

Health Problems, Financial Capacity, and Access to Healthcare of Older Persons in Metro Dumaguete, Negros Oriental, Philippines



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ABSTRACT. This descriptive qualitative study explored the experiences of older persons how they availed of and assessed the quality of available healthcare services to address their needs given their capacity to pay. The focus revolved around the concept of financial capacity for healthcare needs to address health problems during old age. Experiences were documented through face-to-face interviews of purposively identified eight older persons using semi-structured guide questions. Thematic analysis was applied, which revealed that financial capacity matters in health quality relative to the particular health problems the older persons have endured. The findings further revealed differentiated access to healthcare services given the variable economic conditions of older persons. This paper reiterates their recommendations that providing them the needed healthcare assistance and information about the management and prevention of common ailments affecting them may avert their health problems from

becoming worse and more expensive to cure beyond their financial capacity.

1.0. Introduction

Population aging, which refers to the increase in the proportion of older persons, is associated with the rise of non-communicable diseases. Many of these diseases are chronic and expensive to treat, placing heavy burdens on households and health systems (Cabral, 2016). From a health perspective, rapid aging means that the health burden of the community is likely to worsen because older people tend to spend a more significant proportion of healthcare services than other sectors of society. This condition will continue to require a high level of spending on their healthcare needs in the future. However, when required to pay fees or contribute to health care, the amount can be so high compared with their income mainly because of their multiple and complicated health conditions or the demand for more extended care in later life that may result in financial catastrophe (World Health Organization [WHO], 2018). This scenario is worse in cases where older people have less or no savings during their productive years. It is similar to those who do not have retirement plans that ensure their regular monthly pensions to support their basic needs and healthcare maintenance. Villegas (2014) already noted that almost a quarter of Filipinos living in poverty are older persons without a secured financial capacity for the desired quality life.

Financial capacity as a medical-legal construct represents the ability to independently manage one's financial affairs in a manner consistent with one's self-interest and values for quality health (Marson et al., 2012). Older persons now face responsibilities for managing both their financial and healthcare needs, assuming that they have employment-based medical, drug, and life insurance plans and other associated supporting resources (MacLeod et al., 2017). This arrangement, which many do not have, is imperative because older persons are vulnerable to chronic diseases that affect their quality of life or well-being (Tariga & Cutamora, 2015). While it is true that the need for the older population for medical care tends to increase, they also face a reality that quality healthcare services are insufficient. This scenario means the older persons need more attention and financial support to receive the appropriate healthcare services.

Although retirement pensions are available for older persons and a form of financial security, the substantially employed individuals during their productive years are those who only benefited. This form of social protection for older persons is still considered weak, particularly among those who retired from private institutions whose pensions may not be enough for their basic needs and maintenance medicine (Cruz, 2019). The situation is worse among those who did not have regular



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employment before the mandatory retirement age and did not also voluntarily contribute to the Social Security System as self-employed individuals. Thus, when they reached older person status, their families face many financial problems in generating resources to support their healthcare needs. So even if they accumulated enough money, whatever savings they have could be quickly exhausted if they are saddled with multiple prescriptions for chronic conditions due to advancing age as ailments become common.

The Philippine Health Agenda for 2016 to 2022 (Department of Health [DOH], 2010 cited in Cabral, 2016) could answer the financial woes of older persons who need more healthcare services. The program states that the Philippine Health Insurance Corporation (PhilHealth) mandatorily covers all senior citizens pursuant to the National Health Insurance Act of 1995 (Republic Act No. 7875). This provision is a welcome development for the older population. Whatever they earned from productive work would be set aside to secure their own basic needs rather than medical treatment and hospitalization. Similarly, the burdens of more productive household members have been reduced in providing the health needs of their aging members (Tariga & Cutamora, 2015). Although a study considered older patients up to 65 years old more satisfied with the healthcare services they received compared with younger patients (Gerzon & Salugsugan, 2020), these services may not be equally accessible. Only a few can afford to pay the expensive costs of the high-quality services provided by the private hospitals compared with the many poor in already congested government hospitals. Thus, the satisfaction of older persons to meet their healthcare needs depends on their social and economic condition and the politics of access to services in their communities.

