

**BEYOND SOCIOECONOMIC STATUS:
SOME IMPLICATIONS FOR PLANNED
HEALTH INTERVENTIONS AMONG THE POOR**

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INTRODUCTION

Two essential issues emerge in the local literature dealing with the use of health services among the poor. First, studies have drawn different conclusions regarding the question of whether the poor make use of health services, and whether they benefit at all from the services extended to them particularly by public health agencies. The findings of Bautista (1988), Jimenez et al. (1986) and the DLSU Research Center (1983 and 1984) reveal that the poor avail themselves of health services, particularly those delivered by the public sector. Other studies, meanwhile, show that the poor consistently underutilize health services. Moreover, they claim that they do not receive the full benefits of the services to which they are entitled (Carifio et al. 1982; Joves 1979; Solon and Popkin 1986; Akin et al. 1985). Some of these studies further point out that, despite the government's efforts, it is often the middle class, if not the most privileged, who take precedence over those who are more in need.

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Second, the existing local literature also indicates, upon closer scrutiny, the insignificance of certain individual attributes in explaining the utilization of health care services among the poor (Akin et al. 1985; Ching 1986, 1989; Jimenez 1986; Lamberte 1990). If such is the case, then it is important at this point to raise the question: What are the factors that determine the use of health services among the poor? Do the poor avail themselves of health care services, particularly those provided by the public sector?

This paper primarily aims to discuss the insights derived and the lessons learned from two research studies that were recently conducted among families in rural Leyte and the urban poor of Metro Manila. The first study, entitled "Determinants of Maternal Health Care Utilization Among Rural Women: The Case of Three Barangays in Leyte," was conducted from April 1989 to July 1990. The second, entitled "Health and Nutrition Status of and Health Seeking Behavior Among Families in High Risk Urban Communities," was undertaken from November 1991 to October 1992. The discussion is limited to the use of health care services among rural and urban poor families, specifically the use of public and private health facilities and the services of the health functionaries (namely, the doctors).

OVERVIEW OF THE TWO RESEARCH STUDIES

Among their many objectives, the two research studies sought to identify the factors that determine and contribute to the use of health services and facilities among poor families. The first study mainly aimed at ascertaining the determinants of the use of health care services. The second study, on the other hand, had a broader coverage than the first one, and was actually a baseline research meant to gather benchmark information about the health and nutrition status of families in high risk urban poor communities, specifically Kalookan, Tagig and Pasig (see Table 1 for an outline of the objective of the two studies).

Apart from the focus by the two studies on the use of health facilities and doctors' services, both also made use of a combination of four basic research designs—namely, survey method, document study, observation,

TABLE 1
Research Objectives

Determinants of Maternal Health Care Among Rural Women	Health and Nutrition Status of and Health-Seeking Behavior Among Families in High Risk Urban Poor Communities
I. General	Part I: Epidemiological Study
<p>The study generally aimed to determine the patterns of use of maternal health care services among women in a poverty stricken rural setting, and the factors accounting for the differential use of the services.</p>	I. General
II. Specific	II. Specific
<p>It specifically addressed the following questions:</p>	<p>A. To ascertain the prevalence of the following events within the past year:</p>
<p>A. What is the utilization pattern of maternal health care services among rural women in poverty stricken areas?</p>	<p>1. death, including pregnancy wastage and/or unwanted pregnancies;</p>
<p>B. What individual attributes of these rural women exert influence on the use of maternal health care?</p>	<p>2. prevalence of tuberculosis; 3. prevalence of cardiovascular diseases; and</p>
<p>C. What organizational factors influence health care services?</p>	<p>4. prevalence of drug abuse, smoking and the drinking of alcoholic beverages.</p>
<p>D. What structural characteristics of the community are related to the use of services?</p>	<p>B. To ascertain the socioeconomic and cultural factors influencing the decision to seek or not to seek medical help;</p>

TABLE 1 (continued)

C. To identify the varying types of health services availed of by the families and the sources of these services;

D. To determine the factors influencing the use of health facilities among urban poor families;

E. To provide information on the incidence of families' encounters with health service agents and the awareness of the families regarding health promotion campaign activities undertaken in the areas;

F. To determine the pattern of response and dispositions of the urban poor toward initiatives on community-based health activities which are anchored on community participation.

