

**AN ASSESSMENT OF POPULATION,  
HEALTH AND EDUCATION POLICIES  
IN THE PHILIPPINES, 1986-1988**

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## TABLE OF CONTENTS

I.	Introduction .....	1
II.	Population .....	1
	A. Background .....	1
	B. The Population Policy Statement of 1987 .....	2
	Ambiguities in the Policy Statement .....	3
	C. Medium-Term Development Plan 1987-1992 (MTDP) .....	5
	D. Updated Medium-Term Development Plan 1988-1992 .....	6
	E. Philippine Population Program Five-Year Directional Plan 1989-1993 .....	6
	F. State-of-the-Nation's Address .....	6
	G. Conclusion .....	7
III.	Health .....	7
	A. Background .....	7
	B. Intersectoral Resource Allocation: Increased Priority for Health .....	9
	C. Health Service Structure: Greater Emphasis on Basic Health Care .....	9
	D. Greater Efficiency in Resource Use .....	11
	1. Control of ARI .....	11
	2. Generic Act of 1988 .....	12
	3. DOH Experience by Input Categories .....	12
	E. Improving Access to Health Care .....	13
	1. Social Insurance .....	13
	2. Allocation of Budgetary Resources .....	14
	F. Conclusion .....	15
IV.	Education .....	15
	A. Background .....	15
	B. Intersectoral Resource Allocation: Highest Priority for Education .....	17
	C. Educational Input Mix: Improving the Quality of Basic Education .....	18
	D. Increased Public Sector Financing of Education: Uncertain Equity and Quality Impacts .....	18
	1. Free Public Secondary Education .....	18
	2. Assistance to Students in Private Education ....	19
	E. Conclusion .....	20
V.	Summary and Conclusions .....	20
	References .....	25

AN ASSESSMENT OF POPULATION, HEALTH AND EDUCATION  
POLICIES IN THE PHILIPPINES, 1986-1988\*

Alejandro N. Herrin\*\*

I. INTRODUCTION

This paper reviews the major policy initiatives of the Aquino administration in the area of population, health and education. In each of these areas, a brief description is first made of the issues that the Aquino administration was expected to confront. The paper then assesses the major policy responses to these issues.

II. POPULATION

A. Background

Recent estimates show that the rate of natural increase (the difference between the crude birth rate and the crude death rate) remained high at around 2.5 percent from 1975 to 1983. Moreover, while a noticeable decline in fertility was observed between 1970 and 1975, little progress has been made in moderating fertility since 1975 (de Guzman 1989). Recent estimates show that the crude birth rate was fairly stable between 1975 and 1983. The rate was 33.4, 34.0 and 32.8 births per 1,000 population in 1975,

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\*This is Chapter IX of a larger study which reviews the Performance of the Aquino Government in Selected Policy Areas from 1986-1988.

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1980 and 1983, respectively. Moreover, the total fertility rate was hardly changed between 1975 and 1980 (from 5.2 to 5.0 births per woman). In 1983, the rate somewhat declined to 4.5 births per woman, but this rate is still high by international standards. A major immediate factor in the slow decline in fertility is the slow increase in contraceptive use among currently married women of reproductive ages. For all methods, the contraceptive prevalence rate rose from 24.4 percent in 1973 to 37.1 percent in 1978, but declined to 32.1 percent in 1983. When only program methods are considered (i.e., methods promoted by the Commission on Population or POPCOM), the contraceptive prevalence rate was 18.4, 25.3 and 26.8 percent for the years 1973, 1978 and 1983, respectively.

The lack of significant progress in moderating fertility and population growth in the 10 years preceding the Aquino administration has been attributed to a host of factors: demographic (i.e., increasing proportion of women in childbearing ages and declining age at marriage), economic (slow growth in incomes and employment), and the failure of the Population Program to sustain earlier gains (Herrin 1988). The failure of the Population Program in turn has been attributed to the erosion of the early (1970) consensus regarding the urgent and continuing need to pursue an active national program to moderate fertility and population growth rates. Since 1975, the commitment to such a program has declined as evidenced by the declining real resources allocated to the population program. Moreover, frequent changes in the leadership of the Commission on Population (POPCOM) have led to corresponding changes in program strategies and focus. As a result, the program lacked continuity and clear direction.

While hopes were initially high that the Aquino administration would strengthen the Population Program, hopes soon faded when the government failed to quickly make a statement regarding its policy on population. Moreover, when it finally did make a policy statement on population, its position on fertility and population growth was ambiguous.

#### B. The Population Policy Statement of 1987

After a year of official silence, the Commission on Population issued in April 1987 a "Population Policy Statement." The policy states as its ultimate goal the improvement of the quality of human life in a just and humane society. It calls for a broadening of population concerns beyond fertility reduction to include concerns about family formation, the status of women, maternal and child health, child survival, morbidity and mortality, population distribution and urbanization, internal and international migration, and population structure. It recognizes that if current economic and demographic trends continue, the pursuit of alleviating poverty and improving the quality of life will become doubly difficult in the future as rapid population

growth exerts more and more pressure on scarce resources as well as on an environment that is already showing signs of strain. Accordingly, it aims to provide support to efforts directed towards achieving consistency between the country's population growth rate and the state of her resources. Such efforts will be guided by various provisions of the 1987 Constitution which include (a) the right of spouses to found a family in accordance with their religious convictions and the demands of responsible parenthood; (b) the recognition of the family as the foundation of the nation; (c) the right of families or family associations to participate in the planning and implementation of policies and programs that affect them; and (d) the recognition of the sanctity of family life and the protection and strengthening of the family as a basic autonomous social institution.

