compensation payments to 2.2 million veterans with service-connected disabilities, effective August 1, 1972. For those who are 100-percent disabled, a flat increase of $45 a month (from $450 to $495) is provided. For those less than totally disabled (10–90 percent) the increases range from $3 to $25 a month. The additional payments for the more seriously disabled veterans (such as those with multiple amputations) have also been increased, from $56 to $78 a month. Proportionate increases are provided for dependents of a veteran whose disability is rated at 50 percent or higher. The last increase in veterans' compensation payments was effective July 1, 1970.

Effective July 1, 1973, differences between wartime and peacetime compensation rates will be eliminated. For almost 40 years the rates have been different, and since 1948 peacetime veterans have been receiving 80 percent of the amount that wartime veterans receive.

The law authorizes, for the first time, a clothing allowance of $150 per year for service-connected disability of veterans who must wear or use a prosthetic or orthopedic appliance, including the use of a wheelchair. These devices cause unusual wear and tear on wearing apparel.

Another change in the law abolishes the withholding of compensation of unmarried veterans while they are in a hospital or domiciliary. Previous law provided that a veteran's compensation or retirement pay would be reduced after the first 6 months of treatment or care to the greater of $30 a month or 50 percent of the benefit, with the amount of the reduction to be paid in a lump sum upon release of the veteran from the institution.

The law extends to the widows of Spanish-American War veterans the same option available to widows of veterans of other wars to elect to receive their pension under the "new" pension system adopted in 1959 or to remain under the "old" system. Under that legislation, most veterans and survivors of veterans on the rolls before July 1, 1960, could continue to receive the flat-rate monthly pensions under the old system or they could receive pensions under a new system, which relates the amount of pensions inversely to income. Spanish-American War widows can, thus, choose the pension system that will be to their advantage.

Social Security Abroad

Philippine Medical Care Act*

After many years of public pressure for a national health insurance plan to complement the already existing sick pay provisions for employees, the Philippine Government enacted the Philippine Medical Care Act of 1969 (Republic Act No. 6111). The legislation provides for a comprehensive and coordinated (Government and private) medical care program to be introduced gradually, preserving the insured's freedom of choice of physician and hospital. Identical care is foreseen under both parts of the program. Program I covers private and public wage earners and salaried employees who are presently insured under the social security system (SSS) and the government service insurance system (GSIS). Program II will eventually cover everyone else. Thus the 1969 legislation aims at providing universal medical care coverage.

Implementation for both programs had to wait until the appointment of a Medical Care Commission by the President, which was done in August 1971. Program I was put into effect on January 1, 1972, and Program II is expected to become fully operational by 1974. The collection of contributions from employed persons and their employers started on January 1, 1972, and the first payments to the providers began April 1.

COVERAGE AND QUALIFYING CONDITIONS

At the present time, all persons who were compulsorily covered by the Philippine social security system and the government service insurance system are automatically insured under the Medical Care Act.[1] Covered are wage earners in the private and public sector with the exception of (1) agricultural workers and share or leasehold tenants who are not paid a regular daily wage or base pay and who work less than 6

* Prepared by Paul Fisher, Chief, International Staff.

[1] For the preexisting cash sickness benefits, see *Social Security Programs Throughout the World, 1971* (Research Report No. 31), Office of Research and Statistics, pages 178–179.

months a year, (2) domestic servants, (3) casual employees, (4) family workers, and (5) certain employed students and student nurses. At present the medical care system covers 23.5 percent of the economically active population.

Three monthly contributions within the 12 months before the first day of confinement are required. Twelve monthly contributions are needed for deferrable operations such as herniotomy, hemorrhoidectomy, and adenoidectomy.

BENEFITS

The Medical Care Act directly compensates the providers of hospital, surgical, and medical services according to a fixed schedule. Hospitals receive payments of up to 12 pesos[2] per day for not more than 45 days in each calendar year and are paid up to 150 pesos for such services as laboratory examinations, X-rays, and drugs. Reimbursable surgical charges are up to 50 pesos for minor operations, up to 150 pesos for operations of medium complexity, and up to 350 pesos for major surgery. Reimbursable physician charges during hospitalization cannot exceed 5 pesos for visits by practitioners or 10 pesos for visits by specialists, and they may not total more than 100 pesos for any single period of confinement. The insured has free choice of both doctor and hospital and can have his prescriptions filled either by the hospital or by a retail drug store.

The Medical Care Act excludes charges for cosmetic surgery or treatment, routine dental services or surgery, psychiatric care, diagnostic testing, and normal obstetrical services.

FINANCING

The system is financed by equal employer and employee contributions of 1.25 percent of covered wages. For this purpose six wage classes—the first one 0–49.99 pesos per month and the last one from 250 pesos to the ceiling of 300 pesos per month—have been established on the basis of wages existing in 1966 when the average monthly wage and salary was 219 pesos. Five percent of the insured at that time had incomes below 50 pesos a month; an additional 13 percent had incomes below 100 pesos. Although prices have risen by at least 50 percent between 1966 and 1971, wages have not risen correspondingly and the legal minimum wage of 8 pesos per day has not changed. At present, the average wage is estimated at 225 pesos.

The 300 pesos ceiling on contributions under the Medical Care Act is lower than the ceiling of 500 pesos per month for SSS contributions. The smaller amount seems to have been set with the low income of the nonemployed in mind. The amount of the ceiling will be subject to review as soon as Program II becomes operative. The contributions are remitted by the employer to SSS and GSIS and are kept by these organizations in separate health insurance funds.