Part II: Health-Seeking and Health Service Utilization Behavior

I. General

To determine the health-seeking behavior and health maintenance practices among the urban poor families.

II. Specific

A. To identify the pattern and stages of health-seeking behavior among urban-poor families, specifically:

1. food allocation among family members;
2. growth monitoring for pre-school children;
3. breastfeeding and weaning practices;

TABLE 1 (continued)

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4. adolescent pregnancies and maternal care practices;
 5. care of preschool children;
 6. value placed on sanitary toilet practices.

B. To provide a demographic and economic profile of family members who experienced the above events;

C. To inquire into the occurrence and reasons for hospitalizations and medical consultations;

D. To determine the prevalence of common infectious and communicable diseases in the selected high-risk communities. Of specific interest are the prevalence of:

1. diarrheal diseases;
2. respiratory diseases;
3. tuberculosis.

E. To determine the prevalence of malnutrition among preschoolers in these communities;

F. To ascertain the environmental risks to health among the urban poor;

G. To provide information on the health impact of pollution and other community problems in the areas.

and life histories. Further, they utilized similar methods of data collection—namely, face-to-face structured interviews, direct observation, unstructured in-depth interviews, and the use of secondary data. A description of the research methodologies of the two studies is provided in Table 2.

RELEVANT FINDINGS OF THE TWO RESEARCH STUDIES

Salient findings common to the two studies are worth noting. The overall results on visits to doctors indicate that more than the majority of the families visited and/or consulted doctors. In the case of rural Leyte, the most frequently visited of all the facilities was the rural health unit. In the case of the three municipalities in Metro Manila, the most frequently visited facilities were the barangay health centers and the public hospitals. Doctors extending services at the barangay halls, as in the case of those who provided free consultation services, and at the mobile clinics roving around the areas were also consulted by the families. Given the accessibility of the latter, it is not surprising to discover that even the poorest families or those belonging to the lowest income quartile were able to consult doctors within the past six months. Only a small percentage of the families consulted doctors in private clinics and hospitals.

Moreover, families availed themselves not only of the curative care services extended through the public health facilities, but also of preventive care services such as immunization, family planning, pre- and postnatal care, and medical advice. Thus, families went to health centers not only when someone was sick but also when they wanted to avail themselves of the preventive care services extended by the centers. In both studies, it was found out that the most frequent visitors at the health centers were children aged six years and below and married women of varying ages.

Most of the respondents reported satisfaction with the services extended by the public health facilities. In both studies, the sources of dissatisfaction cited by a few respondents were: (1) the lack of available medicine/drugs and vitamins at the centers/health units; (2) the long queue; (3) the absence

TABLE 2
Research Methodology

Determinants of Maternal Health Care Among Rural Women	Health and Nutrition Status of and Health-Seeking Behavior Among Families in High Risk Urban Poor Communities
<p>I. Method of Data Collection</p> <p style="padding-left: 20px;">A. Face-to-face structured interviews</p> <p style="padding-left: 20px;">B. Direct observation</p> <p style="padding-left: 20px;">C. Unstructured in-depth interviews</p> <p style="padding-left: 20px;">D. Use of secondary data</p> <p>II. Geographical Coverage and Subjects</p> <p style="padding-left: 20px;">A. Three barangays representing major types of rural-based economic activity and the level of organization of health care coming from three municipalities of Leyte.</p> <p style="padding-left: 20px;">B. Three groups of respondents were covered:</p> <ol style="list-style-type: none"> 1. 136 married women 2. 15 years old and above 3. health district personnel 4. barangay health workers 	<p>I. Method of Data Collection</p> <p style="padding-left: 20px;">A. Face-to-face structured interviews</p> <p style="padding-left: 20px;">B. Direct observation</p> <p style="padding-left: 20px;">C. Unstructured in-depth interviews</p> <p style="padding-left: 20px;">D. Use of secondary data</p> <p>II. Geographical Coverage and Subjects</p> <p style="padding-left: 20px;">A. Fifteen depressed barangays representing various levels of access/deprivation of basic social as well as infrastructural services and locales (e.g., near esteros, near factory, resettlement areas, etc.), all from three municipalities of Metro Manila.</p> <p style="padding-left: 20px;">B. Two groups of respondents were covered:</p> <ol style="list-style-type: none"> 1. 720 families represented by mothers and/or household heads 2. Unstructured interviews with 50 health personnel