The basic principles governing population policy includes, among others, (a) orientation towards overall improvement of family welfare, not just fertility reduction; (b) respect for the rights of couples to determine the size of their family and to choose voluntarily the means which conform to their moral convictions and religious beliefs; (c) promotion of family solidarity and responsible parenthood; and (d) rejection of abortion as a means of controlling fertility.

The major program thrusts in the area of population growth consist of the following: (a) integrated approach to the delivery of health, nutrition and family planning, a subset of which is the integration of value formation, responsible parenthood and family planning as a vital component of comprehensive maternal and child health; (b) conduct of information, education and motivation in the promotion of responsible parenthood and family planning in line with other development programs, taking personal beliefs and cultural values into consideration; (c) provision of full and sustained information on medically approved and legally acceptable family planning services as the couple's basis for free choice; and (d) assurance of accessibility and availability of family planning services.

#### 1. Ambiguities in the Policy Statement

The policy encompasses a whole gamut of population-related concerns. But in doing so, it becomes ambiguous as to its position regarding fertility and population growth moderation as a component of the overall development strategy. While it acknowledges the problem posed by rapid population growth, and speaks of support to efforts towards achieving "consistency between the country's population growth rate and the state of her resources," it explicitly avoids advocating a policy to moderate fertility and population growth that includes modifying the fertility preferences of couples to complement a policy of increasing resources to support a larger population. The provision of family planning services is viewed essentially as a

health service activity rather than as a direct means to achieve fertility and population growth targets.

In view of the debate that was then raging, the population policy statement was expected to clarify the government's position on two basic issues. The first issue is whether or not an acceptable economic and social development can be achieved within a reasonable time without a moderation of the currently high fertility and population growth rates. This issue needs to be clarified because of opposing views regarding the role of population growth in development. One view being expressed by some influential segments of society says that economic and social development can be achieved even without government action in moderating fertility and population growth. This view is opposed by others who claim that moderating fertility and population growth, given the country's current socioeconomic situation, will facilitate development. While the Population Policy Statement does state that "if current economic and demographic trends continue, the pursuit of alleviating poverty and improving the quality of life will become doubly difficult in the future, as rapid population growth exerts more and more pressure on scarce resources..." such statement is not inconsistent with either of these two opposing policy conclusions: (a) that there is a need to moderate fertility and population growth as an integral component of the overall strategy for development; and (b) that there are enough ways to speed up economic and social development without directly modifying fertility and population growth trends through government action. The Population Policy Statement is not clear on which of these conclusions it accepts.

The second issue is whether or not the government is justified in sponsoring a national program of fertility and population growth moderation. This issue should also be clarified by public policy because of opposing views on the matter. While some segments of society are calling for a stronger government program of family planning and advocacy of a small family norm, other segments of society argue that the determination of the number of children should be left entirely to individual couples. The constitutional provision on the right of spouses to found a family in accordance with their religious convictions and demands of responsible parenthood is often cited to support the latter view. But does this constitutional provision, which is also adopted by the policy statement, preclude any form of government action in the fertility decision making of couples? The program thrusts of the Population Policy Statement already include some forms of government actions in the form of information, education and motivation in the promotion of responsible parenthood and in the provision of family planning services which clearly have fertility impact. But these actions can easily be justified purely on health grounds. What is not clear in the Population Policy Statement is precisely the government's position on the objective of fertility and

population growth moderation and the role that the government will play in attaining such objective beyond promoting family planning essentially as a health service.

Thus, as it now stands, the Population Policy Statement of 1987 issued by the Commission on Population does not offer much guidance to the hotly contested issues described above. By not being explicit about its position on these issues, the government's position is not inconsistent with one that favors no direct action on fertility and population growth moderation that includes modifying the fertility preferences of couples by endorsing a small family size norm. This ambiguity with respect to the objective of fertility and population growth moderation as an integral component of the overall development strategy is also reflected in the various plan documents.

#### C. Medium-Term Development Plan 1987-1992 (MTDP)

In the macro section of the Plan, the role of population growth in development as well as the broader socioeconomic determinants of fertility are recognized. Moreover, moderating fertility is an explicit objective with the target being the achievement of replacement fertility by 2010. The Plan states:

"To harness the economy's long-run capacity to achieve a better life for all, population policy will continue to promote the attainment of small family size on a voluntary basis and a reduced population growth aligned with replacement fertility by 2010. Responsible parenthood, along with efforts to practice family planning, shall be intensified. Likewise, efforts to improve women's education, health and increased socioeconomic opportunities will be pursued to promote the overall welfare of women and bring about a long-term reduction in fertility. This will promote a population level that is more conducive to development" (p. 40).

However, in the chapter on health, nutrition and family planning program, family planning is viewed mainly as a component of maternal and child health aimed at reducing infant and maternal morbidity and mortality. No attention is given to the role of family planning in reducing fertility consistent with a small family size norm. While it speaks of inculcating the value of a small family size, efforts are to be focused on adolescents rather than on couples of reproductive age. In other words, one does not find in this chapter of the Plan a clear and consistent strategy for achieving the objective of moderating fertility mentioned in the macro section of the Plan. Family planning is disassociated with efforts to inculcate the value of a small family size among couples. Moreover, the fertility targets given in the chapter appear modest (a decline in total fertility rate from 4.1 births per woman in 1987 to 3.7 births per woman in 1992) relative to the target of achieving replacement fertility

(a total fertility rate of approximate 2.1 births per woman) in 2010.

D. Updated Medium-Term Development Plan 1988-1992

The Updated Plan considers the moderation of population growth as an important element of its development strategy. Moreover, one of the objectives of the family planning program is to promote responsible parenthood and a small family norm in support of a moderated population growth. While the aims are now clear, particularly the relationship between family planning and the population growth, the fertility and population growth targets are still modest and are not related to any long-term objective such as achieving replacement fertility by 2010, as in the original Plan. For the period 1988 to 1992, population growth is expected to decline from 2.38 percent to 2.21 percent, while the total fertility rate is expected to decline from 4.0 births to 3.7 births. Such targets are likely to be achieved without a government-sponsored fertility reduction program.

