenamar Streets, in Novaliches Proper, Quezon City. Apart from the main office, a medical clinic and a pharmacy, the Novadeci building also houses a consumer cooperative store and a number of other offices.

In September 1993, Novadeci formally launched its NHCP. Although the programme is very similar to commercial health insurance plans, the NHCP offers more affordable rates. The programme was designed specifically to target the members of the cooperative and to provide meaningful health care coverage for members and their families.²

To qualify for the NHCP, an applicant must be a member of Novadeci, and have a fixed deposit of at least Ph.P.1,000 (US\$21) with the cooperative. The applicant should not be over 55 years old and must be able to pay a one-time membership fee of Ph.P.200 (US\$4) plus an annual contribution of Ph.P.600 (US\$13).

In return, those who become members of the NHCP are provided with free medical consultations, free maternity care, free annual medical check-ups and discounted laboratory examinations, dental and optical services. Members are also provided hospitalization

¹ The exchange rate used for the purpose of this paper is Ph.P.48: US\$1. Computation may not add up due to rounding off.

² Each member is allowed up to three dependants.

benefits of up to Ph.P.10,000 (US\$208), while for immediate family members hospitalization benefits are up to Ph.P.5,000 (US\$104).

Last year, the NHCP collected over Ph.P.528,838 (US\$11,007) in individual contributions and disbursed more than Ph.P.452,000 (US\$9,416) in benefits.

1.3 Operations and management

1.3.1 Financial operations

The programme is mainly funded through fixed contributions of the members, service fees collected from Novadeci's medical clinic and laboratory and sales of medicines from the cooperative's pharmacy. Novadeci partly subsidizes the programme by paying the salaries of some of the programme staff.

At present, the programme is far from financially sustainable. Apart from the year 2000, collected revenues, specifically those coming from members' contributions, have not been sufficient to cover the cost of benefits disbursed. This has caused the programme's reserve fund (the Health Care Fund) to slowly dwindle.

Two major policy changes will be made in the year 2001 to redress the problem concerning finances.

- Membership of the NHCP will be compulsory for Novadeci members.
- NHCP members will be reinsured with an external insurance provider (probably with the state-owned Philippine Health Insurance Corporation).

The objective is to increase revenue collections and reduce the cost of benefit disbursements.

1.3.2 Professional and democratic style of management

Basically, the management, leadership and decision-making structure of the NHCP was based on and integrated with that of Novadeci. Trained professionals took care of the day-to-day management and operations and were given considerable freedom in making daily decisions concerning the NHCP. At the policy level, however, it was the cooperative's Board of Directors (BOD) and the General Assembly that made the final decisions.

Daily operations and transactions of the NHCP are now handled by the clinic staff, the Medical Services Department Head and the General Manager. The work involves: attending to the medical and health care needs of NHCP members; monitoring contribution collections, benefit disbursements and other income and expenses of the programme by preparing monthly and annual NHCP reports and advising the Board of Directors on policy matters pertaining to the NHCP.

The officers handling the NHCP practise democratic management. Although professional people run the programme, they are aware of their responsibility and accountability to the individual members of the cooperative.

1.4 Some performance indicators

NHCP members made most use of the clinic services compared to any of the other health services offered by the programme. For the year 2000, a total of 2,811 NHCP members and their dependants used the clinic's services: this represents an 89 per cent consumption rate for clinic services. The hospitalization service, meanwhile, registered only a 3 per cent consumption rate. During the same year, only 98 persons claimed NHCP's hospitalization benefits. However, the cost of providing such benefits to members and their dependants amounted to over Ph.P.331,000 (US\$6,896) or roughly 73 per cent of the year's total benefit disbursements.

The low penetration rate threatens the financial sustainability of the programme. Since its inception in 1993, the programme's target penetration rate has averaged only 11 per cent. However, some indicators show that this rate is slowly increasing; mainly attributable to major policy changes that enhanced the attraction and accessibility of the programme. In 2001, the management expects the target penetration rate to improve significantly as membership into the NHCP is made compulsory for Novadeci members.

2. The Context in which the Novadeci Health Care Programme Operates

2.1 Demographic aspects

Novaliches is basically an urban area situated in the northern portion of Quezon City, which is the largest city in Metropolitan Manila in terms of land size. Novaliches measures 2,275 hectares, or roughly 15 per cent of the total land size of Quezon City. It is divided into 15 barangays: Bagbag, Capri, Greater Lagro, Gulod, Kaligayahan, Nagkaisang Nayon, North Fairview, Novaliches Proper, Pasong Putik, San Agustin, San Bartolome, Santa Lucia, Santa Monica, Sauyo, and Talipapa.

Novaliches accounts for 16 per cent of Quezon City's total. The population density is estimated at 145 persons per hectare, which is the same as the City's average population density. The average household size is five, with two household members engaged in economic and income generating activities. The latest census indicates that there are 328,880 people (or around 67,269 households) living in Novaliches.³

2.2 Economic aspects⁴

In recent years, business growth has been mostly confined to the service sector, particularly wholesale and retail trading. Unfortunately, the employment generating capacity of trading activities is very limited. As a result of slow enterprise development and job creation, unemployment and underemployment have become a problem. In 1998, for example, unemployment was recorded at 11.6 per cent. Compounding the employment problem is

³ Based on 1995 figures.

⁴ Very little data is available that is specific to Novaliches. Data obtained represents data for the whole of Quezon City. Unless otherwise stated, the following data represents Quezon City data.

the existence of a large labour force in the city. Nearly 60 per cent of the population (or roughly 1.2 million) fall within the working age of 15 years and above.

Despite the high unemployment rate and flat enterprise growth, the average family income in Quezon City (recorded in 1997 at Ph.P.34,502 or US\$719) is average for Metro Manila. This is mostly attributed to the huge income gap that exists between Quezon City's rich and poor population. In 1997, for instance, the low-income group (which comprises nearly 50 per cent of the city's population) registered an average monthly income of Ph.P.7,180 (US\$150) while the high-income group's average monthly income amounted to over Ph.P.123,000 (US\$2,562).

2.3 Social aspects

2.3.1 Literacy

Almost all Quezon City's residents have gone through some form of schooling. In 1995, it was recorded that nearly 25 per cent of the population was able to reach or complete elementary level, 34 per cent secondary level, 28 per cent acquired college education, and 4 per cent completed vocational courses.

Local government expects the literacy rate in the City to further improve in the coming years as more children enrol in schools. Statistics show that the enrolment rate has steadily increased in the last four years. From 1996 to 2000, the average increase in enrolment at elementary level was 4.16 per cent. During the same period, however, there was no increase in the rate of enrolment. For the school year of 1999-2000, more than 226,000 and 109,000 students enrolled in the elementary and secondary levels, respectively.

The current classroom-student and teacher-student ratio in the city is 1:50, which is at par with the national level. For the school year 1999-2000, Quezon City had 3,479 classrooms and 8,438 teachers.

2.3.2 Social services

In 1999, the local government's Social Services Department was able to serve more than 152,000 clients through its various welfare programmes (e.g. Community Outreach, Vocational Skills Development, Rehabilitation and Residential, Public Assistance, and Welfare and Relief Operations). Apart from local government, welfare and social services were likewise provided by non-governmental organizations that operate in the City.

2.4 Health indicators

In 1995, the mortality rate in Quezon City was registered at 6.78 persons per 100,000 population. The leading cause of death was pneumonia, which was responsible for 121 deaths per 100,000 population. This was followed by cancer (63 deaths per 100,000) and ischemic heart disease/ myocardial infarction (60 deaths per 100,000). Morbidity rate was estimated at 3,181 per 100,000.

Meanwhile, the leading causes of death for infants were Sepsis Neonatorum or blood infection, immaturity, respiratory distress, and broncho-pneumonia. The incidence of infant death was estimated at 20 deaths per 1,000 live births. Meanwhile, maternal mortality rate was estimated at 1 for every 100,000 population.

The number of cases of infant and maternal death could have been reduced if pregnant women had been attended by physicians and midwives, rather than by the local “*hilot*”⁵.

In the past years, morbidity has steadily fallen. In 1990, there were 173,119 cases of illnesses reported in the City. This fell to 61,788 in 1995, placing the morbidity rate at close to 3,181 per 100,000 population. The leading causes of illness were identified as pneumonia, acute gastroenteritis/diarrhea, and pulmonary tuberculosis.

2.5 Supply of health care

In 1994, there were 1,772 health practitioners working in Quezon City. Approximately 44 per cent of the city’s health workers were para-medical staff while 21 per cent were midwives; people who rendered direct medical services to Quezon City’s population. The rest of the health workers were composed of physicians (14 per cent), nurses (16 per cent) and dentists (5 per cent). The medical personnel-population ratio for 1994 was computed at one medical personnel for every 20,000 persons.

In the same year, Quezon City had a total of 53 health centers, five of which were maternity clinics. These health centers offered an array of services which included medical and dental services, maternal and child health care, communicable disease control, nutrition programmes, family planning, etc.

Aside from the health centres, the city also had a total of 52 hospitals, 15 of which were government-owned. Low-income families which account for 48 per cent of the city’s population, generally attend government hospitals which offer lower health care rates, thus representing a bed-population rate for the year 1995 of 1:1,204.

2.6 National and local health policy

The Philippine health sector needs much improvement, especially in meeting the health care needs of the lower-income groups of the population. Although real and per capita expenditures for health have been increasing in the past years, the cost of health care remains exorbitant. This is partly because most of the funding goes into government hospitals which focus mainly on curative rather than preventive health care. Also, the coverage of public and private health insurance systems still excludes most of the poorer sectors of Philippine society.

During the five year period 1999 to 2004, a five-point health sector agenda programme will be implemented. This includes: providing fiscal autonomy to government hospitals, securing funding for priority health programmes, strengthening the capacity of health regulatory agencies, support for the formation and effective performance of the district health system and the expansion of coverage and benefit expenditure of the National Health Insurance Programme.

