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Health Financing for the Rural Poor: Findings from a Survey Study

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Philippine Institute for Development Studies

Health Financing for the Rural Poor: Findings From a Survey Study

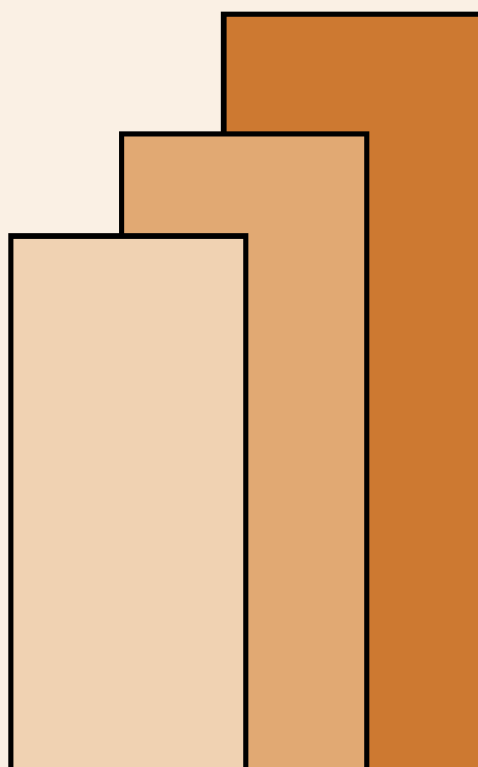
Michael Costello and Marilou Costello

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Health Care Financing for the Rural Poor:

Findings from a Survey Study

Michael A. Costello

and

Marilon Palabrica-Costello

Final Project Report to the DOH-PIDS
Project on Health Care Financing Reform

Research Institute for Mindanao Culture
Xavier University

15 August 1994

Acknowledgments

This study could not have completed without the assistance of many friends and co-workers. The original idea for the project came from Dr. Orville Solon. We are indebted to him for this suggestion, as well as for his patience in awaiting the final output. Our very able field researchers--Zossimo Butil, Paz Moneva, Oliver Patino and Kit Talja--did an efficient job of collecting the primary data, at the same time passing on to us many useful suggestions and insights. Jhat Palma served as project supervisor for editing and coding, while Luceno Badoles and Karen Macapelit handled the computer analysis. Jessica Caharian took care of the word processing for all project reports, often under considerable time pressure.

Dr. Mario Lamberte, of the Philippine Institute for Development Studies, has carefully gone over all reports in this series, including the present one. We greatly appreciate his comments and criticisms since they have helped us to sharpen our thinking or to clarify our positions in several instances. (Indeed, the reader will note that in several instances we use this report to respond to some of the more critical points raised by Dr. Lamberte.)

Our greatest appreciation, however, is reserved for the people who served as our respondents, which is to say those rural folk who graciously allowed us to come unannounced into their homes, with all sorts of questions about areas which are essentially personal and private: their meager earnings and few possessions, their bouts with illness, the deaths of their loved ones. Not a single person selected into the sample refused to participate and only a handful showed mild displeasure when the time required to complete the interview extended (as it so often did) to an hour or more. There is an oft-unrecognized moral dilemma here, particularly for those researchers who would forget that this sort of essential hospitality deserves a comparable response on their part. In the words of the American writer, James Agee (1980, p.7), who once undertook a similar investigation into the living conditions found among Alabama tenant farmers,

"it seems to me curious, not to say obscene and thoroughly terrifying, that it could occur to an association of human beings drawn together...to pry intimately into the lives of an undefended and appallingly damaged group of human beings...for the purpose of parading the nakedness, disadvantage and humiliation of these lives before another group of human beings, in the name of science...of humanity, of social fearlessness, for money, and for a reputation for crusading and for unbiased...and in virtual certitude of almost unanimous public approval."

The only solution to this dilemma, we believe, is for the researcher to depict the situation of the rural poor with as much accuracy, insight and compassion as might be humanly possible. This we have attempted to do, highlighting therefore the many problems faced by our respondents without, we would hope, falling into the error of false sentimentality. For its part, we would hope that our readers will also recognize the implicit debt which they owe the sample households and, as such, be willing to consider our findings carefully, critiquing them where necessary but ultimately acting upon them in one way or another, be it only to write a letter here or to spend an hour there discussing the vagaries of health care financing. For the social mechanism is somehow out of balance. The scales of life--and of death, as well--have surely been tipped against the great bulk of our rural brothers and sisters. And who is there to set them right again if not ourselves?

Chapter One. Introductory Matters

Background and Research Design

This study is concerned with the health care needs, attitudes, behaviors and financing strategies of the rural poor. In general this group is "made up of small-scale farmers and fishermen, the landless laborers, women-headed households and disadvantaged minority groups. Their poverty arises from their lack of productive assets (for example, land, fishing gears), low wages, and the lack of remunerative employment opportunities" (Getubig, 1992, p. 4).

Even though the poverty class has certain commonalities (e.g. low incomes) it would be an error to regard it as a completely homogeneous entity. Small farmers and landless agricultural workers are both poor, but recent studies in the rural sociology of the Philippines have indicated that insecurities are greater in the latter case than in the former (e.g. Ledesma, 1982; Veneracion, 1985). Differences in ethnicity, in household size and composition, in stage of the life cycle, and in place of residence, to name just a few, may also be expected to further differentiate the rural poor. Specific groups experience various problems, thereby implying that programmatic responses should perhaps not be limited to some single approach or strategy. As I.P. Getubig (1992, p. 13) has noted, there is thus a question

"of whether it is necessary to have a different social security instrument or delivery system for each major group amongst the poor (for example,...farmers versus landless workers versus fishermen)....Are not their needs and situations divergent enough to require a different instrument for each? If so, in what ways are these instruments different? What are their essential features as regards design, organization, management, implementation, etc? How do you prioritize between these groups and amongst various programmes and benefits?"

The present study may be viewed as a response to these sorts of questions. It seeks to compare eight different residential/occupational "communities," all of which can be classified as falling within the general category of the rural poor. These communities are follows:

1. Small farmers growing corn in Barangay Kaayonan, Kitaotao, Bukidnon;
2. Small farmers cultivating coconuts in Barangay Odiongan, Gingoog City, Misamis Oriental;

3. Small farmers in an isolated upland setting (Barangay Mat-i, Claveria, Misamis Oriental;
4. Landless agricultural workers on rice farms in Barangay Dumarait, Balingasag, Misamis Oriental;
5. Landless agricultural workers on sugar plantations in Southern Bukidnon (Barangay Butong, Quezon municipality);
6. Landless agricultural workers on rubber plantations in Barangay San Isidro, Talakag, Bukidnon;
7. Municipal fishermen in the "market-linked" setting of barangay Luyong Bonbon, Opol, Misamis Oriental; and
8. Subsistence fishermen in a community with poor market access (Barangay North/South, Medina, Misamis Oriental).

Our general assumption in this regard is that a number of significant differences on health-care related variables will be found to exist among these various "communities."

Even though, major emphasis will be given over to inter-community comparisons, it is evident that this is only one of several levels of analysis which come into play in the determination of health care behaviors and attitudes. On the one hand, both interhousehold variations (e.g. income, parental education, household size and composition) and intrahousehold variations (e.g. gender, age) should be taken into account. On the other, macro-level factors (regional, national, international) must also be considered. Figure 1 illustrates these different levels of analyses by means of a series of concentric circles.

The term "community" is generally defined along geographic (or ecological) lines, i.e. as a group of households clustered together in space, bounded by various criteria such as political demarcations or the distribution of day-to-day exchanges and interactions. In the present instance we retain the locational aspect (since all eight communities are found to lie within a single barangay), adding to this the criterion that the heads of those households selected into each of the eight subsamples should belong to the industrial category under consideration (e.g. small farmers growing corn, landless workers in the sugar industry). Various operational definitions were therefore needed at this point to make it clear as to which households were "landless", which farmers were tilling "small" plots of land, and the like.

It is important to stress at this point that the present effort may best be understood as a descriptive study rather than as an example of explanatory (hypothesis testing) research:

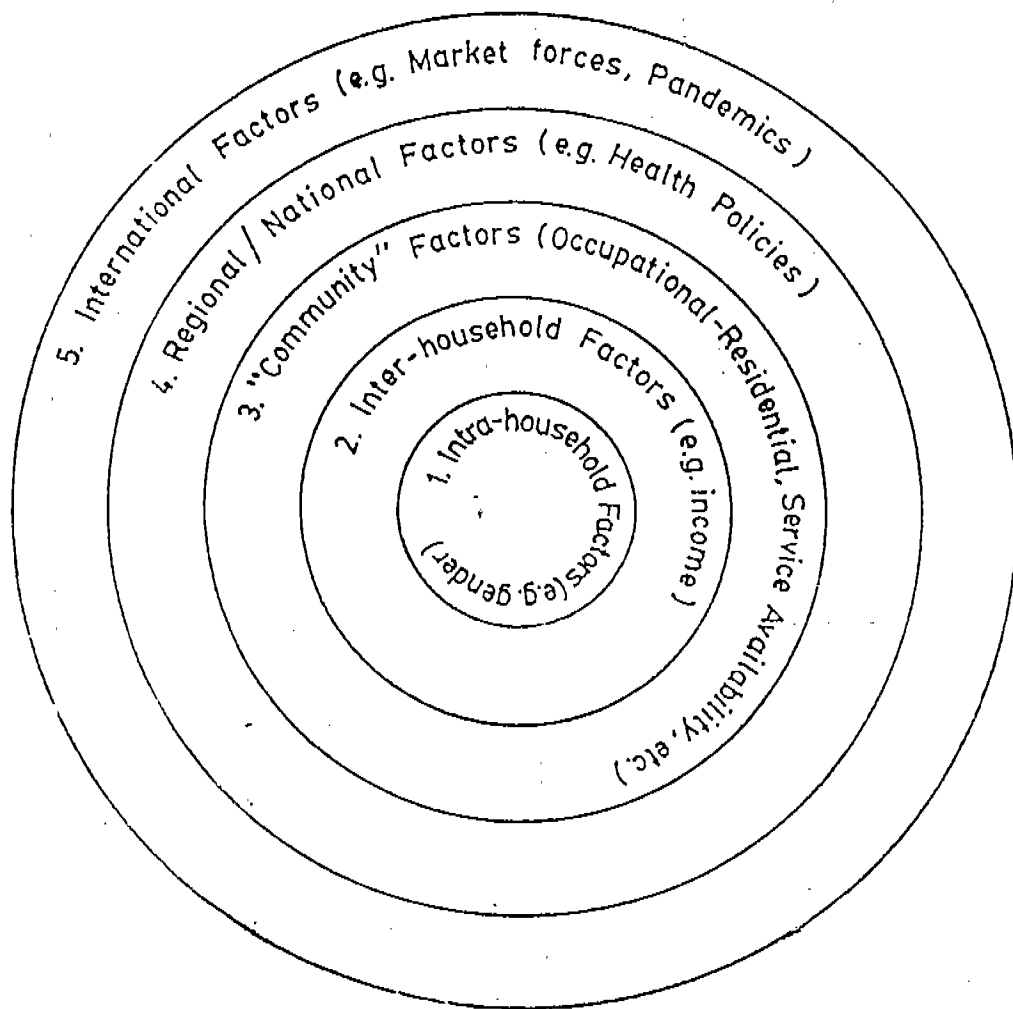


Figure 1. Varying Levels of Analysis for Studies of Health Care-related Phenomena

In the beginning, there is description. When one does not know anything at all about a problem, he must understand it in a general way before beginning to make specific inquiries about...the subject.

A descriptive study does not have a set of clearly delineated dependent and independent variables....(Simon, 1969, pp. 52-53).

Selection of the descriptive approach seems appropriate in this case insofar as we are dealing here with a rather unwieldy study problem, one which calls for a variety of methodological approaches and a wide-ranging set of study variables. The general issue is this: the government's Medicare program appears not to be offering much assistance to the bulk of the rural poor--small farmers, landless agricultural workers, fishermen. There is a need, therefore, to come up with some innovative approaches along these lines, if only to keep faith with the Constitutional guarantees that there is a "right to health" and a "priority for the needs of the underprivileged sick" (Articles II and XIII of the 1987 Philippine Constitution). But how can this be done? What really are the major health problems of the rural poor? How are they now coping (or failing to cope) with these problems? Which of the various strategies for health care financing assistance which have been suggested would be most attractive to members of the rural poverty class? Which will be most feasible for actual implementation?

The immediate implication of all this was that a spectrum of data-gathering techniques would be needed by the study. On the one hand, therefore, we carried out more than 300 structured interviews as based upon randomly selected samples of 40 households per "community". These interviews were in nearly all cases held with the spouse of the household head although there were a few instances (e.g. widowers and female-headed households) in which the household head served as the respondent. The purpose of the interviews was to quantify various individual and household factors related to the study. As a supplement to this, however, information was also needed on the local community itself since it is within this particular geographic context that household-level decisions are made. (One might expect, for example, to find lower levels of "modern" health care utilization in barangays where there are no physicians, midwives or registered nurses holding regular office hours.) A community-level inventory of local conditions and resources was therefore conducted by means of interviews with knowledgeable local informants.

Yet a third methodological technique was adopted in the form of a series of intensive follow-up interviews with a few selected households. These "case studies" were undertaken with a view towards adding an exploratory, or hypothesis generating, perspec-

tive to the study. Again, this is not an uncommon strategy to follow for a descriptive-type study, insofar as analyses of this type will typically employ a variety of data-gathering techniques (cf. Selltitz, Wrightsman and Cook, 1976, p. 102).

Health Care Factors and the Rural Poor: General Consideration

There are at least two reasons for expecting that the health care situation of the poor will be inherently problematic. In the first place, it is quite likely that the Philippine poor may well be less healthy than those persons or households who are fortunate enough to live above the poverty line. Poorer families are generally more subject to such problems as malnutrition, unsanitary water supply, inadequate housing and high fertility, all of which are in turn linked to higher levels of morbidity and mortality (e.g. Costello, 1988).

Even as they experience more frequent illness episodes, members of the poverty class may also be expected to experience lower levels of access to adequate health care facilities. Various studies have thus shown lower class households (i.e. those with low incomes and few assets including parental education) to fare poorly in this regard. Compared to the middle and upper classes, their resort to preventive health care services is less frequent, even as their choice of curative strategies is less likely to lie within the confines of the modern medical approach (e.g. Becker, et al, 1993; Cleland and van Ginneken, 1989; Gerenne and van de Walle, 1989; Elo, 1992). In the Philippines the very poorest groups are considerably less able to utilize high quality private sector health care facilities. In fact, they are even less likely than middle stratum families to visit one of the government-funded clinics or hospitals which were supposedly set up to serve their specific needs (Solon, et al., 1992). Poorer households also tend to delay for a longer period before seeking medical care and are generally less likely to comply fully with the course of treatment prescribed to them.

The nature of the relationship between socioeconomic status and health care behaviors has been addressed by at least two major theories. For its part, the sociocultural explanation emphasizes such factors as the overall political climate, cultural conditions which encourage or discourage female autonomy, mass media use and education, particularly maternal education. Poorer households or nations generally do not fare well on indicators of these variables, thereby explaining their equally low ranking on health and mortality measures. Efforts to inculcate improved health habits among the poor and to make them a more active or assertive health care clientele, however, could turn this situation around, even when incomes and living standards remain low

(e.g. Caldwell, 1986). In contrast, the economic paradigm has emphasized the manner in which the low and irregular incomes accruing to poorer households make it difficult for them to afford decent care, even as macro-level economic constraints (e.g. the international debt problem) prevent many Third World governments from improving their admittedly inadequate health care delivery systems (e.g. Crook, 1993).

Assuming that the economic paradigm is at least partly correct, it immediately becomes apparent that the question of health care financing must play an important role in any discussion of the relationship between poverty and health. At present, higher income families in the country are spending ten to twenty times as much on health care as is true for the poorest rural groups. Further still, the rural poor are practically ignored by government-based health insurance programs. Indeed, only 38 percent of the Philippine population is covered by Medicare, with most of these persons comprising urban-based salaried workers and their dependents (Solon *et al.*, 1992, pp. 27 and 29). It is evident that major differentials of this sort must inevitably be reflected in parallel inequalities in current health status.

Various suggestions have been made for improving the health care financing options of the poor. Some of these work within the present Medicare system, attempting in one way or another to expand the proportion of households that are covered by this. Thus, appropriate macroeconomic policies for stimulating economic growth could be of some help in this regard, by accelerating the structural transformation of the country's labor force out of agriculture and into the urban, formal sector. Unfortunately, progress in this regard has been slow. (1) This being the case, expanded guidelines for Medicare coverage might next be considered, although here, too, some problems to have cropped up:

"(The Philippines)...has probably made the most serious effort to expand coverage to the informal sector, microenterprises and agricultural workers. For instance, the minimum number of employees required for an enterprise to be covered has been gradually reduced from 200 to 1, and agricultural workers, employed at least half of the year, are now entitled to coverage. However, noncompliance is very high..." (Mesa-Lago, 1992, p. 79).

A number of innovative financing strategies have therefore been suggested, both as a means of extending health care coverage to the poor and as a way of improving the efficiency, and ultimately the quality, of the present delivery system. Four of these approaches were discussed extensively at a Regional Seminar on Health Care Financing, which was held in 1987 in Manila (Asian Development Bank, *et al.*, n.d.). These included (1) community

financing schemes, (2) systems of user charges, (3) various health insurance programs, and (4) new ways of involving the private sector.

The present study is not the place to discuss the definitions, strengths and weaknesses of these alternative financing schemes. Interested readers may be referred to review papers or these approaches which were prepared for the Manila Seminar, particularly those by Abel-Smith and Dua (n.d.), Myers (n.d.), Griffin (n.d.), Akin (n.d.) and Andreano and Helminiak (n.d.). What is apparent, though, is that policy or programmatic support for one or a number of these options cannot exist in an informational vacuum. Research is sorely needed on the manner in which poverty groups are presently dealing with their health care problems as well as on their readiness to take part in one or another of the proposed alternatives:

"To achieve greater service utilization efficiency through the design of mechanisms or incentive structures that will modify the behavior of consumers and providers with respect to service utilization, and through the design a delivery structure that will maximize utilization of services and facilities, it is necessary to understand, through careful research and analysis, both the demand and supply factors influencing health service utilization" (Herrin, 1992, p. 29).

The present study takes this goal for its ultimate objective, in the main by focusing on demand-side factors found among the different rural poverty groups.

Major Study Variables

Variables analyzed in the present study may be visualized as falling within four major blocks: (1) background factors, (2) health care inputs, (3) health care outputs, and (4) health care financing factors.

The most important background factor is, of course, the particular poverty group, or "community" which the respondent and her family belong to. Other variables found within this block are the standard social, economic and demographic factors: age and sex, education, marital status, religion/ethnicity, income (magnitude and seasonality of), ownership of productive assets and of consumer durables, media use, accessibility to public and private health care facilities. Some background factors refer more to the household than the individual, e. g. household size and age composition.

Health care inputs may be contrasted along various lines such as modern vs. traditional, public vs. private, preventive vs. curative and self-treatment vs. getting help from a medical specialist. Various KAP ("knowledge, attitudes, practice") items relating to these different dimensions were therefore included on the survey instrument. Other health care inputs which were investigated include delays in seeking out specialized health care practitioners and the quality of doctor-patient relations experienced in the past. As far as this latter factor is concerned, Cleland and Van Ginneken (1989, p. 86) see the Third World poor who seek help from modern sector health care practitioners as undergoing an experience which is "overwhelming and bewildering, alien and frightful," thereby suggesting at least one reason why they do this so rarely and so reluctantly.

An important component of the health inputs question consists of health-related expenditures. These can be substantial, even when the public-sector delivery system is utilized. As one study has pointed out,

For many rural Indians, the direct and indirect costs of even "free" health care are significant. Surveys often show sizable out-of-pocket expenses for transport, unofficial fees, and purchases of drugs prescribed in free facilities but not available there. The opportunity costs to poor families of travel and waiting time at health facilities are also important (Berman, 1991, p. 20).

The survey instrument used in the present study thus included questions on each of these dimensions for all illnesses which occurred (and were treated) during the month preceding the survey. Additional questions were also asked on health care expenditures incurred during the most recent occasion when a family member was hospitalized.

The health care outputs measured in this study revolve around the twin poles of morbidity and mortality. Data are available on infant/childhood deaths and on the type of illness experienced for cases of morbidity and mortality, as well as on chronic diseases and disabilities.

The health care financing variables may refer either to the current situation of the respondent in this regard or to their attitudes towards various proposed schemes. For the former case it will be important to see just how well (or how poorly) the current Medicare program is covering our respondents. We will also want to know about membership in local NGOs, about coverage by other health care financing mechanisms (e.g. work-based programs, private insurance programs) and about the means by which the respondents were able to raise sufficient funds to pay for what-

ever medical emergencies may have arisen during the past few years. In this latter case we might well expect heavy reliance upon informal funding sources, such as loans from friends or relatives. (2)

In other cases, questions of a more hypothetical sort have been asked so as to provide some feedback on alternative financing schemes. Would the respondent be willing to pay some modest amount for the use of public health care facilities? Is she amenable to joining a health care fund such as those now operating in Thailand (Myers, n.d.)? Would the adult household members be willing to offer their labor for a community self-help project? If so, what skills can they contribute in this regard? Answers to these and similar questions could help to design more successful health care financing programs in the years to come.

Appendix I offers further details on the study's empirical framework by listing all study variables measured during the course of the household survey.

Rural Poverty Groups Compared: Some Initial Hypotheses

If the above represents, for the most part, a detailed listing of the study's many "dependent variables" it is perhaps appropriate at this time to say something about our major explanatory factor.

The general assumption here is that the different sustenance patterns under observation (farming, agricultural labor, fishing) will be in some ways associated with corresponding differences in living standards, world views, patterns of health care utilization, and the like. A full-fledged explication of this argument is beyond the scope of this study but a few illustrative examples may perhaps be given.

To begin with, a certain amount of inter-community variation may be expected as far as income and living standards are concerned. One would expect, for example, that the earnings reported by landless workers will generally be smaller than those found for the small-scale farmers. This problem may well be most apparent for those workers employed on rice farms insofar as this now appears to be evolving into something of a declining industry (Lopez, 1993). Rice farms in Northern Mindanao also tend to be rather small, thereby implying that landless workers in this industry will not have a single regular employer, that they will frequently be out of work, and that whatever wages they are able to earn may often fail to meet the standards set by minimum wage legislation. (3) In comparison, both sugar and rubber are plantation crops, a situation which may offer certain advantages to persons working in these two industries. (For example, some of larger plantations may have agreed to offer SSS and Medicare benefits to their regular workers.)

As for the municipal fishermen, a number of studies have enumerated their economic constraints: a generally low level of technology, marketing and credit difficulties, increased competition from commercial trawlers and probable declines in fish stocks, as due to various environmental problems (e.g. Israel-Sobritchea, 1992; Herrin, *et al*, 1978; Ardales and David, 1985; Samonte and Ortega, 1992). Here, too, however, some internal variation might well be found within this apparently homogeneous group. In particular, we would expect the subsistence fishermen of Medina to be experiencing even greater financial hardships than those in Opol. Opol is located adjacent to Cagayan de Oro, thereby making available other (part-time) employment opportunities, along with greater market access. Some of Opol's younger fishermen have also found work on the handful of commercial trawlers that regularly dock there.

Other differentials might also be posited at this point. Landless agricultural workers should be somewhat younger than the small-scale farmers, if only because of the general, secular trend over time towards decreased availability of farmland, on either an ownership or tenancy bases (cf., for example, Suner and Cabacungan, 1985). In the sugar industry, too, it might be expected that plantation workers will be less able to request help from extended relatives during medical emergencies. At present, many of these workers were "imported" from Negros by the big planters of Bukidnon, thereby implying that their nearest relative may well be hundreds of miles away.

Endnotes

1

"The Philippine economy is characterized by unusually slow structural transformation. The percentage of employment in industry in general, and in manufacturing in particular has remained stagnant at around 20 percent for the last 30 years" (Solon, *et al*, 1992, p. 18).

2

Cf., however, Schmidt (1992, pp. 25-26) who notes that "today, many traditional systems cannot guarantee minimal protection to their members any more. These communities are overburdened by the task of maintaining customary compensation mechanisms while, at the same time, keeping pace with the rapid social and economic transformation. In the absence of complementary state institutions, reciprocal networks, based on mutual help, become increasingly important."

3

In her study of landless agricultural workers in Central Luzon, Ma. Corazon J. Veneracion (1985) found that workers in rice were earning less than those in either tobacco or sugar. The rice workers, however, were more likely than those in the sugar industry to have access to one or another secondary income source.

Chapter Two. Community Profiles of the Small Farmer, Landless and Fishing Groups

Introduction:

In this chapter we will attempt to give a broad overview of the eight communities under observation in this study. Data have been taken from a special instrument--the "Community-level Institutional Checklist"--developed specifically for this purpose.

Questions on the checklist refer to the presence or absence of several institutional services in the barangay. These include transport and communication facilities; schools, health care centers, and major business establishments; electrical, water and irrigation infrastructures; availability and cost of some common consumer goods; and the presence and viability of nongovernmental organizations (NGOs). Respondents were knowledgeable persons living in the barangay--e.g. the Barangay Captain, church officials, NGO leaders and clinic administrators. Answers given by the various "key informants" were in all cases compared and reconciled before the final profile was established.

Community Profiles

Small Farmers. Small farmers, both tenants and owners, were interviewed in three contrasting communities. These consisted of corn farmers in Barangay Kauyonan (Kitaotao, Bukidnon), coconut cultivators in a rural barangay (Odiongan) of Gingoog City, Misamis Oriental and the highly inaccessible upland barangay of Mat-i, Claveria, Misamis Oriental.

In terms of accessibility to Cagayan de Oro these are roughly equivalent. Mat-i lies closest to Cagayan de Oro in terms of straightline distance but the fifteen kilometer trip to the town center is fairly expensive and infrequent (8 pesos one way, with about one trip being made every hour). It is another 45 kilometers to Cagayan, with that trip taking about an hour. Odiongan is connected to Gingoog's poblacion by a concrete road. The trip takes about 20 minutes on a jeepney and costs 3 pesos. The subsequent ride to Cagayan then takes about two hours (Gingoog is located 129 kilometers east of Cagayan de Oro). Kitaotao lies more than 150 kilometers due south of Cagayan. A jeepney ride, costing 8 pesos, is also needed to get from Kauyonan to the town center.

Electricity is found in all three study sites. The Proportions of all households connected ranges from about two-thirds in Odiongan to half in Mat-i and only about a quarter in Kauyonan. None of the households in the latter setting, along with only a handful in Odiongan have piped water. In comparison, about a third of Mat-i's households have this service.

There are no irrigation or communication facilities in either Odiongan or Kauyonan. About fifty of Mat-i's farms are irrigated. You can also send an emergency message from there via the local forest guard's radio. All locales had an elementary school and a Barangay Health Station. None had a dentist or a pharmacy. Kauyonan has no secondary school but the other two barangays do have access to such a facility. Both the Department of Agriculture and the DSWD operate a few programs in Kauyonan. These are also available in the other two settings along with programs from the Philippine Coconut Authority and the DAR (Odiongan) and the DENR's Integrated Social Forestry program in Mat-i.

Mat-i has two small eateries, Odiongan one and Kauyonan none at all. Kauyonan also has fewer skilled workers (i.e. nonfarmers like tailors or blacksmiths) and suffers from somewhat higher prices for basic consumer items (e.g. soap, Biogesic). None of the three locations has a large business establishment.

Kauyonan is serviced by only one cooperative, the Kauyonan Multi Purpose Cooperative, or KMPC. It has fifty members and a duly elected set of officers. A similar organization (the Odiongan Multi-Purpose Cooperative) also operates in Odiongan, along with some smaller and less successful groups--e.g. the Coconut Farmer's Association and a DAR-affiliated organization for landless agricultural workers. Mat-i is characterized by the most complex set of non-governmental organizations. These include the Soil and Water Conservation Foundation, the ISF Farmers' Beneficiaries Association, the Datu Manayo Tree Farmers' Association, the Farola Tree Farmers' Project Association, the Mat-i Rural Waterworks and Sanitation Association, the Mat-i Irrigator's Association, the Integrated Farmer's Cooperative and the Mat-i Multi-Purpose Cooperative. A number of these have been set up in connection with the forestry stewardship program of the DENR. Others are based on local concerns, such as irrigation, water and the tomato growing industry.

Landless Agricultural Workers. The first subsample of landless workers was taken from families in Barangay Dumarait, Balingasag, Misamis Oriental. The household heads in this case have no secure position but must instead hire themselves out on local rice farms whenever some work becomes available.

Balingasag is located 45 kilometers east of Cagayan de Oro. A jeepney trip between these two locales costs 10 pesos and takes about an hour. Another twenty to thirty minutes is then required to get to Dumarait, which is accessible only to motorelas, often after a lengthy wait.

The second group of respondents consists of sugar workers in barangay Butong, Quezon, Bukidnon. Several large haciendas have been established in this area, including one being operated by the Bukidnon Sugar Company (BUSCO). BUSCO also operates a sugar mill in Quezon, a town located about 150 kilometers south of Cagayan de Oro. (A bus trip takes about three and one-half hours, with a cost of fifty pesos. The jeepney ride from Quezon's poblacion to Butong costs an additional five pesos.)

The third study site for landless workers lies within the municipality of Talakag, Bukidnon. This municipality borders Cagayan on the south. Jeepneys ply the route at a cost (one-way) of thirteen pesos per trip. Talakag is located in a moderately elevated setting and still retains some forest cover. A major industry is the cultivation of rubber trees. For our sample we chose forty rubber plantation workers who were residing in Barangay San Isidro.

All three study sites are serviced by electricity. Coverage is highest in Butong and least common in San Isidro. San Isidro and Dumarait both lack any sort of waterworks, whereas about a fourth of the households in Butong have piped water. (This is a private service for the BUSCO workers.) Radios are available for an emergency communication in Butong and San Isidro, but not in Dumarait.

The institutional profile of Butong is the most highly developed among the three study sites. The barangay has three elementary/primary schools, five clinics (one BHS and four privately run clinics operated by the larger haciendas), a dentist (from BUSCO), a dozen large business establishments, several eateries and a fairly large number of government programs or offices (DA, DTI, DAR, etc.). It has a barangay council with an unusually large budget, drawn from taxes imposed on local establishments.

Dumarait appears to rank the lowest in terms of institutional complexity. It has a public elementary school but still lacks a Barangay Health Station. There is no dentist, pharmacy, eatery, or large business establishment.

San Isidro has all institutions found in Dumarait along with an additional primary school, the BHS, two eateries and two large business establishments (the FARRECO rubber plantation and a paper mill).

All of the basic consumer items inquired about during the course of our community survey (Biogesic, Vick's Vapor Rub, toilet paper, soap, sugar, milk, bandages, newspaper, ORT solution and razor blades) could be purchased in Butong. This was the only interview site in the study for which this was true. Prices, however, were slightly higher in Butong than in the other two locales, probably because of the greater distance to Cagayan de Oro.

Butong has three major cooperatives. Two of these are associated with the sugar industry workers. A third (the Butong Landless Farmers' and Workers' Multi-Purpose Cooperative) has been set up for the purpose of acquiring lands under the new comprehensive Agrarian Reform Program (CARP).

The major NGO in San Isidro is the First Agrarian Reform Beneficiaries Cooperative (FARBECO). This organization acquired a formerly Menzi-owned rubber plantation under the CARP. It now operates the plantation on a cooperative basis. Another CARP-related NGO (the Associates for Community Rural Development, or ACCORD) is also based in San Isidro.

Three NGOs were located in Dumarait. One of these (the Dumarait Multi-Purpose Farmers' Cooperative) has been set up mainly for small farmers while another (Dumarait Comprehensive Agrarian Reform Farmers' Association) appeals more to the landless agricultural workers. There is also a fairly active youth group--the Camacawan Youth and Civic Organization. In the last few years this group has constructed a basketball court and a multi-purpose building.

Fishing Communities. Interviews were conducted in two fishing communities. The first of these was Barangay Luyong Bonbon in the municipality of Opol, Misamis Oriental. This was considered to be the "market integrated" fishing community because of its accessibility to the regional capital of Cagayan de Oro. Opol lies immediately adjacent to Cagayan, on its western boundary. A jeepney ride between the two cities costs about four pesos and takes only twenty-five minutes.

According to our informants, most homes in Luyong Bonbon are serviced by electricity and piped water facilities. The local economy is still fairly simple, although two large business establishments (a warehouse operated by San Miguel and a processing plant for a prawn exporting firm) have opened up in the past few years. A few specialized workers live in the area (dressmaker, mechanic) and one can also buy a number of simple consumer items (sugar, soap, milk, bandages, razor blades, toilet paper; but neither a newspaper nor ORT packets). Even so, many residents prefer to conduct their shopping in Cagayan, where selection is greater and prices slightly cheaper.

Four large boats operate out of Opol's port. Only one of these is owned by a local resident.

The barangay's institutional profile is modest but sufficient for most purposes. There is public elementary school but the only DOH clinic is in the town poblacion, found near to Luyong Bonbon. The doctor assigned to the clinic comes on Tuesdays and Thursdays. There is also a full-time midwife and a volunteer health worker. The nearest drug store is in the town center, although one can buy nonprescription drugs at local sari-

sari stores. The government's Fisheries Bureau is credited with running a few programs. Occasional immunization and feeding programs are also held. There is one major NGO--the Rural Water-works Sanitation Association. This has a Board of Directors which meets once or twice every month.

