Article

HEALTHCARE QUALITY AND SUFFICIENCY AS PERCEIVED BY OLDER POPULATION IN METRO DUMAGUETE AREA IN NEGROS ORIENTAL

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Abstract: This paper examines the healthcare quality and sufficiency ratings given by older persons of the services they have availed of from health-care providers and institutions in Metro Dumaguete Area. Using a semi-structured survey questionnaire and administered through face-to-face interview, the data show that, on the average, the sampled older persons, who totaled to 229 and proportionately distributed among the study sites, rated "very good" and "very sufficient" the healthcare services they had availed of a year prior to the conduct of the study. No significant differences on the ratings were noted when the older persons were categorized by demographic profile except by sex and residence. Meanwhile, the private healthcare institutions got significantly highest ratings compared to public healthcare institutions and the combined sources on giving right diagnosis and immediate attention to patients as well as in the sufficiency of nurses. An urgent review of the implementation of the healthcare benefits and privileges for the older persons, particularly on miscellaneous services, was recommended so these will further provide health security to older populations in the country.

Keywords: Healthcare quality and sufficiency, health services, health benefits and privileges, older persons

INTRODUCTION

Although statistics would show that population aging in the Philippines, which refers to the change in age composition due to the increase in the proportion of older people, are at low level and in slow rate starting in 2000 (PSA, 2015), this already suggests the favorable results of the investments and efforts of the national and local governments to take care the health needs of the population in the country (Abrigo et al., 2017). More than ten years ago Cruz, (2007, p. 91) already noted that there were "declines in fertility, infant and child mortality and the general improvements in the overall level of health." Moreover, based on statistical records through the years, the older population now has recorded an extended life expectancy compared several decades ago with wives outliving their husbands (Saloma, 2018). In fact the Philippine Statistics Authority (PSA, 2015) reported that in the subsequent years the senior citizens or elderly, also called older persons who aged 60 years and over, numbered to 7,548,769 or about seven percent of the 100,981,437 population of the Philippines in 2015. There was an increase of 2.98 mil-

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lion or 65 percent in the 2015 population which was computed based on the population of 4.57 million in 2000.

The phenomenon of improving life expectancy, assumed by experts as an evidence of an improvement in the healthcare services and facilities available to the aging population (see Dugarova, 2017), actually means an added budgetary burden to the government (Badana and Andel, 2018; Mahmood, 2019), particularly in the case of the Philippines, that has been pestered by disasters due to typhoons and earthquakes. It demands the government to allocate sufficient health funds amidst its national budget deficit and requires prioritization whether to cater more to the health needs of the older population or more to the women of reproductive age and their children (Abrigo & Paqueo, 2017; UP-HPDP, 2017).

In the Philippines, the programs and policies to maintain the quality of life and health of the older population, given the fact that some are already unproductive due to deteriorating physical abilities and are vulnerable to both chronic and infectious diseases, are institutionalized with the passage of the Expanded Senior Citizen Act of 2010 (Republic Act No. 9994) and the Philippine Health Insurance Corporation Act of 2013 (Republic Act No. 10606). These documents contain the list of benefits and privileges related to the healthcare needs and services available to the older population in the country.

Meanwhile, how the married and unmarried children treat their aging parents must have changed over time due to a combination of social, economic and technological factors. There are traditional ways of caring for the older persons that may have been modified, but the family value of supporting aging parents or grandparents has remained in the hearts of many Filipinos (Badana & Andel, 2018). For instance, Natividad and Cruz (1997) had still observed the traditional ways in the patterns of living arrangements and familial support wherein co-residence or living with or near married children increased as parents aged. Cases are common of married children living or working away from their families of orientation who sent financial support perhaps to compensate for their physical absence. And in the case of the absence of support from children, the same study also shows that a good number of older persons had already accepted the idea of living in the homes or institutions for the aged, either managed by the government or private organization (Paguirigan, 2019).

Arguably, social and economic supports are needed by older persons especially when their movements like in going to the health centers or the hospitals, without assistance, is now hampered by advancing age coupled by deteriorating health (Arcury et al., 2005, Fang et al., 2012). This may explain why age has positively influenced the healthcare needs and extent of utilization of healthcare services and facilities particularly when the older persons with enough financial resources and social support can afford the costs (Brenes-Camacho, 2011, see also Salinas, 2016). On the other hand, healthcare service satisfaction is related to the marital status and occupation of older persons and the amount of prescribed medicines which some perhaps presumed as indicative of how they were being diagnosed (Huang, 2015). More than that, the economically privileged older couples in urban centers are more willing to pay for home healthcare services to ease the burdens of family caregivers particularly if they have other social obligations and work responsibilities (Duaqui, 2013; Musich et al., 2017).

As a significant number of older people live longer, there would be a corresponding increase in the demand for ambulatory, in-patient and chronic care especially when they would suffer multiple diseases and comorbidity (Boutayeb & Boutayeb, 2005; Huber et al., 2011), this would require the government to appropriate bigger annual health budget to secure its constituents from all forms of ailments without age discrimination. Thus, population aging exposes low- and middle-income or developing countries, like the Philippines, to the dual challenges of achieving economic growth for the entire population while at the same time supporting the healthcare needs of the older population. But the latter mandate would be difficult to achieve without enough budget because it needs also a social welfare system that adequately provides health insurance, pension, and long-term healthcare benefits (see Bloom et al., 2010).