⁵ The local medicine man/ woman.

Health insurance is a vital element for expanding the coverage of public and private health care to the more indigent sectors of Philippine society. In 1997, nearly 50 per cent of the country's total health expenditure was paid directly by individual families, while only 7 per cent was provided by the government's social insurance programmes.

In view of this, the national government intends to strengthen its NHIP by increasing benefits, expanding the membership base, and improving the quality of health care services.

Specific reform strategies towards this goal have been proposed. These include: increasing benefits to make the NHIP more attractive, enhancing the institutional and organizational capacity of the Philippine Health Insurance Corporation (PHIC) in order to expand coverage, increasing public investment for health insurance and enacting legislation to achieve the necessary reforms.

These are programmes that have yet to be fully implemented and will not have an immediate impact on the country's health sector. Meanwhile, at the local level, the Quezon City government has initiated various health care programmes (which are mostly implemented by the local government's health centres) to attend primarily to the health care needs of indigent groups. Among these programmes is the MEDICAP programme of the Office of the Mayor, which provides poor families the opportunity to access Ph.P.5,000 (US\$104) worth of treatment and medicine costs from the Quezon City General Hospital. This is the only local government programme that approximates to a health care financing scheme.

2.7 Social protection in health

The present situation is that poorer sectors of Philippine society are often excluded from formal social protection programmes, including social protection in health. This is attributed mainly to the limited capacity of the formal social security system to respond to the actual needs and conditions of informal sector participants.

The Philippines basically follows the principle of contributory social insurance, under which social security members pay a regular contribution that is usually deducted from wages or salaries. Responsibility for implementing the country's social security programmes, which includes health insurance lies with SSS, the Government Service Insurance System (GSIS), Philippine Health Insurance Corporation, and the Employment Compensation Commission. However, these institutions and their programmes usually cover workers in the formal sector. Thus, coverage of those working in the informal sector, which has been described as the "poor mans' economy", has so far, been very limited.

In the absence of formal social protection in health for low-income groups, Filipinos began innovating and implementing their own informal social security schemes. The more traditional forms of social protection still exist, and among the more popular are family support, patron-client support, the *bayanihan* (or collective mutual support), and the *damayan* (solidarity). In situations of difficulty and adversity, Filipinos often find economic and social support from individuals, the family, and/or the community.

3. Implementation of the Novadeci Health Care Programme

3.1 The launching of the Programme

Most Filipinos who are poor and who work in the informal sector are excluded from health insurance. Formal health financing systems have failed to acknowledge and integrate the characteristics and dynamics that exist in these sectors, which represent people who have more need for and who stand to gain more from vital health services.

Institutions with responsibility for providing social security in health are the SSS, the Government Service Insurance System (GSIS), the Philippine Health Insurance Corporation (PHIC), and the Employment Compensation Commission (ECC). The programmes of these institutions are basically founded on the principle of contributory social insurance; i.e. individual members pay for the cost of health care through collective mobilization of funds.

These public social-insurance programmes, however, cater mostly to those employed in the formal sector, who have some capacity to pay for the cost of health care. Those who are unemployed or informally employed are generally excluded from health finance coverage. The state of health financing in the Novaliches area is very similar to that in the country in general. Because of widespread poverty and the informal employment arrangements that persist in the area, many people are not covered by any health financial system, and thus find it hard to access health care services

3.2 Health care in Novaliches prior to the launching of the Novadeci Health Care Programme

In 1993 (prior to the launching of the NHCP), there were 14 health establishments operating in the Novaliches area which offered various health care services.

Six of these establishments were privately-owned hospitals while the remaining eight were government-run health centers.

The majority of the population in Novaliches, because of their poverty, relied mostly on the government run health centres for their health care needs. However, despite offering free or inexpensive services, these lacked important infrastructure and equipment such as clinical laboratories and X-ray facilities. This greatly limited the type and quality of services offered.

Similarly, most people were also effectively excluded from private and state-led health financing systems, which in turn was a major cause for inability to afford the cost of health care. Despite the existence and availability of health institutions in the area, a large segment of the Novaliches population were not able to effectively access the services these institutions had to offer. Instead, as indicated by a report prepared by the Quezon City Government, many of the people relied on traditional healers such as the *hilot* to cure their illnesses.

Novadeci members were no exception. The majority of members (or nearly 85 per cent) of the cooperative were informally employed women engaged in micro-enterprise activities, mostly wholesale and retail trading. The members fall within the category of “self-employed”

and “entrepreneurial” poor⁶ whose ages range from 21 to 40 years (47 per cent) and 41 to 60 years (50 per cent).⁷ Again, because of their informal employment status, health care coverage for these people was not ideal. In fact, many were not covered by any health insurance system.

Although Novadeci maintained a medical clinic and a pharmacy to serve the health care needs of its members, they continued to express a need for better health services. Clinic patients were frustrated at not being able to find and afford the types of health services they needed, particularly for laboratory tests and analysis. To fund most of their medical and hospitalization expenses, members borrowed money from the cooperative which offered a special emergency loan package.

3.3 The phases of the Novadeci Health Care Programme implementation

3.3.1 Identifying needs

To follow up on the apparent need of Novadeci members for better health care services, the management held an informal survey that was conducted by the clinic nurse. Walk-in patients were interviewed and asked what types of medical and health care services they needed, and how much they were willing to pay for such services. To help validate the findings of the survey, an analysis was made by Novadeci’s Credit Services Department on how Novadeci members utilized their emergency loans.

The survey results showed that respondents wanted a “one-stop-shop” clinic where patients could have their laboratory tests and analysis done and where they could easily purchase medicines. The respondents also wanted a system that would free them from the complicated financial procedures involved in health financing.

3.3.2 Context, feasibility studies, and defining objectives

With the results of the survey, the clinic nurse made a formal recommendation to the management and the Board of Directors (BOD) for the cooperative to establish a health insurance programme. After close evaluation, the BOD agreed that the proposed health insurance scheme was financially feasible⁸ and would greatly increase the cooperative’s capability to handle the health and medical needs of its members. Consequently, the proposed health insurance programme was approved.

Although no formal and external actuarial study was organized⁹, an internal financial study was performed with the help of the credit services and accounting departments of the

⁶ Using Remenyi’s (1994) poverty pyramid framework.

⁷ The figures are based on a survey of 100 respondents conducted by the author in 1998.

⁸ For some years, NOVADECI had been operating a highly successful insurance scheme called the Damayan. This may have prompted the BOD to look favourably and positively on the proposed new health insurance scheme.

⁹ As of this writing, an on-going actuarial study is being conducted to assess the NHCP’s financial stability.

cooperative. In designing the NHCP, various sources relating to health financing were consulted and schemes employed by existing health insurance systems were adopted.

From the outset, the specific objectives of the programme were to:

- ❑ Provide health care services to Novadeci members by creating a relevant health programme.
- ❑ Extend health care services to families/dependants of Novadeci members.
- ❑ Extend the health care services to the community.
- ❑ Create and mobilize funds for the Novadeci Health Care Fund, specifically by having the cooperative's own medical laboratory, lying-in clinic, pharmacy, medial clinic, and hospital.¹⁰

3.3.3 The target group

Only a few of the cooperative's members (who were the target of the programme) have had any experience with health insurance schemes. Most of them were either formally employed or had sufficient funds to get a private insurance plan. Thus, the concept behind the NHCP was totally new for the majority of the cooperative's members.

On 3rd September 1993, Novadeci members were formally introduced to the NHCP during the cooperative's anniversary. On this occasion members were initially oriented with the programmes goals, objectives, and policies. If the number of NHCP recruits indicated the level of interest in the programme, it would seem that the NHCP failed to attract the interests of Novadeci members.

Only 198 out of the cooperative's 3,277 members initially signed on with the programme: a 6 per cent penetration rate. This may be attributed to the lack of social marketing of the programme prior to its launching.

3.3.4 The launch of the activities

See sections 4.3.2.and 4.3.3.

3.3.5 Leadership and decision-making

From the very beginning, the BOD was responsible for the policies that governed the NHCP. However, the BOD relied heavily on the other actors involved; specifically on the Medical Coordinator¹¹ and the General Manager. The Medical Coordinator's attention to the day-to-day operations of the programme, and the General Manager's close supervision of the finances involved with the NHCP, made their opinion much valued.

¹⁰ All these objectives have been realized, except for the construction of the Novadeci hospital.

¹¹ The clinic nurse who conducted the informal survey, was later promoted to the role of Medical Coordinator because of her immense contribution in setting up the programme.

External technical assistance was not deemed necessary in making and evaluating decisions concerning the NHCP, although some technical assistance was provided by the cooperative's in-house financial staff. The cooperative's finance department helped set up the books and accounting format of the NHCP (based closely on the cooperative's own accounting system). So far, this has been the only technical assistance received by the NHCP.

Basically, the leadership and decision-making structure of the NHCP was also based on and integrated with that of Novadeci. Trained professionals took care of the day-to-day management and operations, and were given considerable freedom in making daily decisions. But at the policy level, it was the BOD and the general assembly that had the final say.

3.4 Operation during the first term

3.4.1 *Members and other beneficiaries*

Only Novadeci members with at least Ph.P.1,000 (US\$21) in fixed deposits were allowed to join the NHCP. Unlike the other insurance programmes of Novadeci, membership into the NHCP was purely voluntary. Members paid in full a one-time membership fee of Ph.P.200 (US\$4) in addition to the fixed annual contribution fee of Ph.P.300 (US\$6). Each member had an average of three dependants, all of whom were directly related to the members. This included the member's spouse and two children or the member's parents. Although the participation rate was perceived as relatively good, it failed to meet the expected target of 1,000 new members. By the end of 1994, around 670 Novadeci members had signed up for the NHCP.