TABLE 2 (continued)

C. The main respondents, the married women, were randomly selected.

C. Stratified random sampling was used in the choice of barangays while systematic random sampling was utilized in selecting the sample families.

III. Method of Data Analysis

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B. Statistical tools used were:

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1. Description statistics, such as percentages, mean, median, mode and standard deviation;

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2. Measures of association were also used particularly for nominal and ordinal types of data, namely, gamma, Cramer's coefficients and chi-square;

2. Measure of correlation and association, namely, Pearson r , Gamma coefficient, Cramer's coefficient, and chi-square;

3. Regression analysis specifically least squares and stepwise regression analysis;

C. Contextual analysis was also used as a mode of analysis for qualitative type of data.

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or physical inaccessibility of the doctor; and (4) the impersonal treatment of the patient by the doctor or by some other health personnel in the center.

With regard to factors that contribute to the various reasons for visiting doctors in health centers/units, the two studies provide interesting findings. The study in rural Leyte showed that organizational and community factors serve as critical variables in the use of health services. Specifically, the visits to health facilities and health functionaries were not mainly attributable to the individual characteristics of the respondents, but more importantly, to the structural conditions of the community (its economic status) and the quality of interventions that health organizations have made in delivering services to the target beneficiaries.

In particular, correlation results (Table 3) show that in a relatively economically developed barangay with an organized health care delivery system, individual characteristics of the respondents (such as need, represented by number of disability days, level of living, and education) were significantly related to the visits to rural health units. In addition, organization-related variables such as home visits conducted by health personnel, satisfaction with services provided by RHUs, and extent of respondents' knowledge about primary health care were also revealed to be related to the frequency of respondents' visits to the rural health unit. In a relatively poor barangay with a less organized health care delivery system, meanwhile, individual predisposing characteristics such as age and family size were found to be related to the frequency of visits to the RHU. Interestingly, in the poorest barangay which coincidentally had a well-organized health care delivery and health personnel who exhibited a greater commitment to educating residents about health practices, individual characteristics and organizational related factors were found to be significantly related to frequency of visits to the RHU.

Correlation results from all the barangays taken together indicate the importance of the level of economic development and the level of organization of health care in the community with regard to the visits to RHU. This is demonstrated by the dummy variable from the community representing the relatively high level of economic development and the dummy

TABLE 3
Point Biserial Coefficients and Chi-square Values for Visits to RHU

Independent variables	Visit to rural health unit			
	Concepcion	Tagbibi	Punong	Total
Dummy for Concepcion	—	—	—	$X^2 = 46.1163^{**}$
Dummy for Punong	—	—	—	$X^2 = 8.4299^{**}$
Home visits of personnel	$X^2 = 3.3195^*$	$X^2 = 0.3234$	$X^2 = 0.0874$	$X^2 = 6.2030^{**}$
Age	$r_{pbi} = 0.1189$	$r_{pbi} = -0.4766^{**}$	$r_{pbi} = 0.2142$	$r_{pbi} = -0.0106$
Family size	$r_{pbi} = -0.1782$	$r_{pbi} = -0.4234^{**}$	$r_{pbi} = 0.1172$	$r_{pbi} = -0.1674$
Employment status	$X^2 = 0.4485$	—	—	$X^2 = 8.3109^{**}$
Type of occupation	$X^2 = 0.0645$	$X^2 = 0.0030$	$X^2 = 0.0566$	$X^2 = 0.0041$
Extent of RHU services available	$r_{pbi} = 0.0298$	$r_{pbi} = 0.1135$	$r_{pbi} = 0.0468$	$r_{pbi} = 0.0098$
Satisfaction of services received at RHU	$X^2 = 5.4741^*$	$X^2 = 0.4742$	$X^2 = 0.4494$	$X^2 = 2.5321$
Education	$r_{pbi} = 0.2421^*$	$r_{pbi} = 0.1328$	$r_{pbi} = -0.2170^*$	$r_{pbi} = 0.0786$