E. Philippine Population Program Five-Year Directional Plan 1989-1993

Recently, a Population Program was approved by the POPCOM Board (June 1989) which consists of two sub-programs: Integrated Population and Development Program, and the Family Planning and Responsible Parenthood Program. Although the Population Program recognizes the potentially adverse impact of continued rapid population growth on development, and that the Family Planning and Responsible Parenthood Program (FPP) is a necessary component of the overall development plan in general and of the health plan in particular, the FPP is still essentially a health service program. The fertility impact of the FPP is only a by-product of reduced infant and child mortality. Moreover, no long-term fertility and population growth targets are stated from which to place the medium-term target in context. Again the medium-term targets are so modest that they could probably be achieved even without direct government programs on fertility reduction.

F. State-of-the-Nation's Address

Recently, President Aquino in her State-of-the-Nation Address considered family planning and responsible parenthood as one of three initiatives to be given high priority. However, no direct reference was given to the relationship between this priority with the objective of moderating fertility and population growth. While the policy statement was well received by those advocating a strengthening of family planning program on health and family welfare grounds, it left open the issues of the role of rapid population growth on development and the role of government in moderating such growth.



### G. Conclusion

From its insecure beginnings, because it was tied up with the issue of fertility and population growth moderation, the family planning program which has significant implications for maternal and child health (an important component of family welfare) now appears to be secure with the approval of POPCOM of the Population Program Plan. This is indeed a welcome development. What is still not clear in spite of policy statements contained in various plans and in the President's State-of-the-Nation Address is where the government stands on the issue of fertility and population growth reduction. A clear policy statement should include the relationship between continued high fertility and population growth on future socioeconomic development, a clear long-term and short-term fertility and population growth target, and a clear statement of the specific strategies and their relative impacts for achieving such targets.

## III. HEALTH

### A. Background

Recent mortality estimates suggest a slowing down of health status improvements during the most recent period prior to the Aquino administration. The life expectancy at birth rose slowly than expected from 61.3 years in 1975, to 62.3 years in 1980, and to 62.9 years in 1984. Moreover, while the infant mortality rate declined from 60.3 per 1,000 births in 1975 to 56.9 per 1,000 births in 1980, the rate rose to 62.8 per 1,000 births in 1984 (de Guzman 1989). The rise of infant mortality rate during the first half of the 1980s is not unexpected given the economic difficulties and cutbacks in government health expenditures and other social services that characterized this period (Herrin and Paqueo 1985).

Infectious and communicable diseases continued to be the leading causes of death for all ages. In 1984, pneumonia accounted for 19 percent of all reported deaths, tuberculosis for 11 percent, and diarrhea, nutritional deficiencies and measles for another 11 percent. Altogether, these readily preventable diseases accounted for 41 percent of all reported deaths; in contrast, degenerative diseases accounted for 28 percent of all reported deaths.

Infant deaths roughly accounted for 20 percent of all reported deaths. Among the leading causes of infant mortality, pneumonia appears to be the single most important cause with no clear sign of significant decline from 1978 to 1984. In 1984, 24 percent of all infant deaths were due to this disease. Other respiratory diseases accounted for 16 percent, while diarrhea,

nutritional deficiencies and measles accounted for another 17 percent. Altogether, these interrelated diseases accounted for more than half (57 percent) of all infant deaths.

The lack of significant progress in health status improvements in the ten years preceding the Aquino administration is the result of an interplay of several factors. The first is the low level of health care service utilization. In 1977, for example, only 33 percent of reported deaths had medical attendance. This figure even declined to 30 percent in 1983 (NEDA 1986a) indicating the continued lack of access to health care services by a large majority of the population. Second, fertility decline has slowed down since 1975 after a rapid fertility decline between 1970 and 1975 as described earlier. It is well known that high fertility is associated with high infant and child mortality. Third, poor environmental sanitation continued to be a major problem as evidenced by the very high prevalence of infectious parasitism among preschoolers. For example, 69 percent of preschoolers examined in a national survey were found to be positive for some type of parasite (FNRI 1984). Fourth, the prevalence of infant and child malnutrition was high and has not shown sustained reduction. Data based on national surveys show that the prevalence of malnutrition among preschoolers (based on weight-for-height measures, for example) was 13.8 percent in 1978. This rate declined to 9.5 percent in 1982, only to rise again to 15.7 percent in 1987 (FNRI 1978, 1982 and 1987 surveys). An independent estimate by the National Nutrition Council through its National Nutrition Surveillance System placed the prevalence rate at 13.3 percent in 1984. The lack of sustained improvements in the nutritional status of preschoolers is partly related to the declining prevalence and duration of breastfeeding between 1973 and 1983 (Zablan 1985).

In addition to the above proximate factors are socioeconomic factors that have indirect impacts on health status through their impacts on the above proximate determinants. These include the increasing poverty rate and slow progress in education, particularly among rural women. Estimates from NEDA (1986b) show that the poverty rate rose from 41 percent in 1971 to 59 percent in 1985. This meant that for the families involved, there is a declining capacity to obtain adequate nutrition and to have financial access to health care, among others. An important social determinant of health status, particularly of infants and young children, is the level of education of the mother. Available census data reveal that illiteracy rates remained high among women aged 25 years and over in the rural areas and that little progress in reducing such rates occurred in the 1970s. In 1980, the literacy rate for these women was only 77 percent compared to 90 percent for urban women.

