



Universiteit Utrecht

Older people's self-perceptions of health and life satisfaction in the Philippines —

A mixed methods application of the capability approach to
monitoring and evaluating local health interventions



Henriikka Laurola

in cooperation with



Student number: 5913446

Thesis supervisor: Dr. Maggi Leung

MSc International Development Studies

Department of Human Geography and Planning

Faculty of Geosciences

Utrecht University

Executive summary

This mixed methods study was built around the implementation of HelpAge International's global M&E tool 'Health Outcomes Tool' (HOT) in the Philippines, facilitated by the local affiliate organisation Coalition of Services of the Elderly, Inc (COSE). HelpAge International is a global network of organisations which promotes the rights of older people to lead healthy, secure, and dignified lives. The monitoring and evaluation (M&E) tool was developed to standardise the assessment of the impacts of the network's health and care programmes world-wide. Specifically, it measures the self-perceived health and life satisfaction of older persons in low- and middle-income countries, and allows the tracking of changes at regional and global levels over time.

This research was designed to contribute to the on-going global validation process of the universalised HOT tool by evaluating its ability to quantify older Filipino people's health capabilities in the unique socio-cultural and political-economic research context of the Philippines. Hence, in addition to collecting baseline health outcomes data, the research objectives were set to explain and contextualise the quantitative findings through qualitative methods. As per the M&E framework, the study assessed the current role and value of COSE's community health programmes, aiming to improve their appropriateness and future targeting. Overall, inspired by the recent strategic objectives of The World Health Organisation, this study has aimed to provide information on how mixed methods applications can benefit health outcomes findings in older populations, and improve development organisations' monitoring, evaluation, and learning (MEL) activities.

The data were collected via fieldwork over a 12-week-period in February-May 2017 in the urban Metro Manila and rural Quezon provinces of the Philippines, specifically in the cities/municipalities of Quezon City, San Juan City, Atimonan and Pagbilao. The sequential mixed methods study design consisted of baseline quantitative survey interviews via the HOT tool (N=309), as well as complementary qualitative applications of participatory focus group discussions (N=5) and follow-up interviews (N=16) with older persons, and key informant interviews (N=4) with a health officer of each research municipality.

The deductive conceptual framework of this study combines HelpAge International's framework of the HOT tool, which is inspired by the WHO's 'healthy ageing' policy framework, and the capabilities approach. To answer the main research question *'How and to what extent does the HelpAge International's Health Outcomes Tool (HOT) help us understand older Filipino adults' health capabilities and the role of local community health programmes in supporting these?'*, the deductive conceptual framework was compared to an inductive conceptual model which was formed through a grounded theory-led analytical process. In addition to the local constructions of health and life

satisfaction, the qualitative analysis delved into the barriers and conversion factors hindering older people's health capabilities; the value of various health capabilities; as well as the role of and needs for COSE's community health programmes. Statistical analysis was used to measure the level and distribution of older people's health and life satisfaction, to assess the validity and reliability of the HOT tool, and to examine the predictors of and barriers to health functionings.

With regards to the validity of the HOT tool in the Philippine context, the statistical analysis revealed a high level of internal consistency for the tested variables measuring general health in the questionnaire ($\alpha = 0,852$). However, through the test-retest procedure and the follow-up interviews, a few potential reliability and validity issues were discovered. These related to the 3-month timeframe of self-perceptions used in the survey, as well as to the deviating financial meanings given to the deductive central concepts of 'work' (as in general livelihood) and 'support', (as in physical support/care). In the executed multiple regression analysis, existing chronic illnesses, poverty, and cohabitation were found to be the best predictors of general health in the data set. Statistically significant differences were found in the median scores of some key variables between urban and rural dwellers as well as COSE beneficiaries and non-beneficiaries.

The inductive conceptual model presenting the older respondents' constructions of health and life satisfaction, as well as the identified barriers to optimal health outcomes confirmed the central role of financial security in defining older Filipinos' health capabilities. Specifically, the health capabilities the respondents had reason to value the most in the socio-cultural and political-economic context they are situated were found to include: the ability to create and maintain healthy and supportive social relationships in family and community settings to enable continuous financial security at older age, and the ability to take responsibility of one's health to self-care to maintain health and avoid the need for health services and medicines, of which use was found to be hindered by various conversion issues related to affordability, quality/availability and accessibility.

From the freedom perspective of the capability approach, the opportunities which are definitive to the ability of the respondents to be healthy, but which are not provided for all the older respondents of this study, are essentially related to the means of achieving a basis of financial security through pension or livelihood opportunities. This is a key implication of the findings to the Philippine health and social security system. In the absence of a universal pension system, financial security of older people is strongly inclined towards an individual's ability to receive financial support from his/her children or other relatives; a capability which not everyone is free to choose. Moreover, it was shown through a case-study how life's uncertainties and changing global realities might obstruct such traditional older age security.

The tension between traditional socio-cultural expectations of filial piety and realities shaped by global processes (e.g. international migration) was found to be a great source of ambivalence for

the older respondents who carried a heavy emotional burden of shame when having to ask for financial support. At times, they prioritised their (grand)children's needs over their own health. The findings of this study have thus implied a comprehensive socio-cultural and political-economic framework of a changing inter-generational contract.

HelpAge International's HOT tool was found to add to our understanding of older Filipinos' health capabilities by focusing on the self-perceived functional ability of the respondents to achieve 'beings and doings'. However, the nature and value of functionings were left for qualitative tools to discover. Hence, while the HOT tool has the ability to track the general situation and development of 'healthy ageing' globally through its key indicators, the findings of this study emphasise the need for complementary qualitative tool(s) to allow the full potential of country-specific learning in the M&E framework the HOT has been designed to serve, particularly in terms of local policy implications and future programme targeting.

Acknowledgements

This study was facilitated and made possible by HelpAge International and the local affiliate Coalition of Services of the Elderly, Inc (COSE). Little did I know almost a year ago, when first contacting HelpAge International and being provided with the opportunity to participate in the implementation of the Health Outcomes Tool (HOT) in the Philippines, what an amazing learning experience, sparking new opportunities, contacts and ideas, this year could be.

Special thanks go to Jonna Bertfelt from HelpAge who was of enormous support for the study at every step of the long process. Many thanks also to Kristin Bodiford from HelpAge USA for her long-term practical guidance and ever so helpful feedback. Emily Beridico and Lerry Luaton from COSE were in central roles in making the data collection possible in the field, spending endless hours in organising all the practicalities. Lerry, who worked as my main research partner, the focus group discussion facilitator, and my translator through all the phases of data collection, deserves much credit for the success of this study. Her companionship in the field was very welcomed since she effortlessly put participants at ease. I am grateful for the whole COSE staff for making me feel welcome, safe and supported from day one in Quezon City. Further, my thesis supervisor Maggi Leung's helpful feedback has guided the design and writing of this study.

I extend my appreciation to the individual participants of this study who opened their doors and hearts to trust us with their perceptions and concerns. The extensive amount of volunteering hours put into the research by local OSCA offices and OPOs in the research municipalities of Atimonan, Pagbilao, Quezon City and San Juan City to recruit participants, to provide premises and to organise research activities demonstrate the accommodating, altruistic and warm nature of all the Filipinos I had the honour to meet during my 3-month stay in the field. Salamat po!

The leading goal of this study, also from a personal perspective, has been to raise awareness of older Filipino adults' current health-related realities and struggles to allow the improvement of means of support available to them. Hopefully, the findings of this study will encourage multi-sectoral cooperation, older people's organisations included, to design efficient age-friendly initiatives to tackle the identified barriers and concerns.

In The Hague on 8 September 2017,

Henriikka Laurola

Table of Contents

Executive summary.....	3
Acknowledgements.....	6
List of tables and figures	9
List of abbreviations.....	10
List of appendices	11
1. Introduction.....	12
1.1 Research background and agenda	13
1.2 Research objectives and questions	14
2. Theoretical framework.....	16
2.1 Frameworks for ageing and health: universalised understandings.....	16
2.2 Anthropology of ageing: local understandings.....	17
2.3 Assessing health-related quality of life.....	18
2.4 The capability approach.....	19
3. Conceptual frameworks	21
3.1 HelpAge International's conceptual framework for health and life satisfaction.....	21
3.2 Health capabilities.....	22
3.3 Deductive conceptual framework.....	23
4. Regional thematic framework.....	24
4.1 National context	24
4.2 Regional context.....	24
4.3 Philippine health sector and key policies	26
4.3.1 Health services in research municipalities.....	27
4.3.2 Community health programmes by COSE	28
4.4 Social security and economic well-being at older age.....	28
4.5 Literature review: ageing and health in the Philippines	30
5. Methodology.....	33
5.1 Research design.....	33
5.1.1 Participatory research and techniques	35
5.2 Participants and sampling strategies.....	35
5.3 Research instruments.....	38
5.4 Data analysis.....	40
5.4.1 Statistical analysis.....	40
5.4.2 Grounded theory guided qualitative analysis.....	40
5.5 Ethical issues	42
5.6 Reflections from the data collection: limitations and positionality	44
6. Contextual findings on health, life satisfaction and health services	47

6.1 Health and life satisfaction findings as per the HOT tool.....	47
6.1.1 Overview of respondents.....	47
6.1.2 Summary of the key HOT findings.....	49
6.2 Health services supporting healthy ageing	53
6.2.1 The role of and needs for community health programmes	53
7. Reliability and validity of the HOT tool in measuring older Filipinos health capabilities	56
7.1 User and respondent experience of the tool.....	56
7.2 Intra-class reliability: test-re-test findings	57
7.3 Measurement validity: HOT scale and rating accuracy.....	59
7.4 Content validity: Internal consistency of the HOT tool.....	60
7.5 Construct validity: qualitative observations from the Philippine context	61
8. Local barriers, lack of capabilities and conversion factors.....	65
8.1 Explanatory variables of general health.....	65
8.2 Barriers to health: qualitative findings	66
8.3 Challenges in converting health resources into health outcomes	69
8.3.1 Conversion factors related to affordability.....	70
8.3.2 Conversion factors related to availability/quality	71
8.3.3 Conversion factors related to accessibility	73
9. Inductive conceptual framework and most valued health capabilities	75
9.1 Inductive conceptual model of health and life satisfaction.....	75
9.1.1 Deductive and inductive conceptual frameworks: similarities and differences	78
9.2 Most valuable health capabilities	79
9.2.1 Situated health agency limited by barriers and uncertain realities.....	80
9.2.2 Health capabilities the respondents have the most reason to value	81
10. Discussion and conclusion.....	83
10.1 Summary of findings.....	83
10.2 The HOT tool's usability and its limitations in the Philippine context.....	85
10.3 The comprehensive framework of changing inter-generational contract	87
10.4. Implications and recommendations.....	88
10.4.1 Policy implications for the Philippine health care system	89
10.4.2 Recommendations for HelpAge International and COSE	90
10.5 Limitations of the study and recommendations for future research.....	92
References.....	94
Appendices	

List of tables and figures

Table 1. Key figures of ageing in the Philippines.	24
Table 2. Characteristics of the research municipalities.	25
Table 3. Age group percentages of Filipinos over 60 and the responding proportions in a full sample of 300 respondents.	36
Table 4. Participants of focus group discussions (N=5).	37
Table 5. Respondents of follow-up interviews (N=16).	37
Table 6. Most important health services for the FGD participants.	53
Table 7. HOT tool variables tested with the Cronbach's alpha procedure.	60
Table 8. A structured list of identified barriers for optimal health.	66
Table 9. Demand and supply perspectives to conversion factors to health.	70
Table 10. A case-study.	80
Figure 1. The capability approach.	19
Figure 2. HelpAge International's framework of health and life satisfaction.	21
Figure 3. The four domains of health by HelpAge International.	22
Figure 4. The deductive conceptual framework.	23
Figure 5. Location of Metro Manila (NRC) and Quezon provinces.	25
Figure 6. Sources of income by sex of those aged 60 or older.	29
Figure 7. Sequential mixed methods research design.	33
Figure 8. HOT measurement scale by HelpAge International.	39
Figure 9. Exemplary code matrix from the analysis process.	42
Figure 10. Respondents by age and gender.	47
Figure 11. Users of community health programmes.	48
Figure 12. The respondents' educational background.	48
Figure 13. Number of residents in households.	49
Figure 14. Average health status by gender and age group.	49
Figure 15. Health status test-retest correlation.	57
Figure 16. Functionality for work test-retest correlation.	58
Figure 17. Health status rating frequencies.	59
Figure 18. Life satisfaction rating frequencies.	59
Figure 19. Reliability statistics of a Cronbach's alpha procedure.	60
Figure 20. Item-Total Statistics of a Cronbach's alpha procedure.	61

Figure 21. Dependency/support needs concept definition in the HOT tool's user guide.	63
Figure 22. Multiple regression analysis model summary 1.	65
Figure 23. Multiple regression analysis model summary 2.	66
Figure 24. Positionality of barriers in the health capability model.	67
Figure 25. NVivo word cloud for deductive node 'access'.	69
Figure 26. Inductive conceptual model of health and life satisfaction.	75
Figure 27. The deductive framework's reach of the inductive conceptual model.	86

List of abbreviations

COPAP = Confederation of Older Persons Association of the Philippines

COSE = Coalition of Services of the Elderly, Inc (COSE)

DOH = Department of Health

DRDF = Demographic Research and Development Foundation of the Philippines

FGD = Focus Group Discussion

HOT = Health Outcomes Tool by HelpAge International

HRQOL = Health-Related Quality of Life

LGU = Local Governmental Unit

M&E = Monitoring and Evaluation

MEL = Monitoring, Evaluating and Learning

NCR = National Capital Region

OPO = Older persons' organisation

OSCA = Office for Senior Citizens Affairs

PSOA = Philippine Study of Ageing

SDGs = Sustainable Development Goals by UN

UHC = Universal Health Care

UN = United Nations

UNFPA = United Nations Population Fund

WHO = World Health Organisation

List of appendices

1. Health Outcomes Tool (HOT) by HelpAge International
2. Health capability model by Frosch, Grande, Tarn and Kravitz (2009)
3. Summary of all research participants (final sample)
4. Focus group discussion guide
5. Photos from the data collection: instruments and practices
6. Follow-up interview guide
7. Key informant interview guide
8. Example of a consent form of the study
9. Frequency and average tables/ HOT full data (N=309)
10. A selection of HOT findings from Quezon province
11. A selection of HOT findings from Metro Manila province
12. Correlations (Spearman's rho) in full HOT data (N=309)
13. Statistically significant differences between respondent sub-groups in HOT data
14. FGDs/institutional diagrams: barangay level results
15. Statistical tables of multiple regression analyses

1. Introduction

'Population ageing presents social, economic and cultural challenges to individuals, families, societies and the global community. It is how we choose to address the challenges and maximize the opportunities of a growing older population that will determine the future of humankind.'

(UNFPA and HelpAge International, 2012, p. 11)

While reflecting great advances in health and quality of life globally, the rapid ageing of the world's populations presents also tremendous challenges for countries' sociocultural and economic environment (ibid.). The global phenomenon consisting of rising life expectancy and declining fertility means that the number of people aged 60 and older will outnumber children under five by 2020 and children under 15 by 2050 (Zaidi, 2015). While longer life may open new kinds of possibilities for older people, their families, and societies as a whole in terms of longer periods of good health and social engagement and productivity, the real-life implications depend crucially on one factor: older people's health (WHO, 2015a).

The older population sector is the fastest growing sector of the Philippine population (Blace and Avenue, 2012). Compared to many of the countries surrounding it (e.g. Taiwan, Singapore and South Korea), the Philippines is experiencing a 'low and slow' process of ageing, which, nevertheless, adds to the efforts of coping with other demographic issues such as a rapidly increasing population and a slow fertility decline, a highly mobile workforce, and a constantly improving life expectancy (Ogena, 2006). The slow process can be seen favourable in the sense that the country has time to prepare for the demographic transition, but also challenging due to the limited resources of the low middle-income country (ibid.). Despite the rapid economic growth that has provided additional finances to expand health care access in the recent years, inequality in health outcomes and access to services due to weak financial protection have persisted as the most significant health issues in the Philippines (WHO, 2011).

In 2002, the General Assembly of the United Nations made a breakthrough in adding populations ageing to the centre of the development agenda by adopting the Madrid International Plan of Action on Ageing¹ (UNFPA and HelpAge International, 2012). While research concerning ageing populations has thus far largely focused on the implications of the phenomenon to the economic and social capacities of higher income countries (EuroHealthNet, 2016), the understanding of the importance of older people and ageing for sustainable development of the global South is on the rise. This is apparent from the post-2015 Sustainable Development Goals (SDGs) agenda: from goal 3 concerning '*ensuring healthy lives and [promoting] well-being for all at all ages*' to the broader commitment of the SDGs to disaggregate all indicators by age (Zaidi, 2016).

¹ The phenomenon of populations ageing has been generally acknowledged by the UN for longer; the first World Assembly on Ageing was held in 1982 in Vienna.

Further, in May 2016 the member organisations of the WHO adopted the Global Strategy and Action Plan on Ageing and Health for years 2016-2020 at the 69th World Health Assembly. The strategy with 'healthy ageing' as its key concept provides a framework for coordinated global action across the SDGs and prepares partner countries for the 'Decade of Healthy Ageing' 2020-2030.

Significantly for this study, the strategic objectives of the WHO include the improving of measurement, monitoring, and research to add understanding and allow action on healthy ageing in specific contexts, as well as to align health systems to the needs and rights of older populations (see WHO, 2016).

1.1 Research background and agenda

HelpAge International is a global network of organisations promoting the rights of older people to lead healthy, secure, and dignified lives. HelpAge has been working in the Philippines for over 25 years with its local affiliate, the Coalition of Services of the Elderly, Inc (COSE). COSE, further introduced in sub-section 4.3.2, is an organisation conducting community-based programmes to address the key challenges older people face, including lack of health care, poverty and social exclusion. To increase information about older people's health and well-being in low- and middle-income countries and to standardise the assessment of the impacts of its health and care programmes, HelpAge International has developed a monitoring and evaluation (M&E) tool called Health Outcomes Tool (HOT). The HOT tool can be used to assess the current self-perceived health and life satisfaction of older persons, and to measure changes in health and well-being at regional and global levels over time (Bertfelt and Dusseau, 2016a). The collected data benefits programming as well as informed policy and advocacy work worldwide (ibid.). Moreover, the standardised survey tool and its validation process respond to the strategic objectives outlined by WHO (2016).

By spring 2017, the validation process of the HOT tool had seen implementations in eight countries, including Bolivia, Colombia, Uganda, Tanzania, Ethiopia, Zimbabwe, Mozambique and India. The 9th implementation in the Philippines took place in March-April 2017, serving to collect a baseline of older person's health outcomes in the Quezon and Metro Manila provinces of the Philippines. This study was designed to complement the survey-based quantitative data collected through the HOT tool with an additional qualitative application executed via in-depth and key informant interviews as well as focus group discussions. In doing so, the research has contributed to HelpAge International's identified need and an on-going effort to develop a complementary qualitative tool to the HOT questionnaire. Further, the study has increased information on what contributes to healthy ageing in a specific context of the Philippines.

Indeed, according to the WHO's *World Report on Ageing and Health* (2015b), an understanding of contextual environmental factors is essential for any strategy aiming to foster health in older adults. When measuring health and its multidimensional domains through standardised tools such as the HelpAge's HOT, it is meaningful to seek a deeper understanding of how the measured domains of

health are perceived and valued in a socio-cultural context which influences older people's choices and capabilities. Objectives of health interventions often seek to improve the access and quality of services by merely assuming what are the meanings that older people themselves attach to these concepts (HelpAge International, 2016a).

Of the relatively scarce few existing studies about older Philippine population, most have been quantitative and measured health-seeking behaviour or quality of life outcomes of older people through standardised global instruments (see section 4.4). Hence, there is a clear knowledge gap regarding qualitative studies focusing on local older people's health capabilities, agency and resilience in the particular socio-cultural context of the Philippines. Diverging from the quantitative approach quality of life research commonly employs, the mixed methods approach focusing on qualitative self-perceptions in this study fills a clear global-level knowledge gap concerning how older people themselves are perceiving ageing in relation to health (Valdez et al., 2013). The findings assist local health service providers in effective targeting and supporting the building of individuals' capabilities to achieve better health and life satisfaction outcomes.

1.2 Research objectives and questions

The objectives of this study have been:

1) To collect baseline health outcomes data through the HelpAge International's HOT tool in Metro Manila (Quezon City and San Juan City) and Quezon provinces (Atimonan and Pagbilao) of the Philippines:

- Measuring the level of health and life satisfaction as well as inequalities between sub-groups in the sample

2) To contribute to validation and evaluation of the standardised HOT tool through the additional application of qualitative methods aiming to contextualise the collected data:

- Adding understanding of local conceptual frameworks of older people related to health and life satisfaction
- Explaining observed health inequalities in their local context and by drawing attention to older people's health capabilities
- Assessing the current role and value of COSE's community health programmes and improving their appropriateness and future targeting to the areas most valued by local older people

3) To provide information how mixed methods applications can benefit health outcomes findings in older populations, and improve development organisations', such as HelpAge International's, MEL activities.

The objectives were achieved through the following **main research question** of this study:

How and to what extent does the HelpAge International's Health Outcomes Tool (HOT) help us understand older Filipino adults' health capabilities and the role of local community health programmes in supporting these?

Sub-questions to answer the main research question have been divided into four categories as follows:

1. Contextual sub-questions exploring the measured health and life satisfaction and the role of the monitored health programmes by COSE

a) What is older adults' self-perceived health and life satisfaction as measured by the HOT tool in the Metro Manila and Quezon provinces of the Philippines?

b) What is the role of and the needs for community health services from the perspective of local older people?

2. Sub-questions assessing the measurement reliability and validity of the HOT tool

c) What are the strengths and weaknesses of the HOT tool in the Philippine context?

3. Sub-questions examining the barriers and conversion factors hindering older Filipinos health capabilities

d) Which barriers, lack of capabilities and conversion factors can explain observed local health inequalities?

4. Sub-questions investigating the inductive conceptual model of health and life satisfaction and the value of different health capabilities

e) How do older Filipino adults themselves construct health and life satisfaction?

f) Which health capabilities do they have a reason to value the most?

The findings of this study, presented in Chapters 7-9 of this thesis have been divided into four chapters as per the above-named sub-question categories.

2. Theoretical framework

This chapter introduces the main theoretical frameworks of this research. First, the prevailing frameworks/discourses for ageing and health used in academia and international policy are discussed. Next, to narrow the theoretical scope from the universalised level, anthropological perspectives and the concept of situated ageing are introduced. Lastly, a short review of health-related quality of life research will be followed by an overview of the capability approach, the main theoretical framework of this study.

2.1 Frameworks for ageing and health: universalised understandings

Developing policy frameworks for ideals concerning ‘quality’ ageing is challenging due to the multiplicity of meanings attached to the concept: in the past decades, quality of life at older age has been conceptualised in literature as, for example, ‘active’, ‘successful’, ‘vital’, ‘positive’, ‘productive’ and ‘healthy’ (Peel, Bartlett and McClure, 2004). These frameworks rose to provide alternative, positive perspective to historical views that saw ageing merely as a process of decline and disengagement (Mortimer, Ward and Winefield, 2008). Such views have generated ageist stereotypes that still have negative impacts on older people’s lives. Of all the frameworks mentioned above, WHO has adopted and popularised two in the development sphere, namely the ‘active ageing’ and ‘healthy ageing’ frameworks (Fernández-Ballesteros, 2008).

The active ageing framework was brought to the development agendas in the UN 2 General Assembly on Ageing where the International Plan of Action on Ageing was approved. WHO’s Active Ageing: A Policy Framework report (2002a) defined ‘active’ in the ageing context as *‘continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force’* (p. 12). The report pictured older people as contributors to their surrounding societies through paid and unpaid activities. With regards to health, the active ageing policy encouraged individuals for *‘personal efforts to adopt positive personal health practices at all stages of life’* (WHO, 2002a, 17). Despite the separation of productivity from income-generating labour, the active ageing discourse has been criticised for its possible counterproductive and oppressive implications. Holstein and Minkler (2007), for instance, argue that the normative standards of the discourse impose unrealistic standards to ageing bodies that can negatively affect one’s self-worth. The discourses and conceptualisations used by WHO are not indifferent since they play a significant part in global, multi-sectoral strategies aiming to manage the challenges proposed by ageing populations.

The World Report on Ageing and Health (WHO, 2015b) outlined a new action framework around the discourse of healthy ageing and its core concept, functional ability. Healthy ageing is defined as

'the process of developing and maintaining the functional ability that enables well-being in older age' (2015, 28, further defined in section 3.1).² Despite seeing the healthy ageing discourse and framework as a positive shift, it has been suggested that the still visible construction of active, healthy, contributing older age ignores the diversity of older people and the physical and societal impacts on their well-being (Stephens, Breheny and Mansvelt, 2015). The political power of discourses is underlined in criticisms matching healthy ageing discourses with neo-liberal ideologies that set individuals responsible for managing their own older age through obedience to public health advice and financial planning (Pond, Stephens and Alpass, 2010). If healthy ageing is constructed as an individual achievement, individuals in poor conditions are then to blame only themselves (Stephens et al., 2015). Hence it is important to bring light to the specific set of environmental as well as physical barriers that affect our identities, self-worth and choices as a response to the general tendency of literature and policy to see older people as a group with common experiences and needs (Lloyd-Sherlock, 2002). Regardless of the criticism of the implied discourses, the WHO policy frameworks contain highly positive and welcomed openings for human-centred, rights-based and agency-focused approaches (Porter, 2015).

2.2 Anthropology of ageing: local understandings

This study sees older people as individuals who negotiate their identities and experiences of ageing in specific socio-cultural and political-economic contexts under certain discourses at a particular time. This represents an anthropological viewpoint, in which frameworks and theories concerning ageing are culturally and socially bound phenomena that concern our constitutive understandings of age and time (Fry, 1999). The meaning of these concepts varies cross- and sometimes intra-culturally, having implications for the local people who define their experiences through a cultural model (ibid.). The theoretical debate on this topic, one that this study addresses, concerns the extent to which experiences of ageing and health, as well as quality of life (see section 2.3), can be universalised for the purposes of measurement, evaluation and comparison.

The concept of situated ageing by Margaret Clark moves beyond the understandings of ageing as a universal process of decline and reframes it as a situated, socially embedded process (Perkinson and Solimeo, 2013). This view of ageing has lately been increasingly adopted in gerontology but also in global health. The WHO report on ageing and health (2015b) does acknowledge that functioning at older age cannot be determined by just assessing mental and physical capacities but requires the consideration of the environmental influences on health, including a society's attitudes and norms, broader policies, natural and built environments, as well as social networks. These all

² The difference between the active ageing and the healthy ageing frameworks is that the first mentioned is a wider umbrella framework including not just health, but also participation and security in the goal of achieving quality of life (Hoskins, n.d.).

shape both people's mental and physical capabilities and define their health-seeking behaviour (ibid).

The anthropological work on ageing suggests that ageing is experienced in an adaptive cultural context, emphasising the diversity and context-specificity of the process (Fry, 1999). Constructing theories about ageing means seeking classifications that are theoretically productive but do not stereotype or over-generalise; the challenge is to separate what in ageing experiences is universal and what is locally defined and specific (Fry, 1999). Inspired by anthropology of ageing, this study seeks to adapt the HelpAge International's conceptual framework located in the healthy ageing discourse of WHO to the socio-cultural context of the Metro Manila and Quezon provinces of the Philippines.

2.3 Assessing health-related quality of life

The quality of life concept has gained a permanent foothold on health policy agendas internationally (Smith, 2000). Various health-related quality of life (HRQOL) measures have been developed to both determine impacts of medical interventions, and to monitor and evaluate health services. This research area, initially dominated by the medical field, has in the past decades gained the interest of social scientists, shifting the focus from objective indicators to subjective factors (e.g. life satisfaction) when measuring quality of life (Smith, 2000).

The hundreds of different HRQOL scales reflect the diversity of conceptualisations of health and life satisfaction. In the context of global health and development, WHO has defined health as '*a state of complete physical, mental, and social well-being not merely the absence of disease*' (1997, 1). Quality of life, as measured for example by WHO's WHOQOL instrument, measures '*individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns*' (WHO, 2002b, 5). The WHOQOL instrument has gone through a rigorous cross-cultural validation process³ and has been translated into more than 20 languages (ibid.) Most conceptualisations of quality of life contain both objective and subjective measures, however, the lack of shared definition for the key concepts causes disagreement on the measurement of these (Smith, 2000).

In the context of older people and quality of life, research has shown that their subjective perceptions of health and well-being are at least as important as objective measures for predicting health outcomes over time (Blazer, 2008). Further considerations are needed when measuring health in older populations since the concept of health in older age is unique and rather complex (Bertfelt and Dusseau, 2016a). For this reason, HelpAge International has developed their own tool (HOT) to measure health and life satisfaction as older people themselves perceive it. Rather than expecting constant improvements in health outcomes, the organisation monitors if their health

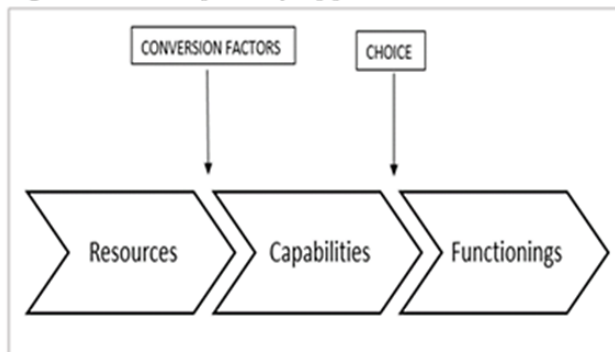
³ Including in The Philippines by De la Vega (2013), further presented in literature review section 4.5.

programmes are supporting older people to maintain and maximise their functional ability as well as resilience for as long as possible (ibid.). HelpAge's own conceptualisation of health and life satisfaction will be further discussed in section 3.1

2.4 The capability approach

The capability approach reflects the subjective and multi-dimensional understanding of health and well-being present in WHO's (2015) and HelpAge International's (Bertfelt and Dusseau, 2016a) frameworks. Similarly to these frameworks, the approach's emphasis is on individual ability and freedom rather than in the possession of health-related resources. As such, it allows us to distance our constructions of older people's well-being from the traditional ideas of individual responsibility and the rejection of physical ageing (Stephens, 2016). The approach, originally developed by Amartya Sen, presents a broad, interdisciplinary framework highly suitable for the assessment and evaluation of individual well-being and social arrangements (Robeyns, 2005). By recognising the difference between means and ends as well as capabilities and outcomes, the approach is ideal for policy design and evaluation as well as in proposals regarding social change (ibid.). Furthermore, the capability approach can be applied across cultural, political and economic borders due to the concept's global-local nature (Wells, n.d.). The main concepts of the capability approach can be presented as follows⁴:

Figure 1. The capability approach.



Resources - set of *rights, entitlements and commodities* that are available to a person in a specific context, e.g. health services.

Conversion factors – define the degree to which an individual can transform available resources into functionings. Conversion factors can occur at individual, social, institutional or environmental levels,

internally, e.g. one's sex, or externally, e.g. social norms.

Capabilities – valuable *opportunities* and individuals' freedom and ability to do and be the things they consider valuable. While some capabilities vary only little with social and cultural circumstances, such as adequate nutrition, others vary significantly based on cultural norms and axes of identity in the society.

Choice – the agency individuals have in achieving outcomes (functionings).

⁴ Sources: Well, n.d.; Lloyd-Sherlock, 2002; Robeyns, 2016. Figure adapted from Verd and Andreu, 2011.

Functionings – the *achievements and outcomes*, ‘beings and doings’ that form a person’s well-being, e.g. being healthy and being part of a community. While capability defines the freedom to be and do things, functioning reflects whether this happens or not.

Freedom is an essential concept of the capability approach. It signifies a real opportunity one has to accomplish what one values. For Sen, freedom consists of two aspects, agency and opportunity (Alkire, n.d.). Agency refers to the capacity of an individual, whereas opportunity points to the surrounding society and its justness in providing all individuals with the ability to do and be what they consider valuable (ibid.) - in this study’s framework, the ability to be healthy.

The most well-known modification of Sen’s approach is that of Martha Nussbaum. The key difference of Nussbaum and Sen’s approaches is that, unlike Sen, Nussbaum provides a definite list of ‘central’ human capabilities. Nussbaum’s way of understanding capabilities as fundamental, universal human rights resonates with the rights-based agendas of the UN’s International Plan of Action on Ageing and NGOs like HelpAge International; however, her list may not match with the diversity of real-life personal preferences in different sociocultural contexts (Lloyd-Sherlock, 2002). A list such as Nussbaum’s will not be used as a deductive list in this study because our actual knowledge of older people’s preferences in the research context is limited, and such knowledge should not be based on assumptions.

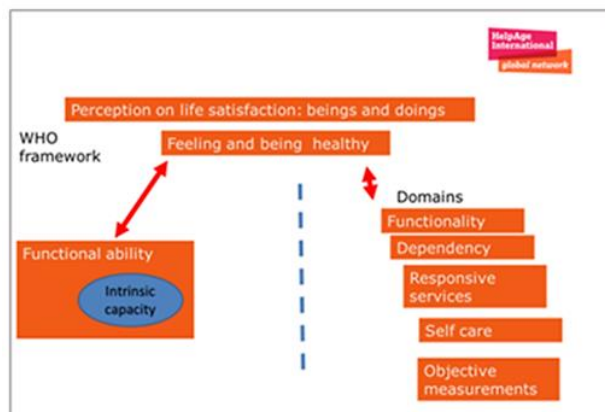
3. Conceptual frameworks

The deductive conceptual framework of this study brings together HelpAge International's conceptualisation of health and life satisfaction at older age which motivates the HOT tool, as well as the specific concept area of health capability of the capability approach. These frameworks will be introduced one by one in the first and second sections of this chapter. The last section will present the final conceptual framework of this study, developed through deductive reasoning.

3.1 HelpAge International's conceptual framework for health and life satisfaction

HelpAge International's theoretical framework, which supports the HOT tool, has its foundations on the healthy ageing framework of WHO (see section 2.1). A guide called '*Health Outcomes Tool (HOT) - Theoretical framework and manager's user guide*' by Bertfelt and Dusseau (2016a) presents the full framework as follows:

Figure 2. HelpAge International's framework of health and life satisfaction.



In this figure, WHO's healthy ageing framework, with its key concept of functional ability, is visible on the left. So-called domains of health as defined by HelpAge and operationalised by the HOT tool are shown on the right. The domains presented are interconnected and have an impact on the outcome, i.e. 'feeling and being healthy' (Bertfelt and Dusseau, 2016a). Separately the domains reflect the organisation's performance in different

areas of health and well-being (ibid.). The overall measure of the tool is presented on top. Perceptions of life satisfaction are seen as 'beings and doings', which translates directly into *functionings* in the capability approach. Moreover, in this theoretical framework of the M&E tool, life satisfaction is understood as being built on the state of feeling and being healthy. The main concepts of this framework can be defined as follows:

Functional ability – consists of the interaction of a person's intrinsic capacity as well as the relevant characteristics of his/her environment; contains the health-related attributes that enable individuals to be and do what they value (WHO, 2015c).

Intrinsic capacity – an individual's genetic inheritance and personal characteristics, including health characteristics, such as health-related behaviours and risks, diseases and physiological changes (WHO, 2015c).

A key outcome of HelpAge International's measure is whether their health programmes in low- and middle-income countries are supporting older people to maintain and maximise their functional ability – or as translated into the capability approach, *capability* – to enable long-term well-being (Bertfelt and Dusseau, 2016a). The corporate indicators behind the M&E measures of the HOT tool are: 'Percentage of older men and women in active HelpAge projects reporting a better perception of their health' and 'Percentage of older men and women in active HelpAge projects reporting a better satisfaction with their life/well-being' (Bertfelt and Dusseau, 2016a).

Figure 3. The four domains of health by HelpAge.



As per HelpAge International, the four subjective domains in the organisation's concept of health (dependency, health services response, self-care and functionality) all relate to an individual's perception of their health and life satisfaction. The domains have been chosen due to their strong connection to WHO's healthy ageing framework as well as

HelpAge's 2020 Global Strategy (Bertfelt and Dusseau, 2016a). The operationalisation of these concepts can be seen from the HOT tool questionnaire (**Appendix 1**). In this study, the domains of health will be understood as health capabilities, consistent with the capability approach.

3.2 Health capabilities

Health is an essential capability as an instrument in achieving other capabilities. The concept of health capability⁵ finds balance between the autonomy and paternalism implicit in the various health frameworks and discourses described in section 2.1 by emphasising the conditions affecting health and one's agency to make choices regarding health (Ruger, 2010). A conceptual model by Frosch, Grande, Tarn and Kravitz (2009) (see **Appendix 2**) was adopted to this study for its ability to capture the complex, multifaceted nature of a person's health, affected by one's unique intrinsic capability as well as the specific geographic and socio-cultural context. According to Ariana and Naveed (2009), health capabilities are determined by the population of which capabilities are being assessed based on how they define health and which characteristics of that conception can be achieved through locally available resources and conversion factors.

To adjust the conceptual model for older people, a few notes must be made. For older persons, certain capabilities are more constrained than for younger people due to external factors such as negative stereotypes of ageing and socially constructed dependency (Lloyd-Sherlock, 2002). To

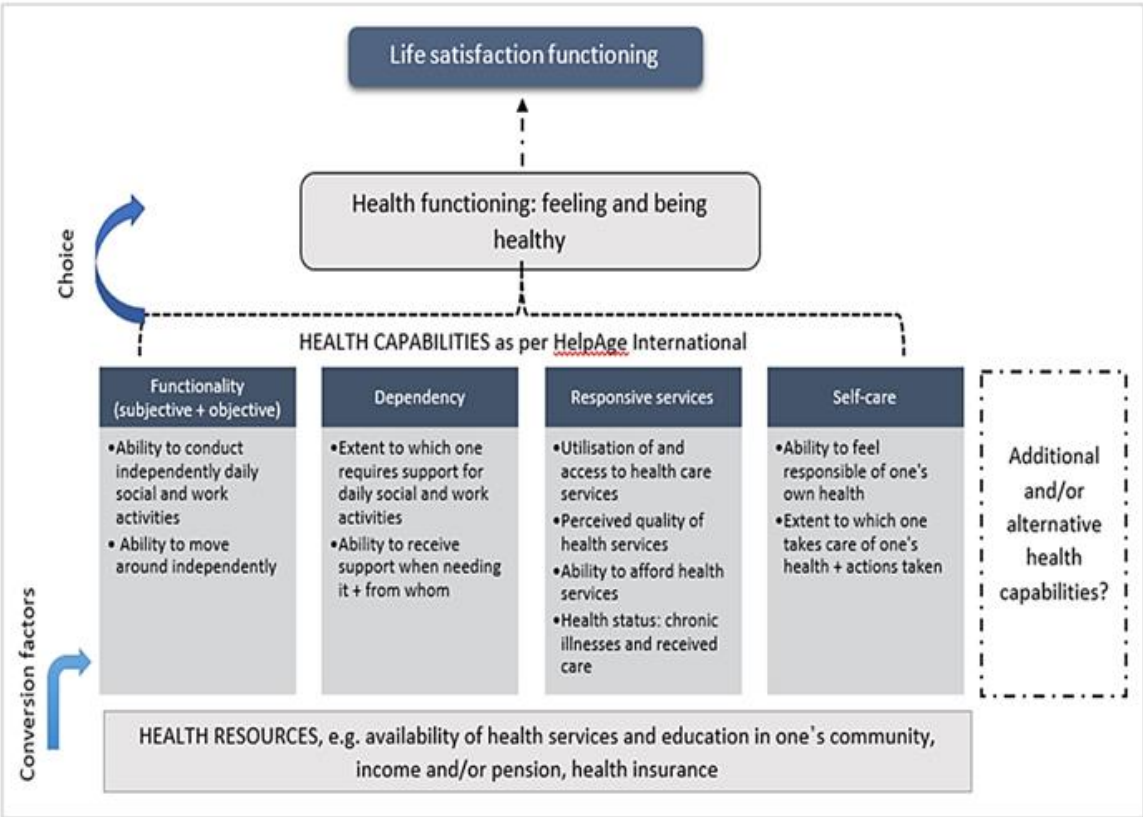
⁵ Health capability as a concept relates to 'capacity' used in WHO's 'healthy ageing' framework. However, whereas capacity refers to quantity or volume, capability reflects rather an ability to perform to achieve the desired outcome (Ruger, 2010). Moreover, the concept of capability reflects the terminology of the capability approach and will be thus preferred over 'capacity' in this study.

support older people’s capabilities, we must accordingly also tackle the external constraining conditions. On another note, certain internal capabilities (such as physical strength) decline when one ages. A challenge for policy is then to be able to effectively separate the internal capabilities from structural constraints; a task which is not easy considering how greatly the intensity, timing and speed of loss of internal capability vary in individuals (Lloyd-Sherlock, 2002). However, the concept of health capability allows us to understand the barriers and conditions that hinder and facilitate health, providing a situated evaluation of both the aim and success of programmes and policies (Ruger, 2010).