3.4.2 *Benefits*

The NHCP offered only one benefits package scheme which included free clinic services (e.g. consultation, check-up, etc), discounts on medicines and laboratory work, and hospitalization benefits. In determining the choices of what types of services to offer, the BOD and management mainly used the results of the informal survey. Other factors considered were the availability of health care services and facilities of the cooperative, capacity of the target group to pay for the cost of the programme, and the cooperative's financial stability. The Medical Coordinator, General Manager, and the BOD were aware that the cooperative had definite limitations in terms of professional staffing, logistics, and financial resources. These limitations were taken into account in choosing which types of services and benefits the NHCP could afford. Table 1 shows the summary of services and benefits covered by the NHCP.

Basically, the cooperative played the twin-role of insurance system and health care provider. The Novadeci Medical Clinic handled most of the members' medical needs. Members had to register their names in the clinic's logbook and their expenses were taken care of by the cooperative. Because of this twin-role, the cooperative exercised control over how the NHCP was designed, managed and operated.

However, Novadeci did not run its own hospital, nor did it have any formal arrangements with external health care providers. Members with more complicated medical needs were then referred to accredited hospitals. A "reimbursement" scheme was used to finance

hospitalization treatments (i.e., members advanced the payment for hospital bills and were later reimbursed).¹²

To ensure that NHCP policies were correctly implemented and followed, the Novadeci and NHCP management regularly prepared and produced simple monthly reports which featured contributions collections, benefit expenses, number of beneficiaries, types of services used, etc. These reports helped to monitor the operations of the programme.

Table no 1: Services covered by the NHCP during its first term

Services	Persons Covered	Co-payment	Maximum coverage limit	Waiting period	Compulsory reference
<p>Unprogrammed Surgical Intervention</p> <p>All types except resulting from:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Attempted suicide <input type="checkbox"/> Excessive self-induced intoxication <input type="checkbox"/> Accident resulting from committing crime <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Abortion 	B	Maximum coverage	Ph.P.10,000 for members; Ph.P.5,000 for dependants	6 months	C
<p>Gynaecological-obstetrical Intervention</p> <ul style="list-style-type: none"> <input type="checkbox"/> Caesarian section <input type="checkbox"/> Normal delivery 	M	Maximum coverage	Ph.P.5,000 for C-Section; Ph.P.2,500 for normal delivery	12 months	C
<p>Medical Hospitalization</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heart by-pass <input type="checkbox"/> Appendicectomy <input type="checkbox"/> Mastectomy <input type="checkbox"/> Rehydration <input type="checkbox"/> H-fever <input type="checkbox"/> Broncho-pneumonia 	B	Maximum coverage	Ph.P.10,000 for members; Ph.P.5,000 for dependants Ph.P.5,000 for members; Ph.P.2,500 for dependants	6 months	C

¹² The NHCP did not reimburse the full amount of hospitalization cost, but only upto the limit allowed (which is a maximum of Ph.P.10,000 for members and Ph.P.5,000 for dependants).

Services	Persons Covered	Co-payment	Maximum coverage limit	Waiting period	Compulsory reference
Programmed Surgical Intervention <input type="checkbox"/> Excision of cyst <input type="checkbox"/> Haemorrhoidectomy <input type="checkbox"/> D & C (raspa)	B M	Maximum coverage	Ph.P.1,000 for members; Ph.P.500 for dependants Ph.P.2,500	O	C
Programmed Ambulatory Care <input type="checkbox"/> Consultation <input type="checkbox"/> Baby check-up <input type="checkbox"/> Pre-natal check-up <input type="checkbox"/> Physical examination	B M	Maximum coverage	O	O	C
Preventive Care <input type="checkbox"/> Immunization	B	Maximum coverage	Depends on discounts for medicines	O	C
Unprogrammed ambulatory <input type="checkbox"/> Medicines/ Drugs	B	Maximum coverage	Depends on amount of discounts for medicines	O	C
Laboratory/ Radiology	B	Maximum coverage	Depends on amount of discounts for medicines	O	C

M= members only, B=other beneficiaries as well, C=reference is compulsory

3.4.3 Financing

During its first year of operation, the NHCP relied heavily on Novadeci subsidies. The cooperative shouldered most of the NHCP expenses, mainly because the latter lacked the necessary funds to set up the facilities required for the new clinic. The subsidies were deemed necessary given the low collection and target penetration rate suffered by the NHCP in its first year, which in turn resulted in the programme's net loss of Ph.P.79,790 (US\$1,662). The annual fixed fee of Ph.P.300 (US\$6) proved to be too small to help finance the NHCP. (Eventually, in 1995, the fixed annual fee was raised to Ph.P.600 (US\$13) to help stem the NHCP's financial losses.) Table 2 summarizes the financial support given by Novadeci.

Table No 2: Resources used to finance the NHCP's creation in its first term

Source	Amount	Aim	Kind
Technical Assistance	-	To set up the books and the accounting system.	Incorporated in the existing operation of Novadeci; no need for additional funds.
Staff	-	To add trained personnel to handle the medical clinic and the pharmacy.	Fixed salary for: <ul style="list-style-type: none"> <input type="checkbox"/> Medical Coordinator <input type="checkbox"/> Medical Technologist <input type="checkbox"/> Pharmacist <input type="checkbox"/> Nurse <input type="checkbox"/> Midwives <input type="checkbox"/> Attendants <input type="checkbox"/> Retainer's fee for: <ul style="list-style-type: none"> <input type="checkbox"/> Doctors <input type="checkbox"/> Pathologist <input type="checkbox"/> Cardiologist <input type="checkbox"/> Dentist
Infrastructure and Equipment	Ph.P.672,906 (US\$14,019)	To set up the clinic and its facilities.	Subsidy from Novadeci; internally generated and financed by the cooperative.

3.4.4 Health care providers

As mentioned earlier, except for hospitalization benefits, Novadeci through its medical clinic was the direct provider of health care services for NHCP members. A large investment was made to improve the facilities of the clinic in an effort to upgrade the services offered. Also, Novadeci took much of the initiative in lending some of its professional staff to develop the management and operations systems of the NHCP. To a large extent, the NHCP was dependent on Novadeci funding and logistics which in turn affected the price of services the NHCP offered. Without these subsidies, the NHCP would have had to set higher prices for its services to avoid financial difficulties.

3.4.5 Administration and management

3.4.5.1 Statutes and regulations

From the onset, the NHCP followed a set of statutes and regulations that guided the administration and management of the programme. These were all found in the *Alituntunin sa Lingap-Pangkalusugan* - the NHCP Policy Guideline divided into eight sections.

Section 1 dealt with the goals and objectives of the programme. Basically, the objective was to expand the services of the cooperative for its members through the provision of health care services, with the ultimate goal of improving the economic, social and spiritual well-being of members.

Section 2 enumerated the application requirements and procedures which were as follows:

- ❑ The applicant must be a member of the cooperative and must have at least Ph.P.1,000 (US\$21) in fixed deposit.
- ❑ A formal application had to be submitted to the NHCP management.
- ❑ Payment of a one-time membership fee of Ph.P.200 (US\$4) and an annual contribution fee of Ph.P. 300 (US\$6) was necessary.

Sections 3 and 4 listed the role of NHCP members, once they were accepted into the programme. This section highlighted the financial obligations of the members, and in return the benefits that were gained by them (e.g. health care services offered and amount of benefits).

Section 5 detailed the restriction imposed by the NHCP, particularly the types of illnesses and services not covered by the programme.

Section 6 enumerated the expected roles of the NHCP management. This focused mainly on the management and administrative responsibility of the NHCP staff to their clients and to the programme.

Section 7 explained the creation of the Novadeci Health Care Fund, which was basically the reserve fund financed through members' contributions.

Section 8 explained the disclaimer clause of the NHCP in the event of "mass hospitalization" where the health care fund was not sufficient to cover expenses.

3.4.5.2 Management organization

The programme was managed and operated solely by the employees and staff of Novadeci, and it utilized the existing organization and management structure, as well as the logistical and human resources available to the cooperative. Specifically, the NHCP was initially run by the Novadeci Medical Clinic Staff. The work primarily involved attending to walk-in patients of the clinic, producing daily accounting records, and updating the clinic inventory.

Meanwhile, the overall responsibility for coordinating and supervising the NHCP staff was assigned to the Medical Coordinator and the General Manager. Apart from their supervisory role, the two officials were also assigned responsibility for collating and analyzing monthly financial reports and giving feedback to the BOD, which in turn, was responsible for policy recommendations. A special committee called the Medical Services Committee, (composed of BOD members), was formed specifically to handle issues and problems relating to the NHCP. Table 3 lists the actors involved with the NHCP while diagram 1 illustrates the organizational structure of the NHCP.

