

ALTERNATIVE SOCIAL-FINANCING SCHEMES FOR THE HEALTH SERVICES IN THE
PHILIPPINES, REGIONS V (BICOL) AND VI (WESTERN VISAYAS)

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Preface

This document reports the findings of a preliminary inquiry into the feasibility of developing alternative social-financing schemes for the health services in the Philippines. This preliminary inquiry is regarded as the first of a number of activities (steps) which collectively are required to inform the design of such schemes and, if all goes well, to lead to the implementation of them.*/ The main focus is upon developing employment-based contributory insurance schemes for those who live and work in the rural, agriculture economy.*/

Introduction

The population of the Philippines stood at about 48 million in 1980 and is growing at the rate of 2.4 percent annually. Gross National Product (GNP) was estimated as roughly equivalent to U.S. \$630 per capita in 1979.*/ The average annual growth rate of real GNP averaged 6.7 percent from 1972 to 1978

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*/ For a general statement of what is entailed by this kind of feasibility assessment, see the author's "Assessing the Feasibility of Alternative Social-Financing Schemes for the Basic Health Services in LDCs," February 1982, henceforth STEVENS/ASSESSING.

*/ A rationale for this focus will be found in STEVENS/ASSESSING, cited foregoing.

*/ See Philippines Country Development Strategy Statement FY 83, Annex A, Philippine CDSS Macroeconomic Analysis, USAID/Philippines, January 1980 (henceforth CDSS/A/83). This document is the source of the macroeconomic data reported in this section.

(it averaged over 5.1 percent during the period 1960-1972). As these data indicate, the Philippines may be characterized as a country with a relatively high per capita GNP (among LDCs) and as a country with a relatively good development performance in recent years. The national government is the main generator of tax revenues, its total collections estimated as about 13 percent of GNP in 1980 (a drop from about 15 percent in 1975). Local government tax revenue generation is estimated as 1.4 percent of GNP in 1980 (a slight improvement from the 1.2 percent of GNP in 1975, this owing in the main to increasing real property tax collections). Although local government revenue performance is poor, it is believed to have the potential for improvement in support of locally directed development projects. This is a potentially important possibility for the prospect of improved health-sector financing, particularly in light of current resource management problems pointed out by CDSS/A/83 (p. 40), viz:

Revenue projections for the 1981 GOP budget show an increase of 17.2 percent, while expenditures are projected to increase by almost 20.0 percent. The 33 percent decline in foreign borrowings experienced in 1980 compared to 1979 will, therefore, have to be reversed in order to accommodate this increase in fiscal outlay. Those borrowings are estimated to reach 74.4 billion in 1981, almost double the 1980 level, and will finance 61 percent of the GOP's operating deficit. With over half of the GOP's capital outlay program tied up with foreign-assisted projects, and a projected peso/dollar counterpart ratio of 2.22:1 for 1981, it is likely that donor projects in 1981 and beyond will again experience shortfalls. This problem will be exacerbated to the extent that the large number of projects begun in 1978-79 get into full swing, thereby requiring substantial amounts of peso cost financing. The year 1981 will also see a large number of new project starts which will push the peso/dollar counterpart ratio to almost 4.8:1 by 1982.

The Philippines is divided into twelve administrative Regions which exhibit considerable socio-economic diversity. USAID/Philippines has adopted a regional focus for its assistance activities such that Regions V (Bicol), VI (Western Visayas) and VIII (Eastern Visayas) are to be the "core regions"

for FY 82-84 with Regions I (Ilocos) and II (Cagayan Valley) to comprise additional regions for FY 84. The criteria which informed USAID's regional focus included the relatively high prevalence of poverty in the selected core Regions, the development plans of the Government of the Philippines (GOP), and other factors.*/ In the two of these Regions selected for this inquiry, i.e., V and VI, USAID now has health-sector projects underway. These projects have trained and fielded Barangay Health Workers (BHWs--the barangay is the most local governmental unit in the Philippines) who will supplement and receive some supervision from the Ministry of Health (MOH) system although they are not literally organization components of that system. The BHWs are expected to be responsive to their clientele at the local level and, as a distinctive feature of these projects, it is contemplated that locally-generated resources will provide for the support of these non-volunteer workers. Thus, these projects already feature attention to alternative financing schemes and it is anticipated that the forthcoming health-sector project (now in the PID stage) will seek to engage alternative-financing issues in a more general way.

To provide some orientation for the reader, a brief characterization of Regions V and VI follows.*/

Region V: The Bicol Peninsula, located in the southeastern tip of Luzon Island, comprises about 6 percent of the total area of the Philippines. The

*/ See Country Development Strategy Statement, FY 1983, USAID/Philippines, January 1981.

*/ These brief accounts are derived mainly from the following documents which themselves provide more detailed accounts, viz: Country Development Strategy Statement, Philippines FY 83, Annex B, Poverty Profile of Western Visayas (Region VI), USAID/Philippines, January 1981 and Dratt, "Economic Profile and Causes of Poverty in Bicol (Region V)," USAID/Philippines, October 13, 1981.

regional population in 1980 was 3.47 million, or about 7.2 percent of the total population of the Philippines. With a GDP per capita of only ₱2,181 (1979), or about 46.0 percent of the national average, Region V has one of the lowest per capita outputs in the country. Employment is concentrated in agriculture, with two-thirds of the total number of employed workers in 1975 belonging to this sector. Bicol's agriculture sector provided one-half of its GDP in 1979 (the industrial sector contributed 18.4 percent and the services sector 31.0 percent). Rice, coconut and abaca are the major crops. In 1975, about 52 percent of the gainfully employed in the region (the gainfully employed represented about 40 percent of the region's working age population) were classified as self-employed or employer, reflecting the fact that most of the farmers in Bicol tend their own farms with the help of household members or some hired labor. According to a recent World Bank study, 286,400 families in Region V (55.4 percent of all families) were living below the poverty line in 1975, an increase from 48.8 percent in 1971. The nation-wide prevalence of poverty in 1975 was 45.3 percent.*/ Rural families in Bicol comprise about 83 percent of all families and had an average 1975 family income of ₱3,934. Of all of the regions in the country, Bicol has the third highest prevalence of poverty among rural families.

Region VI: Western Visayas, comprised of the Islands of Panay, Guimaras and the western half of Negros, and with a population of 4.15 million (about 10 percent of the national population). With a per capita GDP of ₱3,670 (1979), which is about 77 percent of the national average, Region VI features a con-

*/ See World Bank, Aspects of Poverty in the Philippines: A Review and Assessment, Report No. 2984-PH, particularly Volume II: Main Report with Annexes and Statistical Appendix, December 1, 1980 (henceforth, IBRD 1980). This Report includes a detailed description of how the poverty line was calculated. For 1975, it was set at ₱827 per capita (or about ₱4,964 per family) in rural areas and at ₱1,103 (or about ₱6,619 per family) in urban areas.

siderably higher output per capita than does Region V. This is largely accounted for by the highly developed sugar industry in Negros Occidental and Iloilo which generates 92 percent of the region's agriculture product (although representing only about 5 percent of all farms) and which provides 60 percent of the nation's sugar production. Iloilo is also the most productive rice area of the country. And Region VI is rather more urbanized than Region V, with 27 percent of the population located in urban areas. In the case of Region VI, aggregative measures of per capita output and income can be rather misleading as an indicator of regional poverty. Thus, according to IBRD 1980 (p. 153), in 1975 about 50 percent of all households fell below the poverty line (set at the level indicated in the preceding footnote). The Region VI income distribution is badly skewed owing in good part to the distributional implications of the sugar industry. Thus, although this industry generates a large part of regional output, some 62,500 households of landless sugar workers are among the poorest households in the entire country. Also, some 128,000 households of upland and rainfed palay (rice) farmers comprise a major component of the 2.55.4 thousand poor households in rural areas (out of total rural households of about 500 thousand).

The foregoing sketches of some features of Regions V and VI suggest that alternative health-sector financing schemes for beneficiaries who are employed in the agriculture sector would be addressed to not only the majority of the population in these regions but also to the majority of poor families. They also suggest that crop-based insurance schemes (for coconut, rice, sugar) might provide the most appropriate organization format (a possibility which will be explored in some detail in this report).

