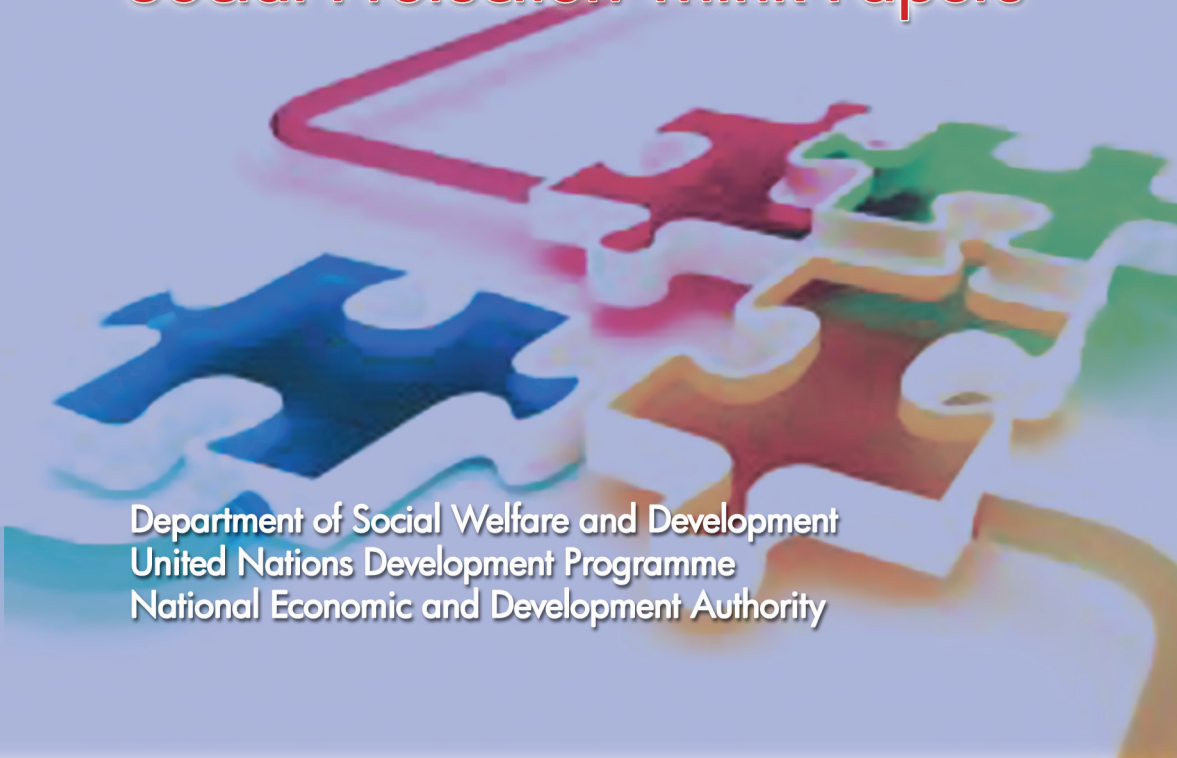
Strengthening Social Protection Components and Strategies in the Philippines:

A Compilation of Social Protection Think Papers



Department of Social Welfare and Development
United Nations Development Programme
National Economic and Development Authority

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Message of the SDC Sub-Committee on Social Protection Chairperson

Since the adoption by the NEDA-Social Development Committee (NEDA-SDC) of the Philippine Definition of Social Protection on 13 February 2007, the government has worked towards converging and aligning its responses to poverty vis-à-vis the identified four Social Protection components: Social Welfare, Social Safety Nets, Social Insurance, and Labor Market Interventions.

It is with pleasure that the Sub-Committee on Social Protection of the NEDA-SDC, through the valuable support of the United Nations Development Programme (UNDP), shares with you these Social Protection Think Papers, which tackle social dimensions of climate change, expanding social protection coverage to informal sector workers, improving coverage of social health insurance, and public workfare programs on social safety nets. Prepared by renowned experts in their field, these papers have gone through rigorous consultations and workshops with members of the sub-committee on social protection and other stakeholders. We are confident that these papers will provide insight on how social protection can address current and emerging development issues, as well as ways in which government, NGOs, and civil society organizations can work together to respond to these issues through policy formulation and/or program development.

ALICIA R. BALA
Chair
Sub-Committee on Social Protection

Message of the UNDP Country Director

After the 2008 global financial crisis, a threatening double dip recession and the recent spate of natural disasters exacerbated by climate change, the challenge of mitigating risks from external and natural shocks has never been more serious. In the Philippines alone, a UNDP study showed that 2 million more Filipinos became poor as result of the 2008 crisis.

It is in this light that UNDP lauds the development and publication of "Strengthening Social Protection Components and Strategies in the Philippines: A Compilation of Social Protection Think Papers" to catalyze initiatives under the Social Protection Framework and Strategy presented to the Cabinet Level Social Development Committee in October 2009.

The four (4) think papers in this publication are expected to contribute to the crafting of the country's Social Protection Plan and develop the capacities of major duty bearers involved in addressing the needs of the vulnerable groups in the Philippines. The coverage of the think papers is strategic and timely as these reflect the realities of vulnerability and measures taken to achieve resiliency in times of shocks and crises. It also comes at a time when the 2015 deadline for the Millennium Development Goals (MDGs) is fast approaching and where the Philippines current progress shows the need to catch up in six out of eight MDGs.

From a UNDP perspective, social protection is relevant because it supports the sustainability of development achievements and it addresses several of the dimensions of human development (education, gender, health, etc.). It helps reduce vulnerabilities for households in poverty or hovering just above the poverty line, by providing access to coping mechanisms that affect their future income generation. It can be a powerful mechanism for reducing inequalities, both in the short and longer term.

Due to devastating social and economic impact of a succession of crises that pounded the country in the last two decades, the Philippine Development Plan (PDP) 2010-2016 espouses that Social Protection sector shall ensure the empowerment and protection of the poor, vulnerable and disadvantaged individuals from all types of risks. The United Nations Development Assistance Framework (UNDAF 2012-2018) for the Philippines also recognizes this and several UN agencies have committed to work together on social protection.

Social protection has never been more important as today as developing countries brace themselves to meet the targets of the Millennium Development Goals (MDGs) by 2015. Some of the shortfalls in meeting the MDGs have been aggravated by the global economic and financial crises. It is for this reason that adopting a social protection strategy would have an impact on the progress to achieve the MDGs.

RENAUD MEYER
UNDP
Country Director

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Thank you very much and more power!

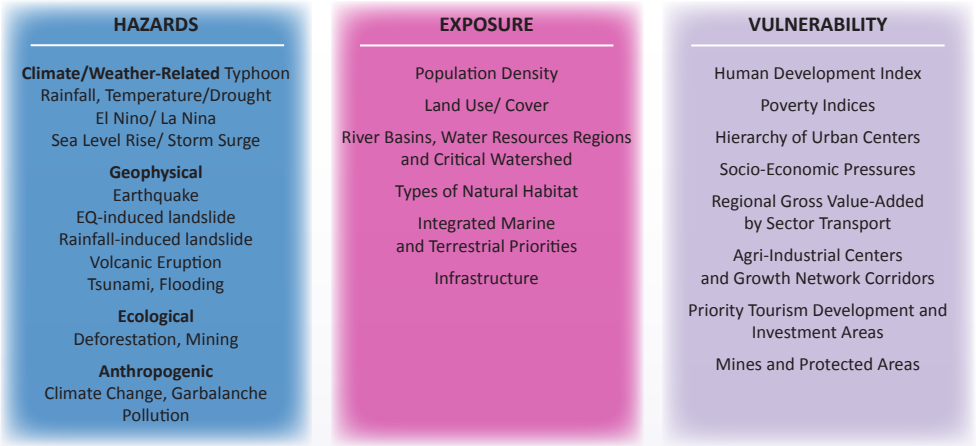
ADDRESSING SOCIAL DIMENSIONS OF CLIMATE CHANGE THROUGH ADAPTIVE SOCIAL PROTECTION [1]

Rosalinda Pineda Ofreneo

Climate change is considered to be the most crucial development challenge of our times. It is a challenge which requires a most urgent and concerted response, considering that the future of the next generations hangs in the balance. If the challenge is not adequately met, most of the efforts expended to meet the Millennium Development Goals will come to naught. Poverty, inequality, and injustice will worsen immeasurably, and the human rights of the poorest and most vulnerable peoples in the world will be trampled upon as they struggle to survive and adapt in a "climate change apartheid", where only rich countries generally have the wherewithal to defend themselves against the problems which are mostly their creation to the detriment of the less developed ones. (Tutu, in the Human Development Report 2007/08:166).

The literature on the social dimensions of climate change invariably emphasizes the increasing vulnerability of the poorest and most disadvantaged groups to risks, defined as "chances of danger, damage, loss, injury, or other undesirable consequences from risky events" associated with such change. (Heltberg et al, 2008:4). An individual or household is considered to be vulnerable to risks associated with climate change if these will result in a loss of well-being that pushes the individual or household below a benchmark or threshold level of well-being." (Ibid, p5). One way of estimating risk is through the HEV formula developed by the UNDP (La Vina 2008:104), where "Risk (R) is an approximation of the compounding effect of Hazard H), Exposure (E) and Vulnerability (V) (Villarin et al, 2008:29).

Figure. 12 Diagram Representation of the HEV formula



RISK SCORE = HAZARD x EXPOSURE x VULNERABILITY (UNDP)

This formula could be enhanced further, according to the World Bank, by exploring Capacity (C) as denominator. (Ibid).

[1] Final "think paper" written by Rosalinda Pineda Ofreneo for the Department of Social Welfare and Development (DSWD) and enriched by comments from the NEDA as well as the members of the NEDA-SDC Sub-committee on Social Protection who were present during its March 29,2011 meeting. The original paper contained inputs gathered in a roundtable discussion (RTD) of the social protection and DRRM clusters of the College of Social Work and Community Development, University of the Philippines. Among the RTD participants are Profs. Teresita V. Barrameda, Lenore Polotan dela Cruz, and Elmer Ferrer; Dr. Emmanuel Luna; Profs. Roselle Leah K. Rivera and Nathalie A. Verceles; Dr. Leticia A. Tojos, and Prof. Romano Antonio V. Wamil, The author acknowledges the research and technical assistance of Ma. Gichelle A. Cruz.

The nexus between poverty and the environment cannot be over-emphasized in any discussion on vulnerability to climate change. Destruction of the natural resource base as a result of environmental degradation aggravates the poverty of coastal, upland and lowland communities who are consequently and increasingly deprived of their sources of livelihood. The desperate poor resort to slash and burn agriculture, dynamite fishing, and other destructive means of survival which in turn further harm the environment. Erosion of watersheds, coupled with torrential rains attributed to climate change, lead to flooding and landslides which again intensify the poverty and suffering of the affected vulnerable poor.

What are the risks associated with climate change that we now face?

> *The country is ranked highest in the world in terms of vulnerability to tropical cyclone occurrence, and third in terms of people exposed to such seasonal events. An average of 20 typhoons traverse the country yearly, causing physical and economic devastation. Climate variability increasingly induces drought during El Nino episodes and floods during La Nina. Consequently, the Philippines faces increasing disaster risks with geologic/seismic dangers closely interacting with such meteorological hazards.*
>
> *Climate change also threatens the ability of the country's ecosystems to provide life-support services. In coastal areas, problems like flooding and inundation are expected to increase due to accelerated sea level rise, in addition to cyclones and storm surges. With coastal and marine ecosystems already suffering from anthropogenic problems like pollution, over-exploitation and uncontrolled development, the country can ill afford to cope with additional stresses.* (Climate Change Commission, National Framework Strategy on Climate Change 2010-2022: 5-6).

The scale, impact, and implications of climate change-related phenomena in the Philippines were amply demonstrated by the devastation wreaked by Typhoons Ondoy and Pepeng in 2009, which left 961 dead, and two million families (or ten million people) affected by floods and landslides. The cost to the country was USD4.98 billion or almost three percent of the GDP (NDCC, 2009, quoted in Polotan dela Cruz et al, 2010:1).[2] This is just portentous of things to come as there are predictions based on GIS spatial analysis that approximately 67 percent (20 million hectares) of the country will be severely affected by flooding, drought, and/or landslides. (Godilano, 2009:10-11). Furthermore, "climate migrants" within and across countries will multiply by the millions, resulting in humanitarian crises for which national and international mechanisms have not yet been put in place. (ADB Report on Climate Change and Migration in Asia and the Pacific, 2011).

Among the most affected by climate change is agriculture, and the outcome is greater food insecurity.[3] An important "underlying risk driver" is "ecosystems degradation" dramatized by the fact that "Of the 27.5 million hectares in the late 1500s, the country's forest lands currently stand at 7.2 million hectares or only 14.17% of the country's total land area." (Climate Change Commission, 2010: 11). Furthermore, "over 80 percent of original mangroves in the country have been cleared, increasing sediment outflow onto reefs." (Ibid). Fishing communities are affected, resulting in the same outcome, with more frequent fish kills, red tide, coral bleaching, etc.[4] The destruction of "weather-dependent" livelihoods not only in agriculture and fishing but also in forestry has a disastrous effect on the rural poor. Their productivity and incomes consequently decline as food supplies likewise decrease and

[2] The impacts on the macro-economy, poverty, employment and livelihood, governance, and vulnerable groups have been well-documented, and the implications on disaster risk reduction and management (DRRM) have been clearly drawn by the Special National Public Reconstruction Commission and the ADB, UN, World Bank Group and other Global Facility for DRR partners in the Typhoon Ondoy and Pepeng Post-Disaster Needs Assessment main report.

[3] Official government reports in 1999 stated that the El Nino phenomenon in 1997-98 resulted in a 6.6 percent drop in GDP (cited in Rincon et al, 2008). It also caused a combined loss of 1.8 million tons in rice and corn production. (PCARRD, 2001, cited in Rincon et al, 2008).

[4] "Reefs in poor condition incrased to 40% in the last 20 years due partly to ocean warming." (Capili et al, 2005, cited in Ricon et al, 2008). Among the other climate-related risks already observed by women in fisheries are sea level rise, "increased water surface temperature affecting fishponds…, increased soil erosion and sedimentation in the coastal areas affecting sea grass, corals, mangrove areas,… disappearance/reduction of migratory fishes " such as alumahan, banak, and hasa-hasa, and "unpredictability of dry and wet season.

food prices increase.[5] The result is increasing poverty and hunger (a trend already well recorded by surveys done by the Social Weather Stations), which are exactly the main problems the Millennium Development Goals seek to minimize. Achieving these goals amidst climate change is now even more difficult to achieve.

The urban poor are also very much affected since they are usually located on river banks and other areas highly vulnerable to flooding and damage caused by typhoons. Because of their vulnerability, exposure, and incapacity to adapt, they bear the brunt of climate change impacts. Their ranks are likely to increase as "climate migrants" stream in from rural areas, compounding the risks they face.

Vector-borne and other infectious diseases such as dengue fever, malaria and cholera are also expected to increase, and will be added burdens to the health sector. Other health-related impacts mentioned by the IPCC Fourth Assessment Report include "malnutrition and its consequences on child development, increased injuries, illness and deaths due to heat waves, floods, droughts, storms and fires," and "increased incidence of diarrhea and cardiovascular diseases." (Ebi, 2008, cited in Rincon et al 2008).[6] Groundwater sources may also be contaminated by sea water, thereby affecting supply of potable water.[7] (Cited in Casis, 2008:13-14). If sea water levels rise due to climate change, it is predicted that even well-maintained aquifers will turn salty and undrinkable. (Villarin et al, 2008:21).[8] Furthermore, "Any decline in groundwater yield will heighten water-related disputes and expose people to water-borne diseases such as cholera and typhoid fever." ((Ibid, p. 24).

As mentioned earlier, the adverse effects of climate change have a differential impact on people, and generally it is the poor who are most vulnerable. In the Philippines, the National Statistical Coordination Board estimated the number of poor families at 3.67 million and the number of poor people at 22.2 million in 2006. (NSCB, Feb. 8, 2011). Typhoons Ondoy and Pepeng in 2009 were expected to increase poverty by three percentage points in the most disaster-stricken areas in Luzon, and .5 percent nationwide, meaning an increase in the number of poor people by 480,000. (Special National Public Reconstruction Commission and the World Bank, 2009). The latest NSCB release on the highlights of the 2009 poverty statistics showed that the number of poor families increased to 3.86 million, and the number of poor people to 23.1 million (a difference of 970,000 Filipinos), with the disaster-stricken areas showing higher incidence.

But the poor are not all the same because among them , there are also differentiating factors such as gender, age, ethnicity, geographic location, resource access, employment, health, and migrant status.

For example, women and girls whose social roles make them more in need and in charge of water procurement will be most affected if they have to walk further to reach water sources in rural areas or to queue longer in water lines in urban areas. When disasters strike and they are brought to evacuation centers, their special health, safety, and sanitation requirements are often not considered, and they suffer consequently. There have been reports of women and children being sexually harassed or even raped in evacuation centers. Women's multiple burdens multiply when disasters strike, because they are in charge of providing food and fuel, taking care of the young, the elderly, and the sick, while at the same time not having enough access to resources, to information, to time, and to decision-making bodies. (Barrameda, 2010). This is particularly true of rural women as well as of women in fisheries. [9]

[5] An IFPRI study for submission to the ADB and the World Bank projects that by 2050, "irrigated rice yields will fall by 15 percent...,: and rice prices will go up by as much as 121 percent with climate change." "Climate change to affect 25M kids in 2050...." Inquirer.net , Sept. 30, 2009).

[6] "Data from the Department of Health showed how malaria cases (more than 1,500 recorded cases) and other diseases increased in 1998, a year when temperature rose as a consequence of El Nino." (Global Health Monitoring 2008, cited in Rincon et al, 2008).

[7] "Saltwater intrusion has been reported to be evident in nearly 28 percent of coastal municipalities in Luzon, 20 percent in the Visayas, and almost 29 percent in Mindanao" (Rellin et al, 1999 as cited in Perez, 2002, as well as in Rincon et al, 2008).

[8] There are predictions that sea water will intrude into Laguna Lake, thereby making it impossible to be a source of fresh water for Metro Manila in the future. (Godilano, 2009:16).

[9] Three reasons are cited for this, in the case of rural women. They have fewer assets to sell when floods or drought ruin crops. Second, they tend to go more into debt due to climate-induced crop failures. Third, when there is food shortage, they prioritize their men and their children in food allocation. (Peralta, 2008). At a more general level, gender advocates in the fisheries sector point out the following: "Gender as a vulnerability category is seldom taken into account in ensuring protection of victims of natural disasters; Gender-based violence continues as a threat to the security and dignity of women even in times of crisis; There is an unmet understanding of male perspectives and masculinities in the context of vulnerabilities and disasters; and gender is seldom taken into account in development programming, particularly in climate change adaptation and disaster preparedness and response." (Tanyang, 2010:28-32).

Indigenous peoples are also at enormous risk, because they live off the land and the resources found on their ancestral domain. As they themselves explain, "Our rights, cultures, livelihoods, traditional knowledge and identities are based on the profound and intricate relationships we forged with our lands, waters, and resources over thousands of years. Thus, when our lands and resources disappear or are altered by climate change, we suffer the worst impacts." (Tebtebba Foundation, 2009, vi). Expectedly, indigenous women are "more disproportionately affected," as they suffer the following impacts: loss of life, livelihood and food security; high health risks; loss of traditional knowledge; water conflicts, violation of gender rights, migration and displacement, less mobility and further marginalization, and loss of identity. (Ibid, pp. 109-112).

Older people are more affected by heat stress due to climate change, while children are more vulnerable to malnutrition, dengue and other vector-borne diseases aggravated by climate change. The number of children affected by disasters resulting from climate change is expected to increase to up to 175 million in the next ten years compared to 66.5 million in the 1990s. (Tanner, 2010).

The social vulnerability of the groups mentioned earlier may already be addressed by existing resources and assistance, but their access and entitlements to these resources remain problematic. Thus their ability to deal with the impact of external stress on their livelihood, security, and well-being may still be impaired, necessitating the "mainstreaming climate change and disaster risk reduction in relevant plans at the national and local levels." (NEDA, 2011).

It is therefore important to note that the MDG-F 1656 on Strengthening the Philippines' Institutional Capacity to Adapt to Climate Change is already in place "to pave the way to mainstream climate change adaptation in the country's development planning process." (NEDA, 2011). A joint program of the Government of the Philippines, UN agencies, and the Spanish Government, MDG-F 1656 "demonstrates adaptation strategies which involve the scientific assessment of current vulnerabilities of specific sectors of the country to climate change impacts, use of appropriate technologies, information on traditional coping practices, diversified livelihoods, improved capacities and current government and local interventions. " (Ibid.)[10]

Policy and Program Context

The Philippines now has very advanced legislation on climate change and disaster risk reduction and management (DRRM). It is also enhancing, strengthening, and rationalizing its social protection policies and programs, and this process can lead to further articulation and integration of climate change and DRRM concerns into current and future strategies and interventions. This "think paper" intends to contribute to the abovementioned process.

The **Climate Change Act of 2009** affirms the sustainable human development framework of Philippine Agenda 21, and "adopts the principle of protecting the climate system for the benefit of humankind on the basis of climate justice." It also highlights the vulnerability particularly of the poor, women, and children to the dangers of climate change, mandates the integration of disaster risk reduction into climate change programs and initiatives, as well as the systematic integration of "the concept of climate change in various phases of policy formulation, development plans, poverty reduction strategies and other development tools and techniques by all agencies and instrumentalities of the government." What is noteworthy is that aside from a national climate change action plan to be formulated in accordance with a national framework strategy, local government units (LGUs) are tasked to be "the frontline agencies in the formulation, planning and implementation of climate change action plans in their respective areas." (Sections 13 and 14). The Climate Change Act is for the synergy

[10] The MDG-F 1656 has demonstration areas in Metro Manila, Bicol, Agusan, Benguet, and Sorsogon which "incorporate the 'learning by doing' approach and tests innovative climate change adaptation measures and approaches as well as the capacity building of community stakeholders." (NEDA, 2011). In Agusan, for example, the ILO-DTI-DOLE Market Research Report recommended measures to address the vulnerability of small farmers to climate change. In Benguet, efficient farming mechanisms were implemented in accordance with a newly formulated adaptation framework. (Ibid.)

of adaptation and mitigation.[11] Key result areas (KRAs) for adaptation are enhanced vulnerability and adaptation assessments, and an integrated eco-system-based management with emphasis on river basin management,[12] building the resilience of coastal and marine ecosystems and communities (including tourism industries), mainstreaming biodiversity adaptation strategies, participative water governance and resource management. They also include securing food and water resources as well as livelihood opportunities through climate-responsive agricultural and health sectors, climate-proofing infrastructure and disaster risk reduction. KRAs for mitigation include energy efficiency and conservation, building the country's renewable energy capacity, developing environmentally sustainable transport systems[13] and infrastructure, reducing emissions from deforestation and degradation (REDD) of our forests and enhancing their potential to serve as a "carbon sink," and full implementation of the Ecological Solid Waste Management Act.

