



PISO

NEWS



Issue No. 6

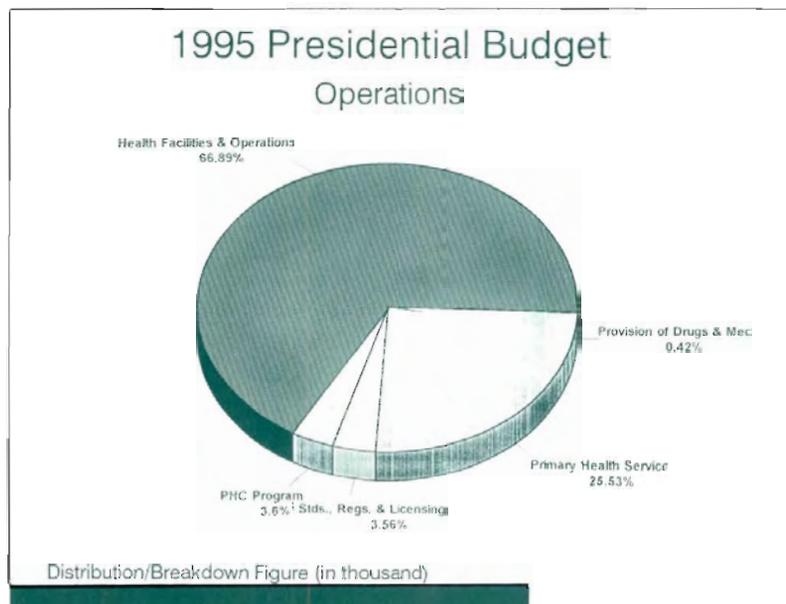
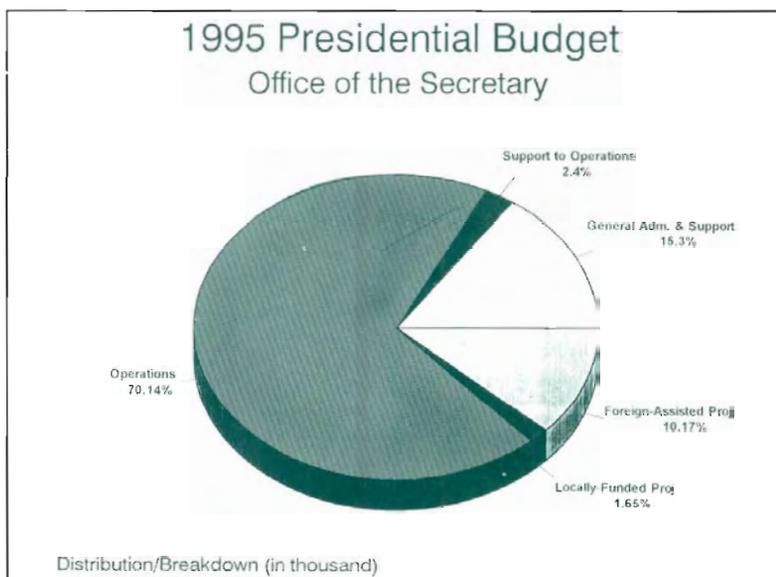
November 1994

DOH 1995 Budget Goes to Senate

By Bernadette Cuevas, DLLO

The DOH 1995 Budget was passed on second reading last October 5 at the Lower House. Senate hearing on the budget begun on October 21. It is in the House of Representatives where all appropriations emanate. As soon as the House approves the budget on third reading, it is transmitted to the Senate where the Senate Committee on Finance starts the official hearings to deliberate on the DOH budget.

The P8B+ 1995 budget of the DOH is geared towards redirecting its roles and strengthening its programs and activities leading towards the realization of its vision of Health for All by the year 2000 and Health in the Hands of the People by 2020 through the provision of equitable and accessible quality of health care. The figures and numbers reflected in the budget should then be interpreted in terms of how it will accomplish the policy directions of the DOH.



The bulk of the DOH budget goes to operations or for expenses for maintaining public health service; PHC programs; health facilities and operations; provisions for drugs and medicines; and standards, regulations and licensing, for a total amount of P5,877,361 billion. P1,305,964 billion will go to general administration and support. P205,743 million is earmarked to support operations. The rest of the budget is appropriated to maintain locally-funded and foreign-assisted projects.

In case Congress fails to approve and/or the President fails to sign the General Appropriations Bill before January 1 of the succeeding Fiscal Year, the preceding year's budget as mandated by the previous GAA shall be in effect, until such time that the pending GAB is enacted into law.



PISO News is a bi-monthly publication of the Health Finance Development Project (HFDP) which is funded by the U.S. Agency for International Development (USAID Manila), Project No. 492-0446.

PISO News seeks to provide a forum for substantive dialogue, and as a source of information on the relevant health financing issues confronting the Philippines, including the development of the health care market, through close cooperation with the private sector, in order to improve health service quality, equity, coverage, and efficiency.

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New Assignments

Doug Palmer Is Newest Addition To HFDP

Douglas Wylie Palmer is the new head of the USAID Health Division with responsibility for USAID contributions to projects in Health Financing Development, Child Survival, and AIDS Surveillance and Education. He takes over Trish Moser's work with the HFDP.

Douglas brings to HFDP over twenty-two years of experience as Foreign Service Officer. In this capacity, he designed, administered and evaluated public health, population and education development projects in six countries. Before coming to the Philippines, he was posted in Pakistan directing a multi-

million dollar cross-border health program for war-affected Afghans, with oversight and management responsibility for a \$60 million Cooperative Agreement (with Management Sciences for Health) and over \$5 million in annual grants to American, Afghan, and European Private Volunteer Organizations.

This is not Douglas' first stint in the Philippines. Back in the late 60's (1965-68), he was a Peace Corps Science teacher (Botany, Biology and General Science) at the Mindanao State University in the southern Philippines city of Marawi. He also taught science courses at St. Mary's



Douglas Wylie Palmer, USAID

Junior College, in Sagada, Mountain Province. He designed and conducted an ethnomedical survey of a mountain tribe during his stay in northern Philippines.

Robles appointed HFDP Director for Administration



Cecille E. Robles

Cecille E. Robles is the new Director for Administration of the HFDP/Management Sciences for Health (MSH). Cecille was previously the HFDP Contracts Manager. She took over the job of running the MSH/HFDP administrative affairs previously handled by Charles C. Stover, who assumed the overall HFDP

project directorship in Boston, Massachusetts.

Cecille brings with her years of experience in the fields of finance, business and administrative management from local and overseas assignments. She has worked with international funding agencies, NGOs and business firms, among them USAID and the Litonjua Group.

Fernandez assumed UPecon-HPDP Deputy Manager Post

The UPecon-Health Policy Development Program (HPDP) has recently appointed Ma. Theresa M. Fernandez as Deputy Project Manager. In her new position, Ms. Fernandez will assist the Project Manager in the overall management of the USAID-financed project under the HPDP.

The former HPDP project officer coordinated the devolution and public resource management activities of the Program. Prior to joining the HFDP, she was the Health, Nutrition and Family Planning Division Chief of the National Economic Development Authority's (NEDA) Social Development Staff. She has

been a specialist on health and nutrition for 14 years.

Ms. Fernandez holds a Master's degree in Community Nutrition from the University of Queensland and a Bachelor's degree in Food Service Administration from the University of Santo Tomas. She is married to Antonio C. Fernandez, Jr. and has two children.

NHA Estimates 1991 Total Health Spending in the Philippines

By Victoria Quimbo, HPDP

The Department of Health (DOH) financed about 30 per cent of the total 23.5 billion pesos of health care expenditures in 1991

The Philippines spent 23.5 billion or 1.84 per cent of Gross National Product (GNP) on health care goods and services in 1991, according to preliminary estimates made by a team of economists based at the University of the Philippines. It ranks among the lowest in the ASEAN region in terms of health spending per person.

The estimates also show the bulk of these spending (86%) were on personal health care, 10 per cent on public health programs and 5 per cent on administra-

"In other developing countries, private health maintenance organizations and social health insurance take care of personal health care expenses. In this way, the government can spend more on programs that would benefit the community such as preventive health care," says Health Undersecretary Juan Nafias.

With the devolution, it is expected that a substantial budget of the DOH will augment local government spending.

Government spending on health including LGUs

The local governments financed about 4 per cent of the 23.5 billion total spending on health in 1991, mostly on public health programs, preliminary estimates show.

The estimates further show that local government spending on personal health care is 1.4 per cent of the total health spending.

(Turn to page 4)

Uses of Funds	Sources of Funds						Total By Use of Funds
	Government		Social Insurance		Private		
	National	Local	Medicare	Employment Compensation	Out-of-Pocket	Private Insurance and HMOs	
Personal Health Care	6073200	325277	1731620	192028	11291697	549754	20163576
Community Health Care	181327	648435	-	-	-	-	829762
Mixed Personal and Community Health Care	1353629	19464	-	-	-	-	1373093
Program Administration and Net Cost of Financial Intermediation	327153	-	97820	19260	-	703738	1147971
Total, By Source of Funds	7935309	993176	1829440	211288	11291697	1253492	23514402

Note: Date on enterprise-based and community-based financing as well as on philanthropy are not yet available.
Source: NHA Team, 1993.

tive costs. Private individuals financed about half of total personal health care spending from out-of-pocket while Medicare financed some 8 per cent. While the national government financed some 8.0 billion or 34 per cent, it financed 26 per cent of personal health care and 1.5 million or 6.3 per cent of public health.

The same preliminary estimates also indicate that the Department of Health (DOH) financed about 30 per cent of the total 23.5 billion pesos of health care expenditures in 1991. Twenty-three per cent went to personal health care while 6.5% went to public health programs. The rest were spent on health administrative costs (1.2%).

Uses of Funds	Government					
	National			Local		
	DOH	%	Non-DOH	%		%
Personal Health Care	5290875	22.5	782325	3.33	325277	1.38
Community Health Care	181327	0.77	-	-	648435	2.76
Mixed Personal and Community Health Care	1347156	5.73	6473	0.03	19464	0.08
Program Administration and Net Cost of Financial Intermediation	286194	1.22	40959	0.17	-	-
Total, By Source of Funds	7105552	30.22	829757	3.53	993176	4.22

Note: Date on enterprise-based and community-based financing as well as on philanthropy are not yet available.
Source: NHA Team, 1993.

Senate Approves NHI Bill on 2nd Reading

The Senate approved on second reading Senate Bill 1738, otherwise known as the National Health Insurance Act of 1994.

The bill which seeks to provide universal health coverage to all Filipinos at affordable cost was certified for immediate enactment by President Fidel V. Ramos.

