Attitudes toward Solidarity, Risk, and Insurance in the Rural Philippines

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Every managerial act rests on assumptions, generalizations, and hypotheses—that is to say on theory. Our assumptions are frequently implicit, sometimes quite unconscious, often conflicting; nevertheless, they determine our predictions that if we do A, B will occur. Theory and practice are inseparable.

—Douglas McGregor 1960

A sustainable health reinsurance system can be fashioned for the informal sector by mobilizing social and economic forces operating within individual communities. The economic analysis in part 1 of this book draws conclusions from success stories in industrial countries and failures in low- and medium-income countries. This analysis leads to the premise that decentralized development of microinsurance units, operating in a market segment left out by for-profit health insurance firms and by national schemes, can be stabilized financially through their affiliation with a reinsurance facility—Social Re (part 1, this volume; Dror and Duru 2000, pp. 30-40; Dror 2001).

Dror, Preker, and Jakab, in chapter 2 of this book, explain how the sociological dimension would theoretically affect the performance of a microinsurer. Findings of the Institute of Medicine reaffirm the active interplay of biology, psychology, behavior, and society in determining people's health attitudes. The institute further reports that, although people's attitudes and actions can readily be altered, these changes need support and reinforcement over time to guarantee better health. Attitudinal and behavioral changes are best prolonged through interventions at multiple levels, from the individual to society at large (Institute of Medicine 2001, pp. 1-1-1-8).

Efforts are required to address the psychosocial factors that influence health status, including, for example, proposing measures such as microinsurance to persuade individuals to accept a healthy way of life and permanently modify their health behavior. Microinsurance schemes provide individuals, households, and
communities mechanisms for financing their health through group risk-pooling mechanisms, leading to a sustained improvement in their access to health services.

Higher up on the social scale, well-evaluated interventions at the organizational level should be encouraged, giving credit to organizations' vital role in influencing individual behavior. Still farther up the scale, community involvement in health-promotion strategies should not be overlooked, because some disease-related factors that are beyond an individual's capacity to modify can be significantly minimized through community efforts. Community empowerment, social support, and other values that protect members from stress are strengthened through community-level interventions. Finally, interventions at the societal level recognize the role of collective organizations influencing individuals' everyday existence (Institute of Medicine 2001, pp. 1-1-1-8).

Underlying assumptions are that members' affiliation with microinsurers is voluntary (individuals can join, stay enrolled, or withdraw at will) and that microinsurers will voluntarily join Social Re. A clue is therefore needed about the considerations that shape individual and collective choices. According to one opinion, "The underlying economic motivation for joining a microinsurance unit is assumed to be a desire to seek reciprocity in sustaining risk-sharing arrangements among essentially self-interested individuals" (Dror and Jacquier 1999, p. 79). This assumption implies that joining a microinsurance unit (and Social Re) is a predictable, rational economic choice by self-interested individuals to maximize total utility (optimal choice theory), and an act of reciprocity, in which giving and getting are somehow linked. According to the utility motive, people will join if they can benefit from joining. However, considering that many people will pay a health insurance premium without getting any cash benefits (if they stay healthy), is it really clear what each individual would consider as his or her exact utility from being insured? As Herrnstein points out, because utility cannot be directly observed, it must be inferred from behavior, from the choices individuals make. Thus, utility is synonymous with the modern concept of reinforcement in behavioral psychology (Herrnstein 1997, p. 226). Dror and Jacquier mention a second motive for joining a microinsurance unit: people's desire to improve their health by controlling their living and working conditions. This control is linked to a deep-rooted human need to seek voluntary and repeated interaction with others in daily life (Dror and Jacquier 1999, p. 80). These interactions may provide material reciprocity or they may reflect altruistic, nonmaterial interactions. The three authors mentioned above suggest that, to understand how microinsurers can attract and retain their clients, they have to know what shapes their clients' behavior in their specific operating context. The same reasoning applies to a microinsurer's decision to affiliate with Social Re.

Since Social Re will be piloted in the Philippines, this examination will be done with reference to that country and culture. The rest of this chapter will provide an overview of the social and institutional structure of Philippine rural and informal society and the attitudes toward solidarity, risk, and insurance that influence choices and help shape the role of microinsurance. This role is quite different from what
could be conjured from classical economic theory on utility, as will be shown. This analysis leads to the conclusion that in the rural Philippines, the introduction of insurance and reinsurance hinges as much, perhaps more, on the structure of society than on the profile of risks and the existence of a market for insurance.