The second fishing community is Barangay North/South in the town of Medina. This municipality is also located in Misamis Oriental but in this case the trip takes about two and one-half hours. (The fare is also concomitantly larger at about 25 pesos per trip.) An additional twenty to sixty minutes, depending on whether one walks or takes a motorela, is needed to get from the barangay to the town center.

Most residents in the area are credited by our informants as enjoying both electrical service and piped water. There are no large establishments, however, and the only consumer items available locally are sugar and soap. There is no health clinic or pharmacy within the barangay, but traditional healers are available, along with a Barangay Health Worker.

The barangay lacks any connection to the outside world (telephone, radio). It must also make do without an elementary school. The great majority of residents are Roman Catholic, as opposed to the predominance of Aglipayans and Seventh Day Adventists in Luyong Bonbon. There are two major NGO's operating in the community; the Rural Improvement Center (RIC) and the Seaside Association. The former is a women's group with about 15 active members. It operates a canteen and gives classes in cooking and sewing. The latter is less formally structured and does not at present have a set of officers.

Health Facilities

Table 2.1 provides an overview of the medical facilities available in the eight study communities. In two instances (Dumarait and Luyong Bonbon) there is no DOH facility in the barangay, not even a simple BHS. In the latter case this is perhaps not a major concern since both the town center and the nearby city of Cagayan de Oro can be reached fairly quickly via a jeepney ride along the all-weather highway.

Most barangay-based clinics are poorly equipped, lacking as they do full-time doctors or nurses and the more sophisticated instruments for a laboratory or surgical procedure. A possible exception to this rule is found in the case of the sugar area (Butong). In this case there is not only the public facility (IHS) but also three private clinics operated by the larger plantations. Our field investigator was not able to gain access to these clinics; we are therefore unsure as to their staffing and equipments. Our general impression, though, is that these company-based clinics are superior to the typical Barangay Health Stations.

Table 2.1 --Health Facilities Available for the Eight Study Communities

	Kauyonan (Corn)		Odiongnan (Coconut)		Mat-i (Upland)		Dumarait (Rice)	
	Brgy.	Town	Brgy.	Town	Brgy.	Town	Brgy.	Town
Number	1	1	1	7	1	3	0	4
Type	BHS	RHU	BHS	Various	BHS	Various	(none)	Various
Doctors	0	1	0	20+	0	7	0	5
Nurses	0	2	0	20+	0	5	0	8
a								
Midwives	0.2	1	0	20+	1	7	0	7
Other professions represented	0	1	0	5	0	2	0	2
Beds	0	2	0	100+	0	15	0	15
Equipment:								
I.P. Kit	*	*	*	*	*	*	0	*
Table	*	*	0	*	*	*	0	*
Microscope	0	*	0	*	0	*	0	*
Dental Chair	0	*	0	*	0	*	0	*
X-ray	0	0	0	*	0	0	0	*
Anesthesia	0	0	0	*	0	0	0	0

Table 2.1 --(Continued)

	Butong (Sugar)		San Isidro (Rubber)		L. Bonbon (Market fishing)		North/South (sub. fish)	
	Brgy.	Town	Brgy.	Town	Brgy.	Town	Brgy.	Town
Number	4	5	1	4	0	1	1	2
Type	BHS, company clinics	Various	BHS	Various	(none)	RHU	BHS	RHU, p
Doctors	?	8	0	4	0	0.4 ^a	0	3
Nurses	?	8	0	6	0	1	0	4
Midwives	?	12	1	6	0	1	1	4
Other professions represented	?	3	0	1	0	2	0	1
Beds	?	68	0	15	0	0	0	22
Equipment:								
I.V. Kit	*	*	*	*	0	*	*	*
Table	?	*	*	*	0	*	*	*
Microscope	?	*	0	*	0	*	0	*
Metal Chair	?	*	0	0	0	0	0	*
X-ray	?	0	0	0	0	0	0	0
Anesthesia	?	0	0	0	0	0	0	0

* At least one such equipment/instrument present

0 No equipment present.

^a Personnel report only one day (0.2) or two days (0.4) per week.

? Unknown (did not visit company clinics).

In cases where the patient is brought to the town center, the provision for his or her health care is universally improved. All towns are served by at least one doctor although the physician of Opol's Rural Health Unit only holds office hours for two days a week. Many families in the town commute to Cagayan when someone is sick. Nurses and midwives are also universally found in the town centers, although the situation for other medical professionals (medical technologists, X-ray technicians, nutritionists, dentists, etc.) is more variable. Medical equipments are also improved although most towns are not prepared for anything approaching major surgery. Overall, Odiongan rated as the barangay with the greatest access to a full set of health care facilities. This is due to its proximity to the poblacion of Gingoog City. Luyong Bonbon is also close enough to Cagayan de Oro to do well in this regard. Kauyonan, Mat-i, and San Isidro appear to rank as the weakest on the question of access to health care facilities.

Other Community-level Information.

In this section we briefly describe some additional factors about the eight communities studied, as were related to our field workers by the key informants. In the case of Kauyonan, the main problem faced by local residents is the fluctuating price of corn. At the time of our first visit (August 1992) corn was selling for six to seven pesos per kilo. Within the next three months, however, this had plunged to only P3.50. Given the high cost of farm inputs, many farmers ended up losing money on their December corn crop. According to our informants, the barangay has been experiencing a net outflow of people during the past decade. This is particularly true for the landless families in the area.

Odiongan is located in the northern part of Gingoog City, along the coastal highway. Most families support themselves through farming or fishing. As with the corn farmers of Kauyonan, a major problem in the area consists in the fluctuating prices for farm products, in this case copra. In 1990 prices reached as low as P3.50 per kilo. This later shot up to nine pesos in 1992 but had fallen again to P5.20 as of our last visit (January 1993). Many of the coconut trees in the barangay are old now, thereby reducing their output.

In a more positive vein, the people of Odiongan were reported by our informants to be willing to work together under a bayanihan work arrangement (in local parlance this is called the pahina system). They have constructed their Barangay Hall in this manner, along with some waiting sheds.

The upland and isolated location of Mat-i has affected it in many ways. About half of the land in the barangay is still forested. However, small-time (illegal) loggers are still at work in the area, leading to ever-growing denudation. Many of the farmers are trying to acquire tenure to their land under the DENR's social forestry program. About a hundred families moved into the barangay in the hopes of gaining land in this way. Most of these applicants are now complaining that their papers are taking too long to be processed.

Mat-i was the scene of fierce fighting between government troops and the NPA during the 1980s. More than fifty people were killed at this time. Many families were forced to evacuate. The present situation is more peaceful. Many farmers are now growing cash crops, like beans and tomatoes. Again, however, prices have fluctuated widely during the past decade.

Farms in Dumarait are generally small. Rice is the main crop. The barangay is connected to the town center by a gravel road. It has an elementary school but lacks a health center, so that residents have to go to one of two nearby barangays if they want to visit a BHS.

A new industry in the community was introduced by the establishment of three new papaya farms in 1992. There is also a recruiter working in the area who brings teenage girls to work in Manila as domestic helpers.

The barangay of Butong is in many ways the most atypical community included in the study. The four large haciendas found therein have led to many changes, such as the establishment of nonagricultural enterprises (small stores, eateries, vulcanizing shops, etc.). Tax collection is also significant, so that the annual budget for the barangay government now stands at over million pesos.

In-migration to the community has been heavy. Many of the newcomers are sugar workers from Negros. There have also been some attempts by organized squatter groups to "invade" some of the sugar estates. These have not been successful, however. Indeed, two of the squatters were killed in a recent confrontation over this issue.

San Isidro is the northernmost barangay of Talakag. That puts it only 24 kilometers away from Cagayan de Oro. (In order to reach the city, though, you must first travel south so as to pass through the Talakag town center.)

The Menzi Development Corporation (a large agricultural enterprise) was ordered by the government (Department of Agrarian Reform) to award its lands to an association of rubber workers, the FARBECO. There are still some unsettled legal questions concerning this issue, but the FARBECO is now operating the plantation.

Beyond the boundaries of the plantation, several small farms are also found in the barangay. The main crop is corn. As with Odiongan and Dumarait, local informants said that the people are still willing to work together under the pahina system.

For the two fishing communities, some conformity was found to the expected pattern of Luyong Bonbon being a more "market integrated" area. Four large fishing boats operate out of this port, thus allowing for a comparison in this case between the fishermen which work as paid/commissioned employees on these boats and those who still operate their own banca. For those in the latter category, data from the municipal profile indicate that about seventy-five percent of these are working out of a non-motorized craft. The most common fishing gear listed for this group is also the simplest: hook and line. Less than half own nets.

Competition between the big and small boats is apparent. The municipal fishermen say they have to do their fishing far from Opol since the presence of industrial establishments and larger boats has reduced their fish catch. Sometimes, though, a small fisherman may work in coordination with one of the big boats. He goes ahead of the larger vessel at night, searching (with lights) for a school of fish. Once this is located he sends a message to the larger boat. After the fish are caught the fisherman is then entitled to one-eighth of the catch. Workers on the large boats are also paid on a percentage basis.

The municipality of Opol extends far inland, into some inaccessible upland areas. In order for a midwife to reach these places she would either have to walk all day or pay eighty pesos (one way). One of the advantages of Luyong Bonbon is thus its ease of accessibility. The barangay also benefits from a water-works program built in 1980 with government and foreign assistance. At present, water is even more available in this barangay than in Opol's poblacion.

For barangay North/South (Medina) there are no large boats and no major industries. The distance from Cagayan is much greater than for Opol, although one smaller chartered city (Gingoog) is relatively close. Most of the barangay residents have access to piped water. The town is also served by a National Comprehensive High School, a privately-run pisciculture center, the DOH Rural Health Unit and a dentist. Most of the fishing households in the area suffer from low and fluctuating incomes.

Summary

This chapter has presented data on community-level characteristics for the eight different groups being compared in this study. It is expected that the information presented herein may be of some utility in interpreting the survey results which will be presented in the next six chapters. For example, the presence of a large number of company-run health clinics in Butong will perhaps facilitate access to health care services among the sugar workers. In comparison, the landless rice workers of Barangay Dumarait do not have this sort of opportunity. In fact, their home barangay does not even have a DOH-run Barangay Health Station, thereby leading us to believe that this group may well rank among the lowest in terms of health care services. The accessibility problem may also loom large for the corn farmers of Barangay Kauyonan, which lies far from any major urban center and for whom the DOH midwife comes only one day a week.

Chapter Three. Social, Demographic and Economic Profiles of the Three Study Groups

Introduction and Sampling Considerations

Data presented in this chapter have been taken from the household surveys conducted in the eight communities. They are concerned chiefly with the demographic, social and economic characteristics of the different study groups. Unless otherwise noted, the sample size for this analysis is approximately 320 cases. That is, forty households were randomly selected for interview in each of the eight barangays.

Research assistants initiated the survey phase of the study by obtaining from the barangay captain a list of all local residents. They went over the list carefully with this official (or some other knowledgeable informant) to determine which persons on the list were eligible for interview (i.e. which households were headed by fishermen, landless rice farmers, etc.) Forty households were then selected randomly from each of the resulting lists, with verification then being made in the field as to whether or not the household had been properly categorized by the local informant. For example, some "landless" rice workers were found to be working on one of the local papaya farms, or to own some farmland. Eliminations were made and substitutions provided in all such cases.

Even though the individual respondents were selected in a random fashion, results from this study cannot be generalized to any larger geographic area, such as Northern Mindanao or the Misamis-Bukidnon subregion. This is so because of the purposive manner in which each study community was selected. Nonetheless, we have gone ahead and reported the results of some simple (bivariate) statistical tests, so as to provide a uniform standard for assessing the magnitude of intergroup differences.

Empirical Findings

Social and Demographic Factors. Tables 3.1 and 3.2 present some of the major background factors associated with each group. Note that in these analyses we are concentrating chiefly upon the comparative characteristics of the small farmer, landless and fishing groups. Additional, and more detailed tabulations have also been made, however, for the eight separate communities. Even though these data will not be fully and formally presented in this chapter, they will typically be referred to in a summary fashion, so as to give some indication of variations which can exist within the larger (aggregated) groupings.

Table 3.1--Social and Demographic Profile of Three Rural Poverty Groups, Northern Mindanao, 1992

1. Age of Household Head (mean number of years)

Farming	45.8	F = 20.98, p < .001
Landless	36.1	
Fishing	41.0	

2. Spouse's Place of Birth, (percent born outside of Region X)

		2
Farming	29.2	X = 7.64, p < .05 U = .15
Landless	46.2	
Fishing	35.0	

3. Husband's Place of Birth (percent born outside Region X)

		2
Farming	36.0	X = 7.15, p < .05 U = .15
Landless	53.4	
Fishing	42.3	

4. Language Spoken at Home (percent speaking some language other than Cebuano)

		2
Farming	14.2	X = 14.11, p < .001 U = .21
Landless	19.2	
Fishing	1.3	

5. Religion (percent non-Catholic)

		2
Farming	25.8	X = 10.06, p < .01 U = .18
Landless	13.3	
Fishing	31.2	

6. Household Size (mean number of residents)

Farming	6.0	F = 2.76, p < .10
Landless	5.3	
Fishing	5.6	

Table 3.2--Education, Media Use and Community Participation among Three Rural Poverty Groups, Northern Mindanao, 1992

1. Education of Household Head (mean number of years)

Farming	5.2	F = 2.60, p < .10
Landless	5.6	
Fishing	6.0	

2. Education of Spouse (mean number of years)

Farming	5.9	F = 3.50, p < .05
Landless	6.5	
Fishing	7.1	

3. Ability to Speak English (percent able to speak "well" or "a little")

		2
Farming	40.8	X = 10.45, p < .01 V = .18
Landless	55.0	
Fishing	63.3	

4. Ability to Speak Tagalog (percent able to speak "well" or "a little")

		2
Farming	49.2	X = 8.52, p < .02 V = .16
Landless	64.2	
Fishing	67.5	

5. Radio Use (percent listening "every day")

		2
Farming	56.7	X = 16.37, p < .001 V = .23
Landless	78.3	
Fishing	55.0	

6. Television Viewing (percent who watch "sometimes" or "frequently")

		2
Farming	27.5	X = 12.42, p < .01 V = .20
Landless	45.0	
Fishing	50.1	

Table 3.2---(Continued)

7. Reading Newspapers (percent who sometimes read)

		2
Farming	43.7	$X = 1.40, p = n.s.$
Landless	45.8	$U = .07$
Fishing	37.6	

8. Participation in Religious Groups (mean number joined)

Farming	0.35	$F = 2.72, p < .10$
Landless	0.22	
Fishing	0.16	

9. Participation in Community Groups (mean number joined)

Farming	0.80	$F = 16.88, p < .001$
Landless	0.38	
Fishing	0.35	

10. Type of Community Organization (percent joining a cooperative, first group mentioned)

		2
Farming	42.9	$X = 11.52, p < .01$
Landless	59.0	$U = .29$
Fishing	16.0	
(N = 141)		

Heads of farming households appear to be significantly older, on average, than those for either of the other two groups. In comparison, landless workers (many of whom were born after the chance to homestead land in Mindanao had already passed) are the youngest. Indeed, sugar workers average only 33.5 years of age, whereas the typical coconut farmer is more than fifty. These differential age profiles should be kept in mind during subsequent reports since it is likely that they will affect both the various health indicators as well as health care service utilization and expenditures.

A little more than a third of all respondents are in-migrants to the study areas from some other region of the Philippines. This pattern is most common among the landless agricultural workers and their spouses, particularly those for the subcommunities involved in sugar and rubber production. The former group is commonly alleged to come largely from the sugar-growing areas of Region VI (Western Visayas), a pattern which is further confirmed by the data on language spoken at home. (A large majority of all respondents are Cebuano speakers except for the case of sugar cultivators, in which case only 48 percent speak this language at home.)

Rice workers, upland farmers, and representatives of both fishing groups are less likely to be migrants. These groups are also dominated very heavily by Cebuanos.

While the overall percentage Catholic appears to be around 85 percent for the Philippines, this figure falls to only a little more than three-quarters for the rural poverty groups taken as a whole. The proportion of non-Catholics is highest among fisherfolks and farmers. In the former case, however, there is a rather extreme variation between the market-linked fishers (where, by historical accident, a majority of local residents belong to the Aglipayan religion) and the subsistence fishermen, which turned out to be entirely Catholic. About a third of the upland and corn farmers are Protestants, thereby indicating that Protestant proselytizing efforts may be bearing fruit among geographically isolated members of the small farming class.

Household sizes are, on average, largest for farmers and smallest for the landless workers. This finding may be related either to the lower levels of living believed to be found among this latter group or to their younger age profile. Again, however, some interesting intragroup variations are apparent. In particular, the upland farmers have by far the largest households (7.2 members on average), whereas the corn farmers rank, along with the sugar and rice workers, lowest in that regard.

Table 3.2 continues with the above analysis, in this case focusing on educational attainment, media use and membership in community organizations. As things turn out, these three "social-

izing" factors do not correlate that highly with one another. Among the fisherfolks, for example, educational levels are relatively high while participation in extra-familial groupings is decidedly low. This group also ranks low on radio and newspaper use, at the same time rating highest on the question about television viewing. This latter finding may well be attributable to the proximity of the market-linked fishing community to Cagayan de Oro. Fully 72 percent of the respondents from Opol said that they were watching television on at least an occasional basis. In comparison, only about a quarter of the farmers living in the most isolated locales (corn and upland farmers) were able to do this. It is possible that the reception of TV signals may be particularly problematic in these areas.

Intragroup variations are also in evidence for some of the other variables. On the educational indicators the intermediate position of the landless workers actually turns out to be an agglomeration of a fairly high level of educational attainment for the rice and rubber workers as combined with a very low level (only 3.8 years on average for the case of household heads) among the sugar workers. Sugar workers and upland farmers also rank low in terms of their professed ability to speak either English or Tagalog.

Variations in TV viewership has been summarized above. For the question about listening to the radio, all three of the landless groups rank high, with more than eighty percent of the rice worker households listening on a daily basis. Newspaper reading is not especially common among any of the groups under observation. More than half of the members of the farming and landless groups and sixty percent of the fisherfolk admitted that they "never" have access to this type of media. These patterns are particularly evident among upland farmers and sugar workers.

The low level of group participation in the fishing communities has been alluded to above. This may be related in some fashion to some working patterns found among this group which will be discussed subsequently. (In general, fishermen work long hours every day; their wives are also more likely to be employed in some capacity.) Participation in both religious and community groups was found to be highest among the rubber workers and, in particular, the coconut farmers. In contrast, sugar and rice workers have very low levels of participation in both types of groups. In fact, not a single household member from the sugar community was found to belong to a community organization.

In the case of the 141 respondents who did belong to at least one community organization, a follow-up question was asked concerning the nature of this group. A little less than half of these cases reported that they were members of a cooperative or credit union. This latter pattern was most commonly found among the coconut farmers and the rubber workers. (Note that the FARBE-CO Corporation mentioned in the previous project report was being

run on a cooperative basis. For their part, exactly, half of the coconut farmers reported themselves as being members of the former Samahang Nayan, which is now called the Odiongan Multi-purpose Cooperative.)

Levels of Living. Table 3.3 initiates our investigation into the economic status now being experienced by the different study groups. We begin in this case with data on their housing conditions. The general pattern appears to be that the landless agricultural workers rank lowest in this regard. Farmers are somewhat more likely to own their homes, and may also be living in stronger dwellings. Access to services, (piped water, toilets, electricity) is relatively good in the fishing communities, while the landless score low on nearly all indicators.

If we go into these patterns in more detail, we can first note that home ownership is particularly high among the coconut and corn groupings. In comparison, all landless groups--particularly those in the sugar industry--rank low on this dimension. Forty, thirty and twenty-eight percent, respectively, of the sugar, rice and rubber workers do not own their home. For coconut and corn farmers these figures fall to only about ten percent.

Access to electricity is good for both fishing groups, especially the one residing in Opol. Corn farmers (32 percent connected to electricity) and sugar workers (none of which had an electrical connection) score lowest in this case.

Results for the question on piped water were similar in pattern, though the overall association is even stronger in this case. Ninety percent or more of both fishing groups enjoyed access to this basic service, as compared to only eight percent of all coconut farmers, five percent of the corn farmers and none of the sugar workers.

One result of the above finding is that the small farmer and landless worker groups must spend considerably more time on average--ten times as much, in fact--in fetching water than do members of the fisherfolk households. Corn farmers, in particular, needed an average of almost 49 minutes to fetch water each day. One can imagine the difficulties entailed in the pursuit of cleanliness and sanitation when so much time is needed to even get a single pail of water.

About three quarters of the two fishing groups claimed ownership of a water-sealed toilet. This was particularly common (82 percent) in the market-linked community of Opol. In comparison, 42 percent of the corn farmers and only 12 percent of the sugar workers enjoyed access to this type of toilet.

Table 3.3--Housing-related Variables among Three
Rural Poverty Groups, Northern Mindanao, 1992

1. Home Ownership (percent owning)

		2
Farming	87.5	$X = 15.24, p < .001$
Landless	67.5	$\chi^2 = .22$
Fishing	82.5	

2. Access to Electricity (percent with an electrical connection)

		2
Farming	45.0	$X = 10.85, p < .01$
Landless	40.8	$\chi^2 = .18$
Fishing	63.8	

3. Access to Piped Water (percent connected)

		2
Farming	32.5	$X = 92.61, p < .001$
Landless	33.3	$\chi^2 = .54$
Fishing	95.0	

4. Time Required to Fetch Water (mean number of minutes)

Farming	27.9	$F = 36.19, p < .001$
Landless	24.6	
Fishing	2.1	

5. Type of Toilet (percent with water-sealed toilet)

		2
Farming	46.7	$X = 16.61, p < .001$
Landless	45.8	$\chi^2 = .23$
Fishing	72.5	

Table 3.3--(Continued)

6. Materials for Walls (percent made from smooth wood or hollow blocks)

		2
Farming	6.7	$X = 20.93, p < .001$
Landless	9.2	$U = .26$
Fishing	27.5	

7. Materials of Floor (percent made from strong materials)

		2
Farming	67.5	$X = 20.73, p < .001$
Landless	33.3	$U = .30$
Fishing	45.0	

8. Roofing Materials (percent made from strong materials)

		2
Farming	55.0	$X = 3.67, p = n.s.$
Landless	40.3	$U = .11$
Fishing	41.3	

A little more than a quarter of all fisherfolk had a home which used good quality materials (hollow blocks or smoothly cut wood) for its walls. Again, this was more common (32 percent) in Ipoh. Few members of the other groups, including none at all among both the sugar workers and the upland farmers, could claim likewise.

Small farmers as a general group did comparatively well for the questions on flooring and roofing materials. Corn farmers scored high on both measures, while the rice workers ranked low in both instances. Results for the other groups on these two survey items were mixed.

Table 3.4 continued this line of investigation by presenting data on the ownership of some common consumer items as well as on income levels for a "typical" month. Somewhat surprisingly, fully one fifth of the fishing households report that they own one or another type of motor vehicle. This pattern is strongest in Ipoh, with 25 percent of the populace being vehicle owners. With the exception of the corn farmers and the subsistence fishermen (both with 18 percent ownership), all other groups score very low on this indicator. (1)

A similar pattern holds for stove ownership. About a quarter of the market-linked fishers, along with 8 percent of those from Medina, own a "modern" (gas, electric or kerosene) stove. Ownership for all other groups is negligible.

A consumer goods scale based on responses about ten separate items (electric stove, electric fan, television, sewing machine, refrigerator, karaoke, sala set, camera, photo album and wall clock) was also constructed. Actually, an eleven-item scale had originally been constructed, but a reliability analysis using Cronbach's Alpha showed that one of the original items (radio ownership) did not scale well. This factor was therefore eliminated.

The results of the scale are interesting though admittedly not definitive. As might have been expected, consumer goods ownership is lowest among the landless agricultural workers, with the fisherfolks ranking highest and the small farmers taking an intermediate position. The magnitude of the differentials involved in this case was not large enough to attain statistical significance, although a strong ($F = 9.75$, $p < .001$) relationship was found when the more detailed (eight category) comparison was made. In this latter instance the sugar workers rank exceedingly low, with an average number of items owned of only 0.4. Rice workers and upland farmers also come out on the scale as relatively poor, with an average of 0.9 and 1.1 items, respectively. Somewhat unexpectedly, the rubber workers (like those in rice and sugar industry a landless group) ended up ranking highest on the consumer ownership scale.

Table 3.4--Income and Ownership of Consumer Items
among Three Rural Poverty Groups, Northern
Mindanao, 1992

1. Ownership of a Motor Vehicle (percent owning)

		2
Farming	7.5	$X = 23.43, p < .001$
Landless	1.7	$V = .27$
Fishing	21.3	

2. Type of Stove (percent owning an electric, gas or kerosene stove)

		2
Farming	0.0	$X = 36.05, p < .001$
Landless	0.8	$V = .34$
Fishing	16.3	

3. Consumer Goods Ownership Scale (mean score)

Farming	1.73	$F = 1.55, p = n.s.$
Landless	1.42	
Fishing	1.84	

4. Monthly Income of the Household, all Sources (mean for a "typical" month)

Farming	P1432.0	$F = 5.26, p < .01$
Landless	1990.2	
Fishing	1558.1	

a

See accompanying text for a further discussion of definition of a "motor vehicle."

Our conclusion that the results for the consumer ownership scale are "not definitive" was made insofar as the scale is based in large part upon the ownership of electrical appliances. Whether the very low standing of sugar workers on the scale is actually a sign of overwhelming poverty on their part is thus at least partially open to debate. Another explanation might simply be that they are unwilling to spend their earnings on electrical appliances, given the fact that they have no way of using the same. (Please refer to our earlier discussion of household access to an electrical connection. None of the sugar workers enjoyed this privilege.)

Be this as it may, the scale is still a useful one in many ways. In the first place, electrical connections are becoming more and more common in the area, so that a majority, even of our rural poverty groups, can lay claim to this advantage. At the same time, the scale is also useful for showing the generally low living standards found among our the respondents. On the average, they did not even own two of the twelve items, despite the fact that some (e.g. photo album, camera) can be purchased relatively cheaply.

Another key indicator is the household's income. In this case we have asked about earnings during a typical month. These include monies paid to the persons actually living in the household as well as any remittances sent back by family members living and working elsewhere (i.e. circulators). (2)

In this case the results turn out quite contrary to what was originally expected. The landless workers claim to be earning the highest incomes at nearly two thousand pesos per month. They are followed in turn by the fisherfolk, with the farmers coming in last (P 1432 per month, on average). Of course, these figures refer to cash incomes and it is quite possible that the farmers are also benefitting from significant earnings in kind. Nonetheless, the cash differences are certainly of some practical importance, besides being large enough to attain statistical significance. They hint at the likely possibility that small farmers may often be short of cash to deal with emergency medical problems.

A detailed tabulation of the income data shows that the high value achieved by the landless group is due entirely to the favorable earnings profile of the sugar and rubber workers. For their part, though, the rice workers rate lowest among all eight groups. Indeed their monthly income is less than a thousand pesos (about 35 U.S. dollars) on average.

The above finding is of some theoretical interest insofar as it is the sugar and rubber workers who are employed by large agricultural enterprises ("agribusiness" or corporate farms). Such establishments are often criticized by defenders of the "family-sized farm," which approximates more closely the situa-

tion of rice farmers in Barangay Dumarait. Our findings hint at the likely possibility that these latter entities may simply be unable to provide enough work for landless agricultural laborers in the vicinity to earn a decent living. (3)

Table 3.5 presents further details on the living standards question, in this case focusing on the ownership of potentially productive assets. A quite consistent pattern emerges here, with the small farmers doing better than either of the other two groups on all indicators. For their part, the landless also rank lowest in all cases.

What are these indicators? Two refer to land ownership (homelot and cultivated farmland), so it is certainly no surprise to see the landless agricultural workers rating poorly in this regard. (4) Three others refer to farm-related assets; namely, farm equipment, livestock, and poultry. Finally, respondents were asked to estimate the value of each asset enumerated--the total of these estimated values thus represents our final, summary measure of the assets dimension. Differences on this latter indicator are especially dramatic, with the assets owned by the small farmers being worth nearly eight times as much on, average, as those found among members of the landless class. (5)

Findings from the detailed tabulations for these variables revealed several additional findings. First, the rubber workers score relatively high on the various indicators found in Table 3.5, certainly more so than either the rice or sugar workers. The rice workers, in fact, only average about 700 pesos (25 U.S. dollars) in total assets. In comparison, the corn farmers are doing much better with an average asset ownership of nearly thirty-four thousand pesos. The coconut farmers of Odiongan and the fisherfolk of Opol rank second and third, respectively, on this dimension, with a net ownership a little less than half as large as that found among the corn farmers. (Note that asset ownership among the fishermen of Opol, is more than three times as large as that found for the case of Medina.)

Job-related Factors. In this section we present background details pertaining to the work situation of each group. We start with a question on the status of the household head's main occupation (first panel of Table 3.6), finding therein the not surprising fact that practically all of the landless agricultural workers hold an employee's status, whether permanent or casual. About a quarter of the fishermen are in a similar state; these persons consist entirely of that subsample of market-linked fishers who were found to be working on a large fishing boat. Finally, nearly all farmers (along with most fishers) may be categorized as self-employed persons.

Table 3.5--Ownership of Other Assets among Three Rural Poverty Groups, Northern Mindanao, 1992

1. Ownership of Homelot (percent owning)

		2
Farming	33.3	X = 16.70, p < .001
Landless	11.7	U = .23
Fishing	28.8	

2. Ownership of Farmland (percent owning)

		2
Farming	37.5	X = 76.76, p < .001
Landless	0.0	U = .49
Fishing	3.8	

3. Ownership of Farm Equipment (percent owning)

Farming	77.5	F = 158.42, p < .001
Landless	7.5	U = .71
Fishing	10.0	

4. Ownership of Livestock (percent owning at least one)

		2
Farming	64.2	X = 18.99, p < .001
Landless	36.7	U = .24
Fishing	56.3	

5. Ownership of Poultry (percent owning at least one)

		2
Farming	40.0	X = 16.53, p < .001
Landless	17.5	U = .23
Fishing	22.5	

6. Estimated Value of All Other Assets (mean)

Farming	₱19,077.8	F = 19.44, p < .001
Landless	2,500.3	
Fishing	9,842.0	

Table 3.6--Job-related Factors among Three Rural Poverty Groups, Northern Mindanao, 1992

<u>1. Status of Household Head's Job (percent permanent or casual employees)</u>			
		2	
Farming	4.2	X = 228.62, p < .001	
Landless	99.2	V = .85	
Fishing	28.8		
<u>2. Amount of Time Spent Working at Current Job (mean number of months)</u>			
Farming	259.8	F = 32.79, p < .001	
Landless	137.2		
Fishing	254.4		
<u>3. Number of Days Worked at Current Job During the Week Preceding the Survey (mean)</u>			
Farming	4.9	F = 0.90, p = n.s.	
Landless	4.7		
Fishing	5.1		
<u>4. Number of Hours Worked per Day at Current Job (mean)</u>			
Farming	7.0	F = 28.46, p < .001	
Landless	7.0		
Fishing	9.4		
<u>5. Employment Status of Spouse (percent working)</u>			
		2	
Farming	11.7	X = 35.25, p < .001	
Landless	2.6	V = .34	
Fishing	32.1		
<u>6. Number of Employed Members in the Household (mean)</u>			
Farming	1.48	F = 14.96, p < .001	
Landless	1.54		
Fishing	2.09		
<u>7. Number of Household Members Working Elsewhere (mean)</u>			
Farming	0.51	F = 5.06, p < .01	
Landless	0.21		
Fishing	0.25		

We have already noted the relatively youthful age distribution of the landless laborers. As a corollary to this we would also expect them to have been working at their present job for a shorter period of time than for the other two groups. This is, in fact, true although it should also be added that the landless workers had been at this type of work for the relatively lengthy period of ten or more years on average. For farmers and fishermen, though, this latter figure is higher still, with their mean value coming to more than twenty years.

Even though many workers may complain about having too much to do, it can be an even greater problem for the rural poor when work opportunities are lacking. When asked about the number of days worked during the week preceding the survey, gross differences between the three groups were not large enough to achieve statistical significance. A more detailed look at these data showed, however, that the rice and sugar workers were (as expected) significantly more beset by the problem of underemployment than were any of the other groups. On the average, both of these groups had worked for a little less than four full days during the previous week. In comparison, the rubber workers had toiled for 6.5 days on average, a figure which was high enough to take the lead position as the least underemployed, as well as to pull up the average for the general category of landless workers.

When our attention shifts to the number of hours worked per day a different pattern emerges. In this case we find the fishermen from Medina toiling for 10.6 hours on average, while those from Opol rank second highest in this regard (8.3 hours). The three farming communities emerged as the lowest ranking on this indicator.

Fishermen can also boast of having contributed the most family members on average to the local labor market. This pattern may be attributed in large part to the much higher employment rates found among the spouses for this group. No doubt many of these women are working hard to sell the fish caught by their husband. Somewhat surprisingly, though, this pattern of gainfully employed spouses is found more typically in Medina (where 47.4 percent of all spouses are employed) than in the so-called "market-linked" sector of Cagayan de Oro. This finding may have come about because many of the fishers in Opol are working as a crew member of someone else's boat. These persons are generally paid in cash rather than kind, so that the household head would actually not have much in the way of fish for his wife to sell.