TABLE 3 (continued)

Independent variables	Visit to rural health unit			
	Concepcion	Tagbibi	Punong	Total
Level of living	$r_{pbi} = 0.4287^{**}$	$r_{pbi} = -0.0923$	$r_{pbi} = -0.1819$	$r_{pbi} = 0.1953$
Extent of knowledge about RHU services	$r_{pbi} = 0.1686$	$r_{pbi} = -0.1680$	$r_{pbi} = 0.1023$	$r_{pbi} = 0.2708^*$
Affordability of physician's fee	$X^2 = 0.4813$	$X^2 = 0.2652$	$X^2 = 0.0008$	$X^2 = 1.0737$
Extent of information about PHC	$r_{pbi} = 0.3198^*$	$r_{pbi} = 0.1478$	$r_{pbi} = 0.4487^{**}$	$r_{pbi} = -0.2484^*$
Number of disability days due to illness	$r_{pbi} = 0.2528^*$	$r_{pbi} = -0.0776$	$r_{pbi} = 0.0634$	$r_{pbi} = -0.0187$

* Significant at 5% level

** Significant at 1% level

variable for the community representing the organizational characteristics of health care provision in the area. Aside from these, organizational factors such as home visits conducted by health personnel, extent of respondents' awareness about services extended by the RHU, and extent of information disseminated about primary health care were also significantly correlated with frequency of visits to the RHU.

In terms of visits to the RHU physician within and outside the RHU facility, results show that the percentage of respondents who visited the RHU physician is higher in the less economically developed barangay with a better organized health care delivery than in the barangay that is also considered to be poor but with a less organized health care delivery, and in the barangay which is economically developed.

Findings from the regression analysis (Table 4) indicate that, taken together, the frequency of visits to the RHU doctor was mainly a function of the cluster of community factors represented by the dummy variables—organizational variables such as home visits conducted by health personnel and respondents' knowledge about RHU services, the need factors indicated by family size and the number of days of inactivity due to illness, and affordability of the physician's fee.

There were significant differences in the frequency of visits to the RHU physicians with respect to the communities that have well-organized health care delivery systems and those that have less organized systems. It may be that it is not the community characteristics per se—such as social economic and cultural attributes—which determine the number of visits, but rather the organizational features of health care provisions in these barangays. This inference becomes all the more plausible because of the significant effects of home visits of personnel. The extent of knowledge of primary health care, and the services provided by the RHU—variables which are clearly associated with the commitment of the health care givers and the organization of health care.

The relative importance of the community and organizational factors in explaining the number of visits to the RHU physician can be clearly gleaned in the step-wise regression results of the study (Table 5). Results

TABLE 4
Regression Coefficients for Number of Visits to RHU Physician

Independent variables	Concepcion		Tagbibi		Punong		Total	
	B	t-value	B	t-value	B	t-value	B	t-value
Dummy for Concepcion	-	-	-	-	-	-	1.5702	1.9899*
Dummy for Punong	-	-	-	-	-	-	3.1795	3.6977**
Home visits of personnel	2.8114	1.9735*	-0.7817	0.0203	-0.1658	0.9563	1.7030	2.2901*
Age	0.1044	1.9709*	0.0911	1.8836	-0.0378	0.6245	-0.0077	0.2168
Family size	0.3187	1.2992	-0.2685	1.0677	0.4535	1.8539	0.2989	1.9553*
Employment status	-0.3471	0.2387	0.7267	0.6332	-0.2845	0.1265	-0.4339	0.5449
Type of occupation	-0.8589	0.6325	-0.6866	0.5019	-0.0541	0.0316	-0.1207	0.1449
Extent of services received at RHU	0.1154	0.5771	0.3377	1.1432	0.4328	1.0188	0.2471	1.6911
Satisfaction of services	0.6550	0.4837	-0.2535	0.4549	0.6896	0.7648	0.4661	1.2284
Education	0.3295	1.1336	-0.2112	0.9391	0.2571	1.2438	0.2814	2.0925*