Under the NHIP,

indigents will receive medical benefit on par with covered members of SSS and GSIS. Persons with no visible means of income or whose incomes are insufficient for basic family subsistence are defined in the bill as "indigents."

Under the bill, the monthly contribution of indigents will be shouldered by the national and local governments in the case of first,

second, and third class municipalities.

If the bill is finally passed, the envisioned program will take effect within a 15 year phase-in period. Funding for the NHI will come from national government sources and the DOH.

A National Health Insurance Corporation (NHIC) will be established to gov-

ern and manage the program. It will be complemented on local provincial levels by the Local Health Insurance Offices or LHIOs which will take charge of locally administering the program and identifying the indigents deserving of government assistance. The NHIC will take over from the PMCC, the management of the overall national insurance program. (MAB)

(Continued from page 3)

NHA Estimates 1991 Total Health Spending

Personal health care benefits individuals while public health programs include community health care and mixed personal and health care services.

In contrast, the national government spent more for personal health care services (26%) and 6.5 per cent for

public health programs such as preventive health care services.

The year 1991 was the last year before health functions of the national government were devolved to local governments.

It is expected that with the devolution in place, local

government spending for personal health care would increase and be an added strain on its budget unless other financing mechanisms to support this are introduced. Several provinces such as Bukidnon, Guimaras, Tarlac, and Bulacan have introduced such mechanisms.

These preliminary estimates were made by a team of health economists and researchers connected with the Health Policy Development Program (HPDP) of the UPecon Foundation at the University

of the Philippines.

The data is part of the National Health Accounts (NHA), which is being estimated for the first time in the Philippines. The NHA shows the different sources of financing for health care spending and the expenditures for the different types of health care goods and services. The sources of financing include the government, social insurance (Medicare), households, private insurance, community financing, etc.

Uses of Funds	Sources of Funds						Total By Use of Funds
	Government		Social Insurance		Private		
	National	Local	Medicare	Employment Compensation	Out-of-Pocket	Private Insurance and HMOs	
Personal Health Care	25.83	1.38	7.36	0.82	48.02	2.34	85.75
Community Health Care	0.77	2.76	-	-	-	-	3.53
Mixed Personal and Community Health Care	5.76	0.08	-	-	-	-	5.84
Program Administration and Net Cost of Financial Intermedian	1.4	-	0.42	0.08	-	2.99	4.89
Total, By Source of Funds	33.76	4.22	7.78	0.9	48.02	5.33	100

Note: Data on enterprise-based and community-based financing as well as on philanthropy are not yet available. Source: NHA Team, 1993.

September 26-28 were red letter days at the DOH as it looked back on what the department has accomplished in terms of service to the people and the achievement of national goals, while reviewing at the same time how it has scored in its commitment to present-day health concerns. On its 96th year, the DOH has also set more productive goals for the future.

“Kahapon, Ngayon at Bukas,” aptly describes the various activities marking the celebration which was opened with a Holy Mass and the blessing of the historical marker in front of the OSEC Building in the sprawling DOH San Lazaro Compound. On this

spread, PISO News shares with our readers choice vignettes in pictures taken during the 3-day celebration. Credit for these pictures goes to Rody O. Pisueno and Romy F. Caparas, official photographers of the DOH.

Kahapon, Ngayon at Bukas

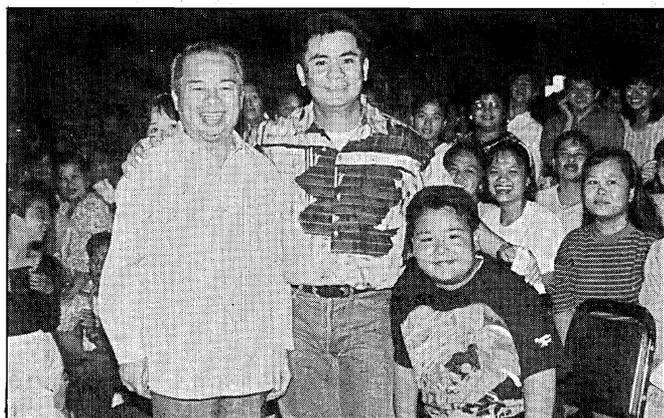
DOH Marks 96 years of Service



The blessing and unveiling of the DOH historical marker with Secretary Juan Flavio Velasco, officials of the DOH and guests.



Alma Moreno in person with Dr. Gerry Bayugo as emcees of a DOH-produced variety show.



The Secretary with singer-actor Ogie Alcasid and young comedian Vandolf at the variety show.



Usec Manuel Roxas cuts the ribbon to open the exhibits.

National Health Insurance Program: Alternative Benefit Packages and Some Estimates of Costs

The Health Finance Development Project (HFDP) of the DOH initiated two studies to quantify the financial resources that will be required to set-up and operationalize a comprehensive national health insurance program in anticipation of the passage of the pending National Health Insurance Bill in both Houses of Congress. These studies entitled "National Health Insurance Program (NHIP): Alternative Benefit Packages and Some Estimates of Costs" by Dinah N. Patao and Rhais M. Gamboa, both of HFDP and "National Health Insurance System Cost Simulation Model" developed by Orville Solon, Joseph J. Capuno, Benedict Quito and Elizabeth Edillon of the HFDP Health Policy Development Program could be useful for both Houses of Congress in estimating overall NHIP costs. This abstract dwells only on the paper by Dinah N. Patao and Rhais M. Gamboa.

The set-up cost estimates in this paper was based on a previous study "How Much Will It Cost to Set-Up and Administer a National Health Insurance Program," which was also done by the same authors. No new data allow the refinement of the set-up cost estimates as previously done, and thus no attempt was made to come up with new estimates. Instead, the authors focused only on the estimation of benefit packages that may be offered under the NHIP.

The paper of Patao and Gamboa aims to (a) estimate the benefit costs of alternative benefit packages that may be provided by the NHIP; (b) provide some indications of administrative cost in running the program; (c) estimate NHIP premium revenues assuming a SSS-Medicare Program I-like premium structure; (d) estimate premium subsidy requirements for the

indigent population; (e) determine the incremental funding requirements for the NHIP given the assumed structure of costs and revenues; and (f) identify some of the implications on policy of the resulting NHIP funding requirements.

HFDP

Abstracts

Study

The authors categorized NHIP costs into (a) benefit payments; (b) recurrent administrative costs; and (c) organizational set-up costs. The authors likewise identified three NHIP sources of revenues. These are (a) premium collections; (b) interest income; and (c) other income such as donations and other fees.

NHIP Costs. Benefit payments are estimated in this paper assuming various combinations of NHIP inpatient and outpatient packages. Two alternative inpatient packages were used in the costing: the current Medicare Program I package, and the inpatient component of the health package proposed to be provided by the Tarlac Health Insurance Project (THIP) which has a higher average value of benefits per confinement than the Medicare Program I package. Inpatient services included in these packages are (a) room and board; (b) drugs and medicine; (c) laboratory and other diagnostics; (d) professional/surgeon fees; (e) operating room fees; and (f) surgical family planning procedures. The outpatient packages, Packages A, B, and C, are the options developed in a Health Finance Development

By Dinah N. Patao and Rhais M. Gamboa. (HFDP Working Paper, October 1994)

Project (HFDP) study titled "Outpatient Package Under Fee-for-Service and Capitation", which are currently being proposed to be provided on a pilot basis under Medicare Program I. The outpatient services included are various combinations of (a) primary consultation; (b) specialist consultation; (c) diagnostic procedures; and (d) minor suturing.

revenues are estimated, assuming a SSS-Medicare Program I-like premium structure and the family as the membership and premium assessment unit.

The paper estimates that at full coverage, the expected total premium collection is about P11 billion. This is a conservative estimate since the computation did not take into account the possibility that there are more than one gainfully-employed or Medicare member in one family. Interest and other income are not estimated in the paper.

Premium Subsidy for the Indigent. The pending bills in both Houses of Congress have specific provisions for the government, both national and local, to provide premium subsidy for the indigent, the determination of which is to be made through a "means test." The paper estimated that the total premium subsidy requirements at universal coverage is about P4.170 billion based on the assumption that 49 percent of the total household population which is below the poverty threshold is granted premium subsidy.

Incremental Funding Requirements refer to additional funding requirements.

Assuming Medicare Program I-like benefits and premium structure, are estimated as the sum of the following: (a) the difference between premium collections and expected benefit payments; (b) the cost of administering the program; (c) the premium subsidy for the indigent; and (d) set-up costs, which is the total organizational set-up cost of P527.724 million spread equally over a 7-year period, i.e., 1994 - 2000.

During the initial year of NHIP implementation, the additional funding requirement is about P2.022 billion. This grows to about 10 billion at universal coverage.

Some Implications on Policy

Funding of this deficit may come from (a) internal

(Turn to Page 7)

The Private Medical Sector in the Philippines

The study assesses the current state of the private sector; develops an understanding of the main constraints on the sector's expansion; and recommends changes in public policy to strengthen it.

The study develops a conceptual framework for public-private interactions in the health sector that distinguishes between the demand and supply sides of the market. Several hypotheses emerge from the framework. These are:

- Governments affect the private sector on the demand side of its market environment, via financing policies, requirements for employment-based financing of medical care, and competition from public sector services.

- Government regulations, taxes, or subsidies on inputs, such as duties on importation of materials, transportation and communication infrastructures, and the training and licensing of personnel, affect the private sector through input markets.

- The economic and medical organization of the institutions delivering medical services is a response to the environment on the demand and supply sides of the market and is a determinant of their performance in delivering medical care.

Among the findings of the study are:

1. *Availability and distribution of the private sector/Structure and Performance.* Private medical services comprise a substantial portion of the Philippine health care market. The private hospital sector is dominated by small primary operations that are widely dispersed across

By Charles C. Griffin, Bienvenido Alano, Maricar Ginson-Bautista and Rhais M. Gamboa. (HFDP Monograph No. 4, April 1994)

the country, with only eleven percent (11%) of them located in Metro Manila.

HFDP Abstracts

Study

The stock of health care personnel appears adequate and latest 1980 estimates show that professional personnel are found mostly in the private sector and are widely dispersed groups, and the number of dentists are the fewest and mostly concentrated in major cities.

Over the last decade, the public sector has overtaken the private sector as the number of government hospitals and beds has expanded while the number of private beds has contracted. Private sector development has lagged behind in improving the quality of care and the mix of services delivered. With devolution, the lower level public hospitals will take on many characteristics of its private sector counterpart and will be exposed to the same incentives created by Medicare and fee-for-service financing that have molded the private system.

2. *Environment of the private sector-demand side.* The government most directly affects the private sector through competition from government services for paying patients and through the Medicare systems. Government hospitals tend to be located in the same cities and towns as private hospitals and a substantial portion of high income households use

subsidized public facilities. Except for the purchase of drugs, the public sector has done little contracting for services from the private sector such as management, laboratory and training.