Female (i.e. spousal) employment is rare among all three of the landless communities. A similar pattern is also found for the question on the total number of employed household members, which is low for the landless and higher for the fisherfolk. The non-availability of employment opportunities for spouses of landless workers has no doubt contributed significantly to their lower levels of monthly cash incomes.

Previous studies on the phenomenon of "circulation" (i.e. temporary labor mobility) have emphasized the predominance of landless agricultural workers in this group. This may be true for other locales but in the Misamis-Bukidnon case there is a significantly greater number of circulators on average from the small farmer group than from the landless. (In fact, the landless workers also rank lower than the fisherfolk.) These patterns may be related not only to the type of job taken on by the household head but also to accessibility to a big city. The fishers of Opol and the rubber workers of Talakag both rate very low in terms of the circulation factor. No doubt this finding may be attributed to the fact that younger members of these households who are looking for a job do not have to circulate to and from Cagayan de Oro in order to achieve this; instead, they can simply commute on a daily basis.

In Table 3.7 we present the results of several questions which are derived from the special circumstances of each group. In the case of the small farmers, for example, specific questions were asked on irrigation, tenancy status, and actual possession of a title, in those cases where the respondent claimed to own his/her farmlot. For the first of these factors, the data showed a fifth of all upland farmers to have access to some form of irrigation. For the other two groups, though, this advantage was virtually nonexistent.

On the tenancy status question only a small proportion (eight percent) of the upland farmers listed themselves as owners. Many of these cases have no formal tenancy status at all (i.e. they are squatting on public lands) while others have applied to the DENR for stewardship status over their farmlot.

About half of the corn and coconut farmers said that they owned the land which they were cultivating. When asked if they actually possessed the legal title for this, however, more than half of these respondents admitted that they did not. This factor will no doubt affect their ability to raise money during one or another health care emergency. (Persons with a titled piece of land will generally find it easier to borrow money at these times.)

Turning our attention for now to the landless agricultural laborers, our first concern is to estimate the extent to which these workers have had to suffer from periodic bouts of unemployment and a resulting decline in income. As expected, virtually all of the rice and sugar workers said that this problem was indeed a reality in their lives. For the rubber workers, though, a very different result turned up. In this case a great majority (97.5 percent) of the respondents said that their income did not fluctuate from one month to another. This differential, which may be linked in some fashion to the different planting/harvesting cycles of rubber, rice and sugar, could be a major reason for the more favorable economic situation which has generally been found for the rubber workers.

Table 3.7--Additional Information on Factors Specific
to Each Occupational Community, Three Rural
Poverty Groups, Northern Mindanao, 1992

1. Small Farmers

1. Access to irrigation (percent partially or fully irrigated)

		2
Corn	0.2	$X = 13.69, p < .01$
Coconut	2.5	$U = .34$
Upland	20.0	

2. Tenancy Status (percent owners)

		2
Corn	46.2	$X = 22.26, p < .001$
Coconut	57.5	$U = .44$
Upland	7.9	

3. Is Farmlot Titled? (percent of all owners with titled land)

Corn	50.0	(N = 18)
Coconut	39.1	(N = 23)
Upland	66.7	(N = 3)

1. Landless Agricultural Workers

1. Income Fluctuations (percent answering that their income fluctuates on a monthly basis)

		2
Rice	97.5	$X = 110.26, p < .001$
Sugar	100.0	$U = .96$
Rubber	2.5	

2. Circulation (percent of household heads who work occasionally in other towns/cities)

		2
Rice	44.7	$X = 37.78, p < .001$
Sugar	2.5	$U = .57$
Rubber	0.0	

3. Working Days per month (mean)

Rice	14.4	$F = 101.93, p < .001$
Sugar	23.7	
Rubber	26.1	

Table 3.7--(Continued)

C. Fishermen.

1. Income Fluctuations (percent answering that their income fluctuates on a monthly basis)

		2
Market-linked	97.5	X = 1.01, p = n.s.
Subsistence	100.0	U = .11

2. Presence in Family of Someone Who Buys/Sells Fish (percent with someone doing this)

		2
Market-linked	32.5	X = 12.83, p < .001
Subsistence	72.5	U = .40

3. Boat Ownership (percent owning)

		2
Market-linked	47.5	X = 14.59, p < .001
Subsistence	87.5	U = .43

4. Does the Boat Have an Engine? (percent of all boat owners with an engine)

		2
Market-linked	36.8	X = 0.39, p = n.s.
Subsistence	28.6	U = .09
(N = 54)		

5. Net Ownership (percent owning)

		2
Market-linked	37.5	X = 5.00, p < .05
Subsistence	62.5	U = .25

6. Ownership of Other Fishing Gears (percent owning)

		2
Market-linked	20.0	X = 49.57, p < .001
Subsistence	97.5	U = .79

On the next survey item we again asked about the circulation phenomenon, in this case with specific reference to the household head. The data showed very few of the sugar workers and none at all of those employed on the rubber plantation to be engaging in this type of behavior. Nearly half (44.7 percent) of the rice workers, however, did say that they occasionally travelled to other towns or cities to take on some sort of gainful employment.

One reason for the above pattern appears to be the significantly greater problem of rural underemployment found among the rice workers. On the average, these respondents were only able to find about fourteen days of employment per month, as compared to 24 and 26, respectively, for the sugar and rubber workers. Again, there does seem to be some advantage in this regard for those landless workers who are able to work as a more-or-less regular employee of a large agricultural estate.

We have seen that monthly income fluctuations are the general rule for the rice and sugar workers. That the same is also true for both of the fishing groups is shown by data found in the bottom portion of Table 3.7. The fishing industry is also characterized by additional opportunities for the employment of household members other than the head. Overall, a little more than half of the fishing households reported at least one of their members as specializing in the buying and selling of fish. In most cases it is no doubt the wife who does this. Again, a rather unexpected finding herein is that the "buy-and-sell" pattern is found most commonly, not in the "market-linked" community of Opol, but among the subsistence fishermen of Medina.

Another apparent paradox lies in the more widespread ownership of the various paraphenelia used by fishermen among members of the Medina subsample. Given the greater poverty found for members of this group (at least as far as the monthly income question is concerned), we would have expected them to also own fewer fishing materials. Such, however, is not the case. Significantly greater numbers of fishermen in Medina were found to own their own boat, fishing net or other fishing gears. Again, our best hypothesis at this time is that the comparative figure for those fishermen operating out of Opol has been brought down insofar as some household heads from this locale have been employed to work on a large fishing boat. In these cases, of course, the "ownership of the means of production" passes from the hands of the individual fisherman to an investor or group of investors wealthy enough to put up the millions of pesos needed for a large and modernized fishing craft.

Summary

This chapter has presented background statistics on the various "special beneficiary groups" being investigated in the present study. Our general expectation was that the landless agricultural workers, a group identified by at least one author (Ledesma, 1982, p. 204) as "the poorest among the rural poor," would rank lower than the other two groups on most of our socio-economic indicators. The general pattern in this case was indeed something along those lines. Important exceptions were, however, also noted at this point. For example, the landless group generally rated higher than the small farmers in terms of educational attainment and also scored higher in terms of media use and monthly (cash) incomes.

Detailed tabulations for the eight separate communities covered by the study revealed some noteworthy internal variations among such supposedly homogeneous groups as "small farmers" or "landless agricultural laborers". In the latter instance, for example, the situation of the rubber workers in Talakag was almost always superior to that found among either the sugar or rice workers. The fact that the rubber plantation was in fact being owned and operated on a cooperative basis may well be a key reason for this. Continued resort to such arrangements on the part of the Department of Agrarian Reform would seem to be supported by this finding. Even without this, it is also evident that the large-scale enterprises found in the sugar industry are also more capable of redounding to the benefit of the landless class than is the case for the small and poorly capitalized rice farms of Dagupan.

In the case of the small farmer subcategory the corn and coconut groups were frequently found to be rather similar with regard to their social and economic profile. Conditions among the upland farmers of Barangay Mat-i, however, were generally inauspicious. Incomes and consumer goods ownership were quite low for this group, and they were also less likely to own other productive assets like farm equipment, livestock or poultry.

In general, therefore, we may conclude that one of the underlying hypotheses of the study--that each special beneficiary group would be found to have its own unique problems and potentials--is well on the way to being confirmed. The Department of Health and its affiliated agencies would be well advised to take this sort of social differentiation into account when designing health care and health care financing programs.

Endnotes

1

A further inspection of the original survey forms was made so as to check on the reasons why so many fisherfolk were said to be owners of a "motor vehicle." The translation of this term from English into Visayan was done via the phrase "sakyanang de motor." It was subsequently discovered that this phrase may be understood to refer to all types of motorized transport equipments, including cars, trucks, motorcycles and motorboats. The reader should thus be informed that in almost all of the cases wherein a fishing family owns a "motor vehicle," the vehicle concerned is either a "pump boat" or a "fishing boat with motor."

2

Cash earnings by members of the rural poverty class are, of course, highly seasonal in nature. Our survey findings in this regard should therefore be interpreted with some caution.

3

Current efforts by the Department of Agriculture to encourage the cultivation of high value crops (e.g. sugar and rubber) also receive some support from the above findings. For another study which showed a favorable economic impact of agribusiness-type of farms, cf. Costello (1989).

4

Some "landless" workers have been found to own homelot parcels. This can occur insofar as our defining procedure for selecting agricultural workers gave priority to establishing their nonownership of any land which was actually being used for farming purposes. Relatively small homelots (e.g. 1000 square meters or less) were allowed for the "landless" category.

5

The variable summarizing the total worth of all assets was obtained by summing the individually-estimated worths for the following items: motor vehicle (presented as an individual item in Table 4 of this report), homelot, farmland, farming equipment, livestock, poultry and fishponds (owned by virtually no respondents and therefore not presented as an individual item in any table).

Chapter Four. Major Health Problems and Their Responses

Empirical Findings

Major Health Problems: Mortality and Morbidity. Before going into the health care financing patterns of our different poverty groups, it will be useful to describe their major health problems and the various preventive and curative strategies which they have adopted over time. The present chapter has therefore been intended as a means for attaining this objective.

Our first concern is with broad patterns of fertility, mortality and morbidity, as found within the 320 households under observation. Data presented in the top panel of Table 4.1 would thus appear to show that levels of childbearing activity, as measured by the mean number of children ever born, are significantly higher among the farming households than for the other two groups. On average, the wives of the small farmers report themselves as having given birth to 5.6 children, as compared to 4.8 for the fisherfolk and only 4.0 for the landless families.

These differences are intriguing insofar as they run counter to prevailing theory (and empirical findings) in the field, both of which argue for a fertility-depressing impact of land ownership (Stokes and Schutjer, 1984). The fact that the small farmers are having an average of 1.6 more children than those in the landless category is therefore quite unexpected. Further still, there may well be a conscious element to this difference since our data on family planning, as will be discussed below, also show the landless respondents to be significantly more likely to be practicing some form of contraception. At the same time, though, it must also be noted that the small farmers are significantly older than the fishermen--nearly ten years so, on average. It will therefore be necessary to subject these findings to a more detailed, multivariate analysis before any decisive conclusions can be reached in this regard.

When the eight different communities are compared, the coconut farmers and those from the upland areas were found to have the highest fertility. Sugar and rubber workers scored lowest in this regard, with a respective average of only 3.5 and 3.9 children ever born. It is perhaps noteworthy that these are the two groups which are employed on large corporate farms, a setting which is not only more integrated into the formal sector of the economy but which is also more likely to offer certain health care benefits (e.g. Medicare coverage, access to company-run clinics with family planning services).

An attempt was made to follow up on the above finding by comparing current pregnancy status among the different groups. In neither case, however, (i.e. either the three- or eight-group comparison) was a statistically significant relationship revealed.

Table 4.1-- Fertility, Mortality and Morbidity
Levels among Three Rural Poverty Groups

1. Fertility (Mean No. of Children Ever Born)

Farming	5.63	F = 7.97
Landless	4.04	p < .001
Fishing	4.77	

2. Current Pregnancy Status (Percent Pregnant)

		2
Farming	9.0	X = 1.07
Landless	8.5	p = n.s.
Fishing	5.1	

3. Mortality (Mean No. of Children Ever Dying)

Farming	0.54	F = 0.84
Landless	0.39	p = n.s.
Fishing	0.59	

4. Chronic Conditions (Mean No. in Household)

Farming	0.96	F = 9.69
Landless	0.58	p < .001
Fishing	1.26	

5. Disabilities (Mean No. in Household)

Farming	0.08	F = 0.55
Landless	0.07	p = n.s.
Fishing	0.04	

6. Occupational Safety (Percent of Household Heads Who Feel Their
Job is Dangerous)

		2
Farming	22.5	X = 20.89
Landless	13.3	p < .001
Fishing	9.0	

The question of infant and child mortality is, of course, of central importance for the present study. Overall, about 10 percent of the children ever born to our sample respondents have already died. Measured in terms of the mean number of children dying this came to 0.39 for the landless group, 0.54 for the farmers and 0.59 for the fisherfolk. While these figures would appear to show the landless respondents to be enjoying the most favorable mortality situation, it would be premature, and probably incorrect, to reach such a conclusion. For one thing, we have already noted that the landless respondents already have fewer children to begin with. They are also somewhat younger than the small farmers, thereby implying that children of the latter group have had about nine or ten years, on average, of additional exposure to the possibility of dying.

We should also note at this point that the statistical test for our indicator of children ever dying does not reveal any significant difference between the three groups. Nor was any revealed when the eight-group categorization scheme was used. In this latter case, however, some interesting differences did occur, particularly for the upland farmers and the rubber plantation families. The former group had the highest average number of children ever dying (0.80) while the latter ranked lowest with an average of only 0.23.

A simple way of taking into account the larger or smaller numbers of children ever born into each group is to compute, for each household, the proportion of all live-born children who later died. (1) If we then find the mean proportion for each group the results are as follows:

Farmers	0.066
Landless	0.056
Fisherfolk	0.080

Results for the more detailed classificatory scheme are also of some interest:

Corn farmers	0.053
Coconut farmers	0.058
Upland farmers	0.086
Rice workers	0.048
Sugar workers	0.070
Rubber workers	0.050
Market-linked fishers	0.067
Subsistence fishers	0.094

In neither case does the associated statistical test show a significant (or particularly large) differential. Nonetheless, it is of interest to note the fairly problematic situation of the fisherfolk, particularly those living in the subsistence fishing community of Medina. The upland farmers and sugar workers were also experiencing above-average levels of mortality while the rice and rubber workers were doing somewhat better than average.

A final perspective on our mortality data may be had by comparing them to comparable figures from a national-level study of the "poorest of the poor" which was carried out by Herrin and Racelis (1993). This analysis reported on data from a sample survey of the bottom 30 percent of the national income distribution. As such, it provides a useful contrast to the present study which (1) limited itself strictly to rural areas in Northern Mindanao and (2) utilized a purposive approach in selecting its major study communities.

The authors of this national-level report provide a table (Table II. C. 1) which shows the distribution of children ever dying among all sampled households. By recomputing these data to show the mean number of deaths per family, we arrive at a figure of 0.27 childhood deaths on average. Note that this is substantially lower than the figures reported for any of our three major poverty groups. While one reason for this may lie in the possibly older age profile of respondents in the present survey (by interviewing only spouses of household heads we excluded those younger couples who would still living with their in-laws in an extended family household), this comparison may be taken as indicating that our data-gathering procedures have been relatively valid. On the one hand, the higher mortality estimates found in the present study demonstrate that we were indeed able to identify some very poor families for our sample. Secondly, it would also appear that the issue of underenumerated child deaths (a frequent outcome in the Philippine context--cf. Madigan, Abernathy, Herrin and Tan, 1976) is probably less problematic for the present data set than for some of the other demographic and health surveys which have been carried out in the country.

The fourth and fifth indicators shown in Table 4.1 concern the presence, among all household members, of chronic conditions and disabilities. These, we should point out, are self-reported measures, so there is a certain element of subjectivity in both. That is, the survey instrument simply asked, for each person in the household, whether he or she had "any form of disability" or "any chronic condition like diabetes, heart disease, ulcers or the like," thus leaving it up to the respondent to decide on the specific application of these concepts.

In general, very few households from any of the eight communities reported themselves as having a disabled member. The average number of disabled persons ranged from only .02 per household (i.e. only one case in the total subsample of 40 households) for the subsistence fishermen to .12 per household for the coconut farmers.

Chronic conditions were considerably more common. In this case, too, some significant differences did crop up with the landless group ranking lowest (an average of 0.58 cases per household), followed by the small farmers (0.96 cases) and the fisherfolk (1.26 cases per household). Comparisons for the de-

tailed subgroups were even more variable, though not necessarily more readily explicable. In this case we find the subsistence-type fisherfolk ranking highest at 2.32 cases per household while those from Opol (the market-linked fishermen) ranked lowest. Upland farmers also ranked somewhat low, while the corn and coconut farmers were second and third highest in terms of chronic conditions. Insofar as the Medina, Odiongan and Kauyanan respondents were all above average in terms of the age of the household head, it could well be that this is an underlying explanation of the above-noted differentials.

Respondents were asked if they thought their husband's job was in some way dangerous. While we originally expected that the threat of drowning would loom large in the minds of the fisher families this was apparently not the case. In fact, none of the respondents from the fishing communities felt that the household head's job was a dangerous one. In comparison, 13.3 percent of the landless and 22.5 percent of the small farmers felt that this was the case for them. When the relationship was tested for the more detailed classification of poverty groups, the comparisons were even more striking (Chi square = 149.99, $p < .001$), with 67.5 percent of the upland farmers and 35.0 percent of the rice workers asserting that their jobs were dangerous versus none at all among both fishing groups, the corn and coconut farmers and the rubber workers of Talakag.

Why did so many upland farmers consider their job to be dangerous? The major reason for this appears to be the high level of pesticide use found there. Overall, 41 of the 43 cases who said their job was dangerous cited their exposure to harmful pesticides as the reason for this allegation. Further still, 80 percent of the upland farmers admitted (in reply to another question) that they were using pesticides on their farm. This was a much higher figure than that found for either the coconut (5.0 percent) or the corn (12.5 percent) farmers. These differentials suggest that, while pesticide use is potentially hazardous, it is by no means a universal phenomenon among Filipino farmers. Health education campaigns on this issue may thus have to be developed and applied at the local level, depending on the need found therein.

In cases where a child had died the respondent was asked to identify his or her cause of death. Again, this is a self-reported assessment, and one which was probably never verified for some cases by an attending physician. Nonetheless, the data are of some interest for showing us what would appear to be the major causes of death among children born into the poor, rural families under investigation in this study. (2)

We thus turn our attention to Table 4.2. Based on the categorization scheme found therein, the major causes of childhood mortality may be ranked as follows: diarrheal disease, "other contagious diseases" (kidney infection, measles, malaria, rabies,

Table 4.2.—Percentage Distribution, Cause of Death

a

Among Children Ever Dying, Three Rural Poverty Groups

Cause of Death	Farming	Landless	Fishing
^b Diarrheal Diseases	23.2	14.3	50.0
^c Respiratory Diseases	25.0	23.8	12.5
^d Other Contagious Diseases	21.4	35.7	12.5
^e Dietary Diseases	3.6	11.9	2.5
Premature Birth/Birth Defects	7.1	2.4	2.5
^f Accidents/Homicides	5.4	7.1	7.5
^g Other Causes	14.3	4.8	12.5
Total	100.0 (N=56)	100.0 (42)	100.0 (40)

a

Total number of dead children in each column may differ slightly from that used in computing the mean (see Table 1). Data on cause of death not available in 21 of 159 cases.

b

Includes "amoeba," "dehydration," "diarrhea" and "stomach ache."

c

Includes "asthma," "bronchial illness," "convulsions/high fever/fever," "cough," "influenza," and "tuberculosis."

d

Includes "kidney infection," "malaria," "measles," "paralyzed," "rabies" and "tetanus."

e

Includes (only) "beri-beri."

f

Includes "harelipped," "premature birth" and "unperforated anus."

g

Includes "car accident," "drowning," "electrocuted" and "murdered."

h

Includes "appendicitis," "boils," "cancer," "cerebral palsy," "heart ailment" and "skin disease."

tetanus), various respiratory diseases, "other causes," accidents, or homicides, dietary disease, and deaths due to birth-related problems or conditions. The first three of these categories account for nearly three quarters of all the deaths reported in our study. This is in one way encouraging since it is precisely such conditions as diarrheal disease, acute respiratory infections, measles and tetanus that the Department of Health has pinpointed in its primary health care program. Of course, the efficacy of these efforts may still be up for debate in some quarters, but at least the DOH seems to be getting its priorities right.

Comparing the different poverty groups, the most noticeable difference is perhaps the stronger impact which diarrheal disease has had upon children from the fishing villages. In comparison, the small farmers score relatively high on respiratory diseases and "other causes" while the two major categories for the landless are respiratory disease and "other contagious diseases." It may be that environmental conditions (e.g. the more densely populated living conditions found in the fishing communities) have something to do with these differentials.

Table 4.3, which deals with chronic conditions continues this line of analysis. In this case, however, we can assume that the data refer largely to adult conditions.

Chronic health problems reported by our low-income respondents include the following: stomach conditions (the most frequently mentioned of which was "ulcer"), respiratory problems, conditions associated with old age (e.g. arthritis), "other internal conditions," "other conditions," degenerative diseases (cancer, heart ailments), nutritional disorders, and skin problems. These have been listed in order of their relative frequency, thereby indicating that the chronic health problems experienced by the Filipino rural poor are indeed rather different from those associated with the childhood deaths and diseases discussed above. (3) Indeed, the large number of serious conditions listed in Table 4.3 makes one wonder if the great importance given by the DOH to primary health care and maternal and child health might not be leading to a complementary underemphasis upon such painful and potentially fatal adult conditions as ulcers, problems of the heart and the circulation system, tuberculosis and its associated conditions, kidney diseases (the largest component of the category for "other internal disease"), hepatitis, and arthritis. Many of our respondents need badly to see a specialist in internal medicine. Whether they will be able to afford such a service, however, is very much open to question.

Comparing across categories, the problem of chronic respiratory conditions appears to be most salient among the fishing families. Stomach conditions (in particular, self-reported ulcers) are most prevalent among the landless, whereas "other internal conditions" (especially kidney problems) are found most

Table 4.3—Percentage Distribution, Type of Chronic Condition
(all Household Members), Three Rural Poverty Groups

Type of Condition	Farming	Landless	Fishing
^a Respiratory conditions	18.3	20.0	27.7
^b Nutritional disorders	5.2	4.3	4.9
^c Stomach conditions	18.3	40.0	20.8
^d Degenerative diseases	7.0	14.3	7.9
^e Other internal conditions	20.9	11.4	7.9
Skin disease	2.6	0.0	1.0
Conditions associated with old age ^f	17.4	4.3	18.8
^g Other conditions	10.4	5.7	10.9
Total	100.0 (N=115)	100.0 (70)	100.0 (101)

^a
Includes "asthma," "bronchial illness," "cough," "influenza," "tonsillitis" and "tuberculosis."

^b
Includes "anemia," "peri-berri" and "goiter."

^c
Includes "heartburn," "stomach ache" and "ulcer."

^d
Includes "cancer," "cyst," "heart ailment" and "high blood pressure."

^e
Includes "amoeba," "appendicitis," "diabetes," "hernia," "malaria" and conditions of the kidney and the liver.

^f
Includes "arthritis," "blindness/cataracts" and "muscle pains."

^g
Includes "fever," "fracture," "epilepsy," "headache/sinusitis," "hemorrhoids," "loss of appetite," "menstrual pains," "nausea," "nervousness," "nosebleed," "relapse" and "toothache."

frequently in the families of the small farmers. Conditions associated with old age are found least of all among the landless, a group which we have already noted as being somewhat younger on average than either the fishers or the farmers.

A checklist of 23 specific medical problems, representing both chronic conditions and acute incidents of illness, was also presented to the respondents. The question in these cases asked whether any household member had experienced these problems during the month immediately preceding the survey. Data from this exercise are presented in Table 4.4.

Conditions cited most frequently by our respondents included the following: cough/cold, fever, headache, toothache, "numbness in the body's extremities," blurred vision and "easily fatigued." Those occurring with intermediate frequency include stomach pains, "loss of appetite," skin problems, "rheuma," dizziness, chest pains, sore throat, painful urination and diarrhea. (This latter condition was actually quite rare among the farmers and the landless but not at all uncommon among the fisherfolk, a finding that reinforces our earlier finding on the high level of deaths due to diarrheal disease found among the children in the fishing villages). Conditions mentioned least frequently were nausea, frequent urination, ear discharge, loss of weight, loss of consciousness and cyst or tumor.

About half (12 out of 23) of the comparisons were able to show a statistically significant difference, at the .05 level, among the three poverty groups. Three others were significant at the .10 level. In nearly all of these the farming community scored highest in terms of the total number of cases reported to the interviewer. This may be in some way due to the older age profile of the small farmers. Indeed, many of the comparisons which attained statistical significance do seem to be associated with old age (easily fatigued, loss of appetite, blurred vision, chest pains, numbness and back pains). In other cases, though, the explanatory power of this factor is somewhat less convincing, e.g. for the cases of headaches, fever, and toothache. In any event, it is apparent that the country's farming sector is beginning to age noticeably, due in large part to the outmigration of young people from rural areas. It is therefore high time for the DOH to take account of this factor in planning for the health needs of farming communities.

In addition to the comparison for diarrheal disease, there was one other category (loss of consciousness) where the fishers scored significantly higher than the other two groups. In another ("loss of weight") it was the landless who scored highest. There seems to be no readily apparent reason why these two differentials would have occurred.

Inspection of the more detailed (eight-group) tabulation shows that the largest number of symptoms are generally reported by the Medina fisherfolk whereas those from Opol tend to rank

Table 4.4—Mean Number of Household Members Reporting
Various Symptoms During the Month Preceding
the Survey, Three Rural Poverty Groups

Symptom	Farming	Landless	Fishers	Significance
Headache	0.92	0.34	0.65	$F = 9.37, p < .001$
Dizziness	0.21	0.16	0.18	$F = 0.44, p = \text{n.s.}$
Lost consciousness	0.02	0.02	0.10	$F = 3.14, p < .05$
Fever	1.22	1.18	0.75	$F = 3.48, p < .05$
Easily fatigued	0.52	0.33	0.42	$F = 5.39, p < .01$
Loss of weight	0.03	0.13	0.12	$F = 3.44, p < .05$
Loss of appetite	0.37	0.15	0.15	$F = 5.40, p < .01$
Cyst/tumor	(6.7)	(2.5)	(5.0)	$\chi^2 = 2.35, p = \text{n.s.}$
Skin ailment	0.28	0.21	0.11	$F = 2.52, p < .10$
Blurred vision	0.60	0.16	0.28	$F = 19.06, p < .001$
Ear discharge	0.13	0.15	0.04	$F = 2.20, p = \text{n.s.}$
Sore throat	0.19	0.10	0.22	$F = 2.72, p < .10$
Cough/cold	1.32	1.32	1.15	$F = 0.47, p = \text{n.s.}$
Chest pain	0.25	0.08	0.22	$F = 5.59, p < .01$
Numbness in extremities	0.67	0.38	0.35	$F = 9.45, p < .001$
Back pain	0.78	0.50	0.50	$F = 6.57, p < .01$
Stomach pains	0.27	0.27	0.29	$F = 0.04, p = \text{n.s.}$
Nausea	0.10	0.07	0.19	$F = 1.49, p = \text{n.s.}$
Diarrhea	0.08	0.04	0.29	$F = 12.99, p < .001$
Frequent urination	0.12	0.09	0.12	$F = 0.29, p = \text{n.s.}$
Painful urination	0.23	0.15	0.10	$F = 2.43, p < .10$
"Rheuma"	0.12	0.15	0.24	$F = 2.18, p = \text{n.s.}$
Toothache	0.96	0.65	0.61	$F = 4.84, p < .01$

a

Statistics for "cyst/tumor" refer to the percentage of all households reporting at least one such case.

rather consistently among the lowest. As such, the fishing families most typically end up taking an intermediate ranking on the different symptom questions. While it is tempting to argue that the Medina respondents have more health problems because they are somewhat older and poorer than those from the market-linked community of Opol, a more likely explanation is simply that there are some idiosyncratic differences between the two groups in terms of their willingness to report illnesses. One rather suggestive finding does occur for the diarrhea measure, though, which again attains statistical significance ($F = 4.74$, $p < .001$) with Medina and Opol ranking first and second highest, respectively, among all groups. In comparison the rubber and sugar groups both score very low on this indicator.(4)

A few other interesting differences can also be noted at this point. In the first case, upland farmers were found to rank highest in terms of skin allergies, a finding which serves to recall our previous observation about the heavy use of pesticides in the upland setting. This particular differential is not large enough to attain statistical significance but it is in the expected direction. Also, it is one of only three cases in which the uplanders ranked first or second highest on one of the symptomatic measures.(5)

We have also noted an apparently high prevalence of stomach disorders among the landless agricultural workers. This pattern receives some confirmation in the present data set insofar as the rice and sugar workers rank second and third highest (after the Medina fishermen) on the question about "stomach pains."(6)

The three oldest study groups are the coconut farmers, the corn farmers and the subsistence fisherfolk of Medina. It is thus of interest to note that these three communities also rank significantly higher ($F = 12.22$, $p < .001$) on the question about "blurred vision." This differential should perhaps remind us that, in addition to the heavy responsibility which it bears with regard to safeguarding the health of our young people, the DOH should also be reminded of the substantial numbers of elderly persons also found in the rural milieu. It would appear that a fairly large proportion of these persons are developing cataract conditions, probably with little or no chance of ever having this condition alleviated.(7)

On average, the small farmers were reporting 9.22 ailments per household for the month preceding the survey. This figure was significantly ($F = 3.75$, $p < .001$) higher than that turned in by the both the landless or the fishing communities, which respectively reported averages of 6.41 and 6.90 ailments.

When the more detailed classification scheme was used, the following intergroup differentials were noted:

<u>Group</u>	<u>Average No. of Ailments</u>
Corn farmers	9.65
Coconut farmers	10.52
Upland farmers	7.50
Rice workers	8.52
Sugar workers	3.92
Rubber workers	6.78
Fishers (market)	2.50
Fishers (subsistence)	11.30

Again, the older age profiles found among the subsistence fishermen, the coconut farmers and the corn farmers may be suggested as a major reason for their higher levels of morbidity. In general, the DOH would do well to keep in mind the special problems of aging rural communities, particularly since this phenomenon is sure to become even more widespread in the years to come.

Health Care Practices. We now turn to an analysis of the health care practices, both preventive and curative, which characterize our rural poverty groups. Table 4.5 contains a number of indicators pertinent to this issue. The first of these represents an extension of the data found in the preceding table. That is, for every condition mentioned by the respondent as occurring during the month preceding the survey, a follow-up item was asked on whether or not the sick family member had been able to see a health care worker. The topmost panel of Table 4.5 summarizes the results of this analysis by reporting the mean number of health care workers consulted by all family members during the time in question.

On average, the landless worker families had more consultations (with a mean value of 1.77) than either the fishers (1.14) or the small farmers (1.02). A one way analysis of variance shows this difference to be highly significant ($F = 11.02$, $p < .001$).

The easiest explanation for this finding would be that, thanks to their ease of access to company-run health care clinics, it is the workers on the sugar and rubber plantations who are able to have the most consultations. For the landless rice workers, though, we expected to find a pattern of less frequent consultations. Such, however, did not prove to be the case. While the rubber and sugar workers did rank second and third highest on this measure (with means of 1.72 and 1.55 visits) they were nonetheless surpassed by the rice workers (2.05 visits on average). The reason for this pattern is not readily apparent.

The least number of visits were turned in by the fishers of Opol, the coconut farmers and the upland farmers. Each of these groups averaged only 0.72 health care consultations during the month prior to the survey.

Table 4.5-- Use of Health Care Services Among
Three Rural Poverty Groups

<u>1. Consultations with a Health Care Worker During the Preceding Month (Mean No.)</u>			
Farming	1.02	F = 11.02	
Landless	1.77	p < .001	
Fishing	1.14		
<u>2. Type of Health Worker Consulted (Percent Going to Hilot or Herbalario on the First Consultation Mentioned)</u>			
		2	
Farming	19.1	X = 8.55, p < .02	
Landless	11.8	V = .20	
Fishing	31.5		
	(N = 215)		
<u>3. Source of Medical Advice "When Someone is Sick in the Family" (Percent Citing "No One", Nonprofessional or Traditional Healer)</u>			
		2	
Farming	50.8	X = 12.42, p < .01	
Landless	30.8	V = .20	
Fishing	51.2		
<u>4. Place Visited for the Consultation (Percent Going to a Gov't-run Center)</u>			
		2	
Farming	54.4	X = 4.73, p < .10	
Landless	49.5	V = .15	
Fishing	35.2		
<u>5. Distance Travelled for Consultation (Percent Going Outside the Home Barangay)</u>			
		2	
Farming	39.7	X = 8.29, p < .02	
Landless	59.1	V = .20	
Fishing	38.9		

Table 4.5 -- (Continued)

6. Visits to Barangay Health Center (Percent Ever Visiting)

		2
Farming	90.0	$X = 2.19, p = n.s.$
Landless	89.2	$V = .08$
Fishing	95.0	

7. Visits to DOH Hospital Facility (Percent Ever Visiting)

		2
Farming	64.2	$X = 0.04, p = n.s.$
Landless	65.0	$V = .01$
Fishing	63.8	

8. Hospitalization Patterns (Percent Who have Ever Had at Least One Family Member Hospitalized)

		2
Farming	56.4	$X = 3.50, p = n.s.$
Landless	65.0	$V = .11$
Fishing	60.8	

By way of review, we have seen that the small farmers were beset by the greatest number of ailments, at the same time being the group which scored lowest on the summary count of the total number of health care workers consulted. In comparison, the landless are in exactly the opposite position, with relatively more consultations and fewer ailments. It is apparent, therefore, that the latter group will exhibit the proportionately highest level of consultations, as might be computed by comparing the means of the ratio of the total number of consultations per household to the total number of ailments. (8)

The empirical results meet this expectation fully. On average, 33.5 percent of the ailments in the landless households were brought to a health care worker, as compared to 26.8 percent for the fishing households and only 12.4 percent for the small farmers. This difference is a highly significant one ($F = 18.62$, $p < .001$, $E = .33$).