The Climate Change Act provided for the **National Framework Strategy on Climate Change 2010-12** which serves as the basis for climate change planning, research and development, extension and monitoring of activities, programs, and projects to protect vulnerable communities." (NEDA, 2011). In its Preface, the Framework "aggressively highlights the critical aspect of adaptation meant to be translated to all levels of governance alongside coordinating national efforts towards integrated ecosystem-based management which shall ultimately render sectors climate-resilient." (p.1). In its Guiding Principles, the Framework reiterates its adoption of the Philippine Agenda 21 for Sustainable Development, "to fulfill human needs while maintaining the quality of the natural environment for current and future generations." (p.4) The National Climate Change Action Plan is also being developed through a consultative process to provide details to the strategies contained in the National Framework, and to guide local government units in the making of their respective plans. (p.6)

The Philippine Disaster Risk Reduction and Management Act of 2010 reinforces the Climate Change Act in the following provisions of its Declaration of Policy:

> *(d) Adopt a disaster risk reduction and management approach that is holistic, comprehensive, integrated, and proactive in lessening the socioeconomic and environmental impacts of disasters including climate change, and promote the involvement and participation of all sectors and all stakeholders concerned, at all levels, especially the local community;*
>
> *(g) Mainstream disaster risk reduction and climate change in development processes such as policy formulation, socioeconomic development planning, budgeting, and governance, particularly in the areas of environment, agriculture, water, energy, health, education, poverty reduction, land-use and urban planning, and public infrastructure and housing, among others;*
>
> *(j) Ensure that disaster risk reduction and climate change measures are gender responsive, sensitive to indigenous knowledge systems, and respectful of human rights;*

The DRRM law signifies a shift from reactive emergency response to a proactive and integrated approach to address, reduce, and prepare for disasters. This shift is embodied in the law's definition of Disaster Risk Reduction as 'the concept and practice of reducing disaster risks through systematic efforts to analyze and manage the causal factors of disasters, including through reduced exposures to hazards, lessened vulnerability of people and property, wise management of land and the environment, and improved preparedness for adverse events". In this context, DRRM is defined as

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[11] Adaptation is defined in the Philippine DRRM Act of 2010 as "the adjustment in natural or human systems in response to actual or expected climatic stimuli or their effects, which moderates harm or exploits beneficial opportunities." Mitigation, on the other hand, refers to "structural and non-structural measures undertaken to limit the adverse impact of natural hazards, environmental degradation, and technological hazards and to ensure the ability of at-risk communities to address vulnerabilities aimed at minimizing the impact of disasters, construction and engineering works, the formulation and implementation of plans, programs, projects and activities, awareness raising, knowledge management, as well as the enforcement of comprehensive land-use planning, building and safety standards, and legislation."

[12] Leaders of the Climate Change Congress of the Philippines (CCCP) have critiqued the river basin management approach, preferring the more encompassing watershed (river to ridge) management approach that goes beyond the traditional political territorial divisions into cities and municipalities. One primary negative example of this is the poor watershed management in Marikina and surrounding cities of Antipolo, San Mateo, Montalban, etc. which was the root cause of the severe flooding experienced by these areas during Typhoon Ondoy.

[13] These could include electric jeeps, and small boats made of indigenous and inexpensive materials invented by people in frequently flooded communities.

"the systematic process of using administrative directives, organizations, and operational skills and capacities to implement strategies and policies" related to DRR.

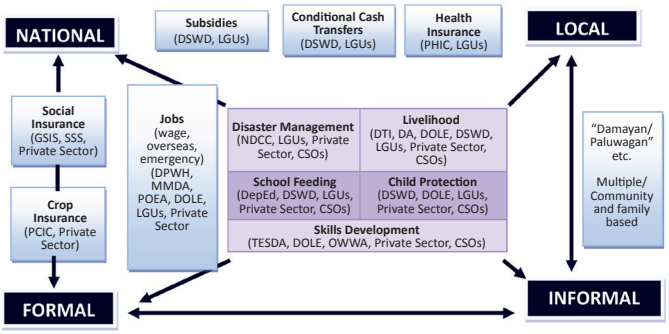
Since the DRRM law itself is a product of concerted CSO advocacy(Agsaoay-Sano, 2010), it places the burden not on government alone but seeks to "engage the participation of civil society organizations (CSOs), the private sector and volunteers in the government's disaster risk reduction programs towards complementation of resources and effective delivery of services to the citizenry." The point is to build not only a disaster-resilient nation but also disaster-resilient communities through community based DRRM., which is defined as "a process of disaster risk reduction and management in which at risk communities are actively engaged in the identification, analysis, treatment, monitoring and evaluation of disaster risks in order to reduce their vulnerabilities and enhance their capacities, and where the people are at the heart of decision-making and implementation of disaster risk reduction and management activities."

In the Philippine context, **social protection** consists of "policies and programs that seek to reduce poverty and vulnerability to risks and enhance the social status and rights of the marginalized by promoting and protecting livelihood and employment, protecting against hazards and sudden loss of income, and improving people's capacity to manage risks." Under this definition, components of social protection include labor market interventions, social insurance, social welfare, and safety nets. It is under the category of safety nets that the following disaster-related programs and projects of the Department of Social Welfare and Development (DSWD) are located: assistance to individuals in crisis situations, core and emergency shelter assistance to victims of disasters, disaster relief operations, food/cash for work assistance, critical incident stress debriefing assistance and the Tindahan Natin Project (food price subsidies). The National Food Authority (NFA) also provides food subsidies. The Department of Health (DOH) also has a program/project on disaster management and preparedness. In addition, the Metro Manila Development Authority (MMDA), the Philippine National Police (PNP) , and the Department of Public Works and Highways (DPWH) provide emergency employment but on a peripheral basis. (DAP, 2009:24-25).

The Development Academy of the Philippines (DAP) recommends the strengthening of these safety nets and proposes a program scoping diagram (see next page) which identifies the roles of national agencies and local government units, formal and informal schemes, and shows which bodies should take care of social, health and crop insurance, jobs, subsidies, CCT, disaster management, school feeding, livelihood, child protection and skills development. What is still missing in the program scoping is climate change adaptation.[14] Also important in terms of visualization is the connection to the global, since risks associated with climate change cannot be dealt with by one country alone and requires international solidarity and action. Even DRRM is now dependent on international cooperation for timely and accurate early warning systems related to weather and other disturbances.

[14] Based on various comments during the March 29, 2011 meeting of the NEDA SDC-Subcommittee on Social Protection, other agencies should appear in the program scoping if climate change adaptation will be seriously taken on board. An example is the Department of Education which is mandated to integrate climate change in the curricula and is now promoting the building of a safe learning environment through green technology and hazard –resilient features. Another is the Department of Agrarian Reform which now has a desk focusing on mainstreaming climate change and DRRM concerns in various programs for its beneficiaries. The Commission on Higher Education is also addressing climate change and the need for social protection through teaching, research, and extension. In fact, it hosted an International Conference on Biodiversity and Climate Change on February 1-3, 2011 together with the Department of Environment and Natural Resources (another agency which should be included in the program scoping because it is mandated under the Implementing Rules and Regulations (IRR) of R.A. 9729 to "oversee the establishment and maintenance of a climate change information management system." Also mentioned in the IRR are the Department of Interior and Local Government (DILG) and Local Government Academy which "shall facilitate the development and provision of a training program for LGUs in climate change and initiate related activities." The Housing and Urban Development Coordinating Council could also be included because of the need to integrate climate change concerns in core shelter plans of local governments.

Figure 39:
Proposed Program Scoping



There have been many studies and critiques of social protection programs (Manasan, 2009 and Development Academy of the Philippines, 2009). Among these are the fact that "the social security system, the social health insurance scheme and many of the non-contributory social protection programs provide poor coverage of the informal sector which includes the transient poor and the near poor," and the fact that "although national government spending on social protection has increased in response to the global financial crisis, national government's spending on social welfare programs, social safety nets and active labor market programs compares unfavorably with that of other countries." (Manasan, 2009:iii).[15] Furthermore, many of the emergency and subsidy schemes do not go beyond doleouts. (Homenet SEA, Homenet Philippines, and MAGCAISA Policy Brief on Social Protection, 2009).

Today, the critique centers on the relatively huge amount of resources being poured on the 4Ps or CCT Program, compared to other government programs that are just as important in the context of social protection.[16] The CCT now serves as the core of the convergence strategies linking employment generation, livelihood, microfinance, community-driven development, and asset reform. These could include environmental protection and conservation projects as was the case in Kalahi-CIDDS (Manasan, 2009:56), as well as the integration of disaster management in the Family Development Sessions of the CCT.[17] Such convergence strategies are mentioned in the chapter on social development in the **Philippine Development Plan (PDP) 2011-2016**, together with other "cross-cutting social sector strategies" such as attaining the MDGs, closing the universal coverage gaps in health care, accelerating asset reform, mainstreaming climate change adaptation and disaster risk reduction in social development interventions, and strengthening civil society-basic sector participation and public private partnership (PPP) in the social sector.

The PDP also contains a chapter on Conservation, Protection and Rehabilitation of Environment and Natural Resources towards Sustainable Development, which highlights efforts "to mainstream and integrate Disaster Risk Reduction (DRR) and Climate Change Adaptation (CCA) in national, sectoral, regional and local development plans." (NEDA, 2011).

Adaptive Social Protection Using a Social Justice and Human Rights Framework

There is increasing recognition that "Social protection policy needs to learn from and incorporate DRR and adaptation approaches to ensure programmes continue to effectively support livelihoods and protect the poor and excluded from shocks and risks in the face of climate change." (Davies et al, 2009:205). Put another way, "Social protection holds significant promise for protecting poor and excluded people against current (DRR) and future (adaptation) weather extremes and tackling increasing levels of risk and vulnerability." (Ibid, p. 212). The Philippine policy and program context discussed above shows that there is indeed a need for inclusion of climate change and DRRM concerns as mandated by existing legislation in the country's social protection strategies.

[15] This was P17 billion or.0.3% of GDP in 2007, and P62 billion or 0.8% of GDP in 2008, less than half of the mean spending (1.9% of GDP) by a group of 87 countries in 1996-2006. (Weigand and Grosh, 2008, cited in Manasan, 2009:72).

[16] Marivic Raquiza of Social Watch, during the March 29, 2011 meeting of the NEDA-SDC Subcommittee on Social Protection, pointed out that while there was an increase in social spending in the current government budget, allocations for agriculture and agrarian reform had gone down. Price support for palay and food subsidy through the National Food Authority (NFA) should not be cut down, since such measures could be considered just as important as the CCT and therefore should not be pitted against it.

[17] This was reported by DSWD Secretary Corazon J. Soliman during a dialogue with the UP CSWCD faculty on March 22, 2011.

The concept of "adaptive social protection", which has the following features, could therefore be considered by policy-makers:

> *An emphasis on transforming productive livelihoods as well as protecting, and adapting to changing climate conditions rather than simply reinforcing coping mechanisms.*

> *Grounding in an understanding of the structural root causes of poverty for particular people, permitting more effective targeting of vulnerability to multiple shocks and stresses*

> *Incorporation of rights-based rationale for action, stressing equity and justice dimensions of chronic poverty and climate change adaptation in addition to instrumentalist rationale based primarily on economic efficiency.*

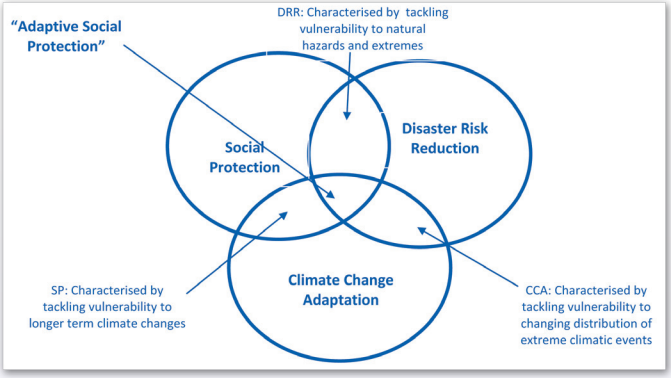
> *An enhanced role for research from both the natural and social sciences to inform the development and targeting of social protection policies and measures in the context of the burden of both geophysical hazards and changing climate-related hazards.*

> *A longer term perspective for social protection policies that take into account the changing nature of shocks and stresses.* (Davies et al, 2009:211-212).

Adaptive social protection is therefore about rights-based action for equity and justice that emphasizes the role of scientific research and sustainable livelihood in addressing chronic poverty and vulnerability to climate-related and other hazards. To be truly effective, adaptive social protection programs rely on science-based vulnerability assessment reports "to determine who are the most vulnerable; where are they located; what are their vulnerabilities, what are the socio-economic impact of these vulnerabilities and the corresponding adaptation measures needed." (NEDA, 2011).

Adaptive social protection seeks the integration of climate change adaptation to tackle "vulnerability to changing distribution of extreme climatic events;" a "preventative and holistic poverty approach to DRR" to address "vulnerability to natural hazards and extremes", and social protection which is "climate-proofed" in the sense that it can address "vulnerability to longer-term climate changes" with "more reliable and accurate predictions and consideration of vulnerability." (Ibid., p. 212).

Adaptive social protection also assumes universality of coverage since climate change and its ensuing impacts do not choose victims. Although the poor are the most exposed and vulnerable, other sections of the population can be severely affected and cannot be excluded from crucial forms of assistance for humanitarian reasons.



Source: Davies et al, "Climate Change Adaptation, Disaster Risk Reduction and Social Protection," in Promoting Pro-Poor Growth Social Protection, OECD, 2009. p. 212.

The need for "adaptive DRR" must also be stressed, "to ensure that all DRR activity is resilient in the face of a changing climate, or as far as possible 'climate proofed 'and does not result in the maladaptation of vulnerable communities." (Huq and Ayers, 2009:145).[18]

[18] One example of maladaptation is the building of dikes to contain floods, but which "began to trap flood waters or actually prolong floods". Another is the construction of coastal structures that have the effect of eroding nearby coasts. It is in this sense that short-term DRR "does not necessarily contribute to longer-term climate change resilience .." (Huq and Ayers, 2009:144).

Taking Off from Transformative, Gender-Responsive, Participatory, and Sustainable Social Protection

Based on its features enumerated in the previous section, "adaptive social protection" may be seen as taking off from the concept of "transformative social protection." This maintains that "social protection can address risks and promote economic growth but poverty and vulnerability are structural and embedded in the socio-political context; social protection must go beyond welfare and support citizens' claim to social protection from the state as a basic right" (Devereux and Sabates Wheeler, 2007:9). "Institutional transformative social protection" is a "means to a life with dignity" as it "**addresses power imbalances in the society**, creating a policy environment conducive to **pro-poor growth, accountable and responsive governance systems, and a social equity-grounded development approach**.' Thus, transformative social protection goes beyond targeted resource transfers; it extends to such arenas as equity, empowerment, as well as economic, social, and cultural rights. It requires legislation, financial commitment, and accountability. (Agenda on Transformative Social Protection…, 2009).

It also integrates a gender perspective developed by social development practitioners both here and abroad (notably Lund, Srinavas, Kabeer, Luttrell and Moser) which has led to an alternative definition of social protection: "All interventions from public, private and voluntary organization and informal networks to support communities, households and individuals, both women and men in their efforts to prevent manage and overcome risks and vulnerabilities throughout their life cycle, and to realize their rights as citizens participating fully and equally in all decision-making which affects their access to and control over resources necessary to maintain and sustain a decent and secure life." (Homenet Southeast Asia, Homenet Philippines and MAGCAISA: Policy Brief on Social Protection, 2009:2).

Part of the broad meaning of social protection is the right to participate in the affairs of the community to which one belongs in order to ensure access to resources as well as to various forms of justice. Many workers, especially women, youth, and those in the informal economy, have been invisible and are hardly consulted or even informed about housing, land development and other programs that affect them directly. The weaknesses of many existing social protection programs are partly due to lack of dialogue, consultation, and participation by the people. The working people, considered to be the targets or objects of many development programs undertaken in their name, often do not have a hand in the design and implementation of these programs.

As earlier discussed, social protection must also address the environmental crisis which is truly worrisome, since it can be the source of "catastrophic risks" which must in turn be addressed by adequate and participatory DRRM and other social protection initiatives at community level. Given the extent of environmental damage and the possibility of even greater damage due to climate change, there is pressing need to build a decent and sustainable economy based on green industry, agriculture and services, while at the same time creating millions of jobs in renewing forests, protecting coastal resources, reviving poisoned soil, cleaning up air and water sources, segregating and recycling mountains of waste, and last but not least, rebuilding damaged and vulnerable communities. It is in this sense that a **green economy is also a solidarity economy**, relying on the capacity of people to organize and create their own means to survive, prosper, and assist each other through cooperatives, fair trade groups, and other social enterprises. Social protection initiatives, therefore, should be linked to the broader goal of sustainable human development. (Ofreneo, R.E.: 2010).

Social, Gender, and Environmental Justice: Some Crucial Links

The notion of realizing rights and entitlements, in social protection literature, is very related to various conceptions of justice –economic and social justice; gender and reproductive justice; and environmental, intergenerational and climate justice. Each of these concepts is important because in human rights discourse, the claim holders (or the citizenry) can always assert various compendiums of rights to the duty bearers (mainly the state) within the ethical ambit of seeking justice, long denied, in any of its current forms.

These interweaving notions of justice are embodied in the **People's Social Protection Agenda (PSPA),** the product of a participatory and consultative process spanning years of sustained advocacy. It is a consolidation of the different views of various stakeholders – informal workers' associations led by Homenet Southeast Asia, Homenet Philippines and MAGCAISA, trade unions, women's groups and agencies, Church-based and business groups, civil-society and community-based organizations, government institutions, academe and others – on how social security and protection can be developed to cover all Filipinos facing various levels of risks and vulnerabilities in life.

Taking a rights-based, transformative, gender-responsive, participatory and sustainable approach to social protection, the PSPA calls for jobs, social security, health care, education and skills, basic services, social assistance, voice, and justice for all. It connects social protection to various conceptions of justice in the context of worsening financial and employment crises, and in the wake of terrible disasters the country just suffered due to climate change.

Social justice has always been the battle cry of trade union, peasant and other class-based movements struggling for more equitable and egalitarian societies. Women have always participated in these usually male-led movements, but their contributions have often been rendered invisible and insignificant in most mainstream histories.

Authors of World Bank publications have actually placed a social justice perspective to various climate change characteristics. They show how less developed countries, poor people, women, and other vulnerable groups have become victims of injustice created by the "correlation of greenhouse gas emissions to wealth and growth," the differential impact of climate change phenomena on various sectors based on their power and relation to natural resources, the increasing importance of and conflict over carbon assets," etc. (Mearns and Norton, 2009:16, Table 1.2).

Economic justice, which is often subsumed under the broader rubric of social justice, involves the exercise of economic rights related to the sphere of work, many of which are enshrined in the Universal Declaration of Human Rights, the International Covenant on Economic, Social, and Cultural Rights (ICESCR), and various ILO conventions, particularly those having to do with core labor standards and decent work. Of particular relevance in these times of financial and economic crisis is Article 11 of the ICESCR, which recognizes the right of everyone and everyone's family to "an adequate standard of living," including "adequate food, clothing, and housing, and to the continuous improvement of living conditions." (Balakrishnan, 2006:26)

These rights are also implicated, according to World Bank authors, when natural impacts of climate change in turn impact on human systems, resulting in death, increased poverty, deprivation, ill health, and homelessness, as well as marginalization and exclusion of women, children, older people, indigenous communities and other vulnerable groups. (Mearns and Norton, 2009:14).

Economic justice also has both participative and (re)distributive aspects. The first refers to the capability to engage in remunerative work and have access to and control of resources to earn an income enough to maintain what has been referred to above as "an adequate standard of living." The second refers to just compensation, fair prices (as propounded by fair trade advocates), and a reasonable share of the economic benefits derived from the application of one's labor and talents. It also includes asset reform, especially when referring to use and ownership of land and water resources.

Key policy recommendations of the PSPA are driven by a strong sense of economic and social justice, specifically those categorized under jobs, social security, health care, education and skills, basic services and social assistance for all. Their major concerns are the interests of majority of the working people who are often invisible, vulnerable, and marginalized – the workers in the informal economy.

The concepts of gender justice and reproductive justice have also been deployed to underpin the PSPA.The conception of gender justice can be interpreted as access to entitlements and enabling mechanisms, as absence of discrimination, or as a compendium of positive rights for women's empowerment. Goetz defines it as "the ending of—and if necessary the provision of redress for—

inequalities between women and men that result in women's subordination to men." (Goetz, 2007). The Asian Communities for Reproductive Justice say that what they are aiming for is "the complete physical, mental, spiritual, political, economic, and social well-being of women and girls, which will be achieved when women and girls have the economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives." (Sister Song, 2010).

Reproductive justice goes beyond the conventional frameworks of reproductive rights and health, since its basic assumption is the "intersectionality" of oppression, whether this is based on gender, class, race, nationality, sexual orientation, age, or any other differentiating factor. It has an integrated and transformative approach, taking into consideration the totality of women's lived experiences at home, at work, in school, in bed, at the dining table, or any other place where they expend their creative energies and seek to alter power relations in their favor. It factors in resource status as a crucial ingredient in accessing comprehensive health care so essential for women to live full, productive, and satisfying lives. It also puts a premium on collective initiatives and movement building, conscious of the fact that patriarchy and other social hierarchies cannot be challenged without the force of a critical mass.

Thus, included in the reproductive justice agenda are universal health care, access to birth control, maternity and sickness benefits, pre and post natal care, child care and nutrition, shared parenting and housework, sex education for young people, etc**.** In the Philippine setting, the conjoined advocacy for both economic and reproductive justice is captured in the campaign of organized women for a Magna Carta for Workers in Informal Employment (MACWIE), for the Reproductive Health bill, and more generally, for the PSPA.

Similar to the discourse on human rights which are invested with inalienability and indivisibility, economic and reproductive justice are two sides of the same coin for women in poverty. Without economic justice, women cannot access services necessary for the attainment of optimum health. Without reproductive justice, women in poverty will neither be free nor be able to work, since they will be immobilized and saddled by multiple burdens and too many children, and will be too tired, too weak, or too vulnerable to sickness to engage in productive employment.

Social and gender justice, however, will come to naught if the web of life continues to be further frayed, Notions of environmental and inter-generational justice are very much linked to the concept of sustainable development. This posits that the well-being of future generations should be assured by present generations through the wise use of natural resources and by refraining from abuse and despoliation of nature which could further endanger the ecosystems on which all life forms depend for continued existence. More specifically, future generations should not suffer the consequences of environmental degradation now accelerating in the context of climate change and global warming. Social protection when connected to this notion involves preparing and empowering whole communities of women and men, young and old, in preventing and addressing environmental disasters, as well as in mitigating their impact. Investing in green jobs and developing a green economy based on solidarity are also part of the solution.

Climate justice, as a related concept, is premised on the need for global equity, by obligating the industrialized countries most responsible for greenhouse gas emissions to compensate and assist the less developed nations now suffering from typhoons, floods, landslides and other after-effects of climate change resulting from these emissions. Such compensation and assistance should not be in the form of loans that lead to greater indebtedness (Tanchuling, 2010) [19] In fact, countries like the Philippines saddled with a huge debt burden should be given the space to write off some of this burden (particularly what are classified as odious or graft-ridden debts)or at least postpone payment until sufficient growth is achieved to make this feasible without sacrificing economic development and social services. The resources thus freed from automatic debt appropriation could be used for social protection and development. As the PSPA elaborates, "The money, during these times of crises, should

[19] In fact, the United Nations Framework Convention on Climate Change (UNFCC), in Article 4,3, provides that this should be in the form of new and additional financing resources. (NEDA, 2011).

go to social infrastructure, investment in public health, education, child care and other social services, to generate decent jobs for women[and men], and relieve their burdens." (p. 24).

A people's social protection agenda anchored on human rights and interweaving notions of justice is necessarily a departure from the dominant development paradigm which privileges economic growth at all costs without regard for its impact on the poor, the vulnerable, and the marginalized. Process-wise, it is based on the principles of participatory development, synthesizing the inputs and opinions of multiple stakeholders but providing utmost consideration to those provided by people's organizations. In terms of vision, it is more in harmony with the tenets of transformative and sustainable human development, which aims to transcend existing social hierarchies based on class, gender, race, ethnicity, etc. through participatory and accountable governance structures as well as cultural institutions promoting alternative lifestyles that simultaneously protect the environment.