3. *Environment of the Private sector-Supply Side.* Bottlenecks created by the government on the supply side are not crucial impediments to the development of the private sector. Government interventions from the least to the most problematic are 1) duties and import restrictions on donated essential machinery and equipment; 2) training and licensing procedures are affected by the

lack of coordination between the DOH and the Medicare system and the required payment of multiple fees; 3) taxation of private health facilities as if they were regular businesses; 4) lack of infrastructure, especially in rural areas, which limits the size of the market on which medical facilities can draw and increases the cost of operating hospitals outside major cities; 5) lack of credit availability so hospitals are undercapitalized and close to financial failure.

The study recommends the following:

1. Changes in financing for end user through more effective and widely available insurance coverage can have a tremendous impact on the mix and quality of services available in the private sector and organization and structure of the industry;

2. The government can make positive - as opposed to strict regulatory - contributions to improving the quality of care from the private sector;

3. Some changes on the supply side - taxes and regulations - could improve the environment of the private sector but would probably make much more marginal contribution than action in the other two areas. (V. Quimbo)

Alternative Benefit Packages ..

(Continued from Page 6)

sources such as investment income which is not considered here, and/or additional premium collections that may be generated by adjusting the current Medicare Program 1 salary ceiling of 3000 per month and/or the current premium rate of 2.5 percent of salary credit to more reasonable levels; and (b) external sources such as government

subsidy and donations from other entities.

The social burden of premium subsidy requirements for the indigent may also be brought to more manageable levels by (a) adopting a more restrictive definition of the indigent, possibly focussing initially on the "real paupers" and expanding to other groups as the financial resources

available to the program may warrant; and (b) premium cost sharing between the government, national and local, and the gainfully employed beneficiaries according to their capacity to pay.

Note: "National Health Insurance Program: Alternative Benefit Packages and Some Estimates of Costs" is available on request, pick-up basis from the HFDP Makati, the address of which is provided in the PISO staff box.

NHI CORE GROUP VISITS BHIP, ILIGAN HEALTH INSURANCE PROJECTS

The Department of Health Core Group on National Health Insurance (NHI) flew to Northern Mindanao recently to look into the progress and gain insights from the experiences of the Bukidnon Health Insurance Project (BHIP) in Bukidnon and the P2.00-a-Day Hospitalization Plan of the Sacred Heart Hospital in Iligan City. The latter is an awardee of the GTZ-sponsored Health and Management Information Systems (HAMIS) Contest.

The visiting team, composed of representatives from the DOH, the Philippine Medical Care Commission (PMCC), the Local Government Assistance and Monitoring Service (LGAMS), the UP-HPDP and the US AID, was led by Dr. Mariquita Mantala of the DOH Health Policy Development Staff.

The group attended a BHIP Information Caravan in Lantapan town, discussed operational concerns with the BHIP Advisory Council and drew inspirational notes from the award-winning project.

The group was informed that BHIP has registered some 5,349 enrollees, achieving about 53.49% of the 10,000 enrollees targeted for 1994. About 322 trained health counsellors are now fielded in barangays provincewide. Health care providers, totalling 104 physicians, 72 hospitals and clinics and 45 dentists were accredited and are now dispensing services to the members. Some P677,518.45 in premium contributions have been collected.

Meanwhile, a number of operational concerns were tackled at the BHIP Advisory Council meeting. These

include the (1) implementation of an intensive marketing training course that will enable health counselors to market the program more effectively and (2) review of the provider payment scheme.

Another concern raised was the inadequacy of the current annual premium of P420 per member. On this matter, the group members proposed a review of the project's previous actuarial assumptions which formed the basis for the premium and benefit costing.

Other needs underscored were LGU-to-LGU partnerships. The involvement of Northern Mindanao Regional and Training Hospital in Cagayan de Oro City as a provider of residents north of the province will be sought through the Regional Health Office.

The core group viewed with interest the structure and benefit package of the low-cost hospitalization plan of Sacred Heart Hospital for SSS and GSIS members.

The members avail of free medical consultations, prenatal services, medicines and minor dressings for outpatient services, and free pay ward accommodations up to P130 per day, medicines in excess of Medicare limits, lab procedures, consultant referrals, deliveries, and surgical operations. Member-families under the plan now number 2,230 and their dependents, 6,014. (MAB)



The DOH-NHI Core Group members take a breather after a hectic exposure tour of the Bukidnon Health Insurance Project (BHIP) and the Iligan hospital-based health insurance program.

Pilot Management Training Program on Decentralized Health System

A pilot management training program in managing health services under a decentralized setup was held from September 5-21 at the University of the Philippines College of Public Administration (UPCPA).

Some 35 participants composed of local government officials, staffs and implementors, and Department of Health Regional Field Office units staff attended the three-week course. The Center for Policy and Administrative Development (CPAD) of the UPCA prepared the curriculum and conducted the pilot program.

The training program was divided into four modules: Module 1—Local Resource Generation for Devolved Public Health and Facilities; Module 2—Processes and Strategies for

Effective Local Management of Decentralized Health System; Module 3—Hospital Facilities as Management Units; and Module 4—Assessing Quality Health Care for Public Health and Hospitals. The training course employs a combination of lecture-discussion, case analysis, and workshop/panel work. The resource persons are health practitioners from both national and local government and non-government organizations and the academe.

The DOH Local Government Assistance and Monitoring Service (LGAMS) and the UPecon-Health Policy Development Program sponsored the training program with funding from the Health Finance Development Project. (VQ)



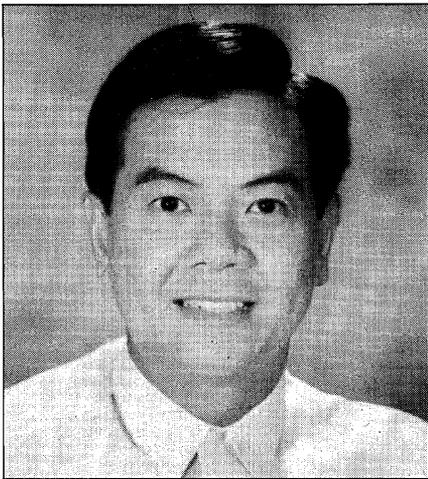
PISO

NEWS



Issue No. 7

February 1995



DOH Acting Secretary Jaime Galvez Tan

Dr. Jaime Galvez Tan is new Health Secretary

Dr. Jaime Galvez Tan is the new Secretary of Health, in an acting capacity. He succeeds Dr. Juan Flavier who is a senatorial aspirant in this year's May election.

The new Secretary is known as JGT or simply "Jimmy." He served as Dr. Flavier's Undersecretary and Chief of Staff for two and a half years. At 46, he is the youngest health secretary.

He was handpicked by Dr. Flavier to serve as his right hand man. He was also the Health Finance Development Project (HFDP), Project Director. Prior to his stint at the DOH, JGT was the "bright boy of Unicef." Long before the idea of "Doctors to the Barrios" was conceived, JGT opted to work among the poorest of the poor in the hardship posts in Mindanao, the Visayas - particularly Negros, and the Cordillera.

(Complete story on page 4)

1995 National Health Insurance Act Signed into Law

Manila - Pinoys from all walks of life have cause to rejoice in the signing into law of the National Health Insurance Act of 1995 by President Fidel V. Ramos in ceremonies at Malacanang last February 14.

The event marks the start of the National Health Insurance Program (NHIP) conceived along the lines of what Acting DOH Secretary Jaime Galvez Tan calls "Piso-Piso, Araw-Araw Paluwagang Pangkalusugan" or national savings system which will benefit all Filipinos regardless of income class, including indigents. This means that Filipinos, through their premium contributions, take active part in the pooling of a common fund for their own health care, to which are added the equity contribution of employers, and the subsidy of national and local governments for indigents.

NHIP is universal and compulsory, and will provide for the coverage of all citizens of the country over a phased 15-year period. It will cover persons eligible to avail of benefits under Medicare Program I for formal wage and salary earners, Medicare Program II for the informal agricultural and self-employed sectors, private insurance plans and those not covered by any of these programs.

Under NHIP, Filipinos will eventually be able to enjoy a more expanded benefit package than that offered by Medicare which used to cover only inpatient hospitalization expenses. NHIP benefits include provisions for outpatient consultation services and diagnostics under a minimum and uniform package. Meanwhile, in the initial implementation of the law, continuity of benefits for those currently enrolled in Medicare will be ensured.

At the same time, the act creates the Philippine National Health Insurance Corporation (PHIC) that will manage the program. It replaces the Philippine Medical Care Commission (PMCC) which made Medicare program policies for SSS and GSIS to implement. Health insurance programs initiated by LGUs, community-based organizations, cooperatives, and other insurance groups will be accredited by the PHIC.

(Complete story on page 4)

THE "NEW" MANCOM



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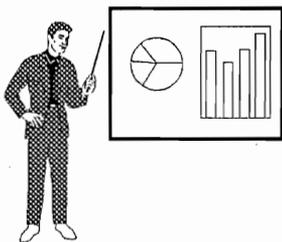
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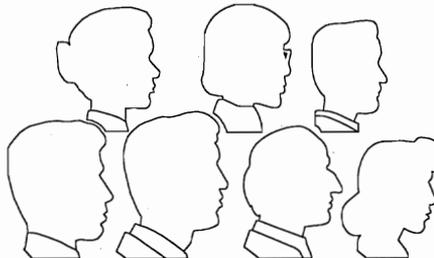
An effective policy process is of paramount importance to the continued development of the health sector. As the leading player in this sector, the DOH requires effective mechanisms for initiating policy recommendations which may eventually be promulgated as departmental, executive or legislative policy.

The DOH Management Committee (MANCOM) provides the venue for the review and deliberation of health policy issues requiring departmental, legislative, executive or judicial actions. To strengthen this, Administrative Order No. 40 s. of 1994 defines the operational guidelines of the MANCOM as the decision-making body in the DOH. The AO was signed last December 22, 1994.



The MANCOM was tasked to make decisions on organizational and operational issues that cut across offices and therefore are outside the authority of the Undersecretary or the Assistant Secretary. It is also the function of the body to decide on the appropriate policy action on health issues.

As part of this changes, the composition of the MANCOM was likewise revised. The Secretary of Health



remains as the Chairperson. The membership to the body will be on a permanent, temporary, or at-large basis. The permanent members are assigned on a continuing basis while temporary members are assigned on rotation every six months.