Some fairly strong differentials also emerged when a similar analysis was undertaken for the full complement of the eight different poverty communities:

<u>Group</u>	<u>Average Percent Consulted</u>
Corn farmers	17.7
Coconut farmers	9.1
Upland farmers	10.5
Rice workers	26.9
Sugar workers	43.7
Rubber workers	29.6
Fishers (market)	37.2
Fishers (subsistence)	18.0

The infrequency with which the upland and coconut farmers seek out professional services for the ill members of their households is apparent from these figures. For the former case, their isolated location, with the associated difficulties of travel, is no doubt a major factor in this regard. The equally prevalent reluctance on the part of the coconut farmers is somewhat more difficult to explain although, again, their older age profile might have something to do with this. (Note that the two other "elderly" groups rank third and fourth lowest in terms of their ratios of consultations to ailments.)

The sugar workers rank highest among all groups in terms of their willingness to seek out one or another health care worker. This finding fits with many of our observations on this group. The reader may also wish to note that the two other landless groups, along with the fisherfolk of Opol, also fare well on this measure.

Further insight into this problem may be had by investigating the type of health care worker visited. We limit our analysis to the first medical condition mentioned by the respondent although it should be noted that rather similar results were also found for the second illness brought to a health care worker (in those cases where two or more illnesses were mentioned).

The results show that it was the fishing families which were most likely to consult a traditional healer. Thirty-one percent of this group (and 39 percent of those living in the subsistence fishing community of Medina) brought their sick member to a hilot or herbalario, as compared to 19 percent of the small farmers and only 12 percent of the landless. This difference is significant at the .02 level of probability. Along with the Medina fishermen, the upland farmers and the coconut farmers also ranked high in this regard, while the corn farmers and sugar workers were the least likely to see a traditional healer.

A slight variation on the above question may be had by inspecting data from a survey item which asked about the person consulted "when someone is sick in the family." The results are similar insofar as it is the landless worker families who were most likely to mention a "modern" health care worker (doctor, nurse, midwife) rather than a traditional healer, a nonprofessional or no one at all. Again this difference is statistically significant (Chi square = 12.42, $p < .01$).

Most frequent resort to someone other than a modern health care worker was found among the three oldest groups: corn farmers, coconut farmers and the Medina fisherfolk. Groups giving this response least often included the sugar workers, upland farms and the rice workers.

If we turn again to the first health care consultation for the month preceding the survey, we find that a little less than half of all respondents went to a government-run center (BHS, RHU or DOH hospital). For the aggregated groups this was somewhat less likely to occur among the fisherfolk than for the other two groups (Chi square = 4.73, $p < .10$).

When the eight subcommunities are compared, a somewhat larger differential emerges (Chi square = 22.30, $p < .01$). Nearly seven out of ten rice workers had gone to a government clinic, leading them to score highest in this regard. This finding seems plausible since it is unlikely that many in this very poor group would be able to go to a private-sector physician or clinic. At the same time, though, we have noted (above) that members of this group were getting health consultations rather frequently, with most of these cases not representing a visit to a traditional healer. It is therefore logical to assume that they must be compensating for their low incomes in some other way, in this case by going to a DOH clinic.

Groups scoring lowest on the use of a government facility were the fishers of Medina and the sugar workers of Quezon municipality. The former pattern is no doubt linked to this group's preference for traditional healers. In contrast, we can again cite the accessibility of company-run clinics for the sugar-workers area as a plausible explanation for their lack of interest in going to a DOH clinic.

"Plausible," perhaps, but not definitive. A final question on the place of consultation concerned whether or not the household member had to be brought to a place of treatment located beyond the boundaries of his/her home barangay. In this case it is the landless in general and the sugar workers in particular who are most likely to follow such a pattern. Indeed, more than ninety percent of all the sugar household cases were brought outside the barangay. (In comparison, less than a third of the sick persons from such groups as the Medina fishers, the upland farmers, the corn farmers and the rice workers were taken outside the barangay.)

These figures do not jive well with the above explanation insofar as the company clinics are located on the plantation premises, well within Barangay Kutong. So why would the sugar workers want to go somewhere else? Some explanations which bear further investigation include the possibilities that (1) the company clinics do not provide services for workers' children, (2) many of the workers are living outside Barangay Kutong and only travel there to work (or to visit the medical clinic) and (3) the cash salaries paid to workers make it easy for them to visit private practitioners located in the municipal poblacion. Their Medicare benefits also make it somewhat easier for this group to be hospitalized (in various places outside of Kutong) in cases where a more serious condition is found.

No significant difference could be found among the three groups on the question of whether or not they had ever visited the nearest Barangay Health Station. For the eight-group comparison however, a significant differential did emerge (Chi square = 16.95, $p < .02$). It is interesting to note in this regard that the rice workers were the most likely among all groups to have visited a PHS, while the sugar workers were the least likely. (9) Both of these findings fit well with the preceding discussion.

Differences among the small farmer, landless and fishing groups were also negligible on the item which asked about prior visits to a DOH hospital. Again, however, a significant differential did emerge for the detailed comparison of the eight poverty groups. A major factor in this case appears to be ease of access. Both the coconut farmers of Gingoog City and the fishermen of Opol have little problem in reaching DOH hospital. For the coconut farmers this is the government-run facility in the city center of Gingoog, while residents of barangay Luyong Bonbon in Opol live only a twenty-minute jeepney ride away from the regional training hospital in Cagayan de Oro. It is thus not surprising

to find that 92.5 percent of the former group and 82.5 percent of the latter one have been able to make such a visit. In contrast, only 47.5 percent of the sugar workers, 45.0 percent of the Medina fisherfolk and 35.0 percent of the upland farmers can make a similar claim. Each of these communities, it may be noted, is located in a fairly inaccessible rural setting.

The final indicator found in Table 4.5 pertaining to whether or not anyone in the family had ever been hospitalized. In a little more than 60 percent of all cases a positive response was given to this question. Intergroup comparison among the farming, landless and fishing communities are not statistically significant but significance is again reached for the more detailed comparison (Chi square = 34.77, $p < .001$). Differences in this case show the rice workers and the upland farmers to rank lowest in this regard. Only 37.5 percent of the former group and 32.5 percent of the latter had ever experienced the hospitalization of a family member. In comparison, such groups as the sugar workers (67.5 percent with a hospitalized member), the fisherfolk of Medina (77.5 percent) and the rubber workers of Talakag (80.0 percent) were much more likely to have used a hospital facility. Again we note the relatively favorable position of the sugar and rubber workers, perhaps because of their probable status as Medicare members.

Table 4.6 continues the above line of investigation, in this case by zeroing in on the specific case of maternal and child health care practices. We begin with an item on the use of family planning, the results for which have already been mentioned in an earlier context. As the data in the table's top panel show, it is the wives of the landless worker who are most likely to be using some form of contraception. In fact, the percent of this group who are current users (63.7 percent) is actually rather higher than that found for the country as a whole, a figure which includes, of course, large numbers of urban, middle-class families. (10) Further study of the reasons behind this high level of family planning adoption would certainly appear called for. Again, the presence of company-run clinics for the sugar and rubber workers may be playing some sort of role in this regard, although it is likewise apparent that this cannot constitute the sole explanation. Overall, prevalence is highest among the sugar workers (70.3 percent current users), followed in order by the rubber workers (61.5 percent) and the rice workers (59.5 percent). Ranking lowest are the coconut farmers, the Medina fisherfolk and (in particular) the upland farm families, only 28.9 percent of whom report contraceptive use.

When asked if their youngest child had received prenatal care, a strong majority of respondents answered in the affirmative. This was particularly true among the landless workers, who very nearly reported universal prenatal coverage. Comparative statistics for the farming and fishing communities were significantly lower, with only about 83 percent coverage in each case.

Table 4.6-- Maternal and Child Health Care Practices,
Among Three Rural Poverty Groups

1. Use of Family Planning (Percent Currently Using)

		2
Farming	36.6	$X = 17.80, p < .001$
Landless	63.7	$U = .24$
Fishing	42.9	

2. Access to Prenatal Care (Percent Using for Youngest Child)

		2
Farming	82.6	$X = 17.08, p < .001$
Landless	98.3	$U = .24$
Fishing	83.3	

3. Type of Prenatal Care (Percent Going to Traditional Health
Care Worker)^a

		2
Farming	17.9	$X = 14.23, p < .001$
Landless	19.3	$U = .23$
Fishing	0.0	

4. Place Visited for Prenatal Care (Percent Going to a PHU)^a

		2
Farming	66.3	$X = 10.13, p < .01$
Landless	62.3	$U = .19$
Fishing	84.6	

5. Type of Birth Attendant (Percent Using a Traditional Birth
Attendant or None at All, Last Birth)

		2
Farming	72.2	$X = 5.99, p < .05$
Landless	81.7	$U = .14$
Fishing	66.7	

^a Cases without any prenatal care treated as not applicable.

Table 4.6 -- (Continued)

6. Place of Birth (Percent Giving Birth at Home, Last Child)

		2
Farming	87.8	$X = 4.96, p < .10$
Landless	94.8	$U = .13$
Fishing	85.9	

7. Immunization (Percent with Youngest Child Fully Immunized)

		2
Farming	70.5	$X = 18.14, p < .001$
Landless	70.4	$U = .24$
Fishing	43.6	

8. Water Purity (Percent Who "Always" or "Sometimes" Boil their Drinking Water)

		2
Farming	19.2	$X = 15.74, p < .001$
Landless	19.2	$U = .22$
Fishing	41.3	

Again, the corn and coconut farmers both scored low on this dimension, along with the Medina fisherfolk. A plausible explanation for the differential, therefore, is that is the groups with more older couples (who gave birth to their youngest child during a time when prenatal care was less routinely administered) which show evidence for the least adequate coverage.

Most couples prefer to go to a modern medical practitioner (in most cases a midwife) for their prenatal care. None of the fisherfolk and a little less than a fifth of the small farmers and the landless reported themselves as having gone to a traditional birth attendant (TBA) for this service. (11)

Use of BHS or a RHU for prenatal care appears to be fairly widespread. About two-thirds of the small farmer and landless groups reported went themselves as having used one of these two government-run facilities, with an even larger proportion (85 percent) of the fisherfolk doing likewise. An even wider intergroup differential is found for the detailed comparison with 80 percent or more of both fishing groups, the corn farmers and the rubber workers going to a government facility, as compared to only 47 percent of the upland farmers and 27 percent of the sugar workers. This latter comparison is highly significant statistically (Chi square = 56.90, $p < .001$, $V = .46$).

Paralll questions were asked concerning health care services used during the birth of the respondents' youngest child. In this case it was the traditional birth attendants who were most typically chosen to act in this capacity rather than a DOH midwife. In all, about 75 percent of the respondents said that they had used only a TBA (or no health care worker at all) during their most recent birth.

Intergroup differences on this variable were only modestly large (Chi square = 5.99, $p < .05$), for the three-group comparison. In this case it was the landless workers who were most likely to use a TBA, while the fisherfolk ranked lowest. Again, however, the detailed classification showed a wider differential, ranging from the 92 percent of all rice workers who spurned a modern practitioner to only 51 percent of the Medina fisherfolk who did likewise.

Most births take place at home. This is particularly true among the landless agricultural workers whom, as we have just seen, are also most likely to request assistance from a TBA.

Most (70 percent) of the spouses of the small farmers and the landless agricultural workers claimed that their youngest child had been fully immunized. For some reason, however, the fishing families turned in a significantly poorer performance (only 43.6 percent fully immunized) in this regard. The reason for this differential is not immediately apparent, particularly since we had earlier noted that it was the fisherfolk who were

somewhat more likely to have ever visited a BHS. In any event, the immunization problem was particularly acute in the subsistence fishing community of Medina where only 31 percent of the youngest children had been fully immunized.

Our final indicator concerns the respondent's readiness to engage in a second type of preventive health care. This is the practice of boiling the family's drinking water, so as to reduce the possibility of becoming infected with one or another diarrheal disease. Physicians frequently advise that this practice should be followed in Third World countries. It is, however, both expensive and somewhat bothersome to do so. As such, only a small minority of our families claimed that they faithfully boiled the household's drinking water. Most, in fact, do not even do this on an occasional basis.

We have noted the increased prevalence of diarrheal illnesses in the fishing households. It would seem that the fisherfolk themselves are also aware of this problem. Overall, about 41 percent of these families were "always" or "sometimes" boiling their water, as opposed to only 19 percent of the other respondents. This difference is statistically significant at the .001 level of probability.

Looking at this pattern in more detail, we find both fishing communities (particularly that from Medina) scoring high on this measure. The rubber workers, too, are more careful in this regard, with 40.0 percent of these households boiling their water on at least an occasional basis. In comparison, very few of the rice workers (only 10.0 percent) and the sugar workers (7.5 percent) report themselves as being concerned enough to take this sort of precaution.

Summary and Conclusions

We again take note of our initial hypothesis that the rural poor are not as homogeneous a group as is commonly assumed. Data presented in this chapter provide wide-ranging support for this perspective. Broadly speaking, health care problems are by no means uncommon among the rural poor. Indeed, about half of our sample families experienced the death of one of their children. The specific patterns taken in those instances, however, can and do vary widely among the different study communities.

Perhaps the most interesting example of this tendency is found for the landless agricultural workers. Poverty, insecurity of tenure, low levels of educational attainment--all these problems are practically coterminous with the landless state. And yet this group is by no means the most problematic on several health care indicators. Their fertility is surprisingly low, and their use of family planning fairly widespread. They report fewer ailments and a smaller proportion of children ever dying. They also rank comparatively high on such indicators as visits to a

health care worker (both in absolute and proportionate terms), the use of modern practitioners and the use of prenatal care services. We have speculated that company-run clinics and eligibility for the Medicare program have helped facilitate these developments, although the case of the landless rice workers presents something of an anomaly in this case. (The rice workers do not have the company clinic option and are probably not covered by Medicare. Nonetheless, they do well on some of the above indicators, most noticeably the use of modern practitioners for nonmaternity-related problems and family planning services. On the other hand, they seem to rely strongly on traditional birth attendants for prenatal care and during the birth itself. Rice workers also report themselves as being less willing or able to bring their family members to a hospital during a crisis situation.)

Turning now to the three communities of small farmers, some special problems and potentials are also apparent in this case. Along with the subsistence fisherfolk of Medina, the corn and coconut farmers have a relatively older age profile than the other groups. In general, they are beset with more of the chronic conditions of old age. It is our impression that the DOH has given relatively less emphasis to these sorts of illnesses. If this is indeed true, it is a problem which should now be addressed. As the rural-to-urban migration of farm youth continues during the next decade, even as the rural birth rate continues to decline, the proportion of elderly persons in the Philippine countryside will surely increase. Preparations should now be underway for insuring that proper medical services can be extended to these older persons, even if they will be too poor to fully pay for the same. Sometimes, too, it is not just a matter of money. The coconut farmers were not the poorest group in our study or the farthest removed from a health clinic. And yet they ranked lowest in terms of the proportion of all ailments that were brought to the attention of a health care worker. Perhaps in some of these cases the old person has no one to bring him or her to the doctor. Or maybe they believe that the local EHS is just there to provide maternal and child care.

Upland farmers are somewhat younger on average. Their main problem may well be that of access to the modern health services which are most typically located in an urban or semi-urban setting. The uplanders have been found by our study to make fewer health care visits (both absolutely and proportionately) and to resort more commonly to a traditional practitioner. Their fertility is high and their use of family planning infrequent. They rank lowest among all groups in terms of visits to or use of a hospital. Their rates of childhood mortality are high. Again, serious thought must be given to developing new ways and means by which the needs of upland agriculturalists may be met, particularly since this is the one rural sector which may be expected to continue growing and attracting in-migrants throughout the coming decades (e.g. Cruz, 1986).

Special health problems may occasionally be linked to one or another environmental factor. We have seen at least two instances of this phenomenon. The first is the greater prevalence of diarrheal conditions in the two fishing communities. Our hypothesis in this case is that the more crowded living conditions found in coastal fishing villages may represent an underlying cause of this differential.

The second example concerns the use of pesticides. For reasons which are not immediately clear, this practice is considerably more common among the upland farmers of Claveria. (12) As a result, more respondents in this setting reported a concern that the household head's job was a potentially dangerous one. So also did we note a somewhat higher level of skin diseases and allergies for this group.

Findings from our study lend support to the strong emphasis given by the DOH to primary health care. Levels of childhood mortality among our rural poverty groups are still high, with about one out of every ten children ever born having already died. Such infectious and communicable conditions as diarrheal disease, acute respiratory illnesses, measles and tetanus were also found to be major contributors to this pattern of early death.

At the same time, however, the widespread prevalence of several chronic conditions was also noted. Ranking particularly high in this regard were ulcers and kidney problems. Heart ailments, arthritis, asthmas, tuberculosis and eye problems (e.g. cataracts) were also common. It is to be hoped that the government health service will be accorded the financial and manpower resources that it will need to tackle these problems, too, along with the childhood conditions pinpointed by the thrust towards primary health care.

Endnotes

1

In carrying out such an operation it will, of course, be necessary to exclude all cases of childless couples.

2

Even though the data refer to the children of our sample respondents, it should be noted that they do not relate exactly to the question of "infant and child" mortality. This is so insofar as some children of the respondents are already adults. A few of the deaths to this group must therefore have occurred well after the childhood stage had been passed.

3

For those readers who may feel that the categories listed in Table 4.3 are too gross to allow for an analysis of the specific conditions now besetting the Filipino rural poor, it may be of interest to note that nine specific conditions were mentioned

ten or more times. These includes, in order of the frequency with which they were mentioned, the following: "ulcer" (61 cases), kidney problem (29 cases), asthma (18 cases), arthritis (17 cases), cough (17 cases), heart ailment (15 cases), tuberculosis (15 cases), muscle pains (14 cases) and blindness/cataracts (11 cases). The very large number of kidney conditions and alleged ulcers is particularly noticeable from these figures. Nutritional deficiencies, stress, impure water and difficulties in maintaining personal hygiene may perhaps be some of the most important factors bringing about these conditions.

4

The sugar workers, in fact, report no cases of diarrhea among all members of their forty-household subsample.

5

For the question on "fever," the upland farming families tied for the highest ranking along with the corn farmers and rubber workers. For that on ear discharges they ranked highest, followed by the rice workers. The latter case was statistically significant but the former was not.

6

The comparison in this case is statistically significant ($F = 2.63$, $p < .02$).

7

Half or more of the households in the three groups mentioned above had at least one member experiencing blurred vision. This made this particular symptom as one of the most frequently reported conditions in the table, following only such common illnesses as headache, fever, cough/cold, back pain and toothache.

8

Again, all six households without any ailments were excluded from the analysis when these ratios were computed.

9

All rice workers families reported at least one visit to a BHS. This figure falls to only 77.5 percent for the sugar workers.

10

The previously-cited study of the "poorest of the poor" found 48.2 percent of the currently married women in this group to be using family planning (Herrin and Racelis, 1993, Table II. 3.2).

11

Comparing across the more detailed categories it is interesting (and not very surprising) to note that the upland farmers and the landless rice workers rank highest in terms of the decision to use a IUD.

12

A possible explanation, however, may be advanced. This is that the commercial cropping (tomatoes and beans) found in Claveria has encouraged a more widespread use of pesticides in that setting than for the semi-subsistence corn and coconut farmers.

Chapter Five. Beliefs and Attitudes about Health Care Provision

In this chapter we seek to describe the beliefs and attitudes about health care which are held by the members of the eight different poverty groups.

Health Care Decisions. Health care practices are preeminently social phenomena, and not only because they are conditioned by cultural, economic, and geographical factors. In the final analysis, such behaviors may be influenced more by household-level factors than by individual ones. Many sick persons (the young, the very old, the seriously ill) are unable to decide on the proper response demanded by their illness. In these cases, the decision to see a health care specialist must instead be made by someone else, usually the household head and/or his spouse. Household-level decisions must also be made with regard to such questions as compliance with the specialist's prescriptions, additional visits to the clinic, preventive-health care practices and the like. Because some households will be more effective than others in coping with all these demands, it therefore becomes apparent that family structural and interaction patterns will also become potent predictors of health care responses and outcomes (e.g., Pratt, 1976). To take but one example, cityward migration of the rural poor typically cuts them off from the traditional cultural milieu of the countryside, as well as from those elderly extended kin who still resort to traditional herbal remedies when they are sick. As such, the use of herbal medicines among the urban poor is generally uncommon, even when explicit efforts are made by NGOs to encourage such practices (Hardon, 1991).

It therefore becomes important to determine the health care beliefs and attitudes of our respondents. (In nearly all cases these consist of the spouse of the household head, i.e. the very same person who will also play the most central role in deciding how to respond to an illness or injury within the family.) A first step in this direction may be had by inspecting the data found in Table 5.1, which were gathered by presenting the respondent with two hypothetical situations and asking her about the response which she would give to each.

The first situation was described as follows:

"Your new baby is showing some signs of diarrhea. You want to be sure he will not get very sick from this disease. What will you do?"

Respondents could give any answer they liked to this question (i.e. it was an "open-ended" item): In general, and as shown in the top panel of Table 5.1, most claimed that they would bring the child to a doctor. A fairly large minority (a little less than 20 percent) also chose to see some other modern-sector

Table 5.1.—Response to Two Medical Emergencies,
Rural Poverty Groups

Situation 1: Baby with "Signs of Diarrhea"

<u>Response</u>	<u>Farming</u>	<u>Landless</u>	<u>Fishing</u>
See doctor	46.2	70.8	68.8
Go to BHS	26.1	19.2	7.5
Other response	27.7	10.0	23.8
Total	100.0	100.0	100.0

2
X = 25.79 , p < .001 U = .20

Situation 2: Child with Cough and Fever

<u>Response</u>	<u>Farming</u>	<u>Landless</u>	<u>Fishing</u>
See doctor	60.5	74.2	71.3
Go to BHS	4.2	10.8	1.3
Other response	35.3	15.0	27.5
Total	100.0	100.0	100.0

2
X = 19.85 , p < .001 U = .18

health care worker, in this case by saying that they would go to the Barangay Health Station (BHS). That leaves another 20 percent or so who selected some other response, such as using a home remedy or making use of a traditional healer.

A number of significant intergroup differences were found for this question. In general, the landless were most likely to say that they would bring their child to a doctor. This compares well with the findings on health care practices described in the previous report. The fisherfolk, too, preferred treatment by a doctor, though they were less in favor of the BHS. In contrast, the small farmers ranked lowest in terms of proposing to visit a physician thereby making them most likely to either go to the BHS or to give some other response.

Comparing across the eight poverty groups, it was the upland farmers who were least likely to say that they would go to the doctor for this type of illness. Only 37.5 percent of the uplanders selected this option, as compared to three-quarters or more of the sugar workers, the Medina fisherfolk and the rubber plantation employees. Again, a similar pattern was noted in our earlier discussion of actual health care practices.

The second situation posed a similar sort of problem, though in this case an explicit reference was made to the financial consequences of visiting a physician:

"Your baby is two years old. All day yesterday she was coughing badly. Last night she had a high fever and did not sleep well. Your neighbor suggests that you should bring her to the doctor but you know that will cost more than P100. What do you think is the best thing to do?"

Responses to this open-ended question were again classified into the three categories of visiting a doctor, going to the BHS and deciding upon some other curative resort.

As shown by the bottom panel of Table S.1, a similar pattern to that for the diarrheal diseases incident prevailed in this case. The landless were most supportive of the physician option, followed by the fisherfolk and the small farmers. Those living in the fishing villages were again least likely to go to the BHS, just as the small farmers ranked highest in terms of selecting some other option.

If there is a difference between the responses to the two situations, this would lie mainly in the significantly smaller numbers of respondents who felt that the acute respiratory infection (ARI) described in the second situation could best be treated at the BHS. More respondents in all three groups would appear to feel that the BHS is better equipped to handle an attack of diarrhea (e.g. through the provision of Oral Rehydration Solution?) than for a case of ARI.

Results for the eight-group comparison are also quite similar to those shown earlier. Again it is the upland farm respondents who were least likely to plan on seeing a doctor, while the Medina fisherfolk, the sugar workers and the rice workers ranked highest. As pointed out in earlier reports, the higher cash incomes, Medicare benefits and access to company-run medical clinics might all serve to make the landless agribusiness employees more amenable to visiting medical practitioners, even though the financial outlay in such cases will usually be rather high.

Table 5.2 provides further information on preferences about preventive and curative resorts. In the topmost panel we report the percentage of all respondents who agreed with the statement that "If my child is sick I prefer to bring him to the doctor right away, rather than waiting two or three days." The results are largely consistent with our preceding discussion. For the three-category comparison the landless group was found to be significantly more likely to agree with this sentiment than were either the small farmers or the fishers. For the more detailed comparison, too, the rice and sugar workers rank highest, with both of these groups showing universal agreement that a sick child should be brought to a doctor "right away." Some possible explanations for why the sugar workers would take this perspective have already been noted above. The willingness of the rice workers to take this course, however, is less expected, given not only their obvious poverty but also their general exclusion from any sort of company benefits. One possible explanation for this pattern might be the rice workers' greater willingness to use the DMS services (a finding highlighted in the preceding chapter). Strictly speaking, this entails an initial visit to the DOH midwife rather than to "a doctor" but this rather fine distinction might have been overlooked by many respondents.

Somewhat later in the questionnaire, respondents were asked the following question:

"Some people prefer to go to a hilot when a person in their family is sick. Others like to go to a regular medical doctor. Which one do you think is usually better for a sick person?"

Most respondents answered this question in terms of the simple dichotomy between "hilot" and "doctor." In some cases, though, the respondent said something on the order of preferring the doctor under certain conditions and the hilot at other times.

In Table 5.2 we have thus presented only the percentages for each group that gave the unqualified answer, "doctor". The results now show the landless to rank lowest on this measure, although it should also be noted that the relationship is a weak one at best (Chi square = 5.43, $p < .10$, $V = .13$). This finding, it must be admitted, does not fit very well with our preceding

Table 5.2.--Beliefs on Health Care Management,
Three Rural Poverty Groups

<u>1. Urgency of Bringing Sick Child to Doctor (Percent Claiming They Would Go "Right Away")</u>		
		2
Farming	78.8	$X = 19.95, p < .001$
Landless	95.8	$V = .25$
Fishing	75.0	
<u>2. Health Worker Preference, Comparing Doctor and Hilot (Percent Giving Unqualified Approval of Doctor)</u>		
		2
Farming	80.2	$X = 5.43, p < .10$
Landless	66.4	$V = .13$
Fishing	71.3	
<u>3. Preferred Purchase, Comparing Toilet and Television Set (Percent Choosing "Toilet")</u>		
		2
Farming	90.0	$X = 0.16, p = n.s.$
Landless	91.5	$V = .02$
Fishing	91.1	

discussion. Worth noting, however, is the strong doctor preference found among the sugar workers. More than 90 percent of this group chose "doctor", thereby ranking them highest in this regard. The weak preference for doctors (38.5 percent) found among the rice workers was thus a major reason for the low ranking found for the general category of landless workers. (Employees of the rubber plantation took an intermediate position with 67.5 percent preferring the physician.)

The last of our situation questions presented our respondents with the following choice:

"Your relative in Saudi Arabia sends you a gift of P5,000. Your house doesn't have a flush toilet and you would like to install one of these. You would also like to buy a television. If you could only buy one of these, which would you choose?"

The results showed a strong preference for toilets, with 90 percent or more of all three groups choosing this option. Of course, some respondents may have given this answer because it seems to be the more "respectable" answer between the two. In some cases, too, the television set represents a useless alternative because the household does not enjoy a direct electrical connection. One should not, therefore, make too much of the seemingly high level of support for toilets over television sets. In any event, no statistically significant difference was found for either the three-group or eight-group comparison.

Attitudes Toward the Department of Health. In Table 5.3 may be found a number of attitudinal items concerning the comparison between public-sector and private-sector health care services. On the one hand, we might expect the DOH to be highly thought of by our respondents considering that it is offering them medical care for free or at a very minimal cost. On the other hand, though, studies conducted in the Philippines have often described the perceived weaknesses of the government's health program, perceptions that are held not only by medical experts and better-educated persons, but even by the "man (and woman) in the street" as well. Public sector health personnel have thus been criticized by local residents for being ill-trained, unfriendly, and liable to hold infrequent and irregular office hours (e.g. Palma-Sealza, 1993). Barangay health stations, too, are seen as lacking the necessary equipment and medicines needed for proper diagnosis and treatment.

A series of statements was read to the respondent on this topic. Replies could range from "strongly agree," to "agree," to "disagree" and "strongly disagree." For example, and as shown in the topmost panel of Table 5.3, about 60 percent of all respondents were willing to either "agree" or "strongly agree" with the statement that doctors from the DOH were "just as good" as those

Table 5.3.--Beliefs and Opinions Regarding Public
Sector Health Care Services, Three Rural
Poverty Groups

1. <u>DOH Doctors vs. Those in Private Practice (Percent Agreeing They Are "Just as Good")</u>		
		2
Farming	65.5	X = 31.44, p < .001
Landless	77.5	U = .31
Fishing	38.8	
2. <u>Public vs. Private Hospitals (Percent Preferring Private if Charges Were "the Same")</u>		
		2
Farming	83.9	X = 2.40, p = n.s.
Landless	84.9	U = .09
Fishing	91.3	
3. <u>Public vs. Private Hospitals (Percent Choosing Private if Needed To Go Now)</u>		
		2
Farming	44.3	X = 16.63, p < .001
Landless	57.1	U = .23
Fishing	73.8	
4. <u>Opinion on DOH Personnel (Percent Agreeing They Are "Kind and Helpful")</u>		
		2
Farming	74.2	X = 4.15, p = n.s.
Landless	82.5	U = .11
Fishing	70.9	
5. <u>Interaction with DOH Doctors (Percent Admitting They Feel "Shy" to Talk to Them)</u>		
		2
Farming	42.9	X = 1.57, p = n.s.
Landless	45.8	U = .07
Fishing	51.9	
6. <u>Views on Bypassing the RHS (Percent Agreeing it Better to Go Straight to DOH Hospital)</u>		
		2
Farming	74.1	X = 5.07, p < .10
Landless	80.0	U = .13
Fishing	87.3	

Table 5.3.--(Continued)

7. Opinion on BHS Services (Percent Rating Them "Good" or

^a
"Very Good")

		²
Farming	83.3	$X = 7.81, p < .05$
Landless	88.8	$\chi^2 = .16$
Fishing	73.1	
(N = 293)		

8. Opinion on Services from DOH Hospitals (Percent Rating Them

^b
"Good" or "Very Good")

		²
Farming	90.3	$X = 16.46, p < .001$
Landless	93.7	$\chi^2 = .28$
Fishing	68.6	
(N = 207)		

^a
Respondents limited to those who had visited a BHS at least once.

^b
Respondents limited to those who had visited a DOH-run hospital at least once.

engaging in private practice. This figure was by no means uniform across all poverty categories, though, varying as it did from 77.5 percent agreement among the landless to 65.5 percent for the small farmers and only 38.8 percent for the fisherfolk. Variation was even greater for the detailed categorization scheme with 75 percent or more of the corn farmers, the sugar workers and the rice workers showing agreement as compared to a mere 5 percent of the Medina fishermen.

Results for the seven other items found in Table 5.3 are generally consistent with the above pattern. In all cases it is the fisherfolk who express the greatest doubts about the medical services offered by the DOH. We thus find the following:

1. Ninety-one percent of the fisherfolk alleged that they would prefer a private to a public hospital if the charges were "the same";
2. Seventy-four percent of this group said that they would choose to go to a private hospital if there was an immediate need for this;
3. Only 71 percent of the fishers argued that the DOH personnel are "kind and helpful;"
4. More than half (52 percent) of those from the fishing villages agreed that they feel "shy" to talk to the DOH doctors;
5. Eighty-seven percent felt it best to bring a sick family member straight to a DOH hospital, thereby voting to bypass the Barangay Health Station;
6. Only 73 percent were willing to grant a rating of "good" to the services provided by the BHS; and
7. Only 69 percent gave a "good" rating for services given by DOH hospitals.

In two of the above cases (preference for private hospitals if charges were the same and willingness to bypass the BHS) a majority of the small farmers and landless agricultural workers also expressed doubts about the efficacy of the DOH programs. Nonetheless, the general pattern for these groups seemed to be one of moderate approval for the government's health care efforts. In contrast, the fishers were consistently more dubious, with this differential often (in four of eight cases) being a statistically significant one.