The preceding discussion shows that the goal for quality health of the older population—a product of quality services, personnel and facilities—incurs higher costs because of their deteriorating physical state, and this is true to the financial experiences of both the government and the concerned families of patients. The utilization of preventive healthcare services may have helped in reducing the cost of getting sick but there are still reasons why older people are less likely to utilize these services not until their health conditions become very serious. Among the

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several reasons include meager income, limited education to understand the seriousness of certain ailments and the urgency of healthcare, absence of health insurance to cover immediate medical attention, and lack of knowledge about the potential health benefits of preventive measures (Salinas et al., 2016; Natividad, 2019a; UP-HPDP, 2017; Mahmood et al., 2019).

Arguably, health is an economic issue in the Philippines. The country has a high household poverty rate, particularly in rural areas, with workers who have low education and unskilled that limited their livelihood or employment opportunities but burdened with high dependency ratio which jeopardizes the health quality of every household member particularly the older persons (Badana & Andel, 2018). This may be a situation where married children have their aging parents who are either widow or widower live with them for support.

Meanwhile, the World Health Organization (WHO, 2015) reports that if the pension systems for the poor are weak, the parents who are already in advanced age usually have large extended households and shared the budget with their married children. In this case, the aging parents are unable to save for retirement because they have to care for their dependents (Duaqui, 2013), particularly of grandchildren who were left to them by their parents for various reasons (Alejandria & Sanchez, 2018). This partly explains why a good number of Filipinos living in poverty are older adults who do not have enough savings to sustain a quality of life when their married children separately live from them (Villegas, 2014).

In Metro Dumaguete, Bustillo (2015) had established that the quality of life of older persons in her study were influenced by their income levels which subsequently determined their health condition and well-being (see also Badana & Andel, 2018). She also found out an inverse relationship between depression and quality of life of older persons which suggests that those who worried more of poor health considered themselves having low quality of life. Logically, depression due to poor health maybe associated also with poor access to and satisfaction about the quality and sufficiency of healthcare services they had accessed as provided by law.

Given this context, this paper examined the quality and sufficiency of services rendered by health-care providers and institutions as rated by older persons in Metro Dumaguete Area. And in order to understand better any variations in the quality and sufficiency ratings given, these ratings were compared according to the sex, age, residence, living arrangement, education, and enjoyment of retirement pension of the respondents. Finally, the significant relationship between the perceived healthcare quality and sufficiency was also established.

METHODOLOGY

This paper employed the comparative and correlative research design. The respondents were sampled from among the older persons, 60 years old and above, who were residents of Dumaguete City and the surrounding municipalities of Bacong, Sibulan and Valencia which are collectively called Metro Dumaguete Area for this study. Dumaguete City is the capital of the province of Negros Oriental where major healthcare facilities, both public and private are located. There is one hospital operated by the provincial government and three private hospitals that cater the health needs of the residents of Dumaguete City and the neighboring municipalities, even beyond the study sites, including the nearby island provinces of Siquijor, southern Cebu and northwestern Mindanao. The convergence of these health-care facilities in the center suggests the health advantage of aging urban residents who can likewise afford to pay for their health needs particularly from the private health-care providers and institutions. And this may have contributed to why Dumaguete City has been cited by the Philippine Retirement Authority as the best place to retire in Philippines (Tilos, 2018).

The questions in the survey questionnaire were developed based on the case interviews conducted prior to the household survey of older persons (see Bustillo et al. 2019). The questionnaire, which was translated into Cebuano, was pre-tested among older persons in barangays not included in the sampling universe and was accordingly revised for greater reliability. The respondents were sampled from among the members of the Federation of Senior Citizens Association (FSCAP) in every study site. The qualified respondents were at least 60 years old during the period of the study and were able to sensibly respond to the interview done by the faculty and graduate students of the College of Nursing of Silliman University. A quota of 229 samples, composed of 115 males and 114 females, was determined prior to the fieldwork and the number was proportionately distributed based on the total number

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of barangays in every study site.

Letters about the survey were sent to the mayors and the presidents of the Federation of Senior Citizens Association of the Philippines (FSCAP) thru the Office of the Senior Citizen's Association (OSCA). The officials and members of the Federation of Senior Citizens in Metro Dumaguete Area were also informed about the study and how the results will benefit them. The assistance of the officials and members of the federation were solicited to ensure greater success of the study. The respondents were contacted with the help of the barangay officials and health workers assigned in every barangay health station. Once identified and located, the respondents were first informed about the goals of the survey before the interviews commenced which generally took place in their respective homes.

Only the older persons who wilfully agreed for the interview were included in the survey whose identities were kept confidential in a secured master list of their names. The interview was conducted during their most convenient time and the condition of the older persons. They were debriefed about the use of the results of the survey—that these would be shared to their respective associations and local government units for use in program design and implementation to ensure the health quality of the older persons in Metro Dumaguete Area.