Thus, when the Aquino government came into being in 1986, the country had a population whose health status has barely improved over the past 10 years due to the interplay of several

unfavorable factors. The roots of such factors may in turn be traced to the nature of public policies and priorities of the previous government. The nature of these policies and priorities had been previously assessed and their shortcomings are now well-known (see, e.g., de Dios 1984; PIDS 1986). Meanwhile, the health sector might have generated greater health impacts than it did were it not for the low priority given to health and other social services in the allocation of government resources; for the inappropriate structure of health care services that were provided relative to the persisting disease patterns; for the lack of focus on specific population sub-groups with little or no access to basic health services; and for the lack of efforts to make the provision of health care services more efficient.

Recognizing these deficiencies, the Aquino government embarked upon major policy reforms in the health sector. The major policy thrusts as indicated in the Medium-Term Development Plan, 1987-1992 include: (a) improved provision and utilization of basic health services especially for the poor, unserved and high risk groups; (b) greater emphasis on, and more vigorous implementation of, preventive and promotive health measures; and (c) increased resource allocation to the health sector and its proper and efficient allocation. These policy thrusts and strategies were reiterated in the Updated Medium-Term Development Plan, 1988-1992. Below are the major activities designed to address these policy thrusts.

B. Intersectoral Resource Allocation: Increased Priority for Health

Government resources for health have been increased under the Aquino administration. Between 1980 and 1985, for example, the budget of the Department of Health (DOH) accounted for only 4.0 percent of total government budget on the average. This ranged from 3.8 percent in 1980 to 4.2 percent in 1985. On the other hand, this percentage rose to 5.5 percent on the average between 1986 and 1989. The budget share of DOH rose from 5.0 percent in 1986, 5.4 percent in 1987, 5.8 percent in 1988, and to 5.9 percent in 1989. Earlier in 1986, the DOH succeeded in making ₱527 million of its reserves available for additional financing of its operating costs and purchase of drugs.

C. Health Service Structure: Greater Emphasis on Basic Health Care

Given the persisting disease pattern described earlier, one would expect that the structure of health care services emphasizes (a) promotive and preventive health care services (e.g., family planning, immunization, environmental sanitation, nutrition and breastfeeding); (b) basic curative care services, particularly for the control of diarrheal diseases and acute respiratory infections; and (c) health education. Moreover, such

services should have been more focused in rural areas where about 70 percent of the population lives. The public and private health care service structure that evolved in the past, however, was characterized by its heavy emphasis on hospital-based, physician-oriented, curative care which was focused mainly in urban areas. The public sector which may be expected to correct such imbalance has actually aggravated it in the recent past. Available data of public sector expenditures for health in the early 1980s reveal that such expenditures have increasingly shifted from preventive to curative care, with an increasing proportion of government health resources being spent to support public hospitals.

The following data illustrate the nature of public choices in health care in the recent past. Of the total government spending between 1981 and 1985, 57 percent on the average was spent for curative care as opposed to only 33 percent for preventive care (INTERCARE 1987). Administrative and training costs accounted for the remainder. Since 1982, the proportion of total government spending for preventive care has been declining. In 1982, this proportion was 37 percent; it fell to 28 percent in 1985. In contrast, the proportion of government spending for curative care rose from 54 percent in 1982 to 63 percent in 1985. Of total government expenditures, 65 percent was accounted for by the DOH on the average between 1981 and 1985. A closer look at DOH expenditures reveal that 22 percent was spent on the average for preventive care while 69 percent was spent on curative care. In fact, the share going to preventive care declined sharply in 1985 to only 14 percent from a level of around 24 percent in previous years, while that for curative care rose to 78 percent from a level of around 66 percent in previous years.

Recognizing the imbalance between the existing health care service structure and the health care needs of the large majority of the population, the new government adopted a more vigorous implementation of preventive and promotive health measures. Data comparable to those described above, however, are not available to determine how much shift in government or DOH expenditures went towards preventive care. Nonetheless, other indicators suggest that notable progress has been achieved in providing basic health care, particularly in the area of maternal and child health.

The maternal and child health (MCH) program involves a set of interrelated activities which include immunization, nutrition, maternal care, family planning, and the control of diarrheal diseases and respiratory infections. The most visible component of the program is the Expanded Program of Immunization (EPI). The government has committed itself to expand the coverage of immunization for the population under three years of age from an estimated 25 percent in 1985 to 90 percent by 1990. In 1988, the DOH reported that about 70 percent of eligible infants and children have been fully immunized (DOH 1988 Annual Report).

Another major component of the MCH program is the control of diarrheal diseases. In 1980, the DOH noted that intravenous therapy, anti-diarrheals, and antibiotics were still overused, while modern concepts of diarrhea management such as Oral Rehydration Therapy (ORT) were not widely practiced. The DOH, therefore, began intensifying efforts to promote techniques of diarrhea control, supported by the production of ORESOL packets. In 1988, the DOH reported that out of 726,935 diarrheal cases among children under five years of age, 91 percent were given ORESOL. The DOH also planned for the implementation of a nationwide program to reduce acute respiratory infections (ARI) among infants and young children based on a new approach to the management of ARI. This is described in the next section.

#### D. Greater Efficiency in Resource Use

Increasing the efficiency in the production of health care services requires the exploring of input substitution possibilities such that less costly inputs will be used instead of more costly ones in producing the same output. Two recent initiatives which serve to modify the input structure of health care services towards greater efficiency include an innovative program in the control of acute respiratory infections and the use of generic terminology in the manufacture, marketing, procurement, and prescribing of drugs. Moreover, data on DOH expenditures by major input categories reveal shifts in input combination with implication for efficiency.