All comparisons save one (choice of a public or private hospital if the charges were "the same") were found to be significant for the eight-group comparison. In every single one of

these cases it was the Medina fishermen who showed the least support for the DOH programs. Insofar as there is no a priori reason why this might be the case, one possibility is simply that the DOH personnel who are now assigned to Medina just happen to not be very accomodating, thereby pulling down the evaluation scores for the respondents living in that municipality. (1) As such, we should perhaps caution the reader not to read too much into this differential, consistent as it may be.

Returning for now to an earlier point, the overall impression from the data found in Table 5.3 is one of moderate, but not enthusiastic, support for the DOH efforts. Most respondents feel that the BHS and the DOH hospitals are doing a "good" job. Most claim that DOH doctors "kind and helpful" in their manner and "just as good" as private sector physicians. At the same time, however, almost half of all respondents admit to feeling "shy" in the presence of DOH personnel, while a considerable majority feel that it is generally best to bypass the local BHS in order to go straight to the nearest DOH hospital. Most telling of all, more than 85 percent admit openly that, if only the private sector charges were not so high, they would choose to go to a private hospital rather than a public one. Indeed, more than half of all respondents--poor as they are--say that, if some critical illness were to come up in the near future, they would choose to go to a privately-run hospital. Given the much higher costs of going to such establishments, it is apparent that the predominant feeling among our respondents is that the private hospitals must be offering better quality care.

Health Care as a Social Class Issue. In a seminal analysis of selected low-income countries which have been able to bring down their mortality levels, John Caldwell has argued that a prerequisite for this sort of demographic change is the mobilization of lower class household to press for a widespread provision, by the public sector, of quality health care and educational services. As Caldwell (1986, p. 191) puts it, "grass-roots political activism and radicalism are key elements in making health systems work, probably more important than governmental radicalism in establishing the programs." In other words, the question is not only one of constructing a chain of health clinics throughout the thousands of barangays found in the rural Philippines, but of (1) energizing the local community to put sufficient pressure on local health clinic personnel to insure efficient, caring service and (2) organizing larger coalitions of such grassroots organizations to lobby with municipal, provincial and national governments for increased budgetary attention to health and education needs.

Three survey items relate in some way to this issue. On the first of these the respondent was asked to agree or disagree with the statement that traditional (i.e. herbal) medicine is "only for the poor." Agreement with this statement, we would argue, may be interpreted as showing a certain amount of resignation on the

part of our poorer respondents to their lot and to the medical paradigm which is said to be appropriate for their "station" in life.

A second item asked for opinions on the statement that "the rich have fewer health problems than the poor." This could again serve as an indirect indicator of the radicalism dimension, insofar as those who disagree with the statement might well be more "sympathetic" to the "problems" of the rich and therefore less willing to join a militant, class-based movement.

The final item was the simple statement that "health care is a basic human right." As things turned out, every single one of our respondents agreed with this notion. We therefore formed a dichotomy by dividing the sample into those who "strongly" agreed with the statement, as opposed to those who merely agreed with it. Again, strong agreement is hereby postulated as indicating a greater potential for political mobilization or activism, particularly since the whole question of "human rights" is generally perceived as being a "leftist" issue in the Philippines.

The results of this analysis may be found in Table 5.4. On two of the three comparisons (traditional medicine as being "only for the poor" and the belief that health care is a basic human right) the fisherfolk are again found to assume a variant perspective. In this case they turn out to be the more militant group, a finding which in some ways fits with their generally high level of dissatisfaction with the services now being provided by the DOH. In both cases, too, the comparison is statistically significant. This is particularly true for the key question on whether or not health care should be viewed as a basic human right.

Differences between the small farmer and the landless group are neither large nor consistent in direction. An examination of the detailed classificatory comparisons also fails to show much of an underlying pattern other than a continued tendency for the Medina respondents to take an outlier position on most items. Thus, the subsistence fisherfolk were least likely to agree with the first and second statements found in Table 5.4 as well as being most in agreement with the human rights issue. In all three cases, it might be noted, the Opol fisherfolk came closest to adhering to the Medina point of view, thereby hinting that the latter's variant stance may not be merely an idiosyncratic matter after all. Perhaps the semiurban residential status of the fisherfolk, or the class-based conflicts which they are now engaged in with well-financed trawlers, have worked to convince members of this group that they ought to take a more radical and activist stance on current issue affecting their welfare.

Viewed as a whole, respondents to our survey do not seem to be the most likely candidates for successfully pressuring the government to make a real commitment towards alleviating the

Table 5.4.---Additional Health Care Beliefs Held By
Members of Three Rural Poverty Groups

Statement	Percent Agreeing	Significance
1. "Traditional (herbal) medicine is only for the poor."		²
Farming	83.3	$X = 30.54, p < .001$
Landless	90.0	$U = .31$
Fishing	58.8	
2. "The rich have fewer health problems than the poor."		²
Farming	84.2	$X = 5.89, p < .10$
Landless	79.8	$U = .14$
Fishing	70.0	
3. "Health care is a basic human right."		^a
		²
Farming	5.8	$X = 93.09, p < .001$
Landless	8.3	$U = .54$
Fishing	56.3	

^a
All respondents agreed with this statement. Percentages shown in the table refer to respondents who "strongly agree" with the statement.

health care problems of the poor. Table 5.3 has already shown a certain willingness on the part of those interviewed to give the DOH the "benefit of the doubt" on a number of dimensions. In Table 5.4 as well, we find widespread but relatively tepid support for the conventional notion that everyone has a right to some form of health care. Yes, all respondents agree with this idea, but only a minority are willing to do so strongly.

In a time when the efficacy of public sector programs is increasingly coming into question, it seems evident that a way must be found to make locally-based DOH personnel more professional and sensitive to the needs of their constituents. Private sector health workers will generally strive to meet these goals insofar as any failure to do so will inevitably mean a loss of clients and, therefore, income. Public sector workers, however, are in a quite different position. Their monthly incomes will remain the same no matter how many (or few) persons they serve. If anything, they would probably prefer to reduce their client load.

For some, the most obvious solution to this dilemma will be to privatize the DOH. As we shall see in a subsequent report, however, there are some definite financial constraints at work in this case. That is, the poorest rural families simply cannot afford a strictly market-style health care approach. In order for them to be served, some sort of public subsidy is going to be needed.

A third strategy, therefore, might be to stay with the current public sector approach but to encourage the growth of "watchdog" grassroots-level organizations that will defend the interests of the rural poor in health care matters. For example, Caldwell (1986, p. 203) reports that "substantial recent declines in mortality in rural West Bengal are now reported...because they have used the party system to appoint cadres at every health center to report on doctors or nurses who do not put all their time and effort into their services or who discriminate between patients." Though this idea might at first seem counterintuitive (why would the government encourage consumers' groups to be critical of its own programs?) such an approach can at least be expected to cost less than any grandiose scheme to help the poor by unilaterally upgrading public health care facilities. At the same time it also acts to keep in place a mechanism which, despite its failures, has at least attempted to pay some attention to the health care needs of the poorest of the rural poor, a group which will surely end up being bypassed by a full-fledged privatization effort.

Ideological support for the "watchdog" approach could perhaps be derived from the current administration's pledge to use "people power" for fostering national development. The primary motivating force for convincing people to join the group could in

turn be one or another health insurance scheme, a topic which will be taken up in our next report. A connection could also be made with the various "women in development" approaches insofar as it is generally the spouse of the household head who has traditionally been expected to look after the family's health care needs (Medina, 1991.) (2) The general goal, however, remains that of mobilizing the local populace by making them more aware of their own needs and of the good and bad aspects of the services being provided by the DOH. At the same time, of course, there will be a need to find ways by which their collective efforts might be used to help them afford more, and better quality, health care.

Summary

This chapter has dealt with beliefs and attitudes about health care provision which are held by members of three rural poverty groups--small farmers, landless agricultural workers and fisherfolk. Even though these groups represent the so-called "poorest of the poor," they generally seem to take a fairly modern stance on health care issues. On the whole, our respondents said that they would rather choose a modern-sector physician for their sick child than to opt for the cheaper solutions offered by traditional healers or home remedies. Most, too, recognized the need for not delaying unduly before bringing their child to a doctor. There was even considerable support for at least one approach to preventive medicine. More than ninety percent said that they would rather have a flush toilet than a television if they were given a choice between the two.

Of course, there is an obvious problem here with "face saving" responses. Some respondents who claimed to prefer the toilet would no doubt actually buy the TV set instead. And our parents do delay before bringing their children to the doctor. If nothing else, however, we can at least say that they do know the "correct" response to make, even if cultural or financial constraints will sometimes force them to do otherwise.

Attitudes toward public sector health care were mixed. On the surface, most respondents praised DOH personnel for being "kind and helpful" and "just as good" as those in the private sector. When the chips are down, however, most say that they would rather go to a private hospital than to one operated by the government. And that is so even with their very low incomes and the high costs involved. Given a hypothetical situation of private-sector costs being "the same" as those for a public sector hospital, more than 85 percent of the respondents opted for the private facility. There also appeared to be substantial uncertainty over the quality of care provided at the Barangay Health Stations, with three-quarters or more of all respondents saying that it is best to simply go straight to a DOH hospital. This latter finding is supported by other research studies (e.g. Palma-Sealza, 1993) which have commented upon the widespread underutilization of the BHS clinics.

A final issue concerned the respondents' readiness to take a more activist ("radical") stance on health care issues. A research study by John Caldwell has indicted that this sort of perspective could, if mobilized, help to lobby for a more effective and sensitive public health care system. Should this indeed be the case, our general impression was that most of our respondents were not yet prepared to take a highly active stance in pressing for their constitutionally-guaranteed right to decent health care. Some suggestions were thus made about approaches which could incorporate or encourage a grassroots movement for better and more relevant health care.

Intergroup differentials have also been explored and discussed. In general, the landless workers (especially those in the sugar areas) were most vociferous in claiming that they would go to a modern-sector physician for their health care needs. Surprising as this finding may be, we should nonetheless point out that it is generally supported by data from the previous chapter, in which actual health care practices were discussed. For their part, the fishing families were most critical of the DOH and most supportive of the grassroots mobilization perspective. No immediate and readily acceptable explanation for this latter pattern could be identified.

The previous chapter has pointed to an apparent problem of access to health care services on the part of the upland farmers. Data reported herein continue to support that perspective. For example, upland farmers were least likely to say that they would bring a child sick with either diarrhea or acute respiratory illness to a doctor. Continued attention to the needs of this far-flung group, e.g. through improved transport and communication linkages, appears needed.

Endnotes

Sixty-five percent of the Medina fishermen said that they felt "shy" to talk to the DOH doctors, while only a slight majority (52 percent) agreed that the DOH physicians are "kind and helpful." Considering the cultural value placed by Filipinos upon euphemism and conflict avoidance (thereby encouraging the so-called "courtesy response") these figures would indeed seem to point to some problems in interpersonal relations for this group.

2

Over the long run, of course, there will be a need to involve the (male) household head in additional "domestic" tasks, including care of the sick. The above recommendation should thus be considered as a short-run alternative which has been suggested for the practical reason that males will probably be less interested than females in local health care initiatives.

Chapter Six. Patterns of Health Care Financing

In this chapter we focus specifically on the economic dimensions of health care provision among the rural poor. We begin with a brief review of the difficulties which poor rural households are facing in their attempt to provide decent medical care for their members, moving on from there to investigate current and proposed methods of health care financing for this group.

At present, the Philippine government is guaranteeing a certain minimal level of health care coverage, even in cases where the family will not be able to pay for this. Many curative services, though, are not covered by the present program. Medicines, hospitalization costs, surgical fees--these must be paid for by the family itself, through one means or another. Of course, there is the government-run hospitalization insurance program ("Medicare") but this has only limited impact, insofar as large numbers of Filipinos are not covered by the program. This latter problem would seem to be particularly true for the groups being analyzed in this study: small farmers, landless agricultural workers and fishermen.

Given these constraints, it becomes apparent that the rural poor will only have a limited number of options to choose from if someone in their family becomes seriously ill. These consist of (1) paying for the medical costs from their personal earnings and/or savings, (2) borrowing money to pay these costs, (3) finding a charitable organization who will pay all or part of their costs, or (4) becoming a member of a formal health care financing (i.e. insurance) scheme. In this latter category we can include a number of alternative options including the government-run Medicare program, purchase of a health care policy from a private insurance company, acquiring some type of job-based medical benefits from one's employer and joining a community-based health care financing plan. In this chapter we will review the extent to which these different options are actually being resorted to by the rural poor, the various correlates of these different options, and prospects for integrating rural folk within one or another of the formal approaches to health care financing.

The Economic Situation Reviewed

Previous chapters have already demonstrated the more-or-less tautological finding that the rural poverty groups contacted during the course of this study are indeed quite poor. Cash incomes for a "typical" month averaged less than two thousand pesos for all three of the major groups, even dropping below a thousand pesos a month for the landless rice workers. Ownership of consumer items--including those as cheap as a radio or a photo album--is by no means widespread. On average, the small farmers do own some fairly valuable assets (a hectare or two of land,

some livestock or poultry, farm implements) but the fisherfolk have only their boats (usually nonmotorized) and the landless have virtually nothing worth selling or mortgaging to help tide them over during a major emergency.

Cash incomes are highly irregular for all three groups. When asked if their incomes fluctuated from one month to another, two-thirds of the landless workers and 99 percent of the fisherfolk answered in the affirmative. (1)

Meanwhile, health care costs are escalating rapidly, in a pattern which has reached even the most remote barrios of the nation. In all, a little more than 60 percent of the respondents have had at least one family member hospitalized during some time in the past. The average amount spent on these occasions was P 3,412, an amount which would surely be very difficult for most of our respondents to come up with. Further still, these figures are based on past expenditures. No doubt current hospitalization costs will average out to a figure than is 50 percent or higher still than that.

Even when a member of the household does not require hospitalization, significant medical costs can still be incurred. To illustrate, more than half (59.4 percent) of the households had at least one member who consulted a health care practitioner (whether modern or traditional, private sector or affiliated with the DOH) during the month preceding the survey. In more than three-fourths of these cases, some consultancy fee was paid, ranging from 5 to 500 pesos. The median category for this question was P10 - 19.99, with fourteen percent of all who paid something incurring a bill of P100 or more. Other expenses were also incurred on these occasions: travel costs (experienced in 61 percent of all cases), charges for medicines (found in 47 percent of all cases) and testing fees (7 percent of all cases). For those experiencing such charges the median amount paid came to P5 - 9.99 (for travel), P100 - 249.99 (for medicines) and P100 - 249.99 (for tests). These figures are clearly going to represent significant expenditures for most of our respondents. (2)

When incomes are both low and irregular, even as medical costs are high, it is to be expected that some situations will arise in which the family cannot come up with the money needed to bring one of their sick members to a doctor. The survey instrument included an item which asked if this had ever occurred. The results showed that exactly 25 percent of all respondents admitted that this had happened to them on one or more occasion. As shown below, this problem occurred most frequently among the fisherfolk and least of all among the landless agricultural workers:

<u>Group</u>	<u>Percent unable to bring sick family member to a doctor</u>
Small farmers	15.0
Landless	13.3
Fisherfolk	41.8

The above results are highly significant statistically (Chi square = 20.68, $p < .001$, $V = 0.25$). What they imply, of course, is that the lives of our rural poor are still very much at risk, due in large part of their very low economic status.

Sources of Health Care Financing

A total of 200 families were located which had experienced the hospitalization of one of their members. These respondents were asked how they had acquired the funds needed to pay the resulting charges. As demonstrated in Table 6.1, the chief strategy used in these cases was to make the payments from current salaries or savings. This was used as the only source of health care funds by 21.5 percent of the respondents. The next-ranking options were the sale or mortgaging of property (10.0 percent), borrowing money from someone or getting a cash advance from one's employer (9.0 percent), using the family's Medicare privileges (7.5 percent) and getting a donation from some friend, relative or agency (8.5 percent.).

Several patterns may be noted from the data shown in Table 6.1. Foremost among these is the frequency with which the rural poor seek out a multiplicity of funding sources for their hospitalization expenses. In 34.5 percent of the cases two different strategies were used, while another 9.0 percent of the households had to obtain the necessary funds from three or more sources. While suggestive, this finding would seem to be open to various interpretations. In one sense the resort to multiple payment sources is functional, since it indicates that (1) the rural poor do have access to a variety of assistance channels and (2) these are often available to them on an interest-free basis. Conversely, the situation of extreme poverty experienced by our respondents, as typified in this case by their difficulties in acquiring ready cash, is also apparent here. Indeed, one almost gets the picture here of the household head and his spouse rushing frantically from one possible source of help to another, all the while wondering if the bill can ever be paid.

Other impressions may also be noted. Medicare payments are by no means unheard of, but they do represent, nonetheless, a definite minority of all cases. Only 7.5 percent of all hospital bills were paid entirely by Medicare while in another 20.0 percent of the cases some partial funding came from this source.

Other formal health care financing schemes fare even more poorly in this regard. In fact, they don't appear at all, whether in the form of employer benefit packages, private sector plans or community-based approaches. In most cases, therefore, the rural household is thrust back upon its own resources as assisted often enough by whatever help it can obtain from friend or relatives. (3)

Table 6.1.--Percentage Distribution, Source of Money for
Most Recent Hospitalization Expenses, Rural
Poverty Groups in Northern Mindanao, 1992

Source	Percentage
Own savings/salary	21.5
Sold/mortgaged property	10.0
Loan	9.0
Medicare	7.5
Donations/Charity assistance	6.5
Savings and property (sold/mortgaged)	2.5
Savings and loan	3.5
Savings and Medicare	0.0
Savings and donations	4.0
Property (sold/mortgaged) and loan	2.0
Property and Medicare	0.5
Property and donations	1.0
Loan and Medicare	11.0
Loan and donations	2.0
Other combinations (three or more sources)	9.0
	100.0

In the remainder of this chapter we will look more deeply into the various strategies for health care financing mentioned above. We begin with the personal funds from the household itself, as raised through savings or the sale/mortgage of property.

Household Sources. If most poorer households are already relying on their own earnings for paying off their medical expenses, does this mean that the situation is already well in hand, with little need for additional inputs from government planners or policy makers? Apparently not. Data from the present study show that, even though this approach may be the most widespread, it can scarcely be characterized as being either highly effective or reliable. For one thing a separate questionnaire item on savings revealed that only 9.7 percent of the respondents could boast of having any cash savings at all as of the survey date.

This inability to set any money aside for a "rainy day" is prevalent among all three groups, most especially the landless agricultural workers and the fisherfolk. While about one out of every five farmers had managed through the years to acquire some savings, the comparable figures for the fisherfolk and the landless workers are only 7.5 and 2.3 percent, respectively. (4)

In theory, our respondents are all in favor of improving their record in this regard. When asked if they thought it is a good idea to save money, a full 98.4 percent of them answered in the affirmative. And, when they were asked to name their first-ranked purpose for saving some cash, the most frequently-cited justification was the need to provide for possible illnesses in the family. Forty-three percent of all respondents mentioned this as their first-ranked rationale, as compared to 29.4 percent who were motivated by their children's educational needs, 17.2 percent who feared becoming unemployed, and about one-tenth who mentioned either housing or retirement.

The only problem, of course, is that it is a lot easier to agree that it is a "good thing" to save money than it is to actually acquire some savings. Further still, a single illness can wipe out the hard-earned accumulation of years in a matter of days. Thus, for those families who had paid from their savings for all or part of the most recent hospitalization expense, about three-fourths (74.4 percent) said that these had been fully depleted by the time the final bill was paid. An additional aspect may also be noted in this regard, namely that most of these families had been hoping to use their savings for some other purpose most typically for setting up or expanding a family's business or for putting one of their children through college. (As such, it would appear that the low levels of access to a workable system of health care financing is reducing in some ways the potential of the rural poor for upgrading their economic status.)

In other cases, household property was sold or mortgaged. Among the families who had hospitalized one or more members, this mode of payment was used 12.5 percent of the time. The most typical item sold or mortgaged was a farm animal (25 out of 40 cases), but in other circumstances it became necessary to dispose of household consumer items, agricultural produce, or even the land itself. (5) The necessity of making these transactions within a short period of time generally meant that the family had to take a loss on the deal. When asked the actual value of the property which was sold or mortgaged the average figure given was P 9,102, an amount which is more than 50 percent higher than the mean amount (P5,868) actually realized by the sale.

When a medical emergency necessitates the mortgage or sale of income-generating property the household loses in two ways. First, it must absorb the cost of the hospital bill. Secondly, its ability to generate income in the future may also be significantly impaired. For the farmer who mortgages his land or the fisherman who sells his boat the ultimate result is most probably going to be downward social mobility---the movement from a life that is already difficult to one of sheer destitution. Even if this latter outcome is avoided, the periodic occurrence of medical emergencies makes it extremely unlikely that the rural poor will ever be able to improve their lot. Ben Kerkvliet's analysis of the social class hierarchy in a village of Central Luzon provides an example:

"During discussions concerning such questions as 'why are some people rich while most others are poor?...the explanation often heard is 'luck and chance' (suwerte, kapalaran)....

From a small tenant farmer comes...(an) illustration....'Just about the time I think I'm going to climb out of poverty, something bad happens.' One time it was his son being hit by a car and practically losing his leg. Hospital expense set back the whole family for years..." (Kerkvliet, 1980, p. 43).

Of course, one could always forego the painful process of selling one's land or work tools. Why not borrow from someone else who has the money? But, as we shall see in the next section, this strategy, too, has a catch. Loans from a friend or relative will usually be far too small to cover all of the expenses involved. After all, most acquaintances of poor folk are themselves poor and therefore unable to offer very much. Or else you go to the usurer, thereby reducing significantly (as was the case with the sale of income-generating property) the net income which the family will be bringing in during the next year or two. With the cards so stacked against them, is it any wonder that the rural poor see their lives as being determined more by suwerte than by all their efforts to work hard and plan their family's future?

Loans. About 30 percent of the families with a hospitalized member had borrowed some money in order to help pay for the resulting expenses. This option, therefore, would appear to be one which is used with some frequency.

Not everyone, though, is able to borrow. This was demonstrated in the present case by asking the following question:

"Suppose your family had a big emergency, for example, if someone was very sick. Do you think you could borrow money from someone to help solve that problem?"

In response, twenty percent of the respondents said that, no, they did not have someone they could turn to in such an emergency.

A follow-up item was then asked as to whether or not the family had ever borrowed some money in a time of trouble. Again there were some (43.8 percent in all) who answered in the negative. Note, too, that this figure is more than twice as large as that obtained for the above question on a hypothetical future loan. It is therefore quite possible that some of the ones who believe that they will be able to borrow some money may eventually receive the unpleasant surprise that they won't be able to do this after all.

In general, the amount of money which can be accessed through loans is not very impressive. The average amount which the respondents believe they can raise in this manner is P 1,104.32, with a median value that reaches only to P 500. The amount of money actually brought in by past loans (among those who had incurred a debt) was lower still, averaging out to only P830.28 with a median value of P300. These statistics would have been lower still if all those respondents who confessed to their inability to get a loan or who were unable to ever do so in the past had also been included. (6)

The source of past and projected loans is also of some relevance for our topic. We have already mentioned two possibilities, namely the person's primary group contacts (friends, neighbors, relatives) and the local usurers. As shown in the top panel of Table 6.2, however, at least four other sources might also be approached; i.e., formal lending institutions (banks, credit unions), community groups (NGOs or POs), employers or landlords, and the middleman (suki) who usually buys the farmer's produce or the fisherman's catch.

In general, the most common source for loans (both actual and projected) lies in the respondents' friends and relatives. A majority of responses on both items (53 percent for projected loans, 64 percent for those actually made in the past) fell within these two categories. Employers or landlords (the former

Table 6.2--Data on Loans for Emergency/Medical
Purposes, Rural Poverty Groups in
Northern Mindanao, 1992

1. Distribution of Responses to Questions on Projected and
Actual Loans During an Emergency

Source of Loan	Percentage Distribution	
	Projected	Actual
Banks, etc.	3.9	0.0
Community groups	0.4	5.6
Employer/landlord	23.4	21.2
Suki	13.3	6.7
Usurer	5.9	2.2
Friend/neighbor	17.6	26.8
Relative	35.5	37.4

2. Percent Believing That They Could Borrow Money, by Poverty Group

Group	Percent	
Small farmers	75.0	$\chi^2 = 19.92, p < .001$ $\chi^2 = 0.25$
Landless workers	92.5	
Fisherfolk	68.8	
Corn farmers	90.0	$\chi^2 = 48.75, p < .001$ $\chi^2 = 0.39$
Coconut farmers	52.5	
Upland farmers	82.5	
Rice workers	77.5	
Sugar workers	100.0	
Rubber workers	100.0	
Market-linked fishers	72.5	
Subsistence fishers	65.5	

Table 6.2--(Continued)

3. Mean Amount Which Could Be Borrowed, by Poverty Group

<u>Group</u>	<u>Mean (P)</u>	
Small farmers	770.25	F = 4.04, p < .02 a N = 320
Landless workers	1230.10	
Fisherfolk	491.98	
Corn farmers	1376.25	F = 6.33, p < .001 a N = 320
Coconut farmers	220.00	
Upland farmers	714.50	
Rice workers	230.25	
Sugar workers	1162.50	
Rubber workers	2297.55	
Market-linked fishers	446.25	
Subsistence fishers	537.504	

4. Source of Projected Loan, by Poverty Group

<u>Source</u>	<u>Farmers</u>	<u>Landless</u>	<u>Fishers</u>
Bank, etc.	4.4	3.6	3.6
Employer	1.1	51.4	3.6
Friend, relative	76.7	26.1	69.1
Other source	<u>17.8</u>	<u>19.9</u>	<u>23.6</u>
	100.0	100.0	100.0

$$\chi^2 = 93.24, p < .001 \quad V = 0.43$$

a All respondents have been included in these tabulations. Those who said that they could not borrow money from anyone were coded as "0" on the above measure.

more often than the latter) were also an important option, comprising as they did 23 percent of all projected loans and 21 percent of the actual ones.

The other categories were of less importance. About 4 percent of the respondents believed that they could get a loan from a bank. No one, though, had actually succeeded in doing this. Usurers represented six percent or less of both actual and projected loans. Community groups were mentioned in a few instances for the question on past loans but no one seemed to expect them to continue this practice in the future. Finally, the suki was expected to help by 13.3 percent of the would-be borrowers but had, in the past, only given help to 6.7 percent of the respondents.

Some interesting variations existed among the different poverty groups on these questions. (7) In general, it is not the farmers and fisherfolk who are most optimistic about their prospects for borrowing money (see the second panel of Table 2). This is true in spite of the fact that it is these groups which are most likely to own some assets (a hectare or two of land, a boat) which could serve as the collateral for such a transaction. In all, 92.5 percent of the landless workers said that they could borrow some money in an emergency, as compared to 75.0 percent of the farmers and 60.8 percent of the fisherfolk.

The high percentage obtained for landless workers on this item stems largely from the experience of the sugar and rubber workers. Every single one of the respondents in these two groups answered the question on emergency loans in the affirmative, as compared to a rather lower figure (77.5 percent) for the rice workers.

Significant variations also existed for the amount of money which could be borrowed and the source of the projected loan. Again it is the landless workers in general and the sugar and rubber plantation employees in particular who stand out in this respect. For the item on the total amount which might be borrowed the landless workers felt that they could come up with an average loan of more than P1,200 as compared to P770 for the farmers and a mere P492 for the fisherfolk. This differential may be attributed largely to the very high averages turned in by the sugar and rubber workers (P1,162 and P2,298, respectively) since the comparative figure for the rice workers (P230) is very low indeed. (8)

The bottom panel of Table 6.2 helps to clarify these findings. As might well be expected (insofar as most farmers and fishermen are self-employed), the landless workers are much more likely to mention their "employer" as the source of their projected loan than are either of the other two groups. As such, the farmers and the fishers are generally limited to the less satisfactory alternative of approaching a friend or relative when an

emergency arises. (9) Again, too, it is the sugar and rubber workers--i.e. those employed on the larger, formal sector farming enterprises--who are most likely to claim that it is their employer who will help them out once the need arises. (In fact, every single one of the sugar workers said that they would deal with a medical emergency by getting a loan from their employer.) It is thus an irony of modern corporate agriculture that it preserves more fully the functional aspects of the age-old patron-client relationship than can now be possible within the context of the Philippine rice industry, dominated as it is by small and often unprofitable farmholds.

We have earlier mentioned the usury problem. To some extent the data from this study show this to be a relatively uncommon state of affairs, at least as far as medical emergencies and hospitalization episodes may go. For the 68 families who had borrowed some money to pay for the hospitalization of one of their members, only 5 said that they had gone to a usurer for this purpose. This may well be due as much to the usurers' unwillingness to take on the poorer rural families as their clients as it is to a reluctance on the part of small-time agriculturalists and fishermen to approach a usurious moneylender. In any event, it certainly noteworthy that most of the loans offered by relatives, friends and even employers appear to be made on an interest-free basis. A question on this revealed that such was the case in 85 percent of all loans for hospital expenses. There also appear to have been fairly liberal terms with regard to the time required for repayment. It was argued that thirty-four percent of the loans transacted could be repaid in four or more months while another 18 percent had, in fact, not yet been repaid at all as of the time of the survey. (10)

Charity. No questions about charitable help for medical bills were included in the survey instrument. We have noted, however, that about 13 percent of all families with a hospitalization episode volunteered the information that they relied on "donations" to pay all or part of their final bill. Four cases (2 percent of all households with a hospitalized member) were also identified in which the hospital bill had not, in fact, been paid in full. Perhaps this represents a sort of "charity" on the part of the hospital. In all probability the actual proportion of unpaid bills may well be higher, assuming, that is, that most respondents would not want to reveal information of this nature.

As is the case with loans from friends and relatives, charitable assistance is generally not a very practical solution for the health care financing needs of the rural poor. For one thing, the problem is just too large to be alleviated by the relatively small sums that can be raised via private donations. In Northern Mindanao alone there are approximately half a million households which fall into the small farmer, landless worker or fisherfolk category. Even if these had only one major emergency (costing a thousand pesos on average) every five years, this would still require an annual fund of a hundred million pesos in order to meet the resulting expenses.

There are also reasons for expecting that most medical foundations set up along charitable lines will concentrate in cities rather than in rural areas. Ease of access is greater in the cities, thereby heightening economies of scale. Doctors associated with such efforts tend to prefer life in the city, since this gives them access to higher-income clientele, modern technologies, and better schools for their children. International funding agencies are also notoriously dependent upon their urban-based contacts. As such, comparative studies of rural and urban areas have shown that city parents are more likely to bring their children to a charitable clinic than are those living in the countryside (e.g. Palabrica-Costello and Costello, 1991). One Manila-based analysis, in fact, even noted that mothers in the National Capital Region can "pick and choose" among various charitable options, thereby leading them to only patronize those that will give them free medicines along with the expected complimentary visit with a physician (Hardon, 1991).

Medicare. An additional way in which the medical (especially hospitalization) needs of the rural poor may be met would be via their participation in one or another formal sector health care financing scheme. Foremost among these in the Philippine context is the state-sponsored Medicare program.

Because Medicare payments are most typically made in the form of payroll deductions, this option has generally been limited to families headed by that minority of Filipino workers who have been able to get a full-time, formal sector job. In theory, self-employed persons are also eligible for the program but in practice this does not happen very often. Indeed, as Herrin, *et al.* (1993, p. 27) have noted,

"Medicare covers only about 20 percent of the total employed labor force. The failure to cover more...is directly traceable to the slow structural transformation of the economy. A large proportion of the labor force remains in hard to cover/hard to enroll agricultural and service sectors of employment."

Given this sort of background, we were mildly surprised to note that the findings of the present study showed 25.3 percent of all sample households to be covered by the government's social insurance program. How could a figure of this magnitude (one which is apparently larger than that found for the nation as a whole), be reached for a study which was aimed specifically at the "hard to cover" rural poverty class?

The answer, of course, lies in our purposive selection of those very same agricultural worker categories which have so frequently differed from the other groupings in this study, i.e. the sugar workers of Quezon municipality and the rubber tappers

of Talakag. Fully 90 percent of the household heads in these two subsamples were bona fide Medicare members as compared to none of the landless rice workers and a mere 4 percent of those in the other five poverty groups. (11)

The same point is demonstrated in the top panel of Table 6.3, though in this case the statistic under review is the mean number of household members who belong to Medicare. The statistical test in this case is therefore a one way analysis of variance which turns out to be highly significant. In fact, the E = Chi square statistic (correlation ratio) for the more detailed typology shows that no less than 63 percent in the variation of the dependent variable may be in this case be accounted for by the explanatory factor (occupational type).

To return to an earlier point, however, it should perhaps be emphasized that our data on levels of Medicare coverage have been gathered as part of an exploratory, theory-building study. As such, they cannot be said to accurately depict the "normal" situation in rural Mindanao, which is characterized by a considerably larger number of small farmers than of agricultural workers on plantation-like farming enterprises. It is therefore almost certainly the case that twenty-five percent of Region X's rural poor do not participate in the Medicare program, nor is it likely that they will do so in the foreseeable future.

For those few who were able to use the Medicare program to pay for the family's last hospitalization episode, the procedures involved do not seem to be too onerous. Eighty-five percent of the claimants were able to file their papers within a single day and all (100 percent) said that payment was made immediately. (This apparently means that the hospital immediately deducted the amount payable by Medicare from the patient's bill.)