Protective, preventive, promotive, and transformative SP strategies

Social protection can enhance adaptation and DRR benefits through protective and preventive strategies for coping, as well as through promotive and transformative strategies for building adaptive capacity. Examples of these social protection instruments and measures which have been found to have this impact by various studies are listed in the following table:

Table 8. Promoting Adaptation through Social Protection

SP Category	SP Instruments	Adaptation and DRR benefits
Protective (coping strategies)	• Social service provision • Social transfers (food/cash) including safety nets • Social pension schemes • Public works programmes	• Protection of those most vulnerable to climate risks, with low levels of adaptive capacity
Preventive (coping strategies)	• Social transfers • Livelihood diversification • Weather-indexed crop insurance • Social insurance	• Prevents damaging coping strategies as a result of risks to weather-dependent livelihoods
Promotive (building adaptive capacity)	• Social transfers • Access to credit • Asset transfer or protection • Starter packs (drought/flood resistant) • Access to common property resources • Public works programmes	• Promotes resilience through livelihood diversification and security to withstand climate related shocks • Promotes opportunities arising from climate change
Transformative (building adaptive capacity)	• Promotion of minority rights • Anti-discrimination campaigns • Social funds • Proactively challenging discriminatory behaviour	• Transforms social relations to combat discrimination underlying social and political vulnerability

Source: Davies et al, "Climate Change Adaptation, Disaster Risk Reduction and Social Protection," in Promoting Pro-Poor Growth Social Protection, OECD, 2009. p. 205.

There are important differences between coping strategies (which are short-term responses that relieve the burden of risk once it has occurred) and strategies which build adaptive capacity, which in the context of climate change is defined as "the actual ability of a system to adjust (or adapt) to climate change, variability and extremes, moderating potential damage, taking advantage of opportunities, coping with consequences, as well as expanding its coping range under existing climate variability or future climate conditions." It also refers to "communities' capacity to take advantage of the benefits and opportunities associated with a changing climate." (Jones et al, 2010:5). Protective measures, in this context, "provide relief from deprivation" and include "social assistance for the chronically poor" (or those with the least adaptive capacity) such as social services, food and cash transfers, pensions, fee waivers and public works. Preventive measures are meant "to avert deprivation," and include "social insurance for economically vulnerable groups," unemployment benefits, social transfers. etc. They also include livelihood diversification and weather-indexed insurance which prevent "damaging coping strategies as a result of risks to weather-dependent livelihoods." On the other hand, "Promotive measures aim to enhance real incomes and capabilities of the poorest and most vulnerable populations…" , thereby enhancing 'resilience through livelihood diversification and security to withstand climate-related shocks". These include social and asset transfers, microfinance,

drought- and flood-resistant starter packs, access to common property resources, and public works." Transformative measures, which are more rights-based, 'seek to address vulnerabilities arising from social inequity and exclusion of the poorest and most marginalized groups," and could include "collective action for workers' rights, protecting minority ethnic groups against discrimination or HIV and AIDS sensitisation campaigns." (Jones et al, 2010:12-13).

It must be pointed out that protective, preventive, promotive, and transformative measures are not mutually exclusive but are actually mutually reinforcing, constituting various dimensions of an iterative process. The transformative potential of all social protection measures exists from the very beginning of implementation and needs to be progressively realized across time and space.

A sectoral approach can also be used in the formulation of strategies. In the public health sector, for example, adaptation is associated with prevention at primary, secondary and tertiary levels:

> *Primary prevention aims to reduce exposures projected to occur with climate change, such as by increasing access to safe water and improved sanitation. Secondary prevention also aims to prevent the onset of adverse health outcomes, including through strengthening disease surveillance programs to provide early intelligence of the emergence or reemergence of vector-borne disease, such as malaria along the edges of its current range. Tertiary prevention consists of measures (often treatment) to reduce long-term impairment and disability and to minimize the suffering caused by existing diseases…"* (Ebi, 2009:131).[20]

Resilience against the health impacts of climate change can be cultivated by increased understanding of associated health risks, enhanced policies, programs, and capacities of health care systems, support for community-based adaptation, and a cross-sectoral approach especially in the use of new and untested technologies. (Ibid., pp. 132-139).

It must be pointed out that in the Philippine context, "the current planning environment is moving towards science-based and risk-based analysis to ensure that desired outcomes will not be affected by climate variability and extremes." (NEDA, 2011). It is in this context that social protection measures can be considered adaptation measures, especially if planned in an anticipatory manner. The current menu of policies and programs under the social protection umbrella can be further analyzed in terms of their adaptive goals and characteristics as well as their transformational potential. This is best done in a participatory manner, inviting multiple stakeholders from both government and civil society organizations, and involving the social protection, DRR and climate change professional communities. Some strategic directions which can be up for discussion are drawn at the last part of this paper.

Offhand, however, it may be pointed out some notable gaps in current strategies. For one, farmers as a sector are not protected from the impact of climate change because they no longer enjoy crop insurance.[21] Ideally, the provision of such insurance should be weather-indexed (i.e., based on the amount of rainfall) so that it can be immediately accessed by affected farmers as soon as destructive flooding occurs in cropping areas. Secondly, the big-ticket conditional cash transfer program has no explicit environmental perspective and clear connection to DRR and CCA concerns in terms of articulated goals. Whatever DRR and CCA –related activities are integrated in the CCT program (e.g., awareness-raising during the Family Development Sessions, building of dikes and other public works for emergency employment especially of fathers with children in the CCT) do not seem to be part of a systematic strategy included in the overall CCT framework. If managed well, however, and if their transformational potential is fully explored in their program design, cash transfers by themselves "are likely to contribute to adaptive capacity". (Wood, 2011).[22]

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[20] See also Table 8-1 – Examples of Adaptation Options to Address Climate-Related Health Risks, in Ebi, 2009, p. 137).

[21] This was pointed out during the meeting of the NEDA SDC Subcommittee on Social Protection last March 29, 2011, to the surprise of those in attendance because crop insurance is included in the social protection program scoping prepared by the DAP (see p. 7 of this paper).

[22] They may contribute in a number of ways: "a)meeting existing basic needs, thereby reducing short-term vulnerability and existing development deficits at the household level; b) helping the poor respond to climate-related shocks; c) reducing the pressure to engage in coping strategies which weaken long-term adaptive capacity, d) helping vulnerably households to better manage risk and therefore consider investment decisions and innovations to increase their adaptive capacity, e) transferring money for investment in long-term livelihood and adaptive capacity improvement, and f) facilitating mobility and livelihood transitions. "

Building Resilient Communities

Resilience is defined as the "ability of a system, community or society exposed to hazards to resist, absorb, accommodate and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions" (UNISDR, 2009). Case studies from the Philippines show that a community's level of resilience is negatively affected by many factors, among which are "the degree of environmental degradation, people's [lack of] access and control of different forms of resources and assets, high levels of poverty and inequality, beliefs, norms and practices that lead to the exclusion of women, children, the elderly and other minority groups, poor and unaccountable formal leadership and governance, lack of public awareness and participation in promoting a culture of safety." (Polotan dela Cruz, Ferrer and Pagaduan, eds., 2010:5).

On the positive side, the literature on the subject shows that there are key strategies in developing resilience at ground level, among which are strengthening local governments and communities; promoting consultation and participation; managing resettlement and rehabilitation; enhancing resilience of indigenous peoples in culturally appropriate ways; and filling knowledge gaps. (Ahmed et al, 2009). The overarching strategy for all this is improving the capacity of various communities to adapt to risks posed by climate change and other environmental hazards, and thereby reduce their vulnerability. The companion strategy for this to enhance the resilience of natural systems through various mitigation measures. (NEDA, 2011).

These are strategies validated by local case studies "which underscored different layers or dimensions of resilience" that at the same time revealed its complexity and multi-dimensionality: "active community participation, access and use of disaster information and knowledge, food security, livelihood security, good governance, development of appropriate technology, disaster preparedness and management planning, among others." (Polotan dela Cruz, Ferrer and Pagaduan, eds., 2010:5).

The authors of the case studies conclude that "Community organizing [CO] is the key strategy for building disaster-resilient communities." CO is built on people's participation in identifying and solving their problems. It builds on what the people know and are already doing, thus cultivating in them a sense of ownership of the process of learning from their experiences and developing systems of survival.[23] It affirms the belief that communities are not helpless even during disasters, and can, with transient support from "external service providers," go beyond being disaster victims towards being agents of their own survival and of social change. This is in view of the fact that there are structural barriers to livelihood security (based on access to and control of productive resources), and there is need to address over the long term "the root causes of people's vulnerability such as landlessness, natural resource degradation, lack of access to technology and credit, among others, and organizing and mobilizing people in order to challenge and transform these conditions." (Ibid, p. 9). The firm belief is that only the organized strength of an awakened people can serve as a counter-force to well-entrenched vested interests which remain in control of major productive assets and which continue to damage and deplete environmental resources. Appropriate technology development in the form of flood-resistant rice varieties and organic rice and vegetable farming can be facilitated by schools, parishes, and local governments. Scientific (or "expert") knowledge and local wisdom can converge and complement each other, as exemplified by the creation and effective use of home-based rainfall monitoring stations as well as water-level measuring stations along rivers. NGOs and CBOs (community based groups) can adopt "a mainstreaming approach" to broaden citizen participation in local planning, budgeting, implementation and evaluation towards ensuring participatory and gender-responsive good governance.

In the context of the case studies, good governance means that "(1) government at the local (and national) levels is able to provide an effective institutional framework, policies and legislations that

[23] One example of this is the homegrown evacuation system of Barangay Salinding to guard against flooding: "They know where to evacuate, whom to help, and when it is time to evacuate. Those with riverboats bring their families to safer ground, then return to help others evacuate. The families with sturdier, elevated houses accommodate the temporary evacuees. These traditional arrangements and practices now form part of an effective system of disaster management in the community; no deaths due to flooding have been recorded thus far in the village."

promote DRR as a priority; (2) institutions, organizations, and individuals who are responsible for reducing disaster risks exhibit accountability and transparency in their work; (3) funds and other resources are made available and are actually spent on activities that reduce vulnerabilities and disaster risks; and (4) local communities and their organizations are able to exert influence and are involved in the promotion of a culture of safety." (Ibid, p. 7).

Having supportive decision-making mechanisms to facilitate the use of practical tools and technologies for preventing and mitigating impacts of climate change is very important (NEDA, 2011). This is well illustrated in the initiatives of Sorsogon City which are components of MDG-F 1656. These include, among others, the replacement of incandescent bulbs in all public buildings with CFL bulbs; the modification of shelter designs to withstand disasters; the construction of safer schools, etc. (unhabitat website).

There are other perspectives and case studies which highlight the convergence of climate change adaptation, DRRM, and social protection, while using a gendered and sectoral approach in examining issues and proposing strategies specifically for women in fisheries (Tanyang, 2010) Examples of specific actions for climate change adaptation in the context of social protection include micro-insurance for men and women in poverty, accessibility of socialized credit for women, simple water provision/ impounding systems manageable at the village level, settlements and tenurial security, health and RH [reproductive health]service delivery, men's involvement in preventive health, referral systems responding to gender-based violence even during disasters, conflict and emergencies, promotion of affordable energy sources, and appropriate infrastructure and technology. Specific actions in the area of disaster preparedness include early warning systems reaching women, gender-responsive disaster management planning, and women-inclusive disaster management structures and decision-making.

Beyond climate change adaptation and DRRM, there is still a need to focus on ecological integrity, including environmental protection, in the building of resilient communities (NEDA, 2011). This means preserving and renewing ecosystems so that these will return to their natural state of being self-sustaining, and self-regulating. This includes "rainforestation," rebuilding of watersheds, protection of endangered species, shifting to organic farming, conserving energy while developing clean and renewable sources of energy, promoting environmentally sustainable transport systems, etc.

The Need for an Alternative, Integrated, Coherent, and Multi-Stakeholder Approach

The risks associated with climate change are multiple and require an integrated and multi-stakeholder approach, involving all who are working on social protection, climate change, and disasters. The risks could be direct and can take the form of disasters or decreased harvest; they could be indirect as in the case of vector-borne epidemics, rising prices and unemployment; they could result in "irreversible damages to life, and human, physical, social/cultural., natural, and political assets." They could occur more frequently and with less predictability. The scale and frequency may not be possible to address by local household and community strategies and require a broad effort from both state and non-state actors and traversing all levels of interventions from local to global. (Heltberg et al, 2008. 25). It is also both unrealistic and unfair to expect individual households and communities to bear the burden of adapting to the adverse impacts of climate change which they had virtually no role in creating.

At the national level, state agencies must build their "institutional adaptive capacity" in terms of scientific knowledge, skills, and attitudes to plan, implement and evaluate strategies in a coherent and coordinated manner to adequately respond to the challenge of climate change. "Measures for institutional effectiveness in reducing vulnerability to climate change" could be considered in such capacity building, including "developing innovative risk transfer mechanisms," providing incentives to agencies "which target zero casualties", preparing "anticipatory plans," investing in "early warning devices and disease surveillance mechanisms," etc. (NEDA, 2011). This capacity must be built not only at the national level but also at the regional, provincial, municipal, and barangay levels. Inter-agency committees and coordinating councils dealing with social protection, DRRM, and climate change at all levels need to be on the same page in terms of analyses, perspectives, frameworks, and directions. Foregrounding the rights-based sustainable human development framework as mandated by both the DRRM and climate change laws is a necessity in this regard.

The institutionalization of civil society participation at all levels of governance – from the local to the global – needs to be ensured so that grassroots advocacy from below can be met by support from above. Forces for change inside and outside government must be able to effectively work together at micro, meso, and macro levels, building unities while respecting differences. Moving towards a green economy, low-carbon development, organic and other sustainable forms of agriculture, food security, community-based DRRM, encouraging indigenous yet science-based innovation; e.g., lifeboats made of GI sheets and wood for flood-prone areas, require enormous political will and corresponding resources. The need to provide universal, long-term, transformative and adaptive forms of social protection, including expanding social insurance schemes for emergency needs, climate-proofed shelter and sustainable livelihood, magnifies the resource concerns. The importance of funding and financing mechanisms from both internal and external sources, as well as the transparent, equitable, and accountable handling of such resources cannot be overemphasized.

In the realm of adaptive social protection, and as highlighted by the post-Ondoy and Pepeng needs assessment, much more resources need to be allocated to measures such as cash or food transfers; i.e., in the form of cash or food for work programs, community block grants to "create meaningful work and leverage sweat equity", trauma counseling, services to meet the specific concerns of women, children, the elder, people with disabilities, etc. Core shelter programs have to be increased, basic services and livelihood opportunities have to be built in relocation areas in a process wherein the affected communities are thoroughly consulted and engaged.[24] Employment is a key concern, not only in terms of emergency work and income support for the most vulnerable, but also of "local economic recovery measures, " "reintegration of displaced peoples, " and promoting decent work, including social protection. (Special National Public Reconstruction Commission and the World Bank, 2009: 34-35).

Both climate change and DRRM problems and proposed solutions transcend political boundaries and require ever expanding arenas of advocacy and solidarity, especially among the poor, the vulnerable, and other victims of injustice. Their visibility and voice are important at all levels for them to exercise agency in claiming their rights and entitlements in an increasingly insecure, unprotected, divided, and violent world. It is in this sense that adaptive social protection can be considered an instrument of social, gender, and environmental justice in the era of climate change.

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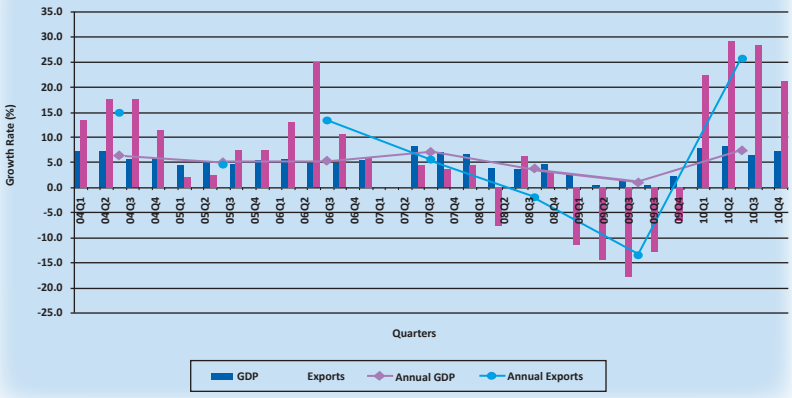
PUBLIC WORK PROGRAMS AS SOCIAL SAFETY NET: ISSUES AND CHALLENGES[1]

Rosario G. Manasan

1. INTRODUCTION

The global financial and economic crisis that started with the implosion of the US housing market and the ensuing recession in key developed economies in the latter half of 2008 has had an adverse impact on the country's exports and, consequently, the growth of the economy. In particular, Philippine exports (in constant prices) registered negative growth in the fourth quarter of 2008 and through all four quarters of 2009 (**Figure 1**). Concomitant with this, the growth of GDP in constant prices decelerated from a high of 7.1% in 2007 to 3.7% in 2008 and 1.1% in 2009 while the growth of GNP slowed down from 7.5% in 2007 to 6.4% in 2008 and 4.0% in 2009. On the other hand, while the remittances of overseas workers continued to post positive growth in 2008 and 2009, its growth waned from 13.2% and 13.7%, respectively, in 2007 and 2008 to 5.6% in 2009.

Figure 1. Quarterly (q-onq) Annual Growth Rates of GDP and Exports, 2004-2010



At the same time, the employment situation deteriorated. Thus, the unemployment rose from a low of 7.3% on the average in 2007 to 7.4% in 2008 and 7.5% in 2009 (**Table 1**). Also, while the underemployment rate dipped from 20.1% in 2007 to 19.3% in 2008 and 19.1% in 2009, the share of the visibly underemployed (i.e., those who worked less than 40 hours a week) to the total number employed is higher in all rounds of the Labor Force Survey (LFS) conducted in 2008 and 2009 relative to those conducted in 2007.

In response to the expected economic slowdown following the contraction of exports and remittances of overseas Filipino workers, the government formulated the Economic Resiliency Plan (ERP) and announced the same in early 2009. The Plan aims (i) to ensure sustained growth through a countercyclical policy, (ii) to save and create as many jobs as possible, and (iii) to protect the most vulnerable sectors – poorest of the poor, returning overseas Filipino workers, and workers in export industries.

[1] This Social Protection Think Paper, prepared by the Consultant (Dr. Rosario G. Manasan), is an output of the project entitled "Towards the Operationalization of the Social Protection Strategy" implemented by the Department of Social Welfare and Development (DSWD) in collaboration with the National Economic and Development Authority (NEDA) – Social Development Staff (SDS), with financial support from the United Nations Development Programme (UNDP), through the UNDP Country Programme Action Plan (CPAP) 2005-2011 Portfolio on Poverty Reduction and Support for the MDGs, with NEDA-SDS as Implementing Partner (IP), under its 2011 Annual Work Plan (AWP).

	Jan	April	July	Oct	Average
Unemployment					
2005	7.3	8.3	7.7	7.4	7.7
2006	8.1	8.2	8.0	7.3	7.9
2007	7.8	7.4	7.8	6.3	7.3
2008	7.4	8.0	7.4	6.8	7.4
2009	7.7	7.5	7.6	7.1	7.5
2010	7.3	8.0	6.9	7.1	7.3
Underemployment					
2005	16.1	26.1	20.5	21.2	21.0
2006	21.3	25.4	23.5	20.4	22.7
2007	21.5	18.9	22.0	18.1	20.1
2008	18.9	19.8	21.0	17.5	19.3
2009	18.2	18.9	19.8	19.4	19.1
2010	19.7	17.8	17.9	19.6	18.8
Share of visibly underemployed to total no. unemployed					
2005	64.5	54.3	61.4	58.9	59.7
2006	60.7	58.3	56.6	61.6	59.3
2007	57.7	58.3	50.9	58.5	56.3
2008	61.2	57.5	55.8	61.8	59.1
2009	60.8	62.6	54.5	59.4	59.3
2010	57.0	58.7	58.1	55.5	57.3
Share of informal sector in total employed					
2006	50.2	49.9	48.0	50.0	49.5
2007	47.6	49.9	47.9	49.9	48.8
2008	49.8	47.2	48.3	48.0	48.3
2009	48.8	49.1	46.2	47.8	48.0
2010	45.9	47.1	48.0	47.3	47.1

Table 1.
Unemployment and Underemployed rate, 2005-2010

Source: Labor Force Survey, National Statistics Office

The ERP is worth PhP 330 billion, divided into PhP 160 billion of government budget interventions, PhP 40 billion of tax cuts, and PhP 130 billion of off-budget interventions consisting mainly of large infrastructure projects to be funded by GOCCs, GFIs and the private sector. The budget interventions include quick-disbursing, labor – intensive, community level infrastructure, the expansion of some social protection programs like the 4Ps, the PhilHealth Sponsored Program, the scholarship program for technical vocational training, the rice price subsidy program under the NFA and the comprehensive livelihood and emergency employment program (which is largely a public workfare program).

The appropriateness of public works programs (PWPs) in providing protection against natural disasters and external economic shocks has been considered with greater interest by various countries and some development agencies in recent years, primarily because of "their attractiveness in information- and capacity-constrained" situations and the scope for self-targeting that they offer (Subbarao *et al.* 2010). In many countries, public works programs (PWPs) are primarily aimed at providing poor households a source of income through the creation of temporary jobs in labor-intensive projects, such as road construction and maintenance, in order to allow them to smoothen their consumption in the wake of a temporary labor market disruption due to global economic volatility, a natural disaster or conflict situation. The need for this type of social safety nets is underscored in countries like the Philippines which do not have formal unemployment insurance program.

This short note aims to evaluate the issues and challenges in the implementation of public works programs to mitigate the impact of external shocks (like the Asian financial crisis of 1998 and the more recent global economic and financial crisis of 2008/ 2009) and disasters/ calamities (whether natural or man-made). It starts by presenting the typology of public works programs (PWPs). It then proceeds with a review of the Philippine experience in the implementation of short-term PWPs. Following this, the paper then explore the use of public works program to provide an employment guarantee, i.e., as a form of unemployment insurance and looks at the merits of establishing an unemployment insurance program in the Philippines. Finally, it ends by summarizing the challenges in implementing PWPs.

2. TYPOLOGY OF PUBLIC WORKS PROGRAMS

Public works programs are programs which "entail the payment of a wage (in cash or in kind) by the state in return for the provision of labor in order to i) enhance employment (i.e., to provide jobs to those unable to find alternative employment) and ii) produce an asset (either physical or social), with the overall objective of promoting social protection" (McCord 2008). McCord (2008) points out

that PWPs are heterogeneous and that they differ significantly in terms of duration, scale, targeting, implementation modalities and relationship to the labor market. She further argues that the failure to recognize the diversity among different variants of PWPs may result in the selection of programs which are not suitable to the specific country context and consequently, errors in program design and implementation.

Subbarao *et al.* (2010) distinguishes among three types of public works programs. The first type of PWP refers to PWPs that act as short-term safety nets. Type 1 PWPs provide short-term employment that create community assets (mostly infrastructure) as a response to labor market shocks. The primary objective of this type of PWP is to temporarily increase aggregate employment, thereby transferring income to those who would otherwise be unemployed and contributing to consumption smoothing.