A BRIEF OVERVIEW OF PHILIPPINE SOCIAL HISTORY

Most Filipinos trace their roots to the Malay people; others are descendents of the Chinese, Indians, Arabs, Spaniards, and Americans. The location of the Philippines, an archipelago of more than 7,000 islands in Southeast Asia, explains some of these lineages. History, colonization, and cultural influences explain the rest. Seventy-six million people, scattered over half of the islands, live with great diversity in language (several dozens are known to be in use), in degree of development, and in prevalent habits. Cultural and political diversity was not always welcome, as attested by the country's history.

Precolonial Culture

Before the 16th century, the big islands of Luzon, Mindanao, and Samar were dotted with many independent villages, each a closed, self-contained political, socioeconomic, and ecological system. Each had its own way of regulating village life, mobilizing village resources, enforcing rules, and dispensing justice. Religion and mysticism largely determined village laws and norms. The system of governance varied, as did religions and beliefs.

Society at the village level was loosely stratified into three classes—the nobility, commoners, and alipin (household and farm help), with mobility across classes permitted. Despite some evidence of intervillage alliances and an awareness of commonality among the different ethnolinguistic groups, national consciousness and culture were absent.2

The Spanish Colonial Experience: Introduction of Central Institutions

The Spaniards, arriving in the middle of the 16th century, established central authority over a vast territory that had never before been bound together as one political entity. The Spanish system of governance, operating out of Manila, was designed to subdue the native inhabitants and maintain control over the territory through the combined interventions of administrative, military, and religious personnel. The Roman Catholic Church reinforced the legitimacy of the Spanish government and was equally influential in the natives' political-economic life. The Spanish governor-general was the undisputed chief executive, legislator, chief justice, and commander-in-chief of the Spanish armed forces over all the Philippine Islands. The territory was divided into geopolitical units, with regional new towns (centrally planned from Manila) serving as centers
(hamlets) for indoctrination of the natives in the Christian religion and for administrative control. In the three centuries of Spanish rule, the people of Luzon and Visayas adapted their indigenous ways to the culture of their new colonial masters, sometimes viewed as “superior” and more “refined.” A collective amnesia of precolonial cultures prevailed among the Philippine lowlanders. Villages (or submunicipal groupings) retained their Spanish appellation: barangay(s).

The American Influence: Economic Forces Gain Political Power

When the Americans arrived in the late 19th century, they retained the key components of the Spanish organization across the country. The Americans established a bicameral legislature, modeled after their own system of democracy. The newly found democratic space allowed landed local elites to access political power, thus combining their political and economic strength into semifeudal structures.

Patronage Politics and New Entrants into the Political Space

Philippine political and economic elites drew their position largely from ownership of vast tracts of land their families had accumulated during the Spanish and American eras. Land ownership was concentrated in few hands, with 14 percent of all landholders owning 64 percent of cultivated lands (Putzel 1992). A reciprocal yet unequal patron-client relationship evolved between landlords and their tenants. Tenants bore the risk of failed crops or damage from natural calamities (for example, typhoons). In the absence of any form of financial risk transfer, landlords were the only fallback to provide some protection and help. As a reciprocal measure of loyalty, tenants’ debts of gratitude to landlords (like their other debts) were paid by the labor of tenants’ sons in the landlords’ fields and their daughters’ service as domestics in the masters’ households, for little or no pay.

To this day, the old power elites dominate national and provincial elections, based on regional representation and patronage politics. Local politics is gradually changing, as well-educated, local professionals acquire some power in the provinces, municipalities, and barangays through their personal authority or entrepreneurial activities.

SALIENT CULTURAL TRAITS

Anthropologists observed that, despite a large variety of ethnolinguistic origins, some features of Philippine beliefs and practices associated with community life are commonly shared.

Jocano (1990) points to the predominance of the kin group and the peer group as bases for collective consciousness. The kin group is composed of near and distant relatives who are known to an individual. It assists the individual or group in times of need, especially when the nuclear family cannot do so. Kin groups range from a few dozen to more than a hundred in a rural community.
Membership in a peer group, loosely organized among equals, enhances an individual's social prestige and acceptance in the community. From peer groups, individuals derive psychological and economic support outside the family and kin group. Peer groups range from three individuals to a few dozen.