Meanwhile, in support of the Expanded Senior Citizen Act of 2010 (Republic Act No. 9994), the Department of Health (DOH) issued Administrative Orders to health implementers for promoting health and wellness of older persons, including the alleviation of their conditions from degenerative diseases. More specifically, Section 5c of RA 9994 mandated the DOH, in coordination with local government units, non-government organizations, and professional organizations for senior citizens, to institute a national health program that shall provide an integrated health service for the older population. Among the strategies provided by law to ensure sufficient and quality services in healthcare are training of community-based health workers and requiring some health personnel in every government health institution to specialize in geriatric care and related needs of the older population.

The preceding discussion suggests the urgency to look into older persons' financial capacity to meet their healthcare needs due to their economic condition and the opportunities available to them. A survey of a larger representative sample of older persons is appropriate. However, an in-depth investigation was first needed to formulate a structured questionnaire. In this regard, this paper aimed to explore the self-assessed health quality of older persons in Metro Dumaguete to set the context regarding how the economic cost of getting sick had burdened them. This paper also described how they availed of and assessed the quality of healthcare services to address their needs within their capacity to pay. Finally, this examined and reiterated the recommendations of older persons what they needed to secure their health as they become more vulnerable as they age.

2.0. Methods

A descriptive qualitative design was used to provide straightforward descriptions of experiences and perceptions of the study participants (Sandelowski, 2010, as cited in Doyle et al., 2020), which refer to the older persons in this paper. This research design was deemed most appropriate for this investigation because it recognizes the subjective nature of the problem and the different experiences of study participants, which are then presented in a way that directly reflect or address the initial research question (Bradshaw et al., 2017; Doyle et al., 2020). More importantly, the qualitative descriptive design emphasizes that analysis is kept at a level at which those to whom the research pertains could easily understand and, therefore, could use the findings in healthcare practice and gain access to it (Chafe, 2017).

The study participants included four males and four females with variable educational, economic, and residential backgrounds. They were identified through a purposive sampling technique. This technique refers to selecting research participants that can relate to meeting the research objectives and who have knowledge and experiences of the phenomenon under scrutiny (Ritchie et al., 2013; Palinkas et al., 2015). The study participants were 60 years old and above, members of the senior citizens' associations within Dumaguete City, and the nearby municipalities of Bacong, Sibulan, and

Valencia that comprised Metro Dumaguete. Four of the study participants had a college education, while four had only attended elementary and high schools. Half of them had retired from government service or were elected local public officials during the period of study. The other half did not have stable financial sources and stayed with their children or only received financial support from them while living separately. Such a profile of the study participants had offered diverse perspectives on the issues under investigation, especially that past employment or livelihood is an indicator of financial capacity. Their experiences, however, were taken not as reflections of all the older persons in the Metro Dumaguete.

Earlier, a research ethics review clearance was secured from the Silliman University Research Ethics Committee to protect the well-being of the study participants as a vulnerable group. Before fieldwork, letters were sent to the mayors in Metro Dumaguete and the presidents of the senior citizens' associations to inform them about the study and to request for endorsement. The study participants gave their preferred schedule for face-to-face interviews, which always started with giving them the background of the research project. The highlight of the introduction was the importance of the information they would share for their associations in formulating policies and designing programs to address the healthcare needs of their members.

After each of the older persons gave informed consent, the interviews done by the nurses in the research team commenced using a digital recording with their permission, which lasted from 45 minutes to an hour. The older persons went through the process of debriefing at the end of each interview. After the completion of the transcriptions of all recorded interviews, the data processing proceeded per question using the six-phase thematic analysis of Braun and Clarke (2006). The phases followed in the analysis included familiarizing the data, generating initial codes, searching for themes, reviewing potential themes, defining and naming themes, and writing the report. Patterns and relevance to the research questions, not the frequency of the experiences or responses, were considered in establishing the themes.