The second type of PWP refers PWPs that act as longer term safety nets. Type 2 PWPs typically involve large scale government employment programs that are implemented in countries that are faced with high chronic unemployment. PWPs of the second type "may provide an employment guarantee for a certain number of days or hire fewer people for longer period of time," serving as a surrogate of the unemployment insurance that is available in more advance countries. Type 2 PWPs seek to achieve not only consumption smoothing and infrastructure development but also poverty reduction by helping participating households cross the poverty line consumption threshold over the year."

On the other hand, the third type of PWP (or Public Works Plus) refers to programs that are meant to serve as a vehicle to "graduate participants out of poverty**,** either via encouragement of savings or via a training component." Thus, this type of program includes training as a core component of the program in order to encourage workers to acquire the needed skills to gain more permanent employment in the future. Type 3 PWPs are suitable "when a large proportion of the youth in a country are unemployed, skill shortages have been pervasive, and the need to integrate the youth into development programs is great."

3. PUBLIC WORKS PROGRAMS IN THE PHILIPPINES OVER TIME

The Philippines has had a long history in implementing public works programs. A public works program was first implemented in the country during the 1986 crisis, then during the 1998 Asian financial crisis and, more recently, during the 2008/ 2009 global financial crisis. It should be emphasized that all these programs are Type 1 PWPs.

3.1 Food for Work Program (During the 1986 Crisis)[2]

This program was launched in 1986 in Negros Occidental and five other provinces. It was meant to mitigate the impact of the sharp decline in world sugar prices on sugar cultivators, particularly the wage-dependent but unemployed sugar workers or *sakadas*. After the completion of its first phase, the program was expanded in 1991 as a strategic program for the development of the province of Negros Occidental. The program covered 25 municipalities and six cities in the province. The program included activities involving land development (small irrigation projects and agro-forestry work in the uplands), physical infrastructure development (constructing and rehabilitating roads and bridges, public markets) and social infrastructure development (day care centres, health and training facilities). The selection of projects followed a bottom-up approach and that was started at the *barangay* level with the participation of the *barangay* council, indigenous NGOs and other community-based organizations. The project plans were then sent to the municipal office of the Department of Interior and Local Government (DILG) for review to ensure consistency with local development plans and priorities. The projects that passed muster were endorsed to an interagency provincial task force that evaluated the proposed projects for both technical and administrative feasibility.

The number of individuals employed by the program fluctuated between 179,000 and 883,000 in 1986 to 1991. Participating workers received both cash and in-kind (rice) payments. In the land development projects, farmers were given rice to help tide them over until they could harvest

[2] The discussion of these programs draws heavily from Subbarao et al. (1996) as presented in Manasan (2001).

their own crops and to encourage them to practice agroforestry in uplands. In this case, the value of the food given to the farmers was less than the market wage rate, since the farm output accrues to the farmers themselves. In the case of the infrastructure development projects, workers were paid the local market wage rate, partly in the form of cash and partly in the form of rice. Specifically, PhP 10 was deducted from the agreed upon daily wage (PhP 90 which is also equal to the market wage rate) in exchange for 2 kilos of rice. Since the actual price of rice was P 12 to P 14 per kilo (higher than the P5 per kilo that was used by the program in its computations), workers were effectively paid P 104 to P 108 per day instead of the market wage rate of P 90 per day.

Subbarao et al. (1996) reported that discussions with the project managers revealed that many laborers were willing to work for as little as PhP 60 per day. In turn, the non-poor were also attracted, which explains why no significant differences in the socioeconomic characteristics were found between participating and non-participating households. Thus, the wage-setting procedure used by the program eroded its essence as a safety net or poverty alleviation measure.

However, the success of the program in providing employment and consumption smoothing to needy households encouraged the Department of Social Welfare and Development (DSWD) to apply the approach in providing some relief to the victims of the Mt. Pinatubo eruption in 1991. Food and cash were given to displaced families and in return they were asked to participate in community activities.

3.2 Second Rural Roads Improvement Project (Prior to the 1998 crisis)[3]

The Government through an executive order issued in 1988 required national and local government agencies to promote labor-intensive methods, especially for small rural-based projects. This approach was used to implement many of the land development projects under the Comprehensive Agrarian Reform Program (CARP).

Adopting labor-intensive methods, the Second Rural Roads Improvement Project was implemented as part of the land development efforts in three settlement areas in Negros Occidental, Sultan Kudarat and Cotabato. It was partly financed by loans from the World Bank (WB). It also received technical assistance from the International Labor Organization (ILO). The labor-based component of the project produced 250 km. of *barangay* roads in 1987 to 1993, using about one million labor-days. At its peak, the project created 247,600 labor days per year.

While successful in generating employment, the project was not seasonally targeted and could have competed with the agricultural activities in the area. Delays in budget releases limited the ability of the program to provide rural employment during the months of March and April when unemployment and underemployment was high in the agriculture sector. This occurred as spending authorizations were usually given close to the planting season. Moreover, the wage rate adopted for the project was 25 to 30 per cent higher than the minimum agricultural wage rate.

3.3 Rural Workers Program (During the 1998 crisis)

In February 1998, the Government issued a memorandum mandating the Department of Labour and Employment (DOLE) to formulate a comprehensive employment plan that will introduce employment preservation mechanisms through the promotion of "flexible working arrangements", as well as "social accords" between labor and management in times of crisis. Thus, the DOLE was geared to prevent job losses where possible and to help displaced workers find employment at the least time and cost possible through the matching of the supply and demand for jobs. The interventions for displaced workers include rural works program, employment facilitation assistance, training, credit and market assistance and livelihood programs. It should be emphasized, however, that this package of assistance reached mainly workers in formal sector establishments.

[3] This sub-section is taken from Manasan (2001).

As part of this program, the DOLE allocated P 14 million to finance the Rural Works Program for displaced workers in Mindanao. The program funded small infrastructure projects (repair and maintenance of schoolrooms; health and daycare centers; roads, bridges and irrigation networks; cleaning of estuaries, drainage and waterworks systems; and reforestation programs) in selected depressed and rural communities to assist workers displaced by company closures/retrenchment and those affected by El Nino. Workers were paid minimum wage, 60 per cent of which was paid by the DOLE and the remaining 40 per cent the by LGUs and NGOs involved. Some 3,364 unemployed workers found temporary jobs in various government infrastructure projects worth P 4.4 million under this program (Reyes et al., 1999).

3.4 Public Works Programs Under the Comprehensive Livelihood and Emergency Employment Program (2008/2009 Global Financial Crisis)

In response to the global financial crisis of 2008, the Arroyo administration crafted the Comprehensive Livelihood and Emergency Employment Program (CLEEP). The CLEEP aims to protect the most vulnerable sectors (e.g., the poor, hungry, returning expatriates, workers in the export industry, and out-of-school youth) from reduced or lost income arising from the economic crisis by creating job opportunities through emergency work programs and livelihood projects.

The public works programs under the CLEEP include the Cash-for-Work program of the DSWD, the Tulong Panghanapbuhay sa Ating Disadvantaged Workers (TUPAD) program, the Out-of-School Youth Servicing Towards Economic Recovery (OYSTER) program of the DOLE, the Bantay Dagat of the Department of the Agriculture (DA), and the Herbal Soap Making Project of the Department of Education (DepEd).

Cash-for-Work program (DSWD).[4] The DSWD's Cash-for-Work program aims to provide temporary employment in community projects and activities, thereby augmenting the income of distressed/ displaced individuals. The program is open to all individuals aged 18 years and above who are willing to render work in identified projects/ activities in exchange for cash, food and/ or other forms of payment in-kind. The program provides work for a minimum number of ten (10) days but the DSWD field office has the discretion to extend the number of working days up to three (3) months.

The community and their local leaders identify the projects that will employ prospective beneficiaries as well as the areas where said projects will be put up. The projects and activities under the program typically involve (i) livelihood and productivity support projects like the construction or repair of small infrastructure facilities in support of the start-up or operation of the SEA-K, Tindahan Natin or other modalities of livelihood and income generating projects, (ii) reconstruction and rehabilitation projects like the repair or construction of shelter units and social services infrastructure such as health stations, day care centers, and schools; (iii) disaster preparedness, mitigation activities, and environment related projects like river dredging and embankment, digging and dredging of canals and drainage, tree planting or reforestation projects; and (iv) hunger mitigation and food security projects like communal farm preparation and planting, repair/ rehabilitation of irrigation structures, repair or construction of post harvest facilities and farm-to-market roads. It is creditable that all the projects and activities in the abovementioned appear to create assets that are productivity enhancing, thereby promoting the long-term benefit of the program.

Program beneficiaries are paid a daily rate that is 75 percent of the prevailing daily wage rate. The program is one of the few programs under the CLEEP which explicitly provides that the wage rate paid to beneficiaries is lower than the minimum wage rate. As such, it helps ensure that only the most economically disadvantaged individuals (i.e., poor individuals who truly have difficulty finding work) will participate in the program. In other words, this feature of the program fosters self-targeting. Also, this feature promotes the automatic graduation of beneficiaries from the program by ensuring that

[4] The Cash-for-Work program of the DSWD is not only targeted towards those affected by the global financial crisis but it also aims to assist individuals and households adversely affected by disasters and conflict situations.

beneficiaries will voluntarily drop out of the program when the labor market improves and better paying jobs becomes available.

However, the number of beneficiaries from the Cash-for-Program is fairly limited. In 2009, there were some 47,000 cash-for-work beneficiaries.

Tulong Panghanapbuhay sa Ating Disadvantaged Workers or TUPAD (DOLE). TUPAD was implemented in all regions of the country covering 68 provinces, 27 cities, and 67 municipalities. It was intended for (i) workers displaced by the global financial crisis; (ii) long-term unemployed poor; (iii) out-of-school youths; (iv) workers in the flood-prone areas; and (v) victims of natural calamities.

The LGUs prepared project proposals for submission to the DOLE regional office having jurisdiction over their area. The projects under TUPAD include various community projects of the LGUs which include simple infrastructure works such as construction of bridges, tire path, rip rapping, flood control, improvement of roads, repair of public facilities, and de-clogging of canals. LGUs also identified and engaged the beneficiaries in their community work projects. On the other hand, the DOLE prepared the recruitment and selection guidelines. It also monitored the progress of program implementation.

The DOLE shouldered the wages of the beneficiaries for the period of employment, while the LGU paid for the PhilHealth premiums (i.e., 50%) of the beneficiaries for one year, the SSS premiums (i.e., 100%) for one month, and the cost of raw materials needed in the construction of community work projects. On the other hand, the PhilHealth subsidized the other half of the premiums for one year.

The beneficiary workers were enrolled in the program for a minimum of one (1) month or a maximum of one (1) year. They were paid a wage rate that was based on the prevailing LGU rates.[5] In addition, every beneficiary was provided livelihood assistance (e.g., capacity building, provision of raw material inputs, tools and equipment). In particular, TESDA provided program beneficiaries with trainings (skills upgrading/re-tooling) or entrepreneurship development to enhance their employability in the future. The trainings were conducted during weekends within the one-month employment period.

Because the wage rate of TUPAD is typically equal to the minimum wage rate, there is no element of self-targeting in the program. As indicated earlier, selection of beneficiaries is undertaken by the participating LGUs. Also, while the official menu of projects that are eligible for TUPAD appear to be productive undertakings, stories about the programs appearing on the DOLE website indicates that some of the TUPAD activities involved not-so-productive projects like community beautification projects.

Out-of-School Youth Servicing Towards Economic Recovery or OYSTER (PNP-DPWH). OYSTER, which was first implemented in 2002, was originally a community-based crime prevention program and a conduit for providing livelihood and employment opportunities/assistance to marginalized out-of-school youth (OSY) in the country. Initially, the program aims to (i) transform the OSY as productive members of society; (ii) reduce crime incidents involving juvenile offenders; and (iii) enhance the image of the PNP as a community partner.

At present, project OYSTER is a roadside maintenance program. As such, activities under the program include desilting/ declogging of drainage canals, repair of manhole covers and inlets, vegetation control (i.e., clearing/gathering of waterlily in rivers and other waterways), planting trees/ shrubs/ flowering plants and other beautification projects, removal of obstructions, manual reshaping of unpaved shoulders, cleaning of sidewalks, street sweeping, repair and repainting of sidewalks, asphalt patching, and assistance to motorists. These activities form part of the year-round routine maintenance works of the DPWH. Workers hired under OYSTER complement the regular workforce for roadside maintenance and provide additional manpower in carriageway maintenance activities in time of calamities. In addition to providing emergency employment, OYSTER also provides education and skills training and sports development.

Each of the workers hired under OYSTER is employed for three months. The basic wage rate is placed at PhP 231 per day nationwide. The DPWH was responsible for the hiring and payment of wages while

[5] Most LGUs pay their casual employees the minimum wage rate.

the PNP assisted in the screening of applicants.

The implementation of the DPWH OYSTER underscores pitfalls associated with the various works program enrolled under the Comprehensive Livelihood and Employment Program (CLEEP). First, self-targeting under the OYSTER is limited. While wage rate used for the OYSTER in 2008 is higher than the regional wage rate in 2 regions (namely, Region V and ARMM), it is just about the equal to the regional wage rate in 3 regions (namely, Regions I, II and CARAGA). On the other hand, while the wage rate under the OSYTER is lower than the regional minimum wage rate in 11 regions, it is gap is fairly small (less than 10%) in 7 regions.

Second, as is true of the TUPAD, some of the projects under the OYSTER menu do not create durable assets that will tend to enhance growth and the productivity of the local community in the future. Examples of this type of projects include planting of shrubs/ flowering plants and other beautification projects, cleaning of sidewalks, street sweeping, and repainting of sidewalks.

Third, the desirability of involving some agencies (e.g., PNP) in identifying projects and beneficiaries under the OYSTER is dubious. Agencies whose participation in the OYSTER is clearly extraneous to their mandates are not likely to make a positive contribution to the project.

Overall assessment of the CLEEP. An assessment of the various programs under the CLEEP that was conducted by the National Anti-Poverty Commission (NAPC) yielded the following findings:

- "Kind of Employment - Some (beneficiaries) have been very thankful in joining the PAPs as they are able to take care of some of their basic needs. However, employment provided was usually very short-term and the salaries below the minimum wage rates in their particular regions.
- Attribution - While employment was addressed by CLEEP, most of those employed by the different PAPs were not affected by the GFC directly.
- Targeting Strategy - Different agencies resorted to different modes of targeting their beneficiaries. It was not made clear if those targeted were those directly affected by GFC.
- Agency Mandates - Some agencies have resorted to projects not part of their mandate.
- Benefits arising from CLEEP – Those who were hired on a daily basis appreciate the additional income provided by the different PAPs of CLEEP. They are able to address some basic needs such as food, clothing and shelter, and even education and health needs.
- Sustainability – Most of the beneficiaries of the different PAPs of CLEEP were not linked to a sustainable livelihood or financing sources.
- Employment Satisfaction – Employees of the different PAPs were satisfied with the type of work provided them, and most are satisfied with their overall employment in their respective PAPs.
- Data on beneficiaries – Data on the list of beneficiaries were not readily available to NAPC such that it was difficult to determine who will be included in the interviews.
- Monitoring of CLEEP performance – Progress reports have been submitted twice monthly, which is so frequent, such that verification and accuracy of reports could not be ascertained. For such type of projects, a once a month report would have sufficed. Monitoring visits, however, may be more frequent.
- Major Problems – Most of the problems were in the delays of payment of wages, delays in procurement of supplies and materials and very low wage rates compared to minimum wage.
- Facilitating factors – Coordination and assistance of implementing agencies and the constant monitoring of CLEEP progress.
- Hindering factors – Stringent rules of COA regarding process of funding proposals particularly an ISLA project; delays in releases of funds from the Department of Budget and Management (DBM).
- Future similar projects – Most clamor for another CLEEP in the future when another crisis happens, however, they would like to have some changes: more sustainable and longer assistance, financial package to come with the assistance.

In conclusion, while CLEEP was able to partially address employment and livelihood problems in most parts of the Philippines, the assistance was very short-term, benefits quite few and unsustainable, and there was less focus on those directly affected by the Global Financial Crisis (GFC), which was the main concern of the ERP.

4. PWP AS UNEMPLOYMENT INSURANCE – RELEVANCE TO THE PHILIPPINES

The Philippine experience with public works programs makes use exclusively of short-term programs aimed at responding to discrete macroeconomic shocks or natural/ man-made disasters. In some countries (notably India), the public works program virtually perform the function of an unemployment insurance and are implemented in response to chronic or sustained levels of high unemployment and/ or poverty incidence (Del Ninno et al. 2009). An example of such programs is India's National Rural Employment Guarantee Act (NREGA). Under the NREGA, the state offers a guaranteed number of days of employment each year (100 days) to one unemployed worker from any rural household on the creation of community assets and paid at the minimum wage (McCord 2008). Ethiopia also implements a similar large-scale program called (the Productive Safety Nets Program or PSNP) as a response to the persistent droughts which occurs annually.

Under such schemes, work is made available to all eligible adults regardless of whether there is a crisis or not. Thus, the coverage of the public works programs is extended to include normal times when demand is likely to be lower relative to the crisis period but is not likely to be zero. "When the crisis is over, the safety net will no longer be needed for the majority of workers and (provided the wage rate is not set too high) they will automatically return to regular work. … If the employment guarantee is credible, such programs help reduce the risks facing the poor in the long term and help fight chronic as well as transient poverty" (Ravallion 2008).

As such, these programs essentially provide a form of non-contributory income insurance by guaranteeing employment to all members of eligible groups on demand (McCord 2008). In the case of both India and Ethiopia, the programs are designed such that government provides cash transfers to eligible program beneficiaries even if the government is unable to supply employment from public works programs. Thus, this payment is thus akin to the benefits that are available under unemployment insurance schemes.

Ravallion (2009) stressed that the budget allocation of such schemes must be sufficient to assure that anyone who wants work at that wage rate and is signed up to a viable community works project will get the work. Otherwise, the effectiveness of the program as insurance will be lost if the work must be rationed.

Unemployment insurance. Recently, in the wake of the global financial and economic crisis and the ensuing rise in the unemployment rate, there is renewed interest on the introduction of unemployment insurance in the country. Earlier assessments on the desirability and prospects of doing so (e.g., Yoo 2001, Esguerra et al. 2002) are not encouraging. They argue that unemployment insurance is not feasible because (i) the share of the informal sector is high (roughly 50% of employed persons are in the informal sector), (ii) both unemployment and underemployment are high, ranging from 7% to 8% and 19% to 26%, respectively, in the last 5 years, (iii) the proportion of the poor among the unemployed is low in relative terms (e.g., in 1997 only 12% of the unemployed are poor but the overall poverty incidence is 25%), and (iv) administrative capacity to monitor the employment status and job search behavior is weak. Given these conditions, unemployment insurance will tend to create inefficiencies and dis-incentives. Esguerra et al. (2002) notes that by imposing contributions to be levied on wages, the cost of labor may increase, contributing to the further growth of the informal sector and the increase of the equilibrium level of unemployment. By intensifying job search and prolonging unemployment spells, unemployment insurance tends to increase the unemployment rate.

5. CHALLENGES IN IMPLEMENTING PUBLIC WORKS PROGRAMS

Del Ninno et al. (2009) notes that the outputs of public works programs are: "(i) jobs of short duration for workers so as to increase their income, and (ii) creation of public goods in the form of new

infrastructure or improvements of existing infrastructure, or delivery of services. Inputs are wage cost (in cash or in kind), managerial costs and material costs. The outputs in turn are expected to lead to three final outcomes (impacts): (a) increased income and consumption-smoothing, (b) a reduction in poverty and poverty gap ratio, and (c) infrastructure development."

In addition to providing distressed workers income transfers to help them smoothen their consumption in times of crisis, public works programs aim to generate public goods that will enhance the productivity of the local community where the project is located. Besides the small public and social infrastructure projects that are included in the menu of options for the Philippine public works programs described above, public works programs in other countries include environmental projects such as reforestation, soil conservations, watershed development and operation of community nurseries. In like manner, the Food/ Cash-for-Work project of the World Food Program in the conflict areas of Mindanao also has environmental management projects as one of its major initiatives.

Subbarao et al. (2010) underscores the need to conduct a feasibility assessment prior to the implementation of a PWP. It aims to help "determine the role of a possible PW program, within the context of a safety net system." The feasibility assessment for a public works program involves an evidenced-based analysis of "(i) the labor market situation, including level of unemployment, underemployment and wage rate (ii) the needs for infrastructure development or other social services that can be provided with public works programs, (iii) the existence of special circumstances such as a sudden crisis, and (iv) the fiscal space available within the envelope of social programs and safety nets" (Subbarao et al. 2010).

On the other hand, Del Ninno et al. (2009) classifies the major challenges in the design and implementation of public works programs into four broad groups: (i) implementation features that reflect the core characteristics and logic of the program and influence its overall cost and labor absorption potential, (ii) features that influence the effectiveness of the program as a safety net, (iii) financing methods and engagement with local governments and community; and (iv) features relating to the quality of the assets created.

Implementation features that influence the labor absorption potential of the program include the wage rate and the labor intensity of activities. Del Ninno et al. (2009) stress that it may be difficult to set the program wage (i.e., the wage rate paid by the public works program) in countries where the market wage is below the minimum wage, thereby limiting the scope for self-selection. However, experts stress the need to strike a balance between a low enough rate to attract mainly the poor or near-poor into the scheme, on the one hand, and the need to ensure that wages provide adequate net transfers to participants, on the other hand (O'Keefe 2005). Subbarao et al. (2003) also point out the program wage should not be set at such a low level that it stigmatizes the work and result in the poor deciding to exclude themselves from the program.

The choice of the payment method (e.g., daily rate vis piece rate) may affect not only targeting but also the outcomes of the program. Subarrao et al. (1997) found that task based payment provides flexibility by allowing several members of the family to share the work and may also attract more women to worksites. However, task-based payments may be more difficult to administer and may be vulnerable to corruption.

On the other hand, the labor intensity of the projects selected (defined as the share of the wage bill to the total project cost) depend on the wage rate, the choice of assets to be created and the availability of technically and economically feasible labor-based methods of production (Subbarao et al. 2003). Obviously, the more labor intensive the project the more likely it is that the project will be cost effective. The experience of South Africa suggests that many construction engineers tend to resist the adoption of labor-intensive methods, largely because of their lack of familiarity with the same (Adato et al, 1999). This problem is even more magnified when project implementation is contracted out. In this regard, Subbarao et al. (2003) highlight the need for the development and dissemination of labor- intensive designs for public works programs.

One of the problems raised with respect to the implementation of public works programs relates to the need to design mechanisms that will trigger the graduation of beneficiaries, especially from programs of long-term duration, i.e., those that are meant to perform an insurance function. Rwanda is one of

the few countries which have built a "graduation" feature into the design of its works program. To wit, participants in the works program are encouraged to save a small part of their wage. Bank accounts are opened in the name of every participant and wages are deposited in said accounts weekly, thus allowing them to save if they wish. After some time, if and when savings accumulate, government offers participants a matching grant if they wish to start their own business, thus providing an incentive for the participants to save, and enabling them to graduate from the program (Subbarao *et al.* 2010).

Design features that promote cost-effectiveness. When the budget for the program is limited (i.e., when demand for participation is large), there might be a need to use other targeting mechanisms including community or geographic targeting in addition to self-targeting (Del Ninno et al. 2009).

On the other hand, the cost-effectiveness of the program is enhanced if the implementation of the program is timed in consonance with seasonality of agricultural slack seasons. However, the program will have to operate year round if the program is also meant to provide some "insurance" function. Del Ninno et al. (2009) reports that "some countries have opted to run the program only during the agricultural slack seasons (for 4-5 months in a year) in which the program would serve "consumption-smoothing" function, but not an "insurance" function. Some countries have opted to run the program throughout the year with varying degrees of intensity providing both insurance and consumption-smoothing for poor households."