3.3 Deductive conceptual framework

The deductive conceptual framework of this research, presented in Figure 4 below, brings together HelpAge International’s framework of health and life satisfaction behind the HOT tool as well as the capabilities approach and particularly its concept area of health capabilities. As such, the conceptual framework has been developed through deductive reasoning based on existing relevant theory and literature. The conceptual framework aims to provide clarity to the concepts examined in this study and reflects the deductive assumptions made prior to the data collection. The deductive framework also presents the operationalisation of HelpAge’s conceptual framework, derived from the HOT questionnaire in **Appendix 1**.

Figure 4. The deductive conceptual framework.



4. Regional thematic framework

This chapter describes the national and regional thematic context of this study, that of the Philippines and its Metro Manila and Quezon provinces. First, geographic information and country/municipality statistics relevant to the area of research will be provided, followed by an introduction to the health sector structure, policies and municipal practices in the Philippines. The community health programmes by COSE will also be defined. Section 4.4 provides an overview of ageing and economic well-being realities, followed by a review of existing literature related to ageing and health in the country context.

4.1 National context

The Philippines is a nation consisting of ca. 7600 islands located in Southeast Asia in the Western Pacific Ocean. Its area of 300,000 square kilometres carries a population of approximately 100 million (Philippine Statistics Authority, 2016a). Around 10 million additional Philippine citizens lived overseas in 2013, forming one of the largest diasporas in the world (Commission on Filipinos Overseas, 2013). The Philippines is defined as a low middle-income country (GDP per capita in 2015: USD 3,540) and as one of the emerging economies by the World Bank (2016). The poverty incidence among Filipinos was estimated at 21.6% in 2015, improved from 25.2% in 2012 (Philippine Statistics Authority, 2016b). An explaining factor behind the national-level poverty incidence is the high disparity across geographical regions and socio-economic classes (Department of Health, 2012). Current key figures concerning older people in the Philippines are:

Table 1. Key figures of ageing in the Philippines	
Indicator	Value
Number of people over 60	7.3 million (HelpAge International, 2016b)
Life expectancy at 60	16.5 for men, 20 for women (PSA, 2010)
Healthy life expectancy at 60	14.3 for men, 16.3 for women (Cruz et al., 2016)
Pension coverage for people over 65	28% (HelpAge International, 2016b)
Rank on the HelpAge Global AgeWatch Index ⁶	50 th (moderate)

4.2 Regional context

The new democratic constitution of 1987 in the Philippines mandated decentralisation, increasing both the resources and responsibilities of provinces, cities, municipalities, and barangays. The constitution transferred the responsibility of basic services, including health services, to local government units (LGUs) that have the authority to develop their own income sources (Azfar et al. 2000). Municipalities carry the responsibility for organising primary health care and disease control, and the purchase of necessary facilities, equipment and supplies. Barangays, the lowest

⁶ The Global AgeWatch Index ranks countries according to the economic and social well-being of older people in four categories: income security, enabling environment, health status and capability (HelpAge International, 2015).

level of government units, are officially, as per the constitution, the primary implementation and planning units of the government but have in practice little policy-making capacity (Azfar and Gurgur, 2008).

Figure 5. Location of Metro Manila (NCR) and Quezon.



This study was conducted in the Metro Manila (also known as National Capital Region, NCR) and Quezon provinces of the Philippines, specifically in urban cities of Quezon City and San Juan City, and rural municipalities of Atimonan and Pagbilao. Caused by its rapid urban development in the past decades due to natural population growth and high levels of migration to the area, Metro Manila has been dealing with challenges such as housing, provision of

health services, water, education and transportation (De La Paz and Colson, 2008). The area is the most populous and most densely populated area in the country, which, together with its urbanisation rate create a polluted environment affecting health and quality of life (ibid.). As a contrast to the almost fully urbanised Metro Manila province, only 33% of the people in Quezon province live in urban areas (Quezon Province, 2016). According to WHO (2011), there is a wide disparity in health services access between urban and rural dwellers in the Philippines. Although rural health units (RHU) have a sufficient coverage, vacant public health sector positions are constantly numerous, hindering people's access to quality health care (ibid.). Some key characteristics of the research municipalities can be presented as follows:

Table 2. Characteristics of the research municipalities ⁷				
	Quezon City	San Juan City	Pagbilao	Atimonan
Province/Region	Metro Manila/ NCR	Metro Manila/ NCR	Quezon/ Region IV Calabarzon	Quezon/ Region IV Calabarzon
Land area	172 km ²	5,95 km ²	171 km ²	240 km ²
Population	2 936 000	122 200	75 000	63 400
Population density	17 099 persons/ km ²	20 534 persons/ km ²	439 persons/ km ²	265 persons/ km ²
Poverty incidence in region (2015)	5,6% (2 nd District NCR)	5,6% (2 nd District NCR)	28,2% (Quezon province)	28,2% (Quezon province)
Income gap in region	16,1 (2 nd District NCR)	16,1 (2 nd District NCR)	23,3 (Quezon province)	23,3 (Quezon province)

⁷ Source: Philippine Statistics Authority, 2015a, 2015b

4.3 Philippine health sector and key policies

The Department of Health (DOH) is the lead policy and regulatory authority of health care in the Philippines and legally accountable for guaranteeing access to basic public health services to all citizens (Boiser, 2012). Also the private sector plays a great role in the financing, provision and regulation of services in the mixed public-private system of the health sector (WHO, 2015d). WHO (2011) has estimated that the national-level health inequality arises from structural problems in the healthcare system, including weak financial protection. Furthermore, quality of public health sector facilities country-wide in terms of infrastructure, technology, patient safety and support services have been lacking behind compared to neighbouring countries (ibid).

In the recent years, fundamental changes have been made, guided by the 2011-2016 national health objectives by the Aquino administration and The Department of Health (2012), a reform which demonstrated strong policy coherence to UN's development agendas⁸. Universal health care (UHC, *Kalusugan Pangkalahatan*) was the key umbrella theme of the national health objectives that contained three strategic areas: 1) 'Financial risk protection by expanding the enrolment and benefit delivery of the National Health Insurance Program', administered by the government corporation PhilHealth; 2) 'Achievement of health-related Millennium Development Goals'; and 3) 'Improved access to quality health care facilities' (Department of Health, 2016a). The Duterte administration, selected in June 2016, has committed to continue the efforts to get all Filipinos covered by the UHC. The Philippine Health Agenda 2016-2022 (Department of Health, 2016b) provides a new three-fold system framework with leading objectives of financial protection, better health outcomes and responsiveness of services.

Scheduled originally to be achieved by 2016, the UHC target has made good progress. UHC coverage measured by PhilHealth was about 92% in June 2016 (Cabulanan, 2016). Through Republic Act 10645 in 2014, all older people over 60 years old became mandatorily covered by the PhilHealth regardless of their social or economic status. However, according to Miasco (2016) by autumn 2016 many if not most older Filipino adults were still unaware of this entitlement. Further, geographical inequalities in service provision still exist, and out-of-pocket payments remain a major expenditure for households (Caraballo, 2017). The basic type of PhilHealth insurance for senior citizens covers only inpatient care, meaning an older person can benefit from the insurance only when confined to a hospital of no less than 24 hours. In such cases, PhilHealth provides a subsidy for room, medicines, laboratory tests, operating room and professional fees given that the reason for confinement is among the recognised cases/procedures of PhilHealth (Department of Health, n.d.). The remaining fees to be paid by the patient on the spot are hard to estimate and might thus hinder an older person's seeking for treatment on time. In the assessment study of (Salenga, Loquias and

⁸ Within the new Sustainable Development Goals, all UN member states have committed to achieving universal health coverage by 2030 (WHO, 2016).

Sarol), 24% of the older people who were insured by PhilHealth or other insurance expressed having never availed its services when getting sick or hospitalised.

Another recent policy change in 2016 aiming to benefit older Filipinos concerns the provision of free maintenance medication for diabetes and hypertension from DOH to LGUs to barangay health centres. Additionally, under RA No. 9994, all senior citizen ID card holders are entitled to 20% discount and VAT exemption on all medications and medical equipment and supplies, dental and medical services in private clinics, and fees for home care services (Official Gazette, 2017).

According to studies (e.g. Salenga et al. 2015.), senior citizens' drug accessibility has remained a challenge despite the entitlements.

4.3.1 Health services in research municipalities

The municipalities of Atimonan, Pagbilao, Quezon City and San Juan City differ greatly in terms of their socio-economic profiles, as pictured in Table 2. In terms of health services, the similarities are mainly limited to public sector services, such as barangay health centres and barangay health volunteers (BHW)⁹. The Local Government Code defines that each municipality has an appointed health officer and a health board. The availability of other types of services, such as private clinics and hospitals as well as NGO-based health programmes (such as those of COSE's) vary greatly between locations. Good practices aiming to support specifically the health of older people exist in all the research municipalities, of which the ones discussed by the key informants and older respondents of this study will be covered here.

To start with the rural municipality of Pagbilao, the LGU provides a yearly monetary benefit amounting to 5000PHP to its senior citizens, consisting of 1000PHP for eye medication, 25000PHP for medical assistance, 500PHP for dental needs and 1000PHP for laboratory services (Municipality of Pagbilao, 2017). In urban San Juan City, a municipal health card provides its owner free doctor's consultation and hospitalisation. Additionally, a one-time financial assistance of 3000 PHP is provided by the municipality to a resident's family confined in a hospital. In Atimonan, the health office organises, e.g. annual consultations/symposiums for senior citizens to stay track on their medical and informative needs and maintains a fund for four types of assistive devices (key informant Atimonan, 2017). In Quezon City, large-scale resources have been recently put into assessing and creating a profile of older persons' diverse medical needs by home visits and interviews conducted by community health workers (key informant Quezon City, 2017).

⁹ BHWs undergo a basic training programme provided by a governmental or non-governmental organisation, and provide primary care in the communities where they live. In barangay health centres, they assist medical personnel. BHW service is a public health service accredited by the Philippines Department of Health and defined in Republic Act No. 7883.

4.3.2 Community health programmes by COSE

The Coalition of Services of the Elderly, Inc. (COSE), is a Philippine non-governmental organisation established in 1989 and part of HelpAge International's global network since 1991¹⁰. COSE aims to address the key challenges that older Filipino people face, including poverty, lack of health care, and social exclusion to ensure that all generations of Filipinos feel secure while ageing (COSE, 2017). COSE has since 1990 led the organising and formation of Philippine Older Persons Organisations (OPOs) which at present totals up to 450 OPOs with an approximate total of 40,000 members country-wide (ibid.). In the area of health and care, COSE advocates to urge healthcare providers, including the government, to address concerns of older people and to prepare for challenges that the populations ageing brings to systems. Furthermore, COSE trains older persons to act as various types of health volunteers serving the communities they live in. The community health programmes COSE has currently in place in the research municipalities of Quezon City and San Juan City include:

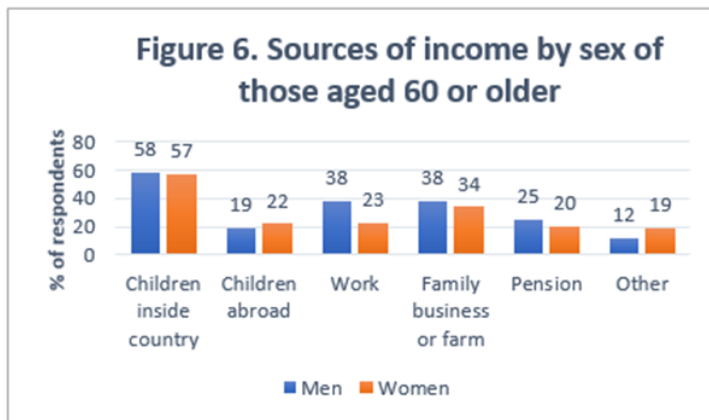
- i. Community pharmacy Botika Binhi, managed by OPOs and selling affordable and non-regulated medicines in the community targeting older persons and their families.
- ii. Homecare Programme for older people, provided by trained Homecare Volunteers and targeting especially the sick and the bedridden.
- iii. Community Health Volunteers such as Community Gerontologist, Community Masseurs and Psychosocial Support Volunteers, trained to respond to the immediate health needs of older and vulnerable people in their communities.
- iv. Health Education and Healthy Ageing Sessions conducted by Community Health Volunteers.

4.4 Social security and economic well-being at older age

Health and economic security are fundamentally intertwined subjects at older age; health problems tend to increase by age while earning capacity decreases, making costs of health care a greater concern (Natividad, Saito and Cruz, 2014). Formal financial support systems for older age are not sufficiently developed in the Philippines, forcing older people to rely heavily on traditional kin-provided sources of support. The benefit-type formal social security system consisting of The Social Security System (SSS) and the Government Service and Insurance System (GSIS) covers private sector and government and state enterprises employees. In addition, self-employed persons have a mandatory coverage under the Regular and Expanded Self Employed Programs. Since 1992, reforms to the system have expanded the coverage to concern also workers from the informal sector with permanent or provisional worker's status. Despite this, the current pension system leaves a sizable population with no pension at all - around 40% in estimates of COSE and HelpAge International (Knox-Vydmanov, Horn and Sevilla, 2017). The reasons, among others, include high

¹⁰ As an affiliate since 2004.

levels of informality and employer's preference to keep employees as non-permanent workers, inability to keeping up with monthly payments due to irregular earnings, and unawareness of the enrolment procedures (Natividad et al., 2014).



On top of the limited coverage of the system, the monthly amount of pension is insufficient to cover basic living and health expenses of an older person and his/her potential dependants (ibid.). Accordingly, older people tend to derive their income from several, in average two, different sources, of which

work earnings, financial support from children within the country and pensions are considered as the top three significant (Cruz, Lavares, Marquez, Natividad and Saito, 2014). However, notable differences exist between the sexes as apparent from Figure 6¹¹ above.

In Cruz et al. (2014) study, more men than women reported earnings from work and farm as their main income source. Men appear to be the main breadwinners of the household also at older age, and continue working until poor health forces them to stop, whereas the type of home-based work women are typically engaged with (store tending, caring) allows them flexibility regardless of their health condition (Natividad et al. 2014). Overall, the findings from the PSOA 2007 study indicate that both sexes are equally at risk of financial uncertainty in the Philippines. To deal with the uncertainty, at least 47% of male and 33% of female respondents of the study were working (Cruz et al. 2014).

The low income of older Filipinos makes them often heavily reliant on their children both residing in the country and abroad. As apparent from Figure 5, almost 60% of older Filipinos cited money from children in the country as a source of income while a fifth received remittances from abroad. On one hand, this reflects the positive impact international labour migration has on older Filipino people's economic well-being. On the other hand, the feminization of labour migration also implies negative effects on the available caregivers of both older people and children; absent parents may force older people to take up full-time caregiver roles (Cruz et al. 2014). As noted by Liebelt (2015), Philippine migration is profoundly intertwined with the so-called intergenerational contract, the expectation that every middle generation at its turn gives support and care for both the younger and older generations.

¹¹ Data source: Cruz et al (2016). Figure adapted from Knox-Vydmann et al. (2017).

Furthermore, co-residence with children can be seen as not only the normative and most prevalent living arrangement (Blace and Avenue, 2012) but also as a two-way intergenerational economic coping strategy that benefits all members of the household (Cruz et al. 2014). Despite the normative expectations for financial support from adult children based on gratitude or “debt”¹² (ibid.), the aim for self-reliance is high. Around 60% of older respondents in the PSOA study did not plan to rely on their children financially (Cruz et al. 2014). Overall, intergenerational exchange of support and co-residence are considered as the principal social security net of older Filipinos (ibid.). As defined also in the Philippine Constitution: ‘*The family has the duty to care for its elderly members although the State may also do so through just programs of social security*’ (Article XV, Section 4 as cited in De Leon, 2014).

The introduction of social pension in 2010 under the Expanded Senior Citizens Act, followed by a campaign by COSE and COPAP, mandated a monthly amount of PHP 500 (≈8,3€) to be paid to indigent persons over 60, i.e. persons facing disability and without income. The implementation began a year later prioritising first those over the age of 77 but expanding gradually to younger age groups, as per the act. A study by COSE, HelpAge and DRDF (Knox-Vydmanov et al. 2016) evaluating the impact of the scheme found that while the social pension had made a clear difference to the recipients’ and their families’ lives, the monthly amount of the pension was too low to meet the basic needs of the recipients. Further, despite the scheme more than half of all older people were still with no pension at all. Further calculations of COSE and HelpAge International have shown that a universal tax-financed social pension would provide a simple and feasible solution to ensure financial security for all older Filipinos, easing also their families’ situation considerably (see Knox-Vydmanov et al. 2017).

4.5 Literature review: ageing and health in the Philippines

Research on issues concerning older Filipino people is limited and reflects the extent to which the concerns of the older population and international frameworks have thus far been mainstreamed in Philippine development discussions (De Leon, 2014). The first comprehensive study of the health-seeking behaviour of older Filipino adults by Guzman et al. (2014)¹³, brought light to the topic of why older people seek health care and how they select the used services. Health-seeking behaviour, i.e. measures taken to restore well-being when in a perceived state of illness, can be understood as a health capability itself since it can lead to improved health promotion, faster diagnoses, and better treatment compliance (see Guzman et al. 2014). The findings of a conjoint survey analysis revealed that a physician’s experience is the most significant attribute for Filipino older people when seeking health care: older people prefer private practitioners with affordable prices (<500 PHP) who

¹² Filial obligations in the Philippines have been described in cultural terms through the concept of *utang ng loob*, literally “the debt inside oneself” (Liebelt, 2015).

¹³ Previous studies include e.g. 1996 Philippine Elderly Survey.

provide comprehensive information about illnesses (ibid). Further, a study by Beliran and Legaspi (2014) examined the relationship between measured quality of life and health-promoting behaviours of older people in Iloilo City through two quantitative QOL instruments. The findings suggested that health-promoting behaviours have a positive relationship with better quality of life scores, although the overall occurrence of health-promoting behaviour was low. Only less than a quarter of the respondents (N=223) had medical diagnoses or had sought health consultation, revealing that older people's medical conditions are commonly underdiagnosed (Beliran and Legaspi, 2014). Significant differences were also apparent in health-promoting behaviours when classified by monthly income, indicating that lack of financial resources affects one's ability to promote health and, consequently, achieve quality of life (ibid).

The quantitative study of De Leon (2014) examined quality of life in terms of health, household relations, access to governmental programmes and services, community participation and overall well-being in older population (N=421) in areas of Manila, Makati and Quezon City and the rural areas of Cabiao, Calapan and Odiongan. Statistical analysis showed that the respondents had overall positive perceptions of their lives, exclusive of inadequate income and health concerns (ibid). De Leon's findings confirm Beliran and Legaspi's (2014) notion of low occurrence of health-seeking behaviour – only around 2% of the respondents in De Leon's study had regular medical check-ups. Both studies reflect that health-seeking behaviour might not be purely a choice-based action but the agency of older people is constrained by various structural factors, such as their poor financial status and the availability of services. Moreover, in De Leon's (2014) study gender was not found to be a significant variable defining quality of life but place of residence (rural/urban) and educational background were. Blace and Avenue (2012) examined if older people's (N=780, General Santos City) functional ability and participation in activities affect their life satisfaction. The findings showed that the functional ability of older people and their participation in activities were statistically significant indicators of their levels of life satisfaction (Blace and Avenue, 2012). These findings hence partly support HelpAge International's framework and its choice of domains (see section 3.1).

The latest and second nationally representative survey of Filipinos aged 60 and older, Philippine Study on Ageing (PSOA) in 2007 focused on the health and well-being of older people as well as the related determinants, revealing substantial health gaps regarding functional disability, hearing and vision impairment and mental and oral health problems (Cruz et al. 2016). Low health insurance coverage and unmet needs for health services were reflected by the poor health services utilisation in the findings (ibid.). The PSOA study recognised further research needs on how to improve existing health-related programmes provided for senior citizens, an objective this research was set to achieve. Moreover, De la Vega (2013) conducted a cultural validation study of WHO's quality of life tool WHOQOL-BREF among 120 community-dwelling older persons from the NCR region. The

translated and culturally adapted tool was found to be a statistically and culturally valid for measuring older persons' quality of life, consisting of domains of physical health, psychological health, social relationships and environment. The findings showed that the older persons were least satisfied with their financial situation and access to health care, further suggesting that the most effective way to improve quality of life goes through enhancing their financial status (De la Vega, 2013).

The relatively few qualitative studies about the older Filipino population have delved into the experiences and perceptions that older adults have of ageing. The themes arising from Valdez et al. (2013) data concerning perceptions towards ageing included, e.g. 'aging as a responsibility'; 'aging as a promising experience'; 'aging as the process of increasing autonomy' and 'aging as a phase of increased productivity' - perceptions that are surprisingly consistent with the 'positive' ageing discourses discussed in section 2.1. The study of De Guzman et al. (2012) focused on exploring the caring expectations and frustrations of older Filipino people who suffer from chronic illnesses. The findings present care as a force driving both care frustrations and expectations, which included the following: genuine empathy and concern of care providers, availability of spiritual and moral support, professionalism, accessibility, and adequacy of facilities (De Guzman et al. 2012). Blace and Avienue's (2012) study similarly emphasised the importance of having the opportunity to participate in religious activities for the life satisfaction of older people, hinting of an inductive aspect in the application of HelpAge International's framework of health and life satisfaction in the context of the Philippines.

5. Methodology

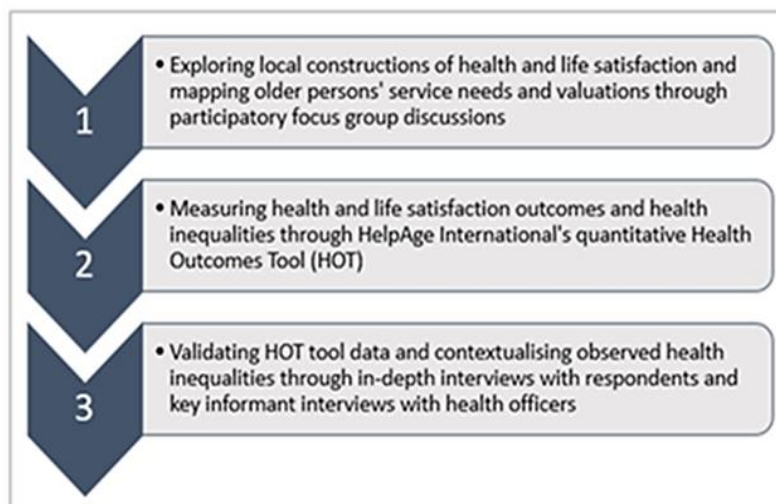
This chapter explains the design and methods of this study, followed by a presentation on the participants and the sampling strategies employed. The third section clarifies the research instruments and justifies the data analysis practices. The chapter ends with a discussion concerning the ethical considerations and limitations of the research.

5.1 Research design

The research was conducted via field-work over a 12-week-period in February-May 2017 in the Metro Manila and Quezon provinces of the Philippines. Prior to the field-work period, the researcher and two representatives from host organisation COSE attended a 4-day-lasting training facilitated by HelpAge International in Chiang Mai, Thailand for the use of the HOT tool.

The research design is based on a sequential mixed methods approach, consisting of both quantitative and qualitative methods. According to Sumner and Tribe (2008), the benefits of such an approach include elaboration and expansion: the use of another type of data analysis adds to the understanding on gains; initiation: the use of the first method sparks new research questions and hypotheses that can be explored by using a different method; and complementarity: together the two different methods generate complementary insights, allowing us to gain a bigger picture of the phenomenon in question. The research process consisted of three sequential phases:

Figure 7. Sequential mixed methods research design.



1) Participatory focus group discussions

Participatory focus group discussions (N=5) started the analytic process aiming to build an inductive conceptual framework of health and life satisfaction and to understand the meanings and valuations the respondents attach to community health

programmes in relation to other local health services. The focus group environment was deemed suitable for the objectives as it reveals the variety of views in a group but also enables the challenging of perspectives which uncovers various layers of the topics discussed (Hennink et al., 2011). The FGDs were conducted in Filipino with a COSE employee working as the main facilitator who translated the discussion simultaneously into English. In most of the focus groups, either an

employee of COSE or a volunteer of an OPO took additional Filipino-spoken notes, to which the researcher's own notes were compared to. The English-speaking transcripts were prepared by the researcher based on the notes and audio files. The focusgroup discussions took 1,5-2 hours to complete.

2) HelpAge International's HOT tool data collection

The goal of the second phase of the study was to implement the HOT tool in four cities/municipalities (Quezon and San Juan Cities, Atimonan and Pagbilao) with 300 respondents to provide a baseline of the health and life satisfaction of older persons for the purposes of longitudinal data tracking. The data collection process started in both provinces with a 1-day hands-on training for the 24 local enumerators recruited by COSE (12 in each locality). The training workshops were conducted by the researcher and a COSE employee. In the field, the enumerators worked in pairs so that one was interviewing respondents while the other was recording the responses through a tablet. The teams were coordinated by the researcher and a COSE employee on-site. Additional support and guidance in finding the respondents' houses were received from local OSCA/OPO volunteers. HelpAge International provided remote technical support throughout the data collection. The Filipino-translated questionnaire, located in a digital format on HelpAge International's SurveyCTO server, allowed immediate and secure data input. It took approximately 30 minutes for the enumerators to complete a survey interview.

3) Qualitative semi-structured interviews with HOT respondents and key informants

The final part of the study design consisted of follow-up interviews (N=16) with HOT respondents. The method of semi-structured interviews was selected since it not only provides the researcher with a guideline of topics of interest to be addressed, but also allows enough freedom to discuss alternative issues arising during the interview (UN, 2006). The interviews were designed to validate the data collected through the HOT tool as well as to contextualise and explain the quantitative findings. According to Perkinson and Salimeo (2013), self-perceptions of ageing, health and life satisfaction as they relate to socio-cultural values, norms and expectations in the framework of situated ageing can best be gathered via interviews. The interviews were held in Filipino in the respondents' homes with the support of a COSE employee. The interviews were later transcribed from an audiotape both in Filipino and in English by a person working in the earlier research phase as an enumerator. Prior to analysis by the researcher, further translations from Filipino into English were made by a COSE employee to verify the validity of the simultaneous translations during the interviews. The length of the interviews was approximately 30 minutes.

The idea and need to conduct key informant interviews with municipal/city health officers was realised during the data collection process. The key informant interviews (N=4) conducted with a health officer in each research location municipality had a complementary and informative role to

the interview data in explaining macro-level challenges of service provision as well as environmental factors that might enable/hinder health outcomes in local older people. The interviews additionally provided an opportunity for the researcher to visit some of the health facilities, e.g. barangay health centres, that the participants were referring to. The approximately 1-hour-lasting¹⁴ interviews with health officers were held in English, audiotaped, and transcribed by the researcher.

5.1.1 Participatory research and techniques

The research methods of semi-structured interviews and focus group discussions are considered as key techniques in participatory research, particularly when supported by visual techniques (UN, 2016). The underlying principle of participatory research is its contribution to social justice and equitable development by creating a safe space for expressing and channelling the unheard voices of the less powerful (Institute of Development Studies, n.d.). Participation implicates the right all people have in being part of shaping the decisions and activities that affect their lives (ibid). This research acknowledged as a starting point that the local older people have the expert knowledge of their needs and priorities required for responsive and effective (community) health services.

The level of participation is not strictly defined in participatory research and can vary widely (Hennink et al. 2011). However, commonalities between all participatory approaches include, e.g. respect for the ability of local people to analyse their realities and a commitment to empowering them; equality between participants and researchers; and an inclusive and encouraging environment to involve marginalised groups (Stewart-Withers et al. 2014). Furthermore, participatory methods entail preparedness to unlearn what has been learned and an openness to relearn from the wisdom of the community (Institute of Development Studies, n.d.). In this study it is thus the older people who direct the social change, express their priorities and accordingly evaluate if the health services/programmes available have succeeded to meet their needs. The qualitative research methods of this study recognised the diversity of realities and perspectives and encouraged the participants to bring forth their own unique interpretations and experiences. The communities guided the research process through participating in the development of the research tools (testing and feedback) and data collection (execution of sampling and recruitment of participants), as detailed below.

5.2 Participants and sampling strategies

The four research municipalities were selected for the HOT tool implementation by COSE and HelpAge International prior to designing this study based on on-going health programming work (Quezon City and San Juan City) and areas of future targeting (Atimonan and Pagbilao). Well before

¹⁴ The key informant interviews were designed to last around 30 minutes but most of them lasted an hour and more since the interviewed health officers were more than willing to share their views and discuss community health programmes and possibilities for cooperation with COSE.

the implementation process of the HOT tool, the local host organisation COSE organised meetings with relevant stakeholders, such as barangay leaders and OPOs, in the research areas to provide information about the objectives and procedures related to the research. COSE in cooperation with OPOs utilised their local knowledge to select the target barangays for the HOT sample with the aim of including a diverse combination of both disadvantaged and advantaged communities.

The HOT tool implementation was designed to include a total sample of 300 persons aged 60 and above. The sampling strategy was based on the latest official age distributions presented in the 2010 Census of Population and Housing (CPH) (Philippine Statistics Authority, 2012). Data were collected in four geographic locations in Metro Manila and Quezon Province, in urban cities of Quezon and San Juan and in rural municipalities of Atimonan and Pagbilao, to allow the assessment of different socioeconomic and demographic settings. In Metro Manila where COSE's health programmes currently operate, the sample was further divided between health programme beneficiaries (50%) and non-beneficiaries (50%) as a control group. The municipal samples of 75 persons were further divided into target clusters of 25 people/barangay.

Table 3. Age group percentages of Filipinos over 60 and the responding proportions in a full sample of 300 respondents.					
Age group	Older people in full population	% of age groups of all older people	Respondents in a sample of 300	Women (55,8%) in a sample of 300	Men (44,2%) in a sample of 300
60-64	2224237	35,70	107	60	47
65-69	1495178	24,00	72	40	32
70-74	1140892	18,31	55	31	24
75-79	705982	11,33	34	19	15
80-84	393405	6,31	19	11	8
85 or older	270786	4,35	13	7	6
In total	6230480	100,00	300	167	133

The target numbers of women and men in different age groups as presented above provided the guidelines for the sampling exercise. As per these calculations, respondents under 70 years of age form 60% of the respondents. In line with the participatory guidelines of this study, cluster sampling in different barangays was executed by local OSCA offices and OPOs based on their member records. The cluster method was to guarantee that barangays with different characteristics and distances to the heart of the municipalities (and health services) are represented in the sample¹⁵. The sampling was not designed to produce findings which could be generalised to all older people in the Philippines.

¹⁵ For the final sample, see sub-section 6.1.1.

In line with the principles of participatory research, the local knowledge and experience of OPOs/OSCA offices were utilised to recruit the participants for the FGDs based upon their membership/participation in the activities of these organisations. The targeted 6-7 participants for each focus group discussion (N=5) were selected to form a relatively homogenous group in relation to their socio-economic status and gender to allow the creation of a comfortable environment and a productive discussion. The five FGDs were conducted in research provinces of Metro Manila (3) and Quezon (2) with the following characteristics:

Table 4. Participants of focus group discussions (N=5)			
Location (municipality)	Number of participants	Gender (men/women)	Average age of participants
Quezon City	7	Women	73 years
Quezon City	6	Men	72 years
San Juan City	7	Women	72 years
Pagbilao	6	Men	73 years
Atimonan	7	Women	70 years

Similarly to the quantitative phase, to achieve the multiplicity of experiences and perspectives, the qualitative samples aimed to cover older people from urban and rural areas, men and women, people from different age groups as well as both beneficiaries and non-beneficiaries of community health programmes. The number of conducted FGDs and interviews were guided by the principle of information saturation within the limits of the research field-work timeframe of 12 weeks. The respondents of the follow-up interviews (N=16) were selected by the researcher among the HOT tool respondents based on their either very low or high scoring on the key indicators of general health and life satisfaction and potential inconsistencies in their answers. This non-random strategy is in line with the guidelines of qualitative methods that require the recruitment of respondents with characteristics that can best inform the research questions (see Hennink et al. 2011). The final sample of the follow-up interview respondents is as follows:

Table 5. Respondents of follow-up interviews (N=16)						
Location (municipality)	Number of participants	Gender (men/women)	Age group 60-64	Age group 65-69	Age group 70-74	Age group ≥80
Quezon City	4	2 men + 2 women	2	1	1	
San Juan City	4	2 men + 2 women		2	1	1
Pagbilao	4	2 men + 2 women	1	2	1	
Atimonan	4	2 men + 2 women	1	3		

Invitations for key informant interviews were sent to the main municipal/city health officer of each research municipality. However, in the urban area, the task was assigned to health officers responsible of the barangays where earlier research activities had been taking place. Four (4) key

informant interviews in total were conducted, 1 in each research municipality. A summary of all research participants is presented in **Appendix 3**.

5.3 Research instruments

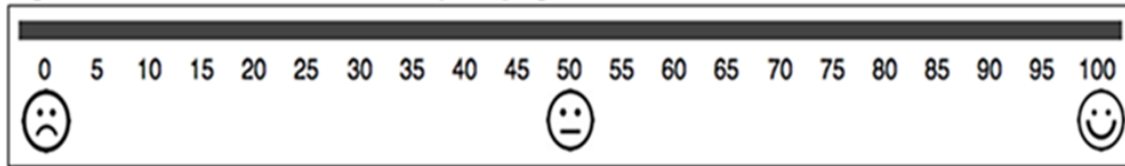
The focus group discussion guide in **Appendix 4** was designed by the researcher, guided by literature (e.g. Heslop, 2002, Hennink et al. 2011) and the expertise feedback from HelpAge International and COSE. The FGDs were built around visual participatory techniques adapted for the needs of older people. According to Heslop (2002), visual methods enable all older people, including the illiterate, to take part in the focus groups as equals. Further, they allow the presentation of complex topics in simple forms (ibid). The guide is divided into three topics each supported by visual methods: conceptualisations of health and life satisfaction (a grouping exercise following the logic of the HOT survey scale), enabling and restraining factors to health (a health capability diagram exercise), and health services and care providers (an institutional diagram exercise). The original English-speaking guide was first translated into Filipino by a professional translator, after which it was modified by COSE employees to ensure the use of age-friendly language. The visual designs presented in the guide were put into practice by drawing them on Manila paper and attaching them on the wall for all the participants to see (see photo 1 in **Appendix 5**).

The second instrument of the study, HelpAge International's HOT tool, has been designed to transfer subjective perceptions regarding health and life satisfaction into quantitative data to capture changes over time and to generate data for the organisation's corporate indicators (see section 3.1). The HOT tool, hosted by SurveyCTO server allows digital data collection via any Android-based device and the filling and storing of survey forms offline in the field. The HOT tool in **Appendix 1** is structured as follows:

1. Introduction and consent
2. Basic information and demographics
3. Questions on health perception and life satisfaction
4. Questions and follow-up questions around the four domains of health presented in section 3.1:
 - o Functionality
 - o Dependency/support needs
 - o Perception of services
 - o Self-care
5. An objective functionality test (from sit to stand)

The survey is interview-based and allows additional qualitative notes to be added along with the quantitative responses. A scoring method consisting of a line with numbering from 0 to 100 is used to help respondents mark their perceptions on a standardised scale. Photo 2 in **Appendix 5** demonstrates the visual HOT scale in action.

Figure 8. HOT measurement scale by HelpAge International.



The HOT scoring method by HelpAge, seen above in the form it was used in collecting data in this study¹⁶, has been influenced by HRQOL-related programmes such as PROMIS by National Institutes of Health (Bertfelf & Dusseau, 2016a). According to the Theoretical framework and Manager's guide publication (ibid.), the alternative line scales from 0 to 100 or 0 to 10 were chosen to allow the tracing of smaller changes in key indicators compared to category scales such as Likert. In implementing the tool to new contexts, HelpAge affiliates have the freedom to use their judgement regarding which scale, 0-10 or 0-100, works best in their countries and whether to use a scoring line with or without smiley faces. The decision in this study was given to COSE. The above-pictured scale was chosen due to its clarity and socio-culturally familiar 0-100 measure.

The third instrument, a follow-up interview guide (see **Appendix 6**) was developed by the researcher to serve the needs of validation of the HOT tool and to answer additional organisational information needs of COSE. Both HelpAge International and COSE participated in the development by providing feedback and comments. The guide focused on encouraging the respondents to explain and contextualise the scores they had given for their health, life satisfaction and other key indicators of the HOT survey, and when applicable, to describe their experiences of COSE's health programmes. The interview guide consists of 12-13 questions in total, depending on the health programme beneficiary status of the respondent. The original English-speaking guide was checked by COSE employees to ensure the relevance and appropriateness of the contents and translated into Filipino by a COSE employee who served as a translator in the interviews.

The final instrument, a key informant interview guide (see **Appendix 7**) with seven questions was similarly developed during the field data collection process. It aimed to provide a complementary service providers'/policy makers' perspective particularly into the concerns and challenges the older respondents had expressed with regards health services. The key informant interviews additionally served as a platform to discuss the cooperation/integration possibilities of municipal health services and COSE's community health programmes. A COSE employee accompanied the researcher in all the interviews held fully in English.

¹⁶ The scale was enlarged to 30x10 cm size, printed and glued on a piece of cardboard to be used as a visual aid.

Excluding the key informant interview guide, all research instruments went through a field testing process¹⁷ for validity purposes. The testing was also seen as a way to engage the community in the development of the research tools by providing them with a possibility to give feedback. The test results were not included in the sample analysed in this research, apart from some of the test-retest findings of the HOT tool in section 7.2¹⁸. The changes made to the research instruments after testing were related to the excess original length of the FGD guide as well as to the accuracy of certain research concepts translations.

5.4 Data analysis

The research methods and instruments of this study produced both quantitative numerical and qualitative textual data. This section will first detail the conducted statistical analysis of the HOT tool data, after which the applied grounded theory-based approach to the analysis of the qualitative FGD and interview data will be described.

5.4.1 Statistical analysis

The HOT tool data-set was downloaded from the SurveyCTO server and cleaned by the researcher in Excel to prepare it for the statistical analysis (final N=309). The main part of the statistical analysis was conducted in SPSS. Excel was used to draw figures presenting the results. The statistical analysis was guided by the sub-questions a., c. and d. of this study (see section 1.2). The statistical analysis made was, however, also used to interpret and complement the qualitative findings and to answer the main research question.