Data processing and analysis used codes and the results were validated with the federation officials and some members before the final report was produced. The analysis started with finding significant differences in the healthcare quality and sufficiency ratings of the respondents if they were grouped according to selected demographic variables and subsequently with measuring significant relationships between health care quality and sufficiency ratings. Chi-square, t-Test, and One-Way Analysis of Variance (ANOVA) were employed in testing the hypotheses developed from the specific research questions. In retrospect, an ethics review clearance was first approved by the Silliman University Research Ethics Committee (UREC) before fieldwork had commenced in order to ensure that the conduct of the study with the older persons would not violate some of their rights as members of the vulnerable population.

RESULTS

Demographics and work history. Majority of all the respondents (52.84%) belongs to the 60-69 age group but this age distribution is true only to the males than among the females where those who aged 70 years old and above constitute almost 51 percent of those sampled older persons. Maybe the difference in the age distribution between the male and female respondents is due to the greater percentage of widows (53.51%) than the widowers (25.22%) who totaled to 39 percent of all the respondents. Those single (4.37%) and separated (2.62%) from their spouses, together with the widowers and widows, are classified having "solo" living status and comprised about 52 percent of the total samples. Those married and with live-in partners are classified as "couples" because they live with someone intimately related to them as compared those who are solo who perhaps live alone or with their children or relatives.

As a whole, out of the 226 respondents who had reported their educational attainment, 87 percent reached up to high school while only almost 13 percent have at least earned a college education. It further shows that the distribution of responses does not tell that the sex of the respondents is associated with their educational attainment although the number of females with at least college education is a little higher compared to the males. There is also no significant association between the sex of the older persons and the location of their residences but the majority of all the samples were from the urban barangays (52.40%). Given the age and marital status of the sampled older persons, it is expected that a majority (79.91%) were living together with their children or relatives for support and company—a form of social security in old age. Only 12 percent live alone during the study which was true to both the male and female respondents.

Meanwhile, Table 1 shows that 86 percent of the respondents had worked or were gainfully employed in the past before their retirement and the distribution in the responses between male (86.96%) and female (85.09%) respondents were almost the same. A majority (77.16%) admitted to be self-employed or had managed their own enterprises in the past, particularly in variety stores, while the rest were employed in private agencies (15.73%) and in government offices (7.11%). The self-employed older female persons (87.63%) outnumbered the self-employed males,

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but the latter likewise outnumbered the former when grouped and compared according to private and government employment. The statistical test shows that the sex of the respondents is significantly associated with types of employment (Chi-square= 11.90, df= 1, p-value= 0.001) or that more of the female older persons were into self-employment while the males were into private and government employment. This may have implication into their retirement pension.

As a whole, although a significant decrease among those who were gainfully working in the past was noted at the time of the study—from 86 to 37 percent at present—a trend that is true to both the male (40.00%) and female (35.09%) respondents, the sex of the respondents was not again significantly associated with their current work engagement. But it is interesting to note that those who claimed to be employed with the government in the past had increased to about 12 percent as compared to the 7 percent in the past. The increase was due to a good number of older persons who served as barangay officials, barangay health workers and related others which they also considered as sources of income. Working for the community had provided them the opportunity not only to put their extra time into socially relevant activities but these also make them still economically productive from the honoraria they received on a regular basis.

Table 1. Work History of the Respondents

Work History	Sex of Respondents		Total (%)
	Male (%)	Female (%)	
Past Work			
Yes	100 (86.96)	97 (85.09)	197 (86.03)
No	15 (13.04)	17 (14.91)	32 (13.97)
Type of Past Work***			
Self-employment	67 (67.00)	85 (87.63)	152 (77.16)
Private employment	23 (23.00)	8 (8.25)	31(15.73)
Employment in government	10 (10.00)	4 (4.12)	14 (7.11)
Current Work			
Yes	46 (40.00)	40 (35.09)	86 (37.55)
None	69 (60.00)	74 (64.91)	143 (62.45)
Current Type of Work			
Self-employment	31 (67.39)	30 (75.00)	61 (70.93)
Employment in government	7 (15.22)	3 (7.50)	10 (11.63)
Private employment	1 (2.17)	4 (10.00)	5 (5.81)
No answer	7 (15.22)	3 (7.50)	10 (11.63)

***p< 0.01

Financial support. It cannot be denied that old age also means a diminishing productivity of a person which the data had showed earlier in terms of a significant decrease in the percentage of the respondents who still gainfully worked during the time of the survey. Thus, not everyone have the capacity or the opportunity to still be gainfully working to support their basic needs. In order to establish how they continue to provide their basic needs, including healthcare, the respondents were asked if they enjoyed monthly retirement pension, benefited from government assistance, and received financial support from their married children.