As the experience of KALAHI-CIDSS show community involvement in the selection of projects has many beneficial effects, namely: (i) the creation of assets that are most responsive to the needs of the community, (ii) the promotion of a sense of community ownership of the asset which, in turn, is hoped to lead to a greater propensity on the part of the community to maintain the asset. Community organizing can be a challenge in conflict areas as well as in areas where political patronage at the local level is strong.

*Financing and other implementation arrangements***.** In countries like the Philippines which are decentralized, the funding of public works programs is typically co-shared by the central government and the local government. A major challenge in these countries is the low fiscal capacity of the local governments where the poorest communities tend to reside. This can be a problem in the Philippines where non-wage funds are typically sourced from LGUs.

Relative to the political economy of LGU involvement, Del Ninno et al. (2009) wrote:

> "In countries where the implementation of public works has been delegated to local elected governments it is important to strengthen accountability and to build their capacity for monitoring and supervision. … Political influence as well as bureaucratic meddling often led to selection of projects which have no benefit to the local community."

Features related to type of assets created. Relative to choice of assets, three points are important. First, do the assets that are created improve the productivity of the local community? Second, are the assets that are created maintained so as to enhance the sustainability of gains from the program? Third, do the assets that are created benefit the poor?

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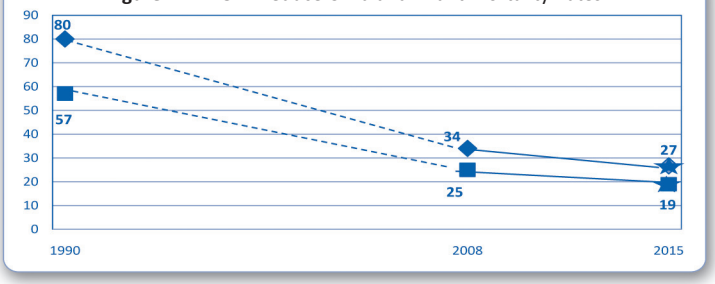
APPROACHES TO IMPROVING COVERAGE OF SOCIAL HEALTH INSURANCE[1]

Rosario G. Manasan

1. BACKGROUND[2]

The Philippines posted notable gains in 1990-2006 in reducing both the infant mortality rate (IMR) and the under-5 mortality rate (U-5MR). During this period, the infant mortality was halved from 57 infant deaths per 1,000 live births in 1990 to 25 in 2008 (**Figure 1**). In like manner, the under-5 mortality rate went down from 80 to 34 under-five deaths per 1,000 children. In both cases, the rate of progress needed to reach the 2015 target is less than the actual rate of progress to date, suggesting that it is likely that the MDG targets for child health will be achieved.

Figure 1. MDG 4: Reduce Child and Infant Mortality Rates



Source: Philipines Fourth Progress Report on the Millennium Development Goals (2010)

On the other hand, the country's performance in reducing the maternal mortality rate (MMR) is not as commendable, with the MMR declining from 209 maternal deaths per 100,000 live births in 1990 to 162 maternal deaths per 100,000 live births in 2006 (**Figure 2**). In other words, the rate of progress necessary to reach the 2015 target is more than 3 times higher than the actual rate of progress in 1990-2006, suggesting that the Philippines would have to reduce the MMR at a considerably faster pace than its historical performance to date. This indicates that the government would have to exert additional effort relative to what it has done in the past, if the Philippines were to attain the MDG target for maternal health.

Moreover, the delivery of major public health services has stagnated, if not deteriorated in more recent years. For instance, the decline in recent years in the proportion of fully immunized children before they turn a year old may put the gains in child health at risk. To wit, the proportion of fully immunized children dipped from 87% in 2000 to 83% in 2006 (**Table 1**). At the same time, the proportion of children with diarrhea given ORS went down from 28% in 1998 to 14% in 2006. Also, the proportion of pneumonia cases among under-5 children given treatment was fairly stagnant at around 95%-96% in 1998-2006, although the indicator reached a high of 97% in 2003 and 100% in 2004.

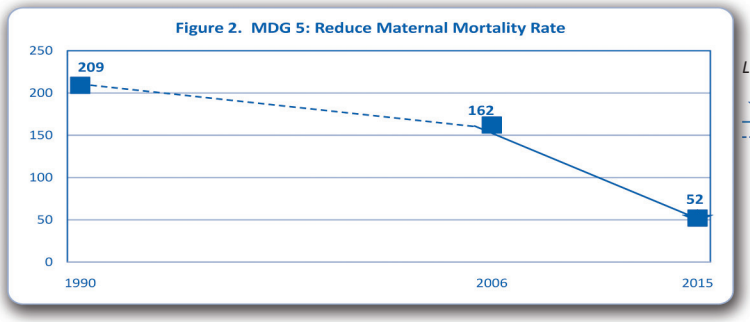
In contrast, the performance with respect to some of the key maternal care interventions has stagnated, if not deteriorated (**Table 1**). In particular, the proportion of pregnant women who had three or more pre-natal visits fluctuated around 61%-65% in 1999-2006. On the other hand, the proportion of pregnant women who received tetanus toxoid vaccination went down from 63% in 2000 to 54% in

[1] This Social Protection Think Paper, prepared by the Consultant (Dr. Rosario G. Manasan), is an output of the project entitled "Towards the Operationalization of the Social Protection Strategy" implemented by the Department of Social Welfare and Development (DSWD) in collaboration with the National Economic and Development Authority (NEDA) – Social Development Staff (SDS), with financial support from the United Nations Development Programme (UNDP), through the UNDP Country Programme Action Plan (CPAP) 2005-2011 Portfolio on Poverty Reduction and Support for the MDGs, with NEDA-SDS as Implementing Partner (IP), under its 2011 Annual Work Plan (AWP).

[2] This subsection is drawn largely from Manasan (2010).

2001-2002 before stagnating at 60%-61% in 2003-2006. Also, the proportion of births attended by a professional health provider was fairly flat at 68%-70% in 1999-2006.

Figure 2. MDG 5: Reduce Maternal Mortality Rate



Source: Philipines Fourth Progress Report on the Millennium Development Goals (2010)

Table 1. Selected Health Outputs Indicators, 1998-2006

	1998	1999	2000	2001	2002	2003	2004	2005	2006
% of pregnant women with 3 or more pre-natal visits	59.4%	65.6%	64.8%	62.9%	60.5%	64.3%	64.7%	62.3%	61.5%
% of pregnant women given tetanus toxoid vaccination at least twice	68.8%	59.4%	62.5%	54.2%	54.3%	59.6%	60.0%	58.8%	59.1%
% of lactating mothers given Vitamin A	49.1%	54.6%	57.0%	55.3%	52.9%	61.6%	53.2%	54.7%	59.3%
% of livebirths attended by medical professional		69.0%	69.0%	70.0%			68.7%	68%	70.0%
% of fully immunized children under 1	84.8%	87.9%	86.5%	81.7%	76.7%	83.7%	84.8%	83.7%	82.9%
% of infants given 3rd dose of Hepa B	37.3%	45.2%	6.2%	41.9%	38.5%	45.2%	45.6%	42.9%	72.9%
% of diarhhea cases amongst children under 5 given ORS	28.4%	25.9%	24.1%	22.4%	17.7%	17.8%	15.5%	14.2%	14.0%
% of pneumonia cases amongst children under 5 given treatment	94.7%	94.5%	93.9%	94.2%	94.7%	97.3%	99.9%	95.3%	96.0%
% of children under 1 given Vitamin A	72.8%	74.0%	76.9%	74.6%	74.7%	89.8%	79.2%	80.0%	81.0%
% of children between 1 and 5 given Vitamin A	89.6%	84.1%	101.3%	95.1%	94.1%	106.1%	111.1%	97.8%	95.7%
TB morbidity rate a/ b/	206.7	203.9	174.1	149.9	154.1	120.3	133.3	137.1	169.9
Malaria morbidity rate a/	96.8	91.8	66.6	39.1	50.3	36.5	24.9	43.3	27.6

* data shown for entire Philippine but data by province and city also available
a/ per 100,000 population
b/ respiratory plus other forms of TB
Source: Field Health Service Information System, various years

Meanwhile, after being cut by about 45% from 90 to 50 per 100,000 population over the three-year period between 1999 and 2002, the decline in the incidence of malaria appears to have faltered, posting a reduction of 25% from 37 to 28 over the three-period between 2003 and 2006 (**Table 1**). On the other hand, the incidence of tuberculosis went up from 120 per 100,000 population in 2003 to 170 per 100,000 population in 2006 after declining from 207 in 1998 to 154 in 2002.

Furthermore, inequitable access is evident for many of major public health services in 2003-2008. Thus, health outcomes for the poor are worse than those for their better-off counterparts. For instance, children from households in the lower wealth quintiles had higher rates of infant mortality and under-five mortality than children from higher wealth quintiles based on the 2003 and 2008 NDHS (**Table 2**). In addition, the poverty gap in the infant mortality rate and under-five mortality rate appears to have worsened between 2003 and 2008. In particular, the ratio of infant mortality rate of the poorest quintile to that of the richest quintile rose from 2.2 in 2003 to 2.7 in 2008. In like manner, the ratio of the under-five mortality rate of the poorest quintile to that of the richest quintile increased from 3.1 in 2003 to 3.5 in 2008.

Table 2. Early Childhood mortality rates by wealth quintiles, 2003-2008.

Wealth Index quintile	Infant mortality	Under-five mortality
2008 NDHS		
Lowest	40	59
Second	29	38
Middle	24	32
Fourth	23	27
Highest	15	17
Total	25	34
2003 NDHS		
Lowest	42	66
Second	32	47
Middle	26	32
Fourth	22	26
Highest	19	21
Total	29	40

Source: 2003 and 2008 NDHS

Also, households' access to various basic health services was highly disparate across income groups in 2003 and 2008. Lower income households continue to have poorer access to basic health services than higher income households for a number of reasons, e.g., physical inaccessibility of facilities, financial constraints, or weak demand for health care. In addition, the poverty gap in households' access to some basic services (e.g., antenatal care and vaccinations) have widened over time.

The proportion of women who had a live birth five years preceding the NDHS did not get their antennal care from medical professionals declined from 7% in 2003 to 5% in 2008. At the same time, the proportion of pregnant women who did not receive any antenatal care also went down from 6% in 2003 to 4% in 2008 (**Table 3**). However, the proportion of women who did not get antenatal care from medical professionals plus the proportion of those who did not get any antenatal care at all is higher for women from less wealthy households than for women from the higher wealth quintiles. Also, the poverty gap (as measured by the ratio of the proportion of women from the poorest quintile who did not receive antenatal care from a medical professional to corresponding proportion for the wealthiest quintile) widened between 2003 (8.8) and 2008 (14.3).

Also, while the proportion of live births in the 5 years preceding the NDHS which were delivered in a health facility increased between 2003 (38%) and 2008 (44%), the proportion remains low (**Table 4**). Also, the proportion of live births delivered in health facility is lower for women from poorer households than relative those from better-off quintiles.

Table 3. Provider of Antenatal Care, 2003-2008

Wealth Index quintile	Doctor	Nurse/ midwife	Traditional birth attendant/other	No one	Total
2008 NDHS					
Lowest	8.6	68.5	14.7	8.2	100.0
Second	24.0	67.4	4.5	4.1	100.0
Middle	39.6	56.3	1.5	2.6	100.0
Fourth	61.6	35.9	1.3	1.1	100.0
Highest	80.1	18.2	0.1	1.5	100.0
Total	39.1	52.0	5.2	3.8	100.0
2003 NDHS					
Lowest	8.6	63.8	14.7	16.2	100.0
Second	22.8	65.3	4.5	6.0	100.0
Middle	38.9	51.8	1.5	4.2	100.0
Fourth	58.5	37.7	1.3	1.5	100.0
Highest	79.9	16.7	0.1	1.0	100.0
Total	38.1	49.5	5.2	6.5	100.0

Source: 2003 and 2004 NDHS

In like manner, the proportion of births in the 5 years preceding the NDHS which were assisted by skilled health providers tends to go up as the mother's wealth status goes up, suggesting that income is an important factor influencing the decision on place of delivery and birth attendant (**Table 5**). On a positive note, the poverty gap in delivery in a health facility became narrower between 2003 and 2008 while the poverty gap in access to medical professional during delivery remained unchanged during these years.

Table 4.
Place of delivery, 2003-2008

Wealth Index quintile	Health Facility		Home	Other/ missing	Total	Percentage delivered a health facility
	Public Sector	Private Sector				
2008 NDHS						
Lowest	11.5	1.5	86.8	0.2	100.0	13.0
Second	26.9	7.1	65.5	0.6	100.0	34.0
Middle	33.0	15.3	51.5	0.2	100.0	48.3
Fourth	39.0	29.7	30.9	0.4	100.0	68.7
Highest	29.4	54.5	15.8	0.2	100.0	83.9
Total	26.5	17.7	55.5	0.3	100.0	44.2
2003 NDHS						
Lowest	9.2	1.2	88.7	0.8	100.0	10.4
Second	20.4	4.4	74.3	0.8	100.0	24.8
Middle	32.2	11.1	56.2	0.4	100.0	43.3
Fourth	37.6	22.2	39.0	1.3	100.0	59.8
Highest	31.5	45.5	22.6	0.2	100.0	77.0
Total	24.2	13.7	61.4	0.7	100.0	37.9

Source: 2003 and 2004 NDHS

Table 5. Assistance during delivery, 2003-2008

Wealth index quintile	Doctor	Nurse	Midwife	Hilot	Relative/ other	No one	Don't know/ missing	Total
2008 NDHS								
Lowest	9.4	0.7	15.6	71.4	2.3	0.4	0.1	100.0
Second	24.4	2.1	29.1	42.8	1.3	0.2	0.2	100.0
Middle	34.5	2.4	38.9	23.7	0.4	0.0	0.2	100.0
Fourth	55.0	1.7	29.3	13.6	0.1	0.0	0.3	100.0
Highest	77.1	0.7	16.6	5.1	0.3	0.0	0.1	100.0
Total	35.0	1.5	25.7	36.4	1.1	0.2	0.2	100.0
2003 NDHS								
Lowest	8.6	0.5	16.0	68.9	4.9	0.4	0.7	100.0
Second	21.0	1.7	28.7	45.4	2.4	0.2	0.7	100.0
Middle	37.4	1.8	33.2	26.3	1.1	0.1	0.2	100.0
Fourth	52.6	0.6	31.2	13.3	1.4	0.0	0.9	100.0
Highest	73.2	1.2	18.0	7.0	0.6	0.0	0.1	100.1
Total	33.6	1.1	25.1	37.1	2.4	0.2	0.6	100.0

Source: 2003 and 2004 NDHS

Furthermore, 75% of mothers with children under five years of age reported having problems in accessing health care in the 2008 NDHS, just slightly lower than the corresponding proportion in the 2003 NDHS (**Table 6**). The most often cited problems include getting money for treatment (55%), concern no drug is available (47%), concern no provider is available (37%), distance to health facility (27%) and having to take transport to go to the facility (27%). As might be expected, these concerns appear to be more important for mothers from poorer households than those from better-off households.

A shift in the type of problems households have in accessing health care is evident between 2003 and 2008. While geographical access appears to be the biggest problem in 2003, the lack of financial protection from the costs associated with illness figured prominently among the concerns faced by households in accessing health care in 2008. For example, 55% of mothers cited "getting money for treatment" while 47% cited "concern that no drugs are available" as problems in accessing health care.

Table 6. Problems in accessing health, 2003-2008

Wealth Index quintile	Problems in accessing health care									
	Knowing where to go for treatment	Getting permission to go for treatment	Getting money for treatment	Distance to health facility	Having to take transport	Not wanting to go alone	Concern no female provider available	Concern no provider available	Concern no drugs available	At least one problem accessing health care
2008 NDHS										
Lowest		16.1	74.0	57.8	56.1	31.8	29.6	54.0	71.0	92.3
Second		10.1	65.4	34.4	31.5	22.1	22.2	46.1	59.1	85.5
Middle		8.3	59.7	26.4	25.7	19.5	16.7	36.1	46.6	78.6
Fourth		5.2	48.4	17.2	17.3	16.5	12.9	32.9	40.2	69.0
Highest		5.2	38.2	12.9	12.8	13.8	10.1	23.4	30.0	57.2
Total		8.4	55.1	27.4	26.5	19.8	17.3	36.8	47.2	74.6
2003 NDHS										
Lowest	27.4	22.0	87.1	59.1	57.1	44.0	31.5			93.5
Second	19.2	12.7	80.1	33.8	32.5	28.8	20.9			87.1
Middle	13.6	8.4	73.0	22.2	20.3	25.2	18.0			80.8
Fourth	10.7	7.5	62.9	18.7	17.4	25.5	18.5			73.6
Highest	8.6	6.8	45.6	13.6	12.0	22.0	17.2			59.7
Total	14.9	10.7	67.4	27.2	25.6	28.1	20.5			77.1

Source: 2003 and 2008 NDHS

This development appears to be consistent with the high and increasing share of out-of-pocket (OOP) expense in the country's total health expenditure (THE) in 2000-2007. To wit, the share of OOP expense to total health expenditures surged from 41% in 2000 to 54% in 2007 (**Table 7**). This occurred as the increase in the share of social health insurance in total health expenditure failed to compensate for the contraction in share of general government spending in THE during the period. In particular, the share of social health insurance in THE increased only marginally from 7% in 2000 to 9% in 2007 while the share of general government spending contracted dramatically from 41% to 26%. This trend is

worrisome considering that countries with high out-of-pocket health expenditures tended to have a higher proportion of households facing catastrophic health expenditures (Xu et al. 2003).[3]

Table 7. Share in Total Health Expenditure by Financing Agents, 2000-2007 (%)

	2000	2001	2002	2003	2004	2005	2006	2007
Government	**40.6**	**36.2**	**31**	**31.1**	**30.7**	**29.4**	**26.6**	**26.3**
National	21.2	17.1	15.8	15.2	15.7	15.3	12.5	13
Local	19.3	19.1	15.2	15.9	15.0	14.1	14.1	13.3
Social Insurance	**7.0**	**7.9**	**9.0**	**9.1**	**9.6**	**9.7**	**8.8**	**8.6**
Philhealth	6.8	7.7	8.8	8.6	9.4	9.7	8.8	8.5
Employee's Compensation	0.2	0.2	0.2	0.5	0.3	0.0	0.0	0.1
Private Sources of which:	**51.2**	**54.5**	**58.6**	**58.6**	**58.5**	**55.8**	**62.6**	**64.8**
Out-of-Pocket	40.5	43.9	46.8	46.9	46.9	49.2	52.3	54.3
Private Insurance	2.0	2.5	2.9	2.3	2.5	2.1	1.8	1.8
HMOs	3.8	3.1	3.6	4.7	4.3	4.5	4.7	5.1
Employer-based Plans	3.7	3.9	4.1	3.4	3.6	2.9	2.7	2.5
Private Schools	1.1	1.2	1.3	1.3	1.2	1	1.1	1.1
Others	**1.3**	**1.3**	**1.4**	**1.2**	**1.2**	**1.1**	**2.1**	**0.4**
Memo Item:								
Total Health Expenditure								
in billion pesos	114.9	116.6	117.2	148.6	165.3	198.4	216.4	234.3
% of GDP	3.4	3.2	3.0	3.4	3.4	3.6	3.6	3.5

Source: National Health Accounts, NSCB, various years

The highly unequal access to health services and the large share of household out-of-pocket spending in total health expenditures in the country underscore the importance of attaining universal health coverage. The objective of this short note is to evaluate the major challenges involved in moving toward universal coverage of the Philippine National Health Insurance Program. The analysis below suggests that broadening the population coverage of country's social health insurance program may be difficult to achieve without concomitant reforms in other elements of the program, particularly the payment mechanism.

2. PHILHEALTH: KEY FEATURES[4]

The National Health Insurance Act of 1995 (Republic Act 7875) created the Philippine Health Insurance Corporation (PhilHealth) which is tasked to administer the National Health Insurance Program (NHIP). The NHIP is envisioned to provide compulsory health insurance coverage for all as a mechanism that will allow all Filipinos to gain financial access to health services.

Membership. The PhilHealth took over the erstwhile Philippine Medical Care Commission (or Medicare) whose coverage was limited only to those with regular employment, i.e., members of the SSS and the GSIS. In contrast, PhilHealth's membership may be partitioned into five groups: (i) the Employed Sector Program, (ii) the Overseas Workers Program, (iii) the Individually Paying Program, (iv) the Sponsored Program, and (v) the Non-paying Program. The Employed Sector Program of the PhilHealth calls for the compulsory coverage of all employees in government and the private sector, including household help and sea-based overseas Filipino workers. That is, all government and private employers are required to register their employees with the PhilHealth and to remit the premium contributions of their employees (including employer's share) to PhilHealth.

On the other hand, all land-based overseas Filipino workers who are registered with the Overseas Workers Welfare Administration (OWWA) are required to register under the Overseas Workers Program (OWP) of the PhilHealth and to pay the annual premium contribution to any PHIC office in the Philippines or abroad. Meanwhile, all self-employed persons, including professionals with their own practice, proprietors of businesses, actors/ actresses, directors, freelance writers and photographers, professional athletes, coaches, and trainers, personnel of civic and religious organizations and

[3] Health spending is said to be catastrophic when a household must reduce its basic expenditure over a period of time to cope with health costs. In practice, health spending of at least 40% of a household's capacity of pay is deemed to be catastrophic where a household's capacity to pay is defined as effective income remaining after basic subsistence needs have been met.

[4] This section is drawn from Manasan (2009).

Philippine-based international organizations, farmers and fisherfolks, daily wage earners such vendors, transport drivers and operators, and unemployed persons who are not qualified as indigents and parents who are not qualified as dependents *are encouraged* to register under the Individually Paying Program (IPP). Under this program, health insurance premiums are remitted voluntarily at any accredited payments centers on a quarterly, semi-annual or annual basis.

The Sponsored Program covers the poor or the indigent, i.e., individuals whose income is insufficient for the subsistence of their families. The Implementing Rules and Regulations of RA 7875 as amended by RA 9241 provide that the members of this program be identified on the basis of a means test using the data from a survey[5] conducted by the Social Welfare and Development Office of the LGU.

The Non-Paying Program covers (i) retirees and pensioners of the SSS and the GSIS prior the enactment of RA 7875 and (ii) PhilHealth members who are aged 60 years and over and who have paid at least 120 monthly contributions.

In addition to the principal member, the PhilHealth covers without additional premium the member's dependents, namely: his/ her legitimate spouse who is not a member in her/ his own right, children and stepchildren below 21 years of age, and parents or step-parents 60 years old and above who are not themselves members of PhilHealth. There is no limit to the number of dependents of each member.

Premium contributions. Under the Employed Sector Program, the monthly premiums (equal to 2.5% of the monthly salary base of the member) are shared equally by employees and their employers and are remitted to PhilHealth by the employer. The member's share in the monthly contribution is deducted and withheld automatically by the employer from the former's salary/ wage. It is then remitted to the PHIC together with the employer's share.

The minimum monthly salary base is set at PhP 4,000 while the maximum monthly salary base is PhP 30,000 effective January 2007. The maximum salary base was adjusted almost yearly since 2000 in order to allow a more equitable sharing of the contributions. Thus, the maximum monthly salary base rose consistently from PhP 5,500 in 2000, to PhP 7,500 in 2001, PhP 10,000 in 2002, PhP 15,000 in 2003, PhP 20,000 in 2005, PhP 25,000 in 2006.