The permanent members of the MANCOM are the Undersecretaries, the Assistant Secretaries, Directors of the DOH Integrated Regional Field Offices (DIRFOS), a representative of a Metro Manila hospital and the Service Directors or Program Managers of the Office of Legal Affairs (OLA), Hospital Operations Management Services (HOMS), Internal Planning Service (IPS), Management Advisory Service (MAS), Department Legislative Liaison Office (DLLO), the Local Government Assistance Monitoring Service (LGAMS) and the Bureau of Food and Drugs.



To provide an opportunity for the other Directors, Program Managers and Hospital Chiefs to sit in the MANCOM, slots for five tempo-

rory or at-large members are provided. The rotating members shall serve for a period of six months which can be extended by the Secretary of Health upon the end of their term. Likewise, the Secretary may invite up to five consultants to serve as MANCOM advisers. Like the

temporary members, they will serve for six months but the invitation can be extended at the discretion of the Secretary.

The Health Policy Development Staff (HPDS) serves as the Secretariat to the MANCOM and is tasked to consolidate all the health policy issues that have been re-



quested by the different Offices, Services or Programs for inclusion in the agenda. The HPDS shall also prepare the minutes of the meeting and materials for discussion in coordination with the offices concerned. The head of the HPDS shall serve as the Secretary to the MANCOM. It is currently finalizing the MANCOM Manual on Systems and Procedures.

With this changes, it is expected that the MANCOM will truly be a forum that will provide the opportunity for regular and transparent debate, discussion and decision-making in the Department of Health. **L. Laureta**

Ilocos Regional Hospital and Rizal Medical Center Undertake Revenue Enhancement Projects

Ilocos Regional Hospital (IRH) in La Union province and Rizal Medical Center (RMC) in Pasig have set onstream revenue enhancement projects to enable them to earn and retain income from inpatient and outpatient health services delivered at the hospitals.

Revenue enhancement for government hospitals retained under the Department of Health is the subject of a study undertaken by Joaquin Cunanan & Co. for the Health Finance Development Project of the DOH. The two hospitals were designated as pilot sites to test-run the various schemes designed for them by the study.

The study is considered significant because traditionally, public hospitals are viewed as free care institutions required to treat everyone. They are prohibited by law to use income derived from any source for its own use. Revenue enhancement and retention at the hospital level, will provide public hospitals with funds needed to cover shortfalls, as well as support the upgrading and maintenance of vital equipment and facilities.

The study recommended such schemes as service pricing, patient billing, and payment collection. New methods of income generation were also introduced. The study on the other hand, reviewed the rules of agencies that regulate public hospitals like the DOH, the Commission on Audit, the Department of Finance, and the Department of Budget and Management, for feasible changes in existing laws.

The study is now in its third phase. The first phase analysed the current regulatory framework and internal financial systems. The sec-

ond phase covered the repricing of services and supplies to conform with actual costs and market conditions, the determination of the optimal mix of pay and free beds, the adoption of "pay first before service" policy, and the establishment of an efficient patient screening system to enforce the latter. The third phase is the pilot implementation phase.

IRH started to implement its revenue operating system in July, 1994 through the creation of committees on pricing, billing/collection, and public information. The hospital started with the pricing of ten top procedures for each of its departments, and the enforcement of a fixed consultation fee of P10.00 for outpatients and P20.00 for emergency patients. According to consultant reports, IRH has, in its demo phase, managed to chalk up about P258,000 in net income over previous levels as a direct result of the new schemes.

Dr. Juanito Rubio, Director of Ilocos Regional Hospital, says of the revenue enhancement program for DOH retained hospitals: "It is an effective way of teaching Filipinos that service always requires something in exchange."

RMC has concluded its information drive for its internal staff and external audiences, and has set its prices based on rates recommended by DOH.

IRH's pricing model was developed based on the full cost of direct materials, direct labor, overhead and administrative expense. The basis for the costing mechanism are latest purchase prices, latest average salaries of medical, nursing, diagnostic and administrative personnel, average consumption of drugs/



Ilocano style "management innovation" at the IRH shows a watcher assisted by the hospital Social Worker at the dietary section for pricing of a bundle of vegetables. The dietician will receive them and will sign the MSS logbook. Vegetables (raised by the patient's family) is accepted in lieu of cash.

supplies for the past six months plus equipment depreciation rates, and administrative expense including office supplies and space utilization.

"At Rizal Medical Center, we see to it that in the implementation of the revenue enhancement program, there is equity in health care. This means that our indigent patients get the same quality of treatment as our pay patients," said RMC Director Dr. Romeo Cruz.

Both IRH and RMC have set their prices according to patients' ability to pay. Additionally, IRH is seeking closer coordination with partner hospitals, LGUs and the Department of Social Welfare and

Development in the accurate identification of indigents.

The other recommendations are: establishment of a billing mechanism wherein agencies endorsing indigents are billed for services rendered these patients, conduct of a sustained IEC campaign to plug the benefits of fee charges to patients by way of improved hospital services, requirement of partial downpayments from pay patients, use of charge slips, and the implementation of the income retention scheme.

If the results of the revenue enhancement programs in the hospitals will be favorable, the systems may be replicated in retained hospitals nationwide. **MABarcelona**

EGYPTIAN DOCTORS TOUR PHILIPPINE HOSPITALS

A team of doctors from Egypt visited the country from December 7-17, 1994 and toured government hospitals to observe and learn from their operation and management systems.

The team consisted of Dr. Sameh Saleeb, Dr. Mohammed Aly Edrees, Dr. Mohammed Abdul Aziz Mustafa, and Dr. Samir Shatir. They were accompanied by USAID representative Richard Ainsworth.

The observation tour was undertaken by the Egyptian physicians to obtain practical information on policy and operational aspects which will assist them in converting their country's free hospitals and polyclinics into fee-for-service and self-sustaining institutions.

The team toured seven hospitals and focused their interest on seven functional areas: medical care services, administration and planning, patient-client relations, finance and accounting, medical staff organization and evaluation, and ancillary services, including pharmacy, laboratory and related departments.

The hospitals visited and the points of concern that were discussed with the directors and chiefs at each site were the following: Rizal Medical Center (RMC): medical records system and the costing methodology of the hospital's revenue enhancement program; National Kidney Institute (NKI): the hospital's corporate structure, marketing plan, equipment, and patient satisfaction program; Tarlac Provincial Hospital (TPH): financial planning and pricing of services; Ilocos Regional Hospital (IRH): revenue enhancement program fee schedules, strategies and results, formulary system and inventory control; Palawan Provincial Hospital (PPH): the hospital pharmacy's cooperative structure, membership and objectives and inter-agency relations; Don Jose Locsin Memorial Hospital (JLMH, Silay City): drug procurement program and health insurance for sugar farmers and government employees; and Tagbilaran City Hospital (TCH): cooperative set-up, revenue generation, capital build-up, community support and quality of services.

Hospital directors who received and briefed the delegation on local systems and processes were Dr. Romeo Cruz of RMC, Dr. Filoteo Alano of NKI, Dr. Consortia Quizon of TPH, Dr. Juanito Rubio of IRH, Dr. Jose Socrates of PPH, Dr. David Lozada of JLMH and Dr. Cirilo Halad of TCH.

The visit was coordinated by HFDP Program Manager Dr. Juan R. Nanagas and Dr. Romy Cruz. Another team of Egyptian doctors is scheduled to make a similar visit to Philippine hospitals this year.

NHI Workshops in Five Head Zones

In preparation for the passage of the National Health Insurance Act (RA 7875), the Health Policy Development Staff (HPDS) spearheaded the conduct of a series of seminar workshops on Health Care Financing and National Insurance. The purpose of the workshops was to create an environment favorable to the acceptance, adoption and implementation of a national health insurance program in the Department of Health. It was specifically designed to orient DOH officials and personnel on the principles and basic concepts that goes with the implementation of the national health insurance program.

A pool of speakers who are all knowledgeable on the subject from both the Health Finance Development Project (HFDP), the Philippine Medical Care Commission (PMCC), the Department Legislative

Liaison Office (DLLO) and HPDS was formed to facilitate the activity. Three major topics were discussed in the series. These are: Health Care Financing: Concepts and Issues; Medicare: Status and Issues and National Health Insurance Bills: Senate and House Versions.

The first workshop was conducted at the DOH Convention Hall, San Lazaro Compound. This was participated in by the Policy, Legislative and Research Coordinators of the different services in the DOH. The seminar-workshop was held for two days. Regional workshops were also conducted in Zamboanga, Tacloban, Tagaytay and La Union. Representatives from the different regions including the regional directors and other senior officers participated in these workshops.

National Health Insurance Act signed into law (Continued from Page 1)

The act was earlier embodied in two bills separately filed by Cong. Hilarion Ramiro, Cong. Jesus Punzalan, Cong. Nerissa Soon-Ruiz, and Cong. Jovito Claudio in the House of Representatives and by Senators Freddie Webb and Edgardo Angara in the Senate. The two versions were reconciled in a bicameral conference prior to ratification by Congress and submission to Malacanang.

The legislation is the result of a close partnership between the Congress and the Department of Health in support of national policies to put health into the hands of the people. It was prompted by the need to expand the coverage of the current national health insurance to the bigger number and poorer segments of the population, the need to include outpatient benefits on top of inpatient services which can be very costly to the peo-

ple, the need to address organizational difficulties among agencies implementing the Medicare program, and the need to design a viable program capable of assuming a bigger percentage of the Filipino patient's medical bill.

The PHIC will be initially funded out of the unexpended portion of the PMCC budget, 25 percent of the proceeds from cigarette taxes mandated by RA 7654, and another 25 percent of the incremental revenues from documentary stamp tax collections provided under RA 7660, apart from subsidies, fund accruals, and donations

Dr. Jaime Galvez Tan is New Health Secretary (Continued from Page 1)

In the next five months, JGT's priorities include the following: (1) women's health; (2) the National Health Insurance Program; (3) health for the health workers; (4) voluntary blood donation; and (5) health for the workforce.

Pesos for Health Part 2 Conference

The UPecon Foundation-Health Policy Development Program recently sponsored a conference showcasing the results of studies on health care reform, national insurance and devolution.

The conference dubbed as "Pesos For Health Part Two: Emerging Results of Current Research on Health Care Reform" featured twelve studies on health financing by young researchers from the Training, Education, Research Activity (TERA) of the HPDP. It is a sequel to the first Pesos for Health Conference in 1993 which assessed health financing reform possibilities.

