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**Working Paper**

## Health-Seeking Behavior of Urban Poor Communities

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Philippine Institute for Development Studies

## Health-Seeking Behavior of Urban Poor Communities

*Olympia Malanyaon*

DISCUSSION PAPER SERIES NO. 95-13

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Baseline Policy Research for Health Care  
Financing Reforms  
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SPECIAL BENEFICIARY GROUP:  
THE URBAN POOR

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## EXECUTIVE SUMMARY

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This study, employing the participatory action research (PAR) approach, sought to determine the socioeconomic conditions in relation to health care of the urban poor communities of Apelo Cruz, Pasay and Bagbag, Novaliches. In seeking to answer this problem, this study looked into the demographic characteristics of the two communities, their perceptions and attitudes towards health care and their health-seeking behavior, and their willingness and readiness to participate in risk-sharing on health maintenance.

Using random and purposive sampling 201 individual interviews (100 in Apelo and 101 in Bagbag) and six focus group discussions (three for each community) were conducted by the trained local research teams with the assistance of the project facilitators. A preliminary social investigation was conducted by the project facilitators prior to the selection of the communities to be studied and of the local research team members.

The research team of Apelo Cruz was composed of seven members while the research team of Bagbag, of eight members. The members were mostly the community leaders themselves. The research teams participated in formulating the research design and instruments, gathering and analysis of data, and presentation of results to the communities.

The findings revealed that the two urban poor communities studied had household heads who were relatively young, had reached or finished highschool, and had been in the area for more than 3 years with no definite plans of migrating to another place. With an average family of four, the average monthly income was P4,000 with average monthly expenditures of P4,500.

Health was a priority concern among the people. The people's attitude towards health was more crisis-oriented, curative rather than preventive. They expressed more confidence in the knowledge and expertise of medical professionals rather than in traditional healers or "herbolaryos". They would go to great lengths -- selling or pawning valuable properties or borrowing money even at usurious rates -- just to finance their health needs.

The respondents also expressed preference for private medical facilities and personnel over government ones given the perceived inadequacy and incompetence of the latter. Several active organizations had been assisting the communities in their problems such as on land tenure and medical expenses.

The respondents expressed willingness to participate in a health care financing scheme (HCFS) provided the terms were acceptable to them. However the sources of funds which they cited to pay for an agreed upon premium were rather unrealistic -- windfall income from small businesses or donations from the government and private institutions. Nevertheless, some were willing to cut down on their vices such as smoking so that they could have money to pay for the premium.

Factors identified that could facilitate the implementation of a successful HCFS included: the "paluwagan" system patronized by the people; the value of amor propio; positive attitude towards

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health and medical doctors and utilization of health care facilities, and Medicare; the people's willingness to work for services rendered them; the extended family prevailing among the people; and the existing organizations in the communities.

On the other hand, the factors identified that could hinder the HCFS implementation were: the people's crisis-orientation towards health; misconceptions about rational health care; lack of confidence in government health personnel and facilities; ideological leaning of some existing organizations in the communities; lack of technical skills and capability of the people; lack of regular source of income; and poor living conditions.

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## I. INTRODUCTION

Poor health remains a leading problem among the country's urban poor population. The leading causes of morbidity and mortality such as all forms of tuberculosis, bronchitis, pneumonia, measles, diarrhea and malaria are prevalent in urban poor communities.

Statistics show that the Philippine's urban poor population is estimated at 11 million with the greatest concentration in Metro Manila, where 3.5 million are spread out in 415 urban poor communities. Of the 3.5 million, 1.9 are squatters living in areas such as esteros, sidewalks, shorelines and riverways. Such areas lack safe drinking water or ample water supply for hygienic waste disposal system.

Aside from unsanitary living conditions, poorly distributed and often substandard health services and facilities cause poor health among the urban poor. Likewise, the spiraling costs of hospitalization, medical consultation and medication prevent the poor from seeking health services. Moreover, the poor's misguided health practices and their lack of knowledge and information on health promotion and disease-prevention contribute in worsening their health situation.

The state-run health care delivery network which provides primary to tertiary medical care is beset with budgetary constraints, thus the inadequacy in health care facilities and supplies to meet the majority's needs. An ordinary family person who gets a daily minimum wage of P127.84, more often than not, opts to lay ill in bed for days rather than spend around P82.50 for a simple medical consultation or a minimum of P96 a day and a night in a government hospital room or P396 in a private one.

On the other hand, the attitudes of most Filipinos towards health are characterized by: 1) a tendency to delay or ignore preventive health care measures until illness becomes evident; and 2) a dependency on doctors even for minor complaints make the treatment of diseases more crisis-oriented rather than preventive.

Both the government and the private sectors have done little to make quality health care more accessible to urban poor families. A lack of affordable health care financing schemes designed especially for the urban poor is prevalent.

The government's health insurance program, Medicare, is enjoyed only by the company employees and those self-employed who can afford to pay the monthly premiums. Despite the implementation of Phase II of Medicare which increases the benefits from 30% to 50% of medical expenses, low income families, especially those without regular paying jobs, still rely on their meager financial resources to meet the exorbitant cost of hospital care.

Likewise, the prevailing private health insurance packages are not encouraging. These insurance

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packages similarly require regular but higher premium payments which are affordable only to middle and higher income families.

The gravity of the urban poor's plight in the area of health and the need to address it cannot be overemphasized. It clearly demands for more genuine initiatives and reforms on the part of both the government and the private sectors. It cannot be solved merely through improved technique. Any lasting and effective solution must first deal with the country's socioeconomic structures which are at the root of most of the nation's ills.

The Department of Health's (DOH) present initiatives in clarifying its policy direction and formulating policies in health care financing to accommodate special groups such as the urban poor are a step towards implementing genuine reforms. It is hoped to open more avenues in providing quality health care to the poor.

Part of these initiatives of the DOH is the formulation of a research agenda for a health financing strategy. The conduct of baseline studies, including this particular study, aims to build a common base of information for health financing and health insurance. With the baseline studies, the DOH hopes to set strategic options for adopting, formulating and implementing a more viable national health insurance system. The options will then guide the development of national consensus and action.

Given the DOH's goal of coming up with a more viable health insurance system for the poor, this study attempts to present a clearer picture of the socioeconomic situation of two urban poor communities in Metro Manila, namely: Barangay Apelo Cruz in Pasay City and Barangay Bagbag in Novaliches. Likewise, this study discusses the two communities, perception and attitudes toward health care and their willingness/readiness to participate in health care financing schemes such as Medicare.

This study does not attempt to identify any viable health care financing scheme for the urban poor because identifying such requires a separate study. However, while it concentrates mainly on providing baseline information as regards the two communities, it tries to present various factors that have to be considered in coming up with a more viable and substantial health care financing scheme.

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## II. STATEMENT OF THE PROBLEM

### STATEMENT OF THE PROBLEM

Given thus, this study attempts to answer the following: "What are the socioeconomic conditions in relation to health care of the urban poor communities of Apelo Cruz, Pasay and Bagbag, Novaliches?"

### STATEMENT OF THE OBJECTIVES

Generally, this study wishes to ascertain the socioeconomic conditions in relation to health care of the urban poor communities of Apelo Cruz and Bagbag.

Specifically, this study aims to:

1. ascertain the demographic characteristics of Apelo Cruz and Bagbag;
  2. determine the perceptions and attitudes of Apelo Cruz and Bagbag towards health care;
  3. identify the health-seeking behavior of Apelo Cruz and Bagbag; and
  4. ascertain the willingness and readiness of Apelo Cruz and Bagbag to participate in risk-sharing or cooperative programs on health maintenance.
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### III. STUDY FRAMEWORK

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This study adapts the framework for the development of terms of reference for a study on health seeking patterns of special beneficiary group formulated by the DOH. The framework identifies three key participants in the health care financing scheme, namely: the beneficiaries, the providers, and financial intermediary or funders.

The framework states that the beneficiaries and the providers are directly linked in self-financing schemes. The types of health care services rendered by providers are largely dependent on the capability of the beneficiaries in financing such services. Likewise, the types of health care services availed of by the beneficiaries are dependent on their capability to finance their health needs. Financial intermediaries come into the picture to reconcile the inability of the beneficiaries to finance their health needs and the inability of the providers to shoulder the cost of the services needed by the former.

This study agrees that the financial capability of the beneficiaries largely determines the type of health services they receive or patronize. However, it equally believes that the beneficiaries' sociocultural conditions and characteristics, their perceptions and attitudes towards health care, influence their health-seeking behavior and the type of health services which they allow themselves to receive and are willing to spend their resources on.

For instance, if the culture of the beneficiaries dictates that traditional healers or "herbolaryos" are more knowledgeable and credible as regards a person's health, then the former will prefer seeing these herbolaryos to medical professionals. On the other hand, if experience tells these beneficiaries that medical professionals are more able to cure their diseases/illnesses rather than the traditional healers, then they will seek the former's services rather than the latter's.

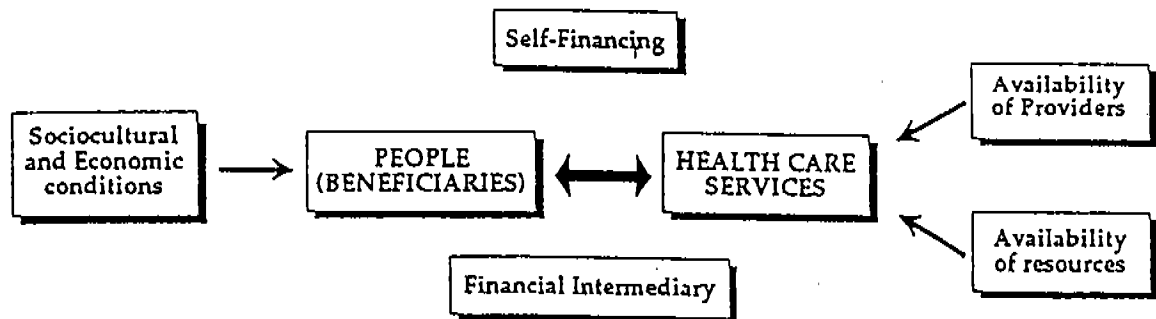
Likewise, accessibility to health care facilities and services provided by both government and private sectors influences the health-seeking behavior of the beneficiaries as well as their pattern of health care spending. For instance, if a private clinic is more accessible to the community rather than a health center, it is more likely that, even if it means higher costs, the community will go to private clinics rather than to centers.

Just as the socioeconomic conditions and characteristics influence the health-seeking behavior of the people in the community, so also the qualities and the capability of health care and the availability of health care resources determine the type and quality of health care services available to the people. For instance, a competent and poor people-oriented health service provider means quality health service at a cost affordable to the poor. In the same manner, adequate health care resources equal complete and modern health facilities equal quality health care services.

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Given thus, the study works under the following framework:

**FIGURE 1**



Aside from accepting the framework developed by the DOH, this study also borrows concepts from the framework of the participatory conscientizing research or better known as the participatory action research (PAR) wherein the participation of the people or the potential beneficiaries themselves in the conduct of the study is encouraged. Participatory research aims to stimulate the underprivileged in developing a more critical understanding of their reality and enhancing confidence in their abilities to solve their problems. The PAR approach enables the people/beneficiaries to own the results of this study and decide and take action based on the results.