The Existing Health-Services Sector: Financing the Demand for Services

Generally speaking, the health-services sector in the Philippines exhibits the pattern which is familiar in many LDCs. There is a Ministry of Health (MOH) system financed in the main from general tax revenues. This system is generally underfinanced, particularly those delivery components which are supposed to provide primary health care for those who live in rural areas. Although the MOH system has developed a network of Rural Health Units (RHUs) and Barangay Health Stations (BHSs), its expenditures are in the main committed to hospital services in the urban areas, particularly, Metro Manila. A large and flourishing private health-services sector (both traditional and modern) operates alongside the public sector (in terms of expenditures, several times the size of the public sector). Although a traditional social-security-type health-insurance scheme was established a few years ago, consumers must rely for the most part upon out-of-pocket payments to finance their demand for health care, obtained mainly from the private sector. In the Philippines, as in many other LDCs, this characteristic pattern sets the context in which we seek to rationalize health-sector financing by developing alternative social-financing schemes.

More particularly, for the Philippines in 1970, government expenditure on health has been reported as 0.4 percent of GDP.*/ For the same year in the Philippines, Richards reports private expenditure on health as 1.5 percent of GDP, i.e., about 80 percent of total health expenditures. This relatively low rate (among LDCs) of government expenditure on health appears to have persisted to later years. Thus, IBRD 1980 reports (p. 29) that in 1975/

*/ See P. J. Richards, "Some Distributional Issues in Planning for Basic Needs Health Care," World Employment Programme, Income Distribution and Employment Programme, Working Paper, International Labor Office, Geneva, June 1979, p. 4. Richards cautions his findings must be taken as approximate.

76, the Government health expenditures amounted to P21.8 per capita, which works out to about 0.3 percent of GDP.*/ The GOP anticipates that in the future, as in the past, personal consumption expenditures will continue to be the major source of financing for health services. The 1983-87 Development Plan projects sources of financing for the health services as follows:*/

	1983	1987
Private	P3.8 billion	P4.2 billion
Government	P1.4 billion	P1.5 billion
MEDICARE */	P417 million	P516 million

It is notable that over this planning period, virutally no increase is planned in central government expenditure for health services. And, these projections anticipate that by 1987, central government expenditure for health will still constitute little more than 20 percent of the total, i.e., maintaining the public vs. private shares which have featured the last couple of decades.

It is evident both from the historical track record and from current GOP plans, that if most consumers of health care in the Philippines are to enjoy the benefits of social financing (distinguish out-of-pocket financing) for most of their health-care expenditures, this will have to be accomplished by some combination of the following financing strategies, viz: (a) more local-government tax revenues allocated to health; (b) expansion of coverage

*/ Taking the 1975 population as 42.3 million and 1975 GDP as P114,721 million, as reported by World Tables, The Second Edition (1980), published for the World Bank by Johns Hopkins University Press.

*/ See Philippines Development Plan 1983-87, Technical Annex (2/23/82 Draft--for internal discussion only), p. 7.7 (henceforth GOP PLAN 83/87).

*/ MEDICARE is the social-security scheme which will be discussed subsequently.

under the existing MEDICARE program; (c) the development of alternative social-financing schemes.*/

Some combination of strategies (b) and (c) would appear to be squarely in line with the GOP's stated policy in this domain. Thus, the 1978-1982 Development Plan included in the ten-year objective for the health-services sector:

- h) to increase coverage of health insurance so as to cover the total population.*/

So far as I have been able to determine, however, it has not been spelled out in any detail how the extension of health-insurance coverage to the total population is to be accomplished.*/ The general idea, however, appears to include a substantial expansion of coverage under MEDICARE, we turn to a brief description of this program.

The Philippines now has a general social security system comprised of the Government Service Insurance System (GSIS) and the Social Security Sys-

*/ USAID/Philippines is actively exploring strategy (a), I do not further discuss it herein.

*/ Five-Year Philippine Development Plan, 1978-1982 including the Ten-Year Development Plan, 1978-1987, Manila, Philippines, Sept. 1977, pp. 188-39 (henceforth FIVE-YEAR PLAN).

*/ Documents which one might suppose would address this issue don't do so. Thus, the MOH has promulgated A National Strategy and Plan of Action for Achieving Health for all Filipinos by the Year 2000, 1980 (henceforth, NATIONAL STRATEGY). Although the MOH calls for a ". . . partnership between communities, the government and the private health organizations. . ." to achieve this goal, overall, NATIONAL STRATEGY gives remarkably little attention to health-sector financing issues and plans at all, including affording no discussion of health insurance.

The Proceedings of a recent workshop on financing PHC noted, in summarizing, a general reluctance among the workshop participants to be explicit about ". . . the selection of alternative strategies for PHC financing (health insurance, cooperatives, etc.)." Proceedings of the Workshop on Financing Primary Health Care (PHC), held on July 9, 1981 at NEDA SA Quezon City, NEDA Social Services Staff, Programs and Projects Office, Sept. 1981, p. 23.

tem (SSS)--for employees in the private sector. These schemes provide work-mens' compensation, old age and survivors insurance. The Philippines Medical Care Act of 1969 as amended 1972 (Republic Act 6111--MEDICARE), has as its purpose under Phase I implementation that all member/employees of SSS and GSIS are automatically covered by MEDICARE which provides (limited) hospital-ization insurance.

MEDICARE is financed by payroll taxes with employee contribution of about 2.5 percent of wages and employer contribution about 3.5 percent. The program covers both employees and their dependents. GSIS and SSS serve as administrators of the Health Insurance Fund. For 1980, MEDICARE paid P320,805,066 in benefits on 1,213,338 claims, an average of P264.62 per claim. In 1980, MEDICARE paid hospital per diems for primary, secondary and tertiary hospitals respectively of P14.00, P16.00 and P18.00. My impression is that these benefits amount to from about one-half to one-third of the per diems charged beneficiaries. In addition, MEDICARE pays some part of the professional fees of hospital based physicians, with only 1.8 percent of the total expenditures going for drugs. The MEDICARE cost-sharing level varies not only with the level of service but also the region. For the Philippines as a whole, for primary, secondary and tertiary facilities respectively, cost sharing was at a rate of about 49 percent, 34 percent and 24 percent. The overall cost-sharing rate was as high as 75 percent in Region II and as low as 29 percent in the National Capital Region. MEDICARE also operates 87 Community Hospital and Health Centers throughout the Philippines in the more rural areas. These are small facilities with 10-15 beds each, the communities supply the land and in some instances the facilities. In 1980, the CHHC program saw 168,347 outpatients and 50,652 inpatients.*/

*/ Philippines Medical Care Commission, Annual Report, 1980, Quezon City, Philippines.

As pointed out, under MEDICARE Phase I, coverage is extended to all member/employees of SSS and GSIS, i.e., the self-employed are excluded. More particularly, according to the Definitions of the SSS Act:

Employment: Any service performed by the employee for his employer, except:

- 1) Agriculture labor when performed by a share leasehold tenant or worker who is not paid any regular daily wage or base pay and who does not work for an uninterrupted period of at least six months a year.

This definition of employment effectively excludes most members of the agriculture work force from coverage under the SSS Act and hence from automatic coverage by MEDICARE under Phase I implementation. It has been my understanding that under Phase II implementation of MEDICARE the agriculture work force is supposed to be included along with other self-employed workers. However, it appears to be uncertain when Phase II might be implemented. One problem in implementating traditional social-security-type schemes of this type for the agriculture work force is that of where the employers' contributions (featured by employer/employee schemes in the urban areas) are to come from. The assumption has been, I am told, that the government will have to make the "employers" contribution. Under this assumption, and given the sharply constrained fiscal capacity of the government, we may wait a very long time indeed for the implementation of Phase II of MEDICARE.*

*/ According to GOP PLAN 83/87 (p. 7.2) there is to be an expansion of coverage under medical insurance ". . . through the comprehensive medical services for all self-employed and their legal dependents, legal dependents of contributing retirees, and all others who may eventually be made a part of the health insurance plan." And (p. 7.7) the expectation is expressed that MEDICARE will cover more than 28 million persons by 1987, i.e., about half of the probable total population in that year. To my knowledge, the details on how all of this is to be implemented have not been worked out.

It is my understanding that the GOP is not committed to sole reliance upon MEDICARE for the extension of coverage under health insurance such that the development of free-standing (i.e., not regarded as integral parts of the existing MEDICARE system) social-financing schemes for the agriculture work force would be an acceptable approach. In this context, I regard as potentially significant the October 19, 1979 Letter of Instruction in which President Marcos instructed the MOH to design, develop and implement programs which focus on health development at the community level, particularly in rural areas by:

1.1, b) developing a strong Primary Health Care system in coordination/cooperation with all the Ministries and Agencies engaged in social, political and economic development.
(Emphasis supplied.)

Surely the effort to involve the Ministry of Agriculture and the cooperative movement in agriculture and other agriculture institutions such as crop-based social amelioration funds, in the implementation of health-insurance schemes fits squarely with this instruction.

