Validation of the Selection Process of PhilHealth Sponsored Members in 4 Barangays in a Municipality in Batangas using the Participatory Action Research

Vincent Bryan DG. Salvador,[1] Ramon P. Paterno,[2] Elizabeth C. Regalado-Paterno,[3,4] Michael D. San Juan,[1] Ma. Angeli B. Sabalo,[1] Sylvette A. Saceda,[1] Carminda J. Pineda,[1] Enrique Miguel S. Unson,[1] Mel Clark R. Taveros,[1] Cecille Marie C. Sales,[1] Gretel B. Puzon,[1] Tonilene E. Rafael[1] and Abel Santini G. Permites[1]

[1]*College of Medicine, University of the Philippines Manila*
[2]*Institute of Health Policy and Development Studies, National Institutes of Health, University of the Philippines Manila*
[3]*Department of Family and Community Medicine, College of Medicine and Philippine General Hospital, University of the Philippines Manila*
[4]*Community Health and Development Program, University of the Philippines Manila*

ABSTRACT

Objective. The present study aims to correlate the LGU list of PhilHealth Sponsored Members in a municipality of Batangas with the list of poor residents as identified by the Participatory Action Research (PAR) methodology.

Method. Interview of key informants documented the processes utilized by the LGU in determining PhilHealth beneficiaries for the Sponsored Program and the Participatory Action Research (PAR) survey in the classification of households into poor, middle and rich in four barangays of the municipality. The list of LGU Sponsored members was then cross matched with the PAR household classification.

Results. The comparison of the LGU list of Sponsored members and the household classification by the PAR survey showed a wide discrepancy: (1) 464 "Not Found" Sponsored households or 70% of the LGU's Sponsored list; (2) inclusion of the non-poor: 140 middle class families as classified by the PAR survey or 21.1% of the LGU's Sponsored list; and (3) exclusion of 413 or 87.5% of true poor families identified by the PAR Survey. Only 59 families or 8.9% of the LGU Sponsored list were classified as poor families by PAR.

Conclusion. PAR offers communities, LGUs and the National Health Insurance Program a tool to validate the coverage of the Sponsored program. LGUs and the PhilHealth should consider such tool or similar tools to validate their identification, selection and enrollment of the poor, which is extremely vital in achieving universal coverage. Given the right tool, communities are in the best position to identify the poor for the Sponsored program. By way of collaboration with the underprivileged themselves, the academe has a role in assisting communities in acquiring collective awareness of their own situation and developing capacity for improving their lives. The academe also has a role in assisting LGUs in improving their health systems and national health programs in validating and improving their implementation. Further studies should be done to investigate the following: the identity of the "not found" SP members; the utilization of PhilHealth benefits by the poor; and the prospect of utilizing the PAR method by other non-academic institutions in monitoring the progress of community programs.

Key Words: Participatory Action Research (PAR), PhilHealth Sponsored Program, LGU sponsored list, Academe LGU Community Partnership, sponsored members, selection process, identification of indigents

Corresponding author: Ramon P. Paterno, MD, MPH
Institute of Health Policy and Development Studies
National Institutes of Health
University of the Philippines Manila
625 Pedro Gil St., Ermita, Manila 1000 Philippines
Telefax: +632 5264349
Email: rppaterno@yahoo.com

Introduction

An equitable health care system is characterized by equal access to health care by all citizens in a country, regardless of their socioeconomic standing. In many developing countries, access to health care is often restricted to those who can afford to pay for health services through out of pocket or health care insurance coverage. The poor are constrained in getting the needed health services, as they do not have the financial means to either pay for care or to secure adequate health insurance for themselves or their families.[1] For this reason, the Philippine Health Insurance Corporation or PhilHealth was created in 1995 to administer the National Health Insurance Program (NHIP). This aimed to "provide all citizens of the Philippines with the mechanisms to gain financial access to health services" and to "serve as the means to help people pay for health care services".[2]

In the implementation of the NHIP, PhilHealth targets to achieve universal coverage by enrolling the formally employed, (both government and private), the informal sector (thru the Individually Paying Program), the retirees (through the Non-Paying Program) and, the indigent population (through the Sponsored Program).[3] The Sponsored Program (SP) for the Indigents is of paramount importance in meeting the objectives of NHIP. Through it,

PhilHealth expects to achieve its mandate of ensuring financial access to health care for all Filipinos. The participation and cooperation of the local government unit (LGU) is crucial for the success of the SP for it is the LGU which identifies and enrolls the Sponsored members and pays part of their premiums. Once the LGU's cooperation is ensured, the determination of the indigent members is then undertaken through the conduct of a social research survey referred to as the 'means test'. This test determines the socioeconomic profile of the indigent sector of each LGU, and provides the LGU with a list of its indigent residents to be enrolled in the SP.[4]

The prescribed method of identifying eligible members for the PhilHealth Sponsored Program is a two-stage screening process. Poor barangays are first identified by the Municipal or City Social Worker. Families with incomes below a certain limit within these selected barangays are then listed as eligible members.[4] In this manner, poor families in "non-poor" barangays are already excluded from the program resulting in significant undercoverage even in the first stage.