Table no 3: Salaried staff employed by the NHCP

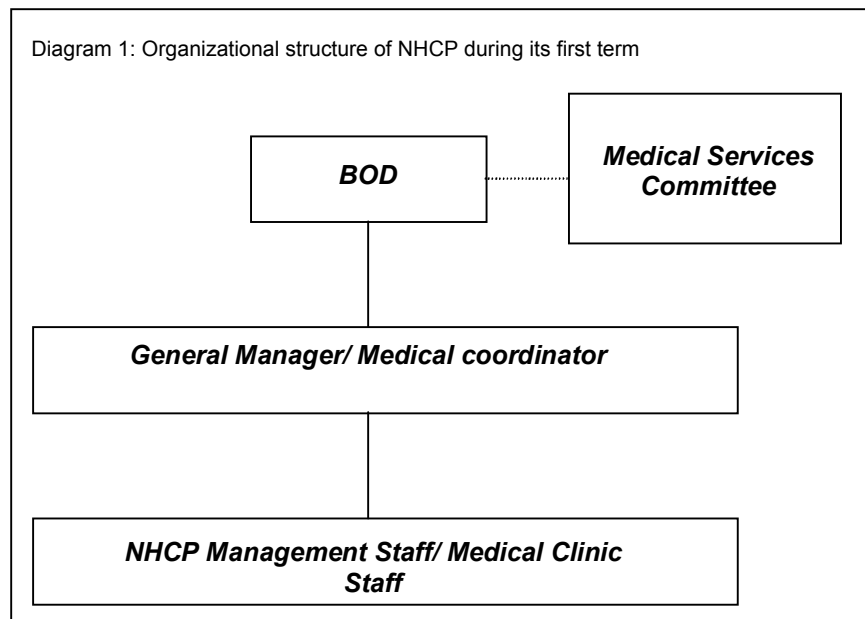
Category	Number	Employer	Percentage of time dedicated to the NHCP
Medical Coordinator	1	Novadeci	Full time
Doctors	3	Retainer	56 hours a week
Nurse	1	Also as Coordinator	Full time
Midwife	2	Novadeci	Full time
Medical Technologist	1	Novadeci	Full time
Pharmacist	1	Novadeci	Full time
Bookkeeper	1	Novadeci	Part-time
Utility/ Attendant	1	Novadeci	Full time
Pathologist	1	Retainer	
Cardiologist	1	Retainer	
Dentist	1	Retainer	

3.4.5.3 Information System

To help the various actors in managing and operating the NHCP, an array of documents were used to systematize information and data on finance and member's profiles. This included members' application/ registration forms, membership cards, contributions register, benefits records and accounting documents. The application form held most of the information about the member: demographic and economic data and the names of the member's dependants/beneficiaries.

3.4.5.4 Technical assistance

As mentioned earlier, technical assistance was provided solely by in-house staff, and mostly concerning financial matters only. Accounting personnel of the cooperative helped in setting up the books and accounting formats of the NHCP. Eventually, one of the accountants of the cooperative became the NHCP's part-time book-keeper.



4. The Characteristics of the Novadeci Health Care Programme

4.1 The target group and the beneficiaries

4.1.1 Target group

Members of the cooperative continue to be the target group of the NHCP. However, changes have been made in the screening programme for potential recruits. For instance, an age requirement was introduced. Members, their spouse and/or parents who are above 55 years old are now excluded from the NHCP as well as the children of NHCP members over the age of 21 years. Also excluded from the NHCP are those already receiving assistance from Novadeci's old-age and disability pension programme.

4.1.2 Various categories of beneficiaries

Only Novadeci members and their dependants are qualified to join the NHCP. However, participation in the NHCP will be made compulsory for all Novadeci members from the year 2001. New recruits of the cooperative will be required to sign-on with the NHCP and current members will be obliged to join the NHCP as soon as they avail themselves of the credit services of the cooperative. This initiative will be undertaken to increase the membership and funds of the programme.

The annual contribution fee has been raised to Ph.P.600 (US\$13) to make the programme more financially viable. Although it was initially feared that the increase might exclude some members from participating in the programme, it soon became clear that the increase did not prove to be a deterrent. After the increase was initiated in 1995, membership into the NHCP continued to grow (although at a very slow rate).

Another major change in NHCP policy was the abandoning of the required pre-membership physical examination. According to the NHCP Medical Clerk, some members expressed their interest in joining the NHCP, but were inhibited from doing so because they did not have the time to visit the Novadeci clinic to take the required physical examination. To solve this problem, the examination was waived and, instead, a 2-year waiting period for specific types of illnesses was put in place. These were: tuberculosis, cardiovascular diseases, diabetes mellitus, asthma, arthritis, hyperthyroidism, cataract, glaucoma, epilepsy, and renal failure or kidney disease.

However, the general conditions and policies governing the NHCP remain the same. The changes introduced were focused mainly on refining the procedures and requirements thus making the programme more efficient and effective.

4.1.2.1 Application procedure

To apply for NHCP coverage, applicants must fulfil certain conditions:

- The applicant must be a member of Novadeci with an existing Ph.P.1,000 (US\$21) fixed deposit with the cooperative.
- The applicant should not be over 55 years old.
- The applicant must not yet be covered by the cooperative's old-age and disability pension programme.

Suitable applicants must then file and submit an application form to the Medical Clerk, who forwards the application to the Medical Services Department Head (initially known as the Medical Coordinator) for evaluation. After the evaluation, the application is sent to the General Manager for approval. As soon as the application is approved, the new member and their dependants are registered into the NHCP files and are provided with membership identification cards. These cards are used to facilitate transactions and expedite benefits entitlement. Applications may be submitted at anytime during the year.

4.1.3 The number of beneficiaries and its evolution

Since it began operations in 1993, the number of NHCP members and beneficiaries have failed to increase significantly, mostly due to lack of social marketing on the part of the management. Although membership greatly improved from 1998 to 1999, this growth spurt was short-lived. In fact, membership fell by 3 per cent from 817 in 1999 to 790 in 2000.¹³ Table 4 shows the evolution of the NHCP and Novadeci membership in the last three years.

¹³ Management contends, however, that it was the impact of the economic crisis brought about by the Asian Financial Crisis which forced some members to fail in paying or renewing their NHCP accounts.

Table no 4: Current number of members and membership growth rate¹⁴

	1998	1999	2000	Growth rate 1998-1999	Growth rate 1999-2000
No. of NHCP members	663	817	790 ¹⁵	23%	-3%
No. of NOVADECI members	5 985	6 034	6 057	1%	0%

4.1.4 Reasons for loss of membership status

There are basically three reasons for exclusion from or loss of NHCP membership status:

- Attainment of age 55.
- Non-renewal of NHCP membership resulting from the expiry of coverage.
- Withdrawal of membership from Novadeci.

The age limit was introduced to prevent abuse of the scheme. It was perceived that those who reached age 55 are high-risk members, and therefore represent a danger to the financial stability of the NHCP. Besides, Novadeci provides an old-age and disability pension programme for its members and therefore those 55 years of age and above benefit from some form of social protection.

4.1.5 Target group's penetration

The target penetration rate of the NHCP is very low and since its inception in 1993, the rate has averaged only 11 per cent. However, there are indications that this rate is slowly increasing, due mainly to policy changes introduced in 1999 (foremost of which was the "no pre-membership physical examination").

For the year 2001, management expects the target penetration rate to improve significantly as the new policy on compulsory membership into the NHCP takes effect. Table 5 shows the evolution of the target penetration rate for the last seven years.

¹⁴ Table 4 is a consolidated version of Tables 6, 6bis, 7 and 8 of the "Methodological Guide for undertaking case studies on health insurance schemes". Due to lack of available information, the consolidation of the said tables was deemed necessary.

¹⁵ 156 male, 634 female.

Table no 5: NHCP membership growth compared to that of Novadeci

	1994	1995	1996	1997	1998	1999	2000
No. of NHCP members	418	492	535	589	663	817	790
No. of Novadeci members	4 280	5 018	5 332	5 962	5 985	6 034	6 057
Target penetration rate	10%	10%	10%	10%	11%	14%	13%

4.2 Benefits and other services offered by Novadeci Health Care Programme

Initially, the choice of services was based on the health care needs of Novadeci members as evidenced by their use of emergency loans and clinic services. However, since the programme started, an array of new services has been introduced. Dental, optical, and childbirth as well as more types of laboratory services were finally made available. These new clinical services were meant to increase the incentive for Novadeci members to join the NHCP and they also provided an additional source of revenue for the Medical Clinic. Table 6 lists the services covered by the NHCP.

During 2000, the five services most commonly used were: the annual physical examination (which included ECG, CBC, Urinalysis, FBS, BUN, BUA, Cholesterol Screening, Hepatitis-B Screening, Pap Smear, and dental check-up), pulmonary aide, ECG, immunization, and minor surgery. Most of those using these services were women.

Table no 6: New services provided by the NHCP

Services	Persons Covered	Co-payment	Maximum Coverage limit	Waiting period	Compulsory reference
Dental Care <input type="checkbox"/> Tooth Extraction <input type="checkbox"/> Prophylaxis <input type="checkbox"/> Temporary tooth filling <input type="checkbox"/> Check-up and consultation	B	Maximum coverage	O	O	C
Laboratory/ Radiology	B	Maximum coverage	Depends on amount of discounts for medicines	O	C
Others <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Cardiovascular diseases	B	Maximum coverage	Ph.P.10,000 for members; Ph.P.5,000 for dependants	2 years	C

<input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Asthma <input type="checkbox"/> Arthritis <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Cataract <input type="checkbox"/> Glaucoma <input type="checkbox"/> Epilepsy <input type="checkbox"/> Renal Failure or Kidney disease					
M= members only, B=other beneficiaries as well, C=reference is compulsory					

NHCP members are informed about the types of services available to them through the distribution of newsletters, flyers, and leaflets. Complementing this promotional action are orientation seminars and refresher courses regularly given to NHCP members.¹⁶

NHCP members are also provided with information on policies and updates concerning programme costs and the need for risk management. It is considered necessary for members to understand how the programme is financed and how risk-management affects its financial stability. To do this, the management makes it clear that the programme is not meant to pay for the full cost of their health care but merely to provide some financial assistance to meet medical and health emergencies. Thus, it is made clear that co-payments play a vital and integral role in the programme's finances; otherwise funding for medical and health care services would be insufficient. Similarly, it is explained to members that the prescribed waiting periods for certain types of services are necessary to allow their contributions to "age" so that there are no liquidity problems. Table 6 summarizes the required co-payments and waiting periods for the new services offered by the NHCP and should be read in conjunction with Table 1.

The management is strict when it comes to these two policies: no one is exempted from paying his/her required participation fee or from observing the waiting period. To ensure that these two important policies are observed, the Medical Clerk is required to screen all benefit claims and to verify the coverage limits of claimants.