The Existing Health-Services Sector: Some Additional Features

As reported by IBRD 1980, of 1975/76 GOP total health-care expenditures of ₱21.8 per capita (at the current exchange rate US\$1.0 = ₱8.5, this would be about \$2.50), ₱13.5 went to field operations and the remainder to specialized services in Manila and to overhead operations, with over 70 percent of the field expenditures claimed by hospital services. The primary health care system received only about 20 percent of the expenditures.

This picture quite well represents the current pattern of the MOH system as it operates in Region V (Bicol).*/ The total amount released and obligated

*/ Region V data from MOH Region V Annual Report for CY 1981.

for government health services in CY 1981 was ₱77.6 million, or about ₱22 per capita for the population of the region. A much larger percentage went to field operations (Acct. 503 "Field Health Services" plus Acct. 505 "Hospital Services")--namely, about 85 percent. Of the expenditures for field operations, hospital services claimed about 70 percent, leaving about ₱5.7 per capita (at the current exchange rate, about US\$0.67 per capita) for the primary health care system operating mainly in rural areas.*/

According to OIC, Data Bank figures, as of January 1982, the Philippines had a total of 77,621 hospital beds, of which 41,995, or about 54 percent, were private. For the country as a whole, the bed to population ratio was about 1.6 beds/1,000 population. Region V had a total of 4,092 beds, of which 2,752, or about 67 percent, were private, i.e., a considerably higher ratio of private to government beds than for the country as a whole. For Region V, the bed to population ratio was about 1.1 beds/1,000 population, considerably below the national average. In 1981, Region V reported 115 RHUs (of which, 50 are characterized as "needs repair" and 15 as "dilapidated"), or about 1 RHU per 30,500 population (as a nation-wide standard, the GOP is aiming at 1 RHU per 20,000 population). In 1981, Region V reported 658 BHSs, the ownership of most of these (563) identified as "community," the remainder owned by the GOP. This gives a BHS to population ratio of near the 1:5,000 population standard set by the GOP. However, of these 658 BHSs, 215 are characterized as "dilapidated" and another 333 as "needs repair." In Region V, the RHUs had a staff of 79 physicians and 163 public health nurses. About 83 percent of the Region V population is rural, such that the ratio of RHU-

*/ These calculations do not include the USAID supported Bicol Integrated Health, Nutrition and Population Project budgeted for CY 1981 at about ₱5.0 million.

based physicians to the rural population is about 1:37,000 population, and the nurse to this population ratio is about 1:18,000. The Region V BHSs report a staff of about 600 midwives, or a ratio of about 1:4,800 of the rural population in the region.

Although I did not assemble as much current data describing the performance of the health-services sector in Region VI as for Region V, I believe that the overall pattern of resource allocation in the MOH system is about the same in the two regions. According to OIC, Data Bank, as of 1982, Region VI had a total of 4,993 hospital beds, for a bed to population ratio of about 1.2 beds/1,000 population, virtually the same ratio as for Region V in that year. (However, in Region VI only about 57 percent of the beds are private, as compared with 67 percent in Region V). In Region VI, for 1974 (as reported in IBRD 1980) the RHU to population ratio was 1:8,333. The staffing patterns of the RHUs and BHSs are supposed to conform to the same national standards.*/

Alternative-Financing Schemes Should Help to Rationalize Overall Health-Sector Financing

It is important that we pause long enough to consider this point before engaging the details of alternative-financing schemes for the Philippines. For, if this point is not understood, much of the significance of the enter-

*/ The picture on the structure and financing of the MOH system for the country as a whole and for Regions V and VI is reasonably clear. However, for both regions (and for the country as a whole), it would be of interest to have more detailed information on the performance of the private sector, e.g., a breakdown of total expenditures by drugs, physicians services and hospital services. A World Bank team has recently completed a detailed study of total health-sector (public and private) financing in the Philippines, I anticipate that the findings from this study will soon be available. It did not seem to me to be an appropriate use of time in the course of my own inquiry to attempt to assemble those same data.

prise entailed by the design and implementation of alternative-financing schemes will not be appreciated such that, indeed, the nature of this enterprise is apt to be evaluated quite incorrectly.

In various countries, pursuant to the national goal of "health for all by the year 2000," Ministry of Health (MOH) systems have embarked upon efforts to enhance their primary health care programs and activities, frequently at the local level and in a context of community participation. This approach entails, among other features, much greater emphasis upon preventive/promotive activities. Consequently, what has been for years a chronic problem for MOH systems--namely, how to make more resources available for preventive/promotive programs, has been greatly exacerbated. And, owing in part to this circumstance, interest has been growing in finding alternative sources of financing for the health services--alternative, that is, to the general tax revenues available to the MOH. In my view, we have tended to take too narrow an approach to this problem, e.g., tending in large part to focus just upon the question how more money might be found for the MOH system. What is really required, as an integral component of the primary health care strategy, is to rationalize the health care financing system as a whole.

What is required is to identify the major problems with the performance of the existing health-services sector to which alternative-financing schemes should be responsive (obviously, these will not be all of the problems confronting the sector) and then attempt to come up with a scheme which would be responsive. We may identify some such problems.

1. A major problem for the MOH system in the Philippines (shared by MOH systems around the world) is that pressure for delivery by the system of curative services overly compromises the capacity of the system to deliver preventive/promotive services. It seems clear that the GOP will not, at least

in the foreseeable future, significantly increase the general tax revenues available to the MOH system. But, here, as elsewhere, this problem is not just a matter of the total resources available to the MOH. Whatever that total, within realistic limits, the pressures for curative services are inexorable and the curative-services domain tends to be a bottomless pit for a delivery system which is supposed to deliver services to the whole population without user charge. Thus, simply providing more funding for the MOH system, although this may help to some extent, is not apt to provide a real remedy for the position. What is required is some kind of structural intervention (e.g., as by resort to an alternative-financing scheme) which will provide an acceptable way to take the curative monkey off the MOH's back, so to speak. Thus, if the government's responsibility for arranging a fair and equitable system for financing the people's demand for curative health services can largely be discharged in some other (non-MOH) program context, the major role of the Ministry of Health tends naturally to be re-defined such that it can move in the direction of becoming, in the main, a Ministry of Public Health. If it obtains, this is a valuable result.

Preventive/promotive services tend to be, in the technical sense, "public" goods such that public financing is peculiarly appropriate for resource allocation to them. The MOH is the logical organization aegis to provide such financing. Under the kind of development suggested here, the MOH should be able to conserve more of the scarce fiscal capacity it controls for the public financing of those important preventive/promotive services which, if not financed by the MOH, are unlikely otherwise adequately to be financed at all. This consideration, always important, has become especially important now as the GOP embarks upon an ambitious primary health care program which focuses in the main upon preventive/promotive activities. It is be-

cause alternative-financing schemes (e.g., contributory insurance schemes) can help to cope with the problem of how the MOH can conserve scarce fiscal capacity for the financing of preventive/promotive activities that such alternative-financing schemes must be regarded as an integral part of the primary health care strategy.

2. Reckoned per capita for the population as a whole, the MOH system's resources are woefully inadequate for it to respond to its charge. If, however, these resources could be concentrated on some small subset of the population, they would be much more nearly adequate to the task of providing reasonable access to curative services while at the same time maintaining preventive/promotive activities. An alternative social-financing scheme can help to achieve this objective by relieving the MOH system of much of its curative load. That is, even with such an alternative in place, it is likely that the MOH system will continue to finance and deliver some curative services, i.e., to those on the lower end of the income distribution who cannot be included in alternative schemes. But this should be a much more manageable situation such that a reasonable level of services could be provided to this clientele.

3. Another major problem in the health services sector is the way in which the demand for services is financed in the relatively large and flourishing private sector--namely, for the most part, by out-of-pocket payments by consumers. The disadvantages of this kind of financing as contrasted with social financing, from both the point of view of the individual consumer and that of social equity, are familiar and need not be rehearsed.

There is, of course, nothing inherently amiss in having a large private health services sector. Indeed, there would seem to be no prima facie reason to suppose that government bureaucracies enjoy a comparative advan-

tage in the management and administration of health-services delivery systems such that governments should be regarded as having a responsibility to go into the health-services delivery business on this account. The way in which the demand for services delivered by the private sector is financed, however, is quite another matter. Here, it might be argued, government does have a responsibility to see to it that consumers have an opportunity to participate in fair and equitable social-financing schemes, rather than being left to the disadvantages of out-of-pocket payment (or other disadvantageous financing mechanisms).