##### 1. Control of ARI

The DOH has developed a national program to control acute respiratory infections (ARI) among infants and children. The program is based on the experience of a pilot project that has been conducted in Bohol Province since 1983, demonstrating that midwives stationed at the Barangay Health Stations (BHS) can be taught to detect and treat moderately-severe ARI cases by using prescribed oral anti-biotics combined with home management without adverse impact on the mortality of children due to ARI. The innovative approach represents a shift in treatment protocols for moderately-severe cases from expensive hospital-based treatment involving physicians, nurses, and the use of sophisticated diagnostic tests, e.g., X-rays, and expensive drugs (intravenous penicillin) to a less expensive BHS-based (complemented with home management) treatment involving midwives and the use of simple diagnostic procedure (detection of rapid breathing and chest indrawing) and less expensive drugs (oral anti-biotics).

Although data are incomplete, rough calculations by an external review team using data from field informants in 1987 suggest that the new combination of inputs is less costly (i.e., about 85 percent reduction in cost) than the previous combination of inputs in producing the same level of output. The output

under consideration is the number of moderately-severe ARI cases treated in the study area. Admittedly, the cost estimates are rough given the lack of more detailed information (unfortunately, obtaining cost information was not part of the activities of the pilot project). However, the estimates provide some insights into the order of magnitude of the benefits to be expected from such a change in input mix. The financial resource savings would in fact be larger in the sense that many moderately-severe cases that could now be easily treated in BHS would not worsen into severe cases which would be more expensive to treat.

It might also be mentioned that in the program to control diarrheal diseases, the shift from relatively expensive (intravenous therapy) and sometimes ineffective (anti-diarrheals and anti-biotics) therapy to simple and low cost modern ORT techniques (e.g., the use of ORESOL) serves to improve efficiency in resource use.

## 2. Generic Act of 1988

In 1985, about 33 percent of total private expenditures for health were spent on drugs. Private health expenditures in turn accounted for 75 percent of total health expenditures. A major reduction in health care expenditures due to drugs might be made by controlling unnecessary use of drugs and by controlling the price of drugs through greater price competition. On the latter, the Philippine government in 1988 passed the Generics Act as part of its overall National Drugs Policy. The Act provided for the use of generic terminology in the importation, manufacture, distribution, marketing, advertising and promotion, prescription and dispensing of essential drugs. It is expected that this policy will help reduce the cost of essential drugs (a major component of the total cost of health care) by giving consumers greater choice in the purchase of drugs.

## 3. DOH Expenditures By Input Categories

Since the production of health care services is a highly labor intensive activity, it is expected that expenditures for manpower services will figure prominently in the overall cost of production. However, to be effective, health manpower must be complemented with various other inputs, i.e., drugs, supplies and materials and transportation. From 1981 to 1985, the DOH expenditures for maintenance and operating expenses have been proportionally declining from 63 percent of total expenditures in 1981 to 51 percent in 1985 (INTERCARE 1987). This would suggest that the overall input mix in the production of health care services have become less efficient. This was clearly recognized by the DOH under its new leadership so that in subsequent years, the proportion of expenditures allocated to maintenance and operating expenses was increased to the extent feasible given the overall budget.

E. Improving Access to Health Care

1. Social Insurance

The public sector expenditures, which account for roughly 25 percent of total health expenditures in 1985, are financed mainly from tax revenues. User charges in public hospitals are limited and cost recovery is only less than 10 percent. On the other hand, private sector expenditures, which accounted for the main bulk of total health expenditures, are financed mostly by user charges/fees and partly by insurance from a government-sponsored social insurance scheme (Medicare). Voluntary private insurance is very limited (less than five percent of the population is covered).

A major issue confronting health insurance is its limited coverage of the needy population. Roughly 42 percent of the population is covered by the combined compulsory and voluntary health insurance schemes. Since those covered by these schemes are the employed persons in the salaried sector of the economy, they are essentially economically better off than the majority who are not covered, i.e., the unemployed and self-employed.

The current Medicare program provides health care benefits to some 21 million public and private sector employees and their dependents. The support value of Medicare, however, has declined from 70 percent in 1972 (its original support value; the insured then were required to pay 30 percent as co-payment) to only 30 percent in 1987. A major factor in the decline in the support value of Medicare is the increasing cost of health care, on the one hand, and the unchanged premium contribution structure, abuses in benefit claims and inefficient management of funds, on the other. Although data are not available to distangle their relative influences, the increased cost of health care can be traced to (a) increased demand (partly induced by the insurance scheme itself); (b) increasing labor costs, i.e., physician services; (c) changing disease patterns, i.e., increasing importance of degenerative diseases that are expensive to treat; and (d) general price movements of commodities.

To arrest the declining support value of Medicare and to restore its original support value, the government has recently increased the support value of benefits to 90 percent based on 1987 costs. Anticipating further cost increases between 1987 and 1989, this support value is expected to be at least 70 to 80 percent of current costs of hospitalization expenses. This increase in support value will initially be financed by Medicare's reserve funds and by government subsidies. By 1991, the increased benefits will be financed by increased premium contributions of Medicare members. To insure that greater benefits can be obtained from premium contributions, the Medicare Commission has also stepped up efforts to control abuses of benefit claims and to encourage better financial management of Medicare funds to realize higher net earnings.

Earlier, the DOH, in trying to increase the support value of Medicare without increasing premium contributions has experimented with an alternative financial/service delivery scheme. This scheme involves a tie-up between Medicare and a Health Maintenance Organization (HMO). The main feature of the scheme is that for an amount equal to the premium contributions of the members who elect to join the scheme (so far, the scheme is limited only to Metro Manila), the collaborating HMO agrees to provide health care services for the members and the dependents through its network of accredited hospitals and health care providers. Because the HMO assumes part of the financial risk, there is an incentive to be efficient in the provision of health care. Thus, the HMO provides not only in-patient care but also out-patient care, the latter to prevent some cases from requiring hospitalization later on because of timely medical intervention.