Once the poor barangays are selected, identification of potential beneficiaries of the SP involves stratification of the families in the community using a set of poverty indices determined by the concerned LGU. Its targeted members are those belonging to the poorest 25% of the population who cannot afford to pay health insurance premiums.[4] Enrolment of indigents to the SP is on an annual basis and the percent coverage is based on official National Statistical Coordination Board (NSCB) poverty estimates.[3,4,5] However, the process of selection utilized is faulty and is undercoverage and even leakages usually arise in the process. As a result, coverage is not extended to those who really need them.[6] This observation has been validated in a previous case study on social health insurance in the Philippines by Obermann et al. who reported that "the identification of the poor is time consuming and prone to political influence." Thus, there is a need for an alternative efficient and reliable identification process.[7]

A similar strategy is being used in Colombia in selecting beneficiaries for social programs. It is called the System for Selecting Beneficiaries of Social Spending or SISBEN. Through the SISBEN, the economic status of households is determined through a statistically derived proxy means test. Municipalities implement SISBEN following two steps. First, municipalities identify poor communities to be surveyed using a variety of information to generate local poverty maps. Second, municipalities conduct the survey using SISBEN questionnaires for all residents in selected communities. People missed in the survey because they live in non-selected poor areas can apply at SISBEN office.[8]

A Participatory Action Research (PAR) survey was recently done in a municipality in Batangas that stratified families into 3 socioeconomic levels using criteria that the residents themselves defined.

Objectives

The present study aims to determine how the LGU list of sponsored members in the municipality correlates with the list of the poor identified by the PAR methodology by: (1) describing the exact processes utilized by the LGU in determining PhilHealth beneficiaries and the PAR survey in identifying indigent families in a municipality in Batangas; and (2) comparing the list of beneficiaries of the PhilHealth SP in that LGU with the list of indigent families identified through the PAR.

Methods

Study Population

The study compared (a) the indigents of 4 barangays of a municipality in Batangas as enumerated in the official list of the LGU's PhilHealth SP beneficiaries with (b) the indigents identified by the PAR survey conducted by the University of the Philippines Manila (U.P. Manila)-LGU program from June 2007 to January 2008. For this study, the four barangays are referred to as Barangays A, B, C and D for confidentiality. Indigents enrolled in the PhilHealth SP are referred to as sponsored members.

Documentation of the Process in Identification of Indigents by LGU and PAR Survey

The standard protocol which describes the detailed process by which the LGU identifies, screens and selects indigent families for inclusion in the PhilHealth SP list of beneficiaries was obtained from the concerned officer-in-charge in the respective barangays. Key informant interviews were done to validate the selection process. The following were interviewed: the officer-in-charge of the Sponsored Program from the Municipal Social Welfare and Development (MSWD) office, a DSWD social worker from Barangay C, and the barangay health workers in charge of the SP list in the 4 barangays. A sample survey questionnaire used by the LGU was obtained from the MSWD Office.

The PAR protocol and sample survey questionnaire were obtained from the social worker of the College of Social Work and Community Development, U.P. Diliman. The PAR Survey protocol included the step-by-step process of undertaking the PAR Survey and the measuring tools used to determine the socioeconomic strata of the families.

Gathering of LGU list of PhilHealth Sponsored Program Beneficiaries and the PAR Survey Results

The official list of active sponsored members of PhilHealth SP within the validity period: January 01, 2008 to December 31, 2008 was obtained from the MSWD Office in a municipality in Batangas. Sources of sponsorship for the

beneficiaries (Provincial or Municipal) were indicated whenever possible.

Comparison of the LGU list of PhilHealth Sponsored Program Beneficiaries and the PAR Survey Results

The collected lists obtained from the LGU and the PAR were encoded in Microsoft Excel, with names of the subjects codified to maintain confidentiality of the subjects' identities. All the sponsored members included in the list of LGU in 4 barangays were classified as to whether they belonged to the poor, middle or rich classification according to the socioeconomic profile obtained from the PAR survey of the community. The data was analyzed to detect discrepancies between the two lists. The frequency of the sponsored members per barangay was reported as well as the tabulated result of the total number of sponsored members enrolled per economic strata in each of the 4 barangays.

The community members were not involved in the comparison of the LGU and PAR lists. After the completion of the study, the authors provided the municipal health officer a verbal briefing and a copy of the study report. The investigators wanted to present the results of the study to the involved communities, but, in the interest of Academe-LGU partnership, deferred to the request of the Municipal Health Officer to refrain from doing so, noting the sensitive nature of the information. There may, however, be an opportunity to present the study to the new mayor.

Results

Description of the LGU Process in Identifying Sponsored Members

Both provincial and municipal DSWD offices utilize a standard process in selecting and identifying families for inclusion in the PhilHealth SP. The MSWD is the government agency assigned to perform the selection process in the municipality.