The design and implementation of alternative social-financing schemes should be regarded as a way to rationalize overall health-sector financing by being responsive to those major problems confronted by the health-services sector which can be addressed through financing mechanisms, e.g., the problems adduced foregoing in this section. The emergence of social-security-type schemes, operating alongside MOH systems in many LDCs, has been a response to various pressures and interests, including at least tacit recognition by governments of the role such schemes can play in rationalizing overall health-sector financing. A major problem has been, however, that such schemes have been based on payroll taxes and have operated in the urban, modern economy--whereas usually, in these countries, the largest part of the work force is employed in agriculture. As long as the focus remained upon financing by means of payroll taxes, it was difficult to see how such schemes could be regarded as general solutions to health-sector financing problems. Financing by means of payroll taxes is, however, by no means peculiar to the logic of such schemes. A statement of the general principle reflected by such schemes is that the parties to economic transactions are eligible for health-insurance benefits financed by a levy or contribution

based on those transactions. There would seem to be no prima facie reason why this principle could not be extended to provide health insurance for the rural, agriculture work force--thereby according to these workers and their families benefits now enjoyed by their fellow urban workers but heretofore denied to them. We may now turn to a consideration of some possibilities of this kind for the Philippines.

Crop-Based Health Insurance: Fund/Coops Schemes

Ubiquitous economic transactions in the agriculture economy are those which entail the sale and purchase of agriculture products and inputs for the production of such products. Some among these transactions are prime candidates to serve as the basis for contributions to health-insurance funds where marketing patterns are such that an administratively feasible way can be found to implement such levies. To my knowledge, there exist at present no crop-based health-insurance funds in the Philippines. There do exist, however, crop-based "social amelioration" funds, notably those financed by levies on coconut (copra) and sugar. These funds (which will be discussed at some length in what follows) may be regarded as establishing a precedent for financing social programs in this way including, I would suppose, as consistent with the spirit of such funds, the possibility of health insurance. The impression I had from all quarters in discussing this matter with various individuals in Region V and VI was that this approach to financing the demand for health care would be politically and socially acceptable--indeed, many of my respondents were very enthusiastic about this possibility.*

*/ I consulted with individuals in the Ministries of Health, Agriculture and Labor and other government agencies and with officers of Samahang Nayan cooperatives, and Agriculture Marketing Cooperatives among other parties.

In addition to a health-insurance fund, such schemes require an organization context in which to operate. Indeed, the success of such schemes will depend in large part on the robustness of the organization framework. In this context, "organized agriculture," represented by various kinds of cooperatives and other farmers' organizations may play an important role. In this section I sketch a possible organization framework for health-insurance for beneficiaries in the agriculture economy in the Philippines. For reference, I identify this organization framework as "Fund/Coops" schemes. As this designation implies, these schemes are comprised of two main components. One, is a crop-based (rice, coconut, sugar) insurance fund (the "Fund"). The other is some organization of farmers (the "Coops") which would in various ways contract with the fund and with other parties. For this initial discussion, we may use the samahang nayan cooperatives (SNs) as the Coops component, subsequently we may identify other organizations which might play this role.

In the Philippines, agrarian reform legislation required all beneficiaries of its provisions to become members of SNs. These were initially regarded as pre-cooperatives, eventually to be aggregated into larger Agricultural Marketing Cooperatives (AMCs) which would become the major feature of cooperativization of the agriculture sector. I am informed that thinking on this score has now changed such that the SNs themselves, now sponsored by the Bureau of Cooperatives of the Ministry of Agriculture (recently transferred from the Ministry of Local Government), are now regarded as permanent, mainstay cooperatives to receive major emphasis in the coming years. SNs are local organizations, at the barangay level, a typical such cooperative having a membership of about 60 households. Opinions differ on the number of SNs that are effective organizations. The SN movement has been in some

disarray, but I am told that there are about 10,000 SNs that can be identified as organizations and that, at present, of these, perhaps 4 to 5 thousand are robust, effectively functioning organizations. Presumably, under the aegis of the Bureau of Cooperatives, this number may be expected to increase.

Under one possible organization framework, a SN or a group of SNs (the Coops) would contract with the Fund (based upon the crop which their members were mainly engaged in producing) to implement a health-insurance program for their members as beneficiaries. Under the terms of this contract, the Fund would make a contribution on health-insurance account to the Coops and they in turn would agree to provide matching funds from their own savings.*/ It would be agreed that the insurance fund built up in this way would be used exclusively for health services for the membership of the Coops. The Coops would then contract with health-services providers to provide services to the membership, compensating the providers on a capitation (so much per member per month) or a salary basis. Providers might be full-time, part-time or some mix of the two depending upon the number of beneficiaries to be served and hence the demand for various types of service. Each beneficiary would be entitled to a drug allowance. And there might be a provision for some consumer cost sharing for drugs and perhaps services (i.e., out-of-pocket payments by the beneficiaries set at some percent of the cost of the drugs or services). The Coops would negotiate with providers for favorable rates of compensation and with suppliers of drugs, medications and other supplies for favorable prices for these inputs. Since the Coops membership would represent a substantial market, the Coops should have some bargaining power, at least where alternatives exist on the supply side of

*/ Members of SNs now contribute a percentage of harvest to the Guarantee Loan Fund and also contribute 3 percent of loans to the Barrio Savings Fund.

the market.

Given this sketch of a possible organization framework, we may consider organizations of farmers which, in addition to the SNs, might be candidates for the Cocps role in Fund/Coops schemes. It has already been noted that individual SNs might agree to form coalitions for the express purpose of implementing health-insurance schemes. The organization structure of agriculture, however, includes some already existing groups of SNs into organizations which might play the role assigned to SNs in the Fund/Coops schemes. The Cooperative Rural Banks represent one type of organization of this kind. The SNs subscribe the capital for these banks which also have rediscounting privileges with the Central Bank (up to 300 percent of net worth). These banks exist in large part to make credit available to farmers on more reasonable terms than they could obtain it elsewhere. On a visit to the 2nd Annual General Assembly Meeting of the Cooperative Rural Bank of Albay, Inc., the officers of this bank with whom we talked seemed favorably disposed to the kind of insurance schemes discussed herein, as did the officers of a number of SNs in attendance at the meeting. (This Bank had a 1981 membership of 171 SNs and 9 Coops--unfortunately I am uncertain whether these Coops were AMCs or some other kind.) Generally speaking, Cooperative Rural Banks would make a good management aegis for health-insurance schemes. The Banks represent already existing aggregations of SNs (their members) the combined membership of which represents a sizeable pool of potential beneficiaries. Also for various reasons (e.g., the legal context within which they operate), the Banks tend to be, I am told, stable organizations with a well developed sense of stewardship for the interests of their members.*

*/ Even where Banks do not serve directly as management aegis for health insurance schemes, it might be well to involve them in some way in the administration of the health-insurance fund, e.g., they could serve as custodians of the funds and as administrators of the funds in the sense of co-authorizing disbursements and the like.

As mentioned previously, the original intention for the SNs was that they would aggregate into Area Marketing Cooperatives (AMCs) which would become the lead organizations in the cooperativization of agriculture. Although this development did not take place as rapidly as anticipated, a number of such AMCs were formed and are operating today, one such being the Iloilo Area Marketing Coop, Inc. (Sta. Barbara, Iloilo) which has a membership of 119 SNs which together have a membership of 4,355 farmers. Like the Rural Banks, the AMCs represent already existing aggregations of SNs the combined membership of which represents a considerable pool of potential beneficiaries.*/ The Manager of this AMC was of the view that the kinds of insurance schemes discussed herein were a good idea and probably feasible. The instant AMC was already "active" on the insurance front in that they gave a paid-up (for one year) P1,000 life insurance policy as a premium to each member who purchased P1,000 or more of fertilizer or other supplies from the Coop.*/

*/ Whether the AMCs tend to be as stable organizationally as the Banks is another question. The instant AMC was being managed by Mrs. Bernardita L. Barranco, a Cooperative Examiner for the MOA, Region VI, i.e., the AMC was in a kind of trusteeship (for reasons which were not spelled out). The AMC was soon to be turned back to its own leadership and, in the view of Ms. Barranco, would function well for in her view the SNs which own the AMC were well functioning, robust organizations.