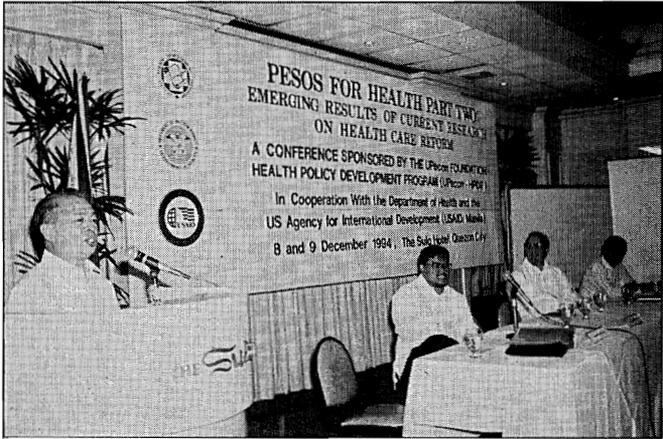
In his keynote address, then Health Secretary Juan Flavio, while noting the need for sick and curative care, underscored the importance of preventive health care saying, "it does not take a lot of money to secure and maintain good health." At the same time, he cited the

importance of useful and relevant research as necessary inputs to health financing but this must be "maneuvered into succeeding."

Both UPecon Foundation Chairman and UP School of Economics Dean Felipe Medalla and USAID/Manila Deputy Mission Director Gordon West stressed the importance of combining research with practical experience in their welcome remarks.

The papers presented during the two-day conference were:

- "Evaluating Health Care Reform Through the National Health Accounts" by Prof. Orville Solon, Ph.D.
- "Initial Estimates of the National Health Accounts" by Rachel Racelis, Ph.D.
- "Analyzing the Impact of Policies on the National Health Accounts" by Carlos Tan, Jr.
- "Dealing with Possible Adverse Response to Insur-



Health Secretary Juan Flavio delivers the keynote address during the "Pesos For Health Part Two: Emerging Results of Current Research On Health Care Reform," a conference sponsored by the UPecon-Health Policy Development Program, in cooperation with the DOH and USAID/Manila.

- ance" by Prof. Michael Alba, Ph.D.
- "Determinants of Health-Seeking Behavior" by Pilipinas Felix-Quising
- "Household Choice of Insurance Coverage" by Lea R. Sumulong
- "Insurance and the Price of Hospital Care" by Stella F. Alabastro
- "Medicare Program: A Critical Review" by Mildred Bolanos

- "Integrating Behavioral Effects into NHI Costing Model" by Arnold Babila
- "Local Health Expenditures and Intergovernmental Interaction" by Joseph Capulong
- "Incentive Effects of IRA on Local Taxation" by Ma. Josefa Quitazol
- "Health Manpower Under Devolution" by Ma. Rita Bustamante. VQ

HFDP Provides MIS for Guimaras P-2 Project

Management Sciences for Health (MSH), through the Health Finance Development Project, officially turned over a computerized Management Information System (MIS) to the Guimaras provincial government to backstop the Medicare P-2 pilot project in the province, during simple ceremonies held recently.

The design and installation of the MIS, and the training of PMCC and the local P-2 staff in systems applications, was part of the technical assistance extended to Guimaras at the instance of Governor Emily Lopez.

The system is composed of four program modules.

These membership monitoring; billing and collection; physician and hospital monitoring and disbursement monitoring. The first two MIS modules have already been installed, while the last two were test-run, using data obtained from actual enrollment from three different municipalities.

Some of the information which can be generated by the MIS are reports on active or lapsed memberships per municipality and barangay, updated enrollee listings, and updated renewal listings.

The turnover ceremonies were attended by Douglas Palmer of USAID, Cecille



Photo shows USAID official Douglas Palmer with members of the Guimaras Provincial Board, PMCC representative Melinda Mercado and HFDP Director of Administration Cecille Robles during simple turnover rites of a computer-based MIS for the Guimaras P2 project.

Robles of MSH, Melinda Mercado of PMCC, member of the provincial board, Provincial Health Officer Marilou Alipao, and officials from

three municipalities. The affair was highlighted by the sample printing of ID cards for distribution to P-2 beneficiaries. MSB

Introductory Baseline Study for IEC Campaign, 1995. Asia Research Organization Inc.

This study on Medicare Program I target beneficiaries' knowledge, attitudes and practices (KAP) aims to generate baseline information that will be used as basis for the design of an Information, Education and Communication (IEC) Campaign on Medicare. The Campaign is intended to increase availment among members, and enrollment among non-members of the program. A nationwide survey was conducted from April 11 to May 15, 1994 among the adult (18-64 years old) members of the population and generated information on the following: health seeking practices and utilization; accessibility to health care facilities; awareness, perceptions, attitudes and interest in health insurance in general and in Medicare in particular; and media exposure.

The survey on health seeking practices showed that 74% of the families generally self-medicate at the onset of sickness. It is only when sickness persists after three days that service providers are consulted by 92% of these families while the remaining 8% do not. Of these 8%, almost all (7%) finally see a doctor when the patient's condition does not improve or gets worse. On accessibility of health facilities, 98% of the surveyed population find the nearest hospital or clinic accessible, averaging a distance of 6.24 kilometers and costing about P5.67 in public fare.

More than 80% of those surveyed are not familiar with the terms "health insurance", "indemnity health insurance", and health maintenance organizations (HMOs). This contrasts with 86% of the adult population who are aware of Medicare, which is perceived as a beneficial program that covers expenses for hospitali-

zation and doctor's bills. Respondents reacted favorably to the idea of including outpatient services, saying these will increase the types and quality of Medicare benefits currently available. Interestingly, of those interested in the planned outpatient services, only 44% were willing to pay additional premiums with an average of P23.02 and a median of P10.00. On the idea of separating Medicare from SSS/GSIS, a plu-

39% of those surveyed preferred the old setup while

24% welcomed the proposed separation. The rest preferred other options.

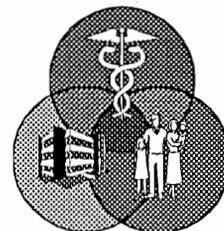
Despite the apparent popularity of Medicare, majority or 65% of those surveyed are non-members of Medicare. Medicare members are classified as either active or inactive. Active Medicare members are those who have paid at least three monthly contributions in the past 12 months, and inactive Medicare members are those with less than three monthly contributions in the past 12 months, and inactive Medicare members are those with less than three monthly contributions in the past 12 months. Of those who claimed to be Medicare members, only 17% are active, and 18% are inactive.

Among those surveyed, interest in Medicare was high at 72%, and 51% said this is primarily because of the coverage of hospital bills by Medicare. Only 24% signified non-interest citing economic reasons such as instability of income and financial burden of premium contributions. **MSB**

Outpatient Benefit Packages Under Fee for Service and Capitation, 1994. PhilamCare Health Systems, Inc.

This study, undertaken from October 1993 to October 1994 by Philamcare Health Systems, Inc., aims to develop outpatient benefit packages which could be provided to members of Medicare Program I initially, on a pilot scale in selected areas and if found viable, on a program-wide basis. Presently, Program I provides only limited benefits, inasmuch as it is an inpatient plan that pays an average of 50% of a patient's actual hospitalization expenses,

C, on the other hand, adds only specialty consultation to Package A.



The study likewise suggests payment schemes for service providers under each of these benefit options, namely fee for service and capitation. Providers can either be private practitioners, clinics, HMOs, hospitals, or a combination of these. In Package A, a provider gets P21.86 per member, per month under the fee for service scheme, or P18.15 per member, per month under capitation. In Package B, a provider gets P36.09 per member, per month under fee for service, or P29.96 under capitation. In Package C, a provider gets P31.86 per member, per month under fee for service, or P26.15 under capitation.

The benefit package, according to the study, were proposed to be pilot-tested in Iloilo City and Dagupan City. The pilot tests will determine the acceptability and affordability of the benefit package and the willingness of providers to participate in the program. A field survey was conducted in March 1994 among service providers and Medicare households in these areas to provide baseline information that will indicate whether the provision of Medicare outpatient benefits can be replicated in the rest of the country; and for validating assumptions and parameters used in designing the benefit package. **MSB**

HFDP Abstracts

Study

given the current cost of medical services.

The study proposes an outpatient benefit package which may be provided to Medicare members on top of the traditional inpatient benefits at the current level of premium contributions. The inclusion of outpatient services will result in advantages such as increased benefits to members; a shift in emphasis from curative to preventive care; reduced hospitalization costs; lessening of unnecessary confinements; more quality health care; and cost efficiency in program administration.

Presented by the study are three benefit options for outpatient services. Package A offers the least number of benefits which includes only primary consultation and five basic diagnostic procedures, namely, complete blood count (CBC), routine urinalysis and fecalysis, chest X-ray, and electrocardiogram (ECG). Package B offers the most benefits, adding specialty consultations, minor suturing, fasting blood sugar (FBS), and extremity X-ray to Package A. Package

Drug Procurement System Demonstration Project: Province of Negros Occidental, 1995. Economic Development Foundation (EDF)

This study by the Economic Development Foundation (EDF) develops and recommends a simplified drug procurement system for the province of Negros Occidental. The objective is to lessen procurement lead time by improving existing LGU processes in the purchase of needed drugs and supplies of devolved hospitals.

The study found that delays in procurement processing are due mainly to causes such as the absence of a carefully prepared annual procurement plan; lack of congruence between the plan and actual purchase requests; unrealistic pricing of drugs; lack of updated lists of accredited suppliers; delay in the holding of bid conferences and preparation of bid abstracts; frequent postponement of deliveries; acceptance of near-expiry medicines; and inefficient inventory systems.

The typical LGU procurement sequence consists of

various stages: purchase request preparation, bidding, and payment processing which, altogether, can take as long as three months. Documents require more than 40 signatures and pass through about 14 channels in the local bureaucracy.

ess is expected to take only 15 days from requisition to payment release. The steps to be taken are as follows:

Purchase Requisition Stage (4 days): Purchase Requisitions are received at the Provincial Health Office (PHO) and checked with the Annual Procurement Plan. The Budget Office checks the PR and certifies appropriation. Treasury then confirms the availability of funds. Accounting

are then delivered and accepted.

Payment Processing Stage (3 days): The PHO prepares the voucher and supporting documents. Papers proceed to the Accounting Office for review then to Treasury for check preparation. The Governor approves the voucher and signs the check for release by Cashiering.

For 1995, the procurement model suggests the holding of one public bidding for the first quarter of the year, followed by only purchase re-orders for the second quarter, as bid prices still hold true for as long as re-orders are made within 90 days of the last purchase. This substantially reduces processing time for succeeding quarters, since purchase re-ordering requires merely the issuance of purchase orders to winning suppliers.

With regard to medical items with limited manufacturers or distributors, the LGU will undertake direct negotiations with these firms, subject to the advice of the Provincial Therapeutic Committees. **MSB**

HFDP Abstracts Study

The new system proposes to reduce the number of channels to nine; additionally, the one-step bulk procurement and simplified bidding process are introduced. In the new scheme, the General Services Officer (GSO) consolidates all hospital purchase requests for one quarter then holds one quarterly consolidated bidding. This contrasts with the previous practice of one bid per hospital request. The whole proc-

obligates the Request of Appropriation then forwards papers to the GSO who initiates the bulk purchase.