Ideally, PAR should involve the community in all phases -- from the conceptualization of the research to the formulation of the research problems, objectives and design to the actual conduct of action based in the results of the study. However, more often than not, conditions in the field hinder the participation of the people in all the phases of the PAR. Thus, the people's participation is at different levels, depending on the availability and capability of the community to participate in the project.

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## DEFINITION OF TERMS

1. Urban Poor - refers to "squatters" with their makeshift dwellings crammed in almost every vacant lot in the city. Because they occupy land without the owner's expressed permission, one of the primary concerns of the urban poor is security of land tenure.

Comprised of casual laborers, various informal workers (i.e., peddlers, scavengers, drivers), unemployed individuals and employees with low wages. Urban poor's income is marked by irregularities and nonpermanence and is way below the poverty line. The poverty threshold in Metro Manila is P5,921.

2. Health Care Financing Scheme (HCFS) - refers to a system or arrangement wherein part or all of the medical expenses incurred by an individual or his/her dependents are paid by a third party. The third party such as a health insurance receives regular payments or premiums from the individual specifically for this purpose.

A form of HCFS is the cooperative in which members and their dependents become the beneficiaries while their organization stands as the third party to administer the collection and disbursement of the members' contributions.

Company-provided health benefits are either paid for by employees who pay a premium regularly, or part of the company's extended benefits to its employees.

Unless stated otherwise in the text, the term "Medicare" refers specifically to the SSS and GSIS Medicare.

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## IV. METHODOLOGY

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This descriptive study mainly utilized the participatory action research approach employing data collection techniques such as individual interviews, focus group discussions (FGD), and the community assemblies.

### ASSEMBLIES

This study looked into three variables which were measured as follows:

1. *Profile of the two urban communities* - refers to the demographic characteristics of Barangay Apelo Cruz in Pasay City and Barangay Bagbag in Novaliches. These include the sex, age, educational attainment, sources of income, and expenditures of the people in the communities. Also included are the health care services and facilities and the organizations existing in the communities.
2. *Health Attitudes, Perceptions and Health-Seeking Behavior* - refer to the people's perceptions and attitudes towards health care services, personnel and facilities in the communities and their health seeking behavior.
3. *Health Care Financing* - refers to the various individual or group measures/actions taken by the people to finance their health needs.

As mentioned earlier, the study employed the PAR approach. The participation of the communities concerned was encouraged and elicited in the formulation of the research design and of the instruments, in conducting individual interviews with household heads and in facilitating focus group discussions with community residents, analyzing the data gathered and in presenting the results to their respective communities for validation.

### SELECTION OF RESEARCH POPULATION AND FORMULATION OF RESEARCH TEAMS

The choice of the two urban poor communities for the research population was based on the willingness of the community to participate, the availability of contacts in the community, and the level of community organization. The two communities selected, after exploratory talks with each of the communities' formal leaders, were Barangay Apelo Cruz in Pasay City and Barangay Bagbag in Novaliches. Local residents of these two barangays were tapped and trained to conduct the study themselves with the assistance of the project facilitators.

Prior to the selection of the two urban poor communities, the research facilitators conducted social investigation. The facilitators looked into the social, economic and political situations of the communities. They made courtesy calls on the formal and informal leaders, introduced themselves and the project they planned to conduct in their respective communities, and solicited the latter's approval and assistance, particularly in identifying potential members of the two research teams, one for each barangay, to be formed.

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The selection of Research Team members was based on the following criteria:

1. a resident in the community,
2. a respected person (of good moral character),
3. can read and write well,
4. has a pleasant personality,
5. willing to commit time and effort to the project.

The research team of Apelo Cruz was composed of seven members. On the other hand, the research team of Bagbag was composed of eight members. Most of the selected members were the community leaders themselves. The members underwent a two-day seminar on PAR, its concepts and process (see Appendix A for the training module). The seminar was followed by a workshop whereby the participants were sent to the field to practise what they had learned in conducting a preliminary survey of their respective communities. Prior to the conduct of the preliminary survey an interview schedule was formulated by the research teams themselves with the assistance of the project facilitators.

Every weekend, the research teams met with the project facilitators to process the former's experiences in the field. The weekend meetings were venues for the members of the research teams to report what they had done in the field, how they practised what they had learned from the seminar/workshop, the difficulties they encountered and the corresponding actions they took to overcome such difficulties.

Each research team conducted a brief political, economic, and social analysis of their respective communities. Likewise, the research teams conducted individual interviews (100 in Apelo Cruz and 101 in Bagbag) and FGDs (three in each community with a total of 67 participants—33 in Apelo and 34 in Bagbag) and facilitated a general assembly in each area with a total of 137 participants—67 in Apelo and 70 in Bagbag. In each activity, the research teams were accompanied by the project facilitators. In conducting the individual interviews, the research team members were divided into groups of four—one interviewee for each group. For FGDs, at least two project facilitators accompanied the research teams.

#### SAMPLING OF RESPONDENTS

The random technique was used in selecting the respondents for individual interviews. Household heads were assigned random numbers. However, as the research progressed a number of the selected household heads were unavailable for the interview. Thus, the research teams interviewed residents who were more accommodating and willing to participate in the survey. A total of 100 residents from Apelo Cruz and 101 from Bagbag were taken as respondents.

On the other hand, purposive sampling was used for selecting participants in the FGDs. A total of 67 residents, 33 in Apelo Cruz and 34 in Bagbag, participated in the six FGDs held.

#### RESEARCH INSTRUMENTS

Instruments used for the study were an interview schedule and an FGD guide (please see Appendices B and C for samples of the instruments).

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The interview schedule in Filipino, formulated by the research teams with the assistance of the research facilitators, adopted some of the question items in a survey questionnaire designed by government institution spearheading the research studies. The research teams conducted a pretest after the formulation of the instrument. During the pretest, it was learned that the instrument was too long for the respondents that the latter refused to finish the interview anymore. Thus, necessary changes were made to shorten the instrument.

The final instrument included sections related to demography, income and expenditure. It also included questions regarding health attitudes and perceptions and health-seeking behavior, and their willingness and actual capacity to participate in risk sharing schemes.

Aside from the interview schedule, an FGD guide was formulated by the research facilitators in consultation with the research teams. The guide included items on the people's knowledge, awareness, and experience on health care financing schemes such as Medicare and their willingness to participate in the formulation of a scheme that is more viable and sustainable for them.

## DATA GATHERING

Data gathering phase of this project (FGD, survey, general assembly) lasted nine (9) months from May 1992 to January 1993. The research teams accompanied by the project facilitators went from house to house and interviewed the household heads identified as respondents. Each interview took an average of two and a half hours.

Aside from individual interviews, the research teams conducted focus group discussions participated in by 10-15 household heads (either father, mother or both). During the FGD, the participants were asked to role-play their attitudes and perceptions on health.

In the process of conducting individual interviews and FGDs, it was learned that most of the respondents were unclear about Medicare and largely ignorant about health maintenance organizations and health insurances. Thus, the project facilitators with the assistance of the research teams held education sessions and distributed pamphlets in Filipino on the said concepts.

Data gathering was temporarily disrupted for about three to four months because of the 1992 synchronized national and local elections. The communities were highly involved in the election proceedings. Miting de avance in the communities and other campaign activities delayed the training and post training self-assessment of the research teams.

In Bagbag, an intense in-fighting occurred among the leaders because there were factions which supported various candidates. The research project was even branded as an extension program of a particular candidate.

## DATA ANALYSIS

For qualitative data, descriptive analysis was used. On the other hand, for quantitative data, descriptive statistics such as frequency distribution and simple percentage and indices of central tendency such as the mean, median and mode were employed. A "p" values less than 0.05 was considered significant.

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## DATA VALIDATION

The results were presented in two separate big group assemblies, one in each community studied. In the assemblies the people gave their feedback, validated the results and provided recommendations and additional information pertinent to the study.

## FEEDBACK ON THE RESULTS OF THE RESEARCH

### Pasay

In Pasay, 67 people attended the assembly conducted in front of the day care center along the main street of the community. The barangay officials and the executive director of Ina-Anak, one of the NGOs working in the community also attended.

The participants confirmed the results of the study. Their reactions toward the establishment of an HCFS in their community were generally positive. While validating the results of the study, they expressed strong reactions toward the quality of health services provided by the health center. They gave suggestions to improve the center's services. These included making essential drugs available; longer clinic hours; and hiring more competent and caring personnel.

On the issue of health care financing, those present were amenable to an HCFS whose structure and guidelines were acceptable to them. Moreover, they suggested that a strong community organization handle the HCFS to safeguard the funds.

However, no consensus was reached regarding the premium to be paid by members. Some were willing to contribute as much as P100 a month. Others could only afford P5 a month.

### Novaliches

In Novaliches, a total of 70 individuals participated in the assembly held in an open basketball court. Among those who attended were officers of the different community associations and people's organization. Like in Pasay, the participants expressed their approval as regards the results of the study.

The ensuing discussion centered on what services the health care financing scheme should offer. Many felt that the emphasis should be on outpatient care more than on hospitalizations. Mothers, in particular, were more interested in making health care services available to the children. Again, no consensus was reached on the premiums to be paid. The group suggested a thorough study on the matter of premiums.

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## V. FINDINGS AND DISCUSSION

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Discussion of the findings of the study is divided into four parts. The first part presents the demographic characteristics of the two urban communities, Apelo Cruz and Bagbag. The second part deals with the communities' perceptions and attitudes toward health care and health-seeking behavior. The third part discusses the communities' perception and attitude toward and willingness to participate in risk-sharing on health care maintenance. Lastly, the fourth part discusses the implications of the findings in the formation of health care financing in the two urban poor communities. It discusses the factors which may facilitate and hinder the successful implementation of whatever financing scheme would be formulated.

### A. PROFILES OF THE COMMUNITIES

#### 1. Barangay Apelo Cruz, Pasay

##### *The Place and the People*

Barangay Apelo Cruz is situated along the Tripa de Gallena creek. Owned by the Alcantara family, its total land area is approximately 40,000 square meters. It has a total population of 4,500 with 1,500 total number of households as of the 1986 local survey. Presently, residents estimate their population as at least twice that number.

An average of three families live in a cramped house, usually a two-story type, of scraps of wood and iron sheets along the polluted river which smells of filth. The houses are built close to one another making ventilation very poor.

Most of the residents who used to be farmers came from the Visayas, Ilocos and Bicol regions. People have been migrating to the area since the 1950's. Most of the people engage in scavenging. Some are employed as side-car drivers, construction workers, factory workers, mechanics, security guards and janitors.

NGOs and POs present in the area include Apelo Women's Health, Samahan ng Nagkakaisang Magulang sa Apelo, SAMAKANA, KABAYAN, ERDA, Apelo Youth Association, Apelo Youth Servant, SAMANA, Lumipas na Kahapon, Rotary Club, Kabataang Barangay, and INA-ANAK.

Apelo Cruz has two government health centers, a general hospital, 13 private clinics, a day care health center and a women's health center. Common diseases in the area are cough and colds, fever, flu and diarrhea.

##### *The Respondents*

A total of 100 residents were taken as respondents for the individual interviews while 30 participated in the three FGDs conducted in the area.