As the sub-question a. reflects, the HOT data was analysed both as an entity and on a province-level (Metro Manila and Quezon provinces separately). The analysis started with producing frequency and average tables for each province and the full data, as well as exploring the correlations between different key variables of the HOT tool. Sub-question c. was approached as an examination of the reliability and validity of the HOT tool, leading to statistical procedures such as Cronbach's alpha and test-retest correlations. Sub-question d. regarding barriers was approached through multivariable regression models revealing the extent different explanatory variables in the HOT tool can predict the dependent variable of general health. In other words, if the association between an explanatory variable and the dependent variable was found strong, the explanatory variable was interpreted to be hinting of a factor working as an enabler/barrier for optimal general health.

5.4.2 Grounded theory-guided qualitative analysis

The FGDs as well as the follow-up and key informant interviews produced textual data in the form of transcripts, which were analysed in NVivo using grounded theory as the guiding methodological

¹⁷ FGD guide was tested with a group of 7 and follow-up interview guide with 2 older persons. The HOT tool two-part test-retest involved 10 older respondents.

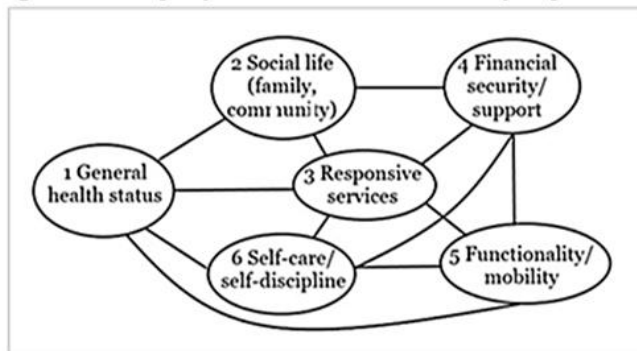
¹⁸ The findings will be discussed merely in the context of evaluating the reliability of the HOT tool.

approach. Focus group discussions also provided materials such as lists and diagrams which were synthesised directly into findings (see findings sub-section 6.2.1) according to the guidelines of participatory research (see Heslop, 2002). Focus group data was, in particular, used to answer the research sub-questions b. and e. The follow-up interview data provided answers to sub-question d. and complemented the quantitative HOT data in sub-question c. and FGD data in sub-question e. Sub-question f. was answered last through reasoning based on findings in sub-questions b., c. and e. Key informant data was used to interpret the FGD and interview data in a macro context and provide a complementary service provider perspective to sub-question c. Overall, the sub-questions formed the basis of the qualitative plan of analysis.

An approach of applied grounded theory, as detailed in Hennink et al. (2011), provided the systematic yet flexible guidelines for the analysis. Grounded theory was considered best suited for this study since it provides a circular, rather than linear, approach. The data analysis begins already in the field through studying, sorting and synthesising early data (Charmaz, 2014). This was significant for the researcher who stepped into new socio-cultural settings and aimed to make sense of local understandings and meanings in a short period of time, developing research instruments in the field based on acute data needs, and collating early findings into reports during the fieldwork period. Moreover, for a study examining a deductive conceptual framework (see section 3.3) and aiming to produce a comparable, inductive model, a type of analysis founded on the interplay between deductive and inductive reasoning was essential. Grounded theory, as Hennink et al. (2011) note, is not a theory but rather a circular analytical process to develop one based on verbatim transcripts, moving beyond description into explanatory frameworks.

The analytic tasks performed as guided by the grounded theory approach (see *ibid.*) included the following: preparing transcripts and anonymising data, developing deductive and inductive codes, coding and describing data, comparing, categorising and conceptualising data. The key informant transcripts were analysed separately from the follow-up interview and FGD transcripts. The textual transcripts were first coded in NVivo with deductive codes derived from the deductive framework as detailed in section 3.2. After that, the data was further coded with inductive codes rising from the transcripts and referring to issues or topics evident in the data. Thick descriptions of the context, depth and breadth of such issues were made. Comparing issues e.g. by respondent sub-groups, helped to identify patterns and associations between different topics; for instance, it was noted that ability to work/secure livelihood was of higher importance for male respondents' life satisfaction than that of female respondents'. Categorising codes into broader categories assisted e.g. in answering the sub-question c. regarding barriers and conversion factors. The categories were a result of reasoning combining deductive frameworks, and connections between deductive and inductive codes in the data. As an example, a code matrix regarding barriers to better health outcomes as discussed by the respondents looked initially as follows:

Figure 9. Exemplary code matrix from the analysis process.



Moreover, the seeking of answers to the sub-question e. concerning local constructions of health and life satisfaction was founded on thick descriptions of codes examining the various aspects of a code, the context and meaning given to it, the frequency of mentions (by which sub-group of respondents) as well as the linkages with

other intersecting codes. Dozens of code matrixes similar to the example in Figure 9 were drawn before the development of the final inductive model presented in section 9.1.

The main research question of this study was answered mainly through comparing the deductive conceptual framework in **Appendix 3** to the inductive model presented in section 9.1. The role of statistical analysis was particularly to reveal the validity and reliability aspects in evaluating the suitability of the global HOT tool for the Philippine context. Furthermore, the statistical and qualitative findings worked to complement and confirm each other in this study, for instance with regards to the identified barriers for optimal health outcomes (see Chapter 8). The mixed methods approach has thus added to the validity of this study by providing the researcher as well as the reader with the opportunity to evaluate the consistency of the findings from both quantitative and qualitative method perspectives. The final task of a grounded theory-based analytic process includes combining existing theories and inductively derived theory to develop a new framework or refine an existing one (Hennink et al. 2011). Such a framework is presented in Chapter 10.

5.5 Ethical issues

Age alone does not define vulnerability. However, in conducting research with potentially vulnerable and marginalised groups such as older people, the challenge is to find ways for the respondents to be able to enter our discourses in their own terms and genres (Krog 2011 as cited in Scheyvens et al. 2014). This was ensured through participatory techniques and by developing respectful relationships with the respondents, paying attention to building rapport and being accountable. It included guaranteeing anonymity and confidentiality and seeking of informed consent at each stage of the research process (see **Appendix 8** for an example consent form¹⁹). To ensure the respondents' understanding, the information in the consent form was explained verbally to them in Filipino, including details about the purpose of the study, use of data, and practices related to securing their anonymity. Those respondents who were unable to sign their names provided a fingerprint to signify consent. Participants were given their own copies of the signed

¹⁹ The consent forms for follow-up interviews and FGDs were translated into Filipino by a professional translator.

consent forms. The researcher and the enumerators of this study have also signed confidentiality agreements.

Respondents had the right to refuse participation at any point of the study without any consequences. They were informed that no current or future health or care support would be affected by their participation or decision not to participate. The qualitative data collected has only been available to the research team and kept safe in electronic formats behind passwords. HelpAge International has taken measures to guarantee the safety of the HOT tool data on the SurveyCTO server. The details of the participants from which they could be recognised have been changed in this publication. The respondents were given the full contact details of the researcher as well as the host organisations for any queries and concerns. Moreover, the sensitive nature of the research topic was taken into consideration during the field-work period by having additional support available should the interviews, FGDs or HOT surveys cause distress of any kind to the respondents or bring up unmet support needs or security concerns. The local host organisation COSE took responsibility in referring participants to relevant support services when required, including a few cases flagged by the enumerators concerning the safety and well-being of respondents.²⁰

This research has directly benefited HelpAge International by contributing to the validation and evaluation of the HOT tool and by supporting the on-going development of a complementary qualitative application. COSE have gained information about the needs and expectations for their health programmes as well as valuable information about older people's health capabilities and outcomes for future advocacy. Most importantly, this study has aimed to benefit the local older people. The older Filipino participants have been respected as experts in the research area. The study has aimed to channel their health-related needs and concerns in their contexts in as authentic form as possible. As mentioned in the objectives of the research (section 1.2), this benefits the older participants by aiming to improve the responsiveness of current and future health programmes in line with their perceptions. The making visible of their health-related needs and concerns enables local service providers and policy makers to consider them in future decisions. Furthermore, rather than depicting older people as passive victims of their circumstances, this research draws attention to their capabilities and agency in making health-related decisions.

²⁰ Further ethical considerations and code of conduct for the main part of this research, i.e. the HOT tool data collection, are outlined in the 'User's guide for the Health Outcomes Tool' publication by HelpAge International (Bertfelt and Dusseau, 2016b). Utrecht University, like other Dutch universities, does not have ethical procedures in place for the field of research nor require an approval. However, a local endorsement was sought and received by The Philippine Health Research Ethics Board (PHREB) in February 2017.

5.6 Reflections from the data collection: limitations and positionality

The key limitations associated with the type of field-work research this study represents are particularly related to the limited time reserved for the data collection as well as data biases caused by the positionalities of the researcher and the respondents (see Scheyvens, 2014). All the data of this study were collected over a period of 12 weeks. Due to this reason, the number of interviews and FGDs conducted is relatively small. However, data saturation was noticeable after the five conducted focus groups. In terms of interviews, a higher number of interviews might have brought up clearer differences between sub-groups of respondents. While such information would be highly beneficial for future advocacy and programming work, the collected amount of data served the needs of this study with regards to the research questions.

Qualitative analysis, in any setting, implies making sense of and managing the respondents' multifaceted and at times contrasting views (Hennink et al. 2011). Nevertheless, as a researcher from another culture and speaking another language, the meanings found from the data are inescapably interpreted through a lens. While the positionality of an 'outsider' brings advantages in being able to potentially capture types of aspects related to health and life satisfaction that might be left unnoticed as 'natural' by a local, the translations of qualitative research instruments and follow-up interview transcripts, as well as the simultaneous translating of FGDs might have transformed the original meanings by the respondents. As English is not the first language of the researcher either, the final findings are unavoidably complex constructions of reality translated in many ways. Precautions taken have included e.g. testing of all research instruments, the use of a local translator/facilitator familiar with the every-day life of the respondents, having interview transcripts transcribed and translated by different persons; and having materials proof-read by several native speakers to ensure the contents are appropriate and sensitive to the local socio-cultural context and the target group.

Moreover, close cooperation with the local host organisation COSE as well as HelpAge International throughout the full research process and particularly in the field have provided the researcher with the opportunity to utilise their long-term expertise. The cooperation has also given her a platform to test and critically reflect on her own interpretations and perceptions on the topic areas of the study. Despite all the precautions, it is possible that plenty of meaning got lost during the process of transcribing, translation, and final English-speaking analysis of the transcripts. Another type of methodological approach, such as discourse analysis, would, of course, be more affected by such a risk. Ideally still, the coding would have been made by a native-speaker from original Filipino transcripts.

The positionality of the researcher and its impacts on the respondents across class, age, gender and ethnicity lines have been critically examined and reflected on before, during and after the fieldwork period. The older Filipino adults and their life histories pose a clear contrast to the researcher's

position as a young, white, educated, Western woman privileged in many ways. To prevent data biases and enable capturing the perceptions of the respondents as authentically as possible, the researcher took time prior and during the field-work period to learn to understand the culture and its history. The researcher believes that the company of a local translator/facilitator from COSE in interviews and FGDs helped considerably in building rapport between the respondents and the researcher. However, it might also have affected the openness of the respondents particularly in terms of expressing critique towards the monitored community health programmes or OPO activities. However, a COSE employee as the research partner brought multiple advantages, such as the skills in communicating with local older persons and knowledge of the service network and entitlements available to them.

The positionality of the participants of the research was also considered. In the field, it became clear that some of the respondents were not used to having the role of an informant and were therefore somewhat reluctant to express themselves. To avoid biases that, for example, the presence of opposite sex might bring to a discussion, focus groups were conducted in women-only and men-only groups. It seemed that the older respondents felt more comfortable being informants in a group compared to one-to-one interviews. While such preference should be considered in further research, it is noted that focus groups and semi-structured interviews produce different types of data particularly in terms of depth. Further challenges related to securing the discussion and interview areas from outsiders whose presence might have impacted on the openness of the participants. Multigenerational co-residence being the most common living arrangement, a family member or few were present in all of the follow-up interviews. The interviews were conducted at homes of the respondents to make the setting as comfortable and easy as possible for them, and to provide the researcher with the possibility to observe and experience the respondents' living spheres. Despite the limitations described above, it is believed that participation in the research was an empowering experience, enhancing the capacity of the respondents as citizens as well as their self-esteem (see Scheyvens et al. 2014). According to the feedback given by the older persons participating in testing the research instruments, the experience allowed them to reflect on their lives with a depth and capacity that is, at their age, rarely requested from them.

The practical challenges faced during the HOT data collection in the Philippines were related to recruitment of respondents as well as dealing with the high expectations for the implementation. The recruitment process of HOT respondents through local OPOs/OSCA offices provided opportunities in some locations for the organisations and/or barangay leaders to cherry-pick respondents for the survey due to un-updated and, at some barangays, non-existing records from which to randomly select respondents. Nonetheless, the final sample of HOT respondents (see section 6.1.1) reflects a diverse combination of advantaged and disadvantaged communities in both research provinces. Furthermore, the data collection process was at times arduous for the

enumerators who had to deal with the disappointment of village leaders, family members and the respondents themselves regarding expectations for the survey and rewards expected from participation. Since COSE's representatives had visited the target municipalities and key stakeholders prior to the implementation process to inform of all the practicalities, such a response was to some extent unexpected. On-site support organised through local OPOs and OSCA offices as well as the research team's feedback and reflection session afterwards eased the effects on the enumerators and the data collection process.

6. Contextual findings on health, life satisfaction and health services

This chapter answers the research sub-questions a. and b. by presenting the main results of the quantitative HOT data as well as findings synthesised from FGD institutional diagrams regarding the role of and needs for COSE's community health programmes. The aim of the chapter is to provide a contextual basis for the following in-depth findings presented in Chapters 7, 8 and 9.

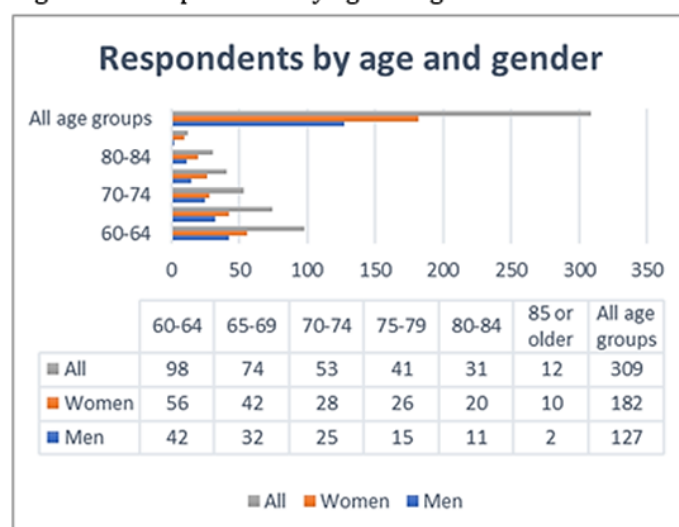
6.1 Health and life satisfaction findings as per the HOT tool

A summary of the key findings based on a quantitative analysis of the HOT data (N=309) is presented in this section. Due to the limited length of this publication, most of the statistical tables and additional graphs referred to have been placed in **Appendices 9-12**.

6.1.1 Overview of respondents

The final sample of the urban Metro Manila province consists of 156 respondents, divided between San Juan City (N=75) and Quezon City (N=81). Respondents from San Juan City come from barangays of St. Joseph (N=24), Pasadena (N=19), Corazon De Jesus (N=25) and San Perfecto (N=7). Quezon City respondents are residents of barangays of Bagong Silangan (N=35), Commonwealth (N=23) and Holy Spirit (N=23). In rural Quezon province, the final sample of 153 respondents are divided between respondents from Pagbilao (N=75) and its barangays of Silangang Malicboy (N=25), Mapagong (N=25) and Ilaya Polo (N=25), as well as Atimonan (N=78) and its barangays of Inalig (N=32), Caridad Ilaya (N=26), San Andres Labak (N=11) and Rizal (N=9).

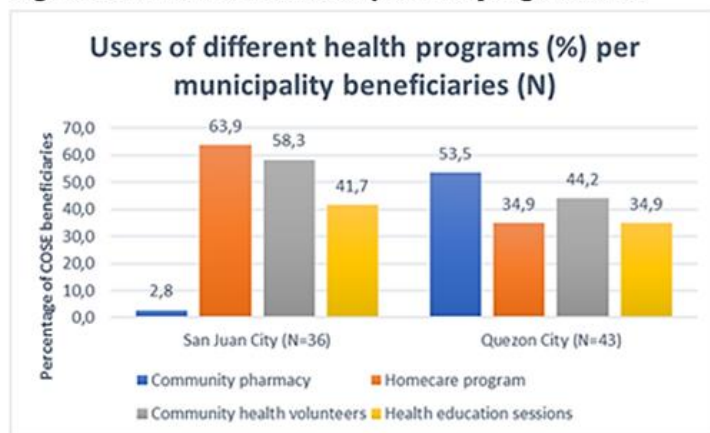
Figure 10. Respondents by age and gender.



olds 10% and 85-year-olds or older 4%.

In the full sample, the sampling strategy produced a respondent group that reflects relatively well the original sampling strategy (see section 5.2). The final sample consists of 309 respondents of which 182 (59%) are women and 127 (41%) men. The respective proportions of respondents in different age groups are: 60-64-year-olds 32%, 65-69-year-olds 24%, 70-74-year-olds 17%, 75-79-year-olds 13%, 80-84-year-

Figure 11. Users of community health programmes.



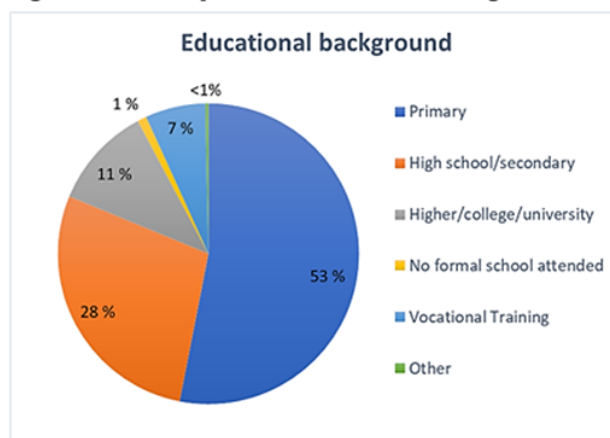
Due to the M&E nature of the HOT tool, the Metro Manila sampling prioritised that at least half of the respondents would be COSE beneficiaries. 48% of the San Juan City and 53% of Quezon City respondents expressed being beneficiaries of COSE's health programmes.²¹ The percentages of users in Figure 11 between the two cities reflect the differences in

current health programme provision; for instance, no community pharmacy currently exists in the research area of San Juan City. Furthermore, beneficiary status seems to cumulate in the data; i.e. a beneficiary of any one programme has often benefited from another programme.

With regards to PhilHealth, in rural Quezon, 95,4% of the survey respondents reported being a member and a beneficiary of PhilHealth. In urban Metro Manila, the percentage of beneficiaries was slightly lower (89,1%) with an additional 5,8% of unsure respondents. Unawareness of the PhilHealth entitlement is thus not a large-scale issue among the older population in Quezon and Metro Manila provinces, as previous literature has suggested (see Miasco, 2016).

More than half (53%) of all the respondents have only a primary level education. Another 28% have been educated to a high school/secondary level, and a minority of 11% have higher/college/university degrees. Differences between the urban and rural provinces are notable: whereas in rural Pagbilao 76% of the respondents reported having only a primary education, in urban San Juan City 43% of the respondents have a high school/secondary degree.

Figure 12. The respondents' educational background.



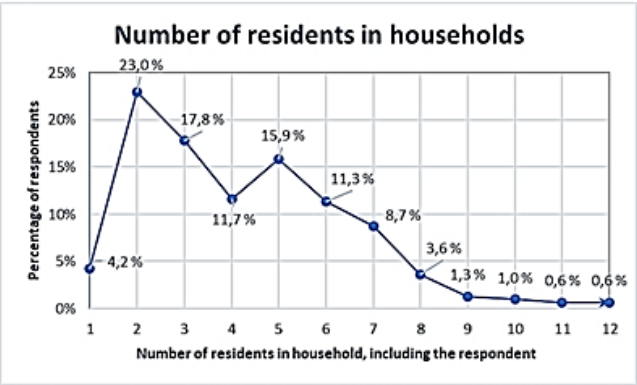
Despite what official statistics imply regarding poverty (see Table 2) in the regions, the percentage of respondents who are *not* able to afford basic needs is relatively high in all self-assessed categories of house/shelter, food, safe drinking water and keeping a good hygiene, and differences

²¹ Accordingly, the sample provides a fairly even beneficiary and control groups for assessing the impacts of the programmes. Women, however, form the majority of beneficiaries in both municipalities, in the sample and in reality; of the 79 beneficiaries in the sample, 55 (=70%) are women.

between municipalities clear (see **Appendices 10 and 11**, figures a-b). For instance, in rural Atimonan 96% expressed being able to afford for a house or a shelter whereas in urban San Juan City the respective percentage was 24%. In Pagbilao, 92% could afford safe drinking water, a proportion considerably lower (64%) in Quezon City.

The general poverty status of the respondents was assessed as they perceive it compared to other households in the same community. Participants were asked to rate their household’s poverty on a scale from 0 to 100. As per the question script of the HOT tool, they were told that 50 represents the same as most other households, 0 a lot poorer and 100 a lot richer than most other households. Perhaps due to the explanation given, the majority of respondents in all municipalities chose the exact score of 50 (San Juan City 43%, Quezon City 49%, Atimonan 68% and Pagbilao 44%). Only 1-3% of respondents in each municipality chose scores of 75-100. Similarly than the basic needs indicator, the self-perceived poverty indicator suggests a higher poverty incidence among the urban dwellers compared to the rural ones; whereas in Atimonan and Pagbilao 1% and 7% of respondents chose scores between 0 and 25, the proportions were 11% for San Juan and 14% for Quezon City (see **appendices 10 and 11**, figures c).

Figure 13. Number of residents in households.



being 2 (23%) and 3 (18%). Households were generally smaller in the countryside (median 3 persons) compared to the urban areas (median 5 persons).

6.1.2 Summary of the key HOT findings

As part of the HOT survey, the respondents were asked to rate their overall health during the past three months on a scale 0 to 100 where 0 represents very poor health and 100 excellent health. Overall, there were no major differences in average scores based on age groups and gender (see

Regarding living arrangements, only 7% of respondents in Quezon province and 2% of respondents in Metro Manila reported living alone. The HOT tool does not specify with whom the respondents live. Yet the respondents were asked how many, they themselves included, live in their households. The given numbers varied from 1 to 16, the most common response

Figure 14. Average health status by gender and age group.

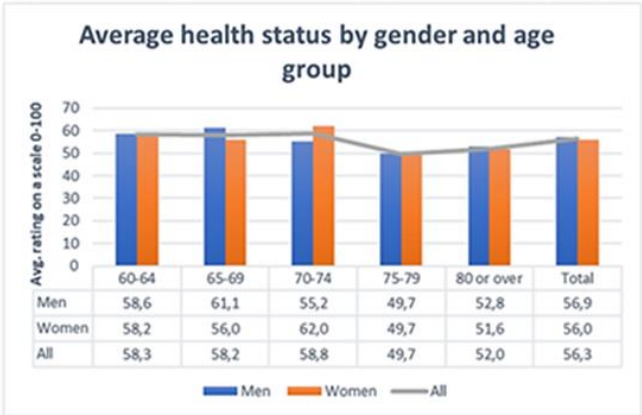


Figure 10). However, the average calculations with standard deviations in **Appendix 9** reveal that the deviation in the total sample is relatively high yet lower than in other continuous indicators of the survey data. Examining the frequency and average tables presented in **Appendix 9**, the following summary of the respondents' health and life satisfaction can be drawn:

General health and life satisfaction

- Around half of the respondents, in both men (48,8%) and women (48,9%), rated their health status on a scale 0-100 between the scores of 41 and 60, interpreted in this study as 'fair'. In addition, another 1/3 of all respondents (32,1%) gave their health either scores 61-80 (21,4%) 'quite good' or scores of 81-100 (10,7%) labelled as 'good' health in this study.
- Almost half of all respondents estimated their life satisfaction as either 'quite good' with scores of 61-80 (26,2%) or 'good' with scores of 81-100 (21,4%). Only 13% of the respondents rated their life satisfaction as 'poor' with scores of 0-20 (4,9%) or 'quite poor' with scores of 21-40 (8,1%). The proportion of individuals in the highest score category for life satisfaction (81-100) dropped dramatically from >20% to <10% when examining the oldest age groups of 75-79 and 80 or older.
- The average health status and life satisfaction scores vary considerably between barangays (see **Appendices 10-11**, figures d) with lowest health scores detected in Ilaya Polo, Pagbilao (mean 42) and highest in San Perfecto, San Juan City (mean 72). Lowest life satisfaction mean score is from Inalig, Atimonan (55) and highest again from San Perfecto (78).
- A positive correlation²² between general health status and life satisfaction was found, proving that an increase in self-perceived health status is moderately associated with an increase in life satisfaction ($r_s=,480$ $<,0005$).

Functionality and support needs

- 60,5% of all respondents gave their functionality for daily and/or social activities either scores of 61-80 'quite high' or 81-100 'high'.
- In terms of self-perceived functionality for work activities, men gave generally higher scores with 62% of male respondents rating their functionality as 'quite high' (scores 60-80) or high (scores 80-100) compared to 50% of female respondents.

²² Since Pearson's correlation is only suitable for normally distributed data, Spearman's correlation test was used to examine associations between various continuous indicators in the data. None of the continuous variables in the data (key indicators measured on a scale from 0 to 100) were normally distributed, as assessed by Shapiro-Wilk's test ($p < ,05$). The interpretation of the strength of a correlation co-efficient is based on definitions given by Weir (n.d.).

- Functionality for both daily/social and work activities seems to decrease noticeably by age, similarly to mobility. Of the youngest age group of 60-64-year-olds, 46% gave their mobility high scores of 80-100 compared to 12% in the oldest age group of 80-year-olds and older.
- Further statistical analysis shows that the indicators of functionality for daily and/or social activities and functionality for work activities have a strong positive correlation ($r_s = .793$, $p < .0005$). Furthermore, the functionality indicators have moderate ($r_s > .4$) correlations with the respective support needs indicators (see **Appendix 12**).
- It seems to be, on average, easier for women to get support when needed (68,2) compared to men (60,2). 74% of the respondents named people they live with and 23% family/relatives living elsewhere as their most likely source of support.

Health service response

- 38% of the respondents found access to health services 'quite easy' (scores of 60-80) or 'easy' (scores of 80-100), whereas 23% of the respondents thought access was 'quite difficult' (scores of 20-40) or 'difficult' (scores of 0-20). More women (19%) than men (10%) gave scores in the highest category of 80-100. Age, however, does not seem to have a clear effect on the experienced access to services.
- 44% of all respondents found the quality of health services to be either 'quite good' (scores of 60-80) or 'good' (scores of 80-100). Another 39% evaluated the quality as 'fair' with scores of 40-60, leaving 17% of the respondents clearly disappointed with the quality with scores of 0-40.
- 1/3 of all respondents found health services 'more or less affordable' with scores of 40-60. 25% considered services as barely or not affordable (scores 0-40), with the remaining 42% choosing scores of 'quite affordable' (60-80) or 'affordable' (80-100).
- The average ratings for access, quality and affordability vary across different barangays in each municipality (see **Appendices 10 and 11**, figures e). Lowest scores for access were given in barangays of Inalig (45) and Rizal (44) in rural Atimonan. Best ratings for the health service response indicators were given in areas where also health and life satisfaction scores were high, e.g. in San Perfecto, San Juan.
- Only 68% of all female respondents and 62% of all male respondents reported accessing health services when needing them. Rural women were most likely to use health services when acquiring them (69%) and rural men least likely (60%). In all groups when categorised by location and gender around 1/3 of the respondents expressed at least hesitation.

Self-care

- Self-care ratings were high across gender, age groups and living area: 52% of all respondents rated their self-care activity as 'high' (scores of 80-100) and another 26% as 'quite high' (scores of 60-80). The mean score for all respondents was 72,2 on a scale of 0-100. Self-care activity seems to decrease with age along with general functionality (see **Appendix 9**) but stays, nonetheless, high: the mean score for self-care among 60-64-year-olds was 85,0 and among 75-79-year-olds 70,6.
- When asked who is mainly responsible for their health, 81% of the respondents reported themselves, 17% chose their household, and the remaining 2% named health workers. According to the results, the respondents seem to highly value self-care.

Objective functionality test

- A majority (67%) of the respondents were able to stand up from a sitting position and stabilise independently without using the support of arms. Another 22% managed to stand on their own on the first try using the support of arms (18%) or after several times (4%). Only 2% of the respondents were completely unable to perform the test and another 9% needed assistance to stand. The findings are in line with the functionality findings; ability to stand up from sitting without support decreases by age, as does self-perceived functionality.

Statistically significant differences between respondent sub-groups

A non-parametric Mann-Whitney U test was used to detect statistically significant difference in the medians of the key indicator scores between sub-groups of respondents (see **Appendix 13** for statistical report and measures). COSE health programme beneficiary status, location (urban/rural) and gender were considered to form important sub-groups of respondents. The following statistically significant differences were found (significance level =,05):

- COSE health programme beneficiaries had statistically significantly higher median scores compared to the non-beneficiaries in the same urban areas in general health status (60 vs. 50), life satisfaction (75 vs. 60), functionality for daily and/or social activities (75 vs. 70) and functionality for work activities (75 vs. 60)
- Urban respondents from Quezon and San Juan Cities, compared to rural respondents from Atimonan and Pagbilao, scored statistically significantly higher in general health status (55 vs. 50) and life satisfaction (65 vs. 55) yet gave lower scores for quality of health services (50 vs. 70).
- No statistically significant differences existed in the medians of scores in any of the survey variables between sub-groups of men and women, meaning gender cannot be treated as an indicator explaining health and life satisfaction differences/inequalities in this data-set.

6.2 Health services supporting healthy ageing

The HOT tool is designed to monitor and evaluate HelpAge International's health and care programmes globally through assessing their long-term effects on older people's health and life satisfaction. However, what the tool results do not directly reveal from each new context it is implemented to is the role of and expectations for the health programmes from the local beneficiary perspective. The participatory focus group discussion guide (see **Appendix 4**) was developed to accommodate this purpose, among other data needs. This section will present the findings from the FGDs related to COSE's community health programmes' role in relation to other local health services and describe the needs the respondents have for the programmes.

6.2.1 The role of and needs for community health programmes

As part of the FGDs, the participants took part in an institutional diagram exercise²³ which aimed to shed light on how older people understand health services and care providers in the first place, and to explore which health services are the most significant to them. First, the participants were encouraged to come up with a list of health services/care providers available to them, after which they were asked to place the items on the list into most/somewhat/not important categories in the institutional diagram. The lists gave a glimpse of the participants' perception of services available and/or accessible to them, and reflected their own categories of services and care providers²⁴. For the full group-level analysis, see **Appendix 14**.

The results in Table 6 were synthesised based on numbers of mentions in the institutional diagrams (N=27) from four FGDs held in Atimonan (Santa Catalina), Quezon City (Commonwealth and Bagong Silangan) and San Juan City (Pasadena)²⁵. All responses in the 'most important' section of the institutional diagrams were taken into account in the following analysis:

²³ In the institutional diagram exercise, the participants were asked to place services/care providers most important to them in the centre of the diagram, those somewhat important to the middle section and services/care providers not important to them furthest away from the centre of the diagram. Each participant received a sheet of paper with the diagram printed on it. Services/care providers were written in the diagrams by hand. Those participants who could not see or write, were assisted in the task.

²⁴ This was a methodological choice by the researcher to allow participants to express their true valuations based on the assumption that people are likely to be able to name/remember the services and types of support that matter most to them (and/or their families and friends). In some focus groups, the participants used the opportunity to also highlight their unmet needs by naming services they feel should be available but are currently not.

²⁵ The diagrams conducted in Pagbilao could not be retrieved, and are thus not included in the analysis.

Table 6. Most important health services for the FGD participants			
Services/care providers identified most often as ‘most important’ (N=27)			
Service/care provider	Number of mentions	Currently available in ²⁶	Notes
1. Doctors	23	Barangay health centres of Pasadena, San Juan City and Bagong Silangan, Quezon City	In all barangays, the need for a regular doctor in health centres was brought up. The participants highlighted the need for regular health monitoring and check-ups as well as (gerontological) understanding of older people’s conditions
2. (Maintenance) medicines	19	All barangays	In all barangays, insufficient supply of (free) medicines in health centres was expressed
3. Nurses	12	All barangays	Nurses were appreciated for their professional knowledge and skills but similarly than in the case of doctors, the participants highlighted the need for home visits.
4. PhilHealth	11	All barangays	PhilHealth was identified and discussed only in two of the FGDs: in Commonwealth, Q.C. and in Pasadena, San Juan. In these locations, it was rated as ‘most important’ by most participants.
5. Barangay health centre	9	All barangays	Health centres were identified and discussed in all focus groups. Health centres were additionally often identified in the ‘somewhat important’ section. In all FGDs, inadequate services (manpower and supply of medicines) were discussed.
6a. BHW (barangay health volunteers)	7	All barangays	BHWs were identified as care providers in all FGDs. They were also regularly mentioned as ‘somewhat important’ in the diagrams.
6b. BP monitoring (blood pressure)	7	Officially part of the BHW service but in reality not available in all barangays. COSE’s health volunteers also do BP monitoring.	In the category of medical procedures, BP monitoring was the most popular topic of discussion in the FGDs, related to the identified need for regular check-ups and health monitoring.

Whereas all the urban groups identified doctors as the primary source of medical support, the rural group of Santa Catalina, Atimonan did not include doctors on their list at all. While the reason related to the unavailability of a doctor in their barangay located 15 km from the municipal centre, the group’s list and diagrams also reflected different perceptions of health services. The rural group

²⁶ Of the FGD locations: barangays of Santa Catalina, Atimonan, Pasadena, San Juan City and Bagong Silangan and Commonwealth in Quezon City.

was the only one including traditional alternative medicine such as herbalario/herbalist and local hilot massage²⁷ on their list and diagrams. Nonetheless, traditional medicine alone was not seen as a sufficient alternative to other services; the diagrams of the women in Santa Catalina reflected an urgent need for support aids such as wheelchairs as well as an improvement in the availability of doctors, medicines and medical facilities in the barangay health centre.

COSE's health programmes are currently running in three out of the four FGD locations, in cities of Quezon and San Juan. Community health volunteers were rated as part of the 'most important' category 4 times and community pharmacy Botika Binhi 1 time by the participants to whom community health services were available. Generally, COSE's community health services were often placed in the 'somewhat important' category: community health volunteers were mentioned 6 times and both community gerontologists and masseurs each 2 times (see **Appendix 14**).

Moreover, when asked which community health services are needed but do not currently exist, the respondents named medical services/procedures generally understood as being part of the public service provision, including blood, blood sugar and asthma testing, vaccines, medicines and vitamins. High need for home visits/care especially for the bedridden was regularly brought up in the FGDs. This type of service can be placed both in the current provision of the BHWs and COSE's community health volunteers and reflects a shared need recognised in all research communities.

The positioning of community health services mostly in the 'somewhat important' section of the diagrams reflects their valued role as complementary services to public (and private) health services. Based on the analysis detailed in Table 6, the strength of COSE's community health programmes is particularly their versatility in responding to different kinds of communities' needs; providing traditional health support (community masseurs), gerontological knowledge (community gerontologists), affordable medicines (Botika Binhi), and home visits and BP monitoring (home care and health volunteers), i.e. needs expressed in the FGDs (see table 6). While the respondents saw community health programmes as a valuable addition to other services they did not consider them as sufficient replacements due to the highly valued expertise of doctors. Nonetheless, the health programmes were found to provide something additional for the older persons compared to the public service provision. As noted by a key informant of this study (Quezon City), by empowering of older people to take care of themselves and their peers, the health programmes both support the health agency of the older persons, and allow them to contribute in a meaningful way to their communities.²⁸

²⁷ Both herbalario/herbalist and hilot refer to traditional and alternative healing practiced in the Philippines. Herbalario/herbalist is a practitioner who uses medicinal plants for healing. Hilot involves massaging, pressing and stretching parts of the body either for a cure or a diagnosis.

²⁸ The ability to contribute to one's community is constructed as an enabler for life satisfaction in the inductive conceptual model presented in section 9.1.

7. Reliability and validity of the HOT tool in measuring older Filipinos health capabilities

Since the first version of the HOT tool was established in 2012, the tool has undergone various changes inspired by a validation process taken place on three continents and eight countries²⁹ before the tool's implementation in the Philippines (Bertfelt and Dusseau, 2016a). An aim of this research has thus been to add to this process by revealing the nature and extent of the current tool's suitability to the Philippine context as well as to point out potential challenges in cross-cultural adaptation overall. This chapter will answer sub-question c. by first noting the strengths and weaknesses of the HOT tool observed in the data collection process, after which the reliability and validity of the tool are further assessed. Reliability and validity of a tool assessing health and life satisfaction matter greatly from the capability approach perspective since a reliable and a valid tool has the potential to quantify the individual and societal impacts of hazards to respondents' well-being and to inform service providers' and policy makers' decisions regarding the just allocation of health-related resources (Tabandeh, Gardoni and Murphy, 2017).

7.1 User and respondent experience of the tool

Collected verbal feedback from the trained enumerators pre- and post-data collection was generally positive. Having received a hands-on training to administer the HOT tool on a tablet, they felt confident and comfortable in approaching their task. Training materials provided by HelpAge³⁰ were of great help for the researcher and COSE before and during the implementation, as was the remote support from HelpAge staff. The SurveyCTO application was experienced as a simple and a user-friendly way of collecting data. The digital process enabled the researcher to monitor and process the data in real-time as it was sent to the server. This allowed immediate intervention when any problems were observed. With regards to the survey contents, the local enumerators felt that the contents of the questionnaire were suitable for the Filipino socio-cultural context in terms of measuring health and life satisfaction, apart from a few conceptual challenges detailed in section 7.5. Moreover, all follow-up interview respondents (N=16) indicated that the participation in the HOT survey was a positive experience, and most stated that the questions in the survey were easy to understand, despite some misunderstandings with the scoring scale.

From the researcher's perspective, the main practical issue in the current survey design relates to the nature of COSE's community health programmes (see sub-section 4.3.1); The beneficiaries may

²⁹ Bolivia, Colombia, Uganda, Tanzania, Ethiopia, Zimbabwe, Mozambique and India.

³⁰ Training materials included e.g. The HOT tool manager's user guide (Bertfelt and Dusseau, 2016a), the HOT tool user's guide (ibid. 2016b) and online and print materials received during the staff training course in Chiang Mai.

consist of persons who receive care and support, e.g. in the form of home care, but many of them are persons who have received training from COSE to act as health/home care volunteers themselves. This requires good mobility/functionality and sufficient health status to begin with. The HOT tool does not capture to which category does a beneficiary belong to (recipient of care and/or provider of care) nor tell us if the beneficiary status is current or if the person has e.g. received training years ago but does not volunteer anymore. Thus while it was found out that COSE beneficiaries score statistically significantly higher in health status, life satisfaction and functionality compared to non-beneficiaries (see section 6.1.2), the lack of further beneficiary variables complicate the drawing of conclusions from the impacts of the monitored community health programmes. Such an analysis was not the purpose of this study nor the aim of a baseline M&E data collection in general, however, it highlights an area where significant findings from an affiliate perspective could be enabled with small additions/modifications to the tool.