As suggested by Willis et al. (2016), researchers using the qualitative descriptive method may report a comprehensive thematic summary as findings, a mix of the narratives of individual study participants in direct quotes, and the corresponding interpretations were presented under particular themes. The direct quotes were extracted from the transcripts to exemplify particular ideas or experiences relative to the concept of financial capacity to meet the healthcare needs of older persons. This analytical framework conformed to the points raised by Neergard et al. (2009) that the focus of the investigation ultimately determines the extent of description and interpretation in a qualitative descriptive study. The initial findings were pursued in quantitative research with a larger sample to determine the distribution of the older persons who shared the experiences documented in this paper (Oracion et al., 2020).

3.0. Results and Discussion

Subjectivity of health quality. This section establishes the contexts of the healthcare services the older persons needed most, given their peculiar health problems. The point for determining first how they subjectively assessed their health quality follows the assumption that the met or unmet health needs of aging persons also suggests the amount and quality of healthcare services they have accessed relative to their financial condition. Meanwhile, among other factors, the past economic activities and lifestyles of older persons contribute to their present health problems. Experts noted that poor health is usual among overworked people, especially if they do not have enough time to rest and never consult a doctor for a regular physical examination. They also failed to take prescribed medications religiously and were abusive to the kind of food and any other substance they consumed (Angel & Settersten, 2013). Among the older persons, their common ailments included hypertension, diabetes, kidney problems, and arthritis, which are related to lifestyle (Tabish, 2017).

However, other older persons in this study who grew old with a healthy lifestyle may not be in that category. A male retired government employee proudly said: "I feel that I am okay, while another male of the association of senior citizens admitted that so far, my screening is okay." These are older persons who are financially able and conscious of their health. A retired teacher also expressed:

I was not admitted to the hospital except when I gave birth...I am not experiencing any health problems. Physically-able older persons may have also maintained good health conditions by getting pre-occupied at home or getting involved in community activities of older people. Despite the hassle, a widow living with her

son's family admitted: As for me, I will only do some cleaning, sometimes I tripped because I am already old ...it's okay, I will bear this. On the other hand, a wife also narrated: I am busy doing the household chores... (but) being the treasurer of our association gives me pleasure.

Meanwhile, the older persons who had chronic health problems expressed these in diverse ways but with a common theme that aging is a physical process towards degeneration depending on how the concerned individuals perceived and took care of their bodies. For example, a housewife summarized her feelings this way when asked how it felt when a person would become old: "Tiresome. Already have body aches. We could no longer freely move our elbows, legs, so we have difficulty moving around." This narrative is an acceptance of aging as physical deterioration, which obliges the concerned individual to take prescribed medicines seriously, particularly for a severe health problem. A retired male teacher admitted: "I have maintenance, uh for my hyper...high blood...I was given a prescription for my heart."

A widow appeared to be in denial and claimed to be still healthy to do all domestic chores; yet, she also admitted to taking maintenance medicine but only when not feeling well. She narrated: "I have maintenance for high blood, but I only drink it when I am not feeling well. I am still active; in fact, I am doing everything at home." Assuring that one is yet physically able, which is still considered a form of denial, a husband compared himself to his wife to tell that he was still physically in better condition. This retired policeman said: "My wife has maintenance, sometimes for high blood, diabetes, what's this...cholesterol?" In contrast, a wife who was a retired teacher with a kidney problem, pointing to her husband during the interview, also said: "He can go around, but he is also drinking medicines for his diabetes." Self-assessed health quality, in all the above cases, is a subjective comparison with the other person.

Financial security determines healthcare access. Having secured or stable finances in the form of a retirement plan or pension and keeping bank accounts are significant considerations in maintaining good health for older persons to easily avail quality healthcare services during emergencies. The study participants said that they felt comfortable having enough and ready money for maintenance medicines for ailments. They had a sense of assurance that they would be cared for by any healthcare providers as compared with those who have yet to wait for assistance coming from married children or borrow money from formal or informal lending institutions and kinship networks.