4.2.1 Benefits payment

When the service provided is in-house, that is if the medical or health care procedures are conducted in the Novadeci Medical Clinic, the NHCP member need only sign his/her name in the clinic's logbook. Unless the cost exceeds the coverage limit, the member does not need to pay for anything.

¹⁶ Yet, according to the NHCP medical clerk, only a few of the NHCP members are genuinely interested in learning more about the program. The majority take only an interest in the NHCP when they need to avail of its services.

However, if the medical or health care procedure is obtained outside the clinic (i.e. external health care provider), the member is obliged to advance the cost of the procedure. Only upon the submission of relevant documents (i.e., medical certificate, hospital bill, laboratory results, official receipt of hospital and drugstore, operative report, NHCP membership card) by the member will be reimbursed. No cash advances are allowed or provided.

No particular sub-group has a significant share in benefits paid, although there are more female beneficiaries than male largely due to the high female membership rate found in Novadeci and NHCP.

4.2.1.1 Reimbursement procedure

To claim for reimbursements, the NHCP member first submits to the Medical Clerk a reimbursement application form accompanied by relevant documents.

The Medical Clerk checks the application form and documents to verify their authenticity. The reimbursement claim is then forwarded to the Medical Services Department Head for evaluation, and then submitted to the General Manager for approval. If the claim is approved, a cheque signed by the General Manager is then provided to the claimant. On average, the whole procedure takes three to five days.

All approved claims are filed and recorded by the Medical Services Department, and reported in the NHCP monthly and annual summary. These summary reports contain basic information on the number of patients served during the month, the members who used the medical, hospitalization and annual physical examination services, the cost of these services, and an update on the Health Care Fund. The report also includes updates and issues about the NHCP.

According to management, there have been very few cases where a reimbursement claim has not been approved. These were mostly cases where the types of medical or health care services used by the NHCP client were not distinctly or specifically covered by the NHCP policy or where fraud was committed.

4.2.2 Other services provided for members

4.2.2.1 Other financial health services

Apart from the NHCP, members have access to emergency medical loans provided by Novadeci. Members can borrow up to Ph. P.20,000 (US\$417) payable within 3 years, with a monthly interest rate of 1.5 per cent. This loan facility, however, is handled by the Credit Services Department which operates separately from the Medical Services Department. However, since the NHCP was introduced, the need for emergency loans has significantly declined.

4.2.2.2 Health supply

Novadeci provided direct medical and health care services for its members through its in-house Medical Clinic, pharmacy and laboratory facilities. Although the clinic was open to the public, NHCP members could obtain free services from the clinic, while Novadeci members could use the services at discounted rates. Non-members were charged the full amount.

Novadeci employs three persons (medical clerk, staff nurse, and utility worker) to directly manage and operate the Medical Clinic and its facilities. The salaries of the rest are financed through the income of the Medical Services Programmes (e.g. clinic and laboratory fees).

4.2.2.3 Prevention and health education

Novadeci, through its Medical Services Department, hosts a variety of health care and medical activities not only for Novadeci and NHCP members, but also for non-members in the community. These programmes include monthly medical field trips to deprived areas. Through sponsorship from pharmaceutical companies and other concerned civic groups, Novadeci is able to finance such medical field trips, which not only form part of the cooperative's social and civic goals, but also provide opportunities for promotion and recruitment.

4.2.2.4 Other services

The NHCP is only one of the services and social security programmes offered by Novadeci. Apart from the NHCP, there are five other major programmes which serve the needs of its members. They are:

- The savings and credit programme began in 1976 and under this members are provided the opportunity to access financial services such as deposit savings and credit. In 1997, Novadeci mobilized a total of Ph.P.93 million (US\$1,937,500) in savings deposits. It also disbursed over Ph.P.277 million (US\$5,770,833) in loans, mostly in the form of business credit. This savings and credit facility is the most popular programme offered by the cooperative.
- Assistance with education, literacy, and scholarship. This was introduced by the cooperative in 1982, and has since helped many of the members' children to finish schooling.
- The *Damayan* --a social insurance programme covering contingencies such as death, old-age, and disability. In 1997, the *Damayan* maintained a reserve fund of over Ph.P.6 million (US\$125,000), and was able to disburse over Ph.P.2.9 million (US\$60,417) in benefit claims.
- A consumer store programme, which began in 1990, tries to increase the economic potential of members who are engaged in or were interested in starting their own small businesses. The programme is basically credit-based.
- The Training Center Programme, which like the previous one, is intended to enhance and develop the economic capabilities of its members.

4.3. Financial aspects of the Novadeci Health Care Programme operations

4.3.1 The Novadeci Health Care Programme's sources of finance

4.3.1.1 Contributions

In its first year, the NHCP charged members Ph.P.300 (US\$6) a year for its services. However, in 1995, the fee was raised to Ph.P.600 (US\$13) to ensure financial viability.

Although some income is generated by Novadeci's clinic, laboratory and pharmacy, members' contributions remain the primary source of funding for the NHCP. As a result, the Medical Services Department is very strict in pursuing outstanding payments. It is up to the Medical Clerk to constantly follow-up non-payment by members and to secure payment.

Members pay their contributions according to their income and capacity, either by lump sum or in monthly instalments. An official receipt is always issued and payments are also recorded into members' passbooks. This helps both members and NHCP staff to monitor payments and balances.

In the last three years, the average monthly contribution collected grew by 38 per cent from Ph.P.31,956 (US\$666) in 1998 to Ph.P.44,069 (US\$918) in 2000. This is noteworthy because collection is finally outpacing benefits expenditure.

During the same period, the average monthly expenditure grew only by 8 per cent from Ph.P.34,918 (US\$727) to Ph.P.37,690 (US\$785).

In its early years, the average monthly expenditure always surpassed the average monthly collection, but this changed after the requirement for a pre-membership physical examination was abandoned in 1999. This new policy increased the incentive and opportunity for interested parties to join the NHCP, and as a consequence, led to increased revenues for the programme.

4.3.1.2 Membership fees and their capacity to pay

A new NHCP member pays a one-time Ph.P.200 (US\$4) membership fee plus an annual contribution of Ph.P.600 (US\$13). Payments can be made either direct to Novadeci or through Novadeci-accredited banks and may be made on a staggered basis and according to the capacity of the member to pay. What is considered important is that the member is able to complete his/her scheduled payments for the year. If payments for the year are less than the required Ph.P.600 (US\$13), only a certain per cent of the benefit will be provided to the member. This is intended to encourage members to pay their contributions on time in order to fully utilize the services of the NHCP. A member, for instance, who is only able to pay less than half of the required annual fee of Ph.P.600 (US\$13) for the year is entitled to only half of whatever benefits that would otherwise be due to him/her. Incomplete payment of contributions for the year means the member is entitled to only a corresponding percentage of his/her full benefit. Table 7a shows how the benefits were computed as per contributions paid for the year.

Table no 7a: Contributions and benefits schedule of the NHCP

<i>Payment made for the year</i>	<i>Corresponding benefit</i>
Zero payment	No benefits
Ph.P.150 (US\$3) to Ph.P.299(US\$6)	25% of benefits
Ph.P.300(US\$6) to Ph.P.499(US\$10)	50% of benefits
Ph.P.500(US\$10) to Ph.P.599(US\$12)	75% benefits
Ph.P.600(US\$13)	100% benefits

During 2001, it is planned to further expand the range of services available to NHCP members in order to make the programme more attractive, and thereby increase the incentive for prompt payment of contributions. A plan to reinsure members of the NHCP with another insurance system (possibly with the state-led Philippine Health Insurance Corporation) to help defray the cost of claims is also being considered.

4.3.1.3 Donations and subsidies from other sources

Because the Novadeci pharmacy is registered as a dispensing unit of the Department of Health, it is able to purchase and retail medicines at cheaper prices. Also, a number of pharmaceutical companies regularly donate medicines and laboratory supplies to Novadeci for use in the cooperative's Medial Clinic and in the monthly medical field trips.

However, the primary donor of the NHCP is Novadeci itself which has channelled into it large amounts of human, logistical, and financial resources. In addition, every year the cooperative allocates a budget for the Medical Services Department (which handles the NHCP and the Medical Clinic). The money is used to cover the cost of operation of the Department, particularly personnel costs.

Even though considerable financial support has been provided to the NHCP, the programme is still far from being financially sound. According to management, there is a definite need for new laboratory equipment such as ultrasound equipment and an x-ray machine, but apparently there are insufficient funds available for this.

4.3.2 Costs

In its first year of operation, the NHCP disbursed nearly Ph.P.262,000 (US\$5,458) in benefits claims. The following year, disbursements amounted close to Ph.P.499,000 (US\$10,396). Since then, the annual disbursement fluctuated between Ph.P.400,000 (US\$8,333) to Ph.P.470,000 (US\$9,792). In 2000, more than Ph.P.452,000 (US\$9,417) in benefits was spent by the NHCP. This figure, however, excluded operations and management costs which amounted to over Ph.P.780,000 (US\$16,250).

4.3.3 Surplus allocation and reserve funds

Surplus funds of the NHCP are kept in a contingency or reserve fund aptly called the Health Care Fund. Although surplus income is generated yearly from the sale of medicines and collection of clinic and laboratory fees, this is not enough to make any impact on the financial status of the programme. In fact, the Health Care Fund has been slowly diminishing in value. For 2000, the Health Care Fund covered only two months of programme operation. There is a need to develop and augment the fund in order to make it more financially secure. Table 7b highlights the evolution of the Health Care Fund.