In contrast, the premium for the Overseas Workers Program is uniformly set at PhP 900 per year for all members regardless of the member's capacity to pay. Prior to October 2010, the premium for the Individually Paying Program is also uniform at PhP 1,200 per year. However, starting in October 2010, the PhilHealth started to implement a two-tiered premium structure for members under the IPP. On the one hand, the premium for professionals earning at least PhP 25,000 monthly was raised to PhP 2,400 per year from PhP 1,200 per year[6] while that for other IPP members remained at PhP 1,200 per year. Note further that under both the OWP and IPP, the premium is shouldered in full by the member.

While the premium for the Sponsored Program is also set at PhP 1,200, it is fully subsidized by government and is paid for jointly by the national government, the province and municipality/ city where the indigent family resides. The national government and the LGU/s (both the province and the municipality/ city) share equally (50%-50%) in the case of LGUs belonging to first, second and third income classes. However, if the LGU belongs to the fourth, fifth or sixth income class, the LGU share rises gradually from 10% in the first and second years of enrollment to 50% in the tenth year. Conversely, the share of the national government in the premium subsidy for indigents residing in 4th-6th income class LGUs declines gradually from 90% in the first and second years of enrollment to 50% in the tenth year of enrollment.

The sharing between the province and the city/ municipality of the LGU share of the premium subsidy is variable. In some areas, the province pays for the entire LGU share. In others, the province and the

[5] The survey aims to determine the socio-economic and health profile of the LGU. At present, the survey follows the so-called Community-Based Information System-Minimum Basic Needs (CBIS-MBN) approach but the Implementing Rules and Regulations of the RA 7875 as amended provides for the adoption of other means test mechanisms.

[6] The premium for this group is programmed to increase to PhP 3,600 per year starting in October 2012.

city/ municipality divides the LGU share of the premium subsidy between them, with the exact sharing formula resulting from some negotiation between the two levels of local government.

Benefits. Principal members and their dependents, regardless of the membership program they belong to, are entitled to:

- in-patient care in accredited hospitals (including room and board, drugs and medicines, professional fees, laboratories and operating room) for confinements of not less than 24 hours;
- out-patient care (including day surgeries, dialysis and cancer treatment procedures such as chemotherapy and radiotherapy) in accredited hospitals and free-standing clinics;
- normal spontaneous deliveries up to the fourth one in accredited hospitals and birthing homes, maternity and lying-in clinics for a fixed case-payment of PhP 6,500 (inclusive of PhP 1,500 for pre-natal care);
- new born care package (including eye prophylaxis, umbilical cord care, Vitamin K, thermal care, administration of BCG vaccine and resuscitation of the new born, first dose of Hepatitis B immunization, and new born screening) from duly accredited hospitals and non-hospital facilities such as lying-in clinics, midwife-managed clinics, birthing homes, rural health units, ambulatory surgical clinics and other analogous health facilities for a maximum with coverage of PhP 1,000;
- TB treatment of new cases of pulmonary and extra-pulmonary tuberculosis in children and adults through the Directly Observed Treatment Shortcourse or DOTS (including diagnostic work-up, consultation services and anti-TB drugs required in an outpatient set-up) in accredited TB-DOTS centers with a fixed case- payment of PhP 4,000;
- SARS and Avian Influenza package (including professional fees, hospital charges) for a coverage of PhP 50,000 per case for non-health worker members and their dependents and PhP 100,000 per case for forefront and high risk health care workers; and
- Influenza A (H1N1) package (including room and board, drugs and medicines, X-ray, laboratory and others, operating room, and professional fees) for a coverage of up to PhP 75,000 for non-health worker members and PhP 150,000 for health worker members.

In addition, indigent members and their dependents may avail of a *special* outpatient benefit package from accredited rural health units that includes: (i) preventive care - primary consultation, blood pressure monitoring, breast examination, rectal exam, body measurement, counseling for the cessation of smoking, and counseling for lifestyle change, (ii) diagnostic services - chest X-ray, sputum microscopy, and visual acetic acid screening for cervical cancer, and (iii) laboratory services - fecalysis, and complete blood count. On the other hand, OWP members and their dependents may avail of an *enhanced* outpatient benefit package that includes: (i) consultation services, (ii) wide ranging diagnostic services like complete blood count (CBC), routine urinalysis, fecalysis, fasting blood sugar, blood typing, hemoglobin/ hematocrit, electrocardiogram (ECG), anti-streptolysin O (ASO-Titer), hepatitis B screening test, treponema pallidum hemaglutination assay (TPHA), potassium hydroxide (KOH), erythrocyte sedimentation rate (ESR), pregnancy test, X-ray (skull, chest, lower and upper extremities), sputum microscopy, and pap smear, (iii) visual acuity examination; (iv) psychological evaluation and debriefing; (v) promotive/ preventive health services; (vi) auditory evaluation; and (vi) treatment of urinary tract infection (UTI), upper respiratory tract infection (URTI), and acute gastroenteritis (AGE).

PhilHealth in-patient care benefits provide “first-peso” coverage up to a maximum amount which is payable to providers on a fee-for-service basis. As such, PhilHealth pays the provider from the first peso of the bill up to the maximum benefit allowable while members are responsible for paying the remaining balance. The coverage cap varies with case type (surgical, general medicine, maternity, pediatrics, etc.) and level of the facility (primary, secondary, tertiary).

In contrast, PhilHealth uses capitation payments for the special outpatient care provided to indigent members. On the other hand, fixed case-payments are made for the TB DOTS, the Maternity package and the SARS and Avian Influenza package.

3. CHALLENGES IN MOVING TOWARDS UNIVERSAL COVERAGE

The strategic approach adopted by the PhilHealth in expanding coverage has been described as "squeezing the middle" (GTZ/Jowett 2006). This approach segregates the population notionally into three groups based on their ability to pay the premium contributions to the PhilHealth: the top segment consists of households which are headed by those who are employed in the formal sector; the bottom segment consists of poor households whose premium contributions are subsidized by the government; and the middle segment consists of non-poor households headed by those who are employed in the informal sector. The strategy consists of (i) "squeezing from the top" by expanding the PhilHealth coverage of the group subject to compulsory enrollment, i.e., the Employed Sector Program, (ii) "squeezing from the bottom" by expanding the coverage of the poor households under the Sponsored Program, and (iii) implementing interventions that are directed at expanding the coverage of non-poor households whose heads are employed in the informal sector under the Individually Paying Program.

3.1 Situation Up to the End of 2010

Taken together, the contributory and non-contributory programs of PhilHealth have 70 million beneficiaries (consisting of both principal members and their dependents) in 2010. The total number of PhilHealth beneficiaries as a ratio of the total population went up from 59% in 2007 and 2008 to 72% in 2008 and 79% in 2010 (**Table 8**).

In 2010, the PhilHealth has 22.4 million registered principal members. The contributory program[7] has 15.9 million principal members, accounting for 71% of the total number of members, 67% of the total number of beneficiaries, 72% of total benefit payments and 93% of total premium contributions.

The Employed Sector Program comprises the bulk (44%) of the total membership of PhilHealth in 2010 while the Non-Paying Program has the smallest share in total membership (2%). On the other hand, the Individually Paying Program and the Overseas Workers Program contributed 17% and 10%, respectively, of total PhilHealth membership in 2010. The share of the Sponsored Program in total membership stood at 27% in 2010, up from 17% in 2007, with the doubling of the total number of Sponsored Program members during the period.

The coverage rate[8] of the contributory programs registered some improvement in 2007-2010 but it remains fairly low. To wit, the coverage of the contributory programs rose from 37% in 2008 to 41% in 2009 and 44% in 2010 (**Table 8**). Said improvement is largely on account of the Individually Paying Program and the Overseas Workers Program as the coverage rate of the Government Employed Sector Program and the Private Employed Sector Program has stagnated during this period. Nonetheless, the Employed Sector Program continues to have the highest coverage rate. On the other hand, the coverage rate of the IPP and OWP combined remains to be the lowest. In contrast, the coverage rate of the Sponsored Program (reckoned relative to the estimated number of poor households[9]) has not only expanded significantly between 2007 and 2010, it has also exceeded 100% in 2009 and 2010.

Government Employed Sector and Private Employed Sector. In 2010, there are 1.9 million principal members under the Government Employed Sector Program and 7.9 million principal members under the Private Employed Sector Program, accounting for 44% of total PhilHealth membership.

The coverage rate of the Government Employed Sector Program deteriorated from 68% in 2007 to 65% in 2010. On the other hand, the coverage rate of the Private Employed Sector Program fluctuated around 48%-55% in 2007-2010.

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[7] The contributory program includes the employed sector program, overseas workers program and individually paying program.

[8] Here, the coverage rate is computed as the ratio of the number of registered principal members to the number of potential principal members based on the Labor Force Survey (LFS).

[9] The number of poor households is based on the NSCB's revised estimates of poverty incidence for 2003-2009.

It is surprising that the coverage rates for the Employed Sector Programs are significantly lower than 100% considering the mandatory nature of said programs. This situation may be attributed to (i) the difference in the way that PhilHealth and the Labor Force Survey (LFS) of the National Statistics Office (NSO) defines formal employment in the government and private sector and (ii) non-compliance on the part of employers to the legal requirement to register their employees as PhilHealth members.

Table 8. Number of members, premium contributions and benefit payments of PhilHealth, 2007-2010

	No. of members (in million)	% dist'n	Coverage rate as % of eligible members	No. of beneficiaries[a] (in million)	% dist'n
2010					
Government employees	1.9	8.7	64.5	6.6	9.4
Private employees	7.9	35.0	54.0	22.6	32.3
Sponsored indigents	6.0	26.9	154.1[b]	22.1	31.6
OWP	2.3	10.4		6.9	9.9
Individually paying members	3.7	16.7	32.9[c]	10.9	15.6
Non-paying members	0.5	2.2		0.9	1.2
Total	22.4	100.0	44.1[d]	70.0	100.0
2009					
Government employees	1.9	9.4	66.3	6.4	9.2
Private employees	7.0	34.7	50.7	20.2	29.6
Sponsored indigents	5.4	26.7	139.6[b]	19.7	31.7
OWP	2.1	10.4		6.2	10.7
Individually paying members	3.3	16.5	29.6[c]	9.7	17.8
Non-paying members	0.5	2.3		0.8	0.9
Total	20.2	100.0	40.9[d]	63.0	100.0
2008					
Government employees	1.9	11.3	67.3	6.3	11.3
Private employees	6.4	38.8	47.7	18.4	33.8
Sponsored indigents	3.3	19.8	85.4[b]	11.9	24.0
OWP	1.8	11.2		5.4	11.7
Individually paying members	2.7	16.5	24.8[c]	7.9	18.2
Non-paying members	0.4	2.4		0.7	1.0
Total	16.5	100.0	37.1[d]	50.6	100.0
2007					
Government employees	1.8	10.9	67.8	6.0	11.5
Private employees	7.0	42.8	55.1	20.1	38.6
Sponsored indigents	2.7	16.6	72.7[b]	10.0	21.2
OWP	1.6	9.7		4.7	10.7
Individually paying members	2.9	18.0	24.7[c]	8.6	17.2
Non-paying members	0.3	2.1		0.6	0.9
Total	16.4	100.0	39.5[d]	50.0	100.0

a/ beneficiaries refer to principal members and dependents; based on member-beneficiary ratio as computed in Benefit Delivery Rate study (DOH 2010)
b/ as % of poor households
c/ combined OFW and individually paying members
d/ refers to contributory program only and estimated relative to total number employed
Source: PhilHealth Corplan Group

On the one hand, compulsory membership under the Employed Sector Program of PhilHealth is applicable only to individuals who have an employee-employer relationship with any government agency or private sector entity. Meanwhile, the classification of workers in the LFS is self-reported. As such, it is likely that some of those who report that that they are government or private sector employees in the LFS are actually hired on a job-order basis in some government agency or as a contractual in some the private sector enterprise.[10] Legally, said individuals are not considered as employees but are more appropriately classified as self-employed. To the extent then that the LFS over-estimates the actual number of government and private sector employees, the estimates of the coverage rate in **Table 8** will tend to under-state the true coverage rates for the Employed Sector Programs and, conversely, tend to over-state that of the IPP and OWP.

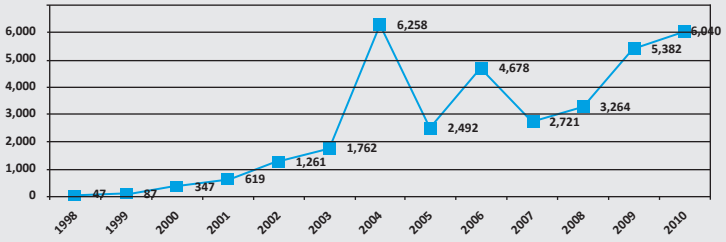
Beyond the measurement issue, the real problem with respect to the Employed Sector Program stems from the non-compliance of employers, especially small enterprises and single proprietorships, to the legal mandate for compulsory enrollment of their employees in PhilHealth. Unfortunately, there are no firm estimates of the extent of evasion. Various ways to minimize evasion in the PhilHealth Employed Sector Program have been proposed, including: (i) PhilHealth access to third party information from other government agencies like the SSS, GSIS and Pag-ibig to help enlarge the list of employees in the formal sector; and (ii) PhilHealth arranging to have LGUs require proof of payment of the PhilHealth contributions in behalf of their employees as a pre-condition to the issuance of business permits (GTZ/ Jowett 2006).

Sponsored Program. Enrollment in Sponsored Program fluctuated erratically in 2004-2006, after rising consistently from less than 350,000 in 2000 to 1.8 million in 2003 (**Figure 3**). Enrollment in surged to 6.3 million families in 2004 due mainly to the Plan 5/25 launched by the Arroyo administration prior to the elections held that year. Plan 5/25 aimed to enroll five million families, or 25 million beneficiaries, under the Sponsored Program. In order to achieve this, funds were earmarked from the Philippine Charity Sweepstakes Office (PCSO) to pay the premium contributions of indigent members in full (i.e., without any LGU contribution).

[10] Job-order "employees" are common in many local government units (LGUs) because of existing limitations on personal service expenditures. Likewise, the "contractualization" of employment is also widespread in the private sector. Contractualization is labor arrangement which replaces regular workers by temporary workers who are not considered employees, and, thus, are not entitled to the benefits given to employees.

When funding from the PCSO stopped, the number of sponsored families dropped to 2.5 million in 2006. Enrollment in the program swelled once again to 4.9 million in 2006 before declining to 2.7 million in 2007. Subsequently, an acceleration in the growth in the number of registered families in the Sponsored Program was evident.

Figure 3. Number of Sponsored Program Members (in thousands), 1998-2010



Thus, the number of sponsored families rose to 3.3 million in 2008 and 5.4 million in 2009. As of the end of 2010, the Sponsored Program covered more than 6 million principal members accounting for 27 percent of the total membership, 22 percent of the total number of beneficiaries, 22 percent of the total benefit payments and 7 percent of total premium contributions (**Table 8**). The dramatic expansion in the number of members enrolled in the Sponsored Program may be attributed to the renewed ties with local chief executives (LCEs) and legislators as well as the participation of private organizations and big corporations which provide counterpart contribution in support of the indigent families (PhilHealth 2009). In particular, LGU-sponsored members represent almost 81 percent of the total sponsored membership.

As a result, the coverage rate of the Sponsored Program (reckoned relative to the estimated number of poor households as per the National Statistics Coordinating Board's revised estimate of poverty incidence for 2003-2009) went up from 73% in 2007 to 85% in 2008, 140% in 2009 and 154% in 2010. If the old set of estimates of poverty incidence (i.e., circa 2006) are used, the coverage rate of the Sponsored Program rose from 58% in 2007 to 70% in 2008, 115% in 2009 and 129% in 2010.

However, the mechanisms used to identify indigents under the Sponsored Program have been criticized by some analysts (e.g., Torregosa 2001 and Manasan 2009). Coverage rates in excess of 100% are an indication of poor targeting under the Sponsored Program. Manasan (2009) report that, in 2007-2009, 23 to 44 provinces have enrolled beneficiaries in excess of the actual number of poor households in their jurisdiction based on the 2006 Family Income and Expenditure Survey (FIES). The "excess" enrollment in these provinces is estimated to account for 57 percent to 64 percent of the actual number of poor households in said provinces on the average. In 2010, 56 provinces have enrolled more beneficiaries than expected based on the 2006 FIES. The "excess" enrollment in these provinces accounts for 73 percent of the actual number of poor households in the said provinces.

But even more telling, only 912,696 households or 21% of the households which are identified as poor under the National Household Targeting System for Poverty Reduction (NHTS-PR) are covered under the Sponsored Program in 2010 (PhilHealth Board Resolution No. 1478 s. 2011). Conversely, only 15% of the 6 million households enrolled under the Sponsored Program in 2010 are considered poor under the NHTS-PR.

Poor targeting under the Sponsored Program stems from the absence of (or the non-adherence to) a good targeting protocol at the local level. The Implementing Rules and Regulations (IRR) of RA 7875 as amended by RA 9241 provide that the beneficiaries of this program will be identified on the basis of a means test using the data from the Community-Based Information System-Minimum Basic Needs (CBIS-MBN) but emphasized that the PHIC reserves the right to adopt other means test mechanism that it may deem appropriate. RA 7875 also provides that the conduct of the means test will be

undertaken by the Barangay Captain in coordination with the Social Welfare Officer of the LGU under the supervision of the Local Health Insurance Office of the PhilHealth.

However, interviews with some barangay officials indicate that the selection process is *ad hoc* even in areas where the Community-Based Monitoring System (CBMS) is currently in place. These interviews also suggest that the selection of Sponsored Program beneficiaries in many LGUs prior to 2011 was highly politicized and as such was susceptible to local patronage politics.

Individually Paying Program and the Overseas Workers Program. In 2010, there are 3.7 million principal members under the Individually Paying Program and 2.3 million principal members under the Overseas Workers Program (**Table 8**). The coverage rate of the Individually Paying Program is the lowest among all the programs of PhilHealth, reflecting the unique difficulties in enrolling and collecting premium contributions from informal sector workers. However, some gains in expanding coverage of these two programs have been made in recent years. Thus, the number of principal members covered under Individually Paying Program and the Overseas Workers Program combined represents 33% of the informal sector workers in 2010, up from 25% in 2007-2008 and 30% in 2009.[11]

With the informal sector accounting for more than 50% of the labor force, the importance of expanding the coverage of the informal sector under the IPP cannot be over-emphasized. Moreover, not only is the coverage of the IPP low, it is reported that about two-thirds of IPP members are not paying their premiums on a regular basis because informal sector workers tend to have uncertain and variable income through the year (Jowett and Hsia 2005).

To broaden the coverage of the IPP, PhilHealth launched the "Kalusugan Sigurado at Abot Kaya sa PhilHealth Insurance" or (KASAPI) in August 2005. Under KASAPI, PhilHealth enters into strategic partnerships with organized groups (OGs) such as microfinance institutions, cooperatives, rural banks and NGOs, many of which specifically serve workers in the informal economy. Under KASAPI, these OGs act as marketing and collection agents for PhilHealth. In exchange, the KASAPI offers the MFIs an incentive (in the form of a discount on the premium contributions due) if they enroll at least 70% of their eligible members under the IPP. The discount increases as the size of the group increases and as the percentage of eligible members enrolled increases. The MFIs then has the option to either pass on the discount, in part or in full, to their members or to use the discount to provide other services to their members. The use of the OGs as collection agents allows members of the OGs greater flexibility in timing the payment of their premiums, and possibly lower premiums and/ or more services from their OGs.

However, the success of the KASAPI has been fairly limited. Out of the 600,000 members of 14 OGs working with the KASAPI program (Asanza 2007), the program enrolled 23,332 informal sector families as of December 2008, up from an initial enrollment of 1,863 in 2006. The PhilHealth faces serious challenges in its effort to expand the coverage of the IPP using the KASAPI model. Many organized groups like worker's associations and smaller cooperatives have less than 1,000 members and, as such, do not meet one of the criteria to qualify under the KASAPI (Schmidt et al. 2005). Thus, there is a need to develop a strategy to more effectively reach the members of these smaller OGs and, more importantly, the unorganized informal sector. In an earlier effort by PhilHealth to partner with smaller OGs, the drop out rate of OG members was found to be high (75% to 85%), only slightly lower than the figure of about 91% for informal worker enrollees prior to the implementation of the initiative (Basa 2005).

3.2 Recent Developments and Present Challenges

With the establishment of the National Household Targeting System for Poverty Reduction (NHTS-PR), government decided that the national government counterpart in the premium contributions of members enrolled in the SP will only be available for families identified as poor under the NHTS-PR. This decision is anchored on the expectation that the use of the NHTS-

[11] For our purposes here, the informal sector workers includes the own account workers, unpaid family workers, wage workers in private households and wage workers in family-owned business.

PR will improve the targeting performance of the Sponsored Program largely by enabling the government to eliminate political intervention in the selection process.

While it helps promote better targeting of the national government subsidy, this new policy direction presents distinct challenges to the PhilHealth in moving towards universal coverage. First, ensuring the enrollment in the program of all the households identified under the NHTS-PR is a major hurdle considering that the selection and enrollment of Sponsored Program beneficiaries are largely initiated by the LGUs and considering the extent of political patronage involved in the process. Second, ensuring the continued enrollment in PhilHealth of some 5.1 million households who were enrolled in the Sponsored Program in 2010 but who are not in the NHTS-PR list of poor households even if they are no longer qualified for the national government subsidy is another major challenge.

To address the first problem, government decided that the premium contribution of all families identified as poor under the NHTS-PR will be shouldered 100% by the national government (PhilHealth Board Resolution No. 1478 s. 2011). However, an amendment of RA 7875 might be needed to put this decision into effect. Note that RA 7875 provides that the "national government shall provide up to 90% of the subsidy for indigents."

This move is meant to achieve three things and appears to be well justified. First, it is expected to eliminate the political economy issues and consequent high leakage associated with the present practice of LGUs identifying the beneficiaries under Sponsored Program. Second, considering the positive and statistically significant relationship between the coverage rate of the Sponsored Program and per capita LGU own-source revenue (Manasan 2011), it is expected to improve the coverage of indigent families even in areas where the fiscal capacity of the LGU is low.[12] Third, it is also meant to help ensure greater stability in the enrollment of indigent families as the national government no longer has to wait for the LGUs to initiate the selection and enrollment process. Thus, funding of the government subsidy for the premium contributions is expected to be better secured.

The 2011 State of the Nation Address Technical Report avers that all of the 5.2 million households identified as poor by the NHTS-PR have been enrolled in the PhilHealth Sponsored Program as July 19, 2011. However, in a roundtable discussion organized by the House of Representatives Committee on Poverty last July 27, 2011, the issue of cross-checking/ validating PhilHealth beneficiaries vis-à-vis the NHTS-PR list was still raised.

To address the second challenge presented by the use of the NHTS-PR in identifying beneficiaries of the Sponsored Program, the PhilHealth Board decided to allow LGUs and other sponsors to renew the membership for 2011 of those families who were enrolled in the Sponsored Program in 2010 even if they are not in the NHTS-PR list of poor families at the existing LGU counterpart contribution rate and for PhilHealth itself to shoulder what used to be the national government counterpart of the premium contribution (PhilHealth Board Resolution No. 1478 s. 2011). PBR No. 1478 s. 2001 has the effect of providing government subsidy (albeit from the PhilHealth) for the premium contribution of non-poor informal sector workers. But perhaps what is even more problematic, this move will tend to have a dis-incentive effect on those who are currently enrolled and contributing to the Individually Paying Program.