Bulk Purchase Processing Stage (8 days): The GSO consolidates the PRs, then invites/negotiates with suppliers. The abstracts and purchase orders are subsequently prepared, approved and issued. The drugs and supplies

Health Sector Review: Philippines, 1993.

By Alejandro N. Herrin, Orville Solon, Michael M. Alba, Rachel H. Racelis, Mario M. Taguiwalo, Angelica Barrozo, and J. Brad Schwartz. HFDP Monograph No. 9. (forthcoming)



This monograph provides information on the current health sector outcomes and performance as of 1993 and policy implications of the findings in the report. The information includes an update on infant mortality trends on a national, regional

and provincial levels and the nutritional status of children. The former data is based on official estimates of infant mortality released by the National Statistical Coordination Board in 1993 and the life table estimates for 1970, 1980 and 1990 made by demographers Fliieger and Cabigon. The report also features and analyzes data based on the 1993 National Demographic Survey that could assist in the evaluation of the maternal and child care and

family planning programs during the period 1988 and to mid-1993.

Data on the extent to which health services, especially those provided by the government, reaches the lowest income population are also reported and analyzed based on a National Statistics Office (NSO) and National Economic Development Authority (NEDA) survey of the bottom 30 percent of the per capita income distribution.

The status of the health programs of the Department of Health (DOH) which were operational in 1993 is included, such as the "Mother and Baby-Friendly Hospital Initiative," "Oplan Alis Disease," "Oplan Sagip Mata," "Araw ng Sangkap Pinoy," among others are discussed.

Lastly, in the area of health care financing, the report discusses the development of the National Health Accounts (NHA) and the preliminary estimates of the 1991 preliminary NHA matrix from which data on the total health care expenditures and sources of funds for the whole country can be gleaned. The report likewise attempted to determine the sources and uses of funds for DOH special programs. **VQuimbo**

1995 GAA allocates P8.5B to DOH

By Kathleen Del Rosario, HPDS

The General Appropriations Act (RA 7845) of 1995 sets aside P8.5 billion for the Department of Health, the equivalent of 2.2% of the national budget. The DOH received a slight increase of P154.1 million from the originally asked for budget of P8.3 billion.

The 8.5B allocation would help the DOH adjust to its new role vis-a-vis the Local Government Code. The allocation would also serve well in the attainment of other DOH goals including (1) the need to give attention to the health requirements of the workforce and communities affected by modernization, urbanization and environmental degradation; (2) the utilization of participatory approaches so that health development may be a stimulus to community development; and (3) the need to address the rise in non-communicable diseases as well as the continued threat of the global menace that is AIDS (Acquired Immune Deficiency Syndrome).

pilothospitals and lastly, health development fund for 22 priority provinces have total appropriations of P371.6M for this year. Health Facilities took the lion's share of Operations at 65.86% or P3.9B. General Administration and Support (GAS) and Support to Operations (SO) got P1.3B and P135.4M respectively. Locally-funded projects got 1.89% or P161.6M, while 10% or P852.5M was allocated to foreign-assisted projects.

There are 21 new DOH programs for 1995 with a total allocation of P73.1M, a P147 +M difference from the P220.1M originally asked for in the Presidential budget.

The largest appropriation of the DOH budget went to expenses for maintaining public health services (Operations) which got P6.4B or 70.83% of the budget, and increase of P1.9B from last year's appropriation. DOH officials attribute the increase to the realignment of some line items to Operations. The Senate made provisions in the 1995 DOH budget for new components in Operations. Thus, regional funds for primary health care, regional funds for drugs and medicines, funds for the center of wellness program for regional and specialty hospitals, funds for health emergency preparedness and response for

CY 1995 APPROPRIATIONS		
Department of Health		
Office of the Secretary		
LINE ITEM	1995	PERCENT
PROGRAMS		
General Administration and Support	1,340,084	15.70%
Support to Operations	135,411	1.58%
Operations	6,044,440	70.83%
PROJECTS		
Locally-Funded	161,602	1.89%
Foreign-Assisted	852,539	10%
TOTAL	8,534,076	100%

COMPARISON OF APPROPRIATIONS			
CY 1995 R.A. 7845 Vs. President's Budget 1995			
(IN - THOUSAND PESOS)			
LINE ITEM	1995 PRES. BUDGET	1995 RA 7845	CUTS/ INITIATIVE
PROGRAMS			
General Administration and Support	1,305,964	1,340,084	34,120
Support to Operations	205,743	135,411	(70,332)
Operations	5,877,361	6,044,440	167,079
PROJECTS			
Locally-Funded	138,284	161,602	23,318
Foreign-Assisted	852,539	852,539	0
TOTAL	8,379,891	8,534,076	154,185

Budget appropriations to the DOH increased at a steady rate of 2.2% during the post-devolution years of 1993 to 1995.

CY 1995 APPROPRIATIONS				
Department of Health				
Office of the Secretary				
LINE ITEM	1994	PERCENT	1995	PERCENT
OPERATIONS				
a. Public Health services	1,302,046	31.82%	1,348,419	22.31%
b. Primary Health Care	211,359	5.17%	101,700	1.68%
c. Health Facilities	2,421,589	59.20%	3,980,742	65.86%
d. Standard and Regulations	130,856	3.20	200,571	3.32%
e. Drugs and Medicines	25,000	.61%	41,329	0.68%
f. Regional Funds for Primary Health care			122,870	2.03%
g. Regional Funds for Drugs & medicines			156,000	2.58%
h. Funds for Center of Wellness Program for Regional and Special Hospitals			20,803	0.34%
i. Funds for Health Emergency Preparedness and Response for Pilot Hospitals			8,890	0.15%
j. Health Dev. Fund for Twenty-two (22) Priority Provinces			63,116	1.04%
TOTAL	4,090,850	100%	6,044,440	100%

PISO

NEWS



Issue No. 9

August 1995



Dr. Hilarion J. Ramiro

Dr. Ramiro Assumes DOH Post

Dr. Hilarion J. Ramiro was appointed Secretary of Health by President Fidel V. Ramos last July 10. The new Secretary of Health was one of the authors of the National Health Insurance Law (RA 7875). He was also the Chairman of the Health Committee of the House of Representatives during his stint as Congressman of Misamis Occidental. Old hands at the DOH also remember Dr. Ramiro as one of its hardworking Regional Directors.

Secretary Ramiro said that he will continue with the current DOH programs, while at the same time focusing on two equally important priority tasks, namely, making health devolution work and implementing the National Health Insurance Program. After months of controversies re-

(Complete story on page 6)

NHI Task Force to Submit Draft IRR for Approval in October

The deadline set for the first draft of the NHI IRR (Implementing Rules and Regulations) is October 30, and for the approval of the final draft before the end of the year. The dates were agreed upon during an IRR Formulation Coordination Workshop held recently in Los Baños, Laguna. In between the two deadlines, consultations with different stakeholders will be conducted. The Los Baños workshop defined assumptions/general considerations in IRR formulation, and the protocol for coordination among the different TWGs drafting the IRR.

Outputs of the various technical working groups (TWGs) will be presented to the PHIC board in a workshop set for the first week of September.

Some of the issues raised during the workshop were the following: (1) coverage of indigents in selected areas by 1996; (2) identification of what goes into the basic benefit package; and (3) selective adoption or study of capitation as a provider payment scheme based on the capability/readiness of PHIC, providers and beneficiaries.

In a related development, newly appointed PHIC President, Atty. Jose A. Fabia met

Consultations with stakeholders set

last August 10 with representatives from the various local government leagues in a bid to call on the support of all LGUs in the implementation of the National Health Insurance Program (NHIP).

The meeting, which was held at the PMCC Board Room is viewed as the start of more meetings/consultations with local government executives. Among the issues raised during the first meeting was on the level of LGU involvement and participation in the NHIP, especially the issue on LGU counterpart subsidy to indigents and the establishment of the local health insurance office.

Atty. Fabia said that it is crucial for LGUs be fully informed of the mandate of law, at the onset, so that they may act accordingly in setting-up the needed resources. "It is important to start the collaborative efforts while the IRR is being formulated," he said. Melinda Mercado, Chief of the Programs Development Service of the PMCC presented an overview of the NHI law including the provision on the relationship of the PHIC and the LGUs.



PHIC Pres. Jose A. Fabia

FVR Appoints PHIC President

President Fidel V. Ramos appointed Atty. Jose Fabia as President of the newly created Philippine Health Insurance Corporation (PHIC). The former DOH Asst. Secretary for Legal Affairs, took his oath of office before President Ramos last August 2 at the Malacañan Palace. As PHIC President, he is responsible for the general conduct of the operations and management functions of the Corporation and for other duties assigned to him by the Board.

The new PHIC President (and chief executive officer) held various positions and responsibilities in the field of health care administration. He has done policy work on

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PHIC President Bats for Efficiency, Integrity and Competence for New Insurance Agency

The new Philippine Health Insurance Corporation President (and chief executive officer), Atty. Jose A. Fabia vows to make the government health insurance lead agency "the epitome of efficiency, integrity and competence."

In an exclusive interview with PISONews, Atty. Fabia enumerated the primary concerns of his office in laying down a strong foundation for the implementation of the National Health Insurance Program as mandated by the recently passed RA 7875. In building this foundation, he cites the following priority tasks: (1)

the immediate formulation of the Implementing Rules and Regulations of the NHIP; (2) inventory of all Medicare beneficiaries under Program I and Program II; (3) preparatory activities to ensure the availability of the start-up fund for indigents; and (4) to facilitate the eventual take-over of the functions of the PMCC by the PHIC.

The PHIC president has set the deadline for the initial draft of the IRR on October 30, 1995. The final draft, Atty. Fabia promised, will be submitted for Board approval before the end of the year. In between the two deadlines, a series of consul-

tations will be conducted with all stakeholders, including beneficiary groups, to assure maximum participation of all in the IRR formulation process.

Atty. Fabia has initiated the building of a good solid team when he met with all the staff and officers of the PMCC, and assured everyone that there will be no layoffs. He allays speculations that the PHIC will hire new staff to take-over present positions.

The Task Force NHI created by then Acting Secretary Jaime Galvez Tan will continue to function as

such, and will provide assistance to the new PHIC president. The lead persons of the task force briefed Atty. Fabia on the status of the IRR formulation and other issues that need to be resolved by the PHIC Board. He said that he was pleased with the work of the task force and instructed the lead persons to continue with their tasks.