It is alarming to note that a majority of the respondents (77.29%) did not enjoy retirement pension and there were more females (84.21%) compared to the males (70.43%) who were into this situation. Inversely, about 30 percent of the males received retirement pension which is more than half of the females who enjoyed the same regular source of financial support. The statistical test further shows that the sex of the older persons is significantly associated with receipts of retirement pension (Chi-square= 6.19, df= 1, p-value= 0.013). This situation is due to the fact that more females admittedly were self-employed in the past compared to the males and the contribution to the Social Security System was only voluntary in their situation. The past employment of the males with either the

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public or private sector demanded them to contribute to their retirement fund as mandated by law.

Meanwhile, Table 2 further shows that 77 percent of all the respondents received some financial assistance from the government, and this figure coincidentally corresponds to those not enjoying retirement pension. More of the female respondents (80.70%) compared to the males (73.91%) received financial assistance from the government in the past 12 months but these figures do not statistically tell that the sex of the respondents is associated with receipt of such assistance. The same pattern is observed regarding the financial assistance from married children where the percentage of females who enjoyed it was higher (64.91%) compared to the males (56.52%). These are finding consistent with the study of Marquez (2019) on family support and intergenerational exchanges which highlighted the fact that children are still valued, and who accordingly behaved, as part of the social security of parents during old age.

Table 2. Types and Sources of Financial Assistance Received

Support Types and Sources	Sex of Respondents		Total (%)
	Male (%)	Female (%)	
Retirement Pension**			
Yes	34 (29.57)	18 (15.79)	52 (22.71)
None	81 (70.43)	96 (84.21)	177 (77.29)
Government Assistance			
Yes	85 (73.91)	92 (80.70)	177 (77.29)
None	30 (26.09)	22 (19.30)	52 (22.71)
Children's Assistance			
Yes	65 (56.52)	74 (64.91)	139 (60.70)
None	50 (43.48)	40 (35.09)	90 (39.30)
Frequency of Children's Assistance			
As needed	43 (66.15)	44 (59.46)	87 (62.59)
Monthly	16 (24.62)	29 (39.19)	45 (32.37)
Weekly	4 (6.15)	1 (1.35)	5 (3.60)
No answer	2 (3.08)	-	2 (1.44)
Total	65 (100.00)	74 (100.00)	139 (100.00)

**p>0.05

The majority of the respondents answered that they only seek assistance when needed (62.59%) like when this is for healthcare needs, and this is also logically the time when the respondents deliberately asked from their married children, according to 66 percent of the husbands than the 59 percent of the wives. About 32 percent of all the respondents said that they received assistance from their married children on a monthly basis, particularly according to the female respondents, while very few said it was done weekly. The difference in the responses of male and female respondents maybe not because the wives needed more assistance but they were traditionally expected by their husbands to ask or receive the money which were intended for both the couple. Perhaps, in some instances the husband maybe were not aware also or directly involved in the transaction and they answered not having received any assistance for them.

Health conditions. In order to determine the health condition of the respondents, they were asked if they got sick during the past 12 months prior to the conduct of the survey. Table 3 shows that 59 percent answered they were sick and 64 percent of these were females while 55 percent were males, but the chi-square test result does not show that getting sick was significantly associated with the sex of the respondents—a finding similar to the study of Natividad (2019b). This means that anyone could get sick, not only due to the deteriorating biological state of older persons but this is also relative to their socio-psychological conditions and their physical and economic environments that define their lifestyles. This trend is consistent with the average number of times they got sick during the said period which was twice (2.08) for all respondents or 1.85 for the males and 2.30 for the females. Moreover, they reported to have suffered, on the average, almost two types of ailments (1.69) or specifically 1.73 for the males and 1.66 for the females.

Several health problems were mentioned by the respondents who got sick during the aforementioned period and these health problems were classified, in consultation with a medical doctor, according to their general categories for a better picture of the extent of their health conditions. Some health complaints were symptoms only of other

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health problems which the respondents cannot exactly tell because they did not go for physical examination and only took self-prescribed medications. These cases included having fever, headache, stomach ache, and related others which were classified under symptoms for purposes of analysis. Based on multiple responses, Table 3 enumerates the list of the top ailments reported by at least 10 percent of the respondents which they experienced or managed to overcome when they got sick during the past 12 months which included cardiovascular (50.00%), musculoskeletal (31.62%), respiratory (21.32%), and endocrinal (13.97%) problems. The first top two ailments were reported in a national survey of the health status of older population (Natividad, 2019b).

Table 3. Response If Sick the Past 12 Months and Health Problems

Variables	Sex of Respondents		Total (%)
	Male (%)	Female (%)	
Response if Sick			
Yes	63 (54.78)	73 (64.04)	136 (59.39)
No	52 (45.22)	41(35.96)	93 (40.61)
Total	115 (100.00)	114 (100.00)	229 (100.00)
Health Problems			
Cardiovascular	30 (47.62)	38 (52.05)	68 (50.00)
Musculoskeletal	27 (42.86)	16 (21.92)	43 (31.62)
Respiratory	13 (20.63)	16 (21.92)	29 (21.32)
Endocrinal	8 (12.70)	11 (15.07)	19 (13.97)
Eye, ears, nose, tongue	5 (7.94)	7 (9.59)	12 (8.82)
Gastro-intestinal	5 (7.94)	5 (6.85)	10 (7.35)
Genito-urinary	6 (9.52)	2 (2.74)	8 (5.88)
Immunologic	5 (7.94)	3 (4.11)	8 (5.88)
Accident-induced	3 (4.76)	1 (1.37)	4 (2.94)
Neurologic	2 (3.17)	1 (1.37)	3 (2.21)
Electrolyte imbalance	-	2 (2.74)	2 (1.47)
Integumentary	1 (1.59)	1 (1.37)	2 (1.47)
Hematologic	1 (1.59)	-	1 (0.74)
Periodontal	-	1 (1.37)	1 (0.74)
Symptoms only	3 (4.76)	17 (23.29)	20 (14.71)

