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Michael A. Costello and Marilou Palabrica-Costello

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Health Care Financing for the Rural Poor: A Comparison of Three Policy Options

Michael A. Costello

Marilou Palabrica-Costello



In what way were we trapped? Where, our mistake . . . ?, the weight and wealth of that strong year when there was more to eat than we could hold, new clothes, . . . and money in the bank? How, how did all this sink so swift away . . . ? (Agee 1988, 78).

This article is the result of a larger study dealing with the health care needs, attitudes, behaviors and financing strategies of lower-income households in rural communities of Misamis Oriental and Bukidnon provinces. Our purpose is to review various descriptive findings from the study to determine the viability of three different policy options for meeting the health care financing needs of the rural poor. The options are an expanded Medicare system, various community financing schemes, including those which take the form of health care cooperatives, and the imposition of user charges for public-sector health care services. Our general conclusion is that the very low living standards experienced by the rural poor make the implementation of all three of these strategies difficult, although prospects for the user-charges approach are probably better than for the first two. Continued subsidization of the rural health care sector will still be needed for some time, assuming that there is still any real support for the Constitutionally-approved view that health care is a basic human right.

Even though the rural poor have certain obvious commonalities, it would be an error to regard this group as essentially homogenous. Small farmers and landless agricultural workers are both poor, but

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recent studies in the rural sociology of the Philippines have tended to conclude that economic insecurities are greater in the latter case than in the former (Ledesma 1982; Veneracion 1985). Other factors, too, can be expected to differentiate the rural poor. Ethnicity, household size and composition, stage in the family life cycle, and degree of geographic isolation all exemplify this conclusion.

The diversity of the poverty experience is an important point for planners and program managers to keep in mind. In particular, if different groups experience different problems, it would seem plausible to argue that programmatic responses should not be limited to a single approach or strategy. As pointed out by I. Getubig (1992, 13) it may eventually prove "necessary to have a different social security instrument or delivery system for each major group among the poor (for example,...farmers versus landless workers versus fishermen) . . ." It will probably prove easier to enroll certain types of landless agricultural workers (i.e., those working in large-scale plantations or corporation farms) in the government's Medicare program than small-scale, self-employed farmers, whether owners or tenants.

The present study has attempted to take this sort of intragroup heterogeneity into account by analyzing a number of different rural poverty groups (or "communities"). These are eight in number and include small corn farmers; small coconut farmers; a group of small farmers growing corn, tomatoes and beans in an isolated upland barangay; landless agricultural workers in the rice, sugar, and rubber industries; and municipal fishermen coming from "market-linked" and "subsistence" settings. Because these "communities" have been purposively chosen for study, there can be no question here of generalizing to the region or the county as a whole. Nonetheless, we feel that our findings are suggestive, for example, in the extent to which major divergencies *do* exist among these groups.

Setting and Research Methodology

Because so little is known about the health care financing patterns of the rural poor, it was decided to use a descriptive study design for the present study. Eight different communities were identified for this purpose. For the small farmer class these were Barangays Kauyonan (Kitaotao, Bukidnon); Odiongan (Gingoog City, Misamis Oriental); and Mat-i (Claveria, Misamis Oriental) for, respectively, the corn, coconut and upland farmers. Landless agricultural workers on

rice farms in Barangay Dumarait, Balingasag, Misamis Oriental were also selected for study, as were comparative samples of workers in the sugar and rubber industries. (These latter two groups were from Barangay Butong, Quezon, Bukidnon and Barangay San Isidro, Talakag, Bukidnon.) For the fisherfolk, the "market-linked" setting was identified as Barangay Luyong Bonbon, Opol, Misamis Oriental, while the subsistence fishing community was Barangay North/South, Medina, Misamis Oriental. Data are available to show that the major sustenance patterns characterizing each of these communities do in fact conform closely to the thumbnail descriptions listed earlier. That is, the corn farmers live in a corn-growing area, the "sugar community" is located in the heartland of Bukidnon's emerging sugar industry, and the like (for further details, cf. Costello and Palabrica-Costello 1994).

Research assistants carried out the data-gathering operations. This involved, interviewing community leaders and other key informants about the characteristics of each selected barangay. The presence of various health care services and specialists was determined at this time along with information on transportation linkages, institutional development, employment opportunities outside of agriculture and the presence of nongovernmental organizations (NGOs).

A simple random sample of forty of these households was then chosen within each of the eight communities, thereby leading to a total sample size of 320 households. Replacements were made in cases where the household was subsequently found to not fit within the specific category under observation.

Members of the three "small farmer" categories included tenants, "stewards" (a tenure status whereby the government grants twenty-five year user rights to farmers in upland areas) and owners. (Many "owners" did not in fact hold a title for their land although they may have been living there for some time and had paid taxes on it.) No farmer with a landholding larger than three hectares was included in the study. Some of the "landless" did in fact own a small plot of land, but in no case did this exceed half a hectare. The main income source for all "landless" families came from work which the household head was able to obtain on nearby rice, sugar, or rubber farms. None of the fishermen were highly capitalized. Most were municipal-type fishermen, although a few from the market-linked fishing community were working as hired hands on a fishing trawler.