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### Sex, Age, and Educational Attainment

Almost all (87) of the total respondents were females (please see Table A1). They had lived in the area for more than three years already. Their stay in the place had been largely dependent on the availability of work and security of land tenure. Almost half of the respondents (41) were young, between 21 and 30 years old (see Table A2). Of the total number of respondents, 67 were able to reach high school. Of the 67, 41 were able to finish high school (please see Table A3).

TABLE A1. SEX

SEX	RESP.
1. Female	87
2. Male	13
Total	100

TABLE A2. AGE

AGE (Years)	RESP.
1. 17-20	9
2. 21-30	41
3. 31-40	27
4. 41-50	10
5. 51-60	12
6. 61 up	1
Total	100

TABLE A3. EDUCATIONAL ATTAINMENT

LEVEL	RESP.
1. Elementary	9
2. Elementary graduate	16
3. High School	26
4. High School graduate	41
5. College	5
6. College graduate	3
Total	100

TABLE A4. HOUSEHOLD MEMBERS

NO. OF HH MEMBERS	RESP.
1. 1	0
2. 2	2
3. 3	18
4. 4	23
5. 5	16
6. 6	18
7. 7	12
8. 8	6
9. 9	5
10. 10	0
Total	100

### Household Members, Income and Expenditures

Most of the respondents (23) had an average of four members per household. Majority earned from P3,000 to P4,000 a month as scavengers, factory or construction workers (see Table A5). The average monthly expenditures of a family of four or five was P4,517 (see Table A6).

The bulk of their expenses went to food and groceries (P2,957.48 or 65%), followed by expenses in vices such as smoking and gambling in the form of jueteng, bingo, sakla, horse racing, and ending

(P420.80 or 9.29%). Very minimal (P81.08 or 1.79%) went to health needs and education (P76.62 or 1.68%). However, a considerable amount went to transportation and clothing (P359.39 or 7.9%), utilities such as payment for house rent and electricity (P312.40 or 6.9%), and others such as appliances bought on credit or "hulugan" or small-scale businesses such as livestock raising (P271.80 or 5.99%).

TABLE A5. AVERAGE MONTHLY INCOME PER HOUSEHOLD

INCOME	RESPONDENTS
1. P1,000 & less	11
2. P1,001 - 1,999	8
3. P2,000 - 2,999	15
4. P3,000 - 3,999	32
5. P4,000 - 4,999	34
6. P5,000 - up	0
Total	100

TABLE A6. AVERAGE EXPENDITURE PER ITEM PER MONTH

ITEM	AMOUNT (P)	%
1. Food & Groceries	2,957.48	65.0
2. Transportation & Clothing	359.39	7.9
3. Vices	420.80	9.29
4. Utilities	312.40	6.9
5. Entertainment	37.52	0.8
6. Health	81.08	1.79
7. Education	76.62	1.68
8. Others	271.80	5.99
Total	4,517.09	99.35

### Organizations Involved In and Benefits Received

Majority (78) of the total number of respondents were members of a community organization. The rest were members of a church-based organization or an organization which an NGO helped established. The benefits they received were usually in the form of loans. Some also received dole-out assistance in cash or in kind.

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TABLE A7. ORGANIZATIONS INVOLVED IN

ORGANIZATION	RESPONDENTS
1. Church-based	4
2. Community	78
3. Non-governmental	8
4. Others	2
Total	92

TABLE A8. ASSISTANCE RECEIVED FROM ORGANIZATION

ASSISTANCE	RESPONDENTS
1. Cash (dole-out)	25
2. Loans	60
3. In kind	12
Total	97

## 2. Barangay Bagbag, Novaliches

### The Place and the People

Barangay Bagbag is situated in Novaliches. It is composed of six sitios and occupies a total land area of 245 hectares. It has a total population of 18,700 with 3,800 households. The people earn their living as factory and construction workers, vendors, overseas and agricultural workers.

The community has three private clinics, a private hospital, puericulture center and lying-in clinic. No health center exists in the community. The people have yet to go to Tandang Sora, a 15-minute walk from the place, to consult at the health center. Common diseases in the area are cough and colds, fever, flu and diarrhea.

### The Respondents

A total of 101 residents were taken as respondents for the individual interviews while 34 participated in the three FGDs held in the area.

### Sex, Age and Educational Attainment

Majority (90) of the respondents in the individual interviews were females (see Table B1 below). Majority of them were between 21 and 30 years old (see Table B2 below). Around half (49) were high school graduates. However, a considerable number, (28) were elementary graduates (see Table B3).

TABLE B1. SEX

SEX	RESP.
1. Female	90
2. Male	11
Total	101

TABLE B2. AGE

AGE (Years)	RESP.
1. 17-20	3
2. 21-30	35
3. 31-40	29
4. 41-50	22
5. 51-60	7
6. 61 up	5
Total	101

TABLE B3. EDUCATIONAL ATTAINMENT

LEVEL	RESP.
1. Elementary	3
2. Elementary graduate	28
3. High School	7
4. High School graduate	49
5. College	8
6. College graduate	5
Total	101

TABLE B4. HOUSEHOLD MEMBERS

NO. OF HH MEMBERS	RESP.
1. 1	5
2. 2	4
3. 3	14
4. 4	29
5. 5	19
6. 6	10
7. 7	10
8. 8	4
9. 9	3
10. 10	3
Total	101

### Household Members, Income and Expenditures

The average number of household members of the respondents was four (see Table B4). Monthly income of the respondents ranged from P2,000 to P4,000 (see Table B5). The average monthly expenditure per household was P4,103 with the bulk going to food and groceries (P2,698 or 65%). A considerable amount (P456 or 11%) went to transportation and clothing. Least amount (P37 or 0.9%) went to education. A minimal amount (P126 or 3%) was also spent for health needs. Other expenditures were on vices which included smoking and gambling (P266 or 6%), entertainment which included seeing movies (P103 or 2%), and utilities which included payment for house rent, house repairs, and electricity (P296 or 7%).

TABLE B5. MONTHLY INCOME PER HOUSEHOLD

INCOME	RESPONDENTS
1. P1,000 & less	10
2. P1,001 - 1,999	13
3. P2,000 - 2,999	27
4. P3,000 - 3,999	25
5. P4,000 - 4,999	26
6. P5,000 - up	0
Total	101

TABLE B6. AVERAGE EXPENDITURE PER ITEM

ITEM	AMOUNT (P)	%
1. Food & Groceries	2,698.16	65.75
2. Transportation & Clothing	456.28	11.11
3. Vices	266.40	6.48
4. Utilities	296.59	7.21
5. Entertainment	103.40	2.51
6. Health	126.80	3.07
7. Education	37.16	0.9
8. Others	118.40	2.87
Total	4,103.19	99.90

Organizations Involved In

Of the total number of respondents, 60 were members of organizations existing in their place. Almost half (27) were members of a community organization. The rest were either members of a church-affiliated organization or an organization established by an NGO. Assistance rendered to the members of the organizations mentioned were usually in the form of loans, and dole-outs in cash or in kind.

A community organization in the community which had more following than the other existing organizations in Bagbag was the Nagkakaisang Samahan ng Maralita (NAKASAMA) whose primary aim was to ensure their members' continued stay in the community. In NAKASAMA, members paid monthly dues of P5 for the association's upkeep. Another form of payment was "suyuan" or "bayanihan" wherein the members rendered labor services instead of money.

TABLE B7. ORGANIZATIONS INVOLVED IN

ORGANIZATION	RESPONDENTS
1. Church-based	13
2. Community	27
3. Non-governmental	19
4. Others	1
Total	60

TABLE B8. ASSISTANCE RECEIVED FROM ORGANIZATION

ASSISTANCE	RESPONDENTS
1. Cash (dole-out)	17
2. Loans	18
3. In kind	28
Total	63

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Unlike the preceding section which separately discussed the demography of the respondents from Apelo Cruz and Bagbag, the succeeding two sections jointly discuss the attitudes, perceptions and health-seeking behavior and risk-sharing on health financing of the respondents given their similar patterns (please see tables A9 and A12 and B9 and B12 on respective health attitudes, perceptions and practices of the respondents for comparison purposes). Responses discussed in these sections were culled from the individual interviews and the FGDs.

## B. HEALTH ATTITUDES, PERCEPTIONS AND HEALTH-SEEKING BEHAVIOR

### Concept of Health

While most of the respondents agreed that a healthy person is a person who has not been sick for a long time and that both the rich and the poor have the same health problems, they did not see the need to regularly see a doctor for medical check-up. They would see a doctor only when ill. More often than not, it is the children whom they would bring to the doctors for consultation. Given their weak and frail bodies, the children are more susceptible to diseases. A mother once shared that self-medication was enough for older people like her.

### Health Workers

The respondents expressed strong faith in medical science, agreeing that a doctor is more knowledgeable on health matters than the traditional healers or "herbolaryo",

Professing confidence in the knowledge and expertise of medical doctors, most of the respondents usually consulted a doctor at the first sign of illness. However, some resorted to self-medication rather than consulting a health professional. Others consulted a midwife or an herbolaryo. Still others sought friends or relatives for advice.

Herbolaryos were usually consulted during seemingly hopeless cases. A case in point was that of a 54-year old man who was suffering from tuberculosis. The patient and his family thought that no cure was possible for the former's illness anymore. An herbolaryo was the last resort. Another case was that of a 32-year old woman who was also suffering from tuberculosis. She went to see an herbolaryo because she could not afford a medical professional's consultation fee.

### Health Services in the Community

Most of the respondents described the available health services in their communities as inadequate. In Pasay, the doctor in the health center was available only on Saturdays. On the other hand, in Bagbag, the nearest health center was a 15-minute walk from the community. Moreover, more often than not, medicine in these health centers were not available. And if they were available, these medicines were sold instead of given free as had always been expected in public health centers.

A mother shared that she once brought her child suffering from tuberculosis to a health center. She was given free medicines. However, when she and her child arrived home, she learned that the

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medicines were past their expiration date. She did not let her child take the medication anymore for fear that the latter's illness would worsen.

*Use of the Health Services (Government vs. Private)*

More often than not, respondents sought private health services rather than government ones. Even if seeking private health services meant higher expenses, the respondents preferred the former to the latter because they perceived the former as of better quality.

The respondents provided a distinction between a government doctor and a private one. For them, private doctors were more competent. They preferred private doctors to government ones because aside from being more competent, private doctors were more available and their clinics were more accessible and they had medicines. Moreover, private clinics or hospitals had adequate facilities. They would only see government doctors and confine themselves in government hospitals as a last resort. Either they did not have any money to seek private health services or they needed immediate relief from their illness and the nearest clinic or hospital where they could get such relief was a government one.

Apelo Cruz's residents lamented that the doctor in the barangay health center was available on Saturdays only. Moreover, the health worker tasked to administer first aid and take a patient's blood pressure gave priority to patients known to him personally. More often, only those he knew received treatment.

In addition, medicines such as analgesics and antibiotics, when available, were sold instead of given free. The respondents expressed their willingness to pay as much as 50% of the cost of medicines provided they were of good quality.

Meanwhile in Bagbag, residents consulted the nearest health center for very minor complaints like cough and colds only. They would rather see private doctors for more serious problems such as cough with fever. Even if it meant higher cost, around P200 per consultation, they would still see the private practitioners because the cost already included the medicines.