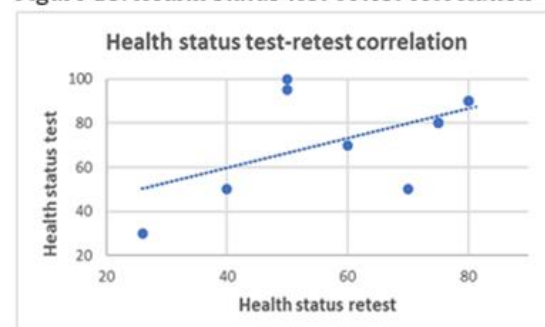
7.2 Intra-class reliability: test-re-test findings

A pilot testing of the HOT tool with 10 older persons consisted of two settings: test and re-test with 4-5 days in between. The idea of such a test-re-test was to detect and analyse changes in responses between the two rounds. In the second round, every time a respondent gave a score that differed from the one given on the first round, a verbal explanation was asked. The test-re-test consisted of the background questions included in the HOT tool (see **Appendix 1**) and of the five key indicators measured on a scale of 0-100: poverty of one's household compared to surrounding community, general health status, life satisfaction, functionality to conduct daily and/or social activities and support needed for daily and/or social activities.

To start with poverty, 4/5 respondents who changed their scoring in the re-test perceived their household as being poorer. Based on the given reasoning, timing of the interview might affect people's perceptions of their financial situation because pension, salary and/or support from family tends to be received at a certain time of the month. This can, based on the findings, make up to 40 points differences in the given score. Correlation (Spearman) between test-re-test findings in poverty was $r_s = ,380$, i.e. weak.

All 10/10 respondents changed their health status score on the re-test round. 9/10 of the respondents gave a better score. Most differences were relatively small but some were up to 50 points. Based on the given explanations it seems that the respondents might face challenges in separating current feelings, pain experiences and acute illnesses

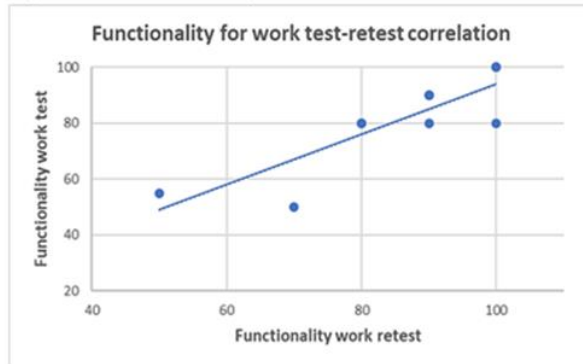
Figure 15. Health status test-retest correlation



such as cough from their general or average health status in the past 3 months. Correlation between test-re-test scores in health status was $r_s=,370$, i.e. weak.

With regards to life satisfaction, 7/10 respondents changed their scores on the re-test round, 5/7 of whom gave a lower score on the second round. As with health status, current emotions and feelings seem to play a major part in the scoring. One of the respondents gave a score 50 points higher in the re-test due to a recently solved argument with his wife. Some felt they had had time to think what is meant by life satisfaction as a concept and could, therefore, provide a more precise number. Correlation between test-re-test findings in life satisfaction was $r_s= ,405$, i.e. moderate.

Figure 15. Functionality for work test-retest correlation



Only 4/10 respondents changed their functionality for work rating on the re-test round. The differences weren't as radical as with some of the health status and life satisfaction scores. Correlation between test-re-test findings in functionality for work activities was $r_s= ,796$, i.e. strong. For the fifth tested variable, support needs for daily and/or social activities, the correlation

coefficient was $r_s= ,301$, i.e. weak. 3/6 respondents who changed their scores chose a lower number in the re-test, whereas 3/6 gave a higher score. Based on the given explanations, the change was mostly related to changes in perceived support available instead of the respondents' actual support needs³¹.

Accordingly, the findings show that functionality as a concept was simpler for the respondents to grasp and a more reliable measurement in the test-re-test setting compared to other key concepts of health, life satisfaction and support needs or the background indicator of poverty. Findings from the follow-up interviews (N=16) support the test-re-test results. The interviews, conducted 1-1,5 months after the HOT data collection encouraged the respondents to explain some of the given scores, and asked whether they would still give the same scores. 11/16 follow-up respondents³² indicated that they would score differently for health status and 6/16 would have changed their scoring for life satisfaction. In three cases respondents said this was because the HOT scale had not been properly explained to them by the enumerators, leading to a misunderstanding in the given ratings. In all other cases, however, the changes were due to acute sensations or conditions that had disappeared or risen after participating in the HOT survey:

³¹ A recorded explanation for a better re-test score given was, e.g. 'she feels that a family member is willing to support her but felt differently last week'.

³² Different from the test-re-test respondents who were not included in the HOT tool sample.

“Yes I chose 25 because during the interview I was not feeling well, especially that time I was not able to sleep well for two days, so my blood pressure was very low [---]” (65-year-old female, Atimonan, changed her health score from 25 to 40)

“It was 85 because I felt okay [---] I’m normal and feeling well except when I have vertigo or feeling dizzy [the respondent is asked how she would rate her health now] Well, maybe 60 or 75 [---] I get easily dizzy when it’s so hot” (66-year-old female, Pagbilao, changed her health score from 85 to 60/75)

“Last month it was really good [but] since 2 weeks ago, I had coughs and colds [---] I already consumed what has been prescribed but still I have coughs” (74-year-old female, San Juan City, changed her health score from 100 to 50)

The findings concerning the reliability of given scores raise a question whether the timeframe of three months in HOT key indicators is difficult for older persons to grasp in relation to acute illnesses, physical sensations and emotions. This affects the reliability of the HOT tool as an M&E tool due to the indicators’ role as HelpAge International’s corporate indicators (see section 3.1). As the above-described findings suggest, on an individual level up to 50-point changes in health and life satisfaction status even in a timeframe of days can be due to causes not in any way related to HelpAge affiliates’ health programmes.

7.3 Measurement validity: HOT scale and rating accuracy

A weakness of the scoring method (as detailed in section 5.3), recognised by HelpAge (see Bertfelt & Dusseau, 2016a), is its tendency to obtain answers around the mid-point of the scale. The frequency findings from the Philippine data support this view, showing how the visual HOT scale seems to encourage respondents to select scores of multiples of ten (10, 20, 30...), odd multiples of five (5, 15, 25...) and especially scores of 50, as visible from the below graphs of rating frequencies:

Figure 17. Health status rating frequencies.

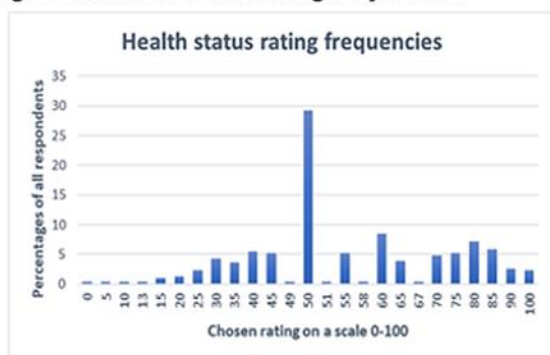


Figure 18. Life satisfaction rating frequencies.



While it may be that people generally tend to select such numbers, the design of the visual HOT scale may also guide them to do so. A respondent from the test-re-test (N=10), as well as two respondents from the follow-up interviews (N=16), indicated that they had understood that not all scores on the scale were available for choosing. While providing a longer training for the

enumerators with an emphasis to double-check verbally the score the respondent has given, and/or increasing quality control checks on research sites might help to reduce rating errors, there is a reason to believe that the data would remain non-normally distributed, affecting the availability of statistical tests to analyse the effects of health programmes to the respondents' health and life satisfaction. This is, despite interpreting the middle category scores as 'moderate agreement' rather than 'indecisive answers', as HelpAge International suggests (Bertfelf & Dusseau, 2016a).

7.4 Content validity: Internal consistency of the HOT tool

A Cronbach's alpha procedure³³ was run in SPSS to statistically analyse the internal consistency of the HOT tool, i.e. if the variables measure what they aim to measure. The variables were selected for the test according to the conceptual framework of HelpAge International behind the tool (see section 3.1). Each of the conceptual domain of the HOT tool contains several variables of which the main ones are continuous in nature (measured on the scale of 0-100). Hence, the following variables were taken into consideration in the procedure:

Table 7. HOT tool variables tested with the Cronbach's alpha procedure	
Domain	Variable
Functionality	Functionality to conduct daily and/or social activities
	Functionality to conduct work activities
	Mobility
Dependency/support needs	Support needs for conducting daily and/or social activities
	Support needs for conducting work activities
	Support provided when needed
Health services response	Access to health services
	Quality of health services
	Affordability of health services
Self-care	Extent of self-care

Figure 19. Reliability statistics table.

Reliability Statistics		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.852	.853	10

Three respondents were excluded from the analysis due to missing values in some test cells of their cases.

Accordingly, 306 respondents in total were included in the Cronbach's alpha calculations.

The reliability statistics in Figure 19 show that the Cronbach's alpha (α) is 0.852, indicating a high level of

internal consistency for the tested variables measuring general health in the questionnaire.

³³ Principal components analysis, a statistical test better suited for measuring internal consistency of a questionnaire with several conceptual domains such as HOT, was not utilised in this research due to its high sensitivity to deviations from multivariate normality.

Figure 20. Item-Total Statistics of a Cronbach's alpha procedure.

Item-Total Statistics					
	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
func_dailyact_bl	563,88	18863,726	,711	,722	,825
func_workact_bl	567,34	18734,402	,676	,690	,827
mobility_bl	565,92	18702,420	,678	,625	,827
supportneed_socialdaily_bl	571,76	19678,820	,540	,532	,840
supporteeded_work_bl	574,85	19517,123	,538	,538	,840
supportprovided_bl	570,23	20520,085	,449	,251	,847
accesshealthcare_bl	576,26	19930,469	,486	,310	,845
quality_bl	571,20	20081,465	,447	,285	,848
afford_bl	573,33	20027,941	,460	,282	,847
selfcareextent_bl	552,93	19836,208	,581	,358	,837

The Item-Total Statistics in Figure 20 reveal the contribution of each survey item to the HOT tool. When the items are measuring the same underlying construct, the correlation co-efficient in column 'Corrected Item-Total Correlation' should be relatively high; coefficients

lower than 0,3 indicate that an item is not measuring the same underlying construct (Laerd Statistics, 2015b). As is apparent from the above figure, all tested variables of the HOT tool pass this requirement, meaning, they all measure the same underlying concept of general health in the Philippine dataset. The variables in the functionality domain show not just strongest intra-class reliability (see section 7.2) but also the highest content validity of the tested indicators.

7.5 Construct validity: qualitative observations from the Philippine context

In addition to content validity and measurement validity discussed above, validity can be understood e.g. as construct validity. Due to the standardised nature of the HOT tool and the theoretical framework of this study, construct validity is here understood to be particularly related to the role of language and socio-cultural realities. Both have their impacts when WHO's policy frameworks are first operationalised into HelpAge's conceptual model and sets of questions in the HOT tool and then translated into local languages. The observed challenges during the Philippine data collection were related particularly to concepts of 'work' and 'support' evident in deductive domains of functionality and dependency/support needs.

The HOT tool measures both the respondents' functionality for work activities as well as their support needs for work activities. In the original English-speaking survey, livelihood-related examples such as cooking and fetching water/firewood are given. During the testing and translation process of the tool, COSE added examples they felt were contextually more appropriate, including farming, fishing and running a family business. However, the enumerators reported that the older respondents had difficulties in grasping the meaning of work activities as something else than income-generating jobs, despite the given examples of livelihood activities that were mostly kept in the survey (see **Appendix 1**). Rather, the given livelihood examples made it difficult for them to differentiate the questions regarding daily and/or social activities and work activities. The

following script³⁴ of a follow-up interview reflects the understanding of the concept of 'work' as something that generates a stable personal income:

Transcript 1

I: *Could you tell us what you do during a normal day from the moment you wake up. What does your normal day look like?*

R: *As of now?*

T: *Yes upon waking up in the morning, what do you do?*

R: *Go out and around.*

T: *Just going out?*

R: *Yes, because I'm not working anymore, I do some household work like cleaning the surroundings.*

T: *Cleaning the house, you are not working? Don't you have a business?*

R: *None.*

T: *Ah this is your wife's business? [pointing the restaurant where the interview is being held]*

R: *Yes. I have a business with one of my children from my first family. I would assist one of my children from my first family who has a store by buying additional stuff for the store.*

(Follow-up interview with a 63-year-old male, Pagbilao, retired with SSS pension)

Activities mentioned as examples in the HOT tool, such as fetching water/firewood, cooking and cleaning were considered as daily activities and chores, also in the rural areas and among respondents with no pension:

Transcript 2

T: *Do you have work?*

R: *None.*

T: *If you are not working, how do you survive?*

R: *I have a small store just enough for my daily needs.*

T: *Do you own this store?*

R: *Yes. I don't have enough capital for my store so the small income I get will be allotted for my food.*

(Follow-up interview with a 63-year-old female, Atimonan, no pension)

Due to the original operationalisation of 'work' in the standardised HOT tool that resembled the Filipino respondents' understanding of daily activities, the ratings given for work functionality might not be directly comparable to other global data. It must be noted that contribution to the community through un-paid activities seems to be of high importance to the respondents, such as roles of responsibility in local OPOs (see section 9.1). Work as a concept, however, serves another, financial meaning.

³⁴ Abbreviations I., T. and R. in the transcript stand for: I.= the interviewer (the researcher), T.= the translator and R.= the respondent

The construct validity challenge related to the conceptual domain of dependency/support needs underlines a dissonance between the theoretical background behind the HOT tool, particularly the concept of ‘functional capacity,’ and the local understandings of (inter-generational) ‘support’. The conceptual domain in the original HOT tool refers particularly to physical support needs, i.e. care needs. This is apparent from the HOT tool training materials aiming to guarantee the correct understanding of the survey concepts. In a guidance table from the HOT User’s Guide³⁵ support needs are discussed synonymously with care needs:

Figure 21. Dependency/support needs definition in HOT user guide.

E. Dependency		
Q6- During the past 3 months to what extent did you require support/help from other people (eg, family or friends or community workers) to carry out your usual social and/or daily activities ?		
As opposed to respondents’ perceived care needs, this question aims to understand the actual extent to which the respondent needs support/ help.	Scoring after discussion Prompt: Do you feel in need of help? Explore with respondent what they need help for, and the extent of help, in order to score. Use the information given in response to the question on functionality to carry out different tasks.	
Q7- When you need it, are you able to get regular care/help easily?		
This question explores whether people are receive the support they feel they need and how easy or difficult it is to get support.	Score after discussion.	Compare answer to the previous question about needing care.

Already during the testing of the HOT tool, it became clear that the respondents understood the concept of ‘support needs’ as referring to their financial support needs instead of physical care/assistance needs. The original meaning of the concept was discussed in the enumerators’ training, and the enumerators

were encouraged to verify the respondents understanding of the concept during the interviews. Despite this, the final data shows inconsistencies due to the varying understandings; many of the respondents are referring to the (lack of) formal pension as well as the financial assistance received from children when rating their support needs. This is evident from the follow-up interview transcripts:

Transcript 1

I: [---] I would like to also ask about your support needs. That was asked in the health survey. So you had to rate your support needs where 0 meant needing a lot of support and 100 not needing any support [showing on the scale] and let me have a quick look what you rated uhm... You rated 85 so not needing much support. But how do you define the support needs you have?

R: What I understood it is the support from the government [referring to his SSS pension and financial medical assistance from the municipality of Pagbilao]

(Follow-up interview with a 63-year-old male, Pagbilao)

³⁵ Bertfelt and Dusseau, 2016b, p. 24, Annex 1: ‘Definitions of concepts in the HOT survey’

Transcript 4

I: [---] *So we also asked you a month ago about your support needs, how much support you need for daily activities and work activities. And a month ago you gave a score of 0 for both and on this scale [showing the scale] 0 means needing a lot of support and 100 would be not needing any support.*

T: *Ok, when you were interviewed before regarding your need of support, what is the kind of support you mentioned?*

R: *Of course I meant financial support.*

T: *What about physical support, do you have somebody supporting you in your daily tasks?*

[Respondent's wife joins the conversation]: *None, we just help each other.*

(Follow-up interview with a 68-year-old male, San Juan City)

As reflected from the above-quoted transcripts, 'support' was understood mostly as financial support, not as physical assistance/care as in the original HOT framework. Due to the interpretation, many respondents did not make a clear difference in their ratings between support needs for daily and/or social activities and support needs for work activities, as reflected by the high statistical correlation between the variables. More than half of the respondents in follow-up interviews (N=16) explained having meant merely financial support from children/government when rating their support needs. The rest indicated having meant both financial and physical assistance when discussing support, but none referred to only to the physical aspects of the concept. The concept of 'support' was, accordingly, interpreted by the respondents in the light of constructions socio-culturally available and significant for them personally, providing the first clues to the context-specific value of the capability of receiving financial support (see inductive conceptual model section 9.1).

8. Local barriers, lack of capabilities and conversion factors

The capability approach has been noted as highly suitable for evaluating the aim and success of health policies and practice since it allows us to explore the conditions that enable and barriers that hinder individuals' ability to make health-related choices (Ruger, 2010). To analyse the conditions and barriers that affect older Filipinos health and agency in the research provinces, this chapter will first present the statistical predictors of general health in the HOT dataset. Next, the quantitative results are complemented with qualitative findings introducing the barriers the older respondents themselves identified. The categorised barriers are located as part of the deductive health capability model (see **Appendix 2**), which has been modified to the research context. The third section of this chapter looks examines the conversion factors hindering the conversion of the locally available health resources into health capabilities and functionings.

8.1 Explanatory variables of general health

Figure 22. Multiple regression analysis model summary 1.

Model 1. (N=300)					
Model Summary ^b					
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.685 ^a	.469	.412	14,198	2,143
a. Predictors: (Constant), selfcareresponsibility_1_bl, hearing_bl, gender_bl, afford_bl, peopleinh_h_number_bl, basineeds_house_bl, dup_chronicillness, supporteeded_work_bl, cosebeneficiary, education_bl, basicneed_hygien_bl, quality_bl, compare_poverty_bl, seeing_bl, remembering_bl, supportprovided_bl, basicneed_water_bl, dup_agegroups, sitstand_bl, lifesatisfaction_bl, selfcareextent_bl, accesshealthcare_bl, basicneeds_food_bl, walking_bl, supportneed_socialdaily_bl, mobility_bl, location_bl, func_workact_bl, func_dailyact_bl					
b. Dependent Variable: healthstatus_bl					

Multiple regression analyses were run in SPSS to determine whether the various independent variables of the HOT tool³⁶ can help explain some of the variation and inequalities of the dependent variable of general health. The eight assumptions required for multiple regression were tested

step-by-step (see Laerd Statistics, 2015c)³⁷, after which the first model, taking into consideration all the variables of the HOT tool surviving the tests, was drawn (Figure 22).

As apparent from the model summary, Model 1 is able of explain only 41% (Adjusted $R^2 = 0,412$) of the variability of the dependent variable general health. Furthermore, as evident from the table of coefficients (**Appendix 15**) and verified through other statistical methods in section 6.1.2,

³⁶ Both nominal background variables e.g. age, location, beneficiary status as well as continuous key variables e.g. functionality, mobility and self-care extent.

³⁷ Indicators were excluded when they did not meet the requirements either based on their non-linearity or because they were not significant as predictors of general health. Outliers were removed from the assessed data. Linearity was assessed by partial regression plots and a plot of studentized residuals against the predicted values. Durbin-Watson statistic was used to define the independence of residuals. Homoscedasticity was examined through visual inspection of a plot of studentized residuals vs. unstandardized predicted values. No evidence of multicollinearity was found (no tolerance values greater than 0.1). Furthermore, no studentized deleted residuals greater than ± 3 standard deviations, no leverage values greater than 0.2, and values for Cook's distance above 1 were present. TAs assessed by Q-Q Plot, the approximate assumption of normality of residuals was met.

background indicators such as gender, age, location and education are not statistically significant indicators in predicting self-perceived health in the study population. Moreover, standardised such as those measuring disabilities or fulfilment of basic needs (Washington group), are not predictive in the data set. Despite the moderate positive correlation between the functionality variables and general health (see **Appendix 12**), these variables were not found to be statistically significant predictors of health when taking into consideration all other variables of the HOT tool. This may, to some extent, reflect the discussed challenges in translating the key concepts of ‘work’ and ‘support’ into the socio-cultural context.

Figure 23. Multiple regression analysis model summary 2.

Model 2. (N=303)					
Model Summary ^a					
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
2	.653 ^a	.426	.408	14,237	2,103
a. Predictors: (Constant), selfcareextent_bl, peopleinhh_number_bl, dup_chronicillness, compare_poverty_bl, supportprovided_bl, accesshealthcare_bl, afford_bl, lifesatisfaction_bl, mobility_bl					

The group of variables tested was next reduced to contain only variables that proved out to be statistically significant ($p < .05$) (see coefficients table in **Appendix 15**) to find the most suitable model to explain and predict health outcomes in the

research population. Reducing variables from 29 to 9 kept the Adjusted R² level almost the same (explaining 40% of the variance) as apparent from the model summary above.

The regression model 2. statistically significantly predicted general health status, $F(9, 293) = 24,157$, $p < .0005$, adj. $R^2 = .408$. Of the nine tested variables, eight added statistically significantly to the prediction, $p < .05$. Of these indicators, including chronic illnesses, number of people in household, mobility, affordability of health services, self-care extent, perceived poverty status compared to community, support provided and life satisfaction, the most significant explaining factors of health are whether or not one has chronic illnesses ($B = -4,196$), number of people in household ($B = .809$) and self-perceived poverty ($B = .215$)³⁸. Statistically, the most significant barriers to health are thus related to poverty, living alone and having existing chronic illnesses.

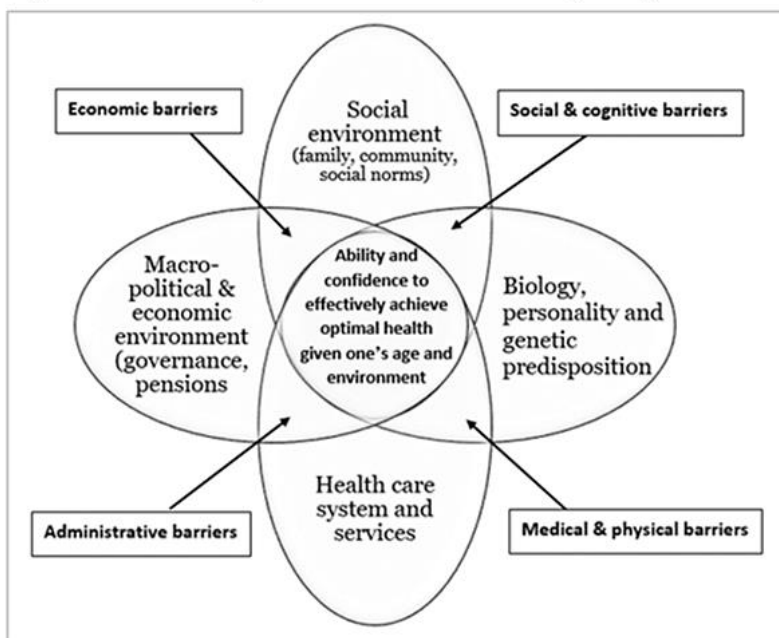
8.2 Barriers to health: qualitative findings

This section turns the scope from statistical predictors of health into barriers to health, as identified and perceived by the older respondents themselves. Factors defining the respondents’ health and hindering an older person’s ability to achieve optimal health were discussed both in FGDs ($N = 5$) and follow-up interviews ($N = 16$), both on personal and general levels (see guides in **Appendices 4 and 6**). The coded textual data were grouped and categorised under wider labels as follows:

³⁸ To put the findings into words, statistically a chronic illness decreases a respondent’s health score by 4,196 on a scale of 0-100 when controlling all other variables. Similarly, 1 person increase in household improves one’s health score by 0,809 points on the scale when controlling all other variables. Finally, with every 1-point improvement in relative self-perceived poverty, one’s health status increases by 0,215 points when controlling all other variables.

Table 8. A structured list of identified barriers to optimal health	
Economic barriers	No access to financial support from one's children
	No livelihood/income opportunities
	Inadequacy of SSS/social pension or no access to a pension
	Unmet basic needs
Social and cognitive barriers	Shame in asking financial support from one's children
	Expectation/choice to invest in (grand)children rather than one's health
	Unawareness of health services available in the community
	Lack of health education and awareness
	Conscious lack of self-care, e.g. having vices and unhealthy eating habits
	Tendency to stress and/or worry
	Overworking or being 'lazy'
	Choosing to not follow doctor's advice
	Weather conditions (traditional beliefs)
Medical and physical barriers	Diagnosed/undiagnosed chronic illnesses
	Ineffectiveness of medication
	Lack of mobility to access health services
	Lack of functionality to work
	Lack of functionality to self-care
Administrative barriers	High prices of health services and medicines in relation to average pension/income
	Unavailability of doctors and/or medicines at barangay health centres
	Nepotism or political affiliation defining access to public health services
	Low quality and ineffectiveness of public health services in relation to private services
	Long queues to access public health services

Figure 24. Positionality of barriers in the health capability model.



The deductive health capability model by Frosch et al. (2009, **Appendix 2**) was adapted to bring the above findings together in a conceptual model, and to present the positionality of the barriers in a wider health capability context, as per the theoretical framework of this study. The positionality of the barriers in Figure 24 reflects the spheres from which the categorised

barriers mainly stem, not the areas to which their impacts are limited. For instance, while the value attached to actions of self-care is related to social norms of a community, it is suggested that personal characteristics such as one's personality define how inclined one is to obey such norms. Similarly, functionality-related barriers were considered as medical and/or physical barriers and located in between the spheres of biology, personality and genetic predisposition and health care system and services despite obvious connections to social and economic spheres, e.g. in the case of 'lack of functionality to work'. This is because functional decline can be decelerated to an extent by the support of professional medical care and rehabilitation, reflecting here potential deficiencies in this domain (further explored in section 8.3).

The category of 'economic barriers' is conceptually located in the model between domains of macro-political and -economic environment and social environment; as discussed in the previous sections regarding validity of the HOT tool, older age security and 'dependency' in the data seem to be strongly informed by a financial aspect in the unique socio-cultural and political-economic context of the Philippines. Lack of (sufficient) income/livelihood/financial support from children was indeed the most common answer given by follow-up interview respondents to explain health outcome differences in their communities, supported by the quantitative findings presented in the previous sections as well as the earlier literature on the insufficiency of pensions and other single sources of income in meeting one's basic and health needs (see section 4.4).

Furthermore, as also discussed in section 4.4, despite the normative and prevalent arrangement of filial piety, i.e. expectation of intergenerational support, the strong aim for self-reliance among the Filipino elderly (see Cruz et al. 2014), is reflected from the data in the form of shame and ambivalence, social barriers conceptually located as stemming from the spheres of social environment and biology, personality and genetic predisposition. The experienced shamefulness of needing to ask financial support from one's children for basic health costs was named as a personal barrier directly by five follow-up respondents. A respondent reported taking rather loans to keep her small-scale livelihood business running than asking support from her children. The theme of expectations for financial support yet unwillingness to directly ask for it was discussed in the data across categories of gender and location (urban/rural), here by an urban male respondent:

Transcript 5:

[Respondent is asked what type of support he meant when rating his support needs]

R: *It's financial really, I need a lot. Though it's shameful to ask from my children.*

T: *Who gives you financial support?*

R: *Actually, I have my source of income.*

T: *So the children are the ones who...?*

R: *Well my children are generous but as much as possible I don't ask [support] from them.*

(66-year-old male respondent, Quezon City)

Another noteworthy barrier located in between the social environment and biology, personality and genetic predisposition domains, and revealing the importance of context-specific social norms in health functionings, is the expectation/choice to invest in (grand)children rather than one's health. Again, this is a barrier discussed in the data specifically on a personal level to explain one's own health behaviour. A transcript of an interview with a female respondent with multiple severe chronic illnesses and no current treatment reflects this ambivalence in priority-setting:

Transcript 6:

T: Mother, you were also asked about your life satisfaction, are you happy and contented with your life now? Your score was 50, are you sure [about the score]?

R: Not so [happy], because I still have one grandchild which I support to go to school.

T: Actually she's not really that happy and contented because at her age she's still supporting the education of her grandchild. [---] So, what do you do to survive in your present situation?

R: Nothing I just pray to God. [---] if I still wake up in the morning... I hope I can still support my grandson.

T: She wants to send her grandson to school.

I: Ok so a normal day for you, what does it look like? What are your daily activities when you wake up?

R: I wake up early to open my store so I would have more sales to buy us food [---] Even though there are times when I have to wake up in the middle of the night to accommodate my customers.

(A 68-year-old female, San Juan City)

Comparing the qualitative findings presented in Table 8 to the statistical results in section 8.1 presenting the most significant predictors of general health, a clear resemblance is detected. Of the statistical indicators, number of people in the household, self-perceived poverty as well as received support create links with the category of economic barriers. Moreover, chronic illnesses and mobility can be placed in the category of medical and physical barriers, and self-care extent in social and cognitive barriers. Affordability of health services, conceptualised here as an administrative barrier, among other administrative barriers will be further discussed as a

Figure 25. NVivo word cloud for deductive node 'access'. conversion issue in the next section.



8.3 Challenges in converting health resources into health outcomes

As defined in section 3.2, conversion factors in the framework of health capabilities refer to the extent to which individuals can transform locally available health resources into health functionings. Having already discussed some key individual and social level barriers to health in the previous section, this section focuses on institutional-level conversion

factors, a level crucial in the M&E framework of this study. In other words, the administrative barriers from the categorisation in the previous section (Table 8) will be discussed as they manifest as conversion factors in the data. The findings will be presented both from supply and demand perspectives; the interview and FGD data present older people's 'demand' perspective, complemented by the 'supply' perspective of the key informant interview data.

A health entitlement available to all senior citizens, such as a PhilHealth membership, does not yet tell about conversion factors but merely of equal opportunities. The concept of conversion factors can, however, explain why respondents get unequal amounts of health out of the same health resources available to them (Ruger, 2010). Table 9 below brings together the administrative barriers identified by the older respondents in the previous section (Table 8) with the complementing perspectives arising from the key informant data. The conversion factors are categorised into affordability, availability/quality and accessibility -related factors:

Table 9. Demand and supply perspectives to conversion factors to health	
Older persons' demand perspective	Health officers' supply perspective
Affordability	
High prices of health services and medicines in relation to average pension/income	Limited and generalised budgets (no specific budgets for senior citizens in all LGUs)
Availability/Quality	
Unavailability of doctors at barangay health centres	Demanding job with competing workloads, high levels of responsibility and low salary – difficulties in filling positions
Low quality and ineffectiveness of public health services in relation to private services	Time-consuming home and barangay visits due to long distances (rural areas)
Long queues to access public health services	Insufficient local government budgets for hiring enough workforce
Unavailability of free medicines at barangay health centres	Occasional unavailability of free medicines due to procurement and distribution issues. Lack of knowledge related to medicines (generic vs. branded)
Accessibility	
Nepotism, corruption and political affiliation in availing public health services	Funding and administration of municipal health services under LGUs instead of the national government, allowing influence of local politics

8.3.1 Conversion factors related to affordability

To start with the category of affordability, the following transcript reflects how lack of income hinders older people from accessing health services in the first-place due to high prices of check-ups and medicines:

Transcript 7

T: We have interviewed other older persons in the community and they gave different ratings on their health status, what do you think is the reason?

R: *I think it depends on their living conditions [---] If they don't have money they will not go to the health centre or to a doctor. Then the health centre also, sometimes they don't have doctors and medicines.*

[family member joins conversation]: *Last week she got a prescription from the doctor but they only give [prescribe] medicines for 5 days.*

R: *I don't have money to buy medicines.*

I: *I understand that the prices of medication and the services is a barrier for you to maintain your health?* [respondent nods] *Yeah OK.*

R: *I haven't bought the medicines prescribed by the doctor, I can't rely on my children in the province because they also have their families to take care of. They were quite worried when they saw me losing weight.*

T: *How do you face this problem?*

R: *Just trying to survive [---] I just pray to God that he will not forsake me even though I'm not taking my medicines.*

(74-year-old female, San Juan City)

Despite the -20% and VAT free benefits provided for Filipino senior citizens to ease their financial burden, previous evidence by Cruz et al. (2007) points out the adverse effects of such policies privileging mainly those who have the means to buy services/medicines but failing to ease the situation of those who cannot afford them. Moreover, in the case of the respondent quoted above, a sudden illness of her child and the main breadwinner of the co-habiting family had thrown them all into sudden poverty. This reflects the lack of public safety networks available to the respondents. The pervasiveness of out-of-pocket payments as the main health financing source forces families to find funds when most vulnerable; according to WHO (2011), it tells of a severe inequity in the Philippine health care system.

Some of the key informants interviewed traced the affordability issue back to the limited and generalised health budgets of some LGUs. When older people's needs and priorities are not specified and treated as their own entity, they may get buried under other groups' priorities from the demand perspective: *'They [the barangay health centre] prioritise the poorest of the poor residents including children but not older persons'* (66-year-old male, Quezon City), backed up by the FGD participants in Pagbilao: *'Most of the medicines in the barangay health centres are for children, there is nothing for the elderly'*. From the supply-perspective, the prioritisation of younger groups seems, however, rational: *'We are limited by certain policies by the national government, although we have so many plans for our senior citizens [---] So unlike in other countries, there are so many senior citizens, only few young generations but in our country, there are so many young as compared to the others'* (key informant, Atimonan).

8.3.2 Conversion factors related to availability/quality

In addition to the affordability factors, the respondent in the above-quoted transcript 7 also refers to the lack of doctors and (free) medicines in barangay health centres, implying that these issues

have a direct effect on low ratings of health in the HOT survey. The lack of doctors and medicines was a topic raised by all the FGD groups and by numerous follow-up interview respondents. As such, it is an aspect central to understanding the older persons' health-seeking behaviour. The concern was generally well understood by the key informants, doctors themselves.

The key informant from Atimonan, working as the only public-sector doctor for 66 000 people in his rural municipality on top of other duties assigned to him, traced the manpower issue back to a lack of political will on the LGU level to realise investment plans regarding health. Backing this view, the key informant from Pagbilao added another side to the issue: *'I hope some day they will give us more doctors so that we could serve the community well. And the problem is, no doctor wants to serve the community. You know why? Because the salary is so low.'* The expanding private sector in cities with better salaries combined with a high overseas demand for Filipino doctors and nurses has not eased the manpower issues: in a global scale, the country ranks as the 1st in nurse and 2nd in doctor exports overseas (Finch, 2013). The key informant interviewees described a job that requires a calling due to the high levels of responsibility and competing workloads in relation to a comparably low salary. When doctors are conducting home visits for the disabled and immobile or visiting remote barangays as part of their weekly medical missions - as hoped and expected by the older respondents (see section 6.2.1) - the time devoted for these visits appears as long queues and inefficiency from the demand perspective: *'The problem number one is, of course, home visitation will take time of the doctor'* (key informant, Quezon City).

With regards to the older respondents' common concern related to the lack of (free) medications in health centres, most of the key informants acknowledged the issue and traced it back to time-consuming procurement processes: *'Most of the time, the medicines are available, but not that perfectly. There are times also when not available because of the process of procurement. [...] From the department of health to the local government to the health centres'* (key informant, Quezon City). However, a key informant from San Juan City framed the issue rather as a conversion factor of lacking knowledge than procurement:

K= *I would like to mention about that. You know, there's certain patients, they would like to have medicine which are branded. So that's the problem. We have medicines here but they're generic. And what do you do and the patient will come and be asking 'doc, I need this medicine', 'we have that but it's generic', 'no I need the branded'. See that's the difference, that's the problem. [--]*

I= So generic medicines are always available?

K= *Yes! There are lots of lots of them! So there should never be a reason for complaints that they have no medicine. We have lots of medicine. Actually these people would complain 'they're out of the branded one'. See? We do a lot of convincing, we do a lot of health education to tell them that it's the same banana. But you know, they were, their private doctors brainwash them to think the brand is better than the generic one.'*

Whichever the source of the availability issue, lack of knowledge or a problem of procurement, the conversion factor is real for poor older persons relying on the free medication to protect their

health from the effects of chronic diseases. Of the HOT respondents, 57% of the Quezon province and 70% of the Metro Manila respondents reported having one or several chronic illnesses. Of these respondents, only around 60% in both provinces expressed receiving regular care or medication for their conditions. Moreover, considering the high levels of self-care action the respondents reported (see section 6.1.2) as well as the significance of self-care in the respondents' constructions of health (upcoming section 9.1), lack of medication, whether real or experienced, can certainly be a great source of stress, as also reflected from Transcript 7 above.

8.3.3 Conversion factors related to accessibility

The accessibility-related conversion factors described by the older respondents related predominantly to experienced inequality in availing public health services; the respondents complained e.g. of nepotism and favouritism based on political affiliation. As a male participant of a Quezon City FGD described: *'Not all older people are assisted by the health centre but there's favouritism. Friends and relatives of barangay officers and doctors get help and medicines. Especially expensive medicines are only given to those they know'*. Others, such as a participant of the Pagbilao FGD, felt very uneasy in approaching the topic of public health services altogether: *'We're hesitant to say anything, if officials would hear you saying things about them they would not provide help anymore'*. In WHO's assessment (2011), equity in access to services was named as the single most significant health problem in the country with evidence of financial barriers and negative perceptions related to public providers' quality. Further, the study of Azfar and Gurgur (2008) showed that mere perceptions of corruption in public health services were of significant discouragement for the use of services, especially among deprived communities in the Philippines. As such, these perceptions can be understood as a hindering factor in converting available public health services into responsive ones. Many older respondents felt powerless in facing the issue:

Transcript 3

T: *What do you think your barangay could do to improve their services?*

R: *Stop graft and corruption.*

T: *Do you have problems in the barangay?*

R: *Nothing has been done to correct their wrong-doings.*

T: *Because the funds of the barangay are not used properly?*

R: *Yes, like the 1% budget allocated for senior citizens, they have not released it yet. They told us [senior citizen organisation] not to interfere.*

T: *Why, you should avail the funds?*

R: *Yes, but* [shrugs]

(70-year-old female, Quezon City)

LGUs in the Philippines have a great deal of autonomy and responsibility in providing basic services. Studies show radical differences locally in the implementation of national policies and

programmes put in place to protect the welfare of older persons, benefiting generally those living in wealthier LGUs compared to the poorer ones (Cruz et al. 2007). The key informant from Atimonan expressed his dissatisfaction with the governance model:

K: 'If they would ask me to re-nationalise health, I would go, I want the health sector to be under the national government, we [would] have the funds, we could move freely. Because of the devolution we are also included whether we like it or not, in the politics. Now that we are under the local government, our boss is the local chief executive. But lucky for Atimonan, our local chief executive is supportive of health. What if, like the other municipalities, not so supportive. So even if you have so many ideas, so many good plans for health, you cannot do all of that because the local government will not give you the much-needed fund. [---]'

It should be noted that none of the key informants directly addressed local politics as a reason for individuals' exclusion from public health services but their concern was more of a macro-level issue, i.e. local politics as a barrier limiting the budgets and health programmes provided for older people among other groups. Despite being tied to the limits their LGUs set for their actions, many of the health officers interviewed took extra steps to acknowledge the special needs of their elderly customers, for instance by providing them a fast lane or dedicated hours in health centres whenever possible (key informants of Quezon City and San Juan City).