However, the Barangay Health Workers and Day Care Workers are the first-line workforce in the individual barangays in the identification of potential candidates for enrollment to the SP. During the actual conduct of the survey, all households in every barangay are screened using a standardized survey questionnaire called the Family Data Survey Form which the respondents in every household answer in the presence of the day care worker assigned in the barangay. The Family Data Survey Form was designed by the provincial DSWD office for this purpose. The family income (obtained from families' Income Tax Returns) is also noted in the survey. Once the survey is completed, the results are tallied by the day care worker in every barangay and the results are submitted to the municipal or provincial DSWD office depending on which LGU requested for it. The Municipal Social Welfare and Development (MSWD) Officer manages the data derived from the Family Data Survey facilitated by the Day Care Workers at their respective barangays. MSWD social worker then conducts his/her own ocular visits and interviews of recommended beneficiaries to verify appropriateness of the recommendations.

There are three main parameters used by both the provincial and municipal DSWD in selecting from the preliminary list of candidates for enrollment in the Program. These parameters consist of monthly family income, the number of times a family eats a meal per day and the appearance of the house. The income range used in the classification of poverty was based on the NEDA recommendation.

Families whose income is greater than P3,900/month but less than P6,000/month are considered qualified for enrollment in the PhilHealth SP. Quota is set by the LGU subject to availability of funds for their counterpart premium (from an initial 10-50% of P1,200 depending on the class of municipality.) A family who eats meals less than three times a day is enrolled automatically in the SP. A family income less than or equal to P3,900/month is also considered as belonging in the Food Threshold and thus is also enrolled in the SP. The appearance of the house itself is enough to classify the candidates as eligible for the PhilHealth SP or not.

Once the preliminary list of candidates for enrollment in the Program is completed by the municipal DSWD office, the list is submitted to the provincial DSWD office for counter checking for any duplication in the list. The official list of the total enrollees for the Program is made by the provincial DSWD office, taking into consideration the quota set by the LGU. The provincial list of sponsored members is finalized by the governor's office. The final list of the provincial sponsored members is then submitted to PhilHealth.

The operational implementation of the SP in the municipality of Batangas involves 2 component arms: the Volunteer Sector and the Indigent Sector. Under the Volunteer Sector, the following sectors could avail of the Program where 50% of the premium is paid by the sponsoring LGU: Barangay Health Workers (BHWs), Barangay Service Point Officer (BSPO), Barangay Nutrition Scholar (BNS), Day Care Workers, barangay police, barangay secretary and other elected barangay officials. Application for inclusion in the Program is often made in the provincial office of DSWD. In cases where a party is not included in the provincial list of enrollees, the municipal office of DSWD can facilitate the processing of the documents. Compared to the selection of indigent families, the volunteer component of the program is not subject to quotas set by the LGU (Figure 1).

The Municipality has its own list of Sponsored Members subject to availability of funds for the premiums. The mayor asks the barangay captains to prepare a list. The Bgy Health

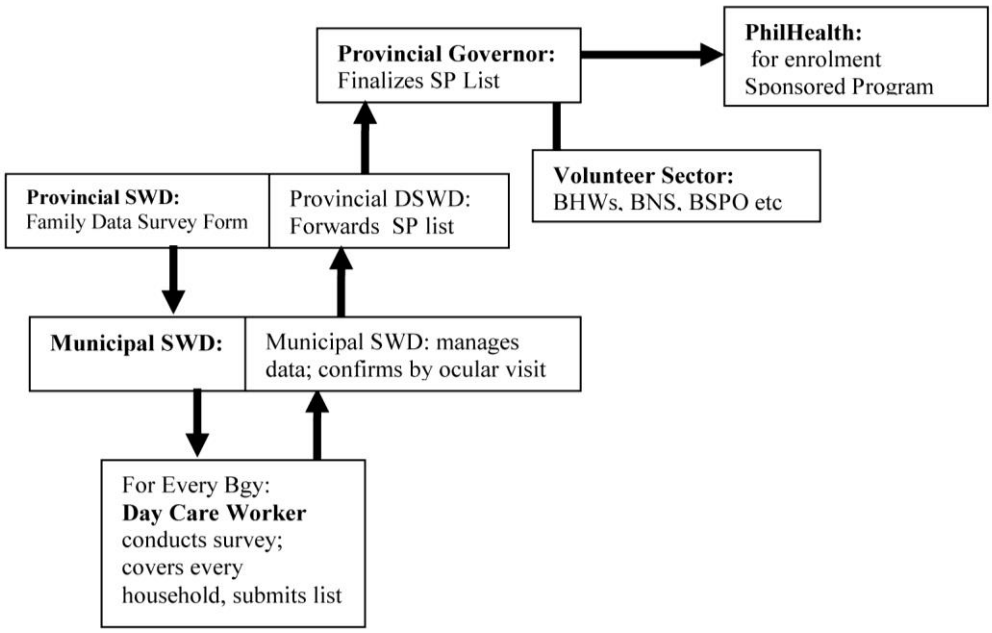


Figure 1. Provincial Identification of SP member

Workers conducts the survey and submits a list to her/his bgy captain who in turn, submits it to the Mayor. The mayor finalizes the list and submits it directly to PhilHealth (Figure 2).