In Apelo Cruz, when the respondents were suffering from cough, abdominal pains or similar complaints that they needed immediate relief, they consulted at the nearest hospital which was a government one.

Relatives of a 54-year old woman confined at a private hospital run by a religious congregation were very satisfied with the service rendered during the latter's confinement. The same however, could not be said about their experience in a government hospital where they were forced to transfer the patient when they ran out of funds. The relatives described the said government hospital as dirty and complained about the lack of doctors on call.

### Drugs and Prescription

Irrational drug use abound with the rampant use of antibiotics even for clearly viral infections only such as flu where antibiotics are unnecessary. They often equated illness with medicines. For perceived very minor complaints like colds, they attempted self-medication. However, for most of their other bodily complaints, they relied heavily on doctors.

More often than not, respondents did not complete a prescribed drug regimen if they felt some relief from their ailments. Leftover medicines were saved for a recurrence of the same symptoms. On the other hand, they would stop taking their medicine if they perceived that such a medicine was ineffective.

A case in point was that of a 32-year old woman with tuberculosis who stopped taking her medicines when she felt that they had not been effective. She had already been admitted at an institute for tuberculous patients in the past. However, she had not returned for a follow-up or for additional medicines. She consulted a few private practitioners who gave her injections until her money ran out.

TABLE A9. INDIVIDUALS USUALLY CONSULTED  
DURING ILLNESS IN APELO

PERSONNEL	RESPONDENTS
1. Doctor	34
2. Nurse	0
3. Midwife	3
4. Herbolaryo	3
5. BHW (Brgy. Health Worker)	0
6. Relatives & Friends	18
7. Others	10
Total	68

TABLE B9. INDIVIDUALS USUALLY CONSULTED  
DURING ILLNESS IN BAGBAG

PERSONNEL	RESPONDENTS
1. Doctor	33
2. Nurse	0
3. Midwife	3
4. Herbolaryo	4
5. BHW (Brgy. Health Worker)	4
6. Relatives & Friends	4
7. Others	7
Total	55

TABLE A10. ATTITUDES, PERCEPTIONS, PRACTICES OF APELO CRUZ

A. ATTITUDES, PERCEPTIONS, PRACTICES	RESPONDENTS	
	YES	NO
1. Being healthy is not being sick for a long time	69	30
2. Only ill persons consult doctors	67	32
3. The rich and poor have the same health problems	71	28
B. HEALTH WORKERS	YES	NO
1. The "herbolaryo" is always correct	20	76
2. The doctor is always correct	83	16
C. HEALTH SERVICES IN THE COMMUNITY	YES	NO
1. The health services are adequate	37	60
2. Government doctors are as good as private ones	65	34
3. Private doctors treat the rich and poor equally	22	78
D. USE OF HEALTH SERVICES	YES	NO
1. Between a government and a private hospital, I'd prefer a private one if costs are the same	65	35
2. I would prefer a private hospital to a government one even if the latter offers excellent service and it is cheaper	78	20
3. Very sick or dying person should be brought to a government rather than a private hospital	91	6
4. Sick elderly persons should be brought to a government rather than a private hospital	85	8
5. I am interested in joining a health care financing scheme	92	6
6. I am willing to give regular dues (either monthly or weekly) in the financing scheme	94	4
E. DRUGS AND PRESCRIPTION	YES	NO
1. A good doctor should prescribe a medicine to sick patients	83	15
2. A patient who feels better can stop taking his/her medicine even if the regimen prescribed has not been completed	49	48
3. One can take previously prescribed medicine for an illness which seems similar to the previous one.	49	49
4. One should take antibiotic right away if one is sick	49	49

TABLE B10. ATTITUDES, PERCEPTIONS, PRACTICES OF BAGBAG

A. ATTITUDES, PERCEPTIONS, PRACTICES	RESPONDENTS	
	YES	NO
1. Being healthy is not being sick for a long time	59	41
2. Only ill persons consult doctors	66	35
3. The rich and poor have the same health problems	50	50
B. HEALTH WORKERS	YES	NO
1. The "herbolaryo" is always correct	28	72
2. The doctor is always correct	74	27
C. HEALTH SERVICES IN THE COMMUNITY	YES	NO
1. The health services are adequate	42	57
2. Government doctors are as good as private ones	56	45
3. Private doctors treat the rich and poor equally	46	55
D. USE OF HEALTH SERVICES	YES	NO
1. Between a government and a private hospital, I'd prefer a private one if costs are the same	64	37
2. I would prefer a private hospital to a government one even if the latter offers excellent service and it is cheaper	72	28
3. Very sick or dying persons should be brought to a government rather than a private hospital	77	24
4. Sick elderly persons should be brought to a government rather than a private hospital	78	22
5. I am interested in joining a health care financing scheme	92	9
6. I am willing to give regular dues (either monthly or weekly) in the financing scheme	92	9
E. DRUGS AND PRESCRIPTION	YES	NO
1. A good doctor should prescribe a medicine to sick patients	63	18
2. A patient who feels better can stop taking his/her medicine even if the regimen prescribed has not been completed	34	67
3. One can take previously prescribed medicine for an illness which seems similar to the previous one.	37	64
4. One should take antibiotic right away if one is sick.	27	74

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## C. HEALTH CARE FINANCING

### Sources of Funds for Medical Needs

Sources of funds identified by the respondents in both individual interviews and FGDs for health care needs such as consultation, medicines and hospitalization included: own earnings, donations or loans from friends or relatives, loans from employers and usurers, other sources of income such as scavenging or buying and selling scrap material for recycling, Medicare/health insurance, selling or pawning of properties, "paluwagan", company-provided benefits, and service-oriented government or non-governmental organizations.

Donations from Relatives. The relatives referred to were parents, grandparents, siblings, uncles and aunts. Any financial assistance received from relatives, no matter how small, was usually the most substantial because no payment was expected.

Loans from employers. Loans from employers were usually in the form of salary advance. Loan payments were made through salary deductions over a certain period of time.

Loans from usurers. In the communities, several known usurers would lend money with 20% interest usually payable in one month. Much as they resented borrowing at usurious rates, the people were forced to because it was the easiest way of securing loans - no collateral required and always available during emergencies.

Loans from friends or relatives. Unlike loans from usurers, loans from friends or relatives were without any interest. However, such loans were expected to be repaid within a certain period of time agreed upon by both borrower and lender.

Medicare/Insurance. Respondents who had regular paying jobs in the government and private sectors have Medicare benefits provided by GSIS or SSS. The GSIS or SSS Medicare shouldered some of the hospitalization expenses of the respondents. However, some respondents expressed dissatisfaction with some Medicare policies. They explained that the Medicare was applicable to hospitalization only and not to outpatient services. Since they seldom got hospitalized, they had not been able to use their Medicare since they started giving contributions.

Likewise, since some members had not been properly oriented about Medicare, they had not been able to avail of its benefits. Nevertheless, despite the perceived lopsided policies of Medicare, the respondents still saw the value of maintaining their Medicare, especially for hospitalization purposes. They recommended that Medicare increase its benefits which would also cover outpatient services and concerned authorities should make the processing of the papers easier.

Sale of property. Some respondents resorted to selling some of their valuable properties to cover medical expenses. A family was forced to sell their house at a very low price and lived with some relatives. Another sold their pig which they were supposed to raise as additional source of income.

Pawning of belongings. Pawnshops abound near these 2 urban poor communities. However, very few valuables of the urban poor can be pawned. Nevertheless, some of the respondents pawned some of their properties and redeemed them once they had been able to secure the money.

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"Paluwagan". Some of the community members banded together and regularly contributed a certain amount to a fund. The members took turns in withdrawing the fund at specific periods of time. During emergency cases, one could arrange to withdraw the fund ahead of schedule.

Company provided benefits. Some companies with which some of the respondents worked provided health financing schemes for their employees. These schemes required compulsory contributions from the employees. The schemes partially covered expenses for hospitalization, doctors' bills, dental services, maternity, and medicines.

In one case, an employee who had an HMO did not spend anything for his hospitalization. Nevertheless, he lamented that the accredited hospitals were far from his residence. Likewise, outpatient consultations were on a refund basis and claiming his refund entailed excessive paperwork.

An employee of a hospital in Manila, in addition to his Medicare benefits, had most of his hospital bills settled through salary deduction. Furthermore, his doctors waived their professional fee and offered to do the same for his dependents.

Government agencies, private organizations, philanthropists or politicians. Since government hospitals could only do so much in providing discounts to the indigent upon discharge, the respondents tapped all available groups or persons who were willing to render assistance for their medical needs. Some organizations, like the Women's Auxiliary Group, provided substantial help in the form of medicines.

In Apelo Cruz, a health cooperative was established by Gabriela, a network of women organization. The cooperative provided services such as loan assistance, free medical consultation, discount of as much as 50% for the total cost of medicines, and free herbal remedies. A nominal fee or voluntary labor services served as contributions or capital share of the members.

Other sources of income. Some people were able to get additional work such as part-time construction workers to earn a little more money. Others sold scavenged scrap metal and other items for recycling.

TABLE A11. SOURCES OF FUNDS FOR CONSULTATIONS  
OF APELO CRUZ

SOURCE	RESPONDENTS
1. Own pocket/savings	26
2. Salary advances	2
3. Insurance	0
4. Loans	1
5. Sale of property	0
6. Pawn of property	16
7. Others	2
Total	47

TABLE A12. SOURCES OF FUNDS FOR  
HOSPITALIZATION OF APELO CRUZ

SOURCE	RESPONDENTS
1. Own pocket/savings	29
2. Salary advance	0
3. Insurance	3
4. Loans	16
5. Sale of property	3
6. Pawn of property	2
7. Others	1
Total	54

TABLE B11. SOURCES OF FUNDS FOR CONSULTATION OF BAGBAG

SOURCE	RESPONDENTS
1. Own pocket/savings	44
2. Salary advance	4
3. Insurance	0
4. Loans	1
5. Sale of property	0
6. Pawn of property	0
7. Others	3
Total	47

TABLE B12. SOURCES OF FUNDS FOR  
HOSPITALIZATION OF BAGBAG

SOURCE	RESPONDENTS
1. Own pocket/savings	9
2. Salary advance	0
3. Insurance	0
4. Loans	2
5. Sale of property	2
6. Pawn of property	1
7. Others	3
Total	17

### Participation in Risk-Sharing

Seeing the value of saving money for emergency situations such as for medical expenses, most of the respondents expressed their willingness to participate in a Health Care Financing Scheme

(HCFS) that would be suited to their needs and capabilities. They were willing to pay the required or agreed upon premium provided the policies were according to their own terms – that the insurance would cover accidents, calamities, and overall health maintenance, and, if possible, the college education of their children. The following were the other terms they wanted implemented in the planned HCFS:

1. A well-organized people's organization based in the community should manage the HCFS.
2. A very good system of recording should be maintained.
3. A financial report should be provided to the members regularly.
4. The monthly share should not be less than P5 and not more than P30. A P20/month share is reasonable.
5. 50% of the total share of the member per year should be refundable if benefits were not availed of.