Gambling has been identified as a popular practice, dating to pre-Hispanic times. Trimillos (1992) explains that current rural religious practices reflect Catholic practices attributable to the Spanish, mixed with singing, storytelling, and gambling typical of pre-Hispanic Southeast Asian traditions.

Kapwa Psychology and the Corresponding Behaviors

Interpersonal relationships among Filipinos are guided by the notion of the "shared inner self," the assumption that what is good for one person is also good for others and that, conversely, what is detrimental to one person is detrimental to others. This is known in Filipino (the national language) as kapwa. A person who is kapwa with another will not act or make any decision that would offend the other person's dignity because he appreciates the other person's being as completely as if it were an extension of his own self (Enriquez 1978). Kapwa may be practiced at varying levels of depths and modes of social interaction. The first five levels apply in relationships with individuals outside the kin or peer group and can be translated as meaning that the prescribed behavior should be sensitivity, conformity, and reciprocity. More intimate relationships, especially those within the family, kin group, or peer group, would command a higher commitment to the welfare of the other.

PERSPECTIVES ON ORGANIZATIONAL BEHAVIOR IN MICROINSURANCE UNITS

The description of the social structure in the rural Philippines invites a query on the powers at play when people are free to make their own choices about insurance, for example, regarding affiliation with microinsurers.

Weber's Bureaucratization Theory versus Social Capital

The description of the formal hierarchy leads to the conclusion that political power is vertical and top-down. The president heads the central government, which enjoys the strongest formal legitimacy, followed by the provincial government with a provincial governor at its head, down to the municipality level, and ending at the barangay level. Within this structure, order is maintained through formal rules (the interest groups alluded to above wield influence mainly by interpreting formal rules to accommodate sectarian interests). Society's goals are defined and achieved through specialization, formalization, and bureaucratization. Specialists, reporting upward, are assigned functions in an organization and are compensated for their contribution to the organizational objectives defined at the higher level. Most people who live at the low end of the hierarchy perceive
this structure as remote from their reality and, in fact, it has not changed essentially since the Spanish period. The keen sense of distance and anonymity accompanying this hierarchical power structure at the grass-roots level translates into distrust of people higher up in this chain. Consequently, grass-roots populations often prefer to limit their interaction with authorities to encounters to obtain immediate and specific material aid instead of engaging in interactive and empowering involvement in decisions and priority setting. This structure, by and large, conforms to Weber's theory of bureaucratization (Silos 1991).

The formal top-down power structure does not deliver universal access to health care and has been unforthcoming in providing support to communities that tried to elaborate alternative solutions (Flavier, Soriano, and Nicolay, chapter 17, this volume). This state of affairs has added distance to a relationship between the informal and the formal sectors that has been characterized by mutual reserve and sometimes distrust. Bearing in mind the mounting empirical evidence that confidence, honest dialogue, even income distribution, social mobility, family relations, religion, and the like are indicators of economic growth, the distance between the informal and the formal sectors has more than ethnological significance (La Porta and others 1997, p. 5; Knack and Keefer 1997; Hjerppe 1998, p. 5; Rothstein 1998, p. 5; Temple and Johnson 1998; Hjerppe and Kajanoja 2000). Low trust can mean lower capacity to reverse the excluded population's unfavorable situation. This consequence of distrust can be reinforced, or abated, by trust within the community.

The few investigations into the internal dynamics of Philippine rural communities recognize that the glue binding people in these social networks and institutions is their acceptance of the prevailing social values and an attitude of trust (Albano 2000). Repeated face-to-face interactions increase mutual respect for group reputation, trust, and acceptance of norms of cooperation and mutual reciprocity. For instance, one microinsurer (Medical Mission Group Hospital and Health Services Cooperative) reported that the increased social cohesion allowed reductions in monitoring and enforcement costs. Another source reported that community-based health organizations generated high social capital—85 percent of their workers were volunteers—a resource contribution that allows these schemes to stretch their limited funds (chapter 17, this volume).

Trust and social capital have a direct impact not only on the degree of grass-roots social organization and operating costs but also on health status. A study from a remote region in Finland compared the health status of Finnish speakers and Swedish speakers. The two groups had the same health benefits from the formal system and were much alike in their classical demographic, social, and economic variables. But significant differences in variables describing social capital appeared to explain why the Swedish-speaking minority was healthier than the Finnish-speaking group (Hyyppä and Mäki 2000, p. 5). The conditional variable was trust, rather than a difference in economic or other quantifiable variable or in access to care. Thus, where affiliation is voluntary and highly influenced by...
trust, there would seem to be more reason to believe that health outcomes are linked to social capital. This conclusion provides further strong support for the hypothesis that microinsurers enjoying high social capital are more likely to achieve better results in enhancing both outreach and health outcomes in the excluded catchment population.