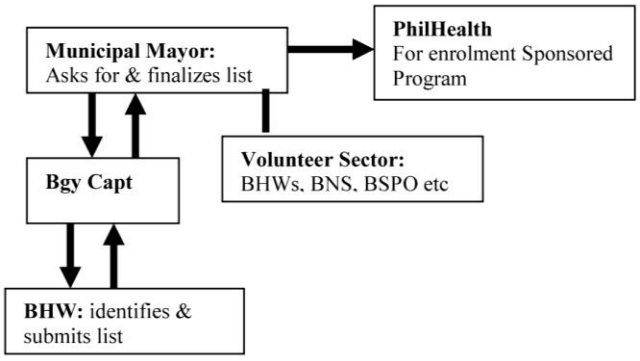


Figure 2. Municipal Identification of SP Members

According to the SP officer-in-charge, the enrollment in the PhilHealth SP is subject to political patronage wherein some constituents seek political intercessions so that they would be allowed to become members of the Program. Inclusion of non-eligible members to the SP was also acknowledged to be one of the ways to get votes.

Identifying the Indigents in a Municipality in Batangas through a Participatory Action Research (PAR) Survey

A Participatory Action Research (PAR) was conducted in 12 barangays in a municipality of Batangas as part of a community-based program being implemented in the area. The program is a partnership between UP Manila (and two colleges of UP Diliman), and the Municipality and is presently on its third year of implementation.

The participatory action research was conceptualized and designed by a team from the College of Social Work and Community Development (CSWCD) of UP Diliman involved in the program. While primarily aimed at gathering baseline information on the prevailing care giving practices of the community for their children, the research according to Professor Rainer Almazan, in charge of CSWCD involvement in the program, also aimed to "lay down the groundwork for the empowerment and organization of barangay health workers and care givers in the municipality towards the community management of the Community Based Health Program." Research design was therefore participatory. Care giving practices were linked to the socioeconomic status of the population, making the determination of their poverty status an important component of the research. The determination of the different socioeconomic levels was done with the participation of the barangay health workers (BHWs) and midwives of the municipality, reflecting their perceptions of poverty within the community. The basic premise is that the people within the community are the ones who are in the best position to define and identify who the poor are in their community.

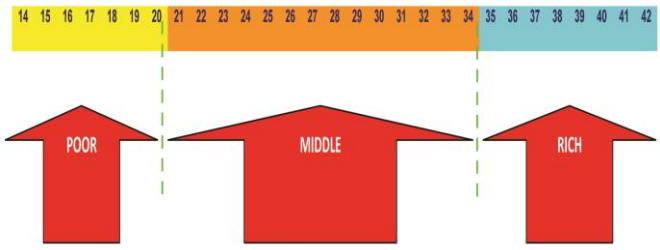
A poverty grading tool was developed using five major indicators of socioeconomic status that were agreed upon in a PAR assembly (that will henceforth be referred to as the assembly) composed of 46 selected BHWs from 42 barangays, 18 of the 19 municipal midwives, 2 municipal

nurses and the UP Medicine consultants and Resident Physicians of the Department of Family and Community Medicine. The community was represented by the municipal nurses, midwives and BHWs who were all from the municipality. Professor Almazan and 2 students from the CSWCD facilitated the discussion. The following were the indicators agreed upon:

1. *kabahayan at ari-arian* (housing and property)
2. *pagkain, damit at sanidad* (food, clothing and sanitation)
3. *serbisyo ng kuryente at tubig* (electric consumption and water)
4. *edukasyon at* child labor (education and child labor)
5. *kita* (income)

Sub-indicators under each major indicator (a total of 14) were likewise agreed upon (Table 1). Focus Group Discussion (FGD) questions were suggested for each of the 14 sub-indicators by the CSWCD contingent and subsequently affirmed by the assembly. BHWs were selected by the assembly and were then trained in facilitating and recording of FGDs, and the questions were pre-tested. The whole process of training and finalization of the FGD questions took 2 months. FGDs in 12 selected barangays were subsequently conducted by the trained BHW facilitators and recorders, under the supervision of the CSWCD students, medical interns and midwife assigned in the barangay where the FGD took place. Results of the FGDs were later collated by the CSWCD students and presented in another meeting of the PAR assembly. Out of the FGD answers, the poverty grading tool was developed. The final poverty grading tool that was used was derived from the final draft of Ms. Catherine E. Adaro of CSWCD, UP Diliman.

Developing the poverty grading tool for the community-based health program – Batangas



The range of these bands (poor, middle and rich) was calculated as follows:

1. There were 14 indicators and 3 levels per indicator. Each level defined characteristics of poorness or richness (1 being the poorest, 3 being the richest) as agreed upon during the assembly.
2. The minimum that a household could score was 14 (14x1=14) while the maximum score a household could attain was 42 (14x3=42).
3. Households whose scores ranged from a minimum 14 to a maximum of 20 were classified as poor. The cut off point (21) between the poor and the middle bands was determined by the score that a household would achieve if it scored the lowest possible score for half of all the indicators (7x1=7) and the next higher score (2) for the remaining 7 indicators. (7x2 =14), giving a total score of 21.
4. Similarly, the cut-off point between the middle and rich bands was determined in the same way. If a household scored the second lowest possible score for half of the indicators (7x2 =14) and then the next highest score (3) for the remaining 7 indicators (7x3 = 21) the total score would be 35. A household that scored between 21 to 34 would fall in the middle category.
5. A household that scored between 35 to 42 would fall into the rich category.