Recognizing that they might have some problems as regards faithfully paying the premium for the HCFS given their meager income, the respondents cited tapping donations from both government and private institutions, remittances of relatives working abroad, and expected profits from their small businesses as other possible sources of funds. Some even expressed willingness to cut down on their vices such as smoking and gambling to have money to pay for the premium.

#### D. FACTORS THAT MAY FACILITATE OR HINDER THE IMPLEMENTATION OF AN HCFS

The following section discusses the possible factors which may facilitate or hinder the successful implementation of an HCFS in the two urban poor communities based on the findings of the study. The factors include values, attitudes and existing structures in the communities.

##### Factors That May Facilitate the Formation of a Successful Health Care Financing Scheme

###### The "Paluwagan" System

The people's favorable attitude towards "paluwagan" which requires an agreed upon regular contribution from those involved is a distinct advantage when setting up a financing scheme. This shows the people's willingness and determination to set aside a part of their earnings and give as contribution to something which they believe would benefit them. To illustrate, the "paluwagan" had been a source of funds to finance hospitalization expenses.

###### The Amor Propio or Word of Honor

The people renders high value in meeting financial obligations. Failing to meet obligations, particularly financial, means a loss of face or credibility among community members. Because urban poor communities are usually small, congested places where residents know one another quite well, the community would know who kept and did not keep his/her word.



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### Positive Attitudes Towards Health, Medical Doctors and Utilization of Medical Facilities

Respondents value their health greatly. They, especially the mothers, see it as a priority concern. Moreover, they have high respect for doctors, particularly the private practitioners. They consult doctors, go to health centers, private clinics or hospitals to seek medical services even if it meant shelling a portion of their meager income.

Established medical practitioners and existing health facilities in the communities, whether government or private, may be included in the scheme in trying to lower the capital outlay for the health system. It is just a matter of striking a balance between the need of the doctors to earn a living and the financial capability of the people to meet their health care needs.

### Willingness to Work for Services Received

Always short of cash, the urban poor are more than willing to render labor as payment for services they receive. Perhaps, they could be employed to maintain and improve existing health centers in order to reduce operating costs.

### Positive Attitude Towards HCFS or Medicare

Despite perceived loopholes in the Medicare programs of GSIS and SSS, the people still see it as necessary in meeting their health care needs, especially during hospitalization. They expressed interest and willingness to participate in a health care financing scheme or HCFS whose terms would be acceptable to them.

### The Extended Family

The extended family is a strong and helpful institution which can be tapped in sustaining regular contributions to the HCFS. It is customary among Filipinos, especially among the poor, to accommodate extended family members to their homes. These family members have always helped one another, especially in times of need, without counting the cost. As illustrated earlier, household heads usually turned to parents and other relatives for assistance to shoulder medical expenses.

### Existing Organizations in the Communities

The organizations, whether NGOs or POs, in these communities are firmly established and have already gained the respect and confidence of the people. Their years of existence in the communities have earned for them considerable experience in dealing with the people.

Linking or networking with these organizations could facilitate the establishment, implementation and monitoring of an HCFS in the community since these organizations have already institutionalized the necessary systems in the effective and efficient implementation and monitoring of programs/projects with the people. Likewise, NGOs could also be tapped in providing technical assistance to local residents, particularly in managing an organization or an HCFS.

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## Factors That May Hinder The Formation Of A Successful Health Care Financing Scheme

### Crisis-Orientation Towards Health

The urban poor's crisis-orientation towards health may pose a hindrance. The people have been used to having other people providing emergency assistance to them, especially during times of crisis. Changing the status quo may meet some resistance from the people. It will take time before a change in orientation could occur.

### Misconceptions About Rational Health Care

Setting up a health care financing scheme that puts emphasis on rational and preventive health care may encounter some difficulties given the curative rather than the preventive health concept of the people. Therefore, an educational campaign is necessary to ensure the success of the scheme.

### Lack of Confidence in Government Health Facilities and Personnel

The lack of confidence of the people in government health personnel and facilities and their exasperation over government bureaucracy may be detrimental to the implementation of a scheme which would elicit the support of the government.

It is therefore necessary to convince the people of the sincerity and commitment of the government to provide adequate health care for all. It is equally necessary to improve the image of government health personnel and upgrade government health facilities, particularly the health centers.

### Ideological Leanings of Existing Organizations in the Community

Some organizations in the communities have varying ideological leanings which may cause conflicts with other organizations. The "group" mentality of the urban poor may hinder the setting up of an organizational backbone to the scheme.

### Lack of Technical Skills and Capability

Most of the residents of these urban poor communities are unskilled workers who have reached high school only. Thus, they lack managerial and administrative skills to run a successful enterprise on their own. Training of potential leaders and members is therefore necessary prior to the implementation of an HCFS.

### Lack of Regular Source of Income

The people barely manage to make both ends meet. Therefore, much as they expressed their interest and willingness to participate in an HCFS, paying premium is an added burden for them. Some mechanisms should be sought and put in place to encourage and help them to participate in the scheme.

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### *Poor Living Conditions*

The poor living condition of the people is often the cause of diseases among the people. In a health plan, more people becoming sick means more expenses. And more expenses mean higher premium payments. Educational campaigns and projects to improve the living conditions are thus necessary to prevent the outbreak of communicable diseases caused by unsanitary living conditions.

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## VI. SUMMARY AND CONCLUSION

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### SUMMARY

Household heads of the two urban poor communities studied were relatively young—between the ages 21 and 30. Most of them had reached or finished high school. They have been in the area for more than 3 years and had no definite plans of migrating to another place. Most of them came from the provinces.

The families earned their living as scavengers, construction and factory workers, janitors, security guards, and by doing the laundry of other people. With an average family of four, the average monthly income was slightly in excess of P4,000. The bulk of their monthly expenditures, averaging P4,500 monthly, went to food and groceries while a considerable amount of their earnings went to vices such as gambling and smoking. Very little went to health care needs and education.

Health was a priority concern of the people. They would go to great lengths—selling or pawning valuable properties or borrowing money even at usurious rates—just to finance their health needs. However, much as they value their health, their attitude toward it was more crisis-oriented, curative rather than preventive. They would see a doctor only when they were ill. Seeking health care services was more for children rather than adults. Self-medication was enough for older people. Moreover, perhaps because of poverty, they often did not complete the prescribed drug regimen for their illness once they felt certain relief.

They expressed more confidence in the knowledge and expertise of medical professionals rather than in traditional healers or “herbolaryos”, who were perceived as the last resort. However, the respondents also expressed preference for private medical facilities and personnel over government ones. They cite the lack of adequate government facilities and the incompetence of government doctors as reasons.

To pay for their medical expenses which included consultations, hospitalization and medicines, the respondents identified the following sources of funds: their own earnings, donations from relatives or friends, loans from employers, usurers, relatives or friends, welfare government and private agencies, Medicare or health insurance, sale or pawning of properties, company-provided benefits, and other part-time jobs.

Several active organizations had been existing in the communities studied. Bagbag had a neighborhood organization which had been ensuring the continued stay of the residents in the area. On the other hand, Apelo Cruz had a cooperative initiated by an NGO which provided medical assistance to the members.

Recognizing the value of a health insurance, the respondents expressed willingness to participate in a health care financing scheme (HCFS) whose terms would be acceptable to them. Among the

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conditions they wanted met in the event an HCFS would be implemented were: 1. management by a well-organized PO in the community; 2. effective and efficient system of keeping records; 3. regular submission of financial report to the members; 4. monthly share of not less than P5 and not more than P30; and 5. a refund of 50% of the annual share of members if benefits are not availed of.

Identified factors which may facilitate the establishment and implementation of a health care financing scheme among the urban poor include: the "paluwagan" system; the people's value of amor propio; people's positive attitudes towards health care, medical doctors and utilization of medical facilities and Medicare or HCFS; their willingness to work for services received; the extended family structure; and existing organizations in the communities whose assistance could be tapped.

On the other, identified factors which may hinder the HCFS's establishment and implementation include: the people's crisis-orientation toward health; misconceptions about rational health care; lack of confidence in government health facilities and personnel; ideological leanings of existing organizations in the community; lack of technical skills and capability of the people; lack of regular source of income; and poor living conditions.

## CONCLUSION

It is difficult at this point to present a definite structure for a viable health care financing scheme for the urban poor. However, it is clear in this study that the present efforts of the government, particularly the DOH, which aim to include the urban poor population in its health care program should take into consideration the latter's economic, political, and sociocultural structures. Perhaps, some of the caveats had already been vocalized by the urban poor themselves: the system should be "transparent" and clearly understood by the people themselves and premium payments should be studied carefully beforehand.

While the people had expressed their willingness to participate in a health care financing scheme, concerned individuals and groups should make sure that such willingness and enthusiasm are sustained. Given the limited human and material resources of urban poor communities, existing organizational structures in the communities as well as government and non-government resources should be tapped and maximized to ensure the effectiveness and efficiency of the planned scheme at lesser costs.

On the whole, whatever the final scheme would be, as long as the participation of the people is encouraged in all levels of the planning, implementation, monitoring and evaluation of the said scheme, the chances of success are high.

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## ACKNOWLEDGEMENT

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## APPENDIX A

### TRAINING MODULE FOR THE RESEARCH TEAM

#### General Objectives

1. to orient the team members on the principles and practice of participatory conscientizing research;
2. to train the interviewers on the essential skills in interviewing and in basic communication skills
3. to provide maintenance mechanisms for monitoring and upgrading of research skills, tactics in getting dependable data, and effective teamwork

#### COMPONENTS:

##### 1. *Two day training seminar*

This is a two day seminar focusing on orienting participants in participatory research, health care financing and risk-sharing, the research design and skills formation in interviewing and documentation.

##### 2. *Weekly tactics sessions*

Weekly meetings with the interviewers are facilitated by research staff to assess problems and difficulties encountered in the research and to come out with resolutions and strategic plans.

##### 3. *Post-workshop evaluation sessions*

As a matter of policy, every major research activity participated in by the staff, the research team or the community must be pursued by evaluation and reflection sessions. These will be documented and analyzed for planning purposes.

### TWO-DAY TRAINING SEMINAR FOR INTERVIEWERS

#### A. Training Objectives

1. To orient interviewers on the principles and methods of participatory conscientizing research.
2. To sharpen skills in interviewing and communicating
3. To train participants on the basic skills in interpreting and responding to verbal and non-verbal cues
4. To foster effective teamwork and clear task relationships among interviewers and the staff

#### B. Program Schedules

##### *Day 1:*

- Health situationer
  - Orientation into research design and framework
  - Communication skills
  - Process observation
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*Day 2:*

- Group handling skills
- Concept of research
- Research skills: focusing on interviewing
- Practicum workshop
- Evaluation and planning

## THE MODULES

### I. EXPECTATION SETTING

A collage of facial expressions is presented on manila paper. Each facial expression denotes an emotion. The participants are then asked to choose which facial expression captures the emotion they feel at the moment. The facilitator then asks each one to share with the group and explain why.

Emotions that relate to seminar are acknowledge and validated. Mental baggages are noted as well so that the staff may provide contingencies just in case these will affect the seminar.

The facilitator then presents objectives of the training seminar and participants are asked if the major expectations and needs will be answered by the seminar.

### II. ORIENTATION INTO THE RESEARCH DESIGN

A brief overview of the research design is again presented to the participants by the overall coordinator.