Multiple responses

The aforementioned top ailments must be chronic health problems they already carried through the years because of old age which understandably demanded them to have enough financial resources to keep them enjoy the remaining days of their lives. One could expect that the financial pressure would be too high for older persons without regular pensions and for married children who have to provide financial assistance as a cultural obligation but also burdened by the financial needs of their respective families, particularly if they have growing-up children. Although the percentage distributions appear that only musculoskeletal problem was prominent among the male older persons while the three other ailments were reported by more females, the statistical test show no significant association between the dominant health problems experienced and the sex of the respondents. This means that non-biological factors may explain the health problems suffered by older persons which may include those work-related and past lifestyles.

Majority of the respondents (55.02%) took maintenance medicines up to the time of the survey but about five percent did so without prescription from physicians, and this is true to both male and female respondents. The proportion of the male and female respondents who did not take maintenance medicines were also almost equal. The statistical test validates that no significant association exists between the taking of maintenance medicine and the sex of the respondents which suggests that quality health consciousness does not vary between male and female older persons. They did not also take maintenance medicine without prescriptions from their physicians. Nonetheless, this shows that getting old and becoming sick now are real which they equally recognized, but the concern that need to be given more attention is how a significant number of the older persons in the study sites can afford to secure maintenance medicine for free or at lower cost and other healthcare privileges and benefits provided by law. This matter will be pursued regarding the extent the respondents had availed of these benefits and privileges, particularly on the purchase of medicines and the professional fees of health-care providers.

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Quality of health-care providers and institutions. Not all the 229 respondents had rated the quality of services and facilities from health-care providers and institutions but only those who had direct experiences with them at the time they were sick during the past 12 months prior to the study. In fact, not everyone who got sick went to see a physician or nurse for consultation and those who did perhaps were not also admitted in the hospitals. The data show that out of the 136 who got sick, 42 (30.85%) were admitted in the hospitals and of this number, 23 (36.51%) were males and 19 (26.03%) were females. Majority of those admitted where in private hospitals (52.38) and the rest were admitted in public hospitals (38.10%) while four (9.52%) of the respondents did not answer in what hospitals they were admitted. They rated the quality of services rendered by the physicians and nurses in both public and private health-care institutions as well as the barangay health workers, if applicable, in their respective communities whom they had consulted at the time they were sick.

In the analysis of the quality of services received by the respondents, these health-care providers were classified by affiliations to the "private" and "public" health-care institutions as well as "both" private and public if the respondents went to both institutions for consultation or treatment. The health-care providers included the physicians, nurses, barangay health workers, and other personnel assigned in the city health office, rural health centers, and barangay health stations rendering healthcare services. The respondents were instructed to rate from 1 (very poor) to 5 (very good) the quality of the healthcare services they had availed of from each of the health-care providers that treated or handled them whether or not they were admitted in the hospitals based on four parameters. They have to rate, based on their subjective assessment, if they got immediate attention or fast treatment when sick, received the right test for diagnostic examination, benefited from appropriate treatment, and experienced easy -to-understand answer to a health-related question. The ratings per health-care providers were added and the average was derived according to the health-care institutions they were affiliated with.

Table 4. Perceived Quality Mean Rating of Health-care Providers According to Sources

Quality Indicators	Health-care Providers			All (SD)
	Private (SD)	Public (SD)	Both (SD)	
Benefitting from right treatment	4.86 (0.63)	4.66 (0.70)	4.75 (0.50)	4.76 (0.61)
Experiencing easy to grasp answer	4.86 (0.63)	4.60 (0.68)	4.76 (0.55)	4.74 (0.62)
Receiving the right diagnosis***	4.93 (0.25)	4.55 (0.70)	4.64 (0.72)	4.71 (0.61)
Getting immediate attention*	4.74 (0.83)	4.33 (0.91)	4.64 (0.87)	4.56 (0.88)
Average Ratings	4.85 (0.68)	4.53 (0.67)	4.70 (0.59)	4.69 (0.60)

Rating scale: 1.00-1.80= very poor, 1.81-2.60 = poor, 2.61-3.40 = fair, 3.41-4.20 = good, 4.21-5.00 = very good
*p< 0.10, ***p< 0.01, SD= standard deviation