Medicare is also popular among those not currently covered by the program. When these respondents were asked if they would like to be enrolled in Medicare, nearly all (94.8 percent) replied in the affirmative. These sorts of positive attitudes were held somewhat more strongly by the landless workers and the fisherfolk than by the small farmers (please see the second panel of Table 6.3).

With health care costs increasing rapidly, there may eventually be a need to raise the Medicare premiums, whether absolutely or perhaps as a proportion of the worker's total salary. Respondents who are currently enrolled in the program were therefore asked if they would be willing to have a larger sum deducted from their regular salary "in order to have more benefits from Medicare." In spite of the generally positive attitudes held toward the program, a slight majority (64 percent) said that they would prefer that this not be the case. Again, the basic dilemma which runs like a thread through the present analysis is encountered: the rural poor have so many needs and so little money to satisfy them. And these, it should be added, are real needs, not the artificial cravings of an urban, consumer-based society.

Table 6.3--Data on Participation in and Attitudes
Toward Medicare, Rural Poverty Groups in
Northern Mindanao, 1992

1. Mean Number of Household Members in Medicare Program

	Mean	
Small farmers	0.08	F = 68.88, p < .001 2
Landless	0.62	
Fisherfolk	0.08	E = .55, E = .30
Corn farmers	0.12	
Coconut farmers	0.10	
Upland farmers	0.03	F = 76.78, p < .001 2
Rice workers	0.00	
Sugar workers	0.95	E = .79, E = .63
Rubber workers	0.90	
Market-linked fishers	0.02	
Subsistence fishers	0.12	

2. Demand for Coverage among the Non-enrolled (Percent Who Would Like to be Covered)

		2	a
Small farmers	90.8	X = 6.76, p < .05	
Landless	97.8	U = 0.17	
Fisherfolk	98.7		

3. Extension of Medicare to Workers Outside the Formal Sector (Percent Agreeing)

		2
Small farmers	95.8	X = 22.62, p < .001
Landless	82.5	U = 0.27
Fisherfolk	100.0	

a

Expected frequencies for three cells fall below five.

Should Medicare be for everyone, even those who do not hold "regular jobs"? A question to this effect was included on the survey instrument. A large majority of our respondents gave an affirmative answer to this query. Seventy-one percent "agreed" with this proposal while another 21 percent went even further and "strongly agreed" with it. As shown by the data in the bottom panel of Table 6.3, however, the three major poverty groups differed somewhat in this regard. In particular, it is the landless workers who have the most doubts about this proposal, probably because they have little or nothing to gain by it and may, in fact, even fear that it would somehow work to dilute their present benefits. (12) As a working hypothesis, therefore, it may be proposed that support for expanded Medicare coverage will generally be weakest among those groups already covered by the program. Unfortunately, it is precisely persons falling into this category (as exemplified by the better educated and middle or upper class residents of urban centers) who now exercise the most influence over the political decision-making process in the country.

Private Insurance Plans. If the Medicare program might be viewed as somewhat urban-based and middle class oriented, how much more might this same drawback be said to apply to private sector insurance schemes. Most such plans have a limited number of participating hospitals (for Northern Mindanao these will generally be confined to the regional urban centers of Cagayan de Oro and Butuan City) and their premiums will typically be reckoned in the thousands of pesos every year. It is thus not surprising to see that the present study was able to locate only seven cases in which the respondent claimed to be enrolled in a program of this sort. Even more telling is the fact that not a single instance was found in which the most recent hospitalization costs had been covered, whether in part or in full, by this option.

This does not seem to be merely a matter of "negative" attitudes or misinformed opinions. Actually, most respondents were willing to concede the point that private sector schemes can make a lot of sense. Thus, when they were asked to evaluate the statement that it is a "waste of money" to buy health insurance, most (73.5 percent) of the interviewees said that they did not agree with this sentiment. (13) Again, however, the real problem is financial in nature: there is just no way the rural poor are going to be able to afford to participate in these programs, given their present orientation towards the "A-B" market.

Job-based Health Care Benefits. Thirteen percent of the respondents said that their husband's employer was offering some sort of health care benefits. In most of these cases (30 of 41 families) coverage was provided for both the consultation fee and any associated medicines that might be needed. In the great majority of cases, too, coverage was extended to the whole family instead of just the employee.

Intergroup variations in this sort of privilege were extreme, to say the least. Virtually all (97.5 percent) of the sugar workers said that their job provided some sort of health care benefits while all other groups had either no such beneficiaries or only one. (14) What is apparently being demonstrated here is the previously-noted pattern whereby the bigger sugar haciendas of Southern Bukidnon are providing company-run medical clinics for their workers and their families.

Community-based Health Care Programs. Increasing interest has been shown in recent years regarding the prospects for setting up community-based health care financing programs for the rural poor. As we will see, this is an idea which does have some applicability to the poverty groups described in this report. The bad news, though, is that the actual implementation of the concept, at least in those areas of Mindanao studied by the present project, is practically nonexistent.

To illustrate, not a single person said that their membership in a community-based health care program had helped them to pay for the most recent hospitalization of a family member. Only five respondents averred that they were currently enlisted in such a program and even some of these appeared to hold a somewhat borderline status (e.g. the one who belonged to an informally organized "huluga", the two who mentioned the local Barangay Health Workers Association). As for the 315 respondents who did not claim membership, only two had even heard of any group which had been organized along these lines. Clearly, then, the community-based health care financing concept still has a long way to go before it can become a reality for the barrio folk in Northern Mindanao.

In order for the community-based approach to succeed, at least three prerequisites will be needed. First, there must be viable organization in place, which is to say a group with a sense of fiscal integrity and good prospects for surviving the test of time. The record of rural-based NGOs and cooperatives in the Philippines is, of course, far from perfect in this respect.

Data which were presented in Chapter Two are of some relevance for assessing this problem, not so much for the question of professional management and accounting practices, but for the simple matter of NGO availability and interest. They show, for example, that both of the two fishing communities would probably have some problems in this regard. For the subsistence fishing community of Medina, the largest NGO available is a local woman's group (the Rural Improvement Center) with only about fifteen active members. As for the market-linked setting, there is but a single NGO, the Rural Waterworks Sanitation Association. This is large enough and sufficiently stable to work for the intended purpose, but what is the guarantee that its Board of Directors would even think of involving the group in a health care scheme?

A greater number of NGOs are found in the agricultural barangays. Many of these, however, are either multi-purpose cooperatives (which do not have a good track record in terms of staying power) or associations of agrarian reform beneficiaries, for which the connection with health care problems does not appear to be very immediate. Again, too, these groups are often small, with irregular meetings and an all-too-evident dichotomy between a core group of active members and a larger mass of the less committed.

Assuming for now that a viable group is in place, the second requirement for a successful community-based program will be to recruit a large, active and enthusiastic set of members. Data from the present study give mixed signals as to the probability that such an outcome can be achieved. On the one hand, large majorities of our respondents hold positive attitudes towards people-based community improvement projects. Consider the following items from the survey instrument:

"Some persons have suggested that the people here should try to make their community a better place by working on some 'self help' projects. For example, they could help to repair the school building or work at the community health center. Do you think this is a very good idea, a good idea, a bad idea, or a very bad idea?"

"Would you be willing to work every week on a 'self-help' project like this?"

"Suppose your family was asked to work on a community project....You see that some of your neighbors are helping, but many are not. Would you still be willing to help if that happened?"

For the first question, every single respondent felt that "self-help" projects were either a "good idea" or a "very good idea." Better still, 86.6 percent averred that they themselves would be willing to contribute their labor to such an effort. (15) Nor will the example of uncooperative neighbors prove a serious drawback (or so they say). When the last question was asked, no less than 97.8 percent said that they would still help, even when community support for the project was less than unanimous.

In a more negative vein, however, there do seem to be at least three potential problems. First of all, and as hinted above, there are quite a lot of poorer rural couples who cannot lay claim to being a member of a single NGO (non-governmental organization), cooperative, or PO (people's organization). In the present study we found this to be true for 44.2 percent of our respondents. Any larger program which proceeds merely by recruiting already existing groups to serve as local affiliates may therefore be expected to bypass a significant number of the rural poor, perhaps including those very families who stand most in need of health care financing assistance.

A second difficulty lies in the fact that we cannot safely assume that each and every barangay in the Philippines is also a "community," if by this latter term we mean a territorially-based group bound by ties of sentiment and mutual cooperation. Anthropological studies of peasant societies (e.g. Foster, 1965; Ranfield, 1958) have shown that, instead, the predominant feelings in such settings may sometimes be those of envy, suspicion and "amoral familism" (i.e. placing the personal interests of one's family far ahead of any local needs). Should this be true for our rural poverty communities, it will obviously weaken the prospects for a community-based approach.

In order to look into this issue, the following question was asked:

"How do you feel about the people here in (name of barangay)? Do you feel that all of them are good and helpful, most of them, or only some of them?"

It is noteworthy, we believe, that the fairly substantial figure of 41.1 percent agreement was found for the last of the above options, i.e. that only some of the local residents are "good and helpful". It may thus be worthwhile to remember that the idyllic portrait of a closely-knit rural community, still imbued with the ancient bayanihan spirit, may only be a vestige of the past, if indeed it ever was true at all.

A third problem with the self-help approach, as well as with proposed strategies that would allow the rural poor to barter their labor for a certain degree of health care coverage, is that there may be a poor match between the labor skills offered and those needed by the community or the project. We have already noted how many of the corn and coconut farmers are getting on in years. Health problems are not uncommon and work experience outside of farming or fishing is more the exception than the rule. Educational levels are low. As such, when they were asked what sort of skills they could contribute to a community-based self-help project, a majority of the respondents were forced to answer that neither they nor their husbands had any real skills at all. About one in five of the husbands knew carpentry and smaller numbers (along with their wives) had picked up some other "blue collar" craft through the years, but few seemed ready to serve as typists, accountants or bill collectors, even though these would surely be the most applicable work roles for a health care financing project. (Please see the top panel of Table 6.4 for a presentation of data on the issue of available work skills.)

If the first prerequisite is related to the group itself and the second refers more to the individual members, the third dimension which must also be taken into account is financing. To be sure, there are economies that can be realized when a sufficiently large number of beneficiaries are brought together. It

might also prove possible for the local government to come up with some sort of subsidy. But sooner or later the coop or NGO members themselves are going to have to make their own contribution to the plan. The question therefore becomes, "how much are they able and willing to pay?"

A series of three survey items is reflective of our respondents' thoughts on this matter. The first of these asked if they would be willing to give money to a fund "which would guarantee to help pay your medical bills if someone in your family gets sick." Most (91.5 percent) of the respondents answered this query in the affirmative. For those that did, a follow-up question was then posed on the amount which the family could "afford to pay every year for this privilege." The average amount mentioned in this case was a mere P163, while the median (P100) was even lower. We thus have one in ten respondents who say that they cannot or will not pay anything at all for this service as coupled with a larger group that is willing to pay but only able to come up with about four or five dollars (U.S.) in this regard.

A third question went as follows:

"In some countries the people pay about P 250 every year to get a special card. This card allows them to see the doctor for free if someone in their family is sick. They also get to save on hospital expenses in case someone has to be hospitalized. Would you be willing to pay that much every year in order to get a card like that?"

Results in this case were a bit more encouraging in the sense that the amount suggested is larger and therefore more likely to have a realistic chance of contributing to a health care fund large enough to provide something more than only the most basic of medical services. At the same time, however, the proportion answering that they would opt to not participate in such a plan also increased somewhat. For the sample as a whole, 70.9 percent affirmed that they would accept the suggested transition, while 29.1 percent said that they would not.

In any event, even the suggested figure of P250 (about 9 or 10 U.S. dollars) is still not very large. It seems likely that any coverage benefits provided by a program with these sorts of premiums must inevitably be rather small.

A brief analysis of the relationship between occupational type and some of the factors mentioned above may help to shed further light on the matter. As may be seen in the second panel of Table 6.4, the different poverty groups vary significantly from one another in their past proclivity to have joined a community-based NGO. Well over half of the small farmers have done this but the corresponding ratio for landless agricultural workers and fisherfolk is less than one in three. A comparison of the eight-group typology is even more revealing in this regard with

Table 6.4--Data on Community-based Financing
Schemes, Rural Poverty Groups in
Northern Mindanao, 1992

1. Skills for Contribution to a "Self-help" Project (Percentage Distribution)

<u>Skill</u>	<u>Respondent</u>	<u>Spouse</u>
None	74.4	54.5
Leadership, planning	3.2	0.7
Other "white collar"	3.2	5.9
Trade	3.5	0.3
Construction	0.3	19.4
Other "blue collar"	13.6	15.9
"Cooperation"	1.3	0.9
"Entertainment"	0.6	0.3
	100.0	100.0

2. Membership in an NGO or PO (Percent Belonging to a Group)

	1	2
Small farmers	64.2	$X = 31.14, p < .001$
Landless	32.8	$U = 0.31$
Fisherfolk	31.2	
Corn farmers	47.5	
Coconut farmers	92.5	2
Upland farmers	52.5	$X = 107.05, p < .001$
Rice workers	22.0	$U = 0.58$
Sugar workers	0.0	
Rubber workers	75.0	
Market-linked fishers	47.5	
Subsistence fishers	15.0	

Table 6.4--(Continued)

3. Willingness of Household Head to Participate in Community Project (Percent Willing)

		2
Small farmers	79.6	F = 6.26, p < .05
Landless	86.3	U = 0.14
Fisherfolk	71.8	
Corn farmers	62.2	
Coconut farmers	84.8	2
Upland farmers	92.1	X = 21.09, p < .01
Rice workers	78.4	U = 0.26
Sugar workers	95.0	
Rubber workers	85.0	
Market-linked fishers	72.5	
Subsistence fishers	71.1	

4. Willingness to Pay P250 for Medical Card (Percent Willing)

		2
Small farmers	63.5	X = 5.38 p < .10
Landless	77.1	U = 0.13
Fisherfolk	72.5	
Corn farmers	55.3	
Coconut farmers	78.4	2
Upland farmers	57.5	X = 16.28, p < .05
Rice workers	71.8	U = 0.23
Sugar workers	82.5	
Rubber workers	76.9	
Market-linked fishers	82.5	
Subsistence fishers	62.5	

membership levels varying from a high of 92 and 75 percent (among the coconut farmers and the rubber workers) to a mere 15 percent among the subsistence fisherfolk and none at all for the sugar workers.

Clear majorities (varying from 72 percent for the fishers to 86 percent among the landless) in all three groups say that the household head would be willing to give some time each week to the proposed "self help" project. In general, the willingness to take on this responsibility was lowest among the corn farmers (for reasons which are not particularly clear) and the two fisher groups. This latter finding may be linked in some way to the long working hours which are most typically turned in by municipal fishermen. (Cf. our findings on this point from Chapter Three.)

As for the question on the 250 pesos health care privilege, it is again the corn farmers who are least supportive of this proposal as joined in this instance by the upland farmers, the subsistence fishers and the rice workers. Since these are four of the poorest groups in the study it is probably fair to say that the income factor remains a basic constraint in limiting the applicability of such a plan. The arguments for institutionalizing some local variation on Thailand's Health Card Fund (Myers, n.d.) are no doubt compelling in their logic, but no one should be surprised if the very poorest of the rural poor are bypassed by this approach.

In sum, we cannot help but strike a somewhat more pessimistic note on the prospects for community-based health care financing schemes than is often found in the literature. There are a number of very real problems with this approach, ranging from group formation and recruitment to the financial constraints faced by small farmers, landless workers and fisherfolk. An optimist might look at the Northern Mindanao's dearth of community based programs and see in this merely a need for stronger efforts to disseminate a new and attractive idea. But we must also consider an opposite conclusion, namely that this approach has not caught on because it just isn't going to work.

Concluding Observations

This chapter has dealt with the sources of health care financing, both actual and proposed, that can be used by rural poverty groups in Northern Mindanao. Participation in formally organized insurance schemes (Medicare, private sector health insurance, community-based approaches) is generally low, although we did find strong evidence for the proposition that landless workers on corporate farming enterprises (sugar haciendas, a cooperatively-run rubber plantation) were gaining entrance to the government's Medicare program. Ongoing trends towards the commercialization of Philippine agriculture (debatable though these might be on other counts) should therefore provide some long-run help in this regard, especially given the current level of governmental support for this approach (e.g. Lopez, 1993).

At present, most health care costs among the rural poor are being paid out-of-pocket or by obtaining help from relatives, employers or friends. Or they are not paid at all which is to say that the family simply declines to make full use of the modern sector health care services which are just now becoming available throughout the region. To take but one example, fully 37.2 percent of the sampled respondents admitted that not a single member of their family had ever been hospitalized. And this is for a population that is somewhat older than the Philippine norm and one which had generally experienced high levels of fertility and child mortality. The argument that no one has been hospitalized because there was no need to do so is therefore highly improbable. What about all the births our respondents experienced? What also of the childhood accidents, the respiratory illnesses or diarrheal cases that suddenly take a turn for the worse? And what of the rural elderly, with their own long list of medical problems--heart attacks, cancerous growths, fevers which threaten to become pneumonia? No. The need is surely there. But it was never attended to, not at least by health care practitioners working within a modern medical paradigm.

In short, there can be no doubt about the necessity of institutionalizing some sort of health care financing mechanism for the rural poor. The only problem is how this can be done. Both Medicare and the private sector plans may be faulted for their inability to sufficiently extend their coverage outside the urban, middle class setting. The community-based approach would therefore seem to be the only viable alternative but it, too, has problems. Many rural barrios lack a group which could serve in this capacity and large numbers of the rural poor cannot lay claim to membership in a single NGO or PO. Perhaps the rural churches could help in this regard, but here, too, the issue of marginal membership (as exemplified by low attendance rates at weekly religious services) is by no means a negligible one. Most important of all, the poorer rural families are generally unable to pay the sort of premiums that would be needed to give them anything approaching adequate health care coverage.

It therefore appears as an inescapable conclusion that any serious attempt to alleviate the health care problems of the Filipino rural poor must necessarily be one in which the government plays some sort of major role. Current calls for increased privatization of health care services are all well and good, but this is not going to serve the interests of, say, the landless rice workers of barangay Dumarait, with their average monthly income of less than \$25.00 (U.S.). It seems, in short, that some sort of subsidy will be needed, most properly one which would not be based on monies generated by the regressive and inefficient tax system now in place. And this, of course, is going to take political will, as based on some of the "old fashioned" notions that free market enthusiasts are so fond of debunking--ideas like the proposition that health care is a basic

human right and that the better-off members of the national community have a moral responsibility to help those who are now being denied this imperative.

The danger is that a nation grown increasingly urban and now on the verge of a long-awaited economic take-off may well prove reluctant to accept this sort of responsibility. It's a long way from the shopping malls of Manila to Barangay Dumarait. And as the Malaysian writer, Helen Ann Peters (1993, p. 43), has recently observed, "money often dulls the conscience and makes us blind to the plight of the less fortunate....Some call it compassion fatigue; others blame it on the 'me first' syndrome...increasingly visible among the nouveaux riches of Asia." Ms. Peters was referring, no doubt, to the "tiger economies" of Eastern Asia, but the continued silence given in answer to the crying needs of the Filipino rural poor cannot help but make one wonder if her remarks might also have a special relevance for better-off Filipinos as well. (16)

Endnotes

1

This question was not asked to the small farmers but it is to be expected (almost by definition) that they would face the same problem. It is also interesting to note that all but one (i.e. 99 percent) of the rice and sugar workers said that their incomes vary from one month to another. In comparison, 98 percent of the rubber worker said that they do not experience this phenomenon. It would seem that rubber is much less affected by seasonal fluctuations in production than is the case for either rice or sugar.

2

Do medical costs vary across the different poverty groups? For those who paid something for any of the above-discussed dimensions, the results showed no significant differences for either travel costs (during the illness episode in the month preceding the survey) or the most recent case of hospitalization. For consultation fees and medicines (again for the month preceding the survey) the fisherfolk were found to be paying significantly more than either the farmers or the landless agricultural workers. This group is more urbanized than the smaller farmers, a factor which may increase its demand for better-quality medical care. At the same time, it does not (as is the case for some of the landless agricultural workers) benefit from any employer-based medical benefits, as could be used to reduce the cost of such consultations.

3

Another item asked the respondent where he or she could get added funds during an emergency. Results were compatible with those discussed above. A large proportion (44.4) they would get money from an informal source (friend or family).

relative) while another 7.6 percent mentioned help from their employer or landlord. Twelve percent thought that their personal savings would suffice and 8 percent said that they could sell their livestock or some other asset. A little less than two percent mentioned Medicare. (No other formal health care plan was mentioned.)

4

These differences are statistically significant (chi-square = 17.78, $p < .001$, $V = 0.24$).

5

The latter outcome occurred in 6 of the 40 cases.

6

That is, one could code all such cases as "0" for the items on projected and actual loans. By doing so, of course, we would raise the sample size to its full complement of 320 cases, thereby decreasing significantly the mean and median amount loaned.

7

The data presented for this topic deal solely with the question on projected (i.e. hypothetical) loans. Generally similar results were obtained when the items dealing with actual (past) loans were analyzed.

8

Another unusually high estimate is the average projected loan of \$1,376 for the corn farmers. No immediate reason can be cited as to why this figure would be so much higher than that found for either the coconut or the upland farmers.

9

"Less satisfactory" because (1) there is a greater likelihood of being turned down (no matter how close they feel to you, one's friends and relatives may lack the ready cash needed to help) and (2) the average amount borrowed will generally not be very large, at least among friends or relatives of poverty class families such as those being analyzed in this study.

10

Nor is there much emphasis upon specifying the collateral needed to secure a loan. In all, this stipulation was only made for a 9 percent of all past loans.

11

In point of fact the number of "household heads" from the other groups said to be Medicare members is lower still. The above figures actually refer to households which are covered by Medicare, i.e. because either the head or his spouse is a member. For most of the small farmer and fisher households it was the spouse who turned out to be the enrollee, e.g. when she happened to be the local school teacher or some other lower-level white collar worker.

12

This point emerges even more clearly when we inspect the manner in which the responses for the item on expanded Medicare coverage correlate with the eight-member poverty group typology. Twenty-two percent of the rubber workers and thirty percent of the sugar cane cutters opposed the proposed expansion as compared to a mere 2.5 percent of all other respondents.

13

Two of the poorer groups (upland farmers and rice workers) contained slight majorities who agreed with the waste-of-money perspective. In comparison the combined percentage holding this opinion among members of the other six groups came to only 18 percent.

14

The resulting statistics for this comparison were therefore extremely large (chi-square = 283.98, $p < .001$, $V = 0.94$).

15

A question on the willingness of the respondent's spouse to help out on such a project was also included. In this case the proportion willing to help was a little lower--80.2 percent.

16

In fairness to the DOH, the basic problem is not that it has failed to prioritize the needs of rural areas, but rather that its share of the national budget is so small (Herrin, et al., 1993, p. 27). Indeed, present DOH policy recognizes explicitly that "for some time government must continue to provide and thereby finance the availment of health services on behalf of 20-30 percent of the poorest segments of the population..." (Anonymous, 1993, p. 8).

Chapter Seven. Summary and Conclusions

Background and Study Questions

Recent years have represented a period of both stability and change for the Philippine health care system. "Stability" because budgetary allocations for the DOH remain as miniscule as ever; also because earlier declines in mortality have now given way to a pattern of unchanged (or possibly even increasing) deaths rates (Herrin, et al., 1993). But so also have there been harbingers of change, such as a new Local Government Code which devolves the task of health service provision to the local political units and an increased emphasis upon finding ways in which the whole process of health care financing may be made more efficient, effective and equitable. The present study represents an outgrowth of this latter concern. Its focus is on that forty percent of the total Philippine population who now comprise the rural poor. Its major task is to determine the ways in which this group might or might not benefit from certain suggested changes in the present system of health care financing.

The importance of such an analysis is immediately apparent. The Philippine rural poor are strong in numbers but frail indeed in the resources (wealth, political power, social status) which can easily be translated into new opportunities, favorable governmental policies or, indeed, increased longevity. Their incomes are low and their mortality rates high. The quality of health care services offered to them is generally inferior. Further still, all of these different problems seem to be closely related to one another, thereby implying the need for systemic reforms:

"In an economic setting of inequitable wealth and income distribution patterns marked by mass poverty, cash poor households would have difficulties in accessing health care goods and services when financing is mainly through out-of-pocket payments on fee for service basis. This creates inequities as the distribution of illnesses and health needs is not likely to match the distribution of the means to pay for health care. When consumers utilize health care according to capacity to pay...inefficiencies arise leading to wrong prices being paid, wrong goods and services and wrong quantities being consumed, and wrong timing of consumption. On the other hand, when providers deliver health care according to capacity to pay cash, inefficiencies are likewise created leading to wrong costs, wrong scale of operations, wrong choice of technologies, wrong investment, and limited pooling of risks..." (Herrin, et al., 1993, p. 26).

Thus, a poor tenant farmer and his wife lose their child to a bout with acute respiratory infection because the local government health station had no budget for mounting a health education campaign on this condition, because the couple delayed treatment

by first going to a hilot, because they failed to buy the full regimen of antibiotics which was eventually prescribed and because they had no health care insurance to pay for hospitalization once the child's condition became life-threatening.

Several research questions served to guide the study at its onset. First among these is the need to assess just how problematic the situation would appear to be right now. To be sure, previous studies have already been conducted on the financial plight of the rural poor (e.g. Madigan, 1988) but fewer still have focused on their major health problems, their health care utilization patterns or the manner in which they go about financing their medical expenditures. In particular, there has been very little study of attitudes and practices relating to some of the more innovative suggestions now being developed along these lines: an expanded Medicare program, new approaches to collecting user charges, private sector insurance programs and community-based health care financing schemes.

A slightly different perspective can be taken on the above question once the fairly obvious point is made that the rural poor are by no means a homogeneous entity (cf. Costello, 1985). The living conditions of small farmers and municipal fishermen are likely to differ in some way; we can also expect additional differences to emerge in the case of the country's fast-growing class of landless agricultural laborers. Internal variations may as well be present within these groups. In Northern Mindanao, for example, it is probable that the corn farmers of Southern Bukidnon will differ in several ways from those who have more recently set up farmsteads in the forested areas of the region's uplands. At the very least we can expect to find differences in this case for five major variables, i.e. tenure status, soil fertility, demographic profiles, cropping patterns, and access to government services. Others may exist as well. The second study objective thus builds upon the first by setting out to chart the comparative situation of the different rural poverty groups.

A third issue is more broadly theoretical in nature. If we assume for now that the rural poor are beset by a wide variety of health care problems (high rates of morbidity/mortality, less-than-optimal patterns of service utilization), the question might well be raised as to the underlying reasons for all this. The obvious role of cost and income factors in this situation might at first suggest a simple economic explanation, i.e. that the poor are not well served by the present system because they can't afford to pay the charges that go along with it. But a second theory, one which rests more on cultural or "ideational" factors than on sheer income effects, might also be broached. This argument begins by pointing to some of the other characteristics of the poor: low levels of educational attainment, subordinate social status, infrequent media use and decreased probability of exhibiting the characteristics associated with a "modern" type of personality (Inkeles and Smith, 1974). In other cases they may

have adapted to their condition by accepting certain "rational" (though dysfunctional, at least in the long run) behaviors or world views. The alleged sense of apathy and fatalism said to be inherent in the "culture of poverty" (Lewis, 1966) illustrates this latter point.

Cultural explanations turn up frequently in the literature on the health care practices of poorer households. Why do the poor prefer traditional health care workers over modern sector physicians? Because, say the cultural theory advocates, the social distance between Third World patients and their doctors is so wide as to lead to miscommunication and stress. Cleland and Van Ginneken (1989, p. 86) thus see the poor as finding the milieu of the modern-type hospital or medical clinic as "overwhelming and bewildering, alien and frightful." Why do the poor not join insurance schemes? Perhaps because health care services in general are not highly valued by them or as due to their feeling that there is no need to pay for private sector services as long as the government is giving them a free ride:

"It was noted that in many developing countries....the government health sector (often) provided free or heavily subsidized services....(Thus) when someone was seriously ill, medical attention was usually available whether or not the person was covered under a plan. To the people who did not attach any particular priority to health, the insurance concept would not generally appeal" (Anonymous, n.d., p. 14).

Cultural factors may also affect the willingness of villagers to mobilize themselves for broad-based community health care projects. In their review of community-based mechanisms for health care financing, Abel-Smith and Dua (n.d., pp. 47-49) thus note that

"a common language, a shared set of religious beliefs and a fairly uniform and undifferentiated set of social classes provide a strong basis upon which community action can be more readily built....Community health projects...tend to be more successful when there are traditions at the village level of other types of cooperative society and a high valuation is placed on local self-sufficiency...."

These authors also note, however, that "different persons who live close together are not always cooperating individuals, groups or organizations with common goals," thereby bringing to mind the alleged "crab mentality" of the Filipino poor.

The final set of questions raised by the study are more practical and policy-oriented. In essence, they revolve around the feasibility of putting into practice several proposed approaches to health care financing.

If we assume that the poor are unable to cover health care costs entirely from their own savings and that the government is also unwilling to provide such services entirely for free, it becomes apparent that some sort of prepayment or risk-sharing scheme may be in order. Some alternatives along these lines might include Medicare, private sector (profit-based) insurance programs, and community-based financing schemes, for which payments may be made in cash, in kind or even in labor. Provision for a more effective and equitable system of user charges should also be included as an additional option now being considered by cash-strapped government offices. In view of the rather large expenditures which will be involved in any attempt to set up one or another of these alternative approaches, to say nothing of the human lives that might be lost if the wrong decision is made, it obviously becomes of critical importance to gather whatever information is now available on these issues. In particular, there is a need to assess acceptable costs levels for the different options, pre-existing participation in programs of this sort, willingness/ability to become involved at some future date, and the like. Things are already moving very fast in this area, thereby implying the need for immediate feedback, before costly and irreversible mistakes are made. (1)

Research Design

This is an empirical study set in a single region (Northern Mindanao) of the Philippines. The study proceeded by, first, identifying three major poverty groups--small farmers, landless agricultural workers and fisherfolk--thought to be characteristic of the Philippine countryside. Further differentiation into a more complex set of poverty subgroups, as were found to be residing in eight purposively selected communities, was then made. These were as follows:

1. Corn farmers in Barangay Kauyenan, Kitaotao, Bukidnon;
2. Coconut farmers in Barangay Odiongan, Gingoog City;
3. Upland farmers growing corn, beans and tomatoes in Barangay Mat-i, Claveria, Misamis Oriental;
4. Landless rice cultivators in Barangay Dumarait, Bali-ngatag, Misamis Oriental;
5. Landless sugar workers living in Barangay Putong, Quezon, Bukidnon;
6. Workers in the rubber industry, Barangay San Isidro, Talakay, Bukidnon;

7. Fisherfolk living in the "market-linked" setting of Barangay Luyong Ronbon, Opol, Misamis Oriental; and
8. Subsistence-type fisherfolk from Barangay North South, Medina, Misamis Oriental.

Various criteria were taken into account in formulating the study's sampling strategy. To begin with, the focus on specific (geographically-based) communities was consciously made insofar as one of the major purposes of the study was to look at the interplay between community-level factors (e.g. health care facilities) and household- or individual-level variables. Cost considerations, too, played a part in this decision, since the budget could not accommodate anything like a regionally-representative sample from a large number of local communities.

Selection of the particular sample sites listed above may be easily defended for three cases: the sugar workers, the rubber workers, and the market-linked fisherman. Barangay Butong is located in the very heart of the Southern Bukidnon's sugar country and includes within its borders several large sugar plantations. More-or-less the same may also be said for Barangay San Isidro, insofar as this appears to be the only barangay in the region with enough full-time rubber workers to meet our minimal sample size of 40 cases. Finally, the "market-linked" criterion suggests a fishing site located adjacent to Cagayan de Oro. This could have been from either Opol in the West or Tagoloan in the East. In the latter case, however, the construction of the PHIVE-DEC Industrial Estate has forced many fishers from their homes, thereby reducing the number of eligible cases. Opol was therefore selected.

For the other groups, it is indeed true that literally hundreds of other barrios in Northern Mindanao could have sufficed to represent (for example) the small-time corn farmers or the subsistence fisherman. The choice of the particular study sites might therefore be regarded as somewhat arbitrary in these cases.

Even so, we would like to believe that our results do have some descriptive validity, at least in the sense that they will not be widely divergent from the actual situation of Northern Mindanao's rural poor. We say this for two reasons. First, comparative statistics from at least one study show results which are relatively similar to those reported herein. Secondly, if there is a bias in the present study, it is one for which the direction can be predicted, thereby facilitating the final interpretation of our results.

The comparative study referred to above is a recent analysis, by Herrin and Racelis (1973), on the "poorest of the (Filipino) poor." Comparative data are available from this analysis on

six indicators: average household size, educational attainment, access to irrigation, childbearing, contraceptive use and childhood mortality. Overall, the data from our eight sample sites compare well with those reported by Herrin and Racelis. Differences between the two study results are invariably either slight or in the expected direction. (2)

Further still, if there is a bias in the present sample, it is probably one which has resulted in an undercount of the very poorest families of rural Region X. We believe this is so insofar as our eight study sites have been limited exclusively to the two provinces of Bukidnon and Misamis Oriental. In assessing this fact it is well to remember that these are two of the more prosperous provinces in the region, certainly more so than for the hinterland areas of Agusan del Sur, Misamis Occidental and Surigao del Norte (cf. Costello, 1989).