TABLE 4 (continued)

Independent variables	Concepcion		Tagbibi		Punong		Total	
	B	t-value	B	t-value	B	t-value	B	t-value
Level of living	-0.1041	0.3301	-0.0981	0.3347	0.3268	0.8798	-0.2339	1.4110
Affordability of physician's RHU services	0.4401	2.6525**	0.0012	0.0001	0.1120	0.4872	2.1607	2.3095*
Extent of knowledge on PHC	0.5374	0.6549	0.3763	2.6107**	0.1648	0.6797	0.1573	1.2474
Number of disability days due to illness	0.0659	0.6626	0.0874	1.5329	0.2719	2.2235*	0.1158	2.5340**
Extent of knowledge on RHU services	0.3535	1.3864	0.0893	0.3715	-0.7269	1.1962	0.8881	2.6404**

* Significant at 5% level

** Significant at 1% level

TABLE 5
**Forward Step Wise Regression Results
 for Number of Visits to RHU Physician**

Variables	R ²	Significant level
THREE BARANGAYS		
Dummy for Punong	0.1044	0.08
Affordability of physician's fee	0.0569	0.17
Home visits	0.0330	0.29
Education	0.0277	0.34
BO. CONCEPCION, HILONGOS		
Age	0.2933	0.05
Family size	0.1857	0.08
Affordability of physician's fee	0.0841	0.22
Occupation	0.1318	0.36
Satisfaction with RHU services	0.0360	0.36
BO. TAGBIBI, HINDANG		
Satisfaction with services	0.5836	0.003
Level of living	0.0695	0.21
Knowledge on PHC	0.1370	0.05
Knowledge on RHU services	0.0707	0.10
Age	0.0284	0.26
Education	0.0725	0.02
Occupation	0.0150	0.18
BO. PUNONG, MATALOM		
Need	0.6555	0.05
Extent of RHU services received	0.2825	0.03
Knowledge on PHC	0.0535	0.07
Level of living	0.0085	0.04

show that only the dummy variable representing the community conditions and the level of organization of health care delivery was found to be significant, accounting for 10 percent of the variations. Three other variables—namely, affordability of physician's fee, home visits, and education—were also included in the model.

A look into the determinants of the frequency of visits to the RHU physician in each barangay provides further insights. In a barangay that is economically developed, the significant determinants are age and family size. In the poorest barangay with the least organized health service delivery system, three organizationally-related variables were found to have significant effects on the number of visits to the RHU physician—namely, satisfaction with the services, knowledge about primary health care, and knowledge about the RHU services. Education of the mothers was also a significant determinant.

In a poor community with a well-organized health services delivery system, organization-related variables were also found to exert an influence on the number of visits to the RHU physician. These variables were the extent of services received from the RHU and the extent of the respondents' knowledge about primary health care. Level of living and need as measured by the number of days the respondent was inactive due to illness, were also revealed to be significant determinants of the frequency of visits to physician.

In summary, the study in rural Leyte showed that the community's level of development and the organization of its health care delivery system significantly determined the number of visits to the physician. Poor residents from communities with better organized health service delivery systems visited physicians more frequently.