The Institute of Medicine (2001, p. 4-19) adds that the impact of social capital on health, as manifested in increased convenience to local services and facilities through united social action, and in supplying more direct social support, increases self-esteem and mutual respect. Even politically, policies that protect the individual's interests are followed in countries that have a strong collective philosophy.

If mutual reciprocity is an expression of social capital, might it be measured by the rate of membership retention? Committed participation in reciprocal arrangements would reduce defection on the grounds that a person has paid for a long time without receiving anything. Yet, all community schemes in the Philippines have large dropout rates. Such dropout rates suggest that Filipinos view membership as participation in a reciprocal arrangement in which gifts are exchanged. They do not view it as an insurance arrangement in which—in the long term—some lucky persons avoid risk and always pay without getting anything in return and some unlucky persons fall ill or sustain losses and repeatedly get more out than they put in. In fact, with the prospect of future repayments, members are more willing to pay than they would be without a return on their payments. Moreover, even if the time of repayment is unknown and the return gift is not of identical value to the original contribution, reciprocity would be considered balanced (Platteau 1997, pp. 767-78). Because of the informal nature of the arrangement, mutual reciprocity requires great trust, strengthened by intimate knowledge of community members, thus reducing the risks of free riding and adverse selection associated with information asymmetry. At the same time, the assumption cannot be rejected that these communities operate a solidarity scheme, founded on dissociation from the idea of risk pooling and possible income redistribution among the members—a transfer that will never be repaid. Members of such schemes in the Philippines reported satisfaction with health services and solidarity with the community as the two top reasons for retaining membership, suggesting that renewal was based on monetary and nonmonetary reasons simultaneously (chapter 17, this volume).

In light of this situation, is the underlying principle of insurance acceptable at all in the Philippine cultural context of kapwa? Kapwa may discourage individuals from acting only upon their personal utility but, in reality, can kapwa exist between one person who is repeatedly lucky and another who is consistently unlucky? Constant good or bad luck might be interpreted to signify supernatural interventions (which break down trust among peers) instead of being viewed simply as fluctuations, explained by normal statistical rules that apply equally to all members. The solution will depend on perceptions of the root cause of misfortune. Supernatural signals call for magical corrections,
whereas statistical fluctuations call for measures to narrow distributions and spread the resultant cost among all players. To explore the approach to insurance further, the next section looks at the relevance of economic thinking to individual choice in this context.

Utility Theory versus Regret and Prospect Theory

The utility (or optimal choice) theory assumes that consumers make choices with the sole objective of maximizing gains. Insurance models based on this (prevalent) assumption view the estimated probability of encountering a contingency, and its average cost, as indicators of individual willingness to pay insurance premiums to remove the risk. This theory implies knowledge of the gain (that is, comparing the cost of the premium with the probability and cost of the risk), but is there sufficient proof that people in the rural Philippines have that knowledge? A different economic theory on utility, the regret theory, holds that people want to replicate good feelings and lessen feelings of regret. When deciding whether or not to buy insurance, people usually act at the beginning of a period but assess their choice at the end, based on the outcome. The pleasure or displeasure associated with a result therefore depends not only on the result itself but also on the alternatives. If, in retrospect, an individual appears to have made the right decision, it is associated with rejoicing, while the wrong decision is associated with feelings of regret (Loomes and Sugden 1982, p. 778). Shafir, Simonson, and Tversky (1993) take this argument a step further, by claiming that decisions are reached by focusing on reasons for a selection instead of on the economics of a problem. Hence, they conclude that, often, perceived utility will not be solely or even mainly the result of pure economic gain or loss.

In their prospect theory, Kahneman and Tversky (2000) suggest a descriptive, value-based analysis of reasons individuals behave differently from what utility theory predicts when making risky choices. They also try to explain why individuals' responses to variations of probability are not linear, as utility theory would predict. Kahneman and Tversky have shown that gains and losses cannot simply be translated into discrete expressions of assets or liabilities; perception of risk influences the way decisions are fashioned or framed; and the experienced utility (the actual experience of an outcome) is a major criterion for evaluating decisions about the intensity of anticipated pleasure or pain.