Generally, based on the descriptive value of the average ratings, the respondents rated "very good" the quality of healthcare services rendered by all the health-care providers they engaged with. However, based on the average ratings given by the respondents to every parameter, it shows that "getting immediate attention" was relatively lower (4.56) compared to the other parameters—the difference is statistically significant at the 0.10 level (ANOVA= 2.12, df= 3, p-value= 0.097). The other parameters of quality have more or less similar ratings in this order: "benefiting from right treatment (4.76), "experiencing easy to grasp answer" (4.74) and "receiving the right diagnosis" (4.71). Moreover, the ratings of respondents to the services in all parameters from the health-care providers in public health-care institutions were lowest as compared to the ratings given by the respondents served by the private health-care providers and those who availed of the personnel from the two institutions. But only the ratings given by the respondents on "receiving the right diagnosis" (ANOVA= 5.218, df= 3, p-value= 0.007) and "getting immediate attention" (ANOVA= 2.732, df= 3, p-value= 0.069) from public health-care providers that they significantly lag behind.

Similarly, the respondents rated "very good" the quality of the healthcare services provided by all the health-care institutions they went to as shown in Table 5. The different health-care institutions do not significantly differ in their quality ratings according to the individual parameters except on "receiving the right diagnosis" wherein the private institutions got the highest numerical rating (4.98) (ANOVA=6.765, df= 3, p-value= 0.002). Meanwhile, the similarity in the quality rating patterns between persons and institutions suggests that the quality of services of health-care providers tend to be linked by the respondents with institutional affiliations. Although the quality ratings are all "very good" based on their descriptive value, the numerical ratings show that the private healthcare institutions (4.92) were rated relatively higher than the public health-care institutions (4.71) similar to the ratings given to the public health-care providers. The respondents who had availed of the services from both health-care institutions gave a relatively lowest rating compared to the respondents who only availed of services from either

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the private or public health-care institutions, however, the difference is not statistically significant.

Table 5. Perceived Quality Mean Ratings of Health-care Institutions According to Sources

Quality Indicators	Healthcare Institutions			All (SD)
	Private (SD)	Public (SD)	Both (SD)	
Benefitting from right treatment	4.89 (0.65)	4.77 (0.44)	4.77 (0.53)	4.81 (0.53)
Receiving the right diagnosis***	4.98 (0.15)	4.71 (0.48)	4.61 (0.60)	4.79 (0.45)
Experiencing easy to grasp answer	4.90 (0.64)	4.69 (0.53)	4.69 (0.62)	4.76 (0.59)
Getting immediate attention	4.89 (0.68)	4.65 (0.56)	4.57 (0.86)	4.70 (0.68)
Average Ratings	4.92 (0.48)	4.71 (0.46)	4.66 (0.52)	4.77 (0.51)

Rating scale: 1.00-1.80= very poor, 1.81-2.60 = poor, 2.61-3.40 = fair, 3.41-4.20 = good, 4.21-5.00 = very good
***p< 0.01, SD= standard deviation

Sufficiency of health-care providers. Generally, the respondents rated "very sufficient" the number of nurses (4.73) and physicians (4.60) in all health-care institutions which must be influenced by the regularity of their encounters with them and they were there when needed. The private health-care institutions were perceived to have very sufficient number of nurses (4.88) and physicians (4.76) unlike the case of public health-care institutions but the average ratings are still within a "very sufficient" level. The sufficiency of nurses and doctors was not a problem from the perspective of the respondents but the pattern suggests that those affiliated with the public health-care institutions were consistently rated lower as compared to those with the private health-care institutions (Table 6). But only in the sufficiency of nurses that the respondents, who experienced both health-care institutions, gave the relatively lowest average numerical rating compared to the ratings of those who only went either to the private or public health-care institutions (ANOVA= 2.393, df= 2, p-value= 0.097).

Table 6. Perceived Sufficiency Mean Ratings of Health-care Providers According to Sources

Healthcare Providers	Healthcare Institutions Affiliation			All (SD)
	Private (SD)	Public (SD)	Both (SD)	
Nurses*	4.88 (0.33)	4.71 (0.65)	4.43 (0.77)	4.73 (0.60)
Physicians	4.76 (0.73)	4.54 (0.69)	4.41 (0.82)	4.60 (0.74)
Average Ratings	4.82 (0.70)	4.65 (0.57)	4.42 (0.79)	4.66 (0.66)

Rating scale: 1.00-1.80= very insufficient, 1.81-2.60 = insufficient, 2.61-3.40 = enough, 3.41-4.20= sufficient, 4.21- 5.00 = very sufficient
*p< 0.10, SD= standard deviation

Sufficiency of healthcare benefits and privileges. The list of healthcare benefits and privileges presented to the respondents to rate according to their sufficiency were based on what are provided by Republic Act 9994. Only those who had availed of such benefits and privileges gave sufficiency ratings and were included in the computation of the average ratings in order to establish a picture which items they sufficiently enjoyed. Table 7 shows that the 20 percent discount in professional fees for attending physicians and purchased of medicines and other items as well as free access to services associated to health from private health-care institutions and business establishments were given 4.54 and 4.31 average ratings, respectively, with a "very sufficient" descriptive value. Paguirigan (2019) also found the 20 percent discount as the most availed benefits and privileges of older persons in his survey. Meanwhile, the discounted professional fees of licensed health-care providers in home healthcare was rated as only "enough" (2.68) with highly dispersed individual ratings evident in high standard deviation.