In contrast, the healthcare access among the not gainfully older persons in the past is more deplorable because they had not availed of the social security program. Some did not voluntarily enroll or contribute to this program because they did not appreciate its value when they were yet younger and productive. The old may have also invested so much in their children; not only are they so concerned about their future, but they may be hoping that they can be sources of support during old age (Duaqui, 2013). This contention will be elaborated in the following section if, indeed, married children could be generally reliable sources of assistance in case of ailments and other economic needs.

Meanwhile, the type of ailment one had to bear also caused financial worries, as shared by a retired teacher who said that serious health problems would demand a lot of expenses, and what her family had put together was not enough for the treatment. She further explained that there were also basic needs and other domestic costs to satisfy. Still, their health needs take such a portion of their financial resources, even if they enjoyed regular monthly pension. She narrated:

I am receiving a pension as a retired teacher, and my husband has a salary as a barangay councilor as well as a former barangay captain.... I have problems with my kidneys, so I have dialysis treatment twice a week. The PhilHealth is of big help but only to 90 sessions, so now I am using my senior citizen's discount. Our finances are sometimes not enough because of my dialysis, maintenance medicines, and our daily expenses.

The case of a retired police officer also reiterated the same theme of how the nature of health problems would drain the financial resources of the family but added that this would be worse when both couples suffered from chronic ailments that demand daily maintenance medicine. In his case, however, it was not only the children that assisted his medical needs. The members of a church

where they belong also contributed a lot to his hospitalization and medicines. He always felt that the pension he received would not be enough for the maintenance medicines as well as daily sustenance without the financial support from their children. He expressed his feelings this way:

I am receiving a pension for my short-stint experience as police before my retirement. My wife has no pension being a high school graduate. Our children are supporting us; in fact, one of them will leave for the US as she married an American. The others also help our daily needs. I had a lot of maintenance medicines after I was discharged from the hospital. Although almost all of my pension went into my medication, I also left a little for myself for emergencies. It is hard if it concerns health needs because it is very insufficient. My wife also has maintenance because of her hypertension.

Social support eases healthcare costs. The financial capacity of older persons to pay for their health needs at present is always relative to their financial sources after retirement or when they are no longer economically productive. Those who have enough savings during their productive years, have substantial pensions, or have continued to engage in entrepreneurial activities may be more secure than the less economically engaged older persons. The question of why it was difficult for poor and unemployed persons or those who did not have regular jobs to prepare for retirement should be answered. One explanation for this is the high dependency ratio which was 56% in 2018 (World Bank, 2019), and shows that more than half are considered dependents who are composed of young adults and children as compared to the productive household members. As mentioned earlier, the older persons must have sacrificed their financial assets for the younger members of the family, and they were not able to save for their retirement.

Meanwhile, having a culture that honors aging parents and recognizes the importance of extended family, some older adults consider economically stable children as a source of financial support and security for old age (Cruz & Cabaraban, 2019; Marquez, 2019). This cultural norm works well in a country like the Philippines, where the pension system for the poor and the support for the older population are non-existent or badly implemented because of insufficient funds. In addition to the retirement and social pensions that are available but not accessible to all older Filipinos, there are other options that the older persons discussed, which they found to be helpful to their colleagues in the same condition.

These other options include the social support mechanisms already hinted earlier wherein assistance comes from circles of friends or affiliates in organizations and kinship networks, including married children who reside within and outside the community or even in another country. When hospitalized, a husband, for example, cannot forget the help he received from the members of the church of his wife. He narrated: "The church of my wife shouldered my daily medications; this had helped a lot." From a relative who was also a physician, a retired teacher reported receiving free medical consultation. However, when her physician-relative was not around, she would go to a private doctor because she could afford to pay. In the case of another older woman, it was a married daughter that assisted in paying her medical expenses and other health needs.