Within this same concept, health behavior theory, as presented by the Institute of Medicine (2001, p. 5-4), explains why people do not persist in performing activities that inhibit or identify an illness early on. The model illustrates the role of apparent vulnerability, an individual's awareness of risk of acquiring a certain condition and its gravity, and the extent to which an individual ascribes harmful costs when illness is established, in supplying the driving force to reduce or eliminate concerns. People's actions are influenced by their perceptions of what reduces a health hazard as well as by the likely harmful results of those actions.

Organizations, both formal and informal, play a role in shaping the social and physical conditions that influence people's choices. Their influence depends on
individual "membership" as worker, patron, client, or patient. A health-conscious organizational culture would most probably implement rules and activities and focus on concerns that would encourage its members' well-being. Such endeavors would signify the organization's culture of health awareness (Institute of Medicine 2001 pp. 6-1–6-2).

Bearing in mind the attributes of Philippine society, particularly the predominant role of reciprocal interactions with peers and kin and the authority of village elites over external influences, social choice among rural Filipinos seems to be context dependent. Thus, for microinsurers, a scheme's acceptance will depend less on its objective characteristics than on whether village dignitaries promote it; whether it addresses locally recognizable problems (instead of introducing protection against unknown and unappreciated risks); and whether it offers reciprocity to all players instead of instituting a game of winners and losers. Under these circumstances, can informal risk-sharing and pooling arrangements function at all in the Philippines?

EVIDENCE FROM PHILIPPINE RURAL MICROINSURERS

To answer this question, the prevalent attitudes of several microinsurers were studied, through interviews of management, staff, and members; program document reviews; and on-site inspections of the project offices. The microinsurers visited include Bagong Silang Multi-Purpose Cooperative (BSMPC), Angono Credit and Development Cooperative (ACDECO), the Barangay Health Workers Aid Organization (BAHAO), Medical Mission Group Hospital and Health Services Cooperative (MMG), Peso-for-Health, and ORT Health Plus Scheme (OHPS).

The first item of interest was whether the microinsurers are run under informal or formal rules. As a short reminder, the traditional system bases compliance or controls on the application of implicit and customary rules for social relationships. In the Philippines, subjectivity, personalism, familism, and reciprocity are key themes that guide social relationships (Jocano 1990). When the microinsurance system leaves ambiguity or a policy gap, members intuitively assume that the customary conventions for social relationships are the default guidelines and behave accordingly. The ambiguity of customary conventions is often reduced as the organization writes down, or codifies, its conventions as formal policies to be enforced by the institution.

The limited field study suggests three prototypes for the way traditional risk-pooling systems and modern insurance systems are used in the installation of a microinsurance system:

- An organization implements the community's traditional solidarity and risk-pooling mechanisms. The scheme implemented within the context of the organization retains its traditional form, with limited written policies and relying on social conventions (for example, ACDECO).
An organization implements microinsurance modeled after modern insurance systems by applying, from inception, the microinsurer's written systems, policies, and procedures (for example, BSMPC as originally conceptualized).

Traditional systems of solidarity and risk sharing are applied within the microinsurance unit but with a conscious and progressive effort to codify the conventions. The microinsurance that evolves begins to resemble the impersonal and bureaucratic systems of the modern insurance system.

In microinsurance run by public authorities (both local government units and the National Health Insurance Program, NHIP), one problem is finding the right pitch to market the plan to targeted families. For instance, the government offered benefits to alleviate hardship among specific groups (for example, the elderly or indigents), but some families rejected these special privileges, partly because they did not want the "stigma" of being called old or being identified as the poorest in the community. In ACDECO, where the insurance program, run by informal rules, was labeled "the manager's," some members decided against participation because of the label and its possible implications in terms of formalization of the scheme's rules.

Microinsurers run by cooperatives have emphasized insurance principles (risk reduction through resource pooling, and the larger the pool the better). These microinsurers have also promoted a sense of ownership among their members. Since affiliation is voluntary, members were concerned about having to pay an additional contribution without the assurance of balanced reciprocity.

An interesting example was BSMPC. When marketed as formal insurance, the project was rejected, but the group reacted favorably when it was marketed as a form of "caring for each other" (damayan).