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Table 7. Perceived Sufficiency Ratings of Healthcare Benefits and Privileges

Health Care Benefits and Privileges	Average Ratings	Standard Deviation
Twenty percent discount	4.54	0.81
Professional fees of attending physician in private hospitals	4.70	0.81
Purchase of medicines and other medical needs	4.62	0.83
Medical and dental services, diagnostic and laboratory fees	4.58	0.96
Professional fees of licensed health provider of home health care	2.68	1.77
Free access	4.31	1.00
Medical and dental services, diagnostic and laboratory fees	4.39	1.00
Vaccination against the influenza virus and pneumococcal disease	4.10	1.41
Use of senior citizens ward in government hospitals	3.45	1.68
Receipt of miscellaneous services	3.38	1.59
Neighborhood support services which provide caregiving services	3.97	1.43
Medical assistance during disasters	2.35	1.77
Substitute family care or group homes for neglected older persons	1.54	1.20
Monthly stipend for medicine	1.31	0.75
After care and follow-up services after hospital discharge	1.22	0.67

Rating scale: 1.00-1.80= very insufficient, 1.81-2.60= insufficient, 2.61-3.40= enough, 3.41-4.20= sufficient, 4.21- 5.00 = very sufficient

On the average, however, the receipt of miscellaneous services within or outside of institutional healthcare facilities was given a rating of 3.38 or "enough" by respondents who tried some of the items under this category being not yet also popular in their communities. But there is one benefit of being an older person under this category which has been traditionally existing as expression of neighborliness. This is a practice similar to extending assistance to association members in times of grief particularly when a member of the household died. Described as neighborhood support services intended to provide caregiving services to members, this has cultural reinforcement that fits well to existing community values and dynamics thus making this popular even without a legislation. However, the respondents considered this as only "sufficient" (3.97) which suggests that this may be made more formal by making this a planned program among members of the association of older persons. This is same with the giving of medical assistance during disasters, which they rated as only "enough" (2.35), but is actually a part of the disaster risk preparedness and reduction program of the local government units.

Meanwhile, they rated "very insufficient" the extent of having substitute family care or group homes for neglected older persons (1.54), giving monthly stipend for medicine (1.31), and providing after-hospital care and follow-up services (1.22). The substitute family care or group homes seemed to draw varied reactions from among the respondents, also referred to by Paguirigan (2019, p. 149) as "institutional forms of living arrangement" which he considered as "not yet well developed in the Philippines", because of the cultural prominence yet of having extended families that promotes intergenerational family solidarity. However, the degree of its relevance is differentiated by social class and geographic backgrounds which eventually may be lost in practice and become part only of the memories of the older persons.

Healthcare quality ratings by demographics. Generally speaking, the respondents perceived the healthcare services they received from health-care providers and their affiliated institutions to be "very good" and "very sufficient" based on their numerical ratings. As the descriptive values are paired with the averages of the ratings of the combined parameters, it would show that even among the best there are still revealing differences which are hidden because the numerical values are lumped to certain labels. In fact, in Table 7, the assessment rating scales always have descriptions corresponding to the scores in order to demarcate the differences in the qualities of these phenomenon. Although limited for its being so subjective as a form of assessment, this procedure actually captures individual experiences as reflections of the engagement of patients, in this case the older persons, with the health-

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care providers and institutions. For instance, Table 8 shows that older persons who were females and residents of rural communities tend to give higher ratings on the quality of the services of health-care providers. Furthermore, the rural residents gave higher ratings to the health-care institutions they went to when they were sick compared to urban residents. The favorable ratings from these sectors suggest an improved health-care delivery system, both in terms of quality and access, which was made available to all older persons regardless of sex and residence.

Table 8. Sex, Residence, and Quality Healthcare Ratings of Older Persons

Variables	Mean (SD)	t-Test	p-value
Quality of health-care providers			
Sex			
Female	4.82 (0.41)	2.019	0.046**
Male	4.32 (0.62)		
Residence			
Rural	4.83 (0.34)	2.014	0.046**
Urban	4.63 (0.65)		
Quality of health-care institutions			
Residence			
Rural	4.89 (0.28)	2.443	0.016**
Urban	4.67 (0.63)		

**p< 0.05, SD= standard deviation

Healthcare quality and sufficiency. Now, the final question to answer is whether or not the perceived quality of the healthcare services rendered by professional providers, which the respondents accessed from particular health-care institutions is associated with their perceived sufficiency. Overall, the data show that the average healthcare quality rating is 4.74 (SD=0.512) while the average healthcare sufficiency rating is 4.55 (SD= 0.771) which already suggests that as the perceived quality of healthcare services rating went higher, the perceived sufficiency of these services and other associated benefits had also correspondingly moved higher. Indeed, the result of the correlation test shows significant relationship between the two variables (Pearson = 0.684, p-value= 0.000, p< 0.01) that support the foregoing exposition. This means that the older persons who considered "very good" the quality of the services they received from the health-care providers and institutions—labelled according to sources as private, public, and both—also perceived these as sufficient.