The survey instrument used for the study was rather broad in nature and went into several subtopics thought to be potentially relevant

for the overall question of health care financing. These included the background characteristics of the household head and his wife, information on income and asset ownership, demographic histories, health care practices and beliefs, attitudes concerning public- and private-sector health care, and practices and attitudes specifically related to the issue of health care financing. These data serve as the major information source for the present paper. For the most part our analysis will proceed by means of comparing the different poverty groups described above.¹

Findings from the Study

As expected, the community-level data showed the infrastructural and institutional profiles of the selected barangays to be poorly developed. Most had access to electricity, but piped water, irrigation projects, telephone lines and the like were typically absent. (An exception here is for the two fishing communities, both of which enjoyed good access to piped water.) Transport linkages to the region's major city (i. e., Cagayan de Oro) varied from excellent (for the case of the market-linked fishing community) to poor (for the corn, sugar and upland farming communities). Few of the sampled barangays had much to offer in the way of educational or health facilities. Most did have a Barangay Health Station in place, although two (Barangays Dumarait and Luyong Bonbon) did not. These centers had little in the way of medical equipment and operated without any sort of regular visits on the part of a doctor, nurse, or dentist. Midwives were assigned to all centers, although in the case of the corn-growing community this was on a one-day-per-week basis.

Each barangay had at least one NGO. The number of active NGOs varied from one to eight, averaging three per barangay. Many of these groups were small and only a few could claim a good track record in carrying out successful community projects. None had been set up specifically for health or health care financing purposes.

The most atypical barangay studied was the one dominated by the sugar-growing industry. Four large haciendas are located within this community, each of which operates a company-run health clinic for workers and their families. Also located within the barangay were three elementary schools, a dentist (associated with the largest of the sugar haciendas), a dozen large business establishments, several eateries and a number of government offices. The Barangay Council

was said to meet regularly and to operate on an annual budget of more than a million pesos, raised from taxes imposed on local establishments. It seems apparent that the sugar industry has helped in this case to stimulate a more complex division of labor and a fairly high level of institutional development.

The socio demographic data on the study respondents, gleaned from the household-level interviews, reveals that, in general, the landless agricultural workers were younger than the other two groups and more likely to have in-migrated from some other region. This latter pattern was particularly noticeable for the sugar and rubber workers. Small farmers growing corn and coconuts averaged nearly fifty years of age, a pattern which is related to the heavy levels of out-migration (mainly by young adults) which have recently been experienced in their home communities.

The average educational attainment for household heads was 5.6 years (6.4 years for spouses). The farmers and the sugar workers ranked lowest in this regard. More than half of all respondents listened to the radio on a daily basis; about forty percent watched television or read newspapers on at least an occasional basis. Media use was lowest in the less accessible communities (i.e., among the corn growers and the upland farmers).

Membership in community organizations was most common for the different farming groups. In many cases this was a multipurpose cooperative group. Rubber workers were also well represented in the cooperative sector, because the rubber plantations in Barangay San Isidro were transferred (under the government's agrarian reform program) to a company-based cooperative. In comparison, very few of the rice workers and *none* of the sugar laborers belonged to a community organization.

Living standards were, of course, low. Home ownership was common (more than three-fourths of the respondents enjoyed this advantage) but about half of these houses were not made from strong materials. Only a third of the two agricultural groups had piped water (the corresponding figure for the fisherfolk was 95 percent) while about half of all respondents had an electrical connection or a water-sealed toilet.

The average cash income earned by the study households during a "typical" month ranged from P1,432 for the small farmers to P1,990 for the landless agricultural workers. It is interesting to note, however, that the landless group was characterized by a substantial internal variation on this measure. When income levels for all eight

subgroups were inspected, the sugar and rubber workers were found to enjoy the highest cash incomes while the rice workers ranked lowest in this regard. On average, the rice workers were earning less than a thousand pesos per month, a finding which can be linked to the patterns of labor utilization among the different landless groups. During the month preceding the survey the rubber and sugar workers were able to find work for an average of 26.1 and 23.7 days, respectively. In comparison, the rice workers were only employed for an average of 14.4 days during the same period.²

A majority of the farmers interviewed were either tenants or residing on public land. A little more than a third of this group, however, did claim to own the land that they were farming.³ None of the landless and only three of the fisherfolk owned more than half a hectare of farmland. Farmers were also more likely to own either some type of farm equipment or one or more farm animals. On average, then, the members of this group owned assets worth about P19,000 as compared to about P10,000 for the fishers (most of whom owned their boat and/or some simple fishing gears) and a mere P2,500 for the landless.

It is well-known that farmers experience substantial fluctuations in their monthly cash incomes (e.g. Ledesma 1982, chapter 3). Findings from the present study indicate that this same pattern was also very common among the two fishing groups as well as for the landless workers in sugar and rice. Overall, nearly 99 percent of the respondents in these four groups answered in the affirmative when asked if their household income varied from one month to the next. This same pattern, however, was not true for the rubber workers, among whom only one respondent gave a similar answer.

Levels of both fertility and infant/child mortality appeared to be high among all groups. On average, the respondents had experienced 4.8 live births and 0.50 children dying. These figures, moreover, do not reflect the complete childbearing experience of these couples since more than half of the housewife respondents were still fecund.

Levels of infant/child mortality appeared to be highest among the fisherfolk, the upland farmers and the sugar workers.⁴ The most common causes of infant and child mortality were diarrheal and respiratory diseases. (Data on both morbidity and mortality showed the problem of diarrheal disease to be particularly acute in the two fishing villages.) Other contagious diseases (e.g. measles, tetanus, "kidney infection") were also reported with some frequency.

The older age profiles found among the corn and coconut farmers and the two fishing groups were linked in turn with the occurrence of a number of chronic conditions associated with the elderly, e.g. arthritis and cataracts. More than half of the farmer households, in fact, reported having at least one member who was experiencing "blurred vision." This appears to be an important but overlooked health problem, particularly since data from a study of older Filipinos (Andrews et al. 1986) support this observation.