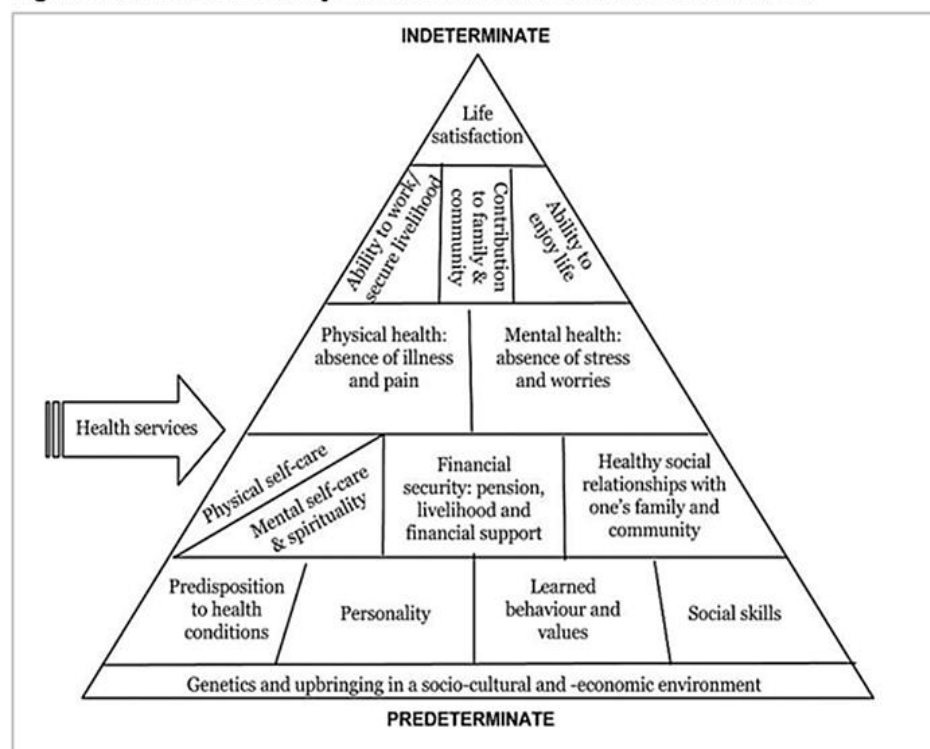
9. Inductive conceptual framework and most valued health capabilities

In this study, the concept of health has been treated as a social construct, situated in time and place, and consisting of the interplay of individual, social and cultural perceptions. The socio-cultural aspects of the concept have been thus emphasised to the detriment of physical, objectively measurable features. This standing is supported by HelpAge International and the HOT tool which focuses on individuals' own perceptions of their health and well-being with an affirmative objective functionality test. However, as with all universalised survey tools, the HOT tool should be cleared of any bias to guarantee its applicability to a broad range of different populations. While quantitative research and repeating a survey in different settings mainly work to confirm or not confirm the preconceptions build into a tool, as Stenner, Coope and Skewington (2003) note, qualitative methods can reveal alternative constructions, highlight missing aspects, and add understanding of the variations same concepts may have in different contexts. This section presents the local constructions of health and life satisfaction emerged from the collected qualitative data in an inductive conceptual model. Further, the second part of the chapter will present the two most valuable health capabilities of the older respondents, highlighted by a case-study.

9.1 Inductive conceptual model of health and life satisfaction

The following Figure 26 reflects the older respondents' constructions and connections between concepts of health and life satisfaction based on a grounded theory-led analysis of the FGD and

Figure 26. Inductive conceptual model of health and life satisfaction.



follow-up interview data. The model should be read from bottom-up so that each layer in the pyramid works as an enabler, in a positive sense, or as a hinderer in a negative sense for the attributes presented in the above layer(s). The further on

the top an attribute/ability has been located, the more its nature can be considered as 'indeterminate' as opposed to 'pre-determinate', i.e. defined at birth.

To start from the bottom, the respondents saw attributes defined by genetics and received upbringing as highly significant in determining their current health behaviour. The constructions had a clear over-generational aspect apparent in the way the respondents described inherited awareness, behaviour, values and skills, and highlighted the importance of transferring these to the younger generations: *'I have a heart problem in my family, that's why I monitor my health regularly and will transfer this awareness to my children'* (FGD participant, Atimonan). Similarly, a FGD participant from San Juan City described how the awareness of her genetics informs her physical self-care action: *'I am aware that there's hypertension in my family so I am careful with what food I eat and take supplements'*. The mentioned values and attributes related to upbringing and learned from one's parents included e.g. *'hard-working mentality'*, *'self-discipline'*, *'valuing health and staying away from vices'* and *'being clean in the house'*. Personality and social skills the respondents had learned at home and felt guided their health behaviour and current health status included, e.g. *'the way I relate to and deal with other people'*, *'being good, respectful and helpful to others'* and *'being a good person due to moral guidance from God'*.

As described above, (learned awareness of) genetic predisposition to illness, learned behaviour and values, personality and social skills enable the next level of the conceptual pyramid in Figure 26, i.e. the level of self-care, financial security and healthy social relationships within one's family and community. Self-care as a concept is constructed as consisting of two types of actions: physical self-care, referring specifically to healthy nutrition, exercise and keeping one's environment clean; and mental self-care, meaning spirituality and positive thinking. The qualitative findings confirm the HOT tool results showing high levels of physical self-care action; the respondents were highly aware of healthy behaviour, and found physical self-care as the main way to improve one's health: *'eat fish and vegetables, fresh foods'*, *'have a well-balanced diet with fruits and vegetables'*, *'go to sleep early and sleep 8-9 hours at a time'*, *'exercise and take vitamins'*. When asked to describe their daily activities, many of the respondents expressed starting their day with some exercise and praying. Praying and another kind of spiritual activity, as well as positive thinking, were constructed as mental self-care activities – similarly than physical self-care, an essential part of healthy daily life. The spirituality theme supports earlier findings of Filipino elderly's life satisfaction and health, e.g. by De Guzman et al. 2012 and Blace and Avenue, 2012. Mental self-care does not necessarily mean being free of problems and worries, rather, it indicates directing attention elsewhere to positive things: *'not thinking of problems or worries'*, *'not worrying about problems and wanting to be happy'* and *'thinking positive, having a light feeling'*. In the inductive conceptual model, mental self-care is an essential enabler of mental health similarly than physical self-care is to physical health.

Social skills, as described above, are constructed as crucial for healthy and meaningful social relationships within one's family and community; according to the respondents, to be ultimately healthy one needs to be *'friendly', 'smiling', 'humble', 'understanding', 'accepting', 'patient', 'courteous' and 'respectful'* to other people. Family was considered as the key unit of healthy social life: *'the quality of relationships inside family is transferred to the community so if you have a happy family, you can also have happy friends and neighbours'*. With good social relations, one *'avoid[s] making friends angry and becoming lonely, hence sick'*. As described in previous chapters, financial security at older age is strongly connected with the nature of relations to one's family and the arrangements of intergenerational support. Hence, the learned social skills, (family-centred) values and behaviour seem pivotal in building such security especially in current times of insecurity and changing global realities. Moreover, values and learned behaviour, including the mentioned *'hard-working mentality'* may have assisted a person in working life to secure a long-term livelihood/pension benefits that continue at older age.

Physical health was constructed by the respondents as the absence of sickness, pain and health conditions, ideally with *'no need to take medicines'*. Further attributes related to physical health included being *'strong', 'energetic'* and *'mobile'*. While the respondents felt that physical self-care action was the most significant enabler of physical health, they strongly believed in the authority of medicine in defining the *'right'* kind of self-care even when it meant enjoying life a little less: *'I follow my doctor's advice, I'm really careful, not like other people whose principle in life is that it's better to die enjoying life, eat all the food that you like [so that] at least before you die you have enjoyed it'* (female follow-up respondent, Pagbilao). The high valuation of and trust towards doctors were reflected from many responses: *'life is to follow everything the doctor tells and then everything will be OK'* (male FGD participant, Pagbilao). The previous sections regarding barriers and conversion factors highlighted the role of one's financial situation in defining access to the valuable instructions and advice by doctors.

The complementing aspect of physical health, i.e. mental health, was constructed as the link to the next level in the inductive model, the ability to enjoy life (see Figure 26). Mental health implies the state of being happy and free of worries; *'[when healthy] you're happy, not feeling like getting old but you are thinking like you're young'*. As discussed above in the context of mental self-care, a person with good mental health has learned to think positively and focus on good things despite health issues or other hardship. Conversely, the absence of mental health was linked with *'having a negative mindset'*. Mental health is thus an attitude for the respondents; according to them, it is learned as part of one's socialisation and supported by healthy social relationships, on lower levels of the inductive model.

Moving to the next level in Figure 26, and taking into consideration all the above-described, being healthy in both physical and mental way enables the ability to work/secure a livelihood. This was

an aspect constructed as highly central in health particularly by the male respondents: *‘when financially stable you are happy and healthy’* and *‘[being healthy is] having a livelihood every day’* (male FGD participants, Quezon City). Moreover, in the constructions being healthy provides the confidence and ability to enjoy life through chosen activities, such as the mentioned ballroom dancing and Zumba, traveling, playing basketball, watching movies or doing *‘anything you want’* and going *‘anywhere you want’*. A highly common ‘doing’ enabled by good health was related to a contribution to one’s family or community. To increase life satisfaction, one should *‘share knowledge and experience to children and other people in the barangay, this will be your contribution to the community and it will make you happy when contributing’* (female FGD participant, Atimonan). Contribution seemed highly important both for women and men, in urban and rural areas. However, whereas women tended to contribute more directly to the community through volunteering and taking part in OPO/church activities, men seemed to draw happiness and life satisfaction from being able to support their families, often financially. For men, not being in good health, meant being *‘not able to work, meaning cannot feed family and being unhappy because other family members are affected’* and *‘insecure that can’t help family’* (male FGD participants, Quezon City).

The link between health and life satisfaction was constructed through the three valued ‘beings and doings’ located on the second highest level of the inductive model: the ability to work/secure livelihood, contribution to family and community, and ability to enjoy life through chosen activities. Life satisfaction was constructed as freedom and as such, something in-determinate compared to the first, pre-determinate levels of the pyramid-shaped model; *‘if you’re happy with life, you’re not obliged to do things, you have others for support, your children are doing well, and you have achieved the phase in life what you want’* (female FGD participant, San Juan City). Additionally, *‘when happy and healthy, everything is yours’* and *‘[one] can ask for anything because everything is available to you’*. While the respondents constructed life satisfaction as something that requires personal effort or agency, they also felt, when asked, that good life satisfaction is available to everyone.

9.1.1 Deductive and inductive conceptual frameworks: similarities and differences

Comparing the inductive conceptual model (Figure 26) to the deductive conceptual framework (section 3.3), both similarities and differences can be found. The domains constituting health in HelpAge’s framework, including functionality, dependency/support needs, responsive services and self-care can all be found from the inductive model yet with context-specific emphasis and contents. To start with the domain of functionality, mobility in the sense of being able to move freely was of particular importance to the respondents. Functionality in the deductive sense, as an ability to do daily/social/work activities *independently*, was not directly discussed. Independence as a value was constructed rather in financial terms in the data, evident in feelings of shame linked with asking for

financial support (see Table 7). Functionality in both the inductive and deductive frameworks is, however, a very significant factor in enabling valued 'beings and doings', although in the inductive model poor health itself does not directly reduce life satisfaction but rather influences a person's ability to secure livelihood, to contribute to one's family and/or community and to enjoy life through chosen activities.

As discussed in section 7.5, support needs in the Filipino context were mainly understood as financial support needs. The inductive framework accordingly includes components of financial security on two levels, reflecting how central it is for the older respondents in the research context. Financial security as a health capability rather than a background factor is, nevertheless, missing from the deductive conceptual framework. The WHOQOL Group (1995) has indeed observed that autonomy, a concept with similar connotations than the concept of independency, is valued as an important QOL dimension in certain cultures while getting meanings of social rejection and egoism in others. Social relations are a vital part of the inductive framework in all levels but fairly invisible in the deductive framework in other than 'dependency' sense³⁹.

Self-care is a highly important domain in both the deductive and inductive frameworks, with the difference that in the inductive constructions self-care consists of both physical and mental activities. Both types of activities are constructed as essential in enabling health – a concept with also both physical and mental aspects for older Filipino persons. In the deductive framework, the construct is limited to the physical side of health. For the older respondents, health services and particularly doctor's expertise, were essential in guiding physical self-care and thus, supporting the development and maintenance of physical health. The mental health side relies on healthy and satisfying social relations within one's family and community as well as on financial security. To summarise, the main lacking aspects in the deductive framework when implemented to the Philippine socio-cultural context are financial and psycho-social, including the important elements of ability to contribute to one's family and community and ability to be financially secure as well as spiritually connected.

9.2 Most valuable health capabilities

As discussed in the section 2.4, freedom is an essential concept of the capability approach, signifying a real opportunity one has to accomplish what one values. In answering the sub-question f. regarding most valued health capabilities, both the agency and opportunity aspects of freedom i.e. ability to act for what matters and the just opportunities provided by the surrounding society for individuals to use their agency, were considered. The analysis brought together the inductive conceptual model in 9.1 as well as the identified barriers and conversion factors to health in

³⁹ Social relations are referred to in the variable of 'functionality for daily and/or social activities' which, however, reflects merely one's physical ability to take part in social activities outside one's home rather than the importance of or opportunities for such action.

Chapter 8. This section discusses first the evidence presented in the previous findings chapters in the light of a case-study. The discussion of the case-study will be concluded by presenting the two main health capabilities that the older Filipino adults in Metro Manila and Quezon provinces have a reason to value the most.

9.2.1 Situated health agency limited by barriers and uncertain realities

Analysing the inductive conceptual model in section 9.1 as well as the identified barriers to health in section 8.2 from the freedom perspective, the opportunities not provided for all older respondents but defining their ability to be healthy are essentially related to the means of achieving a basis of financial security through pension or livelihood opportunities. In the absence of a universal pension system, financial security of older people is strongly inclined towards a person’s ability to receive financial support from his/her children or other relatives – an ability based generally on pre-determinate factors such as one’s ability to have children, or various socio-economic, often over-generational, factors defining one’s and one’s children’s’ ability to become educated and to secure well-paying jobs. Furthermore, the respondents’ personality and learned behaviour, including social skills, have affected the forming of the significant social relationships between a parent and a child which is supported by cultural expectations of intergenerational support. Additionally, social and cognitive barriers identified in Table 8, such as experienced shame in asking financial support from one’s children may complicate one’s ability to be and to feel financially secure.

However, despite having good safety networks to start with, insecurity factors related to contemporary global realities such as precarious and border-crossing working life may break any existing safety networks precipitously. Even state-hold safety and social security networks, such as pension systems, are not always proof against life’s insecurities, as evidenced by the following case-study:

Table 10. A case-study
<p><i>A follow-up interview with a male respondent from Quezon City started with tears. The respondent, a widower living with his three children, opened up about the reasons behind his distress. Some years ago, waiting for his SSS pension, his wife felt severely ill. To pay for her hospitalisation and treatments, the respondent used all their life savings and took an additional loan to cover the hospital fees. The wife’s treatments turned out unsuccessful and she passed away. The husband struggled to pay the loan back in time due to high interest rates. Failing to pay back the loan, the respondent’s SSS pension was denied from him, leaving him in a financial emergency.</i></p> <p><i>At the time of the interview, the respondent was afraid of losing the house he and his children co-habited. Although his children worked and provided him with some financial support, their contract-basis irregular work did not provide a continuous financial security for the family. The respondent had professional skills, which he used to get occasional income. However, nor he or his local OPO had yet been successful in finding him a steady source of livelihood.</i></p>

The respondent gave his health a rating of 30 in the HOT survey. He expressed feeling a lot of pain in his body but retained from seeking help from health services due to his financial situation. The last time he visited a doctor, he was sent to an X-ray but did not go because of the expenses. Hence, he never returned for a follow-up check-up to the barangay health centre. According to the respondent, the factors defining his health were, in addition to his age, not having his basic needs properly met and not being able to eat the right food due to financial issues. He named the costs of health services as the main barrier to achieving better health outcomes and felt that the health centre should do house-to-house visits to identify older people in need of medical help. Supported by his belief in God, the respondent was able to find the strength to deal with his situation, dreaming to be able to see his children and grand-children grow.

9.2.2 Health capabilities the respondents have the most reason to value

As the case-study reflects, lack of financial security can disturb someone's ability to be healthy and satisfied with one's life in various ways. Financial security in the research context relates to one's ability to meet basic needs and take care of oneself through healthy nutrition. In addition to self-care action, financial (in)security has direct impacts on one's mental health, the ability to not think of stress and worries, an ability which, if lacking, disposes one to physical health conditions (see inductive model Figure 9.1). In this context, the ability to create and maintain healthy social relations in and outside one's family becomes crucial. In the above case-study, the local OPO had not found the respondent a steady source of livelihood yet but had managed to find him irregular work. Selecting him as a respondent to this study potentially sparkles further opportunities. However, it does not remove the responsibility of the state to provide just opportunities to its senior citizens to secure their financial situation also in cases of sudden vulnerabilities and emergencies.⁴⁰

Another aspect of the conceptual model not currently providing all the respondents opportunities to be healthy relates to health services and the identified conversion issues (see section 6.4) hindering the availing of public services. Many older respondents in the data relied on their children for getting check-ups paid or admitted that they just do not use health services when needing them. As discussed in section 9.1, doctor's orders were, however, constructed as the 'prescription' for a healthy life, instructions which many of the respondents took very seriously. Thus, a denied opportunity to access health services particularly in acute cases can have severe implications on one's physical health, and through that, on one's opportunities to achieve valued beings and doings, such as the ability to contribute to one's family or community, ability to secure livelihood/work or to enjoy life through chosen activities (see Figure 26). As such, health is constructed as both a functioning with intrinsic value and a capability.

⁴⁰ Policy recommendations regarding this matter will be further outlined in Chapter 7.

While the barriers related to public health services cease to exist on an individual level when one's financial security provided by family/pension/livelihood is sufficient for the use of private services, access to public health services in this study has generally reflected a capability that is highly dependent on one's living area (urban/rural) and functionality, socio-economic status as well as social networks available. Again, factors of which many are pre-determinate rather than free to choose from. This requires high levels of agency in preventing illness to the extent possible given one's genetics and predisposition to illness. Furthermore, the health agency restricted by one's financial situation affects one's opportunities to self-care and invest in social relationships to guarantee older age support and networks. Such networks might open doors for health services shut by nepotism, corruption or political affiliation (see section 8.2). To summarise, the capabilities the respondents have a reason to value the most in the socio-cultural and political-economic context they are situated include:

- ❖ Ability to create and maintain healthy and supportive social relationships in one's family and community to enable continuous financial security at older age, as a solution to inadequate pension systems, livelihood opportunities and uncertain realities
- ❖ Ability to take responsibility to self-care in order to maintain health and avoid the need to use health services and medicines, as a solution to administrative and economic barriers related to (public) health services

The above-mentioned capabilities create connections with various conceptual aspects between the deductive framework and the inductive model. Ability to create and maintain social relationships reflects best the dependency/support needs domain of the HelpAge framework but highlights the lacking yet crucial financial aspect of support. Functionality to conduct daily/and or social activities is another domain that reflects the opportunities the respondents have in creating and maintaining social relations. HOT tool's self-care domain reflects well both the ability to feel responsible for one's health as well as the extent of physical self-care aiming to maintain health, yet fails to capture the mental side of it (spirituality and positive thinking).

10. Discussion and conclusion

This research has delved into the self-perceived health and life satisfaction of older persons in the Quezon and Metro Manila provinces of the Philippines through the implementation of HelpAge International's M&E tool Health Outcomes Tool (HOT) (N=309) as well as additional, complementary qualitative interviews (N=20) and focus group discussions (N=5), to answer the main research question *'How and to what extent does the HelpAge International's Health Outcomes Tool (HOT) help us understand older Filipino adults' health capabilities and the role of local community health programmes in supporting these?'* The preceding chapters have answered each sub- research question of this study, one by one adding our understanding of the older respondents' situated health-seeking behaviour and available health capabilities in a unique socio-cultural and political-economic context, of which characteristics, it has been claimed, are at times challenging to capture under universalised frameworks. This chapter will begin with a summary of the main findings, after which the main research question regarding the HOT tool's usability and its limits in the Philippine context will be answered. The findings of the study are placed in a comprehensive socio-cultural framework of changing inter-generational contracts. The fourth section will present the implications of the findings to the Philippine health sector, after which recommendations regarding the enhancement of the HOT tool and future data collections are provided. Finally, limitations of this study and recommendations for future research are outlined.

10.1 Summary of findings

The assessment of the strengths and weaknesses of the universal HOT tool in the research context was approached as a technical examination of the HOT tool's reliability and validity. While a Cronbach's alpha procedure indicated a high level of internal consistency for the key variables of the tool ($\alpha = 0,852$), certain conceptual variables of the survey turned out challenging for the HOT tool's construct validity and hence, cross-cultural comparisons. The deductive meaning of 'work' activities as general livelihood activities rather than steady income-generating jobs seemed a construction unavailable to the respondents in their socio-cultural settings, as was the concept of 'support' as merely physical support/care rather than financial. An identified potential reliability challenge of the HOT tool was related to the used 3-month timeframe which seemed difficult for the older respondents to grasp in terms of acute illnesses, physical feelings and emotions.

The quantitative analysis of the HOT data revealed that around 1/3 of all respondents (32%) perceived their health status either 'quite good' with scores of 61-80 (21%) or 'good' with scores of 81-100 (11%). The majority of all respondents (49%) in both men and women perceived their health status as 'fair', scoring 41-60 on the HOT scale of 0-100 (see **Appendix 9**). The results are in

line with the findings from the 2007 Philippine Longitudinal Study on Aging (PLSOA) showing similar percentages to those rating their health average (47%). However, the proportion of HOT respondents giving their health ratings of 'quite good' or 'good' (32% in total), is higher than in the PLSOA study with comparable score categories (22%). While the findings of the HOT tool cannot be generalised to a national level, they may, to some extent, reflect the several macro-political level changes introduced after 2007 to improve senior citizens' well-being (e.g. Republic Acts No. 9994 and 10645).

The respondents' health status was found to have a moderate positive correlation ($r_s = .480 < .0005$) with life satisfaction, with life satisfaction scores generally higher than rated general health: almost half of the respondents (47%) estimated their life satisfaction as either 'quite good' with scores of 61-80 (26%) or 'good' with scores of 81-100 (21%). Health status and life satisfaction scores were found to vary considerably between barangays of different socio-economic profile. Further statistical analysis revealed that, on the significance level of .05, urban respondents scored statistically significantly higher in health and life satisfaction than rural dwellers in the data, confirming earlier finding of De Leon (2014). The analysis also showed that COSE health programme beneficiaries gave statistically higher scores than non-beneficiaries in health status, life satisfaction as well as in functionality. However, when controlling all other variables, the beneficiary status or none of the socio-economic background indicators included in the survey (gender, education, age, location) emerged as significant predictors of health, a finding similar than that of the 2007 PLSOA. Rather, in the executed multiple regression analysis, existing chronic illnesses, poverty and living alone were found to be the best predictors.

Qualitative analysis supported the statistical findings regarding the importance of economic, medical and social factors for the respondents' health. The barriers to health the older respondents identified were economic (related to financial insecurity), social and cognitive, (related to one's cognition and social norms and values in the community) medical and physical (related to medical conditions and loss of functional capacity) as well as administrative (related to poor responsiveness of health services). The administrative barriers were further analysed as conversion factors. The findings, presented from both key informants' supply and older respondents' demand perspectives, revealed that the root causes of the affordability, availability/quality and accessibility -related conversion issues can be traced back to the policy, budgets and procurement of local governments, in some cases e.g. in availability of medicines, even national government. Mirroring the identified challenges of public service provision, the role of COSE's community health programmes was found to be, from both the older respondents' as well as the key respondents' perspectives, to complement and patch up deficiencies in services.

The inductive conceptual model of this study (see Figure 26) constructed health and life satisfaction as highly dependent on one's financial security as well as the ability to contribute to one's family and/or community. The health capabilities the respondents have a reason to value the most in the socio-cultural and political-economic context they are living were found to include: the ability to create and maintain healthy and supportive social relationships in family and community settings to enable continuous financial security at older age, and the ability to take responsibility of one's health to self-care to maintain health and avoid the need to use health services and medicines. Both financial situation and access to health care have been recorded as sources of significant dissatisfaction for Filipino elderly also by earlier studies (see e.g. De la Vega, 2013). This emphasises their great role in the design and development of local health interventions.

10.2 The HOT tool's usability and its limitations in the Philippine context

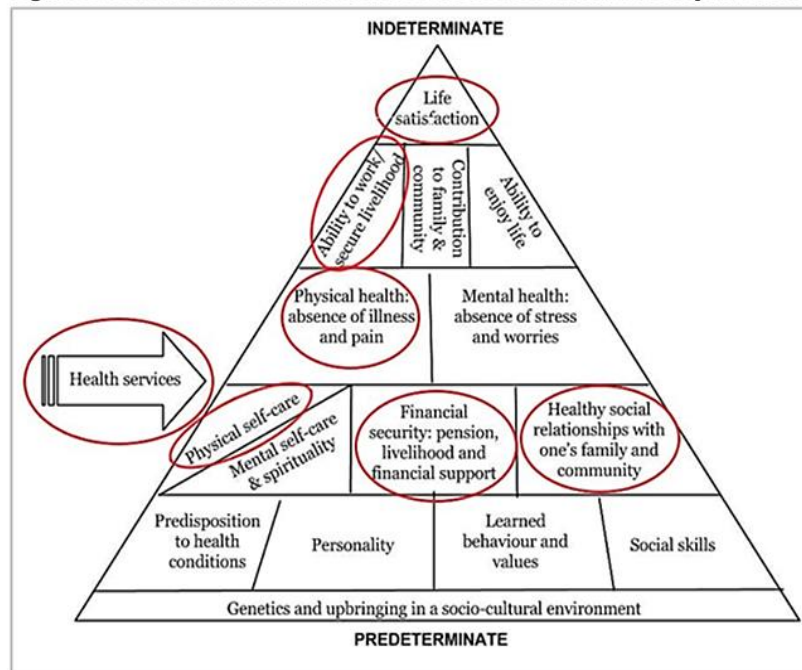
In general terms, the HOT tool adds our understanding of older Filipinos' health capabilities by focusing on the self-perceived functional ability of the respondents to achieve the 'beings and doings' that matter to them. The healthy ageing framework of WHO, adapted to HelpAge International's organisational M&E needs in the HOT tool, rejects the traditional, criticised frameworks that see older age mainly as objectively measured presence or absence of disease and instead, turns the focus on older people's individual capabilities and health agency. The HOT tool allows longitudinal tracking of changes and data collection in a simple and user-friendly offline digital format proposing an appropriate option for traditional resource-intensive procedures for low- and middle-income country contexts, such as that of the Philippines. Moreover, the well-guided implementation process (see Bertfelt and Dusseau 2016a; 2016b) which encourages the involvement of different stakeholders provides a good platform for designing and implementing follow-up policies and practices.

The inescapable challenge in developing quantitative tools for global purposes, well recognised by Quality of Life researchers, is related to allowing meaningful comparisons between cross-cultural data-sets by finding the balance between the subjectivity of the respondents, marked by social factors such as gender, age, class and cultural identity, and objective measures (Stenner et al. 2003). Since individuals always interpret each survey item of the deductive conceptual framework in the light of the subjective constructions socio-culturally available to them, any measure of health and well-being must find ways to deal with the variability (ibid.).

This study discovered that certain variables of the HOT tool, such as mobility, functionality to conduct daily/and or social activities, (physical) self-care as well as the responsive services domain were generally well understood in the Philippine context. Others, including the variables in the dependency/support needs domain and the functionality to conduct work activities variable

differed in meaning for the respondents to an extent that complicates cross-cultural comparisons. However, the findings have shown that the HOT tool's validity and reliability in the Philippine context can be improved with specific modifications (see recommendations sub-section 10.4.2). While the HOT tool has the ability to track the general situation and development of older people's health and life satisfaction globally through its key indicators, the findings of this study emphasise the need for a complementary qualitative tool to allow the full potential of country-specific learning in the M&E framework the HOT has been designed to serve, particularly in terms of local policy implications and future programme targeting.

Figure 27. The deductive framework's reach of the inductive conceptual model.



With regards to the Philippine context, as reflected from the only moderate statistical correlation between the indicators of health and life satisfaction and evident from the inductive conceptual model (Figure 27, areas covered to some extent by the deductive conceptual framework circled in red), poor health itself does not seem to directly reduce older

Filipino's life satisfaction, rather, poor health affects an individual's ability to work/secure livelihood, to contribute to one's family/ community and to enjoy life through chosen activities or 'doings'. While 'functionality to work' variable of the HOT tool links the two levels of health and life satisfaction in the inductive model, the conceptual gap consisting of the mental aspects of health and self-care as well as the ability to contribute to one's family/ community and enjoy life through valued activities is significant not just from a holistic perspective but also from the capability approach perspective. The capability approach turns the focus on the opportunities the respondents have in being and doing what they value, rather than measuring the mere functionings, e.g. physical health or life satisfaction.

As mentioned above, the role of the qualitative methods in this study has been, in addition to explain and contextualise the quantitative results, to fill in the conceptual gaps that the HOT tool's deductive framework has been unable to reach, including the highly significant psycho-social and

financial aspects of older Filipinos health capabilities. Specifically, while the HOT tool contains several indicators for poverty⁴¹, none of the indicators manages to quite catch the pervasive meaning that financial security and inter-generational relationships have in older Filipino persons' lives. The *nature* and *meaning* of capabilities is left for qualitative methods to discover.

The research design of this study with the qualitative tools is, by no means, fully transferrable as it is to any other context since the tools have been developed as part of a grounded theory-based research process. Rather, as per the main research question, the design and tools used in this study have highlighted the context-specific macro-political, economic-environmental as well as social aspects of health and life satisfaction relevant to the HOT tool's M&E framework, which the HOT tool in its universalised form is incapable of fully reaching. Any criticism directed towards the HOT tool as a universalised measuring tool concerns to an extent all global surveys; evidence shows that ageing is a situated, socially embedded process which affects an individual's self-perception of his/her health (see e.g. Marques et al. 2015). Any survey aiming to cross cultures and have evidence-informed policy and practice implications needs to thus take a standing on the extent of its measuring capacity and/or develop procedures or methods to improve its validity, e.g. through mixed methods such as in this study.

10.3 The comprehensive framework of changing inter-generational contract

The findings of this study are consistent with the results from De la Vega (2013) which showed that to improve quality of life of older Filipinos, they should be enabled to take better care of their families and communities through enhancing their financial status. Both the statistical and qualitative findings presented in Chapters 6-9 have revealed the central role of financial security, particularly provided by one's children, in defining the respondents' health capabilities and functionings in this study. However, the study has also identified barriers caused by macro-political and socio-economic realities complicating such traditional older age security. Concern raised Asia-wide in literature has been that contemporary trends such as urbanisation, modernisation, the demographic transition, international migration as well as the spread of Western lifestyles and individualist values will erode traditional filial social contracts (Croll, 2010). In the Philippines, high levels of poverty have encouraged the trends of urbanisation and mass migration abroad, which, combined with high birth rates as well as increasing costs of raising children, have caused competition between young and old generations as the life expectancy increases (Liebelt, 2015).

The financial meaning the deductive concepts of 'support' and 'work' received in the data, as well as the identified shame of asking for one's children for financial support and the expectation/choice to

⁴¹ Indicators measuring poverty include: self-perceived poverty of one's household in relation to surrounding community, ability to fulfil basic needs, and perceived affordability of health services.

prioritise younger generations' needs as social and cognitive barriers to the respondents' health, place the findings in a comprehensive framework of a changing inter-generational contract⁴² in the light of global contemporary realities. The findings, thereby, echo earlier ethnographic data that have captured the re-interpretation and re-negotiation process of the traditional *utang ng loob* contract, the conceptual basis of filial obligations in the Philippines (Liebelt, 2015). As apparent from the inductive conceptual model (Figure 26), social skills and healthy social relationships in one's family and community, are essential in forming the older age safety net of the respondents. Nonetheless, the constructed enabler of life satisfaction, i.e. the ability to contribute to one's family and/or community also reflects the earlier finding of Knox-Vydmanov et al. (2017) regarding the heavy emotional and mental burden older people bear when unable to financially assist their children and grand-children. In this study, such a burden concerned particularly the male respondents, confirming earlier findings of the male role as 'breadwinners' even at older age (see Natividad et al. 2014).

The financial insecurity of Filipino families hinders not just older persons' health and life satisfaction but creates an unsustainable situation where the middle generations are required to trade-off between their children's and parents' needs (e.g. education, health) and possibly sustain from contributing to a pension for their own secured future (Knox-Vydmanov et al. 2017). Implications of such a situation are not just individual burden nor restricted to family settings, but affect the whole society by restricting population groups' abilities to pursue health, education, participation and other valuable doings and beings in a just society. Hence, since older Filipino people's health-seeking behaviour and outcomes are strongly connected with their adult children's socio-economic situation and their grand-children's needs, as this study has shown, comprehensive, integrated approaches are required to tackle older age health inequalities. Such integrated understanding can be found from HelpAge International's and COSE's long-term advocacy through campaigns concerning, e.g. universal social pension.

10.4. Implications and recommendations

This section will present the key policy implications of the findings for the Philippine health care system, after which recommendations for HelpAge International and COSE regarding the enhancement of the HOT tool and future data collections are provided.

⁴² Inter-generational contract in the Filipino context, as discussed in section 4.4, refers to the expectation that every middle generation at its turn gives support and care for both the younger and the older generations.

10.4.1 Policy implications for the Philippine health care system

While the findings of this study are based on data collected in only two provinces and four municipalities of the Philippines, and it is acknowledged that each municipality has its own characteristics, certain general level implications can be drawn to concern the Philippine health care system as organised under LGUs. The implications and recommendations for policy and practice are as follows:

I. Integrated, multi-sector responses to health

The significant, complementary role of community health programmes with regards to public health services reflects a demand for integrated cross-sectoral and multi-agency responses to health which would ease the identified administrative barriers, such as manpower and resource issues.⁴³ The LGUs should, accordingly, look into possibilities of public health services crossing paths with the existing community health and psycho-social programmes to enhance e.g. homecare of persons with functional disabilities as well as patients with complex social and health care needs.

II. Ensuring adequate budgetary funds for affordable quality health services

Integrated health services bringing together public and voluntary sector health programmes, while improving efficiency, should not be used as a loophole to allow budgetary cuts on the LGU level. The LGUs should allocate adequate budgetary funds for affordable primary health care services for older people accessible on the barangay level either through barangay health centres or mobile clinics, including medical check-ups, medicines and home visits for those unable to access health centres.

III. Stakeholders to design solutions for identified challenges in service provision

The findings of this study have echoed the need of bringing stakeholders, including the Department of Health, the Department of Social Welfare and Development, OSCA offices, COPAP and NGOs working with older people and around issues of health and social welfare together to design solutions for the identified challenges in service provision.⁴⁴ Efficient reporting mechanisms that allow filing complaints related to corruption, nepotism and political favouritism should be advanced.

IV. Strengthening older people's rights to and knowledge of their entitlements

Older persons' rights to their entitlements, e.g. free maintenance medication, should be improved by developing back-up systems for procurement issues. Trust towards generic in relation to

⁴³ The interviewed health officers (N=4) all identified the need and expressed their interest in developing cross-sectoral interventions together with COSE and other NGOs.

⁴⁴ The findings of this study have implied powerlessness that older persons feel in facing administrative barriers, hence, the inclusion of them in the development process is crucial.

branded medications should be increased as part of health education (e.g. COSE's health education sessions hold by volunteers). The older respondents of this study expressed that general awareness of available health services and entitlements requires further promotion.

V. Support the sharing of best practices, knowledge and experience

The sharing of knowledge, experience and best practices nation-wide, e.g. medical financial assistance programmes, should be promoted to enable LGUs mutual learning. Universities and research institutes could be utilised in collating such information and developing segregated data models for patients 60+. Key informant interviews revealed that no age-segregated health data of older people currently exists in all municipalities.

VI. Evaluate the reach of livelihood programmes and roll-out universal social pension

The findings of this study have shown the entwined nature of financial security and health and life satisfaction at older age. The current reach of sustainable livelihood programmes should thus be evaluated. More crucially, steps are recommended to be taken towards a speedy roll-out of universal social pension, as recommended by COSE, COPAP and HelpAge International⁴⁵, to tackle health inequalities caused by financial inequality. Short-term solutions suggested by older respondents of this study included emergency fund programmes for sudden and unexpected events such as hospitalisation.

10.4.2 Recommendations for HelpAge International and COSE

The findings sections of this thesis have presented some challenges related to the HOT tool in general terms, and particularly within the socio-cultural context of the Philippines. Since the HOT tool is designed to be used to collect longitudinal data, recommendations for enhancing its validity, reliability and usefulness are provided for both HelpAge and COSE:

The universal HOT tool

- ❖ The findings of this study strongly encourage to continue the development of a complementary qualitative tool for the HOT; the data collection experiences and findings of this study have proven the significant value of follow-up interviews in improving the validity and reliability of the tool in a new country-context. A general follow-up interview guide by HelpAge should allow context-specific adaptation but provide examples of beneficial follow-up questions within each conceptual domain.
- ❖ The research process additionally demonstrates the usefulness of participatory FGDs in evaluating the suitability of the deductive conceptual framework of the survey in a socio-cultural and political-economic context. Visual exercises provide an effective way prior HOT

⁴⁵ Knox-Vydmanov et al. (2017).

implementation to explore the local understandings of the key concepts and to test cultural equivalents in terms of translations.

- ❖ An identified potential reliability challenge of the HOT tool, related to the 3-month timeframe in scaling questions, should be further tested and validated in other socio-cultural contexts. The findings of this study indicated that the Filipino respondents struggled to provide general-level ratings within such a timeframe. This proposes a challenge to the reliability of the HOT tool as a M&E tool due to the key variables' role as HelpAge International's corporate indicators.
- ❖ It is recommended to set clearer guidelines for affiliates worldwide regarding the extent the original conceptual framework and survey items are allowed to be modified to avoid challenges in cross-cultural comparisons afterwards, yet allowing necessary modifications in terms of validity. Affiliates should be encouraged to do back-translations and double-check the key concept meanings in cooperation with HelpAge prior to baseline data collection.
- ❖ The use of participatory approaches in involving communities, including community leaders as well as older people's organisations, for the implementation process, design and planning is recommended to ease the effect of high expectations and disappointment related to expected benefits and outputs on the enumerators. It is recommended that such reactions are foreseen with efficient on-site support and discussed in the enumerators' training. Involving public health authorities would bring additional benefits, as the key informants' involvement in this study have shown, to take up further actions based on the HOT findings.

The Philippine adaptation of the HOT tool

- ❖ As discussed in section 6.2.1, several interviewed older respondents expressed that the scale had not been explained properly to them. It is hence recommended to add length to the training of the enumerators, to ensure the understanding of the HOT scale and its conceptual framework.
- ❖ To reach the full potential of the HOT tool as a M&E tool, variables regarding community health programme beneficiary status (by minimum: recipient/provider of care and current/former beneficiary) should be added to allow analysis regarding the impacts of the existing health programmes.
- ❖ Concepts of the HOT tool of which local understanding deviates from the original conceptual framework, including 'work' and 'support', should be further specified and explained by using examples and/or exploring optional translations.
- ❖ Additional variables regarding the respondents' financial security and sources of income/livelihood are recommended to be added due to the central role of older Filipino

persons' financial situation in predicting their health outcomes. Furthermore, the highly important psycho-social aspects of health and life satisfaction, intersecting with financial and physical aspects, are suggested to be covered to some extent in further applications of the HOT tool⁴⁶.

10.5 Limitations of the study and recommendations for future research

The WHO, currently working on defining the metrics and methods for its healthy ageing framework to enable global population surveys, has recognised the need for multidisciplinary studies on ageing and health to inform the policy and evaluation of age-friendly health interventions (WHO, 2017). While this study has collected such much-needed baseline data and contributed to the development and validation of a global survey tool located in the healthy ageing framework, this study has been limited by both the number of survey respondents (N=309) and particularly by the geographical reach in such as culturally, socio-economically and geographically diverse country as the Philippines. Hence, while the findings of this study have managed to highlight the most significant barriers and conversion factors hindering older persons' health capabilities and outcomes in two urban municipalities in Metro Manila and two rural municipalities in Quezon province with specific policy implications, the findings cannot be generalised on a national-level. A clear need for a third nation-wide Philippine Study of Ageing is therefore evident (previous studies from 1996 and 2007).