DISCUSSION

Generally speaking, the perceived "very good" quality services rendered by health-care providers and institutions reflects the observations of an improving life expectancy of Filipino older population mentioned earlier. The same may be said about the "very sufficient" healthcare services, benefits, and privileges accessed by some older persons although it may be not uniformly enjoyed and appreciated as shown by the highly dispersed ratings they gave, unlike in their assessment of the quality of healthcare services. The correlation test which shows significant positive relationships between perceived healthcare quality and sufficiency reinforces the satisfaction level of the respondents to what kind of healthcare services they have received from private and public health-care providers and institutions. Nonetheless, the differential assessment of healthcare quality and sufficiency, even if both ratings are already very high, suggest some spaces where some interventions may be introduced so access to healthcare services are more democratized.

First, a much desired picture of data, which really warrant a conclusion that all surveyed older persons of various backgrounds shared the same perception about healthcare delivery, is something that shows no significant differences in their health care quality and sufficiency ratings in all parameters. But the present data show significant differences in the assessment ratings of healthcare quality when these were categorized according to the sources of services. This is specifically true in the parameters of providing right diagnosis to patients and giving them prompt attention when they go for medical consultation or treatment. The respondents perceived the public health-care institutions to have significantly lagged behind the private health care institutions—a popular conception that the latter always offers high quality services but at a higher price. Some may contest this conception to be not true all

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the time because there are also poorly-funded and managed private health-care institutions.

Second, although the respondents generally rated very sufficient the healthcare benefits and privileges they received from both types of health-care providers and businesses, there were still items that they perceived to be just enough or insufficient. The very high sufficiency ratings on some benefits and privileges, which according to the law should be at discounted price or for free to the older people, actually show only part of the entire picture which the standard deviation had elucidated how the ratings were at the extreme of very insufficient to very sufficient. For instance, discounted professional fees for home healthcare services from licensed private health-care providers and medical assistance during disasters were perceived to be sufficient and just enough, respectively, but there were actually those who gave opposite ratings. This means there were those very satisfied in one end and those disgruntled in the other end who need to be given serious attention being older persons who are more vulnerable in the communities covered by the study.

And third, there is an urgency to re-examine how the miscellaneous healthcare services, as component of the benefits and privileges provided by law, are being implemented and monitored because of the low assessment ratings. Not only that very few sampled older persons were aware or had availed the items mentioned, a situation which Natividad (2019a) likewise observed in her national data, these were perceived as insufficient and the individual ratings were extremely diverse. Understandably, the miscellaneous healthcare services need more funds for implementation and the question now is whether or not the government, either national or local, has enough funds to sufficiently provide all older persons the monthly stipend for their medicines or for after hospital care and follow-up services if ever they were admitted for serious ailments. Incidentally, in the course of data validation with the health-care providers in the community, there seemed to be confusion what agency is responsible in the delivery of the aforementioned healthcare benefits and privileges—if it is the local government units, the Department of Social Welfare and Development or the Department of Health.

CONCLUSION

In spite of the negative points highlighted in the later part of this paper, the conclusion draws more weights from the brighter side of the perceived outstanding quality and sufficiency of the healthcare services as experienced by the older population in Metro Dumaguete Area. The findings in this paper support the general observations about older Filipinos having a positive outlook towards life and their immediate environment despite their failing physical abilities and chronic ailments relative to the social and financial support from their families and relatives. It is assumed that the frequency certain healthcare services and facilities the older persons had utilized must have increased their appreciation about their quality and sufficiency as compared those who were not aware of these services and subsequently have not accessed or availed of them.

Generally speaking, the male and female older persons in this study did not significantly differ about ailments and in their assessment of the quality of health-care services they had received. However, private health-care providers and institutions were always rated better. So it was not unusual to hear that those economically able preferred to avail of health-care services from the private institutions. Meanwhile, strategically situated barangay health stations provided the healthcare needs of older persons, particularly in rural communities, without going to the city or town's health centers. The majority of the respondents were also employed in the past or had stable livelihood sources that provided them retirement pensions or savings. Some were still productively engaged during the study, which assured them the necessary resources to have access to quality healthcare. The financial assistance and other benefits and privileges the government had provided must have also helped them cope with the increasing cost of getting sick. The cultural expectation that children should support aging parents, especially on matters related to health, has not also disappeared.

As a whole, this paper concludes that the older persons who rated higher the quality of healthcare services they had availed of also rated higher the sufficiency of the said services. Thus, this paper recommends that the healthcare benefits and privileges not availed of by a significant number of older persons, and rated to be very insufficient by the recipients, have to be reviewed in terms of their implementation particularly those other miscellaneous services which require substantial budget. The immediate families and the kinship network of older persons are there for support but the burden and cost of aging is getting higher. There may come a time they could no longer afford to bear the cost particularly among low and middle income households caring for older persons without social security pensions to support their healthcare needs and other basic requirements for a dignified life.

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