As we shall see, the major conclusions from this study are generally rather pessimistic. Overall, we view the rural poor as being underserved by the present health care system and unlikely to be able to participate in many of the alternative models now being proposed. As such, the suspected bias inherent in our sampling procedure will actually work to strengthen these conclusions. That is, if the poorer families in the somewhat well-to-do rural areas of Region X are having a very difficult time under the present system, it is very unlikely that this impression would be changed by drawing a more geographically dispersed sample. If anything, the resulting situation might well be more problematic, thereby leading the report to come up with an even gloomier set of conclusions.

Another potential advantage of the present study stems from the fact that various data-gathering strategies were employed. This was in keeping with its basic adherence to a descriptive study design. First (and of greatest importance for our analysis), a household survey was conducted in forty randomly selected households from each of the above communities. All in all, therefore, a total of 320 respondents were interviewed. In nearly all cases the wife of the household head served as respondent. Community-level data were also collected by means of interviews with knowledgeable residents ("key informants") of the barangay.

Descriptive studies are largely exploratory in nature. Their purpose is to generate preliminary findings and models rather than to provide definite proof on the veracity of one or another hypothesis. As such, findings from this study should not be used as a sole rationale for broad-based programmatic changes. Instead, further (confirmatory) research will still be needed on many of our conclusions. In particular, evaluatory studies of smaller-scale pilot projects on innovative approaches to health care financing would be very much in order at this point.

Major Study Findings

The People and Their Communities. Our analysis begins with the social and demographic profiles of the different poverty groups. Members of the small farmer class were significantly older than either the fishers or, in particular, the landless agricultural workers. The extreme cases in this regard varied from the coconut farmers (with a mean age of more than fifty years) on down to the sugar workers, who averaged 33.5 years of age. About a third of all household heads were in-migrants to Region X, with this pattern being most prevalent among the sugar and rubber workers.

Cebuanos and Roman Catholics predominate in all groups. The sugar workers, though, contained a large number of Ilongoes, and the upland and corn farming groups included numerous Protestants. Upland farmers also ranked quite high in terms of household size, with an average of 7.2 members.

Educational levels for all major groups hovered around five to six years on average for household heads and six to seven years for their spouses. Most respondents said that they could speak only "a little" English or Tagalog, generally being slightly better off in the latter language. Radio use was fairly heavy, especially among the landless group, 70 percent of whom listened on daily basis. Occasional television watching was the general rule, often on a neighbor's set. Newspaper reading was the least frequently used of all media sources, particularly among the upland farmers and the sugar workers.

Three-fourths of the small farmers belonged to at least one local community group (e.g. cooperative, farmers' association). The comparative figure for the other two groups, however, is only about one-third. Sugar and rice workers experienced the lowest level of participation, both for NGOs and church-related groups. In fact, not a single household member from the sugar community was found to belong to a community organization.

Information was also collected on various housing-related factors. These included home ownership and housing materials along with such conveniences as piped water, electricity and water-sealed toilets. As a general rule, the fishing communities rated fairly high on these variables while the landless ranked lowest. Because most small farmer and landless households did not have piped water, a significant amount of time (more than half an hour, on average) was required for them to fetch water.

A consumer goods ownership scale, based on questions about ten separate items, was constructed. On average, respondents only owned about 1.6 of these items, even though some of them (e.g. camera, photo album, wall clock) could be purchased rather cheaply. No significant differences could be found among the groups

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for the scale, but a follow-up question on cash earnings during a "typical" month showed the landless workers to score significantly higher on this variable than either of the other two groups. Further analysis showed the rubber and sugar workers to be doing reasonably well in this regard, while the rice workers were quite poor, earning on average less than a thousand pesos per month. (Comparative figures for the small farmers and the fisherfolk were, respectively, P1432 and P1558 per month.)

If the fishers were best off on the housing variables and the landless ranked highest in terms of income, it is the small farmers who fare best in terms of ownership of assets. The landless laborers, of course, score very low in this regard since, to begin with, they were universally devoid of any significant land holdings. Most landless workers also own nothing in the way of farm equipment, livestock, or even a chicken or two. Among the three different landless groups it is the rubber workers who rank highest on asset ownership while those laboring on rice farms were by far the lowest. On average, the rice workers owned about P 700 worth of assets, a figure which compares poorly with the other two groups of agricultural workers, the fishermen (P 9,000 in assets on average) and the small farmers (who averaged P12,000 in assets).

Fishermen seemed to be working longer hours than either of the other two groups--9.4 hours a day on average as compared to 7.8 for the landless and 7.0 for small farmers. There were also significantly more working wives among the fisherfolk. In many cases the fisherman's spouse is complimenting his efforts to sustain the family by marketing his catch. Only 12 percent of the wives in the small farmer sample and a mere 3 percent of those from the landless category were employed at the time of the interview. Indeed, one of the structural problems of the Philippine rural economy would seem to be the lack of formal employment opportunities for women found therein (also see Costello, 1994).

A few questions were asked to only one of the three major groups. For the small farmers, the major finding from this analysis probably related to the item on farmland ownership. This varied from a high of 58 percent among the coconut farmers to a low of 8 percent for those from the upland setting.

Among both the landless workers and the fisherfolk income fluctuations represent a major problem of subsistence. This pattern was found for virtually all respondents except those working on the rubber plantation. (Harvesting operations are apparently conducted on a more-or-less continual basis in the rubber industry whereas they are highly seasonal for the other crops.) Rubber workers were also benefitting, along with those in sugar, from a fairly steady flow of work opportunities during the most recent month. In comparison, the rice workers were much more heavily underemployed.

By way of summary, we can point to our earlier expectation that, as one author (Ledesma, 1982, p. 204) has put it, the landless agricultural workers would turn out to be "the poorest among the rural poor." Our empirical results, however, showed the situation of this group to be somewhat more complex than this. To be sure, the landless did fare poorly on all the ownership variables: assets, consumer items, housing factors. For the case of monthly cash incomes, though, this group ranked highest. They also outranked the small farmers on the question of educational attainment and were using the various media sources with some frequency. An additional complication is added by the internal variation that is found within the landless group. In general, the sugar and rubber workers are experiencing a much better time of it than the landless laborers in rice, for whom work is irregular, incomes low, the ownership of consumer goods negligible, and housing conditions wretched.

Another example of within-class heterogeneity is found for the small farmers. In general, the circumstances associated with the upland farming class were less auspicious than those found for either the corn or the coconut cultivators.

The above data are for individuals and households. We may also expect to find some community-level variations among the different study sites, e.g. with regard to the presence or absence of medical clinics, commercial establishments, and NGOs. While the results of this analysis are too detailed for full presentation at this point, they do show some interesting patterns. For example, a few barangays did not have a single medical clinic, not even a Barangay Health Station (BHS). Even when such institutions are present, they usually have very little to offer in terms of equipment or personnel. In Barangay Kanyonan, for example, the midwife reports only one day every week. Nearby town centers were usually better equipped but here, too, the facilities for conducting medical tests or surgical procedures were generally lacking.

It will probably be difficult to implement a community-based program of health care financing in those areas where a nongovernmental organization (NGO) with a successful track record cannot be found. This seemed to be the case for some of our study communities. In the subsistence fishing area, for example, the largest NGO is a woman's group with about 15 active members. In other cases the NGO profile is dominated by multi-purpose cooperatives, many of which seemed to be existing more "on paper" than in terms of a steady flow of useful activities.

The presence of a large, formal-sector establishment may at times help to stimulate the growth of other local institutions and opportunities. Thus, the rubber workers of Talakag have formed themselves into what seems to be one of the larger and more successful cooperatives encountered in the course of our research. For their part, too, the sugar workers of Queron municipality had access to a fairly large number of medical clinics, as were being provided by their employers.

Geographic access could also prove to be an important factor. The market-linked fishermen of Barangay Luyong Ronbon can thus bring sick members of their household to a hospital in Cagayan de Oro within the span of a twenty-minute jeepney ride. The higher labor force participation rates found among the fisherfolk wives may also be linked in some fashion to this community's greater access to formal sector work opportunities.

One advantage of the present study is that it has been conducted as part of a larger program of research on a variety of health care financing issues. As part of this program a parallel study on health care financing problems among the urban poor was carried out by Dr. Olympia Malanyaon (1994). Results from this comparative analysis would appear to suggest that the urban poor hold several "advantages" over their rural cohorts, at least as they are represented by respondents to the present study. In general, the urbanites interviewed for the Malanyaon study had higher cash incomes and fewer persons, on average, in the household to provide for. The household head and his wife were typically younger and better educated than for those found in our Region X barrios. They were also more likely to have joined one or another NGO. These differences, which may be largely due to the selective influence of the rural-to-urban migration process, would appear to indicate that the health care financing problems of the rural poor may well be more difficult to solve than will be the case for those residing in urban slums and squatter areas.

Health-related Factors. Patterns of health care financing are strongly linked to the basic demographic variables (fertility, mortality, morbidity) as well as to health care practices, knowledgeability and attitudes. Effective programs of primary health care are typically established with a view towards influencing these parameters. To the extent that this goal can be successfully reached, a corresponding decline in illness episodes and, through this, health care expenditures, should be effected.

Fertility levels were highest among all the small farmer groups, with an average of nearly six children per family. Since at least some of the spouses in this group have not yet completed their childbearing years, it is evident that fertility levels are indeed quite high in this case.

The landless group had given birth to the fewest children on average. While this may be related in some fashion to their younger age profile, it is interesting to note that nearly two-thirds of this group were using some form of family planning at the time of the study. This figure is quite unexpected since, even though it is associated in this instance with one of the most marginalized groups in the country, it is nonetheless substantially higher than the national average.

Nearly half of the sample households had experienced the death of a child. Mortality differentials were not statistically significant but it may be of some interest to note that both fishing communities ranked high in this respect along with the upland farmers and the sugar workers. Despite their very low incomes, the rice workers fared reasonably well in this regard, perhaps because the average educational levels found among members of this group are fairly high. (In comparison, the sugar workers score quite low on the educational factor, which may account for the paradox of high mortality levels found for a group that has been granted free access to company-run medical clinics.) (3)

An item on chronic conditions found the fishing and farming subgroups to be experiencing more of these than was true for the landless category. On average, one or more members of the small farmer and fishing households were experiencing a chronic illness, the most common of which were stomach conditions (e.g. "ulcer"), respiratory problems (asthma, "cough," tuberculosis), conditions associated with old age (arthritis, cataract), and "other internal conditions" (diabetes, kidney problems). About thirteen percent of all households had a member afflicted with a degenerative disease (cancer, heart disease, high blood pressure) with such patterns again being most prevalent among the small farmer and fishing groups.

While a major (and quite appropriate) emphasis of the DOH has been upon reducing levels of infant and child mortality, the above findings show that morbidity conditions common to the older age brackets can also take on considerable importance in the rural Philippines. The high levels of out-migration among young adults from this setting have left behind an aging population that is probably not being well served by the system now in place. To take but one example, approximately 60 percent of the small farming households contained at least one member who complained of "blurred vision". It is obvious, though, that few, if any, of these persons will ever have an opportunity to undergo a cataract operation. Many will probably not even have access to a good pair of eyeglasses. (4)

A question on physical disabilities revealed that these were occurring with far less frequency, being present in only about seven percent of all households. Occupational safety was also relatively nonproblematic except for a minority (a little less than one in five) of farmers and agricultural workers who were concerned about exposure to pesticides. This fear was voiced out most frequently by the upland farmers and the rice workers. Interestingly enough, members of the former subsample were subsequently found to be (1) using substantially more pesticides than any other farming group and (2) experiencing the highest level of skin problems. As such, there may indeed be some real problems in this regard.

The major causes of childhood mortality found in the study may be ranked as follows: diarrheal disease, "other contagious diseases" (kidney infection, measles, malaria, rabies, tetanus), various respiratory diseases, "other causes" (a residual category with a variety of conditions), accidents/homicides, dietary diseases, and congenital conditions. The first three of these categories account for nearly three quarters of all childhood deaths reported in the study. The emphasis given by the DOH to these conditions under its primary health care campaign would therefore seem to be quite proper and commendable.

Intergroup differences in cause of death were not extremely large, although it is interesting to note the predominance of diarrheal diseases for the fishing communities. Half of all the deaths to fisherfolk children could be attributed to this cause. It could be that the more crowded living conditions found in the fishing villages have resulted in increased exposure to the pathogens associated with this type of illness. (5)

A checklist of 23 specific medical problems was also presented to the respondents. The reference period in this case was the month preceding the survey. Conditions which were cited most frequently included cough/cold, fever, headache, toothache, "numbness," blurred vision and "easily fatigued." On average, the small farmers were reporting a significantly larger number of ailments per household than was the case for either of the other two groups. This finding is probably attributable, at least in part, to the older age profiles and larger household sizes found for this group.

A follow-up question on actual visits to a health care practitioner showed that in this case the small farmers ranked lowest whereas the landless households (who had the fewest ailments) came in highest. As such, some rather strong differentials were found in terms of the proportion of all medical complaints which were subsequently referred to a medical practitioner. For example, this happened 44 percent of the time in the sugar worker households, as compared to a mere 9 and 10 percent for, respectively, the coconut and upland farm groupings.

Most consultations (about 80 percent) were with a modern medical practitioner, i.e. a midwife, nurse or doctor. This pattern was most common among the landless and least prevalent for the fisherfolk.

About half of all consultations were in a government-run health center (BHS, Rural Health Unit, DOH hospital). This pattern was most common among the rice workers and less noticeable among the subsistence fisherfolk and the sugar workers. The former group had the strongest preference for traditional healers while the latter had less need to go to the BHS since they had the option of visiting the company clinics.

Most respondents had visited both the local BHS (91 percent overall) and the nearest DOH hospital (64 percent) on at least one occasion. About two out every five respondents had never experienced sending any family member to a hospital. Hospitalization levels were highest among the sugar and rubber workers, a pattern which can no doubt be related to the widespread Medicare coverage found within these two groups. (6)

Most respondents (98 percent) claimed that they had experienced some sort of prenatal care before undergoing their most recent birth. This pattern was most common among the landless group. The typical venue for prenatal care was a government clinic and the typical practitioner was a DOH midwife. In most cases (about 3 out of every 4), however, a traditional practitioner was the one to serve as the birth attendant. This pattern was most common for the landless workers, particularly those employed in the rice industry.

A little more than 60 percent of all children were claimed by their mothers to have been fully immunized. Immunization levels were particularly low (only 31 percent) for children in the subsistence fishing community.

As a general comment on the above findings we can again note the somewhat unexpected patterns obtained for the landless agricultural workers. Despite their apparent poverty and (for the sugar workers at least) their low levels of educational attainment, this group was doing reasonably well in terms of such dimensions as fertility, family planning use, infant/child mortality, visits to modern sector health practitioners, and use of prenatal care. It is likely that the younger age profile found among the landless workers constitutes one reason for these differentials, but some other factors (e.g. access to Medicare and company-run clinics, somewhat higher cash incomes) may also be involved as well.

Some of the other observations which stand out from our analysis include the importance of old-age-related chronic conditions for the farming and fishing groups, the prevalence of diarrheal disease among the fisherfolk, and the threat of pesticides for the upland farmers and rice workers. We also found the upland farmers to be faring badly on a number of other indicators (e.g. family planning use, child mortality, visits to health care practitioners). It is likely that these patterns are related in some fashion to the isolated living conditions found for the uplanders, although their low earnings and educational attainments may also be contributory factors.

A number of questions were asked concerning the health care beliefs and attitudes held by the sample respondents. A general pattern which emerged in this case was for the respondents to say that they preferred modern sector health practitioners to those of a more traditional variety. For example, when faced with two

hypothetical situations (a baby with "signs of diarrhea" and a child with a fever and a cough), fairly large majorities (60 and 69 percent, respectively) said that they would bring the case to the attention of a doctor, even when their attention was explicitly drawn to the expense which this would entail. In both cases it was the landless agricultural workers who were most in favor of making a visit to a physician. On a number of questions of this sort it was the sugar workers who ranked highest. The rice workers also showed a strong preference for modern-sector health workers, a finding which may help to account for the somewhat low levels of child mortality found for this group. In comparison, small farmers in general and the upland farmers in particular were least likely to say that they would go to a doctor when confronted by these sorts of circumstances.

Respondents were next asked to compare the services available from the DOH facilities with those found in privately-run medical clinics or hospitals. While generally being careful to speak well of the DOH personnel (majorities agreed that the DOH doctors are "just as good" as those in private practice, that government health workers are "kind and helpful," that Barangay Health Stations and DOH hospitals are doing a good job, and that they generally do not feel "shy" to talk to the DOH physicians), it is still quite revealing to note that no less than 95 percent of the respondents said that they would choose to go to a private hospital instead of one run by the DOH, assuming, that is, that the financial costs for each would somehow become "the same". In general, it was the fisherfolk who were most vocal with regard to their preference for the private sector approach (or, conversely, their suspicions about the quality of care being offered by the DOH).

Hospitalization charges are not, of course, the same in privately-run institutions as in those run by the DOH. As such, the proportion of respondents who said they would actually go to a private hospital (should the need so arise and should the cost levels found in each retain their presently unequal status) fell to a level which was clearly lower than that found for the earlier question. Even so, a majority of both the landless workers (57 percent) and the fisherfolk (74 percent) alleged that they would still choose the private hospital, expensive as it might be.

Are members of the rural poverty class likely to bypass the local BHS, choosing instead to go directly to a DOH hospital? Apparently yes, since about 80 percent of all respondents in the study agreed that this was generally the best strategy to follow. (7)

A few of the survey items were of help in assessing Caldwell's (1986) thesis that "grass-roots political activism" represents a key prerequisite for bringing down mortality levels in poorer communities of the Third World. The picture emerging in this case is that the respondents, with the possible exception of

the fisherfolk, are not particularly ready to join a militant, class-based group fighting for health care reform. For example, only six percent of the farmers and eight percent of the landless workers were willing to strongly agree with the statement that "health care is a basic human right." It was suggested that additional support for rural-based People's Organizations which would serve in a "watchdog" capacity could perhaps help to mobilize community support for improved governmental service in the health care sector. In turn, this approach might help to mitigate in some way the need to resort to a completely privatized approach, as would inevitably raise user charges to a level beyond that which could be afforded by most households in the rural poverty class.

Health Care Financing: Patterns and Prospects. Chapter Six has presented findings relevant to an evaluation of the efficacy of the different health care financing strategies. To begin with, we first reviewed some very basic data on health care expenditures. For those who had hospitalized at least one family member, the average amount spent at the time was ₱3,421. It seems likely that this expense would have been quite difficult for most of the sample households to meet. Current costs, of course, must be even higher.

Other medical costs were also noted. During the month preceding the survey about 60 percent of the households had consulted a health care practitioner. This generally involved expenses for consultancy fees, travel costs, medicines and (in rarer cases) medical tests. If the median values for the first three of these categories are added together they sum to nearly ₱200. Costs of buying medicines were especially steep in this regard, making up well over half of the above figure. And this, it should be remembered, represents only the one-month cost for a single medical episode. (In some cases the household had two or more sick members in need of medical consultation.)

Economic constraints represent a definite obstacle to fully meeting the health care needs of the rural poor. As an illustration of this, one question revealed that twenty-five percent of all respondents had experienced at least one occasion when they were not able to bring a sick family member to the doctor because the money needed for this was lacking. This pattern (which is no doubt an underestimate) was most commonly found for the fisherfolk and least prevalent among the landless workers.

When hospitalization does occur, how do the rural poor raise the money needed for this service? The most common strategies in this regard were to use current salaries or savings (21.5 percent), sale or mortgage of property (10.0 percent), getting a loan from a friend, relative or employer (9.0 percent), finding someone willing to donate the money (3.5 percent) or using Medicare (7.5 percent). In all of the other cases (43 percent) the family used some combination of two, three or more of the above

strategies. Not a single respondent mentioned getting some assistance in this respect from an employer benefit package, a private-sector insurance plan, or a community-based health care financing scheme.

The predominance given over to "current salaries or savings" in the above tabulation should not be taken to imply that this is a highly effective way of meeting health care costs. For one thing, the vast majority (90.3 percent) of our respondents admitted that they had not been able to set aside any cash savings at all at the time of the study. This problem was particularly prevalent among the landless workers, for whom only 3 of the 120 households surveyed had put aside some money for a "rainy day."

When some money has been saved, it is generally not sufficient to meet all the expenses implied by the decision to hospitalize a family member. In most cases (74 percent) the household savings were fully depleted by this experience. As such, the family not only loses their buffer against a second illness episode but also forfeits whatever chances for upward mobility which the savings might have engendered. (In most cases the money spent on hospitalization had originally been set aside for some other purpose, most commonly for expanding or establishing a family business or for putting a child through school.)

Sale or mortgage of family property also lessens the chances for future economic improvement. Indeed the typical scenario faced by a poverty class family which had experienced a major medical emergency may often be one which brings with it an absolute decline in living standards. In addition, the sale/mortgage option will usually mean the loss of some valuable asset for a price lower--roughly 50 percent lower according to our figures--than its true worth. This occurs because the family cannot afford to wait for a better price.

Another strategy might be to borrow money. Our data show, however, that the possibility of successfully approaching formal lending institutions (banks, credit unions) under these circumstances is generally quite slim for a poorer rural family. This leaves, therefore, the informal money lender (usurers) or well-meaning friends and relatives. The latter option is taken far more frequently than the former one, an outcome which is in some ways fortuitous since credit terms from this source are usually quite liberal (e.g. zero-interest loans). In all likelihood, though, most friends and relatives of the rural poor will also be impoverished themselves, thereby reducing the amount of money available from this source.

When asked if they had someone to turn to for an emergency loan, about twenty percent of the respondents answered in the negative. A similar item on actual loans incurred at some time in the past resulted in an even higher proportion (43 percent) who had never done this. Even for those who could avail of the bor-

rowing privilege, the total amounts available were not very large, as shown by the median values of P500 and P300 for, respectively, the projected future loan and the actual (past) one.

Comparing the different poverty groups, the landless workers were most confident about their ability to secure a loan in an emergency. Again it was the sugar and rubber workers who stood out in this respect. All respondents from these two groups answered the question on a projected loan in the affirmative. Landless workers (in particular the sugar and rubber workers) also ranked highest on the total amount which could be borrowed. Members of these groups were generally of the belief that they could go to their employer for help whereas the small farmers and the fishermen were most likely to approach a friend or relative. (8)

In a few cases our respondents were able to secure charitable assistance in paying their hospital bills. This was not a widely used option, however, and it is evident that the problem of providing health care financing for the literally millions of rural Filipinos who live below the poverty line is far too large to be solved by a purely philanthropic approach. Preliminary evidence from other studies would also appear to indicate that charitable assistance is more available for the urban poor than for their cohorts in the barrio.

Ideally, the rural poor could be helped by the Medicare program of the Philippine government. Several difficulties, however, stand in the way of this approach:

"Social security institutions...of the conventional type...have been designed to cater to the modern, organized, and formal sectors of the economy. These...have been developed in the industrial countries of the West....(and) adopted by developing countries where the majority population earn their livelihood from self-employment or wage labor in agriculture, fishery and the the informal sector of urban areas. These types of employment are characterised by their small-scale and largely unorganised nature. As such, the design and delivery system of the essentially 'imported'...social security...programmes are just not geared to cover the majority population.

Furthermore, one of the fundamental concerns of conventional social security institutions is the profitability and financial viability of their operations. Forcing these institutions by edict to cover the poor in the rural and informal sectors without appropriate adjustments...is likely to create problems.

From the receiving system side, the poor's primary and immediate...preoccupation is that of ensuring the survival needs of his family. The somewhat more distant...need to cover contingencies...is of much less interest to him....Secondly, both the absolute cost of contribution...as well as its cost relative to the subjective value of the benefits...as seen from the eyes of the poor are just too expensive....Added to this is the fact that the poor are widely scattered in location and highly mobile in terms of their habitat and employment...contribute to the difficulty of reaching them..." (Getubig, 1992, pp.6 and 9).

Our data confirm most, though not all, of these observations. A majority of the rural poor are self-employed and most, too, live in highly dispersed settlements. The small farmers of Northern Mindanao, particularly those in the hard-to-reach upland areas, come immediately to mind here. The fishermen, though, live in fairly compact settlements, often within easy reach of a coastal highway. And some landless workers (in our case the sugar and rubber workers) are working for commercial agricultural enterprises, thereby facilitating their entry into Medicare. Rates of Medicare coverage for the other groups are very low indeed but results from the survey's attitudinal items would appear to indicate that this is not as strongly due to voluntary reasons as the above comments would indicate. No less than 95 percent of the respondents who were not enrolled in the program averred that they would like to be so at some future date. Strong majorities also agreed with the statement that Medicare should be expanded to cover more people, even those who do not hold "regular jobs."

The idea of making a profit (or even breaking even) on a Medicare program intended specifically for the rural poor is indeed somewhat implausible. When asked how much money they could contribute to a fund "which would guarantee to help pay your medical bills if someone in your family gets sick" the median annual fee suggested was a mere ₱100. This sort of reply would appear to support the contention that the present-time ("crisis") orientation of the poor weakens their resolve to commit any substantial amount of money to a prepaid insurance scheme. (9) We have also noted a fair number of medical conditions which are presently left untreated. By enrolling the rural poor in a Medicare or community-based prepayment scheme it is likely that much of this pent-up demand would be released, thereby raising system costs.

Low and irregular cash incomes among the self-employed farmers and fishermen would no doubt undermine the prospects for collecting regular Medicare payments from these groups. The alleged situation of "high mobility" in these cases, however, is actually nonproblematic. The children of farmers and fisherfolk

may move to the city or drift from one job to another but the farmers and fishers per se are actually an aging population, kept rooted in place by their attachment to their land, their homes, their fishing grounds. Collection of a semi-annual medical services tax, geared to take place during periods of peak earnings, might prove to be a not-unreasonable strategy, especially in a situation of devolution where local governments can be held accountable for the resulting quality of service delivery.

Returning for now to the survey item on allowing Medicare to cover those without "regular jobs," it is of interest to note that the two groups least in favor of this proposal were the sugar and rubber workers. This would appear to indicate that, all other factors being held constant, it will be those who are already covered by the system who will be least enthusiastic about making a real effort to expand Medicare coverage, particularly if this would imply some loss to the system that would have to be borne by other members (i.e. an implicit subsidy to the rural poor). This raises in turn the problem of political will, particularly with respect to the willingness of the urban, middle class groups to push for an expanded Medicare program.

The difficulties inherent in bringing the Medicare program to the rural poor are found even more strongly for the case of private-sector insurance schemes. Generally speaking, our respondents saw this approach as useful in theory. In practice, though, it was found to be of negligible importance, no doubt because the premiums involved are just too high.

We have noted that the sugar workers were invariably given free access to company-based clinics. This privilege seems to be of some potential benefit insofar as (1) it was typically extended to other family members and (2) it usually covered both consultation fees and the purchase of at least some medicines. This approach is not widespread, however, since it is virtually non-existent for the other seven groups.

Community-based health care financing programs do not appear to be operating in any of the areas covered by this study. A mere five persons claimed to belong to any such group. (Even in these cases it was not at all clear that a health care financing scheme was actually in place.) Nor was there great knowledgeability about this approach. Thus, only two other respondents had even heard of such a scheme. Also noteworthy is the fact that no one had used monies from this source to pay for their most recent hospitalization episode.

There would appear to be a number of reasons for expecting that the community-based approach would have trouble establishing itself in the poorer villages of Northern Mindanao. For one thing, the existence of pre-existing NGOs with an interest in health care financing and a good track record for mobilizing people and managing funds cannot be simply assumed. Our general

impression is that local organizations of this type are generally the exception, not the rule. For another, we found a substantial minority (44 percent) of households who were not affiliated with a single NGO, coop or PO. (10)

The task of building a sense of unity and cooperation among community residents might also encounter its own set of difficulties. True, a large majority (80 to 87 percent) said that either they or their husband would be willing to work on a community project, but other survey items also showed many respondents to be holding a somewhat suspicious attitude towards some of their fellow barangay residents. (11) Even most troublesome in this regard is the fact that most respondents had to answer "none at all" when they were asked if they had any special skill which they could contribute to a community project. This should not be too surprising when we consider that the groups being interviewed include large numbers of older and poorly educated persons, few of whom have had much experience with formal-sector work settings. As such, it would seem that those community-based schemes which would allow the poor to barter their labor for health care coverage may not work too smoothly in practice.

Occupational differentials on these items were not strong. The fisherfolk were somewhat less willing to give their time to a community project, perhaps because of their longer working hours. They also (along with the landless workers) showed lower membership rates in local community groups. Willingness to pay a suggested amount (250 pesos) of health care coverage was generally lower in the poorer and cash-strapped groups, i.e. the corn farmers, the upland farmers, the subsistence fishers and the rice workers.

A final topic relates to the imposition of user charges upon persons who go to one or another of the DQH facilities. The main reason for taking this approach is to help prevent the erosion of service standards in the government hospitals (i.e. by raising cash inflows). However, it can also take on a redistributive character when user fees are computed according to the client's ability to pay. User fees can also help to shift what are now a series of implicit government subsidies for curative services towards the more efficient (and egalitarian) alternative of investing in preventive health care measures (e.g. community sanitation, mosquito spraying for malaria control).

Studies in Third World countries have often found relatively low price elasticities for the use of health care services (cf. Schwartz, *et al.*, 1987, for a Philippine example). This means that most clients, including the poor, would still purchase the service, even if user charges were to be imposed or increased substantially.

Data from the present study send mixed signals in this regard. We have already noted how a quarter of the respondents admitted that there had been at least one occasion when they had not gone to a doctor because they could not afford the resulting expense. The fact that about 40 percent of the households had never hospitalized a family member would also seem to point towards a similar conclusion, i.e. to the idea that a fairly large number of incidents must have taken place in which the family decided not to seek hospitalization, even when it was called for. Such cases, we would argue are probably the result of an inability to afford hospitalization charges on the part of the rural poor. (12) A third strand of evidence supporting this perspective has also been noted. When asked if they would go to a public or a private hospital if the charges were "the same," almost everyone chose the latter option. But when the question was rephrased to eliminate the hypothetical equality of user charges, about 30 percent of the respondents shifted their answer to say they would go to the public facility.

This is not to say, however, that a zero-price system is the best alternative for the DOH. Actually, the rural poor are willing to make some payments if they feel that it will be to their advantage to do so. Thus, a little more than half of the responses to the above-noted hospitalization question still pointed to the private facility as the one to be selected. We have also seen how attitudinal questions generally elicited a strong preference for doctors (in comparison to traditional healers), even when the respondent's attention was explicitly drawn to the higher costs entailed by a visit to a physician.

The possibility of imposing user charges for DOH visits was raised explicitly in the following question:

"In some countries, people pay money when they see a government health worker, like a midwife or a doctor. They believe that this helps to improve the government health services. Would you be willing to do this if it could make our government health services better?"

A large majority (92.8 percent) of the respondents answered this question in the affirmative. In general, user charges were most acceptable to the fisherfolk (as we have seen, this group was invariably the most critical of the DOH services now being offered) and least palatable for the small farmers. (13)

As a general conclusion, therefore, we can say that a system of moderate and equitable (i.e. based to some extent upon the client's ability to pay) user charges could prove acceptable to most poverty class families in our study areas. Of course, the proviso entered into the last-noted survey item should also be

noted here. The poor can afford to pay some user charges but they should only be asked to do so under the assumption that local-level health care provision will indeed be upgraded by this approach. (14)

Conclusions and Policy Implications

As the end of the second millennium approaches, prospects do not seem favorable for achieving the Alma-Ata objective of "health for all by the year 2000." Certainly this is true for the Philippine rural poor, a group which the present study has shown to be experiencing high levels of infant/child mortality and inadequate access to even the most basic of health care services. Indeed, if the first goal of the study has been to assess the difficulties now faced by this group, the results can certainly be said to confirm our worst suspicions in this regard. To wit,

1. Incomes earned by the rural poor are low, irregular, and invariably insufficient to meet the needs of the rather large households which they have formed.
2. Asset ownership is also low, sometimes amounting to less than P1,000 on average.
3. About half of all households have experienced the death of one or more of their children, a figure which is already higher than that found among the Philippine poor in general and therefore substantially greater than any comparable statistic for middle- or upper-class households.
4. Most of these childhood deaths could have been prevented, stemming as they did from such conditions as acute respiratory infections, diarrheal disease, measles, or tetanus.
5. Health care expenditures are quite high, relative to the group's ability to pay. Recent illnesses requiring a visit to a physician frequently involved expenditures of P150 or more, an amount which represents more than ten percent of the average monthly income earned by some of our subgroups. Hospitalization costs were greater still. As a result, decisions were often made to forgo medical care altogether or to seek out a practitioner (e.g. traditional healer or government health care worker) other than the one originally preferred.
6. Participation in various types of insurance schemes was generally low (as in the case of Medicare) or negligible (private sector schemes, community-based programs).

We have also noted, in response to the second set of study questions raised by the study, that the health care situation of the rural poor can vary widely from one poverty group to another. As such, the conceptual distinction between (and within) the categories of small farmers, landless agricultural laborers and fisherfolk is certainly one which should be kept in mind for policy formulation exercises and future research studies. Perhaps the major finding along this line relates to the more favorable position found for the plantation workers than for those landless workers who have been forced to seek out their employment on small family-sized farms devoted to the cultivation of rice. Both the sugar and rubber workers enjoy fairly high incomes, more predictable work routines (i.e. less underemployment), increased opportunities to borrow money during a medical emergency, and widespread access to Medicare privileges. The sugar plantations also seem to be offering free medical clinics for employees and their dependents. These findings would appear to support, on social welfare grounds, the move towards high value crops and corporate agricultural enterprises, debatable as these changes might be on other grounds.