As discussed in the introduction of this thesis, populations ageing is a topic fairly new to the international development agendas yet has taken important legislative steps in countries such as The Philippines. The significance of the financial protection objective of the recent national health agendas (see section 4.3) and areas left to be covered in terms of older age security have been emphasised by the findings of this study. The Administrative Order by the Philippine Department of Health (2017) signed in January 2017 has been set to strengthen older persons' rights and needs in health care, particularly in hospital settings, yet home care and related support remain an area of further focus. This research and its findings, located in a comprehensive socio-cultural framework of a changing intergenerational contract have been limited to the older persons' perspective leaving the informal carers' and family members' viewpoints uncovered. It has been, nevertheless, noted that the older respondents' health and life satisfaction are entangled in a complex way with the younger generations' capabilities and situations. Further research could therefore explore the re-interpretation and re-forming processes of inter-generational support, the factors enabling and restricting the forming of inter-generational solidarity, empathy and support; factors which strongly define older Filipino people's security and safety at older age. The positionality of older

⁴⁶ When developing the additional indicators, previous literature from the Philippine context is recommended to be used. Studies such as De la Vega (2013) contain culturally validated variables to use to measure aspects of older people's mental/psychological health as well as social relationships. The PSOA 2007 study included a variable of its own for 'financial health' measuring it through a variable 'present income enough to meet expenses' (see Cruz et al. 2016).

people in the support transfers and contributions, particularly the extent to which they prioritise younger generations' needs for their own health, should also be further analysed.

All in all, in this study, the quantitative method executed through the HOT tool implementation allowed the collection of a large set of health outcomes data required for monitoring, evaluation and policy-informing purposes, whereas the complementary qualitative applications through FGDs and interviews brought the necessary context-specific meaning and voice to the findings. Hence, this study has shown how further research on healthy ageing, particularly one with a cross-cultural scope, would highly benefit from mixed methods research designs.

References

- Ageingasia.org (2014). *Ageing population in the Philippines*. A web-page by HelpAge International. Available at: <http://ageingasia.org/ageing-population-philippines1/> [Accessed 15 August 2017].
- Ariana, P. & Naveed, A. (2009). Health. In S. Deneulin & L. Shahani (eds.) (2009). *An Introduction to the Human Development and Capability Approach*. International Development Research Centre, London: Earthscan. Chapter 10. Available at: <http://idl-bnc.idrc.ca/dspace/bitstream/10625/40248/1/IDL-40248.pdf> [Accessed 12 August 2017].
- Azfar, O. & Gurgur, T. (2008). Does corruption affect health outcomes in the Philippines? *Economics of Governance*, 9(3), pp. 197-244.
- Azfar, O., Gurgur, T., Kähkönen, S., Lanyi, A. & Meagher, P. (2000). *Decentralization and governance: An empirical investigation of public service delivery in the Philippines*. IRIS center, University of Maryland, College Park. Available at: <https://de.scribd.com/document/300310074/DECENTRALIZATION-AND-GOVERNANCE-AN-EMPIRICAL-INVESTIGATION-OF-PUBLIC-SERVICE-DELIVERY-IN-THE-PHILIPPINES> [Accessed 1 September 2017].
- Beliran, S. & Legaspi, M. (2014). Health-Promoting Behaviors and Quality of Life of Filipino Older Persons. *Asia Pacific Journal of Education, Arts and Sciences*, 1(5), pp. 11-20.
- Bertfelt, J. & Dusseau, C. (2016a). *Health Outcomes Tool (HOT). Theoretical framework and manager's user guide*. London: Help Age International.
- Bertfelt, J. & Dusseau, C. (2016b). *User's guide for the Health Outcomes Tool*. London: HelpAge International.
- Blace, N. & Avenue, M. (2012) Functional Ability, Participation in Activities and Life Satisfaction of the Older People. *Asian Social Science Journal*, 8(3), pp. 75-87.
- Blazer, D. (2008). How Do You Feel About...? Health Outcomes in Late Life and Self-Perceptions of Health and Well-Being. *The Gerontologist*, 48(4), pp. 415-422.
- Boiser, M. C. (2012). *Cph philippine health care system*. FEU-NRMF Medical Center. Available at: <http://www.slideshare.net/mariachermilleboiser/cph-philippine-health-care-system-new> [Accessed 11 August 2017].
- Cabulanan, E. A. (2016). *Philhealth continues to promote universal access to health care services for all Filipinos in region XII*. News article 8.11.2016. Republic of the Philippines. Available at: <http://rdc12.neda.gov.ph/2016/11/08/philhealth-continues-to-promote-universal-access-to-health-care-services/> [Accessed 11 August 2017].
- Caraballo, M. (2017). 'Income inequality high despite robust economy'. News article 23.1.2017. The Manila Times. Available at: <http://www.manilatimes.net/income-inequality-high-despite-robust-economy/308469/> [Accessed 2 August 2017].
- Carlos, C. (1999). Concerns of the Elderly in the Philippines. *Philippine Social Sciences Review*. Available at: <http://journals.upd.edu.ph/index.php/pssr/article/view/1279/1616> [Accessed 10 August 2017].
- Charmaz, K. (2014). *Constructing Grounded Theory*. 2nd Edition. London: SAGE.
- Chaudhry, A., Ahmed, A., Zeeshan, M. & Mehmood, R. (2014). *Income Status and Medical History of Older Persons in Rawalpindi: Anthropology of Ageing*. Published at Research gate. Available at:

https://www.researchgate.net/profile/Dr_Abid_Chaudhry/publication/263749830_Income_Status_and_Medical_History_of_Older_Persons_in_Rawalpindi_Anthropology_of_Ageing/links/0f31753bd33a9b2568000000.pdf [Accessed 13 January 2017].

Commission on Filipinos Abroad (2013). *Stock Estimate of Overseas Filipinos as of Dec. 2013*. Available at: <http://cfo.gov.ph/downloads/statistics/stock-estimates.html> [Accessed 15 January 2017].

COSE (2017). *Community organizing*. Coalition of Services of the Elderly, Inc (COSE). Available at: <http://cose.org.ph/what-we-do-community-organizing-> [Accessed 15 August 2017].

Cruz, G., Lavares, A., Marquez, M., Natividad, J. and Saito, Y. (2014). Gender and Economic Well-being Among Older Filipinos. In: T. Devasahayam (ed.) (2014). *Gender and Ageing: Southeast Asian Perspectives*. Singapore: Institute of Southeast Asian Studies. Chapter 12.

Cruz, G., Natividad, J., Gonzales, M. and Saito, Y. (2016). *Aging in the Philippines: Findings from the 2007 Philippine Study on Aging*. Quezon City: University of the Philippines Population Institute and Demographic Research and Development Foundation, Inc.

De Guzman, A. B., Santos, C. I., Santos, I. B., Santos, J. A., Santos, J. E., Santos, J. M. & Santos, V. E. (2012). Concept of Care, Caring Expectations, and Caring Frustrations of the Elderly Suffering from Chronic Illness. *Educational Gerontology*, 38(5), pp. 299-313.

De La Paz, C. & Colson, L. (2008). Population, Health and Environment Issues in the Philippines. *A Profile of the National Capital Region (NCR)*. Available at: http://www.prb.org/pdf08/pheregionalprofiles_ncr.pdf [Accessed 15 August 2017].

De La Vega, S. (2013). Cultural Validation of the WHOQOL-BREF in Ambulatory Community-dwelling Filipino Older Persons. *Philippine Journal of Health Research and Development*, vol. 17.

De Leon, A. (2014). *The Quality of Life of the Filipino Elderly in Selected Cities and Provinces*. Conference paper in The First Multipartite Regional Meeting on the Financial Security of Older Women in East and Southeast Asia on 15-16 January 2015. Tsao Foundation. Available at: http://tsaofoundation.org/doc/financial-security-older-women-jan-2015/Dr%20Aurora%20De%20Leon's%20Presentation_First%20Multipartite%20Regional%20Meeting%20on%20the%20Financial%20Security%20of%20Older%20Women%20in%20East%20&%20Southeast%20Asia_FINAL.pdf [Accessed 11 August 2017].

Department of Health (n.d.). Family Guide on PhilHealth. Department of Health. Available at: http://www.doh.gov.ph/sites/default/files/publications/Family_Guide_on_Philhealth.pdf [Accessed 6 September 2017].

Department of Health (2012). *National Objectives for Health 2011-2016*. Department of Health. Available at: <http://www.doh.gov.ph/sites/default/files/publications/noh2016.pdf> [Accessed 11 August 2017].

Department of Health (2016a). *UHC to address inequity in the health system*. Web-page of the Department of Health. Available at: <http://www.doh.gov.ph/universal-health-care> [Accessed 11 August 2017].

Department of Health (2016b). *All for health towards health for all. Philippine Health Agenda 2016-2022. Healthy Philippines 2022*. Department of Health. Available at: http://www.doh.gov.ph/sites/default/files/basic-page/Philippine%20Health%20Agenda_Dec1_1.pdf [Accessed 2 February 2017].

Department of Health (2017). *Administrative Order 2017-0001. Policy Guidelines on the Standards of Care for Older Persons in all Healthcare Settings*. Department of Health, Office of the Secretary.

- Available at: <http://cose.org.ph/uploads/files/0d98e316f05be823d2acf60a02070286.pdf> [Accessed 25 August 2017].
- EuroHealthNet (2016). *Scientific Resources*. EuroHealthNet. Available at: <http://www.healthyageing.eu/resources/scientific> [Accessed 10 August 2017].
- Fernández-Ballesteros, B. (2008). *Active Aging: The Contribution of Psychology*. Göttingen: Hogrefe.
- Finch, S. (2013). Philippines brain drain: Fact or fiction? *Canadian Medical Association Journal CMAJ*, 185(12), E557–E558.
- Frosch, D., Grande, D., Tarn D. & Kravitz, R. (2009). A Decade of Controversy: Balancing Policy With Evidence in The Regulation of Prescription Drug Advertising. *American Journal of Public Health*, 100(1), pp. 24-32.
- Fry, C. L. (1999). Anthropological Theories of Age and Ageing. In: V. L. Bengtson & K. Warner Schaie (eds.) (1999). *Handbook of Theories of Ageing*. New York: Springer. Chapter 15.
- Grewal, I., Lewis, J., Flynn, T., Brown, J., Bond, D. & Coast, J. (2005). Developing attributes for a generic quality of life measure for older people: Preferences or capabilities? *Social Science & Medicine*, 62, pp. 1891–1901.
- Guzman, A. B., Lores, K. V., Lozano, M. C., Lozano, M. Z., Lu, D. M., Ma, C. V. & Macrohon, C. R (2014). Health-Seeking Preferences of Elderly Filipinos in the Community via Conjoint Analysis. *Educational Gerontology*, 40 (11), pp. 801-815.
- Commission on Filipinos Abroad (2013). *Stock Estimate of Overseas Filipinos as of Dec. 2013*. Available at: <http://cfo.gov.ph/downloads/statistics/stock-estimates.html> [Accessed 15 August 2017].
- Hennink, M., Hutter, I. & Bailay, A. (2011). *Qualitative Research Methods*. London: SAGE.
- HelpAge International (n.d.). *The Philippines*. HelpAge International. Available at: <http://www.helpage.org/where-we-work/east-asia/the-philippines/> [Accessed 10 August 2017].
- HelpAge International (2015). *Global Age Watch Index 2015*. Available at: <http://www.helpage.org/global-agewatch/> [Accessed 17 August 2017].
- HelpAge International (2016a). *Guidelines for qualitative interviews in monitoring with HOT*. Unpublished technical document. HelpAge International.
- HelpAge International (2016b). *AgeWatch Report Card: Philippines*. HelpAge International. Available at: <http://www.helpage.org/global-agewatch/population-ageing-data/country-ageing-data/?country=Philippines> [Accessed 15 August 2017].
- HelpAge International (2017). *Health Outcomes Tool Data Collection in the Philippines*. Concept Note for a Grant. Internal unpublished document. London: HelpAge International.
- Heslop, M. (2002). *Participatory research with older people: A sourcebook*. London: HelpAge International. Available at: <http://www.participatorymethods.org/sites/participatorymethods.org/files/participatory%20research%20with%20older%20people.pdf> [Accessed 20 August 2017].
- Holstein, M. & Minkler M. (2007) Critical Gerontology: Reflections for the 21st Century. In: Bernard M, Scharf T (eds.) *Critical Perspectives on Ageing Societies*. Cambridge: Polity Press, pp. 13–26.

- Hoskins, I. (n.d.). *A Policy Framework for Active and Healthy Ageing*. WHO Ageing and Lifecourse Programme. Geneva: WHO. Available at: <http://www.cepal.org/celade/noticias/paginas/8/12138/ihoskins.pdf> [Accessed 12 August 2017].
- Institute of Development Studies (n.d.). *About Participatory Methods*. Institute of Development Studies. Available at: <http://www.participatorymethods.org/page/about-participatory-methods> [Accessed 27 August 2017].
- Knox-Vydmanov, C., Sevilla, A. & Horn, D. (2016). *The Philippine Social Pension at Four Years: Insights and Recommendations*. Quezon City: Coalition of Services of the Elderly (COSE) and HelpAge International.
- Knox-Vydmanov, C., Horn, D. and Sevilla, A. (2017). *The Feasibility of a Universal Social Pension in the Philippines*. Quezon City: Coalition of Services of the Elderly (COSE) and HelpAge International.
- Laerd Statistics (2015a). *Mann-Whitney U test using SPSS Statistics*. Statistical tutorials and software guides. Available at: <https://statistics.laerd.com/> [Accessed 1 July 2017].
- Laerd Statistics (2015b). *Cronbach's alpha using SPSS Statistics*. Statistical tutorials and software guides. Available at: <https://statistics.laerd.com/> [Accessed 1 July 2017].
- Laerd Statistics (2015c). *Multiple Regression Analysis using SPSS Statistics*. Available at: <https://statistics.laerd.com/spss-tutorials/multiple-regression-using-spss-statistics.php> [Accessed 1 July 2017].
- Leachon, T. (2016). *Addressing Health Human Resource Gaps in the Philippines*. Philippine College of Physicians Foundation Coalition for Primary Care. Presentation for PHAP. Available at: <http://healthforall.ph/resources/presentation-materials/> [8 March 2017].
- Liebelt, C. (2015). The Gift of Care: On Filipina Domestic Workers and Transnational Cycles of Care. In: E. Alber & H. Drotbohm (eds.) *Anthropological Perspectives on Care: Work, Kinship, and the Life-Course*. Chapter 2.
- Lloyd-Sherlock, P. (2002), Nussbaum, capabilities and older people. *Journal of International Development*, 14, pp. 1163–1173.
- Marques, S., Swift, H. J., Vauclair, C-M., Lima, M. L., Bratt C. & Abrams, D. (2015) 'Being old and ill' across different countries: Social status, age identification and older people's subjective health, *Psychology & Health*, 30(6), pp. 699-714.
- Miasco, M. (2016). *Philhealth exec: Most seniors unaware of health privileges*. The Freeman, Philstar. News article on 2 October 2016. Available at: <http://www.philstar.com:8080/cebu-news/2016/10/02/1629529/philhealth-exec-most-seniors-unaware-health-privileges> [Accessed 15 August 2017].
- Mortimer, P., Ward, L. & Winefield, H. (2008). Successful ageing by whose definition? Views of older, spiritually affiliated women. *Australasian Journal on Ageing*, 27(4), pp. 200–204.
- Municipality of Pagbilao (2017). *LGU awards checks to senior citizens*. Available at: <http://pagbilao.gov.ph/lgu-awards-checks-to-senior-citizens/> [Accessed 2 August 2017].
- Natividad, J., Saito, Y. and Cruz, G. (2014). Work, Retirement and the Gender Divide in the Philippines. In: T. Devasahayam (ed.) (2014). *Gender and Ageing: Southeast Asian Perspectives*. Singapore: Institute of Southeast Asian Studies. Chapter 13.

- Official Gazette (2017). Benefits: *Medical-related privileges*. Official Gazette of the Republic of the Philippines. Available at: <http://www.officialgazette.gov.ph/services/senior-citizens/benefits-medical-related-privileges/> [Accessed 15 August 2017].
- Ogena, N. B. (2006). *The Low and Slow Ageing in the Philippines: Auspicious or Challenging?* University of the Philippines Population Institute (UPPI). Available at: [http://www.academia.edu/7437786/The Low and Slow Ageing in the Philippines Auspicious or Challenging](http://www.academia.edu/7437786/The_Low_and_Slow_Ageing_in_the_Philippines_Auspicious_or_Challenging) [Accessed 8 August 2017].
- Peel, N., Bartlett, H. & McClure, R. (2004). Healthy ageing: how is it defined and measured? *Australasian Journal on Ageing*, 23(3), pp. 115-119.
- Perkinson, M. A. & Salimeo, S. M. (2013). Aging in Cultural Context and as Narrative Process: Conceptual Foundations of the Anthropology of Aging as Reflected in the Works of Margaret Clark and Sharon Kaufman. *The Gerontologist*, 54(1), pp. 101-107.
- Philippine Statistics Authority (2012). *The Age and Sex Structure of the Philippine Population: (Facts from the 2010 Census)*. Philippine Statistics Authority. Available at: <http://psa.gov.ph/content/age-and-sex-structure-philippine-population-facts-2010-census> [Accessed 14 February 2017].
- Philippine Statistics Authority (2015a). *Table 1. Population, Land Area, Population Density, and Percent Change in Population Density of the Philippines by Region, Province/Highly Urbanized City, and City/Municipality: 2015*. Philippine Statistics Authority. Available at: <https://psa.gov.ph/content/philippine-population-density-based-2015-census-population> [Accessed 17 August 2017].
- Philippine Statistics Authority (2015b). *Poverty incidence among Filipinos registered at 26.3%, as of first semester of 2015 – PSA*. Philippine Statistics Authority. Available at: <https://psa.gov.ph/content/poverty-incidence-among-filipinos-registered-263-first-semester-2015-psa> [Accessed 1 September 2017].
- Philippine Statistics Authority (2016a). *Philippine Statistics in Brief 2016*. Philippine Statistics Authority. Available at: <http://psa.gov.ph/content/philippine-statistics-brief-2016> [Accessed 15 August 2017].
- Philippine Statistics Authority (2016b). *Poverty incidence among Filipinos registered at 21.6% in 2015 – PSA*. Press release 27.10.2016 Available at: <https://psa.gov.ph/poverty-press-releases> [Accessed 11 August 2017].
- Pond, R., Stephens, C., & Alpass, F. (2010). Virtuously watching one's health: Older adults' regulation of self in the pursuit of health. *Journal of Health Psychology*, 15, pp. 734-743.
- Porter, T. (2015). *Statement in support of the WHO World Report on Ageing and Health*. HelpAge International. Available at: <http://who.int/ageing/events/world-report-2015-launch/help-age-int-statement-world-report-ageing.pdf> [Accessed 13 August 2017].
- Quezon Province (2016). *Demography*. Provincial Government of Quezon. Available at: <http://www.quezon.gov.ph/homepage/?info=demography> [Accessed 15 August 2017].
- Robeyns, I. (2005). The Capability Approach: a theoretical survey. *Journal of Human Development*, 6(1), pp. 93-117.
- Robeyns, I. (2016). *The Capability Approach*. The Stanford Encyclopedia of Philosophy (Winter 2016 Edition). Available at: <https://plato.stanford.edu/archives/win2016/entries/capability-approach> [Accessed 15 August 2017].

- Ruger, J. (2010). Health Capability: Conceptualization and Operationalization. *American Journal of Public Health*, 100(1), pp. 41–49.
- Salenga, R., Loquias, M. & Sarol, J. (2015). *Impact Evaluation of the Expanded Senior Citizens Act of 2010 (RA 9994) on Drug Accessibility among the Elderly*, vol. 2010, 2015. The Department of Health. Available at: <http://hsrm.doh.gov.ph/researches/view/26> [Accessed 7 September 2017].
- Scheyvens, R., Scheyvens, H. & Murrey, W. (2014). Working with marginalised, vulnerable or privileged groups. In: R. Scheyvens (ed) (2014). *Development Fieldwork: A Practical Guide*. London: SAGE. Ch. 10.
- Smith, A. (2000). *Researching quality of life of older people: concepts, measures and findings*. Centre for Social Gerontology. Working Paper No 7. Available at: https://www.keele.ac.uk/csg/downloads/centreworkingpapers/research_quality.pdf [Accessed 4 August 2017].
- Stenner, P., Cooper, D. and Skewington, S. (2003). Putting the Q into quality of life; the identification of subjective constructions of health-related quality of life using Q methodology. *Social Science & Medicine*, 57, pp. 2161–2172.
- Stenner, P., McFarquhar, T. & Bowling, A. (2010). Older people and ‘active ageing’: Subjective aspects of ageing actively. *Journal of Health Psychology*, 16(3), pp. 467–477.
- Stephens, C. (2016): From success to capability for healthy ageing: shifting the lens to include all older people. *Critical Public Health*, DOI: 10.1080/09581596.2016.1192583
- Stephens, C., Breheny, M. & Mansvelt, J. (2015). Healthy ageing from the perspective of older people: A capability approach to resilience. *Psychology & Health*, 30(6), pp. 715–731.
- Stewart-Withers, R., Banks, G., McGregor, A. & Meo-Sewabu, L. (2014). Qualitative Research. In: R. Scheywens (ed.) (2014). *Development Fieldwork: A Practical Guide*. London: SAGE. Chapter 4.
- Sumner, A. & Tribe, M. (2008). *International Development Studies. Theories and Methods in Research and Practice*. London: SAGE.
- Tabandeh, A., Gardoni, P. & Murphy, C. (2017). A reliability-based capability approach. *Risk analysis: an official publication of The Society of Risk Analysis*, Jun 12, doi: 10.1111/risa.12843.
- UN (2016). *Guidelines for review and appraisal of the Madrid International Plan of Action on Ageing. Bottom-up participatory approach*. Department of Economic and Social Affairs. New York: United Nations. Available at: <http://www.un.org/esa/socdev/ageing/documents/MIPAA/GuidelinesAgeingfinal13%20Dec2006.pdf> [Accessed 25 August 2017].
- Valdez, J., Angeles, J., Pareja-Corpuz, E. & Hernandez, C. (2013). Perceptions towards aging among selected Filipino adults. *International Journal of Research Studies in Psychology*, 2(3), pp. 89–96.
- UNFPA & HelpAge International (2012). *Ageing in the Twenty-First Century: A Celebration and A Challenge*. New York: United Nations Population Fund (UNFPA) and London: HelpAge International. Available at: <https://www.unfpa.org/sites/default/files/pub-pdf/Ageing%20report.pdf> [Accessed 10 August 2017].
- Valdez, J., Angeles, J., Pareja-Corpuz, E. & Hernandez, C. (2013). Perceptions towards aging among selected Filipino adults. *International Journal of Research Studies in Psychology*, 2(3), pp. 89–96.

- Verd, J. M. & Andreu, M. L. (2011). The rewards of a qualitative approach to life-course research. *Forum Qualitative Sozialforschung*, 12. Available at: http://www.qualitative-research.net/index.php/fqs/article/view/1753/3259#footnote_7 [Accessed 27 August 2017].
- Weir, I. (n.d.). *Spearman's correlation. Teach yourself worksheet*. Statstutor. Available at: <http://www.statstutor.ac.uk/resources/uploaded/spearmans.pdf> [Accessed 3 September 2017].
- Wells, T. (n.d.). *Sen's Capability Approach*. Internet Encyclopedia of Philosophy. Available at: <http://www.iep.utm.edu/sen-cap/#H4>. [Accessed 14 August 2017].
- WHO (1997). *WHOQOL Measuring Quality of Life. Division of Mental Health and Prevention of Substance Abuse*. World Health Organisation. Available at: http://www.who.int/mental_health/media/68.pdf [Accessed 13 August 2017].
- WHO (2002a). *Active Ageing: A Policy Framework*. World Health Organisation. Available at: http://apps.who.int/iris/bitstream/10665/67215/1/WHO_NMH_NPH_02.8.pdf [Accessed 12 August 2017].
- WHO (2002b). *WHOQOL-HIV Instrument. User's manual. Scoring and Coding for the WHOQOL-HIV Instruments*. Mental health: Evidence and research department of mental health and substance dependence. Geneva: World Health Organisation. Available at: http://apps.who.int/iris/bitstream/10665/77776/1/WHO_MSD_MER_Rev.2012.03_eng.pdf [Accessed 13 August 2017].
- WHO (2011). *The Philippines Health System Review*. Health Systems in Transition. Vol. 1 No.2. World Health Organisation. Available at: http://www.wpro.who.int/philippines/areas/health_systems/financing/philippines_health_system_review.pdf [Accessed 11 August 2017].
- WHO (2015a). *Ageing and health*. Fact sheet N°404, September 2015. Media Centre of World Health Organisation. Available at: <http://www.who.int/mediacentre/factsheets/fs404/en/> [Accessed 8 August 2017].
- WHO (2015b). *World Report on Ageing and Health*. World Health Organisation. Available at: http://apps.who.int/iris/bitstream/10665/186463/1/9789240694811_eng.pdf?ua=1 [Accessed 8 August 2017].
- WHO (2015c). *Draft 0: Global Strategy and Action Plan on Ageing and Health. 4 What makes up healthy ageing?* Web-based consultation August-October 2015. Geneva: World Health Organisation. Available at: <http://who.int/ageing/global-strategy/GSAP-ageing-makesup.pdf> [Accessed 13 August 2017].
- WHO (2015d). *Philippines Country Cooperation Strategy at glance*. Fact sheet. World Health Organisation. Available at: http://apps.who.int/iris/bitstream/10665/136828/1/ccsbrief_phl_en.pdf [Accessed 11 August 2017].
- WHO (2016). *Global strategy and action plan on ageing and health (2016 - 2020). A framework for coordinated global action by the World Health Organization, Member States, and Partners across the Sustainable Development Goals*. Summary. World Health Organisation. Available at: <http://www.who.int/ageing/GSAP-Summary-EN.pdf?ua=1> [Accessed 8 August 2017].
- WHO (2017). *Data and Research. Ageing and Life-Course*. World Health Organisation. Available at: <http://www.who.int/ageing/data-research/en/>

WHOQOL Group (1995). *The World Health Organisation Quality Of Life Assessment (WHOQOL): Position Paper from The World Health Organisation*. Social Science & Medicine, 41(10), pp. 1403-1409.

World Bank (2016). *The Philippines: Overview*. World Bank. Available at: <http://www.worldbank.org/en/country/philippines/overview#1> [Accessed 11 August 2017].

Zaidi, A. (2016). *Sustainable Development Goals have put ageing back onto the agenda*. Blog post 8.6.2016. HelpAge International. Available at: <http://www.helpage.org/global-agewatch/blogs/asghar-zaidi-20076/sustainable-development-goals-have-put-ageing-back-onto-the-agenda-1006/> [Accessed 8 August 2017].

Appendix 1

Health Outcomes Tool (HOT) baseline survey



February 2017 version modified for the baseline collection in the Philippines

GENERAL INFORMATION (filled in by the enumerator prior to the start of the interview)
Please indicate date of interview. _____
Please select the region you are in. <ul style="list-style-type: none"><input type="radio"/> Africa<input type="radio"/> Americas<input type="radio"/> Eastern Mediterranean<input type="radio"/> Europe<input type="radio"/> South-East Asia<input type="radio"/> Western Pacific
Please select the country you are in. <ul style="list-style-type: none"><input type="radio"/> India<input type="radio"/> The Philippines<input type="radio"/> Thailand<input type="radio"/> Bangladesh<input type="radio"/> Vietnam<input type="radio"/> Indonesia<input type="radio"/> Sri Lanka<input type="radio"/> Cambodia
What is the first and last name of the interviewer 1? _____
What is the first and last name of the interviewer 2? (note taker) _____
What is the name of this project? _____
What kind of project is this? <ul style="list-style-type: none"><input type="radio"/> Health and care<input type="radio"/> Livelihood<input type="radio"/> Social protection<input type="radio"/> Rights and protection<input type="radio"/> Disaster Risk Reduction<input type="radio"/> Voice<input type="radio"/> Other
What kind of health project is this? <ul style="list-style-type: none"><input type="radio"/> Health services<input type="radio"/> Health promotion<input type="radio"/> Selfcare<input type="radio"/> NCD prevention and care<input type="radio"/> Intergenerational<input type="radio"/> Health lifestyles

INTRODUCTION AND CONSENT
Before you get started, read this to the respondent; “My name is _____ I’m a Research Assistant working with _____ to undertake a survey for a project _____. As part of this exercise, you have been selected randomly to participate in the survey. The survey will enable the project to improve its areas of implementation and specifically to effectively monitor and evaluate its activities. The interview will take around 30 minutes.
Do you have any additional questions? <ul style="list-style-type: none"><input type="radio"/> Yes – please answer the questions<input type="radio"/> No

Your participation is voluntary. You are free to withdraw at any time without giving any reason, without any current or future support being affected. Therefore, do you agree to take part in this study?

☐ Yes - Proceed to interview the respondent)

☐ No - (Please thank the person and stop the interview)

Please upload a picture of the respondent's signature. If respondent cannot write, make a thumb print on a piece of paper and take a photo of it.

The respondent will now be assigned an ID by the survey.

Please enter respondent's surname. _____

Please enter respondent's given name. _____

OBSERVE; Gender of respondent.

☐ Female

☐ Male

☐ Other

What is your age? If the respondent doesn't know his/her age, enter 999. _____

Which province is this? _____

Which village is this? _____

Please enter the respondents contact phone number, if available. _____

Who is the owner of this phone number?

☐ The respondent

☐ A family member

☐ A neighbours

☐ A friend

☐ The village leader/chief

Is this location urban, rural or periurban?

☐ Urban

☐ Periurban

☐ Rural

What is your level of highest education?

☐ Pre-primary/nursery

☐ Primary

☐ High school/secondary

☐ Higher/college/university

☐ No formal school attended

☐ Vocational Training

☐ Other

☐ Do not know

Are you a member and a beneficiary of the PhilHealth insurance?

☐ Yes

☐ No

☐ Don't know

Which of the following programmes have you benefited from?




☐ Community Pharmacy – “Botika Binhi”

☐ Homecare Program




☐ Community Health Volunteers (Community Gerontologist, Community Masseurs, Psychosocial Support Volunteers)

☐ Community Health Volunteers (Health Education or Healthy Ageing Sessions in the community)

GENERAL INFORMATION: BASIC NEEDS				
Are you able to pay for the following?				
House or shelter?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Sometimes/partly	
Food?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Sometimes/partly	
Safe drinking water?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Sometimes/partly	

Keeping a good hygiene? (Take a bath and use the toilet)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Sometimes/partly
<p>Compared to other households in the community, is your household poor or not poor? 50 means same as most other households. 0 means a lot poorer than most other households, 100 means a lot richer than most other households</p> <div> <div></div> <div>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</div> <div>    </div> </div>			
How many people live in your household? (Including yourself)			
How many people do you talk to in a month?			

GENERAL INFORMATION: DISABILITIES					
Do you experience any of the following difficulties doing certain activities because of a health problem?					
	Cannot do at all	Yes, big difficulties	Yes, some difficulty	No, no difficulty	Do not know
Seeing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hearing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking or climbing steps?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Remembering or concentrating?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you have difficulty (with self-care such as) washing all over or dressing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using your usual language, communicating or being understood?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>Do any of these difficulties hinder your ability to take part in this survey? If disabilities hinder participation, please thank the participant and end the interview.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>					
DO NOT READ. To the interviewer. Does this person have any disabilities that can hinder participation in the survey?					

LIFE SATISFACTION AND GENERAL HEALTH STATUS
Overall, how would you RATE your HEALTH during the past 3 months?
<p>Please select ANY number between 0 and 100. 0 would represent very poor health. 100 would represent excellent health.</p> <div> <div></div> <div>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</div> <div>    </div> </div>
Overall, how SATISFIED have you felt with your LIFE during the last 3 months?

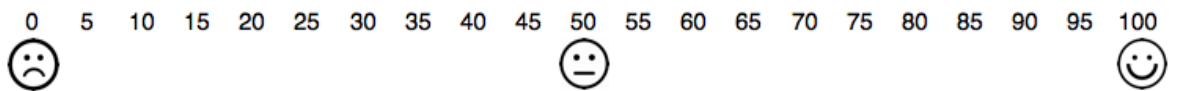
Please select ANY number between 0 and 100. 0 would represent not at all satisfied. 100 would represent very satisfied.



FUNCTIONALITY

During the past 3 months, how would you rate your ability to conduct, by yourself, your usual social and/or daily activities? For example feeding, bathing, dressing up, moving around the house, taking self to toilet, control stool/urine continence, giving own medications, attending a social group etc.

Please select ANY number between 0 and 100. 0 would represent not at all able. 100 would represent completely able.



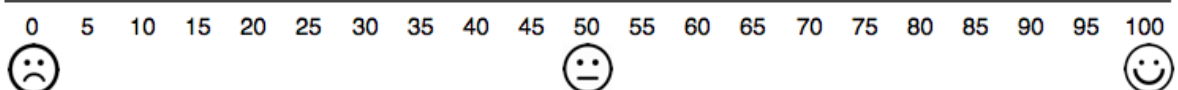
During the past 3 months, how would you rate your ability to conduct, by yourself, your work activities? For example, farming, fishing, running a family business, cooking, fetching water/firewood, washing clothes, going to the market, repairing and looking after things at home etc.

Please select ANY number between 0 and 100. 0 would represent not at all able. 100 would represent completely able.



How far can you MOVE AROUND without anyone helping you?

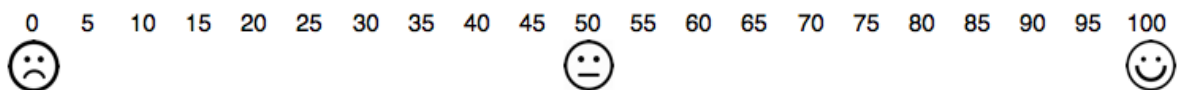
Please select ANY number between 0 and 100. 0 would represent being restricted to the bed, not mobile at all. 100 would represent being completely mobile and able to walk anywhere.



DEPENDENCY/SUPPORT NEEDS







During the past 3 months, to what extent have you REQUIRED SUPPORT from other people to carry out your usual social and/or daily activities? For example, family or friends or community workers.




Please select ANY number between 0 and 100. 0 would represent needing a lot of support. 100 would represent not needing support.















During the past 3 months, to what extent have you REQUIRED SUPPORT from other people to carry out your usual work activities? For example, family or friends or community workers.

Please select ANY number between 0 and 100. 0 would represent needing a lot of support. 100 would represent not needing support.

<div> <div>05101520253035404550556065707580859095100</div> <div>    </div> </div> <p>To what extent are you ABLE TO GET SUPPORT when you need it?</p> <p>Please select a number between 0 and 100. 0 would represent not at all able to get support. 100 would represent getting support all the time.</p>
<div> <div>05101520253035404550556065707580859095100</div> <div>    </div> </div> <p>Who is most likely to provide you support or help when you need it? (Rank top 3)</p> <ul style="list-style-type: none"> <input type="radio"/> People I stay with (in my home) <input type="radio"/> Relatives/family (outside of my home) <input type="radio"/> Neighbours <input type="radio"/> Friends <input type="radio"/> Caretaker <input type="radio"/> Community organisation <input type="radio"/> None of the above <input type="radio"/> Other – please specify <input type="radio"/> I don't know

<p>HEALTH SERVICES RESPONSE: ACCESS, QUALITY AND AFFORDABILITY</p> <p>Over the past 3 months, did you require health care services?</p> <ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
<p>Do you access health care services when you need it?</p> <ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
<p>In your opinion, how easy or difficult is it to access health care?</p> <p>Please select ANY number between 0 and 100. 0 would very difficult to access health services. 100 would represent very easy to access health services.</p> <div> <div>05101520253035404550556065707580859095100</div> <div>    </div> </div>
<p>Do you have any, or several, diagnosed chronic illness/es?</p> <ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
<p>Have you been diagnosed with any of the following illnesses? Read list of answers to the respondent.</p> <ul style="list-style-type: none"> <input type="radio"/> High blood pressure <input type="radio"/> Heart disease <input type="radio"/> Diabetes <input type="radio"/> Cancer <input type="radio"/> Asthma or chronic obstructive pulmonary disease <input type="radio"/> Cataract or other ophthalmic disorders <input type="radio"/> Dementia or other age-related mental disorders <input type="radio"/> Diseases of the central nervous system, e.g. Parkinson's, Epilepsy etc.

<ul style="list-style-type: none"> <input type="radio"/> Body pain, e.g. back, shoulder, legs etc. <input type="radio"/> Recurrent bouts of communicable diseases (e.g. diarrhoea, malaria, Tuberculosis) <input type="radio"/> HIV/AIDS <input type="radio"/> None <input type="radio"/> Other:
<p>Are you receiving regular /care for your condition? This could be care or medication.</p> <ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes/ Partly
<p>How easy do you think it is to ACCESS health services?</p> <p>Please select ANY number between 0 and 100. 0 would very difficult to access health services. 100 would represent very easy to access health services.</p> <div> <div></div> <div>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</div> <div>    </div> </div>
<p>How would you RATE THE QUALITY of health services in your community? For example, health centres giving enough treatment, counselling patients, home based care.</p> <p>Please select ANY number between 0 and 100. 0 would very poor. 100 would represent very good.</p> <div> <div></div> <div>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</div> <div>    </div> </div>
<p>How easy is it to AFFORD health services?</p> <p>Please select ANY number between 0 and 100. 0 would very hard. 100 would represent no difficulty.</p> <div> <div></div> <div>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</div> <div>    </div> </div>

<p>SELF-CARE</p>
<p>Who do you think is primarily responsible for your health? Please rank in order of who is most responsible (Rank up to 3)</p> <ul style="list-style-type: none"> <input type="radio"/> Me <input type="radio"/> My household <input type="radio"/> Health workers <input type="radio"/> None <input type="radio"/> Other– please specify <input type="radio"/> Don't know
<p>How much do you take care of your health?</p> <p>Please select ANY number between 0 and 100. 0 would represent not at all. 100 would represent very much.</p> <div> <div></div> <div>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</div> <div>    </div> </div>
<p>What do you do to take care of your health? (Multiple choice)</p> <ul style="list-style-type: none"> <input type="radio"/> I seek treatment <input type="radio"/> I do physical exercises

- I take balanced food
- I have my blood pressure taken
- None of the above
- Other – please specify
- Don't know

FUNCTIONAL TESTING

Instructions for sitting to standing: Please stand up. Try not to use your arms to support you.

Interviewer is to ensure that the respondent will not be exposed to risk through participating in this test.