The traditional view of having several children as a source of old age security in terms of financial assistance may be valid, but this assumes that they are all economically stable. Otherwise, it is a different story, particularly when these children are already married. One case expressed this sentiment: "We have two children who are both professionals, one nurse in America with her family, and the other one is a teacher, but they already have their respective families." Others also understood the plight of their married children, so they only waited if provided what they needed, especially about health. In this group, one admitted: "Sometimes, when I am not feeling well, I would ask from them, but they would refuse because they were also short of budget... I would wait because they also have children." Another also just waited: "Sometimes they will give when asked, but it is hard as they have a family. It is hard. We explained that we need the money to see a doctor."

Meanwhile, the happy expressions of some older persons that they can personally purchase their medicines without asking assistance suggest their independence for their health needs. They also acclaimed that, on the contrary, they were the ones assisting their married children for whatever the latter asked because they could afford it. A mother admitted: "Thank God, none...none...it is through our expenses. Now, I am afraid that my child will come home this January with her family, we will be spending on them." Independent older persons like this had reached this stage with better plans and preparation for their impending aging. They invested whatever resources they could access to

something productive when they were younger, and even now, they still have the capital to do so. Together as a couple, a male retired government worker described their condition:

As for me, our finances are stable because when I worked in the government, we were able to prepare for the future. We have six tricycles that started in 1983 until now, and we also have houses for rent. So, with my pension and wife's salary, we have more than enough for us to live. We were also able to provide the education of our two children who are now in the UK.

A similar story was narrated by a widow and retired teacher how being economically sufficient, which resulted from a deliberate plan, and wise investment could help in meeting the health needs of older persons:

I am not asking my children; in fact, I am the one helping them. Also, I already have a child working as a nurse in the UK, and I have a small business selling High Desert products. Thank God, I am not having any maintenance medicines, only these supplements, Bee Propolis.

Financial capacity assures quality healthcare. Distinctions were made between the government or public and the private healthcare institutions to determine where the older persons went more often for their healthcare needs. Expectedly, those who chose private healthcare institutions were financially self-sufficient, while those who were not able had to utilize the services and facilities of the government. Thus, the choice of healthcare service depends on its affordability, accessibility, convenience, and so on (Maroof et al., 2018) or, in general, the socioeconomic status of the family (Jain et al., 2006). Those who have the resources and are concerned about getting immediate medical attention would go for private health institutions. According to a father with children abroad: "We go to a private hospital as they give sufficient service; it is a little expensive but responds to needs well." The cost would not be a problem among those with financial support from children or with personal health insurance.

A retired teacher with children abroad did not go to the health center for consultation because of its perceived poor quality of services. She explained: "We have not gone to the health center. I go to the doctor in the Medical Center if ever there are complaints. It is good. Having a regular doctor in a private hospital is an advantage." A retired policeman said: "When admitted in the hospital, my doctor was there, so I was taken cared of well and assured that I would get well." However, it was a bad experience for some who could not well afford to be in private hospitals or doctors. A disgruntled husband with a small business reported: "Now if you will go to private, you will pay. Even the doctors in private practice will not give a 20% discount. That's why I will go to the health center or the provincial hospital."

The general distinction made between public and private hospitals is consistent with the study of Romualdez et al. (2011), which shows that private healthcare providers were favored over public healthcare providers because they are perceived to offer a better quality of care. The financial capacity of those who preferred the healthcare services provided by public healthcare personnel was understandably lower than those who go for private healthcare institutions. This observation is confirmed by the World Bank (2018) report, which states that older persons with low income generally accessed out-patient healthcare services. But there seemed to be a misconception about PhilHealth coverage, which is supposed to include private healthcare services. The same small businessman believed that:

The PhilHealth can only be applied in government hospitals as we cannot afford to go to the Medical Center because it is costly, even the rooms in Medical Center. So, I go to the provincial hospital. However, one will die because they only give generic medicines; the doctors do not prescribe branded.

Nonetheless, the quality of services in a government hospital may not always be considered of low quality since there were also satisfied patients. This assessment is relative to the experience of a recipient—a father who was living with his son—who claimed that what services he availed were enough, and they responded to my needs. He preferred the government because the services are free.