As a general conclusion, the fisherfolk communities were not faring well on most of our study indicators. Mortality levels were highest for this group, perhaps because of sanitation problems brought on by their more densely crowded living conditions. Incomes were low, as was participation in community projects and in nongovernmental organizations. Programs focussing on the rural poor should not overlook the numerous problems faced by this important group.

Upland farmers were also found to be experiencing a number of special problems. As expected, service access was low for this group. Incomes and asset ownership were also rather minimal, while fertility rates and infant/child mortality were both above the overall average found for the study.

The age profiles of several groups were found to include a relatively high concentration of older persons. This was true for the corn and coconut farmers, as well as among the subsistence fishermen. It is our general impression that the rural outreach programs of the DOH have not paid adequate attention to this emerging issue. (15)

Our third objective was to compare cultural and economic paradigms for the explanation of health care utilization patterns. Broadly speaking, the latter approach seemed to be the more useful one of the two. Our respondents were generally showing preferences that could be adjudged as "rational" and up-to-date. Thus, when a choice could be made between traditional and modern sector practitioners, it was generally the second of these two options which was chosen. (16) Respondents gave a high priority to health care issues, and were holding favorable opinions

toward a wide range of behaviors which could fit with improved patterns of health care financing--e.g. acquiring cash savings, enrolling in the Medicare program or private sector insurance schemes, purchasing a prepaid medical card or participating in community projects. They reported themselves as not being particularly intimidated by DOH doctors and seemed to be relatively well-informed about some of the most basic rules for good health (e.g. the danger of delaying too long when a child is sick, the benefits from installing a water-sealed toilet). Indeed, one is almost tempted to argue that the description offered by Caldwell, et al. (1989, p. 242) of the health care situation among Sri Lankan mothers (whom these authors portray as "highly sensitive to illness and the need for treatment within a modern medical system that is accessible to all") is in some ways applicable to our own study communities.

All these "correct" responses, and yet the children are dying. Why might that be? Well, in some case the cultural (or "ideational") paradigm may as yet offer some insights into this. Our analysis of the landless rice workers, a group which suffers from exceedingly low incomes and which cannot (unlike the sugar cane cutters) bring their sick child to a company clinic, suggests in the first place that parental educational attainment still has a crucial role to play in determining levels of infant and child mortality. Despite the above-noted drawbacks, the rice workers were found to exhibit one of the lowest levels of childhood mortality. They were also doing fairly well in terms of recent visits to a modern sector health worker, use of prenatal care, immunization levels and contraceptive prevalence. We have hypothesized that the above-average levels of educational attainment found for this group could be a major reason for these patterns. (17)

Social and cultural factors may also raise certain difficulties when it comes to the question of initiating and sustaining community projects. Because they are poorly educated, most rural folk feel that they do not have any viable skill which they could contribute to such efforts. There also seems to be a certain residue of suspicion towards the other residents of the barangay, a pattern which is in some ways reminiscent of Foster's (1965) thesis of the pervasive sense of "limited good" found in peasant societies.

All in all, however, the evidence in favor of the economic viewpoint was more persuasive. The unequal balance struck between the low incomes (and minimal borrowing power) of the rural poor as compared to the spiralling costs of medical care is apparent for all to see. As such, the paradox that modern-type treatment in general, and treatment within a private sector clinic in particular, are widely preferred in theory but often bypassed in practice may now be resolved. The household in question simply could not afford to seek out what it very well knows to be the best approach to the problem. The low rates of hospitalization

and the significant number of respondents who say there have been occasions when they had to decide against bringing a loved one to the doctor attest to the veracity of this conclusion. So also with private insurance schemes and prepurchased medical cards. Most respondents are willing in principle to adopt such innovations; unfortunately, the amount of money they can put up for this privilege is almost always going to be far too small to be of much practical use.

An example may serve to illustrate the latter point. The Davao-based Medical Mission Group has set up what has now become one of the best-known Cooperative Health Funds in the country. Soon after visiting this facility, Secretary Flavio himself proclaimed the cooperative approach as the "wave of the future" as far as the DOH facilities are now concerned (Arguillas, 1993b). Let us remember, though, that members of the Fund were already paying in 1992 a premium of P1,200 per year, with an added P365 per family member, (Arguillas, 1992). Now, with an average household size of nearly six members (the norm for our present study), this comes to about three thousand pesos per year an amount which is more than eighteen times as large as the average amount of money which our rural respondents felt they could contribute, on an annual basis, in order to belong to a fund "which would guarantee to help pay your medical bills if someone in your family gets sick." (18) Little wonder, then, why an evaluation study of two similar projects carried out in Luzon concluded decisively that this approach "is appropriate only for some people. It is unsuitable for people who have no regular source of income and who are in a dire state of poverty" (Gorra, 1990, p. 28).

The issue raised in the above paragraph has already brought us into the realm of our fourth study objective, namely that of assessing the viability of some of the different and newer approaches to health care financing which are now being suggested. As one way of opening up the topic, we can perhaps go on to quote a second observation made by Gorra, which is that "a community-based... (project) will not immediately attract members because people are reluctant to part with their money on an untried and untested undertaking" (Gorra, 1990, p. 28). Data from the present study provide some support for this perspective in the sense that the amount of money which the respondents would be willing to donate increased somewhat when a second question was asked about purchasing "special card" that is "already being used in other countries." This was in comparison to the rather vague reference on the first question to some unnamed and noncontextualized risk-sharing fund.

The above discussion is relevant for our assessment of the Medicare program in the sense that this approach elicits almost universal recognition and approval on the part of the rural poor. On the one hand, Medicare is not as completely absent from the rural scene as we might have initially speculated, given the

widespread participation within it of plantation (sugar and rubber) workers. And for those who are not now covered, opinions are remarkably favorable, with very strong (95 percent) agreement with the proposal that they, too, would become a part of the program.

Suggestions to extend Medicare to barrio residents might therefore be said to have some merit. Of course, benefits may have to be kept rather low, given the meager amounts which rural folk will typically be able to afford. It is also likely that premium collections will encounter some difficulties, given the fluctuating quality of rural incomes and the dispersed nature of countryside settlement patterns. The former problem could perhaps be dealt with by working through existing NGOs while the latter would seem to indicate a need for gradually phasing in the system. Initial efforts could be made in the coastal areas and farming communities located along major transportation arteries. These places will not only be more accessible to collection agents but may also be expected to enjoy higher living standards as well (Costello, 1989).

The role of community organizations in the approach suggested above will be critical and in some ways problematic. It will generally be necessary for an expanded Medicare program to affiliate with relatively large aggregates of people insofar as a strictly individual and voluntary approach might tend to attract only those households which are already experiencing the most intense medical problems. This implies that membership in the program would have to be made mandatory for all organizational members, a dictum that will no doubt be somewhat controversial. Hopefully, the rather positive sentiments now associated with the Medicare program could overcome most doubts in this regard.

Again, the major problems are likely to stem from, first, the collection of premiums and, secondly, uneven coverage. The NGOs will probably have to be granted some sort of financial overhead to make it worth their while to search for new members and to keep reminding the old ones about their payments. Those groups which are already benefitting their members in some tangible manner (e.g. strong marketing coops for farmers, agrarian reform groups which hold out to the landless the promise of eventual farmstead ownership) will probably encounter the most success in this regard. No one should expect, however, that coverage rates will be universal. This is unfortunate, especially since the disaffiliated households could well turn out to be the ones most in need of health care financing assistance, but probably unavoidable.

Most of the above comments are also applicable to the community-based schemes. In general, though, we have greater hesitation about endorsing this approach than for the Medicare concept. As Gorra has noted, rural folk might be reluctant to get involved in a program that cannot bring with it the "brand name" quality

associated with Medicare. The number of beneficiaries for a strictly local approach will also be too small in many cases to generate the economies of scale needed for a successful risk-sharing program. A particularly bad year health-wise could lead to losses large enough to drive the project out of business. Suggestions that rural folk could pay their premiums in kind or through labor exchange agreements also strike us as naive and impractical.

In short, a strictly "bottoms up" approach is likely to prove difficult to implement in practice. A better strategy might be to begin by capturing the membership of those larger rural NGOs that can claim to reach beyond one or two communities. This might include, for example, some of the federations of local cooperatives, the landless beneficiary groups, or even the churches. Members will pay increased dues to these organizations, obtaining in return certain Medicare privileges.

Problems of personnel will no doubt take on a critical role in such a scenario. Much has been made--and rightly so--of the Department of Health's "Doctor to the Barrio" program but this is actually only a single component of a much larger problem. In general, the more talented rural youth are unwilling to stay in the villages where they were born (Costello, 1987). Whether this is due to economic reasons or the so-called "bright lights" syndrome is not completely clear at this point. What is evident, though, is that there is a crying need for a greatly increased number of community organizers to serve as catalytic agents for the NGOs, health education specialists to help the overburdened midwives implement the primary health care program, agriculturalists and extension workers to stimulate productivity and economic growth, and even accountants to insure the fiscal integrity of any agreed-upon collection system. And all of these roles should of course be staffed by persons who are truly rural-based (at present, many NGOs tasked with spearheading rural development are based in cities, thereby implying that their personnel are actually "outsiders"), to say nothing of being enthusiastic, honest and intelligent to boot! Surely a tall order, and one which brings us out of the realm of health care financing and into the larger spheres of sociocultural change and political economy. For who is to blame the more perceptiveness of our rural youth from opting out of a milieu in which the opportunities for success are so few and the urban-based gospel of consumerism so widely preached? True, such questions are far too large and unwieldy to be settled by the present study, but it is apparent nonetheless that they will have to be addressed if any sort of long-term solution to the "rural problem" is going to emerge.

Proposals have also been made for the DOH to impose some system of user charges. In general, we feel that this is a good idea, albeit one which should be implemented carefully. Rural folk are willing to pay some amount for their medical care and they are quite aware that the fee-for-serve strategy is strongly linked to the better quality of service now available from the private practitioners.

The major problem in this case is equity. This could be dealt with if DOH personnel could only discern with some accuracy the income and ownership profile of each person coming in for treatment. No perfect system of this sort can ever be set up, of course, but a beginning might be made by taking certain obvious factors into account: geographic location (residents of towns will usually be poorer than those in cities, so also for the barrio vs. poblacion comparison), occupation, land ownership, educational attainment and age (e.g. by offering special discount cards for "senior citizens"). The move towards devolution could be an asset in this case since local health officials might be expected to be more knowledgeable about the backgrounds and financial status of their neighbors than would a higher-level administrator in Manila or the provincial capital. (19) We are assuming that some sort of residency requirement would be imposed in this case. It might also prove possible to provide special medical care coupons or consultation hours for the very poorest groups. (Use of such mechanisms tend to be status degrading on the part of the client. This lowers the probability that the nonindigent poor would want to take advantage of the free or reduced charges offered in this manner.)

In closing, we may perhaps point to a recent review of the Philippine health sector (Herrin, et al., 1993, p. 27) which concluded that there are now "many good prospects for achieving health care financing reforms" in the country. While this may be true for the country as a whole, we cannot help but be somewhat more pessimistic for the special case of the rural poor. Attempts to completely overhaul the present system merely as a means of complying with the stringent requirements of structural adjustment programs will surely prove onerous to the great bulk of small-time agriculturalists and municipal fisherfolk. No one needs a sophisticated input-output model to show that the government clinics will go on losing money as long as they provide free or heavily subsidized services to the masses, but so also is it obvious that the landless rice workers of Barangay Dumarait are not going to be able to afford anything approaching decent medical care on an average income of less than a thousand pesos per month. Yes, user charges can be considered for this group, as can prepayment schemes or cooperative health funds. But a subsidy is going to be needed, and one which has been funded largely from the earnings of those who are better off in life: the landed families, corporate interests, the managerial and professional classes. And so we come full circle back to the debate about "cultural" and "economic" explanations for the present dilemma. Actually, the cultural dimension is paramount, but in this case we are talking more of the well-heeled urbanites than of their penniless cousins in the barrio. A change in values is surely needed on that front, one which would emphasize sharing and social justice rather than a continual striving for higher salaries or bigger commissions. For the trickle down process is a painfully slow one and the child who is sick or hungry, the child who may be dying, cannot wait. (20)

Endnotes

Recent statements by the DOH (Arguillas, 1993a; Arguillas 1993b), for example, have indicated strong support for such notions as cooperative hospitals and cooperative health funds. The successful experience of the Medical Mission Group Hospitals and Health Services Cooperative (MMGHHSC) of Davao City is often pointed to in this respect. And yet this approach raises certain other questions, most prominent of which is whether the hard core rural poor (who may be earning only a third, or less, of the income brought in by a typical MMGHHSC member) will be able to afford the premiums charged by these institutions.

2

When the sample of Herrin and Racelis is limited to the poorest thirty percent of Northern Mindanao's population, an average household size of 5.97 persons was found, as compared to 5.64 in our study. (Rural households in the Philippines are generally smaller than those found in cities. So some difference would be expected in this case insofar as Herrin and Racelis were analyzing both rural and urban households.) For poverty class farmers in Northern Mindanao, Herrin and Racelis found an irrigation level of 12.1 percent, as compared to 7.6 percent in our study.

The nationwide data on family formation patterns showed an average number of children ever born of 4.83, an average number of children ever dying of 0.26 and 44.3 percent of all married women being current users of contraception. Comparative estimates from the present study were, 4.82 children ever born, 0.51 children ever dying and 48.3 percent as current users. Fertility and family planning levels thus appear to be close, although infant/child mortality levels are higher in our study. This latter finding seems appropriate since other studies have shown this problem to be particularly serious in Northern Mindanao (cf. Fliieger, Abenoja and Lim, 1981). It is also indicative of reasonably good data quality insofar as the typical problem in this regard is an understatement of infant/child mortality levels (e.g. Madigan, Abernathy, Herrin and Tan, 1976).

3

A review of factors correlated with infant mortality in the Philippines has demonstrated that maternal education is more strongly related to this factor than any other social or economic variable (Costello, 1988).

4

The older age profile found among the farmers and fishers is no doubt a major reason why these groups have more chronic conditions than the landless households.

5

A subsequent item which asked about the presence of diarrheal disease in the household during the month preceding the survey found the fishing communities to rank significantly ($p < .001$) higher in this regard than was the case for either the small farmers or the landless agricultural workers.

6

The subsistence fisherfolk also ranked high in terms of hospitalization patterns. It is not very clear why this might be so.

7

This, by the way, is not necessarily an "irrational" response on the part of the poor. Considering the sad state of most Barangay Health Stations (no professional personnel on call, no available medicine) the decision to proceed directly to the public sector hospital may well be the most cost-effective approach for this group to take. (For further details on the underutilization of Barangay Health Stations, cf. Palma-Sealza, 1993.)

8

The near complete dependence which municipal fishermen have upon such sources for their credit needs has been noted by Samonte and Ortega (1992). These authors go on to observe that "the existing credit delivery system is inadequate for lending to small fishermen....Institutional credit has often failed because it has not been able to cover all the services offered to fishermen by the trader financier." They argue that this situation could be alleviated by setting up a system whereby the banks would lend to fishermen's cooperatives which would then channel these funds, on a more flexible basis, to individual fishing households. While Samonte and Ortega are evidently thinking in terms of production loans for the fisherfolk, results from the present study would suggest that such a system might also be extended to cover certain emergency loans.

9

It is noteworthy that a majority (64 percent) of those persons who are covered by Medicare answered in the negative when they were asked if they would like to have a larger sum deducted from their regular salary "in order to have more benefits from Medicare."

10

As I.P. Getubig (1992, p. 11) notes, "NGOs and self-help organisations have been able to reach only a limited...number of poor. Among the major reasons for this are their lack of financial resources...and their weak administrative base, being limited only to a small area."

11

For example, more than 40 percent of the respondents said that they felt that only some of the residents of their barangay were "good and helpful."

12

The above statement is based on two premises. First, that the typical rural family must have experienced a number of occasions in which hospitalization was indicated. This seems likely considering the relatively old age profile of the respondents (i.e. more years for an accident to take place or a severe illness to develop), their high rates of fertility (more children to fall ill) and the high levels of infant/child mortality which they have experienced. A second assumption is that there are no cultural obstacles constraining the rural poor from entering the hospital. Insofar as a majority of our respondents agreed in one instance with the idea of bypassing the local health clinic (BHS) in order to go directly to a DOH hospital, we would argue that this proposition, too, is basically correct.

13

The comparable percentages in favor of user charges were 98.8 percent for the fisherfolk, 92.5 percent for the landless and 89.1 percent for the small farmers. These differences were significant at the .05 level of probability (chi-square = 6.72, $p = 0.15$).

14

For a helpful discussion of the user charges question, cf. Griffin (n.d.).

15

"Emerging" because migration patterns during the 1960s and 1970s were still bringing large numbers of newcomers (who will generally be in the young adult ages) to rural areas of Mindanao. Current patterns, however, show a strong pattern of rural-to-urban migration within the region (Costello and Ferrer, 1992), thereby insuring that those left behind will include disproportionate numbers of the elderly population.

16

The lone exception to this rule is found for the case of childbirth, in which case the traditional birth attendants are still quite widely used.

17

It is perhaps worthy of note that the Sri Lankan study cited above also placed great emphasis on the role of education in reducing mortality rates.

18

In point of fact the situation is even slightly more problematic than the above statistics indicate. Before asking the question on the amount which could be contributed for acquiring such coverage, respondents were first asked if they wanted to participate in the fund at all. Eight percent said that they did not, probably because of financial constraints.

The idea of allowing rural folk to pay less in user charges than those living in the cities, however, does not fit too well into a completely devolved set-up. Ideally, some of the taxes raised at the national level should be apportioned out to the health offices of the poorer and more isolated towns and provinces. Besides helping to improve the medical services available in these areas, this approach might also serve in some way to reduce the magnitude of the rural-to-urban migration stream.

In his comments on an earlier version of this chapter, Dr. Mario Lamberte suggested that we should discuss three contrasting "policy options," i.e. (1) full-cost pricing with a "viable risk-pooling mechanism to reduce cost to consumers," (2) a program which is "fully subsidized by the government through the price delivery system," and (3) a "partly subsidized risk-pooling mechanism." While foregoing sections of this report have looked at this question from many angles, it is perhaps true that we have not been explicit enough about our broad-based conclusions on the subsidy issue.

In general, we support the last of these three options. Full-cost pricing, as we have seen, will not work to bring any sort of decent health care to the rural poor. Their incomes are simply too low and variable. The amount which they could pay in premiums for any conceivable health care financing scheme would not be adequate to allow any real coverage, especially in cases of an emergency or a serious illness. (Note that we have qualified our above conclusion as applying to the case of the rural poor, a group which we believe to be significantly worse off than their younger, better educated, better organized, and more financially secure cohorts in the urban slums. It is perhaps possible that the full-cost pricing approach could work for those members of the urban poverty class who are receiving some sort of fairly steady income.

Full subsidization by the government is also a less-than-ideal solution, although it should not be forgotten that there will always be some truly indigent families who are incapable of contributing anything for the payment of their health care maintenance needs. Most rural folk, however, will be able to come up with something, if not from their own immediate earnings then at least by borrowing a little money from a friend or relative. In general, payment for services rendered can become a form of empowerment since it means that the relationship between health worker and patient has become more egalitarian and reciprocal. To some extent the health worker will now be accountable for his or her decisions, as well as more client focused and concerned about "quality of care" (Bruce, 1990) issues. This is probably why the attitudinal items in this survey revealed (1) a general preference for private sector medical services and (2) a willingness, on the part of most respondents, to pay for (improved) DHH services.

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Appendix I: Variables Measured by Health Care
Financing Survey of Rural Poverty Groups

I. Background Factors

1. Rural poverty community
2. Household size
3. Children ever born
4. Various characteristics of the household head
 - a. Age
 - b. Sex
 - c. Marital Status
 - d. Currently pregnant?
 - e. Currently going to school?
 - f. Highest grade completed
 - g. Usual occupation
 - h. Secondary occupation
5. Various characteristics of spouse (Same as I.4.a through I.4.h)
6. Province of birth
 - a. Respondent
 - b. Husband
7. Year moved to current residence
 - a. Respondent
 - b. Husband
8. Plans to move away to another place
 - a. Preference to move/stay
 - b. Place where R would like to move
 - c. Reason for desiring to move away
9. Marital status of R
10. Year of marriage
11. Language spoken at home
12. Religion
 - a. Religious affiliation
 - b. Frequency of church attendance
 - c. Does R belong to a religious group?
 - d. Type of group (first group)

A

"R" used herein as an abbreviation for "respondent".

13. Ability to speak English
14. Ability to speak Tagalog
15. Media use (frequency)
 - a. Radio
 - b. Television
 - c. Newspapers
16. Housing status
 - a. Tenancy status (house)
 - b. Monthly rental costs (house)
 - c. Tenancy status (homelot)
 - d. Monthly rental costs (homelot)
17. Ownership of land other than homelot
 - a. Is some land owned?
 - b. Size of other lot(s)
18. Does R's home have electricity?
19. Type of cooking facilities
20. Source of drinking water
21. Type of toilet
22. Housing materials
 - a. Roof
 - b. Walls
 - c. Floor
23. Ownership of consumer durables
 - a. Electric/gas stove
 - b. Electric fan
 - c. Radio
 - d. Television
 - e. Sewing machine
 - f. Refrigerator
 - g. Karaoke
 - h. Sala set
 - i. Camera
 - j. Photo album
 - k. Wall clock
24. Current work situation of household head
 - a. No. of months on the job
 - b. Job status
 - c. Days worked on job during week preceding survey

25. Earnings of household head
 - a. Amount earned last month
 - b. Were last month's earnings typical?
 - c. Reason why earnings were atypical
 - d. Contributions from earnings for household expenses
26. Time allocation of household head
 - a. Job activities
 - b. Household chores
27. Current work situation of spouse (Same as I.24a through I.24.c)
28. Earnings of spouse (Same as I.25.a through I.25.d)
29. Time allocation of spouse (Same as I.26.a and I.26.b.)
30. Employment status of all household members
 - a. No. employed (total)
 - b. No. of employed who are permanent employees
 - c. No. of employed who are casual employees
 - d. No. of employed who are self-employed
 - e. Total no. of days worked, all employed
 - f. Total no. of hours worked per day, all employed
 - g. No. of employed contributing all their earnings to household expenses
31. Family members living and working elsewhere
 - a. Total number
 - b. Age of (first, second, third) member
 - c. Amount of money remitted by members
32. Total monthly income for the household (typical month)
33. Ownership of productive assets
 - a. Motor vehicle
 - b. Residential land
 - c. Farmland
 - i. cultivated
 - ii. uncultivated
 - d. Fishponds
 - e. Farm equipment
 - f. Livestock
 - g. Poultry
34. Total worth of all assets

35. Farm-related variables (Small farmer subsample)

- a. Size of farm
- b. Amount of farmland irrigated
- c. Main crop
- d. Hectares planted to main crop
- e. Harvests per year, main crop
- f. Cans per harvest, main crop
- g. Cultivation of other crops
- h. Tenancy status
- i. Is the farmplot titled? (Owners)
- j. Does R possess other papers for farmplot (e.g. CLT)?
- k. Tenancy arrangement (Nonowners)
- l. Rental costs for farmplot
- m. Farm inputs
 - i. fertilizer
 - ii. pesticides
 - iii. herbicides
 - iv. certified seeds

36. Work-related variables (agricultural workers)

- a. Agricultural jobs done by household head
 - i. plowing
 - ii. planting
 - iii. weeding
 - iv. repair jobs
 - v. harvesting
 - vi. rubber tapping
 - vii. other jobs
- b. No. of working days per month, household head
- c. Circulation
 - i. Does household head work elsewhere?
 - ii. Place where household head works (Rural/urban)
 - iii. No. of months spent in that place
 - iv. Type of job done there
- d. Agricultural jobs done by spouse (Same as I. 36. a.i through I.36.a.vii)
- e. No. of working days per month, spouse
- f. Does spouse sometimes work elsewhere?
- g. No. of other household members who are agricultural workers
- h. No. of working days per month, other household members
- i. No. of other household members who work elsewhere
- j. Seasonality of household income
 - i. Does income fluctuate by seasons?
 - ii. Months during which income is low
 - iii. Coping strategies when income is low

37. Work-related variables (fisherfolk)

- a. Total no. of household members who are fishermen
- b. Boat ownership
 - i. Does family own boat?
 - ii. Size of boat
 - iii. Does boat have an engine?
 - iv. value of the boat
- c. Ownership of a net
- d. Ownership of other fishing gears
 - i. First gear mentioned
 - ii. Second gear
 - iii. Third gear
- e. Does family member buy/sell fish?
- f. Suggested gvmt. project to help fisherfolk
- g. Seasonality of household incomes (Same as I.36.g.1 through I.36.j.iii)

38. Time allocation of R

- a. Work for wages
- b. Work on farm or garden
- c. Searching for food or fuel
- d. Work in own business
- e. Household chores
- f. Civic activities

b

II. Health Care Inputs

- 1. Does R boil their drinking water?
- 2. Method of garbage disposal
- 3. Occupational safety
 - a. Does household head work at a dangerous job?
 - b. Reason why job is dangerous
 - c. Does any other household member work at a dangerous job?
 - d. Reason why job is dangerous
 - e. Total number of family members working at a dangerous job

b

Also see I.2D (Source of drinking water), I.21 (Type of toilet), and I.22 (Housing materials).

4. Visits to health worker last month for various symptoms (Total number of visits by all household members. For symptoms see III. 12.a through III. 12.w.)
5. Visits to health worker last month for any other medical problem
 - a. Total number of visits, all household members
 - b. Reason for first such visit
 - c. Reason for second visit
6. Conditions surrounding visit of some family member to health worker last month (first three cases coded)
 - a. Symptom(s) experienced
 - b. First visit or follow-up?
 - c. Type of health worker consulted
 - d. Place of consultation (type of facility)
 - e. Location (geographic) of consultation place
 - f. Travel cost to facility
 - g. Consultancy fee
 - h. Purchased medicine for the case?
 - i. Amount spent on medicine
 - j. Tests carried out for the case?
 - k. Amount spent on tests
 - l. Number of additional consultations on case
7. Most recent case when someone from the family was hospitalized
 - a. Year in which this occurred
 - b. Person hospitalized (relation to household head)
 - c. Illness of the person
 - d. Amount spent on hospitalization
8. Medical advice
 - a. Person R goes to for this
 - b. Reason for preferring that person
 - c. Reason why R does not go to Barangay Health Center for advice (if applicable)
9. Prenatal care
 - a. Place/facility where R went
 - b. Reason for not going to prenatal (if applicable)
 - c. Health worker visited for prenatal
 - d. Month of pregnancy when prenatal care was first availed of
10. Birth of most recent child
 - a. Place of birth
 - b. Health worker in attendance

11. Immunization

- a. Was youngest child immunized?
- b. Reason for not immunizing
- c. Place of immunization

12. Use of family planning

- a. Current use
- b. Reason for not using
- c. Type of method used
- d. Place where R went for supplies

13. Health-related attitudes/beliefs

- a. Public vs. private physicians
- b. Use of herbal medicine
- c. Use of "Binisaya" medicine
- d. Do rich have fewer health problems?
- e. Public vs. private hospital (two items)
- f. Health insurance
- g. Medicare (three items)
- h. Is health care a basic human right?
- i. Delay before going to doctor?
- j. Do DOH personnel treat patients with respect?
- k. Is R shy in presence of doctors?
- l. Go first to Barangay Health Station?
- m. Doctor vs. hilot
 - i. which is better?
 - ii. why?

14. Use of Barangay Health Center

- a. Knowledge of its location
- b. Has R ever visited?
- c. Opinion on its services
- d. Reason for feeling this way

15. Use of DOH hospital (See II. 14.a through II. 14.d)

16. Three health care decisions (What would R do in each situation?)

- a. Child with diarrhea
- b. Child with cough and fever
- c. Buy toilet or television
- d. Reason for choosing toilet/television

c

III. Health Care Outputs

1. Children ever dying
2. Sex of the first four dead children
3. Age at death, first four dead children
4. Cause of death, first four dead children
5. Medical problems of household head
 - a. Type of disability
 - b. Type of chronic condition
6. Medical problems of spouse (Same as III. 5.a and III. 5.b)
7. Total number of household members with a disability
8. Type of disability of household members other than household head or spouse
 - a. First other member
 - b. Second other member
 - c. Third other member
9. Total number of household members with a chronic condition
10. Type of chronic condition of household members other than household head or spouse
 - a. First other member
 - b. Second other member
 - c. Third other member
 - d. Fourth other member
 - e. Fifth other member
11. Job-related injuries
 - a. Was household head ever injured at his job?
 - b. Type of injury, household head
 - c. Was any other member injured?
 - d. Type of injury
 - e. Total number of injured members

c

Also see II.7c. (illness requiring hospitalization).

12. Various symptoms/illnesses experienced last month (coded for household head and total number of household members)

- a. headache
- b. dizziness
- c. loss of consciousness
- d. fever
- e. fatigue
- f. weight loss
- g. loss of appetite
- h. cyst/tumor
- i. skin allergies
- j. blurred vision
- k. ear discharge
- l. sore throat
- m. cough/cold
- n. chest pain
- o. numbness
- p. lower back pains
- q. stomach pains
- r. nausea
- s. diarrhea
- t. frequent urination
- u. painful urination
- v. toothache

d

IV. Health Care Financing Factors

1. Does R now belong to a community group or NGO?
2. Type of community group
 - a. First group
 - b. Second group
3. Did R formerly belong to a community group/NGO?
4. Type of group which R belonged to
5. Reason for leaving the group

d

Also see I.12.c/d (Membership in a religious group), I.34 (Worth of all assets), and I.38.f. (Time inputs for civic activities).

6. Ability of R to borrow money in an emergency
 - a. Could R borrow?
 - b. From whom?
 - c. Amount which could be borrowed
7. Previous loans
 - a. Has R borrowed?
 - b. From whom?
 - c. Amount borrowed
 - d. Amount of interest paid on loan
8. Savings
 - a. Does R have cash savings?
 - b. Location of savings
 - c. Interest earned on savings
9. Self-help projects
 - a. R's opinion on these
 - b. Reason for holding this opinion
 - c. Preferred leader for such projects
 - d. Sex of preferred leader
 - e. Level of education of preferred leader
 - f. Willingness to join such projects
 - i. respondent
 - ii. husband
 - iii. children aged 15+
 - g. Hours per week available for such projects
 - i. respondent
 - ii. husband
 - iii. children aged 15+
 - h. Skills which could be contributed
 - i. respondent
 - ii. husband
 - iii. children aged 15+
10. Financing decisions, most recent case when someone from the family was hospitalized
 - a. Source of money
 - b. Amount from savings
 - c. Losses from savings-as a result
 - d. Property sold/mortgaged
 - e. Amount raised by sale/mortgage
 - f. Losses on property as a result
 - g. Amount borrowed
 - h. Details of loan
 - i. source
 - ii. time to repay
 - iii. interest charges
 - iv. collateral required

- i. Amount covered by Medicare
- j. Time losses from Medicare
 - i. time to file claim
 - ii. time before reimbursement arrived
- k. Amount covered by private health insurance (p.h.i)
- l. Time losses from p.h.i.
 - i. time to file claim
 - ii. time before reimbursement arrived
- m. Did R pay entire bill?
- n. Amount from bill still owed

11. Medicare coverage

- a. No. of household members covered
- b. Is household head covered?
- c. No. of times Medicare was used

12. Coverage by private health insurance

- a. Name of company
- b. No. of household members covered

13. Medical benefits extended by employer

- a. Does any household member enjoy these?
- b. Conditions of coverage
- c. Coverage extended to whole family?

14. Health care cooperatives

- a. Does any member belong to one of these?
- b. Has R heard of this?
- c. Reason for not joining coop
- d. Organization sponsoring the health care coop
- e. Source of organization's funds
- f. Other activities carried out by coop
- g. Length of time R was in coop
- h. Manner in which contributions are made
- i. Reason for joining
- j. Amount contributed last year
- k. Availment of coop benefits
 - i. When?
 - ii. What sort of benefits?
 - iii. Best thing about organization
 - iv. Worst thing about organization

15. Past coverage of household members by any type of financing insurance plan

- a. Anyone covered?
- b. Type of plan (first three cases)
- c. Year plan discontinued (first three cases)
- d. Reason for discontinuing (first three cases)

16. Past cases when there was no money to treat sick household member
 - a. No. of times this occurred
 - b. Disposition of the case (first three cases)
17. Attitudes toward saving
 - a. Approval/disapproval
 - b. Ranking of various purposes for saving (unemployment vs. illness, retirement, education and housing)
18. Attitudes toward health care fund
 - a. Willing to contribute?
 - b. Amount willing to give (yearly)
 - c. Can R afford P250 per year?
19. Willingness to pay user charges, DOH
20. Source of financing, health care emergency
21. Government funding for hospital expenses (attitudes)
 - a. Should govt. help?
 - b. How much for room and board?
 - c. How much for doctor's fee?
 - d. How much for operation?
 - e. How much for medicine?
22. Opinion on the people who live in R's barangay
23. Willingness to help on a community project when others are not helping
24. Should the barangay captain require all residents to work a community project?