*/ There exists an organization, the Cooperative Insurance Systems Program (CISP) which offers level-premium term life insurance to the members of SNs at a rate of P8.0 per P1,000 of insurance. The CISP enrolls groups, the normal rule being that 75 percent of the membership of a SN must agree to sign up (this is sometimes relaxed to 60 percent, and there is a cut-off point of not less than 25 individuals). CISP has at present about 200,000 beneficiaries. The organization started operation in 1975 with technical assistance from Nationwide Mutual Insurance, Inc. of Columbus, Ohio and Agriculture Mutual Insurance Organization of Japan. It's a hybrid organization (private-public) in that the government initially subscribed one-third of the capital and SNs put up the other two-thirds, 4 members of the 11 man Board are government representatives (at a fairly high level in their respective agencies). CISP has a field organization of 13 provincial offices and their agents work on a commission basis, actively marketing the product and collecting the premiums.

Some of the organization features of CISP may be of potential interest for the design of health insurance schemes. Thus, one might envisage schemes

In addition to farmers' organizations which enroll SNs as members, there are organizations which enroll individual farmers as members. Prominent among these are the Irrigation Services Associations (ISAs), the members of each of which share the same irrigation system (thus, unlike the SNs, the membership boundaries of ISAs are not coterminus with political boundaries). There seems to be general agreement in several quarters that the ISAs are particularly well functioning, robust organizations and, as such might be prime candidates for management aegis for insurance schemes.*/

Another individual membership organization is the Farmers Cooperative and Marketing Association (FACOMA). These were initially organized in 1952

under which the members of SNs made direct individual contributions to an insurance fund (i.e., rather than as suggested foregoing, collective contributions out of SN surplus). Under this pattern, one would still want to preserve the institution of group enrollment but one could do it on the basis of a CISP type 75 percent (or some other) rule. The advantage of this approach is that it gives individuals who do not want to participate in the insurance scheme a chance to opt out. Of course, if there were too many such individuals, the SN would not meet the group enrollment standard.

z/ I visited the offices of the Farm System Development Corp., (FSDC) outside of Iloilo. They are engaged in helping to set up and promote Barangay Integrated Services Associations (BISAs). They describe their operation as one in which the point of entry (and, I gather, the main business to date) is to help with establishing and improving small irrigation systems (a typical BISA will have membership of 40-50 farmers), but they would like to go from this point to develop a more general agriculture extension and assistance program. (It is not clear to me at this writing how the BISAs relate to the ISAs discussed in the text above.) There are something like 72 BISAs in the Iloilo region and the FSDC people with whom we talked felt that these organizations might make good management aegis for health insurance schemes. Indeed, one of these respondents was extremely enthusiastic about the possibilities for such schemes generally speaking.

The FSDC is under the Ministry of Public Works and Highways (the irrigation connection). There is some kind of working relationship with the National Food Authority (NFA) (successor organization to the National Grain Authority--NGA) in the sense that the FSDC tries to encourage farmers to sell palay to the NFA (the problem here being that the NFA has limited funds to buy palay, my understanding is that, overall, the NFA procures only about 15 percent of the palay harvest nationally, and that NFA standards may be hard for the farmers to meet). My understanding is that the head of NFA is on the Board of Administration of the FSDA. There was a suggestion from my FSDC respondents that I consult the NFA regarding the health insurance scheme.

under the then Agricultural Credit and Co-operative Financing Administration (ACCFA), which has now given way to a successor agency, the Agricultural Credit Association (ACA). The idea was to provide a program to help cope with credit and marketing problems confronted by farmers in outlying areas. Included in the membership of FACOMAS may be traders, landowners and small farmers. In the late 1950s and early 1960s the FACOMAS ran into various difficulties leading to attempts at reorganization under the ACA.*/ As of 1976, active membership per FACOMA ranged from 100-500.

Consultation with an officer of the ACA in Iloilo revealed that although ACA originally worked with FACOMAs, pursuant to PD No. 175, these organizations have been transferred to the Bureau of Cooperatives of the MOA. Consequently, ACA's main program activity now is working with and making production loans to another individual membership organization in the agriculture sector, namely the Compact Farms. Compact Farms are formed by small farmers who pool their contiguous hectareage to form larger units (e.g., 30-50 hectares) which can be managed more efficiently (with the aid of a hired manager). According to my respondent, there are now 90 Compact Farms in Region VI. And also according to my respondent, a Compact Farm is a functioning organization with its own management officials, etc.

All in all, the agriculture sector in the Philippines features a large number of cooperatives and cooperative-type organizations of various kinds (undoubtedly there are other organization types in addition to those I have discussed herein). I have had no chance to attempt to determine what percentage of all farmers belong to "organized agriculture" in this sense, but

*/ See Rice Marketing in the Provinces of Iloilo and Capiz: Issues for Regional Planning, Western Visayas, Region VI, NEDA/PCARR/SEARCA/UPLB Study on: "The Process of Regional Planning," Working Paper No. 7, Los Banos, Iloilo, November 1976, pp. 34 et seq.

no doubt the absolute number of such farmers is considerable--considerable enough, that is, to make these organizations significant as potential management aegis for health-insurance schemes for farmers as beneficiaries.

Given this general introduction to Fund/Coops schemes and some of the organization possibilities on this score in the Philippines, it will be helpful now to turn to some consideration of these possible developments on a crop by crop basis--notably, for coconut, sugar and rice, the main agriculture products in Regions V and VI. Market organization and other relevant factors differ as among these crops.*/

Health-Insurance Schemes for Palay (Rice)

The Fund Component: Unlike the cases of sugar and coconut, there exists at present no social-amelioration fund based on rice production. It has been suggested to me by various respondents that it might well be administratively feasible to impose such a levy at the market juncture of the rice mill. The political acceptability of any such levy is open to serious question (and if there were to be such a levy, it would require action at the highest level). The rice sector poses difficult problems for the GOP. It is a major staple in the diet of the people such that the GOP is under constant pressure to keep the price to the consumer low. On the other hand, there are a very large number of rice farmers, many of them at or below the poverty-income threshold, such that the GOP is under constant pressure to increase the price

*/ I should note that one respondent in Region V (Gov. Felix Imperiale) suggested to me an approach under which, rather than implementing insurance programs on a crop by crop basis (each financed by a levy on that crop), we would pool the funds derived from all administratively feasible levies (which might include not only the crops discussed here, but also banana, abaca, pineapple, mining, etc.) and use the pooled resources to provide benefits to all farmers, including those producing crops for which no administratively feasible levy could be devised. Although it raises a number of problems, such an approach is attractive in some ways.

of palay to permit the farmers to make a more adequate income. Given this squeeze, the question is whether there is any room for a social amelioration type fund. If there were to be a rice levy, it would have to be for good and politically popular reasons. Health-care financing is probably an outstanding example of such a reason, but only if there could be some assurance that the other components of Fund/Coops schemes would prove workable such that the revenues from any such levy would actually be reflected in commensurate health-services benefits. Consequently, prior to testing the rice-levy political-feasibility waters in any aggressive way, it would be well to gain some experience with the other components.

The Coops Component: The prior discussion of the features of organized agriculture has already elucidated this component for rice, i.e., these organizations are general and prominent in rice farming.

It should be remarked that a basic feature of the Coops component-- notably, organized consumers using their bargaining power in the market for health services (distinguish consumers as individuals, devoid of much bargaining power and at the mercy of fee-for-service providers) is extremely attractive, and this is so quite apart from the Fund component. Indeed, the question of whether, for rice, the Coops component might be implemented without any assistance from a Fund should seriously be explored. This component entails several assumptions. One is that organization such as, say, Rural Cooperative Banks or AMCs could in fact serve as management aegis for basic health-services programs to benefit their members. Another is that the members would be willing to try this alternative. Another is that, if they were willing to give it a go, they would in fact have significant bargaining power, e.g., that the situation on the supply side of the market would in fact permit these organizations to contract for the provision of services to be com-

pensated on a capitation or salary basis, that advantageous bargains of this kind could be struck and that, similarly, advantageous arrangements for supplies of drugs could be effectuated. Implementing initial trial projects for this component (perhaps with USAID playing the role of temporary, surrogate Fund component) would not require action at high political levels, there is ample discretion at the level of the Coops.

Health-Insurance Schemes for Sugar

Sugar is the major crop in Region VI and the landless sugar workers are generally recognized as among the very poorest of all agriculture workers and from this point of view most worthy of our Project efforts. The situation in sugar (market organization and otherwise) is very different from the rice sector.

The Fund Component: Unlike the situation with rice, there already exists a sugar social amelioration fund. In 1975, PD 621 (as amended by 780) constituted the sugar fund. The levy rate is ₱1.1 per pico (63.25 kg.). This is split as follows: ₱0.1 to the Sugar Industry Foundation, a private, non-profit, social-amelioration type organization. ₱0.1 to the Rural Workers Office of the MOLE. This is, as I understand it, the major source of funding for this office which is in large part concerned with administering the sugar fund and other aspects of the organization of sugar workers. ₱0.9 is supposed to go to the sugar workers. ₱0.63 of this automatically as a cash bonus. And ₱0.27 either as a cash bonus or for amelioration-type projects if there is a "proponent" for such projects. Local Unions of sugar workers are the proponents for such projects (encouraged by the Rural Workers Office). The Iloilo area now has 8 such projects scattered among low cost housing, credit union, scholarship program, consumers coop, and emergency loan pro-

gram.