The findings from the study among urban poor families in three municipalities of Metro Manila, meanwhile, also reinforced the interesting pattern of results in the Leyte study. It is important to note, however, that compared to the study conducted in Leyte, the mode of analysis of the data related to the utilization of health care services for Metro Manila was less rigorous. This is attributed to the fact that the objectives and scope of the

latter study were broader than those of the former. While the Leyte study aimed solely to ascertain what factors determine the use of health services among rural families, the goals set for the Metro Manila study were rather broad. As mentioned earlier in this paper, the general goals of the Metro Manila study were: (1) to provide comprehensive and detailed information about the socioeconomic conditions, health and nutrition status, and community characteristics of the high risk communities covered; and (2) to map out strategies for the planned Urban Health and Nutrition Project. The baseline data were meant to serve as benchmark information for the planned Urban and Health Project to be implemented by the Department of Health with possible funding from the World Bank. Nevertheless, the Metro Manila study provide enlightening and instructive results on the health-seeking behavior of families in high risk urban poor communities.

The overall results of the Metro Manila study indicate a pattern similar to that of the Leyte study. Correlation findings indicate that the number of visits to the barangay health physician made by urban poor families was significantly correlated with a cluster of mother-related individual characteristics and organizational variables (Table 6). Specifically, the number of visits was significantly correlated with the literacy of the mothers, the employment status of the mothers, the travel time required to reach the facility, home visits conducted by the health centers' personnel, the mothers' awareness of the services rendered at the health center, and the occurrence of illness in the family.

Results further showed that the number of visits to barangay health centers was again significantly correlated with a cluster of individual and organizational variables, among which are the ages of parents, the length of stay in Manila, the employment status of the mother, the mothers' awareness of the services extended by the barangay health centers, home visits of the barangay health personnel, and the health status of family members (Table 7).

TABLE 6
Correlation Coefficients: Number of Visits to Doctor

Independent variables	Coefficients	Probability
Age of mother	$r = 0.0477$	$p = 0.2342$
Place of origin	$r_{pbi} = 0.0199$	$p = 0.6196$
Length of stay in Manila	$r = 0.0186$	$p = 0.6427$
Educational attainment of mother	$r = 0.0050$	$p = 0.4716$
Read newspaper	$r_{pbi} = 0.2105^{**}$	$p = 0.0083$
Household size	$r = -0.0496$	$p = 0.2160$
Age of father	$r = -0.0050$	$p = 0.9028$
Educational attainment of father	$r = 0.0317$	$p = 0.4447$
Employment status of father	$r_{pbi} = 0.0193$	$p = 0.6380$
Employment status of mother	$r_{pbi} = 0.1970^*$	$p = 0.0534$
Monthly income of employed mother	$r = 0.2389^{**}$	$p = 0.0038$
Family monthly income	$r = 0.0145$	$p = 0.7772$
Total monthly food expenses	$r = 0.061$	$p = 0.6880$
Minutes of travel to hospital	$r = -0.2017^{**}$	$p = 0.0153$
Home visits to health personnel	$r_{pbi} = 0.1935^*$	$p = 0.0516$
Minutes of travel to barangay health center	$r = 0.0338$	$p = 0.3372$
Awareness of services provided by the barangay health center	$r_{pbi} = 0.1945^*$	$p = 0.0547$
Occurrence of illness in the family	$r_{pbi} = 0.3569^{**}$	$p = 0.0001$

TABLE 7
Correlation Coefficients: Number of Visits to Barangay Health Center

Independent variables	Coefficients	Probability
Age of mother	$r = -0.24001^{**}$	$p = 0.0006$
Place of origin	$r_{pbi} = 0.0501$	$p = 0.2617$
Length of stay in Manila	$r_{pbi} = -0.2500^{**}$	$p = 0.0007$
Educational attainment of mother	$r = -0.0071$	$p = 0.8728$
Read newspaper	$r_{pbi} = 0.0570$	$p = 0.1978$
Household size	$r = 0.0290$	$p = 0.4468$
Age of father	$r = -0.1932^*$	$p = 0.0388$
Educational attainment of father	$r = 0.0128$	$p = 0.7523$
Employment status of father	$r_{pbi} = -0.0067$	$p = 0.8662$
Employment status of mother	$r_{pbi} = -0.2347^{**}$	$p = 0.0001$
Monthly income of employed mother	$r = -0.0151$	$p = 0.8385$
Family monthly income	$r = 0.0119$	$p = 0.8082$
Minutes of travel to public hospital	$r = -0.0395$	$p = 0.3618$
Minutes of travel to barangay health center	$r = -0.0133$	$p = 0.7361$
Awareness of services provided by the barangay health center	$r = 0.2542^{**}$	$p = 0.0001$
Home visits to health personnel	$r = 0.2968^{**}$	$p = 0.0004$
Number of sick members in the family	$r = 0.1969^*$	$p = 0.0514$