Table no: 7b¹⁷: Total amount of budgeted contributions

1993	Ph.P.163,000 (US\$3,396)
1994	Ph.P.183,224 (US\$3,818)
1995	Ph.P.312,182 (US\$6,504)
1996	Ph.P.295,345 (US\$6,153)
1997	Ph.P.297,701 (US\$6,202)
1998	Data not available
1999	Ph.P.167,006 (US\$3,479)
2000	Ph.P.185,197 (US\$3,852)

4.4 Health Care Providers

4.4.1 Health care providers linked to the Novadeci Health Care Programme

The Novadeci Medical Clinic is the primary health care provider of the NHCP. However, the clinic is quite limited in staff and facilities, and thus is not able to totally respond to the members' growing health care needs.

Accredited clinics and hospitals serve as secondary health care providers of the NHCP. The NHCP-accredited hospitals include: Bernardino General Hospital, Legaspi General Hospital, Casaul General Hospital, Chinese General Hospital, Quezon City General Hospital, MCU Hospital, UST Hospital, St. Luke's Hospital, and Philippine Heart Center Hospital. Among the hospitals mentioned, the Novaliches General Hospital is the most accessible because of its proximity to NHCP members.

However, there have been no formal arrangements with the hospitals mentioned which greatly affects the effectiveness of the NHCP as a health insurance provider. For instance, direct payments for hospital expenses are not made and members have to advance the

¹⁷ Note that for the years 1995, 1996, and 1997 the Health Care Fund experienced tremendous growth. This was because membership into the NHCP grew considerably during these years.

payment for hospital bills, and then claim reimbursement from the NHCP. Members consider this procedure highly tedious and a financial burden.¹⁸

4.4.2 The relationship between the Novadeci Health Care Programme and the health care provider

See section 4.1.

4.4.3 Payment of health care providers

Most of the staff working for the Medical Clinic are employees of Novadeci, while the rest are employed on a retainer or part-time basis. The clinic's doctors, apart from receiving a retainer fee, also receive a percentage of the income from clinic fees (see Table 3).

4.5 The Novadeci Health Care Programme administration and management

4.5.1 Statutes and regulations

As mentioned in Part C of this case study, the statutes of the NHCP are defined clearly by the NHCP Policy Guideline, which over the years, has undergone some revisions. Although the general theme and elements of the NHCP remain the same, changes were made regarding the programme's procedures, requirements, and limitations in order to make it more responsive, transparent, and balanced.

A major policy change has been the imposition of an age requirement. Applicants who are over 55 years old are automatically disqualified from joining the programme. Other changes have been the increase in the fixed annual contribution fee from Ph.P.300 (US\$6) to Ph.P.600 (US\$13), and the abandoning of the required pre-membership physical examination.

Changes in operation procedures have also been made. This includes new procedures for NHCP members who have been disqualified for non-payment of contributions to enable them to reapply for membership. More stringent application requirements and procedures have been set up for these members.

The latest version of the NHCP Policy Guideline came out in 1999.

4.5.2 The Novadeci Health Care Programme management organization

The management and organizational structure of the NHCP remain basically the same, except for one significant modification: the creation of the Medical Services Department which replaced the Medical Services Committee. Previously, the Cooperative's Marketing Department handled the NHCP and the Medical Clinic. However, after realizing the need to institutionalize the NHCP and the Medical Clinic as distinct programmes for the cooperative, the BOD and management created another department to specifically handle the affairs of the NHCP, the Medical Clinic, and the other health care projects of the cooperative

¹⁸ Discussions, however, are on-going between the Medical Services Department and the Novaliches General Hospital for possible formalization of working arrangements.

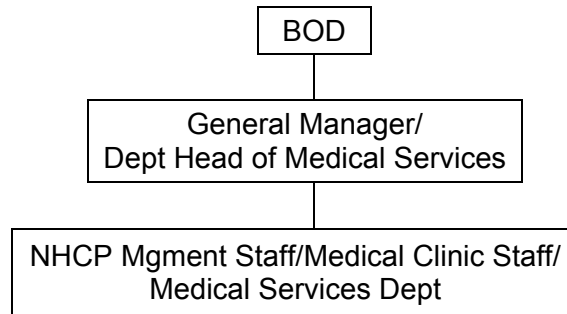
(including the medical field trips). With the creation of the new department, the Medical Coordinator became the head of the Medical Services Department.

The BOD is directly accountable to the general membership, and its officers are elected by the members. However, the management staff of Novadeci and NHCP, although members also of the cooperative, are professional people hired as full-time employees of the cooperative. They are not elected by the general membership and this arrangement is important because it helps prevent management transactions from being influenced by the membership. Table 8 lists the employees of the NHCP, while Diagram 2 illustrates the revised organizational structure of the NHCP.

Table no 8: Personnel (salaried or unsalaried) employed by the NHCP

Job Title	Mode of payment	Creation of post	Qualifications	Main tasks
Medical Coordinator/ Department Head	Salaried	1993	4 year medical course plus background in accounting	Supervision of daily operations
Retainer Doctors	Allowance/ Retainer Fee	1993	BSc. Medicine	Attends to patients; helps in giving of medical seminars
Staff Nurse	Salary	1993	BSc. Nursing	Assists patients; acts as petty cash custodian
Medical Clerk	Salary	1993	Midwifery	Acts as NHCP Clerk; assists patients
Medical Technologist	Salary	1993	BSc. Medical Technology	Takes samples for laboratory testing; and reads results
Pharmacist	Salary	1993	BSc. Pharmacy	Acts as purchaser and cashier of Novadeci pharmacy
Pharmacy Aide	Salary	1995	Midwifery	Assists customers in pharmacy
Utility	Salary	1993	High school graduate	Maintains cleanliness of whole medical area; serves as messenger; assists patients

Diagram 2 – Organizational structure of NHCP



4.5.3 The democratic and cooperative character of the management system

The management practices a high degree of democratic ethic. Although the BOD and management assume a great deal of responsibility in running the cooperative and its programmes (including the NHCP), they are also accountable to the individual members of the cooperative.

Apart from electing the people who will compose the BOD, the members also have some control over the annual budget of the Medical Services Department. If the general membership is not satisfied with the effectiveness, impact and outreach of the Medical Services Department, it is most likely that the department will get a small budget. In the past this department received the smallest budget allocation among the different departments of the cooperative.

Members are informed and consulted by the management on how medical services and the NHCP could be improved. This is done through feedback and appraisal, which is usually conducted through the annual survey during the General Assembly meeting and through informal interaction between clinic patients and staff.

Comments and suggestions are analyzed and included in the recommendations that are regularly submitted to the BOD.

The General Manager and the Medical Services Department provide advice to the BOD, as well as take responsibility for implementing programme policies.

4.5.4 Financial management

The General Assembly and the Novadeci management prepare the annual budget of the Medical Services Department, while the Department Head and the General Manager see that the budget is followed, and expenses do not exceed budget allocations. For its daily cash transactions, the Medical Clerk assumes the role of treasurer and is responsible for handling the programme's petty cash.

To help in the handling of the NHCP financial accounts, the services of a book-keeper (an employee of the cooperative) is enlisted. Together with the Medical Services Department Head and the General Manager, the book-keeper prepares monthly and annual NHCP financial reports which are posted publicly.

4.5.5 The information system and management tools

4.5.5.1 Accounting framework

The Medical Services Department Head supervises the daily operations of the NHCP and the Medical Clinic, including the posting of transactions and the preparation of financial statements at the end of each month. The book-keeper handles the preparation and filing of these records. All NHCP financial reports follow a strict accounting format which includes the publicizing of all income and expenses of the programme and a breakdown of all financial transactions.

4.5.5.2 Information about members, contributions, and benefits

Information about NHCP members, contributions, and benefits used are regularly updated by the NHCP management staff through the use of the available documentation. Among these are the registry and membership cards which record particular information such as types of benefits and services used by the member, the cost of the service, balance of premium and benefits, and the expiration date of the member's plan. These records are systematically kept by the NHCP management staff, but computerization of the records and documents, would facilitate faster retrieval and monitoring of information concerning members, contributions and benefits.

4.5.5.3 Management tools

Every month, the Medical Services Department Head and the NHCP book-keeper prepare the NHCP's financial reports, which consolidates the daily recorded transactions of the NHCP and Medical Clinic. The financial reports (which are basically a breakdown of the programme's income and expenses for the month) together with the monthly NHCP summary report, are submitted to the General Manager for approval.

The monthly NHCP reports contain the programme's financial statement for the past month, and also feature information on the number of patients the Medical Clinic has served, the number of persons who have made use of hospitalization and physical examination benefits, and the status of the Health care fund. Included in the monthly reports are updates of news concerning the NHCP (e.g. policy changes, reminders, promotions, etc.). At the end of every fiscal year, the monthly reports are consolidated to form the NHCP annual report which helps in preparing the proposed budget of the Medical Services Department for the following year.

4.5.5.4 Formalizing management procedures

The NHCP uses a variety of formal procedures and documentary materials for its operation and management activities. The first is the NHCP application form which performs two functions: it provides the NHCP management background information on the applicant and it formalizes the insurance provider-user arrangement between Novadeci (which is the principal operator of the NHCP) and the applicant. Official receipts and vouchers are used to make financial transactions of the programme and other documentation such as the membership cards and registry forms facilitate transactions between the management and members.

In the processing of benefits, the NHCP also employs a variety of procedures and documents. Members claiming reimbursements for hospital treatment need to submit a

completed reimbursement application form together with relevant documents for the claims to be considered.

4.5.6 Financial control

Control over finance and claims disbursements is maintained by the Medical Clerk, the Medical Services Department Head, and the General Manager. These three persons are considered to be the “gate keepers” of the NHCP. They regularly screen applicants and members, monitor benefit disbursements, analyzing programme income and expenses. The use of formal management procedures and tools (e.g. preparation of monthly reports, use of waiting periods and referral systems, strict pre-membership requirements and application and reimbursement procedures) help in accomplishing such tasks. The monthly reports (e.g. financial statement and bank reconciliation) represent the most important control mechanism of the programme.