In cases where a family member falls ill, the probability that a health care worker would be consulted was lowest among the three farming groups and the subsistence fisherfolk. The more isolated living conditions and older age profiles found in these cases may represent the major reasons for this differential. Despite their low levels of educational attainment, it was the sugar workers who were most likely to consult some type of health care worker, a pattern which may be attributable to this group's access to company-funded medical clinics.

Sugar workers and their families were also found to be least likely to consult a traditional health worker like a *hilot* or a *herbolario*. Generally speaking, though, they were not alone in their preference for modern healers, since this option was selected in more than 80 percent of all cases which were eventually referred to a health worker.

Ninety percent or more of all groups knew about, and in fact had visited, a government-run Barangay Health Station. A little less than two-third had visited a DOH hospital. Sixty-three percent of the respondents said that there had been at least one occasion in the past when one of their family members had been hospitalized.

Resort to both traditional and modern health care systems seems to be the rule as far as maternal and child health is concerned. The great majority (89 percent) of births occur at home, usually (more than 70 percent) with the help of a traditional birth attendant. Visits to the local Barangay Health Station for prenatal care, however, were also common, being carried out in roughly two out of every three pregnancies. Immunization is fairly widespread, with 64 percent of all last-born children being said to have completed this regime. Nearly half (48.1 percent) of all fecund women said that they were practising some form of family planning as of the survey date. This figure is somewhat surprising since it is a little higher than the 40 percent family planning prevalence rate which was turned in by a recent nationwide survey of Philippine women in general (National

Statistics Office and Marco International, Inc. 1994). The practice of family planning was most common among the landless worker households (particularly those employed on the sugar and rubber plantations); in comparison, prevalence levels were lowest among spouses of upland farmers.

Various attitudinal items confirmed that the general preference among this sample of low-income rural respondents was for modern medical practitioners, rather than traditional healers. Comparing public and private sector practitioners, opinions are generally in favor of the latter, although the higher charges found in this case necessarily imply that these desires will not always be matched by actual behavior.

Health care expenditures can be substantial, particularly when viewed in comparison to the rather meager earning profiles found among the study households. In cases where a household member had been hospitalized, the average amount spent was a little more than P3,400. Various costs were also incurred for those cases where a health care practitioner had been consulted during the month preceding the survey.⁵ One out of every four respondents, in fact, admitted that there had been at least one occasion when her family had not been able to bring one of its sick members to see a doctor because of lack of funds. This latter problem was most widespread among the fisherfolk and least common among the landless.

A total of 200 families were located which had experienced the hospitalization of one of their members. When respondents were asked how they had acquired the funds needed to pay for this, a highly diverse set of strategies was uncovered (see Table 1). About one in five households depended solely on either their current earnings or on past savings. The next-ranking options (for households which used only a single strategy) were to sell or mortgage property (10.0 percent), to borrow money from a friend, relative or employer (9.0 percent), to get some sort of charitable assistance (8.5 percent) or to use the family's Medicare privilege (7.5 percent).

In a large proportion of cases it was necessary for the family to seek out two or more funding sources for their hospitalization expenses. This would seem to imply that the amount of money available from any one source is typically rather small, a conclusion which seems likely, given the nature of the groups under observation.

About 30 percent of all cases involved payment (whether in full or only partially) after the family had obtained a loan from some-

one. The good news here is that the typical pattern was *not* to go to a userer, a funding source which was reported for only five of the sixty-eight cases where a loan was obtained. Instead, most (85 percent) of these hospitalization-linked loans were interest-free. At the same time, though, it must be noted that the amount of money available from this source is generally not very large. When asked if they had ever borrowed money in "a big emergency . . . (like) if someone was very sick," 56.2 percent of the respondents answered in the affirmative. This is somewhat reassuring, perhaps, but one should also note that the average amount borrowed was only P830 while the median (P300) was even lower.⁶

Table 1. Percentage Distribution, Financing Source for Most Recent Hospitalization Expenses, Low-income Households in Eight Rural Communities of Misamis Oriental-Bukidnon, 1992

Source	Percentage
<u>Single Source:</u>	
Own savings/salary	21.5
Sold/mortgaged property	10.0
Loan	9.0
Donations/Charity assistance	8.5
Medicare	7.5
<u>Two Sources:</u>	
Savings and sale/mortgage of property	2.5
Savings and loan	3.5
Savings and donations	4.0
Savings and Medicare	8.0
Property (sale/mortgage) and loan	2.0
Property (sale/mortgage) and donations	1.0
Property (sale/mortgage) and Medicare	0.5
Loan and donations	2.0
Loan and Medicare	11.0
Three or more sources	9.0
Total	100.0
(N = 200)	

Some significant differences could be noted among the different study groups in this regard. When asked if they believed that they would be able to borrow money in "a big emergency" it was the landless workers who were most likely to answer this question in the affirmative (see Table 2). This group was also most optimistic about the amount of money it could raise in this fashion. On the average, the landless were expecting to borrow more than P1200. as compared to P770 for the farmers and P492 for the fisherfolk. A major explanation for these differentials lay in the more favorable position held by the sugar and rubber workers. Every one of these respondents expressed optimism about getting a loan, with mean expectations reaching as high as nearly P2,300 for the rubber workers. In comparison, the landless rice workers (as well as a number of the other groups) were faring much more poorly.⁷

Table 2 extends the above observations somewhat. As shown therein, the main reason that the landless workers feel optimistic about getting an emergency loan seems to be their ability to borrow money from their employer. In comparison, the farmers and fishers must seek out other (less heavily capitalized) sources.