### III. WORKSHOP: ANALYSIS OF THE PHILIPPINE HEALTH SITUATION

#### Objectives:

1. to maximize the appreciation of health as a social phenomenon and not just a technical problem.
2. to heighten the need for meaningful people's participations in social change.

#### Activity Proper:

A story is presented to the group. The story of Rosario, a child who died of post-measles bronchopneumonia.

In gist, the story presents the odyssey of an urban poor family in coping with illness in the family. Different social, political, cultural and economic factors came into play and all contributed to the death of Rosario. Each of these factors were specified in the story and became the major factors that caused the child to succumb.

The participants are then asked to point out the different specific factors and to classify them accordingly. For example, the facilitator will repeatedly ask why Rosario died after each answer the participant can think of. Until he or she cannot think of other related reasons. Hence the answer may be because of malnutrition. The facilitator then asks why of malnutrition. "Because they are poor." Then why are they poor?

"Because of unemployment and low wages."

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Why is there unemployment and low wages?

"Because of unjust structures in society." And so on and on. All these answers can be plotted on manila paper encircled inside a ballon and linked to the previous answer by a line. And in the center the question is written "Why did Rosarion die?"

A spider web could be drawn by doing this exercise. And, this is to highlight how health is interwoven with other aspects of society that it is actually a social phenomenon.

**Synthesis:**

The participants are asked to review the web they have created and insights are evoked.

Input on the health indices -- of the top 10 causes of death and morbidity -- are presented and analyzed by the participants.

#### IV. PROCESS OBSERVATION AND COMMUNICATION SKILLS

##### A. *On Non-Verbal Communication*

**Objectives:**

1. to highlight the importance of nonverbal cues and verbal communication
2. to practice skills in identifying and analyzing nonverbal cues

**Activity Proper:**

The group is asked to form a tight circle by locking arms with each other. Each is asked to look at a particular spot which he/she would like to go to. After a moment, they are instructed to convince the whole group to move to the spot without breaking the circle and without making any sound.

**Processing:**

After 20 minutes, the group is then asked to unlock arms and assemble for processing.

Feelings are initially asked. Reactions to the activity are evoked and acknowledged.

After which the group then enumerates the helpful and disruptive behaviors or factors that they experienced with the exercise.

**Synthesis:**

A summary of learning is made. A short input on the importance of verbal and nonverbal communication follows. (The nonverbal cues can help interviewer determine interest or indifference of respondents.)

##### B. *On Listening*

**Objective**

To sharpen skills in listening by learning to use clarifying questions, nonverbal cues and eye contact.

### Activity Proper:

The participants are each asked to recall a memorable experience in their childhood which they would like to share with the group.

After five minutes recollecting, triads are formed. The members of each triad are told to decide who among them will share first while the two shall observe. One listener shall observe for the nonverbal cues and the other for content and emotion that it is associated with the content. Each member of the triad will take turn. And after each sharing session, feedback is given by the listeners. The participants are given one hour to finish.

### Synthesis:

In the big group, insights are culled. A framework is used to analyze Facilitative and Non-facilitative behavior.

### C. On Process Observation

#### Objectives:

1. To raise awareness of the importance of process as well as content during group discussions
2. to train simple skills in process observation

#### Activity: Fishbowl observation

The group is divided into two groups. A topic of interest is presented for discussion. Group 1 is asked to leave the room. Group 2 is instructed to watch for communication skills, verbal and nonverbal cues. Each member of the group is assigned a person to observe in group 1.

*Group 1 enters and starts discussion.*

#### First Synthesis:

The members of group 1 are told about process observation. The overall facilitator first presents an observation of how the discussion flowed. High participators and low participators are noted. Monopoly and other phenomena are pointed out. The members of group 2 present their individual feedback.

*Members of group 1 are asked for reactions.*

In the second half, this time, leadership skills are observed by group 1 while group 2 discusses. All the rest is basically the same.

### V. WHAT IS RESEARCH?

A simple explanation is given about research. Highlighted is the need for research to be useful and relevant. It is demystified by showing simple researches already done in other communities.

The different research stages are presented and what constitute each stage

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## VI. RESEARCH SKILLS TRAINING

### Objectives:

1. to level off on what specific skill will be required of the research team/interviewers
2. to develop and practice skills in interviewing
3. to be aware of the different stages of the interview

### *Activity Proper #1 Input*

A lecturette and review of a hand-out on interviewing will be made. (see Appendix 6)

### *Activity Proper #2 Evaluation of preliminary survey and role playing*

A big group evaluation of the preliminary survey conducted by the research team is handled by the facilitator. Problems encountered were again identified and clarified further. And, suggestions on how the problems could have been avoided or resolved were evoked.

In a simulation of the problems encountered, participants were assigned interviewers while selected participants assume problem roles they enumerated. They now try to practice what they have learned.

## VII. EVALUATION AND PLANNING

Evaluation of the seminar and planning for the coming activities in the community end the two-day training course.

## WEEKLY TACTICS SESSIONS

### Objectives:

1. to monitor the performance of the community researchers
2. to surface problems and ventilate difficulties for resolution and planning
3. to process experiences and insights of researchers for deepening.

### *Activity Proper:*

1. A free-flowing sharing sessions of highlights during the week is facilitated by the research staff.
  2. Positive experiences are first highlighted, if any, and processed.
  3. negative experiences are assessed and ventilation of negative emotions facilitated.
  4. Development of plans or contingency measures made for the week.
  5. Scheduling and tasking of plans end the session.
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## APPENDIX B

ISANG PANANALIKSIK PATUNGO SA PAGPAPATUPAD NG PROGRAMANG PANGKALUSUGAN  
PARA SA MGA MARALITANG TAGALUNSOD

PANGALAN NG KINAKAPANAYAM: \_\_\_\_\_

EDAD: \_\_\_\_\_

EDUKASYONG INABOT: \_\_\_\_\_

PETSA: \_\_\_\_\_

ORAS: \_\_\_\_\_

1. Ilan ang miyembro ng inyong pamilya? \_\_\_\_\_

Nais naming tanungin kayo tungkol sa gastusin sa inyong bahay:

2. Sa pangkaraniwan, magkano ang gastos ninyo sa loob ng isang linggo para sa mga sumusunod:

a. pagkain at iba pang bilihin sa palengke o talipapa P \_\_\_\_\_

b. sabon at iba pang nabibili sa grocery, sari-sari store o supermarket P \_\_\_\_\_

k. pamasahang papunta't pauwi mula sa paaralan/trabaho P \_\_\_\_\_

d. alak at sigarilyo P \_\_\_\_\_

e. sine, video, komiks, dyaryo P \_\_\_\_\_

g. mga sariling hatol na gamot P \_\_\_\_\_

h. mga gamot para sa mga malubhang sakit/matagal na sakit  
(halimbawa: alta presyon, diabetes, at iba pa) P \_\_\_\_\_

i. sugal (jueteng, ending, bingo, at iba pa) P \_\_\_\_\_

3. Alin pa sa mga sumusunod ang pinag- kakagastusan ninyo?	4. Gaano kadalas ang bayaran?				5. Magkano bawat bayaran?
	Y	Q	M	O	
[ ] a. kuryente					
[ ] b. tubig					
[ ] k. utang (itukoy)					
_____					
_____					
[ ] d. upa sa bahay					
[ ] e. damit, uniporme					
[ ] g. tuition					
[ ] h. insurance					
[ ] buhay					
[ ] sasakyan					
[ ] pangkalusugan					
[ ] iba pa					
[ ] i. butaw sa kooperatiba					
[ ] l. gastos sa pagpa- paayos ng bahay					
[ ] m. puhunan sa negosyo					

\* Y - taunan Q - tuwing ikatlong buwan M - buwanan O - iba pa (pakitukoy)

6. Pumili sa mga sumusunod na kabuuang kinikita ng pamilya sa isang buwan

- |  |  |
|--|--|
| <input type="checkbox"/> 1,000 pababa  | <input type="checkbox"/> 3,000 - 3,999 |
| <input type="checkbox"/> 1,000 - 1,999 | <input type="checkbox"/> 4,000 pataas  |
| <input type="checkbox"/> 2,000 - 2,999 |  |

7. Gaano ka na katagal sa kasalukuyang bahay?

- |   |  |
|---|--|
| <input type="checkbox"/> Kulang sa taon | <input type="checkbox"/> Dalawang taon   |
| <input type="checkbox"/> Isang taon     | <input type="checkbox"/> Tatlong taon    |
|   | <input type="checkbox"/> Higit sa 3 taon |

8. Lilipat ka ba ng tirahan sa susunod na 3 taon?

#### KALAGAYANG PANGKALUSUGAN:

9. Sa nakaraang buwan, mayroon bang nagkasakit sa pamilya pati na rin ang mga naoperahan, naaksidente, nanganak, at iba pa?

- ☐ Oo  
☐ Hindi (tumuloy sa blg 34)

	yugto 1	yugto 2	yugto 3
10. Sinu-sino ang mga ito?			
11. Ano ang sakit?			
12. Sino ang kinunsulta?			
1 - doktor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 - nars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 - midwife	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 - dentista	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 - arbolaryo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 - BHW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 - kamag-anak/kaibigan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 - walang ikinunsulta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 - iba pa, pakitukoy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Saan naganap ang pagpapakonsulta? (Itukoy)			
14. Magkano ang ginastos ni (P) sa pagbiyahe para makaabot sa pagamutan			
15. Magkano ang ibinayad ni (P) sa pagpapakonsulta?	P	P	P
1 - sariling bulsa			
2 - bawas sa suweldo			
3 - insurance			
4 - utang sa kamag-anak/kaibigan			
5 - nagbenta ng ari-arian			
6 - nagsanla			
7 - iba pa (pakitukoy)			

	yugto 1	yugto 2	yugto 3
17. Magkano ang nagastos ni (P) para sa mga gamot?			
18. Kung naospital, anong uri ng ospital?			
19. Magkano ang nagastos sa pagpapaospital ni ____?	P	P	P

20. Ano ang resulta ng paggamot? \_\_\_\_\_

21. Paano ninyo tinustusan ang mga gastos sa ospital?			
1. sariling ipon/pera	[ ]	[ ]	[ ]
2. pagbenta/sanla ng mga ari-arian	[ ]	[ ]	[ ]
3. utang	[ ]	[ ]	[ ]
4. gamot	[ ]	[ ]	[ ]
5. pribadong insurance	[ ]	[ ]	[ ]
6. tulong mula sa iba	[ ]	[ ]	[ ]
7. iba pang tukoy	[ ]	[ ]	[ ]

(Dagdagan ng papel sa gilid sa kanan kung may iba pang yugto.)

	yugto 1	yugto 2
22. Anu-anong ari-arian ninyo na ipinagbili/isinanla upang makatulong sa pagtustos sa pagpapaospital?		
23. Magkano ninyo ito ipinagbili/isinanla?		
24. Kumikita ba ang mga ari-ariang ito? [ ] Oo [ ] Hindi	[ ] [ ]	[ ] [ ]
25. Magkano ang kinikita nito sa bawat buwan?	P	P
26. Sa tingin ninyo, magkano dapat ang halaga ng inyong ari-arian?	P	P
27. Magkano ang naipangutang ninyo upang idagdag sa pagtustos sa pagpapaospital?	P	P

	yugto 1	yugto 2
28. Kani-kanino kayo nangutang ng pera?		
1. bangko	<input type="checkbox"/>	<input type="checkbox"/>
2. amo/may-ari ng pinapasukan	<input type="checkbox"/>	<input type="checkbox"/>
3. utang sa 5-6	<input type="checkbox"/>	<input type="checkbox"/>
4. kamag-anak	<input type="checkbox"/>	<input type="checkbox"/>
5. kapit-bahay/kaibigan	<input type="checkbox"/>	<input type="checkbox"/>
6. iba pang tukuyin	<input type="checkbox"/>	<input type="checkbox"/>
29. Gaano katagal ang pagbabayad ng inutang ninyong pera?		
30. Magkano ang interes/tubo ng inutang ninyo pera?		
31. Nag-iwan ba kayo ng "prenda" para maka-utang ng pera?		
32. Magkano ang halagang nakuha ninyo mula sa MEDICARE para sa pagpapa-ospital?	P	P
33. Magkano ang halagang nakuha ninyo mula sa "insurance" para sa pag-papaospital?	P	P

Talakayin nating ngayon ang tungkol sa iba't-ibang sistema na kung saan ang isang indibidwal ay nagbabayad para sa pangangailangang pangkalusugan. Ang isang pinakakilalang mekanismo ay suportang ibinibigay ng medicare para sa mga SSS/GSIS.