The incremental fiscal cost to the national government of PhilHealth Board Resolution 1478 for the Sponsored Program is PhP 5.2 billion (equal to the PhP 12.5 billion that represents 100% NG subsidy for the NHTS-PR poor less the PhP 7.3 billion that would have been used to fund the NG counterpart for the premium contribution of the 6 billion members under the Sponsored Program in 2010).[13] In addition, the cost to PhilHealth of subsidizing the premium contribution of the non-poor informal sector workers who used to be enrolled as SP members is PhP 6.2 billion. This cost could go up by another PhP 3.3 billion if the PhilHealth subsidy is extended to those who

[12] However, a similar relationship between the coverage rate and per capita IRA is not established from the data.

[13] These estimates are computed based on the revised annual premium of PhP 2,400 per family enrolled in the Sponsored Program.

are enrolled in the Individually Paying Program. It is not clear if said arrangement is sustainable for the PhilHealth in the medium term.

The discussion above highlights the tension between fiscal sustainability and broader coverage of the informal sector. Given this perspective, there is a need to revisit and redefine the PhilHealth-LGU engagement. One possibility is to treat LGUs in much the same way that organized groups like microfinance institutions, cooperatives, and NGOs are treated under the PhilHealth KASAPI program. In this regard, LGUs may be viewed as a consolidator of informal sector workers wishing to enroll under the Individually Paying Program.[14] LGUs will collect the premium contributions of the non-poor informal sector workers and remit the same to PhilHealth. LGUs may be given the option to co-share the premium contribution with the enrolled members. There is anecdotal evidence that such arrangements are actually in effect in many LGUs even in 2010 and prior years. However, there might be a need to phase in the implied increase in premium contributions of these enrolled members.

As an incentive to LGUs, they may not only be given a discount on the premium contributions due (as is the case with other organized groups) but the health facilities they operate may also receive capitation payments on account of the families they enroll under the Individually Paying Program. This implies that the special outpatient benefits being to the Sponsored Program will also be extended to the Individually Paying Program.

3.3 Depth of Coverage or Service Coverage

The services covered by PhilHealth are heavily skewed in favor of in-patient services. Outpatient consultation and routine diagnostic services are covered only for members enrolled in the Overseas Workers Program and the Sponsored Program but not for those under the Employed Sector Programs and the Individually Paying Program. However, TB DOTS, selected day surgeries, chemotherapy, radiotherapy, and dialysis are available to all members and beneficiaries of PhilHealth.

From the perspective of equity, outpatient consultation and routine diagnostic services should be made available to all members. Also, given that drugs and medicines account for roughly 50% of total out-of-pocket health expenditures of households, the exclusion of drugs and medicines from the outpatient benefit package needs to be revisited. Schwefel (2009) point out failure to use medicines when they are needed can lead to preventable morbidity and mortality, catastrophic episodes of illness that increase impoverishment, and large-scale losses to health systems and employers. In this regard, insurance programs that cover medicines can play a key role in extending access to high risk populations and in encouraging more economical and effective use of medicines.

4. MULTIDIMENSIONAL ASPECT OF UNIVERSAL COVERAGE

Universal coverage may be defined as physical and financial access by all persons in society to the full range of personal and non-personal health services they need at affordable cost. This definition of universal coverage "implies equity in access and financial risk protection" (WHO 2005). To achieve universal coverage, it is critical that the pre-paid contributions that are collected on the basis of ability to pay are pooled and the funds used "to ensure that services are available, accessible and produce quality care for those who need them, without exposing them to the risk of catastrophic expenditures (WHO 2008).

Universal coverage may be thought of as having three dimensions (see **Figure 4**):

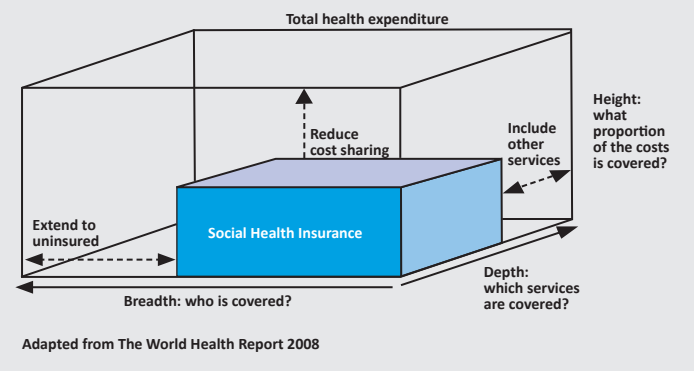
- *breadth of coverage* or population coverage refers to the proportion of the population that enjoys social health protection;

[14] This proposal is consistent with the discussions during a small group meeting with PhilHealth relative to the formulation of the Medium-Term Development Plan last the May 2011 where the need to work with LGUs in paying the premium of the informal sector was pointed out.

- *height of coverage* or financial risk protection refers to the portion of health-care costs that are covered under the social health insurance program; and
- *depth of coverage* or service coverage refers to the range of services that are available from the system (WHO 2008; WHO 2010).

The aforementioned framework is useful in better understanding the challenges in attaining universal coverage under the PhilHealth. The analysis below shows that population coverage is not entirely independent of the proportion of health care costs that is covered by Philhealth nor the health services which are covered.

Figure 4. Three ways of moving towards universal coverage



4.1 Height of Coverage or Financial Risk Protection

The discussion below underscores the fact that the population coverage is not independent of the financial risk protection that social health insurance affords its members.

Availment rate. DOH (2010) estimates the availment rate[15] for the regular benefit package of PhilHealth for the Sponsored Program to be equal to 33% while that for the Non-Sponsored Program to be equal to 42% (**Table 9**). The availment rate is influenced by the availability of accredited providers (facilities as well as health care workers). DOH (2010) documents the large disparity in the accessibility of accredited providers across geographic areas. For instance, the said study reports 25 provinces (e.g., those in ARMM and CAR) have no access tertiary facilities based on the 2008 list of accredited facilities of the PhilHeatlh.

Table 9. Availment rate and support value, by program 2008

	Adjusted Availment Rate	Support Value
Government employees	42%	28%
Private Sector employees	42%	28%
Sponsored program	33%	50%
Individually Paying Program	42%	28%
All programs	42%	34%

Source: DOH 2010

Also, there is a shortage in the number of health workers in many LGUs, especially those in rural areas, partly because of the restrictions on LGU spending on personal services under the Local Government Code. The problem may also be attributed to the lack of incentives for health workers in geographically isolated and disadvantage areas.

Moreover, the shortage of drugs and supplies in certain hospitals, particularly in public facilities, is found to be commonplace (Solutions Inc. 2009). Such shortages tend to discourage members, particularly indigent members, from availing of health care services. For instance, patients have to buy medicines, drugs and supplies they need from pharmacies outside the health facilities when these are not available in the said facilities. Although the cost of the medicines, drugs and supplies

[15] The availment rate is the ratio of the number of members who availed of covered services in PhilHealth accredited facilities to the total number of enrolled members who are eligible to file claims.

[16] A patient exit survey of public hospitals in the Visayas in 2005 shows that the hospital bill accounts for 72% of total medical expenses, with the remaining 28% accounted for by purchases of drugs and medicines outside the hospital.

may be reimbursed (up to a limit), PhilHealth members have to bear the cost of money due to advancing payment for the drugs, medicines and supplies, at the very least.[16] Moreover, the filing of reimbursement claims is tedious and time consuming. Thus, the effective financial support value provided by PhilHealth is eroded (Solutions Inc. 2009).

Another barrier to the availment of PhilHealth benefits stems from the inability of many registered members (particularly those under the Sponsored Program) to submit documentary requirements like birth certificates of children and marriage certificates of spouses that serve as proof of dependence. Many poor families in rural areas do not have these documentary requirements. While late registration of births is possible and the procedures to do so have been streamlined, it is said that families who typically encounter this problem sometimes cannot afford the fees and other attendant cost that are associated with late registration of births.

Support value. The support ratio[17] for the regular benefit package is estimated to be equal to 50% for the Sponsored Program while that for the Non-Sponsored Program is estimated to be equal to 28% (DOH 2010). The higher support value for the Sponsored Program relative to that of the Non-Sponsored Program is attributed by the DOH (2010) to the fact that the poor tended "to use public facilities that continue to be heavily subsidized."

Manasan (2009) notes that:

> "The observed low support value of PhilHealth may also be attributed to (i) the "first peso coverage up to a cap" approach that is followed in the provision of benefits, (ii) paying providers on the basis of fee-for-service, and (iii) the absence of regulations on the fees that providers charge (Gertler and Solon 2002, Jowett and Hsiao 2005, Kwon 2005). Under this setup, the protection provided members may not increase even if the benefit ceiling were adjusted upward. This is so because health care providers are able to capture insurance benefits by raising the prices they charge insured patients (Gertler and Solon 2002). In a sense, there is a ceiling on the maximum risk that PhilHealth will bear but there is no limit on the risk that its members are exposed to (Kwon 2005). In turn, the large out-of-pocket expenditures that households have to shoulder even when they are insured may help explain the low availment rate, especially for the Sponsored Program.
>
> As such, the low financial protection provided by PhilHealth benefits may also have some negative impact on expanding population coverage as it discourages prospective members from joining PhilHealth (under the Individually Paying Program). At the same time, it tends to exacerbate adverse selection, with the danger that lower risk individuals will elect not to join the program (Jowett and Hsiao 2005).
>
> The solution to this problem appears clear cut: (i) introduction of cost sharing mechanisms like deductibles and coinsurance to minimize moral hazard, (ii) shifting of the payment system from fee-for-service to a mix of capitation and case-payments, and (iii) ban on balance billing (Kwon 2005)."

The PhilHealth has taken steps towards these reforms. PhilHealth has started to put into effect no-balance billing for members under the Sponsored Program provided they are confined in a public health facility for 22 medical and surgical cases consisting of 11 medical conditions (dengue I and II, moderate risk and high risk pneumonias, hypertension, cerebrovascular accident I and II, diarrhea, typhoid fever and asthma, asthma and neonatal care package) and 11 surgical procedures (caesarean section, dilation and curettage, hysterectomy, mastectomy, appendectomy, cholecystectomy, herniorrhaphy, thyroidectomy, radiotherapy, hemodialysis, and normal spontaneous delivery).

However, it still remains to be seen how effective this move will be in reducing the out-of-pocket expenditures of poor households considering that the shortage of drugs and medicines is a recurring problem in many public health facilities. Also, this initiative will provide little incentive to non-poor

[17] The support ratio is the ratio of PhilHealth benefit payments to the actual expenditures of eligible PhilHealth members who actually availed of covered services.

households, particularly those whose heads are employed in the informal sector to voluntarily enroll in the PhilHealth, unless and until it is expanded to cover the Individually Paying, the Overseas Workers and the Employed Sector Programs.

5. CONCLUSION AND RECOMMENDATIONS

Coverage of the Employed Sector Programs. To expand the population coverage of the Employed Sector Program, there is a need to improve compliance of employers, especially small enterprises and single proprietorships, to the legal mandate for compulsory enrollment of their employees in PhilHealth. To enhance PhilHealth enforcement activities in this regard, there is need for PhilHealth access to third party information from other government agencies like the SSS, GSIS and Pag-ibig to help enlarge their list of employees in the formal sector. Also, arrangements to have LGUs require proof of payment of the PhilHealth contributions in behalf of their employees as a pre-condition to the issuance of business permits will be helpful (GTZ/ Jowett 2006).

Improving coverage of and improving targeting of the poor. This paper supports the use the NHTS-PR in identifying poor families that will be enrolled under the Sponsored Program. It also supports the move to have the national government to fully subsidize the premium contributions of the poor families enrolled in the Sponsored program. This initiative is well justified on the following grounds. First, it will minimize political interference in the selection of beneficiaries and reduce leakage. Second, it will likely improve the coverage of indigent families even in areas where the fiscal capacity of the LGU is weak. Third, it will help ensure greater stability in the enrollment of indigent families as funding of the government subsidy for the premium contributions is better secured.

New challenges in expanding coverage of the informal sector. There is a need to revisit PhilHealth's proposal to allow LGUs and other sponsors to renew the membership for 2011 of those families who were enrolled in the Sponsored Program in 2010 even if they are not in the NHTS-PR list of poor families at the existing LGU counterpart contribution rate and for PhilHealth itself to shoulder what used to be the national government counterpart of the premium contribution. It has the effect of providing government subsidy for the premium contribution of non-poor informal sector workers, ostensibly because this group belongs to quintile 2 even if the said group is likely to be poorly targeted. Moreover, this move will also tend to have a dis-incentive effect on those who are currently enrolled and contributing to the Individually Paying Program.

Given this perspective, there is a need to redefine PhilHealth-LGU engagement. This paper proposes that the possibility of treating LGUs in much the same way that organized groups like microfinance institutions, cooperatives, and NGOs are treated under the PhilHealth KASAPI program be explored. In this regard, LGUs may be viewed as a consolidator of informal sector workers wishing to enroll under the Individually Paying Program. LGUs will collect the premium contributions of the non-poor informal sector workers and remit the same to PhilHealth. LGUs may be given the option to co-share the premium contribution with the enrolled members. However, there might be a need to phase in the implied increase in premium contributions of these enrolled members.

As an incentive to LGUs, they will not only be given a discount on the premium contributions due (as is the case with other organized groups) but the health facilities they operate will also receive capitation payments on account of the families they enroll under the Individually Paying Program. This implies that the special outpatient benefits being to the Sponsored Program will also be extended to the Individually Paying Program.

Need to improve availment rate and support ratio. Improving compliance of the Employed Sector Programs and expanding the coverage of the informal sector under the Individually Paying Program will not be possible if the availment rate and the support ratio are not increased.

To improve the availment rate, there is a need to upgrade the facilities of public hospitals, RHUs and BHSs so as to increase the number of accredited public health facilities. The Health Facilities Enhancement Program is aimed at achieving this. However, there is need to accelerate its implementation.

To increase the PhilHealth support ratio, there is a need to (i) introduce cost sharing mechanisms like deductibles and coinsurance to minimize moral hazard, (ii) shift the payment system from fee-for-service to a mix of capitation and case-payments, and (iii) ban on balance billing. These changes should be made available not just for the Sponsored Program but for the other programs as well.

Need to improve service coverage. To achieve equity across programs, outpatient consultation and routine diagnostic services should be made available to all members. Also, given that drugs and medicines account for roughly 50% of total out-of-pocket health expenditures of households, the exclusion of drugs and medicines from the outpatient benefit package needs to be revisited.

Sequencing issues. Given the interdependence of population coverage, financial risk coverage and service coverage, government has to pay close attention to sequencing issues and the need to guard against perverse consequences.

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EXPANDING SOCIAL PROTECTION COVERAGE TO INFORMAL SECTOR WORKERS: A THINK PAPER[1]

Rosario G. Manasan and Aniceto C. Orbeta, Jr.[2]

INTRODUCTION

Contrary to expectations, informal employment has grown worldwide (van Ginneken, 2010). This type of employment is usually associated with job insecurity, precarious working conditions, lack of social security coverage and poverty. Lack of access to appropriate risk management instruments are known to have high human costs, in general, but more so for informal sector workers majority of whom are in more precarious situations than formal sector workers. Social protection (SP) coverage is also known to lead into higher productivity (Perry et al, 2007). Extending coverage to informal sector workers is therefore a continuing concern among policy makers.

Providing social protection to informal sector workers is a universally accepted objective. As early as 1948 the right to social security is stipulated in the Universal Declaration of Human Rights[3] adopted by the UN General Assembly. This right is similarly contained in the UN international Covenant on Economic, Social and Cultural Rights[4].

Thus, the issue is not whether there is a need but how can informal sector (IS) workers be efficiently and effectively covered by social protection programs. It is recognized that an ill designed intervention may make matters worse rather than better. This paper attempts to address this issue by discussing the available options and in the process clarifying the issues involve. This is expected to inform discussions on designing interventions to extend social protection coverage for IS workers.

The paper highlights the fact that even though there is a large overlap, not all IS sector workers as officially defined are poor. This distinction is important because poverty is the accepted criterion for eligibility to non-contributory general tax-financed schemes. It then identifies three options for extending coverage for IS workers that are not necessarily mutually exclusive. Heterogeneity of IS workers necessitates varied schemes in order to cover them. The most promising is extending coverage of SP programs for formal sector workers to IS workers. This is considered most promising primarily because of the considerable administrative capacity that has been built up through the years. Another is the nascent self-financed and often self-managed area- or occupation-based schemes. Finally, there is the non-contributory schemes for IS workers that satisfy the eligibility conditions usually based on poverty.

The paper proceeds as follows. The next section describes the most comprehensive and most reliable estimate of the size of the IS workers. This is followed by an overview of the existing SP programs. A description of how IS workers are different from what is assumed in the design of formal sector SP programs follows. The final section discusses the options for extending coverage of SP programs to IS workers.

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[2] Senior Research Fellow, Philippine Institute for Development Studies. The paper has benefited from comments of the members of the SDC Sub-Committee on Social Protection. It has also benefited from the comments of Dante Canlas and Emmanuel Esguerra. Usual disclaimer applies.

[3] Articles 22 and 25.

[4] Article 9

Measures of the Size of the Informal Sector Workers

Despite the problems of the definition of the Informal Sector (IS) and informal employment[5], the NSO provided an estimate of the informal sector workers in the first nationwide Informal Sector Survey (ISS)[6] in 2008. The survey uses the NSCB definition[7], the core criteria for defining the IS from the 1993 System of National Accounts (SNA), and the guidelines of the International Conference of Labor Statisticians (ICLS).

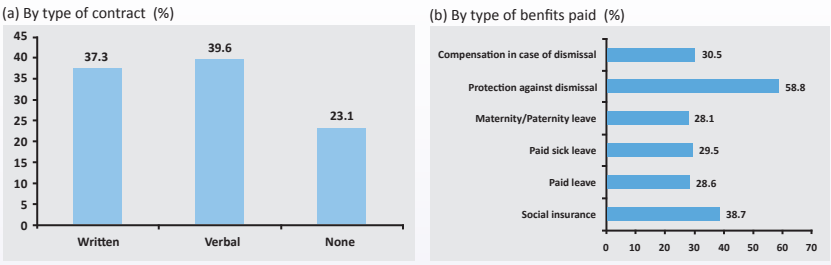
The NSCB definition defines the informal sector as household unincorporated enterprises (HUEs) which consist of (a) informal own-account enterprises and (b) enterprises of informal employers. The informal own-account enterprises are defined as HUEs owned and operated by own-account workers, either alone or in partnership with members of the same or other household which may employ unpaid family workers as well as occasionally/seasonally hired workers but employ employees on a continuous basis. Enterprises of informal employers, on the other hand, are HUEs owned and operated by own-account workers, either alone or in partnership with members of the same or other household, which may employ one or more employees on a continuous basis. This excludes in particular units with 10 or more employees. The NSO further qualifies the HUEs to be HUEs producing at least some goods and services for market (HUEMs) following the product destination criterion in the 1993 SNA in definition of HUEMs/IS. The other two core criteria, namely, legal organization and bookkeeping practices. Legal organization criterion defines IS units as not having a separate legal entity from its owner. The bookkeeping practice criterion defines IS units as not having a clearly separate account from the household.

Informal employment is also defined on the basis of the existence of a contract and/or payments of benefits provided by labor regulations (e.g. Chen, 2008).

Using the above guidelines, the NSO provided estimates of the extent of informal sector employment. On the basis of the type of contracts, the survey says that 40% of 17.7 million wage and salary workers are with verbal contract and an additional 23% have no contract at all (Figures 1)[8]. Thus, more than 60% (11.1 million) of the wage and salary workers can be considered as having informal employment. In term of benefits paid, those in informal employment can be as high as 72% for those with no maternity/paternity benefits or as low as 41% for those with no protection against dismissal.

It also identified 10.5 million IS operators consisting of 9.1 million self-employed and 1.3 million employers[9].

Figure 1. Wage and Salary workers by informality



Combining these all together to provide an estimate of the number of informal sector workers, shows that as much as 29.8 million (89%) of the 33.5 million employed workers in 2008 can be considered informal sector workers (Table 1). The table also shows that as much 91% of the self-

[5] Chen (2008) provides a summary of the evolution of the international definition of the informal sector and informal employment.
[6] The 2008 ISS is a rider to the April round of the Labor Force Survey.
[7] NSCB Resolution No. 15 Series of 2002
[8] NSO Press Release No. 2010-22.
[9] NSO Press Release No. 2009-05.

employed, 88% of the employers, and 76% of employees can be considered informal sector workers. In addition, all of the unpaid family workers are considered informal sector workers.

Table 1. Employed persons by status of employment and informality, 2008

	Level (000)	%
Total	**33,535**	**100.0**
Formal	2,611	7.8
Informal	29,830	89.0
Other[2]	1,095	3.3
Self-Employed	**10,067**	**100.00**
Informal	9,161	91.0
Other[2]	906	9.0
Employers	**1545**	**170.5**
Informal	1,356	87.8
Other[2]	189	13.9
Employees	**17,725**	**100.0**
Informal	13,553	76.5
Formal	2,600	14.7
Other[2]	189	13.9
Domestic Helpers	1,572	8.9
Informal	1,561	8.8
Formal	11	0.3
Unpaid Family	**4,200**	**100.0**

[2]Still to be classified

Overview of Existing Social Protection Programs

Extension of social protection coverage to the informal sector workers needs to recognize what social protection programs are already in place. To give the reader a perspective of the breadth of existing social protection programs it is useful to provide an overview. One way of describing the social protection system is to describe it as consisting of five pillars following Holzmann and Hinz (2005). The pillars are distinguished by the nature of benefits and the primary sources of financing. A summary of the Philippine social protection programs using this framework is given in Orbeta (2010) and reproduced in Table 2. Pillar 0, sometimes called the basic pillar, consist of universal or residual assistance which are poverty-targeted and finance by general tax. This would include the provision of basic services. It would also include special programs of the different line departments such the DSWD, DOH, DOLE that address the needs of the poor. Pillar 1 would include mandatory define benefit (DB) schemes. Included in this pillar would be the social security schemes of the SSS, GSIS and the AFP-RSBS. The health insurance under the PHIC, the work-related accident insurance of the ECC, and the repatriation and work-related risk coverage of the OWWA would also fall under this category. Pillar 2 would include defined contribution (DC) schemes. This pillar would include the savings programs of HDMF or PagIBIG Fund, the life insurance programs of the GSIS and the OWWA. Pillar 3 would include voluntary occupational or personal pension plans and supplementary schemes. This would include company-based provident fund and additional pension schemes of large private corporations and public autonomous corporations. Finally Pillar 4 includes voluntary and supplementary schemes. This would include additional personal pension, insurance, and pre-need plans for many contingencies usually offered by the private sector. The newly introduced PERA will fall under this category. Community-based health schemes will also fall under this category.

Table 2. Social Protection as a Five-Pillar System

Pillar	Description of institutions and programs
Pillar 0 – Universal or residual social assistance, poverty-targeted, general tax-financed	Social assistance and poverty-targeted programs of government departments such as social welfare, health and labor
Pillar 1 – Mandated public pension, defined benefit (DB) schemes	Pension schemes of the SSS for private sector wage workers, of the GSIS for civilian public sector, and the AFP-RSBS for the military; Work-related accident insurance programs of the Employment Compensation Commission (ECC); health insurance program of the Philippine Health Insurance Corporation (PHIC); Overseas Workers Welfare Administration (OWWA) schemes on worker repatriation and work-related risks
Pillar 2 – Mandated occupational or personal pension plans, defined contribution (DC) schemes	HDMF (Pag-IBIG) compulsory savings schemes, AFP-RSBS compulsory saving schemes, GSIS life-insurance, OWWA life-insurance
Pillar 3 – Voluntary, occupational or personal pension plans and supplementary schemes	Company-based provident fund / pension schemes of large private corporations and public finance and autonomous corporations; GSIS mutual fund
Pilar 4 – Voluntary, informal support (family), formal social programs (healthcare), other individual financial and nonfinancial assets (homeownership)	Private pension, insurance and pre-need schemes, tax-deductible investment to personal accounts (PERA), community-based health insurance, life insurance and pension schemes

Source: Author's summary from relevant documents

Another way of organizing social protection programs is to group them into three types, namely: social insurance, labor market interventions and social assistance programs [World Bank (2001), ADB (2003)]. Social insurance programs where those whose benefits are financed mainly by the

contributions of members. The labor market intervention consist of labor market regulations that set workers' rights and active labor market programs that facilitate employment or alternative income-generating activities. Finally, social assistance programs, also often called social safety net programs, are programs that address the needs of the poor and vulnerable and usually finance by general taxes.[10]

One can easily map the two frameworks by considering that Pillar 0 would contain most of the social assistance and labor market intervention programs. Social insurance program are contained in Pillars 1 and 2. The remaining Pillars cover the supplementary personal, family and community-based schemes.