Returning now to Table 1, we can make four more observations about the funding sources used in past cases of hospitalization. First of all, Medicare privileges would appear to have been availed of in a fairly large (27 percent) proportion of all cases. This figure is actually something of an overestimate, thereby supporting the not-unexpected conclusion that poorer rural families are generally unable to benefit from this program. Secondly, all other types of formal health care financing schemes are resorted to even more rarely. In fact, they don't appear at all in the table, whether in the form of employer benefit packages, private sector insurance plans or community-based approaches.

A third point worth making is that the "savings/salary" category probably involves the latter funding source much more frequently than the former. When a separate question was posed as to whether or not the household had put aside some cash savings as of the survey date, a little more than 90 percent of the respondents said that they had not been able to do this.⁸

A final comment concerns the option of selling or mortgaging some property. This mode of payment was used 12.5 percent of the time. The most typical item sold or mortgaged was a farm animal (twenty-five out of forty cases), but in other circumstances it became

necessary to dispose of household consumer items, agricultural produce, or even the land itself. 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 sold or mortgaged, the average figure given was P9,102, as compared to an average sale value of P5,868.

Table 2. Survey Data on Loans for Emergency Medical Purposes, Low-income Households in Eight Rural Communities of Misamis Oriental-Bukidnon, 1992

A. Projected Loans for a "Big Emergency"

Poverty Group	Percent who believe they can borrow money	Mean amount expected to be borrowed
Small farmers	75.0	P 770.25
Landless workers	92.5	P 1,230.10
Fisherfolk	68.8	P 491.88

$\chi^2 = 19.92, p < .001$ ($F = 4.04, p < .02$)

B. Source of Projected Loan, by Poverty Group (Percentage Distribution)

	Small Farmers	Landless Workers	Fisherfolk
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	17.8	18.9	23.6
Total	100.00	100.0	100.0

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

*Sample size for both tabulations in the top panel of this table are 320 cases. For the tabulation on the mean amount expected to be borrowed, all households who believed that they would not be able to borrow anything were coded as "0."

Health Care Financing Policy Options

What are the prospects for extending some form of health insurance coverage to the rural poor? We have already noted that private sector programs and employer-paid plans were not being availed of in any of our study communities. This comes as no surprise, of course, since income levels in these poverty-class households are too low to cover the premiums demanded by private plans and most household heads are either self-employed (the small farmers and fisherfolk) or working on an occasional basis for a large number of small-time farm operators (the landless rice workers). The sugar and rubber workers, of course, do represent a major exception to the latter assertion, but in this case the employing organizations seem to feel that there is no need on their part for a separate insurance scheme, no doubt because they are already required by law to operate a company clinic and to extend Medicare coverage to their workers.

The only viable alternative along these lines, therefore, is the government-run social insurance scheme, Medicare. Even though recent efforts have been made to extend Medicare coverage to self-employed persons, including farmers and fishermen, it still remains true that

Medicare covers only about 20 percent of the total employed labor force. (This) . . . is directly traceable to the slow structural transformation of the economy. A large proportion of the labor force remains in the hard to cover/hard to enroll agricultural and service sectors (Herrin et al. 1993, 27).

In the present study, 25.3 percent of all households were found to be covered by Medicare. This figure is both surprising (insofar as it is higher than the national-level statistic cited above) and to some extent misleading. As a closer look at the data on Medicare coverage will show, this overall figure may be attributed almost entirely to the very high coverage rates (90 percent) found among the sugar and rubber workers selected in our sample. But these groups, it should be recalled, represent only a very small segment of the poverty class households now residing in Mindanao. Numerically speaking, the small farmer group is much more important. As such, it seems unlikely that Medicare coverage for the rural poor in the Misamis-Bukidnon area will be any higher than a mere five or six percent.⁹

Even though government-run social insurance schemes are usually viewed as having only limited applicability outside the urban,

formal sector labor market, this need not always be true. In the case of Brazil, for example, the social insurance system

has expanded rapidly since the 1960s, extending coverage from 23 percent of the economically active population in 1963 to over 85 percent by 1984. Coverage of rural areas and indigents has been accomplished by federal subsidies, acreage taxes, taxes on agricultural sales, and taxes on rural employers (Akin 1987, 217).

Indeed, an expanded Medicare system, one which is intended specifically for small farmers and agricultural laborers, is now being piloted in Bukidnon province.

Prospects for achieving success in this effort, however, appear to be mixed at best. On the one hand, there is an expressed demand for social insurance. When respondents who were not covered by Medicare were asked if they would like to have this privilege, nearly all (94.8 percent) replied in the affirmative. Most persons, too (91.9 percent) agreed with the suggestion that Medicare should be extended to anyone desiring coverage, even if they did not hold a "regular job." At the same time, though, it is apparent that several practical problems remain unsolved. For one thing, it will no doubt prove difficult to obtain a steady flow of Medicare payments from the rural poor. As we have seen, incomes are low and highly irregular. Collections, too, will not be easy to make, particularly for the dispersed and often inaccessible members of the small farmer group.

While most respondents are willing to pay something for insurance coverage, fewer still may be ready to come up with any sort of substantial payment for this. It is interesting to note that a majority (64 percent) of the respondents who were already covered by the Medicare program answered "no" when they were asked if they would be willing to have a larger sum deducted from their regular salary "in order to have more benefits from Medicare."