4.5.7 Role distribution

The management and operation of the NHCP can be divided into six different functions:

- Benefits management.
- Membership management and contribution collection.
- Management of relationship with NHCP.
- Accounting and financial management.
- Control.
- Management of relationship with the beneficiaries and targetgroups.

Table 9 summarizes the role distribution of the NHCP.

Table no 9: Real role distribution

	<i>Members</i>	<i>Salaried Staff</i>	<i>Health Care Provider</i>	<i>Technical Assistance</i>	<i>External Health Care Provider</i>	<i>Board of Directors</i>
Benefits management						
Who decides the services covered?	*	*				
Who makes decisions about coverage?	*	*				
Who decides patient referral to a more complex level?			Clinic's doctor			

	<i>Members</i>	<i>Salaried Staff</i>	<i>Health Care Provider</i>	<i>Technical Assistance</i>	<i>External Health Care Provider</i>	<i>Board of Directors</i>
Who processes benefits claims?		*				
Who monitors benefits?		*				
<i>Membership management and contributions collection</i>						
Who receives membership requests?		*				
Who updates the members' register?		*				
Who initiates membership cards?	*					*
Who decides the exclusion of members?	*					*
Who calculates the contribution amount?	*					*
Who decides the contribution amount?		*				
Who collects contributions?		*				
Who carries out contribution recovery?		*				
Who keeps the contribution register?		*				
<i>Accounting and financial management</i>						
Who implements the accounting framework?	*	*				
Who prepares the budget?		*				
Who implements the treasury plan?		*				
Who works out the income and expenditure		*				

	<i>Members</i>	<i>Salaried Staff</i>	<i>Health Care Provider</i>	<i>Technical Assistance</i>	<i>External Health Care Provider</i>	<i>Board of Directors</i>
account?						
Who prepares the balance sheet?		*				
Who calculates the financial ratios?		*				
Who proposes surplus allocation?	*					
Who determines surplus allocation?	*	*				
Who monitors deposits?		*				
Who recovers debts?		*				
Who determines the financial investment?		*				
Who authorizes expenditures?		*				
Who manages the petty cash?	*	*				
Control						
Who controls the petty cash?		*				
Who implements accounting and financial controls?		*				
Who controls the beneficiaries' status?		*				
Who controls contribution payments?		*				
Who controls beneficiaries' rights to benefit?		*				
Who carries out the medical control?	*					
Who prevents fraud?						

	<i>Members</i>	<i>Salaried Staff</i>	<i>Health Care Provider</i>	<i>Technical Assistance</i>	<i>External Health Care Provider</i>	<i>Board of Directors</i>
Who intervenes in embezzlement cases?	*					
<i>Relationship with the beneficiaries and the target group</i>						
Who decides to call the general assembly?	*					
Who organizes the general assembly?		*				
Who designates the officials?	*	*				
Who informs the beneficiaries of services covered?	*	*				
Who organizes information campaigns for the target group?	*	*				
Who organizes prevention and health education activities?	*	*				
Who carries out prevention and health education activities?	*	*				

4.5.8 Equipment and infrastructure

Novadeci's office is in its own six-story building located in Sarmiento corner Buenamar Streets, in Novaliches Proper, Quezon City. The building also houses the Medical Clinic, the pharmacy, the NHCP office, a consumer cooperative store and a number of other offices.

Novadeci also owns various vehicles and communication facilities including telephones, faxes and e-mail, computers, photocopying machines, and video equipment. This equipment is also available for NHCP use.

4.6 Actors in Relation to the Novadeci Health Care Programme

4.6.1 Reinsurance and guarantee funds schemes

The NHCP is a self-help programme utilizing internal funds generated by the cooperative and itself. It is not linked to any external insurance institution or agency, although there are

plans to reinsure the programme with the Philippine Health Insurance Corporation. This, however, has yet to go beyond the planning and discussion stage.

Although the NHCP maintains a Health Care Fund, which is basically the reserve fund of the programme, this should not be considered as a guarantee fund. There is a disclaimer clause in the NHCP policy guidelines which states that in the event of “mass hospitalization”, only the available funds of the NHCP will be disbursed as benefits to members.

4.6.2 Technical assistance

The only technical assistance received by the NHCP has come from the in-house financial staff of the cooperative. Accounting support is provided by the cooperative to keep the books and records of the NHCP in order and one of the accountants of the cooperative is assigned as a part-time book-keeper of the NHCP.

4.6.3 Social movement and social economy organization

Although the cooperative itself is a member of the National Cooperative Council (NATCCO), one of the largest organizations of cooperatives in the Philippines, the NHCP is not affiliated or linked to any other external organizations. The disadvantage of this policy is that the NHCP is limited in what it can realistically offer its members in terms of benefits and services. Linking it with external organizations, especially those with rich resources and experience, can provide valuable inputs for the NHCP.

There are advantages however, in being detached from other organizations in that the NHCP is insulated from external politics, and bureaucracy. Likewise, it can continue at its own pace, without being pressured by outside influences.

4.6.4 Other actors

The NHCP is an informal micro-insurance scheme, and beyond the scope of existing formal social security arrangements. It therefore operates independently of the government’s social security systems.

The NHCP is able to maintain a good rapport with the community through its medical clinic services and monthly medical field trips, and is able to reach out to a wider population.

5. Indicators of the Novadeci Health Care Programme's Operation

5.1 The membership dynamic

Major policy changes, especially those which have increased incentives for programme participation, have had a tremendous effect on membership. For instance, the 1999 policy which abandoned the required pre-membership physical examination enhanced the attraction and accessibility of the NHCP for potential recruits. As a result, from 1998 to 1999, membership increased by 23 per cent from 663 to 817. Similarly, the target penetration rate increased from 11 per cent to 14 per cent during the same period.

However, according to management, the lingering economic contraction brought about by the Asian Financial Crisis reduced members' capacity to contribute in 2000. Thus, many NHCP members failed to renew their NHCP plans for the year, leading to a 3 per cent drop in membership.

The number of NHCP members as of the end of 2000 was only 790, only 14 per cent of the target group. Given that each member had three dependants, the total number of people covered by the NHCP at the time was 3,160. It is hoped that the new policy (effective 2001), which will require Novadeci members to participate in the NHCP, will spur membership growth for the year 2001 and beyond. The goal is to expand the coverage and scope of the programme, and also to enhance its financial standing.

5.2 Service use

The clinic services of the NHCP are the most popular. In 2000, a total of 2,811 members and their dependants used the clinic's services; representing an 89 per cent consumption rate. This includes those who took advantage of the free annual physical check-up, which registered a consumption rate of only 9 per cent.

Hospitalization service, meanwhile, registered only a 3 per cent consumption rate. During the year only 98 persons used the NHCP's hospitalization benefits. However, the cost of providing such benefits to the members and their dependants amounted to over Ph.P.331,000 (US\$6,898) or roughly 73 per cent of the year's total benefit disbursements.

5.3 Financing issues

The surplus income of the NHCP goes into a reserve fund called the Health Care Fund, which has gradually been shrinking in recent years (see Table 10). This is due to low revenue collection related to the low participation rate. Basically, there are too few members to create a sustainable risk-pooling insurance scheme. At the end of 2000, the Health Care Fund contained little over Ph.P.185,000 (US\$3,854) which is barely enough to sustain two months of NHCP operations (equivalent to benefit expenditure for five months).

Contributions collected have repeatedly failed to effectively cover the cost of operations of the NHCP. except for the year 2000 when collections outpaced disbursements and benefits expenditure exceeded contribution income. In 1998 and 1999, for instance, contribution

income represented 91 per cent of expenditure.¹⁹ This is a major weakness of the programme.

Yet, despite the low contribution revenue, the contribution recovery rate shows that active members are prepared and capable of paying their required contributions. In 1999, a total of Ph.P.428,450 (US\$8,926) in contributions was collected from 817 NHCP members. This represents a contribution recovery rate of 107 per cent, which in the following year rose to 112 per cent. This also shows that the services offered by the NHCP, especially its clinic services, are highly valued by the members.

5.4 Members' participation

Novadeci conducts an annual general assembly which is attended by most of the cooperative's members. On this occasion, a feedback and assessment survey is conducted to see how Novadeci members perceive and value the services offered by the cooperative.

6. The Actor's Point of View Vis-a-Vis the Novadeci Health Care Programme

6.1 Evaluation process

The annual general assembly held by the cooperative is the venue where members' opinions and ideas are expressed, and where the management is given the opportunity to obtain a feedback from members concerning the services and activities of the cooperative. During this event in 2000, the management conducted surveys among members as regards their evaluation of the services offered by the cooperative. Among those included in the surveys were the NHCP. The annual surveys were able to get at least 30 per cent of NHCP members as respondents. In the most recent survey, it was found that NHCP members demanded more health services to be included but without a corresponding increase in their annual contributions.

Apart from the annual surveys, a more frequent assessment of the NHCP was completed through an analysis of the programmes financial operations. The Head of the Medical Services Department and the General Manager were responsible for monitoring the financial status of the programme. They did this by producing monthly and annual financial and operation reports, which were then reviewed by the other department heads and Board of Directors.

The analysis of the finances and operations of the NHCP was used to identify trends in membership growth and contributions, and benefits expenditure. These were considered to be the most vital indicators in assessing the soundness of the programme. In 2000, membership dropped by 3 per cent, which indicated a reduction in interest in NHCP membership. But despite the fall in membership, the average monthly collection increased substantially from Ph.P.35,704 (US\$744) in 1999 to Ph.P.44,069 (US\$918) in 2000.

¹⁹ It was only in 2000 that the contribution-expenditure rate was able to surpass the 100 percent mark.

At present, negotiations are on-going with an external accounting firm to conduct an actuarial study of the NHCP. This will be the first time the NHCP will undergo a formal scientific and financial evaluation.