Older persons need healthcare assistance. One of the provisions of Republic Act 9994, or the Expanded Senior Citizens Act of 2010, is the provision of infirmary rooms for older persons in every government hospital. However, this is not applicable yet in the provincial hospital of Negros Oriental and even in its five district hospitals. One of the respondents shared this scenario as he was familiar with the provisions of the said law, and thus, he frustratingly noted that the absence of such a facility had undermined older persons' vulnerability to chronic ailments. The related healthcare services needed by the older persons included common disease identification, or recognition of signs and symptoms, and free medical consultations. Meanwhile, a retired female employee of a private agency remarked that healthcare financial assistance must also be on top of what the government should provide.

The initial reference to how personal financial insufficiency and perceived limited government assistance become barriers to health quality is logical and practical. It is a fact that enough finances and state-of-the-art health facilities are essential requirements for health security that need due considerations. An unsatisfied male participant, an officer of a senior citizen association, shared the same sentiment, as he was knowledgeable with what assistance the government should extend to them but which they did not enjoy. In support of the wider implication of these claims, studies conducted in the adjacent province similarly revealed that government health institutions, in both community and hospital settings as experienced by patients and assessed by government personnel, are always challenged with insufficient medicines, supplies, facilities, and equipment as well as medical professionals to respond to health needs of the public (Gerzon & Salugsugan, 2020; Gella & Caelian, 2021).

Meanwhile, the older persons also had some ideas about precautionary measures to safeguard their health and to prevent signs of ailment from worsening because of their financial incapacities to secure the needed healthcare services. Although they have the basic knowledge of the importance of preventive healthcare, they still need first information on what health problems are common among older persons and how to handle these without going to see healthcare service providers unless critically required. One study participant explained: "There is a need to prioritize disease detection so that it will not be too late because it is cheaper than getting sick." Another suggested to have fora designed for them: "There should be fora about kinds of diseases associated with aging so that we will know."

Some older persons seemed to forget that the government, through the rural health units and the public hospitals, already provide free consultation and some maintenance medicine. This form of healthcare assistance cannot be offered free in private hospitals, but older persons are supposed to enjoy a 20 percent discount, which also applies to the purchase of medicines. They reiterated that free consultation should be given priority, particularly related to hypertension, asthma, heart problem, diabetes, and arthritis. This list of health problems shows that physical deterioration is real, and older persons need assistance in recognition of their contribution to humanity during their younger and productive years. And this recognition that is due to the older persons would mean that more competent adult caregivers are necessary to respond to a growing older population in the country (Palompon, 2019).

4.0. Conclusion

The narratives of older persons in the study about their health problems, financial capacity, and access to healthcare services imply one significant insight. Their experiences suggest that aging and getting sick are inevitable, which one should not take for granted and surrender to chance—everyone has to prepare for old age. This would mean that economic security equates to health security for the older population. Stable sources of income during productive years and the accompanying social security investment of older persons have contributed to their current financial capacity to meet their healthcare needs. Moreover, they showed that economically stable children and social networks are reliable sources of financial assistance for obtaining sufficient and quality healthcare services. As an offshoot of this qualitative study, a separate study through a sample survey was done to measure the perceived sufficiency and quality of the healthcare services the older population has accessed, given their economic condition and financial capacity (Oracion et al., 2020).

The study showed the severity and how chronic the health problems of older persons also contributed to their financial burdens as they also worry about their daily essentials. This situation implies the relevance of preventive healthcare to decrease the burden of disease and associated risk

factors. It is a better and cheaper option to ensure the health quality of older persons. Promotion of good health even in old age and the prevention of ailments would cushion financial insecurities in the absence of retirement pensions, health insurance, or support from children. Thus, this paper reiterates the recommendations of older persons that they have to be more informed about the prevention of ailments related to aging before their health problems become worse and more expensive to cure. Furthermore, this also goes with the need for a sufficient government budget to effectively implement its existing health programs for the older population, which continues to increase with the improving life expectancy of Filipinos.

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