Social Protection and the Characteristics of Informal Sector Workers

There are many theories trying to explain the existence of the informal sector, in general, and informal sector employment, in particular. Chen (2008) provides the evolution of major theories explaining the existence based on causes and consequences of informal sector work. She argued that an integrated theory can be formulated by understanding the reasons for exit and entry into the sector, by the exclusion from coverage of state-based regulations, and finally by the exploitative employment relations. She also pointed out that a key, albeit unresolved, issue is where informal sector workers are there by choice or forced by circumstances.

Considering the forgoing theory, it is common knowledge that the informal sector is highly heterogenous. As mentioned earlier, some are in the sector as a matter of choice while for others the choice is made by their employers. In contrast, most social insurance schemes are designed with homogeneous clients in mind.

An important challenge for covering informal sector workers is their mobility. While formal sector workers are have more or less regular location of employment, informal sector workers have working locations that are often mobile and even unknown (van Ginneken, 1999).

Formal social insurance schemes also presume regular flow of income. Informal sector work, on the other hand, is often characterized as highly irregular in work time and consequently in pay. This makes the regular contributions of social insurance scheme difficult to comply.

Another important obstacle is that the priority needs of informal sector workers may be different from the formal sector workers. Health care may be high in priority but pension may not be. It has been pointed out that returns of contributory pension schemes maybe low in priority compared to their immediate need for food and shelter or for new equipment and tools, better housing and land or education of their children (van Ginneken, 1999; Vahapassi, 2004). This is will be compounded by the low returns of social security schemes owing to poor investments management and poor credibility of the pension funds.

The current social protection packages may also be requiring contributions beyond what informal sector workers are prepared to pay (van Ginneken, 1999). Informal sector work is often characterized as low-paying which makes contributory schemes less attractive to them. Note that the SSS pension scheme requires a contribution of 10.4% (only 3.33% is paid for by the employee and the rest paid for by the employer) of gross basic monthly salary and is currently under pressure of being increased to improve sustainability of the fund while PhilHealth requires 2.5% (employee pays only half) of basic salary (Orbeta, 2010).

Finally, it needs to be emphasized that one has to differentiate the informal sector from poor households. While there is a large overlap it is not perfect. Not all those in the informal sector are necessarily poor nor all the poor are working in the informal sector (Vahapassi, 2004). This is critical if a proposed scheme is contributory or financed by general taxes.

[10] ADB (2003) separates area-based schemes. These, however, are adaptations of social insurance schemes which are limited either by geographic area or occupation/livelihood. These are attempts catch those not covered by the primary social insurance schemes.

Options for Expanding Social Protection Coverage for Informal Sector Worker

Expansion of coverage of social insurance schemes

Extending coverage of the formal social insurance schemes to the informal sector is one clear option. This is a common theme in papers discussing extension of coverage (van Ginneken, 1999, 2010; Ghai, 2003). It is important to realize that if one examines the eligible population of the Social Security Systems, it includes the self-employed persons, household helpers, separated members, non-working housewives and overseas Filipino workers (OFWs). This covers much of those in the informal sectors. The problem is, for one reason or another, the proportion contributing members of the SSS has not really improved over the years. For wage workers the contributing members is only between 36 to 48 percent from 2000 to 2009 and even lower at 12 to 15 percent for own account workers consisting of the self-employed and employers (Orbeta, 2010). It is noteworthy that estimates from earlier studies also arrive as very similar coverage estimates (ILO,1996; WB, 1995). This may indicate that the system may have hit some ceiling in coverage. Similarly, if one examines the eligible population for PhilHealth it also covers those in the informal sector through its individually-paying program. There is, in fact, a special package under the program called "Kalusugan Sigurado at Abot Kaya sa PhilHealth Insurance" (KASAPI) that utilizes microfinance institutions, cooperatives and organization to expand its memberships while controlling collection costs. Thus, there are existing formal sector social protection programs that are intended to cover the old-age and health needs of the informal sector. What is needed is to improve compliance and contribution collection and this will go a long way in covering a substantial proportion of the informal sector workers.

It is worth mentioning that even if there are controversies on the actual coverage of PhilHealth, it is clear that it is higher than the Social Security System (SSS). What makes this worth noticing is that PhilHealth was established much later than SSS. SSS can perhaps learn from the strategies employed by PhilHealth to improve compliance.

Improving compliance and coverage are always dependent on the credibility of the social insurance funds, particularly, the institutions administering them. Needless to say, administrative capacity is an important component in improving compliance of statutorily covered population. Better management of social security funds is also another important dimension in encouraging compliance and increasing coverage. If returns are low and the integrity of the funds is not assured, informal sector workers may not find it attractive enough compared to other investment opportunities.

One well known challenge to extending coverage of social insurance schemes to the informal sector is the payment of employer's contribution. This is particularly true for the self-employed and own account workers. This may be considered an additional burden. Subsidy can be a justifiable option for poorer segment of the sector but less so for the richer segment. The experience in the indigent program of PhilHealth where the government, both national and local, share in the payment of premium of the beneficiaries should be instructive.

One important challenge in extending coverage to the informal sector is that they may not be able or willing to pay the premiums. One option of addressing this issue is breaking up the package of benefits so that "partial" memberships (with selected benefits) may be allowed (van Ginneken, 2003). The pick and choose mode common in purchasing mobile phone plans can be a model to emulate. This is important as the priorities of informal sector workers is expected to be highly varied as heterogeneity is one feature of the sector. This, of course, implies added complexity in the administration of the scheme. Hence, there might be a trade off between varied benefit package to address heterogeneity of the informal sector and the demand on administrative capacity with more varied benefit packages.

Some Examples. Two examples of attempts at extending coverage of social insurance programs for the formal sector to informal sector workers are worth mentioning. One is the SSS Automatic Debit Account (ADA) system. The other is the already mentioned KASAPI program of the PHIC.

The SSS Auto Debit Arrangement (ADA).[11] As mentioned in the report, among characteristics of IS

[11] This section would have not been written without the help of Cherry Esteban, Policy Research Section Corporate Policy and Planning Department, SSS.

workers that make it difficult to provide coverage is the lack of regularity of income and permanency of place of work. These characteristics make it unattractive to extend membership privileges to them because it will be very expensive to collect contributions as well as to deliver benefits to a mobile population.

The SSS ADA is designed to address this critical hurdle in providing membership privileges to self-employed and voluntary workers. Among the self-employed listed by the program are (a) self-employed professionals; (b) partners, single proprietors of businesses and board directors of corporations duly registered with appropriate government agencies; (c) actors, actresses, directors, scriptwriters and news correspondents who do not fall within the definition of the term "employee" (d) professional athletes, coaches, trainers and jockeys; (e) farmers and fisherfolks; and (f) workers in the informal sector such as sidewalk vendors, ambulant vendors, watch-your-car-boys and those similarly situated. The voluntary workers, on the other hand, include: (a) employed member separated from employment or ceased to be self-employed/OFW/non-working spouse who wishes to continue paying contributions; (b) OFW who is a Filipino recruited in the Philippines by foreign-based employer for employment abroad; having a source of income in a foreign country; and permanent resident in a foreign country; and (c) non-working spouse of a SSS member who devotes full time in the management of household and family affairs may be covered on a voluntary basis provided there is the approval of the working spouse. The person should never have been a member of the SSS. For the non-working spouse, the contributions will be based on 50% of the working spouse's last posted monthly salary credit but in no case shall it be lower than P1,000. It is clear that many of these self-employed and voluntary workers are IS workers. In fact, item (f) of the self-employed group specifically mentions informal sector workers. The voluntary members include those who are not technically part of the labor force such as those OFWs and non-working spouses.

The facility requires one time enrolment with participating banks[12] where savings and current accounts are maintained. From the account, contributions can be automatically deducted and service benefits such as real estate and salary loan proceeds are added periodically.

Data on collection of contributions and payment of benefits by mode of payment show limited success of the scheme. Only a very small proportion (less than 1%) goes through the facility (Table 3). Unfortunately, there appears to be no available data on the number of members using this facility.

Nonetheless, this facility indicates that there is an intension to extend coverage to IS workers by the SSS. What is needed is to understand why the utilization is very low. Of course, there is still the standing issue of low coverage of even the formal sector workers.

Table 3. Aggregate SSS Collections by Mode of Payment, 2010 (Amount in Millions)

	Level (000)	%
Contribution	**79,272.86**	**100.00**
Thru-the-Banks	35,226.09	44.44
Over-the-Counter/Thru the Mails	27,578.10	34.79
SSSNet	14,421.45	18.19
ADA	27.96	0.04
Bayad Center	1,335.56	1.68
Overseas Electronic Transactions	485.48	0.61
Shoe Mart	198.23	0.25
Salary Loan	**15,369.80**	**100.00**
Thru-the-Banks	7,187.46	46.76
Over-the-Counter/Thru the Mails	4,678.38	30.44
SSSNet	1,468.04	9.55
ADA	0.45	0.00
Bayad Center	145.39	0.95
Overseas Electronic Transactions	19.16	0.12
Shoe Mart	21.82	0.14
DDR Deductions	705.7	4.59
Loan Proceed Deductions	1,143.39	7.44
Housing Loan	**698.44**	**100.00**
Thru-the-Banks	95.77	13.71
Over-the-Counter/Thru the Mails	573.77	82.15
SSSNet	-	-
ADA	0.75	0.11
Bayad Center	17.06	2.44
Overseas Electronic Transactions	1.58	0.23
Shoe Mart	9.5	1.36

Source: SSS

The PHIC KASAPI Program. The "Kalusugan ay Sigurado at Abot Kaya sa PhilHeath Insurance" (KASAPI) was launched by PHIC in 2005 as a strategy to extend coverage to informal sector workers. The objectives of the program[13] include (a) boost enrolment and sustain membership in the informal sector; (b) implement an alternative payment scheme to encourage Organized Groups (OGs) to partner with PhilHealth; (c) limit adverse

[12] As of August 15, 2011, there are 10 participating banks, namely: (1) Asiatrust Bank, (2) Banco De Oro (BDO), (3) Bank of the Philippine Islands (BPI), (4) Development Bank of the Philippines (DBP), (5) First Consolidated Bank, (6) Green Bank, (7) Metrobank, (8) Philippine National Bank (PNB), (9) PS Bank, and (10) United Coconut Planters Bank (UCPB).

[13] PhilHeath Circular No 22 s-2005

selection; (d) facilitate shift of some sponsored program members to paying informal sector members; and (e) strengthen solidarity and risk sharing.

Under the program, Microfinance Institutions (MFIs) and cooperatives act as marketing and collection agents of the PHIC in reaching those in the informal sector. It has the potential of reaching members of the MFIs and cooperatives who are not employees of either private or public institutions. Llanto (2007), however, pointed out several potential issues that can hinder success of the program. One glaring problem is the potential conflict with the sponsored (or indigent) program which is mostly partially but often fully tax-financed. It is not difficult to imagine that there is a large overlap of those targeted by the KASAPI program and those targeted under the sponsored program – the bottom 25 percent. Since the sponsored program is subsidized and the benefits are identical, the KASAPI program will be dominated by the sponsored program. Instead of the facilitating the shift of some sponsored program members into paying members, the reverse will be more likely. It has been also pointed out that the requirement of a minimum of 1,000 members for a group to qualify for KASAPI effectively exclude many small organizations from participating in the program. This requirement may have been a reaction to an earlier experience with smaller groups with did not produce good results (Manasan, 2011).

Overall, the indications seem to convey limited success of the program. Of the 14 organized groups cooperating with the KASAPI program less than 4% were enrolled as of December 2008 (Manasan, 2011).

Assisting community and area-based schemes and self-finance schemes

The rise of self-financed and self-manage social security arrangements in developing countries has been noticed. The private social security arrangements arose from long-running trust relationships such as mutual aid societies and community organizations. The use of local organizations such as unions, cooperatives, neighbourhood and community groups, savings and credit associations, has been identified as a good venue for developing social protection programs for the informal sector (Ghai, 2003). Recent additions involved micro-finance institutions that came about from the micro-finance revolution doing micro-lending and recently micro-insurance programs.

Van Ginneken (1999) identified two fundamental requirements for these self-finance schemes to exist, namely: (a) there should be an existing association based on trust; and (b) the association is capable of collecting contribution and paying benefits. The first requirement may be easy to satisfy. This is indicated by the number of community associations existing in the country. The second requirement, however, may be difficult to satisfy. The failure of many cooperatives in the country is one indication. Managing long-term assets and liabilities such as pension funds may be something these organization are not prepared to perform. The entry of micro-finance institutions (MFIs) doing quasi-banking operations may provide the promise. The community associations can link up with the MFIs for mutual benefit. The community associations can also link up with formal social security institution an act as a conduit to facilitate collection of contributions. The example is the KASAPI program of PhilHealth.

It has been argued that one of the strengths of the community associations is that they may have a better understanding of the needs, priorities and contributing capacity of the informal sector workers than formal sector institutions (van Ginneken, 1999). Since social insurance programs must address these issues for the scheme to be attractive to the targeted clients, then community organizations are in a better position to address these issues. It also means tailor-made solutions can be expected. These can consist of group-specific contribution modalities, eligibility criteria and benefit packages that address better the varied needs of informal sector workers. Of course, this has to be tempered by the administrative capacity of the associations.

Since administering social insurance schemes is not their original business, there will always be need for capacity building for these institutions. This may be a good investment area for government in trying to address the coverage gap.

Underlying all these initiatives, the policy on the role of these groups to expand coverage of social security programs must be clear.

Some Examples. Community-based systems mimic the formal systems. Some offer pension and personal insurance schemes while others offer health insurance schemes. We discuss some examples of these schemes in this section

Community-Based Health Insurance Programs. Examples of community-based health insurance schemes are provided in Table 4 . One of the main feature of the schemes is that is always part of and administered and managed by existing association not necessarily organized for the purpose of operating the scheme as emphasized in Van Ginneken (1999). The OHPS is part of the ORT Multi-Purpose Cooperative, the AHMI is part of PATAMABA Angono which is a proponent of a 300-unit housing program under the Community Mortgage Program while the CARD MBA Health is part of the CARD Mutually Reinforcing Institutions. Being one of the earliest examples established as early as 1994, the OHPS has perhaps has the most sophisticated scheme with well defined services including outpatient and in-patient care, basic medicines and laboratory examinations. The CARD MBA AKAP CARD collaborates with a private sector provider to deliver benefits. It is noteworthy that beneficiaries are often confined to members of good standing of the primary organization. This results in small risk pools.

Table 4. Features of Community-based Health Insurance Schemes

Features/ Name	ORT Health Plus Scheme (OHPS)[14]	Angono Health Micro-Insurance Scheme[15]	CARD Mutual Benefit Association Health Program (AKAP CARD)[16]
Beneficiaries	Members ORT Multi-purpose Cooperative, La Union	Members of PATAMABA Angono also proponent of 300-unit housing project under the Community Mortgage program	Members of good standing of CARD MRI Microfinance program, 18-65 years old Covers legitimate spouse and children 90 days old to 18 years
Benefits	Outpatient, In-patient medical care, medicine Consultation clinics in satellite offices on designated days In-patient care provider paid on capitation basis		Out-patient care, In-patient care, Emergency care Annual Physical Exam CARD collaborate with a private sector provider to deliver benefits
Financing	Contribution by type (Single (50 per mo), Regular Family (100 per mo), Large Family (130 per mo) Subsidy from ORT Int'l, Province of La Union, Australian Embassy	Contribution of 50 per month	Annual premium of 1,800 payable in cash or loan; 43 payments at 50 per week
Administration	Managed and administered by ORT Coop	Part PATAMABA Angono	Part of CARD MRI

Community-Based Retirement Savings and Insurance. Similarly community-based retirement and insurance scheme are managed by their mother organizations initially as part of services provided to its members. The schemes shown below include both life insurance and retirement savings accounts (Table 5). Life insurance benefits are proportional to the length of membership. Retirement schemes are both saving schemes.

Table 5. Features of Community-based Life Insurance and Retirement Savings Schemes

Features/Name	CARD Mutual Benefit Association[17] (Life insurance, Retirement Savings)	KASAGANA-KA (KsK) Mutual Benefit Association (Life insurance, Retirement savings)[18]
Beneficiaries	Members of good standing As of 31 August 2011 1.4 active members 7.1 million insured (including dependent) 3.4 billion assets	KBMA members (18-60 years old) As of August 2011 25,240 members NCR (QC, Kalookan, Pasig, Marikina, Valenzuela); Bulacan (Meycauayan, Bocaue, Marilao, San Jose del Monte, Tunkog); Rizal (Antipolo, Montalban, San Mateo, Taytay, Cainta); Cebu
Benefits	Life insurance (illness-Accident) Less 1 yr: 6,000-12,000 1-2 yrs: 10,000-20,000 2-3 yrs: 30,000-60,000 3+: 50,000-100,000 Retirement savings: 5% pa	Life insurance (Illness-Accident) Less than 3 mos: 6,000-12,000 1-2 yrs:10,000-20,000 2-3 yrs:30,000-60,000 3+:50,000-100,000 Retirement savings: 2% pa
Finance	Contributions 20 per week Life insurance: 15 per week Retirement savings: 5 per week	Contribution: 20 per week Life insurance: 15 Retirement savings: 5
Administration	CARD MBA/CARD MRI	KsK-MBA and Partner MFI

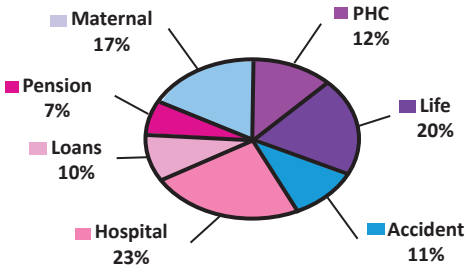
[14] From Yap and Aldaba (2002)
[15] From http://www.homenetseasia.org
[16] Assistance by Dr. A. Alip, Chairman of CARD MIR, S. Tumbado, General Manager of CARD MRI Insurance Agency (CaMIA) is gratefully acknowledged
[17] From Alip (2010)
[18] Assistance of Dr. F. Aldaba and Ma. A. Ignacio of KASAGANA-KA are gratefully acknowledge.

Risks covered. The community-based schemes have evolved into covering many risks. The ILO survey in 2005 showed the distribution of schemes by risks covered (Figure 2).

Figure 2.
Risk covered by community-based schemes, 2005

Source: ILO (2005)

Figure 3. Risk covered by community-based schemes, 2005



Source: ILO (2005)

The figure can be interpreted as an indication of the demand for coverage since the schemes are presumably in response to a felt need of their members. It is interesting to notice the profile of the risks covered by the schemes. In particular, it is clear that life (20%) and medical (hospital 23%, maternal 17%, and accident 11%) insurance schemes are offered by more organizations that pensions (7%).

Non-contributory schemes

Non-contributory or general tax-financed schemes are preferred to address specific populations, particularly the poor, and particular contingencies, such as natural calamities. To the extent that those in the informal sector are poor, they can be covered by these schemes. As mentioned earlier, these schemes, particularly those with universal coverage, are considered under the basic tier. Coverage of the informal sector in means-tested schemes will be justified if the poverty criteria of the program are satisfied.

These schemes, however, require considerable administration capacity particularly the means-tested ones. Identifying the target group and delivering the social assistance benefits effectively and with minimal leakage are common challenges of non-contributory means-tested schemes. The experience with the National Household Targeting for Poverty Reduction (NHTS-PR) used on the 4Ps should provide a sneak preview of what is required in identifying target beneficiaries. The experience of delivering benefits to remote communities and hard to reach areas under 4Ps should also provide a dry-run for delivering benefits to informal sector workers.

The relationship between the non-contributory schemes and the contributory schemes has to be clearly understood so that this may not led to disincentives to participating in the contributory schemes. Among the recommended features for non-contributory schemes are should have more stringent requirements such as higher retirement age and lower benefits than the contributory counter parts (Asher, 2009).

To the best of the author's knowledge the country has not experimented yet with tax-finance social pensions. This is important if poverty incidence among retirees is considerably higher than the total population. What it has experience on is very specific assistance for retirees such as Tulong para kay Lolo at Lola where a one-time cash subsidy of PhP500 were given to qualified senior citizens. Other countries have experimented with non-contributory social pensions some are universal (e.g. South Africa, Namibia) others means-tested (e.g. Zambia) (van Ginneken, 2003). The fact that these countries may have limited administrative capacities should inspire the country to experiment with non-contributory pension schemes if it can be shown that the poverty incidence among retirees is high. But needless to say, the design should consider not only the fiscal but also the administrative capacity of the country to deliver such a service.

Summary

The paper reviews the size and characteristics of the informal sector and informal sector workers using official definitions and statistics. The estimates appear to be much larger than what most people are expecting. These pieces of information are important in the design of social protection systems for the informal sector.

A review of the main features of the existing social protection system is also provided. This gives a perspective of what are the available options for extending coverage to informal sector workers.

The informal sector is characterized as heterogenous. It is also pointed out that even if there is a large overlap between the poor and workers in the informal sector, it is not one-to-one. These characteristics call for more flexibility in SP programs for IS workers and also means that it does not necessarily require everything to be non-contributory.

The paper identified three mutually reinforcing options for extending coverage of social protection programs to informal sector workers. The first is expanding the coverage of social insurance programs currently offered mainly to formal sector workers to informal sector workers. It is worth noting that the enabling laws for both SSS and PHIC already intend to cover informal sector workers. Unfortunately the coverage is still far from universal even for formal sector workers and this has been going on for some time. This can be taken as a signal that current schemes may have hit some ceiling in expanding coverage. The second is to assist community-based schemes improved their capacities and providing some regulatory mechanisms to improved their effectiveness, efficiency and sustainability. These schemes have a lot of promise but their inherent inefficiencies need to be recognized. The third is to design non-contributory schemes which the country still has to generate more experience in doing. Beyond basic health services where universal coverage is desired, other schemes will be mostly means-tested. It is important to re-emphasize that these options are not mutually exclusive. Community-based schemes have known inherent inefficiencies arising from small risk pools and moral hazard emanating from voluntary systems. Heavy fiscal burden, greater demand on administrative capacity and free rider problem beset non-contributory schemes. Thus, it is the opinion of the author that the most efficient and promising option would be expanding the social insurance programs to the informal sector workers. There is no illusion that universal coverage can be achieve in the short-run that is why the other options are needed to complement the expansion of formal sector social protection programs. As new schemes are introduced, there is also the issue of the interaction between the different schemes. A case in point is the KASAPI experience which may have been running in conflict with the indigent program of the PHIC. Finally, there maybe a case of differentiating benefit levels between paying and non-paying segments so as to encourage participation in contributory schemes which could lighten the fiscal implications of needed non-contributory schemes. This may be unacceptable for rights-based proponents, but the trade off between having some coverage which are affordable and no coverage at all is a policy choice that needs to be made.

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