Microinsurers such as the BSMPC and BAHAO use more personal dynamics in their operations. Thus, informal communication such as pakiusapan is routinely practiced. Traditional microinsurers gained members' acceptance by emphasizing the principles of solidarity and sharing. In sociological terms, this is reminiscent of "Theory Y." Groups that operate a microfinance institution have already accumulated similar experiences. For instance, a borrower who does not pay his or her debts on time receives bimonthly visits from a collector to trigger hiya (fear of losing face), thus forcing the debtor to pay without resort to legal procedures.

Several of the microinsurers studied (ACDECO, BSMPC, BAHAO), especially the member-managed schemes, have modified their policies, hence their norms, over the past 12 months. Viewed in terms of sociological and insurance theory discussed earlier, a slow but steady evolution seems to be occurring from balanced reciprocity, based on informality and members' sense of ownership through strong social capital, to formal insurance, with impersonal rules, an implicit notion of winners and losers, and therefore little or no accommodation for personal hardships.
Silos (2001, pp. 2-25) proposes another possible outcome based on the “emergent” theory of Asian organizations. He explains how Asian organizations have been able to install formal codified systems while maintaining traditional values as part of the organizational culture without sacrificing organizational effectiveness. He further explains how integrating values and formal systems within the organization enhances organizational performance. In this scenario, formal insurance systems can theoretically be applied without sacrificing social capital, sense of ownership, and the solidarity ethic within the microinsurance unit.

SPIRAL EVOLUTION OF MICROINSURERS

The microinsurer’s norms and values (as expressed in written or unwritten policies) undergo processes of preservation, elimination, and innovation (table 19.1). The review of existing norms may be set in motion when questions arise about their continued relevance and responsiveness to members’ needs. A norm that outlasts its usefulness becomes obsolete or irrelevant (ACDECO). But any conflict between new and old norms generates confusion and tension, which may disrupt the microinsurance system. Unless the microinsurer’s leaders have appropriate insurance-management skills and knowledge, revision of the system may result in design flaws in the new norms and policies (MMG). However, if members perceive the new norms as an extension of the existing norms and an expression of existing values, the new norms may be easily integrated into the system (BSMPC). Members’ rejection of newly announced norms may result in dysfunctional behavior or withdrawal from active participation in the scheme.

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<th>TABLE 19.1 Microinsurers’ Spiral Learning Process</th>
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<td><strong>Step</strong></td>
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<td>1. Current norm</td>
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<td>2. Challenge of old</td>
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<td>3. Revision of norms</td>
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<td>4. Communication and implementation of new norm</td>
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(BAHAO). The new norms, if accepted, become the basis for behavior, and members recommit and conform to them.

**SECTORAL CULTURES AND RISK**

The microinsurers studied have retained some characteristics that can be traced to their origin as state, business, or civil society organizations (respectively, Peso-for-Health, ACDECO, and OHPS). Both Peso-for-Health and BAHAO were state-launched free programs that eventually started to collect contributions to supplement tax financing. Peso-for-Health used the provincial health office as its extended management system, thus giving the scheme a subsidy covering most or all of its administrative cost. OHPS was started by a nongovernmental organization (NGO) that was financed through grants and technical assistance from foreign donors but that had to resort to various revenue-generating schemes because of grant insufficiency. ACDECO is primarily a business endeavor, owned by its 2,500 members. Although conscious about break-even and cost recoveries, its main concern remains its members’ welfare.

The sectoral distinction seems to be losing some of its edge in the rural Philippines. With low effective demand for privately provided services, businesses tend to engage in social causes; low revenues through taxation push government agencies to charge user fees; and drying up of donations for NGOs have accelerated entrepreneurial ventures of civil society organizations (Alampay 1999).

**STAKEHOLDER INTEREST AND RISK**

Microinsurers can also be looked at according to their corporate character. Three distinct microinsurance options are present in the rural Philippines: consumer-driven (ACDECO, BSMPC), provider-driven (MMG), and fund manager-driven (Peso-for-Health). The three models differ in the degree of voice the members can exercise and their impact on decisions.

Consumer-driven microinsurers give priority to solidarity and members’ welfare. Unlike other schemes where members pay the projected premium, BSMPC collects contributions only for hospitalization. Members agree on the contribution amount and the other fund guidelines. All members seem comfortable with this form of reciprocity, which is at odds with the notion of insurance but perfectly in line with the balanced-reciprocity theory. The practical difference between these two economic theories would depend on the frequency of risk events that call for contributions under the reciprocity model. The higher the frequency, the more similar is the outcome of applying one or the other.