The flow of the sugar fund is as follows: The National Sugar Trading Corp. buys all of the sugar, most of it from the Sugar Centrals but some from other mills as well. The NSTC deposits ₱1.1 per pico to the account of the MOLE in the Republic Planters Bank. Representative of the Sugar Centrals draw on this account to pay a bonus to mill employees and to disburse to each Planters Association its share. The Planters Associations disburse a share to each planter who in turn disburses a share to each plantation worker, proportional to the wages earned by each.

The Coops Component: There is no such component, as such, for the landless sugar workers. The role of this component would be played by Local Unions of sugar workers.

Launching alternative financing schemes in the sugar industry may be a rather complex matter. Each planter is supposed to submit to the Rural Workers Office his payroll, listing his employees by name, the wages they were paid and the bonus each received. Each worker signs the payroll which is supposed to be evidence that he got his bonus as listed. The Rural Workers Office audits these records. When I visited that office in Iloilo, they were kind enough to let me inspect some of the signed payrolls. From the few I inspected, it appears that the bonus is quite substantial in one sense, i.e., it runs from 5-10 percent of wages paid. However, many sugar workers in my small sample had small earnings such that the bonuses were small in absolute amount.*/ These payrolls, assembled by the Rural Workers Office

*/ I might add that some of the payrolls I inspected appeared to me to be probably genuine accounts of wage and bonus payments. Others, however appeared to be pro forma gestures to comply with regulations (e.g., precisely the same wage payment and bonuses listed for every worker) although these were signed by the workers just as the others. The Rural Workers Office has done some surveys, asking sugar workers if they in fact have received a bonus. They say that most sugar workers report that they did receive a bonus but that some report that they did not. There is obviously much room for irregularities of one kind or another in these sugar-bonus arrangements.

pursuant to their obligation to administer the bonus arrangements, are not published. Potentially, however (if their quality appeared reasonable in the sense that they represented accounts of actual payments), they provide a mine of information about wage structure and wage payments in the sugar industry and, of course, about the bonus payments themselves. (It would be well to find out from the Rural Workers Office what the prospects would be for doing a little research on this material.)

Although the sugar industry is quite different from the other agriculture sectors, it is in some ways well set up for alternative financing schemes. There does exist a social amelioration fund (thereby endorsing the general approach discussed herein) and there are institutionalized ways in which proponents of projects can seek to have them funded in this way. Unlike the rest of the agriculture sector, sugar features substantial employer-employee relationships. The work force appears to be fairly stable and concentrated in the sense that the dumaans who live and work regularly throughout most of the year as permanent employees on sugar estates make up nearly three-fourths of all sugar workers. Alternative-financing schemes for this crop might well differ from those for other crops. Thus, for sugar, the scheme might more nearly resemble those in place under the SSS, i.e., such that there would be an employer contribution (for those who employ more than some cut-off number of employees). The employees contribution would be made by proposing health projects to be financed out of the amelioration fund.

There are, of course, also problems. Some of these concern the preferences and capacities of the unions in this domain.* / Thus, even if Local

* / I have as of this writing a very uncertain feel for the extent and character of unionization in this industry. This would be one of the first things to get a better fix on in further study of the feasibility of insurance schemes in this industry.

Unions (leadership and members) wanted to attempt to exploit their collective bargaining power for the purchase of health-care services (and for obtaining direct employer contributions to health-insurance schemes), such that they became "proponents" of health-insurance schemes, questions might still exist about the capacity of the Unions to serve as effective management aegis to conserve the interests of the members. This kind of situation suggests the need for another kind of institutional link on the supply side of the market for health services here--a link which, over the longer run, could turn out to be of much more general significance than just as a solution to the sugar worker problem. This link would be an organization with which such parties as Local Unions of sugar workers could contract (in the suggested scheme, the employers would also be parties to these contracts) for the provision of pre-paid basic health services for their members. It is in this connection that the central feature of the Medikong Bayan scheme, put forward by the Population Center Foundation, has seemed to me of some interest, i.e., to suggest a kind of development (under some aegis, i.e., not necessarily the PCF) which would be of interest.*/ In terms of its central feature, this scheme is a Kaiser-Permanente-type organization which could contract for the provision to groups of beneficiaries a package of basic health services on a pre-paid group practice basis (capitation) with or without modest consumer cost sharing (out-of-pocket payments at some fraction of the cost of services). If an organization of this kind were in existence and functioning, it might, by providing an attractive provider option for various groups (e.g., SNs,

*/ Some of the features of the Medikong Bayan scheme as it now stands do not seem to me attractive, namely, that it proposes to enroll beneficiaries on an individual rather than a group basis and that it proposes to create, train and field a new category of health manpower. A third feature of this scheme, namely that it proposes to be a proprietary scheme, is one with both advantages and disadvantages.

other organized farmers), facilitate the propagation of social financing for health care.

Health-Insurance Schemes for Coconut

Coconut is a major agriculture product in Region V, there being some 95,200 coconut farm households comprising more than one-fourth of the region's total farm population. The number of poor households in this sector has been estimated at about 67 thousand, 30 percent of all rural poverty groups. As such the poor in coconut is the largest group.*/ Clearly, from the point of view of the poverty criterion, the coconut farmers warrant priority attention. At the same time, however, this sector may afford the greatest difficulties for devising alternative-financing schemes.

The Fund Component: On the favorable side is the fact that there is an extant fund, the notorious COCOFUND, one quarter of which goes to social amelioration. */ The Philippine Coconut Producers Association (COCOFED) launched COCOFUND in 1963 and there have been a large number of changes in the program since that time, including changes in the levy rate. At present the levy rate is ₱32 per c.k. of copra or its equivalent in other coconut products. As I understand it, the Philippine Coconut Authority (PCA) now computes the levy on the basis of a formula which translates the world price for coconut

*/ See Household Poverty Profile Bicol Region (Region V), Draft, USAID/Philippines, November 1981.

*/ I say "notorious" because COCOFUND has been embroiled in a large amount of political controversy partly from the point of view of the incidence of the levy which generates the fund as compared with the incidence of the benefits (the who-pays, who-benefits question). For interesting accounts of this situation in coconut, see: The Government Programs in the Coconut Industry: Who Pays, Who Benefits, Institute of Labor and Manpower Studies, Research Paper No. 1 (undated, but recent). Also, Far Eastern Economic Review, Jan. 8-14, 1982, pp. 42 et seq.

oil into a levy rate on copra. Thus, as the world price changes so does the levy rate.*/ Under present arrangement, if the world price falls below US\$0.20 per pound of oil (it is now about US\$0.22) the levy would temporarily be suspended, i.e., to be reimposed when the price rises about this cut-off level. To accommodate administrative feasibility, the levy is imposed at the market juncture of the final-user purchasers of copra but appears to be reflected in prices paid to farmers such that the incidence is upon them.

COCOFUND is a multi-purpose fund, intended in the main for activities to increase the productivity of the coconut industry, including under this head support for coconut organizations. This is reflected in the distribution of the present P32 as follows: P20 to finance the cost of the coconut hybrid replanting program; P2 for the Philippine Coconut Producers Federation (COCOFED); P2 for the Philippine Coconut Authority (PCA); and P8 for the social amelioration programs divided as P2 for a scholarship program for the children of coconut farmers and P6 for the farmers insurance program. This program provides P10,000 worth of paid up life insurance to the beneficiaries. It is my understanding that only a very small percentage of coconut farmers benefit from either of these social amelioration programs.

I have been given the impression in various quarters here that, given the controversy surrounding COCOFUND, it would be politically advantageous if some visible way could be found for the levy to confer more amelioration-type benefits on the farmers and that health-insurance schemes might well fill this bill.