One of the strategies which will be employed by the program now being piloted in Bukidnon will be to make enrollment compulsory for members of certain nongovernmental organizations. This approach seems sensible since it should help to accelerate an expansion in program membership and circumvent the threat posed by the "adverse selection problem" (Akin 1987, 213). At the same time, though, it should not be forgotten that many rural households do not belong to even a single NGO. In the present study this latter figure reached 44.2 percent. We also found several barangays with little in the way of large or active community groups.

Another problem associated with insurance schemes is their tendency to drive up medical costs by artificially increasing the demand for health services. (Sick but insured persons will be more willing to try all possible health care options insofar as they will not be the ones to personally pay for such services.) We can get some insight into this possibility by comparing hospitalization levels among the sugar- and rubber-worker households (for whom Medicare coverage is nearly universal) with households coming from the other six study communities.

Our hypothesis in this case (that hospitalization rates will be highest among the sugar and rubber workers) is supported. Overall, 78.8 percent of the combined sugar/rubber group had sent someone to the hospital on at least one occasion. The comparative figure for all other respondents is only 57.4 percent. This difference is large enough to attain statistical significance. Conversely, the sugar/rubber group was also found to be significantly less likely to say that there had been a time when they did not bring a family member to a doctor because of a lack of ready cash.¹⁰ Overall, then, it is likely that an expanded Medicare program would inflate somewhat the demand for medical services. Whether this is indeed a "problem," though, or actually an opportunity to work towards improved health care coverage is left for the reader to decide.

The basic concept involved in the community financing approach is that collective action is undertaken by a locally-based organization so as to pay in some way for the community's health services. This could involve community-level insurance plans, capitalization schemes (e.g., a sanitation fund for toilet construction), or efforts to set up cooperatively-run health centers or pharmacies. Payment may involve local taxes or individual contributions in cash, in kind, or even in the form of voluntary labor. To generalize, "self-help on a mutual basis is . . . the cornerstone of community action" (Abel-Smith and Dua 1987, 45).

Data from several questions on the survey instrument can help us in assessing the efficacy of this approach. In general, our results would seem to show that some major problems still exists in this regard. To begin with, none of the various schemes listed above had yet been undertaken in any of our eight study communities. As a result, only 1.6 percent of our respondents could claim that they belonged to a community group which offered some sort of health care financing privileges. Even some of these were only borderline cases. (One respondent belonged to an informally organized "huluga" while

two others mentioned the local Barangay Health Workers Association.) Nor does it seem likely that many such programs have been initiated in the Bukidnon-Misamis area. Among the 315 respondents who did not claim membership in such a group, only two of these had even *heard* of any such program.

For the community-based approach to succeed, at least three prerequisites will be needed. First, there must be a 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 (e.g., Castillo 1983, Chapters II and VIII). Data from the present study on viable NGOs and the readiness of the rural poor to enroll in the same also show some weaknesses in this regard.

One strategy for overcoming these problems might be for the government itself (e.g., through the DOH) to initiate a community-based program in primary health care. Again, this would represent an effort which would depend heavily upon organized inputs from local residents. While such an approach may sound workable in theory, actual field studies have turned up a number of problems, not the least of which concerns the all-too-predictable tendency to transform this "bottom-up" approach into the more commonly found (in government programs at least) "top-to-bottom" model (e.g., Bautista, Mariano, Sia and Sodusta 1994).

A second requirement for any such program will be to recruit members who are enthusiastic, active and able to make a useful contribution to community-level projects. On a strictly attitudinal level there is some evidence that these goals can be met, as shown by the positive reactions which our respondents gave to a series of questions about "self-help" projects like helping to "repair the school building or to work at the community health center." Every respondent from the present study agreed that such projects were a "good idea" and most (86.6 percent) averred that they themselves would be willing to join in such an effort. Further still, nearly all (97.8 percent) of this latter group said that they would go on helping even if it became evident that "many" of their neighbors were not doing likewise.

More problematic, however, are this study's findings about the type of help which the rural poor would be able to extend to such efforts. We have noted above that some groups (in particular, the corn and coconut farmers) are now getting on in years. Health problems are not uncommon in these households and work experience outside of farming or fishing is rare. Educational levels are low. As

such, when our respondents were asked specifically about the types of skills which they could contribute to a community-based self-help project, a majority were forced to answer that neither they nor their husband had anything much to offer along these lines.¹¹ About one out of five husbands were said to know some carpentry and smaller numbers (as was true for their wives) had picked up some other "blue collar" skill through the years, but few seemed ready to serve as typists, accountants, bill collectors, or paramedics, even though these would probably represent the most useful skills for a community-based health care project.

A third dimension to consider is the financing issue itself. To be sure, there are cost reductions that can be realized when a sufficiently large number of beneficiaries are brought together. It might also prove possible for local governments to come up with some sort of subsidy. But sooner or later the group members will have to make a definite economic input of their own.

We therefore come to the question of the respondent's willingness and ability to contribute to a prepaid health care plan. By way of contextualizing this question, it might be useful to point out that one highly publicized and Mindanao-based program of this variety (the Doctor's Medical Mission of Davao City, a health services cooperative) was in 1992 requiring its members to pay an annual premium of P1,200 along with an added P365 for each additional family member. For a household with six members (the average for our study sample) this would therefore come to a little more than P3000 per year.¹²

It is evident that many of our study respondents would have only a very small chance to qualify for such a plan. This is certainly true for the rice workers, given their annual cash incomes of less than P12,000. Most of the other groups are also earning very little, while the rubber and sugar workers (two groups which rank reasonably high in this regard) would probably decline to join on the grounds that they already have Medicare coverage.