Table 1. Comparison of poverty indicators used in PAR survey & LGU process

LGU process	PAR survey
1. Monthly family income	**1. buwanang kita ng pamilya**
2. Number of times a family eats a meal per day	**2. pagkain,** damit at sanidad: (a) ilang beses kumakain sa maghapon, (b) kagamitan sa pagkain, (c) damit at (d) uri ng palikuran
3. Appearance of house	**3. kabahayan** at ari-arian: (a) pag-aari ng lote, (b) materyales ng bahay, (c) laki/lawak ng bahay, (d) kagamitan sa loob ng bahay at (e) ari-arian sa labas ng bahay
	4. serbisyo ng kuryente at tubig (a) kuryente at ilaw (b) tubig
	5. edukasyon at "child labor" (a) edukasyon ng mga bata; edukasyon ng magulang (b) "child labor"

An 11-page questionnaire was likewise developed from the FGD results and discussed during the third meeting of the PAR assembly. Final revisions were made after the questionnaire was pilot tested in 3 barangays (which were not included in the 12 barangays actually surveyed). It was agreed during the last PAR assembly that all (100%) of the households in the 12 barangays would be surveyed. All BHWs in the 12 selected barangays were trained to accomplish the survey. Data gathering was done from June 2007 to January 2008. Medical Interns were assigned to monitor the data gathering and to ensure the quality of the

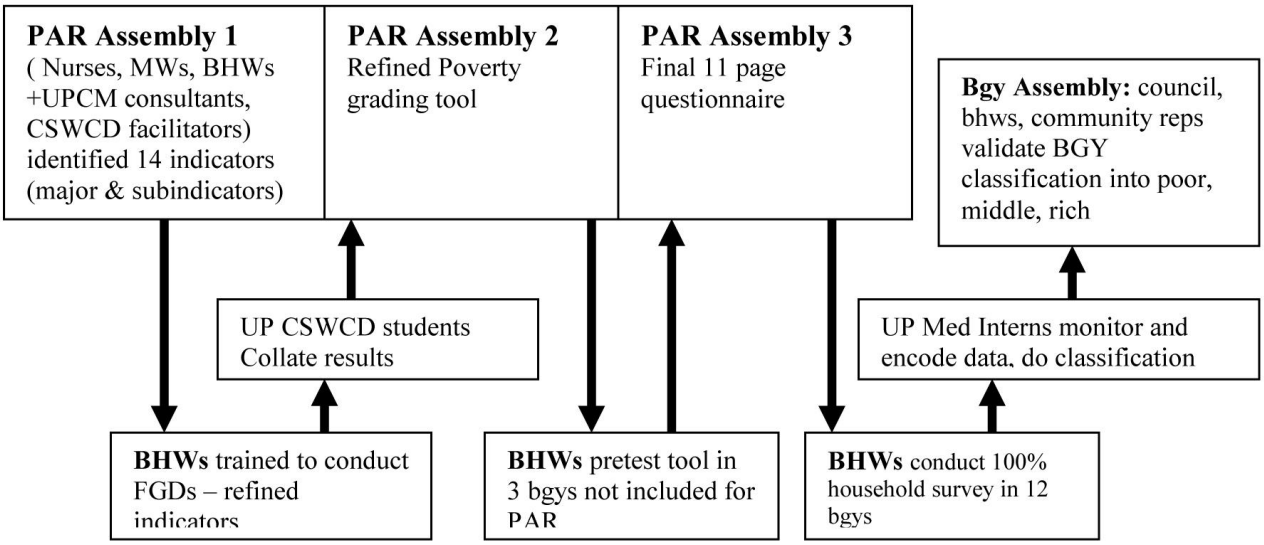


Figure 3. PAR method in poverty classification

survey data before submission for encoding. After data gathering was done in each barangay, the results were fed back to and validated by a barangay assembly composed of the barangay council, the BHWs and interested community members. The households in each barangay were therefore classified into the 3 categories of poor, middle and rich in this manner. The PAR survey in the 12 barangays showed that 24.5% of the households were poor, 71.4% were middle and only 3.3% were rich. (NSO poverty incidence for Batangas in 2006 was 25.6%.)[9](Figure 3).

LGU list of PhilHealth Sponsored Program Beneficiaries, PAR Survey Results & NSCB Poverty Estimate

Table 2 shows the breakdown of PhilHealth enrolled families in each of the 4 barangays according to the provincial and the municipal sponsored lists. There were 663 Sponsored Families, 644 families coming from the provincial list, with only 19 coming from the municipal list. Barangay B had the highest total number of enrolees (229), followed by Barangay A (226), Barangay C (96) and Barangay D (93).

Based on the PAR Survey result shown in Table 3, the majority of the families in the 4 barangays belonged to the middle class (from 60.0% to 78.9%). Barangays A (13.6%) and B (14.7%) had the least number of poor families while Barangay C had the most number of poor families – 179 families, or 39.3% of the families in the said barangay. Barangay D had 119 poor families (31%). Barangay A had the most number of rich families comprising about 7.5% of households.