The Coops Component: There may, however, be difficulties with organiz-

*/ Although the Philippines generates something like 90 percent of the world's coconut oil, it is in direct competition with all other vegetable oils of which it is but a small percentage. Consequently, the Philippines is a price taker in this domain.

ing financing/delivery schemes in this domain. Of the large number of coconut farms, most are very small and appear to be scattered throughout the countryside.*/ A large number of coconut farmers are part-time in this industry, i.e., derive only a portion of their income from it. How farmers with this kind of relationship to the industry should be included in an industry based and financed alternative financing/delivery schemes remains a question. There are, on the other hand, some 5 thousand large farms (25 has. and above, nationally) which might afford a more tractable organization base for these farmers and the workers employed by them. It is also my impression that the SNs (and associated types of cooperative organization) which feature organization for rice production are not similarly characteristic in the coconut industry. My understanding is the COCOFED with regional and more local branches, is the major organizational vehicle in this industry, but whether this organization vehicle is suitable for the instant purposes I do not know. A next step in further exploring the feasibility of health-insurance schemes in the coconut industry would be to get a clear picture of the structure and functions of COCOFED, including the relationships of the lower-level branches to the farmers comprising them.

I may note that, on a visit to the PCA offices in Legaspi, my respondent was generally quite favorably taken with the idea of using some part of COCOFUND for health-services programs. She indicated that although PCA itself would have no say in this, that PCA certainly would interpose no objection.

*/ Of the 432,485 such farms nationally, some 66 percent fall in the 1-5 has. range.

The Supply Response to Demand Events: The Question of Adequacy

At various points in the foregoing discussion it has been suggested that Fund/Coops (or other health insurance) schemes would contract with providers for the provision of services to their member beneficiaries, possibly on favorable terms (reflecting the bargaining power inherent in collective-consumptions arrangements of this kind). Whether such results could reasonably be anticipated, however, depends upon the character of the supply response to these demand events. This in turn depends upon such factors as the number of providers and what their options are. To answer these questions would require some detailed study of each market area proposed for implementation of such schemes. I have not had time to undertake such study. However, some preliminary comments may be in order on this score.

In this context, I am tempted to appeal to the time honored dictum: "Take care of the demand and the supply will take care of itself." Generally speaking, there is a good bit to be said for this dictum.*/ Thus, it probably accurately depicts the course of events to be expected for supplies such as medications, drugs, ORT salts, etc. MOH systems around the world exhibit a chronic incapacity to cope with what has come to be known as the "logistics" of drug supply. Private marketeers, on the otherhand, exhibit no such incapacity. In most situations, if there is a demand for supplies of this kind, the private market will get them there, with no need for the

*/ It is of course true in the health-services sector that demand will not always evoke an effective supply resource without planned interventions on the supply side. Nevertheless, frequently this is a realistic possibility and one which tends to be overlooked by health planners who tend to be preoccupied with planned interventions on the supply side. In this context, it was pointed out to me by one respondent in Region V that the advent of MEDICARE in the Philippines did evoke a supply response in the market for hospital services, i.e., hospitals started appearing where there had been none before.

health-plan manager who relies on this distribution system to fret about "logistics." As evidence of this, it appears that in the Philippines the sari-sari stores operating in the rural areas routinely stock a fair selection of medication and drugs, including antibiotics, for over-the-counter purchase. The capacity of this distribution channel will presumably be enhanced by the MOH's Botika Sa Barangay Project (drug outlets to be operated by existing sari-sari store owners). According to the Annual Report for 1981 of the MOH, Regional Health Office No. 5, there were as of December 31, 1981 2,242 operational Botika Sa Barangay.

Health manpower is a different kind of problem, e.g., for high-level manpower, lags introduced by training times and bottlenecks in the training sector. However, pending a longer-run supply response, it will be possible in some situations to rely upon existing, underutilized health manpower. Thus, it is my understanding that the physicians posted by the MOH to the RHUs are underutilized in that capacity. The Coops might contract with these physicians to provide services on a "per session" basis outside of regular MOH hours. (As matters stand, these physicians now engage in private practice, tolerated, if not strictly legal). There may be additional private practice physicians (in situ or who could be attracted) who could be contracted. Also, I was told in both Regions V and VI that there are considerable numbers of already trained midwives and nurses who now work as clerks, etc. rather than in the professions for which they were trained. This is owing to a want of effective demand for their professional services. Some of these professional providers might respond to the opportunity afforded by the alternative financing schemes to come back into the medical-care market. Where BHWs of the type fielded by the PUSH and Bicol integrated health projects are in place, ways might be found in which some of the ser-

VICES they can provide could be contracted for on a part-time, per session basis.

Clinic-type facilities of a modest kind would not appear to entail serious bottlenecks on the supply side.*/ One possibility would be for the Coops to rent space for part-time use in MOH facilities. MEDICARE affords a precedent for this kind of relationship between insurance schemes and MOH facilities by paying the MOH hospitals the regular per diem when its beneficiaries are admitted to MOH hospitals.

Some Advantages and Disadvantages of Health-Insurance Schemes in the Philippines

This is not the place to undertake an extensive general evaluation of the proposed schemes, this will result from discussion of them in various form. Nevertheless, a couple of points should be made here to help inform the reader's own evaluation of them.

It will have been clear from the foregoing discussion that the implementation of health-insurance schemes for beneficiaries in the agriculture sector in the Philippines will depend upon coping successfully with a number of problems, i.e., it will not be a case of smooth sailing in these waters. But this is also the situation with respects to implementation of any health-services financing/delivery system, including the extant MOH system. Whether efforts to cope with the problems entailed by the implementation of health-insurance schemes are worth it depends upon the alternatives available. There is a strong tendency to evaluate proposed health-

*/ While visiting a PUSH fielded BHW outside of Iloilo, I saw an excellent facility for the construction of which the residents of the barangay had donated labor. MEDICARE's CHHC program has also been able to call upon donated local labor for facilities construction.

insurance schemes relative to "ideal" alternatives (e.g., an efficient, well functioning MOH system so adequately financed from general tax revenues that it actually can deliver an appropriate package of "free" services to the population at large).

However, it should be obvious that the advantages of the proposed health-insurance schemes should be considered relative to the next best alternative actually available (or likely to be available) to the beneficiaries. For most residents in rural areas in the Philippines, the next best actually available alternative would be the present situation of out-of-pocket payments in the private sector for services provided on a fee-for-service basis by western-medicine or traditional practitioners.*/ That is, it appears that individuals who feel in need of medical treatment usually initially resort to self-medication, obtaining drugs from pharmacies, sari-sari stores or perhaps traditional practitioners. If beyond this a consultation is required, they will seek a private practitioner (which may include MOH personnel acting in a private capacity). (Even if they seek care from the MOH system, as such, they may be required to make a "donation" on the

*/ Rather than, that is, the "free" services promised by the MOH's rural health system. I have made no systematic survey of the performance of the MOH system here (e.g., access, utilization rates, nature and quality of services provided, etc) nor have I seen the results of such surveys. And I would agree that caution must be exercised in jumping to conclusions on this score on the basis of casual empiricism. Nevertheless, I regard as relevant on this score the information I have had from every quarter here that, by and large, the MOH system as it now operates in rural areas provides little or nothing in the way of services and is so regarded by the people. I have inquired of respondents in Regions V and VI where the farmers go for their health care. The answers were: to private, modern practitioners if they can afford it, otherwise to traditional practitioners. In no instance was the MOH system mentioned.

order of what would have been the private-sector fee.)*/

As compared with "going bare," i.e., sole reliance upon out-of-pocket payment to finance our demand for medical care, the advantages of health-insurance seem so obvious to most of us that I see no need to rehearse this advantage of the Fund/Coops scheme.*/ I will take this for granted, and draw attention to advantages with respect to the implementation of insurance schemes and certain advantages related to organization structure and control.

Generally speaking, farmers (and others) organize themselves into coops of various kinds (producers coops, consumers coops) in order to gain the advantages of collective action (bargaining power) of this kind in transacting with others. One way to look at the Fund/Coops type of scheme is that it is another instance of this general institutional strategy, this time on

*/ This information from Dr. Theresita R. Lariosa, UP School of Public Health (consistent with information from other sources). Dr. Lariosa found in the course of survey research on care seeking patterns in Region I that a first step for many consumers may be to seek the services of a Mangillo (faith healer) who, based on his diagnosis, may tell the patient to seek care from a physician, or, if the disorder lies within his competence, may prescribe a Wari (offering). This system may afford some fairly effective screening. It is well known that a large number of presenting signs and symptoms are associated with conditions such that they will remit spontaneously. For these conditions, the prescription of wari will appear successful. For the treatment of conditions which require actual medical intervention, wari will fail. Presumably, to prosper in business, the Mangillo will want a track record of mostly successes and few failures. Consequently, Mangillos who have been in business for a long time may have become fairly acute diagnosticians (i.e., as a condition of survival in this trade), referring those cases such that the prescription of wari would result in what the clientele would regard as failures. For those conditions such that wari works, the patient is spared what would have been the much greater expense of resort to medication.