34. Mayroon ba sa inyong pamilya ang miyembro ng medicare? ☐ Oo (Sagutan Blg. 40-52)  
☐ Hindi
35. Mayroong mga ibang tao na sumasali/ naghuhulog sa pribadong "insurance" or HMO? Mayroon ba sa inyong pamilya ang kasapi sa ganitong sistema o HMO. ☐ Oo  
☐ Hindi
36. Mayroon din namang iba na binibigyan ng mga benepisyong pangkalusugan ng mga kompanyang kanilang pinapa sukan. Sa inyo bang pamilya ay may nakararanas ng ganitong benepisyo? ☐ Oo  
☐ Hindi

37. Ikaw ba o sinuman sa inyong pamilya ay kasapi ng isang kooperatibang pangkalusugan na susuporta sa mga gastusing pangkalusugan?
- [ ] Oo (Sagutin Blg. 66-76)  
[ ] Hindi
38. Sakaling may naospital o nagpakonsulta ang sino man sa inyong pamilya, mayroon ba kayong tukoy na tao/grupo na maari ninyong lapitan upang hingan ng tulong?
- [ ] Oo, tukuyin \_\_\_\_\_  
[ ] Hindi  
a. magulang, kapatid  
b. civic group (tukuyin)  
k. kaibigan  
d. kamag-anak  
e. iba pang tukuyin \_\_\_\_\_
39. Anong uri ng tulong/suporta ang maibibigay ng taong ito/grupo sa inyong pamilya?
- a. pera, libre  
b. pera, utang  
k. assistance in kind

#### 1.1 PARA SA MAY MGA MEDICARE

- |   | Kasapi 1 | Kasapi 2 |
|---|----------|----------|
| 40. Ilan sa inyong pamilya an nagbabayad sa Medicare bilang miyembro?                               |          |          |
| 41. Sinu-sino ang mga ito?  |          |          |
| 42. Mayroon bang miyembro ng SSS/GSIS sa inyong pamilya?  |          |          |
| 43. Gaano na katagal kasapi siya/sila ng Medicare?  |          |          |
| 44. Mayroon na ba sa inyong pamilya ang na-ospital at ragamit ang mga benepisyong mula sa Medicare? | Oo       | Hindi    |
| Bakit hindi? _____  |          |          |
|   | Kasapi 1 | Kasapi 2 |
| 45. Sinu-sino ang mga ito?  |          |          |



46. Gaano kadalas ninyo nagamit ang ganitong benepisyo?
47. Kailan ang pinakahuling pagkakataong nagamit ninyo ang Medicare para sa pagpapa-ospital?
48. Mula sa pinakahuling pagkakataong ginamit ninyo ang Medicare, mayroon ba kayong puna tungkol dito? ☐ Oo  
☐ Hindi
49. Anu-ano ang mga punang ito: (Lagyan ng check)
- ☐ Maliit ng porsiyento lamang
  - ☐ Matagal ang pag-aayos ng mga papeles para sa Medicare Iba pang tukoy
  - ☐ Hindi alam kung paano ang pamamaraan ng paggamit ng Medicare
50. Sa inyong palagay, makatutulong ba ako sa mga tao ang maghulog sa Medicare, kahit hindi pa sila na-ospital? Bakit? \_\_\_\_\_ ☐ Oo  
☐ Hindi
51. Mayroon ba sa kasalukuyang programa ng Medicare na nais ninyong linawin o baguhin? ☐ Oo  
☐ Hindi
52. Anong mga konkretong pagbabagong nais ninyong gawin para sa mga sumusunod na aspeto?
- Mungkahi ng Pagbabago
- ☐ mga benepisyo \_\_\_\_\_
  - ☐ prosesong dinaraan/ ginagawa \_\_\_\_\_
  - ☐ premiums \_\_\_\_\_
  - ☐ mga sinasakop/ sinasagot \_\_\_\_\_
  - ☐ legal na pamamaraan \_\_\_\_\_

## 1.2 PARA SA MAY PRIVATE INSURANCE, HMO, KUNG WALA TUMULOY SA BLG. 66

53. Ano ang pangalan ng kompanya na nagbibigay sa inyo ng mga prebilihedong pangkalusugan o sumasagot sa inyong pangangailangang pangkalusugan?

- 
54. Sinu-sino ang benepisyaryo ng ganitong "Health Insurance"?  
☐ direktang manggagawa/miyembro  
☐ direktang-miyembro at ang kanyang asawa  
☐ lahat ng dependyente (tukoy na bilang)  
☐ iba pang tukoy
55. Magkano ang ibinibigay na hulog ng miyembro at ng amo  
☐ premium na hulog ng direktang miyembro P \_\_\_\_\_  
☐ premium na hulog ng amo/sponsor P \_\_\_\_\_  
☐ di alam
56. Ano ang pangalan ng amo na pinapasukan ng miyembro? \_\_\_\_\_
57. Anu-ano mga serbisyong pangkalusugan ang ibinibigay ng inyong "Health Plan"  
☐ sinasagot ang gastos sa ospital, mga gamot, doktor  
☐ iba pang tukoy  
☐ di alam
58. Mayroon bang limitasyon ang mga serbisyong pangkalusugan ibinibigay? ☐ Oo ☐ Hindi
59. Anong uri ng benepisyo ang kanyang nagamit?  
☐ out-patient  
☐ in-patient  
☐ utang pang-medikal na gamit o medical loan  
☐ dental  
☐ para sa salamin para sa mata/optical  
☐ panganganak o maternity  
☐ reseta o prescription
60. Magkano ang nagastos mula sa sariling pera?
61. Gaano katagal na kayong kasapi sa ganitong uri ng sistema?
62. Ano sa tingin ninyo ang maganda/sulit sa ganitong sistema?
-

63. Ano sa tingin ninyo ang di maganda/di sulit sa ganitong sistema?
64. Paano kayo naging kasapi sa ganitong sistema? (health plan)
- ☐ kusa
- ☐ sa pinagtatrabahuan

### 1.3 SAMAHANG KINASASAPITAN

66. Anong uri ng samahan kayo kasali?
- ☐ samahan sa simbahan
- ☐ samahan sa loob ng komunidad
- ☐ PO/NGO
- ☐ iba pang tukoy
67. Saan ito matatagpuan?
- ☐ sa loob ng barangay
- ☐ iba't ibang barangay subalit parehong lunsod
- ☐ iba't ibang bayan subalit parehong probinsiya
- ☐ iba't ibang probinsiya
68. Saan nanggagaling ang pondo ng inyong samahan?
69. Ang inyo bang samahan ay nakikisangkot sa iba't ibang gawain maliban sa kalusugan? ☐ Oo ☐ Hindi
70. Anu-anong mga gawain patungkol sa kalusugan ang kinikilusan ng inyong samahan?
71. Gaano na katagal kayong kasapi sa samahan?
72. Ano ang paraan ng pagbabayad?
- ☐ butaw ng kasapi
- ☐ diskuwento
- ☐ suyuan / bayanihan
- ☐ iba pa, ituloy
73. Sa anong dahilan kayo sumali sa inyong samahan?
74. Kailan ang huling pagkakataon na ang miyembrong inyong pamilya ay nakagamit ng ganitong benepisyo?
- ☐ nakaraang buwan
- ☐ sa loob ng 3 buwan pero mahigit na isang buwan
75. Kailangan bang mag-ipon ng pera para sa mga emergency o dagliang pangangailangan?
- ☐ Oo
- ☐ Hindi

76. Kung kayang gawin ito, anong uri ng mga dagliang pangangailangan ang tatabihan mo ng pera?  
(Atasan ng ranggo, 1 bilang pinakamahalaga)
- ☐ Para sa eskuwela ng mga bata
  - ☐ Pang-retirement
  - ☐ Bahay at lupa
  - ☐ Para sa kalusugan
  - ☐ Para sa pagkain
  - ☐ Iba pa (Pakitukoy)
77. Kung hihingan ka ng butaw, para saan mo gusto itabi ito?  
(Paki-atasan ng ranggo, bilang 1 ang pinakamahalaga)
- ☐ aksidente/kalamidad/sakuna
  - ☐ pangkabuuang pag-aalaga ng kalusugan
  - ☐ edukasyong pang-kolehiyo
78. Saan mo kukunin ang pera para dito?  
(Tukuyin ang lahat na pagkukuhanan mo)
- ☐ suweldo
  - ☐ regalo
  - ☐ tulong ng gobyerno
  - ☐ pinagsasama ang lahat ng kita
  - ☐ remittance
  - ☐ iba pa (pakitukoy)
79. Kung saka-sakaling may biglang ma-ospital sa pamilya mo, saan mo kukunin ang pangtustos dito?
- ☐ mga naipon
  - ☐ utang
  - ☐ magbenta ng ari-arian
  - ☐ pagsangla ng gamit o ari-arian
  - ☐ iba pa (pakitukoy)

#### ATTITUDES, PERCEPTIONS, PRACTICES

##### A. Konsepto ng Kalusugan

Nais naming malaman kung ano ang tingin mo sa kalusugan at ang tamang pangangalaga nito. Basahin ko ang ilang mga pangungusap. Kung sang-ayon ka, sumagot ng "Oo". Kung hindi naman pakisabing "Hindi".