Much the same conclusion is reached when we inspect answers given to three survey items which specifically inquired into this matter. The first of these asked the respondents 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 said that they would like to do this, thereby showing some sort of broad support for the general concept. When a follow-up question was posed on the amount which the family could "afford to pay every year" for this, though, the average

amount mentioned was a mere P163, while the median (P100) was even lower.

A supplementary item mentioned a "special card" (like those used in "some countries") that would entitle the bearer to free consultation with a physician and reduced hospital bills. It then went on to ask the respondent if she would be willing to pay an amount of P250 every year "in order to get a card like that." Overall, 70.9 percent of the respondents said that they would be able to pay this amount, a statistic which indicates fairly wide support for this idea. Even so, nearly one out of three respondents (and 36.5 percent of the small farmers—who comprise a large majority of Mindanao's rural poor) said that they could not meet this minimum fee. Note, too, that the amount involved here is still only *one-twelfth* of the average figure required for enrollment in the Davao plan.

By way of summing up, reference might perhaps be made at this point to a parallel study of health care financing needs among the *urban* poor which was carried out at the same time as the present research project (Malanyaon 1994). Without downplaying the many difficulties faced by poorer households now living in Philippine cities, it is interesting to note that data on this group show them to hold several "advantages" over their rural counterparts. Comparing the two studies, we find that the urbanities had higher cash incomes, on average, and fewer persons per household to provide for. They were also younger, better-educated and more likely to have joined an NGO. It is within this group, therefore, that the goal of finding a sufficiently large number of enrollees for a community-based health care program might prove easiest to meet. In comparison, the viability of this approach within the context of the Philippine countryside appears questionable.

While social insurance schemes and community-based projects would at first appear to make some sort of "contribution" to the plight of the rural poor, the preceding discussion has demonstrated that they also imply some definite (and perhaps insurmountable) costs. In contrast, a somewhat opposite situation prevails in the case of policies which would call for increased health service user fees. On the face of it, this approach seems to be onerous to the poor, because of the financial costs involved. And yet there may be hidden benefits as well:

The most common consequence of negligible prices for health care is that waiting time begins to act as an allocative device . . . As lines

get longer, people pay a higher price in terms of time rather than cash. A second consequence of excessively low prices is that the quality of the service is driven down by lack of resources to the point that it is worth no more to customers than the low price charged, and the waiting lines melt away. A third consequence . . . is that customers begin to seek differential access to the service based on personal connections, employment, position or geographical location.

. . . Often conditions are so unpleasant in government facilities that people completely avoid them despite low nominal prices (Griffin 1987, 106).

Research carried out in the Northern Mindanao area has tended to support these conclusions, e.g., with regard to low utilization rates for local-level health centers (the Barangay Health Stations, or BHS) and clientele concern about the quality of care provided by BHS clinic personnel and facilities (Palma-Sealza 1993).

While the present study did not collect enough information to allow any sort of accurate estimate of the "correct" price for DOH medical services in depressed rural communities, it did come to two rather clear conclusions on this issue. First, it is apparent that people in these areas do understand the problems pointed out by Griffin, particularly with regard to the charge that public sector facilities are providing lower quality health care than is generally found in the private health centers. Secondly, and as a consequence of the prior conclusion, most members of the rural poverty class *are* willing to enter into some sort of payment scheme, as long as this will bring with it an improved quality of care.

Regarding the latter issue, there are actually two comparisons involved. The first of these concerns comparative preferences *within* the public sector system, i.e. between the Barangay Health Station and higher-level DOH facilities (e.g. publicly operated hospitals in provincial or regional capitals). Even though the latter option involves greater travel and time costs, it is interesting to note that 79.7 percent of our survey respondents claimed that they would rather bring a sick family member "straight to a DOH hospital" than to first visit the BHS. Apparently, the local clinics are not well regarded by most rural folk. The chief criticisms here appear to be that these facilities are unable to offer either a well-trained modern practitioner or anything much in the way of equipment and medicines (Palma-Sealza 1993).

Even so, there would also appear to be some doubts about the nature of the services available in the public sector hospitals. On a

survey item which asked the respondents about their preferences for a public- or private-sector hospital "if the costs were the same," a full 86.2 percent chose the second of these two alternatives. Even more revealing, perhaps, is the claim by 56.6 percent of the respondents that, should it prove necessary to bring someone in their family to the hospital "right now," they would opt for a private facility rather than a public one. And this, of course, is with the full knowledge that the costs will by no means be "the same" in this case.

Only one survey item asked specifically about user charges. This read as follows:

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. 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. This is particularly true for consultations which would involve a doctor and/or a better-equipped health care facility, with considerably less enthusiasm being voiced out for Barangay Health Stations and the midwives who staff them.

Conclusions and Policy Implications

Two major conclusions would appear to stand out from the preceding. These deal, on the one hand with the increasing complexity of rural poverty in the Philippine setting and, on the other, with the variant prospects for success implicit in the three approaches to health care financing discussed herein.

On the rural poverty issue it may be useful to review the somewhat one-dimensional picture of this phenomenon that was commonly held only a few decades ago. The emphasis at this time, whether it be found in works of fiction like "Hunger in Barok" (Gonzales 1979) or in the more formal sociological literature (e.g., Lynch 1959), was generally upon a rigid two-class social system which separated landlords and tenants, *patrons* and their clients. The

situation now, however, is clearly one of much greater complexity. For one thing, there has been a noteworthy expansion in rural-based nonextractive occupations over the years (e.g., Fabella 1986). Greater attention has also been paid to small-scale fishermen (e.g., Ardales and David 1985) and to the many households which now support themselves through a multiplicity of sustenance strategies, rather than just a simple concentration on farming (Costello 1990). In the formerly frontier setting of Mindanao we now have the phenomenon of a small farmer class which could legitimately be characterized as living in rather deep poverty even though they hold some form of ownership rights over the land they till. Indeed, continued population growth, coupled with a virtual standstill in the opening up of new agricultural lands, has now reduced average farm size in the North Mindanao region to a mere two hectares (Office of the NSO Administrator 1993), a level which can scarcely be expected to result in a very high living standard.