Table 4 shows the comparison of number of poor families based on NSCB poverty incidence in Batangas, those identified by PAR survey and the LGU SP list. Based on the data from National Statistical Coordination Board (NSCB), the poverty incidence in Batangas was 25.6%. For the four barangays, the PAR survey classified 472 out of 2,086 families or 22.6% as poor, or -3% from the NSCB poverty incidence. For Barangays A and B, the number of poor families identified by the PAR survey was lower than the NSCB poverty incidence for Batangas, (average of 14.2% vs. 25.6%, respectively); for Barangays C & D, the number of poor families by the PAR survey was much higher than the NSCB poverty incidence (39.3% and 31.0% vs 25.6%, respectively). For the PhilHealth sponsored members, the total number of families enrolled for the four barangays (663) is 31.8% of the 2,086 families in the four barangays.

Results of the cross match between the Sponsored list and the PAR survey is shown in Table 5. Four-hundred-sixty-four families or 70% (ranging from 53.1% to 84.6% among the 4 barangays) out of the 663 enrolled Sponsored Members were "Not Found" within the four barangays. The "Not Found" data refer to the beneficiaries listed in either the provincial or municipal PhilHealth SP list that were not found in the aggregated socioeconomic profiling list of PAR survey in the respective barangays.

Aside from those Sponsored Members "Not Found" in the four barangays, the majority of the "found" SP enrolees belonged to the middle class (140 middle class families vs. 59 poor families, respectively). This result is suggestive of leakage. There were no rich families enrolled in the SP for all the 4 barangays.

Only 59 out of the 472 poor families identified by the PAR survey in the four barangays were included in the LGU SP list. Four-hundred-thirteen poor families or 87.5% of poor families identified by PAR were excluded from the LGU Sponsored Members list.

Table 2. Number of beneficiaries enrolled in PhilHealth Sponsored Program per LGU list

BARANGAY	Number of Beneficiaries (PhilHealth Sponsored Program List)		
	Provincial List	Municipal List	Total
Barangay A	226	10	**236**
Barangay B	229	5	**234**
Barangay C	96	2	**98**
Barangay D	93	2	**95**
TOTAL	**644**	**19**	**663**

Table 3. Number (%) of families identified per socioeconomic strata based on PAR survey

BARANGAY	Poor	Middle	Rich	TOTAL
Barangay A	114 (13.6)	663 (78.9)	63 (7.5)	**840**
Barangay B	60 (14.7)	320 (78.6)	27 (6.6)	**407**
Barangay C	179 (39.3)	273 (60)	3 (0.7)	**455**
Barangay D	119 (31)	256 (66.7)	9 (2.3)	**384**
TOTAL	**472**	**1512**	**102**	**2086**

Table 4. Comparison of number (%) of poor families per barangay identified by NSCB poverty estimate, PAR survey & LGU Sponsored Program list

BARANGAY	Number of Poor families (calculated based on NSO poverty incidence in 2006)*	Number of Poor families (PAR Survey)	Number of Poor families enrolled in Sponsored Program by LGU***	Number of Poor Families Excluded from the Sponsored Program****
Barangay A	215 (25.6)	114 (13.6)**	26 (11)	88 (77)
Barangay B	104 (25.6)	60 (14.7)	8 (3.4)	52 (87)
Barangay C	116 (25.6)	179 (39.3)	14 (14.3)	165 (92)
Barangay D	98 (25.6)	119 (31.0)	11 (11.6)	108 (91)
Total	**533**	**472**	**59 out of 663**	**413**

Poverty incidence among families in Batangas in **2006 was **25.6%** (Data from National Statistical Coordination Board)*

***figure in parenthesis = % of total HHs identified by PAR (Table 3)*

****Includes only Sponsored program beneficiaries from January 01, 2008 to December 31, 2008. Figures in parenthesis = % of total beneficiaries of Sponsored Program (Table 4)*

*****Calculated by taking the difference between number of poor families by PAR survey and number of PAR-classified poor families enrolled in Sponsored Program. Figures in parenthesis = % of poor families (PAR survey).*

Table 5. Number (%) of beneficiaries of PhilHealth Sponsored Program per socioeconomic strata based on PAR Survey

BARANGAY	Poor	Middle	Rich	Not Found	TOTAL
Barangay A	26 (11.0)	71 (30.0)	0 (0)	139 (58.9)	**236**
Barangay B	8 (3.4)	28 (12.0)	0 (0)	198 (84.6)	**234**
Barangay C	14 (14.3)	32 (32.7)	0 (0)	52 (53.1)	**98**
Barangay D	11 (11.6)	9 (9.5)	0 (0)	75 (78.9)	**95**
TOTAL	**59**	**140**	**0**	**464 (70.0)**	**663**

Summary of the results

This study has documented through the PAR survey the three major problems of the Sponsored Program as implemented by an LGU in the four barangays: (1) 464 "Not Found" Sponsored members or 70% of the LGU's sponsored list, (2) inclusion of the non-poor, in this case, 140 middle class families as classified by the PAR survey or 21.1% of the LGU's Sponsored list, and (3) exclusion of 413 or 87.5% of true poor families as identified by the PAR Survey. Only 59 families or 8.9% of the LGU Sponsored list were classified as poor families by PAR.