The experiment, limited only to Metro Manila, has been operational for only about nine months. As of May 1989, the number of members enrolled was 12,567 from 32 government agencies and 125 private companies. This number represents only 0.6 percent of total Medicare members. Available data indicate that the HMO for the same amount of resources, i.e., the value of member contributions to Medicare, was able to provide a support value of 44 percent for in-patient care instead of only 30 percent with the standard Medicare plan (prior to the increase in support value to 90 percent as described earlier). Thus, it appears that the financial scheme has the potential to provide more health care service benefits to members for the same level of financial resources.

As mentioned above, the Medicare plan covers only government and private employees. The rest of the population still have to be provided with some form of insurance coverage. While reforms and experiments are being undertaken under the existing Medicare plan, a major study is expected to be undertaken soon to identify various risk coverage schemes that will benefit the rest of the population.

## 2. Allocation of Budgetary Resources

The allocation of the increased budgetary resources for health took account of the need to shift resources towards the provision of services to the poor and underserved areas. Thus, budget increases were allocated (a) on the basis of regional incidence of poverty; (b) at the provincial level, on the basis of population, with 65 percent going to public health and 35 percent to hospitals; and (c) at the hospital level, by occupancy rate.

While the objectives of the allocation procedure are notable, its crudeness might also adversely compromise the poor and underserved population (World Bank 1988). First, there are large regional and provincial differences in poverty incidence.



The allocation of resources between provinces in a poor region on the basis of population might tend to favor better-off provinces within the region since the better-off provinces are likely to have larger population sizes. Moreover, it is possible that more resources per capita will be allocated in a rich province located in a poor region than in a poor province located in a rich region.

With respect to the allocation of resources for hospitals on the basis of utilization rates, there is a need to consider the factors affecting such rates. An underutilized facility in the province may indicate lack of demand because of poor quality of facilities and services. If so, more resources may be needed to upgrade facilities and personnel to obtain better utilization rates. On the other hand, a facility that is fully or over-utilized may not always indicate efficiency but may indicate substantial by-passing of rural health facilities because of poor service in these rural facilities. As a result, hospitals may be treating cases that could either have been preventive or treated at lower-level facilities. Under these circumstances, more resources allocated to these hospitals may only aggravate the misallocation between hospital and public health services with serious implications for public health services that should be reaching the poor.

#### F. Conclusion

The policy reforms in the health sector are a welcome development. Although information is not yet available to quantify their impacts, it is expected that they will help hasten health status improvements over the longer run.

### IV. EDUCATION

#### A. Background

A review of the long-term performance of the educational sector reveals that while the educational system has been reasonably able to absorb the rapidly increasing school-age population, this quantitative performance has been achieved at the expense of the overall quality of basic education as indicated by the slow progress towards increasing literacy rates, and by the low survival rates and achievement levels among elementary and secondary students. Moreover, serious inequalities persist with respect to educational opportunities. These inequalities arise from the large variations in the quality of elementary and secondary education within the public school system, and the lack of access by low income students to private secondary and tertiary schools.

The rapid growth of population over the past three decades meant continuous large increases in the number of school-age children. Since about 96 percent of elementary schools and 63 percent of secondary schools are public, the overall performance of elementary and secondary education is partly dependent on the priority attached by the government to basic education. The low priority attached by the previous administration to education is reflected in the low and declining level of government resources allocated to basic education relative to other sectors. For example, the share of the Department of Education, Culture and Sports (DECS) budget to the national budget which averaged around 25 percent during the late 1960s, declined sharply in the 1970s through the early 1980s so that in 1985, its share was only 11 percent of the national budget. This declining budgetary commitment to public education given the rapidly increasing numbers of school-age children and the policy of keeping enrolments high, could only result in lower quality investment per student (i.e., investment in textbooks and other instructional materials, physical facilities, curriculum development, and teacher training), thereby contributing to the generally low quality of public education.

Moreover, the budgetary allocation procedures and financing policies adopted by the DECS have contributed to the large variations in the quality of public education at both the elementary and secondary levels (World Bank 1981). Budgetary appropriations to elementary education in the past have been made in equal portions to regions on the basis of standard appropriations per student without regard to the differences in educational performance among regions as measured by large numbers of children not in school and low student achievement levels. Such a procedure effectively discriminated against regions with low educational performance, thus aggravating existing inequalities in elementary education.

With respect to public secondary education, one principal factor contributing to the highly uneven quality by type of schools is related to the way such schools were financed. The financing of public secondary schools has traditionally been the responsibility of local government units. Their financial capabilities, however, varied from area to area leading to corresponding variations in the quality of secondary schools by type of schools, i.e., national, provincial, municipal and barangay.

As with basic education, a major problem in tertiary education is the inequality of opportunity stemming largely from its "quality-tuition structure" (World Bank 1988). The high quality, low tuition public tertiary institutions are seldom accessible to low income students because of stringent admission requirements. Low income students are usually at a great disadvantage compared to high income students because of the former's generally poor preparation, having come from low quality

elementary and secondary schools. In the private sector, there is quite a large variation in quality as well as tuition. High quality private schools are also schools which charge high tuition, and hence, are less accessible to low income students. On the other hand, schools with low tuition which low income students can afford are also the schools with low quality, specializing in low-cost courses such as commerce. Thus, low income students have less access to high quality schools, both public and private. On the other hand, high income students have more access not only to high quality private schools but also to high quality and highly subsidized public schools.

Although information is incomplete, the overall quality of tertiary education, public as well as private, may have been gradually declining over the past 10 years or so. For one, it has been observed that the newly established state colleges and universities did not produce high quality programs comparable to the University of the Philippines System as evidenced by their much lower per student budget and poorer faculty profile (Tan 1983). With respect to private institutions, maintaining and improving quality programs have become increasingly difficult with the government's policy to restrict increases in tuition fees, the major source of income of these institutions. As a result, it has become difficult to raise teacher salaries and to maintain school facilities.