Another important change concerns the rapid expansion which has taken place in the number of landless agricultural workers. This group enjoys even fewer tenure rights than may be found within the traditional tenant class. As such, writers of a Marxist bent have tended to view its growth as evidence for the processes of rural "proletarianization" and "immiseration" (e.g., Eviota 1983). Mainstream analysts, too, have taken only a slightly less alarmist view, most typically portraying this class as the "poorest among the rural poor" (Ledesma 1982, 204) or "more deprived, poorer, and more disadvantaged than the farmer" (Castillo 1979, 85).

Our data, however, do not show close conformity to the assumed hierarchy of owners, tenants and landless workers. Rather, the landless workers were in some instances faring somewhat better than the small farmer or fisher groupings, at least as far as a number of health care financing indicators are concerned. While this is an unexpected finding, it is not a completely anomalous one. In particular, various analysts who have looked into the increasingly problematic situation of small farmers in the Philippines have already presented several reasons for expecting that this group may be suffering from a relative decline in its economic and social status.¹³

A major reason for these complexities lies in the role which large-scale, corporate farming enterprises may now be playing in the Philippine countryside. In the present study the impact of this factor has been demonstrated by our data on households headed by workers in Bukidnon's newly emerging sugar and rubber industries. It would

be a mistake, of course, to romanticize the working conditions found on the province's large-scale plantations. There is little reason to believe that workers on these large and highly capitalized farms will ever attain long-term job security or much in the way of cash savings and material possessions. But neither are they victims of a complete and unfettered economic exploitation. In general, underemployment seems to be less endemic in these communities than was true for the rice-growing area. Cash incomes are therefore higher and somewhat more stable, both in comparison to the landless rice workers and the bulk of the small farmer households. There are also certain health-linked occupational benefits, most notably the workers' access to company-funded health clinics, to Medicare, and to short-term loans or cash advances from employers. We have found as well that within the sugar and rubber worker groups hospitalization levels are higher, while fewer such families report themselves as having neglected to go to the doctor, due to a lack of ready cash.

In addition to their role in extending health care benefits to the rural poor, corporate farming enterprises may offer other advantages. They seem to be associated with improved living standards in the community-at-large (Costello 1989b) as well as with the expansion of nonfarm work opportunities (Hackenberg 1980; Sealza 1984). This latter trend could prove particularly helpful to rural women, who have heretofore encountered substantial difficulties in entering the labor market (Costello 1991). Corporate farms specializing in export-linked cash crops may also be better positioned to benefit from the new international economy that is now evolving under the aegis of the GATT accord.

For their part, small farmers specializing in rice, corn and other staple crops might well be advised to move towards some form of joint corporate activity, such as cooperative farming, compact farming or the like (Ledesma 1981). At a minimum this ought to facilitate the extension of certain health care benefits (e.g., Medicare). Hopefully, it can also lead to improvements in productivity and marketing that will bring higher living standards.¹⁴

Comparing the different health care financing options reviewed in this article, one's first impression is certainly that there will be problems in successfully implementing *any* of these.

To a certain extent this seems an unavoidable dilemma, given the magnitude of the health care needs now prevailing among poorer rural households, coupled with their absolute paucity of economic resources. With monthly cash incomes averaging only about P1,500

(U.S.\$27.00), members of Mindanao's rural poverty class are obviously not going to be able to come up with the money needed to fully cover the costs entailed by either a per visit user fee system (i.e. for modern sector health care) or any sort of viable social insurance program. Nor does it seem feasible to set up a system whereby they can contribute in kind or in labor rather than in cash.

Community-based programs that involve payments on a pre-need basis seem particularly unlikely to work. Efforts to promote strong and financially sound NGOs in the rural areas of the country have not been immediately and fully successful, a conclusion which is also supported by data from the present study. Many poorer households are not at present linked with an NGO or a People's Organization (PO). And even for those who do possess this sort of affiliation, the amount of money which they feel capable of contributing to such a scheme is very small indeed, averaging only about US\$5 to \$10 per year for a family of six members. As we have seen, this is a much smaller amount than that which is now being charged by Mindanao's more successful (and urban-based) health care cooperatives. We thus agree fully with an evaluation of two community-based projects from Luzon which concluded 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. . . . (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, 28).

In comparison, government insurance programs suffer from neither the disadvantage of being "untried and untested" nor the difficulty of attracting members. Indeed, most of the small farmer, fisherfolk and rice worker households asserted strongly that they would like to be covered by this program. Again, however, doubts must be raised on the affordability issue as well as on the means by which monthly payments could be remitted within such schemes. Perhaps some sort of system could be worked out with the larger church and NGO groups, as is now being attempted in Bukidnon province. To a large extent, though, the most effective way of expanding Medicare coverage may simply be to put in place a set of appropriate macro-level economic programs, so as to accelerate rural development and structural changes in countryside employment patterns.