Discussion

The present study suggests the inherent potential of communities in knowing their collective health and socioeconomic concerns which include identifying the poor within them. With adequate support, the communities can determine their concerns and utilize their capabilities in implementing long-lasting changes in the community. It was observed in previous experiences that urgent issues that originated from the community members "may be more likely to reflect genuine and central community concerns." And the knowledge acquired by the community members by PAR can be used to effect policy changes in the government level.[10]

Compared to other research methodologies, PAR allows the community to acquire collective awareness of its own situation by way of collaboration with the underprivileged themselves and to bolster its ability for changing its situation.[11] It emphasizes the involvement of people in taking action for the improvement of their own health by engaging them in the whole process of studying the community issues that need to be addressed. It aims to make the people take control of their lives by being aware of their community's present challenges, understanding and improving the existing system. It is by being critically aware of their community's problems that they start to develop the potential for transforming their lives to a better condition.[12]

A previous experience by a multi-ethnic neighborhood in California in employing PAR to address social issues proved to be successful in identifying and addressing the critical social issues of the community. In another instance, the sweeping policy changes enacted to solve the health and environmental problems that used to beset a small community in Halifax County, North Carolina had been made possible by committing to the PAR principles.[13]

In the present study, the communities that participated in PAR in four barangays of a municipality in Batangas were able to classify the households into poor, middle and rich households in accordance with their consensus criteria which were based on their collective knowledge and experiences. They used more socioeconomic indicators in identifying the true poor within them compared to the standard criteria of the local government unit and in the

process documented the poor who were excluded from the PhilHealth Sponsored program, the non-poor who were included and, those Sponsored members who apparently could not be found in their four barangays.

Identification of the poor: use of standard guidelines

The LGU's process in identifying the poor for the Philhealth SP made use of a standardized survey called the Family Data Survey Form provided by the PhilHealth regional office. The Family Data Survey relied mainly on one parameter: the monthly family income, although two other parameters were reportedly used to identify those who qualify for the SP: (1) number of times a family eats a meal per day and (2) the appearance of their house. These two parameters were not part of the Family Data Survey Form and it was also not clear if these parameters were used by the BHWs who initially made the survey or the DSWD members who did the interview and home visits.

The use of income as the only parameter for assessing the economic profile of a family is unreliable. In a previous study by Castańeda on the means test being employed in Colombia, it was suggested that pure income measures are good at measuring short-term (transient) changes in welfare. But it has the drawbacks: (a) it requires frequent updating; and (b) it is unreliable without verifications of incomes and employment, a process that is technically difficult in developing countries due to limited administrative manpower and resources and the large undocumented informal labor sector.[8]

Compared to the LGU process, the PAR survey had predetermined parameters of poverty which were previously identified by the community members themselves through a focus group discussion (FGD). The PAR process used 5 standard parameters in the identification of the poor families. There were no other parameters used that were not identified by the FGD. All the households in the mentioned barangays were surveyed which underscores the probable significance of the "Not Found" sponsored households.

Head-to-head comparison of parameters used by the LGU and the corresponding PAR parameters showed that the parameters used by the LGU are all found in the PAR survey, namely: (1) monthly family income, (2) frequency of meal consumption per day and (3) appearance of the house. It can be noted that 2 parameters were not used by the LGU: (1) electricity and water services and (2) education and child labor. The LGU made use of "appearance of house" as a parameter but the PAR was more specific on the characteristic of the house (e.g. materials used, area of the house, land ownership). PAR also used other poverty indicators such as properties, clothing and toilet facilities. (Table 1)

In a study done by Reyes on alternative means of identifying potential beneficiaries of the SP, three means testing options were recommended based on the Community-Based Monitoring System that is being implemented by some LGUs – income, ownership of assets and socioeconomic characteristics, and electricity consumption. A household is classified as either poor or non-poor using these 3 criteria. If a household is non-poor based on these 3 criteria, then it will not be eligible for the SP.[6]

Inclusion of non-poor or unclassified to the program

The LGU had an additional operational classification of the SP into two component arms: volunteer sector and indigent sector. The so-called "volunteers" (Barangay Health Workers, Barangay Service Point Officer, Barangay Nutrition Scholar, Day Care Workers, barangay police, barangay secretary and other elected barangay officials) were enrolled in the program, with no quota restriction. There were reports of political intercessions so that constituents may be allowed to be enrolled in the program without undergoing the classification process. These were also observed in the study made in Capiz.[14] Vinyals identified the following problems in the SP: (1) inclusion of the non-poor: (a) political indigents – not necessarily poor who become beneficiaries of politicians in exchange for political support and patronage, (b) public servants and volunteers as rewards for their service and (2) non validation by PhilHealth of the Sponsored list through the proper use of means testing to identify the true poor. He further stated that lack of funds is not always a problem. These problems identified in Capiz resulted in the exclusion of the "real poor" and the inclusion of those who are supposed to be in the Individually Paying Program into the SP.

The Volunteer sector of the Barangays deserve PhilHealth coverage because of the services they render, but they should not be enrolled under the Sponsored program because they lead to exclusion of the "true" poor, unless they qualify to be classified as poor. PhilHealth or the LGUs should create another enrollment category for them.