Interviewer is to observe and give response based on the following:

- Needs moderate or maximal assist to stand (the person needs to be supported a lot to stand)
- Needs minimal aid to stand or stabilize (the person needs to be supported a little to stand)
- Able to stand using support of arms after trying several times
- Able to stand on own on first try using support of arms
- Able to stand without support of arms and stabilize independently
- Not able to perform test

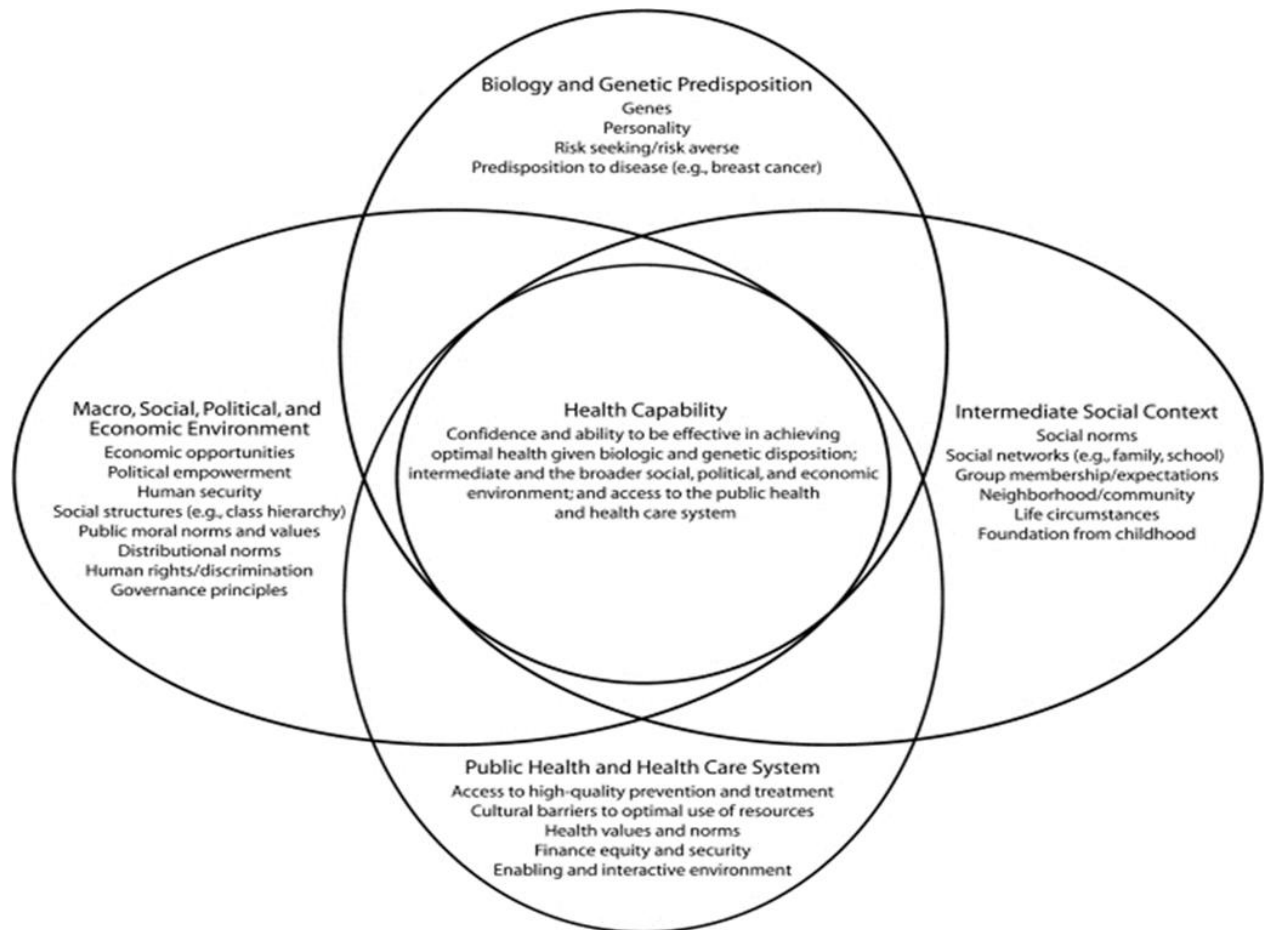
Is there anything else you would like to share?

This interview is now completed. Thank you for your time.

Interviewer please enter any last notes or observations.

Appendix 2

Health capability model by Frosch, Grande, Tarn and Kravitz (2009)



Appendix 3

Summary of all research participants (final sample)

Type of respondent	Place of residence	Research tool	Number of respondents	Total
Older people	Metro Manila province (Quezon City, San Juan City)	Focus group discussions	7 + 6 in Quezon City + 7 in San Juan City	20
Older people	Quezon province (Pagbilao, Atimonan)	Focus groups discussions	6 in Pagbilao + 7 in Atimonan	13
Older people	Metro Manila (Quezon City, San Juan City)	Quantitative HOT survey	81 Quezon City + 75 San Juan City	156
Older people	Quezon province (Pagbilao, Atimonan)	Quantitative HOT survey	75 Pagbilao + 78 Atimonan	153
Older people	Metro Manila (Quezon City, San Juan City)	Follow-up interviews	4 in Quezon City + 4 in San Juan City	8
Older people	Quezon province (Pagbilao, Atimonan)	Follow-up interviews	4 in Pagbilao + 4 in Atimonan	8
Health officers	Metro Manila (Quezon City, San Juan City)	Key informant interviews	1 in Quezon City + 1 in San Juan City	2
Health officers	Quezon province (Pagbilao, Atimonan)	Key informant interviews	1 in Pagbilao + 1 in Atimonan	2

Appendix 4

Focus group discussion guide

[Introductory script removed]

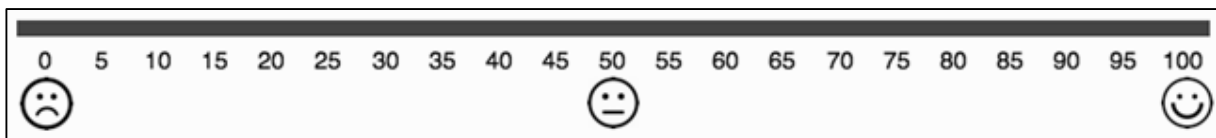
Topic 1: Conceptualisations of health and life satisfaction

Grouping exercise, instructions for facilitator(s):

First round: being healthy

Second round: life satisfaction

- Show the participants the HelpAge International's scoring line (below) and tell them which end represents very poor health and which one very good health
- Ask participants to describe the characteristics of the two extremes



1. Very poor health

Very good health

2. Very unsatisfied with life

Very satisfied with life

Example questions, first round:

What does it mean to be in very good health? What does it enable you to do? What about the opposite? What does it prevent you from doing? What are the characteristics of these extremes?

What are the main things one needs to be healthy? To move along the line towards the positive end, what needs to change in someone's life? (probe for both micro and macro changes; personal traits and environmental factors) What score would be "good enough", can we generalise or is it personal?

Example questions, second round:

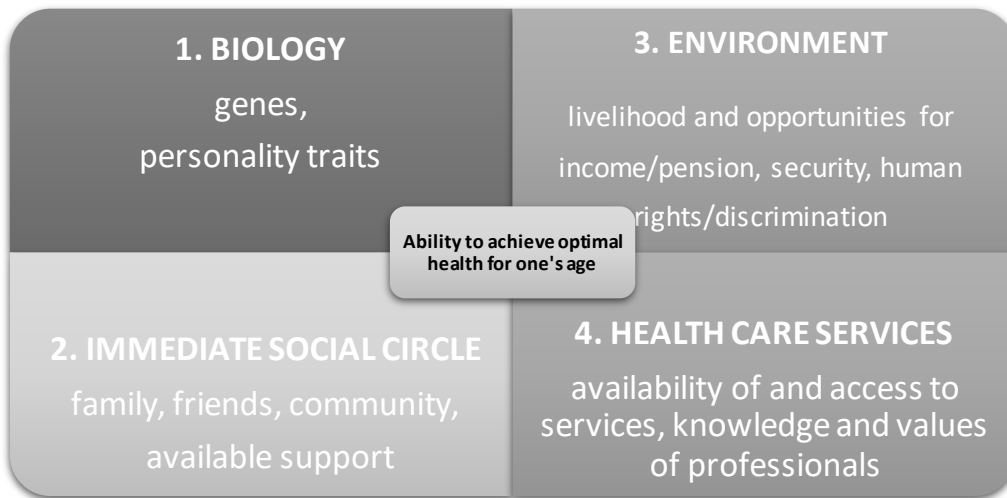
What does it mean to be in very or absolutely satisfied with one's life? What does it consist of? (probe: is it a feeling, an attitude, something else) What about the opposite, what would lead someone to be very unsatisfied with one's life? Is life satisfaction linked with health, if yes, how?

What does one need to be and have to be satisfied with one's life? Are these things available to everyone? How could someone improve their life satisfaction? What score is "good enough", can we generalise or is it personal?

Topic 2. Enabling and restraining factors to health

Health capability exercise, instructions for facilitator(s):

- Show the participants the health capability model below (based on Frosch, Grande, Tarn and Kravitz, 2009 model). Explain how 'ability to achieve optimal health for one's age' can be both enabled and restraint by the four factors presented in the model
- Explain carefully what each of the four factors contain and what is their relation to health. Make sure that everyone understands that optimal health for one's age is relative and might differ from absolute health discussed in the previous exercise.
- The exercise consists of two rounds: first, exploring an ideal situation and secondly, presenting an imaginary case study of a poor situation. Questions to be asked are listed below.



First round: ideal situation

In an ideal situation for an older person in your community, what would these aspects of health (1-4) contain:

- To start with biology, what kind of personality traits and gene-based characteristics would support the achievement of optimal health for someone your age?
- What about immediate social circle, what does one need from it to achieve optimal health?
- Let's move to the environment, which contains economic, political, social and cultural spheres: what kind of environment, policies and actions would support an ageing individual in achieving optimal health?
- How about the health care services, what kind of services would be most valuable and useful? Are these public, private or community-based services? What kind of values and knowledge would the health care professionals need to have to support someone in your community to achieve optimal health?

Second round: poor situation

Let's then imagine a less ideal situation, perhaps a more realistic one. *[insert here a short case study describing a situation that would be easily relatable to the participants, situated in their community]*¹. If you try to step into this person's shoes, what do you think his/her needs and priorities would be to achieve optimal well-being:

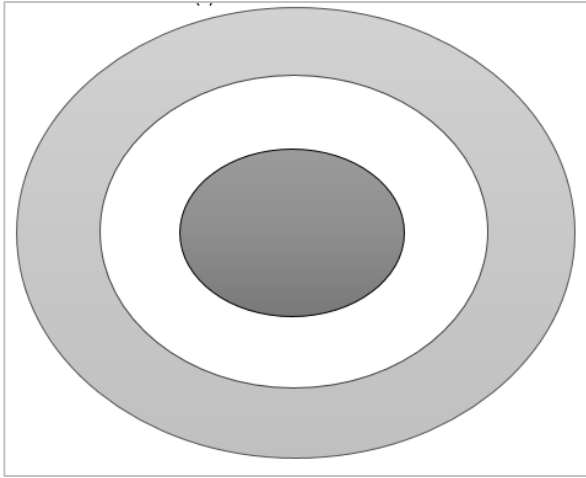
- Which aspect – immediate social circle, health and care services or macro environment – would be the most crucial in supporting this person? Why?
- Is there an aspect that you see as less important, why?
- What kind of personal coping mechanisms could the person have in this kind of a situation that would help him/her to deal with the situation on a daily basis?
- How would prevailing social norms related to health affect this person's situation? (probe: seeking for care/support, providing care within a family, which services to use and how often, are health issues personal or can they be shared with others, negative and positive sides of social norms)

Topic 3: Health services and care providers

Institutional diagram exercise:

¹ In the conducted focus groups, the facilitator (COSE employee) used a case study of a sick older woman who lives alone, receives no support from her relatives and is unable to buy food and medicines she requires.

The idea of an institutional diagram is to show the relative significance and meaning of various health services and care providers to the participants' lives. An example diagram is presented below. The perceptions of roles different health services/care providers have in each participant's life can be presented so that the most important services are placed in the centre of the diagram, those somewhat important in the middle circle and the not/least important in the outer circle. The A4-sized printed diagram is given for each participant. If preferred, they can also draw their own diagrams.



Instructions for facilitator(s):

- I. Ask the participants to identify the key health services and care providers in their lives. This can include family members, self-care, community health services (e.g. COSE's health and homecare volunteers) as well as public and private services (e.g. health clinics, hospitals). This first step should be made together so that the facilitator lists the services/care providers the participants mention in writing on a paper on the wall.
- II. Ask the participants to select the services/care providers relevant to them from the list. Ask them to write them in the diagram so that the ones most significant in their lives are placed in the centre, and the less significant ones further away from the centre. Assist participants whenever needed.
- III. Discuss the diagrams with the following example questions:
 - Could you tell me which services and care providers you placed in the centre and why? What are the needs, priorities or expectations that this service/these services can meet but others can't?
 - Are the services in the centre there because of your own choice and preferences or because of other reasons? What reasons?

Questions specifically about community health services:

- What is the role of community health services such as those of COSE in relation to other services?
- What are your expectations for the community health services and have they met these expectations? If yes, how? If not, why?
- What kind of health-related community services are needed that don't currently exist? What is the need?

To end the focus group session, guide the participants to think positive aspects of their health and lives in general; what is currently well and can be appreciated. Go around the table one by one to check that everyone leaves the room with a positive mindset.

Example questions (probe for a short answer): three things I am grateful about; or a dream I wish to achieve. Finally, thank the participants for their contribution to the study.

Appendix 5

Photos from the data collection: instruments and practices

Photo 1. Focus group discussion setting.



Photo 2. Conducting a HOT tool survey.



Appendix 6

Follow-up interview guide

[introductory script removed]

OPENING QUESTIONS

1. Could you tell me about your living arrangements and the area you are living in?

Probes: who is the respondent living with and why, what are their perceptions of the area in terms of e.g. safety, availability of services

2. What do you do during a normal day (from the moment you wake up)?

Probes: daily and work activities (check how the respondent understands “work” activities), caring responsibilities, chores, social activities

KEY QUESTIONS:

3. In the survey interview a month ago, you were asked to rate your health during the previous 3 months on a scale 0 to 100. You chose [insert number]. You might not remember exactly, but what do you think were the main reasons why you chose this number on the scale?

Probes: new and long-standing health problems, chronic illnesses (see survey response!) and their effects, possible acute illnesses and feelings of pain

4. Would you choose today a different number, if yes, why?

5. Which factors define your health?

Probes: HelpAge domains of functionality (ability to conduct daily, social and work activities and to move around), ability to receive support when needing it (from whom?), responsive services (accessibility, quality and affordability of health services), extent of self-care (ability to take self-care action), others?

6. Among the survey respondents from your barangay, there were older people who gave very good health and life satisfaction scores and others who gave very low scores. What do you think are the main reasons generally for such differences in your community?

Probes: (lack of) income and/or pension, health insurance depth and coverage, availability and accessibility of health services, support from family, other reasons

7. What are the main barriers that hinder your own ability to achieve better health outcomes?

Probes: If a respondent has indicated in the survey that they do not use health services when needing them, ask for reasons

8. (If the respondent has identified barriers) How do you deal with the situation?

Probes: resilience, support from family/community, source of strength (e.g. spirituality)

9. What could be done to ease your or your community's situation in terms of health and who could change it?

Probes: grassroot vs. macro changes: family and community, government, public/private/NGO sectors

10. In the survey interview a month ago, you were asked to provide a score that implicates how much support you have needed from other people during the previous three months. You gave a score of [number] for daily and/or social activities and a score of [number] for work activities. You might not remember exactly, but what do think were the main reasons why you chose these numbers?

Probes: for which activities is help needed for, to what extent, new or long-standing situation, sustainability, what does the respondent understand by “support”

ADDITIONAL QUESTION FOR COSE BENEFICIARIES IN SAN JUAN AND QUEZON CITY

11. You expressed in the survey interview that you have benefited from COSE’s health program(s) [name of the program]. Could you tell me of your experiences with this service?

Probes: needs behind requiring support, how long has been a beneficiary, what is the meaning of the service to the respondent, would their situation regarding health be different without the service, satisfaction with received care/support, recommendations to enhance COSE/COPAP health services

CLOSING QUESTIONS

12. Could you tell me how you experienced the participation in the HOT survey (and this interview)?

13. What would be the ideal situation for you in terms of health and well-being in two years from now [adjust on the basis of the respondent’s current age]?

Ask if the respondent has anything to add to anything discussed or questions about the research.

Thank him/her of his/her time and contribution to the study.

Appendix 7

Key informant interview guide

[introductory script removed]

Background questions

1. What is your position at [organisation]? What are your main responsibilities in the current position?
2. How long have you worked for [organisation]?

Overview of services

3. Could you tell me what kind of health services are generally available for older people in your municipality? Are there differences between barangays?
4. In planning and implementing these services, how are older people's needs and priorities taken into consideration?

Challenges in service provision

5. Have you identified any potential challenges in the current service provision that might have an effect on senior citizens, e.g. their access to the services? If yes, what has been/will be done to address these challenges?
6. In a focus group discussion conducted, older people in your municipality identified the following challenges with regards to health services available to them [provide here a list of the challenges]. What is your view of these challenges and reasons behind them?

Role of community health programs

Asked in Quezon province where COSE does not yet run health programs:

7a) Do you see a need for complementary community health programs of COSE in your municipality in the future? If yes, what kind of programs/services would be most useful? If no, why not?

Asked in Metro Manila where COSE runs health programs:

7b) What do you see as the role of complementary community health programmes such as those of COSE in your municipality? Is there a need for these programs, why/why not?

Appendix 8

Example of a consent form of the study

CONSENT AND INFORMATION FORM: FOCUS GROUPS

Title of Project: Older people's self-perceptions of health and life satisfaction in the Philippines

Researcher: Henriikka Laurola, MSc International Development Studies, Utrecht University, The Netherlands

Introduction to the form: The purpose of this form is to provide you with information so you can decide whether to participate in a focus group discussion conducted as part of this study. Before making the decision, any questions you may have will be answered by the researcher or by the other contact persons provided below. If you agree to participate, please sign this form. Please also indicate whether or not you are willing to be audio recorded. Please note that this recording will not be made available to anyone else than the researcher and the translator present in this meeting. It will only be used for the purposes of transcribing the interview to a textual format and will be fully erased afterwards.

Please note that your participation is fully voluntary and you may decide to leave the study at any time. You may also refuse to answer specific questions you are uncomfortable with. Withdrawal or refusal to participate will not affect any health or care support you receive now or in the future. It will also not affect your relationship with the organisations or individuals involved in this study.

Purpose of the Study: You have been asked to participate in a research that explores how older people in Metro Manila and Quezon provinces in the Philippines perceive their own health and life satisfaction. This research has three phases. First, a survey questionnaire, second, a personal interview, and third, the focus group discussion you are invited to participate. This research phase is complementary to the previous ones and aims to add understanding of what health and life satisfaction means for older Filipino people and how health services could best support you in achieving these goals.

Use of the data: The overall findings of this study will be used to form part of the researcher's Master's thesis and will potentially also be published in publications by the host organisations HelpAge International and COSE. The focus group discussion data will only form a part of these findings, which are a result of combining and summarising all participants' responses. Your anonymity will be fully guaranteed in all publications, meaning your name or any identifiable information will not appear anywhere. If you wish to receive a copy of the final thesis, it will be provided to you. The thesis will be an English-speaking publication.

Procedures to be followed: You have been asked to participate in a one-time focus group discussion with 6-8 other participants of same sex from your community. The facilitator of the discussion will ask the group questions and guide the discussion. Visual aids, such as diagrams, will be used by the facilitator to clarify the questions and guide the discussion. The questions will concern topics of health, life satisfaction as well as health services in general, meaning you are not expected to share any personal information regarding your health status. The time and place of the meeting will be arranged so that it is as convenient for you as possible. The focus group discussion will take no longer than one and a half hours to complete.

Risks of participation: All participants of the focus groups will be asked to respect the privacy of other group members and to not disclose anything to outsiders. It is important to understand that other people in the group with you may still not keep all information private and confidential. Please remember that you are not required to answer any questions during the focus group that would make you feel uncomfortable.

Compensation: You will not receive any type of payment for participating in this study.

Benefits of participation: There are no material benefits for participating in the focus group or the study. However, your community will benefit from the study by helping local service providers to develop their responses to improve the health of older people. The results of this study will also help global development organisations, such as HelpAge International, to understand what it means to age in your country. You are an expert in this area.

Statement of Privacy and Confidentiality: In any publication based on the findings of this study, the data presented will contain no identifying information that could associate it with you unless you specifically request to have your real name associated with your responses. You will be guaranteed full anonymity during and after the research process. All information provided by you will be converted into a digital format and stored on a computer protected by passwords.

Contact Information

Please do not hesitate to contact me in any questions and concerns you might have regarding the research either by phone 0927 416 or by email h.e.laurola@students.uu.nl

Alternatively, you may wish to contact my local research supervisors Emily Beridico or Celerina Luaton at my host organisation COSE, phone: 02 374 6416, email emily.beridico@cose.org.ph and lerry.luaton@cose.org.ph

Or my thesis supervisor, Maggi Leung at Utrecht University, The Netherlands, phone +31 30 253 4433, email: W.H.M.Leung@uu.nl

Confirmation and consent

I confirm that I have freely agreed to participate in the research project and the focus group discussion detailed in this document. I have been briefed on what this involves. I grant permission to publish the information without my name included. I understand that any information with my name will be private and will not appear in any publications. I understand that I can withdraw from this study at any time. I consent to take part in this focus group.

I give/ do not give permission for the interview to be recorded. (Please underline).

Participant signature: _____

Name: _____

Date: _____

I confirm that I agree to keep the undertakings in this contract.

Researcher signature: _____

Name: _____

Date: _____

Please keep this form for future reference. This form exists in two copies.

Appendix 9

Frequency and average tables/ HOT full data

GENERAL HEALTH AND LIFE SATISFACTION

			Total	(%)	by Gender				by Age group									
Question	Values	Labels			Male	(%)	Female	(%)	60 -64	(%)	65-69	(%)	70 - 74	(%)	75-79	(%)	80 or older	(%)
General Health	0 - 20	Poor	11	3,6%	3	2,4%	8	4,4%	2	2,0%	3	4,1%	1	1,9%	4	9,8 %	1	2,3%
	21 - 40	Quite poor	48	15,5%	20	15,7%	28	15,4%	13	13,3%	12	16,2%	6	11,3%	8	19,5 %	9	20,9%
	41 - 60	Fair	151	48,9%	62	48,8%	89	48,9%	49	50,0%	32	43,2%	27	50,9%	19	46,3 %	24	55,8%
	61 - 80	Quite good	66	21,4%	28	22,0%	38	20,9%	23	23,5%	15	20,3%	11	20,8%	8	19,5 %	9	20,9%
	81 - 100	Good	33	10,7%	14	11,0%	19	10,4%	11	11,2%	12	16,2%	8	15,1%	2	4,9 %	0	0,0%
Total			309	100,0%	127	100,0%	182	100,0%	98	100,0%	74	100,0%	53	100,0%	41	100,0 %	43	100,0%
Life satisfaction	0 - 20	Poor	15	4,9%	6	4,7%	9	4,9%	3	3,1%	5	6,8%	1	1,9%	3	7,3 %	3	7,0%
	21 - 40	Quite poor	25	8,1%	15	11,8%	10	5,5%	6	6,1%	5	6,8%	5	9,4%	3	7,3 %	6	14,0%
	41 - 60	Fair	122	39,5%	51	40,2%	71	39,0%	34	34,7%	30	40,5%	22	41,5%	16	39,0 %	20	46,5%
	61 - 80	Quite good	81	26,2%	32	25,2%	49	26,9%	29	29,6%	13	17,6%	14	26,4%	15	36,6 %	10	23,3%
	81 - 100	Good	66	21,4%	23	18,1%	43	23,6%	26	26,5%	21	28,4%	11	20,8%	4	9,8 %	4	9,3%
Total			309	100,0%	127	100,0%	182	100,0%	98	100,0%	74	100,0%	53	100,0%	41	100,0 %	43	100,0%

FUNCTIONALITY

			Total	(%)	by Gender				by Age group									
Question	Values	Labels			Male	(%)	Female	(%)	60 -64	(%)	65-69	(%)	70 - 74	(%)	75-79	(%)	80 or older	(%)
Functionality dailyand/or social activities	0 - 20	Low	13	4,2%	3	2,4%	10	5,5%	0	0,0%	3	4,1%	0	0,0%	4	9,8 %	6	14,0%
	21 - 40	Quite low	20	6,5%	7	5,5%	13	7,1%	2	2,0%	6	8,1%	4	7,5%	4	9,8 %	4	9,3%
	41 - 60	Moderate	89	28,8%	35	27,6%	54	29,7%	27	27,6%	21	28,4%	14	26,4%	13	31,7 %	14	32,6%
	61 - 80	Quite high	93	30,1%	40	31,5%	53	29,1%	27	27,6%	18	24,3%	21	39,6%	14	34,1 %	13	30,2%
	81 - 100	High	94	30,4%	42	33,1%	52	28,6%	42	42,9%	26	35,1%	14	26,4%	6	14,6 %	6	14,0%
Total			309	100,0%	127	100,0%	182	100,0%	98	100,0%	74	100,0%	53	100,0%	41	100,0 %	43	100,0%
Functionality work activities	0 - 20	Low	19	6,1%	9	7,1%	10	5,5%	1	1,0%	1	1,4%	2	3,8 %	5	12,2 %	10	23,3%
	21 - 40	Quite low	30	9,7%	11	8,7%	19	10,4%	3	3,1%	7	9,5%	6	11,3 %	10	24,4 %	4	9,3%
	41 - 60	Moderate	90	29,1%	28	22,0%	62	34,1%	25	25,5%	25	33,8%	16	30,2 %	8	19,5 %	16	37,2%
	61 - 80	Quite high	85	27,5%	42	33,1%	43	23,6%	30	30,6%	16	21,6%	15	28,3 %	13	31,7 %	11	25,6%
	81 - 100	High	85	27,5%	37	29,1%	48	26,4%	39	39,8%	25	33,8%	14	26,4 %	5	12,2 %	2	4,7%
Total			309	100,0%	127	100,0%	182	100,0%	98	100,0%	74	100,0%	53	100,0 %	41	100,0 %	43	100,0%

Mobility	0 - 20	Low	20	6,5%	6	4,7%	14	7,7%	1	1,0%	4	5,4%	2	3,8 %	5	12,2 %	8	18,6%
	21 - 40	Quite low	29	9,4%	18	14,2%	11	6,0%	3	3,1%	9	12,2%	4	7,5 %	6	14,6 %	7	16,3%
	41 - 60	Moderate	76	24,6%	28	22,0%	48	26,4%	18	18,4%	19	25,7%	13	24,5 %	12	29,3 %	14	32,6%
	61 - 80	Quite high	86	27,8%	35	27,6%	51	28,0%	31	31,6%	16	21,6%	20	37,7 %	10	24,4 %	9	20,9%
	81 - 100	High	98	31,7%	40	31,5%	58	31,9%	45	45,9%	26	35,1%	14	26,4 %	8	19,5 %	5	11,6%
Total			309	100,0%	127	100,0%	182	100,0%	98	100,0%	74	100,0%	53	100,0 %	41	100,0 %	43	100,0%

DEPENDENCY/SUPPORT NEEDS

Question	Values	Labels	Total	(%)	by Gender				by Age group									
					Male	(%)	Female	(%)	60 -64	(%)	65-69	(%)	70 - 74	(%)	75-79	(%)	80 or older	(%)
Support needs for dailyand/or social activities	0 - 20	High	26	8,4%	12	9,4%	14	7,7%	5	5,1%	7	9,5%	1	1,9%	5	12,2 %	8	18,6%
	21 - 40	Quite high	33	10,7%	16	12,6%	17	9,3%	13	13,3%	3	4,1%	5	9,4%	7	17,1 %	5	11,6%
	41 - 60	Moderate	104	33,7%	40	31,5%	64	35,2%	33	33,7%	26	35,1%	17	32,1%	13	31,7 %	15	34,9%
	61 - 80	Quite low	96	31,1%	37	29,1%	59	32,4%	27	27,6%	26	35,1%	22	41,5%	12	29,3 %	9	20,9%
	81 - 100	Low	50	16,2%	22	17,3%	28	15,4%	20	20,4%	12	16,2%	8	15,1%	4	9,8 %	6	14,0%
Total			309	100,0%	127	100,0%	182	100,0%	98	100,0%	74	100,0%	53	100,0 %	41	100,0 %	43	100,0%
Support needs for work activities	0 - 20	High	32	10,4%	16	12,6%	16	8,8%	8	8,2%	6	8,1%	4	7,5 %	7	17,1 %	7	16,3%
	21 - 40	Quite high	44	14,2%	18	14,2%	26	14,3%	13	13,3%	3	4,1%	9	17,0 %	10	24,4 %	9	20,9%
	41 - 60	Moderate	107	34,6%	42	33,1%	65	35,7%	32	32,7%	27	36,5%	18	34,0 %	13	31,7 %	17	39,5%
	61 - 80	Quite low	77	24,9%	34	26,8%	43	23,6%	26	26,5%	24	32,4%	13	24,5 %	8	19,5 %	6	14,0%
	81 - 100	Low	46	14,9%	17	13,4%	29	15,9%	18	18,4%	13	17,6%	9	17,0 %	2	4,9 %	4	9,3%
	Empty		3	1,0%	0	0,0%	3	1,6%	1	1,0%	1	1,4%	0	0,0 %	1	2,4 %	0	0,0%
Total			309	100,0%	127	100,0%	182	100,0%	98	100,0%	74	100,0%	53	100,0 %	41	100,0 %	43	100,0%
Ability to get support when needingit	0 - 20	Low	17	5,5%	8	6,3%	9	4,9%	4	4,1%	4	5,4%	2	3,8 %	5	12,2 %	2	4,7%
	21 - 40	Quite low	23	7,4%	12	9,4%	11	6,0%	5	5,1%	6	8,1%	3	5,7 %	5	12,2 %	4	9,3%
	41 - 60	Moderate	130	42,1%	50	39,4%	80	44,0%	38	38,8%	35	47,3%	24	45,3 %	16	39,0 %	17	39,5%
	61 - 80	Quite high	91	29,4%	41	32,3%	50	27,5%	35	35,7%	18	24,3%	16	30,2 %	10	24,4 %	12	27,9%
	81 - 100	High	48	15,5%	16	12,6%	32	17,6%	16	16,3%	11	14,9%	8	15,1 %	5	12,2 %	8	18,6%
Total			309	100,0%	127	100,0%	182	100,0%	98	100,0%	74	100,0%	53	100,0 %	41	100,0 %	43	100,0%

HEALTH SERVICES RESPONSE

			Total	(%)	by Gender				by Age group									
Question	Values	Labels			Male	(%)	Female	(%)	60 -64	(%)	65-69	(%)	70 - 74	(%)	75-79	(%)	80 or older	(%)
Access to health services	0 - 20	Difficult	30	9,7%	17	13,4%	13	7,1%	5	5,1%	8	10,8%	3	5,7%	6	14,6 %	8	18,6%
	21 - 40	Quite difficult	41	13,3%	16	12,6%	25	13,7%	16	16,3%	9	12,2%	4	7,5%	7	17,1 %	5	11,6%
	41 - 60	Somewhat difficult/easy	121	39,2%	49	38,6%	72	39,6%	33	33,7%	30	40,5%	28	52,8%	15	36,6 %	15	34,9%
	61 - 80	Quite easy	70	22,7%	32	25,2%	38	20,9%	26	26,5%	17	23,0%	9	17,0%	9	22,0 %	9	20,9%
	81 - 100	Easy	47	15,2%	13	10,2%	34	18,7%	18	18,4%	10	13,5%	9	17,0%	4	9,8 %	6	14,0%
Total			309	100,0%	127	100,0%	182	100,0%	98	100,0%	74	100,0%	53	100,0%	41	100,0 %	43	100,0%
Quality of health services	0 - 20	Poor	24	7,8%	9	7,1%	15	8,2%	3	3,1%	8	10,8%	2	3,8 %	7	17,1 %	4	9,3%
	21 - 40	Quite poor	29	9,4%	9	7,1%	20	11,0%	11	11,2%	7	9,5%	4	7,5 %	1	2,4 %	6	14,0%
	41 - 60	Fair	121	39,2%	55	43,3%	66	36,3%	42	42,9%	23	31,1%	23	43,4 %	19	46,3 %	14	32,6%
	61 - 80	Quite good	70	22,7%	35	27,6%	35	19,2%	22	22,4%	15	20,3%	16	30,2 %	9	22,0 %	8	18,6%
	81 - 100	Good	65	21,0%	19	15,0%	46	25,3%	20	20,4%	21	28,4%	8	15,1 %	5	12,2 %	11	25,6%
Total			309	100,0%	127	100,0%	182	100,0%	98	100,0%	74	100,0%	53	100,0 %	41	100,0 %	43	100,0%
Affordability of health services	0 - 20	Not affordable	30	9,7%	13	10,2%	17	9,3%	7	7,1%	8	10,8%	2	3,8 %	6	14,6 %	7	16,3%
	21 - 40	Barely affordable	46	14,9%	19	15,0%	27	14,8%	13	13,3%	11	14,9%	7	13,2 %	9	22,0 %	6	14,0%
	41 - 60	More or less	103	33,3%	41	32,3%	62	34,1%	30	30,6%	23	31,1%	23	43,4 %	14	34,1 %	13	30,2%
	61 - 80	Quite affordable	73	23,6%	31	24,4%	42	23,1%	25	25,5%	19	25,7%	14	26,4 %	6	14,6 %	9	20,9%
	81 - 100	Affordable	57	18,4%	23	18,1%	34	18,7%	23	23,5%	13	17,6%	7	13,2 %	6	14,6 %	8	18,6%
Total			309	100,0%	127	100,0%	182	100,0%	98	100,0%	74	100,0%	53	100,0 %	41	100,0 %	43	100,0%

SELF-CARE

			Total	(%)	by Gender				by Age group									
Question	Values	Labels			Male	(%)	Female	(%)	60 -64	(%)	65-69	(%)	70 - 74	(%)	75-79	(%)	80 or older	(%)
Self-care	0 - 20	Low	7	2,3%	3	2,4%	4	2,2%	0	0,0%	0	0,0%	0	0,0%	4	9,8 %	3	7,0%
	21 - 40	Quite low	10	3,2%	6	4,7%	4	2,2%	2	2,0%	6	8,1%	1	1,9%	1	2,4 %	0	0,0%
	41 - 60	Moderate	51	16,5%	17	13,4%	34	18,7%	11	11,2%	15	20,3%	9	17,0%	8	19,5 %	8	18,6%
	61 - 80	Quite high	81	26,2%	35	27,6%	46	25,3%	23	23,5%	15	20,3%	18	34,0%	13	31,7 %	12	27,9%
	81 - 100	High	160	51,8%	66	52,0%	94	51,6%	62	63,3%	38	51,4%	25	47,2%	15	36,6 %	20	46,5%
Total			309	100,0%	127	100,0%	182	100,0%	98	100,0%	74	100,0%	53	100,0%	41	100,0 %	43	100,0%

AVERAGES/MAIN HOT INDICATORS

Group	Question	Total Average	Standard deviation	Average by Gender		Average by age group				
				Male	Female	60-64	65-69	70 - 74	75-79	80 or older
General health and life satisfaction	General health	56,3	19,0	56,9	56,0	58,3	58,2	58,8	49,7	52,0
	Life satisfaction	62,8	21,7	60,7	64,2	66,6	63,5	64,2	57,8	55,9
Functionality	Social and/or daily activities	68,3	22,6	70,5	66,7	76,1	68,1	70,4	59,2	56,6
	Work activities	64,8	24,2	66,0	63,9	73,8	67,8	65,5	55,0	47,7
	Mobility	66,3	24,3	65,9	66,5	76,9	66,4	67,7	55,4	50,2
Dependency/ support needs	Social and/or daily activities	60,4	23,5	59,6	61,0	62,2	62,1	64,6	54,5	53,9
	Work activities	57,1	24,5	55,5	58,2	60,6	62,6	58,7	48,2	46,2
	Ability to get support	61,8	21,7	60,2	62,8	64,2	60,1	63,2	55,9	63,1
Health services response	Access to health services	55,9	24,0	52,6	58,2	59,3	55,9	58,2	49,7	51,3
	Quality of health services	60,9	24,5	59,6	61,8	63,2	61,5	61,6	53,9	60,2
	Affordability of health services	58,5	24,3	58,3	58,7	63,1	57,9	59,1	51,6	55,1
Self-care	Extent of self-care	79,2	21,4	79,5	79,0	85,0	78,2	79,3	70,6	75,9

Appendix 10

A selection of HOT findings from Quezon Province (N=153)

Figure a. Basic needs fulfilment in Atimonan (N=78).

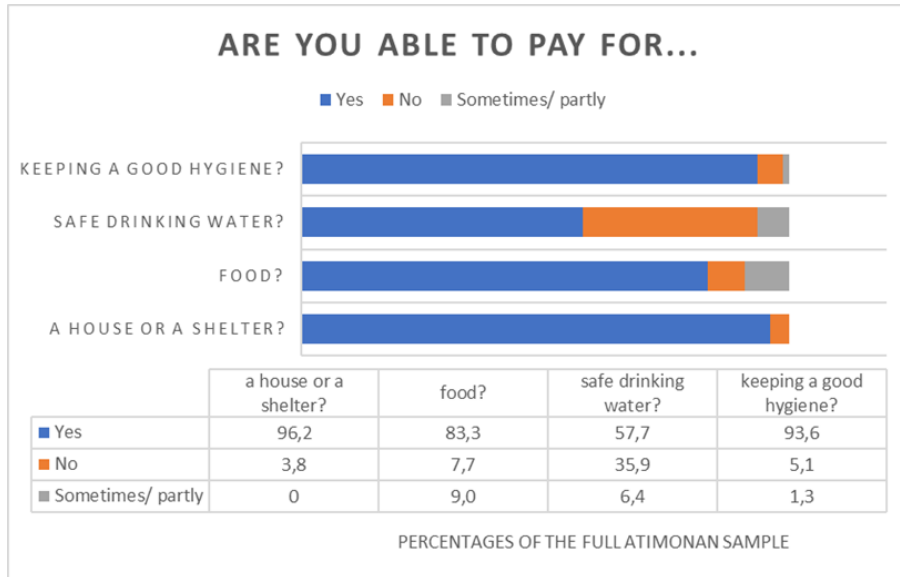


Figure b. Basic needs fulfilment in Pagbilao (N=75).

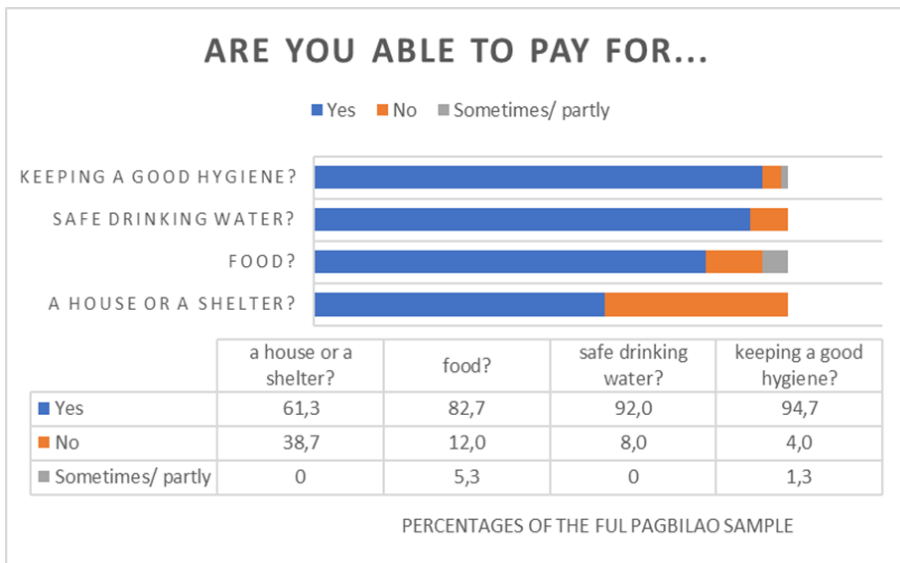


Figure c. Self-perceived poverty in Atimonan and Pagbilao.