Atty. Fabia met with the Board last August 10, 1995. Priority in the agenda was the selection of the four sectoral representatives to complete Board. (L. Laureta)



☞ NHI Organizational Structure

Despite the change in the leadership at the DOH, Task Force NHI will remain under the supervision of Usec. Juan R. Nañagas. The Task Force however will now report to the newly appointed PHIC President, Atty. Jose Fabia on issues such as proposed changes in the organizational structure or on collaborative arrangements between the two agencies.

☞ Public Information Campaign

The public information campaign is now entering its second phase to target a wider audience with the publication of the primer, workshop manual, the NHI law, campaign stickers, folders; the design of the NHI logo and slogan; and the printing of complimentary NHI T-shirts. A 30-second and 45-second television plug for the NHI was completed recently and given an OK by project management. Copies of a 25-minute video documentary are being readied and will be distributed nationwide for broadcast and to serve as additional workshop materials.

The second phase of the campaign is focused on specific stakeholders, such as, LGUs, labor groups, medical and allied medical professions, NGOs.

☞ Internal and External Support Mobilization

The SupMob component is also moving into its second level of constituency building, namely the LGUs, NGOs, and the provider groups. The objective is to disseminate general and specific information on the law to identified stakeholders. This will be done through a series of multi-sectoral fora and focus-group workshops nationwide. The first of this series was held recently with a meeting with key officials of various local government unit leagues at the PMCC. The meeting was presided by the newly appointed PHIC president, Atty. Jose Fabia.



There is a move to combine the Public information and the SupMob group, since both groups are doing information dissemination and advocacy work and share the same

materials currently being turned out for the NHI.

Announcement

Regular screenings of the NHI Video documentary have been scheduled by the NHI Public Information/Communication and Support Mobilization Group. However, interested parties who may want to avail of advance screening or copies of the documentary may get in touch with Ms. Melinda Mercado of the PMCC.

Multisectoral Health Forum Tackles NHI Program

"In the crafting of the NHI implementing rules and regulations, keep in mind that Manila is not the Philippines." This sums up the message of non-Metro Manila health providers and local government officials from Regions VI and VII during the tenth policy discussion of the Multisectoral Health Forum (MHF) held in Cebu City recently.

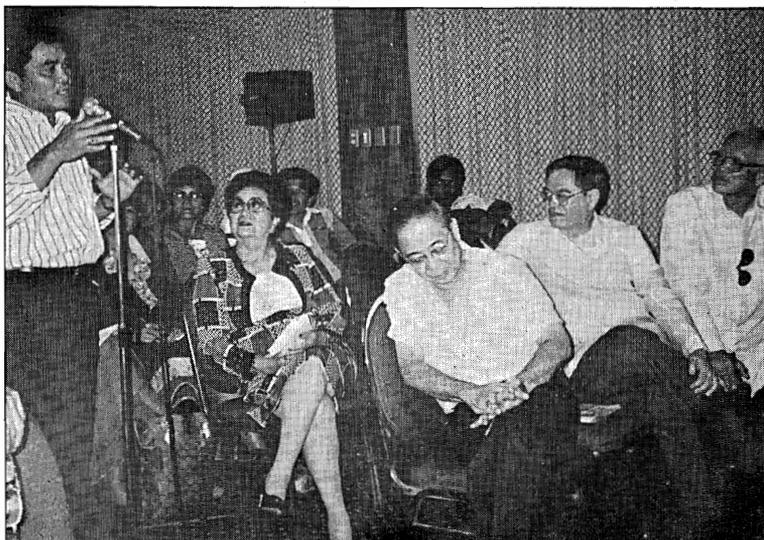
About 83 representatives from the labor, business, hospital, pharmaceutical, dental and other health professionals, NGOs, health maintenance, community financing, and local and political sectors met at the Cebu Plaza Hotel to hear Dr. Rodolfo Maceda, Executive Director of PMCC speak on the NHI's proposed implementing rules and regulations (IRR). Dr. Maceda is also the chair of the NHI Task Force Committee on the IRR.

The representatives voiced their concerns over three issues: the macro-policy issues affecting the health system; operational issues on the crafting of specific guidelines, and the transition from the PMCC to the Philippine Health Insurance Corporation (PHIC).

Pamela Henares, presi-

dent of Riverside Medical Center, stressed the importance of a vision regarding health and asked for a master plan for health so that health providers will know where they fit. "Are we regarded as *partners, cooperators, or nobodies*, she asked during the forum. "Is the health focus moving towards OPD ambulatory care or managed care." she added.

Most of the questions raised however, dealt with the formulation of the specific guidelines regarding NHI. They want to clarify concepts, coverage of the law, compulsory provisions, financing and funding sources, and capability of LGUs to meet obligations. Nick de los Santos, a municipal mayor of Alcoy town in Cebu appealed for clear rules on the selection of indigents so that local government officials will not be accused of favoring political supports. "*Mahirap ilagay sa barangay level and pag-issue ng certification for indigents*," he said.



A participant asked for clarification regarding coverage of the NHI law.

Atty. Rolando Lim of the Cebu Chamber of Commerce and Industry, fears the enrollment in NHI will mean additional costs to employers who already provide health care benefits, oftentimes even above the minimum NHI package. On the other hand, labor sector representative Atty. Alfonso Sayson questioned the legality of integrating SSS and GSIS funds with the NHI funds since the former are trust funds. "The IRR must consider that integrating these funds violates the law because these are held in trust, the workers have been contributing to the SSS since 1957," he said. "It is not enough that we know the right thing, we should be required to do the right thing." he added.

Dr. Delia Mediano, chief nurse of the VSMMC called for the organization of a body to review the utilization of NHI. She also suggested that the number of patients per practitioner should be limited except during emergencies to prevent abuse.

Another participant reminded the drafters of the IRR not to ignore dental care and



Dr. Rodolfo Maceda

to consider pregnancy-related services.

One transition issue dealt with the accreditation of doctors whose Medicare accreditation are going to expire soon. "Do we get accredited under the new NHI law or under Medicare?" they asked.

The well-attended consultation meeting showed the interest of stakeholders in the NHI law and their need to be heard. Many reminded the NHI-IRR authors to see clearly through the issues. They stressed the urgent need to consult and communicate with as many stakeholders throughout the Philippines to ensure no kinks in the implementation of the law later on. (V. Quimbo)

About the Multisectoral Health Forum

The Multisectoral Health Forum (MSF) is a non-stock, non-profit SEC-registered organization founded in April 1993 to promote policy discussions and conduct activities for health policy advocacy. Its Organizing Advisory Committee is composed of the heads and key officials of the following organizations: Philippine Hospital Association, Philippine Chamber of Commerce and Industry, Philippine Medical Association, Pharmaceutical and Health Care Asso-

ciation of the Philippines, Philippine Nurses Association, University of the Philippines Manila, Association of Philippine Medical Colleges, and Philippine Public Health Association. Initial funding for the MSF came from the UPecon-Health Policy Development Program of the Health Finance Development Project (HFDP). HFDP is a project of the Department of Health with assistance from the USAID.

BUKIDNON HEALTH INSURANCE PROJECT (BHIP)

On its first year, the Bukidnon Health Insurance Project (BHIP) has enrolled more than 12,000 members. Roughly, that translates to about 60,000 beneficiaries of health care services provided by the BHIP throughout the province. By end of April 1995, the number of availment for outpatient services was placed at about 15,437, inpatient care at 1348, and dental services at 862. Some 37 members availed of various surgical procedures, while another 36 beneficiaries availed of maternity benefits.

At present, BHIP has 48 active accredited hospitals, 50 accredited physicians and 34 accredited dentists. There are providers in all 22 towns of Bukidnon. In areas where there are no hospitals, like Talakag, the Rural Health Unit (RHU) and the Municipal Health Officer (MHO) serve as the focal providers.

To generate membership, BHIP fields 391 active health counsellors (HC) covering all 22 towns and 454 barangays of Bukidnon. The health counsellors were trained by the BHIP and came from the ranks of barangay health workers (BHW), barangay nutrition scholars (BNS), coop members, and NGOs. Collectively, these health counsellors are credited for the rapidly increasing membership of the BHIP.

An aggressive marketing and information campaign is directed by Marilyn Goles, BHIP Deputy Project Director, who has successfully collaborated with the municipal government units, NGOs, and the various cooperatives in the province. BHIP health counsellors have been invited to various local fora to conduct information campaigns and solicit membership to the BHIP. Recently, BHIP was invited by the Bukidnon Tripartite Industrial Peace Council (BTIPC) through the Department of Labor and Employment (DOLE) Provincial Extension Unit to present its health program to the members of the council.

The Council, composed of members from the labor, management and government sectors, has shown interest

Increased enrollment and funding support from municipal governments chalked on its first year

on the health insurance package provided by the BHIP in line with its program on Health and Safety Benefits for its members.

In a related development, the BHIP is gaining considerable headway with the local government executives from the province who have shown interest in supporting the implementation of the program in their respective municipalities by committing to use 25% of their health fund to subsidize the project. The town of Malaybalay started the ball rolling by subsidizing the BHIP premium of its BHWs.

Mayor Carlos C. Leonardo of Quezon has announced that his local government appropriation for BHIP in 1995 is P1.3M. He said that the funding support shall be utilized to provide annual premium subsidy for qualified beneficiaries from his town. To date, Quezon is gaining a reputation as the fastest growing member town of BHIP.

On the other hand, Congresswoman Socorro O. Acosta of the first district of Bukidnon, contributed P250,000 to the BHIP for drugs and medicines. The contribution came from her Countryside Development Fund. A Fund Utilization Scheme was agreed upon for the disbursement of Congresswoman Acosta's contribution. (GG V Custodio)



The USAID considers the BHIP a "great success story." In his letter to BHIP, Dr. Emmanuel Voulgaropoulos of OPHN said that "We will always regard the BHIP as a major pioneering local government endeavor."



HFDP Bids Goodbye to Tom and Doc Marl

After a three year stint as Health Finance Advisor, Dr. Thomas D'Agnes bade goodbye to HFDP to join the ADB-assisted Primary Health Care Project in Vientianne.



Dr. Tom D'Agnes

We remember Tom with his lampoons, the red pajero he claims could fly over floods at Sta. Cruz, and his blue notebook that he never left home without. Also known as the self-styled "Thomas de Magnifico," his magic act was a regular fare at HPDS parties, and his what-to-look-for-in-a-husband rule became the by-word among HPDS and HFDP single ladies. If Tom had stayed longer, we would have seen the birth of other legends such as "Tom and His Flying Pajero" and "D'Agnes in Search of His Lost Blue Book."

Most importantly, however, we will remember Tom as one of the major players in steering the project since day 1. When things seemed to get complicated, his organized and focused mind helped us navigate through the confusion. HFDP will definitely miss Tom D'Agnes.