The significantly large number of names "not found" should also be subject to further examination. Considering that the PAR survey was carefully carried out for all the households in the 4 barangays, the presence of unfamiliar names in the SP list when cross matched with the PAR survey results is suggestive of possible inclusion in the SP list of non-residents in the respective barangays. These "ghost" enrollees significantly aggravate the problem of exclusion of the true indigents in the community. These "Not Found" enrollees cannot be explained by weakness in the indicators and may reflect the "political indigents" at the provincial level. 644 out of the 663 Sponsored households came from the provincial list.

The data showing the bulk of enrollees coming from the middle class of the 4 barangays could also be explained in terms of the documented process by which the LGU or PAR

survey identifies the poor in the barangays. The LGU process focuses mainly on the individual paying capability which may not reflect the true socioeconomic status of the person especially in the absence of verifiable documents. In such cases, other parameters should be assessed including household condition. PAR survey assigns the socioeconomic strata based on summation of scores from individual and household level data where the higher the number implies a more affluent living condition. There is the possibility that PAR survey is subject to personal bias of the respondents of the survey who may not be rating themselves poor but are still not able to afford the minimum requirements for nutrition, clothing, housing and education.

Though PAR may be challenged in terms of its strength of validity and scientific design rigor, it is still deemed as a justified scientific endeavor where the main goal is to address the problems identified by the people in their communities, and not only for scientific quest of knowledge.[10]

The role of the academe in strengthening health systems and validating and improving performance of national health programs cannot be discounted and instead should be optimized for the benefit of the communities. The present study exemplified how the academe can provide technical support for a community program and evaluate the efficiency of existing health systems. In a systematic literature review of the use of PAR in addressing the disparities in environmental and occupational health in the U.S., it was evident that collaboration among the members of the academe, government scientists and community members led to community-level action to improve the health and well-being of the community. It was observed that community partners who initiated PAR in their own communities recognized the indispensable importance of collaboration with academic researchers who can share their expertise in conducting health researches.[10] By establishing partnerships among the academe, government, and community members, the development of community programs is facilitated by harnessing the strengths of each in terms of resources and expertise in addressing wide range of public health issues. Through combination of broad knowledge of evidence-based practice and observations in the community, the partners can readily translate their findings into community action which would be more likely supported by the local community members.[15] Previous experiences had shown that this partnership could lead to undertaking community-based projects by different universities around the world in improving the well-being and health of the disadvantaged communities.[16]

Conclusion

The government's multi-billion peso National Health Insurance Program (PhilHealth) will fail in its mission of achieving Universal Coverage if it fails to properly identify and enroll the true poor in its Sponsored Program.

PhilHealth's Sponsored Program continues to evolve, even after many years of implementation. Its weaknesses must be addressed while providing the mechanism for effectively ensuring indigents financial access to health services through the LGUs.

The LGUs have the responsibility to identify and submit to Philhealth its list of indigents for enrollment into PhilHealth's Sponsored Program and this study documented an LGU's process.

The communities in 4 barangays in the province of Batangas, through the Participatory Action Research survey, were able to identify the poor households amongst them, using indicators that they themselves identified.

A comparison of the LGU list of Sponsored members and the poor households identified by PAR showed a wide discrepancy: (1) 464 "Not Found" Sponsored households or 70% of the LGUs sponsored list; (2) inclusion of the non-poor, in this case, 140 middle class families as classified by the PAR survey or 21.1% of the LGUs Sponsored list; and (3) exclusion of 413 or 87.5% of true poor families as identified by the PAR Survey. Only 59 families or 8.9% of the LGU Sponsored list were classified as poor families by PAR.

Aside from the selection process utilized, other factors that affect the exclusion of the true poor in the SP could be political patronage, the voluntary sector component of the LGU, lax PhilHealth guidelines, and the LGU's and PhilHealth's lack of validation standards for identifying poor.

PAR offers communities, LGUs and the National Health Insurance Program a tool to validate the coverage of the Sponsored program. LGUs and PhilHealth should consider such tool or similar tools to validate their identification, selection and enrollment of the poor, which is extremely vital in achieving universal coverage. The members of the community are in the best position to validate the list of Sponsored Members. "Although challenging, objective criteria and transparent and participatory engagement by local communities in identifying the poor…are essential to prevent favouritism and leakage to the non-poor."[17]

The academe has a role in assisting communities in acquiring collective awareness of their own situation by way of collaboration and developing competence for improving their lives.[13] The academe also has a role in assisting LGUs in improving their health systems and national health programs in validating and improving their implementation.

The importance of this study extends beyond its primary intent of describing the efficiency of the SP in enrolling its supposed target members. There is a need to address categorically a number of issues brought out by this study. First, the voluntary sector must be separated from the true indigent sector in inclusion in the SP. Second, further study must be done to identify the "not found" SP members.

Third, utilization of PhilHealth benefits by the poor is another issue that must be investigated. Fourth, determining the poor families in non-poor areas could be pursued in future studies. Finally, the possibility of utilizing the PAR method by non-academic institutions (e.g. NGOs, RHUs) in validating and monitoring community programs could be explored.

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