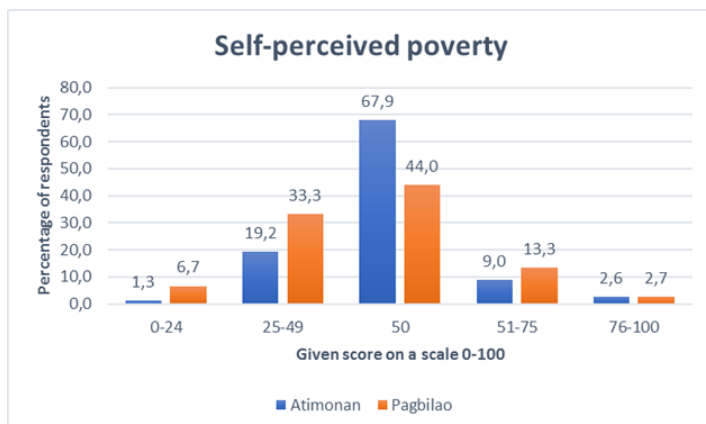


Figure d. Self-perceived health status and life satisfaction by barangay.

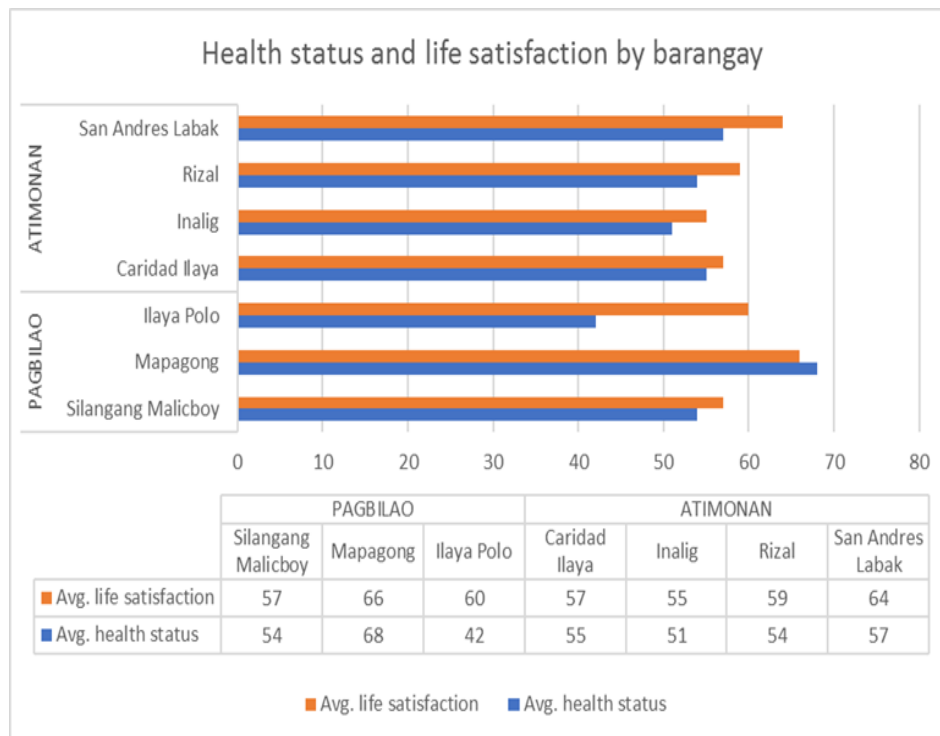
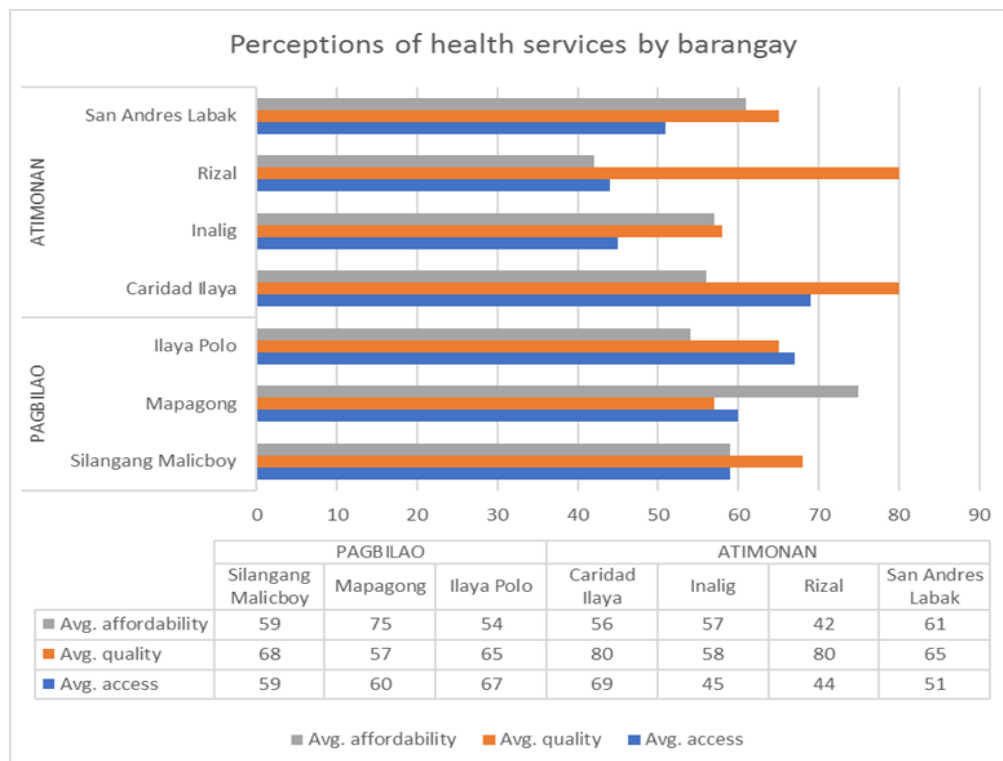


Figure e. Perceptions of health services response by barangay/municipality.



Appendix 11

A selection of HOT findings from Metro Manila (N=156)

Figure a. Basic needs fulfilment in San Juan City (N=75).

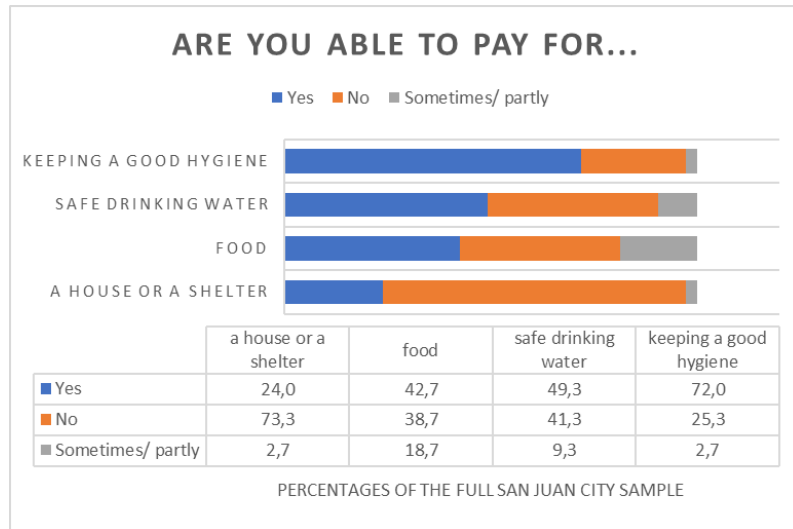


Figure b. Basic needs fulfilment in Quezon City (N=81).

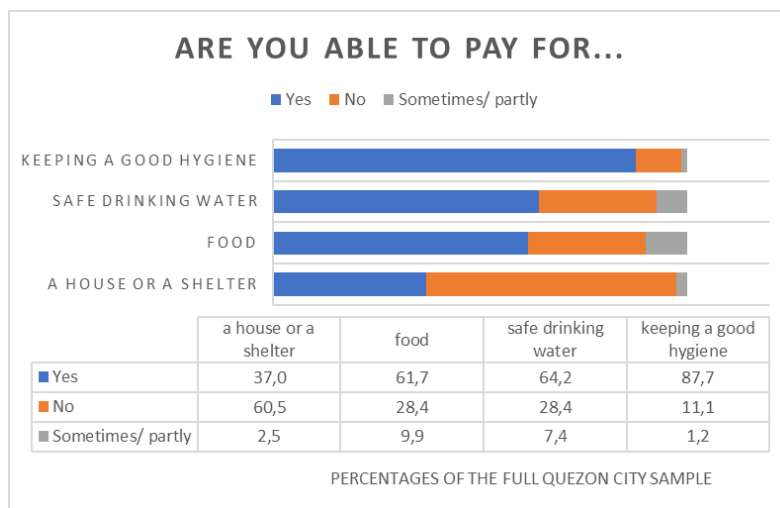


Figure c. Self-perceived poverty in San Juan and Quezon Cities.

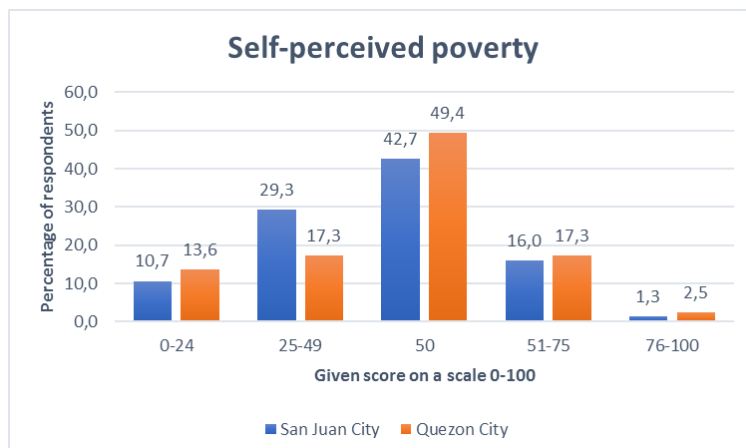


Figure d. Self-perceived health status and life satisfaction by barangay.

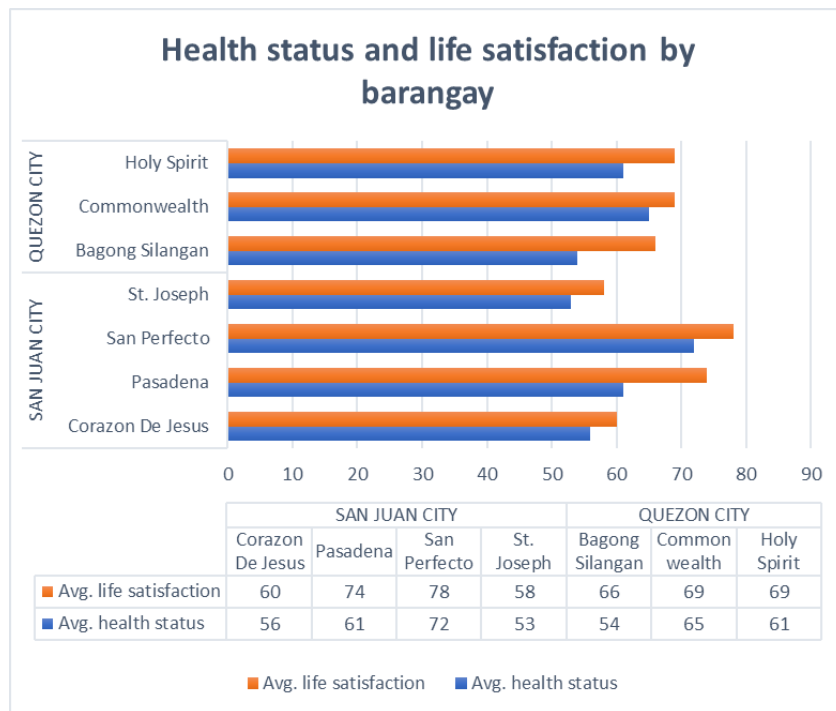
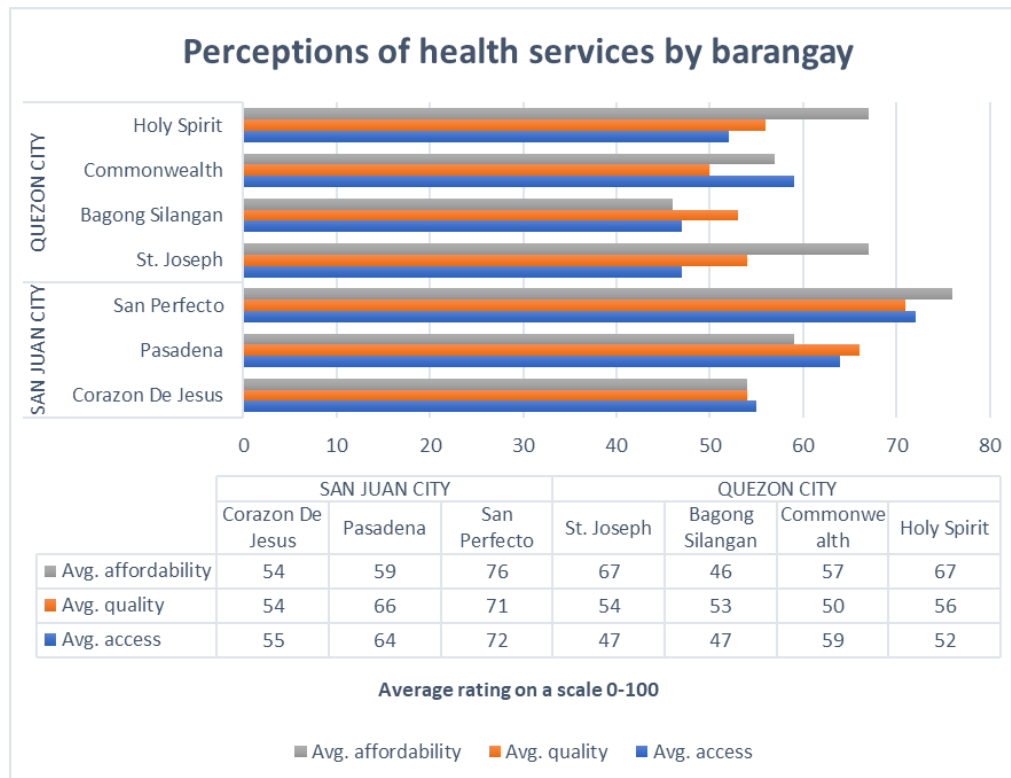


Figure e. Perceptions of health services response by barangay/municipality



Appendix 12

Correlations (Spearman's rho) in full HOT data (N=309)

		Correlations														
			healthstatus_ bl	lifesatisfactio n_bl	age_bl	compare_pov erty_bl	func_dailyact _bl	func_workact _bl	mobility_bl	supportneed_ socialdaily_bl	supporteeded _work_bl	supportprovid ed_bl	accesshealth care_bl	quality_bl	afford_bl	selfcareextent _bl
Spearman's rho	healthstatus_bl	Correlation Coefficient	1,000	,480**	-,136*	,296**	,497**	,476**	,485**	,292**	,231**	,219**	,302**	,154**	,353**	,380**
		Sig. (2-tailed)	.	,000	,017	,000	,000	,000	,000	,000	,000	,000	,000	,007	,000	,000
		N	309	309	309	309	309	309	309	309	306	309	309	309	309	309
	lifesatisfaction_bl	Correlation Coefficient	,480**	1,000	-,190**	,265**	,502**	,472**	,428**	,306**	,264**	,329**	,297**	,199**	,347**	,380**
		Sig. (2-tailed)	,000	.	,001	,000	,000	,000	,000	,000	,000	,000	,000	,000	,000	,000
		N	309	309	309	309	309	309	309	309	306	309	309	309	309	309
	age_bl	Correlation Coefficient	-,136*	-,190**	1,000	-,097	-,303**	-,345**	-,375**	-,115*	-,202**	-,043	-,098	-,073	-,135*	-,197**
		Sig. (2-tailed)	,017	,001	.	,090	,000	,000	,000	,044	,000	,457	,085	,199	,018	,000
		N	309	309	309	309	309	309	309	309	306	309	309	309	309	309
	compare_poverty_bl	Correlation Coefficient	,296**	,265**	-,097	1,000	,184**	,224**	,195**	,186**	,162**	,226**	,205**	,045	,226**	,092
		Sig. (2-tailed)	,000	,000	,090	.	,001	,000	,001	,001	,004	,000	,000	,427	,000	,107
		N	309	309	309	309	309	309	309	309	306	309	309	309	309	309
	func_dailyact_bl	Correlation Coefficient	,497**	,502**	-,303**	,184**	1,000	,793**	,745**	,413**	,347**	,302**	,295**	,269**	,380**	,448**
		Sig. (2-tailed)	,000	,000	,000	,001	.	,000	,000	,000	,000	,000	,000	,000	,000	,000
		N	309	309	309	309	309	309	309	309	306	309	309	309	309	309
	func_workact_bl	Correlation Coefficient	,476**	,472**	-,345**	,224**	,793**	1,000	,712**	,391**	,406**	,256**	,298**	,242**	,299**	,414**
		Sig. (2-tailed)	,000	,000	,000	,000	,000	.	,000	,000	,000	,000	,000	,000	,000	,000
		N	309	309	309	309	309	309	309	309	306	309	309	309	309	309
	mobility_bl	Correlation Coefficient	,485**	,428**	-,375**	,195**	,745**	,712**	1,000	,360**	,337**	,293**	,311**	,281**	,359**	,451**
		Sig. (2-tailed)	,000	,000	,000	,001	,000	,000	.	,000	,000	,000	,000	,000	,000	,000
		N	309	309	309	309	309	309	309	309	306	309	309	309	309	309
	supportneed_socialdaily_bl	Correlation Coefficient	,292**	,306**	-,115*	,186**	,413**	,391**	,360**	1,000	,675**	,319**	,226**	,216**	,230**	,294**
		Sig. (2-tailed)	,000	,000	,044	,001	,000	,000	,000	.	,000	,000	,000	,000	,000	,000
		N	309	309	309	309	309	309	309	309	306	309	309	309	309	309
	supporteeded_work_bl	Correlation Coefficient	,231**	,264**	-,202**	,162**	,347**	,406**	,337**	,675**	1,000	,284**	,227**	,196**	,211**	,303**
		Sig. (2-tailed)	,000	,000	,000	,004	,000	,000	,000	,000	.	,000	,000	,001	,000	,000
		N	306	306	306	306	306	306	306	306	306	306	306	306	306	306
	supportprovided_bl	Correlation Coefficient	,219**	,329**	-,043	,226**	,302**	,256**	,293**	,319**	,284**	1,000	,302**	,303**	,331**	,297**
		Sig. (2-tailed)	,000	,000	,457	,000	,000	,000	,000	,000	,000	.	,000	,000	,000	,000
		N	309	309	309	309	309	309	309	309	306	309	309	309	309	309
	accesshealthcare_bl	Correlation Coefficient	,302**	,297**	-,098	,205**	,295**	,298**	,311**	,226**	,227**	,302**	1,000	,435**	,304**	,343**
		Sig. (2-tailed)	,000	,000	,085	,000	,000	,000	,000	,000	,000	,000	.	,000	,000	,000
		N	309	309	309	309	309	309	309	309	306	309	309	309	309	309
	quality_bl	Correlation Coefficient	,154**	,199**	-,073	,045	,269**	,242**	,281**	,216**	,196**	,303**	,435**	1,000	,218**	,341**
		Sig. (2-tailed)	,007	,000	,199	,427	,000	,000	,000	,000	,001	,000	,000	.	,000	,000
		N	309	309	309	309	309	309	309	309	306	309	309	309	309	309
	afford_bl	Correlation Coefficient	,353**	,347**	-,135*	,226**	,380**	,299**	,359**	,230**	,211**	,331**	,304**	,218**	1,000	,417**
		Sig. (2-tailed)	,000	,000	,018	,000	,000	,000	,000	,000	,000	,000	,000	.	.	,000
		N	309	309	309	309	309	309	309	309	306	309	309	309	309	309
	selfcareextent_bl	Correlation Coefficient	,380**	,380**	-,197**	,092	,448**	,414**	,451**	,294**	,303**	,297**	,343**	,341**	,417**	1,000
		Sig. (2-tailed)	,000	,000	,000	,107	,000	,000	,000	,000	,000	,000	,000	,000	,000	.
		N	309	309	309	309	309	309	309	309	306	309	309	309	309	309

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Appendix 13

Statistically significant differences between respondent sub-groups in HOT data

Differences by community health programme beneficiary status

A non-parametric Mann-Whitney U test was run to determine if differences in the medians of the key indicator scores between COSE beneficiaries and non-beneficiaries in the urban area were statistically significant. The medians were higher among COSE beneficiaries for health, life satisfaction and functionality (daily/social and work) indicators as the below SPSS table shows:

Report ^a				
Median				
cosebeneficiary	healthstatus_bl	lifesatisfaction_bl	func_dailyact_bl	func_workact_bl
no	50,00	60,00	70,00	60,00
yes	60,00	75,00	75,00	75,00
Total	55,00	65,00	75,00	70,00
a. location_bl = urban				

Distributions of the health, life satisfaction and functionality scores for beneficiaries and non-beneficiaries were similar, as assessed by visual inspection. Median health status score was statistically significantly higher in COSE beneficiaries (60,00) than in non-beneficiaries (50,00), $U = 3589,5$, $z = -1,971$, $p = ,049$ that is less than $p < ,05$, rejecting thus the null hypothesis “*the distribution of healthstatus_bl is the same across categories of cosebeneficiary*”. Moreover, the null hypothesis regarding life satisfaction was rejected on the basis that the median life satisfaction score of COSE beneficiaries (75,00) was statistically significantly higher as opposed to the non-beneficiaries’ median score (60,00), $U = 3676,5$, $z = 2,269$, $p = ,023$. The statistical significances ($p = ,049$ and $p = ,023$) indicate that there is indeed a statistically significant difference in median health and life satisfaction scores between COSE beneficiaries and non-beneficiaries in the data. Similarly, COSE beneficiaries’ median scores for functionality for daily and/or social activities (75,00) was statistically significantly higher than that of the non-beneficiaries (70,00), $U = 3751$, $z = 2,527$, $p = ,012$, as was their median for functionality for work activities (75,00), compared to that of the non-beneficiaries (60,00), $U = 3830$, $z = 2,806$, $p = ,005$.

Differences by gender

A Mann-Whitney U test was also run to determine if there are statistically significant differences in the median scores in any of the HOT tool indicators between males and females.

Despite the differences in median scores e.g. in life satisfaction, as pictured on the right, the median life satisfaction score was not statistically significantly different between males (55,00) and females (65,00), $U = 12716$, $z = 1,516$, $p = ,130$. No statistically significant differences existed in the medians of scores in any of the other survey variables either on a significance level of ,05. Hence, in this data set gender cannot be treated as an indicator explaining health and life satisfaction differences/inequalities.

Report		
Median		
gender_bl	healthstatus_bl	lifesatisfaction_bl
male	50,00	55,00
female	50,00	65,00
Total	50,00	60,00

Differences by location (urban/rural)

Report			
Median			
location_bl	healthstatus_bl	lifesatisfaction_bl	quality_bl
rural	50,00	55,00	70,00
urban	55,00	65,00	50,00
Total	50,00	60,00	60,00

A Mann-Whitney U test procedure examining the effect of location (urban/rural) revealed that there are statistically significant differences in the median scores between local and urban dwellers on several key indicators.

Median health status score was statistically significantly different between rural (50,00) and urban (55,00) dwellers, $U = 13628$, $z = 2,187$, p

$= ,029$. For life satisfaction, the median scores (55,00 for rural, 65,00 for urban) were also statistically significantly different, $U=14081,5$, $z= 2,764$, $p= ,006$. Additionally, there is statistical significance, $U= 8760,5$, $z= -4,079$, $0= ,000$ in the differences between the median scores for quality of services between rural (70,00) and urban (50,00) respondents. In summary, on the significance level of ,05 it can be argued that urban respondents scored statistically significantly higher in health and life satisfaction yet gave lower scores for quality of services compared to the rural respondents.

Appendix 14

FGDs/institutional diagrams: barangay level results

Atimonan, Quezon province (Barangay Santa Catalina)

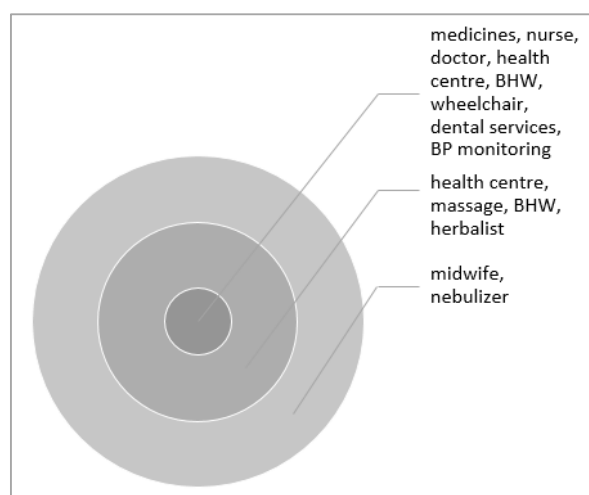
- 7 women, average age 70
- Area highly rural, distance to municipal centre 15 km

List of identified health services:

Health services	Care providers
Health centre	Nurse
Medicines	BHW (barangay health volunteers)
BP monitoring	Nutrition scholar
Nebulizer (asthma)	Midwife
Massage (local hilot)	Herbolario/herbalist
	Masseurs

The participants identified the health services and care providers pictured on the left when asked what are available to them. The list represents the participants' own understanding of categories of services and care providers. The facilitator paid attention to the absence of doctors on the list and when asked, the participants clarified that doctor's services are currently not available to them [in the barangay health centre]. When asked to select the services

from the list that are most important to them, the participants decided to use the opportunity to highlight services that they feel are highly needed in their community but are currently not available.



Most important (number of mentions >1):

Medicines (6/7), nurse (5/7), doctor, health centre, BHW, wheelchair (all 4/7), dental services (2/7), BP monitoring (2/7)

Somewhat important (number of mentions >1):

Health centre (3/7), massage (3/7), BHW (2/7), herbolario/herbalist (2/7)

Not important (number of mentions >1):

Midwife (6/7), nebulizer (4/7)

None of the participants had mobility/functionality issues that would require a wheelchair; it is clear that they considered the needs of their community rather than just reflecting their own. The group was the only one identifying herbolario/herbalist as a health care provider and massage (local hilot) as a health service yet they expressed that modern medicine and doctor's services are also necessary. PhilHealth was not identified as part of the exercise nor discussed by any of the participants. This might reflect both the lack of knowledge of the entitlements provided by PhilHealth and/or the lack of PhilHealth accredited services in the area, located 15 km from the municipal centre in a rural area. Unmet needs identified in the discussion included the unavailability of doctors, incomplete facilities of and lack of medicines in the health centre as well as the following services available currently only in private clinics: ultrasound, BP apparatus, x-ray, laboratory and EGD for heart assessment and blood monitoring.

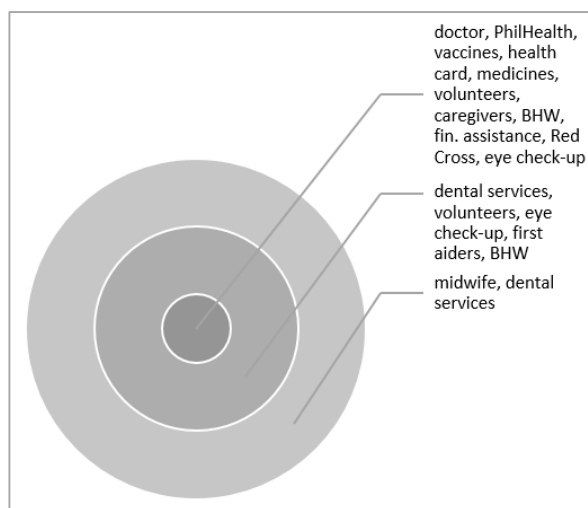
San Juan, Metro Manila (Barangay Pasadena)

- 7 women, average age 72
- Highly urban, located near the border of Quezon City

List of identified health services:

Health services	Care providers
Vaccines (flu & pneumonia)	Doctors
Free (maintenance) medicines/vitamins	Nurse
Dental services	Midwife
Eye check-up	BHW (barangay health volunteers)
Hypertension test/BP monitoring/FBs	(Community health) volunteers
Health card	Dentist
Financial assistance (3000 PHP)	Caregiver
PhilHealth	Firstaider (Red Cross)

The participants identified the health services and care providers pictured on the left when asked what are available to them. The list represents the participants' own understanding of categories of services and care providers. All the services identified are available to the focus group participants.



Most important (number of mentions >1):

Doctors (7/7), PhilHealth (5/7), vaccines (5/7), health card, free medicines (both 4/7), community health volunteers, caregivers (both 3/7), BHW, financial assistance, Red Cross, eye check-up (all 2/7)

Somewhat important (number of mentions >1):

Dentist/dental services (5/7), community health volunteers (3/7), eye check-up (3/7), first aiders, BHW (2/7)

Not important (number of mentions >1):

Midwife (6/7), dentist/dental services (3/7)

Health card and financial assistance refers here to municipal services only available to the residents of San Juan City. Municipal health card provides its owner free doctor's consultation and hospitalisation. Additionally, a one-time financial assistance of 3000 PHP is provided by the municipality to a resident's family confined in a hospital. The participants expressed that the services placed in the centre of the diagram are important to them because they have good medical equipment and complete medication. Free or affordable services were valued the most, including PhilHealth and the municipal health card. However, currently unmet expressed needs included the unavailability of a gerontologist/gerontological clinic. The barangay used to have COSE-trained community health gerontologists available but not anymore. Another unmet need was related to the unavailability of certain types of medication as well as regular doctors in the health centre. Interestingly, 5/6 mentions of vaccines as 'most important' or even 'somewhat important' service came from the Pasadena, San Juan group. This might reflect the better availability of health services in Pasadena and San Juan compared to other barangays/municipalities. San Juan is a rich municipality and its location provides its residents a good availability of both public and private health services.

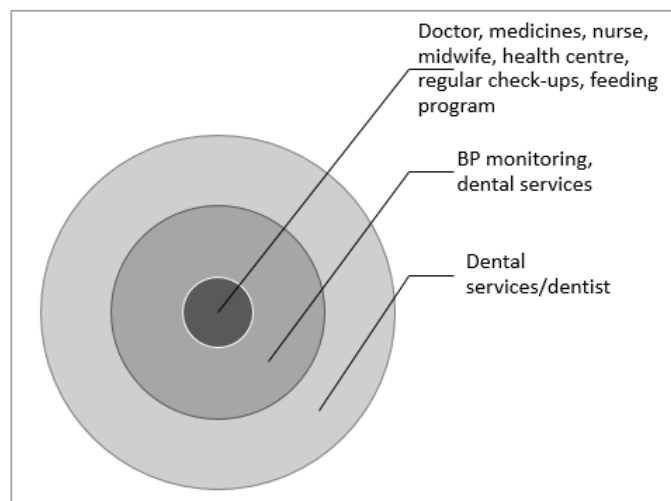
Quezon City, Metro Manila (Barangay Bagong Silangan)

- 6 men, average age 72
- Mostly urban, ¼ farmland, near the border of San Mateo

List of identified health services:

Health services	Care providers
BP monitoring	BHW house visits
Eye check-up	Doctor (irregular)
TB DOT (tuberculosis treatment)	Nurse
BHW house visits	Midwife
Feeding program	
Dental services	
Health centre	
Botika Binhi	
Medical Mission	

The participants identified the health services and care providers pictured on the left when asked what are available to them. The list represents the participants' own understanding of categories of services and care providers. All the services identified are available to the participants.



Most important (number of mentions >1):

Doctor (5/6), availability of medicines (3 + 1 mention of Botika Binhi), nurse, midwife, health centre (all 3/6), regular check-ups and feeding program (both 2/6)

Somewhat important (number of mentions >1):

BP monitoring (2/6), dental services (2/6)

Not important (number of mentions >1):

Dental services/dentist (2/6)

Feeding program identified by the participants may refer both to barangay- or NGO-based health programs that are not, however, a continuous service for older people. The barangay has, due to its location, been prone to natural catastrophes such as monsoon rains, which has created a demand for such programs. The participants expressed that doctors and nurses are most important to them as care providers but regular check-ups needed are not available in their community. The participants additionally mentioned community health volunteers and their services of monitoring health status of older persons as a valuable addition to public health services. Similarly to the previous group, the participants emphasised that doctors should have knowledge of gerontology. The unmet needs concerned the barangay health centre: the challenges the participants identified were lack of medicines and vaccines, irregularity of doctors, occurrence of political and other type of favouritism in supplying medicines to patients. These were named as reasons that sometimes force older persons in the community to use private health services instead of public. The participants expressed their appreciation towards Botika Binhi, the community pharmacy (COSE's program) for the cheap medicine prices. Services that the participants identified as highly needed in their community but not yet existing included vaccines for older persons as well as blood sugar testing.

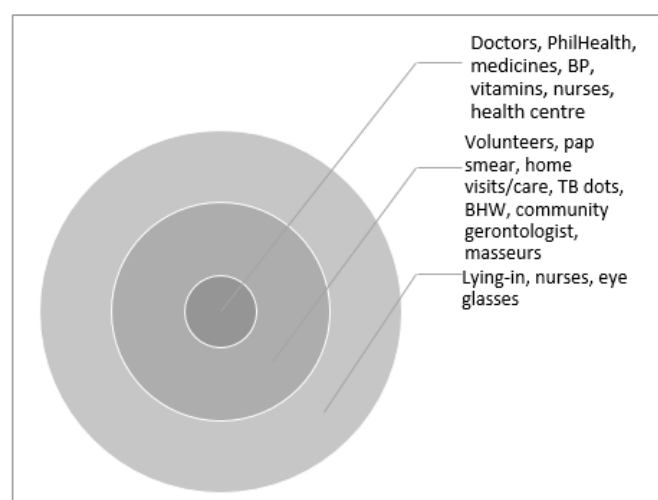
Quezon City, Metro Manila (Barangay Commonwealth)

- 7 women, average age 67
- Urban, largest of the barangays in Quezon City based on population, mostly residential

List of identified health services:

Health services	Care providers
Health centre	Doctors
Community volunteers	Nurses
BHW	Midwife
PhilHealth	Community health volunteers -homecare
Medical nursing	Community gerontologist
Homevisits - Ops	Community masseurs
Maintenance medicines/vitamins	
Vaccines	
Lying in	
TB Dots	
Dental	
Pap smear	
BP monitoring	
Free eyeglasses	
EGG	
Detox	
Ultrasound	
Operation cataract	

The participants identified the health services and care providers listed on the left when asked what are available to them. The list represents the participants' own understanding of categories of services and care providers. Compared to some other groups, the participants were able to name a longer list of health services.



Most important (number of mentions >1):

Doctor (7/7), PhilHealth and maintenance medicines (both 6/7), BP monitoring, vitamins, nurses, health centre (all 2/7)

Somewhat important (number of mentions >1):

Community health volunteers, pap smear, home visits/care (all 3/7), TB dots, barangay health volunteers, community gerontologist and masseurs (all 2/7)

Not important (number of mentions >1):

Lying-in (3/7), nurses, eye glasses (both 2/7)

When asked why they had placed services in the centre of the diagram, the participants explained their high valuation of professional medical assistance (doctors) and free services (PhilHealth). Currently there is no doctor available in the barangay. Although community health volunteers were valued, the participants felt a doctor's assessment of a person's health is necessary before volunteers can be of assistance. Community gerontologist was, however, highly valued for monitoring BP and conducting home visits, which doctors do not do. The participants emphasised that all older people need regular BP monitoring. The unmet expectations and needs of the participants were related to the health centre, as in the previous groups, and included: unavailability of certain medicines and vaccines, doctors and regular check-ups and favouritism in provision of medicines. In addition, (community) health services that do not currently exist but the participants identified a need for, include: home BP apparatuses; blood, blood sugar and asthma testing and availability of vaccines, medicines and vitamins for all older people.

Appendix 15

Statistical tables of multiple regression analyses

Model 1. Coefficients

Coefficients ^a					
		Unstandardized Coefficients		Standardized Coefficients	
Model		B	Std. Error	Beta	t
1	(Constant)	14,483	9,836		1,472
	dup_agegroups	,793	,713	,060	1,112
	dup_chronicillness	-4,466	,992	-,230	-4,503
	gender_bl	-,346	1,774	-,009	-,195
	location_bl	1,701	2,617	,046	,650
	education_bl	,612	,721	,042	,849
	cosebeneficiary	3,115	2,594	,073	1,201
	basineeds_house_bl	-1,403	1,038	-,075	-1,352
	basicneeds_food_bl	1,248	1,445	,055	,863
	basicneed_water_bl	1,288	1,269	,062	1,015
	basicneed_hygien_bl	-,841	1,743	-,028	-,483
	compare_poverty_bl	,208	,066	,157	3,128
	peopleinh_number_bl	,802	,411	,098	1,952
	seeing_bl	,681	1,413	,024	,482
	hearing_bl	,421	1,550	,015	,271
	walking_bl	,950	1,380	,046	,688
	remembering_bl	-1,840	1,706	-,057	-1,078
	lifesatisfaction_bl	,126	,051	,144	2,456
	func_dailyact_bl	,009	,074	,011	,120
	func_workact_bl	,089	,068	,113	1,322
	mobility_bl	,120	,060	,154	1,995
	supportneed_socialdaily_bl	,025	,054	,031	,460
	supporteeded_work_bl	-,041	,052	-,053	-,788
	supportprovided_bl	-,082	,045	-,095	-1,802
	accesshealthcare_bl	,106	,044	,138	2,424
	quality_bl	-,073	,042	-,096	-1,738
	afford_bl	,085	,042	,111	2,046
	selfcareextent_bl	,116	,051	,129	2,280
	sitstand_bl	-,416	,900	-,028	-,462
	selfcareresponsibility_1_bl	-,872	2,015	-,021	-,433

a. Dependent Variable: healthstatus_bl

ANOVA ^a					
Model		Sum of Squares	df	Mean Square	F
1	Regression	48035,815	29	1656,407	8,216
	Residual	54430,782	270	201,595	
	Total	102466,597	299		

a. Dependent Variable: healthstatus_bl

b. Predictors: (Constant), sitstand_bl, cosebeneficiary, supportprovided_bl, selfcareresponsibility_1_bl, peopleinh_number_bl, gender_bl, education_bl, seeing_bl, remembering_bl, compare_poverty_bl, dup_chronicillness, basicneed_water_bl, quality_bl, basineeds_house_bl, afford_bl, supporteeded_work_bl, dup_agegroups, hearing_bl, lifesatisfaction_bl, basicneed_hygien_bl, selfcareextent_bl, accesshealthcare_bl, basicneeds_food_bl, walking_bl, supportneed_socialdaily_bl, mobility_bl, location_bl, func_workact_bl, func_dailyact_bl

Model 2. Coefficients

Coefficients ^a						
		Unstandardized Coefficients		Standardized Coefficients		
Model		B	Std. Error	Beta	t	Sig.
1	(Constant)	14,206	4,695		3,026	,003
	dup_chronicillness	-4,196	,886	-,216	-4,735	,000
	peopleinhh_number_bl	,809	,366	,099	2,207	,028
	mobility_bl	,161	,042	,206	3,842	,000
	afford_bl	,089	,040	,115	2,203	,028
	selfcareextent_bl	,110	,048	,122	2,265	,024
	compare_poverty_bl	,215	,063	,162	3,414	,001
	accesshealthcare_bl	,076	,039	,099	1,919	,056
	supportprovided_bl	-,096	,043	-,111	-2,227	,027
	lifesatisfaction_bl	,183	,047	,210	3,933	,000

a. Dependent Variable: healthstatus_bl

b. Dependent Variable: healthstatus_bl

ANOVA ^a					
Model		Sum of Squares	df	Mean Square	F
2	Regression	44068,601	9	4896,511	24,157
	Residual	59389,841	293	202,696	
	Total	103458,442	302		

a. Dependent Variable: healthstatus_bl

b. Predictors: (Constant), selfcareextent_bl, peopleinhh_number_bl, dup_chronicillness, compare_poverty_bl, supportprovided_bl, accesshealthcare_bl, afford_bl, lifesatisfaction_bl, mobility_bl