*/ The mere fact that health insurance seems advantageous to us does not, of course, imply that it will seem similarly advantageous to potential beneficiaries in the rural areas of the Philippines, nor do I made any such inference. My impression from inquiries in the field is that the general idea of health insurance is very attractive to potential beneficiaries in rural areas here. It remains to be seen whether schemes can be put together to offer health insurance on terms that make particular programs attractive.

the demand side of the market for medical services. The individual consumer of health care has very little bargaining power vis-a-vis the fee-for-service provider in the medical market place. On the other hand, if Fund/Coops could, because of their collective bargaining power, contract with providers for the provision of services to be compensated on a capitation or salary basis (or, failing this, on a discounted-fee basis), considerable savings might be realized.*/ Thus, according to Dr. Lariosa, the standard fee in the rural areas of Region I for an injection is ₱8.0, where the cost of the medications used may be in the ₱0.5 to ₱0.8 range. There would appear to be some room for bargaining in this situation. Similarly, there may be room for bargaining with respect to prices for medications and drugs, per se.

One might inquire at this point why bother about samahang nayons and the like, why not just organize outright consumers coops for the purchase of medical care. One answer is, of course, that I am not proposing just coops, but rather Fund/Coops schemes, and the agriculture coops, as an official part of organized agriculture, are more natural contractors with the Fund component. But there is another point to be made in this context which goes to a very important advantage of the Fund/Coops type scheme. I have already alluded to the necessity for a sturdy organization framework to provide an aegis for health insurance in rural areas.

Generally speaking, if one is seeking such an institutional framework, it will be better to build upon already existing, effective organizations than to attempt to build upon newly created institutions, invented on an

*/ Another frequently adduced advantage of capitation or salary remuneration schemes for providers is that, unlike fee-for-service, they do not afford an incentive for "unnecessary" treatment.

ad hoc basis to serve special functions (e.g., as would be health-care consumer coops). It takes time and experience to build effectively functioning, stable organizations. The "survivor" organizations in agriculture appear to be of this kind. These organizations were, of course, created for reasons other than purchasing health care (and owe their stability to the importance of these other functions and the contributions they can make with respect to them). The governing boards of these organizations are used to dealing with the agriculture market place, not the health-care market place.* Herein may lie a signal advantage of incorporating these organizations into the institutional framework for health-insurance schemes. These governing boards will have developed a sense of stewardship for the welfare of the members of the coops and they are apt to bring a business orientation to the management of health-care systems associated with their organizations which bodes well for the efficiency of these systems. The Fund/Coops incentive to efficiency will be encouraged by their members natural inclination to see that they get full value for their organizations' contribution to the health-insurance fund. And, in addition to an incentive for efficiency the Fund/Coops will enjoy a much better prospect for actually achieving efficiency than does, say, the MOH system. For example, unconstrained by Civil Service personnel rules and practices, they will be able to build in to their personnel policies rewards for good performance by providers and penalties for

*/ It sometimes is remarked that health care is too important to be left to physicians and health planners. The apparent efficiency of the Kaiser-Permanente health-care plans in the U.S. is frequently ascribed to the fact that, historically, these plans grew out of programs created during WW II by Kaisersteel and ship building operations to provide health care for their employees. Thus, at the outset, they had a strong business management component. When, after WW II, these plans were continued as free-standing operations, they retained a strong business management component.

poor performance.

Reverting to advantages more particularly speaking, to afford maximum benefit to consumers, participation in health-insurance schemes should be in some way a collective-consumption decision. Owing to adverse risk selection factors, insurance schemes in which beneficiaries are enrolled as individuals always entail much higher premiums than schemes under which beneficiaries are enrolled as members of groups (usually, groups of employees, one advantage of employment-related health-insurance schemes is that these afford a natural mechanism for group enrollment). Fund/Coops schemes afford a natural mechanism for group enrollment of those who live and work in the rural, agriculture economy.*/

Pursuant to informing evaluation of the health-insurance schemes discussed herein, it will be well to anticipate one frequently suggested disadvantage of such schemes which tends, in some quarters, to dominate evaluation of them. This is that since not everyone in the agriculture work force is a member of effectively organized agriculture (coops or other organizations), such schemes cannot cover the entire agriculture work force and that such schemes are in a sense unfair to those who cannot participate.*/ While this objection is not to be dismissed lightly, neither should it be regarded as prima facie decisive. Implicitly or explicitly, proponents of this view hold to the position that we should work for and hold out for one, grand monolithic scheme which in the not too distant long run would effec-

*/ As the Population Center Foundation recognizes, a major problem with its proposed Project Medikong Bayan is that, although it has the advantage of a pre-paid group practice format, it contemplates enrollment of beneficiaries as individuals. (See their proposal, October 1981.)

*/ This is the same as a standard objection to social-security schemes for the urban work force.

tively cover everybody. Their position might be stronger if this were a realistic probability, which I do not believe it to be in the Philippines. It seems clear that in the Philippines the health-services sector will in any event evolve in a heterogeneous way with different consumers obtaining services in different institutional contexts. And, absent the development of alternative social-financing schemes, too many of these contexts will leave too many consumers who can ill afford it making out-of-pocket payments for services provided in the private sector on a fee-for-service basis. Moreover, the equity argument cuts several ways. Thus one might inquire whether it is fair to deny those who are organized such that they can take advantage of collective action this opportunity just because everyone is not so organized? It seems to me likely that in the longer-run configuration of the health services sector, some consumers who do not have access to alternative social-financing schemes will obtain services from the MOH system or something like it (e.g., perhaps more locally organized and managed, but with social financing based on general tax revenues). The interests of these consumers will be best served by efforts to improve the efficiency of the MOH system in this capacity rather than by denying other consumers alternative opportunities. The case for denying other consumers alternative opportunities is that granting them will significantly diminish the prospects for those who cannot avail themselves of these alternatives. If this were true, the policy makers would confront the ubiquitous problem of inter-personal utility comparisons, i.e., how to evaluate projects which make some people better off but other people worse off. However, as a general proposition, the instant argument is without much force. Indeed, it is more plausible to suppose, prima facie, that the position is the other way around, that as alternative financing schemes relieve the burden on the MOH system, it

will have more resources to devote to those consumers who must patronize the system.

Conclusion

It would not be very meaningful for the investigator to conclude a feasibility-assessment exercise of this kind by asserting as a finding that alternative social-financing schemes "are" or "are not" feasible in the Philippines. This judgment must be, in any event, a probabilistic one. It is the intention of the exercise to assemble information to inform this kind of judgment, not only by the investigator but also by others who review this material in light of their own knowledge of the situation.

In my view, there is a good chance that alternative social-financing schemes can be implemented in Regions V and VI of the Philippines. As has been pointed out foregoing, the overall political climate and, more particularly, the expressed health-sector plans of the GOP, are very favorable for such developments. Also, the organization of the agriculture sector (coops and other farmers organizations) is in general favorable for such developments. And, as pointed out, discussion of this matter with a considerable number of variously placed respondents in the Philippines elicited generally enthusiastic responses.

All in all, the situation is encouraging enough to warrant pushing ahead with additional activities and inquiries to test these waters in a more decisive way and, if the findings continue to be favorable, to attempt to implement such schemes. The next steps to be undertaken would be:

An investigator should work with the Bureau of Cooperatives of the MOA to identify several specific organizations (from among, e.g., the Cooperative Banks, AMCs, SNs, ISAs) who might be good prospects. Similar work should be

undertaken with COCOFED and the National Sugar Trading Corp. and the Sugar Centrals.

Assuming that specific organization components have been identified as good prospects, the investigator should then work with these organizations to explore such questions as the following, viz.: How do the members feel about this approach? How do they feel about direct contributions vs. funding from organization surplus? What do the members now spend collectively out-of-pocket for health-care services and what does this say about acceptable rates of contribution to a health-insurance fund?

An investigator should also investigate the supply side of the market for the medical-services markets in question (i.e., those from which the prospective beneficiaries represented by the identified organizations would obtain services) to determine the number of providers and suppliers and what their current market situation is.

Assuming that the foregoing inquiries continued to show promising results, an attempt would be made to implement such schemes. This would entail attention to a large number of institutional details, e.g., what authorization for disbursements, what procedure to find potential provider/supplier contractors and to authorize any such contracts, what cost-sharing, if any, what limits on drug allowances, etc.

Finally, I should note that from AID's point of view, an interesting question is how the attempt to implement alternative-financing schemes might be included in AID's health-sector assistance portfolio, e.g., what kinds of "projects" might be contemplated in this domain. The author will reserve comments on this score for a general statement to be addressed to these matters.

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