Dr. Mariquita "Doc Marl" Mantala, has also left HFDP to rejoin her former mother unit at the Department of Health. From providing strong backstop to Melahi Pons at the Health Policy Develop-

ment Staff (HDPS), to eventually becoming its officer-in-charge. Doc Marl also helped steer the Information Committee (InfoComm) that pro-



Dr. Mariquita Mantala

duces this newsletter (among other things). With her at the helm of the InfoComm, a good number of HFDP publications passed muster of project management.

On top of that, Doc Marl is also among the stalwarts of the National Health Insurance technical committee that helped draft the recently promulgated NHI law and followed up this stint to help steer the NHI Task Force charged with the work of drafting the implementing rules and regulations.

However, an "old love" beckons, and the equally big challenge of spearheading the department's renewed fight against a killer disease.

Doc Marl, for her part, is happy being where she is because "TB control is my special calling" and her first area of involvement after graduating from medical school. She joined *Alay Kapwa Kilusang Pangkalusugan*, a community-based TB control group for a period of eight years and the Philippine Tuberculosis Society (PTS) for another couple of years before her job stint at the DOH.

Rotarians "Adopt" Hospitals

The Rotary Club District 3800 based at the National Kidney Institute (NKI), embarked on a "Hospital Adoption Program" this August, as part of its service to the community. The program will directly benefit the underprivileged, elderly, disabled, women and children living in communities within the areas of the 50 Rotary Clubs comprising the district.

This was announced by Dr. Ading dela Paz, Rotary district chairman and Dr. Romy Cruz, who heads the district's hospital adoption program

committee. The program is being undertaken by Rotary in coordination with the Department of Health (DOH), and was formalized last July through a Memorandum of Agreement between District 3800 headed by district governor Dr. Fil Alano and the DOH.

Designed as a countrywide activity, the program was launched on August 5 with the holding of "Operation Thyroid," with the participation of 19 hospitals throughout the national capital region (NCR)

FVR appoints PHIC President

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the legal/technical framework of the Philippine Health Development Program. He was also a trustee of one of the country's largest government hospital, the East Avenue Medical Center in Quezon City. He served as the Vice Chairman of the Dangerous Drugs Board and was a member of the central Executive Committee of the Department of Health.

After his fruitful stint at health sector development, Atty. Fabia became involved in local governance as Mayor of Binmaley town in Pangasinan, where his wealth of experience in local health planning and administration was put to good use. The Food and Nutrition, Environment programs and Medicare P2 that he introduced in Binmaley has won him various awards, including the Galing Pook Award from the Asian Institute of Management. His work in local health planning and administration and the pilot project on health insurance coverage for the indigent seemed him a nomination to this year's Ten Outstanding Young Men of the Philippines (TOYM) awards. His P2 experience as

Dr. Ramiro Assumes DOH Post

(Continued from page 1)

guarding the devolution issue, Secretary Ramiro says that everything should now be put aside and instead work at making it succeed. To accomplish this task, a series of consultations with concerned sectors has been set by the office of the Secretary.

Since the Secretary of Health is also the Chairman of the Philippine Health Insurance Corporation (PHIC) and one of the proponents of the national health insurance program, Dr. Ramiro believes that when successfully implemented, the program will be able to provide all Filipinos access to affordable and efficient health care.

While there will be no radical changes in the Department's thrust, Secretary Ramiro has made it known that he will make changes in the Family Planning Program to address the concerns of the Catholic church.

as Mayor of Binmaley is most useful since the NHI's key feature is coverage of indigents.

NHI Means Test Developed and Pilot Tested in Selected Areas

The NHI means test policies and procedures was presented to the technical working committee in charge of the indigents. This is one of the activities being undertaken by the group tasked with the crafting of the NHI implementing rules and regulations (NHI). The Department of Health sought the assistance of the GTZ Social Health Insurance Project to collaborate with HFDP in the development of the means test.

A means test is a comprehensive review (based on a set of socio-economic criteria) of individuals' or households' capacity to pay health insurance premium. The means test will help identify the indigent in the

community whose contributions will be subsidized by the government, as well as determine the varying levels of contributions of other households.

The test defines indigent as a person or a group of persons (household or clan) who at a specific phase of his or their life has no capability to provide for his/their basic needs despite the maximum use of his/their human potentials.

The following conditions were considered for the definition of the term. These are: (1) constituency, maybe an individual, a household, a group in an area; (2) life episode - elderly; (3) physical condition - differently abled, disabled, handicapped; (4) expo-

sure to calamities or disasters; (5) insufficiency of income (below NEDA standards); (6) ailments - chronic diseases, catastrophic illnesses; (7) ownership or control of capital/assets - those without properties, education or skills.

The primary objective of the development of a means test protocol include the following: (1) operational definition of indigent, (2) development of a tool to identify the indigent, (3) policies and procedures for the means test protocol, (4) strategy for periodic evaluation of the protocol and its implementation.

The Federation of HAMIS winners composed of community-based health groups was tapped to do the pilot

tests. The initial output of the group was based on the review of existing means test currently in use in the country and the lessons learned from the experience.

The means test being developed is envisioned to reflect the following characteristics: (1) geographical variability, (2) flexibility, (3) participatory, (4) cognizant of health behavior, and (5) multitiered reflecting the area, household and the individual in the community.

The Federation of HAMIS winners draws from the wealth of experience of its members in managing community health care and financing projects in coming up with the recommendations.

The HFDP-assisted Bukidnon Health Insurance Project (BHIP) was the first to use a means test to determine its member households' capacity to pay premium.

How Communities Cope with the Cost of Health Care

Recent studies conducted by the Department of Health showed, that poor and marginalized communities and the disabled can be "creative and innovative" in pooling resources for health. Mothers' Clubs will hold annual beauty contests where members, including daughters participate, to raise money for a community health fund.

A group of diabetic patients in a provincial hospital forged an agreement with the hospital for a regular medical consultation during which members pay minimal consultation fees. This diabetic club also buys medicine in bulk and resell the same to its members at a lower price. A farming community on the other hand, resorts to "turnohan" a group

saving scheme wherein members take turns withdrawing the cash pot, a portion goes to Medicare 2 as premium contribution, while the rest is spent for family needs. These experiences tend to allay fears that the people may not be able to pay for the insurance premium for National Health Insurance. Now who says we can't "DOH" it.

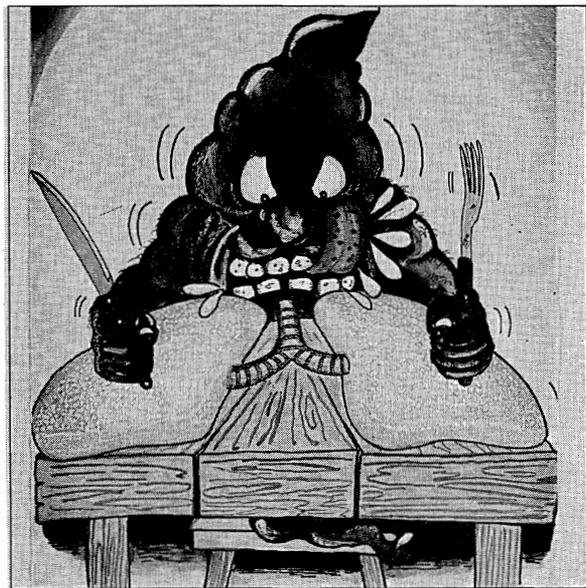


DOH Fights Tuberculosis

The Department of Health's tuberculosis control program is going full blast with its information, education and advocacy activities for August and September. The third in the line up of DOH's health program series, Five for Life in '95, the program is called Target: Stop TB with a campaign call which goes, "Sigaw ng bayan-TB aylabanan!"

The announcement came from Dr. Mariquita Mantala, newly appointed chief of the DOH TB Control Services. Dr. Mantala assumed the post May 3 this year after her stint with the Health Finance Development Project (HFDP) as Program Manager and the Health Policy Development Staff (HPDS) as Officer-in-Charge.

The P150-million TB control program is two dimensional, with an advocacy thrust and a drug supply and distribution component. Information and advocacy efforts, according to Dr. Mantala, "will seek to bring back to the consciousness of policy makers, medical practitioners, program implementors as well as the general public the fact that tuberculosis poses a very real danger to the health of all Filipinos."



TB is spread by people, not by insects, blood supplies or water. Like the common cold - but unlike AIDS - TB is spread through the air and by relatively casual contact.



TB is considered by the World Health Organization (WHO) as the first killer of adults, the fourth killer of mankind, and the fifth cause of illness.

The campaign is nationwide in scope and will involve all regional health offices, rural health units and barangay health centers. Events that are scheduled to take place starting early August include a main launching ceremony at the DOH central office, simultaneous launching activities in the four priority areas of Paranaque, Antique, Ifugao and Surigao del Sur, and separate launchings in the 15 regions.

Contrary to the public perception that tuberculosis has been sufficiently licked by the passage of time and the gains of the pharmaceutical industry, Dr. Mantala informed that the problem has, in fact, grown with the emergence of strains of TB bacilli that are highly resistant to available drugs and medications. The World Health Organization (WHO), in its 1995 Report on the Tuberculosis Epidemic, declared TB

as a "persistent global emergency" and called for a stop to its source - the infectious TB patients themselves who are not cured and multiply in poor and rich countries alike. These sick persons contaminate healthy people they freely mix with everyday, said Dr. Mantala.

By world standards, the disease ranks as the Number 4 cause of death and the Number 5 cause of illness. The Philippines, tops the list in the number of TB cases reported among the Western Pacific belt of nations.

In the Philippines alone, says Dr. Mantala, there are 22 million Filipinos, equivalent to a third of the total population of 64 million, who are positively identified as harboring the TB bacilli. Of this number, about 200,000 are sputum-tested to be active cases. At the rate multi-drug resistant TB is rapidly spreading around the world, the intensified TB program has much ground to cover, she said.

Other aspects of the information campaign are tri-media plugs and announcements, poster production, symposia, and a string of seminar-workshops which will be held jointly with the Philippine Coalition Against Tuberculosis (PHILCAT), a multi-sectoral group at the forefront of the fight against TB. Priority-setting seminars for TB research will also be held in coordination with University of the Philippines - Manila and the Philippine Council for Health Research and Development (PCHRD).

The program also seeks the greater involvement of LGUs, particularly in the areas of policy formulation, resource mobilization, funding assistance and social marketing. "Without the participation of LGUs, the TB control program will hardly make headway, because it leans heavily on the reach they alone can provide," she said. "We call upon them to attend to a matter of great national urgency, to tell their affected constituents that TB medications should not stop at the first sign of recovery, since it is the residual bacilli cells that re-multiply and mutate into the drug-resistant forms that kill," she said. "TB is not the sole responsibility of government," she said, "but of everyone." (MA Barcelona)