ADMINISTRATION

The SSS and GSIS are charged with the day-by-day administration of the program. Policy is set by the 9-man Medical Care Commission, which consists of four members appointed by the President—a Chairman, the Administrator of the Commission, two representatives of the public—and the Administrator of SSS, the General Manager of GSIS, and one representative each from the Philippine Medical Association, the Philippine Hospital Association, and the Ministry of Health. Since by law at least five and preferably six of the members of the Commission must be doctors or representatives of the hospital administrators, the cooperation of these two groups is assured. One of the first acts of the Medical Care Commission was to divide the most commonly performed surgical operations into three groups—minor operations, operations of medium complexity, and major surgery—for compensation under the program.

FUTURE DEVELOPMENTS

The 1969 law provides for a supplementary plan for the medical care of the dependents of those insured under the SSS and GSIS and for

(*Continued on page 25*)

[2] One peso equals 15.5 U.S. cents.

TABLE M-3.—Selected social insurance and related programs: Beneficiaries of cash payments, 1940–72

[In thousands For explanatory footnotes on programs, see table M-1]

At end of selected month	Retirement and disability					Survivor				Railroad temporary disability [4]	Unemployment		
	OASDHI [1]		Railroad [1]	Federal civil service	Veterans	OASDHI	Railroad	Federal civil service	Veterans		State laws [5]	Railroad [4]	Training allowances [6]
	Retirement [2]	Disability											
December:													
1940	148	....	146	65	610	74	3	....	323	....	667	74	....
1945	691	....	173	92	1,534	597	4	(7)	698	....	1,743	13	....
1950	2,326	....	256	161	2,366	1,152	142	25	1,010	32	838	35	....
1955	5,788	....	427	234	2,707	2,172	206	74	1,156	36	912	48	....
1960	10,599	687	553	379	3,064	3,558	256	154	1,393	34	2,165	102	....
1961	11,655	1,027	567	408	3,137	3,812	262	167	1,547	31	1,993	75	(7)
1962	12,675	1,275	585	438	3,177	4,103	270	182	1,653	30	1,585	59	3
1963	13,262	1,452	594	465	3,195	4,321	278	197	1,750	31	1,609	49	21
1964	13,697	1,563	600	494	3,204	4,539	286	214	1,848	29	1,351	41	51
1965	14,175	1,739	620	522	3,216	4,953	291	227	1,924	25	1,035	30	75
1966	15,437	1,970	630	564	3,194	5,360	299	240	1,995	23	936	18	65
1967	15,907	2,141	641	588	3,175	5,659	309	258	2,077	21	989	39	67
1968	16,264	2,335	647	613	3,171	5,963	318	274	2,151	25	941	19	61
1969	16,595	2,488	651	636	3,179	6,229	321	288	2,208	23	1,084	16	52
1970	17,096	2,665	653	697	3,210	6,468	326	308	2,301	22	2,045	21	60
1971	17,660	2,930	660	747	3,251	6,700	330	324	2,365	20	1,500	38	70
1971													
May	17,270	2,773	658	708	3,216	6,576	329	316	....	21	1,908	28	73
June	17,332	2,788	656	711	3,222	6,582	330	315	2,333	24	1,858	32	74
July	17,411	2,799	656	738	3,228	6,571	329	317	....	21	1,603	45	73
August	17,515	2,832	657	741	3,233	6,599	330	318	....	22	1,625	47	69
September	17,579	2,882	660	742	3,236	6,610	330	319	2,297	21	1,469	76	69
October	17,608	2,890	659	744	3,241	6,646	329	321	....	21	1,407	56	70
November	17,626	2,904	661	746	3,295	6,673	331	323	....	24	1,531	49	70
December	17,660	2,930	660	747	3,251	6,700	330	324	2,365	20	1,784	38	70
1972													
January	17,721	2,952	659	750	3,243	6,720	331	326	....	24	2,298	39	64
February	17,768	2,971	659	752	3,242	6,747	332	327	....	23	2,281	30	61
March	17,710	3,002	659	755	3,247	6,758	332	329	2,371	23	2,243	29	68
April	17,774	3,028	659	758	3,255	6,783	333	331	....	20	1,926	23	68
May	17,811	3,053	658	763	3,261	6,797	333	333	....	21	(8)	18	57

[1] Includes dependents

[2] Beginning Oct 1966, includes special benefits authorized by 1966 legislation for persons aged 72 and over and not insured under the regular or transitional provisions of the Social Security Act.

[3] Monthly number at end of quarter.

[4] Average number during 14-day registration period.

[5] Average weekly number For programs included see table M-1, footnote 10

[6] Unemployed workers in training under the Area Redevelopment Act of 1961 (November 1961-June 1966) and the Manpower Development and Training Act of 1962.

[7] Less than 500

[8] Data not available.

Source. Based on reports of administrative agencies.

PHILIPPINE MEDICAL CARE ACT

(Continued from page 22)

the inclusion of all medical care services. Until then—presumably 1974—existing government facilities carry the responsibility for the health coverage. To assure the necessary hospital facilities, private hospitals and clinics will set aside at least 20 percent of their total bed capacity in return for a subsidy of 10 pesos per bed. To encourage the construction of new hospitals, particularly in rural areas, government financial institutions, including SSS and GSIS, are to give preference to long-term hospital loans and offer favorable interest rates. Existing government hospitals are to establish revolving funds for the upgrading and expansion of their facilities.

Philippine residents will be registered and receive medical care cards upon payment of locally determined assessments to local government units. These assessments will be matched by a national government contribution and will be accumulated in community mutual health funds. Within their respective jurisdictions, provincial, city, municipal, and community medical care councils will control these funds, pay doctor and hospital bills, supervise the program, insure homogeneous distribution and maximum utilization of medical facilities, and adjudicate claims.