Given the above problems, what has been the policy responses of the Aquino administration? Described below are the major policy initiatives.

#### B. Intersectoral Resource Allocation: Highest Priority for Education

The declining budgetary commitment to education during the past administration has been reversed under the Aquino administration. In response to the constitutional provision giving education the highest budgetary priority, the budget of the DECS has been increased substantially since 1986. From its share of only 11 percent in 1985, the share rose to 13 percent in 1986, 16 percent in 1987, 17 percent in 1988, and 20 percent in 1989. Much of the budgetary increase thus far, however, has been used for increasing teacher salaries and other benefits, construction and upgrading of physical facilities and financing free public secondary education relative to other educational inputs. In spite of such large budgetary increases, the public educational system at the elementary and secondary levels still face the persisting problems of inadequate facilities and teachers in view of the continued rapid expansion of enrolment.

C. Educational Input Mix: Improving the Quality of Basic Education

A major continuing program for improving the quality of education at the elementary level is the Program for Decentralized Educational Development (PRODED). Initiated in 1981, this program focused on key activities with attention to changing the educational input mix by (a) implementing a new curriculum with strong emphasis on the 3Rs and values education; (b) retraining of teachers and school administrators; (c) production of textbooks and other instructional materials; and (d) upgrading of school facilities. Information is incomplete to fully assess the impact of PRODED. However, recent results of achievement tests which show statistically significant, although small, improvements in achievement levels in elementary education may be partly attributed to the impact of the program.

In 1989, the Secondary Education Development Program (SEDP) was implemented nationwide. Like its counterpart PRODED for elementary education, this program focuses on key activities which include (a) the implementation of a new curriculum; (b) retraining of teachers and school administrators; (c) development of instructional materials; and (d) upgrading of school facilities. Specially noteworthy is the implementation of a new curriculum since the last curriculum reform was made as far back as 1973.

Reforms in budgetary appropriations have also been instituted to give priority to areas which suffer "educational deprivation," thus correcting the bias in the past that tends to aggravate quality variations among schools.

D. Increased Public Sector Financing of Education: Uncertain Equity and Quality Impacts

1. Free Public Secondary Education

In 1988, the government adopted the policy of providing free public secondary education. Such a policy was aimed at providing low income students greater access to public secondary education. In addition, by nationalizing all public high schools, the aim of the policy was to reduce the wide variations in quality among various types of public high school.

The provision of free public secondary education is not likely to have a large impact on equity in the short run given the still low survival rates (66 percent) in the elementary level. Since those who failed to complete the elementary grades are likely to be the poorest of the poor, this means that a large percentage of the poor students would still not benefit from the free public secondary education. Those who will immediately benefit from free public secondary education will be those students who are currently in high school and potentially those

who have completed the elementary grades. The policy will also directly benefit those students enrolled in higher tuition schools, i.e., barangay high schools rather than lower tuition schools or national high schools.

The DECS expects a large increase in enrolment in public high schools as a result of the free public secondary education policy. Current facilities and teachers, however, are inadequate to meet such projected large increase in enrolment. To deal with this problem, the DECS has suggested several approaches. One is the enlarging of class sizes (i.e., 40-50 students per class in the first year and 50-60 students per class in the second to fourth year). Such approach, however, is likely to reduce the quality of instruction. Another approach is for students who cannot be accommodated in public schools to be shifted to cooperating private schools under the Education Service Contracting Program depending on available slots at a cost not higher than government schools. The number that can be accommodated, however, is not likely to be large because private schools also have limited facilities and their ability to expand facilities is constrained by their inability (as a result of policy) to raise tuition fees. Moreover, many students may not be admitted to high quality schools because of their poor preparation, and the costs in such high quality schools are likely to be higher than what the government is willing to pay.

## 2. Assistance to Students in Private Education

Faced with pressures from private schools demanding tuition fee increases in order to enable them to meet the rising cost of education, on the one hand, and from students and parents demanding a freeze in tuition fees to help them cope in these times of economic difficulties, on the other, the government adopted a policy of assistance to students in private schools. Under this policy, the government would, among others, allow tuition fee increases up to some maximum amount depending on the category of schools. Schools are categorized by tuition fee levels. To reduce the impact of such tuition fee increase on the students, the government subsidizes the student with the equivalent of the tuition fee increase, thus enabling him/her to have continued access to education at the same level of tuition fees.

The policy of subsidizing students in private schools, particularly college students, has been criticized for its lack of consideration of the economic justification for such subsidy. It has been argued, for example, that investment in higher education is highly remunerative, with the individual likely to capture much of the returns from the investment. Hence, it is argued that the student should bear the cost of such education on economic efficiency grounds. To address the equity issue, that is, to widen access to educational opportunities (the policy's primary objective), the government should instead consider more

efficient alternatives, e.g., encourage private credit markets to develop or to expand loan programs for education. The funds that are to be placed into direct subsidies to students in private education should instead be directed towards the improvement of the quality of public education.

#### E. Conclusion

The high priority currently being accorded education in terms of budgetary resources; the reforms in budgetary allocations that give priority to areas which suffer from "educational deprivation"; and the programs to increase investments in complementary inputs, i.e., curriculum, teacher retraining, textbooks, other instructional materials, and school facilities, can altogether be expected to have some favorable impact on the overall quality of basic education over time. However, such impact is not likely to be large and sustained given the fact that enrolments will continue to increase due to continued population growth (which is not being adequately addressed by current policy) while resources for education as well as for other uses are limited and will continue to be severely constrained in the years ahead by the country's heavy debt burden and uncertain economic growth.