6.2 The management's viewpoint

6.2.1 Insurance system implementation

The management saw two principal factors for the NHCP's relative success:

- Affordable rates.
- Accessibility to the Novadeci clinic.

Apart from being more affordable, the Medical Clinic (which was the NHCP's primary health care provider) was also very accessible to the members. It was located on the second floor of the Novadeci Building, which is found in the heart of Novaliches' business district. Members could easily take a short ride or walk to get to the clinic.

However, Novadeci members were beginning to demand more specific medical and health care needs, which were not covered by the programme or were beyond the limitations and competence of the clinic and its staff. The emerging problem was that the NHCP had no formal arrangements with tertiary hospitals which could provide services not available in the clinic. This has resulted in two solutions to the problem which were instituted by the Novadeci management. One was to increase the NHCP's revenue by requiring new cooperative members to sign-on with the programme. The revenue collected could help the clinic acquire new equipment and hire more doctors. The other solution was to formalize arrangements with tertiary hospitals (negotiations are continuing with the Novaliches General Hospital for a possible working arrangement between the hospital and the NHCP).

6.2.2 Membership dynamic

Despite the fact that most of the members appreciated the free annual physical check-up and free medical consultation offered by the NHCP, many of them felt that the benefits and services offered by the programme were insufficient although Novadeci operated a very good clinic.

In an effort to retain the interest of current members and attract new ones, the management hired medical specialists such as a pediatrician, an internist, and an optometrist. In addition, a delivery room was constructed within the clinic in order to accommodate the growing demand for child-birth services.

In addition, the management increased the budget for promotional activities for the NHCP as part of a strategy to attract new members and create interest in the programme.

6.2.3 Access to health services and relationship with the health care provider

According to the Medical Clerk, there has been no firm evidence that the health condition of the members has improved. Prior to the NHCP, members always had access to medical and health care funds through the emergency loan facility of the cooperative. However, with the commencement of the NHCP, access to such funds became more convenient and affordable and there has been a considerable drop in the use of emergency loans for

medical and health care services. This indicates that the financial situation of the members has improved.

In the near future, the Medical Services Department envisaged more types of medical and health care services to be covered by the NHCP. This would include the hiring of more medical specialists and the formalization of arrangements with a nearby general hospital. This would enhance the accessibility — in terms of geographical location, affordability and availability — of the health care services offered.

Such initiatives, however, depend on the financing capability of the programme and the cooperative in raising revenue. Late payment of contributions was considered a big problem. To solve this, the Medical Services Department plan to hold free medical and health care seminars in 2001 to encourage interest in health care and health care financing.

6.2.4 Contribution payment

In anticipation of the influx of new recruits in 2001, the management has arranged with the cooperative's Credit Services Department to automatically deduct NHCP payments from loans taken out by coop members. The deductions would then be deposited into the Health Care Fund for use by the NHCP.

6.2.5 Determining the contributions and benefits relationship

Although average monthly contributions collected have steadily increased in the past, the level of these are still not enough to fully cover programme costs. Previously, the programme relied heavily on subsidies provided by Novadeci, and the Health Care Fund slowly diminished.

The management did not raise the annual contribution fee but opted instead to make membership into the NHCP compulsory for Novadeci members. It is anticipated that this will generate more revenue.

6.2.6 Insurance risk-management

Initially, NHCP applicants had to undergo a pre-membership physical examination to enable them to join the NHCP. This policy ended in September 1999 and a new policy was begun, which introduced a two-year waiting period for ten specified diseases. This was viewed as necessary to provide enough time for the member's contribution to "age" and to prevent liquidity problems.

The management is considering reinsuring members through an external health insurance provider, possibly the state-led Philippine Health Insurance Corporation. If the plan goes through, the NHCP will not have to shoulder the total cost of health care, and more health care services would be available.

6.2.7 Fraud

The incidence of fraud is very small and in the few instances where it did occur, the cases mostly concerned the falsifying of hospital and pharmacy receipts. These acts of fraud were easily detected because of NHCP's strict screening procedure for evaluating claims. Once fraud was detected, the management's response was immediate: disallowance of benefits claims plus filing of legal cases against the members involved.

6.2.8 Administration and management

Because much of the operations of the cooperative were handled by professional managers, the level and form of activity generated in the Novadeci and NHCP office is very efficient; with responsible and hard-working staff. The employment of professionals however, made the the cost of operations high.

Computerization of the NHCP information system may help reduce the need for more professional people handling the programme. Although the manual system used is satisfactory, the influx of new NHCP members in the year 2001 may necessitate the need to computerize the data base and information system of the NHCP.

More volunteer workers (e.g. college student doing practical work) for the programme may also have reduce the cost of operations. The disadvantage of such a move is that there would be a high turn-over of people involved in the programme. This may create problems for the NHCP in certain aspects of its operations.

6.2.9 Relationship with the State and local authorities

The NHCP has not been linked with any state or local government agency since its inception. However, plans are underway to link the NHCP with the state-led Philippine Health Insurance Corporation. Informal discussions have been held on how to align the systems of the two health insurance providers.

6.2.10 General operation

The NHCP is very much dependent on the financial and logistical support provided by Novadeci and is far from being self-sustaining. However, management expects to be more forthright with its marketing, reaching out to current and new members to explain and sell the NHCP, expanding the services it has to offer to make it more attractive, and holding health education and awareness campaigns to encourage interest in health issues.

6.3 The health provider's point of view

According to the Medical Clerk, there had been no significant change in the health conditions of the members. What has changed, though, is members' accessibility to more affordable health care services, without asking for an emergency loan.

According to the Medical Clerk, there is much to be done in terms of generating interest among Novadeci members to join the NHCP. Although many of the cooperative's members visit the Medical Clinic for treatment, they still need to be sensitized about joining the scheme.

7. Conclusion

7.1 Some observations

7.1.1 An organization that is trusted and respected by its members and the community

Novadeci has been operating in the area since 1976, and has been able to create and maintain a good rapport with its members and the community. More than this, it has earned the respect of the community as an organization with financial expertise and integrity. This is important given that most of its clients come from poor families. It is important for these clients to be assured that their hard-earned money will not be wasted.

The organization is vital since it gives institutional legitimacy to the health care scheme which assures continuity and some degree of permanence to the programmes. They also provide the leaders, the behavioural norms and expectations, and organizational structure required for the operation of a credible social security programme.

7.1.2 An operating fund-management system and network

Much of the work involves fund management, which is why organizations that have this background such as Novadeci are more likely to succeed with their social security programmes. They already have the system and network set-up, which makes the task of collecting and disbursing funds easy. The problems associated with setting up a financial system is greatly reduced, thereby allowing more time and energy to be focused on improving the design and implementation of the micro-insurance scheme.

7.1.3 The organization offers a more affordable and responsive alternative

The organization must not only offer something new, it must offer something that is more affordable and responsive. Traditional and commercial social security schemes continue to prosper and compete for social security benefits offered by cooperatives and other organizations. This organization must be able to provide a better alternative to such schemes.

7.1.4 Dependence on subsidies reduce the incentive to innovate

It has taken the management a long time to make radical changes in the policies and design of the NHCP. For many years, the NHCP depended on the generosity of Novadeci to provide badly needed funds and logistical support. Although changes have been introduced into the programme to help make it more financially viable, they have fallen short of their expected impact. The subsidies obtained from Novadeci reduced the incentive for management to make innovative and radical changes in the design and policies of the NHCP to improve it financially.

The NHCP began with the use of subsidies coming from Novadeci which were deemed necessary to fund the construction of badly needed infrastructure and the purchase of vital

medical equipment. This has become a problem however because it continues to operate while still depending on Novadeci subsidies.

Present plans to make participation in the NHCP compulsory for Novadeci members and to link the NHCP with external insurance providers are some of the steps being taken towards finding alternative solutions to the funding problem of NHCP.

7.2. Recommendations

7.2.1 Importance of social marketing

The concept and the mechanics of health micro-insurance schemes are a relatively new subject for most people including the poor working in the informal sector. Thus, it is imperative that members first realize the importance of health insurance, and how it can directly and indirectly help raise their standard of living. It is therefore recommended that Novadeci assess the reliability and relevance of its marketing and feedback efforts, and find other ways to further educate members on the rewards and responsibilities that come with health insurance programmes.

The objective should be to align what the actual and specific needs of the clients are, with what the NHCP can offer.

7.2.2 Necessity of actuarial evaluation

Social marketing, however, is not the only problem faced by the NHCP. Because of the lack of any reliable actuarial valuation of the programme, it is possible that the NHCP may not be financially viable or sustainable. Decisions on financial matters, specifically social insurance, must be based on precise and concrete risk assessment procedures. Therefore, the use of formal actuarial valuation methods is highly recommended.

7.2.3 Increase in volume of members

It is vital that the membership of the NHCP be increased to a much higher level, otherwise, the programme may soon find itself in deep financial crisis. The essence of any risk-pooling scheme lies in its ability to attract and mobilize a large volume of people who have the ability and willingness to invest their resources for a common purpose. In the case of the NHCP, it has failed to gain the interest of members of the cooperative, primarily due to unsatisfactory social marketing.

7.3 Final remarks

Health micro-insurance schemes managed by community based organizations are beginning to make their presence felt in the Philippines. Yet, there is still a lack of information on how these schemes can complement the more formal health insurance systems in the country. It is hoped that through more in-depth research, such information will eventually enable both community based organizations and the Government to find ways of improving access to health care for poor and informal sector workers.

The experience of the NHCP illustrates that self-help and informal health financing schemes are feasible, and represent viable ways of providing valuable health services to the poor. The NHCP described in this study has provided one model of a health micro-insurance

scheme and, in addition, has been able to provide observers with a glimpse of areas of concern and opportunities.

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