	Oo	Hindi
> Ang taong malusog ay isang tao na hindi nagkakasakit ng mahabang panahon.	<input type="checkbox"/>	<input type="checkbox"/>
> Kumukunsulta lamang sa doktor kapag may karamdaman na.	<input type="checkbox"/>	<input type="checkbox"/>
> Pareho ang mga problemang pang-kalusugan ng mga mayayaman at mahihirap.	<input type="checkbox"/>	<input type="checkbox"/>

##### B. Ang Pangkalusugang Manggagawa

> Laging tama ang herbolaryo pagdating sa kalusugan	<input type="checkbox"/>	<input type="checkbox"/>
> Laging tama ang doktor pagdating sa kalusugan.	<input type="checkbox"/>	<input type="checkbox"/>

##### C. Uri ng serbisyong pangkalusugan sa aming pamayanan.

> Sapat ang mga serbisyong pangkalusugan sa aming pamayanan.	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

- |  | Oo    | Hindi |
|--|-------|-------|
| > Kasing husay ng mga doktor sa gobyerno ang mga doktor sa pribado.        | [   ] | [   ] |
| > Pantay-pantay ang pagtingin ng pribadong doktor sa kanyang mga pasyente. | [   ] | [   ] |

#### D. Gamit ng Serbisyon Pangkalusugan

- |   |       |       |
|---|-------|-------|
| > Kung pareho ang singilan sa ospital ng gobyerno at sa pribado, higit kong tatangkilikin ang pribadong ospital.                                    | [   ] | [   ] |
| > Kahit mahusay naman ang pribadong ospital ngunit mahal, mas gugustuhin ko pang pumunta sa ospital ng gobyerno dahil sa mura.                      | [   ] | [   ] |
| > Kung malubha ang sakit ng isang taong may edad, dadalhin kaagad siya sa ospital klinika/ospital ng gobyerno kaysa sa pribadong klinika o ospital. | [   ] | [   ] |
| > Kung malubha ang sakit ng isang taong may edad, dadalhin ko siya sa klinika/ospital ng gobyerno kaysa sa pribadong klinika o ospital.             | [   ] | [   ] |
| > Interesado ba kayong lumahok sa isang sistemang tutustos sa mga gastusing pangkalusugan.  | [   ] | [   ] |
| > Papayag ba kayong magbigay ng regular na butas (buwanan o lingguhan) para sa pantustos ng mga pangangailangang pangkalusugan?                     | [   ] | [   ] |

#### E. Drugs and Prescription

- |  |       |       |
|--|-------|-------|
| > Kung mukhang malubha ang sakit ng isang tao, dapat lamang mag-reseta ng gamot ang doktor kung mahusay siya.      | [   ] | [   ] |
| > Kung gumaling ang isang pasyente, maaari nang itigil ang pag-inom ng gamot kahit na hindi pa ubos ang naireseta. | [   ] | [   ] |
| > Maaring gamitin ang dati nang nairesetang gamot para sa isang sakit na kamukha ng dating sakit na gumaling na.   | [   ] | [   ] |
| > Dapat lamang uminom kaagad ng antibiotics kapag may karamdaman.  | [   ] | [   ] |

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## APPENDIX C

### FOCUS GROUP DISCUSSION DATA

#### PROCESSES RULES/GUIDELINES

##### I. OBJECTIVES:

1. To assess present health needs, preferences and attitudes in health seeking towards sharing risk in health financing;
2. To evoke possible problem areas or conflict in the implementation of a health care financing scheme in the community;
3. To identify possible community institutions or mechanisms that may facilitate the putting up of health care financing;

##### II. GUIDELINES:

###### A. *Discussion guidelines:*

1. Participants numbering 10-15 must be either the mother or father of the family in the target communities and some leaders in the community.
2. The discussion is free-flowing and everyone must be able to air their opinions and should conflicts arise -- the basis of conflict must be identified and expressed. There is no need to resolve the conflict.
3. The discussion must be documented by a tape recorder and/or a documentor.
4. The process will take one to one hour and a half.

###### B. *Guide questions:*

1. What health services do you require in the community? and how do you access them at present?
2. What do you understand by cooperative?
3. What do you think of this type of financing?
4. Do you think this system of health care financing will succeed in the community? Why do you think so? Why not? What mechanisms do you suggest to ensure success?

##### III. SYNTHESIS OF FOCUS GROUP DISCUSSIONS:

Six focus group discussions were held in the communities with an average of 10-15 participants per group. 67 people participated and majority are women.

###### A. *Attitudes on health and risk-sharing:*

Discussions on risk-sharing got impeded by discussions of mechanisms and operations of risk-sharing. A discussion of what risk-sharing means had to be done first to clarify what risk-sharing is and what Medicare does. Hand-outs were distributed and discussions of the informal type were held in the communities. Then the focus group discussions were again conducted.

However, most discussants admit they have to consult their husbands first since most of the participants were married women. Even if the fee were P1/day, their husbands had to be consulted.

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Only if the fee were P5/month then no discussion with their husbands is necessary. One participant, a woman of 40 who smokes 10 sticks of cigarettes a day, said that she can pay P5/day -- all she had to do was reduce her smoking to half. But majority agreed that P20/month would be the most reasonable.

Discussions of cost of medical care revealed that the poor were paying exorbitant doctors' fees. One consultation would cost P200 at the very least. This, however, would include the drugs which are only available in the adjacent doctors' drugstore. In one instance, a participant who is a free-lance carpenter, reported spending P400 for the drainage of abscess in a government hospital. This includes cost of drugs, gloves and even the anesthetic agent which he claims did not work.

Another mother spent P2,000 just for drugs in Jose Reyes Memorial Medical Center for a two-week stay of her seven-month old baby who was sick of pneumonia. Consequently, this mother was hoping they could enjoy Medicare benefits, even just for the children.

#### *B. Attitudes towards Medicare*

After one focus group discussion that included a discussion of Medicare, the staff realized that little is known of Medicare by the people. Only a handful of the participants knew and are currently enjoying benefits from Medicare through their husbands who are mostly factory workers. The staff has to intervene by holding orientation sessions on Medicare and distributing leaflets on Medicare.

After the education campaign on Medicare, the focus group discussions were resumed. For people who were covered by Medicare, their experiences with Medicare were generally positive except for the usual complaint of red tape. For those not covered, Medicare enjoys a very credible status. But everyone agreed that the system could use more improvements especially in the area of amount of benefits. Another consensus suggestion was to include out-patient care. Discussion ended with a guarded note on how Medicare can cover the urban poor. The people were concerned about the monthly dues that will be collected and the mechanism of collection. In the end, most of the participants admitted that there must be a genuine organization in the community who can facilitate the collection and the coordination with government institutions who will handle such a health care financing project.

#### *C. Some insights on the health financing project:*

Discussion of how sourcing of financial expenses was severely limited by the fact that the people were too embarrassed to talk about this in a group. Follow-up and prying questions were ignored. Later on, lack of integration of the staff since the focus group discussions were handled early on in the research was spotted as one factor for this limitation.

#### *D. Suggestions from the groups:*

1. Many were willing to pay the government health centers of even up to 50% of costs of medication as long as the drugs are of good quality and of adequate supply.
  2. Hospitalization subsidy by Medicare should be increased to 50% of total hospital cost.
  3. Most participants prefer to go to the private doctors since they are considered better doctors and they have drugs available in their clinics. As a matter of fact, patients who go to the government health centers go there only for the minor ailments like cough and colds. For more serious conditions, they go to the private doctor and later to the government hospitals.
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4. Patients claim that the government health centers are weak because of two things:
    - patronage system -- you are better taken care of and more quickly if you know and offer favors to the health center personnel.
    - lack of drugs -- patients cannot afford the drugs prescribed by the government health physicians--patients cite cost of travel and time consumed just to get to another drugstore for the purchase of an expensive drug.
  5. Observation of facilitators and staff:
    - a. doctor-dependency even for the minor ailments prevail
    - b. irritational drug use abounds as antibiotics are taken even for viral conditions and prescriptions are never completed
    - c. health care seems to be a major concern of the community especially the mothers
    - d. security of land tenure though it did not come out in the discussion is a major concern in the community since threats of demolition were hurled at them months before the research started and many say that this would depend on the outcome of the elections
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**COMMENTS ON THE STUDY**  
**"SPECIAL BENEFICIARY GROUP: THE URBAN POOR"**

By: Mario M. Taguiwalo<sup>1</sup>  
 January 13, 1994

The study of Dr. Olympia Q. Malanyaon is a useful description of the socio-economic conditions that frame the urban poor's possible participation in a health care financing scheme. My comments are of the nature of speculations about the meanings and implications of the study's findings.

1. The study presents a picture of individuals, families and communities living on the edge, literally on the edge of inhabitable land, and figuratively on the edge of dignified existence. They are relatively young (hence low levels of accumulated assets); mostly recent migrants (hence separated from their extended family networks); lack security in housing and employment (hence uncertain physical and economic conditions); operating in chronic financial deficit for ordinary living needs (hence probably in continuous debt).

It seems to me that these conditions, their behavior relative to health is rational and sound. They only act in the face of a health crisis because there are many more important needs to their survival other than setting aside money for a health emergency. As it is they are already in regular deficit and may already be in debt for their ordinary daily needs. They use the community and government as a substitute for the informal family support network which could have been lost upon their migration to the city. These networks normally respond only in a crisis. They use curative and private facilities because the conditions they face during these crises require such capabilities. And they resort to expensive emergency financing in order to pay for these crises because they have probably utilized their regular sources of financing for their non-crisis needs.

2. Can we make the case for more efficient, more appropriate financing behavior under their conditions? Illness is the crisis which the poor regularly meet. Financing the services and goods required to adequately address illness is the challenge that has to be met. In order to sort this out, we could make a distinction between illness that occurs as a random event (e.g., accident, unavoidable cancer, violence, hereditary conditions); and illness that occurs as a logical consequence of lifestyle (e.g., malnutrition, communicable diseases due to poor sanitation, preventable illnesses). Financing personal medical care for the first group of illnesses makes insurance or risk pooling sense because people cannot predict these things and therefore they need to set aside contingent funds for them. Financing personal medical care for the second group of illnesses should be better approached from a public health. Not an insurance standpoint. Instead of setting aside money for a possible hospitalization due to measles, it may make more sense spending money to obtain measles immunization. Instead of cracking our heads looking for ways to finance the treatment of diarrhea, measles, tuberculosis and other communicable and preventable diseases, we should instead focus on altering the known and prevent risk factors of these diseases through better nutrition, health education, household practices, early treatment and cure; measures better undertaken as direct public health interventions rather than services extended via health insurance.

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## COMMENTS OF THE STUDY "SPECIAL BENEFICIARY GROUP: THE URBAN POOR"

By: Mario M. Taguiwalo

January 13, 1994

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The point is that under the conditions of extremely adverse public health conditions of the urban poor, community financing and local health insurance could be a solution looking at the wrong problem. The proper response is vigorous, well funded, effective and wide coverage public health programs, financed by tax money and undertaken by health service institutions whose provisions are subsidized. Once these are in place, it then makes sense to plan and undertake risk pooled, participatorily financed, personal care programs for the illnesses that occur even with the systematic improvement of public health measures.

3. The study documents the availability of health facilities in the activity of the urban poor communities. This is an advantage which the rural poor does not have. But the study also indicates how unresponsive these facilities are to the health needs of the urban poor. Both private and government facilities are indicated. There is no lack of facilities but there is clearly a lack of purchasing power on the part of the urban poor, hence their lack of influence on the operational priorities of these facilities. This to me points to the possibility of converting government subsidies for the health needs of the urban poor, from subsidies to facilities into subsidies to poor consumers utilizing facilities. A system where the poor are entitled to buy health service vouchers at less than their face value, which can then be used for professional services, medicines, hospitalizations and other health services from designated facilities could be a measure to combine government subsidy with people's own contribution so that the poor can buy satisfactory service.