Moreover, the policy of providing free public secondary education and the policy of subsidizing students in private schools, while designed to improve equity, are likely to impose a tremendous pressure on public resources meant to improve the quality of education, thus potentially reducing the prospect for more significant gains in educational performance in the future and resulting in an adverse impact on the poor.

#### V. SUMMARY AND CONCLUSIONS

The Aquino administration inherited difficult problems in the area of human resource development, particularly in the area of population, health and education. During the last 10 years of the Marcos administration, fertility and population growth rates continued to remain high; health status improvements have been very slow; and little gains have been achieved in improving the quality education and in reducing inequalities in educational opportunities. Part of the blame lay in the nature of policies pursued by the previous administration.

During the past three years, the Aquino administration has instituted several major policies that are likely to have significant impact on social and economic development in the years to come. What are these policies?

In the field of population, the policy of government on fertility and population growth moderation is ambiguous at best.

In POPCOM's Population Policy Statement of 1987, the statement acknowledges the problem posed by rapid population growth and speaks of support to efforts towards achieving "consistency between the country's population growth rate and the state of her resources." However, it does not come out explicitly in terms of advocating a policy to moderate fertility and population growth. This includes the modification of the fertility preferences of couples by endorsing the goals of a small family size to complement policies designed to increase resources in order to support a larger population.

The ambiguity in the government's population policy is reflected in the development plans and in the population plan where it is expected that the policy will be fleshed out. In the Medium-Term Development Plan 1987-1992, the policy is explicit about the objective of moderating fertility with a target of achieving replacement fertility by 2010. The objective is to be achieved by intensifying family planning efforts coupled with the promotion of a small family size norm, among others. But in describing these activities in another chapter of the Plan, one finds that family planning is viewed mainly as a means to improve maternal and child health while the inculcation of the value of a small family size is targeted only to adolescent groups rather than to couples of reproductive age. Moreover, the medium-term fertility targets are too modest to be consistent with the objective of replacement fertility by 2010.

In the Updated Medium-Term Development Plan, 1988-1992, the objective of moderating population growth is explicit as is the objective of family planning which is to promote responsible parenthood and a small family norm. However, while the stated aims and means are clear, there is no longer any reference to the long term objective of replacement fertility by 2010, while the medium-term fertility targets are too modest to the extent that they are likely to be achieved without a fertility reduction program.

In the recently approved Philippine Population Program Five-Year Directional Plan, 1989-1993, the potentially adverse impact of continued rapid population growth on development is recognized together with family planning program as a necessary component of the overall development plan in general and of the health plan in particular. Yet, in the description of the family planning program, one finds that it is essentially a health service program where the fertility impact is only a by-product of reduced infant and child mortality. Moreover, no long term fertility and population growth targets are stated from which to place the medium-term targets in context. Again, the medium-term targets are so modest that they could probably be achieved without direct government programs on fertility reduction.

Finally, in her recent State-of-the-Nation Address, President Aquino explicitly stated that family planning and

responsible parenthood is one of three initiatives to be given high priority. However, no direct reference was given to the relationship between this priority and the objective of moderating fertility and population growth. Given the debate on population that has raged during the past three years and the recognition that family planning can be justified solely on maternal and child health grounds, advocating family planning and responsible parenthood is no longer the same as advocating fertility and population growth moderation. Thus, while the President's policy statement was well received by those advocating a stronger family planning program on maternal and child health grounds, it still left the issues open of the role of rapid population growth on development and the appropriate role of government in moderating such growth. In the interest of transparency, the government must once and for all clarify its position on these issues.

In the field of health, the Aquino administration has embarked upon major policy reforms that are expected to have significant impacts on health status improvements. First, public sector resources for health were increased to reflect the increased priority accorded to health together with other social services. Second, greater emphasis was given to basic health care to reverse the growing relative neglect of this type of care during the past administration. A good example of such emphasis is the vigorous implementation of the Expanded Program of Immunization with the ambitious objective of expanding immunization coverage from 25 percent in 1985 to 90 percent by 1990. In 1988, the DOH reported that about 70 percent of eligible infants and children have been fully immunized. Third, innovative programs in public health such as the control of acute respiratory infections have been developed with the aim of expanding coverage at lower cost. To further reduce the cost of health care through the reduction in the cost of drugs, the government passed the Generics Act of 1988 which provided for the use of generic terminology in the manufacture, marketing, prescribing and dispensing of essential drugs. Finally, to improve access to health care, the government recently increased the support value of Medicare to 90 percent based on 1987 prices, restoring the original support value of 70 percent in 1972, which has declined to only 30 percent in 1987. Moreover, efforts are being undertaken to identify other risk coverage schemes that will benefit the rest of the population not currently covered by Medicare. Finally, the DOH is embarking upon a major review of the health sector with attention to formulating long-term policies on other areas of concern including the appropriate organization of service delivery and finance of health care, and the development of hospitals, consistent with current efforts to upgrade public health services.

In the field of education, the relative neglect of education by the past administration has been rectified by giving education the highest budgetary priority. Programs designed to improve the



quality of public education in the elementary level are being continued while a similar one for the secondary level has been initiated. These programs focus on key activities such as the introduction of a new curriculum, retraining of teachers and school administrators, production of textbooks and other instructional materials, and upgrading of school facilities. Policies regarding the financing of education have been instituted. These include the free public secondary education and the assistance to students in private schools. Both policies were designed to improve equity in access to educational opportunities, but their impacts are likely to have adverse impact on equity and efficiency. It appears that not much consideration has been made in the formulation of these policies on their less obvious efficiency and equity implications. A review of such policies and corrective measures are therefore in order. On a broader perspective, the government must confront the issue of whether the quantitative expansion of secondary and tertiary education and the increasing role of government in these levels of education are the policy directions that the government ought to take in view of the all too real trade-offs between quantitative expansion and qualitative improvements under conditions of severe resource constraints.

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