Consumer-driven microinsurers that have evolved from other economic activities (for example, microfinance) have experience with profitability as a key to sustainability. ACDECO is a good example of a group whose common denominator is
its savings and lending operations. Its efficient and sophisticated financial services have influenced its approach to operating a microinsurance unit. The other aspect of multifunctional schemes is that the balanced reciprocity of participating in microinsurance may be perceived as being gained through benefits from other services that provide protection against other risks. Alternatively, revenues from other operations may be used to subsidize social services (for example, ACDECO), or a limited and less costly activity that can reduce health risk exposure (for example, health educational programs run by BAHAO resulted in improved health behaviors by members, which reduced health expenditures).

MMG, a cooperative of health service providers, is a provider-driven microinsurer. Its members consider MMG a third party and do not feel a sense of ownership over the funds or a sense of solidarity with other insureds. The dominant logic for enrolling in a microinsurance scheme is to derive maximum utility from its members' premium payments.

Peso-for-Health has been considered fund manager-driven, since its managers have the authority to decide on the rules of the scheme. (Since it operates out of a hospital, however, it could be viewed as a provider-driven scheme.) Conceived as a way of enhancing outreach as well as income from a very poor population, this project generated new income for the hospital and, for clients, a more attractive payment scheme than user fees. The scheme can offer benefits at extremely low cost (5 or 10 pesos per family per month), partly because hospital personnel handle the plan's administration, and the hospital absorbs the full cost.

Figure 19.1 depicts the different levels of consciousness of the individual (top half) and of the group (bottom half). The sociocultural realm on the left and the economic realm on the right reflect the scale of group consciousness as sociocultural needs and economic needs are addressed. The collective here is the kin group or peer group, less formalized than an organization.

The heavy line delimiting the organizational and supraorganizational levels reflects the psychological barrier that Philippine organizations have to transcend to pursue interorganizational (supraorganizational) interests collectively. This supraorganizational level is theoretically especially difficult to attain because of the small-scale kin and peer-group consciousness that predominate in Philippine social relationships.

In the figure, BSMPC and ACDECO operate in most quadrants because they are member-driven: their members are conscious of organizational interests and pursue them both as members and as an organization. ACDECO is in the supraorganizational level (lower left quadrant), because it has begun to engage in supraorganizational pursuits through a national confederation of cooperatives.

Member-driven BAHAO's profile is similar to BSMPC's and ACDECO's but closer to the collective level because it has not yet developed the more sophisticated organizational system.

The members in Peso-for-Health and OHPS function mainly as individual clients and consumers, hence their location in the individual level in Quadrant B. Logic or participation in these two schemes closely approximates that described
by utility theory. MMG is also in this quadrant because its large membership (32,000 individuals) dilutes the individual sense of solidarity and ownership.

**CONCLUSIONS**

The social and institutional structure of Philippine rural and informal society explains why a single-insurer model is impractical without central government funding for universal access to health care. In the absence of such top-down engagement, single communities at the barangay and subbarangay level use such traditional mechanisms for dealing with risk as kapwa and damayan, based on balanced reciprocity.
The small group size, a handicap in terms of insurance calculations, is an asset in terms of social capital. Repeated social interactions among group members reduce classical market failures, such as free riding and moral hazard, linked to insurer asymmetric information. Small size also increases trust among group members who know each other, a proven asset for improving both health outcomes and scheme management efficiency.

In deciding whether or not to join a microinsurance scheme, individuals in the rural Philippines are likely to be influenced by the views of the group, their own past exposure to risk (rather than abstract risk assessment), and their expectation of reciprocity in return for payment of the contribution. This fundamental attitude toward risk is enhanced by traditional cultural traits such as kapwa. Neither the microinsurer's decisionmaking style (member-driven, provider-driven, or fund manager-driven), nor its ownership (public, NGO, or private) seems to affect these criteria significantly. Nor is there any evidence to support the assumption that optimal or rational choice theory can explain an individual's decision to affiliate and retain membership in a microinsurance scheme. Individuals cannot exercise informed choice without knowing their risk probabilities or their expected cost. At the same time, the prevalence of betting and gambling suggests that people play winner-loser games when they know the cost of a loss in advance and can afford it, even when they do not know the probability. This social custom suggests that if the cost of the insurance premium is perceived as affordable and the risk is better defined, people can be persuaded to buy insurance.