This leaves us, then, with the user charges approach. Our results are perhaps least pessimistic in this regard, since most households are willing to contribute something along these lines and ongoing linkages with relatives, friends and/or employers make it likely that most families will be able to borrow some amount of money during a medical emergency. Indeed, respondents are already quite aware of private sector medical practitioners, and often choose them as their first curative resort, despite the additional costs which this entails. It is also at least theoretically possible that a system of moderate user charges would serve to give poorer rural households a greater sense of *control* over public health personnel, particularly as the overall system moves towards a more devolved model.

According to at least one set of observers (Caldwell, Gajanayake, Caldwell and Peiris 1989), greater attention to those sorts of "political" issues will be needed before substantial improvements can be made in the mortality situations of less developed countries.

All of which is not to say that the answer lies in a strictly *laissez-faire* approach to the problem. Ideally, user charges would be adjusted according to the household's ability to pay. Establishing standards for this will not be easy, but certain gross criteria could perhaps be adopted (e.g. reduced charges for the elderly, for highly marginal farmers and fishermen, for preventive services). It might prove possible as well to offer free or greatly reduced charges during certain days of the week, thereafter allowing the resulting costs in time and status degradation to sort out the truly indigent from those who suffer only from below-average living standards.

It also seems inevitable that revenue from a user-fee system would eventually have to be supplemented by some sort of government subsidy, particularly in the case of poorer and more isolated communities. Present signs point to the beginning of a long-awaited but largely urban-based recovery on the part of the Philippine economy. If anything more than lip service is to be paid to the ideal that health care is a basic human right, however, it is evident that a way will have to be found for channeling some of this new wealth to peripheral rural communities where they can be used to support basic health care services for the very poorest groups.

Notes

1. Overall (univariate) statistics will also be presented. These, however, should be interpreted with some caution since they give equal weight to each of the eight study groups despite the fact that some of these may represent a much larger proportion of Mindanao's overall rural poverty class than do others. For example, there are many more small corn growers in Mindanao than there are landless workers in the island's rubber industry.

2. A ten-item scale of consumer goods ownership was also constructed. The rubber workers were found to rank highest on this whereas the upland farmers and the rice and sugar workers fared most poorly in this regard.

3. Farming on public land was particularly common in the upland barangay. Only about half of the forty-four farmer-owners actually held title to their land.

4. Because of the younger age composition found for the latter two groups, it is likely that controls for age would show their mortality situation to be the most problematic of all. (I.e. the fisherfolk-children are older on average and have therefore been exposed to the probability of dying for a longer period of time than is true for either the upland farmers or the sugar workers.)

5. In all, 59 percent of all households had undergone such a consultation. In more than three-fourths of these cases a consultancy fee was paid (the median amount spent was between P10 and P20). Most consultations also involved travel costs or charges for medicines. The median amount spent on travel ranged from P5 to P10 but the charges for medicine were substantial indeed, with the median category in this case being P100 to P250.

6. The exchange rate during the two year period preceding the survey hovered at around P25 to US\$1.

7. When asked if they believed that they could borrow money, only 77.5 percent of the rice workers answered "Yes." The average amount expected among members of this group was a mere P230, the second-lowest figure noted for the eight-group typology. (The coconut farmers ranked lowest of all in this regard.)

8. A little more than twenty percent of the farmers had acquired some savings as compared to 7.5 percent of the fisherfolk and a mere 2.5 percent of the landless agricultural workers.

9. None of the landless rice workers and only four percent of the households in the other five poverty groups were covered by Medicare. As indicated above, any attempt to come up with a regional-level estimate of Medicare coverage among the rural poor, as based on data collected in this study, would have to assign greater weights to the statistics for the larger groups (i.e. the corn and coconut farmers) and smaller ones for the sugar and rubber workers. (According to the 1981 Census of Agriculture more than two-thirds of all farms in Region X were growing either corn or coconuts. Less than one percent were cultivating either sugar or rubber. Cf. Costello 1989a, Table 7.2)

10. Overall, only 7.5 percent of the sugar/rubber workers had experienced an occasion when financial problems precluded this sort of health care response. Among members of the other six groups, though, this figure stood at 30.5 percent (Chi-square = 17.08, $p < .001$).

11. Seventy-four percent of the respondents answered "none" when asked about their own skills while 54.5 percent asserted that their husband had no special skill.

12. Figures on the cost of joining the Davao cooperative health fund have been taken from Arguillas (1992). Also see another article by this same author (Arguillas 1993) in which she quotes Health Secretary Juan Flavio as enthusiastically proclaiming this approach to be the "wave of the future."

13. Cf. for example, Umehara (1983) on the increasing costs of agricultural inputs and Costello (1989a) on diminishing farm sizes. Also see Arsenio M. Balisacan's (1991, 22) analysis of Philippine rural poverty which concludes that "the intensity of poverty for . . . self-employed households . . . is as severe, if not more severe, than that for wage-dependent households. In agriculture, the poor self-employed heads of households include primarily lessees, tenants, and small owner-cultivators. This group constitutes the largest single block of the total poor...in rural areas."

14. Recent reports (e.g. Anonymous 1994a) indicate, however, that economic prospects in the rice and corn industry are not good. The expected ratification of the GATT accords has also been widely perceived as disadvantageous to small-time producers in rice and corn. According to one news report (Anonymous 1994b), about 45,000 jobs will be lost in the Philippine corn industry once this is ratified. A spokesman for the Department of Labor and Employment was quoted as saying that this agency is preparing several "safety net programs" to deal with this, e.g. entrepreneurial assistance and manpower trainings. Data presented in this study, though, place some doubts on the efficacy of such an approach. In general, we found corn farmers to be old, poorly educated and geographically isolated.

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