* Significant at 5% level

** Significant at 1% level

LESSONS LEARNED

Several important points therefore emerged from the findings of the two recent studies. *First*, the use of the health services among the poor could not be generalized using a linear or continuous model. For instance, an economically poor community with a relatively well-organized health care delivery system was found to have more beneficiaries of health services than its wealthier counterparts. This signifies, therefore, that when analyzing the level of use of health services among poor families, one must consider the level of economic development of the community and the level of organization of the health care delivery system in the community.

Second, the insignificance of variables related to the socioeconomic characteristics of the families (e.g. family income, employment status and occupation of the father) indicates that the circumstances affecting the decision to avail of health services go beyond socioeconomic status characteristics of the household members. What emerged as crucial were those variables related to institutional arrangements and organizational strategies of health care delivery in the communities under study. This inference becomes all the more plausible due to the influence exerted by the variable representing (1) the level of organization of health care delivery in the community; (2) the mothers' awareness of health services provided by the health centers; (3) the range of services offered in the health centers; (4) respondents' knowledge about primary health care; and (5) home visits conducted by the health personnel.

Third, in the poorest communities, the various reasons for availing of health services are accounted for mainly by the variables related to the organization of health care delivery. Reasons for satisfaction/dissatisfaction with health services, home visits conducted by health personnel and the level of mothers' awareness of services offered by the health centers which were found to influence the frequency of respondents' visits to the centers were organization-related variables. This seemed to demonstrate the importance not only of the level of the organization of health care but also of the commitment of health care providers. As aptly posited by several sociolo-

gists, service agents indeed play a crucial role in promoting a wider use of services among the very poor.

Fourth, some individual characteristics of the families also emerged as significant determinants. These, however, need further qualification. A closer look at the data would show that these variables refer more to the demographic variables associated with the need and health status of the family, such as age, family size, and age of children below six years. The individual characteristics of the mothers also appeared to be crucial, particularly the variables on literacy, educational attainment, and employment status. The data further indicate that employment status of the mothers is more closely associated with their availability or the time they can allot to visits to the centers, rather than their socioeconomic status. Furthermore, a closer examination of the data further indicates that employment status of the mothers is more highly correlated with travel time to the health facility than with her monthly income. The negative sign of the coefficients reinforces this observation in that unemployed mothers were observed to be frequent users of the services of physicians and health centers/units.

THE IMPORTANCE OF INSTITUTIONAL ARRANGEMENTS

The importance of organizational factors, as determined by the findings in these two studies, signifies the appropriateness of formulating intervention strategies at the organization level. Many studies have emphasized the importance of capital and financial resources in interventions among the poor. It is not enough, however, to talk of such resources. As demonstrated by these studies, it is important to pay attention as also to organizational factors. One must also understand that when talking about organizational matters, one actually refers to two basic elements of the phenomenon—namely, the individuals and the institutional arrangements and/or structures composing the organization.

As can be gleaned from the two studies, in planning health interventions among the poor, there is a need to give utmost importance to health workers, particularly at the community level. This is because they embody and

symbolize the structure of the organization itself in the public mind. As these studies show, they facilitate the people's participation in health related-programs and projects. They also encourage people to avail themselves of the services rendered by the organization itself. As frontliners and principal service agents, therefore, health workers affect the reaction and responses of their target beneficiaries. Most of all, they reflect the image of the organization, which is crucial to the sustainability and success of organizational intervention. Documented cases of committed, hardworking health personnel in Leyte and in Metro Manila demonstrate this pattern. The findings of these studies show that, indeed, there are committed workers in the public service, as in the Department of Health, an observation similarly noted by Cariño (1992) in her study on the performance problems of the Philippine bureaucracy.