Members are more likely to join a microinsurance scheme if they can participate in other economic activities within the same group. The availability of multiple activities increases the likelihood that a member will obtain the desired return (reciprocity) for contributions paid. People are also more likely to join if their past experience with risk has been negative.

In the process of changing social attitudes to accommodate insurance activity, the roles of group consensus and the village elite are decisive. Communities that have had experience with microfinance give more attention to solvency, profitability, efficiency, and good management than do communities unfamiliar with these ideas. The rules underlying risk transfer are more difficult to modify, however, and in their redesign will have to accommodate mechanisms favoring reciprocation. One such option might be to link the introduction of Social Re with benefit enhancement, offering benefits with high externalities but significant short-term effects. Such a policy can also create acceptance by discounting the reinsurer's premium cost.

Last, there is no evidence that reinsurance would be harder to introduce than first-line insurance. Since the prime motivation is group influence and reciprocity rather than individual risk avoidance, the reinsurance facility could be introduced by targeting communities that have experience with financial accounting and mediation (mainly through functioning microfinance institutions). Such communities will have developed both a concern for profitability and modalities
for cross-subsidization across their different economic activities (for example, by subsidizing health insurance premiums from earnings on their savings).

NOTES

1. *Social Re* is the name of the first pilot reinsurance operation for community-financed health schemes. Part 4 of this book provides more details on the preparations for such a pilot and the conditions under which it could be operated.

2. Prior to the Spanish colonization, no predominant cultural group had emerged in the Philippines as the political and economic elite. In this, the Philippines was unlike its Asian neighbors, Imperial China, Thailand (the Chakri dynasty), or Indonesia (the Sri Vijaya and Majapahit empires).

3. Some Western writers have described the dynamics of rural politics by reference to the “cacique politics” framework of analysis in the South American countries (McCoy and de Jesus 1998).

4. Transaction/civility (pakiktungan); interaction with (pakikisalamuha); joining/participation with (pakikilahok); in conformity with/in accord with (pakikibagay); and being/go ing along with (pakikisama).

5. Being one with (pakikiisa); getting involved (pakikisangkot); being in rapport/understanding/acceptance of (pakikipagpalagay/pakikipagpalagayang-loob).

6. BSMPC is a 40-member farmers' cooperative founded in 1996. It purchases farm inputs in bulk and lends them to its members. Its microinsurance unit was started in 1999 and is based in Nueva Ecija.

7. ACDECO is a community-based cooperative founded in 1966. Its microinsurance unit was started in 1988 and now has 2,500 members. Its activities include lending and deposit taking and running other coop enterprises such as a printing press, a grocery, and a bottled-water store. It is located in Rizal Province.

8. BAHAO is a 100-member association of village health workers, mostly women, organized in 1998. Besides its microinsurance activities, it runs income-generating projects such as medicinal soap-making and iodized salt production. It is located in Cavite Province.

9. MMG, a cooperative of health professionals, runs a coop-owned hospital and a coop-microinsurance unit. Since its founding in 1991, it has established more than a dozen branches all over the country. MMG started its microinsurance unit in 1991, which by 2001 had some 32,000 members. MMG is located in Davao City.

10. Peso for Health is a government-initiated program attached to the district hospital. Its microinsurance unit, located in Negros Oriental Province, has some 3,000 members.

11. OHPS, an NGO-driven microinsurance unit, started in 1990 with 6,250 members. OHPS, located in La Union Province, also runs early child development programs.

12. *Personalism* is an individual's special concern for the welfare of another.

13. *Familism* is the habit of emphasizing the interests of the family or kin group.

14. Damayan also refers to a traditional solidarity mechanism where community members contribute cash to a deceased neighbor's surviving dependents.
15. Pakiusapan means talking issues over discretely and personally before resorting to coercion or litigation.

16. Douglas McGregor (1960) provides two sets of sociological assumptions underlying rulemaking at work: Theory X presents people/workers as lazy, relatively unintelligent, and prone to avoiding work if they can. Under those assumptions, managers must install rigid control systems and use rewards, punishments, and coercion to meet productivity targets. Theory Y presupposes that workers naturally enjoy work and, if given an opportunity, they will be productive, since doing their jobs well gives them a sense of fulfillment. The manager's role in this scenario is to provide an environment that fosters cooperation and nurtures workers' enthusiasm. Insurance schemes often assume Theory X and thus use control mechanisms, incentives, and disincentives to reduce moral hazard and adverse selection.

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