The institutional arrangements within the organization are also worth mentioning. Giddens, a noted sociologist, defined institutions as those modes of belief and behavior that occur and recur. They are patterns of social activity reproduced across time and space. They are also forms of social conduct that are reproduced across time spans and space. According to him, to speak of the reproduction of social conduct is to speak of the repetition of similar patterns of activity by actors separated from each other in time and space. The meaning of institution in this context is completely different in ordinary language, where it is a loose synonym for "group" or "collectivity," as when, say, a prison, school or hospital is referred to as an "institution."

The importance of examining institutional arrangements in planned interventions among the poor is emphasized in current efforts in development work and poverty alleviation strategies. The development experience suggests that an increase in resources is not sufficient for sustainable growth and for the relief of poverty. In addition to capital resources, appropriate institutional structures and arrangements must be established. Such institutions are important, according to Holt (1990), to development and poverty alleviation programs for two main reasons. First, in the absence of institutional arrangements, the benefits of the projects tend to accrue to the elite

and rarely reach the needy. Second, the institutions do not only help to distribute benefits more equitably, but also contribute to the sustainability of the projects and thus to sustainable growth.

A closer look at the organization of health care delivery under the formerly centralized setup of health services indicates the existence of a number of established institutional arrangements that were instrumental in promoting a wider use of services among target beneficiaries. *First*, the well-defined thrust of the Department of Health on the preventive and promotive aspects of health care in various communities facilitated the implementation of standardized strategies among various health centers/rural health units in the country. It was noted in communities covered by the two studies that health personnel themselves became actively involved, as part of their organizational strategy, in a health information campaign among its target beneficiaries. In addition, educational classes and short-term seminars were held in the health personnel's barangays and/or sitios, as were discussions with family members during home visits.

Second, follow-ups of beneficiaries through home visits conducted by health personnel also helped promote the wider use of health services. Frequent visits within the assigned catchment area were made as part of the weekly activities in the community. This follow-up strategy enabled the field health workers to reach out to families that needed assistance. It also enabled the workers to keep track of patients that required additional medical attention. As shown by the two studies and by some previous studies, home visits are very effective methods of reaching out to the poorest sectors, particularly those in most need of services.

Third, the promotion and implementation of primary health care also enhanced the participation of the target communities in health-related projects and activities such as neighborhood campaigns for immunization, environmental sanitation, and maintenance of cleanliness in the community. Participation in community health-related activities seemed to encourage the poor to avail themselves of health services more frequently.

Fourth, the visibility and ready accessibility of the field health workers likewise encouraged target beneficiaries to avail themselves of health

services. Documented cases show that patients and beneficiaries bewailed the physical absence of doctors in the centers. The presence of patient, accommodating midwives and nurses, however, helped appease beneficiaries whenever doctors did not show up on scheduled consultation days. It must be pointed out that the Department of Health required all its field health personnel to reside in or near the communities they were assigned to. The oft-quoted institutional requirement "reside or resign" is well-known to all DOH personnel.

Lastly, target setting is another institutional arrangement that, in a way, also facilitated the promotion of health services among the most needy. This organizational activity enabled the staff to determine specific and priority groups that needed attention within a given time period. It also specified the resources and actions required to meet the targets defined by the center's staff.

CONCLUSION

In conclusion, the two studies provided insights into the importance of organizational factors when working with the poor. They specifically illustrated the importance of individuals working within a health organization, and the specific institutional arrangements that have been established to maintain and provide equitable and sustainable service to the people. A major lesson from these studies, therefore, is that planned health intervention must heed not only resource requirements, but, more importantly, the type of institutional strategies that should be developed to attain defined goals and objectives. Appropriate institutional arrangements are thus imperative for planned health interventions targeting economically poor communities.

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